IN THE STATE COURT OF GWINNETT COUNTY
STATE OF GEORGIA

LINDA HOLLOWAY, PLAINTIFF, — *VERSUS* — KAISER PERMANENTE INSURANCE COMPANY THE SOUTHEAST PERMANENTE MEDICAL GROUP, INC. KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC. KAISER FOUNDATION HEALTH PLAN, INC. KAISER FOUNDATION HOSPITALS, INC. SAINT JOSEPH'S HOSPITAL OF ATLANTA, INC. EMORY HEALTHCARE, INC. CHEICKNA DIARRA, MD DARRYL J. TOOKES, MD JOHN/JANE DOE 1-10, DEFENDANTS	CIVIL ACTION FILE NO. _____ JURY TRIAL DEMANDED

PLAINTIFF'S COMPLAINT

Nature of the Action

1. This medical malpractice action arises out of medical services negligently performed on Linda Holloway on February 6, 2020.

2. Plaintiff asserts: (i) a claim of professional malpractice by Dr. Diarra and Dr. Tookes, (ii) a claim of "ordinary" negligence in the administration of the Kaiser and Emory healthcare practices, (iii) a defense to a putative arbitration agreement, (iv) an alternative claim for fraudulent inducement, pertaining to the arbitration agreement (if it is deemed otherwise valid), (v) an alternative claim for breach of fiduciary duty, and (vi) a claim for negligence in connection with extracting the putative arbitration agreement.

3. Plaintiff demands a jury trial on all issues.

4. Plaintiff specifically demands a jury trial on the issue of the validity of the putative arbitration agreement.

5. Pursuant to OCGA § 9-11-9.1, the Affidavit and Supplemental Affidavit of Peter Mowchenson, MD, are attached hereto as Exhibits 1-2. This Complaint incorporates the opinions and factual allegations contained in those affidavits, except that the Defendants need not answer the statements contained in exhibits to this Complaint.

6. 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.

Notes

Matter that Requires No Response from Defendants

Defendants need not respond to statements that are not made in numbered paragraphs, except where a numbered averment explicity incorporates accompanying matter that is not in a numbered paragraph.

Defendants need not respond to statements in footnotes.

Defendants need not respond to citations to Bates-stamped pages of records or graphics that accompany allegations. The citations and graphics are included only to make it easy to respond to substantive allegations, but are not part of the allegations. Plaintiff stipulates that an answer to an allegation does not constitute an answer to anything concerning an accompanying citation or graphic.

Extra Time to Respond

This complaint gives unusually detailed notice of the basis of the claims. The purpose is to narrow the disputes at the outset, and thereby to simplify discovery and trial.

However, because this complaint is so detailed, Plaintiff will agree to any reasonable request for extra time to file an answer.

Defendants, Jurisdiction, and Venue[1]

Note: Based on publicly available information, the corporate entities named below appear to be proper parties. However, if any are not, we encourage them to contact

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[1] OCGA §§ 14-2-510 and 14-3-510 provide identical 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."

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.

Plaintiff's counsel before filing an answer. Given clear evidence that an entity is not a proper party, Plaintiff will dismiss the entity.

7. **KAISER PERMANENTE INSURANCE COMPANY ("KPIC")** is an insurance company registered to do business in Georgia. Their registered agent and registered office are: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092, in Gwinnett County.

8. **KPIC** is subject to the personal jurisdiction of this Court.

9. **KPIC** is subject to the subject-matter jurisdiction of this Court in this case.

10. **KPIC** has been properly served with this Complaint.

11. **KPIC** 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.

12. Pursuant to OCGA § 9-10-31, **KPIC** is directly subject to venue in Gwinnett County.

13. At all relevant times, **KPIC** was a principal of Dr. Cheickna Diarra.

14. At all relevant times, **KPIC** was a principal of Dr. Darryl Tookes.

15. If any other entity was a principal of those individuals, 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.

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.

OCGA 9-10-31 provides that, "joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in 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."

16. **KPIC** participated in the management of medical facilities and practices that Dr. Cheickna Diarra participated in, and which created requirements that Dr. Diarra was subject to in his practice as a Kaiser Permanente physician.

17. **THE SOUTHEAST PERMANENTE MEDICAL GROUP, INC. ("SPMG")** is a Georgia corporation. Their registered agent and registered office are: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092, in Gwinnett County.

18. **SPMG** is subject to the personal jurisdiction of this Court.

19. **SPMG** is subject to the subject-matter jurisdiction of this Court in this case.

20. **SPMG** has been properly served with this Complaint.

21. **SPMG** 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.

22. Pursuant to OCGA § 9-10-31, **SPMG** is directly subject to venue in Gwinnett County.

23. At all relevant times, **SPMG** was a principal of Dr. Cheickna Diarra.

24. At all relevant times, **SPMG** was a principal of Dr. Darryl Tookes.

25. If any other entity was a principal of those individuals, 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.

26. **SPMG** participated in the management of medical facilities and practices that Dr. Cheickna Diarra participated in, and which created requirements that Dr. Diarra was subject to in his practice as a Kaiser Permanente physician.

27. **KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC. ("KFHPG")** is a Georgia insurance company. Their registered agent and registered office are: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092, in Gwinnett County.

28. **KFHPG** is subject to the personal jurisdiction of this Court.

29. **KFHPG** is subject to the subject-matter jurisdiction of this Court in this case.

30. **KFHPG** has been properly served with this Complaint.

31. **KFHPG** 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.

32. Pursuant to OCGA § 9-10-31, **KFHPG** is directly subject to venue in Gwinnett County.

33. At all relevant times, **KFHPG** was a principal of Dr. Cheickna Diarra.

34. At all relevant times, **KFHPG** was a principal of Dr. Darryl Tookes.

35. If any other entity was a principal of those individuals, 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.

36. **KFHPG** participated in the management of medical facilities and practices that Dr. Cheickna Diarra participated in, and which created requirements that Dr. Diarra was subject to in his practice as a Kaiser Permanente physician.

37. **KAISER FOUNDATION HEALTH PLAN, INC. ("KFHP")** is a California corporation. Their registered agent and registered office are: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092, in Gwinnett County.

38. **KFHP** is subject to the personal jurisdiction of this Court.

39. **KFHP** is subject to the subject-matter jurisdiction of this Court in this case.

40. **KFHP** has been properly served with this Complaint.

41. **KFHP** 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. Pursuant to OCGA § 9-10-31, **KFHP** is directly subject to venue in Gwinnett County.

43. At all relevant times, **KFHP** was a principal of Dr. Cheickna Diarra.

44. At all relevant times, **KFHP** was a principal of Dr. Darryl Tookes.

45. If any other entity was a principal of those individuals, 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.

46. **KFHP** participated in the management of medical facilities and practices that Dr. Cheickna Diarra participated in, and which created requirements that Dr. Diarra was subject to in his practice as a Kaiser Permanente physician.

47. **KAISER FOUNDATION HOSPITALS, INC. ("KFHI")** is a California corporation. Their registered agent and registered office are: Corporation Service Company, 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092, in Gwinnett County.

48. **KFHI** is subject to the personal jurisdiction of this Court.

49. **KFHI** is subject to the subject-matter jurisdiction of this Court in this case.

50. **KFHI** has been properly served with this Complaint.

51. **KFHI** 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.

52. Pursuant to OCGA § 9-10-31, **KFHI** is directly subject to venue in Gwinnett County.

53. At all relevant times, **KFHI** was a principal of Dr. Cheickna Diarra.

54. At all relevant times, **KFHI** was a principal of Dr. Darryl Tookes.

55. If any other entity was a principal of those individuals, 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. **KFHI** participated in the management of medical facilities and practices that Dr. Cheickna Diarra participated in, and which created requirements that Dr. Diarra was subject to in his practice as a Kaiser Permanente physician.

57. **The "Kaiser Defendants"** refers collectively to **KPIC, SPMG, KFHPG, KFHP, and KFHI.**

58. **SAINT JOSEPH'S HOSPITAL OF ATLANTA, INC. ("SJHA")** is a Georgia nonprofit corporation. Their registered agent and registered office are: Amy Adelman, Emory University, 201 Dowman Drive, 312 Administration Building, Atlanta, GA, 30322, in DeKalb County.

59. **SJHA** is subject to the personal jurisdiction of this Court.

60. **SJHA** is subject to the subject-matter jurisdiction of this Court in this case.

61. **SJHA** has been properly served with this Complaint.

62. **SJHA** 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. Pursuant to OCGA § 9-10-31, **SJHA** is subject to venue in this Court because some of its co-defendants are directly subject to venue here

64. At all relevant times, **SJHA** was a principal of Dr. Cheickna Diarra.

65. At all relevant times, **SJHA** was a principal of Dr. Darryl Tookes.

66. If any other entity was a principal of those individuals, 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.

67. At all relevant times, **SJHA** participated in the administration of the hospital operating under the trade name Emory Saint Joseph's Hospital at 5665 Peachtree Dunwoody Rd, Atlanta, GA 30342.

68. **EMORY HEALTHCARE, INC. ("EHI")** is a Georgia nonprofit corporation. Their registered agent and registered office are: Amy Adelman, Emory University, 201 Dowman Drive, 312 Administration Building, Atlanta, GA, 30322, in DeKalb County.

69. **EHI** is subject to the personal jurisdiction of this Court.

70. **EHI** is subject to the subject-matter jurisdiction of this Court in this case.

71. **EHI** has been properly served with this Complaint.

72. **EHI** 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. Pursuant to OCGA § 9-10-31, **EHI** is subject to venue in this Court because some of its co-defendants are directly subject to venue here

74. At all relevant times, **EHI** was a principal of Dr. Cheickna Diarra.

75. At all relevant times, **EHI** was a principal of Dr. Darryl Tookes.

76. If any other entity was a principal of those individuals, 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.

77. At all relevant times, **EHI** participated in the administration of the hospital operating under the trade name Emory Saint Joseph's Hospital at 5665 Peachtree Dunwoody Rd, Atlanta, GA 30342.

78. **The "Emory Defendants"** refers collectively to **SJHA and EHI.**

79. **CHEICKNA DIARRA, MD** is a Georgia resident. He resides at 1864 Vinings Mill Walk SE, Smyrna, GA 30080-6344, in Cobb County.

80. **Dr. Diarra** is subject to the personal jurisdiction of this Court.

81. **Dr. Diarra** is subject to the subject-matter jurisdiction of this Court in this case.

82. **Dr. Diarra** has been properly served with this Complaint.

83. **Dr. Diarra** 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.

84. Pursuant to OCGA § 9-10-31, **Dr. Diarra** is subject to venue in this Court because some of his co-defendants are directly subject to venue here.

85. At all relevant times, **Dr. Diarra** was employed by one or more of the "Kaiser Defendants" identified below.

86. If any other entity was a principal of **Dr. Diarra**, 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.

87. **DARRYL J. TOOKES, MD** is a Georgia resident. He resides at 1470 Niskey Lake Road SW, Atlanta GA 30331-6310 (Fulton County).

88. **Dr. Tookes** is subject to the personal jurisdiction of this Court.

89. **Dr. Tookes** is subject to the subject-matter jurisdiction of this Court in this case.

90. **Dr. Tookes** has been properly served with this Complaint.

91. **Dr. Tookes** 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.

92. Pursuant to OCGA § 9-10-31, **Dr. Tookes** is subject to venue in this Court because some of his co-defendants are directly subject to venue here.

93. At all relevant times, **Dr. Tookes** was employed by one or more of the "Kaiser Defendants" identified below.

94. If any other entity was a principal of **Dr. Tookes**, 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.

95. **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.

Cause of Action 1: Professional Malpractice (All Defendants)

General Notice of the Claim

96. Dr. Diarra and Dr. Tookes are directly liable to Linda Holloway for professional malpractice.

97. On February 6, 2020, Dr. Diarra and Dr. Tookes each owed professional duties of care to Linda Holloway.

98. On February 6, 2020, Dr. Diarra and Dr. Tookes each violated professional duties of care they owed to Linda Holloway.

99. Those violations caused harm to Linda Holloway.

100. The Kaiser Defendants and Emory Defendants are vicariously liable for the negligence by Dr. Diarra and Dr. Tookes in their responsibilities to Linda Holloway.

101. Dr. Diarra and Dr. Tookes were actual and/or ostensible agents or otherwise servants and/or employees of the Kaiser Defendants.

102. Dr. Diarra and Dr. Tookes were actual and/or ostensible agents or otherwise servants and/or employees of the Emory Defendants.

More Detailed Notice of the Claim

103. The foregoing averments suffice to state a claim. The following averments are not needed in order to give the required notice. They are presented instead to give the Defendants additional notice, to narrow the disputes, and to simplify discovery and trial.[2]

Facts

Wednesday, February 5, 2020 — at Kaiser Permanente

Before Kaiser

104. All times stated in this chronology are approximate.

105. On Wednesday, February 5, 2020, around noon or 1300 hrs, Linda Holloway begins having abdominal pain that increases in intensity.

106. The pain is similar to abdominal pain Linda Holloway has experienced in the past, but feels different — "more throughout my entire colon."

107. At approximately 1600 hrs, Linda Holloway's husband, Dan, asks if she feels like she needed to go to an Emergency Room. Linda Holloway replies that she doesn't want to.

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[2] *See Atlanta Women's Specialists v. Trabue*, 310 Ga. 331 (2020) ("Georgia is a notice pleading jurisdiction. Generally, our Civil Practice Act (CPA) advances liberality of pleading. … [A] complaint need only provide fair notice of what the plaintiff's claim is and the grounds upon which it rests. 'It must be remembered that the objective of the CPA is to avoid technicalities and to require only a short and plain statement of the claim that will give the defendant fair notice of what the claim is and a general indication of the type of litigation involved; the discovery process bears the burden of filling in details.'") (cleaned up).

108. A couple hours later, around 1758 hrs, Dan calls Kaiser Permanente (Linda Holloway's HMO) for advice. Staff nurse Norma Barnes advises Dan to take Linda Holloway to Kaiser's "Advanced Care" center in Kennesaw, Georgia.

- EJa 635

Norma Barnes, RN 2/5/2020 5:48 PM

ADVICE CALL NOTE

Action Requested from Provider:
None

Guideline Recommended and Member Disposition:
KPOC Emergent: (30 min to 2 hours) Advised KP Urgent Care per Consult HUB MD Dr. Olha Azad.

Report given to Nurse . ETA 6:30 pm.

Chief Complaint:
Severe lower abd pain x 3 hours. Denies fever/N/V. Unrelieved with aleve. Hx of hysterectomy.

ALLERGIES: Reviewed in its section.

Patient instructions:

CALLER ADVICE UNDERSTANDING/AGREEMENT:
Member given opportunity to ask questions/make comments. Yes

At Kaiser Permanente in Kennesaw

109. At 1841 hrs, Linda Holloway and Dan arrive at Kaiser Permanente's Advanced Care Center at 750 Townpark Lane in Kennesaw, Georgia.

- EJa 626

Department

Name	Address	Phone
TownPark Advanced Care Center	750 Townpark Lane Kennesaw GA 30144	404-365-0966

...

Arrival Information

Arrival	Means of Arrival	Escorted By	Service	Admission Type
2/5/2020 6:41 PM	Sent by Advice	Relative	Ambulatory Urgent Care	Urgent

110. At 1850 hrs, Nurse Kathryn Camille Skinner notes Linda Holloway's problem as "Severe stomach pain for 4 hours, nauseated, no vomiting or diarrhea."

- EJa 640

Billing #:
ED Complt: Severe stomach pain for 4 hours, nauseated, no vomiting or diarrhea.

Contact Level

Admission
User: SKINNER RN, *
Adm Date: 2/5/2020
Adm Time: 6:50 PM

111. Linda Holloway tells ED physician Dr. Susan Goggans that Linda Holloway has had nothing to eat all day, apart from a couple crackers Linda Holloway thought might help the pain. (The crackers didn't help.) Linda Holloway reports that she had a bowel movement in the morming.

- EJa 628

Md Susan P Goggans 2/5/2020 9:50 PM
68 yo F presents with c/o lower abdominal pain x 4 hrs. Pt states that she has not had anything to eat because she is afraid it's going to make the pain worse. Denies N/V/D, dysuria or hematuria. Pt states she had a normal bowel movement today. Surg hx: TAH. Last bowel movement was this AM. She has not had anything to eat today.

112. At about 2012 hrs, Linda Holloway is taken for a CT scan.

113. At 2019 hrs, Nurse Clifford notes, "Pt states she is very nauseated at this time, pt taken to CT via wheelchair. Husband at bedside. RN to medicate for pain upon return."

- EJa 634

Danielle O Clifford RN 2/5/2020 8:19 PM

Pt states she is very nauseated at this time, pt taken to CT via wheelchair. Husband at bedside. RN to medicate for pain upon return

114. At 2033 hrs, Nurse Danielle O'Clifford gives Linda Holloway 2 mg of morphine through an IV.

- EJa 638

Medication Administration from 02/05/2020 1841 to 02/06/2020 0034

Date/Time	Order	Dose	Route	Action	Action by
02/05/2020 2016	Sodium Chloride 0.9% IV Premix	0 mL	intraVENOUS	Infusion Completed	Danielle O Clifford RN
02/05/2020 1929	Sodium Chloride 0.9% IV Premix	1,000 mL	intraVENOUS	New Bag	Danielle O Clifford RN
02/05/2020 1930	Ketorolac Inj 15 mg (TORADOL)	15 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2033	morphine Inj Soln 2 mg	2 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2146	HYDROmorphone Inj Syg 0.5 mg (DILAUDID)	0.5 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2147	Ondansetron (PF) Inj 4 mg (ZOFRAN)	4 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2207	Sodium Chloride 0.9% IV Premix	1,000 mL	intraVENOUS	New Bag	Danielle O Clifford RN

115. At 2113 hrs, Nurse Kathy Wooley gives Linda Holloway 2 mg of morphine through an IV.

- EJa 634

Kathy Wooley RN 2/5/2020 9:13 PM

---- **HIGH ALERT MEDICATION VERIFICATION WITH TWO NURSES** ----

High Alert Medication ordered by Dr. Goggans. Independent double verification performed with Danielle, RN. Patient received morphine 2mg SIVP (med name) .

116. Around 2130 hrs, radiologist Dr. Joseph G. Todaro reviews Linda Holloway's CT images. In his report, Dr. Todaro writes that the CT findings are "consistent with small bowel obstruction and raise[] concern for closed loop obstruction and internal hernia."

- EJa 623

hydronephrosis on either side. There are a few scattered 1-2 mm low-density lesions in each kidney which are too small to characterize.
Stomach and bowel: There is mild small bowel dilatation measuring up to 3 cm extending down to the midline where there are 2 adjacent rapidly tapering zones of transition. This is consistent with small bowel obstruction and raises concern for closed loop obstruction and internal hernia.
Appendix: No evidence of appendicitis.
Intraperitoneal space: There is a small amount of free fluid within the pelvis.
Vasculature: The aorta demonstrates mild atherosclerotic calcification. No aneurysm.

117. Dr. Todaro recommends a surgical consult.

- EJa 624

IMPRESSION:
~~Small bowel~~ obstruction with suspicion for closed loop or internal hernia and a small amount of free fluid in the pelvis. Surgical consultation suggested.
There are 2 large hepatic masses. One is exophytic. Both have features suggesting hemangiomata but are incompletely characterized. Recommend further evaluation with liver MRI.
Small indeterminate renal lesions. No further workup is recommended.

118. Dr. Todaro speaks to Dr. Goggans about the CT findings.

- EJa 623

Addendum

Findings were discussed with GOGGANS, MD, at 2/5/2020 10:08 PM EST.

This Final Addended report was electronically signed by Todaro, Joseph, MD on 5 Feb 2020 10:08
PM EDT.

Addended by Md Joseph G Todaro on 2/5/2020 10:08 PM

119. At 2146 hrs, Nurse Danielle O'Clifford gives Linda Holloway 0.5 mg of hydromorphone through an IV.

- EJa 634

Danielle O Clifford RN 2/5/2020 9:47 PM

---- HIGH ALERT MEDICATION VERIFICATION WITH TWO NURSES ----

High Alert Medication ordered for the patient by Dr. Goggans for Linda M Holloway is a 68 year old female . Independent double verification performed with Kathy, RN. Patient is receiving 0.5 mg dilaudid PIV (med, dose, route, and time) for pain (indication).

- EJa 638

Medication Administration from 02/05/2020 1841 to 02/06/2020 0034

Date/Time	Order	Dose	Route	Action	Action by
02/05/2020 2016	Sodium Chloride 0.9% IV Premix	0 mL	intraVENOUS	Infusion Completed	Danielle O Clifford RN
02/05/2020 1929	Sodium Chloride 0.9% IV Premix	1,000 mL	intraVENOUS	New Bag	Danielle O Clifford RN
02/05/2020 1930	Ketorolac Inj 15 mg (TORADOL)	15 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2033	morphine Inj Soln 2 mg	2 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2146	HYDROmorphone Inj Syg 0.5 mg (DILAUDID)	0.5 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2147	Ondansetron (PF) Inj 4 mg (ZOFRAN)	4 mg	intraVENOUS	Push	Danielle O Clifford RN
02/05/2020 2207	Sodium Chloride 0.9% IV Premix	1,000 mL	intraVENOUS	New Bag	Danielle O Clifford RN

Transfer to Emory St. Joseph's Hospital

120. At 2149 hrs, Dr. Goggans arranges for Linda Holloway to be transferred to Emory St. Joseph's hospital, into the care of Dr. Cheickna Diarra, a general surgeon. Dr. Goggans speaks to Dr. Diarra.

- EJa 633-34

MEDICAL DECISION MAKING:
I spoke with Dr. Diarra who has accepted the pt to general surgery service for admission at ESJ.

ASSESSMENT:
Small bowel obstruction
PLAN:
Transfer to Emory St. Joseph

Brooke A Bruno RN 2/5/2020 9:49 PM

Name of Physician Requesting Bed: Dr Goggans
Current location of patient: TP ACC 6

Hospital: Emory St Joseph
Bed Type: Med/surg
Diagnosis: SBO
Accepting Physician: Dr Diarra
Time requested: 9:48pm
Sonya at Emory Transfer Center notified, face sheet faxed, and Case Manager has been notified via secure messaging.

Brooke A Bruno RN 2/5/2020 9:49 PM

Caller's Name: Dr Goggans
Call back number: 770-514-5686
Diagnosis: SBO
ACC/CDU Location: Town Park
Room in ACC/CDU: ACC6
Drips: IVF
For conference call with hospitalist No
For Hub MD consultation only Yes

Which [redacted]spital: Emory St Joseph [redacted] [redacted]

Dr Diarra has accepted pt. IMS is not needed.

121. Around 2300 hrs, Kaiser Nurse Cox checks on the status with Emory. Still not ready for Linda Holloway.

- EJa 627

Linda Ann Ainslie RN 2/5/2020 11:00 PM
Plans for transfer admit to Emory /Saint Joseph's Hospital of Atlanta ; pending bed assignment. (pt and pt family member aware of plan and agreeable.)
IVF; infusing freely.
Pt kept NPO .
Call bell at bedside , side rails up.

Wendy Cox RN 2/5/2020 10:59 PM
Spoke with Brooke at ECM Hub. Patient is awaiting bed assignment at Emory St. Joseph.

122. Around midnight, Kaiser Nurse Anna Carroll checks with Emory again. Still not ready for Linda Holloway.

- EJa 627

Rn Anna D Carroll 2/5/2020 11:50 PM
Spoke with Lawanda at ETC, no bed assigned at this time, will follow-up

123. Shortly after midnight, at 0018 hrs, Emory is ready for Linda Holloway, and Kaiser calls an ambulance to transfer Linda Holloway.

- EJa 627

Provider Authorizing transport name: Dr. Goggins
Member's Current Location: TP ACC Room number 6
Diagnosis: SBO
Transport Destination: Emory St Joseph
Room number359

Accepting Physician: DR. Diarra
If going to the ER to be seen by PMG or Emory ED physician? PMG

...

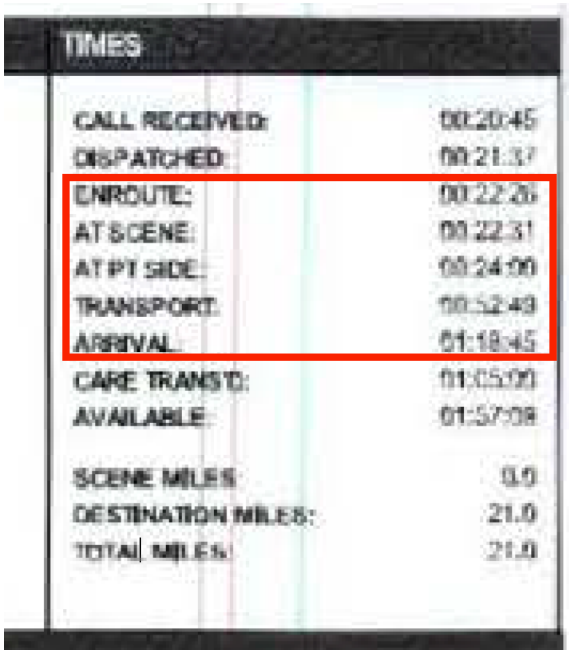
Transport Type: ALS
Transport Level: Level 3 (IMMEDIATE: 60 min or less

Estimated body mass index is 20.67 kg/m² as calculated from the following:
Height as of an earlier encounter on 2/5/20: 5' 2" (1.575 m).
Weight as of an earlier encounter on 2/5/20: 113 lb (51.3 kg).
Equipment Needed: Oxygen, Monitor and IV Access

Ambulance Call Time: 0018
Ambulance ETA: 1 hour
hourAmbulance Confirmation #: aed1

124. At 0024 hrs, the ambulance EMT's are at Linda Holloway's bedside, preparing to transport her.

- EJa 23



125. At 0034 hrs, Kaiser Nurse Linda Holloway Ann Ainslie copies Linda Holloway's medical records to send to Emory, and makes the CT study available to Emory electronically.

- EJa 626

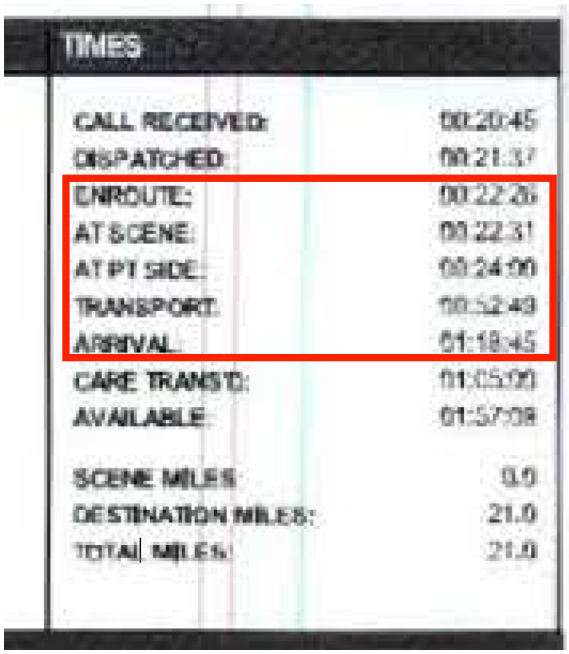
Linda Ann Ainslie RN 2/6/2020 12:34 AM
AMR ; EMS Here. (report provided)
cahrt copied.
Images pushed thru on PAC's .

Rn Anna D Carroll 2/6/2020 12:19 AM
Patient is assigned to Emory saint Joseph room 359 report to 678-843-5370

Notified nurse Wendy at TP ACC of transfer information which includes hospital, bed assignment, phone # for nurse report, and expected ETA of ambulance. Requested copies of the pertinent medical records and test results, including a CD of any scans or x-ray, be sent with the patient when transported.

126. At 0118 hrs, the ambulance arrives at Emory.

- EJa 23



Thursday, February 6, 2020 — at Emory St. Joseph's

127. From 0137 hrs to 0157 hrs, Emory Nurse Preema Sharma performs a patient intake routine with Linda Holloway in her hospital room.

- EJa 330

Order: **Patient Intake**			
Order Start Date/Time: 2/6/2020 01:37 EST			
Order Status: Completed	Department Status: Completed	Catalog Type: Patient Care	Activity Type: Patient Care
End-state Date/Time: 2/6/2020 01:57 EST		End-state Reason:	
Ordering Physician: SYSTEM,SYSTEM		Consulting Physician:	
Entered By: SYSTEM,SYSTEM on 2/6/2020 01:37 EST			
Order Details: 2/6/20 1:37:56 AM EST, Once			
Order Comment: Order entered secondary to patient admission			
Action Type: Complete	Action Date/Time: 2/6/2020 01:57 EST	Action Personnel: Sharma,Preema	

128. At 0146 hrs, Nurse Sharma notes Linda Holloway's pain level as 7 out of 10.

- EJa 481

	Recorded Date Recorded Time Recorded By	2/6/2020 02:29 EST Sharma,Preema	2/6/2020 01:46 EST Sharma,Preema
Procedure			
Pain Location		-	abdomen
Pain Scale Used		Numeric O4	Numeric
Pain Score		7 O4	7
Behavioral Pain Indicators		Grimacing O4	-

129. At 0230 hrs approximately, Dr. Cheickna Diarra evaluates Linda Holloway.

130. Dr. Diarra has Kaiser's medical records, including the CT report, available.

- EJa 626

Linda Ann Ainslie RN 2/6/2020 12:34 AM
AMR ; EMS Here. (report provided)
cahrt copied.
Images pushed thru on PAC's .

Rn Anna D Carroll 2/6/2020 12:19 AM
Patient is assigned to Emory saint Joseph room 359 report to 678-843-5370

Notified nurse Wendy at TP ACC of transfer information which includes hospital, bed assignment, phone # for nurse report, and expected ETA of ambulance. Requested copies of the pertinent medical records and test results, including a CD of any scans or x-ray, be sent with the patient when transported.

131. In his History & Physical, Dr. Diarra writes that Linda Holloway has had abdominal pain for four hours. That is inaccurate. In fact, Linda Holloway has had abdominal pain for 13 or 14 hours, starting around noon or 1300 hrs the previous day.

- EJa 57

Chief Complaint: **Abdominal pain, bowel obstruction**

HPI: _68 yo F presents with c/o lower abdominal pain x 4 hrs. Pt states that she has not had anything to eat because she is afraid it's going to make the pain worse. Denies N/V/D, dysuria or hematuria AT HOME BUT HAD ONE EPISODE OF EMESIS AT THE ACC. Pt states she had a normal bowel movement today. Denies flatus for the past few hours. Surg hx: TAH. Pain is 5/10

132. Dr. Diarra notes that Linda Holloway had one episode of vomiting at the Kaiser care center.

- EJa 57

Chief Complaint: **Abdominal pain, bowel obstruction**

HPI: _68 yo F presents with c/o lower abdominal pain x 4 hrs. Pt states that she has not had anything to eat because she is afraid it's going to make the pain worse. Denies N/V/D, dysuria or hematuria AT HOME BUT HAD ONE EPISODE OF EMESIS AT THE ACC. Pt states she had a normal bowel movement today. Denies flatus for the past few hours. Surg hx: TAH. Pain is 5/10

133. Dr. Diarra performs a physical exam and notes, "GI - soft, mildly distended, mildly tender and tympanic, decreased bowel sounds, no organomegaly, no diffuse peritonitis."

- EJa 58

Constitutional- NAD, well-nourished
Eyes - PERRLA, EOM intact
ENMT - normal nasal mucosa, clear oropharynx without erythema, trachea midline, no masses, no thyromegaly
Cardiovascular - RRR, no m/r/g, no JVD.
Respiratory - Clear to auscltation, no crackles or wheezes
GI - soft, mildly distended, mildly tender and tympanic, decreased bowel sounds, no organomegaly, no diffuse peritonitis.
Musculoskeletal -Normal strength and muscle tone
Heme/Lymph Nodes/Imm - No cervical lymphadenopathy, no bruising
Skin - No rashes, skin warm and dry

134. Dr. Diarra reviews the CT performed at Kaiser. He copies the CT report findings and impression into his History & Physical — putting the text relating to the bowel in bold.

- EJa 59-60

KAISER LABS: WBC 5.8 HGB 14.0 PTL 289 LYTES: NL
Radiology: I have personally reviewed all pertinent imaging related to the current encounter

...

Kidneys and ureters: There is a 7 mm left interpolar renal lesion which is too small to characterize but most likely represents a cyst. No renal calculus or hydronephrosis on either side. There are a few scattered 1-2 mm low-density lesions in each kidney which are too small to characterize.
Stomach and bowel: There is mild small bowel dilatation measuring up to 3 cm extending down to the midline where there are 2 adjacent rapidly tapering zones of transition. This is consistent with small bowel obstruction and raises concern for closed loop obstruction and internal hernia.
Appendix: No evidence of appendicitis.
Intraperitoneal space: There is a small amount of free fluid within the pelvis.
Vasculature: The aorta demonstrates mild atherosclerotic calcification. No aneurysm.
Lymph nodes: Unremarkable. No enlarged lymph nodes.

...

Small-bowel obstruction with suspicion for closed loop or internal hernia and a small amount of free fluid in the pelvis. Surgical consultation suggested.
There are 2 large hepatic masses. One is exophytic. Both have features suggesting hemangiomata but are incompletely characterized. Recommend further evaluation with liver MRI.
Small indeterminate renal lesions. No further workup is recommended.

135. Dr. Diarra writes in his assessment, "Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction."

- EJa 60

Plan/Assessment:
Diagnosis: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction
Comment:

Diagnosis: Small bowel obstruction
Comment:
Ordered: Admit to Inpatient; 02/06/20 1:46:00, Diarra, Cheickna, For Inpatient Certification-see comments, Small bowel obstruction, Constant Indicator, 02/06/20 1:46:00, 3 Days

Additional Orders:
Comment:
Ordered: Alternating Leg Pressure Device,02/06/20 1:49:00, ALP/SCDs Knee High

136. Dr. Diarra notes in additional comments that Linda Holloway may have a closed loop obstruction, but that it is unclear without a CT performed with oral (as opposed to IV) contrast. Dr. Diarra notes that if Linda Holloway does have a closed loop obstruction, she will need a diagnostic laparoscopy and possibly an exploratory laparotomy.

- EJa 61

Small bowel obstruction. possible closed loop?
Unclear with absence of oral contrast
Pt Hemodynamically stable and non-toxic appearing
No acidosis or leukocytosis, abd pain mild, no peritonitis
NPO/NGT/IVF
Repeat CT with PO and IV contrast today
Dr. Tookes to see pt today in AM
if closed loop present, will need diagnostic laparoscopy, possible exlap.

Cheickna Diarra, MD, FACS
General, Minimally Invasive & Robotic Surgery
Kaiser Permanente / TSPMG
PIC # 55083

137. Dr. Diarra writes that his plan is to repeat the CT in the morning at 8 AM, with oral and IV contrast, and to have Dr. Tookes follow up with Linda Holloway.

- EJa 61

Small bowel obstruction. possible closed loop?
Unclear with absence of oral contrast
Pt Hemodynamically stable and non-toxic appearing
No acidosis or leukocytosis, abd pain mild, no peritonitis
NPO/NGT/IVF
Repeat CT with PO and IV contrast today
Dr. Tookes to see pt today in AM
if closed loop present, will need diagnostic laparoscopy, possible exlap.

Cheickna Diarra, MD, FACS
General, Minimally Invasive & Robotic Surgery
Kaiser Permanente / TSPMG
PIC # 55083

138. Dr. Diarra orders a CT "routine" for 8:00 AM, to rule out a closed loop obstruction.

- EJa 60

Additional Orders:
Comment:
Ordered: Alternating Leg Pressure Device,02/06/20 1:49:00, ALP/SCDs Knee High
Ordered: Ambulate,02/06/20 1:49:00, qDay
Ordered: CBC,Stat, 02/06/20 1:46:00, Blood
Ordered: CMP - Comprehensive Metabolic Panel,Timed Study, 02/06/20 1:46:00, Blood
Ordered: CT Abdomen + Pelvis w/ IV Contrast,Routine, 02/06/20 8:00:00, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.

- EJa 299

Order: **CT Abdomen + Pelvis w/IV Contrast**			
Order Start Date/Time: 2/6/2020 08:00 EST			
Order Status: Completed	Department Status: Completed	Catalog Type: Radiology	Activity Type: Radiology
End-state Date/Time: 2/6/2020 12:17 EST		End-state Reason:	
Ordering Physician: Diarra,Cheickna		Consulting Physician:	
Entered By: Diarra,Cheickna on 2/6/2020 02:54 EST			
Order Details: Routine, 2/6/20 8:00:00 AM EST, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.			

139. CT transport does not come to get Linda Holloway until 1052 hrs — nearly 11:00 AM.

140. CT transport returns with Linda Holloway a few minutes later — before the CT was done — because Linda Holloway is too dizzy to ride in a wheelchair. Linda Holloway's nurse says they'll have to do the CT later. Linda Holloway's husband insists that they take Linda Holloway for the CT now, in her bed, which has wheels. The nurse and transport person agree and take Linda Holloway to the CT again, at 1103 hrs.

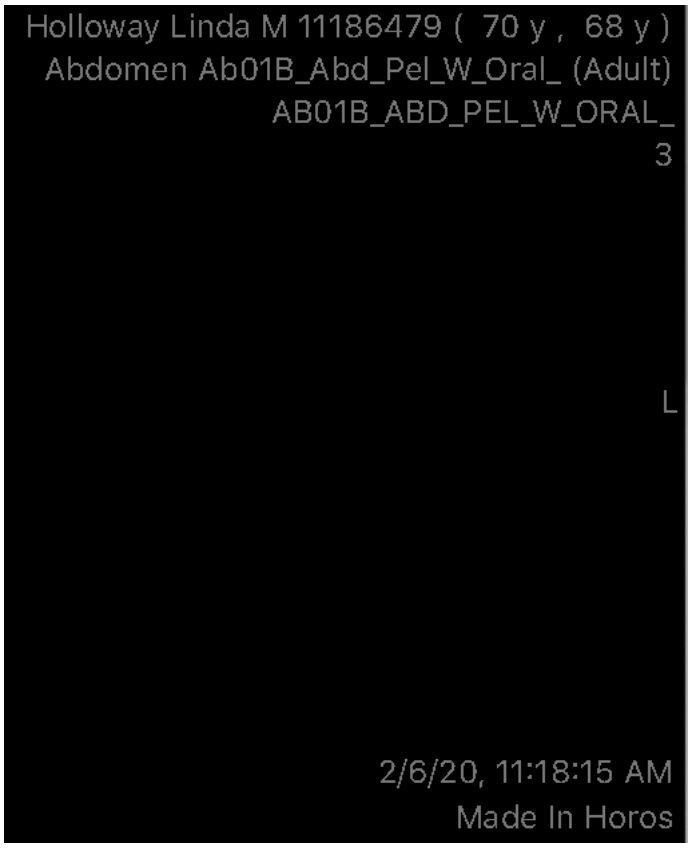
141. The nurse and transport person agree and take Linda Holloway to the CT again, at 1103 hrs.

142. The CT imaging begins at 1115 hrs and ends by 1119 hrs.

- DICOM imaging metadata

Patient name	Study Description	Modality	Date Acquired
▶ Holloway Linda M	Ct Abdominal Outside Image Ref Only	CT	2/5/20, 8:18 PM
▶ Holloway Linda M	Xr Thoracoabdomen High Kub	DX	2/6/20, 3:52 AM
▶ Holloway Linda M	Xr Thoracoabdomen High Kub	DX	2/6/20, 5:05 AM
▶ Holloway Linda M	Xr Thoracoabdomen High Kub	DX	2/6/20, 6:22 AM
▶ Holloway Linda M	Abdomen Ab01B_Abd_Pel_W_Oral_ (Adult)	CT	2/6/20, 11:15 AM

- DICOM images



143. Linda Holloway is back from the CT by 1133 hrs.

144. At 1145 hrs approximately, Dan asks the nurse to ask the doctor in charge to make sure any additional imaging (an MRI, if needed) is ordered and performed stat — so there won't be additional hours-long delay for imaging. At this point, Dan still doesn't know who the attending physician is.

145. At 1214 hrs, Radiologist Dr. William Clark Small finalizes and signs his CT report. He writes, "Segment of edematous appearing small bowel with configuration of dilation and central tethering suggesting closed loop obstruction with poor mucosal enhancement suggestive of early ischemia."

- EJa 347

IMPRESSION:

1. Segment of edematous appearing small bowel with configuration of dilation and central tethering suggesting closed loop obstruction with poor mucosal enhancement suggestive of early ischemia. No evidence of perforation. More proximal and more distal bowel loops unremarkable in appearance. Likely reactive peritoneal fluid.
2. Somewhat heterogeneous pattern of hepatic enhancement with 2 dominant liver lesions, incompletely characterized, the more inferior with some features of hemangioma, recommend elective MRI characterization both of these lesions and liver overall.

**** Final ****

Electronically Signed By: Small, William Clark
on 02/06/2020 12:14

146. At 1217 hrs, Dr. Darryl Tookes, a general surgeon, comes into Linda Holloway's room. Dr. Tookes tells Linda Holloway and Dan that the radiologist called him to say Linda Holloway had a closed loop obstruction. Speaking to Dan, Dr. Tookes explains what that means and its implications. He uses his phone to pull up a diagram showing a closed loop obstruction. Part way into the conversation, Dan gets Dr. Larry Schlachter on the phone to participate in the conversation. Dr. Tookes, Dr. Schlachter, and Dan all agree on the need for emergency surgery. Dan tells Linda Holloway of the plan.

147. At 1356 hrs, anesthesia is ready.

- EJa 65

Case Times SJH OR

	Entry 1
SN - Set-Up	
SN - Patient	
In Time	02/06/20 13:44:00
Out Time	02/06/20 16:29:00
SN - Anesthesia	
Anesthesia Ready	02/06/20 13:56:00
SN - Surgery	
Start Time	02/06/20 14:32:00
Stop Time	02/06/20 16:07:00
SN - Clean-Up	
Last Modified By:	Pope, Penny L 02/06/20 16:28:58

148. At 1432 hrs, surgery begins. It continues until 1607 hrs.

- EJa 65

Case Times SJH OR

	Entry 1
SN - Set-Up	
SN - Patient	
In Time	02/06/20 13:44:00
Out Time	02/06/20 16:29:00
SN - Anesthesia	
Anesthesia Ready	02/06/20 13:56:00
SN - Surgery	
Start Time	02/06/20 14:32:00
Stop Time	02/06/20 16:07:00
SN - Clean-Up	
Last Modified By:	Pope, Penny L 02/06/20 16:28:58

149. Dr. Tookes finds ischemic small bowel with a band around it. The bowel had volvulized on itself — that is, the bowel had become twisted.

- EJa 75

The camera was inserted again, and there was no obvious traumatic injury into the abdomen. The visualization of the abdominal cavity revealed ischemic bowel. The abdomen was desufflated. A midline incision was made through the umbilicus measuring approximately 7 cm in size. The subcutaneous tissue was dissected through. The linea alba and peritoneum were opened. The ischemic bowel was identified. There was a band around the ischemic part of the bowel, which had volvulized on itself. This band was incised and the bowel was

150. Dr. Tookes finds 135 cm — about 53 inches, or about 4-1/2 feet — of ischemic small bowel. The ischemic section runs from about the middle of Linda Holloway's ileum to the ileocecal valve, where the small intestine joins the large intestine.

- EJa 76

> eviscerated out. The bowel was measured and approximately 135 cm of bowel was found to be ischemic. This extended from the proximal and middle ileum to the distal ileum at the level of the ileocecal valve. The appendix was identified and the appendix had a nodule on the tip. The GIA stapler was fired across the small bowel proximal to the ischemic region. A GIA stapler was fired across the cecum. The mesentery in between was taken down with the Harmonic scalpel. The specimen was removed. The appendix was included in this as well. The remaining small bowel was measured and approximately 165 cm was remaining. The ileocecal valve was removed with the cecal specimen. The remaining small bowel was reanastomosed to the proximal right colon in a side-to-side isoperistaltic fashion with a GIA stapler. The holes of the GIA stapler made were closed off with a TA-60 stapler. The mesenteric defect was closed off with a running 3-0

151. Dr. Tookes cuts out the ischemic small bowel and the cecum, along with the ileocecal valve and the appendix.

- EJa 76

> eviscerated out. The bowel was measured and approximately 135 cm of bowel was found to be ischemic. This extended from the proximal and middle ileum to the distal ileum at the level of the ileocecal valve. The appendix was identified and the appendix had a nodule on the tip. The GIA stapler was fired across the small bowel proximal to the ischemic region. A GIA stapler was fired across the cecum. The mesentery in between was taken down with the Harmonic scalpel. The specimen was removed. The appendix was included in this as well. The remaining small bowel was measured and approximately 165 cm was remaining. The ileocecal valve was removed with the cecal specimen. The remaining small bowel was reanastomosed to the proximal right colon in a side-to-side isoperistaltic fashion with a GIA stapler. The holes of the GIA stapler made were closed off with a TA-60 stapler. The mesenteric defect was closed off with a running 3-0

152. Dr. Tookes measures the remaining small bowel. It is approximately 165 cm (65 inches, or about 5-1/2 feet).

- EJa 76

eviscerated out. The bowel was measured and approximately 135 cm of bowel was found to be ischemic. This extended from the proximal and middle ileum to the distal ileum at the level of the ileocecal valve. The appendix was identified and the appendix had a nodule on the tip. The GIA stapler was fired across the small bowel proximal to the ischemic region. A GIA stapler was fired across the cecum. The mesentery in between was taken down with the Harmonic scalpel. The specimen was removed. The appendix was included in this as well. The remaining small bowel was measured and approximately 165 cm was remaining. The ileocecal valve was removed with the cecal specimen. The remaining small bowel was reanastomosed to the proximal right colon in a side-to-side isoperistaltic fashion with a GIA stapler. The holes of the GIA stapler made were closed off with a TA-60 stapler. The mesenteric defect was closed off with a running 3-0

153. Before the surgery, Linda Holloway's small bowel totaled approximately 300 cm (135 + 165).

154. By the time Linda Holloway received surgery, approximately 45% of her small bowel was ischemic and had to be cut out.

155. The tissue cut out was sent to pathology. Pathologist Dr. Jackie Hoffman issues a report describing the physical appearance of the small bowel as "multiple loops of pink-purple, diffusely dusky appearing small bowel attached to a pink-tan and viable appearing portion of cecum. … There is abundant hemorrhagic fluid and clot material in the lumen of the small bowel. The mucosa at the proximal margin and the most proximal 3.5 cm of the specimen is pink-tan and viable appearing. The small bowel mucosa distal to this small segment of viable tissue adjacent to the proximal margin is notable for a 92 cm in length dark purple and dusky area that demonstrates the usual folds that appears nonviable."

- EJa 339-40

Part C is received in formalin and is labeled with the patient's name "Holloway, Linda M" and "terminal ileum and cecum". The specimen consists of multiple loops of pink-purple, diffusely dusky appearing small bowel attached to a pink-tan and viable appearing

portion of cecum. Both margins are stapled closed. The specimen measures 104.5 cm in overall length to include a 98 cm in length by 3.2 cm in diameter segment of small bowel and a 6.5 cm in length by 4.8 cm in diameter portion of cecum/ascending colon. No definite appendiceal tissue is noted on the surface of the specimen. There is scant yellow fat attached to the portion of cecum. There is a moderate amount of mesenteric fat attached to the small bowel that is diffusely dark purple and dusky. There is no discrete area of stricture or dilatation. No exudate or evidence of perforation is noted.

The specimen is opened. There is abundant hemorrhagic fluid and clot material in the lumen of the small bowel. The mucosa at the proximal margin and the most proximal 3.5 cm of the specimen is pink-tan and viable appearing. The small bowel mucosa distal to this small segment of viable tissue adjacent to the proximal margin is notable for a 92 cm in length dark purple and dusky area that demonstrates the usual folds that appears nonviable. This area is located 2.5 cm from the ileocecal valve and 7 cm from the distal margin. The cut surfaces of this area are dark purple and dusky with no viable tissue appreciated. The thickness of the wall in this area

Dr. Diarra's & Dr. Tookes' Professional Malpractice

Task 1: Respond to findings suspicious for a looped bowel obstruction.

Requirement

156. Given CT findings that are suspicious for a closed-loop bowel obstruction, the standard of care requires a general surgeon to perform an emergency laparoscopy. If done promptly, before radiologic signs of ischemia, surgical intervention can likely avoid any loss of bowel.

157. Small bowel obstructions occur frequently and are well known to the medical community.

158. Closed loop bowel obstructions are unlikely to resolve without surgery.

159. Closed loop bowel obstructions may become ischemic rapidly.

160. Even absent signs of current bowel ischemia, signs of a closed loop bowel obstruction require surgical exploration by laparoscopy, without delay.

- *Shackelford's Surgery of the Alimentary Tract*, Eighth Edition (Elsevier 2019)

"swirl sign" (Fig. 72.6). If the obstruction is severe enough or volvulus occurs, bowel ischemia ensues with subsequent infarction and/or perforation. Closed-loop obstructions should be considered an indication for urgent surgical intervention in most cases because they are exceedingly unlikely to resolve with nonoperative therapy and the potential for bowel ischemia is high and increases with delay in definitive therapy. In one recent series, 23 of 24 patients (95.8%) with closed-loop obstruction identified on CT scan required bowel resection for ischemia or necrosis.[23] The use of water-soluble contrast

161. Further diagnostic imaging (*e.g.,* to repeat the CT with oral contrast) is unnecessary, but if it is to be performed, it must be performed without delay.

162. If laparoscopy confirms a closed loop obstruction, then absent some contraindication, the surgeon must proceed immediately to surgical remediation.

Negligence — Point 1

163. When called by ED physician Dr. Goggins, the standard of care required Dr. Diarra to identify Linda Holloway's suspected looped bowel obstruction as an emergency, requiring immediate transfer from Kaiser to Emory — for a laparascopy to be performed as soon as possible upon Linda Holloway's arrival at Emory.

164. Dr. Diarra's failure to identify the emergency during the phone call with Dr. Goggins caused a multi-hour delay in transferring Linda Holloway from Kaiser to Emory. The call occurred around 2149 hrs on February 5. Because of delays at Emory's end, the ambulance was not called for Linda Holloway until 0018 hrs the next morning — a delay of about 2-1/2 hours.

Negligence — Point 2

165. Furthermore, while Linda Holloway arrived at Emory at 0118 hrs, Dr. Diarra did not come to Linda Holloway's bedside until about 0230 hrs — another delay of over an hour.

Negligence — Point 3

166. When Dr. Diarra finally assessed Linda Holloway around 0230 hrs, the standard of care required Dr. Diarra to perform an emergency laparoscopy. The purpose is to confirm or rule out a looped bowel obstruction — and if so, repair it — before the bowel becomes ischemic and requires surgical excision.

167. Given a patient with approximately 12 hours or more of severe abdominal pain, and radiologic findings suspicious for a looped bowel obstruction, it was unreasonable to wait for another CT scan. It is grossly unreasonable, and dangerous to the patient, to wait multiple hours.

168. The lack of oral contrast on the prior CT did not require another CT before a laparoscopy.

169. In cases of suspected total obstruction, oral contrast is not advised.

Negligence — Point 4

170. However, if another CT were to be performed with oral contrast, it was unnecessary, unreasonable, and dangerous to wait hours in order to suction gastric contents with a nasogastric tube.

171. Dr. Diarra violated the standard of care by failing to perform an emergency laparoscopy, and by intentionally creating a delay of at least 5-1/2 hours (from 0230 hrs to 0800 hrs) merely for another (unnecessary) CT.

Negligence — Point 5

172. After negligently causing dangerous delay, Dr. Diarra compounded the danger by failing to provide orders or instructions to the nurses, to notify him or another physician of worsening signs or symptoms — including pain.

173. Pain is a symptom of bowel obstruction. Severe and increasing pain escalates the concern for ischemia and eventually necrosis of the bowel.

174. Over several hours, Linda Holloway's pain worsened dramatically, requiring heavy doses of hydromorphone. But the nurses never notified any physician of Linda Holloway's worsening pain.

Causation & Damages

175. Dr. Diarra's negligence caused harm to Linda Holloway.

176. The CT performed at the Kaiser facility showed no signs of ischemic bowel.

177. Furthermore, when surgery was eventually performed around 1400 hrs on February 6, the pathologist described the resected bowel as "pink-purple, diffusely dusky" in appearance.

178. If Dr. Diarra had performed an emergency laparoscopy — nearly 12 hours before the ultimate surgery — it is likely that Linda Holloway would have had no ischemic bowel, that Linda Holloway would have lost no bowel. It is all but certain that if Linda Holloway lost any bowel, she would not have lost 4-1/2 feet of it (or 45% of the total length of her small bowel).

Task 2: Order a CT scan for a patient with suspected looped bowel obstruction

Requirement

179. As discussed above, another CT scan for Linda Holloway was unnecessary and inappropriate when Dr. Diarra assessed Linda Holloway. However, if a CT scan was to be ordered then, the standard of care would require that it be ordered stat.

180. Furthermore, while it would violate the standard of care to create a multi-hour delay for another CT, if a delayed CT was to be ordered, the standard of care would require ordering it to be performed stat at the appointed time — rather than "routine" at the appointed time, which would create the risk of still more hours of delay.

Negligence

181. Dr. Diarra further violated the standard of care by ordering the unnecessary CT with a deliberate delay of approximately 5-1/2 hours.

182. A desire for oral contrast did not justify delaying an additional CT. First, oral contrast is not advised in cases of suspected total bowel obstruction. Second, even if oral contrast was to be used, it did not require further delay.

183. Dr. Diarra compounded the negligence by ordering the CT "routine" — creating the risk (and then the fact) of an additional multi-hour delay.

Causation & Damages

184. The delay attributable to Dr. Diarra's order for the unnecessary CT amounted to approximately 9-1/2 hours — from about 0230 hrs when Dr. Diarra saw Linda Holloway, to about 1200 hrs when the radiologist reported his findings to Dr. Tookes.

185. The delay of 9-1/2 hours likely caused all of the ischemia that required resection of Linda Holloway's small bowel. If Dr. Diarra had performed a laparoscopy without that delay, it is likely that none of Linda Holloway's small bowel would have had to be cut out.

186. Pursuant to OCGA Title 51, Chapter 4, Linda Holloway is entitled to recover from Dr. Diarra and the Kaiser Defendants for all damages caused by Dr. Diarra's professional malpractice.

Task 3: Attend to a patient admitted overnight for a suspected closed loop bowel obstruction

Requirement

187. When a general surgeon comes on duty at a hospital in the morning to make rounds, the standard of care requires the surgeon to survey the patients needing his or her care, and to set priorities for making rounds.

188. A patient admitted overnight for a suspected closed loop bowel obstruction is a high-priority patient — particularly one in Linda Holloway's situation, who by 0700 hrs on Feb 6 had been suffering severe pain for at least 16 hours.

189. Unless other higher-priority patients delay the surgeon — or unless the systems in place at the hospital make it impracticable to identify the priority of patient conditions — the standard of care requires the surgeon coming on duty to immediately attend to a patient admitted overnight for a suspected closed loop bowel obstruction.

Facts

190. Dr. Darryl Tookes was a general surgeon who came on duty the morning of February 6, 2020.

- *See* Dr. Diarra's HPI, at EJa 61

Small bowel obstruction. possible closed loop?
Unclear with absence of oral contrast
Pt Hemodynamically stable and non-toxic appearing
No acidosis or leukocytosis, abd pain mild, no peritonitis
NPO/NGT/IVF
Repeat CT with PO and IV contrast today
Dr. Tookes to see pt today in AM
if closed loop present, will need diagnostic laparoscopy, possible exlap.

Cheickna Diarra, MD, FACS
General, Minimally Invasive & Robotic Surgery
Kaiser Permanente / TSPMG
PIC # 55083

191. Dr. Tookes did not see Linda Holloway until after noon — 5 hours after the typical start time of 0700 hrs.

Negligence

192. Dr. Tookes violated the standard of care by failing to evaluate Linda Holloway urgently, at the start of his shift.

Causation & Damages

193. If Dr. Tookes had assessed the priority of his patients and attended to Linda Holloway promptly upon beginning his shift, less of Linda Holloway's small bowel would have had to be cut out.

Cause of Action 2: Negligence (the Kaiser Defendants & the Emory Defendants)

General Notice of the Claim

194. The Kaiser Defendants and the Emory Defendants owed duties of care to Linda Holloway.

195. More specifically, the Kaiser Defendants and the Emory Defendants owed duties of *ordinary* care to Linda Holloway

196. The Kaiser Defendants and the Emory Defendants violated duties of ordinary care to Linda Holloway.

197. More specifically, the Kaiser Defendants and the Emory Defendants violated their duties of ordinary care, (a) through the actions of their non-professional administrators, and (b) through the actions of their professional staff in performing purely administrative tasks.

198. Negligent administration by the Kaiser Defendants and the Emory Defendants created unreasonable potential for medical errors by the physicians and nurses involved in the care of Linda Holloway. That is, mal-administered systems and organizational cultures promoted, rather than prevented, medical error.

199. By violating their duties of ordinary care, the Kaiser Defendants and the Emory Defendants harmed Linda Holloway.

200. The individuals directly responsible for acts of negligent administration were actual and/or ostensible agents or otherwise servants and/or employees of the Kaiser Defendants and/or the Emory Defendants.

201. The Kaiser Defendants and Emory Defendants are vicariously liable for the negligence of the individual administrators whose negligence contributed to injure Linda Holloway.

More Detailed Notice of the Claim

202. The foregoing averments suffice to state a claim. The following averments are not needed in order to give the required notice of the claim. They are presented instead to give the Defendants additional notice, to narrow the disputes, and to simplify discovery and trial.

Negligence, not Professional Malpractice

203. This is not a claim for professional malpractice as defined in OCGA 9-11-9.1. This is a claim for negligence — that is, "ordinary" or "simple" negligence.

204. This claim is premised largely on the negligence of individuals who are not licensed for professions listed in OCGA 9-11-9.1.

205. Any negligence by an individual not licensed for a profession listed in OCGA 9-11-9.1(g) is ordinary negligence, not professional malpractice.

206. Georgia law recognizes that ordinary negligence in the form of negligent administration can contribute to a chain of events that includes medical malpractice and harms a patient.[3]

207. Georgia law recognizes that both ordinary negligence & medical malpractice can exist and combine to cause harm — creating liability for both ordinary negligence and medical malpractice.

208. The Georgia courts have not catalogued every purely administrative duty in a hospital.

209. To the extent this claim is premised on the negligence of individuals who *are* licensed for professions listed in OCGA 9-11-9.1, this claim addresses only actions that could permissibly be performed by people who are not so licensed.

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[3] *See, e.g.:*

Dent v. Memorial Hospital, 270 Ga. 316 (1998) (medical malpractice case; reversing judgment in favor of hospital, because jury instructions did not make clear that both ordinary negligence and professional malpractice would authorize a verdict against the hospital);

Lowndes County Health v. Copeland, 352 Ga. App. 233 (2019) (medical malpractice case; affirming verdict for both ordinary negligence and professional negligence against a skilled nursing facility).

210. To the extent the trial and appellate courts ultimately determine that any particular act constituted professional malpractice as defined in OCGA 9-11-9.1, Plaintiff stipulates that the act does not support a claim ordinary negligence.

Principles of Healthcare Administration

211. The averments in this "Principles of Healthcare Administration" section and its subsections are drawn primarily from the Joint Commission accreditation standards for hospitals and from the United States Health & Human Services regulations for hospitals that participate in the Medicare program (which includes virtually all American hospitals). The averments in this section also draw from the literature on hospital administration, patient safety, and quality improvement.

The Scale of Medical Error, & System Failures as a Cause

212. Preventable medical error is the third leading cause of death in America.

213. The Institute of Medicine's 1999 report, *To Err is Human*, became, and still is, widely known in the healthcare industry, including by the healthcare organizations in this case.

214. The Institute of Medicine's 1999 report, *To Err is Human*, estimated that in American hospitals 44,000 to 98,000 patients died each year from medical errors — with a financial cost between 17 and 29 billion dollars.

215. Approximately one third of medical errors cause harm. Most medical errors do not cause harm. If all medical errors could be identified and addressed promptly, many if not all medical errors could be prevented before they cause serious harm.

216. One central function of healthcare administration is to create systems and organizational cultures that facilitate exposing medical errors before they cause serious harm.

217. The federal government has invested billions of dollars to promote patient safety programs.

218. The complexity of hospital care creates potential for medical errors of various kinds — *for example,* inattention, failures of communication, lack of preparedness, mistaken assumptions that someone else is addressing a problem, and others.

219. Medical errors usually involve both (a) error by the individual clinicians directly involved in a patient's care, and (b) system failures that create unnecessary potential for error.

220. For at least 20 years, it has been generally known among hospital administrators — including by the healthcare organizations in this case — that system failures contribute substantially to medical errors that hurt patients.

221. Human error in hospitals can be reduced by well-designed systems. And system failures in hospitals can be reduced by a culture of safety and a program of continuous improvement — continually working to expose vulnerabilities and to fix them before they hurt patients.

222. Protecting patients' safety requires identifying and fixing system failures and harmful parts of an organization's culture.

223. One central function of healthcare administration is to create and maintain systems and organizational cultures that protect patients against medical error.

Patient Safety & Healthcare Administration

Management or Administration as a Distinct Discipline

224. Managing or administering a healthcare organization is not the same as practicing medicine or nursing. Management or administration involves different roles, different actions, different responsibilities.

225. Hospital administrators need education, training, and skills different from those required to be a physician or nurse. Non-professional hospital administrators must have education or training in management, but need not have gone to medical or nursing school. Physicians or nurses need not have training in managing organizations.

226. Hospital administrators are not generally required to be physicians or nurses, except for specific positions such as Chief Medical Officer or Chief Nursing Officer.

227. Physicians and nurses working in a hospital typically have not studied healthcare administration or obtained any degree or certification in it.

228. OCGA 9-11-9.1(g) does not include hospital administrators in the list of professionals to which OCGA 9-11-9.1 applies.

229. Non-professional hospital administrators — because they are not medical professionals — do not apply medical judgment in their work.

230. Where physicians or nurses occupy administrative roles, some of their duties include administrative tasks that do not require being a physician or nurse — for example, checking to make sure a certain policy has been communicated to hospital staff, or checking to make hospital staff has undergone certain training.

Non-Professional Administrators & Patient Safety

231. Clinicians treating patients are not in a position to fix problems with the systems and organizational culture in a hospital.

232. Frequently, hundreds of individual physicians practice in a given hospital. The individual physicians practice within the systems and organizational culture maintained by hospital administrators. The individual physicians must rely on, and are constrained by, the work of hospital administrators.

233. Patient safety is not solely the responsibility of the physicians and nurses treating a patient.

234. Hospital administrators acting in a purely administrative capacity have responsibilities for protecting patient safety.

235. Negligence by non-professional administrators can and does foreseeably cause harm to patients. Within the healthcare industry, this principle is accepted and well understood by clinicians and non-clinicians alike.

Responsibilities of Hospital Administrators for Patient Safety

The Fact of Responsibility

236. Federal regulations impose requirements on hospital administrators concerning patient safety.

237. The Joint Commission's accreditation standards impose requirements on hospital administrators concerning patient safety.

238. Industry standards indicate requirements for hospital administrators concerning patient safety.

239. Federal regulations, Joint Commission standards, and industry standards inform — but do not conclusively dictate — what counts as reasonable conduct by hospital administrators under a given set of circumstances.

240. Pursuant to industry standards: Non-professional hospital administrators are responsible for the systems and organizational culture of the hospital — and for ensuring they protect patient safety.

241. Non-professional hospital administrators are not on their own, to invent solutions to system failures from scratch. To the contrary, hospital administrators have tools and assistance available from multiple patient-safety organizations.

Overall Responsibilities

242. Non-professional hospital administrators must learn about the common sources of medical error industry-wide and ensure that those general sources of error are addressed effectively in the administrators' own hospital.

243. Non-professional hospital administrators must organize efforts to identify common sources of medical error in the administrators' own hospital, and to address those sources of error effectively.

244. Concerning policies or protocols for medical care, non-professional hospital administrators have limited but important responsibilities.

245. Concerning policies or protocols for medical care, non-professional hospital administrators are responsible for:

a. making sure need-assessments are performed to identify what policies or protocols should be created,

b. making sure policies and protocols are communicated effectively to hospital staff (instead of just papering the file),

c. making sure training is given so that hospital staff understand how to apply the policies and protocols in practice,

d. making clear that the policies and protocols must be followed (*that is,* that the policies and protocols are not bureaucratic formalities which staff can disregard),

e. monitoring compliance, and

f. ensuring remedial actions are taken where compliance problems arise.

246. Non-professional hospital administrators must engage all hospital staff in actively seeking out problems in the hospital's system and culture — and fixing the problems before they cause further harm.

247. Non-professional hospital administrators must ensure the hospital is actually implementing practices that protect patients. Just papering the file is not enough.

Specific Areas of Responsibilities

248. Non-professional hospital administrators have important responsibilities in a variety of specific areas. The following is a non-exhaustive list:

a. Culture of Safety

b. Quality Monitoring & Improvement

c. Staffing & Training

d. Communication and Patient Hand-offs

e. Patient Rights & Grievance Process

f. Sentinel Events.

Professional Malpractice Contrasted with Ordinary Negligence

249. Negligence in the following tasks would constitute **professional** malpractice. This list is not exhaustive.

a. Deciding whether a policy is needed for a specific medical task based on the intrinsic difficulty of the task (e.g., whether a policy is needed concerning the ordering or placement of supra-pubic catheters).

b. Writing the substantive medical content of a policy concerning a specific medical task (e.g., the ordering or placement of supra-pubic catheters).

c. Writing the substantive medical content of a training program on a medical policy or other medical topic (e.g., the ordering or placement of supra-pubic catheters).

d. Implementing a medical policy in the course of treating a patient.

250. Negligence in the following tasks would constitute **ordinary** negligence. This list is not exhaustive.

a. Reading the literature on patient safety in order to identify common sources of medical error that have been identified industry-wide.

b. Sending out surveys to physicians, nurses, or patients to get feedback on a given patient safety issue; organizing a discussion group for the same purpose.

c. Analyzing statistical data available to the hospital to identify problem areas in the hospital's medical care that require assessment.

d. Promoting a "Culture of Safety" — that is: (i) telling hospital staff that patient safety is the first priority in all aspects of hospital operations, (ii) telling hospital staff that the goal is zero medical errors, (iii) telling hospital staff that every individual is empowered and required to raise any concerns they have about a patient's care and to press the concern until it is addressed —bregardless of status or authority hierarchies, and without fear of criticism or reprisal, (iv) giving these instructions consistently and repeatedly, so they actually take hold and govern conduct, (v) consistently monitoring the culture of the hospital through surveys.

e. Organizing medical staff to assess the need for a policy on a given medical task. Making sure the assessment gets done.

f. Organizing medical staff to write policies, where a need assessment determines a policy is needed.

g. Disseminating the policy to hospital staff.

h. Requiring staff to read the policy.

i. Telling the hospital staff that the policy is meant to be complied with — that it's not a bureaucratic formality that can be ignored.

j. Organizing the medical staff to assess the need for training on a given medical policy.

k. Where training is determined to be needed, organizing the medical staff to develop the substantive content of the training.

l. Deciding administrative matters concerning training - e.g., whether to conduct it online, in person, through simulation; whether to give a test after the training; scheduling and verifying attendance; etc.

m. Making the training available to hospital staff.

n. Monitoring compliance with policies by surveys or statistical analysis.

o. Creating a patient-grievance program.

p. Telling patients about the hospital's patient-grievance program.

q. Administering the patient-grievance program.

r. Creating a sentinel-event policy.

s. Administering a sentinel-event program.

t. Determining the level of resources (staff, time, money) required to support the implementation of policies, and providing the resources.

251. As to issues of negligent administration that would involve new or revised policies, the breakdown of non-professional, administrative tasks vs. professional tasks is generally as shown in the following chart. (*This averment incorporates the chart below.)*

Non-Professional Task	**Professional Task**
Direct an assessment of sources of medical error at this healthcare organization, and the need for a new or revised policy.	

Non-Professional Task	Professional Task
Perform the assessment. *Includes both professional and non-professional tasks.* *Non-professional administrators can perform surveys and analyze relevant statistical data.* *Medical professionals can qualitatively evaluate evidence of care provided to patients.*	
Where a new or revised policy is needed, direct the medical staff to create it. Identify and allocate the resources (staff time, staff support, money) necessary to develop the policy.	
	Create the substance of the policy.
With input from clinical staff, develop a plan for implementing the policy effectively, with accountability. Identify and allocate the resources (staff time, staff support, money) necessary to implement the policy effectively.	
Disseminate the final policy to all relevant staff.	

Non-Professional Task	Professional Task
Direct an assessment of the need for training on how to understand and implement the policy properly.	

Perform the assessment.

Includes both professional and non-professional tasks.

Non-professional administrators can perform surveys and analyze relevant statistical data.

Medical professionals can qualitatively evaluate evidence of care provided to patients.

Direct the creation of training on how to understand and implement the policy properly.	

Create the training.

Includes both professional and non-professional tasks.

Non-professional administrators can participate in general issues concerning the method of training.

Medical professionals must address the substantive issues — for example, helping residents to identify the limits of their abilities and to know when to seek help.

Direct the provision of training, and allocate resources and support needed for it to be effective (*e.g.,* trainer time, trainees time, facilities, mandate to participate).	

Non-Professional Task	Professional Task
	Implement the policy in day-to-day patient care.
Monitor the effectiveness of policy implementation. *Note: Monitoring can take various forms, from the simple (e.g., patient surveys, physician or nurse surveys) to the complex (e.g., statistical analysis of aggregate data available through the electronic health record system).*	
If implementation is ineffective, direct the creation of remedial actions.	

Design remedial actions.

May be a professional or non-professional task (or a combination), depending on the issue.

Review the proposed remedial actions for personnel, logistical, and efficacy issues.	
Direct the implementation of the final remedial actions.	

Implement the remedial actions.

May be a professional or non-professional task (or a combination), depending on the issue.

Non-Professional Task	Professional Task
[continue the monitoring/remediation cycle]	

Accountability for Hospital administrators

252. Purely administrative negligence can contribute substantially to medical error that hurts patients.

253. It would be dangerous to exempt hospital administrators from accountability for their own negligence.

254. Exempting hospital administrators from accountability for their own negligence would remove an important incentive for administrators to work diligently to create systems that protect patients.

Negligent Administration in This Case

255. The Kaiser Defendants and Emory Defendants violated duties of ordinary care, through administrative negligence, and in so doing they caused harm to Linda Holloway.

256. Without discovery, Plaintiff cannot pinpoint the precise acts of administrative negligence that contributed to injury. Unlike the facts of the medical treatment that appear in the medical records, the facts of hospital administration are not recorded in documents available pre-suit. However, the facts of the medical care permit inferences of administrative negligence in various respects.

257. The facts of the medical care of Linda Holloway permit inferences of administrative negligence in the following respects. The following list does not necessarily exhaust the administrative negligence in this case:

a. **Nighttime Problems**: Both the Kaiser Defendants and the Emory Defendants failed to properly address the known, industry-wide problem of negligent care in hospitals at night. This problem requires focused attention and remedial measures. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect. The failure caused harm to Linda Holloway.

b. **Patient Hand-Offs**: Both the Kaiser Defendants and the Emory Defendants failed to take reasonable efforts to ensure effective patient hand-off systems and practices. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect. The failure caused harm to Linda Holloway by depriving Dr. Darryl Tookes of information that would have identified Linda Holloway as a patient needing urgent care as soon as Dr. Tookes took over in the morning of February 6.

c. **Culture of Safety**: Both the Kaiser Defendants and the Emory Defendants failed to take reasonable efforts to create a culture of safety — in which patient safety takes first priority and all hospital staff are empowered and required to raise concerns about patient safety until they are properly addressed. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect. The failure caused harm to Linda Holloway. *First*, it permitted Dr. Diarra to tolerate a delay that was dangerous to Linda Holloway. *Second*, this failure disempowered nurses who otherwise could and would have raised concerns about a multi-hour delay in treating a patient suspected to have a closed loop bowel obstruction.

d. **Training re. medical errors generally**: Both the Kaiser Defendants and the Emory Defendants failed to take reasonable efforts to train hospital staff on general issues of patient safety — including the frequency of medical error and common sources of medical error (such as late night care and cognitive biases). This lack of training

contributed to medical error by Dr. Diarra, and lack of follow-up by the nursing staff when Linda Holloway suffered increasing pain.

e. **Patient Rights**: Both the Kaiser Defendants and the Emory Defendants failed to take reasonable efforts to ensure that patient rights are known and respected by medical staff. These rights include (i) the right to be informed of the risks of one's medical condition, (ii) the treatment options, and (iii) the risks and benefits of the various treatment options. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect, and it caused harm. If Dr. Diarra had informed Linda Holloway and her husband appropriately, they would not have consented to a multi-hour delay of treatment or further diagnostic imaging.

f. **CT Protocols**: The Emory Defendants failed to take reasonable steps to create and implement a protocol for ensuring that CT scans are performed with the urgency intended by surgeons — particularly when ordered for a specific future time. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect, and it caused harm to Linda Holloway by creating unnecessary delay beyond even what Dr. Diarra intended, and required even more of Linda Holloway's small bowel to be cut out.

g. **Training re. medical issues**: The Emory Defendants failed to take reasonable steps to ensure proper training for nurses. Much of this work is a matter for medical professionals, but non-professional administrators play an important ancillary role even here. These entities committed administrative negligence in this respect and caused harm, by leaving Linda Holloway for several hours solely in the care of nurses who did not understand the urgency of treatment for a closed loop bowel obstruction. This contributed to unnecessary delay that caused additional bowel ischemia.

h. **Patient Grievance Process**: The Emory Defendants failed to take reasonable steps to implement a proper patient-grievance process. Important parts of that work (though not the whole of it) are purely administrative. These entities committed administrative negligence in this respect. This act of negligence in Linda Holloway's case specifically did not cause harm, because by the time Linda Holloway had a grievance, the harm was done. However, the broader failure to implement a proper patient-grievance process more likely than not caused harm by allowing dangerous practices to go unnoticed and unremedied — so that Linda Holloway was brought into a system set up for failure.

i. **Sentinel Event Process**: The Emory Defendants failed to take reasonable steps to implement a proper sentinel-event process. Important parts of that work (though not the whole of it) are administrative. These entities committed purely administrative negligence in this respect. This negligence more likely than not caused harm in the same way the negligent patient-grievance process caused harm.

258. The non-professional, administrative tasks relating to the foregoing issues involve varying levels of sophistication. However, even the simplest ministerial tasks are important. For example, failure to disseminate a policy would be among the simplest possible tasks, but negligence as to that task would cause harm.

259. Pursuant to OCGA Title 51, Chapter 4, Linda Holloway is entitled to recover from the Kaiser Defendants and the Emory Defendants for all damages caused by their negligent administration.

Defense to Arbitration Agreement, with Jury Demand

260. This count is not an affirmative claim, but is a defense against the invocation of a putative arbitration agreement.

Jury Demand

261. Plaintiff demands a jury trial as to the validity of the putative arbitration agreement (which is attached as Exhibit 3).

262. The arbitration agreement form is governed by the Federal Arbitration Act.

- EJa 578

AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION: I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory, shall be resolved by final and binding arbitration, except as otherwise provided herein. I agree that this provision is governed by the terms of the Federal Arbitration Act.

263. The Federal Arbitration Act provides for a jury trial on the validity of an arbitration agreement.[4]

264. The putative arbitration agreement is invalid for two general reasons: (i) defective drafting that appears on the face of the agreement, and (ii) the circumstances in which the agreement was signed (assuming it was in fact signed).

Defective Drafting

265. The putative agreement was drafted unilaterally and exclusively by Emory Healthcare, Inc.

266. The putative agreement is void for indefiniteness.

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[4] *See* 9 USC 4 states, "If the making of the arbitration agreement or the failure, neglect, or refusal to perform the same be in issue, the court shall proceed summarily to the trial thereof. If no jury trial be demanded by the party alleged to be in default, or if the matter in dispute is within admiralty jurisdiction, the court shall hear and determine such issue."

Circumstances

267. The putative agreement is void because of the circumstances of this case, in at least two respects.

268. *First*, pursuant to OCGA 13-3-25, the agreement is voidable — and void at Linda Holloway's election here — because Linda Holloway was "intoxicated" by narcotics at the time her signature was obtained.[5] Her physical and mental abilities were markedly diminished by morphine and hydromorphone.

269. *Second*, pursuant to OCGA 13-5-6, Linda Holloway signed under duress. An employee of Emory Healthcare, Inc. told Linda that she needed to sign in case surgery was needed. Linda knew she may need surgery to avoid a fatal bowel rupture. So, though she was unable to read the papers or understand them, she signed.[6]

Cause of Action 3: Fraudulent Inducement (the Emory Defendants)

270. This is an alternative claim, which is moot (or which Plaintiff will waive) if the putative arbitration agreement is ruled invalid.

271. Linda Holloway's signature on the arbitration agreement was fraudulently induced.

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[5] OCGA 13-3-25. "Intoxicated persons. A contract made by an intoxicated person is not void, though the intoxication is brought about by the other party, but is merely voidable at the election of the intoxicated person and may be ratified by him expressly or by conduct inconsistent with its rescission."

[6] OCGA 13-5-6. "Duress. Since the free assent of the parties is essential to a valid contract, duress, either by imprisonment, threats, or other acts, by which the free will of the party is restrained and his consent induced, renders the contract voidable at the election of the injured party. Legal imprisonment, if not used for illegal purposes, does not constitute duress."

272. An employee of Emory Healthcare, Inc. told Linda Holloway sometime between 1130 hrs and 1208 hrs on February 6, 2020, that Linda Holloway needed to sign certain papers in case she needed surgery. The employee pointed out where Linda Holloway was to sign.

273. The employee's statement was false.

274. Linda Holloway did not know the statement was false.

275. The arbitration agreement itself contradicted the employee's statement. But Linda Holloway had no way to know that at the time. She was then unable to read the agreement. Her physical and mental powers were markedly diminished by hydromorphone, a narcotic given her for control of acute, severe pain.

276. Linda Holloway relied on the employee's statement.

277. In reliance on the employee's statement, Linda Holloway signed where the employee pointed.

278. Linda Holloway's signature was fraudulently induced.

279. Linda Holloway elects tort remedies for the fraudulent inducement of the arbitration agreement.

280. The fraudulent inducement has caused Linda Holloway to suffer special damages in the amount of at least $25,000.

Cause of Action 4: Breach of Fiduciary Duty (the Emory Defendants)

281. This is an alternative claim, which is moot (or which Plaintiff will waive) if the putative arbitration agreement is ruled invalid.

282. The Emory Defendants hold themselves out to the public as able and willing to provide healthcare services to the sick and infirm. The Emory Defendants invite sick and infirm people to come to them for medical care.

283. Many of the patients who come to the Emory Defendants for care are sick, infirm, suffer disabilities, and are vulnerable physically, intellectually, and emotionally. The Emory Defendants know this.

284. The Emory Defendants offer to give advice and care to the sick and vulnerable.

285. The Emory Defendants invite the sick and vulnerable to rely on them (or the providers made available by the Emory Defendants) for advice and care.

286. The Emory Defendants are obligated not to take advantage of the infirmity and vulnerability of their patients, in order to extract concessions from the patients.

287. The Emory Defendants willingly accept an obligation to behave in a manner that does not involve taking advantage of the infirmity and vulnerability of their patients, in order to extract concessions from the patients.

288. The Emory Defendants purport to behave in a manner that does not involve taking advantage of the infirmity and vulnerability of their patients, in order to extract concessions from the patients.

289. Emory may not adopt used-car salesman morals, or resort to used-car-salesman tactics, in dealing with their patients.

290. The Emory Defendants stand in a confidential relationship with those of their patients who are sick, infirm, vulnerable, and reliant on them or the providers made available by the Emory Defendants.

291. On February 6, 2020, when an Emory employee extracted signatures from her, Linda Holloway had been in severe pain for well over 12 hours, was exhausted by lack of food and restorative sleep, and was drugged by heavy doses of hydromorphone, a narcotic.

292. In the circumstances at the time, Linda Holloway was not capable of reading the arbitration agreement.

293. In the circumstances at the time, Linda Holloway was not capable of understanding the arbitration agreement even if she could have read it.

294. In the circumstances at the time, Linda Holloway was not capable of understanding the arbitration agreement if the employee had read it out loud to her.

295. The employee did not read the arbitration agreement out loud to Linda Holloway.

296. The employee did not summarize the terms of the arbitration agreement to Linda Holloway.

297. The employee did not tell Linda Holloway she was signing an arbitration agreement.

298. The employee just told Linda Holloway — sick, in pain, drugged, at risk of death from a bowel rupture — that she needed to sign a document in order to get surgery if she needed it.

299. The Emory Defendants took advantage of Linda Holloway's vulnerability to extract concessions that Linda Holloway was not obligated to make and could not, at that time, understand she was even making.

300. The Emory Defendants thereby breached duties it owed to Linda Holloway by virtue of the confidential relationship it invited and accepted.

301. The Emory Defendants' breach caused harm to Linda Holloway, including special damages of at least $25,000.

Cause of Action 5: Negligence in Connection with the Putative Arbitration Agreement (the Emory Defendants)

302. This is an alternative claim, which is moot (or which Plaintiff will waive) if the putative arbitration agreement is ruled invalid.

303. Plaintiff incorporates the allegations in Counts 3-5, as if restated in this Count.

304. The Emory Defendants owed Linda Holloway a duty of ordinary care to abstain from taking advantage of her in order to extract concessions from her.

305. The Emory Defendants violated that duty, and the violation caused harm to Linda Holloway, including special damages of at least $25,000, which she is entitled to recover from the Emory Defendants.

Damages

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

307. 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.

308. 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;

c. Expenses of litigation pursuant to OCGA 13-6-11;

d. Punitive damages; and

e. Such other and further relief as the Court deems just and proper.

February 2, 2022

Respectfully submitted,

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

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Attorneys for Plaintiff

AFFIDAVIT OF PETER M. MOWSCHENSON, MD REGARDING TREATMENT OF LINDA HOLLOWAY

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

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

2. This affidavit addresses specific matters that Plaintiff's counsel have asked me to address — namely, the conduct of Dr. Cheickna Diarra and the mental effects of narcotics dosed for hospital patients for control of acute, severe pain.

3. I do not address all standard-of-care violations by all providers. I have not attempted to state every causation opinion I have. I have not attempted to anticipate or address issues that might arise as the case unfolds.

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. Plaintiff's counsel drafted this affidavit after consulting with me, and I reviewed the draft and edited it to make sure it correctly states my views. However, I have not edited the affidavit for style, so the particular language is not necessarily mine.

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

7. If additional information becomes available later, my views may change.

8. I understand that Plaintiff's counsel will provide this affidavit to the Defendants, and that they will hire lawyers and medical experts to review this case and to review this affidavit. If the Defense team believes I have not been given, or have overlooked or misconstrued, any relevant information, I invite the Defense to communicate with me by letter, copied to Plaintiff's counsel.

Exhibit 1

9. The Defense need not wait to take my deposition to communicate with me. I will consider any information the Defense wishes to bring to my attention by letter. If appropriate, I will provide a supplemental affidavit.

Qualifications

10. I attach my CV as Exhibit A.

11. I have been a general surgeon for many years, and was actively practicing as a general surgeon in the five years before the events of February 5 & 6, 2020.

Evidence Considered

12. I have reviewed medical records from Emory St. Joseph's Hospital (Bates-stamped EJa 1-648) pertaining to Linda Holloway.

13. I have also reviewed contemporaneous text messages from Linda's husband, Dan.

14. I invite the Defense to send me any evidentiary materials or commentary they believe may help to exonerate any Defendant.

Opinions

Task 1: Respond to findings suspicious for a looped bowel obstruction.

Requirement

15. Given CT findings that are suspicious for a closed-loop bowel obstruction, the standard of care requires a general surgeon to perform an emergency laparoscopy. If done promptly, before radiologic signs of ischemia, surgical intervention can likely avoid any loss of bowel.

Facts

16. Linda Holloway went to a Kaiser Permanente facility at 1841 hrs on Wednesday, February 5, 2020.

- EJa 626

Holloway, Linda M (MRN 2184958) Encounter Date: 02/05/202(

Department

Name	Address	Phone
TownPark Advanced Care Center	750 Townpark Lane Kennesaw GA 30144	404-365-0966

☐ Holloway, Linda M #2184958 (Acct:N/A) (68 year old F) PCP: PINERA, M (404-365-0966)

TACC06

Patient Demographics

Patient Name	Sex	DOB	SSN	Address	Phone
Holloway, Linda M	Female			33 11TH ST NE UNIT 1901 ATLANTA GA 30309-4672	470-829-3035 (Home) 470-829-3035 (Work) 470-829-3035 (Mobile)

Arrival Information

Arrival	Means of Arrival	Escorted By	Service	Admission Type
2/5/2020 6:41 PM	Sent by Advice	Relative	Ambulatory Urgent Care	Urgent

Chief Complaint

Complaint	Comment
ABDOMINAL PAIN	Pt c/o of 4 hours of lower abdominal pain. She denies any associated comlaints of n/v/d/fever

17. At 1850 hrs, Nurse Kathryn Camille Skinner notes Linda's problem as "Severe stomach pain for 4 hours, nauseated, no vomiting or diarrhea."

- EJa 640

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Billing #:
ED Complt: Severe stomach pain for 4 hours, nauseated, no vomiting or
           diarrhea.

                                   Contact Level

Admission
     User: SKINNER RN, *
 Adm Date: 2/5/2020
 Adm Time: 6:50 PM
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- EJa 634

Kathryn Camille Skinner RN 2/5/2020 6:50 PM
Two patient identifiers and demographics verified and confirmed upon arriving from the waiting area.

Linda M Holloway is 68 year old female DOB:

Chief Complaint
Patient presents with
- ABDOMINAL PAIN
  Pt c/o of 4 hours of lower abdominal pain. She denies any associated comlaints of n/v/d/fever

18. Around 2130 hrs, radiologist Dr. Joseph G. Todaro reviews CT images of Linda. In his report, Dr. Todaro writes that the CT findings are "consistent with small bowel obstruction and raise[] concern for closed loop obstruction and internal hernia."

- EJa 623

hydronephrosis on either side. There are a few scattered 1-2 mm low-density lesions in each kidney which are too small to characterize.
Stomach and bowel: There is mild small bowel dilatation measuring up to 3 cm extending down to the midline where there are 2 adjacent rapidly tapering zones of transition. This is consistent with small bowel obstruction and raises concern for closed loop obstruction and internal hernia.
Appendix: No evidence of appendicitis.
Intraperitoneal space: There is a small amount of free fluid within the pelvis.
Vasculature: The aorta demonstrates mild atherosclerotic calcification. No aneurysm.

19. Dr. Todaro recommends a surgical consult.

- EJa 624

IMPRESSION:
~~Small bowel~~ obstruction with suspicion for closed loop or internal hernia and a small amount of free fluid in the pelvis. Surgical consultation suggested.
There are 2 large hepatic masses. One is exophytic. Both have features suggesting hemangiomata but are incompletely characterized. Recommend further evaluation with liver MRI.
Small indeterminate renal lesions. No further workup is recommended.

20. Dr. Todaro speaks to Dr. Goggans about the CT findings.

- EJa 623

Addendum

Findings were discussed with GOGGANS, MD, at 2/5/2020 10:08 PM EST.

This Final Addended report was electronically signed by Todaro, Joseph, MD on 5 Feb 2020 10:08
PM EDT.

Addended by Md Joseph G Todaro on 2/5/2020 10:08 PM

21. At 2149 hrs, Dr. Goggans arranges for Linda to be transferred to Emory St. Joseph's hospital, into the care of Dr. Cheickna Diarra, a general surgeon. Dr. Goggans speaks to Dr. Diarra personally.

- EJa 633-34

MEDICAL DECISION MAKING:
I spoke with Dr. Diarra who has accepted the pt to general surgery service for admission at ESJ.

ASSESSMENT:
Small bowel obstruction
PLAN:
Transfer to Emory St. Joseph

Brooke A Bruno RN 2/5/2020 9:49 PM
Name of Physician Requesting Bed: Dr Goggans
Current location of patient: TP ACC 6

Hospital: Emory St Joseph
Bed Type: Med/surg
Diagnosis: SBO
Accepting Physician: Dr Diarra
Time requested: 9:48pm
Sonya at Emory Transfer Center notified, face sheet faxed, and Case Manager has been notified via secure messaging.

Brooke A Bruno RN 2/5/2020 9:49 PM
Caller's Name: Dr Goggans
Call back number: 770-514-5686
Diagnosis: SBO
ACC/CDU Location: Town Park
Room in ACC/CDU: ACC6
Drips: IVF
For conference call with hospitalist No
For Hub MD consultation only Yes

Which [redacted]spital: Emory St Joseph

Dr Diarra has accepted pt. IMS is not needed.

22. Shortly after midnight, at 0018 hrs, Emory is ready for Linda, and Kaiser calls an ambulance to transfer Linda.

- EJa 627

Provider Authorizing transport name: Dr. Goggins
Member's Current Location: TP ACC Room number 6
Diagnosis: SBO
Transport Destination: Emory St Joseph
Room number359

Accepting Physician: DR. Diarra
If going to the ER to be seen by PMG or Emory ED physician? PMG

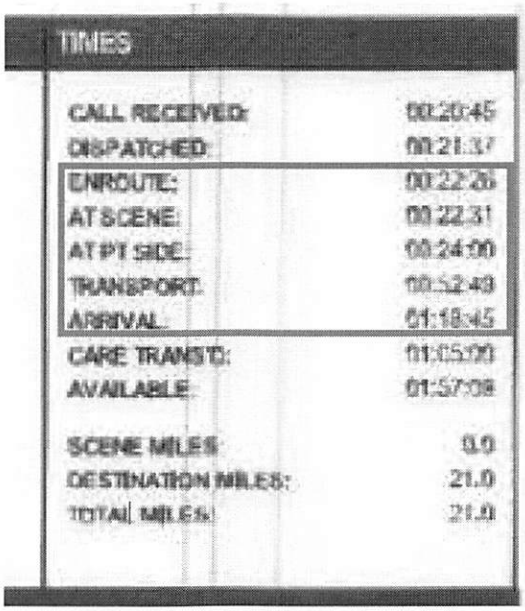
Transport Type: ALS
Transport Level: Level 3 (IMMEDIATE: 60 min or less

Estimated body mass index is 20.67 kg/m² as calculated from the following:
Height as of an earlier encounter on 2/5/20: 5' 2" (1.575 m).
Weight as of an earlier encounter on 2/5/20: 113 lb (51.3 kg).
Equipment Needed: Oxygen, Monitor and IV Access

Ambulance Call Time: 0018
Ambulance ETA: 1 hour
hourAmbulance Confirmation #: aed1

23. At 0024 hrs, the ambulance EMT's are at Linda's bedside, preparing to transport her.

- EJa 23



TIMES	
CALL RECEIVED:	00:20:45
DISPATCHED:	00:21:37
ENROUTE:	00:22:26
AT SCENE:	00:22:31
AT PT SIDE:	00:24:00
TRANSPORT:	00:52:49
ARRIVAL:	01:18:45
CARE TRANS'D:	01:05:00
AVAILABLE:	01:57:08
SCENE MILES:	0.0
DESTINATION MILES:	21.0
TOTAL MILES:	21.0

24. At 0034 hrs, Kaiser Nurse Linda Ann Ainslie copies Linda's medical records to send to Emory, and makes the CT study available to Emory electronically.

- EJa 626

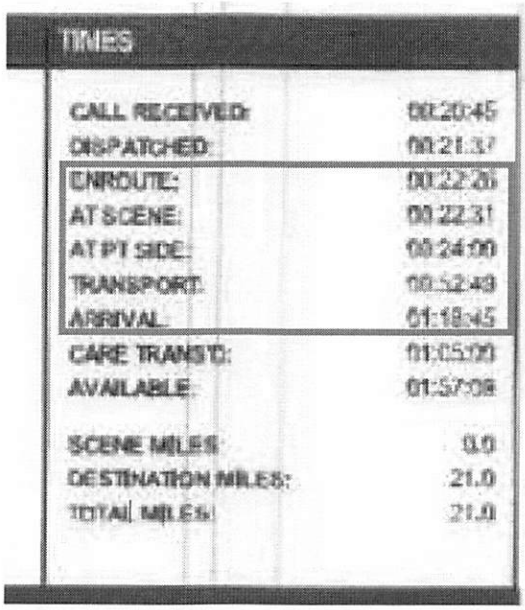
Linda Ann Ainslie RN 2/6/2020 12:34 AM
AMR ; EMS Here. (report provided)
cahrt copied.
Images pushed thru on PAC's .

Rn Anna D Carroll 2/6/2020 12:19 AM
Patient is assigned to Emory saint Joseph room 359 report to 678-843-5370

Notified nurse Wendy at TP ACC of transfer information which includes hospital, bed assignment, phone # for nurse report, and expected ETA of ambulance. Requested copies of the pertinent medical records and test results, including a CD of any scans or x-ray, be sent with the patient when transported.

25. At 0052 hrs, the ambulance leaves Kaiser. At 0118 hrs, the ambulance arrives at Emory.

- EJa 23



26. From 0137 hrs to 0157 hrs, Emory Nurse Preema Sharma performs a patient intake routine with Linda in her hospital room.

- EJa 330

Order: **Patient Intake**			
Order Start Date/Time: 2/6/2020 01:37 EST			
Order Status: Completed	Department Status: Completed	Catalog Type: Patient Care	Activity Type: Patient Care
End-state Date/Time: 2/6/2020 01:57 EST		End-state Reason:	
Ordering Physician: SYSTEM,SYSTEM		Consulting Physician:	
Entered By: SYSTEM,SYSTEM on 2/6/2020 01:37 EST			
Order Details: 2/6/20 1:37:56 AM EST, Once			
Order Comment: Order entered secondary to patient admission			
Action Type: Complete	Action Date/Time: 2/6/2020 01:57 EST	Action Personnel: Sharma,Preema	

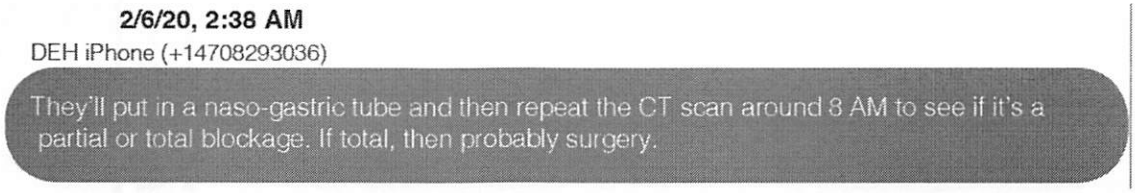
27. At 0146 hrs, Nurse Sharma notes Linda's pain level as 7 out of 10.

- EJa 481

Recorded Date Recorded Time Recorded By	2/6/2020 02:29 EST Sharma,Preema	2/6/2020 01:46 EST Sharma,Preema
Procedure		
Pain Location	-	abdomen
Pain Scale Used	Numeric O4	Numeric
Pain Score	7 O4	7
Behavioral Pain Indicators	Grimacing O4	-

28. At 0230 hrs approximately, Dr. Cheickna Diarra evaluates Linda. (Note, however, that the time given on Dr. Diarra's History and Physical is 0255 hrs.)

- DHM 8

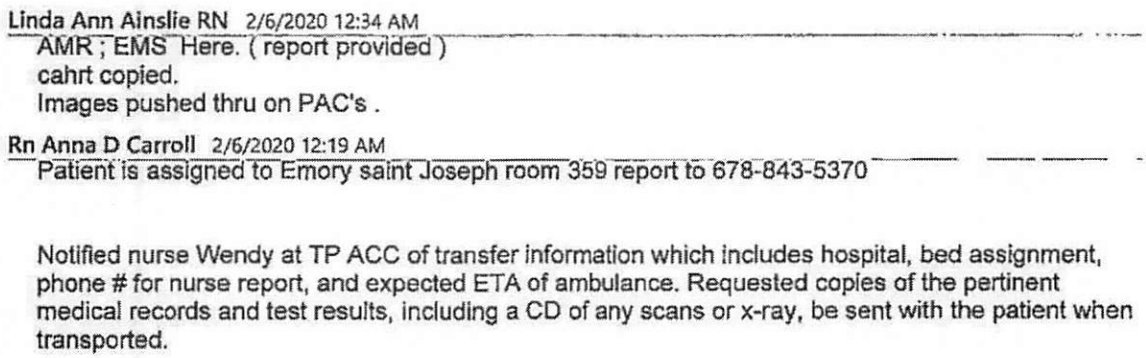


- EJa 57

DOCUMENT NAME:	History and Physical Hospital
SERVICE DATE/TIME:	2/6/2020 02:55 EST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Diarra,Cheickna (2/6/2020 03:04 EST)
SIGN INFORMATION:	Diarra,Cheickna (2/6/2020 03:04 EST)

29. Dr. Diarra had Kaiser's medical records, including the CT report, available.

- EJa 626



30. In his History & Physical, Dr. Diarra writes that Linda had abdominal pain for four hours. That is inaccurate. At 1850 hrs the previous day, a Kaiser nurse had noted "stomach pain for 4 hours." That would mean Linda's pain started no later than around 1500 hrs. By the time of Dr. Diarra's assessment, Linda had suffered extreme pain for at nearly 12 hours — a clinically important fact.

- EJa 57

Chief Complaint: Abdominal pain, bowel obstruction

HPI: _68 yo F presents with c/o lower abdominal pain x 4 hrs. Pt states that she has not had anything to eat because she is afraid it's going to make the pain worse. Denies N/V/D, dysuria or hematuria AT HOME BUT HAD ONE EPISODE OF EMESIS AT THE ACC. Pt states she had a normal bowel movement today. Denies flatus for the past few hours. Surg hx: TAH. Pain is 5/10

31. Dr. Diarra notes that Linda had one episode of vomiting at the Kaiser care center.

- EJa 57

Chief Complaint: Abdominal pain, bowel obstruction

HPI: _68 yo F presents with c/o lower abdominal pain x 4 hrs. Pt states that she has not had anything to eat because she is afraid it's going to make the pain worse. Denies N/V/D, dysuria or hematuria AT HOME BUT HAD ONE EPISODE OF EMESIS AT THE ACC. Pt states she had a normal bowel movement today. Denies flatus for the past few hours. Surg hx: TAH. Pain is 5/10

32. Dr. Diarra performs a physical exam and notes, "GI - soft, mildly distended, mildly tender and tympanic, decreased bowel sounds, no organomegaly, no diffuse peritonitis."

- EJa 58

Constitutional- NAD, well-nourished
Eyes - PERRLA, EOM intact
ENMT - normal nasal mucosa, clear oropharynx without erythema, trachea midline, no masses, no thyromegaly
Cardiovascular - RRR, no m/r/g, no JVD.
Respiratory - Clear to auscitation, no crackles or wheezes
GI - soft, mildly distended, mildly tender and tympanic, decreased bowel sounds, no organomegaly, no diffuse peritonitis
Musculoskeletal -Normal strength and muscle tone
Heme/Lymph Nodes/Imm - No cervical lymphadenopathy, no bruising
Skin - No rashes, skin warm and dry

33. Dr. Diarra reviews the CT performed at Kaiser. He copies the CT report findings and impression into his History & Physical — putting the text relating to the bowel in bold.

- EJa 59-60

KAISER LABS: WBC 5.8 HGB 14.0 PTL 289 LYTES: NL
Radiology: I have personally reviewed all pertinent imaging related to the current encounter

...

Kidneys and ureters: There is a 7 mm left interpolar renal lesion which is too small to characterize but most likely represents a cyst. No renal calculus or hydronephrosis on either side. There are a few scattered 1-2 mm low-density lesions in each kidney which are too small to characterize.
Stomach and bowel: There is mild small bowel dilatation measuring up to 3 cm extending down to the midline where there are 2 adjacent rapidly tapering zones of transition. This is consistent with small bowel obstruction and raises concern for closed loop obstruction and internal hernia.
Appendix: No evidence of appendicitis.
Intraperitoneal space: There is a small amount of free fluid within the pelvis.
Vasculature: The aorta demonstrates mild atherosclerotic calcification. No aneurysm.
Lymph nodes: Unremarkable. No enlarged lymph nodes.

...

Small-bowel obstruction with suspicion for closed loop or internal hernia and a small amount of free fluid in the pelvis. Surgical consultation suggested.
There are 2 large hepatic masses. One is exophytic. Both have features suggesting hemangiomata but are incompletely characterized. Recommend further evaluation with liver MRI.
Small indeterminate renal lesions. No further workup is recommended.

34. Dr. Diarra writes in his assessment, "Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction."

- EJa 60

Plan/Assessment:
Diagnosis: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction
Comment:

Diagnosis: Small bowel obstruction
Comment:
Ordered: Admit to Inpatient; 02/06/20 1:46:00, Diarra, Cheickna, For Inpatient Certification-see comments, Small bowel obstruction, Constant Indicator, 02/06/20 1:46:00, 3 Days

Additional Orders:
Comment:
Ordered: Alternating Leg Pressure Device,02/06/20 1:49:00, ALP/SCDs Knee High

35. Dr. Diarra notes in additional comments that Linda may have a closed loop obstruction, but that it is unclear without a CT performed with oral (as opposed to IV) contrast. Dr. Diarra

notes that if Linda does have a closed loop obstruction, she will need a diagnostic laparoscopy and possible an exploratory laparotomy.

- EJa 61

> Small bowel obstruction. possible closed loop?
> Unclear with absence of oral contrast
> Pt Hemodynamically stable and non-toxic appearing
> No acidosis or leukocytosis, abd pain mild, no peritonitis
> NPO/NGT/IVF
> Repeat CT with PO and IV contrast today
> Dr. Tookes to see pt today in AM
> if closed loop present, will need diagnostic laparoscopy, possible exlap.
>
> Cheickna Diarra, MD, FACS
> General, Minimally Invasive & Robotic Surgery
> Kaiser Permanente / TSPMG
> PIC # 55083

36. Dr. Diarra writes that his plan is to repeat the CT in the morning at 8 AM, with oral and IV contrast, and to have Dr. Tookes follow up with Linda.

- EJa 61

> Small bowel obstruction. possible closed loop?
> Unclear with absence of oral contrast
> Pt Hemodynamically stable and non-toxic appearing
> No acidosis or leukocytosis, abd pain mild, no peritonitis
> NPO/NGT/IVF
> Repeat CT with PO and IV contrast today
> Dr. Tookes to see pt today in AM
> if closed loop present, will need diagnostic laparoscopy, possible exlap.
>
> Cheickna Diarra, MD, FACS
> General, Minimally Invasive & Robotic Surgery
> Kaiser Permanente / TSPMG
> PIC # 55083

37. Dr. Diarra orders a CT "routine" for 8:00 AM, to rule out a closed loop obstruction.

- EJa 60

Additional Orders:
Comment:
Ordered: Alternating Leg Pressure Device,02/06/20 1:49:00, ALP/SCDs Knee High
Ordered: Ambulate,02/06/20 1:49:00, qDay
Ordered: CBC,Stat, 02/06/20 1:46:00, Blood
Ordered: CMP - Comprehensive Metabolic Panel,Timed Study, 02/06/20 1:46:00, Blood
Ordered: CT Abdomen + Pelvis w/ IV Contrast,Routine, 02/06/20 8:00:00, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.

- EJa 299

Order: **CT Abdomen + Pelvis w/IV Contrast**			
Order Start Date/Time: 2/6/2020 08:00 EST			
Order Status: Completed	Department Status: Completed	Catalog Type: Radiology	Activity Type: Radiology
End-state Date/Time: 2/6/2020 12:17 EST		End-state Reason:	
Ordering Physician: Diarra,Cheickna		Consulting Physician:	
Entered By: Diarra,Cheickna on 2/6/2020 02:54 EST			
Order Details: Routine, 2/6/20 8:00:00 AM EST, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.			

Negligence

38. The standard of care required Dr. Diarra to perform an emergency laparoscopy. The purpose is to confirm or rule out a looped bowel obstruction — and if so, repair it — before the bowel become ischemic and requires surgical excision.

39. Given a patient with approximately 12 hours or more of severe abdominal pain, and radiologic findings suspicious for a looped bowel obstruction, it is unreasonable wait for another CT scan. It is grossly unreasonable, and dangerous to the patient, to wait multiple hours.

40. The lack of oral contrast on the prior CT did not justify performing another CT before a laparoscopy.

41. However, if another CT were to be performed with oral contrast, it was unnecessary, unreasonable, and dangerous to wait hours in order to suction gastric contents with a nasogastric tube.

42. Dr. Diarra violated the standard of care by failing to perform an emergency laparoscopy, and by intentionally creating a delay of at leat 5-1/2 hours (from 0230 hrs to 0800 hrs) merely for another (unnecessary) CT.

Causation & Damages

43. Dr. Diarra's negligence caused harm to Linda Holloway.

44. The CT performed at the Kaiser facility showed no signs of ischemic bowel.

45. Furthermore, when surgery was eventually performed around 1400 hrs on February 6, the pathologist described the resected bowel as "pink-purple, diffusely dusky" in appearance.

- EJa 339

Specimen(s) Received
A:APPENDIX WITH NODULE, PLUS ADDITIONAL NODULE
B:ANASTOMOSIS
C:TERMINAL ILEUM AND CECUM

...

Specimen(s) Received
A:APPENDIX WITH NODULE, PLUS ADDITIONAL NODULE
B:ANASTOMOSIS
C:TERMINAL ILEUM AND CECUM

portion of cecum. Both margins are stapled closed. The specimen measures 104.5 cm in overall length to include a 98 cm in length by 3.2 cm in diameter segment of small bowel and a 6.5 cm in length by 4.8 cm in diameter portion of cecum/ascending colon. No definite appendiceal tissue is noted on the surface of the specimen. There is scant yellow fat attached to the portion of cecum. There is a moderate amount of mesenteric fat attached to the small bowel that is diffusely dark purple and dusky. There is no discrete area of stricture or dilatation. No exudate or evidence of perforation is noted.

The specimen is opened. There is abundant hemorrhagic fluid and clot material in the lumen of the small bowel. The mucosa at the proximal margin and the most proximal 3.5 cm of the specimen is pink-tan and viable appearing. The small bowel mucosa distal to this small segment of viable tissue adjacent to the proximal margin is notable for a 92 cm in length dark purple and dusky area that demonstrates the usual folds that appears nonviable. This area is located 2.5 cm from the ileocecal valve and 7 cm from the distal margin. The cut surfaces of this area are dark purple and dusky with no viable tissue appreciated. The thickness of the wall in this area is 0.4 cm with no attenuation of the wall, defect or intramural lesion identified. No discrete area of intramural hemorrhage is identified. The small bowel mucosa immediately proximal to the ileocecal valve, the mucosa surfacing the ileocecal valve, and all of the cecal/colonic mucosa is pink-tan with the usual folds and viable. No duskiness or mucosal lesion is identified. During removal of the staple line of the distal colonic margin, a 1.1 cm in length appendiceal stump is identified. The distal aspect of the appendix is entrapped in the staple line at the distal margin and it does not appear that the appendiceal tip is present. Due to the fact that the distal aspect of the appendix is completely entrapped in the staples at the distal margin, the completeness of the appendix cannot be fully evaluated. The cut surfaces of the appendix adjacent to the staple line at the distal margin show a pinpoint lumen and unremarkable cut surfaces with no lesion or evidence of perforation noted. No other appendiceal tissue is identified along the cecum or in the attached fat. No adhesions are noted between the appendix and adjacent cecum. The average thickness of the cecal wall is 0.5 cm. The cut surfaces of the periappendiceal fat are viable and unremarkable. The cut surfaces of the small bowel mesenteric fat are diffusely dusky and dull with no definite lymph node candidates appreciated. Separately received in the specimen container is a single anastomotic ring that measures 1.1 cm in length by 2.2 cm in diameter. The ring has multiple staple lines and is partially surfaced by pink-tan unremarkable mucosa. No other tissue is received in the specimen container. Representative sections are submitted as follows:

46. If Dr. Diarra had performed an emergency laparoscopy — nearly 12 hours before the ultimate surgery — it is likely that Linda would have had no ischemic bowel, that Linda would have lost no bowel. It is all but certain that if Linda lost any bowel, she would not have lost 4-1/2 feet of it (or 45% of the total length of her small bowel).

- *See* the operative report, at EJa 76

> eviscerated out. The bowel was measured and approximately 135 cm of bowel was found to be ischemic. This extended from the proximal and middle ileum to the distal ileum at the level of the ileocecal valve. The appendix was identified and the appendix had a nodule on the tip. The GIA stapler was fired across the small bowel proximal to the ischemic region. A GIA stapler was fired across the cecum. The mesentery in between was taken down with the Harmonic scalpel. The specimen was removed. The appendix was included in this as well. The remaining small bowel was measured and approximately 165 cm was remaining. The ileocecal valve was removed with the cecal specimen. The remaining small bowel was reanastomosed to the proximal right colon in a side-to-side isoperistaltic fashion with a GIA stapler. The holes of the GIA stapler made were closed off with a TA-60 stapler. The mesenteric defect was closed off with a running 3-0

Task 2: Order a CT scan for a patient with suspected looped bowel obstruction

Requirement

47. As discussed above, another CT scan for Linda was unnecessary and inappropriate when Dr. Diarra assessed Linda. However, if a CT scan was to be ordered then, the standard of care would require that it be ordered stat.

48. Furthermore, while it would violate the standard of care to create a multi-hour delay for another CT, if a delayed CT was to be ordered, the standard of care would require ordering it to be performed stat at the appointed time — rather than "routine" at the appointed time, which would create the risk of still more hours of delay.

Facts

49. Dr. Diarra orders a CT "routine" for 8:00 AM, to rule out a closed loop obstruction.

- EJa 60

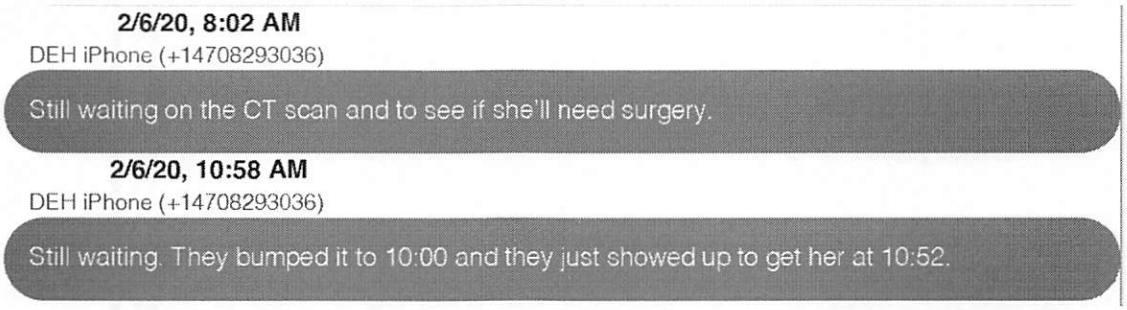
> **Additional Orders:**
> Comment:
> Ordered: Alternating Leg Pressure Device,02/06/20 1:49:00, ALP/SCDs Knee High
> Ordered: Ambulate,02/06/20 1:49:00, qDay
> Ordered: CBC,Stat, 02/06/20 1:46:00, Blood
> Ordered: CMP - Comprehensive Metabolic Panel,Timed Study, 02/06/20 1:46:00, Blood
> Ordered: CT Abdomen + Pelvis w/ IV Contrast,Routine, 02/06/20 8:00:00, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.

- EJa 299

Order: **CT Abdomen + Pelvis w/IV Contrast**			
Order Start Date/Time: 2/6/2020 08:00 EST			
Order Status: Completed	Department Status: Completed	Catalog Type: Radiology	Activity Type: Radiology
End-state Date/Time: 2/6/2020 12:17 EST		End-state Reason:	
Ordering Physician: Diarra,Cheickna		Consulting Physician:	
Entered By: Diarra,Cheickna on 2/6/2020 02:54 EST			
Order Details: Routine, 2/6/20 8:00:00 AM EST, Reason: Bowel obstruction, Bowel obstruction; bowel obstruction. rule out closed loop small bowel obstruction.			

50. CT transport does not come to get Linda until 1052 hrs — nearly 11:00 AM.

- DHM 8



Negligence

51. Dr. Diarra further violated the standard of care by ordering the unnecessary CT with a deliberate delay of approximately 5-1/2 hours.

52. Dr. Diarra compounded the negligence by ordering the CT "routine" — creating the risk (and then the fact) of an additional multi-hour delay.

Causation & Damages

53. The delay attributable to Dr. Diarra's order for the unnecessary CT amounted to approximately 9-1/2 hours — from about 0230 hrs when Dr. Diarra saw Linda, to about 1200 hrs when the radiologist reported his findings to Dr. Tookes.

54. The delay of 9-1/2 hours likely caused all of the ischemia that required resection of Linda's small bowel. If Dr. Diarra had performed a laparoscopy without that delay, it is likely that none of Linda's small bowel would have had to be cut out.

55. Starting at 2033 hrs on February 5, Linda was medicated on morphine and then hydromorphone — both narcotics — for severe pain.

56. Narcotics are well known to cause a marked diminishment of physical and mental control. Narcotics cause drowsiness, confusion, and impaired judgment. Narcotics also cause dizziness and weakness.

57. These effects occur at the low doses prescribed for medium or long-term use for control of chronic pain. Even when physicians prescribe narcotics at low doses, we advise patients not to drive or to make important decisions while under the influence of the drugs.

58. At the higher doses used for control of severe acute pain, the side effects discussed above occur with greater effect.

59. When Linda was medicated with morphine or hydromorphone on February 5 and 6, she almost certainly suffered a marked diminishment of physical and mental control — including drowsiness, confusion, and impaired judgment.

60. I have read the "Admission/Registration Agreement" at EJa 577-78, which includes an "Agreement to Alternative Dispute Resolution" ("ADR agreement"). It is fanciful to suppose that a typical person medicated on narcotics as Linda was on Feb 5 & 6 could read that agreement, understand it, and intelligently consent to it.

61. The entire agreement Linda purportedly signed consists of three densely printed pages. It is extremely unlikely that a person medicated as Linda was could read the entire document, much less process the information and understand it.

62. Taking the ADR agreement by itself, to understand its meaning Linda would, for example, have had to search the larger document for the definition of the term "Emory":

> **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory, shall be resolved by final and binding arbitration, except

That definition occurs at the top of the previous page, in the middle of a paragraph:

CONSENT FOR TREATMENT: I consent to routine diagnostic and treatment procedures/examinations including, but not limited to injections, infusions of intravenous fluids, insertion of internal tubes, laboratory testing, administration of medications, radiographic procedures, physical tests, therapies, assessments and treatments, monitoring, psychological counseling and daily care considered reasonably necessary for the care and treatment of my condition during my admission ("Procedures") to an Emory hospital or my outpatient care at an Emory facility including but not limited to those listed above ("Emory"). I understand that the Procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and prognosis before allowing the Procedures to be performed. I consent to treatment and care

That definition presumably references a list in the document header, printed in very small type:

EMORY HEALTHCARE

EMORY HEALTHCARE
EMORY UNIVERSITY HOSPITAL
EMORY UNIVERSITY HOSPITAL MIDTOWN
EMORY SAINT JOSEPH'S HOSPITAL
EMORY JOHNS CREEK HOSPITAL
THE EMORY CLINIC
EMORY UNIVERSITY ORTHOPAEDICS & SPINE HOSPITAL
EMORY UNIVERSITY HOSPITAL AT WESLEY WOODS
WESLEY WOODS CENTER OF EMORY UNIVERSITY, INC. d/b/a WOODRUFF TERRACE
DIALYSIS ACCESS CENTER OF ATLANTA
EMORY SPECIALTY ASSOCIATES
ES REHABILITATION, LLC
EHCP REHABILITATION, LLC
EMORY DECATUR HOSPITAL
EMORY LONG TERM ACUTE CARE
EMORY KILLEARDALE HOSPITAL

HOLLOWAY, LINDA M
AGE: 68 SEX: F
SJH MR:002359761
FIN:065290600036
065290600036
ADM: 02/08/20

Admission/Registration Agreement Page Number: 1 of 3

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

I. **CONSENT FOR TREATMENT:** I consent to routine diagnostic and treatment procedures/examinations including, but not limited to injections, infusions of intravenous fluids, insertion of internal tubes, laboratory testing, administration of medications, radiographic procedures, physical tests, therapies, assessments and treatments, monitoring, psychological counseling and daily care considered reasonably necessary for the care and treatment of my condition during my admission ("Procedures") to an Emory hospital or my outpatient care at an Emory facility including but not limited to those listed above ("Emory"). I understand that the Procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and prognosis before allowing the Procedures to be performed. I consent to treatment and care

Taking only this single example of information search, processing, and reasoning: It is unlikely to the point of preposterous that a person medicated as Linda Holloway was could understand what "Emory" means in the ADR agreement.

63. I have reviewed the affidavits of Linda Holloway and Dan Holloway. While I would not intrude on the jury's responsibility to judge credibility, I can say that Linda and Dan's descriptions of Linda's mental capacity while on narcotics is entirely consistent with what I would expect based on my experience with thousands of hospital patients medicated with narcotics for control of severe, acute pain.

Conclusion

64. This affidavit does not exhaust all my opinions.

PETER M. MOWSCHENSON, MD

SWORN TO AND SUBSCRIBED before me

20th January, 2021

NOTARY PUBLIC

My Commission Expires: February 24, 2023

ZEHRA AGALLIU
Notary Public
Commonwealth of Massachusetts
My Commission Expires Feb 24, 2023

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
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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.

SUPPLEMENTAL AFFIDAVIT OF PETER M. MOWSCHENSON, MD REGARDING TREATMENT OF LINDA HOLLOWAY

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:

1. This is a supplemental affidavit. I intend it as a continuation of my prior affidavit regarding the treatment of Linda Holloway.

Opinions (continued)

Task 3: Attend to a patient admitted overnight for a suspected looped bowel obstruction

Requirement

2. When a general surgeon comes on duty at a hospital in the morning to make rounds, the standard of care requires the surgeon to survey the patients needing his or her care, and to set priorities for making rounds.

3. A patient admitted overnight for a suspected closed loop bowel obstruction is a high-priority patient — particularly one in Linda's situation, who by 0700 hrs on Feb 6 had been suffering severe pain for at least 16 hours.

4. Unless other higher-priority patients delay the surgeon — or unless the systems in place at the hospital make it impracticable to identify the priority of patient conditions — the standard of care requires the surgeon coming on duty to immediately attend to a patient admitted overnight for a suspected closed loop bowel obstruction.

Facts

5. Dr. Darryl Tookes was a general surgeon who came on duty the morning of February 6, 2020.

- *See* Dr. Diarra's HPI, at EJa 61

Exhibit 2

Small bowel obstruction. possible closed loop?
Unclear with absence of oral contrast
Pt Hemodynamically stable and non-toxic appearing
No acidosis or leukocytosis, abd pain mild, no peritonitis
NPO/NGT/IVF
Repeat CT with PO and IV contrast today
Dr. Tookes to see pt today in AM
if closed loop present, will need diagnostic laparoscopy, possible exlap.

Cheickna Diarra, MD, FACS
General, Minimally Invasive & Robotic Surgery
Kaiser Permanente / TSPMG
PIC # 55083

6. Dr. Tookes did not see Linda Holloway until after noon — 5 hours after the typical start time of 0700 hrs.

Negligence

7. On the facts available to me now, it is likely that Dr. Tookes violated the standard of care by failing to evaluate Linda urgently, at the start of his shift.

8. However, if evidence emerges to show that higher-priority (or at least equal-priority) patients necessarily delayed Dr. Tookes' evaluation of Linda, I will revise my opinion.

9. Similarly, if evidence emerges to show that the systems in place at the hospital made it impracticable for Dr. Tookes to assess the priority of patient conditions, or if the information obtained by Dr. Diarra was not conveyed to Dr. Tookes upon his arrival or earlier, I will revise my opinion.

10. As indicated in my prior affidavit, if any such evidence exists, I invite the Defense to send it to me promptly by letter copied to Plaintiff's counsel.

Causation & Damages

11. If Dr. Tookes had assessed the priority of his patients and attended to Linda promptly upon beginning his shift, it is *more likely than not* that less or even none of Linda's small bowel would have required resection.

Conclusion

12. This affidavit does not exhaust all my opinions.

1/31/2022

PETER M. MOWSCHENSON, MD

SWORN TO AND SUBSCRIBED before me

January 31, 2021

NOTARY PUBLIC

My Commission Expires: February 24, 2023

ZEHRA AGALLIU
Notary Public
Commonwealth of Massachusetts
My Commission Expires Feb 24, 2023