House Committee on Veterans' Affairs
"VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability."

Written Testimony by Dr. Christian Head (Executive Summary)
Associate Director, Chief of Staff, Legal and Quality Assurance within the VA Greater Los Angeles Healthcare System

Tuesday, July 8, 2014 at 7:30 p.m.

Dr. Christian Head comes before Congress to testify, not motivated by any political agenda, but based purely on a genuine interest in seeking solutions to address employee mistreatment, but most importantly, to improve the healthcare provided to our Country's heroes.

Dr. Head is uniquely qualified to testify regarding issues within the VA system. Dr. Head is a world-renown, board certified Head and Neck Surgeon. Between 2002 through 2013, Dr. Head held dual appointments at the UCLA David Geffen School of Medicine becoming a tenured Associate Professor in Residence of Head and Neck Surgery, as well as an attending surgeon at the West Los Angeles Campus of the VA Greater Los Angeles Healthcare System ("GLAHS"). In 2007, Dr. Head was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHS.

Dr. Head's clinical and academic successes over the years have been numerous. However, despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Head has endured and witnessed, firsthand, illegal and inappropriate discrimination and retaliation of physicians, nurses, and staff members within GLAHS. During his testimony, Dr. Head intends to speak on the growing number of complaints coming from VA employees, complaints ranging from racial, gender, and age discrimination and harassment to complaints regarding substandard patient care and treatment.

Additionally, Dr. Head will address the inappropriate and often illegal response, or at times lack of response, by VA administration in regards to complaints by hospital employees. For example, Dr. Head will testify about how administrators and supervisors within GLAHS have created a climate of fear and intimidation, where the system not only fails to protect whistleblowers, but actively seeks to retaliate against them.

Further, Dr. Head will discuss the general lack of accountability of VA administrators and supervisors who actively retaliate against and ostracize hospital employees who attempt to speak out against illegal behavior. Dr. Head will testify, firsthand, about the climate within GLAHS which perpetuates this illegal behavior, due in large part to the system's failure to take any action against certain individuals. Specifically, how wrongdoers are left in positions of high leadership to continue their illegal behavior without recourse.

Dr. Head will further discuss how the current morale of employees within GLAHS is dangerously low. Dr. Head will testify about how the system's failure to properly respond to complaints leaves employees within GLAHS with a sense of helplessness, creating undue stress and anxiety amongst those attempting to provide quality healthcare to our Country's veterans.

Finally, but most importantly, Dr. Head will testify how this dangerous climate of intimidation and retaliation against whistleblowers negatively affects patient care. Dr. Head will discuss how he has witnessed, firsthand, veterans receiving below-standard healthcare, or no healthcare at all, because of the retaliatory behavior and lack of accountability within the system.

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Introduction

Chairman, Hon. Jeff Miller
Vice Chairman, Hon. Gus Bilirakis

Dr. Christian Head[1] comes before Congress to testify, not motivated by any political agenda, but based purely on a genuine interest in seeking solutions to address employee mistreatment, but most importantly, to improve the healthcare provided to our Country's heroes. Dr. Head submits this testimony in response to Congress's request to appear and testify on this issue.

Dr. Head is uniquely qualified to testify regarding issues within the VA system. Dr. Head is a world-renown, board certified Head and Neck Surgeon. Between 2002 through 2013, Dr. Head held dual appointments at the UCLA David Geffen School of Medicine becoming a tenured Associate Professor in Residence of Head and Neck Surgery, as well as an attending surgeon at the West Los Angeles Campus of the VA Greater Los Angeles Healthcare System ("GLAHS"). In 2007, Dr. Head was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHS.

Dr. Head's clinical and academic successes over the years have been numerous. However, despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Head has endured and witnessed, firsthand, illegal and inappropriate discrimination and retaliation of physicians, nurses, and staff members within GLAHS. Throughout this testimony, Dr. Head will speak on the growing number of complaints coming from VA employees, complaints ranging from racial, gender, and age discrimination and harassment to complaints regarding substandard patient care and treatment.

Additionally, Dr. Head will address the inappropriate and often illegal response, or at times lack of response, by VA administration in regards to complaints by hospital employees. For example, this testimony will focus on how administrators and supervisors within GLAHS have created a climate of fear and intimidation, where the system not only fails to protect whistleblowers, but actively seeks to retaliate against them.

Further, Dr. Head's testimony here will discuss the general lack of accountability of VA administrators and supervisors who actively retaliate against and ostracize hospital employees who

[1] To avoid confusion, I will refer to myself in the third person throughout this testimony.

attempt to speak out against illegal behavior. Dr. Head will testify, firsthand, about the climate within the GLAHS which perpetuates this illegal behavior, due in large part to the system's failure to take any action against certain individuals. Specifically, how wrongdoers are left in positions of high leadership to continue their illegal behavior without recourse.

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Finally, but most importantly, Dr. Head's testimony here will explain how this dangerous climate of intimidation and retaliation against whistleblowers negatively affects patient care. Dr. Head will discuss how he has witnessed, firsthand, veterans receiving below-standard healthcare, or no healthcare at all, because of the retaliatory behavior and lack of accountability within the system.

Background

Dr. Christian Head is a prominent Head and Neck Surgeon, known worldwide. As some would say, "one of our finest surgeons in Southern California. . . . [Who is] generous with his time and talent, helping Veterans and giving back to our community both locally and nationally. . . . [W]ho will make a difference in our world with his skills as a surgeon, his scientific research and laboratory." Unfortunately, Dr. Head has been the victim of outrageous racial harassment, discrimination, and retaliation occurring within GLAHS.

Dr. Head obtained his Doctor of Medicine degree from Ohio State University, College of Medicine in 1993. Between 1992 and 1993, Dr. Head completed an Internship in Surgery at the University of Maryland at Baltimore. Between 1994 and 1996, Dr. Head commenced his employment with a Fellowship in Neuro-Otology Research at UCLA School of Medicine. Between 1996 and 1997, Dr. Head completed a Surgical Internship at UCLA School of Medicine. Between 1997 and 2002, Dr. Head worked as a Resident in the UCLA School of Medicine Head and Neck Surgery Department. In 2002, Dr. Head joined the faculty as a Visiting Professor in Head and Neck Surgery at UCLA. In 2002, Dr. Head also joined GLAHS. During his time with GLAHS, Dr. Head worked as a Head and Neck Surgeon, and in 2007, was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHA. In August 2003, Dr. Head joined the faculty of the UCLA Geffen School of Medicine as a full time Head and Neck Surgeon. Dr. Head left UCLA in 2013. Dr. Head has been board certified in Head and Neck Surgery since June 2003.

Over the years, Dr. Head's work has included clinical practice, surgery, academia, and research. Dr. Head has received accolades for his work, including the National Institute for Health–National Cancer Institute Faculty Development Award. In or around 2001 to 2002, Dr. Head was nominated for the UCLA Medical Center Physician of the Year award. In or around November 2003, Dr. Head launched the UCLA Jonsson Cancer Center Tumor Lab, which has been tremendously successful, yielding valuable research and benefitting many physicians and patients at UCLA and worldwide. In 2003, Dr. Head was one of a few surgeons nationwide to receive the

Faculty Development Award from the National Institute of Health Comprehensive Minority Biomedical Branch, intended to increase the number of minority physicians in cancer research at major academic institutions.

An important point relevant to this testimony includes the relationship between GLAHS and the University of California, Los Angeles ("UCLA"). UCLA has several affiliated hospitals, one of which includes GLAHS. As part of this affiliation, UCLA provides physicians and surgeons to staff GLAHS. Until his departure from UCLA in July 2013, Dr. Head worked at both entities under this UCLA/GLAHS affiliation.[2]

Dr. Head's supervisors include Marilene Wang, M.D. ("Dr. Wang"), UCLA/GLAHS Head and Neck Surgeon and Dr. Head's immediate clinical supervisor at GLAHS; Dean Norman, M.D. ("Dr. Norman"), GLAHS Chief of Staff; Matthias Stelzner, M.D. ("Dr. Stelzner"), GLAHS Chief of Surgical Services; and Donna Beiter, RN, MSN ("Ms. Beiter"), GLAHS Director. Dr. Head's immediate supervisor at UCLA was Gerald Berke, M.D. ("Dr. Berke"), Chairman of the UCLA Department of Head and Neck Surgery, who has tremendous power and influence at GLAHS.

Discrimination and Retaliation Against Dr. Head

Despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Berke and Dr. Wang have made several inappropriate racial comments about black people, including Dr. Head. In or around 2003, Dr. Wang made comments that Dr. Head was hired as a Visiting Professor because he was an "affirmative action hire" and "affirmative action project." In or around 2003, Dr. Wang also publicly stated that Dr. Head is inferior because he is black, that he would not pass the boards, and that he was unqualified. In or around 2003, Dr. Wang stated that "cream rises to the top," that Dr. Head "would not make it in academic medicine," and that Dr. Head and "doctors like him" who are black, were the reason for failed hospitals like King Drew. In or around mid-2003, Dr. Berke stated that "we're about to have some color" in the department. Dr. Berke also stated, "I guess we'll have our first Nigger" now.

From 2003 to present, Dr. Head has lived with Dr. Wang's threats and affirmative actions to destroy Dr. Head's career, reputation, and ability to earn a living. In that regard, in 2003, Dr. Wang, who has supervisory authority over Dr. Head at GLAHS and prepared evaluations of his performance, clearly indicated it was her intention to prevent Dr. Head from receiving promotions, full time equivalents, tenure, and advancement. Dr. Wang's discriminatory conduct has been continuous and consistent throughout Dr. Head's employment.

Starting in or around 2003, Dr. Wang began stating to other surgeons that she fully intended to interfere with Dr. Head's professional advancement, in part by giving Dr. Head subpar evaluations and falsely attacking Dr. Head's credentials and performance at GLAHS.

In March 2004, Dr. Head submitted an EEO complaint outlining the discriminatory and hostile behavior against him by Dr. Wang. (A true and correct copy of this EEO complaint is attached hereto as Exhibit 1.)

[2] While there may be additional information relevant to Dr. Head's testimony, because of certain conditions, Dr. Head will focus his testimony here solely on incidents related to his employment at GLAHS.

In or around June 2004, Dr. Wang was ordered by UCLA officials to stop submitting negative evaluations about Dr. Head after Dr. Wang was reported by Dr. Head as having called Dr. Head an "affirmative action hire," amongst other racist comments. At that time, Dr. Wang promised not to interfere with Dr. Head's career advancement. However, in direct violation of this order, Dr. Wang continued to submit negative supervisor evaluations at GLAHS regarding Dr. Head's performance, which evidenced her obvious racial bias against Dr. Head. Dr. Wang's ongoing harassment and retaliation against Dr. Head in this way continued to negatively impact Dr. Head's career advancements.

In or around November 2005, Dr. Wang gave Dr. Head a retaliatory and harassing evaluation of his teaching and performance at GLAHS in an attempt to interfere with his advancement at UCLA. Dr. Wang rated Dr. Head a 1 out of a possible 4 points in his review. Dr. Wang further wrote that Dr. Head "doesn't teach, yells at junior residents," "poor availability, doesn't respond to messages," and "poor example & role model for residents." Dr. Wang's performance review was in sharp contrast to reviews and comments made by other colleagues.

On or about February 2, 2006, Dr. Head sent a letter to Dr. Rosina Becerra ("Dr. Becerra"), then-Vice Provost for Faculty Diversity and Development at UCLA, regarding this harassment, discrimination, and related problems at UCLA and requested financial and other support to stop the harassment, retaliation, and interference with his career advancement. Dr. Head also requested that he be assigned more time working at UCLA in order to be removed from Dr. Wang's supervision at GLAHS. In response, Dr. Becerra told Dr. Head that she could not help him, and warned Dr. Head it was not a good idea to participate in an investigation against Dr. Wang.

In or around April 2006, Dr. Head was contacted for the first time by Investigator Nancy Solomon ("Investigator Solomon") of the Office of Inspector General ("OIG") regarding an investigation of Dr. Wang for time card fraud concerning work Dr. Wang performed at GLAHS. Dr. Head learned from Investigator Solomon that Dr. Wang was under investigation by the federal government for submitting and/or approving false time cards pertaining to services provided at GLAHS. Dr. Head was asked by Investigator Solomon to testify about Dr. Wang's involvement in time card fraud. Dr. Head requested protection from Investigator Solomon, stating that he feared retaliation for his participation in the investigation. With a promise by Investigator Solomon regarding protection from retaliation for his cooperation, Dr. Head testified in an OIG deposition regarding Dr. Wang's time card issues.

The OIG investigation concluded that Dr. Wang had in fact committed time card fraud. There was a recommendation by the OIG that Dr. Wang be removed from her leadership position and terminated from GLAHS; however, Dr. Wang's immediate supervisor, Dr. Berke, took steps to save Dr. Wang's job and leadership position—UCLA transferred vacation hours to Dr. Wang's account and research funds were transferred from Dr. Berke. Additionally, Dr. Berke approached Dean Norman, M.D. ("Dr. Norman"), GLAHS Chief of Staff, to request that Dr. Wang not be terminated. Due to Dr. Berke's intervention and powerful influence, Dr. Norman did not terminate Dr. Wang, did not dock her pay, and did not remove her from her leadership position as Chief of Head and Neck Surgery at GLAHS, despite the recommendation for termination by the OIG. In

fact, the only action taken was a written warning issued to Dr. Wang and termination of a subordinate.

Prior to Dr. Head's participation in the time card fraud investigation of Dr. Wang, Dr. Head had been nominated for Head and Neck Department teacher of the year. However, following Dr. Head's participation and truthful testimony in connection with Dr. Wang's time card fraud investigation in April 2006, Dr. Berke and Dr. Wang escalated their campaign of intimidation, harassment, discrimination, and retaliation against Dr. Head.

In or around April/May 2006, Dr. Head met with Dr. Berke to discuss Dr. Head's total compensation package for the academic year 2006-2007. Dr. Berke threatened Dr. Head stating, "If you complain about Dr. Wang," and about not getting the compensation enhancement (a Full-Time Equivalent ("FTE") that was available, which Dr. Wang denied Dr. Head and gave to another surgeon from outside the hospital), "you won't get anything, you'll be removed."

In or around April/May 2006, shortly after Dr. Head provided deposition testimony to the OIG, Dr. Wang discussed with the residents of the UCLA Head and Neck Department, whom she supervised and worked with, about Dr. Head's participation in the time card fraud investigation. In addition, Dr. Wang spoke with many of the residents who worked under her supervision as they each testified in the time card fraud investigation. As a result, these residents, began to participate in the intimidation, harassment, discrimination, and retaliation of Dr. Head. Dr. Head began to experience horribly offensive discriminatory comments, graphic racial photos, and retaliatory actions and statements.

In or around May 2006, Dr. Head reported to Dr. Dennis Slamon ("Dr. Slamon") that he was being harassed and retaliated against by Dr. Berke and Dr. Wang and was worried about his future. Dr. Slamon responded, "They [Dr. Berke, Dr. Wang, and Dr. Abemayor] think you ratted out Wang in the IG investigation. You need to keep your head down and stay out of this. Don't complain."

In or around May 2006, Dr. Head requested a full-time appointment at GLAHS, but did not receive the appointment despite being more qualified than other choices.

In or around June 2006, at the year-end closing ceremony and party for the UCLA Head and Neck Department—attended by approximately 200 people including UCLA and VA faculty, staff, chairs, residents, and spouses—the resident class presented a slide show. The slide show, presented by the Residents had an entire section about Dr. Head. These slides, directed toward Dr. Head, were exceptionally vulgar, disturbing, defamatory, discriminatory, retaliatory, humiliating, degrading, disgusting, demoralizing, and racist. One slide, referencing the OIG time card fraud investigation of Dr. Wang, showed Dr. Head on the telephone and read: "If all else fails call 1-800-488-VA IG." (See Exhibit 2.) The other slides throughout the presentation were similar to Dr. Wang's comments in her performance "evaluations" of Dr. Head: that he is a bad doctor, bad researcher, and bad teacher.

In or around June 2006, Dr. Head's surgical practice was restricted, and more complex surgical operating room time was being given to vastly under qualified surgeons.

In or around December 2006, Dr. Wang continued to submit false critical evaluations of Dr. Head, assigning him the lowest marks possible. Caused by her malice, personal vendetta, and discriminatory bias towards Dr. Head, Dr. Wang's false evaluations were defaming to Dr. Head's professional reputation, criticizing his competence generally and as a teacher, researcher, and mentor.

In or around early 2007, Dr. Head learned that Dr. Berke and Dr. Wang were planning on terminating Dr. Head's employment if given the opportunity. Consistent with the repeatedly expressed intention to remove Dr. Head, Dr. Berke and Dr. Wang micromanaged Dr. Head's performance, concerning trivial matters or matters that were entirely manufactured. Although Dr. Head actively and successfully thwarted Dr. Berke's and Dr. Wang's efforts to vex, annoy, and harass him into voluntarily resigning his position, Dr. Wang continued to provide negative evaluations of Dr. Head between 2007 and 2008.

In or around December 2007, Dr. Wang submitted another critical evaluation of Dr. Head giving him all 1's out of 5's. Dr. Wang made false statements such as: "Difficult to reach on pager." "No tangible research activity." "Poor role model."

On or about May 5, 2008, Dr. Wang again submitted a Teaching Evaluation—knowing it was to be submitted into Dr. Head's Promotions Packet for tenure decisions—marking all 1's (Unsatisfactory), stating "poor clinical judgment, poor availability, poor role model." (See Exhibit 3.) Dr. Wang continued to provide negative false information and evaluations about Dr. Head, despite orders to stop.

In or around July 2008, in a further attempt to harass and retaliated against Dr. Head, he was wrongfully accused of ten counts of timecard fraud and lying to his supervisor.

In July 2008, Dr. Head was forced to file another EEO complaint regarding the threatening and retaliatory treatment against him by VA administrators and supervisors. (A true and correct copy of this EEO complaint is attached hereto as Exhibit 4.)

In or around August 2008, in order to further retaliate against Dr. Head, his salary was reduced. At this time, in order to undermine Dr. Head's teaching, a fee-based physician was hired in the clinic to see Dr. Head's patients at an increased cost to GLAHS.

In or around August 2008, Dr. Head was transferred to the Quality Assurance program to minimize the retaliation by management resulting from his 2004 EEO complaint.

On or about September 10, 2008, Dr. Michael Mahler ("Dr. Mahler"), Chief of Organizational Improvement at GLAHS wrote a detailed account of the harassment, discrimination, and retaliation against Dr. Head. In this letter, Dr. Head was exonerated of timecard fraud. Furthermore, it was found that "Dr. Stelzner and Dr. Wang improperly treated Dr. Head differently than other members of the section." (See Exhibit 5.)

In early 2009, Dr. Head again consulted with Dr. Becerra regarding Dr. Wang's unfair and improper evaluations of Dr. Head and her treatment of Dr. Head in assignments and research opportunities. Dr. Becerra responded, "Oh my God, here we go again. I am going to legal with this." Dr. Becerra replied, "Come back to see me if you don't get tenure, otherwise you're not damaged."

In or around January 2009, in an attempt to further sabotage Dr. Head's tenure and career advancement, Dr. Wang again submitted false evaluations of Dr. Head.

On several occasions, regarding Dr. Wang's unfair treatment and improper evaluations of Dr. Head's performance, Dr. Head individually met with Dr. Gold, Dr. Rosenthal, Dr. Mechoso, and Dr. Becerra, all of whom communicated a similar message that if Dr. Head wanted tenure, he better not take any action against Dr. Wang.

In or around January 2009, Dr. Head presented to Dr. Richard H. Gold ("Dr. Gold"), Assistant Dean of Academic Affairs, a report conducted at GLAHS showing findings that Dr. Wang was biased against Dr. Head in her evaluations of his performance, assignments, and research. When Dr. Head first received this report, Dr. Head informed Dr. Berke that he had this report and could prove that Dr. Wang was treating him differently and unfairly in assignments and research opportunities. Dr. Berke offered to pay Dr. Head for the report saying, "How much do you want for the report? You can't release that report." Dr. Head replied he did not want money, he wanted to be treated fairly and to receive the tenure he deserved and had earned.

In or around October 2009, another GLAHS employee reported being transferred to another department and refused promotion for not submitting false reports against Dr. Head concerning his attendance at GLAHS.

Also around this time, prior to Dr. Norman's vacation to Fiji, Dr. Head and Dr. Norman met to discuss Dr. Head's fear of more intense retaliation and loss of income at GLAHS. Dr. Norman stated that Dr. Head would be protected with a significant salary increase; however, that increase never occurred, instead, Dr. Head endured further retaliation. On information and belief, Dr. Norman later told a faculty member on his trip to Fiji that "he really liked Dr. Marilene Wang and that they had a good relationship."

In or around September through November 2010, Dr. Head participated as a witness, and later in March through October 2011, and even through today, Dr. Head has testified on behalf of Dr. Jasmine Bowers in a racial discrimination case against GLAHS. Dr. Wang is on the peer-review panel at GLAHS and considered a witness in the Bowers Case. Immediately after Dr. Head participated in the Bowers Case, Dr. Berke, Dr. Wang, and Dr. Norman escalated the retaliation and harassment against Dr. Head.

In or around June 2011, in an effort to further discredit Dr. Head, Dr. Wang began making accusations of wrongdoing against Dr. Head. Dr. Wang stated to a group of surgeons that Dr. Wang was sure Dr. Head would not last long and that he would be investigated at GLAHS where Dr. Wang is Chief of Head and Neck Surgery.

In or around September 2011, Dr. Norman confronted Dr. Head, stating "you're a bad doctor" and wrongfully accusing Dr. Head, claiming "you're never here" and asking Dr. Head about his work hours. Dr. Norman threatened Dr. Head stating "I'm very worried about you."

In or around October 2011, James Itamura, EEO Investigator, wrote a detailed account of the harassment, discrimination, and retaliation occurring against Dr. Head at GLAHS, which was provided to the Office of Special Counsel. (See Exhibit 6.)

On or about October 25, 2011, Dr. Head was on an emergency call at UCLA when he contacted Vishad Nabili, M.D. ("Dr. Nabili") to cover for him on an elective surgery at GLAHS. A few days later, Dr. Head learned that he was accused of not showing up for a surgical procedure, which was reported to Human Resources. Despite his promise to correct Dr. Head's time cards to correctly reflect Dr. Head's work, Dr. Norman charged Dr. Head with being Absent Without Leave ("AWOL") and reduced Dr. Head's pay approximately $7,000.

Around this time, Dr. Head was being told by co-workers that Dr. Norman was trying to push Dr. Head out of GLAHS. In or around November 2011, Dr. Joel Sercarz ("Dr. Sercarz"), fellow Head and Neck Surgeon at UCLA, informed Dr. Head that Dr. Wang told Dr. Sercarz that GLAHS was planning to "get [Dr. Head] on time card fraud." Dr. Head reported these allegations to Dr. Norman and others. In retaliation, Dr. Norman tried to restrict Dr. Head's tour of duty.

On or about November 20, 2011 Dr. Norman ordered his assistant to mark Dr. Head AWOL for 90% of the pay period. This action resulted in severe financial distress for Dr. Head, causing his house to go into foreclosure. Despite Dr. Head providing evidence showing he in fact did work his tour of duty, Dr. Norman did not turn in Dr. Head's time cards for several weeks. It was not until after Congresswoman Karen Bass and others inquired into Dr. Head's pay, that Dr. Head finally received a check.

On November 23, 2011, Dr. Head filed a formal EEO complaint.

On or about April 17, 2012, Dr. Head filed a lawsuit against the Regents of the University of California and certain individuals. The case, *Christian Head, M.D. v. Regents of the University of California, et al.*, Case No. BC 482981, was filed in Los Angeles Superior Court. In or around July 2013, the case was settled and "The matter has been resolved to everyone's satisfaction."

On or about July 18, 2013, UCLA release a statement which read:

> The Regents of the University of California and Dr. Christian Head today reached a settlement in a civil case he brought against the University last year. The case presented difficult issues of alleged discrimination and retaliation that were strongly contested.
>
> The University acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The University regrets that this occurred. The University does not admit liability, and the parties have decided that the case should

be resolved with a mutual release of all legal claims. The matter was settled to the mutual satisfaction of the parties.

(A true and correct copy of this press release is attached hereto as Exhibit 7.)

Unfortunately, the retaliation against Dr. Head did not stop with Dr. Head himself, but spread to anyone that even attempted to support Dr. Head or provide truthful testimony on Dr. Head's behalf. In or around June/July 2012, Dr. Jeff Suh ("Dr. Suh"), fellow Head and Neck Surgeon at UCLA, told a representative of a sinus surgery supply company not to assist Dr. Head with necessary surgical supplies or with his lawsuit or the representative would lose all business at UCLA. Around this same time, Dr. Suh also threatened Dr. Sercarz not to assist Dr. Head with his lawsuit or his complex surgical cases or he would not receive help or referred cases. Dr. Suh claimed he was speaking on behalf of Dr. Wang in regards to these threats. Because of this retaliation, Dr. Sercarz was forced to bring his own civil action to protect his name and reputation. (A true and correct copy of this civil complaint is attached hereto as Exhibit 8.)

On or about August 2, 2012, in further harassment and retaliation against Dr. Head, Dr. Wang refused to treat one of Dr. Head's patients, leaving the patient in the emergency room for days, using the patient's care and safety as a weapon against Dr. Head, creating a hostile environment and jeopardizing patient safety.

Dr. Head was one of the first to draw attention to the delay in care and the backlog of patients within the VA system. On November 16, 2012, Dr. Head sent Dr. Norman an email discussing the issue of delayed patient care at the VA. Specifically, Dr. Head informed Dr. Norman that the delayed diagnosis of cancer was a major issue facing the VA. (A true and correct copy of this email and accompanying attachments is attached hereto as Exhibit 9.)

In or around May 2014, Dr. Head learned that VA administrators had improperly taken approximately 60-100 days of sick leave time and approximately 80-90 days of vacation time from Dr. Head in retaliation for Dr. Head's protected whistleblower activity, specifically, Dr. Head's truthful testimony regarding Dr. Wang's illegal time card fraud, testimony in support of Dr. Bowers's racial discrimination case, and reports of delayed care and backlog of veterans within the VA system. Less than two months ago, administrators within GLAHS retroactively took these accrued time-off days, falsely claiming that Dr. Head had previously failed to enter his time.

Retaliation Against Other Whistleblowers

Because of Dr. Head's leadership position within GLAHS and his willingness to stand up against wrongdoers within the system, Dr. Head has become aware of many other VA employees who are enduring their own retaliation.

Incident 1:

One instance involved a 53-year-old African American woman, Dr. Jasmine Bowers ("Dr. Bowers"), who is a board-certified anesthesiologist and has practiced in anesthesia and pain management for over 24 years.

In May 2010, Dr. Bowers was offered a per-diem, fee-basis position, which was an hourly position with capped weekly hours, and no benefits. Because of the dire need for anesthesiologists at the VA, Dr. Michelle Braunfeld ("Dr. Braunfeld"), chief of anesthesiology, assured Dr. Bowers that the appointment would likely last longer than a year. When Dr. Bowers inquired about full-time positions, Dr. Braunfeld stated that the only available position was for an acute pain specialist. Having her fellowship in pain management, and more than twenty years of experience in the field, Dr. Bowers expressed interest in the position. Dr. Braunfeld was dismissive, and stated Dr. Bowers would likely have to have board certification in pain management to be hired for the position. Unbeknownst to Dr. Bowers, Dr. Braunfeld had advertised for a "general anesthesiologist" position in May 2010. In addition, at or around the same time Dr. Bowers was hired (in June 2010), Dr. Braunfeld offered a full-time, FTE anesthesiologist position to Dr. Corey Downs ("Dr. Downs"), who began working at the VA in approximately July 2010. Dr. Downs was fresh out of his residency at UCLA, and was not board certified in anesthesia. Dr. Bowers began her fee-basis appointment on or about July 6, 2010, but continued to make inquiries regarding a full-time FTE position. At one point in her employment, Dr. Bowers overheard Dr. Braunfeld stating to someone else, "We can't hire certain people for full time jobs because it's too hard to get rid of them."

After beginning her fee-basis position, Dr. Bowers began to experience demeaning and disrespectful conduct from the certified nurse anesthetists ("CRNAs") at the VA. The harassment began with relatively minor incidents, including several CRNAs referring to her by her first name, and one particular CRNA, Krista Douglas ("Douglas") making a rude comment in the CRNA lounge. Douglas and other CRNAs reprimanded Dr. Bowers in front of others, including patients, and were consistently treating her with disdain and disrespect. In over 24 years of practice working with nurses and CRNAs without such issues, Dr. Bowers decided to speak to the lead CRNA, Dana Grogan ("Grogan") and Dr. Braunfeld about her concerns. After she complained, the harassment escalated. Douglas refrained from speaking to her altogether, and refused to relieve her during surgeries, in spite of her duty to do so. On one occasion, Dr. Bowers had a conversation with a man working at an administrative desk in the surgery department, Terry Woods ("Woods"), and mentioned her issues with Douglas. Woods told her that Douglas had treated another African American anesthesiologist in a similar manner, and told Dr. Bowers to "watch her back."

Following a surgery on September 14, 2010 in which Dr. Bowers administered anesthesia, Grogan went to Dr. Braunfeld with printouts from the blood pressure monitor ("strips") from the surgery, and the intra-operative anesthesia one-page report, but not the patient's chart. Grogan claimed that she went to Dr. Braunfeld to report her concerns about the patient's low blood pressure and what she found to be discrepancies between the handwritten chart and the blood pressure monitor strips. Dr. Braunfeld then went to Dr. Stelzner with her concerns, and then went to the Chief of Staff, Dr. Norman. Dr. Braunfeld later stated that she discussed her concerns with Dr. Norman and that they agreed to remove Dr. Bowers from the September schedule, and investigate the matter. Dr. Norman told Dr. Braunfeld to obtain a written response from Dr. Bowers. At the end of that day, and after Dr. Bowers was allowed to administer anesthesia all day, Dr. Braunfeld brought Dr. Bowers into her office and accused her of falsifying medical records and allowing a patient to remain hypotensive for 45 minutes during the surgery, essentially endangering the patient. Dr. Braunfeld told her she would not be allowed to return to work, pending an investigation, and did not ask Dr. Bowers to provide any written response. Dr. Bowers asked to be allowed to provide

a written response, which she did on September 20, 2010. In her response, Dr. Bowers requested an independent, administrative review of the case, and expressed that she was shocked and upset at being accused of misconduct, especially in light of the fact that the surgery had no complications and was successful.

The VA obtained a report from Dr. Nitin Shah ("Dr. Shah") who is an expert, author, professor, and anesthesiologist at the Long Beach VA. On November 2, 2010, Dr. Shah spoke with Dr. Mahler, deputy Chief of Staff and head of Risk Management about his findings. Dr. Shah stated that while there were some discrepancies between the hand-written chart and the monitor strips, he did not believe there was any misconduct in charting. He also found no negligence, nor patient endangerment, by Dr. Bowers, in light of the patient's history of low blood pressure, and successful outcome of the surgery with no complications. Dr. Shah expressed that he was troubled by Grogan's failure to mention her purported "concerns" during the surgery to her supervising anesthesiologist or to the surgeon. Although instructed by the VA not to comment on the standard of care, Dr. Shah submitted a report on November 4, 2010, with his findings. He stated that out of 16 blood pressure chart entries, 7 attributed to Dr. Bowers were inconsistent with the monitor readings. He stated that this may be the result of "sloppiness," but not misconduct. He also stated that discrepancies in charting do occasionally happen when the anesthesiologist is managing other aspects of the patient's care. He reiterated his determination that there was no patient endangerment in the management of the patient's blood pressure by Dr. Bowers during the surgery.

Dr. Head, in his role as head of Quality Assurance, reviewed the patient's charts and records. He spoke with the surgeon, the resident who participated in the surgery, the supervising anesthesiologist, and the CRNA and Dr. Raj who started the case. After determining there was no issue with the patient's low blood pressure, he told Dr. Norman and Dr. Mahler that he was troubled with the manner in which Dr. Bowers was being treated. Dr. Head also heard other medical staff discussing the case, and people stating that Dr. Bowers had "almost killed a patient." This was determined to have started with Grogan, and Dr. Head heard the same comment from Sandra Riley-Graves, an administrative assistant in Dr. Norman's office. Shortly after discussing his findings with Dr. Norman, Dr. Head overheard Riley-Graves state, "It's a black thing" to Dr. Mahler, implying that Dr. Head was supporting Dr. Bowers because he was also African American. After he heard Dr. Mahler yelling at Riley-Graves behind the closed office door, Dr. Mahler came out of the office and told Dr. Head to "stand down" on the investigation and leave it alone.

Dr. Braunfeld never contacted Dr. Bowers again, and never provided Dr. Shah's report to Dr. Bowers. In spite of Dr. Shah's favorable review, that there was no negligence, misconduct, or patient endangerment, Dr. Bowers was never reinstated or placed back on the schedule.

Shortly after Dr. Bowers initiated the EEO process, Congresswoman Diane Watson wrote to Donna Beiter ("Beiter"), Director and CEO of the VA, with her concerns and questions about ongoing discrimination at the VA. The VA's response to Congresswoman Watson contains inconsistencies. For example, Beiter stated that Dr. Bowers never provided a response to the allegations, which was false.

Dr. Bowers initially contacted the EEO office on September 30, 2010. The EEO Office issued a Notice of Acceptance. After conducting its investigation, the EEO's assigned investigator,

James Itamura, concluded that a culture of racial and age discrimination exists in the anesthesiology department at the VA, wherefrom Dr. Bowers and other older and non-white anesthesiologists were removed in order to make room for younger replacements from UCLA.

Incident 2:

Dr. Saroja Rajashekara (commonly referred to as "Dr. Raj") was a cardiac anesthesiologist at the VA from 2002 to 2011. Dr. Raj reported to the EEO Investigator she observed and experienced age discrimination at the VA. While she was initially hired by then-Chief of Anesthesia, Richard Chen, Dr. Raj worked under Dr. Braunfeld after she became Chief of Anesthesia in January 2010. After her mother became ill in early 2010, Dr. Raj took leave (which was approved) to visit her mother in India. While she initially expected to return in early May, she sent correspondence to Dr. Braunfeld stating that she needed to extend her leave. Dr. Braunfeld contacted the HR Department at the VA asking how to deem Dr. Raj AWOL. In Dr. Braunfeld's correspondence with HR, she lied about her prior contact and correspondence with Dr. Raj. As a result, Dr. Raj was considered "AWOL" and was removed from the cardiac schedule. She ultimately provided evidence of her contact with Dr. Braunfeld, and the AWOL status was removed from her personnel file; however, Dr. Braunfeld did not reinstate her on the cardiac schedule. Instead, Dr. Braunfeld had her replaced with younger UCLA graduates, who were far less qualified, with the knowledge and approval of Chief of Staff, Dr. Norman.

Dr. Raj reported to the EEO Investigator her concerns regarding Dr. Bowers's treatment by the VA. (See Exhibit 10.) She was aware that there was a need for anesthesiologists at the time of Dr. Bowers's hire at the VA, but Dr. Braunfeld was "holding" jobs for younger, less-qualified residents from UCLA. Dr. Raj also remarked about the unusual manner in which Dr. Bowers was immediately removed from the schedule following the September 14, 2010 surgery. Specifically, she stated it was not the typical protocol for a case such as Dr. Bowers's to bypass the Quality Assurance process, and that Dr. Bowers was "fired" in spite of the patient having no complications.

Incident 3:

Dr. Carol Bennett, an African American woman, has worked at the VA for over 15 years and is currently the Chief of Urology. Dr. Bennett filed an EEO complaint against Dr. Stelzner and Dr. Norman in 2005 based on race discrimination. Dr. Bennett was discovered to have been allowing her nurse to use her CPRS code to sign off on prescriptions on the electronic chart, albeit with her full knowledge and consent. On August 24, 2005, she received a letter from Dr. Stelzner advising her that she was placed on administrative leave. Dr. Bennett was immediately taken off duty without an investigation. She admitted to Dr. Stelzner her mistake, but that it was common practice among surgeons in order to move on to the next patient. All of the entries were with the surgeons' knowledge, and they would review and sign the chart later. In her EEO complaint, Dr. Bennett addressed the fact that another non-African American physician was found to have a similar infraction, but was only given warnings. She also complained that she was being "super-audited" by Dr. Stelzner, as compared to other non-African American medical staff in the Department of Surgery. After mediation, Dr. Bennett was fully reinstated as Chief of Urology.

Incident 4:

In another instance, an employee working as an EEO Counselor in the Office of Resolution Management was retaliated and terminated for making a protected whistleblower complaint. This employee, considered to be one of the top EEO counselors in the nation, filed a report to internal investigators regarding missing EEO files which contained private personnel information of specific VA employees. Because this employee's report reflected negatively on his supervisor, Ms. Tracy Strub, Ms. Strub retaliated against the employee, initiating an unjustified Performance Improvement Plan.

In or around July 2013, shortly after Dr. Head settled his lawsuit with UCLA, VA administrators questioned this employee about whether or not this employee had helped Dr. Head with his lawsuit. This employee denied that he had helped Dr. Head, but because of this employees close relationship with Dr. Head, VA administrators did not believe him. Within hours of this meeting, the employee was terminated.

Incident 5:

In another instance, Dr. Wang discriminated against a Nurse Practitioner working in the Head and Neck Department at the VA based on her national origin and Muslim faith. After seeing this employee working with Dr. Head, Dr. Wang also told this employee not to work with Dr. Head or provide him any assistance with patient care. Because of Dr. Wang's discriminatory animus towards this employee, as well as continued retaliation against Dr. Head, Dr. Wang had the employee terminated the day before her probationary period ended.

Incident 6:

In a recent incident, an OR tech complained to VA management about dangerous conditions in the operating rooms, specifically, surgeons using dirty instruments while operating on patients. Following this report, this employee was given both verbal and written reprimands. Recently, the employee was suspended for 14 days for making these complaints.

Climate of Fear and Retaliation Within the GLAHS

As outlined above in detail, administration within GLAHS has created a climate of fear and intimidation, where the system not only fails to protect whistleblowers, but actively seeks to retaliate against them. This retaliation by VA supervisors and administrators often takes shape through a similar process.

Whistleblowers are first threatened and isolated, often being warned early that speaking out would not be beneficial to their career. Whistleblowers are made aware, in no uncertain terms, that if you tell the truth, you will be punished.

If the whistleblower chooses to speak out despite the threats, they are quickly defamed and humiliated. Supervisors and administrators will begin spreading false information about the whistleblower, suggesting to co-workers that the person is incompetent, lazy, and untrustworthy.

Finally, supervisors place the whistleblower under intense scrutiny, looking for any reason to find fault in the person's work. Whistleblowers, who otherwise have had long, outstanding careers within the federal system, all of the sudden are subpar workers who begin receiving failing evaluations, verbal and written reprimands, salary cuts, transfers, demotions, and sometimes even being forced to retire, or worse, terminated. Even those in high administration within GLAHS that attempt to do the right thing are not safe. For example, Dr. Mahler, former deputy Chief of Staff and head of Risk Management, who provided a written statement in support of Dr. Head, was eventually forced out.

Administrators and supervisors with GLAHS have created a toxic environment with a clear message, if you do not follow the agenda and behave as a "team player," you will suffer the consequences.

Lack of Accountability

The current system within the VA is one of a general lack of accountability of administrators and supervisors who actively retaliate against and ostracize hospital employees who attempt to speak out against illegal behavior. This climate only perpetuates this illegal behavior, due in large part to the system's failure to take any action against certain individuals. Specifically, wrongdoers are left in positions of high leadership to continue their illegal behavior without recourse. In some circumstance, wrongdoers may even be promoted rather than disciplined.

For example, the investigation regarding Dr. Wang led to a finding that Dr. Wang had committed time card fraud during a certain period of time in her leadership position at GLAHS. However, rather than being disciplined, Dr. Wang was instead promoted. Even worse, Dr. Head then was retaliated for providing truthful testimony in Dr. Wang's time card fraud investigation.

Leaders within GLAHS, such as Ms. Beiter and Dr. Norman, not only have played an active role in retaliating against whistleblowers, but in other cases have chosen to ignore certain occasions of retaliation by GLAHS supervisors. Ms. Beiter and Dr. Norman have had many opportunities to take action against wrongdoers, but have chosen instead to look the other way.

Low Morale Amongst Healthcare Providers

Unfortunately, the current climate of fear and retaliation, coupled with the system's failure to properly respond and hold wrongdoers accountable, has caused morale to be dangerously low, leaving employees within GLAHS with a sense of helplessness, creating undue stress and anxiety amongst those attempting to provide quality healthcare to our Country's veterans.

Dr. Head has witnessed a general sense of fear amongst VA employees. Workers within GLAHS have stated that they are scared to speak out for fear of being blamed and punished. Good people who are used to doing the right thing and standing up for others want to speak out about issues throughout the system, but fail to do so for fear of jeopardizing their careers.

Negative Affect on Patient Care

The issue facing the VA system involves a growing epidemic in hospitals throughout our Country—hospital bullying. This issue spans race, gender, religion, and politics because of the life and death danger it poses to patients. This problem, while certainly applicable to the VA system, is an issue that plagues every hospital nationwide and must eventually be addressed by Congress.

In her MSNBC article, *Hospital Bullies Take a Toll on Patient Safety*, JoNel Aleccia outlines how hospital bullying "threatens patient safety and has become so ingrained in health care that it's rarely talked about." (Exhibit 11.) Additionally, in Dr. Kevin Pho's article for FoxNews entitled *Bullies in Hospitals?*, he concluded that "targeting the toxic culture that perpetuates the problem [of hospital bullying] requires everyone to share responsibility. Not just doctors, but nurses, hospital administration, and medical educators as well. Only when every stakeholder is part of the solution do we stand a better chance of eliminating bullying behavior in hospitals altogether." (Exhibit 12.) Dr. Pho's article was a response to a highly-touted New York Times article by Theresa Brown entitled *Physician, Heel Thyself*, in which she detailed bullying behavior she experienced as a nurse and explained how hospital bullying poses a critical problem for patient safety which, not surprisingly, leads to a rise in medical errors. (Exhibit 13.)

Of course, all of these articles came after The Joint Commission published Sentinel Event Alert, Issue 40, on July 9, 2008 which described how:

> Intimidating and disruptive behaviors can foster medical errors, . . . contribute to poor patient satisfaction and to preventable adverse outcomes, . . . increase the cost of care, . . . and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. . . . Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team. (Exhibit 14.)

Unfortunately, health care organizations have not addressed the problem, and doctors, nurses, and hospital administrators are left to bully and belittle others; and sadly, anyone who dares speak out about this behavior threatens not only their job, but their entire career in the healthcare profession.

Possible Solutions

While this testimony has focused on current problems within the VA system, all hope is not lost. The mission of the VA system is good and noble and should be maintained. The VA system has some of the best healthcare providers in the world; however, certain changes must be considered. There are a number of possible solutions that can be implemented to affect change and improve the system.

The first, and obvious, solution is one of leadership. Administrators and supervisors within the VA system that are contributing to the current culture must be held accountable. New leadership

must be established—leaders who will encourage and welcome open discussion and dialogue, leaders who will root out divisive and intimidating behavior, and leaders who will create a safe and enjoyable atmosphere that focuses on top-quality patent care for our veterans.

Another important improvement to the system would involve a change in the appointment scheduling of veterans. Rather than the current process of adding patients to a long list based on when the person calls for an appointment, patients need to be assigned appointments based on conditions. There is a Standard Operating Procedure ("SOP") in place that could be updated and implemented which would greatly improve patient scheduling. Based on SOP flowcharts, schedulers would be able to schedule more critically ill patients sooner, ensuring every veteran receives the proper healthcare he/she deserves.

Additionally, there needs to be some type of computer accountability process implemented. Currently, the computer records can be too easily manipulated to hide scheduling and patient backlog issues. Hospital administrators should not be able to clear patient information unchecked. Perhaps some type of centralized data collection can be created to ensure individual hospitals are not fraudulently changing records.

Finally, the current proposal of simply assigning more patients to already overwhelmed physicians is not the answer. The system desperately needs to add additional primary care physicians. Then, veterans should be matched up to one specific primary care physician. This would allow the physician to establish a relationship with the patient and would create a vested interest with that physician who would then be more inclined to ensure his/her patient received proper medical care. That way, if the physician's patient is not receiving the needed care, that primary care physician would do what private practice physicians do and call his/her colleagues and follow up. For example, Dr. Head's wife, who is an interventional radiologist within the VA system, is deeply vesting in each of her patient's healthcare and does what is needed to ensure her patients are receiving the proper health services.

Dr. Head provides this testimony with the hopes of finding solutions to address employee mistreatment and improve the quality of healthcare provided to our Country's veterans. As a long time employee within the VA healthcare system, Dr. Head is optimistic that appropriate changes can be implemented, and he looks forward to being an integral part of that change and the bright future that is ahead.

Dated: July 2, 2014

By: Christian Head, M.D.
CHRISTIAN HEAD, M.D.

For additional information, you may contact Dr. Christian Head through his attorneys:

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EXHIBIT 1

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF RESOLUTION MANAGEMENT
Western Operations-Vancouver Division
Vancouver, WA 98661

EEO COUNSELOR'S REPORT – Stephanie Hettman
CASE NUMBER: 200N-0691-2004101969

NAME, ADDRESS AND TELEPHONE NUMBER OF AGGRIEVED PARTY	Dr. Christian Head 247 22nd Street Santa Monica, CA 90402 310-458-1400
BUSINESS ADDRESS AND TELEPHONE NUMBER	VA Greater LA HCS 11301 Wilshire Blvd. Los Angeles, CA 90073 310-478-3711, Ext. 41750 Page: 310-206-6766
EMPLOYEE, FORMER EMPLOYEE OR APPLICANT	Employee
POSITION TITLE AND SERIES/GRADE **Title 5, Title 38 OR Hybrid T38** **TYPE OF APPOINTMENT: Probationary, Career; Career-Cond; Temp; or Term** **WORK SCHEDULE: Full-time or Part-time**	Head and Neck Surgeon Title 38 Career-Conditional Part-Time
ORGANIZATIONAL SERVICE/SECTION/ DIVISION AND TELEPHONE #	Head and Neck Surgery
NAME AND ADDRESS OF RESPONSIBLE FACILITY	Same as above

Date/Initial Contact:03/11/04	**Date/Initial Interview:** 03/15/04
Date/Rights & Respon. Rec'd:	**Date/Final Interview:** 6/7/04
Date/Notice of Right to File:6/7/04	**Date/Right to File Rec'd:**

BASES	CLAIM	RESOLUTION
Race (African-American), Color (Black) and Reprisal (EEO involvement)	The Aggrieved claims that he has been harassed by Dr. Maylene Wong, Consultant, as evidenced by the following incidences: **Incident #1:** In November 2002, Dr. Wong denied the Aggrieved a .8 FTE, even though Dr. Berke, Division Chief had assured the Aggrieved he would have a .8 FTE. **Incident #2:** In Mid-December 2002, Dr. Wong denied the Aggrieved Laboratory space for tumor research, even though a week prior, Kurt	A surgeon to evaluate the Aggrieved's performance instead of Dr. Wong. The "fictitious" performance evaluation removed from the Aggrieved's record. To be made aware of what information Dr. Wong used to gauge his performance rating. A full FTE.

	Bormann, Associate Director, had guaranteed the Aggrieved Lab space. **Incident #3:** In February 2004, Dr. Wong gave the Aggrieved his performance evaluation 14 months late and in the evaluation, Dr. Wong rated the Aggrieved as "Satisfactory" even though Dr. Wong rated other Surgeons with less qualifications and poor attendance as "Outstanding." The Aggrieved added that Dr. Wong marked "frequent contact" on his evaluation, even though she only works with the Aggrieved for 1 ½ hours one day per week. Incident #4: The Aggrieved stated he received an email from Dr. Wong requesting to respond to a complaint after on 3/22/04, but he did not receive the action complaint until 3/24/04 in his mail box.	

Name of Representative: N/A **Attorney:** [ ] Yes [ ] No

Representative's Address/Telephone #:

Did aggrieved party choose to remain anonymous?	[ ] Yes	[X] No
Mixed Case Issue:	[ ] Yes	[X] No
MSPB Filed	[ ] Yes	[X] No
Bargaining Unit Employee	[ ] Yes	[X] No
Union Grievance Filed:	[ ] Yes	[X] No
Was there an agreement to participate in ADR	[ ] Yes	[X] No

Initial Interview: March 15, 2004

The Aggrieved party's rights and responsibilities were discussed to include the Aggrieved party's right to anonymity and representation, and the role of the EEO Counselor. The claim and resolutions described on page one of this report, were presented by the Aggrieved party as follows:

Claim #1: – The Aggrieved claims that he has been harassed by Dr. Maylene

Wong, Consultant, from November 2002 to present, as evidenced by the following incidences:

Incident #1: In November 2002, Dr. Wong denied the Aggrieved a .8 FTE, even though Dr. Berke, Division Chief had assured the Aggrieved he would have a .8 FTE.
The Aggrieved stated that on July 1, 2002, he was hired by the VA as a .15 FTE. The Aggrieved stated that soon after Dr. Edward H. Livingston, Chief of Surgery Department, increased his FTE to .28 and gave him special pay for being a Surgeon.

In November 2002 right before the Thanksgiving weekend, Dr. Gerald Berke, Division Chief of Head and Neck Surgery at UCLA (which is part of VA facility) told the Aggrieved that Dr. Keith Blackwell, (get title), had a 1.0 FTE open and Dr. Berke planned to have the Aggrieved fill part of Dr. Balckwell's FTE, to bring the Aggrieved to a total of .8 FTE.

The Aggrieved stated that after the Thanksgiving holiday, he spoke to Dr. Wong about getting the .8 FTE, but Dr. Wong stated the Aggrieved would not be getting a .8 FTE nor did she think the Aggrieved would be working at the facility much longer because he did not have a "vested interest."

The Aggrieved stated that he has always been uncomfortable talking alone with Dr. Wong because she speaks and acts towards him in a threatening manner. The Aggrieved stated that he is the first Black Surgeon recruited through the Center of Excellence and trained in Head and Neck Surgery at the VA/UCLA, and he believes that is why Dr. Wong is so demeaning and threatening to him.

The Aggrieved stated that Dr. Berke told him that Dr. Wong had planned on hiring her brother, Steve Wong, even though the Aggrieved was a much better Surgeon and there are "nepotism laws" that prohibit such a hire.

The Aggrieved stated that he spoke with Dr. Dean Wilkerson (UCLA) about the withheld FTE and Dr. Wong's behavior, but Dr. Wilkerson referred the Aggrieved to the Ombudsman, who then referred the Aggrieved to Dean Norman.

The Aggrieved stated that he then spoke to his mentor, Dr. Dennis Slamon and again to Dr. Berke, who then spoke to Dr. Wong. Dr. Berke stated that Dr. Wong then agreed to raise the Aggrieved's FTE to .53 FTE.

Even so, Kurt Bormann, AO for Surgery, told the Aggrieved that Dr. Wong did not initiate the paperwork and expressed that she had no intention of increasing the Aggrieved's FTE. The Aggrieved stated that he confronted Dr. Wong, who laughed and said she never intended on increasing the Aggrieved's FTE.

The Aggrieved stated that he went to Dr. Berke and Dr. Holmes Division Chair of

Surgery, and they assured him that the FTE issue would be rectified. However, to date, the Aggrieved's FTE has not been increased.

The Aggrieved stated that in late January 2004, he spoke with Dr. M. Stelzner, Chairperson for Surgery, who assured him that the FTE would be taken care of. However, Dr. Stelzner responded that Dr. Wong did not need anymore FTE and that his "hands were tied," in the matter. The Aggrieved stated that Dr. Stelzner recommended that if the Aggrieved was not getting the management support he needed, maybe the Aggrieved should just leave the VA to work elsewhere.

The Aggrieved stated when he initially spoke to Dr. Wong regarding the initial increase in FTE, she told him that she controlled the number of FTE he would receive and that that "you think you are special, but you are not. " The Aggrieved stated Dr. Wong spoke to him with racial undertones. The Aggrieved stated he went to the Dean, Lou Ann Rocherson and she recommended that he talk to the University Obudmand, Ms. Fransan. Ms. Fransan advised the Aggrieved to talk to Dr. Burke and explain exactly what happened. Dr. Burke stated that he thought it was bad, but Dr. Wong was upset because she unable to hire her brother. The Aggrieved stated he expressed his concern to Dr. Burke that Dr. Wong would evaluate him unfairly, but Dr. Burke assured him that Dr. Wong would not do that.

The Aggrieved stated that Dr. Wong told him that they had worked out a deal where the Aggrieved would receive .25 FTE, which would push him slightly over .5, but Dr. Wong never submitted the paperwork to increase the additional FTE. The Aggrieved stated he approached Dr. Wong in April 2003, and questioned her as to why she had not submitted the paperwork, and she responded that she had not told the truth and that she was not going to do it. The Aggrieved stated Dr. Wong wanted to know why he was so upset.

The Aggrieved stated that he did not contact the Office of Resolution Management (ORM) when this problem arose because he thought UCLA and the VA facility would correct the situation.

Incident #2: In Mid-December 2002, Dr. Wong denied the Aggrieved Laboratory space for tumor research, even though a week prior, Kurt Bormann, Associate Director, had guaranteed the Aggrieved Lab space.

The Aggrieved stated that in Mid-December 2002 Kurt Bormann told him that he would be granted extra space for tumor research.

The Aggrieved stated that he has been given over $1,000,000,000 (one million dollars) funding from the Cancer Society and $200,000 in grants from another agency, yet Dr. Wong refused to give the Aggrieved the needed research space.

The Aggrieved stated in late February 2003,.Kurt Bormann told him that Dr. Wong had

denied the space and had put pressure on them because she did not want the Aggrieved to have research space.

Incident #3: In February 2004, Dr. Wong gave the Aggrieved his performance evaluation 14 months late and in the evaluation, Dr. Wong rated the Aggrieved as "Satisfactory" even though Dr. Wong rated other Surgeons with less qualifications and poor attendance as "Outstanding." The Aggrieved added that Dr. Wong marked "frequent contact" on his evaluation, even though she only works with the Aggrieved for 1 ½ hours one day per week.

The Aggrieved stated that when he received his performance evaluation, 14 months late, he noticed it included fictitious information. The Aggrieved stated that Dr. Wong only works with him about one and a half hours a week on Wednesdays and could not review his performance with such little interaction and observation. The Aggrieved stated that Dr. Wong checked "frequent contact" on the evaluation form, which is untrue.

The Aggrieved stated that he believes other Surgeons, such as James Andrews and Keith Blackwell, were given "Outstanding" ratings. The Aggrieved stated that Dr. Frankel was also given an "Outstanding" rating, even though he only shows up to work once a month. The Aggrieved stated that when Dr. Frankel and others fail to show for their shift, Dr. Wong marks them as present and allows them to get paid for time they do not work.

The Aggrieved stated that she met with Dr. Wong during the first week of March 2004, and asked why she gave him the evaluation she had given him. The Aggrieved stated that Dr. Wong was "flippant" and replied that she could have given him "Unsatisfactory" if she wanted. The Aggrieved stated that Dr. Wong acted as if the whole thing was a "joke." The Aggrieved stated that Dr. Wong suggested that she find the Aggrieved a position at local County facilities, Harver or Olive View, which she had no authority to do.

The Aggrieved contacted this Counselor on March 22, 2004, and added the following information:

Incident: Dr. Berke spoke with Dr. Wong about the Aggrieved's complaint regarding his performance evaluation and that the Aggrieved had initiated an EEO complaint. The Aggrieved stated that on the same day, Dr. Wong emailed him and said there was a patient complaint about him that had been made on March 19, 2004, and now it was going to be investigated. The Aggrieved stated that Dr. Wong would not give him any further details about the complaint. The Aggrieved stated that Dr. Berke conveyed that Dr. Wong said the Aggrieved received "Satisfactory" on his evaluation because there are more stringent guidelines then there used to be. However, the Aggrieved stated it that is so, why did other Surgeons get an "Outstanding" rating. The Aggrieved stated that he believes Dr. Wong is Reprising against him for his EEO involvement.

Through a telephone conversation with the Aggrieved on March 26, 2004, the Aggrieved stated that he spoke with Dr. Busitell, Director of Surgery for UCLA, who stated that he would try to get resolution on the Aggrieved's complaint.

The Aggrieved also stated that on March 24, 2004, a faculty member, Dr. Joel Sercarz, told the Aggrieved that Dr. Wong came to Dr. Sercarz in confidence and said she was very disturbed at the Aggrieved complaining about her and said, "This is what happens when you have an **affirmative action** case at the facility, that's what Chris (the Aggrieved) is, an affirmative action case. Affirmative action cases run an institution down."

Responding Management Official(s) response to Claim #1: No RMO's were interviewed because the Aggrieved Party decided that he did not want to pursue the matter and he reported to the Dean at the University of Southern California not the Chief of Staff at the VA Greater Los Angeles.

Witness(es) Response(s): None

Management's response to resolution sought by aggrieved: No interviews for management took place because the Aggrieved decided not to continue the his complaint.

Summary of resolution efforts: Mediation through the Alternative Dispute Resolution (ADR) program was explained to the aggrieved party. The Agency and the Aggrieved did not wish to mediate this claim.

Jurisdiction/Procedural Acceptability Issues: None

FINAL INTERVIEW

On 6/7/04, the results of resolution efforts and the following claim(s) were discussed with the aggrieved:

Claim #1: Harassment (non-sexual)

The aggrieved was informed of the information gathered and that the claim(s) listed above was/were the only claim(s) addressed during the informal EEO counseling and, if a formal EEO Complaint of Discrimination is filed, claims not discussed with me may not be accepted for formal complaint processing.

Case #:200N-0691-2004101969
Name of Aggrieved: Head, Christian
Name of Facility: VA Greater Los Angeles Healthcare System
Date of Initial Contact: 3/11/04

The Notice of Right to File a Discrimination Complaint and Form 4939 were hand-delivered/mailed on 6/7/04.

Mable Pope, EEO Counselor — 6/7/04 Date

Documents reviewed regarding claim(s) listed above:

(List Documents)

EXHIBIT 2

#2 If all else fails call 1-800-488-VAIG

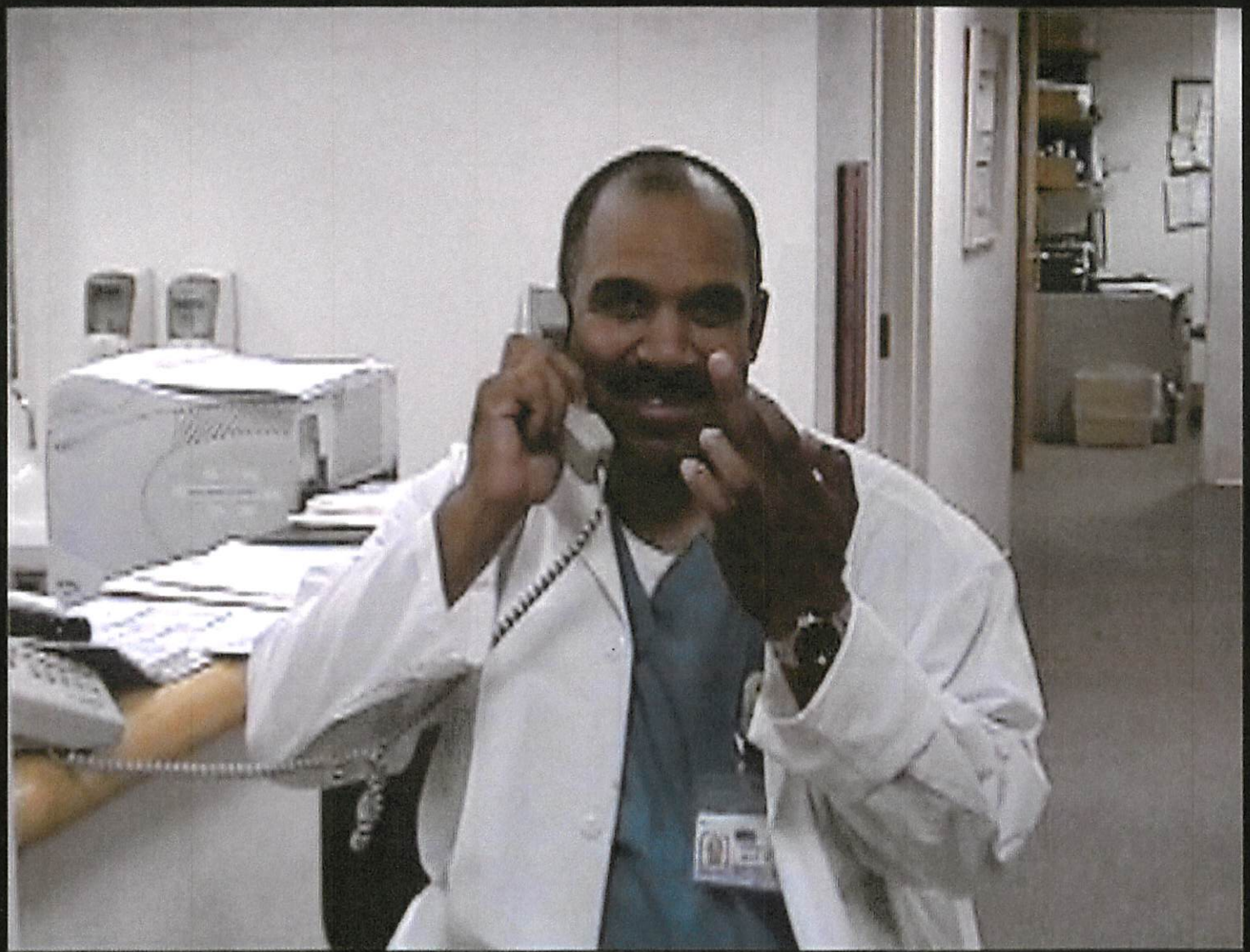

EXHIBIT 3

PEER REVIEW TEACHING EVALUATION

FACULTY MEMBER: Christian Head, M.D. **DATE: May 5, 2008**

The University requires that teaching performance of faculty be evaluated by their colleagues. Please help us in this endeavor by giving us a thoughtful evaluation of the performance of the faculty member listed above. Thank you.

SCALE:	CE	1	2	3	4
	can't evaluate	unsatisfactory	satisfactory	very good	outstanding

(Please circle below)

1. BREADTH OF KNOWLEDGE: CE (1) 2 3 4
(Has sufficient knowledge of the material pertinent to the area of instruction or supervision.)
Comments:

2. TEACHING: CE (1) 2 3 4
(Provides well-prepared and carefully researched lectures or other presentations. Is able to communicate the material or provide supervision in an effective and intellectually stimulating manner.)
Comments:

3. CLINICAL TEACHING: CE (1) 2 3 4
(Relates basic principles and techniques to surgical situations.)
Comments:

4. AVAILABILITY: CE (1) 2 3 4
(Is readily available for discussion, questions, consultations and conference.)
Comments:

5. SUPERVISION OF RESEARCH ACTIVITIES: CE (1) 2 3 4
(Provides adequate and organized instructions in the preparation and performance of research projects. Demonstrates a strong commitment to research and encourages pursuit of research activities.)
Comments:

6. ROLE AS MENTOR: CE (1) 2 3 4
(Actively provides individualized opportunities for academic career development of junior faculty, residents, fellows and students.)
Comments:

7. OVERALL CONTRIBUTION: CE (1) 2 3 4
(Provides effective overall contribution to this department's teaching program.)
Comments:

8. What traits of this faculty member have been most helpful in the development of junior faculty, fellows, residents, and students? (Please include suggestions for improvement.)
Comments: Poor clinical judgment, poor availability, poor role model

PIF Exhibit 5
Date: 9-27-11
Witness: Marilene Wang
Susan S. Kokis
CSR# 11303

EXHIBIT 4

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF RESOLUTION
MANAGEMENT
Western Operations

EEO COUNSELOR'S REPORT

CASE NUMBER: 200P-0691-2008103860 **COUNSELOR NAME: Vickye E. Gammage**

Name of Aggrieved Party:	Christian Head
Home and/or Alternate Address:	246 22nd Street., Santa Monica, CA 90402
Home Telephone Number:	310-738-31519 Cell
Business Address:	16111 Plummer Ave. Sepulveda, CA 91343
Business Telephone & Fax Number:	Use cell number above
Email Address:	
Position Title/Series/Grade:	Physician
Employee [x] Former Employee [ ] Job Applicant [ ]	
VHA [X] VBA [ ] NCS [ ] Canteen [ ] Other:	
Title 5 [ ] Title 38 [X] Hybrid T38 [ ] Full Time [X] Part Time [ ]	
Probationary [ ] Career [X] Career Conditional [ ] Temporary [ ] Term [ ]	
Name of Facility:	VAMC West Los Angeles
Service/Section/Mail Routing Symbol:	Surgical
Address of Facility:	11301 Wilshire Blvd. Los Angeles, CA 90073
Facility Telephone Number:	310-478-3711
Name of Representative:	**N/A Attorney: Yes [ ] No [ ]**
Representative's Address:	
Representative's Telephone:	

NOTIFICATION OF PROCEDURAL RIGHTS

Initial Contact:			**Date:**	7/18/08
Rights & Responsibilities/Notices:	**FedEx/Cert Mail:**	7/22/08	**Rec'd:**	7/25/08
Notice to Unreachable Aggrieved:	**FedEx/Cert Mail:**		**Rec'd:**	
Agreed to Waive Anonymity:	**YES [X]**	**NO [ ]**		7/22/08
Release of Medical Information:	**Mailed/Faxed:**		**Rec'd:**	
ADR Agreed to by Aggrieved:	**YES [ ]**	**NO [X]**	**Date:**	7/22/08

Case Number: 200P-0691-2008103860
Name of Aggrieved Party: Christian Head
Name of Facility: VAMC West Los Angeles
Date of Initial Contact: July 18, 2008

ADR Agreed to by RMO(s):	**YES [X]**	**NO [ ]**	**Date:**	7/18/08
Extension Granted for ADR [ ] or Counseling [ ]:	**Number days granted:**		**Date Ext. Rec'd:**	
Settlement Agreement (SA):	**YES [ ]**	**NO [ ]**	**Date:**	
Withdrawal (WD):	**YES [ ]**	**NO [ ]**	**Date:**	
Notice of Closure (for SA/WD):	**FedEx/Cert Mail:**		**Rec'd:**	
Notice of Right to File:	**FedEx/Cert Mail:**	8/17/08	**Rec'd:**	8/26/08

EVIDENCE OF PRIOR COMPLAINT ACTIVITY: YES [X] NO [ ]

Complaint Number	Date Filed Formal	Claims/Basis(es)	Status of Complaint
200P-069-2004101969	Did not file	Race (Blk) Color(Blk) Reprisal	Closed

RMO/WITNESS INFORMATION

Responding Management Official(s): ***(Name, Title, Telephone Number)***	Dr. Matthias Stelzner, Chief Surgical Service 310-268-4341
Witness(es) Suggested for Interview by Aggrieved Party *(Name, Title, Telephone Number)*:	None
Witness(es) Suggested for Interview by RMO *(Name, Title, Telephone Number)*:	None

Assignment of this complaint was received by the undersigned July 18, 2008. The initial interview with the aggrieved party was held on July 22, 2008, at which time the EEO process, ADR, and rights and responsibilities were discussed.

The Notice of Rights and Responsibilities, signed by the aggrieved, was received in the Western Operation ORM Office on August 12, 2008. Notification of informal counseling to the facility Director was sent via regular mail on July 22, 2008.

Mediation was offered to Dr. Head on July 22, 2008, and on the same date he declined.

DESCRIPTION(S) OF THE CLAIM(S) AND RESOLUTION(S) AS PRESENTED BY THE AGGRIEVED PARTY:

CLAIM 1	**Whether the aggrieved was discriminated against on the basis of Reprisal with respect to Harassment/Hostile Work Environment, when on July 16, 2088, he was questioned by his supervisor Matthias Stelzner, Chief Surgical Service about leaving the medical center with out permission.**

Mixed Case Issue:	**[ ] Yes**	**[X] No**	
MSPB Filed:	**[ ] Yes**	**[X] No**	**Date Filed:**
Union Grievance Filed	**[ ] Yes**	**[X] No**	**Date Filed:**
Is Claim Timely Raised?	**[X] Yes**	**[ ] No**	

Brief Description of Claim:

Dr. Head stated the following:

He was called to a meeting with Dr. Stelzner who "interrogated" him with questions regarding his leaving his duty station. Dr. Stelzner asked him if he left the medical center, and if he requested sick leave and was actually at UCLA doing surgery?

He informed Dr. Stelzner that he did leave the medical center but his tour of duty was over and he did go to UCLA. He did not call in sick or do surgery at UCLA.

Resolution Sought:

Cease harassment – wants to be free from "combative meetings"
Increased time with Chief of Staff
Diversity training for Dr. Stelzner

Claim 1 Documents for Review:

None

RMO's Response to Claim:

Dr. Matthias Stelzner, Chief Surgical Service 310-268-4341

Dr. Stelzner stated the following:

He met with Dr. Head to discuss the incident that had come to his attention; that he had left his duty station without permission to perform duties at UCLA.

All physicians have a clause in their Time & Attendance memo if they are full time and are on staff at UCLA. If they leave the medical center they are to send an email to their supervisor informing them that they have left to attend to patient(s) at UCLA. However, their VA patients are primary.

Response to Resolution Sought by Aggrieved Party:

Dr. Stelzner said that he was not combative when he met with Dr. Head and he has no authority to increase his time with the Chief of Staff. He doesn't believe he needs diversity training.

Proposed Alternative Resolution for Claim 1:

None

CLAIM 2	**Whether the aggrieved was discriminated against on the basis of Reprisal with respect to Assignment of Duties, when in March 2008, he is not allowed research time.**

Mixed Case Issue:	**[ ] Yes**	**[X] No**	
MSPB Filed:	**[ ] Yes**	**[X] No**	**Date Filed:**
Union Grievance Filed	**[ ] Yes**	**[X] No**	**Date Filed:**
Is Claim Timely Raised?	**[ ] Yes**	**[X] No**	See below

Timeliness: Dr. Head stated he brought it up because Dr. Stelzner was questioning him about being away from his duty station, but couldn't explain why he did not come forward within the 45-day regulation.

Brief Description of Claim:

Dr. Head stated the following:

He is not allowed time work on his research project however, a new physician is allowed 50% time to work his research and he doesn't have a research grant.

Resolution Sought:

Allowed time to do research
Increased time with Chief of Staff
Diversity training for Dr. Stelzner

Claim 2 Documents for Review:

None

RMO's Response to Claim:

Dr. Matthias Stelzner, Chief Surgical Service 310-268-4341

Dr. Stelzner stated the following

Dr. Head does not have a VA funded research grant, therefore he is not given VA time to work on his research project. His project is funded by another entity and his lab is located at UCLA.

Regarding the physician given 50% time, all physician are allowed time within their first two years of employment to gather data, so that they can write a research grant. If that physician writes and is approved for a research grant and it's not funded by the VA they will not be given VA time for their research either.

Response to Resolution Sought by Aggrieved Party:

Dr. Head's research is not VA funded, therefore he can't give him research time. He has no authority to increase his time with the Chief of Staff. He doesn't believe he needs diversity training.

Proposed Alternative Resolution for Claim 1:

None

SUMMARY OF RESOLUTION EFFORTS

FINAL INTERVIEW

Case Number: 200P-0691-2008103860
Name of Aggrieved Party: Christian Head
Name of Facility: VAMC West Los Angeles
Date of Initial Contact: July 18, 2008

On August 21, 2008, the results of resolution efforts and the following claim was discussed with the aggrieved party:

CLAIM 1: Whether the aggrieved was discriminated against on the basis of Reprisal with respect to Harassment/Hostile Work Environment, when on July 16, 2088, he was questioned by his supervisor Matthias Stelzner, Chief Surgical Service about leaving the medical center with out permission.

CLIAM 2: Whether the aggrieved was discriminated against on the basis of Reprisal with respect to Assignment of Duties, when in March 2008, he is not allowed research time.

The aggrieved was informed that the claim(s) listed above were the only claim(s) addressed during the informal EEO counseling. If a formal Complaint of Discrimination is filed, claims not discussed with ORM may not be accepted for formal complaint processing.

The Notice of Right to File a Discrimination Complaint and VA Form 4939 were sent by Federal Express and regular mail on May 16, 2008, and records indicate that the documents were received on August 26, 2008.

Vickye E. Gammage
Vickye E. Gammage, EEO counselor

August 29, 2008
Date

EXHIBIT 5

Department of
Veterans Affairs

Memorandum

Date : September 10, 2008

From: Chief, Organizational Improvement (10H)

Subj : Administrative Fact Finding, re: Dr. Christian Head and Dr. Matthias Stelzner

To : Chief of Staff (11)

1. On July 28, 2008 you charged Dr. Dennis Schaberg and me to investigate allegations brought by Dr. Matthias Stelzner, Chief of Surgery, and Dr. Christian Head, a surgeon in the Ear Nose and Throat section of the Department of Surgery and Associate Chief of Staff for Risk Management, against each other.

2. Dr. Stelzner alleged that Dr. Head has violated VHA and GLA policies about time and attendance and conflict of interest by engaging in clinical activity at UCLA during his VA tour of duty. Dr. Head alleged that Dr. Stelzner has discriminated against him regarding his tour of duty; assignment of clinical and academic responsibilities; and his annual proficiency evaluations. Dr. Head further alleged that Dr. Stelzner harassed him about his time and attendance during a meeting to discuss these issues.

3. Dr. Schaberg and I reviewed the tours of duty at work assignments for the members of the ENT section. We also reviewed an evidence file compiled by Dr. Stelzner including various memoranda and e-mails regarding the time and attendance of Dr. Head and other surgeons in the department. We obtained copies of the UCLA Operating Room record for Dr. Head for some of the days in question. We also interviewed Dr. Stelzner; Dr. Head; Roland Castillo, Administrative Assistant for the Department of Surgery; and Nancy Kram, administrative program assistant in the Department of Surgery.

Findings

4. Both Dr. Stelzner and Dr. Head acknowledged that on several days in June and July of this year, Dr. Head left the VA during his tour of duty to attend to medical emergencies at UCLA. In the memorandum that Dr. Stelzner prepared outlining Dr. Head's tour of duty, he instructed Dr. Head to notify the department when he needs to attend to a medical emergency at UCLA. Apparently, in these instances, Dr. Head did notify the department when he needed to leave to attend to these emergencies, although there was some confusion at the time that notification had occurred.

5. Dr. Stelzner alleged that Dr. Head left the VA early on Thursday, July 10 to operate at UCLA. However, a close examination of the operating room record shows that the operation in question occurred on Wednesday, July 9 and the time that Dr. Head entered the OR at UCLA was nearly an hour after the conclusion of his VA tour of duty. In addition, Dr. Stelzner alleged that Dr. Head used sick leave from the VA on the days that he operated at UCLA. Dr. Head denied

RIF Exhibit 4
Date: 9-27-11
Witness: Marilene Wang
Susan S. Kokis
CSR# 11303

going to UCLA after leaving the VA because he was sick. He produced an operating room record that showed he operated on the Saturday following his days of VA sick leave, apparently because he rescheduled cases from the previous afternoon.

6. The tour of duty prepared for Dr. Head by the section chief, Dr. Marilene Wang, on July 8, 2008 and approved by Dr. Stelzner is a slight modification of the standard full-time tour of duty, with a slightly longer day on Thursday (7 a.m. to 5:30 p.m.) and a slightly shorter day on Friday (ending at 3:30 p.m.). Although Dr. Head is a full time physician, his responsibilities are divided between the Department of Surgery (5/8) and the Chief of Staff office (3/8). On Wednesday, Thursday, and Friday Dr. Head is scheduled to be in ENT clinics, primarily, with an unspecified amount of time available for ENT conferences and OR time. Monday and Tuesday are designated for duties in the Chief of Staff office. This tour of duty and clinical assignment appears to differ from those of the other full and part time surgeons in the ENT section of the department. For example, one of the part time surgeons has a tour of duty with split schedules on some days and duty hours that do not correspond to times when clinics are in session, including an assignment to a nonexistent clinic at Sepulveda. Another part time surgeon is assigned to work at UCLA 5 hours each week and 4 hours each week at a nonexistent clinic at West LA. Another newly hired part time surgeon has a tour of duty consisting of a 7 a.m. to 8 p.m. schedule on two days each week, including a full day devoted to research. The other full time physician in the ENT section has a tour of duty with extended hours on some days and a split schedule (morning and afternoons) on other days. The tours of duty for most of the members of the section were created to provide flexibility for the surgeons to balance their VA and non- VA activities, and to balance their clinical, administrative, and research responsibilities within their VA tours of duty. The tour of duty created for Dr. Head does not provide comparable flexibility or balance. It appears that Dr. Head is treated as a part time surgeon within the ENT section rather than as a full time VA physician, and his schedule affords less flexibility than the other full or part time surgeons in the section.

7. Dr. Stelzner explained that Dr. Head was not given protected time for research because Dr. Head does not have any VA approved research protocols. It is true that Dr. Head does not have any VA approved research protocols. Prior to June 2008, the Chief of Staff had guidelines for provider service agreements including protected research time, but these were not incorporated into a formal written Policy or Standard Operating Procedure. In June 2008, the Chief of Staff did produce a Standard Operating Procedure entitled "Guidelines Governing Provider Service Agreements." However it is not clear that this was signed and distributed to all of the appropriate services. An informal survey of several services showed that service Chiefs use the basic principle that approved and funded research deserves protected time, but there are variations between the services. Within the ENT section of the Department of Surgery, none of the members with protected research time have funded research at GLA, and only one has VA approved research protocols. Dr. Stelzner explained that the newly hired part time surgeon was given protected research time in order to develop a research program and therefore his situation was different than Dr. Head's situation. However, it is not clear that the June 2008 Standard Operating Procedure allows for large amounts of protected research time for prospective investigators without approved research projects. The Standard Operating Procedure does allow for protected time (bridge support) in some cases where investigators are developing proposals for funded projects, but this must be approved by the Associate Chief of Staff for research and the Chief of Staff. While Dr. Head does not appear to meet the GLA criteria for protected time

for research, it seems that other members of the department who also do not meet the criteria do have protected time.

8. Dr. Head said that he was unfairly given a Satisfactory rating on his annual proficiency evaluation. Dr. Stelzner indicated that the section chief, Dr. Marilene Wang, provided the evaluation and that she "is a hard grader." Dr. Stelzner also said that there are no specific criteria within the department to be used when completing proficiency of valuations. This creates vulnerability for inconsistency when evaluating surgeons within and across sections of the department.

9. Dr. Head said that in 2004 he had lodged an EEO complaint at UCLA because of allegations that the Department of Surgery and ENT section discriminated against him. Dr. Head said that a signed agreement resolving the EEO allegations included the provision that Dr. Wang would not be responsible for his proficiency evaluations. While Dr. Stelzner and the Chief of Staff recall that an agreement was signed, neither they nor Dr. Head were able to provide a copy of that document. If it is true that the prior agreement precluded Dr. Wang from evaluating Dr. Head's proficiency, her continued responsibility for doing that would be a violation of that agreement.

10. Dr. Head alleged that Dr. Stelzner harassed and intimidated him when they met on July 16, 2008. Dr. Head said that he believed they were going to meet to attempt to resolve all of the issues, including his concerns that he was being harassed about time and attendance and had been treated in an unfair and discriminatory fashion regarding his tour of duty and work assignments. Dr. Head said that when they met, Dr. Stelzner discussed his time and attendance in an accusatory and intimidating manner. A written summary of the meeting that Dr. Stelzner prepared on July 16 shows that they discussed Dr. Head's work station assignment and the alleged violations of his VA tour of duty (described above in paragraphs 4 and 5). Dr. Stelzner said that he treated Dr. Head the same way he treated other part time surgeons in the section who had problems with their tours of duty. Mr. Roland Castillo, who was present during the meeting, said that Dr. Stelzner did not behave in an aggressive, offensive, inappropriate, or discriminatory manner towards Dr. Head. Mr. Castillo, who is African-American, said that he would have noticed if Dr. Stelzner had harassed Dr. Head in a discriminatory manner.

Conclusions

11. While there have been some discrepancies in Dr. Head's time and attendance in relationship to his VA tour of duty, those that are documented fall within the category of providing emergency medical care at UCLA, consistent with the department policy and memorandum outlining the tour of duty. Dr. Head may not have communicated about those incidents as clearly as expected, but it appears that he did attempt to let people in the department know when he left to provide emergency care at UCLA. We did not find evidence that Dr. Head used sick leave while operating at UCLA. We did not find evidence that Dr. Head systematically or fraudulently violated VA policy regarding his tour of duty or conflicts of interest. (Note: We did not have access to the complete OR logs at UCLA.)

12. We believe there is a significant difference in the tour of duty assigned to Dr. Head in comparison to the other members of the section. Dr. Head's tour of duty does not provide the flexibility of time or balance of assignments afforded to the other members of the section.

13. While we cannot determine if a rating of Satisfactory is appropriate for Dr. Head's proficiency evaluations, if Dr. Wang was responsible for the evaluation in violation of a previous agreement settling an EEO complaint, it would support the conclusion that this is a continuation of the previous difficulties that led to that agreement. Furthermore, not using consistent and clear criteria for evaluations throughout the department creates vulnerability for unfair and inconsistent evaluations. In other words, it cannot be acceptable that two surgeons of equal proficiency might receive different evaluations because one is in a section with a chief who is a hard grader.

14. Although we conclude that Dr. Stelzner and Dr. Wang improperly treated Dr. Head differently than other members of the section, we do not know if that represented racial discrimination. We did not have sufficient information to determine their motivation.

Recommendations

15. Dr. Stelzner, in conjunction with the Chief of Staff, should review the issue of fairness within the ENT section and implement corrective measures where necessary.

16. Dr. Head and Dr. Stelzner should meet with the Chief of Staff to negotiate a new tour of duty and work assignment schedule. The tour of duty and work assignment schedule should incorporate appropriate flexibility and balance of outpatient, OR, and academic responsibilities.

17. Dr. Head should submit his research protocols to the GLA Research Service for approval. This is consistent with VHA and GLA policy for full time physicians engaged in research. This would also allow Dr. Head to negotiate for protected time to work on his research.

18. Dr. Stelzner should review the protected research time for all members of the Department of Surgery to assure that the assignment of protected research time is consistent with the June 2008 Standard Operating Procedure. This review should be discussed with the Chief of Staff.

19. Dr. Head should review the relevant VHA policies on physician time and attendance and conflict of interest to be sure that he understands them fully and endeavors to minimize any discrepancies in his adherence to those policies. The Department of Surgery clinical and administrative leadership should also review these policies to be sure that they are applied consistently and appropriately to full and part-time surgeons.

20. The Chief of Staff should consider reassigning Dr. Head's FTE to the office of the Chief of Staff. Dr. Head's clinical responsibilities would remain within the ENT section of the Department of Surgery and the Department of Surgery clinical leadership would have input into his proficiency evaluation, but administrative supervision and final responsibility for his proficiency evaluation would fall under the Chief of Staff.

Michael E. Mahler, MD

Dennis Schaberg, MD

EXHIBIT 6

E-Filing form printed on 11/1/2011 3:18 AM

Form11 10/6/2011

Status	Processed
Original Entry Date	10/6/2011 9:18 PM
Last Modified	10/25/2011 9:59 AM
Case Number	MA-12-0310

User Information

Christian Head
head@ucla.edu
Agency: Veterans Affairs

A summary of the data you entered:

Did the incident occur while federally employed?
Yes

Were you employed by any of the following Federal agencies?
a Federal agency not listed above

Your name: prefix
Dr.

Your name: First name
Christian

Your name: Middle name
Stephen

Your name: Last name
Head

Your name: Suffix

Your home address: Street
247 22nd Street

Your home address: Apt No

Your home address: City
Santa Monica

Your home address: State
California

Your home address: Zipcode
90402

Your home address: country
UNITED STATES

Your phone numbers: International Number
False

Your phone numbers: Country Code
00000

Your phone numbers: Home
(310) 458-1400

Your phone numbers: Home Ext

Your phone numbers: Work
(310) 478-3711

Your phone numbers: Work Ext

Your phone numbers: Cell
(310) 738-3159

Your phone numbers: Cell Ext

Your phone numbers: Fax

Your phone numbers: Fax Ext

Your phone numbers: Other

Your phone numbers: Other Ext

Your phone numbers: Email
head@ucla.edu

Outreach Info: How did you first become aware that you could file a complaint with OSC?
OSC Web Site

Outreach Info: For Other, please describe:

Outreach Info: Date (approximate):

10/6/2011

Do You Have a Representative?
Yes

Your Representatives name: prefix
Mrs.

Your Representatives name: First name
Shannon

Your Representatives name: Middle name
M.

Your Representatives name: Last name
Foley

Your Representatives name: Suffix

Is your representative an attorney?
Yes

Your representatives address: Street
1500 Rosecrans Avenue, Suite 500

Your representatives address: Apt No

Your representatives address: City
Manhattan Beach

Your representatives address: State
California

Your representatives address: Zipcode
90266

Your representatives address: Country
UNITED STATES

Your representatives Address: Firm Name
Foley Lyman Law Group LLP

Your representatives phone numbers: International Number
False

Your representatives phone numbers: Country Code
00000

Your representatives phone numbers: Home

Your representatives phone numbers: Home Ext

Your representatives phone numbers: Work
(310) 706-4050

Your representatives phone numbers: Work Ext

Your representatives phone numbers: Cell

Your representatives phone numbers: Cell Ext

Your representatives phone numbers: Fax
(310) 356-3105

Your representatives phone numbers: Fax Ext

Your representatives phone numbers: Other

Your representatives phone numbers: Other Ext

Your representatives phone numbers: Email
sfoley@shannonfoley.com

Agency Address: Agency Name
Veterans Affairs

Agency Address: Street
11301 Wilshire Boulevard

Agency Address: Apt No

Agency Address: City
Los Angeles

Agency Address: State
California

Agency Address: Zipcode
90402

Agency Address: Country
UNITED STATES

Job Info: Title
Surgeon/Associate Director

Job Info: Series
GS-1500

Job Info: Grade
GS-15

Are you covered by a collective bargaining agreement (or union contract)?
No

Enter Your Employment Status: Competitive Service
Career or career-conditional appointment

Enter Your Employment Status: Excepted Service
VA title 38 (doctor, nurse, etc.)

Enter Your Employment Status: Senior Executive Service (SES), Supergrade, or Executive Level
Career SES

Enter Your Employment Status: Applicant for federal employment (not current employee)
False

Enter Your Employment Status: Excepted Service (For Other, please specify)

Enter Your Employment Status: Other (For Other, please specify)

Actions Taken: Filed appeal with Merit Systems Protection Board (MSPB)

Actions Taken: Filed petition for reconsideration of initial MSPB decision

Actions Taken: Initial MSPB decision No.

Actions Taken: Filed USERRA claim with VETS in Department of Labor

Actions Taken: Filed grievance under agency grievance procedure

Actions Taken: Filed grievance under negotiated grievance procedure

Actions Taken: Matter heard by arbitrator under grievance procedure

Actions Taken: Matter is pending in arbitration

Actions Taken: Filed discrimination complaint with agency

Actions Taken: Appealed discrimination complaint decision to Equal Employment Opportunity Commission

Actions Taken: Filed appeal with Office of Personnel Management (OPM)

Actions Taken: Filed unfair labor practice (ULP) complaint with Federal Labor Relations Authority (FLRA)

Actions Taken: Filed lawsuit in federal court

Actions Taken: Court name

Actions Taken: Reported matter to agency Inspector General

Actions Taken: Reported matter to one or more members of Congress
10/6/2011

Actions Taken: Names of senators or representatives
Congresswoman Diane Watson

Actions Taken: Other (specify)

Actions Taken: For Other, please specify

Actions Taken: None
False

Please describe your complaint in detail.
October 6, 2011

I fear severe retaliation at the VA for providing testimony in an EEO case. I asked West Los Angeles VA regional office for protection from retaliation. They told me that I couldn't be protected from retaliation. It is a violation of the EEO laws not to retaliation and/ or protect persons who participate as witnesses in discrimination and harassment cases.

I was told by attorney Stein off the record that Regional Counsel represents, that he protects Chief of Staff's office only and cannot protect the employees of the VA.

My testimony was honest and damaging to the Dr. Dean Norman and Donna Beiter. My tour of duty has been changed without notice. My time is being super audited as it has been in the past. I have never had any issues in the past. I have also been retaliated in the past for a prior IG investigation on Marilene Wang, M.D. in 2006. The investigator was Nancy Solomon.

Please respond back to me. The retaliation by the VA and others is alarming.

Christian S. Head, MD

(310) 738-3159

What corrective action or remedy are you requesting if you prevail in your complaint?
protection

Choose ONE complaint category that applies to your complaint.
15. Reprisal for cooperating with, or providing information to, OSC or an Inspector General.

Reprisal for Assisting with Non EEO Reprisal Victim: Were you the victim of the reprisal?
Yes

Reprisal for Assisting with Non EEO Reprisal Victim: First Name

Reprisal for Assisting with Non EEO Reprisal Victim: Last Name

Reprisal for Assisting with Non EEO Reprisal Victim: Job Title

Reprisal for Assisting with Non EEO Reprisal Victim: Phone

Reprisal for Assisting with Non EEO Reprisal Victim: Phone Ext

Reprisal for Assisting with Non EEO About Complaint: Briefly describe the substance of the appeal, complaint or grievance you filed.
October 25, 2011

Special Counsel

Re: SERIOUS CONCERNS RE RACE DISCRIMINATION AND RETALIATION AT VA FOR PARTICIPATION IN EEO COMPLAINT

Dear Special Counsel:

I am writing you regarding serious issues that have arisen at the VA with an accomplished tenured professor and head & neck surgeon, Christian Head, M.D. We are disheartened to learn that at our VA- Los Angeles campus there appears to be some discriminatory and retaliatory employment practices based on racial bias that must be addressed. We request a meeting with you, but offer this information as background.

In recent months, there has been a reoccurrence of discrimination, unfair treatment and retaliation against one of our finest surgeons in Southern California. Chris Head, M.D. attended the University of Virginia, and Ohio State for Medical School, then did his residency at UCLA. He has a great reputation as a doctor at UCLA and the Veteran's Administration. He's generous with his time and talent, helping Veterans and giving back to our community both locally and nationally. He is a doctor who will make a difference in our world with his skills as a surgeon, his scientific research and laboratory. He is an Associate Professor in Residence at UCLA. He attained Tenure in 2009, and was named Most Innovative Surgeon of the Year in 2010 by Black Enterprise; Top 100 Surgeons in the Country in 2008 Black Enterprise. He has a joint appointment at UCLA and the VA-LA.

It is imperative that we help him remain in academic medicine as he is being pushed out of UCLA and now being retaliated against at the VA.

In November 2010, he participated in an EEO complaint at the VA, which was based on race and age discrimination against an African American anesthesiologist, Dr. Jasmine Bowers. Shortly thereafter, Dr. Head's boss at UCLA (Dr. Gerald Berke) commenced a campaign to retaliate against him at UCLA, restricting his compensation, his teaching assignments, patient referrals and clinic days, thereby limiting his income.

Dr. Christian Head's clinical hours were limited to one day per week; his calls for referred patients were sent to a voicemail box off site, while everyone else's patients were scheduled immediately by central head and neck scheduling (as his used to be). This resulted in a drastic reduction in his surgeries and loss of income. (It's a difference from $14,000 to $150,000 in patient billings per month) It makes a difference of being able to pay his mortgage or not, paying for his girls tuition or not. The effect is dramatic and Dr. Head's superiors at UCLA know it will cripple him financially and drive him out of UCLA and Academic Medicine.

Dr. Head went to the Vice Provost of Diversity for assistance in this matter with the issues of retaliation and discrimination. She said she could not help with the school of medicine. A DFEH complaint was filed for race discrimination and harassment as well as retaliation and failure to prevent discrimination and retaliation.

UCLA eventually permitted Dr. Head to schedule as he used to, but this retaliatory "slap" lasted 4 months and the lag time has cost him 6 months of income. He awaits the next retaliatory event, which is in process and is designed to prevent his testimony in the Bowers EEO case.

Dr. Head's recent financial struggles caused by the retaliation are designed to push him out of UCLA and his chosen career in academic medicine.

Another time in August 2008, Dr. Christian Head's Division Chief of Head and Neck Surgery, Dr. Berke at UCLA, unlawfully reduced his negotiated salary that was based on $315,000 per annum to a paycheck of $.23 and another for $.48. This also resulted in loss of Dr. Head's disability coverage and other benefits.

This loss of benefits and all income occurred at a time when Dr. Head had just been released from the hospital after a serious medical condition. We have witnesses in the Finance Office who support that Dr. Berke and his underling Michael Saxe told them to reduce Dr. Chris Head's compensation knowing this was not allowed under the Practice Plan or under University Policies.

Other Doctors in the Practice Group are not treated this way. They are on the Practice Plan, paid the guaranteed negotiated salary amount.

At the VA, Dr. Head was targeted another time with False allegations of time card issues, which were established to be false in a VA report dated September 2008. Dr. Head claimed he was being treated differently than his colleagues at the VA, which was established. He was the only person without protected Lab time, and who was working the hours. Dr. Stelzner was found to have made false claims against Dr. Head at the VA.
It was a set up by his superiors in response to his prior EEO activity. This document is available.

GRAPHIC RACIAL PICTURES SHOW CHRIS HEAD AS A GORILLA

This follows many incidents of SERIOUS and HIDEOUS RACIALLY CHARGED COMMENTS, GRAPHIC PICTURES, etc which we will describe so you understand the culture and hostile environment he works in at UCLA and with cross over doctors from the VA.

The graphic picture is a gorilla with Dr. Christian Head's face superimposed onto it. It also has his boss, Dr. Gerald Berke sodomizing him from behind. It's disgusting, humiliating, dehumanizing, and tells the tale of what has happened to the only African American in Head & Neck Surgery in the layers of discrimination and retaliation over the years. This horrible gorilla picture of Dr. Head was shown to about 300 people at a UCLA sponsored event – a Head & Neck Resident's graduation party in 2006. These slide shows are routinely reviewed for content by Dr. Berke. In years past, he edited such shows and pulled some pictures if he deemed them to be offensive to gays or women.

Dr. Head immediately told Dr. Berke how humiliated he was by this slide, how could he let it happen. There was never an apology from the Division Chair or the Residents or anyone at UCLA. It's deplorable, shameful and needs to be exposed.

The residents and UCLA have refused to turn over that slide. UCLA purportedly denies that it exists.

There are written admissions that the gorilla picture was shown at the UCLA resident party with Dr. Head's face on it. There are written admissions that two residents photo-shopped it. There is an email from the two residents who made the slides that states, we photo-shopped Berkes and Head's faces onto pictures. This slide was not produced with the rest of the slide show when Dr. Head requested it.

There is also a slide that shows retaliation for participating in an EEO investigation with the Investigator General on a Federal EEO complaint at the VA.
One of the offenders at UCLA and the VA, Dr. Marilene Wang openly stated to Dr. Head and to a cooperative witness, "Dr. Head is an Affirmative Action Hire." She and Dr. Berke have interfered with, and provided false information to CAP and other promotion committees, to block and/or derail Dr. Chris Head's promotions and advancement for years. In addition, there has been a concerted effort to interfere with his financial success and drive him out of UCLA, because his only compensation at UCLA is clinical earnings.

Dr. Christian Head is the only African American in Head and Neck Surgery. He's 18 years out of Medical School. If he's forced out, there is not another African American on the horizon anywhere to replace him. He has accomplished great things there with research in cancer, tumors, with the National Cancer Institute, Jonsson Cancer Institute. Chris Head has a leadership position at the VA as Associate Director Chief of Staff. He has an important role on the Risk Management Committee at both the VA and UCLA.

Now, we have learned that UCLA and the VA are acting in concert, to suppress the slide of the gorilla which we believe is in the email archives at UCLA and at the VA . They are also working to "set up" Dr. Christian Head" for working at UCLA when they say he should have been at the VA…. trying to make him look like the bad guy. He's in an administrative position at the VA, he does much of his administrative work in the evenings bringing files home, or late at night going back to the office. He's not an hourly employee who clocks in and out of the VA.

They do not want him to testify in the upcoming depositions scheduled in August and September, or the EEO hearing in the Jasmine Bowers case regarding the racial bias and discrimination that exists with the VA and UCLA physicians.
Dr. Head was told to "stand down" by VA officials when he and the Risk Management Committee were involved in evaluating the Bowers issues. They indicated that Dr. Jasmine Bowers, a Board Certified Anesthesiologist, the other African American who filed an EEO, was not "smart enough" to understand the EEO issues without his assistance. He was told, "It's not a black thing, stay out of it."

TIME IS OF THE ESSENCE. UNLESS ACTION IS TAKEN NOW, DR. HEAD WILL BE FORCED OUT OF HIS POSITION AT UCLA /VA AND WE WILL HAVE LOST THE ONLY AFRICAN AMERICAN HEAD AND NECK SURGEON AND PROFESSOR AT UCLA AND THE VA.

There are several statutes that the legislature enacted that protect whistleblowers and those who need protections from discriminatory and retaliatory employers

The California Whistleblower Protection Act at Government Code 8547 et. seq. and the FEHA and EEO laws are designed to protect our workers from retaliation. But when they are retaliated against and made to suffer financially and forced out of their jobs before they can obtain judicial relief, this is deplorable. This retaliation by a governmental body, the UC system, the VA against the individual complainant is carried out through its Division and Departmental Chairs, Vice Chancellors and Directors.

In this case, the VA's CEO, the VA Chief of Staff, the UCLA Vice Chancellor of Legal Affairs all are well aware of the issues, including the gorilla, the EEO complaints at the VA, the subsequent retaliation and harassment. They pretended to be looking toward resolution and "investigated" only to cover their tracks. The Vice Chancellor immediately told the offending witnesses and harasser, Dr. Berke, who called and threatened the witnesses, "Why are you helping Chris Head," "why are emailing Ben Crane," (he had the gorilla slide) then continued retaliatory conduct against the complainant and witnesses who feared retaliation as well. This is well documented and has occurred as recently as two weeks ago. The VA pretended they would look for the gorilla slide on their system, but then claimed they were not even looking, that Chris Head could help him look through emails. It requires an IT search through archives.

Chris Head needs some immediate help and action to intervene at the VA and UCLA. Pressure needs to be placed on VA and UCLA to stop interfering with Dr. Chris Head's career advancement at the VA and UCLA, and UCLA needs to make up for past discrimination and interference with his advancement and assure that it will not occur again in the future. UCLA needs to be held accountable for its failure to stop the retaliation and efforts to push Dr. Chris Head out of UCLA and the VA and for its efforts to prevent his testimony and discrimination claims.

The Black Caucus wants to set up a mechanism to monitor the number of African American Surgeons, especially Head and Neck Surgeons, and monitor their progress through the UC system as compared to other UCLA doctors. The AG can be instrumental in watching and helping with this task.

There should be some accountability, either through Attorney General or legislative oversight regarding diversity in Academic Medicine. There are not many African Americans in any areas at UCLA. They do nothing to retain blacks at UCLA. Other highly qualified African Americans have left UCLA after having been shamed, humiliated and financially pushed out.

Because of this treatment, Dr. Chris Head's research is now behind schedule. He is fighting for financial survival. Dr. Head has not been able to concentrate on his research. UCLA's financial squeeze forced him to close his lab. The University is not taking responsibility to help re-launch his lab. This is how they keep him down and prevent his advancement to the next level of Professor. He won't be able to make it because he can't do research when he's fighting over each retaliatory financial move.

Those who have interfered with Dr. Head's career should not be involved in future promotion decisions that could move him to the next level of full professorship. Steps must be taken to prevent the kind of retaliation that occurs behind closed doors.

We thank you for your interest in Dr. Christian Head, and in all the African American and physicians of color, who have worked tirelessly toward their top rated educations and to serve the people of our communities. We'd like to help keep Dr. Head at UCLA/VA, where he did his residency, where he has done his research, and where he has established his practice. Unfairness for anyone who is driven out, not for performance, but for "discriminatory and retaliatory bias" needs to be addressed and abolished in our University of California and VA system.

Please respond back to me. He retaliation by the VA and others is alarming. I reported these concerns to:

James Itamura
EEO Investigator
Office of Resolution Management

1601 East 4th Plain Blvd

Bldg 17; B-402
Vancouver, Washington 98661
Office: (360) 759-1617 Fax: 1618

Reprisal for Assisting with Non EEO About Complaint: When did the victim file the complaint?
8/26/2011

Reprisal for Assisting with Non EEO/Personnel Actions Taken: an appointment
none

Reprisal for Assisting with Non EEO/Personnel Actions Taken: a promotion or selection for a position

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Reprisal for Assisting with Non EEO/Personnel Actions Taken: a reprimand, suspension, removal or other disciplinary or corrective action;

Reprisal for Assisting with Non EEO/Personnel Actions Taken: a detail, transfer, reassignment, or change in duty station

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Reprisal for Assisting with Non EEO/Personnel Actions Taken: a reinstatement, restoration or reemployment

---

Reprisal for Assisting with Non EEO/Personnel Actions Taken: a decision about pay, benefits, or awards

Reprisal for Assisting with Non EEO/Personnel Actions Taken: a decision about education or training

Reprisal for Assisting with Non EEO/Personnel Actions Taken: an annual performance evaluation

Reprisal for Cooperating Reprisal Victim: Were you the victim of the reprisal?
Yes

Reprisal for Cooperating Reprisal Victim: First Name

Reprisal for Cooperating Reprisal Victim: Last Name

Reprisal for Cooperating Reprisal Victim: Job Title

Reprisal for Cooperating Reprisal Victim: Phone

Reprisal for Cooperating Reprisal Victim: Phone Ext

Reprisal for Cooperating About Disclosure: Briefly describe your cooperation with, or disclosure to OSC or an IG.
Witness in fraud investigation Dr. Marilene Wang, MD

Reprisal for Cooperating About Disclosure: When did the victim cooperate or disclose information??
3/23/2006

Reprisal for Cooperating/Personnel Actions Taken: an appointment

Reprisal for Cooperating/Personnel Actions Taken: a promotion or selection for a position

Reprisal for Cooperating/Personnel Actions Taken: a reprimand, suspension, removal or other disciplinary or corrective action;

Reprisal for Cooperating/Personnel Actions Taken: a detail, transfer, reassignment, or change in duty station
none

Reprisal for Cooperating/Personnel Actions Taken: a reinstatement, restoration or reemployment

Reprisal for Cooperating/Personnel Actions Taken: a decision about pay, benefits, or awards
none

Reprisal for Cooperating/Personnel Actions Taken: a decision about education or training

Reprisal for Cooperating/Personnel Actions Taken: an annual performance evaluation

Reprisal for Cooperating/Personnel Actions Taken: a decision to order psychiatric testing or examination

Reprisal for Cooperating/Personnel Actions Taken: any other significant change in duties, responsibilities, or working conditions.

Reprisal for Cooperating/Personnel Actions Taken: Details
1. showed a slide suggesting I told the IG about Dr. Wangs fraud.
2. showed a slide of my head photoshoped on a gorilla being sexually assaulted by my boss

Reprisal for Cooperating Involved: Made Decision First Name
Marilene

Reprisal for Cooperating Involved: Made Decision Last Name
Wang

Reprisal for Cooperating Involved: Made Decision Job Title
surgeon

Reprisal for Cooperating Involved: Made Decision Phone
(310) 206-6766

Reprisal for Cooperating Involved: Made Decision Phone Ext

Reprisal for Cooperating Involved: Made Recommendation First Name
Dean

Reprisal for Cooperating Involved: Made Recommendation Last Name
Norman

Reprisal for Cooperating Involved: Made Recommendation Job Title

Reprisal for Cooperating Involved: Made Recommendation Phone

Reprisal for Cooperating Involved: Made Recommendation Phone Ext

Reprisal for Cooperating Involved: Approved Decision First Name
Gerald

Reprisal for Cooperating Involved: Approved Decision Last Name
Berke

Reprisal for Cooperating Involved: Approved Decision Job Title

Reprisal for Cooperating Involved: Approved Decision Phone

Reprisal for Cooperating Involved: Approved Decision Phone Ext

Reprisal for Cooperating Involved: How did the persons you just identified know about the victim's cooperation or disclosure?
Not sure

Reprisal for Cooperating More Details: What specific information do you have to support your belief that the agency took or failed to take the action(s) about which you complain because of the victim's cooperation?
emails, witness

Reprisal for Cooperating More Details: What specific information do you have to support your belief that the personnel action was not justified?
emails, witness

Reprisal for Cooperating Complaints Filed: Union
no

Reprisal for Cooperating Complaints Filed: Date Union Grievance Filed

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Reprisal for Cooperating Complaints Filed: Union Grievance Outcome

---

Reprisal for Cooperating Complaints Filed: agency
no

Reprisal for Cooperating Complaints Filed: Date agency Grievance Filed

---

Reprisal for Cooperating Complaints Filed: agency Grievance Outcome

---

Reprisal for Cooperating Complaints Filed: EEO
no

Reprisal for Cooperating Complaints Filed: Date EEO Grievance Filed

---

Reprisal for Cooperating Complaints Filed: EEO Grievance Outcome

---

Reprisal for Cooperating Complaints Filed: MSPB
no

Reprisal for Cooperating Complaints Filed: Date MSPB Grievance Filed

---

Reprisal for Cooperating Complaints Filed: MSPB Grievance Outcome

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Please use this page to describe additional incidents related to the PPP Category you have chosen.

Required Signature
summer99

Consent Statement

Consent Statement 1
I *consent* to OSC's communication with the agency involved in my complaint. I agree to allow OSC to disclose my identity as the complainant, and information from or about me, to the agency if OSC decides that such disclosure is needed to investigate the allegation(s) in my complaint (for example, to request information from the agency, or seek a possible resolution through mediation or corrective action). I understand that regardless of the Consent Statement I choose, OSC may disclose information from my complaint file when permitted by the Privacy Act (including circumstances summarized in Part 5, below).

Consent Statement Signature
summer99

Reprisal for Assisting with Non EEO/Personnel Actions Taken: a decision to order psychiatric testing or examination

---

Reprisal for Assisting with Non EEO/Personnel Actions Taken: any other significant change in duties, responsibilities, or working conditions.
none

Reprisal for Assisting with Non EEO/Personnel Actions Taken: Details
1. Change in tour.
2. harassment
3. threats
4. reports from other staff
5. salary loss

Reprisal for Assisting with Non EEO Involved: Made Decision First Name
Dean

Reprisal for Assisting with Non EEO Involved: Made Decision Last Name
Norman

Reprisal for Assisting with Non EEO Involved: Made Decision Job Title
Chief of Staff

Reprisal for Assisting with Non EEO Involved: Made Decision Phone
(310) 478-3711

Reprisal for Assisting with Non EEO Involved: Made Decision Phone Ext

---

Reprisal for Assisting with Non EEO Involved: Made Recommendation First Name
Donna

Reprisal for Assisting with Non EEO Involved: Made Recommendation Last Name
Beiter

Reprisal for Assisting with Non EEO Involved: Made Recommendation Job Title

CEO

Reprisal for Assisting with Non EEO Involved: Made Recommendation Phone
(310) 478-3711

Reprisal for Assisting with Non EEO Involved: Made Recommendation Phone Ext

Reprisal for Assisting with Non EEO Involved: Approved Decision First Name

Reprisal for Assisting with Non EEO Involved: Approved Decision Last Name

Reprisal for Assisting with Non EEO Involved: Approved Decision Job Title

Reprisal for Assisting with Non EEO Involved: Approved Decision Phone

Reprisal for Assisting with Non EEO Involved: Approved Decision Phone Ext

Reprisal for Assisting with Non EEO Involved: How did the persons you just identified know about the victim's appeal, complaint, or grievance?
They caused the personnel action against Jasmine Bowers.

Reprisal for Assisting with Non EEO More Details: What specific information do you have to support your belief that the agency took or failed to take the action(s) about which you complain because of the victim's appeal, complaint, or grievance?
Actions by Dean Norman.

Reprisal for Assisting with Non EEO More Details: What specific information do you have to support your belief that the personnel action was not justified?
emails

Reprisal for Assisting with Non EEO Complaints Filed: Union
no

Reprisal for Assisting with Non EEO Complaints Filed: Date Union Grievance Filed

Reprisal for Assisting with Non EEO Complaints Filed: Union Grievance Outcome

Reprisal for Assisting with Non EEO Complaints Filed: agency
no

Reprisal for Assisting with Non EEO Complaints Filed: Date agency Grievance Filed

Reprisal for Assisting with Non EEO Complaints Filed: agency Grievance Outcome

Reprisal for Assisting with Non EEO Complaints Filed: EEO
no

Reprisal for Assisting with Non EEO Complaints Filed: Date EEO Grievance Filed

Reprisal for Assisting with Non EEO Complaints Filed: EEO Grievance Outcome

Reprisal for Assisting with Non EEO Complaints Filed: MSPB
no

Reprisal for Assisting with Non EEO Complaints Filed: Date MSPB Grievance Filed

Reprisal for Assisting with Non EEO Complaints Filed: MSPB Grievance Outcome

Please use this page to describe additional incidents related to the PPP Category you have chosen.

EXHIBIT 7

Statement addressing settlement of litigation by Dr. Christian Head

July 18, 2013

The Regents of the University of California and Dr. Christian Head today reached a settlement in a civil case he brought against the University last year. The case presented difficult issues of alleged discrimination and retaliation that were strongly contested.

The University acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The University regrets that this occurred. The University does not admit liability, and the parties have decided that the case should be resolved with a mutual release of all legal claims. The matter was settled to the mutual satisfaction of the parties.

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EXHIBIT 8

COPY

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Manhattan Beach, CA 90266
Telephone: 310.802.1500
Telefax: 310.802.0500

Attorneys for Plaintiff
JOEL SERCARZ, M.D.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

BC540837

JOEL SERCARZ, M.D., Plaintiff, v. GERALD BERKE, M.D.; and DOES 1-50, inclusive, Defendant.	Case No. **PLAINTIFF'S VERIFIED COMPLAINT FOR DAMAGES:** **1) HEALTH & SAFETY CODE § 1278.5** **2) GOVERNMENT CODE § 8547** **DEMAND FOR JURY TRIAL**

BY FAX

Plaintiff, JOEL SERCARZ, M.D., respectfully submits the instant Verified Complaint for Damages and Demand for Jury Trial and alleges as follows:

CASE OVERVIEW

"No good deed goes unpunished." This is a case about someone who saw horrendous injustice and was the only person who had the courage to do anything about it. DR. JOEL SERCARZ, a prominent UCLA Head and Neck Surgeon, witnessed outrageous racial discrimination and patient health and safety retaliation occurring within UCLA Medical Center, and in particular against his colleague, Dr. Christian Head. Because DR. SERCARZ chose to speak up and testify honestly about the rampant injustice occurring at UCLA, he was ostracized

and retaliated against. This is a story of a man, DR. BERKE, who used his power, influence, and official authority to manipulate, intimidate, and coerce those around him for the sole benefit of his own advancement and narcissistic endeavors. In fact, DR. BERKE, the mastermind and primary perpetrator behind the horrendous treatment of Dr. Head and the retaliation against DR. SERCARZ, went so far as to cause DR. SERCARZ to be terminated from his position at Olive View-UCLA Medical Center for his involvement and support in Dr. Head's lawsuit.

PARTIES AND JURISDICTION

1. Plaintiff, JOEL SERCARZ, M.D. (hereafter "DR. SERCARZ" or "Plaintiff"), was at all times relevant to this action, a member of the medical staff, employee, and/or wrongfully terminated employee of the Regents of the University of California (hereafter "Regents"), County of Los Angeles ("County"), and County of Los Angeles Department of Health Services Olive View-UCLA Medical Center (hereinafter "Olive View"). While employed by Regents and Olive View, and at all times relevant to this action, Plaintiff worked and resided in Los Angeles County.

2. Defendant, GERALD BERKE, M.D. ("DR. BERKE"), is a licensed medical doctor who practices, teaches, and is Chairman of the UCLA Department of Head and Neck Surgery. DR. BERKE is also a member of the medical staff at the Ronald Reagan UCLA Medical Center and the Santa Monica UCLA Medical Center and Orthopaedic Hospital, pursuant to Health & Safety Code § 1278.5(i). Plaintiff believes, and thereby represents that, DR. BERKE is a resident of Los Angeles County, California. Defendant, DR. BERKE, was at all times a "supervisor" as defined by Government Code §12926(r).

3. Venue and jurisdiction are proper because the majority of the events giving rise to this action took place in Los Angeles County; because Defendants were doing business in the Los Angeles County; because Plaintiff's employment was entered into in Los Angeles County; because Plaintiff worked for and with Defendants in Los Angeles County, because the damages sought

exceed the jurisdictional minimum of this Court; and because the majority of witnesses and events occurred in Los Angeles County.

4. Plaintiff is ignorant of the true names and capacities of the Defendants sued herein as DOES 1 through 50. Defendants Does 1 through 50 are sued herein under fictitious names pursuant to California Code of Civil Procedure section 474. Plaintiff is informed and believes, and on that basis alleges, that each Defendant sued under such fictitious names is in some manner responsible for the wrongs and damages as alleged herein. Plaintiff does not at this time know the true names or capacities of said Defendants, but prays that the same may be inserted herein when ascertained.

5. At all times relevant, each and every Defendant was an agent and/or employee of each and every other Defendant. In doing the things alleged in the causes of action stated herein, each and every Defendant was acting within the course and scope of this agency or employment, and was acting with the consent, permission, and authorization of each remaining Defendant. All actions of each Defendant as alleged herein were ratified and approved by every other Defendant or their officers or managing agents.

STATEMENT OF FACTS

6. DR. SERCARZ obtained his Doctor of Medicine degree from UCLA School of Medicine in 1986. Between 1986 and 1987, DR. SERCARZ completed an Internship in Surgery/Head and Neck Surgery at UCLA School of Medicine. Between 1987 and 1988, DR. SERCARZ completed a residency in Head and Neck Surgery at UCLA School of Medicine. Between 1988 and 1992, DR. SERCARZ completed a residency in Otolaryngology at UCLA School of Medicine. DR. SERCARZ joined the faculty as a Professor-in-Residence of the UCLA Geffen School of Medicine and Department of Head and Neck Surgeon. DR. SERCARZ has been board certified in Head and Neck Surgery since 1993.

7. Throughout his 20 years as a Head and Neck Surgeon, DR. SERCARZ has had a stellar career, becoming one of the leading experts in anterior skull base surgery, endoscopic sinus surgery, head and neck cancer, minimally invasive parathyroid surgery, and thyroid surgery. DR.

SERCARZ has also publishing nearly 100 research papers in the areas of laryngeal physiology, head and neck oncology, head and neck reconstruction, and laser surgery for head and neck cancer.

8. In fact, it was DR. SERCARZ's dream to follow in the footsteps of his father, a renowned and well-loved Immunologist at UCLA. Unfortunately, that dream has been destroyed, all because DR. SERCARZ bravely chose to testify honestly about the rampant injustice—the racial discrimination and patient health and safety retaliation—occurring within UCLA Medical Center, and in particular against his colleague, Dr. Christian Head.

9. Regents operates the UCLA Health Systems ("UCLA") where the majority of events, occurrences, and transactions relative to this action transpired. Regents owns and operates the Ronald Reagan UCLA Medical Center and the Santa Monica UCLA Medical Center and Orthopaedic Hospital, acute care hospitals located in the County of Los Angeles. Recently, Ronald Reagan UCLA Medical Center received a failing grade for patient safety in a national report card by the Leapfrog Group, a nonprofit focused on health care. The failing grade for the Ronald Regan UCLA Medical Center was nationally reported. Only 25 hospitals received a failing grade for safety on the national level. UCLA Medical Center is a "hospital facility" pursuant to Health & Safety Code § 1250(a) and a "health facility" pursuant to Health & Safety Code § 1278.5(i).

10. Olive View, was at all times relevant to this action, an entity of the County of Los Angeles, California, engaged in operating an acute care hospital and providing medical services in the Sylmar, California. Olive View is a "hospital facility" pursuant to Health & Safety Code § 1250(a) and a "health facility" pursuant to Health & Safety Code § 1278.5(i).

11. As a Head and Neck Surgeon at UCLA, DR. SERCARZ works under the leadership of DR. BERKE. DR. SERCARZ's colleagues within the Head and Neck Department also include, Elliot Abemayor, M.D. ("Dr. Abemayor"), Keith Blackwell, M.D. ("Dr. Blackwell"), Dinesh Chhetri, M.D. ("Dr. Chhetri"), Vishad Nabili, M.D. ("Dr. Nabili"), Maie St. John M.D. ("Dr. St. John"), Marilene Wang, M.D. ("Dr. Wang"), and Christian Head, M.D. ("Dr. Head"). At Olive View, DR. SERCARZ worked under the leadership of Jesse Thompson, M.D. ("Dr. Thompson").

12. In fact, the retaliation against DR. SERCARZ began because DR. SERCARZ became aware of harassing, discriminatory, retaliatory, and defamatory conduct directed at Dr. Head, and DR. SERCARZ was the only person to speak out against this illegal behavior. In order to fully understand DR. SERCARZ's story, it is important to understand the facts related to Dr. Head.

13. Dr. Head first came to UCLA in 1994 to complete a Fellowship in Neuro-Otology Research and then a Surgical Internship. Between 1997 and 2002, Dr. Head worked as a Resident in the UCLA School of Medicine Head and Neck Surgery Department. In 2002, Dr. Head joined the faculty as a Visiting Professor in Head and Neck Surgery at UCLA. In August 2003, Dr. Head joined the faculty of the UCLA Geffen School of Medicine as a full time Head and Neck Surgeon.

14. Over the years, Dr. Head received accolades for his work; however, despite Dr. Head's many accomplishments and contributions to UCLA, various members of the medical staff, in particular DR. BERKE and Dr. Wang, made several inappropriate racial comments about black people, including Dr. Head. In 2002, DR. BERKE questioned Dr. Head, the only Black person in the department, when DR. BERKE's computer was stolen by the janitor. Another Head and Neck physician commented that it was "racist" of DR. BERKE to accuse the only Black person around, and nobody else, despite the fact that Dr. Head was a well-accomplished Head and Neck resident physician. In or around 2003, Dr. Wang made comments that Dr. Head was hired as a Visiting Professor because he was an "affirmative action hire" and "affirmative action project." In or around 2003, Dr. Wang also publicly stated that Dr. Head is inferior because he is black, that he would not pass the boards, and that he was unqualified. In or around 2003, Dr. Wang stated that "cream rises to the top," that Dr. Head "would not make it in academic medicine," and that Dr. Head and "doctors like him" who are black, were the reason for failed hospitals like King Drew.

15. On information and belief, in or around mid-2003, DR. BERKE stated that "we're about to have some color" in the department. DR. BERKE also stated, "I guess we'll have our first Nigger" now. These comments by DR. BERKE were overheard by Alma Rose Montoya, UCLA

Residency Coordinator. A true and correct copy of the Declaration of Alma Rose Montoya is attached hereto as Exhibit K.

16. From 2003 on, Dr. Wang made it clear it was her intention to destroy Dr. Head's career and reputation. In fact, Dr. Wang took affirmative action to prevent Dr. Head from receiving promotions, advancements, and tenure. Dr. Wang was also responsible for supervising the residents at UCLA and had supervisory authority over Dr. Head, preparing evaluations of his performance.

17. Starting in or around 2003, Dr. Wang began stating to other surgeons throughout the Head and Neck Department, including DR. SERCARZ and Dr. Blackwell, that she fully intended to interfere with Dr. Head's professional advancement, in part by giving Dr. Head subpar evaluations and falsely attacking Dr. Head's credentials and performance.

18. In or around June 2004, UCLA Senior Associate Dean for Academic Affairs, Dr. William Friedman ("Dean Friedman") met with and ordered Dr. Wang to stop submitting negative evaluations about Dr. Head after Dr. Wang was reported by Dr. Head as having called Dr. Head an "affirmative action hire," amongst other racist comments. At that time, Dr. Wang promised not to interfere with Dr. Head's career advancement. However, in direct violation of Dean Friedman's orders, Dr. Wang continued to submit negative supervisor evaluations regarding Dr. Head's performance, which evidenced her obvious racial bias against Dr. Head. Dr. Wang's ongoing harassment and retaliation against Dr. Head in this way continued to negatively impact Dr. Head's career advancements. Sadly, in or around December 2005, Dean Friedman passed away.

19. In or around November 2005, Dr. Wang gave Dr. Head a retaliatory and harassing evaluation of his teaching and performance in an attempt to interfere with his advancement at UCLA and in violation of the agreement reached with Dean Friedman.

20. In or around December 2005, a colleague of Dr. Head, Dr. Donald Becker ("Dr. Becker"), suggested to Dr. Head he contact Dr. Rosina Becerra ("Dr. Becerra"), then-Vice Provost for Faculty Diversity and Development, and report the harassment and discrimination he was experiencing by Dr. Wang. In or around December 2005, Dr. Head did meet with Dr. Becerra to

discuss these issues. Dr. Head also reported the discrimination to DR. BERKE, Dr. Ronald Busuttil ("Dr. Busuttil"), Executive Chairman of the UCLA Department of Surgery, Dr. Carmach Holmes, former Chair of Surgery, and Dr. Becker. On or about February 2, 2006, Dr. Head sent a follow up letter to Dr. Becerra regarding this harassment, discrimination, and related problems at UCLA and requested financial and other support to stop the harassment, retaliation, and interference with his career advancement. Dr. Head also requested that he be assigned more time working at UCLA in order to be removed from Dr. Wang's supervision at an affiliated hospital. In response, Dr. Becerra told Dr. Head that she could not help him, and warned Dr. Head it was not a good idea to participate in an investigation against Dr. Wang.

21. In or around April 2006, Dr. Head was contacted for the first time by Investigator Nancy Solomon ("Investigator Solomon") of the Office of Inspector General ("OIG") regarding an investigation of Dr. Wang for time card fraud concerning work Dr. Wang performed at an affiliated hospital. Dr. Head learned from Investigator Solomon that Dr. Wang was under investigation by the federal government for submitting and/or approving false time cards pertaining to services provided at an affiliated UCLA health facility. Dr. Head was asked by Investigator Solomon to testify about Dr. Wang's involvement in time card fraud. Dr. Head requested protection from Investigator Solomon, stating that he feared retaliation for his participation in the investigation. With a promise by Investigator Solomon regarding protection from retaliation for his cooperation, Dr. Head testified in an OIG deposition regarding Dr. Wang's time card issues.

22. In or around April/May 2006, UCLA Residents Dr. Lee, Dr. Crane, and others were called to testify in the time card case regarding Dr. Wang as well. Those residents reported to Dr. Wang information concerning the investigation.

23. The OIG investigation concluded that Dr. Wang had in fact committed time card fraud. There was a recommendation by the OIG that Dr. Wang be removed from her leadership position and terminated; however, Dr. Wang's immediate supervisor, DR. BERKE, took steps to save Dr. Wang's job and leadership position—UCLA transferred vacation hours to Dr. Wang's

account and research funds were transferred from DR. BERKE. Additionally, DR. BERKE approached the affiliated hospital's Chief of Staff to request that Dr. Wang not be terminated. Due to DR. BERKE's intervention and powerful influence, the Chief of Staff did not terminate Dr. Wang, did not dock her pay, and did not remove her from her leadership position as Chief of Head and Neck Surgery, despite the recommendation for termination by the OIG. In fact, the only action taken was a written warning issued to Dr. Wang and termination of a subordinate.

24. Dr. Head's participation and truthful testimony in connection with Dr. Wang's time card fraud investigation in April 2006, further incited DR. BERKE and Dr. Wang to continue their campaign of intimidation, harassment, discrimination, and retaliation against Dr. Head.

25. In or around April/May 2006, during a meeting regarding Dr. Head's compensation, DR. BERKE threatened Dr. Head stating, "If you complain about Dr. Wang," and about not getting the compensation enhancement (a Full-Time Equivalent ("FTE") that was available, which Dr. Wang denied Dr. Head and gave to another surgeon from outside the hospital), "you won't get anything, you'll be removed" like another professor who had been recently removed at UCLA.

26. In or around April/May 2006, shortly after Dr. Head provided deposition testimony to the OIG, Dr. Wang discussed with the residents of the UCLA Head and Neck Department, whom she supervised and worked with, including Dr. Lee and Dr. Crane, about Dr. Head's participation in the time card fraud investigation. In addition, Dr. Wang spoke with many of the residents who worked under her supervision as they each testified in the time card fraud investigation. As a result, these residents, including Dr. Lee and Dr. Crane, began to participate in the intimidation, harassment, discrimination, and retaliation of Dr. Head. Dr. Head began to experience horribly offensive discriminatory comments, graphic racial photos, and retaliatory actions and statements.

27. In or around May 2006, Dr. Head reported to Dr. Dennis Slamon ("Dr. Slamon") that he was being harassed and retaliated against by DR. BERKE and Dr. Wang and was worried about his future. Dr. Slamon responded, "They [DR. BERKE, Dr. Wang, and Dr. Abemayor]

think you ratted out Wang in the IG investigation. You need to keep your head down and stay out of this. Don't complain."

28. In or around June 2006, at the year-end closing ceremony and party for the UCLA Head and Neck Department, attended by approximately 200 people including UCLA faculty, staff, chairs, residents, and spouses, the resident class presented a slide show. The slide show, presented by the Residents, including Dr. Crane and Dr. Lee, had an entire section about Dr. Head. These slides, directed toward Dr. Head, were exceptionally vulgar, disturbing, defamatory, discriminatory, retaliatory, humiliating, degrading, disgusting, demoralizing, and racist. One slide, depicted a hairy, black gorilla with Dr. Head's face superimposed on the gorilla, being sodomized by a white naked man with the head of DR. BERKE superimposed on the body (the "Gorilla Slide"). When this slide was shown, Dr. Wang and others in the crowd laughed that Dr. Head was "being screwed by his boss." Another slide (referencing the OIG time card fraud investigation of Dr. Wang) showed Dr. Head on the telephone and read: "If all else fails call 1-800-488-VA IG." The other slides throughout the presentation were similar to Dr. Wang's comments in her performance "evaluations" of Dr. Head: that he is a bad doctor, bad researcher, and bad teacher. (In the years past and since, DR. BERKE has reviewed each resident class' year-end slide show and vetoed slides with inappropriate jokes directed at homosexuals and/or women or slides with offensive content. In fact, based on information and belief, this slide show, including the Gorilla Slide, was reviewed by DR. BERKE and others who worked at UCLA, who did nothing to stop the presentation.)

29. Dr. Head immediately complained to DR. BERKE during the event about the offensiveness of these slides. Dr. Head was outraged and horrified how a prestigious public university such as UCLA would publicly display such hostility, bigotry, and hatred toward blacks. After voicing his shame and disgust, Dr. Head immediately left the event.

30. DR. BERKE admitted to DR. SERCARZ that the slide show was "in poor taste." DR. BERKE also admitted to Dr. Head that the slide depicting him sodomizing Dr. Head as a gorilla was "in bad taste" and that Dr. Head had the right to, and did in fact complain to DR.

BERKE that night. DR. BERKE responded, stating that DR. BERKE was drunk during the school sponsored event. Although the Gorilla Slide is likely to be the single worst expression of racist hate speech in UCLA history, no investigation of the incident was conducted at the time. As an act of ratification, DR. BERKE and Dr. Wang helped Dr. Crane, one of the residents responsible for presenting the slide show, obtain a fellowship position with Regents at the UCLA Jules Stein Eye Institute following graduation. Dr. Crane was also hired by Dr. Wang at an affiliated UCLA Hospital.

31. In or around December 2006, Dr. Wang continued to submit false critical evaluations of Dr. Head, assigning him the lowest marks possible. Caused by her malice, personal vendetta, and discriminatory bias towards Dr. Head, Dr. Wang's false evaluations were defaming to Dr. Head's professional reputation, criticizing his competence generally and as a teacher, researcher, and mentor at UCLA.

32. In or around December 2007, Dr. Wang submitted another critical evaluation of Dr. Head giving him all 1's out of 5's. Dr. Wang made false states such as: "Difficult to reach on pager." "No tangible research activity." "Poor role model."

33. Dr. Head was also treated differently than other surgeons throughout the Head and Neck Department who had a financial "deficit," such as Nina Shapiro, M.D. ("Dr. Shapiro"), Dr. St. John, and Dr. Nabili. In an April 11, 2008 memo to Michael Sachs ("Mr. Sachs"), administrator in the Head and Neck Department, DR. BERKE stated, "to keep us from showing a deficit this year while we are applying for dept status we had to use some of the Slatkin money to cover Nina, Chris, St. John, and Nabili until they get going again." According to the Health Sciences Compensation Plan and/or Physician Compensation Plan, base compensation for professors at UCLA is to be protected. Based on information and belief, these other surgeons were all paid by DR. BERKE based upon their agreed compensation plan, possibly using money from the Slatkin funding.

34. In or around April 2008, after Dr. Head's negotiated compensation was set, Mr. Sachs, acting at DR. BERKE's direction, instructed the Financial Analyst for the Head and Neck

Department to reduce Dr. Head's total negotiated salary ("TNS') compensation. The Financial Analyst objected that this was not permitted. Nevertheless, the first payment in the new academic year starting in August 2008, Regents failed to deposit the TNS pay into Dr. Head's account. Dr. Head received notice to pick up his net paycheck, which totaled $0.23. The next net paycheck totaled $0.24. Dr. Head's insurance was cut off, including disability insurance and all benefits, because his TNS compensation was so low. DR. BERKE, Sachs, and Stephanie Shaw ("Shaw"), Surgery Administrator, knew of this pay reduction and that Dr. Head would lose all his benefits at UCLA as a result.

35. Dr. Head complained to Dr. Thomas Rosenthal ("Dr. Rosenthal"), Vice Chancellor of the UCLA Geffen School of Medicine, who admitted that DR. BERKE could not legally reduce his TNS compensation under the circumstances. Dr. Rosenthal stated that Dr. Head could challenge the compensation cut, but "doing so would adversely affect [Dr. Head's] pending tenure decision." By this time, the institutional message was clear, "complainers will not receive tenure."

36. In April 2008, after a patient with mental health issues made a complaint regarding Dr. Head, DR. BERKE commented in a writing to Dr. Head and DR. SERCARZ, "I guess Chris won't make tenure now." This comment and attitude was consistent with the constant environment of "waiting" for Dr. Head to fail in his position and DR. BERKE threatening that Dr. Head would not make tenure.

37. On or about, May 5, 2008, Dr. Wang again submitted a Teaching Evaluation—knowing it was to be submitted into Dr. Head's Promotions Packet for tenure decisions—marking all 1's (Unsatisfactory), stating "poor clinical judgment, poor availability, poor role model." Dr. Wang continues to provide negative false information and evaluations about Dr. Head. Dr. Wang asserts that Dean Friedman's ban on her evaluations of Dr. Head does not apply to her at UCLA.

38. In or around May 2008, DR. BERKE accused Dr. Head of taking mind altering drugs and forced him to take a drug test. Dr. Rosenthal, Dr. Marshall Morgan, Director of Emergency Medicine, DR. BERKE, and Dr. Wang were all involved in the drug testing of Dr. Head. All of the test results were negative, but UCLA waited several weeks to advise Dr. Head of

the results. Dr. Wang interjected herself into the issue, claiming she would take adverse employment action against Dr. Head if the results were positive. DR. BERKE's and Dr. Wang's reaction and response were clearly discriminatory and improper because DR. BERKE was known for enjoying and offering marijuana to other members of the medical staff during off hours. DR. BERKE and Dr. Wang never admonished or announced that use of marijuana would not be tolerated within the UCLA Head and Neck Department.

39. The required drug test of Dr. Head was ironically hypocritical of DR. BERKE, due to the well-known fact that DR. BERKE often smoked marijuana himself. In fact, one year, during the year-end Resident slide show, one particular slide, approved by DR. BERKE, showed DR. BERKE in his office, smoking a marijuana joint, with another doctor knocking on DR. BERKE's door informing DR. BERKE that a patient was prepped for surgery and waiting in the operating room for DR. BERKE to operate. There is also a video that was shown at another year-end event showing DR. BERKE rolling and smoking a marijuana joint. Also, on another occasion, DR. BERKE offered marijuana to Dr. Head, which was unequivocally refused by Dr. Head who does not use marijuana and did not wish to engage in illegal activity with DR. BERKE or engage in conduct to risk patient safety.

40. The Ronald Regan UCLA Medical center is accredited by The Joint Commission, an independent, not-for-profit organization, that accredits and certifies more than 19,000 health care organizations and programs in the United States. On or about July 9, 2008, The Joint Commission issued a "Sentinel Event Alert" concerning "Behaviors that undermine a culture of safety." As a requirement of accreditation, this alert should have been known to leadership and care providers within the hospital. The alert establishes a clear link between medical errors and intimidating/disruptive behaviors. A true and correct copy of the Sentinel Alert is attached hereto as Exhibit A.

41. As part of the tenure and promotion process, physicians are required to obtain references outside UCLA. In or around October 2008, while requesting such a reference from a Head and Neck surgeon at another university, DR. BERKE stated, "Dr. Head is the ONLY

minority male we have ever trained or admitted to the faculty. He was offered a minority supplement grant onto one of UCLA's most distinguished researchers, Dennis Slamon, who discovered Hercepten and has actually developed a pretty decent SCCa cell bank. I gave him a position . . . , but it has been a tremendous time sink dealing with all his EOE [EEO sic] complaints and issues (no good deed goes unpunished). He is actually a very nice genteel guy, . . despite being a minority it is going to be very close and probably unattainable . . . gb"

42. In early 2009, Dr. Head again consulted with Dr. Becerra regarding Dr. Wang's unfair and improper evaluations of Dr. Head and her treatment of Dr. Head in assignments and research opportunities. Dr. Becerra responded, "Oh my God, here we go again. I am going to legal with this." Dr. Becerra replied, "Come back to see me if you don't get tenure, otherwise you're not damaged."

43. In or around January 2009, in an attempt to further sabotage Dr. Head's tenure and career advancement at UCLA, Dr. Wang was submitting false evaluations and DR. BERKE misrepresented to CAP the number of research publications that Dr. Head had completed. DR. BERKE falsely stated that Dr. Head only had one publication. Once Dr. Head learned there was an "issue" concerning his promotion, in order to fully prove that DR. BERKE's statements were false, Dr. Head submitted a complete list of his research, detailing over twenty publications completed by Dr. Head.

44. In or around January 2009, Dr. Head presented to Dr. Gold a report conducted at an affiliated hospital showing findings that Dr. Wang was biased against Dr. Head in her evaluations of his performance, assignments, and research. When Dr. Head first received this report, Dr. Head informed DR. BERKE that he had this report and could prove that Dr. Wang was treating him differently and unfairly in assignments and research opportunities. DR. BERKE offered to pay Dr. Head for the report saying, "How much do you want for the report? You can't release that report." Dr. Head replied that he did not want money, he wanted to be treated fairly and to receive the tenure he deserved and had earned.

45. In or around February through July 2009, Dr. Head reported to Dr. Carlos Mechoso ("Dr. Mechoso"), then-Chair of the Academic Senate, the various problems and issues he was having regarding DR. BERKE and Dr. Wang, such as incorrect salary compensation and Dr. Wang's unfair and improper evaluations and treatment regarding assignments and research. Dr. Mechoso responded that an investigation would need to be conducted.

46. On several occasions, regarding Dr. Wang's unfair treatment and improper evaluations of Dr. Head's performance, Dr. Head individually met with Dr. Gold, Dr. Rosenthal, Dr. Mechoso, and Dr. Becerra, all of whom communicated a similar message that if Dr. Head wanted tenure, he better not take any action against Dr. Wang.

47. In or around June 2009, at the year-end Resident graduation, Dr. Head observed DR. BERKE caressing and exchanging an open-mouthed, prolonged kiss with Dr. Wang. Dr. Head immediately told DR. SERCARZ, who was standing next to Dr. Head but did not see the kiss, what he saw. Several days later, when Dr. Head confronted DR. BERKE about this, DR. BERKE acknowledged the conduct, but DR. BERKE stated that he was drunk at the event. Based on UCLA policy preventing romantic relationships between supervising faculty members, Dr. Head reported to UCLA leadership, Dr. James Economou, Division Chief of Surgical Oncology, that Dr. Wang and DR. BERKE were engaged in a romantic relationship. Additionally, numerous other UCLA physicians and staff observed and discussed the romantic relationship between Dr. Wang and DR. BERKE, including a witness at an affiliated hospital where Dr. Wang would discuss her relationship with DR. BERKE with colleagues and staff. Based on Dr. Head's report of this inappropriate romantic relationship between DR. BERKE and Dr. Wang pursuant to UCLA policy, Dr. Head began to endure further harassment and retaliation.

48. A few days later, Dr. Head confronted DR. BERKE about DR. BERKE's romantic relationship with Dr. Wang. Dr. Head told DR. BERKE that he had seen DR. BERKE and Dr. Wang kissing while Dr. Head was standing talking with DR. SERCARZ.

49. In or around July/August 2009, Dr. Head met with Fawzy Fawzy, M.D. ("Dr. Fawzy"), Executive Dean of the School of Medicine, to discuss several issues throughout the

hospital. During this meeting, when Dr. Head reported the inappropriate relationship between DR. BERKE and Dr. Wang, Dr. Fawzy stated that he did not care if DR. BERKE and Dr. Wang were having a romantic/sexual relationship (despite such behavior being in violation of UCLA Policy). Dr. Head told Dr. Fawzy that this inappropriate relationship was having negative consequences.

50. In or around October 2009, Dr. Head asked Dr. Slamon whether he would support him in his complaint regarding DR. BERKE and Dr. Wang. Dr. Slamon laughed and informed Dr. Head, "It does not surprise me that Berke and Wang are involved." Repeatedly, Dr. Slamon warned Dr. Head, "Stay away from it, or they will destroy you if you expose them."

51. On or about October 15, 2009, Dr. Head sent Dr. Mechoso an email which read "I recently received information from multiple faculty members and UCLA/VA workers that there is a 'relationship' between two faculty members related to my case. This information is of a sensitive nature and has had a direct impact on my past work environment and will affect my future at UCLA."

52. In or around October 2009, even after Dr. Head obtained tenure, Dr. Mechoso was concerned about the issue of harassment and discrimination by DR. BERKE and Dr. Wang and their violations of UCLA Policies. Dr. Head discussed with Dr. Mechoso the inappropriate romantic/sexual relationship between DR. BERKE and Dr. Wang. Dr. Head informed Dr. Mechoso that he had witnessed DR. BERKE and Dr. Wang kissing, saw them go upstairs together late one night when the office was closed, and had learned from several other sources that they were involved in a relationship. Dr. Mechoso told Dr. Head, "Give me DR. BERKE's number." After his discussion with DR. BERKE, Dr. Mechoso told Dr. Head, "They're having a relationship. This is serious, her contract could be removed and he could be sanctioned." Dr. Head continued to endure harassment and retaliation for making this protected report regarding violation of UCLA policy. The sexual favoritism between DR. BERKE and Dr. Wang was adversely affecting Dr. Head's career at UCLA.

53. Around this time, Dr. Head met with DR. BERKE to discuss DR. BERKE's actions. DR. BERKE began crying and threatening Dr. Head that "this is going to end very badly for you."

54. Following this meeting, Dr. Head met with DR. SERCARZ and warned DR. SERCARZ that DR. BERKE was planning to retaliate against DR. SERCARZ.

55. Around this time, Dr. Thompson, based on "information he got from UCLA," suggested to William Loos, M.D. ("Dr. Loos"), Medical Director at Olive View, that the County should investigate DR. SERCARZ and "pull his surgery records."

56. From November 2010 to present, material witnesses who show support, or tell the truth in support of Dr. Head, have been directly retaliated against in their assignments, withdrawal of departmental support, and/or threat of taking away business or patients. DR. SERCARZ has been directly retaliated against for truthfully responding to inquiries regarding and in support of Dr. Head.

57. In or around November 19, 2010 through March 4, 2011, a directive was issued by managers of the Head and Neck Department such that Dr. Head's schedule was routed to another support staff scheduler named "Lorena," causing disruption with patient care, patient dissatisfaction, and the appearance that Dr. Head was unprofessional and inaccessible. After the times Dr. Head was objecting to the unlawful conduct of DR. BERKE and Dr. Wang, this same support staff was part of the team designated by DR. BERKE to send emails to Dr. Head to make it appear that Dr. Head was not responsive to inquiries and requests for information.

58. Furthermore, in or around late December 2010 to early January 2011, Dr. Head complained to DR. BERKE about his scheduling and lack of patients. DR. BERKE stated "it's not a Black thing" when asked why he was sending all Dr. Head's calls to another secretary "Lorena," off-site, resulting in drastically fewer patients scheduled for Dr. Head and drastically less income.

59. In or around January 2011, DR. BERKE commented to Dr. Head that the Martin Luther King Holiday is the day they celebrated the "assassination" rather than the birthday of

Martin Luther King. Also, in or around March 2011, DR. BERKE commented that Dr. Head's nieces' death "must have been an overdose" because she is a young black woman.

60. In or around February/March 2011, when it became known that Dr. Head had reported to Vice Provost Littleton the harassment, discrimination, retaliation, and financial issues he was experiencing, both Dr. Busuttil and DR. BERKE offered Dr. Head additional compensation or personal loans. Additionally, DR. BERKE threatened Dr. Head, telling him that he will never become a board examiner and threatening his privileges and reputation.

61. On April 20, 2011, Dr. Head filed a complaint of discrimination under the provisions of the California Fair Employment and Housing ("FEHA") which was assigned case number E201011R7497-00. In his DFEH complaint, Dr. Head alleged harassment, discrimination, and retaliation based upon his race, his participation in protected activities, and for his association with people of color. Specifically, as to Dr. Head's protected activities, Dr. Head noted his participation in a race discrimination investigation and investigations by the United States IG concerning Defendant Dr. Wang.

62. On April 22, 2011, notice of Dr. Head's DFEH complaint was provided directly to Defendant Regents and Dean Washington. Also on April 22, 2011, Dr. Head disclosed that all unlawful conduct prior to this time had been brought "to the attention of all levels of management within the school of medicine at UCLA and to the Vice Provost of Diversity to no avail."

63. On or about April 25, 2011, Dr. Head sent to his supervisors, Dr. Fawzy, Dr. Busuttil, Dean Washington, and Vice Provost Littleton, a letter stating that he was being discriminated against by UCLA.

64. In or around May 2011, Dr. Busuttil indicated to Dr. Head that Dr. Busuttil did not want any more communications regarding DR. BERKE.

65. In or around June 2011, in an effort to further discredit Dr. Head, Dr. Wang began making accusations of wrongdoing against Dr. Head. Dr. Wang stated to a group of surgeons that Dr. Wang was sure Dr. Head would not last long and that he would be investigated at an affiliate hospital where Dr. Wang is Chief of Head and Neck Surgery.

66. In or around June 2011, Dr. Head participated in a UCLA internal investigation conducted by Pamela Thomason, Title IX officer in the Chancellor's office regarding Dr. Head's claims of discrimination, harassment, retaliation, and whistleblowing issues, as well as DR. BERKE's unlawful behavior. Dr. Head reported that DR. BERKE continued to protect Dr. Wang, rather than protect patient safety, by failing to report Dr. Wang's medical malpractice and Risk Management cases to the Review Board or make Dr. Wang report them to the California Medical Board—a clear violation of state laws. Thomason never actually inquired into or questioned witnesses regarding this illegal behavior by DR. BERKE. Following this investigation, DR. BERKE contacted several material witnesses, including DR. SERCARZ, and threatened them regarding their employment if they were to offer support for Dr. Head or corroboration of his reports and complaints.

67. In or around July 2011, DR. SERCARZ was interviewed by Thomason regarding UCLA's discrimination against Dr. Head. DR. SERCARZ told Thomason that he feared retaliation for providing truthful testimony concerning Dr. Wang's discrimination and the facts of the Gorilla Slide, as well as other illegal acts committed by DR. BERKE and Dr. Wang against Dr. Head. Thomason did not offer DR. SERCARZ any protection from retaliation; instead, Thomason told DR. SERCARZ that it seemed he was under stress and, as a result, DR. SERCARZ should leave UCLA.

68. DR. SERCARZ discovered that the information he disclosed to Thomason, which he thought was confidential, was being shared with DR. BERKE and others within UCLA.

69. Also around this time, DR. SERCARZ was receiving tremendous pressure from Thomason and UCLA Vice Chancellor of Legal Affairs, Kevin Reed ("Reed"), who claimed that DR. SERCARZ was the only person supporting Dr. Head. Thomason and Reed shared information about other witnesses and tried to dissuade DR. SERCARZ from telling the truth about the discrimination and retaliation against Dr. Head. DR. SERCARZ provided the names of other witnesses, but Thomason and Reed insisted that nobody else was supporting Dr. Head.

70. Soon thereafter, DR. BERKE sent an email to DR. SERCARZ, inquiring about DR. SERCARZ's role as a witness in Dr. Head's case. Specifically, DR. BERKE wanted to know why DR. SERCARZ had emailed Dr. Crane. DR. BERKE contacted DR. SERCARZ, and in an angry, threatening voice said, "What are you doing? Why are you calling Ben Crane trying to get the slide? Why are you helping Chris? His case is bullshit!"

71. On or about July 15, 2011, DR. SERCARZ immediately complained to Thomason and Reed about DR. BERKE's email and phone call, telling them he was being retaliated against for speaking honestly about Dr. Head. Reed did not offer any protection to DR. SERCARZ from retaliation.

72. In response to DR. SERCARZ's complaints of retaliation, DR. BERKE sent DR. SERCARZ a text message which read, "Hey Joel everything is cool. NBD [no big deal] with helping Chris [Head]. I promise you're going to be fine with the county hassles. Gb."

73. DR. BERKE's reference to "the county hassles" referred to the County's sham investigation of DR. SERCARZ's time cards. In or around late 2009, the County, with direction and support from UCLA, launched an investigation into DR. SERCARZ's County time cards in an attempt to retaliate against DR. SERCARZ and pressure him to resign his employment with the County and/or UCLA. However, DR. SERCARZ's time cards were often completed by an assistant, Lorena Ponce ("Ponce"), who would fill in DR. SERCARZ's time cards based on the schedule or by copying older time cards. Ponce would often complete time cards for approximately 20-30 other surgeons.

74. The time card investigation against DR. SERCARZ was ironic considering the fact that DR. SERCARZ was one of the few physicians at Olive View who actually fulfilled his hourly commitment. In fact, DR. SERCARZ would spend countless hours of his own time conducting research and performing clinical duties at Olive View, more than any other Head and Neck Surgeon. Additionally, DR. SERCARZ is aware of other department members who did not fulfill their commitments to Olive View, but none of these physicians have been investigated for time card issues, let alone terminated. Coincidently, none of these other physicians had the courage to

testify truthfully about the rampant discrimination and retaliation at UCLA, specifically the illegal behavior directed at Dr. Head.

75. DR. SERCARZ informed the County of his role as a witness for Dr. Head in his claims against UCLA and that DR. SERCARZ believed the time card investigation was in retaliation for truthful testimony and support of Dr. Head. As such, in light of the County's close affiliation with UCLA, the County should have brought in an outside investigator; instead, the County's "investigation" was performed by an internal, County employee, Nicole Young ("Young").

76. The County initially attempted to explain its decision to single-out and retaliate against DR. SERCARZ by claiming that UCLA's administration started the investigation. Later, the County claimed that it received an "anonymous" complaint concerning DR. SERCARZ. The County neither shared the anonymous complaint with DR. SERCARZ, nor did it investigate the motives of the anonymous complaining party. Actually, the truth was later revealed when Dr. Loos testified that there in fact was never an anonymous complaint.

77. The County's investigation relied heavily on information provided to the County by UCLA. In support of this sham time card investigation against DR. SERCARZ, UCLA provided the County with private patient operating room records/logs without DR. SERCARZ's consent and without the consent of the patients, despite HIPAA laws prohibiting the disclosure of these records. DR. SERCARZ's believes and thereon alleges that DR. BERKE was aware of UCLA's role in the time card investigation, and not only supported but actually instigated the County's investigation in an attempt to retaliate against DR. SERCARZ for supporting Dr. Head. In fact, DR. BERKE learned from Dr. Wang's time card fraud at the VA that the best way to cause problems for a physician was to allege time card fraud.

78. DR. SERCARZ communicated with DR. BERKE about DR. SERCARZ's fears of retaliation and concerns about losing his job at the County. DR. BERKE attempted to assuage DR. SERCARZ's concerns by providing false oral and written assurances that the County's investigation would not result in DR. SERCARZ's termination. DR. BERKE claimed that

"others" at the county were "out to get" DR. SERCARZ; however, the truth was that DR. BERKE was out to get DR. SERCARZ because DR. SERCARZ was supporting Dr. Head, and DR. BERKE clearly had the power and authority to influence the investigation and termination of DR. SERCARZ.

79. On or about August 15, 2011, DR. SERCARZ received an intimidating letter from UCLA regarding the settlement of another case called *Hack v. UC Regents*. The letter threatened to report DR. SERCARZ to the Medical Board on alleged charges of malpractice. Although DR. SERCARZ was not a defendant in the *Hack* case, UCLA's threatening letter to DR. SERCARZ was intended as a form of retaliation for DR. SERCARZ's testimony in Dr. Head's case. This letter was also intended to demonstrate to DR. SERCARZ that UCLA had the power and ability to destroy DR. SERCARZ's career if he continued to testify truthfully in support of Dr. Head. In an attempt to protect his name and reputation, DR. SERCARZ immediately responded to this letter. However, as further evidence this letter was only intended to intimidate DR. SERCARZ, no report was ever made against DR. SERCARZ to the Medical Board.

80. On August 17, 2011, Dr. Head filed a complaint of Harassment under the provisions of the California Fair Employment and Housing ("FEHA"), which was assigned case number E201112R5615-01. In his FEHA complaint, Dr. Head alleged harassment based upon his race, his participation in protected activities, and for his association with people of color. Specifically, as to Dr. Head's protected activities, Dr. Head noted his participation in a race discrimination investigation and investigations by the United States IG concerning Defendant Dr. Wang.

81. In or around August 2011, after filing a DFEH complaint and reporting the details of the harassment, discrimination, and retaliation to the Chancellor's office and its investigator, Dr. Head was called out of town. While Dr. Head was gone, Regents, through the Santa Monica UCLA Medical Center and Orthopaedic Hospital Administration, sent a memo to "discipline" Dr. Head for not covering his "on call duty;" however, Dr. Head had provided coverage during his absence and notified the paging operator and hospital administrator of this coverage. DR. BERKE

took additional steps to make it appear as though Dr. Head was not taking care of his patients while out of town, such as (1) placing Dr. Head's name on the surgical schedule, knowing he was out of town, and (2) sending text messages suggesting that Dr. Head was not covering and caring for his patients. In DR. BERKE's text message to Dr. Head, he stated that "Dr. Blackwell is covering for you." When in fact, Dr. Blackwell never saw this patient and Dr. Head was literally sitting with the patient when he received DR. BERKE's text message. Had Dr. Head not been in town, this critically ill patient would not have been covered by Head and Neck attending physicians or residents.

82. At all relevant times and according to UCLA policy, Residents are required to provide medical coverage for patients of Attending Physicians/Head and Neck Surgeons when they are not available, or at night and/or emergencies. Contrary to this policy, in or around September 2011 to present, leadership of the UCLA Head and Neck Department has instructed Residents that they are not to provide medical coverage to Dr. Head, and only Dr. Head. All other Attending Physicians/Head and Neck Surgeons at UCLA, who are not black, have Head and Neck Residents assist with their surgical cases, especially complex cases. As a clear act of reprisal, Dr. Head is denied Residents to assist on his complex cases or to provide medical coverage. For example, one Resident, Dr. Duarte was instructed that he did not have to assist Dr. Head with his surgical cases.

83. In September 2011, Alice Huffman ("Ms. Huffman") of the NAACP sent a letter to the Regents, including Regents President Mark Yudof, explaining the Gorilla Slide and the mistreatment, discrimination, harassment, and retaliation against Dr. Head. Ms. Huffman asked the Regents to take a serious look at this horrific incident. Regents Vice President and General Counsel for Legal Affairs, Charles Robinson responded to Ms. Huffman that the campus investigated but found no merit to Dr. Head's allegations.

84. On October 6, 2011, Dr. Head sent a letter addressed to Dr. Gene Block ("Chancellor Block"), Chancellor of UCLA, with Dean Washington, Dr. Busuttil, Keith Parker, and Christine Littleton copied. In this letter, Dr. Head complained about the disruptive and

intimidating behavior in the workplace, including harassing and retaliatory behavior he was experiencing, such as: (1) attempts to terminate his privileges at Santa Monica UCLA Medical Center and Orthopaedic Hospital by DR. BERKE using false allegations that Dr. Head was not provided call coverage, (2) refusal by the department to provide Dr. Head with Resident coverage or assistance, (3) false statements by DR. BERKE that Dr. Blackwell was covering Dr. Head's patients, (4) DR. BERKE placing Dr. Head on the surgery schedule when he knew Dr. Head would be out of town, and (5) ongoing and escalating racial harassment and discrimination. This communication is attached hereto as Exhibit B.

85. On October 11, 2011, Dr. Head filed a complaint of harassment, discrimination, and retaliation under the provisions of the California Fair Employment and Housing ("FEHA") which was assigned case number E201112R6252-01. In his DFEH complaint, Dr. Head alleged harassment based upon his race, his participation in protected activities, and for his association with people of color. Specifically, as to Dr. Head's protected activities, Dr. Head noted his participation in a race discrimination investigation and investigations by the United States IG concerning Defendant Dr. Wang.

86. On October 13, 2011, notice of Dr. Head's DFEH complaints filed August 17, 2011 and October 11, 2011 was served directly on Defendants DR. BERKE and Dr. Wang with Dr. Busuttil copied.

87. On October 14, 2011, notice of Dr. Head's DFEH complaints filed August 17, 2011 and October 11, 2011 was served directly on Chancellor Block, Dean Washington, and Mark Yudof, President of the University of California. This letter also explained how the investigation conducted by UCLA was a sham and how Regents failed to address the ongoing retaliation against Dr. Head. This notice is attached hereto as Exhibit C.

88. To date, Regents have taken no action against DR. BERKE for his harassment, discrimination, and retaliation of Dr. Head or his actions against DR. SERCARZ. Rather, in or around January 2012, DR. BERKE was promoted by Regents to Chairman of the UCLA Department of Head and Neck Surgery.

89. The County, by and through Dr. Thompson, Chief of Staff at Olive View, Nicole Young, and other County employees and managing agents, have published numerous post-termination, non-privileged defamatory and disparaging remarks to uninterested County employees and third parties. These defamatory remarks falsely accuse DR. SERCARZ of being dishonest and engaging in misconduct, namely timecard fraud. (A true and correct copy of the first page of DR. SERCARZ's County personnel file is attached hereto as Exhibit D.) The County, by and through Dr. Thompson, Nicole Young, and other County employees and managing agents, knew or should have known that these defamatory statements were false and that these defamatory statements would injure Plaintiff's name and professional reputation.

90. Beginning on or about February 20, 2012, several Head and Neck residents, including Dr. DeConde, Dr. Sidell, Dr. Jagmeet Mundi, Dr. Audrey Calzada, and Dr. Ashley Balaker exchanged a series of emails which contained perhaps the most egregious form of retaliation imaginable in a hospital environment. In these emails, Dr. DeConde, Dr. Sidell, Dr. Mundi, Dr. Calzada, and Dr. Balaker discuss how they intend to use the health, safety, and care of patients as a form of retaliation against Dr. Head. These resident surgeons discuss and agree on a plan that includes not covering Dr. Head's patients, not covering his cases, not assisting in his surgical cases, and not staffing his patient's rooms, thereby expressly agreeing to intentionally jeopardize the health and safety of patients at UCLA hospital. For example, Dr. DeConde states, "I have been thinking about how to handle the mandate to cover Dr. Head . . . . Part of me wants to continue to ignore until someone gets more mad at us." Dr. Calzada replies, "what if we just refuse to cover him and say based on the previous 'collective' resident experience, we refuse to staff his room? what can they (vishad, berke) honestly do if we as a program flat out refuse to cover his cases . . . ?" Dr. Balaker replies, "that if we are going to refuse to cover his cases we have to all agree and stick to it." Dr. Balaker further states that it would be good "if no residents are scrubbed in his cases." Dr. Mundi suggests that "we cover his room as a last priority (even after peds), sending a token R4/3 to cover a septo or two next week, then not again for another month, then maybe another random friday to cover another septo. I think that will be enough to

keep things quiet and we can go on ignoring him for the most part." Finally, regarding the requirement to staff Dr. Head's cases, Dr. Sidell adds that they should "talk to the people who are supposedly making the rules that we don't like, especially if we are going to break them."

91. In or around February 2012, DR. SERCARZ was terminated from his employment with Olive View. The County's decision to terminate DR. SERCARZ for time card fraud is clearly pretextual and designed to cover up and conceal retaliatory motives by DR. BERKE and UCLA.

92. In fact, Dr. Thompson has testified that he refused to sign DR. SERCARZ's termination notice because he did not support the termination decision.

93. In fact, time cards have a limited role because DR. SERCARZ is a salaried, exempt employee, such that time cards were not required for him to be paid. As a salaried, exempt employee, DR. SERCARZ's time cards do not establish his actual pay or his meal breaks, rest breaks, or overtime pay. DR. SERCARZ was not required to record actual hours worked, unlike non-exempt employees who must record actual hours worked to calculate their rat of pay (straight time and overtime rates) and compensation for missed meals or rest breaks. It is absurd that the County would claim "time card fraud" and the basis for terminating and defaming DR. SERCARZ.

94. The time cards under attack were old, and represented a tiny sample of actual time records pertaining to DR. SERCARZ's employment. The time card investigation determined alleged violations during a three-month period between January 4, 2010 and March 31, 2010 even though DR. SERCARZ worked for the County for almost twenty years, at over 230 months. The County questioned only 19 incidents. The time cards under attach, therefore, constituted substantially less than one percent (.01%) of the time spent by DR. SERCARZ at the County.

95. Of the 19 disputed time cards, there are perhaps two time cards that may have required clarification. Furthermore, many of DR. SERCARZ's time cards were completed by Ponce. Several time cards at issue pertained to days when DR. SERCARZ did not have morning responsibilities because Akira Ishiyama, M.D. ("Dr. Ishiyama") was assigned at that particular time. In these instances, the time cards were filled out in a pattern, as instructed by Ponce.

96. Additionally, it was discovered that 14 of these 19 time cards involved work performed in the form of administrative hours. DR. SERCARZ was not instructed on the definition of "administrative hours" until June 2011, when DR. SERCARZ met with Rima Matevosian, M.D. ("Dr. Matevosian") (over one year after the subject time cards were filled out) regarding the County's administrative hours policy. Dr. Thompson distributed a written policy statement following this meeting in June 2011 wherein he clarified the County's administrative hours policy. There was no clarification of the meaning of "administrative hours" prior to the June 2011 meeting. Under these circumstances, it was unfair and made no sense for the County to attach time cards from an earlier time period when the County had not provided training or clarification on the administrative hours policy.

97. Following DR. SERCARZ's termination from the County, DR. BERKE attempted to conceal his retaliatory motives by offering DR. SERCARZ a better compensation package at UCLA. The timing and circumstances of DR. BERKE's financial offer was interesting and had the appearance of an attempt to keep DR. SERCARZ from further supporting Dr. Head.

98. On March 23, 2012, Dr. Head sent a follow up letter addressed to Chancellor Block referencing his prior letter (Ex. B) of October 6, 2011. In this follow up letter, signed under penalty of perjury, Dr. Head again complained about the daily harassing, retaliatory, and disparaging behavior he was experiencing and UCLA's failure to respond to this retaliation. Dr. Head specifically addressed the misuse of his NIH funding by UCLA, failure of UCLA to schedule patients with Dr. Head, racial discrimination, illegal conduct by DR. BERKE and Dr. Wang, and threats to patient care and safety, including residents being removed from covering Dr. Head's surgical cases. Dr. Head also stated UCLA reported that it did not find any evidence to support his claims after investigating. This communication is attached hereto as Exhibit E.

99. On or about April 17, 2012, in an attempt to further harass and retaliate against Dr. Head, DR. BERKE told Dr. Gerratt that DR. BERKE refused to consult on any of Dr. Head's cases, thereby significantly compromising patient safety.

100. On or about April 17, 2012, Dr. Head filed a lawsuit against Regents, DR. BERKE, and Dr. Wang for: (1) Discrimination, (2) Harassment, (3) Failure to Prevent harassment, Discrimination and Retaliation, (4) Retaliation under FEHA, (5) Retaliation under Labor Code 1102.5, (6) Intentional Infliction of Emotional Distress, and (7) Retaliation under Government Code 8547. The case, *Christian Head, M.D. v. Regents of the University of California, et al.*, Case No. BC 482981, was filed in Los Angeles Superior Court. The complaint was later amended to include defendants Dr. Suh, Dr. Crane, and Dr Lee, as well as causes of action for Retaliation under Health and Safety Code 1278.5 and Defamation. The filing of this case generated publicity, both online and in the mainstream media, and DR. SERCARZ's name was disclosed by the media as a key witness in Dr. Head's case.

101. On or about May 2, 2012, an article came out in the Wave discussing Dr. Head's lawsuit against UCLA. In this article, DR. SERCARZ was publicly identified as a witness in Dr. Head's case. In regards to DR. SERCARZ, the article stated:

> There were about 200 people at the event but everybody didn't find it funny, though. Dr. Joel Sercarz, professor of surgery, was still so offended by "The Gorilla Slide" that he sent an email to UCLA Chancellor Gene Block after he made a stirring campus-wide call for "tolerance, civility and respect" last month.
>
> "I appreciate your concern about diversity and tolerance," Dr. Sercarz wrote, "But why allow my colleague, Dr. Head, an African-American physician to be depicted at a UCLA event with his head superimposed on the body of a gorilla? You are aware of this, aren't you?" Dr. Sercarz has received no reply to his March 10 email to Chancellor Block

(A true and correct copy of this article is attached hereto as Exhibit F.)

102. Since the time DR. SERCARZ was disclosed as a witness to Dr. Head's case, DR. SERCARZ has experienced extreme ostracism and further retaliation. DR. SERCARZ has suffered a drop in patient referrals. Many of DR. SERCARZ's professional colleagues at UCLA no longer speak to him. When DR. SERCARZ confronted one of his colleagues about the change in treatment toward him, his colleague admitted that it was because DR. SERCARZ was supporting Dr. Head. DR. SERCARZ knows that Dr. Head has experienced a loss of support from UCLA residents during surgeries. DR. SERCARZ has also suffered from a lack of support in retaliation for his role as a witness in Dr. Head's case.

103. On or about May 18, 2012, Dr. Head was denied the assistance of residents or other Head and Neck physicians on a complex surgical case where such assistance would otherwise be routinely provided, severely compromising patient safety.

104. On May 20, 2012, Dr. Head sent a letter addressed to Chancellor Block and Dean Washington with Dr. Rosenthal and Dr. Feinberg copied. In this letter, Dr. Head complained about dangerous and potentially life threatening patient care and safety issues by UCLA. Specifically, Dr. Head reported UCLA's failure in providing him with Resident assistance during high-risk surgical cases. In this letter Dr. Head stated, "On Friday, May 18, 2012, I performed a very difficult and high-risk surgery on a UCLA Medical Center patient. . . . I was denied surgical assistance of residents/physicians in the department, which would have routinely been granted in such a case. . . . I have an obligation to protect my patients from harm. It is unacceptable to subject my patients to increased surgical risk due to the University's unjust behavior." This communication is attached hereto as Exhibit G.

105. On May 22, 2012 and May 30, 2012, Chancellor Block sent a communication through an email and then through the UCLA press, respectively, to all employees, students, and faculty of UCLA stating there was "no substantiation" for Dr. Head's claims. In this communication, which also went to Dr. Head, Chancellor Block specifically acknowledged, "The person making these allegations [Dr. Head], was given all the information necessary to decide whether to make full use of those internal procedures or **to bypass them in favor of the legal system.** ***That is a choice any faculty member . . . can make.***" This communication is attached hereto as Exhibit H.

106. Since the May 2012 publication in the Wave publicly identifying DR. SERCARZ as a witness in Dr. Head's case, DR. SERCARZ has received intense hostility from members of the UCLA Head and Neck department, including DR. BERKE and Dr. Suh.

107. In fact, in or around June/July 2012, Dr. Suh told DR. SERCARZ, that if DR. SERCARZ continued to help and support Dr. Head, DR. SERCARZ would be punished by the other surgeons throughout the Head and Neck Department and nobody would assist him on cases.

Dr. Suh would say to DR. SERCARZ, "Why would you do that? Why would you help Chris?" Around this same time, Dr. Suh also threatened DR. SERCARZ not to assist Dr. Head with his complex surgical cases or UCLA would not help or refer cases to DR. SERCARZ. Dr. Suh claimed he was speaking on behalf of Dr. Wang in regards to these threats. Additionally, Dr. Suh threatened Cappalonga, a surgical supply representative of Balloon Sinuplasty supplies with Johnson & Johnson, that UCLA would withhold orders of his product if he assisted or supplied Dr. Head or DR. SERCARZ with necessary surgical supplies, or provided Dr. Head with any assistance regarding his lawsuit. These threats by Dr. Suh dangerously compromised patient health and safety by attempting to prevent DR. SERCARZ from assisting Dr. Head, and by trying to force DR. SERCARZ and Dr. Head to use medically inferior surgical supplies.

108. On or about July 10, 2012 Dr. Head sent a letter to Chancellor Block, Dean Washington, Dr. Jonathan Hiatt ("Dr. Hiatt"), Vice Dean for Faculty-David Geffen School of Medicine, DR. BERKE, Dr. Wang, and Dr. Suh. In this letter, Dr. Head complained that: (1) physicians and residents were being threatened not help Dr. Head with surgeries, (2) other physicians were being told that if they assist Dr. Head with his complaints against UCLA, it would be problematic for them in the department, and (3) a medical supply representative was told not to provide supplies or support to Dr. Head or it would adversely affect UCLA's future orders with him. This communication is attached hereto as Exhibit I.

109. On or about August 2, 2012, in further harassment and retaliation against Dr. Head, Dr. Wang refused to treat one of Dr. Head's patients, leaving the patient in the emergency room for days, using the patient's care and safety as a weapon against Dr. Head, creating a hostile environment and jeopardizing patient safety.

110. On or about August 8, 2012, one of Dr. Head's patients, who had been told that Dr. Head no longer worked at UCLA and that he needed to come in to schedule with a new doctor, drove miles to see Dr. Head at the clinic. Dr. Head informed this patient that "Yes, I do still work here."

111. On the same day, in yet another example of Defendants using the patients' care and safety as a weapon against Dr. Head and creating a hostile environment, thereby jeopardizing patient safety, another of Dr. Head's patients, a Black woman, was disrespected and mistreated by the UCLA Head and Neck Clinic staff. This patient reported to Dr. Head that staff was disrespectful toward her, treated her rudely, and made her wait over an hour, taking other patients out of turn in order to intentionally aggravate her. She noted that the staff was not treating other physicians' patients this way. These patients, and others, were given DR. BERKE's business card and told by hospital administrator, Judy Williams, "If you're upset, file a complaint *against* Dr. Head." However, none of these patients were upset with Dr. Head, but rather with the Head and Neck Department staff and DR. BERKE.

112. In a letter dated August 13, 2012 and emailed August 24, 2012 to Dean Washington, Dr. Rosenthal, and Dr. Hiatt, Dr. Head again complained about the harassing and retaliatory behavior he was experiencing, such as: (1) his patients being retaliated against, demeaned, and treated with hostility and rudeness, (2) his patients being taken away which was upsetting the patients, (3) the false reports that Dr. Head was not returning his pages, and (4) the staff failing to forward Dr. Head's messages to him. This communication is attached hereto as Exhibit J.

113. On or about September 17, 2012, DR. SERCARZ filed a complaint with the Department of Fair Employment and Housing against Regents. Shortly thereafter, this complaint, signed under penalty of perjury, was served on DR. SERCARZ's supervisor/manager.

114. On or about September 21, 2012, DR. SERCARZ filed a civil action against Regents of the University of California and County of Los Angeles for Retaliation, Discrimination, and Defamation. The case, *Joel Sercarz, M.D. v. Regents of the University of California, et al.*, Case No. BC 492513, was filed in Los Angeles Superior Court and is currently ongoing.

115. In or around September 2012, during an event at Dr. Blackwell's home, some graduating Residents showed a video disparaging Dr. Head and DR. SERCARZ. In this video, Dr. Head was ridiculed for exposing the truth of the Gorilla Slide. DR. SERCARZ was depicted in a

"memorial" montage showing pictures of DR. SERCARZ as if he had recently died, which was meant to refer to the demise of DR. SERCARZ's professional career because of his participation as a witness in Dr. Head's case. DR. BERKE and Dr. Nabili knew the contents of the video and that it was to be shown during this event.

116. On or about July 18, 2013, UCLA release a statement which read:

> The Regents of the University of California and Dr. Christian Head today reached a settlement in a civil case he brought against the University last year. The case presented difficult issues of alleged discrimination and retaliation that were strongly contested.
>
> The University acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The University regrets that this occurred. The University does not admit liability, and the parties have decided that the case should be resolved with a mutual release of all legal claims. The matter was settled to the mutual satisfaction of the parties.

(A true and correct copy of this press release is attached hereto as Exhibit L.)

117. Despite this "acknowledgment" and "University regret," DR. SERCARZ has still yet to receive an apology from any member of the Regents, UCLA, or the County for the adverse employment actions taken against him for his role and support in Dr. Head's lawsuit. In fact, to this day, DR. SERCARZ still continues to endure harassment and retaliation for his involvement in Dr. Head's lawsuit.

118. On or about July 25, 2013, it was reported that Dr. Head settled his lawsuit for $4.5 million. (A true and correct copy of this article is attached hereto as Exhibit M.)

119. On or about October 15, 2013, a report was released outlining the findings of a year-long independent investigation regarding acts of bias and discrimination involving faculty at UCLA. This investigation, led by former California Supreme Court Justice Carlos Moreno, "conclude[d] that UCLA's policies and procedures for responding to incidents of perceived bias, discrimination and intolerance involving faculty are inadequate." This report further found:

> Our review suggests that UCLA's reaction to a report of a perceived incident of bias or discrimination directed toward a faculty member has consistently been to attempt to remedy the problem by making whole the injured faculty member, ***without any repercussions to the offending party***.
>
> . . . .

. . . However, since substantial deterrents exist to instituting formal Academic Senate proceedings as discussed below, the university's current procedures focus exclusively on remedies at the expense of investigation, fact-finding and disciplinary sanction.

. . . .

Every faculty member of color who we interviewed described incidents of perceived bias, discrimination or intolerance that they had personally experienced while at UCLA. Although nearly every one of these faculty members had achieved tenure and professional success at the university, they were still upset by these incidents. ***Almost universally, they felt that the offending parties had never been required to face consequences for their actions***.

. . . .

Despite these challenges, the Review Team finds that there is much that current university policies, procedures and mechanisms can do to improve in addressing these issues. Specifically, the Review Team concludes that:

- UCLA's nondiscrimination policy fails to adequately define discriminatory conduct;
- UCLA has failed to adequately train UCLA employees, including faculty, in what constitutes discriminatory, biased, or intolerant behavior.
- UCLA's nondiscrimination policy fails to provide for a process for responding to reports of incidents of perceived discrimination that involves investigation and referral to disciplinary proceedings;
- UCLA leadership has failed to convince at least a vocal subset of faculty members of its commitment to diversity in admissions and hiring;
- UCLA has failed to adequately inform faculty members of their reporting options for complaints and grievances;
- The process by which UCLA addresses incidents of perceived bias and discrimination is not clear;
- UCLA lacks a mechanism for the impartial investigation of such incidents; and
- UCLA has failed to clearly communicate that consequences will ensue for those engaging in biased, discriminatory, or intolerant behavior or conduct.

. . . .

The lack of a self-executing mechanism by which reports are investigated and findings made constitutes a serious shortcoming in UCLA's policies and procedures for responding to such reports. ***For instance, this system fails to communicate the consequences of violations of the university's policies on nondiscrimination and therefore fails to act as a deterrent. Faculty members complained that this has contributed to a culture of impunity at UCLA as far as perceived violations of the nondiscrimination policies are concerned***.

We further find that UCLA's policy for reacting to incidents of perceived discrimination lacks coherence and credibility. Faculty complained, almost unanimously, that the university's responses to certain high-profile incidents of perceived bias or discrimination were disappointing and unhelpful. Several faculty members noted that the Chancellor's public statements reacting to the well-publicized incidents of alleged racial bias and/or discrimination had essentially asserted that the conduct at issue in the incidents was not reflective of "the university I know." Faculty members felt that such statements, far from communicating a commitment to diversity and nondiscrimination, instead communicated that administration was out of touch with the reality of the racial climate at UCLA. As one senior faculty member complained, where nondiscrimination is concerned, the administration of UCLA is administering to a "vision rather than a reality."

University stakeholders described this disconnect as a structural issue within the Chancellor's office itself. One former senior administration official wrote in a letter to us that, "in recent years, it has been clear to me that ***UCLA's current administrative style is to actually hide 'hot button' issues*** even from its own executive leadership team, preferring a narrowly construed 'need to know' approach with respect to a range of campus incidents and problems." Several faculty members and administrators noted a belief that that the Chancellor's office does not currently include a senior African American or Latino/Latina administrator; however, this is not presently the case.

. . . .

The university stakeholders who spoke to us on the subject opined that the recent high-profile racial incidents at UCLA were merely the "tip of an iceberg" of a campus racial climate that has deteriorated markedly for students and faculty of color. "It is as if I have stepped into a time machine and been propelled backward 40 years to 1971 when Blacks, Latinos—and yes even Asians—were just beginning to enter prestigious, predominantly white institutions like UCLA in any serious numbers," one faculty member who has taught at UCLA for twenty-five years wrote in a letter.

. . . .

As noted above, UCLA's policies fail to adequately define what constitutes racial or ethnically discriminatory conduct, and fail to provide a procedure for responding to reports of such conduct. ***Similarly, UCLA's current procedures fail to rectify this problem***. UCLA currently relies on an ad hoc network of resources to respond to complaints regarding incidents of perceived bias or discrimination. However, the university has failed to adequately inform faculty members of these reporting options. For instance, the only

> comprehensive resource guide for faculty complaints and grievances, apparently created by campus counsel, is available from a relatively hard-to-reach link on the Office of Academic Personnel website.
>
> . . . .
>
> ***We find that UCLA's current procedures fail to adequately communicate the consequences that will ensue for those who engage in discriminatory conduct***. Many faculty members complained during interviews that administration officials often offered a remedy to faculty of color who had experienced an incident of discrimination, but that the ***administration rarely if ever meted out punishment to the offending party, even eschewing confrontation of that party altogether***. This approach of crafting workarounds and not punishing the individual engaging in discriminatory conduct sends the message that ***those who violate the university's policies against discrimination will not be punished***. Faculty members assert that without an effective deterrent message, ***a culture of impunity has developed at UCLA***.

Moreno, Hon. Carlos (Ret.), et al., *Independent Investigative Report on Acts of Bias and Discrimination Involving Faculty at the University of California, Los Angeles*, Oct. 15, 2013 [hereinafter *Investigative Report*] (emphasis added). (A true and correct copy of this report is attached hereto as Exhibit N.)

120. Despite Regents knowledge of DR. BERKE's illegal actions, and the settlement of Dr. Head's case related to those illegal actions, Regents still continue to employ DR. BERKE.

121. In or around late-2013, Dr. St. John was promoted to the position of co-director of the Multidisciplinary Head and Neck Oncology Group. Dr. St. John has used the prestige of this title to increase her profile in the head and neck cancer community, locally and regionally. This action constitutes retaliation by Regents because DR. SERCARZ was not considered for this position despite having more clinical experience and more research publications in the area of head and neck cancer. DR. SERCARZ should have been interviewed for this position at the very least.

122. DR. SERCARZ has suffered a severe loss of salary and benefits and experienced major financial distress, injury to his credit, damage to his professional reputation, and emotional distress as a result of the retaliation by DR. BERKE leading to the defamation and wrongful termination by County.

123. On or about January 27, 2013, DR. SERCARZ attempted to amend his complaint to add DR. BERKE as a defendant; however, the Court denied DR. SERCARZ's motion to amend

and suggested DR. SERCARZ bring a separate action. (A true and correct copy of this Order is attached hereto as Exhibit O.)

124. DR. SERCARZ has fulfilled his filing requirements pursuant to Gov't Code § 8547.10(c) by first filing a complaint with the DFEH, signed under penalty of perjury, and serving this complaint on his supervisor/manager at UCLA, on or about September 17, 2012, pursuant to Gov't Code § 8547.10(a). Plaintiff is within his right to bring this action as no other decision was reached within the 120 day time limit established by Regents as contained in the "University of California Policy for Protection of Whistleblowers from Retaliation and Guidelines for Reviewing Retaliation Complaints."

FIRST CAUSE OF ACTION

(Violation of Health and Safety Code § 1278.5)

125. The allegations set forth in this complaint are hereby re-alleged and incorporated by reference.

126. The California Legislature has determined that, in order to protect patients, "it is the public policy of the State of California to encourage patients, nurses, members of the medical staff, and other health care workers to notify government entities of suspected unsafe patient care and conditions."

127. Therefore, pursuant to California Health & Safety Code § 1278.5(b), "[n]o health facility shall discriminate or retaliate, in any manner, against any patient, employee, member of the medical staff, or any other health care worker of the health facility because that person . . . [p]resented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the medical staff of the facility, or to any other governmental entity." Pursuant to § 1278.5(i), "'health facility' means any facility defined under this chapter, including, but not limited to, the facility's administrative personnel, employees, boards, and committees of the board, and medical staff." DR. BERKE is a "health facility" pursuant to Health & Safety Code § 1278.5(i).

128. Plaintiff is an employee of Regents and a member of the UCLA medical staff. Plaintiff was formerly an employee of County and a member of the Olive View medical staff.

129. Defendant discriminated and retaliated against Plaintiff because he reported concerns about patient care, services, and hospital conditions. Furthermore, according to The Joint Commission, "Intimidating and disruptive behaviors can foster medical errors . . . . All intimidating and disruptive behaviors are unprofessional and should not be tolerated." (A true and correct copy of The Joint Commission, Sentinel Event Alert is attached hereto as Exhibit A.)

130. Section 1278.5(d)(1) states, "There shall be a rebuttable presumption that discriminatory action was taken by the health facility, or by the entity that owns or operates that health facility, or that owns or operates any other health facility, in retaliation against an employee, member of the medical staff, or any other health care worker of the facility, if responsible staff at the facility or the entity that owns or operates the facility had knowledge of the actions, participation, or cooperation of the person responsible for any acts described in paragraph (1) of subdivision (b), and the discriminatory action occurs within 120 days of the filing of the grievance or complaint by the employee, member of the medical staff or any other health care worker of the facility."

131. Discriminatory and retaliatory action was taken against Plaintiff within 120 days of presenting complaints regarding patient care, services, and/or hospital conditions.

132. California Health & Safety Code § 1278.5 has no administrative or judicial exhaustion requirement.

133. As an actual and proximate result of the aforementioned violations, Plaintiff has been harmed in an amount according to proof, but in an amount in excess of the minimum jurisdiction of this Court.

134. The above described actions were perpetrated and/or ratified by a managing agent or officer of Defendant. These acts were done with malice, fraud, oppression, and in reckless disregard of Plaintiff's rights. Further, said actions were despicable in character and warrant the imposition of punitive damages in a sum sufficient to punish and deter Defendants future conduct.

SECOND CAUSE OF ACTION

(Violation of Government Code § 8547)

135. The allegations set forth in this complaint are hereby re-alleged and incorporated by reference.

136. California Government Code § 8547.1 states, "The Legislature finds and declares that state employees should be free to report waste, fraud, abuse of authority, violation of law, or threat to public health without fear of retribution." Government Code § 8547.3(a) states, "An employee may not directly or indirectly use or attempt to use the official authority or influence of the employee for the purpose of intimidating, threatening, coercing, commanding, or attempting to intimidate, threaten, coerce, or command any person for the purpose of interfering with the rights conferred pursuant to this article."

137. Plaintiff reported "Improper Governmental Acts" to his supervisor as defined in the California Government Code § 8547.2(c).

138. Defendant violated Government Code § 8547 when he unlawfully harassed, discriminated, and retaliated against Plaintiff for his reports regarding illegal harassment, discrimination, and retaliation.

139. Government Code § 8547.10(a) states, "A University of California employee, including an officer or faculty member, or applicant for employment may file a written complaint with his or her supervisor or manager, or with any other university officer designated for that purpose by the regents, alleging actual or attempted acts of reprisal, retaliation, threats, coercion, or similar improper acts for having made a protected disclosure, together with a sworn statement that the contents of the written complaint are true, or are believed by the affiant to be true, under penalty of perjury."

140. Plaintiff fulfilled the filing requirement pursuant to Gov't Code § 8547.10(a) when he filed a written complaint with his supervisors/managers. On or about September 17, 2012, Plaintiff filed a complaint with the DFEH against Regents under penalty of perjury. This complaint was then served on Plaintiff's supervisor/manager at UCLA.

141. Government Code § 8547.10(c) states, "In addition to all other penalties provided by law, any person who intentionally engages in acts of reprisal, retaliation, threats, coercion, or similar acts against a university employee, including an officer or faculty member, or applicant for employment for having made a protected disclosure shall be liable in an action for damages brought against him or her by the injured party. Punitive damages may be awarded by the court where the acts of the offending party are proven to be malicious. Where liability has been established, the injured party shall also be entitled to reasonable attorney's fees as provided by law. However, any action for damages shall not be available to the injured party unless the injured party has first filed a complaint with the university officer identified pursuant to subdivision (a), and the university has failed to reach a decision regarding that complaint within the time limits established for that purpose by the regents. Nothing in this section is intended to prohibit the injured party from seeking a remedy if the university has not satisfactorily addressed the complaint within 18 months."

142. Plaintiff has met the requirements of Gov't Code § 8547.10(c) by first filing a complaint with the DFEH, signed under penalty of perjury, and serving this complaint on his supervisor/manager at UCLA, pursuant to subdivision (a) as outlined above. Plaintiff is within his right to bring this action as no other decision was reached within the 120 day time limit established by Regents as contained in the "University of California Policy for Protection of Whistleblowers from Retaliation and Guidelines for Reviewing Retaliation Complaints." Therefore, Plaintiff has met all his requirements pursuant to Gov't Code § 8547.10(c).

143. As an actual and proximate result of the aforementioned violations, Plaintiff has been harmed in an amount according to proof, but in an amount in excess of the jurisdiction of this Court.

144. The above described actions were perpetrated and/or ratified by a managing agent or officer of Defendant. These acts were done with malice, fraud, oppression, and in reckless disregard of Plaintiff's rights. Further, said actions were despicable in character and warrant the imposition of punitive damages in a sum sufficient to punish and deter Defendants future conduct.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment against Defendant and any other defendants who may be later added to this action as follows:

1. For compensatory damages, including, but not limited to lost wages, benefits, and non-economic damages in the amount according to proof;

2. For attorneys' fees and costs pursuant to all applicable statutes or legal principles;

3. For cost of suit incurred;

4. For punitive damages or other penalties recoverable by law;

5. For prejudgment interest on all amounts claimed pursuant to Civil Code section 3287 and/or 3288;

6. For injunctive relief to prevent Defendant from engaging in unlawful discrimination, harassment, and retaliation and to enjoin Defendant from violating California Health and Safety Code laws and for attorneys fees for enforcing said laws; and

7. For such other and further relief as the court may deem proper.

Dated: March 27, 2014

By: _____
LAWRANCE A. BOHM, ESQ.
PATRICIO T.D. BARRERA, ESQ.
BRADLEY J. MANCUSO, ESQ.

Attorneys for Plaintiff
JOEL SERCARZ, M.D.

DEMAND FOR JURY TRIAL

Plaintiff hereby demands trial by jury for this matter.

Dated: March 27, 2014

By: _____
LAWRANCE A. BOHM, ESQ.
PATRICIO T.D. BARRERA, ESQ.
BRADLEY J. MANCUSO, ESQ.

Attorneys for Plaintiff
JOEL SERCARZ, M.D.

VERIFICATION OF COMPLAINT FOR DAMAGES
CCP SECTION 446, 2015.5

JOEL SERCARZ, M.D. v. GERALD BERKE, M.D.
Los Angeles County Superior Court.

I, JOEL SERCARZ, M.D., declare:

I am the Plaintiff in the above-entitled matter. I have read the attached Complaint for Damages and hereby attest to the truth of all matters asserted therein except for those alleged on information and belief.

I declare under penalty of perjury, pursuant to the laws of the State of California that the foregoing is true and correct to the best of my personal knowledge.

3-19-14
Date

JOEL SERCARZ, M.D.

EXHIBIT A

The Joint Commission

Sentinel Event Alert

July 09, 2008

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) "Any behavior which impairs the health care team's ability to function well creates risk," says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. "If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk."

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with "blowing the whistle" on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are "let off the hook" for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
   - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
   - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
   - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
   - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
   - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

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* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

-Top-

EXHIBIT B

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

Department of Surgery—Head and Neck
62-132 Center for Health Sciences
Los Angeles CA 90095

October 6, 2011

Chancellor Eugene Block
University of California, Los Angeles

Re: Dr. Christian Head

Dear UCLA Chancellor and Department Chair and Executives:

I need your urgent attention to a serious matter. The retaliation against me, since I filed my DFEH complaint for Discrimination based on Race, Retaliation and Failure to Prevent Discrimination in April 2011, has escalated to levels that are beyond anything that I can tolerate. Each week, I am being targeted with new tactics by my boss, Dr. Gerald Berke, Chief of Head and Neck Surgery. He has recruited others in the department to participate in the retaliation so that the environment is so hostile that it is becoming impossible to work.

PRIVILEGES AT SANTA MONICA-UCLA:

Recently, Dr. Gerald Berke attempted to terminate my privileges for failing to provide call coverage. I arranged for call coverage while I was out of town on vacation. I gave written notice of the coverage arrangements to the call operator, the residents and, the hospital administrator. When I returned, I became aware that Dr. Berke was planning to adjust the Santa Monica-UCLA call schedule in anticipation of termination of my privileges at the hospital, without notice or a call to me after 18 years at UCLA. After I presented the evidence of my written notices to everyone prior to my vacation, I was placed back on the call schedule at Santa Monica-UCLA with acknowledgement by the hospital CEO that I had made adequate notification of my coverage.

RESIDENT TEACHING AND EVALUATIONS

I am the only faculty member on the head and neck surgery faculty that currently never has a resident to cover my operations. In addition, by depriving me of a surgical assistant, it prevents me from having positive teaching interactions with the residents. This removes one of my core functions as a tenured professor. The lack of resident coverage first occurred and was documented at the VA hospital.

The latest group of resident evaluations has included slanderous accusations of lying and unethical behavior. My integrity has never been questioned previously. Dr. Berke first told me about these evaluations when he came to my clinic after I filed my complaint. He asked me to drop the complaint,

stating "...I will keep your secrets if you keep mine." I reported this incident to the University at that time. Because of my core values, I would never commit such a dishonest act.

DR. BERKE'S FALSE STATEMENT "BLACKWELL COVERING YOUR PATIENT" WHEN HE THOUGHT I WAS OUT OF TOWN

In another incident, when Dr. Berke thought I was out of town with my brother—who was being evaluated for a new cancer--he sent me a text message that Dr. Blackwell was seeing my patient who was in need of immediate care.

That was not true. I had delayed my out of town trip because I was at my patients' bedside at the hospital for three hours that night. Dr. Blackwell informed me that he never saw my patient that night, contrary to Dr. Berke's statement.

A CONTRIVANCE BY DR. BERKKE OF PLACING ME ON SURGERY SCHEDULE THINKING I WAS OUT OF TOWN

In addition, an operation was planned for the above mentioned patient by one of my colleagues, Dr. Dinesh Chhetri. The original surgery slip only had the name Dr. Chhetri on it (which I have); my name was added by someone after the slip had already been submitted. I just happened to be in the hospital surgery area 1.5 hours prior to the scheduled surgery to hear my name called. I responded and found that my name had been placed on the surgical schedule by someone who knew I had planned to be out of town. As it turned out that the patient had been sick and could not have his surgery as scheduled, so it was cancelled.

I found out later that Dr. Nabili alerted Dr. Blackwell and others about my presence by a text message decrying, "He's here, he's here" when he saw me in the hallway at the Veterans Hospital and not out of town as he had expected. Obviously, there was a plan in effect to discredit me and falsely claim that I do not show up for surgery, or to see my patients.

Every week there is another plan to escalate the retaliation. If I had not been vigilant to catch them in the act, they would taken my privileges [when I properly arranged for call coverage in advance of my vacation as stated above], and would have been reprimanded or worse by asserting I was not taking care of patients [when I was at the patient's bedside], or would have been treated to disciplinary action by not showing up for surgeries [for which I was never scheduled when they thought I was out of town].

I cannot leave town for fear of a total set up while I'm gone. I cannot turn my back, as they are always gunning for me in retaliation for filing the DFEH complaint and to try to prevent me from filing the lawsuit on that complaint.

RETALIATION IS BEYOND BELIEF

The retaliation at UCLA is beyond belief. An ultimate humiliation which I reported was when my face was placed with Photoshop on a gorilla with Dr. Gerald Berke sodomizing me from behind. Dr. Berke has verbally acknowledged that he is aware of the image. I then reported that Dr. Berke has protected Marilene Wang and treated her differently. UCLA, Dr. Berke, Dr. Fawzy and the entire

department has allowed this retaliation to continue against me. The ongoing rampage of retaliation has got to stop!

The retaliation has escalated against me and against witnesses who when interviewed, told the truth of the discrimination, harassment, and retaliation at the VA and UCLA. Dr. Berke has escalated the retaliation against them and me as well, including Dr. Joel Sercarz, who is being subjected to an unprecedented investigation for "time card fraud," with the cooperation and encouragement of Dr. Berke and UCLA. He is simply reporting the truth of my treatment with no incentive beyond doing the responsible thing. Dr. Sercarz is a direct witness to the racial comment by Dr. Marilene Wang when she called me an "affirmative action failure" and he also witnessed the gorilla slide.

Dr. Berke is creating an atmosphere of hostility. The faculty and residents now fear that working or cooperating with me is a sign of disloyalty. This behavior is not only reprehensible, but also potentially dangerous to my patients, if my colleagues will not cover for me. This cannot be tolerated. The efforts with the Vice Chancellor of Legal Affairs, Kevin Reed, as well as investigator Pamela Thomason from the Chancellor's office, Dr. Fawzy Fawzy, Executive from the Geffen School of Medicine, have not been helpful to date. No one is stopping Dr. Gerald Berke from retaliating after I filed the DFEH complaint. It's getting worse every day. This treatment has continued for years; each time I have reported these events to supervisors at UCLA, the retaliation was escalated.

I came to UCLA because I thought that it would be a great environment, and had an outstanding head and neck surgery training program. My goal has always been to be an academician: to perform complex surgery, teach, and start a translational cancer laboratory with other scientists. Through substantial effort, I received a faculty development award during my final year of training, allowing me to achieve my academic goals at UCLA. This success has been possible only through a significant investment by the NCI and my family.

I am disgusted that UCLA will allow the only African American Head and Neck Surgeon to be pushed out of the University with such blatant tactics of retaliation and racism. I have every right to be successful at this public institution. The economic harm that has been inflicted on my family and the crippling of my ability to be a functional member of the academic community is wrong. The damage to my family has been tremendous and needs to be rectified. There are many who have witnessed these events and have given me support but their fear of retaliation is ever present.

Your assistance would be greatly appreciated.

Sincerely,

Christian Head, M.D.

CC:
Dr. Washington, A. Eugene, Dean of the David Geffen School
of Medicine and Vice Chancellor of Health Sciences
Dr. Ronald Busuttil, Executive Chairman of Surgery
Keith Parker, Assistant to Vice Chancellor
University of California, Los Angeles

EXHIBIT C

Foley Lyman
LAW GROUP, LLP
1500 Rosecrans Ave., Ste.500 ▸ Manhattan Beach, CA 90266 ▸ *Phone:* (310) 706-4050 ▸ *Fax:* (310) 706-4052
shannon@foleylymanlaw.com ▸ rlyman@foleylymanlaw.com ▸ **www.foleylymanlaw.com**

October 14, 2011

Via Certified Return Receipt
Eugene Block
Chancellor, UCLA
Box 951405, 2147 Murphy Hall
Los Angeles, CA 90095-1405

Via Certified Return Receipt
A. Eugene Washington
Dean of the Geffen School of Medicine
10833 Le Conte Avenue
Los Angeles, CA 90095

Via Certified Return Receipt
President Yudof
Regents of the University of California
1111 Franklin Street, 12th Floor
Oakland, CA 94607

Re: Christian Head, M.D. v. Regents of University of California, Los Angeles and UCLA Geffen School of Medicine, as well as individuals.

Dear Chancellor Block, Dean Washington and President Yudof of the UC Regents:

Pursuant to California Government Code Section 12962(a) we are hereby serving you as an executive officer of Regents of the State of California and the Dean of the UCLA Geffen School of Medicine with the DFEH Complaint of Christian Head, M.D. filed October 11 and August 17, 2011 and the Notices of Case Closure and Right to Sue Letters issued August 17, 2011 and October 11, 2011. This notice of case closure and right to sue notice issued by the State of California allows Dr. Christian Head to proceed with his claims against Regents and UCLA in court on his DFEH Claims for Retaliation and other claims after filing his DFEH in April, August and October 2011 and for actions taken against him since participating in the "investigation" of his discrimination and retaliation claims at UCLA.

Following a sham "investigation," material witnesses have been retaliated against as Dr. Head has been. Dr. Head sought help from management without results. UCLA

Investigated, then immediately fed all the information to the harasser. Then, the harassers contacted witness inquiring "why are you helping Chris Head?" False statements were made to and about Dr. Head. Dr. Head has been set up for termination and retaliated against since filing the April 20 discrimination, harassment and retaliation complaint. All of this is forcing him out of the institution and causing damages emotionally and economically.

The investigation was a sham, as many witnesses that we provided names for were never contacted, others were never asked about the racial aspects of the case. Those who did have favorable material information in the investigation have been targeted for retaliation and termination. Nobody has prevented the rampage of retaliation that has occurred post DFEH filing and post investigation of the Gorilla issues with Dr. Head's face on a Gorilla's body being sodomized by his boss at UCLA. The Gorilla picture of Chris Head was shown to the UCLA/VA Residents, faculty and families at their Year End UCLA sponsored party people laughed. There are emails stating the UCLA doctors photo shopped the photo of Dr. Head and Dr. Berke. We have acknowledgement from several witnesses of these Racial Gorilla facts that they saw the picture shown at the event and they acknowledge the UCLA doctors/ residents involved. The African American community and others of course, are outraged at this.

Dr. Head's last DFEH filed October 11th specifies the recent retaliation and he wrote to the Chancellor asking for help with the retaliation. He is now being forced out of UCLA by the conduct of his managers with the ratification of Dr. Berke's and the Department of Head and Neck Surgery's retaliation and wrongful conduct at the highest levels of management. We believe there is institutional discrimination, harassment and retaliation in this case. It is interesting that there are no African Americans in the Head and Neck Department other than Dr. Head who is currently being pushed out, and there is only one other African American surgeon at UCLA.

Very truly yours,

Shannon M. Foley
Foley Lyman Law Group LLP

enclosure

* * * EMPLOYMENT * * *

COMPLAINT OF DISCRIMINATION UNDER THE PROVISIONS OF THE CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT

DFEH # E201112R5615-02

DFEH USE ONLY

CALIFORNIA DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

YOUR NAME (Indicate Mr. or Ms.) | TELEPHONE NUMBER (INCLUDE AREA CODE)

HEAD, CHRISTIAN | **(310)738-3159**

ADDRESS

247 22ND STREET

CITY/STATE/ZIP | COUNTY | COUNTY CODE

SANTA MONICA,CA,90402 | **LOS ANGELES** | **037**

NAMED IS THE EMPLOYER, PERSON, LABOR ORGANIZATION, EMPLOYMENT AGENCY, APPRENTICESHIP COMMITTEE, OR STATE OR LOCAL GOVERNMENT AGENCY WHO DISCRIMINATED AGAINST ME:

NAME | TELEPHONE NUMBER (Include Area Code)

WANG, MARILENE | **(310)206-6688**

ADDRESS | DFEH USE ONLY

200 MEDICAL PLAZA, SUITE 550

CITY/STATE/ZIP | COUNTY | COUNTY CODE

LOS ANGELES, CA 90095

NO. OF EMPLOYEES/MEMBERS (If known)	DATE MOST RECENT OR CONTINUING DISCRIMINATION TOOK PLACE (month,day, and year)	RESPONDENT CODE
1000+	07/21/2011	02

THE PARTICULARS ARE:

I allege that on about or before 07/21/2011, the following conduct occurred:

___ termination	___ denial of employment	___ denial of family or medical leave
___ laid off	X denial of promotion	___ denial of pregnancy leave
___ demotion	___ denial of transfer	___ denial of equal pay
X harassment	___ denial of accommodation	___ denial of right to wear pants
___ genetic characteristics testing	X failure to prevent discrimination or retaliation	___ denial of pregnancy accommodation
___ constructive discharge (forced to quit)	X retaliation	
___ impermissible non-job-related inquiry	___ other (specify)	

by WANG, MARILENE (Name of Person) **DIRECTOR, NASAL & SINUS CENTER** (Job Title (supervisor/manager/personnel director/etc.))

because of :

___ sex	___ national origin/ancestry	___ disability (physical or mental)	X retaliation for engaging in protected activity or requesting a protected leave or accommodation
___ age	___ marital status	___ medical condition (cancer or generic characteristic	
___ religion	___ sexual orientation		
X race/color	X association	X other (specify) Harassment HWE for filing VA EEO complaints	

State of what you believe to be the reason(s) for discrimination

DR. HEAD IS BEING DISCRIMINATED AGAINST BASED ON RACE, RETALIATED AGAINST FOR PARTICIPATING IN AND FILING A COMPLAINT FOR DISCRIMINATION AND RETALIATION. SUPERVISORS AND CO-WORKERS HAVE PARTICIPATED IN THE HOSTILE WORK ENVIRONMENT, GRAPHIC RACIST PHOTOS INCLUDING A GORILLA WITH DR. HEAD'S FACE SUPER IMPOSED ON IT BEING SODOMIZED BY SUPERVISOR DR. BERKE. THIS WAS SHOWN TO 300 PEOPLE AT A UCLA SPONSORED RESIDENT PARTY. RETALIATORY BEHAVIOR CONTINUES TO DATE WHICH IS CONDONED AND RATIFIED BY THE EMPLOYER. THE EMPLOYER FAILED TO PREVENT RETALIATION AND HARASSMENT WHICH CONTINUES NOW AND WILL CONTINUE DUE TO THE TAINTED

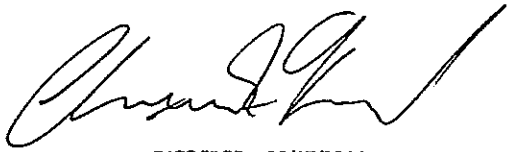
I wish to pursue this matter in court. I hereby request that the Department of Fair Employment and Housing provide a right-to-sue. I understand that if I want a federal notice of right-to-sue, I must visit the U.S. Equal Employment Opportunity Commission (EEOC) to file a complaint within 30 days of receipt of the DFEH "Notice of Case Closure," or within 300 days of the alleged discriminatory act, whichever is earlier.

I have not been coerced into making this request, nor do I make it based on fear of retaliation if I do not do so. I understand it is the Department of Fair Employment and Housing's policy to not process or reopen a complaint once the complaint has been closed on the basis of "Complainant Elected Court Action."

By submitting this complaint I am declaring under penalty of perjury under the laws of the State of California that the foregoing is true and correct of my own knowledge except as to matters stated on my information and belief, and as to those matters I believe it to be true.

Dated **08/17/2011**

At **Los Angeles**



DATE FILED: **08/17/2011**

* * * EMPLOYMENT * * *

COMPLAINT OF DISCRIMINATION UNDER THE PROVISIONS OF THE CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT

DFEH # E201112R5615-02

DFEH USE ONLY

State of what you believe to be the reason(s) for discrimination

DR. HEAD IS BEING DISCRIMINATED AGAINST BASED ON RACE, RETALIATED AGAINST FOR PARTICIPATING IN AND FILING A COMPLAINT FOR DISCRIMINATION AND RETALIATION. SUPERVISORS AND CO-WORKERS HAVE PARTICIPATED IN THE HOSTILE WORK ENVIRONMENT, GRAPHIC RACIST PHOTOS INCLUDING A GORILLA WITH DR. HEAD'S FACE SUPER IMPOSED ON IT BEING SODOMIZED BY SUPERVISOR DR. BERKE. THIS WAS SHOWN TO 300 PEOPLE AT A UCLA SPONSORED RESIDENT PARTY. RETALIATORY BEHAVIOR CONTINUES TO DATE WHICH IS CONDONED AND RATIFIED BY THE EMPLOYER. THE EMPLOYER FAILED TO PREVENT RETALIATION AND HARASSMENT WHICH CONTINUES NOW AND WILL CONTINUE DUE TO THE TAINTED ENVIRONMENT MANAGEMENT HAS CREATED. WITNESSES AND THOSE ASSOCIATED HAVE BEEN DISSUADED FROM COMING FORWARD WITH TRUTHFUL INFORMATION REGARDING DISCRIMINATION, HARASSMENT AND RETALIATION BY MANAGEMENT'S INAPPROPRIATE ACTIONS. ALL THIS CONTINUES TO INTERFERED WITH MY ADVANCEMENT AT THE UNIVERSITY. LITTLE OR NO CORRECTIVE ACTION IS BEING TAKEN.

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

EDMUND G. BROWN, JR., Governor

DEPARTMENT OF FAIR EMPLOYMENT & HOUSING

Phyllis W. Cheng, Director

1055 WEST 7TH STREET, SUITE 1400, LOS ANGELES, CA 90017
(213) 439-6770
www.dfeh.ca.gov

August 17, 2011

HEAD, CHRISTIAN
247 22ND STREET
SANTA MONICA,CA,90402

RE: E201112R5615-02
HEAD/WANG, MARILENE, AS AN INDIVIDUAL

Dear HEAD, CHRISTIAN:

NOTICE OF CASE CLOSURE

This letter informs that the above-referenced complaint that was filed with the Department of Fair Employment and Housing (DFEH) has been closed effective August 17, 2011 because an immediate right-to-sue notice was requested. DFEH will take no further action on the complaint.

This letter is also the Right-To-Sue Notice. According to Government Code section 12965, subdivision (b), a civil action may be brought under the provisions of the Fair Employment and Housing Act against the person, employer, labor organization or employment agency named in the above-referenced complaint. The civil action must be filed within one year from the date of this letter.

If a federal notice of Right-To-Sue is wanted, the U.S. Equal Employment Opportunity Commission (EEOC) must be visited to file a complaint within 30 days of receipt of this DFEH *Notice of Case Closure* or within 300 days of the alleged discriminatory act, whichever is earlier.

DFEH does not retain case files beyond three years after a complaint is filed, unless the case is still open at the end of the three-year period.

Sincerely,

Tina Walker

Tina Walker
District Administrator

cc: Case File

MARILENE WANG
DIRECTOR, NASAL & SINUS CENTER
REGENTS OF UNIV OF CALIF, LA SCHOOL OF MEDICINE
200 MEDICAL PLAZA, SUITE 550
LOS ANGELES, CA 90095

* * * EMPLOYMENT * * *

COMPLAINT OF DISCRIMINATION UNDER THE PROVISIONS OF THE CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT

DFEH # E201112R6252-01
DFEH USE ONLY

CALIFORNIA DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

YOUR NAME (Indicate Mr. or Ms.): **HEAD, CHRISTIAN**
TELEPHONE NUMBER (INCLUDE AREA CODE): **(310)738-3159**

ADDRESS: **247 22ND STREET**

CITY/STATE/ZIP: **SANTA MONICA,CA,90402**
COUNTY: **LOS ANGELES**
COUNTY CODE: **037**

NAMED IS THE EMPLOYER, PERSON, LABOR ORGANIZATION, EMPLOYMENT AGENCY, APPRENTICESHIP COMMITTEE, OR STATE OR LOCAL GOVERNMENT AGENCY WHO DISCRIMINATED AGAINST ME:

NAME: **BERKE, GERALD**
TELEPHONE NUMBER (Include Area Code): **(310)825-5179**

ADDRESS: **62-132 CENTER FOR THE HEALTH SCIENCES**
DFEH USE ONLY

CITY/STATE/ZIP: **LOS ANGELES, CA 90095**
COUNTY:
COUNTY CODE:

NO. OF EMPLOYEES/MEMBERS (if known)	DATE MOST RECENT OR CONTINUING DISCRIMINATION TOOK PLACE (month,day, and year)	RESPONDENT CODE
1000+	10/11/2011	01

THE PARTICULARS ARE:

I allege that on about or before 10/11/2011, the following conduct occurred:

___ termination	___ denial of employment	___ denial of family or medical leave
___ laid off	___ denial of promotion	___ denial of pregnancy leave
___ demotion	___ denial of transfer	___ denial of equal pay
X harassment	___ denial of accommodation	___ denial of right to wear pants
___ genetic characteristics testing	X failure to prevent discrimination or retaliation	___ denial of pregnancy accommodation
___ constructive discharge (forced to quit)	X retaliation	
___ impermissible non-job-related inquiry	___ other (specify)	

by **BERKE, GERALD** (Name of Person) **DIVISION CHIEF OF HEAD & NECK SURGERY** (Job Title (supervisor/manager/personnel director/etc.))

because of :

___ sex	___ national origin/ancestry	___ disability (physical or mental)	X retaliation for engaging in protected activity or requesting a protected leave or accommodation
___ age	___ marital status	___ medical condition (cancer or genetic characteristic	
___ religion	___ sexual orientation	X other (specify) for participating in VA EEO Race case	
X race/color	___ association		

State of what you believe to be the reason(s) for discrimination

DR. HEAD WAS RETALIATED AGAINST AFTER HE FILED HIS APRIL 2011 DFEH AND PARTICIPATED IN AN INVESTIGATION AT UCLA AND IN THE VA EEO RACE CASE. SOME OF THE RETALIATORY AND HARASSING EVENTS INCLUDE BUT ARE NOT LIMITED TO: DIVISION OF HEAD AND NECK SURGERY BERKE SENT MEMO TO TAKE AWAY PRIVILEGES AT SANTA MONICA HOSPITAL STATING DR. HEAD DID NOT COVER HIS CALL. THIS WAS FALSE AND NOT BASED ON FACT. DR. BERKE AND DR. WANG HAVE SOUGHT AND OBTAINED NEGATIVE TEACHING EVALUATIONS ON DR. HEAD. THEY HAVE ALSO DIRECTED RESIDENTS NOT TO ASSIST DR. HEAD IN SURGEY DENYING THE TEACHING/ACADEMIC OPPORTUNITY. DR. BERKE SENT A FALSE TEXT TO DR. HEAD

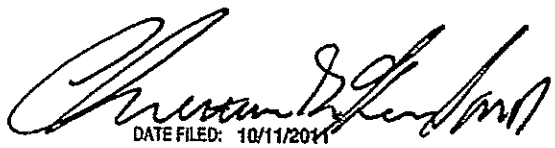
I wish to pursue this matter in court. I hereby request that the Department of Fair Employment and Housing provide a right-to-sue. I understand that if I want a federal notice of right-to-sue, I must visit the U.S. Equal Employment Opportunity Commission (EEOC) to file a complaint within 30 days of receipt of the DFEH "Notice of Case Closure," or within 300 days of the alleged discriminatory act, whichever is earlier.

I have not been coerced into making this request, nor do I make it based on fear of retaliation if I do not do so. I understand it is the Department of Fair Employment and Housing's policy to not process or reopen a complaint once the complaint has been closed on the basis of "Complainant Elected Court Action."

By submitting this complaint I am declaring under penalty of perjury under the laws of the State of California that the foregoing is true and correct of my own knowledge except as to matters stated on my information and belief, and as to those matters I believe it to be true.

Dated 10/11/2011

At Santa Monica, California



DATE FILED: 10/11/2011

* * * EMPLOYMENT * * *

COMPLAINT OF DISCRIMINATION UNDER THE PROVISIONS OF THE CALIFORNIA FAIR EMPLOYMENT AND HOUSING ACT

DFEH # E201112R6252-01

DFEH USE ONLY

State of what you believe to be the reason(s) for discrimination

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STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

EDMUND G. BROWN, JR., Governor

DEPARTMENT OF FAIR EMPLOYMENT & HOUSING

Phyllis W. Cheng, Director

1055 WEST 7TH STREET, SUITE 1400, LOS ANGELES, CA 90017
(213) 439-6770
www.dfeh.ca.gov

October 11, 2011

HEAD, CHRISTIAN
247 22ND STREET
SANTA MONICA,CA,90402

RE: E201112R6252-01
HEAD/BERKE, GERALD, AS AN INDIVIDUAL

Dear HEAD, CHRISTIAN:

NOTICE OF CASE CLOSURE

This letter informs that the above-referenced complaint that was filed with the Department of Fair Employment and Housing (DFEH) has been closed effective October 11, 2011 because an immediate right-to-sue notice was requested. DFEH will take no further action on the complaint.

This letter is also the Right-To-Sue Notice. According to Government Code section 12965, subdivision (b), a civil action may be brought under the provisions of the Fair Employment and Housing Act against the person, employer, labor organization or employment agency named in the above-referenced complaint. The civil action must be filed within one year from the date of this letter.

If a federal notice of Right-To-Sue is wanted, the U.S. Equal Employment Opportunity Commission (EEOC) must be visited to file a complaint within 30 days of receipt of this DFEH *Notice of Case Closure* or within 300 days of the alleged discriminatory act, whichever is earlier.

DFEH does not retain case files beyond three years after a complaint is filed, unless the case is still open at the end of the three-year period.

Sincerely,

Tina Walker

Tina Walker
District Administrator

cc: Case File

BUSUTTIL RONALD
UCLA CHAIRMAN OF SURGERY
UCLA GEFFEN SCHOOL OF MEDICINE
200 MEDICAL PLAZA, SUITE 214
LOS ANGELES, CA 90095

EXHIBIT D

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

TOP OF FILE

Employee Name	Employee No.	Classification
Joel Sercarz	263842	Physician Specialist

Department Number: 240	Effective: February 2, 2012

REMARKS:

EMPLOYEE DISCHARGED FOR DISHONESTY AND TIMECARD FRAUD
DO NOT RE-HIRE
WITHOUT FIRST CONSULTING WITH
DHS HUMAN RESOURCES
Performance Management Section

Departmental Civil Service Representative Initials: NY Date: 2/6/2012

c: Official Personnel File
Performance Management File

EXHIBIT E

UNIVERSITY OF CALIFORNIA, LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

DEPARTMENT OF HEAD AND NECK SURGERY
UCLA SCHOOL OF MEDICINE
200 UCLA MEDICAL PLAZA, SUITE 550.
LOS ANGELES, CA 90095-6959
(310) 825-5179
FAX (310) 206-2331

March 23, 2012

Chancellor Eugene Block
University of California, Los Angeles

Re: Dr. Christian Head Retaliation for Whistleblowing at UCLA

Dear Chancellor Block:

I wrote to you on October 6, 2011 regarding the retaliation being exacted upon me by UCLA, Berke and Wang after I reported unlawful conduct at UCLA to my supervisors and to the Chancellor's Office and their Investigator Pamela Thomason. The unlawful conduct included protected activity under FEHA, EEO, as well as violations of the Business and Professions Code, NIH, CFR's, Penal Code and Improper Governmental Activity by my supervisors Gerald Berke and Marilene Wang as well.

In June 2011, I specifically reported that Dr. Wang has many malpractice cases that were not being reported to the medical board in violation of the Risk Management Policies and process at UCLA and violating Business & Professions Code Licensing Requirements. I also reported that somehow Dr. Berke was protecting Dr. Wang's malpractice cases from being reported to the Medical Board. This selective treatment and protection of one doctor was pointed out to the Chancellor's office and the Investigator for the Vice Chancellor of Legal Affairs. This endangers patients' lives and public has a right to know when selecting a doctor whether there are lawsuits or settlements against a physician.
Since that report by me, Dr. Wang's cases were reported to the Medical Board. However, Dr. Wang and Dr. Berke have retaliated against me in many ways through UCLA and elsewhere. Dr. Wang stated to physicians at UCLA that Dr. Head will not be a problem [for me] any longer, he will be investigated for time card fraud at the VA. The VA is an affiliated hospital with UCLA and Dr. Wang has dual appointment and is one of Dr. Head's supervisors at the VA. In addition, all the retaliatory events outlined in my October 6, 2011 and more events have occurred since my report to the Chancellor.

Nothing has been done by UCLA/Regents to stop the retaliation or to investigate further. Nobody has asked to interview me regarding these incidents.

During the June to July Investigation, I also reported to the Chancellor's office that my NIH funds had been inappropriately used by UCLA and that they tried to take my donor funds for salary when I should have been placed on disability when he was on notice that I was in the hospital. After that time, my physicians' compensation salary was unlawfully reduced to $.48 and $.23. My NIH Lab has suffered from the continuous retaliation.

Since the report to the investigator regarding the NIH funds for my lab research, as I reported to you UCLA told another physician that my Lab was available, as I no longer needed it. Many retaliatory events have occurred including but not limited to those in the October 6, 2011 letter to you. Dr. Berke and Michael Sachs have again directed staff not to schedule patients for me, they are told I cannot be seen for six months. The Patients are directed to another physician when they specifically ask to schedule with me. Other patients have been told not to have me do their surgery, resulting in loss of income.

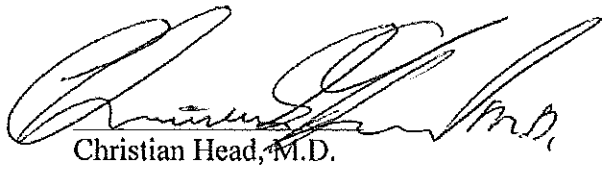
Finally, I have reported that I was portrayed as a Gorilla at a Year End Resident Party. Those residents involved were rewarded and were promoted, one was given a promotion to the Jules Stein Institute, the other received a VA appointment to work with Dr. Wang. The Chancellor's office denied the gorilla exists, the witnesses who observed it were retaliated against. We have additional witnesses who have come forward and admit they were at the party, they viewed the slide, that it was racist, inappropriate and in bad taste.

The investigation was completed, and UCLA reported that it did not find any evidence to support my claims. UCLA Vice Chancellor of Legal Affairs office denied that any of our evidence was true. It is my understanding, UCLA denied the existence of the Gorilla as well. I have been disparaged, retaliated against and subject to a hostile work environment every day I work here. I have had patients taken away, schedulers refusing to schedule appointments for my patients, residents removed from the schedule so I have no assistance on cases and no teaching opportunity. All because I reported the truth of the discrimination and retaliation of what happened here at UCLA.

I intend for this to be confirmation that the prior June 2011 report was intended as Whistleblower complaints. The June 2011 report/claim was investigated and closed. The October 6, 2011 and this letter is and was intended as a report of retaliation for whistleblowing. I have been available to cooperate and answer questions regarding the retaliation since October 6, 2011 almost 6 months, nobody has called me. No report has been issued to me. I reserve all my rights to pursue my FEHA complaints for Retaliation, Harassment and Discrimination.

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

Dated: March 21, 2012

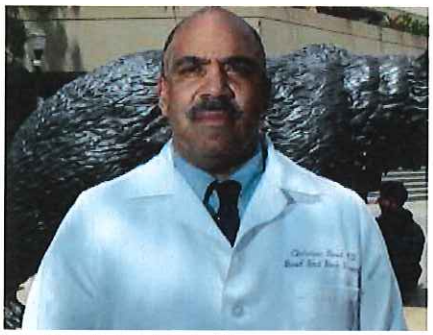


Christian Head, M.D.

EXHIBIT F

BOTTOM LINE

Black surgeon's claim details racism among UCLA doctors



Gary McCarthy/Los Angeles Wave

Discrimination claim

UCLA Associate Professor Dr. Christian Head has filed suit against the University of California Board of Regents and two administrators of the UCLA Medical Center alleging a decade-long campaign of discriminatory acts.

Posted: Wednesday, May 2, 2012 8:18 pm | *Updated: 5:04 pm, Wed May 23, 2012.*

By Betty Pleasant, Contributing Editor | 7 comments

Where's the story?

4 Points Mentioned

A highly regarded African-American surgeon and UCLA associate professor recently filed a lawsuit against the University of California Board of Regents and the administrators of the UCLA Medical Center for implementing a decade-long campaign of discriminatory acts against him — the most egregious being the public depiction of him as a big black gorilla being sodomized by a White man.

In a 40-page complaint filed in Superior Court on April 17, Dr. Christian Head, a tenured and history-making head and neck surgeon at UCLA, describes a litany of racial bullying, badgering, harassment and overt mistreatment he has endured virtually from the day he accepted an assistant professor appointment to the UCLA Medical School faculty in 2002.

Prior to his UCLA appointment, Dr. Head, 50, launched the UCLA Johnson Cancer Center Tumor Lab, which was has been deemed successful and reportedly has yielded valuable research and benefited many of the patients at UCLA and worldwide. This was followed by his receipt of the 2002 National Institute for Health National Cancer Institute Faculty Development Award that same year, and by about 10 awards and 10 research grants in the years hence.

Before UCLA picked him to teach, Dr. Head had conducted neuro-otology research at UCLA for two years, served a head and neck surgery residency for six years at UCLA and interned in surgery for one year at UCLA. Yet, he was publicly regarded by his UCLA supervisors as someone less than a doctor and unworthy of his teaching appointment at that university. (Dr. Head earned his medical degree in 1993 from Ohio State University College of Medicine, then served a year-long surgery internship at the University of Maryland at Baltimore and became certified by the American Board of Otolaryngology in 2003. He was named "Most Innovative Surgeon" by Black Enterprise in 2010.)

Dr. Head became the first African-American in head and neck surgery to become a UCLA faculty member and then promoted to associate professor; he is the only Black head and neck surgeon at the place and he is currently one of only two Black faculty members in UCLA's Department of Surgery. (The other one is Dr. Langston Holly.)

According to his lawsuit, Dr. Head's Black presence rankled his supervisors to the point that they were driven to flagrant racism. According to the complaint, Dr. Marilene Wang, a full professor who supervises Dr. Head, was

dismissive of his qualifications and repeatedly referred to him as "an affirmative action hire" and "part of the university's affirmative action program" in conversations with medical colleagues despite his training, awards and certification in his speciality.

The suit states that Dr. Wang said Dr. Head "and doctors like him — who are African-American, were the reason for failed hospitals like King Drew." It also claims that she stated her intentions to prevent Dr. Head's promotions, his ability to get full-time equivalents, tenure and advancement. She is claimed to have stated she "intended to take action to destroy Dr. Head's career at UCLA."

Toward that end, Wang reportedly issued Head nothing but negative supervisor and peer evaluations until the medical school's dean, the late William F. Friedman, ordered her to stop in accordance with the 2004 Equal Employment Oopportunity Resolution enacted after she called Head an "affirmative action hire."

Head said Wang did stop issuing him scurrilous evaluations until Friedman died in August 2005. "Then, she just picked up where she stopped," Head said.

Dr. Head claimed to be a victim of a double whammy in terms of race hatred in his workplace, as the complaint states Dr. Gerald Berke, chairman of the Head and Neck Surgery Department in which Head works, directed residents (doctors in training) not to work with Dr. Head and denied him teaching opportunities and assistance with his cases. Head asserts that Berke joined Wang in making inappropriate racial comments and insinuations about him and all Blacks over the past four years.

For example, Berke is said to have openly mocked the Martin Luther King Jr. Holiday, and, upon learning that Dr. Head's African-American niece had died, Berke asked, "Did she overdose?" And Berke looms large in the sodomizing gorilla atrocity we'll get to soon (I want to keep you reading!).

According to the court document, Dr. Head — who is married to a cardiologist and has two children — had taken none of the offenses committed against him lightly, for he had complained through all the university's proper channels in his fruitless attempt to end the discriminatory treatment his two supervisors were affording him. But to no avail.

In fact, every time he lodged an official complaint, he was retaliated against for having done so. For example, his number of clinic days were reduced, his hospital privileges were threatened, his money was treated funny — so much so that in August 2008 Dr. Head received a paycheck in the amount of 48 cents and for the following month, a paycheck was issued to him in the amount of 23 cents! His salary was $315,000 a year.

Now, the gorilla. At the end of each year, the UCLA Head and Neck Department and its resident class holds a closing ceremony and party attended by the faculty, staff, chairmen/women, residents and spouses at which the residents put on a year-end slide show under the supervision of Berke. One such ceremony and party featured a slide show in which Dr. Head was the unfortunate star.

The show consisted of about 30 or 40 slides, of which about half were reportedly about Dr. Head, and one in particular plowed new fetid ground that led directly to this lawsuit. It was a picture of a big, black hairy gorilla that had Dr. Head's face Photoshopped on the gorilla, who was being sodomized by a white man wearing Berke's Photoshopped face. "When this slide was shown, Wang and others in the crowd laughed that Dr. Head was 'being screwed by his boss,'" the lawsuit states.

There were about 200 people at the event but everybody didn't find it funny, though. Dr. Joel Sercarz, professor of surgery, was still so offended by "The Gorilla Slide" that he sent an email to UCLA Chancellor Gene Block after he made a stirring campus-wide call for "tolerance, civility and respect" last month.

"I appreciate your concern about diversity and tolerance," Dr. Sercarz wrote, "But why allow my colleague, Dr. Head, an African-American physician to be depicted at a UCLA event with his head superimposed on the body of a gorilla? You are aware of this, aren't you?" Dr. Sercarz has received no reply to his March 10 email to Chancellor Block.

Dr. Head is not only suing the University of California regents for doing nothing to stop the racial terror meted out to him, but he's suing Berke and Wang as individuals, as well. He is demanding a jury trial and is seeking general and compensatory damages for lost salary, both front and back pay, bonuses, benefits ... punitive and exemplary damages against Berke and Wang and for damages to his credit, for prejudgment interest at the maximum rate allowed by law and for attorneys' fees pursuant to the various state, labor and civil codes.

"This lawsuit is an action of last resort," Dr. Head said. "I have made numerous complaints and I have tried every avenue possible within the university to solve this. The only redress left is in a court of law," he said.

Dr. Head has the full support of the Beverly Hills NAACP Chapter, to which he turned for assistance last summer. "We are outraged, horrified and repulsed by the discriminatory treatment of Dr. Head, a leading surgeon at UCLA Medical Center," said Ron Hasson, the chapter president. "This type of wrongdoing by the UCLA Medical Center and UC Regents, for that matter, is outrageous.

"There are so few Black surgeons at UCLA; we now understand why and demand that appropriate action be taken against this discrimination and repulsive activity and those responsible for it be disciplined."

Wang did not return my page when I sought her comments Tuesday. I will try again to reach her and Berke next week, because I really, really, really want to talk to these people.

Posted in Opinion, Bottom line on *Wednesday, May 2, 2012 8:18 pm. Updated: 5:04 pm.* | Tags: University Of California Board Of Regents, Ucla Medical Center, Dr. Christian Head, Dr. Joel Sercarz, Ucla Chancellor Gene Block, Beverly Hills Naacp Chapter, Ucla Johnson Cancer Center Tumor Lab

Similar Stories

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- The mugging of Genethia Hudley-Hayes
- Shut up!
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- Lawyers for accused serial killer seek to block evidence
- Walmart opens hiring center near new South Gate store
- Lawyers for accused serial killer seek to block evidence
- Shut up!

7 comments:

Phil Hampton posted at 9:06 am on Tue, May 8, 2012.

Posts: 1

It's unfortunate that your readers were not afforded the benefit of UCLA's response to the inflammatory allegations made by Dr. Christian Head. UCLA is committed to and promotes diversity, and the campus takes all appropriate steps to protect employees from harassment and intimidation. State whistleblower laws prohibit retaliation against employees who express concerns about what they consider to be illegal activity. University policies embrace these laws, and the campus is committed to preventing any such retaliation. Allegations of discrimination and retaliation are taken very seriously and investigated thoroughly.

While privacy laws prevent us from discussing details, UCLA investigated Dr. Head's allegations and found that the evidence does not substantiate the claims of unlawful activity. Dr. Head was directed to take up the issues with the Academic Senate committee charged with resolving faculty allegations of mistreatment, and thus far he has declined to do so.

Phil Hampton, Associate Director
UCLA Media Relations

Log In to report. | Link

virtualact1 posted at 5:47 pm on Wed, May 9, 2012.

What's unfortunate is that UCLA only has two african american surgeons out of three

Posts: 3

hundred. And what about the gorilla photo? No response from Mr. Hampton on that. While the photo itself may not be "illegal",it certainly is crude,racist and unethical. What Mr. Hampton also won't tell you is that the person responsible has been given a promotion! So much for the protection Mr. Hampton talks about.
The fact is the environment that Dr. Head has to confront is inexcusable and a disgrace to UCLA. The lack of African Americans(less than 1%) in the ranks of its surgeons is only one example of the university's insensitivity and so called commitment to diversity.

Log In to report. | Link

UCLA Black Alum posted at 10:28 pm on Wed, May 9, 2012.

Posts: 2

Mr. Hampton fails to acknowledge that this is not an isolated issue. In recent years, UCLA's problems with diversity have risen. And the Wave has documented those problems. The number of African American students has dropped dismally. UCLA's own recent reports show a failure to attract and retain African American faculty, especially at the Medical Center. As the spokesperson for UCLA, Mr. Hampton has clearly reinforced in two brief paragraphs UCLA's absolute racial insensitivity.

As African Americans, we know the difference between words and actions.

Mr. Hampton & Chancellor Block, since when is putting a Black man's face onto the body of a gorilla at a university sponsored event acceptable or tolerable? UCLA's simple failure to recognize and address this universally accepted racist depiction only confirms the absolute disregard for respect for African Americans and for diversity.

How dare you suggest that the victim of this public humiliation has made "inflammatory allegations!" The only thing inflammatory is UCLA's disrespect to Black people. You see, I attended UCLA. I marched for African American, Latino and Asian American faculty when UCLA refused to give them the tenure they earned. I marched when UCLA

Log In to report. | Link

read more (about 6 more lines)

skipperick posted at 10:46 am on Fri, May 18, 2012.

Posts: 1

Dr. Head's allegations are Inflammatory, Mr. Hampton? Really? After all the opportunities UCLA has had to investigate Dr. Head's allegations are you any closer to reporting whether the allegations are true? Your response on behalf UCLA is what is inflammatory!

Log In to report. | Link

EmpoweredPro posted at 10:43 pm on Sat, May 26, 2012.

Posts: 3

It is so sad to see people maintaining a disgusting position such as racism. I stand firmly behind Dr. Head and cringe at the hate, hurt and humiliation he must have suffered, as a person just trying to keep his job.
PETITION
http://www.change.org/petitions/ucla-medical-center-and-university-fire-them-from-ucla-mecical-center-and-university

U.S. DEPT OF EDUCATION
Leader: Arne Duncan
1-800-USA-LEARN
www.facebook.com/SecretaryArneDuncan

U.S. DEPT OF JUSTICE
Leader: Thomas E. Perez
202- 514-4609
www.facebook.com/DOJ

Log In to report. | Link

EmpoweredPro posted at 10:49 pm on Sat, May 26, 2012.

Posts: 3

@Phil Hartmon, the fact that you were brazen enough to show your face in light of this exposure of pure hate and evil towards another person, in itself shows just how

institutionalized racism is within the walls of UCLA. Anyone who has placed another person's face on a gorilla's body, then show him being sodomized is dispicable! And you feel the need to defend such animalistic behavior? Yes I'm convinced. You are a representative of the institution and obviously one who supports this. Do you really think that the public will believe that a person just made up these stories? The likelihood of that is slim to none. I'm sure the racism is entrenched so many of you have spoken to your faculty to remain quiet and hushed. Even worse, you may not have, as racists know what to do already.

PLEASE SHARE THIS WITH IN YOUR EMAILS, TWITTER AND FACEBOOK FRIENDS.

PETITION
http://www.change.org/petitions/ucla-medical-center-and-university-fire-them-from-ucla-mecical-center-and-university

Log In to report. | Link

read more (about 7 more lines)

virtualact1 posted at 7:36 am on Sun, May 27, 2012.

Posts: 3

If you go to the California Medical board website (http://www2.mbc.ca.gov /LicenseLookupSystem/PhysicianSurgeon/Search.aspx) and look up Dr. Marilene Wang,She has THREE malpractice suits since 2007. Only 7% of doctors in her field has had ONE. So not only is she racist,she's also incompetent. Should she really be managing anybody????

Log In to report. | Link

Rules of Conduct

1 **Keep it Clean.** Please avoid obscene, vulgar, lewd, racist or sexually-oriented language.

2 **Don't Threaten or Abuse.** Threats of harming another person will not be tolerated. AND PLEASE TURN OFF CAPS LOCK.

3 **Be Truthful.** Don't knowingly lie about anyone or anything.

4 **Be Nice.** No racism, sexism or any sort of -ism that is degrading to another person.

5 **Be Proactive.** Use the 'Report' link on each comment to let us know of abusive posts.

6 **Share with Us.** We'd love to hear eyewitness accounts, the history behind an article.

EXHIBIT G

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200 UCLA MEDICAL PLAZA, SUITE 550,
LOS ANGELES, CA 90095-6959
(310) 825-2848
FAX (310) 206-2331

May 20, 2012

Dear Dr. Eugene Washington and Chancellor Gene Block:

On Friday, May 18, 2012, I performed a very difficult and high-risk surgery on a UCLA Medical Center patient. Normally, in such cases, the faculty member would have one or more resident physicians assigned to assist. However, in the case this morning, I was denied surgical assistance of residents/ physicians in the department, which would have been routinely granted in such a case. Assistance is often needed for retraction purposes and for continuity of care in the post-operative period. I received assistance from a plastic surgery resident. Thankfully, the surgery went well.

It seems that the retaliation that I have been subjected to over the last several years by Dr. Berke and others is now intensifying because of my public reporting of it. I should not have expected any less. However, when Dr. Berke and the University chose to expose the lives of UCLA Medical Center patients to increased risk in order to accomplish such retaliation, he is putting more than just careers at stake. It's one thing to retaliate against me financially and by trying to set me up for failure in my career. It's quite another to attempt to do so by risking the lives of patients. This is outrageous and exposes me, the Medical Center and the University to terrible consequences. I have reported this behavior directly to you and others in the recent past.

I have an obligation to protect my patients from harm. It is unacceptable to subject my patients to increased surgical risk due to the University's unjust behavior. I no longer feel it is safe for my patients to undergo high complexity surgery at UCLA or its affiliate hospitals without the necessary surgical assistance provided to all of my colleagues. I have no choice but to significantly reduce my practice to protect my most vulnerable patients due to the denial of support by UCLA.

Other surgical Attending Physicians outside my department, have noticed the lack of coverage on my cases and are extremely troubled by it. This requires immediate action.

Sincerely,

Christian S. Head, M.D.

cc: Dr. David T. Feinberg, MD, President of Health Systems, UCLA School of Medicine
Dr. Thomas Rosenthal, M.D. Chief Medical Officer of UCLA Health

EXHIBIT H

From: Chancellor Gene D. Block [chancellor@ucla.edu]
Sent: Tuesday, May 22, 2012 12:11 PM
To: allemployees@bruinpost.ucla.edu
Subject: Recent Allegations of Discrimination

[http://www.maildoc.ucla.edu/images/ucla_bruinpost_03.png]Office of the Chancellor

To the Campus Community:

Many of you have either seen or heard about the recent allegations of racial discrimination and retaliation made by one of our faculty members at the David Geffen School of Medicine. Since a lawsuit was filed, the facts will emerge through the legal system, and I cannot comment on such matters while the case is in litigation.

I do want to assure you, however, of the commitment made by me — and by UCLA as a whole — to create and maintain a diverse and welcoming environment for research, teaching and learning. The allegations, which stem from an incident that occurred six years ago, are now being spread through a YouTube video circulated online, but they do not accurately describe the UCLA that I have the honor of leading. The UCLA you and I know is a place based on the concepts of diversity and respect — as they relate to our ideas, our backgrounds and our cultures. This is a core value at UCLA, a philosophy that helps guide how we manage one of the greatest universities and medical enterprises in the world.

Part of that commitment means having internal procedures for addressing allegations of discrimination and for remedying situations found to involve violations of UCLA policy. When these allegations were brought to my attention, the university conducted a review of the charges and was unable to substantiate them. At that time, the person making these allegations was given all the information necessary to decide whether to make full use of those internal procedures or to bypass them in favor of the legal system. That is a choice any faculty member, or indeed any student or staff member, can make. Such a choice does not mean that UCLA administrators failed to act on this person's behalf or that UCLA failed to respond.

We have been, are now and will in the future be ready to assist any faculty member, staff member or student who believes they have been subjected to any form of discrimination. If you have concerns about the treatment you have received, I urge you to contact one or more of the following campus resources, which are specifically designed to address these issues:

Office of Ombuds Services
(informal and confidential mediation)
www.ombuds.ucla.edu<http://www.ombuds.ucla.edu>

Office of the Vice Provost for Diversity and Faculty Development
(information, referrals and assistance with informal or formal concerns)
www.faculty.diversity.ucla.edu<http://www.faculty.diversity.ucla.edu>

Academic Senate Grievance Advisory Committee
(information and assistance with formal charge and grievance procedures)
www.senate.ucla.edu/committees/gac/<http://www.senate.ucla.edu/committees/gac/>

True Bruin Respect reporting website
www.reportincidents.ucla.edu<http://www.reportincidents.ucla.edu>
Sincerely,

Gene D. Block
Chancellor

EXHIBIT I

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FAX (310) 206-2331

copy

rec 7/10/12 12:40p

Chancellor Gene Block, Dean Washington, John Hiatt, Gerald Berke,

Re: More Retaliation and Discrimination, Hostile Work Environment Against Christian Head re Surgeries and threats against witnesses. THREATS TO PATIENT SAFETY AGAIN.

Dear Chancellor Block, Dean Washington, Dr. Hiatt, Dr. Berke, Dr. Wang and Dr. Suh:

I received two separate calls today from two different people informing me that they were told not to help me with surgeries or with products needed for my surgeries. Specifically, the Medical Supply Rep Giovanni was told by Dr. Jeff Suh that his apparent support for me and/or Dr. Sercarz was not looked upon favorably and it would adversely affect UCLA's future orders from the Head and Neck department at UCLA of the Sinus Balloon product used for Sinusplasty. There was a specific threat to destroy the Rep's business if he "helped Chris Head do his surgeries" with the sinus balloon supplies. There was also the threat to discontinue ordering supplies Dr. Head requires for his surgical cases.

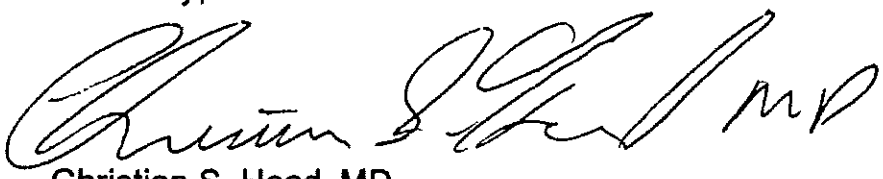
On July 5, 2012, Joel Sercarz, M.D. was directly confronted by UCLA Head & Neck Asst. Professor, Jeff Suh, M.D. and told that he and Marilene Wang, M.D. did not appreciate the support he was giving Chris Head in surgical cases, that he had to stop helping Chris Head on his complex cases. Dr. Jeff Suh also told Joel Sercarz that his help of Chris Head on his legal case would be problematic for him in the department, that the rest of the Department would not support or help Sercarz any longer. This is direct retaliation against me, witnesses in my case and surgeons and suppliers who make it possible for me to work at UCLA.

Another doctor, Dorothy Wang, M.D. who works with Marilene Wang, M.D. called the Rep Giovanni to warn him that Dr. Jeff Suh was discussing the fact that he (Giovanni) was supporting Dr. Head. She was giving him "Heads up and

warning," that Dr. Suh was trying to retaliate against any one working with Dr. Head.

Again, retaliation and discrimination by the doctors in the Head & Neck Department creates this horribly hostile work environment that has to do with my reporting discrimination at UCLA. I am being treated differently than my colleagues. These actions are deliberate to push me out, to make me fail and to create an intolerably hostile work environment and worst of all, increasing risk to patients. Patient Safety matters the most to me. UCLA is an increasingly dangerous and hostile place to work with this insidious discrimination and retaliatory behavior against me. It is difficult if not impossible to practice medicine under these conditions.

Sincerely,



Christian S. Head, MD

EXHIBIT J

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FAX (310) 206-2331

August 13, 2012

Dean Eugene Washington, M.D.
J. Thomas Rosenthal, M.D.
John Hiatt, M.D.
UCLA Geffen School of Medicine
Los Angeles, CA

Re: Christian Head, M.D. at UCLA; Hostile Work Environment toward me and my patients, neglect of my Patients by H & N Department, False Statements to my patients telling them to schedule with other doctors.

As you are well aware, I spoke with Dr. Hiatt and Dr. Rosenthal this week regarding the issues of Hostile Work Environment toward me and directed toward my patients.

I took a necessary medical leave due to elevated blood pressure and other medical issues that prevented me from conducting clinical duties after UCLA and its management were involved in retaliation and hostile work environment against me through Jeff Suh, M.D. and others, directing a vendor not to assist me in Surgery with necessary supplies and telling a physician not to assist me on complex cases. All this was directly related to my filing for discrimination, harassment and retaliation against Regents, Berke and Wang.

I gave notice of the time I would be out, including time away from the OR and Clinic due to the medical leave and time to attend the NMA medical conference.

FAILURE TO COVER PATIENT VICTOR COACH- HE SAT IN ER
Head and Neck Service (Marilene Wang was on call) refused to cover my patient Victor Coach who was directed to go to the ER, rather than being seen in Head & Neck. However, the Head & Neck doctors refused and did not consult, but kept the patient in the ER, neglecting his needs.

The patient Victor Coach who had been a patient of Dr. Head's and his wife reports that they were told Dr. Head would not be coming back to work. Coach and his wife were told they had to reschedule with Dinesh Chhetri, M.D. in the clinic, although they would only admit him into the

ER. Nobody in Head and Neck would see him until the following Friday or take care of him as usually done for all other Attending Doctors. Ms. Coach was alarmed that the Head & Neck staff was more concerned about my involvement to treat her husband, than in answering the patients' questions about why they were sitting in the ER for days.

SET UP REGARDING CANCELLED SURGERY ON AUGUST 3, 2012—LIES ABOUT NOT RETURNING PAGES

As scheduled, I returned for my regular duties on Friday to perform surgery at UCLA. On Thursday, I was in contact with the Clinic by Telephone once I landed at LAX , although I had duties at the VA on Thursday. I did not have any appointments scheduled for Thursday.

I performed the surgeries scheduled at the Surgery Center on August 3, 2012. I learned at 4:14 by way of a page, which I returned 2 minutes later, that Manny at UCLA was under the impression that I was to perform another surgery that same day. The first notice I received from the Page Operator was the one I returned at 4:14 pm. I had no other calls on my phone. The Page Operator said another call came in at 1:22 pm while I was in surgery on another case. Manny apparently called the surgery center, knew I was there in surgery. He never asked them to give me a message.

When I spoke to Hiatt, he said "I had not returned 10-20 pages on this date of August 3, 2012. This is absolutely false. The page operator verified to me that this is false.

After further investigation, I confirmed there was no surgery scheduled with that patient, as it had been CANCELLED on August 1, 2012. We have the Fax confirmation sheet on this.

Claire the scheduler, made an error on the form, stating August 6th rather than August 3rd, but I received a phone call that the Surgery with that patient was cancelled. Cynthia Pearson, CRNA in Pre-op said she "cancelled the case and put it in the Medical Record." Cynthia Person notified me of the cancellation of the surgery because there were further medical issues involving the patient. The patient had angina and needed a cardiac work up prior to surgery. There are several witnesses who verify these facts.

The next clinic day on August 8, 2012, my patients were treated rudely and dismissively. They were shocked, disgusted and outraged by the hostile treatment they received by the Head & Neck staff.

Some reported that staff of Head & Neck, including, Judy and Joe had called them and told them " You have a new Doctor, Dr. Head no longer works here. You need to come in to meet your new doctor."

Some were specifically referred to Dr. Chhetri. One was told he had to re-schedule surgery.

Some patients showed up at clinic to see for themselves if "Dr. Head" was still working there. They were upset when they realized the staff had lied to them to get them to schedule with someone else.

I immediately called John Hiatt to inform him of the problems I was observing and the hostility toward my patients.

I asked Nancy, the RN in charge, what was going on and why the patients were being disregarded and treated this way. It seems they were retaliating against me on the backs of my patients. This is unacceptable and dangerous unethical medicine.

Several Patients went downstairs to complain about the poor and hostile treatment by staff in Head & Neck. They said the other patients were not being treated the way they were being treated.

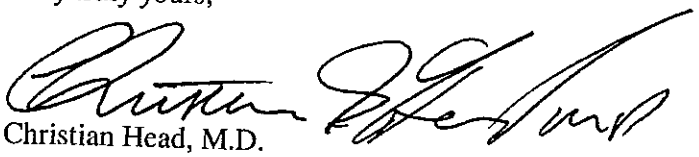
SURGERY AUGUST 10, 2012—FALSE STATEMENTS ABOUT LEAVING PATIENT WHEN PROCEDURE WAS DONE.

I finished my surgical cases on Friday, August 10, 2012. I left the OR to speak to the family, as is customary. The procedure was complete. The Resident was in the OR. When I returned within a few minutes after talking with the patient's family and Dr. Bradley, I was accused of abandoning a patient during surgery. This is ridiculous. Again, they threw out that they tried to page me. I was NEVER paged in those few minutes. There was no adverse issue or problem with the patient or reason that I could not step out to talk to the family. Then they backpedaled, stating they "emailed me." Why would they email me to try to reach me?

I cannot practice medicine this way. These Residents and Nurses dragged my patient and family into this discrimination, retaliation, hostile work environment. Other Doctors are not treated this way. They have supportive staff who help with the families and surgeries. At every turn, UCLA is creating obstacles to my success in treating my patients. All of this is making me sick and unable to effectively work.
UCLA knows what it is doing in trying to drive me out. This concerted effort by all of you to further retaliate and create this hostility toward me is so disheartening. I just want to practice medicine at UCLA in peace.

The Head & Neck staff is undermining me, not supporting me in conducting surgeries, or taking care of patients. I keep thinking you'll stop, but you escalate the horrible treatment of me.

Very truly yours,



Christian Head, M.D.

Dr. Sercarz sent a letter to the Chancellor complaining about how he was being treated and the retaliation. (Sercarz documents attached)

Marilene Wang, M.D. has Multiple Malpractice Claims against her, which UCLA just made her post. Berke had protected her cases and complications from being reviewed or report at UCLA. She has these on her Medical Board License. (Attached) This should take away her privileges at the VA and UCLA. If Chris Head had these malpractice claims, he would have lost his license and privileges at both hospitals.

Marilene Wang is still the Director of Sinus and Disease Center at UCLA with her Malpractice Claims.

He notices comments about him even when he is present, Chris is not here says Dr. Nibili, Then Dr. Head shows up and says, I am here, I was here this morning, I was in the surgical area or risk management area investigating a case.
Nabili calls and texts Dr. Berke, "He's here."

2011-2012 present Dr. Head has no Resident Coverage
Dr. Nabili discusses with Residents no need to cover Dr. Christian Head's UCLA or SM Hospital surgeries.
Dr. Christian Head has not had resident coverage, or minimal coverage since he filed his DFEH. Adverse Action- reduction of his duties, no ability to teach residents which is part of his duties and responsibilities.

Mid December 2011
UCLA Santa Monica Hospital Nurses and Doctors send Chris Head's patient to another Doctor

Dr. Chris Head's patient was referred to Dr. Kedeshian by UCLA OR staff which resulted in adverse action, loss of income to Chris Head of the Case.
Patient - Witness heard and observed Doctor and Nurses at SM Hospital disparaging Dr. Head
The Doctor referred to has misdiagnosed several patients, has malpractice claims, etc.

February 2012
Jerry Berke admits the Gorilla Slide and that he was sodomizing Chris Head in the slide during a conversation. Berke admits to Chris Head that he has referred to Chris Head a "bad doctor" in the last year, but that he is not a bad doctor.

EXHIBIT K

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Phone (310) 706-4050
Fax (310) 706-4052

Attorneys for Plaintiff
CHRISTIAN HEAD, M.D.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

CHRISTIAN HEAD, M.D., Plaintiff, v. REGENTS OF THE UNIVERSITY OF CALIFORNIA; EUGENE BLOCK, PH.D.; JOHN ROSENTHAL, M.D.; KEVIN REED, J.D.; GERALD BERKE, M.D.; MARILENE WANG, M.D.; BENJAMIN CRANE, M.D.; JOSPEH LEE, M.D.; JEFFREY SUH, M.D.; and DOES 1-50, inclusive, Defendant.	Case No. BC 482981 **DECLARATION OF ALMA ROSE MONTOYA**

I, Alma Rose Montoya, know the following facts based on my personal knowledge. If called to testify, I could and would testify truthfully to the facts below:

1. I was the UCLA Residency Coordinator when Dr. Christian Head became a resident physician at UCLA.

2. Dr. Head was voted in to the Head & Neck Department by members of the Head & Neck

Department faculty. At the time, Dr. Head was already at UCLA doing research for Dr Vincente Honrubia.

3. Shortly after Dr. Head was voted in to the Head & Neck Department, I was present and overheard a discussion between Dr. Gerald Berke and another Head & Neck faculty member, in which Dr. Gerald Berke stated in reference to Dr. Christian Head, substantially these words: "we will have some color in the department. We will have our first nigger in the department now."

4. I specifically recall Dr. Gerald Berke using the word "nigger" in referring to Dr. Head in this conversation. Dr. Head was the only African American Resident and Doctor in the Head & Neck Department.

5. There was a situation where Dr. Head was accused of something at Olive View, Dr. Abemayor, the Director of the Residency Program, contacted me to coordinate at meeting with Dr. Christian Head concerning the event at Olive View Medical Center. I showed Dr. Christian Head a copy of the letter from Olive View so he was prepared for the meeting with Olive View. I contacted Dr. Abemayor and coordinated a meeting for him to meet with Dr. Head. After the UCLA/Olive View situation was investigated, Dr. Head was cleared, it was determined that Dr. Head had done nothing wrong.

6. During the time I worked there, on two occasions I observed Dr. Berke take a thick envelope with the days' cash from the front desk at the end of the day Mondays and or Fridays from Gloria Lorena Carbonaro, in left pocket of his lab coat. Dr. Berke put the envelope with the money in his lab coat pocket. Christina Hernandez said to Lorena, "has Dr. Berke received his envelope yet?"

7. I was informed by the graduating residents in the classes of 1995 and 1996, that they were having the graduation roasts reviewed and approved by Dr. Berke, and that was the regular process.

8. At one of the Head & Neck Academic Year End Graduation Roasts, the residents presented a slide showing a patient prepped for surgery in the Operating Room. The slide showed the residents knocking on Dr Berke's office door while a resident was posing as Dr. Berke inside the office smoking a joint. The Chief Resident received approval from Dr. Berke.

9. Based on my interactions with Dr. Berke, I believe he is prejudiced against African Americans.

10. I worked at UCLA starting August 1, 1986. I transferred to the Head and Neck Division on March 31, 1995 until September 1, 1999. I was released from UCLA, as Residency Coordinator by Dr. Berke, he said there was no more funding for my position. I primarily worked for Dr. Elliot Abemayor who ran the residency program at UCLA. Dr. Berke and Dr. Abemayor both wrote a letter a recommendation when I left the Head and Neck Division.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed: Los Angeles, California

Dated: May 24, 2013

Alma Rose Montoya

EXHIBIT L

Statement addressing settlement of litigation by Dr. Christian Head

July 18, 2013

The Regents of the University of California and Dr. Christian Head today reached a settlement in a civil case he brought against the University last year. The case presented difficult issues of alleged discrimination and retaliation that were strongly contested.

The University acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The University regrets that this occurred. The University does not admit liability, and the parties have decided that the case should be resolved with a mutual release of all legal claims. The matter was settled to the mutual satisfaction of the parties.

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Pritzker Family Foundation supports foster youth at UCLA with $3 million gift

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EXHIBIT M

BOTTOM LINE

UCLA doctor settles with UC Board of Regents

Posted: Thursday, July 25, 2013 11:29 am

By Betty Pleasant, Contributing Editor | **0 comments**

Dr. Christian Head, the highly regarded African-American surgeon and UCLA associate professor who claimed UCLA administrators subjected him to a decade-long campaign of disparaging racist acts — the most egregious of which was the public depiction of him as a big black gorilla being sodomized by a white man — has been offered $4.5 million to settle a discrimination lawsuit he filed last year against the University of California Board of Regents.

In his 40-page lawsuit, filed on April 17, 2012, Dr. Head, 51, described a litany of racial bullying, badgering, harassment and overt mistreatment he endured from the day he accepted an assistant professor appointment to the UCLA Medical School faculty in 2002. The general tenor of the abuse being that he was Black, therefore inhuman and inferior and consequently, had no business among the other doctors at the UCLA Medical School.

Dr. Head complained of his abuse to UCLA administrators and was ignored. But he filed suit in Superior Court after he was subjected to the vilest of insults: he — and his witnesses — said Dr. Head was featured in a slide show in which his face was superimposed on the body of a big black gorilla being sodomized by his white supervisor. The slide show was presented at a year-end party of UCLA's medical faculty and staff, where he was the object of shame, derision and hilarity.

UCLA officials vehemently denied every complaint and charge Dr. Head made, including the gorilla-sodomizing slide show. However, the regents voted for Dr. Head's $4.5 million settlement in a closed session July 18 and issued a statement acknowledging that an "inappropriate slide" had been shown at a public university party.

In agreeing to settle with Dr. Head, the regents' stated: "The case presented difficult issues of alleged discrimination and retaliation that we strongly contested. The university acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The university regrets that this occurred. The university decided that the case should be resolved with a mutual release of all legal claims."

Last week's statement by the regents was as far removed from UCLA's reaction when this reporter broke the Dr. Head story last year as the Earth is from Antares. Some 14 months ago, Phil Hampton, associate director of UCLA Media Relations, wrote the following on The Wave's website beneath the story of Dr. Head's plight:

"It is unfortunate that your readers were not afforded the benefit of UCLA's response to the inflammatory allegations made by Dr. Christian Head. UCLA is committed to and promotes diversity, and the campus takes all appropriate steps to protect employees from harassment and intimidation. State whistleblower laws prohibit retaliation against employees who express concerns about what they consider to be illegal activity. University policies embrace these laws, and the campus is committed to preventing any such retaliation. Allegations of discrimination and retaliation are taken very seriously and investigated thoroughly. While privacy laws prevent us from discussing details, UCLA investigated Dr. Head's allegations and found that the evidence does not substantiate the claims of unlawful activity."

Comes now Dr. Joel Sercarz, a 20-year board certified surgeon and 10-year colleague of Dr. Head at UCLA and

other medical facilities, who also filed suit against the University of California Board of Regents last year because he was discriminated and retaliated against, mistreated and ultimately fired from his job because, according to the suit, he supported Dr. Head in his fight against his abusers, protested Dr. Head's mistreatment and backed up Dr. Head's complaints of discrimination.

Dr. Sercarz wrote letters to UCLA administrators denouncing their treatment of Dr. Head and once the administrators learned Dr. Sercarz was a witness for Dr. Head against UCLA, the administrators terminated him for "time card fraud" — claiming he was stealing time.

Dr. Sercarz, who is the first physician terminated by UCLA from a Los Angeles County hospital, has engaged the legal services of the renown Bohm Law Group in Sacramento. His attorney said Sercarz' case is in discovery now and is focusing on how UCLA had him terminated for stealing time by working at UCLA? We'll have to wait and read what Hampton has to say about this on our website.

Posted in Bottom line, Opinion, News on *Thursday, July 25, 2013 11:29 am.* | Tags: Dr. Christian Head, Ucla Associate Professor, University Of California Board Of Regents, Ucla Medical School, Dr. Joel Sercarz

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EXHIBIT N

Independent Investigative Report on Acts of Bias and Discrimination Involving Faculty at the University of California, Los Angeles

October 15, 2013

Presented to:
Executive Vice Chancellor and Provost Scott L. Waugh
UCLA Office of the Chancellor
2147 Murphy Hall, Box 951405
Los Angeles, CA 90095-1405

Investigation and Report by:
Hon. Carlos Moreno (Ret.), Chair
Dr. Maga Jackson-Triche
Professor Gary Nash
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EXECUTIVE SUMMARY

Several high-profile incidents of racial and ethnic bias and/or discrimination have roiled the University of California, Los Angeles (UCLA) campus in recent years. In 2012, the UCLA Chancellor and Executive Vice Chancellor and Provost were approached by a group of concerned faculty about perceived racial bias, discrimination and intolerance at the university. In response to these concerns, Chancellor Gene Block authorized Executive Vice Chancellor and Provost Scott L. Waugh[1] to appoint an independent review team to conduct an assessment and present recommendations to address issues that the team discovered. Executive Vice Chancellor Waugh, in cooperation with faculty, formed the External Review Team to undertake this task.

This report is the culmination of several months of investigation regarding the university's policies, procedures, and mechanisms for responding to incidents of perceived bias, discrimination, and intolerance at UCLA involving faculty of color—including in hiring and advancement decisions. The Review Team interviewed twelve university administrators and eighteen faculty members who were willing to share their candid perspectives. We thank these individuals for their time and commitment to this important issue. The Review Team also conducted a town hall meeting and solicited written submissions from concerned faculty. In additional to anecdotal evidence, the Review Team reviewed UCLA's written policies and gathered statistics on recorded incidents of racial bias and discrimination against faculty.

UCLA is an institution that, by its own account, is "firmly rooted in its land-grant mission of teaching, research, and public service."[2] It is located in Los Angeles, one of the most ethnically diverse cities and counties in the United States. Despite these facts, we found widespread concern among faculty members that the racial climate at UCLA had deteriorated over time, and that the university's policies and procedures are inadequate to respond to reports of incidents of bias and discrimination. Our investigation found that the relevant university policies were vague, the remedial procedures difficult to access, and from a practical standpoint, essentially nonexistent. Faculty of color at UCLA must rely on a patchwork of diversity resources and the generic Faculty Senate complaint and grievance procedures in order to seek redress. While this ad hoc process has sometimes succeeded, it has failed to adequately record, investigate, or provide for disciplinary sanctions for incidents which, if substantiated, would constitute violations of university nondiscrimination policy.

There was clear consensus among faculty members who reported to the Review Team that the administration has demonstrated a lack of leadership on these issues. Faculty identified two main perceived barriers to implementation of changes. First, the primacy of freedom and autonomy for faculty members that characterizes a major research institution. Second, the competition among elite institutions for talented faculty members, particularly

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[1] Hereafter, "Executive Vice Chancellor Waugh."

[2] 2009 Chancellor's Advisory Group on Diversity, Draft UCLA Strategic Plan for Diversity 1, *available at* https://diversity.ucla.edu/strategic-plan/20092010_CAGD_Strategic_Plan.pdf.

those adept at procuring grant dollars. While these are legitimate concerns for the administration, they cannot be prioritized to the exclusion of all other issues. UCLA is a workplace like any other, and adequate processes must exist to ensure that the faculty has opportunities and avenues for redress when faced with incidents perpetrated by colleagues and coworkers that create an intimidating, hostile, or offensive work environment.

As detailed below, we conclude that UCLA's policies and procedures for responding to incidents of perceived bias, discrimination and intolerance involving faculty are inadequate. The university administration must work to find solutions to this problem. The formation of the Review Team is an encouraging first step, but the UCLA leadership must take more action to reform and give teeth to its enforcement of existing nondiscrimination policies. Our recommendations for reform include:

- Enhancing procedures to provide a standardized process for investigation of incidents of perceived bias, discrimination, and intolerance, and for referral of the matter, if necessary, to the appropriate local disciplinary regime.

- Implementation of educational and training programs that aim to prevent such incidents from occurring in the first place, and provide for record-keeping in order to monitor the problem moving forward.

- Creation of a single Discrimination Officer who, assuming that the university provides adequate resources, can fulfill these important functions of education and training, informal and formal investigation and fact-finding, and record-keeping.

I. INTRODUCTION

A. Background & Charge

In recent years several incidents of racial bias and/or discrimination have occurred on the UCLA campus and garnered public attention. Subsequent university press releases regarding the incidents, as well as statements by UCLA Chancellor Block, also received attention.

The incidents and the subsequent statements by UCLA officials, caused consternation among certain faculty members of color at the university. On June 15, 2012, roughly thirty such concerned faculty members sent Executive Vice Chancellor Waugh a letter in which they requested a review of the campus racial climate, as well as the appointment of an independent review committee to address the university's policies and procedures for responding to incidents of racial bias on campus.

Executive Vice Chancellor Waugh met with the concerned faculty members regarding their request in summer 2012, and discussions between the parties concerning the scope of the review continued until November 2012, when they reached agreement on the Review Team's charges and the membership. On November 24, 2012, the Review Team received its charge letter from the Executive Vice Chancellor. The charge was to carry out the following tasks:

- Assess the efficacy and appropriateness of existing university mechanisms and procedures for addressing faculty concerns about perceived acts of bias, intolerance, and discrimination at the UCLA campus.

- Review and assess how existing policies and procedures address faculty concerns about perceived acts of bias, intolerance, and discrimination in the hiring and advancement of faculty at the UCLA campus.

- Recommend changes and additional reviews, if appropriate, to improve the University's understanding of faculty concerns about perceived acts of bias, intolerance, and discrimination at the UCLA campus.

- Identify and explore incidents of alleged racial and ethnic bias or discrimination experienced by UCLA faculty since 2007 and assess and review how such claims have been addressed by the university's mechanisms and procedures for resolving such claims.

- Solicit comments from the UCLA community about such incidents and assess the manner in which resolution or redress was achieved.

- Prepare a written report to the university on the Review Team's findings and recommendations with respect to the above matters.

While the results of the Review Team's work are intended to be public, it is important to note that our recommendations are purely advisory and are not binding on the Executive Vice Chancellor or UCLA.

B. Methodology

The Review Team decided on a basic methodology for its work during an initial meeting in November 2012. First, conduct a review of UCLA's written policies, procedures and mechanisms for handling incidents of racial or ethnic bias. Second, gather information about the real-world implementation of those policies from those who filled the relevant administrative positions. Third, solicit input from UCLA faculty about their experiences—both in written form and through interviews or in a town hall meeting. Finally, gather and review any information available from institutional sources about past allegations or reports of incidents of racial bias or discrimination.

We gathered public information about existing policies, procedures and mechanisms for responding to incidents of perceived discrimination from UCLA's web site. Through this process, we also identified some institutional stakeholders to interview. Additional interviewees were identified by the Executive Vice Chancellor's office, and included many of the concerned faculty.

Attorneys from Irell & Manella LLP, which was engaged by the university to conduct this investigation along with the Review Team, interviewed twelve individuals

regarding the implementation and functioning of UCLA's relevant policies and procedures. These individuals included staff administrators and faculty members in administrative or Academic Senate leadership positions whom had served in their positions during the period of 2007 to the present. Irell & Manella conducted individual interviews with eighteen ladder-rank faculty members, the majority of whom were faculty of color. Three senior faculty members presented their views and experiences directly to the Review Team during an April 2013 meeting. We also conducted a town hall meeting on the UCLA campus that was attended by approximately 50 faculty and administration members, and solicited faculty members to share their thoughts on the university's racial and ethnic climate and its procedures for addressing incidents of perceived bias, discrimination and intolerance. Ten faculty members submitted written statements.

The Review Team received data from the Office of Ombuds Services at UCLA and the UCLA Academic Senate regarding reports of perceived acts of racial or ethnic bias, discrimination and/or intolerance at UCLA from 2007 to the present. The Review Team is thankful to all—administrators, staff, and faculty—who took time to speak with us.

II. FINDINGS

A. The University of California and UCLA Already Have Policies Regarding Nondiscrimination

Unsurprisingly, the University of California (UC) has an official policy forbidding discrimination against or harassment of any person employed or seeking employment with the University of California on the basis of, among other things, race, color, national origin, ancestry, or religion.[3] University policy also prohibits retaliation against any employee or person seeking employment for bringing a complaint of discrimination or harassment pursuant to this policy.[4]

Similarly, the UCLA Faculty Code of Conduct prohibits discrimination by a faculty member against any university employee or another faculty member for reasons of race, color, ethnic origin, national origin, or ancestry.[5] Violations of the Code of Conduct may result in sanctions after a disciplinary process in accordance with Academic Senate bylaws. The Committee on Privilege and Tenure is charged with investigating grievances arising from incidents of bias, including those based on race.[6]

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[3] University of California Academic Personnel Manual, Affirmative Action and Nondiscrimination in Employment § 35(a).

[4] *Id.*

[5] University of California Academic Personnel Manual, Faculty Code of Conduct § 15, Part II § C(5), D(2).

[6] UCLA Website, Academic Senate, Committees, Privilege & Tenure, http://www.senate.ucla.edu/committees/pt/.

B. Existing University Procedures and Mechanisms for Responding to Incidents of Perceived Bias and Discrimination

1. Introduction

We find that to make a complaint or bring a grievance, faculty members are faced with multiple apparent paths. They may seek to address the issue through campus resources put in place for minority faculty, or alternately through the university's general faculty complaint and grievance process. UCLA has numerous overlapping resources that fill these two spaces. Faculty members most consistently addressed their concerns to the Office of Diversity and Faculty Development and its analog, the David Geffen School of Medicine's Office of Diversity Affairs. Some faculty instead raised their concerns with the Office of the Ombuds Services. These offices have engaged in informal resolution of hiring and advancement issues involving minority faculty, as well as data collection regarding faculty diversity issues.

Our review suggests that UCLA's reaction to a report of a perceived incident of bias or discrimination directed toward a faculty member has consistently been to attempt to remedy the problem by making whole the injured faculty member, without any repercussions to the offending party. We find that a significant reason for this failure is UCLA's lack of a centralized resource for responding to incidents of bias and discrimination experienced by faculty members. Current university procedures tend to treat such reports either as interpersonal conflicts or nascent hiring, advancement, and tenure disputes. Accordingly, current procedures emphasize informal resolution over formal investigation into potential violations of university policy.

Furthermore, all of these offices, and the other campus resources to which we learned that faculty members of color make reports, lack the authority or the resources to investigate and make findings regarding incidents of perceived discrimination as violations of university policy. At most, they can, and on occasion do, refer complainants and grievances to the appropriate formal Academic Senate processes that offer formal investigation and fact-finding. However, since substantial deterrents exist to instituting formal Academic Senate proceedings as discussed below, the university's current procedures focus exclusively on remedies at the expense of investigation, fact-finding and disciplinary sanction.

2. Formal Processes

(a) Governance System

Codified by the UC Regents in 1920, the Academic Senate is the vehicle through which faculty share in the operation and management of the university. The Senate is delegated authority over a range of matters, including degree and enrollment requirements and program establishment, disestablishment, and review. The Senate also has a formal advisory role in academic personnel actions. According to the UCLA website, "[t]he Academic Senate's efforts derive from the premise that the university's excellence cannot be

sustained without faculty, administration, staff, and students all making substantive contributions to the university in an involved, respectful and collaborative fashion."[7]

(b) Formal Academic Senate Committees

The Academic Senate provides for a faculty grievance process, governed by Academic Senate Bylaw 335.[8] Grievances are defined as a complaint that any specific administrative act was arbitrary or capricious or violated applicable University rules, regulations, or personnel policies and adversely affected the individual's rights.[9] Grievances are handled by the Committee on Privilege and Tenure (also referred to as the Privilege and Tenure Committee). Another committee, the Committee on Charges (also referred to as the Charges Committee), handles disciplinary actions against faculty members.

As part of its duties, the Charges Committee reviews charges of alleged violations of the Faculty Code of Conduct, including the sexual harassment policy, by faculty members. Anyone may bring a complaint to the Charges Committee if the complaint concerns an alleged violation of one or more provisions of the Code. The Committee may require the complainant to exhaust administrative remedies and to determine that no satisfactory resolution can be implemented at the departmental or college level.[10]

If, after an informal hearing,[11] the Committee makes a finding of 'probable cause' of violation of the Code, it transmits the complaint to the Vice Chancellor of Academic Personnel who in turn refers the complaint to the Privilege and Tenure Committee, which holds formal hearings and makes recommendations to the Chancellor on disciplinary sanctions. Some verbal complaints are fielded and resolved informally.[12]

The Privilege and Tenure Committee makes recommendations to the administration in disciplinary, grievance, and early termination matters involving Senate members. Faculty members complaining about UCLA administrative actions file their complaints *directly* with the Privilege and Tenure Committee. Grievances may be concerned with alleged procedural irregularities in the academic personnel process, including prejudicial action based on race,

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[7] UCLA Website, Academic Senate, An Overview, http://www.senate.ucla.edu/committees/pt/SharedGovernanceOverview.htm.

[8] *See generally* Bylaws of the Academic Senate, University of California, Part III, § 335, *available at* http://www.universityofcalifornia.edu/senate/manual/blpart3.html#bl335.

[9] Campus Counsel, Resource Guide: Faculty Grievances and Discipline § 1(A), http://www.campuscounsel.ucla.edu/documents/OutlineGrievancesversuDiscipline3.pdf.

[10] UCLA Website, Academic Senate, Committees, Charges, http://www.senate.ucla.edu/committees/charges/.

[11] *Id*.

[12] UCLA Website, Academic Senate, Committees, Charges, Charges Informational Packet, Charges Committee Bylaws, http://www.senate.ucla.edu/committees/charges/bylaws.htm.

religion, or sex.[13] In the case of alleged violations of the Faculty Code of Conduct, the Committee conducts formal hearings after the Charges Committee has made a 'probable cause' determination. After a formal hearing, the Committee delivers a report to the Chancellor, including a recommendation of sanction. The Chancellor then makes a final decision in the matter.[14] The Academic Senate's role in personnel actions is, ultimately, advisory.

These Academic Senate committees reported receiving few complaints or grievances involving perceived acts of discrimination, bias or intolerance. The Privilege and Tenure Committee reported that it receives three to four grievances of any kind a year, and resolves most matters informally by speaking to the grievant and the other parties separately. Formal proceedings are rare; for instance, the Privilege and Tenure Committee reports that it has held only one formal hearing in the past two-and-a-half years. These committees reported that typically such processes take one to three months to conclude, although other administration officials characterized the process as taking much longer.

The Academic Senate provided statistics to the Review Team regarding complaints filed with its formal committees from the period of 2007 to the present. During this time, two charges of perceived discrimination brought by faculty members were filed with the Charges Committee. One of the formal charges filed by a faculty member, brought in the 2011-2012 academic year, claimed that another ladder-rank faculty member had engaged in discrimination on the basis of race or ethnicity both against the complainant faculty member and a graduate student.[15]

From 2007 to the present, the Privilege and Tenure Committee heard one case involving allegations of racial or ethnic discrimination. The case was adjudicated during the 2008-2009 academic year and involved the filing of a formal charge by the Vice Chancellor for Academic Personnel against a ladder-rank faculty member. Among other violations of the Code of Conduct, the subject of the hearing was perceived to have harassed and discriminated against a staff member on the basis of race. The Privilege and Tenure Committee recommended, and the Vice Chancellor found, that the faculty member in question had violated the Code of Conduct.[16]

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[13] UCLA Website, Academic Senate, Committees, Privilege & Tenure, http://www.senate.ucla.edu/committees/pt/.

[14] UCLA Website, Committees, Grievance Advisory Committee, Grievance Advisory Committee Manual, Appendix XII, §§ 9 (D), 10, http://www.senate.ucla.edu/FormsDocs/Appendices/appxii.htm.

[15] Several key administration officials who discussed this case remarked on the fact that the allegedly offending faculty member was in fact also a member of an underrepresented minority group.

[16] Appendix A contains a flowchart illustrating the current process, including the informal processes discussed in the following sections.

(c) UCLA Office of the Campus Counsel

The Office of the Campus Counsel notes on its website that it "supports the diverse and dynamic educational environment of the University of California Los Angeles, by providing legal advice and assistance related to the activities of the UCLA campus and its professional schools."[17] According to the university, reviewing, investigating, and advising campus leadership on responses to discrimination falls within the purview of the Office.

(d) Sexual Harassment Officer/Title IX Officer

We learned that the university has also begun utilizing UCLA's Sexual Harassment Officer to investigate charges of acts of racial bias or discrimination that reach the stage of formal Academic Senate processes.[18] The current Sexual Harassment Officer is an attorney and was formerly a lawyer for the Los Angeles district office of the Equal Opportunity Employment Commission. She stated that she has undertaken three such investigations since 2007.

3. Informal Procedures

(a) Vice Provost for Diversity & Faculty Development

We learned that faculty often took reports of incidents of perceived discrimination or bias to the Vice Provost for Diversity & Faculty Development (commonly referred to as the "Vice Provost for Faculty Diversity") or her medical school analog, the Associate Dean for Diversity Affairs at the David Geffen School of Medicine. The Vice Provost is the chief officer of the Diversity & Faculty Development Office, which states that its mission is to provide "academic leadership for achieving and sustaining faculty diversity," and that it fulfills this mission by "educating, communicating, and collaborating with the faculty and administrators on campus on all aspects of faculty diversity." It also seeks to provide resources to promote faculty development and diversity.

On its website, the office provides a link to the Office of Academic Personnel page for complaints and grievances, which informs complainants of the informal and formal grievance resources available. The Diversity & Faculty Development Office also provides links to external compliance agencies which complainants can contact regarding filing a complaint of discrimination, including the Los Angeles district office of the United States Equal Employment Opportunity Commission.

The Vice Provost reported that she receives complaints and grievances from faculty members. She stated that she received six to eight such complaints a year. Most involved tenure matters, and therefore came during the times each year when tenure is granted. Most

[17] UCLA Website, Office of the Campus Counsel (OCC), http://www.campuscounsel.ucla.edu/mission.html.

[18] The university's use of the Title IX Officer in this regard appears to mirror its use of her regarding complaints regarding sexual harassment filed with the Charges Committee. *See* UCLA Procedure 630:1: Responding to Reports of Sexual Harassment § VI.

of these complaints involve gender, with some sexual orientation and some disability-related. A small number are race or ethnicity based. She stated that her offices did not keep official records of complaints, but that she recalled four complaints involving perceived discrimination since her tenure began in 2010. Two of the matters were resolved with tenure grants, one through the Academic Senate processes, and one informally through intervention with a department chair. The other two matters remain unresolved. The Vice Provost said that she refers about two to four complaints a year for further investigation or institution of formal Academic Senate grievance processes. Her predecessor recalled only two complaints regarding incidents of perceived discrimination from 2002 to 2010 that resulted in the filing of formal Academic Senate charges. Any other complaints were resolved informally.

The current Vice Provost characterizes herself as a "fixer" for faculty members. She meets with faculty members to hear their concerns and in some cases seeks input from Executive Vice Chancellor Waugh to "assert moral suasion" on a problem. She often attempts to resolve issues informally by placing a call to a dean or department chair. Unlike the UCLA Ombud, the Vice Provost may be required to report certain activities undertaken by her office to the Executive Vice Chancellor and Chancellor. However, she noted that she initially keeps a matter to herself while she attempts to resolve it informally. If she believes that a matter warrants further investigation, she may refer it to the Executive Vice Chancellor or the Office of Campus Counsel.

The Associate Dean for Diversity Affairs at the David Geffen School of Medicine also reported that her office fields complaints and grievances from minority faculty members in the health sciences. She stated that the vast majority of these complaints did not allege overt instances of racial bias or discrimination—in fact, the office has received only one such complaint since 2009. Normally, the complaints by minority faculty members involve a variety of topics: a desire for mentoring, complaints of lack of support and adequate finances for carrying out work, the feeling that something was promised to the faculty member that was not delivered, interpersonal conflicts, reports of intimidation, misunderstanding and complaints of feeling unappreciated. The Associate Dean emphasized that the majority of the complaints involved either funding or other job status issues. She estimated that she was able to informally resolve about half of the complaints, and referred the rest of the complainants to the Academic Senate processes.

(b) Office of the Ombuds Services

The UCLA Office of Ombuds Services offers informal and confidential services in resolving conflicts, disputes, or complaints. It is independent and neutral, and attempts to facilitate communication and assist parties in reaching their own mutually-acceptable agreements. The Ombud may engage in informal fact-finding, clarify issues, expedite processes or initiate mediation. If the Ombud detects a trend or pattern in conflicts or concerns, it may make recommendations for review or change in policies or procedures.

The Office of the Ombud serves three main constituencies: students (40%), staff (40%) and faculty (11-12%), with the remainder being members of the campus community, such as parents. Clients initiate contact by calling the office or walking in. The Ombud characterized the function of her office as "pointing complainants in the right direction."

She stated that she may either recommend formal processes or informal ones. She stated that some complainants may either desire to pursue a remedy, or "just want to talk." She stated that in an effort to resolve matters informally, she may sometimes engage in "shuttle diplomacy." She has spoken to department chairs or deans on behalf of faculty. The Ombud reported that the number of complaints initiated by faculty members of color has been increasing annually. Although the office did not consistently gather ethnicity data before 2011, the office estimated that from 2007 to 2011, the number of self-reported discrimination cases brought to the office averaged one to two per year, and were most often gender cases brought by Caucasian female faculty.

In 2011-2012, the office reported it received thirty complaints by minority faculty members, seventeen of which came from Academic Senate members. Of these complaints, fifteen (50%) were by Asian or Asian-American faculty members, five (17%) were by Middle Eastern faculty members, four (13%) by Chicano/Latino faculty members, three (10%) by African-American faculty members, and three (10%) other ethnic minorities. Of the thirty complaints in 2011, six involved "general incivility," four "discrimination," and three "bullying." The Ombud noted that the increase in complaints by minority faculty members might be due to the Office's hiring of an Ombudsperson to directly serve the Center for Health Sciences. The Office stated that all of the self-reported discrimination, incivility and bullying cases were given referral information on how to further address their concerns.

(c) Grievance Advisory Committee

The Grievance Advisory Committee (GAC) is operated by the Academic Senate and provides an informal process for members of the campus community to resolve complaints or grievances. The members of the GAC are all former Privilege and Tenure or Charges Committee members.[19] Academic Senate staff informed us that when an individual has questions about individual rights or privileges or is considering bringing a grievance, he or she may contact the Academic Senate Coordinator for the GAC, who will refer the individual to a GAC member who will advise the complainant on policy and procedure, which standing committee to approach and how to proceed with a case. All advice is confidential. Academic Senate staff stated that while complainants are often advised to exhaust their complaints before their department or school, they are not required to do so if the complaint involves the department chair or a dean.

Because GAC members meet individually with complainants under confidential circumstances, GAC members are not collectively aware of the number or nature of complaints. Academic Senate staff stated that two complaints of incidents of perceived bias and discrimination have been brought to the GAC since 2003. Of these, one resulted in a formal process before the Privilege and Tenure Committee that resulted in disciplinary sanction against a tenured faculty member for discriminatory conduct toward a staff member, and the other involved a charge recently dismissed by the Charges Committee, after an investigation by the university's Title IX officer, for lack of probable cause. The

[19] UCLA Website, Academic Senate, Committees, Grievance Advisory Committee, http://www.senate.ucla.edu/committees/gac/.

charge involved an allegation of discriminatory conduct by a tenured faculty member against another faculty member.

(d) Other Resources

UC has an official whistleblower policy that encourages the reporting of "improper governmental activities."[20] While such activities are normally limited to the "statutory definition" of improper government activities, official UC policy recognizes that "serious or substantial violations of University policy" may constitute improper governmental activities.[21] The policy protects any person who makes a protected disclosure of an improper governmental activity from retaliation or official interference.[22] It provides that a whistleblower may file a retaliation complaint pursuant to the formal grievance processes applicable (for instance, an Academic Senate grievance under Senate Bylaw 335 or a non-Senate academic personnel grievance pursuant to Academic Personnel Manual section 140) or directly with a local official designated to hear retaliation complaints.[23]

The UCLA Administrative Policies and Compliance Office, which is responsible for receiving and responding to whistleblowing reports, stated to the Review Team the office's function is to receive reports and to exercise its discretion to initiate and coordinate formal investigations into possible improper governmental activity. The Office stated that the university had intended the Office's whistleblowing hotline, which is available 24 hours a day and administered by a third party, to serve as a clearinghouse for any and all complaints of violations of university policy, including allegations of discrimination. Despite this, however, the Office reported that it did not receive many reports solely concerned with incidents of perceived bias or discrimination, and that the Office had not initiated a formal investigation into a claim of bias or discrimination by a faculty member.

C. Specific Incidents of Perceived Bias, Discrimination and Intolerance

Every faculty member of color who we interviewed described incidents of perceived bias, discrimination or intolerance that they had personally experienced while at UCLA. Although nearly every one of these faculty members had achieved tenure and professional success at the university, they were still upset by these incidents. Almost universally, they felt that the offending parties had never been required to face consequences for their actions.

Below, we discuss three notable findings arising from our interviews: (1) intradepartmental conflict with a racial component in two UCLA departments; (2) two

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[20] University of California Policy on Reporting and Investigating Allegations of Suspected Improper Governmental Activities (Whistleblower Policy), *available at* http://www.ucop.edu/academic-personnel/_files/apm/apm-190-a1.pdf.

[21] *Id.*

[22] University of California Policy for Protection of Whistleblowers From Retaliation and Guidelines for Reviewing Retaliation Complaints (Whistleblower Protection Policy), *available at* http://www.ucop.edu/academic-personnel/_files/apm/apm-190-a2.pdf.

[23] *Id.*

egregious incidents of bias and discrimination experienced by UCLA faculty members; and (3) reports of incidents of perceived bias in hiring, advancement, and retention decisions.

(a) Department A and Department B

Faculty members alleged that certain departments in particular appear to have been, or are currently, flash points of racial conflict between faculty members: one during the 2000s and one at the present time. The conduct complained of included perceived discriminatory statements as well as discriminatory advancement and retention decisions and the creation of a hostile climate. These departments will be referenced only as "Department A" and "Department B" in order to preserve the confidentiality of the reporting faculty members.

(i) Department A

Two members of Department A described it as becoming polarized along gender and racial lines during the 2000s. They alleged that a group of senior Caucasian male professors began to systemically discriminate against the minority and female faculty members in the department. Such treatment ranged from junior faculty members of color being told that they would not make tenure, to the department's failure to make efforts to retain tenured faculty members of color who had received offers of employment from other universities, to discriminatory remarks leveled at minority faculty members such as "I thought Asian women were supposed to be submissive." Many of these minority junior faculty members later left the university.

One former faculty member in the department, a formerly fully tenured Caucasian professor, told the Review Team that he had spoken out against this conduct, had been retaliated against by the department's chair in the form of a recommendation against a merit increase in pay, and had subsequently retired from UCLA rather than continue working in the department. Another faculty member, a female faculty member of color, told the Review Team that she threatened to sue the university after the department voted to deny her promotion to full professor. After receiving a settlement from the university, she retired because she had no further desire to remain in the department.

(ii) Department B.

Two current faculty members in Department B alleged that it was currently divided among racial lines. These faculty members also alleged that they had experienced incidents of bias or discrimination by other faculty members, including senior and/or leadership faculty, within the department. At least one faculty member has filed formal complaints with the appropriate Academic Senate Committees regarding perceived incidents of bias or discrimination. Another faculty member in the Department told the Review Team that he had been passed over for consideration for the department chair position despite his perceived seniority and leadership credentials. The faculty member stated that he believed that this had been due to his ethnicity. The faculty member further perceived that a clique of Caucasian male professors was "in charge" of the department, and that he had personally witnessed faculty in leadership positions within the department use racially or ethnically insensitive language.

(b) Incidents of Racism

Two other UCLA faculty members described egregious incidents of racism. The first involved a Latino faculty member in the health sciences. In 2008, soon after the professor was hired as a fully tenured faculty member at UCLA, a "senior faculty member" in the professor's department, upon seeing him for the first time in the hallway, asked loudly in front of a group of students, "What is that fucking spic doing here?" Upset, the professor went to his assistant dean, who expressed sympathy but advised him that going to the dean of the school would only cause more trouble. The assistant dean promised that he would talk to the senior faculty member. The professor is not sure whether the assistant dean ever did so. The professor stated that he still feels threatened by the faculty member, who is still at UCLA, and that he believes that the man left a screwdriver in the Latino professor's faculty mailbox in 2010.

The second incident involved an untenured professor at UCLA. Several years ago, she received an anonymous communication that criticized her work in vitriolic terms, attacked her for focusing on race-related issues, and contained racist statements regarding African-Americans. The professor told us that she contacted the UCLA Police Department but was told that there was nothing that could be done at that point in time. The professor informed her faculty colleagues of the incident, but knows of no official action taken by her department or the university, such as further investigation of the incident.

(c) Hiring, Advancement and Retention Decisions

The majority of incidents of perceived bias and discrimination we learned about involved hiring, advancement, and retention decisions. We spoke to faculty members who perceived that they had been denied advancement due to bias and discrimination, usually in the form of a negative departmental vote or an unfavorable letter from a department chair or dean. At least one faculty member complained that the empirical nature of the research favored by his department disadvantaged minority faculty who specialized in a different sort of scholarship. Several faculty members described incidents of which they knew in which UCLA department heads failed to match offers made by competing institutions to faculty members of color at UCLA. In both cases an informal resolution (i.e., an increase in salary or research funding to retain the professor) was effectuated, in one case by the Vice Provost for Faculty Diversity, and in the other case by the Executive Vice Chancellor and Chancellor. However, the faculty member personally involved in one of these retention events was still upset about the incident, and in the other case a faculty member close to the situation described the solution as a temporary "workaround."

Several faculty members felt that they had been the subject of adverse employment actions due to discrimination or bias. The two faculty members in "Department A" felt that they had been denied advancement as tenured professors due to discrimination. Two other senior, tenured faculty members perceived that they had been either passed over for leadership positions or treated differently than Caucasian faculty members, events that they perceived as discriminatory. We also learned from minority faculty members that a

department had recently conducted a "waiver of search" for a Caucasian candidate.[24] The concerned faculty felt that the candidate did not meet the high standard for a waiver of search, and therefore that the department in question was abusing the waiver process in order to hire a Caucasian candidate favored by certain faculty members. After the concerned faculty objected and called a departmental meeting, the department withdrew a verbal offer of employment to the candidate.

Other interviewees discussed incidents of perceived discrimination in hiring decisions involving minority candidates. In one account from a senior faculty member, an African-American full professor from an Ivy League institution was rejected for a position at UCLA primarily on the basis of a plagiarism accusation involving a single citation in a 300-page manuscript. While the senior faculty member disputed the merit of the plagiarism accusation, he was most upset by the "racist" tenor of the discussion about the candidate, which implied that the candidate was incompetent, a shyster, and a hustler. The senior faculty member reported the racially inappropriate comments and other irregularities in the process to his dean, who agreed that the candidate's rights had been violated, but asserted that since the candidate was not UCLA faculty, no action could be taken.

D. Findings on Current University Policies, Procedures and Mechanisms

1. Challenges

We acknowledge the elusive and challenging nature of this issue. Our interviews with university stakeholders revealed that the structure of the academic workplace requires both junior and tenured faculty members to participate in hiring, advancement, and retention decisions alongside their fellow faculty members, to undergo periodic reviews by those peers, and to receive supervision by senior faculty members serving in positions such as department chairs or deans. Most of the incidents of perceived bias and discrimination reported by minority faculty members who spoke to the Review Team involved conduct by other faculty members, often senior faculty or faculty serving as deans. Junior faculty members in particular perceive that a wrong step in their early academic career may damage future professional opportunities. Such concerns deter the reporting of incidents of perceived bias or discrimination.

Several university stakeholders told the Review Team that the unique nature of the academic workplace also contributes to the problem. A tenured faculty member of color stated that she believes that the true difficulty lies with the power afforded to tenured faculty members on campus. She noted that the Chancellor has very little direct authority over faculty members, and took issue with the notion that the administration has the power to

[24] "Waiver of search" refers to a specific permission granted by the Chancellor's Office to allow for the targeting of a specific candidate. As such, a waiver of search bypasses some of the normal protocols involved in candidate searches, including consideration of diversity issues. *See* UCLA Diversity & Faculty Development Office, Faculty Search Committee Toolkit, at 4-5, *available at* https://faculty.diversity.ucla.edu/resources-for/search-committees/search-toolkit/2FacultySearchToolkitPrintVersion.pdf.

resolve any such problems. "If you want to change the university," she told the Review Team, "you have to change the faculty."

We note that several faculty members who spoke to us compared their opportunities for redress unfavorably to those available to staff, where, under the applicable personnel procedures, the administration may directly investigate and discipline university employees who engage in discriminatory conduct. By contrast, the administration may only charge and sanction ladder-rank faculty members in a formal Academic Senate Privilege and Tenure proceeding, an adversarial, litigation-like hearing.

2. Findings

Despite these challenges, the Review Team finds that there is much that current university policies, procedures and mechanisms can do to improve in addressing these issues. Specifically, the Review Team concludes that:

- UCLA's nondiscrimination policy fails to adequately define discriminatory conduct;
- UCLA has failed to adequately train UCLA employees, including faculty, in what constitutes discriminatory, biased, or intolerant behavior.
- UCLA's nondiscrimination policy fails to provide for a process for responding to reports of incidents of perceived discrimination that involves investigation and referral to disciplinary proceedings;
- UCLA leadership has failed to convince at least a vocal subset of faculty members of its commitment to diversity in admissions and hiring;
- UCLA has failed to adequately inform faculty members of their reporting options for complaints and grievances;
- The process by which UCLA addresses incidents of perceived bias and discrimination is not clear;
- UCLA lacks a mechanism for the impartial investigation of such incidents; and
- UCLA has failed to clearly communicate that consequences will ensue for those engaging in biased, discriminatory, or intolerant behavior or conduct.

(a) University Policy

Examining the university's written policies, including official administration procedures and the Faculty Code of Conduct, we find that these policies fail to define what constitutes discriminatory conduct. In contrast, UC's sexual harassment policy includes a definition of sexual harassment, and a guarantee that the university will respond to any

reports of such conduct.[25] UCLA nondiscrimination policies further fail to provide for a centralized resource for fielding, investigating and making findings regarding such incidents. Again, in contrast, we note that the UCLA's sexual harassment policies provide detailed procedures for reporting and investigating reports of sexual harassment.

The lack of a self-executing mechanism by which reports are investigated and findings made constitutes a serious shortcoming in UCLA's policies and procedures for responding to such reports. For instance, this system fails to communicate the consequences of violations of the university's policies on nondiscrimination and therefore fails to act as a deterrent. Faculty members complained that this has contributed to a culture of impunity at UCLA as far as perceived violations of the nondiscrimination policies are concerned.

We further find that UCLA's policy for reacting to incidents of perceived discrimination lacks coherence and credibility. Faculty complained, almost unanimously, that the university's responses to certain high-profile incidents of perceived bias or discrimination were disappointing and unhelpful. Several faculty members noted that the Chancellor's public statements reacting to the well-publicized incidents of alleged racial bias and/or discrimination had essentially asserted that the conduct at issue in the incidents was not reflective of "the university I know."[26] Faculty members felt that such statements, far from communicating a commitment to diversity and nondiscrimination, instead communicated that administration was out of touch with the reality of the racial climate at UCLA. As one senior faculty member complained, where nondiscrimination is concerned, the administration of UCLA is administering to a "vision rather than a reality."

University stakeholders described this disconnect as a structural issue within the Chancellor's office itself. One former senior administration official wrote in a letter to us that, "in recent years, it has been clear to me that UCLA's current administrative style is to actually hide 'hot button' issues even from its own executive leadership team, preferring a narrowly construed 'need to know' approach with respect to a range of campus incidents and problems." Several faculty members and administrators noted a belief that that the Chancellor's office does not currently include a senior African American or Latino/Latina administrator; however, this is not presently the case.

Faculty also criticized the university's policies and procedures for meeting diversity goals in admissions and faculty hiring. While these policies, and an overall survey of the

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[25] "Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when submission to or rejection of this conduct explicitly or implicitly affects a person's employment or education, unreasonably interferes with a person's work or educational performance, or creates an intimidating, hostile or offensive working or learning environment. In the interest of preventing sexual harassment, the University will respond to reports of any such conduct." University of California Policy on Sexual Harassment, *available at* http://www.ucop.edu/ucophome/coordrev/policy/PP021006Policy.pdf.

[26] The Chancellor's public statement regarding the so-called "Asians in the Library" video may be seen at http://www.youtube.com/watch?v=6feGp0GQVJ8 (last visited October 10, 2013).

campus racial climate, are beyond the purview of our charge or the scope of this report, they are relevant to our inquiry. Several faculty members and administrators linked the lack of a perceived "critical mass" of students and faculty of color to the university's inadequate procedures and mechanisms for responding to incidents of discrimination.[27]

The university stakeholders who spoke to us on the subject opined that the recent high-profile racial incidents at UCLA were merely the "tip of an iceberg" of a campus racial climate that has deteriorated markedly for students and faculty of color. "It is as if I have stepped into a time machine and been propelled backward 40 years to 1971 when Blacks, Latinos—and yes even Asians—were just beginning to enter prestigious, predominantly white institutions like UCLA in any serious numbers," one faculty member who has taught at UCLA for twenty-five years wrote in a letter.

In particular, university stakeholders criticized UCLA's reaction to Proposition 209 as "extraordinary" and "beyond what was required by law," comparing it unfavorably with that of other major UC campuses such as Berkeley. They complained that the university had not taken sufficient steps to develop policies to further diversity on campus within the strictures of Proposition 209, nor communicate to the campus community that it was the university's policy to do so despite the law. In fact, interviewees describe an administration more concerned with warning the campus community against violation of Proposition 209 in admissions and hiring decisions than suggesting proactive steps to further racial diversity on a campus that the Chancellor publicly touts as diverse.[28]

(b) University Procedures

As noted above, UCLA's policies fail to adequately define what constitutes racial or ethnically discriminatory conduct, and fail to provide a procedure for responding to reports of such conduct. Similarly, UCLA's current procedures fail to rectify this problem. UCLA currently relies on an ad hoc network of resources to respond to complaints regarding incidents of perceived bias or discrimination. However, the university has failed to adequately inform faculty members of these reporting options. For instance, the only comprehensive resource guide for faculty complaints and grievances, apparently created by campus counsel, is available from a relatively hard-to-reach link on the Office of Academic Personnel website.[29]

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[27] It is beyond the External Review Team's charge to determine whether such a lack of "critical mass," assuming it can be defined, exists at UCLA. Nonetheless, the data suggests that there have been significant demographic shifts at the university. Appendices C, D, and E to this Report provide some historical enrollment data for minority undergraduate, graduate and professional schools, as well as current number of minority faculty at UCLA. We thank UCLA for providing this information.

[28] "UCLA represents the very best of what a university can be—a diverse community of talented people who enrich our society through education, research and service." Statement of Gene D. Block, Chancellor, *available at* http://chancellor.ucla.edu/welcome.

[29] *See* http://www.campuscounsel.ucla.edu/documents/OutlineGrievancesversuDiscipline3.pdf.

We find that faculty, in general, report complaints and grievances regarding incidents of perceived discrimination to the Vice Provost of Faculty Diversity, the Ombud's Office, and the GAC. Faculty members also indicated that they rely on the four ethnic studies research centers on campus for support with such issues. However, with the exception of the GAC, none of these resources are solely devoted to fielding complaints and grievances. Moreover, few faculty members utilize the GAC, perhaps because it is perceived as a gateway to the more formal Senate processes. While faculty use of the Ombuds office appears to be increasing, historically it has not been widely utilized. Nor has the Administrative Policies and Compliance Office (the whistleblowing office).

To some degree, the offices of the Vice Provost for Faculty Diversity and Associate Dean for Academic Diversity present a logical first stop for minority faculty with complaints involving hiring and advancement decisions since both offices carry the official charge of helping the university and medical school meet faculty diversity goals. We find that the Vice Provost has indeed informally resolved complaints by minority faculty members involving advancement and retention decisions. However, the existence of an official who can and does apply, in an unofficial capacity, "moral suasion" to solve problems does not necessarily address faculty concerns regarding the university's overall plan to respond to incidents of bias and discrimination. Moreover, a lack of transparency exists in these resolutions, due in part to the fact that the issues often involve compensation.

While this may be understandable, it contributes to a lack of clarity regarding the resources offered by UCLA where incidents of perceived bias and discrimination are concerned. Additionally, we find that the offices of the Vice Provost for Faculty Diversity, Associate Dean for Academic Diversity, and UCLA Ombud lack important components commonly associated with officials vested with authority to respond to incidents that constitute violations of university policy. They do not have: (1) responsibility for planning and managing education and training programs; (2) responsibility for developing procedures for prompt and effective response to reports of such incidents; or (3) responsibility for maintaining records of complaints of such incidents, or for preparing periodic reports on complaint activity to senior administration officials. Therefore, while we acknowledge that these offices currently play an important role in the university's response to perceived incidents of bias and discrimination, that role is insufficient to address faculty concerns regarding the university's response to such incidents.

We also find that the university lacks a mechanism for impartial investigation of such incidents outside of a formal Academic Senate proceeding. The university currently has no official procedure by which a complaint triggers an informal or formal investigation by a dedicated, impartial official. As noted above, administration officials appear to have instituted the practice of asking the school's Title IX Officer to investigate certain incidents of alleged discrimination, perhaps using as a model the procedure for investigation of sexual harassment complaints brought to the Charges Committee. However, because the Sexual Harassment Officer appears to only investigate discrimination complaints brought to the Charges Committee, there is no mechanism by which the above-mentioned offices or any other campus office that engages in informal dispute resolution regarding such complaints, may directly call upon her services. This compares unfavorably with the university's sexual harassment procedures, which provide for a single office that fields complaints and offers

informal resolution options, but also may launch a formal investigation. High-ranking administration officials involved in academic personnel matters told us that they believed that a more professional process in investigations is needed to address incidents of perceived bias and discrimination. We agree.

Moreover, the Title IX Officer's impartiality remains unclear, as she informed us that she investigated a recent incident of alleged racial bias and/or discrimination in the context of advising the school on a potential settlement. The use, on an ad hoc basis, of an investigator who has at times acted on behalf of campus counsel in anticipation of litigation, is insufficient to address faculty concerns in this area. While key administration personnel praised the Title IX Officer's professional training and ability, her use in this capacity by the administration lacks transparency and credibility.

We find that UCLA's current procedures fail to adequately communicate the consequences that will ensue for those who engage in discriminatory conduct. Many faculty members complained during interviews that administration officials often offered a remedy to faculty of color who had experienced an incident of discrimination, but that the administration rarely if ever meted out punishment to the offending party, even eschewing confrontation of that party altogether. This approach of crafting workarounds and not punishing the individual engaging in discriminatory conduct sends the message that those who violate the university's policies against discrimination will not be punished. Faculty members assert that without an effective deterrent message, a culture of impunity has developed at UCLA.

In short, the university's current ad hoc system of resolving complaints, which relies on a patchwork of resources and unofficial fixing of disputes by key administration officials, focusses on making victims whole, not meting out consequences. This focus on redress, not repercussions, may address the immediate needs of a particular party needing a remedy, but neglects the long-term needs of the campus community. Disciplinary sanctions for conduct that violates university policy deter both the specific offender and campus community from subsequent offenses. It will also encourage those who have experienced discriminatory incidents to report them. It further sends the message that the university values diversity and takes discriminatory conduct seriously.

The formal Academic Senate processes do not offer a viable solution to these issues. Few complaints and grievances regarding incidents of perceived discrimination reach the Charges or Privilege and Tenure Committees. The process for bringing a formal complaint or grievance can be bewildering to faculty members, and can take months to conclude. Some faculty members who considered instituting proceedings told us that they had concluded they could not afford legal fees for counsel. Other university stakeholders said that they considered the Academic Senate processes to be a last resort for individuals who had nothing to lose, such as a professor who has been denied tenure. In short, the prospect of engaging in the quasi-litigation that characterizes a Privilege and Tenure Committee proceeding deters many faculty members from using that process.

We recognize that not all of the incidents of perceived discrimination of which faculty members complain will be actionable. Several faculty members referenced the notion of "microaggressions," which researchers have defined as "subtle verbal and

nonverbal insults directed toward non-Whites, often done automatically and unconsciously. They are layered insults based on one's race, gender, class, sexuality, language, immigration status, phenotype, accent, or surname."[30] It is not clear to us whether any workable definition of discriminatory conduct is capable of capturing every such microaggression experienced by a minority faculty member. We also recognize that advancement and tenure decisions are notoriously subjective, and those making the decisions may advance plausible, race-neutral reasons for those decisions. Heightened awareness of the issue of racially insensitive conduct may help to reduce microaggressions or other subtle behaviors that degrade the work environment for faculty of color. Some enhanced recordkeeping would allow the university to monitor the number of complaints regarding such incidents, and therefore to better understand the campus climate for faculty (and students) of color. And finally, investigations might deter those who would engage in such conduct, even if their actions would likely not constitute a violation of university policy.

III. RECOMMENDATIONS

A. Chancellor's Policy Statement

We recommend that the Chancellor issue a statement to the campus community acknowledging faculty concerns regarding the university's policies, procedures, and mechanisms relating to incidents of alleged bias, discrimination, and intolerance on the UCLA campus and in hiring and faculty advancement decisions, and reflecting the university's commitment going forward to "zero tolerance" for such incidents. A link to this report should be included in this statement, and the report should be available online on the UCLA website. Empirical research has confirmed that "no tolerance" statements, along with protocols for disciplinary procedures, are among the most effective means in the sexual harassment context of reducing reports of sexual harassment and assault.[31]

B. Discrimination Officer

We recommend that the university institute a Discrimination Officer to address incidents of alleged bias, discrimination, and intolerance. Although the university does not currently keep official records on the volume of complaints of such incidents, because it is possible that the existence of such an Officer may itself improve reporting practices, we envision that this be a full-time position.[32] We recommend that the Officer have the following responsibilities, many of which are analogous to the responsibilities of the university's Sexual Harassment Officer.

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[30] Daniel Solorzano, Ph.D, Walter R. Allen, Ph.D, and Grace Carroll, Ph.D, *Keeping Race in Place: Microaggressions and Campus Racial Climate at the University of California, Berkeley*, 23 Chicano-Latino L. Rev. 15, 17 (2002).

[31] Working Group at the Yale School of Medicine, *Findings of the Working Group in Examining Sexual Harassment and Sexual Assault Procedures and Processes at the Yale School of Medicine* 3 (Dec. 7, 2007).

[32] We also note the possibility that the Discrimination Officer's responsibilities could encompass other types of discrimination, including on the basis of gender, age, and sexual orientation.

First, the Discrimination Officer will review and investigate complaints of incidents of alleged bias, discrimination, or intolerance when a report of such an incident is received. This should include advising complainants of available resolution options, as well as information such as timeframes. However, the Officer should also have the independent authority to conduct fact-finding investigations, to notify individuals accused of violating the university's discrimination policy and to compile reports at the conclusion of each investigation. We must emphasize that this independent authority to conduct investigations constitutes the core responsibility of the office. This authority is vital to giving the position the credibility and authority needed to respond adequately to reports of incidents of bias and discrimination. Without such authority, the administration's processes for responding to such incidents lack credibility and deterrent power. Complainants must feel that they have the ability to request such an investigation directly from the Officer. We envision the Officer's investigations as existing concurrently with the probable cause investigations undertaken by the Academic Senate Committees in the same manner as sexual harassment investigations.[33]

Second, the Discrimination Officer will plan and manage education and training programs. This responsibility should involve dissemination of the aforementioned general UC and UCLA policies on nondiscrimination to the campus community, as well as the design and implementation of educational measures to illustrate what conduct would constitute a violation of those policies. It would further involve design and implementation of measures to inform faculty members of reporting procedures for incidents of perceived bias and discrimination.

It is crucial that such training include leadership diversity training for campus leaders, in particular department chairs and deans. Our interviews revealed that many complaints by a minority faculty member involved, in some capacity, the action or inaction of a department chair, dean, or assistant dean. Leadership training on diversity issues for these officials is therefore key to addressing such incidents moving forward.

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[33] The Campus Procedures for Implementation of University Policy on Faculty conduct and the Administration of Discipline provides for special grievance procedures in the case of sexual harassment complaints. *See generally* UCLA Website, Academic Senate, Committees, Grievance Advisory Committee, Grievance Advisory Committee Manual, Appendix XII, http://www.senate.ucla.edu/FormsDocs/Appendices/appxii.htm. In the case of all complaints against a faculty member other than sexual harassment or scientific misconduct complaints, the Charges Committee has the responsibility to determine whether probable cause of violation exists. *Id.* § 1(F). In contrast, when a sexual harassment complaint is filed against a faculty member, the Chair of the Charges Committee and the Vice Chancellor, Academic Personnel are notified and they jointly appoint a factfinder, which at UCLA is the Sexual Harassment Officer. *Id.* §§ 1(G), 5(B). The factual inquiry is conducted in accordance with the University Sexual Harassment Policies, and the Sexual Harassment Officer functions as an arm both of the Charges Committee and the University administration. *Id.* § 1(G). The Charges Committee then uses the Sexual Harassment Officer's report as a basis for probable cause *vel non*. *Id.* § 5(B).

Third, the Discrimination Officer will maintain records of incidents of perceived bias and discrimination experienced by faculty. As noted above, UCLA currently has no centralized database of incidents of bias and discrimination—at least those involved with faculty hiring and advancement decisions. Such records should include records of investigations, resolutions, and disciplinary action.

Finally, the Discrimination Officer should be the primary referral for all faculty members seeking to report incidents of perceived bias, discrimination or intolerance, as well as for advice regarding pursuing redress through the formal Academic Senate processes.[34]

C. UCLA Procedure for Responding to Reports of Incidents of Bias or Discrimination

We recommend that UCLA issue a procedure for responding to incidents of perceived bias, discrimination or intolerance that: (1) provides for the creation of the Discrimination Officer and describes the responsibilities of that office; (2) encourages members of the campus community to contact the Discrimination Officer with reports of conduct that might be subject to the university's policy on nondiscrimination; (3) provides for procedures for informal resolution of such reports and more formal investigations; (4) provides for remedies and referral to the appropriate local disciplinary proceedings; and (5) provides for privacy and confidentiality for complainants, and the retention of records.

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[34] We wish to briefly address the issue of overlap between the duties of the Vice Provost for Faculty Diversity and the envisioned duties of the Discrimination Officer. As noted above, the Office of Diversity & Faculty Development has fielded reports of incidents of perceived discrimination involving faculty, and has engineered informal resolutions to hiring, advancement and retention issues involving minority faculty. Although such actions are unofficial and characterized by a lack of transparency, we acknowledge that the Office fulfills an important function in advocating in this manner. We further acknowledge that at times, it may be difficult to separate a complaint from a minority faculty member regarding an adverse employment decision from a complaint regarding an incident of perceived discrimination.

Thus, some overlap exists between the Vice Provost's current functions and the envisioned function of the Discrimination Officer where faculty members are concerned. However, the fact remains that no official mechanism exists by which the Office of Diversity & Faculty Development may initiate fact-finding that leads either to a recommendation that the complainant seek redress through formal processes, or findings of violations of university policy. We further believe that such investigations should not be undertaken by the Vice Provost. The Vice Provost's position, as currently designed, does not require the training or experience required to carry out such investigations. Moreover a potential conflict of interest exists between any investigatory function and the Vice Provost's mission to advance diversity among UCLA faculty. Appendix B contains a flowchart demonstrating the role of the Discrimination Officer in the formal grievance process.

D. Creation of Gateway

We also recommend that UCLA create a website that clearly communicates UC and UCLA's policies and procedures regarding discrimination, including descriptions of what constitutes discriminatory conduct, policy statements regarding discrimination at the university, and most importantly, a clear statement of the disciplinary procedures that will result from a finding of discriminatory conduct. The site should also provide (1) a step by step resource guide outlining the options that a complainant may pursue at each step of the process, and provide an easy entry points, such as an online form, for submitting a report of an incident of perceived discrimination; (2) information on resources available to complainants both on and off campus, and (3) contact information for the Discrimination Officer. We recommend that prominent links to this website be placed on websites such as the Office for Diversity and Faculty Development, the Office of Academic Personnel, and the website of the Office of Diversity Affairs at the David Geffen School of Medicine, among other appropriate websites.

E. Further Review of Diversity Efforts in Admissions and Hiring

Concerned faculty members described a campus racial climate in near-crisis. As noted above, senior faculty members and former administration officials contended that the recent high-profile racial incidents at UCLA were only the tip of the iceberg, and that the campus racial climate, for a variety of reasons, has regressed since the mid-twentieth century. Several of these experienced faculty and administration officials mentioned that many of the faculty concerns described in this report may be in part due to the lack of a critical mass of minority faculty and undergraduate and graduate students at the UCLA campus.[35] Those interviewed further described a university administration that, at its highest levels, had failed to convince the public and the campus community of its commitment to diversity.

Accordingly, we recommend further review of the effectiveness of the university's ongoing efforts to achieve diversity in its student population and faculty.[36] This review should include an examination of the efficacy of current university measures in furtherance of diversity goals in the university's admissions policies both for undergraduate and graduate students, as well as campus-wide faculty hiring. The review should explore whether UCLA has adequately communicated these diversity goals both to the general

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[35] *See* Footnote 31, *supra*; see also Appendixes C, D, and E to this Report.

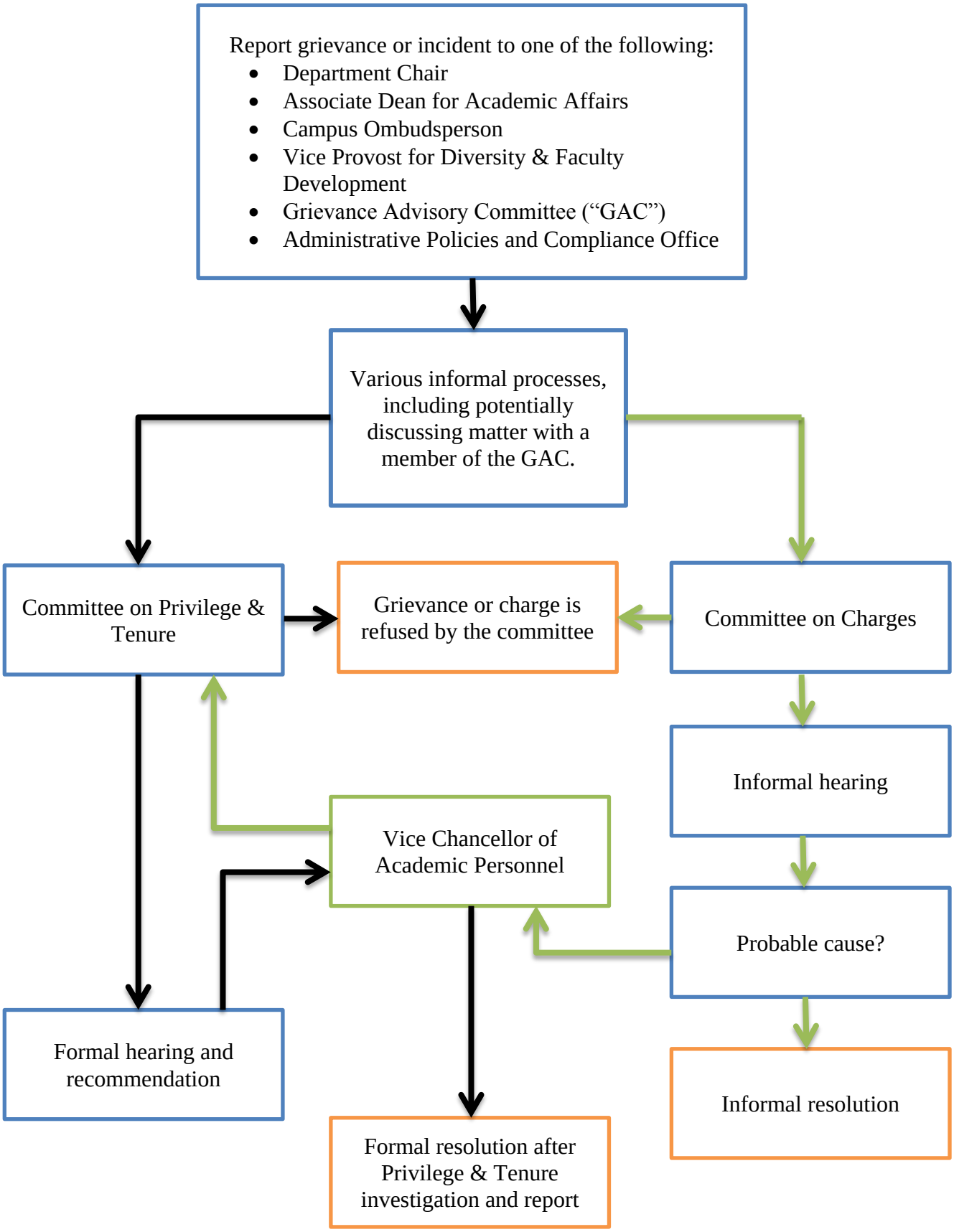
[36] *See* Message from the Chancellor, available at https://diversity.ucla.edu/chancellors-message ("Diversity is a core value of UCLA*")*; *see generally* 2009 Chancellor's Advisory Group on Diversity, Draft UCLA Strategic Plan for Diversity, *available at* https://diversity.ucla.edu/strategic-plan/20092010_CAGD_Strategic_Plan.pdf; *see also* University of California, *Regents' Policy 4400, University of California Diversity Statement* (Sept. 20, 2007), *adopted as amended September 15, 2010* ("Because the core mission of the University of California is to serve the interests of the State of California, it must seek to achieve diversity among its student bodies and among its employees."), *available at* http://www.ucop.edu/ucophome/coordrev/policy/PP063006DiversityStatement.pdf.

public and to decision-makers in admissions and faculty hiring within the campus community, and in particular examine whether the administration has adequately explained to those decision makers how to pursue such diversity goals within the legal requirements of Proposition 209. The review should include a written report to the university and recommendations for changes in procedures if appropriate. To ensure that campus decision-makers are adequately reassured that the university is acting within the strictures of 209, the Review Team recommends that Campus Counsel take a proactive and leading role in examining the university's response to 209, designing and implementing new strategies, if needed, to pursue diversity goals within the bounds of 209, and educating campus decision-makers on those strategies and policies.

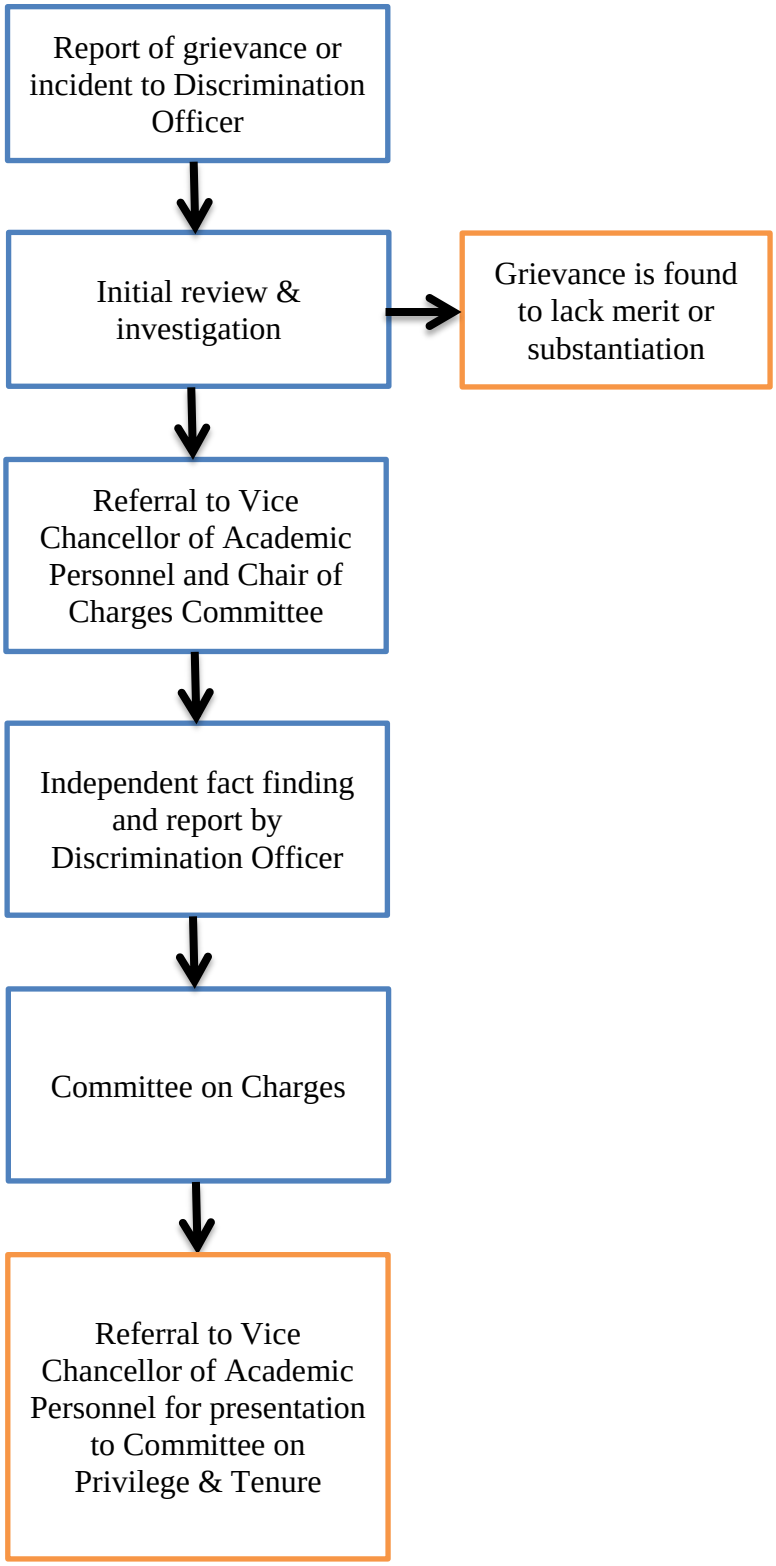
F. Implementation of Recommendations

We recommend the formation of an internal committee to oversee the implementation of our recommendations. All of the recommendations may be acted upon by the administration immediately, and we believe that the recommendations are practical, fiscally responsible, and realistic first steps toward addressing the faculty concerns discussed in this report. The internal committee may therefore set a timetable for implementation of the recommendations. We further recommend that the committee review the implementation of the recommendations themselves, including the drafting of university procedures for responding to incidents of perceived discrimination, and reviewing the reports of the envisioned Discrimination Officer regarding the reports received of such incidents and investigations, outcomes, and disciplinary actions taken.

Appendix A: Current Racial Bias or Discrimination Grievance Process



Appendix B: Proposed Role of Discrimination Officer



Appendix C: UCLA Undergraduate Enrollment by Ethnicity 1973-2012*

UNIVERSITY OF CALIFORNIA LOS ANGELES

UNDERGRADUATE FALL HEADCOUNT ENROLLMENT BY ETHNICITY

1973-2012

		1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Los Angeles	African American	1,319	1,144	1,073	1,045	1,111	1,011	998	925	1,101	1,146	1,294	1,303	1,423	1,544	1,580	1,659	1,678
	American Indian	130	136	116	89	98	83	82	73	60	93	106	116	136	155	175	203	232
	Asian/Pacific Islander	2,006	2,144	2,398	2,566	2,736	2,837	3,216	3,370	3,847	4,300	4,657	4,704	4,767	4,892	5,198	5,398	5,849
	Chicano/Latino	1,075	1,040	1,106	1,165	1,228	1,271	1,312	1,226	1,360	1,457	1,725	1,977	2,332	2,699	3,104	3,434	3,715
	International	529	585	599	547	498	570	723	770	889	764	721	716	578	526	529	556	585
	Other/Unknown	1,113	1,753	1,434	1,111	597	545	517	2,299	1,439	1,050	910	837	755	710	759	669	657
	White	13,968	14,104	15,044	14,094	13,925	13,872	14,234	13,341	13,913	14,123	13,721	13,240	12,910	12,225	12,156	11,904	11,568
Los Angeles Total	**Total Enrollment**	**20,140**	**20,906**	**21,770**	**20,617**	**20,193**	**20,189**	**21,082**	**22,004**	**22,609**	**22,933**	**23,134**	**22,893**	**22,901**	**22,751**	**23,501**	**23,823**	**24,284**

* Statistics for Appendices C, D, and E provided by the UCLA Office of Diversity& Faculty Development

UNIVERSITY OF CALIFORNIA LOS ANGELES

UNDERGRADUATE FALL HEADCOUNT ENROLLMENT BY ETHNICITY (CONT'D)

1973-2012

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1,587	1,462	1,424	1,369	1,396	1,433	1,437	1,407	1,306	1,167	1,068	948	921	895	829	799	756	865	938	986	1,076	1,099	1,083
244	269	260	252	250	255	231	203	176	147	130	120	115	115	110	112	106	108	104	121	128	144	157
6,610	7,351	7,574	8,078	8,884	9,069	9,016	9,013	8,987	9,138	9,291	9,496	9,454	9,657	9,337	9,448	9,784	9,968	10,126	10,145	9,712	9,941	9,954
3,715	3,862	3,786	3,681	3,807	4,009	4,044	3,946	3,736	3,605	3,499	3,545	3,633	3,956	3,821	3,788	3,824	3,812	3,945	4,103	4,126	4,502	4,799
460	501	470	489	584	601	639	655	625	620	698	726	702	877	968	893	958	1,075	1,189	1,280	1,522	2,014	2,895
630	647	863	652	562	545	644	690	1,378	1,664	1,844	1,928	1,807	1,748	1,600	1,441	1,298	1,239	1,228	1,173	1,131	1,013	938
10,888	10,276	9,272	8,371	8,136	7,857	7,903	8,011	7,895	8,327	8,481	8,565	8,267	8,467	8,281	8,330	8,706	8,861	9,006	8,879	8,467	8,486	8,115
24,207	**24,368**	**23,649**	**22,892**	**23,619**	**23,769**	**23,914**	**23,925**	**24,013**	**24,668**	**25,011**	**25,328**	**24,899**	**25,715**	**24,946**	**24,811**	**25,432**	**25,928**	**26,536**	**26,687**	**26,162**	**27,199**	**27,941**

Percentage Distribution of UCLA Undergraduate Headcount Enrollment by Declared Ethnicity, Fall 1973 to Fall 2012

	Fall 73	Fall 74	Fall 75	Fall 76	Fall 77	Fall 78	Fall 79	Fall 80	Fall 81	Fall 82	Fall 83	Fall 84	Fall 85	Fall 86	Fall 87	Fall 88	Fall 89	Fall 90	Fall 91	Fall 92
African American	6.5	5.5	4.9	5.1	5.5	5.0	4.7	4.2	4.9	5.0	5.6	5.7	6.2	6.8	6.7	7.0	6.9	6.6	6.0	6.0
American Indian	0.6	0.7	0.5	0.4	0.5	0.4	0.4	0.3	0.3	0.4	0.5	0.5	0.6	0.7	0.7	0.9	1.0	1.0	1.1	1.1
Chicano/Latino	5.3	5.0	5.1	5.7	6.1	6.3	6.2	5.6	6.0	6.4	7.5	8.6	10.2	11.9	13.2	14.4	15.3	15.6	15.8	16.0
Subtotal: URM	12.5	11.1	10.5	11.2	12.1	11.7	11.3	10.1	11.2	11.8	13.5	14.8	17.0	19.3	20.7	22.2	23.2	23.2	23.0	23.1
Asian/Pacific	10.0	10.3	11.0	12.4	13.5	14.1	15.3	15.3	17.0	18.8	20.1	20.5	20.8	21.5	22.1	22.7	24.1	27.3	30.2	32.0
White/Caucasian	69.4	67.5	69.1	68.4	69.0	68.7	67.5	60.6	61.5	61.6	59.3	57.8	56.4	53.7	51.7	50.0	47.6	45.0	42.2	39.2
Other and Unknown	5.5	8.4	6.6	5.4	3.0	2.7	2.5	10.4	6.4	4.6	3.9	3.7	3.3	3.1	3.2	2.8	2.7	2.6	2.7	3.6
International	2.6	2.8	2.8	2.7	2.5	2.8	3.4	3.5	3.9	3.3	3.1	3.1	2.5	2.3	2.3	2.3	2.4	1.9	2.1	2.0
All Undergraduates	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

	Fall 93	Fall 94	Fall 95	Fall 96	Fall 97	Fall 98	Fall 99	Fall 00	Fall 01	Fall 02	Fall 03	Fall 04	Fall 05	Fall 06	Fall 07	Fall 08	Fall 09	Fall 10	Fall 11	Fall 12
African American	6.0	5.9	6.0	6.0	5.9	5.4	4.7	4.3	3.7	3.7	3.5	3.3	3.2	3.0	3.3	3.5	3.7	4.1	4.0	3.9
American Indian	1.1	1.1	1.1	1.0	0.8	0.7	0.6	0.5	0.5	0.5	0.4	0.4	0.5	0.4	0.4	0.4	0.5	0.5	0.5	0.6
Chicano/Latino	16.1	16.1	16.9	16.9	16.5	15.5	14.6	14.0	14.0	14.6	15.4	15.3	15.3	15.0	14.7	14.9	15.4	15.8	16.6	17.2
Subtotal: URM	23.2	23.1	24.0	23.9	23.2	21.6	19.9	18.8	18.2	18.8	19.3	19.1	18.9	18.4	18.5	18.8	19.5	20.4	21.1	21.6
Asian/Pacific	35.3	37.6	38.2	37.7	37.7	37.3	37.0	37.1	37.5	38.0	37.6	37.4	38.1	38.5	38.4	38.2	38.0	37.1	36.5	35.6
White/Caucasian	36.6	34.4	33.1	33.0	33.5	32.8	33.8	33.9	33.8	33.2	32.9	33.2	33.6	34.2	34.2	33.9	33.3	32.4	31.2	29.0
Other and Unknown	2.8	2.4	2.3	2.7	2.9	5.7	6.7	7.4	7.6	7.3	6.8	6.4	5.8	5.1	4.8	4.6	4.4	4.3	3.7	3.4
International	2.1	2.5	2.5	2.7	2.7	2.6	2.5	2.8	2.9	2.8	3.4	3.9	3.6	3.8	4.1	4.5	4.8	5.8	7.4	10.4
All Undergraduates	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Appendix D: Graduate Students in the College, Professional Schools, Health Sciences and Self-Supporting Programs at UCLA
Headcount Enrollment by Declared Ethnicity, Fall 1998 to Fall 2012

	Fall 98	Fall 99	Fall 00	Fall 01	Fall 02	Fall 03	Fall 04	Fall 05	Fall 06	Fall 07	Fall 08	Fall 09	Fall 10	Fall 11	Fall 12
African American	95	93	88	73	77	86	75	86	84	93	93	91	86	98	100
American Indian	19	15	21	21	19	21	18	20	22	22	21	20	14	13	12
Chicano/Latino	154	165	170	173	203	224	221	215	209	212	221	203	211	210	207
Subtotal: URM	**268**	**273**	**279**	**266**	**298**	**331**	**314**	**320**	**315**	**327**	**334**	**314**	**310**	**320**	**319**
Asian/Pacific	430	402	389	385	408	404	384	381	370	358	366	353	382	394	397
White/Caucasian	1,406	1,342	1,348	1,301	1,345	1,314	1,284	1,299	1,352	1,374	1,351	1,364	1,301	1,279	1,351
Other and Unknown	111	124	154	165	191	199	198	206	222	211	231	225	227	179	159
International	473	491	539	535	543	557	515	482	467	479	475	491	505	496	526
Letters & Science	**2,687**	**2,632**	**2,708**	**2,652**	**2,784**	**2,804**	**2,694**	**2,687**	**2,725**	**2,748**	**2,757**	**2,746**	**2,724**	**2,666**	**2,751**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	193	164	174	155	169	185	200	193	185	206	195	190	208	215	219
American Indian	30	13	12	17	17	25	24	27	28	28	28	26	25	32	35
Chicano/Latino	405	388	386	417	480	513	499	505	523	529	558	543	519	549	511
Subtotal: URM	**627**	**565**	**571**	**588**	**665**	**722**	**723**	**725**	**735**	**762**	**780**	**759**	**751**	**796**	**764**
Asian/Pacific	818	841	861	895	970	1,062	1,078	1,030	1,078	1,047	1,048	1,052	1,085	1,064	998
White/Caucasian	2,066	1,961	1,887	1,930	2,051	2,111	1,975	1,931	1,958	2,019	1,972	1,967	1,954	1,979	1,840
Other and Unknown	254	360	403	439	440	474	479	468	505	515	522	510	453	351	412
International	691	766	904	1,007	997	998	895	806	875	901	936	1,023	1,133	1,253	1,302
General Campus Schools	**4,455**	**4,491**	**4,625**	**4,858**	**5,123**	**5,366**	**5,148**	**4,959**	**5,151**	**5,244**	**5,258**	**5,310**	**5,376**	**5,442**	**5,314**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	119	124	116	131	133	119	120	107	104	102	102	82	100	115	133
American Indian	11	10	8	9	9	9	6	8	8	12	13	10	11	12	10
Chicano/Latino	207	212	203	188	189	184	171	159	155	161	154	143	175	198	232
Subtotal: URM	**336**	**346**	**327**	**328**	**330**	**311**	**297**	**274**	**267**	**274**	**268**	**234**	**286**	**325**	**375**
Asian/Pacific	669	658	590	538	514	513	501	470	467	467	381	334	438	580	675
White/Caucasian	844	877	844	854	853	835	847	827	794	787	705	662	663	717	737
Other and Unknown	183	164	209	259	335	411	418	436	545	646	756	879	743	550	357
International	123	121	132	167	179	182	170	166	147	147	156	145	150	148	139
Health Sciences	**2,155**	**2,164**	**2,100**	**2,145**	**2,210**	**2,251**	**2,233**	**2,172**	**2,218**	**2,320**	**2,265**	**2,252**	**2,279**	**2,319**	**2,282**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	407	380	378	359	378	389	394	386	373	400	389	362	393	428	451
American Indian	59	38	40	46	44	54	48	54	57	62	61	56	49	56	57
Chicano/Latino	765	765	758	777	871	920	891	878	886	901	932	888	904	956	949
Subtotal: URM	**1,231**	**1,183**	**1,176**	**1,182**	**1,293**	**1,363**	**1,333**	**1,318**	**1,316**	**1,363**	**1,382**	**1,306**	**1,346**	**1,440**	**1,457**
Asian/Pacific	1,917	1,900	1,839	1,817	1,891	1,978	1,962	1,880	1,914	1,871	1,794	1,738	1,904	2,037	2,069
White/Caucasian	4,315	4,179	4,078	4,084	4,248	4,259	4,106	4,056	4,104	4,180	4,027	3,992	3,918	3,974	3,927
Other and Unknown	547	647	765	862	965	1,083	1,094	1,109	1,271	1,371	1,509	1,613	1,423	1,079	927
International	1,287	1,378	1,575	1,709	1,719	1,737	1,579	1,454	1,488	1,526	1,567	1,658	1,787	1,896	1,966
State-Supported Programs	**9,297**	**9,287**	**9,433**	**9,654**	**10,116**	**10,420**	**10,074**	**9,817**	**10,093**	**10,311**	**10,279**	**10,307**	**10,378**	**10,426**	**10,346**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**

African American	32	32	27	26	28	28	29	32	40	38	43	45	44	47	47
American Indian	2	3	5	2	2	2	1	-	3	1	1	1	5	6	7
Chicano/Latino	45	45	47	43	46	44	49	59	65	73	85	103	88	96	101
Subtotal: URM	**79**	**80**	**79**	**71**	**76**	**74**	**79**	**91**	**108**	**112**	**129**	**149**	**137**	**149**	**155**
Asian/Pacific	142	154	171	181	223	253	275	286	328	382	440	473	489	495	491
White/Caucasian	417	407	398	432	451	435	412	389	390	463	511	544	573	581	575
Other and Unknown	49	61	85	100	113	122	122	133	121	110	99	116	142	123	82
International	18	18	33	41	34	36	58	98	139	170	226	274	276	296	355
Self-Supporting Programs	**705**	**720**	**766**	**825**	**897**	**920**	**946**	**997**	**1,086**	**1,237**	**1,405**	**1,556**	**1,617**	**1,644**	**1,658**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	439	412	405	385	406	417	423	418	413	438	432	407	437	475	498
American Indian	61	41	45	48	46	56	49	54	60	63	62	57	54	62	64
Chicano/Latino	810	810	805	820	917	964	940	937	951	974	1,017	991	992	1,052	1,050
Subtotal: URM	1,310	1,263	1,255	1,253	1,369	1,437	1,412	1,409	1,424	1,475	1,511	1,455	1,483	1,589	1,612
Asian/Pacific	2,059	2,054	2,010	1,998	2,114	2,231	2,237	2,166	2,242	2,253	2,234	2,211	2,393	2,532	2,560
White/Caucasian	4,732	4,586	4,476	4,516	4,699	4,694	4,518	4,445	4,494	4,643	4,538	4,536	4,491	4,555	4,502
Other and Unknown	596	708	850	962	1,078	1,205	1,216	1,242	1,392	1,481	1,608	1,729	1,565	1,202	1,009
International	1,305	1,396	1,608	1,750	1,753	1,773	1,637	1,552	1,627	1,696	1,793	1,932	2,063	2,192	2,321
All Graduate Students	10,002	10,007	10,199	10,479	11,013	11,340	11,020	10,814	11,179	11,548	11,684	11,863	11,995	12,070	12,004

Graduate Students in the College, Professional Schools, Health Sciences and Self-Supporting Programs at UCLA
Percentage Distribution of Headcount Enrollment by Declared Ethnicity, Fall 1998 to Fall 2012

	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	3.5	3.5	3.3	2.8	2.8	3.1	2.8	3.2	3.1	3.4	3.4	3.3	3.1	3.7	3.6
American Indian	0.7	0.6	0.8	0.8	0.7	0.7	0.7	0.7	0.8	0.8	0.7	0.7	0.5	0.5	0.4
Chicano/Latino	5.7	6.3	6.3	6.5	7.3	8.0	8.2	8.0	7.7	7.7	8.0	7.4	7.7	7.9	7.5
Subtotal: URM	**10.0**	**10.4**	**10.3**	**10.0**	**10.7**	**11.8**	**11.6**	**11.9**	**11.5**	**11.9**	**12.1**	**11.4**	**11.4**	**12.0**	**11.6**
Asian/Pacific	16.0	15.3	14.4	14.5	14.6	14.4	14.3	14.2	13.6	13.0	13.3	12.8	14.0	14.8	14.4
White/Caucasian	52.3	51.0	49.8	49.1	48.3	46.9	47.7	48.3	49.6	50.0	49.0	49.7	47.8	48.0	49.1
Other and Unknown	4.1	4.7	5.7	6.2	6.9	7.1	7.3	7.7	8.1	7.7	8.4	8.2	8.3	6.7	5.8
International	17.6	18.7	19.9	20.2	19.5	19.9	19.1	18.0	17.1	17.4	17.2	17.9	18.5	18.6	19.1
Letters & Science	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	4.3	3.6	3.8	3.2	3.3	3.4	3.9	3.9	3.6	3.9	3.7	3.6	3.9	4.0	4.1
American Indian	0.7	0.3	0.3	0.3	0.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.7
Chicano/Latino	9.1	8.6	8.3	8.6	9.4	9.6	9.7	10.2	10.1	10.1	10.6	10.2	9.7	10.1	9.6
Subtotal: URM	**14.1**	**12.6**	**12.4**	**12.1**	**13.0**	**13.5**	**14.0**	**14.6**	**14.3**	**14.5**	**14.8**	**14.3**	**14.0**	**14.6**	**14.4**
Asian/Pacific	18.4	18.7	18.6	18.4	18.9	19.8	20.9	20.8	20.9	20.0	19.9	19.8	20.2	19.5	18.8
White/Caucasian	46.4	43.7	40.8	39.7	40.0	39.3	38.4	38.9	38.0	38.5	37.5	37.1	36.4	36.4	34.6
Other and Unknown	5.7	8.0	8.7	9.0	8.6	8.8	9.3	9.4	9.8	9.8	9.9	9.6	8.4	6.4	7.7
International	15.5	17.1	19.5	20.7	19.5	18.6	17.4	16.3	17.0	17.2	17.8	19.3	21.1	23.0	24.5
General Campus Schools	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**

African American	5.5	5.7	5.5	6.1	6.0	5.3	5.4	4.9	4.7	4.4	4.5	3.6	4.4	5.0	5.8
American Indian	0.5	0.5	0.4	0.4	0.4	0.4	0.3	0.4	0.4	0.5	0.6	0.4	0.5	0.5	0.4
Chicano/Latino	9.6	9.8	9.6	8.8	8.5	8.2	7.7	7.3	7.0	6.9	6.8	6.3	7.7	8.5	10.2
Subtotal: URM	**15.6**	**16.0**	**15.6**	**15.3**	**14.9**	**13.8**	**13.3**	**12.6**	**12.0**	**11.8**	**11.8**	**10.4**	**12.5**	**14.0**	**16.4**
Asian/Pacific	31.0	30.4	28.1	25.1	23.2	22.8	22.4	21.6	21.0	20.1	16.8	14.8	19.2	25.0	29.6
White/Caucasian	39.2	40.5	40.2	39.8	38.6	37.1	37.9	38.1	35.8	33.9	31.1	29.4	29.1	30.9	32.3
Other and Unknown	8.5	7.6	9.9	12.1	15.1	18.3	18.7	20.1	24.6	27.8	33.4	39.0	32.6	23.7	15.7
International	5.7	5.6	6.3	7.8	8.1	8.1	7.6	7.6	6.6	6.3	6.9	6.4	6.6	6.4	6.1
Health Sciences	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	4.4	4.1	4.0	3.7	3.7	3.7	3.9	3.9	3.7	3.9	3.8	3.5	3.8	4.1	4.4
American Indian	0.6	0.4	0.4	0.5	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.6
Chicano/Latino	8.2	8.2	8.0	8.1	8.6	8.8	8.8	8.9	8.8	8.7	9.1	8.6	8.7	9.2	9.2
Subtotal: URM	**13.2**	**12.7**	**12.5**	**12.2**	**12.8**	**13.1**	**13.2**	**13.4**	**13.0**	**13.2**	**13.4**	**12.7**	**13.0**	**13.8**	**14.1**
Asian/Pacific	20.6	20.5	19.5	18.8	18.7	19.0	19.5	19.2	19.0	18.2	17.5	16.9	18.4	19.5	20.0
White/Caucasian	46.4	45.0	43.2	42.3	42.0	40.9	40.8	41.3	40.7	40.5	39.2	38.7	37.8	38.1	38.0
Other and Unknown	5.9	7.0	8.1	8.9	9.5	10.4	10.9	11.3	12.6	13.3	14.7	15.7	13.7	10.4	9.0
International	13.9	14.8	16.7	17.7	17.0	16.7	15.7	14.8	14.8	14.8	15.3	16.1	17.2	18.2	19.0
State-Supported Programs	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American															
American Indian	0.3	0.4	0.7	0.2	0.2	0.2	0.1	-	0.3	0.1	0.1	0.1	0.3	0.4	0.4
Chicano/Latino	6.4	6.3	6.1	5.2	5.1	4.8	5.2	5.9	6.0	5.9	6.0	6.6	5.4	5.8	6.1
Subtotal: URM	**11.2**	**11.1**	**10.3**	**8.6**	**8.5**	**8.0**	**8.4**	**9.1**	**9.9**	**9.1**	**9.2**	**9.6**	**8.5**	**9.1**	**9.3**
Asian/Pacific	20.1	21.4	22.3	21.9	24.9	27.5	29.1	28.7	30.2	30.9	31.3	30.4	30.2	30.1	29.6
White/Caucasian	59.1	56.5	52.0	52.4	50.3	47.3	43.6	39.0	35.9	37.4	36.4	35.0	35.4	35.3	34.7
Other and Unknown	7.0	8.5	11.1	12.1	12.6	13.3	12.9	13.3	11.1	8.9	7.0	7.5	8.8	7.5	4.9
International	2.6	2.5	4.3	5.0	3.8	3.9	6.1	9.8	12.8	13.7	16.1	17.6	17.1	18.0	21.4
Self-Supported Programs	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

	Fall 98	**Fall 99**	**Fall 00**	**Fall 01**	**Fall 02**	**Fall 03**	**Fall 04**	**Fall 05**	**Fall 06**	**Fall 07**	**Fall 08**	**Fall 09**	**Fall 10**	**Fall 11**	**Fall 12**
African American	4.4	4.1	4.0	3.7	3.7	3.7	3.8	3.9	3.7	3.8	3.7	3.4	3.6	3.9	4.1
American Indian	0.6	0.4	0.4	0.5	0.4	0.5	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Chicano/Latino	8.1	8.1	7.9	7.8	8.3	8.5	8.5	8.7	8.5	8.4	8.7	8.4	8.3	8.7	8.7
Subtotal: URM	**13.1**	**12.6**	**12.3**	**12.0**	**12.4**	**12.7**	**12.8**	**13.0**	**12.7**	**12.8**	**12.9**	**12.3**	**12.4**	**13.2**	**13.4**
Asian/Pacific	20.6	20.5	19.7	19.1	19.2	19.7	20.3	20.0	20.1	19.5	19.1	18.6	19.9	21.0	21.3
White/Caucasian	47.3	45.8	43.9	43.1	42.7	41.4	41.0	41.1	40.2	40.2	38.8	38.2	37.4	37.7	37.5
Other and Unknown	6.0	7.1	8.3	9.2	9.8	10.6	11.0	11.5	12.5	12.8	13.8	14.6	13.0	10.0	8.4
International	13.0	14.0	15.8	16.7	15.9	15.6	14.9	14.4	14.6	14.7	15.3	16.3	17.2	18.2	19.3
All Graduate Students	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Appendix E: UCLA Faculty by Ethnicity 2006-2012

Number of UCLA Regular/Ladder Rank Faculty FTE as of 10/1: Campuswide

	African American	Asian	Hispanic	Native American	Subtotal Minority	White	Unknown	Total
2006-07	55.5	249.3	97.5	6.0	408.3	1402.7	14.0	1825.0
2007-08	53.5	262.0	100.5	6.0	422.0	1406.2	17.0	1845.2
2008-09	57.5	277.5	107.5	5.0	447.5	1409.3	16.0	1872.8
2009-10	59.5	280.6	112.5	8.0	460.6	1404.0	18.0	1882.6
2010-11	61.5	291.3	111.5	9.0	473.3	1377.8	10.0	1861.1
2011-12	53.5	262.0	100.5	6.0	422.0	1406.2	17.0	1845.2
2012-13	61.5	296.0	112.8	9.0	479.2	1301.8	2.0	1783.0

Percentage of UCLA Regular/Ladder Rank Faculty FTE as of 10/1: Campuswide

	African American	Asian	Hispanic	Native American	Subtotal Minority	White	Unknown	Total
2006-07	3.0%	13.7%	5.3%	0.3%	22.4%	76.9%	0.8%	100.0%
2007-08	2.9%	14.2%	5.4%	0.3%	22.9%	76.2%	0.9%	100.0%
2008-09	3.1%	14.8%	5.7%	0.3%	23.9%	75.3%	0.9%	100.0%
2009-10	3.2%	14.9%	6.0%	0.4%	24.5%	74.6%	1.0%	100.0%
2010-11	3.3%	15.7%	6.0%	0.5%	25.4%	74.0%	0.5%	100.0%
2011-12	2.9%	14.2%	5.4%	0.3%	22.9%	76.2%	0.9%	100.0%
2012-13	3.4%	16.6%	6.3%	0.5%	26.9%	73.0%	0.1%	100.0%

SOURCE: UCLA Office of Faculty Diversity and Development, Diversity Statistics: Regular Rank Faculty, 2006-2012

EXHIBIT O

TENTATIVE RULING

HEARING DATE: **January 27, 2014** TRIAL: June 25, 2014

CASE: **Joel Sercarz, M.D. v. Regents of the University of California, et al.**

CASE NO.: **BC492513**

Opposed: **Yes.**

MOTION FOR LEAVE TO AMEND COMPLAINT

MOVING PARTY: Plaintiff Joel Sercarz, M.D.

RESPONDING PARTY(S): Defendant Regents of the University of California

PROOF OF SERVICE:

- Correct Address: Yes.
- 16/21 (CCP § 1005(b)): OK. Served by FedEx (overnight) on December 31, 2013.

- **DENY motion for leave to amend complaint.**

ANALYSIS

Request for Judicial Notice

Defendant The Regents of the University of California requests that the Court take judicial notice of the following: (1) UCLA Procedure 620.1, Reporting Whistleblower Complaints (August 1, 2002); (2) University of California Policy for Protection of Whistleblowers From Retaliation and Guidelines for Reviewing Retaliation Complaints (Whistleblower Protection Policy); (3) Verified Third Amended Complaint filed by Dr. Christopher Head in Head v. Regents of the University of California, Case No. BC4828981. Requests Nos. 1 and 2 are GRANTED. The Court may take judicial notice of the official acts of the UC Regents. See Provost v. Regents of University of California (2011) 201 Cal.App.4th 1289, 1292. Request No. 3 is GRANTED per Evid. Code § 452(d)(court records).

Motion for Leave to Amend

The Court has examined the proposed complaint and agrees with Defendant UC Regents that this appears to be an attempt, in part, to relitigate UC Regent's Dr. Berke's conduct against Dr. Head in Head v. Regents of the University of California, which settled. Indeed, upon reading the proposed complaint one would believe this lawsuit is being brought by Dr. Head as one of the named Plaintiffs, if not the primary plaintiff.

To the extent that Plaintiff is alleging retaliatory acts by UC Regents following Plaintiff's termination from the County's Olive View Medical Center, and which occurred after the instant complaint was filed, Plaintiff can file a new action based on such actions.

To the extent that Plaintiff is alleging a violation of Health and Safety Code § 1278.5 by retaliation for reporting concerns about patient care, services and hospital conditions, this is a new theory which Plaintiff can assert in a new action.

As to Plaintiff's purported Gov Code § 8547 cause of action, Defendant appears to be correct that Plaintiff has failed to plead the exhaustion of administrative remedies required by Gov. Code § 8547.10(c).

Finally, Plaintiff's negligent retention cause of action is based on Dr. Berke's conduct as alleged in Head v. Regents of the University of California. This theory will not be permitted in this action.

The motion for leave to file an amended complaint is DENIED.

The proposed first amended complaint lodged conditionally under seal is ordered returned to Plaintiff.

EXHIBIT 9

From: "Norman, Dean" <Dean.Norman@va.gov>
Date: November 16, 2012 at 7:50:54 AM PST
To: <sinussurgery@gmail.com>
Subject: Re: delay cancer diagnosis

Thanks for sending me this.

From: sinussurgery [mailto:sinussurgery@gmail.com]
Sent: Friday, November 16, 2012 12:40 AM
To: Norman, Dean
Subject: delay cancer diagnosis

Dean

I know we have not had time to discuss the issues of delayed diagnosis of cancer in great detail at the VA. Consults and timely diagnosis of cancer has been a major issue facing all large health care institutions. If you perform a google search on the subject most of the articles are written by attorneys. I have spent the last 2 weeks reviewing all the torts at our institution over the last 10 years. I believe that there are many lessons to be learned. I also believe many of the questions that were asked recently by outside leadership did not necessary address the complexity of the problem and our unique population of patients. I believe it would be prudent to prepare to present our data in a logical patient safety oriented fashion if more detail answers are necessary. This would also make it easier to compare our data with other institutions. Many of the questions have already been formulated by much smarter people than me. See article related to this subject--- attachment.

You might share this article with leadership. See you in the morning

Christian Head

National Cancer Institute at the National Institutes of Health | www.cancer.gov

SURVEILLANCE RESEARCH
CANCER CONTROL AND POPULATION SCIENCES

SEER 13 Delay Model Adjusted for the Backlog of VA Cases in Submission Year 2011

A policy change of the Department of Veterans Affairs (VA) regarding data sharing on VA cancer cases resulted in underreporting on VA hospital cases for submission years 2007-2011. Correction factors to adjust for this underreporting (PDF) have been provided in the online version of the SEER Cancer Statistics Review.

Beginning with the 2009 submission of SEER data, some SEER registries began to report VA cases that had previously been withheld due to the VA policy changes. This caused a bolus of backlogged VA cases being reported in 2009, 2010 and 2011 that typically would have been reported in 2006-2008. This delay in reporting of VA cases represents a unique situation associated with the VA policy change and does not represent a reporting delay that would be expected to continue into the future. The SEER delay model is designed to adjust for cases that are reported to the registry after information for their diagnosis year is first made public and is modeled based on the past history of cases with delayed reporting. Since the VA policy change led to a one time short term increase in late cases, these excess cases in 2009, 2010 and 2011 should not be included in predicted the reporting delay factor for current and future years. This report described the methods used to readjust the VA cases received in 2009, 2010 and 2011 so that the bolus of cases received from the VA does not inappropriately influence the delay model. The adjustment to the VA cases described below are used to estimate the delay factors for current incidence estimates and will be used when fitting the delay model in future years.

As with the 2009 and 2010 submissions, to take into account of the VA backlog in 2011 submission in the delay adjustment model, the counts are adjusted by re-distributing VA cases in 2011 submission to previous submission years according to the expected counts from the delay distribution conditional on the current submission. Specifically, for each of the diagnosis year 2004 – 2008, given the total cancer count in submission year 2011, the proportion of cumulative cancer count in each subsequent submission year is calculated based on the estimated parameters from previous year's reporting delay model. The VA cases in 2011 are re-distributed to each of the prior submission year according to this proportion. The adjusted total cancer count in that submission year was then calculated by combing the non-VA cases and the re-distributed VA counts.

Method Details

For diagnosis year *i*, Denote

p_{1ij} = probability that a reported case is first reported in submission year j,
p_{2ij} = probability that a previously reported case is removed in submission year j,

and

$$p_{ij} = p_{1ij} - p_{2ij}$$

Note that p_{ij} represents the probability of a case in diagnosis year *i* is counted in submission year *j*.

For diagnosis years *i* = 2004 to 2008 and submission years *j* = *i* + 2 to 2011, let

A_{ij} = number of reported cancers first reported in submission year j (adds),
D_{ij} = number of previously reported cancers removed in submission year j (drops),
$N_{ij} = \sum_{k=i+3}^{j}(A_{ik} - D_{ik})$ = total cancer count in submission year j,
V_{ij} = number of cancers reported from VA hospitals in submission year j.

For diagnosis year *i*, given the total cancer count in submission year 2011, the proportion of cumulative cancer count in submission year j is

$$p_{ij}^{*} = \frac{E(N_{ij})}{E(N_{i,2011})} = \frac{\sum_{k=i+2}^{j} p_{ik}}{\sum_{k=i+2}^{2011} p_{ik}}.$$

Using the estimated parameters from previous year's reporting delay model, we calculate p_{ij} for diagnosis year *i* = 2004 to 2008 and submission years *j* = *i* + 2 to 2011, and consequently, we calculate p_{ij}^{*}.

For the registries that have VA count V_{ij} available, we verify that the net gain of VA counts is not greater than net gain of cases. If that happens, we replace the VA counts in the previous years such that

$$V_{i,j-1} = V_{i,j} - (A_{i,j} - D_{i,j}).$$

Then set

$$N_{ij}^{*} = (N_{ij} - V_{ij}) + p_{ij}^{*} \times V_{i,2011}.$$

N_{ij}^{*} is then rounded to the nearest integer. N_{ij}^{*} is the adjusted total cancer count in submission year j.

The adjusted "add count" A_{ij}^{*} is calculated by

$$A_{ij}^{*} = N_{ij}^{*} - N_{ij-1}^{*} + D_{ij}.$$

Algorithm

The detailed adjustment algorithm is given below.

if V_{ij} = is available then

```
do i = 2004 to 2008
/* Verify that the net gain of VA counts is not greater than net gain of cases*/
  do j = 2011 to i + 3
    If ( Vi,j - Vi,j-1 ) > ( Ai,j - Di,j ) then Vi,j-1 = Vi,j - ( Ai,j - Di,j );
  end { do j = 2011 to i + 3 }
/* calculate adjusted total count Nij*. */
  do j = i + 2 to 2011
    1)  calculate pij*, using the estimated parameters from the reporting delay model.
    2)  Nij*  =  ( Nij – Vij )  +  pij* × Vi,2011
(note that Ni,2011* = Ni,2011, since pi,2011* = 1).
    3)  round Nij* to the nearest integer.
    4)  if ( Nij* < Nij ) then set Nij* = Nij.
    end { do j = i + 2 to 2011 }
 /* make sure that adjusted add count Aij* is nonnegative. */
  do j = 2011 to i + 3 by -1:
    if ( Ni,j-1* > Nij* +  Dij ) then set Ni,j-1* = Nij* +  Dij.
    end { do j = 2011 to i + 3 by -1 }
 /* calculate adjusted add count Aij*. */
 When = i + 2, A_( i i+2 )^*=N_( i i+2 )^*.
 For j > i+2,
  do j = i + 3 to 2011:
    calculate the adjusted add count Aij*:
      Aij*  =  Nij* – Ni,j-1* + Dij.
    end { do j = i + 2 to 2011 }
  end { do i = 2004 to 2008 }
```

NHS
National Patient Safety Agency
National Reporting and Learning Service

Delayed diagnosis of cancer

Thematic review

RCGP Royal College of General Practitioners

Contents

Acknowledgements

NPSA delayed diagnosis of cancer project team:

Edana Minghella, Mayur Lakhani, Cathy Hughes, Ben Thomas.

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Executive summary

Delayed diagnosis of cancer: Thematic review **presents the findings of a project at the National Patient Safety Agency (NPSA) which was designed to explore issues of patient safety around delayed diagnosis of cancer, and provide the NHS with potential solutions.**

Three main methods were used in this project:

- Literature review (English language publications since the year 2000);
- Review of incidents reported to the NPSA's National Reporting and Learning System (NRLS);
- Consultation with stakeholders (focus groups, discussions and presentations).

Additionally, consideration was given to other sources of patient safety data such as complaints, litigation and audits.

National Reporting and Learning System (NRLS) analysis

During one year (June 2007 to May 2008) around 1,650 patient safety incidents were reported to the NRLS relating to actual or potential delayed cancer diagnosis. This will be an underestimate of the total number of incidents because of the reporting bias inherent in voluntary reporting systems, especially in primary care where the level of reporting is very low (constituting only 0.4% of all patient safety incidents reported nationally). With approximately 294,000 people diagnosed with cancer in the UK per year, this represents a small but nonetheless important issue.

Of the patient safety incidents reported to the NRLS, 508 were considered in detail. Of these, 89 (17%) were reported as resulting in death (2), severe harm (25) or moderate harm (62). However, degree of harm was very difficult to assess because the consequences of any delay in cancer diagnosis may not be known.

Detail of the estimated length of delay was available for 150 of these patient safety incidents. In 37 (25%) cases the delay was less than one month, with 56 (37%) showing delays of 1-3 months and 57 (38%) showing delays of more than three months, with a maximum delay of up to three years.

The site of the primary tumour was indicated in 294 patient safety incident reports. The most common tumour group was gynaecological (17%), followed by skin (16%), urological (15%), breast (12%), lower GI (10%) and lung (9%).

The types of patient safety incident were classified as relating to:

- Diagnostics (53%)
  - Pathology (41%)
  - Radiology (12%)
- Communication (26%)
- Cancellations (15%)
- Clinical assessment (5%)
- Waiting lists (<1%)

Patient safety incidents relating to pathology were broken down into those occurring pre-laboratory (47%), in-laboratory (44%) and post-laboratory (9%). Pre-laboratory problems included incorrect labelling, poor preservation of specimens and transport issues. In-laboratory problems included reporting delays, reporting errors and processing errors.

Post-laboratory problems were primarily related to results not being communicated or acted upon by clinical teams.

Patient safety incidents relating to radiology were primarily concerned with failures in the communication of results and reporting delay. Communication problems related to the communication of accurate and relevant patient information in a timely fashion, referrals and communication of results. Diagnostic and communication problems highlighted deficiencies in processes to ensure action is taken to track investigations and act on results. Cancellations of surgery and procedures due to inadequate preparation and clinic appointments were also seen to cause delays.

Although failures in clinical assessment was seen in only 5% of cases in this review, that is probably a reflection of reporting culture. Data from other sources was used to demonstrate this concern more accurately.

Consultation with stakeholders

Consultation with stakeholders took the form of two focus group events (one in Manchester, one in London), involving 50 participants recruited through Cancer Networks (including patients, carers, healthcare professionals and commissioners), direct discussions with Cancer Network representatives and feedback from presentations at two national early diagnosis meetings. Key issues from these workshops and discussions included:

- doctor-patient communication, for example patients not feeling that GPs were listening to them;
- poor communication between care settings;
- poor clinical assessment and management, with guidelines not being followed;
- cultural issues – patients adopting a passive role and not feeling empowered to challenge health professionals;
- lack of a patient safety culture in primary care.

Additional sources of information

Three additional sources of information on delays were reviewed and related primarily to primary care:

- A report from the Medical Defence Union (2003). This showed that more than half the claims settled against GPs were for delayed diagnosis. The major risk area was cancer.
- An analysis of 1,000 cases of delayed or missed diagnosis published by the Medical Protection Society. Again, cancer formed the largest category.
- Reports from the Scottish Primary Care Cancer Group analysing 4,181 cases of cancer diagnosed in 2006 and 2007 and 7,430 between 2007 and 2008. These reports provide data on average patient delays and GP delays by tumour type.

Recommendations

This report makes five broad recommendations (described in detail from page 36):

1. Development of an accessible diagnostic tool for use in primary care.
2. Identify, review and disseminate good practice in the process of ordering, managing and tracking tests and test results.
3. Review and develop methods for empowering patients who may be on a cancer diagnostic pathway.
4. Develop a model for stronger leadership and improved patient safety reporting and learning, including Significant Event Audit (SEA), at a local and national level.
5. Develop indicators of delayed diagnosis for routine monitoring.

1. Introduction and background

The National Patient Safety Agency (NPSA) began a programme of work in 2007 to improve patient safety in cancer. The programme consists of three main areas: radiotherapy, chemotherapy and delayed diagnosis.[1]

This review forms part of the NPSA's work on the theme of delayed diagnosis, and aims to:

- scope the patient safety issues related to delayed diagnosis of cancer;
- identify potential solutions for delayed diagnosis of cancer;
- develop patient safety recommendations for earlier diagnosis of cancer;
- make recommendations for improvement to practitioners and policy makers.

Every year around 294,000 people in the UK will be diagnosed with cancer and around 155,000 will die from the disease.[2] It is the leading cause of mortality in people under the age of 75.[3]

Cancer mortality and late diagnosis

Outcomes for people with cancer are improving in the UK. In England, cancer mortality in people under 75 years of age fell by over 17% between 1996 and 2005; equating to approximately 60,000 lives saved over this period. Wales also reports 'real improvements in cancer survival'.[4] However, although there may be difficulties in interpreting cancer data between countries because of differing data coverage and collection methods, there are concerns that outcomes in the UK are not as good as many other European countries[5] or North America. The EUROCARE-4 cancer survey showed that the UK ranked 9th for male cancer mortality rates (where first equals lowest rates), and 22nd for female cancer mortality rates, compared with 27 other European countries.[6]

Although treatment availability, quality of care, screening programmes and the effectiveness of public health initiatives are among the factors likely to be implicated in survival rates, late or missed diagnosis has been suggested as a major contributor to the UK's ranking.[3] Cancers are diagnosed at a more advanced stage in the UK compared with other European countries: in the National Cancer Research Institute 2008 conference public lecture, Professor Michel Coleman noted that, by taking out of the EUROCARE statistics all women who die within a year of diagnosis of breast cancer (since their cancer was likely to have been diagnosed at an advanced stage), survival rates in the UK fall into line with the European average.[7] The implication is that late diagnoses are responsible for the lower UK figures.

Cancer survival is an important issue but delayed diagnosis can also have a negative effect on quality of life, with the use of more toxic treatments when cancer is diagnosed at an advanced stage and an increase in psychological distress.[8]

Cancer strategies in England and Wales

Cancer Services in Wales[9] was published in 1996 and represented Wales' first national cancer plan. *Designed to Tackle Cancer in Wales*[10] was published at the end of 2006 with the aim of improving cancer care in Wales. It presented a three year strategic framework for improvement, and a vision for 2015 in which early detection and improved access to diagnosis were highlighted as priorities. Reducing the delay to diagnosis was specifically underlined as a necessity if outcomes in Wales are to be improved.

The NHS Cancer Plan[11] for England was published at the end of 2000 and set out a comprehensive 10 year strategy to improve prevention, screening, early diagnosis and treatment

for cancer. The *Cancer Reform Strategy (CRS)*[3] was published at the end of 2007 to build upon the achievements of the *NHS Cancer Plan* and set the direction for the next five years. Early diagnosis of cancer was highlighted as one of the most significant challenges to be addressed.

National Awareness and Early Diagnosis Initiative (NAEDI)

The National Awareness and Early Diagnosis Initiative (NAEDI) was announced in the CRS and launched formally in November 2008. NAEDI is led jointly by the Department of Health (DH) and Cancer Research UK.[12]

NAEDI works across nine areas of activity:

- Measuring public awareness of cancer
- Promoting earlier presentation
- Reducing primary care delay
- Key messages
- Review of the evidence base
- International comparisons
- New research
- Diagnostics
- Health economics

The NPSA programme of work on late diagnoses of cancer informs the NAEDI steering group. This project excluded the other workstreams already covered by NAEDI, including public awareness of symptoms and the national audit of cancer diagnosis in primary care led by the Royal College of General Practitioners (RCGP).[13]

What is meant by delayed diagnosis of cancer?

What constitutes a delayed diagnosis and the effect of that delay is a complex and much debated issue in cancer. Cancer diagnoses are made on screening, as incidental findings and following the presentation of an individual with symptoms to a healthcare practitioner. A delay in diagnosis can occur for many reasons. For example: when an individual does not attend for screening; when the screening service does not diagnose the cancer or initiate a treatment pathway; when an incidental finding is not appropriately acted upon; when an individual does not recognise a symptom of cancer; when an individual with symptoms does not seek healthcare advice or when a healthcare practitioner or system fails to detect a cancer or initiate a treatment pathway.
For this project, a working definition of the concept of delayed diagnosis was developed:

Delayed diagnosis in cancer is when someone who has cancer:

- is not investigated or referred for investigation; *or*
- having been investigated, is not diagnosed at the time of the investigation; *or*
- is diagnosed incorrectly; *or*
- where a positive test result or diagnosis is not communicated effectively to a clinician with the ability to act on the information; *or*
- where a positive test result or diagnosis is not acted upon and treatment commenced as appropriate.

Delays may occur at different stages of the cancer diagnostic journey and have been commonly defined as being either patient focused or healthcare provider focused.[14] One of the most influential models for describing delay was proposed by Andersen et al. in 1995.[15] This model of 'total patient delay' described six stages from the individual detecting signs and symptoms, through to beginning treatment. A number of types of delay were posited in this model:

- Appraisal – delay in symptom interpretation
- Illness – delay in decision to seek medical attention
- Behavioural – delay in making an appointment
- Scheduling – delay in time from making appointment to being seen
- Treatment – delay in receiving treatment

In Andersen's model, the emphasis is on 'patient delay' rather than delays which occur later in the pathway; four stages of the delay are attributable to the patient and only the fifth stage is attributable to healthcare providers. Indeed, research has tended to focus on delays attributable to patients and, as a result, delay is often ascribed to patients because that is where there is evidence. Yet this conclusion may be an artefact of the research focus; delays further along the pathway are likely to be significant, have been underestimated and under researched.[16]

Some studies have defined a series of delays that relate not only to patients, but also to providers in primary and secondary care. Hansen et al. describe three overall categories of delay in the cancer diagnostic pathway:[17]

- Patient delay;
- Doctor delay – primarily seen as primary care practitioner delay;
- System delay – primarily seen as hospital or secondary care delay.

These overall categories are further broken down and graphically portrayed in Figure 1:

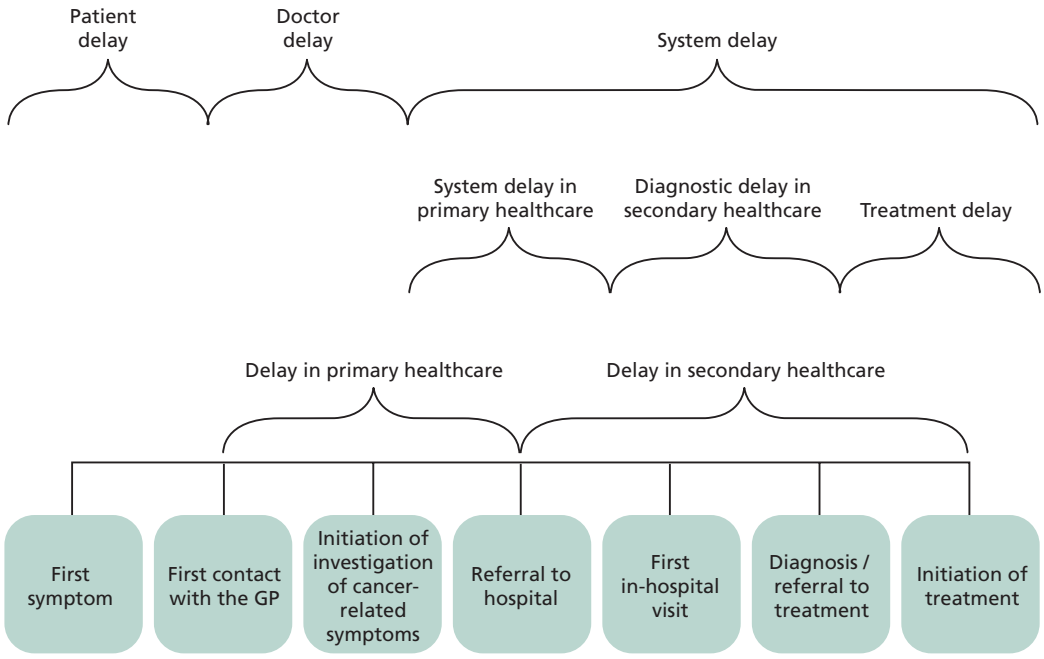

Figure 1: Categorisation of diagnostic delay

Copyright © 2008 Hansen et al; licensee BioMed Central Ltd.
BMC Health Serv Res 2008; 8: 49.

This NPSA review uses Hansen's model as an analytical framework to understand risks to patient safety in the diagnostic pathway. Hansen et al. use the term 'doctor delay' to represent healthcare practitioner delays in primary care. The term healthcare practitioner will be used in this review to encompass the many practitioners that are involved in giving healthcare advice and assessment in the UK, such as dentists, nurses, opticians, pharmacists etc. It is worth noting that diagnosis is a process that can be complex, and will include detection of malignancy, defining of primary site and tumour type, together with the extent of the disease or stage. Diagnostic testing and work-up can include biochemistry, histopathology and imaging, as well as surgical interventions that may also be definitive treatments. Individuals with cancer will present to primary care practitioners and directly to secondary care.

2. Methods

Three main methods were employed in this review project:

1. **A focused literature review: to provide updated evidence on causes of, and solutions to, late diagnosis.**
2. **A systematic interrogation of the NPSA's National Reporting and Learning System (NRLS): to identify patient safety incidents in relation to delayed or missed cancer diagnoses.**
3. **Consultation with stakeholders: to improve our understanding of what goes wrong, what works, and what improvements could be made to support early diagnosis.**

Other relevant sources of information, where reports of patient safety incidents might be received and recorded, such as the NHS Litigation Authority, the Medical Defence Union (MDU) and the Medical Protection Society (MPS), were also considered.

Focused review of the literature

A focused review of literature to September 2008 was undertaken to identify factors contributing to delayed diagnosis of cancers, the various types of cancer involved and any models, tools or approaches developed to improve cancer diagnosis. The initial literature search was limited to research published in the English language since the year 2000, which saw the publication of the *NHS Cancer Plan* and significant changes in cancer services (although it is recognised that papers published in 2000 represent data collected prior to that date).[11] Peer-reviewed published literature, web-based publications and some of the 'grey' literature, such as conference proceedings, dissertations, clinical trial registrations, guidelines and protocols, were also reviewed.

Review of incidents reported to the National Reporting and Learning System (NRLS)

The NPSA's NRLS holds a unique data set to help understand provider and system delays to diagnosing cancer. The NRLS is a voluntary reporting system to collect and learn from patient safety incidents. A patient safety incident is defined as:

"Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care".[18]

Patient safety incidents are reported by individual NHS staff through local trust risk management systems and web based e-forms. Patients and carers can also report directly through an open access e-form. The NRLS was set up in 2003 and there are now more than three million incident reports on the database.

Local risk management systems remain the dominant route for submitting reports to the NRLS; the proportion of reports submitted through this route has not dropped below 98% since 2004. Generally speaking, the local reporting culture is more established in acute and mental health hospitals than in primary care; even within primary care, general practices are much less likely to report incidents than community services.

The NRLS is a confidential reporting system and the individual reports are not investigated or verified by the NPSA. Since these incidents are self-reported they are not necessarily

representative of the NHS across England and Wales and therefore need interpreting with care. In particular, it may not be appropriate to use these figures for describing the actual level of occurrence for incident types, as voluntary systems are known to be inherently biased.

Of particular importance here is the lack of reporting culture in primary care compared with acute hospitals, which means that any analysis will show only a small proportion of incidents in primary care, and from general practice in particular. Nevertheless, the findings do represent actual events and problems that have occurred. It is also important to note that not all people diagnosed with cancer come through the urgent GP referral route; patients are also referred through routine non-cancer pathways and referrals within secondary care.

Using lessons learnt from a preliminary data analysis, a full search of the NRLS was undertaken for patient safety incidents occurring between 1 June 2007 and 31 May 2008 using a range of search terms.[19] By making the search terms inclusive it was anticipated that a significant number of the incidents identified would not be relevant. However, if any of the search terms were removed, relevant incidents were lost. A random sample (n=1,500) of the total number of patient safety incidents (n=4,855) was, therefore, analysed in detail to ascertain relevance as follows:

- **Diagnostic delay:** patient safety incidents indicating a definite or probable delay in diagnosing cancer or potential cancer;
- **High risk:** patient safety incidents representing a risk of delay to cancer diagnosis but without enough details to confirm an actual diagnostic delay;
- **Not relevant or unclear:** patient safety incidents not indicating a diagnostic delay and/or cancer.

A separate search on the phrase 'two week wait/delay' was also undertaken. This returned relevant reports that would not have been identified in the main search and are referred to throughout this analysis.

Consultation with stakeholders

Members of Cancer Networks in England and Wales were invited to regional focus groups facilitated by the project team. The aims of the focus groups were to:

- develop an understanding of the issues associated with late diagnosis;
- generate illustrative examples of problems and issues in the local diagnostic pathway;
- work with cancer specialists regionally to identify and test out ways to improve early diagnosis and patient safety reporting around late diagnosis;
- generate examples of good practice, tools, and improved processes, including better data sources and data capture, that could be generalised and/or shared nationally to improve patient safety in cancer.

Additionally, the project team presented early findings, facilitated workshops and listened to participants at national events, including the NAEDI launch and the 10th annual Britain Against Cancer conference.[20] Finally, national leaders in cancer were consulted in focused discussions.

3. Findings from the literature review

The literature on delay in cancer diagnosis is extensive. While it was not within the scope of this thematic review to provide a complete systematic review of the existing literature, an overview of different areas researched on delay in cancer diagnosis and key findings was collated.

The aim of this overview was to direct and enhance the consultation with stakeholders, complement the findings from the NRLS data and provide an indication of how and where risks were most likely to occur along the cancer diagnostic pathway. In addition, the literature highlights risks of delay in relation to varying tumour sites/tumour groups, although there is evidence to suggest that some cancers have been studied more extensively than others.[21] This section sets out the key findings of the NPSA literature review and will be presented following Hansen's model of patient delay, practitioner delay and system delay, as discussed in section 1.

Patient delay

Patient delay is generally defined as the length of time an individual will be aware of symptoms before seeking healthcare practitioner advice. Most of the literature reviewed focused on patient delay in the diagnostic journey and highlighted the following risk factors:

- symptom recognition and interpretation;
- psychological factors;
- socio-demographic and ethnicity factors.

Symptom recognition and interpretation

The manner in which individuals interpret and label their symptoms has been shown to influence help-seeking behaviour in a wide range of illnesses including cancer. It has been suggested that symptom recognition accounts for at least 60% of the total delay in cancer treatment in women with breast and gynaecological cancer.[22] Vague or non-specific symptoms are more likely to be attributed to everyday explanations such as indigestion, old age or the menopause.[23] For example, in a study of oral and pharyngeal cancers, Brouha et al. found that most patients attributed their pharyngeal cancer to a common cold or infection and their oral cancer to an infection or dental problems.[24] However, well recognised specific symptoms are more likely to lead to prompt recognition of serious illness.[24] For example, a survey of 996 women concerning breast cancer knowledge showed that a painless breast lump was widely recognised as a significant symptom, but non-lump breast symptoms were less likely to be attributed to breast cancer.[25]

Individuals who do not identify symptoms as cancer are more likely to delay seeking healthcare advice than those who do.[26,27] A population-based study of breast cancer patients found that just over half of the patients delayed seeking a doctor's advice for more than a month because they considered their symptoms to be harmless.[28] In another example, 53% of the patients found to have oral cancer waited 31 days before seeking help from a healthcare practitioner, and 39% waited more than three months because they attributed the symptoms to minor, self correcting conditions.[29]

Psychological and behavioural factors

A link has been suggested between psychological factors and help-seeking behaviour in healthcare. Cancer can be associated with pain, suffering and death.[24] In a Cancer Research UK

survey in 2007, cancer was shown to be the number one fear; topping the list over Alzheimer's disease, heart attacks and terrorism.[30]

In several studies, fear and anxiety have been shown to impact on patient delay.[24,28,31] In a qualitative literature review by Smith et al., fear of cancer and fear of embarrassment were identified as key factors contributing to delay in patient presentation to a healthcare practitioner.[23] The anxiety associated with recognising a potential cancer symptom has also been shown to result in delayed presentation.[32]

Guilt and fear of medical judgement were considered by Tromp et al. as two psychological factors that might explain patient delay in patients who drank five or more alcoholic drinks per day.[33] However, Brouha et al. found no relationship between smoking and alcohol consumption and patient delay in oral and pharyngeal cancer.[24]

Socio-demographic and ethnicity factors

Research on the relationship between socio-demographic factors and patient delay has shown mixed results. For example, Brouha et al. found no association between marital status, living situation (alone or with family), education or income, and patient delay for oral or pharyngeal cancer.[24] A systematic review of 54 studies looking at delays in the diagnosis of colorectal cancer found little evidence that age, gender or socio-economic status had an effect on patient delay.[32] Hansen et al. found that women who were employed and those who smoked experienced longer patient delay than women who were retired and those who did not smoke, but demonstrated no specific socio-economic predictors for patient delay in men.[17]

Age was identified as an important socio-demographic factor, being older has been cited as a factor leading to delay patient.[34,29] In breast cancer, older women are not only more at risk of developing the disease, but have also been shown to have poorer knowledge about breast cancer risks and symptoms and are more likely to delay presentation to a healthcare provider.[26] However, the previously held view that the elderly under-consult and are less likely to seek help for symptoms that are not causing pain or disrupting functionality, was dismissed by a review in 1985.[35]

Research examining the impact of cultural and ethnic factors on patient delay has identified how such factors may contribute to late presentation of cancer. Breast cancer examination can be difficult for religious Muslim women; Islamic laws prohibit nudity and self exposure in front of any man other than one's husband. Lack of availability of female doctors was seen as a deterrent for Muslim women accessing breast screening services.[36] Following culturally tailored interventions for Israeli-Arab women, marked improvements were found in the number of women who presented for breast cancer screening.[37]

Healthcare practitioner or provider delay

This is the interval between first consultation with a healthcare provider and referral for diagnostic tests or specialist assessment. Some authors refer to this phase of delay as primary care delay or delay in general practice. When assessing potential delays on the diagnostic pathway, healthcare provider delay is under-estimated and under-researched. Some of the factors contributing to provider or practitioner delay include:

- symptom misattribution;
- no examination or investigation of malignancy;
- co-morbidity;
- patient characteristics.

In the systematic review by Mitchell et al., healthcare provider delay related to initial misdiagnosis and insufficient examination by the practitioner, was the most commonly occurring theme associated with delay in referral.[32]

A study of women subsequently diagnosed with ovarian cancer reported that GPs did not investigate their symptoms thoroughly or alternatively attributed their symptoms to a non-cancer cause and treat accordingly.[16] In a separate study of 132 women with ovarian cancer who were surveyed by the charity Target Ovarian Cancer, over 60% experienced difficulties with diagnosis and over a third visited their GP with symptoms between three and five times. Almost two-thirds of the women expressed a concern that the GP had not taken their issues seriously.[38] Inconclusive or false negative test results have also been seen as factors causing delays.[32]

Data from the *National Survey of NHS Patients: Cancer* found that patients who did not see their GP prior to diagnosis (those attending screening, presenting to A&E or secondary care) had shorter delays in all six cancer groups studied, than those who did see their GP.[39] Co-morbidity may contribute to delay with GPs attributing the symptoms to the existing disease. In a study of lung cancer, co-morbidity delayed the diagnosis in just over 20% of patients.[40] However, co-morbidity has also been shown to prompt earlier referrals[41] while having no impact for others.[42]

Patient characteristics have also been identified as having some influence on provider delay. Hanson et al. found that men experienced longer doctor delays, and women with a larger household fortune experienced the shortest delay.[17] The Mitchel et al. review of colorectal cancer delay found that older people, those from higher social classes and higher socio-economic groups were referred more quickly, although the findings were inconclusive regarding gender.[32]

System delay

System delay refers to the interval between referral and definite diagnosis or treatment. This includes waiting times for tests in secondary care, further investigations of symptoms in secondary or specialist care, and administration. It is under-researched but there is evidence to suggest that, even with improved diagnostic and treatment pathways in cancer, there are still problems with:

- waiting times for tests;
- waiting times for non-urgent referrals;
- administrative delays for follow up (leading to increased patient delays).

Both the DH and the Welsh Assembly Government (WAG) have strong commitments to ensure that patients with suspected cancer are seen by a specialist within two weeks.[10,11] However, not all patients with cancer are referred for further tests or consultations.

In the Bjerager et al. study of diagnostic delay for lung cancer patients in primary care, waiting times for tests was highlighted as a key reason for delay. This system delay ranged from one to 57 days, with a median of 14 days, and was due mainly to waiting times for chest x-rays (some of which were conducted in primary care, median delay was longer for tests carried out in secondary care). The lack of explicit follow-up appointments were also shown in this study to have prolonged the delay for 11% of lung cancer patients who waited for up to seven months to consult their GP again.[41]

Davies et al. used clinical audits, qualitative data from patients and feedback from GPs to identify possible delays in referral for colorectal cancer patients. The analysis revealed problems with communication, information and support about diagnosis, with most delays occurring in secondary care, often after non-urgent referrals. Implementing referral guidelines and developing a faxable urgent referral pro forma along with educational meetings reduced average waiting times.[43]

Tumour site

Much of the research identified related to specific tumour sites; delays to diagnosis may have different consequences depending on tumour site. Delayed presentation of symptomatic breast cancer of three months or more is associated with lower survival rates. Richards et al. reported that patients with a delay of three months or more had a 12% lower five year survival than those without delay.[44] Colorectal cancer survival rates vary according to the stage of disease at diagnosis: the 90% five year survival rate for early cancers falls to 15% for advanced tumours.[45] Patients whose initial symptoms of tongue and glottic cancer were overlooked by their GPs were at significantly increased risk of death at three years compared with patients initially referred or followed-up.[46] However, delays between referral and diagnosis may not always be associated with a poorer prognosis.[47]

Different cancers have different referral routes, which will have important implications for how delay in diagnosis is mitigated. Barratt et al. examined the route to diagnosis for individuals with lung cancer. They found that only 28% followed the urgent cancer referral pathway. While 68% were referred to outpatients, less than half were referred to a respiratory department. More than a fifth were admitted as an emergency, having previously described a lung cancer symptom to their doctor. While the interval from first symptom to referral was similar across the different pathways, the referral to diagnosis interval was significantly longer in patients misdirected to other outpatient departments (66 days) than those sent to respiratory clinics (29 days) or admitted as an emergency (16 days).[48]

Childhood cancers

There appears to be less research specifically on delay in childhood cancers. While delays tend to be shorter for children, there are nonetheless specific problems for children and young people in getting a diagnosis, especially at the point of healthcare practitioner delay. Findings from a survey conducted at the annual Teenage Cancer Trust 'Find your Sense of Tumour' conference for teenagers and young people with cancer reported in the CRS[3], revealed that over a third of young people visited their GP with cancer symptoms five times before being referred to a specialist. Despite the fact that no age data was provided for the teenagers and young people surveyed, this finding is in line with evidence to suggest that younger children have less delay than older children.[49]

In addition to factors such as age, the literature suggests that the two main issues that contribute to delayed diagnosis in children and young people are misattribution of symptoms and the role of parents (and the relationships between doctors and parents). Timely diagnosis of cancer in children is difficult due to misinterpretation of symptoms by patients, parents and healthcare practitioners alike. Both parent delay in seeking healthcare advice and practitioner delay in diagnosis has been related to uncommon clinical presentation of symptoms, but symptom misattribution by healthcare provider caused longer delays.[50] For example, another study by the same authors found a median patient delay of nine days, but a median healthcare provider delay of 30 days (ranging up to 69 days).[50]

A qualitative study of parents of children and young people found that parents recognised something was wrong with their child, despite early symptoms often being vague, partly because of changes in their child's behaviour and mood. Yet they felt doctors tended to discount their views and fail to see the seriousness of the child's symptoms. In some cases disputes opened up between parents and doctors.[51]

4. Findings from the National Reporting and Learning System (NRLS)

Overview

A total of 4,855 patient safety incidents from the NRLS meeting our search criteria were identified for the 12 month period 1 June 2007 to 31 May 2008. A computer-generated random sample of 1,500 incidents were individually reviewed. A detailed analysis of the data was carried out.[19]

The project team regrouped the incidents as follows:

- Group 1 (diagnostic delay): 388 reports (26%)
- Group 2 (high risk of diagnostic delay): 120 reports (8%)
- Group 3 (not relevant): 992 reports (66%)

Group 3 incidents were excluded from the analysis. They included reports where it was clear that the investigation or abnormality was not related to cancer; where the mention of the oncology team was irrelevant to the incident; or where the incident concerned cancer treatment or palliative care rather than diagnosis.

Incidents from groups 1 and 2 were included in the analysis. These amounted to a total of 508 incidents. Extrapolating from the random sample[52] suggests that:

Between 1 June 2007 and 31 May 2008 there were approximately 1,650 patient safety incidents reported to the NRLS relating to actual or potential delayed diagnosis.

Groups 1 and 2 were differentiated in this final report because some aspects of the patient safety incident reports in group 2 meant that it was not possible to be certain the incidents constituted delays in diagnosis.

There is a fine line between groups 1 and 2; all are patient safety incidents that have the potential to put patient safety at risk. Many of the patient safety incidents in the high risk group were not in group 1 simply because there was not enough information in the report to establish whether a delay had actually happened.

Note: *The examples in the following boxes represent text taken from the incident reports. They have been altered to remove identifiable data, grammar and spelling has been corrected and shorthand elaborated on to aid understanding, but they essentially remain the words of the individual making the report.*

Group 1 represents actual delays, as illustrated by the example in box 1:

Box 1: Specimen unable to be processed in pathology (Group 1: diagnostic delay)

Breast core specimens were left in the faxitron machine after x-ray and not put in the specimen pot for sending to Pathology. This resulted in a delay of almost 24hrs before pathology received the specimen. The specimen had 'dried out ' and was unable to be processed; therefore the diagnosis is inadequate and the patient will need another biopsy.

Examples from Group 2 are shown in boxes 2 and 3:

MRI request received in MR dated 10th January. Patient sent appointment date for 27th February. Patient rang the breast team to say she knew nothing about having an MRI. Following enquiries by the breast cancer nurse it was discovered that the appointment was intended for another patient

Box 2: Appointment letter sent to wrong patient (Group 2: high risk)

The incident in box 2 presents a risk of diagnostic delay to the patient who should have received the appointment letter. However, there was no way of knowing whether there was a delay or whether in fact the correct patient was sent a timely appointment (or indeed could have had the original appointment).

Trus (transrectal ultrasound) biopsy specimen incorrectly labelled with another patient's name and number

Box 3: Mis-labelled specimen (Group 2: high risk)

Similarly, the patient safety incident in box 3 describes a mis-labelled specimen. The wrong label was spotted and reported as a patient safety incident; however, it is not known whether the correct patient's specimen was received at the laboratory and dealt with appropriately. Nevertheless, there is a risk that the specimen was not matched up with the correct patient resulting in a diagnostic delay.

Length of delay and degree of harm

Detail of the length of delay was provided in only 150 of the incident reports. However, where data were available, diagnostic delays ranged from one day to over two years. It is likely, although not inevitable, that longer delays will cause greater harm. Figure 2 shows the estimated length of delay where an indication was provided:

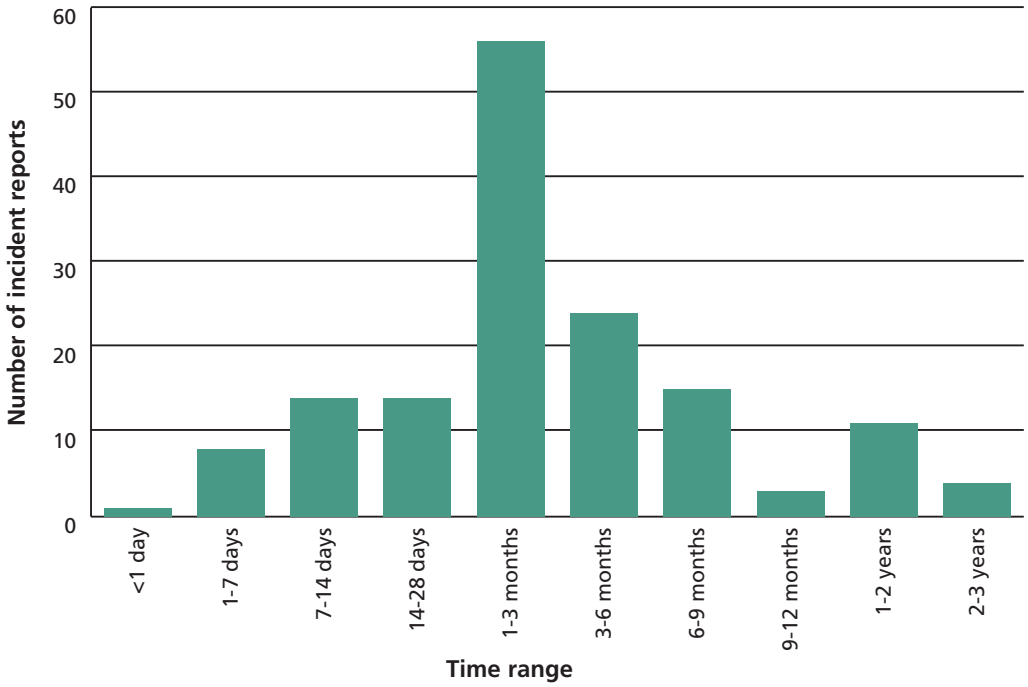

Figure 2: Estimated delay where indicated (150 of the 508 incidents relating to actual or potential delay in cancer diagnosis: a random sample of NRLS data from 1 June 2007 to 31 May 2008)

The degree of harm caused by the patient safety incident is estimated by the person reporting the incident. Most patient safety incidents reported to the NRLS are described as causing little or no harm, which is consistent with the data reviewed for this report, as shown in table 1. There were 331 incidents described as 'no harm' and a further 88 as 'low harm'. Twenty-five incidents were described as severe harm with an additional two resulting in death. The deaths and severe harms were in group 1 (diagnostic delay) and represented 7% of those incidents.

Table 1: Degree of harm (random sample of NRLS data from 1 June 2007 to 31 March 2008 relating to an actual or potential delay in cancer diagnosis)

	Percentage of incidents (number in sample)	
Death	<1%	(2)
Severe harm	5%	(25)
Moderate harm	12%	(62)
Low harm	17%	(88)
No harm	65%	(331)
Total	100%	(508)

Examples of incidents resulting in severe and moderate harm are shown in boxes 4 and 5:

Box 4: An incident reported as severe harm

A lady was referred urgently by the general practitioner to a consultant dermatologist in August 2006. She was seen in November 2006, diagnosed with a "sebaceous cyst" and referred on to a general surgeon. Nothing happened and the general surgeon was not aware of the referral. The general practitioner then referred again in July 2007 to the breast clinic. The patient was seen in 5 days and diagnosed with a 4.3cm invasive ductal carcinoma, grade 2. The specialist said there were no features of a sebaceous cyst whatsoever and reported that this was a significant delay in this lady's diagnosis of around 12 months.

Box 5: An incident reported as moderate harm

A 76-year old patient experienced a 6 month delay in the diagnosis of melanoma to the foot, resulting in what was described as 'moderate harm'. The person had been referred from community podiatry with a non-healing right heel ulcer. Reviewed by two medical consultants who both agreed on diagnosis and treatment for diabetic foot ulcer. After a few visits the ulcer remained non-healing. Patient was then referred to a dermatologist who initially agreed with the diagnosis. However, on the second review of the patient in dermatology clinic, the dermatologist biopsied the wound and diagnosed melanoma.

It is worth noting that it is likely to be difficult to predict degree of harm on an incident report that is completed before the outcome of investigations and treatments are known (see box 6). In cancer cases, the person may be in an advanced stage of the disease before the error comes to light or the error may lead to an increased risk of cancer recurrence. Further, some types of 'harm' are not considered as severe, because they are not life-threatening or disabling, despite resulting in notable emotional and/or physical distress (see box 7).

Box 6: An incident reported as no harm without knowledge of further test results

A barium enema was requested by clinic last year and was carried out on this person in October 2006. The result was not sent to the surgeon's office nor was it made available until August 2007. The patient was recalled immediately and, on further investigation, has been found to have a stricturing lesion which may be malignant.

Box 7: Examples of incidents where disease consequences are unknown but likely to cause emotional distress and reported as no harm

- *The patient's operation was cancelled due to lack of theatre staff. The patient and family were upset and enquiring about the risk of cancer spreading.*
- *There was a delay in the patient receiving a follow-up appointment after vulval biopsy. Treatment has been delayed as a result.*

Patient group and tumour site

Age, gender or tumour site were not provided on all patient safety incident reports in the NRLS. Age was not provided in 185 (36%) cases but, where it was provided, all ages were represented in the data, with a fairly even distribution between the ages of 36 and 85 years. A small group of incidents were reported as involving children and young people under the age of 18 (n=18), including three babies under the age of one year, although sometimes the free text did not match up with the age range listed. The largest groups implicated were the 56 to 65 year olds and 66 to 75 year olds (figure 3).

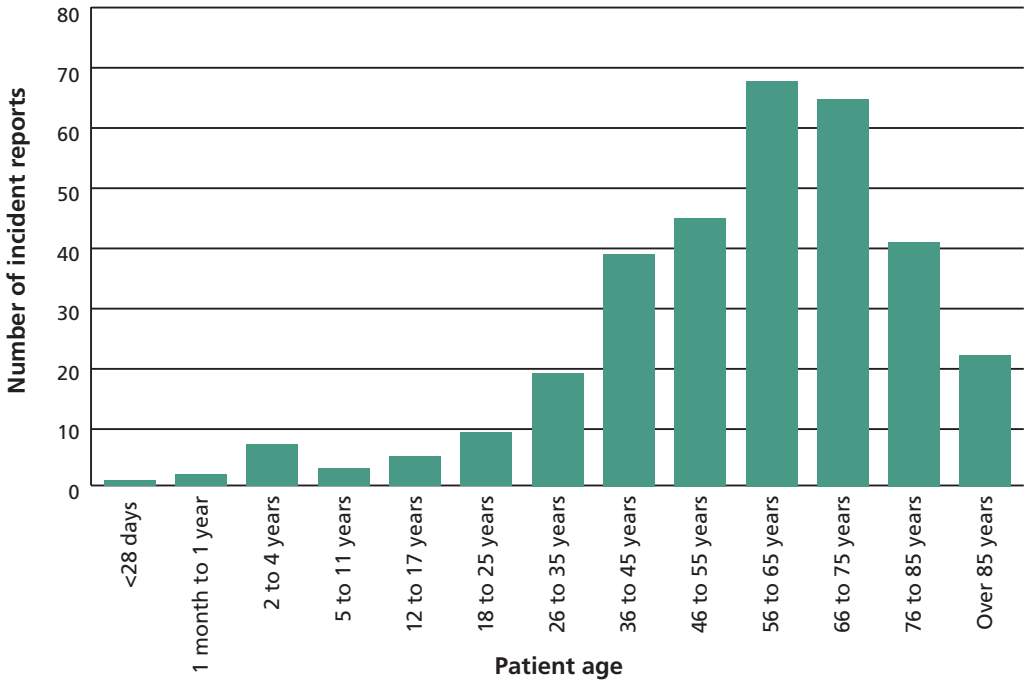

Figure 3. Incident report by age range (326 of the 508 incidents relating to actual or potential delay in cancer diagnosis: a random sample of NRLS data from 1 June 2007 to 31 May 2008)

Gender was included in 330 of the incident reports and was listed as 185 female and 148 male.

In 214 incidents there was no indication of tumour site, but where available the data showed that a range of tumour sites were affected, as shown in table 2. The three most frequently cited tumour sites/groups were gynaecological, skin and urological.

Table 2: Tumour sites where indicated as reported in incidents of actual or potential delay in cancer diagnosis: random sample of NRLS data from 1 June to 31 May 2008 (due to rounding down of percentages they may not all add up to 100%)

Tumour site	Group 1: Diagnostic delay (%)	Group 2: High risk (%)	Total (%)
Gynaecological	36 (9)	15 (12)	51 (10)
Skin	34 (9)	12 (10)	46 (9)
Urological	35 (9)	9 (7)	44 (9)
Breast	23 (6)	13 (11)	36 (7)
Lower gastrointestinal	26 (7)	3 (2)	29 (6)
Lung	23 (6)	3 (2)	26 (5)
Head and neck	18 (5)	1 (<1)	19 (4)
Brain and central nervous system	12 (3)	2 (2)	14 (3)
Upper gastrointestinal	9 (2)	4 (3)	13 (3)
Haematological	10 (3)	1 (<1)	11 (2)
Bone and sarcoma	4(1)	0 (0)	4 (<1)
Other	1 (<1)	0 (0)	1 (<1)
Unknown	157 (40)	57 (47)	214 (42)
Total	**388 (100)**	**120 (100)**	**508 (100)**

NRLS incident types

Because of the inherent reporting bias of the NRLS, almost all of the reported incidents occurred at the point of 'system delay', primarily secondary care. The qualitative analysis of the free text identified several types of incident within this part of the diagnostic pathway where diagnostic delays, or the risk of delay, occurred. These are summarised in table 3:

Table 3: Types of incident in order of frequency as reported in incidents of actual or potential delay in cancer diagnosis: random sample of NRLS data from 1 June to 31 May 2008

Settings or aspects of the pathway	Group 1: Diagnostic delay (%)	Group 2: High risk (%)	Total (%)
Diagnostics	208 (54)	62 (52)	270 (53)
Pathology	149 (38)	58 (48)	207 (41)
Radiology	59 (15)	4 (3)	63 (12)
Communication	84 (22)	48 (40)	132 (26)
Cancellations	65 (17)	10 (8)	75(15)
Clinical assessment	27 (7)	0 (0)	27 (5)
Test waiting list	2 (<1)	0 (0)	2 (<1)
Unknown	2 (<1)	0 (0)	2 (<1)
Total	**388 (100)**	**120 (100)**	**508 (100)**

All categories of incident were analysed in further detail.

Diagnostics

Pathology

Pathology, primarily histopathology, was the largest category of patient safety incident reported in the random sample. It should be remembered that the search terms were designed to find patient safety incidents regarding diagnostic tests that could be associated with cancer, for example biopsy. When considering 'pathology', this report includes incidents related to the complete patient pathway, from the ordering of a test to the taking of a sample, transporting and processing the sample, to the result being acted upon. Table 4 presents a breakdown of a more detailed analysis of these incidents:

	Group 1: Diagnostic delay (%)	Group 2: High risk (%)	Total (%)
Pre-lab problems	62 (42)	31 (53)	93 (45)
In-lab problems	72 (48)	23 (40)	95 (46)
Post-lab problems	15 (10)	3 (5)	18 (9)
Unclear	0 (0)	1 (2)	1 (<1)
Total	**149 (100)**	**58 (100)**	**207 (100)**

Table 4: Breakdown of pathology (primarily histopathology) incidents as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Pre-laboratory incidents (almost half the total number of pathology incidents) included problems with:

- taking samples;
- labelling;
- preserving samples;
- arrival in the laboratory (either delayed or not at all).

Looking separately at patient safety incidents related to 'two week waits', there were incidents where samples were not correctly labelled as urgent and were consequently delayed beyond the two-week time period.

Box 8: Examples of pre-laboratory incidents as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Taking samples: *A patient attending for an urgent cancer referral had their pathology results delayed after lab reported receiving an empty specimen pot.*

Labelling: *A batch of 5 breast biopsies was sent to the histopathology lab. A labelling / numbering error occurred which caused the biopsies from part of one case to be given the lab number of one of the other cases. The error was noted in the lab. Although the investigation identified the blocks most likely to have been affected by the error, DNA testing was requested on all the blocks to confirm. The 5 patients were called to clinic to have blood samples taken to act as reference samples for the DNA testing. The DNA tests… confirmed the expected outcome; only two cases had been affected by the error. These cases were relabelled with the correct numbers and the slides submitted to the pathologist for reporting. The outcome is that five patients had a delay in receiving their biopsy result.*

Preserving samples: *A patient underwent a mastectomy on 7th August - the time taken on the request card was indicated as 14.30hrs. The specimen was not received in Cellular Pathology until 09.00hrs on 8th August. As a result the specimen was extremely poorly fixed and the preservation of the tumour very poor. This will hinder accurate diagnosis regarding histological grade and may make hormone receptor status impossible to assess.*

Arrival in the laboratory: *A urine sample was sent on this patient by taxi along with a pleural fluid sample on another patient (for) leukaemia diagnosis….at 11.40. The section rang at 16:00 …to say that the sample had not arrived.*

Incidents occurring in the laboratory (46% of the total) included reporting delays of weeks or months or errors in reporting where malignancies were erroneously reported as benign. Processing errors were also noted. Box 9 provides examples:

Box 9: Examples of incidents in the laboratory as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Reporting delay: *Tissue sent to the lab on 16th June was not reported until 28th August. The patient in meantime has died. The diagnosis was cancer.*

Reporting error: *Report on breast core biopsy for Patient A erroneously reported as no evidence of malignancy as pathologist confused slides from this case with another case of Patient B. The error was not detected at the multidisciplinary team meeting because the cases had only just been reported prior to the meeting. This resulted in Patient B with a benign breast condition receiving a malignant diagnosis and subsequently undergoing a wide local excision. Meanwhile, Patient A with malignant breast disease received a benign diagnosis initially and then needed an additional biopsy later to achieve the correct diagnosis.*

Processing error: *There was a processing malfunction which affected all the biopsies processed overnight …. This particular case was a cervical biopsy. A full report could not be issued. A repeat biopsy was suggested if clinically appropriate.*

Post-laboratory incidents included failure to review the results and/or appropriately act upon the result.

The consultant… approached me… to inform me that a biopsy that I had carried out had been filed in this patient's notes. The findings show a basal cell carcinoma. The consultant's concern was that the pathology form had been filed in the notes and there was no evidence that the results had been looked at by a doctor.

Patient attended for 3 month appointment post prostate surgery…Biopsies showed cancer of the prostate but patient unaware and thought that after this length of time everything was ok. Very distressed. Apology and explanation given. Histology sent to secretary for filing…, not signed. Patient given treatment and investigation options…

Box 10: Examples of post-laboratory incidents reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Radiology

Radiology issues accounted for 59 diagnostic delays and a further four where the risk of delay was high. These reports were primarily concerned with failures in communication of abnormal results, reporting delay and reporting error. Examples are shown in box 11:

Failure in acting upon abnormal results: *This lady was initially seen in February with post-menopausal bleeding, thought to be a urethral caruncle. However, the ultrasound scan showed endometrial thickness of 6.6mm. Further follow up was not arranged. The lady was found to have cancer of the endometrium in October.*

Report not sent: *The patient was referred to out-patients with epileptic seizures. The patient was seen on 21st September. An MRI took place beginning of October and was reported the next day as a malignant brain tumour. The report was not relayed to the clinician or GP. The GP enquired beginning of November and was given the result. The GP faxed an urgent referral to the specialist. Meanwhile, the patient developed bad headaches as a result of tumour growth and required an emergency admission and surgery.*

Delay in reporting: *Chest x-ray suggesting lung cancer on film obtained on the 1st November 2007. Reported on 24th November 2007. Delivered on 1st February 2008.*

Box 11: Examples of radiology incidents as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

There were two incidents specifically concerning the Picture Archives and Communications System (PACS), which is a relatively new system that enables images such as x-rays and scans to be stored electronically and viewed on screens. The system is being rolled out over a three year period from 2007 and it may take some time before related patient safety incidents start being reported. The two incidents are shown in box 12:

- *An earlier examination was reported instead of the current one. This happened because PACS changes the screen on which the current exam is being displayed, at random. This would have led to the patient not being treated for his cancer.*
- *Patient has an attendance for a CT (computerised tomography) Biopsy. It has not been processed (or cancelled) and yet there are not images on PACS.*

Box 12: Examples of incidents concerning the use of PACS in radiology as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Communication

Communication incidents accounted for around a fifth of the sample. A further breakdown is shown in table 5:

Table 5: Breakdown of incidents concerning communication as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

	Group 1: Diagnostic delay (%)	Group 2: High risk (%)	Total (%)
Follow up communication problems	31 (37)	2 (4)	33 (25)
Appointment miscommunication	26 (31)	2 (4)	28 (21)
Referral communication problems	16 (19)	1 (2)	17 (13)
Accuracy of information	8 (10)	43 (90)	51 (39)
Other	3 (3)	0 (0)	3 (2)
Total	**84 (100)**	**48 (100)**	**132 (100)**

Incidents in this category related to the systems in place to ensure the communication of accurate and relevant patient information, referrals, booking of appointments and follow up of patients. These are largely administrative tasks and illustrate the need for robust processes to be in place to ensure failures do not occur. Many of these processes should be in place as part of national cancer standards.

Examples are provided in box 13:

Box 13: Examples of incidents relating to communication as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Follow up:

- *A 28 year old woman was seen in out patients on 5th October as a new patient. No notes were available so the consulting doctor took notes on a pad and asked the secretary to make up a set of notes. The doctor ordered a biopsy, the results of which showed CIN3. A letter was dictated and this was left with the secretary to type and make a follow up appointment. The GP contacted the doctor on 9th June the following year to ask whether the patient had had any treatment; when the doctor investigated, it emerged the patient had not been seen since the OPA.*
- *Patient had skin biopsy taken February 2006. Results showed further appointment and treatment necessary. Letter dictated by Consultant dated March 2006 stated further appointment would be made. No further appointment or follow up actually arranged. Error noted when patient was re- referred by GP in July 2007, with recurrence of basal cell carcinoma at left temple.*

Referral:

- *On tracking a set of patient notes, I discovered a referral letter from a GP for another patient in her case notes. The second patient is a lady with metastatic cervical cancer and had been referred as an emergency.*
- *Patients wife contacted department as awaiting date from …and had not heard anything. Notes traced to consultant desk. Patient seen in clinic 22nd June, letter typed 4th July. Letter found in pile of unsigned correspondence, consultant away on holiday from 7th July for two weeks. Who was going to sign letter and send? How long would it be sat on desk unless patient phoned? 37 year old with probable cancer of the rectum.*

Inevitably, there is some potential overlap between communication and other categories but, if the incident was primarily about communication, it was categorised here; for example, some reports categorised as communication issues came from pathology settings where actions were not taken in response to a report. Similarly, some reports were about cancellations, but if the

problem was about communication of the cancellation, or for example, communication of the urgency of the required test, then the report was categorised under communication.

Communication was also the most commonly seen failure in the 'two week wait' search, with 15 of the 30 patient safety incidents linked to the process of referral and communication of results, as shown in box 14:

Communication between primary and secondary care and between clinicians: *I returned from holiday on Monday 4th September to find 5 two week wait patient forms left on my desk. Messages were left on the fax front sheet stating ' sorry, tried to call but no answer, I have left a message on your answer machine'. Hospital numbers had been faxed through on 28th August and had appointment target dates of 7th Sept.*

Communication between departments in secondary care: *Patient with weight loss seen as two week referral on 26th April. Referred to dietician and for urgent CT scan. Scan performed on 4th May and patient reviewed by dietician on 23rd May. Scan result and notes not brought to my attention until 25th October. This is an unacceptable delay and posed a serious risk to the patient.*

Communication about patient's status: *Patient was booked onto Urology clinic on 2nd Jan under the two week wait rule. The clinic was cancelled due to sickness of the consultant but it was not identified that this patient was on a 14 day target and he was therefore not rebooked onto an appropriate clinic.*

Box 14: Examples of incidents relating to communication in the 'two week wait' data search of incidents reported to the NRLS from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Cancellations

Despite targets for reducing cancellation of surgery, cancellations were the third most important theme in this dataset. A common problem was the need to cancel procedures because of a lack of beds, or (particularly with children) a lack of a specialist service. Other problems included clinics cancelled due to staff absence and lack of available, working equipment to carry out procedures. Some reports indicated poor planning and preparation for investigations.

Examples included not ensuring the availability of specialist staff, poor communication when booking investigations and ensuring other staff or the patient were aware of the importance of the appointment and/or requirements for adequate preparation for the procedure.

Examples are provided in box 15:

Lack of specialist anaesthetist: *One year old child presented with concerns over intracranial pathology and possible cerebral tumour. We were unable to carry out an MRI scan due to the inability to provide anaesthesia.*

Poor preparation: *The patient was supposed to have been prepared for a PET (positron emission tomography) scan arranged urgently. This meant Nil By Mouth (NBM) before the procedure. On arrival the scan had to be cancelled as the patient had been given lunch on the ward, despite nursing staff being aware of the NBM requirement. The scan was vital to this patient's management regarding surgery for a brain tumour. The patient will now have to wait a further week for the PET to be rescheduled.*

Poor preparation/lack of suitable equipment: *Patient came to theatre for laparoscopy and lymph node biopsy. There were no 30 degree scopes available to carry out the procedure safely, therefore the lymph node biopsy was not performed. Patient woken up and the surgeon informed.*

Clinic cancellations: *Four patients returning to clinic for results had appointment on 8th Feb cancelled….Rebooked for weeks or months later i.e. 23rd May clinic reduced – non urgent patient left on, cancer patient removed. Three other patients involved.*

Box 15: Examples of incidents relating to cancellations as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

Clinical assessment and other incidents

Other categories of incidents were in the minority, accounting for less than 10%, but were nonetheless important.

Notably, errors at the point of clinical assessment accounted for 7% of the actual delays. These reports referred to cases where the clinician missed a diagnosis of cancer; examples are shown in box 16. This type of incident may be reported less frequently by clinical staff. All of these incidents took place in secondary healthcare services, but this is most likely to be an artefact of the reporting culture rather than an implication that such errors do not occur in primary care settings.

Box 16: Examples of incidents relating to clinical assessments as reported in a random sample of NRLS data from 1 June 2007 to 31 May 2008 concerning incidents of actual or potential delay in cancer diagnosis

- *A young woman presented in A&E (accident and emergency) with a fit, confusion and headache. She had already been seen at another hospital and discharged. She was found by A&E to have a brain tumour.*
- *This patient was moved from the Medical Assessment Unit after being seen by an F2 doctor only, without any senior review. The patient came in following a fall, and the doctor examined her knee. However it has now been noted that the patient has bleeding per rectum, abdominal mass and atrial fibrillation.*
- *A diagnosis of oral cancer was missed by two clinicians - one in October and one in November. Staff member informed mid December.*

Other reports included two incidents where waiting times were breached and two where no details were provided.

5. Findings from workshops

Two focus group events were held, one in Manchester and one in London.[53] Participants were recruited through Cancer Networks. A total of 50 people participated in the events, including patients, carers, general practitioners (GPs), public health specialists, Cancer Network directors, nurses, cancer specialists, service improvement directors and commissioners.

Participants were invited to prepare vignettes recounting diagnostic delays from their own experience. During the workshops these vignettes were explored using the principles of Root Cause Analysis[54] to gain a better understanding of where and how things go wrong and to pinpoint areas for improvement.

In addition to the specially planned events, the preliminary findings of the NRLS analysis were presented at the NAEDI launch, the Britain Against Cancer conference and to individual Cancer Networks. Feedback from these meetings is also included with the analysis.

The findings focused mainly on primary and secondary care delays in the pathway. The most frequent message heard was that some patients go to their GP several times with the same symptoms that are not fully investigated. There are several issues underlying this problem, as well as others that were raised. These issues often overlapped, but were categorised into themes:

- communication;
- clinical assessment and management;
- cultural issues.

Communication

Communication was an important, multifaceted theme that arose during the meetings. Most communication issues were raised about doctor-patient communication. However, communication between care settings and communication between systems was also mentioned.

Doctor-patient communication

"I knew something was wrong. I know my body better than they do." Event participant

Patients and carers commented that the consultation with GPs felt too short, and they had limited opportunity within the time available to discuss all their concerns. Furthermore, they felt that GPs did not always listen to them. One participant felt her GP was too quick to dismiss her symptoms as menopausal or 'neurotic'. Box 17 provides a further example from the focus groups:

Note: *Quotes are taken from comments made during the focus group events held by the NPSA in 2008 to explain the issues around delayed diagnosis of cancer. All names have been changed in the following examples to protect anonymity.*

"Alice", a woman in her early 60s, returned to her GP several times with abdominal discomfort and other symptoms. She felt he did not listen to her, that he found her a 'nuisance'. She eventually consulted a private practitioner, whom she felt took her seriously. She described this practitioner as a partner in her care. The private practitioner arranged for a series of tests. Alice disclosed that when she was finally given a diagnosis of ovarian cancer, she had actually thanked the consultant for the diagnosis, because she felt vindicated.

Box 17: An older woman who did not feel listened to

It was not only listening skills but other communication skills, including questioning skills, which were raised in the focus groups. If patients do not realise they have a symptom or sign that might be unusual or important, they will not necessarily mention it, even though it might be critical in making a diagnosis. Unless GPs ask the right questions, these critical symptoms can be missed. This is supported by the literature around diagnosis where obtaining critical information improves diagnostic accuracy.[55]

Non-verbal communication (especially repeated attendances at the practice) was also mentioned as an important indicator. It was suggested in the focus groups that sometimes GPs did not notice or take action when patients' behaviour changed. A patient might start to attend the practice frequently after having attended infrequently in the past; this could be a sign of a persistent set of symptoms that was not being adequately treated. There were several examples of patients going to their GP on several occasions with the same symptoms but not getting the right advice/action, as illustrated in box 18:

Box 18: A person who started to attend frequently with the same set of symptoms

"Vernon" was 75. His wife had died and he had poor social networks. He had rarely visited his GP in the past but he started to attend frequently with aches and pains and stiffness. The GP assumed Vernon was depressed. He was not signposted to any other services. One year later he was diagnosed with prostate cancer with bony metastasis.

Conversely there were also examples where GPs did recognise unusual behaviours in their patients and acted, as shown in box 19. In these cases, the GPs usually had a relationship with the patient, could recognise that the pattern of attendance or the type of complaints had changed, and were able to act rapidly and effectively. This could be compromised in group practices where patients saw different GPs each time, or where patients saw locums, resulting in discontinuity of care.

Box 19: A GP recognises unusual pattern of attendance and complaint

Dr "Patel" saw Mrs "Martin", whom she knew well, in early January. Mrs Martin complained of nausea and vomiting, which Dr Patel and Mrs Martin attributed to Christmas and New Year excess. Three weeks later Mrs Martin returned, having lost three quarters of a stone. She was still vomiting and her abdomen was tender. Dr Patel ordered an urgent ultrasound scan and blood tests. Mrs Martin was diagnosed with a small bowel tumour.

In such situations, the relationship between GP and patient seemed to be important. On the other hand, there were occasions where patients found seeing a locum or a different doctor beneficial. The new doctor saw patients' stories with a fresh eye, which meant they were sometimes able to make a diagnosis of cancer that had been missed in previous consultations. The notion that a 'second opinion' can be beneficial despite the risk of discontinuity of care has been recognised in the literature.[56]

Communication between care settings and systems

A number of examples were raised where communication had failed between care settings. Most commonly, there were communication problems when patients attended Accident and Emergency, with tests being carried out in the hospital and not communicated in a timely way to the GP, or even the attendance not being communicated. This could result in serious events being missed by the GP. Communication between primary care and secondary care were considered especially important in diagnostics, where tests are commonly ordered in primary care but carried out in secondary care. Effective mechanisms for tracking results was not established in all practices and issues such as results being returned to the non-referring GP, or to a group of GPs, had the potential to cause delays.

There were also communication problems and lack of co-ordination *within* the primary care setting. Box 20 describes an example of where communication broke down between various departments:

"Roisin" went to the practice nurse with a lump on her vulva. The practice nurse examined the lump and stated that it was probably a cyst, but no tests were ordered. Roisin returned several times to the nurse as the lump became larger and more painful. The nurse did not escalate the problem up to the GP. Roisin then had several GP appointments but she did not see the same GP each time. She also saw different gynaecologists and went to A&E. After 15 months' delay, Roisin was finally diagnosed with vulval cancer.

Box 20: Communication problems across a number of settings

A group of communication issues came from secondary care providers. They sometimes felt they did not have adequate information from primary care when first seeing a patient. Some clinicians called for standardised referral forms to aid the diagnostic process. It was also noted that, at the multidisciplinary team (MDT) milestone, if a patient comes with late stage disease the patient is regarded as a 'late presentation' – implying that the delay lies with the patient rather than the system. This is not helped by the problem of not having details routinely recorded about the care pathway into and through primary care. A possible audit of late stage presentation to MDT would be hampered by the lack of information available on the care pathway.

Clinical assessment and management

Clinical assessment is closely linked to good communication and there were examples where doctor-patient communication problems resulted in poor clinical management. However, there were also more concrete issues relating to routine procedures and processes.

For instance, guidelines and policy recommendations were not always acted on, could feel overwhelming in volume (described as a 'plethora' by one practitioner), and sometimes resulted in confusion if they contrasted with national campaigns: all of these factors contributed to examples of delays. The example in box 21 describes a situation where the GP did not follow guidelines:

"Alaia" went to the GP with a suspect skin mole. The GP was young, and new to the practice. He was not a designated skin GP. Contrary to the guidelines, he decided to excise the lesion – using 'cut and burn' - and he disposed of the material. However, he did refer the patient to hospital. The dermatologist eventually diagnosed melanoma but the diagnosis was delayed because the GP was not able to send a sample.

Box 21: GP not following guidelines

It also emerged in discussions that practitioners were not always sure how to respond when the patient did not fit a particular set of guidelines or expectations. Examples were raised with childhood cancers, in particular, where practitioners did not expect to see cancer symptoms, and also in other age groups where cancer was not expected, as shown in box 22:

"Paulette" was 29 years old. She had recently given birth and was breastfeeding. She went to her GP with a breast lump. The GP assumed the problem was mastitis and did not refer her to the breast clinic. Paulette returned twice more to the GP as the lump did not go away. When she was finally diagnosed, she had advanced breast cancer with extensive spread.

Box 22: Patient much younger than expected so guidelines not followed

Unusual or rare cancers were also difficult for practitioners to identify, although there were concerns when patients returned time and again with persistent symptoms and many of the examples showed that they were not investigated for possible cancer.

Clinical assessment was also sometimes hampered by test ordering and results. Practitioners described being falsely reassured after ordering tests which came back negative. This might be because they had not tested for the relevant disease or because the test was not sensitive enough or the results were equivocal. Receiving negative, or false negative results, has been cited in the literature as a cause of delay.[33] Further, some tests ordered as urgent or emergency were reported as still taking too long; one GP gave an example of an emergency scan taking three weeks.

Cultural issues

A common theme in the focus groups and discussions was the culture of the doctor-patient relationship in which the patient tends to assume a passive 'patient' role. This concept was first described more than 50 years ago by Talcott Parsons but still appears to be relevant.[57] Despite persistent symptoms, which do not get better, patients return again and again to their GP without feeling that their symptoms have been addressed; they rarely complain or ask for a second opinion. If a test result does not come through they tend not to ask about it and may not realise the testing process has failed. For example, GPs can tell patients they will be contacted if the result of a test is problematic, so if they are not contacted, the patient assumes nothing is wrong, despite continuing to experience symptoms. One patient commented that if she had not had a supportive partner she would not have persisted in seeking help. Another finally refused to continue with her own doctor and sought help in the private sector, as shown in box 23:

Box 23: From 'passive' to 'active' patient

Mrs "Ahmed" was a 76 year old lady who attended her GP in May with difficulty swallowing. She returned three more times, without her symptoms getting better. She went to see her dentist, who needed to fit new dentures. In October she returned to the GP having lost a stone and a half. Mrs Ahmed had a gastroscopy, carried out by a nurse, which did not show any abnormalities. She was then referred to a gastroenterologist but she refused to go, based on the results of the gastroscopy. Instead she consulted a private Ear Nose and Throat specialist. In November she was diagnosed with end stage oral cancer.

The passive patient role can often be reinforced by GPs and practice staff; patients are not empowered to challenge or to be experts in their own condition. Box 24 gives an example that shows how the system supports the culture:

Box 24: The passive patient culture

Mr "Rossi" had been seen by the haematologist at the local hospital. He was informed by the hospital when the GP should have his results. He went along to the surgery to check whether they had been received. The receptionist said she could not see any results but that in any case, they would not be able to divulge results to Mr Rossi without written proof of consent from the hospital that Mr Rossi could see his results. Mr Rossi explained he would like to see his GP as he was worried he might have leukaemia. The receptionist could not offer an appointment for a week and suggest that Mr Rossi should fax the hospital to ask them to speed up the results. Three days later, Mr Rossi was able to see his GP due to a cancellation. After the consultation, the GP contacted the hospital then rang Mr Rossi with the news that he had chronic lymphatic leukaemia.

Leadership, organisational culture and patient safety

The other issue that became apparent was the culture of patient safety in primary care. The focus group participants discussed the need to improve patient safety culture amongst GPs. Examples included deviation from established guidelines, failure to fast-track patients at risk, and not regarding incidents such as the examples in this report as patient safety incidents which offer an opportunity for widespread learning. In the workshops there was a call for patient safety data to be collected in a consistent manner.

Meanwhile, some of the Cancer Networks reported that there was no primary care lead in their Network. Although three years of funding was provided to set up these posts following the *NHS Cancer Plan*, the posts have not necessarily been sustained.

6. Primary care perspective

This section considers the key issues in primary care in relation to delays in the diagnostic pathway, including what is known about delays in primary care, the perspective of GPs and what improvements need to occur.

The generic issue of missed diagnoses in primary care

Diagnostic delay is an issue that is recognised to be important by GPs.[58] Figures from the MDU in 2003[59] show that more than half the claims settled against GPs were for delayed diagnosis. The major risk area was cancer with tumour types as follows:

- breast (22%)
- bowel (14%)
- cervix (13%)
- skin (8%)
- brain (7%)
- lymphoma (5%)

The MDU identified the reasons for delay as:

- failure to examine the patient properly;
- inadequate follow-up arrangements;
- lack of appropriate investigations;
- reports misfiled in notes (usually kept in paper files);
- dysfunctional communication between healthcare staff and between healthcare staff and patients;
- incomplete or inadequate record keeping, and failure to refer or ambiguous prioritisation of referral.

Published data from the MPS regarding general practice negligence claims also highlights the problems of delayed or misdiagnosis, with cancer forming the largest category in this 1,000 case analysis.[60] The three main cancers sites were gynaecological, digestive organs and breast.

What are the key issues in cancer diagnosis in primary care?

The Scottish Primary Care Cancer Group reports on cancer diagnosis give significant insight into the primary care component in the cancer pathway.[61,62] These reports involved analysis of 4,181 cases of cancer diagnosed between 2006 and 2007, and 7,430 between 2007 and 2008. This project offers the most detailed analyses available to date in the UK. It is important to note that fast track electronic referral was not introduced in Scotland until 2006.

The findings of the reports are summarised as:

- Patients with head and neck cancer took the longest time to present (median 30 days). Patients with melanoma and colorectal cancer also presented comparatively late (median 26 days and 21 days).

- Patients with bladder cancer, leukaemia, cervical cancer and breast cancer took the shortest time to present from first noticing a sign or symptom.
- There was wide variation between practices in the time taken for patients to be referred to hospital. Patients with breast cancer and melanoma were referred quickly whereas, for other tumour groups (notably lung and prostate), patients spent longer in the primary care part of the journey.
- Even when cancer was suspected patients were not always fast tracked. The report emphasised the importance of implementing referral guidelines and enforcing fast track schemes. It would appear that practices interpreted the guidelines differently.
- Patients with non-specific symptoms and/or co-morbidity caused particular difficulty.
- Level of GP engagement with the national audit was high with GPs showing evidence of reflection and being open about the issue.
- There were differences between practices even in the same health board and between tumour types.
- A significant number of cancers were diagnosed outside of the fast track system. The report called for improvements in routine care and referrals.
- The report highlights the importance of prompt access to investigations in primary care.
- The report's success suggested that a national process of data collation and synthesis across a region/district is worth considering.

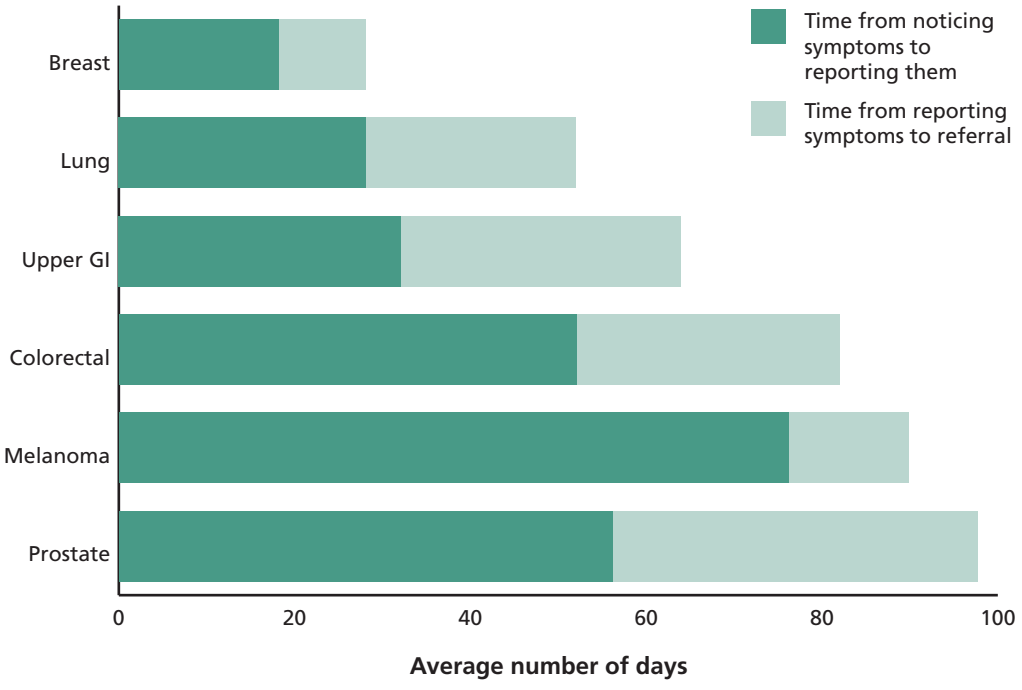

Figure 4: Data from the first Scottish Primary Care Group report showing the average number of days delay in cancer diagnosis in primary care. This shows that patients have symptoms for a significant period of time before seeking help and that there can be considerable delay in referral, particularly for some tumour types.

The primary care patient pathway

The primary care patient pathway can be described as:

1. **Health seeking behaviour:** patient with symptoms or concern – decision to seek assistance from primary care;
2. **Access:** appointment with GP or practice nurse;
3. **Clinical assessment:** evaluation of symptoms, use of guidelines and shared decision making;
4. **Test ordering:** access and management of tests – blood tests/ imaging;
5. **Follow up with results;**
6. **Referral to secondary care:**
   a. missed referral;
   b. inappropriate prioritisation of urgency;
7. **Assessment in secondary care.**

Figure 5 provides a graphical overview of the pathway. Because of lack of systematic data, particularly from primary care, it is not possible with absolute certainty to define levels of risk along the pathway.

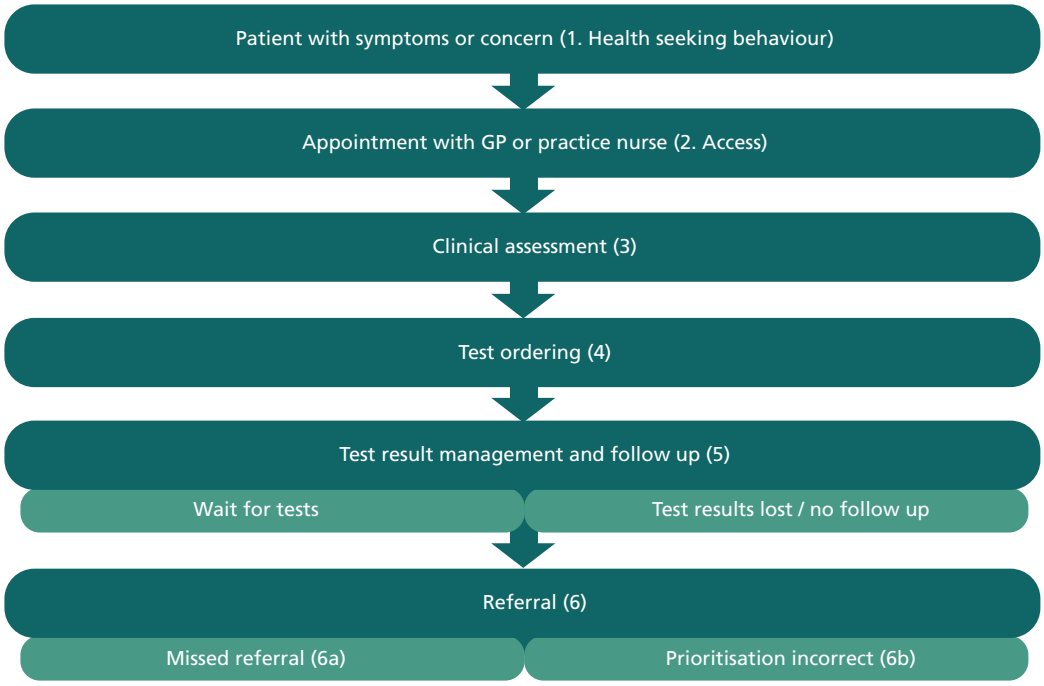

Figure 5: Primary care patient pathway

An adult patient was diagnosed with Iron deficiency anaemia. Given parenteral Iron. No other investigations. Still iron deficient six weeks later. Referred by letter to general surgical outpatients. Seen three weeks later. Patient had bowel cancer and in retrospect had met criteria for fast tract lower GI referral. (Case from a Cancer Network Audit)

Box 25: Example of stages 3 and 6b of the primary care patient pathway

Incident reporting in primary care

General practice contributes only 0.4% of all patient safety incidents reported nationally. GPs have their own system of reporting called Significant Event Audit (SEA). This technique is widely practised and is part of the Quality and Outcomes Framework (QOF) of the General Medical Services (GMS) contract, where primary care teams have to undertake a review of 12 events, including new cancer diagnoses, over three years. The technique has many strengths, particularly its educational ethos. However, there is a wide variation in the quality of SEA, no systematic sharing of learning and low levels of reporting into local and national systems. A major issue is

the use of differing terminology (critical incidents, significant event, serious untoward incident (SUI), adverse event) despite attempts at defining a common language.

There is a need for greater standardisation, use of agreed and accessible terminology and improvement in the practice of SEA. The Scottish Audits show levels of participation in national audits can be high and provide significant opportunity for learning. This was achieved through an agreed designated enhanced service (DES) specification as part of the GP contract.

In October 2008 the RCGP and the NPSA published guidance on significant event auditing.[63]

Box 26: Detailed perspectives from GPs: reflections for learning (Scottish Primary Care Cancer Group)

- *Perhaps if my colleague had done a PR (rectal) examination at the initial contact the rectal tumour would have been identified and the pathway for this patient may have then been faster. (rectal cancer)*
- *With hindsight the patient should have been referred sooner and more urgently for further investigation by myself. (bladder cancer)*
- *My colleague said he would refer in December but referral was not made. Patient contacted the practice again in February. We have since looked into our system for sending referrals. (lymphoma)*
- *Patient presented with weight loss and suggestion of pelvic mass. Urgent pelvic ultra sound scan requested, but four weeks later patient had to be admitted with ascites (abnormal build up of fluid in the abdomen). Management of the developing ascites might have been made easier had we been able to get the scan (and hence diagnosis) earlier. (ovarian cancer)*

Nature of general practice and difference with secondary care

GPs are not complacent and recognise that cancer is a leading cause of concern to the public, and that prompt diagnosis is an important issue to patients and doctors.[60]

Making an accurate diagnosis can sometimes be difficult in primary care because of non-specific symptoms at presentation. Latest figures available show that just over 300 million consultations took place in general practice in England in 2008.[64] Many patients will have co-morbidity which can make the evaluation of symptoms such as tiredness, which can indicate cancer, complex. Diagnosis can be challenging and this can be source of conflict between primary and secondary care. The positive predictive value of a symptom or a test is dependent on the prevalence of a condition in a setting. For example, most patients with a cough in general practice will not have lung cancer, whereas the probability of lung cancer in patients with a cough attending a specialist respiratory clinic is higher. As prevalence falls, the number of false positives increases, which results in a lower predictive value.[65]

GPs refer thousands of individuals with cancer every year through the two week fast track scheme, but they investigate and assess many more patients who do not have cancer. The assessment of a classic 'textbook' presentation of cancer is relatively straightforward. However, the more usual and difficult scenario is the patient with vague symptoms with co-morbidity. Frequently, clinical encounters are inconclusive without it being possible to make an accurate diagnosis. Whilst greater vigilance is needed, it has been stated that it is important not to routinely over-investigate or make inappropriate referrals.

The distinction between the task of a generalist and a hospital specialist is essential for understanding the diagnoses in general practice.[66]

The role of the GP is to:

- tolerate uncertainty;
- explore probability; and
- marginalise danger.

The role of the hospital specialist is to:

- reduce uncertainty;
- explore possibility; and
- marginalise error.

This distinction is essential to consider when developing solutions, for example, the use of more formal methods of diagnosis, such as probabilities of signs and symptoms, and use thresholds for investigation and referral.[67]

The changing nature of general practice means there are additional providers and practitioners where patients can enter the system, for example, walk-in centres. These have the potential to increase access but also the potential for fragmentation of care.

7. Summary and recommendations

Summary of findings, discussion and conclusions

This review has presented an analysis of incidents related to diagnostic delay in cancer reported to the NPSA's NRLS. Analysis of a sample of patient safety incidents suggested there were more than 132 incidents a month concerning a delayed or potential for delayed diagnosis of cancer between 1 June 2007 and 31 May 2008.

The analysis of the NRLS sample demonstrated patient safety incidents that primarily occurred in secondary care. Combining this with a focused review of the literature and consultation with a range of stakeholders revealed a range of safety concerns and risks along the cancer diagnostic pathway.

Patient delay

Most of the published literature focused on the delay in patients seeking help. Patient delay was not an area covered by the NRLS or that featured heavily in the consultation exercise, but two themes were nonetheless significant.

Firstly, the literature suggests that one of the most important reasons for patient delay is symptom misattribution. This has a major impact on delayed diagnosis: people who do not identify their symptoms as possible symptoms of cancer are more likely to delay going to the doctor. The consultation exercise found examples where a critical symptom (such as change in bowel habit) may seem unremarkable for the patient.

Secondly, the evidence also points to fear as being an inhibitor to people seeking help for a possible cancer.

Both of these themes have implications for patient safety in terms of improving public information and also for working with primary care to improve doctor and patient awareness of relevant symptoms. Older people may be particularly affected by patient delay and activity to increase awareness might be best targeted to people in older age groups.

Doctor / provider delay

There is some research on doctor or provider delay. This usually, but not always, refers to primary care. Only a small proportion of patient safety incidents are reported to the NRLS from primary care and this is an indicator of one of the patient safety concerns: that there continues to be a need to increase reporting from primary care.

The material gained through the workshops resonated with the findings reported in the research literature. One important overall theme in both the literature and from the consultation was repeated attendance on the part of some patients with the same symptoms, and GPs misattributing those symptoms to another condition. Underpinning this theme were the linked issues of doctor-patient communication and a tendency for patients to accept the lack of diagnosis or symptom resolution without complaint: the 'passive patient' role.

A lack of adherence to guidelines and problems when patients did not fit expectations, especially when they were out of the expected age range for cancers, was seen in the literature and the workshops. The literature suggests that there are also specific issues facing young people and children, and that communication between doctors and parents makes an important

contribution to delays in diagnosis. The NRLS revealed a small group of incidents affecting young people with cancer; however, these were all events that took place in secondary care.

System delay

Nearly all of the NRLS data related to diagnostic delays in secondary care, with some at the interface between primary and secondary care. The top three categories were patient safety incidents that occurred in the context of diagnostics, primarily histopathology, delays due to a variety of communication issues, and cancellations.

At least a third of the patient safety incidents reviewed resulted in reported harm to patients, including death and serious harm. Problems included: samples not being delivered safely to the laboratory; errors within the laboratory; administration problems leading to patients being misinformed of results or not sent appointments; and cancellations of procedures due to lack of availability of staff or equipment or inadequate preparation for the procedure. Incidents involving diagnostic services accounted for over half of the reports in the NRLS. Problems between secondary and primary care included GPs not being informed of results and GPs alerting secondary care providers of a problem by making contact to find out what had happened to their patient's test – albeit several months after the test was ordered.

Recommendations and next steps

As this report demonstrates, there is scope for improving the diagnosis of cancer. Many of the issues highlighted will be taken forward through NAEDI and wider improvements in the NHS through the *High Quality Care for All: Next Stage Review* (NSR).[68] This includes strategies for greater patient involvement and empowerment, more responsive primary and community care including better models of care, quality metrics, stronger commissioning and proposals for leadership. The NSR also places quality as the organising principle of the NHS. Provider quality, including those in primary care, should become more consistent and responsive through proposals for quality accounts and registration with the Care Quality Commission (CQC).

During this project, five key patient safety areas have been identified. Two of these recommendations are straightforward and are already being taken forward. The remaining three recommendations are complex and need collaborative approaches and embedding within existing quality improvement workstreams.

Key patient safety area 1: Recognition of cancer in primary care

This project suggests that there is a need to improve support for primary care professionals in diagnosing cancer earlier. Clinical diagnostic errors or delays are often considered as failures linked to skills and training but, in keeping with our understanding of patient safety, there are system fixes that can decrease their frequency. Support is needed to give GPs better, easy to use tools to evaluate signs and symptoms and for practices to improve their systems. Collaboration with the RCGP will establish how this is best undertaken in line with other initiatives currently being developed, including the national primary care audit of cancer diagnosis. Computer-based decision support systems have been developed but are not currently in widespread use. Symptom misattribution and communication issues in primary care were important factors raised in consultations and in the literature. Existing referral guidelines for cancer diagnosis were published by the National Institute for Health and Clinical Excellence (NICE) in 2005.[69] In the consultation exercise, there was a call for these to be updated, and presented in a new way with further development of diagnostic tools.

Recommendation 1: An accessible diagnostic tool for use in primary care.

The NPSA is working with partners such as the RCGP and the National Cancer Action Team to adapt cancer referral guidelines.

Key patient safety area 2: Test ordering, processing and tracking of results

This project found a number of problems with diagnostic testing – from poor preparation and processing of tests, through to failures in communicating results and cancellations. All of these problems increased the risk of error and potential delay in diagnosis. Delay may not be recognised because of an apparent lack of accountability and audit of the system 'as a whole' together with significant 'hand over' of responsibility along the pathway. NHS providers should have in place robust clinical risk management protocols to ensure a safe system for the management of test results using electronic processes. Guidance documents have been produced in relation to radiology results, including an NPSA Safer Practice Notice and the communication of unexpected radiology results have been addressed in cancer peer review.[70, 71]

Recommendation 2: Identify, review and disseminate current good practice in the process of ordering, managing and tracking tests and test results.

Reviewing good practice in primary and secondary care, for example, using computer-based systems for following patients along the cancer diagnostic pathway, would serve to:

- identify areas of good practice which could be shared nationally and be the basis of new agreed national standards;
- identify data requirements and computer-based systems for improvements to be standardised and measured, locally and nationally.

These systems would need to be able to deal efficiently and effectively with test results, detect overdue and missing results, register the issuing of amended or supplementary reports and highlight if significant results are expected. Connecting for Health are taking forward this recommendation in collaboration with other partner organisations.

Key patient safety area 3: Empowering patients

The workstreams underway as part of NAEDI are key to addressing some of the issues found in this review. In particular, promoting awareness and encouraging early presentation will be essential in tackling patient delay, which featured strongly in the literature. However, there was evidence in this review that patients can get stuck in the diagnostic pathway in primary or secondary care. Colleagues participating in the workshops were keen to see the development of ways of enabling patients to overcome some of these barriers and take more control of their own safety.

Recommendation 3: Review and develop methods for empowering patients on a cancer diagnostic pathway.

The aim would be to help patients ensure they are kept informed, can ask for a second opinion if they wish and are enabled to follow up test results relating to their own care. Methods could include:

- Patients being given an information card whenever test results are outstanding. The card would outline what tests have been performed, when the results are expected and who to contact if a result has not been communicated to them, together with what to do if the result is negative but symptoms persist;
- Posters in GP surgeries and outpatient clinics designed to positively to encourage patients to ask questions;
- Exploring the concept of 'three strikes and you are in' approach where patients who remain undiagnosed after three consultations with persisting symptoms are referred.

All partner organisations, including the RCGP and their Patient Partnership Group, Cancer Networks, service users and cancer charities are asked to consider existing models and approaches which might exist in other areas of care but which could be adapted for use in cancer pathways.

Key patient safety area 4: Improving patient safety culture in diagnostic delay

The starting point is to recognise late diagnosis as a patient safety issue and focus on improving leadership and organisational learning culture in primary and secondary care. Good quality communication between practitioners, particularly across interfaces, and between practitioners and patients is essential. Very few patient safety incidents are reported to the NRLS from primary care. Despite SEA being part of QOF, there is no compulsion for SEAs to deal with patient safety incidents, nor for action to be taken locally to collate SEAs to enable learning and development. Opportunities exist for GPs through appraisal to consider any case of delayed diagnosis and to show learning and change. Cancer Networks are not routinely informed of patient safety incidents in relation to cancer which have occurred within their Network. Mechanisms that exist for national learning in patient safety are not embedded in the Cancer Network learning and development structure.

Recommendation 4: Develop a model for stronger leadership and improved patient safety reporting and learning, including SEA, at a local and national level.

- Primary care commissioners should consider setting out requirements for better data collection at primary care level, including undertaking and sharing of SEA on all diagnostic delays, and specific quality outcomes to be achieved in line with local need.
- Patient safety leads in Strategic Health Authorities and Local Health Boards working with Cancer Networks should include leadership and reporting in their local patient safety strategy.
- Primary Care Trusts and Local Health Boards should encourage practices to report diagnostic delays, perhaps through a designated enhanced service (DES), or by sharing SEAs, with metrics of delay in number of days (patient, doctor and system) and mechanisms for feedback including appraisal schemes for GPs.
- The NPSA will continue to work to improve reporting to the NRLS, including from primary care, through developments including an eform specifically tailored to GPs and through building specialist learning portals within Patient Safety Direct,[72] and by the development of a national standardised proforma for undertaking SEA.

Key patient safety area 5: Improve understanding of delayed diagnosis

Late presentation to the MDT is often assumed to be a result of patient delay. This review has found that there are many other parts of the pathway where delay can take place. Late presentation to the MDT, therefore, presents an opportunity to understand more about what has happened to each patient and whether there are patterns of patient safety errors that increase the risk of late diagnosis locally that could be corrected.

Recommendation 5: To improve routine monitoring of delayed diagnosis.

- Organisations should review systems their cancer MDTs have in place to identify, report and investigate delays (whether attributable to patient, doctor and/or system) for referral to an appropriate cancer specialist team.
- The process would be initiated by the cancer MDT but would need to involve primary care, other disciplines (for example, non-cancer specialists who have been involved in the patient's care), and managers. The aim would be for teams to identify cases meriting review and to identify what could be improved for future patients.

The NPSA provides aggregate Root Cause Analysis tools which can be helpful for such investigations.

Summary

In summary, this review has highlighted a number of issues that contribute to delay in the diagnosis of cancer. The data from the NRLS and consultation exercise focused mainly on delays at primary care and secondary care, and the interface between the two. A series of practical recommendations based on collaboration with clinicians, patients and national and local cancer leaders have been made.

There is considerable scope for improvements in practice. Change will require a multifaceted approach using existing enablers such as commissioning. Factors more likely to lead to improvements include greater patient empowerment, stronger clinical leadership, local processes that engage clinicians using systematic monitoring of delay indicators, education and training, particularly in use of clinical guidelines, and the promotion of improved safety culture towards learning organisations.

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Ref: 0968 March 2010

EXHIBIT 10

B4

Itamura, James (ORM)

From: saroja rajashekara [sarojaraja@gmail.com]
Sent: Tuesday, April 12, 2011 10:36 AM
To: Itamura, James (ORM)
Cc: Shannon M. Foley
Subject: Re: Dr. Janice Bowers EEO Investigation

Mr.Itamura,

I was a staff anesthesiologist,hired for the subspeciality of cardiac anesthesia exclusively,to create a strong cardiac anesthesia program for patient care and for training of UCLA residents.

I worked from 2002 to march 2011.

Initially, when ,I was hired , Dr. Richard Chen was the chief of anesthesia.

later, Dr. Kevin Win was the chief and the coordinator.

since Jan.2010 ,Dr. Braunfeld is the chief of anesthesia.

I did observe and experience age discrimination by Dr.Braunfeld against me and Dr.Richard Pieton.

Dr. Pieton was one of the anesthesia staff at VA.They collected some incidents in the management of a case and took him out of work. He was 66 yrs. old. has worked,I believe for 25+years., at the VA. All that time he was supervising other anes.personnel. All of a sudden it was changed and was made to do the cases by himself and found some reasons to relieve him of his work. The man is completely destroyed, depressed and taking medical leave.

I had taken emergency leave to take care of my extremely sick mother, 87 yrs. old with terminal cancer. The chief Dr. Braunfeld ,denied that I had sent email requests to extend my leave and placed me AWOL. ,even when my family leave was approved. She has not explained why she said she did not receive my emails..Finally through grievance hearing, it was rescinded. She told me that I was irresponsible and as a retaliation,took me of cardiac schedule, after I reported back to work{my mother died].She replaced me with younger UCLA graduates,with no cardiac fellowship and some with fellowships who are all younger than me. I am the only 66 yrs. old there.I went through mediation with no resolution. I have been forced out as I cannot compile enough cardiac cases to maintain my TEE license and have to look for a job elsewhere as a cardiac anesthesiologist.

Dr. Dean Norman is aware of all this and is an equal participant.

Thank you

Saroja Rajashekara.

On Tue, Apr 12, 2011 at 9:07 AM, Itamura, James (ORM) <James.Itamura@va.gov> wrote:

| Hello Dr. Rajashekara,

I am the EEO investigator assigned to Dr. Bowers case.

Dr. Bowers alleges she was the subject of discrimination because of her age. She provided your name as someone who could perhaps provide information tot hat end.

If you don't mind, perhaps you can consider the following questions:

1. What is/was your position with the Greater Los Angeles VAMC (GLA)?
2. How long did you work for the GLA?
3. Who was your supervisor?
4. Did you observe or experience what you might describe as Age discrimination in your department at the GLA?

   If yes, please provide a detailed description of your observation or experience and provide names of who in management discriminated against you.

Thank you for your time!

James Itamura

EEO Investigator
Office of Resolution Management

1601 East 4th Plain Blvd

Bldg 17; B-402
Vancouver, Washington 98661
Office: (360) 759-1617 Fax: 1618

"Don't Waste Your Pain!"

How were my services today?

Itamura, James (ORM)

From: saroja rajashekara [sarojaraja@gmail.com]
Sent: Tuesday, April 12, 2011 11:05 AM
To: Itamura, James (ORM)
Cc: Shannon M. Foley
Subject: Re: Dr. Janice Bowers EEO Investigation

Mr. Ishimura,

I did not address Dr.Bowers case.

She was hired by Dr.Braunfeld when I was on leave. When I came back she was working there on a fee basis. She was a board certified anesthesiologist with a fellowship in pain.

The dept. has need of Pain specialists. They had the position for it available. I saw and heard Dr.Braunfeld say in the anesthesia room, that She would love to hire 2 anesthesiologists from UCLA for that position. But they will be available only the following year as they have to complete residency. But she may not be able to keep the position open till then. She has to see. That means she was not going to hire Bowers,even though she had the credentials.

The only difference I can see is Dr, Bowers,is 55 and african american. She is already board certified and with 20 years of experience in private practice. Dr.Braunfeld wants to bring a person or persons from UCLA,who have not yet finished their training. that means they are holding the job for them. Braunfeld is from UCLA amd still works there. That is blatantly wrong.,to hold position for somebody who is not even trained versus a person with the qualifications.

The case for which they dismissed Dr. Bowers is difficult to understand. There was not a dept.investigation. Atleast I am not aware of it I came to VA from UCI as a director of cardiac anesthesia at UCI for 17 years.In cases like this ,it is discussed at the faculty meeting,then at the QA meeting. The person involved and the rest will have extensive discussion and come to a conclusion. None of that happened.At least I am not aware of it.I should have been,as I started that case. From what I know, patient went home with no complications or sequele of anesthesia.. there was no due process. So, I do not know why they fired Dr. Bowers.

The only reason I can think of is She is black,55 yrs. old ,can do her own cases and manage them.,which Dr. Braunfeld did not want. She wants younger,newer graduates from UCLA, .Obviously VA as an equal oppurtunity employer is a misnomer. It is a satelite of UCLA as far as anesthesia department is concerned, and follow orders from Dr.Kapur,the chair at UCLA. Dr.Win knows it very well. So also Dr.Dean norman. I am sure they will deny it.

Thank you

Dr.Rajashekara

On Tue, Apr 12, 2011 at 9:07 AM, Itamura, James (ORM) <James.Itamura@va.gov> wrote:

Hello Dr. Rajashekara,

3/4

I am the EEO investigator assigned to Dr. Bowers case.

Dr. Bowers alleges she was the subject of discrimination because of her age. She provided your name as someone who could perhaps provide information tot hat end.

If you don't mind, perhaps you can consider the following questions:

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2. How long did you work for the GLA?
3. Who was your supervisor?
4. Did you observe or experience what you might describe as Age discrimination in your department at the GLA?

   If yes, please provide a detailed description of your observation or experience and provide names of who in management discriminated against you.

Thank you for your time!

James Itamura

EEO Investigator
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"Don't Waste Your Paint"

How were my services today?

4/4

EXHIBIT 11

Hospital bullies take a toll on patient safety

By JoNel Aleccia Health writer msnbc.com
7/9/2008 1:03:04 PM ET

NBCNews.com

They're the bullies of the operating room, the browbeaters of bedside manner: doctors, nurses and other clinicians who make a habit of behaving badly.

They yell, they cuss, they throw things. Or they engage in more subversive behaviors: ignoring questions, acting impatient, insulting colleagues or speaking to them in condescending tones.

"It can go from verbal abuse to sexual harassment and physical assault," said Dianne Felblinger, an associate professor of nursing at the University of Cincinnati who studies medical intimidation.

The acts are bad enough when they affect staff morale, leading to greater turnover and less job satisfaction. But the Joint Commission, a national hospital accrediting agency, warned Wednesday that there's mounting evidence that such disruptive behaviors are tied to medical errors that can cause patient harm — and that hospitals across the country should no longer tolerate it.

Starting in January, the agency will require hospitals to establish codes of conduct that define inappropriate behaviors and create plans for dealing with them. Suggested actions include better systems to detect and deter unprofessional behavior; more civil responses to patients and families who witness bad acts; and overall training in "basic business etiquette," including phone skills and people skills for all employees.

The Joint Commission's first-ever alert about the problem is the latest industry effort to address an issue that has challenged the medical community for years, said Dr. Gerald Hickson, director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center in Nashville, Tenn.

"The data is clear that certain members of the team don't play so well with other members of the medical team," said Hickson. "We've dealt more effectively with drugs and alcohol than we have dealt with the kicking, spitting and cussing."

Dr. Mark Chassin, president of the Joint Commission, said growing emphasis on preventing medical errors has made it clear that a culture of intimidation contributes to the mistakes.

"It's a problem that goes underreported, threatens patient safety and has become so ingrained in health care that it's rarely talked about," Chassin told reporters Wednesday.

Nearly everyone who has worked in hospitals can recount a tale of bad behavior. Hickson recalled a doctor who hurled a table across a room, sending shards flying back at co-workers. Felblinger remembered when a doctor threw a used needle at a nurse, piercing her skin.

Don't ignore bad behavior

Ignoring bad behavior has potentially serious consequences for patients, said Felblinger, author of an analysis of studies on medical bullying published this spring in the journal of Obstetric, Gynecologic & Neonatal Nursing.

About 70 percent of nurses studied believe there's a link between disruptive behavior and adverse outcomes, and nearly 25 percent said there was a direct tie between the bad acts and patient mortality, she said.

A 2004 study of workplace intimidation by the Institute for Safe Medication Practices (ISMP) in Horsham, Pa., found that nearly 40 percent of clinicians have kept quiet or ignored concerns about improper medication rather than talk to an intimidating colleague.

Linda Petitt, 54, a clinical nurse specialist in Cincinnati, Ohio, said she went into private practice several years ago because she could no longer tolerate the atmosphere that allowed a doctor to scream and yell in an operating room — with no repercussions.

"He told me: I refuse to talk to you, so now what are you going to do about it?" said Petitt, who was the charge nurse at the time.

Only a small percent are bad actors

Estimates based on malpractice claims suggest that between 4 percent and 6 percent of doctors and other health workers actually engage in intimidation, Hickson said. That's probably about the same percentage of bad actors in any profession, he added.

But that small proportion has a big impact, said Felblinger.

"I think it is endemic," she said. "We've been so used to having these behaviors occur for so long."

In the ISMP study of about 2,000 clinicians, more than 90 percent said they'd experienced condescending language or voice intonation; nearly 60 percent had experienced strong verbal abuse and nearly half had encountered negative or threatening body language.

"Some people are intimidated because they think the doctor has the higher authority," said Renee Setteducato, 55, a nurse at Lutheran Medical Center in Brooklyn, N.Y.

It's important to note that bad behavior is not limited to doctors, said Dr. Joseph Heyman, chair of the board of directors for the American Medical Association. The Joint Commission warning also covers nurses, pharmacists and other clinicians, he noted.

It's not just doctors

Setteducato observed her share of tantrums and slammed phones in 37 years of nursing. But it's not just doctors bullying nurses, she said. Nurses do their share of intimidation, too.

"The experienced nurses are not patient with the new doctors," she observed.

The AMA has had a policy calling for zero tolerance for disruptive behavior for all workers for years. Heyman said he believes the climate is much better now than when he was a resident in the 1970s.

"I don't see it as a huge problem," he said, adding: "Having standards encourages hospitals to look for this kind of behavior and head it off at the pass."

The Joint Commission standards and suggestions will offer hospitals a clear model for establishing

guidelines and consequences that will help decrease disruptive behavior, Hickson said. He said he was optimistic that hospitals would actually put the plans into practice, mostly to improve workplace morale, but also to boost patient safety — and head off legal trouble.

Hickson, who researches why patients file medical malpractice lawsuits, says arrogant or insensitive behavior can influence whether people decide to sue. That holds for employees who believe they've been mistreated, too.

“When they feel that a physician doesn’t care for them, he won’t return their calls, won’t answer their questions, those are the kind of events and circumstances that will be the last straw,” he said.

The new guidelines are a fine effort to address a long-standing problem, experts said, but it could take years for a major culture shift. In the meantime, there’s no substitute for professional confidence, said Setteducato, the veteran nurse.

Faced with arrogant doctors or those who scream and throw patient charts on the floor, Setteducato adopts a practiced, calm response. "You have to nip that in the bud," she said.

“I say, ‘You know what, doc? That doesn’t work here. And we’re going to have to do this together as a team. Because that’s what it’s all about.'”

EXHIBIT 12

OPINION

Bullies In Hospitals?

By **Kevin Pho, M.D.** 21 40 0
Published May 28, 2011
FoxNews.com

Theresa Brown's New York Times op-ed, Physician, Heel Thyself, recently introduced hospital bullying into the national health care conversation. (1)

In it, she recounted a hospital vignette while working as an oncology nurse. A patient asked a doctor who should he blame for a late test result. The physician, turning to Brown, said, "if you want to scream at anyone, scream at her."

That type of boorish physician behavior certainly cannot be tolerated. Brown was brave to bring hospital bullying to light in a national forum.

But soon after her piece was published, many physicians, including myself (2), were defensive as Brown essentially singled out doctors for the bullying that goes on in hospitals.

"Because doctors are at the top of the food chain," she wrote, "the bad behavior of even a few of them can set a corrosive tone for the whole organization. Nurses in turn bully other nurses, attending physicians bully doctors-in-training, and experienced nurses sometimes bully the newest doctors."

But I wonder if the issue is more complicated than simply blaming physicians. Most doctors I know harbor nothing but the greatest respect for nurses, and realize how important they are to quality patient care. It seems unfair to tar them with such a broad stroke.

And besides, others in the hospital are responsible for bullying as well. Like nurses themselves, for instance.

Last year on Well, the Times' health blog, Brown herself wrote that "overwhelmed and angry nurses take their frustration out on the rest of us stuck in the corner with them, or on anyone they perceive as being less powerful than they are." (3)

Indeed, 60% of new nurses leave their first position because of bullying from their colleagues, such as verbal abuse or harsh treatment. (4)

Brown calls for changes up top, such as hospital administrators adopting uniform standards of professionalism for every staff member, no matter how important they are, and having offending parties undergo civility training.

But those policies are already present. University of Pennsylvania bioethicist Arthur Caplan, in response to Brown's column, points out that "hospitals are instituting courses about bullying, reporting systems are increasingly in place, and punishment is happening."

Instead, change also needs to occur from the bottom up. Consider how physicians are educated.

The culture that perpetuates bullying can be traced as far back as medical school, when as students, future doctors are trained in a pecking order not unlike the military. During the first two years, medical students have little exposure to patients and are exposed to the hierarchical tendencies and behaviors of their professors.

This needs to change. Medical students need to learn, from the beginning, how to work as members of a team. They need to understand that patient care is not only about the doctor and patient, but about how doctors, nurses, and medical assistants form a cohesive unit for the singular goal of helping patients.

That's beginning to happen at some institutions, like Harvard Medical School, where patient care concepts are introduced in the first year. Harvard student Ishani Ganguli, writing in the Boston Globe's health blog, says "through role play and interviews with volunteer patients, we learn the vocabulary, even seating positions, that allow us to take detailed histories from patients and show empathy for them. We carry the skills from this course with us through subsequent years of medical school and no doubt beyond."

She makes a point that such a curriculum should be expanded to teach medical students how to interact with nurses more collegially as team members, rather than as part of a superior-subordinate hierarchy.

Hospital bullying is often shrouded in silence, and Theresa Brown should be applauded for publicizing the issue. But targeting the toxic culture that perpetuates the problem requires everyone to share responsibility. Not just doctors, but nurses, hospital administration, and medical educators as well. Only when every stakeholder is part of the solution do we stand a better chance of eliminating bullying behavior in hospitals altogether.

Kevin Pho, MD is a primary care physician in Nashua, NH, and is founder and editor of MedPage Today's KevinMD.com.

Also on the Web

More from Fox News

EXHIBIT 13

May 7, 2011

Physician, Heel Thyself

By THERESA BROWN
Pittsburgh

IT was morning rounds in the hospital and the entire medical team stood in the patient's room. A test result was late, and the patient, a friendly, middle-aged man, jokingly asked his doctor whom he should yell at.

Turning and pointing at the patient's nurse, the doctor replied, "If you want to scream at anyone, scream at her."

This vignette is not a scene from the medical drama "House," nor did it take place 30 years ago, when nurses were considered subservient to doctors. Rather, it happened just a few months ago, at my hospital, to me.

As we walked out of the patient's room I asked the doctor if I could quote him in an article. "Sure," he answered. "It's a time-honored tradition — blame the nurse whenever anything goes wrong."

I felt stunned and insulted. But my own feelings are one thing; more important is the problem such attitudes pose to patient health. They reinforce the stereotype of nurses as little more than candy stripers, creating a hostile and even dangerous environment in a setting where close cooperation can make the difference between life and death. And while many hospitals have anti-bullying policies on the books, too few see it as a serious issue.

Today nurses are highly trained professionals, and in the best situations we form a team with the hospital's doctors. If doctors are generals, nurses are a combination of infantry and aides-de-camp.

After all, patients are admitted to hospitals because they need round-the-clock nursing care. We administer medications, prep patients for tests, interpret medical jargon for family members and double-check treatment decisions with the patient's primary team. Nurses are also the hospital's front line: we sound the alert if a patient takes a serious turn for the worse.

But while most doctors clearly respect their colleagues on the nursing staff, every nurse knows at least one, if not many, who don't.

Indeed, every nurse has a story like mine, and most of us have several. A nurse I know, attempting

to clarify an order, was told, “When you have ‘M.D.’ after your name, then you can talk to me.” A doctor dismissed another’s complaint by simply saying, “I’m important.”

When a doctor thoughtlessly dresses down a nurse in front of patients or their families, it’s not just a personal affront, it’s an incredible distraction, taking our minds away from our patients, focusing them instead on how powerless we are.

That said, the most damaging bullying is not flagrant and does not fit the stereotype of a surgeon having a tantrum in the operating room. It is passive, like not answering pages or phone calls, and tends toward the subtle: condescension rather than outright abuse, and aggressive or sarcastic remarks rather than straightforward insults.

And because doctors are at the top of the food chain, the bad behavior of even a few of them can set a corrosive tone for the whole organization. Nurses in turn bully other nurses, attending physicians bully doctors-in-training, and experienced nurses sometimes bully the newest doctors.

Such an uncomfortable workplace can have a chilling effect on communication among staff. A 2004 survey by the Institute for Safe Medication Practices found that workplace bullying posed a critical problem for patient safety: rather than bring their questions about medication orders to a difficult doctor, almost half the health care personnel surveyed said they would rather keep silent. Furthermore, 7 percent of the respondents said that in the past year they had been involved in a medication error in which intimidation was at least partly responsible.

The result, not surprisingly, is a rise in avoidable medical errors, the cause of perhaps 200,000 deaths a year.

Concerned about the role of bullying in medical errors, the Joint Commission, the primary accrediting body for American health care organizations, has warned of a distressing decline in trust among hospital employees and, with it, a decline in the quality of medical outcomes.

What can be done to counter hospital bullying? For one thing, hospitals should adopt standards of professional behavior and apply them uniformly, from the housekeepers to nurses to the president of the hospital. And nurses and other employees need to know they can report incidents confidentially.

Offending parties, whether doctors or nurses, would be required to undergo civility training, and particularly intransigent doctors might even have their hospital privileges — that is, their right to admit patients — revoked.

But to be truly effective, such change can’t be simply imposed bureaucratically. It has to start at the top. Because hospitals tend to be extremely hierarchical, even well-meaning doctors tend to respond much better to suggestions and criticisms from people they consider their equals or

superiors. I've noticed that doctors otherwise prone to bullying will tend to become models of civility when other doctors are around.

In other words, alongside uniform, well-enforced rules, doctors themselves need to set a new tone in the hospital corridors, policing their colleagues and letting new doctors know what kind of behavior is expected of them.

This shouldn't be hard: most doctors are kind, well-intentioned professionals, and I rarely have a problem talking openly with them. But unless we can change the overall tone of the workplace, doctors like the one who insulted me in front of my patient will continue to act with impunity.

I wish I could say otherwise, but after being publicly slapped down, I will think twice before speaking up around him again. Whether that was his intention, or whether he was just being thoughtlessly callous, it's definitely not in my patients' best interest.

Theresa Brown, an oncology nurse, is a contributor to The Times's Well blog and the author of "Critical Care: A New Nurse Faces Death, Life and Everything in Between."

EXHIBIT 14

The Joint Commission

Sentinel Event Alert

July 09, 2008

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) “Any behavior which impairs the health care team’s ability to function well creates risk,” says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. “If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk.”

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with “blowing the whistle” on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are “let off the hook” for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
   - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
   - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
   - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
   - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
   - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

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* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

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