State Court of Fulton County
EFILED
File & ServeXpress
Transaction ID: 65608791
Date: Apr 30 2020 12:11PM
LeNora Ponzo, Chief Clerk
Civil Division

IN THE STATE COURT OF FULTON COUNTY
STATE OF GEORGIA

MYUNG JA OH Individually and as Representative of the Estate of BYUNG (BEN) OH, deceased,

Plaintiff,

— *versus* —

"ATLANTA MEDICAL CENTER"

WELLSTAR HEALTH SYSTEM, INC.

ADEFISAYO M. ODUWOLE, MD

MOREHOUSE HEALTHCARE, INC.

BARRY JEFFRIES, MD

DIAGNOSTIC IMAGING SPECIALISTS, P.A.

AMY D. WYRZYKOWSKI, MD

WELLSTAR MEDICAL GROUP, LLC

KHALID IQBAL, MD

ATLANTA SOUTH NEPHROLOGY PC

THOMAS W. SCHOBORG, MD

ATLANTA UROLOGICAL GROUP, P.C.

CIVIL ACTION

FILE NO. 20EV002508

JURY TRIAL DEMANDED

ZANDRAETTA L. TIMS-COOK, MD)
)
JOHN P. OUDERKIRK, MD)
AIDS HEALTHCARE FOUNDATION (INC))
)
JOHN/JANE DOE 1-10,)
Defendants)

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of the Action

1. This medical malpractice, wrongful-death action arises out of medical services negligently performed on Byung (Ben) D. Oh at Wellstar's Atlanta Medical Center from April 30, 2018, through June 9, 2018.

2. Plaintiff Myung Ja Oh is the wife of Ben Oh, deceased.

3. At the time of his death, Ben Oh was 77 years old with a life expectancy of an additional 10.7 years.[1]

4. As representative of Mr. Oh's estate, Plaintiff Myung Oh asserts a claim for harm Mr. Oh suffered before he died.

---

[1] *See* National Vital Statistics Reports, Vol. 68, No. 7, June 24, 2019, Table 3. Life table for females: United States, 2017, available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf.

5. Plaintiff also asserts a wrongful-death claim pursuant to OCGA Title 51, Chapter 4.

6. Pursuant to OCGA § 9-11-9.1, the Affidavit of Peter M. Mowschenson, MD, and the Affidavit of Meldon C. Levy, MD, are attached hereto as Exhibits 1 and 2, respectively. This Complaint incorporates the opinions and factual allegations contained in those affidavits.

7. As used in this Complaint, the phrase "standard of care" means that degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to the Defendant's actions under discussion.

Parties, Jurisdiction, and Venue

8. **Plaintiff Myung Ja Oh** is a citizen of Georgia and the wife of Byung (Ben) D. Oh, deceased.

9. **Defendant "Atlanta Medical Center"** refers to the primary employer of the nursing staff at the hospital that is located at 303 Parkway Drive NE, Atlanta, Georgia 30312 (the "Hospital") and that does business under the name *Atlanta Medical Center* in May 2018.

10. Plaintiff believes that employer was Defendant Wellstar Health System, Inc. However, if any other entity was the employer, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

11. **Defendant Wellstar Health System, Inc. ("WHS")** is a Georgia corporation that places its Registered Office in Cobb County. WHS may be served through their Registered Agent, Leo E. Reichart, at 793 Sawyer Road, Marietta, Georgia 30062.

12. At all relevant times, WHS was the employer of the nurses whose conduct is at issue in this lawsuit.

13. Pursuant to OCGA §§ 14-2-510 and 14-3-510,[2] WHS is subject to venue in this county because the cause of action originated in Fulton County and the corporation has an office and transacts business in that county.

14. Additionally, pursuant to OCGA § 9-10-31, WHS is subject to venue in this county because various co-defendants are subject to venue in this county.[3]

---

[2] OCGA §§ 14-2-510 and 14-3-510 provide identical for venue provisions for regular business corporations and for nonprofit corporations:

> "Each domestic corporation and each foreign corporation authorized to transact business in this state shall be deemed to reside and to be subject to venue as follows: (1) In civil proceedings generally, in the county of this state where the corporation maintains its registered office…. (3) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated, if the corporation has an office and transacts business in that county; (4) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated."

Note: These same venue provisions apply to Professional Corporations, because PCs are organized under the general "Business Corporation" provisions of the Georgia Code. *See* OCGA § 14-7-3. These venue provisions also apply to Limited Liability Companies, *see* OCGA § 14-11-1108, and to foreign limited liability partnerships, *see* OCGA § 14-8-46.

[3] "Subject to the provisions of Code Section 9-10-31.1 [regarding *forum non conveniens*], joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in

15. WHS has been properly served with this Complaint.

16. WHS has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

17. **Defendant Adefisayo M. Oduwole, MD** is a Georgia citizen. He lives in Fayette County and may be served at 155 Longcreek Drive, Fayetteville, Georgia 30214.

18. Pursuant to OCGA § 9-10-31, Dr. Oduwole is subject to venue in this county because various co-defendants are subject to venue here.

19. Dr. Oduwole has been properly served with this Complaint.

20. Dr. Oduwole has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

21. At all relevant times, Dr. Oduwole acted as an employee or agent of Defendant Morehouse Healthcare, Inc.

22. **Defendant Morehouse Healthcare, Inc. ("MHI")** is a Georgia corporation. MHI places its Registered Office in Fulton County. MHI may be served through their Registered Agent, Michael A. Rambert, at 720 Westview Drive SW, Atlanta, GA, 30310.

---

different counties, may be subject to an action as such in the same action in any county in which one or more of the defendants reside."

23. Plaintiff believes MHI was the employer or other principal of Dr. Oduwole, at all times relevant to this lawsuit. However, if any other entity was his principal, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

24. Pursuant to OCGA §§ 14-2-510 and 14-3-510, MHI is subject to venue in this county because it places its Registered Office here.

25. MHI has been properly served with this Complaint.

26. MHI has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

27. **Defendant Barry Jeffries, MD,** is a Georgia citizen. He lives in Fulton County and may be served at 5785 De Claire Ct, Atlanta, Georgia 30328.

28. Dr. Jeffries is subject to venue in this county because he resides here.

29. Dr. Jeffries has been properly served with this Complaint.

30. Dr. Jeffries has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

31. At all relevant times, Dr. Jeffries acted as an employee or agent of Defendant Diagnostic Imaging Specialists, P.A.

32. **Defendant Diagnostic Imaging Specialists, P.A. ("DIS") —** despite the misleading name — is a Georgia corporation.[4] DIS places its Registered Office in Fulton County. DIS may be served through their Registered Agent, National Registered Agents, Inc., at 289 S. Culver Street, Lawrenceville, GA, 30046.

33. Plaintiff believes DIS was the employer or other principal of Dr. Jeffries, at all times relevant to this lawsuit. However, if any other entity was his principal, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

34. Pursuant to § OCGA 14-2-510, DIS is subject to venue in this county because it resides here.

35. If DIS were a professional association, as its name implies, DIS would be subject to venue in this county because (a) pursuant to OCGA § 14-10-16, it has the power to sue and be sued in its own name, and it places its Registered Office in this county, and (b) because DIS is an unincorporated association[5] of which Dr. Jeffries is a member, and Dr. Jeffries resides in this county.

36. DIS has been properly served with this Complaint.

---

[4] Despite the "P.A." in the name, DIS was incorporated on July 1, 1977. DIS filed "Articles of Incorporation" and consistently identified itself in those articles as a "corporation," not as an unincorporated professional association.

[5] OCGA § 14-10-2: "'Professional association' means an unincorporated association, as distinguished from a partnership…."

37. DIS has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

38. **Defendant Amy D. Wyrzykowski, MD** is a Georgia citizen. Dr. Wyrzykowski resides in Fulton County and may be served at 505 Allen Road NE, Atlanta, Georgia 30324.

39. Dr. Wyrzykowski is subject to venue in this county because she lives here.

40. Dr. Wyrzykowski has been properly served with this Complaint.

41. Dr. Wyrzykowski has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

42. At all relevant times, Dr. Wyrzykowski acted as an employee or agent of Defendant Wellstar Medical Group, LLC.

43. **Defendant Wellstar Medical Group, LLC ("WMG")** is a Georgia limited liability company. WMG places its Registered Office in Cobb County. WMG may be served through their Registered Agent, Leo E. Reichart, at 793 Sawyer Road, Marietta, Georgia 30062.

44. Plaintiff believes that at all relevant times, WMG was the employer or other principal of Dr. Wyrzykowski. However, if any other entity was her principal, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

45. Pursuant to OCGA §§ 14-2-510 and 14-11-1108, WMG is subject to venue in this county because the cause of action originated in Fulton County and the corporation has an office and transacts business in that county.

46. Additionally, pursuant to OCGA § 9-10-31, WMG is subject to venue in this county because various co-defendants are subject to venue here.

47. WMG has been properly served with this Complaint.

48. WMG has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

49. **Defendant Khalid Iqbal, MD**, is a Georgia citizen. He resides in DeKalb County and may be served, at 2432 Circlewood Road NE, Atlanta, Georgia 30345.

50. Pursuant to OCGA § 9-10-31, Dr. Iqbal is subject to venue in this county because various co-defendants are subject to venue here.

51. Dr. Iqbal has been properly served with this Complaint.

52. Dr. Iqbal has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

53. At all relevant times, Dr. Iqbal acted as an employee or agent of Defendant Atlanta South Nephrology PC.

54. **Defendant Atlanta South Nephrology PC ("ASN")** is a Georgia professional corporation. ASN places its Registered Office in Fulton County. ASN

may be served through their Registered Agent, Muhammed Muhammedi, at 1275 East Cleveland Ave, East Point, GA, 30344.

55. Plaintiff believes ASN was the employer or other principal of Dr. Iqbal, at all times relevant to this lawsuit. However, if any other entity was his principal, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

56. Pursuant to OCGA §§ 14-2-510 and 14-7-3, ASN is subject to venue in this county.

57. ASN has been properly served with this Complaint.

58. ASN has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

59. **Defendant Thomas W. Schoborg, MD**, is a Georgia citizen. He resides in Fulton County and may be served at 781 Ashland Avenue NE, Atlanta, Georgia 30307.

60. Dr. Schoborg is subject to venue in this county because he lives here.

61. Dr. Schoborg has been properly served with this Complaint.

62. Dr. Schoborg has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

63. At all relevant times, Dr. Schoborg acted as an employee or agent of Defendant Atlanta Urological Group, P.C.

64. **Defendant Atlanta Urological Group, P.C. ("AUG")** is a Georgia professional corporation. AUG places its Registered Office in Fulton County. AUG may be served through their Registered Agent, Thomas W. Schoborg, at 285 Boulevard NE, Atlanta, Georgia 30312.

65. Plaintiff believes AUG was the employer or other principal of Dr. Schoborg, at all times relevant to this lawsuit. However, if any other entity was his principal, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

66. Pursuant to §§ OCGA 14-2-510 and 14-7-3, AUG is subject to venue in this county.

67. AUG has been properly served with this Complaint.

68. AUG has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

69. **Defendant Zandraetta L Tims-Cook, MD**, is a Georgia citizen. She resides in DeKalb County and may be served at 4442 Brookes Walk, Tucker, Georgia 30084.

70. Pursuant to OCGA § 9-10-31, Dr. Tims-Cook is subject to venue in this county because various co-defendants are subject to venue here

71. Dr. Tims-Cook has been properly served with this Complaint.

72. Dr. Tims-Cook has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

73. At all relevant times, Dr. Tims-Cook acted as an employee or agent of Defendant AIDS Healthcare Foundation (Inc.).

74. **Defendant John P. Ouderkirk, MD**, is a Georgia citizen. He resides in Fulton County and may be served at 1785 Monroe Drive NE, Atlanta, Georgia 30324.

75. Dr. Ouderkirk is subject to venue in this county because he lives here.

76. Dr. Ouderkirk has been properly served with this Complaint.

77. Dr. Ouderkirk has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

78. At all relevant times, Dr. Ouderkirk acted as an employee or agent of Defendant AIDS Healthcare Foundation (Inc.).

79. **Defendant AIDS Healthcare Foundation (Inc.) ("AHF")** is a foreign corporation authorized to do business in Georgia. AHF places its Registered Office in Gwinnett County. AHF may be served through their Registered Agent, Corporation Service Company, at 40 Technology Parkway South, #300, Norcross, GA, 30092.

80. Plaintiff believes AHF was the employer or other principal of Dr. Tims-Cook and Dr. Ouderkirk, at all times relevant to this lawsuit. However, if any other

entity was the principal of either doctor, then each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

81. Pursuant to OCGA §§ 14-2-510 and 14-3-510, AHF is subject to venue in this county because the cause of action originated in Fulton County and the corporation has an office and transacts business in that county.

82. Additionally, pursuant to OCGA § 9-10-31, AHF is subject to venue in this county because various co-defendants are subject to venue here.

83. AHF has been properly served with this Complaint.

84. AHF has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

85. **Defendants John/Jane Doe 1-10** are those yet unidentified individuals and/or entities who may be liable, in whole or part, for the damages alleged herein. Once served with process, John/Jane Doe 1-10 are subject to the jurisdiction and venue of this Court.

86. This Court has subject matter jurisdiction over all claims in this lawsuit.

87. This Court has personal jurisdiction over all Defendants in this lawsuit.

Facts

88. On April 30, 2018, Ben Oh, 77 yrs old, arrived at Wellstar's Atlanta Medical Center ER by ambulance, after falling from a ladder while doing yard work. Mr. Oh suffered a burst fracture of the anterior vertebra at T12.

89. Mr. Oh was admitted as an inpatient, with spine surgery planned for days later, after a cardiac screening. The surgery would not happen until May 4.

90. This Complaint centers on three primary issues on which Ben Oh suffered from medical negligence:

> *First*, a failure by hospital staff to properly manage Mr. Oh's chronic cardiac problems. This failure led to atrial fibrillation with rapid ventricular rate, severe respiratory distress, and respiratory interventions that put Mr. Oh at risk of infections. Mr. Oh eventually died from complications of infections.
>
> This first primary act of negligence implicates cardiologist Dr. Adefisayo M. Oduwole and the nursing staff of Atlanta Medical Center.
>
> *Second*, misplacement of a supra-pubic catheter that either caused or greatly aggravated a chyle leak — worsening Mr. Oh's immune-compromised state and contributing to his death from sepsis.
>
> This second primary act of negligence implicates interventional radiologist Dr. Barry Jeffries.
>
> *Third*, mismanagement of the chyle leak after the misplaced catheter began draining multiple liters of chylous fluid. This also worsened Mr. Oh's immune-compromised state and contributed to his death from sepsis.
>
> This third primary act of negligence implicates attending physician, Dr. Amy D. Wyrzykowski, consulting nephrologist Dr. Khalid Iqbal, consulting urologist Dr. Thomas W. Schoborg, and consulting infectious-disease physicians, Dr. Zandraetta L. Tims-Cook and Dr. John P. Ouderkirk.

91. These three primary acts of negligence do not exhaust the negligence that Mr. Oh suffered at Atlanta Medical Center. Some of the additional acts of negligence not detailed in this Complaint were committed by residents, whom we believe to have been employees of one or more of the corporate Defendants.

92. Mr. Oh had a history of atrial fibrillation, and he regularly took amiodarone to control it.

93. Mr. Oh's wife and daughter brought in a list of Mr. Oh's home medications. Twice, despite being specifically pressed to do so, the nurse failed to record Mr. Oh's use of amiodarone.

94. Before the surgery, cardiologist Dr. Oduwole examined Mr. Oh but did not ask about Mr. Oh's home medications and did not order amiodarone for Mr. Oh.

95. On May 4, 2018, Mr. Oh underwent surgery to repair and stabilize the spine. During the surgery, Mr. Oh's heart went into atrial fibrillation, then returned to sinus rhythm.

96. After the operation, Mr. Oh was transferred to the Neuro ICU.

97. On May 5, 0630 hours, an X-Ray Chest report noted "Interval development of moderate atelectasis or infiltrate at the right lung base with a small right pleural effusion. Mild atelectasis is now seen at the left lung base."

98. Cardiac problems, including atrial fibrillation with rapid ventricular rate, can cause or worsen respiratory distress.

99. The interventions for respiratory distress can increase the risk of infection.

100. Mr. Oh was at particular risk of suffering harm from infection, because (in addition to his age) his lymphocyte levels were low from the time his first blood test was taken after he fell off the ladder and fractured his vertebra.

101. Lymphocytes are a type of white blood cell that play an important role in fighting infections.

102. Because Mr. Oh's immune system had been compromised by low lymphochyte levels, it was particularly dangerous to him if he were to enter Afib with RVR and develop severe respiratory distress that would require interventions that frequently entail infections.

103. However, despite Dr. Oduwole entering daily progress notes for Mr. Oh, amiodarone was not prescribed for Mr. Oh for days.

104. On May 8, Mr. Oh began experiencing respiratory distress.

105. A May 8 x-ray of his abdomen was ordered because of abdominal distension.

106. A May 8, 2258 hours, progress note recorded: "BAT called to pt's room for increased work of breathing. Pt seen and evaluated. Vital signs as follows: sats 94% on 4L NC, HR 120s, SBP 120s. Pt tachypneic with crackles heard throughout the precordium. Stat ABG consistent with respiratory alkalosis, paO2 50. CXR without evidence of ptx, consistent with bilateral congestion. EKG consistent with a.fib with RVR. Pt currently not on any rate controlling medications. Given a.fib with RVR and increasing tachypnea and risk of respiratory failure, pt transferred to the ICU with stat labs ordered. Amiodarone bolus and continuous gtt ordered.

Pulmonary toilet, redirect pt - pt confused and agitated. Continue left chest tube to suction."

107. At that time — the night of May 8 — Mr. Oh still was "currently not on any rate controlling medications."

108. That night, Mr. Oh was transferred to the Cardiac ICU.

109. On May 9, Mr. Oh was started on a bipap machine to help him breathe.

110. A May 11, 0611 hours note recorded: "Pulm: ABG c/w respiratory alkalosis, on bipap this morning, pulmonary toilet, L CT to suction, yesterday CXR shows stable b/l pulmonary infiltrates. CTA chest neg for PE. Being treated for pneumonia."

111. On May 11, at 1135 hours, Mr. Oh was "in afib, rate in the 110s."

112. A May 12, 0806 hours note recorded: "abdomen is soft without significant tenderness, masses, organomegaly or guarding."

113. A May 13, 0916 hours note recorded: "Patient still requiring high supplemental 02, currently on vapotherm. Also still in A-fib despite scheduled metoprolol and PO amiodarone."

114. On May 14, Mr. Oh was discovered to have a MRSA infection, and treatment for it began.

115. A May 15, 2000 hours note recorded: "respiratory rate very tachypnea and pt on 85% FiO2 on vapo therm's, suctioned as needed."

116. A May 17, 2139 hours note recorded: "will resume PO regimen for afib to better control Hr. Respiratory status slightly improved until about 20 minutes

after Pt. Desaturation with thick sputum. Suctioned aggressively and saturations improved with increase of 02 on vapotherm. … will insert dobhoff tube for nutrition and meds."

117. On May 18, Mr. Oh was intubated: "Called for the ICU team for consultation for urgent/emergent intubation for this patient. … At the time of intubation his 02 sat was 80% on a non-rebreather and his PO2 was 48. He appeared to be in extremis, with RR 30-40."

118. A 1238 hours note that day recorded: "He was intubated without difficulty and a large amount of thick secretions were suctioned out of his airway. His sats then came up to 100%. A bronchoscopy was then preformed with copious secretions noted. … Wean vent as tolerated. Continue NG meds and tube feeds."

119. On May 22, nephrology consulted and began following Mr. Oh. The initial consult record noted "suprapubic fullness" in the abdomen and noted, "Bladder scan done at bedside (nursing) revealed about 530cc urine in bladder despite foley catheter in place. Will need to rule out obstruction amidst suggestions of ATN sec to hypotension and ARDS plus/- drug related intestitial nephritis in this diabetic pt who needed contrast evaluation of his injury."

120. A May 23, 0959 hours ultrasound of the retroperitoneal area found "A free ascites fluid is present throughout the abdomen."

121. A May 23, 2031 hours note recorded: "Concern that foley is non-functional given 1L in bladder scan and minimal UOP. … I performed a bedside sonogram exam to evaluate for foley position. I as well as my chief resident on call

were both able to visualize the foley in th bladder. To confirm this, we flushed the foley with 30cc NS and a total of 50cc of urine was returned albeit not the 1L we can see on the bladder scan. Given this, and at the request of Dr. Wyrzykowsi, I placed a stat consult to Urology for recommendations since we are not getting adequate urine return given functional foley and 1L bladder scan. I personally spoke with Urologist Dr. Schoberg who recommends we attempt to place a coude catheter. He believes our foley may be in the prostatic urethra given BPH. He would like us to place a coude and hub it to make sure its in the bladder. If this fails or we are unable to pass this, he recommends placing of a Suprapubic catheter."

122. A May 24, 0609 hours note recorded: "Bedside suprapubic catheter placement attempted yesterday, was not successful. Will have CT guided placement with urology today."

123. A May 24, 0700 hours, note recorded: "Dr. Schoborg at bedside. Foley cath placed. Noted pt with large amount of urine saturating 2 pads. Dressing to SP attempt site saturated. Urine draining. Foley cath with 200ml of urine noted as well. Slightly blood tinged. Linen and gown changed."

124. A May 24, 0800 hours note recorded: "Drainage pouch placed to low pubis area to drain urine into bag."

125. A May 24, 0900 hours note recorded: "Spoke with Dr. Schoborg. Notified him that surgery thought he was getting a SP cath placed in IR. Stated pt didn't need SP and order cancelled."

126. On May 24, urologist Dr. Thomas W. Schoborg consulted and began following Mr. Oh. Dr. Schoborg's initial note stated: "Chief Complaint: urethral stricture. Modifying Factors: inability to insert cath. Respiratory: No use of accessory muscles on room air. Abd/GI: Soft, Not tender, Not distended. Endo: No buffalo hump or hyperpigmentation."

127. On May 26, lab results showed that the MRSA infection had been cleared.

128. A May 26, 0938 hours, note recorded: "Gl: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site. Renal: Foley in place with minimal output. Urostomy over SPT attempt site with >1L UOP"

129. A May 28, 0607 hours, note recorded: "Gl: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site. Renal: Foley in place with minimal output. Urostomy over SPT attempt site with 650cc UOP during day shift."

130. A May 28, 1357 hours, urology note recorded: "i performed a bladder scan(personally) and felt the bladder was decompressed wthe foley.there is some persistent drainage from a prior attempt to insert an s-p tube. Will schedule a ct scan but not medically transportable at this juncture. Will schedule a renal u/s at the bedside to further assess any pssibility ok obstructive uropathy."

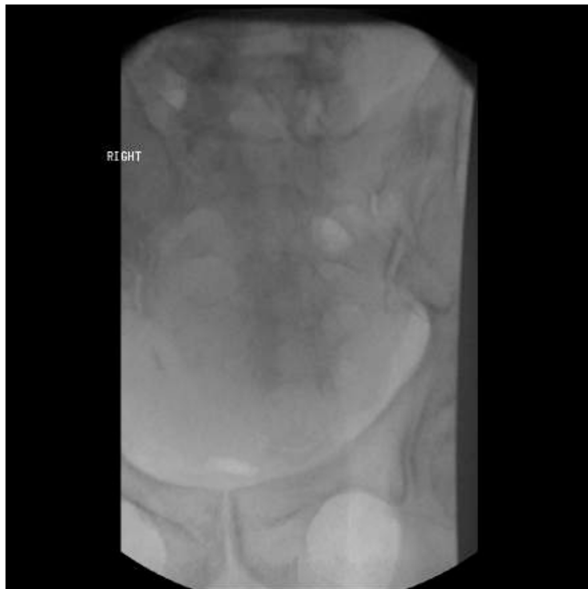
131. A May 29, 0608 hours, note recorded: "Gl: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site. Renal: Foley in place with minimal output. Urostomy over SPT attempt site with 400cc UOP during

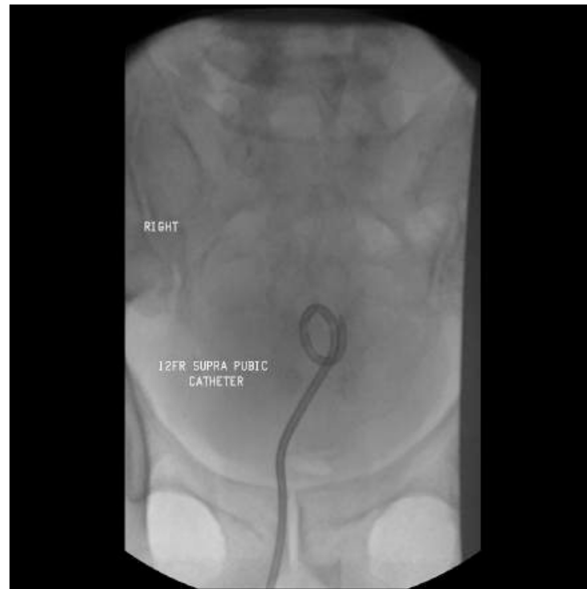
day shift,Foley with 140 cc OP in past 24 hrs. Renal: Got HD yesterday. Urology on board, attending performed bladder scan and reported adequate decompression of bladder. Poss CT per urology when patient more stable."

132. The next day, May 29, interventional radiologist Dr. Barry Jeffries placed a suprapubic catheter in Mr. Oh.

133. Dr. Jeffries' procedure note said: "Using local anesthesia, a 22-gauge needle was advanced into the bladder from a suprapubic approach. Needle position was confirmed by injection of 5 mL of Omnipaque 350. A 0.018 guidewires introduced followed by a 5 French exchange catheter and trocar. The tract was dilated to a 12 French diameter. A 12 French drainage catheter was introduced. The cope loop was reshaped. The catheter was attached to dependent drainage. Approximately 500 mL of whitish-brown urine was drained spontaneously. The catheter was secured to skin utilizing a single ligature of 3-0 nylon suture. There were no complications and the patient tolerated the procedure well."

134. Dr. Jeffries either did not perform or did not record contrast imaging to assist in placing the catheter. Dr. Jeffries recorded only two images — x-rays that could not confirm proper placement of the catheter:





135. In fact, Dr. Jeffries misplaced the catheter.

136. A later CT Pelvis with contrast (taken June 8) showed: "A suprapubic catheter has been placed superior to the urinary bladder and not within the urinary bladder. Extensive contrast material, presumably injected through the suprapubic tube is in the peritoneum outlining loops of bowel."

137. The misplaced suprapubic catheter immediately began producing large amounts of chylous fluid — seven liters in the first day — putting Mr. Oh at risk of further immune-suppression and thus increased vulnerability to infection.

138. A May 30, 0701 hours, note recorded: "Suprapubic catheter placed yesterday by IR. Per nurse, 7L whitish UOP since placement. Foley discontinued. SPT with 7L recorded UOP since placement. Urine whitish and cloudy appearing."

139. A May 30, 1555 hours, note recorded: "Abdominal exam significantly improved since adequate drainage of bladder. … MRSA bacteremia. Resolved. F/U

cultures negative at 72 hours. … Bladder outlet obstruction. S/p SPT with copious urine output. Will follow volume status and electrolytes closely."

140. A May 31, 0558 hours, note recorded: "Renal: Foley discontinued. SPT with >4L recorded UOP in last 24 hrs. Urine whitish and cloudy appearing. … Heme/lnfectious: Afebrile. Leukocytosis resolved and maintenance Cx negative. Completed treatment of Candida PNA with diflucan and MRSA bacteremia with zyvox. No Abx currently."

141. On May 31, Mr. Oh underwent a percutaneous tracheostomy.

142. A June 1, 1058 hours, nephrology note recorded: "He has significant post obstructive diuresis which is slowly decreasing. … Most of his post obstructive diuresis is expected excretion of accumulated fluid volume."

143. A June 2, 1002 hours, note recorded: " SPT with 9L recorded UOP in last 24 hrs. Urine is milky white. Dialyzed yesterday. … Urine sent for studies (lipids, calcium, phos) given milky white appearance."

144. A June 3, 1328 hours, nephrology progress note recorded: "He has significant post obstructive diuresis which persists indicating significant tubular injury and nephrogenic DI. Lymph leak in urine, possibly linked to lymphatic injury/obstruction. … Plan: In view of continuing polyuria, will try ddavp as sodium is now beginning to go up. Continue IVF / pressors to keep MAP more than 60. We have to be careful not to give too much fluid as it can perpetuate the polyuria. Will also give IV calcium gluconate to see if hypocalcemia may be contributing to the polyuria."

145. A June 4, 1600 hours, nephrology note recorded. "Polyuria with chyluria. Suprapubic catheter draining milky urine. Shock ? Sepsis ? Volume depletion caused by polyuria. Persistent chyluria may lead to severe protein loss, consider TPN if it persists."

146. A June 5, 0614 hours, note recorded: "SPT with approx 7L recorded UOP in past 24 hrs. Urine is less milky appearing today."

147. On June 6, the Infectious Disease service consulted and began following Mr. Oh. The initial infectious disease note recorded: "Chyluria and MRSA … Patient's urine was reportedly normal prior to the placement of the suprapubic catheter. Repositioning the catheter is recommended, if this is feasible."

148. A June 6, 1728 hours, nephrology note recorded: "Chyluria worsening. Suprapubic catheter draining milky urine."

149. A June 7, 0609 hours note recorded: "Approx 10 liters of milky fluid drained through catheter in past 24 hours. Intake 11670. Output 14225 (Urine 13875; Stool 350)."

150. On June 8 — 10 days after the misplaced catheter began draining large amounts of chyle from Mr. Oh's body — the hospital staff made an incidental discovery that the catheter had been misplaced.

151. A June 8, 0608 hours, note recorded: "today the patient went to radiology for a cystogram through the suprapubic tube that had been placed by interventional radiology. When contrast was injected through the catheter, it flowed freely into the peritoneal cavity and not the bladder. The tip of the tube was in the

mesentery of the small bowel and no portion of the tube was within the bladder. Therefore, the tube was removed."

152. On June 9, at the instigation of Mr. Oh's family, Mr. Oh was transferred to the Atlanta VA hospital.

153. Attending physician Dr. Amy D. Wyrzykowski, consulting nephrologist Dr. Khalid Iqbal, and consulting urologist Dr. Thomas W. Schoborg — each of these physicians became aware of the large volume of abnormal fluid the day after the catheter was placed. The consulting infectious-disease physicians, Dr. Zandraetta L. Tims-Cook and Dr. John P. Ouderkirk, became aware of it on June 6 and June 7.

154. None of those physicians responded in a reasonable or timely way to the large, ongoing chyle leak.

155. Even after the misplaced suprapubic catheter was pulled, chyle continued leaking from the hole in Mr. Oh's abdomen, where the catheter had been inserted.

156. The VA records contain the following information:

- June 19, 0754 hours: "Currently bag is set to gravity and draining peritoneal fluid, studies of the fluid reveal that fluid is seroequivalent with elevated TG. Chlylous ascites likely from postoperative cause (retoperitoneal lymph node dissection)."
- June 20, 1446 hours: "Patient continues to put large amts of lymphatic fluid out of old drain site."
- June 21, 1602 hours: "Regarding losses, currently we are investigating mechanisms to decrease chylous losses (approx 1.8 liters overnight)."
- June 23, 1527 hours: "Chylous Ascitic fluid output: Concern for excess volume loss from abdomen decreasing oncotic pressure via protein loss,

and worsening fluid losses. We are attempting to minimize nutritient and protein loss with initation of conservative therapies- Med chain TG, reduced lipids in TF. Will consider octreotide pending response to aforementioned items."

- June 25, 2125 hours: "Shock: Likely fluid losses/ low oncotic pressure, doubt uncontrolled sepsis source. -continue midodrine, wean levophed, continue albumin. -Addressing chylous ascitic fluid losses. --Chylous Ascites- s/p injury to abdominal lymph draining vessel. Changed TF to include Med chain lipids, decrease fat content. Considering octreotide pending response to above. Awaiting fat sol vitamin levels. Serum IgM IgG low -likely lost in chyle. Discuss with hem/onc utility of replacing IgG in setting of infection. -discuss with emory IR possibility of performing lymphangiogram."
- June 26, 1443 hours: "Major issue now is chylous fistula putting out large amounts."
- July 12, 1454 hours: "Abdominal ostomy/fistula output which appears to be chylous based on serologies remains a difficult problem to medically address and surgery has not been offered due to his unstable clinical status. Remains critically ill."

157. On July 21, at 1848 hours, Mr. Oh died.

158. The Death Certificate, issued on July 30, identified the cause of death as "Septic shock with multiorgan failure, due to prolonged chyle leak."

32. Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest. Or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE		Approximate interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	A. SEPTIC SHOCK WITH MULTIORGAN FAILURE	WEEKS
	Due to, or as a consequence of B. PROLONGED CHYLE LEAK	MONTHS
	Due to, or as a consequence of C. TRAUMATIC FALL	MONTHS

Cause of Action: Injuries & Wrongful Death from Professional Negligence

159. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

160. The individual Defendants and the nursing staff of Atlanta Medical Center committed negligent acts and omissions that harmed Ben Oh.

161. The standard of care required the nursing staff to record Mr. Oh's home medications and to request orders to continue administering his heart medication. The nursing staff failed to do so, and thereby violated the standard of care and harmed Mr. Oh by contributing to his cardiac disturbances, respiratory distress, and vulnerability to infection.

162. The standard of care required Dr. Oduwole to review Mr. Oh's home medications and to enter orders to continue administering his heart medication. Dr. Oduwole failed to do so, and thereby violated the standard of care and harmed Mr. Oh by contributing to his cardiac disturbances, respiratory distress, and vulnerability to infection.

163. The standard of care required Dr. Barry Jeffries to place the suprapubic catheter with a reasonable degree of care and skill to ensure the catheter was in the bladder. Dr. Jeffries failed to do so, and thereby violated the standard of care and harmed Mr. Oh by contributing to his immune-suppression and vulnerability to infection, from which Mr. Oh died.

164. Upon their respective discoveries of the large volume of abnormal fluid produced by the suprapubic catheter, the standard of care required each of the

attending and consulting physicians — Dr. Amy D. Wyrzykowski, Dr. Khalid Iqbal, Dr. Thomas W. Schoborg, Dr. Zandraetta L. Tims-Cook, and Dr. John P. Ouderkirk — immediately to investigate the nature of the fluid and the cause of the leak, and then to investigate and pursue treatment options. Each of these physicians failed to respond in a reasonable, timely way. They each thus violated the standard of care and harmed Mr. Oh by contributing to his immune-suppression and vulnerability to infection, from which he died.

165. These primary acts of negligence do not exhaust the negligence from which Mr. Oh suffered at Atlanta Medical Center. Some of the additional acts of negligence not detailed in this Complaint were committed by residents, whom we believe to have been employees of one or more of the corporate Defendants.

166. These acts of negligence caused Mr. Oh to suffer conscious pain and suffering while he lived, and they caused his untimely death.

167. The principals of the individual Defendants and of the Atlanta Medical Center nursing staff are vicariously liable for the negligence of their agents.

168. Mr. Oh's estate is entitled to recover from the Defendants for the physical, emotional, and economic injuries Ben Oh suffered before he died, as a proximate result of the standard-of-care violations identified here.

169. Pursuant to OCGA Title 51, Chapter 4, Ben Oh's wrongful death beneficiaries are entitled to recover from the Defendants for the lost value of Mr. Oh's life and for special damages including funeral costs and other direct financial costs suffered as a proximate result of the standard-of-care violations identified here.

Damages

170. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

171. As a direct and proximate result of the Defendants' conduct, Plaintiff is entitled to recover from Defendants reasonable compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury for all damages Plaintiff suffered, including physical, emotional, and economic injuries.

172. WHEREFORE, Plaintiff demands a trial by jury and judgment against the Defendants as follows:

a. Compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;
b. All costs of this action; and
c. Such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/ Lloyd N. Bell
Georgia Bar No. 048800
Daniel E. Holloway
Georgia Bar No. 658026

BELL LAW FIRM
1201 Peachtree St. N.E., Suite 2000
Atlanta, GA 30361
(404) 249-6767 (tel)
bell@BellLawFirm.com
dan@BellLawFirm.com

Attorneys for Plaintiff

Affidavit of Peter M. Mowschenson, MD re. Byung D. Oh

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Peter M. Mowschenson, MD, who after first being duly sworn, states as follows:

Introduction and Limited Purpose of Affidavit

1. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

2. This affidavit does not state all my opinions concerning this case. This affidavit only serves the requirements of the statute — that is, it only identifies one standard-of-care violation for each medical provider at issue.

3. After consulting with me, Plaintiff's counsel did the typing for this affidavit and supplied the legalese, the formatting, the medical record chronology, etc. I reviewed and edited the draft text. The substantive opinions and conclusions presented here are mine.

4. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

5. I hold all the opinions expressed below to a reasonable degree of medical certainty — that is, more likely than not.

Topic & Opinions

6. This affidavit concerns medical services provided to Byung D. Oh in May and June 2018 at Wellstar's Atlanta Medical Center.

7. More specifically, this affidavit concerns the standards for a physician (a) confirming proper placement of a medical device inserted into the body and (b) an attending physician in a hospital responding to grossly abnormal fluid losses by a post-surgical patient.

8. **Dr. Barry Jeffries** violated his standards of care as follows:

Dr. Jeffries inserted a supra-pubic catheter intended to be inserted into the bladder. The standard of care required Dr. Jeffries to confirm proper placement of the catheter. But despite being a radiologist and having the ability to confirm placement with radiological imaging, Dr. Jeffries did not do so. Instead, Dr. Jeffries both misplaced the catheter and he left it misplaced.

9. The following attending and consulting physicians violated their standards of care:

Amy D. Wyrzykowski, MD (attending physician)

Khalid Iqbal, MD (consulting nephrologist)

Thomas W. Schoborg, MD (consulting urologist)

Zandraetta L Tims-Cook, MD (consulting infectious disease physician)

John P Ouderkirk, MD (consulting infectious disease physician)

10. The foregoing physicians violated the standard of care as follows:

Each of these physicians learned that the suprapubic (SP) catheter placed in Mr. Oh immediately began producing fluids that were grossly abnormal both in volume and in color. The physicians also knew that Mr. Oh had suffered serious infections and presumed kidney injury. Upon discovery of the abnormal SP catheter production, the standard of care required the attending and consulting physicians immediately to investigate the composition and cause of the abnormal fluid. None of these physicians did so. They therefore violated the standard of care.

Qualifications

11. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.

13. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

14. The acts or omissions at issue here occurred in May-June 2018.

15. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In May and June 2018, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

   Specifically, I was then licensed by the State of Massachusetts to practice medicine.

b. In May and June 2018, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:

   - Confirming proper placement of a medical device inserted into a patient's body.
   - Responding to grossly abnormal fluid productions by a post-surgical hospital patient, as an attending or consulting physician.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of

specialty of my profession for at least three of the five years prior to May and June 2018, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I am a board-certified surgeon in a teaching hospital and for years have practiced and taught medical residents in the care of patients both in surgery and after surgery, including the handling of post-operative complications.

Evidence Reviewed

16. I have reviewed Byung Oh's medical records from Wellstar's Atlanta Medical Center, the Atlanta Veteran's Administration Hospital, and the Death Certificate for Mr. Oh.

Discussion and Factual Basis for Opinions

General Principles

17. Misplacement of a medical device in a patient's body may cause serious, lasting damage to the patient.

18. After a medical device has been placed, subsequent medical providers may assume (properly or improperly) that the device was correctly placed. That may cause misplacement of a device to go unrecognized and unremedied — increasing the harm caused by the device.

19. As a general matter, therefore, when a medical device is inserted into a patient's body, proper placement must be confirmed. When feasible, the standard of care requires radiological confirmation — most often by X-Ray or CT scan.

20. Post-surgical patients in the hospital are vulnerable to infection. The risk increases for elderly patients and for patients with invasive placement of medical devices — including intravenous lines, intubation and ventilator devices, tracheostomy tubes, and catheters.

21. Abnormal fluid loss may indicate an infection or disease process, or be an indicator of a complication resulting from an inserted device.

22. Abnormal urine may indicate infection or an abnormal communication of the urinary system with another structure such as intestine

23. A large loss of chyle — indicated by a milky color —impairs the body's immune system by depleting lymphocytes and causing malnutrition both of which increase the patient's vulnerability to infection.

24. As a general matter, therefore, when an attending or consulting physician learns that a post-operative patient is producing grossly abnormal fluids, the physician must promptly investigate the nature and cause of the fluid production.

25. This duty increases in importance when the patient is at heightened risk of infection, or heightened danger from an infection.

Medical Record Chronology

The medical records indicate the following:

26. April 30, 2018: Byung (Ben) Oh, 77 yrs old, arrived at Wellstar's Atlanta Medical Center ER by ambulance, after falling from a ladder while doing yard work. (WHS 63, 68.)

27. Burst fracture of the vertebra at T12. (WHS 1327-29.)

28. May 4, 2018: surgery to repair and stabilize the spine. (WHS 996.). This was performed through the left chest, and a chest tube was placed.

29. Intra-op: Atrial fibrillation, then return to sinus rhythm. (WHS 994, 996.)

30. Post-op: Transfer to Neuro ICU. (WHS 65.)

31. May 5, 0630 hours: X-Ray Chest report — "Interval development of moderate atelectasis or infiltrate at the right lung base with a small right pleural effusion. Mild atelectasis is now seen at the left lung base." (WHS 1318.)

32. May 6, 1246 hours: Transfer to Med Surg unit. (WHS 65.)

33. May 8, 1757 hours: "mild respiratory distress today. CXR showed small apical pneumothorax, chest tube placed back on suction. Continue pain control and Pt. Monitor chest tube output." (WHS 713.). It is important to note that no abnormal fluid drained via the chest tube.

34. May 8: X-Ray abdomen ordered because of abdominal distension. (WHS 1312-13.)

35. May 8, 2258 hours:

> "BAT called to pt's room for increased work of breathing. Pt seen and evaluated. Vital signs as follows: sats 94% on 4L NC, HR 120s, SBP 120s. Pt tachypneic with crackles heard throughout the precordium. Stat ABG consistent with respiratory alkalosis, paO2 50. CXR without evidence of ptx, consistent with bilateral congestion. EKG consistent with a.fib with RVR. Pt currently not on any rate controlling medications.
>
> "Given a.fib with RVR and increasing tachypnea and risk of respiratory failure, pt transferred to the ICU with stat labs ordered. Amiodarone bolus and continuous gtt ordered. Pulmonary toilet, redirect pt - pt confused and agitated. Continue left chest tube to suction. Repeat ABG in AM. Discussed with Dr. Dougherty who is in agreement with plan."
>
> (WHS 707.)

36. May 8, 2327 hours: Transfer to Cardiac ICU. (WHS 66.)

37. May 9: Begin bipap machine. (WHS 708.) (As of at least May 11, Mr. Oh still had the bipap. (WHS 672.))

38. May 9, 1212 hours: Order antibiotics for pneumonia, and continuing chest tube suction. (WHS 707.)

39. May 11, 0611 hours: "Pulm: ABG c/w respiratory alkalosis, on bipap this morning, pulmonary toilet, L CT to suction, yesterday CXR shows stable b/l

pulmonary infiltrates. CTA chest neg for PE. Being treated for pneumonia." (WHS 663.)

40. May 11, 1135 hours: "still in afib, rate in the 110s. Will add lopressor standing to PO amio." (WHS 663.)

41. May 12, 0806 hours: "abdomen is soft without significant tenderness, masses, organomegaly or guarding." (WHS 623.)

42. May 13, 0916 hours: "Interval History: Patient still requiring high supplemental 02, currently on vapotherm. Also still in A-fib despite scheduled metoprolol and PO amiodarone." (WHS 597.)

43. May 14, 0617 hours: "Blood Cx grew MRSA, on vanc." (WHS 581.)

44. May 15, 0609 hours: "Heme/Infectious: afebrile, treating for pneumonia with cefepime day 6/7. Blood Cx grew MRSA, on vanc day 4/14." (WHS 574.)

45. May 15, 2000 hours: "respiratory rate very tachypnea and pt on 85% FiO2 on vapo therm's, suctioned as needed. D51/2 N/s with 20 klc In progress , no acute distress noted, pt on isolation for MRSA in the Blood. Bilateral wrist restraint in place." (WHS 558.)

46. May 16, 1501 hours: "Given noted RR, increased respiratory intervention, mental status, and s/s of aspiration, recommend NPO/alternate means of nutrition/hydration and completion of instrumental swallow study as indicated. Oral cavity clear at end of evaluation." (WHS 549.)

47. May 17, 1645 hours: "X-Ray Chest ... Impression: Persistent pattern of pulmonary edema and/or consolidation/infiltration unchanged from multiple previous exams." (WHS 1303.)

48. May 17, 2139 hours: "PO meds not given this morning, will resume PO regimen for afib to better control Hr. Respiratory status slightly improved until about 20 minutes after Pt. Desaturation with thick sputum. Suctioned aggressively and saturations improved with increase of 02 on vapotherm. Discussed patients

condition at length with daughters Susan and Amy - will insert dobhoff tube for nutrition and meds." (WHS 529.)

49. May 18, 0544 hours:

> Called to evaluate the patient for desaturation after rolling him. He was satting in the mid 80s, using accessory muscles, on a NRBM. I called and spoke to his daughter Susan about the need for intubation. She requested a second opinion from the Anesthesia team but ultimately agreed. He was intubated without difficulty and a large amount of thick secretions were suctioned out of his airway. His sats then came up to 100%.
>
> A bronchoscopy was then preformed with copious secretions noted. These were aspirated and cultures sent.
>
> Will add zosyn for additional antibiotic coverage. Continue Vane and Diflucan.
>
> Wean vent as tolerated.
>
> Continue NG meds and tube feeds
>
> (WHS 522.)

50. May 18, 1024 hours: Intubation. "Called for the ICU team for consultation for urgent/e merge nt intubation for this patient. Pt has a history of fall, SDH, cervical fracture, complicated by ARDS, afib. Pt has a history of DM and CAD s/p CABG. At the time of intubation his 02 sat was 80% on a non-rebreather and his PO2 was 48. He appeared to be in extremis, with RR 30-40." (WHS 983-85.)

51. May 19: MRSA present in blood. (WHS 830.)

52. May 20, 2221 hours:

> 1. Acute respiratory failure with hypoxia and hypercapnia. ABG today shows resolution of respiratory acidosis. Oxygenation adequate on ABG with FiO2 45%. Decrease FiO2 to 40% then slowly wean PEEP as tolerated. Will accept

a SaO2 of 88-92%. Discussed with RT. Possibility of trach broached with daughter today in our daily update.

2. Afib. Rate controlled. Cardiology desires systemic anticoagulation. Given TBI and spinal surgery, will clear with NSGY before initiation of heparin gtt. Heparin gtt chosen over eliquis or other agent for ease of turning off and correcting PTT in light of likely need for additional invasive procedures. Amio gtt completes this evening and will continue with po amio.

3. Dysphagia. Tube feeds at goal.

4. Hyperglycemia. BG 398 on am labs. Will initiate insulin gtt to control BG with a goal of 150-170.

5. Adrenal insufficiency. On steroids. Will treat for 7 days then taper. Steroids contributing factor in hyperglycemia.

6. MRSA bactermia. On zyvox for treatment. Remains intermittently febrile. F/u culture results and taper abx as appropriate.

S/p left thoracotomy for spine exposure. Less than 150 mL out of CT in 24 hours. Will d/c today. Family (daughter Susan) updated by me.

(WHS 493.)

53. May 22, 1050 hours: Initial Nephrology consult. Notes “suprapubic fullness” in the abdomen. Assessment/Plan:

1. AKI: sec to multiple factors. Bladder scan done at bedside (nursing) revealed about 530cc urine in bladder despite foley catheter in place. Will need to rule out obstruction amidst suggestions of ATN sec to hypotension and ARDS plus/- drug related intestitial nephritis in this diabetic pt who needed contrast evaluation of his injury.

2. Respiratory Failure with ARDS

3. Hx of Diabetes with uncontrolled BS on steroid therapy.

4. Leucocytosis - on antibiotics.

5. Anemia

(WHS 862, 866.)

54. May 23, 0604 hours: "Currently treating Candida PNA with diflucan and MRSA bacteremia with zyvox. Continue and will f/u BAL and blood cultures for narrowing – blood grew MRSA, BAL grew Candida. On heparin gtt for therapeutic anticoagulation. Endo: hyperglycemic, on insulin ggt. Better controlled today. On high dose steroids for adrenal insufficiency." (WHS 270.)

55. May 23, 0959 hours: Ultrasound Retroperitoneal notes "A free ascites fluid is present throughout the abdomen." (WHS 1295.)

56. May 23, 2031 hours:

Concern that foley is non-functional given 1L in bladder scan and minimal UOP. At the request of my attending physician, Dr. Amy Wyrzykowski, I performed a bedside sonogram exam to evaluate for foley position. I as well as my chief resident on call were both able to visualize the foley in th bladder. To confirm this, we flushed the foley with 30cc NS and a total of 50cc of urine was returned albeit not the 1L we can see on the bladder scan. Given this, and at the request of Dr. Wyrzykowsi, I placed a stat consult to Urology for recommendations since we are not getting adequate urine return given functional foley and 1L bladder scan.

I personally spoke with Urologist Dr. Schoberg who recommends we attempt to place a coude catheter. He believes our foley may be in the prostatic urethra given BPH. He would like us to place a coude and hub it to make sure its in the bladder. If this fails or we are unable to pass this, he recommends placing of a Suprapubic catheter.

- will proceed with this plan and will notify family.

(WHS 450.)

57. May 24, 0039 hours: Consult to Interventional Radiology for placement of suprapubic catheter. (WHS 1431.)

58. May 24, 0609 hours: "Bedside suprapubic catheter placement attempted yesterday, was not successful. Will have CT guided placement with urology today. Renal: BUN/cr rising. Renal on board, working up obstructive vs intrarenal etiology. Lovenox switched to heparin, vanc switched to zyvox. Monitor and will avoid nephrotoxic agents. Plan for vascath placement and dialysis. Urology to place CT guided suprapubic catheter today." (WHS 271, 276.)

59. May 24, 0700 hours: "Dr. Schoborg at bedside. Foley cath placed. Noted pt with large amount of urine saturating 2 pads. Dressing to SP attempt site saturated. Urine draining. Foley cath with 200ml of urine noted as well. Slightly blood tinged. Linen and gown changed." (WHS 3339.)

60. May 24, 0800 hours: "Drainage pouch placed to low pubis area to drain urine into bag." (WHS 3339.)

61. May 24, 0900 hours: "Spoke with Dr. Schoborg. Notified him that surgery thought he was getting a SP cath placed in IR. Stated pt didn't need SP and order cancelled." (WHS 3524.)

62. May 24, 0902 hours: Initial Urology consult. "Chief Complaint: urethral stricture. Modifying Factors: inability to insert cath. Respiratory: No use of accessory muscles on room air. Abd/GI: Soft, Not tender, Not distended. Endo: No buffalo hump or hyperpigmentation Hematologic/Lymphatic: No significant lower extremity edema Genitourinary: abnormal genitalia. Genital edema without foley." (WHS 845, 848.)

63. May 26: MRSA cleared from blood. (WHS 830.)

64. May 26, 0938 hours: "GI: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site. Renal: Foley in place with minimal output. Urostomy over SPT attempt site with >1L UOP" (WHS 277.)

65. May 28, 0607 hours: "Gl: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site. Renal: Foley in place with minimal output. Urostomy over SPT attempt site with 650cc UOP during day shift." (WHS 359.)

66. May 28, 1357 hours: Urology Progress Note

> Plan:i performed a bladder scan(personally) and felt the bladder was decompressed wthe foley.there is some persistent drainage from a prior attempt to insert an s-p tube.
>
> Will schedule a ct scan but not medically transportable at this juncture
>
> Will schedule a renal u/s at the bedside to further assess any pssibility ok obstructive uropathy.(spent 35 mins in direct pt care)
>
> (WHS 379-80.)

67. May 29, 0608 hours:

> Gl: Soft, NTND, no rebound or guarding. Urostomy bag collection urine from SPT attempt site.
>
> Renal: Foley in place with minimal output. Urostomy over SPT attempt site with 400cc UOP during day shift,Foley with 140 cc OP in past 24 hrs
>
> ...
>
> Renal: Got HD yesterday. Urology on board, attending performed bladder scan and reported adequate decompression of bladder. Poss CT per urology when patient more stable.
>
> (WHS 372-73.)

68. May 29, 1346 hours: Interventional Radiology report by Dr. Barry Jeffries, re. placement of suprapubic catheter:

> PROCEDURE: All elements of maximal sterile barrier technique were utilized including cap and mask and sterile gown and sterile gloves and a large sterile sheet and hand hygiene and a 2% chlorhexidine for cutaneous

antisepsis. Using local anesthesia, a 22-gauge needle was advanced into the bladder from a suprapubic approach. Needle position was confirmed by injection of 5 mL of Omnipaque 350. A 0.018 guidewires introduced followed by a 5 French exchange catheter and trocar. The tract was dilated to a 12 French diameter. A 12 French drainage catheter was introduced. The cope loop was reshaped. The catheter was attached to dependent drainage. Approximately 500 mL of whitish-brown urine was drained spontaneously. The catheter was secured to skin utilizing a single ligature of 3-0 nylon suture. There were no complications and the patient tolerated the procedure well. He left the department satisfactory condition.

IMPRESSION: Successful suprapubic cystostomy as described

(WHS 1289.)

69. May 29, 1844 hours: Nephrology progress note: "Subjective: Overnite events reviewed with staff RN. Remains orally intubated on vent. Urine out put dropped overnite. Suprapubic cystostomy non functional. Bladder scan showed 500 ml of urine in bladder." (WHS 361.)

70. May 30, 0701 hours: "Suprapubic catheter placed yesterday by IR. Per nurse, 7L whitish UOP since placement. Foley discontinued. SPT with 7L recorded UOP since placement. Urine whitish and cloudy appearing." (WHS 351.)

71. May 30, 1555 hours:

1. Acute respiratory failure. On vent. Marginal weaning parameters today. Will rest on SIMV and try again in morning. If not able to extubate tomorrow, will proceed with tracheostomy. Discussed this in detail with patient's daughter, Susan, and wife.

2. Dysphagia. TFs at goal. Well tolerated. Abdominal exam significantly improved since adequate drainage of bladder.

3. Acute renal failure. Likely combination of ATN (multifactorial: vane, zosyn, anesthesia, hypotension) and obstruction. HD as per renal. Creatinine today 3.45 with a BUN > 100. Remains lucid in spite of elevated BUN.

4. Adrenal insufficiency. Resolved.

5. Hyperglycemia. Improved now that steroids have been weaned. Well controlled off insulin gtt.

6. MRSA bacteremia. Resolved. F/U cultures negative at 72 hours. D/C abx.

7. Bladder outlet obstruction. S/p SPT with copious urine output. Will follow volume status and electrolytes closely.

8. Hyponatremia. Decrease free water flushes.

(WHS 353.)

72. May 31, 0558 hours:

GI: Soft, Nt, noticeably less distended abdomen since SP cath placement compared with previous exams, no rebound or guarding.

Renal: Foley discontinued. SPT with >4L recorded UOP in last 24 hrs. Urine whitish and cloudy appearing.

...

GI/Fen: Malnutrition related to chronic illness. Nepro tube feeds. Now 200 cc q8hrs FWF given slight hyponatremia

Renal: Nephro following for AKI, HD as needed. Got HD 3 days ago. SBT placed by IR with 4L UOP recorded in last 24 hrs.

Heme/Infectious: Afebrile. Leukocytosis resolved and maintenance Cx negative. Completed treatment of Candida PNA with diflucan and MRSA bacteremia with zyvox. No Abx currently. Hemoglobin stable, 8.5 today

Endo: hyperglycemic, insulin ggt discontinued, getting basal dose now. Steroids for adrenal insufficiency, now resolved, off steroids.

Attending Comments:

1. Acute respiratory failure. Patient's breathing labored on CPAP trial with a pressure support of 10.

Given the current clinical appearance, I am not comfortable extubating the patient. Tracheostomy discussed in detail with daughter and informed consent obtained by me.

2. A fib. Controlled with po amiodarone.

3. Dysphagia and malnutrition. On TFs at goal.

4. AKI requiring HD. To be dialyzed today for clearance given magnitude of uremia according to nephrology note.

5. Hyponatremia. Decrease free water flushes.

6. Obstructive uropathy. Now with SPT and experiencing post obstructive diuresis. Management of SPT as per urology.

7. No current ID issues

(WHS 331-33.)

73. May 31, 0929 hours: Nephrology progress note. "He was noted with rising SCr from 5/19/18 and now it is 2.79 and we have been consulted. He was noted to have AKI and started on dialysis. Subsequently he was noted to have obstructive uropathy secondary to urethral stricture. He had suprapubic catheter replaced and has had good Uo. Remains polyuric. ABDOMEN: Abdomen is soft, non tender, no organomegaly. . . . Assessment: AKI secondary to Obstructive uropathy/ ATN . He has significant post obstructive diruesis and has had significant increase in azotemia overninght." (WHS 334-37.)

74. May 31, 1418 hours: Operative Note: Percutaneous Tracheostomy. (WHS 895.)

75. June 1, 1058 hours: Nephrology progress note. "Assessment: AKI secondary to Obstructive uropathy/ ATN. He has significant post obstructive diuresis which is slowly decreasing. S/P dialylsis yesterday. . . . Plan: Most of his post obstructive diuresis is expected excretion of accumulated fluid volume. Patient is not getting any IVF, however, if his blood pressure remains low, SW increases and UO decreases would restart at a lesser rate to maintain IV volume." (WHS 319-23.)

76. June 2, 0835 hours: Nephrology progress note. "He had suprapubic catheter replaced and has had good Uo. Remains polyuric and Urine has been milky." (WHS 315.)

77. June 2, 1002 hours: "Renal: Foley discontinued. SPT with 9L recorded UOP in last 24 hrs. Urine is milky white. Dialyzed yesterday. Renal: Nephro following for AKI, HD as needed. Dialyzed yesterday. SBT OP still high. IVF given polyuria. Urine sent for studies (lipids, calcium, phos) given milky white appearance." (WHS 283-85.)

78. June 3, 1328 hours: Nephrology progress note.

> Remains polyuric and Urine has been milky.
>
> Assessment
>
> AKI secondary to Obstructive uropathy/ ATN .
>
> Polyuria. He has significant post obstructive diuresis which persists indicating significant tubular injury and nephrogenic DI
>
> Lymph leak in urine, possibly linked to lymphatic injury/obstruction
>
> Mild hyponatremia, resolved
>
> Plan
>
> No indication for dialysis today. If further dialysis is needed would use CRRT
>
> In view of continuing polyuria, will try ddavp as sodium is now beginning to go up. AKI contraindicates use of NSAIDS or thiazide

Continue IVF / pressors to keep MAP more than 60. We have to be careful not to give too much fluid as it can perpetuate the polyuria.

Will also give IV calcium gluconate to see if hypocalcemia may be contributing to the polyuria.

Continue to monitor renal function, UO and lytes to determined need for further RRT

Strict I/O

Dose all medications for GFR less than 30

Continue antibiotics per primary team

Other per ICU team

(WHS 308, 312.)

79. June 4, 0546 hours: Pulmonary edema noted on chest xray. (WHS 1283.)

80. June 4, 1600 hours: Nephrology progress note. "Polyuria with chyluria. Suprapubic catheter draining milky urine. Shock ? Sepsis ? Volume depletion caused by polyuria. Persistent chyluria may lead to severe protein loss, consider TPN if it persists." (WHS 296.)

81. June 5, 0614 hours: "SPT with approx 7L recorded UOP in past 24 hrs. Urine is less milky appearing today." (WHS 252.)

82. June 5, 1907 hours: Nephrology progress note. "Chyluria continues but some clearance of urine. Milky urine." (WHS 247-48.)

83. June 6, 1258 hours: Initial Infectious Disease consult.

Chyluria and MRSA

"Patient's urine was reportedly normal prior to the placement of the suprapubic catheter. Repositioning the catheter is recommended, if this is feasible."

"He has also required placement of a suprapubic catheter for management of urinary retention. He has had chyluria since the suprapubic catheter was placed."

"GU: small abrasion on head of penis; suprapubic catheter in place, no leakage, chylous urine collected."

(WHS 830-34.)

84. June 6, 1728 hours: Nephrology progress note. "Chyluria worsening. Suprapubic catheter draining milky urine." (WHS 236.)

85. June 7, 0609 hours: "Approx 10 liters of milky fluid drained through catheter in past 24 hours. Intake 11670. Output 14225 (Urine 13875; Stool 350)." (WHS 218.)

86. June 8, 0608 hours: "today the patient went to radiology for a cystogram through the suprapubic tube that had been placed by interventional radiology. When contrast was injected through the catheter, it flowed freely into the peritoneal cavity and not the bladder. The tip of the tube was in the mesentery of the small bowel and no portion of the tube was within the bladder. Therefore, the tube was removed. It is unclear to me how or when the tube came out of the bladder." (WHS 153.)

87. June 8, 1554 hours: CT Pelvis with contrast — results called to Jacob in Coronary ICU. "A suprapubic catheter has been placed superior to the urinary bladder and not within the urinary bladder. Extensive contrast material, presumably injected through the suprapubic tube is in the peritoneum outlining loops of bowel." (WHS 1279.)

88. June 8: Suprapubic catheter repositioned. (WHS 95.)

89. June 8, 1912 hours: Nephrology progress note. "It appears that the suprapubic catheter was in the peritoneal cavity. It has been pulled. I spoke to Dr Schoborg in the morning. The plan is to do a bladder scan and decide on replacing it today. Agree with catheter holiday. Will stop CRRT for now and carefully monitor renal function and acid base balance. If acidosis increases, will restart bicarbonate infusion. Will restart HD/CRRT based on labs. Continue high protein and low fat

diet. Continue IV antibiotics, vent support and pressors per pr care team." (WHS 199.)

90. June 9, 0951 hours: Infectious Disease progress note. "MRSA Bacteremia and sepsis, recurrent Clearance of bacteremia is likely impeded by the continued presence of indwelling catheters and spinal hardware." (WHS 95.)

91. June 9: Transfer to Atlanta VA hospital. (VA 303.)

92. June 12, 1518 hours: "Patient continue to leak chyle via the SBT requiring re-imaging with contrasted CT demonstrating SPT in the peritoneal cavity, catheter subsequnelty remove and patient has contiuned to leak chylous fluid up to 12L/day. Veterans daughter and wife decided to transfer care to the VA on ventilator. General surgery called for evaluation of abdominal wound. ... Chylous ascites not a general surgery problem. No surgical intervention at this time." (VA 1475-77.)

93. June 19, 0754 hours: "Currently bag is set to gravity and draining peritoneal fluid, studies of the fluid reveal that fluid is seroequivalent with elevated TG. Chlylous ascites likely from postoperative cause (retoperitoneal lymph node dissection)." (VA 1286.)

94. June 20, 1446 hours: "Patient continues to put large amts of lymphatic fluid out of old drain site." (VA 1277.)

95. June 21, 1602 hours: "Regarding losses, currently we are investigating mechanisms to decrease chylous losses (approx 1.8 liters overnight)." (VA 1221-22.)

96. June 23, 1527 hours: "Chylous Ascitic fluid output: Concern for excess volume loss from abdomen decreasing oncotic pressure via protein loss, and worsening fluid losses. We are attempting to minimize nutritient and protein loss with initation of conservative therapies- Med chain TG, reduced lipids in TF. Will consider octreotide pending response to aforementioned items." (VA 1176-77.)

97. June 25, 2125 hours: "Shock: Likely fluid losses/ low oncotic pressure, doubt uncontrolled sepsis source. -continue midodrine, wean levophed, continue albumin. - Addressing chylous ascitic fluid losses. --Chylous Ascites- s/p injury to abdominal lymph draining vessel. Changed TF to include Med chain lipids, decrease fat

content. Considering octreotide pending response to above. Awaiting fat sol vitamin levels. Serum IgM IgG low -likely lost in chyle. Discuss with hem/onc utility of replacing IgG in setting of infection. -discuss with emory IR possibility of performing lymphangiogram." (VA 1121-22.)

98. June 25, 2245 hours: "Currently bag is set to gravity and draining peritoneal fluid, studies of the fluid reveal that fluid is seroequivalent with elevated TG. Chlylous ascites likely from postoperative cause (retoperitoneal lymph node dissection). General surgery evaluated on admission with no recommendation for surgical intervention." (VA 1124-31.)

99. June 26, 1443 hours: "Major issue now is chylous fistula putting out large amounts." (VA 1142.)

100. July 4, 1202 hours: "Has had minimal output via tube since 6/30." (VA 846-54.)

101. July 12, 1454 hours: "Abdominal ostomy/fistula output which appears to be chylous based on serologies remains a difficult problem to medically address and surgery has not been offered due to his unstable clinical status. Remains critically ill." (VA 577-78.)

102. July 21, 1848 hours: Mr. Oh dies.

103. July 30: Death Certificate. "Septic shock with multiorgan failure, due to prolonged chyle leak."

Discussion

104. The suprapubic catheter placement on 5/29/2018 was below the standard of care. Dr. Jeffries was required to ensure the catheter was in its proper place. The resources of a radiology unit were available. The misplacement of the catheter indicates carelessness either in failing to confirm placement or in reading the radiology images taken to confirm placement. The failure to properly confirm the placement of the catheter violated the standard of care.

105. Very shortly after the suprapubic catheter was placed, the catheter began returning fluid that was grossly abnormal. The fluid was intended to be from the bladder, but it did not look like urine. Furthermore, according to the infectious disease physician, Mr. Oh's urine was reportedly normal before the SP catheter was placed. And after that catheter was placed, it produced very large volumes of fluid.

106. The amount and color of the fluid were suspicious.

107. Furthermore, by May 29 when the SP catheter was placed, Mr. Oh had been in the hospital for approximately a month — with a difficult course involving cardiac problems, respiratory distress requiring intubation, and a MRSA infection that had only recently been cleared (among other problems).

108. When the SP catheter was placed and returned grossly abnormal fluid, Mr. Oh was highly vulnerable and at risk. To assume that abnormal signs were benign would put Mr. Oh unnecessarily in danger. To delay investigation of abnormal signs would put Mr. Oh unnecessarily in danger.

109. On May 30, immediately on learning of the abnormal fluid returned by the SP catheter, the attending and consulting physicians should have diligently investigated the nature and cause of the fluid returned. They did not do so. Accordingly, they violated the standard of care.

Miscellaneous

110. To repeat, this affidavit does not exhaust my current opinions and of course does not reflect any opinions I may form later.

111. Again, I hold each opinion expressed in this affidavit to a reasonable degree of medical probability or certainty; that is, more likely than not.

Peter M. Mowschenson, MD

SWORN TO AND SUBSCRIBED before me

april 29, 2020

Pamela Haidt Lee

NOTARY PUBLIC

My Commission Expires: 03-07-2022

Curriculum Vitae

Date Prepared: 11/11/19

Name: Peter Michael Mowschenson

Office Address: 1180 Beacon St.
Brookline, MA 02446

Home Address: 1 Charles St. South, 15D
Boston, MA 02116

Work Phone: 617-735-8868

Work Email: pmowsche@caregroup.harvard.edu

Work FAX: 617-730-9845

Place of Birth: Penang, Malaya

Education

1969	B.Sc. (First Class Honours)	Guy's Hospital Medical School, University of London, England
1973	L.R.C.P., M.R.C.S.	
1973	M.B.,B.S. (First Class Honors)	
1975	M.R.C.P. (U.K.)	
1977	F.R.C.S. (Eng)	

Postdoctoral Training

1973-1975	Registrar	Surgery	Guy's Hospital, London
1975-1979	Resident	Surgery	Beth Israel Hospital
1979-1980	Surgical Coordinator		Beth Israel Hospital
1980-1982	Fellow	Endocrinology	Harvard School of Public Health

Faculty Academic Appointments

7/81-9/90	Clinical Instructor in Surgery	Harvard Medical School
1990-2016	Clinical Assistant Professor of Surgery	Harvard Medical School

2017	Assistant Professor of Surgery		Harvard Medical School

Appointments at Hospitals/Affiliated Institutions

1981-1987	Assistant Surgeon	Dept. of Surgery	Beth Israel Hospital
1987-1988	Associate Surgeon	Dept. of Surgery	Beth Israel Hospital
1989-	Surgeon	Dept. of Surgery	Beth Israel Hospital [after 1996: Beth Israel Deaconess Medical Center]

Major Administrative Leadership Positions

Local

1984-1988	Chief of Surgery, Brookline Hospital, Brookline, MA
1994-1997	Executive Board Member, Harvard Center for Minimally Invasive Surgery
1995- 2019	President, Affiliated Physicians Inc., Beth Israel Deaconess Medical Center [prior to 1996: Affiliated Physicians Inc., Beth Israel Hospital]
1996-2014	Vice President & Board Member, Beth Israel Deaconess Care Organization [prior to 2013: Beth Israel Deaconess Physicians Organization]
2001-2010	Member, Board of Trustees, Beth Israel Deaconess Medical Center
2014-Present	Board Member, Beth Israel Deaconess Care Organization

Committee Service

Local

1982-2000	Staff Council	Beth Israel Hospital
1988-2001	Medical Executive Committee	Beth Israel Hospital [after 1996: Beth Israel Deaconess Medical Center]

Professional Societies

1983-Present	American Association of Endocrine Surgeons	Member
1983-Present	American College of Surgeons	Fellow
1987-	Boston Surgical Society	Member

Present		
1981-Present	Massachusetts Medical Society	Member
1990-Present	Society Of Laparendoscopic Surgeons	Member
1990-Present	New England Surgical Society	Member
1990-Present	Society for Surgery of the Alimentary Tract	Member

Honors and Prizes

1968	Michael Harris Prize In Anatomy	Guy's Hospital Medical School
	Gowland Hopkins Prize In Biochemistry	Guy's Hospital Medical School
	Pharmacology Prize	Guy's Hospital Medical School
	University Award For Best Performance In 2nd M.B. Examination	Guy's Hospital Medical School
1970	Dermatology Prize	Guy's Hospital Medical School
1971	Charles Oldham Prize in Ophthalmology	Guy's Hospital Medical School
1972	Beaney Prize In Patholgy	Guy's Hospital Medical School
	Golding Bird Gold Medal and Scholarship in Bacteriology	Guy's Hospital Medical School
	Hillman Prize In Paediatrics	Guy's Hospital Medical School
	Hillman Prize In Haematology 1973	Guy's Hospital Medical School
	Charles Foster Prize In Cardiology	Guy's Hospital Medical School
	Begley Prize of The Royal College of Surgeons	The Royal College of Surgeons
	Honours in the Final M.B.,B.S. Examination in Medicine, Surgery, Pharmacology, Pathology	Guy's Hospital Medical School
	University Gold Medal - Top Performance in the final qualifying examination for M.B.,B.S.	Guy's Hospital Medical School
1975	Hallet Prize of The Royal College of Surgeons for Top Performance in the F.R.C.S Examination	The Royal College of Surgeons
1976	Harris Yett Prize In Orthopaedics	Beth Israel Hospital

1986	Harold Bengloff Award	Dept. of Surgery, Beth Israel Hospital	Teaching
2004	Harold Bengloff Award	Dept. of Surgery, Beth Israel Deaconess Medical Center	Teaching

Report of Local Teaching and Training

Teaching of Students in Courses

1981-present	*Introduction to Clinical Medicine* Surgical preceptor for Harvard Medical Students	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 2 hrs per week
2000-2013	"Surgery of Inflammatory Bowel Disease" *Core Clerkship in Surgery* 3rd year medical students	Beth Israel Deaconess Medical Center 1 hr lecture, 3-4 times/year

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

1988-1993	Text Review sessions for surgical residents. Weekly sessions for topic review and regular multiple choice question examination.	Beth Israel Hospital 4 hrs weekly

Clinical Supervisory and Training Responsibilities

1981-	*Core Clerkship in Surgery* 3rd year medical students Clinical teacher on rounds and in the OR	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 3-4 operative days; daily inpatient rounds
1981-	*Residency Program in General Surgery* PGY 1-5 Clinical teacher on rounds and in the OR	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 3-4 operative days; daily inpatient rounds

Formal Teaching of Peers (e.g., CME and other continuing education courses)

No presentations below were sponsored by outside entities.

1992- 2016	Mowschenson PM. Advances in the Medical And Surgical Treatment of Inflammatory Bowel Disease. Harvard Medical School Department of Continuing Education.	Boston, MA

Local Invited Presentations

No presentations below were sponsored by outside entities.

1983	Surgical Treatment of Hyperparathyroidism. Surgical Grand Rounds/Beth Israel Hospital, Boston, MA

1987 Management of substernal goiters.
Primary Care rounds/Beth Israel Hospital, Boston, MA

1989 Controversies regarding Hyperparathyroidism.
Surgical Grand Rounds/Beth Israel Hospital, Boston, MA

1990 Abdominal Pain.
Medical Grand Rounds/Beth Israel Hospital, Boston, MA

1991 Surgical approach to thyroid disorders.
Primary Care Rounds/Beth Israel Hospital, Boston, MA

1991 Current options in the surgery of ulcerative colitis.
Anesthesia Grand Rounds/Beth Israel Hospital, Boston, MA

1992 Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital.
Surgical Grand Rounds/Beth Israel Hospital, Boston, MA

1993 The Ileoanal Pouch Operation: Controversies and Outcome.
Surgical Grand Rounds/Brigham & Women's Hospital, Boston, MA

1994 Surgical advancements in the treatment of inflammatory bowel disease.
Medical Grand Rounds/Beth Israel Hospital, Boston, MA

1995 Ileoanal pouch surgery.
Surgical Grand Rounds/New England Deaconess Hospital , Boston, MA

1996 Surgical Management of Hyperparathyroidism.
Surgical Grand Rounds/Mt. Auburn Hospital, Cambridge, MA

1997 Advances in the surgical treatment of inflammatory bowel disease.
Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA

1999 Advances in the surgical treatment of inflammatory bowel disease.
Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA

2000 Ten years of ileoanal pouch surgery. What lessons can be learned?
Surgical Grand Rounds/Beth Israel Deaconess Medical Center, Boston, MA

2001 Current Surgical Treatment of Inflammatory Bowel Disease.
Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA

2005 Instructor in Laparoscopic Colectomy.
Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA

2014 Is our treatment of Hyperparathyroidism evidence based?
Annual Pallotta Stevens Lecture: Beth Israel Deaconess Medical Center, Boston, MA

2014 Is our treatment of Hyperparathyroidism evidence based?
Surgical Grand Rounds/Mount Auburn Hospital, Cambridge, MA

2015 Hyperparathyroidism. To Operate or Not. What is the evidence?
Surgical Grand Rounds/Beth Israel Deaconess Medical Center, Boston, MA

Report of Regional, National and International Invited Teaching and Presentations

Invited Presentations and Courses

No presentations below were sponsored by outside entities.

Regional

1984 Surgical Treatment of Hyperparathyroidism.
Surgical Grand Rounds/Salem Hospital, Salem, MA

1986 Surgical Treatment of Hyperparathyroidism.
Surgical Grand Rounds/Bay State Medical Center, Springfield, MA

1990 Controversies regarding Hyperparathyroidism
Medical Grand Rounds/Hale Hospital Haverhill MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Bay State Medical Center, Springfield, MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Salem Hospital, Salem, MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/St. Vincent's Hospital, Univ. of Massachusetts, Worcester, MA

1992 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Univ. of Massachusetts Medical Center, Worcester, MA

1992 Improving the cost effectiveness of laparoscopic cholecystectomy.
Massachusetts Chapter, American College of Surgeons

1992 Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital.
Surgical Grand Rounds/Framingham Union Hospital, Framingham, MA.

1994 Management of the Rectum in ulcerative colitis.
Spring meeting Massachusetts Chapter, American College of Surgeons, Needham, MA

1994 Preservation of sexual and urinary function following ultralow rectal dissection for the ileoanal pouch operation.
New England Surgical Society

1995 Thyroid surgery - How I do it.
Massachusetts Chapter, American College of Surgeons

1998 New Strategies in IBD therapy.
Rhode Island Chapter, Crohn's and Colitis Foundation, Newport, RI

1999 Controversies in the treatment of ulcerative colitis.

New England Surgical Society Spring Meeting, Boston, MA

1999 Ileoanal Pouch Operation: Long Term Outcome With or Without Diverting Ileostomy. New England Surgical Society Annual Meeting

2002 Controversies in inflammatory bowel disease. New England Surgical Society Annual Meeting September 2002

2013 Advances in thyroid and parathyroid surgery. St. Elizabeth's Medical Center, Boston, MA

National

1992 Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital. Buffalo Surgical Society, Buffalo, NY

1992 Advances in the Medical and Surgical Therapy of IBD. Crohn's & Colitis Foundation of America, Inc.

1993 **Mowschenson PM,** Critchlow JF, Rosenberg SJ, Peppercorn MA. Ileoanal pouch operation without diverting ileostomy in fulminant ulcerative colitis. American Gastroenterology Association, Boston, MA

1994 Crohn's and Colitis Foundation physician's seminar on surgical treatment of ulcerative colitis.

1994 **Mowschenson** PM, Hodin RA, Wang HH, Upton M, Silen W. Fine Needle Aspiration of Normal Thyroid Tissue May result In the Misdiagnosis of Follicular Neoplasms. American Association of Endocrine Surgeons

1994 American Gastroenterology Association New Orleans Forum on Inflammatory Bowel Disease, New Orleans, LA

1994 **Mowschenson PM**, Critchlow JF. Outcome of surgical complications following ileoanal pouch operation without diverting ileostomy. Society for Surgery of the Alimentary Tract, New Orleans, LA

1995 Surgical approaches to IBD during pregnancy - Inflammatory Bowel Disease Forum American Gastroenterology Association, San Diego, CA

1995 Feasibility of outpatient thyroid and parathyroid operations. American Association of Endocrine Surgeons

1996 Surgical Management of Crohn's disease. Crohn's and Colitis foundation

1999 Green A.K., **Mowschenson P**, Hodin RA. Is radioguided parathyroidectomy really cost-effective? American Association of Endocrine Surgeons, Yale, New Haven, CT

International

1999 Experience with outpatient thyroid and parathyoid surgery.

Retirement symposium for Professor the Lord McColl/Guy's Hospital, London

Report of Clinical Activities and Innovations

Current Licensure and Certification

1976	Massachusetts medical license
1980	Board certification in general surgery (Recertified in 1989, 2001, 2009)

Practice Activities

1981-	General Surgery (thyroid, parathyroid surgery)	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital]	3-4 operative days; daily inpatient rounds

Report of Education of Patients and Service to the Community

Recognition

2009-2015	Best Doctors Boston
2010-2014	America's Top Surgeons Consumer Council of America
2010-2015	Patient's Choice Award
2011-2014	Most Compassionate Dr. Award
2013-2015	Town of Brookline Favorite Doctor Award
2013-2015	Boston Super Doctors
2014-2016	Talk of the Town Massachusetts: Excellence in Patient Satisfaction

Report of Scholarship

Publications

Peer reviewed publications in print or other media

Research Investigations

1. Davies GC, **Mowschenson PM**, Salzman EW. Thromboxane B2 and fibrinopeptide A levels in Platelet consumption and thrombosis. Surg Forum 1978;29:471-472.

2. **Mowschenson PM**, Schonbrunn A. Leupeptin inhibits stimulated prolactin synthesis and secretion in a clonal strain of rat pituitary cells. Prog. of the 63rd Meeting of the Endocrine Society, Cincinnati Ohio .1981.

3. **Mowschenson PM**, Rosenberg S, Pallotta J, Silen W. Effect of hyperparathyroidism and hypercalcaemia on lower esophageal sphincter pressure. Am J Surgery 1982;143:36-39.

4. Kim D, Porter DH, Siegel JB, **Mowschenson PM**, Steer ML. Common bile duct biopsy with the Simpson atherectomy catheter. Am J Roentgenol 1990;154(6):1213-5.

5. Lion J, Vertrees J, Malbon A, Harrow B, Collard A, **Mowschenson PM**. The case mix of ambulatory surgery as measured by ambulatory visit groups. J Ambul Care Manage 1990;13(1):33-45.

6. Lion J, Vertrees J, Malbon A, Collard A, **Mowschenson PM**. Toward a prospective payment system for ambulatory surgery. Health Care Financ Rev 1990;11(3):79-86.

7. **Mowschenson PM**, Critchlow JA, Peppercorn MA. The ileoanal pouch operation without covering ileostomy. American Society of Gastroenterology, New Orleans. June 1991

8. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. The rectal inhibitory reflex is not required for the preservation of continence following ileoanal pouch operation. American Society of Gastroenterology, San Francisco May 1992

9. Muggia A, **Mowschenson PM**, Chopra S. Urinary ascites in the immediate postpartum period. Am J Gastroenterol 1992;87(9):1196-7.

10. **Mowschenson P**, Weinstein M. Why catheterize the bladder for laparoscopic cholecystectomy? J Laparoendosc Surg 1992;2(5):215-217.

11. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. Pouch ileoanal anastomosis without diverting ileostomy in fulminant ulcerative colitis. Annales de Chirugie 1992;46(10) International Symposium on the Pouch Anal Anastomosis. Versailles, France.

12. **Mowschenson PM**. Improving the cost effectiveness of laparoscopic cholecystectomy. J Laparoendosc Surg 1993;3(2):113-9.

13. Laparoscopically assisted intestinal resection: Preliminary results from the Harvard interhospital laparoscopic group (HILG) Accepted for S.S.A.T. May 1993

14. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. Ileoanal pouch operation without diverting ileostomy in fulminant ulcerative colitis. Gastroenterology 1993;104 (4):A749.

15. **Mowschenson PM**, Resnick RH, Parker JH, Critchlow JF. Ileoanal pouch mucosal permeability assessment using oral (99MTC) DTPA. Gastroenterology 1993;104 (4):A749.

16. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. The ileoanal pouch operation: Factors favoring continence, the avoidance of a diverting ileostomy, and small bowel conservation. Surg Gynecol Obstet 1993;177(1):17-26.

17. **Mowschenson PM**, Hodin RA, Wang HH, Upton M, Silen W. Fine needle aspiration of normal thyroid tissue may result in the misdiagnosis of follicular neoplasms. Surgery 1994;116:1006-9.

18. **Mowschenson PM**, Critchlow JF. Outcome of surgical complications following ileoanal pouch operation without diverting ileostomy. Am J Surg 1995;169:143-6.

19. Fraser JL, Jeon GH, Hodin RA, **Mowschenson PM**, Pallotta J, Wang HH. Utility of repeat fine needle aspiration in the management of thyroid nodules. Am J Clin Pathology 1995;104 (3):328-9.

20. **Mowschenson PM**, Hodin RA. Feasibility, safety, and cost savings of outpatient thyroid and parathyroid operations. Surgery 1995;118:1051-1054.

21. Saldinger PF, Matthews JB, **Mowschenson PM**, Hodin RA. Stapled laparoscopic splenectomy: Initial experience. J Am Coll Surg 1996;182(5): 459-461.

22. Greene AK, **Mowschenson PM**, Hodin RA. Is Sestamibi-guided parathyroidectomy really cost-effective? Surgery 1999;126:1036-41.

23. **Mowschenson PM**, Critchlow JA, Peppercorn MA. Ileoanal pouch operation: Long term outcome with or without diverting ileostomy. Arch Surg 2000;135(4):463-466.

24. Schoetz DJ, Hyman NH, **Mowschenson PM**, Cohen JL. Controversies in inflammatory bowel disease. Arch Surg 2003;138(4):440-6.

25.Evenson A, **Mowschenson P**, Wang H, Connolly J, Mendrinos S, Parangi S, Hasselgren PO. Hyalinizing trabecular adenoma--an uncommon thyroid tumor frequently misdiagnosed as papillary or medullary thyroid carcinoma. Am J Surg 2007;193(6):707-12.

26.O'Neal PB, Poylin V, **Mowschenson P**, Parangi S, Horowitz G, Pant P, Hasselgren PO. When initial postexcision PTH level does not fall appropriately during parathyroidectomy: What to do next? World J Surg 2009;33(8):1665-73.

27.O’Neal P, **Mowschenson P**, Connolly J, Hasselgren PO. Large parathyroid tumors have an increased risk for atypia and carcinoma. Am J Surg 2011;202:146-150.

28.Mendiratta-Lala M, Brennan DD, Brook OR, Faintuch S, **Mowschenson PM**, Sheiman RG, Goldberg SN. Efficacy of radiofrequency ablation in the treatment of small functional adrenal neoplasms. Radiology 2011;258(1):308-16.

29.Cypess AM, Doyle AN, Sass CA, Huang TL, **Mowschenson PM**, Rosen HN, Tseng YH, Palmer EL III, Kolodny GM. Quantification of human and rodent brown adipose tissue function using 99mTc-methoxyisobutylisonitrile SPECT/CT and 18F-FDG PET/CT. J Nucl Med 2013;54(11):1896-901.

30. Mehrzad R, Connolley J, Wong H, **Mowschenson P**, Hasselgren PO. Increasing incidence of papillary thyroid carcinoma of the follicular variant and decreasing incidence of follicular adenoma: co-incidence or altered criteria for diagnosis? Surgery (2016 May) 159(5):1396-406
Other peer-reviewed publications

31. Rectal Eversion Technique: A Method to Achieve Very Low Rectal Transection and Anastomosis With Particular Value in Laparoscopic Cases Poylin V, Mowschenson P, Nagle D Diseases of the Colon & Rectum. 60(12):1329-1331, December 2017.

Non-peer reviewed scientific or medical publications/materials in print or other media

Reviews:

1. **Mowschenson PM**, Silen W. Development in Hyperparathyroidism. Curr Opin Clin Oncol 1990;2(1):95-100.

2. **Mowschenson PM**. Advances in the surgery of inflammatory bowel disease. Seminars in Colon & Rectal Surgery. March 1993.

Editorials:

1. **Mowschenson PM**. Double-Stapled versus Handsewn Pouch - Does it Matter? Inflammatory Bowel Diseases 1995;1(2):169.

2. **Mowschenson PM**. Is a One Stage Pouch Too Risky? Inflammatory Bowel Diseases 1998;4(4):332.

Book chapters:

1. Glotzer DJ, **Mowschenson PM**. Chronic Ulcerative Colitis. In: Current Surgical Therapy, Fifth Edition. Cameron, ed. St. Louis: C.V. Mosby Company, 1995. pp150-159.

Books edited:

1. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 1st edition. London: Churchill Livingstone; 1978.

2. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 2nd edition. London: Churchill Livingstone; 1982.

3. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. German language edition. London: Churchill Livingstone; 1984.

4. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 3rd edition. London: Churchill Livingstone; 1989.

5. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 4th edition. London: Churchill Livingstone; 1994.

Narrative Report

-

I joined the staff at Beth Israel Hospital in 1981 after completing by surgical training and have remained on staff through the merger when Beth Israel Hospital became Beth Israel Deaconess Medical Center.

While certified in General Surgery, my particular areas of interest and expertise evolved into surgery for inflammatory bowel disease, and thyroid and parathyroid surgery. These are the main areas of my publications. I have given numerous lectures on both these topics as detailed in my CV.

I have been an active teacher on the clinical side all these years, providing operating room and office teaching for residents at all levels in addition to HMS students. I have a very busy clinical practice, and residents who rotate on my service end up with greatly above average experience in thyroid and parathyroid surgery.

I have never had any basic science responsibility but have participated in published research along with basic scientists. I continue to be active in clinical research in the areas or surgery for inflammatory bowel disease and endocrine surgery.

I was president of the Affiliated Physicians Group from1983 to 2019 which is a major component of BIDCO along with HMFP (Harvard Medical Faculty Practice), and involved in monthly board meetings of BIDCO. For many years I was active in the Crohn's and Colitis Foundation.

AFFIDAVIT OF MELDON C. LEVY, MD
REGARDING BYUNG D. OH

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Meldon Levy, MD, who after first being duly sworn, states as follows:

Introduction and Limited Purpose of Affidavit

1. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

2. This affidavit does not state all my opinions concerning this case. This affidavit only serves the requirements of the statute — that is, it only identifies one standard-of-care violation for each medical provider at issue.

3. After consulting with me, Plaintiff's counsel did the typing for this affidavit and supplied the legalese, the formatting, the medical record chronology, etc. I reviewed and edited the draft text. The substantive opinions and conclusions presented here are mine.

4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation of my views, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. In particular, while I cite evidence from the medical records for various facts, I do not necessarily cite *all* the evidence for a given point.

5. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty — that is, more likely than not.

Topic & Opinions

7. This affidavit concerns medical services provided to Byung D. Oh in May and June 2018 at Wellstar's Atlanta Medical Center.

8. More specifically, this affidavit concerns the standards for a hospital nurse and a consulting cardiologist for recording a patient's home cardiac medications and (for the physician) deciding whether to order those medications to be administered in the hospital.

9. I believe the nursing staff of Wellstar Atlanta Medical Center and Adefisayo M. Oduwole, MD, violated their standards of care as follows:

   a. The nursing staff violated their standard of care by failing to record Mr. Oh's home cardiac medications.

   b. Dr. Oduwole violated his standard of care by failing to consider whether to order amiodarone to be administered to Mr. Oh, to control his atrial fibrillation, and by failing to enter such an order in the absence of good cause to deny amiodarone to Mr. Oh.

10. This does not exhaust my opinions in this case.

Qualifications

11. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

12. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.

13. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

14. The acts or omissions at issue here occurred in May 2018.

15. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In May 2018, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

   Specifically, I was licensed by the State of California to practice medicine. That's where I was practicing medicine in May 2018.

b. In May 2018, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:

   - Inquiring into a hospital patient's home cardiac medications and deciding whether to order that they be administered to the patient in the hospital.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to May 2018, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

   Specifically, I am a board-certified cardiologist and for decades have routinely engaged in patient communication and cardiovascular clearance for medical procedures.

Evidence Reviewed

16. I have reviewed Byung Oh's medical records from Wellstar's Atlanta Medical Center, the Atlanta Veteran's Administration Hospital, and the Death Certificate for Mr. Oh.

Discussion and Factual Basis for Opinion

Medical Record Chronology

The medical records indicate the following:

17. April 30, 2018: Byung (Ben) Oh, 77 yrs old, arrived at Wellstar's Atlanta Medical Center ER by ambulance, after falling from a ladder while doing yard work. (WHS 63, 68.)

18. Burst fracture of the vertebra at T12. (WHS 1327-29.)

19. May 2: According to Susan Oh, daughter of patient (and a pharmacist), "Wednesday, 5/2/18: My mother brought in my father's list of home meds to neuro ICU (3rd day of admission) and gave it to the nurse (pregnant). My father explained how he took his meds with the nurse."

20. May 2, 2049 hours: Initial cardiology consult. (WHS 886.)

21. May 3: According to Susan Oh: ""Thursday, 5/3/18: The home medication list was reviewed again with the same nurse. This nurse did not enter the home medications into the system." "Thursday, 5/3/18: Dr. Odawalla (cardiologist) asked my father about his heart history, but did not ask about my father's home medications."

22. May 4, 2018: surgery to repair and stabilize the spine. (WHS 996.)

23. Intra-op: Atrial fibrillation, then return to sinus rhythm. (WHS 994, 996.)

24. Post-op: Transfer to Neuro ICU. (WHS 65.)

25. May 5, 0630 hours: X-Ray Chest report — "Interval development of moderate atelectasis or infiltrate at the right lung base with a small right pleural effusion. Mild atelectasis is now seen at the left lung base." (WHS 1318.)

26. May 6, 1246 hours: Transfer to Med Surg unit. (WHS 65.)

27. May 8, 1757 hours: "mild respiratory distress today. CXR showed small apical pneumothorax, chest tube placed back on suction. Continue pain control and Pt. Monitor chest tube output." (WHS 713.)

28. May 8: X-Ray abdomen ordered because of abdominal distension. (WHS 1312-13.)

29. May 8, 2258 hours:

> "BAT called to pt's room for increased work of breathing. Pt seen and evaluated. Vital signs as follows: sats 94% on 4L NC, HR 120s, SBP 120s. Pt tachypneic with crackles heard throughout the precordium. Stat ABG consistent with respiratory alkalosis, paO2 50. CXR without evidence of ptx, consistent with bilateral congestion. EKG consistent with a.fib with RVR. **Pt currently not on any rate controlling medications.**
>
> "Given a.fib with RVR and increasing tachypnea and risk of respiratory failure, pt transferred to the ICU with stat labs ordered. Amiodarone bolus and continuous gtt ordered. Pulmonary toilet, redirect pt - pt confused and agitated. Continue left chest tube to suction. Repeat ABG in AM. Discussed with Dr. Dougherty who is in agreement with plan."
>
> (WHS 707.)

30. May 8, 2327 hours: Transfer to Cardiac ICU. (WHS 66.)

31. May 9: Begin bipap machine. (WHS 708.) (As of at least May 11, Mr. Oh still had the bipap. (WHS 672.))

32. May 9, 1212 hours: Order antibiotics for pneumonia, and continuing chest tube suction. (WHS 707.)

33. May 11, 0611 hours: "Pulm: ABG c/w respiratory alkalosis, on bipap this morning, pulmonary toilet, L CT to suction, yesterday CXR shows stable b/l pulmonary infiltrates. CTA chest neg for PE. Being treated for pneumonia." (WHS 663.)

34. May 11, 1135 hours: "still in afib, rate in the 110s. Will add lopressor standing to PO amio." (WHS 663.)

35. May 13, 0916 hours: "Interval History: Patient still requiring high supplemental 02, currently on vapotherm. Also still in A-fib despite scheduled metoprolol and PO amiodarone." (WHS 597.)

36. May 14, 0617 hours: "Blood Cx grew MRSA, on vanc." (WHS 581.)

37. May 15, 0609 hours: "Heme/Infectious: afebrile, treating for pneumonia with cefepime day 6/7. Blood Cx grew MRSA, on vanc day 4/14." (WHS 574.)

38. May 15, 2000 hours: "respiratory rate very tachypnea and pt on 85% FiO2 on vapo therm's, suctioned as needed. D51/2 N/s with 20 klc In progress , no acute distress noted, pt on isolation for MRSA in the Blood. Bilateral wrist restraint in place." (WHS 558.)

39. May 16, 1501 hours: "Given noted RR, increased respiratory intervention, mental status, and s/s of aspiration, recommend NPO/alternate means of nutrition/hydration and completion of instrumental swallow study as indicated. Oral cavity clear at end of evaluation." (WHS 549.)

40. May 17, 1645 hours: "X-Ray Chest ... Impression: Persistent pattern of pulmonary edema and/or consolidation/infiltration unchanged from multiple previous exams." (WHS 1303.)

41. May 17, 2139 hours: "PO meds not given this morning, will resume PO regimen for afib to better control Hr. Respiratory status slightly improved until about 20 minutes after Pt. Desaturation with thick sputum. Suctioned aggressively

and saturations improved with increase of 02 on vapotherm. Discussed patients condition at length with daughters Susan and Amy - will insert dobhoff tube for nutrition and meds." (WHS 529.)

42. May 18, 0544 hours:

> Called to evaluate the patient for desaturation after rolling him. He was satting in the mid 80s, using accessory muscles, on a NRBM. I called and spoke to his daughter Susan about the need for intubation. She requested a second opinion from the Anesthesia team but ultimately agreed. He was intubated without difficulty and a large amount of thick secretions were suctioned out of his airway. His sats then came up to 100%.
>
> A bronchoscopy was then preformed with copious secretions noted. These were aspirated and cultures sent.
>
> Will add zosyn for additional antibiotic coverage. Continue Vane and Diflucan.
>
> Wean vent as tolerated.
>
> Continue NG meds and tube feeds
>
> (WHS 522.)

43. May 18, 1024 hours: Intubation. "Called for the ICU team for consultation for urgent/e merge nt intubation for this patient. Pt has a history of fall, SDH, cervical fracture, complicated by ARDS, afib. Pt has a history of DM and CAD s/p CABG. At the time of intubation his 02 sat was 80% on a non-rebreather and his PO2 was 48. He appeared to be in extremis, with RR 30-40." (WHS 983-85.)

44. May 19: MRSA present in blood. (WHS 830.)

[Additional lengthy hospital course not reflected here.]

Discussion

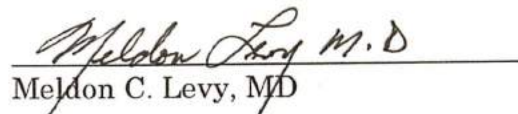
45. The standard of care required the nursing staff to record Mr. Oh's home cardiac medications. It appears the staff did not do so, and thus they violated the standard of care.

46. The standard of care required Dr. Oduwole to consider whether to order amiodarone to be administered to Mr. Oh to control his atrial fibrillation — and to make such an order unless there was good cause to withhold amiodarone. It appears Dr. Oduwole did not consider this, and thus he violated the standard of care.

Miscellaneous

47. To repeat, this affidavit does not exhaust my current opinions and of course does not reflect any opinions I may form later as further information becomes available.

48. Again, I hold each opinion expressed in this affidavit to a reasonable degree of medical probability or certainty; that is, more likely than not.



Meldon C. Levy, MD

SWORN TO AND SUBSCRIBED before me

April 29, 2020

NOTARY PUBLIC

My Commission Expires: 03-07-2022

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE DIPLOMATE SUBSPECIALTY BOARD OF CARDIOVASCULAR DISEASE

MELDON C. LEVY, M.D., F.A.C.C.
A PROFESSIONAL CORPORATION
CENTURY CITY MEDICAL PLAZA
2080 CENTURY PARK EAST • SUITE 704 • LOS ANGELES, CALIFORNIA 90067
TELEPHONE (310) 277-9126

CURRICULUM VITAE

Personal Information

Name in full	Meldon Cary Levy, M.D.
Business Address	2080 Century Park East, Ste. 704 Los Angeles, CA 90067
Business Phone	(310) 277-9126
Home Address	10465 Eastborne Ave. Los Angeles, CA 90024
Home Phone	(310) 475-8150
Date of Birth	June 6, 1946
Place of Birth	Chicago, Illinois
Citizenship	U.S.A.

Education

High School	University High School, Los Angeles, CA, 1963
College or University	University of California at Berkeley, B.A., 1967
Medical School	University of Southern California, M.D., 1971
Internship	Cedars-Sinai Medical Center, July 1971-June 1972 Straight Medical
Residencies	Cedars-Sinai Medical Center, July 1972-June 1974 Internal Medicine
Fellowships	Cedars-Sinai Medical Center, July 1974-June 1976, Cardiovascular Disease
Licensure	California, 1972 (Certificate G22855)
Board Certification	American Board of Internal Medicine, 1974 Subspecialty Board of Cardiovascular Disease, 1977 National Board of Echocardiography Certification in Comprehensive Adult Echocardiography, 2002

Exhibit A

Professional Background	
Academic Appointments	Clinical Instructor in Medicine, University of California Los Angeles, 1977-1979 Assistant Clinical Professor in Medicine, University of California, Los Angeles, 1979-1984 Assistant Clinical Professor in Medicine, Keck School Medicine, University of Southern California, Los Angeles, 2008 to present
Administrative Responsibilities	Director, Cardiac Noninvasive Laboratory, Century City Hospital, Los Angeles, 1978-2000 Chief of Staff, Century City Hospital, Los Angeles, 1987-1989 Chairman, Governing Board, Century City Hospital, Los Angeles, 1997-1999 Medical Director, Beverly Glen Medical Systems, Los Angeles, 2000-2002 Chief of Cardiology, Century City Doctors Hospital, Los Angeles, 2005-2007 Director, Cardiac Noninvasive Laboratory, Century City Doctors Hospital, 2005-2008 Chairman, Critical Care Committee, Century City Doctors Hospital, 2005-2008
Awards and Achievements	Testamur, ASEeXAM, August 7, 1997
Military Service	None
Other Employment or Activity	President, Housestaff Association, Cedars-Sinai Medical Center, Los Angeles, 1973-1974 Member, Medical Executive Committee, Century City Hospital, Los Angeles, 1980-1991 Member, Governing Board, Century City Hospital, Los Angeles, 1987-2000 Member, Utilization Review Committee, Cedars-Sinai Medical Center, Los Angeles, 1985-1994 Member, Medical Executive Committee, Century City Doctors Hospital, Los Angeles, 2005-2008

Society Memberships

Local

Los Angeles County Medical Association, 1979
California Medical Association, 1977
Los Angeles County Heart Association, 1977
Los Angeles Society of Echocardiography, 1982

National

American Heart Association, 1977
American College of Cardiology, 1974
American College of Physicians, 1977
American Society of Echocardiography, 1977

Research Activities

Principal Investigator

1987-1990 Lovastatin Dose-Ranging Multicenter Study in Patients with Type II Hypercholesterolemia, Total Cholesterol 240-300 mg/dl with or without Evidence of Coronary Artery Disease (CRI-Clinical Research International/Merck, Sharp and Dohme)-Protocol 022 and Extension 023

1988-1990 A Randomized Controlled Phase III Study of Milrinone, Digoxin, and Captopril in Congestive Heart Failure Patients (Sterling Drug, Inc.)-MIL-1035

1988-1990 A Prospective, Randomized, Milrinone, Survival Evaluation (Promise) (Sterling Drug, Inc.)-MIL-1064

1987-1989 A Double-Blind, Parallel Group, Dose Response Study Comparing the Efficacy and Safety of 2.5mg, 10mg and 40mg Bisoprolol to Placebo Given Once Daily (After an Atenolol Run-in-Phase) in Patients with Stable Angina Pectoris due to Coronary Artery Disease. (American Cyanamid Company)-Bisoprolol, D57P4

1989-1989 Parallel Comparison of Four Doses of Perindoprilter-Butylamine, and Placebo in Patients with Mild to Moderate Hypertension. (McNeil Pharmaceutical)-Protocol PB

Research Activities (cont'd)
Principal Investigator

1989-1991 Outpatient Evaluation of the Safety and Efficacy of Oral Rocainam Maintenance Therapy for Control of Symptomatic Paroxysmal Supraventricular Tachycardia (Wyeth-Ayerst Research)-Protocol 519B-314-US

1989-1990 Double-Blind, Parallel Group, Placebo-Controlled, Outpatient Evaluation of the Safety and Efficacy of Oral Recainam in the Prevention of Recurrence of Spontaneously Occurring Symptomatic Paroxysmal Supraventricular Tachycardia (Wyeth-Ayerst Research)-Protocol 519B-313-US

1989-1991 A Study Investigating the Dose Response and Duration Effect of Isosorbide-5-Mononitrate in Controlled Release Formulation in Patients with Stable Effort Angina Pectoris. (Schering Corporation)-Protocol S89-03

1990-1990 A Multicenter Trial to Evaluate Efficacy and Lipid Effects of Doxazosin as Initial Therapy in Mild to Moderate Essential Hypertension. (Pfizer, Inc., Roerig Division)

1993-1996 A randomized, Double-Blind Study to Compare the Efficacy and Safety of Fixed Low Doses of Coumadin Plus Aspirin to Aspirin Alone in the Prevention of Reinfarction, Cardiovascular Death, and Stroke in Post-Myocardial Infarction Patients. (DuPont Merck Research)-Protocol 647-003-311

1993-1995 A Multicenter, Double-Blind, 4-Month Placebo-Controlled, 1-Year Active-Controlled Study Comparing the Safety and Efficacy of Once Daily Atorvastatin with that of Lovastatin in Patients with Elevated LDL-Cholesterol. (Parke-Davis Research)-Protocol 981-08-10

Research Activities (cont'd)

Principal Investigator

1993-1995 A 1-Year (6 Month Double-Blind, 6-Month Open Label) Extension to Protocol 981-08 to Evaluate the Long-Term Safety and Efficacy of Atorvastatin as Compared with Lovastatin in Patients with Elevated LDL-Cholesterol (Parke-Davis Research)-Protocol 981-62-10

1997-1999 A Randomized, Multicenter, Interventional Trial in Congestive Heart Failure. A Double-Blind, Placebo-Controlled Survival Study with Metoprolol CR/XL in Patients with Decreased Ejection Fraction and Symptoms of Heart Failure. Merit-HF. Study Number SH-MET-00

Bibliography

Carmo, E., Levy, M.C., and Newmann, M., "Ebstein's Anomaly." American Review of Diagnostic, a:33-38, Nov.-Dec., 1982

Carmo, E., Levy, M.C., "Echocardiographic Diagnosis of Left Atrial Myxoma." Applied Cardiology Vol. 13 No. 4: 1985