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1 of 3

being duly sworn, deposes and says:

1. I am a state licensed physician, board certified in Internal Medicine, and board certified in the subspecialty of Cardiovascular Diseases, familiar with the standard of care for interns, residents, laboratory technicians, and physicians practicing internal medicine and/or cardiology during the month of July, 2001.

2. I have reviewed the Notice of Intent in the matter of *Henry Clark* and *James Glazier, M.D., et al*, pursuant to MCL §600.2912b, as well as the medical records for Henry Clark furnished to me by Plaintiff's counsel, which include records from Harper Hospital for admission from June 27, 2001 through July 3, 2001, and autopsy report .

3. The standard of care applicable in this matter is that of a reasonably prudent physician, laboratory technician, and/or medical care provider under like circumstances.

4. It is my professional opinion that Harper Hospital, The Detroit Medical Center, James Glazier, M.D., and the staff thereof, breached the standard of care in their/its care and treatment of Plaintiff's Decedent Henry Clark, by failing to do the actions outlined below.

5. To comply with the required standard of care, the above mentioned entities, physicians, and medical staff thereof, should have done the following:

a. Order and / or arrange for "H & H" (hemoglobin and hematocrit) studies to be carried out at least every 6 to 8 hours post-operatively;

b. Order and/or arrange for the taking of vital signs after patient complained of significant complaints, including complaints of diaphoresis and dizziness;

c. Timely order a "stat" H & H study at 11:45 am on July 1, 2001, after it was known patient was diaphoretic, and had a PTT of 106;

d. Recognize and diagnose the patient's internal hemorrhage, the first clinical signs of which occurred at 11:45 am when the patient was noted to be diaphoretic after moving around, a PTT of 106, as well as the physical findings and complaints noted thereafter;

e. Order a stat CBC after the patient presented with signs and symptoms consistent with a suspected hemorrhage, which would have revealed a drop in the patient's hemoglobin and hematocrit, which would have prompted treatment including discontinuation of the patient's Heparin and the administration of blood products which would have prevented patient from suffering from a fatal bleed;

f. Recognize and diagnose the patient's internal hemorrhage when his systolic blood pressure was decreased and when having symptoms of light headedness at 1:40 pm, which would have warranted a stat CBC which would have revealed a drop in the hemoglobin and hematocrit, which would have prompted treatment included discontinuation of the Heparin and the administration of appropriate blood products such that the patient would not have suffered from a fatal bleed;

g. Ensure the carrying out of the July 1, 2001, 4:00 pm coagulation studies as requested by Dr. Glazier and/or the Pharmacy Anticoagulation Service, which would have noted an increasing PTT, which would have prompted the discontinuation of the Heparin, and most likely would have warranted the administration of the Heparin antidote ,Protamine, which would have stopped the patient's fatal bleeding.

h. Recognize and diagnose the patient's internal hemorrhage when he had persistent complaints of episodes of dizziness and reduction in blood pressure throughout the day and evening of July 1, 2001, which would have warranted a stat CBC which would have revealed and required those items as mentioned above.

i. Timely order a "stat" CBC and /or H & H on July 1, 2001, after it was known the patient's blood pressure was consistently low, which would have revealed a significantly low hemoglobin, which would have prompted the discontinuation of Heparin, the administration of the Heparin antidote Protamine, and the administration of appropriate blood transfusions / products, all of which would have prevented Mr. Clark's fatal bleeding.

j. Refrain from ordering / administering anticoagulant agents in excessive doses which caused patient to suffer his fatal bleed;

k. Refrain from starting patient's anticoagulation therapy too soon after surgery.

3 of 3

6. The breaches of the standard of care committed by the above-named physicians, entities, and staff, were the proximate cause of Plaintiff's Decedent's death.

7. This Affidavit is filed in accordance with MCLA §600.2912b.

Dated: 12/11/03

Subscribed and sworn to before me
this 11 day of Dec., 2003.