In the State Court of Muscogee County
State of Georgia

CORY BROWN, individually and as representative of the estate of JEFFREY TODD BROWN,

Plaintiff,

— versus —

WILLIAM E. TAYLOR, MD,

COLUMBUS SURGICAL SPECIALISTS, LLC,

JAMES E. HULL, DO,

SOUTHEASTERN HOSPITALIST SERVICES, PC,

MICHAEL N. METRY, MD,

ST. FRANCIS HEALTH, LLC,

LIFEPOINT HEALTH, INC,

EMORY HEALTHCARE, INC,

EMORY HEALTHCARE SERVICES MANAGEMENT, LLC, and

JOHN/JANE DOE 1-10,

Defendants.

CIVIL ACTION

FILE _____

JURY TRIAL DEMANDED

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of This Action

1. This medical-malpractice action concerns medical services negligently and tortiously provided to 49-year-old Jeffrey Brown before and during his hospitalization at St. Francis Hospital, in Columbus, Georgia ("St. Francis" or "Hospital"), in December 2019, resulting in Jeffrey's wrongful death.

2. This action is brought by Jeffrey's wife, Cory Brown ("Plaintiff" or "Cory"), individually and on behalf of Jeffrey's estate.

3. As representative of the estate, Plaintiff asserts a claim for harm Jeffrey suffered as a result of the negligent and tortious conduct alleged here.

4. Plaintiff also asserts a wrongful-death claim pursuant to OCGA Title 51, Chapter 4, on behalf of all wrongful-death beneficiaries.

5. Pursuant to OCGA § 9-11-9.1, the affidavits of Surgeon Stephen M. Cohen, MD, MBA; Intensivist Gerardo P. Carino, MD, PhD; Internist Jonathan M. Schwartz, MD, MBA; and Nurse Judith Climenson, RN, are attached as Exhibit 1-4, respectively. This Complaint incorporates the opinions and allegations in those affidavits.

6. As used here, the phrase "standard of care" means the degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to Defendants' conduct here.

7. This Complaint relies largely on uncontroversial medical principles and facts.

8. This is a straightforward case:

   a. In an outpatient procedure, Surgeon William Taylor excised a lesion from Jeffrey's rectum, plus additional tissue as margins. Pathologist Clinton McElroy found that the lesion had only a stage-1 cancer, that Dr. Taylor had excised the entire lesion, and that the margins were negative for carcinoma and even dysplasia.

   b. Nevertheless, misrepresenting those findings, Dr. Taylor urged Jeffery to undergo LAR surgery—a major surgery to excise part of his bowel. Dr. Taylor then performed the non-indicated surgery, without obtaining Jeffrey's actual informed consent.

   c. Three days later, after Dr. Taylor and Intensivists Michael Metry and James Hull had failed to treat Jeffrey with antibiotics, fecal matter appeared in Jeffrey's surgical drain.

   d. Although the fecal matter was a clear sign of an anastomotic leak and fecal peritonitis, Dr. Taylor did not even try to achieve timely source-control. In fact, for about 24 hours, Dr. Taylor and Dr. Hull failed even to obtain a CT-scan, to confirm or rule out the leak and peritonitis.

   e. By the time Dr. Taylor performed a laparotomy to fix the anastomotic leak, Jeffrey was critically ill with septic shock and organ failure. Three days later, after cardiac arrest, he was dead from multi-system organ failure.

Parties, Jurisdiction, and Venue[1]

9. **Plaintiff Cory Brown** is a citizen and resident of Georgia.

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

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

10. **Defendant William Ernest Taylor, MD,** is a citizen of Georgia. He may be served at his residence, 7579 River Crest Drive, Columbus, GA 31904-2027 (Muscogee County). Dr. Taylor has been properly served with this Complaint.

11. Dr. Taylor is subject to the personal jurisdiction of this Court.

12. Dr. Taylor is subject to venue in this Court because he is a resident of Muscogee County, and one of his co-defendants is subject to venue here.

13. At all times relevant to this Complaint, Dr. Taylor acted as an employee or other agent of Columbus Surgical Specialists, LLC.

14. **Defendant Columbus Surgical Specialists, LLC ("CSS")** is a Georgia limited liability company. Registered Agent: Andy Roddenbery, MD. Physical address and principal office: 2223 Wildwood Circle, Columbus, GA 31906 (Muscogee County). CSS has been properly served with this Complaint.

15. CSS is subject to the personal jurisdiction of this Court.

16. CSS is subject to venue in this Court, because CSS maintains its registered office in Muscogee County; because the cause of action originated in, and CSS has an office and transacts business in, Muscogee County; and because one of CSS's co-defendants is subject to venue here.

17. At all times relevant to this Complaint, CSS was the employer or other principal of Defendant William E. Taylor. If another entity was his employer or other principal during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

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.

OCGA § 9-10-31 provides that, "joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in different counties, may be subject to an action as such in the same action in any county in which one or more of the defendants reside."

18. **Defendant James Edward Hull, DO,** is a citizen of Michigan. Dr. Hull may be served at his residence, 8793 Pine Island Court S, Mattawan, MI 49071-9555. Dr. Hull has been properly served with this Complaint.

19. Dr. Hull is subject to the personal jurisdiction of this Court.

20. Pursuant to OCGA § 9-10-93, Hull is subject to venue in this Court, because the cause of action arose in Muscogee County and because one of his co-defendants is a Georgia resident subject to venue here.

21. At all times relevant to this Complaint, Dr. Hull acted as an employee or other agent of Southeastern Hospitalist Services, P.C.

22. **Defendant Southeastern Hospitalist Services, P.C. ("SHS")** is a Georgia professional corporation. Registered Agent: Corporation Service Company. Physical Address: 2 Sun Court, Suite 400, Peachtree Corners, GA, 30092 (Gwinnett County). Principal Office Address: 265 Brookview Centre Way, Suite 400, Knoxville, TN 37919. SHS has been properly served with this Complaint.

23. SHS is subject to the personal jurisdiction of this Court.

24. SHS is subject to venue in this Court, because the cause of action originated in, and SHS has an office and transacts business in, Muscogee County, and because one of SHS's co-defendants is subject to venue here.

25. At all times relevant to this Complaint, SHS was the employer or other principal of Defendant James E. Hull. If another entity was his employer or other principal during those times, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

26. **Defendant Michael Najeeb Metry, MD,** is a citizen of Georgia. He may be served at his residence, 8209 Frank Houser Avenue, Columbus, GA 31909-2492, or 7215 Grand View Court, Columbus, GA 31904-1988 (both, Muscogee County). Dr. Metry has been properly served with this Complaint.

27. Dr. Metry is subject to the personal jurisdiction of this Court.

28. Dr. Metry is subject to venue in this Court, because he is a resident of Muscogee County, and one of his co-defendants is subject to venue here.

29. **Defendant St. Francis Health, LLC ("St. Francis Health")** is a Delaware limited liability company. Registered Agent: Neal Callahan. Physical Address: 111 12th Street, Suite 300, Columbus, GA 31902 (Muscogee County). Principal Office: 330 Seven Springs Way, Brentwood, TN 37027. St. Francis Health has been properly served with this Complaint.

30. St. Francis Health is subject to the personal jurisdiction of this Court.

31. St. Francis Health is subject to venue in this Court, because St. Francis Health maintains its registered office in Muscogee County; because the cause of action originated in, and St. Francis Health has an office and transacts business in, Muscogee County; and because one of St. Francis Health's co-defendants is subject to venue here.

32. At all times relevant to this Complaint, St. Francis Health was the employer or other principal of Nurses Lauren Duncan, Heather Novak, and Adam Creech, as well as other nurses who provided care to Mr. Brown at St. Francis during those times.

33. In addition, at all times relevant to this Complaint, St. Francis Health managed, operated, or administered St. Francis Hospital.

34. **Defendant LifePoint Health, Inc.** ("LifePoint") is a Delaware corporation. Registered Agent: The Corporation Trust Company. Physical Address: Corporation Trust Center, 1209 Orange Street, Wilmington, DE 19801. Business address: 330 Seven Springs Way, Brentwood, TN 37027. LifePoint has been properly served with this Complaint.

35. LifePoint is subject to the personal jurisdiction of this Court.

36. LifePoint is subject to venue in this Court, because the cause of action originated in, and LifePoint has an office and transacts business in, Muscogee County, and because one of LifePoint's co-defendants is subject to venue here.

37. At all times relevant to this Complaint, LifePoint was the employer or other principal of Nurses Lauren Duncan, Heather Novak, and Adam Creech, as

well as other nurses who provided care to Mr. Brown at St. Francis during those times.

38. In addition, at all times relevant to this Complaint, LifePoint owned, managed, operated, and administered St. Francis Hospital.

39. **Defendant Emory Healthcare, Inc. ("Emory Healthcare")** is a Georgia nonprofit corporation. Registered Agent: Amy Adelman. Physical address: 201 Dowman Drive NE, 101 Administration Building, Atlanta, GA 30322 (Dekalb County). Emory Healthcare has been properly served with this Complaint.

40. Emory Healthcare is subject to the personal jurisdiction of this Court.

41. Emory Healthcare is subject to venue in this Court, because the cause of action originated in, and Emory Healthcare has an office and transacts business in, Muscogee County, and because one of Emory Healthcare's co-defendants is subject to venue here.

42. At all times relevant to this Complaint, Emory Healthcare was the employer or other principal of Nurses Lauren Duncan, Heather Novak, and Adam Creech, as well as other nurses who provided care to Mr. Brown at St. Francis during those times.

43. In addition, at all times relevant to this Complaint, Emory Healthcare managed, operated, or administered St. Francis Hospital.

44. **Defendant Emory Healthcare Services Management, LLC ("EHSM")** is a Georgia limited liability company. Registered Agent: Amy Adelman. Physical Address: Emory University, 201 Dowman Drive, 312 Administration Building, Atlanta, GA 30322 (Dekalb County). Principal Office: 1365 Clifton Road, Atlanta, GA 30322. EHSM has been properly served with this Complaint.

45. EHSM is subject to the personal jurisdiction of this Court.

46. EHSM is subject to venue in this Court, because the cause of action originated in, and EHSM has an office and transacts business in, Muscogee County, and because one of EHSM's co-defendants is subject to venue here.

47. At all times relevant to this Complaint, EHSM was the employer or other principal of Nurses Lauren Duncan, Heather Novak, and Adam Creech, as

well as other nurses who provided care to Mr. Brown at St. Francis during those times.

48. In addition, at all times relevant to this Complaint, EHSM managed, operated, or administered St. Francis Hospital.

49. Herein, "Emory Defendants" refers collectively to Defendants Emory Healthcare, Inc., and Emory Healthcare Services Management, LLC.

50. If an entity other than St. Francis Health, LifePoint, or the Emory Defendants was the employer or other principal of Nurse Duncan, Nurse Novak, Nurse Creech, or a nurse who provided care to Mr. Brown at St. Francis Hospital during the times relevant to this Complaint, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

51. If an entity other than St. Francis Health, LifePoint, or the Emory Defendants managed, operated, or administered St. Francis Hospital during the times relevant to this Complaint, that entity is hereby on notice that, but for a mistake concerning the identity of the proper party, this action would have been brought against that entity.

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

53. No Defendant has a defense to this action based on undue delay, whether based on the statute of limitations, the statute of repose, laches, or any other similar theory.

54. This Court has subject-matter jurisdiction over this case.

General Medical Principles

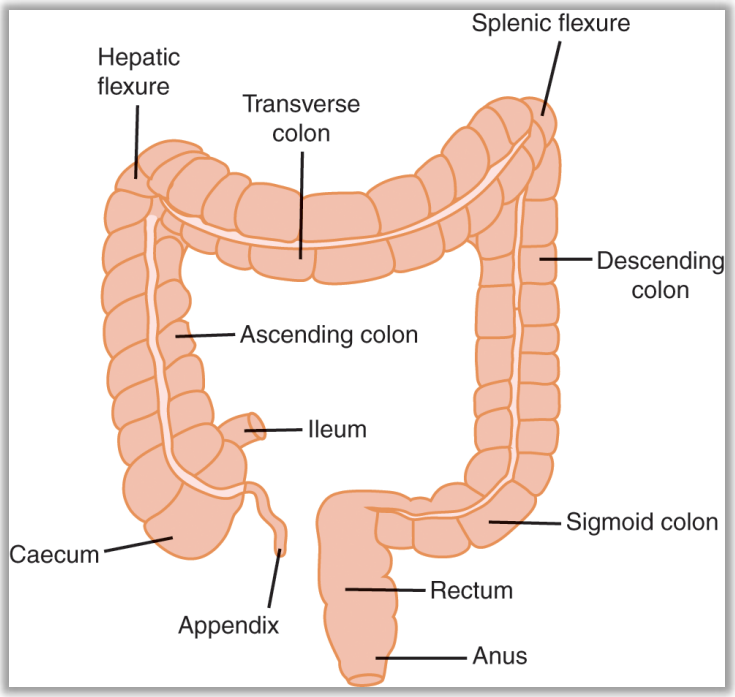
The Large Intestine

55. The digestive system includes the small intestine (small bowel) and the large intestine (large bowel).

56. The ileum is the name for the last section of the small intestine.

57. The large intestine is made up of the colon, which is about 5 feet long, and the rectum, which is about 12 inches long.

58. As food passes from the ileum into the large intestine, it travels up the ascending colon, across the transverse colon, and down the descending colon.



59. After food passes the sigmoid colon, the colon pushes waste into the rectum, where it collects until it is expelled in a bowel-movement.

Intestinal Wall

60. The large intestine is tube-shaped. The canal inside is called the lumen.

61. The wall of the large intestine consists of the following layers, from inner-most to outer-most:

    a. The mucosa, the inner lining of the large intestine. (Nearly all colorectal cancers start in the mucosa.)

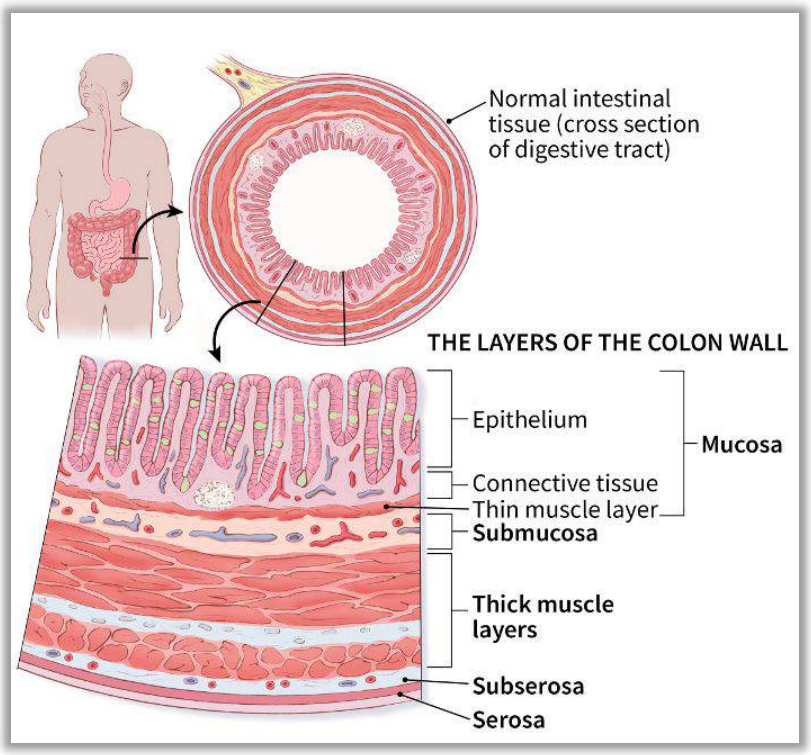
    b. The submucosa, a fibrous tissue.

c. Thick layers of muscle, called muscularis externa or muscularis propria.

d. The subserosa and serosa, the outermost layers of connective tissue.

62. The serosa and subserosa cover the colon but not the rectum.

63. The mucosa consists of the epithelium, connective tissue, and a thin layer of muscle called the muscularis mucosa.



64. The epithelium is thus the innermost lining of the large intestine.

65. The epithelium is a thin layer of gland-like cells called epithelial cells.

The Lymphatic System

66. The lymphatic (or lymph) system is part of the body's immune system.

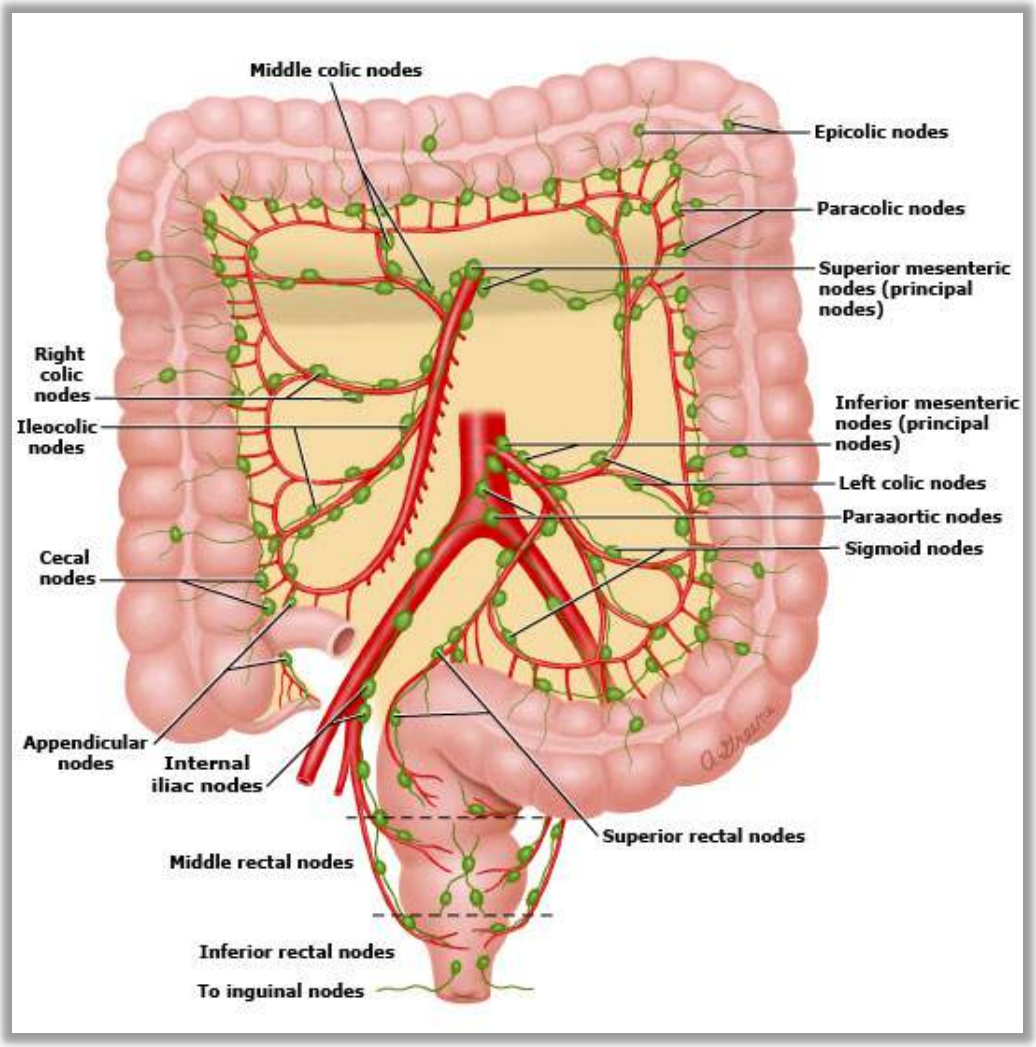
67. The lymphatic system works like a filtration system.

68. The lymphatic system includes lymph nodes and lymph vessels.

69. Lymph nodes are small bean-shaped structures arranged in clusters.

70. The clusters are concentrated in the neck, armpits, groin, chest, and abdomen.

71. There are hundreds of lymph nodes throughout the body. Some are located deep inside the body, between the lungs and around the large intestine.



72. Lymph nodes are connected to one another through lymph vessels.

73. Lymph vessels carry a clear watery fluid called lymphatic fluid, or lymph.

74. Lymph contains white blood cells called lymphocytes.

75. Lymph drains from all the tissues of the body through the channels of the lymphatic vessels to nearby lymph nodes, for filtering.

76. Lymph nodes work as filters for foreign substances, such as infections and cancer cells.

77. When an infection or cancer activates the immune system, lymphocytes may multiply to fight off the disease.

78. As lymphocytes multiply, the lymph may become swollen.

79. Adenopathy is the disease or swelling of the glands, including the lymph nodes. Lymphadenopathy is swelling of the lymph nodes specifically.

80. Doctors often use adenopathy as a shorthand for lymphadenopathy.

81. Each lymph node filters the substances picked up by the lymph vessels that flow into the node.

82. Lymph fluid from the fingers, for example, works its way to the chest, joining lymph fluid from the arms. Lymph nodes at the elbows and underarms filter this lymph fluid.

83. Germs and cancer cells may spread through the predictable channels of the lymphatic system.

84. Cancer can appear in the lymph nodes in two ways. It can start in the lymph nodes themselves or it can spread to them from another place in the body.

85. Cancer that starts in the lymph nodes is called lymphoma.

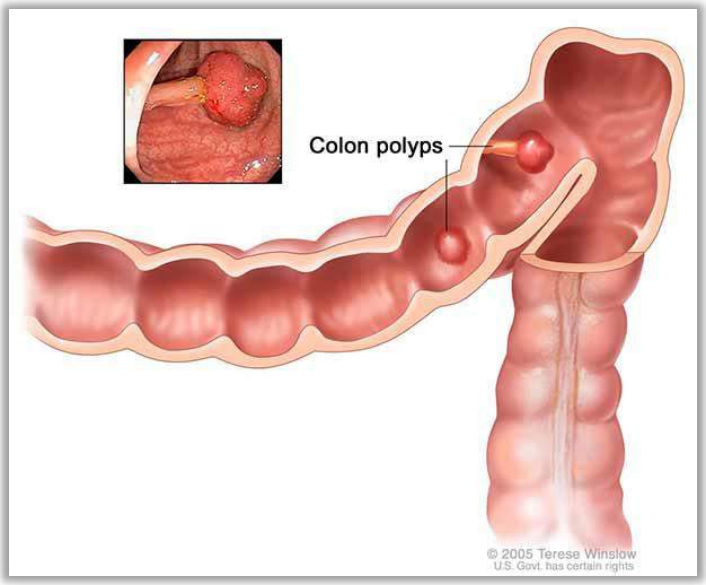
86. More often, as further explained below, cancer starts elsewhere and spreads to the lymph nodes, through the predictable channels of the lymphatic system.

Polyps

87. A polyp is an abnormal growth on the epithelium (the inner intestinal lining) that protrudes into the lumen (the intestinal canal).

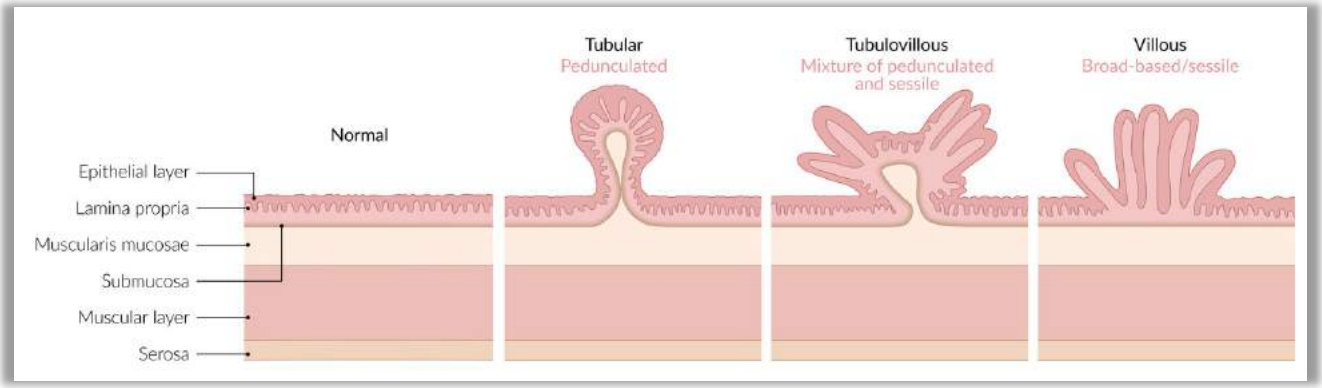
88. Polyps are common. About 50% of people 60 or older have at least one polyp.

89. The risk of having polyps increases with age.



90. Viewed with the naked eye, polyps may be classified by shape as either pedunculated (mushroom-shaped) or sessile (flat, with a broad base).

91. Viewed under a microscope, polyps may be classified by shape into these three types: tubular, villous, or tubulovillous.



92. Viewed through a microscope, a polyp may also be described as "serrated," meaning that it has a saw-tooth appearance.

93. Sometimes doctors refer to a polyp or polyp-like growth as a "polypoid lesion" or "polypoid mass," or simply "lesion" or "mass."

Adenocarcinoma

94. Polyps are considered benign (noncancerous), but they may become malignant (cancerous) as they grow.

95. A hyperplastic polyp is an increase in the number of cells in tissue. The cells reproduce (proliferate) faster than normal (hyperproliferation).

96. Hyperplastic polyps are benign and have no significance.

97. A hyperplastic polyp, however, may grow into an adenomatous polyp, also called an adenoma.

98. An adenoma is a benign (noncancerous) growth that starts in the epithelial tissue—in the organs and structures that have such tissue.

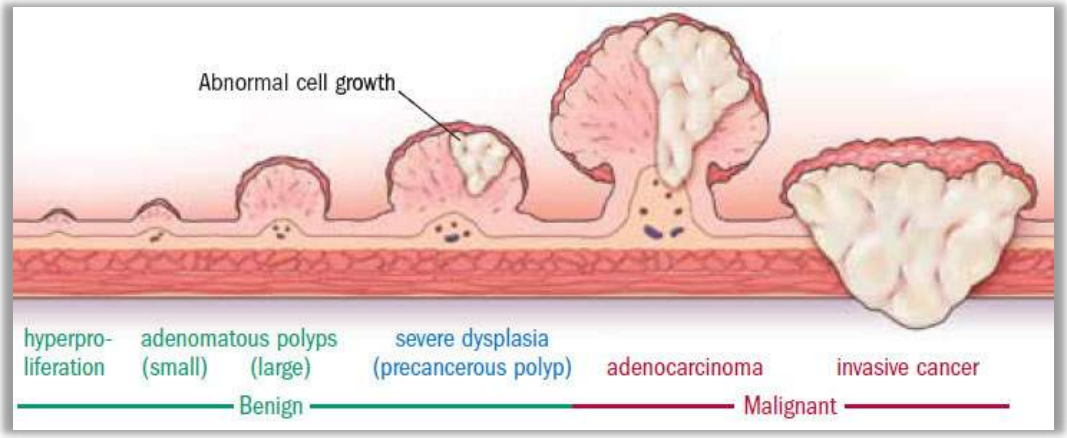
99. An adenoma with dysplasia is considered precancerous because it may grow into a malignant (cancerous) tumor if not removed or otherwise treated.

100. A patient who has an adenoma with dysplasia has increased risk of developing cancer at the site of the adenoma if the adenoma is not removed.

101. As explained below, the word "dysplasia" describes the degree to which a polyp looks abnormal under a microscope without yet being cancer.

102. Less than 10% of adenomas turn into invasive cancer, but over 95% of colorectal cancers develop from adenomas.

103. In general, all adenomas of the colon must be completely removed.



104. An adenoma with severe dysplasia may grow into an adenocarcinoma.

105. An adenocarcinoma is a malignant (cancerous) growth.

106. Adenocarcinoma starts in epithelial tissue and develops inside an organ.

107. Adenocarcinoma is the most common type of colorectal cancer.

108. An adenocarcinoma that grows and spreads beyond the mucosa is called an invasive (or infiltrating) adenocarcinoma.

109. Invasive cancer spreads beyond the layer of tissue in which it developed and grows into surrounding healthy tissue.

110. An invasive adenocarcinoma in the colon or rectum thus invades the mucosa, penetrating into the intestinal wall.

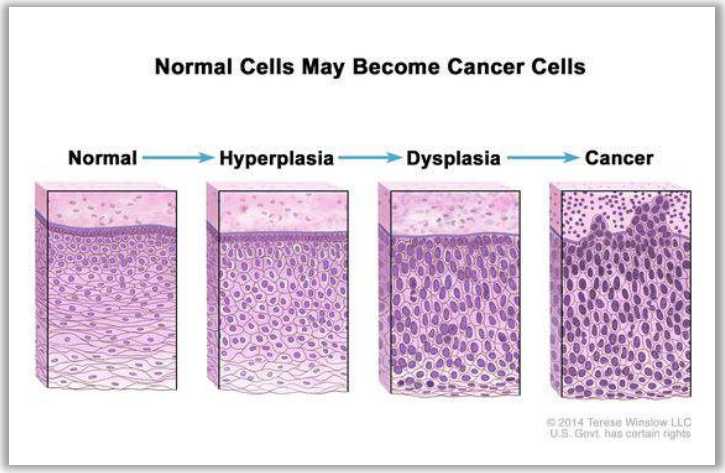
111. The process of a polyp becoming invasive cancer usually occurs slowly over a period of 10-20 years.

112. Sometimes doctors refer to an abnormal growth in the large bowel as a "lesion" or "mass," especially if it's not yet clear whether it's an adenoma, adenocarcinoma, or some other type of growth.

Hyperplasia and Dysplasia

113. Hyperplasia and dysplasia are abnormal changes in tissues of the body.

114. Before cancer cells form, they first go through these abnormal changes.



115. Hyperplasia and dysplasia may or may not become cancer.

116. In hyperplasia, there is an increase in the number of cells in a tissue, but the cells appear normal under a microscope.

117. Hyperplastic cells thus proliferate (reproduce) faster than normal, leading to an abnormal growth.

118. Dysplasia describes the degree to which a polyp looks like cancer under the microscope, without yet being cancer.

119. Dysplasia can be mild, moderate, or severe, depending on how abnormal the cells look under a microscope and how much of the tissue or organ is involved.

120. Polyps that are only mildly abnormal are said to have low-grade (mild or moderate) dysplasia.

121. Polyps that are more abnormal and look more like cancer are said to have high-grade (severe) dysplasia.

Differentiation

122. Differentiation is the grade of a cancer based on how abnormal the cells look under a microscope.

123. The grade is one of many factors doctors use to predict how likely the cancer is to grow and spread.

124. Colorectal cancer is usually divided into these three grades:

    a. Poorly differentiated, or high grade,

    b. Moderately differentiated, or intermediate grade, and

    c. Well differentiated, or low grade.

125. Poorly differentiated (high grade) colorectal cancers tend to spread more quickly than moderately differentiated and well differentiated cancers.

Colorectal Cancer

126. Cancer is an abnormal growth of cells.

127. Cancer cells reproduce rapidly despite the limitations of space and nutrients, and despite signals sent from the body to stop reproducing.

128. Cancer cells are often shaped differently from healthy cells, do not function properly, and may spread to many areas of the body.

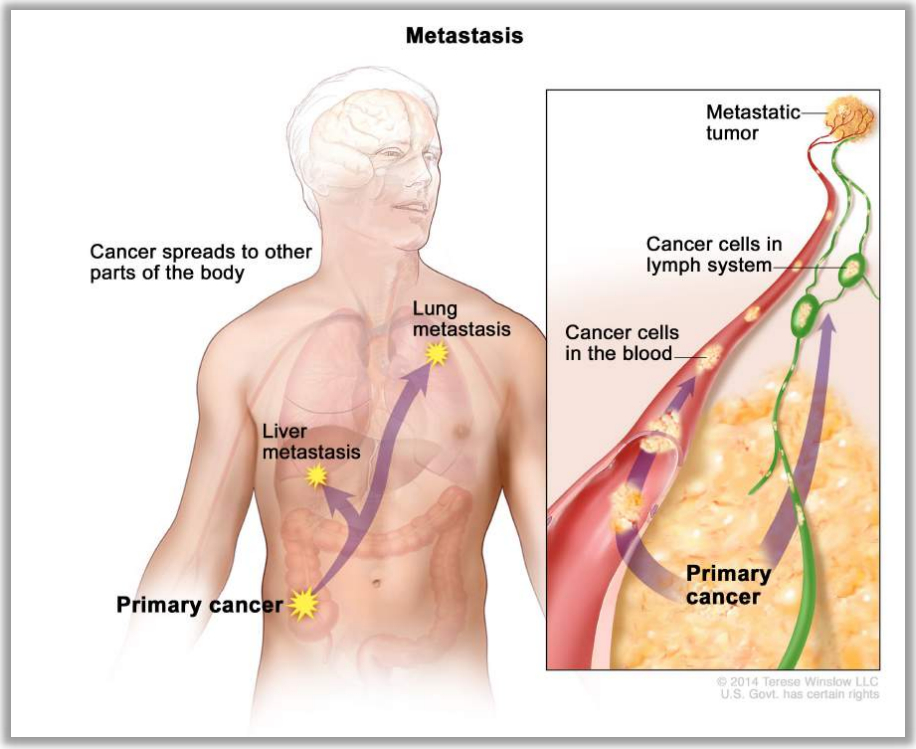
129. Colorectal cancer is cancer that forms in the colon or rectum or both.

130. About 4.3% of men (1 in 23) and 4.0% of women (1 in 25) will be diagnosed with colorectal cancer at some point during their lives.

Metastasis

131. Metastasis is the spread of cancer from the place where it started (the primary site) to other parts of the body.

132. When cancer cells break away from a tumor, they can travel to other areas through either the bloodstream or the lymphatic system.



133. Most escaped cancer cells die before they can start growing somewhere else.

134. But one or few cancer cells may settle in a new area, begin to grow, and form new tumors. Metastasis refers to this spread of cancer.

135. Metastatic cancer is cancer that has spread from the place where it started to a distant part of the body.

136. Colorectal cancer, for example, tends to spread to the liver and lungs.

137. Notably, the metastatic tumor is the same type of cancer as the primary tumor. If rectal cancer spreads to the lungs, for example, the cancer cells in the lungs are rectal-cancer cells, not lung-cancer cells.

138. Most metastatic cancers, including metastatic colorectal cancer, are classified as stage-4 cancers.

Stages of Colorectal Cancer

139. Staging is the process of determining how much cancer is within the body (tumor size) and if it has spread.

140. Staging helps doctors determine the severity of a patient's cancer, the patient's chances of survival, and the treatment plan for the patient.

141. The staging system most often used for colorectal cancer clinically is TNM, which stands for: tumor, node, and metastasis.

142. The TNM system stages each criteria by answering these questions.

    a. **Tumor:** Has the tumor grown beyond the mucosa? If so, how deep?

    b. **Node**: Has the tumor spread to lymph nodes? If so, where and how many?

    c. **Metastasis:** Has the cancer spread beyond the lymph nodes to other parts of the body? If so, where and how much?

143. In staging a patient's cancer in a clinical setting, doctors first stage each criteria, as reflected in the table below.

	T staging
T1	Tumor invades mucosa and submucosa
T2	Tumor invades but does not penetrate muscularis propria
T3	Tumor invades subserosa through muscularis propria
	T3a: tumor extends <1 mm beyond muscularis propria
	T3b: tumor extends ≥1-5 mm beyond muscularis propria
	T3c: tumor extends >5-15 mm beyond muscularis propria
	T3d: tumor extends ≥15 mm beyond muscularis propria
T4	Tumor invades peritoneal reflection (T4a) or other organs (T4b)
	N staging
N0	No metastatic lymphnodes
N1	Metastasis in 1-3 perirectal nodes
N2	Metastasis in 4 or more perirectal nodes
	M staging
M0	No distant metastasis
M1	Distant metastasis

144. The T stage thus reflects the degree to which the tumor has invaded the wall of the colon or rectum.

145. A stage T1 tumor, for example, has grown through the mucosa into the submucosa. Likewise, a stage T2 tumor has grown into the muscularis propria.

146. A stage N1 tumor, for example, has spread to 1-3 lymph nodes.

147. A stage M1 tumor has spread to a distant tissue or organ, such as the liver.

148. The stage of a patient's cancer is the combined TNM staging, as reflected in the table below.

Table. Colon and Rectum Cancer Staging[6]		
AJCC Stage	**TNM Stage**	**Description**
0	Tis N0 M0	Tumor is confined to mucosa
I	T1 N0 M0	Tumor invades submucosa
I	T2 N0 M0	Tumor invades muscularis propria
IIA	T3 N0 M0	Tumor invades subserosa or beyond, no other organs involved
IIB	T4 N0 M0	Tumor invades adjacent organs or perforates visceral peritoneum
IIIA	T1-2 N1 M0	Metastasis to 1-3 regional lymph nodes with tumor invasion of submucosa and/or muscularis
IIIB	T3-4 N1 M0	Metastasis to 1-3 regional lymph nodes with tumor invasion of subserosa or adjacent organs
IIIC	Any T, N2 M0	Metastasis to 4 or more lymph nodes
IV	Any T, any N, M1	Metastasis to distant organs
Abbreviations: AJCC, American Joint Committee on Cancer; Tis, tumor (carcinoma) in situ.		

149. As the table above shows, a patient with the following TNM staging would have stage-1 cancer:

    a. T1: the cancerous tumor has invaded no further than the submucosa.

    b. N0: the tumor has not spread to any lymph node.

    c. M0: the tumor has not spread to any other organ.

Rectal-Cancer: Survival Rates

150. The survival rate for rectal cancer varies by stage.

151. The 5-year survival rate for stage-1 and stage-2 rectal cancer is 89%.

152. The 5-year survival rate for stage-3 rectal cancer is 72%.

153. The 5-year survival rate for stage-4 rectal cancer is 16%.

154. The survival rate varies by age, gender, race, and other factors.

155. The 5-year survival rate for a white male 45-54 years of age with local rectal cancer (which includes stage-1 cancer) is 94.5%.

SEER 18, Relative Survival by Stage (2011-2017)

Selections:

Statistic type = Relative survival;
Race = White;
Sex = Male;
Age at diagnosis = 45-54;
Stage at diagnosis = Localized;
Survival interval = 5-year;

Results:

All Sites	90.4%
Colon and Rectum	94.5%

Colonoscopy and Sigmoidoscopy

156. A colonoscopy is an exam used to detect changes or abnormalities in the large intestine, including polyps and colorectal cancer.

157. A colonoscopy is an important screening test for colorectal cancer.

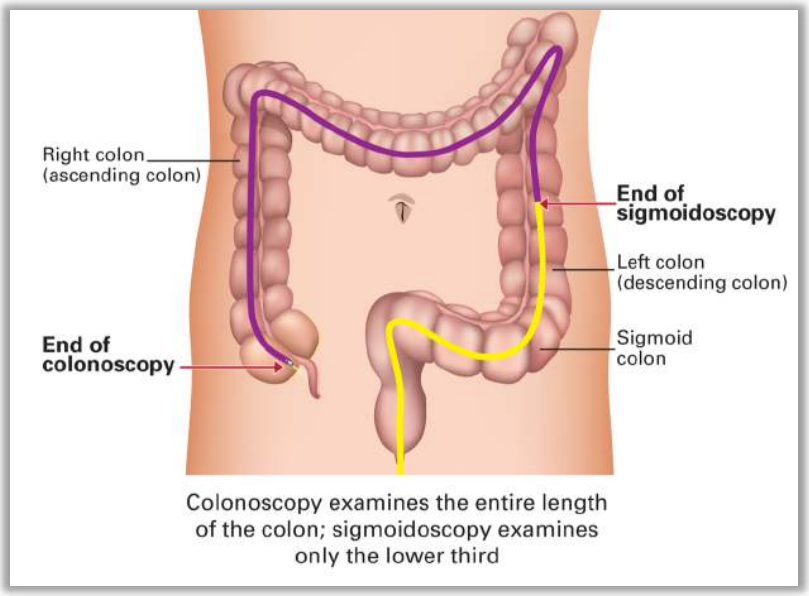
158. During the procedure, a doctor inserts a long, flexible tube (a colonoscope) into the rectum and advances it gently to the colon.

159. A tiny camera at the tip of the tube allows the doctor to view the inside of the entire large bowel.

160. The camera sends images to a monitor.

161. The colonoscope tube also allows the doctor to pump air or carbon dioxide into the colon, to inflate the colon and provide a better view of its lining.

162. A sigmoidoscopy is a similar procedure that examines only the rectum, the sigmoid (lower) colon, and part of the descending colon.



Colonoscopy examines the entire length of the colon; sigmoidoscopy examines only the lower third

163. A colonoscopy, in contrast, reaches and examines the entire large intestine.

164. An endoscopy is a procedure to examine any part of the gastro-intestinal tract. A colonoscopy and sigmoidoscopy are types of endoscopy.

Biopsy & Polypectomy

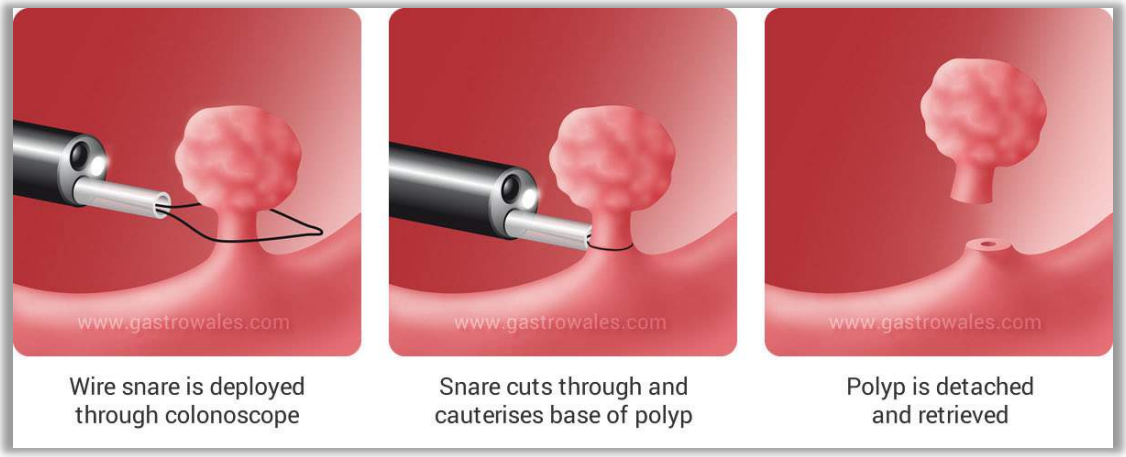
165. During a colonoscopy (or sigmoidoscopy) a doctor can insert instruments (such as a snare) through an instrument port in the colonoscope.

166. The doctor can use an instrument to perform a biopsy—the removal of a specimen (tissue sample) for diagnostic analysis by a pathologist.

167. A pathologist is a doctor who examines the biopsy specimen under a microscope to determine if it is cancerous.

168. The doctor performing the colonoscopy can also use an instrument called a "snare" to perform a polypectomy.

169. A polypectomy is a procedure to excise (cut out) a polyp using a snare during a colonoscopy or sigmoidoscopy.



170. Polyps that are too large or too flat cannot be removed during a colonoscopy or sigmoidoscopy.

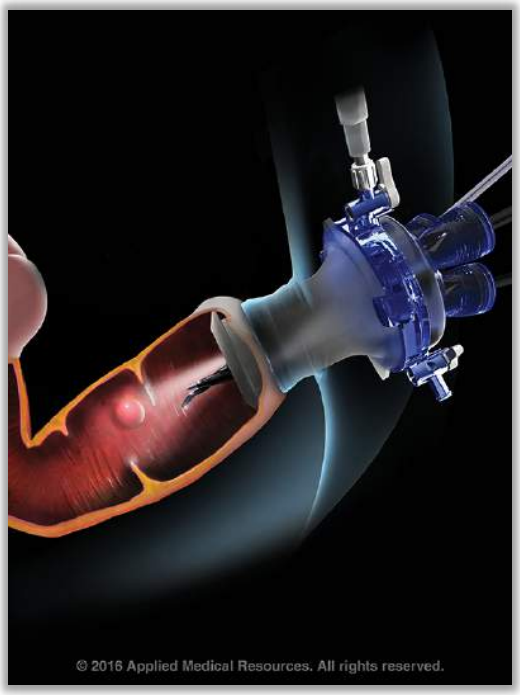
171. Instead, they must be removed through TAMIS, or LAR surgery.

TAMIS - Transanal Minimally Invasive Surgery

172. A transanal minimally invasive surgery ("TAMIS") is a procedure to excise rectal polyps.

173. TAMIS allows surgeons to use standard laparoscopic instruments to remove rectal polyps through the anus.

174. During TAMIS, a specialized surgery port is placed into the anus.



175. The laparoscope and instruments are passed through the port to the rectum.

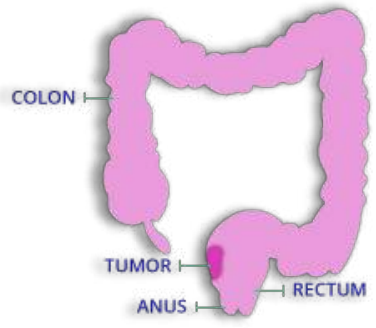
176. A laparoscope is a slender tool with a tiny video camera and light on the end.

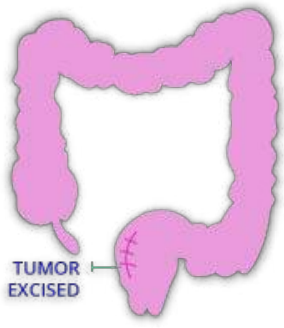
177. The camera allows surgeons to see inside the rectum on a video monitor.

178. The surgeon uses excision instruments to cut out the tumor, as illustrated.

179. Once the lesion (tumor) is removed, the hole in the rectum is sutured (sewn).

180. Because TAMIS accesses the rectum through the anal opening, no skin incision is needed.





181. TAMIS allows surgeons to remove polyps that are too large or too flat to be removed during a colonoscopy or sigmoidoscopy.

182. The most significant drawback of TAMIS is that lymph nodes cannot be assessed for the spread of cancer.

183. For that reason, TAMIS is only used for patients with very early-stage rectal cancer. Later-stage cancer may require LAR surgery.

Advantages of TAMIS

184. TAMIS has the following advantages compared to LAR surgery: TAMIS involves no external incisions, removes only the tumor and not a segment of the bowel, avoids the need for an anastomosis and stoma, involves less pain, and leads to faster recovery and shorter hospital stays.

185. Unlike TAMIS, LAR is a major surgery, with potentially serious complications.

Lower Anterior Resection ("LAR") Surgery

186. Lower anterior resection ("LAR") surgery removes part or all of the rectum.

187. LAR surgery is done to treat rectal cancer.

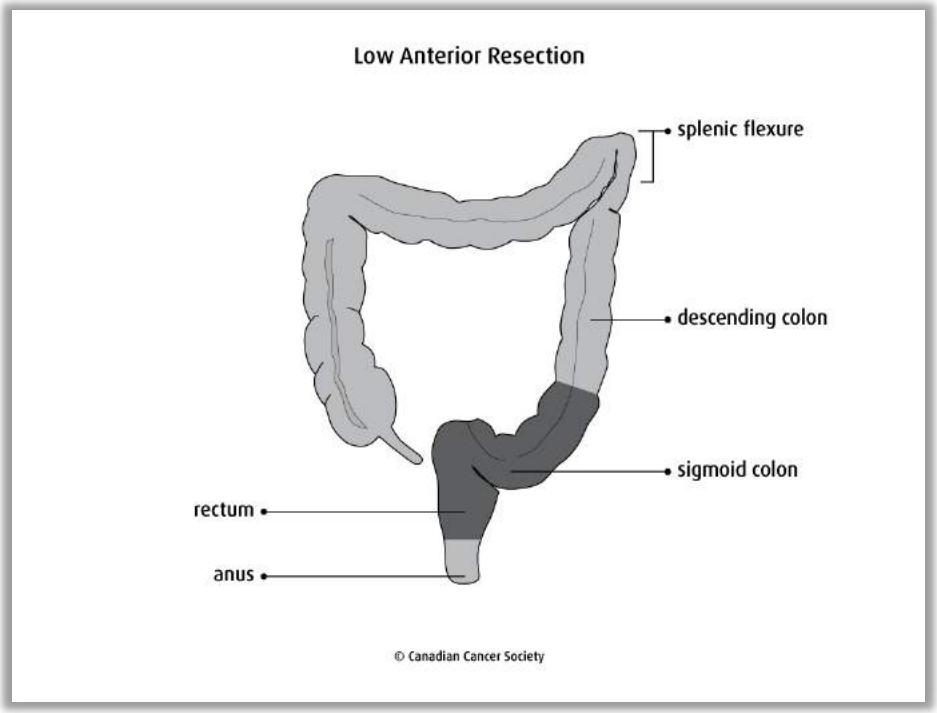
188. LAR surgery typically removes at least 30 centimeters (12.5 inches) of the rectum and sigmoid colon, from about 2 centimeters below the rectal cancer up to the lower sigmoid colon.

189. LAR surgery also removes the lymph nodes where the cancer drains.

190. LAR surgery typically removes at least 12 lymph nodes.

191. Rectal cancer drains into lymph nodes up by the sigmoid colon.

192. As a result, to remove those lymph nodes, LAR surgery typically also removes part of the sigmoid colon.



193. After removing the diseased portion of the rectum, the surgeon surgically connects the colon to the rectal stump or the anus.

194. This surgical reconnection is called an anastomosis, as explained below.

195. In some cases, as also explained below, the surgeon may create a stoma to divert stool away from the anastomosis.

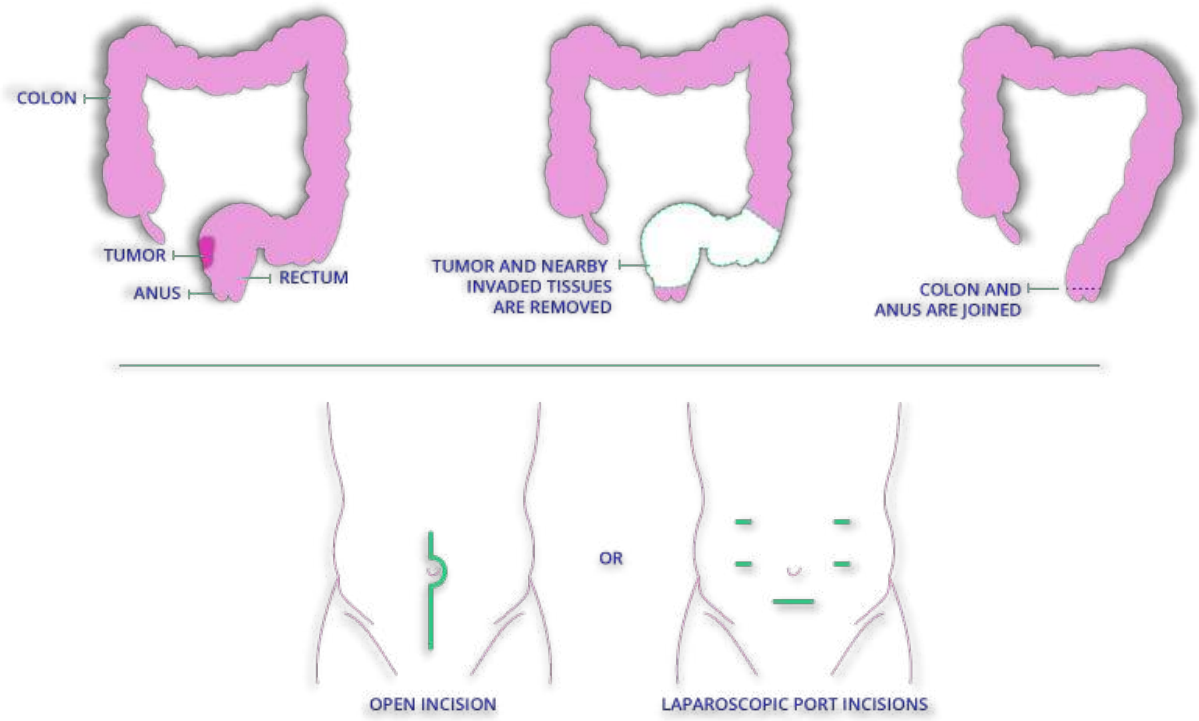
196. LAR surgery is associated with significant morbidity and mortality.

197. Anastomotic leak is a common cause of death after LAR surgery.

LAR Techniques

198. LAR may be an open surgery, or a laparoscopic (minimally invasive) surgery.

199. Open surgery requires an incision on the patient's abdomen.



200. The incision is large enough to allow the surgeon to see the rectum and perform the procedure using handheld tools.

201. The cancerous part of the rectum is taken out through this long incision.

202. Laparoscopic surgery requires a few small incisions on the abdomen.

203. A surgeon inserts a laparoscope and instruments through the incisions.

204. The surgeon uses the handheld instruments to remove the cancer while viewing magnified 2-D images from the laparoscope on a video monitor.

205. The surgeon manipulates the instruments mechanically.

206. Laparoscopic surgery is now the standard operation for rectal cancer.

207. The latest approach to laparoscopic surgery is robotic surgery.

208. During robotic surgery, the surgeon sits at a console near the patient and remotely operates surgical instruments using tiny, wristed controls.

209. The instruments instantly mimic the movements of the surgeon's wrist.

LAR Indication

210. An indication is a medically valid reason to use a test, medication, procedure, or surgery on a patient.

211. A surgery is indicated only if there is a medically valid reason for its use. Absent a medically valid reason, a surgery is non-indicated.

212. LAR surgery is indicated only to remove rectal cancer. LAR is not indicated for a patient without rectal cancer.

213. A surgeon who recommends LAR surgery to a patient without rectal cancer makes the recommendation without a medically valid reason.

214. A surgeon who performs LAR surgery on a patient without rectal cancer performs the surgery without a medically valid reason.

215. A surgeon who recommends or performs a non-indicated LAR surgery breaches the standards of care and ethics of the medical profession.

Ileostomy

216. An ileostomy is a procedure often done in conjunction with LAR surgery.

217. An ileostomy diverts the small intestine to a surgically created opening in the abdominal wall.

218. During the procedure, the ileum (the end of the small intestine) is passed through the opening and stitched into place.

219. The stitched, completed opening is called a stoma.

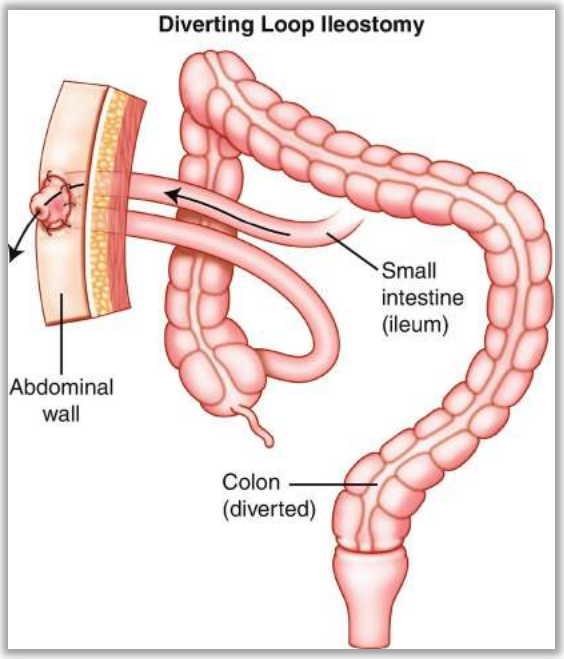
220. After an ileostomy, digested food no longer reaches the large intestine.

221. Instead, after passing through the small intestine, digested food is diverted by the ileum to the stoma.

222. The patient's stool thus leaves the body through the stoma, into a plastic pouch that covers the stoma.

223. For these reasons, the procedure is sometimes called a "diverting ileostomy."

224. There are two types of ileostomy: loop and end.



225. In a loop ileostomy, a loop of the ileum is passed through the surgical incision, cut open, and then stitched into place to form the stoma.

226. In an end ileostomy, the end of the ileum is separated from the colon and passed through the opening to form the stoma.

227. An ileostomy may also be temporary or permanent.

228. Loop ileostomies are usually intended to be temporary; end ileostomies, permanent.

229. After LAR surgery, the surgeon will often create a temporary loop ileostomy, to allow the colorectal anastomosis to take hold and the large bowel to heal.

230. A reversal ileostomy pulls the ileum out of the abdominal wall, stitches it back together, and places it back in the abdominal cavity.

Surgical Drains

231. A surgical drain is a tube used to remove pus, blood, or other fluids from a surgical wound.

232. A surgical drain is placed to keep fluid or infectious material from building up at the site of the incision.

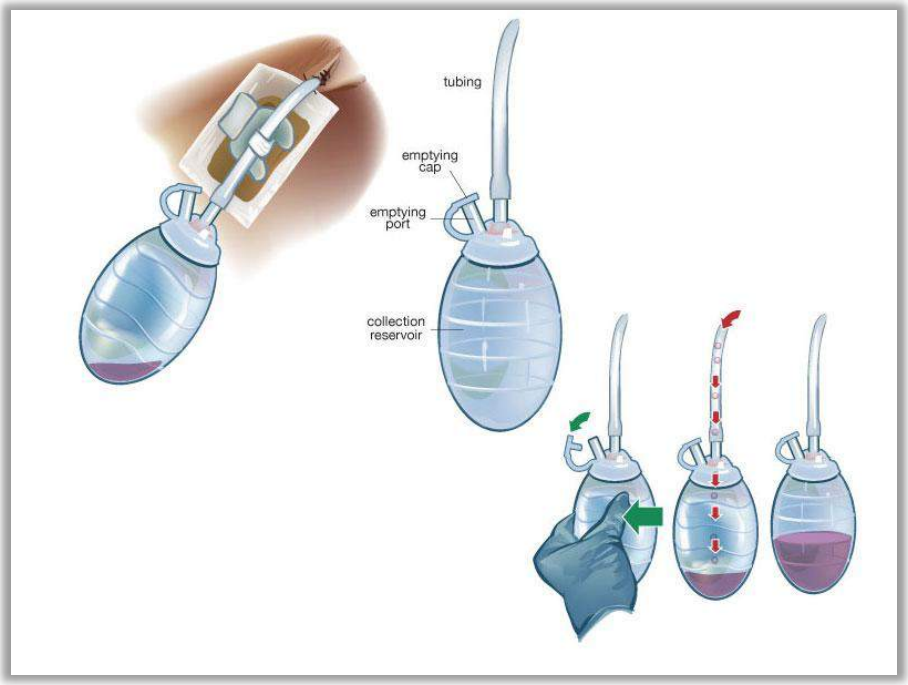
233. The most common type of surgical drain carries the fluid into a collection bulb that nurses or other providers check and empty.

234. This type of drain is often called by its brand name: Jackson Pratt or JP drain.

235. A surgical drain must be regularly monitored and assessed, to make sure it is working properly, without complications.

236. If the drainage shows evidence of contamination or infection, a nurse assessing the drain must promptly notify the attending or treating physician.

237. If the surgical drain for LAR surgery has fecal matter or even drainage suspected to be fecal matter, a nurse assessing the drain must immediately notify the attending or treating physician.



Anastomosis

238. An anastomosis is the surgical joining of tubular structures (arteries, veins, intestine) together so that they become continuous.

239. After the diseased part of the rectum is removed during LAR surgery, the colon is surgically reconnected to the rectal stump or the anus.

240. The surgical reconnection is an anastomosis.

241. A circular stapler may be used to create the anastomosis.

242. A surgeon may also create an anastomosis by suturing the two ends together.

Anastomotic Leaks: Generally

243. A large-bowel anastomosis should be airtight and watertight.

244. If not, fecal matter may leak into and contaminate the abdominal cavity, rapidly leading to peritonitis and sepsis.

245. Anastomotic leakage ("AL") is a common complication after LAR surgery.

246. Anastomotic leaks occur in approximately 7-12% of patients undergoing colorectal surgery.

247. AL is one of the most dangerous and feared complications after LAR surgery.

248. Anastomotic leaks can lead to significant morbidity and mortality.

249. Anastomotic leak is the most common cause of death after colorectal surgery.

250. Symptomatic anastomotic leaks are associated with mortality of between 6% and 22%.

Anastomotic Leaks: Prompt Diagnosis

251. Early diagnosis of AL is crucial for the prevention of mortality.

252. The signs and symptoms of AL can be subtle or obvious.

253. Fecal matter in the LAR surgical drain is a clear sign of an anastomotic leak.

254. The definitive investigation for a suspected anastomotic leak is a CT-scan with contrast of the abdomen and pelvis.

255. A CT-scan will demonstrate the presence of any extraluminal contents.

256. Inadequate or delayed diagnosis and delayed surgical intervention may lead to multiple and cumulative complications including fistulae, sepsis, multi-organ dysfunction and failure, and death.

Anastomotic Leaks: Emergency Surgery

257. There should be heighten suspicion for leaks and a readiness to undertake reoperation if leakage is suspected.

258. For patients presenting with diffuse peritonitis, emergency surgical exploration is mandatory along with fluid resuscitation.

259. Source-control with washout and fecal diversion are the main goals of surgical intervention for AL. Fecal diversion can be accomplished by taking down the anastomosis and creating an end colostomy.

260. Early source-control improves mortality by minimizing the duration of severe sepsis or septic shock and preventing multiple-organ failure.

261. In a patient with a significant anastomotic leak, early diagnosis and reoperation is crucial, as delay often leads to catastrophic "snowballing" sepsis and multi-organ failure. Once two or more body systems become impaired, survival falls to only about 50%.

Peritonitis: Generally

262. The peritoneum is a silk-like (serous) membrane that lines the inner wall of the abdominal cavity and that covers the organs in the abdominal cavity.

263. Peritonitis is an acute inflammation of the peritoneum.

264. Peritonitis is an important cause of morbidity and mortality.

265. Peritonitis may be caused by pathogens such as bacteria.

266. The causes of peritonitis include traumatic perforation of the bowel, anastomotic dehiscence, translocation of germs, and appendicitis.

267. Peritonitis can be life-threatening if not treated promptly.

268. Peritonitis is also called intra-abdominal infection or intra-abdominal sepsis.

Acute Bacterial Peritonitis

269. Acute bacterial peritonitis is inflammation of the peritoneum caused by a bacterial infection.

270. Acute bacterial peritonitis is associated with a high risk of mortality.

271. Acute bacterial peritonitis may be caused by leakage of feces, blood, bile, urine, pancreatic juice, or other bodily fluids into the abdominal cavity.

272. Clinically, acute bacterial peritonitis may be classified as local or diffuse.

273. Local acute bacterial peritonitis is contained by adjacent organs.

274. Diffuse bacterial peritonitis is "generalized," that is, has spread throughout the abdominal cavity.

275. Acute bacterial peritonitis can also be classified by the source of the infection.

    a. Primary peritonitis occurs without a break in the integrity of the gastrointestinal tract. Instead, infectious bacteria migrate into the abdominal cavity through the circulatory or lymphatic system.

    b. Secondary peritonitis is an acute infection of the peritoneum due to the loss of integrity of the gastrointestinal tract or other visceral organ.

    c. Tertiary peritonitis is peritonitis that reappears at least 48 hours after the apparent resolution of a primary or secondary peritonitis.

276. Secondary peritonitis may have an iatrogenic cause, including anastomotic leaks, endoscopic perforation, or use of an infected foreign body.

277. "Iatrogenic" refers to the process of medical treatment. An iatrogenic injury or illness is thus one caused by a medical provider while providing treatment.

Fecal Peritonitis

278. Fecal peritonitis is one of the most common forms of peritonitis.

279. Fecal peritonitis occurs when fecal matter leaks into the peritoneal cavity and causes an infection.

280. A failed anastomosis is a common cause of the leak. Surgery is another.

281. Fecal peritonitis is a type of acute bacterial peritonitis. Fecal peritonitis is also an example of secondary bacterial peritonitis.

Fecal Peritonitis: Diagnosis & Management

282. Because acute bacterial peritonitis (including fecal peritonitis) can rapidly lead to fatal complications such as septic shock, a quick diagnosis followed by appropriate treatment are essential.

283. These are the cornerstones of managing acute bacterial peritonitis, including fecal peritonitis:

    a. early clinical diagnosis,

    b. adequate source-control to stop ongoing contamination,

    c. appropriate antimicrobial therapy (antibiotics), and

    d. aggressive fluid resuscitation (rapid infusion of intravenous fluids) if the patient is septic, in order to reperfuse the organs.

284. A patient should receive peritonitis treatment immediately after acute bacterial peritonitis is diagnosed.

285. If acute bacterial peritonitis is not promptly treated, the infection can quickly spread through the body, resulting in sepsis, septic shock, and death.

286. In cases of diffuse peritonitis, immediate exploratory laparotomy is needed.

Fecal Peritonitis: Source-Control

287. Source-control refers to the efforts to control the source of an infection.

288. Examples of source-control include removing infected devices or hardware, tissue debridement, abscess draining, and limb amputation.

289. If the source of the infection requires surgical intervention, surgery should be performed as soon as medically and logistically possible.

290. Source-control should begin immediately after fecal peritonitis is diagnosed.

291. In patients with secondary bacterial peritonitis, surgical intervention for source-control remains the cornerstone treatment, along with antimicrobial therapy and resuscitation.

292. For patients presenting with diffuse peritonitis, emergency surgical exploration is mandatory along with fluid resuscitation.

293. For an infection in the colon, a colectomy may be needed as source-control.

294. When the inflammatory response gets out of control, multi-organ failure will ensue and surgery can no longer limit the immune response, emphasizing the need for timely operation in suspected peritonitis, the mainstay of treatment.

295. In patients with acute bacterial peritonitis, early source control improves mortality by minimizing the duration of severe sepsis or septic shock and preventing the progression to multiple-organ failure and death.

Fecal Peritonitis: Antibiotic Therapy

296. Antibiotics are almost always needed to treat acute bacterial peritonitis.

297. Every 30-minute delay in administering antibiotics after diagnosing secondary peritonitis increases death rates with an odds ratio of 1.021.

298. Antibiotic therapy is not a substitute for surgery where surgery is needed for source-control. Instead, antibiotics serve only as a temporizing therapy.

Laparotomy

299. A laparotomy is a major surgery to open up the abdomen.

300. An exploratory laparotomy is a surgery to open up the abdomen in order to examine the abdominal organs for disease or injury.

301. In patients with diffuse peritonitis, an immediate exploratory laparotomy is needed as a source-control measure.

302. If the patient has a significant anastomotic leak, a laparotomy should be performed emergently, as a source-control measure.

Colectomy & Proctectomy

303. A colectomy is a surgical procedure to remove all or part of the colon. A proctectomy is a surgical procedure to remove all or part of the rectum.

304. These procedures may be used to remove cancer from the large bowel.

305. When a patient has acute bacterial peritonitis caused by an anastomotic leak, a colectomy may be necessary to remove the part of the colon that is infected.

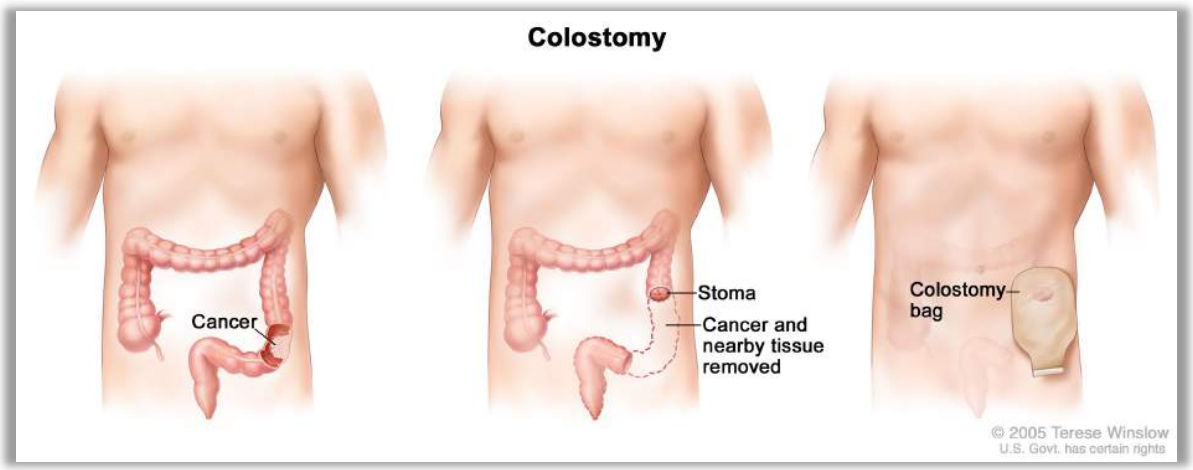
Colostomy

306. A colostomy is a surgical procedure that diverts the colon to a stoma on the patient's abdominal wall.

307. The word "colostomy" is also used to refer to the opening itself.

308. The stoma is created by drawing the upper end of the colon through an incision on the abdominal wall and suturing the end of the colon in place.

309. A colostomy is usually performed in conjunction with a colectomy.



310. After a colostomy, digested food leaves the body through the stoma, into a plastic pouch called a "colostomy bag."

Sepsis: Generally

311. Sepsis is a critical illness that requires early detection and intervention to prevent disability and death.

312. Sepsis is not a disease in itself, but rather a systemic inflammatory response to infection. Sepsis is the body's extreme over-response to an infection.

313. In a septic patient, the body's response to an infection injures the body's own tissues and organs. The body's immune system turns on itself.

314. If not promptly treated, the uncontrolled systemic response causes tissue damage, organ failure, and death.

315. Sepsis is the most common cause of death in intensive care units, with a mortality rate of 28-40%.

Sepsis Continuum

316. In the broad sense of the word, sepsis unfolds on continuum, from:

    a. systemic inflammatory response syndrome (SIRS), to

    b. sepsis in the narrow sense of the word, to

    c. severe sepsis, to

    d. septic shock, and finally to

    e. multi-organ dysfunction syndrome (MODS).

317. With each step in the continuum, the risk of death rises.

Septic Shock & Organ Failure

318. Shock is a critical condition resulting from a sudden drop in blood pressure throughout the body.

319. Septic shock occurs when the body's systemic inflammatory response to an infection dilates blood vessels throughout the body, causing blood pressure to plummet.

320. The lower blood pressure severely impairs blood-flow to the organs. Blood carries oxygen and nutrients vital to organ health.

321. If untreated, the shortage of blood can therefore cause organ damage, organ failure, and even death.

Sepsis: SIRS and qSOFA Scores

322. The SIRS Criteria and qSOFA Criteria are screening tools for identifying patients with potential sepsis.

323. A SIRS or qSOFA score is easily obtained within minutes in a hospital setting.

SIRS Criteria (≥ 2 contemporaneous variables)	qSOFA Criteria (≥2 contemporaneous variables)
36 > Temp > 38 (Celsius)	Systolic BP ≤ 100 mmHg
HR > 90 beats/min	RR ≥ 22 beats/min
RR > 20 beats/min	Altered Mental Status (GCS<15)
4,000 > WBC > 12,000	

Figure 1: Criteria for systemic inflammatory response syndrome (SIRS) and quick sequential organ failure assessment (qSOFA) score.

324. With each tool, if a patient meets at least two criteria, the score is positive, and the patient should be further evaluated for potential infection and sepsis.

General Safety Principles

Medical Error

325. In 2000, the Institute of Medicine estimated that 44,000 to 98,000 Americans died each year from medical error at that time. After that, the healthcare industry, policymakers, and academia started to focus on patient safety.

326. Nevertheless, in 2016, Johns Hopkins concluded that over 250,000 Americans die each year from medical error. The Johns Hopkins study found that medical error ranks as the third leading cause of death in the United States.

System Failures

327. It is now generally accepted that medical errors result largely from system failures.

328. That is, medical errors are not caused solely by "bad apple" individual clinicians directly involved in patient care.

329. Instead, medical errors are often the result of systemic failures. As one authority[2] explains:

> Quality, as an important policy consideration, gained significant public focus in the United States with two publications by the Institute of Medicine (IOM): *To Err Is Human* (Kohn, Corrigan, & Donaldson, 2000) and *Crossing the Quality Chasm* (Institute of Medicine, 2001). *To Err Is Human* first brought public attention to the issue of medical errors, concluding that between 44,000 and 98,000 people die every year from these errors. It also diagnosed the quality problem as not one of poorly performing people, but of people struggling to perform within a system that is riddled with opportunities for mistakes to happen. The second IOM report, *Crossing the Quality Chasm*, outlined a number of goals for improving the quality and performance of the U.S. healthcare system, as well as some of the methods for achieving those goals.

330. Systemic sources of medical error are well recognized. They include:

    a. The failure to implement or enforce protocols for urgent or emergent care.

    b. The failure to train, supervise, or support healthcare providers.

    c. Lack of teamwork and communication.

    d. Flaws in procedures meant to prevent breakdowns in communication.

    e. Defects in procedures for the handoff of patient care.

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[2] Buchbinder, Sharon B. and Shanks, Nancy H., *Introduction to Health Care Management*, Second Edition, Jones & Bartlett Learning, LLC, 2012, at Chapter 7.

f. Understaffing, particularly overnight, weekends, and holidays.

g. Problems with morale—from overwork, understaffing, unfair employment practices, and poor management.

h. Shortages of equipment, instruments, supplies, or medications.

i. Gaps in the systems for preventing medication mix-ups and delays.

j. Absence of mechanisms to escalate patient-safety issues in real-time, without fear of retaliation.

k. A culture that punishes providers who speak out on patient-safety issues.

l. A culture that discourages the recognition and remediation of errors.

m. A culture that condones incompetence, sloppiness, laziness, or apathy.

n. Flaws in procedures for credentialing qualified providers.

o. Failure to implement and enforce procedures for triggering and responding to EMR alerts.

331. The Joint Commission defines a culture of safety as the collection of "beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety."

332. A culture of safety includes the perceived freedom of people to speak up when something doesn't fit with the goals of safety and quality.

Managers & Administrators

333. Managers and administrators of healthcare organizations (including hospitals) are responsible for acting affirmatively to (a) protect patient safety and (b) prevent systemic failures enabling individual medical error.

334. Managers and administrators are responsible for the operational infrastructure in which licensed professionals provide treatment to patients.

335. The core responsibilities of managers and administrators include:

a. Structuring and executing a cohesive plan to ensure the effective and efficient delivery of services.

b. Ensuring that financial, human, and facility resources are allocated in a manner that is consistent with the organization's clinical priorities.

c. Organizing the review and verification of clinical practice guidelines and quality indicators to ensure patient safety and quality of care.

d. Analyzing data to identify trends of improvement or areas of concern, and maintaining processes designed to follow up on areas of concern.

e. Coordinating performance-improvement activities, including maintaining documentation to support credentialing.

f. Overseeing and confirming professional and staff development.

g. Assessing and identifying specific services, facilities, equipment, and personnel needed to address the current and future healthcare needs of the community and the funding required to provide such services.

h. Supervising the activities of all departments, including clinical, HR, finance, operations, maintenance, and admission and scheduling.

336. Managing and administering a healthcare organization are distinct from treating patients. To illustrate: While licensed professionals may substantively develop a treatment policy relying on professional judgment, managers and administrators are responsible for implementing the policy effectively.

337. Their responsibilities thus include: promulgating the policy, ensuring that providers are trained on and understand the policy, monitoring compliance with the policy, enforcing the policy, and taking corrective action when the policy is not followed or proves ineffective.

338. Because management and administration are distinct, managers and administrators often are not licensed professionals—a fact readily apparent from even a cursory review of bios and postings for those roles.

339. In some cases, licensed professionals perform managerial or administrative functions within a healthcare organization, especially when officially serving in management or administrative roles.

340. When discharging managerial or administrative duties, managers and administrators do not act as licensed healthcare providers, and do not engage in the practice of medicine, even if they also happen to be licensed healthcare professionals.

341. Whether or not performed by licensed professionals, functions that are clearly managerial or administrative include:

    a. Staffing and scheduling.

    b. Organizing the creation and implementation of systems that identify and prevent medical error, including technologies and protocols.

    c. Organizing the training of healthcare providers and others on patient-safety and quality-assurance policies and procedures.

    d. Providing proper supervision and support to individual providers, especially nurses and residents.

    e. Monitoring standards through assessments, evaluations, and audits.

    f. Taking administrative action against non-compliance with procedures.

    g. Ensuring the competence and qualification of providers at credentialing.

    h. Organizing the creation and implementation of systems that ensure operational support to patient care.

    i. Maintaining provider morale through institutional transparency, accountability, and responsiveness.

342. These functions do not involve, much less require, medical training or judgment. They involve and require managerial or administrative skill.

Medical Chronology of Jeffrey's Treatment

343. To make it as easy as possible for Defendants to confirm and answer the numerated allegations, this section has screenshots of Jeffrey's medical records. Defendants need not answer the statements in the screenshots.

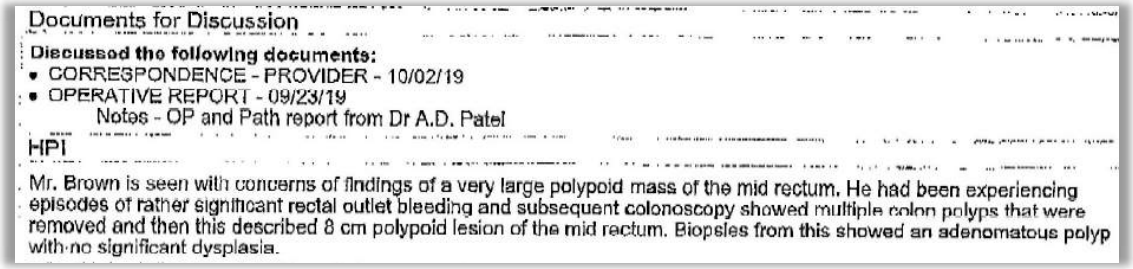
Rectal Lesion Found

344. In August 2019, when Jeffrey Brown was 49, he experienced "episodes of rather significant rectal outlet bleeding." SFH 1474.

345. On September 23, 2019, Jeffrey underwent a colonoscopy at Columbus Endoscopy Center, in Columbus, Georgia. SFH 1474.

346. During the procedure, Dr. Ashwin D. Patel found "multiple colon polyps that were removed." SFH 1474.

347. Dr. Patel also found an "8 cm polypoid lesion of the mid rectum," which he did not remove. SFH 1474.



Documents for Discussion

Discussed the following documents:

- CORRESPONDENCE - PROVIDER - 10/02/19
- OPERATIVE REPORT - 09/23/19

Notes - OP and Path report from Dr A.D. Patel

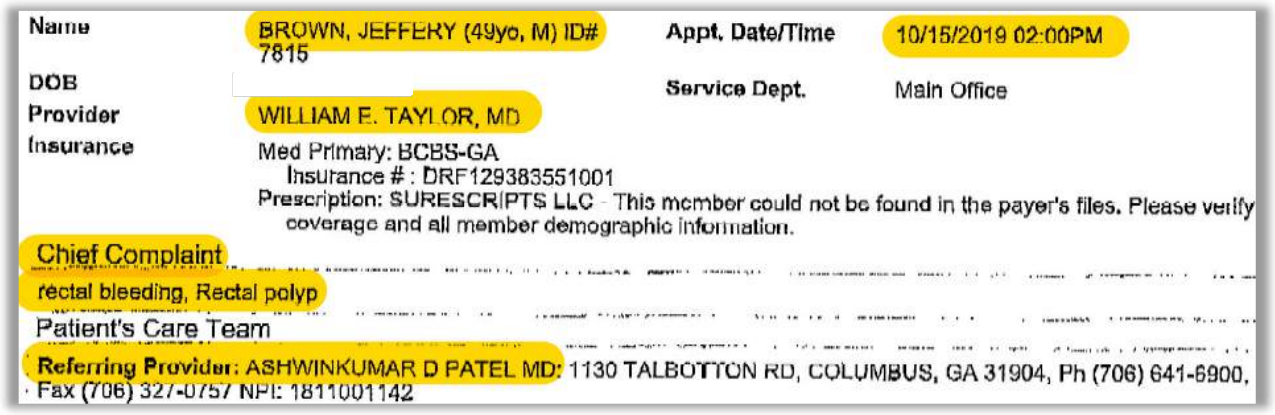
HPI

Mr. Brown is seen with concerns of findings of a very large polypoid mass of the mid rectum. He had been experiencing episodes of rather significant rectal outlet bleeding and subsequent colonoscopy showed multiple colon polyps that were removed and then this described 8 cm polypoid lesion of the mid rectum. Biopsies from this showed an adenomatous polyp with no significant dysplasia.

SFH 1474.

Surgeon William Taylor Outlines Plans to Remove Lesion

348. On October 15, 2019, upon a referral by Dr. Patel, Colorectal Surgeon William E. Taylor met with Jeffrey and his wife, Cory Brown, at Columbus Surgical Specialists, in Columbus, Georgia. SFH 1473.



Name BROWN, JEFFERY (49yo, M) ID# 7815
Appt. Date/Time 10/15/2019 02:00PM
DOB
Service Dept. Main Office
Provider WILLIAM E. TAYLOR, MD
Insurance Med Primary: BCBS-GA
Insurance # : DRF129383551001
Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information.
Chief Complaint
rectal bleeding, Rectal polyp
Patient's Care Team
Referring Provider: ASHWINKUMAR D PATEL MD: 1130 TALBOTTON RD, COLUMBUS, GA 31904, Ph (706) 641-6900, Fax (706) 327-0757 NPI: 1811001142

SFH 1473.

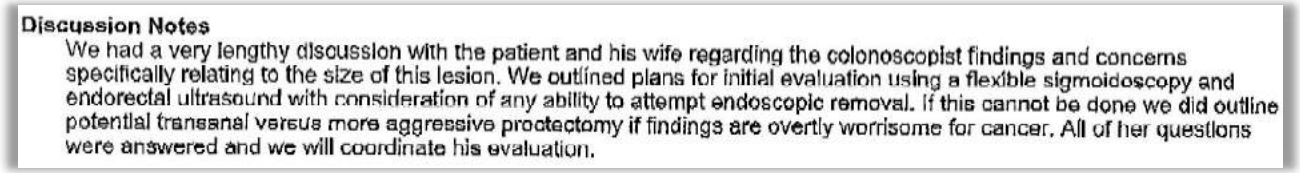
349. At that time, Dr. Taylor "had a very lengthy discussion with the patient and his wife regarding the colonoscopist findings and concerns specifically relating to the size of this lesion." SFH 1475.

350. Dr. Taylor also outlined "plans for initial evaluation using a flexible sigmoidoscopy and endorectal ultrasound with consideration of any ability to attempt endoscopic removal." SFH 1475.

351. In the event endoscopic removal did not work, Dr. Taylor also outlined "potential transanal versus more aggressive proctectomy if findings are overtly worrisome for cancer." SFH 1475.

352. Dr. Taylor thus acknowledged that even the TAMIS might be unnecessary, if "endoscopic removal" during the sigmoidoscopy worked.

353. Nevertheless, Dr. Taylor looked past the TAMIS, and previewed the "more aggressive proctectomy"—meaning LAR surgery. SFH 1475.



Discussion Notes
We had a very lengthy discussion with the patient and his wife regarding the colonoscopist findings and concerns specifically relating to the size of this lesion. We outlined plans for initial evaluation using a flexible sigmoidoscopy and endorectal ultrasound with consideration of any ability to attempt endoscopic removal. If this cannot be done we did outline potential transanal versus more aggressive proctectomy if findings are overtly worrisome for cancer. All of her questions were answered and we will coordinate his evaluation.

SFH 1475.

354. Dr. Taylor scheduled the sigmoidoscopy for October 21, 2019, on an outpatient basis. SFH 1475.

355. As shown below, this was the first in a series of discussions Dr. Taylor had with Jeffrey and Cory to obtain their consent to surgery.

Sigmoidoscopy Shows Lesion Consistent with T1 Cancer

356. On October 21, 2019, Dr. Taylor performed a "sigmoidoscopy with cold biopsies," at the St. Francis Hospital Endoscopy Unit. SFH 1489, 1297.

357. The procedure revealed "a very large friable irregular appearing exophytic mass in the midportion of the rectum at the 2nd dominant fold."[3] SFH 1489.

358. The lesion "appeared to be over 10 cm in size." SFH 1489.

359. The sigmoidoscopy also showed that "at least a quarter of the luminal circumference [of the lesion] involved with adenomatous-appearing tissue which likely precluded direct endoscopic attempted removal." SFH 1489.

360. In addition, the lesion had "areas of firmness and ulceration worrisome for frank malignancy." SFH 1489.

361. Dr. Taylor's "findings" were "most consistent with a T1 cancer," with "no clear evidence of associated adenopathy." SFH 1489.

Technique
The patient was brought to the procedure room and following placement of full cardiopulmonary monitoring was placed in left lateral decubitus position. Titrated analgesia and sedation was used to affect throughout the course of the procedure as administered per the nursing staff. Digital rectal examination revealed no ability to palpate this large rectal lesion although the patient's body habitus did limit examination. The well lubricated colonoscope was inserted per the anus and immediately we encountered a very large friable irregular appearing exophytic mass in the midportion of the rectum at the 2nd dominant fold. This appeared to be over 10 cm in size. The scope was advanced into the sigmoid with no lesions above this noted. Withdraw the scope back down to the level of the lesion revealed had at least a quarter of the luminal circumference involved with adenomatous appearing tissue which likely precluded direct endoscopic attempted removal. In addition this lesion had areas of firmness and ulceration worrisome for frank malignancy. We did pass a large snare around a portion of it to attempt large volume biopsy but the electrocautery would not function with this and the snare was removed. Directed multiple cold biopsies were taken and again a portion of this at lease had some significant firmness to it worrisome for malignancy. We proceeded with 2 separate submucosal injections directly below this area to decrease demarcate potential area of resection. The scope was withdrawn and the rigid proctoscope was placed. Both static and real-time imaging was obtained for evaluation. Unfortunately there was no paper for the endoscopic ultrasound and only limited pictures were obtained for permanent visualization. This lesion was very exophytic making direct ultrasound imaging somewhat difficult but findings are most consistent with a T1 cancer and no clear evidence of associated adenopathy. The remainder of the root low rectum was without further abnormalities. The patient was assessed prior to his dismissal. He will be seen back in a week with review of pathology to determine further treatment course.

[3] The word "exophytic" describes an abnormal growth that sticks out from tissue. The word "friable" describes tissue that tears, sloughs, or bleeds easily on touch.

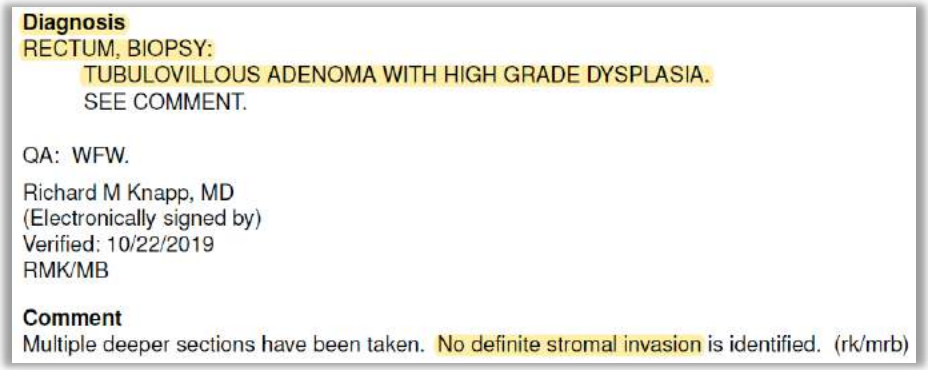
SFH 1489.

362. Dr. Taylor took multiple cold biopsies of the lesion, a portion of which had "some significant firmness to it worrisome for malignancy." SFH 1489.

Pathologist Richard Knapp Diagnoses the Lesion as Precancerous – an Adenoma with High-Grade Dysplasia

363. On October 21, 2019, Pathologist Richard Knapp performed a microscopy of the "rectal mass biopsy" taken during the sigmoidoscopy. SFH 1526.

364. Dr. Knapp diagnosed the specimen as a "tubulovillous adenoma with high grade dysplasia." SFH 1526.



Diagnosis
RECTUM, BIOPSY:
TUBULOVILLOUS ADENOMA WITH HIGH GRADE DYSPLASIA.
SEE COMMENT.

QA: WFW.

Richard M Knapp, MD
(Electronically signed by)
Verified: 10/22/2019
RMK/MB

Comment
Multiple deeper sections have been taken. No definite stromal invasion is identified. (rk/mrb)

SFH 1526.

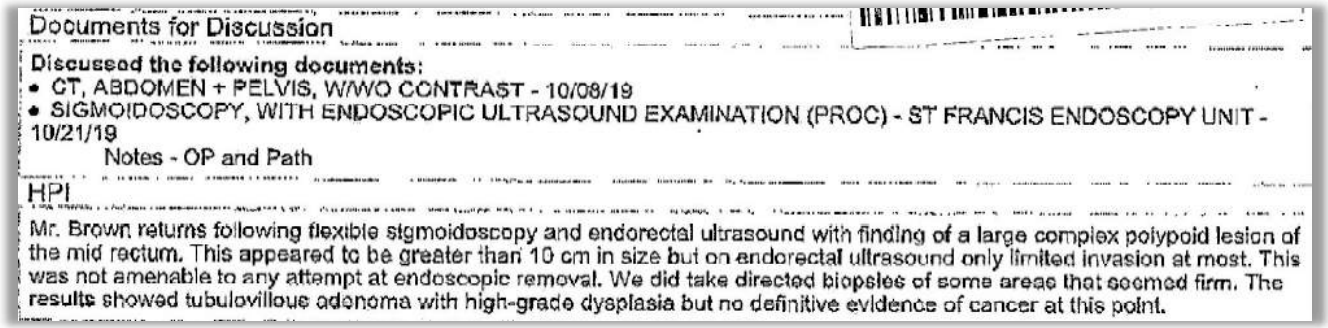
365. Dr. Knapp found "no definite stromal invasion."[4] SFH 1526.

Dr. Taylor Meets with Jeffrey and Cory Again, Presenting TAMIS and LAR Surgery as Alternatives

366. On October 25, 2019, Dr. Taylor again met with Jeffrey and Cory, this time to review the results of Dr. Knapp's pathology report. SFH 1296.

[4] Here, the word "stromal" refers to tissue.

367. According to Dr. Taylor, consistent with the pathology report, "the results showed tubulovillous adenoma with high-grade dysplasia but no definitive evidence of cancer at this point." SFH 1297.



Documents for Discussion

Discussed the following documents:

- CT, ABDOMEN + PELVIS, W/WO CONTRAST - 10/08/19
- SIGMOIDOSCOPY, WITH ENDOSCOPIC ULTRASOUND EXAMINATION (PROC) - ST FRANCIS ENDOSCOPY UNIT - 10/21/19

Notes - OP and Path

HPI

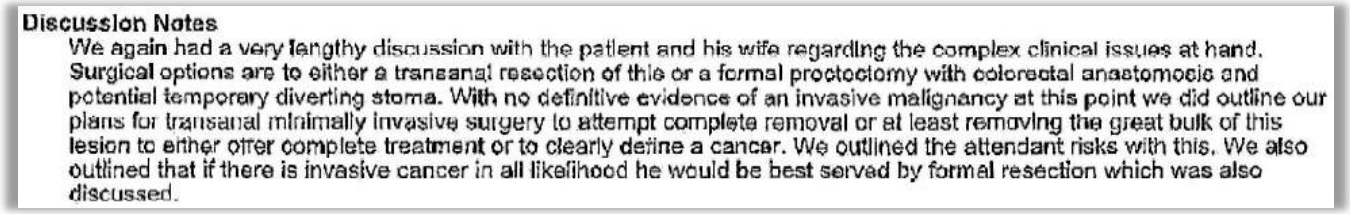
Mr. Brown returns following flexible sigmoidoscopy and endorectal ultrasound with finding of a large complex polypoid lesion of the mid rectum. This appeared to be greater than 10 cm in size but on endorectal ultrasound only limited invasion at most. This was not amenable to any attempt at endoscopic removal. We did take directed biopsies of some areas that seemed firm. The results showed tubulovillous adenoma with high-grade dysplasia but no definitive evidence of cancer at this point.

SFH 1297.

368. Dr. Taylor then "again had a very lengthy discussion with the patient and his wife regarding the complex clinical issues at hand." SFH 1298.

369. Dr. Taylor presented Jeffrey and Cory two "options" for removing the adenoma: "a transanal resection of this or a formal proctectomy with colorectal anastomosis and potential temporary diverting stoma." SFH 1298.

370. "With no definitive evidence of an invasive malignancy at this point," Dr. Taylor outlined "plans for transanal minimally invasive surgery to attempt complete removal or at least removing the great bulk of this lesion to either offer complete treatment or to clearly define a cancer." SFH 1298.



Discussion Notes

We again had a very lengthy discussion with the patient and his wife regarding the complex clinical issues at hand. Surgical options are to either a transanal resection of this or a formal proctectomy with colorectal anastomosis and potential temporary diverting stoma. With no definitive evidence of an invasive malignancy at this point we did outline our plans for transanal minimally invasive surgery to attempt complete removal or at least removing the great bulk of this lesion to either offer complete treatment or to clearly define a cancer. We outlined the attendant risks with this. We also outlined that if there is invasive cancer in all likelihood he would be best served by formal resection which was also discussed.

SFH 1298.

371. Dr. Taylor also "outlined that if there is invasive cancer in all likelihood he would be best served by formal resection, which was also discussed." SFH 1298.

372. Dr. Taylor thus again previewed LAR surgery as an option downstream, even though:

    a. Dr. Knapp had concluded that the lesion was *pre*cancerous at that time—a "tubulovillous adenoma with high grade dysplasia";

    b. Dr. Taylor himself recognized that there was "no definitive evidence of an invasive malignancy" at that point; and

    c. a TAMIS in any event could completely remove the lesion, including any associated cancer, as turned out to be the case.

373. The TAMIS was scheduled for the afternoon of November 7, 2019. SFH 1298.

During TAMIS, Dr. Taylor Removes the Lesion and Margins, with "No Evidence of Residual Disease"

374. On November 7, 2019, Dr. Taylor performed the "transanal minimally invasive surgery for removal of rectal mass," with a "flexible sigmoidoscopy." SFH 1315.

375. The procedure revealed "a large soft somewhat friable polypoid mass" in "the right lateral extending both anteriorly and posteriorly." SFH 1315.

376. The mass was "a very broad-based stalk encompassing nearly 50% of the circumference of the rectal lumen." SFH 1315.

377. After "a portion of the apex of the polypoid mass fractured," Dr. Taylor resected "the base of the mass." SFH 1315.

378. Dr. Taylor resected the base "flush with the rectal wall." SFH 1315.

379. Also, after "direct inspection revealed 3 separate small areas of potential residual polyp," Dr. Taylor removed those pieces "as margins." SFH 1315.

380. Dr. Taylor thus removed the entire lesion, plus additional tissue as margins.

381. In fact, after completing the procedure, there was "no evidence of residual disease at this point." SFH 1315.

Technique
The patient was brought to the operating room and following adequate general endotracheal anesthesia was prepped and draped in a normal sterile fashion in the prone jack-knife position. Digital rectal examination revealed a long but patent anal canal. We proceeded to place the transanal minimally invasive platform within the anal canal. It was somewhat difficult to keep this seated in the anal canal given the patient's body habitus. Fixation sutures were placed. With the rectum dilated under insufflation direct visualization revealed in the right lateral extending both anteriorly and posteriorly was a large soft somewhat friable polypoid mass. We proceeded to elevated using a grasping forceps and then divided what turned out to be a very broad-based stalk encompassing nearly 50% of the circumference of the rectal lumen using the Harmonic scalpel to maintain complete hemostasis. Resection was in a partial-thickness fashion. A portion of the apex of the polypoid mass fractured and was sent separately then the base of the mass that was resected flush with the rectal wall. The rectal lumen was copiously irrigated and direct inspection revealed 3 separate small areas of potential residual polyp that were taken using Harmonic scalpel and sent separately as margins. Inspection confirmed complete hemostasis at the resection line. We proceeded to reapproximate the mucosal defect using the interrupted stitch suturing device. The platform was removed and on the table flexible sigmoidoscopy was performed. The scope was advanced to 40 cm with extensive loose stools throughout the left colon. This was aggressively irrigated aspirated clear. Withdraw the scope back down to the rectum revealed an intact suture line with complete hemostasis directly at the apex of the 1st dominant fold. There was no evidence of residual disease at this point. The rectal vault was irrigated using dilute Betadine solution suction clear and final inspection again confirmed intact suture line and complete

SFH 1315.

382. Dr. Taylor then sent the following specimens to pathology: the base of the lesion, the fractured apex of the lesion, and the margins. SFH 1315-16.

Pathologist Clinton McElroy Confirms T1 Adenocarcinoma, and Margins Negative for Carcinoma and Even Dysplasia

383. On November 7, 2019, Dr. McElroy examined and diagnosed the specimens. SFH 1360-62, SFH 1394-97.

384. The "base of polypoid lesion" was "a tubulovillous adenoma with high-grade dysplasia." SFH 1394.

385. A "moderately differentiated invasive colonic adenocarcinoma, approximately 2.5 cm focus," arose within the adenoma. SFH 1394.

386. Although the adenocarcinoma was "invasive," there was "no lymphovascular or perineural invasion." SFH 1394.

387. Instead, the tumor invaded only to the level of "the submucosa." SFH 1394.

Surgical Pathology Report

Diagnosis

A. RECTAL MASS "BASE OF POLYPOID LESION", TRANSANAL EXCISION:
MODERATELY DIFFERENTIATED INVASIVE COLONIC ADENOCARCINOMA, APPROXIMATELY 2.5 CM FOCUS, ARISING WITHIN A TUBULOVILLOUS ADENOMA WITH HIGH-GRADE DYSPLASIA.
TUMOR INVADES THE SUBMUCOSA (AT LEAST T1 LESION, SEE COMMENT).
NO LYMPHOVASCULAR OR PERINEURAL INVASION IS IDENTIFIED.
SEE COMMENT.

SFH 1394.

388. In fact, insofar as "muscularis propria [was] identified, no invasive carcinoma [was] appreciated." SFH 1395.

Comment

A. Only focal areas show portions of muscularis propria. Where muscularis propria is identified, no invasive carcinoma is appreciated. Clinical correlation is required. Results of MMR immunohistochemical stains will be performed on block A1 and reported in an addendum.

SFH 1395.

389. The specimen was thus at least a T1 lesion. SFH 1394, SFH 1397.

Microscopic Description

Per AJCC 8th Edition Criteria this is at least a pT1 lesion.

SFH 1397.

390. The fragmented apex confirmed the diagnosis of the base. SFH 1394-97.

391. The apex also showed a "focal moderately differentiated invasive colonic adenocarcinoma arising within fragments of tubulovillous adenoma with high-grade dysplasia." SFH 1395.

392. Like the base, the apex also revealed "no lymphovascular or perineural invasion." SFH 1395.

393. Instead, as with the base, the adenocarcinoma in the apex invaded only "the submucosa without visible involvement of the muscularis propria." SFH 1395.

Diagnosis

FOCAL MODERATELY DIFFERENTIATED INVASIVE COLONIC ADENOCARCINOMA ARISING WITHIN FRAGMENTS OF A TUBULOVILLOUS ADENOMA WITH HIGH-GRADE DYSPLASIA.
TUMOR INVADES THE SUBMUCOSA WITHOUT VISIBLE INVOLVEMENT OF MUSCULARIS PROPRIA.
NO LYMPHOVASCULAR OR PERINEURAL INVASION IS IDENTIFIED.

SFH 1395.

394. Dr. McElroy also examined the margins—"portions of benign colon including small portions of muscularis propria." SFH 1395.

395. The margins were "**negative for dysplasia or carcinoma**." SFH 1395 (emphasis added).

C. "MARGINS", TRANSANAL EXCISION:
PORTIONS OF BENIGN COLON INCLUDING A SMALL PORTION OF MUSCULARIS PROPRIA.
NEGATIVE FOR DYSPLASIA OR CARCINOMA.

SFH 1395.

396. That is to say: "**No dysplasia or carcinoma [was] identified at the surgical margins**." SFH 1396 (emphasis added).

B. Microscopic Findings:
1. Histologic Grade: Intermediate
2. Nuclear Grade: Intermediate
3. Vascular invasion: Not identified
4. Perineural invasion: Not identified
5. Surgical margins: Please see specimen C. No dysplasia or carcinoma is identified at the surgical margins

SFH 1396.

397. Dr. McElroy's microscopy thus established the following about the lesion excised by Dr. Taylor during the TAMIS:

a. The lesion was "a tubulovillous adenoma with high-grade dysplasia." SFH 1394.

b. The adenoma included a "moderately differentiated invasive colonic adenocarcinoma," measuring about 2.5 cm (1 inch) in size. SFH 1394.

c. The carcinoma invaded the rectal wall only to the submucosa, without involvement of the muscularis propria. SFH 1394, SFH 1395.

d. There was "no lymphovascular or perineural invasion." SFH 1395.

e. The adenocarcinoma was thus a T1 tumor. SFH 1394, SFH 1397.

398. Dr. McElroy's microscopy also established the following about the margins excised by Dr. Taylor during the TAMIS:

a. The margins, which included portions of the muscularis propria, had no carcinoma. SFH 1395, SFH 1396.

b. The margins did not even show any dysplasia. SFH 1395, SFH 1396.

B. Microscopic Findings:
1. Histologic Grade: Intermediate
2. Nuclear Grade: Intermediate
3. Vascular invasion: Not identified
4. Perineural invasion: Not identified
5. Surgical margins: Please see specimen C. No dysplasia or carcinoma is identified at the surgical margins
6. Lymphocytic infiltrate:
Intratumoral lymphocytes: None
Peritumoral lymphocytes: None
7. Lymphatic invasion: Not identified
8. Lymph nodes:
Total number: Not applicable
Number with metastases: Not applicable

SFH 1396.

Nevertheless, Dr. Taylor Offers Jeffrey LAR Surgery

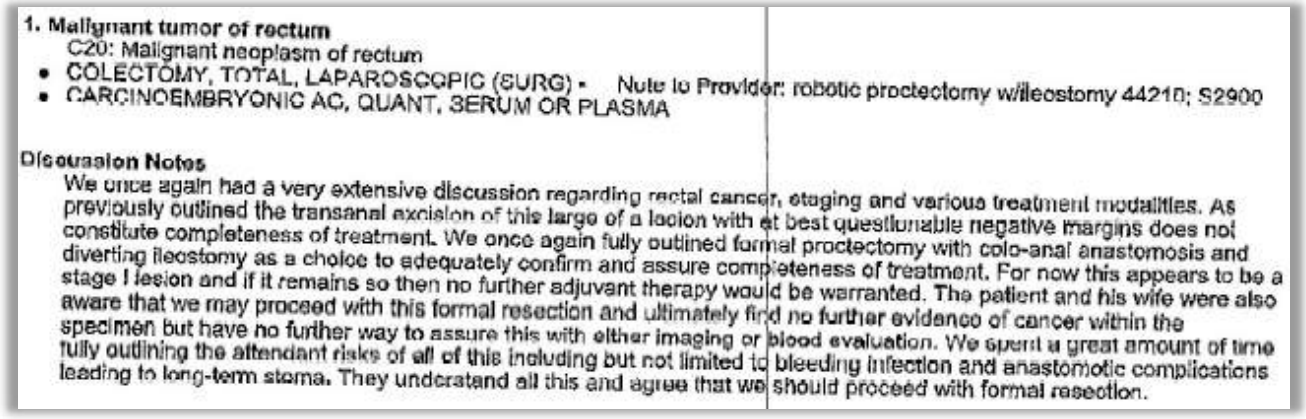
399. On November 20, 2021, Dr. Taylor again met with Jeffrey and Cory, "following transanal excision of a very large complex polypoid lesion which demonstrated T1 cancer." SFH 65.

HPI
Mr. Brown returns followina transanal excision of a very large complex polypoid lesion which demonstrated T1 cancer. Margins at best appeared to be negative but given the very complex and large nature of the polyp this is certainly very difficult to assess for completeness of resection. He has done fine since the procedure with no difficulties. His prior CT imaging showed no evidence of hepatic based disease. His prior ultrasound of the rectum showed no clear evidence of lymphadenopathy,

SFH 65.

400. Dr. Taylor "once again had a very extensive discussion" with Jeffrey and Cory "regarding rectal cancer, staging and various treatment modalities." SFH 66.

401. Dr. Taylor told Jeffrey and Cory that "the transanal excision of this large of a lesion with at best questionable margins does not constitute completeness of treatment." SFH 66.



1. Malignant tumor of rectum
C20: Malignant neoplasm of rectum
- COLECTOMY, TOTAL, LAPAROSCOPIC (SURG) - Note to Provider: robotic proctectomy w/ileostomy 44210; S2900
- CARCINOEMBRYONIC AG, QUANT, SERUM OR PLASMA

Discussion Notes

We once again had a very extensive discussion regarding rectal cancer, staging and various treatment modalities. As previously outlined the transanal excision of this large of a lesion with at best questionable negative margins does not constitute completeness of treatment. We once again fully outlined formal proctectomy with colo-anal anastomosis and diverting ileostomy as a choice to adequately confirm and assure completeness of treatment. For now this appears to be a stage I lesion and if it remains so then no further adjuvant therapy would be warranted. The patient and his wife were also aware that we may proceed with this formal resection and ultimately find no further evidence of cancer within the specimen but have no further way to assure this with either imaging or blood evaluation. We spent a great amount of time fully outlining the attendant risks of all of this including but not limited to bleeding infection and anastomotic complications leading to long-term stoma. They understand all this and agree that we should proceed with formal resection.

SFH 66.

402. According to Dr. Taylor, the margins "at best appeared to be negative but given the very complex and large nature of the polyp this is certainly very difficult to assess for completeness of resection." SFH 65.

403. In fact, contrary to the information Dr. Taylor provided to Jeffrey and Cory, Dr. McElroy unequivocally concluded that the margins were "negative for dysplasia or carcinoma," and that "no dysplasia or carcinoma [was] identified at the surgical margins." SFH 1395-96.

404. Nevertheless, based on the premises that the TAMIS did "not constitute completeness of treatment" because the margins were "at best questionable" and "at best appeared to be negative," Dr. Taylor again offered LAR surgery to Jeffrey, this time as the immediate next step in the treatment plan. SFH 66.

405. Dr. Taylor "once again fully outlined formal proctectomy with colo-anal anastomosis and diverting ileostomy as a choice to adequately confirm and assure completeness of treatment." SFH 66.

406. Dr. Taylor also made Jeffrey and Cory "aware that we may proceed with this formal resection and ultimately find no further evidence of cancer within the

specimen but have no further way to assure this with either imaging or blood evaluation." SFH 66.

407. Dr. Taylor finally "spent a great amount of time fully outlining the attendant risks of all of this including but not limited to bleeding infection and anastomotic complications leading to long-term stoma." SFH 66.

408. Dr. Taylor thus anticipated complications that in fact followed the LAR surgery: an anastomotic leak and a colostomy.

409. By the end of the consultation, Jeffrey and Cory understood "all this" and agreed to "proceed with formal resection." SFH 66.

410. Accordingly, Dr. Taylor planned a "robotic proctectomy w/ileostomy." SFH 66.

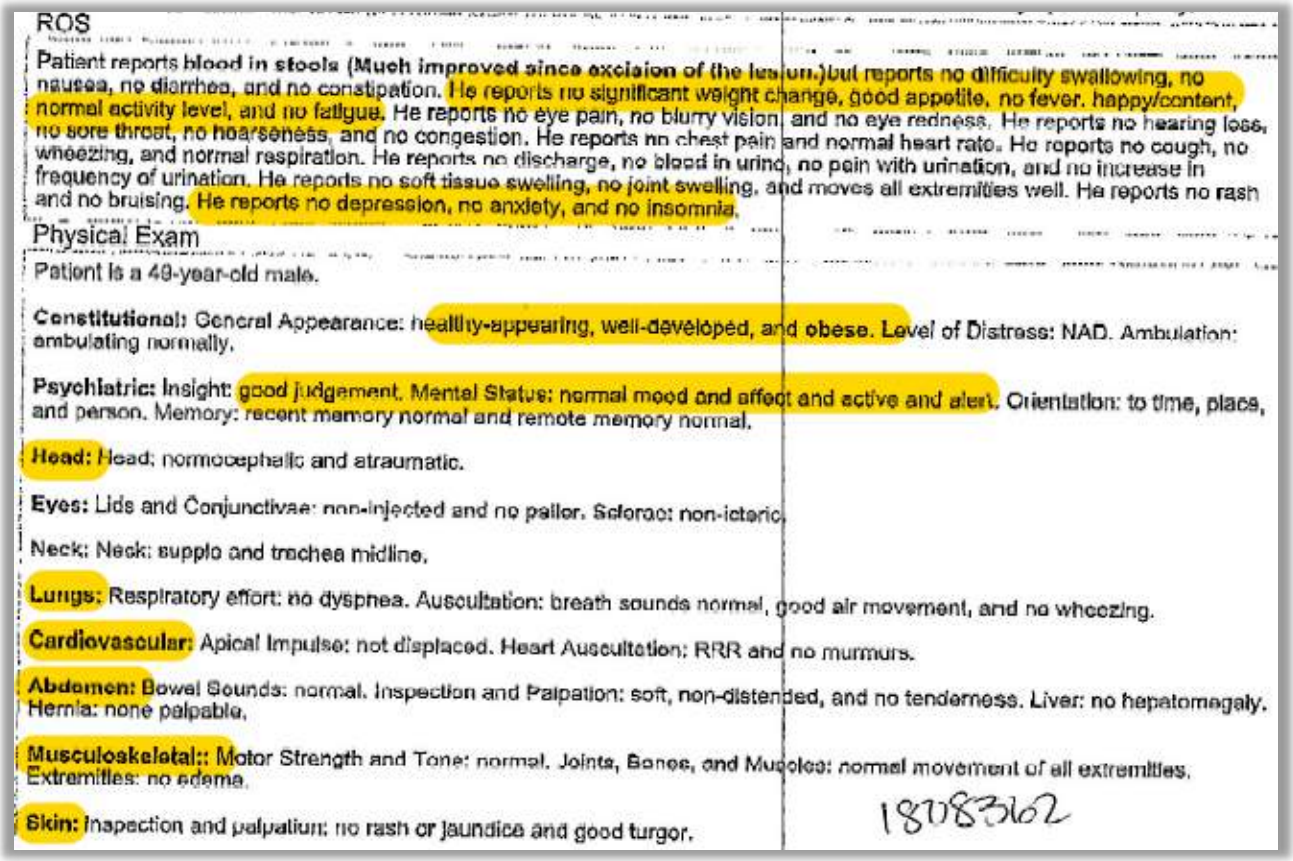
411. At the time of this consultation, 23 days before the planned LAR surgery, Jeffrey was generally in good health. SFH 65. Among other things:

    a. He was "happy/content" with "good appetite" and "normal activity level," and with "no fatigue" and "no depression, no anxiety, and no insomnia." SFH 65.

    b. He was "healthy-appearing, well-developed, and obese." SFH 65.

    c. He demonstrated "good judgment" and "normal mood and affect," and was "active and alert." SFH 65.

    d. His head, lungs, cardiovascular system, abdomen, liver, musculoskeletal system, and skin were all generally normal. SFH 65.



ROS

Patient reports blood in stools (Much improved since excision of the lesion.)but reports no difficulty swallowing, no nausea, no diarrhea, and no constipation. He reports no significant weight change, good appetite, no fever, happy/content, normal activity level, and no fatigue. He reports no eye pain, no blurry vision, and no eye redness. He reports no hearing loss, no sore throat, no hoarseness, and no congestion. He reports no chest pain and normal heart rate. He reports no cough, no wheezing, and normal respiration. He reports no discharge, no blood in urine, no pain with urination, and no increase in frequency of urination. He reports no soft tissue swelling, no joint swelling, and moves all extremities well. He reports no rash and no bruising. He reports no depression, no anxiety, and no insomnia.

Physical Exam

Patient is a 49-year-old male.

Constitutional: General Appearance: healthy-appearing, well-developed, and obese. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal.

Head: Head: normocephalic and atraumatic.

Eyes: Lids and Conjunctivae: non-injected and no pallor. Sclerae: non-icteric.

Neck: Neck: supple and trachea midline.

Lungs: Respiratory effort: no dyspnea. Auscultation: breath sounds normal, good air movement, and no wheezing.

Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: RRR and no murmurs.

Abdomen: Bowel Sounds: normal. Inspection and Palpation: soft, non-distended, and no tenderness. Liver: no hepatomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal. Joints, Bones, and Muscles: normal movement of all extremities. Extremities: no edema.

Skin: Inspection and palpation: no rash or jaundice and good turgor.

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SFH 65.

412. After the consultation, Jeffrey signed an "informed consent" form, authorizing Dr. Taylor "to perform robotic proctectomy with ileostomy." SFH 267-68.

Dr. Taylor Performs "Dirty" LAR Surgery

Friday, December 13: Day of LAR Surgery

413. At 17:36, Dr. Taylor performed the LAR surgery—a "robotic converted to open proctectomy with colo-anal anastomosis and diverting loop ileostomy." SFH 203.

414. During the surgery, Dr. Taylor encountered three surgical issues.

415. First, after making laparoscopic incisions and introducing robotic instruments into Jeffrey's abdomen, Dr. Taylor was unable to obtain "acceptable visualization" robotically, despite "multiple attempts at positioning and

instrumentation retraction." SFH 203. As a result, he converted the robotic procedure to open. SFH 203.

416. Second, the anastomosis failed during the LAR surgery. SFH 203-04.

417. After Dr. Taylor made the anastomosis with a stapler, a sigmoidoscopy revealed an "anterior separation at the anastomotic line." SFH 203.

418. As a result, Dr. Taylor "proceeded to place multiple full-thickness 3 0 Vicryl sutures to reapproximate the suture line." SFH 203. Dr. Taylor sewed the frayed anastomosis by hand. SFH 203.

Technique
The patient was brought to the operating room and following adequate general endotracheal anesthesia was prepped and draped in a normal sterile fashion. CO2 pneumoperitoneum was established to 15 mm of mercury through supraumbilical port site and 4 additional ports were placed in the left and right far lateral and paramedial positions. Cursory inspection revealed marked fatty replacement throughout the abdomen somewhat obscuring visualization of both lobes of the liver but there was no overt capsular disease visualized. Transversus abdominis block was performed using 0.5% bupivacaine. The left colon was widely mobilized from its retroperitoneal attachments all the way from the pelvic brim back in through the splenic flexure to afford tension-free reach for anticipated low pelvic anastomosis. The total mesorectal plane was developed at the sacral promontory and carried back to the base of the superior hemorrhoidal pedicle that was divided hemostatically using Harmonic scalpel. Left ureter was identified and preserved throughout the course of dissection. The robot was docked and we proceeded in a total mesorectal plane from the sacral promontory on down into the pelvis. As we approach the peritoneal reflection we encountered a markedly contracted pelvis with a severely fat replaced mesorectum secondary to the patient's body habitus and despite multiple attempts at positioning and instrumentation retraction we could not have acceptable visualization for continuation of our dissection. The robot was undocked and we proceeded in an open fashion by making long midline incision and proceeded to place a Bookwalter retractor. Under direct vision we continued the total mesorectal dissection well below the peritoneal reflection and using sigmoidoscopic guidance were able to clearly identify our distal margin below the previously placed clips from transanal excision of this tumor. The bowel was divided here using a stapler. The bowel was opened to confirm clear distal margin below prior transanal resection site. The specimen was handed off for pathologic review. Pelvis was copiously irrigated aspirated clear and point hemostasis was achieved using electrocautery. The rectal stump was irrigated and aspirated clear of residual stool revealing an intact staple line. The proximal bowel had an anvil placed in was occluded using a 2 0 Prolene pursestring suture. Under direct vision the stapler was introduced per antrum and coupled to the proximal anvil and tightened and fired. Back table examination revealed intact distal ring but a separated proximal ring. On the table flexible sigmoidoscopy with the pelvis filled with saline revealed anterior separation at the anastomotic line. I proceeded to place multiple full-thickness 3 0 Vicryl sutures to reapproximate the suture line and with further air insufflation there was no further air leak noted. The pelvis was aspirated clear of all fluid and debris and hemostasis was assured. Flexible sigmoidoscopy was performed with the scope advanced above the

SFH 203.

anastomosis revealing significant amount of residual stool that was irrigated aspirated clear as possible so as to decompress the colon. A drain was left in the pelvis and brought out through the left lateral trocar site and secured at the skin using a nylon. The right paramedial trocar site was expanded and a diverting loop ileostomy was matured here using interrup 3 0 chromic sh in a standard Brooke fashion. The midline fascia was closed using running double-stranded 0 PDS and the skin was closed over a drain using staples. The remaining skin sites were closed using Monocryl. Sterile dressings were applied patient was transferred intensive care unit because of noted sclerae edema and length of operation.

SFH 204.

419. Third, Dr. Taylor found residual stool above and below the anastomotic line. SFH 203-04.

420. After the resected bowel "was handed off for pathology review," the "rectal stump was irrigated and aspirated clear of residual stool revealing an intact staple line." SFH 203.

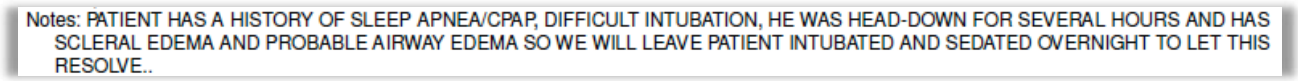
421. After the anastomosis was fixed, the sigmoidoscopy revealed "significant amount of residual stool" in the colon "above the anastomosis." SFH 203-04.

Jeffrey Goes to ICU on a Ventilator, without Antibiotic Treatment

422. At 17:45, Jeffrey "was transferred [to the] intensive care unit because of noted sclerae edema and length of operation." SFH 204.

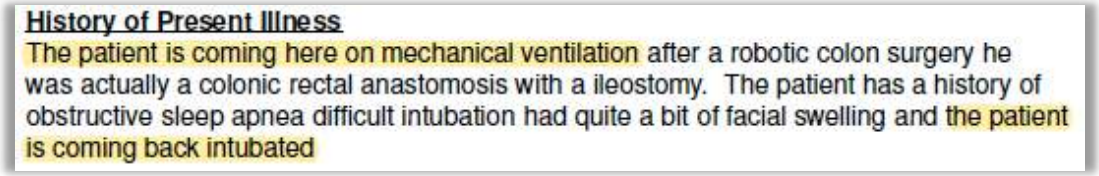
423. At 18:06, Dr. Christopher Kiggins performed a post-anesthesia evaluation of Jeffrey. SFH 21-22.

424. Because Jeffrey "was head-down for several hours and has scleral edema and probable airway edema," Dr. Kiggins decided to "leave patient intubated and sedated overnight to let this resolve." SFH 22.


Notes: PATIENT HAS A HISTORY OF SLEEP APNEA/CPAP, DIFFICULT INTUBATION, HE WAS HEAD-DOWN FOR SEVERAL HOURS AND HAS SCLERAL EDEMA AND PROBABLE AIRWAY EDEMA SO WE WILL LEAVE PATIENT INTUBATED AND SEDATED OVERNIGHT TO LET THIS RESOLVE..

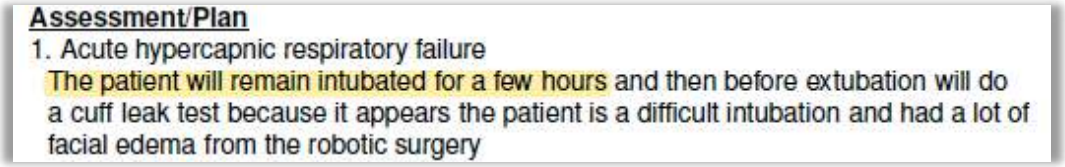
SFH 22.

425. At 18:28, Intensivist Michael N. Metry noted Jeffrey's arrival at the ICU "on mechanical ventilation." SFH 188.


History of Present Illness
The patient is coming here on mechanical ventilation after a robotic colon surgery he was actually a colonic rectal anastomosis with a ileostomy. The patient has a history of obstructive sleep apnea difficult intubation had quite a bit of facial swelling and the patient is coming back intubated

SFH 188.

426. Dr. Metry planned to keep Jeffrey "intubated for a few hours." SFH 188.


Assessment/Plan
1. Acute hypercapnic respiratory failure
The patient will remain intubated for a few hours and then before extubation will do a cuff leak test because it appears the patient is a difficult intubation and had a lot of facial edema from the robotic surgery

SFH 188.

427. There appears to be no record that Dr. Taylor, Dr. Metry, Dr. Hull, or any another provider gave Jeffrey post-operative antibiotics at this time or at any other time before post-operative day 4.

Over Weekend, Jeffrey Is Extubated, He Has Bowel-Movement, and Acute Issues Are Resolved

Saturday, December 14: Post-Operative Day 1

428. At 08:32, Dr. Metry examined Jeffrey. SFH 116-19. Jeffrey's "surgical wound sites" looked "excellent." SFH 119.

429. At 09:44, Surgeon Seaborn Roddenbery examined Jeffrey, who remained "intubated," with "no events overnight." SFH 174.

430. Dr. Roddenbery planned to "wean to extubate today." SFH 178.

Sunday, December 15: Post-Operative Day 2

431. At 03:38, Jeffrey's Procalcitonin was 2.91 ng/ml. SFH 721. As it was above 2.0 ng/ml, it posed "a high risk of severe sepsis and/or septic shock." SFH 721.

Collected Date	12/18/2019	12/15/2019		
Collected Time	09:02 EST	03:38 EST		
Procedure			Units	Reference Range
Procalcitonin	**119.14** H I6 *1	**2.91** H I6 *1	ng/mL	[<=0.08]

Interpretive Data
i6: Procalcitonin
A concentration of <0.5 ng/mL represents a low risk of severe sepsis and/or septic shock.
A concentration of >2 ng/mL represents a high risk of severe sepsis and/or septic shock.

SFH 721.

432. At 08:41, Dr. Metry examined Jeffrey. SFH 114-16. Though "extubated yesterday," he remained "dependent on noninvasive ventilation." SFH 114.

433. Dr. Metry diagnosed Jeffrey with acute kidney injury and acute metabolic encephalopathy. SFH 116.

7. Acute metabolic encephalopathy
He has an acute metabolic encephalopathy will be very judicious with the use of narcotics and sedatives

8. AKI (acute kidney injury)
Creatinine is increased to 1.6 but I believe the patient is fluid overloaded now will watch the creatinine very closely

SFH 116.

434. At 09:21, Dr. Roddenbery examined Jeffrey. SFH 170-74. Jeffrey was "extubated yesterday," but was now "on BiPAP." SFH 170. According to the nurses, Jeffrey was "experiencing some agitation." SFH 170.

Document Type:	Progress Note Generic
Service Date/Time:	12/15/2019 09:21 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Roddenbery,MD,Seaborn (12/15/2019 09:24 EST)

Subjective
Patient was extubated yesterday. He is on BiPAP. According the nursing staff he is experiencing some agitation

SFH 170.

435. At some point between 06:00 and 18:00, Jeffrey had a small bowel-movement. SFH 290.

436. The volume of the stool was 10 milliliters—about 2 teaspoons. SFH 290.

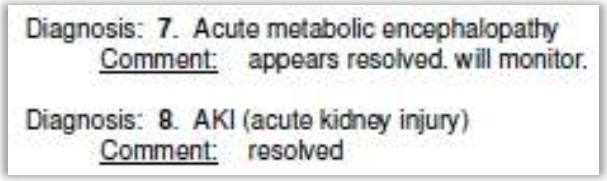
OUTPUT		12/15/2019 - 12/16/2019			12/16/2019 - 12/17/2019		
All time in EST		0600 - 1800	1800 - 0600	Total	0600 - 1800	1800 - 0600	Total
Output : #1 Bulb suction Abdomen Left, Lower	mL	35	25	60	30	25	55
Output : Decompression (NG/OG, Anderson) Nare, left	mL	300	-	300	200	100	300
Output : Urethral Indwelling/Continuous	mL	2250	500	2750	1250	1250	2500
Stool Volume : Hound, Regular Pink, Moist	mL	10	-	10	260	325	585
12 Hour Total	mL	**2595**	**525**		**1740**	**1700**	
24 Hour Total	mL		**3120**			**3440**	

SFH 290.

Monday, December 16: Post-Operative Day 3

437. At 07:47, Intensivist James E. Hull examined Jeffrey. SFH 108-14.

438. At that time, Jeffrey's "acute metabolic encephalopathy" and "acute kidney injury" appeared to be "resolved." SFH 113.



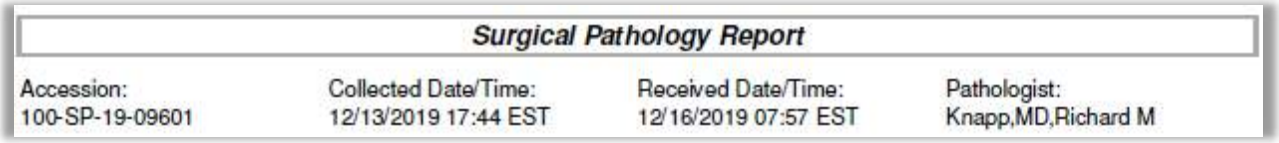
Diagnosis: 7. Acute metabolic encephalopathy
Comment: appears resolved. will monitor.

Diagnosis: 8. AKI (acute kidney injury)
Comment: resolved

SFH 113.

Dr. Knapp Confirms That TAMIS Removed Cancer, Leaving No Residual Malignancy

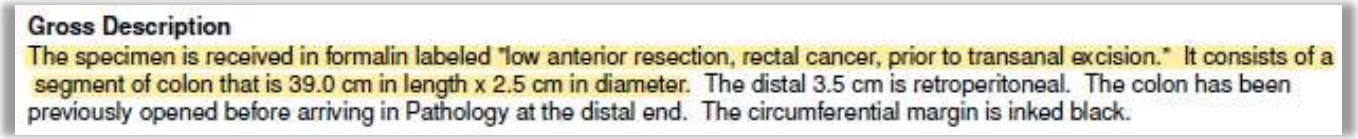
439. At 07:57, Dr. Knapp received the LAR-surgery specimen. SFH 725.



Surgical Pathology Report

Accession:	Collected Date/Time:	Received Date/Time:	Pathologist:
100-SP-19-09601	12/13/2019 17:44 EST	12/16/2019 07:57 EST	Knapp,MD,Richard M

440. Dr. Knapp then performed a microscopy of the specimen—"a segment of colon that [was] 39.0 cm in length x 2.5 cm in diameter." SFH 725.

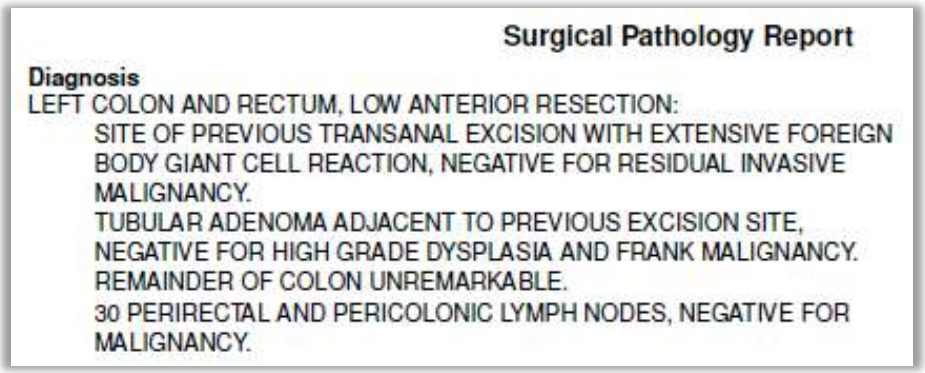


Gross Description
The specimen is received in formalin labeled "low anterior resection, rectal cancer, prior to transanal excision." It consists of a segment of colon that is 39.0 cm in length x 2.5 cm in diameter. The distal 3.5 cm is retroperitoneal. The colon has been previously opened before arriving in Pathology at the distal end. The circumferential margin is inked black.

SFH 725.

441. At the "site of previous transanal excision," the specimen was "negative for residual invasive malignancy." SFH 725.

442. In addition, a "tubular adenoma adjacent to previous excision site" was "negative for high grade dysplasia and frank malignancy." SFH 725.



Surgical Pathology Report

Diagnosis
LEFT COLON AND RECTUM, LOW ANTERIOR RESECTION:
SITE OF PREVIOUS TRANSANAL EXCISION WITH EXTENSIVE FOREIGN BODY GIANT CELL REACTION, NEGATIVE FOR RESIDUAL INVASIVE MALIGNANCY.
TUBULAR ADENOMA ADJACENT TO PREVIOUS EXCISION SITE, NEGATIVE FOR HIGH GRADE DYSPLASIA AND FRANK MALIGNANCY.
REMAINDER OF COLON UNREMARKABLE.
30 PERIRECTAL AND PERICOLONIC LYMPH NODES, NEGATIVE FOR MALIGNANCY.

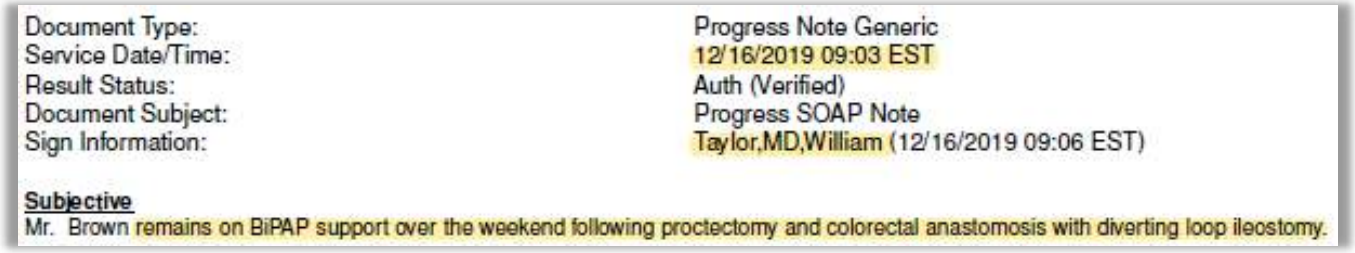
SFH 725.

443. The specimen included "30 perirectal and pericolonic lymph nodes," also "negative for malignancy." SFH 725.

Jeffrey Is Alert, Dr. Taylor Plans to Wean Him from BiPAP

444. At 09:03, Dr. Taylor examined Jeffrey during morning rounds. SFH 166-70.

445. Jeffrey remained "on BiPAP support over the weekend following proctectomy and colorectal anastomosis with diverting loop ileostomy." SFH 166.



Document Type:	Progress Note Generic
Service Date/Time:	12/16/2019 09:03 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Taylor,MD,William (12/16/2019 09:06 EST)

Subjective
Mr. Brown remains on BiPAP support over the weekend following proctectomy and colorectal anastomosis with diverting loop ileostomy.

SFH 166.

446. Jeffrey was alert, responded to questions, and moved all extremities to command. SFH 166.

447. Jeffrey's heart rate had "regular rate and rhythm," but he had had "some tachypnea with attempted weaning at this point." SFH 166.

448. Jeffrey's ileostomy was "pink and functional," and his surgical drain had "minimal serous output." SFH 166.

Physical Exam
He is alert and does respond to questions and moves all extremities to command.
He is on BiPAP with bilateral breath sounds and evidently has had some tachypnea with attempted weaning at this point.
Heart has regular rate and rhythm
Abdomen soft his incisions are clean. His ileostomy is pink and functional. His surgical drain has minimal serous output.

SFH 166.

449. Dr. Taylor decided that "any enteral feeding will be delayed until pulmonary status is stabilized and ileostomy exhibits function." SFH 169.

450. Dr. Taylor also decided to try weaning Jeffrey from BiPAP "again today." SFH 169.

Assessment/Plan
1. Acute hypercapnic respiratory failure
2. Acute pulmonary edema
3. Rectal cancer
   49-year-old male with some respiratory difficulties following proctectomy for rectal cancer. Trial of weaning from BiPAP will be carried out again today. For now any enteral feeding will be delayed until pulmonary status is stabilized and ileostomy exhibits function.
4. Pulmonary HTN
5. Obesity hypoventilation syndrome
6. HTN (hypertension), malignant
7. Acute metabolic encephalopathy
8. AKI (acute kidney injury)

SFH 169.

Jeffrey Has Two Large Bowel-Movements

451. At 14:00, Robin George performed a gastrointestinal assessment. SFH 1040.

452. By that time, Jeffrey had passed a "large" stool. SFH 1040, SFH 290.

453. The volume of this second stool was 260 milliliters—over a cup. SFH 290.

Recorded Date Recorded Time Recorded By	12/17/2019 20:00 EST Creech,Adam	12/17/2019 07:00 EST Novak,Heather	12/16/2019 19:00 EST Duncan,RN,Lauren	12/16/2019 14:00 EST George,Robin
Procedure				
Abdomen Description	Rounded	Normal for Age/Size	Normal for Age/Size	-
Abdomen Palpation	Firm, tender to palpation	Soft, Non-tender	Soft, Non-tender	-
Bowel Movement Last Date	-	-	12/16/19	12/16/2019
Stool Color	-	-	Brown	Brown
Stool Amount	-	-	Small	Large
Stool Description	-	-	Pasty	Liquid
Nausea Level	Mild	None/absent	None/absent	-

SFH 1040.

454. At 19:00, Nurse Duncan performed another gastrointestinal assessment. SFH 1040. Jeffrey had passed another stool. SFH 1040.

455. Although Nurse Duncan described this third stool as "small," it was actually the largest. SFH 1040, SFH 290.

456. The volume of the third stool was 325 milliliters, nearly 1.4 cups. SFH 290.

OUTPUT		12/15/2019 - 12/16/2019			12/16/2019 - 12/17/2019		
All time in EST		0600 - 1800	1800 - 0600	Total	0600 - 1800	1800 - 0600	Total
Output : #1 Bulb suction Abdomen Left, Lower	mL	35	25	60	30	25	55
Output : Decompression (NG/OG, Anderson) Nare, left	mL	300	-	300	200	100	300
Output : Urethral Indwelling/Continuous	mL	2250	500	2750	1250	1250	2500
Stool Volume : Hound, Regular Pink, Moist	mL	10	-	10	260	325	585
12 Hour Total	mL	**2595**	**525**		**1740**	**1700**	
24 Hour Total	mL		**3120**			**3440**	

SFH 290.

Shortly After Bowel-Movements, Jeffrey's Vitals Spike, He Reports Pain, and He Becomes Agitated

457. At 19:00, Nurse Duncan performed an assessment of Jeffrey's pain. SFH 896.

458. At that time, Jeffrey's pain-level was a 7 on a scale of 1-10. SFH 896.

Recorded Date	12/16/2019	12/16/2019
Recorded Time	19:00 EST	18:00 EST
Recorded By	Duncan,RN,Lauren	George,Robin
Procedure		
Pain Present	Yes actual or suspected pain	No actual or suspected pain
Preferred Pain Tool	Numeric rating scale	-
Self Report Pain Evaluation	Pain level acceptable	Pain level acceptable
Numeric Rating Pain Scale	7	-
Numeric Rating Pain Score	7 />14	-

SFH 896.

459. Shortly after the last stool, Jeffrey experienced a spike in his vitals.

460. At 19:43, Jeffrey's temperature shot up to 38.6° C, or 101.48° F. SFH 847.

461. That reading was a significant departure from the five prior readings over the prior 19 hours, all of which were 37.7° or 37.8° C. SFH 849-56.

462. At 19:45, Jeffrey's heart-rate was 91 beats per minute (bmp)—the first time it had exceeded 90 bmp during the entire hospitalization. SFH 847.

		Recorded Date Recorded Time Recorded By	12/16/2019 19:45 EST Duncan,RN,Lauren	12/16/2019 19:43 EST Davis,Bobbie
Procedure	Units	Reference Range		
Temperature Axillary	Deg C	[35.2-36.7]	-	38.6 H
Temperature Axillary Imperial	Deg F		-	101.48 c3 b2
Heart Rate Monitored	bpm	[60-100]	91	-
Respiratory Rate	br/min	[14-20]	24 H	-

SFH 847.

463. At 20:33, upon an order by Dr. Taylor on December 13, Nurse Duncan gave Jeffrey 650 mg of Tylenol, for "temperature greater than 101F/38.3 C." SFH 325.

464. From 20:45 through midnight, over the subsequent 14 readings, Jeffrey's heart-rate fluctuated between 98 and 105 bpm. SFH 845-47.

465. At 20:48, Nurse Duncan again assessed Jeffrey's pain-level, which remained a 7. SFH 896.

Recorded Date Recorded Time Recorded By	12/17/2019 04:00 EST Duncan,RN,Lauren	12/17/2019 00:00 EST Duncan,RN,Lauren	12/16/2019 20:48 EST Duncan,RN,Lauren
Procedure			
Pain Present	-	-	Yes actual or suspected pain
Preferred Pain Tool	Numeric rating scale	Numeric rating scale	-
Numeric Rating Pain Scale	0 = No pain	0 = No pain	7
Numeric Rating Pain Score	0	0	7 />13

SFH 896.

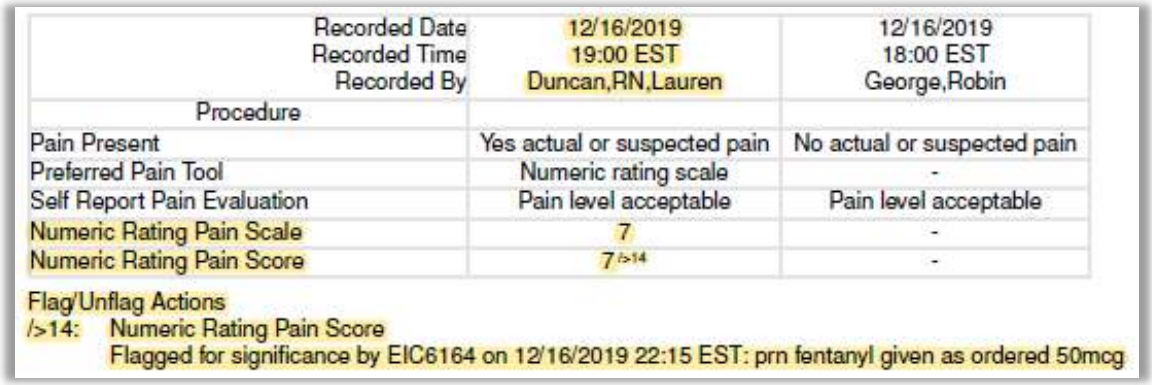
466. At 22:00, Jeffrey's heart-rate was the highest for the entire hospitalization up to this point: 105 bmp. SFH 846.

467. At 22:13, the 38.6° C (101.48° F) temperature noted at 19:43 was "flagged for significance by EIC6164." SFH 847-48.

Flag/Unflag Actions
/>2: Temperature Axillary Imperial
Flagged for significance by EIC6164 on 12/16/2019 22:13 EST: prn tylenol given as ordered 650mg

SFH 848.

468. At 22:15, the pain-level noted at 19:00 was "flagged for significance by EIC6164," and Jeffrey was given 50mcg of fentanyl "as ordered." SFH 896.

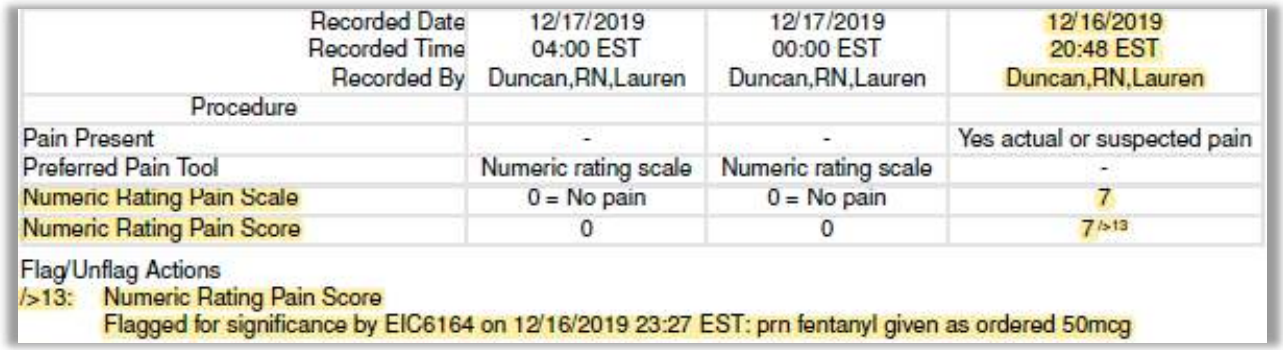


Recorded Date Recorded Time Recorded By	12/16/2019 19:00 EST Duncan,RN,Lauren	12/16/2019 18:00 EST George,Robin
Procedure		
Pain Present	Yes actual or suspected pain	No actual or suspected pain
Preferred Pain Tool	Numeric rating scale	-
Self Report Pain Evaluation	Pain level acceptable	Pain level acceptable
Numeric Rating Pain Scale	7	-
Numeric Rating Pain Score	7 />14	-

Flag/Unflag Actions
/>14: Numeric Rating Pain Score
Flagged for significance by EIC6164 on 12/16/2019 22:15 EST: prn fentanyl given as ordered 50mcg

SFH 896.

469. At 23:27, the pain-level noted at 20:48 was "flagged for significance by EIC6164," and Jeffrey was given 50mcg of fentanyl "as ordered." SFH 896.



Recorded Date Recorded Time Recorded By	12/17/2019 04:00 EST Duncan,RN,Lauren	12/17/2019 00:00 EST Duncan,RN,Lauren	12/16/2019 20:48 EST Duncan,RN,Lauren
Procedure			
Pain Present	-	-	Yes actual or suspected pain
Preferred Pain Tool	Numeric rating scale	Numeric rating scale	-
Numeric Rating Pain Scale	0 = No pain	0 = No pain	7
Numeric Rating Pain Score	0	0	7 />13

Flag/Unflag Actions
/>13: Numeric Rating Pain Score
Flagged for significance by EIC6164 on 12/16/2019 23:27 EST: prn fentanyl given as ordered 50mcg

SFH 896.

Tuesday, December 17: Post-Operative Day 4

470. At 00:00, Jeffrey's respiratory-rate rose to 35 breaths per minute, the highest rate in nearly two days (over 46 hours). SFH 845.

		Recorded Date	12/17/2019	12/17/2019
		Recorded Time	00:15 EST	00:00 EST
		Recorded By	Duncan,RN,Lauren	Duncan,RN,Lauren
Procedure	Units	Reference Range		
Heart Rate Monitored	bpm	[60-100]	94	99
Respiratory Rate	br/min	[14-20]	**34** H	**35** H
Systolic Blood Pressure	mmHg	[90-140]	**160** H	**155** H
Diastolic Blood Pressure	mmHg	[60-90]	74	72
Mean Arterial Pressure,Cuff	mmHg		106	104

SFH 845.

471. At 00:27, Jeffrey's temperature peaked at 39.2° C, or 102.56° F. SFH 844.

472. This was Jeffrey's highest temperature for the entire time he was at St. Francis for this hospitalization. SFH 801-872.

473. At 00:30, Jeffrey's heart-rate again reached 105 bpm. SFH 844.

		Recorded Date	12/17/2019	12/17/2019
		Recorded Time	00:30 EST	00:27 EST
		Recorded By	Duncan,RN,Lauren	Davis,Bobbie
Procedure	Units	Reference Range		
Temperature Axillary	Deg C	[35.2-36.7]	-	**39.2** H
Temperature Axillary Imperial	Deg F		-	**102.56** c2,5,1
Heart Rate Monitored	bpm	[60-100]	**105** H	-
Respiratory Rate	br/min	[14-20]	**28** H	-
Systolic Blood Pressure	mmHg	[90-140]	**177** H	-
Diastolic Blood Pressure	mmHg	[60-90]	80	-
Mean Arterial Pressure,Cuff	mmHg		115	-
Temperature Type			-	Axillary

SFH 844.

474. The spike vital signs was consistent with his clinical presentation: overnight Jeffrey was "agitated" and "dislodged a number of tubes." SFH 163, SFH 104.

Fecal Drainage Confirms Anastomotic Leak

475. At 07:00, Heather Novak assessed Jeffrey's surgical drains. SFH 1094.

476. At that time, Jeffrey's #1 Bulb drain contained "brown" drainage. SFH 1094.

Recorded Date Recorded Time Recorded By	12/17/2019 20:00 EST Creech,Adam	12/17/2019 16:00 EST Novak,Heather	12/17/2019 07:00 EST Novak,Heather	
Procedure				Units
#1 Bulb suction Abdomen Left, Lower				
Surgical Drain,Tube Activity:	Assessment	-	Assessment	
Surgical Drain,Tube Care:	Checked & patent	-	Checked & patent	
Surgical Drain Site Condition:	No complications	-	No complications	
Surgical Drain,Tube Drainage Desc:	Brown	-	Brown	
Surgical Drain Drainage Amount	Scant	-	Small	
Surgical Drain,Tube Dressing Activity:	Changed	-	-	
Surgical Drain,Tube Dressing Condition:	Clean, dry & intact	-	Clean, dry & intact	
Surgical Drain,Tube Drainage Method:	Compression	-	Compression	
Surgical Drain,Tube Output:	-	5	-	mL
#2 Penrose Abdomen				
Surgical Drain,Tube Activity:	Assessment	-	Assessment	
Surgical Drain,Tube Care:	Checked & patent	-	Checked & patent	
Surgical Drain Site Condition:	No complications	-	No complications	
Surgical Drain,Tube Line Dressing:	Gauze	-	Gauze	
Surgical Drain,Tube Dressing Activity:	Changed	-	-	
Surgical Drain,Tube Dressing Condition:	Clean, dry & intact	-	-	

SFH 1094.

477. Despite that finding, there appears to be no record that Nurse Novak or anyone else immediately notified any physician about the drainage.

478. Despite the drainage, the next drain-assessment did not take place until 20:00—13 hours later. SFH 1094.

Although He Prescribes Zosyn for Anastomotic Leak, Dr. Hull Takes No Step to Achieve Source-Control

479. At 07:54, during morning rounds, Dr. Hull examined Jeffrey. SFH 104-08.

480. Dr. Hull recognized that Jeffrey had been "agitated overnight," and had experienced a "large rectal BM" and "fever development." SFH 104.

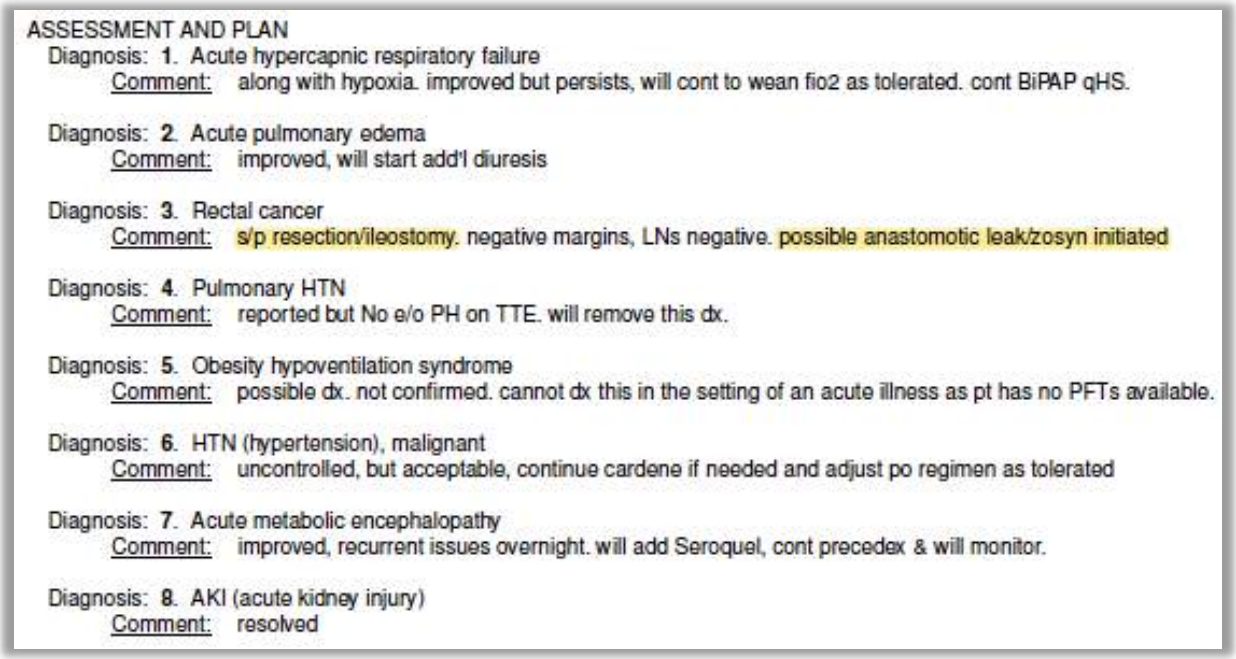
Document Type:	Critical Care Progress Note
Service Date/Time:	12/17/2019 07:54 EST
Result Status:	Auth (Verified)
Document Subject:	Progress Note
Sign Information:	Hull,DO,James E (12/17/2019 19:13 EST)

SUBJECTIVE
24 hour events: pt agitated overnight, large rectal BM, fever development. pt currently denies symptoms, is somnolent on precedex.

SFH 104.

481. Dr. Hull also noted the high-water marks of Jeffrey's temperature overnight: 39.2° C, 38.4° C, and 37.8° C at 00:27, 01:18, and 03:33, respectively. SFH 104.

482. Dr. Hull even recognized that Jeffrey had suffered a "possible anastomotic leak." SFH 107. As a result, Dr. Hull decided to start Jeffrey on the broad-spectrum antibiotic Zosyn. SFH 107.



ASSESSMENT AND PLAN

Diagnosis: **1**. Acute hypercapnic respiratory failure
Comment: along with hypoxia. improved but persists, will cont to wean fio2 as tolerated. cont BiPAP qHS.

Diagnosis: **2**. Acute pulmonary edema
Comment: improved, will start add'l diuresis

Diagnosis: **3**. Rectal cancer
Comment: s/p resection/ileostomy. negative margins, LNs negative. possible anastomotic leak/zosyn initiated

Diagnosis: **4**. Pulmonary HTN
Comment: reported but No e/o PH on TTE. will remove this dx.

Diagnosis: **5**. Obesity hypoventilation syndrome
Comment: possible dx. not confirmed. cannot dx this in the setting of an acute illness as pt has no PFTs available.

Diagnosis: **6**. HTN (hypertension), malignant
Comment: uncontrolled, but acceptable, continue cardene if needed and adjust po regimen as tolerated

Diagnosis: **7**. Acute metabolic encephalopathy
Comment: improved, recurrent issues overnight. will add Seroquel, cont precedex & will monitor.

Diagnosis: **8**. AKI (acute kidney injury)
Comment: resolved

SFH 107.

483. Nevertheless, Dr. Hull's treatment plan failed even to mention the need to achieve source-control by fixing the leak. See SFH 107.

484. As alleged below, Dr. Hull failed even to order a CT-scan, which would have quickly, objectively, and definitively diagnosed the anastomotic leak. SFH 107.

Dr. Taylor Also Recognizes the Anastomotic Leak, Does Nothing to Achieve Source-Control

485. At 08:36, during morning rounds, Dr. Taylor examined Jeffrey. SFH 162-66.

486. Dr. Taylor recognized and documented the following developments:

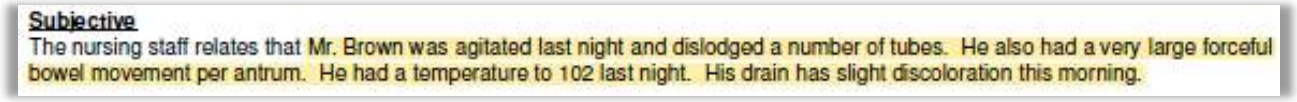
a. Jeffrey "was agitated last night and dislodged a number of tubes."

b. Jeffrey "had a temperature to 102 last night."

c. Jeffrey "also had a very large forceful bowel movement per antrum."

d. Jeffrey's drain had "slight discoloration this morning."

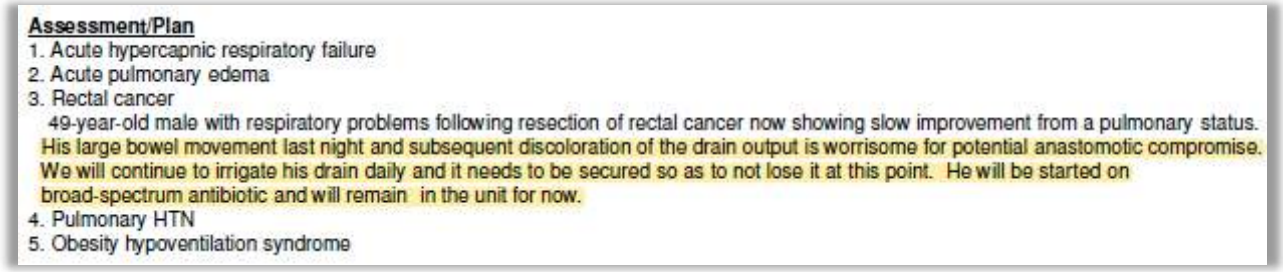
SFH 163.



Subjective
The nursing staff relates that Mr. Brown was agitated last night and dislodged a number of tubes. He also had a very large forceful bowel movement per antrum. He had a temperature to 102 last night. His drain has slight discoloration this morning.

SFH 163.

487. Dr. Taylor also recognized what those developments meant: that Jeffrey's "large bowel movement last night and subsequent discoloration of the drain output" were "worrisome for potential anastomotic compromise." SFH 165.



Assessment/Plan
1. Acute hypercapnic respiratory failure
2. Acute pulmonary edema
3. Rectal cancer
   49-year-old male with respiratory problems following resection of rectal cancer now showing slow improvement from a pulmonary status. His large bowel movement last night and subsequent discoloration of the drain output is worrisome for potential anastomotic compromise. We will continue to irrigate his drain daily and it needs to be secured so as to not lose it at this point. He will be started on broad-spectrum antibiotic and will remain in the unit for now.
4. Pulmonary HTN
5. Obesity hypoventilation syndrome

SFH 165.

488. Nevertheless, Dr. Taylor failed to take any steps to control the source of the fecal contamination and infection—the anastomotic leak. SFH 165.

489. In fact, Dr. Taylor also failed even to order a CT-scan, which would have quickly, objectively, and definitively diagnosed the anastomotic leak.

490. Instead, recognizing the risk of peritonitis, Dr. Taylor started Jeffrey on an antibiotic (Zosyn), without taking any step to achieve source-control. SFH 165.

Jeffrey Finally Receives Antibiotics—After Further Delay

491. At 10:14, Dr. Hull ordered the broad-spectrum antibiotic Zosyn (piperacillin-tazobactam), specifically for "abdominal infection." SFH 661.

Order: **piperacillin-tazobactam (Zosyn)**		
Order Date/Time: 12/17/2019 10:14 EST		
Order Status: Discontinued	Department Status: Discontinued	Activity Type: Pharmacy
End-state Date/Time: 12/18/2019 17:25 EST	End-state Reason:	
Ordering Physician: Hull,DO,James E	Consulting Physician:	
Entered By: Baxley,Andrew on 12/17/2019 10:14 EST		
Order Details: Abdominal infection, Other, 3.375 g 1 EA, IV Piggyback, every 8 hr for 5 days, Administer over: 4 hr, First Dose: 12/17/19 10:00:00 AM CST, Stop Date: 12/18/19 4:25:00 PM CST		
Action Type: Discontinue	Action Date/Time: 12/18/2019 17:25 EST	Electronically Signed By: Hull,DO,James E
Communication Type: Written / Fax		
Action Type: Order	Action Date/Time: 12/17/2019 10:14 EST	Electronically Signed By: Baxley,Andrew
Communication Type: Phone with Read Back		

SFH 661.

492. At 11:30, Nurse Novak administered Zosyn to Jeffrey via IV. SFH 323.

Medication Name: piperacillin-tazobactam (Zosyn)	
Admin Date/Time: **12/17/2019 11:30 EST**	Charted Date/Time: **12/17/2019 11:30 EST**
Ingredients: Sodi0.9Sol100mLMBP 100 mL; piperatazo3g0375glnj 3.375 g	
Admin Details: (Auth) IV Piggyback, Forearm Lower, Left	
Action Details: Order: Hull,DO,James E 12/17/2019 10:14 EST; Perform: Novak,Heather 12/17/2019 11:30 EST; VERIFY: Novak,Heather 12/17/2019 11:30 EST	

SFH 323.

493. The first dose of Zosyn was thus given to Jeffrey at least 21.5 hours after Jeffrey had his first large bowel-movement and at least 4.5 hours after fecal matter was first found in his surgical drain. SFH 661.

494. Thus, insofar as the ICU at this time responded at all to Jeffrey's primary problem by giving him antibiotics, they failed to act on an emergent basis.

As Fecal Matter Continues to Drain, Dr. Taylor and Dr. Hull Still Do Nothing to Achieve Source-Control

495. At 16:00, Nurse Novak found 5 milliliters of additional output in Jeffrey's #1 Bulb drain. SFH 1094.

496. At 18:28, Nurse Novak gave Zosyn to Jeffrey via IV. SFH 322. The "early/late reason" for the administration was: "Medication not available." SFH 322.

Medication Name: piperacillin-tazobactam (Zosyn)
Admin Date/Time: **12/17/2019 18:28 EST** Charted Date/Time: **12/17/2019 18:28 EST**
Ingredients: Sodi0.9Sol100mLMBP 100 mL; piperatazo3g0375glnj 3.375 g
Admin Details: (Auth) IV Piggyback, Forearm Lower, Left
Action Details: Order: Hull,DO,James E 12/17/2019 10:14 EST; Perform: Novak,Heather 12/17/2019 18:28 EST; VERIFY: Novak,Heather 12/17/2019 18:28 EST
Early/Late Reason: Novak,Heather 12/17/2019 18:28 EST
Medication not available

SFH 322.

497. At 20:00, at least 13 hours after fecal matter was first found in Jeffrey's surgical drain, Adam Creech assessed Jeffrey's surgical drains. SFH 1094.

498. The #1 Bulb drain continued having "brown" drainage. SFH 1094.

Recorded Date Recorded Time Recorded By	12/17/2019 20:00 EST Creech,Adam	12/17/2019 16:00 EST Novak,Heather	12/17/2019 07:00 EST Novak,Heather	
Procedure				Units
#1 Bulb suction Abdomen Left, Lower				
Surgical Drain,Tube Activity:	Assessment	-	Assessment	
Surgical Drain,Tube Care:	Checked & patent	-	Checked & patent	
Surgical Drain Site Condition:	No complications	-	No complications	
Surgical Drain,Tube Drainage Desc:	Brown	-	Brown	
Surgical Drain Drainage Amount	Scant	-	Small	
Surgical Drain,Tube Dressing Activity:	Changed	-	-	
Surgical Drain,Tube Dressing Condition:	Clean, dry & intact	-	Clean, dry & intact	
Surgical Drain,Tube Drainage Method:	Compression	-	Compression	
Surgical Drain,Tube Output:	-	5	-	mL
#2 Penrose Abdomen				
Surgical Drain,Tube Activity:	Assessment	-	Assessment	
Surgical Drain,Tube Care:	Checked & patent	-	Checked & patent	
Surgical Drain Site Condition:	No complications	-	No complications	
Surgical Drain,Tube Line Dressing:	Gauze	-	Gauze	
Surgical Drain,Tube Dressing Activity:	Changed	-	-	
Surgical Drain,Tube Dressing Condition:	Clean, dry & intact	-	-	

SFH 1094.

499. Despite that finding, there appears to be no record that Nurse Novak, Nurse Creech, or anyone else notified any medical provider of the brown drainage.

500. There is also no record that Dr. Taylor, Dr. Hull, or any other provider at this point even considered achieving source-control by fixing the anastomotic leak.

Overnight, as Fecal Matter Continues to Drain, Jeffrey Has "Further Fevers" and "Worsening Kidney Function"

Wednesday, December 18: Post-Operative Day 5

501. At 00:00, Nurse Creech again assessed Jeffrey's surgical drains. SFH 1093.

502. The #1 Bulb drain continued to produce "brown" drainage. SFH 1093.

503. At 04:00, Nurse Creech again assessed Jeffrey's surgical drains. SFH 1093-94. He did not describe the output found, if any. SFH 1093-94.

504. Jeffrey continued to be "febrile overnight." SFH 98. He "had further fevers overnight" and "now demonstrated some tachycardia with normal hemodynamics and worsening kidney function." SFH 159.

Though Fecal Drainage Now Emits Foul Odor, Dr. Taylor and Dr. Hull Still Do Nothing to Achieve Source-Control

505. At 07:00, Nurse Novak assessed Jeffrey's surgical drains. SFH 1093-94.

506. Jeffrey's #1 Bulb drain continued to emit "brown" drainage at that time—at least 24 hours after fecal matter first appeared. SFH 1093.

507. The drainage had a "foul odor." SFH 1093.

Recorded Date	12/18/2019	12/18/2019	12/18/2019	
Recorded Time	07:00 EST	04:00 EST	00:00 EST	
Recorded By	Novak,Heather	Creech,Adam	Creech,Adam	
Procedure				Units
#1 Bulb suction Abdomen Left, Lower				
Surgical Drain,Tube Activity:	Assessment	Assessment	Assessment	
Surgical Drain,Tube Care:	Checked & patent	Checked & patent	Checked & patent	
Surgical Drain Site Condition:	No complications	No complications	No complications	
Surgical Drain,Tube Drainage Desc:	Brown, Foul odor	-	Brown	
Surgical Drain Drainage Amount	Scant	-	Scant	
Surgical Drain,Tube Dressing Condition:	Clean, dry & intact	Clean, dry & intact	Clean, dry & intact	
Surgical Drain,Tube Drainage Method:	Compression	Compression	Compression	

SFH 1093.

508. At 07:42, Dr. Hull examined Jeffrey. SFH 98-104. At that time, Dr. Hull noted that Jeffrey continued to be "febrile overnight." SFH 98.

509. At 08:51, Dr. Taylor ordered a stat CT-scan of abdomen and pelvis without contrast. SFH 691.

Order: **CT Abdomen and Pelvis WO Contrast**		
Order Date/Time: 12/18/2019 08:51 EST		
Order Status: Completed	Department Status: Completed	Activity Type: Radiology
End-state Date/Time: 12/18/2019 09:55 EST	End-state Reason:	
Ordering Physician: Taylor,MD,William	Consulting Physician:	
Entered By: Perry,John on 12/18/2019 08:51 EST		
Order Details: 12/18/19 7:51:00 AM CST, STAT, Reason: Other (please specify), Reason: post surgical, post surgical, Patient has IV, Patient on O2		
Action Type: Complete	Action Date/Time: 12/18/2019 09:55 EST	Electronically Signed By: Henson,MD, Nicholas

SFH 691.

510. At 08:56, Dr. Taylor examined Jeffrey. SFH 159-62. Jeffrey's drain was "darkened and foul smelling worrisome for soilage from an anastomotic compromise." SFH 159.

Physical Exam
He is alert but drowsy on sedation medication at this point. His family is at his side.
Lungs are bilateral breath sounds she remains on a Venti mask at this point
Heart exhibits tachycardia without murmur
Abdomen is soft. His drain has minimal output but it is darkened and foul smelling worrisome for soilage from an anastomotic compromise. His ileostomy is pink with minimal function.

SFH 159.

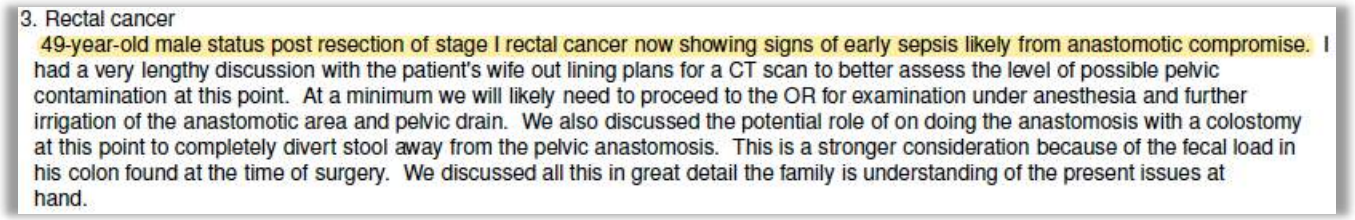
511. Dr. Taylor again expressly recognized what this meant: "All of this is likely reflective of some level of pelvic soilage following challenging of the anastomosis with aggressive bowel movement on Monday." SFH 159.

Document Type:	Progress Note Generic
Service Date/Time:	12/18/2019 08:56 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Taylor,MD,William (12/18/2019 08:59 EST)

Subjective
Mr. Brown is had further fevers overnight and has now demonstrated some tachycardia with normal hemodynamics and worsening kidney function. All of this is likely reflective of some level of pelvic soilage following challenging of the anastomosis with aggressive bowel movement on Monday.

SFH 159.

512. In fact, Jeffrey was "now showing signs of early sepsis likely from anastomotic compromise." SFH 162.



3. Rectal cancer
49-year-old male status post resection of stage I rectal cancer now showing signs of early sepsis likely from anastomotic compromise. I had a very lengthy discussion with the patient's wife out lining plans for a CT scan to better assess the level of possible pelvic contamination at this point. At a minimum we will likely need to proceed to the OR for examination under anesthesia and further irrigation of the anastomotic area and pelvic drain. We also discussed the potential role of on doing the anastomosis with a colostomy at this point to completely divert stool away from the pelvic anastomosis. This is a stronger consideration because of the fecal load in his colon found at the time of surgery. We discussed all this in great detail the family is understanding of the present issues at hand.

SFH 162.

513. Dr. Taylor thus recognized that the large bowel movement nearly two days earlier had caused an anastomotic leak that was now culminating in early sepsis—from fecal peritonitis. A few hours later, Jeffrey was in septic shock.

Dr. Taylor Outlines Source-Control Laparotomy to Cory

514. After the 08:56 examination, Dr. Taylor "had a very lengthy discussion with the patient's wife," this time to outline his treatment plan for Jeffrey's anastomotic leak and resulting fecal peritonitis. SFH 162.

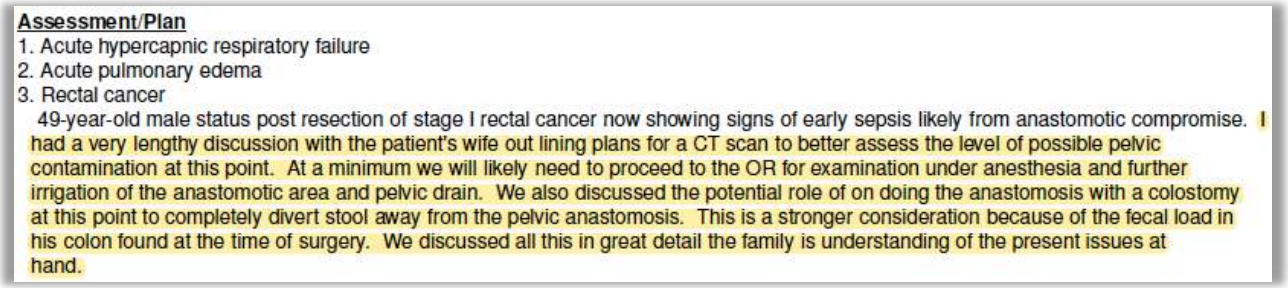
515. First, instead of turning his focus to achieving source-control without further delay, Dr. Taylor outlined his "plans for a CT-scan to better assess the level of possible pelvic contamination at this point." SFH 162.

516. Thus, although Dr. Taylor recognized that Jeffrey was suffering from fecal peritonitis, Dr. Taylor inexplicably doubted the underlying fecal contamination, deeming it "possible." SFH 162.

517. Second, Dr. Taylor previewed a laparotomy—the "likely need to proceed to the OR for examination under anesthesia and [perform] further irrigation of the anastomotic area and pelvic drain." SFH 162.

518. Third, Dr. Taylor outlined "the potential role of [] doing the anastomosis with a colostomy at this point to completely divert stool away from the pelvic anastomosis." SFH 162.

519. Dr. Taylor recognized that the laparotomy with anastomosis and colostomy was "a stronger consideration because of the fecal load in his colon found at the time of surgery." SFH 162.



Assessment/Plan
1. Acute hypercapnic respiratory failure
2. Acute pulmonary edema
3. Rectal cancer

49-year-old male status post resection of stage I rectal cancer now showing signs of early sepsis likely from anastomotic compromise. I had a very lengthy discussion with the patient's wife out lining plans for a CT scan to better assess the level of possible pelvic contamination at this point. At a minimum we will likely need to proceed to the OR for examination under anesthesia and further irrigation of the anastomotic area and pelvic drain. We also discussed the potential role of on doing the anastomosis with a colostomy at this point to completely divert stool away from the pelvic anastomosis. This is a stronger consideration because of the fecal load in his colon found at the time of surgery. We discussed all this in great detail the family is understanding of the present issues at hand.

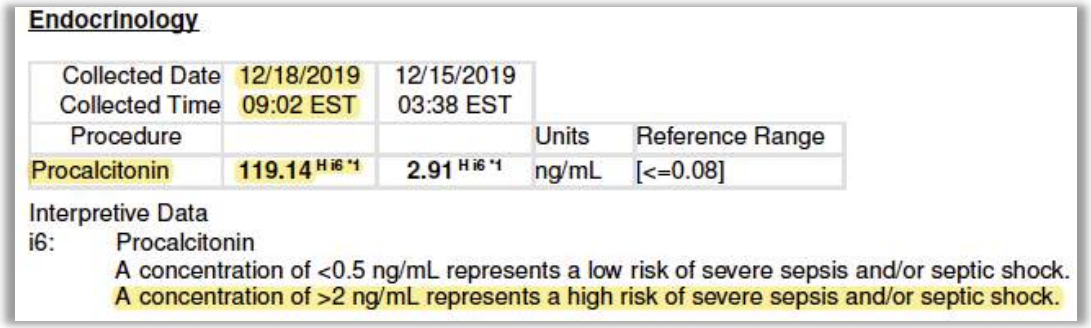
SFH 162.

520. Dr. Taylor "discussed all this in great detail," again going out of his way to note the family's "understanding of the present issues at hand." SFH 162.

Dr. Taylor Continues to Put Off Source-Control, Even After CT Confirms Leak and Sepsis Worsens

521. At 9:02, over three days after his first Procalcitonin test, Jeffrey's Procalcitonin was 119.14 ng/ml. SFH 721. For perspective, the reference range was equal to or less than 0.08. SFH 721.

522. The Procalcitonin level represented "a high risk of severe sepsis and/or septic shock." SFH 721.



Endocrinology

Collected Date	12/18/2019	12/15/2019		
Collected Time	09:02 EST	03:38 EST		
Procedure			Units	Reference Range
Procalcitonin	119.14 H i6 *1	2.91 H i6 *1	ng/mL	[<=0.08]

Interpretive Data
i6: Procalcitonin
A concentration of <0.5 ng/mL represents a low risk of severe sepsis and/or septic shock.
A concentration of >2 ng/mL represents a high risk of severe sepsis and/or septic shock.

SFH 721.

523. At 09:43, Radiologist Nicholas Henson performed CT-scan without contrast of Jeffrey's abdomen and pelvis. SFH 727-28.

524. The CT-scan was thus performed over 25 hours after Dr. Taylor recognized that Jeffrey's bowel movements had likely caused an anastomotic leak, and over 26 hours after fecal matter was first found in Jeffrey's surgical drain.

525. The CT-scan revealed:

a. "Scattered free air predominantly within the superior abdomen." SFH 727. This air was "likely related to recent surgery" SFH 728.

b. "Scattered fluid throughout the abdomen particularly within the right upper abdomen along the anterior margin of the liver." SFH 727.

c. "Rectal anastomosis with apparent anastomotic leak and what appears to be fecal material outside the rectal lumen within the posterior pelvis (series 3, image 320)." SFH 727.

d. "No definite pathologically enlarged lymph nodes." SFH 727.

CT Abdomen without contrast: The sensitivity for focal lesion detection within the solid abdominal viscera is diminished without the use of IV contrast. Enteric tube terminates within the distal gastric body. Scattered free air predominantly within the superior abdomen. Scattered fluid throughout the abdomen particularly within the right upper abdomen along the anterior margin of the liver. Wall enhancement cannot be evaluated without intravenous contrast. The liver is enlarged with steatosis. Spleen is mildly enlarged measuring approximately 14.3 cm in maximal dimension. The adrenals and pancreas are within normal limits. No hydronephrosis. No radiopaque renal or ureteral calculi. Postoperative changes noted along the ventral midline abdomen with superficial drain along the midline incision with air is focal dehiscence containing a loop of bowel (series 3, image 226 along the left aspect of the umbilicus. Postoperative changes of relatively recent LAR with additional surgical drain terminating within the right aspect of the pelvis superiorly. Right lower quadrant diverting ileostomy. Portions of the colon are poorly distended and therefore incompletely evaluated. Nonspecific generalized mesenteric/omental edema. No pneumatosis. No bowel obstruction, pneumatosis, or pneumoperitoneum. Within normal limits right lower quadrant appendix. No abdominal aortic aneurysm. Vascular patency cannot be evaluated without intravenous contrast. Shotty retroperitoneal and mesenteric lymph nodes are nonspecific though statistically are likely reactive.

CT Pelvis without contrast: Foley catheter to compressing the urinary bladder. Tiny right and small left fat-containing inguinal hernias. The prostate gland seminal vesicles are within normal limits. Rectal anastomosis with apparent anastomotic leak and what appears to be fecal material outside the rectal lumen within the posterior pelvis (series 3, image 320). No definite pathologically enlarged lymph nodes.

SFH 727.

526. In sum, the CT confirmed the following: "Postoperative changes of relatively recent LAR . . . concerning for rectal anastomotic leak with apparent moderate amount of feculent material within the posterior pelvis." SFH 728, SFH 157.

IMPRESSION:
1. Postoperative changes of relatively recent LAR with concerning for rectal anastomotic leak with apparent moderate amount of feculent material within the posterior pelvis. Correlate clinically.
2. Surgical drains present including a superficial subcutaneous drain with apparent dehiscence of the rectus fascia with a small left periumbilical hernia containing an uncomplicated loop of small bowel abutting the posterior aspect of the superficial surgical drain.
3. Small volume free air likely related to recent surgery.
4. Scattered fluid throughout the abdomen.
5. Trace pleural effusion. Probable passive atelectasis involving the dependent lung bases versus less likely multifocal pneumonia. Correlate clinically.
6. Hepatomegaly with hepatic steatosis.
7. Please see above report for full details.

These findings were discussed with Dr. Bill Taylor at 0950 hours 12/18/2019 by Dr. Nicholas Henson.

SFH 728.

527. At 09:50, Dr. Hensen discussed his findings with Dr. Taylor. SFH 157.

528. At 10:27, an order was entered for an "Exploration Laparotomy." SFH 700.

529. The procedure, however, did not start for at least three additional hours. SFH 700, SFH 304.

Surgery

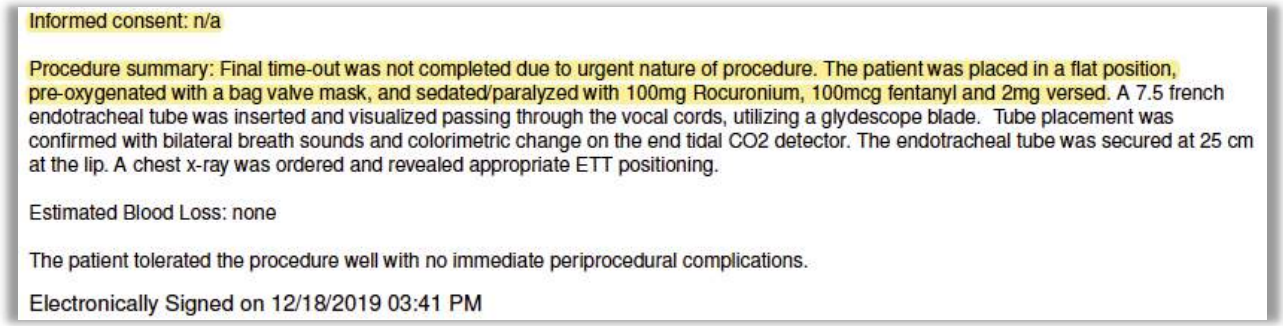
Order: **Exploration Laparotomy**		
Order Date/Time: 12/18/2019 10:27 EST		
Order Status: Completed	Department Status: Completed	Activity Type: Surgery
End-state Date/Time: 12/18/2019 15:27 EST	End-state Reason:	
Ordering Physician:	Consulting Physician:	
Entered By: Fuller,Rebecca (Per-Sch) on 12/18/2019 10:27 EST		
Order Details: Taylor, MD, William, 12/18/19 1:00:00 PM CST, IP - Inpatient, Elective, Rectal Cancer, Anastomotic Failure, Primary Procedure?, None, Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)..., General, 110, 10, 10, Concurrent Indicator, ORD_SET_REQ_DT_RANGE		
Action Type: Complete	Action Date/Time: 12/18/2019 15:27 EST	Electronically Signed By: Karandisevsky, RN,Chandler
Communication Type:		
Action Type: Activate	Action Date/Time: 12/18/2019 13:29 EST	Electronically Signed By: Karandisevsky, RN,Chandler
Communication Type:		
Action Type: Order	Action Date/Time: 12/18/2019 10:27 EST	Electronically Signed By: Fuller,Rebecca (Per-Sch)

SFH 700.

Jeffrey Slides Quickly Into Septic Shock

530. At 10:40, Dr. Hull intubated Jeffrey. SFH 194-95.

531. Jeffrey was "sedated/paralyzed" for the procedure. SFH 195. Dr. Hull did not complete a final time-out "due to urgent nature of procedure." SFH 195.



Informed consent: n/a

Procedure summary: Final time-out was not completed due to urgent nature of procedure. The patient was placed in a flat position, pre-oxygenated with a bag valve mask, and sedated/paralyzed with 100mg Rocuronium, 100mcg fentanyl and 2mg versed. A 7.5 french endotracheal tube was inserted and visualized passing through the vocal cords, utilizing a glydescope blade. Tube placement was confirmed with bilateral breath sounds and colorimetric change on the end tidal CO2 detector. The endotracheal tube was secured at 25 cm at the lip. A chest x-ray was ordered and revealed appropriate ETT positioning.

Estimated Blood Loss: none

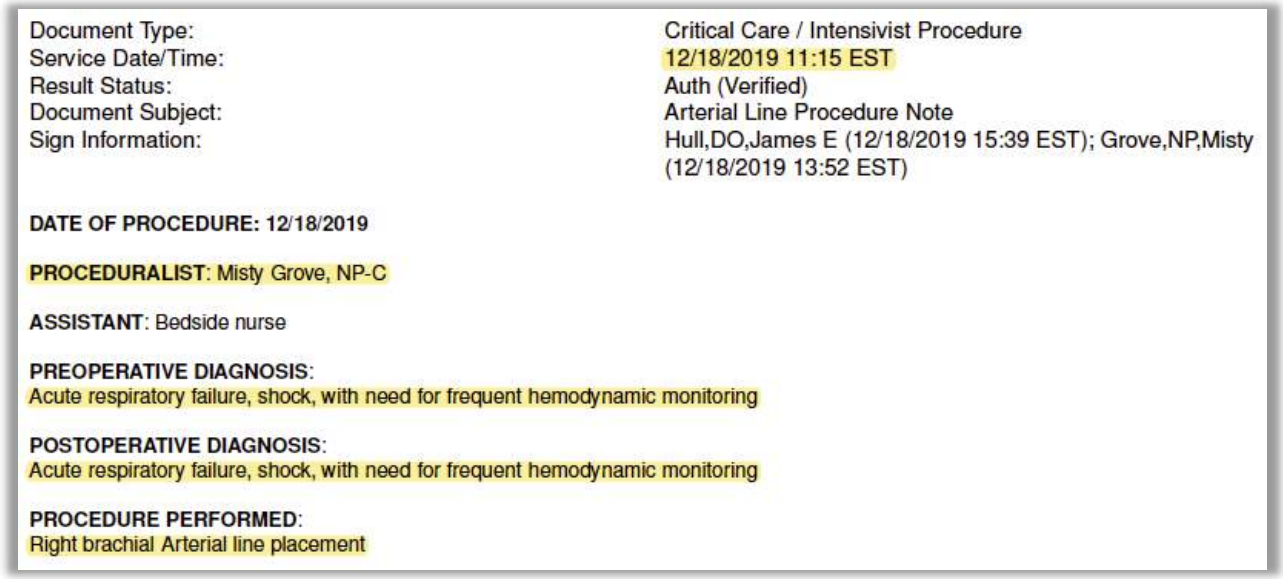
The patient tolerated the procedure well with no immediate periprocedural complications.

Electronically Signed on 12/18/2019 03:41 PM

SFH 195

532. At 10:44, Dr. Hull ordered a stat Procalcitonin test, to be taken "every 3 days, for 2 times." SFH 581.

533. At 11:15, NP-C Misty Grove placed a central line in Jeffrey's right brachial artery, for "acute respiratory failure, shock, with need for frequent hemodynamic monitoring." SFH 197-98.



Document Type:	Critical Care / Intensivist Procedure
Service Date/Time:	12/18/2019 11:15 EST
Result Status:	Auth (Verified)
Document Subject:	Arterial Line Procedure Note
Sign Information:	Hull,DO,James E (12/18/2019 15:39 EST); Grove,NP,Misty (12/18/2019 13:52 EST)

DATE OF PROCEDURE: 12/18/2019

PROCEDURALIST: Misty Grove, NP-C

ASSISTANT: Bedside nurse

PREOPERATIVE DIAGNOSIS:
Acute respiratory failure, shock, with need for frequent hemodynamic monitoring

POSTOPERATIVE DIAGNOSIS:
Acute respiratory failure, shock, with need for frequent hemodynamic monitoring

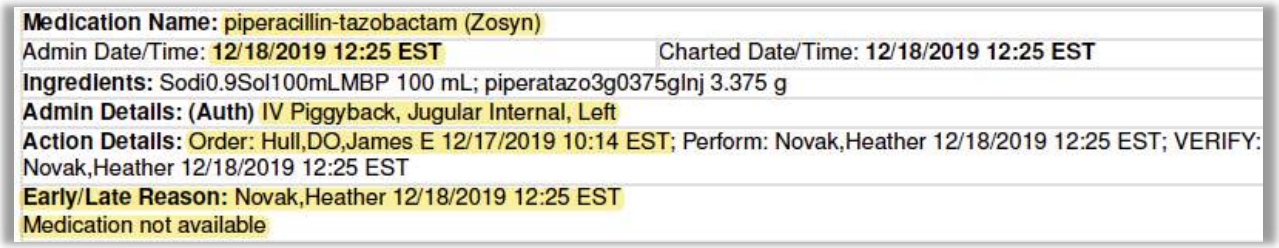
PROCEDURE PERFORMED:
Right brachial Arterial line placement

SFH 197.

534. At 11:55, NP-C Grove placed a central line in Jeffrey's right internal jugular vein, for "acute respiratory failure, sepsis, with inadequate IV access." SFH 196-97.

535. At 12:25, upon an order by Dr. Hull entered at 10:14, Nurse Novak administered Zosyn to Jeffrey through his left internal jugular vein. SFH 318.

536. The "early/late reason" for the administration was: "Medication not available." SFH 318.

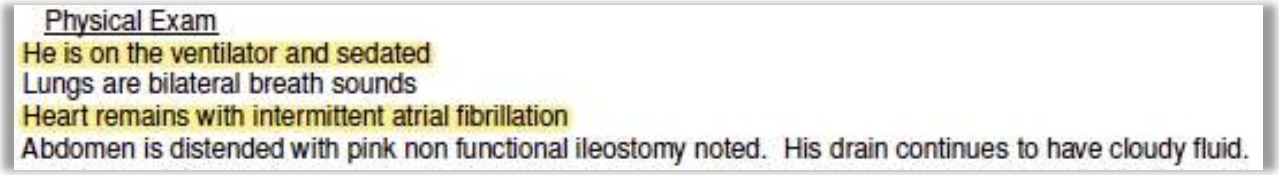

Medication Name: piperacillin-tazobactam (Zosyn)
Admin Date/Time: **12/18/2019 12:25 EST** Charted Date/Time: **12/18/2019 12:25 EST**
Ingredients: Sodi0.9Sol100mLMBP 100 mL; piperatazo3g0375glnj 3.375 g
Admin Details: (Auth) IV Piggyback, Jugular Internal, Left
Action Details: Order: Hull,DO,James E 12/17/2019 10:14 EST; Perform: Novak,Heather 12/18/2019 12:25 EST; VERIFY: Novak,Heather 12/18/2019 12:25 EST
Early/Late Reason: Novak,Heather 12/18/2019 12:25 EST
Medication not available

SFH 318.

Dr. Taylor Finally Recommends Source-Control Laparotomy—
After Jeffrey Has Become Critically Ill

537. At 13:34, nearly four hours after the CT-scan was completed, Dr. Taylor examined Jeffrey again. SFH 154-58.

538. Jeffrey was now "on the ventilator and sedated." SFH 154. His heart remained "with intermittent atrial fibrillation."[5] SFH 154.


Physical Exam
He is on the ventilator and sedated
Lungs are bilateral breath sounds
Heart remains with intermittent atrial fibrillation
Abdomen is distended with pink non functional ileostomy noted. His drain continues to have cloudy fluid.

SFH 154.

[5] Atrial fibrillation is an irregular and often chaotic heart rhythm. During atrial fibrillation, the heart's atria (its small, upper chambers) beat chaotically and irregularly, out of sync with the lower chambers (the ventricles). As occurred here, atrial fibrillation can result in cardiac arrest and death.

539. Dr. Taylor recognized that the CT-scan showed "evidence of significant pelvic contamination." SFH 154.

540. Indeed, Jeffrey's surgical drain continued to have "cloudy fluid." SFH 154.

541. Jeffrey was now suffering from "critical illness secondary to anastomotic failure and pelvic enteric soilage despite diverting loop ileostomy." SFH 158.

542. Dr. Taylor finally decided to transfer Jeffrey "to the OR for emergent abdominal exploration and anticipated colostomy so as to prevent any further abdominal source of his ongoing sepsis." SFH 158.

543. Dr. Taylor thus finally focused on trying to achieve source-control.

544. Dr. Taylor "again discussed all this in detail with the patient's wife and family," answering "all of the family's questions" as best he could. SFH 158.

Assessment/Plan
1. Acute hypercapnic respiratory failure
2. Acute pulmonary edema
3. Rectal cancer
   49-year-old male with critical illness secondary to anastomotic failure and pelvic enteric soilage despite diverting loop ileostomy. We again discussed all this in detail with the patient's wife and family. As previously outlined we will transfer to the OR for emergent abdominal exploration and anticipated colostomy so as to prevent any further abdominal source of his ongoing sepsis. All of the family's questions were answered as best we could and pending care issues were outlined with the OR nursing staff and the anesthesiology team.
4. Obesity hypoventilation syndrome
5. HTN (hypertension), malignant
6. Acute metabolic encephalopathy
7. AKI (acute kidney injury)

SFH 158.

545. Dr. Taylor thus went out of his way, yet again, to document consent.

Dr. Taylor Finally Achieves Source-Control—Laparotomy with Colectomy and Diverting Colostomy

546. At 13:50, Dr. Taylor started the laparotomy. SFH 304.

Procedure: **Exploration Laparotomy (None)**		
Last Updated: 12/18/2019 15:27 EST; Karandisevsky, RN,Chandler	**Status:** Active	**Procedure Date:** 12/18/2019 13:50 EST (49 years)
Code:	**Location:** STFR Main OR	**Ranking:**
Provider: Taylor,MD,William	**Last Reviewed:**	**Related Diagnosis:**

SFH 304.

547. At 15:15 or later, Dr. Taylor completed the "abdominal exploration with creation of end-colostomy." SFH 201. By that time:

    a. Over 27 hours had passed since Jeffrey was started on Zosyn. SFH 323.

    b. Over 30 hours had passed since Dr. Taylor realized that the "large bowel movement last night and subsequent discoloration of the drain output" were "worrisome for potential anastomotic compromise." SFH 165.

    c. Over 31 hours had passed since Dr. Hull decided to order Zosyn specifically "for abdominal infection." SFH 661.

    d. Over 32 hours had passed since fecal matter was first found in Jeffrey's surgical drain. SFH 1094.

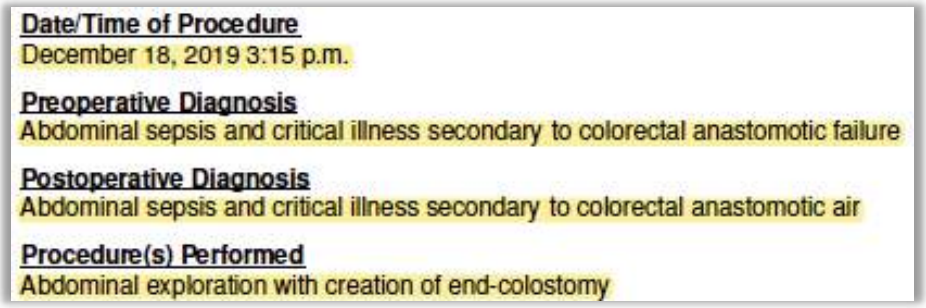
    e. Over 38 hours had passed since Jeffrey's temperature peaked at 39.2° C, 102.56° F, the highest point of the entire hospitalization. SFH 844.

    f. Over 39 hours had passed since Jeffrey's heart-rate soared to 105 bmp. SFH 846.

    g. Over 44 hours had passed since Jeffrey's second large bowel-movement. SFH 1040, SFH 290.

    h. Over 49 hours had passed since Jeffrey's first large bowel-movement. SFH 1040, SFH 290.

548. The reason for the surgery was "abdominal sepsis and critical illness secondary to colorectal anastomotic failure." SFH 201.



Date/Time of Procedure
December 18, 2019 3:15 p.m.

Preoperative Diagnosis
Abdominal sepsis and critical illness secondary to colorectal anastomotic failure

Postoperative Diagnosis
Abdominal sepsis and critical illness secondary to colorectal anastomotic air

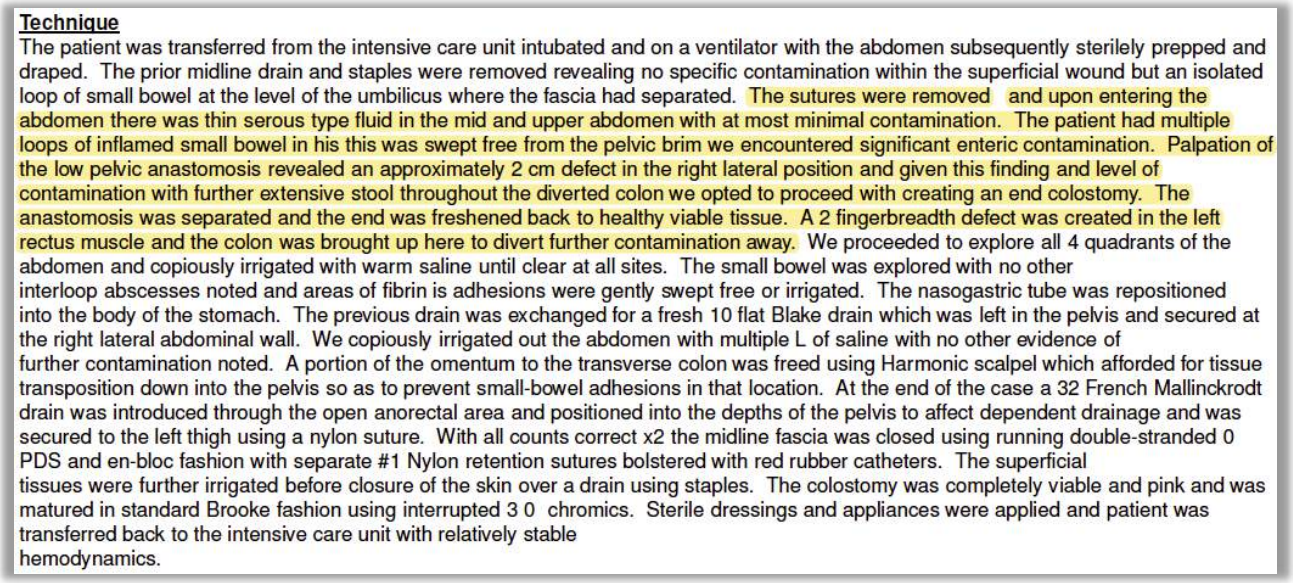
Procedure(s) Performed
Abdominal exploration with creation of end-colostomy

SFH 201.

549. During the procedure, Dr. Taylor found "multiple loops of inflamed small bowel" and "significant enteric contamination." SFH 202.

550. Dr. Taylor also found "an approximately 2-cm defect in the right lateral position" of the anastomosis. SFH 202.

551. In light of that defect and the "level of contamination with further extensive stool throughout the diverted colon," Dr. Taylor "opted to proceed with creating an end colostomy," in order "to divert further contamination away." SFH 202.



Technique
The patient was transferred from the intensive care unit intubated and on a ventilator with the abdomen subsequently sterilely prepped and draped. The prior midline drain and staples were removed revealing no specific contamination within the superficial wound but an isolated loop of small bowel at the level of the umbilicus where the fascia had separated. The sutures were removed and upon entering the abdomen there was thin serous type fluid in the mid and upper abdomen with at most minimal contamination. The patient had multiple loops of inflamed small bowel in his this was swept free from the pelvic brim we encountered significant enteric contamination. Palpation of the low pelvic anastomosis revealed an approximately 2 cm defect in the right lateral position and given this finding and level of contamination with further extensive stool throughout the diverted colon we opted to proceed with creating an end colostomy. The anastomosis was separated and the end was freshened back to healthy viable tissue. A 2 fingerbreadth defect was created in the left rectus muscle and the colon was brought up here to divert further contamination away. We proceeded to explore all 4 quadrants of the abdomen and copiously irrigated with warm saline until clear at all sites. The small bowel was explored with no other interloop abscesses noted and areas of fibrin is adhesions were gently swept free or irrigated. The nasogastric tube was repositioned into the body of the stomach. The previous drain was exchanged for a fresh 10 flat Blake drain which was left in the pelvis and secured at the right lateral abdominal wall. We copiously irrigated out the abdomen with multiple L of saline with no other evidence of further contamination noted. A portion of the omentum to the transverse colon was freed using Harmonic scalpel which afforded for tissue transposition down into the pelvis so as to prevent small-bowel adhesions in that location. At the end of the case a 32 French Mallinckrodt drain was introduced through the open anorectal area and positioned into the depths of the pelvis to affect dependent drainage and was secured to the left thigh using a nylon suture. With all counts correct x2 the midline fascia was closed using running double-stranded 0 PDS and en-bloc fashion with separate #1 Nylon retention sutures bolstered with red rubber catheters. The superficial tissues were further irrigated before closure of the skin over a drain using staples. The colostomy was completely viable and pink and was matured in standard Brooke fashion using interrupted 3 0 chromics. Sterile dressings and appliances were applied and patient was transferred back to the intensive care unit with relatively stable hemodynamics.

SFH 202.

Jeffrey Remains Critically Ill with "Severe Sepsis with Septic Shock," Receives Renal Replacement Therapy

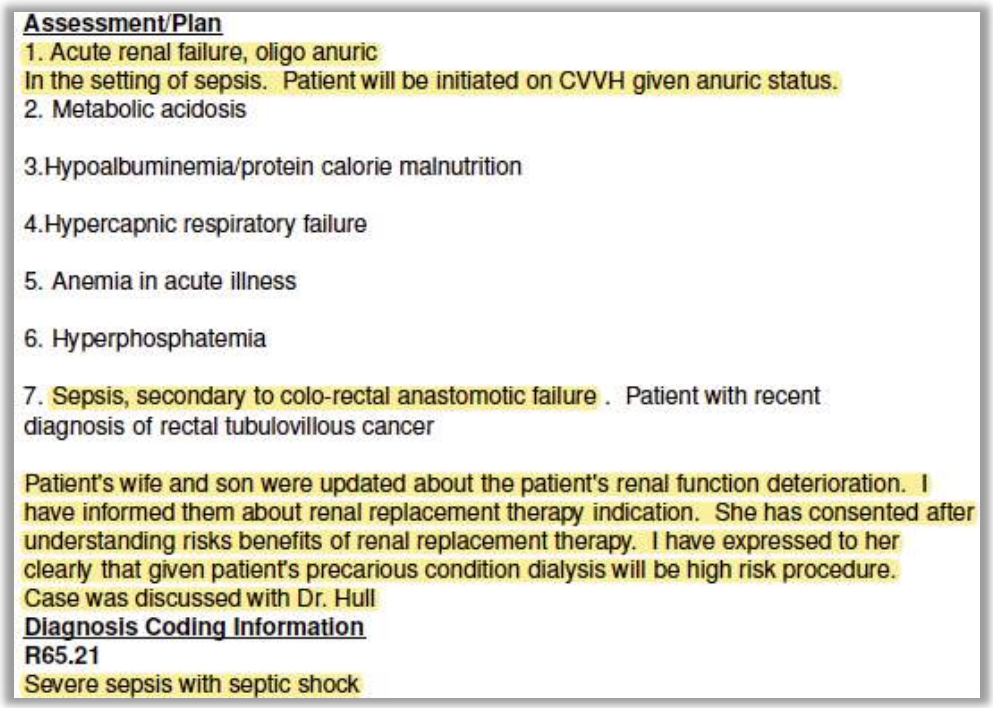
552. At 15:52, the Cerner system belatedly entered a "Discern Expert" order for "Possible Sepsis," signed by Heather Novak. SFH 607.

553. At 16:50, Nephrologist Sarfraz Molvi evaluated Jeffrey for "acute renal failure and worsening metabolic acidosis." SFH 191.

554. By now, Jeffrey had "sepsis, secondary to colo-rectal anastomotic failure," and "severe sepsis with septic shock." SFH192.

555. At that time, Dr. Molvi was unable to obtain a review of systems "given patient's critically ill condition." SFH 196.

556. Dr. Molvi decided to initiate "CVVH given anuric status."[6] SFH 192.



Assessment/Plan
1. Acute renal failure, oligo anuric
In the setting of sepsis. Patient will be initiated on CVVH given anuric status.
2. Metabolic acidosis

3.Hypoalbuminemia/protein calorie malnutrition

4.Hypercapnic respiratory failure

5. Anemia in acute illness

6. Hyperphosphatemia

7. Sepsis, secondary to colo-rectal anastomotic failure . Patient with recent diagnosis of rectal tubulovillous cancer

Patient's wife and son were updated about the patient's renal function deterioration. I have informed them about renal replacement therapy indication. She has consented after understanding risks benefits of renal replacement therapy. I have expressed to her clearly that given patient's precarious condition dialysis will be high risk procedure.
Case was discussed with Dr. Hull
Diagnosis Coding Information
R65.21
Severe sepsis with septic shock

SFH 192.

557. At 17:33, the Cerner system entered another belated "Discern Expert" order for "Possible Septic Shock" signed by Heather Novak. SFH 607.

Jeffrey Is "Not Arousable," His Kidneys Fail, and He Has Atrial Fibrillation

Thursday, December 19: Post-Operative Day 6

558. At 07:00, Nurse Novak assessed Jeffrey's surgical drains, 24 hours after the last assessment. SFH 1093

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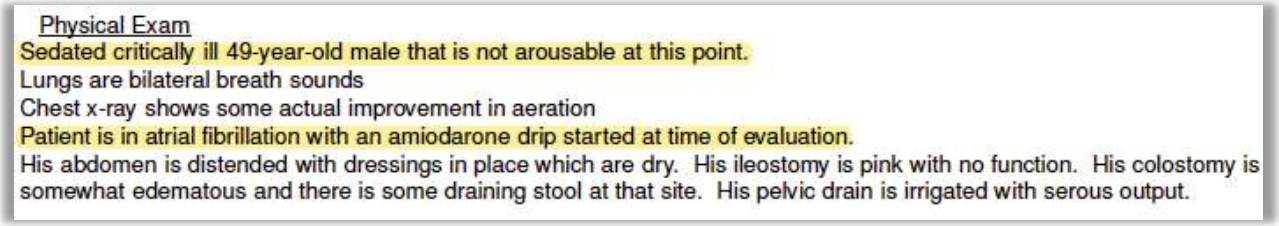
[6] Continuous Veno-Venous Hemofiltration (CVVH) is a short-term treatment used in ICU patients with acute or chronic renal failure. When a patient has low blood-pressure or some other contradindicator to hemodialysis, CVVH may be a necessary alternative.

559. At 10:39, Dr. Taylor examined Jeffrey. SFH 148-53. Jeffrey remained "critically ill with signs of significant sepsis." SFH 148.

560. Jeffrey was "not arousable at this point." SFH 149.

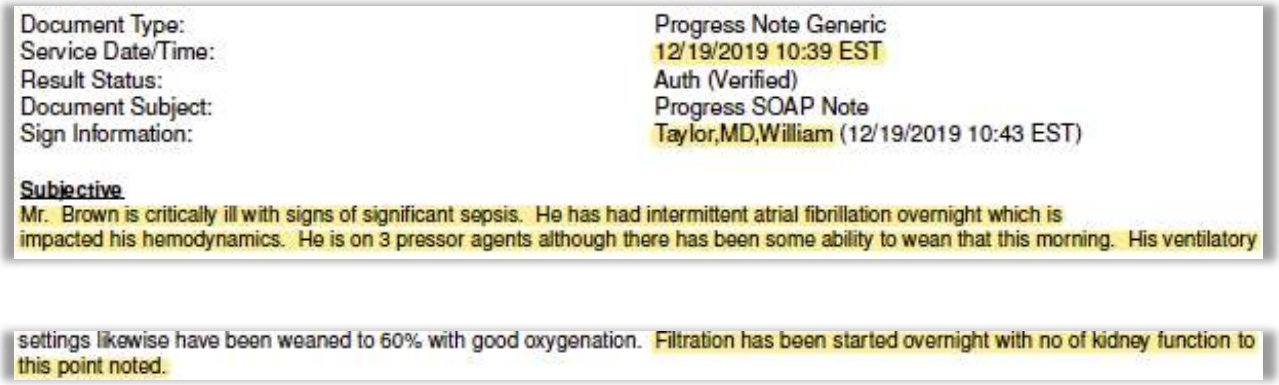


Physical Exam
Sedated critically ill 49-year-old male that is not arousable at this point.
Lungs are bilateral breath sounds
Chest x-ray shows some actual improvement in aeration
Patient is in atrial fibrillation with an amiodarone drip started at time of evaluation.
His abdomen is distended with dressings in place which are dry. His ileostomy is pink with no function. His colostomy is somewhat edematous and there is some draining stool at that site. His pelvic drain is irrigated with serous output.

SFH 149.

561. Jeffrey had had "intermittent atrial fibrillation overnight," impacting his hemodynamics. SFH 148. Consequently, Dr. Taylor started Jeffrey on an amiodarone drip (a potent anti-arrhythmia agent). SFH 148-49.

562. "Filtration" was "started overnight with no kidney function to this point noted." SFH 149.



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Service Date/Time:	12/19/2019 10:39 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Taylor,MD,William (12/19/2019 10:43 EST)

Subjective
Mr. Brown is critically ill with signs of significant sepsis. He has had intermittent atrial fibrillation overnight which is impacted his hemodynamics. He is on 3 pressor agents although there has been some ability to wean that this morning. His ventilatory settings likewise have been weaned to 60% with good oxygenation. Filtration has been started overnight with no of kidney function to this point noted.

SFH 148-49.

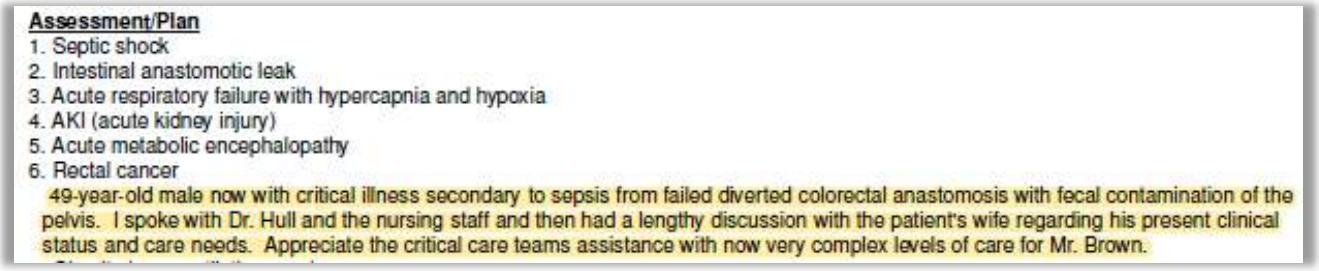
563. Jeffrey also had "septic shock," and "severe sepsis with septic shock." SFH 153.

564. In sum, Jeffrey had "critical illness secondary to sepsis from failed diverted colorectal anastomosis with fecal contamination of the pelvis." SFH 153.

Dr. Taylor Meets with Cory, Thanks ICU for Assistance with "Very Complex" Case

565. After speaking "with Dr. Hull and the nursing staff," Dr. Taylor "had a lengthy discussion with the patient's wife regarding his present clinical status and care needs." SFH 153.

566. Dr. Taylor also documented his appreciation for the ICU's "assistance with now very complex levels of care for Mr. Brown." SFH 153.



Assessment/Plan
1. Septic shock
2. Intestinal anastomotic leak
3. Acute respiratory failure with hypercapnia and hypoxia
4. AKI (acute kidney injury)
5. Acute metabolic encephalopathy
6. Rectal cancer

49-year-old male now with critical illness secondary to sepsis from failed diverted colorectal anastomosis with fecal contamination of the pelvis. I spoke with Dr. Hull and the nursing staff and then had a lengthy discussion with the patient's wife regarding his present clinical status and care needs. Appreciate the critical care teams assistance with now very complex levels of care for Mr. Brown.

SFH 153.

567. At 15:16, Dr. Molvi examined Jeffrey. SFH 125-132. Jeffrey was still "mechanically ventilated and sedated." SFH 126.

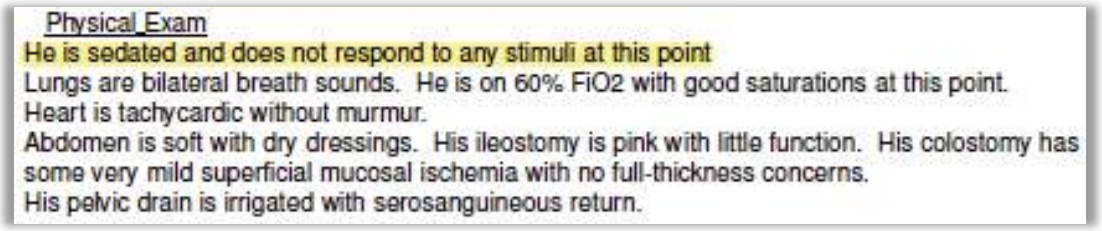
568. Dr. Molvi was unable to perform a review of systems because of Jeffrey's "critically ill condition." SFH 126.

Jeffrey Suffers "Multiorgan Dysfunction Syndrome/Shock Liver"

Friday, December 20: Post-Operative Day 7

569. At 07:36 Eastern, the Cerner system belatedly entered a "Discern Expert" order for "Possible Septic Shock" signed by Heather Novak. SFH 606.

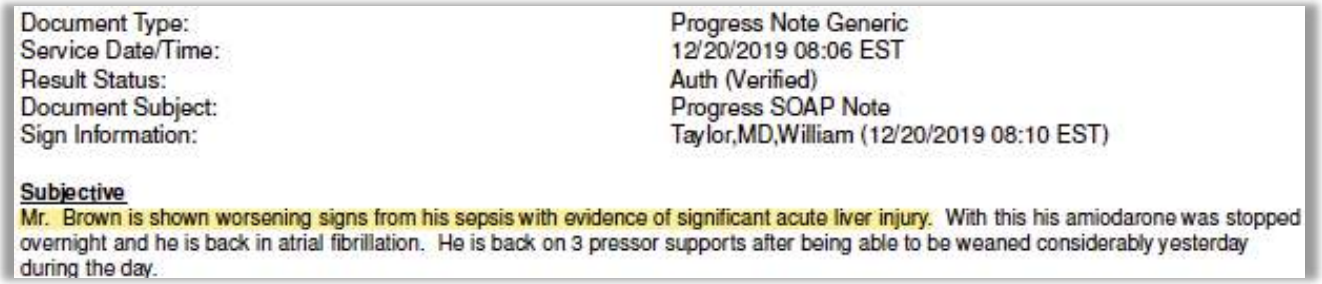
570. At 08:06, Dr. Taylor examined Jeffrey. SFH 143-48. Jeffrey remained "sedated" and did not "respond to any stimuli at this point." SFH 143.



Physical Exam
He is sedated and does not respond to any stimuli at this point
Lungs are bilateral breath sounds. He is on 60% FiO2 with good saturations at this point.
Heart is tachycardic without murmur.
Abdomen is soft with dry dressings. His ileostomy is pink with little function. His colostomy has some very mild superficial mucosal ischemia with no full-thickness concerns.
His pelvic drain is irrigated with serosanguineous return.

SFH 144.

571. Jeffrey now showed "worsening signs from his sepsis with evidence of significant acute liver injury." SFH 143.



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Service Date/Time:	12/20/2019 08:06 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Taylor,MD,William (12/20/2019 08:10 EST)

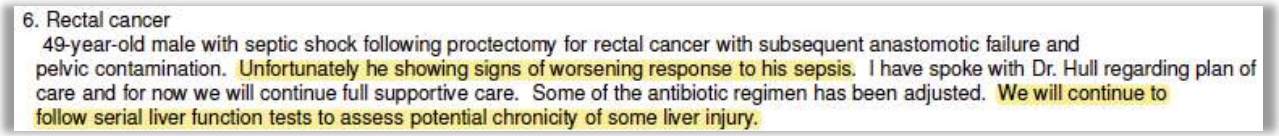
Subjective

Mr. Brown is shown worsening signs from his sepsis with evidence of significant acute liver injury. With this his amiodarone was stopped overnight and he is back in atrial fibrillation. He is back on 3 pressor supports after being able to be weaned considerably yesterday during the day.

SFH 143.

572. Dr. Taylor and Dr. Hull decided to "continue full supportive care." SFH 148.

573. Dr. Taylor and Dr. Hull also decided "to continue to follow serial liver function tests to assess potential chronicity of some liver injury." SFH 148.



6. Rectal cancer

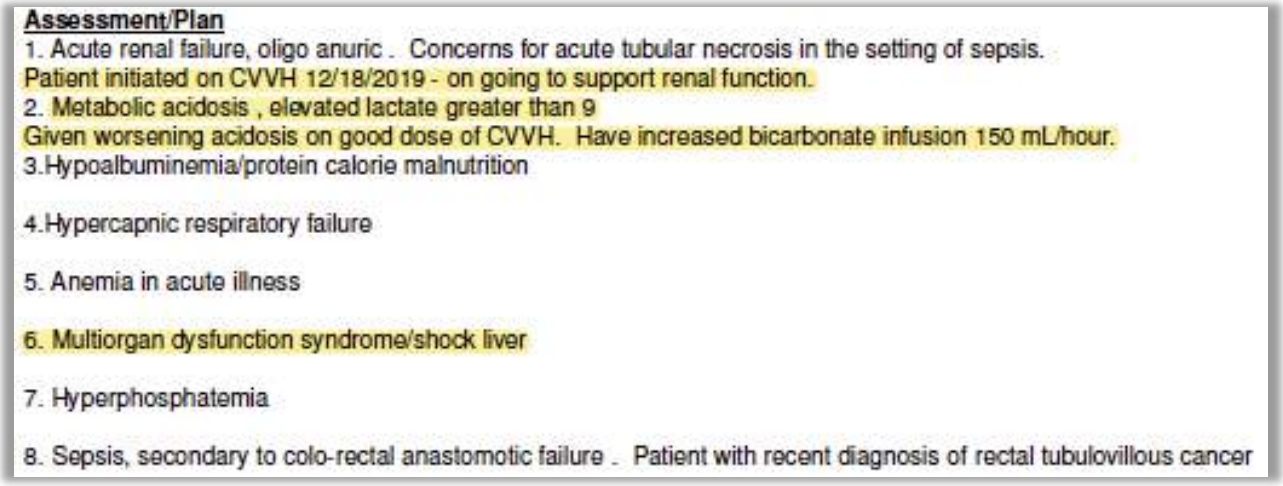
49-year-old male with septic shock following proctectomy for rectal cancer with subsequent anastomotic failure and pelvic contamination. Unfortunately he showing signs of worsening response to his sepsis. I have spoke with Dr. Hull regarding plan of care and for now we will continue full supportive care. Some of the antibiotic regimen has been adjusted. We will continue to follow serial liver function tests to assess potential chronicity of some liver injury.

SFH 148.

574. At 12:13, Dr. Molvi evaluated Jeffrey again. SFH 119-25.

575. Jeffrey remained "critically ill." SFH 119, SFH 120. CVVH was "ongoing to support renal function." SFH 124.

576. Jeffrey now had "multiorgan dysfunction syndrome/shock liver." SFH 124.



Assessment/Plan
1. Acute renal failure, oligo anuric . Concerns for acute tubular necrosis in the setting of sepsis.
Patient initiated on CVVH 12/18/2019 - on going to support renal function.
2. Metabolic acidosis , elevated lactate greater than 9
Given worsening acidosis on good dose of CVVH. Have increased bicarbonate infusion 150 mL/hour.
3.Hypoalbuminemia/protein calorie malnutrition

4.Hypercapnic respiratory failure

5. Anemia in acute illness

6. Multiorgan dysfunction syndrome/shock liver

7. Hyperphosphatemia

8. Sepsis, secondary to colo-rectal anastomotic failure . Patient with recent diagnosis of rectal tubulovillous cancer

SFH 124.

577. Dr. Molvi therefore "informed" Cory "about worsening overall clinical condition." SFH 124.

578. At 18:21 and 22:40, the Cerner system belatedly entered a "Discern Expert" order for "Possible Septic Shock" signed by Adam Creech. SFH 604, SFH 603.

Jeffrey Brown Dies

Saturday, December 21: Post-Operative Day 8

579. At 03:21, the Cerner system belatedly entered a "Discern Expert" order for "Possible Septic Shock" signed by Adam Creech. SFH 603.

580. At 7:33, the Cerner system entered a final "Discern Expert" order for "Possible Septic Shock," signed by the System. SFH 602.

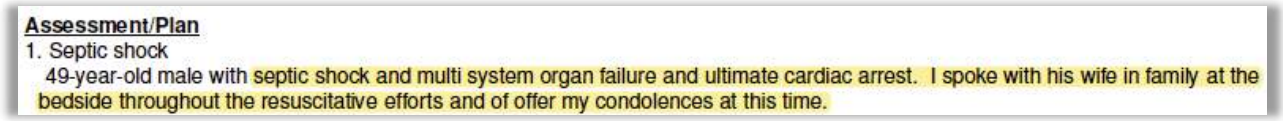
581. At 08:45, Jeffrey coded. SFH 78. The "likely etiology" was "fulminant hepatic [liver] failure with progressive shock with profound hyperkalemia." SFH 78.

582. At 09:22, after receiving CPR, Jeffrey Todd Brown died. SFH 4, SFH 78.

583. Jeffrey's death certificate identified the immediate cause of death as "multi system organ failure due to or as a consequence of sepsis." SFH 4.

584. At 09:29, Dr. Taylor entered a final note about Jeffrey. SFH 141-43.

585. Jeffrey had "acute and subacute hepatic failure without coma." SFH 143.

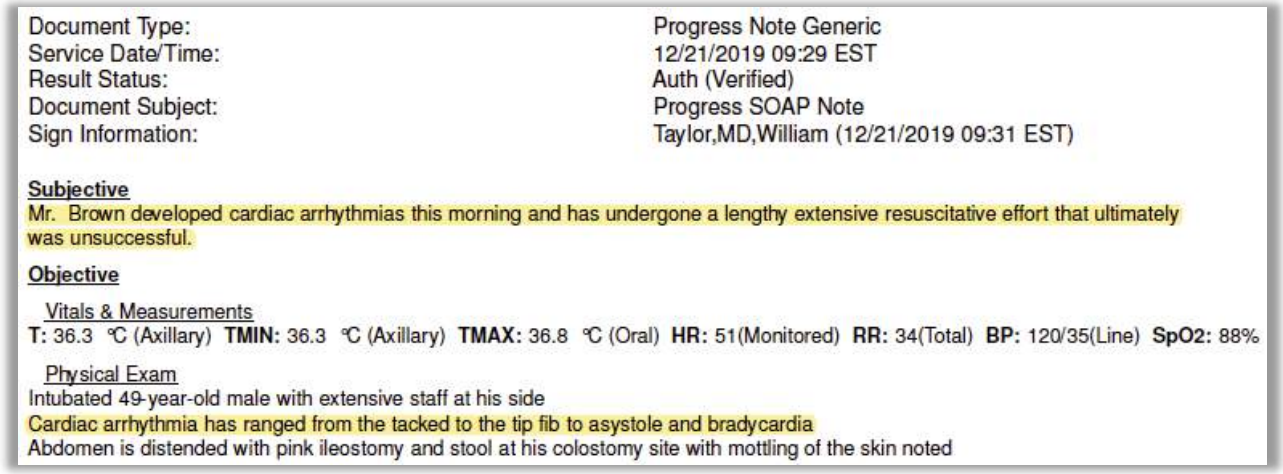


Assessment/Plan
1. Septic shock
49-year-old male with septic shock and multi system organ failure and ultimate cardiac arrest. I spoke with his wife in family at the bedside throughout the resuscitative efforts and of offer my condolences at this time.

SFH 142.

586. Jeffrey "developed cardiac arrhythmias" and underwent "a lengthy extensive resuscitative effort that ultimately was unsuccessful." SFH 141.

587. The cardiac arrhythmias "ranged from the tacked to the tip fib to asystole and bradycardia." SFH 141.



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Service Date/Time:	12/21/2019 09:29 EST
Result Status:	Auth (Verified)
Document Subject:	Progress SOAP Note
Sign Information:	Taylor,MD,William (12/21/2019 09:31 EST)

Subjective
Mr. Brown developed cardiac arrhythmias this morning and has undergone a lengthy extensive resuscitative effort that ultimately was unsuccessful.

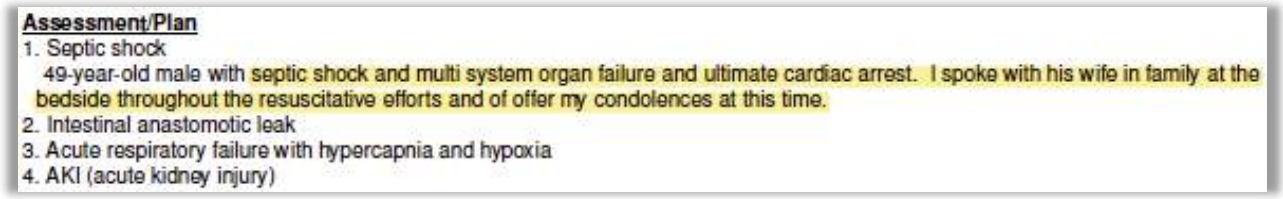
Objective

Vitals & Measurements
T: 36.3 ℃ (Axillary) **TMIN:** 36.3 ℃ (Axillary) **TMAX:** 36.8 ℃ (Oral) **HR:** 51(Monitored) **RR:** 34(Total) **BP:** 120/35(Line) **SpO2:** 88%

Physical Exam
Intubated 49-year-old male with extensive staff at his side
Cardiac arrhythmia has ranged from the tacked to the tip fib to asystole and bradycardia
Abdomen is distended with pink ileostomy and stool at his colostomy site with mottling of the skin noted

SFH 141.

588. Jeffrey suffered from "septic shock and multi system organ failure and ultimate cardiac arrest." SFH 142.



Assessment/Plan
1. Septic shock
49-year-old male with septic shock and multi system organ failure and ultimate cardiac arrest. I spoke with his wife in family at the bedside throughout the resuscitative efforts and of offer my condolences at this time.
2. Intestinal anastomotic leak
3. Acute respiratory failure with hypercapnia and hypoxia
4. AKI (acute kidney injury)

SFH 142.

589. Dr. Taylor spoke with Jeffrey's family "at the bedside throughout the resuscitative efforts" and offered his "condolences at this time." SFH 142.

Professional Negligence

590. The following circumstances are present in this case:

a. upon the recommendation of a surgeon (here, Dr. Taylor), a patient (here, Jeffrey Brown) undergoes transanal minimally invasive surgery ("TAMIS"), to remove a lesion in his rectum;

b. during the TAMIS, the surgeon excises the entire lesion, plus additional tissue as margins;

c. a pathologist (here, Dr. McElroy) finds that the lesion contains a stage-T1 adenocarcinoma, without involvement of the muscularis-propria, and without lymphovascular or perineural invasion;

d. the pathologist also finds that the margins are negative for carcinoma and even dysplasia;

e. nevertheless, the surgeon recommends lower anterior resection ("LAR") surgery to the patient;

f. as a result, a few weeks after the TAMIS, the surgeon performs LAR surgery on the patient;

g. during the procedure, the surgeon encounters these three surgical issues:

i. after being unable to obtain an acceptable view of the bowel, the surgeon converts the robotic laparoscopic procedure to open surgery;

ii. after the surgeon removes 39 centimeters (about 15 inches) of bowel and creates an end-to-end anastomosis using a surgical stapler, the anastomosis breaks, and the surgeon therefore sutures the anastomosis by hand; and

iii. the surgeon finds and irrigates residual stool, both above and below the anastomosis line;

h. after the surgery, the surgeon and two intensivists (here, Dr. Metry and Dr. Hull) manage the patient in the ICU;

i. on post-operative day 4, after fecal matter appears in the patient's surgical drain, the surgeon and an intensivist recognize an anastomotic failure; and

j. about 30 hours later, after the patient has become septic, the surgeon performs a laparotomy with a colectomy on the patient.

591. This Complaint next outlines how Defendants violated the standard of care under those circumstances.

Count 1: Recommending Non-Indicated Surgery – Against Dr. Taylor and CSS

592. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

593. In the circumstances summarized in Paragraph 590, the standard of care forbids the surgeon from proposing or recommending to the patient a surgery for which there is no indication. This requirement applies with special force where the procedure is a major surgery with known significant risks.

594. On November 20, 2019, Dr. Taylor violated this requirement, by proposing and recommending LAR surgery to Mr. Brown.

595. As Dr. McElroy's pathology report made clear, the TAMIS had already removed the entire lesion with clear margins, providing assurance that no further malignant pathology was present.

596. There was therefore no valid medical reason for Dr. Taylor to propose or recommend further surgery at that time, let alone a more-invasive major procedure like LAR surgery. LAR surgery was not indicated.

597. Dr. Taylor's violation was all the more egregious because:

a. in his operative report for the TAMIS, Dr. Taylor himself recognized that he had excised the lesion and margins, with "no evidence of residual disease at this point";

b. contrary to Dr. McElroy's unambiguous findings, Dr. Taylor told Mr. Brown that the margins were "at best questionable";

c. even if the margins had been "questionable," indeed, even if the margins had been cancerous, LAR surgery remained unnecessary, because another TAMIS would have been the indicated procedure in that case; and

d. LAR surgery is a major surgery with known potential complications and significant risks, including peritonitis, sepsis, and death.

598. Dr. Taylor thus proposed and recommended a major surgery that served no valid medical purpose, that Mr. Brown did not need, and that unnecessarily exposed Mr. Brown to serious risks.

599. On November 20, 2019, as revealed by Dr. Taylor's review of systems, Mr. Brown was generally in good health.

600. In addition, because the excised tumor had a stage-T1 cancer, Mr. Brown had about a 95% chance of surviving for at least five years.

601. Had Dr. Taylor not proposed and recommended LAR surgery, Mr. Brown would not have undergone the surgery, and therefore would not have suffered the complications that followed, including the anastomotic leak and fecal peritonitis that led to his sepsis and untimely death. Mr. Brown would have also been spared yet another surgery—the laparotomy with colectomy.

602. Dr. Taylor's proposal and recommendation thus caused Mr. Brown an anastomotic leak, fecal peritonitis, a colectomy, sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

603. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

Count 2: Performing Non-Indicated Surgery – Against Dr. Taylor and CSS

604. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

605. In the circumstances summarized in Paragraph 590, the standard of care forbids the surgeon from performing a surgery for which there is no indication. This requirement applies with special force where the procedure is a major surgery with known significant risks.

606. On December 13, 2019, Dr. Taylor violated this requirement by performing LAR surgery on Mr. Brown.

607. As Dr. McElroy's pathology report made clear, the TAMIS had already removed the entire lesion with clear margins, providing assurance that no further malignant pathology was present. There was therefore no valid medical reason for Dr. Taylor to perform any surgery at that time, let alone LAR surgery. LAR surgery was not indicated.

608. Dr. Taylor's violation was all the more egregious because LAR surgery is a major surgery with known potential complications and significant risks, including peritonitis, sepsis, and death.

609. Dr. Taylor thus performed a major surgery that served no valid medical purpose, that Mr. Brown did not need, and that unnecessarily exposed Mr. Brown to serious risks.

610. On November 20, 2019, as revealed by Dr. Taylor's review of systems, Mr. Brown was generally in good health.

611. In addition, because the excised tumor had a stage-T1 cancer, Mr. Brown had about a 95% chance of surviving for at least five years.

612. Had Dr. Taylor not performed the LAR surgery, Mr. Brown would have entirely avoided the complications of the surgery, including the anastomotic leak and fecal peritonitis that led to his sepsis and untimely death. Mr. Brown would have also been spared the laparotomy with colectomy.

613. Dr. Taylor's violation thus caused Mr. Brown an anastomotic leak, peritonitis, a colectomy, sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

614. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

Count 3: Performing LAR Surgery without Patient's Informed Consent – Against Dr. Taylor and CSS

615. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

616. The standard of care forbids a surgeon from performing surgery without the patient's informed consent. As a corollary of that requirement, the standard of care also requires a surgeon to obtain the patient's informed consent to surgery. These requirements apply with special force where the surgery is a major surgery with known significant risks.

617. On December 13, 2019, Dr. Taylor violated these requirements, by performing the LAR surgery without Mr. Brown's informed consent. Also, from November 20 through December 13, 2019, Dr. Taylor violated these requirements, by failing to obtain Mr. Brown's informed consent to the surgery.

618. Instead, in proposing and recommending LAR surgery to Mr. Brown, Dr. Taylor failed to inform Mr. Brown that there was no indication or need for any surgery at that time, much less LAR surgery. In addition, Dr. Taylor proposed and recommended the LAR surgery on the erroneous premises that the TAMIS did "not constitute completeness of treatment" because the margins were "at best questionable" and "at best appeared to be negative."

619. In light of such misinformation, any consent Mr. Brown formally gave to the LAR surgery was not and could not be informed consent. Dr. Taylor thus performed the LAR surgery without Mr. Brown's actual informed consent.

620. Dr. Taylor's violations were all the more egregious because:

    a. the information Dr. Taylor shared with Mr. Brown was directly contrary to Dr. McElroy's pathology report, which unequivocally concluded that the margins were "negative for dysplasia or carcinoma" and that "no dysplasia or carcinoma [was] identified at the surgical margins"; and

    b. LAR surgery is a major surgery with known potential complications and significant risks, including peritonitis, sepsis, and death.

621. On November 20, 2019, as revealed by Dr. Taylor's review of systems, Mr. Brown was generally in good health.

622. In addition, because the excised tumor had a stage-T1 cancer, Mr. Brown had about a 95% chance of surviving for at least five years.

623. Had Dr. Taylor provided Mr. Brown complete and accurate information, Mr. Brown would have understood that the LAR surgery was not indicated or necessary. As a result, Mr. Brown would have denied his consent to the proposed LAR surgery, and would not have undergone the LAR surgery.

624. In turn, Mr. Brown would not have suffered the complications of the LAR surgery, including the anastomotic leak and fecal peritonitis that led to his sepsis and untimely death. Mr. Brown would have also been spared yet another surgery—the laparotomy with colectomy.

625. Dr. Taylor's failure to obtain informed consent to the LAR surgery thus caused Mr. Brown an anastomotic leak, fecal peritonitis, a colectomy, sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

626. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

Count 4: Failure to Achieve Timely Source-Control – Against Dr. Taylor and CSS

627. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

628. After fecal matter appears in the patient's surgical drain, the standard of care requires the surgeon to achieve timely source-control.

629. On December 17 and 18, 2019, after fecal matter appeared in Mr. Brown's surgical drain, Dr. Taylor violated this requirement, by failing to achieve timely source-control. In fact, despite recognizing that Mr. Brown likely had an anastomotic leak, Dr. Taylor did not even try to achieve source-control for about 30 hours after the fecal matter was first found.

630. Dr. Taylor's violation was all the more egregious because:

    a. Mr. Brown's anastomosis failed during the LAR surgery;

b. the fecal matter in Mr. Brown's surgical drain was highly suspicious for, if not conclusive evidence of, an anastomotic leak;

c. on December 16, 2019, Mr. Brown had two large bowel-movements;

d. in the hours after the bowel-movements, Mr. Brown's vitals, pain, and agitation were consistent with anastomotic rupture and fecal peritonitis;

e. the morning of December 17, 2019, Dr. Taylor himself noted a possible anastomotic leak caused by "a very large forceful bowel movement";

f. the morning of December 17, 2019, Dr. Hull also noted an anastomotic leak, for which he ordered Zosyn;

g. on December 17 and 18, 2019, fecal matter continued to appear in Mr. Brown's surgical drain; and

h. Dr. Taylor failed even to order a CT-scan, which would have quickly, objectively, and definitively confirmed the anastomotic leak and the need for emergent source-control.

631. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused Mr. Brown to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

632. Dr. Taylor thus had a wide window of opportunity—well over 24 hours—to perform an emergent laparotomy and achieve timely source-control.

633. Had Dr. Taylor performed the laparotomy promptly after fecal matter was first found in Mr. Brown's surgical drain, Dr. Taylor would have achieved source-control before Mr. Brown entered and decompensated along the sepsis continuum, becoming critically and fatally ill.

634. Dr. Taylor's failure to achieve timely source-control thus caused Mr. Brown sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

635. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

Count 5: Failure to Advocate for Timely-Source Control – Against Dr. Hull and SHS

636. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

637. After fecal matter appears in the patient's surgical drain, the standard of care requires the on-call intensivist promptly to advocate with the surgeon, on behalf of the patient, for timely source-control. Insofar as the surgeon then refuses to attempt source-control, the standard of care then requires the intensivist to advocate for timely source-control up the hospital's surgical or medical chain-of-command.

638. On December 17 and 18, 2019, after fecal matter appeared in Mr. Brown's surgical drain, Dr. Hull violated this requirement, by failing to advocate with Dr. Taylor or anyone else, on behalf of Mr. Brown, for timely source-control.

639. As a result, Dr. Taylor did not even attempt to achieve source-control for about 30 hours after the fecal matter was first found.

640. Dr. Hull's violation was all the more egregious because:

a. Mr. Brown's anastomosis failed during the LAR surgery;

b. the fecal matter in Mr. Brown's surgical drain was highly suspicious for, if not conclusive evidence of, an anastomotic leak;

c. on December 16, 2019, Mr. Brown had large, forceful bowel-movements;

d. in the hours after the bowel-movements, Mr. Brown's vitals, pain, and agitation were consistent with anastomotic rupture and fecal peritonitis;

e. the morning of December 17, 2019, Dr. Hull himself noted an anastomotic leak, for which he ordered Zosyn;

f. the morning of December 17, 2019, Dr. Taylor also noted a possible anastomotic leak caused by "a very large forceful bowel movement";

g. on December 17 and 18, 2019, fecal matter continued to appear in Mr. Brown's surgical drain; and

h. Dr. Hull failed even to order a CT-scan, which would have quickly, objectively, and definitively confirmed the anastomotic leak and the need for emergent source-control.

641. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused Mr. Brown to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

642. Dr. Hull thus had a wide window of opportunity—well over 24 hours—to advocate for timely source-control on behalf of his patient.

643. Even if Dr. Taylor had then refused to attempt source-control, Dr. Hull had an ample opportunity to advocate for timely source-control up the Hospital's surgical or medical chain-of-command.

644. Had Dr. Hull promptly advocated for source-control, Dr. Taylor or another surgeon would have achieved source-control earlier than the afternoon of December 18, 2019—before Mr. Brown entered and decompensated along the sepsis continuum, becoming critically and fatally ill.

645. Dr. Hull's failure to advocate for timely source-control thus caused Mr. Brown sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

646. As Dr. Hull's employer or other principal at the time of his negligence, SHS is vicariously liable for his negligence, because Dr. Hull was acting within the scope of his employment or agency with SHS at that time.

Count 6: Failure to Obtain Stat CT-Scan – Against Dr. Taylor and CSS, and Dr. Hull and SHS

647. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

648. After fecal matter appears in the patient's surgical drain and the surgeon nevertheless decides not to try to achieve source-control, the standard of care then requires the surgeon and the on-call intensivist to obtain a stat CT-scan of the patient's abdomen and pelvis.

649. Under those circumstances, the CT-scan provides a quick, objective, and definitive diagnosis of an anastomotic leak and fecal peritonitis. The intensivist can then use the diagnosis to advocate for timely source-control.

650. On December 17, 2019, and part of December 18, 2019. Dr. Taylor and Dr. Hull each violated this requirement, by failing to obtain a CT-scan of Mr. Brown's abdomen and pelvis.

651. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused him to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

652. Had Dr. Taylor or Dr. Hull promptly obtained a CT-scan after fecal matter first appeared in Mr. Brown's surgical drain, the CT-scan would have provided them an objective and definitive diagnosis of Mr. Brown's anastomotic leak and fecal peritonitis.

653. As a result, Dr. Taylor or another surgeon would have proceeded urgently to achieve timely source-control.

654. Instead, Dr. Taylor delayed source-control for about 30 hours or more, until after Mr. Brown had decompensated along the sepsis continuum.

655. The failure to obtain a stat CT-scan thus caused Mr. Brown sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

656. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

657. As Dr. Hull's employer or other principal at the time of his negligence, SHS is vicariously liable for his negligence, because Dr. Hull was acting within the scope of his employment or agency with SHS at that time.

Count 7: Failure to Treat Patient with Antibiotics – Against Dr. Taylor and CSS, Dr. Metry, and Dr. Hull and SHS

658. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

659. In the circumstances summarized in Paragraph 590, the standard of care requires the surgeon to treat the patient with antibiotics in the immediate post-operative period.

660. Dr. Taylor (on December 13, 14, 15, and 16, 2019, and part of December 17, 2019), Dr. Metry (on December 13, 14, and 15, 2019), and Dr. Hull (on December 16, 2019, and part of December 17, 2019) each violated this requirement, by failing to treat Mr. Brown with antibiotics.

661. These violations were all the more egregious because:

    a. Mr. Brown underwent LAR surgery, a procedure with a significant risk of infection;

    b. Dr. Taylor made incisions for both laparoscopic and open surgery;

    c. Mr. Brown's anastomosis broke during the procedure;

    d. there was no doubt that this was a contaminated or dirty surgery, because Dr. Taylor found residual stool above and below the anastomosis line; and

    e. as a result, empiric therapy with broad-spectrum antibiotics was indicated.

662. Had Dr. Taylor, Dr. Metry, or Dr. Hull treated Mr. Brown with antibiotics in the immediate post-operative period, the antibiotic therapy likely would have delayed the onset of sepsis, providing Dr. Taylor or another surgeon additional time to achieve timely source-control.

663. Each failure to treat Mr. Brown with antibiotics in the post-operative period thus contributed to his decompensation along the sepsis continuum.

664. Each such failure thus led to Mr. Brown's sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

665. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

666. As Dr. Hull's employer or other principal at the time of his negligence, SHS is vicariously liable for his negligence, because Dr. Hull was acting within the scope of his employment or agency with SHS at that time.

Count 8: Failure to Obtain Patient's Informed Consent to Treatment – Against Dr. Taylor and CSS, and Dr. Hull and SHS

667. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

668. After fecal matter appears in the patient's surgical drain, the standard of care requires the surgeon and on-call intensivist to obtain the patient's informed consent to a course of treatment that omits timely source-control.

669. On December 17, 2019, and on the morning of December 18, 2019, Dr. Taylor and Dr. Hull each violated this requirement by:

a. failing promptly to inform Mr. Brown that he likely had an anastomotic leak;

b. failing to inform Mr. Brown that the anastomotic leak had likely caused, or would imminently cause, fecal peritonitis;

c. failing to inform Mr. Brown that Dr. Taylor had decided against trying to achieve source-control at that time;

d. failing to obtain Mr. Brown's informed consent to a course of treatment that excluded a stat CT-scan to objectively and definitively confirm or rule out the anastomotic leak and the need for source-control;

e. failing to obtain Mr. Brown's informed consent to a course of treatment that excluded timely source-control; and

f. failing to obtain Mr. Brown's informed consent to a course of treatment that delayed an attempt to achieve source-control for about 30 hours.

670. Insofar as Mr. Brown's medical condition rendered him unable to provide informed consent on December 17 or 18, 2019, the standard of care required Dr. Taylor and Dr. Hull to obtain the informed consent of Mr. Brown's wife, Cory Brown. Dr. Taylor and Dr. Hull each violated the standard of care insofar as each failed to obtain Mrs. Brown's informed consent when required.

671. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused him to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

672. Had Dr. Taylor or Dr. Hull sought Mr. Brown's (or, when required, Mrs. Brown's) informed consent to a course of treatment that excluded timely source-control, Mr. Brown (or Mrs. Brown) would have denied consent, instead demanding and seeking timely source-control.

673. In response to that demand, Dr. Taylor or another surgeon likely would have attempted and achieved timely source-control.

674. Dr. Taylor's and Dr. Hull's failure to obtain informed consent thus deprived Mr. Brown of the opportunity to obtain timely source-control of his fecal peritonitis, before it caused him irreparable harm and death.

675. Each failure to obtain informed consent thus caused Mr. Brown sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

676. As Dr. Taylor's employer or other principal at the time of his negligence, CSS is vicariously liable for his negligence, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

677. As Dr. Hull's employer or other principal at the time of his negligence, SHS is vicariously liable for his negligence, because Dr. Hull was acting within the scope of his employment or agency with SHS at that time.

Count 9: Failure to Advocate for Patient's Well-Being – Against St. Francis Health, LifePoint, and the Emory Defendants

678. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

679. When a nurse concludes that an attending physician has overlooked a treatment vital to the patient's well-being, the standard of care requires the nurse to advocate for the treatment with the physician on behalf of the patient. Insofar as the nurse meets that requirement and the physician nevertheless overlooks or disregards the treatment, the standard of care then requires the nurse to advocate for the treatment up the hospital's chain-of-command.

680. On December 13, 14, 15, 16, 17, and 18, 2019, the St. Francis nurses caring for Mr. Brown violated these requirements, by failing to advocate on his behalf when his attending physicians overlooked treatment vital to his well-being.

681. Those failures included:

a. the failure to advocate for timely source-control, after fecal matter appeared and reappeared in Mr. Brown's surgical drain;

b. the failure to advocate for a stat CT-scan, when Dr. Taylor and Dr. Hull took no action to achieve timely source-control despite the fecal drainage; and

c. the failure to advocate for antibiotic treatment in the immediate post-operative period, even after Mr. Brown had positive sepsis scores.

682. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused him to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

683. Had a Hospital nurse advocated for Mr. Brown, Dr. Taylor or another surgeon likely would have achieved timely source-control, before Mr. Brown suffered permanent injury and death. For example:

a. Had a nurse promptly advocated for source-control, Dr. Taylor or another surgeon would have achieved source-control earlier than the afternoon of December 18, 2019—before Mr. Brown entered and decompensated along the sepsis continuum, becoming critically and fatally ill.

b. Had a nurse advocated for a stat CT-scan after fecal matter appeared in Mr. Brown's surgical drain and Dr. Taylor nevertheless decided not to try to achieve source-control, the CT-scan would have timely provided an objective and definitive diagnosis of Mr. Brown's anastomotic leak and fecal peritonitis. As a result, Dr. Taylor or another surgeon would have proceeded urgently to achieve timely source-control.

c. Had a nurse advocated for antibiotic treatment in the immediate post-operative period, Dr. Taylor, Dr. Metry, Dr. Hull, or another physician likely would have given Mr. Brown antibiotics. The antibiotic therapy

likely would have delayed the onset of sepsis, providing Dr. Taylor or another surgeon additional time to achieve timely source-control.

684. Each such failure to advocate for Mr. Brown's well-being thus contributed to his decompensation along the sepsis continuum. Each such failure thus led to his sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

685. As the employer or other principal of these nurses at the time of their negligence, St. Francis Health, LifePoint, and/or one or more of the Emory Defendants is/are vicariously liable for the nurses' negligence, because the nurses were acting within the scope of their employment or agency with one or more of those Defendants at that time.

Count 10: Failure Immediately to Report Fecal Drainage –
Against St. Francis Health, LifePoint, and the Emory Defendants

686. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

687. When a nurse finds fecal matter in the patient's surgical drain, the standard of care requires the nurse immediately to notify the surgeon and the on-call intensivist of the fecal drainage.

688. On December 16 and/or 17, 2019, Nurse Lauren Duncan and Nurse Heather Novak each violated this requirement, by failing immediately to notify Dr. Taylor, Dr. Hull, or any other physician of the fecal matter that first appeared in Mr. Brown's surgical drain overnight on those dates.

689. On December 17, 2019, and/or the morning of December 18, 2019, Nurse Novak and Nurse Adam Creech each violated this requirement, by failing immediately to notify Dr. Taylor, Dr. Hull, or any other physician of the fecal matter that continued to appear in Mr. Brown's surgical drain.

690. Had Nurse Duncan, Nurse Novak, or Nurse Creech immediately notified Dr. Taylor, Dr. Hull, or another physician of the fecal drainage, each notification would have raised suspicion for an anastomotic leak, fecal peritonitis, and sepsis among Mr. Brown's medical providers.

691. On such heightened alert, Dr. Hull or another physician likely would have:

a. obtained a stat CT-scan to objectively and definitively confirm the anastomotic leak and fecal peritonitis, when there was still time to achieve timely source-control; and

b. successfully advocated for timely source-control.

692. In turn, as a result of those measures, Dr. Taylor or another surgeon would have performed a laparotomy to achieve source-control prior to the afternoon of December 18, 2019—before Mr. Brown entered and decompensated along the sepsis continuum, becoming critically and fatally ill.

693. Each failure immediately to notify a physician of the fecal drainage thus contributed to Mr. Brown's sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

694. As the employer or other principal of Nurse Duncan, Nurse Novak, or Nurse Creech at the time of their negligence, St. Francis Health, LifePoint, and/or one or more of the Emory Defendants is/are vicariously liable for these nurses' negligence, because these nurses were acting within the scope of their employment or agency with one or more of those Defendants at that time.

Count 11: Failure to Recognize and Report Signs of Sepsis – Against St. Francis Health, LifePoint, and the Emory Defendants

695. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

696. The standard of care requires a nurse to recognize and report signs and symptoms of potential sepsis.

697. Nurse Lauren Duncan (on December 16 and 17, 2019), Nurse Heather Novak (on December 17, 2019), and Nurse Adam Creech (on December 17 and 18, 2019) each violated these requirements, by failing to recognize and report signs and symptoms of potential sepsis.

698. Insofar as St. Francis had a sepsis protocol or other procedures for evaluating patients for sepsis, Nurses Duncan, Novak, and Creech also violated these requirements by failing to initiate or follow such procedures.

699. These violations were all the more egregious because:

a. a sepsis screen can be performed within minutes;

b. Mr. Brown underwent LAR surgery, a procedure with a serious risk of infection;

c. Dr. Taylor made incisions for both laparoscopic and open surgery;

d. Mr. Brown's anastomosis broke during the procedure;

e. there was no doubt that this was a contaminated or dirty surgery, because Dr. Taylor found residual stool above and below the anastomosis line;

f. at times on December 14, 15, and 16, 2019, Mr. Brown's temperature, heart-rate, respiratory-rate, and/or white-blood-cell count were elevated, so that his sepsis score was at least a 2 under the SIRS Criteria on each date;

g. on December 15, 2019, Mr. Brown's Procalcitonin was 2.91, a level that triggered an alert for "high risk of severe sepsis and/or septic shock";

h. on December 16, 2019, Mr. Brown had two large bowel-movements;

i. on February 16 and 17, 2019, in the hours following the second of these bowel-movements, Mr. Brown's vitals, pain, and agitation were consistent with anastomotic rupture and fecal peritonitis; and

j. during those hours, among other things:

    i. at the time of the second bowel-movement, Mr. Brown's pain-level rose to a 7, and was flagged for significance;

    ii. Mr. Brown's temperature rose abruptly to 38.6° C (101.48° F), the highest level to that point in the hospitalization;

    iii. Mr. Brown's heart-rate rose to 105 beats per minute, the highest level to that point in the hospitalization; and

    iv. Mr. Brown's temperature peaked at 39.2° C (102.56° F), and was flagged for significance.

700. On December 17, 2019, Mr. Brown's anastomotic leak and fecal peritonitis had not yet caused him to become septic. Even at 08:59 on December 18, 2019, Dr. Taylor noted that Mr. Brown was still in "early sepsis."

701. Had Nurse Duncan, Nurse Novak, or Nurse Creech promptly recognized and reported Mr. Brown's signs and symptoms of potential sepsis, each report would have raised suspicion for sepsis among Mr. Brown's medical providers.

702. On such heightened alert, Dr. Hull or another physician likely would have:

    a. obtained a stat CT-scan to objectively and definitively confirm the anastomotic leak and fecal peritonitis, when there was still time to achieve timely source-control; and

    b. successfully advocated for timely source-control, after fecal matter first appeared in Mr. Brown's surgical drain.

703. In turn, as a result of those measures, Dr. Taylor or another surgeon, more likely than not, would have performed a laparotomy to achieve source-control prior to the afternoon of December 18, 2019—before Mr. Brown entered and decompensated along the sepsis continuum, becoming critically and fatally ill.

704. Each failure to recognize and report Mr. Brown's signs and symptoms of potential sepsis thus contributed to Mr. Brown's sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

705. As the employer or other principal of Nurse Duncan, Nurse Novak, or Nurse Creech at the time of their negligence, St. Francis Health, LifePoint, and/or one or more of the Emory Defendants is/are vicariously liable for these nurses' negligence, because these nurses were acting within the scope of their employment or agency with one or more of those Defendants at that time.

Civil Battery

Count 12: Performing Surgery without Consent – Against Dr. Taylor and CSS

706. Plaintiffs incorporate by reference all paragraphs of this Complaint as though fully set forth herein.

707. On December 13, 2019, Dr. Taylor intentionally performed LAR surgery on Jeffrey Brown.

708. On that date, Dr. Taylor performed LAR surgery without obtaining Mr. Brown's actual informed consent to the surgery.

709. In recommending the surgery, Dr. Taylor failed to inform Jeffrey that there was no indication or need for any surgery at that time, much less LAR surgery.

710. In addition, Dr. Taylor told Jeffrey that the TAMIS did "not constitute completeness of treatment" because the margins were "at best questionable" and "at best appeared to be negative."

711. Dr. Taylor's misrepresentations were egregious because:

    a. they were directly contrary to Dr. McElroy's pathology report, which unequivocally concluded that the margins were "negative for dysplasia or carcinoma" and that "no dysplasia or carcinoma [was] identified at the surgical margins"; and

    b. LAR surgery is a major surgery with known potential complications and significant risks, including peritonitis, sepsis, and death.

712. In light of those misrepresentations, any consent Mr. Brown formally gave to the LAR surgery was not and could not be actual informed consent.

713. Dr. Taylor performed the LAR surgery without Mr. Brown's actual informed consent. Dr. Taylor performed the surgery with fraudulently induced consent.

714. The LAR surgery was thus an unlawful contact with Jeffrey.

715. In fact, each incision, cut, suture, and other invasive act constituted an intentional, willful, wanton, and unlawful contact with Jeffrey.

716. After the TAMIS, as shown by Dr. Taylor's review of systems, Jeffrey was generally in good health. In addition, because the excised tumor had a stage-1 cancer, Mr. Brown had a 95% chance of surviving for at least five years.

717. The LAR surgery thus caused Mr. Brown harm, including the physical, mental, and emotional injury associated with (a) the LAR surgery itself, (b) the subsequent laparotomy with colectomy, and (c) the complications resulting

from the LAR surgery, including anastomotic leak, fecal peritonitis, sepsis, septic shock, organ failure, pain, suffering, cardiac arrest, and death.

718. As Dr. Taylor's employer or other principal at the time of the LAR surgery, CSS is vicariously liable for his tortious conduct, because Dr. Taylor was acting within the scope of his employment or agency with CSS at that time.

Ordinary Negligence

Count 13: Failure to Safeguard Patient Safety – Against St. Francis Health, LifePoint, and the Emory Defendants

719. Plaintiffs incorporate by reference all paragraphs of this Complaint as though fully set forth herein.

720. Insofar as they managed or administered the Hospital, Defendants St. Francis Health, LifePoint, and the Emory Defendants owed patients a duty to safeguard their safety and provide quality care at the Hospital.

721. Insofar as they managed or administered the Hospital, these Defendants, through their managers and administrators, breached those duties in providing care to Mr. Brown.

722. The repeated confounding failures by the individual providers reveal and exemplify such managerial and administrative failures. For example:

    a. Dr. Taylor's decision to perform a non-indicated LAR surgery reveals serious flaws in St. Francis's credentialing process.

    b. Dr. Taylor's delay in achieving source-control reveals that St. Francis failed to have, disseminate, and/or enforce a protocol for the rapid evaluation and treatment of patients with a high risk for sepsis.

    c. The failure by at least three physicians—Dr. Taylor, Dr. Metry, and Dr. Hull—to treat Mr. Brown with antibiotics during the immediate post-operative period suggests that St. Francis failed to hire or contract qualified and competent medical providers.

    d. Dr. Hull's failure to advocate for timely source-control suggests that St. Francis lacked an effective process for escalating patient-safety issues.

e. Dr. Hull's failure to obtain a CT-scan to advocate for timely source-control reveals that St. Francis lacked cooperation, communication, and coordination among medical providers.

f. Nurse Duncan's, Nurse Novak's, and Nurse Creech's failure immediately to report fecal drainage suggests that St. Francis failed to train and supervise its nurses even on basic safety and quality-of-care practices.

g. Nurse Duncan's, Nurse Novak's, and Nurse Creech's failures to recognize and report signs and symptoms of potential sepsis reveal the same institutional failure. Their failures also suggest that St. Francis lacked a protocol for the prompt evaluation and treatment of potential sepsis.

h. The nursing staff's failures to advocate for Mr. Brown's well-being, including for timely source-control, antibiotic therapy, and a CT-scan, reveal that St. Francis lacked an effective process for escalating patient-safety issues, and instead had a culture that discouraged or perhaps even retaliated against nurses who spoke out.

i. Dr. Taylor's and Dr. Hull's failure to obtain Mr. Brown's informed consent to a course of treatment that excluded timely source-control reveals that St. Francis failed to have, disseminate, and/or enforce a policy for obtaining such consent. Dr. Taylor's failure to obtain Mr. Brown's informed consent to LAR surgery confirms the same systemic failure.

723. The failures by individual clinicians thus reflect and exemplify systemic failures by the Hospital's management and administration.

724. Stated conversely: managerial and administrative failures caused, led to, or enabled individual error by Mr. Brown's providers.

725. Insofar as individual failure caused harm to Mr. Brown, so did the underlying systemic failures that caused, led to, or enabled individual failure.

726. The systemic failures by managers and administrators were thus a cause of the harm Mr. Brown suffered, including sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

727. The following additional problems in Mr. Brown's care also reflect systemic failures by management and administration:

a. The failure to take Mr. Brown emergently to the operating room for source-control, even after Dr. Taylor decided to perform the laparotomy.

b. The failure to monitor Mr. Brown's procalcitonin for days, even after it triggered an alert for "high risk of severe sepsis and/or septic shock."

c. The gaps in monitoring the surgical drain, even after it had fecal output.

d. The nursing staff's failure to provide appropriate daily care to Mr. Brown.

e. The delays in administering Zosyn and Fluconazole to Mr. Brown, because they were "not available."

f. The delays in starting Mr. Brown on CVVH, because equipment was unavailable or malfunctioned.

g. The failure of the EMR to issue timely sepsis alerts.

h. The use of axillary temperature (which is less reliable than other methods).

728. Insofar as they contributed to the failure to diagnose Mr. Brown's peritonitis or to achieve timely source-control, each such problem also contributed to his sepsis, septic shock, organ failure, pain, suffering, other injury, and death.

729. Thus, far from creating a culture of safety and quality, the management and administration at St. Francis Health, LifePoint, and/or one or more of the Emory Defendants oversaw a dysfunctional system that apparently enabled sloppiness, laziness, incompetence, and apathy at the Hospital.

Loss of Consortium

Count 14: Loss of Consortium – Against All Defendants

730. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

731. As a result of the negligent and tortious conduct discussed above, Cory Brown has suffered loss of consortium with her husband, Jeffrey.

732. Mrs. Brown is entitled to recover from Defendants for that loss.

Damages

733. Pursuant to OCGA Title 51, Chapter 4, Plaintiff is entitled to recover from all Defendants for all damages caused by their negligence.

Survival Action: Estate Claim

734. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

735. Plaintiff is entitled to damages for Jeffrey's conscious pain and suffering associated with the non-indicated LAR surgery and its complications, including an anastomotic leak, fecal peritonitis, sepsis, septic shock, organ failure, pain, cardiac arrest, and death.

736. Plaintiff is also entitled to damages for Jeffrey's conscious pain and suffering associated with the laparotomy with colectomy and colostomy.

737. Plaintiff is also entitled to damages for Jeffrey's conscious pain and suffering over the hours he endured an anastomotic leak and fecal peritonitis, without antibiotic therapy or source-control.

738. Plaintiff is also entitled to damages for the existential terror Jeffrey faced during the days he decompensated along the sepsis continuum, through severe sepsis, septic shock, organ failure, cardiac arrest, and death.

Wrongful-Death Claim

739. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

740. Jeffrey grew up in Columbus, in a close-knit family, with his late parents and his younger brother, Scott, who survived him. Jeffrey's father was Marshall of Muscogee County, and his mother was a civil servant at Fort Benning.

741. Jeffrey grew up hunting, fishing, dirt-biking, and working with his father.

742. Jeffrey's father taught him how to build and fix things—from cars, to machinery, to homes. At his father's side, Jeffrey developed the work ethic and skills that would make him self-reliant the rest of his life.

743. Through 2018, Jeffrey worked for about 23 years for Pitney Bowes as a field technician servicing mailing equipment and machines.

744. At the time of his death, Jeffrey was working for Entrust Datacard as a field technician servicing sophisticated equipment. Because Entrust offered him opportunities for growth, Jeffrey was looking forward to expanding his career.

745. Jeffrey was also a real-estate entrepreneur. He purchased, renovated, and rented properties in Alabama. He started with a duplex, and by 2019, had grown to 12 properties. He did much of the renovation work himself.

746. He viewed his business as a means to supplement his family's income and to provide for them after he retired and passed away—with age.

747. At the time of his death, Jeffrey had recently purchased 5 properties. He did not have the opportunity to renovate them.

748. Jeffrey met Cory on the job. She worked in output services for TSYS, a customer Jeffrey serviced for Pitney Bowes and Entrust.

749. Jeffrey and Cory married on September 22, 2003, after dating for three years. They were married on Herbert Glacier in Alaska, arriving there by helicopter.

750. In 2011, Jeffrey and Cory had a daughter, named Lydia.

751. During their marriage, Jeffrey and Cory leaned on and stuck by each other through health, family, and financial adversity—like many other couples.

752. At the time of his death, Jeffrey and Cory thought they were "on the other side of all that," and they were looking forward to the next phase of their lives.

753. Jeffrey and Cory had a supportive, caring relationship. They did everything together, and considered each other their best friend in life.

754. After Lydia was born, Cory became seriously ill, with a condition later diagnosed as Mixed Connective Tissue Disease (which encompasses lupus, rheumatoid arthritis, trigeminal neuralgia, polymyositis, and thyroid disease).

755. In the years that followed, when Cory was debilitated by her condition, Jeffrey not only took care of her, but also picked up the slack in running the household and raising Lydia—all while working on the job and the business.

756. In 2017, Cory was diagnosed with thyroid cancer and underwent a thyroidectomy. That year, Cory also had meningitis and a brain aneurysm.

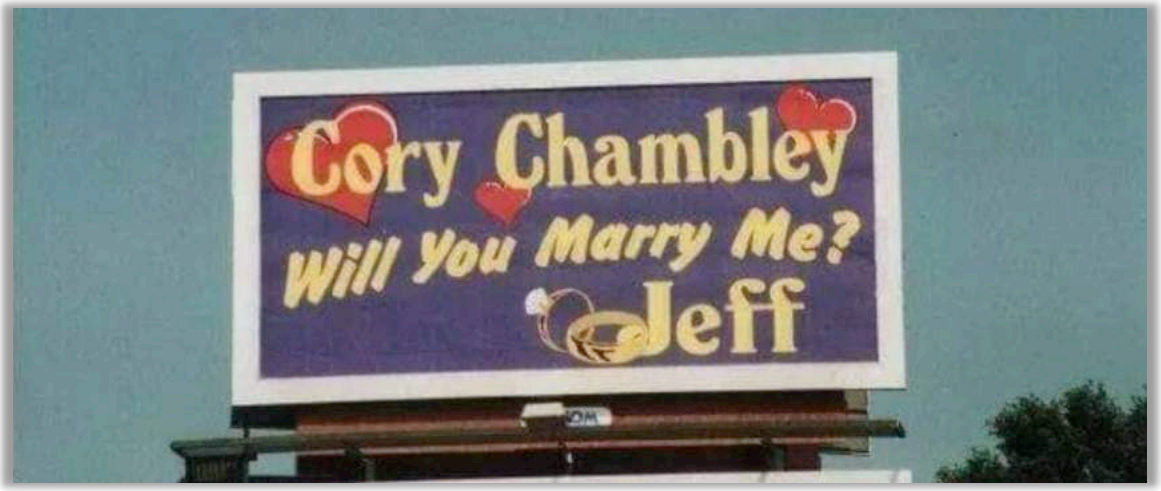
757. Through those ordeals and when Cory's autoimmune disease flared up, Jeffrey never left her side. He also took care of all household and childcare responsibilities by himself.

758. With Jeffrey's death, Cory has been left to fend for herself, as well as take care of his responsibilities, leading to further declines in her health. Put simply: Not having Jeffrey has made Cory sicker.

759. Jeffrey was survived by two children—his 25-year-old son Hunter, and 10-year-old Lydia. Jeffrey did not live to see Hunter get married this year.

760. Everyone liked Jeffrey. He had a bright, cheerful, and contagious personality. He had a tireless optimism for life. His presence was larger than life.

761. Jeffrey proposed to Cory with this billboard.



762. He was the person everyone called on for help. He was the person who would give others the shirt off his back.

763. When he died, a family attorney said: "They don't make them like that anymore. He was the salt of the earth."

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764. As a direct and proximate result of 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 Jeffrey Brown and Plaintiff suffered.

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

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

b. All costs of this action;

c. Expenses of litigation pursuant to OCGA 13-6-11, including attorneys fees;

d. Punitive damages; and

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

November 18, 2021

Respectfully submitted,

/s/ Lloyd N. Bell
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