Declaration of Paul A. Ironside, MD

I am a citizen of the State of California County of Riverside, USA practicing at 74-399 Highway 111 Palm Desert, CA 92260, age 67, in good health and willing to testify. I am a licensed to practice medicine and surgery in California – C29231 **(Exhibit #1)**

In the mid 80's I came up with an idea to build in Simi Valley a total outpatient facility. Four other physicians joined me in this effort. We bought land just off the 118 Freeway on Sycamore Avenue a block from Simi Valley Hospital (SVH). At this point we asked the Hospital to join with us, but they were not interested. We became partners with Balboa Construction headed by Michael Goland. When the building was approximately 85% completed Balboa Construction went bankrupt. Nothing happened for 6 or 7 months while we tried to entice any venture capital group or hospital corporation to help us. We once again went to Simi Valley Hospital and the President, Robert Carmen. They joined us becoming a 51% owner and the managing partner.

Around this time our group bought out one of our partners secondary to an internal conflict.

The Aspen Center was completed. It contained a complete radiology department, a dedicated building with a MRI, three surgical suites, multiple office suites, a medical laboratory, etc. The Simi Valley Hospital, because they controlled insurance contracts, ran the Center into bankruptcy. The four of us lost everything. Two of us over $500,000 and the other two lost $350,000. Aspen Center became very successful. **(Exhibit #2)** Robert Carmen made all Hospital decisions, but remaining aloof by having his administrator, Allan Rice front for him. I, as the leader of our group, tried many things to keep Aspen afloat. All were unsuccessful. The Hospital was angry with all of us and threatened to sue us and to push me into peer review. They did not sue us, but they did force me into a peer review process. Only one of the physicians in our group has remained on the staff, but his stature was diminished since HMO's that the hospital was involved with directed orthopedic consults elsewhere. The other two were radiologists whose contracts were not renewed.

Susan F. Van Hall from Jeffer, Mangels, Butler & Marmaro was both the hospital attorney and acted as the Medical Staff attorney, an obvious conflict of interest. She engineered with the help of a few strategically placed Hospital controlled physicians to bypass the Medical Staff By Laws and have multiple cases brought before a Judicial Review in order to have my vascular surgical privileges removed. The charge was that my complication rate was excessive. Approximately half of the cases were vascular access procedures done on renal dialysis patients. These patients are quite ill, many with advanced diabetes mellitus and multiple medical problems, including advanced atherosclerosis. These grafts are the bane or vascular surgeons, since their grafts are prosthetics and they fail frequently. At that time I was doing about 85-90% of the renal access work at Simi Valley. The nephrologist Kant Tucker, MD was happy with my

services. He two other vascular surgeons he could have gone to. When these cases were lumped with my other vascular procedures my complication rate was naturally high.

I went to the California State Court in 1993 in Ventura to try to get an injunction, but it was thrown out because the administrative remedies had not been exhausted.

It was about this time that the head of the anesthesia department Alan Heng, MD got arrested for cocaine. He was placed in jail and then a rehab facility. The only thing we physicians at the Hospital knew was that he was "away". The Chief of Staff at that time was Martin Wareham, MD. When Dr Heng was released after a short stay Dr. Wareham told the Medical Executive Committee that all was OK and that Dr. Heng was to return to his regular anesthesia duties. Atul Aggarwal, MD asked what problem he had had and the cocaine arrest came out. Dr Heng was placed back in his regular rotation of giving anesthesia as if nothing were wrong. I then knew why Dr. Heng was frequently going to the bathroom in the middle of cases and allowing the circulating nurse to watch his patients. I was the only surgeon who refused to allow him to give anesthesia until his entire rehab program was completed. The administration and especially Dr. Wareham were very unhappy with my decision.

Dr. Wareham is the son of the Chief of Thoracic Surgery at Glendale Memorial Hospital a flagship of the Adventist system. Knowing the nepotism in the Adventist system, why was he in Simi? It is my understanding that he got caught with cocaine and subsequently relegated to Simi. He also claimed to be Dr. Heng's best friend – very unlikely since they have no similar interests except cocaine. I can't prove this, but I am sure it can be.

A judicial review was conducted in 1992, for six nights over a couple of months time. A jury of Hospital physicians, picked by Ms Van Hall and the new Chief of Staff, were present. Dr. Wareham was the only physician that Ms Van Hall could find to represent the Hospital. There was an attorney acting as moderator and decision-maker should any procedural questions arise. The moderator was Jesse Miller. When Ms. Van Hall graduated from law school she went to work for Music, Peeler & Garrett. Mr. Miller was her mentor at that firm. At Ms Van Hall's requests the scheduled dates for the meetings were changed several times for unusual reasons. Every time Ms Van Hall made a request it was granted. Every time I made one, it was refused. This is a glowing example: The By Laws stated that at the conclusion of the hearing proceedings either party could submit a summary of their position. It had to be submitted by a certain number of days after final testimony. I wrote a summary, which took a week to prepare and turned it in on the afternoon of the last day. A few days later Mr. Miller called to tell me that he had extended the time for Ms Van Hall to submit one. I found out only several years later the connection between Jesse Miller and Van Hall.

After the first session the new Chief of Staff, Atul Aggarwal, MD, refused to permit any more Staff monies to be used for this process. The Hospital gladly picked up the costs – which were horrendous. And at the last meeting after another Van Hall delay they hired a substitute advocate – the Chief of Vascular Surgery at USC.

The jury of my peers exonerated me. The decision went to the Medical Executive Committee who agreed with their decision and sent it to the Hospital Board. Ms Van Hall decried their decision since it was not in a legal form – listing every case and giving their reasons for deciding in my favor. They refused stating that they had spent an inordinate amount of time, listened to all the arguments and rendered their verdict and they all agreed. The Medical By Laws specifically stated that the judicial reviews were not to be conducted like a courtroom trial.

In March or April of 1993 I received notice that I was under "summary suspension" for renal access surgery. Ms Van Hall engineered this in a Medical Executive Committee meeting. Most Committee members had no understanding of the consequences regarding this ruling. "Summary Suspension" is reserved for those situations where a physician is impaired – alcohol, drugs, mental disease, etc. I was still performing carotid, aortic, peripheral bypass and thoracic surgery during this period. Several weeks passed before I was permitted to meet with the Medical Executive Committee. The Committee immediately reinstated my privileges, but since a month had elapsed an 805 report was to be automatically generated. She screwed up. It was over 6 months before she realized that this report had not been sent in.

The Hospital Board was chaired by Robert Carmen and consisted of about five other members of the community none of whom were physicians. I was called to the Aspen Center to meet with them. None of the Board members except Robert Carmen, knew that I had conceived of the building and medical programs that surrounded them. A couple of months later Ms Van Hall informed my lawyer that the Board wanted to do it all over again on the basis that the first jury of peers had not performed their duty properly.

In late September of 1993 I was told that a new hearing would take place in mid October. I explained that I was not available at that time since I had a planned vacation, but I would be available in November. I was subsequently told that I would be tried in my absence. Ms Van Hall had previously and frequently moved meeting dates all over for her convenience. Then she hired physician jurors not on the Hospital Staff. She did not want to take any chances and lose again.

In late 1993 at the behest of a friend who had been the administrator of Westlake Community Hospital and had been in Tennessee for the past several years called again asking me to come to Tennessee to practice. My children were all through college and successfully employed, my medical practice had been ruined at Simi Valley Hospital. I went to Tennessee. In December of 1993 Ms Van Hall found out where I was and sent an unsolicited letter to the Scott County Hospital strongly suggesting that I was a bad surgeon and that they should look further into the matter. The Chief of Staff Atul Aggarwal, MD was asked to sign this letter on two occasions, but refused. Ms Van Hall who authored the letter waited until January of 1994 and had the new Chief of Staff Harry Drummond, MD sign it. At this time I had moved from Scott County Hospital to Morristown, TN and Lakeway Hospital – owned by the same corporation that owned

Scott County Hospital. The population of Scott County was not sufficient to maintain a practice of thoracic and vascular surgery. I was an outsider with no friends. Simi Valley sent them all the adversarial materials. Lakeway canceled my contract ($12,000/month). I had joined the staff of the other hospital in town, but things were not going well and I resigned from the staff.

In January of 1997 I was notified that 805 reports were filed after the second trial, which I was not present. The California Medical Board was investigating. I was heading to court. At a pretrial meeting I was offered a "deal". I declined to the amazement of the Judge and a two-week trial was held by the Medical Board of California - Division of Medical Quality - Department of Consumer Affairs by the Attorney General for the Medical Board. The Board hired a vascular surgeon of good reputation. These were all the same peer review cases I had been tried for in 1992 and 1993 at SVH. I was totally successful. The California Medical Board adopted the decision of Judge B. Dash, Administrative Law Judge. All charges were dropped. (No. 05-93-33243; OAH No. L-1997090037) **(Exhibit #3)**

The Decision was sent to Simi Valley Hospital who was given 30 days to challenge. They did not

Prior to this I had contacted Judy McCarthy an attorney in '93 in Knoxville, TN, and she initiated a lawsuit in Federal Court against Simi Valley Hospital. They first tried to have it moved to CA, but were refused. Next they hired Senator Howard Baker's law firm and were successful in having the cases thrown out. An appeal was finally heard in the Federal Court of Appeals in Cincinnati in 1998. I begged Mrs. McCarthy to enter into the court record the Decision of the California Medical Board. She would not. I have always wondered, why not. The excuses or reasoning she gave sounded hollow. The suit had to do with the SVH sending the unsolicited letter. I had been vindicated from the charges that Ms. Van Hall created. The appeal was lost and I was unable to file a suit in California. **(Exhibit #4)**

There was a series of articles in the Los Angeles Time written by Tom Gorman and Eric Lichblau regarding the Adventist system. The one dated August 13, 1998 showing how they treat physicians who don't agree with them. **(Exhibit #5)** Their method of control in Simi Valley was to give key physicians, who were on the Medical Executive Committee, contracts for "directing" pulmonary care, ICU, rehabilitation, etc., in exchange for their votes. They were all aware that those contracts could and would be taken from them if they didn't play ball.

I lost my reputation, ability to make a living practicing in my area of expertise – thoracic and vascular surgery, lost millions of dollars of income, ran up costly legal expenses and was forced into bankruptcy.

It is my understanding that Ms Van Hall and the same administrative persons in the Western Adventist Hospital group have and are attempting to ruin the reputation and medical practices of physicians in California.

1.
2. 22. I declare under penalty of perjury under the laws of the State of /California that
3. the foregoing is true and correct. This declaration was executed in Riverside County on
4. March 24, 2004.
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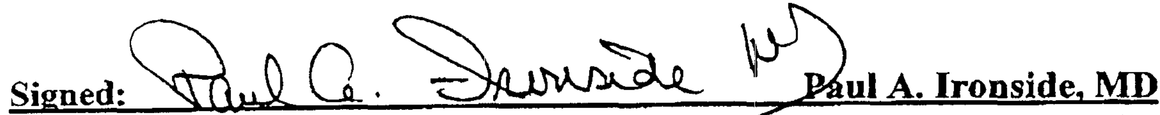
6.
7. **Signed:**  **Paul A. Ironside, MD**
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Exhibit # 1

Curriculum Vitae

CURRICULUM VITAE

Name: Paul Allan Ironside, Jr., M.D.

Birthplace: Camden, New Jersey

Date of Birth: September 29, 1935

Home: 44-406 Royal Lytham Drive
Indio, CA 92201
Phone: 760 200 4987
Facsimile: 760 200 8537
Cell: 760 989 0544
E-Mail: pironside@prodigy.net

Education

High School

Haddonfield Memorial High School
Haddonfield, NJ
Graduated 1953
Mercersburg Academy
Mercersburg, PA
Graduated 1954

College

Washington and Lee University
Graduated BS Degree 1958

Medical School

Hahnemann University
Philadelphia, PA
Graduated MD Degree 1962

Graduate Training

Internship

West Jersey Hospital
Camden, NJ
Rotating
July 1962 - June 1963

Residencies

Hahnemann University Hospital
Philadelphia, PA
General Surgery
July 1963 - June 1964
Chief: Jack Cole, M.D.

Licensure:

M.D. New Jersey 1963 - 1967 / 1995 - 1997 MA19653
M.D. California l963 - 2005 C29231
M.D. Tennessee 1993 - 2003 MD024964
Radiography and Fluoroscopy X-ray Supervisor and Operator
Private Pilot - Multi-Engine Land, Instrument

Board Certification:

Recommended by John Y. Templeton, III, M.D., for the General Surgery Boards and by John Jones, M.D., for the Thoracic Boards. Successfully completed the written examination for the General Surgery Boards in 1968.
Fellow American College of Angiology

Society Memberships:

Ventura County Medical Society
California Medical Association
American Medical Association
Associate Fellow of the American College of Angiology
Fellow of the Internal College of Angiology
Lakeway Medical Society

Articles:

<u>Internal Mammary to Coronary Artery Anastomosis - a Non-Suture Technique</u>
Paul A. Ironside, M.D., Victor Satinsky, M.D.
Hahnemann Clinical Research, 1961

<u>A New Method of Pre-Clotting Fabric Prosthesis</u>
Peter B. Samuels, M.D., Paul A. Ironside, M.D., Mark M. Kartchner, M.D.
The American Journal of Surgery, 138:238; 1979

<u>Human Growth Hormone - recombinate</u>
Paul A. Ironside, M.D.
Newsline, 1:1; 1996

Pennsylvania Hospital
Philadelphia, PA
General Surgery
July 1963 - June 67
Chief: John Y. Templeton, III, M.D.

Hospital of the Good Samaritan
Los Angeles, CA
Thoracic and Cardiovascular Surgery
June 1967 - September 1968
Chief: John Jones, M.D.

Teaching Responsibilities:

Medical Students Hahnemann University Hospital - wards
Medical Students Pennsylvania Hospital - wards
Nurses Training Course Heart Care Unit Hospital of the Good Samaritan
Medical Staff Lectures - Thoracic and Vascular Surgery Topics
- **Westlake Hospital - Westlake, CA**
- **Simi Valley Hospital - Simi Valley, CA**
- **Palmdale Hospital - Palmdale, CA**
- **Tarzana Hospital - Tarzana, CA**

Continuing Medical Education – recent:

Harvard Medical School - Angioscopy
April 1989
Kendall Regional Medical Center - Endoscopy, Thoroscopy
September 1991
Harbor - UCLA Medical Center - Endovascular Surgery Symposium
December 1993
University of Texas Southwestern Medical Center at Dallas
Southern Association for Vascular Surgery Annual Conference
January 1995
Vanderbilt University Medical School
Nashville, TN
Drug Prescribing course August 2000
Ambulatory Treatment of Varicose Veins
Las Vegas, NV
August 2002

Military Service:

Classification 4A - Solo Surviving Son

Practice:

Thoracic and Vascular Surgery 1969 – 1993 in Southern California (Thousand Oaks, Westlake Village, San Fernando Valley and Antelope Valley)

Thoracic and Vascular Surgery 1994-1995 in Oneida and Morristown, Tennessee

Family Practice and Phlebology 1995-2001 in Morristown, Tennessee

Family Practice and Phlebology 2002 – Present in Palm Desert, California

Westlake Community Hospital
4415 S. Lakeview Canyon Road
Westlake Village, CA 91361

West Valley Hospital
22141 Roscoe Boulevard
Canoga Park, CA 91304

Tarzana Regional Hospital
18321ClarkStreet
Tarzana, CA 91356

Lakeway Regional Hospital
McFarland Drive
Morristown, TN 37814

Northridge Hospital Medical Center
18300 Roscoe Boulevard
Northridge, CA 91328

Antelope Valley Hospital
1699 West Avenue J
Lancaster, CA 93534

West Hills Hospital
7300MedicalCenter Drive
Canoga Park, CA 91307

Antelope Valley Hospital
1600 West Avenue J
Lancaster, CA 93534

Simi Valley Hospital
Sycamore Drive
Simi Valley, CA 93065

Morristown-Hamblen Hosp.
West 4th North Street
Morristown, TN 37814

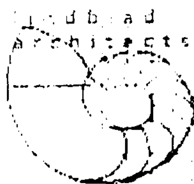
Lancaster Community Hospital
43830 10th Street West
Lancaster, CA 93534

http://www.lindbladarchitects.com/practice/aspencenter/index.html

http://www.rfkmustdie.com/chapterone/body1.html

Exhibit # 2

Aspen Center



Aspen
Center

Lindblad
Architects

the Practice

CAD
Discussion

Outpatient Surgery Center & MRI Facility

A regional prototype outpatient care medical facility located in Simi Valley, Califiomia. Support services include a same-day surgicenter for cases which in the past required overnight stays, diagnostic imaging center with a wide complement of procedures are performed such as ultrasound, mammography, CT scanning, fluoroscopy, and X-ray.

Clinical lab services, the latest Endoscopy lab and gastrointestinal lab, Home Health Center, Breast Center, Pain Management Center and Colo-Rectal Center round out the comprehensive one-stop patient visit within a holistic setting.

The main building entry creates a focal point for community activities and festive events which require public space.

Open since January 1989, the Aspen Center Medical Complex successfully brings together humanistic patient services, and efficient, technologically advanced facilities in a dramatic architectural setting. Aspen Center's architect, J. Paul Lindblad, Principal of Lindblad Architects, expressed and

refined the sleek glass and concrete high-tech design theme to complement state-of-the-art outpatient support and Magnetic Resonance Imaging (MRI) equipment, the most technologically advanced diagnostic tool available to medicine today.

Clear room dimension design requirements for the Main Building (comprising diagnostic service and treatment) generated a typical 24 foot wide by 36 foot deep structural bay. A 45° angled, 30-foot wide, 36-foot tall main public waiting and patient entry reception penetrates the northwest building corner and features a two-story reflective glass, 50-foot long skylight and exposed glass elevator. Nova Engineering designed a long span post-tensioned concrete frame for the main building to allow critical room dimensions and flexibility, wood frame construction for the MRI building to minimize magnetic field interference, and steel framing to allow clarity in the main entry and MRI entry arcade.

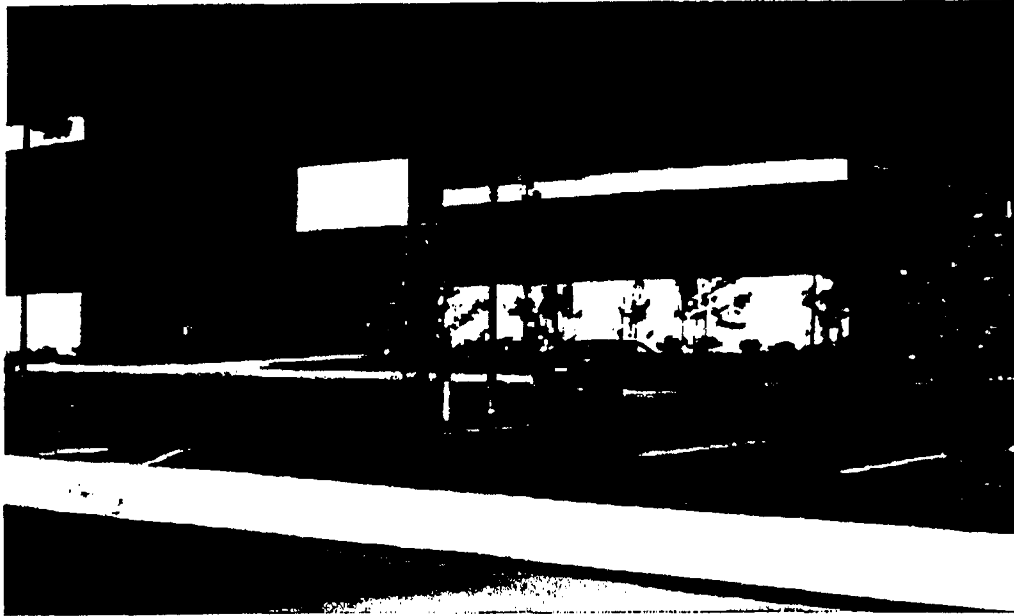
Storms and Lowe contributed mechanical and electrical engineering experience required for the special systems and sophisticated support facilities. Jones Construction Management provided construction management services based on a design-build approach to best answer the project sequencing and construction problems. With a ratio of 31,620 net square feet to 35,500 gross, the 89% efficiency rate of the Aspen Center is a competitive rate for the medicenter, a medical office building prototype. The Architect and consulting engineers worked closely to minimize the volume of non-usable space in various ways. For example, a glass curtain wall was placed over a clear span concrete moment-resisting structural system to free core and shell areas for greater space planning efficiency. Heating and cooling equipment was located on the roof top to increase net usable area inside. Public restrooms were centralized where possible to avoid any annoying interference experienced by departments.

A Welcoming Space

The modernist, sleek bronze-reflective glass and post-tensioned building structure sports an impressive two-story glass enclosed elevator within a mall with fountains, notable works of art and plantings which combine to give the patient a sense of wellness that blends with the area's progressive and friendly spirit.

The specific mix of Aspen Center's core services: administration systems, lab services, endoscopy services, home health care, same day surgeries, diagnostic imaging center, MRI, and a future cardiovascular/catheterization lab define the Center as a leading catalyst for changing traditional health care systems in the future to more economical, faster, simpler diagnosis, treatment, and recovery. Ambulatory patient care and surgery reduce the need for overnight facilities. The methodology is particularly suited to the lifestyle and consumer demands of an aging national "baby-boomer" population that generates an corresponding increased patient load.

High Tech Diagnostics



This pioneering medical center offers residents of the West San Fernando Valley and Ventura County one of the first installations of Magnetic Resonating Imaging (MRI), the state-of-the-art non-evasive diagnostic tool.

Inside the new offices of Lindblad Architects

MRI is the most advanced diagnostic tool available today which allows the medical clinician to view the interior of the human body with a superior method than X-rays because no radiation is used. MRI images have much better resolution than CT scans and are able to discern different body tissues in healthy and diseased conditions without making an incision. MRI hardware configuration is a cylindrical magnet with a bore large enough to slide a patient through on a moving table. The nuclei of our body's biochemical elements, such as hydrogen and carbon, have magnetic properties. When a uniform magnetic field is applied, bulk magnetization is created parallel to the field. A second magnetic field is applied rotating with the nuclei's unique Larmor frequency which is based on properties of the nucleus and the strength of the applied magnetic field. Radio frequencies (RF) are applied (as gradients) in sequential pulsations on the nuclei defining the image "slice" and causing them to skew. After the pulses are turned off and on, the nuclei tilt returns to its original position, resonating faint radio signals (Free Induction Decay - FID). Reading FID signals using Fourier transforms, a computer can plot their location and produce an image of the body's interior and its biochemical nature.

St. Jane's Church Interior Renovation

As can be expected, being surrounded by the magnet's bore and the sound of emitting radio signals can be a frightening

experience, especially for the uninitiated. "To diminish such fears," comments Architect Lindblad, "We conceived the Aspen Center to elicit the openness and vitality required to form a sense of well-being for patients and visitors." The Center's design underscores the rolling hills and open expanse of Simi Valley. Lindblad points out that while an architect's immediate response to the design problem might have been a different building style, the center's location within Simi Valley's medical campus and rapidly expanding area, and the need for the building to identify visitors with the Center's leading technology made high-tech the suitable architectural response.

The Ambulatory Surgery Department has three surgery suites with the amenities of a good acute care hospital. Day surgical procedure patient flow begins at the two-story entry lobby check-in area. Patient traffic continues into the locker area, through patient preparation into surgery suites, recovery and finally back to the locker area. Surgery patients leave the building using a dedicated exit. Home Health Care provides personal attention and case to patients whose condition prevents a visit to the Center. Services include high-tech nursing, pulmonary and respiratory therapy, chemotherapy, insulin therapy, paranteral nutrition, and intravenous therapy. Medical equipment and supplies for home use can be purchased from the facility.

The Occupational Care Center provides emergency treatment specializing in industrial accidents on a 10-hour day basis. The Radiology Department, in the main building, offers radiological diagnostic tests, ultrasound, and mammography, plus a variety of digital subtraction angiography and computerized tomography (CT scan). The emission tomography unit is one of four installations in Southern California. Aspen Center offers new treatment modalities beyond the core surgical and diagnostic services including: the Breast Center, featuring a cancer awareness program, diagnostic techniques and specialized treatment; the Pain Management Center, focussed on evaluating a patient's medical, psychological, and physical factors to determine the cause of pain; and the Colo-Rectal Center which provides comprehensive colon cancer screening and the most current technology for identifying and treating all rectal problems. Departments on the second floor include general office areas and future plans for a cardiovascular/catheterization lab. Robert Zasa, of Ambulatory Systems Development based in Glendale, whose projects span the U.S. coordinated the development of the Center's services. Says Mr. Zasa: "We brought ambulatory care multiple diagnostic services in one place which complements the Adventist Hospital in-patient care nearby."

The Aspen Center project concept was originated by Dr. Paul Ironside, a thoracic surgeon who then contacted Drs. Aucreman and Hebbard. Together they created a partnership to build an independent medicenter with full diagnostic and treatment capability. The original physician planning group purchased the Aspen Center's building site and finalized partnership agreements with the Adventist Hospital. Lindblad Architects, an architecture firm with a health-care facility emphasis located in Valley Glen CA was selected to design the complex and to obtain various jurisdictional approvals. The Aspen Center epitomizes the rapid change occurring in today's health care delivery system. Third-party payors (Medicare, Medical, and other health insurers) have passed along budget cutbacks to health care providers (physicians) through reimbursement restrictions. Alternate, less expensive health care delivery, best characterized by outpatient diagnostic and treatment centers have the highest ratio of payment dollars to billed charges. Health care providers have responded to this trend by establishing free-standing, non-hospital based medicenters such as the Aspen Center to maintain a marketshare of the health care industry.

Colfax-Magnolia Corner Commercial Mixed Use Rejuvenation

Baldwin Park Condominiums

Address	Telephone	E-Mail
Lindblad Architects Suite 110A 14547 Titus Street Panorama City, CA 91402-4919	(818) 785 ARCH (2724) **Fax** (818) 785- 8091	General Information: info@lindbladarchitects.com Client Support: support@lindbladarchitects.com

Last Updated 10-08-2002
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Exhibit # 3

Decision California Medical Board

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

PAUL A. IRONSIDE, JR., M.D.
201 Rouse Road
Morristown, TN 37813

Physician's and Surgeon's Certificate No. C29231,

Respondent.

No. 05-93-33243

L-1997090037

PROPOSED DECISION

This matter came on regularly for hearing before Ralph B. Dash, Administrative Law Judge with the Office of Administrative Hearings, on April 6, 7, 8, 9, 10, 13, 14, 15 and 21, 1998 at Los Angeles, California.

Complainant was represented by E.A. Jones, III, Deputy Attorney General.

Respondent was present throughout the proceedings and was represented by Paul Spackman, Attorney at Law.

The parties requested and were granted permission to file post-trial briefs. The same were timely served and filed. The matter was deemed submitted as of June 29, 1998.

Oral and documentary evidence having been received and the matter submitted, the Administrative Law Judge makes the following Findings of Fact:

* * * * *

1. Ron Joseph made the Accusation in his official capacity as Executive Director of the Medical Board of California ("Board").

2. At all times pertinent hereto, Respondent Paul A. Ironside, Jr., was and now is licensed by the Board as a physician and surgeon, certificate number C 29231. Said certificate will expire, unless renewed, on September 30, 2001.

3. Respondent is a well credentialed, well respected vascular surgeon who, at the time of the acts complained of, had a very busy surgical practice. The charging allegations of the Accusation arise out of Respondent's handling of seven patients in 1989 and 1990 at Simi Valley Adventist Hospital ("hospital"). The evidence at trial was voluminous and highly technical. The charging allegations against Respondent are generally similar for each of the patients in question; that is that Respondent used poor surgical technique during surgery and/or Respondent used poor medical judgment in performing the surgery at all. Because each patient presented a unique medical profile, the charging allegations against Respondent will be dealt with, patient by patient, in the order presented in the Accusation.

The standard of proof Complainant must meet to establish the charging allegations in these proceedings is "clear and convincing" evidence. Ettinger v. Board of Medical Quality Assurance, 135 Cal.App.3d 853 (1982). This means the burden rests on Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. In re Marriage of Weaver, 224 Cal.App.3d 478 (1990).

PATIENT A.S.

4. This patient was a 67 year old female with severe left leg claudication. She had a history of rest pain in her left foot. She also had a history of diabetes, chronic obstructive pulmonary disease and coronary artery disease with an ejection fraction of 50%, the lowest end of normal. She was admitted to the hospital on October 10, 1989 for left leg revascularization. Respondent performed this surgery on October 11, 1989 utilizing the distal superficial femoral artery ("SFA") to midleg posterior tibial artery bypass, with non-reversed saphenous vein graft. Two days post-operatively her graft thrombosed. She was returned to the operating room two days later where the saphenous vein graft was found to be inadequate. The arterial pressure in the now arterialized saphenous vein had caused the vein to tear and subsequently occlude. A bypass grafting procedure using Gortex and a Miller cuff to repair the tear was performed satisfactorily. The two procedures are hereafter referred to collectively as "the first surgery".

5. On February 12, 1990, A.S. was again admitted to the hospital, this time for surgery on her right leg (the "second surgery"). On February 13, 1990, Respondent performed a right proximal popliteal to tibial-peroneal trunk bypass with non-reverse saphenous vein graft.

6. Complainant's expert, Dr. Foran, criticized Respondent's technique on the first surgery because Respondent used inflow from the SFA rather than the common femoral artery, which would have been his choice. While Dr. Foran's opinion may be correct in the abstract, it was not correct in connection with this patient. Dr. Foran did not have access to all of the medical records at the time he rendered his initial report to the Board, nor had he seen all of the records even as of the time of trial. A full review of the records shows that Respondent's choice of the SFA in this patient was correct.

7. A.S. had already been seen by Dr.Tandon, another vascular surgeon, at least one month before Respondent first saw her. Dr. Tandon diagnosed peripheral vascular disease and ordered an arteriogram of the lower extremities. This revealed occlusive disease involving the popliteal arteries bilaterally. Respondent reviewed the angiogram and its accompanying report prior to the first surgery. He decided to use the distal SFA for inflow because it showed no evidence of atherosclerosis. During surgery, Respondent found the SFA was soft with a bounding pulse and thus satisfactory for use. Also because use of the SFA created a shorter graft than use of the common femoral artery, it was a preferable choice. Under all of these circumstances, Respondent's choice of the SFA for inflow as opposed to the common femoral artery was medically appropriate. S.A. was discharged in satisfactory condition after the first surgery.

8. Dr. Foran's criticism of the second surgery, the bypass on the right leg, was that this procedure should not have been performed at all. A.S., had severe claudication in her right leg after the first surgery on her left leg. This is not an uncommon development inasmuch as patients typically, once relieved of pain in one leg, become more active, hence more cognizant of the growing pain in the other leg. At the time the second surgery was performed, the right leg claudication was increasing.

It was Dr. Foran's opinion that the type of procedure Respondent performed during the second surgery should never be undertaken unless the patient is experiencing rest pain or has developed ulceration or gangrene. That is, the surgery should never be done unless the patient is in imminent danger of losing a limb. It was Dr. Foran's opinion that Respondent should have told this patient to "live with" her situation, not walk as much and the like.

9. Respondent presented independent highly credible expert testimony that the type of procedure Respondent performed in the second surgery was reasonable and medically necessary, and that indications for such surgery are not so severely limited as Dr. Foran opined. Severe limiting claudication (which Dr. Tandon had noted in the right leg as well as the left before the first surgery) and which is increasing in intensity, is an appropriate medical indication to proceed with the revascularization. Modern surgical techniques help ensure patient safety (a concern expressed by Dr. Foran) during the revascularization. Waiting for development of the late phase of the disease process, when amputation would otherwise become the only alternative to bypass surgery, is not the appropriate measure to determine when the surgery is medically indicated.

PATIENT R.D.

10. This patient was a 55 year old male with intermittent right leg claudication at five feet, who on June 21, 1990 was admitted to the hospital for surgery. Extensive evidence was presented regarding the surgery performed, to wit: endarterectomies of common femoral and tibial-peroneal trunk with femoral-tibial bypass using in situ saphenous vein, end-to-end from the proximal SFA to the tibial peroneal trunk. R.D. was clearly a high risk patient for this type of surgery, based on his history of cerebrovascular and coronary artery disease. However, Dr. Foran's criticism of Respondent was, as with the preceding patient, that surgery should not have been performed at all in the absence of rest pain, ulceration or gangrene.

11. As was the case with a number of the patients whose records Dr. Foran reviewed, Dr. Foran had not been supplied with complete medical records. A thorough review of the records presented at trial does indeed show that R.D. did have a documented history of rest pain, and Dr. Foran conceded that in light of that, surgery was indicated for this patient. In fact, Dr. Foran further indicated that given this patient's needs, surgery may have been indicated, even in the absence of rest pain, provided the risks were fully and carefully explained.

PATIENT W.W.

12. The medical evidence presented with respect to this patient, a 62 year old male, was extremely complex and comprehensive. Although some of the surgical techniques used by Respondent with respect to this patient were called into question, the charging allegations of the Accusation were straightforward, to wit: that Respondent erred by first revascularizing the patient's left kidney before addressing the much more serious aortic occlusion and leg ischemia. However, in

order to determine whether Respondent did violate the standard of practice as charged, it is necessary to review all of the medical evidence, including the claimed improper surgical techniques.

13. W.W. had been admitted to the hospital from the emergency room on September 22, 1989 within 24 hours of suffering an embolism which occluded his abdominal aorta. On September 25, 1989, Respondent performed an aortic thrombectomy, an aortofemoral bypass, and reimplantation of the left renal artery. This last specified procedure was performed first, and according to Dr. Foran, should not have been performed at all given the patient's grave condition. Since it is necessary to understand Dr. Foran's criticism by referencing his testimony, the following excerpt from his report to the Board (with which he testified in conformity) is hereafter presented:

> Angiogram showed total occlusion of the aorta below the renal arteries, total occlusion of the left renal artery, and a 50% right renal artery stenosis with a small, non-functional left kidney. Creatinine was normal. Surgery on 9/25/89 consisted of an aortic thrombectomy, aortofemoral bypass, and reimplantation of the left renal artery, which was performed as a preliminary procedure. The aorta was cross-clamped below the superior mesenteric artery, above the renal arteries, for endarterectomy of the aorta. Subsequently, the clamp was placed below the right renal artery, and the left renal artery was reimplanted. The aortic anastomosis for the aortofemoral graft originated below the inferior mesenteric artery. The following day, 9/26/89, a thrombectomy of the left profunda femoris artery was performed. Following surgery, the patient developed ATN [acute tubular necrosis] which required hemodialysis....the patient suffered a cardiac arrest on 10/7/89 which resulted in his death....Analysis: The patient was high-risk with multiple system diseases on admission. Nonetheless, the patient required urgent revascularization of his lower extremities to relieve an acute aortic occlusion. The operation of 9/25/89 should have addressed this problem primarily with only secondary consideration of a renal artery procedure if the primary was successfully and quickly accomplished. Dr. Ironside instead focused first on an attempt to revascularize a small, non-functioning left kidney. This involved clamping above the renal arteries an extended time, a procedure which may have caused embolization or ischemic infarction of the patient's good right kidney....Attention to the primary problem, the aortic occlusion and ischemia of the legs, required priority. Dr. Ironside's preliminary procedure for the left kidney contributed directly to an adverse outcome.

14. Respondent's rationale for his attention to the left kidney, and the surgical techniques he employed, were essentially as follows. At surgery, Respondent found the patient's right renal artery to have an adequate pulse. Because the thrombosis extended up to the renal arteries it was necessary to cross clamp the abdominal aorta above the right renal artery. A thrombo-endarterectomy of the infrarenal abdominal aorta was performed. An attempt to pull an atherosclerotic plug out of the left renal artery was abandoned and the cross clamp was placed below the night renal artery. The left renal artery was transected and back bleeding was encountered. Both Respondent and his assistant surgeon felt that the left kidney was salvageable so they performed an anastomosis of the left renal artery. This took less than 15 minutes. The aortic cross clamp was then moved below the left renal artery anastomosis and Respondent observed excellent blood flow to the left kidney. Respondent undertook this procedure because it was done quickly and without additional risk to the patient, and could possibly provide the patient with a second functioning kidney in case he embolized to the right kidney.

15. Respondent's expert concluded that reimplanting the left renal artery did not add to the surgical risk, and in any event, the benefit of possibly revitalizing the left kidney in light of a 50% stenosis of the right kidney, making it more easily subject to total occlusion, was worth the brief time it took. Respondent presented further expert testimony which showed the clamp placements to be correct and medically indicated; however, in light of the limited nature of the charging allegations in the Accusation, it is not necessary to determine whether clamp placement was appropriate for the procedure. Based upon all available medical data, it cannot be said that reimplantation of the left renal artery prior to performing the other surgical procedures violated the standard of care.

PATIENT L.S.

16. Respondent is criticized with respect to this patient for his failure to use a protective shunt at the beginning of a left carotid endarterectomy with vein patch, employing the same only after 35 minutes of carotid occlusion time had elapsed. The circumstances were as follows:

17. L.S. was a 69 year old male who was admitted to the hospital on February 13, 1990 from a board and care facility after a syncopal episode. He had a history of prior strokes and Parkinson's disease, and was on Coumadin. An angiogram was performed, showing 90% stenosis of the right internal carotid artery and 30% to 40% stenosis of the left internal carotid artery (although Dr. Foran initially believed and so reported that it was 80% stenosed). It further revealed total occlusion

of the infrarenal abdominal aorta. On February 15, 1990, Respondent performed a right carotid endarterectomy with vein patch (the "first surgery"). The operation was successful. L.S. recovered in an improved condition with increased cognition, and was discharged.

18. L.S. was readmitted to the hospital and on March 7, 1990 and Respondent performed a left carotid endarterectomy (the "second surgery"). The second surgery was performed without a protective shunt being inserted at the outset of the procedure, although Respondent did apply one later during the course of the operation. A shunt is used to insure adequate circulation to the brain while the artery is clamped during surgery. Dr. Foran opined that unless the clamp or occlusion time will be less than 15 minutes, use of a shunt is necessary. Respondent's expert placed the "outer limit" of occlusion time without a shunt at 30 minutes.

19. During the course of the second surgery, L.S. was prepared in the appropriate manner and when adequate anti-coagulation had been obtained, vascular clamps were placed on the external, internal and common carotid arteries. The internal carotid artery was exposed up to the distal stenosis. Fiber and clot was found within the lumen. A vein patch was applied and at completion the vascular clamps were removed starting blood flow initially into the external carotid artery and then into the internal carotid artery. There was quite a bit of bleeding as the suture lines did not hold. Vascular clamps were replaced on the internal, external and carotid arteries and a Javid shunt was placed between the common and internal carotid arteries and flow re-established. It was found that the psuedoedema of the edarterectomized segment was pulling away. An extensive endarterectomy of the entire carotid artery was then carried out, down around the external as well as the common carotid arteries. The clamps were removed and flow re-established, but there was a leak at the superior end of the internal carotid artery suture line. The vessels were again reclamped and the leak repaired.

20. According to Respondent's operative report, the occlusion time between the second clamping of the carotid arteries and the placement of the Javid shunt was 3 minutes and 50 seconds, with a "total occlusion time of 35 minutes". However, this apparently did not take into account the third clamping to repair the leak at the end of the internal carotid artery suture line. According to the anesthesia records of the second surgery, total occlusion time was 39 minutes and 45 seconds consisting of 32 minutes for the first clamping, 3 minutes, 45 seconds for the second clamping and 4 minutes for the third clamping.

21. Respondent offered well-reasoned medical opinions as to why a shunt on an operation such as the second surgery is not the choice of many surgeons, including the fact that a shunt takes up valuable space and can get in the way. However, even Respondent's expert conceded that 30 minutes was the outer limit of acceptable occlusion time without the use of a shunt, and during the second surgery, the first occlusion time alone was 32 minutes. All of the medical evidence indicates that Respondent should have employed a shunt at a point in time earlier than he did. The Accusation charges that Respondent's failure to use a shunt was an act of gross negligence; however, it was Dr. Foran's opinion, both in his report and in his testimony, that this was an act of simple negligence. While Respondent may have been justified in not using a shunt immediately upon the first clamping of the carotid arteries if he reasonably believed the occlusion time would not be long, he certainly should have inserted one well before the 32 minutes of the first occlusion time had elapsed.

PATIENT H.B.

22. Respondent performed a surgical resection of an abdominal aortic aneurysm on this 80 year old male patient on August 9, 1990. The surgery included an aortobifemoral graft and ligation of the inferior mesentery artery ("IMA"). Respondent did not reimplant the IMA. The Accusation alleges four separate and distinct instances in connection with Respondent's treatment of this patient as grounds for discipline as follows: (a) that there was insufficient indications for surgery; (b) that by opening the groins first so that a femoral graft could be used, rather than staying within the abdomen in an attempt to use the iliac arteries first, Respondent performed surgery that was "more extensive than customary"; (c) that Respondent "failed to seriously consider reimplantation of the IMA"; and (d) that Respondent's post-operative care by his failure to perform a sigmoidoscopy and otherwise aggressively investigate post surgical problems was an extreme departure from the standard of care.

23. The medical evidence presented at trial regarding H.B. was extensive. Unfortunately, Dr. Foran had not been provided with all of H.B.'s records at the time he rendered his report to the Board, nor at any time prior to his direct examination. Accordingly, much of his testimony was based upon incomplete data and was not supported by all of the evidence. Taking the charging allegations in the order presented in the Accusation, the weight of the evidence showed the following:

a. Surgery took place on August 8, 1990. Comparison of a CAT scan and a later angiogram, coupled with the patient's complaints of back pain, reasonably led Respondent to believe that H.B. had an expanding aneurysm, which necessitated the surgery. Even without being apprised of all of the medical evidence, Dr. Foran, during his direct examination, could not say whether Respondent's decision to perform the surgery was wrong. He testified that while he believed surgery "was not mandatory", he did not know whether the patient insisted on it. He did agree that presence of the lower back pain could have been an indication of an expanding aneurysm which is an indication for surgery.

b. Review of the angiographic films, which Respondent saw prior to surgery but which Dr. Foran had not seen at all, showed the iliac arteries to be arteriosclerotic and tortuous and thus unsuitable for a graft from the aorta. Thus Respondent, of necessity, had to open H.B.'s groins first because he had no choice but to do an aortofemoral graft. While staying within the abdomen and keeping the surgery as simple as possible for this 80 year old patient by doing a graft to the iliac arteries would have been preferable, it was not feasible.

c. The IMA laid approximately 2 centimeters along the aneurysm before it passed on to supply the colon with blood. Back bleeding was noted coming from this artery, indicating the presence of collateral circulation to the colon, which appeared to be of normal color, which further indicated sufficient blood supply. Independent expert testimony produced by Respondent was to the effect that reimplantation of the IMA in this case was unnecessary in this case and is in fact rarely done.

d. For reasons not explained by the evidence, Dr. Foran believed the surgery took place on August 1, 1990, as opposed to August 8, 1990. This, in large part, led to his initial criticism of Respondent's post surgical care. Following surgery, H.B. showed signs of diarrhea with blood. Dr. Foran opined that this was an "absolute indication" for Respondent to perform a sigmoidoscopy, and that his failure to do so until three weeks after the surgery, particularly in light of H.B.'s fever and elevated white blood cell count, contributed to H.B.'s sudden death on August 21, 1990.

A review of the entire medical records of H.B., however, shows Dr. Foran was mistaken. Surgery took place on August 8, 1990. The nursing notes show that at 11:30 p.m. on August 11, 1990, Respondent was notified that H.B. had bloody diarrhea. Respondent immediately ordered a "flat plate" of the abdomen, a complete blood count and electrolyte panel and a gastroenterological consult for the following morning. These orders were duly executed and a G.I. consult by a well respected board certified specialist was had within twelve hours of the

order. From that point on, while Respondent was still "captain of the ship" with respect to post surgical care, he deferred to the specialist. It was this doctor's opinion that H.B. was too ill to undergo a sigmoidoscopy at the time, and that he would follow H.B. closely. In fact he did so. By August 18, 1990, H.B.'s elevated blood count was back to normal and he was being prepared for discharge in a few days, after a sigmoidoscopy was to be done on August 21, 1990. That procedure was in fact done, but H.B. died shortly thereafter. While there is substantial evidence in the records to suggest that H.B. died of an excess of potassium in his system, the actual cause of death need not be determined in these proceedings. It was clear that Respondent acted appropriately in securing the services of a specialist and in deferring to him the timing of the sigmoidoscopy.

PATIENT V.P.

24. V.P., a 73 year old female, was admitted to the hospital on December 7, 1989 with a diagnosis of "bulging aorta". She had had a long history of low back pain and on November 16, 1989 had an MRI study which revealed lumbar disc disease at multiple levels. The MRI also revealed incidentally an aneurysmal dilatation of the abdominal aorta. Accordingly, an abdominal MRI, as a follow up, was performed on November 28, 1989. This confirmed the aneurysm, which the radiologist estimated at 6 centimeters in diameter. V.P. was referred to Respondent, who saw her at his office on December 5, 1989. Respondent noted tenderness of the aneurysm, and also noted a history of intermittent claudication in the lower extremities at 20-30 feet.

25. In addition to her back problems, V.P. had a history of insulin dependent diabetes mellitus, hypertension, congestive heart failure, recent transient ischemic attacks, coronary artery disease with coronary bypass grafts done in 1986, chronic obstructive pulmonary disease and peptic ulcer. An angiogram via the left femoral artery showed a 4.2 centimeter abdominal aortic aneurysm. A CT scan, with and without contrast, performed the next day, showed the aneurysm to be 3.1 centimeters.

26. The angiogram, which was performed with a #5 French pigtail catheter, also showed one right renal artery with 30% stenosis at the point of origin, 80-85% stenosis at point of origin of the smaller inferior left renal artery, bilateral stenosis at the origins of the common iliac arteries of 75-80%, 30% stenosis of the distal left common iliac artery and extensive stenosis (from 70 to 90%) in areas of the left and right superficial femoral arteries and the right popliteal artery. The angiogram also showed marked irregularity of the flow lumen

through the aneurysm and enlargement of the supra renal abdominal aorta which extended superiorly to the celiac artery. Following the angiogram, V.P. suffered nausea and vomiting, and her cholesterol level was elevated to 312.

27. On admission, V.P. underwent examination by a cardiologist. The cardiologist opined that if V.P. was asymptomatic with the incidental finding of abdominal aneurysm, he would recommend the conservative approach and repeat an MRI or CT scan every six months. However, he did not conclude that from a cardiologic standpoint, V.P. should not undergo surgery, and stated "As far as the indication for surgery, I would leave this one up to the primary physician, Dr. Ironside." Respondent was concerned that the tenderness on palpation indicated an inflammatory aneurysm, and surgery was indicated. After the angiogram and V.P.'s resulting nausea, a gastroenterology consult was had on December 8, 1989 and found "no contraindications for [V.P.] to undergo surgery within the next several days."

28. On December 11, 1989, Respondent performed surgery on V.P. by resecting the abdominal aneurysm. An extensive amount of calcific atherosclerosis was encountered. An endarterectomy of the proximal aorta was done, including the area at the level of the renal artery orifices and above. Surgery also included an endarterectomy of the bilateral common femoral arteries for use in the bypass grafting, as the iliac arteries proved too tortuous and arteriosclerotic for safe use. During the surgery, the aorta was cross-clamped at the level of the diaphragm as well as infrarenal. When the abdomen was being prepared for closure, a small mass in the ileum was detected and the assistant surgeon resected the same. Pathology later reported this as "infarcted".

29. One day post-operatively, V.P.'s leg was found cool to the touch and pulseless, even when Doppler was used. V.P. had suffered a thrombotic occlusion of the right superficial femoral artery resulting from an intimal flap. According to all of the expert testimony, this is not an uncommon occurrence, and it was corrected under local anesthesia. Subsequently, V.P. continued to have severe acidosis. She also developed renal insufficiency. She died on December 13, 1989. Autopsy revealed the presence of multiple atheroemboli, cholesterol crystals, in all of the major organs and systems.

30. A thorough review of all of the medical evidence and the testimony of the witnesses shows the following: The abdominal aortic aneurysm was not inflamed. The previously undetected infarcted ileum was the probable source of tenderness on palpation. The extreme nausea resulted from atherosclerotic plaque being dislodged by the pigtail catheter during the angiogram. This also resulted in the multiple emboli found in all major systems and was a very significant factor in the cause of death.

31. The Accusation charges Respondent departed from the standard of care in five instances in his care of V.P. and are dealt with seriatim:

a. The first charge is that Respondent should not have ordered the angiogram. Little testimony was offered on this point, and the charge is not supported by the evidence offered. Virtually every doctor, and there were many, who looked at V.P. at the time, and post mortem at trial, were of the opinion the angiogram was necessary. Dr. Foran testified that he could not say one way or the other whether it was a departure from the standard of care for Respondent to have ordered the angiogram.

b. The second charge is that there were insufficient indications for surgery initially, and that V.P.'s condition following the angiogram also indicated surgery should be postponed. There seemed to be a clear split in medical opinion as to when an abdominal aneurysm in a patient such as V.P. should be resected. Dr. Foran's opinion was that tenderness alone was not an appropriate indication. Respondent offered the opinion of one expert who opined that presence of the aneurysm in and of itself was sufficient justification for surgery. Respondent offered the opinion of another expert who clearly stated that presence of the aneurysm coupled with suspicion of inflammation, as was the case here, was ample reason to go ahead. This seemed to be the most balanced and well reasoned of all of the opinions expressed, and the one best supported by the analyses offered by the various experts. As to performing the surgery after the angiogram, Respondent acted reasonably in obtaining a gastroentolgic consult which cleared V.P. for the operation.

c. The third charge is that Respondent's high cross-clamping of the aorta, at the level of the diaphragm was an extreme departure from the standard of care. The weight of the medical evidence however was that the high cross clamping was not only acceptable, but was necessary, particularly in light of the angiogram which showed enlargement of the supra renal abdominal aorta which extended superiorly to the celiac artery.

d. The fourth charge is that Respondent performed an unnecessary endarterectomy of the renal artery orifices. Again, the weight of the medical evidence was that a reasonably prudent surgeon would have removed what amounted to "plugs" at the opening of the renal arteries, which the angiogram showed to be profoundly stenosed at the point of origin.

e. The fifth charge is that Respondent's poor surgical technique resulted in an intimal flap causing thrombosis of the right superficial femoral artery, which caused V.P. to have to undergo a second procedure. Even Complainant's expert opined that leaving an intimal flap can happen to the best of surgeons and is not evidence, by itself, of a lack of skill.

PATIENT M.Y.

32. On November 2, 1989, Respondent performed surgery on M.Y., a 65 year old female, which consisted of resection of a large abdominal aortic aneurysm with aortofemoral bypass graft. The Accusation charges Respondent with having fallen below the standard of care in his treatment of M.Y. during surgery by (1) using unnecessarily high cross-clamping of the aorta (at the subdiaphragmatic level) and (2) causing an avoidable episode of de-clamping hypotension which lead to acute tubular necrosis in the patient's only kidney (from which she subsequently recovered).

33. At trial, Dr. Foran testified on direct examination that his only criticism of Respondent was the high cross-clamping. The weight of the medical evidence showed that the aneurysm was large and right at or about the level of the renal arteries. The cross clamp was placed as far away from the aneurysm as possible for patient safety (to avoid possible puncture), was in place for approximately one minute and was done so that Respondent could clearly see what would be involved in the resection. The clamp was released and the aorta reclamped below the renal arteries for completion of the resection. The weight of the medical testimony showed that clamping in the subdiaphragmatic area as Respondent did in this case did not pose any unnecessary risk to the patient and was within the standard of care.

* * * * *

DETERMINATION OF ISSUES

1. Respondent committed a simple act of negligence by reason of Findings 16 through 21.

2. Except as expressly found herein to be true, the remaining charging allegations of the Accusation are found to be unproven by clear and convincing evidence.

3. A single act of negligence is not grounds for discipline under the provisions of Business and Professions Code Section 2234 (c); nor does it constitute incompetence within the meaning of Business and Professions Code Section 2234 (d). See Gromis v. Medical Board, 8 Cal. App. 4th 589 (1992) and James v. Board of Dental Examiners, 172 Cal. App. 3d 1096 (1985).

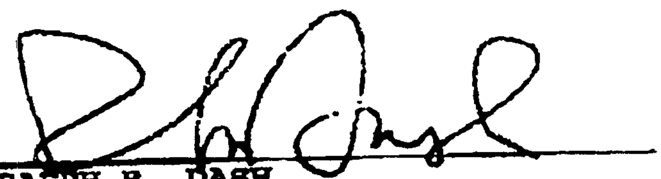
* * * * *

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Accusation is dismissed.

Date: 7-8-98



RALPH B. DASH
Administrative Law Judge

Exhibit # 4

Federal Appeals Court Decision

Decided and Filed December 23, 1996

Before: MERRITT, COLE, and GODBOLD (*)., Circuit Judges.

GODBOLD, Circuit Judge. The plaintiff, a physician practicing in Tennessee, sued a California hospital where previously he had practiced, and persons connected with it, alleging that they defamed him and tortiously interfered with his contract with a Tennessee hospital by sending a letter to the hospital. The letter referred to a report to the Medical Board of California concerning the suspension of plaintiff's clinical privilege at the California hospital and suggested that the Tennessee hospital, in evaluating plaintiff, question the California Medical Board concerning his licensure.

The district court granted defendants' Rule 12(b)(6) motion on the grounds that: (1) the defendants were immune from suit under the Tennessee Peer Review Act, Tennessee Code Ann. § 63-6-219, which provides for immunity to persons providing information to a hospital peer review committee; (2) that the letter contained no falsity, and (3) that, while it 'bordered on defamation by inference or implication' it was not defamatory. We hold that these issues could not be decided pursuant to the Rule 12(b)(6) motion and therefore reverse the judgment of the district court.

Plaintiff practiced medicine in California. A lengthy series of disputes arose between him and Simi Valley Hospital, at which he practiced, and its governing body. In October 1993 plaintiff moved to Oneida, Tennessee, and began practicing medicine at Scott County Hospital.

In January 1994 the president and the hospital administrator of Simi wrote an unsolicited letter addressed as follows:

Medical Staff Office

Scott County Hospital

U. S. Highway 27

Oneida, Tennessee 37841

ATTN: Medical Peer Review Committee

RE: Paul Ironside, M.D.

Medical Board of California Section 805 Report

Dear Medical Peer Review Committee:

The letter stated :

(T)his letter is being sent to your Medical Peer Review Committee (as that term is used in the Tennessee Statutes, Section 63-6-219), for Scott County Hospital (which we understand is a licensed health care institution) for the purpose of assisting the committee in evaluating the competence or professional conduct of a physician.

Due to a delay in filing a report to the Medical Board of California, pursuant to the reporting requirements concerning a summary suspension of Dr. Ironside's clinical privileges at Simi Valley Hospital & Health Care Services, we suggest that you query the Medical Board regarding his licensure as this report may be pertinent to your evaluation.

Meanwhile, plaintiff had moved to Morristown, Tennessee, where he entered into practice at Lakeway Regional Hospital pursuant to a contract that guaranteed substantial earnings and fringe benefits. Lakeway is owned by the same parent company as Scott County Hospital. Scott County Hospital forwarded the Simi Valley letter to Lakeway.

Plaintiff sued Simi Valley Hospital, the president and administrator who had signed the letter, the attorney for the hospital (who had drafted the letter) and the attorney's law firm. He claimed tortious inducement to breach of contract and defamation and alleged that the letter had caused him to lose his position at Lakeway.

Defendants filed a Rule 12(b)(6) motion to dismiss alleging that the complaint did not state a cause of action and:

However, all defendants are immune from liability pursuant to the Tennessee Peer Review Act of 1967, Tenn. Code Ann. § 63-6-219 (the "Act"), and sections 43.8 and 47 of the California Civil Code.

The court denied the motion to dismiss. It referred to a provision of the Tennessee Peer Review Act that grants immunity to one who "participates with or assists a medical review committee," or furnishes information to such committee, if the person acts in good faith and without malice (and on the basis of facts reasonably known or reasonably believed to exist). The "good faith and without malice" language appears in subsection (c)(1). Responding to this provision the district court held: "Obviously, the good faith and absence of malice on the part of the defendants is highly disputed in this action and immunity cannot be granted before the facts are developed."

Defendants moved to reconsider on the basis that they had not relied upon the "good faith and without malice" provision in (c)(1) but rather on the more specific immunity provision in subsection (c)(2) of the Act that provides:

(2) Notwithstanding the provisions of subdivision (c)(1), any person providing information, whether as a witness or otherwise, to a medical review committee regarding the competence or professional conduct of a physician is immune from liability to any person, unless such information is false and the person providing it had actual knowledge of such falsity.

Defendants asserted that the letter was true and that, under (c)(2), their motive in providing it is irrelevant to the immunity issue. The court entered an opinion on the motion for reconsideration, stating that the matter was back before the court to consider the contention of defendants that they were immune from liability under subsection (c)(2) and:

They also offer evidence that the information they provided in the letter was, in fact, true and contend that, under subsection (c)(2), because the information

was true, their motive in providing it is irrelevant to the immunity issue.

The court held that there was no dispute that plaintiff's privileges were summarily suspended in California and that a report had been belatedly filed or at least submitted to the Medical Board. It noted plaintiff's contentions that the suspension was not a "reportable peer review action" within the meaning of California statutes and that the Medical Board recognized that the event should not have been reported and had refused to accept the report. The court went on to hold that there was nothing in the evidence to show that the report was in fact rejected by the Board or, if it was, the reason why it was rejected; therefore the court "does not find this part of the letter defamatory." With respect to the suggestion of the letter that the reader query the Medical Board, the court found it was not a false statement but that there was a problem with plaintiff's continuation of his privileges at Simi Valley, and the court held: "This one aspect of the otherwise carefully crafted letter borders on defamation by inference or implication."

The court went on to hold that the defendants were immune under (c)(2) because they did not knowingly provide false information but only "an arguably unnecessary question" in the reader's mind, not actual false statements of fact but rather "an arguably false implication made in the protected context of a confidential communication."

The court's disposition presents several problems. Immunity is an affirmative defense that pursuant to Rule 8(c) must be pleaded. *Kennedy v. City of Cleveland*, 797 F.2d 297, 300 (6th Cir. 1986); *Bentley v. Cleveland Cty. Bd.*

of County Com'rs , 41 F.3d 600. 604 (10th Cir. 1994); *Gomez v. Toledo* , 446 U. S. 635, 640 (1980). The burden was upon the defendants to establish their affirmative defense, which required proof that Scott County Hospital in fact had a medical peer review committee as provided by the Tennessee statute. In *Wilmoth v. Durfey* , 1988 WL

136391 (Tenn. Ct. App. 1988), a defamation action, the court considered confidentiality under § 63-6-219 of letters sent to various officials of a hospital. The court concluded that there was insufficient evidence for it to determine whether the documents were covered by the confidentiality provision of the Act. It held:

The record fails to show that there was a medical review committee as defined in subsection (a) of the statute. We are not here finding that no such committee existed. Rather, we are finding, based on our review of the record and citations thereto by the parties, that the evidence is insufficient to conclude that such a committee did exist so as to bring the statute into application. We have not been cited nor has our search revealed any statement of policy of any of the entities involved as to existence of a standing committee or as to formation of a committee upon the occurrence of an incident.

Subsection (a) defines 'medical review committee' with some specificity, and the tenor of the language in the definition indicates the drafters had in mind some degree of formality.

The court went on to hold that the legislature did not intend for the immunity to apply to a random group of doctors or other health care professionals even within a given organization. Therefore, there must be proof that the committee was serving a function under the statute or proof of the policy whereby that function is served by the medical staff. (1)

Defendants seek to escape their burden by a contention that Tennessee regulations that govern hospitals require the institution have a medical staff and committees and

procedures that cover granting, revoking and suspending privileges, and it must be presumed that Scott Hospital acted in conformity with the regulations. This presumption does not carry Simi Valley's burden of proving the affirmative defense of immunity.

There is a second problem. If statutory immunity is present by reason of the letter being furnished to a medical review committee, the plaintiff must show that the information is false and that the person providing it had actual knowledge of the falsity. Plaintiff acknowledged in his response to the motion to reconsider that it was his burden to show that the letter was in fact false but contended that this was an issue that could not be determined pursuant to a Rule 12(b)(6) motion. This implicates whether the letter's reference to a report being belatedly filed with the California Medical Board, and plaintiff's being summarily suspended, were true, in the face of plaintiff's contentions that the report was not properly reportable to the Board, that the Medical Board refused to accept it and that the Board reinstated his privileges. The court placed upon plaintiff the burden to show that the report was rejected by the Board or, if it was, the reason why it was rejected, and in the absence of this evidence found this part of the letter was not defamatory.

The court also found that the suggestion that Scott County query the Medical Board, while it did not contain any false statement of facts, implied that there was a question of his licensure and that it bordered on defamation by inference or implication.

The issues of the existence of a peer review committee and of falsity, and therefore of immunity and of defamation, could not be determined short of summary judgment. No motion for summary judgment was filed.

Simi Valley's affirmative defense of immunity could be raised incident to a "speaking motion" under Rule 12(b)(6). 2A James W. Moore, et al., *Moore's Federal Practice* ¶ 12.09[3] (2d ed. 1996). But the merits of the affirmative

defense could not be decided short of summary judgment. When a 12(b) motion asserts failure to state a claim upon which relief can be granted, the motion may be converted to summary judgment, see Rule 12(b), but it does not appear that an order converting Simi Valley's motion was ever entered.

REVERSED and REMANDED .

FOOTNOTES

[*]

The Honorable John C. Godbold, Circuit Judge of the United States Court of Appeals for the Eleventh Circuit, sitting by designation.

[1] On rehearing, the court reversed its decision on ground that the statements in question had not been published to third persons. *Wilmoth v. Durfey*, 1989 WL 36643 (Tenn. Ct. App. 1989).

Exhibit # 5

L. A. Times Articles

Famous Hospital Traverses Some Rocky Terrain; Doctors have departed with various complaints, from favoritism to dismissals of outspoken colleagues. Officials admit tensions but say they have passed. Series: SHAKEN FAITH. An American Church in Turmoil. First in a two-part series:[Home Edition]

TOM GORMAN, ERIC LICHTBLAU. **The Los Angeles Times.** (Record edition). Los Angeles, Calif.: Aug 13, 1998. pg. 22

Full Text (1059 words)

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Loma Linda University Medical Center stands as one of the brightest marquees of the Seventh-day Adventist Church.

Hundreds of infants have been saved by heart transplants pioneered by Loma Linda doctors. The separation of Siamese twins in 1996--and the birth of another set this year--have stirred the hearts of parents everywhere.

A high-tech cancer treatment center has reduced the debilitating side effects of radiation on patients. Personal-health research at the medical center has promoted smarter lifestyle decisions.

And the gallant--albeit controversial--effort to save newborn Baby Fae with the heart of a baboon in 1984 showed the world that Loma Linda dared to make a difference.

But like the church itself, the hospital in the town of Loma Linda, 60 miles east of Los Angeles, has been beset by internal controversy over its style of management.

Dozens of physicians have left the 880-bed medical center alleging everything from religious favoritism and blatant nepotism to the firing of outspoken doctors as a warning to others.

"One of the real difficulties with Adventism is that the leadership feels they're doing God's work, so you can't argue with them," said Dr. Alan Jacobson, an Adventist who quit Loma Linda about seven years ago.

Some Say Anxieties Linger

Officials of the medical center and its affiliated Loma Linda University, a health sciences institution, acknowledge that there have been some rocky years but say relations at the Adventist-owned hospital have steadied since the departure of a number of disaffected doctors.

"Certainly, Loma Linda is not a perfect place," said Loma Linda University President Dr. L. Lyn Behrens. "But the spirit of Loma Linda is positive, is productive, and we have the ability to solve problems in a way that is professional and appropriate."

Although Loma Linda veterans agree that much of the open bitterness has eased, some contend that anxieties linger below the surface.

Physicians who practice at the hospital work for private doctor-operated medical groups, generally organized according to specialty, and must teach at the university as part of their employment.

"There are physicians here who are apprehensive about speaking out too strongly on issues because their employment might be at stake," said Dr. Keith Colburn, chairman of the Clinical Sciences Faculty Advisory Council.

"I can't say whether those fears are realistic," he said. "But in any system where there is top-down management

without a strong faculty organization, one always has to be concerned about jeopardizing his job security."

Those concerns stem largely from a series of tumultuous events that began in the early 1990s when two doctors formerly at the medical center sued Loma Linda officials for allegedly stealing their potentially lucrative research--a charge the school denied.

Three prominent doctors who were outspoken in support of their colleagues eventually were fired, prompting more outcries. Two-thirds of the doctors in the School of Medicine called for their reinstatement.

A letter of protest signed by 20 doctors concluded that "the church has long been known for integrity and honesty, and for preaching the Gospel--love the Lord thy God with all thy heart and thy neighbor as thyself. We believe that the manner in which this administration has dealt with many {employees} is in stark contrast to our motto to 'Make Man Whole.' "

The American Assn. of University Professors weighed in too, censuring Loma Linda in 1992 for the firings--a censure that remains in place today, one of 55 from the group that are currently in effect nationwide.

Loma Linda administrators dismiss the association as little more than a biased labor union and say its chief complaints about the handling of faculty grievances have been addressed.

Although the doctors who alleged that their research was stolen have settled their cases out of court for undisclosed sums, wrongful-discharge lawsuits filed by two of the fired physicians are heading toward trial.

Meanwhile, last summer the hospital's neurosurgery residency program was placed on probation by a national accreditation team. The group's report concluded that the department's leadership suffered from "long-standing instability" and that "faculty do not get along or collaborate effectively in the training of residents," jeopardizing their morale.

Loma Linda officials say the problems are being addressed. Another accreditation review is scheduled for next year.

Another physician, vascular surgeon Alan Koslow, is suing the hospital, alleging that after an argument with a supervisor led to his 1993 departure, he was deemed incompetent by a Loma Linda physicians panel that secretly reviewed his work. Koslow, who had earlier received numerous accolades from Loma Linda, said the review--posted on a nationwide physicians databank--cost him a new job.

A subsequent independent study cleared Koslow, concluding that "from the nature of the strictness with which his work was judged, there was something else afoot that does not really appear herein."

After the pejorative information was removed from the databank, a lower court judge dismissed Koslow's suit for financial damages--a ruling the physician is appealing. Citing the ongoing litigation, Loma Linda officials declined comment.

Probe of Contract Urged

In another episode, a former president of the worldwide Seventh-day Adventist Church told The Times that there should be a review of whether the awarding of a lucrative contract was unduly influenced by family connections.

Neal Wilson, now a Loma Linda trustee, said the contract could spark "views of nepotism, that there's a family tie-in here, a kind of royal succession. . . . I think there is an ethical question, definitely."

The contract--to maintain the hospital's proton beam accelerator, a state-of-the-art device for radiation treatment--was awarded to the son of the chairman of the radiation medicine department. The contract also gave the son's company exclusive rights to build and market proton accelerators internationally, using technology acquired by and further developed at Loma Linda--a deal potentially worth millions of dollars. Both the father and son have denied any wrongdoing.

Wilson, the church's president from 1979 to 1990, has earned a reputation for speaking his mind. But he saves his sharpest words for those who would challenge the medical center's administration--a philosophy that seems embedded in the Seventh-day Adventist Church itself.

Wilson said unequivocally that the medical center will not tolerate "a dissident type of mind" that "sows the seeds of discontent."

"If the situation demands it," he said, "the best way {to deal with it} is just to relieve people {of their jobs} . . . and wish them well."

Credit: TIMES STAFF WRITERS

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U.S. Drops Inquiry of Simi Hospital, Doctors Medicine: The three physicians were accused of taking non-repayable loans for referring patients to the health facility.:[Ventura County Edition]

CARLOS V. LOZANO. **The Los Angeles Times (Pre-1997 Fulltext)**. Los Angeles, Calif.: Jun 27, 1992. *pg. 1*

Full Text (677 words)

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Federal authorities have dropped a two-year investigation against Simi Valley Hospital and three physicians accused of referring patients to the medical facility in the mid-1980s in exchange for non-repayable loans, hospital officials said Friday.

Hospital President Alan Rice called the decision an exoneration of the hospital and of the physicians, who still practice there.

"Our board of directors is pleased to see this come to an acceptable conclusion," Rice said. "We can now focus all of our energies and resources on meeting the community's health needs."

Rice said the U.S. Department of Health and Human Services had informed the hospital recently that it had dropped its inquiry of the hospital and Drs. George Dichter, Geoffrey Graham and Vahe Azizian.

Elliot Kramer, the federal inspector in charge of the investigation, did not return calls to his San Francisco office Friday.

Rice said the hospital, as "a good-will gesture," agreed to pay $50,000 to the federal government to help cover the costs of the investigation, which involved a previous set of administrators at the hospital.

"They had quite an investigation and this was a way to help defray some of the expenses," Rice said. "It was part of a good-faith effort."

The three physicians who were targeted in the federal inquiry were suspected of taking hundreds of thousands of dollars in non-repayable loans from the hospital in the mid-1980s in return for referring patients to the facility.

Darwin Remboldt, the hospital's chief administrator at the time, later testified before the Ventura County Grand Jury that the practice of giving doctors financial benefits for referring patients had been hospital policy.

Remboldt, who answered questions only after being granted immunity from prosecution, said such practices were necessary for the hospital to attract physicians to fast-growing Simi Valley.

The 1990 grand jury report concluded that the hospital and the doctors had violated state law, but county prosecutors concluded that no charges could be filed under state law because too much time had passed since the alleged crimes.

Because federal law allowed more time to file charges, Kramer's office announced it would conduct its own investigation to determine whether there was sufficient evidence to pursue the case through the U.S. attorney's office.

The three physicians could not be reached for comment Friday. But Christopher Caldwell, an attorney representing Dichter and Graham, confirmed that the investigation had been suspended and his clients cleared of any wrongdoing.

"All three doctors have been relieved" of any claims against them, Caldwell said. "What they are doing now is

practicing medicine and taking care of their patients."

Caldwell has maintained all along that his clients received substantial loans from the hospital but never as part of an agreement to bring patients to the hospital. He said Graham and Dichter are still paying back the $300,000 loan they received from the medical facility in 1986 to set up practice in Simi Valley.

"They are quality physicians," Rice said in defense of the hospital's decision to offer the loans to attract the doctors. "This has never been an issue of the quality of care at the hospital."

Azizian, in an earlier interview, acknowledged that he had received a $25,000 loan from the hospital in 1985 with the agreement that the hospital would forgive at least part of the loan in return for patient referrals.

But Azizian said he continued to refer patients to other hospitals. Like Dichter and Graham, Azizian said he, too, was in the process of paying the hospital back.

Rice said the hospital still makes loans to doctors as an incentive to bring needed specialists to the area, but the loans must be paid back.

Since Rice took over as president of the hospital in 1989, the medical facility has changed its name from Simi Valley Adventist Hospital to Simi Valley Hospital and has spent more than $5 million on new medical equipment and renovation work.

Rice said the name change had nothing to do with the investigation. He would not discuss the hospital's financial status, except to say that it was headed in a "favorable direction."

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