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PLAINTIFFS IN LIMITED SCOPE REPRESENTATION PURSUANT TO CRC 3.35-3.37
ATTORNEYS FOR PLAINTIFFS, JANE AND JOHN DOE

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SANTA CLARA
UNLIMITED CIVIL JURISDICTION

JANE DOE; JOHN DOE Plaintiffs v. DR. ROY HONG, M.D., an individual; PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation; DR. FREDERICK DIRBAS, M.D., an individual; STANFORD HOSPITAL AND CLINICS, a professional corporation, et al and DOES 1 - 50, Defendants.	Case No.: 1-14-CV-261702 Assigned for all Purposes to: Hon. Theodore C. Zayner Dept. 6 Complaint Filed: March 5, 2014 Trial Date : None **PLAINTIFFS' NOTICE OF RELATED CASES PURSUANT TO CALIFORNIA RULES OF COURT 3.300 REGARDING STANFORD'S UNLAWFUL STAFF CELL PHONE PHOTOS OF SEDATED PATIENTS' BODIES AND GENITALS AND THE FREE DISSMEMINATION OF THOSE PHOTOS**

TO ALL PARTIES HEREIN AND THEIR ATORNEYS OF RECORD: NOTICE IS HEREBY GIVEN that PLAINTIFFS Jane Doe and John Doe submit the following Notice of Related Cases in accordance with California Rules of Court 3.300. As discovery of these related cases is ongoing, Plaintiffs assert that these related cases may be expanded.

BACKGROUND

The referenced STANFORD Defendant cases all involve a matter of public safety and of wide public interest. Stanford Hospitals and Clinics render surgical and anesthesia services to hundreds of thousands of patients. As a general perspective of the magnitude of health care resources and sheer number of patients who are "run" through Stanford's 60 purported facilities, in 2016 Stanford received upwards of $220,000,000 million dollars of Medicare revenue just in one year.

STANFORD DEFENDANTS

Plaintiffs have a mutual interest in prosecuting the deviant and sexual exploitation of sedated patients at Stanford by Stanford staff and physicians who regularly take surreptitious photos of sedated patients and freely disseminate those among staff and outside vendors.

In particular, a significant and disturbing number of Stanford Defendant cases reverberate identical issues of wide public interest and concern. Namely, in addition to the overt molestation victims which are represented in San Mateo in relation to convicted felon and Stanford employee Robert Lastinger, Stanford appears to have a culture of tolerance of surreptitious photography of sedated patient bodies, breasts, and genitals by staff cell phones, and thereafter the free exchange of those abhorrent photos by staff.

The staff cell phone photos of sedated patient bodies are not only in violation of Stanford's own cellphone policy (attached hereto as Exhibit "A") but also a violation of Civil Code 1708.85, and Health and Safety Codes which regulate "medical photography".

Thus, Plaintiffs assert that a cause of action with punitive awards, and attorneys fees per 1012.5 may be applicable to these cases where a common cause of action is " Invasion of Privacy" and "Patient Exploitation by Stanford", with subsequent retaliation, harassment, and ad hominem

attacks on both the patient victims who file grievances in civil suit, as well as the few Stanford employees who have filed grievances within Stanford.

Upon information and belief, all cases are civil cases filed in Northern California Superior Courts. None of the cases are designated as Complex.

PROCEDURAL POSTURE

In relevant parts, Rule 3.300. Related cases (a) Definition of "related case"
A pending civil case is related to another pending civil case, or to a civil case that was dismissed with or without prejudice, or to a civil case that was disposed of by judgment, if the cases:
(1) Involve the same parties and are based on the same or similar claims;
(2) Arise from the same or substantially identical transactions, incidents, or events requiring the determination of the same or substantially identical questions of law or fact;
(3) Involve claims against, title to, possession of, or damages to the same property; or
(4) Are likely for other reasons to require substantial duplication of judicial resources if heard by different judges.

The noticed related cases all have these facts in common:

1. Stanford is the defendant and all cases have issues of paramount public importance of highly offensive invasion of privacy through Stanford photos of sedated patients.
2. Thus, whereby the public are at risk and must be protected from ongoing abuse and violation by Stanford employees.
3. The staff cell phone photos of sedated patient bodies are not only in violation of Stanford's own cellphone policy (attached below), but also a violation of Civil Code 1708.85, and Health and Safety Codes which regulate "medical photography".

Thus, Plaintiffs Jane and John Doe hereby give timely notice pursuant to Rule 3.300 (b) and (c).

THIS NOTICE IS TIMELY.

In accordance with Rule 3.300(e), Plaintiffs uncovered the *Young vs. Stanford* case on or after November 13, 2017. Thus, this Notice of Related Case is being served and filed as soon as

possible, but no later than 15 days after the facts concerning the existence of related cases become known. Due to the exigent circumstance of a petition before the Supreme Court due imminently, Plaintiffs would require additional time to detail the earliest related case and which department that case is in. Plaintiffs request leave of Court to do so at the first available opportunity or to submit an amended or corrected Notice of Related Case.

JUDICIAL ACTION AND PREFERENCE FOR VENUE

Pursuant to Rule 3.300 (h) (2) (A) "If the related cases are pending in more than one superior court on notice to all parties, the judge to whom the earliest filed case is assigned may confer informally with the parties and with the judges to whom each related case is assigned, to determine the feasibility and desirability of joint discovery orders and other informal or formal means of coordinating proceedings in the cases."

Plaintiffs do hereby request that the cases be coordinated *out* of Santa Clara County to avoid an unfair adversary at trial and the hometown Stanford bias in Santa Clara County. Stanford is the largest employer in this county and has a wide reaching influence. Thus, in the interest of justice, these cases should be set for preference out of Santa Clara County. Upon information and belief, Plaintiffs in these actions state the desirability of having their cases heard in venues outside of Santa Clara, including Alameda or San Mateo County.

FACTUAL ALLEGATIONS OF FREE DISSEMINATION OF UNSUTHORIZED STANFORD CELL PHONE PHOTOS

Stanford Staffs' Dissemination of Unauthorized Staff Cell Phone Photos of Sedated Patients.

As referenced in the *Young case vs. Stanford* and September 29, 2017 Fox news KTVU: [Ms.] Hutner said she decided to file the complaint in Alameda County Superior Court, which she believes is a more favorable jurisdiction than Santa Clara County" (Reference http://www.ktvu.com/news/stanford-health-care-worker-alleges-racism-safety-violations-after-co-worker-dresses-as-kkk).

Stanford retained the deviant perpetrators like Robert Lastinger and Roy Hong, M.D. who molested young boys while under general anesthesia and took the abhorrent cell phone photos of women's body parts and, respectively. In this case *Doe vs. Hong* et al, Dr. Roy Hong admitted to taking surreptitious photos of a patient's breasts (Jane Doe) on his personal cell phone on December 12, 2012 at Stanford. Nobody stopped him; the Stanford nurses wrote in their report that no photos were taken in the operating room. Moreover, Dr. Hong is still entitled to use Stanford facilities where he reports he operates regularly.

To date, Dr. Roy Hong is operating at Stanford on women's breasts and no action has been taken against Hong. To Stanford's detriment, such ratified misconduct of unauthorized cell phone photography of sedated patients has resulted in nearly half a dozen active suits.

Mr. Lastinger was arrested and in jail for his lewd conduct (similar to deviant Dr. Roy Hong) of taking unauthorized cell phone photos of sedated patients, and Stanford doctors paid for his defense. As Stanford has a pattern of conduct of tolerance of gross misconduct, it is rumored and alleged that Mr. Lastinger will be again rehired by Stanford upon release. Similarly, Dr. Hong has reported that Stanford took no action against him and he is active and practicing at Stanford.

In the Young vs. Stanford recent action, while Stanford claimed that the staff practice of exchanging cell phone photos of sedated patients was not ratified, nonetheless, Stanford acknowledged that the practice is known to Stanford. Then Defendant Stanford admitted that Stanford was aware of the abhorrent conduct and allegedly terminated the employees who took inappropriate pictures.

However, in the George Baez complaint, Stanford terminated Mr. Baez who had complained about the deviant conduct of operating room staff including, convicted child molester and Stanford employee Robert Lastinger.

Repetitive Pattern of Misconduct: Stanford staff take personal cell phone photos of unclothed unconscious patients and freely disseminate the photos.

It should be noted that this Doe action is one of many involving Stanford that all reference the well known deviant conduct of Stanford operating room and medical staff of taking unauthorized and surreptitious photos of unclothed patients' bodies, breasts, and genitals, with their personal cell phones and then freely exchange and disseminate the same. Dr. Hong in this action claims that it was

normal for him to take photos on his cell phone " when the hospital camera was not available.". Notwithstanding Dr. Hong's admission that he too, took cell phone photos of Jane Doe's breasts and carried them on his cell phone next to his Christmas party photos, the extent of the free dissemination of those photos in unknown.

JUDICIAL EFFICINECY MANDATES THAT ALL OF THESE STANFORD STAFF CELL PHONE PHOTOS OF SEDATED PATIENTS BE ADUJICATED IN THE SAME COURT.

Thus it is in the interest of justice that all of these Stanford Defendants cases regarding the surreptitious photography of naked patients sedated often for surgery be adjudicated in the same court. Should there be a more widespread practice as believed, this cause of action may need to be split and pursued as a class action for all members of the public who were affected by Stanford's allowance of unlawful staff cell phone photography of sedated patients' breasts, bodies, perineum, genitals, and " fat women".

It is also alleged in multiple complaints that Stanford terminated or retaliated against the medical staff and employees who reported the abhorrent conduct. Stanford terminated Mr. George Baez and threatened and refused to promote Ms. Quiqio Young. (Reference http://www.ktvu.com/news/stanford-health-care-worker-alleges-racism-safety-violations-after-co-worker-dresses-as-kkk). In unrelated conduct, Stanford University terminated and then filed a retaliatory cross-complaint against James Phills, Ph.D. for his reports of harassment by the Dean of the school of business. (*Phills vs. Stanford* Case No.: 1-14-CV-263146)

STANFORDS' USE OF STAFF CELL PHONE PHOTOS OF SEDATED PATIENS IS UNLAWFUL AND OFFENSIVE TO ONE'S SENSES

Stanford staff taking of the patient photographs alone constitutes a violation of these patients' right of privacy, and their expectation of privacy while they are under anesthesia and under medical care.

The act of taking these patients' photographs, standing alone, even without dissemination or publication does constitute an actionable invasion of these patients' right of privacy. Thus, liability exists and defendant's conduct was such that he should have realized that it would be offensive to

persons of ordinary sensibilities. (Rest., Torts, Vol. 4, § 867, comment d, pp. 400-401; see, also, cases collected: Annos. 138 A.L.R. 22, 46; 168 A.L.R. 446, 452; 14 A.L.R.2d 750, 752.) [8] Whether there has been such an offensive invasion of privacy is "to some extent one of law." (41 Am.Jur., Privacy, § 12, p. 935; Schuyler v. Curtis, 147 N.Y. 434 [42 N.E. 22, 26, 31 A.L.R. 286, 49 Am.St. Rep. 671]; Reed v. Real Detective Pub. Co., 64 Ariz. 294 [162 P.2d 133, 139]; Cason v. Baskin, 155 Fla. 198 [20 So. 2d 243, 251, 168 A.L.R. 430].)

In considering the nature of the pictures in question, it is significant that these photos were surreptitiously snapped on private grounds, and involuntary posed by the patients. These photos were not taken of plaintiffs or patients in a pose voluntarily assumed in a public market place. So distinguishable are cases such as *Barber v. Time, Inc.,* 348 Mo. 1199 [159 S.W.2d 291], where the picture showed plaintiff in her bed at a hospital, which circumstance was held to constitute an infringement of the right of privacy.

Such situation is readily indistinguishable from cases where the right of privacy has been enforced with regard to the publication of a picture which was shocking, revolting or indecent in its portrayal of the human body. (See *Douglas v. Stokes, 149 Ky. 506 [149 S.W. 849, 42 L.R.A.N.S. 386, Ann.Cas. 1914B 374]; Bazemore v. Savannah Hospital*, 171 Ga. 257 [155 S.E. 194].)

As outlined in *Gill v. Curtis Pub. Co*., 38 Cal. 2d 273 [239 P.2d 630], and authorities there cited, there are two main questions involved in right of privacy cases: (1) Is the publication of a character which would offend the feelings and sensibilities of the ordinary person; and (2) if it does so offend, is there such a public interest in the subject matter of the publication with reference to its news or educational significance that it may be published with impunity. In the first instance the question is whether there has been any tort (violation of the right of privacy) committed, and in the second, having found the tort, is it privileged.

There are multiple known Stanford Defendant cases with similar allegations of sexual misconduct and unauthorized photos by Stanford staff of unconscious patients, and the FREE dissemination of those photos by staff:

- 16CV300476 Baez vs. Stanford

- CV-261702 Does M.D. vs. Hong and Stanford
- Young vs. Stanford RG17877051 (Alameda County)

- 14-1-CV-263807 Lyons, M.D. vs. Stanford
- San Mateo CIV 537723 Mark Roe vs. Stanford
- San Mateo 16CIV01627 Robert Doe vs. STANFORD healthcare
- 16CV- 300476 People vs. Robert Lastinger

STANFORD is also listed in multiple current lawsuits for rampant misconduct of STANFORD staff taking and freely disseminating photos of patients while under general anesthesia. Mr. George Baez, former Stanford Director for outpatient surgery, alleged in his complaint that he was terminated by Stanford for reporting sexual assault of anesthetized patients and under aged boys by anesthesia technician Robert Lastinger. (16CV- 300476)

All recent Stanford defendant cases with similar allegations of sexual misconduct and unauthorized photos by Stanford staff of unconscious patients, and the FREE dissemination of those abhorrent photos of patients' genitalia and sexual parts by staff.

16CV300476 BAEZ VS. STANFORD

Baez vs. Stanford- p. 14 of Complaint #50 "Depuy employee Nick Cardenas (an SHC vendor) had been receiving pictures of "dicks" and "fat women" taken by [Robert] Lastinger [Stanford anesthesia tech] of patients in the operating room at OSC. Plaintiff Baez was told that Cardenas was sharing these pictures of naked and sedated patients with other Depuy employees."
p. 21 "Plaintiff Baez requested a complete investigation into the sexual molestation prior to March 20,2015 and the photographing of patients in the operating room."

DOE, M.D. AND DOE, M.D. VS. STANFORD ET AL. 1-14 CV 261702

Doe, MD vs. Stanford - p. 10 of complaint addresses exactly the unauthorized staff personal cell phone photos of Jane Doe's breasts by various staff while she was under anesthesia.

"Fourth Cause of Action: Invasion of Privacy: Intrusion Into Private Matter

¶52 "California Constitution, Article I, Section I and the common law protect individuals' right to privacy."

"Defendants HONG and/or DOES 26-50 intentionally photographed JANE DOE's breasts with their **cellular telephones while she was unconscious** under general sedation during her breast reconstruction procedure which Defendants HONG and/or DOES 26-50 performed on her on or around December 12, 2012. JANE DOE had an expectation of privacy while she was unconscious under general sedation during surgery. Defendant HONG and/or DOES 26-50, by taking pictures [on their *personal* cell phones] of JANE DOE's breasts during surgery, invaded JANE DOE's privacy in a manner that would be highly offensive to a reasonable person."

Doe, MD vs. Stanford- MSC Statement

Page 9 and P.57 , p. 58, Stanford's cell phone policy is accessed at http://med.stanford.edu/shs/update/archives/FEB2011/cellphone.htm

."Cell phone pictures by physicians or any non-family member are prohibited at SHC (and LPCH) unless taken with the patient's own phone at the patient's request."

Page 65 "Stanford is also in multiple lawsuits for staff taking and freely disseminating photos of patients while under general anesthesia. Mr. Goerge Baez, former Stanford Director for outpatient surgery was terminated by Stanford for reporting sexual assault of anesthetized patients by anesthesia technician Robert Lastinger. (16CV- 300476) "

YOUNG vs. STANFORD RG17877051 (Alameda County)

Young vs. Stanford p. 46 Complaint, #85, 86 " Staff circulated photos of patients circulated freely, disfigured genitals."

p. 2 "**Unlawful Retaliation and Discrimination for Association With Stanford Cancer Center Surgeons Who Reported Stanford's Endangerment of Its Patients, Stanford Staff Dressing Like the KKK and Secretly Photographing Patient Genitals, Racism and Retaliation at Stanford;"**

p. 2 “Unlawful Retaliation for Reporting Stanford's Further Endangerment of Its Patients;”

p. 8 ¶ 4 “secretly photographed patient genitalia and circulated the same”

p. 66 ¶ 134 “Natalie showed other staff that photo along with a photo of a patient’s disfigured perineum, the area between the genitalia and anus, joking that the KKK was going to do the same thing to Qiquia”

p. 95 ¶ 208, (First Cause of Action) “ Unlawful Retaliation and Discrimination for Association With Stanford Cancer Center Surgeons Who Reported Stanford’s Endangerment of Its Patients, Stanford Staff Dressing Like the KKK and Secretly Photographing Patient Genitals, Racism and Retaliation at Stanford in Violation of Government Code §12940 et seq.”
[MS. YOUNG],

p.95, ¶211 “ 211. As set forth herein, Stanford Cancer Center Physicians engaged in protected activity by reporting concerns to STANFORD HEALTH CARE DEFENDANTS’ managing agents regarding STANFORD HEALTH CARE DEFENDANTS’ endangerment of its patients, STANFORD HEALTH CARE DEFENDANTS’ staff dressing like the KKK and secretly photographing patient genitals, and racism and retaliation”

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STANFORD UPCODING, FALSE DIAGNOSIS LEADING TO FALSE BILLING, AND BILLING FRAUD

The case *Doe vs. Stanford et al* highlights Stanford's pattern of upcoding, fraudulent billing for pre-operative visits which are included in the global surgery fee, and double charging for exorbitant artificial skin substitute products which are not used in the surgery.

Tomaya Gaines v Stanford Health Care 316-cv-02831 vc federal court 9th division addresses billing fraud and upcoding by Stanford.

14-1-CV-263807 Lyons vs. Stanford addresses billing fraud and upcoding by Stanford.

Young vs. Stanford addresses upcoding, billing irregularities, and substandard medical care with fecal contamination of reusable rubber bands used on patients.

DATA BREACH OF PATIENT INFORMATION AND SENSITIVE DATA

Shana Springer v. Stanford Hospitals & Clinics and Multi-Specialty Collection Services, LLC, Case No. BC470522, Superior Court of the State of California, County of Los Angeles, Central District.

In that case, on March 19, 2014, Los Angeles Superior Court Judge Elihu Berle indicated his intent to preliminarily approve the Stanford Hospital data breach class action settlement, after minor revisions to the Class notice were made. The Stanford data breach lawsuit initially sought damages in the amount of $1,000 per affected patient. Approximately 20,000 patients were allegedly affected by the data breach. While the payout proposed by the class action settlement offers substantially less money to Class Members, the class action attorneys state that the Stanford data breach settlement would be the largest of any medical data breach settlement to date.

The case *Doe vs. Stanford et al* highlights the data breach and release of highly sensitive test results by Stanford from December 2012 to present.

CONCLUSIONS

In the interest of judicial efficiency and pursuant to Rule 3.300, Plaintiffs submit the herewith Notice of Related case and grant this request, or in the alternative that that the Court grant leave to amend this Notice with additional cases and facts.

DATED: November 27, 2017

Respectfully Submitted,

J. Doe

CERTIFICATE OF INTERESTED PARTIES

PROOF OF SERVICE

A true and correct copy of this Notice and Exhibits were electronically served on the interested parties on the attached list utilizing either Truefiling or a comparable electronic service.

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   RENE C. DAVIDSON COURTHOUSE
   Plaintiff, RG17-8770551
   Qiqiuia Young vs. Stanford Hospital and Clinics, Stanford HealthCare, and The Leland Stanford Junior University
   Alameda County Superior Court

3. 14-CV- 263807
Lyons, M.D.et al. vs. Stanford
Santa Clara Superior Court

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4. Santa Clara Superior Court
14-CV-261702
Doe vs. Hong and Stanford

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San Mateo CIV 537723 Mark Roe vs. Stanford
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6. San Mateo 16CIV01627 Robert Doe vs. Stanford 09/28/2016
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DECLARATION

1. I am a natural adult over the age of 18 and a party to this action. If called to do so I would testify under oath to the same facts within.

2. Attached as Exhibits to this Application are true and correct copies of the relevant portion of the Complaints filed in the referenced Notice, and Plaintiffs' true and correct Exemplar brief on Stanford and Defendants' conduct in Doe. Vs. Hong CV-261702.

DATED: November 27, 2017

Respectfully Submitted,

J. Doe

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PLAINTIFFS IN LIMITED SCOPE REPRESENTATION PURSUANT TO CRC 3.35-3.37
ATTORNEYS FOR PLAINTIFFS, JANE AND JOHN DOE

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SANTA CLARA
UNLIMITED CIVIL JURISDICTION

JANE DOE; JOHN DOE Plaintiffs v. DR. ROY HONG, M.D., an individual; PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation; DR. FREDERICK DIRBAS, M.D., an individual; STANFORD HOSPITAL AND CLINICS, a professional corporation, et al and DOES 1 - 50, Defendants.	Case No.: 1-14-CV-261702 Assigned for all Purposes to: Hon. Theodore C. Zayner Dept. 6 Complaint Filed: March 5, 2014 Trial Date : None **PLAINTIFFS' EXHIBITS TO NOTICE OF RELATED CASES PURSUANT TO CALIFORNIA RULES OF COURT 3.300 REGARDING STANFORD'S UNLAWFUL STAFF CELL PHONE PHOTOS OF SEDATED PATIENTS' BODIES AND GENITALS AND THE FREE DISSMEMINATION OF THOSE PHOTOS**

Exhibit A

This policy applies to: ☑ *Stanford Hospital and Clinics* ☑ *Lucile Packard Children's Hospital*	**Last Approval Date:** January 2008
Name of Policy: Photographing of Patients by Physicians, Staff Members, Patients and/or Visitors	**Page 1 of 9**
Departments Affected: All Departments	

I. PURPOSE

This policy describes when photographs or other electronic recordings of a patient are permitted to be taken by physicians, staff members, volunteers, visitors, patients, and the Media on or within Stanford Hospital and Clinics (SHC) and Lucile Packard Children's Hospital (LPCH), and the procedures to be followed when such photographs are taken, used or disclosed. *Workforce members* who take photographs of a patient pursuant to this policy are bound by the hospital's Code of Conduct policy to protect the patient's identity and confidential information. *Business Associates* are required to abide by the confidentiality provisions set forth in the Business Associates Agreement. Any other individual taking a photograph who is not bound by a confidentiality agreement or the hospital's Code of Conduct policy (excluding patients, visitors, or the media for publication purposes) will be asked to sign a confidentiality statement to protect the patient's identity and confidentiality and to only use the photograph in the manner consented to by the patient (e.g., vendors).

II. DEFINITIONS

For purposes of this policy/procedure, the following definitions apply:

A. Photograph: the term *photograph* shall refer to any photographs, motion pictures, videotapes, computer feeds or electronic recordings.
B. Patient shall refer to either the patient or his/her properly designated representative if the patient does not have capacity.
C. Consent refers to the agreement by the patient for an individual/entity to take a photograph.
D. Authorization refers to permission from the patient to use or disclose Protected Health Information to an individual or entity for purposes other than treatment, payment, healthcare operations or other uses or disclosures allowed by law without an authorization. For further information on authorizations, see the HIPAA: Disclosures of Protected Health Information policy.
E. Patient Identifiable Photographs are defined in Appendix A of this policy.
F. Visitor – An individual who comes to the hospital to spend time with or to visit a patient.
G. Visiting Observer – An individual who is invited by a SHC, LPCH or SoM employee to watch patient care or administrative functions for educational or training purposes..

III. POLICY STATEMENT

It is the policy of SHC and LPCH that consent be obtained from the patient when photographs are taken of a patient, any part of a patient's body, or any part of a procedure the patient may be undergoing and documented in the medical record as described below.

IV. PRINCIPLES

A. Consent to photograph is obtained from the patient when s/he signs the Terms and Conditions of Service in either the outpatient or inpatient setting. Photographs taken for the patient's treatment will be maintained in the patient's medical record. The permitted uses and disclosures are described in the Procedures section.

B. If the patient is unable to give consent, consent must be obtained from the properly designated representative if available, or from the patient as soon as reasonably possible by having s/he sign the Terms and Conditions of Service. The consent will be retroactive to the date of admission of the patient to the hospital or the date of the clinic appointment when the photograph was taken.. A photograph should not be used until the patient or properly designated representative consents, unless it is for treatment purposes.

C. Visitors and patients are not allowed to take photographs of other patients, visitors, staff members or physicians without that individual's permission. Further guidance is provided below.

D. Except for family or friends of the patient, any individual taking a photograph pursuant to this policy shall only photograph the minimum necessary amount of images required for his/her purpose. For example, if a photograph of identifiable characteristics of the patient is not required, such a photograph should not be taken.

E. Physicians, staff members, volunteers and business associates are not allowed to take photographs of patients or visitors with a personal cell phone or other portable electronic device except at the request of a patient with the patient's portable device.

F. Visiting Observers are not allowed to take photographs pursuant to the Visiting Observer policy.

F. All photographs taken under this policy, except for patient or visitor use or per agreement by SUMC, must be taken with hospital approved equipment and are the property of SHC, LPCH or Stanford University. Except for research, permission must be obtained from SUMC for use of the photographs external to SHC or LPCH. For research publication, permission must be obtained by submitting a protocol or proposed use to the IRB.

G. If the patient requests that the photography stop, photographs should not be taken after this request.
   1. If the photographs are a part of the patient's treatment, the patient's physician should be contacted to address the patient's concerns.
   2. If photographs have already been taken with consent prior to the patient's request to stop, then the photographs can generally remain in the medical record and be used for treatment and health care operations.
   3. If the patient signed a General Authorization form allowing for the photograph to be used for other purposes, the patient may revoke the authorization and the photographs will not be used to the extent the authorization has not been relied upon.

V. PROCEDURES

A. Photographs of a Patient, a Patient's Medical/Surgical Condition, or Treatment Taken for the Purpose of Treatment and Health Care Operations
   1. Consent for photographs taken for a patient's treatment or for hospital operations, such as quality assurance, training and education, is obtained when the Terms and Conditions of Service or the Consent to Operation form is signed (Form 15-01). This consent covers photographs with identifiable and de-identified information.
   2. These photographs, taken for treatment or operational purposes, can be used for:
      a. The patient's treatment;
      b. Internal or external activities consistent with the missions of SHC and LPCH, such as education and research, conducted in accordance with the Hospitals' policies.

3. Photographs that are taken for external purposes, such as for the media or on behalf of vendors, require separate, specific consent and authorization. Unless described in Section C below, the Privacy Office or Risk Management Office should be consulted for guidance on such consent and authorization.

B. Photographs for Patient/Family/Visitor Use

1. Hospital consent is not required for a patient, family member, or visitor who wishes to take photographs of the patient, family or visitor for personal use. The patient or properly designated representative must give permission for such a photograph to be taken.
2. Photographs of physicians, staff members, volunteers, other patients, or visitors are not allowed without that individual's permission.
   a. If a staff member or physician has questions about providing consent for their photograph to be taken, s/he should consult with Risk Management before any photographs are taken.
   b. If consent was given by the staff member or physician, they have the right to revoke the consent immediately after conclusion of the taking of the photograph.
3. In the event that a patient or visitor takes a photograph in violation of this policy, the following steps should be taken and Risk Management consulted:
   a. Staff should instruct the individual to immediately stop taking the photograph. If the individual refuses, hospital Security and Risk Management should be contacted.
   b. Inform the individual that hospital staff will need to view the photograph and determine whether appropriate permission was obtained.
   c. If proper permission was not obtained, the individual will be asked to destroy the photograph (by whom?). SUMC reserves the right to remove/destroy any photograph taken in violation of this policy.
4. Photographs of medical equipment or devices are not allowed (excluding tubes attached to the patient) unless the request to photograph the medical equipment or device(s) is for a business purpose and has been approved by Materials Management.

5. Visitors, patients and families are not allowed to take photographs, which may include photographs of other individuals in public areas of the hospital, such as the cafeteria.

C. Photography for Media Relations Purposes

1. If the hospital Media Relations office wishes to obtain photographs of a patient, a particular procedure involving a patient, or is contacted by an external media organization, the media relations staff will obtain approval from the patient's physician and request that the patient's physician discuss the concept with the patient.
2. Following approval by the patient's physician, the media relations staff will discuss the specific photographs to be taken with the patient, and have the patient sign the Consent to Photograph and Authorization to Use and Disclose Health Information for A Communications or Media Relations Activitity form (Form 15-2332). This form will be sent to HIMS for inclusion in the patient's medical record.
3. If the photographs are taken in the operating room, the media relations staff will also complete an OR observation request form, obtain the signature of the patient's physician and send it to Surgery Administration as soon as the media event is scheduled.
4. All requests by an external media organization (e.g., major networks) must be coordinated and supervised by the Media Relations staff.

D. Photography for Research Purposes

1. Special requirements exist if photographs are taken for research purposes. For more information, consult with the IRB at http://humansubjects.stanford.edu.

E. Photography for Other Reasons

1. If a physician, staff member, or other individual wishes to take a photograph of a patient for purposes other than identified above, s/he should contact the Privacy or Risk Management Office for guidance on whether or not this activity will be allowed and for the necessary consent and authorization forms.

VI. RELATED DOCUMENTS

A. HIPAA Use and Disclosures of PHI
B. HIPAA Education Policy
C. HIPAA Research and Patient Privacy Policy

D. HIPAA Definitions Policy

E. Form: Consent To Operation, Procedure and Administration of Anesthesia, (Form 15-01)

F. Form: Authorization to Use and Disclose Health Information for a Stanford University Medical Center Communications or Media Relations Activity

VII. DOCUMENT INFORMATION

A. Legal Authority/References
   1. JC RI 2.50
   2. Health Insurance Portability and Accountability Act (HIPAA) of 1996
   3. Title 22 Section 70763
   4. California Civil Code section 3344

B. Author/Original Date
   September 1987

C. Gatekeeper of Original Document
   Compliance Policy Manual Coordinators and Editors

D. Distribution and Training Requirements
   1. This policy resides in the Compliance Policy Manual.
   2. New documents or any revised documents will be distributed to Compliance Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.

E. Review and Renewal Requirements
   This policy will be reviewed and/or revised every three years or as required by change of law or practice.

F. Review and Revision History
   August 1991, C. Price, Director of Physician Services and Risk Management
   May 1994, M. Eaton, PharmD, JD, Risk Management Counsel
   August 1995, to reflect Stanford Health Services title
   February 1997, M. Eaton, PharmD, JD, Risk Management Counsel
   January 2001, L. L. Smith, J.D. Vice President and Director of Risk Management
   January 2004, S. Shah, JD Risk Management Specialist
   October 2007, S. Shah, JD Director Risk Management, D. Meyer, Chief Compliance Officer, S. Stayn, JD, Office of the General Counsel

G. Approvals

December 2007 Quality Improvement and Patient Safety Committee
January 2008, SHC Medical Executive Committee
January 2008, SHC Board of Directors

Appendix A

A photographic or electronic reproduction is deemed to identify the patient in the following circumstances:

1. If the photographic or electronic reproduction shows the full face or comparable image of the patient, or
2. If one or more of the following identifiers of the patient, the patient's relatives or household members, or the patient's employers are present, and the hospital does not have actual knowledge that the following identifiers could be used alone or in combination with other information to identify the patient:
   - a. Name
   - b. Social Security number
   - c. Telephone number
   - d. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combing all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000;
   - e. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
   - f. Fax number
   - g. Electronic mail address
   - h. Medical record number
   - i. Health plan beneficiary number
   - j. Account number
   - k. Certificate/license numbers
   - l. Vehicle identifiers and serial numbers, including license plate numbers
   - m. Device identifiers and serial numbers
   - n. Web Universal Resource Locators (URLs)

o. Internet Protocol (IP) address numbers
p. Biometric identifiers, including finger and voice prints
q. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the research data)

3. And the covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

Exhibit B

SUM-100

SUMMONS
(CITACION JUDICIAL)

NOTICE TO DEFENDANT:
(AVISO AL DEMANDADO):

The Leland Stanford Junior University, Stanford Health Care, Stanford Hospital and Clinics, Chanrath Flores, and Does 1 through 50, inclusive.

YOU ARE BEING SUED BY PLAINTIFF:
(LO ESTÁ DEMANDANDO EL DEMANDANTE):

Qiqiuia Young

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)

ENDORSED
FILED
ALAMEDA COUNTY

SEP 28 2017

CLERK OF THE SUPERIOR COURT
By Molly J. Kautz Deputy

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.

¡AVISO! *Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.*

Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (www.sucorte.ca.gov), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.

Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (www.lawhelpcalifornia.org), en el Centro de Ayuda de las Cortes de California, (www.sucorte.ca.gov) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.

The name and address of the court is:
(El nombre y dirección de la corte es): Alameda County Superior Court
1225 Fallon Street
Oakland, CA 94612

CASE NUMBER:
(Número del Caso) RG17877051

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):
Lara Villarreal Hutner, Villarreal Hutner PC, 575 Market St., #1700, SF, CA 94105. (415) 543-4200

DATE: *(Fecha)* SEP 28 2017 Chad Finke Clerk, by *(Secretario)* Molly J. Kautz , Deputy *(Adjunto)*

(For proof of service of this summons, use Proof of Service of Summons *(form POS-010).)*
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, *(POS-010)).*

[SEAL]

NOTICE TO THE PERSON SERVED: You are served
1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify):*
3. ☐ on behalf of *(specify):*
   under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
   ☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
   ☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
   ☐ other *(specify):*
4. ☐ by personal delivery on *(date):*

Form Adopted for Mandatory Use
Judicial Council of California
SUM-100 [Rev. July 1, 2009]

SUMMONS

Code of Civil Procedure §§ 412.20, 465
www.courtinfo.ca.gov

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Attorneys for Plaintiff
QIQIUIA YOUNG

SUPERIOR COURT OF CALIFORNIA

COUNTY OF ALAMEDA

RENE C. DAVIDSON COURTHOUSE

QIQIUIA YOUNG,

Plaintiff,

v.

THE LELAND STANFORD JUNIOR UNIVERSITY, STANFORD HEALTH CARE, STANFORD HOSPITAL AND CLINICS, CHANRATH FLORES, and DOES 1 through 50, inclusive,

Defendants.

Case No. RG17877051

COMPLAINT FOR:

(1) **Unlawful Retaliation and Discrimination for Association With Stanford Cancer Center Surgeons Who Reported Stanford's Endangerment of Its Patients, Stanford Staff Dressing Like the KKK and Secretly Photographing Patient Genitals, Racism and Retaliation at Stanford;**

(2) **Unlawful Retaliation for Reporting Stanford's Further Endangerment of Its Patients;**

(3) **Unlawful Whistleblower Retaliation for Reporting Stanford's Further Endangerment of Its Patients;**

(4) **Race Harassment and Discrimination:**

(5) Unlawful Retaliation for Reporting Race Harassment and Discrimination;

(6) Unlawful Retaliation for Reporting Religious Harassment and Discrimination Against Stanford's Muslim Patients;

(7) Failure to Prevent, Investigate and/or Remedy Unlawful Harassment, Discrimination and Retaliation;

(8) Assault and Battery;

(9) Violation of Right to Freedom from Intimidation and Threat;

(10) Interference with Constitutional Right to Equal Protection;

(11) Failure to Pay Wages for All Hours Worked;

(12) Failure to Reimburse for Expenses Incurred In the Discharge of Duties;

(13) Failure to Provide Meal or Rest Breaks;

(14) Failure to Provide Accurate Wage Statements; and

(15) Unfair Business Practices

JURY TRIAL DEMANDED

TABLE OF CONTENTS

PLAINTIFF QIQIUIA YOUNG, ("MS. YOUNG") hereby complains against DEFENDANTS THE LELAND STANFORD JUNIOR UNIVERSITY ("STANFORD UNIVERSITY"), STANFORD HEALTH CARE, and STANFORD HOSPITAL AND CLINICS (STANFORD UNIVERSITY, STANFORD HEALTH CARE, and STANFORD HOSPITAL AND CLINICS collectively referred to throughout as "STANFORD HEALTH CARE DEFENDANTS"), Chanrath Flores ("DEFENDANT FLORES"), and DOES 1 through 50, alleges as follows, and demands a trial by jury:

I. INTRODUCTION

1. STANFORD HEALTH CARE DEFENDANTS bear all the hallmarks of a world-class provider of medical treatment, claiming a mission of "healing humanity through science, and compassion, one patient at a time." Indeed, patients are promised "[a]t Stanford Health Care, we seek to provide patients with the very best in diagnosis and treatment, with outstanding quality, compassion, and coordination." STANFORD HEALTH CARE DEFENDANTS lure patients in, claiming "we are committed to providing clear, accurate, and honest information about our quality of care, so that patients can make informed health decisions." https://stanfordhealthcare.org/about-us.html.

2. Nothing could be further from the truth.

3. On information and belief based on a July 12, 2017 article on "Palo Alto Online," STANFORD HEALTH CARE DEFENDANTS placed in **the bottom-performing 25% of hospitals nationwide for hospital-acquired "conditions," including infections**. Moreover, the article reports STANFORD HEALTH CARE DEFENDANTS received a penalty reduction in reimbursements from the Centers for Medicare & Medicaid Services in fiscal years 2016 and 2017 after STANFORD HOSPITAL had higher than appropriate rates of hospital-acquired infections, including surgical site infection after colon surgery and abdominal hysterectomy; diarrhea-causing Clostridium difficile (C. diff), and catheter-associated urinary tract infections, among others, according to data from the Centers for Medicare. https://paloaltoonline.com/news/2017/07/11/union-claims-high-infection-rates-in-stanford-hospital-dispute

4. Moreover, whether dealing with patients or employees, STANFORD HEALTH CARE DEFENDANTS are equally duplicitous, as PLAINTIFF QIQIUIA YOUNG, an African-American employee of STANFORD HEALTH CARE DEFENDANTS, knows all too well. While STANFORD HEALTH CARE DEFENDANTS pay lip service to having policies against harassment, discrimination, and retaliation, and policies protecting patient privacy, STANFORD HEALTH CARE DEFENDANTS' medical staff and employees know otherwise. In fact STANFORD HEALTH CARE DEFENDANTS' agents and employees have, among other things: dressed like the Ku Klux Klan (while at work, in a patient room in the Stanford Cancer Center) to intimidate MS. YOUNG and cause her to fear for her safety; secretly photographed patient genitalia and circulated the same; used the "N" word repeatedly at work in MS. YOUNG's presence, and then accused her of lying about it when she reported it; said "Go pray in your own fucking country!" to a Muslim patient praying in the waiting room; and "explained" to an African-American patient that an anal catheter was accidentally inserted into her vagina because the patient's skin was too "dark down there" for the nurse to see what she was doing. Moreover, after reporting further instances of co-workers using the "N" word at work, MS. YOUNG's manager compounded the impact of the racism by sending two racist videos to MS. YOUNG, both of which repeat the "N" word *ad nauseum* and one of which "joked" about the racist stereotype about Black women loving fried chicken.

5. And each time any of these incidents was reported to STANFORD HEALTH CARE DEFENDANTS, including, among others, STANFORD UNIVERSITY past-President John Hennessey, STANFORD UNIVERSITY past-Chief Operating Officer James Hereford, Sridhar Seshadri, Vice President of STANFORD CANCER SERVICES, Mariann Byerwalter then-CEO of DEFENDANT STANFORD HEALTH CARE, Mark Lane Welton, M.D., then-Chief of Staff of STANFORD HEALTH CARE, Brendan C. Visser, M.D., Medical Director of Gastrointestinal Cancer Care Program, and, on information and belief, STANFORD HEALTH CARE Chief Executive Officer David Entwhistle and Chief Operating Officer Quinn McKenna, STANFORD HEALTH CARE DEFENDANTS denied

any wrongdoing, failed to investigate, or offer any redress. Instead, they cite to a farcical "no retaliation policy" while engaging in a campaign of punitive reprisals, including accusing MS. YOUNG of being a liar, "gaslighting"[1] her, failing to promote her, excluding her from meetings, trumping up false accusations against her which malign her integrity and professional reputation, writing her up based on these trumped up accusations, moving her to an isolated location with worse and drastically reduced work hours, while alternately forcing her to perform management-type duties beyond the scope of her salary and position, and stripping her of her more advanced job responsibilities, thereby destroying any chance for professional development and advancement. Moreover, on information and belief, STANFORD HEALTH CARE DEFENDANTS plan to eradicate the department MS. YOUNG works in to force her out of a job and keep her from continuing to shed light on the truth about, not only the open racism she has been subjected to, but the gross negligence that endangers STANFORD HEALTH CARE DEFENDANTS' patients on a regular basis, examples of which are set forth below.

6. Crippled by fear of retaliation (which has in fact come to pass), MS. YOUNG initially was forced to stand silent as incompetent management and medical staff at STANFORD HEALTH CARE DEFENDANTS' Cancer Center allowed immune-compromised cancer patients to be regularly endangered by exposure to tuberculosis, and other highly infectious diseases such as scabies, shingles, HIV, AIDS, MRSA, and C. difficile. Perhaps even worse, rather than "providing clear, accurate, and honest information about our quality of care, so that patients can make informed health decisions," as marketed to the public, STANFORD HEALTH CARE DEFENDANTS forbade MS. YOUNG and other employees from informing those immune-compromised cancer patients that they had been exposed to infectious diseases.

///

[1] "Gaslighting" is the use of persistent denial, lying, misdirection, and contradiction in an attempt to delegitimize a person's belief or experience or make them think they are crazy.

7. But STANFORD HEALTH CARE DEFENDANTS' treacherous incompetence was not limited to exposing its immune-compromised cancer patients to risk of highly infectious diseases. Indeed, MS. YOUNG was instructed by management to lie to safety auditors and say that all daily safety "checks" (referred to as "Ever Ready" Checklists) were being completed properly, when they were not: other than MS. YOUNG, no one was trained on how to properly check and stock the emergency crash cart used to resuscitate patients in emergency situations, and yet the records were falsified daily to show that the crash cart had been checked and was in working order. But when a cancer patient "coded" – *i.e.,* went into cardiac arrest – the emergency crash cart in the Cancer Center was not functioning. And when, shortly thereafter, another cancer patient suddenly needed oxygen, the crash cart had no compatible oxygen tubing to deliver oxygen to the patient gasping for air! To save the patient's life, MS. YOUNG had to run as fast as she could from one building to another to find the oxygen tubing and bring it back to resuscitate the patient.

8. It was after this experience that MS. YOUNG was no longer willing to remain silent about all the ways in which STANFORD HEALTH CARE DEFENDANTS were endangering patients' lives. Still, she feared for her job if she raised these issues. Fortunately, MS. YOUNG felt safe turning for help to her supervising physician, a well-trusted and highly-respected surgeon in the Cancer Center, who also had a master's degree from the Harvard School of Public Health and whose research focused on the impact of hospital quality on disparities in cancer survival rates in California, and who, too, is an African-American woman.

9. MS. YOUNG confided in the Cancer Center surgeon about her co-workers dressing like the KKK and circulating a photo of the same to intimidate her, as well as all the ways in which she was seeing STANFORD HEALTH CARE DEFENDANTS' patients endangered, the direction from management to lie to regulatory authorities about the same, and about MS. YOUNG's fear of retaliation.

10. When the Cancer Center surgeon reported MS. YOUNG's concerns to STANFORD HEALTH CARE DEFENDANTS' managing agents, including, among others,

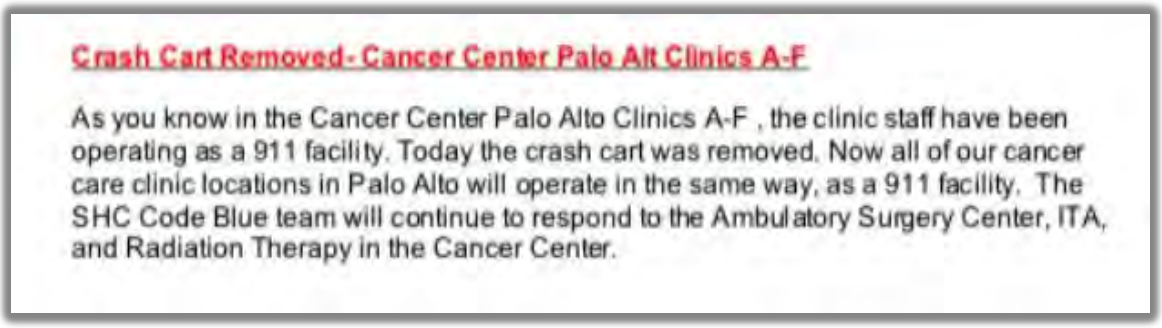
James Hereford, then-Chief Operating Officer of STANFORD UNIVERSITY, Sridhar Seshadri, Vice President of STANFORD HEALTH CARE's CANCER SERVICES, Mark Lane Welton, M.D., then-Chief of Staff of STANFORD HEALTH CARE, and Brendan C. Visser, M.D., Medical Director of Gastrointestinal Cancer Care Program, they responded by saying "our lawyers said we are 'in the clear' about the 'KKK incident,'" and conducted a sham investigation, never even interviewing MS. YOUNG.

11. Particularly telling was STANFORD HEALTH CARE DEFENDANTS' response to being informed that the emergency crash cart in the Cancer Center was not being maintained safely, but that fraudulent records were being created daily stating that it was in compliance. Rather than remedying the problem that had left a cancer patient "coding" and another cancer patient without access to oxygen – the problem being the medical staff in the Cancer Center had not been trained how to check the emergency crash cart to ensure it was fully functional – instead, STANFORD HEALTH CARE DEFENDANTS focused on covering up the regulatory violation of having fraudulent reports claiming safety checks of the crash cart were occurring daily, as required by law, when they were not. To cover up these daily regulatory violations, STANFORD HEALTH CARE DEFENDANTS gathered the fraudulent safety reports, and used "White Out" to fraudulently back date and revise the records. And to "remedy" the problem of no one knowing how to properly check and stock the emergency crash cart, STANFORD HEALTH CARE DEFENDANTS removed the emergency crash cart from the Cancer Center altogether, such that, now, if a cancer patient "codes" there is no crash cart on site.

12. Fortunately, given the unscrupulous manner in which STANFORD HEALTH CARE DEFENDANTS were known to respond to reports of patient endangerment, copies of the fraudulent crash cart reports were made before they were fraudulently and retroactively revised with "White Out" in an effort to dupe an investigating regulatory agency. On information and belief, true and correct copies of the original fraudulent records evidencing (1) STANFORD HEALTH CARE DEFENDANTS' violations of regulatory requirements; and (2) STANFORD HEALTH CARE DEFENDANTS' "White Out" cover up of the same,

are maintained in Alameda, County.

13. Setting aside STANFORD HEALTH CARE DEFENDANTS' flagrant and outrageous disregard for the lives of at-risk cancer patients in removing the emergency crash cart from the Cancer Center, what is particularly glaring is the underlying deceit in the reasoning given for the crash cart removal. While at the present time it is unclear whether the decision to remove the emergency crash cart from the Cancer Center was the result of STANFORD HEALTH CARE DEFENDANTS' desire to bury the regulatory violation found in the crash cart's fraudulent records or simply not caring enough about their patients to train employees to properly maintain the crash cart, an announcement was made inferring that the crash cart was being removed for the sake of "consistency," as other Cancer Centers did not have one. A facility that has no crash cart to resuscitate coding patients has to rely on calling "911" and is referred to as a "911 facility" as referenced in the announcement about the removal of the crash cart from the Cancer Center below:



Crash Cart Removed- Cancer Center Palo Alt Clinics A-F

As you know in the Cancer Center Palo Alto Clinics A-F , the clinic staff have been operating as a 911 facility. Today the crash cart was removed. Now all of our cancer care clinic locations in Palo Alto will operate in the same way, as a 911 facility. The SHC Code Blue team will continue to respond to the Ambulatory Surgery Center, ITA, and Radiation Therapy in the Cancer Center.

Such an "explanation" for removing a life-saving machine – based on the insane premise that all STANFORD HEALTH CARE DEFENDANTS' cancer patients' lives should be placed equally at risk by having to wait for a 911 response – underscores the unfathomable lengths to which STANFORD HEALTH CARE DEFENDANTS will go to cover up liability and risk patient lives.

14. And inasmuch as STANFORD HEALTH CARE DEFENDANTS' managing agents have a policy of "White Out" when it comes to burying fraudulent records, they have a policy of "Black Out" when it comes to trying to jettison African-American employees who refuse to turn a blind eye to STANFORD HEALTH CARE DEFENDANTS' rampant

racism, bullying, intimidation, lying, and chicanery and utter disregard for patient safety. As a result, shortly after making reports on MS. YOUNG's behalf, STANFORD HEALTH CARE DEFENDANTS subjected the reporting Cancer Center surgeon to retaliation that paralleled that of MS. YOUNG, which ultimately resulted in the Cancer Center surgeon's forced resignation without other secured employment.

15. Without the voice, protection, and assiduous oversight of the Cancer Center surgeon, STANFORD HEALTH CARE DEFENDANTS' retaliatory bullying, intimidation, and harassment of MS. YOUNG escalated, as did the number of careless errors that endangered patients on a regular basis. But MS. YOUNG was repeatedly warned by a number of STANFORD HEALTH CARE DEFENDANTS' employees – including the Cancer Center surgeon who was forced out – that, if she valued her job, she should stay quiet about the patient endangerment, retaliation, discrimination, harassment and racism by STANFORD HEALTH CARE DEFENDANTS. But MS. YOUNG began her career in health care after her father died due to gross medical negligence (negligence the medical provider tried to cover up and hide from her family). And MS. YOUNG's mother had fled to California from Oklahoma because she did not want her children living in fear of the KKK, as she had. (As an African-American in Oklahoma, it was common for her to have to run down the street while having rocks thrown at her, as even university professors were KKK members, and the streets were named for the "KKK elite.") So, despite multiple warnings to keep quiet, MS. YOUNG could not, and would not, remain silent about either the ongoing endangerment to STANFORD HEALTH CARE DEFENDANTS' patients or the rampant racism and retaliatory harassment she has endured on an ongoing basis.

16. For example, on May 13, 2016, MS. YOUNG reported her ongoing concern that feces-covered rubber bands were being reused from patient to patient. Rubber bands were used on instruments that would be inserted into the anus of the unsuspecting hemorrhoid surgery patient, who would unknowingly have the fecal matter of some stranger(s), and all diseases and bacteria contained therein, inserted into his or her anus. Having previously reported the risk of reusing feces-covered rubber bands to no avail, and

having been subjected to retaliatory intimidation and hostility by her direct supervisor and manager as a result, on this instance MS. YOUNG reported her concern about the feces-covered rubber bands being reused on patients directly to Sridhar Seshadri ("SESHADRI"), Vice President of STANFORD HEALTH CARE DEFENDANTS' Cancer Center. And in response, MS. YOUNG was scolded for bringing the patient endangerment risk to management's attention and accused of wrongdoing herself. Moreover, SESHADRI responded to MS. YOUNG's report by cc'ing two of STANFORD HEALTH CARE DEFENDANTS' *employment lawyers*, Angeline Covey and Mary Gaines, Director of Labor and Employee Relations. As MS. YOUNG had not reported an employment issue, the clear and intended message was that, by making the report of patient endangerment, MS. YOUNG had further placed her employment squarely at risk: she was now being scrutinized by not one, but two, of STANFORD HEALTH CARE DEFENDANTS' employment lawyers. SESHADRI's inclusion of the employment lawyers, including the Director of Labor and Employee Relations, on his response to MS. YOUNG had the desired effect of intimidating her and instilling further fear of retaliation.

17. Setting aside the years of continued, and continuing, racial and retaliatory harassment, intimidation, bullying, discrimination, and defamation of MS. YOUNG, one of the most devastating aspects of STANFORD HEALTH CARE DEFENDANTS' retaliatory campaign was to "gaslight" her. For example, when MS. YOUNG reported that her co-workers had targeted her by threatening to dress like the KKK, and then doing it, the Director of the Cancer Center blamed MS. YOUNG for not having reported the threat, because, she was told, "you could have stopped it from happening." Moreover, the Director of the Cancer Center feigned ignorance of the employees dressing like the KKK to terrify and intimidate MS. YOUNG. Later, MS. YOUNG discovered that STANFORD HEALTH CARE DEFENDANTS' managing agents, including the Director of the Cancer Center, had known about their employees dressing like the KKK at work the month before MS. YOUNG found out and reported it, and instead of initiating a prompt investigation and taking disciplinary action against the employees, they chose to sit on their hands until MS. YOUNG

brought it to their attention. And then, when she did, MS. YOUNG's performance suddenly underwent heightened scrutiny, she was wrongly accused of coming to work late every day for a year, and she was passed up repeatedly for promotion, despite the support of the Cancer Center surgeon to whom she reported. As a result of the deceitfulness of STANFORD HEALTH CARE DEFENDANTS' managing agents, and the immediate campaign of retaliation against her, MS. YOUNG learned to document as much as she could.

18. And so, when SESHADRI, STANFORD HEALTH CARE DEFENDANTS' management, and its employment attorney responded to MS. YOUNG's report of patient endangerment by scolding and threatening her, calling her a liar, denying any problem, and telling MS. YOUNG that they needed her to "trust" management and "be happy," MS. YOUNG made a 3 minute and 31 second video documenting that the equipment inserted into patients' anuses was being returned, sealed, with the prior patient's feces-covered rubber bands attached and ready for reuse in the next unsuspecting surgical patient.

19. Having her report of the risk of reuse of the feces-covered rubber bands flatly denied, MS. YOUNG reported the patient endangerment issues she had witnessed to the Joint Commission, the standard-setting accreditation agency tasked with ensuring health care organizations' regulatory compliance (and the agency that received and, on information and belief, was successfully duped by STANFORD HEALTH CARE DEFENDANTS with the fraudulent "White Out" documentation of the "Ever Ready" Checklists).

20. In her report to the Joint Commission on May 18, 2016, MS. YOUNG reported the following:

> "Joint Commission:
>
> My name is Qiqiuia Young. I have worked in GI Oncology in the Stanford Health Care Cancer Center … for the past five years as a Medical Assistant and most recently as a Patient Testing Technician III in the Pelvic Floor Clinic that is also in the Cancer Center. I am concerned about several ongoing patient (and employee) safety issues in the Stanford Cancer Center, and management covering up safety issues that

are brought to their attention:

1. Feces covered rubber bands on hemorrhoid ligators: The Colorectal Surgeons use hemorrhoid ligators to band hemorrhoids. The Medical Assistants are responsible for banding the ligators with two black rubber bands. Back in November of 2015, **I noticed that the ligators were coming back from the sterile processing department sealed with rubber bands still on them that had been in the prior patient's anus**. **When the rubber bands that are not used come out of the patient's anus, they are covered in feces and are supposed to be thrown away before the hemorrhoid ligator is sent to be sterilized and sealed and used on the next patient.** I brought this to the attention of the other Medical Assistants in the group and asked if they were placing them in the exam rooms for the Colorectal Surgeons this way, and they said yes. I immediately brought this issue to the attention of my manager, Christina Guijarro last year, but it is still happening. When I reported it to Christina last year, she and Matthew Burke (the Clinical Operations Manager) had a meeting with Joe who is the supervisor in Sterile Processing, who admitted that they were aware that they sometimes send sterilized ligators back to GI Oncology with rubber bands on them that have been in the last patient's anus. Joe apparently advised Ms. Guijarro and Mr. Burke to have the Medical Assistants shoot the rubber bands off that are left over after the surgeon is finished before the ligator goes to Sterile Processing. The managers in GI Oncology said that there has been a new process in place for the hemorrhoid ligators so that the dirty feces covered rubber bands that come out of the patient's anus are removed and the ligator is wiped down before it is even sent to Sterile Processing. However, some of the ligators are still coming back from processing sealed with dirty rubber bands on them that were in the

prior patient's anus. I brought this to management's attention in January of 2016 and I believe that Dr. _____[2] brought it to management's attention and to the Joint Commission's attention earlier this year as well, and it is still happening.

2. No terminal cleaning when blood, feces or bodily fluids are left in exam rooms: The exam rooms are not being terminally cleaned when blood, feces or bodily fluids are left in exam rooms. We have patients that come in with different types of infections, including HPV, HIV, AIDS, C Diff, MRSA, TB, VRE, shingles and scabies, and we were trained by previous management that when these type of infections are presented in clinic, once the patient leaves, we have to call housekeeping for a terminal clean, then the exam room has to be closed down for at least one hour to prevent the spread of infection. The current managers in GI Oncology instead tell the Medical Assistants that they should not call housekeeping for a terminal clean if they see small amounts of blood, feces, or other bodily fluids but should clean the exam room themselves with Clorox wipes because it "takes too long" for housekeeping to come, and the doctors need to keep seeing patients (the Cancer Center's Patient Satisfaction score for wait times has been terrible, and management wants it to improve). This is a real patient health and safety concern (given that many of our cancer patients are immune compromised), as well as an employee health and safety concern. Although several Medical Assistants don't feel comfortable cleaning the rooms themselves, they are afraid to tell management because they fear retaliation.

3. Stanford cancer patients and employee exposure to infectious

[2] The names of those referenced in this Complaint who reported patient endangerment and their own and others' experience of racism, discrimination, and retaliation to STANFORD HEALTH CARE DEFENDANTS and outside agencies have been omitted to protect their privacy.

patients: A lot of Stanford's cancer patients are currently going through chemotherapy and radiation treatment, and when patients show up with infections, we don't always have the room capacity to room them right away when they check in. So our infectious patients are sitting out in the lobby with our cancer treatment patients who may have compromised immune systems. As if this wasn't bad enough, management forbids us to tell those patients who may have been exposed to infections that they may have been exposed. We are even forbidden to alert those patients that sit down in the very same seat in the waiting room right after an infectious patient has been in the seat right before them, and terminal cleans are hardly ever done in the waiting room.

4. Failure to check supplies in exam rooms: The supplies in the exam rooms are not being checked the way they should be. For example, supply rooms have housed expired items because the rooms are not being checked properly by the Medical Assistants on a daily basis.

5. Prescription medications are being left open and exposed overnight: I have seen opened bottles of Botox left sitting open overnight in the work room for GI Oncology.

6. Stanford Cancer Center Management tries to prevent reporting by Infection Control: An Infection Control employee assigned to the Cancer Center has said that the Cancer Center is a "mess" and that the new managers just aren't getting the process of how things need to be done. The Infection Control employee happened to be doing a walk through and when she saw certain things that we[re] not compliant and began taking pictures when someone in management snatched her phone away from her to prevent her from taking pictures.

7. Requests by management to lie to the Joint Commission: I worked as the Colorectal Medical Assistant up until November of 2015. In April

or May of 2015, I was told directly by the Manager of GI Oncology (during the time of a Joint Commission inspection) that if I was asked by one of the inspectors, I was expected to lie and say that I don't set up the Flexible Sigmoidoscopy procedure because the department didn't have a manual put together to explain the process. I was told to lie and say that the Colorectal Surgeons do it themselves and to just say that I get the supplies they need, which was not true. Also, I was told that if the inspectors ask me, I should not tell the truth regarding how I was trained by the lead Colorectal Nurse at the time and the previous Medical Assistant that was doing the set up before me. The manager told me to say I learned the process by a module on Health Stream. I told her that I was not going to lie and I have experienced ongoing harassment by management as a result. Then, in February of this year, I was told by a Medical Assistant acting as an Interim Assistant Manager to lie when the next Joint Commission Inspection happens and say we do a "Time In and Time Out" during procedures - which we don't do. She asked if we knew where to locate the On Boarding Pass in the patient's chart. I told her I know where it is at but we don't do the Time In and Time Out. Her response to me was, 'I know, but I was told to come around and show everybody how to do it in case you're asked by the inspectors.'

8. Stanford Cancer Center Management falsified documents: In January/February of this year, I witnessed Christina Guijarro and the Director of Cancer Care Programs Patricia Falconer standing near my desk with the Crash Cart Log book. Christina was using White-Out on the log book. I believe she was altering dates and information after it was brought to management's attention that the crash cart log book was not being filled out properly because the crash cart was not being checked properly each day."

21. Less than a week later, MS. YOUNG came into work early in the morning and found an unemptied hazardous waste bin filled with feces and a canister of feces that had been left dripping on the floor overnight in the Cancer Center Procedure Room, where the last immune-compromised cancer patient of the previous day had had a wound care procedure. Not surprisingly, when MS. YOUNG reported this egregious patient endangerment risk, management's response was denial, scolding, and more hollow platitudes about STANFORD HEALTH CARE DEFENDANTS "healing humanity through science and compassion, one patient at a time." As a result, MS. YOUNG reported the patient endangerment directly to the Joint Commission and the California Department of Health.

22. Specifically, on May 24, 2016, MS. YOUNG sent an email to the Joint Commission entitled "Abandoned Feces in Stanford Cancer Center Procedure Room - Follow Up to Incident #12440JAC-42563OSO" reporting the following:

> "Joint Commission,
>
> I made a report last week about patient health and safety problems at Stanford Cancer Center that I was told is Incident # 12440JAC-42563OSO.
>
> Since I made a report to the Joint Commission, Stanford has claimed in writing that management "can personally assure you that all of our current GI CCP MA's are fully trained on this new standard work" and "we specifically asked all of the MA's to explain the new process and all of them are well-versed and trained on the new processes," but **this morning I came in to work to find a suction canister of patient feces dripping from a tube onto the Stanford Cancer Center procedure floor from yesterday.**
>
> This was in Procedure Room C of the Stanford Cancer Center, and **the feces were left there during a patient's wound care procedure, which is only supposed to happen in a sterile environment**. Stanford patients should not be put at risk of infection

from C Diff (and MRSA) by having feces left to contaminate the patient care room.

I reported this incident to Stanford management, but because of the false assurances they have given me instead of addressing the prior patient safety concerns I have reported, and the way they have tried to bully and intimidate me in retaliation for bringing these problems to their attention, I am reporting these potentially deadly patient safety issues from this morning to the Joint Commission and the Department of Public Health, too."

23. Below are photographs of the canister of patient feces left dripping through a tube overnight on the Cancer Center Procedure Room floor, and which had been present during the wound care procedure of the immune-compromised cancer patient the previous day, as well as the feces left over night in the Procedure Room:

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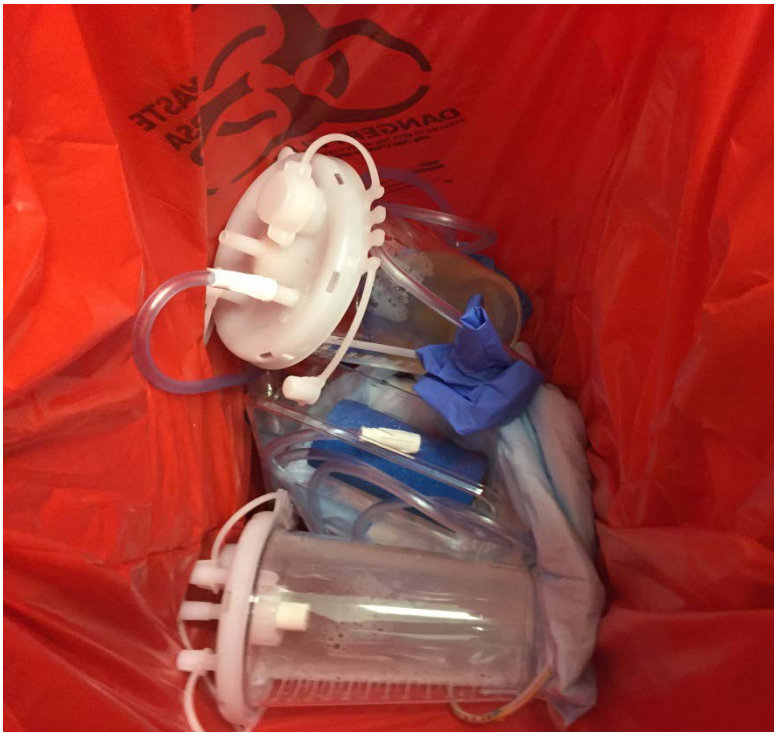
OLYMPUS
TC-C1 CLINIC



24. Not surprisingly, on information and belief, STANFORD HEALTH CARE DEFENDANTS, **rank in the bottom 25% of hospitals nationwide based on "hospital-acquired conditions,"** and have received a penalty reduction in reimbursements from the Centers for Medicare & Medicaid Services in fiscal years 2016 and 2017 based on STANFORD HOSPITAL's rates of hospital-acquired infections, including surgical site infection after colon surgery and abdominal hysterectomy; diarrhea-causing Clostridium difficile (C. diff), and catheter-associated urinary tract infections, among others, according to data from the Centers for Medicare. (*See* Exhibit A attached to this Complaint.)

25. In response to MS. YOUNG's reports to the Joint Commission and the California Department of Public Health, STANFORD HEALTH CARE DEFENDANTS doubled down on their retaliatory harassment of MS. YOUNG, which included physical intimidation and harassment by management, and false and defamatory accusations for which STANFORD HEALTH CARE DEFENDANTS issued a disciplinary write up to MS. YOUNG, the only discipline she had ever received in her entire career.

26. By this time, the Cancer Center surgeon had long been worried about the injustices she had witnessed MS. YOUNG be subjected to. (So much so, that she had gone with MS. YOUNG to meet with various lawyers, and had found MS. YOUNG's present lawyer for her to protect MS. YOUNG's rights. Put another way: MS. YOUNG's supervising surgeon thought MS. YOUNG needed a lawyer to protect her against the ongoing racism and retaliation STANFORD HEALTH CARE DEFENDANTS subjected her to, and helped her find one.) When the Cancer Center surgeon was forced to leave STANFORD HEALTH CARE DEFENDANTS' employ, she was very concerned that no one was left to protect MS. YOUNG from further retaliation. As a result, on information and belief, the Cancer Center surgeon enlisted another Stanford Cancer Center physician, an Oncologist protected by tenure (and so immune to STANFORD HEALTH CARE DEFENDANTS' known campaign of retaliation), to report, among other things, the ongoing racism, retaliation and harassment directed at MS. YOUNG to DEFENDANT STANFORD UNIVERSITY then-President, John L. Hennessey and then-CEO of DEFENDANT

STANFORD HEALTH CARE, Mariann Byerwalter, as well as blatantly racist and sexist comments by cancer surgeon Brendan C. Visser, M.D., DEFENDANT STANFORD HEALTH CARE's Medical Director of Gastrointestinal Cancer Care Program.

27. In an email dated June 14, 2016, with the subject line **"Meeting with President Hennessey,"** the tenured Stanford Oncologist wrote:

> "**President Hennessey**, … At Halloween … **testing technician Natalie [Burazon] took a photo of a medical assistant with a pillowcase pulled over her head, pretending to be a member of the Ku Klux Klan. Natalie showed other staff that photo along with a photo of a patient's disfigured perineum, the area between the genitalia and anus, joking that the KKK was going to do the same thing to Qiquia [MS. YOUNG], an African-American/Cherokee medical assistant**. **Subsequently, a staff member addressed Qiquia with the N-word**. In addition, **a male Associate Professor of Surgery [Brendan C. Visser, M.D.] once entered a work room where several staff were eating lunch together, and asked, *"What do you people eat anyway? Bushmeat?"*** He is also notorious for inappropriate sexist jokes. … Our goal is that the **President's office will ensure … that Qiquia and other staff of color will feel safe in the Cancer Center**."

28. Following his report to President Hennessey, the tenured Stanford Oncologist wrote an email dated June 18, 2016, with the subject line "Protecting the vulnerable." In this email, he wrote:

> **"At President Hennessy's request, I sent my statement to Mariann Byerwalter, CEO of Stanford Health Care and emerita member of the Stanford Board of Trustees. The fall-out from our meeting will percolate back to Cancer Center administrators.** The natural response of Cancer Center administrators will be to "look further into the matter". **Those of us who depend on resources and employment at the Cancer**

Center will be vulnerable, but *the most vulnerable will be QiQuia Young …*"

29. Identification of MS. YOUNG as "the most vulnerable" to retaliation following the report of racism, retaliation, and intimidation to STANFORD HEALTH CARE DEFENDANTS' managing agents' was prescient: just as their "solution" to the problem of the crash cart being unchecked was to just get rid of it (thereby putting their patients at even higher risk of death), their "solution" to the racism, retaliation, and intimidation MS. YOUNG experienced in the Cancer Center was to remove her from the Cancer Center and instead place her in a remote location, as the sole experienced person in the Pelvic Floor Clinic, and drastically reduce her hours such that she could barely make ends meet.

30. Moreover, the retaliation MS. YOUNG suffered escalated following the report made to STANFORD UNIVERSITY President John L. Hennessy and STANFORD HEALTH CARE's interim CEO and current CEO on her behalf in the following ways: in an effort to force her out, MS. YOUNG was made to reapply for her position, and STANFORD HEALTH CARE DEFENDANTS, and their managing agents, trumped up a new job requisition solely to include new, increased and irrelevant educational requirements they knew MS. YOUNG did not have in order to force her out of a job; MS. YOUNG was moved out of the Cancer Center to prevent her from witnessing and reporting further incidents of patient endangerment in the Cancer Center, and moved to work in a remote location and as the sole person with experience in the Pelvic Floor Clinic; and she was repeatedly subjected to hearing the "N" word at work.

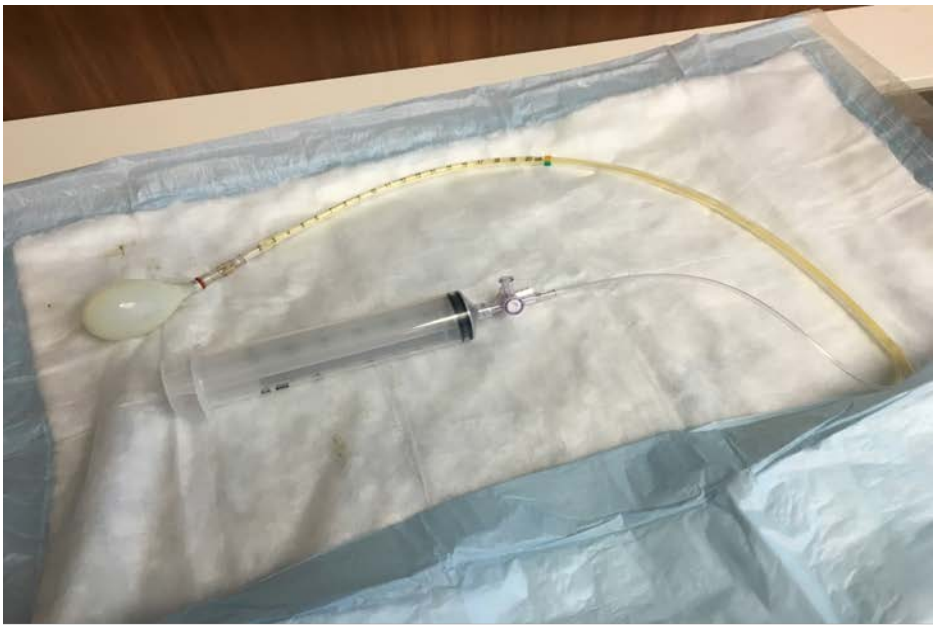
31. Additionally, after the departure of the Cancer Center surgeon, no physician was present for patient testing in the Pelvic Floor Clinic. (Nevertheless, on information and belief, STANFORD HEALTH CARE DEFENDANTS continued to bill patients and their insurance, including low-income patients being treated under MediCal, as if a physician had been present for the Pelvic Floor Clinic testing.) The result was that MS. YOUNG was the only trained, experienced person in the room at the time of Pelvic Floor testing. Moreover,

on information and belief, STANFORD HEALTH CARE's interim CEO Marriann Byerwalter, CEO David Entwhistle, COO Quinn McKenna, and CFO Linda Hoff refused to approve a budget that would allow new staff assigned to the Pelvic Floor Clinic to be trained or to have even a proper hospital bed for Pelvic Floor Clinic testing. One of the results of this was that patients suffered and were continually endangered, as set forth more fully below.

32. Ironically, on August 2, 2016, STANFORD HEALTH CARE DEFENDANTS issued a Press Release claiming "Stanford Health Care's renowned Stanford Hospital has again been recognized as one of the nation's premier hospitals by *U.S. News & World Report*, earning a spot on its national Honor Roll." Included in this Press Release was the statement that "… once again Stanford Hospital has received national recognition from *U.S. News & World Report* for delivering the highest quality to patients who entrust us with their care," said David Entwistle, President and CEO of Stanford Health Care. "As we extend access to Stanford Health Care throughout the Bay Area, our goal is to provide every patient, in every encounter with innovative, coordinated care matched by outstanding service and patient experience."

33. Just over two weeks later, on August 18, 2016, during anal testing in STANFORD HEALTH CARE DEFENDANTS' Pelvic Floor Clinic, the protective balloon on the end of a pointed metal catheter was negligently pumped full of air by the untrained nurse practitioner until the balloon exploded in the patient's anus!

34. Not only did the patient have to push the ruptured balloon out of his anus, but MS. YOUNG had to sift through the patient's feces to ensure that all pieces of the balloon had come out and were accounted for. And most significantly, the balloon provided protection for the patient from the pointed end of the metal guide wire, so when the balloon exploded, the exposed pointed end of the metal guide wire put the patient at high risk of having his colon perforated, which could cause infection, require surgery, or even result in the patient needing a colostomy bag!



35. In her report of the negligent testing MS. YOUNG witnessed, the nurse practitioner blamed "equipment failure," which was not at all the case. MS. YOUNG had seen exactly what had gone wrong, how the nurse practitioner pumped too much air into the balloon, and yet no one ever asked MS. YOUNG what she had witnessed. Indeed, the

nurse practitioner admitted that her lack of training was at issue by reporting in an email about the accident and expressed concern about *liability*.

36. In response to the nurse continuing to blame her own negligence on "equipment failure," the following week MS. YOUNG wrote to STANFORD HEALTH CARE DEFENDANTS' management in an attempt to tactfully set the record straight: "I agree the patients need to be safe and have been very concerned about this incident and would like to make sure nothing like this ever happens again. I have never heard of a balloon coming off before and this is the first time I have ever seen one of them burst. Please let me know when you would like to talk about what happened so that we can do everything possible to avoid having a repeat."

37. No one ever followed up with MS. YOUNG, the only properly trained person in the Pelvic Floor Clinic, to ensure no other patients would be similarly put at risk of colon perforation.

38. Shortly thereafter, MS. YOUNG walked into a workspace where her co-workers were listening to an explicit song on Pandora that was using the "N" word. MS. YOUNG was shocked and offended, and reported it to management. Nothing was done about it, and instead the behavior escalated and employees began singing using the "N" word openly in the workplace, twisting lyrics to include the "N" word. For example, one of MS. YOUNG's co-workers sang the Dr. Dre song "Bitches Ain't Shit" aloud to MS. YOUNG, and changed the lyrics to include the "N" word, where the original lyrics did not, specifically singing: "Bitches ain't shit but niggas and hoes." (The actual lyrics are "Bitches ain't shit but hoes and tricks," which does not include the "N" word.)

39. Moreover, the same employees began pretending to "imitate" people speaking Mandarin when MS. YOUNG walked in the room, repeating the word "niga, niga, niga." In tears, MS. YOUNG reported this, too, to management. And again her complaint fell on deaf ears, and resulted in retaliatory gaslighting. So instead of investigating, issuing appropriate discipline, and resolving the issue, MS. YOUNG again was made to feel she had done something wrong for complaining, and was further made to think that she simply heard

employees speaking Mandarin, when she had not – her complaint was about a non-Chinese employee directing the "N" word at MS. YOUNG under the guise of mocking someone speaking Mandarin. Incredibly, MS. YOUNG's manager responded by sending her an email with a link to an article entitled "What is the common Chinese word that sounds like "nigga" (to American ears)?" and included two highly offensive videos repeating the "N" word *ad nauseum* and mocking Black women. One of the highly offensive videos MS. YOUNG's manager sent to her, in which the word "niga" is said repeatedly, has been removed for content from YouTube, and another is of comedian Russell Peters, in which he describes going to Kentucky Fried Chicken in China, stating "I'm at KFC in Beijing … And standing in line in front of me … is a Black woman … the only Black woman in China, and she found the chicken …" and then he goes on to repeat the "N" word under the guise of mocking someone speaking Mandarin! When MS. YOUNG reported that management's response to her report of use of the "N" word at work was even *more* offensive than what she had initially reported.

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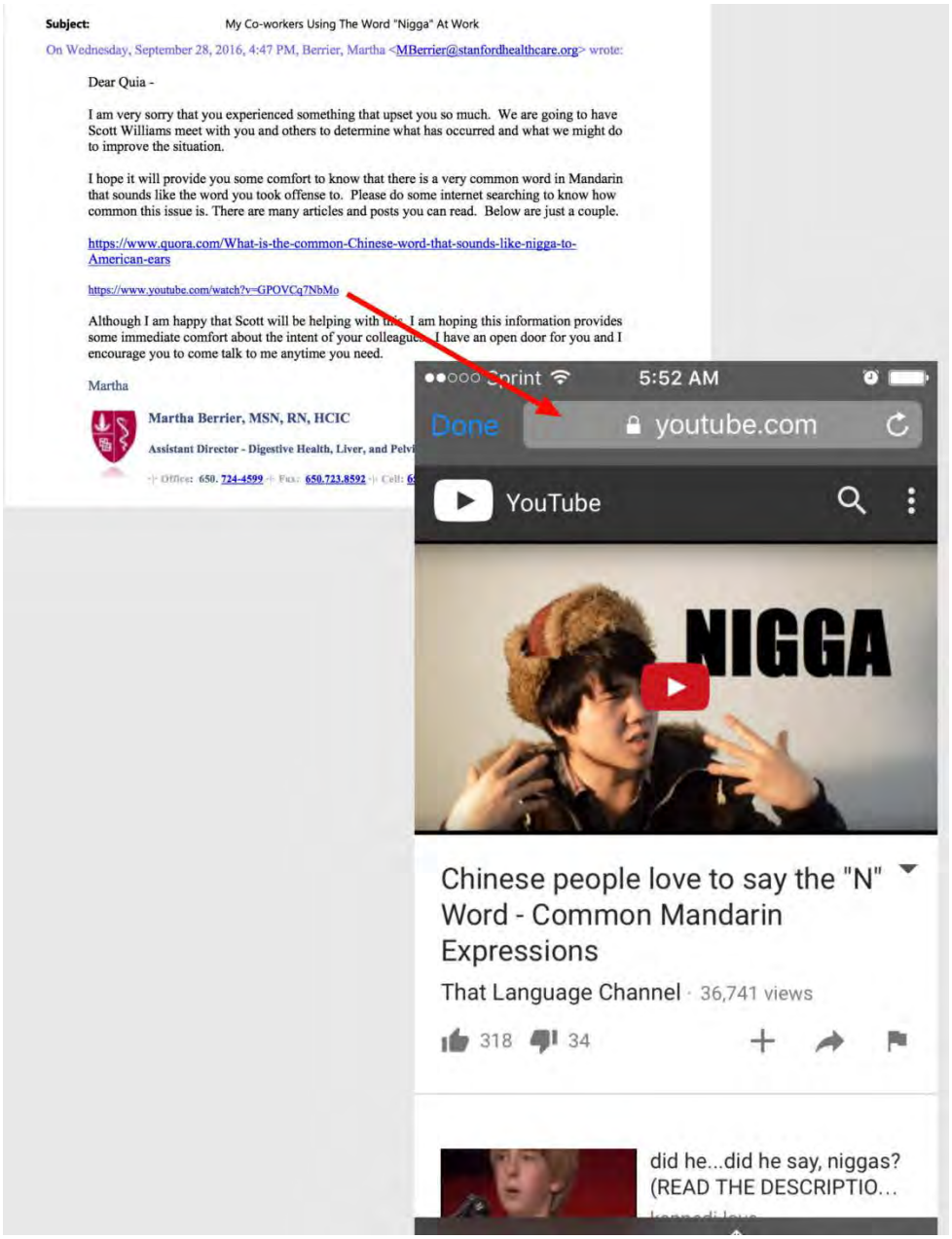
40. Below is a photograph of both her manager's response to MS. YOUNG's complaint and of the highly offensive video MS. YOUNG's manager attached to her email:



41. MS. YOUNG then reported this racist response from her manager, and her complaint fell on totally deaf ears. No one responded.

42. Shortly thereafter, MS. YOUNG reported that one of the Medical Assistants in Gastrointestinal Oncology saw a Muslim patient praying in the waiting room and

responded by saying under her breath, "Go pray in your own fucking country!" MS. YOUNG, whose husband is Muslim, was highly offended by the bigoted comment directed at the Muslim patient during the patent's prayers and reported the same to STANFORD HEALTH CARE DEFENDANTS' management.

43. In response to MS. YOUNG's complaints about the employees who repeatedly said the "N" word in her presence, and who said the Muslim patient should pray "in your own fucking country," those employees' supervisor, DEFENDANT CHANRATH FLORES ("DEFENDANT FLORES") began a campaign of assault and battery against MS. YOUNG, aggressively running into MS. YOUNG in the hallway, shoving furniture into her, leering at her, and once even on the weekend, following her into a store in New Park Mall in Newark, when MS. YOUNG was vulnerable, alone with her toddler.

44. MS. YOUNG repeatedly reported the assault and battery and openly hostile work environment DEFENDANT FLORES was creating for MS. YOUNG in retaliation for MS. YOUNG reporting DEFENDANT FLORES' employees using the "N" word at work and making the Islamophobic comment about a patient. MS. YOUNG gave management the names of those who witnessed DEFENDANT FLORES' repeated assaults, including an employee who asked MS. YOUNG, "Why does [DEFENDANT FLORES] look like she wants to slap the shit out of you?" But instead of conducting an appropriate investigation, management gave MS. YOUNG a performance review and used that opportunity to raise her report about DEFENDANT FLORES and to blame MS. YOUNG for not having dealt with DEFENDANT FLORES directly to stop the assault and battery. Moreover, rather than taking prompt remedial action of any real consequence, shortly thereafter STANFORD HEALTH CARE DEFENDANTS made DEFENDANT FLORES "Employee of the Month."

45. Further, MS. YOUNG was forced to continue to stand by and witness the gross incompetence and racism of her new co-workers in the Pelvic Floor Clinic and its effect on patients. For example, on November 18, 2016, MS. YOUNG reported that the nurse practitioner she worked with "accidentally tried to insert a catheter in a Black patient's vagina instead of her rectum. [She], as the nurse, didn't notice her mistake, but the patient

sure did and said, "Aren't you supposed to be going in my back side and not my 'kitty cat'"? In response, [the nurse] said, "Oh, I'm sorry. I can't see – it's dark down there." I was totally stunned when [the nurse] blamed her mistake on the color of our patient's skin. All this happened in front of me and the patient's husband. Please talk to me about who the patient was because I would like for someone to call and apologize to her – not just for the error, but for the comment about her being too "dark down there" for [the nurse] to be able to see. It's totally outrageous that our patients of color should be treated and spoken to this way."

46. In her initial response, all MS. YOUNG's supervisor said in her reply was: 'Qiqiuia, Thanks for letting us know."

47. And, incredibly, less than 6 months later, it happened again! But this time, the painful testing was actually completed erroneously in the patient's vagina, not her rectum, as a direct result of STANFORD HEALTH CARE DEFENDANTS' managing agents' refusal to approve training for the Pelvic Floor Clinic that MS. YOUNG had reported was so desperately needed to protect vulnerable patients.

48. As management clearly had been ineffective in responding to MS. YOUNG's warning, this time MS. YOUNG made a report directly to Dr. Natalie Kirilcuk, the colorectal surgeon in the Gastrointestinal Cancer Program who had replaced the Cancer Center surgeon who STANFORD HEALTH CARE DEFENDANTS had forced out.

49. Specifically, MS. YOUNG reported in an email with the subject line "Anorectal Manometery Testing on Stanford Patient's Vagina, Not Rectum":

> "Hi Dr. Kirilcuk,
>
> On Friday 4-28-17, we tested a patient who you referred to the Pelvic Floor Clinic in Redwood City for Anorectal Manometry and the testing went horribly wrong when the nurse conducted the testing on the patient's vagina- not her rectum.
>
> The anal sphincter electromyography (EMG) went well. However, during the Anorectal Manometry, when the air started being pushed into the patient for the RAIR, the patient started shouting out

"Aww! Aww! Aww!" At that point, before we checked for the sensations, I checked the position of the catheter to see what could be causing the pain, and realized that the nurse placed the catheter in the patient's vagina instead of her rectum.

As soon as I realized this I asked the nurse to stop what she was doing and come over to see the catheter.

It took a while for the nurse to realize her error- she didn't see it on her own, I had to point it out to her that she had placed the catheter in the patient's vagina and not the patient's rectum.

The nurse asked the patient if she was having any pain and the patient said yes, she was having cramping in her lower abdomen. The nurse apologized, told the patient that she accidentally inserted the catheter into her vagina and not her rectum.

The nurse had me prepare a new catheter and then proceeded to do the Anorectal Manometry again, this time inside the patient's rectum.

I explained to the nurse that she should put in a SAFE report but I'm not sure how accurate it is or what is being done about the patient. The nurse told me today that she thinks she hit the patient's cervix because she had pumped 60 cc of air into her vagina.

If you want to talk I can let you know who the patient is so you can follow up with her. The whole thing made me sick to my stomach and I've been worried about the patient all weekend."

50. Dr. Kirilcuk did not respond to MS. YOUNG's report of gross negligence and patient endangerment. So at the end of the week, MS. YOUNG wrote to Dr. Kirilcuk again to make sure she had received MS. YOUNG's email about the patient who had had testing done accidentally in her vagina.

51. On May 5, 2017, MS. YOUNG sent Dr. Kirilcuk a reply email with the subject line: "RE: Anorectal Manometry Testing on Stanford Patient's Vagina, Not Rectum"

stating:

"Hi Dr. Kirilcuk,

Would you mind letting me know if anyone has spoken to the patient from last Friday? I know last Friday was an awful day, but I keep thinking about our patient and I'm worried and I hope she's ok, and want to make sure she's not forgotten about as a result of Friday's terrible tragedy. If you would let me know that someone has reached out to her and has made sure she's ok, I'd really appreciate it.

Also, I wanted to make you aware that yesterday one of the patients who I had talked to [my supervisor] about last week – a patient who [my supervisor] was supposed to have [the nurse practitioner] reschedule based on your note from your examination- was bleeding when [my supervisor] did his rectal exam yesterday. I think the procedure was not completed because the patient was in so much pain.

Dr. Kirilcuk, I'm very worried about the treatment our patients are getting and the fact that nobody working in the Pelvic Floor Clinic seems to know what they are doing. Just today, we had a patient with both internal and external hemorrhoids who was so scared, and I had to direct [the nurse practitioner] on which way she should go with the catheter to avoid the external hemorrhoid. I helped the patient calm down by breathing with her to relax the anal muscles and had her squeeze my hands while [the nurse practitioner] inserted the catheter. And the end, [the nurse practitioner] told me that without me, she or the patient wouldn't have made it through the testing. I am very worried about how our patients are being treated when I am excluded from the testing, and I really don't understand why no one seems to be getting training. It's been almost a year now.

I would really like to talk to you about what I am seeing happen to

our patients, would you please let me know when you have time?"

52. Dr. Kirilcuk never responded to either of MS. YOUNG's emails. Instead, she issued a letter to the patient who had had the painful testing completed erroneously in her vagina falsely stating that there had been "no untoward events" during the testing.

53. Upon seeing that her serious concerns about patient endangerment were being ignored and covered up by Dr. Kirilcuk (the very surgeon heading the Pelvic Floor Clinic) by reporting "no untoward events," MS. YOUNG then contacted the tenured Stanford Oncologist who had made the reports on her behalf the previous year.

54. On May 17, 2017, MS. YOUNG sent the tenured Stanford Oncologist an email with the subject line "FW: Anorectal Manometry Testing on Stanford Patient's Vagina, Not Rectum" and forwarded the two emails to Dr. Kirilcuk to him, stating:

> "Hi Dr. ____,
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> I sent this email to Kr. Kirilcuk a couple of weeks ago, but didn't hear back from her. I was worried about the patient, so I followed up with Dr. Kirilcuk, but she still didn't respond. Then last Friday I seen that the result letter for the patient said that there were no untoward events. I'm really worried about how our patients are being treated in the Pelvic Floor Clinic and no one seems to be doing anything about it. It's been almost a year and still no one is getting proper training. I don't know if there is anything you can do about this Dr. ____, but I thought I would at least try."

55. No one ever responded to MS. YOUNG's pleas to protect STANFORD HEALTH CARE DEFENDANTS' patients.

56. And in retaliation for MS. YOUNG's continued reporting of ongoing patient endangerment in the Pelvic Floor Clinic, on information and belief, DEFENDANT STANFORD HEALTH CARE's CEO David Entwistle, CFO Linda Hoff, and COO Quinn McKenna refused to approve the purchase of even one single bed for the Pelvic Floor Clinic's patient testing. In the past year, since the move to Redwood City, all patients have

had to undergo painful Pelvic Floor testing on an unstable, wobbly gurney, despite MS. YOUNG's repeated requests for a stable bed, and management's assurances that one would be ordered as soon as CEO Entwistle, CFO Hoff and/or COO McKenna approved the Pelvic Floor Clinic budget. On information and belief, DEFENDANT STANFORD HEALTH CARE's CEO, CFO, and/or COO refuse to approve a budget that provides for even one single bed or for the training of the Pelvic Floor staff because STANFORD HEALTH CARE DEFENDANTS' plan is to close the Pelvic Floor Clinic to force MS. YOUNG out of a job. More than a year has passed since the Pelvic Floor Clinic was moved to Redwood City, and still no training for the Pelvic Floor Clinic has been approved by CEO Entwistle, CFO Hoff and/or COO McKenna which has resulted in each of the egregious occasions of patient endangerment described herein.

57. Moreover, rather than conducting a prompt, thorough investigation as a result of the tenured Stanford Oncologist's report of race harassment and discrimination involving MS. YOUNG, instead STANFORD HEALTH CARE DEFENDANTS and their managing agents, paid a consultant to conduct a non-specific "climate survey." This was the second "climate survey" STANFORD HEALTH CARE DEFENDANTS conducted following its employees dressing like the KKK, the first occurring in August of 2015. During each "climate survey," medical employees who were interviewed dissolved into tears. And, not surprisingly given STANFORD HEALTH CARE DEFENDANTS' pattern of denying and burying problems and liability, the results of each "climate survey" were kept secret and nothing changed. Moreover, following the 2015 and 2016 "climate surveys," there was no mandatory anti-harassment training required of employees.

58. Instead, following the 2016 "climate survey," SESHADRI, Vice President of STANFORD HEALTH DEFENDANTS' CANCER SERVICES "invited" employees to attend voluntary "sensitivity training" that would explain the "business case" for respect in the workplace, a "business case" being a justification for a proposed change based on its expected economic benefit to an organization. Clearly, for STANFORD HEALTH CARE DEFENDANTS, profit always ranks first in importance and is their prime motivation.

Because by their own admission, a "business case" is needed for STANFORD HEALTH CARE DEFENDANTS to do the right and lawful thing, MS. YOUNG has been left no choice but to turn to the judicial system for redress. As a result, she brings the following claims to hold each of the defendants responsible for the crushing fear, intimidation, despair, isolation, humiliation, and alienation they have inflicted on her in conscious disregard of MS. YOUNG's rights and safety and their conscious disregard of the rights and safety of the patients they were entrusted to care for, protect, and cure.

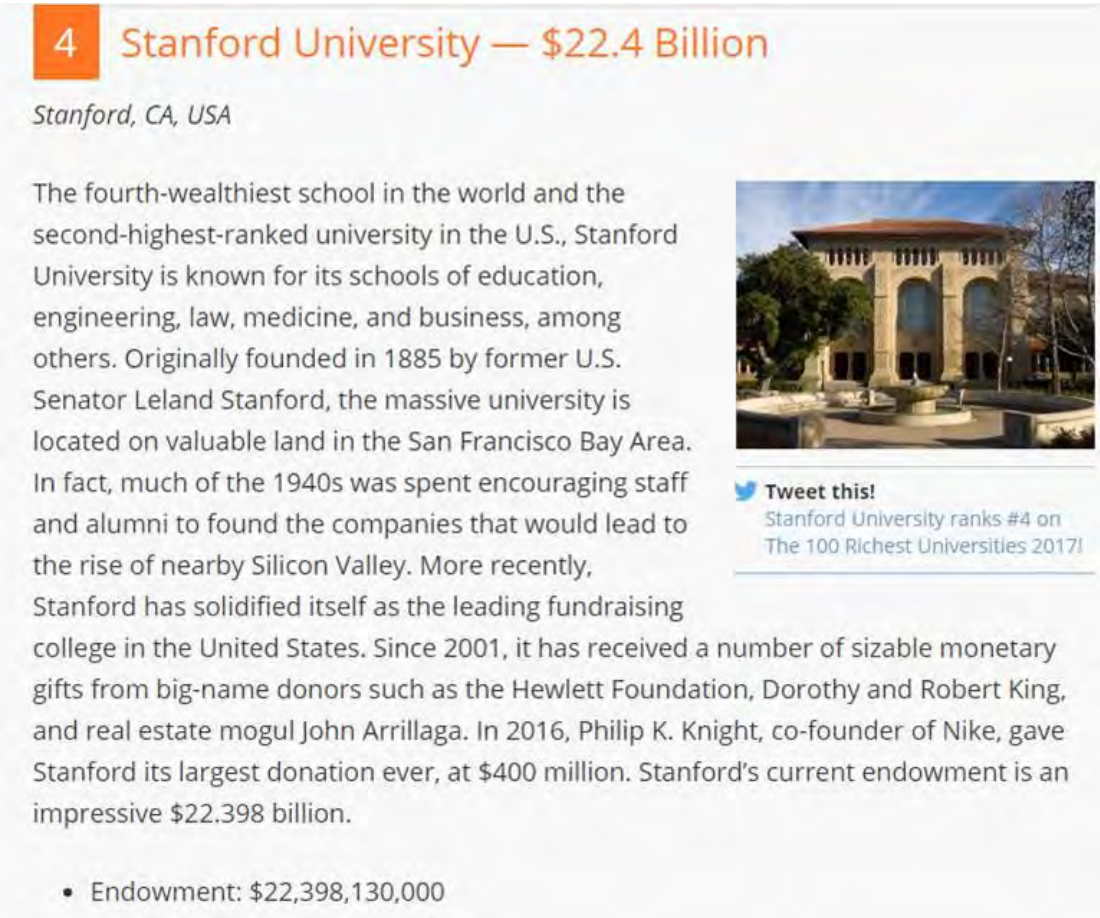
II. PARTIES

59. PLAINTIFF QIQIUIA YOUNG ("MS. YOUNG") is an adult individual who is, and at all times mentioned in this Complaint, has been a resident of Alameda County, California. MS. YOUNG is an African-American woman. Her family hails from Oklahoma, home to many of the "Grand Wizards" of the Ku Klux Klan. MS. YOUNG's mother moved her family to California specifically to protect them from the KKK as she herself had had to run from people throwing rocks at her in the streets. MS. YOUNG went into health care to help people and their families after her own family experienced an unnecessary tragedy as the result of medical incompetence and the cover-up of the same: while in the care of a medical facility MS. YOUNG's family entrusted to care for her ill father, MS. YOUNG's father suffered a fall due to medical negligence. Moreover, instead of treating her father for the resulting concussion, the medical facility hid the fact of the fall and the resulting concussion from MS. YOUNG and her family. Sadly, as a result of the concussion, MS. YOUNG's father suffered a stroke and passed away. It was this shocking and horrific experience that led MS. YOUNG to seek a career in health care. As a result, MS. YOUNG began working for STANFORD HEALTH CARE DEFENDANTS in 2011 as a Medical Assistant. And in her initial annual performance reviews, MS. YOUNG was praised as follows: "Q displays a positive attitude consistently on a day to day basis despite the workload. She is respectful of others and goes above and beyond to protect patient's confidentiality and personal integrity. Qiqiuia cares very much for her patients … Q has been a great addition to the GI Oncology team. I have enjoyed teaming with her to work on

establishing best practices and look forward to involving her more in creation of new patient processes … Q has great empathy and concern for her patients. She truly loves this patient population and loves her interactions with them … Q is professional and takes great pride in her work. She is constantly coming up with constructive ideas on how to improve the patient experience. She is highly observant …"

60. DEFENDANT CHANRATH FLORES ("DEFENDANT FLORES") is an adult individual who is, and at all times mentioned in this Complaint, has been a resident of Alameda County, California.

61. DEFENDANT THE LELAND STANFORD JUNIOR UNIVERSITY ("STANFORD UNIVERSITY") is a "non-profit" California corporation, and the fourth wealthiest university in the world with an endowment of nearly ***$22.4 Billion***.



4 Stanford University — $22.4 Billion

Stanford, CA, USA

The fourth-wealthiest school in the world and the second-highest-ranked university in the U.S., Stanford University is known for its schools of education, engineering, law, medicine, and business, among others. Originally founded in 1885 by former U.S. Senator Leland Stanford, the massive university is located on valuable land in the San Francisco Bay Area. In fact, much of the 1940s was spent encouraging staff and alumni to found the companies that would lead to the rise of nearby Silicon Valley. More recently, Stanford has solidified itself as the leading fundraising college in the United States. Since 2001, it has received a number of sizable monetary gifts from big-name donors such as the Hewlett Foundation, Dorothy and Robert King, and real estate mogul John Arrillaga. In 2016, Philip K. Knight, co-founder of Nike, gave Stanford its largest donation ever, at $400 million. Stanford's current endowment is an impressive $22.398 billion.

- Endowment: $22,398,130,000

Based on information and belief as described on its website, STANFORD UNIVERSITY

owns DEFENDANT STANFORD HOSPITAL AND CLINICS and DEFENDANT STANFORD HEALTH CARE (for ease of reference, STANFORD UNIVERSITY, STANFORD HOSPITAL AND CLINICS, AND STANFORD HEALTH CARE are collectively referred to herein as "STANFORD HEALTH CARE DEFENDANTS"), each of which also is a California "non-profit" corporation and an agent of STANFORD UNIVERSITY. STANFORD UNIVERSITY and STANFORD HEALTH CARE DEFENDANTS have known about systemic racial discrimination on its campus and within its wholly owned subsidiaries STANFORD HOSPITAL AND CLINICS and STANFORD HEALTH CARE for years, through MS. YOUNG's reports and complaints and through the myriad reports and complaints of others. But instead of addressing and correcting the pattern and practice or discrimination, including retaliation, instead they choose to cover up and deny discrimination, and blatantly retaliate against those like MS. YOUNG who have been brave enough to report it.

62. Indeed, STANFORD HEALTH CARE DEFENDANTS have not only covered up the systemic race discrimination in their operations, but have also covered up recurring patient risk at their facilities, and have attacked and retaliated against those like MS. YOUNG who have courageously spoken up and reported patient endangerment and injuries. The motivation for the cover up of patients' lives being put at risk and injuries is to protect and advance an admittedly "audacious" fundraising campaign to pull in $1 Billion more in contributions by, in large part, misrepresenting a dedication to "deliver the absolute best care" to its patients. (http://www.mercurynews.com/2012/05/07/stanford-hospital-launches-1-billion-campaign-to-build-new-hospital-fund-research/) One of the sales pitches STANFORD HEALTH CARE DEFENDANTS have used in their quest to make the fourth wealthiest university in the world even wealthier was to promise STANFORD HEALTH CARE DEFENDANTS' donors that "Over the next 50 years we want to be able to deliver the absolute best care to that next patient who walks through our door. We need to deliver care that leverages innovation and technology, but that is also patient- and family-oriented." However, despite receiving in excess of ***$500 Million*** from small and superrich donors with

promises of a goal to deliver "the absolute best care to that next patient who walks through our doors," the care *actually* delivered to its patients is the polar opposite of the world-class care STANFORD HEALTH CARE DEFENDANTS promise in their glossy sales brochures and their posh fundraisers, and that they want the public to "Imagine" in their new advertising campaign.

63. As described below, MS. YOUNG, a health care technician on the front lines of patient care at STANFORD HEALTH CARE DEFENDANTS has witnessed the reality of trying to deliver basic, patient-focused, non-life-threatening-care in a non-discriminatory workplace. MS. YOUNG's courageous contributions, including repeatedly risking her reputation, career, and livelihood to protect patients, have been as important as any $100 Million donation from the superrich that STANFORD HEALTH CARE DEFENDANTS boast about and openly advertise. But, as described below, MS. YOUNG did not receive any plaque, or photograph of herself shaking hands with STANFORD HEALTH CARE DEFENDANTS' CEO or the President of STANFORD UNIVERSITY. Rather, she received harassment, mistreatment, retaliation, threats of termination, and violence.

64. DEFENDANTS STANFORD UNIVERSITY, STANFORD HOSPITAL

AND CLINICS and STANFORD HEALTH CARE have by-laws, policies, procedures, and practices that are to be followed, but which were not followed in the treatment of MS. YOUNG.

65. STANFORD HEALTH CARE DEFENDANTS own and operate physical locations in the California counties of Alameda, San Mateo, and Santa Clara.

66. As of 2017, DEFENDANT "STANFORD HEALTH CARE has a new home in Emeryville." Specifically, STANFORD HEALTH CARE DEFENDANTS increased their physical presence in Alameda County by opening a four-story, 90,000-square-foot facility called ***Stanford Health Care – Emeryville***.

67. The names and true capacities of the individuals sued herein as Defendants DOES 1 through 50, inclusive, are unknown to MS. YOUNG and are therefore sued by their fictitious names. DOES 1 through 50 are in some way responsible for the acts and omissions alleged herein. When MS. YOUNG learns their names and true capacities, she will amend this Complaint accordingly.

III. VENUE AND JURISDICTION

68. California Code of Civil Procedure section 395(a) provides the "general rule" of venue as "the county in which the defendants or some of them reside at the commencement of the action." Cal. Civ. Proc. Code § 395(a).

69. Venue is proper in the County of Alameda because DEFENDANT FLORES is a resident of Alameda County.

70. Venue also is proper in the County of Alameda pursuant to section 393 of the Code of Civil Procedure, which provides "the county in which the cause, or some part of the cause, arose, is the proper county for trial . . . [f]or the recovery of a penalty or forfeiture imposed by statute." MS. YOUNG's claim against STANFORD HEALTH CARE DEFENDANTS for recovery of unpaid wages (resulting from being forced to work off-the-clock), accrued when she worked from her home, in Alameda County, and her claim against STANFORD HEALTH CARE DEFENDANTS for failure to reimburse her for the use of her personal cell phone for work purposes also accrued when she worked from her home, in

Alameda County.

71. Venue also is proper in Alameda County under the special venue provisions of the California Fair Employment and Housing Act ("the FEHA"), California Government Code section 12965(b) which provides a "wide choice of venue afforded plaintiffs by the FEHA venue statute effectuates enforcement of that law by permitting venue in a county which plaintiffs deem the most appropriate and convenient." *Brown v. Superior Court*, 37 Cal. 3d 478, 486 (1984). The FEHA provides, in relevant part: "An action may be brought in any county in the state in which the unlawful practice is alleged to have been committed, in the county in which the records relevant to the practice are maintained and administered, or in the county in which the aggrieved person would have worked or would have had access to the public accommodation but for the alleged unlawful practice, but if the defendant is not found within any of these counties, an action may be brought within the county of the defendant's residence or principal office." Cal. Gov't Code §12965(b). Here, records relevant to MS. YOUNG's claims are maintained in Alameda County. Moreover, as advertised publically DEFENDANT "STANFORD HEALTH CARE HAS A NEW HOME IN EMERYVILLE." Therefore, venue is proper under FEHA as well.

IV. FACTUAL ALLEGATIONS

72. In 2011, PLAINTIFF QIQIUIA YOUNG began her employment with STANFORD HEALTH CARE DEFENDANTS as a Medical Assistant ("M.A.") in the Gastrointestinal Oncology ("GI Oncology") unit of STANFORD HEALTH CARE's Cancer

Center in Palo Alto, California. As an M.A., MS. YOUNG was responsible for, among other things, preparing patient examination rooms prior to the visit to ensure that proper equipment and supplies were set-up for examinations, required procedures, and/or treatments; escorting patients to exam rooms, measuring and recording vital signs, documenting medication, and collecting medication information and specimen samples; cleaning exam rooms following visits; performing routine examination and treatment procedures; and administering medication under the supervision of a licensed physician or nurse.

73. As an M.A., MS. YOUNG was assigned to work with multiple physicians in the Cancer Center, including the Cancer Center surgeon who created and ran STANFORD HEALTH CARE DEFENDANT's Pelvic Floor Clinic, which focuses on pelvic floor disorders. The main pelvic floor disorders treated by the Pelvic Floor Clinic are urinary incontinence, fecal incontinence, and pelvic organ prolapse. An important part of the services offered by the Pelvic Floor Clinic includes the diagnostic services provided by its Pelvic Floor Testing. (At present, MS. YOUNG is the technician who runs the machine that does Pelvic Floor Testing.)

74. At the outset of her employment, management recognized MS. YOUNG's attention to detail, empathy, and love for her patients. In her initial annual performance reviews, MS. YOUNG was praised as follows: "Q displays a positive attitude consistently on a day to day basis despite the workload. She is respectful of others and goes above and beyond to protect patient's confidentiality and personal integrity. Qiqiuia cares very much for her patients … Q has been a great addition to the GI Oncology team. I have enjoyed teaming with her to work on establishing best practices and look forward to involving her more in creation of new patient processes … Q has great empathy and concern for her patients. She truly loves this patient population and loves her interactions with them … Q is professional and takes great pride in her work. She is constantly coming up with constructive ideas on how to improve the patient experience. She is highly observant …"

75. Moreover, her initial management team recognized that MS. YOUNG's ability to see problems and find solutions was an asset to STANFORD HEALTH CARE

DEFENDANTS and their patients. As a result, MS. YOUNG's initial manager recognized in her 2014-2015 performance review: "Q is professional and takes great pride in her work. She is constantly coming up with constructive ideas on how to improve the patient experience … Q is a good team player … and one of the "Goals" her initial manager set for her was to "[W]ork with May Riley from Infectious disease, other Patient Care Techs and management to improve our sterile processing for scopes in the GI clinic."

76. However, beginning in or about 2014, there was a shift in management in GI Oncology. Kathryn Gail Bailey ("BAILEY") was promoted to be the Director of Clinical Operations of the Cancer Center, reporting to Vice President of the Cancer Clinic, Sri Seshadri ("SESHADRI"). Tim Svozil ("SVOZIL") was hired as the Assistant Clinic Manager for GI Oncology, and, on information and belief, Assistant Manager SVOZIL hired Natalie Burazon ("BURAZON") as an M.A. in GI Oncology. On further information and belief, Assistant Manager SVOZIL had a romantic relationship with BURAZON such that BURAZON was allowed to torment MS. YOUNG based on her race on an ongoing basis, and Assistant Manager SVOZIL would ratify the hostile work environment BURAZON created for MS. YOUNG.

77. For example, beginning when MS. YOUNG was pregnant in 2014, BURAZON would unplug MS. YOUNG's computer, requiring MS. YOUNG to crawl under her desk (with a pregnant belly) to plug her computer back in so that she could perform her job duties. When MS. YOUNG reported this harassment to Assistant Manager SVOZIL, as a result of his sexual relationship with BURAZON, he did nothing. As a result of Assistant Manager SVOZIL's inaction, MS. YOUNG began maintaining a notebook to document the harassment BURAZON was subjecting her to. BURAZON stole MS. YOUNG's notebook. And when MS. YOUNG reported the same to Assistant Manager SVOZIL, he again did nothing.

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A. Stanford Health Care Defendants' Staff Dresses Like The Ku Klux Klan At Work And Circulates A Photograph Directed At Ms. Young, While Management Feigns Ignorance.

78. The day before Halloween in 2014, a member of STANFORD HEALTH CARE DEFENDANTS' GI Oncology staff threatened MS. YOUNG by saying that she was going to dress like the Ku Klux Klan ("KKK") for Halloween. MS. YOUNG was shaken, offended, and horrified.

79. The following day, Elizabeth Dobbins ("DOBBINS") dressed like the KKK in a Cancer Center exam room and BURAZON photographed her and circulated the photograph among the Medical Assistants and, on information and belief, to Assistant Manager SVOZIL. DOBBINS and BURAZON's racist actions were committed with the intent of intimidating MS. YOUNG, and creating a hostile work environment for her.

80. Despite Assistant Manager SVOZIL's knowledge that his staff had dressed as a member of the KKK at work to create a threatening and hostile work environment for MS. YOUNG, he did nothing about it.

81. Even worse, in early November of 2014, BAILEY, the Director of Clinical Operations for the Cancer Center was told that STANFORD HEALTH CARE DEFENDANTS' staff had dressed like the KKK to intimidate MS. YOUNG, and she also took no action. Instead, she pretended it had not happened and, when, a month later MS. YOUNG discovered and reported it immediately thereafter, BAILEY feigned ignorance. Moreover, BAILEY blamed MS. YOUNG for not having brought the initial threat to her attention sooner, as if BAILEY had been unaware, and as if it had been MS. YOUNG's responsibility to prevent staff from dressing like the KKK to intimidate her.

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82. Below is the photograph of STANFORD HEALTH CARE DEFENDANTS' staff dressed and photographed as a member of the KKK, which photograph was circulated for the purposes of threatening and intimidating MS. YOUNG based on her race:

83. Moreover, this was not the first time STANFORD HEALTH CARE DEFENDANTS' Cancer Center staff had used Halloween as an excuse to create a patently hostile work environment for African-American employees. When MS. YOUNG began working for STANFORD HEALTH CARE DEFENDANTS she was made aware that staff previously had come to work on Halloween wearing "blackface," a remnant of the United States' blatantly racist past in which White actors would paint their faces black and proceed to mock Black people as minstrels.

84. Although STANFORD HEALTH CARE DEFENDANTS' managing agents

were made aware of prior staff coming to work in "blackface" at Halloween, no preventative measures were taken to ensure nothing of the sort occurred again. As a result, overt racism did recur, and directly impacted MS. YOUNG's work environment and was so severe as to alter the terms and conditions of employment by creating an objectively hostile work environment. Moreover, even after MS. YOUNG made her report, nothing whatsoever was done to prevent further racism or a racially-charged hostile work environment at STANFORD HEALTH CARE DEFENDANTS' workplace. As a result, it continued.

B. Stanford Health Care Defendants' Staff Secretly Photograph Disfigured Patient Genitals And Disseminate Same.

85. Also in or about November 2014, BURAZON secretly photographed and circulated disfigured patient genitals. Later, in his report to Stanford University President John L. Hennessey, the tenured Stanford Oncologist reported:

> "**President Hennessey**, … At Halloween … **testing technician Natalie [Burazon] took a photo of a medical assistant with a pillowcase pulled over her head, pretending to be a member of the Ku Klux Klan. Natalie showed other staff that photo along with a photo of a patient's disfigured perineum, the area between the genitalia and anus, joking that the KKK was going to do the same thing to Qiquia [MS. YOUNG], an African-American/Cherokee medical assistant**."

86. When it was reported that BURAZON had secretly photographed and circulated disfigured patient genitals, STANFORD HEALTH CARE DEFENDANTS' response was to provide training on patient privacy rights. But STANFORD HEALTH CARE DEFENDANTS and their managing agents did nothing to provide training to prevent race harassment in their workplace, and so it continued, and continued to create a devastating hostile work environment for MS. YOUNG.

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C. Ms. Young Discovers And Immediately Reports Stanford Health Care Defendants' Staff Dressing Like The Ku Klux Klan At Work, And Begins To Suffer Immediate Gaslighting And Retaliation.

87. On December 15, 2014, one of the staff who had been privy to the fact that STANFORD HEALTH CARE DEFENDANTS' medical staff had dressed like the KKK and circulated a photograph of the same in order to threaten and intimidate MS. YOUNG, and thereby create a hostile work environment for her, approached MS. YOUNG and told her BURAZON and DOBBINS were "not (her) friends." She further told MS. YOUNG that BURAZON and DOBBINS had dressed like the KKK in STANFORD HEALTH CARE DEFENDANTS' Cancer Clinic and circulated the photograph depicted above. Further, MS. YOUNG was led to believe the conduct was known to and sanctioned by BURAZON's paramour, Assistant Manager SVOZIL. In response to hearing this and seeing the photograph depicted above, MS. YOUNG felt immediately threatened and subject to a hostile work environment as a result of being an African-American woman.

88. MS. YOUNG immediately reported her co-workers dressing like the KKK and circulating the photograph to intimidate her to Kim Ko ("KO") of Human Resources and to BAILEY. Almost immediately, MS. YOUNG was subjected to increased harassment and retaliation, including, but not limited to:

a. gaslighting;
b. heightened scrutiny of her performance and attendance, including accusing MS. YOUNG of showing up to work late every day for a year;
c. increased performance expectations;
d. increased responsibilities (coupled with denial of support in execution of her duties);
e. denial of promotional opportunities;
f. denial of pay commensurate with her experience;
g. denial of pay increases;

h. denial of title;

i. denial of overtime pay for hours worked;

j. denial of meal and rest periods; and

k. defamation *per se*.

D. As A Result Of Stanford Health Care Defendants' Immediate Campaign Of Retaliation, Ms. Young Turns To The Cancer Center Surgeon For Help And Stanford Health Care Defendants Then Retaliate Against The Cancer Center Surgeon By Inexplicably Closing The Pelvic Floor Clinic She Headed.

89. Suddenly having to defend her job as the result of reporting blatantly racist and threatening behavior at work, MS. YOUNG turned for support to the Cancer Center surgeon who ran the Pelvic Floor Clinic, who MS. YOUNG reported to, and who also is an African-American woman. It was only after the Cancer Center surgeon supported MS. YOUNG's report of race harassment that STANFORD HEALTH CARE DEFENDANTS took heed and conducted an investigation.

90. But as a result of her support of MS. YOUNG, the Cancer Center surgeon then also became a target for STANFORD HEALTH CARE DEFENDANTS' campaign of retaliation, which resulted in their inexplicable closure of the Cancer Center surgeon's Pelvic Floor Clinic.

E. The Cancer Center Surgeon Recommends Promoting Ms. Young To Be The Patient Testing Technician Needed To Reopen Her Pelvic Floor Clinic, But Management Continues Its Retaliation Campaign By Repeatedly And Inexplicably Passing Ms. Young Up For Promotion.

91. Through the Spring and Summer of 2015, the Pelvic Floor Clinic was closed, purportedly because it lacked a Patient Testing Technician. MS. YOUNG applied for and was qualified for the position. Indeed, the Cancer Center Surgeon who ran the Pelvic Floor Clinic recommended her as the candidate most qualified for the position, which would allow the Pelvic Floor Clinic to reopen. Still, Spring and Summer passed and, in retaliation for making a complaint, the position was offered to others, but not to MS. YOUNG.

92. When the Cancer Center surgeon realized that STANFORD HEALTH CARE DEFENDANTS were inexplicably, and without her approval, offering the Pelvic Floor Clinic's Patient Testing Technician position to candidates less qualified for the position than MS. YOUNG, she advised MS. YOUNG to find an attorney to protect her rights. But MS. YOUNG, who had just had a baby, could not devote the time to doing so. As a result, the Cancer Center surgeon took it upon herself to help MS. YOUNG find an attorney to help protect her rights.

93. Indeed, the Cancer Center surgeon was very concerned about the blatant retaliation she witnessed being directed against MS. YOUNG for having reported her co-workers dressing like the KKK and circulating the photograph of the same to threaten her. As a result, the Cancer Center surgeon questioned the legitimacy of STANFORD HEALTH CARE DEFENDANTS' reasons for continuing to pass up MS. YOUNG for promotion to the Pelvic Floor Clinic's Patient Testing Technician position, despite being the most qualified candidate and despite the Cancer Center surgeon's support, particularly as the Cancer Center surgeon *ran the Pelvic Floor Clinic*.

94. Finally, in August of 2015, under heightened scrutiny from the Cancer Center surgeon, STANFORD HEALTH CARE DEFENDANTS had ran out of excuses and promoted MS. YOUNG, who was, and had always been, the most qualified person for the job. After months of having her promotion inexplicably denied, MS. YOUNG was promoted from a Medical Assistant to a Patient Testing Technician, III for the Pelvic Floor Clinic. Nevertheless, STANFORD HEALTH CARE DEFENDANTS tried to deny her pay commensurate with the title.

95. When the Pelvic Floor Clinic reopened that Fall, MS. YOUNG witnessed that the Cancer Center surgeon was being treated like a second-class citizen within the Cancer Center, and that whenever MS. YOUNG worked with her, MS. YOUNG's working conditions deteriorated, such that she was not scheduled to take meal periods, and often was denied meal periods entirely (but was not compensated for missing them, as required by law).

F. Out Of Fear Of Further Retaliation, Ms. Young Asks The Cancer Center Surgeon To Report Egregious Patient Endangerment Issues She Witnessed To Stanford Health Care Defendants And When She Does, Their Response Puts Patients At Greater Risk Of Death And They "White Out" Documents To Fraudulently Conceal Records Relating To The Same.

96. After having been subjected to repeated retaliation, MS. YOUNG felt forced to stand silent as incompetent management and medical staff at Stanford's Cancer Center allowed immune-compromised cancer patients to be regularly endangered by exposure to tuberculosis, and other highly infectious diseases such as scabies, shingles, HIV, AIDS, MRSA, and C. difficile. Perhaps even worse, STANFORD HEALTH CARE DEFENDANTS forbade MS. YOUNG and other employees from informing those immune-compromised cancer patients that they had been exposed to infectious diseases, or to even discuss the matter.

97. Of additional concern was the fact that MS. YOUNG was instructed by management to lie to safety auditors and say that all daily safety "checks" (referred to as "Ever Ready" Checklists) were being completed properly, when they were not. Prior management had known how to properly check and stock the emergency crash cart used to resuscitate patients in emergency situation, and had trained MS. YOUNG how to do so. However, others who were hired after MS. YOUNG were not properly trained. As a result, no one other than MS. YOUNG knew how to properly check and stock the emergency crash cart, and yet the "Ever Ready" checklist records were falsified daily to show that the crash cart had been checked and was in working order, when it was not. So when a cancer patient "coded" – *i.e.*, went into cardiac arrest – the emergency crash cart was not in working order!

98. And when shortly thereafter, another patient in the Cancer Center needed oxygen, the emergency crash cart was not stocked with proper oxygen tubing! To save the patient's life, MS. YOUNG had to run as fast as she could from one building to another to find the oxygen tubing and bring it back to resuscitate the patient.

99. The dangerous issue of the emergency crash cart not being properly checked

first came to management's attention by July 1, 2015. Still, nothing was done.

100. After these horrendous risks to patient safety four months later, in November of 2015, MS. YOUNG was no longer willing to remain silent about all the ways in which STANFORD HEALTH CARE DEFENDANTS were endangering patients' lives. Still, she feared for her job if she raised these issues, and so asked the Cancer Center surgeon to report the issues to STANFORD HEALTH CARE DEFENDANTS.

101. The Cancer Center surgeon holds a master's degree from the Harvard School of Public Health, and validated the seriousness of the patient endangerment issues MS. YOUNG had witnessed, as well as the regulatory violations presented by STANFORD HEALTH CARE DEFENDANTS creating false records of "safety checks" that had never actually happened.

102. In December 2015 and January 2016, the Cancer Center surgeon reported the patient endangerment issues and the fraudulent records relating to the Cancer Center crash cart that MS. YOUNG had told her about to STANFORD HEALTH CARE DEFENDANTS' managing agents, including, among others, James Hereford, STANFORD UNIVERSITY's then-Chief Operating Officer, SESHADRI, Vice President of STANFORD CANCER SERVICES, Mark Lane Welton, M.D., then-Chief of Staff of STANFORD HEALTH CARE, and Brendan C. Visser, M.D., Medical Director of Gastrointestinal Cancer Care Program.

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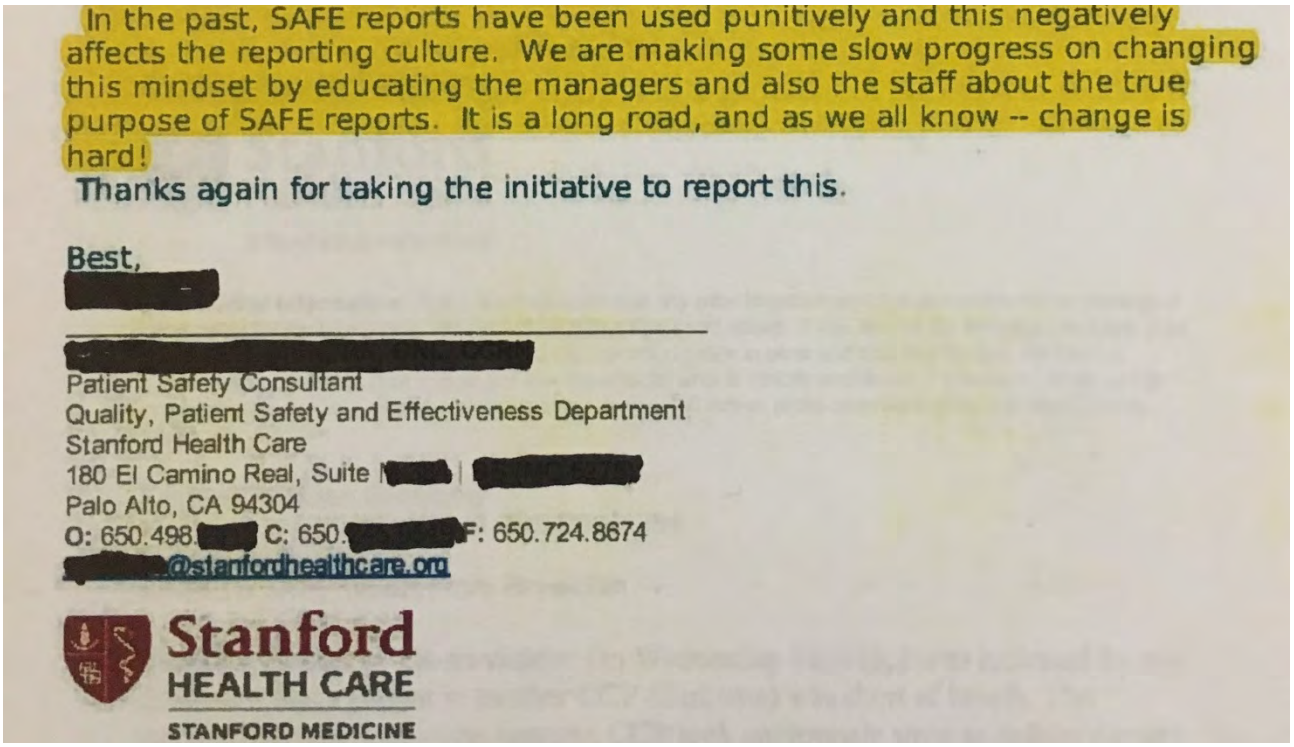
103. In response to the Cancer Center surgeon's inquiry about why STANFORD HEALTH CARE DEFENDANTS' employees are so terrified to report patient safety concerns (called "SAFE reports"), STANFORD HEALTH CARE DEFENDANTS' Quality, Patient Safety and Effectiveness Department responded candidly, admitting that employees are afraid to come forward because punitive measures are taken by management against those who make such reports. Below is a photograph of a portion of the Quality, Patient Safety and Effectiveness Department's admission about STANFORD HEALTH CARE DEFENDANTS' "punitive" response to safety reports:


In the past, SAFE reports have been used punitively and this negatively affects the reporting culture. We are making some slow progress on changing this mindset by educating the managers and also the staff about the true purpose of SAFE reports. It is a long road, and as we all know -- change is hard!

Thanks again for taking the initiative to report this.

Best,

[redacted]

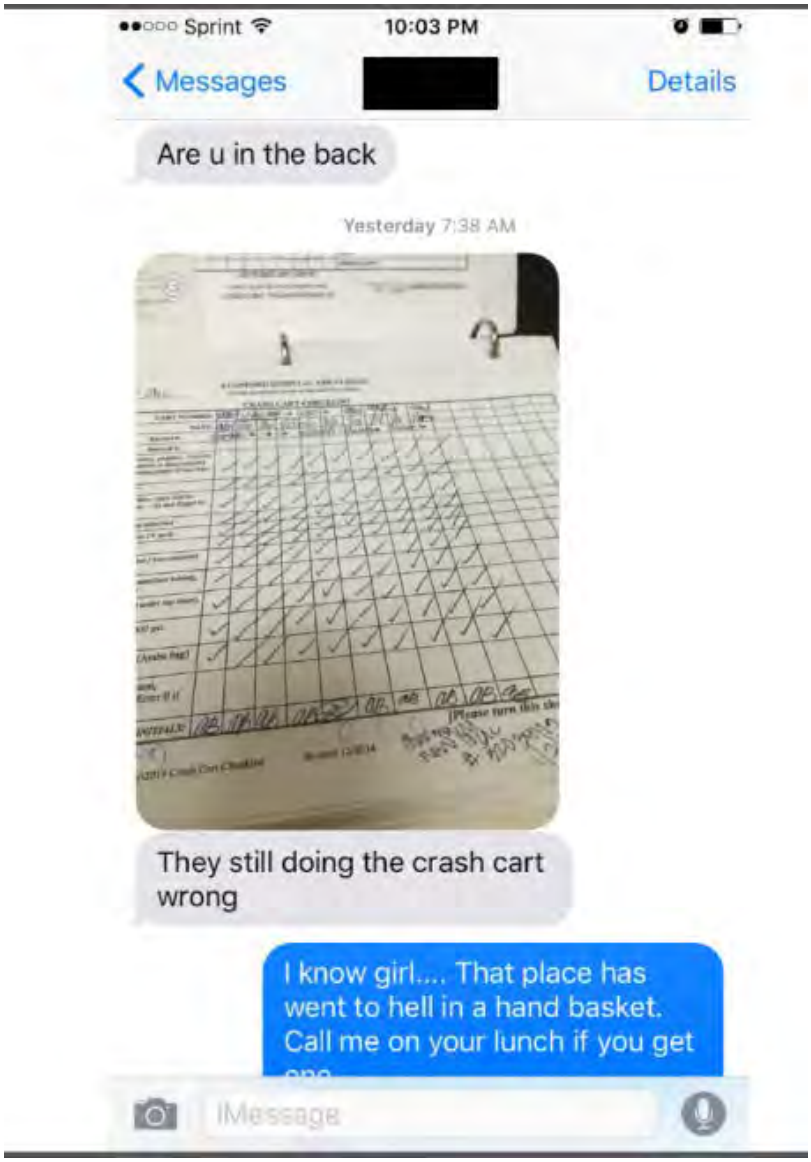
Patient Safety Consultant
Quality, Patient Safety and Effectiveness Department
Stanford Health Care
180 El Camino Real, Suite [redacted]
Palo Alto, CA 94304
O: 650.498.[redacted] C: 650.[redacted] F: 650.724.8674
[redacted]@stanfordhealthcare.org

Stanford HEALTH CARE
STANFORD MEDICINE

104. Moreover, rather than remedying the terrifying problem that had left one cancer patient "coding" without access to an operating crash cart – and another cancer patient needing but without access to oxygen – by simply training Cancer Center staff on how to stock and check the emergency crash cart to ensure it was fully functional, instead, STANFORD HEALTH CARE DEFENDANTS focused on covering up their violations of having fraudulent reports showing safety checks were occurring daily, as required by law, when they were not.

105. To cover up their daily regulatory violations, STANFORD HEALTH CARE DEFENDANTS gathered the fraudulent safety reports, and used "White Out" to fraudulently back date and revise the records.

106. Months later, another Medical Assistant texted MS. YOUNG (in blue, on the right) that, even after doctoring the regulatory compliance records with "White Out," still no one in the Cancer Center could figure out how to check the emergency crash cart!



107. Perhaps even more frightening, to "remedy" the problem of no one knowing how to properly check and stock the emergency crash cart, STANFORD HEALTH CARE DEFENDANTS removed the emergency crash cart from the Cancer Center altogether, such that, now if a cancer patient "codes" in the Cancer Center, there is no crash cart on site.

G. Ms. Young's Co-Worker Uses The "N" Word In Her Presence And When Ms. Young Reports It, She Is Accused Of Lying And Bullying Others.

108. At the end of December 2016, one of MS. YOUNG's co-workers, Eduardo Sudano ("SUDANO") used the "N" word at work in MS. YOUNG's presence and in the presence of another co-worker, Breeanna Kent ("KENT").

109. Given her prior experience of retaliation, MS. YOUNG was afraid to report her co-worker's use of the "N" word at work for fear of further retaliation, but the Cancer Center surgeon encouraged her to stand up for herself and make a report to KO of Human Resources. As a result, MS. YOUNG made such a report.

110. In response to MS. YOUNG's report of use of the "N" word at work, STANFORD HEALTH CARE DEFENDANTS' KO met with MS. YOUNG, but then inexplicably assigned the sham "investigation" to an African-American woman whom MS. YOUNG had never met, Denise Bailey ("D. BAILEY"). On information and belief, D. BAILEY was assigned to conduct this sham investigation because STANFORD HEALTH CARE DEFENDANTS wanted her to appear unbiased based on her race.

111. However, D. BAILEY was nothing more than a person of color used as a pawn for STANFORD HEALTH CARE DEFENDANTS. Rather than conducting a prompt, fair and thorough investigation, BAILEY was dismissive of MS. YOUNG's complaint, incredulous, and accused MS. YOUNG of lying.

112. BAILEY also defamed MS. YOUNG to MS. YOUNG's co-worker, KENT, who had witnessed SUDANO use the "N" word in MS. YOUNG's presence. BAILEY further told KENT she should not "let [MS. YOUNG] bully you" into corroborating that SUDANO had in fact used the "N" word at work, after he had denied it. In fact, even when KENT corroborated that SUDANO had used the "N" word at work, MS. YOUNG's report of SUDANO using the "N" word at work was deemed "inconclusive" and no action whatsoever was taken against SUDANO.

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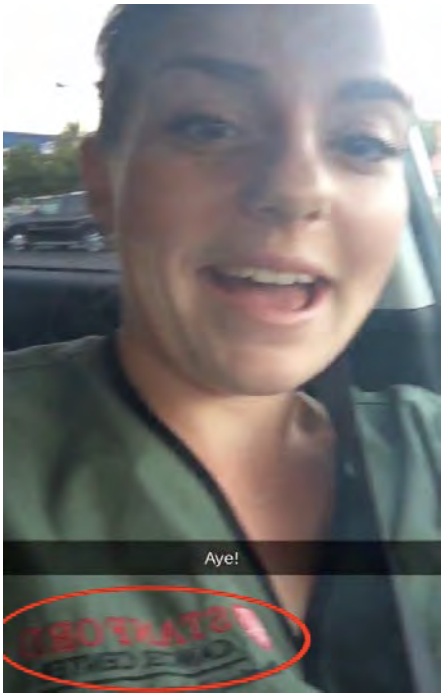
113. Below are still photos from video of SUDANO and KENT smoking marijuana together in SUDANO's vehicle while at STANFORD HEALTH CARE. And yet SUDANO was believed and MS. YOUNG was accused of lying and of "bullying" KENT – even when KENT finally admitted that she heard him say the "N" word!



114. Moreover, again, no anti-harassment training was provided to prevent further use of the "N" word in the workplace, and so, again, it recurred.

H. <u>The Cancer Center Surgeon Reports Racism And Retaliation, Including Ms. Young's Experience Of The Same, And Is Immediately Subjected To A Heightened Campaign Of Retaliation That Forces Her Resignation Within A Matter Of Months.</u>

115. In December 2015 and January 2016, the Cancer Center surgeon also reported the racism and retaliation she and MS. YOUNG had experienced to STANFORD HEALTH CARE DEFENDANTS' managing agents, including, among others, James Hereford, STANFORD UNIVERSITY's then-Chief Operating Officer, SESHADRI, Vice President of STANFORD HEALTH CARE DEFENDANTS' Cancer Center, Mark Lane Welton, M.D., then-Chief of Staff of STANFORD HEALTH CARE, and Brendan C. Visser, M.D., Medical Director of Gastrointestinal Cancer Care Program.

116. On information and belief, STANFORD HEALTH CARE DEFENDANT's managing agents, including, but not limited to, Dr. Mark Lane Welton, and STANFORD UNIVERSITY's COO James Hereford believed they were "in the clear on the 'KKK'" incident, and, as a result, no one bothered to talk with MS. YOUNG.

117. Moreover, STANFORD HEALTH CARE DEFENDANTS failed to provide any anti-harassment training in response to the Cancer Center surgeon's report.

118. Instead, STANFORD HEALTH CARE DEFENDANTS redoubled their campaign of retaliation against the Cancer Center surgeon, and began, among other things, to "gaslight" her.

119. As a result of STANFORD HEALTH CARE DEFENDANTS' swift and relentless campaign of retaliation, by mid-2016, the Cancer Center surgeon felt she had no choice but to resign from her employment with STANFORD HEALTH CARE DEFENDANTS, despite having no other secured employment.

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I. Ms. Young Is Repeatedly Warned To Stay Silent About Ongoing Patient Endangerment Issues, And When She Does Not Remain Silent, Stanford Health Care Defendants Retaliate With Veiled Threats, Intimidation, Gaslighting, And Ultimately Removing Ms. Young From The Cancer Center And Reducing Her Hours And Pay.

120. Without the voice and protection of the Cancer Center surgeon, STANFORD HEALTH CARE DEFENDANTS' retaliatory bullying, intimidation, and harassment of MS. YOUNG escalated. Moreover, without the Cancer Center surgeon's assiduous oversight, the number of careless errors that endangered patients on a regular basis increased in severity and frequency.

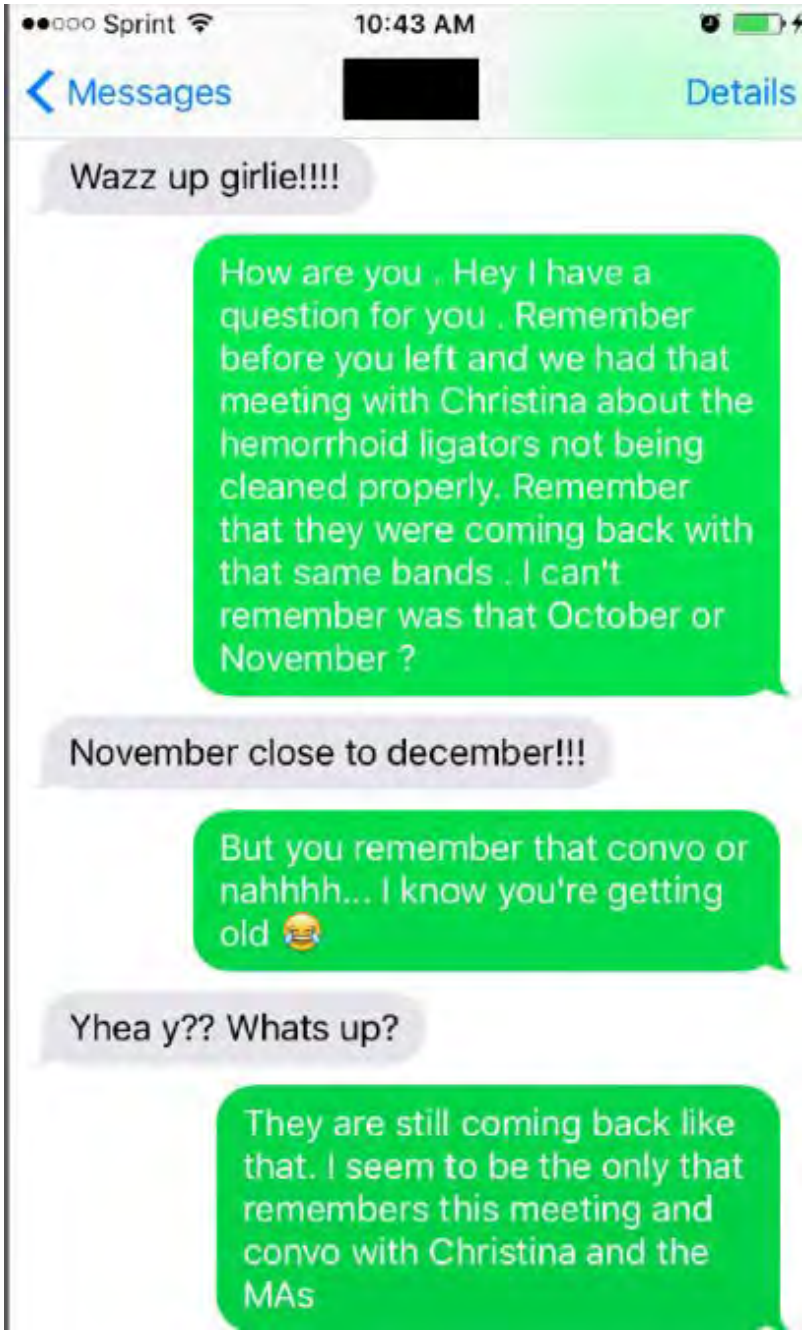
121. MS. YOUNG was repeatedly warned by a number of STANFORD HEALTH CARE DEFENDANTS' employees that, if she valued her job, she should stay quiet about the patient endangerment she witnessed on a regular basis.

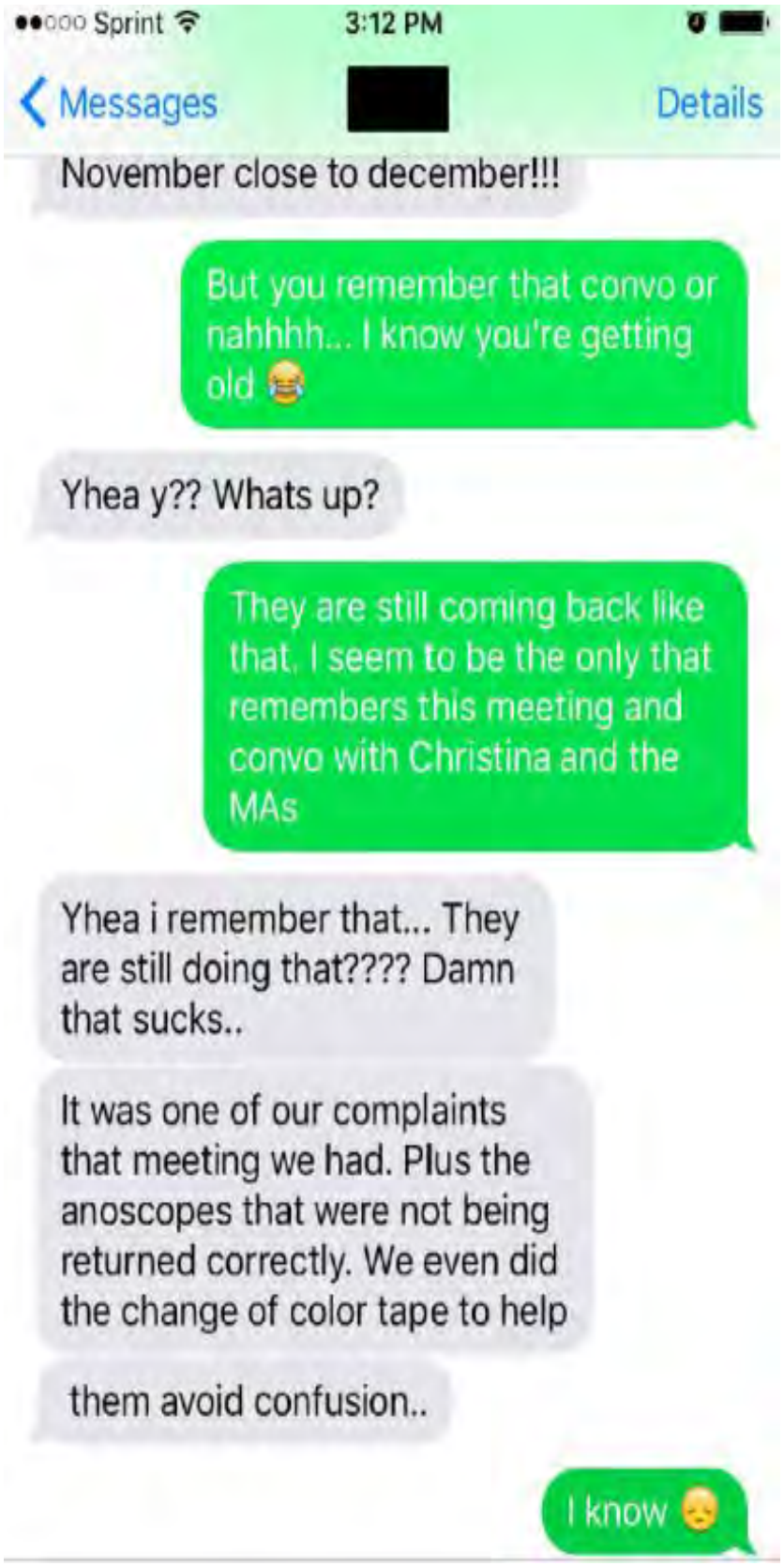
122. But as MS. YOUNG began her career in health care after her father died from gross medical negligence that the medical provider tried to cover up and hide from her family, MS. YOUNG could not, and would not, remain silent about STANFORD HEALTH CARE DEFENDANTS' ongoing endangerment to its patients that she witnessed regularly.

J. Ms. Young Repeatedly Reported The Risk Of Feces-Covered Rubber Bands Being Inserted Into Unsuspecting And Vulnerable Surgery Patients, And Was Accused Of Lying And Fabricating The Same.

123. On May 13, 2016, MS. YOUNG reported her concern that feces-covered rubber bands were being reused from patient to patient. Six months earlier, in November 2015, she had first reported the risk of reusing feces-covered rubber bands to her direct supervisor Christina Guijarro ("GUIJARRO") and manager Matt Burke ("BURKE"), but that report met with nothing but further retaliatory intimidation and hostility, including GUIJARRO becoming physically aggressive and threatening to MS. YOUNG, and management trumping up false accusations against MS. YOUNG and writing her up based on these false accusations. Absolutely nothing was done about this potentially fatal risk to patients.

124. When the feces-covered rubber bands still were being returned for reuse, MS. YOUNG confirmed that this issue had long ago been brought to management's attention. Below is a text exchange between MS. YOUNG (whose texts are in green, on the right) and another Medical Assistant recalling that the potential reuse of feces-covered rubber bands had been reported:




●●○○○ Sprint
3:12 PM
Messages
[redacted]
Details
November close to december!!!
But you remember that convo or nahhhh... I know you're getting old
Yhea y?? Whats up?
They are still coming back like that. I seem to be the only that remembers this meeting and convo with Christina and the MAs
Yhea i remember that... They are still doing that???? Damn that sucks..
It was one of our complaints that meeting we had. Plus the anoscopes that were not being returned correctly. We even did the change of color tape to help
them avoid confusion..
I know

125. Then in January 2016, MS. YOUNG again reported her fears about patient safety resulting from unclean medical devices with feces-covered rubber bands being inserted into unsuspecting and vulnerable surgery patients to KO when she reported SUDANO's use of the "N" word at work.

126. Neither KO nor STANFORD HEALTH CARE DEFENDANTS took any preventative or protective measures to ensure that the risk to patients stopped. So in May of 2016, an M.A. brought to MS. YOUNG's attention that the hemorrhoid ligators used for hemorrhoid surgery still were being sealed for reuse with the previous feces-encrusted rubber bands ready to be inserted into the next patient with a conscious disregard for the safety of vulnerable patients.

127. Having her concerns twice fall on deaf ears, on May 13, 2016, MS. YOUNG reported her concern about the unclean and unsanitary medical devices being used to insert feces from one patient into another directly to SESHADRI, Vice President of STANFORD HEALTH CARE DEFENDANTS' Cancer Center, a photograph of which is below:

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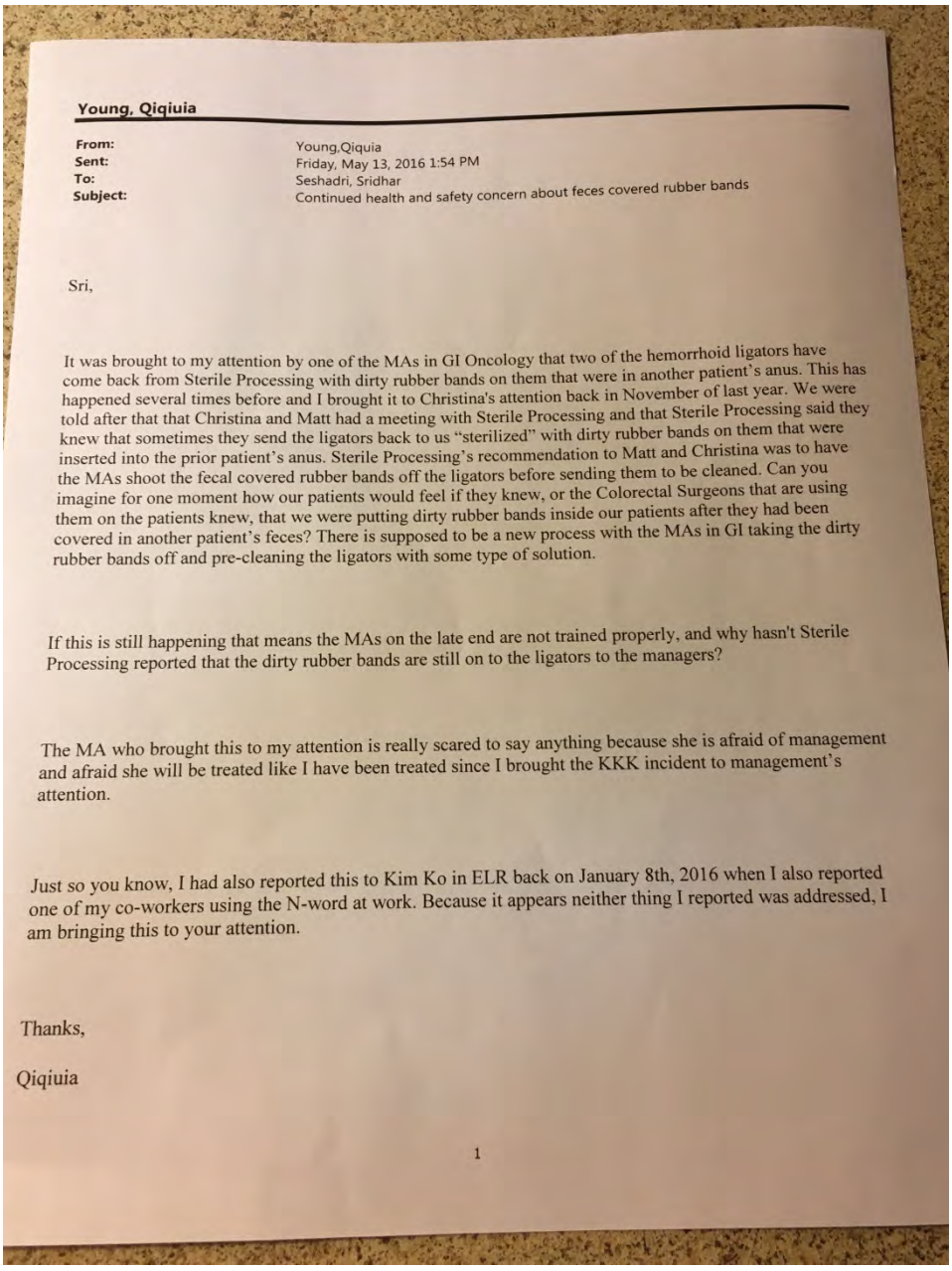

Young, Qiqiuia

From: Young,Qiquia
Sent: Friday, May 13, 2016 1:54 PM
To: Seshadri, Sridhar
Subject: Continued health and safety concern about feces covered rubber bands

Sri,

It was brought to my attention by one of the MAs in GI Oncology that two of the hemorrhoid ligators have come back from Sterile Processing with dirty rubber bands on them that were in another patient's anus. This has happened several times before and I brought it to Christina's attention back in November of last year. We were told after that that Christina and Matt had a meeting with Sterile Processing and that Sterile Processing said they knew that sometimes they send the ligators back to us "sterilized" with dirty rubber bands on them that were inserted into the prior patient's anus. Sterile Processing's recommendation to Matt and Christina was to have the MAs shoot the fecal covered rubber bands off the ligators before sending them to be cleaned. Can you imagine for one moment how our patients would feel if they knew, or the Colorectal Surgeons that are using them on the patients knew, that we were putting dirty rubber bands inside our patients after they had been covered in another patient's feces? There is supposed to be a new process with the MAs in GI taking the dirty rubber bands off and pre-cleaning the ligators with some type of solution.

If this is still happening that means the MAs on the late end are not trained properly, and why hasn't Sterile Processing reported that the dirty rubber bands are still on to the ligators to the managers?

The MA who brought this to my attention is really scared to say anything because she is afraid of management and afraid she will be treated like I have been treated since I brought the KKK incident to management's attention.

Just so you know, I had also reported this to Kim Ko in ELR back on January 8th, 2016 when I also reported one of my co-workers using the N-word at work. Because it appears neither thing I reported was addressed, I am bringing this to your attention.

Thanks,

Qiqiuia

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128. True to form, STANFORD HEALTH CARE DEFENDANTS' response was one of bullying and gaslighting both. First, to intimidate MS. YOUNG, SESHADRI immediately cc'd two of STANFORD HEALTH CARE DEFENDANTS' *employment lawyers* in response to her report of a serious patient safety issue, including the Director of Labor Relations. Next, BURKE denied that there was any problem and called MS. YOUNG a liar, scolding MS. YOUNG, accusing her of "jumping to conclusions," and finally threatened that she needed "to trust management" and "be happy" to keep her job.

129. Finally, the *employment defense lawyer* – whose expertise is presumably defending employment lawsuits and not the best practices for patient safety when it comes to the reuse and sterilization of equipment used in hemorrhoid surgeries – chimed in (unaware that MS. YOUNG was still on the email chain), and proposed a pablum response to be sent from BURKE to MS. YOUNG ostensibly "thanking" her for her report, while denying any problem and accusing MS. YOUNG of having jumped to conclusions.

130. Fortunately, as a result of the deceitfulness of STANFORD HEALTH CARE DEFENDANTS' managing agents, and their persistent campaign of retaliation and retaliatory gaslighting against her, MS. YOUNG had learned to document as much as she possibly could. And so, in response to STANFORD HEALTH CARE DEFENDANTS' attempt to make MS. YOUNG sound like she did not know what she was talking about, MS. YOUNG made a 3 minute and 31 second video documenting that the equipment inserted into patients' anuses was being returned, sealed, with the prior patient's feces-covered rubber bands attached and ready for reuse, which is evidence to be presented at trial.

131. Having her report of the risk of reuse of the feces-covered rubber bands flatly denied, MS. YOUNG reported the patient endangerment issues she had witnessed to the Joint Commission, the standard-setting accreditation agency tasked with ensuring health care organizations' regulatory compliance (and the agency that received and, on information and belief, was successfully duped by STANFORD HEALTH CARE DEFENDANTS with the fraudulent "White Out" documentation of the "Ever Ready" safety checklists used for the crash cart) as well as to the California Department of Public Health. MS. YOUNG's May 18, 2016 report to the Joint Commission is set forth in full in Paragraph 18 of this Complaint.

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K. Canister Of Feces Left Dripping In The Cancer Center Procedure Room During A Wound Care Procedure For An Immune-Compromised Cancer Patient, And Feces Left In The Hazardous Waste Bin In The Cancer Center Procedure Room Overnight.

132. Less than a week later, MS. YOUNG came into work early in the morning and found a canister of feces had been left dripping on the floor overnight in the Cancer Center Procedure Room, where the last immune-compromised cancer patient of the previous day had had a wound care procedure. Moreover, feces had been left overnight in the hazardous waste bin. Management's response to MS. YOUNG's report was again met with scolding and more hollow platitudes about Stanford "healing humanity through science and compassion, one patient at a time." As a result, this time MS. YOUNG reported the patient endangerment directly to the Joint Commission and the California Department of Health. MS. YOUNG's full May 24, 2016 report is set forth in Paragraph 20 of this Complaint along with photographic evidence of the canister of feces left dripping overnight on the Cancer Center Procedure Room floor and in the hazardous waste bin in the Cancer Center Procedure Room set forth in Paragraph 21.

L. The Tenured Stanford Oncologist Makes A Report To Stanford University Then-President John L. Hennessey Describing The Racism Ms. Young Has Been Subjected To And Makes A Plea "That The President's Office Will Ensure … That Qiquia And Other Staff Of Color Will Feel Safe In The Cancer Center."

133. By Summer of 2016, the Cancer Center surgeon had been forced out. On information and belief, the Cancer Center surgeon enlisted a tenured[3] Stanford Oncologist, and person of color, to report, among other things, the ongoing racism, retaliation and harassment directed at MS. YOUNG to DEFENDANT STANFORD UNIVERSITY then-President, John L. Hennessey and then-CEO of DEFENDANT STANFORD HEALTH CARE, Mariann Byerwalter, as well as blatantly racist and sexist comments by cancer

[3] A tenured faculty member like the Oncologist cannot be subject to termination in the same way as other employees, and therefore, was protected from retaliation experienced by the Cancer Center surgeon and, on information and belief, others who were forced to leave after reporting harassment, discrimination, retaliation, and patient endangerment.

surgeon Brendan C. Visser, M.D., DEFENDANT STANFORD HEALTH CARE's Medical Director of Gastrointestinal Cancer Care Program.

134. In an email dated June 14, 2016, with the subject line **"Meeting with President Hennessey,"** the tenured Stanford Oncologist wrote:

> "**President Hennessey**, … At Halloween … **testing technician Natalie [Burazon] took a photo of a medical assistant with a pillowcase pulled over her head, pretending to be a member of the Ku Klux Klan. Natalie showed other staff that photo along with a photo of a patient's disfigured perineum, the area between the genitalia and anus, joking that the KKK was going to do the same thing to Qiquia [MS. YOUNG], an African-American/Cherokee medical assistant**. **Subsequently, a staff member addressed Qiquia with the N-word**. In addition, **a male Associate Professor of Surgery [Brendan C. Visser, M.D.] once entered a work room where several staff were eating lunch together, and asked, *"What do you people eat anyway? Bushmeat?"*** He is also notorious for inappropriate sexist jokes. … Our goal is that the **President's office will ensure … that Qiquia and other staff of color will feel safe in the Cancer Center**."

135. Following his report to President Hennessey, the tenured Stanford Oncologist wrote an email dated June 18, 2016, with the subject line "Protecting the vulnerable." In this email, he wrote:

> **"At President Hennessy's request, I sent my statement to Mariann Byerwalter, CEO of Stanford Health Care and emerita member of the Stanford Board of Trustees. The fall-out from our meeting will percolate back to Cancer Center administrators.** The natural response of Cancer Center administrators will be to "look further into the matter". **Those of us who depend on resources and employment at the Cancer**

Center will be vulnerable, but *the most vulnerable will be QiQuia Young …*"

136. Identification of MS. YOUNG as "the most vulnerable" to retaliation following the report of racism, retaliation, and intimidation to STANFORD HEALTH CARE DEFENDANTS' managing agents' was prescient: much like their liability-dodging "solution" with the emergency crash cart, their "solution" to the racism, retaliation, and intimidation MS. YOUNG experienced in the Cancer Center, and to the patient safety issues she witnessed and reported there, was to remove her from the Cancer Center and instead place her in a remote location, as the sole experienced person in the Pelvic Floor Clinic, and drastically reduce her hours such that she could barely make ends meet.

M. Stanford Health Care Defendants Retaliate By Trumping Up False Accusations Against Ms. Young And Wrongfully Disciplining Her, Moving Her Out Of The Cancer Center To A Remote, Unprepared Location, And Trumping Up A Fraudulent Job Requisition For Ms. Young's Position To Increase The Education Requirements In An Attempt To Oust Ms. Young From Her Job.

137. In response to MS. YOUNG's reports to the Joint Commission and the California Department of Public Health, as well as the tenured Stanford Oncologist's report on MS. YOUNG's behalf to STANFORD HEALTH CARE DEFENDANTS' managing agents, STANFORD HEALTH CARE DEFENDANTS doubled down on their retaliatory harassment of MS. YOUNG, which included physical intimidation and harassment by management, and false and defamatory accusations for which STANFORD HEALTH CARE DEFENDANTS issued a disciplinary write up to MS. YOUNG, the only discipline she had ever received in her entire career. (The patent falsity of this write up was made apparent by MS. YOUNG's annual performance review a month later, which was excellent.)

138. After being blindsided by a harassing meeting with Human Resources and Management, on Friday, April 8, 2016, MS. YOUNG's supervisor, Christina Guijarro ("GUIJARRO"), demanded that MS. YOUNG call a phone number to talk with someone she had never heard of and further refused to inform MS. YOUNG of why she was to make the

call. MS. YOUNG's stomach was in knots, so she repeatedly asked GUIJARRO and GUIJARRO'S manager, Matthew Burke ("BURKE") to tell her what the call was going to be about. Neither GUIJARRO nor BURKE responded to MS. YOUNG's requests. Having been recently blindsided and wrongly accused by Human Resources, MS. YOUNG told GUIJARRO and BURKE that she would not be calling the number if they did not let her know what the call was in regards to.

139. Instead of speaking with MS. YOUNG and assuaging her concerns, GUIJARRO attacked and assaulted MS. YOUNG in anger in front of other employees, lunging at her and standing menacingly over MS. YOUNG, who was seated. MS. YOUNG felt that GUIJARRO wanted to hit her, and because she could not, she was doing what she could to physically intimidate MS. YOUNG.

140. The following Monday, April 11, 2016, MS. YOUNG reported the assault by her supervisor, GUIJARRO, by sending to Kimberly Ko ("KO") of Human Resources an email with the subject line: "Complaint About Christina's Open Hostility and Threatening Behavior."

141. Eleven days passed, and KO never even acknowledged receiving MS. YOUNG's complaint of GUIJARRO's hostility and threatening behavior.

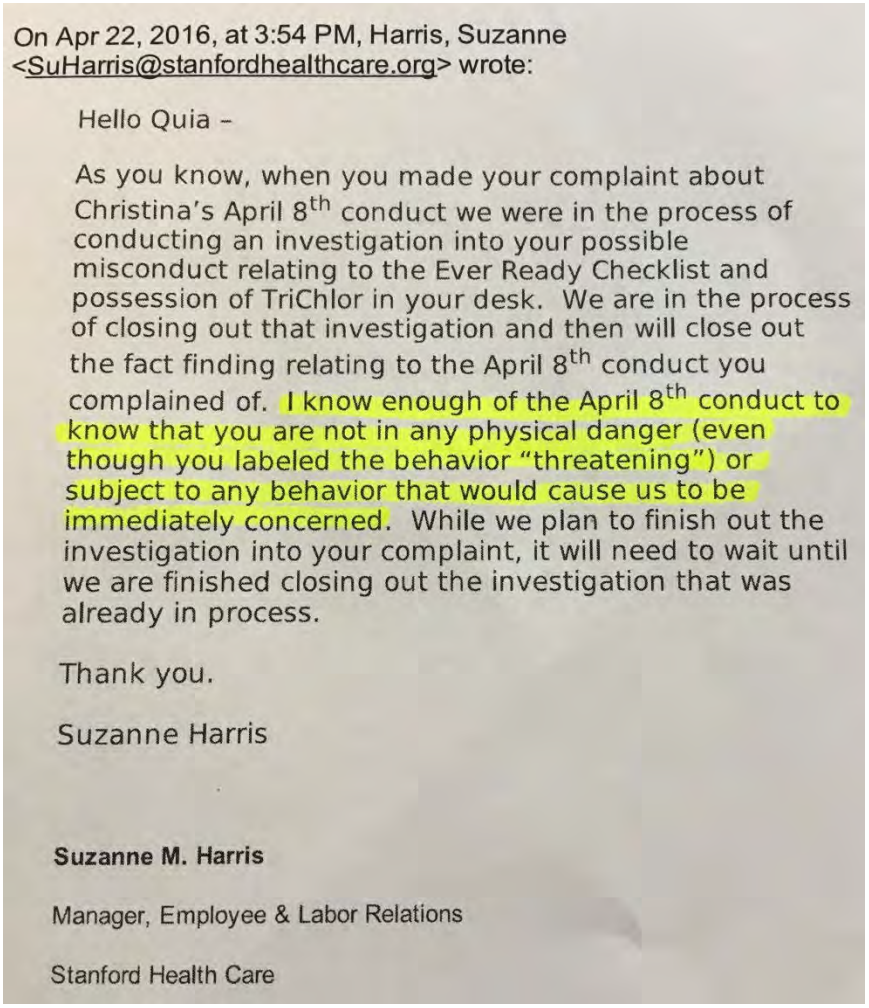
142. On Friday, April 22, 2016, MS. YOUNG sent a follow-up email to KO, stating, "Can you please tell me what the status is on the investigation into my complaints of harassment and retaliation by [GUIJARRO]? It's been two work weeks since I brought these issues to your attention (again), and I have heard nothing."

143. In (non)response to MS. YOUNG's inquiries, on Friday afternoon, April 22, 2016, KO escalated the issue by copying her manager, Suzanne M. Harris ("HARRIS"), Manager of Employee and Labor Relations for Stanford Health Care on the emails.

144. In response, HARRIS – the Director of Employee and Labor Relations – and someone who MS. YOUNG had no prior contact with – sent an email dismissing MS. YOUNG's report of GUIJARRO'S threatening behavior out of hand as nothing she was

concerned about, and in true bully-fashion, further informs MS. YOUNG that *she* – MS. YOUNG – is under investigation!

145. Below is a photograph of HARRIS's introductory bullying email to MS. YOUNG:



On Apr 22, 2016, at 3:54 PM, Harris, Suzanne <SuHarris@stanfordhealthcare.org> wrote:

Hello Quia –

As you know, when you made your complaint about Christina's April 8th conduct we were in the process of conducting an investigation into your possible misconduct relating to the Ever Ready Checklist and possession of TriChlor in your desk. We are in the process of closing out that investigation and then will close out the fact finding relating to the April 8th conduct you complained of. I know enough of the April 8th conduct to know that you are not in any physical danger (even though you labeled the behavior "threatening") or subject to any behavior that would cause us to be immediately concerned. While we plan to finish out the investigation into your complaint, it will need to wait until we are finished closing out the investigation that was already in process.

Thank you.

Suzanne Harris

Suzanne M. Harris

Manager, Employee & Labor Relations

Stanford Health Care

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146. In response to receiving this bulling introduction from the Director of Employee and Labor Relations, whom she had never met or had any prior contact, MS. YOUNG replied:

"Hi Suzanne,

Your email [] is an awkward introduction, to say the least.

Setting aside for a minute your insulting and cavalier attitude regarding my report of [GUIJARRO]'s threatening behavior, can someone please tell me why there is an investigation opened about me for "possible misconduct relating to the Ever Ready Checklist and Possession of TriChlor at my desk"? Can someone please tell me what I am being accused of doing wrong? And please tell me what I am doing differently than the other people who were trained to do the Ever Ready Checklist by the same people who trained me? …

Which leads me to the other thing everyone seems to be ignoring, which is that [GUIJARRO] (and pretty much everyone else) has seen me filling out the Ever Ready Checklist all this time, and they have seen me do it more times than I can count. I have never hidden the way I do it – why would I? I was trained to do it this way –
and not [GUIJARRO] or anyone else has ever once said anything to me about the way that I do it. So why is it suddenly an issue now …?

I'll tell you why it's suddenly an issue now – because **Stanford is looking to trump up a reason to fire me in retaliation for me complaining about racism and retaliation at Stanford**, including the way management has been singling me out and harassing me, and for me complaining about [GUIJARRO]'s friend Eduardo

using the N-word at work. …

And I don't know what you base your cavalier and insensitive statement on that "you are not in physical danger … or subject to any behavior that would cause us to be immediately concerned." You weren't there when [GUIJARRO] came at me. Has anyone talked to any of the people who witnessed it? I have a co-worker who doesn't want to be named (because she is afraid of what will happen if she comes forward and doesn't want to be treated like I am being treated at work), who told me that [GUIJARRO]'s cousin that works in the Cancer Center has admitted that both [GUIJARRO]'s husband and her husband were gang members. So while you, who have the luxury of working behind a locked door, may not feel like [GUIJARRO]'S actions are threatening to me, I sure do. She has access to my home address and now her family is making it known in the Cancer Center that her husband was a Norteño. No one should be treated like this at work, and talk of gang membership should never happen in the workplace. (I can't even believe that I have to explain why you need to take my concerns seriously.) But I am really glad I asked on Friday about the status of my complaint about [GUIJARRO]'s hostile and threatening behavior toward me, so at least now I know you have not taken my complaint seriously, and I'm really glad I asked so that I now know I have been "under investigation" for "possible misconduct."

I hope this makes clear that there was, and is, no "possible misconduct" on my part (and anyone who was trained by prior management can vouch for that), and that your attention should be placed where it belongs – in making sure that everyone (not just me) feels safe at work and that management's retaliation and mistreatment of me stops.

Thanks,

Qiqiuia"

147. No one ever responded to MS. YOUNG's complaints of hostility and threatening behavior by GUIJARRO.

148. Instead the following day, MS. YOUNG was written up based on false accusations. As if to underscore the retaliatory nature of the write-up, the write up itself even referenced GUIJARRO's openly threatening and harassing behavior toward MS. YOUNG!

149. On May 3, 2016, MS. YOUNG sent an email to HARRIS stating, among other things,

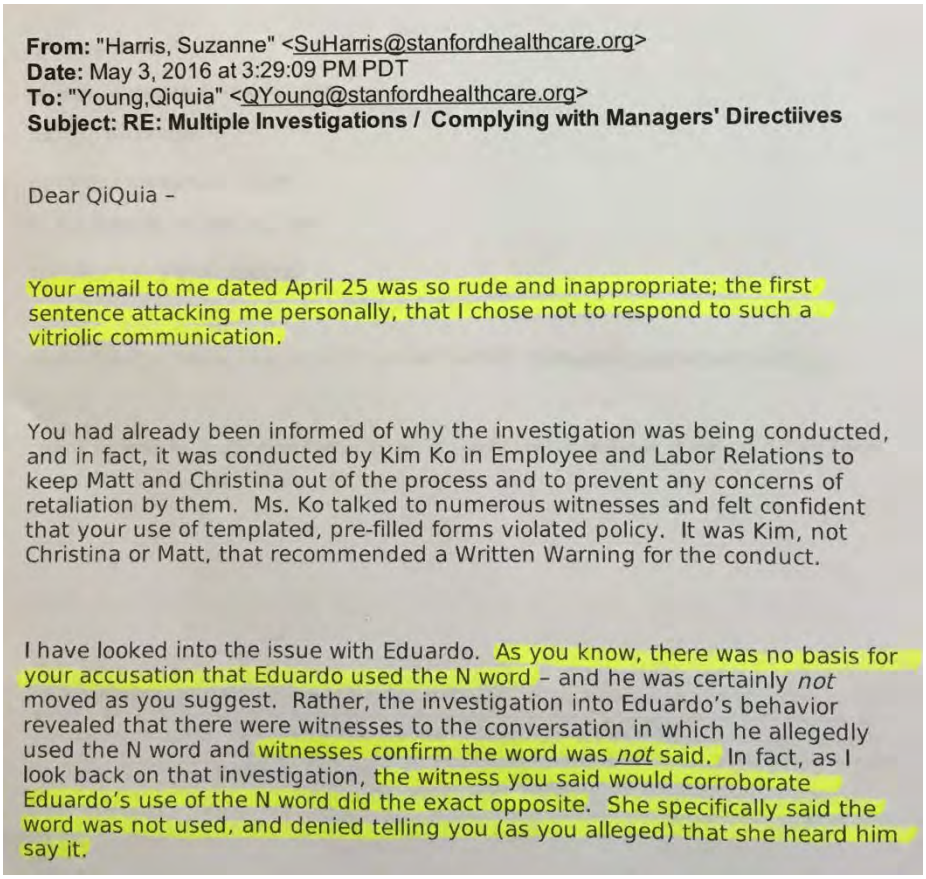
"Hi Suzanne,

When you did not respond to my April 24th email I assumed you understood my explanation of how I came to do the Ever Ready Checklist and have the TriChlor. So

you can imagine how surprised I was when the very next day I was called into a meeting with [GUIJARRO] and [BURKE] who issued a written warning to me. (And imagine how surprised I was when the day after that I was told that [GUIJARRO] gave TriChlor to the Medical Assistants.) …"

150. In furtherance of STANFORD HEALTH CARE DEFENDANTS' agenda of racism, retaliation, and oppression, later that day, HARRIS – STANFORD HEALTH CARE's *Director of Employee and Labor Relations* – bullied MS. YOUNG for having had the ***audacity*** to stand up for herself as a Black woman, and essentially called MS. YOUNG a liar.

151. A photograph of a portion of STANFORD HEALTH CARE's Director of Employee and Labor Relations HARRIS' bullying response to MS. YOUNG is below:



From: "Harris, Suzanne" <SuHarris@stanfordhealthcare.org>
Date: May 3, 2016 at 3:29:09 PM PDT
To: "Young,Qiquia" <QYoung@stanfordhealthcare.org>
Subject: RE: Multiple Investigations / Complying with Managers' Directiives

Dear QiQuia –

Your email to me dated April 25 was so rude and inappropriate; the first sentence attacking me personally, that I chose not to respond to such a vitriolic communication.

You had already been informed of why the investigation was being conducted, and in fact, it was conducted by Kim Ko in Employee and Labor Relations to keep Matt and Christina out of the process and to prevent any concerns of retaliation by them. Ms. Ko talked to numerous witnesses and felt confident that your use of templated, pre-filled forms violated policy. It was Kim, not Christina or Matt, that recommended a Written Warning for the conduct.

I have looked into the issue with Eduardo. As you know, there was no basis for your accusation that Eduardo used the N word – and he was certainly *not* moved as you suggest. Rather, the investigation into Eduardo's behavior revealed that there were witnesses to the conversation in which he allegedly used the N word and witnesses confirm the word was *not* said. In fact, as I look back on that investigation, the witness you said would corroborate Eduardo's use of the N word did the exact opposite. She specifically said the word was not used, and denied telling you (as you alleged) that she heard him say it.

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152. Shortly thereafter, STANFORD HEALTH CARE DEFENDANTS made the retaliatory decision to move the entire Pelvic Floor Clinic out of the Cancer Center and to a remote, unplanned and unprepared location. And significantly, MS. YOUNG was the only member of the Pelvic Floor Clinic who was made to move.

153. Rather than simply moving MS. YOUNG to the new, unbuilt, unfurnished, unplanned location, to work without trained staff, STANFORD HEALTH CARE DEFENDANTS concocted yet another poorly executed ruse – this time in the form of requiring MS. YOUNG to reapply for her job, and significantly enhancing her position's educational requirements such that she would no longer be qualified for it.

154. When MS. YOUNG realized what was happening, she brought the new, fraudulently drafted job requisition to the Cancer Center Director, BAILEY's replacement, Patricia Falconer ("FALCONER") who had no explanation for why MS. YOUNG might suddenly find herself unqualified for her job (simply because it was moved to a new building). On Mother's Day weekend 2016, MS. YOUNG was terrified that she was on the verge of losing her job due to STANFORD HEALTH CARE DEFENDANTS' chicanery. So MS. YOUNG asked FALCONER for reassurance that reapplying for her job – with the suddenly and dramatically enhanced educational requirements she did not possess – was just a formality. But rather than reassuring her, FALCONER and SESHARDI took the opportunity to scold MS. YOUNG and warn her that she needed to behave in order to have a chance of keeping her job, and to add insult to injury, ending the email wishing MS. YOUNG an enjoyable Mother's Day!

155. The jig was up, however, when MS. YOUNG met with Manager Freida Acu, the person FALCONER had said was responsible for creating the enhanced educational requirements for MS. YOUNG's position. In asking Manager Freida Acu why the Patient Testing Technician III position now required a college degree when it never had before, Ms. Acu said that she had no idea. She clarified that not only was she not the person who had drafted the job requisition, she saw no need for MS. YOUNG to reapply for her job simply because it was moving buildings. In fact, Ms. Acu informed MS. YOUNG that she

had specifically told Manager BURKE that there was no need for MS. YOUNG to reapply for her job at all; that all he needed to do was let Human Resources know she was in a new building location!

156. Indeed, the clearest evidence of STANFORD HEALTH CARE DEFENDANTS' blatant and outrageous attempt to trump up an excuse to "disqualify" MS. YOUNG from her position (following the retaliatory decision to oust her from the Cancer Center) is the fact that, after being told she had to reapply for her position with the newly enhanced educational requirements enhanced beyond that which she possessed, Ms. Acu never had her reapply for the position at all.

N. Stanford Health Care Defendants Continued To Fraudulently Bill Patients And Their Insurance, Including Medical Patients, For Pelvic Floor Testing With A Physician Present, Although No Physician Was Present For Testing After The Cancer Center Surgeon Was Forced Out.

157. As the Pelvic Floor Clinic's Patient Testing Coordinator III, MS. YOUNG operates the testing machine used during patient pelvic floor testing. This is the position she fought so hard to be promoted to in 2015, and she is the only person qualified to operate the complicated testing machinery.

158. After the departure of the Cancer Center surgeon, MS. YOUNG witnessed that no physician was present for patient testing in the Pelvic Floor Clinic. Nevertheless, on information and belief, STANFORD HEALTH CARE DEFENDANTS continued to fraudulently bill patients and their insurance, including low-income patients being treated under MediCal, as if a physician had been present for the Pelvic Floor Clinic testing, when none was there.

159. Moreover, on information and belief, STANFORD HEALTH CARE DEFENDANTS' CEO David Entwistle, COO Quinn McKenna, and CFO Linda Hoff refused to approve a budget that would allow new staff assigned to the Pelvic Floor Clinic to be trained or to have even a proper hospital bed for Pelvic Floor Clinic testing. One of the results of this was that patients suffered and were continually endangered.

O. <u>Stanford Health Care Defendants Are Ironically Recognized As A "Premier Hospital" Just Two Weeks Before Medical Negligence Causes A Protective Balloon To Explode In A Patient's Rectum, Leaving A Pointed Metal Guidewire In His Anus Putting Him At Risk For A Perforated Colon.</u>

160. On August 2, 2016, STANFORD HEALTH CARE DEFENDANTS issued a Press Release claiming "Stanford Health Care's renowned Stanford Hospital has again been recognized as one of the nation's premier hospitals …"

161. Just over two weeks later, on August 18, 2016, during anal testing in STANFORD HEALTH CARE DEFENDANTS' Pelvic Floor Clinic, the protective balloon on the end of a pointed metal guidewire was negligently pumped full of air by the untrained nurse practitioner until the protective balloon exploded in the patient's anus! Not only did the patient have to push the ruptured balloon out of his anus, but MS. YOUNG had to sift through the patient's feces to ensure that all pieces of the balloon had come out and were accounted for. And most significantly, the balloon provided protection for the patient from the pointed end of the metal guide wire, so when the balloon exploded, the exposed pointed end of the metal guidewire put the patient at high risk of having his colon perforated, which could cause infection, require surgery, or even result in the patient needing a colostomy bag!

P. <u>Ms. Young Reports The Exploding Protective Balloon And Resulting Patient Risk Of Rectal Perforation And No One Inquires Further, Or Provides Training, But Instead Simply Voices Concern Regarding "Legal Liability."</u>

162. In her report of the negligent testing MS. YOUNG witnessed, the nurse practitioner blamed "equipment failure," which was not at all the case. MS. YOUNG had seen exactly what had gone wrong, how the nurse practitioner pumped too much air into the balloon, and yet no one ever asked MS. YOUNG what she had witnessed. And, indeed, even the nurse practitioner admitted that her lack of training was at issue by reporting in an email about the accident resulting in the pointed metal guidewire exposing the patient to risk of colon perforation, stating: "Re: further training – Martha is working on getting the trainer out to us." The nurse practitioner further stated: **"[a]side from patient safety, legal liability would be significant if someone got hurt : o".** (emoji in the original)

163. In response to the nurse continuing to blame her own negligence on "equipment failure," the following week MS. YOUNG wrote to STANFORD HEALTH CARE DEFENDANTS' management in an attempt to tactfully set the record straight: "I agree the patients need to be safe and have been very concerned about this incident and would like to make sure nothing like this ever happens again. I have never heard of a balloon coming off before and this is the first time I have ever seen one of them burst. Please let me know when you would like to talk about what happened so that we can do everything possible to avoid having a repeat."

164. No one ever followed up with MS. YOUNG, the only properly trained person in the Pelvic Floor Clinic, to ensure no other patients would be similarly put at risk of colon perforation. And no training was approved by STANFORD HEALTH CARE DEFENDANTS' CEO David Entwistle, COO Quinn McKenna, and CFO Linda Hoff.

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Q. Ms. Young's New Co-Workers Listen To Music Using The "N" Word In Open Work Spaces, And Twist Song Lyrics To Include The "N" Word In Ms. Young's Presence, Singing "Bitches Ain't Shit But Niggas And Hoes."

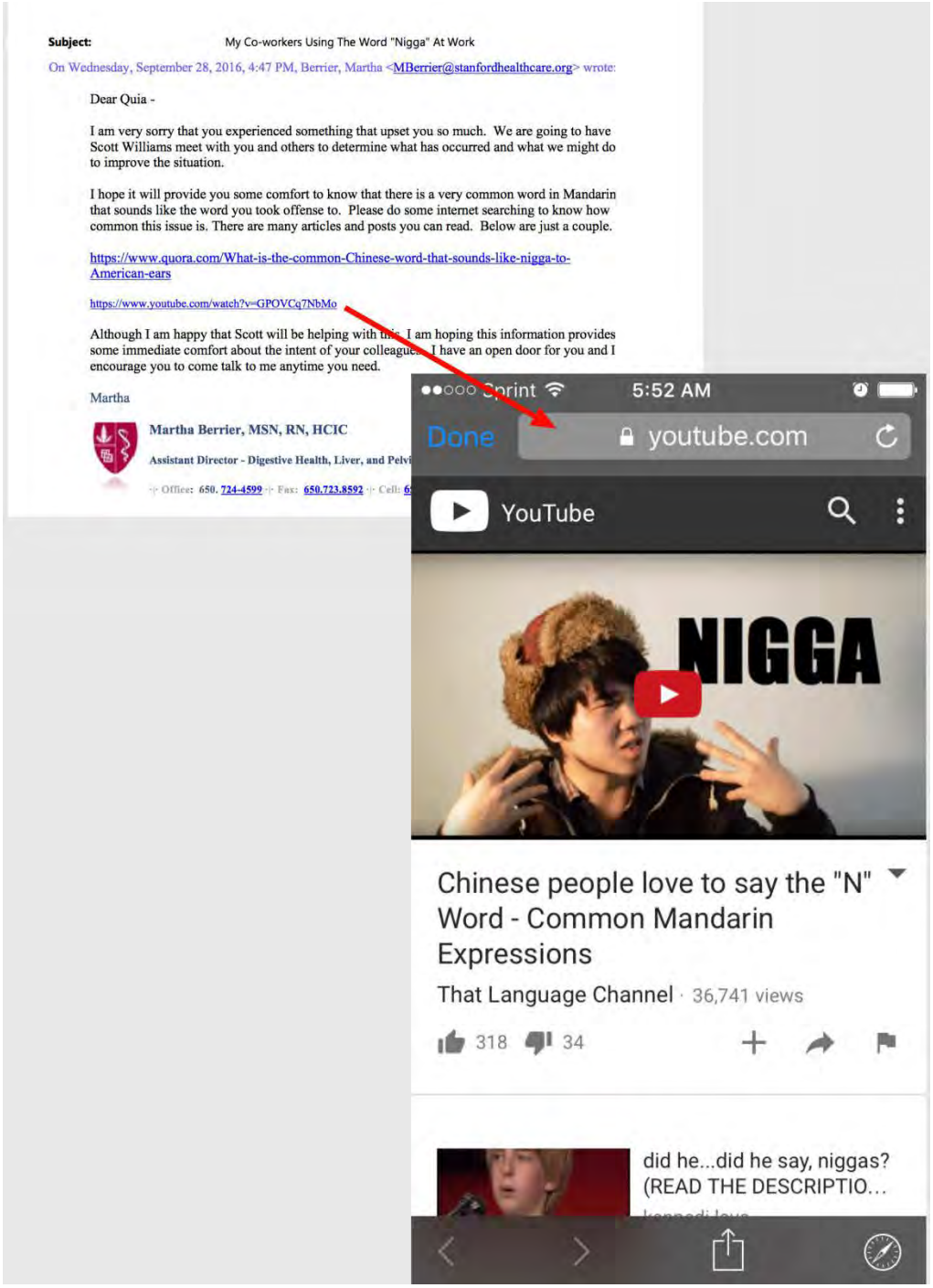
165. Shortly thereafter, MS. YOUNG walked into a workspace where her co-workers were listening to an explicit song on Pandora that was using the "N" word. MS. YOUNG was shocked and offended, and discretely reported it to management. Nothing was done about it, and instead the behavior escalated and employees began singing using the "N" word openly in the workplace, twisting lyrics to include the "N" word. For example, one of MS. YOUNG's co-workers sang the Dr. Dre song "Bitches Ain't Shit" aloud to MS. YOUNG, and changed the lyrics to include the "N" word, singing: "**Bitches ain't shit but niggas and hoes."** (The actual lyrics are "Bitches ain't shit but hoes and tricks," which does not include the "N" word.)

R. Ms. Young's *Non-Chinese Speaking* Co-Worker Pretends To Mock Someone Speaking Mandarin, Repeating The Word "Niga" While Looking At Ms. Young, And In Response To Ms. Young's Report To Management, Management Gaslights Her, And Sends Highly Offensive Videos And A Link To An Article Entitled "What Is The Common Chinese Word That Sounds Like "Nigga" (To American Ears)?"

166. At the same time, one of the same employees began "imitating" people speaking Mandarin when MS. YOUNG walked in the room, repeating the word "niga, niga, niga." In tears, MS. YOUNG reported this, too, to management. And again her complaint fell on deaf ears. Instead of investigating, issuing appropriate discipline, and resolving the issue, MS. YOUNG again was made to feel she had done something wrong for complaining, and that she somehow "misunderstood" what she was complaining about. In short, management continued its campaign of gaslighting and wanted MS. YOUNG to believe she had merely overheard someone (who does not speak Chinese) speaking Mandarin. And, incredibly, MS. YOUNG's manager responded by sending her an email with a link to an article entitled "What is the common Chinese word that sounds like "nigga" (to American ears)?" and included two highly offensive videos repeating the "N" word *ad nauseum* and

mocking Black women.

167. *See* email below from MS. YOUNG'S manager, Martha Berrier ("BERRIER") and a screen shot of the first video BERRIER sent to MS. YOUNG, below, which has been removed from You Tube for its content:



168. The second of the highly offensive videos BERRIER sent to MS. YOUNG, in which the "N" word is said repeatedly is of comedian Russell Peters, replete with racist stereotypes, and in which he describes going to Kentucky Fried Chicken in China, stating "I'm at KFC in Beijing … And standing in line in front of me … is a Black woman … the only Black woman in China, and she found the chicken …" and then he goes on to repeat the "N" word under the guise of mocking someone speaking Mandarin! https://www.youtube.com/watch?v=BrsWp07BwVk.

169. When MS. YOUNG reported that BERRIER's response to her report of use of the "N" word at work was even *more* offensive than what she had initially reported, her complaint fell on totally deaf ears. No one investigated or responded to MS. YOUNG *at all*.

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S. Ms. Young's Reports A Co-Worker Saying "Go Pray In Your Own Fucking Country!" To A Muslim Patient Praying In The Waiting Room.

170. In early November of 2016, Ms. Young heard a co-worker had seen a Muslim patient praying while in the STANFORD HEALTH CARE DEFENDANTS' waiting room, and said "Go pray in your own fucking country!" Ms. Young was horrified by the hatred behind the Islamophobic statement made in what is supposed to be a place of healing. Moreover, the Islamophobic statement by her co-worker was particularly chilling and offensive to MS. YOUNG as her husband is Muslim.

171. MS. YOUNG immediately reported the hate comment to management. Still, no mandatory anti-harassment training occurred, and instead she was subjected to retaliation by the supervisor of the employees she had reported for using the "N" word and the Islamophobic hate comment in the workplace.

T. In Retaliation For Reporting Her Co-Workers' Use Of The "N" Word And The Islamophobic Hate Speech Directed At A Muslim Patient, Their Supervisor Begins A Campaign Of Assault And Battery Directed At Ms. Young.

172. In response to MS. YOUNG's reports of employees repeatedly saying the "N" word in her presence and making the Islamophobic hate statement to a Muslim patient, two of the employees promptly were made "Employee of the Month." Moreover, those employees' supervisor, DEFENDANT FLORES, began a campaign of assault and battery against MS. YOUNG, aggressively running into MS. YOUNG in the hallway, shoving furniture into her, leering at her, and once even on the weekend, following her into a store in New Park Mall in Newark, when MS. YOUNG was vulnerable, alone with her toddler.

173. MS. YOUNG repeatedly reported the assault and battery and openly hostile work environment DEFENDANT FLORES was creating in retaliation for MS. YOUNG reporting DEFENDANT FLORES' employees using the "N" word and Islamophobic hate speech at work. MS. YOUNG gave management the names of those who witnessed DEFENDANT FLORES' repeated assaults, including an employee who asked MS. YOUNG, "Why does [DEFENDANT FLORES] look like she wants to slap the shit out of

you?" No one spoke to MS. YOUNG's witnesses, and DEFENDANT FLORES' retaliatory assault and battery of MS. YOUNG continued.

174. Incredibly, instead of conducting an investigation, MS. YOUNG's manager conducted MS. YOUNG's performance review, and used her performance review as an opportunity to counsel MS. YOUNG about her report of DEFENDANT FLORES' assault and battery, and to castigate her for not resolving DEFENDANT FLORES' retaliatory harassment by herself.

U. Ms. Young Reports Incompetent Stanford Health Care Staff Accidentally Inserting An Anal Catheter Into An African-American Patient's Vagina, And Further Blaming The Negligence On The Darkness Of The Patient's Skin.

175. Additionally, MS. YOUNG was forced to continue to stand by and witness the gross incompetence and racism of her new co-workers in the Pelvic Floor Clinic and its effect on patients. For example, on November 18, 2016, MS. YOUNG reported that the nurse practitioner she worked with "accidentally tried to insert a catheter in a Black patient's vagina instead of her rectum. [She], as the nurse, didn't notice her mistake, but the patient sure did and said, "Aren't you supposed to be going in my back side and not my 'kitty cat'"? In response, [she] said, "Oh, I'm sorry. I can't see – it's dark down there." I was totally stunned when she blamed her mistake on the color of our patient's skin. All this happened in front of me and the patient's husband. Please talk to me about who the patient was because I would like for someone to call and apologize to her – not just for the error, but for the comment about her being too "dark down there" for [the nurse] to be able to see. It's totally outrageous that our patients of color should be treated and spoken to this way."

176. In response, all MS. YOUNG's supervisor said in her initial reply was: 'Qiqiuia, Thanks for letting us know."

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V. Less Than Six Months Later Another Stanford Health Care Staff Member Actually Completes Painful Pelvic Floor Testing On A Patient's Vagina, Not Her Rectum, And Despite Ms. Young's Repeated Reports Of The Same, Nothing Is Done.

177. The last Friday in April of 2017, a different nurse of STANFORD HEALTH CARE DEFENDANTS accidentally inserted the anal catheter in a patient's vagina and completed the painful testing on her vagina instead of her rectum.

178. As management clearly had been ineffective in responding to MS. YOUNG's prior warning, this time MS. YOUNG made a report directly to Dr. Natalie Kirilcuk, the colorectal surgeon in the Gastrointestinal Cancer Program who had replaced the Cancer Center surgeon STANFORD HEALTH CARE DEFENDANTS had forced out the previous year.

179. Specifically, MS. YOUNG reported in an email with the subject line **"Anorectal Manometery Testing on Stanford Patient's Vagina, Not Rectum":**

> "Hi Dr. Kirilcuk,
>
> On Friday 4-28-17, we tested a patient who you referred to the Pelvic Floor Clinic in Redwood City for Anorectal Manometry and the testing went horribly wrong when the nurse conducted the testing on the patient's vagina- not her rectum.
>
> The anal sphincter electromyography (EMG) went well. However, during the Anorectal Manometry, when the air started being pushed into the patient for the RAIR, the patient started shouting out "Aww! Aww! Aww!" At that point, before we checked for the sensations, I checked the position of the catheter to see what could be causing the pain, and realized that the nurse placed the catheter in the patient's vagina instead of her rectum.
>
> As soon as I realized this I asked the nurse to stop what she was doing and come over to see the catheter.

It took a while for the nurse to realize her error- she didn't see it on her own, I had to point it out to her that she had placed the catheter in the patient's vagina and not the patient's rectum.

The nurse asked the patient if she was having any pain and the patient said yes, she was having cramping in her lower abdomen. The nurse apologized, told the patient that she accidentally inserted the catheter into her vagina and not her rectum.

The nurse had me prepare a new catheter and then proceeded to do the Anorectal Manometry again, this time inside the patient's rectum.

I explained to the nurse that she should put in a SAFE report but I'm not sure how accurate it is or what is being done about the patient. The nurse told me today that she thinks she hit the patient's cervix because she had pumped 60 cc of air into her vagina.

If you want to talk I can let you know who the patient is so you can follow up with her. The whole thing made me sick to my stomach and I've been worried about the patient all weekend."

180. Dr. Kirilcuk did not respond to MS. YOUNG's report of gross negligence and patient endangerment. So at the end of the week, MS. YOUNG wrote to Dr. Kirilcuk again to make sure she had received MS. YOUNG's email about the patient who had had testing done accidentally in her vagina.

181. On May 5, 2017, MS. YOUNG sent Dr. Kirilcuk an reply email with the subject line: "RE: Anorectal Manometry Testing on Stanford Patient's Vagina, Not Rectum" stating:

"Hi Dr. Kirilcuk,

Would you mind letting me know if anyone has spoken to the patient from last Friday? I know last Friday was an awful day, but I keep thinking about our patient and I'm worried and I hope she's ok, and want to make sure she's not forgotten about as a result of Friday's terrible

tragedy. If you would let me know that someone has reached out to her and has made sure she's ok, I'd really appreciate it.

Also, I wanted to make you aware that yesterday one of the patients who I had talked to [my supervisor] about last week – a patient who [my supervisor] was supposed to have [the nurse practitioner] reschedule based on your note from your examination- was bleeding when [my supervisor] did his rectal exam yesterday. I think the procedure was not completed because the patient was in so much pain.

Dr. Kirilcuk, I'm very worried about the treatment our patients are getting and the fact that nobody working in the Pelvic Floor Clinic seems to know what they are doing. Just today, we had a patient with both internal and external hemorrhoids who was so scared, and I had to direct [the nurse practitioner] on which way she should go with the catheter to avoid the external hemorrhoid. I helped the patient calm down by breathing with her to relax the anal muscles and had her squeeze my hands while [the nurse practitioner] inserted the catheter. And the end, [the nurse practitioner] told me that without me, she or the patient wouldn't have made it through the testing. I am very worried about how our patients are being treated when I am excluded from the testing, and I really don't understand why no one seems to be getting training. It's been almost a year now.

I would really like to talk to you about what I am seeing happen to our patients, would you please let me know when you have time?"

182. Dr. Kirilcuk never responded to either of MS. YOUNG's emails. Instead, Dr. Kirilcuk issued a letter to the patient who had had the painful testing completed erroneously in her vagina falsely stating that there had been "no untoward events" during the testing.

183. Upon seeing that her serious concerns about patient endangerment were being

ignored and covered up by Dr. Kirilcuk as the surgeon heading the Pelvic Floor Clinic, MS. YOUNG then contacted the tenured Stanford Oncologist who had made the reports on her behalf the previous year.

184. On May 17, 2017, MS. YOUNG sent the tenured Stanford Oncologist an email with the subject line "FW: Anorectal Manometry Testing on Stanford Patient's Vagina, Not Rectum" and forwarded the two emails to Dr. Kirilcuk to him, stating:

> "Hi Dr. ____,
>
> I sent this email to Kr. Kirilcuk a couple of weeks ago, but didn't hear back from her. I was worried about the patient, so I followed up with Dr. Kirilcuk, but she still didn't respond. Then last Friday I seen that the result letter for the patient said that there were no untoward events. I'm really worried about how our patients are being treated in the Pelvic Floor Clinic and no one seems to be doing anything about it. It's been almost a year and still no one is getting proper training. I don't know if there is anything you can do about this Dr. ____, but I thought I would at least try ..."

185. No one ever responded to MS. YOUNG's pleas to protect STANFORD HEALTH CARE DEFENDANTS' patients or to provide training.

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W. Stanford Health Care Defendants' Policy and Practice of Honoring Its Patients' Racial Prejudices Subjects Ms. Young To Open Racial Hostility From Multiple Patients.

186. STANFORD HEALTH CARE DEFENDANTS have adopted as a matter of policy and practice, the honoring of its patients' racial preferences to exclude care and treatment by technicians, faculty, staff, and students of color. As a result, STANFORD HEALTH CARE DEFENDANTS have allowed and empowered its patients to discriminate against and harass MS. YOUNG in her workplace.

187. The week of June 19, 2017, not one, but *three* patients of the Pelvic Floor Clinic expressed open and overt racial hostility toward MS. YOUNG, or anyone of her race (African-American) participating in their care. This racial discrimination and bigotry was expressed in the presence of the Pelvic Floor Clinic's nurse practitioner. MS. YOUNG was offended and demoralized by the racial hostility directed at her by STANFORD HEALTH CARE DEFENDANTS' patients. However, because she was aware of STANFORD HEALTH CARE DEFENDANTS' policy and practice of honoring patients' racial prejudices, MS. YOUNG felt she had no recourse but to back up, fade into the background, and remove herself from the patients' line of sight. Even the nurse practitioner – who was angered by witnessing the patients' race-based hostility directed at MS. YOUNG – initially told MS. YOUNG that she would make a complaint to management on MS. YOUNG's behalf, but was then silenced by the realization of the strong policy of STANFORD HEALTH CARE DEFENDANTS to comply with the racial prejudices of patients despite the hostile work environment and discriminatory workplace it creates for technicians, faculty, staff, and students of various races.

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X. With No Response to Ms. Young's Expressed Concerns About Patient Safety and The Lack of Training of Medical Staff, The Following Month More Painful Anal Testing Is Conducted In The Dark and a Colorectal Cancer Patient Undergoing Chemotherapy is Left Screaming and Leaving a Trail of Blood in the Pelvic Floor Testing Room.

188. On Friday, June 23, 2017, although patients were scheduled for Pelvic Floor Testing, the lights in the Pelvic Floor Testing Room lights were not working – *i.e.*, the lights were ***out***. But instead of rescheduling the painful anal testing for patients, over Ms. Young's objection and expressed concern for patient safety, Ms. Young was forced to participate in conducting the painful anal testing on patients ***in the dark***!

189. Later that day, a patient who was going through chemotherapy as a result of Colorectal cancer was subjected to painful anal testing. MS. YOUNG witnessed that instead of informing the patient of all the risks associated with the anal testing, the patient ***only*** was advised that there was a "low risk" of the protective balloon irritating the lining of the patient's rectum. At this point, the patient advised the nurse that the patient had to stop using the prescribed enemas because it was causing anal bleeding, and that the patient had notified STANFORD HEALTH CARE DEFENDANTS' medical staff of the same, but no one had responded.

190. At this point, the nurse told MS. YOUNG that she was nervous about testing the patient and she was not sure why Dr. Kirilcuk was having the patient go through this procedure. Still, the nurse proceeded with the painful anal testing, and when the nurse pushed the air into the patient, the patient started screaming so loudly that *two different nurses* came and knocked on the testing room door out of concern!

191. When the nurse pulled out the anal catheter, the patient's blood covered the protective balloon, and there was blood on the gurney sheet as the patient ran to the bathroom. MS. YOUNG then heard the patient tell the nurse that she continued to bleed in the bathroom.

192. While nothing was done to remedy the ongoing risks to patients, in

retaliation for MS. YOUNG'S continued reporting of ongoing patient endangerment in the Pelvic Floor Clinic, on information and belief, DEFENDANT STANFORD HEALTH CARE's CEO David Entwistle, CFO Linda Hoff, and COO Quinn McKenna refused to approve the purchase of even one single bed for the Pelvic Floor Clinic's patient testing. In the past year, since the move to Redwood City, all patients have had to undergo painful Pelvic Floor testing on an unstable, wobbly gurney, despite MS. YOUNG's repeated requests for a stable bed, and management's assurances that one would be ordered as soon as CEO Entwistle, CFO Hoff and/or COO McKenna approved the Pelvic Floor Clinic budget. On information and belief, DEFENDANT STANFORD HEALTH CARE's CEO, CFO, and/or COO refuse to approve a budget that provides for even one single bed or training of the Pelvic Floor staff because STANFORD HEALTH CARE DEFENDANTS' plan is to close the Pelvic Floor Clinic to force MS. YOUNG out of a job. More than a year has passed since the Pelvic Floor Clinic was moved to Redwood City, and still no training for the Pelvic Floor Clinic has been approved by CEO Entwistle, CFO Hoff and/or COO McKenna which has resulted in each of the egregious occasions of patient endangerment described herein.

Y. Stanford Health Care Defendants Again Dupe The Public Such That They Are Recognized as a "Premier" Hospital, While Ranking In The Bottom 25% for Rate of "Hospital-Acquired Conditions," Including Infections, and Not Even Ensuring That Its Clinics' Pillows Are Cleaned or That Pillowcases Are Changed Daily.

193. Despite MS. YOUNG's repeated, unheeded efforts to protect patients from endangerment, STANFORD HEALTH CARE DEFENDANTS' efforts to dupe regulatory agencies and the public have met with success: on August 8, 2017, STANFORD HEALTH CARE DEFENDANTS again were recognized as a "premier" hospital.

194. This was despite, on information and belief, **STANFORD HEALTH CARE DEFENDANTS ranking in the bottom 25% of hospitals nationwide for "hospital-acquired conditions," resulting in a penalty reduction in reimbursements from the Centers for Medicare and Medicaid Services in fiscal years 2016 and 2017 after**

STANFORD HOSPITAL had higher than "appropriate" rates of hospital-acquired infections, including surgical site infection after colon surgery and abdominal hysterectomy; diarrhea-causing Clostridium difficile (C. diff), and catheter-associated urinary tract infections, among others, according to data from the Centers for Medicare. *See* https://paloaltoonline.com/news/2017/07/11/union-claims-high-infection-rates-in-stanford-hospital-dispute, attached as Exhibit A.

195. Indeed, on information and belief in response to a patient infection, on August 14, 2017, STANFORD HEALTH CARE DEFENDANTS' Director of Infection Prevention and Control inquired of STANFORD HEALTH CARE DEFENDANTS' Director of Clinic Operations and Activation what Clinics' practice was to ensure soiled pillows were not passed among patients.

196. Specifically, the Director of Infection Prevention and Control asked *"Does housekeeping ever clean the pillow?"* To which the Director of Clinic Operations and Activation, responded, **"*I am not sure.*"** At this point, the Director of Infection Prevention and Control inquired of the Director of Environmental Services (Housekeeping), asking, *"So, I am wondering what the Housekeepers do when the clinic staff do not take the pillow cases off"?* The Director of Environmental Services then instructed unambiguously, ***"Pillow cases should be replaced between patients."***

197. Incredibly, it was only then that this "premier" institution implemented what should be a common-sense policy and STANFORD HEALTH CARE DEFENDANTS' Director of Clinic Operations and Activation instructed her Clinic managers, supervisors, and staff to "Please add to your … work ***to replace pillow cases after each patient use*** as part of Infection Control practice."

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Z. Ms. Young Attended Stanford Health Care Defendants' August 24, 2017 "Town Hall" Meeting Called in Response to Racist Demonstrations by White Supremacists and Neo-Nazis in Charlottesville and Vandalism on Stanford Campus, and While Leadership Offered No Hope of Change, Stanford Physicians and Medical Students Corroborated Ms. Young's Experience of Racism, Discrimination, and Retaliation.

198. On August 24, 2017, MS. YOUNG attended the "Town Hall" meeting which was billed as being put on for the purpose of showing how STANFORD HEALTH CARE DEFENDANTS were going to address racism and discrimination in the wake of racist demonstrations by White Supremacists and Neo-Nazis in Charlottesville and vandalism on Stanford campus. MS. YOUNG hoped to see recognition of the discrimination and problem of racism at STANFORD HEALTH CARE DEFENDANTS, and to hear some kind of plan from Leadership to end these systemic problems. What she saw and heard did not set forth a plan to address the problem or even confirm recognition of the problem. Instead, it underscored how her complaints and those of others were ignored, and why they experienced retaliation for their complaints. STANFORD HEALTH CARE DEFENDANTS' managing agents' response to a multitude of reports by very credible medical students and physicians was nothing more than backpedaling, a series of laughable excuses, passing-the-buck, and nonsensical bumper-sticker platitudes.

199. During that meeting, a Caucasian medical student expressed that she has witnessed first-hand the racial problems within STANFORD HEALTH CARE DEFENDANTS. Specifically, she said she has witnessed times when *Stanford doctors wait for all the people of color to leave the room before they start talking about them* and they assume that because she's White, she thinks it is funny or wants to chime in. Further, the medical student said that when she has reported such incidents to stand up for people of color *her grades were drastically reduced*. STANFORD HEALTH CARE DEFENDANTS' leadership, including Dean Lloyd Minor and CEO David Entwistle had no response to the

student's first-hand experience of racism directed toward patients or the retaliation she suffered for reporting it, other than to say, nonsensically, "people change institutions and institutions change people."

200. Also during the August 24, 2017 Town Hall meeting, a medical student of color stated to STANFORD HEALTH CARE DEFENDANTS' leadership, "Racism is here at Stanford and you as the leaders know it exists!" Dean Lloyd Minor had no response to the medical student's statement and instead asked Dr. Bonnie Maldonado to respond. In response, all Dr. Maldonado could offer was the hollow platitude "change is difficult and sometimes change comes with pain."

201. Another medical student of color then asked STANFORD HEALTH CARE DEFENDANTS' Leadership why they have not hired a Chief Diversity Officer, and demanded to know what STANFORD HEALTH CARE DEFENDANTS are doing to resolve racism at Stanford. In response, STANFORD HEALTH CARE DEFENDANTS' Leadership responded that they have heard that bringing in a Chief Diversity Officer may not work. In response, a medical student asked, "Why does it seem like you don't care?" to which there was no answer from STANFORD HEALTH CARE DEFENDANTS' Leadership. Another medical student stated that STANFORD Leadership has no urgency to fix the problem that people of color are going through at STANFORD.

202. Still another medical student reported that patients are coming in wearing Confederate flags and demanding not to be treated by certain doctors and medical staff based on the color of their skin. The medical student reported, "How do we protect ourselves from that? This is our livelihood. This is not just happening in Charlottesville, it's happening right here in our own backyards." In response, Leadership stated that STANFORD HEALTH CARE DEFENDANTS' policy was to force physicians and medical staff to honor patients' racially prejudiced preferences – even despite the discrimination and hostile work environment it created for STANFORD HEALTH CARE DEFENDANTS' faculty, staff, employees and students of various races. STANFORD HEALTH CARE DEFENDANTS' mandated and ratified discrimination and endorsement of racism by patients against staff and

students was yet another kind of racism at STANFORD HEALTH CARE DEFENDANTS that MS. YOUNG had experienced first-hand. Just as complained of by the medical student, racist patients were allowed to exclude MS. YOUNG and other staff and students of color from assisting in the treatment of patients.

203. Both a physician and a medical student further reported that STANFORD UNIVERSITY AND STANFORD HEALTH CARE DEFENDANTS have both internal and external racial problems. And, incredibly, when asked point blank by a medical student why Dean Lloyd Minor had no response to the racism being reported, but instead asked others to respond in his place, all Dean Minor could say was that he "feels the urgency, but can't change it overnight – no one can." And as if to purposefully underscore how far short of the mark Leadership's non-responses were, Dean Minor stated that grew up in Little Rock Arkansas when it was segregated, and the Black kids were nice to him – and added, nonsensically, that he had read J.D. Vance's book "Hillbilly Elegy," a book that stands for the premise that anyone who, unlike its Venture Capitalist author, cannot escape working class life is essentially at fault.

204. At the Town Hall meeting, MS. YOUNG heard first-hand STANFORD HEALTH CARE DEFENDANTS' managing agents' excuses for accepting institutionalized discrimination, racism, and retaliation, and for taking no real steps and creating no real plans for change. STANFORD HEALTH CARE DEFENDANTS' Leadership's response to those like MS. YOUNG who reported discrimination and asked for change was simply to advise them that they needed to "realize just how difficult change actually is." Most importantly, MS. YOUNG concluded STANFORD HEALTH CARE DEFENDANTS' Leadership does not realize or care just how difficult working in a discriminatory workplace actually is. MS. YOUNG now recognizes change from within is an impossible dream and she has been left no choice but to turn to the judicial system for redress, and to correct STANFORD HEALTH CARE DEFENDANTS' indifference to discrimination, racism, retaliation, and to their patients being put in harm's way.

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205. Shortly thereafter, on September 21, 2017, MS. YOUNG received STANFORD HEALTH CARE DEFENDANTS' patient surveys (called "Press Ganey Comments") in an email with the subject line "Press Ganey Comments 9/20/17" which contained **negative** patient comments paralleling the reports MS. YOUNG has been making now for years, including "**incompetent staff** and impossible bureaucracy"; "one has the distinct feeling that **Stanford couldn't care less about the patient** and that one should feel lucky to be there"; and "**the "Stereo typing! THANKS BUT NO THANKS. I'm sick and the MD looks at me with a stare that would melt anyone but she didn't have to show it so much. And the LIES!!! YES and it really hurts ZERO COMPASSION."**

206. As a result, MS. YOUNG brings the following claims to hold each of the defendants responsible for the crushing fear, intimidation, despair, isolation, humiliation, and alienation they have inflicted on her in conscious disregard of MS. YOUNG's rights and safety and their conscious disregard of the rights and safety of the patients they were entrusted to care for, protect, and cure.

V. EXHAUSTION OF ADMINISTRATIVE REMEDIES

207. Prior to the initiation of this lawsuit, MS. YOUNG filed a complaint and several amended complaints against each named Defendant with the California Department of Fair Employment and Housing ("DFEH") pursuant to California Government Code §§ 12900, et seq., alleging the claims described in this Civil Complaint, including, but not limited to the continuing harassment, discrimination and retaliation. MS. YOUNG requested and received an immediate "right-to-sue" notice from the DFEH for each complaint and amended complaint filed. All conditions precedent to the institution of this lawsuit have been fulfilled, and this lawsuit for the continued violation of MS. YOUNG's rights under the Fair Employment and Housing Act has been timely filed within the statutorily proscribed timeframe.

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VI. CAUSES OF ACTION

FIRST CAUSE OF ACTION

Unlawful Retaliation and Discrimination for Association With Stanford Cancer Center Surgeons Who Reported Stanford's Endangerment of Its Patients, Stanford Staff Dressing Like the KKK and Secretly Photographing Patient Genitals, Racism and Retaliation at Stanford in Violation of Government Code §12940 et seq.

(Against STANFORD HEALTH CARE DEFENDANTS)

208. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

209. At all times during her employment with STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has been an employee covered by the Fair Employment and Housing Act (the "FEHA"), California Government Code § 12940, et seq., which prohibits an employer from engaging in unlawful retaliation and discrimination against an employee because she associated with an employee who engaged in protected activity.

210. As an employer of five or more persons, STANFORD HEALTH CARE DEFENDANTS were at all times an employer as defined under the FEHA.

211. As set forth herein, Stanford Cancer Center Physicians engaged in protected activity by reporting concerns to STANFORD HEALTH CARE DEFENDANTS' managing agents regarding STANFORD HEALTH CARE DEFENDANTS' endangerment of its patients, STANFORD HEALTH CARE DEFENDANTS' staff dressing like the KKK and secretly photographing patient genitals, and racism and retaliation directed at MS. YOUNG and others.

212. By the conduct herein alleged, STANFORD HEALTH CARE DEFENDANTS threatened, harassed, and discriminated against MS. YOUNG in the terms and conditions of her employment in retaliation for her association with the Stanford Cancer Center Physicians who engaged in protected activity.

213. STANFORD HEALTH CARE DEFENDANTS' conduct was in violation of California Government Code § 12940 et seq.

214. As a direct and proximate result of the acts and omissions of STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

215. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from discrimination and retaliation based on association with others engaged in protected activity, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

216. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Government Code § 12965(b) and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

217. WHEREAS, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

SECOND CAUSE OF ACTION

Unlawful Whistleblower Retaliation For Reporting Stanford's Endangerment of Its Patients in Violation of California Health and Safety Code § 1278.5

(Against STANFORD HEALTH CARE DEFENDANTS)

218. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

219. MS. YOUNG is a health care worker, as defined by California Health and Safety Code §1278.5.

220. STANFORD HEALTH CARE DEFENDANTS own and operate a health facility as defined by Health and Safety Code §1278.5.

221. STANFORD HEALTH CARE DEFENDANTS have engaged in a pattern and practice of harassing, discriminating and retaliating against health care workers like MS. YOUNG who report and complain of conditions allowed to exist at STANFORD HEALTH CARE DEFENDANTS that endanger patients, including STANFORD HEALTH CARE DEFENDANTS' immune-compromised cancer patients.

222. STANFORD HEALTH CARE DEFENDANTS' conduct was in violation of California Health and Safety Code § 1278.5.

223. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' retaliatory harassment and discrimination of MS. YOUNG, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

224. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment, discrimination, and retaliation based on making reports and complaints of conditions that allowed to exist at STANFORD HEALTH CARE DEFENDANTS that endanger patients, including STANFORD HEALTH CARE DEFENDANTS' immune-compromised cancer patients, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

225. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Code of Civil Procedure § 1021.5 and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

226. WHEREAS, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

THIRD CAUSE OF ACTION

Unlawful Whistleblower Retaliation For Reporting Stanford's Endangerment of Its Patients in Violation of California Labor Code § 1102.5

(Against STANFORD HEALTH CARE DEFENDANTS)

227. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

228. MS. YOUNG has reported numerous instances of STANFORD HEALTH CARE DEFENDANTS' non-compliance with and violation of state and federal law and regulations to those at STANFORD HEALTH CARE DEFENDANTS with authority over her, and who had the duty and authority to investigate, discover, or correct the violations, as well as to government agencies.

229. STANFORD HEALTH CARE DEFENDANTS retaliated against MS. YOUNG for reporting and disclosing that information, including, but not limited to, materially reducing her job responsibilities and pay, as set forth more fully above.

230. STANFORD HEALTH CARE DEFENDANTS' conduct was in violation of California Labor Code §1102.5.

231. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' retaliatory harassment and discrimination of MS. YOUNG, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

232. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment, discrimination, and retaliation based on making reports and complaints of conditions that allowed to exist at STANFORD HEALTH CARE DEFENDANTS that endanger patients, including

STANFORD HEALTH CARE DEFENDANTS' immune-compromised cancer patients, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

233. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Code of Civil Procedure § 1021.5, and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

234. WHEREAS, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

FOURTH CAUSE OF ACTION

Race Harassment and Discrimination in Violation of California Government Code §§ 12940 (a) and (j)

(Against STANFORD HEALTH CARE DEFENDANTS)

235. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

236. At all times during her employment with STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has been an employee covered by the FEHA, California Government Code §§ 12940 (a) and (j), which prohibit an employer from discriminating against and harassing an employee on the basis of color and race.

237. As an employer of five or more persons, STANFORD HEALTH CARE DEFENDANTS were at all times an employer defined under the FEHA.

238. MS. YOUNG is African-American.

239. MS. YOUNG has been subjected to a continuing pattern and practice of race harassment dating back to her first days of employment, and the above-described conduct by STANFORD HEALTH CARE DEFENDANTS and/or DOES 1 through 50, inclusive, constitutes unlawful racial harassment in violation of the FEHA.

240. MS. YOUNG has been subjected to working in a severe, persistent and/or pervasively hostile and abusive work environment based on her race and color, which alters

the terms and conditions of her employment by, among other things, interfering with her work performance, denying her employment privileges, and adversely affecting the terms and conditions of her job on the basis of her color and race.

241. The harassing conduct to which MS. YOUNG has been subjected has been so severe, widespread, and/or persistent or pervasive that a reasonable person in her circumstances would have considered the work environment to be hostile or abusive.

242. MS. YOUNG considers the work environment to be hostile and/or abusive.

243. The conduct, statements, acts and omissions described herein were an ongoing part of a continuing scheme and course of conduct. STANFORD HEALTH CARE DEFENDANTS' directors, officers and managing agents participated in and/or knew the substance of the above-described facts and circumstances and ratified the wrongs and injuries mentioned herein by failing to investigate, prevent and/or remedy the wrongs.

244. STANFORD HEALTH CARE DEFENDANTS' violations of the FEHA caused MS. YOUNG to suffer harm.

245. As a result of STANFORD HEALTH CARE DEFENDANTS' violations of the FEHA, MS. YOUNG is entitled to damages as set forth herein.

246. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' discrimination and harassment, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

247. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment and discrimination based on her race, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

248. As a direct and proximate result of the foregoing conduct, MS. YOUNG is

entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Government Code § 12965(b) and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

249. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

FIFTH CAUSE OF ACTION

Unlawful Retaliation for Complaining About Race Harassment and Discrimination in Violation of California Government Code § 12940(h)

(Against STANFORD HEALTH CARE DEFENDANTS)

250. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

251. At all times during her employment with STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has been an employee covered by the FEHA, California Government Code §§ 12940 (a) and (h), which prohibit an employer from retaliating against an employee for engaging in protected activity.

252. As an employer of five or more persons, STANFORD HEALTH CARE DEFENDANTS were at all times an employer defined under the FEHA.

253. MS. YOUNG complained of harassment and discrimination that she reasonably believed violated the FEHA, which constitutes a protected activity.

254. STANFORD HEALTH CARE DEFENDANTS took no action to ensure that MS. YOUNG was not retaliated against, subjected to punitive action, or otherwise harassed or threatened as a result of having complained. After her complaints, the harassment, discrimination, and retaliation intensified: she was gaslighted, defamed, written up, prevented from receiving promotions, and subjected to further race harassment.

255. STANFORD HEALTH CARE DEFENDANTS failed to take any appropriate action to protect MS. YOUNG.

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256. As a result of STANFORD HEALTH CARE DEFENDANTS' action and inaction, MS. YOUNG was subject to an increasingly hostile work environment due to harassment and retaliatory treatment.

257. MS. YOUNG's complaints were a motivating reason for STANFORD HEALTH CARE DEFENDANTS and their employees and agents' retaliatory harassment and treatment of MS. YOUNG.

258. STANFORD HEALTH CARE DEFENDANTS and their employees and agents' violations of the FEHA caused MS. YOUNG to suffer harm as set forth herein.

259. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' retaliatory harassment and discrimination of MS. YOUNG, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

260. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment, discrimination, and retaliation based on making reports and complaints of race harassment and racist comments, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

261. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Government Code § 12965(b) and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

262. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

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SIXTH CAUSE OF ACTION

Unlawful Retaliation for Complaining of Religious Harassment and Discrimination Against Stanford's Muslim Patients in Violation of California Government Code § 12940(h)

(Against STANFORD HEALTH CARE DEFENDANTS)

263. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

264. At all times during her employment with STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has been an employee covered by the FEHA, California Government Code §§ 12940 (a) and (h), which prohibit an employer from retaliating against an employee for engaging in protected activity.

265. As an employer of five or more persons, STANFORD HEALTH CARE DEFENDANTS were at all times an employer defined under the FEHA.

266. MS. YOUNG complained of harassment and discrimination based on a hate-filled statement from an employee of STANFORD HEALTH CARE DEFENDANT who said "Go pray in your own fucking country!" to a Muslim Stanford patient who had begun to pray in the waiting room.

267. STANFORD HEALTH CARE DEFENDANTS took no action to ensure that MS. YOUNG was not retaliated against, subjected to punitive action, or otherwise harassed or threatened as a result of having complained in support of STANFORD HEALTH CARE DEFENDANTS' Muslim patients. After her complaints, the harassment, discrimination, and retaliation intensified: she was gaslighted, defamed, and subjected to assault and battery by management.

268. STANFORD HEALTH CARE DEFENDANTS failed to take any appropriate action to protect MS. YOUNG.

269. As a result of STANFORD HEALTH CARE DEFENDANTS' action and inaction, MS. YOUNG was subject to an increasingly hostile work environment due to harassment and retaliatory treatment.

270. MS. YOUNG's complaints were a motivating reason for STANFORD

HEALTH CARE DEFENDANTS and their employees and agents' retaliatory harassment and treatment of MS. YOUNG.

271. STANFORD HEALTH CARE DEFENDANTS and their employees and agents' violations of the FEHA caused MS. YOUNG to suffer harm as set forth herein.

272. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' retaliatory harassment and discrimination of MS. YOUNG, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress the exact amount of which will be proven at trial.

273. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment, discrimination, and retaliation based on making reports and complaints of race harassment and racist comments, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

274. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Government Code § 12965(b) and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

275. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

SEVENTH CAUSE OF ACTION

Failure to Prevent, Investigate and/or Remedy Unlawful Harassment, Discrimination and Retaliation in Violation of California Government Code § 12940, et seq.

(Against STANFORD HEALTH CARE DEFENDANTS)

276. MS. YOUNG incorporates by reference the foregoing paragraphs of this

Complaint.

277. At all times during her employment with STANFORD HEALTH CARE DEFENDANTS, MS. YOUNG has been an employee covered by the FEHA, California Government Code §§ 12940 (a) and (k), which makes it an unlawful employment practice for an employer to fail to take all reasonable steps to prevent discrimination, harassment and retaliation from occurring.

278. As an employer of five or more persons, STANFORD HEALTH CARE DEFENDANTS were at all times an employer defined under the FEHA.

279. STANFORD HEALTH CARE DEFENDANTS failed to take all reasonable steps to prevent the harassment, discrimination and retaliation described above. STANFORD HEALTH CARE DEFENDANTS knew or should have known of the racially offensive, abusive, and humiliating behavior directed at MS. YOUNG and of the multiple adverse employment actions taken against MS. YOUNG and failed to prevent, investigate, or remedy said behavior and actions.

280. Despite being on notice of said racially offensive, abusive, and humiliating conduct and adverse actions directed at MS. YOUNG, STANFORD HEALTH CARE DEFENDANTS failed to act to prevent the further harassment, discrimination and retaliation that occurred following MS. YOUNG's complaints.

281. STANFORD HEALTH CARE DEFENDANTS also failed to enact any meaningful anti-discrimination policy and/or failed to distribute it appropriately and failed to effectively train its employees to prevent racial harassment, discrimination, or retaliation.

282. As a result of STANFORD HEALTH CARE DEFENDANTS' action and inaction in violation of the FEHA, MS. YOUNG suffered harm as set forth herein.

283. As a direct and proximate result of STANFORD HEALTH CARE DEFENDANTS' failure to prevent, investigate and/or remedy the unlawful harassment, discrimination and retaliation, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

284. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from harassment, discrimination, and retaliation based on making reports and complaints of race harassment and racist comments, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

285. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, attorneys' fees and costs pursuant to California Government Code § 12965(b) and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

286. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

EIGHTH CAUSE OF ACTION

Assault and Battery

(Against All Defendants)

287. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

288. STANFORD HEALTH CARE DEFENDANTS, FLORES, and DOES 1 through 50, assaulted and battered MS. YOUNG.

289. Supervisor Christina Guijarro ("GUIJARRO") engaged in conduct, including, but not limited to, physically intimidating MS. YOUNG by getting in close to MS. YOUNG's face in a threatening manner, and talking about her family's gang affiliations at work to intentionally threaten MS. YOUNG and place MS. YOUNG in apprehension of harmful contact.

290. In doing and saying the above things, GUIJARRO intended to cause or place MS. YOUNG in apprehension of a harmful contact with her person.

291. FLORES engaged in conduct, including but not limited to, aggressively running into MS. YOUNG in the hallway, shoving furniture into her, leering at her, and on one occasion, following her to a store in New Park Mall in Newark, when MS. YOUNG was vulnerable, alone with her toddler.

292. In doing the above things, FLORES touched MS. YOUNG and intended to cause or place MS. YOUNG in apprehension of a harmful contact with her person.

293. It reasonably appeared to MS. YOUNG that GUIJARRO and FLORES intended to and in fact did carry out the threat and/or harmful contact.

294. At no time did MS. YOUNG consent to any of the acts of GUIJARRO or FLORES as alleged herein.

295. As a direct and proximate result of the acts of GUIJARRO and FLORES, MS. YOUNG suffered physical pain and suffering.

296. At all times GUIJARRO and FLORES were acting as the agents and employees of STANFORD HEALTH CARE DEFENDANTS and Does 1 through 50.

297. These acts of assault and battery occurred as a result of STANFORD HEALTH CARE DEFENDANTS refusing and failing to take immediate and effective action to discipline GUIJARRO and FLORES, and impress upon them that aggressive, assaultive conduct and threats of violence would not be tolerated.

298. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from fear, threats of harm, assault, battery, and intimidation, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of FLORES and STANFORD HEALTH CARE DEFENDANTS.

299. MS. YOUNG is entitled to recover, in addition to the damages alleged above, prejudgment interest pursuant to California Civil Code §§ 3287, 3288, 3291.

300. WHEREFORE, MS. YOUNG prays for judgment against FLORES and STANFORD HEALTH CARE DEFENDANTS as set forth below.

NINTH CAUSE OF ACTION

Violation of Right to Freedom From Intimidation and Threat of Violence in Violation of California Civil Code § 51.7

(Against All Defendants)

301. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

302. STANFORD HEALTH CARE DEFENDANTS, FLORES, and DOES 1 through 50, assaulted and battered MS. YOUNG.

303. Supervisor GUIJARRO engaged in conduct, including, but not limited to, physically intimidating MS. YOUNG by getting in close to MS. YOUNG's face in a threatening manner. Moreover, after MS. YOUNG reported the assault, GUIJARRO began talking about her family's gang affiliations at work to intentionally threaten MS. YOUNG and place MS. YOUNG in apprehension of harmful contact.

304. FLORES engaged in conduct, including but not limited to, aggressively running into MS. YOUNG in the hallway, shoving furniture into her, leering at her, and on one occasion, following her to a store in New Park Mall in Newark, when MS. YOUNG was vulnerable, alone with her toddler.

305. MS. YOUNG reported each occasion when GUIJARRO and FLORES made threats of violence to MS. YOUNG.

306. Instead of taking immediate effective action, and investigation of the threats of violence, STANFORD HEALTH CARE DEFENDANTS denied the threats occurred and effectively accused MS. YOUNG of lying and insubordination, while trumping up false accusations against her.

307. In violation of STANFORD HEALTH CARE DEFENDANTS' duty under Civil Code §51.7, and despite knowledge of the violence, threats of violence and the continuing race based threats against MS. YOUNG, STANFORD HEALTH CARE

DEFENDANTS failed to provide MS. YOUNG with a workplace free of violence or intimidation. As a result of STANFORD HEALTH CARE DEFENDANTS' failure to provide these statutory protections MS. YOUNG was subjected to a workplace of intimidation and repeated violence.

308. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to work in an environment free from fear, threats of harm, assault, battery, and intimidation, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of FLORES and STANFORD HEALTH CARE DEFENDANTS.

309. As a direct and proximate result of the aforementioned acts and omissions of FLORES and STANFORD HEALTH CARE DEFENDANTS, and each of them, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

310. MS. YOUNG is entitled to recover, in addition to the damages alleged above, prejudgment interest pursuant to California Civil Code §§ 3287, 3288, 3291.

311. WHEREFORE, MS. YOUNG prays for judgment against FLORES and STANFORD HEALTH CARE DEFENDANTS as set forth below.

TENTH CAUSE OF ACTION

Interference with Constitutional Rights in Violation of California Civil Code § 52.1

(Against STANFORD HEALTH CARE DEFENDANTS)

312. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

313. STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50

interfered with MS. YOUNG's constitutional right entitling her to equal protection and a substantial motivating factor was her race.

314. The American Medical Association's ethics codes bars doctors from refusing to treat people based on race, gender, and other protected criteria, but provides no specific policies for responding to patients' racial preferences.

315. Although it is well-settled that an employer's desire to cater to the racial preferences of its customers (or patients) is not a defense to treating its employees differently based on race, STANFORD HEALTH CARE DEFENDANTS have adopted as a matter of policy and practice, the honoring of its patients' racial preferences to exclude care and treatment by technicians, faculty, staff, and students of color.

316. As a direct and proximate result of enacting and promulgating a decades-old policy and practice of catering to the racial prejudice of its patients, STANFORD HEALTH CARE DEFENDANTS, and each of them, have allowed and empowered its patients to discriminate against MS. YOUNG, thereby interfering with her right to be free from discrimination on the basis of her race and depriving MS. YOUNG of her constitutional right entitling her to equal protection.

317. As further direct and proximate result of the aforementioned acts and omissions by STANFORD HEALTH CARE DEFENDANTS, and each of them, MS. YOUNG has suffered and continues to suffer damages in the form of lost wages and other employment benefits, and emotional distress, the exact amount of which will be proven at trial.

318. The foregoing conduct engaged in, authorized and ratified by STANFORD HEALTH CARE DEFENDANTS and DOES 1 through 50, inclusive, and each of their directors, officers and/or managing agents, constitutes malice, fraud, and oppression, and was authorized, ratified, and carried on with a conscious and willful disregard of MS. YOUNG's right to equal protection, so as to justify punitive and exemplary damages in an amount appropriate to punish and make an example of STANFORD HEALTH CARE DEFENDANTS.

319. MS. YOUNG is entitled to recover, in addition to the damages alleged above, prejudgment interest pursuant to California Civil Code §§ 3287, 3288, 3291.

320. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

ELEVENTH CAUSE OF ACTION

Failure to Pay Wages for All Hours Worked in Violation of California Labor Code §§ 204, 218, 558, 1194 and 1194.2

(Against STANFORD HEALTH CARE DEFENDANTS)

321. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

322. At all relevant times, MS. YOUNG was employed by STANFORD HEALTH CARE DEFENDANTS pursuant to the California Labor Code and the applicable Wage Order of the Industrial Welfare Commission, Wage Order No. 5-2001, codified at Title 8, California Code of Regulations § 11050.

323. Pursuant to the California Labor Code, including sections 204, 218, 558, 1194, and 1194.2 and the applicable Wage Order of the Industrial Welfare Commission, Wage Order No. 5-2001, any employer who suffers or permits an employee to work owes the employee wages, and must pay the employee for all hours worked at the proper rate of pay pursuant to the California Labor Code, applicable Industrial Wage Orders, or by contract.

324. From 2015 through the present, STANFORD HEALTH CARE DEFENDANTS forced MS. YOUNG to work off-the-clock, and did not pay MS. YOUNG for all hours worked. Specifically, when MS. YOUNG was at home in Alameda County and not on the clock or scheduled to work, STANFORD HEALTH CARE DEFENDANTS and their agents and employees suffered MS. YOUNG to work by sending work-related text messages to her and requiring that she respond promptly to the same, as well as by calling MS. YOUNG regarding work issues while she was off-the-clock and at home.

325. STANFORD HEALTH CARE DEFENDANTS have failed to pay MS.

YOUNG for all wages she is owed by failing to pay her for all hours that she was suffered or permitted to work.

326. STANFORD HEALTH CARE DEFENDANTS owe MS. YOUNG wages at her agreed upon rate of $35.21 an hour for all hours she was suffered or permitted to work while she was off-the-clock and working from home, in an amount to be proven at trial.

327. As a direct, foreseeable, and proximate result of STANFORD HEALTH CARE DEFENDANTS' conduct, as described above, MS. YOUNG has suffered and lost income, the precise amount of which will be proven at trial.

328. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, reasonable attorneys' fees and costs pursuant to California Labor Code §§ 218.5 and 1194, civil penalties pursuant to California Labor Code § 558, liquidated damages pursuant to California Labor Code § 1194.2 and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

329. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

TWELFTH CAUSE OF ACTION

Failure to Reimburse for Expenses Incurred in the Discharge of Duty in Violation of California Labor Code § 2802

(Against STANFORD HEALTH CARE DEFENDANTS)

330. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

331. Pursuant to California Labor Code § 2802, an employer is required to indemnify its employees for all necessary expenditures or losses incurred by the employee as a direct consequence of the discharge of her duties.

332. MS. YOUNG maintains a cellular phone for personal use, the bills for which are issued to her home address in Alameda County.

333. For years, STANFORD HEALTH CARE DEFENDANTS have required MS. YOUNG to communicate with their supervisors and managers regarding work by using her

personal cell phone, for which she had to pay out of her own pocket, and for which she was not reimbursed any portion of her cell phone expenses. Specifically, even when at home and not on the clock, STANFORD HEALTH CARE DEFENDANTS and their agents and employees suffered MS. YOUNG to work by sending text messages to her regarding work-related issues and requiring that she respond to same, as well as by calling her regarding work-related issues on her cell phone.

334. Despite requiring MS. YOUNG to use her cell phone for work-related purposes, STANFORD HEALTH CARE DEFENDANTS have never reimbursed MS. YOUNG for any of the cell phone expenses she has necessarily incurred, in violation of California Labor Code § 2802.

335. As a direct, foreseeable, and proximate result of STANFORD HEALTH CARE DEFENDANTS' conduct, as described above, MS. YOUNG has suffered and continues to suffer substantial losses, the precise amount of which will be proven at trial.

336. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, reasonable attorneys' fees and costs pursuant to California Labor Code § 2802, and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

337. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

THIRTEENTH CAUSE OF ACTION

Failure to Provide Meal Periods in Violation of California Labor Code §§ 226.7 and 512

(Against STANFORD HEALTH CARE DEFENDANTS)

338. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

339. At all relevant times, MS. YOUNG was employed by STANFORD HEALTH CARE DEFENDANTS pursuant to the California Labor Code and the applicable Wage Order of the Industrial Welfare Commission, Wage Order No. 5-2001, codified at Title 8,

California Code of Regulations, section 11050.

340. On each day that MS. YOUNG worked more than six hours, STANFORD HEALTH CARE DEFENDANTS, and each of them, were required to provide MS. YOUNG with a meal period completely free from all duties, on or before the fifth hour of work, in compliance with Labor Code §§ 226.7 and 512, Wage Order No. 5-2001, and all other applicable laws and regulations.

341. MS. YOUNG did not qualify for any exemption from these requirements.

342. STANFORD HEALTH CARE DEFENDANTS, and each of them, repeatedly failed to provide MS. YOUNG with meal periods that were completely free from any work obligations, on or before the fifth hour of work, in violation of Labor Code §§ 226.7 and 512, Wage Order No. 5-2001, and all other applicable laws and regulations.

343. Accordingly, STANFORD HEALTH CARE DEFENDANTS were and are required to pay MS. YOUNG one hour premium pay as required by Labor Code section 226.7 and 512, and Wage Order No. 5-2001, for each workday in excess of six hours that STANFORD HEALTH CARE DEFENDANTS failed to provide MS. YOUNG with a meal period free from all work duties on or before the fifth hour of work, in an amount to be proven at trial.

344. MS. YOUNG is entitled to recover, in addition to the damages alleged above, prejudgment interest pursuant to California Civil Code §§ 3287, 3288, 3291.

345. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

FOURTEENTH CAUSE OF ACTION

Failure to Provide Accurate Wage Statements in Violation of California Labor Code § 226

(Against STANFORD HEALTH CARE DEFENDANTS)

346. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

347. California Labor Code § 226(a), requires employers, semi-monthly or at the

time of each payment of wages, to furnish each employee with an accurate statement itemizing, among other things, the total actual hours worked and the corresponding rate of pay for each employee. Labor Code § 226(b) provides that if an employer knowingly and intentionally fails to provide such an accurate statement, then the employee is entitled to recover the greater of all actual damages or fifty dollars ($50) for the initial violation and one hundred dollars ($100) for each subsequent violation, up to four thousand dollars ($4,000).

348. STANFORD HEALTH CARE DEFENDANTS knowingly and intentionally failed to provide MS. YOUNG with accurate itemized wage statements showing the total actual hours worked and total compensation owed as required by California Labor Code § 226(a), as a result of failing to pay her for all hours worked when she worked off-the-clock, at home in Alameda County.

349. As a direct consequence of STANFORD HEALTH CARE DEFENDANTS' failure to provide MS. YOUNG with accurate wage statements, MS. YOUNG suffered damages in an amount to be proven at trial. Additionally, as a consequence of STANFORD HEALTH CARE DEFENDANTS' failure to provide MS. YOUNG with accurate wage statements, STANFORD HEALTH CARE DEFENDANTS are subject to statutory penalties for their conduct.

350. As a direct and proximate result of the foregoing conduct, MS. YOUNG is entitled to recover, in addition to the damages alleged above, reasonable attorneys' fees and costs pursuant to California Labor Code § 226(e), and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, and 3291.

351. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

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FIFTEENTH CAUSE OF ACTION

Unfair Business Practices in Violation of California Business and Profession Code § 17200, et seq.

(Against STANFORD HEALTH CARE DEFENDANTS)

352. MS. YOUNG incorporates by reference the foregoing paragraphs of this Complaint.

353. STANFORD HEALTH CARE DEFENDANTS, and each of them, are "persons" as defined under California Business and Professions Code section 17201. Each of the directors, officers, and/or agents of STANFORD HEALTH CARE DEFENDANTS are equally responsible for the acts of the others as set for the in California Business and Professions Code section 17095.

354. California Business and Professions Code § 17200 prohibits unfair competition in the form of any unlawful, unfair or fraudulent business act or practice.

355. California Business and Professions Code § 17204 allows "any person acting for the interests of itself, its members or the general public" to prosecute a civil action for violation of UCL.

356. STANFORD HEALTH CARE DEFENDANTS' violation of California law, as set forth above, including their failure to pay wages for hours suffered or permitted to work; failure to reimburse for necessary expenses incurred in the discharge of duties; failure to provide timely meal periods free from all duties and failure to pay premium pay as a result of the same; and failure to provide accurate wage statements, constitutes unfair business acts and practices in violation of California Business and Professions Code § 17200 et seq.

357. STANFORD HEALTH CARE DEFENDANTS' violations have resulted in their unlawful financial gain by exploiting MS. YOUNG, by taking her labor without lawful compensation and forcing her to incur work-related expenses without required reimbursement.

358. STANFORD HEALTH CARE DEFENDANTS' violations further have resulted in the underreporting, or not reporting, of all wages earned by MS. YOUNG, and

therefore, the underpayment or non-payment of their unemployment premiums and workers' compensation premiums.

359. As a result of STANFORD HEALTH CARE DEFENDANTS' unfair business practices, STANFORD HEALTH CARE DEFENDANTS have reaped unfair benefit, illegal competitive advantage, and illegal profit at the expense of MS. YOUNG and other current and former similarly situated employees, and the general public.

360. STANFORD HEALTH CARE DEFENDANTS' unfair business practices entitled MS. YOUNG to seek preliminary and permanent injunctive relief, including, but not limited to orders that STANFORD HEALTH CARE DEFENDANTS account for, disgorge, and restore to MS. YOUNG all compensation unlawfully withheld.

361. MS. YOUNG further requests that the Court issue a preliminary injunction against STANFORD HEALTH CARE DEFENDANTS to prevent them from committing further violations of the Labor Code and the unfair business practices alleged herein.

362. MS. YOUNG acts in the public interest by exposing STANFORD HEALTH CARE DEFENDANTS' unfair business practices and seeking injunctive relief to remedy those practices. MS. YOUNG therefore requests an award of attorneys' fees and costs under California Code of Civil Procedure section 1021.5, and prejudgment interest pursuant to California Civil Code §§ 3287, 3288, 3291.

363. WHEREFORE, MS. YOUNG prays for judgment against STANFORD HEALTH CARE DEFENDANTS as set forth below.

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VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff Qiqiuia Young prays for relief as follows:

1. General and special damages according to proof;

2. Loss of earnings and earning capacity, according to proof;

3. Prejudgment interest to the extent allowed by law;

4. A declaratory judgment that the practices complained of herein are unlawful and violate the California Labor Code, the California Civil Code, the California Fair Employment and Housing Act, and the California Business and Professions Code;

5. A preliminary injunction prohibiting the STANFORD HEALTH CARE DEFENDANTS from committing further violations of California Law, including the California Labor Code, the California Civil Code, the California Fair Employment and Housing Act, and the California Business and Professions Code;

6. Costs of suit incurred herein;

7. Punitive and/or exemplary damages in an amount punish Defendants;

8. Attorneys' fees in prosecuting this action;

9. Statutory damages; and

10. Any such other and further relief as the Court may deem just and proper.

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Updated: Wed, Jul 12, 2017, 2:03 pm
Uploaded: Tue, Jul 11, 2017, 9:28 pm

Union claims high infection rates in Stanford Hospital dispute

Medicare penalized Stanford Health Care two years in a row for high hospital-acquired infections

by Sue Dremann / Palo Alto Weekly

High rates of hospital-acquired infections at Stanford Health Care have caused Medicare to reduce payments to the hospital for the second year in a row.

Now, members of Service Employees International Union-United Healthcare Workers West (SEIC-UHW), the union that represents 1,800 employees at Stanford Hospital, claim the high rates are because of inadequate staffing and training, union members said during a press conference at Stanford Medical Center on Tuesday.

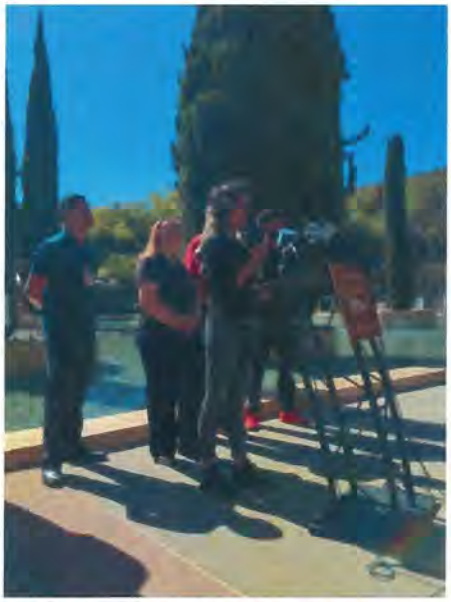
But hospital officials are disputing that assertion. They say the data is old and the union is using a strong-arm tactic to gain leverage during contract negotiations. The current contract expires in August, according to union spokesman Tom Parker.

The dispute over infection rates is focused on Stanford's Palo Alto campus alone, Parker said.

Union members said on Tuesday that the issue isn't just another ugly fight over a contract. They have been asking for more stringent changes and better staffing for a year.

"That is not a bargaining tactic," said Linda Cornell, a union member and 37-year patient-unit secretary. "We are not here today as a first course of action."

A Nov. 21 union memo to Suzanne Harris of Stanford Employee and Labor Relations shows that union members had been asking the hospital to address high-infection-rate and worker and patient safety concerns for at least several months. Two weeks ago, union representatives were to meet with hospital CEO David Entwistle to discuss the concerns related to the infection data but the hospital canceled the meeting, they said.



Salyna Nevarez, a Stanford Health Care phlebotomist, discussed her concerns about acquiring patient infections at a SEIU-UHW press conference on July 11, 2017. Photo by Sue Dremann.

Stanford Health Care received a penalty reduction in reimbursements from the Centers for Medicare & Medicaid Services in fiscal years 2016 and 2017 after the hospital had higher than appropriate rates of hospital-acquired infections, including surgical site infection after colon surgery and abdominal hysterectomy; diarrhea-causing Clostridium difficile (C. diff), and catheter-associated urinary tract infections, among others, according to data from the Centers for Medicare.

The hospital-reported data was from 2016.

The Centers for Medicare Services' Hospital-Acquired Condition Reduction Program ranked 3,203 hospitals nationwide during fiscal year 2017 for their hospital-acquired infection rates and penalized 769 hospitals.

Children's hospitals, VA hospitals and critical access hospitals, among others, are exempt from the reductions.

On a scale from 1 to 10, with 10 being the most severe, Stanford had an overall hospital-acquired conditions score of 7.85 in fiscal year 2017. Specific ratings that contributed to that score included:

- Central-line-associated blood stream infections: 7

- Catheter-associated urinary tract infections: 8

- Surgical-site infection: 10

- Methicillin-resistant staphylococcus aureus infection: 6

- Clostridium difficile infection: 9

In addition, the score includes the Agency for Healthcare Research and Quality Patient Safety Index (or PSI 90 Composite), which considers eight safety concerns, including pressure ulcer rate, postoperative hip fractures, postoperative sepsis, accidental punctures or lacerations, pulmonary embolism and deep-vein thrombosis (around time of surgery), among others. Stanford scored a 7.

Placing in the bottom-performing 25 percent of hospitals nationwide for hospital-acquired conditions, Stanford received a 1 percent reduction in Medicare reimbursements for each of the two fiscal years. The penalty for fiscal year 2017 runs from October 2017 through September 2018. Hospital spokeswoman Lisa Kim did not immediately know the equivalent in dollars.

Stanford maintains the figures represented by the union are outdated, coming from 2014 California Office of Statewide Health Planning and Development data that compared seven Bay Area teaching hospitals on one gastrointestinal infection, Clostridium difficile.

That data shows an infection rate at Stanford nearly double the rate for University of California, San Francisco Medical Center, which was the second worst of the other teaching hospitals.

Stanford instead pointed to U.S. Centers for Disease Control and Prevention's National Healthcare Safety Network metrics to show the hospital has greatly improved in recent years.

The Standardized Infection Ratio scores for C. diff, for example, showed rate of infection for the first quarter of 2017 is 0.871 cases per 1,000 patient days, which is better than the 1.0 benchmark, Stanford interim Chief Quality Officer Dr. Ann Weinacker said. That's an improvement over 1.09 in 2015 and 1.12 in 2016.

Weinacker did not provide scores for the other infectious disease rates that are also measured by the CDC's Healthcare Safety Network.

Data is submitted to the Safety Network monthly, Kim said.

"National Healthcare Safety Network is the only reliable source of these data because they provide training in standard surveillance methods. It's also the nation's most widely used healthcare-associated infection-tracking system," Kim said in an email.

Weinacker said that one reason Stanford's C. diff rate jumped in recent years by more than 100 percent is because the hospital began using new and much more sensitive testing procedures that are picking up more cases. The hospital began using the sensitive tests in 2012.

State data shows that Stanford first had a huge jump in C. diff cases in 2011, rising to 1.05 cases per 1,000 patient days compared to 0.30 in 2010.

Weinacker said the hospital has been tracking its data monthly so that staff can make adjustments to procedures. The hospital has signage for every room and pictograms of all precautionary procedures for a particular disease that staff and visitors must follow before entering a room, such as hand-washing and wearing a mask or a gown.

But the union claims protocol enforcement has been inconsistent, communication is poor and staffing is inadequate.

Nate Anderson, who has worked at the hospital for three years as a transporter bringing patients from the emergency room, said he was tested three times in one year for tuberculosis. Anderson said the tests came back negative, but he is still concerned about the potential for exposure.

"People come through the ER and we aren't told if they are suspected of having an infection," he said.

Anderson fears that as he moves from room to room or has passed patients and visitors in the hallways, he might be contaminating people. When patients potentially have a disease passed by droplets through sneezing or coughing, they should be wearing masks. Often they are not when they are handed off to him, he said.

"Everyone is confused about the proper protocol. Ask two different people and you get two different answers; ask three people and you get three different answers," he said.

Salyna Nevarez, a phlebotomist, said she worries on a daily basis about diseases she could bring home.

Exhibit C

"About one month ago there was a patient with active TB (tuberculosis)," she said. The patient was placed in a unit where phlebotomists were exposed to the infected patient but not given any notice to take precautions. It wasn't until after she'd gone into other patients' rooms that management informed Nevarez that she had been exposed, she said.

Other employees said that housekeeping workers are put on a strict schedule of cleaning rooms that don't give them adequate time. Cornell said that housekeepers are given 28 minutes to clean a room of a noninfectious patient and 43 minutes to clean an isolation room. In addition, the cleaning staff must handle conference rooms, nursing stations and hallways.

"There is not enough staffing in all areas. They are under constant pressure. They are rushing to beat the clock," she said.

Anish Singh, a member of the Patient Companion Pool, which brings staff to sit with patients for up to eight hours a day, said he has also seen things left uncleaned because of staffing shortages.

Stanford staff said the number of housekeepers per bed is 98 to 100 percent of the industry benchmarks established by Vizient, a ranking organization.

Cornell and Nevarez also said because of hospital overcrowding, some infectious patients are placed in the hallways and are surrounded by screens, but they are concerned that the hallways might be contaminated.

Weinacker did not refute that some patients are placed in halls when necessary, but she said that every precaution is taken to protect them and others from being contaminated. The hospital also has an active control group that works to refine protocols.

"There are hours and hours of training for workers and managers to ensure how to protect themselves from potential infection. They receive in-person and online training. We take this very seriously," she said.

In a statement, Stanford staff said through the hospital's "escalation policy," all employees are encouraged to share concerns through established channels.

And although the hospital maintains the union's data is outdated, staff have shared the information with its quality department, which will conduct a thorough review of the information, Stanford stated.

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Comments

Posted by **Wally**
a resident of Woodside
on Jul 12, 2017 at 2:57 am

35 people like this

It's alarming to hear that a renowned hospital would be so careless in the safety of the community. When there's a legitimate cause of the high rates of infection, what's the use of making it seem not so accurate? Fact to the matter is, Stanford should be held accountable whether there's little to more infection based of this data. I can't help to think that this hospital is making excuse of saying that the data that the union presented is outdated. For me, having to rely my own health and the rest of my family on a very respected hospital with huge concern of risking their visit to acquire such infection is a big deal for everybody. The new hospital is huge...I wonder if there would be enough workers to be hired? Are they new and not hire this honest union members that courageously stepped forward??? Or could the new big hospital be just enough aesthetics to attract more clients?

Email Town Square Moderator Report Objectionable Content

Posted by **True!**
a resident of Midtown
on Jul 12, 2017 at 9:13 am

42 people like this

When I was in Stanford Hospital a couple of years ago for a knee replacement, I acquired an infection in the knee.

A 5-day stay turned into a 15- day stay--at my financial and physical expense!!

To make matters worse, I was in horrific pain every single night. My morphine pump would be empty by 11:00 pm, and the alarm would go off intermittently all night until a nurse would finally appear to refill it at 7:00 am!

That's right-- I never saw a nurse between 11:00 pm and 7:00 am. Not even to take my vital signs

Exhibit D

ANGELA ALIOTO, SBN 130328
STEVEN L. ROBINSON, SBN 116146
LAW OFFICES OF JOSEPH L. ALIOTO AND ANGELA ALIOTO
700 Montgomery Street
San Francisco, CA 94111
Telephone: (415) 434-8700

Attorneys for Plaintiff
GEORGE BAEZ

SUPERIOR COURT OF CALIFORNIA

THE COUNTY OF SANTA CLARA

GEORGE BAEZ

Plaintiff,

vs.

STANFORD HEALTH CARE, BOARD OF TRUSTEES OF THE LELAND STANFORD Jr UNIVERSITY dba STANFORD UNIVERSITY, and DOES 1 to 100,

Defendants.

Case No.: 16 CV300476

FIRST AMENDED COMPLAINT FOR DAMAGES

1. **Whistleblower (Health & Safety Code 1278.5);**
2. **Whistleblower Retaliation (Labor Code Section 1102.5);**
3. **Whistleblower Retaliation (Labor Code Section 6310);**
4. **Discrimination–FEHA;**
5. **Retaliation –FEHA;**
6. **Negligent Hiring/Retention/ Supervision**
7. **Wrongful Termination in Violation of Public Policy (Tameny);**
8. **Breach of Contract;**
9. **Breach of Covenant of Good Faith & Fair Dealing;**
10. **Fraud;**
11. **Intentional Infliction of Emotional Distress.**

JURY TRIAL DEMANDED

THE PARTIES AND JURISDICTION

1. GEORGE BAEZ ("PLAINTIFF" or "BAEZ") was, at all relevant times herein, a resident of the County of Santa Clara in the State of California, and an employee of DEFENDANT STANFORD HEALTH CARE. PLAINTIFF BAEZ reported to work at the Stanford Health Care Redwood City Outpatient Center ("OSC") located in the County of San Mateo, California, at 450 Broadway, Redwood City, CA 94063.

2. DEFENDANT STANFORD HEALTH CARE is a corporate entity with its employees, managers, executives and board members, currently headquartered at 300 PASTEUR DRIVE Palo Alto, in the County of Santa Clara, California 94305. STANFORD HEALTH CARE owns and operates the Stanford Health Care Redwood City Outpatient Center ("OSC") located in the County of San Mateo, California, at 450 Broadway, Redwood City, CA 94063.

3. DEFENDANT **BOARD OF TRUSTEES OF THE LELAND STANFORD Jr UNIVERSITY dba STANFORD UNIVERSITY ("STANFORD UNIVERSITY")** is a private entity that employs the doctors who work at Stanford Healthcare's hospital and related offices and clinics. . During relevant portions of PLAINTIFF BAEZ's employment, employees of DEFENDANT STANFORD UNIVERSITY managed and employed DEFENDANTS Kaufman and Fanton who influenced and directed the retaliation of PLAINTIFF BAEZ, actions that were adopted and ratified by DEFENDANT STANFORD HEALTH CARE. Employees of DEFENDANT STANFORD UNIVERSITY worked out of DEFENDANT STANFORD HEALTH CARE'S Redwood City Outpatient Center ("OSC") located in the County of San Mateo, and STANFORD HEALTH CARE's hospital located in Santa Clara County.

4. Gary Fanton, MD ("Fanton") was, at all relevant times herein, an employee of DEFENDANT STANFORD UNIVERSITY, hired by DEFENDANT STANFORD HEALTH CARE as an Orthopedic Surgeon. Upon information and belief, Fanton also operates a practice whereby he services private clients, including the National Football League's San Francisco 49er franchise.

5. David I. Kaufman, MD ("Kaufman") was, at all relevant times herein, an employee of DEFENDANT STANFORD UNIVERSITY, hired by DEFENDANT STANFORD HEALTH CARE. Kaufman is a Clinical Associate Professor, Anesthesiologist, and a specialist in Perioperative and Pain Medicine for DEFENDANT STANFORD UNIVERSITY. Upon information and belief, Kaufman also operates a practice whereby he services private clients.

6. DEFENDANT STANFORD HEALTH CARE and DEFENDANT STANFORD UNIVERSITY were at all times relevant headquartered in Santa Clara County.

7. DEFENDANT STANFORD HEALTH CARE and DEFENDANT STANFORD UNIVERSITY were at all times responsible for the harm caused to PLAINTIFF BAEZ.DEFENDANT STANFORD HEALTH CARE and DEFENDANT STANFORD UNIVERSITY have each, at all times herein relevant, employed more than five employees within the State of California.

8. PLAINTIFF BAEZ is ignorant of the true names and capacities of the individual Defendants sued herein as DOES 1 through 100, inclusive, and therefore sues these Defendants by such fictitious names. PLAINTIFF BAEZ will amend this complaint to show the true names and capacities of these Defendants when the same have been ascertained. PLAINTIFF BAEZ is informed and believes, and thereon alleges that each of these fictitiously named Defendants are responsible in some manner for the occurrences herein alleged, and that the PLAINTIFF BAEZ's

damages as herein alleged were proximately caused by the acts of the aforementioned Defendants.

9. PLAINTIFF BAEZ is informed and believes, and thereon alleges, that each of the Defendants and parties named herein were at all times relevant, the agent, servant, employee and representative of each of the other Defendants, and in performing the acts herein alleged, was acting within the course and scope of such agency and employment, and with the full knowledge, permission, authorization, ratification, active assistance and encouragement, and/or consent, express or implied, of each of the other Defendants. All actions of each Defendant alleged in the causes of action into which this paragraph is incorporated by reference were ratified and approved by the officers or managing agents or members of every other Defendant.

10. The Statement of Facts herein are not required or intended to be a complete account of all the facts in this matter. PLAINTIFF BAEZ reserves the right to supplement the same during discovery or at trial.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

11. Plaintiff has exhausted all applicable administrative remedies.

STATEMENT OF FACTS

12. Over the past several years, all DEFENDANTS have created an atmosphere of intimidation at the Redwood City Outpatient Center (OSC) through countless acts of harassment, intimidation and retaliation for the legally protected activities of employees. DEFENDANT STANFORD HEALTH CARE and it's managers have acknowledged that this same intimidation was the reason that hospital staff failed to report the sexual assault/ molestation of at least four

patients (including Mark Roe, Plaintiff in San Mateo Superior Court Case No. CIV537723) at the hands of convicted sex offender and longtime protected employee Robert Lastinger.

13. DEFENDANT STANFORD HEALTH CARE concluded that six nurses and staff would not face any discipline for failing to report the sexual assault of patients because DEFENDANT STANFORD HEALTH CARE's management, through its own acts, had created this atmosphere of intimidation. Had the DEFENDANT STANFORD HEALTH CARE's staff reported the first identified sexual assault of Victim Mark Roe on March 20th, 2015, all DEFENDANTS could have prevented the molestation of at least three other patients, including one minor.

14. DEFENDANT STANFORD HEALTH CARE, including its executive team and at least one member of the Stanford Health Care Board of Directors, tolerated a known group of self-appointed managers at the Redwood City Outpatient Surgery Center (OSC) which include Kaufman, Fanton, at least four nurses and convicted sex offender and molester, Robert Lastinger. These doctors and their staff have overridden the authority of DEFENDANT STANFORD HEALTH CARE managers and executives and have directed the termination, demotion and other retaliatory acts against more than a dozen employees. As Interim Director of Ambulatory Perioperative, PLAINTIFF BAEZ thoroughly investigated the allegations against convicted molester Lastinger and other members of the protected group, which ultimately resulted in his retaliatory and wrongful termination.

15. Convicted sex offender Lastinger was hired by DEFENDANT STANFORD HEALTH CARE in or about 1996 as an Anesthesia Technician and continued as an employee for nearly four years. He was given the opportunity to resign in September 2000 instead of being terminated. Notwithstanding his forced resignation, DEFENDANT STANFORD HEALTH

March 24, 2014. At this time, PLAINTIFF BAEZ's responsibilities included financial reporting and contract management for the OSC branch and the management of the staff of Interventional Radiology at the Stanford Hospital main campus. Despite the promotion in title, PLAINTIFF BAEZ's job reclassification and increased pay was consistently denied. PLAINTIFF BAEZ complained to his manager Amy Semple (Director of Clinical Operations) with no success. PLAINTIFF BAEZ has been denied the back pay to date.

19. On or about December 7, 2014, Dani Martin was hired as Patient Care Manager in the OSC and was tasked with enforcing Stanford Health Care policies and procedures.

20. On or about February 1, 2015, PLAINTIFF BAEZ's manager Amy Semple (Director of Clinical Operations) went on maternity leave. In addition to his duties as Director of Operations, PLAINTIFF BAEZ took on the duties of Interim Director of Ambulatory Perioperative (over business and Clinical Operations). It was at this time that PLAINTIFF BAEZ's temporary responsibilities included the management of personnel at the OSC.

21. In or about January 30, 2015, Martin discovered the theft of two vials of prescription medicine at the OSC.

22. In or about February and March 2015, Dani Martin conducted a narcotic medication audit as part of her investigation. Kaufman and PLAINTIFF BAEZ were aware of the audit and were included in written correspondences regarding the same. PLAINTIFF BAEZ notified Vice President Gunderson and the Director of the Pharmacy that Martin would be conducting an investigation regarding the missing vials.

23. In this new position, PLAINTIFF BEAZ noticed that Fanton and Kaufman were inappropriately asserting themselves into operational, management and human resource decisions related to the employees at the OSC. Neither were employees of DEFENDANT

STANFORD HEALTH CARE. Both doctors were, however, employees of DEFENDANT STANFORD UNIVERSITY assigned the DEFENDANT STANFORD HEALTH CARE's Redwood City Outpatient Surgery Center (OSC).

24. On or about March 12, 2015, PLAINTIFF BEAZ met with Employee Relations Specialist Ko to complain about the level of involvement of these non-employee doctors in human resource decisions at the OSC.

25. In or about March of 2015, Martin concluded that convicted sexual offender Lastinger was directly involved in the theft of the vials. Martin brought her conclusions to the attention of PLAINTIFF BAEZ and Kaufman. Kaufman responded by becoming belligerent, defending convicted sexual offender Lastinger and taking responsibility for the diversion. Kaufman and Fanton complained about the investigation to DEFENDANT STANFORD HEALTH CARE's executive management and insisted that Martin be removed from the unit. Consistent with past practices, DEFENDANT STANFORD HEALTH CARE acquiesced. Vice President Doug Gunderson was instructed to immediately and abruptly remove Ms. Martin from the unit without notice.

26. Convicted sex offender Lastinger admitted to employees that he played a part in the removal of Martin. He also noted that the office was in a flurry after he had Martin removed and that he believed that the allegations against him were related to the changes in management that he had mandated.

27. On or about March 17, 2015, Employee Relations Specialist Ko confirmed to PLAINITFF BAEZ that, consistent with past practices, Fanton and Kaufman had been making human resource decisions by demanding the removal of Dani Martin and other employees to hospital executives.

28. Assistant Manager Todd Valentine and PLAINTIFF BAEZ complained to Vice President Gunderson that Martin was being retaliated against for reporting Lastinger's illegal diversion of prescription medicine. Vice President Gunderson also confirmed to PLAINTIFF BAEZ that the protected physicians had complained to DEFENDANT STANFORD HEALTH CARE's Chief Executive Officer Amir Rubin and Chief Operating Officer James Hereford that Dani Martin was disruptive and needed to be removed immediately from the unit. CEO Rubin and COO Hereford instructed Vice President Gunderson to immediately remove Martin from the unit pursuant to the orders of the physicians. Vice President Gunderson complied and had Martin removed.

29. Approximately a dozen employees (managers and or assistant managers) resigned, were forcefully transferred or terminated in the eight years that the unit has been open because the self-appointed managers would force people out. This atmosphere of fear and retaliation created by the doctors and supported by DEFENDANT STANFORD HEALTH CARE's executives prevented nurses and other staff members from immediately reporting Lastinger'ssexual molestation of sedated patients.

30. On or about March 20, 2015, Registered Nurse (RN) Yi, observed Lastinger sexually molest sedated Victim A (identified by his lawsuit as alias "Mark Roe"). As a direct result of the atmosphere of intimidation, RN Yi failed to act to stop or prevent the sexual assault of other sedated patients.

31. On or about March 31, 2015, Registered Nurse Camenga and Registered Nurse Reyes observed Lastinger sexually molest sedated Victim B (as identified by SHC). As a direct result of the atmosphere of intimidation, RN Camenga and Reyes failed to act to stop or prevent the sexual assault of other sedated patients.

32. On or about March 31, 2015, Registered Nurse Reyes and Anesthesia Tech Rodriguez observed Lastinger sexually molest sedated Patient C, a minor, at the OSC. *Stanford Health Care had eleven days (March 20 to March 31) to prevent the molestation of a sedated 16 year old child, but failed to act.*

33. Registered Nurse Camenga told Scrub Tech Krumm that a number of nurses (Yi, Fernandez and Scully) had seen Lastinger similarly molest other patients at the OSC. Krumm told Camenga to tell each employee to report the molestations to management, but employees were are not comfortable reporting to management for fear of retaliation. As of March 31, 2014, Krumm was aware that the nurses did not come forward sooner and were apprehensive about reporting the molestation because of the intimation and fear of retaliation by the self-appointed physician management.

34. Just one day before the next molestation of a sedated patient, DEFENDANT STANFORD HEALTH CARE had the knowledge of an employee who sexually molested two patients, but failed to act. Furthermore, DEFENDANT STANFORD HEALTH CARE was on notice of a cancer of intimidation and retaliation that prevented the reporting of sexual molestations of sedated patients.

35. On or about March 31, 2015, PLAINTIFF BAEZ received a text message from Krumm that two nurses (Cecilia Camenga and Irish Reyes) wanted to talk to him. Krumm did not give specifics about the request for a meeting despite PLAINTIFF BAEZ's follow-up inquiry.

36. A handful of nurses, including those that witnessed, but failed to report the sexual assault of sedated patients, later complained that they were afraid to report the molestations

because they feared the retaliation they witnessed against Ms. Martin. The staff believed that Martin was moving the OSC in the right direction.

37. On or about April 1, 2015, Kaufman sent PLAINTIFF BAEZ an email telling him that he wanted to clear the air about decisions that he (Kaufman) and Fanton had made about the *operation of the OSC*. PLAINTIFF BAEZ thought this to be strange because ***officially,*** Fanton and Kaufman were not employees of DEFENDANT STANFORD HEALTH CARE and had no operational authority over the OSC. Both Kaufman and Fanton were employees of DEFENDANT STANFORD UNIVERSITY. PLAINTIFF BAEZ complained to Employee Relations Specialist Ko about this email from Kaufman.

38. On or about April 1, 2015, Registered Nurse Reyes and Registered Nurse Scully observed the sexual molestation of yet another sedated patient at the OSC, Victim D.

39. On or about April 2, 2015, Registered Nurse Yi told Assistant Manager Todd Valentine that she saw Lastinger molest a sedated patient and that she did not know who to report it to. Valentine told her to report it to Martin, but Martin had been removed by Lastinger and the informal management group just two months prior.

40. Assistant Manager Valentine immediately contacted PLAINTIFF BAEZ wherein BAEZ learned that two clinical nurses (Cindy Yi and Cecilia Camenga) had each witnessed Anesthesia Tech Lastinger molest a patient while the patient was sedated at the OSC (in apparent reference to Victim Mark Roe and Victim B on March 20 and March 31st, respectively). On the same day, PLAINTIFF BAEZ received an email from Assistant Manager Valentine noting that the employees are fearful of retaliation from Lastinger and his friends in executive management. PLAINTIFF BAEZ immediately contacted Kim Ko (Employee Relations Specialist), Gunderson (Vice President of Interventional Services), Sam Wald (Vice President of Interventional Services

and Associate Chief Medical Officer), and initiated an investigation pursuant to Stanford policy. Other DEFENDANT STANFORD HEALTH CARE executives up the chain of command and the Redwood City Police Department were also immediately notified.

41. Pursuant to PLAINTIFF BAEZ's quick action, Lastinger was immediately removed from the workplace and placed on temporary relief from duty pending the results of the investigation.

42. On or about April 3, 2015, Assistant Manager Valentine told PLAINTIFF BAEZ that Nurse Yi and Irish were not conformable talking at work and that it was not a safe place to express their feelings.

43. On or about April 3, 2015, Registered Nurse Rojmar Fernandez reported to Employee Relations Specialist Ko that he thought he saw Lastinger inappropriately touch patients in Fernandez's first year of employment 2-3 times. Two years prior in December 2014, he warned Nurse Yi to watch Lastinger and noted that he is gay and he touches patient's genitals. Fernandez also mentioned to Registered Nurse Scully that in 2014, he noticed Lastinger rub patients in the genitals four times. DEFENDANT STANFORD HEALTH CARE failed to further investigate and disclose further victims because the information was not specific. A proper investigation would have potentially revealed three years of sexual assault/ molestation victims, however doing so would have opened a pandora's box of litigation and bad press.

44. On or about April 8, 2015, Kaufman, approached PLAINTIFF BAEZ to tell him that he was turning over "operational leadership" of the OSC to PLAINTIFF BAEZ.Kaufman noted that he asserted control over the OSC due to a lack of leadership. He noted that, going forward, Kaufmanwould direct employees to PLAINTIFF BAEZ for operational decisions. PLAINTIFF BAEZ was stunned that Kaufman actually believed he had operational control of

the OSC without any official real authority. PLAINTIFF BAEZ notified Director of Clinical Operations Amy Semple, Vice President Doug Gunderson, and Employee Relations Specialist Kimberly Ko of the conversation. Vice President Gunderson and Director Semple responded by confirming that Kaufman had no operational authority over the OSC.

45. On or about April 16, 2015, PLAINTIFF BEAZ noticed that one of the employees wrote on the white board in the employee common area, "What we do… back stabbing each other and not helping each other." Prior to being wiped clean, PLAINITFF BAEZ took a picture of it and emailed it to Employee Relations Specialist Ko, Director of Clinical Operations Semple and Patient Care Manager Renico. PLAINTIFF BAEZ suspected that the culprit was one of the members of the "informal management team" sending a message to co-workers and management.The graffiti confirmed and contributed to the atmosphere of intimidation that existed at the OSC.

46. On or about April 17, 2015, PLAINITFF BAEZ was asked by managers to compile a list of all the patients that may have been treated in the operating room while the sexual predator Lastinger was working. PLAINITFF asked Patient Care Manager Renico to pull the report. It was determined that only two years of records were available. The information was given to management, but no further investigation was conducted to determine who the potential other victims and patients were, because the list was would have been too great.

47. Employee Relations Specialist Kimberly Ko and PLAINTIFF BAEZ determined that the self-appointed physician managers at DEFENDANT STANFORD HEALTH CARE have been deeply involved and perpetuated an ongoing toxic environment among the staff whereby employees were retaliated against for doing anything against this core group. It was

determined that the witnesses to the molestations were reluctant to report the allegations against Lastinger for fear of retaliation.

48. The executive management of DEFENDANT STANFORD HEALTH CARE decided that none of the registered nurses would be disciplined despite their prior knowledge, their failure at all levels to protect the patients they were tasked to serve, and their failure to immediately report the sexual assault to law enforcement. Because DEFENDANT STANFORD HEALTH CARE executive management had perpetuated an ongoing toxic and retaliatory environment among the staff, no disciplinary action was taken against these nurses.

49. On or about May 4, 2015, RN Kristy Thompson came into PLAINITFF BAEZ' office and told him that Assistant Patient Care Manager Luckhurst had been aware of sex offender Lastinger's propensity to molest patients prior to her promotion over a year prior, that she was later promoted, and that Manager Luckhurst decided to disregard this damaging information. Furthermore, Thompson noted that an assistant patient care manager (APCM)was terminated for allegations of sexual harassment against sex offender Lastinger, despite the fact that it was alleged that the two had a relationship which ended in hostilities by Mr. Lastinger. If these statements were true, Manager Luckhurst's 2014-2015 glowing review of Lastinger the year prior is further evidence of a cover-up and knowledge and ratification of prior inappropriate conduct.

50. On or about May 5, 2015, PLAINTIFF BAEZ received a telephone call from Registered Nurse Julissa Soto who told him that Depuy employee Nick Cardenas (an SHC vendor) had been receiving pictures of "dicks" and "fat women" taken by Lastinger of patients in the operating room at OSC. PLAINTIFF BAEZ was told that Cardenas was sharing these pictures of naked and sedated patients with other Depuy employees. The Depuy reps were

inquiring as to why Cardenas was no longer receiving these lewd pictures. Lastinger had been terminated and arrested eight days prior.

51. PLAINTIFF BAEZ immediately reported this to his managers who conducted no investigation and failed in their duty to identify victims. It was determined by DEFENDANT STANFORD HEALTH CARE executives that since convicted molester Lastinger had been terminated on April 27th, no further action would be taken. A proper investigation would have disclosed the participation and/or notice and ratification of others in the operating room as well as well as the identity of a number of victims.

52. On or about May 18, 2015, Director of Clinical Operations Amy Semple returned from maternity leave and PLAINTIFF BAEZ returned to the duties as Director of Business Operations. PLAINTIFF BAEZ continued to co-lead the investigation of Lastinger and the related investigation of the atmosphere of intimidation. PLAINTIFF BAEZ continued to be paid at the same pay grade as his prior job classification from March 2014. By this date, Vice President Gunderson had transferred out of Stanford Health Care. PLAINITFF BAEZ and Director Semple reported to Vice President of Interventional Services and Associate Chief Medical Officer, Dr. Sam Wald.

53. On or about May 20, 2015, Kaufman sent PLAINTIFF BAEZ an email requesting to meet with Director Semple and Baez and telling PLAINTIFF BAEZ that Kaufman and Fanton share in all major decisions affecting the OSC. Fanton and Semple were also copied on the email. Director of Clinical Operations Semple was upset that the email was not directed to her since she was in charge and that Kaufman and Fanton were making their unofficial role as managers, official. Without Vice President Gunderson in charge, Semple complained to Vice President Dr. Sam Wald, who refused to act

54. PLAINTIFF BAEZ concluded that Assistant Patient Care Manager Luckhurst and Kaufman were significantly contributing to the culture of retaliation that led to the delays in reporting the molestations. PLAINTIFF BAEZ complained to DEFENDANT STANFORD HEALTH CARE executives that Manager Luckhurst be terminated and that Kaufman be removed from the oversight position of Medical Director. PLAINTIFF BAEZ complained to human resource manager(s) Kety Duron (Vice President of Human Resources), Amy Semple (Director of Clinical Operations), Mary Gaines, and Kim Ko (Employee Relations Specialist). DEFENDANT STANFORD HEALTH CARE executives determined that Assistant Patient Care Manager Luckhurst would be terminated citing her contributions to the toxic and hostile environment, but Kaufman and Fanton escaped all discipline.

55. On or about May 28, 2015, PLAINTIFF BAEZ and Director of Clinical Operations Amy Semple met with Kaufman and Fanton (the two of the doctors named as creating an atmosphere of fear and retaliation). The purpose of the meeting was to give them an update on the Lastinger investigation. Initially both doctors were upset and defensive of Lastinger and believed that he was being retaliated against. This was the exact same reaction that Kaufman had when he was notified of Lastinger's theft of prescription medications earlier that year. Both doctors became defensive and acted as though sex offender Lastinger was the victim. They insisted that each staff member who reported the molestation be questioned and fired if it was determined that they lied about the molestations. This suggestion was consistent with the toxic and retaliatory atmosphere at the OSC.

56. During this meeting, PLAINTIFF BAEZ highlighted Lastinger's history in 2013 of lewd sexual misconduct in the operating room (previously unknown to PLAINTIFF BAEZ). Kaufman told PLAINTIFF BAEZ, Fanton, and Director Semple that the prior assistant patient

care manager was "sex craved" and that she regularly flashed her breasts at him (Kaufman) in the operating room. Recognizing that he had publicly acknowledged his failure to report the prior lewd conduct in his operating room, Kaufman immediately retracted the statement. PLAINTIFF BAEZ reported this conversation to Vice President of Human Resource Kety Duron, Director of Clinical Operations Amy Semple, and Employee Relations Specialist Kimberly Ko.

57. DEFENDANT STANFORD HEALTH CARE was on notice that Kaufman had violated hospital policy by failing to report the lewd conduct. To this day, no investigation has been conducted and no discipline has been levied on Kaufman. This lack of action is yet another example of DEFENDANT STANFORD HEALTH CARE and DEFENDANT STANFORD UNIVERSITY'S protection of Kaufman and his unofficial power and control over DEFENDANT STANFORD HEALTH CARE executive management.

58. On or about May 28, 2015, PLAINTIFF BAEZ notified management in an email about the conversation he and Director Semple had with DEFENDNTS Kaufman and Fanton.

59. Both PLAINTIFF BAEZ and Employee Relations Specialist Ko became concerned that DEFEDNANTS Kaufman and Fanton would further retaliate against the witnesses. PLAINTIFF BAEZ became concerned that the doctors would look for a way to retaliate against him.

60. The very next day, on or about May 29, 2015, DEFEDNANT Kaufman retaliated against PLAINTIFF BAEZ. Kaufman complained to Director of Clinical Operations Semple that PLAINTIFF BAEZ was harassing and retaliating against Kristi Thompson. In fact, PLAINTIFF was merely investigating Thompson's complaint to him that Assistant Patient Care Manager Luckhurst had known about Robert Lastinger's propensity to sexual molest patients before she was promoted over a year before the molestations in March 2015. (See May 4, 2015

paragraph). Kaufman was attempting to (1)interfere with and stop the investigation, and (2) retaliate against PLAINTIFF BAEZ. PLAINTIFF BAEZ reported this retaliation to his managers on May 29 and again on June 1, when he complained that Kaufman was "*gunning for [him] now too...*"

61. On or about June 16, 2015, PLAINTIFF BAEZ requested and was denied the back pay and 21% bonus he was entitled for doing the job of Business Operations Director for the Ambulatory Perioperative Services from March of 2014 to approximately June 7, 2015.

62. On or about July 7, 2015, Assistant Patient Care Manager Jill Luckhurst was terminated for contributing to the atmosphere of intimidation relating to the informal management group.

63. Throughout the next few months (summer of 2015), PLAINTIFF BAEZ insisted on a meeting with Chief Operating Officer James Hereford to demand the removal of DEFENDANTS Kaufman and Fanton as co-directors, including several complaints to Vice President and Chief Medical Officer Dr. Sam Wald. PLAINTIFF BAEZ had determined that DEFENDANTN KAUFAN and Fanton had been contributing to a hostile environment that lead to nurses failing to report the molestation of patients. Chief Operating Officer Hereford refused to meet on the topic and deferred the meeting to Catherine Krna (Vice President of Ambulatory Specialty Care). (Krna was hired to replace Doug Gunderson in or about July 2015.)

64. In September of 2015, the Joint Commission Agency (a regulatory agency tasked with setting standards for hospital care in the United States), completed its narrow investigation into the DEFENDANT STANFORD HEALTH CARE policy. It was the stated policy of DEFENDANT STANFORD HEALTH CARE executives to give investigators as little information as possible and never offer additional information so as limit the scope of the

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regulatory agency's investigation. Vice President of Human Resources Kety Duron verbally counseled employees to withhold unsolicited information from the regulatory agency.

65. During the week September 29, 2015, PLAINTIFF BAEZ and Director of Clinical Operations Semple continued to press for a meeting to discuss the "informal leadership" and the atmosphere of intimidation they created at STANFOR HEALTH CARE.

66. On or about October 1, 2015, in anticipation of the meeting, Employee Relations Specialist Ko asked PLAINTIFF BAEZ to come up with the names of the non-physician employees that were a part of the core group. PLAINITFF BAEZ identified nine employees. PLAINTIFF insisted to his managers that until Kaufman was removed from Medical Direction, the problems of the hostile work environment would not be solved. The meeting took place, but no further action was taken.

67. On or about January 29, 2016, PLAINTIFF BAEZ took three co-workers (two female and one male) to a local restaurant at approximately 3:30pm after work to thank them for their hard work. PLAINTIFF BAEZ and other managers at Stanford Health Care would commonly thank employees and co-workers in this way. Approximately two weeks later, PLAINITFF BAEZ was called in to a meeting with Vice President Katherine Krna. Krna noted that she came to work and somebody (anonymously) had left a note on her desk that stated that they saw PLAINTIFF BAEZ out with a male employee (implying inappropriate sexual behavior). Vice President Krna told PLAINTIFF that she was "disappointed" and that being seen out with this young man from work was not comporting to the standards of the organization as a Director. She noted that he should not be seen in a situation that may be perceived as inappropriate or unethical.

68. PLAINTIFF BAEZ, responded that (1)he had done nothing wrong, (2) that he had taken three staff members out to thank them, (3) that it was quite common, and (4) that focusing on "another gay male" was an insulting persecution of Plaintiff's gender/sexual orientation. Vice President Krna insisted that the conduct was inappropriate. Later that day, Plaintiff complained to his manager Director of Clinical Operations Amy Semple that he was inappropriately being singled-out as a gay male in an attempt to defame his reputation.

69. On or about March 10, 2016, Victim A (Mark Roe) filed a lawsuit in San Mateo Superior Court alleging, inter alia,negligent hiring and supervision, failure to warn, premises liability, sexual battery and IIED as a result of the sexual battery that occurred on him by Lastinger on March 20, 2015.

70. On March 16, 2016, DEFENDANT STANFORD HEALTH CARE was served the complaint for damages in the Mark Roe matter.

71. Two days after being served the Mark Roe lawsuit, on March 18, 2016, PLAINTIFF BAEZ received an email from the Vice President of Ambulatory Clinics Catherine Krna asking to meet. During the meeting on March 23, 2016, Vice President Krna informed PLAINTIFF BAEZ that his employment was terminated effective June 1, 2016.

72. On or about April 15, 2016, in a meeting with Vice President Krna and Employment Labor Specialist Denise Bailey, PLAINTIFF BAEZ was given an official termination/ severance letter. PLAINTIFF BAEZ was told that "due to budgetary and operational needs, Stanford Health Care has decided that [his] position as a Director of Finance, and Business Operations, Perioperative Outpatient Services [was being] eliminated[.]"

73. In the same meeting, both Vice President Krna and Bailey fraudulently misrepresented (verbally and in writing) to PLAINTIFF BAEZ that he had preferential treatment

for re-employment and that they would help him get re-employed with SHC. However, begining on the Monday following this meeting, PLAINTIFF BAEZ found and applied for jobs, including one similar to his own posted on the DEFENDANT STANFORD HEALTH CARE website.

74. Between March 30, 2016 and April 18, 2016, PLAINTIFF BAEZ applied for seventeen (17) positions at Stanford Health Care for which he was qualified. He was immediately denied each position or denied an interview or follow-up.

75. Around the time of the termination letter, PLAINTIFF BAEZ was approached by a prominent doctor at DEFENDANT STANFORD HEALTH CARE who told him that certain doctors had "blacklisted" him due to reports to management and his investigation that resulted in the termination of sex offender Lastinger and his manager Jill Luckhurst. Both were members of the protected group.

76. On or about May 24, 2016, PLAINTIFF BAEZ sent an email to Administrative Director of Employee Labor Relations, Mary Gaines with a copy to Amy Semple (Administrative Director of Ambulatory Perioperative Services), Catherine Krna (Vice President of Ambulatory Specialty Care), Mariann Byerwalter (Member of the SHC Board of Directors and Interim Chief Executive Officer) and James Hereford (Chief Operations Officer). In that correspondence, PLAINTIFF BAEZ complained that SHC had tolerated an atmosphere of intimidation and retaliation against employees that report members of the self-appointed informal leadership team at OSC, and that his termination on June 1st was yet another example of the same. PLAINTIFF BAEZ also requested a complete investigation into the sexual molestations prior to March 20, 2015 and the photographing of patients in the operating room.

77. On or about May 27, 2016, Ms. Gaines responded by claiming no knowledge "of the self-appointed informal leadership." Ms. Gaines also stated that "ELR [had] not been made

aware of reports of photographing of patients." PLAINTIFF BAEZ was removed as Interim Director of Ambulatory Perioperative over business and clinical operations twelve days after making this report.

78. On June 1, 2016, PLAINTIFF BAEZ was wrongfully terminated in retaliation for his complaints and investigation of a convicted sex offender and the self-appointed informal leadership team of doctors and nurses at DEFENDANT STANFORD HEALTH CARE. Consistent with a pattern and practice of retaliation against employees, PLAINTIFF BAEZwas retaliated against for (1) reporting and investigating the molestation allegations against Lastinger and (2) alerting management that Lastinger had taken naked pictures of patients without their consent and sent them to an individual associated with PLAINTIFF BAEZ, (3) insisting on disciplinary action against Dr. Kaufman, Dr. Fanton, Assistant Patient Care Manager Luckhurst, and (4) other complaints as detailed herein. DEFENDANT STANFORD HEALTH CARE has acknowledged responsibility for creating this atmosphere of intimidation in writing, yet it continuously supports the bad actors and perpetuates this toxic and retaliatory work environment.

79. Robert Lastinger was arrested by the Redwood City Police Department on or about April 27, 2015. He was arraigned on or about April 29, 2015 on four counts of California Penal Code Section 243.4b (Sexual Assault). On May 16, 2016, Lastinger and the San Mateo District Attorney entered into a plea deal whereby Lastinger plead "nolo contendere" to the first two counts in exchange for a dismissal of counts 3 and 4, a maximum of one year in county jail, three years of probation, and 290 sex offender registration. On June 29, 2016, Lastinger was sentenced to one year in county jail for count 1 and 2 (served concurrently), three years of probation, and 290 sex offender registration for life. Absent the plea deal, the maximum penalty

pursuant to the California Penal Code the court could have awarded was sixteen years in state prison.

FIRST CAUSE OF ACTION
Whistleblower (Health & Safety Code 1278.5)
(As to All Defendants)

80. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

81. PLAINTIFF BAEZ brings this claim under California Health & Safety Code 1278.5. California Health & Safety Code 1278.5(b) (1) prohibits the retaliation, in any manner, against employee, member of the medical staff, or any other health care worker for (A) presenting 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, or for (B) initiating, participating, or cooperating in an investigation related to the quality of care, services, or conditions at Stanford Health Care.

82. Defendants have retaliated against PLAINTIFF BAEZ for reporting the diversion of controlled substances, the sexual assault of at least four patients (including one minor), lewd and lascivious conduct in the operating room and other conduct affecting the care of patients, services and conditions at Stanford Health Care.

83. Defendants adopted and enforced a policy of preventing employees from disclosing information to hospital management, government officials and law enforcement agencies, where the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or violation or noncompliance with a state or federal regulation or affecting the care of patients, services and conditions at Stanford Health Care.

84. Defendants retaliated against, harassed and intentionally inflicted emotional distress on PLAINTIFF BAEZ. DEFENDANT STANFORD HEALTH CARE ratified, adopted and took direction from DEFENDANTS Fanton and Kaufman (employees of DEFENDANT STANFORD UNIVERSITY). All retaliatory acts by each Defendant was in violation California Health & Safety Code 1278.5.

85. As a proximate result of such retaliation and harassment, PLAINTIFF BAEZ has suffered extreme emotional distress, anxiety, fear and humiliation.

86. As a further proximate result of such wrongful and retaliatory conduct, PLAINTIFF BAEZ has suffered loss of income, loss of benefits, loss of career opportunity and loss of other job benefits, all in amounts to be proven at trial.

87. Defendants acted, as alleged, with the malicious intention of depriving the PLAINTIFF BAEZ of employment opportunities and benefits that must be accorded to all employees. Such wrongful and retaliatory conduct was malicious, oppressive, fraudulent and in conscious disregard of plaintiffs' rights, such that punitive damages are warranted to punish all Defendants, to deter such conduct by Defendants in the future and to make an example of Defendants, all in amounts to be proven at trial.

88. An employee who has been discriminated against in employment pursuant to California Health & Safety Code 1278.5 shall be entitled to reinstatement, reimbursement for lost wages and work benefits caused by the acts of the employer, and the legal costs associated with pursuing the case, or to any remedy deemed warranted by the court or any other applicable provision of statutory or common law. A member of the medical staff who has been discriminated against pursuant to this section shall be entitled to reinstatement, reimbursement for lost income resulting from any change in the terms or conditions of his or her privileges

caused by the acts of the Stanford Health Care and the legal costs associated with pursuing the case, or to any remedy deemed warranted by the court pursuant to this chapter or any other applicable provision of statutory or common law.

89. Pursuant to *California Code Civ. Proc. § 1021.5*, a court may award attorneys' fees to a successful party against one or more opposing parties in any action which: (l) has resulted in the enforcement of an important right affecting the public interest; (2) a significant benefit has been conferred on the general public or a large class of persons; and (3) the necessity and financial burden of private enforcement renders the award appropriate. Under *Jaramillo v.County of Orange (2011) 200 Cal.App.4th 811, 829*, protecting whistleblowers from retaliation is a strong public interest that confers a significant benefit on the general public - namely, empowering people to step forward to expose fraud, corruption, and other wrongdoing.

SECOND CAUSE OF ACTION
Whistleblower Retaliation (Labor Code Section 1102.5)
(As to DEFENDANT STANFORD HEALTH CARE)

90. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

91. PLAINTIFF BAEZ brings this claim under *California Labor Code Section 1102.5, 1104, and 1105. California Labor Code Section 1102.5(a)* prohibits an employer from making, adopting, or enforcing any rule, regulation, or policy preventing an employee from disclosing information to government or law enforcement agencies, where the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or violation or noncompliance with a state or federal regulation.

92. *California Labor Code Section 1102.5(b)* prohibits retaliation against an employee for disclosing information to government or law enforcement agencies, where the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or violation or noncompliance with a state or federal regulation.

93. *California Labor Code § 1102.5(c)* prohibits retaliation by an employer against an employee who refuses to participate in an activity that would result in violation of a state or federal statute, or a violation or noncompliance with a state or federal rule or regulation. The California Legislature enacted *Labor Code § 1102.5(c)* with the express intent, "to protect employees who refuse to act at the direction of their employer or refuse to participate in activities of an employer that would result in a violation of law."

94. DEFENDANT STANFORD HEALTH CARE has adopted and enforced a policy of preventing employees from disclosing information to a government or law enforcement agency, where the employee has reasonable cause to believe that the information discloses a violation of state or federal statute, or violation or noncompliance with a state or federal regulation.

95. Such policy was enforced against PLAINTIFF BAEZ when he made the complaints noted herein and when he was instructed by DEFENDANT STANFORD HEALTH CARE not to provide additional information to outside government agencies regarding violations of State laws and regulations.

96. DEFENDANT STANFORD HEALTH CARE retaliated against, harassed and intentionally inflicted emotional distress on PLAINTIFF BAEZ due to his complaints and disclosure of illegal activities of DEFENDANT STANFORD HEALTH CARE's employees.

97. PLAINTIFF BAEZ had a reasonable belief that the information disclosed was a violation of State statute and/or a violation of State regulation. Such conduct by DEFENDANT STANFORD HEALTH CARE violated *California Labor Code Section 1102.5.*

98. As a proximate result of such retaliation and harassment, PLAINTIFF BAEZ suffered extreme emotional distress, anxiety, fear and humiliation. PLAINTIFF BAEZ is entitled to receive damages for these losses and hereby demands an award of damages against DEFENDANT STANFORD HEALTH CARE in an amount according to proof at trial.

99. As a further proximate result of such wrongful and retaliatory conduct, PLAINTIFF BAEZ suffered loss of income, loss of benefits, loss of career opportunity and loss of other job benefits, all in amounts to be proven at trial.

100. DEFENDANT STANFORD HEALTH CARE's acted, as alleged, with the malicious intention of depriving the PLAINTIFF BAEZ of employment opportunities and benefits that must be accorded to all employees. Such wrongful and retaliatory conduct was malicious, oppressive, fraudulent and in conscious disregard of plaintiffs' rights, such that punitive damages are warranted to punish DEFENDANT STANFORD HEALTH CARE, to deter such conduct by DEFENDANT STANFORD HEALTH CARE in the future and to make an example of DEFENDANT STANFORD HEALTH CARE, all in amounts to be proven at trial.

101. Pursuant to *Labor Code §1102.5(f)*, DEFENDANT STANFORD HEALTH CARE is liable for a civil penalty for each violation *Labor Code § 1102.5(c)*. As more fully set forth above, PLAINTIFF BAEZ provided notice of his intention to seek recovery of civil penalties for DEFENDANT STANFORD HEALTH CARE's violations of *Labor Code §1102.5(c)*. Upon the expiration of thirty-three (33) days from the date of PLAINTIFF BAEZ's

notice, PLAINTIFF BAEZ will seek to amend this Complaint to assert a claim for civil penalties against DEFENDANT STANFORD HEALTH CARE.

102. Pursuant to *California Code Civ. Proc. § 1021.5*, a court may award attorneys' fees to a successful party against one or more opposing parties in any action which: (l) has resulted in the enforcement of an important right affecting the public interest; (2) a significant benefit has been conferred on the general public or a large class of persons; and (3) the necessity and financial burden of private enforcement renders the award appropriate. Under *Jaramillo v.County of Orange (2011) 200 Cal.App.4th 811, 829*, protecting whistleblowers from retaliation is a strong public interest that confers a significant benefit on the general public - namely, empowering people to step forward to expose fraud, corruption, and other wrongdoing.

THIRD CAUSE OF ACTION
Whistleblower Retaliation (Labor Code Section 6310)
(As to DEFENDANT STANFORD HEALTH CARE)

103. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

104. PLAINTIFF BAEZ brings this claim under *California Labor Code Section 6310. California Labor Code Section 6310* prohibits and employer from discharging or in any manner discriminating against any employee because the employee has made any oral or written complaint to the division, other governmental agencies having statutory responsibility for or assisting the division with reference to employee safety or health, his or her employer, or his or her representative.

105. PLAINTIFF BAEZ made the complaints of unsafe working conditions or work practices to his employer when he notified his employer that Lastinger had been sexually assaulting patients, involved in other lewd behavior noted herein at his place of employments,

and intimidating employees to the extent that those employees failed to immediately notify management and law enforcement of the sexual assault of sedated patients.

106. DEFENDANT STANFORD HEALTH CARE retaliated against, harassed and intentionally inflicted emotional distress on PLAINTIFF BAEZ due to his complaints noted herein.

107. PLAINTIFF BAEZ had a reasonable belief that Lastinger's acts had created an unsafe working environment. Such retaliatory conduct by DEFENDANT STANFORD HEALTH CARE violated *California Labor Code Section 6310.*

108. As a proximate result of such retaliation and harassment, PLAINTIFF BAEZ suffered extreme emotional distress, anxiety, fear and humiliation. PLAINTIFF BAEZ is entitled to receive damages for these losses and hereby demands an award of damages against DEFENDANT STANFORD HEALTH CARE in an amount according to proof at trial.

109. As a further proximate result of such wrongful and retaliatory conduct, PLAINTIFF BAEZ suffered loss of income, loss of benefits, loss of career opportunity and loss of other job benefits, all in amounts to be proven at trial.

110. DEFENDANT STANFORD HEALTH CARE's acted, as alleged, with the malicious intention of depriving the PLAINTIFF BAEZ of employment opportunities and benefits that must be accorded to all employees. Such wrongful and retaliatory conduct was malicious, oppressive, fraudulent and in conscious disregard of plaintiffs' rights, such that punitive damages are warranted to punish DEFENDANT STANFORD HEALTH CARE, to deter such conduct by DEFENDANT STANFORD HEALTH CARE in the future and to make an example of DEFENDANT STANFORD HEALTH CARE, all in amounts to be proven at trial.

111. Pursuant to *California Code Civ. Proc. § 1021.5*, a court may award attorneys' fees to a successful party against one or more opposing parties in any action which: (1) has resulted in the enforcement of an important right affecting the public interest; (2) a significant benefit has been conferred on the general public or a large class of persons; and (3) the necessity and financial burden of private enforcement renders the award appropriate. Under *Jaramillo v.County of Orange (2011) 200 Cal.App.4th 811, 829*, protecting whistleblowers from retaliation is a strong public interest that confers a significant benefit on the general public - namely, empowering people to step forward to expose fraud, corruption, and other wrongdoing.

FOURTH CAUSE OF ACTION
DISCRIMINATION – FEHA
Cal. Gov. Code § 12940
(As to DEFENDANT STANFORD HEALTH CARE)

112. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

113. At the time of his termination from employment, Plaintiff was a member of a class protected by **FEHA,** he is a gay male.

114. At all times herein relevant, Plaintiff's job performance was always satisfactory and was usually excellent.

115. Defendant, as alleged herein, discriminated against PLAINTIFF BAEZ based on his gender and sexual orientation by, among other things: verbal reprimand for alleged "inappropriate" socializing with another gay male co-worker and retaliation for his complaints of gender/sexual orientation discrimination.

116. Defendant, as alleged herein, discriminated against PLAINTIFF BAEZ based on his gender/ sexual orientation by, among other things: making offensive comments and

subjecting Plaintiff to harassing discipline based on his gender, sexual orientation and stereotypes about his gender and sexual orientation; giving preferential treatment to employees outside of Plaintiff's protected class; refusing to addressing Plaintiff's complaints; and unduly criticizing Plaintiff's job performance; oral reprimand; and termination.

117. PLAINTIFF BAEZ is informed and believes, and thereon alleges, that this cause of action is not preempted by the California Workers' Compensation Act on the grounds that employment discrimination on the basis of gender/ sexual orientation is not a risk or condition of his employment.

118. As a result of the aforesaid failure acts of discrimination in employment, PLAINTIFF BAEZ has suffered and is continuing to suffer losses of wages/salary, benefits and other employee compensation in an amount which is currently unascertained. The Plaintiff's job history is now blemished because of the discriminatory actions by Defendant. Thus, as a result of the discriminatory acts of Defendants PLAINTIFF BAEZ herein faces a substantial diminution of his future earning capacity in an amount which is currently unascertained. Plaintiff will request leave of the court to amend his Complaint to state the amount of all such damages when they have been ascertained or upon proof at the time of trial.

119. As a result of the aforesaid acts of discrimination in employment, PLAINTIFF BAEZ was held up to great derision and embarrassment and has suffered emotional distress because Defendants demonstrated to the Plaintiff that it would not recognize nor accept him as an employee solely because of his sexual orientation/gender. Defendants by and through their officers and managing agents, further acted intentionally and unreasonably because it knew and/or should have known that its discriminatory conduct was likely to result in severe mental

distress. Plaintiff therefore seeks damages for such emotional distress in an amount to be proven at time of trial.

120. Because of the wrongful acts of Defendants as herein above alleged, Plaintiff has been and will in the future be required to employ physicians and surgeons to examine, treat and care for him and will incur additional medical expenses in an amount to be proven at the time of trial.

121. In doing the acts set forth above, Defendants acted as herein alleged with a conscious disregard of PLAINTIFF BAEZ' rights to employment notwithstanding his gender/sexual orientation. Defendants, in utter disregard of their obligation under the law, acted with the malicious. In addition, Defendants, their officers and managing agents have knowingly retained, coddled and protected vicious employees known to be hostile toward older employees. The officers and managing agents of Defendants made a conscious decision that they would not comply with the law of this state and would not tolerate people with Plaintiff's sexual orientation in the work place. This conduct by Defendants was, and is, despicable, cruel and oppressive. The Plaintiff is therefore entitled to an award of punitive damages in an amount to be proven at trial.

122. In bringing this action, Plaintiff has been required to retain the services of counsel. Pursuant to Government Code § 12965(b), he is entitled to an award of attorney fees and expert witness fees.

FIFTH CAUSE OF ACTION
RETALIATION –FEHACal. Gov. Code § 12940
(As to DEFENDANT STANFORD HEALTH CARE)

123. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

124. This is an action for damages arising from retaliation against Plaintiff for having opposed discrimination based upon his sexual orientation. This action is brought pursuant to the California FAIR EMPLOYMENT AND HOUSING ACT ["FEHA "], i.e.,*Cal.Gov.Code §12900, 12921, 12926, 129240 and 12965.*

125. PLAINTIFF BAEZ engaged in activity protected by the FEHA in opposing unlawful discrimination and harassment due to his gender/ sexual orientation.

126. As a result of PLAINTIFF BAEZ's protected activity, he suffered the following adverse employment actions: verbal reprimand and termination of his employment.

127. At all times herein relevant, Plaintiff's job performance was always satisfactory and was usually excellent.

128. Plaintiff is informed and believes, and thereon alleges, that this cause of action is not preempted by the California Workers' Compensation Act on the grounds that retaliation for having opposed discrimination made unlawful by the FEHA is not a risk of employment.

129. As a result of the aforesaid acts of discrimination in employment, PLAINTIFF BAEZ has suffered and is continuing to suffer losses of wages/salary, benefits and other employee compensation in an amount which is currently unascertained. The Plaintiff's job history is now blemished because of the discriminatory actions by Defendant. Thus, as a result of the discriminatory acts of Defendant the Plaintiff herein faces a substantial diminution of his future earning capacity in an amount which is currently unascertained. Plaintiff will request leave of the court to amend his Complaint to state the amount of all such damages when they have been ascertained, or upon proof at the time of trial.

130. As a result of the aforesaid acts of retaliation in employment, PLAINTIFF BAEZ was held up to great derision and embarrassment with the public, members of the media, professional athletes, coaches and owners, friends, and his family, and has suffered emotional distress because Defendant demonstrated to the Plaintiff that it would not recognize nor accept him as an employee because he opposed unlawful discriminatory practices. Defendant by and through its agents and employees, further acted intentionally and unreasonably because it knew

and/or should have known that its retaliatory conduct was likely to result in severe mental distress. Plaintiff therefore seeks damages for such emotional distress in an amount to be proven at time of trial.

131. Because of the wrongful acts of Defendants as herein above alleged, Plaintiff has been and will in the future be required to employ physicians and surgeons to examine, treat and care for him and will incur additional medical expenses in an amount to be proven at the time of trial.

132. In doing the acts set forth above, Defendants acted as herein alleged with a conscious disregard of PLAINTIFF BAEZ's rights to oppose unlawful discriminatory practices. Defendants, in utter disregard of their obligation under the law, acted with the malicious intention of removing Plaintiff from the workplace solely because he opposed unlawful discrimination. In addition, said Corporate Defendants, their officers and managing agents have knowingly retained, coddled and protected vicious employees. The officers and managing agents of Corporate Defendants made a conscious decision that it would not comply with the law of this state and would not tolerate such individuals in the work specifically PLAINTIFF BAEZ. This conduct by Defendants was, and is, despicable, cruel and oppressive. The Plaintiff is therefore entitled to an award of punitive damages in an amount to be proven at trial.

133. In bringing this action, Plaintiff has been required to retain the services of counsel. Pursuant to Government Code § 12965(b), he is entitled to an award of attorney fees and expert witness fees.

SIXTH CAUSE OF ACTION
Negligent Hiring/Retention/ Supervision
(As to Defendants STANFORD HEALTH CARE and STANFORD UNIVERSITY)

134. PLAINTIFF BAEZ incorporates by reference all of the facts set forth in paragraphs 1 through 79 with the same force and effect as though fully pleaded at length herein.

135. DEFENDANT STANFORD HEALTH CARE and DEFENDANT STANFORD UNIVERSITY and each of them, had a duty not to retain LASTINGER, Fanton, Kaufmanand

Defendants acted and refused to act, as alleged, with the malicious intention or with the knowledge that its acts or failure to act would cause the PLAINTIFF BAEZ severe emotional distress. Defendants have retained and promoted vicious employees and managers. This conduct was despicable, cruel and oppressive. PLAINTIFF BAEZ is therefore entitled to an award of punitive damages in an amount to be proven at trial.

DEMAND FOR JURY TRIAL

PLAINTIFF BAEZ hereby demands trial of this matter by jury.**PRAYER FOR RELIEF**

Wherefore, PLAINTIFF BAEZ prays for judgment as follows:

1. For compensatory damages according to proof;
2. For monetary damages to compensate for the emotional distress suffered by BAEZ;
3. For punitive damages in an amount appropriate to punish Defendants for their wrongful and malicious conduct and to set an example for others;
4. For interest on the sum of damages awarded;
5. For reasonable attorneys' fees;
6. Expert fees;
7. For costs of suit herein incurred;
8. For reinstatement, reimbursement for lost wages and work benefits pursuant to California Health & Safety Code 1278.5;
9. For such other and further relief as the Court deems proper.

Date: December 20, 2016

ANGELA ALIOTO, ESQ
Attorney for the Plaintiff

Exhibit E

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Attorneys for Plaintiffs
JANE DOE and JOHN DOE

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SANTA CLARA

UNLIMITED CIVIL JURISDICTION

JANE DOE; JOHN DOE,

Plaintiffs,

v.

DR. ROY HONG, M.D., an individual; PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation; DR. FREDERICK DIRBAS, M.D., an individual; STANFORD HOSPITAL AND CLINICS, a professional corporation; and DOES 1-50,

Defendants.

Case No.: 114CV261702

COMPLAINT FOR DAMAGES

1) **MEDICAL MALPRACTICE**

2) **BATTERY**

3) **INVASION OF PRIVACY; INTRUSION INTO PRIVATE MATTER**

4) **INVASION OF PRIVACY; WRONGFUL DISCLOSURE OF PRIVATE INFORMATION**

5) **VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT**

6) **LOSS OF CONSORTIUM**

By Fax

JURY TRIAL DEMANDED

PRE-JUDGMENT INTEREST DEMANDED

PARTIES

1. Plaintiff JANE DOE (hereinafter "PLAINTIFFS" when referenced jointly with Plaintiff JOHN DOE) is an adult natural person, over age 18, who was at all times mentioned herein a resident of Monarch Beach, California.

2. Plaintiff JOHN DOE (hereinafter "PLAINTIFFS" when referenced jointly with Plaintiff JANE DOE) is an adult natural person, over age 18, who was at all times mentioned herein a resident of Monarch Beach, California.

3. PLAINTIFFS file this complaint under fictitious names because the content and nature of this lawsuit constitute an 'exceptional circumstance' of a personal nature that justify the use of fictitious names.

4. PLAINTIFFS are informed and believe, and hereon allege, that Defendant DR. ROY HONG, M.D. (hereinafter "HONG") is an adult natural person, over age 18, who was at all times mentioned herein a licensed physician practicing medicine in Santa Clara County, in the State of California.

5. PLAINTIFFS are informed and believe, and hereon allege, that Defendants PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation (hereinafter "PAFMG") and/or DOES 1-25, unknown business entities, were at all times material to this Complaint, the employer(s) of, partners of, and/or otherwise retained Defendants HONG and/or DOES 26-50 on their medical staff, and were doing business in the County of Santa Clara, State of California, and are entities subject to suit before this Court.

6. PLAINTIFFS are informed and believe, and hereon allege, that Defendant DR. FREDERICK DIRBAS, M.D. (hereinafter "DIRBAS") is an adult natural person, over age 18, who was at all times mentioned herein a licensed physician practicing medicine in Santa Clara County, in the State of California.

7. PLAINTIFFS are informed and believe, and hereon allege, that Defendants STANFORD HOSPITAL AND CLINICS (hereinafter "STANFORD"), a corporation, and/or DOES 1-25, unknown business entities, were at all times material to this Complaint, the employer(s) of, partners of, and/or otherwise retained Defendants HONG, DIRBAS and/or DOES 26-50 on their

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medical staff, and were doing business in the County of Santa Clara, State of California, and are entities subject to suit before this Court.

8. Defendants DOES 1-50 are sued herein under fictitious names. Their true names and capacities are unknown to PLAINTIFFS. PLAINTIFFS are informed and believe, and hereon allege, that DOES 1-25 are business entities of unknown form who were the employers of, partners of, and/or otherwise retained Defendants HONG, DIRBAS, and/or DOES 26-50 on their medical staff. PLAINTIFFS are informed and believe, and hereon allege, that DOES 26-50 are doctors, nurses, technicians, assistants and/or other health care providers and/or staff who performed the surgery and related pre- and/or post-surgical care and/or billing which are the subject of this litigation. PLAINTIFFS are further informed and believe, and hereon allege, that DOES 26-50 were the employees, actual and/or ostensible agents, and/or contractors of, and/or partners of Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-25, who were operating within the scope and course of their agency and/or employment and/or partnership at all times material to this Complaint.

9. PLAINTIFFS are informed and believe, and hereon allege, that at all times relevant herein, each and every Defendant was the agent, servant, partner, joint venturer, and/or employee of each and every other Defendant, and acted pursuant to a common plan, design, venture, or scheme such that each Defendant authorized, negligently supervised, and/or ratified each act of every other Defendant in the acts complained of by PLAINTIFFS.

10. PLAINTIFFS are informed and believe, and hereon allege, that at all times relevant herein there existed and exists a unity of interests between each and every Defendant, such that any individuality and separateness between these certain Defendants has ceased, and those Defendants are the alter ego of the other certain Defendants and exerted control over each other. Adherence to the fiction of the separate existence of these Defendants as an entity distinct from other certain Defendants will permit an abuse of the corporate privilege and would sanction fraud and/or promote injustice.

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VENUE & JURISDICTION

11. Venue is proper because the relevant actions, conduct, and damages set forth herein occurred in the County of Santa Clara. PLAINTIFFS are informed and believe, and hereon allege, that venue is also proper because Defendants HONG, PAFMG, DIRBAS, STANFORD, and/or DOES 1-50 either reside or have their principle places of business in the County of Santa Clara.

12. Subject matter in this action is properly heard in this Court, as the action incorporates an amount in controversy as set forth in the complaint which exceeds $25,000.00.

13. PLAINTIFFS complied with the requirements of California Code of Civil Procedure Section 364 by timely service of notice of intent to sue. This Complaint's medical negligence causes of action are therefore brought in a timely fashion within the time provided by the tolling provisions of Section 364. This Complaint's other causes of action are brought within their relevant statutes of limitation.

14. At all times mentioned herein, California's Patient's Bill of Rights, California Code of Regulations, Title 22, Section 70707, among others, was in full force and effect, and was binding upon Defendants HONG, PAFMG, DIRBAS, STANFORD, and/or DOES 1-50, and each of them.

FACTS COMMON TO ALL CAUSES OF ACTION

15. JANE DOE was at high risk of developing breast cancer, and so she decided to undergo a single stage, concurrent bilateral mastectomy and breast reconstruction surgery at Defendant STANFORD and/or DOES 1-25, which was scheduled to occur on or around December 12, 2012.

16. On or around December 11, 2012, PLAINTIFFS attended a preoperative conference with Defendants HONG and/or DOES 26-50 to discuss the breast reconstruction surgery that Defendants HONG and/or DOES 26-50 would perform on JANE DOE the following day, December 12, 2012.

17. In the preoperative conference, PLAINTIFFS reiterated to Defendants HONG and/or DOES 26-50 what they had stated to them several times in previous telephonic conferences, namely that they wanted Defendants HONG and/or DOES 26-50 to place implants between 350cc and

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400cc in volume 'subpectorally,' or underneath JANE DOE's pectoral muscles, during surgery, and Defendants HONG and/or DOES 26-50 represented that they had adequate experience and training to perform this procedure as JANE DOE requested and consented to.

18. On or around December 12, 2012, Defendants DIRBAS and/or DOES 26-50 performed a bilateral mastectomy procedure on JANE DOE, after which Defendants HONG, and/or DOES 26-50 performed a breast reconstruction procedure on PLAINTIFF.

19. Immediately after Defendants DIRBAS and/or DOES 26-50 completed their mastectomy procedure, Defendants HONG and/or DOES 26-50 conducted a breast reconstruction procedure on JANE DOE.

20. During the breast reconstruction procedure, Defendants HONG and/or DOES 26-50 placed 533cc silicon implants in JANE DOE's breasts, contrary to PLAINTIFFS' expressed consent in preoperative consultations.

21. Defendants HONG and/or DOES 26-50 inserted these silicon implants above JANE DOE's pectoral muscles in the 'subcutaneous space' of JANE DOE's breasts, contrary to PLAINTIFFS' expressed consent in preoperative consultations.

22. During the breast reconstruction procedure, without the knowledge and/or consent of JANE DOE and while she was under general anesthesia Defendant HONG and/or DOES 26-50 took photographs of JANE DOE's breasts with their personal cellular telephones, which they later shared with other unknown individuals.

23. As a result of Defendants HONG's and/or DOES 26-50's decision to place the larger 533cc implants subcutaneously, JANE DOE suffered excessive scarring inside her breasts, which resulted in extremely painful "capsular contraction" around JANE DOE's breast implants that required revision surgery to correct.

24. The weight and size from the excessively large 533cc implants that Defendants HONG and/or DOES 26-50 placed in JANE DOE's breasts created excessive pressure around JANE DOE's breast and blood supplying tissue, cut off blood circulation bilaterally to her nipple areolar complexes in the days after the December 12, 2012 surgery, which caused bilateral necrosis of JANE DOE's nipple areolar complexes.

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25. The day after her surgery on December 13, 2012, Defendants DIRBAS and/or DOES 26-50, JANE DOE's treating physicians, examined JANE DOE's breasts to evaluate her for discharge from Defendants STANFORD's and/or DOES 1-25's facility despite examining her surgical wounds and noting that they did not appear normal. As part of this evaluation, Defendant DIRBAS and/or DOES 26-50 knew or in the exercise of their medical judgment should have known that JANE DOE should not have been discharged, and should have been held for further evaluation, treatment, and possible revision surgery to prevent the damages which JANE DOE claims in this suit.

26. During a postoperative visit on December 13, 2012 at Defendants PAFMG's and/or DOES 1-25's facility, Defendants HONG and/or DOES 26-50 noticed that JANE DOE's breasts were blanched and purple with black nipples and areola–signs of impending necrosis–and knew or should have known through the exercise of their medical judgment that intervention was necessary to prevent further damage to JANE DOE's breast tissue and nipple areolar complexes, but failed to act to prevent or reduce the damage to JANE DOE's breast tissue and nipple areolar complexes.

27. Five days after surgery, during another postoperative visit to Defendant PAFMG's and/or DOES 1-25's facility on December 16, 2012, Defendants HONG and/or DOES 26-50 applied a surgical "Marena" bra to JANE DOE's breasts that constricted circulation to them, which they knew or should have known, through the exercise of their medical judgment, contravened the standard of care.

28. Defendants HONG and/or DOES 26-50, postoperatively knew that JANE DOE's breast and tissue were being damaged, and that the standard of care required them to intervene to prevent further damage.

29. At various times during December of 2012, Defendant HONG and/or DOES 26-50 shared confidential details about JANE DOE's breast reconstruction surgery, without JANE DOE's knowledge or consent, with Dr. Kristen Ganjoo, M.D. and unknown others, who were not involved in JANE DOE's care and treatment.

30. The necrosis of JANE DOE's nipple areolar complexes took approximately four months of

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subsequent wound therapy to treat, and left JANE DOE with discolored areolae and without nipple protrusion. As a result of the conduct detailed above, JANE DOE suffered income loss during her recovery and the subsequent surgical revision of her breasts.

31. On or about April 22, 2013, JANE DOE consulted with a plastic surgeon regarding revision surgery of her breasts, at which time she expressed her desire for smaller implants placed subpectorally; and on May 22, 2013, the plastic surgeon went forward with the revision surgery as JANE DOE requested.

FIRST CAUSE OF ACTION
MEDICAL MALPRACTICE: BREAST RECONSTRUCTION PROCEDURE
Against Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50

32. PLAINTIFFS incorporate by reference the allegations set forth above, as though fully set forth herein.

33. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed a duty to JANE DOE to exercise a degree of skill, knowledge, and care in the diagnosis and treatment that other reasonably careful health care practitioners would have used under similar circumstances.

34. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 , and each of them, failed to exercise the requisite degree of skill, knowledge, and care in the diagnosis and treatment required of them with respect to the care and treatment of JANE DOE. During the surgeries and related pre- and post-surgical care, Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, breached their duty to JANE DOE as described herein by, including but not limited to, 1) using 533cc breast implants that were too large for JANE DOE and inserting those implants in the subcutaneous position instead of the consented to subpectoral position, which resulted in, including but not limited to, capsular contraction, nipple areolar complex necrosis, nipple inversion, and areolar discoloration; 2) failing to adequately follow up postoperatively on JANE DOE's necrotizing nipple areolar complexes, which resulted in JANE DOE having to undergo four months of wound therapy; 3) failing to postoperatively advise JANE DOE that removing the 533cc breast implants would have prevented her nipple areolar complexes from necrotizing, resulting in extensive necrotization of JANE DOE's nipple areolar complexes;

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and 4) failing to a) adequately examine JANE DOE postoperatively, b) diagnose her condition, and/or c) refer her to a competent specialist for examination and/or before discharging her from STANFORD's and/or DOES 1-25's facility in which she had undergone her breast reconstruction surgery.

35. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed JANE DOE a duty to supervise the care given by HONG, DIRBAS, and/or DOES 26-50 who were the medical practitioners, nurses, staff, employees, and/or actual or ostensible agents under Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50's supervision, control, and/or who were actively participating in any of the surgical procedures JANE DOE underwent.

36. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, failed to exercise that degree of skill and care commonly required of their profession, in that they failed to train properly, supervise and monitor HONG, DIRBAS, and/or DOES 26-50, and knew or should have known that the failure to properly supervise and/or monitor these persons would cause serious injury to JANE DOE and other members of the public seeking medical care from Defendants HONG, DIRBAS, and/or DOES 26-50, and each of them.

37. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed a duty to JANE DOE to use reasonable care to select and periodically evaluate its medical staff, including but not limited to HONG, DIRBAS, and/or DOES 26-50, to insure the adequacy of medical care rendered to patients in its facility, including JANE DOE.

38. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 breached their duty of care owed to JANE DOE by failing to provide the procedures, policies, facilities, supplies, and/or qualified personnel reasonably necessary for her treatment, and/or by failing to periodically evaluate its medical staff, including Defendants HONG, DIRBAS, and/or DOES 26-50, to insure the adequacy of medical care rendered to patients in its facility.

39. JANE DOE is informed and believes, and hereon alleges, that Defendants PAFMG, STANFORD, and/or DOES 1-25 are also liable for the medical negligence of Defendants HONG, DIRBAS, and/or DOES 26-50 as described herein, because Defendants HONG, DIRBAS, and/or DOES 26-50 committed their negligence within the course and scope of their employment and/or agency,

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either actual or ostensible, with Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 and each of them.

40. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, also owed a duty to JANE DOE to obtain her informed consent by explaining the likelihood of success and the risks of agreeing to each course of treatment in language that JANE DOE could understand, giving JANE DOE as much information as she needed to make an informed decision, including any risk that a reasonable person would consider important in deciding to have the proposed treatment or procedure, and any other information skilled practitioners would disclose to JANE DOE under similar circumstances, including but not limited to any risk of serious injury or significant potential complications that might occur if the procedure were performed.

41. A reasonable person in JANE DOE's position would not have agreed to the medical procedures described herein if she had been fully informed of the results and risks and/or alternatives to those procedures.

42. As a direct and proximate result of Defendants HONG's, DIRBAS's, PAFMG's, STANFORD's, and/or DOES 1-50's, and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, wage loss, medical expenses, and costs, in an amount to be proven at trial.

43. As a direct and proximate result of Defendants HONG's, DIRBAS's, PAFMG's, STANFORD's, and/or DOES 1-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

44. JANE DOE prays for damages as more fully set forth below.

SECOND CAUSE OF ACTION
MEDICAL BATTERY
Against Defendants HONG and/or DOES 26-50

45. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

46. Defendants HONG, and/or DOES 26-50 intentionally used 533cc breast implants that were larger

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than the 350cc to 400cc implants JANE DOE asked for and consented to in her preoperative consultation with Defendant HONG and/or DOES 26-50.

47. Defendants HONG, and/or DOES 26-50 intentionally placed breast implants in the subcutaneous position and not the subpectoral position that JANE DOE asked for and consented to in her preoperative consultation with Defendants HONG and/or DOES 26-50.

48. JANE DOE did not consent either to the larger 533cc breast implants or to having them implanted in the subcutaneous position.

49. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

50. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

THIRD CAUSE OF ACTION
INVASION OF PRIVACY: INTRUSION INTO PRIVATE MATTER
Against Defendants HONG and/or DOES 26-50

51. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

52. California Constitution, Article I, Section I and the common law protect individuals' right to privacy.

53. Defendants HONG and/or DOES 26-50 intentionally, and without the consent or knowledge of JANE DOE, photographed JANE DOE's breasts with their cellular telephones while she was unconscious under general sedation during her breast reconstruction procedure which Defendants HONG and/or DOES 26-50 performed on her on or around December 12, 2012.

54. JANE DOE had an expectation of privacy while she was unconscious under general sedation during surgery.

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55. Defendant HONG and/or DOES 26-50, by taking pictures of JANE DOE's breasts during surgery, invaded JANE DOE's privacy in a manner that would be highly offensive to a reasonable person.

56. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

57. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

58. Defendants HONG and/or DOES 26-50's decision to photograph JANE DOE's breasts while she was under general sedation during her breast reconstruction surgery exhibits malicious and conscious disregard for the rights of others, including JANE DOE.

FOURTH CAUSE OF ACTION
INVASION OF PRIVACY: WRONGFUL DISCLOSURE OF PRIVATE INFORMATION
Against Defendants HONG and/or DOES 26-50

59. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

60. California Constitution, Article I, Section I and the common law protect individuals' right to privacy.

61. Defendants HONG and/or DOES 26-50 intentionally and repeatedly discussed confidential details of JANE DOE's surgery with Dr. Kristen Ganjoo, M.D. and other unknown individuals, who were not involved with JANE DOE's treatment, during December of 2012.

62. Defendant HONG and/or DOES 26-50's conversations about JANE DOE's confidential medical information constituted a public disclosure of private facts.

63. The information that Defendant HONG and/or DOES 26-50 disclosed would be highly

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offensive and objectionable to a reasonable person.

64. The details of JANE DOE's medical record that Defendants HONG and/or DOES 26-50 disclosed were not of legitimate public concern.

65. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

66. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

67. Defendants HONG and/or DOES 26-50's decision to share details of JANE DOE's medical record exhibits malicious and conscious disregard for the rights of others, including JANE DOE.

FIFTH CAUSE OF ACTION
VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT
Against Defendants HONG and/or DOES 26-50

68. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

69. Civ. Code, §§ 56 et seq. (the Confidentiality of Medical Information Act) prohibits health care providers from disclosing medical information about patients without first obtaining authorization.

70. Defendants HONG and/or DOES 26-50 intentionally and repeatedly discussed confidential details of JANE DOE's surgery, which Defendants HONG and/or DOES 26-50 performed on December 12, 2012, with Dr. Kristen Ganjoo, M.D. and other unknown individuals during December of 2012.

71. The details of JANE DOE's surgery constitute medical information.

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72. Under Cal. Civ. Code § 56.35, A health care provider who discloses a patient's medical information in violation of Cal. Civ. Code § 56.10 is liable for the patient's compensatory damages and punitive damages not exceeding $3,000, and attorneys' fees not to exceed $1,000, and the costs of litigation.

SIXTH CAUSE OF ACTION
LOSS OF CONSORTIUM
Against Defendants DIRBAS, HONG, PAFMG, STANFORD, and/or DOES 26-50

73. JOHN DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

74. JOHN DOE is the husband of JANE DOE, and was married to her at the time she suffered the injuries that have given rise to this complaint.

75. As a direct and proximate result of JANE DOE's injuries sustained in the course of the incidents giving rise to this Complaint, JOHN DOE suffered loss of consortium damages including but not limited to loss of care, comfort, companionship, protection, support, assistance, love, affection and society previously received from his wife, all to his general damage.

PRAYER FOR RELIEF

WHEREFORE, PLAINTIFFS prays for judgement as follows:

FIRST CAUSE OF ACTION: BREAST RECONSTRUCTION PROCEDURE:

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;
2. For general damages, in an amount to be determined at trial;
3. For costs of suit;
4. For prejudgment interest according to law;

SECOND CAUSE OF ACTION: MEDICAL BATTERY:

1. For special damages, including but not limited to lost wages, medical expenses, and

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incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

THIRD CAUSE OF ACTION: INVASION OF PRIVACY: INTRUSION INTO A PRIVATE MATTER

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

FOURTH CAUSE OF ACTION: INVASION OF PRIVACY: WRONGFUL DISCLOSURE OF A PRIVATE MATTER

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

FIFTH CAUSE OF ACTION: VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT:

1. For general damages, in an amount to be determined at trial;

2. For costs of suit;

3. For prejudgment interest according to law;

4. For statutory damages

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SIXTH CAUSE OF ACTION: LOSS OF CONSORTIUM:

1. For general damages, in an amount to be determined at trial;
2. For costs of suit;
3. For prejudgment interest according to law;

PLAINTIFFS request relief for each cause of action separate and apart from all other causes of action herein alleged.

DATED: March 5, 2014

THE DOLAN LAW FIRM

By: _____

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Exhibit F

ATTORNEYS FOR PLAINTIFFS, JANE AND JOHN DOE

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF SANTA CLARA

JANE DOE; JOHN DOE Plaintiffs v. DR. ROY HONG, M.D., an individual; PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation; DR. FREDERICK DIRBAS, M.D., an individual; STANFORD HOSPITAL AND CLINICS, a professional corporation, and DOES 1 - 50, Defendants.	Case No.: 1-14-CV-261702 Assigned for all Purposes to: Hon. Theodore C. Zayner Dept. 6 **SETTLEMENT CONFERENCE STATEMENT ON BEHALF OF PLAINTIFFS** [Filed and served concurrently herewith Exhibits and Declaration of Lisa Curcio, M.D, Decl. John Shamoun, M.D., and Economics Report of Daryl Zengler, CPA.] Complaint Filed: March 5, 2014 Trial Date: March 20, 2017 Hearing Date: March 15, 2017 Hearing Time: 9:00 a.m. Location: Dept. 6

TABLE OF CONTENTS

CASES

Perry vs. Shaw,
[88 Cal. App. 4th 660] (Ct. App. 2001)

Heckert v. MacDonald,
208 Cal. App. 3d 832, Cal. Rptr. 369 (Ct. App. 1989)

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STATUTES

Calif Rules of Court 3.1380 Mandatory settlement conferences

26 U.S.C. § 104(a)(2)

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Cal. Bus. & Prof. Code,
§ 801
§ 805.
§ 1281
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REGULATIONS

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EXHIBITS (Submitted Herewith)

EXHIBITS (Under Seal)

Exhibits A-Y Under Seal Pursuant to Court Protective Order Nov. 21, 2015.

I. INTRODUCTION TO THE NEEDLESS DEBILITY OF BELOVED WIFE AND MOTHER DUE TO OUTRAGEOUS ERRORS AND WILLFUL AND WANTON DISREGARD

On December 12, 2012 beloved married Jane Doe, new expectant mother of twin girls, was needlessly debilitated and horribly traumatized at age 42, due to outrageous system errors by defendants herein. The defendants' institutional failures of permitting prohibited "drive-through mastectomy", human experimentation without proper consent, a multitude of system errors in improper mastectomy aftercare and instructions, and violations of the Medical Privacy Act in this case were unequivocal.

At Christmas of 2012 when it should have been the most joyful time in the Does' lives in starting their family and expecting the birth of their babies, the Does went through a very dark and private Hell. Ms. Doe became needlessly disabled, placed on medical bed rest, required prolonged wound care, disfigured, and existing in horrific pain nearly 24 hours a day 7 days a week.

What should have been a straightforward, common, preventative, and elective healthy woman procedure in otherwise skilled hands, became a cluster of avoidable complications. Much of the issues arose from misrepresentation of a surgeon about his failed skill and experience in performing newer single-stage or "one-and-done" reconstructions, battery through failure to obtain consent, a grossly mismanaged operation with hospital upcoding for $34,600 of a state-of-the-art artificial skin (Alloderm) which was *Ultimately Not* implanted, unbundling of pre-operative visits from global surgical fees for unjust enrichment, and premature hospital discharge by an unlicensed doctor less than 24 hours after double major surgery.

Stanford's care in this patient's case not only violated multiple Federal and State statutes including false claims laws (referenced infra), Stanford also demonstrated conduct contradictory to many of the hospital's own published internal policies and protocols on medical privacy as well as prohibited staff personal cell phone photography of (unconscious) patients under general anesthesia.

In Summary, Plaintiffs allege institutional system failures including but not limited to:

- Violation Of Anti-Drive-Through Mastectomy Laws
- Violation of Mandated Woman's Health Patient Handouts on Breast Reconstruction Option, Breast Implant Materials, and WHCRA (1998)
- Failure to Obtain Surgical Consent
- Wrong Consent
- Physicians Noting Complications Failing To Act Upon His Exam, Or Even Documenting His Visit
- Uncoded And Unbunded Billing (For Global Surgery Codes and Alloderm)
- Unauthorized Release Of Highly Sensitive And Protected Medical Records To Outside Agencies Without Required Patient Consent, Without A Valid Subpoena, And In Violation Of Court Protective Order
- Privacy Violation
- Unauthorized CellPhone Photos Of Patients While Under Anesthesia
- Unlicensed Practice Of Medicine without Supervision and Co-Signatures
- Failure of Stanford and Guest Services to respond to Patient Grievance

Plaintiffs Seek:

- Economic Damages
- Past and future Medical Expenses
- Pain and Suffering
- Battery Award
- Punitive Damages
- Hospital's Adoption of New Mastectomy Safety Protocols
- Attorney Fees, Expert Costs, and Costs

II. HISTORY OF SETTLEMENT NEGOTIATIONS: PLAINTIFFS' DEMAND

Previously, mediation of this case was contemplated as early as November 2014, just prior to the withdrawal of the law firm representing Dr. Hong. Most recently, preliminary talks were initiated by Judicate West in late 2016. Settlement offers were made by defendants Hong and PAMF to pay only Plaintiff Jane Doe for a total of $59,999.98 (fifty nine thousand, nine hundred ninety nine dollars). Defendants structured the settlement below reporting limits so as to not report Dr. Hong to the Medical Board. In addition, defendants insisted on an unusual waiver to settle all claims and potential claims against *defense counsel* by requiring that Plaintiffs not file any complaints about the ethical breaches and conduct of defense counsel[1] in the case. Defendants

[1] Defense Counsel were subject to Plaintiffs' Motion to Disqualify Counsel for allegations of ethical breeches, multitude of violations of the Court Protective Order, and a deceiving "staged" deposition exhibit production whereby counsel repeatedly concealed 4 pages of a 5 page document to threaten Jane Doe's medical license with false claims, which was filed in December 2016.

justified their offer as fair, in part, due to Jane Doe's former attorneys who purportedly waived earnings, an alleged status that significantly lowered the economic value of the lost wage and future wage component of plaintiffs' claim. Plaintiffs declined the offer.

At and following settlement efforts as recent as December 2016, plaintiffs were also disappointed by intransigence by the defendants in illegally refusing to also produce to plaintiffs the hospital's and defendant's electronic disclosures logs for Jane and John Doe's medical records. Just prior to the 2/3/17 hearing of Plaintiffs' Motion to Disqualify Counsel and Motion for Sanctions, defendant Stanford was found to have produced a partial hospital electronic access log for Plaintiffs' medical records to an outside firm not involved in this litigation, in violation of HIPPA and multitude of other Health and Safety Code violations.

A recent awareness of changes of California law regarding Women's Breast health and extraordinary further revelations of wrongdoing by the defendants (detailed infra), as well as uncovered case and global upcoding and unbundling billing practices weigh heavily in favor of a substantial increase of defendants' offer. Moreover, per *Perry vs. Shaw,*[88 Cal. App. 4th 660] (Ct. App. 2001), a parallel battery case by a plastic surgeon for unauthorized breast implants as in this case, is a tort and not subject to MICRA. Therefore, battery may be compensated without such statutory limitation by the jury. Plaintiffs seek court guidance in obtaining maximum fair compensation. As detailed below, plaintiffs would seek at least $1.1 million at trial in compensatories, in addition to tort award for battery, plus punitive damages, attorney fees, and expert costs.

The two plaintiffs in the action are: (1) Jane Doe, now age 47 (2) John Doe, age 47.

Total potentially recoverable compensatory damages plaintiffs would seek at trial are at least $1,074,595 as discussed below, plus punitive damages, costs, experts, and attorneys fees.

III. THE DOES' NON-ECONOMIC DAMAGES AND LOSS OF CONSORTIUM ARE SUBSTANTIAL AND $500,000 IN SUCH DAMAGES ARE RECOVERABLE

Plaintiffs and their newborn twins (delivered by surrogacy 2 months after this 12/12/12 surgery) have suffered horribly. During what was to be the most cherished and exciting time in

starting their family, Plaintiffs were both frantic and suffered not knowing how and who would take care of the premature newborn twins without their mother. Plaintiff was debilitated and unable to hold her newborns on her chest and enjoy bonding with them for the better part of 6 months until after recovering from a rescue explant surgery on 5/20/13. Her husband and newborns had to endure being without Jane Doe for another round of general surgery and recovery in May 2013. Plaintiffs are entitled to the maximum available $250,000 for their own loss of consortium and pain and suffering damages in connection with the debility of their beloved wife/mother.

IV. ECONOMIC DAMAGES TOTAL AT MINIMUM $300,000 PER ZENGER LOSS REPORT AND OTHER RECORDS

On February 17, 2017, expert economist Mr. Daryl Zengler projected the economic loss sustained due to the debility of Jane Doe. The economic loss is measured as the loss of Ms. Doe's income and household services and is summarized below:

Past Earnings Loss	$ 119,417
Present Value of Future Earnings Loss	$ 175,000 - $851,538
Total Earnings Loss	**$294,417 – $970,955**

In addition, out of pocket medical expenses of over $**7,810.19,** and the Ms. Doe's out-of-pockets of $**13,948** for child care, wound care supplies, and **$5526.72** for locum doctors to help to cover Jane Doe from 12/27/2 to June 2013 are also recoverable.

Total Economic Loss	**$321,701.91– $970,955**
Stanford refund for unlawful billing of pre op visit [2]	$341

- [2] Stanford's unjust enrichment for improper billing of a global surgical fee preoperative visit as "CPT 99215" on 12/11/12 was $494, which was paid at $341 and now due back to the patient.

Stanford refund for improper billing for 2 Alloderm	$17,549
The total estimated future economic damages are:	**$970,955**
The total estimated medical and surgical costs are $34,600 for 2 sheets of Alloderm $120,000 for surgical fees and facility charges Total potential compensatory damage jury verdict:	**$1,074,953++**

According to the American Society of Plastic Surgeons report in 2016 most insurance companies continue to consider fat grafting not "medically necessary" and will not reimburse for any procedure related to fat grafting. As such, members should develop a "self-pay" package for this service outlining the cost of the procedure to include pre/postoperative care, surgeon and anesthesiologist fees, cost of drugs and supplies, etc. The Does are expected to have to pay for multiple fat transfer surgeries including general anesthesia and operating room and anesthesia fees. https://www.plasticsurgery.org/Documents/Health-Policy/Reimbursement/insurance-2015-autologous-fat-grafting-breast.pdf

V. BATTERY IS AN INTENTIONAL TORT AND NOT SUBJECT TO MICRA CAPS

1. Stanford's permissibility of "Ghost Surgery" is an Authorized Basis for an Award of Battery Damages Outside of MICRA Without any Expert Analysis or Even Provable Injury (CACI 530A)

Jane Doe conditioned her consent for mastectomy to performance by Dr. Fred Dirbas. She specifically spoke with Dr. Dirbas on 12/12/12 before surgery and again indicated she was authorizing only him to be her surgeon. She was entitled to and did conditioned her consent implicitly on *who* would be her surgeon. However, Dr. Dirbas in partial "ghost surgery"

7. I authorize the following practitioner(s) (**NAME OF PRACTITIONER** performing procedure):
Dr Fred Dirbas

to perform the following **OPERATION OR PROCEDURE:** ***[Spell out all words, do not abbreviate and identify side/level of procedure to be performed upon if applicable]:*** Bilateral nipple sparing prophylactic mastectomy

Additional comments, addendums to consent:

Dr. Dirbas against Ms. Doe's consent assigned large portions if not nearly all of his duties to Dr. Jon Gerry, a resident. Dr. Jon Gerry dictated the operative report. Dr. Jon Gerry was the first to speak to Jane Doe after the surgery and tell her he had to "dissect into dermis (near to the surface of the skin)" many times and that her mastectomy dissection was very "challenging". Thereby, Dr. committed battery. CACI 530A

Judicial Council of the American Medical Association, Opinion 8.12 (1982), reads as follows: To have another physician operate on one's patient without the patient's knowledge and consent is a deceit. The patient is entitled to choose his own physician and he should be permitted to acquiesce in or refuse to accept the substitution. The surgeon's obligation to the patient requires him to perform the surgical operation: (1) within the scope of authority granted by the consent to the operation; (2) in accordance with the terms of the contractual relationship; and (3) with complete disclosure of all facts relevant to the need and the performance of the operation. It should be noted that it is the operating surgeon to whom the patient grants consent to perform the operation. The patient is entitled to the services of the particular surgeon with whom he or she contracts. The surgeon, in accepting the patient is obligated to utilize his personal talents in the performance of the operation to the extent required by the agreement creating the physician-patient relationship.

He cannot properly delegate to another the duties which he is required to perform personally. Under the normal and customary arrangement with private patients, and with reference to the usual form of consent to operation, the surgeon is obligated to perform the operation, and may use the services of assisting residents or other assisting surgeons to the extent that the operation reasonably requires the employment of such assistance. If a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.

2. Stanford's Conduct *Even Without Any Expert Testimony* Amounts To Battery Which Falls Outside Of MICRA Per *Perry Vs, Shaw.*

Stanford obtained consent for prosthesis under 400cc, a surgically sounds and safe volume for single stage mastectomy. Also in this case, it is irrefutable that the surgeon placed two identical **dangerously sized prosthesis (533cc)** after the mastectomy against the Does' consent to a safer, less than 400cc size. Dr. Hong affirmed his deviation from the consented implant size. Stanford allowed it. At no time, did the Does ever consent to a 533cc implant.. (Dr. Hong Deposition Transcript Feb 18, 2016 P. 17, 3-8)

Q. So preoperatively, what did Dr. A and her husband, and/or her husband, tell you about what size she wanted?

A. She called me after our initial meeting, um, about a few days before surgery, and -- and said that she decided she wanted a 400 cc implant.

Dr. Hong's testimony affirmed battery pursuant to *Perry vs. Shaw,* [88 Cal. App. 4th 660] (Ct. App. 2001) through his admitted *and intended* deviation (not as a complication) from the consent where he performed a completely different surgery- an under the chest muscle implant with Alloderm was consented but he performed without any consent an over the muscle implant without any coverage, and without tacking down the implant (it was left free floating in the chest). (Hong Deposition Transcript Feb 18, 2016 p.74 5-7, 20-22)

Dr. Hong testified that the 2 surgeries are "substantially different" and also carry different risks which would have to be explained in the consent process. Per *Perry (id)*

> ["With the patient unconscious under an anaesthetic, and unable to be consulted, the mere desirability of the operation does not protect the surgeon, who becomes liable for battery which ... renders quite immaterial any question of whether he has complied with good professional practice"].)

Q. (By Mr. Weinberg): They have different risks; correct?
A. Yes, some, yes.
Q. And they are done differently in terms of where you put the implant; correct?
A. Uh-huh.

2. Juries may award any amount for Battery and awarded 1 million dollars in Perry.

Q. Is a subcutaneous implant a substantially different procedure than a subpectoral implant?
A. Substantially different, it is the same risks

At trial, Ms. Perry and her medical experts confirmed that her case was premised on her lack of consent to the breast surgery, and she did not offer any evidence to suggest that the surgery performed by Dr. Shaw was negligently performed. Indeed, the court told the jurors that, although it was irrelevant to the informed consent issue, uncontroverted evidence had established that the surgery performed by Dr. Shaw was within the standard of care. In closing argument, Ms. Perry's lawyer explained that although two causes of action were alleged, there was but a single issue for the jurors' consideration: "The issue here is not whether [Dr. Shaw] did the surgery correctly. The issue here is not whether he improved [Ms. Perry's] looks .... The only issue, the very simple issue for you to decide is whether, in fact, Dr. Shaw had consent to do what he did. The simple answer is: No, he did not." That negligence was also pleaded and proved shows only that Ms. Perry's lawyer was understandably unable to predict the jury's verdict.

[1b] In that case, Dr. Shaw performed an operation to which Ms. Perry did not consent. He committed a battery. The Appeals Court agreed with Ms. Perry that, as a result,

Dr. Shaw's liability was greater than it would have been for the sort of "technical battery" distinguished by the court in Cobbs v. Grant."

"But there is nothing in the legislative history generally, or with regard to section 3333.2 specifically, to suggest that the Legislature intended to extend the $250,000 limitation to intentional torts."

According to *Perry* "The jury believed that Dr. Shaw performed the breast enlargement without Ms. Perry's consent and contrary to her express wishes or, in legal terms, that Dr. Shaw is liable for the intentional tort of battery. Based on those findings, the jury awarded about $1 million in noneconomic damages. We see no reason to reduce that amount and therefore affirm the judgment."

Jane Doe's needless debility was due to a multitude of institutional failures and system errors, and 2 of these were cited by CMS by findings of deficiencies in 2012. (See https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt9grp1&ID=050441)).

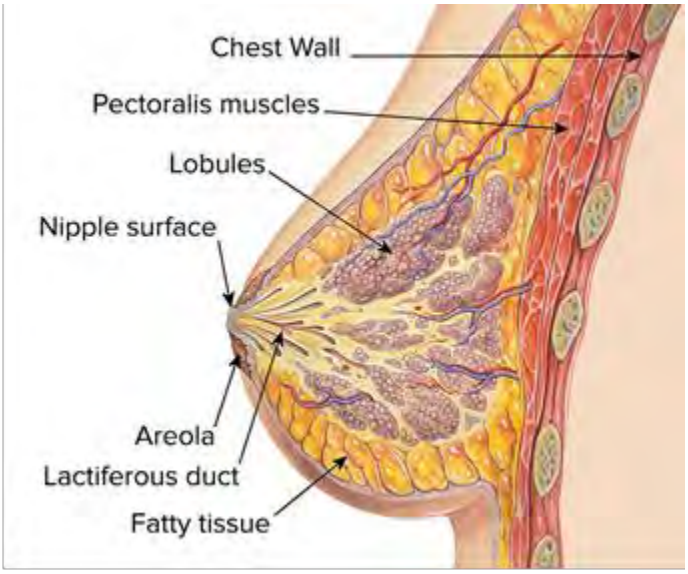
3. PRIVACY BREECH IS NOT SUBJECT TO MICRA CAPS

Plaintiffs have multiple causes of action for privacy and invasion of privacy. Defendant's privacy breaches are not subject to MICRA. It is uncontroverted that Stanford allowed its own privacy policies to be violated by taking photos of the patient under anesthesia with a doctor's cell phone. Stanford has known problems (and active litigation) with similar violations of patients under anesthesia being photographed and the photos being freely disseminated by staff and transmitted. Stanford's former director of outpatient surgery has filed court documents and public declarations of multiple Stanford employees who have attested to the violations of patient privacy while under anesthesia. Staff take patient photos while patients are unaware and under anesthesia. As in this case, the Stanford nurses notes indicated no photos or video were taken. The surgeon's notes do not say any photos were taken. However, against consent and Stanford's institutional policies, the surgeons admitted he did take photos on his personal cell phone and carried them next to his Christmas photos.

E. Plaintiffs Expert Evidence

1. The report of Plaintiffs' consulting expert, Lisa Curcio, M.D., showed that there were a multitude of demonstrable breeches in the pre-operative, operative, and post operative care as well as premature discharge of the patient from Stanford less than 24 hours after critically placed, pre-pectoral, oversized breast implants and improper aftercare instructions.

   Figure 2: normal breast



Dr. Curcio testified that, including, but not limited to, that it is her professional opinion that the breast surgeon independently and jointly with the facility operative team and nursing staff have an ethical obligation and duty to the patient and must conduct themselves accordingly to ensure patient health and safety; that the Stanford staff and operating team had an ethical duty to ensure that the proper consent was given and if anything was scratched out on the consent form that a new one must be executed to insure informed consent and the proper surgical procedure is performed.

Dr. Crucio testified that one stage reconstruction is reserved for patients who select the same size or slightly smaller size breasts after a skin and nipple sparing mastectomy and it would not be the proper procedure where the breast size would be larger; that the community standard of care is placement of the implant post mastectomy in the sub-pectoral space; that it is below the standard of care to place oversized breast implants in a patient in the subcutaneous location; placing 533 cc implants in Plaintiff Jane Doe's breasts after a skin and nipple sparing mastectomy was a substantial factor in placing increased pressure on the nipple areolar complex and adding to the risk of skin and tissue loss.

Dr. Curcio testified that the skin flaps in a skin and nipple sparing mastectomy would be particularly at risk and any significant compromise in the blood flow to those flaps as with oversized breast implants could and likely would cause an unacceptable increase in the risk of surgical harm to a patient as it did with Plaintiff Jane Doe which as below that standard of care; that it was below the standard of care to combine an oversized breast implant and supra-pectoral implant placement following a skin and nipple sparing subcutaneous mastectomy which would predicate a poor surgical outcome; that this would also raise the global risks including, but not limited to, local and systemic bacterial and fungal infections, implant infections, and exposure to the loss of the implant.

Dr. Curcio testified that Dr. Dirbas' failure to fully evaluate the compromised skin and take corrective action was a breach of the standard of care which was a factor in the other complications that Plaintiff Jane Doe experienced after surgery; that Dr. Dirbas breached the standard of care by failing to recognize compromised skin signs post-operatively, urgently notify the patient, and

immediately take corrective measures to release the critical pressure on the skin that was already injured after the mastectomy; that prudent and expeditious removal of the oversized implants, thereby releasing the excessive pressure on the thin mastectomy skin would allow Plaintiff Jane Doe to heal in a timely fashion.

Dr. Curcio testified that Dr. Dirbas' failure to undertake remedial action was a breach of the standard of care which was a substantial factor in the damages to Plaintiff Jane Doe; that the combination of the medical and surgical staff to Plaintiff Jane Doe at Stanford Hospital was a breach of the standard of care and a substantial factor in the unfavorable outcome suffered by Plaintiff Jane Doe.

Dr. Curcio testified that Dr. Kazaure did not perform an examination of Plaintiff Jane Doe's breast prior to discharge; that the December 13, 2012, postoperative note was not signed by Dr. Dirbas, Plaintiff Jane Doe's attending physician responsible for her health and safety at Stanford hospital; that Dr. Kazaure was an unlicensed physician on December 13, 2012; that Dr. Dirbas fell below the standard of care for not ensuring that there was an examination of Plaintiff Jane Doe's breast on December 13, 2012, prior to discharge, as it would have revealed the compromised nipple areolar complex; Dr. Dirbas and Stanford Hospital fell below the standard of care by not meeting its obligation to disclose to Plaintiff Jane Doe at discharge her breast condition and the risks to her health and that is was a substantial factor in causing her damages including, but not limited to, necrotizing of her nipple areolar complex requiring further corrective surgery, disfigurement, and the attended pain and financial expense.

2. The report of Plaintiffs' consulting plastic and reconstructive expert, John Shamoun, M.D., F.A.C.S. issued on December 24, 2015, showed: There were a multitude of professional negligence in performing a total subglandular mastectomy as well as the manner of reconstruction chosen.

3. The Review Of Plaintiffs' Consulting Expert, Hisham Seify, M.D., Ph.D. And Expert Reviewer for the Medical Board of California showed: There were a multitude of departures from standard of care in the informed consent process as well as the post operative tight binding of the breasts after an implant based reconstructed mastectomy.

4. The Report Of Plaintiffs' Consulting Expert, Felicia Cohn, Phd., Showed:

There were a multitude of negligent conduct in taking unauthorized photos of the patient on Dr. Hong's personal cellular phone, as well as performing experimental unconsented surgery without IRB approval and a consent for human experimentation.

Dr. Cohn will testify as to whether Defendants Dr. Dirbas, Stanford Hospital & Clinics, Dr. Hong, and Palo Alto Foundation Medical Group engaged Plaintiff Jane Doe (and John Doe where proper) in an ethically adequate informed consent process and whether ethical obligations of privacy were met. The issue of informed consent includes, but is not limited to, discussing with Plaintiff Jane Doe (and John Doe where proper) the diagnosis if known; the nature and purpose of a proposed treatment or procedure; the risks and benefits of proposed treatment or procedure; alternatives (regardless of costs or extent covered by insurance); the risks and benefits of alternatives; and the risks and benefits of not receiving treatments or undergoing procedures.

The informed consent form should document this disclosure of information and discussion between physician and patient and that federal guidelines suggest that the form should reference: name and signature of the patient, or if appropriate, legal representative; name of the hospital; name of procedure(s); name of all practitioners performing the procedure and the individual; significant tasks if more than one practitioner; risks; benefits; alternative procedures and treatments and their risks; date and time consent is obtained; statement that procedure was explained to patient or guardian; signature of person witnessing the consent if necessary; and the name and signature of person who explained the procedure to the patient or guardian. If the treatment plan may change during the procedure due to foreseeable complications, the contingency plan should also be notes.

5. The Operative Report Of Plaintiffs' Treating Plastic And Reconstructive Surgeon: Chris Nolan, M.D., FACS on or about May 20, 2013, showed[A1]: Dr. Nolan explanted oversized 533cc implants, treated severe bilateral Grade IV capsular contractures, and had no difficulty in easily placing more reasonable sized 375cc implants in the proper submuscular space with use of Alloderm.

VI. HOSPITAL VIOLATIONS OF LEGAL STATUTES AND WHCRA (1998): WOMEN'S HEALTH AND CANCER RIGHTS ACT

Women's health, particularly reproductive health and breast/ mastectomy have been hotbeds of mandated legislative protection. As early as **President Clinton's** State of the Union Address there have been **attacks on the dangerous practice of "drive-through mastectomy"**: (Accessed at http://millercenter.org/president/clinton/speeches/speech-5495)

PRESIDENT CLINTON: (February 4, 1997)

> "Just as we ended drive-through deliveries of babies last year, *we must now end the dangerous and demeaning practice of forcing women home from the hospital only hours after a mastectomy.* I ask your support for bipartisan legislation to *guarantee that a woman can stay in the hospital for 48 hours after a mastectomy.* With us tonight is Dr. Kristen Zarfos, a Connecticut surgeon whose outrage at this practice spurred a national movement and inspired this legislation."

In 1998, the Federal Women's Health and Cancer Rights Act (WHCRA 1998) was enacted granting inalienable rights to breast reconstruction and longer hospital stays. In 1999, California enacted similar and more protective statutes to prevent exactly these types of preventable adverse events in this case, including prohibition of "drive-through mastectomy" and requirements for reasonable inpatient hospitalization after this major surgery in consultation with the patient and physician. In 2011, California Law in response to "drive- through mastectomy" practices was again amended and mandated by SB 255 which reads:

> "the length of a hospital stay associated with mastectomy procedures to be determined post surgery, consistent with sound clinical principles and processes."

1. New California Law enacted in 2012 specifically prohibited Stanford's premature hospital discharge after Ms. Doe's "Drive-Through Mastectomy".

On September 22, 2012

California Governor, Mr. Jerry Brown

signed into law

Senate Bill No. 255 Chapter 449 : An act to amend Sections 1367.6 and 1367.635 of the Health and Safety Code. In relevant parts:

"Existing law requires every health care service plan contract and health insurance policy that provides coverage for mastectomies and lymph node dissections to allow the length of any hospital stay to be determined by the attending physician and surgeon in consultation with the patient, to cover prosthetic devices or reconstructive surgery, and to cover all complications from a mastectomy."

"The bill would require the consultation regarding the length of any hospital stay to be conducted postsurgery."

"(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, postsurgery, consistent with sound clinical principles and processes. No health care service plan shall require a treating physician and surgeon to receive prior approval from the plan in determining the length of hospital stay following those procedures."

"(c) No individual, other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section."

"(d) No insurer shall do any of the following in providing the coverage described in subdivision (a): (2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee or subscriber in a manner inconsistent)

According to the California Medical Association (CMA),

> **"*premature discharge of breast cancer patients from the hospital can lead to adverse outcomes, including infection and inadequately controlled pain***. CMA contends that SB 255 ensures that the length of hospital stay is a decision made by the physician and patient taking individual needs into account".

According to the commercial covering insurance carrier in effect on 12/12/12, the

> "Required Minimum Approvals for Hospital Admissions:
> You may stay in the hospital for: Covered breast cancer surgery (radical or modified radical mastectomy) **at least 48 hours."**

"Y. Breast surgery : We cover mastectomies: **At least a 48-hour hospital** stay following a radical or modified radical mastectomy"
" **Not less than 24 hours of inpatient care** following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. You *and* the attending physician can determine if a shorter stay in the hospital is appropriate when you have these procedures." **There is no evidence that Ms. Doe ever was ever offered or instructed to remain at Stanford, or that Ms. Doe at anytime otherwise refused or signed out against medical advice "AMA" from Stanford.** (Accessed at p. 37 https://mss.anthem.com/Documents/VAVA_CAID_MemberHandbookMadallion.pdf)

3. Stanford Practiced "Drive-Through Mastectomy" In Violation of State and Federal Statutes

Per the Office of Statewide Health Planning and Development (OSHPD), in 2012 Stanford had 181 hospital discharges for mastectomy procedures. For example, in 2013 , that volume dropped to 174 patients. The average length of stay (LOS) was 2.24 days per patient in 2012, and 2.15 days in 2013. Therefore, in this data there is the inference that Stanford does perform drive-through mastectomy, while perhaps more patients are kept for 48 hours or longer, as they should.

Stanford data for mastectomy discharge, the report of Karen Henderson, the Research Program Specialist at Healthcare Information Resource Center, Healthcare Information Division.

	Stanford Mastectomy Discharges	Avg LOS
year		
2012	181	2.24
2013	174	2.15

4. Stanford Bypassed A Multitude of Required Women's Breast Health Notices

Health and Safety Code 2259 (Cosmetic Implant Act of 1992) requires physicians to provide written information to patients considering implant surgery. Jane Doe had consented to saline implants and understood that was the product that would be implanted. Neither Dr. Hong or Stanford never gave Ms. Doe any written information about silicone, or any implant for that matter.

California Health and Safety Code Section 109275 as amended on September 29, 1996:

"Be Informed" " If you are a patient being treated for any form of breast cancer, or prior to performance of a biopsy for breast cancer, your physician or surgeon is required to provide you with a written summary of alternative efficacious methods

> of treatment, pursuant "The information about methods of treatment was developed by the State Department of Health Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures." Signs must be posted in English, Spanish, and Chinese. Quality Assurance Not indicated. Effective Date 1980 enactment;."

Dr. Hong and Stanford never gave Ms. Doe any written information, and no signs pursuant to were H&S Code supra were posted at Stanford.

Moreover, the U.S.C 42 2SEC. 399NN-1 (D)(E), Breast Reconstruction Education Part V of title III of the Public Health Service requires:

> all providers to provide handouts to *all women* on breast reconstruction options and entitles *all* women the *right to choose* a provider of reconstructive care, including the potential transfer of care to a surgeon that provides breast reconstructive care and to do so at *time of their choosing for "personal or medical reasons".*

Stanford failed to give Ms. Doe any handouts at any time on her rights on breast treatment *options and reconstruction*. Stanford violated this Federal statue and not one single page of its 573 pages of medical records show any contrary evidence that any written breast brochures or required information was provided.

5. The Joint Commission Censured Stanford In 2012 for Failures in Postop Instructions

In 2012, the Joint Commission ranked Stanford BELOW the State average for giving patients inadequate post operative instructions. (See https://www.qualitycheck.org/accreditation-history/?bsnId=10010[A2])

6. Stanford Surgeons Reported High (30%) Mastectomy Complication Rates and Knew There Were Institutional Deficiencies in Women's Health

Stanford surgeons and administration *knew* or should have known the hospital had high mastectomy complication rates but the hospital did not alter or adjust its "drive-through mastectomy" practices. According to Stanford's own peer reviewed, scientific publication from a retrospective chart review from 2008 to 2013:

> "Conclusions: Our [Stanford] incidence of mastectomy skin necrosis was 30%. Despite our high incidence mastectomy skin necrosis". (See *Management of Mastectomy Skin Flap Necrosis In Autologous Breast Reconstruction* Ann Plast Surg. 2014; Gordon Lee, M.D. Dept of Plastic Surgery https://www.ncbi.nlm.nih.gov/pubmed/24667879)

Demonstrating more system error and in another highly hazardous practice *known* to Stanford, Stanford surgeons *knew* there were dangerous mastectomy complication rates with oversized implant reconstruction but did not alter their care, observation or management practices in Jane Doe. According to Stanford's own peer reviewed scientific publication from 189 similar breast procedures, there were "**higher complication rates in patients with implants greater than 450 cc**". (Stanford *Nipple Reconstruction: Risk Factors and Complications after 189 Procedures* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780439).

In this case, there is not a scintilla of evidence that Ms. Doe *was consulted* (per SB 255) about her hospital stay or her time sensitive surgical condition. There is no evidence that Ms. Doe at anytime refused to stay, or signed out of Stanford against medical advance on 12/13/12.

7. Stanford Was Cited By Medicare As Substandard In Timeliness Of Care.

The Joint Commission and Medicare have each independently issued multiple substandard findings which would require a plan of correction necessary to prevent needless patient injuries and "never events" (like this unconsented surgery and wrong cavity placement) at Stanford Hospital. According to the U.S. Government, Stanford's "Timeliness of Care" (as in this case) was **below** the National Average.
(https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt9grp1&ID=050441).

Medicare's publicly published statement of below state average deficiencies for Stanford Hospital related to the failure to provide adequate post operative or discharge instructions. That document censured Stanford Hospital, on or about mid 2012, in connection with Stanford's performance below the national average for aftercare instructions as well as below national average for "Timeliness" of Care.

In summary, Stanford Hospital was found by DHS Medicare to have "failed to provide timely care at the national average" (Jane Doe was not timely assessed and provided timely return to the operating room) and failed to provide at the State average standard for aftercare instructions. Jane Doe was not instructed to return to Stanford in 12-24-48-72 hours or anytime for a recheck.

The failure of the attending physician to respond to Patient's emergent medical condition for four hours, and then failing to hold the premature hospital discharge more likely than not contributed significantly to the debility of Patient.

9, Stanford Failed to abide by a mandated "Safe Surgery Checklist".

Stanford also failed to abide by Medicare's "Safe Surgery Checklist" by permitting unconsented surgery to proceed and then failing to have a recovery plan for the patient to properly monitor for complications. (See https://www.medicare.gov/hospitalcompare/hospital-safe-surgery-checklist.html). Stanford failed to obtain a research consent from this patient for the 1st time surgery performed in this case. (See Cal. Experimental Subject's Bill of Rights under Health & Safety Code 24172).

According to respected resources on mastectomy, "Hospital stays for mastectomy average 3 days or less. If you have a mastectomy and reconstruction at the same time, you may be in the hospital a little longer." (See http://www.breastcancer.org/treatment/surgery/mastectomy/expectations). In fact, Stanford's insurance authorization for Ms. Doe's hospitalization required and was pre-approved for "2-3 days"

9. **Stanford Failed To File The Mandatory 1279.1 Report AND Failed To Notify The Does Of The Adverse Event**

Moreover, hospitals are statutorily required to inform the patient or the party responsible for the patient of the adverse event when it makes a 1279.1 Report! Cal. Health & Safety Code § 1279.1(c). Accord July 27, 2007 and January 12, 2009 report of Kathleen Billingsley, R.N. Deputy Director of the California Department of Public Health "the hospital must inform the patient or the party responsible for the patient of the adverse event by the time the report is made." (See https://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-09-05.pdf)

The California Mandatory Adverse Event reporting law defines an "adverse event" as one of 28 enumerated occurrences that could negatively impact patient care and safety; the list reflects the "Never 27" events – the 27 occurrences the National Quality Forum identified in 2002 as those that should never occur at a health care facility. The events are organized under six headings:

surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events. Section 1279.1 (C) "The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent." Section 127.9 (B) addressed Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, etc. The law also includes a new catchall, "Never 28" event: "an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor."

Section 1279.2 details the Department's investigatory responsibilities when it receives a 1279.1 Report. If a 1279.1 Report or a complaint about a hospital indicates "an ongoing threat of imminent danger of death or serious bodily harm," then the Department must perform an onsite inspection or investigation within 48 hours or two business days, whichever is greater (the law does not address the difference between an "inspection" or an "investigation"). Stanford failed to generate a 1279.1 report on Ms. Doe as required by law.

10. Stanford Demonstrated A Multitude Of Institutional Failures

g) UNLICENSED STANFORD DOCTORS MADE UNSUPERVISED DECISIONS

Of the 4 Stanford employed M.D.'s who were responsible for Ms. Doe, only 2 could be verified with the Medical Board of California as having a license to practice medicine in the State on 12/12/12. Astonishingly, both Dr. Hazida Kazurae and Dr. Calloway were not licensed and practicing without authorization; neither doctor informed Ms. Doe they were unlicensed and both directly provided medical care and prescribed medications without any attending co-signatures on their notes or orders.

h) UNLICENSED AND/ OR NON-REGISTERED STANFORD NURSES

Of the 4 RN nursing staff reported for Ms. Doe, only 1 can be verified with the California Department of Consumer Affairs as having a valid RN license. Stella Marinos, RN is license # 126431. Somewhat troubling is that Elaina Favis, RN and Janet Whitmore, RN -none of these

individuals can be verified according to California Department of Consumer Affairs Board of Registered Nursing. Vicki Murri, R.N., alias, Victoria Maria Atkinson, Board of Nursing License 827759, was only issued on 8/23/12 (4 months before taking care of Ms. Doe) and has been delinquent and expired as of 8/2016.

i) STANFORD'S FEDERAL FALSE CLAIMS ACTS (FCA) VIOLATIONS

Additionally, Stanford had a number of coding and billing irregularities in this case alone, which were demonstrable as a practice pattern. Stanford's upcoding and unjust reimbursement received has to date not been rectified or refunded by the hospital to the proper parties.

Stanford upcoded and **unbundled** pre-operative visits which were rightfully under a global surgical fee. For example, in this case Stanford charged $494 on 12/11/12 CPT code "99215" for a comprehensive visit, although per CMS the pre-op visit is not separately billable. This resulted in unjust enrichment to Stanford of more than $341 for this case alone. The note on Ms. Doe on 12/11/12 was unbundled and upcoded as a 99215. Dr Dirbas' s PA note- care rendered by a PA

> We explained that this is a prophylactic procedure and that it is elective, that she does not have a biopsy-proven breast cancer, and she understands this. We discussed the risks, benefits, and alternatives, including seroma, hematoma, poor wound healing, and poor cosmetic outcome. The patient is undergoing immediate reconstruction with implants with Dr. Roy Hong. She is scheduled to have her surgery tomorrow December 12, 2012. All the patient's questions were answered at the time of the visit and she signed a consent for bilateral nipple areolar sparing mastectomies with immediate reconstruction with implants.
>
> Candice Schultz, PA-C
>
> Frederick M Dirbas, MD
>
> SJN: 542372800 DJN: 651139
> D: 12/11/2012 18:30:00 T: 12/11/2012 19:02:33 / MODL

DR. DIRBAS WAS NOTIFIED OF UNLAWFUL CODING AND FALSE CLAIMS ACTS

On or about March 6, 2017 Stanford's billing department acknowledged receipt of the notice of the above up coding defects.

Per The Office of Statewide Health Planning and Development (OSHPD), in 2012 Stanford had 181 hospital discharges for mastectomy procedures. That would equate to likely an average of

181 times $300-$494 unbundled and wrongfully collected fees- totaling approximately **$64,000 of squandered health care dollars** in mastectomy alone. That does not account for all of the other thousands of other surgeries which are not analyzed here. Stanford data was provided for mastectomy discharges, the report of Karen Henderson, the Research Program Specialist at Healthcare Information Resource Center, Healthcare Information Division. This is a genuine public health issue and subject to Federal False Claim Acts.

Section 6401 of the Affordable Care Act (ACA) required Dr. Hong and the hospital to have a billing fraud, waste, and abuse Compliance plan beginning in January 2011. According to the report of Dr. Ashby Wolfe Chief Medical Officer for CMS of California and Region IX, all providers even single practices were required to have a compliance plan. (See p. 15 http://www.mbc.ca.gov/Publications/Newsletters/newsletter_2015_10.pdf),

The Department of Health and Human Services and the Centers for Medicare and Medicaid have issued responsive coding, billing, and payment records for Defendant Roy Hong and PAMF through a FOIA (Freedom Of Information Act). These publicly available reports identify very conflicting pictures. While in one public forum (Superior Court documents) Dr. Hong on 2/18/16 testified under oath that he had performed TWO single stage immediate implant based mastectomy reconstructions (CPT "19340"), in another public forum (CMS billing) Dr. Hong did in fact bill the U.S. Government and received payment for this same CPT "19340 " THIRTY times from 4/20/2010 through 5/14/2014, and that is not even counting the non- Medicare beneficiaries. More troubling is that of the 30 instances where Dr. Hong billed CMS and received payment for CPT 19340, 28 of these were purportedly performed at an outpatient ambulatory center and only 2 cases were performed at an inpatient hospital. The place of service is also conflicting because mastectomy is a major surgery and almost always performed at an inpatient hospital. These highly conflicting reports on Dr. Hong present concern for multiple mastectomy negligence issues, ethical breaches, and improper utilization of government health care dollars in upcoding and false claims to government entities.

VII. PATTERN FALSE CLAIMS ACTS: STANFORD HOSPITAL FRAUDULENTLY BILLED AND COLLECTED UNJUST ENRICHMENT FOR 2 UNITS OF ALLODERM (ARTIFICIAL TISSUE) ($34,600) BUT USED *NONE* IN JANE DOE

In summary, the hospital had multiple highly *conflicting* reports in the medical record for upcoding of 2 units of Alloderm CPT code 15171. It is therefore impossible that all of the contradictory records were correct. One or more of these records were disingenuous.

Criminal False Claims Act (18 U.S.C. § 287) and California False Claims Acts. Dr. Shamoun, Plaintiffs' expert testifies that Alloderm should have been used for Ms. Doe's surgery and would have prevented the complications and tissue death that ensued. Decl. Shamoun Exh BB. (Depo Dr. Hong p .20 12-20)

1. 12/12/12 14:52 PM S. Marinos RN reported that 2 units (sheets) of Alloderm were implanted into the Right and Left Chest. Code "1" is " implanted."

12/7/1969 SEX F
N 1310197664 18
Addressograph or Label - Patient Name, Medical Record Number

PROCEDURE • OPERATION • IMPLANT/EXPLANT
Note: for Tissue Implant/Explant Only use form 15-1311-1

IMPLANTING PHYSICIAN	IMPLANT SITE
Dr R. Hong	Bil Breast

IMPLANT MANUFACTURER
MTF

DESCRIPTION	MODEL / CAT #	LOT/SERIAL #	EXP Date	QTY	ACTION
The Following Additional Tests Were Performed On Donor 0351108718 HCV AB;HIV 1-2 AB;CMV ANTIBODY;HBV NAT; HTLV I/II					
THIS TISSUE IS SUITABLE FOR TRANSPLANTATION Lyt Breast	011816		Aug 10 2015	1	I
Lyt Breast					
Musculoskeletal Transplant Foundation Exp Date: 14Jun2015 ITEM: 011816 SERIAL No: 00211067841023 DESC: DermaMatrix -8 cm x 16 cm Right	011816		Aug 11 2015	1	I

ACTION CODE:
1 = Implanted 2 = Explanted 3 = Implanted and Explanted 4 = Wasted 5 = Charge Only (Not implant Item)

FORM COMPLETED BY	DATE	TIME
S. MARINOS	12/12/12	1452

15-1311 (10/09) **White** - Medical Records **Pink** - OR Region

2. 12/12/12 5:02 PM Dr. Hong reported in his operative report that he implanted and explanted only one sheet of Alloderm into the Left chest, so he "wasted" and did not leave any Alloderm in the patient's body.
3. 12/12/12 5:08 PM Dr. Hong reported in his immediate op report that he performed bilateral dermal matrix implants.
4. 12/12/12 Stanford billed patient $34,600 for 2 sheets of Alloderm and received unjust enrichment for these products. In fact, the upcoded Alloderm accounted for 1/4th of the total approximately $146,000 billed for the less than 18 hours of post op care at Stanford. Criminal False Claims Act (18 U.S.C. § 287) and California False Claims Act.
5. 2/18/16 Dr. Hong affirmed he did not use any Alloderm in Jane Doe. (Depo Dr. Hong p. 21, 15-17)

> Q. So as I understand it, the way you ultimately did the surgery, you didn't use AlloDerm; true?
> A. Tried to. Tried to initially. But did not.

6. The public is adversely affected by Stanford's practices. Per The Office of Statewide Health Planning and Development (OSHPD), in 2012 Stanford had 181 hospital discharges for mastectomy procedures. That would equate to a potential of 181 times $15,000 of upcoded and wrongfully collected fees- totaling approximately **$2,715,000 of squandered health care dollars in just 2012** in mastectomy alone. That does not account for all of the other thousands of other surgeries which do use Alloderm or other supplies and implants which are not analyzed here. Stanford data was provided for mastectomy discharges, the report of Karen Henderson, the Research Program Specialist at Healthcare Information Resource Center, Healthcare Information Division. This is a genuine public health issue and subject to Federal False Claim Acts. Although these billing discrepancies have not been made public, the upcoding and

unbundling in this case reaches the magnitude of foreseeable basis of a Qui Tam lawsuit filed with the Department of Justice.

On date of service 12/12/12, Dr. Hong's associated Stanford billing and medical records were also conflicting. The patient ultimately received no units of medical device/ implant of Alloderm CPT code "15171" or" 15170" in the surgery. Stanford upcoded and billed for **2 units** of Alloderm for $34,600. This too resulted in unjust enrichment of more than approximately $10,000 to Stanford. Both the patient and Anthem paid 100% of the allowable on this fee, each in proportion.

- The surgeon's operative report for 12/12/12 , *if to be believed*, reflects that the patient left the operating room with no Alloderm implanted. It shows one sheet was implanted and explanted on the left side only.

- The O.R. nursing record, *if to be believed*, showed 2 units of large 8x16 sheets of Alloderm were implanted in the patient. The nursing note states that none were wasted and none were explanted.

- The surgeon's deposition testimony, *if to be believed,* reflects that 1 unit or partial unit of Alloderm was used and explanted.

- Coincidentally, an outside institution's independent (Mission Hospital) May 20, 2013 operative and pathology records for the patient show that no Alloderm was in the patient.

Since the PAMF reflected that their billing department requested the Stanford records on 1/3/12, then it would seem reasonable to assume that Stanford and PAMF were both aware of the surgery reports, upcoding, and Alloderm non-usage at that time.

7.

a) DR. HONG WAS NOTIFIED OF UNLAWFUL CODING AND FALSE CLAIMS ACTS

On or about 12/19/16 Dr. Hong mailed Plaintiffs a signed copy of amended health records from about 11/22/12 where Dr. Hong had misrepresented for an insurance prior authorization that Ms. Doe had "bilateral history of breast cancer" when she did not have any cancer. H&S Code 2266.

In follow up, on 2/1/17, Plaintiffs requested and obtained from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services its responsive document

production vis a vis a password protected file with the billing and coding records of Defendant Dr. Hong from 2011 to present. That document demonstrated that Dr. Hong upcoded his mastectomy reconstructions consistently from at least 2012 through March 2014, when he ceased completely billing Medicare for CPT Code 19340, immediate implant based reconstruction, based on Medicare data alone. Dr. Hong did not bill a single CPT code 19340 to CMS after 2014, ironically after this suit was brought forth, and only billed a total of 6 breast reconstruction codes CPT 19342 (Delayed Reconstruction) from 2016 to present date.

On 12/19/16 Dr. Hong submitted a signed verification showing the false claims submitted to multiple entities reporting that Jane Doe had "Bilateral History of Breast Cancer", which was entirely fabricated and not true.[3] Exhibit A and B attached hereto.

1. Dr. Hong upcoded modified -22 for a complex manipulation of the "mastectomy pocket" for an under skin prosthesis placement while billing CPT 19340, a single stage post mastectomy implant based reconstruction code. The -22 modifier is a highly unusual code, an aggressive one, and one that is not used very often, except when a doctor is reflecting much much, much, greater added work for a particular procedure.

    - The modifier -22 with CPT 19340 appeared in the coding for Ms. Doe's surgery on 12/12/12. Now, as CPT 19340 is in fact for a single stage mastectomy reconstruction with permanent implants, it would appear non-standard why Dr. Hong billed and received enrichment for this extra fee per -22 in a standard uncomplicated, single-stage "one-and-done" case. Moreover, this code would per RVU standards reflect the extra work with an submuscular implant- therefore extra time to dissect the chest muscle on both sides.

      That modifier mis-use issue led us to a lengthy further investigation, retrieval of billing data, and expert analysis of Dr. Hong's billing for CPT 19340, single stage reconstructions. Those mass public data billing records were sent to Dr. Hong and his billing department on March 8, 2017.

[3] Jane Doe has <u>never</u> had any cancer; she has never had breast cancer.

The interesting finding was it turned out that there were some overall errors in coding CPT 19340. According to CMS, Dr. Hong had a number of these upcdoding and "maximizing" reimbursement efforts for a much larger number of patients. **From 12/1/09 to 11/28/16 Dr. Hong billed CMS $488,575.80 for just breast codes alone. In the same period, Dr. Hong billed CMS $1745833.75 in total.** There were on or about at least a dozen plastic surgeons at PAMF in this same department with presumably the same billing practices. That figure fals to capture the number of Stanford doctors who were also upcoding breast surgeries.

2.

- For example, Dr. Hong upcoded and billed 19357 and 19340 on the same patient, on the same bilateral breasts. Pursuant to CPT, The correct codes should have been billed of 19357 and 11970, which pay much less. As a result of the False Claims Act violation, there was potential unjust enrichment of $1617.20 to Dr. Hong. $539.07 and $1078.13 for this one patient alone.
- In addition, Dr. Hong upcoded by adding on 2 units of 19380, reconstruction of a breast, codes for an potential unjust enrichment of $361.50 + $361.50+ $723. In total, Dr. Hong received an unearned enrichment from Medicare, and the Medicare beneficiaries totaling $2340.20 for patient pseudonymized HIC #0211348772460.

0211348772460	365487504565	A	1749	V8401		12/6/2011		21	2	19357	LT			
0211348772460	365487504565	A	1749	V8401		12/6/2011		21	2	19357	RT	51		
0212123443690	365487504565	A	V103	V4571		4/18/2012		24	2	19340	LT			
0212123443690	365487504565	A	V103	V4571		4/18/2012		24	2	19340	RT	51		
0212123443690	365487504565	A	V103	V4571		4/18/2012		24	2	19380	LT	51		
0212123443690	365487504565	A	V103	V4571		4/18/2012		24	2	19380	RT	51		

As another example, we found other instances of misapplication for CPT 19340.

0910326132220	32090303889	A	1749			11/12/2010		21	2	19357	LT			
0211059176780	32090303889	A	V4571	V103		2/23/2011		24	2	19340	LT			
0211059176780	32090303889	A	V4571	V103		2/23/2011		24	2	19370	LT	51		
0211348772480	32090303889	A	V4571	V103		12/5/2011		22	2	19340				
0211348772480	32090303889	A	V4571	V103		12/5/2011		22	2	19370	51			
0211276371650	51709405817	A	6111			9/23/2011		21	2	19318	RT			

HIC # for this beneficiary showed that Codes 19357 (tissue expander) and 19340 (implant) were again used in the same patient, whereas an expander exchange would not correctly result in a

19340 code, new mastectomy reconstruction code. CPT 19357 leads to exchange of the tissue expander, a code 11970 which would be a less RVU code than a "one and done" CPT code 19340.

b) ALTERED, STALE DATED, CONCEALED AND/OR OMITTED MEDICAL RECORDS

Dr. Hong and Dirbas have been each reported in the peer review process at Stanford. Dr. Hong affirmed in his deposition testimony that he underwent a peer review but refused to disclose the findings.

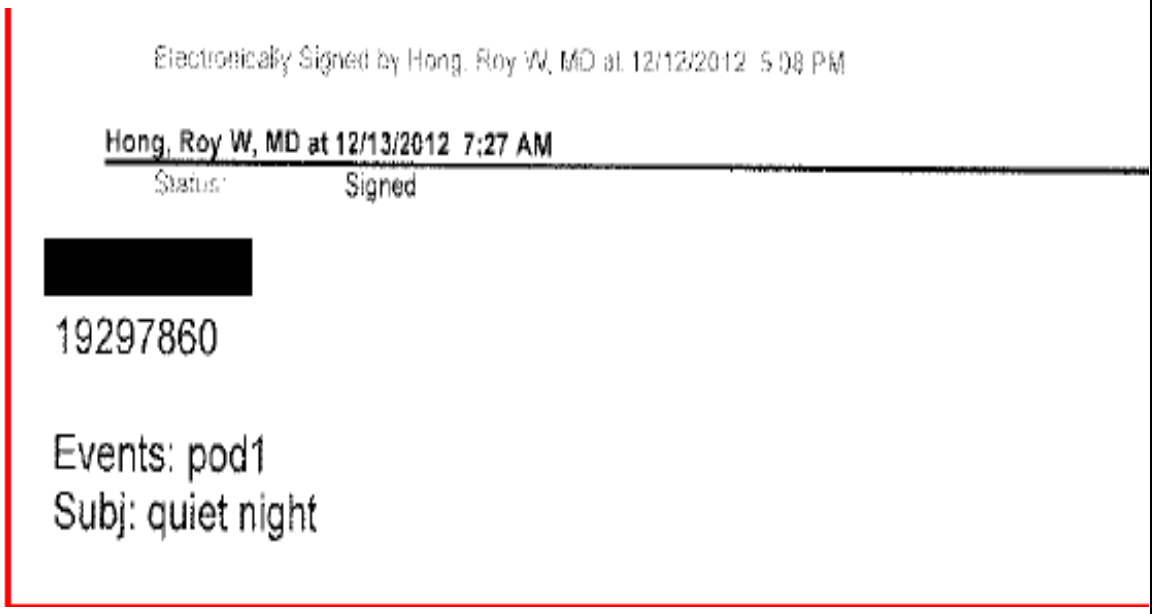
Troubling to the discerning reader, Stanford records included some 2-3 different and altered versions of Dr. Hong's operative reports for 12/12/12. Some were dated 12/12/12 5:00 PM, 12/12/12 5:08 PM, and others on 12/20/12. Dr. Hong added about 4 sentences to the operative report on 12/20/12 when he purportedly edited his reports, however, his report was full of inaccuracies and failures according to his own deposition testimony. (Hong Depo 2/18/16)

Dr. Hong's 12/13/12 post op day #1 dictated note had multiple omissions and concealments. For example, although nursing had recorded 6 calls for post op pain and complications from 12/12/12 7:50 PM through 12/12/12 Midnight , Dr. Hong recorded *"quiet night*" in his note of 12/13/12, demonstrating his utter disregard to the patient's symptoms. The "Nursing Communication Flowsheet" in relevant parts read

"12/13/12 0023	EF paged Doctor	Medication Issue
12/12/12 2348	EF paged Doctor	Patient Request
12/12/12 2255	EF Paged Doctor	Medication Issue
12/12/12 2116	EF Paged Doctor	Medication Issue
12/12/12 2103	EF Paged Doctor	Medication Issue
12/12/12 1950	CB Paged Dr. Dirbas	Patient Request.

As a 2nd example, despite Ms. Doe and her husband's unmistakable distress voiced and grievances on 12/13/12 7:30 AM to Dr. Hong and others about his conduct and the unconsented

surgery, Dr. Hong's note recorded *"no complaints" and " quiet night", concealing the complicaitons.*


Electronically Signed by Hong, Roy W, MD at 12/13/2012 5:08 PM

Hong, Roy W, MD at 12/13/2012 7:27 AM

Status: Signed

[redacted]

19297860

Events: pod1
Subj: quiet night

PE: bilateral flaps healthy, no hematoma, Drains serosanguinous

None of the true adverse reports were recorded by Dr. Hong. Dr. Hong also concealed the true exam findings of his physical exam of darkened nipples, and red vascular ischemia (early signs of skin death). Evidence Code 412, B&P 2266.

Astonishingly, Stanford records also had absolutely *no evidence* of the 12/13/12 breast exam and visit by Dr. Dirbas. (Evidence Code 413) However, Dr. Hong's records did include a stale dated "pre-op" note which was written 2 days after the purported 12/11/2 visit. Stanford and Dr. Hong both also refused for more than 4 years to produce an electronic access log of accesses to Ms. Doe's records, and Dr. Hong refused to provide any of his hand written notes. B&P Code 2266; California Health & Safety Code Section 123100 et seq., 2225.5. (a) (1); Civil Code Section 56.101; and Confidentiality of Medical Information Act.

Plaintiffs believe that a cover up by the hospital justifies and requires judicial action in the form of injunctive relief requiring the hospital to follow the law and voluntarily

provide adverse event reports to all affected families/patients, as well as file voluntary refunds for overpayments to CMS; in this case it took four years and filing of multiple motions including a motion to disqualify defense counsel before the hospital followed the law and produced to plaintiffs its electronic disclosures log for Plaintiffs over the debility of Jane Doe. Stanford, a purported non-profit hospital, charged exorbitant fees ($146,000 for less than 24 hours) which resulted in unearned enrichment. Stanford also valued its good name above and beyond patient safety. **Absent a fair settlement, extraordinary misconduct by defendants justifies punitive damage awards in this case.**

d) STANFORD VIOLATED THE MEDICAL PRIVACY ACT

On or about January 25, 2017, Jane Doe received a correspondence dated January 11, 2017, from Bernice Zander, BS, RHIT, CCS, Director HER Integrity and HIMS Operations for Stanford. Enclosed with the letter was Plaintiff's request and partial list of Stanford's electronic PHI disclosures. The list was not inclusive and omitted any records sent internally, requested by various staff, accesses within Stanford, or anything for "treatment, payment, and operations."

Through Stanford's communication, astonishingly Plaintiffs discovered that on December 23, 2015, their entire Stanford records with both parties' PHI which included tests subject to H&S code 12110 was released to "Donnelly, Nelson, Depolo and Murray, a Professional Corporation" that is described as an "accomplished Medical Malpractice Defense Firm" in Northern California. (See http://www.dndmlawyers.com/). It is worth noting that John Doe's medical records are not subject of the law suit, nevertheless, they were included in these documents. Plaintiffs were never served a Notice to Consumer or a Deposition Subpoena from Stanford or their attorneys for the release of their PHI to Donnelly. Plaintiffs were not given any authorization forms permitting Stanford to release all records. Civil Code 56.10 et. seq.. Code of Civil Procedure 1985 et. seq. Furthermore, among these highly protected records are both Plaintiffs' highly sensitive and Federally psychological evaluations, genetic testing, and "other" special testing. Records of third parties were also released among these documents by Stanford and Stanford REI, against consent.

The institutional failure and system errors in Stanford REI Clinic's handling of patient files of third party medical records, psychotherapy records, and HIV and HTLV records is troubling for the public at large since Stanford REI purportedly treats 20,000 patients a year. Studies of REI's practices and record practice management demonstrate this is an institutional error. (accessed https://obgyn.stanford.edu/divisions/rei.html)

Stanford could have followed proper procedure for this with subpoenas, which they did not do. They could have notified the patient, which they did not do. As a non-involved or third party, Stanford could have objected to the portion of the record which was not allowable for release. Stanford's duty was to protect the patient which it failed miserably to do. Stanford could have communicated their objection or minimize the release the higher confidential medical records. Stanford could have had the attorneys compel production of records that were relevant to the case. More troubling, for the September 2013 record production, Stanford was negligent in releasing records prematurely in another unrelated matter, after they knew that the underlying case was stayed and the subpoena was invalid. Stanford received multiple letters putting them on notice that nothing from REI was to be released at all without at minimum notice to them. Stanford never called, wrote, emailed, or notified Plaintiffs in any manner that a multitude of highly protected documents were released, multiple times without their authorization.

Any psychiatric component of a medical record must have been highly guarded and protected by Stanford Federal and State privacy laws specially govern these highly confidential medical records.

The Doe's Stanford medical records included highly sensitive and private information protected by Health and Safety Codes 121110, 120975, 120980, 121922, 123148, 121075 among other sections. Stanford's release of those records was therefore a violation of H&S Codes, as well as an institutional failure whereby none of the REI clinic records are properly segregated.

j) STANFORD VIOLATED JOHN DOE'S MEDICAL PRIVACY RIGHTS

John Doe's identified PHI with his date of birth for these special tests were contained unredacted and unsegregated within Stanford's medical records for Jane Doe. Accordingly,

Stanford's release of John Doe's medical records violated Health and Safety Codes 121110, 120975, 120980, 121922, 123148, 121075 among other sections.

k) STANFORD VIOLATED 3RD PARTY MEDICAL PRIVACY RIGHTS

Additionally, as Stanford's records through their specialized REI clinic included similar highly sensitive records and special tests for third parties including John Doe, as well as multiple parties not party to this litigation. The release of those records was also a violation of those non-party's medical privacy rights. Code of Civil Proced. 1985.3 and Civil Code 56. Et. seq.

l) STANFORD VIOLATED COURT PROTECTIVE ORDERS

Defendant Stanford has violated in addition to medical privacy laws for both Plaintiffs, the Stipulated Protective Agreement of March 23, 2015 and the Court Protective Order of November 18, 2015 by releasing Jane Doe's PHI without a CCP 1985.3 notice or any authorization to do so.

At all times, defendants vehemently denied sending or receiving any protected health related documents from or to entities outside of the parties in this instant litigation. At all times defendant Stanford REI reassured Plaintiffs that their records were segregated and not released to anyone. However, on or about 1/25/17 Defendants released responsive documents that unequivocally demonstrated that this claim was false **in clear violation of the court ordered Protective Order** and Defendants confirmed that they had failed to redact or protect sensitive records, and released both Jane and John Doe's protected health information to a multitude of parties including the Donnelly Law Firm who is not a party to this or any litigation known to Plaintiffs. Additionally, Defendants released records with special PHI to 3rd parties outside of this instant case.

VIII. TERRIBLE FAMILY IMPACT FROM DEBILITY OF BELOVED WIFE AND MOTHER MS. DOE

The impact of Jane Doe's debility has been terrible. Her debility has robbed the family of their chief caretaker, a hard worker and wage earner and the family's joy and spark. Jane Doe lived life with joy and devoted herself to her husband and her family. She loved to take care of the family, organize family reunions and holidays, and make every day fun, new, and exciting by doing outings, entertaining and doting upon the family. She loved the anticipation of starting her new family with her beloved husband and true love and be intimately involved in the day to day

care of her newborns and always planned to be very hands on in raising the newborns with her husband without outside help. Her debility has left the family sad and depressed, and every day after the December surgery had been an immense struggle for them.

Jane is John's true love and only wife. He had to immediately step up to take care of the twin newborns, including care for the two daughters for the painful and long months while his wife was unable to hold the newborns on her chest. He worked very hard every day to take care of the newborns, including feeding and holding them while juggling depression and distress over his wife's condition and constant pain, his work and paying the bills that his wife used to help cover with her job.

The twins now 4 years old lost precious bonding time with their mom in the newborn days, and again at age 4 months when she was away from them for more than 2-3 weeks recovering from her urgent explant surgery in May 2013. The twins now have to be explained mom's condition while the family carves out time for another round of risky surgeries and prolonged recovery.

John Doe, now 47, was over the moon to become a first time father in February of 2013. He had never had any experience with newborns or knew how to take care of the twins. He had relied on Jane Doe to help them with raising their newborns together. He struggled with work and apprehension and anxiety, problems he never had before his wife's debility. The twins, now 4, never knew the warmth and security of being held on their mother's chest in the first 5-6 months of life or what it's like to have that close touch and bonding with their mother. The Does do not have any other children.

IX. WILLFUL AND WANTON DISREGARD FOR MS. DOE

A. Defendants committed a litany of errors that caused or contributed to the needless debility and injuries to Jane Doe

Defendants committed errors including the following:

- Defendant's own preoperative planning requested "2-3 days hospitalization" and that was approved by Plaintiff's insurance carrier. Defendant failed to follow it's own hospital plan.

- Plaintiff Jane Doe underwent a double mastectomy on December 12, 2012. The surgery was complete at 5:02 PM.
- Doe was effectively discharged from the hospital by 11:00 AM (Stanford's check out time) on December 13, 2012 which was less than 24 hours after the double breast mastectomy.
- Defendants were reckless in failing to properly observe Jane Doe after surgery.
- Defendants failed to institute any type of tissue commercially available perfusion monitoring or tissue oxygenation measurements.
- Defendants failed to institute any rescue therapy to increase perfusion to Jane Doe's skin and nipples, and neglected to timely return Jane Doe to the operating room to prevent the skin necrosis which ensued.
- Defendants willfully bound Jane Does's breasts in a tourniquet fashion thereby ensuring tissue death, and instructed her to tightly bind her breasts 24 hours a day 7 days a week.
- Defendants discharged Jane Doe prematurely from Stanford without adequate and timely follow up.

The surgical floor nurse – defendant Stanford's Vicki Murri, R.N., never once lifted Jane Doe's surgical garment or looked at the mastectomy wound or nipples before discharge and documented in fact that she did not examine Ms. Doe's wounds on 12/13/12. She was the last person to see Jane Doe prior to her discharge, yet she in wanton disregard for the applicable standard of care which provides that the patient must be discharged in stable condition and receive adequate follow up and instructions, she failed to notify supervisors.

The surgical attending – defendant Dr. Fred Dirbas, who on 12/13/12 did lift Jane Doe's surgical garment and saw the dark and red mastectomy wounds and nipples before discharge, did not write a note or make any record of his exam in outrageous disregard for the Medical Practice Act and Business and Professions Code 2266; CACI 204, Evidence Code 413.

Dr. Dirbas was intimately knowledgeable of the very thin skin flaps and deep "dermal dissection" which his resident created in Jane Doe and that the flaps could not have tolerated shoving of oversized silicone shells directly into the flaps. The implant should never be

aggressively shoved into the fresh mastectomy pocket and manually directly sandwiched between thin traumatized bloody skin and the silicone plastic shell. Another "never event" was using a tourniquet to essentially kill off any remaining chance of survival by Jane Doe. Deliberately tightly binding the breast skin with a "Spanx" type surgical girdle did nothing but squeeze out the last drops of blood going to the skin in those areas. Since causing necrosis "tissue death" put not only the woman's breasts and nipples at risk of sloughing off, which is what happened here, this may put the woman at risk of implant extrusion, infection, debility, intractable pain, and need for multiple corrective surgeries, which is also what happened here.

In fact, placement of implants beneath the chest muscle (not under the skin) with artificial tissue (Alloderm) is the safest method for single stage mastectomy reconstruction. California Health and Safety Code 1348 (e). See Medscape: Incorporating Single-Stage Implant Breast Reconstruction Plast Reconstr Surg. 2015;136(2):221-231; and ACS Surgery: Principles & Practice Breast Procedures accessed at http://www.medscape.com/viewarticle/503006_12).

Direct-to-Implant reconstructions, also called "One-Step Reconstructions," or "One-Stage Reconstructions," almost always require the use of a tissue matrix. A tissue matrix is a substitute for your own tissue made from either human or animal tissue. Alloderm®, one of several available tissue-matrix products, is made from donated human skin using a proprietary technique. With the use of a tissue matrix such as Alloderm®, some women are able to avoid the tissue-expansion phase of breast reconstruction in what has been termed a "straight-to-implant" procedure. During this kind of surgery, the lower edge of the pectoralis muscle is detached from the chest and lifted up to form the upper part of a "pocket" that will eventually contain a breast implant. The upper portion of the breast implant is placed under the lifted muscle; tissue matrix is then used to span the space between the edge of the detached muscle and the chest, thereby covering the lower portion of the breast implant. The tissue matrix is attached between the muscle edge and the chest wall so that behind the muscle and the implanted tissue matrix a pocket large enough to

accommodate an implant can be created without the need for tissue expansion. Typically, small- to medium-sized breasts can be reconstructed in this manner. [4]

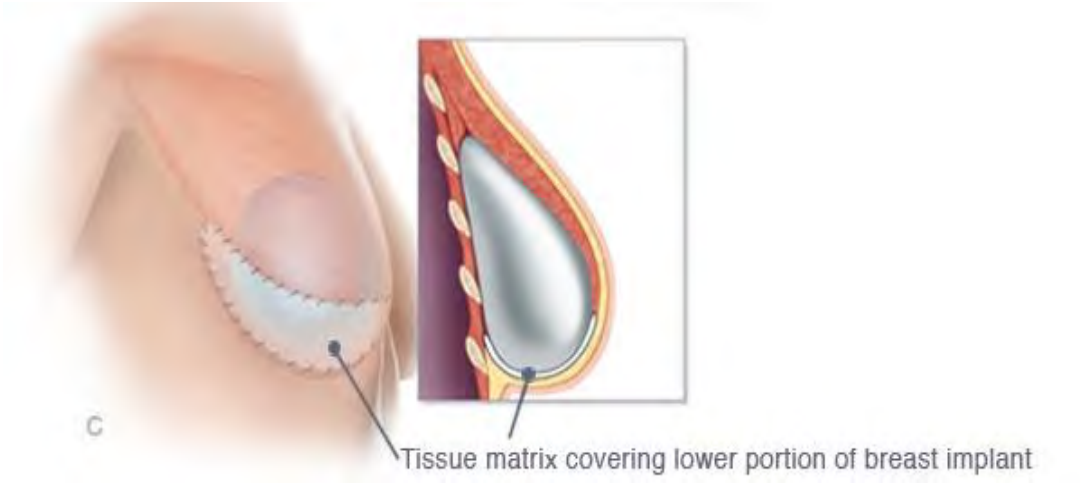


Figure 1: Proper surgical technique with artificial tissue to hold implant

Jane Doe had never had breast cancer, never been irradiated (no radiotherapy) , had no breast scars, was not diabetic, was not ever a smoker, and had no risk factors for surgery. Also according to Stanford:" **Radiotherapy was the only parameter that was associated with a statistically significant increase in postoperative complication rate (51.7 percent vs. 6.25 percent**." Jane Doe lost both of her nipples and areola, which are now in a formalin jar. According to Stanford's own publication: "In fact, the nipple areolar complex (NAC) has been described as the defining element of the female breast." (See Stanford's own publication *Nipple Reconstruction: Risk Factors and Complications after 189 Procedures accessed at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780439). Smoking status, increased age, tumescent mastectomy technique, and high (>66.67%) intraoperative tissue expander fill to confer increased risk of mastectomy flap necrosis. (See J Plast Surg Hand Surg. 2014 Oct;48(5):322-6. https://www.ncbi.nlm.nih.gov/pubmed/24495186. **Risk factors for mastectomy flap necrosis following immediate tissue expander breast reconstruction.)**

The nurses and staff who tended to Jane Doe after surgery failed to act upon and failed to record that Jane and her husband made multiple complaints of intractable pain while her chest and nipples were actively suffocating without blood and oxygen. The nurses and staff who tended to Jane Doe post-surgery failed to examine and record the skin and nipple color and blood perfusion, including the degree of skin necrosis the woman (and first time mother to-be) had post-operatively;

The nurses and staff, including Dr. Dirbas and Vicki Murri, Registered Nurse, did not properly inspect and re-inspect the surgical site before discharge, another flagrant disregard for the standard of care. *See* B& P code 2266 and NCLEX RN.

B. Error Timeline

Herewith is a brief summary of errors made by hospital personnel and staff in just a short 24 hour period, starting with the admission to Stanford:

a. 12/12/12 7:40 AM J. Velasco, "PAS", Stanford Operating Staff , without proper discretion accepted a crossed through, altered and illegible faxed consent form received from PAMF/ Dr. Hong rather than require a properly executed consent prior to administration of anesthesia.

Official Copy

STANFORD

STANFORD HOSPITAL
450 BROADWAY STREET
REDWOOD CITY, CA 94063

[redacted]

Enc. Date:12/28/12

DEC. 12. 2012 7:40AM 650-853-2852 PAMF PLASTIC SURGERY NO. 1099 P. 2 PAGE 02/03

STANFORD HOSPITAL
STANFORD, CALIFORNIA 94305

131019766418 F

[redacted]

MRN: 19297860
ADM: 12/12/12
HAR: 534

Addressograph or Label - Patient Name, Medical Record Number

CONSENT - CONSENT TO OPERATION - PROCEDURE AND ADMINISTRATION OF ANESTHESIA

Page 2 of 2

7. I authorize the following practitioner(s) (NAME OF PRACTITIONER performing procedure): [illegible]

to perform the following OPERATION OR PROCEDURE: [Spell out all words, do not abbreviate and identify side/level of procedure to be performed upon if applicable]: [illegible]

Additional comments, addendums to consent: [illegible]

[redacted]

SIGNATURE (Patient, Parent or Properly Designated Representative)

Violation of CMS 42 CFR 482.13(b)(2); the Medical Records CoP at 482.24(c)(2)(v); and the Surgical Services CoP at 482.51(b)(2). 2007 letter by Thomas E. Hamilton from CMS; (42 CFR 482.13(b)(2)) in the Patients' Rights CoP discusses the patient's or patient's representative's right to make informed decisions regarding the patient's care, and Title 16 2746.5(b) Title 22 70217(m). (*Cobb vs. Grant 1972*.)

b. 12/12/12 7:30 AM Stanford Professor and attending surgeon Dr. Dirbas meet with the Does. Does stated emphatically that they did not authorize any resident to operate on Jane Doe and conditioned their consent on the surgery being performed by Dr. Dirbas. Dr. Dirbas stated he would have his chief resident Jon Gerry also perform Jane Doe's surgery against her consent. CFR 482.51(b)(2) and 482.24(c)(2)(v).

c. 12/12/12 8:00 AM Stanford circulating nurse and operating room staff permit anesthesia and surgery to begin despite no valid signed consent from the patient for reconstruction by Dr. Hong. Nurses failed to confirm the procedure. 42 CFR 482.51(b)(2)

d. 12/12/12 3:30 PM Dr. Hong failed to obtain consent from Ms. Doe's husband to alter the surgical consent where he decided to place nearly double sized prosthesis under the skin instead of the proper cavity. 42 CFR 482.51(b)(2) and 482.24(c)(2)(v).

e. 12/12/12 5:00 PM Dr. Hong left the operating room promptly at 5:00 sharp and told John Doe that he placed much larger than agreed upon implants in the wrong chest cavity but everything will be fine and "her breasts will be beautiful". CFR 482.24(c)(2)(v).

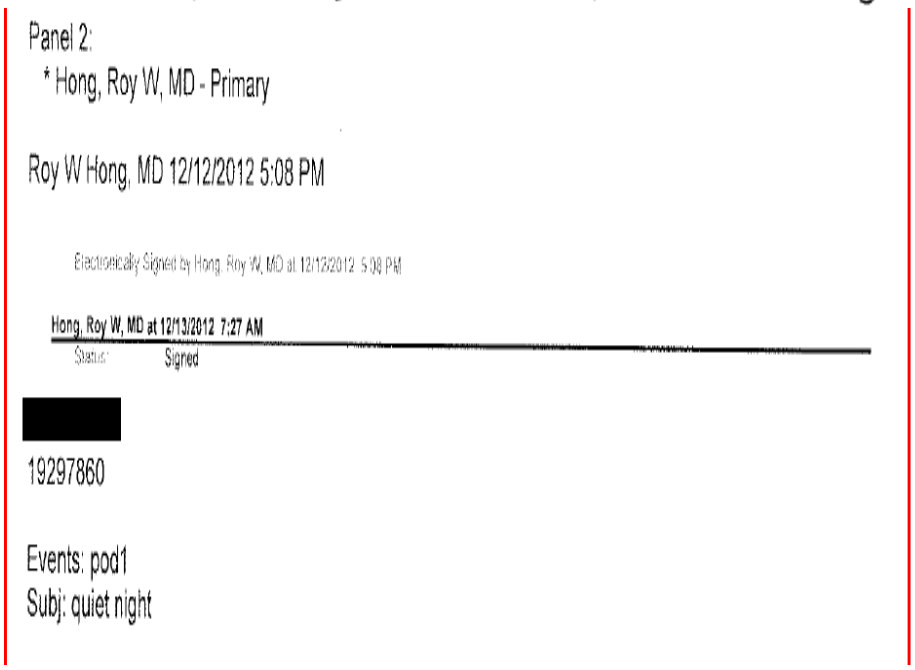
f. 12/12/12 5:03 PM Dr. Hong dictated his immediate operative report and misreported that he reconstructed the breasts with double sheets of Alloderm (which he did not do). (See Medline *Incorporating Single-Stage Implant Breast Reconstruction* Plast Reconstr Surg. 2015;136(2):221-231. National Accreditation Program for Breast Centers (NAPBC) Standard 2.18 Reconstructive Surgery). CFR 482.24(c)(2)(v) and B&P Code 2266.

g. 12/12/12 8 PM to 12/13/12 00:23 More than 6 calls and pages were made to Stanford doctors for Jane Doe's uncontrolled pain but neither Dr. Hong or Dr. Kazaure's progress notes mention these calls overnight. CFR 482.24(c)(2)(v).

h. 12/13/12 7:11 AM Dr. Hong applied a more constricting "Spanx" type breast binder and orders Ms. Doe's hospital discharge. No follow up appointment was scheduled.

i. 12/13/12 7:34 AM Dr. Hong concealed his true exam findings and wrote that bilateral flaps were healthy when they were already darkened and had undergone vascular compromised.

PE: bilateral flaps healthy, no hematoma, Drains serosanguinous



Panel 2:
* Hong, Roy W, MD - Primary

Roy W Hong, MD 12/12/2012 5:08 PM

Electronically Signed by Hong, Roy W, MD at 12/13/2012 5:08 PM

Hong, Roy W, MD at 12/13/2012 7:27 AM
Status: Signed

[redacted]

19297860

Events: pod1
Subj: quiet night

But Dr. Hong testified on 2/18/16 that there were in fact ischemic changes on 12/13/13, that it just was not "black". (Hong Depo p. 20, 12-21)

Q. Didn't look like there was any impaired circulation, any deteriorating skin condition?
A. There is always -- there is always ischemic changes that you see, but nothing -- had I been concerned that there was really something terrible going on, there would have been maneuvers we would have taken. But no, I didn't see anything.
Q. What is your definition of seeing anything terrible going on?
A. If it is black. If there is, um, if I feel

j. 12/13/12 8:34 AM Unlicensed new graduate doctor Dr. Kazaure failed to examine Jane Doe's wounds or nipples but ordered her hospital discharge.

k. 12/13/12 9:30 AM Dr. Hong entered a stale dated note about 12/11/12 and allegedly discussed the 12/11/12 visit and titled it "pre operative" whereas the note was inarguably written post op. CFR 482.24(c)(2)(v) and BP Code 2266.

l. 12/13/12 1:21 PM Discharge Summary Electronically Signed by Vicki Murri, R.N. stated "D/C teaching done and information given. Gave info on follow up visits, safety, S&S of trouble, care of wound". She processed the final papers and transferred Jane Doe from Stanford Hospital to the parking lot. NCLEX RN

m. 12/12/12 7: 00 PM Stanford Nurses, did not inspect the chest wounds and skin (mandatory) and did not record in the medical records inspection of the surgical site. NCLEX RN Title 22 70217(m), 70527(c). (See National Accreditation Program for Breast Centers (NAPBC) Certified Breast Care Nurse (CBCN) (Oncology Nursing Certification Corporation)[5]

n. 12/12/12 5:00 PM to 12/13/12 11:09 AM: All nursing notes failed to documents even a single wound incision exam or nipple exam. Stanford Nursing Flowsheets and Notes denote Ms. Doe

- [5] Stanford Hospital is not certified for breast care by the National Accreditation Program for Breast Centers (NAPBC), a program administered by the American College of Surgeons. Only Stanford Health Care-ValleyCare in Pleasanton is actually certified by NAPBC.

was **never checked by any nursing** prior to discharge. All notes stated **"unable to access"** although they nurses checked the drains only.

"Wounds Chest- Site Closure" Nobody was looking!

12/13/12 1109	"Initial Documentation Date 12/12/12 MS"
12/13/12 0920	"unable to access" "VM"
12/13/12 0800	"unable to access" "VM"
12/13/12 0409	"unable to access" "EF"
12/12/12 2345	"unable to access" "EF"
12/12/12 2047	"unable to access" "EF"
12/12/12 2000	"unable to access" " CB"
12/12/12 1930	"unable to access" "MS"
12/12/12 1900	"unable to access" "MS"
12/12/12 1830	"unable to access" "CB"
12/12/12 1800	"unable to access" "CB"
12/12/12 1730	"unable to access" "MS"
12/12/12 1715	"unable to access" "VS"
12/12/12 1700	"unable to access"

All of Stanford's **Nursing notes for Ms. Doe's double mastectomy surgery under "Skin and Tissue" exam stated: "Appropriate for Race".** (See "page 188" of Stanford Records printed by Ramirez-Queen on 12/23/13 3:28 PM.)

o. 12/13/12 8:30 AM – According to Stanford records, unlicensed intern doctor Hadiza S. Kazaure, PGY-1 was the last doctor to see this patient prior to discharge from Stanford. Health& Safety Code § 70527;

p. Dr. Kazure's Surgery Progress Note 12/13/12 8:41 AM, and filed at 8:44 AM. Note was never co-signed by any licensed doctor including Dr. Dirbas.

q. Ms. Kazure wrote "No acute events overnight"- despite that nurses paged the on call doctors no less than SIX times from 12/12/12 7:50PM to 12/13/12 12:23 AM for patient pain issues.

r. Ms. Kazure wrote "Pain well controlled "despite adequate records of OVERNIGHT MORE THAN SIX calls documented to on call doctors for pain management issues. The "Nursing Communication Flowsheet"

s. Dr. Kazaure wrote "Chest: Dressings on, incision clean and dry "despite that with "dressings on", she could not have examined the incisions of which there were TWO distinct large incisions, not just one incision.

t. Dr. Kazaure, a nonlicensed surgical intern, did not report that the chest skin and nipples had good blow flow and had a good color, and this omission was not caught by the Supervising and/or Attending Physician, Registered Nurses (RN), Charge Nurse, Nurse Supervisor, Nurse Manager.

u. 12/12/12 7PM- MN Dr. Hollin Calloway, PGY 1 also was an unlicensed doctor who had graduated on 5/13/12, just 7 months before taking care of Jane Doe. Dr. Calloway was called more than 4 times for pain and did not examine the patient once. Dr. Calloway ordered pain medication by telephone multiple times, but her orders were not co-signed by a licensed doctor. She did not become licensed to practice medicine until 7/12/13 with license 126431, which was exactly 7 months after she practiced medicine on Ms. Doe. (accessed https://www.breeze.ca.gov/datamart/detailsCADCA.do?selector=false&selectorType=&selectorReturnUrl=&anchor=ec23850.0.0**)**

v. 12/13/12 12:30 PM – Dr. Dirbas, Stanford surgeon and patient's attending, did not report his findings that the chest skin and nipples had poor blow flow and had signs of necrosis, and this intentional omission was not caught by the Supervising and/or Attending Physician, Registered

Nurses (RN), Charge Nurse, Nurse Supervisor, Nurse Manager. CACI 204, Evidence Code 413, NCLEX RN Title 22 70213(c), 70217(m).[6]

w. 12/12/12 9:00 AM - The Charge Nurse, Nurse Supervisor and/or Nurse Manager did not ensure that the patient's surgery was what she consented to or that she was watched closely in the hospital. Title 22 70213(c), 70214(a). (See CACI 554)

x. 12/12/12 09:05AM[A3]- -, RN and/or all operating room RNs assigned to Ms. Doe's care did not check the surgical consent and ensure she underwent the surgery to which she had given consent. NCLEX RN.

y. 12/12/12 07:00 – All postop and recovery room RNs assigned to Ms. Doe's care did not act as a patient advocate when the patient and her husband complained about the wrong surgery performed failed to record their complaints in violation of Title 22 70213(c), 70217(m).

12/13/12 7:00 AM – Vicki Murri, R.N. a non-compliant non- breast certified nurse, and/or all surgical RNs assigned to Ms. Doe's care did not properly inform the appropriate practitioners about Ms. Doe's concerns and pain. (*See* Standard 2.14 National Accreditation Program for Breast Centers (NAPBC) Certified Breast Care Nurse (CBCN) (Oncology Nursing Certification Corporation)[7];

z. 12/13/12 7:31 AM: Vicki Murri, RN and/or all postop RNs assigned to Ms. Doe's care did not properly report the patient's signs and symptoms when the patient and her husband complained about wrong surgery performed against their consent, these are tell-tale signs of potential ethical breeches in hospital care. Title 22 70213(c), 70217(m).

aa. 12/13/12 7:32 AM – Roy Hong, MD, noticed the darkening skin and nipples, intentionally neglected to document it in his note. Dr. Hong should have cancelled the discharge.

[6] http://www.rn.ca.gov/pdfs/regulations/npr-b-53.pdf Nursing duties and responsibilities.
[7] https://www.facs.org/quality-programs/napbc/standards

California Health and Safety Code Section 109275 ; mandatory per NCLEX RN ; Cal. Bus. & Prof. Code, § 2234(b)(c).

bb. 12/13/12 8:34 AM – Hadiza Kazaure, MD, failed to properly communicate or document the overnight pain episodes and examine the wounds to see the dire nature of the patient's condition (pressure necrosis of surgical wounds). Urgent consultation and report to the attending surgeon should have followed, and contemplation to remove the pressure causing necrosis prosthesis. Mandatory per NCLEX RN, Section 2234(b)(c).

Vicki Murri, RN, Elaina Favis, RN, Janet Whittemore, RN and/or all surgical RNs assigned to Ms. Doe's care did not act as a patient advocate when the patient and her husband repeatedly complained about uncontrolled pain, the unconsented surgery, and the oversized implants placed in the wrong chest cavity and failed to record their complaints in the medical record in violation of Title 22 70213(c). CACI 204, Evidence Code 413,

cc. 12/13/12 11:30 AM - Per the surgical floor RN progress notes, no notes were made on the exam performed by Dr. Fred Dirbas. The patient was showing signs of necrosis and symptoms were clearly attributable to oversized pressure causing her skin flap threatening necrosis. [8] Title 22 70213(c) Cal. Bus. & Prof. Code, §§ 2234(b)(c), 2266. CACI 204, Evidence Code 413.

dd. 12/13/12 11:30 AM- 12:00 Noon – Fred Dirbas, MD concealed from the patient that he was aware of the impending necrosis, and tissue death of the breast skin, nipples, and areola could not be excluded. (Dr. Ganjoo later testified in deposition that Dirbas told her the tissues were necrosing on 12/13/12.) A compromised nipple is an urgent condition in mastectomy and

[8] Risk factors for mastectomy flap necrosis following immediate tissue expander breast reconstruction. J Plast Surg Hand Surg. 2014 Oct;48(5):322-6. doi: 10.3109/2000656X.2014.884973. Epub 2014 Feb 4.

requires urgent assessment and intervention. [9] The implant must be deflated or removed to relieve the pressure as well as removal of any breast binders or tourniquets placed on the breast and nipples. [10]

Oversized implants should be urgently removed or deflated immediately after noticing necrosis; every minute that the breasts are tightly bound with the tight breast augmentation surgical garment or the oversized implants compressing the mastectomy skin remain in the patient puts the patient at great risk of injury, irreversible tissue death, permanent deformity, and debility.

Once the initial recognition and diagnosis of vascular insufficiency and compromised skin had been made (hours earlier), Dr. Dirbas, the Stanford Professor of Surgery, should have urgently notified the other treating doctor(s) and nursing staff so that they could have inspected the breast and nipple skin and prepped Ms. Doe for immediate intervention, 2nd opinion surgical and wound consultation, and urgent explant surgery, or at a minimum, deferred the discharge from hospital. (Moore v. Preventive Medicine Medical Group, Inc. (1986) 178 Cal.App.3d 728, 736 [223 Cal.Rptr. 859].) California Health and Safety Code Section 109275; Cal. Bus. & Prof. Code, § 2234(b)(c); CACI 204, Evidence Code 413; (*Moore v. Preventive Medicine Medical Group, Inc*. (1986) 178 Cal.App.3d 728, 736 [223 Cal.Rptr. 859].) (See Medscape Plast Reconstr Surg. 2015;136(2):221-231. Incorporating Single-Stage Implant Breast Reconstruction http://www.medscape.com/viewarticle/853385_5 and American Society of Plastic Surgeons (ASPS) Website. Evidence-Based Clinical Practice Guideline: Breast

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[9] Effects of nitroglycerin ointment on mastectomy flap necrosis in immediate breast reconstruction Plast Reconstr Surg. 2015 Jun;135(6):1530-9. doi: Accessed https://openi.nlm.nih.gov/detailedresult.php?img=PMC4494482_gox-3-e412-g004&req=4

[10] American Society of Plastic Surgeons (ASPS) Website. Evidence-Based Clinical Practice Guideline: Breast Reconstruction with Expanders and Implants. 2012. Retrieved from http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidencepractice/breast-reconstruction-expanders-with-implants-guidelines.pdf

Reconstruction with Expanders and Implants. 2012. Retrieved from http://www.plasticsurgery.org/Documents/medical-professionals/)

ee. 12/13/12 12:30 – Vickin Murri RN and Fred Dirbas MD, failed to properly communicate the dire nature of the patient's condition. The tight surgical garment acting as a tourniquet should have been immediately removed, nitropaste placed, and discharge deferred. (See J Plast Surg Hand Surg. 2014 Oct;48(5):322-6. https://www.ncbi.nlm.nih.gov/pubmed/ 24495186.) Compression and pressure necrosis of the skin and nipples causing her limb-threatening necrosis; pressure necrosis is one of the leading risk factors of mastectomy flap necrosis. (Deposition of Dr. Hong 2/18/16, Decl. Plaintiff Expert Dr. Shamoun)

ff. 12/13/12 12:30 PM - The surgical floor RN secondary assessment and flow sheet notates no exam of the mastectomy skin and nipples. (Dr. Dirbas testified in deposition that he was aware of the darkened skin and nipples and potential necrosis. Dr. Hong testified that the nipples looked ischemic, not " black".

- The surgical floor RN secondary assessment and flow sheet notates no exam of the mastectomy skin and nipples. (Dr. Dirbas testified in deposition that he was aware of the darkened skin and nipples and potential necrosis. Dr. Hong testified that the nipples looked ischemic, not " black".
- Vickin Murri RN and Fred Dirbas MD, failed to properly communicate the dire nature of the patient's condition. The tight surgical garment acting as a tourniquet should have been immediately removed, nitropaste placed, and discharge deferred. (See J Plast Surg Hand Surg. 2014 Oct;48(5):322-6. https://www.ncbi.nlm.nih.gov/pubmed/ 24495186.) Compression and pressure necrosis of the skin and nipples causing her limb-threatening necrosis; pressure necrosis is one of the leading risk factors of mastectomy flap necrosis. (Deposition of Dr. Hong 2/18/16, Decl. Plaintiff Expert Dr. Shamoun)
- Dr. Dirbas, Stanford surgeon and patient's attending, did not record anywhere his visit with Jane Doe or his findings that the chest skin and nipples had poor blow flow and

had signs of necrosis, and this omission in documentation was not caught by the Supervising and/or Supervising Physicians, Registered Nurses (RN), Charge Nurse, Nurse Supervisor, Nurse Manager. B&P Code 2266, Division 2. Healing Arts [500 - 4999.129]) Chapter 5. Medicine [2000 - 2525.5]; CACI 204, Evidence Code 413; NCLEX Rn Title 22 70213(c), 70217(m).[11]

gg. 12/13/12 1:21 PM – V. Murri, RN and/or all postop RNs assigned to Ms. Doe's care discharged the patient prematurely, based upon the patient's and her husband's complaints. V. Murri, RN and/or all postop RNs assigned to Ms. Doe's care had an obligation to the patient to investigate improperly placed oversized implants which were heavily compressed as a possible cause of her intractable pain and symptoms. Title 22 70213(c), 70217(m).

- Vicki Murri, RN, a non-breast care specialist, did not report that the chest skin and nipples had good blow flow and had a good color prior to discharge , and this omission was not caught by the Supervising and/or Attending Physician, Registered Nurses (RN), Charge Nurse, Nurse Supervisor, Nurse Manager. NCLEX RN Title 22 70213(c), 70217(m).[12]
- V. Murri RN and/or all perinatal RNs assigned to Ms. Doe's care did not examine or record the color and necrosis of patient's wounds. NCLEX RN and Post Mastectomy Care Algorithm *The American Association of Breast Care Professionals.*

C. Summary of Errors

Unfortunately for Jane Doe, recognition of the errors if ever, came too little, too late. The actions and inactions of several members of the hospital personnel and staff cost this patient her health and body and cost her family time with a precious wife and mother which can never be

[12] http://www.rn.ca.gov/pdfs/regulations/npr-b-53.pdf Nursing duties and responsibilities.

replaced. This debilitating injury started with the preoperative holding area failing to verify an unambiguous signed surgical consent prior to surgery- the consent faxed from PAMF on 12/12/12 at 7:40 AM was not timely, was illegible, was "not spelled out", and was crossed through 2 totally different procedures (a 2 stage delayed closure with a temporary tissue expander versus a 1 stage permanent implant closure), institutional failures that are not allowed, and continued with the substandard treatment by the hospital staff that did not meet the standards set by all applicable standards of care for post operative nursing monitoring. California Health and Safety Code, the NCLEX RN and the California Health and Safety Code under Titles 16 and 22 or under the Nursing Practice Act. (See also other citations cited herein).

D. **Laws Violated By Defendants**

Codes that were in violation by defendants' actions and/or omissions also include but are not limited to:

a. Women's Health and Cancer Rights Act (WHCRA 1998)

b. Health and Safety Code 2259 (Cosmetic Implant Act of 1992)

c. California SB 255

d. Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148)

e. Health Care Education and Reconciliation Act of 2010 (Public Law 11-152)

f. 42 U.S.C. 280m SEC. 3. Breast Reconstruction Education. Part V of title III of the Public Health Service Act () is amended by adding at the end the following: SEC. 399NN-1.

g. 42 U.S.C 280m SEC. 399NN-1 (D) (E) Breast Reconstruction Education Part V of title III of the Public Health Service Act13 26 U.S.C.§ 104(a)(2)14

h. Code of Federal Regulations, 42 C.F.R. § 489.3;

i. Criminal False Claims Act (18 U.S.C. § 287) "CFCA"

j. California False Claims Acts

k. U.S.C. Title 42 Section 17921(5)

l. California Civil Jury Instructions, CACI Nos. 204, 501, 502, 504, 514,530A, 530B, and 533, 534, 554

m. California Health and Safety Codes §§1348(e) 1704.5, 1704.55, 109275 to 109277 ; §§121110, 120975, 120980, 121922, 123148, 121075, 24172,

n. Cal. Bus. & Prof. Code, §§ 1317.1(D)(b)(1)(f) (j); 801,805; 2334(b)(c); 2725;

o. California Health and Safety Codes §§ 70213,70527, 2746.5(b), 24172, 10123.8 & 10123.86, 109275

p. California Code of Regulations (C.C.R.) Title 22 Section 70213(a) (b) (c), 70214(a), 70215(1)(d), 70217(m), 70223(d) (3), (g); 70527(c), 70749(a)(16), 70415(a)(2)(c), 70451, 70455(a)(5), 70954(b)(1).

q. Code of Federal Regulations, 42 C.F.R. § 489.20(r)(2) and 489.24(j)(1-2).

r. California Business & Profession Codes 651 (a)(b) (1) , 2397(a)

s. Evidence Code section 413

t. §482.13(b)(2)

u. Business and Professions Code Section 2052 of The Medical Practice Act

v. Penal Code Section 1170 (h)

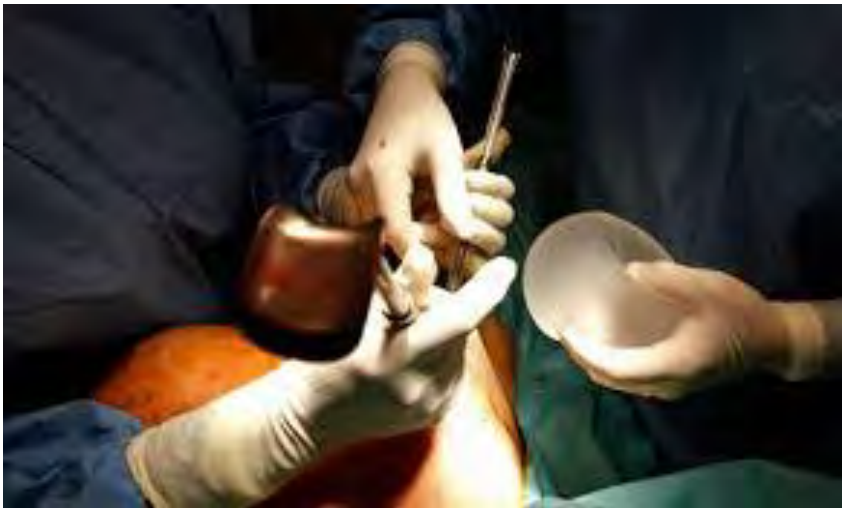
w. Civil Code Sec. § 56 et seq. California Confidentiality of Medical Information Act: 56.10

x. 42 CFR 482.51(b)(2), 482.24(c)(2)(v)

y. Section 6401 of the Affordable Care Act (ACA) Compliance plan to prevent billing fraud and abuse.

F. Cause and Manner of Debility: Improper and negligent management of post operative mastectomy care and premature " drive through" hospital discharge.

The pathologic and surgical evidence is irrefutable as to the competent producing cause of debility: oversized 533 cc silicone implants with Grade IV capsular contractures removed from Jane Doe on 5/20/13 in an urgent rescue surgery.



The misplaced oversized prosthesis and mismanaged complications resulted in massive double tissue necrosis (death) and a cascade of multitude of body and health failures. Figure 4

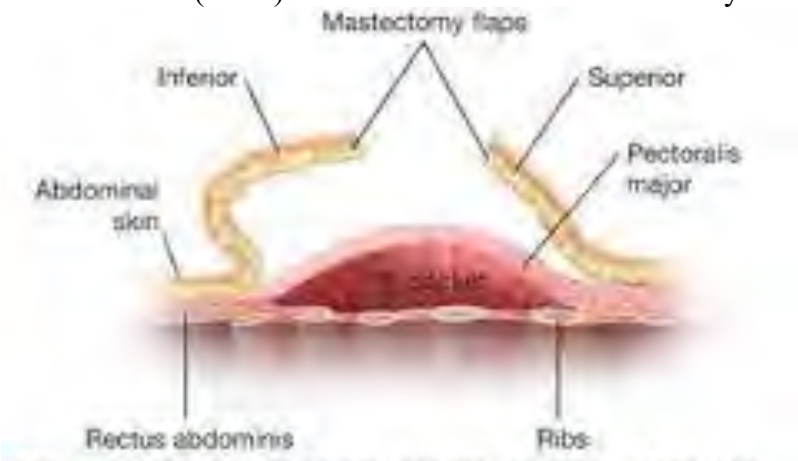


FIG 5 ■ Schematic diagram patient anatomy when the pectoralis major originates at or below the IMF. In this case, a submuscular pocket can be created down to the IMF that will be supple and respond well to expansion. TE, tissue expander.

The damage is confirmed by defendants' own experts and defense medical exam report with photos. It should also be noted that the defense medical examiner agreed that multiple surgeries are required to restore the function and health of Plaintiff. The manner of debility was not an accident, but a result of a multitude of institutional failures and system errors by Defendants. These system errors indicate that the preventable complications due to the premature hospital discharge after a complicated and essentially experimental surgery in a health care environment with board certified surgeons at one of the nations's preeminent and respected medical institutions

with registered nurses in attendance with supervising physicians and residents standing by, is not a natural or reasonable course.

CAUSE OF DEBILITY:

Grotesque deformities, horrific emotional suffering, double nipple and breast skin necrosis and loss, severe pain, and need for multiple, multiple corrective surgeries.

CONTRIBUTING CONDITIONS:

Surgeon ethical breaches
Misrepresented experience
Misplaced implants on top of the chest muscle instead of under
Oversized Prosthesis nearly double volume of agreed upon size
Failure to use Alloderm (artificial tissue)

MANNER OF DEBILITY:

Intentional Misrepresentation, Concealment, Medical Record Alteration, False Claims Acts, and Battery

1. 12/12/12 at 7:40AM Stanford records show that Ms. Doe was admitted on in stable and alert condition for an elective (non-emergent) preventative double mastectomy. Her admission diagnoses were as follows: (1)Fibroadenoid breasts (2)Family history of breast cancer.

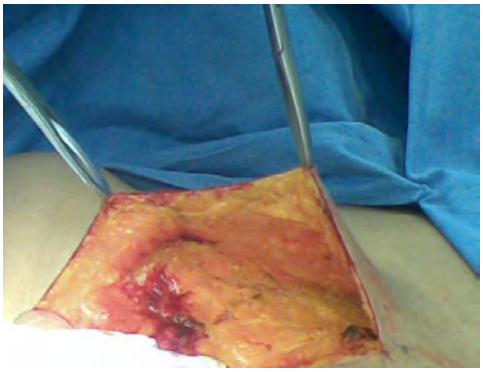
2. 7:40 AM on 12/12/12 The pre-operative nurse received by Fax the Dr. Hong illegible and marked through consent form on or after. (Cal. H&S Code §§ 70213, 70223, 70527)

3. 12/12/12 9:05 AM The nursing staff took Jane Doe back to the operating room without a proper consent for reconstruction.

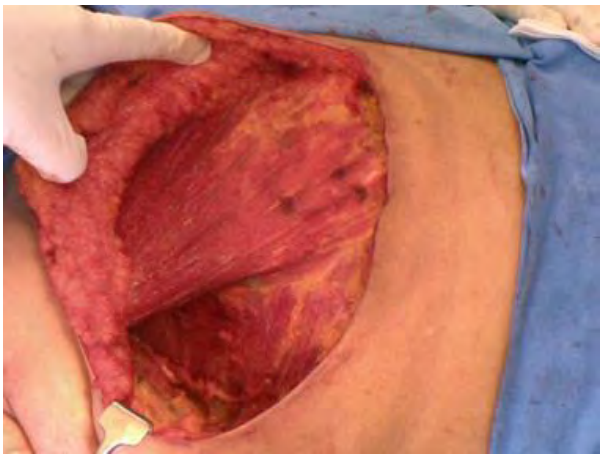
4. 12/12/12 3:01 PM The operative report of the double mastectomy confirms that the Stanford <u>breast surgeon Dr.Dirbas permitted his resident against the patient's consent to perform key aspects of the breast dissection</u> into the dermis (superficial skin).

12/13/12 Operative Report dictated by Jon Gerry, M.D. 15:01 PM, transcribed at 16:51 PM, signed by Gerry, MD. On 12/14/12 and co-signed by Dr. Dirbas at 1/1/2013 2:07PM. (Exh. K)

5. Dr. Gerry and Dr. Dirbas removed all glandular tissue and subcutaneous fat in a highly aggressive and skeletonizing fashion in a patient with absolutely no breast cancer. The pathology report showed completely benign breast tissue with no cancer cells. Figure 5, 6, 7 listed below:

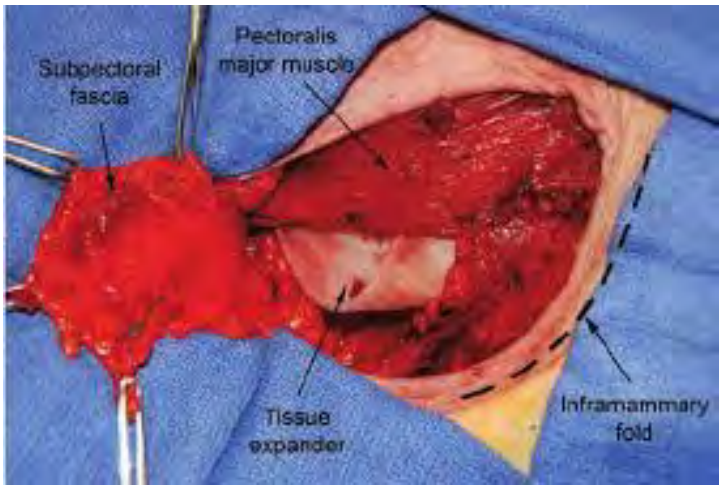


Schematic of Mastectomy dissection before removal of all breast tissue and fat.



Schematic of Mastectomy wound after dissection and pectoral muscle.

5. This would have been the correct placement of a tissue expander in the chest pocket, had one been used.



Schematic of Mastectomy wound and proper placement of prosthesis in proper pocket, UNDER the pectoral muscle.

6. 12/12/12 3:47 PM Dr. Hong placed 533cc implants in the wrong chest cavity and failed to use Alloderm.

7. 12/12/12 to 12/13/12 : There is a complete absence of any physician's progress notes describing the final 12 hours of post operative time indicating a course of uncontrolled pain, multiple calls to the on all doctors, and deterioration of patient's blood flow to critical structures despite knowledge by at least 2 Stanford professors and attending doctors of a clear and convincing medical hazard and no attempts to hold her discharge, stabilize her vascular injuries with nitroglycerin paste[15], or any instructions to remain at Stanford or immediately return to the operating room.

8. 12/13/12 Dr. Hong bound the mastectomy breasts with a nylon Marena surgical bra. Figure 8:

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[15] Effects of nitroglycerin ointment on mastectomy flap necrosis in immediate breast reconstruction Plast Reconstr Surg. 2015 Jun;135(6):1530-9. doi: Accessed https://openi.nlm.nih.gov/detailedresult.php?img=PMC4494482_gox-3-e412-g004&req=4

9. 12/13/12 8:34 AM : The next progress note states that an unlicensed intern, Dr. Kazaure, ordered the patient's discharge at 17 ½ hours after the double surgery.
10. 12/13/12 11:30 AM: Dr. Dirbas evaluated Ms. Doe at Stanford and diagnosed necrosis (as testified by Dr. Ganjoo) but failed to document the visit or exam. However, in his 2014 deposition, the surgeon later declared the necrosis condition to be a "watch and see" and not imminent. Dr. Dirbas did not record his exam, visit, or findings in any record. CACI 204, Evidence Code 413, and H & S Section 1317.1(f).
11. 12/13/12 1:21 PM The final progress note states that Ms. Doe's last encounter at Stanford was her discharge by Nurse Murri at 1:21 PM on 12/13/12. Ms. Murri did not check the patient's wound or document her skin exam. She wrote about the wounds "unable to access". (Exh. A). NCLEX RN

Ms. Doe was discharged from Stanford under 24 hours after a "Drive-through mastectomy" with known onset of tissue death and an urgent yet missed opportunity to prevent active necrosis.

Stanford Nursing Flowsheets and Notes "Wounds"
"Wounds Chest- Site Closure"

12/13/12 1109 "Initial Documentation Date 12/12/12 MS"
12/13/12 0920 "unable to access" "VM"
12/13/12 0800 "unable to access" "VM"
12/13/12 0409 "unable to access" "EF" Elaina Favis RN
12/12/12 2345 "unable to access" "EF"
"Skin and Tissue" exam stated: "Appropriate for Race"
Identified as "page 188" of Stanford Records printed by Ramirez-Queen on 12/23/13 3:28 PM.

12. 12/17/12 Dr. K instructed Ms. Doe to immediately discontinue the surgical compression bra, advised her of the urgent condition, and to take antibiotics.
13. 12/19/12 Dr. K examined the patient. Records show bilateral chest necrosis, a critical condition, and pending implant loss. Wound cultures are taken and antibiotics are started for bilateral chest infections.
14. 5/20/13 Urgent rescue explant surgery: The pathology report from the urgent recue surgery of 5/20/13 showed 2 intact 533cc sized permanent silicone implants removed. The surgical

report of 5/20/13 confirmed severe grade IV (the worst possible) capsular contractures of both implants which resulted in 6 months of horrific pain and deformity. Cal H&S Code 2259 (Cosmetic Implant Act of 1992).

15. Therefore, the etiology of the sequelae of a grotesque bilateral double tissue necrosis (death), double nipple slough and loss, bilateral deformities and skin loss, intractable pain, disability, and debility is irrefutable. [16]

16. Dr. Dirbas later testified in his 2014 deposition that he became aware of the misplaced large prosthesis on 12/13/12 and at the same time he observed the patient's nipples and breasts were darkening, dusky (turning purple) and that and that her condition was still guarded and could be body and limb threatening. Dr. Dirbas never produced *any* note or documentation.

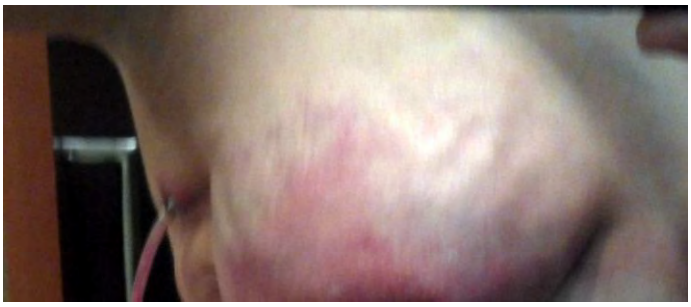
17. 12/13/12 Dr. Dirbas intentionally concealed his exam and findings from nearly everyone. He never warned the nursing staff of his concerns or to examine Ms. Doe's nipples and skin before discharge. He never instructed the hospital nursing staff to hold or delay Ms. Doe's premature "drive-through mastectomy" discharge. In fact, he never could bring himself to even tell the Does on 12/13/12 of the known "medical hazard" of his observation and the potential urgent chest necrosis (skin death).(Spoliation of the Evidence)

18. 12/13/12 Dr. Dirbas, through an admitted silence of omission[17], left out his critical observations of necrosis altogether from the record in violation of Evid. Code 413 and CACI 204. He did not wish to negatively impact or implicate his medical school buddy, Dr. Hong. He valued his friendship and loyalty to Dr. Hong above his duty to patient safety. His failure to document his exam and opinion of Jane Doe's imminent demise on

1. [16] Medscape Plast Reconstr Surg. 2015;136(2):221-231. Incorporating Single-Stage Implant Breast Reconstruction http://www.medscape.com/viewarticle/853385_5

12/13/12 has unjustly prohibited Ms. Doe from seeking an early settlement in this matter.[18] However, the effect of destruction of evidence (or deliberate omission) is that it can destroy fairness and justice, increasing the risk of erroneous decisions and possibly increasing litigation costs as parties attempt to reconstruct what is no longer readily available. CACI 204, Evidence Code 413.

19. 12/17/12 Ms. Doe presented to Dr. Hong as instructed on post operative day #5. He saw Jane Doe and documented that her nipples and breasts were necrosing and advised to continue binding and constricting her breasts and blood flow with a tight surgical Marena bra. (
20. 12/17/12 post op day #5 True appearance of mastectomy rippling, redness, and ischemia. Schematic Figure 9: 12/17/12 Dr. Hong's exam



Dr. Hong pushed more controlled pain medications and gave Ms. Doe a new Percocet prescription. He did not culture the wounds. He did not start antibiotics. He did not order her to be re-admitted to Stanford. Dr. Hong did not prescribe any nitropaste, and he did not offer to take the patient to the operating room to remove or downsize the implants. Dr. Hong documented no vital signs. He astonishingly took no photos. . Dr. Hong did not measure her blood pressure; her temperature was not monitored and her wounds were not cultured despite being red and hot. She was described as in pain. She was 5 days post an experimental mastectomy but no one from Stanford had called her or asked her to come to surgery department for a wound check. Evidence Code 413 and 204.

21. Dr. Hong instructed Ms. Doe to shower. He told her to bind the breasts 24 hours a day/ 7 days week and dispensed a 2nd Marena compressing surgical compression bra.

22. 12/27/12 Medical records Demand- Dr. Hong did not provide any hand written notes for any of his encounters although he was seen taking notes.

23. 2/18/16 Dr. Hong again refused to produce any of his handwritten notes from the medical records for Jane Doe.

X. THE HOSPITAL NURSING STAFF BREECHED THEIR DUTY AND PERMITTED PHOTOS OF THE PATIENT TO BE TAKEN ON HIS PERSONAL CELL PHONE WHILE SHE WAS UNDER ANESTHESIA

Unbeknownst to the Does, hospital staff and nurses had permitted Dr. Hong to take unauthorized photos of Jane Doe's breasts while she was under anesthesia. The nursing notes for 12/12/12 4:51 PM declared **that no photos/ video were taken**. "videos/photos: N/A/" signed off by Nurse M.S.

Post Evaluation

	12/12/12 1651
Post Evaluation	
Discharged to?	ASC Post-op -MS
Post-op airway status?	Non-intubated -MS
Level of consciousness?	Arousable when stimulated -MS
Allergy band on	Yes -MS
ID Band on?	Yes -MS
Implant sheet completed?	Yes -MS
Blood Products Returned	N/A -MS
Video/photo to.	N/A -MS
Recorded by	[MS] MS
Team Debrief	
Name of procedure and wound class	Yes -MS

None of the 7 Stanford RN's present in Ms. Doe's case as noted above stopped Dr. Hong from taking photos on his personal cell phone in violation of Stanford's photo policy.

This is the log of the Stanford nurses who participated in Jane Doe's surgery.

Staff Info

Staff Type	Staff Member	Start	End	OT
Circulator Primary	Marinos, Stella M, RN	9:19 AM	9:48 AM	
Circulator Primary	Marinos, Stella M, RN	10:00 AM	12:14 PM	
Circulator Primary	Marinos, Stella M, RN	12:46 PM	1:47 PM	
Circulator Primary	Marinos, Stella M, RN	2:02 PM	3:22 PM	
Scrub Primary	Jackson, Latisha	9:45 AM	11:51 AM	
Scrub Primary	Jackson, Latisha	12:43 PM	1:47 PM	
Scrub Primary	Jackson, Latisha	1:55 PM	5:00 PM	
PreOp RN	Balamiento, Mia S, LVN			
Circulator Relief	Cailles, Sandra, RN	9:47 AM	10:05 AM	
Circulator Relief	Cailles, Sandra, RN	12:14 PM	12:50 PM	
Circulator Relief	Cailles, Sandra, RN	1:46 PM	2:06 PM	
Scrub Relief	Campbell, Catherine	11:51 AM	12:43 PM	
Scrub Relief	Ernst, Jacqueline	1:46 PM	1:55 PM	
Circulator Primary	Shaji, Moly	3:03 PM	5:02 PM	
PACU RN Phase I	Blanco, Cheryl, RN	5:00 PM	5:30 PM	
PACU RN Phase I	Soriano, Vanessa N, RN	5:30 PM	5:50 PM	

Jane Doe was unaware that Dr. Hong had taken pictures of her on 12/12/12 with his personal cell phone. Civil Code 3344 in relation to unauthorized photos provides Punitive damages may also be awarded to the injured party or parties. The prevailing party in any action under this section shall also be entitled to attorney's fees and costs." H&S Code § 70763 addressed Medical Photography. "The hospital shall have a policy regarding the obtaining of consent for medical photography"

Dr. Hong 's conduct using his personal cell phone was in violation of multiple Federal Statutes as well as Stanford's own internal policy, and violated privacy statutes. He did not document the photos in the operative report. The nurses report said no photos or videos were taken. Dr. Hong had no consent to photograph Jane Doe on his cell and she had not given verbal consent at any time for his intraoperative photos. While Dr. Dirbas had not admitted to taking any photos, he did purportedly execute a consent as below. Even if Dr. Hong claims he purportedly did consent for photos, which he did not and has no evidence, the consent would have required any photos must be in line with the hospital's policies.

6. I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for treatment or internal or external activities consistent with the Hospital's mission, such as education and research, conducted in accordance with Hospital policies.

Stanford's cell phone policy is accessed at http://med.stanford.edu/shs/update/archives/FEB2011/cellphone.htm.

"Cell phone pictures by physicians or any nonfamily member are prohibited at SHC (and LPCH) unless taken with the patient's own phone at the patient's request."

Additionally, Dr. Hong's cell phone photos of Ms. Doe and Stanford nursing staffs' indifference is a violation of Stanford's own cell phone policy as accessed at http://med.stanford.edu/shs/update/archives/FEB2011/2_11PhonePolicy.pdf. .

> Bryan Bohman, chief of staff at Stanford: "But we are in a healthcare institution where patient confidentiality and privacy are vital to our patients' well being and protected under HIPAA regulations."

On 12/13/12 Dr. Dirbas also noted that the patient was likely unstable. Dr. Dirbas discussed a plan to return to the operating room and urgently remove the offending prosthesis with a non-treating Stanford doctor. Dr. Dirbas contemplated a plan for a timely rescue surgery at Stanford to remove the implants and downsize, but Dr. Dirbas never communicated that plan to the patient, her husband, nursing staff or any decision maker.

G. Defendants' Liability

The operative note of the reconstructive surgeon indicates that he could not place the implants in the correct chest cavity so he abandoned that surgery and proceeded with a completely experimental placement which he had never done. He was supposed to use artificial tissue (Alloderm) to protect the skin but there was no artificial tissue used. B&P Code 651.

Stanford billed $34,600 for double sheets of the artificial tissues (Alloderm) but the operative report showed that the patient ultimately had none of what she was charged or even implanted. (B& P Code 651)

The reconstructive surgeon was supposed to communicate a recovery plan to the breast surgeon, and tell them that he altered the surgery so the surgical team and nurses could monitor the patient's skin and nipples closely. However, the surgical team and nurses responsible for watching the patient overnight had no idea what surgery was ultimately performed (there is hospital liability

in any case). The "immediate post operative note" written by the surgeon and required by the hospital still said "bilateral implant with DermMatrix" B&P Code 651.

12/12/12 5:07 PM Dr. Hong entered and signed note at 5:08 PM
"Immediate Post-Op note" Procedure: " Bilateral Nipple Sparing Mastectomies, Immediate Reconstruction With Bilateral Implant Placement, Derma Matrix" despite the fact that Dr. Hong did not use derma matrix at all. (Exhibit L).

Progress Notes

Hong, Roy W, MD at 12/12/2012 5:08 PM
Status: Signed

Stanford Hospital and Clinics
Immediate Post-Op Note

Today's Date: 12/12/2012
Time: 5:08 PM

Pre-Operative Diagnosis: STRONG FAMILY HISTORY OF BREAST CANCER V16.3
Post-Operative Diagnosis: Same as above

Description of Findings: bilateral mastectomy and implants

Procedure: Procedure(s):
BILATERAL NIPPLE SPARING PROPHYLACTIC MASTECTOMIES, IMMEDIATE RECONSTRUCTION WITH BILATERAL IMPLANT PLACEMENT, DERMA MATRIX.

There is no indication that the intern, nurse, or supervising nurse examined the breast and nipple skin to rule out evolving necrosis. NCLEX RN
The question of whether there was sufficient vascular compromise in the wounds to justify an urgent explant surgery, or at minimum just longer inpatient observation was answered by the testimony of non-treating Stanford physician Dr. Ganjoo. There were several signs at least as early as 12/13/12 11AM showing tissue necrosis. This represented early onset necrosis in a surgery which was at best "experimental" where no alloderm or artificial tissue was used and the prosthesis was greater than 450cc critical size, and was misplaced in the wrong chest cavity.
Thus, we conclude that there was sufficient number of signs, symptoms, and indications from the noted necrosis to justify further investigation to reach a diagnosis of impending full thickness necrosis and severe patient disability from leaving the implants intact.

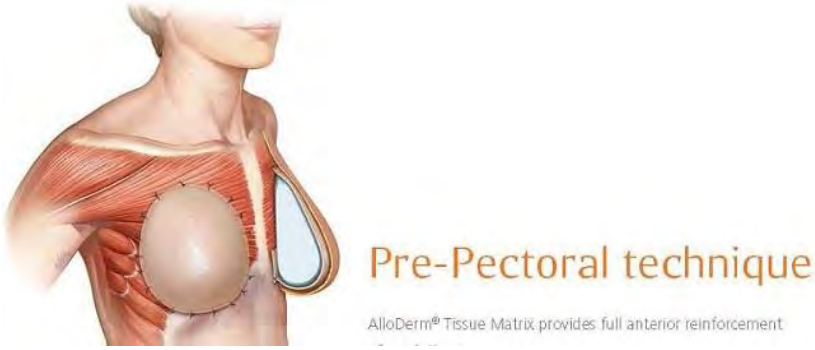


Figure 10: Illustration of proper subcutaneous reconstruction with an inflatable saline implant in a very thick skin mastectomy patient consented for this procedure in 2016 (A) following mastectomy, pocket is empty. B, The ADM (shown in magenta) is sutured to the periphery of the mastectomy pocket and the underfilled adjustable implant is placed beneath the ADM in the prepectoral position. C, The implant is filled postoperatively using the remote injection port. D, After 5 or 6 months, the injection port can be removed using a local anesthetic. E, Filled implant. Schematic assimilation of the placement of an *adjustable saline implant under the skin with Alloderm. (This procedure was* ***not even published in 2012****). Figure 11: Proper expander*

The failure to perform a one minute examination of the patients breasts, nipples, and skin and fail to report the impending necrosis immediately to the attending physician was an act of gross negligence.

Additionally, on 12/12/12 the charge nurse and the circulating nurse in the operating room were also responsible for making certain that the unconscious patient underwent the surgical procedure to which she had consented. There was also a duty owed to the patient by the operating room nursing staff to ensure that the surgeon was not permitted to perform unconsented procedures or to entirely circumvent the informed consent process. NCLEX RN.

Moreover, the 12/13/12 discharge instructions to the patient failed to emphasize that symptoms as described in the "Call MD" section are a medical emergency and could be life threatening. The instructions should have said to return in 12-24 hours for a wound exam."

H. Conscious Pain and Suffering

The record clearly shows that the patient was awake and oriented up until the time of the procedure (12/12/12 at 07:47AM). After surgery, she suffered severe pain as evidenced by the physician orders for Dilaudid, a strong narcotic pain reliever over night. During the night of 12/12/12 the doctors were urgently paged by the nurses nearly every hour for pain medications. Therefore, the evidence supports a conclusion of conscious pain and suffering from 12/12/12 at 7:00 pm until she was ordered at 7:34 AM on 12/13/12 to be discharged from Stanford Hospital by Dr. Hong. Additionally, Ms. Doe only became aware of her impending debility shortly after seeing Dr. Hong on 12/17/12 at his office.

I. Stanford Fell Below State Standards for post operative Instructions to Patients

In 2012, the Joint Commission ranked Stanford BELOW the State average for giving patients adequate post operative instruction. (See Quality Alliance https://www.qualitycheck.org/accreditation-history/?bsnId=10010)
This information can also be viewed at www.hospitalcompare.hhs.gov

The National Accreditation Program for Breast Centers (NAPBC) has not certified Stanford for breast care or mastectomy. Stanford Hospital has failed to meet the rigorous criteria for NAPBC. Stanford has failed Section 2.14 since nursing care is provided by or referred to nurses without specialized knowledge and skills in diseases of the breast. Nursing assessment and

interventions are guided by evidence-based standards of practice and symptom management. The nursing care in this Stanford case was defined by NAPBC as "non-compliant" and not provided by Certified Breast Care Nurses (CBCN).

The reconstructive care was provided by "non-compliant" physicians who were not certified by the National Accreditation Program for Breast Centers (NAPBC). Standard 2.18 for Reconstructive Surgery required that all appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon are board certified and specialize in the breast. Neither Dr. Jon Gerry, Dr. Hadiza Kazaure, and others on the operative team were certified by NAPBC for breast care.

> According to the Official U.S. Government for Medicare in Hospital Compare, Stanford was ranked as BELOW the national average for "timeliness of care". (See https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt9grp1&ID=050441)

According to CMS, Stanford failed to complete the surgery safe checklist in this case. Stanford failed to safe surgery checklist which includes safe surgery practices during each of the three critical perioperative periods:

- The period prior to the administration of anesthesia;
- The period prior to skin incision; and
- The period of closure of incision and prior to patient leaving the operating room. For example, the 2nd critical point failures were (period prior to skin incision) "Confirm patient identity, procedure and surgical incision site" and Communication among surgical team members of anticipated critical events.
- Third critical point (period of closure of incision and prior to patient leaving the operating room) was to identify key patient concerns for recovery and management of the patient.

Dr. Dirbas did not adequately communicate to Dr. Hong that the mastectomy flaps were very thin, cut through the dermis (skin) in parts, and were extremely skeletonized with no fat remaining under the skin. Moreover, Dr. Hong then did not communicate to Dr. Dirbas that he placed oversized implants in the wrong chest cavity and that he failed to protect the skin with artificial

tissue (Alloderm) as planned. (See https://www.medicare.gov/hospitalcompare/hospital-safe-surgery-checklist.html)

The nursing staff were not alerted to the nonstandard surgery, greater risks of necrosis, or that they would need to closely watch wounds and possibly start nitropaste if the flaps became low on circulation and started to suffocate. (See **Effects of nitroglycerin ointment on mastectomy flap necrosis in immediate breast reconstruction** Plast Reconstr Surg. 2015 Jun;135(6):1530-9. doi: Accessed https://www.ncbi.nlm.nih.gov/pubmed/26017589).

J. Stanford Performed Experimental Surgeries On Patients Without Consents And Nursing Failure To Monitor And Report For Fear Of Retaliation From Stanford Management

(See World Health Organization Patient Consent and Disclosure, http://www.who.int/surgery/publications/en/SCDH.pdf?ua=1 p 1-7 and 1-8) 2009 Patient's Right to Self Determination http://www.who.int/gpsc/5may/5may2013_patient-participation/en/)

According to recent news articles, Stanford has been facing serious problems for many months and years, including significant litigation against its surgeons. *See, e.g.*, Lawsuits against Stanford, Dr. Michael Dake for Experimental Procedures[19], Filed by San Francisco Firms Rouda Feder Tietjen & McGuinn and Emison Hullverson LLP accessed at San Francisco Business Wire. (See http://www.businesswire.com/news/home/20121010006553/en/Lawsuits-Stanford-Dr.-Michael-Dake-Experimental-Procedures.)

The article explains that Suits allege Stanford doctors "performed invasive and life-threatening surgeries – considered by renowned physicians to be completely experimental – outside of a clinical trial, violating accepted ethical standards for human subject research. In the process, he caused permanent harm to trusting patients. It's unbelievable that this happened, and under Stanford's respected banner,"

[19] California law requires a California Experimental Subject's Bill of Rights under Health & Safety Code '24172, requires that any person asked to take part as a subject in research involving a medical experiment, or any person asked to consent to such participation on behalf of another, is entitled to receive the following list of rights written in a language in which the person is fluent. This list includes the right to: 1. Be informed of the nature and purpose of the experiment.

Suits also allege Stanford University "physicians harmed patients by breaking rules for ethics, safety and medical research in performing CCSVI surgeries outside of a clinical trial."

The Stanford doctors were alleged to have" abandoned fundamental policies for medical research and patient consent". "They also allege that Stanford failed to protect patients by allowing Dake's unapproved experiments to continue outside of a clinical trial, despite the recognized, life-threatening risks associated with Dake's procedures and a lack of evidence to support any benefit from the treatment, court documents state. As a result, both men now suffer permanent and life-altering injuries."

J. Stanford's Culture of Fear in Reporting or Criticizing misconduct and Retaliation from Stanford Management

The latest headlines just a few months ago read "Stanford Health Care, formerly known as Stanford Hospital, has been sued for negligence by a former patient who was sexually assaulted by an employee. Stanford is also in multiple lawsuits for staff taking and freely disseminating photos of patients while under general anesthesia. Mr. Goerge Baez, former Stanford Director for outpatient surgery was terminated by Stanford for reporting sexual assault of anesthetized patients by anesthesia technician Robert Lastinger. (16CV- 300476) Multiple former employee declarations attest that Stanford concealed these wrongdoing acts by their staff. "The lawsuit alleges that nurses, managers, patient care coordinators, anesthesia techs and scrub techs all failed to report" the perpetrators for troubling behavior. Moreover, the suit alleges that about 25 employees and managers knew about the misconduct but had suppressed and concealed for fear of retaliation. The article cites that "some Stanford leaders fostered a toxic environment by allowing a group of managers to band together and look out for each other." "Instead of sounding the alarm, they stuck their head in the sand,"

October 21, 2016, by Jacqueline Lee at Mercurynews.com. The article explains that:

> Patients trusted the doctor's medical opinion –"in no small part because of Stanford's prestigious reputation – and wound up as a guinea pig for his experiments". One of the other patients in that experimental debacle reported that "I certainly didn't need the added pain, health risks and emotional toll of this mistreatment."

As recent as 2/9/17 Stanford was once again in the news about its violation of women's rights. Reporter Joe Drape of The New York Times reported on Stanford's decision to fire a female attorney who spoke out about criticisms on Stanford's handling of campus rape victims. https://www.nytimes.com/2017/02/09/sports/stanford-lawyer-sexual-assault-accusations.html?_r=0

Stanford has not been following research protocols and hospital administrators have been aware for some time that the number of suits rising because of non-standard surgeries is problematic. Stanford has not been following the Federal Anti- "drive-through mastectomy" rules nor has it been adhering to its own internal ruled for privacy, medical record releases, and informed consent.

J. Stanford's Litany of Oversights

8) STANFORD'S DEMEANING TREATMENT OF MASTECTOMY PATIENTS

The demeaning and hazardous treatment, and negative impact to women and patients caused by Stanford Hospital's institutional failures and system errors cannot be overstated.

Dr. Dirbas determined he contributed to the lack of daily rounding and compliant charting in the (surgical unit) in this case. This failure to comply with standard documentation disrupted the continuity of care of surgical patients and contributed to (the hospital's) unacceptably high preventable debility rate.

Unfortunately, this patient's irreversible and catastrophic injuries from the premature and unlawful discharge from Stanford in violation of anti "drive-through mastectomy", both Federal and State legislation ,was caused by many of the noted deficiencies, including and especially the lack of immediate or time sensitive surgical intervention which could and would have saved her life altering injuries.

The failures for mastectomy care included the following:

• Failure to obtain informed consent[20] and IRB approval prior to experimental surgeries
• Toxic environment by Stanford surgeons banding together to look out for each other
• Employees and managers who knew about others' misconduct but concealed it
• A substantial number of unanticipated morbidities with improvement opportunities (that is, preventable injury).
• Falsified and misleading attending surgeon medical records.

9) NEGLIGENT TRAINING OF MASTECTOMY CARE NURSES

- Multiple unlicensed nurses provided care;
- Nursing failures to do even *1* wound check or skin exam anytime before discharge; and
- Nurses are not specially trained in mastectomy care.

10) NEGLIGENT SUPERVISION OF UNLICENSED DOCTORS

- There was a failure of any attending surgeon or any licensed doctor to co-sign the unlicensed Hadiza Kazaure, M.D. 's post op note or discharge note on 12/13/12 and absence of daily surgical team rounding together in the post surgical care unit.
- There was a failure of any attending surgeon or any licensed doctor to co-sign the Calloway, M.D. 's multiple prescription medications prescribed overnight to Jane Doe on 12/12/12 and absence of daily surgical team rounding;
- There was use of non-licensed personnel (Dr. Kazaure) to prematurely discharge patients after a major double mastectomy from Stanford without any documented attending physician oversight;
- There was a falsified and deliberate silence of omission of a key medical record (exam of 12/13/12 11:30 AM) by the attending Stanford surgeon.

11) NEGLIGENT HIRING AND CREDENTIALING OF DR. HONG

- Stanford Hospital was aware of performance deficiencies of Dr. Hong through multiple prior lawsuits and complaints lodged with Stanford. Despite this knowledge, through other surgical negligence cases filed like 2004-1-CV-

[20] California law, under Health & Safety Code '24172, requires that any person asked to take part as a subject in research involving a medical experiment, or any person asked to consent to such participation on behalf of another, is entitled to receive the following list of rights written in a language in which the person is fluent. This list includes the right to: 1. Be informed of the nature and purpose of the experiment.

028720 S. Martinez vs Stanford Health Services and Dr. Hong, Stanford continued to credential Dr. Hong for surgery at the facility.

- Dr. Hong was investigated by the Medical Board of California on multiple occasions for botched breast surgeries, including this instant case as well as one horrific mastopexy performed on a local female newscaster. That case was reviewed by MBC expert Dr. Debra Robinson. Stanford's failure to restrict Dr. Hong's surgeries is "that its findings show a lack of institutional support for the patients' rights or attempts to address identified deficiencies in reconstructive services by both hospital administration and medical staff which directly contributed to the inability" to correct those deficiencies."

12) STANFORD'S FAILURE TO RESPOND TO MS. DOE'S GRIEVANCE LETTER

- A prime example of the lack of administrative and medical staff support for correcting identified deficiencies in surgical services was the failure of the hospital administration to put in place a mechanism to ensure that the complaints were handled within 7 days, and that staff doctors were required to re-credential.

J. A Hospital Cover-Up Justifies Injunctive Relief

1. Cal. Health & Safety Code § 1279.1 Requires Reporting Of Adverse Events To Patients And To The California Department Of Public Health

Defendants' delays and intransigence in failing to voluntarily produce to plaintiffs for its adverse event over Jane Doe suggests a worrisome cover up; such a cover up is extremely worrisome given the likelihood that the hospital has failed to produce its adverse event report to all the other families and patients who have been victims of the hospital's failure to abide by anti-drive through mastectomy laws instituted just precisely to prevent such preventable injuries to women undergoing double mastectomy procedures. These are precisely the untoward events and catastrophes that have led to more than half a dozen Federal legislation to entitle women rights on just mastectomy, breast lumpectomy, and women's breast health laws.

Defendants' delays and intransigence in producing complete medical records and electronic access logs pursuant to Calif. SB850 is also troubling. Although requested as early as February 2014, Stanford finally produced for the first time the electronic access log to Jane Doe's records on or about January 21, 2017, more than 4 years after the injury.

On September 29, 2006, California Governor Arnold Schwarzenegger signed into law Senate Bill 1301, which affected hospitals' licensure and created powerful and unprecedented reporting obligations for hospitals for failing to properly report on Adverse Events.

Four Cal. Health and Safety Code sections, which all became effective on July 1, 2007, mandate that hospitals report "adverse events"; that the Department of Health Services (the Department) investigate those reports within a set timeframe; and that the Department make the substantiated reports and the results of the investigations publicly available. The law is intended to serve two basic purposes: (1) to improve hospital quality of care through more state oversight, and (2) to help health care consumers make more informed decisions when choosing a hospital!

Cal. Health and Safety Code Section 1279.1 requires general acute care hospitals, acute psychiatric hospitals, and special hospitals (hospitals) to report "adverse events" to the Department five days after a hospital detects the adverse event, or, "if the event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel, or visitors, not later than 24 hours" after detection ("1279.1 Report").

Moreover, hospitals are statutorily required to inform the patient or the party responsible for the patient of the adverse event when it makes a 1279.1 Report! Cal. Health & Safety Code § 1279.1(c). According to the July 27, 2007 report of Kathleen Billingsley, R.N. Deputy Director of the California Department of Public Health "the hospital must inform the patient or the party responsible for the patient of the adverse event by the time the report is made."

The California Mandatory Adverse Event reporting law defines an "adverse event" as one of 28 enumerated occurrences that could negatively impact patient care and safety; the list reflects the "Never 27" events – the 27 occurrences the National Quality Forum identified in 2002 as those that should never occur at a health care facility. The events are organized under six headings:

surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events. The law also includes a new catchall, "Never 28" event: "an adverse event or series of adverse events that cause the debility or serious disability of a patient, personnel, or visitor."

Section 1279.2 details the Department's investigatory responsibilities when it receives a 1279.1 Report. If a 1279.1 Report or a complaint about a hospital indicates "an ongoing threat of imminent danger of debility or serious bodily harm," then the Department must perform an onsite inspection or investigation within 48 hours or two business days, whichever is greater (the law does not address the difference between an "inspection" or an "investigation").

Defendants' reliance upon Section 1157 of the California Code of Evidence to justify withholding the adverse event report over Jane Doe is misplaced because that section is specific and only prohibits the discovery of internal proceedings and records of "organized committees of medical . . . staffs in hospitals, or of a peer review body . . . having the responsibility of evaluation and improvement of the quality of care rendered in the hospital . . . " Cal. Evid. Code, § 1157. Here, on the other hand, the Adverse Event report was sent outside, to the California Department of Public Health. As a result of the production to a third party, there is no Cal. Evid. Code, § 1157 privilege and certainly no attorney-client privilege.

The California Department of Public Health (CDPH) and/or CMS are not considered medical committees who are subject to the Evid. Code, § 1157 privilege. Additionally, the purpose of § 1157 is not to protect communications with government agencies, but rather to preserve internal deliberations and inquiries within a medical facility. Reports sent to Public Health are necessarily sent to third parties and thus are plainly outside the rule of Evidence Code Section 1157 and plainly also not attorney client privileged.

The purpose behind Evid. Code Section 1157 was considered in *Matchett v. Superior Court*, 40 Cal. App. 3d 623, 628 (1974), in which the Court explained the balance the legislature sought to strike between a plaintiff's ability to obtain discovery and the public interest in protecting internal deliberations at a hospital:

> When medical staff committees bear delegated responsibility for the competence of staff practitioners, the quality of in-hospital medical care depends heavily upon the committee members' frankness in evaluating their associates' medical skills and and [sic] their objectivity in regulating staff privileges. Although compared of velunteer [sic] professionals, these committees are affected with a strong element of public interest. California law recognizes this public interest by endowing the practitioner-members of hospital staff committees with a measure of immunity from damage claims arising from committee activities.

Evidence Code § 1157.7 only protects "proceedings and records of any committee established by a local governmental agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including, but not limited to trauma care services, provided by a general acute care hospital which has been designated or recognized by that governmental agency as qualified to render specialty health services." Cal. Evid. Code, § 1157.7.

Evidence Code § 1157.7 only protects "proceedings and records of any committee established by a local governmental agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including, but not limited to trauma care services, provided by a general acute care hospital which has been designated or recognized by that governmental agency as qualified to render specialty health services." Cal. Evid. Code, § 1157.7.

In *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. App. 1st Dist. 1956), the Court of Appeals observed that the doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient; the same is true of the hospital-patient relationship; in the event of the debility of the patient while under the care of the doctor and the hospital, the spouse has a right to know the cause of debility; and withholding information would in a sense amount to misrepresentation.

2. <u>Adverse Event Reports are Relevant and an Admissible Basis For Expert Analysis, Reports and Testimony Regarding Causation</u>

Adverse event reports are relevant and an admissible basis for expert analysis, reports and testimony regarding causation. Adverse event reports "are commonly used by experts in the field to determine causation in correlation with other evidence." *See In re Levaquin Prods. Liab. Litig.*, 2014 U.S. Dist. LEXIS 163777, at *29-31 (J.P.M.L. Nov. 21, 2014); *see also Schedin v. Johnson*

& Johnson (In re Levaquin Prods. Liab. Litig.), 2010 U.S. Dist. LEXIS 145282, at * 11 (D. Minn. Nov. 9, 2010), citing *In re Viagra Prods. Liab. Litig.*, 658 F. Supp. 2d 950, 961-62 (D. Minn. 2009) (allowing evidence of adverse event reports as a safety signal as discussed by Dr. Blume).

K. Punitive Damage Threshold

The departures on the part of both medical, nursing, management, and surgical personnel immediately after the admission of Jane Doe for her double mastectomy are as follows:

- Nursing failures to conduct one minute routine examination of her surgical wounds at anytime;
- Nursing failure to ensure with the patient and surgeon a properly executed and legible informed consent.
- Failure to hold the patient's discharge until *at minimum* 48 hour post op observation and monitoring after the double mastectomy.

It is well known that the failure to examine the mastectomy wounds and flaps prior to discharge placed the patient at unnecessary and preventable risk for general debility, tissue necrosis, infection, and potential debility from sepsis. Similarly, it is well known that urgent to quick intervention with nitropaste (to increase local circulation), close observation and tissue perfusion monitoring is vital to survival and wellbeing of the compromised mastectomy patient.

Urgent surgical intervention to remove the voluminous prosthesis which were misplaced over the chest muscle instead of in the proper space, was vital to Jane Doe's mastectomy survival. However, Stanford failed to examine Jane Doe's wounds and nursing noted " wounds not accessible" over and over and over- leading up to Ms. Doe's premature discharge from Stanford at 1:10PM on 12/13/12. Nurses called/ paged the doctors nearly hourly from 1212/12 at 7 PM through 3 AM on 12/13/12 on Jane Doe. Mastectomy patients presenting as Ms. Doe did in Stanford with nearly hourly pages to the on call doctor for uncontrollable pain should not be prematurely discharged less than 18 hours after major surgery in violation of Federal anti-drive through legislation. Therefore, such failure was a wanton and callous disregard of Ms. Doe's and her family and well-being and, as such, requires a demand for punitive damages.

"(A) NOTWITHSTANDING SECTION 146, any person who practices or attempts to practice, or who advertises or holds himself or her self out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment. "

Defendants violated State Health and Safety Codes as well as Business and Professions Code which requires a valid California license for practicing medicine in this state. In this case Stanford institutional failures permitted an unlicensed doctor to discharge the patient without supervision. Stanford's records are ambiguous as to if the general surgery attending or the plastic surgery attending was ultimately responsible for the 12/13/12 7:37 AM premature discharge order.

Here, the punitive damage susceptible violations by the defendants include:

(1) The surgeon disregarded the health and safety of the patient when he recklessly and blatantly forced nearly double sized prosthesis into the wrong chest space into the patient in a hurried manner;

(2) The surgical team exceeded the bound of their professional licensure, when they permitted a "guinea pig" experimental operation to proceed without an investigational approved consent, or *any* legible informed consent in violation of H&S Code 24172. *Cobbs v. Grant* (1972) 8 Cal.3d 229 [104 Cal.Rptr. 505, 502 P.2d 1];

(3) The unlicensed intern acted with complete disregard for the health and safety of the patient when she did not inspect the patient's chest wounds and skin after she forcibly and prematurely discharged the patient on 12/13/12. (not noticing the moderately purple and darkened

nipple and areola and breast skin that was becoming red found during the exam of her attending surgical oncologist.)

(4) The hospital failed to provide standards of care by not having all mastectomy patients wound and skin inspected by the attending surgeon responsible for the patient's health and safety, a simple precaution that could ensure the health and safety of all women undergoing such proedures.

(5) The intern and nursing staff failed to act as a patient advocate including failure to adhere to standard protocols or institutional policies and procedures. (providing reckless care and omitting critical procedures)

(6) The support nursing staff failed to assess and monitor, including failure to interpret a patient's signs and symptoms the patient's uncontrolled pain from the time the oversized implants were placed in the wrong chest cavity.

(7) The hospital failed to provide the proper intern supervision that is required to operate a surgical service with support teaching staff, the staff lacked the knowledge and/or experience required to properly monitor a patient's mastectomy flaps in the immediate 24-48 hours after undergoing the major surgery and no one informed the staff that the monitoring methods were inadequate. (wound never checked by any nursing staff- all wrote " wounds not accessible")

(8) The support nursing staff failed to diagnose the impeding mastectomy necrosis and vascular compromise as a further complication of the experimental "guinea pig" surgery performed. As early as 7:00 AM on 12/13/12 the patient and her spouse constantly complained about the experimental surgery performed and told both attending surgeons and staff about the pain and concerns about the pressure of the implants on the mastectomy skin through and past the time attending surgeon removed the surgical dressings and placed a heavy Marena surgical compression binder on the patient at 7:27 AM on 12/13/12, until the hospital discharge on 12/13/12 1:10 PM (more than 5 hours).

(9) The higher authorities (Charge Nurse, Nurse Supervisor, Nurse Manager, and Nurse Director) at the hospital failed to properly train and audit Nurses and Nurse Assistants (how to

remove the dressings or surgical garment and inspection the skin of the breast and nipples, with recorded documentation, and verification every time)

(10) The support nursing staff failed to provide proper care to the patient and discharged the patient prematurely early prior to ensuring that the patient had adequately recovered from the double mastectomy.

(11) The support nursing staff failed to make a referral appropriate to the patient's condition.

(12) The supervising physician and surgeon failed to provide proper standards of care the supervising physician/surgeon is the principal while the intern is the agent. Regardless of the physician's involvement (or lack thereof) in the patient's treatment.

(13) Several supporting staff interns and nurses were questioned by the patient and her spouse about the experimental and unconsented surgery and uncontrolled pain, all nurses that were staffed failed to listen to the patient's complaints and act on them.

(14) During her hospital stay the patient's oversized implants weighed heavily on the mastectomy flaps and were becoming necrotic and with uncontrolled pain, the staffed nurses also failed to communicate with a supervising physician and surgeon about the patient's condition and a wound exam to ensure the health and safety of the patient.

(15) The Surgical Oncology attending and Stanford teaching Professor failed to provide standard of care and failed to provide adequate post operative monitoring when became aware of the dangerous surgery performed. While being aware of the deficiencies in the patient's care, the surgical attending turned a blind's eye and failed to notify the nursing personnel to monitor the patient's wounds before discharge. CACI 204, Evidence Code 413, H & S Code Section 1317.1(f).

(16) The breast surgeon was made aware of the "never" reconstruction surgery performed by the second surgeon at latest by 11:30 AM to 12:00 Noon on 12/13/12. At latest, he had 1-2 hours to hold the discharge and communicate with the surgical team to continue inpatient observation of the patient. He did not communicate his observations of skin necrosis (debility) and vascular compromise to BOTH breasts to the surgical staff. He only told in concealed silence to

another Stanford doctor who was not part of the patient's team or responsible attending. Even that doctor failed to responsibly object and insist that the patient's discharge be stopped. H & S Section 1317.1(f), CACI 204, Evidence Code 413.

There were at least 2 hours response time available to communicate to the surgical team and nursing staff where the surgical attending had been made aware of the patient's symptoms and downward course but he took no effort to responsibly communicate his findings or allow time to response to the patient's critical conditioning. "When I left the OR the plan was to do the under the muscle placement surgery" to the patient and her husband

a. The patient's hospital course from 12/12/12 7:00 AM through 12/13/12 1:21 PM was plagued with failures that resulted in her resulting debility and irreversible injuries from the failures to follow standards of care (including exceeding the bounds of professional licensure or lack thereof), to communicate (inform a physician and surgeon), to document, to assess, to monitor, to act as a patient advocate, and to provide proper supervision. Section 109275 of the California Health and Safety Code, CACI 204, Evidence Code 413, (42 CFR 482.24(c)(2)(v (42 CFR 482.51(b)(2)) §482.13(b)(2).

Any major surgery performed other than one consented to by the patient(unless emergency or life threatening) is not allowed by a surgeon as stated in CALIFORNIA[A4] TITLE 16 SECTION 2746.5 (b). These actions are EGREGIOUS and in complete violation of FEDERAL LAW AND CALIFORNIA LAW. The hospital administration, nurses, supervising physicians and surgeons, and supporting staff nurses failed to follow the law and provide the most basic level of rights to a woman's right to informed consent, and shared choice in elective mastectomy reconstruction and safe surgical care. Dr. Hong not only failed to obtain the patient's consent pre-operatively for the surgery which he ultimately performed, he also failed to even attempt to obtain Ms. Doe's husband's consent during the surgery, despite Jane Doe's written authorization to Stanford for the same. (Dr. Hong Depo Transcript P. 73, 15-25)

Q. You get to the point in the surgery where you conclude that the placement of the implant subpectoral doesn't have a pleasing appearance to you.

Did you go out and talk to her husband, the board-certified doctor, to explain to him your finding and your recommendation?

A. Did not.

A. Because in my judgment, this decision was an important decision for me and for the patient. I felt that I had the -- you know, I -- I -- I was responsible.

73

The method of wrong chest space reconstruction used by the surgeon is dangerous and reckless, it is not encouraged in any medical book and it violates Section 2746.5 (b), the surgeon was in a hurry as staff nurses observed he needed to leave by precisely 5:00 on 12/12/12. He evidently had a holiday event to attend right after the patient's surgery and could not bothered by ensuring a safe procedure or requesting a second opinion consult in the operating room. Immediately at 5:00 PM on 12/12/12, the operating team requested assistance with moving the patient to the recovery room.

Signs of tissue necrosis (debility): The signs and symptoms of impending tissue flap debility are redness, pain, darkening of the nipples and areola, and a purple blanch color, and severe pain that persists (constant calling the on call doctor through the night for more pain medication and Dilaudid).According to the U.S. FDA Clinical trials, "Even a small area of necrosis especially the nipple area can be cause for concern." If any part of the mastectomy skin flaps start turning colors, the patient will need treatment right away to avoid complications. Early intervention is imperative, like use of nitroglycerin paste, other objective based tissue monitoring, or even hyperbaric oxygen. In unmitigable flap compromise, expeditious and urgent return to the operating room to remove the implant may become critical. "In patients undergoing mastectomy

and immediate reconstruction, there was a marked reduction in mastectomy flap necrosis in patients who received nitroglycerin ointment. Nitroglycerin ointment application is a simple, safe, and effective way to help prevent mastectomy flap necrosis." (See https://clinicaltrials.gov/show/NCT01608880)

A public or private institution and its employees may be held liable for punitive damages. Plaintiffs believe also that these entities may also be held liable for such damages where, as here, the award of such damages would serve to protect other patients.

Even though certain damages are punitive in nature and for example barred against even a public entity, Cal Gov't Code § 818 does not bar recovery of punitive damages when they are not simply or solely punitive in purpose and they serve legitimate compensatory functions. Here the failures occurred in a private instruction whose system errors and institutional failures were even more egregious considering the reputation of Stanford as a top notch institution.

When it is proved by clear and convincing evidence that a defendant is liable for physical or financial abuse of elderly or dependent adults and that the defendant has been guilty of recklessness, oppression, fraud or malice in commission of the abuse, then the court shall award reasonable fees and costs (including fees for a conservator for the lawsuit), and the limitations on damages imposed by Code of Civil Procedure § 337.34 shall not apply. The Fourth District held that the additional damages available under this provision were not punitive damages within the meaning of § 818 because the damages were computed on the basis of compensating for harm. (*Marron v. Superior Court*)

Other provisions of law that take precedence over the immunity from punitive damages in Gov. Code, § 818 include statutory penalties that also serve a compensatory purpose. [See, for example, *People ex rel. Younger v. Superior Court*, 16 Cal. 3d 30, 127 Cal. Rptr. 122, 544 P.2d 1322 (1976) (penalty assessed under Wat. Code, § 13350 for spilling oil did not constitute punitive damages within the meaning of Gov. Code, § 818 where award fulfilled a legitimate compensatory function)]

For example, in *Kizer v. County of San Mateo*, 53 Cal. 3d 139, 279 Cal. Rptr. 318, 806 P.2d 1353 (1991), as modified, (Mar. 28, 1991), the court held a publicly operated health care facility to the same standard of liability applied to private entities. The county-operated long-term health care facility argued that it could not be assessed statutory penalties and citations for violations of the state "Long-Term Care, Health, Safety and Security Act of 1973." It argued that since the penalties under the statute constituted punitive or exemplary damages, they were entitled to immunity under a state statute prohibiting such damages. The California Supreme Court held that the immunity statute did not prevent the assessment of penalties against a county-operated facility. It stated that the immunity "intended to limit the state's waiver of sovereign immunity and, therefore, to limit its exposure to liability for actual compensatory damages in tort cases."

XI. THE COSTS OF PLAINTIFFS' ATTORNEYS FEE ATTORNEY'S FEES SHOULD BE THE RESPONSIBILITY OF THE HOSPITAL

The costs of plaintiffs' attorneys fees should be the responsibility of the Defendant hospital. Defendants' assumption of responsibility for attorney's fees is justified under equitable principles because making plaintiffs whole requires defendants to pay plaintiffs their full damages. Defendants should agree to pay attorney fees equaling the amount of the plaintiffs' fees, contingent fees and/or under lodestar analysis. This concept is recognized under the analogous CA "tort of another" doctrine, where attorney's fees may be recovered, not as an award of attorney's fees as such, but as an element of damages arising from tortious conduct. A person who has been required by the tort of another to act in the protection of his or her interests by bringing or defending an action against a third person is entitled to recover compensation for the reasonably necessary attorney's fees incurred. *Prentice v. North Amer. Title Guar. Corp*., 59 Cal. 2d 618, 620, 30 Cal. Rptr. 821 (Cal. 1963); *Heckert v. MacDonald*, 208 Cal. App. 3d 832, 837, 256 Cal. Rptr. 369 (Ct. App. 1989).

From day one of the terrible botched effort to misplace oversized prosthesis in the wrong chest cavity and bind the skin overlying these tightly and monitor her recovery after the "guinea pig" experimental surgery it was or should have been clear to everyone involved at the hospital

that a NEVER EVENT, or ADVERSE EVENT had occurred and that the hospital and its staff were 100% responsible for the events that led to the patient's debility and irreversible bodily harm. (Evident by the statutes requiring reporting of the NEVER EVENT, no matter how the hospital tried to minimize their complicity by using ambiguous language and by concealing multiple versions of the operative reports and electronic accessed medical records from the family for years). From at least the December 2012 a 4 page communication to Stanford Guest Services and CEO Dan Ruben where the Does notified Stanford of the events and concerns on 12/12/12, Stanford should have expeditiously handled the matter. Rather, Stanford responded to Plaintiffs that they should redirect their letters to another facility despite the surgery and malfeasance which had been performed at Stanford.

> **From:** "Oltmans, Anita" <AOltmans@stanfordmed.org>
> **To:** "'----------@yahoo.com'" ←------@yahoo.com>
> **Sent:** Wednesday, January 16, 2013 12:12 PM
> **Subject:** your concerns were received
>
> Hello,
>
> This is to inform you that your email sent to Guest Services at Stanford has been received and reviewed. Because your concern relates to a physician from Palo Alto Medical Foundation, your concern should be redirected to that organization.
>
> You may send your email to: pamfpatientrelations@pamf.org or call 1-888-850-4598. A point of contact there for their Patient Relations Department is Gayle Hoover.
>
> If I can be of any further assistance, please don't hesitate to call me directly.
>
> Anita L. Oltmans
> Senior Patient Representative
> Patient Representation, Guest Services
> Stanford Hospital & Clinics
> aoltmans@stanfordmed.org
> 650-498-6161 direct line
> 650-498-3333 main office

Had the hospital been forthcoming and initiated settlement work prior to the family obtaining representation, then there would not have been a need for attorney's fees. The plaintiffs feel that the hospital has had nothing but time to find a way to resolve this tragedy in an equitable

and honorable manner, instead they have fought and obstructed the claims by ignoring the law and delaying for years production of the full medical records and electronic disclosures reports.

Similarly, plaintiffs will seek to amend their complaint to seek injunctive relief by way of order requiring the hospital to produce its adverse event reports to all affected mastectomy or lumpectomy patients and/or families, all Stanford billing for Alloderm/ any type of dermal matrix, all Stanford upcoding for unbundled pre-operative visits which were rightfully under a global fee will seek related attorney's fees under the private attorney general statute at CCP 1021 and CCP 1021.5. which states in relevant parts "Upon motion, a court may award attorneys' fees to a successful party against one or more opposing parties in any action which has resulted in the enforcement of an important right affecting the public interest if: (a) a significant benefit, whether pecuniary or nonpecuniary, has been conferred on the general public or a large class of persons".

XII. PLAINTIFFS SEEK THE HOSPITAL'S ADOPTION OF NEW MASTECTOMY PATIENT SAFETY PROTOCOLS

It is plaintiffs' hope that in light of this tragedy the hospital will implement a new policy regarding the proper monitoring and premature discharge of mastectomy and lumpectomy patients, and a policy to require a licensed physician to examine a patient prior to discharge after double mastectomy, a policy that has accountability thru verification. The new policy should start with new forms with designated places to enter the objective measurements of vascular sufficiency of the mastectomy skin flaps and nipples if present for at minimum the first 24-48 hours post op. The policy should in compliance with California Law also offer all mastectomy and lumpectomy patients in conjunction with their attending physicians to stay inpatient a minimum of 48 hours to control pain and monitor wounds as required.

Patients must be transparently notified of "medical hazard" which means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery. Health and Safety Section 1317.1(f).

Nursing staff must examine with sterile gloves the wound and skin (not just the dressing) of the patient before a mastectomy patient is discharged from the hospital and document that

finding. If there is any evidence of vascular compromise, the patient must be notified and offered the opportunity to continue inpatient observation until the safety of the patient has been ascertained for the first 48 hours after surgery. The final skin exam and wound assessment should be verified by another professional of equal or higher ranking.

Plaintiffs seek the hospital's adoption of new mastectomy safety protocols regarding premature discharge of mastectomy patients.

(1) Internal Forms should be changed because they currently fail to require a mandatory exam of the mastectomy skin before discharge.

(2) New mastectomy patient consent forms should have designated multiple line spaces for printed and legible surgery and details of what will be performed. The surgeon must first discuss with the next of kin any deviations in surgery while a patients is under general anesthesia unless it is a true medical or surgical emergency documented and verified by two licensed physicians and a witness.

(3) Input of nursing exam of mastectomy skin and nipple if applicable should be mandatory.

(4) One minute inspection of the mastectomy wound should be mandatory and a report of findings written on a form.

(5) The hospital discharge order and note should be signed by an attending and licensed physician for verification.

(6) Audits of these mechanisms and checks total should be conducted by the end of the shift.

XIII. PLAINTIFFS SEEK DEFENDANTS' ADOPTION OF COMPLIANT HEALTH CARE BILLING AND VOLUNTARY REFUNDS

(1) Stanford must become compliant with correct coding and billing initiatives by eliminating improper charges for "pre-operative" visits which are after the decision for surgery has

been made. According to CMS, these are not separately billable and included as the global surgery fee payment. [21] California Health and Safety Code 1348(e.)

(2) These upcharges are improper and would unnecessarily mis-utilize and misappropriate healthcare dollars which are already accounted for in the global surgical fees for mastectomy. California Health and Safety Code 1348(e).

(3) This institutional failure when corrected would result in an average health spending savings of $200-$494 per visit per mastectomy patient at Stanford, and moreover account for millions of dollars of recouped Medicare dollars when implemented hospital wide. [22]

(4) Stanford must conduct a voluntary audit of it's pre operative visit upcoding and billing and generate a report to Medicare and its commercial payers with a refund for the past 5 years.

(5) Defendant reconstructive Surgeon Dr. Hong and PAMF must undergo coding and ethics training and become compliant with national correct coding initiatives by ceasing his improper upcoding and misuse of CPT code 19340[23] (Immediate post mastectomy implant

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[21] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GloballSurgery-ICN907166.pdf What services are included in the global surgery payment? Medicare includes the following services in the global surgery payment when they provide them in addition to the surgery: • Pre-operative visits after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery.

[22] Stanford upcoded and improperly charged a comprehensive patient visit on 12/11/12 for a pre-operative physician assistant (PA) session which was by Correct Coding Initiative (CCI) included in the global surgical fee for the mastectomy. Therefore, Jane Doe paid $494 to Stanford which is doe back to her.

[23] Hong did not code 19342 at all before June 2014. He coded all of his implant reconstructions improperly as 19340 which paid higher. He stopped billing Medicare for 19340 shortly after March 2014.

repair which reimburses on average $952.85) and use the proper code CPT 19342 (delayed post mastectomy reconstruction which pays an average of $806.94).

(6) All Defendants must comply with Section 6401 of the Affordable Care Act (ACA) and institute a compliance plan to prevent fraud and abuse.

(7) Defendant Dr. Hong and PAMF's institutional failures in upcoding of these mastectomy reconstruction codes would result in an average health care cost savings of $146.26 per 1 breast, and moreover account for hundreds of thousands of dollars of recouped Medicare dollars when implemented institution wide. California Health and Safety Code 1348(e).

(8) The Court has jurisdiction to order Defendant hospital and institution to submit to a voluntary audit of these mastectomy repair upcoding and billing and generate a report to Medicare and its commercial payers with a refund for the past 5 years.

(9) Defendant should also receive ethics training in ceasing mis-reporting patients as "history of bilateral breast cancer"[24] who are healthy and have no breast cancer.

(10) The false entry and diagnosis of "breast cancer" by Dr. Hong would among other troubling implications negatively and financially impact a woman's ability to obtain life, disability, long term care, and future health insurance.

XVI. PLAINTIFFS SEEK STANFORD AND THE REPRODUCTIVE ENDOCRINOLOGY (REI)CENTER'S ADOPTION OF NEW MEDICAL RECORDS PRIVACY PROTOCOLS

It is plaintiffs' hope that in light of the privacy breeches of specially protected confidential medical records highlighted in this case, REI and the hospital will immediately implement a new policy regarding the proper segregation of patient charts within the REI system, as well as segregation of specially protected HIV and psychotherapy records and notes to ensure compliance with HIPAA and Federal guidelines.

[24] Dr. Hong falsely reported to the commercial health insurance carrier that Ms. Doe had a "history of bilateral breast cancer" which was untrue. Ms. Doe never had breast cancer. Dr. Hong on 12/19/16 corrected his false medical record entry upon the written demand of Ms. Doe's counsel pursuant to HIPAA and H&S Code.

Plaintiffs seek a new medical records policy that has accountability thru verification which would require a health records manager to examine REI patient records prior to release.

a. The new policy should also ensure separate charts for male partners of female patients, and any third parties' records, who are undergoing treatments at REI.

b. The new policy should also start with segregated portions of the patient chart for special test records and a separate area for psychotherapy notes or references. Those protected portion of the chart must be marked with warnings that would notice any one accessing those records about privacy breeches.

c. The new medical record release forms must have specially designated places to enter the sensitive records which are requested and authorized by the patient (s).

d. The policy should require independent and advance notice by REI staff and independent confirmation to all patients and third parties whose records Stanford REI intends to release for any reason.

e. All subpoenas must be first verified by the medical records manager. If there is any evidence of questionable release of records there must be a court order if there is demand for ALL records including HIV, genetic tests, other protected tests and psychotherapy records.

f. With all record subpoenas, to ensure privacy of protected and sensitive HIV, genetic testing, and psychotherapy records, the patient must be notified in advance by REI and offered the opportunity to verify, object, or file a motion to quash if applicable.

g. The final record release must be verified by a second health records professional of equal or higher ranking who must attest and verify that all protected health records have been withheld and segregated from the released record production.

h. Plaintiffs seek the REI and the hospital's adoption of new privacy protocols regarding REI patients.

i. Internal Filing Protocols should be changed because they currently fail to require proper segregation of individual partner files within the REI main patient file.

j. Audits of these safety mechanisms and checks should be conducted by the end of each month.

XV. CONCLUSION

Defendants negligently treated and cared for the Does during and following mastectomy; failed to properly examine the breast skin and Mrs. Doe following the "gunnie pig" experimental surgery to confirm there was adequate blood flow to the skin and nipples.; failed to diagnose Mrs. Doe's impeding tissue death and pain and treat properly; and prematurely discharged Ms. Doe from a "drive through mastectomy" without adequate and standard medical care or instructions, or timely care At all relevant times, Defendants were employees and/ or agents of Stanford Hospital or credentialed by Stanford Hospital to render care and treatment at their facility.

Plaintiffs seek fair maximum compensation for the needless and preventable deformities of their beloved wife and mother, Ms. Doe. Their total economic damages of $419,734-$1.1 Million Dollars, plus emotional pain and suffering damages of $500,000 total $1.6 million in recoverable damages, not including punitive damages, battery awards, and attorneys' fees.

/J. Doe

Jane Doe in Limited Scope Representation pursuant to CRC 3.36 ATTORNEYS FOR PLAINTIFFS JANE AND JOHN DOE

Date: March 8, 2017

Exhibit G

FIRST AMENDED

SUM-100

SUMMONS
(CITACION JUDICIAL)

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)

NOTICE TO DEFENDANT:
(AVISO AL DEMANDADO):

STANFORD HOSPITALS AND CLINICS, INC., a California Corporation; DANIEL GROSSMAN, M.D.; (SEE ATTACHMENT A)

YOU ARE BEING SUED BY PLAINTIFF:
(LO ESTÁ DEMANDANDO EL DEMANDANTE):

RENEE LYONS AND JEFF KALIBJIAN, as individuals

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.

¡AVISO! *Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.*

*Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (*www.sucorte.ca.gov*), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.*

*Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (*www.lawhelpcalifornia.org*), en el Centro de Ayuda de las Cortes de California, (*www.sucorte.ca.gov*) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.*

The name and address of the court is:
(El nombre y dirección de la corte es):

Superior Court of California County of Santa Clara
191 N. First Street, SanJose, CA 95113

CASE NUMBER:
(Número del Caso):
114CV263807

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):

DATE: *(Fecha)*

Clerk, by *(Secretario)* _____ , Deputy *(Adjunto)*

(For proof of service of this summons, use Proof of Service of Summons *(form POS-010).)*
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, *(POS-010)).*

[SEAL]

NOTICE TO THE PERSON SERVED: You are served

1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify):*
3. ☐ on behalf of *(specify):*

under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
☐ other *(specify):*

4. ☐ by personal delivery on *(date):*

Form Adopted for Mandatory Use
Judicial Council of California
SUM-100 [Rev. July 1, 2009]

Code of Civil Procedure §§ 412.20, 465
www.courtinfo.ca.gov

LYONS, ET AL V. STANFORD HOSPITAL AND CLINICS (CASE NO. 114CV 263807)

SUMMONS - ATTACHMENT A

ADDITIONAL DEFENDANTS:

ERROL O. OZDALGA, M.D.; ROBERT LEE NORRIS. M.D.; CAMILLA KILBANE, M.D.; JOHN KUGLER, M.D.; And DOES 1-50, Inclusive;

Joel C. Golden (SBN 47904)
2356 Moore Street, Suite 201
San Diego, CA 92110
Telephone: (619) 294-7918
Fax: (619) 296-8229
Attorney For Plaintiffs Renee Lyons and Jeffrey Kalibjian

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SANTA CLARA

RENEE LYONS and JEFF KALIBJIAN, as individuals,

Plaintiffs,

V,

STANFORD HOSPITAL AND CLINICS INC, a California corporation; DANIEL GROSSMAN, M.D.;| ERROL O. OZDALGA, M.D.; ROBERT LEE NORRIS, M.D.; CAMILLA KILBANE, M.D.; JOHN KUGLER, M.D.;

And DOES 1 -50, Inclusive; |

Defendants.

Case No. 1-14- cv-263807

FIRST **AMENDED COMPLAINT FOR DAMAGES**

1. BATTERY
2. ASSAULT
3. SEXUAL BATTERY
4. FALSE IMPRISONMENT
5. MEDICAL MALPRACTICE
6. BATTERY
7.LOSS OF CONSORTIUM

EACH PLAINTIFF DEMANDS A JURY TRIAL

COME NOW Plaintiffs RENEE LYONS and JEFF KALIBJIAN, who allege against Defendants, and each of them, as follows:

GENERAL ALLEGATIONS

1. Plaintiffs RENEE LYONS (hereinafter referred to as ("LYONS") and JEFF KALIBJIAN (hereinafter referred to as ("KALIBIJIAN") (both collectively referred to as ("PLAINTIFFS" or "Plaintiffs"), are informed and believe and thereon allege, as their Complaint and causes of action against the above-named Defendants the following.

2. At all relevant times, PLAINTIFFS were residents of the County of Alameda, State of California.

3. At all times herein mentioned, Defendant STANFORD HOSPITAL AND CLINICS hereinafter referred to as ("STANFORD") was and is a California corporation, duly organized and authorized to do business in California. STANFORD is located at 300 Pasteur Drive, Stanford, California, 94305, where all of the actions and omissions alleged in this Complaint occurred, except where stated otherwise.

4. The true names and capacities of the DEFENDANTS, Does 1-50, whether individual, corporate, associate or otherwise, are unknown to PLAINTIFFS at the time of filing this First Amended Complaint and PLAINTIFFS, therefore, sue said DEFENDANTS by such fictitious names and will ask leave of court to amend this First Amended Complaint to show their true names or capacities when the same have been ascertained. Plaintiffs allege that each of the fictitiously named Defendants, some of whom were unlicensed physicians, are legally responsible in some manner for the occurrences herein alleged, and that Plaintiffs' damages as herein alleged were proximately caused by the negligent and/or intentional acts committed by Does 1 through 50.

5. All of the acts and omissions alleged herein were performed by, and/or attributed to, all DEFENDANTS, each acting as agents and/or employees, and/or under the

direction and control of each of the other DEFENDANTS, and said acts and failures to act were within the course and scope of said duties, agency, employment and/or direction and control.

6. At all times herein mentioned, Defendant DANIEL GROSSMAN, M.D. (hereinafter referred to as "GROSSMAN") is and was a physician duly licensed to practice medicine in the State of California.

7. At all times herein mentioned, Defendant ERROL O. OZDALGA, M.D. (hereinafter referred to as "OZDALGA") is and was a physician duly licensed to practice medicine in the State of California.

8. At all times herein mentioned, Defendant ROBERT NORRIS, M.D. (hereinafter referred to as "NORRIS") was and is a physician duly licensed to practice medicine in the State of California.

9. At all times herein mentioned, Defendant CAMILLA KILBANE, M.D. (hereinafter referred to as "KILBANE") was and is a physician duly licensed to practice medicine in the State of California.

10. At all times herein mentioned, Defendant JOHN KUGLER, M.D. (hereinafter referred to as "KUGLER") was and is a physician duly licensed to practice medicine in the State of California.

11. PLAINTIFFS are informed and believe, and thereon allege, that at all times mentioned herein, each of the defendants sued herein, including the DOE defendants, was and is the agent and/ or employee of each of the remaining defendants, and was at all times acting with the purpose and scope of such agency and/or employment with STANFORD.

FACTS COMMON TO ALL ALLEGATIONS

12. On January 14, 2013 shortly after 9:00 p.m. LYONS and KALIBJIAN arrived at the parking lot near the back entrance of Stanford Hospital. LYONS and KALIBJIAN went to STANFORD for the sole purpose of finding for LYONS urgent care for her severe sore throat with associated swelling, pain and difficulty swallowing. LYONS, accompanied by her husband, Plaintiff KALIBJIAN, entered through the back entrance of STANFORD. While PLAINTIFFS were merely standing and looking at signs in order to direct them to urgent care, four (4) male STANFORD employees, whose identities are not known to PLAINTIFFS, walked into the area where PLAINTIFFS were standing and without good cause, explanation, or provocation on the part of LYONS or KALIBJIAN, violently grabbed each of LYONS' limbs without her consent and forcibly restrained her to a gurney. The four (4) male employees of STANFORD then hastily wheeled LYONS, helpless in four point restraints, through a hallway and into a small room, which the medical records later indicated was in the emergency department.

13. LYONS remained calm and still in four point restraints surrounded by the four male STANFORD employees and accompanied by her husband KALIBJIAN. LYONS had been forcefully and quickly wheeled to this room without medical need or consent or provocation on the part of LYONS and against the protests of LYONS and her husband KALIBJIAN to a room where they still had not had anyone interview them or show any interest in introducing themselves or identifying who they were or what they were doing and the reasons for doing so.

14. Immediately thereafter, GROSSMAN, who did not identify himself to the PLAINTIFFS , along with unidentified STANFORD employees identified in the medical record as nurses, entered the small room which medical records later indicated was in the emergency dapartment to which LYONS had been forcefully and hastily wheeled. LYONS was held against her will in this room and was still in four point restraints with the STANFORD male employees at the entrance of the door to the small room and without LYONS having been admitted as a patient to STANFORD still without explanation, consent, physical examination, or the taking of a medical history from LYONS or KALIBJIAN. Dr. GROSSMAN entered the room and did not introduce himself to LYONS or KALIBJIAN.

15. GROSSMAN did not order LYONS to be unrestrained. GROSSMAN was able to observe LYONS lying quietly and helplessly with four point restraints surrounded by the men who had assaulted her unprovoked in the hallway around the corner.

16. GROSSMAN did not ask any of the men in the room the reasons for their actions in restraining LYONS. LYONS and KALIBJIAN had been quiet at the entry of the hospital and remained quiet in the room. GROSSMAN without explanation, medical necessity or medical consent, without interview or examination other than to observe LYONS lying helplessly and quietly on a gurney in four point restraints, ordered a nurse to place an IV in LYONS and then ordered a nurse to inject LYONS with an unknown substance which he had personally brought into the room and handed to the nurse without explanation, medical necessity, history, or examination, or medical consent for treatment. GROSSMAN ignored all medical obligations on the part of his medical license and his federal DEA license and did without medical necessity, medical consent, examination,

history, interview or introduction or explanation ordered the injection of medication into LYONS. GROSSMAN ordered the battery of LYONS by ordering the placement of an IV in her arm. GROSSMAN ordered another battery of LYONS by ordering a chemical be placed into the IV thereby chemically restraining LYONS rendering her immediately unconscious.

17. GROSSMAN participated in keeping LYONS restrained in the room where she lay helplessly and quietly in four point restraints when he first entered the room. GROSSMAN participated in and was grossly negligent in the misuse of his medical license and DEA privileges by ordering a medication, without medical need or consent, that rendered LYONS unconscious for approximately the next eighteen hours.

18. Soon after LYONS was rendered unconscious, she was whisked away from the small room she and her husband were in, by STANFORD staff for alleged testing. STANFORD employees did not allow Plaintiff KALIBJIAN to accompany LYONS.

19. LYONS was then out of KALIBJIAN's presence for approximately 45 minutes. When LYONS was returned to KALIBJIAN's presence she was still unconscious. Other than the time LYONS was out of KALIBJIAN's presence for supposed testing, PLAINTIFFS were kept in that same small room in the emergency department the entire time while LYONS was unconscious and restrained. LYONS even remained unconscious and restrained in the transfer to the medical ward the next day. LYONS remained unconscious and restrained when moved to the room to which she was transferred on the medical ward where she eventually woke up. LYONS remained unconscious and restrained when her clothes were removed and she was changed into a hospital gown.

20. During LYONS' eighteen hours of unconsciousness KALIBJIAN protested to at least three doctors who the record shows were only interns in STANFORD hospital residency programs regarding the wrongful and inappropriate use of medication on LYONS. No one in the record is identified as a STANFORD attending Physician other than GROSSMAN and NORRIS, both of whom did not take a history or perform a physical for LYONS in the presence of KALIBJIAN or when LYONS was conscious.

21. KALIBJIAN repeatedly objected to these STANFORD physicians who interviewed him, identified in the records as interns in residency programs of STANFORD about the lack of any medical reasons to render LYONS unconscious. A male, identified in the medical record as a medical intern, identity unknown, informed KALIBJIAN that they thought LYONS had a brain infection/encephalitis. Not one of the STANFORD physicians who interviewed KALIBJIAN in those 18 hours took action upon being informed by KALIBJIAN of his protests about GROSSMAN'S behavior and about GROSSMAN'S grossly negligent battery of LYONS by wrongfully chemically restraining her and rendering her unconscious without any cause or justification. Instead, all the physicians who interviewed him ignored KALIBJIAN's protests and plea to look into the fact that GROSSMAN had wrongly and without medical need or examination or explanation wrongfully rendered her unconscious. These physicians repeatedly told him all night that LYONS had a brain infection/encephalitis.

22. On Tuesday, January 15, 2013, LYONS became conscious in the room on the medical ward to which she had been transferred from the emergency room that day. She was still laboring under the deleterious and prolonged side-effects of the wrongful medication which rendered her immediately unconscious for eighteen hours. LYONS in

the presence of KALIBJIAN requested an Infectious Disease consultation from all the doctors she saw that day and every other day she was at STANFORD because she was told by STANFORD employees that she was suffering from encephalitis. The request was summarily denied.

23. During her hospital stay, and instead of ordering an evaluation by an Infectious disease physician for which LYONS had made repeated requests, DEFENDANTS OZDALGA, KILBANE, and KUGLER and the physicians they supervised, and the intern supervised by DEFENDANT NORRIS, without any medical indication, wrongfully diagnosed LYONS with altered mental status and knowingly made false entries into the medical records in an attempt to support a theory of psychosis. They repeatedly ordered psychiatry consultations to evaluate LYONS. DEFENDANTS OZDALGA, KILBANE, and KUGLER and the physicians they supervised, and the intern supervised by NORRIS repeatedly omitted from the STANFORD medical record important and relevant clear and consistent reports by LYONS and KALIBJIAN.. DEFENDANTS OZDALGA, KILBANE, KUGLER and other DEFENDANTS also became aware of the assault, battery and false imprisonment committed upon LYONS on the evening PLAINTIFFS entered the hospital and took actions to cover up the fact that those torts were committed by STANFORD. STANFORD Defendants falsified and omitted documentation in the STANFORD medical records of the serious detailed complaints made by LYONS and KALIBJIAN.

24. On Wednesday January 16th, 2013, LYONS reported that she was experiencing significant vaginal bleeding, which she believed resulted from vaginal penetration during her unconscious state. LYONS demanded to be interviewed and evaluated by an

OBGYN, which requests were consistently refused by DEFENDANTS along with consistently refusing her continuous requests to see an Infectious Disease specialist.

25. On Thursday, January 17, 2013 LYONS again requested both OBGYN and Infectious Disease consultations from the medical ward physicians she came into contact with that day but all of LYONS' requests were refused without explanation.

26. On January 17, 2013 LYONS then told DEFENDANTS she was considering leaving the hospital altogether. The STANFORD physicians indicated that they still believed she needed IV antibiotics and antivirals that they had continued to keep her on and it would be Against Medical Advice to leave. STANFORD physicians had not yet determined which oral antibiotics and antivirals they would recommend since they still were not sure which IV antibiotics and antivirals they were giving her were effective because she still was being treated for a brain infection . LYONS, under the false fear of having a brain infection as relayed to her by DEFENDANTS, acquiesced to remain in the hospital.

27. On Friday, January 18, 2013 LYONS once again requested both OBGYN and Infectious Disease consultations from all the physicians she saw that day on the ward. They again refused. However, on Friday January 18, 2013, STANFORD physicians informed PLAINTIFFS they no longer thought LYONS had a brain infection and that IV based antibiotics would no longer be required and that LYONS could be discharged from the hospital without any antibiotics or antivirals.

28. Defendant KUGLER indicated to LYONS in the presence of KALIBJIAN during her stay that in fact she may have been correct in stating that whatever wrongful medication the emergency room had given her was in fact most likely the problem. KUGLER also told LYONS and KALIBJIAN that what also supported their complaints is that no one

would have recovered from such an infection as a brain infection/encephalitis as rapidly as she had. LYONS in the presence of KALIBJIAN was told by STANFORD attending physicians that they were not responsible for the behavior of STANFORD employees in the emergency room. On January 18, 2013 STANFORD physicians asked LYONS to leave as soon as possible after informing LYONS that they decided she not only did not need IV antibiotics and antivirals, but that she needed no medications upon discharge. They also stated that she had recovered so quickly they were certain she did not have encephalitis and that indeed the symptoms of altered mental status were consistent with her reports of being wrongly medicated in the emergency room. .

29. LYONS again requested both an OBGYN and an Infectious Disease consultation. LYONS' requests were again refused; however, STANFORD physicians and nurses indicated that she could go back to the emergency room to have the emergency room doctors examine her and only STANFORD emergency room personnel would be allowed to interview and examine her regarding these complaints because this was STANFORD protocol. LYONS and KALIBJIAN refused to go to the emergency room. The attending physician KUGLER had already admitted to LYONS and KALIBJIAN that the uncalled for STANFORD emergency room medication most likely caused her symptoms. But LYONS and KALIBJIAN were informed STANFORD medical ward physicians would not order or allow LYONS to have an OBGYN or Infectious Disease consultation before leaving the hospital.

30. PLAINTIFFS then requested that the hospital call Palo Alto police and also requested a hospital social worker be called to LYONS' room. STANFORD physicians who wrote notes in the medical records, some without having seen LYONS that day (January 18,

2013), actively delayed this process for at least seven hours and kept encouraging LYONS and KALIBJIAN, by phone and by sending in nurses asking them to leave the hospital, to leave without an OBGYN examination unless she physically went to the STANFORD emergency room where she and her husband had repeatedly reported these previous events to all the medical ward staff since Wednesday January 16, 2013.

31. PLAINTIFFS reported the initial physical assault on LYONS by the four STANFORD employees, medical assault and battery by GROSSMAN, sexual assault, and LYONS' false imprisonment in the hospital to the social worker employed in the emergency room. After significant delay the social worker finally came to LYONS' room on the medical ward later on the night of Friday, January 18, 2013.

32. LYONS and KALBJIAN also informed the social worker of the need to keep the camera evidence of their entry to the hospital where LYONS was initially assaulted by the four male STANFORD employees. LYONS and KALIBJIAN also informed the social worker of having given this information to all the STANFORD medical ward physicians since Jan 16, 2013 and that this camera video would identify the initial assailants and also allow a quick investigation so that all employees involved in the assault and battery and rape would be identified. LYONS told the social worker she hoped such an identification would prevent this from happening to any other patient at the hospital in the future. Again, LYONS and KALIBJIAN further requested that the social worker inform appropriate STANFORD personnel of the need to retain all STANFORD camera evidence from the night of January 14 and January 15, 2013 in the STANFORD emergency room and all areas in the hospital to which she may have been transported. She also requested video be preserved of all activity involving STANFORD

employees approaching the room where she may have been transported still laying unconscious strapped to a gurney and without her husband and possibly showing evidence of touching her while she was unconscious , These persons entered and exited shortly before and after she arrived and was taken out of any rooms where she may have been transported. LYONS demanded that STANFORD retain camera evidence of locations where STANFORD personnel came into contact with her or rooms she was in or transported in and out of throughout her time at STANFORD on January 14-January 18, 2013.

33. When Palo Alto police arrived, PLAINTIFFS reported the initial physical assault on LYONS by the four STANFORD employees, medical assault and battery by GROSSMAN, sexual assault, and LYONS' false imprisonment in the hospital. LYONS and KALIBJIAN also informed the police of the need to obtain and retain all camera evidence at the entry where they informed the police would provide clear identification of the original assailants. LYONS and KALIBJIAN further asked the police to retain all camera evidence the night of January 14 and January 15, 2013 in the hospital as it would also show evidence of where she was assaulted. She also asked them to retain camera evidence of locations STANFORD personnel came into contact with her or rooms she was in or transported in and out of throughout her time at STANFORD on January 14-January 18, 2013.

34. LYONS left STANFORD with the Palo Alto Police and KALIBJIAN at approximately l0:00 p.m. on Friday, January 18, 2013.

I.

FIRST CAUSE OF ACTION

(BATTERY)

LYONS AGAINST STANFORD AND DANIEL GROSSMAN, M.D.

AND DOES 1-50

35. Plaintiffs re-allege and incorporate by reference the allegations contained in Paragraphs 1 through 34.

36. On January 14, 2013, LYONS was touched by four unidentified males, named as DOE DEFENDANTS, who were employed by STANFORD when they violently grabbed LYONS' limbs and pinned her to a hospital gurney and further restrained her. LYONS alleges that she was touched by said employees of STANFORD with intent on their part to harm and/or offend LYONS. LYONS did not consent to the touching and LYONS was harmed and/ or offended by said touching. A reasonable person in LYONS' situation would have been offended by the touching. DEFENDANT GROSSMAN also ratified and consented to and participated in the maintaining of battery on LYONS by the men who were surrounding her and her husband in this room to which she had been taken after battery. GROSSMAN aided and abetted the initial battery and assault, by leaving LYONS helplessly and quietly lying in four point restraints in the small room. GROSSMAN prolonged the restraint by chemically restraining her causing LYONS to become immediately unconsciousness without her consent. GROSSMAN also was an accessory to allowing the unlawful touching by observing her lying before him quietly and helplessly tied to the gurney in the four point restraints with the initial male assailants

at the entry of the door of the small room and in the room and not ordering an immediate investigation or reporting these matters.

37. On January 14, 2013, LYONS was touched by GROSSMAN, M.D., when he wrongfully medicated her to immediate unconsciousness by way of injection against her will and without her consent. GROSSMAN touched her with the intent to harm and/or offend LYONS. LYONS did not consent to the touching and LYONS was harmed and offended by said touching. A reasonable person in LYONS' situation would have been offended by the touching. GROSSMAN authorized and participated in the unnecessary chemical sedation of LYONS to immediate unconsciousness despite her husband KALIBJIAN'S protests and objections.

38. As a direct and proximate cause of these acts and omissions LYONS has suffered distress, humiliation, loss of enjoyment of life, damage to reputation, fear for her safety in a place that had previously been most comfortable and home to her, physical pain and suffering and economic damages all in an amount to be determined at trial.

II.

SECOND CAUSE OF ACTION

(ASSAULT)

LYONS AGAINST STANFORD AND DANIEL GROSSMAN, M.D.

AND DOES 1-50

39. Plaintiffs re-allege and incorporate by reference the allegations contained in Paragraphs 1 through 38.

40. On January 14, 2013, four unidentified males who were employed by Defendant STANFORD, approached LYONS as she was standing near the rear entrance of

STANFORD and acted, maliciously intending to cause harmful and/ or offensive contact with her person. LYONS believed she was about to be touched in a harmful and/or offensive manner by said DEFENDANTS. LYONS did not consent to said DEFENDANTS' conduct and was harmed therefrom. DEFENDANTS' conduct as set forth herein was a substantial factor in causing LYONS' harm.

41. On January 14, 2013, GROSSMAN, approached LYONS as she was tied in four point restraints to a gurney in a small room in the emergency department and acted, intending to cause a harmful and/or offensive contact with LYONS by ordering an unnamed DOE Defendant and STANFORD employee to approach her with a needle with the intent to inject the needle into LYONS. LYONS was frightened as she believed she was about to be touched in a harmful and/ or offensive manner upon orders by GROSSMAN. LYONS did not consent to GROSSMANS conduct, and was harmed by that conduct. GROSSMAN'S conduct as set forth herein was a substantial factor in causing LYONS' harm.

42. As a direct and proximate cause of these acts LYONS has suffered distress, humiliation, loss of enjoyment of life, damage to reputation, fear for her safety, physical pain and suffering, and economic damages all in an amount to be determined at trial.

III.

THIRD CAUSE OF ACTION

(FALSE IMPRISONMENT)

LYONS AGAINST STANFORD AND DANIEL GROSSMAN, M.D.

AND DOES 1-50

43. Plaintiffs re-allege and incorporate by reference the allegations contained in Paragraphs 1 through42.

44. On January 14, 2013, four unidentified males, referenced as DOE DEFENDANTS, who were employed by Defendant STANFORD, approached LYONS as she was standing near the rear entrance of Defendant STANFORD hospital and intentionally deprived LYONS of her freedom of movement by the use of force when they violently grabbed LYONS' limbs and pinned and strapped her to a hospital gurney and further restrained her. The restraint and confinement compelled LYONS to involuntarily stay in the hospital gurney and at STANFORD for some appreciable time. LYONS did not knowingly or voluntarily consent to said restraint and confinement, and was actually harmed therefrom. STANFORD's conduct was a substantial factor in causing LYONS' harm.

45. On January 14, 2013, and following the restraint and confinement committed by Defendant STANFORD as set forth above, GROSSMAN, further intentionally deprived LYONS of her freedom of movement by wrongfully medicating or ordering her to be medicated to an immediate unconscious state. LYONS, was already deprived of freedom of movement by unnecessarily being physically restrained and tied to the gurney in four points despite her being quiet and calm. LYONS did not knowingly or voluntarily consent to said wrongful chemical restraint and confinement, and was actually harmed therefrom. GROSSMAN'S conduct was a substantial factor in causing LYONS' harm.

46. As a direct and proximate cause of these acts LYONS has suffered distress, humiliation, loss of enjoyment of life, damage to reputation, fear for her safety, physical pain and suffering and economic damages all in an amount to be determined at trial.

IV.

FOURTH CAUSE OF ACTION

(SEXUAL BATTERY)

LYONS AGAINST ALL DEFENDANTS

47. Plaintiffs re-allege and incorporate by reference the allegations contained in Paragraphs 1 through 46.

48. On Tuesday, January 15, 2013, and after being rendered unconscious by the medication wrongfully ordered by GROSSMAN and wrongfully administered to LYONS on the evening of January 14, 2013, for some eighteen (18) hours, LYONS regained consciousness. On Wednesday January 16th, LYONS reported that she was experiencing significant vaginal bleeding, which she believed resulted from vaginal penetration during her unconscious state. LYONS demanded to be evaluated by an OBGYN, which requests were consistently refused by DEFENDANTS. As a result of LYONS' requests to be evaluated by an OBGYN, Defendants OZDALGA and KILBANE and NORRIS supervised and began asking LYONS and KALIBJIAN intrusive questions and repeatedly denied LYONS access to an OBGYN.

49. LYONS contends that after being rendered unconscious by the medication wrongfully ordered by GROSSMAN and wrongfully administered to her on the evening of January 14, 2013. While LYONS was in an unconscious state on January 14 through January 15, 2013, at STANFORD, DEFENDANTS intended to cause a harmful contact

with LYONS' sexual organs, and a sexually offensive contact with LYONS resulted. LYONS did not consent to the touching and was harmed by DEFENDANTS' conduct.

50. As a direct and proximate cause of these acts LYONS has suffered distress humiliation, loss of enjoyment of life, damage to reputation, fear for her safety, physical pain and suffering and economic damages, all in an amount to be determined at trial.

V.

FIFTH CAUSE OF ACTION

(PROFESSIONAL NEGLIGENCE)

(MEDICAL MALPRACTICE)

LYONS AGAINST ALL NAMED DEFENDANTS ICLUDING DOES 1-50

51. LYONS incorporates by reference each and every preceding paragraphs 1 through 50 as if recited verbatim herein.

52. DEFENDANTS GROSSMAN, OZDALGA, NORRIS, KILBANE AND KUGLER and each of them and DOES 1 through 50, inclusive, as physicians and nurses, undertook the care and treatment of LYONS and rendered professional medical services or failed to do so in the diagnosis, care and treatment of Plaintiff beginning on or about January 14, 2013 continuing thereafter.

53. At the date and time aforesaid, DEFENDANTS and each of them named in paragraph 52 of this **First** Amended Complaint owed LYONS a duty of care in a doctor and patient relationship and in a nurse and patient relationship to use such skill, prudence and diligence as other members of their profession and health care providers commonly possess.

54. These DEFENDANTS, as named in paragraph 52, and each of them breached the duty of care owed to Plaintiff and failed to exercise the proper degree of knowledge and skill and standard of care and so negligently, carelessly, recklessly and unlawfully treated, provided care, monitoring, examination and other professional services or failed to do so in that, among other things, 1) each of them failed to adequately and properly diagnose and treat Plaintiff ; 2) each of them failed to advocate for medically necessary treatment for Plaintiff. and 3) each of them failed to satisfy the basic tenets of a doctor - patient relationship and nurse- patient relationship.

55. As a direct and proximate result of the negligence and breach of duty by each of these DEFENDANTS as identified in paragraph 52, through their acts and/or omissions, caused LYONS to suffer damages in an amount to be determined at trial.

56. All named DEFENDANTS and each of them and DOES 1 through 50, inclusive, as physicians and nurses, undertook the care and treatment of LYONS and rendered professional medical services or failed to do so in the diagnosis, care and treatment of her beginning on or about from January 14, 2013 through approximately January 18, 2013.

57. During that time and those dates aforesaid, DEFENDANTS and each of them named AND DOES1-50 owed LYONS a duty in a doctor -patient and nurse -patient relationship to use such skill, prudence and diligence as other members of their profession and health care providers commonly possess and use.

58. These DEFENDANTS, and each of them, breached the duty of care owed to Plaintiff and failed to exercise the proper degree of knowledge and skill and standard of care and so negligently, carelessly, recklessly and unlawfully treated, provided care, monitoring, examination and other professional services or failed to do so including, but

not limited to the following: 1) Each of them failed to adequately and properly diagnose and treat Plaintiff for her medical condition; 2) Each of them failed to advocate for medically necessary treatment for Plaintiff; 3) Each of them failed to properly and completely document all material information relating to LYONS and her treatment and history provided by her and KALIBJIAN; 4) Each of them knowingly falsified and omitted relevant facts from STANFORD medical records ; 5) DEFENDANTS failed to satisfy the basic tenets of a doctor patient and nurse patient relationship relating to care and treatment, failed to document accurate medical records and reports, failed to provide full disclosure and failed to obtain consent from LYONS; 6) Each of them failed to obtain consent from LYONS for treatment, examination, medications injected into her, radiologic studies, labs and procedures; 7) Each of them failed in their duties owed to LYONS to properly supervise individuals who administered care to LYONS or failed to do so ; 8) STANFORD failed in its duty owed to LYONS to monitor relevant video which would have shown the initial assault and battery and prevent further harm to LYONS. They also, failed in their duty owed to LYONS to protect her on the premisis by monitoring the video at the time of the assault and STANFORD failed in its duty owed to LYONS to take all necessary actions to preserve relevant video and/or audio recordings during the time LYONS entered the hospital on January 14, 2013 until she left the hospital on January 18, 2013; 9)STANFORD and its employees invaded LYONS' right to privacy and violated HIPAA laws; and 10) STANFORD and its employees demonstrated gross medical negligence and battery upon LYONS by additionally allowing some of the individuals, who were unlicensed physicians, On January 14 through 18 to touch LYONS and to attend to her as a patient without informing her or her

husband KALIBJIAN and obtaining her express written consent to allow unlicensed physicians to be present or act as physicians in her care.

59. Plaintiff alleges that DEFENDANTS' negligence caused Plaintiff LYONS to become and remained medicated and unconscious without a medical indication from January 14 through January 15, 2013. Plaintiff alleges she was harmed by said negligence and that DEFENDANTS' negligence was a substantial factor in causing said harm.

60. Plaintiff further contends that DEFENDANTS were negligent in the care and treatment of Plaintiff by incorrectly diagnosing and treating plaintiff LYONS for encephalitis and altered mental status and failing to have LYONS evaluated by an OBGYN and an Infectious Disease specialist during the course of her hospitalization. Plaintiff alleges she was harmed by said negligence and that DEFENDANTS' negligence was a substantial factor in causing said harm.

61. As a direct and proximate cause of these acts LYONS has suffered distress humiliation, loss of enjoyment of life, damage to reputation, fear for her safety, physical pain and suffering and economic damages all in an amount to be determined at trial.

VI.

BATTERY

STANFORD AND DOE DEFENDANTS

62. Plaintiffs incorporate by reference paragraphs 1 through 61 as stated verbatim herein.

63. Additionally on January 14 through January 18 STANFORD and its employees committed battery and gross medical negligence upon LYONS by allowing some of the individuals, DOE Defendants, who they knew were unlicensed physicians, to touch

LYONS without her consent and to attend to her as a patient without her express written consent to allow this by unlicensed physicians.

64. As a direct and proximate cause of these acts LYONS has suffered distress humiliation, loss of enjoyment of life, damage to reputation, fear for her safety, physical pain and suffering and economic damages all in an amount to be determined at trial.

VII.

SIXTH CAUSE OF ACTION

(LOSS OF CONSORTIUM)

BY PLAINTIFF KALIBJIAN AGAINST ALL DEFENDANTS

65. Plaintiff re-alleges and incorporates by reference the allegations contained in Paragraphs 1 through 64.

66. KALIBJIAN allege that he has been harmed by the injury to his wife as a result of the intentional and negligent torts pled herein by LYONS against DEFENDANTS as they were husband and wife when the injuries to LYONS occurred. KALIBJIAN alleges that, as a result of the torts alleged herein by LYONS, he suffered a loss of his wife's companionship and services and seeks damages for the non-economic harm caused therefrom including distress, humiliation and loss of enjoyment of life.

NOTICE

67. PLAINTIFFS have complied with and provided timely notice pursuant to California Code of Civil Procedure Section 364.

WHEREFORE, PLAINTIFFS pray for judgment against DEFENDANTS as follows:

1. For general and special damages according to proof;
2. For costs of suit as permitted by statute;
3. For statutory interest on the foregoing;
4. For punitive damages arising from the intentional torts pled herein and according to proof; and,
5. For such other relief as the court may order.

DATED: October 9, 2014

By: _____

Joel C. Golden
Attorney For Renee Lyons and
Jeff Kalibjian

Exhibit H

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Attorneys for Plaintiff
MARK ROE

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN MATEO

CIV537723

MARK ROE, Plaintiffs, vs. STANFORD HEALTH CARE; ROBERT LASTINGER; and DOES 1 THROUGH 25, INCLUSIVE, Defendants.	CASE NO. **COMPLAINT FOR DAMAGES** **(1) Negligence** **(2) Negligent Hiring/Retention** **(3) Negligent Supervision/Failure to Warn** **(4) Premises Liability** **(5) Battery** **(6) Sexual Battery** **(7) Intentional Infliction of Emotional Distress** **DEMAND FOR JURY TRIAL**

BY FAX

COMES NOW Plaintiff MARK ROE, by and through his undersigned attorneys, for causes of action against Defendants, and each of them, hereby alleges as follows:

1. All acts, occurrences and transactions hereafter mentioned occurred in the City of Redwood City, County of San Mateo, State of California.

2. At all relevant times herein, Plaintiff MARK ROE (hereinafter "Plaintiff") was, and is currently, a competent adult and resident of the State of California.

3. Plaintiff is informed and believes, and upon such information alleges, that Defendant STANFORD HEALTH CARE at all relevant times herein was, and is now, a

corporation organized and existing under the laws of the State of California, with its principal place of business located at 300 Pasteur Drive H3200, in the City of Stanford, County of Santa Clara, State of California at all relevant times herein did, and does currently, govern, own, operate and control the Stanford medical facility located at 450 Broadway Street in the City of Redwood City, County of San Mateo, State of California.

4. At all relevant times herein, Defendant ROBERT LASTINGER was, and is believed to be currently, an individual residing within the County of Alameda. At all relevant times herein, Defendant ROBERT LASTINGER (hereafter "LASTINGER") was an employee of Defendants STANFORD HEALTH CARE and DOES 1-10, and each of them. Plaintiff is informed and believes, and upon such information alleges, that LASTINGER was hired, trained, retained, supervised, and held out to be an employee of Defendants STANFORD HEALTH CARE and DOES 1-10, and each of them, and as such, routinely had access to individuals at the premises before, during, and after surgery, in their most vulnerable states. At all relevant times herein, LASTINGER was acting within the course and scope of his employment for Defendants STANFORD HEALTH CARE and DOES 1-10, and each of them.

5. Plaintiff is unaware of the true names and capacities of Defendants sued in this Complaint as DOES 1 through 25, inclusive, and therefore sues these Defendants by such fictitious names. Plaintiff will amend this Complaint to allege their true names and capacities when ascertained.

6. Plaintiff is informed and believes, and upon such information alleges, that each of the fictitiously named Defendants is responsible in some manner, or ratified and condoned the behavior and acts of each other Defendant, for the occurrences herein alleged and that Plaintiff's injuries and damages herein were proximately caused by that conduct.

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7. At all times mentioned herein, each and every of the Defendants herein was the agent, ostensible agent, licensee, servant, partner, joint venturer, employer, employee, assistant, relative, or volunteer of each of the other Defendants, and each was at all times alleged herein acting in the course and scope of said agency, ostensible agency, license, service, partnership, joint venture, employment, assistance, relation, and volunteering.

8. Plaintiff alleges that at all times mentioned herein Defendants STANFORD HEALTH CARE and DOES 1-10, and each of them, were in possession of, owned, operated, managed, supervised, monitored, maintained, and controlled the medical facility premises located at 450 Broadway Street in the City of Redwood City, County of San Mateo, State of California, whereon Defendants carried on the business of operating an outpatient surgical and medical facility. Defendants STANFORD HEALTH CARE and DOES 1-10, and each of them, actively and expressly held this outpatient facility to be a safe, comfortable, and professional environment wherein individuals at the premises, including Plaintiff, could receive top-quality treatment and care.

9. Prior to March 20, 2015, LASTINGER engaged in conduct that would have provided notice to a reasonably prudent person of his propensity to engage in inappropriate sexual contact with individuals at Stanford medical facilities. His superiors at Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, knew or reasonably should have known, that his behavior was abnormal, troubling, and suggestive of proclivity to have inappropriate sexual contact with individuals at Stanford medical facilities. LASTINGER's conduct included, but was not limited to, inappropriately touching and fondling male individuals' genitalia while they were anesthetized, either before, during, or after various surgical procedures.

10. Despite the fact that LASTINGER engaged in conduct that would have provided notice to a reasonably prudent person of his propensity to engage in inappropriate sexual contact

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with individuals at the premises, of which his superiors at Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, were aware, his superiors negligently hired, referred, retained, and supervised LASTINGER and failed to warn individuals at the premises of LASTINGER's propensity to engage in this behavior. Further, Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, failed to suspend, report, or fire LASTINGER upon initially hearing about this disturbing behavior prior to March 20, 2015. Based on their prior knowledge of LASTINGER's conduct and propensities, STANFORD HEALTH CARE and DOES 1 through 10, and each of them, ratified, authorized, and/or condoned the conduct of LASTINGER.

11. On or about March 20, 2015, Plaintiff underwent arthroscopic elbow surgery at the Stanford medical facility located at 450 Broadway Street in the City of Redwood City, County of San Mateo, State of California. This outpatient surgery was performed by Emilie V. Cheung, M.D. and was assisted by Nathan Douglass, M.D. The anesthesiologist who treated Plaintiff during this surgery was Naola S. Austin, M.D. LASTINGER was a staff member working at the Stanford medical facility.

12. On or about March 20, 2015, LASTINGER used his position as an employee of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, with access to individuals at the premises before, during, and after surgeries, in their most vulnerable states, to engage in unlawful sexual battery of Plaintiff, among other tortious conduct, resulting in injuries and damages. This behavior was witnessed by others in the surgical theater.

JURISDICTION AND VENUE

13. Venue is proper in the County of San Mateo under California Code of Civil Procedure §395, subd. (a), on the basis that the injury that is the subject of this Complaint for Damages occurred in the City of Redwood City, County of San Mateo, State of California.

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FIRST CAUSE OF ACTION

(Negligence – As Against All Defendants)

14. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 13 of this Complaint as though fully set forth herein.

15. Defendants, and each of them, had a duty to protect Plaintiff as an individual at a Stanford outpatient surgical facility.

16. Defendants, and each of them, knew or should have known of LASTINGER's propensity to engage in inappropriate sexual contact with individuals at the premises and/or that he was an unfit agent. It was reasonably foreseeable that if Defendants breached their duty of care owed to individuals at the premises, including but not limited to Plaintiff, these individuals would be vulnerable to battery and sexual battery by LASTINGER.

17. Defendants, and each of them, breached their duty of care owed to Plaintiff by: failing to adequately hire, supervise, retain, and control LASTINGER, whom they permitted to have access to Plaintiff and other individuals at the premises; failing to adequately and competently investigate LASTINGER once complaints had been made; failing to alert law enforcement that LASTINGER may have been sexually battering individuals at the premises; failing to adequately and competently investigate LASTINGER given that past complaints had been made against him; failing to warn of LASTINGER's assaultive, dangerous, and sexually exploitative propensities after Defendants knew or had reason to know that LASTINGER had engaged in inappropriate sexual contact with individuals at the premises, thereby enabling Plaintiff to be sexually battered by LASTINGER.

18. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff was injured in his strength, health, and activity, sustaining shock and

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injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great mental pain, embarrassment, humiliation, distress, anguish and suffering, all to his damage in an amount to be proven at the time of trial of this action.

19. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff has been, and in the future will be, required to obtain the services of physicians and psychologists, obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

SECOND CAUSE OF ACTION

(Negligent Hiring/Retention – As Against Defendant STANFORD HEALTH CARE and DOES 1 through 10)

20. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 19 of this Complaint as though fully set forth herein.

21. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, had a duty not to hire and/or retain LASTINGER given his propensity to engage in inappropriate sexual conduct with individuals at the premises prior to, during, and/or after surgical procedures at Stanford medical facilities.

22. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, knew or should have known of LASTINGER's propensity to engage in inappropriate sexual contact with individuals at the premises and/or that he was an unfit agent.

23. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff was injured in his strength, health, and activity, sustaining shock and injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great

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mental pain, embarrassment, humiliation, distress, anguish and suffering, all to his damage in an amount to be proven at the time of trial of this action.

24. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff has been, and in the future will be, required to obtain the services of physicians and psychologists, obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

THIRD CAUSE OF ACTION

(Negligent Supervision/Failure to Warn – As Against Defendant STANFORD HEALTH CARE and DOES 1 through 10)

25. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 24 of this Complaint as though fully set forth herein.

26. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, had duty to: provide adequate supervision of LASTINGER; use reasonable care in investigating complaints of inappropriate behavior by LASTINGER; provide adequate supervision and protection to individuals at the premises with whom Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, allowed LASTINGER to have contact; provide adequate warnings to the Plaintiff, and other individuals at the premises, of LASTINGER's unfitness, troubling and abnormal behavior, dangerous propensities, and proclivities to engage in the battery and sexual battery of individuals at the Stanford medical facility.

27. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, knew or should have known of LASTINGER's dangerous, and exploitative propensities, that he was an unfit agent, and of his proclivities to have inappropriate sexual contact with individuals at the premises. It was reasonably foreseeable that if Defendants breached the duty of care owed to

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individuals at the premises, including but not limited to Plaintiff, the individuals at the premises would be vulnerable to sexual battery by LASTINGER.

28. Despite receiving actual and/or constructive notice of LASTINGER's propensities to engage in inappropriate sexual conduct with individuals at the premises, Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, negligently failed to supervise LASTINGER, thereby allowing him the ability and opportunity to commit wrongful acts against Plaintiff. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, further failed to: adequately and competently investigate LASTINGER; warn individuals at the premises about LASTINGER's propensities; alert law and enforcement or authorities that LASTINGER may have been sexually battering individuals at the premises after Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, knew or had reason to know of his inappropriate conduct; take adequate measures to prevent future sexual battery of individuals at the premises, including that which was perpetrated upon Plaintiff.

FOURTH CAUSE OF ACTION

(Premises Liability – As Against Defendant STANFORD HEALTH CARE and DOES 1 through 10)

29. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 28 of this Complaint as though fully set forth herein.

30. On or about March 20, 2015, while lawfully on the Stanford medical facility premises located at 450 Broadway Street, Redwood City, CA, Plaintiff was sexually battered on the premises by LASTINGER, an employee and/or agent of Defendants STANFORD HEALTH CARE and DOES 1 through 10, resulting in injuries and damages. LASTINGER engaged in this conduct while Plaintiff was sedated, in or around the surgical theater wherein Plaintiff was undergoing or had just undergone arthroscopic elbow surgery.

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31. Said premises was owned, operated, maintained, monitored, inspected, supervised, instructed, controlled, managed, possessed, and designed by Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them.

32. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, failed to provide adequate safeguards against the known danger of LASTINGER engaging in inappropriate conduct with individuals at the premises before, during, and after surgeries, failing to properly supervise LASTINGER and other staff members at all times, and failing to develop, implement, and enforce rules and regulations necessary to ensure the safety of all persons lawfully on the Stanford facility premises. As a result, the premises was in a dangerous condition at the time of the conduct perpetrated upon Plaintiff, and said dangerous condition was a direct, legal, and proximate cause of Plaintiff's injury and created a reasonably foreseeable risk of the type of injury Plaintiff sustained. Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, had actual and/or constructive notice of the dangerous condition for a sufficient time prior to Plaintiff's injury to take measures to protect Plaintiff and others against the dangerous condition.

33. By negligently, willfully, intentionally, carelessly, and recklessly owning, operating, maintaining, monitoring, inspecting, supervising, instructing, controlling, managing, possessing, designing the premises and allowing such a dangerous condition to exist on its premises without taking appropriate and adequate measures to protect individuals at the premises, including Plaintiff, from a substantial risk of injury, Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, failed to conform to the standard or care required of them.

34. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff was injured in his strength, health, and activity, sustaining shock and injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great

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mental pain, embarrassment, humiliation, distress, anguish and suffering, all to his damage in an amount to be proven at the time of trial of this action.

35. As a further direct, legal, and proximate result of the negligence, willfulness, intent, carelessness, and recklessness of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, Plaintiff has been, and in the future will be, required to obtain the services of physicians and psychologists, obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

FIFTH CAUSE OF ACTION

(Battery – As Against Defendants ROBERT LASTINGER and DOES 11 through 20)

36. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 35 of this Complaint as though fully set forth herein.

37. On or about March 20, 2015, Defendants LASTINGER and DOES 11 through 20, and each of them, used their position as employees of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, at the premises to intentionally engage in unpermitted, harmful, offensive, and unlawful sexual contact and battery upon the person of Plaintiff.

38. Plaintiff did not consent to these acts of battery.

39. As a direct, legal, and proximate cause of the conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged above, Plaintiff was injured in his strength, health, and activity, sustaining shock and injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great mental pain, embarrassment, humiliation, distress, anguish and suffering, all to his damage in an amount to be proven at the time of trial of this action.

40. As a further direct, legal, and proximate result of the conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged above, Plaintiff has been, and in the future will be, required to obtain the services of physicians and psychologists,

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obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

41. The acts of Defendants LASTINGER and DOES 11 through 20, and each of them, alleged above were done maliciously, oppressively, and/or fraudulently, entitling Plaintiff to recover punitive damages in an amount to be proven at the time of trial of this action.

SIXTH CAUSE OF ACTION

(Sexual Battery – As Against Defendants ROBERT LASTINGER and DOES 11 through 20)

42. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 41 of this Complaint as though fully set forth herein.

43. On or about March 20, 2015, Defendants LASTINGER and DOES 11 through 20, and each of them, used their position as employees of Defendants STANFORD HEALTH CARE and DOES 1 through 10, and each of them, at the premises to intentionally engage in unpermitted, harmful, offensive, and unlawful sexual contact and battery upon the person of Plaintiff. Plaintiff did not consent to these acts of sexual battery. Defendants LASTINGER and DOES 11 through 20's conduct against Plaintiff constitutes sexual battery within the meaning of California Civil Code Section 1708.5, and resulted in significant injuries and damages to Plaintiff.

44. The acts of sexual battery willfully committed by Defendants LASTINGER and DOES 11 through 20 upon Plaintiff included, but are not limited to: touching Plaintiff's genitalia while Plaintiff was still anaesthetized prior to, during, and/or following arthroscopic elbow surgery.

45. As a direct, legal, and proximate result of the conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged above, Plaintiff was injured in his strength, health, and activity, sustaining shock and injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great mental pain, embarrassment, humiliation, distress, anguish and suffering, all to his damage in an amount to be proven at the time of trial of this action.

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46. As a further direct, legal, and proximate result of the conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged above, Plaintiff has been, and in the future will be, required to obtain the services of physicians and psychologists, obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

47. The acts of Defendants LASTINGER and DOES 11 through 20, and each of them, alleged above were done maliciously, oppressively, and/or fraudulently, entitling Plaintiff to recover punitive damages in an amount to be proven at the time of trial of this action.

SEVENTH CAUSE OF ACTION

(Intentional Infliction of Emotional Distress – As Against Defendants ROBERT LASTINGER and DOES 11 through 20)

48. Plaintiff hereby re-alleges and incorporates herein by reference each and every allegation contained in Paragraphs 1 through 47 of this Complaint as though fully set forth herein.

49. The conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged was intentional, extreme, outrageous, malicious, and committed for the purpose of causing Plaintiff to suffer humiliation, mental anguish, and severe emotional distress.

50. As a direct, legal, and proximate result of the conduct of Defendants LASTINGER and DOES 11 through 20, and each of them, as herein alleged above, Plaintiff was injured in his strength, health, and activity, sustaining shock and injury to his nervous system, all of which have caused, and will continue to cause Plaintiff great mental pain, embarrassment, humiliation, distress, anguish, emotional distress, and suffering, all to his damage in an amount to be proven at the time of trial of this action.

51. As a further direct, legal, and proximate result of the Defendants LASTINGER and DOES 11 through 20's conduct as herein alleged above, Plaintiff has been, and in the future will be,

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required to obtain the services of physicians and psychologists, obtain treatment and care, and incur medical and incidental expenses in an amount to be proven at the time of trial of this action.

52. The acts of Defendants LASTINGER and DOES 11 through 20 as alleged above were done maliciously, oppressively, and/or fraudulently, entitling Plaintiff to recover punitive damages in an amount to be proven at the time of trial of this action.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment as follows:

A. For general (non-economic) damages according to proof;

B. For special (economic) damages according to proof;

C. For exemplary (punitive) damages on according to proof;

D. For prejudgment interest as permitted by law;

E. For costs of suit herein;

F. For such other and further relief as the Court may deem just and proper.

G. For attorney's fee pursuant to C.C.P. §§ 1021.4 and 1021.5

DEMAND FOR JURY TRIAL

Plaintiff demands a trial by jury on all issues so triable.

Dated: March 4, 2016

MATIASIC & JOHNSON LLP

By: _____

Paul A. Matiasic
Hannah E. Mohr
Attorneys for Plaintiff
MARK ROE

Matiasic & Johnson LLP
44 Montgomery St., Suite 3850
San Francisco, CA 94104

Exhibit I

9/20
LM

MICHAEL T. LUCEY (SBN: 099927)
DON WILLENBURG (SBN: 116377)
GORDON & REES LLP
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Attorneys for Defendant
STANFORD HEALTH CARE

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN MATEO

ROBERT DOE,

Plaintiff,

vs.

STANFORD HEALTH CARE; ROBERT LASTINGER; and DOES 1 THROUGH 25, INCLUSIVE,

Defendants.

CASE NO. 16CIV01627

DECLARATION OF JOHN KRUMM IN SUPPORT OF DEFENDANT STANFORD HEALTH CARE'S MOTION FOR SUMMARY ADJUDICATION

Date: September 20, 2017
Time: 9:00 a.m.
Dept: Law and Motion

I, John Krumm, submit this declaration in support of Stanford Health Care's motion for summary adjudication. I have personal knowledge of the information contained in this declaration.

1. I am currently a Surgical Technologist at Stanford Health Care. I was employed in this capacity during the Spring of 2015.

2. Attached hereto as exhibit A is a true and correct copy of a text message exchange I had with George Baez on March 31, 2015. To my knowledge, at that time,

Mr. Baez held the position of Interim Director of Ambulatory Perioperative Services at Stanford Health Care.

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

Executed this 5 day of July, 2017 at Gilroy, California.

John Krumm

Gordon & Rees LLP
275 Battery Street, Suite 2000
San Francisco, CA 94111

To: George

Good day, will you be over here redwood city today or tomorrow? Have a few nurses that want to talk you about something.

Maybe Wednesday or Friday

Can give one of them your number. It would be Cece who gave your number too but it's a group that have problem an not sure who to talk to.

I will talk to them, Friday?

Ok. That works I'll tell Cece. So just ask for Cece. You know who Cece is? Just checking.

Mar 31, 2015, 1:07 PM

Exhibit J

9/20
LM

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Attorneys for Defendant
STANFORD HEALTH CARE

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN MATEO

ROBERT DOE,

Plaintiff,

vs.

STANFORD HEALTH CARE; ROBERT LASTINGER; and DOES 1 THROUGH 25, INCLUSIVE,

Defendants.

CASE NO. 16CIV01627

DECLARATION OF DON WILLENBURG IN SUPPORT OF DEFENDANT STANFORD HEALTH CARE'S MOTION FOR SUMMARY ADJUDICATION

Accompanying Papers:

1. Notice of Motion and Motion
2. Memorandum
3. Request for Judicial Notice
4. Separate Statement of Undisputed Material Facts
5. Declaration of John Krumm
6. Declaration of Suzanne Harris

Date: September 20, 2017
Time: 9:00 a.m.
Dept: Law and Motion

Action Filed: September 28, 2017

Gordon & Rees LLP
275 Battery Street, Suite 2000
San Francisco, CA 94111

I, Don Willenburg, declare as follows:

1. I am an attorney at law, a member in good standing of the State Bar of California and duly admitted to practice before this and other courts. I am partner with Gordon & Rees LLP, counsel of record for defendant Stanford Health Care in this matter and one of the attorneys chiefly responsible for this representation. In that capacity I have personal knowledge of filings and other matters contained or described in this declaration. I make this declaration in support of Stanford Health Care's motion for summary adjudication.

2. Attached hereto as exhibit A are true and correct copies of excerpts from the deposition transcript of Cecilia Camenga taken on December 2, 2016.

3. Attached hereto as exhibit B are true and correct copies of excerpts from the deposition transcript plaintiff Robert Doe taken on June 2, 2017.

4. Attached as exhibit C are true and correct copies of exhibits 3-5 to the Camenga deposition referenced in the statement of undisputed material facts.

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

Executed this 7th day of July 2017, at Oakland, California.

Don Willenburg

Don Willenburg

Gordon & Rees LLP
275 Battery Street, Suite 2000
San Francisco, CA 94111

EXHIBIT A

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN MATEO

---:---

ROBERT DOE, Plaintiff, vs. STANFORD HEALTH CARE; ROBERT LASTINGER; and DOES 1 THROUGH 25, INCLUSIVE, Defendants.	CASE NO. 16-CIV-01627

VIDEOTAPED DEPOSITION OF CECILIA CAMENGA, R.N.

Taken on behalf of the Plaintiff Robert Doe, at the office of Certified Legal Video Services, 1111 Bishop Street, Suite 500, Honolulu, Hawaii, commencing at 8:46 a.m., on Friday, December 2, 2016, pursuant to Notice.

BEFORE:

Amy Muroshige, CSR 166
State of Hawaii

A I don't understand the question.
Q Sure. You indicated that at or around the time you were hired, you received an employee handbook, correct?
A Yes.
Q Did you ever receive, subsequent to that occasion, any revised handbook or amended handbook or --
A No amended handbook. They did reiterate after the arrest of Lastinger the fact that -- they brought the whole department in for meeting about, you know, the importance of if you see something, you need to report it.
Q Let's talk --
A And they let us know what numbers and stuff to report to, which I didn't know.
Q Okay. You may have kind of partially answered my next question, your clairvoyance is coming out, but before Lastinger's arrest, do you recall receiving specific training or instruction regarding the necessity to report if you see somebody engage -- a coworker engaging in inappropriate behavior like Lastinger did?
A Yes, it was in -- yearly we had the computer things and our Healthstream and it was in our Healthstream.
Q So in the yearly instruction, you received a self-study on the Healthstream --
A Self-study, yes.
Q There was information regarding the necessity of

reporting if you see something inappropriate, is that true?
A Yes.
Q At any point in time prior to Lastinger's arrest, did you receive any training or instruction from Stanford regarding your duties as a mandatory reporter?
A Yes.
Q Do you know what the term mandatory reporter means?
A Yes.
Q What does it mean to you?
A It means that I'm required by law to report any -- anything that I see.
Q And do you know -- obviously nurses were mandatory reporters, correct?
A Yes.
Q Were anesthesia techs mandatory reporters --
A Yes.
Q -- if you know?
And when you say that you had a duty to report anything that you saw, do you mean any type of inappropriate --
A Yes.
Q -- activity?
A Correct.
Q What training or instruction did you receive prior to Lastinger's arrest regarding whether or not to report

something if you were unsure whether the conduct was inappropriate?
A I believe that was in our Healthstream also yearly.
Q And what did that -- what type of training did you receive via Healthstream -- the Healthstream training yearly that dealt with that particular issue?
A I believe it tells you that you are -- if you are unsure, to report to your immediate supervisor.
Q And that training was provided in the yearly Healthstream modules?
A Correct.
Q Is that what it's called, a module?
A Yes.
Q At the time that you were hired, did you receive any type of document indicating or advising you that you were a mandatory reporter that you had to sign?
A I don't remember.
Q Do you recall receiving any such document at any time while you worked at Stanford?
A I don't remember.
Q Prior to Lastinger's arrest, do you recall receiving any type of training or instruction from Stanford regarding to whom you should report if you believed that a coworker was engaging in inappropriate conduct?
A We were supposed to report to our supervisor.

MR. MATIASIC: Yeah, it sounds good. We'll go for a couple of minutes and then we'll --

Q Other than the intranet, did you receive any type of training prior to Lastinger engaging in inappropriate touching of a patient relative to your duties as a mandatory reporter from any other source?

MS. CABRERA: Vague and ambiguous as to time. Even predating Stanford?

Q (By Mr. Matiasic) You can go ahead and answer the question.

A I don't -- so predating Stanford, too?

Q No, well, and --

A Just joining Stanford?

Q Yeah, just -- my question -- in terms of how this process works, people may interject from time to time. Unless your attorney instructs you not to answer a question, then you go ahead and answer the question that I posed, okay?

So I'll rephrase -- or restate it for you. My question is other than the intranet Healthstream modules that you may have gone over with Stanford, did you receive any type of training or instruction regarding your duties as a mandatory reporter from any other source prior to witnessing Lastinger engaging in inappropriate touching of a patient?

MS. CABRERA: It's vague and ambiguous as to time.

THE WITNESS: I don't remember.

Q (By Mr. Matiasic) And do you have -- prior to Lastinger engaging in that inappropriate touching, did you have an understanding of the timing associated with your duties as a mandatory reporter? For example, how soon after witnessing something you had to report it?

A Yes.

Q And what was your understanding in that respect?

A As soon as you can, meaning immediately.

Q And prior to witnessing Lastinger engaging in that inappropriate touching, did you have an understanding as to whom you should report in conjunction with the duties as a mandatory reporter?

A Yes.

Q And what was your understanding?

A My understanding was you were to speak to your supervisor.

Q Exclusively?

A You're supposed to follow the chain of command.

MR. MATIASIC: Okay, why don't we take a break.

(Recess from 10:04 a.m. to 10:15 a.m.)

Q (By Mr. Matiasic) Okay, Miss Camenga, you understand you're still under oath?

A Yes.

A The exact date?
Q If you remember it.
A I don't remember the exact date.
Q Okay. If I gave you --
A It was in 2015 in March and I don't remember if it was a Monday or a Tuesday. I was doing an ACL with Dr. McAdams and, to be honest, I don't remember if it was a Monday or Tuesday, but it was a Monday or Tuesday.
Q Okay. And you spoke with the police in this matter, correct?
A Correct.
Q If I represent to you that you communicated to the police that it was about -- on or about Tuesday, March 31st --
A Yes, okay.
Q -- 2015, does that refresh your recollection?
A Yes.
Q Initially you may have told the police Monday, March 30th, and then at a certain point, you indicated that you were mistaken and that you believed it was Tuesday, March 31st. Does that ring a bell?
A Sounds good, yeah.
Q Okay. So using this date of March 31st, 2015, that's the occasion that you saw Lastinger engage in the inappropriate touching, correct?

A Correct.
Q And that's when you had an opportunity -- or had occasion to discharge your duties as a mandatory reporter?
A Yes.
Q And so this conversation that you had with Cindy Yee occurred approximately one week before March 31st?
A Yes.
Q And how did the topic come up?
ME. DYAS: Vague as to what topic and when and with who.
Q (By Mr. Matiasic) Sure, let me try to rephrase it. You had this conversation with Cindy Yee regarding the fact that she was uncomfortable going to the supervisor about what she saw Lastinger do. How did that conversation start?
A I was scrubbed in and I was setting up for a procedure. Cindy was helping opening up stuff for the case. She was -- became emotional, she looked distraught and I asked her what was wrong and she said that she had witnessed something and she didn't know what to do and I probed her in regards to -- I asked, you know, well, what -- who and what did you see and she had told me that she had witnessed Rob touching a patient inappropriately and, of course, it was very shocking for me and it was obviously very disconcerting for her.
She was very emotional, she said she wanted to -- she

one leg, I was holding the other leg, Ricardo was on the left side, Rob was on the right side and then the anesthesiologist was at the head for moving the patient over to the other bed.

Q Do you recall the name of the anesthesiologist?

A I don't recall. This was an anesthesiologist who rarely came to our facility. It was a woman, but I don't remember her name.

Q Do you recall that the ortho on this particular surgery was Dr. McAdams?

A Yes.

Q Is that Timothy McAdams?

A Yes.

Q And then there was a Dr. Packer?

A Ah, yeah.

Q Is that the anesthesiologist?

A No.

Q Okay. Who was Dr. Packer?

A Dr. Packer was the fellow.

Q And were --

A I can't remember.

Q Okay. So, go ahead, you were describing when Rob came.

A What I saw, so what happened was -- this was a large patient so that's why Ishy was with one leg and I was with

another, just kind of holding both legs for this person, so what happened is normally the anesthesiologist -- you know, we wait for the anesthesiologist to tell us when it's ready or when the patient is ready to be moved over 'cause this is a critical time 'cause you don't want to go into like laryngeal spasm or bronchospasm or anything, so they're concentrating on the patient's airway and making sure they're starting to breathe before moving over.

So while waiting, we kind of just stand there and usually we're looking at -- for the anesthesiologist to give us the okay, but because I'm more focused on Rob now, I do notice his hands and what he does is -- we have draw sheets to help move patients over. So what he did was fold the sheet over on top of the patient and laid his hand over where the genitals would be and sort of did like a -- like a motion to kind of, you know, touch it or kind of grind it, it was slight, but inappropriate, and I was like, holy shit, this is what he's been doing? And I was shocked and I was like, oh, my god, that's it, I can't believe he did it in front of me and in front of everybody, how fricking blatant and what an asshole, and I was in complete shock, but then what happened is we turned the patient, the board goes under and then as we moved the patient, you know, he pushes, Ricardo will pull and the patient goes over, but what I noticed was his hand very quickly and very slyly went under

the blankets and -- at the genital region and kind of did a swish and then back up and that I -- excuse me.

When people had described like what they had saw, they had more described the other things so I wasn't expecting that other part and that like blew my mind and I was like enraged and I was like in disbelief that this had happened in front of me and like I knew like I had to -- I had -- no if's, and's or but's, this fucker is going down because that's not right and so --

And I looked at Ishy and we kind of made eye contact and I -- like I knew that she saw it, too, and I was like, holy crap, but then like things still have to go on, right, so like the patient is still -- you know, I made sure the patient is covered, I still have to like, you know, finish my charting and we got to clean up for the next case, but like, holy fuck, what just happened, and so we're cleaning up and I'm like, holy crap, I can't believe this.

So Ricardo happened to be there, Ricardo is somebody that I trust and I told Ricardo, I said you -- watch him. You know, I told him what I just saw and I said just please keep an eye on, I'm going to report this, but, you know, keep an eye because it's fricking not cool, and so as soon as I could, I saw John in the break room when, you know, when I was able to get out and I said I need -- I need to talk to George, you need to -- you know, call him right now

and tell him that I need to talk to him because I saw and Ishy was right there, she witnessed it, too, and I -- something needs to be done.

Q Okay. Let me ask you a couple followup questions, and I appreciate the difficulty of talking about this so thanks for bearing with us here. So if I understand your testimony correctly, there basically were two acts, if you will, that you saw Lastinger engage in that were inappropriate with this patient?

A Correct.

Q And one was what happened when you were -- when the draw sheet was being moved and he put his hand underneath --

A He didn't put his hand underneath with the draw sheet. Laying it on top, he was on top of it.

Q I apologize, so the first instance was when he was moving his hand in a circular fashion on the patient's genitalia on top of the draw sheet?

A Yeah.

Q Okay. And I believe you may have described this before as kind of like moving around a stick shift?

A Yeah, (demonstrating) it was kind of -- yeah.

Q Is that what you remember telling the police?

A Uh-huh.

Q Is that a yes?

A Yes.

Q Okay.
A Sorry.
Q And then the second instance you saw is when the patient was being moved and he put his hands --
A Yes.
Q -- underneath the sheet?
A Underneath, yeah.
Q And touching the genitals?
A Yes.
Q And I believe you told the police that you were certain that his hand was making contact with the genitalia, is that correct?
A Yes.
Q And can you tell me all the different people who were in the room when Rob engaged in those two acts of inappropriate touching of the patient?
A Well, there was the anesthesiologist, there was Rob, Ricardo, Ishy, me. Dr. McAdams had left and was going to the next room to start his next case. The other doctor was on the phone like, you know, recording the case. People come in to clean the room, but I don't remember who 'cause I was kind of blown, but I know there was other people that came in to help clean up 'cause it's, you know, it's kind like a pick crew once the patient is done, we all come in and (making sounds) clean and get ready for the next one

so --
Q Sure.
A -- there's more people, but I can't recall who.
Q Okay.
A But they were in the outskirts cleaning and stuff.
Q And was Dr. Packer present at the time he engaged --
A Yeah, he was on the phone.
Q Okay. Your clairvoyance keeps coming out because my next question is do you know whether anyone else observed what you saw in terms of Rob engaging in these two acts of inappropriate touching of the patient?
MS. CABRERA: It calls for speculation.
THE WITNESS: I don't believe so, because there -- I mean their minds would have been blown, they would have -- I don't believe so, besides Ishy and I.
Q (By Mr. Matiasic) Okay. Is it fair to say that you don't know one way or another --
A Correct.
Q -- whether anybody else actually observed it?
A Correct.
Q You're just testifying that way because you believe if somebody else would have observed it, they would have had a similar reaction to you did?
A Yeah.
Q Okay. But you and Irish Reyes made eye contact so

ME. DYAS: Thank you.

MS. CABRERA: It calls for speculation.

THE WITNESS: Yeah, I don't know.

Q (By Mr. Matiasic) Okay. Do you recall ever asking Irish Reyes to follow Rob when he went to the next OR to insure he didn't touch another patient?

A Yes.

Q And when did you give that instruction to Irish?

A After this case, after my case that I witnessed.

Q So what I'm wondering is did you give this instruction to Ricardo and Irish at the same time or separately or --

A I don't recall. Maybe -- probably separately.

Q And do you remember specifically what you told each of them?

A No.

Q Can you just describe the general gist of what you told them? I know you already described it --

A Without expletives?

Q Whatever you recall saying is fine.

A Just to keep an eye on him, try and, you know, protect them.

Q And did Irish agree to do that?

A Yes.

Q And did Ricardo agree to do that?

A He didn't -- I don't think he knew exactly what I was

talking about because I don't think he had the reference of, you know, what? 'Cause even -- in thinking back to what Cindy had told me, it -- it didn't really make sense so I don't think that he understood so, you know, I told him to just keep an eye on, so I don't think he would, you know, know how to protect anybody 'cause he didn't know.

Q At some point in time, did you learn that Rob had inappropriately touched another patient that same day?

A Yes.

Q And when did you learn that?

A After the case was done next door.

Q Okay, so after you were done with the --

A With my -- my case was done and then the -- there was an ACL done next door and after that case was done.

Q Okay. And so after you were done with the patient whom you saw Rob inappropriately touch, you then subsequently learned that he went next door to the next OR and inappropriately touched another patient?

A Yes.

Q And you learned about that inappropriate touching following the completion of your duties with the first patient, correct?

A Yes.

Q And are you aware of the identity of the second victim that day?

A Yes.
Q And was that patient a minor?
A Yes.
Q Was he sixteen at the time?
A Yes.
Q Do you know the name of that patient?
MS. CABRERA: It's the same objection as before.
THE WITNESS: It's all in there. Here (indicating).
Q (By Mr. Matiasic) Well, I'm just asking you from --
A Yes, I know his name.
Q Okay. Does his -- and how do you know his name?
A He was supposed to be in my room, but they switched orders because the case next door went earlier or something or finished earlier so they decided to pull him from my room and he went into the next room instead, so they flip-flopped cases, so I knew his 'cause I sort of got everything ready for his case.
Q Did you have occasion to interview him for his --
A No, I did not.
Q This minor, the second victim on March 31st, 2016, does the first letter of his first name begin with the letter E?
A No. Of maybe not.
Q What's your basis for believing that? Is that because you're looking down --

A Yeah.
Q -- at the pleading?
A Maybe I forgot.
Q So, just for the record, we've pre-marked as Exhibit 1 to your deposition Plaintiff Robert Doe's notice of taking deposition with request for production of documents. Is that what you're referring to --
A Yes.
Q -- when you -- okay. So --
A Maybe I don't know his name.
Q Yeah. Robert Doe is a fictitious name --
A Copy that.
Q -- all the way around.
A Okay.
Q So I used two fictitious names, not just for the first and last.
A Okay.
Q Outside of any pleading in this case, do you have a recollection of the person's first name?
A Then, no.
Q Okay. At any point in time, did you learn the nature of the inappropriate touching that Rob engaged in with the second patient on March 31st, 2016?
A I didn't ask specifically details so, no.
Q And how did you learn that a second patient had been

touched on that day?
A Ishy told me.
Q What did she tell you?
A That he did the same thing.
Q Did she provide any additional details regarding what that meant?
A No.
Q What did you say in response?
A That motherfucker.
Q Did -- at that point in time, had you already spoken with John?
A I believe so.
Q And do you know whether Irish had communicated what she had observed Rob do to the second patient to anyone else prior to discussing it with you?
MS. CABRERA: It calls for speculation.
THE WITNESS: I don't know.
Q (By Mr. Matiasic) You indicated that you didn't tell anybody else about what had occurred on March 31st other than John Crumm until Thursday, a couple days later, correct?
A Yes.
Q And that would have been around April 2nd?
A Sure.
Q And that's perfectly okay, if the date doesn't ring any bell, that's all right, too.

A It does not.
Q But you remember that you observed the conduct on a Tuesday and then this conversation that you had with Todd where you next disclosed was --
A Was on Thursday.
Q -- was on Thursday. Were you off work on Wednesday? If you know?
A No, I was working.
Q You were working. So on Wednesday you didn't have a conversation with anybody about what you had observed the day before, correct?
A Correct.
Q And as of March 31st and April 1st, who was your immediate supervisor?
A Wait, excuse me, what date was that?
Q The day that you saw Rob engage in inappropriate touching and the following day, who was your immediate supervisor?
A I don't remember who the charge nurse was at the time. Jill would have been my supervisor then, but she was on vacation, so I didn't have like an assistant manager. Manager, our manager had just got moved to a different facility so there was like an acting sort of manager, which was Theresa, who was our -- who'd only been there like a week who was like supposed to be our education coordinator,

and the assistant manager for pre-pac was somebody who'd only been there for not very long either, so people that weren't there for very long so I don't know them.

Q Okay. So you said Theresa Renico, that's R-e --

A That's her, yeah, that's her last name.

Q R-e-n-i-c-o?

A I don't know.

Q Okay. That was the acting manager during that week?

A Correct.

Q Was Jill Luckhurst gone that entire week, if you know?

A Yes, she was on vacation.

Q And this relatively new assistant manager in the pre-pac unit, do you know the name of that person?

A Christie.

Q Do you know her last name?

A No.

Q Do you know whether anybody at any time reported Rob's inappropriate behavior to Christie?

ME. DYAS: Calls for speculation.

THE WITNESS: Yeah, I don't know.

Q (By Mr. Matiasic) Do you know whether anybody at any time reported Rob's inappropriate behavior to Theresa Renico?

A I don't know.

ME. DYAS: Same objection.

Q (By Mr. Matiasic) Any particular reason why you didn't

report what you had seen the day before the next day when you came to work on Wednesday, April 1st?

A 'Cause I decided I was going to tell George, who was like a director who could get shit done.

Q And you had an understanding that George wasn't going to be in the facility until --

A Friday.

Q -- Friday, okay.

But then on Thursday, you were at the control desk with Cindy, is that correct?

A Uh-huh.

Q Is that yes?

A Yes.

Q And what is the control desk?

A The control desk is where the charge nurse is, it's kind of like our control hub for everything. Our charge nurse is usually there, we have our monitors with cameras in all the rooms so they can, you know, oversee everything, we have our big screens up that have all the cases up so they can keep track of everything and if any, you know -- the hub.

Q Okay. And Todd Valentine was the charge nurse that day?

A Correct.

Q And he was at the control desk?

A Correct.
Q Do you recall the charge nurse on duty at the time you saw Rob engage in inappropriate touching?
A I don't remember.
Q What about the next day on Wednesday?
A I don't remember.
Q And do you recall how the conversation with Todd started?
A I don't remember.
Q And you believe that Cindy was the first one to tell Todd about what she saw, correct?
A I believe so.
Q And do you recall whether she gave him the specifics of what she had --
MS. CABRERA: It calls for speculation.
THE WITNESS: I don't remember.
Q (By Mr. Matiasic) And at some point, did you give the specifics of what you had witnessed to Todd?
A To Todd? No.
Q What do you recall --
A I don't remember.
Q What do you recall telling Todd in that conversation?
A That I saw him touching somebody.
Q And did you provide any additional details at that time?

(Recess from 11:24 a.m. to 11:29 a.m.)

Q (By Mr. Matiasic) Okay, Miss Camenga, thanks for your patience with us. I may or may not, during the course of a couple questions, have said March of 2016. All this conduct that we're talking about related to Lastinger which you observed, that all occurred in March of 2015, is that true?

A Correct.

Q In March of 2016 you were in Hawaii?

A Yeah.

Q Okay. After communicating what you did to Todd Valentine, what is the next time that you spoke with anybody about what you observed Rob doing with respect to inappropriately touching patients?

A I was escorted to a Building C and I reported to George, Kim and there might have been other people, but I don't remember. Kim Ko.

Q And she worked -- she was an employee, a labor relations specialist at Stanford?

A To my knowledge, yes.

Q And George, you're speaking of George Baez?

A Correct.

Q And were you escorted there pursuant to being called down to the control desk 'cause you referenced earlier?

A Yeah, I went to the control desk and I think I was escorted, I don't know, I was confused, to Building C, and I

don't remember what floor, to a conference room.
Q And anyone else present other than George Baez and Kim Ko?
A I believe so, but I don't remember. I only remember Kim Ko and George.
Q And what, if anything, did you communicate to George and Kim at that time?
A I told them what I witnessed.
Q And was there anything different than what you already told us here today?
A No, but then I also told him that there were other witnesses that I believe would be willing to come forward.
Q And what other witnesses did you identify to George and Kim?
A Cindy, Irish, Ricardo, Dan and Roj. Rojmar.
Q And that's Rojmar Fernandez?
A Correct.
Q R-o-j-m-a-r?
A Correct.
Q Do you know whether your conversation with George and Kim was recorded in any way?
A I don't remember.
Q Did they ask you whether you had seen any type of inappropriate conduct on Lastinger's part prior to what you witnessed a couple days before?

A I don't remember if they asked that.
Q Okay. Prior to witnessing what you did with Rob on March 31st, the two instances of inappropriate touching with that patient, do you recall any other conduct that you witnessed prior to that day that, in hindsight, now seems inappropriate?
ME. DYAS: Asked and answered.
THE WITNESS: As far as he was a bully and very aggressive, he argued, very quick to argue with nurses, even with doctors, but not perverted-wise, just asshole-wise.
Q (By Mr. Matiasic) Okay. And describe for me, prior to you witnessing -- prior to the occasion where you witnessed Rob engage in inappropriate touching of a patient, the type of instances where you believed you saw Rob engage in bullying type of activity.
A Wait, say that again?
Q Sure, it was a very long-winded question. Basically prior to observing him inappropriately touch that patient on March 31st, describe for me the instances that come to mind when you're thinking of the fact that Rob was a bully prior to that day.
A I can only speak for myself. There is like a hip positioner that's supposed to be positioned a certain way and they set it up wrong and I told them that he set it up wrong and he would argue and I was like just set it up this

you a document. It's been marked Exhibit 2. At the top of the document, it says New Employee and Transfer Checklist --

A Uh-huh.

Q -- Stanford Hospital/Clinic and LPCH. Does your signature appear on the bottom of this document?

A Yes.

Q Do you recall this document?

A No.

Q I think you testified previously that you attended an orientation at Stanford?

A Yes.

Q And do you recall if you -- go ahead and take a look at this. These were the various topics and issues that were covered with you at the time of your orientation?

A Yes.

Q And do you recall if you placed the check marks on this form?

A I don't recall, but I don't argue it.

Q And I believe you testified that you were hired in 2010. Were you actually hired in 2011?

A Oh, there you go. Yes.

Q Did you attend the orientation before you actually started performing duties as a staff nurse at Stanford?

A Wait, can you say that again?

Q Sure. Did your orientation occur before you actually

started performing duties?
A Yes.
Q Okay.
(Exhibit No. 3 was marked for identification.)
Q (By Ms. Cabrera) The court reporter has just handed you a documented that's been marked Exhibit 3. It's titled Abuse Reporting Requirements for Health Practitioners Under California Law, it's an acknowledgement form. Does your signature appear on this document?
A Yes.
Q And is that your handwriting and --
A Yes.
Q -- your date?
And if you see the second paragraph, it says "I will consult the relevant Stanford Hospital and Clinics and/or LPCH policies as they apply to each code section and will follow the procedures indicated therein for all instances where I am required to report abuse." Did you actually look up those policies or in any way inform yourself of what those policies stated?
A No.
Q Do you recall if those policies were provided to you?
A I don't remember if they were actually provided for me, but I would be able to look it up because they had told us where to look it up.

Q Okay.
A Where all of them are.
Q Okay. Including the policies that would fall under this acknowledgement form?
A Exactly.
(Exhibit No. 4 was marked for identification.)
Q (By Ms. Cabrera) The court reporter has just handed you a document, it's been marked Exhibit 4. It states at the top Student and Group Transcript Report. You can see on the right-hand side, it says Healthstream.
A Uh-huh.
Q Have you ever seen this document before?
A No.
Q Okay. I believe you testified before that you took some training through Healthstream?
A Correct, every year.
Q Okay. 'Cause I understand that one of the training modules you took every year was about abuse. Does sound right to you?
A Yes.
(Exhibit No. 5 was marked for identification.)
Q (By Ms. Cabrera) The court reporter has just handed you a document that's been marked Exhibit 5. It states Abuse Module. If you could just take a look through the document and let me know if you recall this module as the one that you

Q When the meeting happened that was after Mr. Lastinger's arrest where you say that Stanford reiterated to the whole department the importance of reporting, who actually gave that presentation?
A It was somebody from HR, but I don't recall who.
Q And when you say the whole department, does that include management?
A Yes, management was there.
Q When you went to nursing school, were you informed of what your duties were as a mandatory reporter?
A Yes.
Q And, in fact, understanding those duties is a requirement of obtaining your license as a nurse in California, correct?
A Yes.
Q And at your prior jobs, were you informed of your duties in relation to mandatory reporting?
A Yes.
Q I believe that you testified that during -- actually let me start with an open question. At the time that Cindy Yee told you what she had witnessed in relation to Mr. Lastinger's conduct, was Jill Luckhurst out of the office?
MR. MATIASIC: May call for speculation.
THE WITNESS: I don't recall. I know around that time

C E R T I F I C A T E

STATE OF HAWAII)

) SS:

CITY AND COUNTY OF HONOLULU)

I, Amy Muroshige, Certified Shorthand Reporter, do hereby certify:

That on Friday, December 2, 2016, at 8:46 a.m. appeared before me CECILIA CAMENGA, R.N., the witness whose deposition is contained herein; that prior to being examined, he was by me duly sworn;

That the deposition was taken down by me in machine shorthand and was thereafter reduced to typewriting; that the foregoing represents, to the best of my ability, a true and correct transcript of the proceedings had in the foregoing matter.

That pursuant to Rule 30(e) of the Hawaii Rules of Civil Procedure, a request for an opportunity to review and make changes to this transcript:

X Was made by the deponent or a party (and/or their attorney) prior to the completion of the deposition.
Was not made by the deponent or a party (and/or their attorney) prior to the completion of the deposition.

I further certify that I am not counsel for any of the parties hereto, nor in any way interested in the outcome of the cause named in the caption.

Dated this 12th day of December 2016, in Honolulu, Hawaii.

Amy Muroshige, CSR No. 166

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SAN MATEO

ROBERT DOE,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 16CIV01627
	)	
STANFORD HEALTH CARE; ROBERT LASTINGER; and DOES 1 THROUGH 25, INCLUSIVE,	)	
	)	
	)	
Defendants.	)	
	)	

VIDEOTAPED DEPOSITION OF ROBERT DOE

Friday, June 2, 2017

VIGNATI REPORTING
1537 Fourth Street, Suite 215
San Rafael, California 94901
(415) 456-4640
FAX (415) 456-3107
e-mail: avignati@sbcglobal.net

REPORTED BY: ANNE M. VIGNATI, CSR NO. 4781

A. Right.

Q. Where were you when you were awake and oriented?

A. I was in a hospital room.

02:37 Q. Like a recovery room or something like that?

A. Right.

Q. This was outpatient surgery so that you didn't spend the night; right?

A. Right.

02:37 Q. And did Doctor McAdams tell you -- come in and talk to you about the surgery at some point?

A. I don't remember.

Q. Okay. Did the surgery work?

A. Yes.

02:37 Q. How's the knee?

A. Good.

Q. And have you up to today seen a picture of Lastinger?

A. Yes.

02:38 Q. Okay. And how did you see that?

MR. MATIASIC: Other than anything that may have been shared with you by an attorney. But if you saw it through another source, you can tell him.

THE WITNESS: On the news. His picture was on the news.

02:38

BY MR. LUCEY:

Q. Okay. And having seen his face, do you have a recollection of seeing him any time that day on the 31st?

A. No.

Q. Okay. So do you from your own memory have a knowledge of whether he was even there or not?

A. No.

Q. Okay. Do you remember any nurses or doctors that stand out in your mind? Probably let's just leave out the surgeon himself.

A. Right. I thought I did in the beginning, but I don't know. I don't remember.

Q. Could you identify by name any of the nurses or other technicians that were in your room before or after the surgery?

A. No.

Q. How about just by sight what they look like?

A. No.

Q. Anybody that you became particularly friendly with who said something that stuck out in your mind, anything like that?

A. No.

Q. Do you know whether an anesthesiologist was the one who administered the drug that put you out before

I, ANNE M. VIGNATI, a Certified Shorthand Reporter duly licensed by the State of California, do hereby certify:

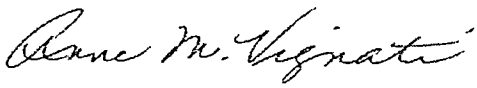
That ROBERT DOE, the witness in the foregoing deposition, was by me duly sworn to testify the truth, the whole truth, and nothing but the truth, in the within-entitled cause;

That said deposition was reported at the time and place therein stated by me, and thereafter transcribed under my direction;

That when so transcribed, the witness was afforded the opportunity to read, correct and sign the deposition.

I further certify that I am not interested in the outcome of said action, nor connected with, nor related to, any of the parties in said action or to their respective Counsel.

IN WITNESS WHEREOF, I have hereunto set my hand this 13th day of June, 2017.



ANNE M. VIGNATI, CSR NO. 4781

Exhibit K

Christopher B. Dolan (SBN 165358)
Marjorie J. Heinrich (SBN 124682)
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Attorneys for Plaintiffs
JANE DOE and JOHN DOE

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SANTA CLARA

UNLIMITED CIVIL JURISDICTION

JANE DOE; JOHN DOE,

Plaintiffs,

v.

DR. ROY HONG, M.D., an individual; PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation; DR. FREDERICK DIRBAS, M.D., an individual; STANFORD HOSPITAL AND CLINICS, a professional corporation; and DOES 1-50,

Defendants.

Case No.: 114CV261702

COMPLAINT FOR DAMAGES

1) **MEDICAL MALPRACTICE**

2) **BATTERY**

3) **INVASION OF PRIVACY; INTRUSION INTO PRIVATE MATTER**

4) **INVASION OF PRIVACY; WRONGFUL DISCLOSURE OF PRIVATE INFORMATION**

5) **VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT**

6) **LOSS OF CONSORTIUM**

By Fax

JURY TRIAL DEMANDED

PRE-JUDGMENT INTEREST DEMANDED

PARTIES

1. Plaintiff JANE DOE (hereinafter "PLAINTIFFS" when referenced jointly with Plaintiff JOHN DOE) is an adult natural person, over age 18, who was at all times mentioned herein a resident of Monarch Beach, California.

2. Plaintiff JOHN DOE (hereinafter "PLAINTIFFS" when referenced jointly with Plaintiff JANE DOE) is an adult natural person, over age 18, who was at all times mentioned herein a resident of Monarch Beach, California.

3. PLAINTIFFS file this complaint under fictitious names because the content and nature of this lawsuit constitute an 'exceptional circumstance' of a personal nature that justify the use of fictitious names.

4. PLAINTIFFS are informed and believe, and hereon allege, that Defendant DR. ROY HONG, M.D. (hereinafter "HONG") is an adult natural person, over age 18, who was at all times mentioned herein a licensed physician practicing medicine in Santa Clara County, in the State of California.

5. PLAINTIFFS are informed and believe, and hereon allege, that Defendants PALO ALTO FOUNDATION MEDICAL GROUP, a professional corporation (hereinafter "PAFMG") and/or DOES 1-25, unknown business entities, were at all times material to this Complaint, the employer(s) of, partners of, and/or otherwise retained Defendants HONG and/or DOES 26-50 on their medical staff, and were doing business in the County of Santa Clara, State of California, and are entities subject to suit before this Court.

6. PLAINTIFFS are informed and believe, and hereon allege, that Defendant DR. FREDERICK DIRBAS, M.D. (hereinafter "DIRBAS") is an adult natural person, over age 18, who was at all times mentioned herein a licensed physician practicing medicine in Santa Clara County, in the State of California.

7. PLAINTIFFS are informed and believe, and hereon allege, that Defendants STANFORD HOSPITAL AND CLINICS (hereinafter "STANFORD"), a corporation, and/or DOES 1-25, unknown business entities, were at all times material to this Complaint, the employer(s) of, partners of, and/or otherwise retained Defendants HONG, DIRBAS and/or DOES 26-50 on their

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medical staff, and were doing business in the County of Santa Clara, State of California, and are entities subject to suit before this Court.

8. Defendants DOES 1-50 are sued herein under fictitious names. Their true names and capacities are unknown to PLAINTIFFS. PLAINTIFFS are informed and believe, and hereon allege, that DOES 1-25 are business entities of unknown form who were the employers of, partners of, and/or otherwise retained Defendants HONG, DIRBAS, and/or DOES 26-50 on their medical staff. PLAINTIFFS are informed and believe, and hereon allege, that DOES 26-50 are doctors, nurses, technicians, assistants and/or other health care providers and/or staff who performed the surgery and related pre- and/or post-surgical care and/or billing which are the subject of this litigation. PLAINTIFFS are further informed and believe, and hereon allege, that DOES 26-50 were the employees, actual and/or ostensible agents, and/or contractors of, and/or partners of Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-25, who were operating within the scope and course of their agency and/or employment and/or partnership at all times material to this Complaint.

9. PLAINTIFFS are informed and believe, and hereon allege, that at all times relevant herein, each and every Defendant was the agent, servant, partner, joint venturer, and/or employee of each and every other Defendant, and acted pursuant to a common plan, design, venture, or scheme such that each Defendant authorized, negligently supervised, and/or ratified each act of every other Defendant in the acts complained of by PLAINTIFFS.

10. PLAINTIFFS are informed and believe, and hereon allege, that at all times relevant herein there existed and exists a unity of interests between each and every Defendant, such that any individuality and separateness between these certain Defendants has ceased, and those Defendants are the alter ego of the other certain Defendants and exerted control over each other. Adherence to the fiction of the separate existence of these Defendants as an entity distinct from other certain Defendants will permit an abuse of the corporate privilege and would sanction fraud and/or promote injustice.

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VENUE & JURISDICTION

11. Venue is proper because the relevant actions, conduct, and damages set forth herein occurred in the County of Santa Clara. PLAINTIFFS are informed and believe, and hereon allege, that venue is also proper because Defendants HONG, PAFMG, DIRBAS, STANFORD, and/or DOES 1-50 either reside or have their principle places of business in the County of Santa Clara.

12. Subject matter in this action is properly heard in this Court, as the action incorporates an amount in controversy as set forth in the complaint which exceeds $25,000.00.

13. PLAINTIFFS complied with the requirements of California Code of Civil Procedure Section 364 by timely service of notice of intent to sue. This Complaint's medical negligence causes of action are therefore brought in a timely fashion within the time provided by the tolling provisions of Section 364. This Complaint's other causes of action are brought within their relevant statutes of limitation.

14. At all times mentioned herein, California's Patient's Bill of Rights, California Code of Regulations, Title 22, Section 70707, among others, was in full force and effect, and was binding upon Defendants HONG, PAFMG, DIRBAS, STANFORD, and/or DOES 1-50, and each of them.

FACTS COMMON TO ALL CAUSES OF ACTION

15. JANE DOE was at high risk of developing breast cancer, and so she decided to undergo a single stage, concurrent bilateral mastectomy and breast reconstruction surgery at Defendant STANFORD and/or DOES 1-25, which was scheduled to occur on or around December 12, 2012.

16. On or around December 11, 2012, PLAINTIFFS attended a preoperative conference with Defendants HONG and/or DOES 26-50 to discuss the breast reconstruction surgery that Defendants HONG and/or DOES 26-50 would perform on JANE DOE the following day, December 12, 2012.

17. In the preoperative conference, PLAINTIFFS reiterated to Defendants HONG and/or DOES 26-50 what they had stated to them several times in previous telephonic conferences, namely that they wanted Defendants HONG and/or DOES 26-50 to place implants between 350cc and

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400cc in volume 'subpectorally,' or underneath JANE DOE's pectoral muscles, during surgery, and Defendants HONG and/or DOES 26-50 represented that they had adequate experience and training to perform this procedure as JANE DOE requested and consented to.

18. On or around December 12, 2012, Defendants DIRBAS and/or DOES 26-50 performed a bilateral mastectomy procedure on JANE DOE, after which Defendants HONG, and/or DOES 26-50 performed a breast reconstruction procedure on PLAINTIFF.

19. Immediately after Defendants DIRBAS and/or DOES 26-50 completed their mastectomy procedure, Defendants HONG and/or DOES 26-50 conducted a breast reconstruction procedure on JANE DOE.

20. During the breast reconstruction procedure, Defendants HONG and/or DOES 26-50 placed 533cc silicon implants in JANE DOE's breasts, contrary to PLAINTIFFS' expressed consent in preoperative consultations.

21. Defendants HONG and/or DOES 26-50 inserted these silicon implants above JANE DOE's pectoral muscles in the 'subcutaneous space' of JANE DOE's breasts, contrary to PLAINTIFFS' expressed consent in preoperative consultations.

22. During the breast reconstruction procedure, without the knowledge and/or consent of JANE DOE and while she was under general anesthesia Defendant HONG and/or DOES 26-50 took photographs of JANE DOE's breasts with their personal cellular telephones, which they later shared with other unknown individuals.

23. As a result of Defendants HONG's and/or DOES 26-50's decision to place the larger 533cc implants subcutaneously, JANE DOE suffered excessive scarring inside her breasts, which resulted in extremely painful "capsular contraction" around JANE DOE's breast implants that required revision surgery to correct.

24. The weight and size from the excessively large 533cc implants that Defendants HONG and/or DOES 26-50 placed in JANE DOE's breasts created excessive pressure around JANE DOE's breast and blood supplying tissue, cut off blood circulation bilaterally to her nipple areolar complexes in the days after the December 12, 2012 surgery, which caused bilateral necrosis of JANE DOE's nipple areolar complexes.

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25. The day after her surgery on December 13, 2012, Defendants DIRBAS and/or DOES 26-50, JANE DOE's treating physicians, examined JANE DOE's breasts to evaluate her for discharge from Defendants STANFORD's and/or DOES 1-25's facility despite examining her surgical wounds and noting that they did not appear normal. As part of this evaluation, Defendant DIRBAS and/or DOES 26-50 knew or in the exercise of their medical judgment should have known that JANE DOE should not have been discharged, and should have been held for further evaluation, treatment, and possible revision surgery to prevent the damages which JANE DOE claims in this suit.

26. During a postoperative visit on December 13, 2012 at Defendants PAFMG's and/or DOES 1-25's facility, Defendants HONG and/or DOES 26-50 noticed that JANE DOE's breasts were blanched and purple with black nipples and areola–signs of impending necrosis–and knew or should have known through the exercise of their medical judgment that intervention was necessary to prevent further damage to JANE DOE's breast tissue and nipple areolar complexes, but failed to act to prevent or reduce the damage to JANE DOE's breast tissue and nipple areolar complexes.

27. Five days after surgery, during another postoperative visit to Defendant PAFMG's and/or DOES 1-25's facility on December 16, 2012, Defendants HONG and/or DOES 26-50 applied a surgical "Marena" bra to JANE DOE's breasts that constricted circulation to them, which they knew or should have known, through the exercise of their medical judgment, contravened the standard of care.

28. Defendants HONG and/or DOES 26-50, postoperatively knew that JANE DOE's breast and tissue were being damaged, and that the standard of care required them to intervene to prevent further damage.

29. At various times during December of 2012, Defendant HONG and/or DOES 26-50 shared confidential details about JANE DOE's breast reconstruction surgery, without JANE DOE's knowledge or consent, with Dr. Kristen Ganjoo, M.D. and unknown others, who were not involved in JANE DOE's care and treatment.

30. The necrosis of JANE DOE's nipple areolar complexes took approximately four months of

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subsequent wound therapy to treat, and left JANE DOE with discolored areolae and without nipple protrusion. As a result of the conduct detailed above, JANE DOE suffered income loss during her recovery and the subsequent surgical revision of her breasts.

31. On or about April 22, 2013, JANE DOE consulted with a plastic surgeon regarding revision surgery of her breasts, at which time she expressed her desire for smaller implants placed subpectorally; and on May 22, 2013, the plastic surgeon went forward with the revision surgery as JANE DOE requested.

FIRST CAUSE OF ACTION
MEDICAL MALPRACTICE: BREAST RECONSTRUCTION PROCEDURE
Against Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50

32. PLAINTIFFS incorporate by reference the allegations set forth above, as though fully set forth herein.

33. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed a duty to JANE DOE to exercise a degree of skill, knowledge, and care in the diagnosis and treatment that other reasonably careful health care practitioners would have used under similar circumstances.

34. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 , and each of them, failed to exercise the requisite degree of skill, knowledge, and care in the diagnosis and treatment required of them with respect to the care and treatment of JANE DOE. During the surgeries and related pre- and post-surgical care, Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, breached their duty to JANE DOE as described herein by, including but not limited to, 1) using 533cc breast implants that were too large for JANE DOE and inserting those implants in the subcutaneous position instead of the consented to subpectoral position, which resulted in, including but not limited to, capsular contraction, nipple areolar complex necrosis, nipple inversion, and areolar discoloration; 2) failing to adequately follow up postoperatively on JANE DOE's necrotizing nipple areolar complexes, which resulted in JANE DOE having to undergo four months of wound therapy; 3) failing to postoperatively advise JANE DOE that removing the 533cc breast implants would have prevented her nipple areolar complexes from necrotizing, resulting in extensive necrotization of JANE DOE's nipple areolar complexes;

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and 4) failing to a) adequately examine JANE DOE postoperatively, b) diagnose her condition, and/or c) refer her to a competent specialist for examination and/or before discharging her from STANFORD's and/or DOES 1-25's facility in which she had undergone her breast reconstruction surgery.

35. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed JANE DOE a duty to supervise the care given by HONG, DIRBAS, and/or DOES 26-50 who were the medical practitioners, nurses, staff, employees, and/or actual or ostensible agents under Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50's supervision, control, and/or who were actively participating in any of the surgical procedures JANE DOE underwent.

36. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, failed to exercise that degree of skill and care commonly required of their profession, in that they failed to train properly, supervise and monitor HONG, DIRBAS, and/or DOES 26-50, and knew or should have known that the failure to properly supervise and/or monitor these persons would cause serious injury to JANE DOE and other members of the public seeking medical care from Defendants HONG, DIRBAS, and/or DOES 26-50, and each of them.

37. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 owed a duty to JANE DOE to use reasonable care to select and periodically evaluate its medical staff, including but not limited to HONG, DIRBAS, and/or DOES 26-50, to insure the adequacy of medical care rendered to patients in its facility, including JANE DOE.

38. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 breached their duty of care owed to JANE DOE by failing to provide the procedures, policies, facilities, supplies, and/or qualified personnel reasonably necessary for her treatment, and/or by failing to periodically evaluate its medical staff, including Defendants HONG, DIRBAS, and/or DOES 26-50, to insure the adequacy of medical care rendered to patients in its facility.

39. JANE DOE is informed and believes, and hereon alleges, that Defendants PAFMG, STANFORD, and/or DOES 1-25 are also liable for the medical negligence of Defendants HONG, DIRBAS, and/or DOES 26-50 as described herein, because Defendants HONG, DIRBAS, and/or DOES 26-50 committed their negligence within the course and scope of their employment and/or agency,

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either actual or ostensible, with Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50 and each of them.

40. Defendants HONG, DIRBAS, PAFMG, STANFORD, and/or DOES 1-50, and each of them, also owed a duty to JANE DOE to obtain her informed consent by explaining the likelihood of success and the risks of agreeing to each course of treatment in language that JANE DOE could understand, giving JANE DOE as much information as she needed to make an informed decision, including any risk that a reasonable person would consider important in deciding to have the proposed treatment or procedure, and any other information skilled practitioners would disclose to JANE DOE under similar circumstances, including but not limited to any risk of serious injury or significant potential complications that might occur if the procedure were performed.

41. A reasonable person in JANE DOE's position would not have agreed to the medical procedures described herein if she had been fully informed of the results and risks and/or alternatives to those procedures.

42. As a direct and proximate result of Defendants HONG's, DIRBAS's, PAFMG's, STANFORD's, and/or DOES 1-50's, and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, wage loss, medical expenses, and costs, in an amount to be proven at trial.

43. As a direct and proximate result of Defendants HONG's, DIRBAS's, PAFMG's, STANFORD's, and/or DOES 1-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

44. JANE DOE prays for damages as more fully set forth below.

SECOND CAUSE OF ACTION
MEDICAL BATTERY
Against Defendants HONG and/or DOES 26-50

45. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

46. Defendants HONG, and/or DOES 26-50 intentionally used 533cc breast implants that were larger

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than the 350cc to 400cc implants JANE DOE asked for and consented to in her preoperative consultation with Defendant HONG and/or DOES 26-50.

47. Defendants HONG, and/or DOES 26-50 intentionally placed breast implants in the subcutaneous position and not the subpectoral position that JANE DOE asked for and consented to in her preoperative consultation with Defendants HONG and/or DOES 26-50.

48. JANE DOE did not consent either to the larger 533cc breast implants or to having them implanted in the subcutaneous position.

49. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

50. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

THIRD CAUSE OF ACTION
INVASION OF PRIVACY: INTRUSION INTO PRIVATE MATTER
Against Defendants HONG and/or DOES 26-50

51. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

52. California Constitution, Article I, Section I and the common law protect individuals' right to privacy.

53. Defendants HONG and/or DOES 26-50 intentionally, and without the consent or knowledge of JANE DOE, photographed JANE DOE's breasts with their cellular telephones while she was unconscious under general sedation during her breast reconstruction procedure which Defendants HONG and/or DOES 26-50 performed on her on or around December 12, 2012.

54. JANE DOE had an expectation of privacy while she was unconscious under general sedation during surgery.

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55. Defendant HONG and/or DOES 26-50, by taking pictures of JANE DOE's breasts during surgery, invaded JANE DOE's privacy in a manner that would be highly offensive to a reasonable person.

56. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

57. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

58. Defendants HONG and/or DOES 26-50's decision to photograph JANE DOE's breasts while she was under general sedation during her breast reconstruction surgery exhibits malicious and conscious disregard for the rights of others, including JANE DOE.

FOURTH CAUSE OF ACTION
INVASION OF PRIVACY: WRONGFUL DISCLOSURE OF PRIVATE INFORMATION
Against Defendants HONG and/or DOES 26-50

59. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

60. California Constitution, Article I, Section I and the common law protect individuals' right to privacy.

61. Defendants HONG and/or DOES 26-50 intentionally and repeatedly discussed confidential details of JANE DOE's surgery with Dr. Kristen Ganjoo, M.D. and other unknown individuals, who were not involved with JANE DOE's treatment, during December of 2012.

62. Defendant HONG and/or DOES 26-50's conversations about JANE DOE's confidential medical information constituted a public disclosure of private facts.

63. The information that Defendant HONG and/or DOES 26-50 disclosed would be highly

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offensive and objectionable to a reasonable person.

64. The details of JANE DOE's medical record that Defendants HONG and/or DOES 26-50 disclosed were not of legitimate public concern.

65. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's , and each of their actions, JANE DOE was harmed, and as a result suffered and will continue to suffer special damages including, but not limited to, lost wages, medical expenses, and costs, in an amount to be proven at trial.

66. As a direct and proximate result of defendants HONG's, and/or DOES 26-50's, and each of their actions, JANE DOE suffered and will continue to suffer general damages including, but not limited to, pain and suffering, emotional distress, mental anguish, anxiety, loss of enjoyment of life, inconvenience, in an amount to be proven at trial.

67. Defendants HONG and/or DOES 26-50's decision to share details of JANE DOE's medical record exhibits malicious and conscious disregard for the rights of others, including JANE DOE.

FIFTH CAUSE OF ACTION
VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT
Against Defendants HONG and/or DOES 26-50

68. JANE DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

69. Civ. Code, §§ 56 et seq. (the Confidentiality of Medical Information Act) prohibits health care providers from disclosing medical information about patients without first obtaining authorization.

70. Defendants HONG and/or DOES 26-50 intentionally and repeatedly discussed confidential details of JANE DOE's surgery, which Defendants HONG and/or DOES 26-50 performed on December 12, 2012, with Dr. Kristen Ganjoo, M.D. and other unknown individuals during December of 2012.

71. The details of JANE DOE's surgery constitute medical information.

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72. Under Cal. Civ. Code § 56.35, A health care provider who discloses a patient's medical information in violation of Cal. Civ. Code § 56.10 is liable for the patient's compensatory damages and punitive damages not exceeding $3,000, and attorneys' fees not to exceed $1,000, and the costs of litigation.

SIXTH CAUSE OF ACTION
LOSS OF CONSORTIUM
Against Defendants DIRBAS, HONG, PAFMG, STANFORD, and/or DOES 26-50

73. JOHN DOE incorporates by reference the allegations set forth above, as though fully set forth herein.

74. JOHN DOE is the husband of JANE DOE, and was married to her at the time she suffered the injuries that have given rise to this complaint.

75. As a direct and proximate result of JANE DOE's injuries sustained in the course of the incidents giving rise to this Complaint, JOHN DOE suffered loss of consortium damages including but not limited to loss of care, comfort, companionship, protection, support, assistance, love, affection and society previously received from his wife, all to his general damage.

PRAYER FOR RELIEF

WHEREFORE, PLAINTIFFS prays for judgement as follows:

FIRST CAUSE OF ACTION: BREAST RECONSTRUCTION PROCEDURE:

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;
2. For general damages, in an amount to be determined at trial;
3. For costs of suit;
4. For prejudgment interest according to law;

SECOND CAUSE OF ACTION: MEDICAL BATTERY:

1. For special damages, including but not limited to lost wages, medical expenses, and

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incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

THIRD CAUSE OF ACTION: INVASION OF PRIVACY: INTRUSION INTO A PRIVATE MATTER

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

FOURTH CAUSE OF ACTION: INVASION OF PRIVACY: WRONGFUL DISCLOSURE OF A PRIVATE MATTER

1. For special damages, including but not limited to lost wages, medical expenses, and incidental expenses according to proof;

2. For general damages, in an amount to be determined at trial;

3. For costs of suit;

4. For prejudgment interest according to law;

FIFTH CAUSE OF ACTION: VIOLATION OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT:

1. For general damages, in an amount to be determined at trial;

2. For costs of suit;

3. For prejudgment interest according to law;

4. For statutory damages

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SIXTH CAUSE OF ACTION: LOSS OF CONSORTIUM:

1. For general damages, in an amount to be determined at trial;
2. For costs of suit;
3. For prejudgment interest according to law;

PLAINTIFFS request relief for each cause of action separate and apart from all other causes of action herein alleged.

DATED: March 5, 2014

THE DOLAN LAW FIRM

By: _____

CHRISTOPHER B. DOLAN
MARJORIE J. HEINRICH
CHRISTOPHER B. JOHNSON
Attorneys for Plaintiffs
JANE DOE and JOHN DOE

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conversation is, Dr. Hong, I have decided -- I thought about it, and I decided I want 400 cc implants.

So we hear that a lot in plastic surgery. And whether it is in breast augmentation or whether it is in the discussion, that sets a trigger in us to say it is not that easy. And there are numerous factors involved in the decision of how big the implant is -- it is okay to use.

Q. (By Mr. Weinberg): Which gets me to my next question.

On -- in Exhibit 3, which is your November 9th progress note, pages three and four?

A. November 9th, yes.

Q. In the sentence -- I'm sorry, the second paragraph that begins "certainly," the second paragraph that begins with the word "certainly."

Actually, about the fourth paragraph down. The second sentence -- third sentence says, "The question is whether this should be a high profile or moderate plus profile."

What does that mean, high profile versus moderate plus?

A. It is the -- you may have two similar size, so you may have two 500 cc implants. The moderate profile will be higher and less projected. The high profile

will be narrow and more projected. It is where you want the volume.

Q. Okay. But those terms do not relate to the size, but more to the shape?

A. Yes.

Q. Did she convey to you her preference as to shape?

A. The -- the reason why I included this, I believe, is because there are many different types of implants. Some are shaped implants, called tear drop shape implants.

There are implants that we use very frequently for breast reconstruction, and they are wonderful implants, but they don't give a lot of fullness. They don't give a lot of cleavage. And at some point, I believe, she relayed that she wanted -- she wanted to have a little bit more cleavage than she had. But not too much.

Q. Did you speak with her husband after the surgery?

A. When after the surgery?

Q. Immediately after.

A. Yes.

Q. I mean, sometimes doctors walk out --

A. Yes, yes.

Q. -- and talk to the family.

Do you remember that?

A. Yes.

Q. Was anybody else present when you had this conversation?

A. I believe Dr. Ganjoo was present.

Q. Do you recall what you said?

A. I believe I advised him that I felt the surgery went well, and I explained to them the process that occurred, uh, with the progression of the surgery.

How I tried to put it in initially under the muscle with AlloDerm. And then how eventually I placed it above the muscle. That's my recollection.

Q. Do you recall anything else about what you told him?

A. I recall that I thought that I might have shown them photos from, um, my cell phone to document that.

Q. Those photos, what stage during the surgery were they taken?

A. The -- at the stage when I had one breast under the muscle and the AlloDerm on the left side. And then on the other side, it was above the muscle, so I could compare both lying down and sitting up.

Q. Okay. So I may have been provided with those photographs. And I didn't think I was going to use

photographs.

But now that you are telling me that --

A. Uh-huh.

Q. -- which was going to be a question.

These two photographs, which I am going to mark -- I will mark them nine and ten and perhaps you can do some description.

MR. HUDSON: Which is nine?

MR. WEINBERG: I have no way to describe it.

Q. (By Mr. Weinberg): Nine looks like it is --

MR. HUDSON: Why don't we give them to the doctor, and have him orient.

Q. (By Mr. Weinberg): That's what I was going to say.

Tell us what -- how you would describe nine and how you would describe ten.

A. Nine, this is a view from the patient's foot looking up.

Q. Okay.

A. This (indicating) is the left breast.

Q. When you say "this," this young lady doesn't know what you are pointing at. It doesn't matter to her. Because somebody is going to be reading this in the future.

So when you say "this is the left breast," you

are actually pointing to the breast that is on the right side of the photograph; is that true?
A. Yes.
Q. All right.
A. It is the patient's left.
MR. HUDSON: And just for orientation, Mr. Weinberg, the holes on the paper -- bottom of the paper of Exhibit 9 is how the doctor is orienting the photograph so we can tell right from left.
MR. WEINBERG: Gotcha. Okay.
Q. (By Mr. Weinberg): So in Exhibit 9, is one implant subcutaneous and one implant subpectoral?
A. On the left.
Q. Yes-or-no question.
A. Yes.
Q. All right.
So tell me which one is subpectoral.
A. The left.
Q. The patient's left breast, which is on the right-hand side of the photograph?
A. Yes.
Q. And on the right breast, then the implant is subcutaneous?
A. Yes.
Q. Are they both the same size implant?

A. Yes.
Q. The subcutaneous implant on the right, does that have AlloDerm?
A. On the patient's left and your right?
Q. No. No. On the -- on the patient's right, my -- which would also --
MR. HUDSON: On the patient's rights.
Q. (By Mr. Weinberg): On the patient's right.
A. Patient's right.
Q. That is subcutaneous placement; right?
A. Yes.
Q. Is there AlloDerm on that photograph?
A. No.
Q. On the patient's left, which is subpectoral, is there AlloDerm?
A. Yes.
Q. All right.
Then let's look at photograph ten.
And again, the holes or the three black dots which are three-ring hole punches are on the bottom of the photograph.
Is that at the same stage in the surgery as Exhibit 9?
A. Yes.
Q. What is the view or the angle that you are

depicting there?
A. The patient is now sitting up (indicating). That's a view that we will typically use to assess.
Q. So the patient is sitting up.
So that you are still at the foot of the table?
A. Yes.
Q. All right.
And so the patient's left breast is on the right-hand side of the photograph, and the patient's right breast is on the left-hand side of the photograph?
A. Yes.
Q. And when you say the patient is sitting up, how was that accomplished?
A. The operating tables have a bend, and you are able to bend the table up to about 60 or 70 degrees.
Q. So the table is elevated. The patient is still unconscious; correct?
A. Yes.
Q. All right.
And the purpose of that photograph was to accomplish or illustrate what?
A. We used the sitting up view to get a better sense of the shape of the breast when they are sitting up or standing.
It's another test for us to see what the shape

of the breast would look like with that particular implant.
Q. Okay. Are those the only two photographs you took with your cell phone?
A. Yes.
Q. During the surgery, I mean?
A. Yes.
Q. Okay. Why did you use your cell phone?
A. There was no other cell -- there was no other device around to take a photo.
Q. Is that typical at Stanford that there is no photograph -- well, let me back up.
Do you take pictures during every breast reconstructive surgery that you do?
A. No.
Q. Why did you take pictures during this surgery?
A. Because of the decision-making, and I thought these photographs were very illustrative of the decision-making process that I went through.
And I felt it was important to be able to show to Dr. A and her family.
Q. Did you subsequently show those photographs to Dr. A?
A. Yes.
Q. When did that occur?

A. I believe it was --
Q. You can put your hand down now.
Go ahead.
A. I believe it was the following morning when I rounded on her.
Q. Okay. And what was her -- it would be -- we will give it to Terry.
What was her reaction?
A. I don't recall. I don't recall. I think she was still sleepy. But she did not seem particularly upset.
Q. Did you show those photographs to her husband immediately after surgery when you went out and talked to him?
A. I believe I did.
Q. And did you tell him that you had opted to place the implants subcutaneous rather than subpectoral?
A. I went through the same process I described to you earlier.
Q. What was his reaction?
A. Didn't seem upset. Seemed relieved that the operation was -- was -- was completed.
Q. Did you feel -- withdraw that.
At the time, did you think that if you were allowed to use tissue expanders, you could complete the

surgery subpectorally even though it would be in two stages?
A. Repeat that question again, please.
Q. Sure. While you were going through this thought process of I am not happy with subpectoral and they look better subcutaneous, um, that there is plus and minus of both, did you think to yourself as an option, if I could use tissue expanders, we could complete the surgery subpectorally, it would just be a two-stage process?
A. Yes.
Q. Why didn't you go out and have that conversation with her husband?
A. Because she in no -- no uncertain terms told me several criteria which she was not willing to accept. Tissue expanders was one.
There were many techniques we could use if to -- to -- to maybe tighten up the breast tissue, but that would involve making scars and possibly losing the nipple -- moving the nipple.
So early on, it became very clear what she was willing to accept and what she was not willing to accept.
MR. WEINBERG: This is eight.
(PAMF medical records marked Plaintiffs'

Exhibit 8 for identification.)
MR. HUDSON: What is eight?
MR. WEINBERG: That's -- I don't remember.
MR. HUDSON: Thank you. The court reporter got it.
THE WITNESS: Post-op note.
Q. (By Mr. Weinberg): 17th?
A. Yeah.
Q. December 17th.
You ready?
THE COURT REPORTER: You bet.
Q. (By Mr. Weinberg): Okay. When you went out after surgery and talked to Dr. A's husband and Dr. Ganjoo, do you recall telling the husband that you used some fancy stitch work under the left breast?
A. I don't know about fancy stitch work. I might have described tightening the inframammary fold and along the sides of the breast.
Q. Did you do that only on one side?
A. I did that on both sides.
Q. Okay.
A. Yes.
Q. So that phrase "fancy stitch work" doesn't sound familiar to you?
A. Not -- not -- (Shakes head from side to side.)

Q. Post-op day one, December 13th, she is still in-patient, did you speak with Dr. Dirbas that day?
A. I don't recall.
Q. Have you spoken with Dr. Dirbas about Dr. A since the surgery?
A. No, sir.
Q. Have you done one of these -- and I don't mean it in a pejorative way, just a phrase I am using, tag-team kind of surgeries, have you done that with Dr. Dirbas since the surgery?
A. Yes.
Q. Have you, since Dr. A, done a subcutaneous implant immediate post mastectomy?
A. Post mastectomy or post -- not post mastectomy but post implant removal, yes, in a capsulectomy, but not post mastectomy.
Q. Have you had a surgery where you did a -- where Dr. Dirbas or somebody else, any other doctor, did a mastectomy and then you immediately did a reconstruction since Dr. A?
A. Single-stage reconstruction?
Q. Yeah.
A. No. Not since then.
Q. Have you made a decision not to do single-stage reconstructions anymore?

A. No. If anything, I think we are going to be asked to do them more and more because it is becoming more and more popular now.

Q. Why is that, do you know?

A. The same reasons that we described earlier. There are limitations with the submuscular placement with implants. They cause a flattening. They are more painful. And they cause significant animation deformity sometimes.

Q. What does that mean, animation deformity?

A. When a woman has a breast augmentation -- if you just look at a woman without an implant and they lift something heavy, the breast does not move.

If you have an implant that's under the muscle and you lift weights or you are reaching something, that muscle contracts and the breast can jump around. It looks unnatural.

Sometimes for women that are avid exercisers, women who are very lean, gymnasts, very thin, it is not a good option to put implants in the muscle. That's becoming more and more clear.

There is no breast tissue to camouflage, so many women bitterly complain about animation deformity.

Q. And I know it is going to raise an objection because it is not the same process.

MR. HUDSON: Object.

MR. WEINBERG: Overruled.

Q. (By Mr. Weinberg): Does it matter to you whether the -- the skin flap is thick or thin in terms of your decision to do subcutaneous versus subpectoral placement of the breast implant?

MR. HUDSON: Vague and ambiguous. But go ahead. And incomplete hypothetical.

Go ahead.

THE WITNESS: Can I -- can I -- I think the more important issue is the vascularity to the skin flaps.

If the skin flaps are relatively thin, it may be because the patient is thin. That's all you get. But it is very healthy, robust, the breast size is, you know, reasonable, then if I felt confident in my ability to judge the profusion and health of that, I would be okay with it.

Q. (By Mr. Weinberg): In that -- and then step two of that is is there any circumstances where you think AlloDerm is necessary in subcutaneous implant?

A. I -- personally for me, no. But that's personal view. That's a personal view. And there are many doctors who routinely use AlloDerm.

Q. Subcutaneous?

A. Everywhere. Anywhere.

Q. Okay. Do you think the presence or absence of AlloDerm in a subcutaneous implant immediate post mastectomy increases risks of complications?

A. I think it can. I think it is a foreign body. It can cause a seroma. It can cause an infection. There is an allergic reaction that people describe, if the skin is very red, it can cause infection, so yes, it can.

Q. Does it increase the risk of devascularization of the nipple and areolar complex?

A. If it gets infected.

Q. So whether it is there or not there doesn't change the risk of devascularization of the nipple-areolar complex?

MR. HUDSON: That misstated his testimony, but go ahead.

THE WITNESS: That's not the -- I don't believe that's the most important factor, but profusion to the nipple-areolar complex aside.

Q. (By Mr. Weinberg): The presence or absence of AlloDerm?

A. Yes.

Q. Okay. December 17th, 2012, was the last time that you saw her personally?

A. Yes.

Q. And you have no recollection of actually speaking with her on the phone after that date?

A. No.

Q. Have you reviewed any records of any medical care and treatment of Dr. A after December 17th?

A. No.

Q. Have you read her deposition?

A. No.

Q. If you put the implants subcutaneous in a patient like Dr. A, immediate post mastectomy reconstruction, how do you secure the implants so they don't move around and cause that animation deformity that you described?

MR. HUDSON: Well, you are -- you are mixing and matching.

MR. WEINBERG: I could be.

MR. HUDSON: The animation deformity was subpectoral, and you are now talking about subcutaneous.

MR. WEINBERG: That's my question.

Q. (By Mr. Weinberg): Okay. So maybe the better question is, you put the implants subcutaneous, do you still have that risk of animation deformity?

A. No.

Q. What keeps them from moving around subcutaneous

as opposed to subpectoral?
A. In both instances, your body very rapidly forms scar tissue called a capsule. And that capsule is a pocket in which stabilizes the implant. It takes about two to three weeks to form.
Q. And that happens whether it is subcutaneous or subpectoral?
A. Yes.
MR. WEINBERG: Can I see -- yeah. Thanks.
Q. (By Mr. Weinberg): Okay. Yeah.
Look at, if you don't mind, Exhibit 5 again, which is the December -- the February 11, 2013 telephone encounter. Page 49.
A. Yes.
Q. In the middle of what I am going to call the first paragraph, it says -- where you are describing your December 17th office visit, quote, she expressed disappointment in the fact that the implants had been placed in the subglandular position rather than in the subpectoral position.
First of all, what was the -- did she say why she was disappointed? Do you remember if she said why she was disappointed?
A. When she left, uh, the last time I saw her on post-op day five, I had no idea that she was

disappointed or angry. It was not until I received the text message, um, when she had gotten back to Newport Beach that she expressed disappointment.
Q. So what you are talking about when you get that -- when you make that statement, aren't you relating what happened in post-op day five?
A. No.
Q. It says, quote, she was discharged from the hospital on postoperative day one and was seen in my office on postoperative day five, December 17, 2012.
At that time, she still had drains in place and some partial ischemia to the nipple-areolar complex. She also expressed disappointment in the fact that the implants had been placed in the subglandular position rather than the subpectoral position.
So is that relating to something she said during the December 17th visit?
A. It is -- uh, that's interesting, because I -- my recollection is that I don't remember her being angry or, quote-unquote, disappointed. I mean, I think she had questions regarding it, but I don't remember her expressing concerns.
But I do know by the time I wrote this, I know she was furious with people on -- based on different events.

Q. Based on what?
A. Based on a number of different events.
Q. Tell me the events.
A. The text. The -- mainly the letter to Stanford.
Q. Okay. Still referring to the February 11th, telephone encounter, Exhibit 5, page 49.
A. Um, yes.
Q. You, again, use that phrase "subglandular."
A. I'm sorry.
Q. You used it twice.
Were you intending to imply that there was glandular tissue remaining when you did your implant on -- back on December the 12th?
A. No. It is just lazy, lazy vocabulary.
Q. And when using that term "subglandular," you were intending to mean subcutaneous?
A. Yes. I think with this issue, we -- we -- it comes up so frequently with breast augmentation patients that we use it interchangeably. It is not accurate. You are right, though.
Q. Okay.
A. Yes.
Q. I will give those back to you before I put them in my briefcase.

Looking again at Exhibit 8, which is the December 17th clinic note.
A. Yes.
Q. Pages 44 and 45.
At the end of that visit, were there any instructions to Dr. A?
A. There were many instructions, uh.
Q. Well, what were they?
A. One would be when to shower, how often to empty out the drains, things to watch out for, uh, pain medication management, how long to take antibiotics, when she should she see a physician, when she should see her surgeon.
At that time, I think I was under the impression she was going to come back one more time to see me. But those are routine things that we would discuss.
Q. They are not in your progress note?
A. Yes.
Q. Correct?
A. Yes.
Q. Would they be someplace else in --
MR. WEINBERG: I don't think we should answer that. 888 call.
MR. HUDSON: I think they will hang up. Is

that coming through?
THE VIDEOGRAPHER: I can hear it, but is there an off button?
MR. WEINBERG: Do not disturb.
MR. HUDSON: Oh.
Q. (By Mr. Weinberg): So the instructions that you gave to her after that December 17th visit were not in your progress note, would they be someplace else in the PAMF record?
A. I don't believe so. I don't believe so.
Q. So again, and quite frankly, with some level of embarrassment, I say that I have learned that the PAMF electronic health records, when printed out, don't print out the entire electronic health record. And follow-up instructions are in a different part of the system that need to be printed out separately; is that true?
A. Yes. That is called "after visit summary."
Q. After visit summary.
MR. WEINBERG: Do you remember that phrase, Ms. Court Reporter? We heard a lot about that, which was really weird, because I got records certifying that they were complete, and then at trial hundreds of pages of after visits summary showed up. Who would have thought.
Can we get the after visit summaries, counsel?

126

MR. HUDSON: I will see if there are any.
THE WITNESS: Can I say something. It is really useful for primary care. But most surgical departments don't use them. I don't believe that our department uses them.
Q. (By Mr. Weinberg): So when the patient leaves after a visit with you, are they given written instructions, because that's what that after visit summary generates, at least in the primary care department?
A. Not in our practice.
Q. Do they get any written instructions from you?
A. They -- they -- many times they receive written instructions before surgery that talks about how to clean skin, drain, things like that.
But on a regular postoperative visit, we spend -- I try to spend time advising of things to look out for or instructions. That's why I give them my cell phone so I can take a call at any time.
Q. So there is no preprinted form you give them after that first office visit after surgery?
A. No.
Q. And no handwritten instructions that you generate and no after visit summary that is produced?
A. Not in our department.

127

Q. Okay. So what did you tell Dr. A on the December 17th visit with regard to this -- what you call postsurgery support bra, in terms of use?
A. This is at some point, and I am not sure when, I didn't like the way that binder was sitting. Can I -- the binder is an elastic -- like a halter top. Remember in those days, halter top? Because it is Velcro, and it comes down and squishes flat. Useful for things like a tissue expander.
But for Dr. A who has a breast implant in a half shaped breast, I didn't like the way it was sitting. So I wanted to get her something that had some cups and some support.
So at some point, and I am not sure whether it was in the morning, the next morning after surgery or when she came in post-op, I believe I gave her one of our standard bras.
Q. Okay. You are sharing that with us from memory?
A. Yes.
Q. That sequence of events is not written -- recorded anywhere?
A. No.
Q. Other than what you have heard from your attorney, have you heard from anybody else what happened

128

to Dr. A after you last saw her?
A. Can you -- who is everybody?
Q. Anybody. I am just talking about anybody.
A. To this day, I don't -- I don't know what has happened to her.
Q. Okay. Have you had any further conversation with Dr. Ganjoo?
A. Not at all.
Q. Is she still a colleague, somebody you see in the hospital, whatever?
A. Not very much. She -- she -- we used to -- she used to refer some patients, um, every so often, but now since this has developed, I have not seen any patients from her. And I have not seen her in the hospital.
Q. And just only because it is my curiosity, what is her specialty?
A. She is a hematologist oncologist.
Q. Okay. Separate and apart from the risks of a breast reconstruction in Dr. A's circumstances subpectorally with AlloDerm, are there different risks doing your reconstruction subcutaneous without AlloDerm?
MR. HUDSON: Been asked and answered.
Go ahead.
THE WITNESS: I -- they are the same operation. It is a single-stage reconstruction using an implant.

129