IN THE STATE COURT OF GWINNETT COUNTY
STATE OF GEORGIA

GLENDA YARBROUGH Individually and as Representative of the Estate of RONALD YARBROUGH, deceased,	)	
Plaintiff,	)	CIVIL ACTION
— *versus* —	)	FILE NO. 20-C-02832-S4
GWINNETT HOSPITAL SYSTEM, INC.	)	JURY TRIAL DEMANDED
CARDIOVASCULAR GROUP, P.C.	)	
LANCE B. FRIEDLAND, MD	)	
JOHN/JANE DOE 1-10,	)	
Defendants	)	

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of the Action

1. This medical malpractice, wrongful death action arises out of medical services negligently performed on Ronald Yarbrough in October 2018 and May 2019.

2. Plaintiff Glenda Yarbrough is the wife of Ronald Yarbrough, deceased.

3. At the time of his death, Ronald Yarbrough was 64 years old with a life expectancy of an additional 19.5 years.[1]

4. As Adminstrator, Plaintiff Glenda Yarbrough asserts a claim on behalf of the estate of Ronald Yarbrough for harm he suffered before he died.

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

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

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

Parties, Jurisdiction, and Venue

8. **Glenda Yarbrough** is a citizen of Georgia and the wife of Ronald Yarbrough, deceased, and the representative of his estate.

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[1] *See* National Vital Statistics Reports, Vol. 68, No. 7, June 24, 2019, Table 2. Life table for males: United States, 2017, available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf.

9. **Defendant Gwinnett Hospital System, Inc. ("GHS")** is a Georgia corporation with its Registered Office in Gwinnett County. GHS may be served through their Registered Agent, Peter B. Wheeler, at 100 Medical Center Boulevard, Admin., Suite 110, Lawrenceville, Georgia 30046.

10. GHS has been properly served with this Complaint.

11. GHS 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 §§ 14-2-510 and 14-3-510,[2] GHS is subject to venue in this Court because (a) it maintains its registered office in Gwinnett County and (b) the cause of action originated in Gwinnett County and the corporation has an office and transacts business in that county.

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[2] 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."

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

13. Plaintiff believes that at all relevant times, GHS was the employer or other principal of the individuals who conducted the pre-admission, pre-surgery screening of Ronald Yarbrough in May and June 2019 for his planned colon resection surgery. However, 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.

14. **Defendant Cardiovascular Group, P.C. ("CVG")** is a Georgia professional corporation with its Registered Office in Gwinnett County. CVG may be served through their Registered Agent, Philip A. Romm, at 755 Walther Road, Lawrenceville, Georgia 30046.

15. CVG has been properly served with this Complaint.

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

17. Pursuant to OCGA 14-2-510 and OCGA 14-7-2 and -3,[3] CVG is subject to venue in this Court because (a) it maintains its registered office in Gwinnett County and (b) the cause of action originated in Gwinnett County and the corporation has an office and transacts business in that county.

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[3] Defining a "professional corporation" as a corporation organized under OCGA Title 14, Chapter 2 (and thus subject to OCGA 14-2-510).

18. Plaintiff believes that at all relevant times, CVG was the employer or other principal of Dr. Lance B. Friedland and the other individuals responsible for recording the CT calcium scoring results in Ronald Yarbrough's chart, or for reviewing those results, or for communicating the importance of those results to Mr. Yarbrough. However, 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.

19. **Defendant Lance B. Friedland, MD,** is a citizen of Georgia, residing in Fulton County. He may be served with process at his residence: 1010 Chesson Court, Alpharetta, Georgia 30022. If not found there, Dr. Friedland may be served at his place of business: Cardiovascular Group, 755 Walther Road NW, Lawrenceville, Georgia, 30045.

20. Dr. Friedland has been properly served with this Complaint.

21. Dr. Friedland 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, Dr. Friedland is subject to venue in this Court because his co-defendant, CVG, is subject to venue in this Court.

23. At all times relevant to this Complaint, Dr. Friedland acted as an employee or agent of CVG.

24. **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.

25. This Court has subject matter jurisdiction, and venue is proper as to all Defendants in this Court.

Facts

26. When a cardiologist has a patient undergo testing, the physician and the physician's practice group are responsible for reviewing the results, identifying any concerning results, correctly informing the patient of any important abnormal results, arranging for any appropriate follow-up testing or counseling, and ensuring that the results are recorded in the patient's chart and readily available to the physician.

27. These tasks are important to patient safety. If these tasks are not performed diligently, then dangerous, treatable medical conditions may go unaddressed — with catastrophic results.

28. The cardiologist and the practice group bear joint responsibility for the tasks described above.

29. Generally, when a cardiologist examines a patient in advance of anticipated medical procedures, the cardiologist must consider whether the patient's cardiovascular condition is suited for the potential procedures, and must issue any cautions or warnings that may be necessary.

30. Where a cardiologist does not issue such cautions or warnings, a patient may be erroneously cleared for a surgery or other procedure that the patient's heart cannot safely withstand.

31. On March 7, 2017, upon a referral from Ronald's primary care physician, Dr. Robert Deimler, Ronald underwent a stress test, an exercise treadmill test (ETT), at Gwinnett Medical Center.

32. Dr. Louis Heller reviewed the ETT results. Dr. Heller noted "ST Changes: 2-3 mm inferior and anterolateral ST-T wave downsl." Dr. Heller's overall impression was "Abnormal ETT."

33. Because of the abnormal ETT, Ronald was scheduled for an exercise dual isotope myocardial perfusion scan (DIMPS).

34. Dr. Lance Friedland reviewed the results of the DIMPS and found it to be normal, noting "There is no evidence of Ischemia or Infarction at a maximal level of exercise."

35. More than a year and half later, on October 15, 2018, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group and ordered a CT calcium scoring examination.

36. On October 26, 2018, Mr. Yarbrough went to the Gwinnett Hospital System for a noncontrast CT scan of his heart, which provided calcium scoring. The report for that exam noted that Mr. Yarbrough's coronary artery calcification score in his left anterior descending artery ("LAD") was 469.

37. The standard of care required CardioVascular Group and Dr. Friedland to review these test results, to place them in Mr. Yarbrough's chart, and to make sure the information was readily available to Dr. Friedland in future reviews or examinations of Mr. Yarbrough.

38. The calcium scoring results meant Mr. Yarbrough likely had extensive atherosclerotic plaque in his LAD — that is, that Mr. Yarbrough likely had a high-grade stenosis in one of the critical arteries to the myocardium.

39. The standard of care required Dr. Friedland to follow up with Mr. Yarbrough, for further evaluation and potential treatment of the coronary artery disease.

40. Dr. Friedland did not follow up with Mr. Yarbrough on the calcium scoring. Dr. Friedland thereby violated the standard of care.

41. Instead, on October 30, 2018, CardioVascular Group sent a letter to Mr. Yarbrough, telling him in essence that his calcium scoring results were unconcerning.

42. The letter from CardioVascular Group specifically indicated that Dr. Friedland had noted Mr. Yarbrough's elevated calcium score, but cited an old cardiac catheterization and a 2017 stress test as alleviating concerns from the calcium score. ("Your Calcium score is elevated, but your last cardiac cath showed non-obstructive disease. . . . Your stress test in 2017 was negative.")

43. Ronald Yarbrough reasonably relied on the letter from CardioVascular Group interpreting the CT calcium score in light of the prior stress test and cardiac catheterization.

44. However, Dr. Friedland's October 2018 office note referred only to a cardiac catheterization from 2006 (twelve years earlier) and a stress test from March 2017 (1-1/2 years earlier).

45. It was grossly unreasonable to regard Mr. Yarbrough's highly elevated calcium score as unconcerning based on a 12-year-old cardiac catheterization and a 1-1/2-year-old stress test.

46. The stress test was abnormal in it showed exercise-induced 2-3 mm ST segment depression consistent with ischemia.

47. Several months after the CT calcium scoring, in 2019, Mr. Yarbrough suffered abdominal pain for which he went to a hospital Emergency Room. In response to his abdominal problems, a colonoscopy and endoscopy were planned.

48. Before those procedures, Mr. Yarbrough returned to Dr. Friedland.

49. On May 6, 2019, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group. Dr. Friedland understood that Ronald had been to the ER for abdominal pain and that Ronald was scheduled for a colonoscopy and endoscopy.

50. At this office visit, the standard of care required Dr. Friedland to consider whether Mr. Yarbrough could safely undergo the colonoscopy and endoscopy.

51. Because of the high calcium score and additional risk factors, the standard of care required Dr. Friedland to do a cardiac workup before the colonscopy and endoscopy, to exclude ischemic heart disease.

52. Dr. Friedland did not do such a workup.

53. Dr. Friedland's office note made no reference to Mr. Yarbrough's CT calcium scoring from October 2018.

54. On May 9, 2019, Mr. Yarbrough underwent a colonoscopy that revealed benign polyps in his colon, including a non-obstructive mass for which the gastroenterologist referred Mr. Yarbrough for a surgical consult.

55. On May 15, 2019, Mr. Yarbrough saw a surgeon, Dr. Kota Venkatesh, to consider a colon resection.

56. On May 23, 2019, Mr. Yarbrough went through a pre-admission screening at Gwinnett Hospital, by Nakia Vasey-Evans, RN.

57. The screening included a discussion of cardiological conditions. Mr. Yarbrough told the hospital staff that he experienced tachycardia, hyperlipidemia, and difficulty with certain tasks.

58. The preadmit testing record indicates "medical consents/clearance" by Dr. Robert Deinler (internal medicine) and by Dr. Friedland.

59. For a nurse conducting a pre-surgery screening, the standard of care requires the nurse to obtain direct, unambiguous medical clearance for the surgery from the patient's treating physicians.

60. On information and belief, the nurse did not obtain medical clearance from Dr. Friedland but erroneously recorded a clearance from him. The nurse thus violated the standard of care.

61. On June 4, 2019, before the surgery, Mr. Yarbrough underwent a pre-anesthesia evaluation, which reviewed the same cardiological information as given in the May 23 pre-admit screening.

62. The information obtained in the pre-admission and pre-anesthesia screenings was consistent with the October 30, 2018, letter from CardioVascular Group to Mr. Yarbrough.

63. As of October 2018 — nearly eight months before the scheduled surgery — Mr. Yarbrough likely had a high-grade arterial stenosis that (without treatment) rendered a non-urgent surgery dangerous to Mr. Yarbrough.

64. A non-minor surgery places physical stress on the cardiovascular system, in part because of the effects of anesthesia, which can cause cardiac depression and hemodynamic instability. The stress of surgery thus can place demands on the heart that are dangerous in a patient with untreated cardiac disease.

65. Even as of October 2018, without further cardiological treatment, a non-urgent colectomy for Mr. Yarbrough would have posed a significant risk of inducing a heart attack. That risk would likely have increased in the nearly eight months from the October 26, 2018, calcium scoring to the June 4, 2019, colectomy.

66. Mr. Yarbrough was not medically qualified for the June 4 surgery.

67. If Dr. Friedland had been asked to provide written medical clearance for Mr. Yarbrough's June 4 colectomy, then Dr. Friedland likely would have reviewed Mr. Yarbrough's CT calcium scoring results, realized Mr. Yarbrough was not fit for surgery, and refused to clear him for the surgery.

68. If Mr. Yarbrough's arterial stenosis had been identified and treated appropriately beginning in October 2018, with careful evaluation before the June 2019 colectomy, Mr. Yarbrough likely could have undergone the colectomy safely.

69. On the afternoon of Tuesday, June 4, 2019, Mr. Yarbrough underwent the colectomy.

70. About a day and a half after the surgery, while Mr. Yarbrough recovered, in the early morning hours of Thursday, June 6, 2019, Mr. Yarbrough showed signs of cardiac distress.

71. At approximately 1:00 AM on June 6, cardiologist Dr. Martin B. Siegfried examined Mr. Yarbrough. Dr. Siegfried noted that Mr. Yarbrough was experiencing chest pain with elevated troponin levels. Dr. Siegfried suspected demand ischemia.

72. Several hours later, at approximately 0930 hours, another cardiologist, Dr. Salil Patel, noted that Mr. Yarbrough's troponin levels continued to rise and noted that the EKG suggested myocardial ischemia with sinus tachycardia.

73. On Friday, June 7, Dr. Priya Baronia noted that Mr. Yarbrough had suffered a non-ST-elevation myocardial infarction and would probably have a heart catheterization the following Monday.

74. On Saturday, June 8, cardiologist Dr. Siegfried noted that a heart catheterization had been delayed to allow time for the healing of the surgical bed.

75. On Sunday, June 9, Dr. Siegfried noted that Mr. Yarbrough likely suffered a focal LAD disease.

76. On Monday, June 10, Dr. Rodica Ellis noted that Mr. Yarbrough had been referred to cardiac surgery for a coronary artery bypass evaluation, due to severe arterial disease and ischemic cardiomyopathy.

77. On Tuesday, June 11, Dr. Lance Friedland noted that it appeared Mr. Yarbrough would receive bypass surgery the following week, because the surgeon Dr. Venkatesh recommended that bypass surgery wait until at least 10 days after the abdominal surgery.

78. On Sunday, June 16, Mr. Yarbrough's physicians noted that Mr. Yarbrough had a bone-healing deficiency that made a traditional open-sternum bypass surgery dangerous.

79. On Monday, June 17, Mr. Yarbrough's physicians planned to transfer Mr. Yarbrough to Emory St. Joseph's Hospital, for a robot-assisted minimally invasive surgery.

80. On Monday, June 17, Mr. Yarbrough was in fact transferred to Emory St. Joseph's.

81. At Emory St. Joseph's, Mr. Yarbrough was prepared for bypass surgery to occur on Friday, June 21.

82. From the afternoon of Friday, June 21 through the early morning of Saturday, June 22, Mr. Yarbrough underwent an approximately 10-hour cardiac surgery.

83. The surgery encountered complications that required switching from a minimally-invasive, robot-assisted approach to a sternotomy. Mr. Yarbrough experienced ventricular arrhythmias and hypokinesis during the surgery. At the close of surgery, Mr. Yarbrough appeared reasonably stable.

84. On Saturday, June 22, after the surgery, at about 8 AM, a hospital progress note suggests that Mr. Yarbrough remained intubated and on a ventilator but appeared stable.

85. Twenty-four hours later, by 8 AM on Sunday, June 23, Mr. Yarbrough was showing signs of kidney failure.

86. Another day later, by about 11 AM Monday, June 24, Mr. Yarbrough's condition had become critically ill, with cardiogenic shock and respiratory instability as well as kidney failure.

87. Another day later, on Tuesday, June 25, Mr. Yarbrough had deteriorated more.

88. That day, June 25, Mr. Yarbrough was transferred to Emory University Hospital.

89. Over the next 2-1/2 weeks, Mr. Yarbrough's family watched him deteriorate and made the decision to let him pass away.

90. On July 12, 2019, Mr. Yarbrough died.

91. Mr. Yarbrough died from organ failure caused by cardiogenic shock.

92. If Dr. Friedland, CardioVascular Group, and Gwinnett Medical Center had not violated their standards of care, Mr. Yarbrough's LAD stenosis could have been addressed safely and timely, and the June 2019 post-surgery heart attack and premature death could have been avoided.

93. If Mr. Yarbrough's LAD stenosis had been identified and addressed properly in October 2018, Mr. Yarbrough likely would have lived at least another 10 years.

Count 1 – Injuries & Wrongful Death from Professional Negligence — GHS

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

95. The standard of care required the hospital staff who conducted the preadmit screenings for the colectomy to obtain a medical clearance from Dr. Friedland and to bring the CT calcium scoring result to the attention of the anesthesia team.

96. The staff violated that standard of care.

97. That violation substantially contributed to Mr. Yarbrough suffering a heart attack induced by the surgery — leading ultimately to organ failure and death.

98. GHS is vicariously liable for the negligence of the staff, because they acted within the scope of their agency for GHS.

99. Mr. Yarbrough's estate is entitled to recover from GHS for the physical, emotional, and economic injuries Mr. Yarbrough suffered before he died, including special damages such as funeral costs and other direct financial costs, as a proximate result of the Defendants' negligence.

100. Pursuant to OCGA Title 51, Chapter 4, Ronald Yarbrough's wrongful death beneficiaries are entitled to recover from GHS for the value of Mr. Yarbrough's life lost as a proximate result of the Defendants' negligence.

Count 2 – Injuries & Wrongful Death from Professional Negligence — CardioVascular Group and Dr. Friedland

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

102. The standard of care required Dr. Friedland to follow up on the CT calcium score results, correctly inform Mr. Yarbrough of the results and their significance, and to evaluate Mr. Yarbrough for further treatment of his arterial stenosis.

103. The standard of care required CVG itself (through its staff) to ensure that the score results were recorded in Mr. Yarbrough's chart, brought to Dr. Friedland's attention, and correctly communicated to Mr. Yarbrough.

104. Dr. Friedland and the CVG staff violated these standards of care.

105. These violations substantially contributed to Mr. Yarbrough suffering a heart attack induced by the surgery — leading ultimately to organ failure and death.

106. Dr. Friedland is directly liable for his own negligence.

107. CVG is vicariously liable for the negligence of Dr. Friedland and of other CVG staff, because those individuals were acting within the scope of their agency for CVG.

108. Mr. Yarbrough's estate is entitled to recover from CardioVascular Group and Dr. Friedland for the physical, emotional, and economic injuries Mr. Yarbrough suffered before he died, including special damages such as funeral costs and other direct financial costs, as a proximate result of the Defendants' negligence.

109. Pursuant to OCGA Title 51, Chapter 4, Ronald Yarbrough's wrongful death beneficiaries are entitled to recover from CardioVascular Group and Dr. Friedland for the value of Mr. Yarbrough's life lost as a proximate result of the Defendants' negligence.

Damages

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

111. 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.

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

a. Compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;

b. All costs of this action; and

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

May 8, 2020

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 MELDON C. LEVY, MD REGARDING PROFESSIONAL NEGLIGENCE BY LANCE B. FRIEDLAND, MD AND CARDIOVASCULAR GROUP, P.C.

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

Introduction and Limited Purpose of Affidavit

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

2. This affidavit states my views of the matters discussed below — views I formed from my review of the evidence. However, Plaintiff's counsel drafted this document in consultation with me. Plaintiff's counsel did the typing, supplied the snapshots from medical records, the legalese, the formatting, etc., and inserted the general factual narrative from the medical records. The medical analysis and opinions are mine.

3. This affidavit does not attempt to state or summarize all my opinions. This affidavit addresses specific matters that Plaintiff's counsel have asked me to examine for purposes of testimony at trial. I have not attempted to identify every person who may have violated a standard of care. Nor have I attempted to identify every standard of care that a particular person violated. If additional information becomes available later, then of course my opinions may change.

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

Exhibit 1

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

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

Topic & Opinions

7. This affidavit concerns medical services provided to Ronald Yarbrough in and after October 2018, by Lance B. Friedland, MD, and CardioVascular Group, P.C.

8. More specifically, this affidavit concerns the standards for informing a patient of abnormal cardiovascular test results and standards for a cardiologist's clearing of a patient for surgery.

9. I believe Dr. Friedland and CardioVascular Group violated their standards of care as follows:

a. Dr. Friedland and CardioVascular Group violated their standards of care by failing to inform Mr. Yarbrough of abnormal results from a CT calcium scoring examination on October 26, 2018.

b. Dr. Friedland and CardioVascular Group violated their standards of care by failing to further evaluate Mr. Yarbrough after that abnormal result.

c. Dr. Friedland and/or CardioVascular Group violated their standards of care by falsely telling Mr. Yarbrough — in a letter dated 10/30/2018 — that his CT calcium scoring exam showed no significant calcification in the arteries leading to his heart.

d. Dr. Friedland violated his standard of care by failing to consider the abnormal calcium score when seeing Mr. Yarbrough before the scheduled colonscopy.

10. I believe these standard-of-care violations caused injury to Ronald Yarbrough.

Qualifications

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

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

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

14. The acts or omissions at issue here occurred in October 2018 and May 2019.

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

a. In October 2018 and May 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

Specifically, I was licensed by the State of California to practice medicine. That's where I was practicing medicine in October 2018 and May 2019.

b. In October 2018 and May 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:

- Within a cardiology practice, ensuring that a patient is accurately informed of cardiovascular test results.

- Within a cardiology practice, ensuring that a patient is not cleared for potential medical procedures that would be unsafe because of the patient's cardiovascular condition.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to October 2018 and May 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

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

Evidence Reviewed

16. I have reviewed Ronald Yarbrough's medical records from CardioVascular Group, Southern Endoscopy Suite, Colon and Rectal Clinic, and Gwinnett Medical Center.

Discussion and Factual Basis for Opinion

General Principles

17. When a cardiologist has a patient undergo testing, the physician and the physician's practice group are responsible for reviewing the results, identifying any

concerning results, correctly informing the patient of any important abnormal results, arranging for any appropriate follow-up testing or counseling, and ensuring that the important test results are recorded in the patient's chart where the information will be readily available to the physician when treating the physician in the future.

18. These tasks are important to patient safety. If these tasks are not performed diligently, then dangerous, treatable medical conditions may go unaddressed — with catastrophic results for the patient.

19. The cardiologist and the practice group bear joint responsibility for the tasks described above.

20. Generally, when a cardiologist examines a patient in advance of anticipated or potential medical procedures, the cardiologist must consider the potential medical procedures that may be required, must consider whether the patient's cardiovascular condition is suited for the potential procedures, and must issue any cautions or warnings that may be necessary — including an instruction to obtain further review by a cardiologist if heart-stressing procedures (like surgery) are later recommended.

21. Where a cardiologist does not issue such cautions or warnings, a patient may be erroneously cleared for a surgery or other procedure that the patient's heart cannot safely withstand — with catastrophic results.

Ronald Yarbrough's Course of Treatment

22. On October 15, 2018, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group and ordered a CT calcium scoring examination. (CVG 6-9.)

YARBROUGH, RONALD H

Date of visit: 10/15/2018

. . .

IMPRESSION/PLAN

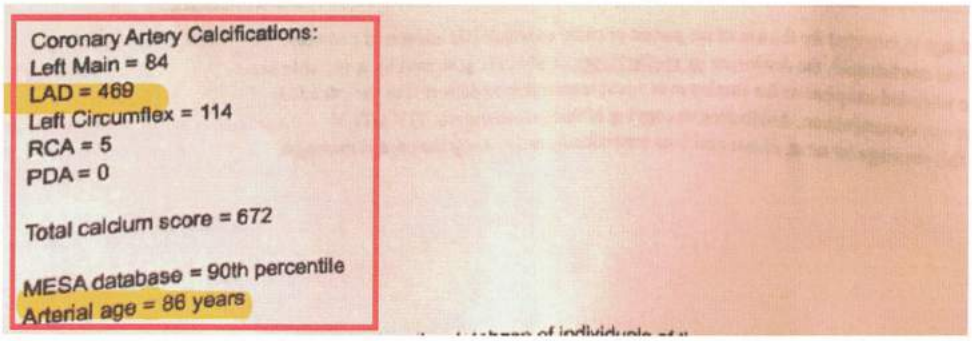
1. Chest pains, resolved. He had a normal stress DIMPS March 7, 2017 with left ventricular ejection fraction of 67%..

He has a history of minor nonobstructive coronary artery disease by cardiac catheter in 2006.
2. Paroxysmal atrial fib. His episode was in 2000 and he has not had any recurrent symptoms. Echocardiogram March 7, 2017 showed normal left and right ventricular function.
3. Essential hypertension, stable on his current medical regimen. He'll monitor his blood pressure home.
4. Hyperlipidemia on statin and Zetia. His lipid profile is at goal. He was encouraged to watch his diet lose weight and exercise.
5. Diabetes mellitus type 2 followed by endocrinology
6. Osteogenesis imperfecta
7. Chronic low back pains on pain meds.
8. Chronic kidney disease, III.

TODAYS ORDERS

1. Coronary Calcium Score: First Available
2. Diet_mgmt_edu,_guidance_and_counseling: TODAY
3. Patient Electronic Access: Today
4. 12 Lead EKG: Today
5. Return Visit: 6 months

23. On October 26, 2018, Mr. Yarbrough went to the Gwinnett Hospital System for a noncontrast CT scan of his heart, which provided calcium scoring. The report for that exam noted that Mr. Yarbrough's coronary artery calcification score in his left anterior descending artery ("LAD") was 469.



24. The standard of care required CardioVascular Group and Dr. Friedland to review these test results, to place them in Mr. Yarbrough's chart, and to make sure the information was readily available to Dr. Friedland in future reviews or examinations of Mr. Yarbrough.

25. The calcium scoring results meant Mr. Yarbrough likely had extensive atherosclerotic plaque in his LAD — that is, that Mr. Yarbrough likely had a high-grade stenosis in the critical artery to the myocardium.

26. The standard of care required Dr. Friedland to follow up with Mr. Yarbrough, for further evaluation and potential treatment of the coronary artery disease.

27. Dr. Friedland did not follow up with Mr. Yarbrough on the calcium scoring. Dr. Friedland violated the standard of care in that respect.

28. Instead, on October 30, 2018, CardioVascular Group sent a letter to Mr. Yarbrough, telling him in essence that his calcium scoring results were unconcerning.

Dear Ronald Yarbrough:

Your recent coronary artery calcium score was reviewed by Dr. Friedland. It showed no significant calcification in the arteries leading to the heart. Your Calcium score is elevated, but you your last cardiac cath showed non-obstructive disease. please continue to take your Rosuvastatin (cholesterol medication) and Aspirin. Your stress test in 2017 was negative. If you are not having any symptoms or problems there is not need to perform a nuclear stress test this year. Follow a good low fat low cholesterol diet. Continue all of your current medications. No changes are recommended in your therapy at this time. Please continue your current medications. Your next appointment is scheduled at our _LAW office on 04/17/19 at 10:30 AM. Let us know 24 hours in advance if you are unable to keep this appointment. Meanwhile, if your condition worsens or if you have questions about the results, please contact our office. Enclosed is a copy of the results for your records.

Thank you,

CardioVascular Group staff member: SUZIE CLARK

29. From my experience with thousands of patients over decades of practice, I would expect the overwhelming majority of patients to rely on the explanation given in the letter that "Your calcium score is elevated, but you your last cardiac cath showed non-obstructive disease." I believe a patient's reliance on such a letter is reasonable (even though the letter itself was incorrect).

30. The letter from CardioVascular Group specifically indicated that Dr. Friedland had noted Mr. Yarbrough's elevated calcium score, but went on to cite an old cardiac catheterization and a 2017 stress test as alleviating concerns from the calcium score. ("Your Calcium score is elevated, but your last cardiac cath showed non-obstructive disease. . . . Your stress test in 2017 was negative.")

31. Dr. Friedland's October 2018 office note referred only to a cardiac catheterization from 2006 (twelve years earlier) and a stress test from March 2017 (1-1/2 years earlier). (CVG 7.)

PAST HISTORY
Past Medical Illnesses: insomnia, anxiety, DM-non-insulin dependent, depression, GERD, history of colon polyps, Osteogenesis Imperfecta, renal insufficiency
Cardiovascular Illnesses: hyperlipidemia-Mixed, hypertension, Minor Nonobstructive CAD 2006, atrial fibrillation-paroxysmal
Infectious Diseases: mumps, measles and chickenpox during childhood, pertussis
Surgical Procedures: bilateral shoulder surgery- rotator cuff
Cardiology Procedures-Invasive: cardiac cath (left) May 2006
Cardiology Procedures-Noninvasive: Holter monitor May 1991, echocardiogram May 1991, myocardial perfusion study (Nuclear) September 2002, myocardial perfusion study (Nuclear) March 2017, echocardiogram March 2017, carotid Doppler March 2017
Left Ventricular Ejection Fraction: LVEF of 67% documented via nuclear study on 03/07/2017

Peripheral Vascular Procedures: carotid doppler March 2017

32. It was unreasonable and below the standard of care to disregard Mr. Yarbrough's highly elevated calcium score, based on a 12-year-old cardiac catheterization and a 1-1/2-year-old stress test.

33. The stress test was abnormal in the following way: There was exercise-induced 2-3 mm ST segment depression consistent with ischemia.

34. Months later, in 2019, Mr. Yarbrough suffered abdominal pain for which he went to a hospital Emergency Room. In response to his abdominal problems, a colonoscopy and endoscopy were planned. Before those procedures, Mr. Yarbrough returned to Dr. Friedland.

35. On May 6, 2019, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group. Dr. Friedland understood that Ronald had been to the ER for abdominal pain and that Ronald was scheduled for a colonoscopy and endoscopy. (CVG 2-3.)

HISTORY OF PRESENT ILLNESS
Delightful 64-year-old white male comes the office today for follow-up of his paroxysmal atrial fibrillation and nonobstructive coronary artery disease.

The patient denies any cardiac symptoms. He's trying to be active but does have chronic low back pains on opiates. He is watching his diet. He is currently using an insulin pump system. The patient denies any shortness of breath, chest pains, palpitations, orthopnea, dizziness, syncope, PND,or nausea. He was evaluated in the emergency room at Eastside for abdominal pains and was started on Zantac. He is scheduled to have a colonoscopy and upper endoscopy this week.

36. At this office visit, the standard of care required Dr. Friedland to consider whether Mr. Yarbrough could safely undergo the colonoscopy and endoscopy.

37. Because of the high calcium score and additional risk factors, the standard of care required Dr. Friedland to do a cardiac workup before the colonscopy and endoscopy — another stress test with imaging, to exclude ischemic heart disease.

38. Dr. Friedland did not do such a workup.

39. Dr. Friedland's office note made no reference to Mr. Yarbrough's CT calcium scoring from October 2018. (CVG 2-5.)

IMPRESSION/PLAN

1. Chest pains, resolved. He had a normal stress DIMPS March 7, 2017 with left ventricular ejection fraction of 67%..

   He has a history of minor nonobstructive coronary artery disease by cardiac cath in 2006.
2. Paroxysmal atrial fib. His episode was in 2000 and he has not had any recurrent symptoms.

MRNO: 388262 Page 3 of 4 Create Date: 2019-5-6

CVG 0004

   Echocardiogram March 7, 2017 showed normal left and right ventricular function.
3. Essential hypertension, stable on his current medical regimen. He'll monitor his blood pressure home.
4. Hyperlipidemia on statin and Zetia. His lipid profile is at goal. He was encouraged to watch his diet lose weight and exercise.
5. Diabetes mellitus type 2 followed by endocrinology
6. Osteogenesis imperfecta
7. Chronic low back pains on pain meds.
8. Chronic kidney disease, III.

40. On May 9, 2019, Mr. Yarbrough underwent a colonoscopy that revealed benign polyps in his colon, including a non-obstructive mass for which the gastroenterologist referred Mr. Yarbrough for a surgical consult. (SGA 64-67.)

appendiceal orifice, and rectum were photographed.

Findings:

- The perianal and digital rectal examinations were normal.
- The terminal ileum appeared normal.
- Multiple small and large-mouthed diverticula were found in the sigmoid colon, descending colon and transverse colon.
- A fungating, polypoid and ulcerated non-obstructing large mass was found in the proximal ascending colon. The mass was circumferential. The mass measured two cm in length and was just distal to the IC valve. No bleeding was present. Biopsies were taken with a cold forceps for histology. Area was tattooed with an injection of 3 mL of Spot (carbon black). Estimated blood loss: none.

Recommendation:

- Await pathology results.
- Discontinue aspirin and NSAIDs.
- Check labs now as ordered.
- Refer to a colo-rectal surgeon at the next available appointment. Contact information for Dr. Venkatesh provided and my staff is attempting to schedule an appointment per family request.
- Repeat colonoscopy in 1 year for surveillance.
- Return to my office at the next available appointment.
- Patient has a contact number available for emergencies. The signs and symptoms of potential delayed complications were discussed with the patient. Return to normal activities tomorrow. Written discharge instructions were provided to the patient.

41. On May 15, 2019, Mr. Yarbrough saw a surgeon, Dr. Kota Venkatesh, to consider a colon resection. (CRCb 6-8.)

05/15/2019

Progress Notes: Kota Venkatesh MD

Current Medications

Taking

- Atenolol 25 MG Tablet 1 tablet Orally Once a day, Notes: 12.5 mg
- Actos 30 MG Tablet 1 tablet Orally Once a day
- GlyBURIDE 2.5 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day
- BusPIRone HCl 5 MG Tablet 1 tablet Orally Three times a day, Notes: 2/day
- Zetia 10 MG Tablet 1 tablet Orally Once a day
- Simvastatin 80 MG Tablet 1 tablet in the evening Orally Once a day
- Sertraline HCl 100 MG Tablet 1 tablet Orally Once a day, Notes: 150 mg
- Tizanidine HCl 6 MG Capsule 1 capsule as needed Orally Three times a day, Notes: 8/mg
- Turmeric 1053 MG Tablet as directed

Reason for Appointment

1. Ascending colon ulcerative mass/polyp (pain 0/10)

Assessments

1. Epigastric pain - R10.13
2. Polyp of colon - K63.5

Treatment

1. Epigastric pain

Notes: Fungating, polypoid, Recommended Laparoscopic Right Colon Resection, possible open.The risks, benefits, and alternatives were discussed extensively with the patient and documented in the informed consent form. Risks including bleeding, infection, allergic reaction, scar formation, paralysis, brain damage, cardiac arrest, death, injury to adjacent structures, sexual/urinary problems, injury to ureters, and need for ostomy if there was a leak from the anastomosis,were discussed with the patient and the patient wants to proceed with it. ulcerated, nonobstructing large mass in the proximal ascending colon. Biopsy revealed adenomatous tissue.

42. On May 23, 2019, Mr. Yarbrough went through a pre-admission screening at Gwinnett Hospital, by Nakia Vasey-Evans, RN. The screening included a discussion

of cardiological conditions. Mr. Yarbrough told the hospital staff that he experienced tachycardia and hyperlipidemia. (GMC 319-31 at 324.)

MEDICAL CONDITIONS/HISTORY

CARDIOLOGY

HISTORY OF CARDIOVASCULAR DISEASE: Yes

Page 5 of 13 on 05/23/2019 14:32

DESCRIPTION: Other
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
COMMENT: TACHYCARDIA

DESCRIPTION: Other
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
MOST RECENT: 5/23/19
COMMENT: ACTIVITY: YARDWORK, CLIMB STAIRS, ADL'S W/O CP OR SOB

DESCRIPTION: Hyperlipidemia
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
PAST: Yes

RESPIRATORY

43. The preadmit testing record indicates "medical consents/clearance" by Dr. Robert Deinler (internal medicine) and by Dr. Friedland. These consents were recorded by Nurse Vasey-Evans. (GMC 329.)

MEDICAL CONSENTS/CLEARANCE

DATE/TIME: 05/23/2019 12:56 RECORDED BY: VASEY-EVANS, NAKIA - RN
PRIMARY PHYSICIAN NAME: DR. ROBERT DEINLER
PHYSICIAN TYPE: internal medicine
DATE/TIME: 05/23/2019 12:58 RECORDED BY: VASEY-EVANS, NAKIA - RN
PRIMARY PHYSICIAN NAME: DR. LANCE FREIDLAND
PHYSICIAN TYPE: cardiologist

44. On June 4, 2019, before the surgery, Mr. Yarbrough underwent a pre-anesthesia evaluation, which reviewed the same cardiological information as given in the May 23 pre-admit screening. (GMC 285-86.)

Cardiovascular

Hyperlipidemia

Onset Date	
Most Recent Date	
Comment	
Current	Yes
Past	Yes

PRE-ANESTHESIA EVALUATION
Account #: 1915580326

Other

Onset Date	
Most Recent Date	5/23/19
Comment	ACTIVITY: YARDWORK, CLIMB STAIRS, ADL'S W/O CP OR SOB
Current	Yes
Past	

Renal/Urogen

45. The information obtained in the pre-admission and pre-anesthesia screenings was consistent with the October 30, 2018, letter from CardioVascular Group to Mr. Yarbrough.

46. As of October 2018 — nearly eight months before the scheduled surgery — Mr. Yarbrough likely had a high-grade arterial stenosis that (without treatment) rendered a non-urgent surgery dangerous to Mr. Yarbrough.

47. A non-minor surgery places physical stress on the cardiovascular system, in part because of the effects of anesthesia, which can cause cardiac depression and hemodynamic instability. The stress of surgery thus can place demands on the heart that are dangerous in a patient with untreated cardiac disease.

48. Even as of October 2018, without further cardiological treatment, a non-urgent colectomy would have posed a significant risk of inducing a heart attack. That risk would likely have increased in the nearly eight months from the October 26, 2018 calcium scoring to the June 4, 2019, colectomy.

49. Mr. Yarbrough was not medically qualified for the June 4 surgery, and he would not have been cleared for it, if Dr. Friedland and CardioVascular Group had reviewed, recorded, and communicated the October 2018 calcium scoring results.

50. If Mr. Yarbrough's arterial stenosis had been identified and treated appropriately beginning in October 2018, with careful evaluation before the June 2019 colectomy, Mr. Yarbrough likely could have undergone the colectomy safely.

51. On the afternoon of Tuesday, June 4, 2019, Mr. Yarbrough underwent the colectomy. (CRCb 9-10.)

> Date of Procedure: 06/04/2019
>
> SURGEON: Kota R Venkatesh MD
>
> PREOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.
>
> POSTOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.
>
> NAME OF PROCEDURE: Laparoscopic right colectomy with partial omentectomy.

52. About a day and a half after the surgery, while Mr. Yarbrough recovered, in the early morning hours of Thursday, June 6, 2019, Mr. Yarbrough showed signs of cardiac distress. At approximately 1:00 AM on June 6, cardiologist Dr. Martin B. Siegfried examined Mr. Yarbrough. Dr. Siegfried noted that Mr. Yarbrough was experiencing chest pain with elevated troponin levels. Dr. Siegfried suspected demand ischemia.

DOS: 06/06/2019
ROOM#:

CONSULTANT: MARTIN R SIEGFRIED, MD
REFERRING PHYSICIAN: KOTA R VENKATESH, MD

REASON FOR CONSULTATION: Sinus tachycardia.

CLINICAL IMPRESSION:
1. Chest pain with troponin 0.105. No acute ischemic changes on electrocardiogram. Patient is tachycardic and had an episode of hemoptysis, coughing out a blood clot. On a setting of chest pain, shortness of breath, tachycardia, and coughing up blood clots, will need to rule out possible pulmonary embolism.
2. Elevated troponin, possible demand ischemia, status post surgery with chronic kidney disease. He is also tachycardic, heart rate in the 130s. Will need to rule out possible acute coronary syndrome if troponin continues to trend up significantly.

53. Several hours later, at approximately 0930 hours, another cardiologist, Dr. Salil Patel, noted that Mr. Yarbrough's troponin levels continued to rise and noted that the EKG suggested myocardial ischemia with sinus tachycardia. (GMC 204, 240)

HISTORY OF PRESENT ILLNESS: The patient was seen overnight. He is having some chest pain, had some reported hemoptysis this morning, he is somnolent. He denies chest pain, denies shortness of breath. His wife and one of the friends who is a nurse here in the hospital are at the bedside. He looks very different than he did yesterday. His troponins have gone from 0.1-0.257. Creatinine 1.5. VQ scan read as low probability. He is 2 days status post laparoscopic right colectomy.

PHYSICAL EXAMINATION: On my exam, somnolent, awakens to voice, falls right back to sleep. Heart sounds are tachycardic. Neck veins are not distended. GI is soft and quiet bowel sounds are not heard. Respirations are shallow with no audible rales or rhonchi.

LABORATORY DATA: His EKG reviewed by me shows is suggestive of myocardial ischemia with sinus tachycardia.

The patient's echo shows a large anterior apical wall motion abnormality consistent with an anterior MI. Repeat echo shows improvement in ST depression. He denies having current chest pain. His x-ray did show some pulmonary edema. He got Lasix.

54. On Friday, June 7, Dr. Priya Baronia noted that Mr. Yarbrough had suffered a non-ST-elevation myocardial infarction and would probably have a heart catheterization the following Monday. (GMC 241.)

DOS: 06/07/2019
ROOM#:

SUBJECTIVE: Patient is sitting up in chair, awake, confused. Family is at bedside. Complaining of some chest discomfort. HE is on the heparin drip. No bleeding anywhere. No shortness of breath.

OBJECTIVE: Vital Signs: Afebrile. Pulse 85, respiration 25, blood pressure 131/62, 98% saturating on room air. General Appearance: No distress. HEENT: Atraumatic, normocephalic. Pupils equal, reactive to light. Chest: Clear. No wheezing. No crackles. Cardiovascular: S1, S2, regular. No murmurs. Abdomen: Soft, nondistended, nontender. Bowel sounds present. Extremities: No edema.

LABORATORY DATA: Reviewed. Hemoglobin is 11.3, platelets 160.

ASSESSMENT AND PLAN:
1. Non-ST-elevation myocardial infarction. Cardiology is on the case. He will probably go for heart cath on Monday. Meanwhile, continue with the heparin drip and the medications.
2. Recent laparoscopic right colectomy and partial omentectomy on 06/04/2019.
3. Ascending colon ulcer with adenomatous tissue and Dr. Venkatesh is on the case.
4. Diabetes type 2. Blood glucose well controlled.
5. Pulmonary infiltrates. Continue with as needed breathing treatments, Zosyn, and diurese as needed per cardiology.
6. Chronic kidney disease stage III.
7. Order chest x-ray for tomorrow morning _____ .

55. On Saturday, June 8, cardiologist Dr. Siegfried noted that a heart catheterization had been delayed to allow time for the healing of the surgical bed. (GMC 244.)

DOS: 06/08/2019
ROOM#:

The patient is seen in his room. His wife and several family members are at the bedside. He had a colon surgery recently, and looks like he has had a non-STEMI. The maximum troponin is only 0.74 and trending downward. He is on heparin and tolerating it well. Catheterization has been delayed until Monday to allow time for the healing of the surgical bed. He did have an ultrasound done which showed evidence of a wall motion abnormality in the LAD territory. A repeat ultrasound was done this morning. It has not yet been read. Vital signs and labs are as per the note written by the APP.

PHYSICAL EXAMINATION: Eyes: EOMI. PERRL. Ears, Nose, Mouth And Throat: Mucous membranes are moist. No lesions are noted. Neck: Supple without JVD. Lungs: Clear to auscultation with good air movement. Cardiac: Regular rate without murmurs, rubs or gallops. Abdomen: Soft, nontender, nondistended. Bowel sounds are quiet. Extremities: Two-plus pulses without cyanosis, clubbing or significant lower extremity edema. Psychiatric: Alert and oriented x3 with normal affect. Neurologic: Cranial nerves II through XII are grossly intact.

IMPRESSION:
1. Non-ST elevation myocardial infarction.
a. Peak troponin 0.7.
b. Left heart cath is planned for Monday.
c. Wall motion abnormality involving the mid to distal left anterior descending territory.
d. Previous cath 2006 suggested mild nonobstructive disease.
2. Colectomy, omentectomy.
3. Diabetes.
4. Kidney disease.
5. Hyperlipidemia.

56. On Sunday, June 9, Dr. Siegfried noted that Mr. Yarbrough likely suffered a focal LAD disease. (GMC 247.)

DOS: 06/09/2019
ROOM#:

This is a CVG cardiology progress note.

The patient is seen in his room. He is pain-free. He is sitting at the bedside. He is on heparin. He had a non-STEMI with a peak troponin of 0.7 after GI surgery. His echo shows a wall motion abnormality involving the entire anteroseptal wall, which is likely due to focal LAD disease. A cath in 2006 showed only luminal irregularities. He is scheduled for cath tomorrow.

57. Monday, June 10. (GMC 318.)

CORONARY FINDINGS: Coronary angiography in this right dominant system demonstrated severe 2-vessel coronary disease. The LMCA had mild luminal irregularities. The LAD had a moderately calcified 95 percent proximal stenosis involving the takeoff of 2 small-to-moderate size diagonal branches, each of which had 90 percent ostial stenoses. There were mild luminal irregularities in the distal LAD. The ramus branch had a 90 percent proximal stenosis and no disease distally. The LCX had a 40-50 percent proximal lesion and a 90 percent distal lesion, but the distal LCX was quite small. The RCA had a 40 percent PDA lesion and a very high RPL takeoff.

Given the complexity of the LAD lesion as well as a ramus stenosis, I think it would be reasonable to discuss and consider bypass surgery versus high risk PCI. I suspect he would need rotational atherectomy of the LAD and this would compromise 2 small to moderate-sized diagonal branches. In addition, the ramus PCI would put at risk both the LAD and the circumflex.

58. Monday, June 10. (GMC 208-10.)

ASSESSMENT & PLAN: The patient is a pleasant 64-year-old male who unfortunately suffered a non-ST elevation myocardial infarction following his right colectomy surgery. Does appear that he has a mild ischemic cardiomyopathy with an ejection fraction at 40% to 45%. He has also been diagnosed with Clostridium difficile colitis and is currently being treated. His creatinine has been stable at 1.4 over the past few days, however, he does have baseline stage III chronic kidney disease. We do recommend proceeding with coronary bypass surgery. However, we will discuss this with his gastrointestinal surgeon, Dr. Venkatesh, to determine when it will be safe to proceed with full heparinization. We will also get infectious disease to see

59. On Monday, June 10, Dr. Rodica Ellis noted that Mr. Yarbrough had been referred to cardiac surgery for a coronary artery bypass evaluation, due to severe arterial disease and ischemic cardiomyopathy. (GMC 249.)

IMPRESSION AND PLAN:
1. Hypomagnesemia, replete. The patient will be on replacement protocol.
2. Clostridium difficile on p.o. vancomycin. Would continue perioperatively, and then afterwards perhaps another week at least. He is improved.
3. Severe coronary artery disease, was referred to cardiovascular surgery for a coronary artery bypass graft evaluation.
4. Ischemic cardiomyopathy with ejection fraction 45%.
5. Chronic kidney disease stage III at baseline.
6. Status post right colectomy on June 4, postoperative day #6 for ascending colon ulcer with adenomatous tissue. Dr. Venkatesh following the patient.
7. Type 2 diabetes. Continue Lantus and sliding scale. The patient still with elevated blood sugars. Will increase the Lantus.

Discussed with patient in the presence of his wife.

60. On Tuesday, June 11, Dr. Lance Friedland noted that it appeared Mr. Yarbrough would receive bypass surgery the following week, because the surgeon Dr. Venkatesh recommended that bypass surgery wait until at least 10 days after the abdominal surgery. (GMC 252.)

IMPRESSION AND PLAN:
1. Multivessel coronary artery disease. Preoperative for bypass surgery. Dr. Venkatesh has stated that he should wait at least 10 days postoperative following his abdominal surgery for bypass surgery.
2. Mild ischemic cardiomyopathy with left ventricular ejection fraction of 45%.
3. Clostridium difficile. On oral vancomycin.
4. Diabetes mellitus type 2.
5. Hyperlipidemia. On a statin.
6. Osteogenesis imperfecta.
7. Chronic low back pains.
8. Continue current medical regimen. Preoperative for bypass surgery.

61. On Sunday, June 16, Mr. Yarbrough's physicians noted that Mr. Yarbrough had a bone-healing deficiency that made a traditional open-sternum bypass surgery dangerous. (GMC 273, 275.)

ASSESSMENT AND PLAN:
1. Non-ST elevation myocardial infarction with diffuse coronary disease in the background of diabetes mellitus. Thoracovascular surgery and cardiology to discuss treatment options. If the patient undergoes sternotomy, there is concern that stern will not heal due to the presence osteogenesis imperfecta. Continue the recommendations as per thoracovascular surgery and cardiology.

ASSESSMENT:
1. Acute phase of renal dysfunction, improving.
2. Underlying chronic renal insufficiency of stable nature.
3. Hypomagnesemia and hypophosphatemia. Remains corrected.
4. Clostridium difficile colitis appears to be controlled and no further diarrhea noted.
5. Osteogenesis imperfecta with multiple bone fractures in the past, but healed and the avascular necrosis of right hip, managed, and blue sclerae. This osteogenesis imperfecta, however, has paused with increased risk for coronary surgery, as per Dr. Langford, and surgery will probably be not offered. Non-aggressive management of coronary disease, being recommended.
6. Diabetes mellitus is managed. Blood sugar results are slightly higher and ranging from 165 to 246 mg percent. Patient relates this to his stress.

62. On Monday, June 17, Mr. Yarbrough's physicians planned to transfer Mr. Yarbrough to Emory St. Joseph's Hospital, for a robot-assisted minimally invasive surgery. (GMC 276-77, 278.)

3. He underwent left heart cath by Dr. Yuri Pride on 06/10/2019 and was noted to

have 2 vessel disease. Coronary artery bypass grafting versus percutaneous coronary intervention.
4. Due to osteogenesis imperfecta, unable to perform sternotomy open CABG. Dr. Langford is planning to transfer him to St. Joseph for robotic CABG.
5. He is on heparin drip for acute coronary syndrome and two-vessel severe coronary artery disease with severe coronary calcification, widespread atherosclerotic disease, left ventricular dysfunction, awaits robotic CABG on a heparin drip, half normal saline.
6. Metabolic acidosis, resolved. He is getting half normal saline with bicarbonate. He is able to drink enough fluids. Hence, will discontinue bicarbonate drip. His CO2 has become normal. Metabolic acidosis corrected. Creatinine continues to improve. Urine output maintained well.
7. Discussed with patient and wife. Continue to monitor renal functions.
8. He had C. difficile colitis being managed by Dr. Kusan.

Prognosis is guarded. Call us with any questions.

RECOMMENDATIONS:
1. The patient is considered high risk for sternotomy and complete surgical revascularization. Dr. Langford has arranged for the patient to be transferred to St. Joseph Hospital for a robotic LIMA to the LAD.
2. He would be a candidate for percutaneous coronary intervention of some of his residual disease depending on his symptoms going forward.
3. Further recommendations after his robotic LIMA to the LAD.

63. On Monday, June 17, Mr. Yarbrough was in fact transferred to Emory St. Joseph's. (GMC 190; ESJ 76.)

Admit Date:	06/04/19
Discharge Date:	06/17/19
Discharge Disposition:	02,IP - DC - Hospital (acute care hospita)
Age:	64
Sex:	M
Attending MD:	10777,VENKATESH,KOTA

Admit Date: 06/17/19 06:31 PM
Discharge Date: 06/25/19 09:30 PM
LOS: 8
Financial Class: Medicare A
Disposition: 02 - SHORT TERM HOSPITAL
Admitting Physician: Halkos, Michael E
Attending Physician: Halkos, Michael E
Consulting Physician: Gonzalez, Adriana
Chang, George Lee
Handelsman, Cory
Maloney, John Martin III
Admission Type: 2-Urgent
Admission Source: 4 - TRANSER FROM OTH HOSP
Patient Type: Inpatient
Hospital Service: Thoracic Surgery

64. At Emory St. Joseph's, Mr. Yarbrough was prepared for bypass surgery to occur on Friday, June 21. (ESJ 100-09, 126-32, 118-25.)

DOCUMENT NAME:	History and Physical Hospital
SERVICE DATE/TIME:	6/18/2019 11:20 EDT
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Earnshaw,Madhuree (6/18/2019 11:21 EDT)
SIGN INFORMATION:	Diwa,Renjay (7/16/2019 22:51 EDT); Halkos,Michael E (6/21/2019 10:47 EDT); Earnshaw,Madhuree (6/18/2019 13:56 EDT)

Cardiothoracic Surgery H&P

Mr. Ronald Yarbrough is a 64 y/o male who was transferred from GMC to STJEM for robotic CABG evaluation. He had recenlty undergone a right colectomy and partial colectomy for a non-cancerous lesion and developed a NSTEMI during post op recovery. His PMH is significant for DM-2 (10 years), CKD, HLD, chronic back pain, BPH, osteogenic imperfecta and c-dificile. He is followed by Dr. Naland Shanoy for his diabetes and was last seen 2 weeks ago. He manages his diabetes with a VGO 30, glyburide 2.5, Actos 30mg and Humalog sliding scale. He also wears a Freestyle Libre. He is up to date with his diabetic eye exam, and reports his last A1c to be 7.6%. He will be undergoing a robotic CABG by Dr. Halkos on Firday. Cur service has been consulted for diabetes management within the context of impending CABG.

This is a 64 year old male with past medical history significant for HTN, HLD, PAF, CKD stage III, IDDM, BPH, osteogenesis imperfecta who was transferred from Gwinnett Medical Center to ESJH on 6/17/19 for surgical evaluation. On 6/4/19 he underwent righ: colectomy and partial omentectomy due to colon ulcer with adenomatous tissue. Pathology was negative for malignancy. He became hypoxic and complained of chest pain during the post-op period. He was walking POD 1 from colon surgery and felt shoulder and chest burning. Work up was negative for a PE and showed elevated troponin. He was diagnosed with NSTEMI and underwent LHC that demonstrated revealed 95% pLAD, 90% ramus, 40-50% ramus, 40-50% pCx, 90% dCx (small), 40% RCA. He recently completed vancomycin therapy for C0diff, which has since tested negative. He is being evaluated by Dr. Halkos for robotic LIMA-LAD. Dr. Chang has been consulted to evaluate the patient for Hybrid revascularization.

65. From the afternoon of Friday, June 21 through the early morning of Saturday, June 22, Mr. Yarbrough underwent an approximately 10-hour cardiac surgery. (ESJ 147-61.)

Case Times SJH OR

	Entry 1
SN - Set-Up	
SN - Patient	
In Time	06/21/19 14:04:00
Out Time	06/22/19 00:42:00
SN - Anesthesia	
Anesthesia Ready	06/21/19 14:12:00
SN - Surgery	
Start Time	06/21/19 15:20:00
Stop Time	06/22/19 00:36:00
SN - Clean-Up	
Last Modified By:	Watson, Sheree 06/22/19 00:41:03

66. The surgery encountered complications that required switching from a minimally-invasive, robot-assisted approach to a sternotomy. Mr. Yarbrough experienced ventricular arrhythmias and hypokinesis during the surgery. At the close of surgery, Mr. Yarbrough appeared reasonably stable. (ESJ 157-61.)

pedicle. As we were getting ready to close, there was some bleeding noted from around the anastomosis and it appeared that there was a tear just above the anastomosis and the mammary which may have been from lung insufflation. We were able to control bleeding after reheparinizing with 5000 units to get a better look and to see exactly what happened. At this point, I did not feel we could proceed any further safely with a minimally invasive approach, and therefore, we made the decision to proceed with a sternotomy to be able to redo the anastomosis. At this point, under controlled conditions we were able to proceed with a median sternotomy without any difficulty. At the same time,

...

He was entirely stable. As we began to close the chest, however, he began developing ventricular arrhythmias. The chest was reopened. He had several bouts of V-tach which responded to cardioversion. However, given this new finding, I felt that we needed to carefully inspect our grafts to make sure there was not a bypass graft problem. The chest was reopened. We recannulated the ascending aorta as well as the right atrium and went back on cardiopulmonary bypass. The lie of both grafts was excellent. The proximal

...

The right ventricle and inferior wall and lateral wall function was excellent. The basal and midanterior walls were excellent, but there was persistent septal as well as apical hypokinesis. He remained stable on modest doses of inotropes. We watched in the operating room for approximately 2 hours after coming off cardiopulmonary bypass. Hemostasis was reasonable. Chest tubes were placed. Two ventricular wires were placed. The chest was closed in the usual fashion with sternal wires, 1 PDS for fascia, 3-0 Monocryl for subcutaneous tissue, 4-0 Monocryl for skin. After a prolonged period of stability, we felt it was safe to proceed upstairs to the ICU for ongoing resuscitation and monitoring.

67. On Saturday, June 22, after the surgery, at about 8 AM, a hospital progress note suggests that Mr. Yarbrough remained intubated and on a ventilator but appeared stable. (ESJ 259-62.)

Subjective
24h interval
complex operation overnight
now intubated, with iabp, but weaned to minimal vent support
awakens to voice, nonfocal

68. Twenty-four hours later, by 8 AM on Sunday, June 23, Mr. Yarbrough was showing signs of kidney failure. (ESJ 255-59.)

Impression and Plan
Impression: 64M POD2 robotic converted to open CABGx2

-intubated and sedated
-iabp +pressors and low dose inotropes
-nonfocal exam and minimal vent support
-poor diuretic response, acute kidney injury but still with adequate uop

Plan
-blood transfusion, hgb target 9, will give 1u prbc this am
-80lasix/500 diuril after blood
-wean to extubate this am
-iabp trial for tomorrow am

69. Another day later, by about 11 AM Monday, June 24, Mr. Yarbrough's condition had become critically ill, with cardiogenic shock and respiratory instability as well as kidney failure. (ESJ 237-50.)

Respiratory
Pulmonary insufficiency following surgery (ICD10-CM J80, Discharge, Medical).
Cardiovascular
Atherosclerotic heart disease of native coronary artery with unstable angina pectoris (ICD10-CM I25.110, Discharge, Medical).
Other cardiomyopathies (ICD10-CM I42.8, Discharge, Medical).
Postoperative shock, cardiogenic (ICD10-CM T81.11XA, Discharge, Medical).
Nephrology
Acute kidney failure, unspecified (ICD10-CM N17.9, Discharge, Medical).
Hematology
Postoperative anemia due to acute blood loss (ICD10-CM D62, Discharge, Medical).
Infectious Disease
Enterocolitis due to Clostridium difficile (ICD10-CM A04.7, Discharge, Medical).
Endocrine
Type 2 diabetes mellitus without complications (ICD10-CM E11.9, Discharge, Medical).
Counseled: Patient.

Comments
Time Spent
The patient is critically ill and requires continued critical care treatment.
I have spent 70 minutes in critical care management directly related to this patient and/or with family regarding medical decision making issues.
The critical care time documented above does not include time spent on other procedures performed on this patient.
Critical condition(s) addressed for impending deterioration include
Respiratory.
Cardiovascular.
Central nervous system.
Metabolic.
Renal.

70. Another day later, on Tuesday, June 25, Mr. Yarbrough had deteriorated more. (ESJ 196-210.)

Last 24 Hour Events: POD #4, very unstable overnight requiring increasing doses of Norepi and Vasopressin. Angiotensin 2 was started by CTS. He is on CRRT, but unable to take much fluid off due to persistent hypotension. Pulmonary status has worsened significantly due to diffuse pulmonary edema. No urine out, CTD is well controlled. Very tenuous. D/W Dr Halkos and Dr Miller. Repeatedly at bedside throughout the day. Ultimately, the decision has been made to proceed to A-V ECMO and LV support with Femoral Impella instead of the IABP. Hopefully, that will allow cardiac recovery, but the prognosis is still very guarded if the patient can survive the procedure at all. Coordinated the procedure with Dr George Chang, Invasive Cardiology and Dr. Meni from EUH, transplant/ECMO surgeon. Whether patient after procedure and stabalization will remain at ESJH or transfer to EUH is still yet TBD. The patient is currently in the cath lab for the procedure.

71. That day, June 25, Mr. Yarbrough was transferred to Emory University Hospital. (EUH 84.)

Title: ICD-10 Inpatient Coding Summary
Hospital Name: Emory University Hospital
Hospital Address: 1364 Clifton Road
Hospital City/State/Zip: Atlanta, GA 30
Patient Name: YARBROUGH, RONALD HENRY
Sex: M
Birth Date:
MR Number: EUH2514270
Account Number: EUH014677749176
Admit Date: 06/25/19 10:31 PM
Discharge Date: 07/12/19 03:50 PM

72. Over the next 2-1/2 weeks, Mr. Yarbrough's family watched him deteriorate and made the decision to let him pass away. (EUH 85, 92.)

```
Admit Diagnosis (Code/Text): R570 Cardiogenic shock
Principal Diagnosis (POA/Code/Text): Y T8111XA Postprocedural cardiogenic shock, initial
encounter
Secondary Diagnosis (POA/Code/Text): Y @ I214 Non-ST elevation (NSTEMI) myocardial
infarction
N @ R402114 Coma scale, eyes open, never, 24 hours or more after hospital admission
N @ R402214 Coma scale, best verbal response, none, 24 hours or more after hospital
admission
N @ R402314 Coma scale, best motor response, none, 24 hours or more after hospital
admission
N @ I608 Other nontraumatic subarachnoid hemorrhage
Y @ N170 Acute kidney failure with tubular necrosis
Y @ K7200 Acute and subacute hepatic failure without coma
N @ I6389 Other cerebral infarction
Y @ A419 Sepsis, unspecified organism
Y @ E43 Unspecified severe protein-calorie malnutrition
Y @ J158 Pneumonia due to other specified bacteria
Y @ J95821 Acute postprocedural respiratory failure
E # Q780 Osteogenesis imperfecta
N # K2210 Ulcer of esophagus without bleeding
N # K920 Hematemesis
N # I472 Ventricular tachycardia
N # R0489 Hemorrhage from other sites in respiratory passages
Y # D62 Acute posthemorrhagic anemia
Y # A0472 Enterocolitis due to Clostridium difficile, not specified as recurrent
N # G9340 Encephalopathy, unspecified
N # E872 Acidosis
N # K625 Hemorrhage of anus and rectum
N # E873 Alkalosis
N   Z66 Do not resuscitate
N   Z515 Encounter for palliative care
Y   Y832 Surgical operation with anastomosis, bypass or graft as the cause of abnormal
```

Addendum by Caridi-Scheible, Mark E on July 13, 2019 07:07

Pt without return of awareness despite no sedation x1 week, continues with ARDS high vent settings and renal failure. Over prior 24 hours had to be shocked over 23 times and multiple anti-arrhythmic agents given to maintain adequate ejection. Discussed with family that given his prolonged multi-organ failure he would not be candidate for any durable therapy and with certainty would not survive to meaningful recovery. Family was understanding of situation and patient made DNR with intention to separate from ECMO and allow a natural death.

73. On July 12, 2019, Mr. Yarbrough died.

GEORGIA DEATH CERTIFICATE

State File Number 2019GA000041921

1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last)	1a. IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX	2a. DATE OF DEATH (Mo., Day, Year)
RONALD HENRY YARBROUGH		MALE	ACTUAL DATE OF DEATH 07/12/2019

74. Mr. Yarbrough died from organ failure caused by cardiogenic shock.

32. Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, Or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.		Approximate interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	A. MULTI-SYSTEM ORGAN FAILURE	3 WEEKS
	Due to, or as a consequence of B. CARDIOGENIC SHOCK	3 WEEKS
	Due to, or as a consequence of C. CORONARY ARTERY DISEASE	3 WEEKS

75. If Dr. Friedland and CardioVascular Group had done their jobs, Mr. Yarbrough's LAD stenosis could have been addressed safely and timely, and the June 2019 post-surgery heart attack and premature death could have been avoided.

76. If Mr. Yarbrough's LAD stenosis had been identified and addressed properly in October 2018, Mr. Yarbrough likely would have lived at least another 10 years.

Miscellaneous

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

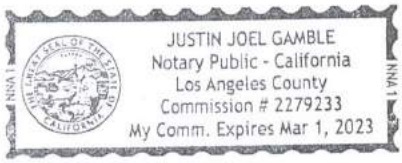
78. Again, I hold each opinion expressed in this affidavit to a reasonable degree of medical probability or certainty; that is, more likely than not.

Meldon Levy MD

Meldon C. Levy, MD

SWORN TO AND SUBSCRIBED before me

4/04/16, 2020



NOTARY PUBLIC

My Commission Expires: 03-01-2023

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

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

CURRICULUM VITAE

Personal Information

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

Education

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

Professional Background

Academic Appointments	Clinical Instructor in Medicine, University of California Los Angeles, 1977-1979 Assistant Clinical Professor in Medicine, University of California, Los Angeles, 1979-1984 Assistant Clinical Professor in Medicine, Keck School Medicine, University of Southern California, Los Angeles, 2008 to present
Administrative Responsibilities	Director, Cardiac Noninvasive Laboratory, Century City Hospital, Los Angeles, 1978-2000 Chief of Staff, Century City Hospital, Los Angeles, 1987-1989 Chairman, Governing Board, Century City Hospital, Los Angeles, 1997-1999 Medical Director, Beverly Glen Medical Systems, Los Angeles, 2000-2002 Chief of Cardiology, Century City Doctors Hospital, Los Angeles, 2005-2007 Director, Cardiac Noninvasive Laboratory, Century City Doctors Hospital, 2005-2008 Chairman, Critical Care Committee, Century City Doctors Hospital, 2005-2008
Awards and Achievements	Testamur, ASEeXAM, August 7, 1997

Military Service None

Other Employment or Activity

President, Housestaff Association, Cedars-Sinai Medical Center, Los Angeles, 1973-1974
Member, Medical Executive Committee, Century City Hospital, Los Angeles, 1980-1991
Member, Governing Board, Century City Hospital, Los Angeles, 1987-2000
Member, Utilization Review Committee, Cedars-Sinai Medical Center, Los Angeles, 1985-1994
Member, Medical Executive Committee, Century City Doctors Hospital, Los Angeles, 2005-2008

Society Memberships

Local

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

National

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

Research Activities

Principal Investigator

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

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

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

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

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

Research Activities (cont'd)
Principal Investigator

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

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

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

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

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

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

Research Activities (cont'd)
Principal Investigator

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

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

Bibliography

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

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

AFFIDAVIT OF MARCIA BELL, RN, BSN, CAPA
REGARDING RONALD YARBROUGH

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Marcia Bell, RN, who after first being duly sworn, states as follows:

Introduction and Limited Purpose of Affidavit

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

2. This affidavit states my views of the matters discussed below — views I formed from my review of the evidence. However, Plaintiff's counsel drafted this document in consultation with me. Plaintiff's counsel did the typing, supplied the snapshots from medical records, the legalese, the formatting, etc., and inserted the general factual narrative from the medical records. The substantive analysis and opinions are mine.

3. This affidavit does not attempt to state or summarize all my opinions. This affidavit addresses specific matters that Plaintiff's counsel have asked me to examine for purposes of testimony at trial. I have not attempted to identify every person who may have violated a standard of care. Nor have I attempted to identify every standard of care violation by any particular person. If additional information becomes available later, then of course my opinions may change.

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

EXHIBIT 2

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

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

Topic & Opinions

7. This affidavit concerns medical services provided to Ronald Yarbrough in May 2019 by the pre-admit screening staff of Gwinnett Hospital System.

8. More specifically, this affidavit concerns the standards for clearing a patient for surgery.

9. I believe the pre-admit screening staff of Gwinnett Hospital System violated their standards of care by failing to obtain proper medical clearance from Dr. Lance Friedland, Ronald Yarbrough's cardiologist, for the colectomy scheduled for Mr. Yarbrough.

10. I believe the pre-admit screening staff of Gwinnett Hospital System violated their standards of care by failing to identify relevant medical tests and inform the anesthesia team of the tests and results.

Qualifications

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

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

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

14. The acts or omissions at issue here occurred in October 2018 and May 2019.

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

a. In May 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

Specifically, I was licensed by the State of Maryland to practice as a registered nurse. That's where I was practicing in May 2019.

b. In May 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the area of screening a patient for a scheduled surgery, including obtaining and recording medical clearance from the patient's physicians.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to May 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I am a registered nurse and for several years have routinely been responsible for conducting pre-surgery screenings of patients, including obtaining medical clearance for the surgery.

Evidence Reviewed

16. I have reviewed Ronald Yarbrough's medical records from CardioVascular Group, Southern Endoscopy Suite, Colon and Rectal Clinic, and Gwinnett Medical Center.

Discussion and Factual Basis for Opinion

General Principles

17. When a patient is scheduled for a non-urgent surgery, the surgical facility is responsible for conducting a screening of the patient, to ensure that the patient can safely undergo the surgery.

18. Part of the pre-surgery screening process is to obtain medical clearance from the patient's treating physicians.

19. The screening staff must obtain medical clearance directly from the treating physicians, in writing. If exigent circumstances preclude written clearance, the screening staff must personally speak to the clearing physician and document the substance of the discussion.

20. The requirement for written clearance serves an important role in preventing mistakes: The written-clearance requirement ensures there is no mistake of identity about what patient is being cleared, or about what surgical operation the patient is being cleared for. The requirement for written (as opposed to telephonic) clearance also ensures that the treating physician has a full opportunity to review the relevant parts of the patient's medical chart, before giving a clearance.

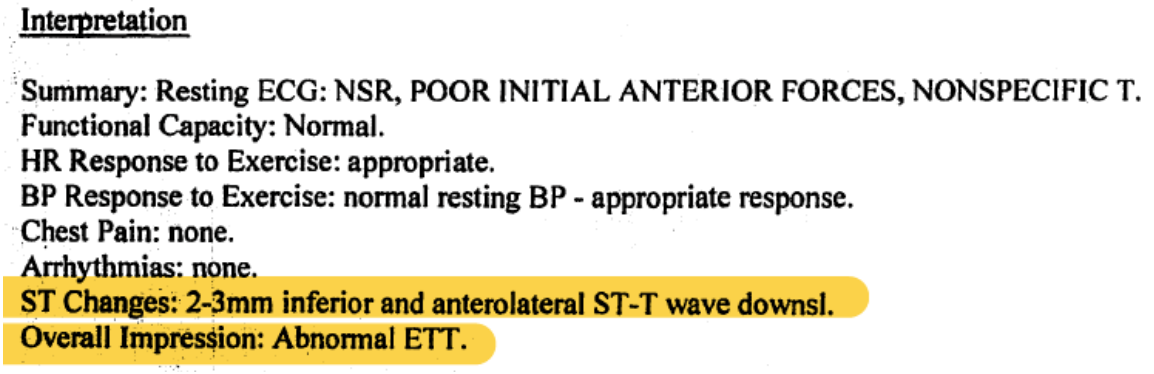
21. Part of the pre-surgery screening process is to identify relevant medical tests and to inform the anesthesia team of those tests and results, so the anesthesiologist can personally assess the patient's fitness for the operation.

22. Mistakes in the medical clearance process can cause catastrophic harm to the patient.

Ronald Yarbrough's Course of Treatment

23. On March 7, 2017, upon a referral from Ronald's primary care physician, Dr. Robert Deimler, Ronald underwent a stress test — an exercise treadmill test (ETT) — at Gwinnett Medical Center.

24. Dr. Louis Heller reviewed the ETT results. Dr. Heller noted "ST Changes: 2-3 mm inferior and anterolateral ST-T wave downsl." Dr. Heller's overall impression was "Abnormal ETT." (CVG 22-23.)



Interpretation

Summary: Resting ECG: NSR, POOR INITIAL ANTERIOR FORCES, NONSPECIFIC T.
Functional Capacity: Normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: 2-3mm inferior and anterolateral ST-T wave downsl.
Overall Impression: Abnormal ETT.

25. Because of the abnormal ETT, Ronald was scheduled for an exercise dual isotope myocardial perfusion scan (DIMPS). Dr. Lance Friedland reviewed the results of the DIMPS and found it to be normal, noting "There is no evidence of Ischemia or Infarction at a maximal level of exercise." (CVG 14-16.)

```
!FINDINGS:
!Normal Exercise Dual Isotope Myocardial Perfusion Scan
!There is no evidence of Ischemia or Infarction at a maximal level of
!exercise. Diaphragm attenuation.
!Normal LV Systolic Function. LVEF 67%.
+-------------------------------------------------------------------
!Recommendation
+-------------------------------------------------------------------
!Continue medical therapy.
!Risk factor modification.
!Follow up with Ordering physician and/or primary physician.
+-------------------------------------------------------------------
!Signatures
+-------------------------------------------------------------------
!-------------------------------------------------------------
!Electronically signed by Friedland, Lance MD(Interpreting
!cardiologist) on 03/08/2017 19:12
!-------------------------------------------------------------
```

26. On October 15, 2018, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group and ordered a CT calcium scoring examination. (CVG 6-9.)

YARBROUGH, RONALD H

Date of visit: 10/15/2018

. . .

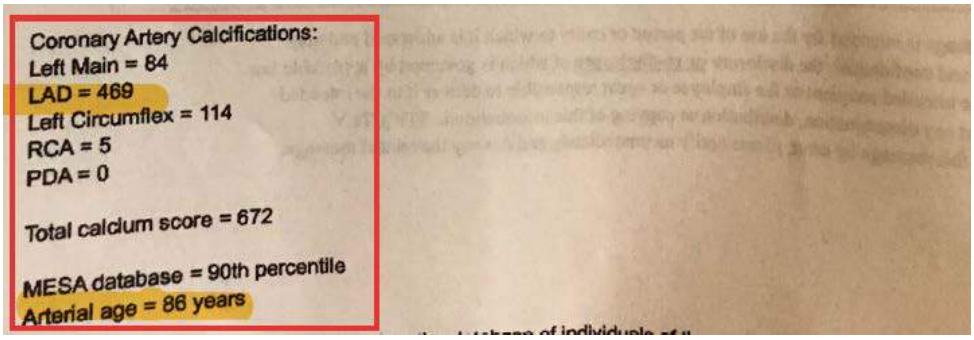
IMPRESSION/PLAN

1. Chest pains, resolved. He had a normal stress DIMPS March 7, 2017 with left ventricular ejection fraction of 67%..

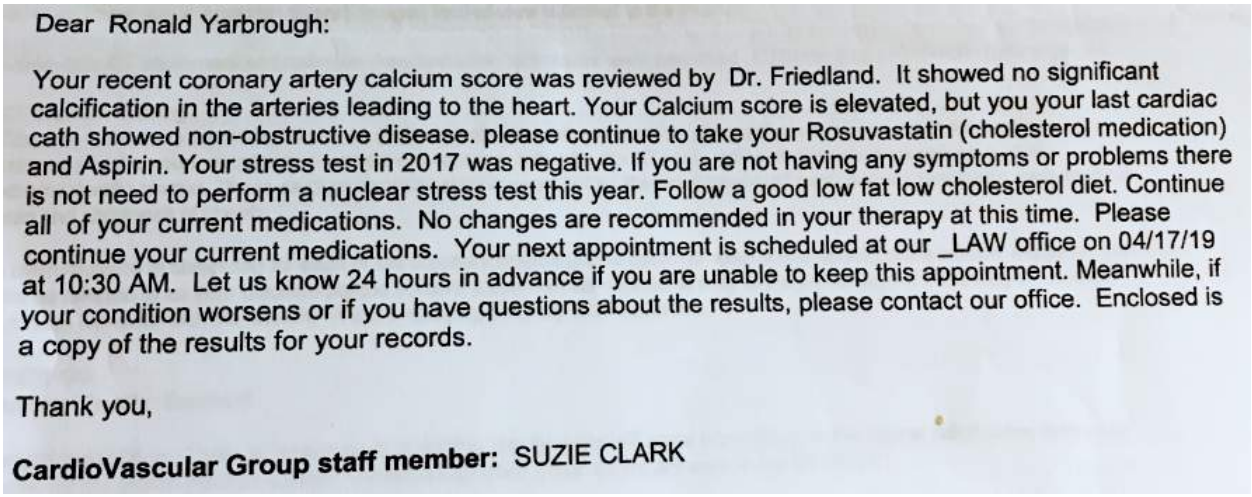
He has a history of minor nonobstructive coronary artery disease by cardiac catheter in 2006.
2. Paroxysmal atrial fib. His episode was in 2000 and he has not had any recurrent symptoms. Echocardiogram March 7, 2017 showed normal left and right ventricular function.
3. Essential hypertension, stable on his current medical regimen. He'll monitor his blood pressure home.
4. Hyperlipidemia on statin and Zetia. His lipid profile is at goal. He was encouraged to watch his diet lose weight and exercise.
5. Diabetes mellitus type 2 followed by endocrinology
6. Osteogenesis imperfecta
7. Chronic low back pains on pain meds.
8. Chronic kidney disease, III.

TODAYS ORDERS
1. Coronary Calcium Score: First Available
2. Diet_mgmt_edu,_guidance_and_counseling: TODAY
3. Patient Electronic Access: Today
4. 12 Lead EKG: Today
5. Return Visit: 6 months

27. On October 26, 2018, Mr. Yarbrough went to the Gwinnett Hospital System for a noncontrast CT scan of his heart, which provided calcium scoring. The report for that exam noted that Mr. Yarbrough's coronary artery calcification score in his left anterior descending artery ("LAD") was 469.



28. On October 30, 2018, CardioVascular Group sent a letter to Mr. Yarbrough, telling him in essence that his calcium scoring results were unconcerning.



Dear Ronald Yarbrough:

Your recent coronary artery calcium score was reviewed by Dr. Friedland. It showed no significant calcification in the arteries leading to the heart. Your Calcium score is elevated, but you your last cardiac cath showed non-obstructive disease. please continue to take your Rosuvastatin (cholesterol medication) and Aspirin. Your stress test in 2017 was negative. If you are not having any symptoms or problems there is not need to perform a nuclear stress test this year. Follow a good low fat low cholesterol diet. Continue all of your current medications. No changes are recommended in your therapy at this time. Please continue your current medications. Your next appointment is scheduled at our _LAW office on 04/17/19 at 10:30 AM. Let us know 24 hours in advance if you are unable to keep this appointment. Meanwhile, if your condition worsens or if you have questions about the results, please contact our office. Enclosed is a copy of the results for your records.

Thank you,

CardioVascular Group staff member: SUZIE CLARK

29. The letter from CardioVascular Group specifically indicated that Dr. Friedland had noted Mr. Yarbrough's elevated calcium score, but went on to cite an old cardiac catheterization and a 2017 stress test as alleviating concerns from the calcium score. ("Your Calcium score is elevated, but your last cardiac cath showed non-obstructive disease. . . . Your stress test in 2017 was negative.")

30. Dr. Friedland's October 2018 office note referred to a cardiac catheterization from 2006 (twelve years earlier) and a stress test from March 2017 (1-1/2 years earlier). (CVG 7.)

PAST HISTORY
Past Medical Illnesses: insomnia, anxiety, DM-non-insulin dependent, depression, GERD, history of colon polyps, Osteogenesis Imperfecta, renal insufficiency
Cardiovascular Illnesses: hyperlipidemia-Mixed, hypertension, Minor Nonobstructive CAD 2006, atrial fibrillation-paroxysmal
Infectious Diseases: mumps, measles and chickenpox during childhood, pertussis
Surgical Procedures: bilateral shoulder surgery- rotator cuff
Cardiology Procedures-Invasive: cardiac cath (left) May 2006
Cardiology Procedures-Noninvasive: Holter monitor May 1991, echocardiogram May 1991, myocardial perfusion study (Nuclear) September 2002, myocardial perfusion study (Nuclear) March 2017, echocardiogram March 2017, carotid Doppler March 2017
Left Ventricular Ejection Fraction: LVEF of 67% documented via nuclear study on 03/07/2017

Peripheral Vascular Procedures: carotid doppler March 2017

31. Months later, in 2019, Mr. Yarbrough suffered abdominal pain for which he went to a hospital Emergency Room. In response to his abdominal problems, a colonoscopy and endoscopy were planned. Before those procedures, Mr. Yarbrough returned to Dr. Friedland.

32. On May 6, 2019, Dr. Friedland examined Mr. Yarbrough at CardioVascular Group. Dr. Friedland understood that Ronald had been to the ER for abdominal pain and that Ronald was scheduled for a colonoscopy and endoscopy. (CVG 2-3.)

HISTORY OF PRESENT ILLNESS
Delightful 64-year-old white male comes the office today for follow-up of his paroxysmal atrial fibrillation and nonobstructive coronary artery disease.

The patient denies any cardiac symptoms. He's trying to be active but does have chronic low back pains on opiates. He is watching his diet. He is currently using an insulin pump system. The patient denies any shortness of breath, chest pains, palpitations, orthopnea, dizziness, syncope, PND,or nausea. He was evaluated in the emergency room at Eastside for abdominal pains and was started on Zantac. He is scheduled to have a colonoscopy and upper endoscopy this week.

33. Dr. Friedland's office note made no reference to Mr. Yarbrough's CT calcium scoring from October 2018. (CVG 2-5.)

IMPRESSION/PLAN

1. Chest pains, resolved. He had a normal stress DIMPS March 7, 2017 with left ventricular ejection fraction of 67%..

   He has a history of minor nonobstructive coronary artery disease by cardiac cath in 2006.
2. Paroxysmal atrial fib. His episode was in 2000 and he has not had any recurrent symptoms.

MRNO: 388262 Page 3 of 4 Create Date: 2019-5-6

CVG 0004

Echocardiogram March 7, 2017 showed normal left and right ventricular function.

3. Essential hypertension, stable on his current medical regimen. He'll monitor his blood pressure home.
4. Hyperlipidemia on statin and Zetia. His lipid profile is at goal. He was encouraged to watch his diet lose weight and exercise.
5. Diabetes mellitus type 2 followed by endocrinology
6. Osteogenesis imperfecta
7. Chronic low back pains on pain meds.
8. Chronic kidney disease, III.

34. On May 9, 2019, Mr. Yarbrough underwent a colonoscopy that revealed benign polyps in his colon, including a non-obstructive mass for which the gastroenterologist referred Mr. Yarbrough for a surgical consult. (SGA 64-67.)

appendiceal orifice, and rectum were photographed.

Findings:

- The perianal and digital rectal examinations were normal.
- The terminal ileum appeared normal.
- Multiple small and large-mouthed diverticula were found in the sigmoid colon, descending colon and transverse colon.
- A fungating, polypoid and ulcerated non-obstructing large mass was found in the proximal ascending colon. The mass was circumferential. The mass measured two cm in length and was just distal to the IC valve. No bleeding was present. Biopsies were taken with a cold forceps for histology. Area was tattooed with an injection of 3 mL of Spot (carbon black). Estimated blood loss: none.

Recommendation:

- Await pathology results.
- Discontinue aspirin and NSAIDs.
- Check labs now as ordered.
- Refer to a colo-rectal surgeon at the next available appointment. Contact information for Dr. Venkatesh provided and my staff is attempting to schedule an appointment per family request.
- Repeat colonoscopy in 1 year for surveillance.
- Return to my office at the next available appointment.
- Patient has a contact number available for emergencies. The signs and symptoms of potential delayed complications were discussed with the patient. Return to normal activities tomorrow. Written discharge instructions were provided to the patient.

35. On May 15, 2019, Mr. Yarbrough saw a surgeon, Dr. Kota Venkatesh, to consider a colon resection. (CRCb 6-8.)

05/15/2019 **Progress Notes: Kota Venkatesh MD**

Current Medications

Taking

- Atenolol 25 MG Tablet 1 tablet Orally Once a day, Notes: 12.5 mg
- Actos 30 MG Tablet 1 tablet Orally Once a day
- GlyBURIDE 2.5 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day
- BusPIRone HCl 5 MG Tablet 1 tablet Orally Three times a day, Notes: 2/day
- Zetia 10 MG Tablet 1 tablet Orally Once a day
- Simvastatin 80 MG Tablet 1 tablet in the evening Orally Once a day
- Sertraline HCl 100 MG Tablet 1 tablet Orally Once a day, Notes: 150 mg
- Tizanidine HCl 6 MG Capsule 1 capsule as needed Orally Three times a day, Notes: 8/mg
- Turmeric 1053 MG Tablet as directed

Reason for Appointment

1. Ascending colon ulcerative mass/polyp (pain 0/10)

Assessments

1. Epigastric pain - R10.13
2. Polyp of colon - K63.5

Treatment

1. Epigastric pain

Notes: Fungating, polypoid, Recommended Laparoscopic Right Colon Resection, possible open.The risks, benefits, and alternatives were discussed extensively with the patient and documented in the informed consent form. Risks including bleeding, infection, allergic reaction, scar formation, paralysis, brain damage, cardiac arrest, death, injury to adjacent structures, sexual/urinary problems, injury to ureters, and need for ostomy if there was a leak from the anastomosis,were discussed with the patient and the patient wants to proceed with it. ulcerated, nonobstructing large mass in the proximal ascending colon. Biopsy revealed adenomatous tissue.

36. On May 23, 2019, Mr. Yarbrough went through a pre-admission screening at Gwinnett Hospital, by Nakia Vasey-Evans, RN. The screening included a discussion of cardiological conditions. Mr. Yarbrough told the hospital staff that he experienced tachycardia, hyperlipidemia, and difficulty with certain tasks. (GMC 319-31 at 324.)

MEDICAL CONDITIONS/HISTORY

CARDIOLOGY

HISTORY OF CARDIOVASCULAR DISEASE: Yes

Page 5 of 13 on 05/23/2019 14:32

DESCRIPTION: Other
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
COMMENT: TACHYCARDIA

DESCRIPTION: Other
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
MOST RECENT: 5/23/19
COMMENT: ACTIVITY: YARDWORK, CLIMB STAIRS, ADL'S W/O CP OR SOB

DESCRIPTION: Hyperlipidemia
CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04
CURRENT: Yes
PAST: Yes

RESPIRATORY

37. The preadmit testing record indicates "medical consents/clearance" by Dr. Robert Deinler (internal medicine) and by Dr. Friedland. These consents were recorded by Nurse Vasey-Evans. (GMC 329.)

MEDICAL CONSENTS/CLEARANCE

DATE/TIME: 05/23/2019 12:56 RECORDED BY: VASEY-EVANS, NAKIA - RN
PRIMARY PHYSICIAN NAME: DR. ROBERT DEINLER
PHYSICIAN TYPE: internal medicine

DATE/TIME: 05/23/2019 12:58 RECORDED BY: VASEY-EVANS, NAKIA - RN
PRIMARY PHYSICIAN NAME: DR. LANCE FREIDLAND
PHYSICIAN TYPE: cardiologist

38. In the records from Gwinnett Hospital System, I see no written clearance from Dr. Friedland.

39. In the records from CardioVascular Group, I see no written clearance from Dr. Friedland.

40. Nor do I see any indication of a telephone call between Nurse Vasey-Evans and Dr. Friedland, in which Dr. Friedland provided medical clearance. Even if such a telephone call had been conducted, however, it would not meet the standard for medical clearance for a non-urgent surgery, unless unusual circumstances prevented the nurse from obtaining written clearance. And if such unusual circumstances had existed, the standard of care would require the nurse to

document the substance of the oral discussion in which Dr. Friedland cleared Mr. Yarbrough for surgery.

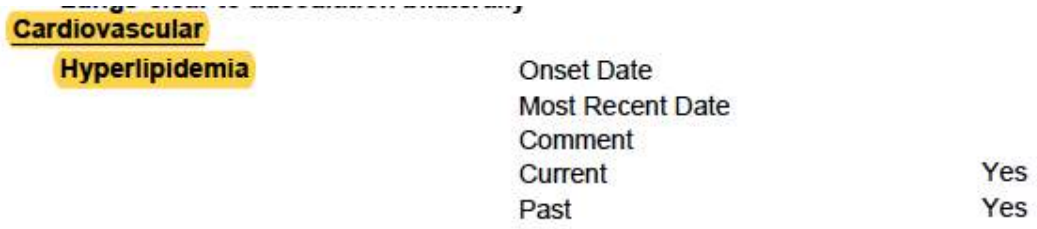
41. I believe Nurse Vasey-Evans violated the standard of care by failing to obtain proper medical clearance from Dr. Friedland.

42. Additionally, it does not appear from the records that Nurse Vasey-Evans identified the relevant medical tests for Mr. Yarbrough — including his CT calcium scoring result — or informed the anesthesia team of those tests and results.

43. On June 4, 2019, before the surgery, Mr. Yarbrough was assessed by Nurse Anderson. Her assessment documented the same cardiological information as given in the May 23 pre-admit screening. This June 4 screening did not correct the deficiencies in the May 23 screening. Nurse Anderson also violated the standard of care by failing to obtain proper medical clearance from Dr. Friedland. (GMC 334.)

44. Additionally, it does not appear from the records that Nurse Anderson identified the relevant medical tests for Mr. Yarbrough — including his CT calcium scoring result — or informed the anesthesia team of those tests and results.

45. On June 4, 2019, before the surgery, Mr. Yarbrough underwent a pre-anesthesia evaluation, which reviewed the same cardiological information as given in the May 23 pre-admit screening. This June 4 screening did not correct the deficiencies in the May 23 screening. (GMC 285-86.)



PRE-ANESTHESIA EVALUATION
Account #: 1915580326

Other

Onset Date	
Most Recent Date	5/23/19
Comment	ACTIVITY: YARDWORK, CLIMB STAIRS, ADL'S W/O CP OR SOB
Current	Yes
Past	

Renal/Urogen

46. On the afternoon of Tuesday, June 4, 2019, Mr. Yarbrough underwent the colectomy. (CRCb 9-10.)

Date of Procedure: 06/04/2019

SURGEON: Kota R Venkatesh MD

PREOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

POSTOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

NAME OF PROCEDURE: Laparoscopic right colectomy with partial omentectomy.

47. About a day and a half after the surgery, while Mr. Yarbrough recovered, in the early morning hours of Thursday, June 6, 2019, Mr. Yarbrough showed signs of cardiac distress. At approximately 1:00 AM on June 6, cardiologist Dr. Martin B. Siegfried examined Mr. Yarbrough. Dr. Siegfried noted that Mr. Yarbrough was experiencing chest pain with elevated troponin levels. Dr. Siegfried suspected demand ischemia.

DOS: 06/06/2019
ROOM#:

CONSULTANT: MARTIN R SIEGFRIED, MD
REFERRING PHYSICIAN: KOTA R VENKATESH, MD

REASON FOR CONSULTATION: Sinus tachycardia.

CLINICAL IMPRESSION:
1. Chest pain with troponin 0.105. No acute ischemic changes on electrocardiogram. Patient is tachycardic and had an episode of hemoptysis, coughing out a blood clot. On a setting of chest pain, shortness of breath, tachycardia, and coughing up blood clots, will need to rule out possible pulmonary embolism.
2. Elevated troponin, possible demand ischemia, status post surgery with chronic kidney disease. He is also tachycardic, heart rate in the 130s. Will need to rule out possible acute coronary syndrome if troponin continues to trend up significantly.

48. Several hours later, at approximately 0930 hours, another cardiologist, Dr. Salil Patel, noted that Mr. Yarbrough's troponin levels continued to rise and noted that the EKG suggested myocardial ischemia with sinus tachycardia. (GMC 204, 240)

HISTORY OF PRESENT ILLNESS: The patient was seen overnight. He is having some chest pain, had some reported hemoptysis this morning, he is somnolent. He denies chest pain, denies shortness of breath. His wife and one of the friends who is a nurse here in the hospital are at the bedside. He looks very different than he did yesterday. His troponins have gone from 0.1-0.257. Creatinine 1.5. VQ scan read as low probability. He is 2 days status post laparoscopic right colectomy.

PHYSICAL EXAMINATION: On my exam, somnolent, awakens to voice, falls right back to sleep. Heart sounds are tachycardic. Neck veins are not distended. GI is soft and quiet bowel sounds are not heard. Respirations are shallow with no audible rales or rhonchi.

LABORATORY DATA: His EKG reviewed by me shows is suggestive of myocardial ischemia with sinus tachycardia.

The patient's echo shows a large anterior apical wall motion abnormality consistent with an anterior MI. Repeat echo shows improvement in ST depression. He denies having current chest pain. His x-ray did show some pulmonary edema. He got Lasix.

49. On Friday, June 7, Dr. Priya Baronia noted that Mr. Yarbrough had suffered a non-ST-elevation myocardial infarction and would probably have a heart catheterization the following Monday. (GMC 241.)

DOS: 06/07/2019
ROOM#:

SUBJECTIVE: Patient is sitting up in chair, awake, confused. Family is at bedside. Complaining of some chest discomfort. HE is on the heparin drip. No bleeding anywhere. No shortness of breath.

OBJECTIVE: Vital Signs: Afebrile. Pulse 85, respiration 25, blood pressure 131/62, 98% saturating on room air. General Appearance: No distress. HEENT: Atraumatic, normocephalic. Pupils equal, reactive to light. Chest: Clear. No wheezing. No crackles. Cardiovascular: S1, S2, regular. No murmurs. Abdomen: Soft, nondistended, nontender. Bowel sounds present. Extremities: No edema.

LABORATORY DATA: Reviewed. Hemoglobin is 11.3, platelets 160.

ASSESSMENT AND PLAN:
1. Non-ST-elevation myocardial infarction. Cardiology is on the case. He will probably go for heart cath on Monday. Meanwhile, continue with the heparin drip and the medications.
2. Recent laparoscopic right colectomy and partial omentectomy on 06/04/2019.
3. Ascending colon ulcer with adenomatous tissue and Dr. Venkatesh is on the case.
4. Diabetes type 2. Blood glucose well controlled.
5. Pulmonary infiltrates. Continue with as needed breathing treatments, Zosyn, and diurese as needed per cardiology.
6. Chronic kidney disease stage III.
7. Order chest x-ray for tomorrow morning _____ .

50. On Saturday, June 8, cardiologist Dr. Siegfried noted that a heart catheterization had been delayed to allow time for the healing of the surgical bed. (GMC 244.)

DOS: 06/08/2019
ROOM#:

The patient is seen in his room. His wife and several family members are at the bedside. He had a colon surgery recently, and looks like he has had a non-STEMI. The maximum troponin is only 0.74 and trending downward. He is on heparin and tolerating it well. Catheterization has been delayed until Monday to allow time for the healing of the surgical bed. He did have an ultrasound done which showed evidence of a wall motion abnormality in the LAD territory. A repeat ultrasound was done this morning. It has not yet been read. Vital signs and labs are as per the note written by the APP.

PHYSICAL EXAMINATION: Eyes: EOMI. PERRL. Ears, Nose, Mouth And Throat: Mucous membranes are moist. No lesions are noted. Neck: Supple without JVD. Lungs: Clear to auscultation with good air movement. Cardiac: Regular rate without murmurs, rubs or gallops. Abdomen: Soft, nontender, nondistended. Bowel sounds are quiet. Extremities: Two-plus pulses without cyanosis, clubbing or significant lower extremity edema. Psychiatric: Alert and oriented x3 with normal affect. Neurologic: Cranial nerves II through XII are grossly intact.

IMPRESSION:
1. Non-ST elevation myocardial infarction.
a. Peak troponin 0.7.
b. Left heart cath is planned for Monday.
c. Wall motion abnormality involving the mid to distal left anterior descending territory.
d. Previous cath 2006 suggested mild nonobstructive disease.
2. Colectomy, omentectomy.
3. Diabetes.
4. Kidney disease.
5. Hyperlipidemia.

51. On Sunday, June 9, Dr. Siegfried noted that Mr. Yarbrough likely suffered a focal LAD disease. (GMC 247.)

DOS: 06/09/2019
ROOM#:

This is a CVG cardiology progress note.

The patient is seen in his room. He is pain-free. He is sitting at the bedside. He is on heparin. He had a non-STEMI with a peak troponin of 0.7 after GI surgery. His echo shows a wall motion abnormality involving the entire anteroseptal wall, which is likely due to focal LAD disease. A cath in 2006 showed only luminal irregularities. He is scheduled for cath tomorrow.

52. On Monday, June 10, Dr. Rodica Ellis noted that Mr. Yarbrough had been referred to cardiac surgery for a coronary artery bypass evaluation, due to severe arterial disease and ischemic cardiomyopathy. (GMC 249.)

IMPRESSION AND PLAN:
1. Hypomagnesemia, replete. The patient will be on replacement protocol.
2. Clostridium difficile on p.o. vancomycin. Would continue perioperatively, and then afterwards perhaps another week at least. He is improved.
3. Severe coronary artery disease, was referred to cardiovascular surgery for a coronary artery bypass graft evaluation.
4. Ischemic cardiomyopathy with ejection fraction 45%.
5. Chronic kidney disease stage III at baseline.
6. Status post right colectomy on June 4, postoperative day #6 for ascending colon ulcer with adenomatous tissue. Dr. Venkatesh following the patient.
7. Type 2 diabetes. Continue Lantus and sliding scale. The patient still with elevated blood sugars. Will increase the Lantus.

Discussed with patient in the presence of his wife.

53. By about 11 AM Monday, June 24, Mr. Yarbrough's condition had become critically ill, with cardiogenic shock and respiratory instability as well as kidney failure. (ESJ 237-50.)

Respiratory
Pulmonary insufficiency following surgery (ICD10-CM J80, Discharge, Medical).
Cardiovascular
Atherosclerotic heart disease of native coronary artery with unstable angina pectoris (ICD10-CM I25.110, Discharge, Medical).
Other cardiomyopathies (ICD10-CM I42.8, Discharge, Medical).
Postoperative shock, cardiogenic (ICD10-CM T81.11XA, Discharge, Medical).
Nephrology
Acute kidney failure, unspecified (ICD10-CM N17.9, Discharge, Medical).
Hematology
Postoperative anemia due to acute blood loss (ICD10-CM D62, Discharge, Medical).
Infectious Disease
Enterocolitis due to Clostridium difficile (ICD10-CM A04.7, Discharge, Medical).
Endocrine
Type 2 diabetes mellitus without complications (ICD10-CM E11.9, Discharge, Medical).
Counseled: Patient.

Comments
Time Spent
The patient is critically ill and requires continued critical care treatment.
I have spent 70 minutes in critical care management directly related to this patient and/or with family regarding medical decision making issues.
The critical care time documented above does not include time spent on other procedures performed on this patient.
Critical condition(s) addressed for impending deterioration include
Respiratory.
Cardiovascular.
Central nervous system.
Metabolic.
Renal.

54. On Tuesday, June 25, Mr. Yarbrough was transferred to Emory University Hospital. (EUH 84.)

Title: ICD-10 Inpatient Coding Summary
Hospital Name: Emory University Hospital
Hospital Address: 1364 Clifton Road
Hospital City/State/Zip: Atlanta, GA 30
Patient Name: YARBROUGH, RONALD HENRY
Sex: M
Birth Date:
MR Number: EUH2514270
Account Number: EUH014677749176
Admit Date: 06/25/19 10:31 PM
Discharge Date: 07/12/19 03:50 PM

55. Over the next 2-1/2 weeks, Mr. Yarbrough's family watched him deteriorate and made the decision to let him pass away. (EUH 85, 92.)

Admit Diagnosis (Code/Text): R570 Cardiogenic shock
Principal Diagnosis (POA/Code/Text): Y T8111XA Postprocedural cardiogenic shock, initial encounter
Secondary Diagnosis (POA/Code/Text): Y @ I214 Non-ST elevation (NSTEMI) myocardial infarction
N @ R402114 Coma scale, eyes open, never, 24 hours or more after hospital admission
N @ R402214 Coma scale, best verbal response, none, 24 hours or more after hospital admission
N @ R402314 Coma scale, best motor response, none, 24 hours or more after hospital admission
N @ I608 Other nontraumatic subarachnoid hemorrhage
Y @ N170 Acute kidney failure with tubular necrosis
Y @ K7200 Acute and subacute hepatic failure without coma
N @ I6389 Other cerebral infarction
Y @ A419 Sepsis, unspecified organism
Y @ E43 Unspecified severe protein-calorie malnutrition
Y @ J158 Pneumonia due to other specified bacteria
Y @ J95821 Acute postprocedural respiratory failure
E # Q780 Osteogenesis imperfecta
N # K2210 Ulcer of esophagus without bleeding
N # K920 Hematemesis
N # I472 Ventricular tachycardia
N # R0489 Hemorrhage from other sites in respiratory passages
Y # D62 Acute posthemorrhagic anemia
Y # A0472 Enterocolitis due to Clostridium difficile, not specified as recurrent
N # G9340 Encephalopathy, unspecified
N # E872 Acidosis
N # K625 Hemorrhage of anus and rectum
N # E873 Alkalosis
N Z66 Do not resuscitate
N Z515 Encounter for palliative care
Y Y832 Surgical operation with anastomosis, bypass or graft as the cause of abnormal

Addendum by Caridi-Scheible, Mark E on July 13, 2019 07:07
Pt without return of awareness despite no sedation x1 week, continues with ARDS high vent settings and renal failure. Over prior 24 hours had to be shocked over 23 times and multiple anti-arrthymic agents given to maintain adequate ejection. Discussed with family that given his prolonged multi-organ failure he would not be candidate for any durable therapy and with certainty would not survive to meaningful recovery. Family was understanding of situation and patient made DNR with intention to separate from ECMO and allow a natural death.

56. On July 12, 2019, Mr. Yarbrough died.

GEORGIA DEATH CERTIFICATE

State File Number 2019GA000041921

1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last)	1a. IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX	2a. DATE OF DEATH (Mo., Day, Year)
RONALD HENRY YARBROUGH		MALE	ACTUAL DATE OF DEATH 07/12/2019

57. The death certificate says Mr. Yarbrough died from organ failure caused by cardiogenic shock.

32. Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, Or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.		Approximate interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	A. MULTI-SYSTEM ORGAN FAILURE	3 WEEKS
	Due to, or as a consequence of B. CARDIOGENIC SHOCK	3 WEEKS
	Due to, or as a consequence of C. CORONARY ARTERY DISEASE	3 WEEKS

Miscellaneous

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

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

Marcia L. Bell

Marcia Bell, RN

SWORN TO AND SUBSCRIBED before me

May 6, 2020

Pamela Haidt Lee

NOTARY PUBLIC

My Commission Expires:

PAMELA HAIDT LEE
NOTARY PUBLIC
My Commission Expires
03-07-2022
GWINNETT COUNTY, GEORGIA

CURRICULUM VITAE

MARCIA LYNN BELL, RN, BSN, CAPA
9863 Wilderness Lane
Laurel, MD 20723
Cell Phone: (410) 660-7025
Email: marciablnc@yahoo.com

EDUCATION

RN, Roberts Wesleyan College, B.S. in Nursing, magna cum laude, 1981

CERTIFICATION

CAPA, Certified Ambulatory Perianesthesia Nurse, American Society of Perianesthesia Nurses, 11/2010, renewed 10/2016

PROFESSIONAL EXPERIENCE

April 2015 to present
Mercy Medical Center, Baltimore, MD

- Responsibilities: Preop, Phase 1 and Phase 2 PACU staff RN
- Duties: preoperative and post anesthesia care of adult patients receiving general, spinal, and local anesthesia; receive and review medical histories and physicals, discharge teaching; extensive experience with general surgery, orthopedic surgery, plastic surgery, GYN surgery; ACLS and PALS certified; cross-trained to Phase I

September 2011 to December 2012
Piney Orchard Surgery Center, Odenton, MD

- Responsibilities: PACU prn staff nurse
- Duties: post anesthesia care of pediatric and adult patients receiving general and local anesthesia; discharge teaching; ENT surgery cases only

November 1996 to April 2016
SurgiCenter of Baltimore, Owings Mills, MD

- Responsibilities: PACU and preop staff RN
- Duties: preoperative and post anesthesia care of pediatric and adult patients receiving general, spinal, and local anesthesia; receive and review medical histories and physicals, discharge teaching, chart review for over 10 years, conduct studies from medical records; extensive experience with general surgery, endoscopy procedures, orthopedic surgery, ENT surgery, plastic surgery, GYN surgery, and urology; ACLS and PALS certified; occasional circulator for pain procedures

February 1996 to November 1996
Thornton, Summers, Biechlin**,** Dunham & Brown, L.C., San Antonio, TX

- Resposibilities: nurse legal assistant for defense malpractice attorney
- Duties: wrote summaries of medical records, developed chronologies of medical records, wrote interrogatories and requests for production

November 1991 to February 1996
San Antonio Surgery Center, San Antonio, TX

- Resposibilities: PACU and preop staff RN
- Duties: patient care, discharge teaching, follow-up calls

April 1991 to December 1991
Medical Personnel Pool, Favorite Nurses, San Antonio Nurses Unlimited, San Antonio, TX

- Responsibilities: Agency Nurse: Intensive Care Units, Recovery Room
- Duties: patient care

May 1989 to January 1991
Willis Knighton Medical Center, Shreveport, LA

- Responsibilities: PACU staff nurse
- Duties: post anesthesia care of patients receiving general, spinal, local, and epidural anesthesia; set up PCA and epidural pumps; recovered all ICU patients except open heart; took call two or three nights per week, ACLS certified

October 1987 to May 1989
LSU Medical Center, Shreveport, LA

- Responsibilities: PACU Staff Nurse, Policy and Procedure Committee member
- Duties: post anesthesia care of patients receiving general, spinal, local, and epidural anesthesia; recovered ICU patients when bed in the unit was not available, took call every third weekend

March 1987 to October 1987
LSU Medical Center, Shreveport, LA

- Responsibilities: SICU Staff Nurse
- Duties: took care of patients with ventilators, balloon pumps, invasive lines, open heart surgery, trauma, general surgery, and neurosurgery

August 1985 to February 1987
St. Francis Medical Center, Monroe, LA

- Responsibilities: SICU/MICU staff nurse
- Duties: took care of patients with ventilators, balloon pumps, invasive lines, open heart surgery, trauma, general surgery, and neurosurgery; ran charge often on days and evenings; ACLS certified; taught neuro lecture to new RNs.

January 1984 to July 1985

Maryland Institute Of Emergency Medical Services Systems, Baltimore, MD

- Responsibilites: Staff Nurse, NeuroTrauma Unit
- Duties: took care of two acute or three subacute patients with head and spinal cord trauma; worked with ventilators, chest physiotherapy, invasive lines, Richmond bolts, intraventricular catheters; emphasis on primary nursing and family centered care.

May 1983 to December 1983

South Baltimore General Hospital, Baltimore, MD

- Responsibilites: Charge Nurse, Ortho/Neuro unit
- Duties: ran charge in absence of head nurse; preoperative and postoperative care; evaluated RNs, LPNs, and aides.

June 1981 to April 1983

The Johns Hopkins Hospital, Baltimore, MD

- Responsibilites: Staff Nurse, Ortho/General Surgery unit
- Duties: preoperative and postoperative care; ran charge often; worked with patients with total hip, knee, and shoulder prosthesis, Harrington rods, fractures, abdominal surgery, thoracic surgery, and vascular surgery; primary nursing care system.

PROFESSIONAL QUALIFICATIONS

Current:
BLS (Basic Life Support) Certification
ACLS (Advanced Life Support) Certification
PALS (Pediatric Life Support) Certification
CAPA (Certified Ambulatory Perianesthesia Nurse) Certification

PROFESSIONAL MEMBERSHIPS

American Society of Perianesthesia Nurses (ASPAN)

PUBLICATIONS

Bell, Marcia L. “Pregnancy Testing Policy Reviewed”, AAASC Newsletter, Fall 2001.

Reviewed 1/30/18