LIVE VIRTUAL COMMITTEE MEETING

FEBRUARY 11, 2021 AT 9:00 AM*

DISABILITY PROCEDURES & SERVICES COMMITTEE MEETING

*The Committee meeting will be held following the Board of Retirement meeting scheduled prior.

TO VIEW VIA WEB

https://members.lacera.com/lmpublic/live_stream.xhtml

TO PROVIDE PUBLIC COMMENT

You may submit a request to speak during Public Comment or provide a written comment by emailing PublicComment@lacera.com. If you are requesting to speak, please include your contact information, agenda item, and meeting date in your request.

Attention: Public comment requests must be submitted via email to PublicComment@lacera.com no later than 5:00 p.m. the day before the scheduled meeting.

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

AGENDA

THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

9:00 A.M., THURSDAY, FEBRUARY 11, 2021 **

This meeting will be conducted by the Disability Procedures and Services Committee by teleconference under the Governor's Executive Order No. N-29-20.

Any person may view the meeting online at https://members.lacera.com/lmpublic/live_stream.xhtml.

The Board may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE TRUSTEES:

JP Harris, Chair
Wayne Moore, Vice Chair
Herman B. Santos
Gina Zapanta
William Pryor, Alternate

I. CALL TO ORDER

II. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of January 14, 2021

III. PUBLIC COMMENT

IV. ACTION ITEMS

A. Consider Application of Mark K. Urman, M.D., as a LACERA Panel Physician (Memo dated January 28, 2021)

V. FOR INFORMATION ONLY

A. Discussion regarding Applications when the Member has been Terminated for Cause by the County of Los Angeles (Memo dated January 29, 2021)

VI. ITEMS FOR STAFF REVIEW

VII. GOOD OF THE ORDER
(For information purposes only)

VIII. ADJOURNMENT

***The Board of Retirement has adopted a policy permitting any trustee of the Board to attend a standing committee meeting open to the public. In the event five (5) or more trustees of the Board of Retirement (including trustees appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Trustees of the Board of Retirement who are not trustees of the Committee may attend and participate in a meeting of a Board Committee but may not vote, make a motion, or second on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting. Please be on call.**

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to trustees of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence. Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

MINUTES OF THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

THURSDAY, JANUARY 14, 2021

This meeting was conducted by the Board of Retirement by teleconference under the Governor's Executive Order No. N-29-20.

COMMITTEE TRUSTEES

PRESENT:
JP Harris, Chair
Herman B. Santos, Vice Chair
Ronald A. Okum
Gina Zapanta
William Pryor, Alternate

ALSO IN ATTENDANCE:

BOARD TRUSTEES AT LARGE

Shawn Kehoe
Vivian Gray
Keith Knox
Wayne Moore
Les Robbins
Alan Bernstein

STAFF, ADVISORS, PARTICIPANTS

Ricki Contreras, Disability Retirement Services Manager
Tamara Caldwell, Disability Retirement Services Supervisor
Francis J. Boyd, Senior Staff Counsel

I. CALL TO ORDER

The Meeting was called to order by Chair Harris at 12:28 p.m., in the Board Room of Gateway Plaza.

II. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of December 10, 2020

Mr. Okum made a motion, Mr. Pryor seconded, to approve the minutes of the regular meeting of December 10, 2020. The motion passed unanimously.

III. PUBLIC COMMENT

There were no requests from the public to speak.

IV. FOR INFORMATION ONLY

A. Educational Opportunities 2021 (Memo dated December 31, 2020)

Committee trustees requested for staff to include "Termination for Cause" in future educational opportunities for 2021.

Ms. Contreras and Mr. Boyd were present to answer any questions from the Trustees.

V. ITEMS FOR STAFF REVIEW

Disability Procedures and Services Committee requested that staff provide the Los Angeles County Department of Human Resources/Risk Management hiring practice information mentioned today to the Board and Committee Trustees.

VI. GOOD OF THE ORDER

Mr. Kehoe shared comments regarding a Sheriff's department staff member complimenting Ms. Contreras and Mr. Boyd on their involvement and assistance with helping out members and stated how passionate they both are about trying to do the right thing for our members.

Trustees stated that they appreciated and took the comments to heart and they did not want Ms. Contreras' and Mr. Boyd's hard work behind the scenes to go unnoticed.

VII. ADJOURNMENT

With no further business to come before the Disability Procedures and Services

Committee, the meeting was adjourned at 12:55 p.m.

January 28, 2021

TO: Disability Procedures & Services Committee
JP Harris, Chair
Wayne Moore, Vice Chair
Herman B. Santos
Gina Zapanta
William Pryor, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: February 11, 2021, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF MARK K. URMAN, M.D., AS A LACERA PANEL PHYSICIAN**

On November 4, 2020, staff confirmed Dr. Mark K. Urman wished to pursue appointment to the LACERA Panel of Examining Physicians and would agree to LACERA's contractual terms.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s)

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Mark K. Urman, M.D. to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJP:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

January 28, 2021

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: February 11, 2021 Disability Procedures & Services Committee

SUBJECT: Recommendation for Cardiologist Applying for LACERA's Panel of Examining Physicians – Mark K. Urman, M.D.

RECOMMENDATION

Based on our efforts to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends the Application of Mark K. Urman, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

The Disability Retirement Services Division engaged National Disability Evaluations (NDE) to discuss potential candidates for the LACERA Panel of Examining Physicians. NDE provides timely high-quality disability evaluations and reports to government entities and private insurance carriers throughout the United States. Their network includes experienced local physicians/experts across a wide range of medical specialties. NDE's local professional presence enhances quality of service and improves workflow in the independent medical review process.

Dr. Urman holds multiple certifications and fellowships--Diplomate, National Board of Medical Examiners, Board Certified, American Board of Internal Medicine and Subspecialty Cardiovascular Diseases, Fellow, American College of Cardiology, Fellow, American Society of Echocardiography, to name a few. He received his Bachelor's Degree (B.A.) from Northwestern University in 1984 and his medical degree from Northwestern University Medical School in 1988. Dr. Urman was and intern and resident at Cedars-Sinai Medical Center from 1988-1991 and Cardiology Fellowship at UCLA Medical Center from 1991-1994. Dr. Urman is presently the Clinical Professor of Medicine at Cedars-Sinai Medical Center and David Geffen Scholl of Medicine at UCLA.

Dr. Urman has 20 years of experience performing medical legal evaluations and 10 years conducting disability evaluations. He served as an Agreed Medical Examiner for 15 years.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician's management team, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. Staff also advised that all physicians must immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians.

NDE will be responsible in making sure that Dr. Urman adheres to the rules set forth in the Guidelines and all other requirements as discussed. NDE was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

IT IS THEREFORE RECOMMENDED THAT the Application of Mark K. Urman, M.D., be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

RC:tlc

LACERA
Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-6132 ● 800/786-6464

GENERAL INFORMATION Please attach a list of any additional locations.	Date 7/17/2020
Physician Name: Mark K. Urman	Group Name: First Medical Experts
Primary Address: 1516 S. Bundy Dr. Suite 307, Los Angeles, CA 90025	
Primary Contact: Rick Albert	Title: President
Telephone: (310) 593-4920 ext. 1 Fax: (310) 392-0831	Email: rick@firstmedicalexperts.com
Secondary Address: Click or tap here to enter text.	
Telephone: Click or tap here to enter text. Fax: Click or tap here to enter text.	Email: Click or tap here to enter text.

PHYSICIAN BACKGROUND	
Field of Specialty: Cardiology Board Certification ☒Yes ☐No	Subspecialty: Click or tap here to enter text. Board Certification ☐Yes ☐ No
License # **G 66869** Expiration Date: **7/31/2021**	
Has your license been suspended in the last 3 years? ☐Yes ☒No Has there been any disciplinary actions filed against you in the last 3 year? ☐Yes ☒ No	

EXPERIENCE AND CURRENT PRACTICE
Indicate the number of years of experience that you have in each category and the time spent performing each activity.

Type	Number of Years	Current Practice	Time Spent (%)
AME	15	Treatment	95
IME	0	Evaluations	1
QME	0	Research	2
Workers' Compensation Evaluations	15	Teaching	2
Disability Evaluations	10		100 %
Med-Legal Reports	20		

Performing Medical Evaluations for Public Organizations ☐Yes ☒No Performing Medical Evaluations for Private Organizations ☐Yes ☒No Please Names of Organizations:	
Estimated Time from Appointment to Examination: ☐2 weeks ☒3-4 Weeks ☐Over a month	Able to Submit a Final Report and Invoice in 30 days: ☒Yes ☐No

LACERA FEE SCHEDULE	
Initial Examination/Report	$ 1,500 – 1,800 flat rate (depending on specialty)
Review of Records	$ 350.00 per inch
Supplemental Report	$ 350.00 per hour
Other Fees	
Administrative Hearing Preparation	$ 350.00 per hour
Depositions and Expert Testimony	$ 350.00 per hour

Cancellation Policy and Fees
Please indicate your cancellation policy and any applicable fees.

What is you Cancellation Policy? (Attach policy, if applicable)

Cancellation must take place 6 business days prior to the appointment. $500 no show fee.

Cancelled Exams:	Fee: $ **500**
Cancelled Hearing:	Fee: $ **500**

Name of person completing this form:

Print Name: Lilly Garzona	Title: Office manager
Physician Signature: *Electronically signed by Mark K. Urman, MD*	Date 07/17/2020

Please provide the following allow with the application:

- **Curriculum Vitae**
- **Attach 2 Sample "Redacted" Medical Reports**
- **Copy of Medical License**
- **Copy of Board Certification(s)**
- **Certificate of Insurance**

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date: Interview Time:	Interviewer: All documents received: ☐Yes ☐No

MARK K. URMAN, M.D., F.A.C.C., F.A.S.E., F.A.H.A.

Curriculum Vitae

Personal History:

Business address:	Cedars-Sinai Medical Office Towers 8635 West Third Street, Suite 890-W Los Angeles, California 90048
Business telephone:	(310) 659-0715 FAX: (310) 659-0664
	e-mail: mark.urman@cshs.org
Web Pages:	http://bio.csmc.edu/view/3944/Mark-K-Urman.aspx http://www.CORMedicalGroup.com/mark-k-urman-md-facc-fase-faha
Home Address:	[redacted]
Home telephone:	[redacted]
Date of Birth:	[redacted]
Place of Birth:	Los Angeles, California
Citizenship:	U.S.A.
Marital Status:	[redacted]
Social Security Number:	Available upon request

Education:

Summer 1980	**HARVARD UNIVERSITY** Cambridge, Massachusetts -Studies in Physiology
9/81 to 6/84	**NORTHWESTERN UNIVERSITY** Evanston, Illinois -Bachelor of Science in Medicine June 1986 -Honors Program in Medical Education
9/84 to 6/88	**NORTHWESTERN UNIVERSITY MEDICAL SCHOOL** Chicago, Illinois (Subsequently named Feinberg School of Medicine) -Doctor of Medicine June 1988
6/88 to 6/91	**CEDARS-SINAI MEDICAL CENTER** Los Angeles, California -Internship and Residency in Internal Medicine
7/91 to 6/94	**WEST LOS ANGELES / UCLA VA MEDICAL CENTER** **Wadsworth Division** Los Angeles, California -Cardiology Fellowship

Licensure:

California, G066869 August 1989
DEA Registration Number: BU2044030

Certification:

-Diplomate, National Board of Medical Examiners 1989
-Board Certified, American Board of Internal Medicine 1991
-Board Certified, Subspecialty Cardiovascular Diseases 1995 (recertified through 2025)
-Diplomate, National Board of Echocardiography 1996 (Adult transthoracic plus stress echocardiography – recertified through 2026)
-Fellow, American College of Cardiology 1996
-Fellow, American Society of Echocardiography 2006
-Fellow, American Heart Association (Council on Clinical Cardiology) 2010
-SHAPE Certification as Heart Attack Prevention Specialist by the Society for Heart Attack Prevention and Eradication (SHAPE) 2010
-Fellow, Royal Society of Medicine (Overseas Fellow) 2010

Hospital Privileges:

Cedars-Sinai Medical Center, Attending Physician (on medical staff since 1994)

Professional Experience:

2014 to present	**SecondOpinionExpert, Inc.** Dana Point, California -Director of Physician Relations and Quality Assurance (2014) -Vice President, Physician Relations and Quality Assurance (2015 - present)
2004 to present	**CEDARS-SINAI MEDICAL CENTER** Los Angeles, California -Clinical Professor of Medicine (2014 – present) -Medical Director, Consultative and Preventive Heart Center, Cedars-Sinai Heart Institute (2009 – 2010) -Medical Director, Heart Center at the Cedars-Sinai Heart Institute (2007 – 2009) -Clinical Chief, Division of Cardiology (2005 - 2009) -Vice Clinical Chief, Division of Cardiology (2004)
1994 to present	**DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA** Los Angeles, California - Clinical Professor of Medicine (2010 – present) - Associate Clinical Professor of Medicine (2002 – 2010) - Assistant Clinical Professor of Medicine (1996 – 2002) - Clinical Instructor of Medicine (1994 – 1996)
1996 to 1998	**MIDWAY HOSPITAL MEDICAL CENTER** Los Angeles, California -Director, Stress Echocardiography Laboratory

Professional Activities:

American College of Cardiology (District Councilor, California Chapter 2010 – 2014)
American College of Cardiology Foundation Prevention Committee (2010 – 2014)
American Heart Association (Clinical Cardiology Council)
American Society of Echocardiography, Los Angeles Society of Echocardiography
Los Angeles County Medical Association, California Medical Association

Consulting and Advisory Activities:

Medical Advisory Board member, Bodimetrics 2016 - 2019
Consultant, ZendyHealth 2016 - present
Mentor, Cedars-Sinai Techstars Healthcare Accelerator 2015 - present
Board of Medical Experts, VoyagerMed 2015 - present
Certified Specialty Physician, Armada Health 2014 - present
Member, Scientific Advisory Board, International Academy of Cardiology 2010, 2013 - 2019
Consultant, Professional Practice Evaluation Physician Advisor, Cedars-Sinai Medical Center 2011-2012
Consulting echocardiographer, Cedars-Sinai Medical Center 1996 – 2005
Consultant for Astra-Zeneca Pharmaceuticals, Novartis Pharmaceuticals 2002
Staff cardiology consultant, Congestive Heart Failure Service, Cedars-Sinai 1999-2000
Consultant for Medical Charting Software development for Hewlett Packard 1994-1995

Speakers Bureaus

Medical Education Speakers Network (2003-2013)
CV Therapeutics (2006-2007)
Vascular Biology Working Group (2002 – 2007)
Novartis Pharmaceuticals Corporation (2003-2007)
Pfizer, Inc. (2002-2007)
GlaxoSmithKline Pharmaceuticals (2001-2003, 2005)
Merck/Schering-Plough Pharmaceuticals (2002-2003)
Wyeth Pharmaceuticals (2002)

Community Service:

Board of Directors, American Heart Association, Los Angeles County Division, 2009-2014; Beverly Hills Chapter, 1995-1999
The Jewish Federation Council of Greater Los Angeles, Medical Division Cabinet, 1996-99
Board of Directors, Save A Heart Foundation, 1997-2006
Medical Advisory Board, The Heart Foundation at Cedars-Sinai Medical Center, 2003-present
Moderator of semi-annual Community Health Symposia/Lecture Series presented by Save A Heart Foundation, 1998 – 2008.
Co-chair, Annual Giving Campaign, Sinai Akiba Academy, Los Angeles, California 2011-2014
Co-chair, 50th Anniversary Gala, Sinai Akiba Academy, Los Angeles, California 2017 – 2018, Annual Event 2020
Member, Board of Directors, Sinai Temple, Los Angeles, California 2015 – present
Member, Board of Directors, Sinai Akiba Academy, Los Angeles, California 2019 - present
Health education talks at local hospitals and schools and interviews on radio interview shows and many local TV newscasts and newspapers

Hospital Service:

Co-chair, Performance Improvement Committee (PIC), Division of Cardiology, Cedars-Sinai Medical Center (CSMC) 2005 - 2008
Member, Cardiology PIC, CSMC, 1997-2001, 2004 – 2009, 2014-2017; Ex-officio member 2009 - present
Member, Medical Executive Committee, CSMC 2004 – 2009
Member, Chief of Staff Advisory Committee, CSMC 2005 - 2012
Member, IT Executive Steering Committee & Physician Advisory Committee, CSMC 2006 - 2012
Member, Department of Medicine PIC, CSMC 2004 - 2008
Member, Medical Staff Leadership Review Committee, CSMC 2008, 2009
Co-Chair, Information Technology (IT) Steering Committee, Cardiology, CSMC 2007
Member, Pioneer in Medicine Award Nominating Committee, 2006, 2011
Member, Acute Myocardial Infarction Task Force, CSMC, 1997-2001, 2004-2005
Member, Invasive Cardiology PIC, CSMC, 1998-1999
Member, Housestaff PIC, CSMC, 1998-2001
Member, Cardiology Peer-Review Committee, CSMC, 1999
Member, Cardiac Transplant Performance Improvement Task Force, CSMC, 2000-2001
Co-chair, Cardiology Pharmacy and Therapeutics sub-committee, CSMC 2002
Member, Quality Improvement Committee, CSMC 2002-2003
Member, Pharmacy and Therapeutics PCX Sub-committee, CSMC 2002-2003
Member, Critical Care Committee and Bioethics Committee at Midway Hospital, 1995-1996

Honors, Recognition and Special Awards:

Castle Connolly Top Doctors, 2011 – 2020 (Los Angeles and Beverly Hills)
US News Top Doctors (*US News & World Report*), 2012
Southern California Super Doctors, 2008, 2009-2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020 (published in *Los Angeles Magazine*, December 2008 issue, and January issues in 2010, 2011, 2012, 2013, 2014, 2015, 2016 and 2017, and published in the Los Angeles Times 2018, 2019, 2020). Honored in the *Super Doctors* Hall of Fame since 2018
Los Angeles Magazine Top Doctor 2018, 2019, 2020
Guide to America's Top Cardiologists, 2006 - 2018
The Leading Physicians of The World, 2010, 2013, 2015/2016, 2017/2018
Doctor of Excellence, Leaders in Healthcare Network, 2014
Top Cardiologist in Los Angeles, International Association of Cardiology, 2009, 2015/2016, 2017/2018 (Beverly Hills in 2012)
Hollywood's Top Doctors List (*The Hollywood Reporter* and Castle Connolly), 2014, 2015
Featured in "Icons of Beverly Hills," *Modern Luxury Beverly Hills Magazine,* 2019
Los Angeles Top Doctor & Dentist Award ("Top Doc" Los Angeles) 2011
Outstanding Teaching Award, Cardiology Fellowship Program, Cedars-Sinai Medical Center, 2006 - 2007
America's Top Physicians, Cardiology, Consumer's Research Council of America, 2003, 2004-2005, 2006
American College of Cardiology/Syntex Continuing Medical Education Scholarship Award, 1994
Ben Newman, MD Award, Cedars-Sinai Medical Center 1991 (Recognition for compassion and empathy towards patients)
Medical School Honors: Intensive Care Unit, Senior Cardiology, Electrocardiography (1st in class), Physiology, Medicine clerkship, Pediatrics clerkship 1986 - 1988
Dean's List, Northwestern University 1982, 1983
Valedictorian (1st out of 650) Polytechnic High School, Long Beach, California 1981

Invited Lectures:

"Triage of the Patient with Chest Pain in the Emergency Department." Emergency Department Grand Rounds, Cedars-Sinai Medical Center, February 22, 1996
"Vitamins and Coronary Artery Disease," Save A Heart Foundation annual health symposium, Cedars-Sinai Medical Center, April 4, 1998
"Cardiovascular Dysmetabolic Syndrome," Medical Grand Rounds, Queen of Angels-Hollywood Presbyterian Hospital Medical Center, November 1, 2002. Also at Medical Grand Rounds, Northridge Hospital Medical Center, February 13, 2004
"Evaluation and Treatment of Chest Pain—Focus on Coronary Artery Disease: Diagnosis and Implications for Treatment," Medical Grand Rounds, Simi Valley Hospital, November 13, 2003. Also at Medical Grand Rounds at Ventura Community Memorial Hospital, December 16, 2003.
"Management of the Acute MI Patient: Critical Interventions Do Not End with Reperfusion Therapy," Medical Grand Rounds, Lancaster Community Hospital, November 19, 2003.
"Cardiovascular Dysmetabolic Syndrome-A Paradigm for Global Cardiovascular Risk Assessment and Aggressive Risk Factor Modification," Medical Grand Rounds, JF Kennedy Memorial Hospital, Indio, California, March 10, 2004

Invited Lectures (continued):

Regional Program Chair and faculty member for "From Hypertension to Advanced Cardiovascular Disease: Optimizing Management of the At-Risk Patient," and "Aggressive Hypertension Control: Applying Guidelines to Practice (JNC 7, ADA, ISHIB)." The Peninsula Hotel, Beverly Hills, California, April 29, 2004.

Program Chair and Panelist, American Heart Association – (Greater Los Angeles) Fall Symposium: Panel on Alternative and Complementary Approaches to Coronary Artery Disease, October 2, 2004

"Atherosclerosis and the Changing Paradigm of Cardiovascular Disease Treatment: Focus on Hypertension," Medical Grand Rounds, Glendale Adventist Medical Center, Glendale, California, July 5, 2006, December 17, 2008; also at Olive View/UCLA Medical Center, Los Angeles, California, July 6, 2006; Santa Monica/UCLA Medical Center, Santa Monica, California, September 27, 2006; Monterey Park Hospital, Monterey Park, California, January 30, 2007; Pacifica Hospital of the Valley, Sun Valley, California, April 3, 2008.

Faculty Member "Controversies and Advances in the Treatment of Cardiovascular Disease," October 5 – 6, 2006, October 4 – 5, 2007, September 4 – 5, 2008 and September 30 – October 2, 2009 at the Beverly Hills Hotel, sponsored by Cedars-Sinai Heart Institute, British Cardiovascular Society and the California Chapters of the American College of Cardiology and Society of Thoracic Surgeons.

"Pre-operative Cardiology Evaluation (and Optimization) of the Bariatric Surgical Patient," Your Weight Loss Surgery Patients: Selection, Pre-op Risk Assessment and Long-term Care, at La Quinta Resort & Club, La Quinta, California, sponsored by Cedars-Sinai Medical Center, October 27, 2007.

"The Evolution of Cardiometabolic Risk Factors: 2009 B.C. – 2009 A.D.," Grand Rounds at Providence Holy Cross Medical Center, Mission Hills, California, April 21, 2009.

"Cardiology for Psychiatrists 2017," Southern California Psychiatric Society's *Internal Medicine for Psychiatrists*, Cedars-Sinai Medical Center, Los Angeles, California, April 1, 2017

Lectures and Presentations at Scientific Meetings:

1. **Urman MK**, Shah PK: "Does Plasminogen Activator Inhibitor (PAI-1) Correlate With A Worse Outcome In Acute Coronary Syndromes?", poster session presented at Solomon Scholars Research Program, UCLA, Los Angeles, California, June 4, 1991

2. **Urman M**, Shah PK: "Is Endogenous Fibrinolysis Impaired in Acute Coronary Syndromes?", oral abstract presentation at American College of Cardiology 42nd Annual Scientific Session, March 16, 1993 Anaheim, California

3. **Urman M**, Duerinckx AJ, Lewis B: "Limitations of MR Coronary Angiography" poster/abstract presented at 2nd Biennial Scientific Congress of the International Society of Cardiovascular Ultrasound / Cardiostim, Nice, France, June 16-18, 1994

4. **Urman M**, Pollick C: "Routine Echocardiographic Views Miss Significant Pleural Effusions: Bilateral Chest Scanning is Required." poster/abstract presented at 2nd Biennial Scientific Congress of the International Society of Cardiovascular Ultrasound / Cardiostim, Nice, France, June 16-18, 1994

PUBLICATIONS

Research Papers (Peer Reviewed):

1. Duerinckx AJ, **Urman MK**,: "Two-dimensional Coronary MR angiography: Analysis of initial clinical results." *Radiology* 1994; 193(3):731-738.

2. **Urman MK**, Pollick C: "Routine Echocardiographic Views Miss Significant Pleural Effusions: Bilateral Chest Scanning is Required." *Echocardiography* 1995; 12,5: 449-455.

3. Duerinckx AJ, Atkinson DP, Mintorovitch, J, Simonetti OP, **Urman MK**: "Two-dimensional coronary MRA: limitations and artifacts." *European Radiology* 1996; 6:312-325.

Reviews

1. Duerinckx AJ, Lewis BS, Louie HW, **Urman MK**: "MRI of Pseudoaneurysm of a Brachial Venous Coronary Bypass Graft" (Case report) *Catheterization & Cardiovascular Diagnosis* 1996; 37 (3): 281-286.

Abstracts:

1. **Urman M**, Shah PK: "Is Endogenous Fibrinolysis Impaired in Acute Coronary Syndromes?" *J Am Coll Cardiol,* 1993, 21;2 (Suppl A):137A.

2. Duerinckx AJ, **Urman M**, Sinha U, Atkinson D, Simonetti O: "Evaluation of Gadolinium-enhanced MR coronary angiography", presented at Radiological Society of North America (RSNA) 79th Scientific Assembly and Annual Meeting, Chicago, Nov 28-Dec 3, 1993. *Radiology* 1993; 189(P):278

3. Uppal P, Sharma PP, Ahmed R, Sarma JSM, **Urman MK**, Farahi J, Singh BN: "QT Dispersion in Normal Subjects and Patients With Myocardial Infarction." *J Am Coll Cardiol*, 1994, 23;2 (Suppl A).

4. Duerinckx AJ, **Urman MK**: "Hemodynamically significant coronary artery lesions missed by MR Coronary Angiography." presented as poster/abstract at the First Meeting of the Society of Magnetic Resonance (SMR), Dallas, Texas, March 5-9, 1994; *JMRI* 1994; 4:80.

5. Duerinckx AJ, **Urman MK**, Lewis B: "Coronary artery bypass graft imaging using MR Coronary Angiography." presented as poster/abstract at the First Meeting of the Society of Magnetic Resonance (SMR), Dallas, Texas, March 5-9, 1994; *JMRI* 1994; 4(P): 811.

6. Duerinckx AJ, **Urman MK**, Atkinson DJ, Simonetti OP, Sinha U: "Optimal Imaging Planes for MR Coronary Angiography." presented at North American Society for Cardiac Imaging (NASCI) 21st Annual Meeting, Dallas, Texas, March 4-6, 1994; and European Society for Magnetic Resonance in Medicine and Biology, ESMRMB 11th Annual Congress, Vienna, Austria, April 20-24, 1994

7. **Urman M**, Duerinckx AJ, Lewis B: "Limitations of MR Coronary Angiography" *Eur J.C.P.E.* 1994, 4;2 (Suppl 4):250

8. **Urman M**, Pollick C: "Routine Echocardiographic Views Miss Significant Pleural Effusions: Bilateral Chest Scanning is Required" *Eur J.C.P.E.* 1994, 4;2 (Suppl 4):247

Medical Illustration:

1. Medical illustration in R. Vazquez, MD; M. Racenstein, "A Method to Prevent Unintentional Removal of a Hickman Catheter" *The Journal of Parenteral and Enteral Nutrition* 11:509-510, 1987

RESEARCH WORK

1995 to 2015	Clinical investigator for several clinical cardiac research trials (See attached list)
11/93 to 12/94	**DEPARTMENT OF CARDIOLOGY, HOSPITAL OF THE GOOD SAMARITAN** Assessment of pleural effusions by transthoracic echocardiography (working with Charles Pollick, M.D.)
10/92 to 12/94	**DEPARTMENT OF CADIOLOGY, WEST LA VAMC** **DEPARTMENT OF RADIOLOGY, UCLA and WEST LA VAMC** Hemodynamics in Coronary Arteries and Bypass Grafts using MRI and intravascular Doppler flow-wires. (working with Basil Lewis and Andre Duerinckx) MR Coronary Angiography compared to Fluoroscopic coronary angiography Magnetic Resonance imaging of coronary perfusion compared to Thallium imaging
10/92 to 6/94	Assessment of Myocardial Viability using PET and Thallium with reinjection to Determine Benefit for Revascularization (working with Freny V. Mody)
7/89 to 3/93	**DEPARTMENT OF CARDIOLOGY, CEDARS-SINAI MEDICAL CENTER** Endogenous fibrinolysis as measured by Plasminogen Activator Inhibitor-1 activity in acute coronary syndromes (working with P.K. Shah)
2/87 to 2/88	**DEPARTMENT OF SURGERY, EVANSTON HOSPITAL NORTHWESTERN UNIVERSITY** Retrospective surgical case study comparing different procedures for acute diverticulitis

CLINICAL RESEARCH TRIALS

Mark K. Urman, M.D., F.A.C.C. as co- (or sub-) investigator

1. Weekly Intervention With Zithromax for Atherosclerosis and Related Diseases (WIZARD). Sponsored by Pfizer, Inc. Study completed.

2. Multi-Country, Randomized, Double-blind, Parallel, Placebo-controlled Trial to Assess the Effect of Valsartan on Morbidity and Mortality, Signs and Symptoms and Quality of Life in Patients with Stable, Chronic Congestive Heart Failure (ValHeFT Study). Sponsored by Novartis Pharmaceutical. Study completed.

3. The Effect of LDL-Cholesterol Lowering Beyond Currently Recommended Minimum Targets on Coronary Heart Disease (CHD) Recurrence in Patients with Pre-Existing CHD (TNT Study). Sponsored by Parke-Davis/Pfizer. Study completed.

4. Omapatrilat Versus Enalapril Randomized Trial of Utility in Reducing Events (OVERTURE Study). Sponsored by Bristol-Myers Squibb. Study completed.

5. Candesartan Cilexitil in Heart Failure Assessment of Reduction in Mortality and Morbidity Program (CHARM Study). Sponsored by AstraZeneca. Study completed.

6. Warfarin-Antiplatelet Therapy in Chronic Heart Failure (WATCH Study). Sponsored by the Department of Veteran's Affairs, Cooperative Studies Program. Study completed.

7. African-American Heart Failure Trial (A-HeFT), A placebo-controlled trial of BiDil added to standard therapy in African-American patients with heart failure. Study completed.

8. The Studies of Oral Enoximone Therapy in Advanced Heart Failure (ESSENTIAL). To determine if low-dose enoximone thrapy is an effective treatment for advanced chronic heart failure. Sponsored by Myogen, Inc. Study completed.

9. Clinical Evaluation of Acorn Cardiac Support Device Therapy in Patients with Dilated Cardiomyopathy – A Randomized Trial in the United States. Sponsored by Acorn Cardiovascular, Inc. Study completed.

10. Randomized, MultiCenter Evaluation of Intravenous Levosimendan Efficacy Versus Placebo in the Short Term Treatment of Decompensated Chronic Heart Failure – The REVIVE Study. Sponsored by Orion Pharma.

11. Multicenter, Double-Blind, Placebo-Controlled, Randomized Trial to Evaluate the Effect of Extended Release Metoprolol Succinate (Toprol-XL) on Cardiac Remodeling in Asymptomatic Heart Failure Patients with Left Ventricular Dysfunction – The REVERT Study. Sponsored by Astra-Zeneca.

12. Irbesartan in Heart Failure with Preserved Systolic Function (I-PRESERVE). Sponsored by Bristol-Myers Squibb and Sanofi-Synthelabo. Study completed.

13. A Randomized, Double-Blind, Placebo-controlled, Multicenter Parallel Group Phase III Study Measuring Effects on Intima Media Thickness: an Evaluation Of Rosuvastatin 40 mg (METEOR). Sponsored by Astra-Zeneca. Study completed.

14. A Phase II-III Prospective, Randomized, Double-Blind, Placebo-controlled Efficacy and Safety of Oxypurinol added to Standard Thrapy in Patients with NYHA Class III-IV Congestive Heart Failure (The OPT-CHF Trial). Sponsored by Cardiome-Pharma. Study completed.

15. Phase 3, Multi-Center, Double-Blind, Randomized, Parallel Group, Carotid B-Mode Ultrasound Evaluation of the Anti-Atherosclerosis Efficacy, Safety, and Tolerability of Fixed Combination CP-529,414 (torcetrapib, a CETP inhibitor)/Atorvastatin, Administered Orally, Once Daily (QD) for 24 Months, Compared with Atorvastatin Alone, in Subjects with Mixed Hyperlipidemia. Sponsored by Pfizer. Study stopped.

16. A phase III, double-blind, randomized placebo-controlled study to evaluate the effects of RO4607381 (Dalcetrapid, a CETP Inhibitor) on cardiovascular (CV) risk in stable Coronary Heart Disease (CHD) patients with a documented recent acute coronary syndrome (ACS). Sponsored by F. Hoffman – La Roche.

17. Treatment of Preserved Cardiac function heart failure with an Aldosterone antagonist (TOPCAT). Multi-center, international, randomized, double blind placebo-controlled trial of the aldosterone antagonist, spironolactone. Sponsored by the National Heart, Lung, and Blood Institute of the National Institutes of Health (NIH).

August [redacted]

[redacted], M.D.
[redacted]

RE: [redacted]
Date of Birth: [redacted]
Social Security Number: [redacted]
Date of Examination: August [redacted]
Claim Number: [redacted]
Employer: [redacted]
Date of Injury: [redacted]

Dear Dr. Silver:

I. INTRODUCTION

The patient, Ms. [redacted] was seen and examined by me on August [redacted] for a cardiovascular evaluation requested by you regarding recurrent syncope. This evaluation, record review and report was authorized by [redacted] of [redacted] Insurance as per [redacted], R.N. I personally spent approximately 75 minutes with the patient as well as approximately 15 minutes with Ms. [redacted].

II. HISTORY

The patient was personally interviewed and examined by me. Details of her past employment and medical history, social and family history, and review of symptoms were obtained. Medical records were reviewed covering the period from [redacted] through [redacted] as well as a neurological evaluation from [redacted]. There are approximately 22 pages.

The applicant is a [redacted] year-old white [redacted] who slipped and fell on February [redacted] while at work. She recalls having pain in most areas of her body right away although had no fractures, and has had "chronic neck and back pain and headaches" since. She was diagnosed with fibromyalgia in September [redacted] when she had worsening recurrent throbbing pains in her arms, back and legs and also has had chronic insomnia and depression. She was placed on disability approximately one year after her injury.

She recalls experiencing syncope for the first time in the late summer of [redacted], possibly in September, when she was living in a tent in her backyard due to earthquake damage to her house

and inability to pay her bills. She had just stood up after sitting for a while on a stool and went to open up a heavy lid of a large chest with her left arm. While she was holding this heavy lid with her left arm upstretched, she started seeing "gray speckles" in the periphery of her visual field with a gradually worsening tunnel vision and lightheadedness followed by blacking out. She fell to the ground and the lid of the chest hit her on the left forehead. She does not know how long she lost consciousness for. She does not recall any palpitations, chest pain, or shortness of breath either prior to or right after the event. She started having similar type episodes around once every three months with a gradually increasing frequency of up to 5 or 6 episodes per month over the past several months. She estimates she has had approximately 100 syncopal episodes in the last four years as well as uncountable near-syncopal episodes. Her last episode occurred three days ago, on Saturday, August [redacted]. She was walking at home from the kitchen (after she had been sitting on a stool) to her bedroom using her cane for support when she experienced the "gray speckles" for about five seconds followed by lightheadedness and then frank syncope. She does not know exactly how long she was unconscious on the ground but does not think it was for "too long."

She admits to gradually worsening general memory and that she cannot quite always recall all of the details about most of her episodes. She has noted a general association between most of these episodes and getting up from a sitting or supine position. She does not recall any of the episodes being associated with diaphoresis, nausea or vomiting. She has had several episodes of near-syncope when bending over or down to the ground and may have had a few frank syncopal episodes with bending down as well. One syncopal episode occurred while the patient was in the bathtub and several episodes resulted in trauma to different parts of her body. One in particular resulted in what she feels was a significant amount of time of subsequent unconsciousness as she awoke with dried blood on her scalp from a resultant laceration. A few times she has a small amount of urine loss but no frank bowel or bladder incontinence. A few episodes may have been witnessed by others but she does not recall what they may have seen. She does not know of any tonic-clonic movements being witnessed or foaming at the mouth. She also has had very frequent falls due to general weakness, lower extremity and/or knee weakness and unsteadiness. These were evaluated by Dr. [redacted] in neurologic consultation last year and felt to be likely due to the patient's generally poor physical condition. She specifically states that her syncopal episodes are different and separate from the falling episodes evaluated by Dr. [redacted].

While she has had intermittent and frequent chest pains associated with movement of her torso and mental stress she has had no chest discomfort associated with exertion. She also has had intermittent dyspnea at times, usually associated with mental stress or asthma exacerbations but not specifically with exertion. She also denies orthopnea. She has awakened at night feeling as if she cannot catch her breath but she recalls all of these episodes being related to night mares. She does have sleep apnea and does wear CPAP an night. There is no family history of sudden cardiac death or syncope or premature coronary artery disease. She denies any history of hypertension, diabetes mellitus or thyroid disease. The patient is quite sedentary which has been the case for the past 4 – 5 years. She recently started on a physical therapy program but has not been able to participate as often as prescribed.

CURRENT MEDICATIONS: Trazodone 50 mg q a.m. & q p.m. and 400 mg qhs.
Neurontin (gabapentin) 600 mg b.i.d.

Wellbutrin (buproprion) 150 mg b.i.d.
Effexor XR (venlafaxine) 150 mg q a.m., 75 mg q p.m.
Prilosec (omeprazole) 20 mg q p.m.
Lorazepam 1 mg p.r.n.
Singulair 10 mg q.d., p.r.n.
Gingo Biloba 120 mg p.r.n.
Neomycin and Polymyxin and hydrocortisone otic solution
Ibuprofen 400 – 800 mg p.r.n.
Multiple vitamin q.d.
Calcium, magnesium, zinc, vitamins C and B12 q.d.
Vioxx and Propulsid were recently discontinued.
Flonase and Vanceril were self discontinued by the patient recently because she ran out of them and cannot afford to refill them.

ALLERGIES: No known drug allergies. Penicillin however has given her altered mental status and bell peppers have caused prolong vomiting and diarrhea.

PAST MEDICAL HISTORY:
-S/P cholecystectomy [redacted]
-Pneumonia [redacted]
-S/P carpal tunnel release [redacted]
-S/P ulnar (right elbow) release [redacted]
-History of chronic neck and lower back pain and headaches since [redacted]
-History of fibromyalgia
-History of psychological disorders
-Degenerative joint disease (osteoarthritis) of both knees
-Sleep apnea
-Possible asthma followed by a pulmonologist

SOCIAL HISTORY:

He has been never married and has no children.

Smoking/Tobacco: She quit smoking 10 years ago after smoking ½ - 2 packs per day off and on over a 20 year period (she estimates for a total of 10 years).

Alcohol: None for several years and rare in the remote past.

WORK HISTORY: The patient started working at [redacted] around September [redacted] as a secretary for the music department. She says she functionally worked as a music

production coordinator and administrator for the music department. She has not been able to work since her injury in February [redacted].

FAMILY HISTORY: Her father died at age 78 of "congestive heart failure" and "long-term effects of WWII injuries"; her mother is age 80 with no specific medical illnesses. She has two brothers, age [redacted] with high cholesterol and age [redacted] with a "heart condition" of which she knows no details.

PERTINENT REVIEW OF SYSTEMS:

General: No significant change in weight or appetite. Chronic insomnia for several years; no documented recurrent fevers, but the patient has had vague occasional chills and possibly night sweats.

Head and Neck: Chronic headaches, neck pain and stiffness.

Skin: No recent itching, rashes, sores or change in moles.

Respiratory: Occasional dry cough improved with inhaled steroids but no hemoptysis. No recent audible wheezing. Occasional short-lived shortness or breath related to mental stress but also sometimes responsive to inhalers.

Cardiovascular: As per history. No history of rheumatic fever, endocarditis, or a heart murmur.

Gastrointestinal: She has had intermittent nausea, vomiting, and "heartburn" as well as both constipation and diarrhea.

Genitourinary: Still actively menstruating.

Hemilymphatic: No swollen glands, easy bruising or bleeding.

Musculoskeletal: Multiple different complaints.

Neurological: Significantly positive related to multiple musculoskeletal complaints but no history of TIA or CVA.

Endocrine: No polyuria, polydypsea, polyphagia.

III. PRESENTING COMPLAINT(S)

The patient wants to make sure that she does not have a problem with her heart leading to her recurrent fainting episodes.

IV. EXAMINATION

GENERAL:	The applicant was a well-developed and obese female in no acute distress. Height: [redacted] weight [redacted] lbs; Body Mass Index (BMI): 40.
VITAL SIGNS:	Supine pulse: 72/minute and regular with a blood pressure in the right arm of 110/80 mm Hg; blood pressure sitting upright right arm: 92/palpable with 30 seconds of lightheadedness; blood pressure right arm standing was 94/70 mm Hg with a pulse of 78/minute and transient lightheadedness; Respiratory rate: 16; Oral temperature: 98.0 °F
HEENT:	Normocephalic, atraumatic; extraocular movements intact; pupils equal, round and reactive to light; fundi not well seen but grossly with flat discs and no hemorrhages, exudates or AV nicking.
NECK:	Supple with full range of motion. No lymphadenopathy, palpable thyroid or nodules.
CHEST:	Symmetrical
LUNGS:	Clear to ausculatation and percussion with no rales, wheezes or rhonchi.
CARDIOVASCULAR:	Jugular venous pressure estimated at 7 cm. PMI non-displaced, no heaves, lifts, or thrills. Regular rate and rhythm with normal S1 and normal physiologically split S2. No murmurs, rubs, gallops, or clicks. Carotid upstrokes are full with no audible bruits. Pulses are full throughout with no bruits.
ABDOMEN:	Obese with normoactive bowel sounds. Soft and non-tender with no organomegaly nor masses. No palpable abdominal aortic aneurysm or auscultated bruits.
EXTREMITIES:	No cyanosis, clubbing or edema

V. X-RAY AND LABORATORY

An electrocardiogram and chest x-ray were authorized by [redacted], R.N. The ECG showed normal sinus rhythm and late R-wave progression (probably a normal variant for body habitus) with otherwise normal QRS axis and intervals and was otherwise normal. A chest radiograph revealed no acute cardiopulmonary abnormalities, no interstitial edema or cardiomegaly.

VI. IMPRESSION:

A. DIAGNOSES:

1) Recurrent **syncope** most likely due to **orthostatic hypotension**. Given no increase in the pulse with standing, there is no reason to suspect intravascular volume depletion or dehydration. The most likely explanation would be autonomic dysfunction or a central autonomic neuropathy. The patient recalls her syncopal episodes starting prior to being on trazodone but she cannot recall with certainty. Trazodone has been reported to be associated with orthostatic hypotension and/or syncope and thus needs to be strongly considered as a possible etiology. Also quite possible is autonomic dysfunction with resultant orthostasis due to a prolonged and profound sedentary lifestyle. While usually this has been described in patients with several days or weeks of mostly bed rest, this patient's severe degree of inactivity certainly could be contributing. Whether the patient's recurrent syncope could be part of a more profound disorder such as neurocardiogenic (or vasodepressor) syncope cannot be definitively excluded but also needs to be considered. There is no evidence for any significant valvular disease by cardiac exam but the patient's obesity may make adequate auscultation difficult. A brady- or tachyarrhythmia need to also be considered on the differential especially in light of the patient's underlying sleep apnea which can increase the risk of dysrhythmias. There is no reason currently to consider myocardial ischemia or coronary artery disease as clinically relevant at this time.

   Whether her syncope is a true "cardiac" health problem cannot be determined without further diagnostic testing and reevaluation of the patient's response to my recommendations. As the patient's syncope might be related to a medication (or treatment) for her work-related injury or due to inactivity subsequent to her work-related injury, it is possible that her syncope may be indirectly related to her injury of February [redacted].

2) Morbid obesity.

3) History of fibromyalgia.

4) History of depression.

5) History of sleep apnea.

6) History of asthma.

B. RECOMMENDATIONS FOR FURTHER WORK-UP AND TREATMENT:

1) 24-hour ambulatory Holter monitor to exclude any significant arrhythmias (authorized and approved by [redacted], R.N. today and the patient was hooked up).
2) Trans-thoracic two-dimensional echocardiogram to exclude any underlying structural heart disease.
3) Consider a trial off of trazodone if otherwise clinically feasible and felt to be safe by Dr. [redacted] to see if the patient's postural lightheadedness improves and/or her syncope becomes less frequent.
4) Consider a trial of TED hose compression stockings to see if prevention of venous pooling in the lower extremities might help decrease the risk of recurrent syncope. The patient should wear these before getting out of bed in the morning and not remove them until secure in bed at night.
5) Encourage the patient to continue on with her physical therapy program. She was also advised to rise very slowly from supine or sitting positions and make sure she is steady with no lightheadedness prior to proceeding with ambulation.
6) I would not consider other medical intervention with agents such as ProAmantine (midodrine, an alpha agonist), Florinef (fludrocortisone), or theophylline at this time although they may need to be considered later. A beta-blocker would be contraindicated given her history of asthma.

If the Holter monitor were negative and the patient continued to have recurrent syncope off of trazodone and while wearing TED hose then an event-recorder with loop memory might be necessary to exclude a dangerous dysrhythmia. If the patient were to have a typical syncopal episode while wearing the Holter however and no dysrhythmia were seen than an event recorder would not be necessary. Likewise, given definite orthostatic changes on current physical exam, a tilt-table test would be unlikely to add any information at this time. I would recommend that I reevaluate her in one to two months after results of the Holter monitor and a 2D echo were done.

VII. DISCLOSURE

The above assessment and report is for medical-legal purposes only. It is not to be construed as a complete medical history or physical examination for general health purposes.

I declare under penalty of perjury that the information contained in this report, and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I may have indicated receiving from others. As to that information, I declare under penalty of perjury

that the information accurately describes the information provided me and, except as noted herein, I believe it to be true.

Respectfully yours,

Mark K. Urman, M.D., F.A.C.C.
Assistant Clinical Professor of Medicine
U.C.L.A. School of Medicine

Cc: [redacted]

[redacted]

April [redacted]

[redacted], Esq.
[redacted] A.P.C.
[redacted]

RE: [redacted] et al., Case No. [redacted] (RNBx) (C.D.Cal.)

Dear Mr. [redacted]:

As per your request, and pursuant to Federal Rule of Civil Procedure 26(a)(2)(B), this letter represents my expert medical opinion based on the information provided to me thus far. As you know, but for the record, I have not yet personally interviewed or examined Ms. [redacted] as of today's date. Likewise, there still may be other medical records which will be subsequently available for my review. This report will first summarize the events noted in the records provided to me last month and a few days ago.

The first record is a new patient cardiovascular evaluation dictated by Dr. [redacted] from [redacted] when Mrs. [redacted] (hereafter referred to as "the patient") was seen at [redacted] Physicians Medical Group. The patient presented as a [redacted] year-old female presenting with a six-month history of chest pains. There was a history of hyperactive airway disease from May of June of [redacted] which were treated with Proventil and Aerobid inhalers. She had intermittent chest discomfort with her respiratory difficulty which she assumed were related but the chest pains continued off and on even after her breathing difficulties improved. She reported chest pain after eating and walking. In the few weeks prior to this evaluation of [redacted] she was having more frequent and longer-lasting episodes. The pains would radiate to the left side and felt like tightness at times occasionally accompanied by nausea and dyspnea. She had a past medical history of "borderline" hypertension which was controlled with salt reduction. The family history was notable for her mother dying of a heart attack at age 65 and her father had been a diabetic. Her blood pressure was 154/90 but the cardiac exam was otherwise unremarkable. An electrocardiogram was interpreted as revealing evidence of an anteroseptal infarction "probably in the recent past." An old EKG from [redacted] reportedly did not reveal evidence of an anteroseptal infarction. Dr. [redacted]'s impression was that the patient had had a recent anteroseptal infarction with recurrent angina and mild hypertension. He recommended that the patient start on diltiazem, oral nitrates and aspirin. An echocardiogram was planned with possible coronary angiogram if her anginal symptoms were not controlled by medications. A chest radiograph from [redacted] reportedly was normal.

As per a history and physical examination dictation by Dr. [redacted] from [redacted], the echocardiogram confirmed an anteroseptal infarction. The patient could not tolerate diltiazem because of dizziness. Thus she proceeded with a coronary angiogram at [redacted]

Hospital in [redacted] on [redacted] by Dr. [redacted] which revealed a total occlusion of the proximal left anterior descending (LAD) coronary artery "just at the origin of the diagonal and septal branches." Right-to-left collaterals were present and the left circumflex coronary artery (LCx) and right coronary artery (RCA) did not have angiographic stenoses. Left ventriculography revealed hypokinesia of the anteroapical wall. The patient was seen by Dr. [redacted], a cardiac surgeon who agreed with proceeding with percutaneous transluminal coronary angioplasty (PTCA) of the LAD. According to the second cardiac catheterization report and discharge summary of the hospitalization, the patient underwent an angioplasty on [redacted] which was successful and the patient was discharged on [redacted] and prescribed Procardia XL (nifedipine) and aspirin. Electrocardiograms from [redacted] and [redacted] both reveal a QS in V1, V2 and V3 with inverted T-waves in leads V1 – V4 and a flat T-wave in V5 all consistent with a prior anteroseptal myocardial infarction. The EKG from [redacted] showed a qRS in V3 but was otherwise without significant change from the two prior tracings.

The patient complained of continued intermittent chest tightness when she saw Dr. [redacted] on [redacted]. She underwent a nuclear medicine myocardial perfusion exercise scan on [redacted] which revealed anterior and apical wall myocardial ischemia. As per a history and physical dictation by Dr. [redacted] on [redacted], the patient continued to have chest tightness, with and without exertion and sometimes postprandial. The patient underwent another coronary angiogram on [redacted] by Dr. [redacted] which showed "luminal irregularities and plaquing" of the proximal LAD with a "mild area of narrowing approximately 20-25% with distal flow." The diagonal branch of the LAD was reported as a small vessel but with a high grade stenosis at its origin with sluggish flow. It was recommended that the patient be managed medically. The patient started in a cardiac rehabilitation program at [redacted] Hospital in late January [redacted]. She was reported to have chest tightness both with and without exertion during her program. Lab results from [redacted] revealed a total cholesterol of 207, triglycerides 182, HDL 69, and LDL of 109. She was seen on [redacted] (I cannot make out the signature of the physician) and reportedly was "doing well" with no tightness on exertion. However, a cardiac rehabilitation note from [redacted] notes that the patient has "chest tightness with exercise." Also noted is "one notable EKG change." The patient complained of mild chest tightness and left arm pain during an exercise stress test on [redacted], although the myocardial perfusion study was "normal" according to an office note of [redacted]. At the appointment on [redacted] and again on [redacted] the patient continued to complain of "recurrent episodes of angina associated with generalized fatigue." Dr. [redacted] prescribed Tenormin (atenolol) 25 mg daily on [redacted].

She continued to have chest pain after the Tenormin was increased to 50 mg and a nuclear myocardial perfusion exercise stress test study was done on [redacted] which was read as normal. The patient was seen on [redacted] by, I believe Dr. [redacted], and given the normal nuclear study and the continued symptoms, vasospastic angina was considered as a possible diagnosis. Based on an "Attending Physician's Statement" signed by Dr. N. [redacted] the patient was partially disabled from [redacted] until [redacted] and then totally disabled due to "mild angina on exertion and with mental stress." At that time, the patient's daily medications included Procardia XL (nifedipine) 30 mg, Tenormin

(atenolol) 12.5 mg, baby aspirin 3 times a week, Premarin, Provera, and a Ventolin inhaler. An electrocardiogram from [redacted] is notable for evidence of an old anteroseptal infarct without any significant ST-T wave abnormalities.

The next note from a physician is from [redacted] when the patient saw Dr. [redacted] who thought her cardiac status was stable. She was then seen by Dr. [redacted] on [redacted] who recommended stopping the Procardia XL even though the patient did have occasional left arm discomfort which was not related to physical exertion. The patient had a treadmill stress test with myocardial perfusion imaging the latter of which was normal on [redacted]. The patient was seen by Dr. [redacted] on [redacted] when she complained of the beta-blocker giving her "somewhat of a fuzzy feeling with fuzzy thinking at times." She otherwise was tolerating being off of the Procardia XL and the Tenormin was decreased to 25 mg as the physician wished to keep the patient on at least a low-dose of a beta-blocker. When seen on [redacted], the patient apparently said that "her thinking ability seems to have improved significantly with the decrease in her beta-blockers and the elimination of the calcium blockers." She denied chest pain but had some dyspnea on exertion. A note from Dr. [redacted] to Dr. [redacted] on [redacted] reports that the patient had been under a great deal of emotional stress lately and was having episodic chest and left arm pain. The patient underwent another nuclear myocardial perfusion stress test on [redacted] at which time she reached only 83% of maximum predicted heart rate for her age. The myocardial perfusion was normal. An echocardiogram from the same day was read as normal.

The patient was seen by Dr. [redacted] of the [redacted] of [redacted] on [redacted]. His history mentions that the patient first had episodic chest pain radiating to her left arm with shortness of breath and nausea while on vacation in late [redacted]. It was after this that she was first evaluated with evidence of changes on her EKG. Also mentioned is that she had had peripheral edema from Procardia in the past and that both diltiazem and Procardia had given her difficulty in concentrating. She had similar feelings of a "window screen" between her and her thoughts on atenolol but it was less intense. On physical exam, her blood pressure was 140/80 and an "intermittent click" was heard. Dr. [redacted]'s impression was that the patient had a "syndrome consistent with ischemic pain." He mentioned that she had known coronary artery disease and that even without significant angiographic evidence of obstruction at the last coronary angiogram, he suspected that she had "Syndrome X." He felt her anti-anginal medications were impacting her mental acuity. He felt that the patient may have vasospastic angina to some degree and it was his feeling that she "clearly has an inability at this point to function in her stated profession."

The patient had no complaints when she saw Dr. [redacted] on [redacted] but did report to "continue to have some chest pressure and tightness in association with physical exertion" and she also still complained of "a sensation of fatigue and lethargy related to the beta-blockers." At her doctor's visit with Dr. [redacted] on [redacted], she complained of shortness of breath and on [redacted] she stated that she "continues to have episodes of chest discomfort when exposed to stressful situations, high humidity or pollutants." A letter from Dr. [redacted] on [redacted] stated that Mrs. [redacted] had a cardiac condition which

made her unable to serve as a juror. At her appointment on [redacted], Dr. [redacted] noted that she continued to have intermittent chest pain but she was clinically stable. She had similar symptoms when seen on [redacted] and a "very soft fourth heart sound" was heard by Dr. [redacted] on exam. She had another nuclear stress test on [redacted] which was interpreted as normal. She was started on Zocor (simvastatin) by Dr. [redacted] on [redacted].

The patient was evaluated by Dr. [redacted] of [redacted] Specialists on [redacted] as an independent medical examiner. The patient had complaints of chest pain while she was being examined and an EKG was done which Dr. [redacted] stated "showed no acute changes." In his discussion, Dr. [redacted] thought that most of her symptoms were "subjective and do not have any organic basis at this time." He also thought that her ability to play bridge but not concentrate while performing her job were "opposing" facts. It was his conclusion that Mrs. [redacted] was not disabled from a cardiac stand point. He also stated that "stress as a contributing factor for heart disease has never been borne out in several studies, except in relationship to fireman and policeman." An exercise stress test was done on [redacted] by Dr. [redacted] which was interpreted as borderline for ischemia and the patient did complain of some substernal chest discomfort "consistent with mild angina pectoris."

A copy of the deposition of Dr. [redacted] was provided for me and also reviewed.

After review of the records provided for me thus far and without having actually interviewed or examined Mrs. [redacted], my medical impression is as follows:

(1) Coronary artery disease, status post anteroseptal myocardial infarction during the latter part of [redacted].

(2) Status post percutaneous transluminal coronary angioplasty (PTCA) of the left anterior descending (LAD) coronary artery [redacted]. Evidence of significant obstructive disease of a diagonal branch at repeat coronary angiography on [redacted]. This may have been caused by "plaque shifting" during the angioplasty the prior month. No significant obstruction in the LAD itself on [redacted] but some residual mild stenosis was seen. Interestingly, the nuclear myocardial perfusion study from [redacted] showed reversible defects in the anterior and apical wall which presumably was supplied by the LAD. There is no mention of possible ischemia in the diagonal territory even though that was the area of most significant disease in the post-PTCA angiogram. One possibility, is that any ischemia caused by the diagonal disease was of a relatively small amount and thus not picked up by the nuclear study. It is a well known fact that false positive nuclear studies can occur within 1 – 2 months post PTCA and the anteroapical ischemia seen on the nuclear study ironically may have actually represented this phenomenon. That is, the abnormality objectively seen by the nuclear study was a "false abnormality" so soon after the PTCA of the LAD. Even though no myocardial ischemia was specifically mentioned as being evident in the diagonal territory, it is very

(3) conceivable that even a small amount of myocardial ischemia from the diagonal disease was the true cause of the patient's symptoms.

(4) Essential systemic hypertension.

(5) Family history of premature coronary artery disease, specifically the patient's mother died of a heart attack in her early sixties.

(6) Recurrent chest and left arm tightness and shortness of breath. Very likely is due to coronary vasospasm which has clearly been shown to be provocable by mental stress as well as exercise. This can occur due to coronary artery endothelial dysfunction even with mild atherosclerotic lesions.

(7) Intolerance of different degrees to multiple different anti-ischemic medications. Depression of mental function has been reported with all types of anti-anginal medications and is most notoriously noted for being a potential side effect of beta-blockers. Tenormin (atenolol) is the least lipophilic of the beta-blocker class and is reportedly the least likely to cause central nervous system effects. However, it has been reported to none the less cause general fatigue and vague mental slowing in some patients. While an infrequent side effect, my experience with patients has been that it can clearly be seen at times. On the other hand, beta-blockers have been proven time and again to be cardioprotective in that they decrease the risk of recurrent myocardial infarction and/or death in patients with known coronary artery disease. Thus, it is always considered ideal to continue these medications indefinitely in cardiac patients if at all possible and this practice would be considered the standard of care.

(8) Asthma.

I look forward to the opportunity to interview and examine Mrs. [redacted] Pending my examination, I would plan on using at least a fair amount of the current records that I have seen as exhibits with any possible subsequent depositions or testimony involving me. You already have a copy of my curriculum vitae and my publications as well as my hourly rates for consulting, deposition and trial testimony. To the best of my memory, I have not testified as an expert at trial or by deposition in the last four years.

Respectfully yours,

Mark K. Urman, M.D., F.A.C.C.
Assistant Clinical Professor of Medicine
U.C.L.A. School of Medicine

[redacted]

August [redacted]

[redacted], M.D.
[redacted]

RE: [redacted]
Date of Birth: [redacted]
Social Security Number: [redacted]
Date of Examination: August [redacted]
Claim Number: [redacted]
Employer: [redacted]
Date of Injury: [redacted]

Dear Dr. Silver:

I. INTRODUCTION

The patient, Ms. [redacted] was seen and examined by me on August [redacted] for a cardiovascular evaluation requested by you regarding recurrent syncope. This evaluation, record review and report was authorized by [redacted] of [redacted] Insurance as per [redacted], R.N. I personally spent approximately 75 minutes with the patient as well as approximately 15 minutes with Ms. [redacted].

II. HISTORY

The patient was personally interviewed and examined by me. Details of her past employment and medical history, social and family history, and review of symptoms were obtained. Medical records were reviewed covering the period from [redacted] through [redacted] as well as a neurological evaluation from [redacted]. There are approximately 22 pages.

The applicant is a [redacted] year-old white [redacted] who slipped and fell on February [redacted] while at work. She recalls having pain in most areas of her body right away although had no fractures, and has had "chronic neck and back pain and headaches" since. She was diagnosed with fibromyalgia in September [redacted] when she had worsening recurrent throbbing pains in her arms, back and legs and also has had chronic insomnia and depression. She was placed on disability approximately one year after her injury.

She recalls experiencing syncope for the first time in the late summer of [redacted], possibly in September, when she was living in a tent in her backyard due to earthquake damage to her house

and inability to pay her bills. She had just stood up after sitting for a while on a stool and went to open up a heavy lid of a large chest with her left arm. While she was holding this heavy lid with her left arm upstretched, she started seeing "gray speckles" in the periphery of her visual field with a gradually worsening tunnel vision and lightheadedness followed by blacking out. She fell to the ground and the lid of the chest hit her on the left forehead. She does not know how long she lost consciousness for. She does not recall any palpitations, chest pain, or shortness of breath either prior to or right after the event. She started having similar type episodes around once every three months with a gradually increasing frequency of up to 5 or 6 episodes per month over the past several months. She estimates she has had approximately 100 syncopal episodes in the last four years as well as uncountable near-syncopal episodes. Her last episode occurred three days ago, on Saturday, August [redacted]. She was walking at home from the kitchen (after she had been sitting on a stool) to her bedroom using her cane for support when she experienced the "gray speckles" for about five seconds followed by lightheadedness and then frank syncope. She does not know exactly how long she was unconscious on the ground but does not think it was for "too long."

She admits to gradually worsening general memory and that she cannot quite always recall all of the details about most of her episodes. She has noted a general association between most of these episodes and getting up from a sitting or supine position. She does not recall any of the episodes being associated with diaphoresis, nausea or vomiting. She has had several episodes of near-syncope when bending over or down to the ground and may have had a few frank syncopal episodes with bending down as well. One syncopal episode occurred while the patient was in the bathtub and several episodes resulted in trauma to different parts of her body. One in particular resulted in what she feels was a significant amount of time of subsequent unconsciousness as she awoke with dried blood on her scalp from a resultant laceration. A few times she has a small amount of urine loss but no frank bowel or bladder incontinence. A few episodes may have been witnessed by others but she does not recall what they may have seen. She does not know of any tonic-clonic movements being witnessed or foaming at the mouth. She also has had very frequent falls due to general weakness, lower extremity and/or knee weakness and unsteadiness. These were evaluated by Dr. [redacted] in neurologic consultation last year and felt to be likely due to the patient's generally poor physical condition. She specifically states that her syncopal episodes are different and separate from the falling episodes evaluated by Dr. [redacted].

While she has had intermittent and frequent chest pains associated with movement of her torso and mental stress she has had no chest discomfort associated with exertion. She also has had intermittent dyspnea at times, usually associated with mental stress or asthma exacerbations but not specifically with exertion. She also denies orthopnea. She has awakened at night feeling as if she cannot catch her breath but she recalls all of these episodes being related to night mares. She does have sleep apnea and does wear CPAP an night. There is no family history of sudden cardiac death or syncope or premature coronary artery disease. She denies any history of hypertension, diabetes mellitus or thyroid disease. The patient is quite sedentary which has been the case for the past 4 – 5 years. She recently started on a physical therapy program but has not been able to participate as often as prescribed.

CURRENT MEDICATIONS: Trazodone 50 mg q a.m. & q p.m. and 400 mg qhs.
Neurontin (gabapentin) 600 mg b.i.d.

Wellbutrin (buproprion) 150 mg b.i.d.
Effexor XR (venlafaxine) 150 mg q a.m., 75 mg q p.m.
Prilosec (omeprazole) 20 mg q p.m.
Lorazepam 1 mg p.r.n.
Singulair 10 mg q.d., p.r.n.
Gingo Biloba 120 mg p.r.n.
Neomycin and Polymyxin and hydrocortisone otic solution
Ibuprofen 400 – 800 mg p.r.n.
Multiple vitamin q.d.
Calcium, magnesium, zinc, vitamins C and B12 q.d.
Vioxx and Propulsid were recently discontinued.
Flonase and Vanceril were self discontinued by the patient recently because she ran out of them and cannot afford to refill them.

ALLERGIES: No known drug allergies. Penicillin however has given her altered mental status and bell peppers have caused prolong vomiting and diarrhea.

PAST MEDICAL HISTORY:
-S/P cholecystectomy [redacted]
-Pneumonia [redacted]
-S/P carpal tunnel release [redacted]
-S/P ulnar (right elbow) release [redacted]
-History of chronic neck and lower back pain and headaches since [redacted]
-History of fibromyalgia
-History of psychological disorders
-Degenerative joint disease (osteoarthritis) of both knees
-Sleep apnea
-Possible asthma followed by a pulmonologist

SOCIAL HISTORY:

He has been never married and has no children.

Smoking/Tobacco: She quit smoking 10 years ago after smoking ½ - 2 packs per day off and on over a 20 year period (she estimates for a total of 10 years).

Alcohol: None for several years and rare in the remote past.

WORK HISTORY: The patient started working at [redacted] around September [redacted] as a secretary for the music department. She says she functionally worked as a music

production coordinator and administrator for the music department. She has not been able to work since her injury in February [redacted].

FAMILY HISTORY: Her father died at age 78 of "congestive heart failure" and "long-term effects of WWII injuries"; her mother is age 80 with no specific medical illnesses. She has two brothers, age [redacted] with high cholesterol and age [redacted] with a "heart condition" of which she knows no details.

PERTINENT REVIEW OF SYSTEMS:

General: No significant change in weight or appetite. Chronic insomnia for several years; no documented recurrent fevers, but the patient has had vague occasional chills and possibly night sweats.

Head and Neck: Chronic headaches, neck pain and stiffness.

Skin: No recent itching, rashes, sores or change in moles.

Respiratory: Occasional dry cough improved with inhaled steroids but no hemoptysis. No recent audible wheezing. Occasional short-lived shortness or breath related to mental stress but also sometimes responsive to inhalers.

Cardiovascular: As per history. No history of rheumatic fever, endocarditis, or a heart murmur.

Gastrointestinal: She has had intermittent nausea, vomiting, and "heartburn" as well as both constipation and diarrhea.

Genitourinary: Still actively menstruating.

Hemilymphatic: No swollen glands, easy bruising or bleeding.

Musculoskeletal: Multiple different complaints.

Neurological: Significantly positive related to multiple musculoskeletal complaints but no history of TIA or CVA.

Endocrine: No polyuria, polydypsea, polyphagia.

III. PRESENTING COMPLAINT(S)

The patient wants to make sure that she does not have a problem with her heart leading to her recurrent fainting episodes.

IV. EXAMINATION

GENERAL:	The applicant was a well-developed and obese female in no acute distress. Height: [redacted] weight [redacted] lbs; Body Mass Index (BMI): 40.
VITAL SIGNS:	Supine pulse: 72/minute and regular with a blood pressure in the right arm of 110/80 mm Hg; blood pressure sitting upright right arm: 92/palpable with 30 seconds of lightheadedness; blood pressure right arm standing was 94/70 mm Hg with a pulse of 78/minute and transient lightheadedness; Respiratory rate: 16; Oral temperature: 98.0 °F
HEENT:	Normocephalic, atraumatic; extraocular movements intact; pupils equal, round and reactive to light; fundi not well seen but grossly with flat discs and no hemorrhages, exudates or AV nicking.
NECK:	Supple with full range of motion. No lymphadenopathy, palpable thyroid or nodules.
CHEST:	Symmetrical
LUNGS:	Clear to ausculatation and percussion with no rales, wheezes or rhonchi.
CARDIOVASCULAR:	Jugular venous pressure estimated at 7 cm. PMI non-displaced, no heaves, lifts, or thrills. Regular rate and rhythm with normal S1 and normal physiologically split S2. No murmurs, rubs, gallops, or clicks. Carotid upstrokes are full with no audible bruits. Pulses are full throughout with no bruits.
ABDOMEN:	Obese with normoactive bowel sounds. Soft and non-tender with no organomegaly nor masses. No palpable abdominal aortic aneurysm or auscultated bruits.
EXTREMITIES:	No cyanosis, clubbing or edema

V. X-RAY AND LABORATORY

An electrocardiogram and chest x-ray were authorized by [redacted], R.N. The ECG showed normal sinus rhythm and late R-wave progression (probably a normal variant for body habitus) with otherwise normal QRS axis and intervals and was otherwise normal. A chest radiograph revealed no acute cardiopulmonary abnormalities, no interstitial edema or cardiomegaly.

VI. IMPRESSION:

A. DIAGNOSES:

1) Recurrent **syncope** most likely due to **orthostatic hypotension**. Given no increase in the pulse with standing, there is no reason to suspect intravascular volume depletion or dehydration. The most likely explanation would be autonomic dysfunction or a central autonomic neuropathy. The patient recalls her syncopal episodes starting prior to being on trazodone but she cannot recall with certainty. Trazodone has been reported to be associated with orthostatic hypotension and/or syncope and thus needs to be strongly considered as a possible etiology. Also quite possible is autonomic dysfunction with resultant orthostasis due to a prolonged and profound sedentary lifestyle. While usually this has been described in patients with several days or weeks of mostly bed rest, this patient's severe degree of inactivity certainly could be contributing. Whether the patient's recurrent syncope could be part of a more profound disorder such as neurocardiogenic (or vasodepressor) syncope cannot be definitively excluded but also needs to be considered. There is no evidence for any significant valvular disease by cardiac exam but the patient's obesity may make adequate auscultation difficult. A brady- or tachyarrhythmia need to also be considered on the differential especially in light of the patient's underlying sleep apnea which can increase the risk of dysrhythmias. There is no reason currently to consider myocardial ischemia or coronary artery disease as clinically relevant at this time.

   Whether her syncope is a true "cardiac" health problem cannot be determined without further diagnostic testing and reevaluation of the patient's response to my recommendations. As the patient's syncope might be related to a medication (or treatment) for her work-related injury or due to inactivity subsequent to her work-related injury, it is possible that her syncope may be indirectly related to her injury of February [redacted].

2) Morbid obesity.

3) History of fibromyalgia.

4) History of depression.

5) History of sleep apnea.

6) History of asthma.

B. RECOMMENDATIONS FOR FURTHER WORK-UP AND TREATMENT:

1) 24-hour ambulatory Holter monitor to exclude any significant arrhythmias (authorized and approved by [redacted], R.N. today and the patient was hooked up).
2) Trans-thoracic two-dimensional echocardiogram to exclude any underlying structural heart disease.
3) Consider a trial off of trazodone if otherwise clinically feasible and felt to be safe by Dr. [redacted] to see if the patient's postural lightheadedness improves and/or her syncope becomes less frequent.
4) Consider a trial of TED hose compression stockings to see if prevention of venous pooling in the lower extremities might help decrease the risk of recurrent syncope. The patient should wear these before getting out of bed in the morning and not remove them until secure in bed at night.
5) Encourage the patient to continue on with her physical therapy program. She was also advised to rise very slowly from supine or sitting positions and make sure she is steady with no lightheadedness prior to proceeding with ambulation.
6) I would not consider other medical intervention with agents such as ProAmantine (midodrine, an alpha agonist), Florinef (fludrocortisone), or theophylline at this time although they may need to be considered later. A beta-blocker would be contraindicated given her history of asthma.

If the Holter monitor were negative and the patient continued to have recurrent syncope off of trazodone and while wearing TED hose then an event-recorder with loop memory might be necessary to exclude a dangerous dysrhythmia. If the patient were to have a typical syncopal episode while wearing the Holter however and no dysrhythmia were seen than an event recorder would not be necessary. Likewise, given definite orthostatic changes on current physical exam, a tilt-table test would be unlikely to add any information at this time. I would recommend that I reevaluate her in one to two months after results of the Holter monitor and a 2D echo were done.

VII. DISCLOSURE

The above assessment and report is for medical-legal purposes only. It is not to be construed as a complete medical history or physical examination for general health purposes.

I declare under penalty of perjury that the information contained in this report, and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I may have indicated receiving from others. As to that information, I declare under penalty of perjury

that the information accurately describes the information provided me and, except as noted herein, I believe it to be true.

Respectfully yours,

Mark K. Urman, M.D., F.A.C.C.
Assistant Clinical Professor of Medicine
U.C.L.A. School of Medicine

Cc: [redacted]

[redacted]

April [redacted]

[redacted], Esq.
[redacted] A.P.C.
[redacted]

RE: [redacted] et al., Case No. [redacted] (RNBx) (C.D.Cal.)

Dear Mr. [redacted]:

As per your request, and pursuant to Federal Rule of Civil Procedure 26(a)(2)(B), this letter represents my expert medical opinion based on the information provided to me thus far. As you know, but for the record, I have not yet personally interviewed or examined Ms. [redacted] as of today's date. Likewise, there still may be other medical records which will be subsequently available for my review. This report will first summarize the events noted in the records provided to me last month and a few days ago.

The first record is a new patient cardiovascular evaluation dictated by Dr. [redacted] from [redacted] when Mrs. [redacted] (hereafter referred to as "the patient") was seen at [redacted] Physicians Medical Group. The patient presented as a [redacted] year-old female presenting with a six-month history of chest pains. There was a history of hyperactive airway disease from May of June of [redacted] which were treated with Proventil and Aerobid inhalers. She had intermittent chest discomfort with her respiratory difficulty which she assumed were related but the chest pains continued off and on even after her breathing difficulties improved. She reported chest pain after eating and walking. In the few weeks prior to this evaluation of [redacted] she was having more frequent and longer-lasting episodes. The pains would radiate to the left side and felt like tightness at times occasionally accompanied by nausea and dyspnea. She had a past medical history of "borderline" hypertension which was controlled with salt reduction. The family history was notable for her mother dying of a heart attack at age 65 and her father had been a diabetic. Her blood pressure was 154/90 but the cardiac exam was otherwise unremarkable. An electrocardiogram was interpreted as revealing evidence of an anteroseptal infarction "probably in the recent past." An old EKG from [redacted] reportedly did not reveal evidence of an anteroseptal infarction. Dr. [redacted]'s impression was that the patient had had a recent anteroseptal infarction with recurrent angina and mild hypertension. He recommended that the patient start on diltiazem, oral nitrates and aspirin. An echocardiogram was planned with possible coronary angiogram if her anginal symptoms were not controlled by medications. A chest radiograph from [redacted] reportedly was normal.

As per a history and physical examination dictation by Dr. [redacted] from [redacted], the echocardiogram confirmed an anteroseptal infarction. The patient could not tolerate diltiazem because of dizziness. Thus she proceeded with a coronary angiogram at [redacted]

Hospital in [redacted] on [redacted] by Dr. [redacted] which revealed a total occlusion of the proximal left anterior descending (LAD) coronary artery "just at the origin of the diagonal and septal branches." Right-to-left collaterals were present and the left circumflex coronary artery (LCx) and right coronary artery (RCA) did not have angiographic stenoses. Left ventriculography revealed hypokinesia of the anteroapical wall. The patient was seen by Dr. [redacted], a cardiac surgeon who agreed with proceeding with percutaneous transluminal coronary angioplasty (PTCA) of the LAD. According to the second cardiac catheterization report and discharge summary of the hospitalization, the patient underwent an angioplasty on [redacted] which was successful and the patient was discharged on [redacted] and prescribed Procardia XL (nifedipine) and aspirin. Electrocardiograms from [redacted] and [redacted] both reveal a QS in V1, V2 and V3 with inverted T-waves in leads V1 – V4 and a flat T-wave in V5 all consistent with a prior anteroseptal myocardial infarction. The EKG from [redacted] showed a qRS in V3 but was otherwise without significant change from the two prior tracings.

The patient complained of continued intermittent chest tightness when she saw Dr. [redacted] on [redacted]. She underwent a nuclear medicine myocardial perfusion exercise scan on [redacted] which revealed anterior and apical wall myocardial ischemia. As per a history and physical dictation by Dr. [redacted] on [redacted], the patient continued to have chest tightness, with and without exertion and sometimes postprandial. The patient underwent another coronary angiogram on [redacted] by Dr. [redacted] which showed "luminal irregularities and plaquing" of the proximal LAD with a "mild area of narrowing approximately 20-25% with distal flow." The diagonal branch of the LAD was reported as a small vessel but with a high grade stenosis at its origin with sluggish flow. It was recommended that the patient be managed medically. The patient started in a cardiac rehabilitation program at [redacted] Hospital in late January [redacted]. She was reported to have chest tightness both with and without exertion during her program. Lab results from [redacted] revealed a total cholesterol of 207, triglycerides 182, HDL 69, and LDL of 109. She was seen on [redacted] (I cannot make out the signature of the physician) and reportedly was "doing well" with no tightness on exertion. However, a cardiac rehabilitation note from [redacted] notes that the patient has "chest tightness with exercise." Also noted is "one notable EKG change." The patient complained of mild chest tightness and left arm pain during an exercise stress test on [redacted], although the myocardial perfusion study was "normal" according to an office note of [redacted]. At the appointment on [redacted] and again on [redacted] the patient continued to complain of "recurrent episodes of angina associated with generalized fatigue." Dr. [redacted] prescribed Tenormin (atenolol) 25 mg daily on [redacted].

She continued to have chest pain after the Tenormin was increased to 50 mg and a nuclear myocardial perfusion exercise stress test study was done on [redacted] which was read as normal. The patient was seen on [redacted] by, I believe Dr. [redacted], and given the normal nuclear study and the continued symptoms, vasospastic angina was considered as a possible diagnosis. Based on an "Attending Physician's Statement" signed by Dr. N. [redacted] the patient was partially disabled from [redacted] until [redacted] and then totally disabled due to "mild angina on exertion and with mental stress." At that time, the patient's daily medications included Procardia XL (nifedipine) 30 mg, Tenormin

(atenolol) 12.5 mg, baby aspirin 3 times a week, Premarin, Provera, and a Ventolin inhaler. An electrocardiogram from [redacted] is notable for evidence of an old anteroseptal infarct without any significant ST-T wave abnormalities.

The next note from a physician is from [redacted] when the patient saw Dr. [redacted] who thought her cardiac status was stable. She was then seen by Dr. [redacted] on [redacted] who recommended stopping the Procardia XL even though the patient did have occasional left arm discomfort which was not related to physical exertion. The patient had a treadmill stress test with myocardial perfusion imaging the latter of which was normal on [redacted]. The patient was seen by Dr. [redacted] on [redacted] when she complained of the beta-blocker giving her "somewhat of a fuzzy feeling with fuzzy thinking at times." She otherwise was tolerating being off of the Procardia XL and the Tenormin was decreased to 25 mg as the physician wished to keep the patient on at least a low-dose of a beta-blocker. When seen on [redacted], the patient apparently said that "her thinking ability seems to have improved significantly with the decrease in her beta-blockers and the elimination of the calcium blockers." She denied chest pain but had some dyspnea on exertion. A note from Dr. [redacted] to Dr. [redacted] on [redacted] reports that the patient had been under a great deal of emotional stress lately and was having episodic chest and left arm pain. The patient underwent another nuclear myocardial perfusion stress test on [redacted] at which time she reached only 83% of maximum predicted heart rate for her age. The myocardial perfusion was normal. An echocardiogram from the same day was read as normal.

The patient was seen by Dr. [redacted] of the [redacted] of [redacted] on [redacted]. His history mentions that the patient first had episodic chest pain radiating to her left arm with shortness of breath and nausea while on vacation in late [redacted]. It was after this that she was first evaluated with evidence of changes on her EKG. Also mentioned is that she had had peripheral edema from Procardia in the past and that both diltiazem and Procardia had given her difficulty in concentrating. She had similar feelings of a "window screen" between her and her thoughts on atenolol but it was less intense. On physical exam, her blood pressure was 140/80 and an "intermittent click" was heard. Dr. [redacted]'s impression was that the patient had a "syndrome consistent with ischemic pain." He mentioned that she had known coronary artery disease and that even without significant angiographic evidence of obstruction at the last coronary angiogram, he suspected that she had "Syndrome X." He felt her anti-anginal medications were impacting her mental acuity. He felt that the patient may have vasospastic angina to some degree and it was his feeling that she "clearly has an inability at this point to function in her stated profession."

The patient had no complaints when she saw Dr. [redacted] on [redacted] but did report to "continue to have some chest pressure and tightness in association with physical exertion" and she also still complained of "a sensation of fatigue and lethargy related to the beta-blockers." At her doctor's visit with Dr. [redacted] on [redacted], she complained of shortness of breath and on [redacted] she stated that she "continues to have episodes of chest discomfort when exposed to stressful situations, high humidity or pollutants." A letter from Dr. [redacted] on [redacted] stated that Mrs. [redacted] had a cardiac condition which

made her unable to serve as a juror. At her appointment on [redacted], Dr. [redacted] noted that she continued to have intermittent chest pain but she was clinically stable. She had similar symptoms when seen on [redacted] and a "very soft fourth heart sound" was heard by Dr. [redacted] on exam. She had another nuclear stress test on [redacted] which was interpreted as normal. She was started on Zocor (simvastatin) by Dr. [redacted] on [redacted].

The patient was evaluated by Dr. [redacted] of [redacted] Specialists on [redacted] as an independent medical examiner. The patient had complaints of chest pain while she was being examined and an EKG was done which Dr. [redacted] stated "showed no acute changes." In his discussion, Dr. [redacted] thought that most of her symptoms were "subjective and do not have any organic basis at this time." He also thought that her ability to play bridge but not concentrate while performing her job were "opposing" facts. It was his conclusion that Mrs. [redacted] was not disabled from a cardiac stand point. He also stated that "stress as a contributing factor for heart disease has never been borne out in several studies, except in relationship to fireman and policeman." An exercise stress test was done on [redacted] by Dr. [redacted] which was interpreted as borderline for ischemia and the patient did complain of some substernal chest discomfort "consistent with mild angina pectoris."

A copy of the deposition of Dr. [redacted] was provided for me and also reviewed.

After review of the records provided for me thus far and without having actually interviewed or examined Mrs. [redacted], my medical impression is as follows:

(1) Coronary artery disease, status post anteroseptal myocardial infarction during the latter part of [redacted].

(2) Status post percutaneous transluminal coronary angioplasty (PTCA) of the left anterior descending (LAD) coronary artery [redacted]. Evidence of significant obstructive disease of a diagonal branch at repeat coronary angiography on [redacted]. This may have been caused by "plaque shifting" during the angioplasty the prior month. No significant obstruction in the LAD itself on [redacted] but some residual mild stenosis was seen. Interestingly, the nuclear myocardial perfusion study from [redacted] showed reversible defects in the anterior and apical wall which presumably was supplied by the LAD. There is no mention of possible ischemia in the diagonal territory even though that was the area of most significant disease in the post-PTCA angiogram. One possibility, is that any ischemia caused by the diagonal disease was of a relatively small amount and thus not picked up by the nuclear study. It is a well known fact that false positive nuclear studies can occur within 1 – 2 months post PTCA and the anteroapical ischemia seen on the nuclear study ironically may have actually represented this phenomenon. That is, the abnormality objectively seen by the nuclear study was a "false abnormality" so soon after the PTCA of the LAD. Even though no myocardial ischemia was specifically mentioned as being evident in the diagonal territory, it is very

(3) conceivable that even a small amount of myocardial ischemia from the diagonal disease was the true cause of the patient's symptoms.

(4) Essential systemic hypertension.

(5) Family history of premature coronary artery disease, specifically the patient's mother died of a heart attack in her early sixties.

(6) Recurrent chest and left arm tightness and shortness of breath. Very likely is due to coronary vasospasm which has clearly been shown to be provocable by mental stress as well as exercise. This can occur due to coronary artery endothelial dysfunction even with mild atherosclerotic lesions.

(7) Intolerance of different degrees to multiple different anti-ischemic medications. Depression of mental function has been reported with all types of anti-anginal medications and is most notoriously noted for being a potential side effect of beta-blockers. Tenormin (atenolol) is the least lipophilic of the beta-blocker class and is reportedly the least likely to cause central nervous system effects. However, it has been reported to none the less cause general fatigue and vague mental slowing in some patients. While an infrequent side effect, my experience with patients has been that it can clearly be seen at times. On the other hand, beta-blockers have been proven time and again to be cardioprotective in that they decrease the risk of recurrent myocardial infarction and/or death in patients with known coronary artery disease. Thus, it is always considered ideal to continue these medications indefinitely in cardiac patients if at all possible and this practice would be considered the standard of care.

(8) Asthma.

I look forward to the opportunity to interview and examine Mrs. [redacted] Pending my examination, I would plan on using at least a fair amount of the current records that I have seen as exhibits with any possible subsequent depositions or testimony involving me. You already have a copy of my curriculum vitae and my publications as well as my hourly rates for consulting, deposition and trial testimony. To the best of my memory, I have not testified as an expert at trial or by deposition in the last four years.

Respectfully yours,

Mark K. Urman, M.D., F.A.C.C.
Assistant Clinical Professor of Medicine
U.C.L.A. School of Medicine

[redacted]

January 29, 2021

To: Disability Procedures & Services Committee
J.P. Harris, Chair
Wayne Moore, Vice Chair
Herman B. Santos
Gina Zapanta
William Pryor, Alternate

From: Francis J. Boyd,
Senior Staff Counsel

For: February 11, 2021 Disability Procedures & Services Committee

Subject: **APPLICATIONS WHEN THE MEMBER HAS BEEN TERMINATED FOR CAUSE BY THE COUNTY OF LOS ANGELES**

At its December 10, 2020, meeting, the Board of Retirement requested to revisit its policy for processing disability-retirement applications when a member has been terminated for cause. The below-stated policy was last adopted at the Board's July 3, 2019, meeting after discussing the matter at the June 5, 2019, Disability Procedures & Services Committee meeting. Copies of my May 29, 2019, memorandum to the Committee and the Committee's June 20, 2019, recommendation to adopt the policy are attached.

The purpose of this memorandum is to facilitate the discussion on the topic. The following is the policy which was adopted at the July 3, 2019, Board of Retirement meeting.

POLICY FOR PROCESSING DISABILITY-RETIREMENT APPLICATIONS WHEN THE MEMBER HAS BEEN TERMINATED FOR CAUSE

1. Disability Retirement Services will accept applications for processing so the Board of Retirement can determine members' eligibility to apply for a disability retirement and members' eligibility for the benefit.

2. Members will be evaluated by a panel physician to determine whether or not they were permanently incapacitated on the day before the date of the event which gave cause for the member's dismissal.

3. The panel physician will be only asked the following two questions:

    - Please state whether or not your review of the medical evidence establishes that the applicant was permanently incapacitated on [insert

date prior to the event which gave cause for the member's termination]. Please explain your opinion.

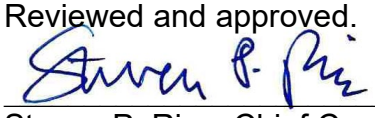
- Did the applicant's employment play a role in any injury or illness that the applicant claims to cause incapacity? Please explain your opinion.

4. **For psychiatric cases**, the panel physician will be provided with all of the details surrounding the termination.

   For non-psychiatric cases, the panel physician will be informed that the member has been terminated for cause without being provided with any of the details surrounding the termination.

5. The Board of Retirement will be provided with all the facts surrounding the member's termination.

Reviewed and approved.



Steven P. Rice, Chief Counsel

FJB

Attachments

c: Each Trustee, Board of Retirement

May 28, 2019

To: Disability Procedures & Services Committee
J.P. Harris, Chair
Herman Santos, Vice Chair
Ronald A. Okum
Gina Zapanta-Murphy
William Pryor, Alternate

From: Francis J. Boyd,
Senior Staff Counsel

For: June 5, 2019, Disability Procedures & Services Committee

Subject: **APPLICATIONS WHEN THE MEMBER HAS BEEN TERMINATED FOR CAUSE BY THE COUNTY OF LOS ANGELES**

INTRODUCTION

The Board of Retirement has requested a discussion regarding the processing of disability-retirement applications where a member has been terminated for cause by the County of Los Angeles. The Board has expressed some concerns about the prejudicial effects of providing a history of the member's termination to the examining panel physician as well as to the Board itself during its adjudication process.

On April 3, 2019, the Committee was presented with the attached March 20, 2019, memorandum which outlines the law addressing post-termination applications for disability retirement. This memorandum provided several policy suggestions for the Committee to consider. The discussion at the Committee meeting raised several issues which will be addressed in this memorandum. Also, since the April 3, 2019, meeting, the Court of Appeal has issued a new decision on this issue, *Martinez v Public Employees' Retirement System*,[1] which will also be addressed.

The purpose of this memorandum is to facilitate the discussion of the adjudication process so that staff can draft a policy for processing these applications.

[1] *Martinez v. Public Employees' Retirement System* (2019) 33 Cal.App.5th 1156.

ATTACHMENT A

LEGAL AUTHORITY

The Board of Retirement has the plenary authority and fiduciary responsibility to administer the retirement system, and it holds executive, legislative, and quasi-judicial powers. It has the sole authority to determine eligibility for a disability retirement. In administering its duties, the Board has the authority to promulgate rules, regulations, and policies.[2]

LAW

Haywood v. America River Fire Protection Dist. and *Smith v. City of Napa*

The attached memorandum provides a complete discussion of the law under *Haywood v. America River Fire Protection Dist.*[3] and *Smith v. City of Napa.*[4] In a nutshell, the *Haywood* decision held that when an employee is terminated for cause and the discharge is neither the ultimate result of a disabling medical condition nor preemptive of an otherwise valid claim for disability retirement, the termination of the employment relationship renders the employee ineligible for disability retirement.

In *Smith*, the court held that if a member were to prove with unequivocal evidence that the right to a disability retirement *matured* before the date of the event giving cause to dismiss, the dismissal would not preempt the right to receive a disability pension.

In both *Haywood* and *Smith*, the boards deciding the applications, and the administrative law judges whose decisions ruled on the appeals that were brought back to the board for approval, were provided with all of the details that led up to the termination.

Resignation in lieu of termination is tantamount to a dismissal for purposes of applying the *Haywood* criteria—*Martinez v. Public Employees' Retirement System* (April 2019)[5]

Martinez was an employee of the State Department of Social Services. In 2014, the Department moved to terminate her employment with a notice of adverse action. In response, Martinez filed an unfair labor practices complaint. In September 2015, the parties negotiated a settlement wherein Martinez agreed to voluntarily resign from her employment and agreed "she will never again apply for or accept any employment position" with DSS. The Department, in turn, agreed to cooperate with any application for disability retirement filed by Martinez. Martinez then filed her application, but in

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[2] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725; *Preciado v. County of Ventura* (1982) 143 Cal.App.3d 783, 789.
[3] *Haywood v. American River Fire Protection Dist.* (1998) 67 Cal.App.4th 1292.
[4] *Smith v. City of Napa* (2004) 120 Cal.App.4th 194.
[5] *Martinez v. Public Employees' Retirement System* (2019) 33 Cal.App.5th 1156.

June 2015, CalPERS notified her that her application had been cancelled and gave the following reasons:

> We have determined that you were dismissed from employment for reasons which were not the result of a disabling medical condition. Additionally, the dismissal does not appear to be for the purpose of preventing a claim for disability retirement. Therefore, you are not eligible for a disability retirement.

CalPERS relied on the *Haywood* and *Smith* decisions as well as a 2013 CalPERS Precedential Decision, *In the Matter of Application for Disability Retirement of Vandergoot*,[6] which ruled that when an employee settles a pending termination for cause and agrees not to seek employment, this agreement is "tantamount to a dismissal" thus precluding a disability retirement. In deciding *Martinez,* the Court of Appeal agreed, stating: "From this perspective, *Vandergoot* is eminently logical: resignation in these circumstances does indeed appear to be 'tantamount to a dismissal for purposes of applying the *Haywood* criteria.'"[7]

In the *Martinez* case, the board deciding the application, and the administrative law judge whose decision ruled on the appeal that was brought back to the board for approval, were provided with all of the details that led up to the termination.

The Board of Retirement is the trier of fact and it has the discretion to exclude prejudicial evidence.

The California Constitution and the Government Code give the Board of Retirement sole authority to determine members' eligibility for a disability retirement.[8] And the Board exercises its quasi-judicial powers and acts as the trier of fact when it decides eligibility for disability-retirement benefits.[9]

Under California Evidence Code section 352, the court in its discretion may exclude evidence if its probative value is substantially outweighed by the probability that its admission will create a substantial danger of undue prejudice. These same principals apply to the Board of Retirement when it is exercising its adjudicatory powers.

APRIL 3, 2019 DISABILITY PROCEDURES & SERVICES COMMITTEE MEETING

During the April 3, 2019, Disability Procedures & Services Committee meeting, Committee Members discussed the policy considerations in regard to eliminating

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[6] *In the Matter of Application for Disability Retirement of Vandergoot* (2013) CalPERS Precedential Dec. No. 13-01 (Vandergoot).
[7] *Martinez v. Public Employees' Retirement System* (2019) 33 Cal.App.5th 1156, 1176.
[8] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725.
[9] *Preciado v. County of Ventura* (1982) 143 Cal.App.3d 783, 789.

prejudicial information related to the applicant's termination that is provided to the Board of Retirement and the panel physician. The Committee's discussion raised issues that are outlined below.

A. Information Provided to the Board of Retirement

- **Non-psychiatric cases**

There was a general consensus that the Board of Retirement should be informed of the applicant's termination in order for it to properly adjudicate the application under the applicable law. However, Committee Members were concerned that the Board of Retirement did not necessarily need to know the details leading up to the member's termination, especially when the probative value of the specific details was outweighed by the propensity to prejudice the Board against the member. Other Committee Members voiced concern that withholding information regarding the details of the termination may hinder the Board's ability to determine the credibility of the applicant.

- **Psychiatric cases**

Post-termination applications involving psychiatric disabilities pose challenges because the Board must determine, under *Haywood,* whether or not the termination was the result of a disabling medical condition. For psychiatric cases, the Board should be provided with all of the details leading up to the termination so that it can determine whether or not the termination was the result of a disabling psychiatric condition.

- **Bifurcating certain applications**

The Committee Members also discussed bifurcating the application process into two steps when the facts contained information that may be prejudicial to the applicant. It was suggested that in these instances, the application first be brought to the Board for a determination of whether or not the applicant should be evaluated by a Board's panel physician. This approach would treat certain post-termination applications differently and has the potential of raising due-process issues. It would also involve staff weighing the evidence, instead of the Board, on credibility issues.

Recommendation

- **Non-psychiatric cases**

Staff recommends that the Board of Retirement be informed that the member has been terminated and be provided with the date(s) of the event(s) which led to the termination so that it can properly adjudicate the application under the applicable law.

Staff's role in the application process is to gather the facts and provide the Board with facts related to members' inability to perform their usual duties. As the trier of fact, the

Board has the discretion not to consider certain evidence when the probative value of that evidence is outweighed by the probability that the facts will create undue prejudice against the member. Oftentimes there are nuances in the evidence and it is difficult to determine whether the value of the evidence is outweighed by its prejudicial effect. Creating a policy that instructs staff to perform a probative-value/prejudicial-effect determination takes away from the Board its discretion to the weigh the evidence in these circumstances. The Board should be trusted with the discretion to determine the probative value of the evidence presented and disregard evidence that is prejudicial. Also, having staff withhold evidence may hinder the Board in making a determination of credibility. Therefore, staff recommends that the Board of Retirement be provided with all the facts surrounding the member's termination.

- **Psychiatric cases**

Staff recommends that the Board be advised of all the details concerning the applicant's termination when the application is based on a psychiatric condition so that it can determine whether or not the termination was the result of a disabling psychiatric condition.

B. Information Provided to the Panel Physician

- **Non-psychiatric cases**

Staff had originally recommended that the panel physician not be informed that the applicant had been terminated. At the April 3, 2019, Committee meeting, the Board's Medical Advisor voiced concerns over this approach and indicated that withholding this information would prevent the physician from having a complete and accurate history and hinder the physician's ability to measure the applicant's credibility, particularly with respect to pain complaints, when determining his or her disability status on the relevant date.

- **Psychiatric cases**

When the claim involves a psychiatric condition, the panel psychiatrist should be provided with all of the details that led up to the applicant's termination so that the panel psychiatrist can opine as to whether or not the termination was the result of a disabling medical condition.

Recommendation

- **Non-psychiatric cases**

The panel physician's role in non-psychiatric cases is to review the medical records and provide the Board with a medical opinion as to whether or not the medical evidence supports a conclusion that the member was medically unable to perform his or her usual

duties before the date of the event giving cause to the member's dismissal. It is the Board's role to take this medical opinion, weigh it with the facts surrounding the dismissal, and make a determination regarding the eligibility for benefits. Staff therefore recommends that the panel physician not be told that the member was terminated in non-psychiatric cases.

- **Psychiatric cases**

For psychiatric applications, staff recommends that the panel psychiatrist be provided with all of the details leading up to the termination.

SUGGESTED POLICY CONSIDERATIONS

The following policy considerations are provided for the consideration by the Committee. Staff welcomes any further suggestions from the Committee.

1. Staff recommends that the Board maintain its current practice of accepting the application for processing so it can determine the member's eligibility to apply for a disability retirement and the member's eligibility for the benefit.

2. Staff recommends that the Board maintain its current practice of having the member evaluated by a panel physician to determine whether or not the member was permanently incapacitated on the day before the date of the event which gave cause for the member's dismissal.

3. Staff recommends that the panel physician only be asked the following two questions:

    - Please state whether or not your review of the medical evidence establishes that the applicant was permanently incapacitated on [insert date prior to the event which gave cause for the member's termination]. Please explain your opinion.

    - Did the applicant's employment play a role in any injury or illness that the applicant claims to cause incapacity? Please explain your opinion.

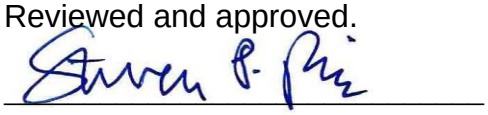
4. **For psychiatric cases**, staff recommends that the panel physician be provided with all of the details that led to the termination.

    For non-psychiatric cases, staff recommends that the panel physician not be told that the member was terminated.

5. Staff recommends that the Board of Retirement be informed that the member has been terminated when the application is presented for a decision.

6. Staff recommends that the Board be provided with all of the details of the termination.

Reviewed and approved.



Steven P. Rice, Chief Counsel

Attachment

c: Each Member, Board of Retirement

June 20, 2019

To: Each Member
Board of Retirement

From: Disability Procedures & Services Committee
J.P. Harris, Chair
Herman Santos, Vice Chair
Ronald A. Okum
Gina Zapanta-Murphy
William Pryor, Alternate

For: July 3, 2019, Disability Retirement Meeting

Subject: **APPLICATIONS WHEN THE MEMBER HAS BEEN TERMINATED FOR CAUSE BY THE COUNTY OF LOS ANGELES**

RECOMMENDATION

That the Board of Retirement adopt the *Proposed* Policy for Processing Disability-Retirement Applications Where a Member Has Been Terminated for Cause.

INTRODUCTION

The Disability Procedures & Services Committee has held discussions with Francis Boyd, Senior Staff Counsel, regarding the processing of disability-retirement applications where a member has been terminated for cause by the County of Los Angeles. The discussions have prompted the Committee to recommend that the Board of Retirement adopt the *Proposed* Policy for Processing Disability-Retirement Applications When the Member Has Been Terminated for Cause.

LEGAL AUTHORITY

The Board of Retirement has the plenary authority and fiduciary responsibility to administer the retirement system, and it holds executive, legislative, and quasi-judicial powers. It has the sole authority to determine eligibility for a disability retirement. In administering its duties, the Board has the authority to promulgate rules, regulations, and policies.[1]

[1] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725; *Preciado v. County of Ventura* (1982) 143 Cal.App.3d 783, 789.

ATTACHMENT B

LAW

Haywood v. America River Fire Protection Dist. and *Smith v. City of Napa.*

In *Haywood v. America River Fire Protection Dist.*,[2] the Court of Appeal held that when an employee is terminated for cause and the discharge is neither the ultimate result of a disabling medical condition nor preemptive of an otherwise valid claim for disability retirement, the termination of the employment relationship renders the employee ineligible for disability retirement.

In *Smith v. City of Napa,*[3] the court held that if a member were to prove with unequivocal evidence that the right to a disability retirement *matured* before the date of the event giving cause to dismiss, the dismissal would not preempt the right to receive a disability pension.

Resignation in lieu of termination is tantamount to a dismissal for purposes of applying the *Haywood* criteria.

In a recent April 2019 decision, *Martinez v. Public Employees' Retirement System*,[4] the court held that when an employee settles a pending termination for cause and agrees not to seek employment, the agreement is "tantamount to a dismissal for purposes of applying the *Haywood* criteria" thus precluding a disability retirement.[5]

The Board of Retirement is the trier of fact and it has the discretion to exclude prejudicial evidence.

The California Constitution and the Government Code give the Board of Retirement sole authority to determine members' eligibility for a disability retirement.[6] And the Board exercises its quasi-judicial powers and acts as the trier of fact when it decides eligibility for disability-retirement benefits.[7]

Under California Evidence Code section 352, the court in its discretion may exclude evidence if its probative value is substantially outweighed by the probability that its admission will create a substantial danger of undue prejudice. These same principals apply to the Board of Retirement when it is exercising its adjudicatory powers.

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[2] *Haywood v. American River Fire Protection Dist.* (1998) 67 Cal.App.4th 1292.
[3] *Smith v. City of Napa* (2004) 120 Cal.App.4th 194.
[4] *Martinez v. Public Employees' Retirement System* (2019) 33 Cal.App.5th 1156.
[5] *Id.* at 1176.
[6] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725.
[7] *Preciado v. County of Ventura* (1982) 143 Cal.App.3d 783, 789.

REASONING FOR THE DISABILITY PROCEDURES & SERVICES COMMITTEE'S RECOMMENDATIONS

A. Information Provided to the Board of Retirement

The Committee recommends that the Board of Retirement be provided with all the facts surrounding the member's termination.

Staff's role in the application process is to gather the facts and provide the Board with facts related to members' inability to perform their usual duties. As the trier of fact, the Board has the discretion not to consider certain evidence when the probative value of that evidence is outweighed by the probability that the facts will create undue prejudice against the member. Oftentimes there are nuances in the evidence and it is difficult to determine whether the value of the evidence is outweighed by its prejudicial effect. Creating a policy that instructs staff to perform a probative-value/prejudicial-effect determination takes away from the Board its discretion to weigh the evidence in these circumstances. The Board should be trusted with the discretion to determine the probative value of the evidence presented and disregard evidence that is prejudicial. Also, having staff withhold evidence may hinder the Board in making a determination of credibility. Therefore, the Committee recommends that the Board of Retirement be provided with all the facts surrounding the member's termination.

B. Information Provided to the Panel Physician

- **Non-psychiatric cases**

The Committee recommends that the panel physician be informed that the member has been terminated for cause but not be provided with any of the details surrounding the termination. The Committee has concluded that withholding the fact that the member had been terminated would prevent the physician from having a complete and accurate work history.

- **Psychiatric cases**

When the claim involves a psychiatric condition, the panel psychiatrist should be provided with all of the details that led up to the applicant's termination so that the panel psychiatrist can opine as to whether or not the termination was the result of a disabling medical condition.

PROPOSED POLICY FOR PROCESSING DISABILITY-RETIREMENT APPLICATIONS WHEN THE MEMBER HAS BEEN TERMINATED FOR CAUSE

1. Disability Retirement Services will accept applications for processing so the Board of Retirement can determine members' eligibility to apply for a disability retirement and members' eligibility for the benefit.

2. Members will be evaluated by a panel physician to determine whether or not the they were permanently incapacitated on the day before the date of the event which gave cause for the member's dismissal.

3. The panel physician will be only asked the following two questions:

    - Please state whether or not your review of the medical evidence establishes that the applicant was permanently incapacitated on [insert date prior to the event which gave cause for the member's termination]. Please explain your opinion.

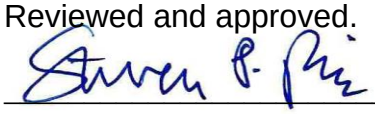
    - Did the applicant's employment play a role in any injury or illness that the applicant claims to cause incapacity? Please explain your opinion.

4. **For psychiatric cases**, the panel physician will be provided with all of the details surround the termination.

    For non-psychiatric cases, the panel physician will be informed that the member has been terminated for cause without being provided with any of the details surrounding the termination.

5. The Board of Retirement will be provided with all the facts surrounding the member's termination.

Reviewed and approved.



Steven P. Rice, Chief Counsel