Gil N. Mileikowsky, M.D.

Infertility • Gynecology • Laser Surgery
In-Vitro Fertilization • Reproductive Endocrinology

6/14/00

Sent by Fedex

Airbill #

658254844 2

Beverly. PARKS

INSTITUTE for Medical Quality

CMA

221, Main Str.- 2nd floor

San FRANCISCO- CA- 94105

Re: ENCINO. TARZANA Regional Medical Center
Survey by the Institute for Medical Quality

Dear Ms. PARKS,

Thank You very much for spending Your time With me during Our phone Conversation on 6/12/00.

Please find enclosed the letter of Ms. HANSON of 7/27/99 and other pertinent material as Well as Copy of my letter to Ms. HANSON dated 6/14/00.

I shall be in Phoenix this Coming Friday

West Valley Medical Center

5363 Balboa Boulevard. Suite 245 • Encino. CA 91316 • 818/981-1888 • 213/858-1888

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6/16/00 Where I am to attend the delivery of Quadruplets of a patient of mine.

I shall be available to You Monday 6/19/00 and thereafter.

Please do not hesitate to call me at (310) 858 1300.

Respectfully Yours,

G. N. Mileikowsky

Mailing address.
2934 1/2, Beverly Glen Circle #373
LA - CA - 90077.

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5363 Balboa Boulevard. Suite 245 • Encino. CA 91316 • 818/981-1888 • 213/858-1888

Gil N. Mileikowsky, M.D. 6/15/00

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Note. After I Spoke With You on 6/12/00 I received a phone call from a Horney Jennifer, Nutter Seeking my opinion regarding a law suit she filed on behalf of Mrs Donna, HEAD operated at TARZANA Hospital on 11/12/97. Both of her Tubes Were removed Without a Consent form for removal of ANY tube. The Same Surgeons removed mistakenly the Wrong tube in another patient - Mrs. Barbara, KLEIN as the Ectopic Pregnancy progressed in the other tube they re-operated the patient and removed her other tube. To the best of My Knowledge neither one of these 2 cases Were EVER reviewed by the ob/gyn Peer and Chart Review Committee nor Was it EVER discussed at the ob/gyn departmental meeting. I also mentioned to You today 6/15/00 the Absence of reporting of the Mix-up of Sperms at the IVF Program about 1½ to 2 years ago.

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TO WHOM IT MAY CONCERN:

We have heard the following:

In December of 1997, two separate female infertility patients were scheduled to undergo surgery at Encino Tarzana Regional Medical Center (Tarzana location) to have their eggs, which had been prepared for "harvest" in their infertility treatment, extracted. Following removal, the eggs were to be fertilized in the fertility laboratory at the hospital. One of these patients was a patient of Dr. Michael Vermesh, the medical director of the fertility program at the hospital and the other a patient of Dr. Paul Greenberg, another physician carrying out fertility procedures at the same hospital laboratory. Nurse Anna Richardson was charged at the hospital with the coordination of time schedules for the surgery of the fertility patients. Standard procedure at the hospital when multiple patients are scheduled for fertility treatments on the same day, is to separate the cases by one hour. This allows the short staffed and overworked fertility laboratory crew time to finish the treatment of one set of eggs prior to dealing with the eggs of the case to follow. For some unknown reason, on this date, both of the above patients had their surgeries scheduled by Nurse Richardson at the same hour.

The fertility laboratory technician scheduled to work that day was Cheryl Lamb. Cheryl was new to the Tarzana program. She had received no orientation from the infertility program medical director prior to beginning her duties.

With the surgery scheduling mix-up, instead of having two technicians present to deal with the two simultaneous cases, a decision was made to have Cheryl handle both cases. Both patients scheduled for surgery were made aware of the fact that there had been a scheduling "conflict", but were assured that this would not prove to be a problem.

Cheryl prepared for the two cases in standard fashion. Cheryl scratched the name of one patient on to the bottom of a small, plastic petri dish that would be used to hold and store that patient's eggs as they were collected at surgery. Onto a second dish, she scratched the name of the second patient.

Cheryl went to the operating room to accompany Dr. Ben-Ozer, Dr. Vermesh's associate as the first egg extraction was performed on Dr. Vermesh's patient. The case was seemingly uneventful, and 9 eggs were recovered. With a rush to prepare for the second case and the arrival of the second physician, Cheryl rapidly again went to the operating room, this time for Dr. Greenberg's patient. Once again, all appeared fine, with seven eggs being obtained by Dr. Koopersmith, Dr.

Greenberg's partner. Following their wives surgeries, the husbands of each patient produced a semen specimen in a properly labeled container. These specimens were to be used to inseminate their respective wives eggs. Each of the wives made an uneventful post operative recovery and went home a few hours after surgery.

As is the routine, three days after the surgery, each couple was scheduled to return to the hospital fertility laboratory to receive their now fertilized and growing embryos. Dr. Ben-Ozer was scheduled for the first embryo transfer. Dr. Vermesh's patient, being managed by Dr. Ben-Ozer was on the way to the laboratory to be prepared to receive her embryos. As Dr. Ben-Ozer reviewed the fertility laboratory paperwork associated with her patient, she noted a startling inconsistency. The paperwork on her patient indicated that "7 eggs" had been inseminated with her patient's husband's sperm. Dr. Ben-Ozer clearly recalled obtaining nine eggs at the time of surgery. Panic struck behind the doors of the fertility laboratory. Cheryl, present now to assist with the return of the embyos to the two patients was quickly questioned by Dr. Ben-Ozer about the discrepancy. Cheryl's face grew long in disbelief. She rapidly checked the laboratory data sheet on the second patient on whom Dr. Koopersmith had recovered seven eggs. The nature of the medical disaster was confirmed with the notation that "9 eggs" supposedly from Dr. Koopersmith's patient, but in reality from Dr. Vermesh's patient had been inseminated with the sperm from Dr. Koopersmith's patient's husband. And vice versa. Live, human embryos from each of the two women had been produced with "crossed" husband's sperm specimens. As noted, Cheryl was a new technician at the program, and had never been provided an orientation to her job by the medical director. She was never advised by the medical director of a policy requiring the technician to verify patient identities by checking patient wrist bands prior to each surgery.

With the patients, having now arrived at the hospital, anxiously awaiting word on the progress of their embryos, Dr. Ben-Ozer placed an urgent call to Dr. Vermesh. An emergency meeting was convened with the CEO of the hospital, Dale Surowitz, Tenet's risk management coordinators, Tenet attorneys, Drs. Vermesh and Ben-Ozer and the laboratory director, Dr. Hill, to discuss the handling of this grave matter. Dr. Greenberg was out of town. At the meeting, the decision was made by Dr. Vermesh, with the full concordance of Mr. Surowitz and the Tenet attorneys, and with the strong support of Dr. Ben-Ozer *not* to advise either of the patients involved of the true nature of the error related to the mixing of their eggs and sperm. The decision at the meeting was to immediately, and without notification of the patients, destroy the embryos resulting from the crossed sperm-egg specimens and to simply indicate to the patients that the handling of the embryos was "not consistent with laboratory protocols". They were simply to be advised that as a result of the "protocol deviation", no embryo transfer would be possible for either couple.

Such was the information provided to the two couples involved whom to this day remain unaware of what actually transpired. At the time of notification of the patients of the "deviation from protocol", the hospital adopted a stance of seeming "benevolence", granting each couple "three free additional IVF attempts". One of the couples was quite suspicious about what had happened and, on a "free" repeat IVF attempt, the husband would not allow his sperm or his wife's eggs out of his sight. It is said that one of the couples became pregnant on one of the "free" cycles, and the other did not.

As the story ends, Cheryl the technician was given the option of resigning or being fired. She resigned while considering a harassment suit over Dr. Vermesh's threats to her about ever "spilling the beans", and is now working elsewhere in Los Angeles, still shaken by this matter. Nurse Anna Richardson continues at the program, but constantly voices her unhapiness with Dr. Vermesh. Dr Hill, the interim laboratory director at the time resigned in disgust over the matter. He continues to serve as the Director at another large Tenet fertility program. He remains a highly respected scientist in his field, who adamantly refuses any additional association with Dr. Vermesh. The second laboratory technician at ETRMC who was off at the time of the incident also resigned in protest of Dr. Vermesh's actions, and transferred to Dr. Hill's program. Dr. Koopersmith has left the program but continues to practice locally. Dr. Greenberg continues with the program but has continued to express dissatisfaction with Dr. Vermesh's direction of the program. Drs. Vermesh and Ben-Ozer continue with their practice, and to this day, have never revealed the truth about what transpired. As medical director of the program, Dr. Vermesh should have brought the entire matter before the many quality assurance committees that we know exist in the hospital. To date, over one year later, this has not occurred. Dr. Vermesh is, however, currently under medical staff investigation for an unrelated infertility patient management irregularity. Hospital rules to protect patients clearly matter no more to Dr. Vermesh than California state law which also appears to have been violated. We obtained a document indicating that State law mandates that patients be advised of and "provide their *informed consent*" for *any* handling of their embryos, and clearly prior to the destruction of such embryos by their physician. This incident may qualify as a test of that law.

CONTACTS: Cheryl Lamb (818) 248-3565 David Hill (310) 201-0619
Paul Greenberg (818) 996-5550 Dale Surowitz (818) 881-0800
Anna Richardson RN (818) 708-5389

PATIENTS: Mr. & Mrs. redacted Mr. & Mrs. redacted