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**SUPERIOR COURT OF ARIZONA
COUNTY OF MARICOPA**

RAINER W. G. GRUESSNER, M.D., an
individual,

Plaintiff,

v.

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
nonprofit corporation; UNIVERSITY
PHYSICIANS HEALTHCARE, an Arizona
nonprofit corporation; UNIVERSITY OF
ARIZONA MEDICAL CENTER, an
Arizona nonprofit corporation; MICHAEL
WALDRUM, an Arizona resident;
ANDREW COMRIE, An Arizona resident
and STEVEN GOLDSCHMID, an Arizona
resident.

Defendants.

Case No.

CV 2014-014301

COMPLAINT



COPY
DEC 03 2014
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K. LAVERY
DEPUTY CLERK

1 Plaintiff Rainer W.G. Gruessner, M.D., through counsel, seeks relief against the
2 above-captioned Defendants for claims of:

- 3 1. Breach of employment contract;
- 4 2. Breach of the implied covenant of good faith and fair dealing;
- 5 3. Intentional interference with contractual relationship;
- 6 4. Wrongful termination of employment (whistleblowing), A.R.S. § 23-
7 1501(A)(3)(c)(ii);
- 8 5. Defamation;
- 9 6. 42 U.S.C. § 1983 (federal constitutional right to due process);
- 10 7. 42 U.S.C. § 1983 (federal constitutional right to free speech);
- 11 8. Violation of Arizona constitutional right to due process (Ariz. Const. art.
12 2, sec. 4); and
- 13 9. Declaratory and injunctive relief for failure to pay wages, A.R.S. § 12-
14 1831 et seq., and A.R.S. § 23-350 et seq.

15 **PARTIES, JURISDICTION & VENUE**

16 1. Plaintiff Rainer W. G. Gruessner, M.D. ("Dr. Gruessner") is a resident of
17 the state of Arizona who is licensed as an Arizona physician.

18 2. Defendant Arizona Board of Regents ("ABOR") is, and has been at all
19 times material to this Complaint a political subdivision of the State of Arizona and a
20 body politic.

21 3. The ABOR owns, governs and operates the public universities of the State
22 of Arizona pursuant to A.R.S. §§ 15-1601, 15-1625, and 15-1626; this includes the
23 University of Arizona located in Tucson, Arizona, and the University of Arizona's
24 College of Medicine.

11. This Court has personal jurisdiction over the parties, and venue of this case is proper in Maricopa County pursuant to A.R.S. §§ 12-401(7), and A.R.S. 12-822.

GENERAL ALLEGATIONS

12. By this Complaint, Dr. Gruessner seeks compensatory and punitive damages and injunctive and equitable relief, including full clinical and administrative reinstatement in his previous position, for the damage inflicted upon him by the Defendants as a result of their actions below described; those actions include unlawfully suspending and then terminating him from his positions as COM faculty, surgeon, medical staff member, Surgical Director of the HepatoPancreaticoBiliary Program, Chief of Transplantation, and Chair of the Department of Surgery at the COM and UAMC.

13. The actions taken by Defendants were without cause, and in direct violation of the applicable internal policies of Defendants, and in violation of Dr. Gruessner's federal and state constitutional free speech and due process rights, as well as his contractual rights.

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

14. Dr. Gruessner is a world-renowned transplant and general surgeon. A true copy of his Curriculum Vitae is attached as Exhibit 1.

15. Dr. Gruessner has performed hundreds of transplant surgeries and has authored or coauthored approximately 600 scholarly publications, 80 book chapters, and two textbooks.

16. In late 2006, following a national search, Dr. Gruessner was recruited to move to Arizona and assume various positions with the COM and UPH; he was also offered full tenure, and promises were made to him involving his role for the next ten years, through June 30, 2016.

17. Dr. Gruessner agreed to accept the roles; he then signed a contract with UPH and COM and a true copy of that contract is attached as Exhibit 2.

1 18. Since starting work in early 2007, Dr. Gruessner has served for more than
2 six years as a Tenured Professor, Chief of Transplantation, and Chair of the Department
3 of Surgery at the COM and UAMC.

4 19. He is or has been jointly employed by the COM in an academic capacity
5 and by UPH, which employs medical practitioners at UAMC.

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

10 21. Dr. Gruessner has been a tremendous asset to the COM and UAMC,
11 causing its national reputation as a surgical and transplant hospital to rise dramatically,
12 along with a substantial increase in patient revenue income for the COM and UAMC.

13 22. At UAMC, Dr. Gruessner performed Arizona's first intestinal transplants,
14 the first multivisceral transplant, the first living donor liver transplant in a child, and the
15 first islet transplant.

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

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

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

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34. According to that Five Year review, Exhibit 4, 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."

36. But in sharp contrast, the 2013 Academic Program Review of the Department of Medicine, which was previously led by Dr. Goldschmid, determined that it was “an underperforming department . . . [that] lacks a clear identity and focus.”

38. The Academic Program Review, Exhibit 5, alleged 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.

40. The Department of Surgery's action plan was outlined in an agreement dated May 1, 2013.

1 41. A true copy of the Department of Surgery's May 1, 2013 action plan
2 agreement is attached as **Exhibit 6**.

3 42. The agreement required Dr. Gruessner to meet certain achievement levels
4 by July 1, 2013.

5 43. Dr. Gruessner achieved and exceeded all goals under his control as
6 required by that agreement well before July 1, 2013. The contract's deadline was
7 October 1, 2013.

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

9 44. In recent years there were disagreements and differences of opinion
10 between Dr. Goldschmid, now former Dean of the COM, and Dr. Gruessner.

11 45. Prior to becoming Dean of the COM, Dr. Goldschmid had been the Chair
12 of the COM's Department of Medicine.

13 46. As Chairman of the Department of Surgery, Dr. Gruessner has an intrinsic
14 interest in the direction of the medical school. The school's standing directly affects and
15 affected his ability to achieve the goals he had set for his department.

16 47. In December 2012, Dr. Gruessner was asked by members of the
17 University of Arizona's Committee of 11 (the "Committee of 11") to provide input
18 regarding ongoing concerns and the state of the COM under Dr. Goldschmid's
19 leadership.

20 48. The Committee of 11 is an official committee that evaluates and seeks
21 solutions to faculty problems within the University of Arizona; it is created pursuant to
22 the University of Arizona Faculty Constitution, Article V, Section 3.

23 49. In the supposedly confidential meeting, Dr. Gruessner disclosed to
24 members of the Committee of 11 that he was concerned about Dr. Goldschmid's
25 leadership of the COM.

1 50. In that meeting, Dr. Gruessner told how the College's NIH ranking had
2 not improved, grant funding to the COM was slumping, key faculty in the Cancer
3 Center and clinical departments had left and could not be replaced, and a climate of fear
4 and retaliation had been created under Dean Goldschmid which had resulted in low
5 morale among faculty and staff.

6 51. Problems with morale in the COM are now part of the public record after
7 a June 29, 2014 story in the *Arizona Star* entitled "Faculty survey gives UA College of
8 Medicine low marks."

9 52. Dr. Gruessner told members of the Committee of 11 that he felt Dr.
10 Goldschmid would not be able to take the COM to the next level and attain a better
11 national reputation.

12 53. Upon information and belief, Dr. Goldschmid learned what Dr. Gruessner
13 had told members of the Committee of 11.

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

16 55. Upon information and belief, Dr. Barker also spoke with the Committee
17 of 11 and was very critical of the course of the COM and its leader, Dr. Goldschmid.

18 56. Upon information and belief, Dr. Goldschmid learned what Dr. Barker
19 had told members of the Committee of 11; and soon thereafter, Dr. Barker was
20 terminated by Dean Goldschmid in May 2013 for reasons that did not justify his
21 termination.

22 57. Upon information and belief, Dr. Goldschmid awarded faculty who did
23 not criticize him with salary increases and other forms of favoritism, further eroding
24 morale among the medical faculty
25

1 58. Dr. Goldschmid was Dr. Gruessner's direct supervisor for most of the last
2 five years.

3 59. Under University rules, Dean Goldschmid was required to provide an
4 annual review to Dr. Gruessner. Dean Goldschmid was also required to provide Dr.
5 Gruessner with a more extensive five-year review.

6 60. Those reviews are required by the following sections of The University
7 Handbook for Appointed Personnel (UHAP): Section 5.08 (called "Annual Performance
8 Review") and Section 5.09 (called "Guidelines For Five-Year Reviews Of Deans And
9 Department Heads.").

10 61. The current UHAP rules are available online at the following website:
11 http://uhap.arizona.edu/Chapter_5#5.08.

12 62. While all other means of feedback about Dr. Gruessner's performance
13 rated him as "outstanding," Dr. Goldschmid failed to provide Dr. Gruessner any annual
14 evaluation as required.

15 63. Although a five-year review of the Department of Surgery was conducted,
16 and that review had high praise for Dr. Gruessner (**Exhibit 4**), Dr. Goldschmid failed to
17 provide the Five-Year Administrative Review for Dr. Gruessner specifically, as
18 required.

19 64. At no time during the entire period while Dr. Goldschmid was Dr.
20 Gruessner's supervisor, did Dr. Goldschmid ever provide Dr. Gruessner with any
21 written or emailed communication that listed any performance deficiencies by Dr.
22 Gruessner.

23 65. Upon information and belief, Dr. Goldschmid even went so far as to
24 insult Dr. Gruessner's nationality in the most defamatory and humiliating way by
25 calling him a "Nazi" behind his back and in front of Dr. Gruessner's colleagues and
26

1 subordinates. This was particularly hurtful to Dr. Gruessner, whose grandfather was a
2 judge in Nazi Germany who spent time in a concentration camp for standing up to the
3 Nazi Regime and subsequently died of the consequences. Dr. Goldschmid made these
4 defamatory remarks in his office and in his capacity as Dean of the College of Medicine
5 and interim CEO of UPH and UAHN.

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

9 67. In making the request, Dr. Goldschmid alleged a "record of poor
10 performance."

11 68. Dr. Gruessner was initially shocked, and he refused to step down.

12 69. Despite the former Dean's assertion of a "record of poor performance,"
13 Dr. Gruessner, at around the same time, received what is believed to be the highest
14 bonus payment of any COM Chair based on objective UAHN/UPH achievement
15 benchmarks.

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

19 71. Thereafter, and despite the recent Notice of Reappointment and the May
20 1, 2013 plan/contract with the October 1, 2013 deadline, Dr. Goldschmid again asked
21 Dr. Gruessner to step down as Chair.

22 72. After careful reflection, Dr. Gruessner decided it would be best to find an
23 amicable solution.

24 **Dr. Gruessner and Dean Goldschmid Ostensibly Settle Their Differences**

1 73. Dr. Gruessner, after difficult negotiations with ever changing deadlines
2 and demands, signed an agreement that would have allowed Dr. Gruessner to continue
3 as tenured faculty member with a guaranteed salary for at least three more years, as
4 agreed upon in the original 2007 contract.

5 74. Dr. Gruessner also agreed he would transition out of administrative duties
6 as Chairman of the Department of Surgery, but would retain the title of Chair for a
7 period of at least six months.

8 75. A true copy of the COM Agreement and Release is attached as Exhibit 7.

9 76. Dr. Gruessner asked that he be allowed to continue to serve as Chief of
10 Transplantation at UAMC, but Dean Goldschmid, who also held leadership positions at
11 UAHN and UPH, refused to allow it.

12 77. A true copy of the email from UA counsel explaining that Dr. Gruessner
13 must unequivocally give up all of his administrative titles and duties is attached as
14 Exhibit 8.

15 78. A true copy of the UPH Amendment to Member Practice Agreement,
16 which purports to strip Dr. Gruessner of all administrative titles at the hospital and all
17 duties associated with them, is attached as Exhibit 9.

18 79. Dr. Gruessner has complied with all obligations required of him under his
19 agreement with UPH and the COM, Exhibit 2.

20 80. Upon information and belief, Dean Goldschmid and possibly others still
21 wanted Dr. Gruessner out of any role at the University and thereafter undertook a series
22 of steps that culminated nine days later in an unlawful suspension.

23 **Dr. Gruessner Discovers Errors in UNOS Data**

89. In his capacity as the Surgical Director of the Liver Transplant Program, Dr. Gruessner oversaw all procedural aspects of the program, including acceptance of organs and directing the role and participation of transplant surgeons in the actual procedures.

98. 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 reporting regarding transplant services.

1 99. The Centers for Medicare & Medicaid Services had also audited UAMC
2 and also recommended that it obtain a quality coordinator to assist with the quality of
3 reporting regarding transplant services.

4 100. Notwithstanding those recommendations, UAMC had not hired any
5 quality coordinator.

6 101. The UAMC transplant director left UAMC in early September, 2013;
7 upon information and belief, she left UAMC in part because of her frustration with the
8 lack of support the administration was providing.

9 102. Dr. Gruessner had no role in entering or maintaining data about the
10 identity of the primary or first assistant surgeon in UNOS reporting data.

11 103. Dr. Gruessner informed Mr. McCarthy that the data could not possibly be
12 correct because he had been primary surgeon on most of the liver transplants performed
13 during his tenure at UAMC.

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

15 104. Dr. Gruessner told Mr. McCarthy that the incorrect data needed to be
16 looked into and suggested looking at the actual OR notes to find out where the
17 discrepancy was.

18 105. Mr. McCarthy then, of his own accord, attempted to make the changes
19 himself based on his assessment of the OR notes.

20 106. After making a few changes, Mr. McCarthy realized he could not easily
21 identify the primary and first assistant surgeons because the information was not clear to
22 him from the OR notes.

23 107. On Tuesday, September 10, 2013, and on McCarthy's request, Dr.
24 Gruessner met with Mr. McCarthy to review additional UNOS reporting data along with
25 actual OR notes for previous UAMC liver transplants.

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

111. Dr. Gruessner did not suggest any change to any medical record or operating room record, and no change to any OR record or any medical record was ever made.

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

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

117. A true copy of the email from Mr. McCarthy to Ms. Mlawsky is attached as **Exhibit 10**.

16

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

3 120. In her Response, Ms. Mlawsky stated: "We are looking into this."

4 121. A true copy of Dr. Gruessner's email to Mlawsky with her response is
5 attached as **Exhibit 11**.

6 **Dr. Gruessner Is Suspended**

7 122. Within hours of receiving Ms. Mlawsky's response, Dr. Gruessner
8 received an email from Dr. Goldschmid stating: "I am providing you notification from
9 both UPH and the University of Arizona that, effective immediately, you are being
10 placed on administrative leave with pay from both of those organizations." A true copy
11 of that September 19, 2013, email is attached as **Exhibit 12**.

12 123. Dean Goldschmid also stated: "You are not permitted to return to campus
13 without first making arrangements through UAMC security to do so." **Exhibit 12**.

14 124. Attached to the Goldschmid email were signed letters stating that each
15 organization was placing Dr. Gruessner on administrative leave.

16 125. A true copy of the letter from UPH is attached as **Exhibit 13**.

17 126. The attached UPH letter, **Exhibit 13**, was sent on University of Arizona
18 Health Network ("UAHN") letterhead, and signed by Defendant Waldrum; it stated, in
19 part:

20 The reason for this leave is that information has come to our attention that
21 you either altered or directed others to alter records related to transplant
22 procedures by substituting your own name as primary surgeon for others
23 who may have actually served as primary surgeons, and that you removed
24 your name as primary surgeon on other cases where adverse events may
25 have occurred and substituted the names of other surgeons as primary
26 surgeons in those cases.

27 127. The attached letter from the COM, **Exhibit 14**, as signed by Defendant
28 Comrie, stated: "I have determined that your continued presence on the University

1 campus is likely to constitute a substantial interference with the orderly functioning of
2 the University and the Department of Surgery." It continued: "I have received
3 information from UAHN that you either altered or directed others to alter records
4 related to transplant procedures . . . [the remainder mirrors the allegations contained in
5 the UPH letter]."

6 128. The letter from the COM, Exhibit 14, then stated that, "[b]ecause your
7 employment with the University is conditioned upon your maintaining membership in
8 good standing with UPH, and that membership is in jeopardy based on this alleged
9 conduct, I am placing you on leave at this time pending further action by UPH."

10 129. Before he was summarily suspended, no one from the COM, UPH, or
11 UAHN asked Dr. Gruessner about the allegations found in the suspension letters,
12 Exhibits 13 and 14.

13 130. Dr. Gruessner was not offered any opportunity to defend himself prior to
14 the summary suspension from either organization—despite the fact that Dr. Gruessner
15 according to UAHN policies was entitled to a hearing within 30 days after being
16 summarily suspended.

17 131. The suspension letters, Exhibits 13 and 14 do not offer or provide him
18 any form of post-deprivation hearing or due process.

19 132. Upon information and belief, at or soon after the suspension, hospital
20 security was given photos of Dr. Gruessner to identify him to ensure he could not set
21 foot on the campus.

22 133. By not allowing Dr. Gruessner to return to the hospital and see patients or
23 perform surgery, his hospital privileges were essentially removed without a hearing, in
24 violation of his property rights.

142. Dr. Gruessner was immediately confronted, at national medical association meetings, with rumors that he had falsified medical records, had embezzled several millions of dollars, had been escorted out by security, and was forbidden to set foot on campus.

19

1 143. Immediately after he was summarily suspended, Dr. Gruessner responded
2 by email on Friday, September 20, 2013, and requested additional information to clarify
3 the charges and ensure he could respond as fully and accurately as possible.

4 144. A true copy of Dr. Gruessner's September 20, 2013, email is attached as
5 **Exhibit 15.**

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

10 146. A true copy of the Provost's September 20, 2013 email is attached as
11 **Exhibit 16.**

12 147. Through counsel, Dr. Gruessner followed up on the requested clarification
13 and documentation on September 26, October 1, and October 2, 2013 and true copies of
14 those emails are attached as **Exhibit 17.**

15 148. On October 4, 2013, an attorney representing UPH sent a letter that stated
16 the requested records would be delivered to Dr. Gruessner's home that day and
17 demanded that he respond within five (5) business days; a true copy of that letter is
18 attached as **Exhibit 18.**

19 149. Dr. Gruessner's counsel told UPH counsel that Dr. Gruessner was out of
20 town in an October 4, 2013 email, a true copy of which is attached as **Exhibit 19.**

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

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

1 152. Leaving those documents with a cleaning crew was a violation of HIPAA
2 Privacy Rules, as found in the Health Insurance Portability and Accountability Act of
3 1996 (HIPAA), Public Law 104-191, and 45 CFR Part 160 and Part 164, Subparts A
4 and E.

5 153. Dr. Gruessner was finally able to review the documents upon his return
6 home.

7 154. Although the cover letter claimed the package included documentation on
8 31 liver transplant cases, there was only documentation for 30 cases, and the package
9 was missing OR notes for four of the 30 cases that were provided.

10 155. In response to an inquiry as to whether Dr. Gruessner would ever receive
11 the missing documents, UPH responded evasively: "Yes, this is among what was
12 delivered to his house on 10/4." A true copy of the email reflecting this, dated October
13 9, 2013, is attached as **Exhibit 20**.

14 156. In the initial summary suspension letter from UPH/UAHN, it was claimed
15 that Dr. Gruessner failed to proceed "according to usual protocol for identifying
16 potential anomalies." **Exhibit 13**.

17 157. When Dr. Gruessner asked for a copy of that protocol, UPH stated that, in
18 fact, there was no written protocol and that the summary suspension notice was
19 "inartfully worded." See **Exhibit 20**.

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

22 159. A true copy of Dr. Gruessner's October 9, 2013 letter is attached as
23 **Exhibit 21**.

168. Dr. Gruessner refused to resign because he has done nothing wrong; he was wrongfully suspended and believes that the real reason for his summary suspension

1 was that Dean Goldschmid wanted him out of the COM and UPH because of his
2 personal and professional animosity towards Dr. Gruessner.

3 169. Upon information, the contracts that Defendants signed, wherein Dr.
4 Gruessner agreed to step down as Chair, were done in bad faith. Although the Dean
5 knew about the data corrections days before the new contract took effect, he deliberately
6 waited several days until he went on the offensive.

7 **Dr. Gruessner sues for reinstatement**

8 170. Dr. Gruessner informed UPH and the COM that he intended to sue if he
9 was not reinstated; a true copy of an October 30, 2013 email reflecting this is attached
10 as **Exhibit 24.**

11 171. UPH and the COM continued to hold Dr. Gruessner in limbo (suspension
12 with no clinical/administrative duties) as they pressed for his departure.

13 172. Dr. Gruessner filed a lawsuit in Pima County, Arizona, Superior Court on
14 November 13, 2013 seeking reinstatement, and the case was assigned as cause number
15 CV2013-6289.

16 173. On Dr. Gruessner's request, the Pima County Superior Court scheduled a
17 preliminary injunction hearing to determine whether it should order Dr. Gruessner
18 reinstated.

19 174. The hearing was set for Monday, December 16, 2013.

20 **UPH Terminates Dr. Gruessner Without Cause or Reason**

21 175. On the afternoon of Friday, December 13, 2013, just one business day
22 prior to the scheduled preliminary injunction hearing the following Monday, UPH
23 delivered a letter, purporting to terminate Dr. Gruessner's membership in the
24 organization. A true copy of the December 13, 2013 email and letter is attached as
25 **Exhibit 25.**

177. As a result, Dr. Gruessner was forced to continue the hearing on the preliminary injunction to amend his complaint and prepare for the suddenly changed circumstances.

179. On January 9, 2014, Dr. Gruessner filed a whistleblower complaint with the University of Arizona complaining that (1) adverse actions against him were taken by the Dean in retaliation for Dr. Gruessner's disclosures to members of the Committee of 11; and (2) that Dr. Gruessner had discovered and reported inaccurate data about transplants that could result in allowing unqualified persons to be allowed to perform transplants, and he was thereafter suspended. A true copy of the January 9, 2014 whistleblower complaint is attached as **Exhibit 26**.

180. Only one day after the whistleblower complaint was filed, on January 10, 2014, the University of Arizona delivered a letter stating that, as a result of UPH's purported termination action, it was following suit and recommending termination to the

1 University President. A true copy of the January 10, 2014 letter is attached as Exhibit
2 27.

3 181. Then, on February 7, 2014, the University of Arizona responded to Dr.
4 Gruessner's whistleblower complaint, denying Dr. Gruessner's request for an
5 investigation and claiming that Dr. Gruessner's claims were not proper whistleblower
6 claims under the relevant ABOR policy. A true copy of the February 7, 2014 letter is
7 attached as Exhibit 28.

8 182. On February 21, 2014, in accordance with ABOR policy, Dr. Gruessner
9 then timely requested an independent hearing regarding his whistleblower complaint. A
10 true copy of the February 21, 2014 letter is attached as Exhibit 29.

11 183. On February 25, 2014, the University of Arizona responded denying Dr.
12 Gruessner's request for an independent hearing regarding his whistleblower complaint.
13 A true copy of the February 25, 2014 letter is attached as Exhibit 30.

14 **The Summary Suspension and Purported Termination Were Illegal**

15 184. Dr. Gruessner had a constitutionally protected property interest and liberty
16 interest in his continued employment as a physician, a tenured professor, Chief of
17 Transplantation, and as chair of the Department of Surgery.

18 185. It was a violation of his federal and state due process and contract rights
19 for the Defendants to summarily suspend Dr. Gruessner in the manner in which he was
20 suspended.

21 186. It was a separate violation of his due process and contract rights for UPH
22 to purport to terminate Dr. Gruessner in the manner in which he was purportedly
23 terminated.

1 187. It was yet a separate violation of his due process rights to leave Dr.
2 Gruessner suspended and then to terminate him without providing a hearing in order to
3 clear his name.

4 188. The summary suspension and termination had nothing to do with the
5 quality of his patient care or job performance, both of which were outstanding by all
6 accounts. This was confirmed repeatedly by Defendants at the time of the Court and
7 Panel hearings.

8 189. Upon being summarily suspended, Dr. Gruessner was prevented from
9 seeing patients and providing patient care, which caused many patients to be deprived of
10 advanced surgical treatment that only Dr. Gruessner was well qualified to provide.
11 Clinical programs that Dr. Gruessner had built were closed and patients were
12 mendaciously told that Dr. Gruessner was no longer working at UAMC.

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

16 191. In summarily placing Dr. Gruessner on administrative leave with pay and
17 then purporting to terminate him, Defendants did not follow UAMC Bylaws, Rules &
18 Regulations.

19 192. The conduct listed in the Suspension and Termination letters, if true,
20 would be covered conduct that should be reviewed by peer review, under the UAMC
21 Bylaws, § 7.2.1.

22 193. No peer review was provided to Dr. Gruessner.

23 194. No UAMC medical staff committee was involved in any investigation
24 about Dr. Gruessner.

1 195. Dr. Gruessner also has due process rights as a tenured COM faculty
2 member.

3 196. In summarily placing Dr. Gruessner on administrative leave with pay and
4 then apparently terminating him, Defendants did not follow the relevant Arizona Board
5 of Regents' ("ABOR") policies.

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

8 198. Under Conditions Section 6-201(J)(1)(a), a tenured faculty member
9 cannot be suspended or terminated without "just cause."

10 199. There was no just cause to take any action against Dr. Gruessner, by way
11 of suspension, termination, or otherwise.

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

15 201. Dr. Gruessner was summarily placed on leave with pay and terminated
16 thereafter without being given any opportunity to respond to the allegations.

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

19 203. Defendants never fully investigated the allegations against Dr. Gruessner
20 which lead to his summary suspension and later termination.

21 204. Dr. Gruessner was summarily suspended and then purportedly terminated
22 unfairly and unlawfully:

23 A. in retaliation for providing opinions critical of Dean Goldschmid
24 to members of the Committee of 11; and/or
25

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

3 205. In addition, the summary suspension and termination were and are
4 extremely damaging to Dr. Gruessner with respect to, inter alia, his national reputation,
5 emotional well-being, and the loss of valued relationships with other physicians and co-
6 workers.

7 206. The fact of his suspension ("alteration/falsification of medical records")
8 and purported termination became nationally known among his peers across the nation
9 and in the media.

10 207. It is important for a surgeon to maintain his skills and abilities by
11 continued practice and for seeking future employment.

12 **The Pima County Court Orders a Due Process Hearing**

13 208. Based on the evidence presented at the preliminary injunction hearing, the
14 court found that Dr. Gruessner was, in fact, denied due process. A true copy of the
15 court's minute entry order dated March 7, 2014 is attached hereto as **Exhibit 31**.

16 209. The court found that UPH was a state actor when it terminated Dr.
17 Gruessner. **Exhibit 31**.

18 210. The court ordered that UPH provide Dr. Gruessner with a hearing under
19 its policies, the process to be started within 15 days. **Exhibit 31**.

20 211. The court dismissed the University of Arizona and ABOR from the case
21 because of failure to exhaust administrative remedies. **Exhibit 31**.

22 212. Counsel for University of Arizona and ABOR expressed disappointment
23 with the order because it left unresolved Dr. Gruessner's status with UPH, the sole
24 reason the University of Arizona sought tenure removal, effectively staying the tenure-
25

1 removal proceedings pending the outcome of the UPH hearing. *See* Transcript dated
2 March 7, 2014, CV2013-6289, p. 141 l.17 – p. 142 l.16.

3 213. On or about March 14, 2014, Dr. Gruessner served a Notice of Claim on
4 certain defendants; a true copy of the Notice of Claim is attached as **Exhibit 32**. This
5 Complaint is timely filed because the parties have entered into a tolling agreement.

6 214. Upon information, the transplant database manager that had testified and
7 confirmed Dr. Gruessner's testimony was given an ultimatum almost immediately after
8 the court's ruling in favor of Dr. Gruessner: that he would either be demoted with a
9 salary reduction or he could leave and take a severance package. Upon information, he
10 resigned within a few weeks. UAHN's VP and General Counsel, Scott Sahlman, also
11 had to leave shortly after the court's ruling. By then, Dean Goldschmid had already
12 been "transferred" out of his position as Dean of the College of Medicine.

13 **UPH Foot-Dragging, COM Salary Reduction, and Other Retaliation**

14 215. After being ordered to do so, UPH provided the required notice that Dr.
15 Gruessner could request a hearing. A true copy of UPH's notice is attached as **Exhibit**
16 **33**.

17 216. The notice changed the extremely damaging allegations against Dr.
18 Gruessner from "altered or directed others to alter records" to mere "involvement in
19 causing changes to UAMC's OTTR database." **Exhibit 33**.

20 217. UPH has repeatedly changed and dropped its allegations against Dr.
21 Gruessner once they were proven wrong—from "altering records" to "changing a
22 database" (after the Court hearing) to "being disruptive" (after the Panel hearing).

23 218. Although UPH began the process within 15 days of the court's order, as
24 required by the Court, UPH thereafter unnecessarily delayed and prolonged the process.
25

226. On June 9, 2014, the University of Arizona notified Dr. Gruessner that his Notice of Appointment would reduce his salary, effective July 1, 2014, to 0.5 FTE based on his reduced ability to perform his responsibilities.

1 despite there being financial support to continue to fund her full-time position. Her
2 superiors continue to question her as to when she is leaving the institution. Upon
3 information and belief, this salary reduction and harassment is attributed to "political
4 reasons." Although no damages are sought in this complaint on behalf of Dr. Angelika
5 Gruessner, these allegations are included to demonstrate the depth of retaliatory actions
6 against Dr. Gruessner and to show damage to the marital community.

7 **Panel Clears Dr. Gruessner of All Charges and Finds There Was No Ground for**
8 **Suspension or Termination**

9 236. Despite the court's order indicating Dr. Gruessner's independent hearing
10 should be commenced by the end of June 2014, the UPH hearing did not take place until
11 August 5, 2014, in violation of the standard 60 day timeline for a hearing after a
12 summary suspension.

13 237. The independent panel consisted of three nationally-reputed transplant
14 surgeons from outside Arizona.

15 238. Before the hearing, Dr. Gruessner asked UPH to produce former-dean Dr.
16 Goldschmid for testimony at the hearing, but UPH refused to produce Dr. Goldschmid
17 as a witness.

18 239. The panel members even expressed their dissatisfaction with lack of a
19 valid reason for Goldschmid's absence.

20 240. UPH's only live witnesses were its former general counsel Scott Sahlman,
21 who testified by phone, and the UAHN CEO Michael Waldrum.

22 241. For the remaining witnesses, UPH selected pieces of the transcript from
23 the preliminary injunction hearing and had "readers" testify in their place.

1 242. The subject of the hearing was whether Dr. Gruessner improperly caused
2 changes to a database and whether his termination by UPH was justified and should be
3 upheld. See Exhibit 33.

4 243. At the hearing Defendant Waldrum admitted that neither he nor any expert
5 on his behalf had looked at the evidence that was presented against Dr.
6 Gruessner before he took action against him, including reporting him to the Arizona
7 Medical Board.

8 244. In closing arguments, counsel for UPH even argued that the panel should
9 not even consider whether the changes to the database were correct.

10 245. The panelists unanimously cleared Dr. Gruessner of any wrongdoing.

11 246. The panel ultimately found that UPH did not prove that the termination of
12 Dr. Gruessner was justified. A true copy of the panel's findings is attached as Exhibit
13 37.

14 247. Because the hearing was limited in time, Dr. Gruessner was not provided
15 the opportunity to fully address all of the superfluous/false issues alleged by UPH.

16 248. Dr. Gruessner focused on the allegation that he improperly caused
17 changes to a database and on the fact that the suspension and termination were not
18 justified.

19 249. The panel made the following conclusions:

20 A. "The panel, knowledgeable in UNOS and database reporting,
21 concluded that Dr. Gruessner did not 'alter records.' He acted reasonably to correct
22 errors he found in the OTTR database. Bringing these errors to the attention of the
23 OTTR data base manager was a reasonable approach. His conduct was appropriate."

24 Exhibit 37 ¶ 8.

1 B. "UPH did not even attempt to prove that the changes to the OTTR
2 data base (which remain today) were incorrect, with one exception: a procedure where
3 Dr. Jie and Dr. Rana extracted a liver and placed a new liver in the patient before Dr.
4 Gruessner even arrived at the operating room. Both Dr. Gruessner and Dr. Rana testified
5 that Dr. Gruessner was not the primary surgeon, while Dr. Jie disagreed. The panel
6 believes that Dr. Gruessner would not aptly be designated the primary surgeon on this
7 particular procedure based on the testimony and operative notes." **Exhibit 37** ¶ 9.

8 C. "In sum, the panel felt that [UPH] did not meet its burden of
9 proving that the termination was justified." **Exhibit 37** ¶ 12.

10 250. The panel stated it believed the parties too quickly resorted to attorneys.
11 **Exhibit 37** ¶ 5.

12 251. But, early in the process, UPH instructed Dr. Gruessner to only
13 communicate through his attorney. A true copy of the email is attached as **Exhibit 38**.

14 252. In addition to the core findings, the panel made several additional
15 recommendations which went beyond its primary task of evaluating the alleged
16 wrongdoing by Dr. Gruessner and whether or not the termination was wrongful:

17 A. "[T]he panel feels that the University of Arizona should do
18 everything within reason to facilitate [Dr. Gruessner's search for employment
19 elsewhere]." **Exhibit 37** ¶ 14.

20 B. "The panel recommends reinstatement of employment, but not
21 privileges or titles, essentially a faculty member without titles or clinical duties."
22 **Exhibit 37** ¶ 15.

23 C. "[I]n order to facilitate his re-entry into practice, Dr. Gruessner
24 should be named a Professor of Surgery." **Exhibit 37** ¶ 16.

1 D. The panel suggested, without having access to arguments and
2 evidence, that each side should bear their own legal fees because "both sides bear
3 significant responsibility for the mutual animosity and falling out." **Exhibit 37** ¶ 18.
4 This recommendation was made by three medical transplant experts who lack any
5 relevant legal training, and who did not have the benefit of argument or evidence so
6 support this recommendation.

7 E. Nevertheless, the panel stated that "UPH should pay Dr. Gruessner
8 for up to one additional year, or until he finds a new position." **Exhibit 37** ¶ 18. This
9 recommendation was made by three medical transplant experts who lack any relevant
10 legal training and any experience in senior administrative leadership positions, and who
11 did not have the benefit of argument or evidence to support this recommendation.

12 F. "UPH should issue Dr. Gruessner a public apology of its design
13 that wishes Dr. Gruessner well in his future endeavors and thanks him for his role in
14 making UMC/UPH a world class transplantation center. It should specify that any prior
15 discussion of misconduct have been officially retracted." **Exhibit 37** ¶ 19.

16 G. "UPH should retract its allegations to the Arizona Medical Board
17 accusing Dr. Gruessner of "unethical conduct." **Exhibit 37** ¶ 20.

18 H. "The panel believes that Dr. Gruessner deserves to have his name
19 cleared." **Exhibit 37** ¶ 21.

20 253. UPH Policy A227 that governs the hearing at issue requires UPH to
21 convene and take action on the panel's recommendations.

22 254. The UPH Board then convened to review the panel's decision on
23 September 5, 2014.

24 255. Upon information and belief, the UPH Board voted to accept the panel's
25 recommendations.

1 256. UPH issued a press release about the vote on September 5, 2015, but
2 never informed Dr. Gruessner or his counsel about the vote. This was in violation of
3 UPH Policy A227, according to which Dr. Gruessner should have been informed in
4 writing about the board's decision. Dr. Gruessner only found out about the decision
5 because a member of the media contacted him for comment.

6 257. UPH's attorney has demanded that Dr. Gruessner sign a release and
7 waiver of all claims he has against UPH, UAHN, COM, and the University of Arizona
8 in order to implement the panel's recommendations.

9 258. UPH and the remaining defendants have expressed their willingness to
10 accept all of the panel's recommendations, including the refusal to allow Dr. Gruessner
11 to perform any more surgeries, the failure to award him his fees, and the failure to
12 award him any damages.

13 259. Dr. Gruessner is not willing to sign a full release of his claims, and,
14 instead, has chosen to pursue his claims in this litigation.

15 260. Dr. Gruessner concurs with the panel's findings found in their paragraphs
16 1 -12 (Exhibit 37).

17 261. Dr. Gruessner does not and cannot accept the panel recommendations that
18 are found in paragraphs 14-18 because:

19 A. Those recommendations were outside of the purview of the panel;

20 B. Dr. Gruessner did not provide evidence to the Panel about the
21 matters covered by those recommendations; this occurred, in part, because the hearing
22 was limited in time—he was only allowed a total of four (4) hours to offer testimony
23 and argument.

24 C. The recommendations ignore Dr. Gruessner's contract rights, his
25 tenure rights, and his due process rights and the applicable law; they require him to
26

1 depart within a year notwithstanding his rights to stay longer and to not be terminated
2 without good cause proven through due process;

3 D. The recommendations have no consideration for the citizens of
4 Southern Arizona where Dr. Gruessner has lived for many years and where he desires to
5 live and to continue to treat patients.

6 E. The recommendations give no consideration to or measure of the
7 damages already suffered by Dr. Gruessner and likely to be suffered in the future.

8 262. Just two weeks after the panel's decision, the UA attorney working on Dr.
9 Gruessner's case, Vicki Gotkin, suddenly left her position at the institution.

10 **Damages Have Been Significant**

11 263. The damages caused to Dr. Gruessner by the defendants have been severe
12 and ongoing.

13 264. Dr. Gruessner's reputation has been damaged, possibly irretrievably,
14 nationally, internationally, and locally; there have been dozens if not hundreds of media
15 reports about his suspension, termination, and the false claims made about him by the
16 defendants; his suspension and termination, and information about them, have been
17 widely disseminated in the transplant community and elsewhere, and many people may
18 continue to believe the charges about him even though he has been cleared by the panel.

19 265. Dr. Gruessner's job prospects have been greatly diminished and possibly
20 irretrievably damaged; before he was summarily suspended Dr. Gruessner had a number
21 of job opportunities but when he was suspended those opportunities all disappeared;
22 upon information, future job opportunities will be difficult to find if not impossible and
23 Dr. Gruessner has already lost income from missed opportunities. In all, Dr. Gruessner
24 has applied at over 30 institutions, but he has not been offered a position due to the
25 widely disseminated reports of his altering/falsifying records.

1 266. By not allowing Dr. Gruessner to resume clinical duties, Dr. Gruessner's
2 surgical career appears doomed due to the long period of clinical inactivity that was
3 unfairly and wrongfully imposed upon him by UPH.

4 267. OPTN bylaws require that transplant surgeons maintain patient
5 involvement over the last two years. Most hospitals require some form of surgical
6 activity within one year for unlimited privileges. And, of course, the complaint to the
7 Arizona Medical Board precludes Dr. Gruessner's application for a medical license in
8 other states, making it currently impossible to obtain other positions. Thus, even when
9 Dr. Gruessner is cleared by the Board, his then-two-year absence from any clinical
10 activity will potentially prohibit him from ever working against as a (transplant)
11 surgeon.

12 268. He has suffered a loss of income and likely will continue to suffer such a
13 loss in the future.

14 269. Dr. Gruessner has also suffered emotional distress, shame, humiliation,
15 inconvenience, and anxiety because of the actions of defendants and the false charges
16 made about him. His family, who are also in the medical profession, have suffered
17 similarly.

18 270. This burden has taken a physical toll on Dr. Gruessner. Since the
19 culmination of these events, Dr. Gruessner has lost a great deal of weight that he only
20 started regaining after the panel cleared him. The stress has caused him to lose
21 considerable sleep. The pain of losing such a tremendous career at or near its prime has
22 been excruciating.

23 271. In a profession where reputation means everything, Defendants have
24 utterly destroyed Dr. Gruessner's career. The fact that he has contributed so much to the
25 medical community, performed many "firsts" in surgical procedures—not only in
26

1 Arizona but in the Southwest, saved countless lives, and demonstrated incomparable
2 leadership now means nothing. The degree of viciousness and callousness these
3 institutions have shown Dr. Gruessner after he has worked tirelessly for more than six
4 years is unimaginable. In the course of just over a year, Defendants have reduced Dr.
5 Gruessner's life's work to ruins.

6 272. Dr. Gruessner has incurred approximately \$350,000 just in attorney fees
7 and taxable costs to date in an effort to obtain due process and in an effort to defend the
8 charges wrongfully brought against him, and these sums are sought here as a separate
9 element of damages to the extent not obtained from the Pima County Superior Court in
10 case CV2013-6289.

11 **COUNT ONE**

12 **(Breach of Contract - A.R.S. 23-1501(A)3(a))**
13 **(Against ABOR, COM, UAHN, and UPH)**

14 273. Incorporate by reference all prior allegations as if fully set forth herein.

15 274. Dr. Gruessner had an employment contract with ABOR, COM, and UPH
16 in the form of Exhibit 2.

17 275. He also had contract rights from various ABOR, COM, UAHN, and UPH
18 policies, which constitute additional contract terms with him.

19 276. By summarily suspending Dr. Gruessner and excluding him and
20 prohibiting him from setting foot on campus or seeing patients, ABOR, COM, UPH,
21 and, to the extent it was involved, UAHN breached Dr. Gruessner's contract rights.

22 277. By terminating him, UPH, and, to the extent it was involved, UAHN
23 committed further breaches of Dr. Gruessner's contract rights.

278. As a result of those breaches, Dr. Gruessner suffered direct and consequential damages in an amount to be proven at trial, in excess of the minimum amount for Superior Court jurisdiction.

279. This is an action arising from contract, and Dr. Gruessner is entitled to recover his reasonable attorneys' fees incurred herein pursuant to A.R.S. § 12-341.01.

COUNT TWO

**(Breach of the Implied Covenant of Good Faith and Fair Dealing)
(Against ABOR, COM, UAHN, and UPH)**

280. Incorporate by reference all prior allegations as if fully set forth herein.

281. All contracts in Arizona include an implied covenant of good faith and fair dealing, which require that no party to the contract do anything that prevents any other party from receiving the benefits of the agreement.

282. By summarily suspending Dr. Gruessner without justification or even post-deprivation due process and then excluding him and prohibiting him from setting foot on campus or seeing patients, ABOR, COM, UPH, and, to the extent it was involved, UAHN breached that implied covenant.

283. By terminating him, UPH, and, to the extent it was involved, UAHN committed further breaches of that implied covenant.

284. As a result of those breach, Dr. Gruessner suffered direct and consequential damages in an amount to be proven at trial in excess of the minimum amount for Superior Court jurisdiction.

285. This is an action arising out of a written contract, and Dr. Gruessner is entitled to recover his reasonable attorneys' fees incurred herein pursuant to A.R.S. § 12-341.01.

COUNT THREE

**(Intentional Interference with Contractual Relations)
(Against UPH, UAHN, and Goldschmid)**

286. Incorporate by reference all prior allegations as if fully set forth herein.

287. Dr. Gruessner had a contractual employment relationship with ABOR, COM, UPH, and UAHN.

288. UPH, UAHN, and Dr. Goldschmid knew about this contractual relationship and improperly interfered with it, causing a breach of that relationship.

289. Dr. Goldschmid was acting outside the scope of his authority as Dean of the COM and for his own personal benefit and for revenge in interfering with Dr. Gruessner's employment.

290. Dr. Gruessner suffered damage caused by UPH's, UAHN's, and Dr. Goldschmid's interference, including damage to reputation, emotional distress, loss of prospective wages and embarrassment.

291. The actions of Dr. Goldschmid were willful, intentional and malicious and he should be assessed punitive damages in order to punish him and to deter others.

COUNT FOUR

**(Wrongful Termination – Whistleblower Claim, A.R.S. § 23-1501(A)(3)(c)(ii))
(Against UPH and UAHN)**

292. Incorporate by reference all prior allegations as if fully set forth herein.

293. Dr. Gruessner disclosed critical information to the Committee of 11 about Dr. Goldschmid's performance of his duties.

294. Dr. Gruessner's disclosure was based on a reasonable belief that continued service by Dr. Goldschmid may violate various state laws, including laws requiring fairness in governance of faculty such as A.R.S. § 15-1601(B) (requiring that

1 university faculty "shall participate in the governance of their respective universities
2 and shall actively participate in the development of university policy") and avoiding
3 waste [such as A.R.S. § 15-1664 (requiring that funds be spent according to Board of
4 Regents policy)].

5 295. Dr. Gruessner reasonably believed that the Committee of 11 was in a
6 managerial or supervisory position and had the authority to investigate the information
7 he provided and to take action to prevent further violations.

8 296. Dr. Gruessner further disclosed information of a matter of public concern
9 when he uncovered and reported the incorrect data reporting to UAMC Employee Mike
10 McCarthy and later to UAMC CEO Karen Mlawsky.

11 297. Dr. Gruessner's disclosure was based on a reasonable belief that the
12 incorrect data may violate various state laws, including laws prohibiting false statements
13 in public records (A.R.S. § 13-2407) or in obtaining a benefit by a false statement
14 (A.R.S. § 13-2310)

15 298. Dr. Gruessner reasonably believed that both McCarthy and Mlawsky were
16 in a managerial or supervisory position and had the authority to investigate the
17 information he provided and to take action to prevent further violations.

18 299. Defendants took retaliatory action for Dr. Gruessner's disclosures by
19 suspending and later purporting to terminate him.

20 300. The actions of defendants were willful and malicious and these defendants
21 should be assessed punitive damages in order to punish them and to deter others.

22 301. As a result of this retaliatory action, Dr. Gruessner has been damaged
23 emotionally; his reputation has been damaged; and he has and may in the future
24 continue to suffer a loss of compensation and wages and other harm and damages.
25

COUNT FIVE

(Defamation)

(Against ABOR, COM, UPH, UAHN, and Goldschmid)

302. Incorporate by reference all prior allegations as if fully set forth herein.

303. In suspending Dr. Gruessner on or around September 19, 2013, Defendants COM, UAHN, UPH, and Goldschmid stated that Dr. Gruessner altered or directed others to alter records.

304. Those statements about Dr. Gruessner were false.

305. The conduct of suspending Dr. Gruessner and barring him from seeing patients or coming on campus, also stated or implied that Dr. Gruessner had committed some terrible act, and conduct can be a false statement in and of itself.

306. Defendants knew that their statements or the implication of their statements were false or they acted in reckless disregard of whether the statements were true or false when made.

307. Dr. Gruessner was forced to republish the statements in order to defend himself and explain Defendants' actions.

308. The republication was foreseeable and Defendants are liable to Dr. Gruessner for all damages caused by any republication.

309. The actions of defendants were willful and malicious and defendants UPH and UAHN should be assessed punitive damages in order to punish them and to deter others.

310. As a result of Defendants' defamatory statements and implications, Dr. Gruessner has been damaged emotionally, his reputation has been damaged, and he has and may in the future suffer a loss of compensation and wages and other harm or damages.

COUNT SIX

**(42 U.S.C. § 1983 – Violations of Fourteenth Amendment Right to Due Process)
(Against Comrie, Goldschmid, and Waldrum)**

311. Incorporate by reference all prior allegations as if fully set forth herein.

312. Dr. Gruessner had both a property interest in his employment and a liberty interest in his professional reputation, which rights are protected by the due process clause of the federal and Arizona constitutions.

313. Defendants Comrie, Waldrum, and Goldschmid deprived Dr. Gruessner of his constitutional right to due process by summarily suspending him without justification, without any proper due process; the suspension was in violation of ABOR policy and was without proper investigation and without offering any form of pre- or post- suspension hearing.

314. Defendant Waldrum thereafter further deprived Dr. Gruessner of his constitutional right to due process by purporting to terminate him from his publicly supported employment, again without any due process.

315. These individual defendants were acting in their official capacities on behalf of ABOR, COM, UAHN, and UPH.

316. ABOR, COM, UAHN, and UPH are all state actors in the context of 42 U.S.C. § 1983.

317. Although UAHN and UPH are ostensibly nonprofit entities, their de jure and de facto relationships with ABOR and COM, as well as the public service they provide, make them state actors.

318. The Pima County Superior Court has determined, in Case No. C2013-6289, that UPH is a state actor. Minute Entry dated March 7, 2014, p.2. UPH acquiesced in that determination by (a) failing to seek relief from such determination, and then (b) subsequently participating in the due process hearing the Pima County

Superior Court ordered. Dr. Gruessner requests that this Court take judicial notice of that Pima County Superior Court finding pursuant to A.R.S. Rules of Evidence, Rule 201.

319. In this Count, Dr. Gruessner solely seeks prospective injunctive relief against Defendants Comrie, Waldrum, and Goldschmid.

320. Dr. Gruessner has no adequate remedy at law, and unless enjoined, defendants will continue to suspend and /or terminate him, and he will continue to suffer irreparable harm to his reputation and his patients and prospective patients will also suffer irreparable harm without his professional services. In consequence, Dr. Gruessner may not be employable as a surgeon in the future due to the wrongfully imposed prolonged period of clinical inactivity.

321. Dr. Gruessner therefore requests that the Court preliminarily and permanently enjoin these defendants from continuing to suspend him or taking any further action to terminate him, and further requests affirmative relief such that he is reinstated to all positions he held, including Chair of the Department of Surgery.

322. Dr. Gruessner is entitled to his reasonable attorneys' fees and expert costs for this claim, as provided by 42 U.S.C. § 1988(b)&(c).

COUNT SEVEN

(42 U.S.C. § 1983 – Violation of First Amendment Right of Free Speech) (Against Comrie, Goldschmid, and Waldrum)

323. Incorporate by reference all prior allegations as if fully set forth herein.

324. Defendants Comrie, Waldrum, and Goldschmid deprived Dr. Gruessner of his U.S. Constitutional First Amendment right to free speech by suspending him after he spoke out as a citizen about matters of public concern, (1) when he spoke to the

1 Committee of 11, supra, and (2) when he later spoke to McCarthy and then Mlawsky
2 about the OTTR database errors, supra.

3 325. The suspension and later termination (supra) were taken for the purpose
4 of retaliation against Dr. Gruessner for his speaking out on those matters.

5 326. These individual defendants were acting in their official capacities on
6 behalf of ABOR, COM, UAHN, and UPH.

7 327. ABOR, COM, UAHN, and UPH are all state actors in the context of 42
8 U.S.C. § 1983.

9 328. In this Count, Dr. Gruessner solely seeks injunctive relief against these
10 named individual defendants.

11 329. Dr. Gruessner has no adequate remedy at law, and unless enjoined,
12 defendants will continue to suspend and /or terminate him, and he and his patients and
13 prospective patients will continue to suffer irreparable harm.

14 330. Dr. Gruessner therefore requests this court to preliminarily and
15 permanently enjoin these defendants from continuing to suspend him or to take any
16 action to terminate him, and further requests affirmative relief such that he is reinstated
17 to all positions he held, including Chair of the Department of Surgery.

18 331. Dr. Gruessner is entitled to his reasonable attorneys' fees and expert costs
19 for this claim, as provided by 42 U.S.C. § 1988(b)&(c).

20 **COUNT EIGHT**

21 **(Violation of Due Process Clause of the Arizona Constitution)**
22 **(Against ABOR, COM, UAHN, and UPH)**

23 332. Incorporate by reference all prior allegations as if fully set forth herein.

24 333. Dr. Gruessner has the right to due process under the Arizona State
25 Constitution, Art. 2, Section 4 ("no person shall be deprived of life, liberty or property
26

without due process of law”) with respect to the Defendants because all were and are acting on behalf of the State, except with respect to Count Three, supra.

334. This is an independent (“free standing”) claim, separate from any claim under the United States Constitution or under 42 U.S.C. §1983 and is brought directly under the Arizona Constitution as a claim for damages.

335. Defendants ABOR, COM, UAHN and UPH deprived Dr. Gruessner of his Arizona state constitutional right to due process by suspending him without any proper due process; the suspension was in violation of ABOR policy and was without proper investigation and without offering any form of pre- or post- suspension hearing.

336. Defendants UPH and UAHN thereafter further deprived Dr. Gruessner of his constitutional right to due process by purporting to terminate him without any due process.

337. Dr. Gruessner has been damaged by the wrongful suspension and termination and seeks all relief allowed by law as the result of the Defendants’ violations of his Arizona Constitutional right to due process.

COUNT NINE

**(Declaratory Judgment and Equitable Relief re Diminished and Unpaid Wages,
A.R.S. § 12-1831 et seq. and A.R.S. § 23-350 et seq.)
(Against ABOR, COM, UAHN, and UPH)**

338. Incorporate by reference all prior allegations as if fully set forth herein.

339. A controversy has arisen between Dr. Gruessner and Defendants ABOR, COM, UAHN, and UPH as to their respective contract rights.

340. On July 2, 2014, Dr. Gruessner’s compensation and wages were unilaterally reduced by one-half in breach and direct violation of his employment contract.

342. In this Court, Dr. Gruessner seeks a declaratory judgment that his contract compensation and wages cannot be unilaterally reduced and that he must be paid his full contract compensation and wages for the duration of his contract term, and he seeks injunctive relief accordingly.

344. Dr. Gruessner therefore requests that this Court enter a declaration under the Uniform Declaratory Judgment Act, A.R.S. §12-1831 et. seq. so stating.

346. Dr. Gruessner therefore requests that the Court preliminarily and permanently enjoin these defendants from continuing to reduce his pay.

RELIEF REQUESTED

48

1 A. For compensatory damages, and general and consequential
2 damages against all Defendants in an amount to be proven at trial;

3 B. For punitive damages against Defendants Goldschmid, UPH, and
4 UAHN in an amount sufficient to punish those Defendants for their malicious and
5 tortuous conduct, and to discourage similar wrongful conduct from other persons
6 similarly situated;

7 C. For Dr. Gruessner's costs;

8 D. For Dr. Gruessner's reasonable attorneys' fees incurred herein;

9 E. For declaratory judgment that Dr. Gruessner's pay cannot be
10 reduced to one half or in any lesser amount;

11 F. For preliminary and permanent injunctive relief, including inter
12 alia:

13 i) Reinstatement to all former positions held by Dr. Gruessner
14 with respect to the Defendants, including as Chair of the Department of Surgery;

15 ii) An order to pay and restore all lost compensation and
16 benefits and to fully comply with the terms of the contracts to which Dr. Gruessner is a
17 party or intended beneficiary; and

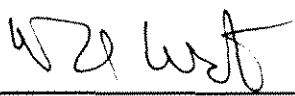
18 G. For such other and further relief as the Court deems just and
19 proper.
20

21 **Demand for Trial by Jury if Removed to United States District Court**

22 In the event that any or all of the Defendants remove this action to the United
23 States District Court, Plaintiff Dr. Gruessner demands a jury trial pursuant to the United
24 States Constitution Seventh Amendment and Federal Rules of Civil Procedure, Rules
25 38(a & b) and 39(a).
26

1 DATED this 3rd day of December, 2014.

2
3 Jaburg & Wilk, P.C.

4 
5 Kraig J. Marton
6 Aaron K. Haar
7 3200 N. Central Avenue, 20th Floor
8 Phoenix, AZ 85012
9 Attorneys for Plaintiff

10 **Certification by Plaintiff**

11 Pursuant to A.R.S. 12-1803(B) and A.R.S. Rules of Civil Procedure, Rule 80(i), I
12 declare and verify under penalty of perjury that I have read this Complaint, know the
13 contents herein, and that it is true based upon my own personal knowledge or upon my
14 information and belief.

15 Executed this 3rd day of December, 2014.

16 
17 Rainer W. G. Gruessner, M.D.
18
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26

**Attached exhibits, incorporated herein by reference
pursuant to A.R.S. Rules of Civil Procedure, Rule 10(c):**

1. Dr. Gruessner's Curriculum Vitae
2. Dr. Gruessner's UA-UPH Contract
3. Department of Surgery, Academic Program Review
4. Department of Surgery, Five-Year Administrative Review
5. Department of Medicine, Academic Program Review
6. Department of Surgery, Action Plan, dated May 1, 2013
7. College of Medicine, Agreement & Release
8. Email from UA Counsel re administrative duties, dated Sep. 6, 2013
9. UPH Amendment to Member Practice Agreement
10. McCarthy email to CEO Mlawsky, dated Sep. 11, 2013
11. Email chain between CEO Mlawsky and Dr. Gruessner
12. Email from Dr. Goldschmid suspending Dr. Gruessner, Sep. 19, 2013
13. UPH-UAHN Administrative Leave Letter, Sep. 19, 2013
14. COM-UA Administrative Leave Letter, Sep. 19, 2013
15. Dr. Gruessner's initial response to administrative leave, Sep. 20, 2013
16. Provost's response to request for additional information, Sep. 20, 2013
17. Dr. Gruessner's follow-up emails re charges
18. Letter from UPH that patient info will be delivered to home, Oct. 4, 2013
19. Response to UPH letter re delivery of patient info, Oct. 4, 2013
20. UPH email re missing notes and "inartful wording", Oct. 9, 2013
21. Dr. Gruessner's letter answering charges, Oct. 9, 2013
22. UPH letter making further accusations, Oct. 21, 2013
23. UPH email attempting to negotiate exit, Oct. 25, 2013
24. Dr. Gruessner's final email requesting reinstatement, Oct. 30, 2013
25. UPH letter and email terminating membership, Dec. 13, 2013
26. Whistleblower Complaint, Jan. 9, 2014
27. COM-UA Letter: Recommendation of Dismissal, Jan. 10, 2014
28. Denial of Whistleblower Claim, Feb. 7, 2014
29. Request for Independent Whistleblower Hearing, Feb. 21, 2014
30. Denial of Request for Independent Whistleblower Hearing, Feb. 25, 2014
31. Minute Entry Order, Mar. 7, 2014
32. Notice of Claim, Mar. 14, 2014
33. UPH Notice of Right to Request a Hearing, Mar., 20, 2014
34. Minute Entry Order, May 27, 2014
35. COM-UA Letter Reducing Pay, Jun. 9, 2014
36. COM-UA Notice of Appointment, Aug. 7, 2014
37. Independent Panel's Decision
38. UPH-UAHN email directing communication through attorneys, Sep. 20, 2013

Exhibit 1

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: Gru1rg@gmail.com

MARITAL STATUS: Angelika Gruessner, M.S., Ph.D.
2 children

CITIZENSHIP: USA

CURRENT POSITION: Chairman, Department of Surgery, 7/07 to present
Director, Hepatopancreaticobiliary Center
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 *PrivatDozent* (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 preemptive living donor liver transplant for oxalosis (1998)
First laparoscopic living donor distal pancreatectomy and nephrectomy (2000)
First robot-assisted total pancreatectomy with islet autotransplant (2012)

First living donor liver transplant, first living donor intestinal transplant,
first combined living donor intestinal and liver transplant, first multivisceral
transplant, 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, 2013
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 Oversight 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:

Astellas, Inc., Advisory Board, 2014
Berlex Transplant Advisory Board 2004-2006
Fujisawa Transplant Advisory Board 2001-2004

EDITORIAL BOARDS:

Editorial Board, Pancreatic Disorders & Therapy, 2013-present
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, Zeitschrift für Kinderchirurgie, 1993-2001
Editorial Board, Graft, 1998-2001

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 (ILTS)	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

HONORS AND AWARDS *(since 7/2007)*

Diabetes Cure Award, American Diabetes Assoc, AZ chapt	2012
Physician of the Year Award, Pima County Medical Assoc	2011
Innovation Award, University of Arizona	2009

RESEARCH PROJECTS AND GRANTS *(since 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 Immunosuppression
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 improvement 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)

Annual Effort - 5%

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

<i>Benoit Barrou, M.D.</i>	<i>1991 to 1992</i>
<i>Daniel Casanova, M.D.</i>	<i>1991 to 1992</i>
<i>Carlos Fasola, M.D.</i>	<i>1991 to 1992</i>
<i>Jon Fryer, M.D.</i>	<i>1991 to 1992</i>
<i>Christoph Troppmann, M.D.</i>	<i>1991 to 1995</i>
<i>Enrico Benedetti, M.D.</i>	<i>1992 to 1995</i>
<i>Nadey Hakim, M.D.</i>	<i>1993 to 1995</i>
<i>Basil Papaloi, M.D.</i>	<i>1993 to 1995</i>
<i>Jacques Pirenne, M.D.</i>	<i>1993 to 1995</i>
<i>Allen Farney, M.D., Ph. D.</i>	<i>1995 to 1997</i>
<i>Miguel West, M.D.</i>	<i>1995 to 1997</i>
<i>Abhinav Humar, M.D.</i>	<i>1996 to 1998</i>
<i>James Harmon, M.D.</i>	<i>1997 to 1998</i>
<i>Mark Reza Laftavi, M.D.</i>	<i>1997 to 1998</i>
<i>Thiagarajan Ramcharan, M.D.</i>	<i>1999 to 2001</i>

<i>Steven Paraskevas, M.D.,Ph.D.</i>	<i>2000 to 2002</i>
<i>Roger Denny, M.D.</i>	<i>2000 to 2002</i>
<i>Khalid Khwaja, M.D.</i>	<i>2001 to 2003</i>
<i>Massimo Asolati, M.D.</i>	<i>2001 to 2003</i>
<i>Keith Melançon, M.D.</i>	<i>2001 to 2003</i>
<i>Ty Dunn, M.D.</i>	<i>2002 to 2004</i>
<i>Miguel Tan, M.D.</i>	<i>2003 to 2005</i>
<i>Vince Casingal, M.D.</i>	<i>2003 to 2005</i>
<i>Mark Sturdevant, M.D.</i>	<i>2004 to 2006</i>
<i>Raquel Roca-Garcia, M.D.</i>	<i>2005 to 2006</i>
<i>Elizabeth Gross, M.D.</i>	<i>2005 to 2007</i>
<i>Michael Hughes, M.D.</i>	<i>2006 to 2007</i>

37 Chief Residents, Department of Surgery, University of Arizona *2007 to present*

M.S./Ph.D. GRADUATES:

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

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, M.D.: An initial experience with laparoscopic donor distal
pancreatectomy for living donor pancreas transplantation
2014 ATC Junior Investigator Award
Abbas Rana, M.D.: The Survival Benefit of 25 Years of Solid Organ
Transplantation in the United States

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:

Textbooks	2
Published Manuscripts	313
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)

Chinese Edition, 2013

(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 thePancreas. 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. Chinese Edition 2013.
- 3 LATIFI, R, **GUESSNER, R.W.G.**, RHEE, P (Editors). Technological Advances in Surgery, Trauma and Critical Care. Springer, New York, 2015.

- 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).
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- 91 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Molecular Medicine
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- 92 **GRUESSNER, R.W.G.:** Living Pancreas and Intestinal Donation. Living Organ Donation Conference.
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- 93 **GRUESSNER, R.W.G.:** Evolution of Living Donor Liver Transplantation. 70th Annual University of
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- 95 **GRUESSNER, R.W.G.:** The Amsterdam and Vancouver consensus conferences – the status of living
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- 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.
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- 108 **GRUESSNER, R.W.G.:** Current Status of Pancreas and Islet Transplantation. Transplant Grand Rounds, June 28, 2007, Xi'an University, Xi'an, China.
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- 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.
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- 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.
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- 118 **GRUESSNER, R.W.G.:** Current Advances in Hepatopancreatic Biliary Surgery. Arizona Chapter, American College of Surgeons 2008 Annual Scientific Meeting. November 1-2, 2008, Tucson, Arizona.
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- 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 Hepaticopancreaticobiliary 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.
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- 128 **GRUESSNER, R.W.G.:** Pancreas Transplant: Techniques and management. The First Egyptian Organ
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- 129 **GRUESSNER, R.W.G.:** Recent Advances in Transplantation and Complex Abdominal Surgery.
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- 130 **GRUESSNER, R.W.G.:** Transplant Surgery. Carondelet St. Mary's Hospital Symposium. June 9, 2010,
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- 131 **GRUESSNER, R.W.G.:** Living Donor Pancreas and Intestinal Transplant: Are they still indicated? 5th
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- 132 **GRUESSNER, R.W.G.:** Rebuilding the Department of Surgery at the University of Arizona. Arizona
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- 133 **GRUESSNER, R.W.G.:** Current State of Abdominal Transplantation. Texas Tech University Health
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- 134 **GRUESSNER, R.W.G.:** Transplant Options for the Treatment or Prevention of Insulin-Dependent
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- 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
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- 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
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- 140 **GRUESSNER, R.W.G.:** An update on pancreas and islet transplantation, 2nd National Congress of the
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- 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
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- 143 **GRUESSNER, R.W.G.:** Current Status of Whole Organ Pancreas Transplant for Diabetes. American
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- 144 **GRUESSNER, R.W.G.:** What defines Success in Islet and Pancreas Transplantation?
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- 145 **GRUESSNER, R.W.G.:** Laparoscopic Surgery for Chronic Pancreatitis. The International Symposium on
the Medical and Surgical Treatment of Chronic Pancreatitis, February 7, 2014,
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Exhibit 2



College of Medicine

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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 proceed.

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.

Administration of Medical Student and Graduate Medical Education:

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 represent 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:

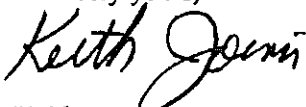
Your moving expenses would be reimbursed to you up to a total of \$25,000 from the COM and an additional \$5,000 from UPH subject to any agreement with the University or UPH for repayment of these amounts should you leave employment prior to the time period established by either employer. Such agreement 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.

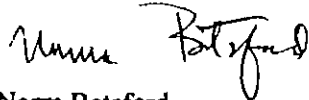
My colleagues and I are very excited at the prospect of you assuming this role in the Department of Surgery. We believe that you are the ideal individual to strengthen and develop initiatives in the Department focused on clinical care, education and research.

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 3



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,

A handwritten signature in black ink, appearing to be 'J. Fung'.

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.

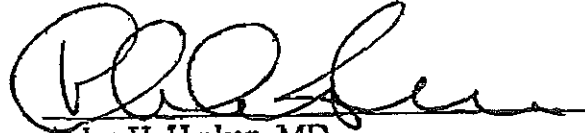
12) Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off. The burst of programmatic surgical development (with its constructive penumbra influence on other COM disciplines) has not yet, in our view, been completed.

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.

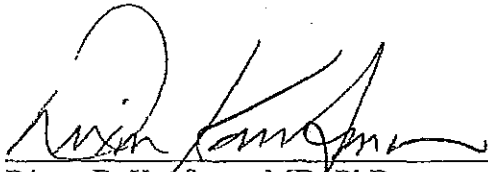
Academic Program Review
Department of Surgery
University of Arizona
April 1-2, 2010



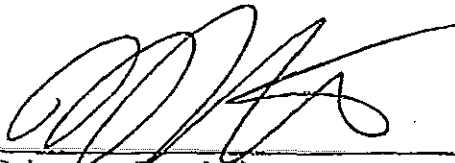
John Fung, MD, PhD
Professor and Chairman
Department of General Surgery
Director, Transplantation Center
Cleveland Clinic



Aiden 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.

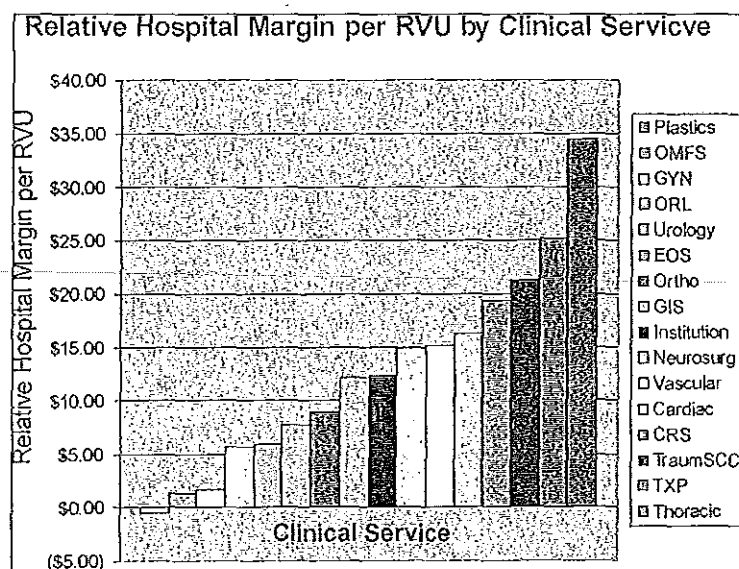


Figure Legend: Relative hospital margin (RHM0 per RVU varies greatly by service. Mean RHM per RVU was 12.64 mu (standard deviation = 9.76 mu) with range from a loss of 0.57 mu per RVU (plastic surgery) to a gain of 34.55 mu per RVU (thoracic surgery). GIS, gastrointestinal surgery; TXP, liver, kidney, and pancreas transplant; CRS, colorectal surgery division; EOS, endocrine and oncologic surgery; ORL, otorhinolaryngology; TraumSCC, 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 4

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

I. Charge to the Committee

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

II. Composition of the Committee

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

III. Data Acquisition by the Committee

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

IV. Report of the Committee

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

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

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

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

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

Grant funding and research dollars have significantly increased since FY07. 19 DOS faculty members currently receive funding for a total grant money support of 4.2 million dollars in FY12 (as compared to 1.9 million prior to Dr. Gruessner's arrival). Individual faculty members continue to garner national and international academic reputations, as evidenced by leaderships on society boards, textbook authors, serving as editor-in-chief of academic journals, functioning as course directors of international society CME courses and being frequently 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.
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Michael Lemole, M.D.
Professor of Surgery
Chief, Division of Neurosurgery

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

Exhibit 5

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 be 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 PGY1 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 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 6



THE UNIVERSITY OF ARIZONA HEALTH NETWORK

May 1, 2013

Rainer Gruessner, MD
Department Head, Surgery

Goal:

Create an excellent Department of Surgery (DoS) that aligns with College of Medicine (CoM) and The University of Arizona Health Network's (UAHN) goal to create a Premier Academic Medical Center.

UAHN/CoM cannot be successful without having an excellent DOS. Our combined goal is to have a highly successful DOS as measured by financial sustainability, patient experience, quality of care, and surgeon satisfaction.

Measures:

Finances: Profit, Adherence to budget, Efficiency (OR utilization etc.), and Productivity (as per RVU measures).

Patient experience: HCAHPS and CCAHPS

Quality: UHC Mortality O/E, NSQIP, AHRQ-PSI

Surgeon Satisfaction: Faculty Turnover, Survey data

Others: Patient/staff/faculty complaints.

In order to accomplish that goal, the head of the DoS must work with the other stakeholders/constituents in a collaborative fashion and set the standard of professionalism. This will require a new kind of leadership that:

- Builds and Maintains trust with stakeholders/partners.
- Actively works to dissolve the "us vs. them" mentality that has been created within the department.
- Assure that the health and vitality of the overall organization is the primary concern.
- Avoids blame and proactively addresses business concerns.
- Actively manages poor behavior and professionalism by setting the standard and modeling professionalism.
- Works within the rules, policies and organizational structures of UA CoM and UAHN.

The hope is that the current Chair of the DoS can rise to this leadership challenge. In order to do so, we are willing to invest in a leadership development program that must result in new skills, personal insights and knowledge to excel in this uniquely challenging time.

Corporate Administration

1501 N. Campbell Avenue • Tucson, Arizona 85724-5128

Telephone - 520.694.6530 • Fax - 520.694.6648

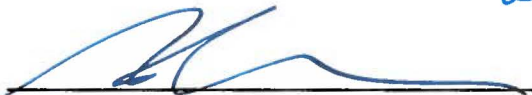
The plan will include:

- Personal Coach: To include DISC profile, 360 evaluation, and personal development plan. To be appointed and overseen by the Dean of the CoM and CEO of UAHN.
- Engage the DOS in an open, multi-stakeholder and transparent financial review and improvement process (Financial Oversight Committee-FOC). To be appointed and overseen by the Dean of the CoM and CEO of UAHN.
- Include the Dean of the CoM and the CEO of UAHN in DoS division director meetings on a regular basis.
- Become actively involved in proactively addressing professionalism issues of surgical faculty.
- Remove the current interim DoS administrator and form a multi-stakeholder search committee to find a replacement. This search committee is to be appointed by the Dean of the CoM and CEO of UAHN. Final selection must be agreed upon by the DoS Head, the Dean of the CoM and CEO of UAHN.

This plan must move on a defined timeline as follows.

- Removal of Interim DoS administrator: By ^{July 1,} June 15 2013 and severance will be determined by VP of HR for UAHN and in compliance with UAHN board compensation committee recommendations.
- Identification of DoS administrator search committee by: June 15 2013. Signoff and agreement of participants by UAHN CEO and CoM Dean.
- Identification of Development Partner (Coach) by July 1st. Agreement on coach by UAHN CEO and DoS Head required.
- 360 Evaluation and DISC assessment completed by September 1st.
- Development Plan: finalized by October 1st.
- Milestones of Plan as defined by the plan.
- Appointment of DoS FOC: By July 1 2013.

This leadership plan is a sign of significant investment in and confidence in the current Head of DoS and it is our hope that it will be received in that spirit. We understand that this plan will require significant introspection, learning and change of behaviors by the Head. Any attempt to take actions to derail this process and investment will be viewed as the DoS Head not wanting to make the changes that are needed to advance his career or UAHN. If the DoS Head takes this approach, appropriate and necessary disciplinary actions will be taken and will result in removal as the Head of Surgery. *(This MOU does not negate existing contracts with the com)*



Steve Goldschmid, MD
Dean, College of Medicine



Michael R. Waldrum, MD
President & CEO, UAHN

I agree to participate in this development plan per the terms outlined above: 

Exhibit 7

AGREEMENT AND RELEASE

This Agreement and Release (the "Agreement"), signed on the date set forth below, is between Rainer R.W. Gruessner, M.D. (hereafter "Gruessner"), the Arizona Board of Regents, the University of Arizona, and its College of Medicine (COM) (collectively referred to in this Agreement as the "University"). The University and Gruessner are sometimes individually referred to as a "Party" and collectively are referred to as the "Parties."

RECITALS

1. Gruessner is currently employed by the University as Head, Department of Surgery, Professor, Immunobiology (non-tenure eligible), and Professor, Surgery (tenured), as reflected in the Notice of Reappointment he signed on July 25, 2013, which describes his appointments and salary between July 1, 2013, and June 30, 2014.
2. The parties have agreed that it is in the best interests of all concerned if Gruessner relinquishes all of his administrative duties as of the date of execution of this Agreement.
3. The Parties have determined that it is in their mutual interests to enter into this Agreement in order to set forth the parties' understandings, and to ensure a smooth transition of leadership within the Department of Surgery.

AGREEMENT

In consideration of the mutual promises set forth below, the Parties agree as follows:

1. Gruessner will cease performing the administrative duties of Head, Department of Surgery, or exercising any other administrative authority within the College of Medicine upon the effective date of this Agreement.
2. Notwithstanding the foregoing, Gruessner will retain his title as Head, Department of Surgery, also sometimes referred to as Chair, Department of Surgery, through at least March 10, 2014, but in no event after June 30, 2014, and he will perform no administrative duties associated with that title after the effective date of this Agreement.
3. Gruessner will neither use nor assume any University titles that are not specifically described in his Notice of Reappointment dated July 25, 2013, after the date of execution of this Agreement without specific authorization from either the Dean of the College of Medicine (hereafter "Dean") or the University President.
4. If a new permanent Department Head is identified and put in place between March 10, 2014, and June 30, 2014, Gruessner will immediately relinquish his title as Head, Department of Surgery.

5. At all times after relinquishing his administrative duties as Head, Department of Surgery, Gruessner will cooperate with either an interim or a new permanent Department Head to ensure a smooth transition of leadership within the Department of Surgery.

6. As long as he bears the title of Head, Department of Surgery, Gruessner will report directly to the Dean with respect to his duties within the Department of Surgery. Therefore, if a new permanent Department Head is put in place after March 10, 2014, the new Department Head will determine whether Gruessner will report to the Department Head or continue to report to the Dean.

7. Gruessner will retain his full salary, as set forth in his Notice of Reappointment dated July 25, 2013, through the end of his current appointment, June 30, 2014, unless he otherwise terminates his employment with the University prior to that date.

8. Gruessner will maintain his other faculty appointments in the COM, as reflected on his Notice of Reappointment, through June 30, 2014.

9. Between July 1, 2014, and June 30, 2016, Gruessner's faculty salary will be set at the 75th percentile of the AAMC salary benchmark for a tenured transplant professor, based on his faculty teaching, research, and clinical activity as determined in accordance with established performance standards for clinical productivity within the College of Medicine and the compensation plan established by the physician practice plan, as anticipated by his original letter of offer dated February 25, 2007.

10. The Parties will execute any other documents as necessary to carry out the provisions of this Agreement.

11. This Agreement is considered to have been drafted, executed and delivered within the State of Arizona, and the rights and obligations of the Parties will be construed and enforced in accordance with, and governed by, the laws of the State of Arizona.

12. This Agreement is the entire agreement between the Parties with respect to its subject matter and supersedes all prior and contemporaneous oral and written agreements and discussions. This Agreement may be amended only by a further written agreement, which must be signed by the Parties and the Dean.

13. Each Party has had an opportunity to participate in the drafting and preparation of this Agreement; therefore, each party will be considered equally responsible for its content.

14. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision.

15. The Parties agree that this Agreement may not be used as evidence in any subsequent proceeding of any kind except for the enforcement of the terms of this Agreement.

16. In exchange for the promises set forth in this Agreement, Gruessner, on his own behalf and on behalf of his marital community, his heirs, children, executors, successors, administrators and assigns, forever releases, discharges, cancels, waives, and acquits the University and any of its current or former employees and agents, agencies, colleges, departments, political subdivisions, officials, officers, owners, boards, attorneys, successors, insurers, representatives, predecessors, and assigns, from any and all liabilities, causes of action, claims, damages, penalties, attorneys' fees, costs, or expenses that Gruessner has, had, or may hereafter have against any of them, arising out of the issues related to the subject matter of this Agreement. This release does not relate to the promises set forth in this Agreement, but is intended to be a full release related to any claims about Gruessner relinquishing his title as Head, Department of Surgery.

17. This agreement is effective upon its execution by all of the persons set forth below.

18. This Agreement may be executed in identical counterparts, which when considered together shall constitute the Parties' entire agreement. Signature pages may be detached from the counterparts and attached to a single copy of the Agreement to physically form one document. Signatures by facsimile, .pdf, or electronic signature are as binding and valid as an original signature. A copy of this Agreement shall be deemed as binding and valid as an original.

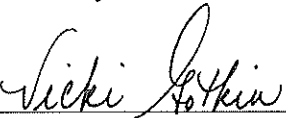
The undersigned have read this Agreement in its entirety, understand it, and sign it voluntarily.

Dated this 9th day of September, 2013.

Rainer Gruessner, M.D.

Approved as to form:

Kraig Marton, J.D.
Attorney for Rainer Gruessner



Vicki Gotkin, J.D.
Senior University Attorney on behalf of ABOR

On behalf of the Arizona Board of Regents
and the University of Arizona



Andrew C. Comrie, Ph.D.,
Senior Vice President for Academic Affairs
And Provost

Steve Goldschmid, M.D.
Dean, College of Medicine

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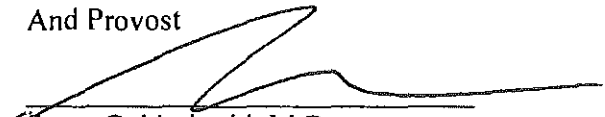
On behalf of the Arizona Board of Regents
and the University of Arizona

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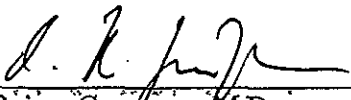
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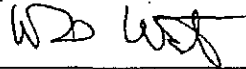
Dated this 9th day of September, 2013.

On behalf of the Arizona Board of Regents
and the University of Arizona



Rainer Gruessner, M.D.

Approved as to form:



Kraig Marton, J.D.
Attorney for Rainer Gruessner, M.D.

Andrew C. Comrie, Ph.D.,
Senior Vice President for Academic Affairs
And Provost

Steve Goldschmid, M.D.
Dean, College of Medicine

Vicki Gotkin, J.D.
Senior University Attorney on behalf of ABOR

Exhibit 8

From: [Gotkin, Vicki - \(vickig\)](#)
To: [Kraig J. Marton](#)
Subject: Agreement -- Versions that are acceptable to the University
Date: Friday, September 06, 2013 1:51:42 PM
Attachments: [AGREEMENT AND RELEASE with VG revisions 9-6-2013 no redline.doc](#)
[AGREEMENT AND RELEASE with VG revisions 9-6-2013.doc](#)

Dear Kraig,

Attached please find the revised Agreement to which my clients will agree. I have been instructed that, if this Agreement is not acceptable to your client, then we will not further negotiate. Many of my comments are imbedded in the document in the redline format, but several points need to be made:

- Your version did not reflect the June 30, 2014, end date for Dr. Gruessner to be able to use the title as Department Head in the event a new permanent head is not appointed prior to that date. That is a critical element of the Agreement the Dean made.
- The date of the Agreement was supposed to be September 1; therefore, extending the “guarantee” during which Dr. Gruessner could use that title if another permanent head were appointed should be March 1; however, given that you said that Dr. Gruessner may not be available to sign this agreement until September 10, I have extended the date to March 10, rather than the 15th, which was not a date we discussed in any form.
- Dr. Gruessner must relinquish all his administrative duties upon signing the agreement. He will retain no directorship, nor titles to that effect. The Dean will not agree not to give another physician a director title for the transplant program, because it will be necessary to comply with UNOS. Because this was a new term that you posed, which was not incorporated into the Agreement itself, it will not be added at a later time.
- There is no reason to include language about there being “differences” between the Dean and Dr. Gruessner in this Agreement; again, the President needs no reason to change a Department Head’s duties or title, and this will not be included in the Agreement, which benefits Dr. Gruessner by allowing him to retain his title for a period of time to make him more marketable.
- I previously advised you that this Agreement cannot be contingent on Dr. Gruessner reaching a similar agreement with UPH, and your including this in the Agreement was a surprise to me, as you indicated that only those terms to which we previously noted our agreement would be included in the draft your sent. We are moving backwards if this is an expectation.
- Similarly, the salary provision, which I explained in my earlier email was not written in the manner to which the Dean agreed. This is language that is nearly identical to what is in Dr. Gruessner’s letter of offer, dated February 22, not March 22, 2007 (your document said March 22), and signed February 25, 2007.
- Dr. Gruessner will have no administrative duties as Head; this is a title with nothing more. And, no matter when a new permanent Department Head is appointed, he must cooperate with an interim Department Head as well should he remain on the faculty. Your draft suggested he need not cooperate unless a new permanent head were appointed.

- The Dean, when acting as Dean, does not have a parallel role in UAHN/UPH. We will not agree to characterizing his role as Dean when acting on behalf of UPH, and the provision regarding any clinical or academic duties has been removed. That is something with which he will have to negotiate with UPH.
- There will be no reference to “removal” of Dr. Gruessner as Department Head. He will be relinquishing his title and his duties. I made this consistent wherever it appeared in the document.
- I added a provision regarding counterparts.

There are some additional comments in the margins as noted. This is the University’s last offer. No further changes, requests or revisions will be entertained. I expect you will have an opportunity to review this with Dr. Gruessner, as you have been including him on the emails you send to me, and we would like an answer – i.e., whether this will be put in final form *as is*, or not, by close of business today. If it is acceptable, I can finalize it and get it to you in time for Dr. Gruessner to sign it on Tuesday.

I look forward to hearing from you. Both a redline and a clean version are attached.

Vicki

Vicki Gotkin, J.D.
Senior University Attorney

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

CONFIDENTIALITY NOTICE

The information contained in this e-mail is privileged and confidential, and intended only for the individuals or entities named above. If you are not the intended recipient, any disclosure, copying, distribution, electronic storage, or use of this communication is prohibited.

If you received this communication in error, please notify me immediately by e-mail, or by telephone (520.626.7451), and delete the original message from your computer and network.

Thank you.

From: Kraig J. Marton [mailto:kjm@jaburgwilck.com]
Sent: Friday, September 06, 2013 10:48 AM
To: Gotkin, Vicki - (vickig)
Cc: Dr. Rainer W.G. Gruessner [gru1rg@gmail.com]
Subject: RE: Redlined version - agreement acceptable to dr. Gruessner

Vicki,

I look forward to hearing from you. However, the clean copy was MSWord, and another copy is attached. This is the actual agreement that Dr. Gruessner would sign. The redline was as a pdf. We do that so the metadata is removed.

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

NOTICE: this email may be between attorney and client, and, as such, is intended to be private, privileged and confidential. If you have received this transmission in error, please reply that you have received it mistakenly, and destroy the original email and any attachments. Thank you.

From: Gotkin, Vicki - (vickig) [<mailto:vickig@email.arizona.edu>]

Sent: Friday, September 06, 2013 10:30 AM

To: Kraig J. Marton

Subject: RE: Redlined version - agreement acceptable to dr. Gruessner

Kraig, what you sent are pdfs. I was able to bring up my earlier version and do a "compare documents," so I can see the changes you are proposing. I have forwarded your request to the Dean regarding the use of the title Dr. Gruessner has been using that was not officially conferred; however, as I have advised you in the past, Dr. Goldschmid is out of the office today and may not be able to reply. I suspect that the request will not be a problem because the title is not an official title, should not have been used without permission, and probably wouldn't be created to confer on someone else, but I need to get confirmation of this from my clients before I can put that in stone.

I hope to be able to get something back to you soon.

Vicki

Vicki Gotkin, J.D.

Senior University Attorney

Office of the General Counsel

The University of Arizona

Administration Building, Room 103

PO Box 210066

Tucson, AZ 85721-0066

Telephone: 520.626.7451

Facsimile: 520.626.7540

E-mail: vickig@email.arizona.edu

CONFIDENTIALITY NOTICE

The information contained in this e-mail is privileged and confidential, and intended only for the individuals or entities named above. If you are not the intended recipient, any disclosure, copying, distribution, electronic storage, or use of this communication is prohibited.

If you received this communication in error, please notify me immediately by e-mail, or by telephone (520.626.7451), and delete the original message from your computer and network.

Thank you.

From: Kraig J. Marton [<mailto:kjm@jaburgwilk.com>]
Sent: Friday, September 06, 2013 10:27 AM
To: Gotkin, Vicki - (vickig)
Cc: Dr. Rainer W.G. Gruessner [gru1rg@gmail.com]
Subject: Redlined version - agreement acceptable to dr. Gruessner

Vicki,

Attached is a redlined version showing the exact changes that Dr. Gruessner would like to the agreement previously sent to him. The only thing not showing up are the University logo and headers but the verbiage shows you all changes requested to the wording.

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

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Exhibit 9



AMENDMENT TO MEMBER PRACTICE AGREEMENT

This Amendment to the University Physicians Healthcare Member Practice Agreement ("MPA") executed on or about July 1, 2007, between Rainer Gruessner, M.D. ("Provider"), and University Physicians Healthcare ("UPH"), is for the purpose of ensuring a smooth transition as Provider steps down from his administrative duties with UPH. The Agreement amends the terms of the MPA and Letter of Offer executed in July 2007, and is effective September 1, 2013.

Effective September 1, 2013, Provider shall no longer perform any duties as Head, Department of Surgery and, furthermore, Provider shall not perform any UPH-related administrative duties with respect to this title after that date, unless UPH directs that he do so. Provider shall no longer hold the title of Chairman and Head, UPH Department of Surgery (or Department Director, UPH) or Chairman of UAMC – University Campus Department of Surgery. Provider shall no longer hold the title of Clinical Services Chief at UAMC – University Campus and shall no longer exercise any duties associated with that title.

Provider will remain a dually-employed faculty member under the terms of his appointment with the University of Arizona and Member Practice Agreement with UPH, unless Provider submits a letter of resignation. The Provider's clinical duties and responsibilities shall not change. With respect to clinical duties within the Department of Surgery, Provider will report directly to Steve Goldschmid, M.D. The Sites at which the Provider shall render clinical services shall not change.

Provider and UPH agree that effective September 1, 2013, Provider will be a 1.0 Clinical Full-Time Equivalent (CFTE) surgeon in the Department of Surgery, and will maintain or increase Provider's clinical productivity at or above FY2013 levels, as measured by Provider's work Relative Value Units. If Provider fails to maintain the expectations for clinical productivity, Provider's salary will be subject to adjustment in accordance with the UPH compensation plan.

In order to remain a Member of UPH in good standing, Provider shall:

- Not engage in any disruptive behavior at the University of Arizona Medical Center – University Campus;
- Not disparage UPH, UAMC- University Campus, UAHN or any of their employees or affiliated persons and entities;
- Not disrupt the UAMC- University Campus operating room schedule or surgical volumes;
- Not solicit staff or faculty for employment elsewhere;

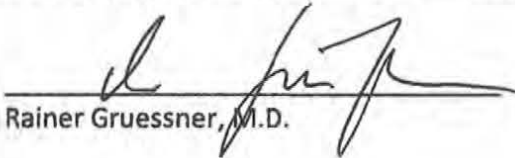
- Not misrepresent to any third party the terms of this Amendment or the reasons for it;
- Not communicate with any outside regulatory agencies about the status of any program within UPH or UAMC-University Campus or any changes to any such program;
- Refer all outside inquiries about this Amendment and all programs within UPH or UAMC-University Campus to the office of Steve Goldschmid, M.D.
- Assist to ensure for a smooth transition of leadership in the Department of Surgery;
- Follow the rules, policies and organizational structures of the organizations with which Provider works, including without limitation, behaving in a professional manner;
- Perform other duties as assigned.

In exchange for the promises set forth in this Agreement, Provider, on his own behalf and on behalf of his marital community, heirs, children, executors, successors, administrators and assigns, forever releases, discharges, cancels, waives, and acquits UPH, UAHN and any of its current or former employees and agents, departments, officials, officers, owners, boards, attorneys, insurers, representatives, predecessors, successors, and assigns from any and all liabilities, causes of action, claims, damages, penalties, attorneys' fees, costs, or expenses that Provider has, has had, or may hereafter have against any of them, arising out of his employment with UPH up through the effective date of this agreement, whether known at the time of execution of this Agreement or not.



Steve Goldschmid, M.D.
University Physicians Healthcare

Acknowledged and agreed to this ____ day of August, 2013.



Rainer Gruessner, M.D.

Exhibit 10

McCarthy, Michael S.

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.

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

9/12/2013

Exhibit 11

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 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 12

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 13



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, *M2W*
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 14

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 15

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; Craig 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 16

From: Comrie, Andrew C - (comrie) [\[mailto:comrie@email.arizona.edu\]](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 [\[mailto:rgruessner@surgery.arizona.edu\]](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.

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 17

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 Healthcare 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 policies and pursuant to Dr. Gruessner's due process rights. However, since Dr. Gruessner has been directed to communicate only through 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 confirm 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

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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

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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:

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 Healthcare 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 policies and pursuant to Dr. Gruessner's due process rights. However, since Dr. Gruessner has been directed to communicate only through 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 confirm 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

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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

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From: Gittler, Amy J. (Phoenix) [<mailto:GittlerA@jacksonlewis.com>]

Sent: Tuesday, October 01, 2013 5:26 PM

To: Kraig J. Marton

Cc: Chenoweth, 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
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Phoenix, Arizona 85016

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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
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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,

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 Healthcare 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 through 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 confirm 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.

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Exhibit 18



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Fax 602 714-7045
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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

Exhibit 19

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.

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

Please see the attached.

Regards,

Amy J. Gittler
Attorney at Law
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Phoenix, Arizona 85016

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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
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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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

Adam S. Kunz
Of Counsel

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?

Conclusions¹.

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,

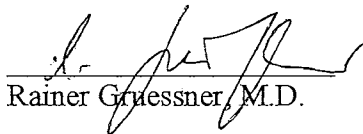
JABURG & WILK, P.C.



Kraig J. Marton

KJM:kmr

Approved:


Rainer Gruessner, M.D.

cc: Vicki Gotkin, Esq
Laura Johnson, Esq.

Exhibit 22



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
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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 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 23

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

Representing management exclusively in workplace law and related litigation.

Exhibit 24

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

NOTICE: this email may be between attorney and client, and, as such, is intended to be private, privileged and confidential. If you have received this transmission in error, please reply that you have received it mistakenly, and destroy the original email and any attachments. Thank you.

Exhibit 25

Kraig J. Marton

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

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

Thank you.

Regards,

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

602.714.7057 | Direct
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Sent Regular Mail and Delivery Service

December 13, 2013

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

Dear Dr. Gruessner:

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

Sincerely,

A handwritten signature in black ink, appearing to read "M. Waldrum", is positioned above the printed name.

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

Exhibit 26



January 9, 2014

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

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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Aaron K. Haar
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

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

Dear President Hart:

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

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

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

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

Adam S. Kunz
Of Counsel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Ann Weaver Hart

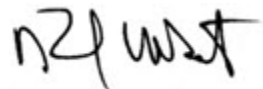
January 9, 2014

Page 5

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

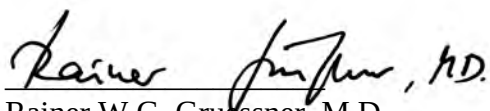
Sincerely,

JABURG & WILK, P.C.



Kraig J. Marton

Approved:



Rainer W.G. Gruessner, M.D.

KJM:akh

ENC.:

Exhibit A – UPH Membership Termination Letter

Exhibit B – Email from University of Arizona re Commencement of Termination Proceedings

Exhibit C – Reviews of the Department of Surgery Under Dr. Gruessner

Exhibit D – Email Chain with CEO Karen Mlawsky

Exhibit E – Email and Suspension Letters from Dean Goldschmid

Exhibit F – Dr. Gruessner's Response to Allegations

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

Exhibit A

Kraig J. Marton

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

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

Thank you.

Regards,

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

602.714.7057 | Direct
602.714.7045 | Fax

gittlera@jacksonlewis.com

www.jacksonlewis.com

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Sent Regular Mail and Delivery Service

December 13, 2013

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

Dear Dr. Gruessner:

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

Sincerely,

A handwritten signature in black ink, appearing to read "M. Waldrum", is positioned above the printed name.

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

Exhibit B

Kraig J. Marton

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

Dear Kraig,

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

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

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

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

Vicki

Vicki Gotkin, J.D.
Senior University Attorney

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

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The information contained in this e-mail is privileged and confidential, and intended only for the individuals or entities named above. If you are not the intended recipient, any disclosure, copying, distribution, electronic storage, or use of this communication is prohibited.

If you received this communication in error, please notify me immediately by e-mail, or by telephone (520.626.7451), and delete the original message from your computer and network.

Thank you.

Exhibit C



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,

A handwritten signature in black ink, appearing to be 'J. Fung'.

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.

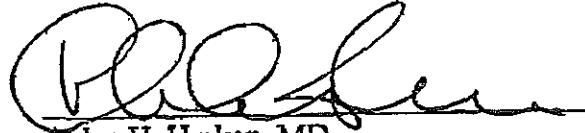
12) Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off. The burst of programmatic surgical development (with its constructive penumbra influence on other COM disciplines) has not yet, in our view, been completed.

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.

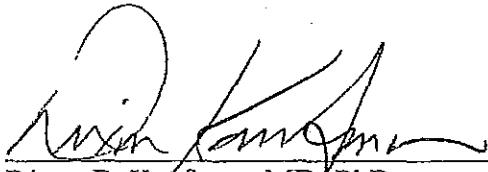
Academic Program Review
Department of Surgery
University of Arizona
April 1-2, 2010



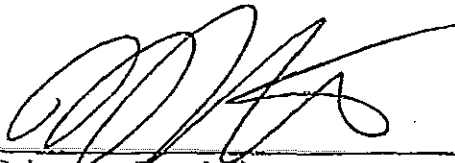
John Fung, MD, PhD
Professor and Chairman
Department of General Surgery
Director, Transplantation Center
Cleveland Clinic



Aiden 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 (ASTECC) – 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.

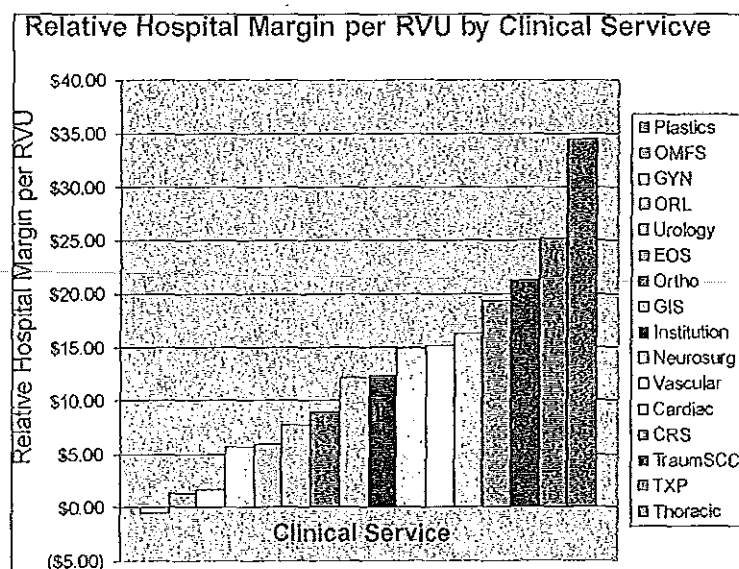


Figure Legend: Relative hospital margin (RHM0 per RVU varies greatly by service. Mean RHM per RVU was 12.64 mu (standard deviation = 9.76 mu) with range from a loss of 0.57 mu per RVU (plastic surgery) to a gain of 34.55 mu per RVU (thoracic surgery). GIS, gastrointestinal surgery; TXP, liver, kidney,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

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

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

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

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

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

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

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

I. Charge to the Committee

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

II. Composition of the Committee

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

III. Data Acquisition by the Committee

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

IV. Report of the Committee

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

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

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

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

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

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

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

2. Comments on the Interview with Dr. Gruessner

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

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

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

3. Results of the Survey Questionnaire

a. Respondents

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

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

b. Numerical Results by Core Content Area

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

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

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

Categorical breakdown:

A. Faculty: (overall 4.37)

Strongest scores in:

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

Weakest scores in:

1. Conflict resolution -- 3.79
2. Mentoring -- 3.87

B. Staff: (overall 4.00)

Strongest scores in:

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

Weakest scores in:

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

C. Residents/Fellows (overall 4.53)

Strongest scores in:

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

Weakest scores in:

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

D. Department heads (overall 4.35)

Strongest scores in:

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

Weakest scores in:

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

c. Subjective Portion of the Questionnaire

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

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

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

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

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

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

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

Other useful comments

V. Summary and Comment

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

Signature Page

for

Rainer Gruessner, M.D., Administrative Review

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

Lisa Chan, M.D.
Professor of Emergency Medicine

Randall Friese, M.D.
Associate Professor of Surgery

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

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

Exhibit D

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

Rainer,

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

Karen D. Mlawsky
CEO, UAMC

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

Karen,

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

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

Exhibit E

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

Dear Rainer,

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

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

Sincerely,
sg

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



MEMORANDUM

TO: Rainer Gruessner, M.D.

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

RE: Notice of Placement on Leave with Pay

DATE: September 19, 2013

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

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

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



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

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



THE UNIVERSITY OF ARIZONA
HEALTH NETWORK

MEMORANDUM

Human Resources Department

To: Rainer Gruessner, MD, Department of Surgery

From: Michael Waldrum, MD, MSc, MBA, President and CEO, *M2W*
The University of Arizona Health Network, Inc.

Date: September 19, 2013

Re: Paid leave

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

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

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

Exhibit F



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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

Adam S. Kunz
Of Counsel

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?

Conclusions¹.

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,

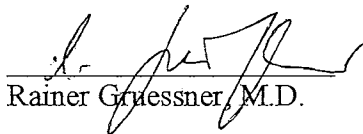
JABURG & WILK, P.C.



Kraig J. Marton

KJM:kmr

Approved:


Rainer Gruessner, M.D.

cc: Vicki Gotkin, Esq
Laura Johnson, Esq.

Exhibit 27

*Sent Certified Mail, Return Receipt Requested
Regular U.S. Mail and Email*

January 10, 2014

Rainer W.G. Gruessner, M.D.
6408 N. Placita del Zopilote
Tucson, AZ 85750

Re: Recommendation of Dismissal

Dear Dr. Gruessner:

I am writing to inform you that I am recommending your dismissal from your tenured professorship in the Department of Surgery at the University of Arizona to President Ann Weaver Hart, under Arizona Board of Regents (ABOR) Policy 6-201, *et seq.*, the *Conditions of Faculty Service*. My recommendation is based on a request from the Dean of the College of Medicine, which included a letter from University of Arizona Health Network (UAHN) CEO, Michael Waldrum, M.D., dated December 13, 2013, advising you that your membership in University Physicians Healthcare, Inc. (UPH) was being terminated effective that date. I am advised that the parties attempted to negotiate your amicable departure from UAHN, UPH and the University, but that those discussions failed to resolve the issues, and the December 13, 2013, termination became effective on December 27, 2013.

Under the terms of your original University letter of offer, your appointment and subsequent renewals of your appointment with the University are contingent, among other things, upon your *membership and employment in good standing with UPH* if you are engaged in clinical care of patients. (Emphasis added.) That requirement was an express condition of your initial and continued employment with the University. The termination of your membership in UPH requires the University to take action to dismiss you from your appointment at the University.

Under the *Conditions of Faculty Service*, “[t]enured faculty members can only be dismissed or suspended without pay with just cause.” (ABOR 6-201(J)(1)(a).) Because you no longer are a member in good standing of UPH and have been relieved of all your UPH-related responsibilities, you are unable to carry out your duties as contemplated in your University letter of offer, your notice of appointment and notices of reappointment, and therefore, just cause, as contemplated by ABOR Policy 6-201(J)(1)(a), exists to dismiss you from your tenured faculty appointment at the University of Arizona.



Letter to Rainer W.G. Gruessner, M.D.
January 10, 2014
Page 2 of 2

Under ABOR Policy 6-201(J)(1)(a) and 6-201(L)(3)(a), as well as *University Handbook for Appointed Personnel* Policy 3.17, you may appeal this recommendation by submitting a written notice of appeal to President Hart *no later than ten (10) days* following the date on which this letter was mailed. The procedures for this process are covered in ABOR Policy 6-201(L).

You will remain on administrative leave with pay until this matter concludes.

Sincerely,



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

enclosure – letter from Michael Waldrum

cc: Ann Weaver Hart, President
Joe G.N. Garcia, M.D., Senior Vice President for Health Sciences
Steve Goldschmid, M.D., Dean, College of Medicine
Alexander Chiu, M.D., Interim Head, Department of Surgery

COPY



Sent Regular Mail and Delivery Service

December 13, 2013

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

Dear Dr. Gruessner:

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

Sincerely,

A handwritten signature in blue ink, appearing to read "M. Waldrum", is positioned above the printed name.

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

Exhibit 28

February 7, 2014

Rainer W.G. Gruessner, M.D.
6408 N. Placita del Zopilote
Tucson, AZ 85750

Dear Dr. Gruessner:

I am writing on behalf of President Hart and the Arizona Board of Regents (ABOR) regarding your January 9, 2014 letter (as supplemented by Mr. Marton's January 24, 2014 letter), which you characterize as a "whistleblower complaint" under Arizona Board of Regents (ABOR) Policy 6-914. You further allege that, as a result of making a disclosure of wrongful conduct, not only to the University's Committee of 11, but also to leadership within UAHN, you suffered retaliation when UPH terminated your membership and the University initiated dismissal proceedings as a result of your loss of membership in that organization.

I conclude that the statements you made to the University's Committee of 11 were not disclosures of wrongful conduct as defined by the ABOR whistleblower policy, and therefore, your complaint of retaliation is not a whistleblower complaint under that Policy. I further find that the statements you allegedly made to UAHN officials regarding the record-keeping activities within the transplant program you directed do not qualify as disclosures to a public official or designated University officer. Therefore, I conclude that further investigation under Policy 6-914 is not warranted.

Making a "disclosure," as defined by ABOR Policy 6-914, is a prerequisite to bringing a whistleblower complaint. You did not make a "disclosure" of wrongful conduct to a public body or designated University official on a matter of public concern, as those terms are defined under ABOR Policy 6-914. You stated that you were invited to meet with a few members of the Committee of 11 in December 2012 in your capacity as Department Head of the Department of Surgery. You stated that, during that meeting:

- You were asked "to provide input regarding the state of the College of Medicine (COM) under Dean Steve Goldschmid's leadership."
- You expressed "*concern* about Dean Goldschmid's leadership."
- "You explained how the *college's NIH ranking had not improved*, how *key faculty in the Cancer Center and clinical departments had left and could not be replaced*, and how a *climate of fear and retaliation had been fostered by the Dean, resulting in low morale among faculty and staff*."
- You gave your opinion that the Dean "would not be able to take the college to the next level and attain a national reputation."

At some point thereafter, you allege that "[your] comments to these members of the Committee of 11 were conveyed to Dean Goldshmid," but do not state by whom such comments were communicated. You further surmise that Dean Goldschmid began a course of action that resulted



in the eventual loss of your UPH membership and the recommendation that you be dismissed from the University because you no longer maintained membership in UPH.

You attended the meeting with the Committee of 11 in your official capacity as Department Head of the Department of Surgery, and gave opinions regarding Dr. Goldschmid's leadership at the COM in that official capacity. Thus, the comments you made, as described in your January 9, 2014, letter, do not qualify as whistleblower disclosures, nor do they rise to the level of matters of public concern.

Nor does your report to UAHN about transplantation documentation at the hospital constitute a disclosure under ABOR policy. As I stated in my January 14, 2014, letter to you, UAHN and UPH are separate private legal entities. Although closely aligned with the University's mission, they are not the University,¹ nor can disclosures regarding procedures over which you had control as the Director of the service and over which the University had no control or knowledge, be construed as disclosures to the University. The purpose of the whistleblower policy is to allow the University to take appropriate action once a disclosure of wrongful conduct has been made to *it*. Making a disclosure (whether it would qualify as such under the whistleblower policy or not if made to an appropriate University official) to a non-University entity about its own practices, protocols and procedures, does not qualify as a disclosure to a public body or a designated University official under ABOR policy. No one to whom you reported your concern about transplant surgery documentation was a public official or a designated University officer. Thus, I conclude that your January 9, 2014, letter does not qualify as a whistleblower complaint.

The personnel action you now face at the University is, as I understand it, directly related to your loss of membership in UPH, which is a condition of your continued employment with the University. You are entitled to due process under ABOR Policy before the University can dismiss you, which I understand is underway.

Under the whistleblower policy, it is my obligation to refer you to other available University grievance or appeal processes to address your concerns. You have exercised your rights to appeal the recommendation of dismissal. The University Handbook for Appointed Personnel, Section 6.02, provides a grievance mechanism as well, should you believe it is applicable to your situation. See <http://hr.arizona.edu/policy/appointed-personnel/6.02>.

Sincerely,



Professor Thomas P. Miller,
Associate Provost for Faculty Affairs

cc: Nancy Tribbensee, General Counsel, Arizona Board of Regents
Ann Weaver Hart, President
Andrew Comrie, Ph.D., Senior Vice President for Academic Affairs and Provost

¹ At the time you made the "disclosure" to hospital officials, it is my understanding that you were the director of the transplant program, and ostensibly responsible for appropriately reporting procedures.



Exhibit 29



February 21, 2014

Via E-Mail hartaw@email.arizona.edu

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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Aaron K. Haar
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Adam M. Weiler
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

Re: Request for a Whistleblower Hearing -- Dr. Rainer Gruessner

Dear President Hart:

This letter constitutes a request for a whistleblower hearing by an external hearing officer pursuant to Arizona Board of Regents' Policy 6-914(J) and is hereby submitted and filed within 15 days after receipt of the university officer's unsatisfactory February 7, 2014 decision.

The Complainant is Dr. Rainer W.G. Gruessner, Chairman Department of Surgery, Professor of Surgery and Immunology, University of Arizona College of Medicine, 1501 N. Campbell Ave., #4410, Tucson, AZ 85724, (520) 626-4409. As Dr. Gruessner is currently barred from entering university premises, he may be contacted through me, at the address, phone number, and email address listed on this letter.

The university officer who issued the February 7, 2014 decision on Dr. Gruessner's whistleblower complaint is Professor Thomas P. Miller, Associate Provost for Faculty Affairs, Administration Building, P.O. Box 210066, Tucson, AZ 85721, (520) 626-0202.

As required by ABOR Policy 6-914(J), the reasons for requesting a hearing and the specific relief or remedy requested are below. Copies of the original whistleblower complaint (**Exhibit 1**) and the Associate Provost's decision are attached (**Exhibit 2**).

Overview

Dr. Gruessner filed a written whistleblower complaint on January 9, 2014 on grounds that adverse personnel action was taken against him in retaliation for two distinct disclosures of wrongful conduct regarding matters of public concern.

Adam S. Kunz
Of Counsel

First, Dr. Gruessner reported Dean Steve Goldschmid's mismanagement, abuse of authority, and waste of public funds at the College of Medicine to members of the university's Committee of Eleven. Second, Dr. Gruessner reported incorrect (potentially fraudulent) transplant data reporting—which constituted mismanagement and a specific danger to public health and safety—to the University of Arizona Medical Center's CEO and business manager.

As a result of these disclosures, Dr. Gruessner was first placed on administrative leave on September 19, 2013 and held in limbo indefinitely, as the retaliating parties attempted to "negotiate" his permanent departure. When Dr. Gruessner refused to be bullied out, his UPH membership was unlawfully terminated without cause on December 13, 2013, just one business day before a scheduled injunction hearing regarding his reinstatement. Based solely on that illegal termination, proceedings to terminate him as a tenured professor at the College of Medicine were commenced thereafter on January 10, 2014.

Without further investigation of Dr. Gruessner's case, Associate Provost Miller concluded (1) that statements Dr. Gruessner made to the university's Committee of Eleven were not disclosures of wrongful conduct under the policy and (2) that statements Dr. Gruessner made to University of Arizona Medical Center officials did not qualify as disclosures to a public official or designated university officer under the policy. On both accounts, Associate Provost Miller is mistaken.

Brief Statement of Facts

Dr. Gruessner was included on a mass email from representatives of the Committee of Eleven "to discuss ongoing concerns dealing with the COM." Of his own accord, and apart from any responsibility as a tenured faculty member or chairman of the Department of Surgery, Dr. Gruessner chose to speak with the committee members out of his grave concern for the mismanagement, abuse of power, and waste of public funds that Dean Goldschmid posed to the College of Medicine. He believed the wellbeing of the College of Medicine—and, as a result, the great number of citizens and patients in Tucson and across Arizona who are reliant on the College—was at stake. He firmly believed the Dean was failing to properly manage the school to the detriment of all stakeholders. [And although school administrators are currently standing by the Dean's leadership, likely to avoid implication and liability, the administration recently "created" a new position for Dr. Goldschmid to move him out of his role as Dean of the College of Medicine. Although the move has been pitched as lateral, Dean Goldschmid, in his new role, will be reporting to the new interim Dean of the College of Medicine.]

Dr. Gruessner later found that his comments to the committee members were conveyed to the Dean (which is documented). This led to a worsening of conditions. The Dean began taking actions to eliminate Dr. Gruessner from his position at the College of Medicine and the University of Arizona Medical Center, where the Dean also served as co-chief executive officer of UPH. Despite Dr. Gruessner's glowing 7- and 5-year reviews the Dean continued to withdraw support of the Department of Surgery and asked Dr. Gruessner to step down, citing "a record of poor performance." This came as a surprise to Dr. Gruessner since the Dean had not provided him in five years with an annual evaluation (as required) nor was there any communication of potentially "poor performance" of Dr. Gruessner. Quite to the contrary, only a couple weeks later, Dr. Gruessner received one of the highest performance-based bonus payments of all chairs in Fiscal Year 2013.

In this environment, Dr. Gruessner uncovered and disclosed another matter of even graver public concern. With the Dean forcing him out, Dr. Gruessner eventually decided that he did not want to fight with a supervisor. He decided to step down on certain conditions. In one of his last actions as the Surgical Transplant Director, Dr. Gruessner found, to his surprise, that the hospital had reported incorrect transplant data to UNOS, the organization that qualifies transplant doctors and programs. Although Dr. Gruessner was not responsible for reporting transplant data to UNOS, he wanted a count of the number of transplants he had performed during his tenure at the University of Arizona. Initially just suspecting that the incorrect data was the result of an honest mistake, Dr. Gruessner approached the business manager for transplant services to compare the actual operating notes with UNOS data. Dr. Gruessner informed the business manager that hospital administration should be notified and the data should be corrected. Dr. Gruessner even mentioned the incorrect reporting during a conversation with hospital CEO Karen Mlawsky. Shortly thereafter, Dr. Gruessner received notice from the Dean that he was being suspended from the College of Medicine and from the hospital for “altering or directing others to alter records.” He was never given a hearing or an opportunity to demonstrate that the UNOS data were false and not a single record was changed. Instead, the administration has continually attempted to “negotiate” his departure—again, most likely to avoid the fallout that would result if Dr. Gruessner was given due process and the ability to present evidence.

In context, Dr. Gruessner now believes that he may have uncovered fraudulent misreporting to UNOS. If Dr. Gruessner was to leave the school (perhaps after being chased away), someone else would have to replace him as surgical director of liver transplantation—someone who would be qualified by UNOS to fill that role. Upon information, Dr. Gruessner believes that the individual who was chosen by the Dean to replace him (and who had met with the Dean several times about this matter without Dr. Gruessner’s knowledge) would not have been properly qualified if not for the misreporting that occurred. In violation of the UNOS request that the former program director signs a new application, Dr. Gruessner was not asked by UAMC administration to sign the application for the new surgical director of the liver transplant program—Dr. Gruessner’s would likely not have signed the application since he believes the proposed individual did not have the surgical expertise nor had he performed the required number of liver transplants at UAMC. Thus, Dr. Gruessner believes the misreporting may have been orchestrated as part of the Dean’s global strategy to remove him, not only as surgery chair but also as chief of transplantation, in an effort to discredit his experience and to marshal in a seamless transition despite the unqualified nature of his apparent successor.

Whether the misreporting was in fact malicious or was simply an honest mistake as Dr. Gruessner initially suspected, the misreporting has serious implications for the public’s health and safety. UNOS maintains demanding standards of its qualified surgeons because of the concern for patient safety. If an improperly qualified surgeon is qualified to perform the procedure, catastrophic outcomes may result. Before Dr. Gruessner was unlawfully suspended and purportedly terminated, the University of Arizona performed approximately two liver transplants per month. In the past five months, the university has attempted only one liver transplant with a disastrous outcome. Dr. Gruessner was told that this one transplant drained a substantial reserve of blood, required three re-explorations, and concluded with a poor long-term outlook for the patient. In addition, at least two patients on the liver transplant waiting list have died—which could have potentially been avoided if a more aggressive treatment approach had been chosen. Dr. Gruessner believes this is all the result of an unqualified

surgeon who was improperly deemed qualified. Unquestionably, the public health is at risk. Furthermore, Medicare payments are contingent on UNOS Certification. So, if the University and its hospitals improperly and fraudulently qualified its program based on incorrect data reporting, the organizations could be faced with charges of Medicare fraud.

All of this is likely why Dr. Gruessner has encountered a brick wall at every corner when requesting peer review or a hearing to demonstrate his actions were not improper. And now, without further investigation involving Dr. Gruessner, Associate Provost Miller has dismissed Dr. Gruessner's plea for justice based on a conclusory finding that Dr. Gruessner's case "does not qualify" as a whistleblower complaint.

Associate Provost Miller's Conclusions Are Incorrect

Associate Provost Miller's decision indicates that he placed the entirety of the investigation on Dr. Gruessner's shoulders. He wrote: "you allege that '[your] comments to these members of the Committee of 11 were conveyed to Dean Goldschmid,' but do not state by whom such comments were communicated." See Miller's decision attached as **Exhibit 2**. Dr. Gruessner has hard evidence that his comments were communicated to the Dean. But he never had the opportunity to provide such evidence as part of an investigation that was never begun. The policy does not indicate that the whistleblower is required to first conduct an extensive investigation on their own and then only present the evidence to the university officer once it is properly tied up in a bow. Rather, Section 6-914(F) states that "[t]he university officer and/or designees will conduct an investigation into the allegations of the disclosure and will take necessary corrective action, as warranted." Thus, the actual burden of an investigation is to be borne by the university official. And rightfully so: the associate provost's office actually has the authority to conduct such an investigation. By nature of the adverse action taken against him, Dr. Gruessner not only cannot access university computer systems and databases, but he is restricted from even setting foot on campus.

It is beyond the scope of a whistleblower complaint to prove by a standard of evidence that the Dean was directing the adverse action or that he otherwise had knowledge of the disclosures. The policy only requires Dr. Gruessner to make particular allegations, constituting a prima facie claim under the policy. See 6-914(I). Dr. Gruessner carefully made such allegations in his initial whistleblower complaint. However, Associate Provost Miller narrowly and wrongly construed the policy against Dr. Gruessner and quashed the whistleblower investigation before it could even begin. Such has been the nature of Dr. Gruessner's experience as the object of the Dean's hostility.

Associate Provost Miller also claims that statements Dr. Gruessner made to members of the university's Committee of Eleven were not disclosures of wrongful conduct under the policy. The policy defines "alleged wrongful conduct" as "(1) a violation of any law, (2) mismanagement, (3) gross waste or misappropriation of public funds, (4) a substantial and specific danger to public health and safety; or (5) an abuse of authority." ABOR Policy 6-914(D). The mismanagement of the College of Medicine certainly falls within such wrongful conduct and indisputably rises to the level of public concern. The College of Medicine is a public entity that trains future doctors and treats thousands of patients. Any faltering of the organization is of an enormous concern, both to the public fisc and to those who rely on the doctors at the school now and in the future. Dr. Gruessner disclosed to members of the Committee of

Eleven that the Dean was mismanaging the College of Medicine, abusing his authority, and wasting public funds. It is difficult to see how Associate Provost Miller could claim, without further inquiry, that such disclosures did not qualify as wrongful conduct of a public concern.

The disclosure to representatives of the Committee of 11 is unquestionably to a public body. Under ABOR Policy 6-914(E)(14) public body is defined as “The Arizona Attorney General; the Arizona Legislature; the Governor of Arizona; a federal, state, or local regulatory or law enforcement agency; the local county attorney; a member of the Arizona Board of Regents; a university president, provost, vice president, vice provost, college dean, or non-academic department director.” Aside from some of the members’ capacity as department heads, the Committee itself is an official committee of the university duly organized and authorized under the Bylaws of the Faculty of the University of Arizona. See Article V, Bylaws of the Faculty of the University of Arizona. Other such governing bodies similarly created include the Committee on Faculty Membership, Grievance Clearinghouse Committee, Committee on Conciliation, Committee on Academic Freedom and Tenure, etc. *Id.*

Dr. Gruessner’s uncovering of the incorrect data reporting was also a disclosure of wrongful conduct. The health and safety concerns accompanying improper qualification of transplant surgeons are indisputably matters of public concern. The mismanagement leading to this danger to public health and safety constitutes the wrongful conduct. Despite the “investigative” role the Associate Provost’s office was supposed to play, he argued that Dr. Gruessner was personally responsible for that data reporting and therefore was not eligible to blow the whistle, essentially, against himself. However, it is the responsibility of the hospital, as an OPTN member, to report data to UNOS and not the responsibility of an individual physician. Thus, the Associate Provost’s circular argument is disingenuous at best. If Dr. Gruessner were responsible for maintaining the data, how could he possibly be subject to adverse personnel action for “altering or directing others to alter” them? The university cannot have it both ways. Either he appropriately suggested corrections to the data as the individual responsible, or he suggested corrections to the data outside the scope of his responsibilities—and is thereby subject to protection as a whistleblower. That Dr. Gruessner was purportedly terminated and has been denied his right to a hearing or peer review under University of Arizona Medical Center bylaws and under the bylaws of University Physician’s Healthcare, the nonprofit responsible for managing the hospital, makes this reasoning particularly suspect.

Associate Provost Miller then argued that statements Dr. Gruessner made to University of Arizona Medical Center officials did not qualify as disclosures to a public official or designated university officer under the policy. He claims that these entities are protected because they are private entities. And although the University of Arizona Medical Center and University Physicians Healthcare are now in fact private nonprofits, the nature of the organizations and their relation to this particular claim renders them legally inseparable from the university. In fact, Dean Goldschmid was in leadership positions for both the University of Arizona and UPH/UAHN. And, in this regard, if Dr. Gruessner only blew the whistle to a private official, how was he suspended from both the university and the hospital simultaneously? A closer look at the law demonstrates Associate Provost Miller’s incorrect conclusion in this regard.

First, private hospitals with public ties cannot hide from responsibility simply by organizing behind a private entity. For example, see *Milo v. Cushing Mun. Hosp.*, 861 F.2d 1194, 1197 (10th Cir.

1988) (“The defendants cannot escape liability by delegating responsibility to another party.” (internal quotations omitted)); *Jatoi v. Hurst–Euless–Bedford Hosp. Auth.*, 807 F.2d 1214, 1221–22 (5th Cir. 1987) (“The private defendants cannot receive public funds, utilize public facilities, and serve a public purpose, yet insist that their private status forestalls any correction of a violation of the constitutional rights of their medical staff.”); *Malak v. Assoc. Physicians, Inc.*, 784 F.2d 277, 282 (7th Cir. 1986) (“[T]he conduct of a public hospital and its employees is clearly state action and the conduct of otherwise private entities that act jointly with them is also state action.”). Additionally, the law recognizes such public-affiliated hospitals, like the University of Arizona Medical Center, as a quasi-public entity. See *Peterson v. Tucson Gen. Hosp., Inc.*, 114 Ariz. 66, 69, 559 P.2d 186, 189 (Ct. App. 1976) (a hospital is quasi-public “if what otherwise would be a truly private hospital was constructed with public funds, is presently receiving public benefits or has been sufficiently incorporated into a governmental plan for providing hospital facilities to the public.”).

Although private, the University of Arizona Medical Center has strong public ties. The hospital was initially founded and built with public funds. The hospital acts as the teaching hospital for the public University of Arizona College of Medicine. In fact, the College of Medicine could not even exist if not for the existence of its teaching hospitals and their management. That a public institution would utterly collapse in the absence of its private crutch is strong evidence that the private entity is actually a part of the public institution. As such, the University of Arizona Medical Center, its management, and the College of Medicine are to be treated similarly.

Furthermore, as joint actors, all of the entities must be treated as one. Dr. Gruessner was jointly employed by the University of Arizona and at the University of Arizona Medical Center, through membership in University Physicians Healthcare. They share the cost of his salary and the benefit of his services. The university was responsible for issuing his joint paycheck. Dr. Gruessner’s employment at one of his joint employers was contingent on his employment at the other of his joint employers. And there is substantial overlap among the leadership at the College of Medicine, University of Arizona Medical Center, and University Physicians Healthcare. For instance, Dr. Goldschmid was dean of the College of Medicine, a director at University Physicians Healthcare, and co-chief executive officer and a director of University of Arizona Health Network which oversees the joint nature of the institutions. And now the public university is allegedly taking action in conformity with the “private” hospital based solely on the “private” organization’s unilateral and unlawful action.

Dean Goldschmid’s wrongful allegations that Dr. Gruessner “altered records” and the UPH termination are all part of the same retaliatory action that is subject to this whistleblower complaint. Refusal to consider all of what happened is to ignore a significant part of the plot. Determination of whether Dr. Gruessner improperly “altered records” (which he clearly did not) is important to solving this matter. Ignoring this information effectively allows university leadership to retaliate at will so long as it is executed through a private affiliated entity. This would practically render the whistleblower policy—and, more importantly, the protections of tenure—ineffectual. Certainly the relevant ABOR and university policies were not contemplated to allow such unrestricted indulgence.

Specific Relief and Remedy Requested

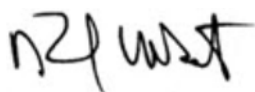
The whistleblower policy was intended to protect individuals in Dr. Gruessner's position. But when an administration is allowed to protect itself throughout the process by refusing to investigate or refusing to provide a hearing, the protections fail those who need them most. Because of the apparent absolute power exercised by the Dean in this instance, Dr. Gruessner is unlikely to receive a fair investigation if conducted internally. The outcome of his first whistleblower claim is proof. A disinterested, external party will best be able to evaluate the truth of the allegations and arrive at the most equitable conclusion, free from the fear of retaliation.

Dr. Gruessner does not seek money. He does not seek retribution. He simply wants his rightful job back. He was unlawfully suspended and apparently terminated for disclosing wrongful conduct regarding matters of public concern. It is in the best interest of all parties involved if these claims can be settled quickly and administratively rather than under the expensive public microscope of a courtroom. Bringing in an external hearing officer will allow the parties to adjudicate their rights as efficiently as possible. In the alternative, Dr. Gruessner requests that you intervene and send this whistleblower complaint back down to the associate provost's office for a full and fair investigation. One way or another, the truth will come out. Standing in its way at this point will only serve to place the imposing individual on the wrong side of history. Therefore, we urge the parties evaluating this claim to determine whether Dr. Gruessner qualifies for a whistleblower hearing to err on the side of fairness with an eye toward a search for truth.

Due to the foregoing, Dr. Gruessner respectfully requests that he be granted a whistleblowing hearing by an external hearing officer under ABOR Policy 6-914(J).

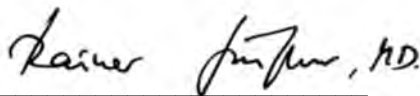
Sincerely,

JABURG & WILK, P.C.



Kraig J. Marton

Approved:



Rainer W.G. Gruessner, M.D.

KJM:akh

ENC. Exhibit 1 – Dr. Gruessner's Original Whistleblower Complaint
Exhibit 2 – Associate Provost Miller's Whistleblower Decision

cc: Mr. Rick Myers, Chairman, Arizona Board of Regents (rick.myers@azregents.edu)
Ms. Eileen Klein, President, Arizona Board of Regents (eileen.klein@azregents.edu)

Dr. Andrew Comrie, Provost, University of Arizona (comrie@email.arizona.edu)

Dr. Thomas Miller, Associate Provost for Faculty Affairs, University of Arizona
(tpm@email.arizona.edu)

Dr. Michael Waldrum, President & Chief Executive Officer, (michael.waldrum@uahealth.com)
University Physicians Healthcare & University of Arizona Health Network

Dr. Michael Covert, Chairman, UAHN (michael.covert@palomarhealth.org)

Dr. Joe G.N. "Skip" Garcia, Vice President, Academic Health Center
(skipgarcia@email.arizona.edu)

Vicki Gotkin, Attorney for University of Arizona (vickig@email.arizona.edu)

Amy Gittler, Attorney for UPH & UAHN (gittlera@jacksonlewis.com)

Michael Goodwin, Assistant Attorney General (michael.goodwin@azag.gov)

Exhibit 1



January 9, 2014

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

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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Aaron K. Haar
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

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

Dear President Hart:

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

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

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

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

Adam S. Kunz
Of Counsel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Ann Weaver Hart

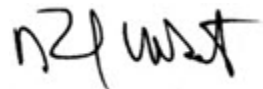
January 9, 2014

Page 5

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

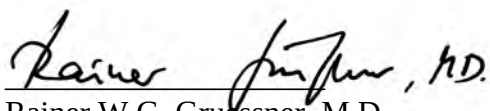
Sincerely,

JABURG & WILK, P.C.



Kraig J. Marton

Approved:



Rainer W.G. Gruessner, M.D.

KJM:akh

ENC.:

Exhibit A – UPH Membership Termination Letter

Exhibit B – Email from University of Arizona re Commencement of Termination Proceedings

Exhibit C – Reviews of the Department of Surgery Under Dr. Gruessner

Exhibit D – Email Chain with CEO Karen Mlawsky

Exhibit E – Email and Suspension Letters from Dean Goldschmid

Exhibit F – Dr. Gruessner's Response to Allegations

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

Exhibit A

Kraig J. Marton

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

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

Thank you.

Regards,

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

602.714.7057 | Direct
602.714.7045 | Fax

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Sent Regular Mail and Delivery Service

December 13, 2013

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

Dear Dr. Gruessner:

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

Sincerely,

A handwritten signature in black ink, appearing to read "M. Waldrum", is positioned above the printed name.

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

Exhibit B

Kraig J. Marton

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

Dear Kraig,

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

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

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

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

Vicki

Vicki Gotkin, J.D.
Senior University Attorney

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

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The information contained in this e-mail is privileged and confidential, and intended only for the individuals or entities named above. If you are not the intended recipient, any disclosure, copying, distribution, electronic storage, or use of this communication is prohibited.

If you received this communication in error, please notify me immediately by e-mail, or by telephone (520.626.7451), and delete the original message from your computer and network.

Thank you.

Exhibit C



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,

A handwritten signature in black ink, appearing to read 'J. Fung'.

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.

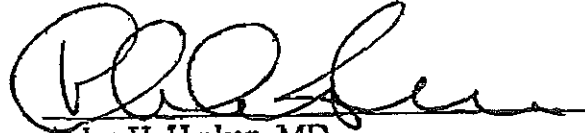
12) Probably the greatest threat to the Department of Surgery is that the current growth trajectory will be allowed to level off. The burst of programmatic surgical development (with its constructive penumbra influence on other COM disciplines) has not yet, in our view, been completed.

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.

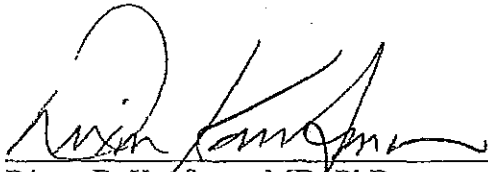
Academic Program Review
Department of Surgery
University of Arizona
April 1-2, 2010



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



Aiden 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.

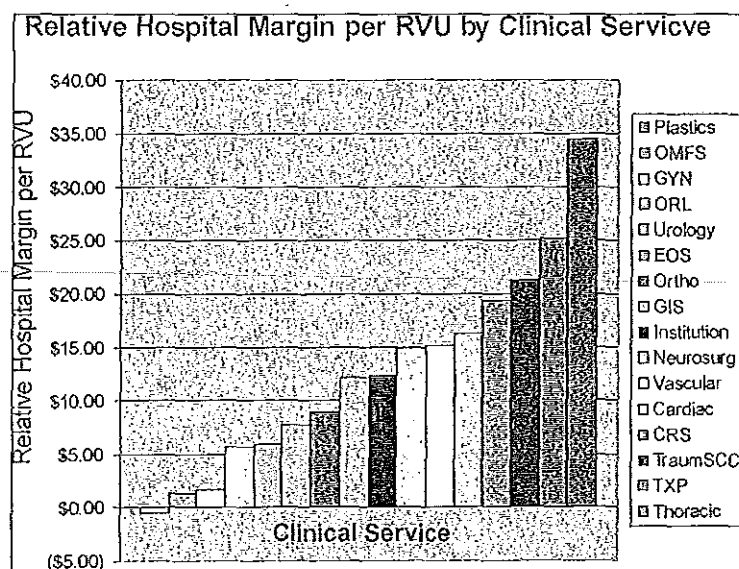


Figure Legend: Relative hospital margin (RHM0 per RVU varies greatly by service. Mean RHM per RVU was 12.64 mu (standard deviation = 9.76 mu) with range from a loss of 0.57 mu per RVU (plastic surgery) to a gain of 34.55 mu per RVU (thoracic surgery). GIS, gastrointestinal surgery; TXP, liver, kidney,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

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

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

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

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

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

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

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

I. Charge to the Committee

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

II. Composition of the Committee

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

III. Data Acquisition by the Committee

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

IV. Report of the Committee

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

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

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

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

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

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

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

2. Comments on the Interview with Dr. Gruessner

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

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

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

3. Results of the Survey Questionnaire

a. Respondents

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

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

b. Numerical Results by Core Content Area

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

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

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

Categorical breakdown:

A. Faculty: (overall 4.37)

Strongest scores in:

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

Weakest scores in:

1. Conflict resolution -- 3.79
2. Mentoring -- 3.87

B. Staff: (overall 4.00)

Strongest scores in:

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

Weakest scores in:

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

C. Residents/Fellows (overall 4.53)

Strongest scores in:

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

Weakest scores in:

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

D. Department heads (overall 4.35)

Strongest scores in:

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

Weakest scores in:

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

c. Subjective Portion of the Questionnaire

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

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

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

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

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

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

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

Other useful comments

V. Summary and Comment

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

Signature Page

for

Rainer Gruessner, M.D., Administrative Review

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

Lisa Chan, M.D.
Professor of Emergency Medicine

Randall Friese, M.D.
Associate Professor of Surgery

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

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

Exhibit D

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

Rainer,

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

Karen D. Mlawsky
CEO, UAMC

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

Karen,

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

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

Exhibit E

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

Dear Rainer,

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

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

Sincerely,
sg

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



MEMORANDUM

TO: Rainer Gruessner, M.D.

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

RE: Notice of Placement on Leave with Pay

DATE: September 19, 2013

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

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

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



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

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



THE UNIVERSITY OF ARIZONA
HEALTH NETWORK

MEMORANDUM

Human Resources Department

To: Rainer Gruessner, MD, Department of Surgery

From: Michael Waldrum, MD, MSc, MBA, President and CEO, *M2W*
The University of Arizona Health Network, Inc.

Date: September 19, 2013

Re: Paid leave

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

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

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

Exhibit F



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

David L. Allen
Shawdy Banihashemi
Mark D. Bogard
Neal H. Bookspan
Mervyn T. Braude
Jason B. Castle
Roger L. Cohen
Beth S. Cohn
Jennifer R. Erickson
David N. Farren
Lauren L. Garner
Renee Gerstman
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

Adam S. Kunz
Of Counsel

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?

Conclusions¹.

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,

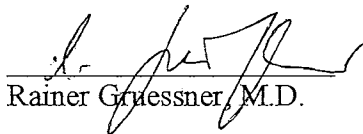
JABURG & WILK, P.C.



Kraig J. Marton

KJM:kmr

Approved:


Rainer Gruessner, M.D.

cc: Vicki Gotkin, Esq
Laura Johnson, Esq.

Exhibit 2

February 7, 2014

Rainer W.G. Gruessner, M.D.
6408 N. Placita del Zopilote
Tucson, AZ 85750

Dear Dr. Gruessner:

I am writing on behalf of President Hart and the Arizona Board of Regents (ABOR) regarding your January 9, 2014 letter (as supplemented by Mr. Marton's January 24, 2014 letter), which you characterize as a "whistleblower complaint" under Arizona Board of Regents (ABOR) Policy 6-914. You further allege that, as a result of making a disclosure of wrongful conduct, not only to the University's Committee of 11, but also to leadership within UAHN, you suffered retaliation when UPH terminated your membership and the University initiated dismissal proceedings as a result of your loss of membership in that organization.

I conclude that the statements you made to the University's Committee of 11 were not disclosures of wrongful conduct as defined by the ABOR whistleblower policy, and therefore, your complaint of retaliation is not a whistleblower complaint under that Policy. I further find that the statements you allegedly made to UAHN officials regarding the record-keeping activities within the transplant program you directed do not qualify as disclosures to a public official or designated University officer. Therefore, I conclude that further investigation under Policy 6-914 is not warranted.

Making a "disclosure," as defined by ABOR Policy 6-914, is a prerequisite to bringing a whistleblower complaint. You did not make a "disclosure" of wrongful conduct to a public body or designated University official on a matter of public concern, as those terms are defined under ABOR Policy 6-914. You stated that you were invited to meet with a few members of the Committee of 11 in December 2012 in your capacity as Department Head of the Department of Surgery. You stated that, during that meeting:

- You were asked "to provide input regarding the state of the College of Medicine (COM) under Dean Steve Goldschmid's leadership."
- You expressed "*concern* about Dean Goldschmid's leadership."
- "You explained how the *college's NIH ranking had not improved, how key faculty in the Cancer Center and clinical departments had left and could not be replaced, and how a climate of fear and retaliation had been fostered by the Dean, resulting in low morale among faculty and staff.*"
- You gave your opinion that the Dean "would not be able to take the college to the next level and attain a national reputation."

At some point thereafter, you allege that "[your] comments to these members of the Committee of 11 were conveyed to Dean Goldshmid," but do not state by whom such comments were communicated. You further surmise that Dean Goldschmid began a course of action that resulted



in the eventual loss of your UPH membership and the recommendation that you be dismissed from the University because you no longer maintained membership in UPH.

You attended the meeting with the Committee of 11 in your official capacity as Department Head of the Department of Surgery, and gave opinions regarding Dr. Goldschmid's leadership at the COM in that official capacity. Thus, the comments you made, as described in your January 9, 2014, letter, do not qualify as whistleblower disclosures, nor do they rise to the level of matters of public concern.

Nor does your report to UAHN about transplantation documentation at the hospital constitute a disclosure under ABOR policy. As I stated in my January 14, 2014, letter to you, UAHN and UPH are separate private legal entities. Although closely aligned with the University's mission, they are not the University,¹ nor can disclosures regarding procedures over which you had control as the Director of the service and over which the University had no control or knowledge, be construed as disclosures to the University. The purpose of the whistleblower policy is to allow the University to take appropriate action once a disclosure of wrongful conduct has been made to *it*. Making a disclosure (whether it would qualify as such under the whistleblower policy or not if made to an appropriate University official) to a non-University entity about its own practices, protocols and procedures, does not qualify as a disclosure to a public body or a designated University official under ABOR policy. No one to whom you reported your concern about transplant surgery documentation was a public official or a designated University officer. Thus, I conclude that your January 9, 2014, letter does not qualify as a whistleblower complaint.

The personnel action you now face at the University is, as I understand it, directly related to your loss of membership in UPH, which is a condition of your continued employment with the University. You are entitled to due process under ABOR Policy before the University can dismiss you, which I understand is underway.

Under the whistleblower policy, it is my obligation to refer you to other available University grievance or appeal processes to address your concerns. You have exercised your rights to appeal the recommendation of dismissal. The University Handbook for Appointed Personnel, Section 6.02, provides a grievance mechanism as well, should you believe it is applicable to your situation. See <http://hr.arizona.edu/policy/appointed-personnel/6.02>.

Sincerely,



Professor Thomas P. Miller,
Associate Provost for Faculty Affairs

cc: Nancy Tribbensee, General Counsel, Arizona Board of Regents
Ann Weaver Hart, President
Andrew Comrie, Ph.D., Senior Vice President for Academic Affairs and Provost

¹ At the time you made the "disclosure" to hospital officials, it is my understanding that you were the director of the transplant program, and ostensibly responsible for appropriately reporting procedures.



Exhibit 30

PERSONAL AND CONFIDENTIAL

February 25, 2014

Rainer W.G. Gruessner, M.D.
6408 N. Placita del Zopilote
Tucson, AZ 85750

Re: Request for Whistleblower Hearing

Dear Dr. Gruessner:

President Hart has asked that I respond to your February 21, 2014, correspondence, in which you request a whistleblower hearing by an external hearing officer "pursuant to Arizona Board of Regents' Policy 6-914(J)." I am writing to let you know that your request is based on an apparent misunderstanding of ABOR Policy and is therefore denied.

As I have explained in previous correspondence, before an employee can file a whistleblower *complaint*, he or she must make a *disclosure* of wrongful conduct on a matter of public concern, as those terms are defined by the Policy. If an individual does not meet that initial threshold of making a disclosure, he cannot file a complaint based on reprisal for having done so. If there is no complaint, then there can be no whistleblower complaint review from which a request for hearing may follow if the individual is dissatisfied with the decision of the University hearing officer following this review. My finding in this case is that you did not make a disclosure of wrongful conduct on a matter of public concern when you 1) met with the Committee of 11 or 2) when you brought concerns to the attention of UAHN leadership regarding transplant record-keeping practices. Therefore, no complaint review occurred and no external hearing is available.

You are not entitled to appeal a determination that your initial "disclosure" did not satisfy the requirements of ABOR Policy 6-914 by requesting a hearing under ABOR Policy 6-914(J). I have advised you of other avenues of redress, as required by that policy, and encourage you to pursue those if you wish. This matter is closed and not subject to any appeals or hearings.

Sincerely,

Professor Thomas P. Miller,
Associate Provost for Faculty Affairs

cc: Ann Weaver Hart, President
Andrew Comrie, Ph.D., Senior Vice President for Academic Affairs and Provost
Nancy Tribbensee, Arizona Board of Regents



Exhibit 31

FILED

3/7/14

TONI L. HELLON, Clerk

Deputy

MAR 10 2014

ARIZONA SUPERIOR COURT, PIMA COUNTY

HON. CARMINE CORNELIO

CASE NO. C20136289

COURT REPORTER: Mary Beth Simpkins
Courtroom - 480

DATE: March 07, 2014

RAINER W.G. GRUESSNER, MD
Plaintiff

Kraig J. Marton, Esq. and Aaron Haar, Esq.
counsel for Plaintiff

VS.

UNIVERSITY PHYSICIANS HEALTHCARE,
ARIZONA BOARD OF REGENTS,
UNIVERSITY OF ARIZONA COLLEGE OF
MEDICINE, and
UNIVERSITY OF ARIZONA HEALTH
NETWORK
Defendants

Amy J. Gittler, Esq. counsel for Defendants
University Physicians Healthcare and University
Of Arizona Health Network

Michael K. Goodwin, Esq. counsel for Defendants
Arizona Board Of Regents and University Of
Arizona College Of Medicine

MINUTE ENTRY

PENDING MOTIONS/ORDER TO SHOW CAUSE COURT RULING

Both parties are present.

THE COURT FINDS that there are administrative remedies that the Plaintiff has taken advantage of that are in process which provide due process and must be exhausted, and there is an administrative appeal right from those administrative remedies.

IT IS ORDERED that the University of Arizona's Motion to Dismiss is GRANTED.

The Court will sign an order prepared by the University's counsel dismissing that portion of the complaint; counsel for the University may cite the finality rule, as this is a separate and distinct claim from University Physicians Healthcare (hereinafter UPH).

THE COURT FINDS therefore that the University of Arizona's opposition to the Plaintiff's Motion to Amend is now moot.

IT IS ORDERED that Plaintiff's Motion to Amend as to UPH is GRANTED, and UPH's Motion to Dismiss is DENIED.

Cassandra Kerton
Deputy Clerk

MINUTE ENTRY

Page 2

Date: March 07, 2014

Case No.: C20136289

IT IS ORDERED that the Plaintiff's Request for Preliminary Injunction to reinstate his employment with UPH is DENIED for the following reasons:

1. The statute cited by UPH, on its face, prevents the Court from entering a Preliminary Injunction against terminating someone.
2. The public policy and likely future management by this Court or another Court regarding compliance with the injunction and the practicality of it would be overly burdensome and problematic. Moreover, given the likely and potential damages to Defendants, the nominal amount of the bond argued by the Plaintiff would clearly be insufficient and the required bond would be extremely high
3. The Court believes it has an appropriate and equitable alternative remedy.

IT IS ORDERED that UPH proceed and conduct a hearing in accordance with its own policies and procedures as to the due process provisions of the policy the Court has discussed in open court, to be commenced within 15 days. The Court does so as a result of its belief and finding that UPH's own contract, rules, regulations and policies either directly or indirectly provide for employees such as the Plaintiff (in these unique circumstances) to have or reasonably believe that termination will occur only after some due process.

THE COURT FINDS that no due process was given to the Plaintiff in this matter.

THE COURT FURTHER FINDS that should an independent hearing be conducted, there is potentially a substantial likelihood that the initial allegations made as to Dr. Gruessner as to his changing of records, or requiring and ordering someone else to change records, may not be found to be entirely accurate.

THE COURT FURTHER FINDS that given the interrelationship between the state actors, who have been dismissed from this case, and UPH, the co-employment and interrelationship between the University of Arizona, the hospital and UPH, the fundamental rights that Dr. Gruessner has with his employment contract and contract with the University, the nature of decision-making regarding his termination and facts supporting it was a confluence of conduct with his "multiple hats" of employment and makes uncertain who the private "employer" is under these unique circumstances.

Accordingly, under the facts of this case, UPH's termination is a "state" actor. The facts are that there was no immediate or even foreseeable patient harm from Plaintiff's alleged conduct, and there was no material reliance by UPH, U of A or UMC. The changed records (data) appear to not be materially inaccurate nor corrected back. This reflects that a full, further hearing and opportunity for Dr. Gruessner to present his complete case and UPH's complete case to an independent Hearing Officer is warranted. That Hearing Officer

Cassandra Kerton
Deputy Clerk

MINUTE ENTRY

Page 3

Date: March 07, 2014

Case No.: C20136289

can then make findings and a recommendation to the board as is required and the Board of UPH can be fully informed in its determination decision and Dr. Gruessner will have been accorded due process.

Ms. Gittler suggests that a \$50,000.00 bond be set in this matter.

The Court finding it appropriate,

IT IS ORDERED setting a \$50,000.00 cash bond in this matter; the posting of the bond will be necessary for the order herein to be fully effective.

(Clerk's Note: The trial Minute Entry from this date shall be processed separately from this order.)

The Court signs this Minute Entry in lieu of a more formal order.



HON. CARMINE CORNELIO

cc: Hon. Carmine Cornelio
Amy J. Gittler, Esq.
Kraig J. Marton, Esq.
Michael K. Goodwin, Esq.

Cassandra Kerton
Deputy Clerk

Exhibit 32



March 14, 2014

Arizona Board of Regents
2020 North Central Avenue
Suite 230
Phoenix, AZ 85004

Office of the General Counsel
University of Arizona College of Medicine
103 Administration Building
1401 East University Boulevard
Post Office Box 210066
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David N. Farren
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Renee Gerstman
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Aaron K. Haar
Laurence B. Hirsch
Amy M. Horwitz
Ronald M. Horwitz
Gary J. Jaburg
Janessa E. Koenig
Michelle M. Lauer
Michelle C. Lombino
Kraig J. Marton
Nate D. Meyer
Mitchell Reichman
Laura A. Rogal
Kathi M. Sandweiss
Jeffrey A. Silence
Maria Crimi Speth
Adam M. Weiler
Susan E. Wells
Lawrence E. Wilk
Nichole H. Wilk

Re: Dr. Rainer Gruessner's Notice of Claim Against Arizona Board of Regents and University of Arizona College of Medicine

Dear Sir/Madam:

This letter constitutes Dr. Rainer W.G. Gruessner's Notice of Claim prior to commencing a lawsuit against a public entity (Arizona Board of Regents and University of Arizona College of Medicine, collectively the "university") pursuant to Ariz. Rev. Stat. §12-821.01. Dr. Gruessner's causes of action arising from the university's unlawful suspension that occurred on September 19, 2013. This Notice of Claim is filed within 180 days thereafter in accordance with the statute.

This letter also constitutes a Notice of Claim arising under the university's refusal to consider Dr. Gruessner's whistleblower complaint which was filed pursuant to university policy. Since the university refuses to consider or even investigate that whistleblower complaint, this notice of claim also includes claims arising under the university's refusal to act or accept jurisdiction.

This letter lays out the facts and legal basis for the claims and appeal, and sets out the specific amount for which the claims can be settled as justified by the facts.

Factual Basis for Claim of Unlawful Suspension

Dr. Gruessner is a tenured professor of surgery and immunology at the University of Arizona, College of Medicine, where he also serves as chairman of the Department of Surgery. He also served as chief of transplantation and, at UAMC, as the UNOS surgical director of the transplant program. By all accounts, Dr. Gruessner has been a valuable asset to the citizens of Arizona, Tucson, the

Adam S. Kunz
Of Counsel

university, the College of Medicine, and the Department of Surgery.

In December 2012, Dr. Gruessner was invited to speak with representatives of the Committee of Eleven at the university regarding the direction of the College of Medicine and “ongoing concerns dealing with the CoM.” In his meeting with committee representatives, Dr. Gruessner reported his concerns about then-Dean Steven Goldschmid’s leadership. He explained that Dr. Goldschmid had fostered an environment of fear and favoritism, oversaw a decline in NIH funding and ranking, was not able to replace key faculty that had left, oversaw financial deterioration of both the College of Medicine and UPH while giving financial favors to his supporters, and was simply unable to take the College to the next level.

Soon after speaking with Committee of Eleven representatives, Dr. Gruessner found that his comments had been conveyed to the dean. Thereafter, the dean, who is also co-CEO of UAHN and a board member of UPH, embarked on a campaign to push Dr. Gruessner out of the College of Medicine. Moreover, the dean began making very derogatory and insulting comments about Dr. Gruessner to others at the university.

Despite the tremendous success and corresponding accolades that Dr. Gruessner’s presence brought to the College of Medicine, the dean called Dr. Gruessner by Skype from his vacation home in Canada on July 22, 2013 and demanded that Dr. Gruessner step down from his position as chairman of the Department of Surgery, citing “a record of poor performance.” Dr. Gruessner was stunned by the request because he had never received any annual reviews in five years or any negative reports of his performance as a professor or as chairman of the Department of Surgery. He also had not received the five-year review from the dean as required by university policy.

Interestingly, three days later, Dr. Gruessner received his reappointment from the President’s office, reappointing him as chairman of the Department of Surgery. And just a few weeks later, Dr. Gruessner received one of the highest bonus payments among department chairs based on objective UAHN/UPH achievement benchmarks. Furthermore, Dr. Gruessner had timely achieved all departmental benchmarks as set out by the dean in a May 1, 2013 agreement.

When asked to step down, Dr. Gruessner was initially confused given the fact that all the previously stated benchmarks had been fulfilled and because he had no real prior notice of dissatisfaction with his work. Thus, Dr. Gruessner refused to step down, knowing full well that there was no basis for the dean’s demand. However, the dean continued his efforts to push him out. Eventually, under serious pressure from the dean and university attorneys likely rising to the level of duress, Dr. Gruessner agreed to step down from his administrative positions on certain conditions. His plan was that, in the meantime, he would search for similar leadership positions at other institutions. As part of the agreement to transition out of his administrative duties, Dr. Gruessner was told by Dean Goldschmid that he could not continue in his capacity as chief of transplantation and by UPH that he had to relinquish all his administrative duties, which included the position of UNOS surgical director of UAMC’s transplant program, an action he warned could potentially lead to the transplant program becoming disqualified by UNOS.

On the day Dr. Gruessner was to officially relinquish his administrative duties, he sent a letter to the UAMC CEO and to UNOS resigning as transplant director effective immediately. UNOS/OPTN bylaws require that such transitions be reported within seven days of the change. Dr. Gruessner had to inform UNOS immediately since all administrative duties had been taken away from him that very day. UAMC then had 30 days to replace Dr. Gruessner as the UNOS transplant director.

Prior to stepping down, Dr. Gruessner also requested a final count of all liver transplants he had performed during his tenure at the College of Medicine. The business manager of transplant services gave him a count from the OTTR database, which the hospital uses to report transplant data to UNOS. Dr. Gruessner immediately knew the count was incorrect due to the fact that he had performed a significantly higher number of procedures than what was reported in the database. Dr. Gruessner told the business manager that the data needed to be corrected. The business manager pulled the actual OR reports and started making changes on his own until he realized that he could not determine from the actual OR reports who the primary surgeon and first assist were. He called Dr. Gruessner and asked for his help in determining who the primary surgeon and first assist were based on the actual OR reports since there were no written or unwritten policies in place as to how to identify the primary surgeon and first assistant surgeons.

The business manager then printed out copies of the operating notes and brought them to Dr. Gruessner's office so Dr. Gruessner could clarify who the primary surgeon and first assist were for each liver transplant. Dr. Gruessner went through each operating note and wrote the appropriate surgeons' initials on each printout. Of note, Dr. Gruessner did not know what the original entries in the OTTR database were.

The data reporting to UNOS is important because UNOS qualifies transplant surgeons based on the number of operations in which the surgeon has served as primary or first assist. The qualification does not differentiate between primary and first assist; they are considered equally important for purposes of qualifying as a UNOS transplant director. Prior to Dr. Gruessner's corrections, the OTTR database incorrectly listed, in two-thirds of the transplants, that there was only one surgeon on the procedure when, in fact, all liver transplants at UAMC were performed with two and often three surgeons. After Dr. Gruessner suggested corrections, every liver transplant surgeon on staff at UAMC either had the same or more liver transplants to his/her credit as primary surgeon or first assist than had been incorrectly reported in the OTTR database. So every surgeon was either better off or unaffected by the corrections. As a result, the hospital and its related institutions were much better situated regarding UNOS. And, of course, the data reporting was now actually correct. Of note, the data corrections that were suggested by Dr. Gruessner are still in effect six months after his suspension—demonstrating UAMC's and UPH's actual agreement with the corrected data.

In response to Dr. Gruessner's suggestion that UNOS data in OTTR needed to be corrected, UPH/UAHN and the College of Medicine summarily suspended ("administrative leave with pay") Dr. Gruessner and forbid him to set foot on campus. Both organizations falsely cited "evidence that [he] either altered or directed others to alter records." Although medical records were at no time changed, UPH/UAHN and the College of Medicine claimed that he posed a threat to the orderly operation of the institutions. Contrary to policy, before he was suspended, Dr. Gruessner was never given an opportunity to respond or explain. No one asked him anything. He was not allowed to present evidence. He was

refused access to an unbiased decision maker. He was instead suspended indefinitely while the administration pushed for his departure. But the suspension was made public and many of the institutions that had expressed interest in hiring Dr. Gruessner refused to move forward with any consideration of hiring him.

The suspensions were illegal, contrary to policy, not done properly, and were not based in fact.

After making no progress in his plight for reinstatement, Dr. Gruessner was forced to seek an injunction in Pima County Superior Court. On the eve of the initial injunction hearing, UPH delivered a letter to Dr. Gruessner purporting to terminate his membership at UPH. The purported termination changed the nature of Dr. Gruessner's legal claims, and he was forced to postpone the hearing. Shortly thereafter, the University of Arizona commenced termination proceedings against Dr. Gruessner solely on grounds that he was no longer a member of UPH, as required by his contract.

At the continued injunction hearing, the Court granted Dr. Gruessner's request for an injunction against UPH. The court found "that no due process was given to [Dr. Gruessner] in this matter." (ME Order Mar. 7, 2014 p. 2). The court ordered that UPH provide Dr. Gruessner with a fair investigation and impartial hearing. In so ordering, the Court found that Dr. Gruessner's corrections posed "no immediate or even foreseeable patient harm." *Id.* The Court further found that "[t]he changed records (data) appear to not be materially inaccurate" and acknowledged that the corrected records were not even changed back. (*Id.*). The Court concluded that "should an independent hearing be conducted, there is potentially a substantial likelihood that the initial allegations made as to Dr. Gruessner as to his changing of records, or requiring and ordering someone else to change records, may not be found to be entirely accurate." (*Id.*).

As to the College of Medicine, the Court dismissed the request for an injunction on grounds that Dr. Gruessner should first exercise his administrative rights within the university system. Of course, this placed the university in the untenable position of proceeding with termination based on Dr. Gruessner's now-unresolved UPH membership status. Dr. Gruessner remains out-of-work and in limbo.

The suspension by the university has been very damaging to Dr. Gruessner in many ways. It was widely publicized the Dr. Gruessner had engaged in "falsification of records" in the national media, and even the fact of his suspension by the university was widely reported. There were rumors that he was even escorted out of university premises by security. Dr. Gruessner has found and continues to find that other institutions have no interest in hiring him. Although Dr. Gruessner has continued receiving his paycheck during this period of time, his reputation and career prospects have diminished substantially from the unlawful suspension (or "administrative leave with pay") by the university.

While Dr. Gruessner may have other claims against the university and the College of Medicine, this notice of claim is based on the September 19 suspension and is being served within 180 days of that action.

Legal Basis for Claims

Dr. Gruessner has several claims against the university. His claims include breach of contract, breach of the implied covenant of good faith and fair dealing, defamation, conspiracy to commit defamation, a whistleblower claim, conspiracy to retaliate against a whistleblower, and claims under 42 U.S.C. §§ 1983 & 1985 for deprivation of and conspiracy to interfere with his civil rights. Each cause of action is briefly discussed below.

Dr. Gruessner has a cause of action for breach of contract. To prevail, Dr. Gruessner must demonstrate the existence of a contract, breach of the contract, and resulting damage. *See Graham v. Asbury*, 112 Ariz. 184, 185, 540 P.2d 656, 657 (1975). As a tenured professor, Dr. Gruessner unquestionably has a contract of employment with the university. His contract rights arise under both written contracts and university policy. His contract rights were breached because the university wrongfully suspended his employment, placing him on administrative leave with pay, without just cause. As a result of that breach, Dr. Gruessner was injured by his inability to find alternative employment and by damage to his reputation as a world renowned transplant surgeon. The damage appears to be irreparable.

Dr. Gruessner also has a cause of action for breach of the implied covenant of good faith and fair dealing. Every contract in Arizona contains an implied covenant of good faith and fair dealing to ensure neither party to a contract acts “to impair the right of the other to receive the benefits which flow from their agreement or contractual relationship.” *Maleki v. Desert Palms Profl Properties, L.L.C.*, 222 Ariz. 327, 333, 214 P.3d 415, 421 (Ct. App. 2009). When the university suspended Dr. Gruessner, it impaired his right to receive the benefits of the contractual relationship. He was no longer able to teach and keep his skills sharp. And the value of his position was greatly diminished as indicated by his inability to find alternative work.

Dr. Gruessner also has a cause of action for defamation. The elements of a claim for defamation are (1) a false statement concerning the plaintiff; (2) the statement was defamatory; (3) the statement was published to a third party; (4) fault on the part of the defendant; and (5) resulting damage. *Morris v. Warner*, 160 Ariz. 55, 62, 770 P.2d 359, 366 (Ct. App. 1988). To be defamatory, a statement must be false and bring the defamed person into disrepute, contempt, or ridicule, or impeach his honesty, integrity, virtue, or reputation. *Godbehere v. Phoenix Newspapers, Inc.*, 162 Ariz. 335, 341, 783 P.2d 781, 787 (1989). The allegation that Dr. Gruessner improperly altered or directed others to alter records to improve his transplant statistics is false. The university stated this reason for its immediate suspension. The statement was defamatory because it brought Dr. Gruessner into disrepute and impeached his integrity. The publication requirement is met for several reasons: The fact that disciplinary action was taken at all implicates Dr. Gruessner’s reputation. The fact that the suspension was unwarranted makes the suspension unlawful and improperly injures Dr. Gruessner’s reputation. Additionally, since the suspension was made public, Dr. Gruessner was forced to self-publish the reason for the suspension to prospective employers. *See Xi Lin v. Circuit City, Inc.*, 106 F.3d 412 (9th Cir. 1996); *see also Elmore v. Shell Oil Co.*, 733 F.Supp. 544, 546 (E.D.N.Y. 1988) (doctrine of compelled self-publication is especially appropriate where discharged employee is compelled to repeat alleged defamation to others to explain his sudden departure from employment). Since he was unable to obtain reinstatement through internal means, Dr. Gruessner was forced to publicize the reason for suspension again in his lawsuit seeking reinstatement. The university is at fault because it carelessly took action in

suspending Dr. Gruessner on unfounded grounds. And, again, Dr. Gruessner is damaged by the erosion of his skills and his inability to find alternative work. To the extent Dr. Gruessner was defamed by joint action between UPH, UAHN, and the university, Dr. Gruessner has a cause of action for civil conspiracy to defame him.

Additionally, Dr. Gruessner has a whistleblower claim against the university. Arizona Revised Statute § 38-532 prohibits adverse personnel actions in reprisal against a public employee for disclosing information that is a matter of public concern. Although A.R.S. § 38-533 exempts employees of state universities or the board of regents from the statute, the university has utterly refused to investigate the claims and then refused to grant an independent hearing as required by ABOR Policy 6-914. Therefore, Dr. Gruessner has a whistleblower claim under A.R.S. § 38-532. Furthermore, Arizona courts have held that the administrative remedy found in the whistleblowing statute is permissive and not mandatory. *See, e.g., Walters v. Maricopa Cty.*, 195 Ariz. 476, 481, 990 P.2d 677, 682 (Ct. App. 1999). Dr. Gruessner disclosed two matters of public concern, for which he was suspended in retaliation. First, he spoke to the Committee of Eleven regarding the dean's mismanagement, abuse of authority, and waste of public funds at the College of Medicine. Second, he reported incorrect data reporting to UNOS, which constituted a serious matter of public health and safety as well as mismanagement. As a result, Dr. Gruessner was suspended and thereby damaged by his inability to work or find work elsewhere. And to the extent UPH, UAHN, and the university worked together to retaliate against Dr. Gruessner for his disclosures, the university is liable to Dr. Gruessner for civil conspiracy to retaliate against a whistleblower.

Dr. Gruessner also has a cause of action under 42 U.S.C. §§ 1983 & 1985 for deprivation of his civil rights.¹ By unlawfully suspending Dr. Gruessner without any prior notice, right to respond, or a hearing, the university deprived him of his due process rights under the Constitution, and he is entitled to recover damages under 42 U.S.C. § 1983. Furthermore, to the extent the university worked with UPH and UAHN to prevent Dr. Gruessner from maintaining his position at the university, the university is liable to Dr. Gruessner for conspiracy to interfere with his civil rights under 42 U.S.C. § 1985.

Amount Required for Settlement

Dr. Gruessner has damages to his reputation, emotional distress damages, and other general damages which he will assert. However Dr. Gruessner is willing to resolve all of his claims on either of two alternative bases.

Dr. Gruessner will accept payment of the amount of \$18,960,000 as payment in full for all of his claims. Dr. Gruessner calculated that sum as below:

Salary from Age 57 to 61	4 x	\$775,000	=	\$ 3,100,000
Salary from Age 61 to 66	5 x	\$850,000	=	\$ 4,250,000
Bonus payments	9 x	\$ 90,000	=	\$ 810,000
Fringe benefits, tuition				\$ 300,000

¹ Technically, because these are federal statutes, no notice of claim is required before filing suit. However, since we're making a notice of claim, we wanted to include all possible claims, and so we assert them here.

Attorneys' fees	\$ 500,000
Damage to reputation	<u>\$10,000,000</u>
TOTAL	<u>\$18,960,000</u>

Dr. Gruessner has loved and continues to love the University of Arizona and the College of Medicine, and he sincerely regrets having to make any demand. But he feels that the actions of the university, especially in combination with the actions of UPH and UAHN, give him no other choice. However, Dr. Gruessner is willing to settle all claims on a second and independent basis.

Specifically, Dr. Gruessner is willing to settle all of his claims against the university for full, unconditional reinstatement as tenured professor and chairman of the Department of Surgery, as long as the university pays Dr. Gruessner's attorneys' fees incurred to date (those fees are approximately \$250,000 as of the date of this notice and so Dr. Gruessner will accept \$250,000 or in the alternative, whatever amount is determined by a court of competent jurisdiction to be his reasonable attorneys' fees).

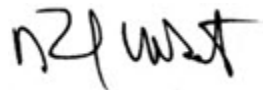
Dr. Gruessner recognizes that any reinstatement requires some degree of participation and collaboration by and between UPH and UAHN. However, since the institutions have worked so closely together in creating these claims, we imagine the institutions have similar incentive and sufficient overlap to justify reaching a common understanding to rectify the claims. Furthermore, these actions against Dr. Gruessner appear to have been orchestrated by the now-former dean of the College of Medicine. Now that he is no longer dean, Dr. Gruessner is hopeful that he and the university can reconcile.

Dr. Gruessner would prefer reinstatement. Such a settlement also appears to be in the best interest of the university. However, Dr. Gruessner will pursue his claims as outlined in this Notice of Claim if the offending actions against him continue unresolved.

Under the terms of Ariz. Rev. Stat. §12-821.01, this claim will be deemed denied and Dr. Gruessner will have the right to file suit against the university and the College of Medicine automatically within 60 days of the date of this notice or sooner if the claim is explicitly denied before then. Thank you for your time and consideration.

Very truly yours,

JABURG & WILK, P.C.



Kraig J. Marton

KJM:akh

Exhibit 33



THE UNIVERSITY OF ARIZONA
HEALTH NETWORK®

March 20, 2014

Kraig J. Marton, Esq.
Jaburg & Wilk
3200 N. Central Avenue, Suite 2000
Phoenix, AZ 85012

Direct Fax: 602-297-5017

Dear Kraig:

The Court has ordered that UPH follow the procedures for the hearing that is optional under UPH Administration Policy A227. Pursuant to the Court's order and that Policy, you and your client, Rainer Gruessner, MD, are given notice that a professional review action has been taken involving Dr. Gruessner. As you and your client know full well, the subject concerns Dr. Gruessner's involvement in causing changes to UAMC's OTTR database. Please see the transcript from the preliminary injunction hearing for more details.

Pursuant to Section 2.0 of Policy A227, UPH is advising that Dr. Gruessner has a right to request a hearing on the professional review action. If he chooses to request a hearing, he must do so in writing within 30 days of the date of this notice. If he requests a hearing, one will be set pursuant to Policy A227, and Dr. Gruessner will have the rights as set forth in Section 3.0 of the Policy, a copy of which is in your possession. On the other hand, Dr. Gruessner may waive his right to a hearing by giving written notice of his waiver to Dr. Waldrum or to me, Dr. Waldrum's designee, within 30 days of the date of this notice. If Dr. Gruessner fails to request a hearing in writing within 30 days of the date of this notice, he shall be deemed to have automatically waived his right to a hearing. If Dr. Gruessner waives his right to a hearing, the UPH Board will reconvene within 14 days of the effective date of the waiver and render a final decision.

As provided for in the Policy, no written discovery or depositions shall be permitted in conjunction with a hearing unless mutually agreed to by the parties. UPH will not agree to any written discovery or depositions.

If you think that any aspect of this notice fails to comply with Policy A227 or the Court's order, including the fact that it is being served on you instead of your client, please specify precisely and immediately your concerns.

Very truly yours,

Scott A. Sahlman
Vice President & General Counsel

Corporate Administration

1501 N. Campbell Avenue • Tucson, Arizona 85724-5128

Telephone - 520.694.6530 • Fax - 520.694.6648

Exhibit 34

ARIZONA SUPERIOR COURT, PIMA COUNTY

HON. CARMINE CORNELIO

CASE NO. C20136289

COURT REPORTER: Mary Beth Simpkins
Courtroom - 480

DATE: May 27, 2014

RAINER W.G. GRUESSNER, MD
Plaintiff

Kraig J. Marton, Esq. (appearing telephonically)
Counsel for Plaintiff

VS.

UNIVERSITY PHYSICIANS HEALTHCARE and
UNIVERSITY OF ARIZONA HEALTH
NETWORK
Defendants

Amy J. Gittler, Esq. (appearing telephonically)
Counsel for Defendants

MINUTE ENTRY

TELEPHONIC CONFERENCE

No parties are present.

Counsel argue to the Court.

The Court has conducted a status conference. Dr. Gruessner, through his counsel, Mr. Martin, has complained about alleged foot-dragging by UPH. The Court makes no determination regarding foot-dragging at this time.

The Court notes, however, that UPH designated a Hearing Officer on April 28, 2014.

It is this Court's view that the Hearing Officer, not this Court, is to conduct the proceedings. Accordingly, subsequent discussions between the parties regarding the appointment of panel members, the methodology of appointment of panel members, etc., ought to (at least in the first instance) be addressed to the Hearing Officer. The same is true regarding the timing of these appointments, etc.

Dr. Gruessner, through his counsel, Mr. Martin, suggests that this Court, rather than the Hearing Officer, should insert itself into the decision making on the process for panel member selection. The Court declines to do so.

Counsel for UPH agrees and represents that by 5:00 p.m. on Wednesday, May 28, 2014, they should be able to obtain a certification by the Hearing Officer, Mr. Yavitz, that he has no ties with the various entities, or entities' law firms.

B. Miller
Deputy Clerk

MINUTE ENTRY

Page 2

Date: May 27, 2014

Case No.: C20136289

The Court strongly urges the parties to promptly schedule a meeting with Mr. Yavitz to discuss the appointment of the panel, the panel selection, and prospective hearing dates.

Mr. Marton can, to the Hearing Officer, make his arguments regarding panel selection and disqualification or objection to potential panel members.

It does seem to this Court that the process of panel selection and commencement of the first hearing date should be “doable” by the end of June 2014.

The Court will take no further action at this time. The Court directs the clerk to file the correspondence received from Ms. Gittler. Counsel are admonished to file appropriate pleadings in this matter rather than sending letters to the Court going forward.

cc: Hon. Carmine Cornelio
Amy J. Gittler, Esq.
Kraig J. Marton, Esq.
Neal Bookspan, Esq.

B. Miller
Deputy Clerk

Exhibit 35

June 9, 2014

Rainer W.G. Gruessner M.D.
6408 N. Placita del Zopilote
Tucson, AZ 85750

Dear Dr. Gruessner,

I am writing to advise you that, as of July 1, 2014, a new salary and FTE have been set for you for the period July 1, 2014, through June 30, 2015. These will appear on the Notice of Appointment you will receive in July 2014, subject to conditions outlined below.

As we are all aware, your administrative appointment as Head, Department of Surgery, ends effective June 30, 2014, and will not be renewed. Therefore, your new faculty salary for your tenured appointment as Professor, Surgery, in the Department of Surgery does not include an administrative stipend.

During the previous contract year, UPH contributed 77% of your total salary, based on your work as an administrator of the UPH Department of Surgery and on your clinical and operating room activities. The remaining 23% of your salary, which the University contributed, represented the portion of your salary attributable to your University Department Head duties, your teaching, research, and service obligations to the University.

For the 2014-2015 fiscal year, your salary will be set at \$541,000, at 0.50 FTE, yielding an effective salary of \$270,500. We considered your initial letter of offer and the Agreement you signed in September 2013, your current ability to provide services to the University, and the provisions of the University Handbook for Appointed Personnel Section 5.07 and ABOR Policy 6-103 in setting your new salary. Specifically:

- The 75th percentile of the AAMC salary survey for professors of transplant surgery, which was the benchmark to be utilized in calculating your new salary in accordance with your initial letter of offer and the Agreement you signed in September 2013, would be \$541,000 per annum. AAMC Salary survey information is attached and the data pertaining to you is highlighted.
- Based on your current and projected faculty teaching, research, and clinical activity, your FTE is being reduced to 0.50, which the University is providing to ensure that you remain benefits-eligible during the appointment period. This FTE may be increased if the outcome of the court-ordered hearing UPH is obligated to provide results in your reinstatement as a member of UPH and you resume clinical service as determined in accordance with established performance standards for clinical productivity within the College of Medicine and the compensation plan established by the physician practice plan. On the other hand, if your membership in UPH is not reinstated, the University will resume the administrative process to terminate your University employment.



Should you have any questions about this salary assignment, please respond to me no later than June 13, 2014, so that I can address your questions prior to the distribution of your Notice of Appointment and prior to leaving for scheduled out-of-state travel.

Sincerely,

A handwritten signature in blue ink, appearing to read 'A. Comrie', with a long horizontal flourish extending to the right.

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

c: Joe G.N. Garcia, M.D., Senior Vice President for Health Sciences and
Interim Dean, College of Medicine
Alexander Chiu, M.D., Interim Head, Department of Surgery

enclosure - AAMC Transplant Surgery Benchmark

AAMC Faculty Salary Survey, 2011-2012
The University of Arizona Health Network Special Report



Total Compensation of M.D. or Equivalent Faculty, Clinical Sciences
Public Medical Schools
AAMC Data Services
February 4, 2013

Department/Specialty	Statistic	Instructor	Assistant	Associate	Professor	Chief	Chair
	Mean	247	379	484.6	557.2	622.3	887
Transplant Surgery	Count	11	56	53	53	21	7
	25th Percentile	75	254	344	327	422	741
	40th Percentile	80	277	400	405	500	809
	50th Percentile	80	288	415	451	549	814
	60th Percentile	102	300	441	500	569	886
	75th Percentile	102	341	511	541	780	995
	Mean	93.1	298.3	432.8	457.1	611.3	1006
Trauma/Critical Care Surgery	Count	4	161	72	64	24	7
	25th Percentile		252	302	342	410	599
	40th Percentile		277	325	368	460	615
	50th Percentile		291	349	380	472	622
	60th Percentile		310	381	404	489	627
	75th Percentile		331	408	443	520	635
	Mean		302.7	360.6	399.5	484.1	645.7
Urology	Count	21	188	102	107	20	29
	25th Percentile	60	244	277	311	397	457
	40th Percentile	60	261	304	352	437	494
	50th Percentile	60	281	335	384	446	508
	60th Percentile	67	302	357	400	468	571
	75th Percentile	100	334	400	462	498	616
	Mean	84.1	291.6	351.5	413	440.5	537.9
Vascular Surgery	Count	0	93	44	53	27	4
	25th Percentile		250	307	325	370	
	40th Percentile		273	333	394	407	

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Exhibit 36



Executive Office of the President

NOTICE OF APPOINTMENT

August 07, 2014

Rainer W Gruessner
6408 N Placita Del Zopilote
Tucson, AZ 85750

Department: Surgery 0702
EmplID: 16501818
Current Status: Active

The following appointment(s) with the University of Arizona has/have been approved. This Notice of Appointment incorporates any authorized agreements or letters of offer you have signed with either your department or college that contain specific conditions related to your employment with the University of Arizona.

Professor, Surgery (Tenured) in Surgery, effective from July 01, 2014 through June 30, 2015 at 0.500 FTE, with an annualized fiscal base salary of \$541,000.00. This appointment is subject to and incorporates the provisions of *Arizona Board of Regents (ABOR) Policy Manual*, Policy 6-201, Conditions of Faculty Service, and Chapter 3 of the *University Handbook for Appointed Personnel (UHAP)*.

Your appointment also includes the following titles:

Professor, Immunobiology (Non-Tenure Eligible). This appointment is subject to and incorporates the provisions of *Arizona Board of Regents (ABOR) Policy Manual*, Policy 6-201, Conditions of Faculty Service, and Chapter 3 of the *University Handbook for Appointed Personnel (UHAP)*.

Salaries at the University may be funded from a variety of sources, including state appropriations, and other non-state appropriated sources, such as retained tuition dollars, grants, contracts, clinical revenue, or other funds earned by the institution. Your salary is funded by non-state appropriated sources. In the unlikely event these non-state appropriated funds are no longer available, your FTE and/or salary could be reduced, or your appointment could be terminated if you are not in a tenured or continuing status appointment.

If your appointment(s) is not intended to extend beyond six months or you have an adjunct faculty appointment(s), you will not be entitled to a notice of non-renewal or review with respect to the short-term or adjunct appointment(s) listed on this document.

In the past, the University has implemented a furlough plan as a cost-saving measure, as directed by ABOR. Should additional furloughs be approved, you will be notified in accordance with duly adopted furlough plan guidelines, and will be required to comply with any such measures during the course of your employment. If furloughs are implemented, applicable information will be made available by the Division of Human Resources.

Sincerely yours,

Ann Weaver Hart, President

By accepting this appointment under the conditions stated above, I agree that I am subject to ABOR Conditions of Service

and corresponding provisions of the UHAP, as referenced above.

I understand that employment status changes such as leaves of absence and FTE modifications that occur during the Fiscal Year will be reflected on a Personnel Action Form (PAF), and will be available through my department's business office and UAccess.

I agree to comply with the rules, regulations, and policies of the University of Arizona and the Arizona Board of Regents related to my appointment, including, but not limited to, the intellectual property policies as from time to time amended and the standards of professional conduct referenced in policies of the University.

I hereby assign to the Arizona Board of Regents all my right, title and interest to intellectual property created or invented by me in which the Arizona Board of Regents claims an ownership interest under its Intellectual Property Policy (the "ABOR IP Policy"). I agree to promptly disclose such intellectual property as required by the ABOR IP Policy, and to sign all documents and do all things necessary and proper to effect this assignment of rights. I have not agreed (and will not agree) in consulting or other agreements to grant intellectual property rights to any other person or entity that would conflict with this assignment or with the Arizona Board of Regents' ownership interests under the ABOR IP Policy.

Signed ELECTRONIC SIGNATURE NEEDED

Please accept this appointment within 14 days (for fiscal appointees) or 30 days (for academic appointees).

Exhibit 37

Findings and Recommendations of Hearing Panel

Parties: Rainer Gruessner, M.D.
University Physician Healthcare (UPC)

Panel Members:

John Fung, M.D. (Cleveland Clinic)
Stuart Knechtle, M.D. (Emory University)
Sander Florman, M.D. (Mount Sinai Medical Center)

Issue: Was Dr. Gruessner's termination by University Physician Healthcare justified, meaning was it reasonable and for good cause?

Proceeding: A hearing was held on August 5, 2014 in the Patagonia Room of the UPH offices at 575 E. River Road in Tucson, Arizona. The hearing began at 9:00 am and was completed at 6:30 pm. Randy Yavitz served as the Hearing Officer.

Background Facts:

1. Commencing July 1, 2007, Dr. Gruessner entered into a Member Practice Agreement with UPH.
2. At the same time, Dr. Gruessner also assumed a number of positions at the University of Arizona, ("UA") College of Medicine and the University of Arizona Medical Center ("UAMC"), including:
 - Chair of the Department of Surgery;
 - Chief of Transplantation; and,
 - Professor.
3. UA College of Medicine, UAMC, and UAHN are not parties to this hearing.
4. UMAC is a member of the United Network for Organ Sharing ("UNOS"). Dr. Gruessner was UAMC's designated UNOS Surgical Director for the kidney, liver, pancreas, living donor and intestinal transplant programs.
5. Effective September 1, 2013, Dr. Gruessner agreed to an Amendment to Member Practice Agreement with UPH and an Agreement and Release with the UA College of Medicine. Dr. Gruessner agreed to relinquish certain positions and titles.

6. Dr. Gruessner was suspended by University Physicians Healthcare on September 19, 2013 because it was said that he “either altered or directed others to alter records related to transplant procedures.”
7. UPH then terminated Dr. Gruessner on December 16, 2013 without providing any reason.
8. On March 7, 2014, a Court found that Dr. Gruessner had not been given due process in the suspension or termination and ordered that a hearing be held.
9. On March 20, 2014, UPH gave a notice that said that the termination was because of concerns over “Dr. Gruessner’s involvement in causing changes to UAMC’s OTTR database.”
10. UPH and Dr. Gruessner then agreed on a hearing with these panel members.

Exhibits and Witnesses:

1. The Panel was presented with two binders of exhibits, and a third binder with transcripts of Court hearings. The exhibits, together with opening statements by each party were provided in advance of the hearing to each panel member by use of a computer “Dropbox.”
2. UPH, because it bore the burden of proving that the termination of Dr. Gruessner was justified by a preponderance of the evidence, presented first. UPH called the following witnesses:

Scott Sahlman (telephonic)

- Former Vice President & General Counsel of The University of Arizona Health Network

Michael McCarthy (by transcript)

- Manager Business Systems for the Transplant Department

Karen Mlawsky (by transcript)

- CEO of the Hospital Division for University of Arizona Health Network (CEO of The University of Arizona Medical Center)

Tun Jie, M.D. (by transcript)

- Interim Chief of Abdominal Transplant

Michael R. Waldrum, M.D.

- President and CEO of University Physicians Healthcare and
President and CEO of The University of Arizona Health Network

3. Dr. Gruessner presented the following witnesses:

Rainer Gruessner, MD

- * Professor of Surgery and Immunology

Abbas Rana, MD (telephonic)

- * Assistant Professor of Surgery at Baylor University

Steven J. Barker, PhD, MD (telephonic)

- * Professor of Anesthesiology, former Chair, Department of
Anesthesiology

Farid Gharagozloo, MD

- * Professor of Surgery, Chief of Thoracic Surgery, Chief of
Robotic Cardiothoracic Surgery, Chief of Esophageal Surgery, Chief of
Southwestern Lung Cancer Program

Panel Findings:

1. Dr. Gruessner is a liver transplant surgeon with a nationally recognized high reputation. At the hearing, UPH acknowledged that the quality of his care and his skill as a surgeon were certainly not at issue.
2. UPH acknowledged Dr. Gruessner's contribution in building the transplant program at UPH and UMC, which, under his direction, grew explosively during his 6 years' tenure as head of the program.
3. Dr. Gruessner explained that he and the dean of the program, Dr. Goldschmidt, did not get along personally, and did not agree professionally. This culminated in August, 2013, when Dr. Goldschmidt asked Dr. Gruessner to step down as Chair of the Surgery Department. Dr. Gruessner explained that he signed the Amendment in anticipation of achieving a dignified exit from the program.

4. Unfortunately, Dr. Gruessner's exit was anything but dignified. The panel believes that the charged political rivalry between Dr. Goldschmidt and Dr. Gruessner led to misunderstandings which, had good will and trust prevailed, could have been readily avoided.
5. The signature problem that developed after the Amendment was signed was poor communication, exacerbated by the quick resort to attorneys, a poor choice by anyone seeking to avoid conflict.
6. The panel was told that Dr. Goldschmidt was no longer Dean at the Medical School of U of A. Several doctors characterized his leadership style negatively; Dr. Barker called him a "tyrant"; Dr. Gharagozloo related how he refused to sign his contract for 4 months after moving to Arizona with his surgical team; and Dr. Gruessner testified that he recommended to the "committee of 11" that Dr. Goldschmidt should be relieved of his responsibilities. Dr. Goldschmidt did not testify; a decision not explained by UPH.
7. UPH relied on two alternative grounds as its "good cause" to terminate Dr. Gruessner:
 - a. Alteration of the OTTR database by directing Mike McCarthy, the database manager, to revise the data, most importantly to identify the primary surgeon and secondary surgeon.
 - b. Writing to UNOS notifying it of the transition in leadership.
8. The panel, knowledgeable in UNOS and database reporting, concluded that Dr. Gruessner did not "alter records." He acted reasonably to correct errors he found in the OTTR database. Bringing these errors to the attention of the OTTR data base manager was a reasonable approach. His conduct was appropriate.
9. UPH did not even attempt to prove that the changes to the OTTR data base (which remain today) were incorrect, with one exception: a procedure where Dr. Jie and Dr. Rana extracted a liver and placed a new liver in the patient before Dr. Gruessner even arrived at the operating room. Both Dr. Gruessner and Dr. Rana testified that Dr. Gruessner was not the primary surgeon, while Dr. Jie disagreed. The panel believes that Dr. Gruessner would not aptly be designated the primary surgeon on this particular procedure based on the testimony and operative notes
10. With respect to the UNOS communication, the panel remains unclear on Dr. Gruessner's motivation with respect to his communication with UNOS dated September 10, 2013. The panel believes that some notice of his resignation was required in any event, and while UNOS' reaction undoubtedly caused

consternation, there was no showing of harm to UPH, so the episode did not rise to the level of a firing offense, nor was it cited initially as grounds for Dr. Gruessner's suspension or termination.

11. While more recent communications with UNOS do no credit to Dr. Gruessner and his counsel, crossing the boundaries of constructive criticism and entering the realm of malice, they are unrelated to the issues in this case. The panel found the behavior of both sides to be unprofessional.
12. In sum, the panel felt that UMC did not meet its burden of proving that the termination was justified.
13. The panel considered its recommendations.
14. The panel concluded that the initial charge by the University of Arizona Physicians that the modifications of the OTTR database were illegal, was erroneous. However these actions led to the subsequent ripostes by Dr. Gruessner, which the panel concluded, created an environment in which a functional relationship based on trust and communication cannot be restored. Therefore it would be in neither party's interest to force reconciliation by pretending that restoration of relationship to pre-April 2013 is doable. Given the prior agreement that Dr. Gruessner would voluntarily resign from his position at the University of Arizona and seek employment elsewhere, the panel feels that the University of Arizona should do everything within reason to facilitate this.
15. The panel recommends reinstatement of employment, but not privileges or titles, essentially a faculty member without titles or clinical duties.
16. Dr. Gruessner should not be reinstated to all his former positions, including Chairman of the Department of Surgery, Chief of Abdominal Transplantation, and Director of the HepatoPancreaticoBiliary Program because he voluntarily resigned these posts and his appointment would be disruptive of the current efforts to resuscitate the UMC transplantation program. However, in order to facilitate his re-entry into practice, Dr. Gruessner should be named a Professor of Surgery.
17. Under the circumstances, a reinstatement of Dr. Gruessner's staff privileges does not make sense unless it is done as a formality based on an agreement by Dr. Gruessner not to exercise his clinical or administrative privileges.
18. The panel debated whether to recommend that UPH pay Dr. Gruessner's attorneys fees. Given that both sides bear significant responsibility for the

mutual animosity and falling out, each side should bear their own legal fees subject to the following recommendation.

The Panel notes that Dr. Gruessner has been paid since he was suspended in September, 2013. UPH should pay Dr. Gruessner for up to one additional year, or until he finds a new position

19. UPH should issue Dr. Gruessner a public apology of its design that wishes Dr. Gruessner well in his future endeavors and thanks him for his role in making UMC/UPH a world class transplantation center. It should specify that any prior discussion of misconduct have been officially retracted.
20. UPH should retract its allegations to the Arizona Medical Board accusing Dr. Gruessner of "unethical conduct."
21. The panel believes that Dr. Gruessner deserves to have his name cleared. The Panel is hopeful that Dr. Gruessner will pursue his career as opposed to litigation.



John Fung, M.D.

Stuart Knechtle, M.D..

Sander Florman, M.D.

mutual animosity and falling out, each side should bear their own legal fees subject to the following recommendation.

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mutual partnership agreement, and the partnership agreement shall be
subject to the provisions of the agreement.

The Partnership shall have a term of ten years, commencing on the first day of
September, 1961, and continuing until the expiration of the term, and shall be
terminated by the expiration of the term.

19. The Partnership shall have a term of ten years, commencing on the first day of
September, 1961, and continuing until the expiration of the term, and shall be
terminated by the expiration of the term.

20. The Partnership shall have a term of ten years, commencing on the first day of
September, 1961, and continuing until the expiration of the term, and shall be
terminated by the expiration of the term.

21. The partnership agreement shall be subject to the provisions of the agreement. The
Partnership shall have a term of ten years, commencing on the first day of
September, 1961, and continuing until the expiration of the term.

John F. Fung, M.D.


Stuart H. Fung, M.D.

Stuart H. Fung, M.D.

Exhibit 38

From: Sahlman, Scott A. [<mailto:Scott.Sahlman@uahealth.com>]

Sent: Friday, September 20, 2013 3:08 PM

To: Rainer Gruessner

Subject: Notice of Placement on Leave

I have been provided with your email communication from this morning to Dr. Waldrum and he has authorized me to advise you that, from this point on, all further communications between yourself and UPH should be conducted through our respective attorneys. We have retained attorney, Amy Gittler, of the law firm of Jackson Lewis in Phoenix, to represent UPH. Our understanding is that you have retained attorney, Kraig Marton, to represent you in this matter. If that is not the case, please advise accordingly. Ms. Gittler will be contacting Mr. Marton to discuss how to proceed. Thank you for your anticipated cooperation.

Scott A. Sahlman,
Vice President & General Counsel
The University of Arizona Health Network
1501 N. Campbell Avenue
Tucson, AZ, 85724
Ph: 520-694-4403 | Fax: 520-694-6648



PLEASE NOTE MY NEW EMAIL ADDRESS IS Scott.Sahlman@uahealth.com

"CONFIDENTIALITY NOTICE: This message and any included attachments are from The University of Arizona Health Network and are intended only for the addressee. The information contained in this message is confidential and may constitute inside or non-public information under international, federal, or state laws and is intended only for the use of the addressee. Unauthorized forwarding, copying, printing, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error by e-mail or you may call The University of Arizona Health Network in Tucson, Arizona, USA at (520) 694-4357."