

IN THE STATE COURT OF GWINNETT COUNTY
STATE OF GEORGIA

GLEND A YARBROUGH
Individually and as Representative
of the Estate of RONALD
YARBROUGH, deceased,

Plaintiff,

— *versus* —

GWINNETT HOSPITAL
SYSTEM, INC.

CARDIOVASCULAR GROUP,
P.C.

LANCE B. FRIEDLAND, MD,

COLON AND RECTAL
CLINIC, LLC

KOTA VENKATESH, MD

JOHN/JANE DOE 3-10,

Defendants

CIVIL ACTION

FILE NO. 20-C-02832-S4

HON. RONDA COLVIN LEARY

JURY TRIAL DEMANDED

PLAINTIFF'S AMENDED COMPLAINT FOR DAMAGES

Summary of Amendment

1. Plaintiff hereby amends the Complaint to add (a) a cause of action, Count 3, alleging professional negligence by Colon and Rectal Clinic, LLC ("CRC") and Kota Venkatesh, MD, (b) procedural allegations concerning CRC and Dr. Venkatesh, and (c) claims pursuant to OCGA § 13-6-11 and for punitive damages.

2. The allegations added by this amendment are reflected in paragraphs 1-3, 9, 27-36, 68, 82, and 123-141, and 144.

3. This Amended Complaint otherwise includes the entirety of the Complaint without changes, except adding “that” in paragraph 59 for grammatical purposes and changing “Complaint” to “Amended Complaint” where appropriate.

Nature of the Action

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

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

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

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

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

9. Pursuant to OCGA § 9-11-9.1, the Affidavit of Meldon C. Levy, MD; the Affidavit of Marcia Bell, RN; and the Affidavit of Stephen Cohen, MD, are attached

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

hereto as Exhibits 1-3. This Amended Complaint incorporates the opinions and factual allegations contained in those affidavits.

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

Parties, Jurisdiction, and Venue

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

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

13. GHS has been properly served with this Amended Complaint.

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

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

16. Plaintiff believes that at all relevant times, GHS was the employer or other principal of the individuals who conducted the pre-admission, pre-surgery screening of Ronald Yarbrough in May and June 2019 for his planned colon resection surgery. However, if any other entity was a principal of those individuals, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

17. **Defendant Cardiovascular Group, P.C. (“CVG”)** is a Georgia professional corporation with its Registered Office in Gwinnett County. CVG may

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

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

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

be served through their Registered Agent, Philip A. Romm, at 755 Walther Road, Lawrenceville, Georgia 30046.

18. CVG has been properly served with this Amended Complaint.

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

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

21. Plaintiff believes that at all relevant times, CVG was the employer or other principal of Dr. Lance B. Friedland and the other individuals responsible for recording the CT calcium scoring results in Ronald Yarbrough's chart, or for reviewing those results, or for communicating the importance of those results to Mr. Yarbrough. However, if any other entity was a principal of those individuals, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

22. **Defendant Lance B. Friedland, MD**, is a citizen of Georgia, residing in Fulton County. He may be served with process at his residence: 1010 Chesson

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

Court, Alpharetta, Georgia 30022. If not found there, Dr. Friedland may be served at his place of business: Cardiovascular Group, 755 Walther Road NW, Lawrenceville, Georgia, 30045.

23. Dr. Friedland has been properly served with this Amended Complaint.

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

25. Pursuant to OCGA 9-10-31, Dr. Friedland is subject to venue in this Court because his co-defendant, CVG, is subject to venue in this Court.

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

27. **Defendant Colon and Rectal Clinic, LLC (d/b/a “Colon & Rectal Clinic) (“CRC”)** is a Georgia limited liability company with a principal office at 3126 Sproull Way, Duluth, GA 30097 (Gwinnett County) and offices at 3905 Johns Creek Court, Suite 200, Suwanee, GA 30024 (Gwinnett County), and 761 Walther Road, Suite 300, Lawrenceville, GA 30046 (Gwinnett County). CRC may be served through its registered agent, Kota Venkatesh, at 3590 Moye Trail, Duluth, GA 30097 (Gwinnett County).

28. CRC has been properly served with this Amended Complaint.

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

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

31. Plaintiff believes that CRC was the employer or other principal of Defendant Kota Venkatesh at the time of the negligent acts or omissions alleged against Dr. Venkatesh herein. If any other entity was an employer or other principal of Dr. Venkatesh at that time, 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 it.

32. **Defendant Kota Venkatesh, MD**, is a citizen of Georgia residing in Gwinnett County. He may be served with process at his residence: 3590 Moyer Trail, Duluth, GA 30097. If not found there, Dr. Venkatesh may be served at one of his places of business: 3905 Johns Creek Court, Suite 200, Suwanee, GA 30024, and 761 Walther Road, Suite 300, Lawrenceville, GA 30046.

33. Dr. Venkatesh has been properly served with this Amended Complaint.

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

35. Pursuant to OCGA 9-10-31, Dr. Venkatesh is subject to venue in this Court because he is a resident of Gwinnett County and also because one of his co-defendants is subject to venue in this Court.

36. At all times relevant to this Amended Complaint, Dr. Venkatesh acted as an employee or agent of Defendant CRC.

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

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

Facts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

55. The letter from CardioVascular Group specifically indicated that Dr. Friedland had noted Mr. Yarbrough's elevated calcium score, but cited an old cardiac catheterization and a 2017 stress test as alleviating concerns from the

calcium score. (“Your Calcium score is elevated, but your last cardiac cath showed non-obstructive disease. . . . Your stress test in 2017 was negative.”)

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

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

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

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

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

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

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

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

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

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

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

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

68. On May 15, 2019, Mr. Yarbrough saw a surgeon, Dr. Kota Venkatesh, to consider a colon resection. As part of the pre-colectomy assessment, Dr. Venkatesh failed to inquire about and identify the significant cardiovascular risk-factors contributing to perioperative risk in Mr. Yarbrough's case.

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

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

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

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

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

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

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

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

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

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

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

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

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

82. On the afternoon of Tuesday, June 4, 2019, Dr. Venkatesh performed the colectomy on Mr. Yarbrough.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

108. The standard of care required the hospital staff who conducted the preadmit screenings for the colectomy to obtain a medical clearance from Dr.

Friedland and to bring the CT calcium scoring result to the attention of the anesthesia team.

109. The staff violated that standard of care.

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

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

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

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

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

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

115. The standard of care required Dr. Friedland to follow up on the CT calcium score results, correctly inform Mr. Yarbrough of the results and their

significance, and to evaluate Mr. Yarbrough for further treatment of his arterial stenosis.

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

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

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

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

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

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

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

Count 3 – Injuries & Wrongful Death from Professional Negligence — Colon and Rectal Clinic and Dr. Venkatesh

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

124. In providing medical services to Ronald Yarbrough, Dr. Venkatesh committed at least the following four violations of the standard of care.

125. As part of a pre-operative assessment, the standard of care requires a surgeon to identify cardiovascular risk-factors contributing to perioperative cardiac risk.

126. On or about May 15, 2019, as part of the pre-colectomy assessment of Mr. Yarbrough, Dr. Venkatesh violated this requirement, by failing to identify the significant cardiovascular risk-factors contributing to perioperative risk in Mr. Yarbrough's case.

127. When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care requires a colo-rectal surgeon to obtain clearance from a cardiologist before authorizing or performing a colectomy on the patient.

128. Dr. Venkatesh violated this requirement by failing even to seek, much less obtain, a cardiologist's clearance for Mr. Yarbrough's colectomy.

129. When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care requires a colo-rectal surgeon to

obtain the patient's informed consent to the risk prior to performing a colectomy on the patient.

130. Dr. Venkatesh violated this requirement by:

- a. failing to inform Mr. Yarbrough of cardiovascular risk-factors contributing to perioperative cardiac risk in his case;
- b. failing to inform Mr. Yarbrough that cardiology clearance for the colectomy had not been sought or obtained;
- c. failing to inform Mr. Yarbrough of the risk of performing the colectomy without prior cardiology clearance; and
- d. failing to obtain Mr. Yarbrough's consent to undergoing the colectomy without prior cardiology clearance.

131. When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care bars a colo-rectal surgeon from performing a colectomy on the patient without prior clearance from a cardiologist.

132. On June 4, 2019, Dr. Venkatesh violated this requirement by performing a colectomy on Mr. Yarbrough without prior clearance from a cardiologist. This violation was all the more egregious because the surgery could have been postponed safely—without detriment to the patient.

133. But-for Dr. Venkatesh's violations of the standard of care:

- a. he would have identified Mr. Yarbrough's cardiovascular risk-factors;
- b. he would have sought clearance from cardiology;
- c. cardiology would have found the lesion in Mr. Yarbrough's left anterior descending artery;

- d. cardiology would have denied clearance for the surgery;
- e. the colectomy would have been postponed pending cardiovascular treatment; and
- f. the complications the surgery induced, including myocardial infarction, would not have occurred.

134. By permitting the colectomy to go forward, Dr. Venkatesh's violations thus brought pain, suffering, myocardial infarction, organ failure, and ultimately death upon Mr. Yarbrough.

135. Dr. Venkatesh is directly liable for his own negligence.

136. Defendant CRC is vicariously liable for Dr. Venkatesh's negligence, because he was acting within the scope of his employment or agency with CRC.

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

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

OCGA § 13-16-11 Claims – GHS, CardioVascular Group and Dr. Friedland

139. Plaintiff incorporates by reference all paragraphs of this Complaint as though fully set forth herein.

140. Plaintiff shows that Defendants have acted in bad faith, have been stubbornly litigious, and have caused Plaintiff unnecessary trouble and expense.

141. Plaintiff is thus entitled to her expenses of litigation pursuant to OCGA § 13-16-11, including reasonable attorneys' fees.

Damages

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

143. As a direct and proximate result of the Defendants' conduct, Plaintiff is entitled to recover from Defendants reasonable compensatory damages in an amount exceeding \$10,000.00 to be determined by a fair and impartial jury for all damages Plaintiff suffered, including physical, emotional, and economic injuries.

144. 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.

May 14, 2021.

Respectfully submitted,

/s/ Lloyd N. Bell

Georgia Bar No. 048800

Daniel E. Holloway

Georgia Bar No. 658026

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Attorneys for Plaintiff

IN THE STATE COURT OF GWINNETT COUNTY
STATE OF GEORGIA

GLEND A YARBROUGH
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the Estate of RONALD YARBROUGH,
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LLC

KOTA VENKATESH, MD

JOHN/JANE DOE 3-10,

Defendants.

CIVIL ACTION

FILE NO. 20-C-02832-S4

HON. RONDA COLVIN LEARY

CERTIFICATE OF SERVICE

The undersigned has served this **Plaintiff's Amended Complaint for Damages** upon all parties to this proceeding by electronically filing the same with the Clerk of Court using Odyssey eFileGA as follows:

Paul Weathington, Esq.
J Gabriel Banks Esq.
WEATHINGTON FIRM
191 Peachtree Street, NE, Suite 3900
Atlanta, GA 30303

Carol O Michel, Esq.
John K Train IV, Esq.
Weinberg Wheeler Hudgins, Gunn & Dial, LLC
3344 Peachtree Rd NE, Suite 2400
Atlanta, GA 30316

May 14, 2021

BELL LAW FIRM

/s/ Lloyd N. Bell

Lloyd N. Bell

Georgia Bar No. 048800

Attorney for Plaintiff

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Bell@ BellLawFirm.com

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

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

Introduction and Limited Purpose of Affidavit

1. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.
2. This affidavit states my views of the matters discussed below — views I formed from my review of the evidence. However, Plaintiff's counsel drafted this document in consultation with me. Plaintiff's counsel did the typing, supplied the snapshots from medical records, the legalese, the formatting, etc., and inserted the general factual narrative from the medical records. The medical analysis and opinions are mine.
3. This affidavit does not attempt to state or summarize all my opinions. This affidavit addresses specific matters that Plaintiff's counsel have asked me to examine for purposes of testimony at trial. I have not attempted to identify every person who may have violated a standard of care. Nor have I attempted to identify every standard of care that a particular person violated. If additional information becomes available later, then of course my opinions may change.
4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation of my views, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. In particular, while I cite evidence from the medical records for various facts, I do not necessarily cite *all* the evidence for a given point.

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

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

Topic & Opinions

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

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

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

- a. Dr. Friedland and CardioVascular Group violated their standards of care by failing to inform Mr. Yarbrough of abnormal results from a CT calcium scoring examination on October 26, 2018.
- b. Dr. Friedland and CardioVascular Group violated their standards of care by failing to further evaluate Mr. Yarbrough after that abnormal result.
- c. Dr. Friedland and/or CardioVascular Group violated their standards of care by falsely telling Mr. Yarbrough — in a letter dated 10/30/2018 — that his CT calcium scoring exam showed no significant calcification in the arteries leading to his heart.

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

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

Qualifications

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

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

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

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

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

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

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

- b. In October 2018 and May 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:
- Within a cardiology practice, ensuring that a patient is accurately informed of cardiovascular test results.
 - Within a cardiology practice, ensuring that a patient is not cleared for potential medical procedures that would be unsafe because of the patient’s cardiovascular condition.
- c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to October 2018 and May 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

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

Evidence Reviewed

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

Discussion and Factual Basis for Opinion

General Principles

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

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

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

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

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

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

Ronald Yarbrough's Course of Treatment

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

YARBROUGH, RONALD H

Date of visit: 10/15/2018

...

IMPRESSION/PLAN

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

MRNO: 388262 Page 3 of 4 Create Date: 2018-10-15

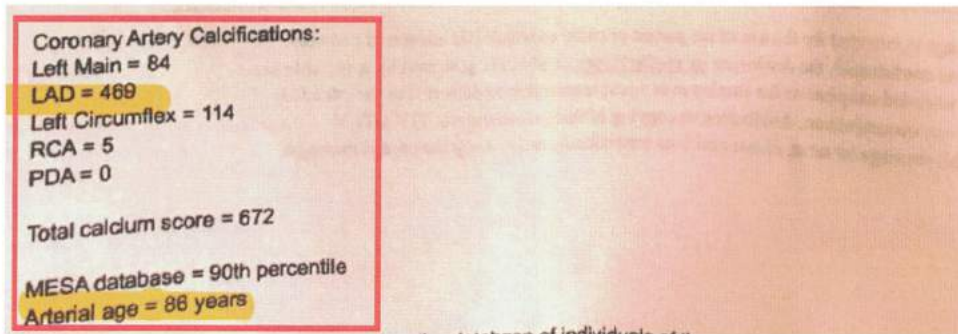
CVG 00

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

TODAYS ORDERS

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

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



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

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

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

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

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

Dear Ronald Yarbrough:

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

Thank you,

CardioVascular Group staff member: SUZIE CLARK

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

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

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

PAST HISTORY

Past Medical Illnesses: insomnia, anxiety, DM-non-insulin dependent, depression, GERD, history of colon polyps, Osteogenesis Imperfecta, renal insufficiency

Cardiovascular Illnesses: hyperlipidemia-Mixed, hypertension, Minor Nonobstructive CAD 2006, atrial fibrillation-paroxysmal

Infectious Diseases: mumps, measles and chickenpox during childhood, pertussis

Surgical Procedures: bilateral shoulder surgery- rotator cuff

Cardiology Procedures-Invasive: cardiac cath (left) May 2006

Cardiology Procedures-Noninvasive: Holter monitor May 1991, echocardiogram May 1991, myocardial perfusion study (Nuclear) September 2002, myocardial perfusion study (Nuclear) March 2017, echocardiogram March 2017, carotid Doppler March 2017

Left Ventricular Ejection Fraction: LVEF of 67% documented via nuclear study on 03/07/2017

Peripheral Vascular Procedures: carotid doppler March 2017

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

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

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

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

HISTORY OF PRESENT ILLNESS

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

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

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

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

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

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

IMPRESSION/PLAN

1. Chest pains, resolved. He had a normal stress DIMPS March 7, 2017 with left ventricular ejection fraction of 67%..
He has a history of minor nonobstructive coronary artery disease by cardiac cath in 2006.
2. Paroxysmal atrial fib. His episode was in 2000 and he has not had any recurrent symptoms.

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CVG 0004

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

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

appearance, and return were photographed.

Findings:

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

Recommendation:

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

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

05/15/2019

Progress Notes: Kota Venkatesh MD

Current Medications

Taking

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

Reason for Appointment

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

Assessments

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

Treatment

1. Epigastric pain

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

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

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

MEDICAL CONDITIONS/HISTORY
CARDIOLOGY
HISTORY OF CARDIOVASCULAR DISEASE: Yes

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DESCRIPTION: Other

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

DESCRIPTION: Other

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

DESCRIPTION: Hyperlipidemia

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

RESPIRATORY

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

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

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

Cardiovascular

Hyperlipidemia

Onset Date	
Most Recent Date	
Comment	
Current	Yes
Past	Yes

PRE-ANESTHESIA EVALUATION
Account #: 1915580326

Other

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

Renal/Urogen

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

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

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

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

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

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

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

Date of Procedure: 06/04/2019

SURGEON: Kota R Venkatesh MD

PREOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

POSTOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

NAME OF PROCEDURE: Laparoscopic right colectomy with partial omentectomy.

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

DOS: 06/06/2019
ROOM#:

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

REASON FOR CONSULTATION: Sinus tachycardia.

CLINICAL IMPRESSION:

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

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

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

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

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

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

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

DOS: 06/07/2019

ROOM#:

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

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

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

ASSESSMENT AND PLAN:

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

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

DOS: 06/08/2019

ROOM#:

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

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

IMPRESSION:

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

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

DOS: 06/09/2019

ROOM#:

This is a CVG cardiology progress note.

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

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

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

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

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

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

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

IMPRESSION AND PLAN:

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

Discussed with patient in the presence of his wife.

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

IMPRESSION AND PLAN:

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

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

ASSESSMENT AND PLAN:

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

ASSESSMENT:

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

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

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

have 2 vessel disease. Coronary artery bypass grafting versus percutaneous coronary intervention.

4. Due to osteogenesis imperfecta, unable to perform sternotomy open CABG. Dr. Langford is planning to transfer him to St. Joseph for robotic CABG.

5. He is on heparin drip for acute coronary syndrome and two-vessel severe coronary artery disease with severe coronary calcification, widespread atherosclerotic disease, left ventricular dysfunction, awaits robotic CABG on a heparin drip, half normal saline.

6. Metabolic acidosis, resolved. He is getting half normal saline with bicarbonate. He is able to drink enough fluids. Hence, will discontinue bicarbonate drip. His CO2 has become normal. Metabolic acidosis corrected. Creatinine continues to improve. Urine output maintained well.

7. Discussed with patient and wife. Continue to monitor renal functions.

8. He had C. difficile colitis being managed by Dr. Kusan.

Prognosis is guarded. Call us with any questions.

RECOMMENDATIONS:

1. The patient is considered high risk for sternotomy and complete surgical revascularization. Dr. Langford has arranged for the patient to be transferred to St. Joseph Hospital for a robotic LIMA to the LAD.

2. He would be a candidate for percutaneous coronary intervention of some of his residual disease depending on his symptoms going forward.

3. Further recommendations after his robotic LIMA to the LAD.

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

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

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

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

DOCUMENT NAME:
SERVICE DATE/TIME:
RESULT STATUS:
PERFORM INFORMATION:
SIGN INFORMATION:

History and Physical Hospital
6/18/2019 11:20 EDT
Auth (Verified)
Earnshaw, Madhuree (6/18/2019 11:21 EDT)
Diwa, Renjay (7/16/2019 22:51 EDT); Halkos, Michael E
(6/21/2019 10:47 EDT); Earnshaw, Madhuree (6/18/2019
13:56 EDT)

Cardiothoracic Surgery H&P

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

This is a 64 year old male with past medical history significant for HTN, HLD, PAF, CKD stage III, IDDM, BPH, osteogenesis imperfecta who was transferred from Gwinnett Medical Center to ESJH on 6/17/19 for surgical evaluation. On 6/4/19 he underwent right colectomy and partial omentectomy due to colon ulcer with adenomatous tissue. Pathology was negative for malignancy. He became hypoxic and complained of chest pain during the post-op period. He was walking POD 1 from colon surgery and felt shoulder and chest burning. Work up was negative for a PE and showed elevated troponin. He was diagnosed with NSTEMI and underwent LHC that demonstrated revealed 95% pLAD, 90% ramus, 40-50% ramus, 40-50% pCx, 90% cCx (small), 40% RCA. He recently completed vancomycin therapy for C0dff, which has since tested negative. He is being evaluated by Dr. Halkos for robotic LIMA-LAD. Dr. Chang has been consulted to evaluate the patient for Hybrid revascularization.

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

Case Times SJH OR

	Entry 1
SN - Set-Up	
SN - Patient	
In Time	06/21/19 14:04:00
Cut Time	06/22/19 00:43:00
SN - Anesthesia	
Anesthesia Ready	06/21/19 14:12:00
SN - Surgery	
Start Time	06/21/19 15:20:00
Stop Time	06/22/19 00:36:00
SN - Clean-Up	
Last Modified By:	Watson, Shere 06/22/19 00:41:03

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

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

...

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

...

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

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

Subjective

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

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

Impression and Plan

Impression: 64M POD2 robotic converted to open CABGx2

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

Plan

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

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

Respiratory

Pulmonary insufficiency following surgery (ICD10-CM J60, Discharge, Medical).

Cardiovascular

Atherosclerotic heart disease of native coronary artery with unstable angina pectoris (ICD10-CM I25.110, Discharge, Medical).

Other cardiomyopathies (ICD10-CM I42.8, Discharge, Medical).

Postoperative shock, cardiogenic (ICD10-CM T81.11XA, Discharge, Medical).

Nephrology

Acute kidney failure, unspecified (ICD10-CM N17.9, Discharge, Medical).

Hematology

Postoperative anemia due to acute blood loss (ICD10-CM D62, Discharge, Medical).

Infectious Disease

Enterocolitis due to Clostridium difficile (ICD10-CM A04.7, Discharge, Medical).

Endocrine

Type 2 diabetes mellitus without complications (ICD10-CM E11.9, Discharge, Medical).

Counseled: Patient.

Comments

Time Spent

The patient is critically ill and requires continued critical care treatment.

I have spent 70 minutes in critical care management directly related to this patient and/or with family regarding medical decision making issues.

The critical care time documented above does not include time spent on other procedures performed on this patient.

Critical condition(s) addressed for impending deterioration include

Respiratory.

Cardiovascular.

Central nervous system.

Metabolic.

Renal.

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

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

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

Title: ICD-10 Inpatient Coding Summary

Hospital Name: Emory University Hospital

Hospital Address: 1364 Clifton Road

Hospital City/State/Zip: Atlanta, GA 30

Patient Name: YARBROUGH, RONALD HENRY

Sex: M

Birth Date:

MR Number: EUH2514270

Account Number: EUHQ14677749176

Admit Date: 06/25/19 10:31 PM

Discharge Date: 07/12/19 03:50 PM

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

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

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

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

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

GEORGIA DEATH CERTIFICATE			
			State File Number 2019GA000041921
1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last) RONALD HENRY YARBROUGH	1a. IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX MALE	2a. DATE OF DEATH (Mo., Day, Year) ACTUAL DATE OF DEATH 07/12/2019

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

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

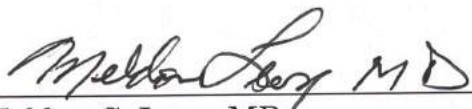
75. If Dr. Friedland and CardioVascular Group had done their jobs, Mr. Yarbrough's LAD stenosis could have been addressed safely and timely, and the June 2019 post-surgery heart attack and premature death could have been avoided.

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

Miscellaneous

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

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


Meldon C. Levy, MD

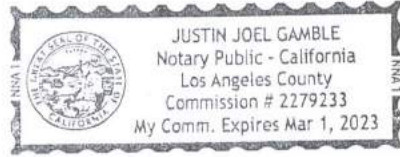
SWORN TO AND SUBSCRIBED before me

↑ 04/16, 2020



NOTARY PUBLIC

My Commission Expires: 03-01-2023



MELDON C. LEVY, M.D., F.A.C.C.

A PROFESSIONAL CORPORATION

CENTURY CITY MEDICAL PLAZA

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TELEPHONE (310) 277-9126

CURRICULUM VITAE**Personal Information**

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

Education

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

Professional Background

Academic Appointments

Clinical Instructor in Medicine, University of California Los Angeles, 1977-1979
Assistant Clinical Professor in Medicine, University of California, Los Angeles, 1979-1984
Assistant Clinical Professor in Medicine, Keck School of Medicine, University of Southern California, Los Angeles, 2008 to present

Administrative Responsibilities

Director, Cardiac Noninvasive Laboratory, Century City Hospital, Los Angeles, 1978-2000
Chief of Staff, Century City Hospital, Los Angeles, 1987-1989
Chairman, Governing Board, Century City Hospital, Los Angeles, 1997-1999
Medical Director, Beverly Glen Medical Systems, Los Angeles, 2000-2002
Chief of Cardiology, Century City Doctors Hospital, Los Angeles, 2005-2007
Director, Cardiac Noninvasive Laboratory, Century City Doctors Hospital, 2005-2008
Chairman, Critical Care Committee, Century City Doctors Hospital, 2005-2008

Awards and Achievements

Testamur, ASEeXAM, August 7, 1997

Military Service

None

Other Employment or Activity

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

Society Memberships

Local

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

National

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

Research Activities

Principal Investigator

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

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

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

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

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

Research Activities (cont'd)

Principal Investigator

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

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

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

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

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

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

Research Activities (cont'd)

Principal Investigator

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

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

Bibliography

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

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

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

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

Introduction and Limited Purpose of Affidavit

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

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

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

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

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

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

Topic & Opinions

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

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

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

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

Qualifications

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

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

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

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

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

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

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

- b. In May 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the area of screening a patient for a scheduled surgery, including obtaining and recording medical clearance from the patient's physicians.
- c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to May 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

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

Evidence Reviewed

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

Discussion and Factual Basis for Opinion

General Principles

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

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

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

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

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

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

Ronald Yarbrough's Course of Treatment

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

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

Interpretation

Summary: Resting ECG: NSR, POOR INITIAL ANTERIOR FORCES, NONSPECIFIC T.

Functional Capacity: Normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: 2-3mm inferior and anterolateral ST-T wave downsl.

Overall Impression: Abnormal ETT.

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

!FINDINGS:

!Normal Exercise Dual Isotope Myocardial Perfusion Scan

!There is no evidence of Ischemia or Infarction at a maximal level of exercise. Diaphragm attenuation.

!Normal LV Systolic Function. LVEF 67%.

+-----
!Recommendation

+-----
!Continue medical therapy.

!Risk factor modification.

!Follow up with Ordering physician and/or primary physician.

+-----
!Signatures

+-----
!Electronically signed by Friedland, Lance MD(Interpreting cardiologist) on 03/08/2017 19:12
+-----

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

YARBROUGH, RONALD H

Date of visit: 10/15/2018

...

IMPRESSION/PLAN

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

MRNO: 388262 Page 3 of 4 Create Date: 2018-10-15

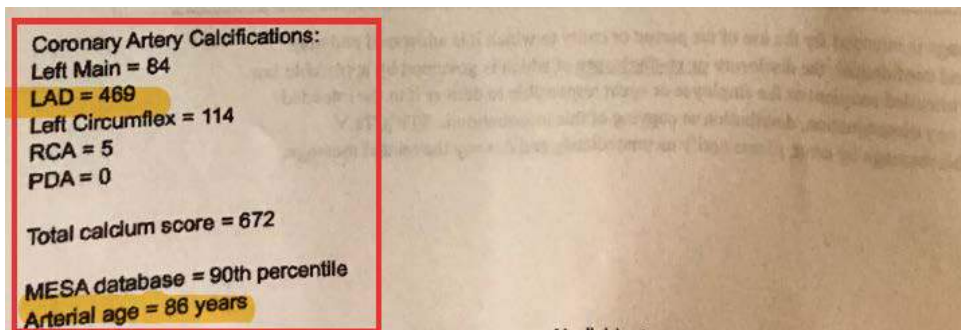
CVG 00

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

TODAYS ORDERS

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

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



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

Dear Ronald Yarbrough:

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

Thank you,

CardioVascular Group staff member: SUZIE CLARK

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

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

PAST HISTORY

Past Medical Illnesses: insomnia, anxiety, DM-non-insulin dependent, depression, GERD, history of colon polyps, Osteogenesis Imperfecta, renal insufficiency

Cardiovascular Illnesses: hyperlipidemia-Mixed, hypertension, Minor Nonobstructive CAD 2006, atrial fibrillation-paroxysmal

Infectious Diseases: mumps, measles and chickenpox during childhood, pertussis

Surgical Procedures: bilateral shoulder surgery- rotator cuff

Cardiology Procedures-Invasive: cardiac cath (left) May 2006

Cardiology Procedures-Noninvasive: Holter monitor May 1991, echocardiogram May 1991, myocardial perfusion study (Nuclear) September 2002, myocardial perfusion study (Nuclear) March 2017, echocardiogram March 2017, carotid Doppler March 2017

Left Ventricular Ejection Fraction: LVEF of 67% documented via nuclear study on 03/07/2017

Peripheral Vascular Procedures: carotid doppler March 2017

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

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

HISTORY OF PRESENT ILLNESS

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

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

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

IMPRESSION/PLAN

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

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

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CVG 0004

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

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

appendiceal orifice, and rectum were photographed.

Findings:

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

Recommendation:

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

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

05/15/2019

Progress Notes: Kota Venkatesh MD

Current Medications

Taking

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

Reason for Appointment

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

Assessments

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

Treatment

1. Epigastric pain

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

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

MEDICAL CONDITIONS/HISTORY
CARDIOLOGY
HISTORY OF CARDIOVASCULAR DISEASE: Yes

DESCRIPTION: Other

CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04

CURRENT: Yes

COMMENT: **TACHYCARDIA**

DESCRIPTION: Other

CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04

CURRENT: Yes

MOST RECENT: 5/23/19

COMMENT: **ACTIVITY: YARDWORK, CLIMB STAIRS, ADL'S W/O CP OR SOB**

DESCRIPTION: Hyperlipidemia

CONFIRMED BY: VASEY-EVANS, NAKIA - RN AT: 05/23/2019 14:04

CURRENT: Yes

PAST: Yes

RESPIRATORY

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

MEDICAL CONSENTS/CLEARANCE

DATE/TIME: 05/23/2019 12:56

RECORDED BY: VASEY-EVANS, NAKIA - RN

PRIMARY PHYSICIAN NAME: DR. ROBERT DEINLER

PHYSICIAN TYPE: internal medicine

DATE/TIME: 05/23/2019 12:58

RECORDED BY: VASEY-EVANS, NAKIA - RN

PRIMARY PHYSICIAN NAME: DR. LANCE FREIDLAND

PHYSICIAN TYPE: cardiologist

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

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

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

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

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

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

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

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

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

Cardiovascular

Hyperlipidemia

Onset Date

Most Recent Date

Comment

Current

Yes

Past

Yes

PRE-ANESTHESIA EVALUATION
Account #: 1915580326

Other

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

Renal/Urogen

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

Date of Procedure: 06/04/2019

SURGEON: Kota R Venkatesh MD

PREOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

POSTOPERATIVE DIAGNOSIS: Ascending colon ulcer with adenomatous tissue.

NAME OF PROCEDURE: Laparoscopic right colectomy with partial omentectomy.

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

DOS: 06/06/2019
ROOM#:

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

REASON FOR CONSULTATION: Sinus tachycardia.

CLINICAL IMPRESSION:

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

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

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

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

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

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

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

DOS: 06/07/2019

ROOM#:

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

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

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

ASSESSMENT AND PLAN:

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

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

DOS: 06/08/2019

ROOM#:

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

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

IMPRESSION:

1. Non-ST elevation myocardial infarction.

a. Peak troponin 0.7.

b. Left heart cath is planned for Monday.

c. Wall motion abnormality involving the mid to distal left anterior descending territory.

d. Previous cath 2006 suggested mild nonobstructive disease.

2. Colectomy, omentectomy.

3. Diabetes.

4. Kidney disease.

5. Hyperlipidemia.

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

DOS: 06/09/2019

ROOM#:

This is a CVG cardiology progress note.

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

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

IMPRESSION AND PLAN:

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

Discussed with patient in the presence of his wife.

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

Respiratory

Pulmonary insufficiency following surgery (ICD10-CM J60, Discharge, Medical).

Cardiovascular

Atherosclerotic heart disease of native coronary artery with unstable angina pectoris (ICD10-CM I25.110, Discharge, Medical).

Other cardiomyopathies (ICD10-CM I42.8, Discharge, Medical).

Postoperative shock, cardiogenic (ICD10-CM T81.11XA, Discharge, Medical).

Nephrology

Acute kidney failure, unspecified (ICD10-CM N17.9, Discharge, Medical).

Hematology

Postoperative anemia due to acute blood loss (ICD10-CM D62, Discharge, Medical).

Infectious Disease

Enterocolitis due to Clostridium difficile (ICD10-CM A04.7, Discharge, Medical).

Endocrine

Type 2 diabetes mellitus without complications (ICD10-CM E11.9, Discharge, Medical).

Counseled: Patient.

Comments

Time Spent

The patient is critically ill and requires continued critical care treatment.

I have spent 70 minutes in critical care management directly related to this patient and/or with family regarding medical decision making issues.

The critical care time documented above does not include time spent on other procedures performed on this patient.

Critical condition(s) addressed for impending deterioration include

Respiratory.

Cardiovascular.

Central nervous system.

Metabolic.

Renal.

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

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

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

Admit Diagnosis (Code/Text): R570 Cardiogenic shock
Principal Diagnosis (PCA/Code/Text): Y T8111XA Postprocedural cardiogenic shock, initial encounter
Secondary Diagnosis (PCA/Code/Text): Y @ I214 Non-ST elevation (NSTEMI) myocardial infarction
N @ R402114 Coma scale, eyes open, never, 24 hours or more after hospital admission
N @ R402214 Coma scale, best verbal response, none, 24 hours or more after hospital admission
N @ R402314 Coma scale, best motor response, none, 24 hours or more after hospital admission
N @ I608 Other nontraumatic subarachnoid hemorrhage
Y @ N170 Acute kidney failure with tubular necrosis
Y @ K7200 Acute and subacute hepatic failure without coma
N @ I6389 Other cerebral infarction
Y @ A419 Sepsis, unspecified organism
Y @ E43 Unspecified severe protein-calorie malnutrition
Y @ J158 Pneumonia due to other specified bacteria
Y @ J95821 Acute postprocedural respiratory failure
E # Q780 Osteogenesis imperfecta
N # K2210 Ulcer of esophagus without bleeding
N # K920 Hematemesis
N # I472 Ventricular tachycardia
N # R0489 Hemorrhage from other sites in respiratory passages
Y # D62 Acute posthemorrhagic anemia
Y # A0472 Enterocolitis due to Clostridium difficile, not specified as recurrent
N # G9340 Encephalopathy, unspecified
N # E872 Acidosis
N # K625 Hemorrhage of anus and rectum
N # E873 Alkalosis
N 266 Do not resuscitate
N 2515 Encounter for palliative care
Y Y832 Surgical operation with anastomosis, bypass or graft as the cause of abnormal

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

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

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

GEORGIA DEATH CERTIFICATE			
		State File Number	2019GA000041921
1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last)	1a. IF FEMALE, ENTER LAST NAME AT BIRTH	2. SEX	2a. DATE OF DEATH (Mo., Day, Year)
RONALD HENRY YARBROUGH		MALE	ACTUAL DATE OF DEATH 07/12/2019

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

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

Miscellaneous

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

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

Marcia L. Bell

Marcia Bell, RN

SWORN TO AND SUBSCRIBED before me

May 6, 2020

Pamela Haidt Lee

NOTARY PUBLIC

My Commission Expires:



CURRICULUM VITAE

MARCIA LYNN BELL, RN, BSN, CAPA

9863 Wilderness Lane

Laurel, MD 20723

Cell Phone: (410) 660-7025

Email: marciablnc@yahoo.com

EDUCATION

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

CERTIFICATION

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

PROFESSIONAL EXPERIENCE

April 2015 to present

Mercy Medical Center, Baltimore, MD

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

September 2011 to December 2012

Piney Orchard Surgery Center, Odenton, MD

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

November 1996 to April 2016

SurgiCenter of Baltimore, Owings Mills, MD

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

February 1996 to November 1996

Thornton, Summers, Biechlin, Dunham & Brown, L.C., San Antonio, TX

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

November 1991 to February 1996

San Antonio Surgery Center, San Antonio, TX

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

April 1991 to December 1991

Medical Personnel Pool, Favorite Nurses, San Antonio Nurses Unlimited, San Antonio, TX

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

May 1989 to January 1991

Willis Knighton Medical Center, Shreveport, LA

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

October 1987 to May 1989

LSU Medical Center, Shreveport, LA

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

March 1987 to October 1987

LSU Medical Center, Shreveport, LA

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

August 1985 to February 1987

St. Francis Medical Center, Monroe, LA

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

January 1984 to July 1985

Maryland Institute Of Emergency Medical Services Systems, Baltimore, MD

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

May 1983 to December 1983

South Baltimore General Hospital, Baltimore, MD

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

June 1981 to April 1983

The Johns Hopkins Hospital, Baltimore, MD

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

PROFESSIONAL QUALIFICATIONS

Current:

BLS (Basic Life Support) Certification

ACLS (Advanced Life Support) Certification

PALS (Pediatric Life Support) Certification

CAPA (Certified Ambulatory Perianesthesia Nurse) Certification

PROFESSIONAL MEMBERSHIPS

American Society of Perianesthesia Nurses (ASPN)

PUBLICATIONS

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

Reviewed 1/30/18

**AFFIDAVIT OF STEPHEN COHEN, MD, MBA, REGARDING
RONALD YARBROUGH**

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Stephen Cohen, MD, who after first being duly sworn, states as follows.

Introduction

1. This affidavit addresses medical negligence concerning the colectomy Ronald Yarbrough underwent on June 4, 2019, at Gwinnett Medical Center, in Lawrenceville, Georgia.
2. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.
3. The process of creating this affidavit was as follows:
 - a. Plaintiff's counsel contacted me, outlined the basic facts of the case, and identified the issues they wanted me to analyze. I reserved judgment until I reviewed the medical records myself.
 - b. Upon reviewing the medical records, I formed my own views and reached my own conclusions, and then shared them with Plaintiff's counsel.
 - c. Plaintiff's counsel then prepared a draft of this affidavit, based on my views and conclusions.
 - d. I then reviewed the draft and edited it to make sure it correctly states my views and conclusions. I did not edit the affidavit for style.
4. This affidavit addresses matters that Plaintiff's counsel have asked me to address. I have not attempted to identify all standard-of-care violations, state every causation opinion I may have, or anticipate or address issues that the Defense might raise or that may otherwise emerge as the case unfolds.
5. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation, but I have not attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details.

6. I use the term “standard of care” to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same or similar circumstances and like surrounding conditions as pertained to the medical provider I discuss here.
7. I hold all the opinions expressed below to a reasonable degree of medical certainty—that is, more likely than not. If additional information later becomes available, my views may change.
8. The purpose of this affidavit is to let the Defendants, their lawyers, and their insurers know the conclusions I will testify to at trial—in enough detail that the Defense can evaluate them and prepare to cross-examine me.
9. I understand that Plaintiff’s counsel may have consulted with other experts, who may have drawn the same conclusions. I would expect most other experts, possibly all, to draw the same or similar conclusions.
10. I understand that Plaintiff’s counsel will provide this affidavit to the Defendants’ lawyers, and that Defendants’ insurers will hire lawyers and medical experts to review this case and this affidavit. If anyone on the Defense concludes that I have not been given, or have overlooked or misconstrued, any relevant information, I invite the Defense to communicate with me by letter through Plaintiff’s counsel. The Defense need not wait to take my deposition to communicate with me. I will consider any information the Defense wishes to bring to my attention, and if appropriate, I will reconsider my conclusions and provide a supplemental affidavit.

Evidence Considered

11. I have reviewed medical records of Ronald Yarbrough’s pre-operative assessment at Colon & Rectal Clinic in Suwanee, Georgia, on May 15, 2019, and medical records related to his colectomy at Gwinnett Medical Center in Lawrenceville, Georgia, on June 4, 2019.

Principal Opinions

12. My principal opinions are summarized here. In deposition or trial testimony, I may elaborate upon these principal opinions, and in doing so, I may offer related, subsidiary, or incidental opinions.

Standard-of-Care Violations

13. First violation: Failure to identify risk-factors in prep-op assessment.

Requirement: As part of a pre-operative assessment, the standard of care requires a surgeon to identify cardiovascular risk-factors contributing to perioperative cardiac risk.

Violation: On May 15, 2019, as part of the pre-colectomy assessment of Ronald Yarbrough, Colo-Rectal Surgeon Kota Venkatesh violated this requirement, by failing to identify the significant cardiovascular risk-factors contributing to perioperative risk in Mr. Yarbrough's case.

14. Second violation: Failure to get clearance.

Requirement: When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care requires a colo-rectal surgeon to obtain clearance from a cardiologist before authorizing or performing a colectomy on the patient.

Violation: Dr. Venkatesh violated this requirement by failing even to seek, much less obtain, a cardiologist's clearance for Mr. Yarbrough's colectomy.

15. Third violation: Failure to obtain the patient's informed consent.

Requirement: When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care requires a colo-rectal surgeon to obtain the patient's informed consent to the risk prior to performing a colectomy on the patient.

Violations: Dr. Venkatesh violated this requirement by:

- a. failing to inform Mr. Yarbrough of cardiovascular risk-factors contributing to perioperative cardiac risk in his case;
- b. failing to inform Mr. Yarbrough that cardiology clearance for the colectomy had not been sought or obtained;
- c. failing to inform Mr. Yarbrough of the risk of performing the colectomy without prior cardiology clearance; and

d. failing to obtain Mr. Yarbrough's consent to undergoing the colectomy without prior cardiology clearance.

16. Fourth violation: Performing surgery without required clearance.

Requirement: When a patient has cardiovascular risk-factors that may contribute to perioperative cardiac risk, the standard of care bars a colo-rectal surgeon from performing a colectomy on the patient without prior clearance from a cardiologist.

Violation: On June 4, 2019, Dr. Venkatesh violated this requirement by performing a colectomy on Mr. Yarbrough without prior clearance from a cardiologist. This violation was all the more egregious because the surgery could have been postponed safely—without detriment to the patient.

Causation

17. But-for Dr. Venkatesh's violations of the standard of care:

- a. he would have identified Mr. Yarbrough's cardiovascular risk-factors;
- b. he would have sought clearance from cardiology;
- c. cardiology would have found the lesion in Mr. Yarbrough's left anterior descending artery;
- d. cardiology would have denied clearance for the surgery;
- e. the colectomy would have been postponed pending cardiovascular treatment; and
- f. the complications the surgery induced, including myocardial infarction, would not have occurred.

18. By permitting the colectomy to go forward, Dr. Venkatesh's violations thus brought pain, suffering, myocardial infarction, organ failure, and ultimately death upon Mr. Yarbrough.

Qualifications

19. I am over 18 years of age, lack legal disabilities, and provide this affidavit upon my own personal knowledge and belief.
20. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.
21. My curriculum vitae, attached as Exhibit A, provides additional detail regarding my qualifications. I incorporate and rely upon it here.
22. The acts and omissions at issue here occurred in May and June 2019.
23. I am qualified to provide expert testimony pursuant to OCGA 24-7-702, based on the following facts.
 - a. In May and June 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession. Specifically, I was licensed by the State of Virginia to practice medicine as a physician, and I was practicing medicine there.
 - b. In May and June 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to—specifically, the tasks identified above on which I offer standard-of-care opinions.

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

Specifically, I was at that time, and I am today, a physician specializing in colon and rectal surgery and general surgery, in the settings of hospitals and other long-term-care facilities, and for many years I have had great familiarity with each of the tasks on which I offer standard-of-care opinions here.



Stephen Cohen, MD, MBA

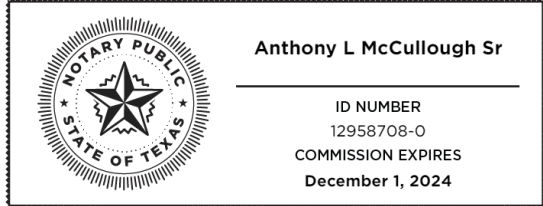
SWORN TO AND SUBSCRIBED before me

_____, May 6th _____, 2021



NOTARY PUBLIC

My Commission Expires 12/01/2024



Notarized online using audio-video communication

CURRICULUM VITAE

STEPHEN M. COHEN, MD, MBA, FACS, FASCRS

Associate Clinical Professor, Department of Surgery
Virginia Commonwealth University
Richmond, Virginia
12/2017 - present

Hunter Holmes McGuire Veterans Administration Medical Center
Staff Surgeon
Department of Surgery
10/2017 - present

Greenbrier Valley Medical Center
Ronceverte, West Virginia
Director
Acute Care Surgery
10/2014 – 10/2017

Atlanta Colon and Rectal Surgery
Atlanta, Georgia
07/1994 – 10/2014

West Virginia School of Osteopathic Medicine
Lewisburg, West Virginia
Associate Professor
5/2016 – 10/2017

Associate Clinical Professor
Department of Surgery
Emory University School of Medicine
07/1998 – 10/2014

PERSONAL DATA:

OFFICE ADDRESS: 1201 Broad Rock Blvd.
Richmond, VA 23249
(O) 804-675-5112 X6566

Cell (404) 680-9898
Stephencohen615@gmail.com

DATE OF BIRTH: June 15, 1962
BIRTHPLACE: Brooklyn, New York
MARITAL STATUS: Married-Patricia, RN, MSN
CHILDREN: Daniel-August 9, 1991
Zachary-November 24, 1992
Alana-February 8, 1995

CITIZENSHIP: USA

EDUCATION:

MASTERS OF BUSINESS
ADMINISTRATION Walden University
2011-2013

FELLOWSHIP: Colon and Rectal Surgery
Cleveland Clinic Florida
3000 West Cypress Creek Road
Ft. Lauderdale, Florida 33309
Chairman: David G. Jagelman, M.D.
Steven D. Wexner, M.D.
1992-1994

INTERN/RESIDENCY: General Surgery
Boston University Medical Center
88 East Newton Street
Boston, Massachusetts 02118
Chairman: Ed Spatz, M.D.
1987-1992

MEDICAL SCHOOL: University of California, LA
Los Angeles, California 90025
Degree: Medical Doctor
1983-1987

COLLEGE: University California, Riverside
Riverside, California
Degree: Bachelor of Science
Biomedical Science
1980-1983
Honors: Dean's Honor List

ACTIVE MEDICAL LICENSES:

CA, FL, GA, IA, IL, LA, MS,
NC, NJ, NY, OH, UT, VA, WV,
PA, TX, IN, AZ, ID, AL, TN,
MN, MI, WI

CERTIFICATION:

1. Diplomat, National Board of Medical Examiners: July 1988
2. General Surgery- Certification # 38322
Initial- 04 May 1993 / End Date: 01 Jul 2003
Recertification: 19 Oct 2001/ End Date: 01 Jul 2013
Recertification: 06 Dec 2011/ End Date: 01 Jul 2023
3. Colon and Rectal Surgery- Certification # 335
Initial: Sep 1996
Recertification: 01 Jan 2007/ End Date: 31 Dec 2016
Recertification: 12 May 2016/End Date: 31 Dec 2026

AWARDS/HONORS:

Dean's Honor List-UCR
Chief Resident's Appreciation Award-Best all around,
1988-1989
Administrative Chief Resident, 1991-1992
Life Styles Southern Arc Magazine- www.lifestylesmagazine.net –voted Top
Colon and Rectal Surgeon for 2006 and 2007. pg. 51. May 2007 issue
Top Docs for Colon/Rectal surgery Lifestyles Magazine May 2009 page 40
Top Doctor for Atlanta Magazine for 2009, 2010, 2011, 2012, 2013, 2014

PROFESSIONAL AFFILIATIONS:

American College of Surgeons, Fellow
American Society of Colon and Rectal Surgeons, Fellow

ACTIVE STAFF PRIVILEGES

Hunter Holmes McGuire VAMC
1201 Broad Rock Blvd.
Richmond, VA 23249

FACULTY

World Congress of Compression Anastomosis (WCCA)
Inaugural Symposium- January 27-28, 2012

Industry and physician driven organization to teach new technology
Write, produce, and edit the lecture for surgeon education

Honorable Editor, Medcrave online (MOJ Surgery, Gastroenterology/Hepatology)

MedCrave is an Open Access Publishing website that contains ample scientific research information on categorized topics. MedCrave is a huge Online Publishing Library, where anyone can view, share and download research papers

LEADERSHIP POSITIONS –

Hunter McGuire VAMC, Richmond, VA

2017-Present –

Section Chief, General Surgery and In-Patient Surgical Services

1. Peer Review
2. P and T committee
3. MOD Supervisor

West Virginia School of Osteopathic Medicine, Lewisburg, WV

2016-2017

1. Surgical Discipline/Course Advisor
2. Lectures to 1st and 2nd year students
3. CS1 Abdominal exams
4. Open lab
5. OSCE
6. Development of 3rd and 4th year curriculum, lectures, and Campus Visits
7. Creation of videos for educational days

Greenbrier Valley Medical Center, Ronceverte, WV (122 beds)

2014-2017

1. Peer Review Committee
2. Quality Improvement Committee
3. Patient Safety Committee – Chairperson
4. Infection Control Committee – Chairperson
5. Antibiotic Stewardship Committee
6. Chairman of Surgery, September 2016

Southern Regional Medical Center, Riverdale, GA (331 Bed)

Chairman, Department of Surgery

2013-2014

Transformational health care change agent

Oversee the day-to-day operations of the Surgery Department and operating room

Help to direct the hospital and administration with research, personnel, and education to improve the access, quality, and efficiency of the surgical process

Ensures that administrative, Joint Commissions regulations, and quality measures are followed appropriately

Strong advocate of evidence-based medicine

Improved efficiency with changing the operating room block utilization process

Helped to implement the electronic medical record system
Physician champion for surgical services
Integral part of the Robotic surgery venture for Clayton County

Medical Director, Spivey Station Surgery Center 2005-2014
Jonesboro, GA
(4 OR's, 3 Minor rooms)

Administrative and faculty committees
Continuing medical education for staff
Implementation of quality and electronic medical records
Peer Review liaison
Helped change the culture to a 'team' approach
Directly guided new surgeons to expand surgical volume
Leader in indigent care for the community

Vice Chairman, Department of Surgery 2000-02, 2009-13

Led the peer-review process
Physician champion and leader for the implementation of EMR
Expanded the communication network

Chairman, Peer Review Committee 2000-02, 2009-13

Chairman, CME Committee 2009-2014

Developed weekly lecture series for medical students
Monthly presentations on surgical issues and diseases

Physician Liaison, VAC 2010-2014

Established as the physician decision-maker for innovative technology
Organized monthly meetings for streamlined utilization

Chairman, Oncology Committee 2011-2013

Organized and recruited physicians for monthly presentations
Increased attendance by 50%
Led the way for integration with Emory for joint conferences
Continued to support the tumor registry

PUBLICATIONS: ABSTRACTS

1. Cohen SM, Schmitt SL, Lucas FL, Wexner SD. How accurate is the diagnosis of anal ulcers in AIDS patients? *Dis Colon Rectum* 1993; 35 (4): p24.
2. Binderow SR, Cohen SM, Wexner SD, Schmitt SL, Nogueras JJ, Jagelman DG. Must early postoperative oral intake be limited to laparoscopy? *Dis Colon Rectal* 1993; 36 (4): p33.
3. Cohen SM, Wexner SD, Clem MF, et al. A prospective randomized comparison of a new laparoscopic stapling technique. *Surgical Endoscopy* 1993; 7 (3): 265.
4. Binderow, SR, Cohen SM, Wexner SD, et al. Must early postoperative oral intake be limited to laparoscopy? *Surgical Endoscopy* 1993; 7 (3)265.
5. Cohen SM, Tremaroli JV, Wexner SD, Jensen JE. Calcium gluconates effect on segmental colonic transit times: a blinded, randomized, placebo controlled crossover study. *Am J Gastroenterol* 1993; 88 (9): 1570
6. Cohen SM, Binderow SR, Jensen JE, Ehrenpreis ED, Ruberman WB, Nogueras JJ, Bonner GB, Wexner SD. A prospective randomized endoscopic-blinded comparison of two oral colonic lavage solutions for colonoscopy. *Am J Gastroenterol* 1993; 88 (9): 1589.
7. Cohen SM, Lucas FV, Wexner SD, Nogueras JJ, Jagelman DG. How accurate is the diagnosis of anal ulcers in AIDS patients? *Am J Gastroenterol* 1993; 88 (9): 1589.
8. Binderow SR, Cohen SM, Wexner SD, Schmitt SL, Nogueras JJ, Jagelman DG. Must early postoperative oral intake be limited to laparoscopy? *South Med J* 1993; 86 (9): S16.

9. Cohen SM, Wexner SD, Schmitt SL, Lucas FV, Nogueras JJ. Does xylene mesenteric fat clearance improve lymph node harvest after colon resection? *South Med J* 1993; 86 (9): S17.
10. Binderow SR, Cohen SM, Wexner SD, et al. Must early postoperative oral intake be limited to laparoscopy? *Int J Colorectal Disorders* 1994; 8 (4): p230.
11. Reissman P, Teoh TA, Cohen SM, Weiss EG, Nogueras JJ, Wexner SD. Is early oral feeding safe after elective colorectal surgery? *Dis Colon Rectum* 1994; 37 (4): 14-15.
12. Cohen SM, Wexner SD, Binderow SR, et al. A prospective randomized endoscopist-blinded trial comparing precolonoscopy bowel cleansing methods. *Dis Colon Rectum* 1994; 37 (4): 16-17
13. Cohen SM, Wexner SD, Laparoscopic Colorectal surgery: Are we being honest with our patients? *Dis Colon Rectum* 1994; 37 (4):p21.
14. Reiver D, Kmiot WA, Cohen SM, et al. A prospective comparison of laparoscopic and open procedure in colorectal surgery. *Dis Colon Rectum* 1994; 37 (4): p22.
15. Cohen SM, Nogueras JJ, Wexner SD. Laparoscopic colorectal surgery-ascending the learning curve. *Dis Colon Rectum* 1994; 37 (4):p26.
16. Cohen SM, Kmiot WA, Reiver D, et al. Is ileal pouch anal anastomosis safe in patients over 60 years of age? *Dis Colon Rectum* 1994; 37 (4):p29-30.
17. Kmiot WA, Reiver D, Cohen SM, et al. Outcome after restorative proctocolectomy for ulcerative colitis compared with indeterminate colitis. *Dis Colon Rectum* 1994; 37 (4): p31.
18. Cohen SM, Vaccaro CA, Kaye MD, Wexner SD. Can segmental colonic transit times be reproduced with reliable results? *Dis Colon Rectum* 1994; 37 (4): p44.
19. Weiss EG, Reiver D, Daniel N, Cohen SM, et al. How safe is elective colorectal surgery in the elderly? *Dis Colon Rectum* 1994; 37 (4):p48-49.
20. Kmiot W, Reiver D, Binderow S, Cohen SM, Nogueras J, Jagelman D, Wexner S. Prospective comparison of laparoscopically assisted and open colorectal surgery. *Br J Surg* 1994; 84: p762.
21. Weiss EG, Reiver D, Reissman P, Cohen SM, Nogueras JJ, Wexner SD. Septic complications of ileal pouch anal anastomosis (IPAA). *S. Med J* 1994; 87: pS19.

22. Cohen SM, Wexner SD, Binderow SR, Daniel N, Ehrepreis ED, Jensen J, Ruderman WB, Bonner GF. Prospective randomized blinded trial comparing precolonoscopy bowel cleansing methods. *S. Med J* 1994; 87:pS20.
23. Reissman P, Weiss EG, Cohen SM, Nogueras JJ, Wexner SD, Teoh TA. Is early oral feeding safe after elective colorectal surgery? *S Med J* 1994; 87: pS21.
24. Weiss EG, Kmiot WA, Reiver D, Sohen SM, Reissman P, Lucas FV, Nogueras JJ, Wexner SD. Outcome after restorative proctocolectomy for ulcerative colitis compared with outcome after same procedure for indeterminate colitis.
25. Weiss EG, Reiver D, Reissman P, Cohen SM, Nogueras JJ, Wexner SD. Septic complications of ileal pouch anal anastomosis (IPAA). *Am J. Gastroenterol* 1994; 89: p1699.
26. Weiss EG, Kmiot WA, Reiver D, Cohen SM, Reissman P, Lucas FV, Nogueras JJ, Wexner SD. Outcome after restorative proctocolectomy for ulcerative colitis compared with indeterminate colitis. *Gastrointestinal Endoscopy* 1994; 41.
27. Reissman P, Cohen SM, Kmiot WA, Reiver D, Weiss EG, NOgueras Jj, Wexner SD. Is ileal pouch anal anastomosis safe in patients over sixty years of age? *Gastrointestinal Endoscopy* 1995;41.
28. Reissman P, Teoh TA, Cohen SM, Weiss EG, Nogueras JJ, Wexner SD. Is early oral feeding safe after elective colorectal surgery? *Gastrointestinal Endoscopy* 1995; 41.
29. Kamal M.F., Itani, M.D., Wilson, M.D., Awad, M.D., Jenson, M.S., Finn, B. A., Abramson, M.D., M.P.H., Cohen SM investigator. Ertapenem versus Cefotetan Prophylaxis in Elective Colorectal Surgery. *The New England Journal of Medicine*. December 21, 2006. Vol. 355 No. 25 pg.2640
30. Singh J, Hum M., Cohen S, MD, Liberman H, MD, Thorson A, MD, Dine A, MD, and the MISS Study Group. Presented at: 47th Annual Interscience Conference on Antimicrobial Agents and Chemotherapy. Chicago, IL 9/2007. Multicenter Infection Surveillance Study Comparing Two Types of Postoperative Pain Management, Surgical Site Using ON-Q SilverSoaker and Local Anesthetics vs. Systemic Narcotics Following Colorectal Procedures.

PUBLICATIONS: MANUSCRIPTS

1. Cohen SM, Cogliano FD. The surgical management of perforated diverticulitis: One community hospital experience. *Colo-proctology* 1993; (3): 167-171.
2. Cohen SM, Wexner SD. Laparoscopic colorectal resection for cancer: The Cleveland Clinic Florida experience. *Surgical Oncology*; 2: Suppl. 1,35-42.
3. Wexner SD, Cohen SM, Johansen OB, Noguerras JJ, Jagelman DG. Laparoscopic colorectal surgery: a prospective assessment and current perspective. *Br J Surg* 1993; 80: 1602-1605
4. Wexner SD, Cohen SM, Johansen OB, Noguerras JJ, Jagelman DG. Cirurgia Colorectal Laparoscopica. *Revista do Colegio Brasileiro de Cirurgioes*. Vol. XX-Suplemento; 1993; 20 (5): 26-29
5. Cohen SM, Clem M, Wexner SD, Noguerras JJ, Jagelman DG. An initial comparative study of two techniques of laparoscopic colonic anastomosis and mesenteric defect closure. *Surg Endosc* 1994;8:130-134
6. Reissman P, Cohen SM, Weiss E, Wexner SD. Simple Technique for pelvic drain placement in laparoscopic abdominoperineal resection. *Dis Colon Rectum* 1994; 37:381-382
7. Wexner SD, Cohen SM. Anastomosis leakage after anterior resection. *Eur J Surg* 1994; 160(5): 299-300
8. Cohen SM, Schmitt SL, Lucas FV, Wexner SD. How accurate is the diagnosis of anal ulcers in AIDS patients? *Int J Col Dis* 1994; 9:169-173.
9. Cohen SM, Wexner SD, Schmitt SL, Lucas FV, Noguerras JJ, Jagelman DG. Does xylene mesenteric fat clearance improve lymph node harvest after colon resection? *Eur J Surg* 1994; 160:693-7
10. Cohen SM, Wexner SD. Laparoscopic right hemicolectomy. *Surgical Rounds* 1994; 17(11): 627-635
11. Binderow SR, Cohen SM, Wexner SD, Schmitt SL, Noguerras JJ, Jagelman DG. Must early postoperative oral intake be limited to laparoscopy? *Dis Colon Rectum* 1994;37:584-589
12. Schmitt SL, Cohen SM, Wexner SD, Noguerras JJ, Jagelman DG. Does laparoscopic-assisted ileal pouch anal anastomosis reduce the length of hospitalization? *Int J Colorect Dis* 1994; 9(3):134-7

13. Cohen Sm, Wexner SD, Binderow SR, Nogueras JJ, Daniel N, Ehrenpreis ED, Jenson J, Bonner G, Ruderman W. A prospective randomized endoscopic-blinded trial comparing pre-colonoscopy bowel cleansing methods.
14. Wexner SD, Cohen SM. Port site recurrence after laparoscopic colorectal surgery for cure of malignancy. *Br J Surg* 1995; 82:295-8.
15. Cohen SM. Colonic Ischemia. In *Selected Topics in Colorectal Surgery, Volume 7, 1994, Continuing Medical Education Department, USSC.*
16. Wexner SD, Cohen SM, Ulrich A, Reissman P. Laparoscopic colorectal surgery: Are we being honest with our patients? *Dis Colon Rectum* 1994;38: 723-7.
17. Reissman P, Weiss E, Teoh TA, Cohen SM, Wexner SD. Laparoscopic-assisted perineal rectosigmoidectomy for rectal prolapse-brief clinical report. *Surgical Laparoscopy and Endoscopy* 1995; 5(3):217-218.
18. Reissman P, Cohen SM, Weiss EG, Nogueras JJ, Wexner SD. Laparoscopic Colorectal Surgery: Ascending the learning curve. *World J Surg* 1996; 20: 277-82.
19. Reissman P, Teoh TA, Cohen Sm, Weiss EG, Nogueras JJ, Wexner SD. Is early oral feeding safe after elective colorectal surgery? *Ann Surg* 1995; 222 (1): 73-7.
20. Preparation of The Standards Task Force practice parameters: The management and treatment of complicated diverticulitis. *American Society of Colon and Rectal Surgeons.*
21. Cohen SM, Kmiot WA, Reiver D, Wexner SD. A prospective comparison of laparoscopic and open procedures in colorectal surgery. *J Roy Soc Med* (In press).
22. Reissman P, Cohen SM. Problem solving in laparoscopic surgery- "Where did all the instruments go?" *Surg Endosc* (letter). (Inpress).
23. Cohen SM, Roberts PL, Streitz JM. Intraoperative colonic lavage for strangulated sigmoid colon through a traumatic diaphragmatic hernia. Submitted for publication.
24. Cohen SM, Chair. Novel Applications for Biologic Mesh: Innovations in Complex Hernia Repair. *General Surgery News*. September 2011.

VIDEO PRODUCTIONS:

1. Laparoscopic-assisted right hemicolectomy. SD Wexner, SM Cohen.
2. Laparoscopic-assisted restorative proctocolectomy with ileo-anal reservoir. SD Wexner, DG Jagelman, SM Cohen.
3. Pelvic Dissection Techniques. SD Wexner, DG Jagelman, SMCohen.
4. Paracolostomy Hernia Repair with Veritas Mesh: Tricks of the Trade in Colorectal Surgery Web Symposium. October 13, 2011. SMCohen.
5. Colostomy closure with Low Anterior Resection using RALC stapler. Covidien. 2012

BOOK CHAPTERS:

1. Cohen SM, Wexner SD. Laparoscopic colorectal surgery: the USA experience. In: Monson JRT, Darzi A (eds). Laparoscopic Colorectal Surgery. Oxford: Isis Medical Media Ltd. 1995; 188-92.
2. Cohen SM, Wexner SD. Does laparoscopic assisted ileal pouch anal anastomosis reduce the length of hospitalization? In: Serio G, Delaini GG, Hulten L, Nicholls J, Vestweber KH (eds). Inflammatory bowel diseases. Edinburgh, United Kingdom: Graffham Press 1994; 133-5.
3. Cohen SM, Wexner SD. Laparoscopic restorative proctocolectomy. In: Jager RM, Wexner SD (eds). Laparoscopic Colorectal Surgery. New York: Churchill-livingstone 1996; 201-8.
4. Cohen SM, Wexner SD. Justifiability of laparoscopic colorectal surgery. In: Jager RM, Wexner SD (eds). Laparoscopic Colorectal Surgery. New York: Churchill-Livingstone 1996; 291-8.
5. Cohen SM, Wexner SD. Laparoscopic right hemicolectomy. In: Lezoche E, Paganini AM, Cuschieri A (eds). Minimally invasive colorectal surgery. Milan, Italy: Documento Editoriale srl, 1994; 23-26.
6. Cohen SM, Wexner SD. Laparoscopic restorative proctocolectomy. In: Lezoche E, Paganini AM, Cuschieri A (eds). Minimally invasive colorectal surgery. Milan, Italy: Documento Editoriale srl, 1994; 62-65.
7. Wexner, SD, Cohen SM. Laparoscopic colectomy for malignancy—advantages and limitations. In: Wexner SD, Cady B (eds). Surgical Oncology Clinics of North America 1994; 3 (4): 637-43.

8. Wexner SD, Cohen SM. Laparoscopic appendectomy and colectomy. In: Zuidema GD, Condon RE (eds). Shackelford's Surgery of the Alimentary Tract (4th ed). Philadelphia: WB Saunders Co. 1995:164-83.
9. Mazier WP, Levien DH, Luchtefeld MA, Senagore AJ (eds). Polyposis Syndrome. Surgery of the Colon, Rectum, and Anus. W.B. Saunders Co. 1995: 566-576.
10. SM Cohen, SD Wexner. Bowel preparation. Clinical Decision Making in Colorectal Surgery. SD Wexner, Am Vernava, (eds). Igaku-Shoin. 1995: 23-26.
11. M. Piccirillo, SM Cohen, SD Wexner. Cirugia Colorectal Laparoscopica. Tribuna Medica. Santa Fe De Bogota, Colombia. (Inpress).

PUBLICATIONS: (EDITORIALS AND LETTERS)

1. Wexner SD, Cohen SM. Anastomotic leakage after anterior resection. Eur J Surg 1994; 160 (5): 299-300.
2. Teoh TA, Reissman P, Cohen SM, Weiss EG, Wexner SD. Laparoscopic loop ileostomy. Dis Colon Rectum 1994; 37 (5): 514.

POSTER PRESENTATIONS:

1. How accurate is the diagnosis of anal ulcers in AIDS patients? The American Society of Colon and Rectal Surgeons, Chicago, May 2-7, 1993.
2. Must early postoperative oral intake be limited to laparoscopy? The American Society of Colon and Rectal Surgeons, Chicago, May 2-7, 1993.
3. Does laparoscopy confer an advantage over standard colectomy? The first European Congress of the European Association for Endoscopic Surgery-E.A.E.S., Cologne, Germany, June 3-5, 1993.
4. Calcium gluconates effect on segmental colonic transit times: a blinded, randomized, placebo controlled study. 58th Annual Scientific Meeting American College of Gastroenterology, New York, October 3-6, 1993.
5. Does laparoscopic assisted ileal pouch anastomosis reduce the length of hospitalization? 58th Annual Scientific Meeting American College of Gastroenterology, New York, October 3-6, 1993. 1993 ACG/MERCK SENIOR FELLOW AWARD RECIPIENT.
6. How Accurate is the diagnosis of anal ulcers in AIDS patients? 58th Annual Scientific Meeting American College of Gastroenterology, New York, October 3-6, 1993.

7. A prospective randomized endoscopists blinded comparison of two oral lavage solutions for colonoscopy. 58th Annual Scientific Meeting American College of Gastroenterology, New York, October 3-6, 1993.
8. Is Ileal Pouch Anal Anastomosis safe in patients over sixty years of age? 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
9. Outcome after Restorative Proctocolectomy for Ulcerative Colitis Compared with Indeterminate Colitis. 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
10. Can Segmental Colonic Transit Times be reproduced with reliable results? 93rd Annual Convention of American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
11. How safe is elective Colorectal Surgery in the elderly? 93rd Annual Convention of the American Society of Colon and Rectal Surgeon, Orlando, Florida, May 8-13, 1994.
12. D'Hoore A, Cohen S, Albert M, Herbst F, Senagore A, Stamos MJ, Pahlman L, Wexner SD. COMPRES final results: nitinol compression anastomosis results in a much lower than expected rate of anastomotic leak in low anterior resection (LAR). Poster presented at: Annual Scientific Meeting of the American Society of Colorectal Surgeons (ASCRS); June 2-6, 2012; San Antonio, TX.
13. The PARSC trial, a prospective study for the assessment of recurrence risk in stage II colon cancer patients using ColoPrint. Authors: R. Salazar, J. Marshall, J. Capdevila, B. Glimelius, J. de Waard, J. Van Der Hoeven, J. Klaase, F. Bibeau, T. Bachleitner-Hofmann, R. A. Midgley, E. A. Levine, W. L. Law, M. Asano, G. J. Chang, S. M. Cohen, R. W. Beart, P. M. Goldfarb, M. McCarter, L. Stork-Sloots, R. Rosenberg

FORMAL PRESENTATIONS:

1. The Surgical management of perforated diverticulitis: One community hospital's experience. First Annual Resident's Grand Rounds, Boston University Medical Center, Boston, December 14, 1990.
2. A prospective randomized comparison of a new laparoscopic stapling technique. The Greater Miami Chapter of the American College of Surgeons, Miami, April 28, 1993.

3. A prospective randomized comparison of a new laparoscopic stapling technique. The first European Congress of the European Association for Endoscopic Surgery-E.A.E.S., Cologne, Germany, June 3-5, 1993.
4. Does laparoscopic-assisted ileal pouch anal anastomosis reduce the length of hospitalization? The First European Congress of the European Association for Endoscopic Surgery-E.A.E.S., Cologne, Germany, June 3-5, 1993.
5. Is laparoscopic surgery oncologically sound? SD Wexner, SM Cohen. The First European Congress of the European Association for Endoscopic Surgery-E.A.E.S., Cologne, Germany, June 3-5, 1993.
6. Recognition and management of common benign anorectal disorders. Fairhaven Country Club, Tamarac, Florida, September 12, 1993.
7. Pathophysiology of radiation injury. SD Wexner, SM Cohen. American College of Surgeons, San Francisco, October 10-15, 1993.
8. Current Surgical Therapy in Inflammatory Bowel Disease. Meeting the Challenge Through Knowledge: New Strategies in the Treatment of Inflammatory Bowel Disease. Florida Tri-Coast Chapter of the Crohn's and Colitis Foundation of America, Inc. Melbourne, Florida, October 16, 1993.
9. Does xylene mesenteric fat clearance improve lymph node harvest after colon resection? 87th Annual Scientific Assembly of the Southern Medical Association, New Orleans, October 28-31, 1993. 1st PLACE; PHYSICIANS'-IN-TRAINING COMPETITION
10. A prospective randomized endoscopic-blinded trial comparing pre-colonoscopy bowel cleansing methods. Annual Meeting of the Northeastern Society of Colon and Rectal Surgeons, Palm Beach, Florida, November 6-11, 1993.
11. Laparoscopy for inflammatory bowel disease. SD Wexner, SM Cohen. Fourteenth Annual Symposium on Colorectal Surgery, Cleveland, Ohio, November 19-20, 1993.
12. Laproscopic-assisted right colectomy for chronic ileocecal volvulus (Video presentation). Annual Endoscopic Exposition for the Society of Laparoendoscopic Surgeons, Orlando, Florida, December 9-11, 1993.
13. Laparoscopic-assisted total abdominal colectomy with restorative proctocolectomy (Video presentation). Annual Endoscopic Exposition for the Society of Laparoendoscopic Surgeons, Orlando, Florida, December 9-11, 1993.

14. A prospective randomized trial of new laparoscopic stapling technique. Annual Endoscopic Exposition for the Society of Laparoendoscopic Surgeons, Orlando, Florida, December 9-11, 1993.
15. Laparoscopic colorectal surgery. Grand Rounds, Cleveland Clinic Hospital, May 4, 1994.
16. Laparoscopic colorectal surgery ascending the learning curve. 5th Annual Surgical Research Forum of the South Florida Chapter of the American College of Surgeons, Miami, Florida, May 4, 1994. 3rd PLACE: RESIDENT PAPER COMPETITION.
17. Long Term Outcome of the Double Stapled Ileoanal Reservoir. 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
18. Is Early Oral Feeding Safe After Elective Colorectal Surgery? 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
19. A Prospective Randomized Endoscopic-Blinded Trial Comparing Pre-Colonoscopy Bowel Cleansing Methods. 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
20. Laparoscopic Colorectal Surgery – Are We Being Honest with our Patient? 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
21. A prospective Comparison of Laparoscopic and Open Procedures in Colorectal Surgery. 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994.
22. Laparoscopic Colorectal Surgery-Ascending the Learning Curve. 93rd Annual Convention of the American Society of Colon and Rectal Surgeons, Orlando, Florida, May 8-13, 1994
23. Contemporary Techniques In Gastrointestinal Surgery. Presented by: Emory University School of Medicine Department of Surgery. Presentation subject: Techniques for Benign Anorectal Disease. May 3, 2008.
24. Northern Division of Georgia SGNA 6th Annual Seminar. Molding our GI Futures. Piedmont Hospital. Colon Ring Compression Anastomosis, The Future of Natural Healing. March 13, 2010.
25. Ohio Chapter American College of Surgeons. 56th Annual Meeting. Presentation: Concurrent Session B: Complex Parastomal Hernia Repair. May 5-7, 2011. www.ohiofac.org

26. American College of Osteopathic Surgeons Annual Convention. September 15-18, 2011. Presentation: Transhemorrhoidal Deterialization (THD)- A New Approach for an Old Disease.

CO-AUTHOR PRESENTATIONS:

1. Kmiot W, Reiver D, Binderow S, Cohen S, Noguerras J, Jagelman D, Wexner S. Prospective comparison of laparoscopic assisted and standard colorectal surgery. 79th Meeting of the Surgical Research Society at the Institute of Education, University of London, January 6-7, 1994, London, United Kingdom. (Presentation by WA Kmiot, M.D.)
2. Kmiot, W, Reiver D, Binderow S, Cohen S, Noguerras J, Jagelman D, Wexner S. Prospective comparison of laparoscopic assisted and standard colorectal surgery. Association of coloproctology at the Royal Society of Medicine, January 1994, London, United Kingdom. (Presentation by WA Kmiot, M.D.)
3. Kmiot W, Reiver D, Cohen S, Lucas F, Noguerras J, Jagelman D, Wexner S. Prospective comparison of restorative proctocolectomy for indeterminate colitis versus ulcerative colitis. British Society of Gastroenterology, Annual Meeting, March 23-25, 1994, Manchester, United Kingdom. (Presentation by WA Kmiot, M.D.)
4. Kmiot W, Reiver D, Binderow S, Cohen S, Noguerras J, Jagelman D, Wexner S. Prospective comparison of laparoscopic assisted and standard colorectal surgery. Association of the Surgeons of Great Britain and Ireland, Annual Scientific Meeting, April 20-22, 1994, Harrogate, United Kingdom. (Presentation by WA Kmiot, M.D.)
5. Reissman P, Weiss EG, Cohen SM, Noguerras JJ, Wexner SD. The functional outcome of the double-stapled ileoanal reservoir in patients over sixty years of age. Society for Surgery of the Alimentary Tract, May 16-18, 1994, New Orleans, Louisiana. (Presentation by Reissman, M.D.)
6. Weiss EG, Reiver D, Reissman P, Cohen S, Noguerras JJ, Wexner SD. Septic complications of ileal pouch anal anastomosis. Annual Meeting of the American California, September 28-29, 1994. (Poster presentation by Eric G. Weiss, M.D.)
7. Weiss EG, Kmiot WA, Reiver D, Cohen SM, Reissman P, Lucas FV, Noguerras JJ, Wexner SD. Outcome after restorative proctocolectomy for ulcerative colitis compared with indeterminate colitis. World Congress of Gastroenterology, Los Angeles, California, October 2-7, 1994. (Poster presentation by E. Weiss, M.D.)
8. Reissman P, Cohen, SM, Kmiot WA, Reiver D, Weiss EG, Noguerras JJ, Wexner SD. Is ileal pouch anal anastomosis safe in patients over sixty years

- of age? World Congress of Gastroenterology, Los Angeles, California, October 2-7, 1994. (Poster presentation by P. Reissman, M.D.)
9. Reissman P, Teoh TA, Cohen SM, Weiss EG, Nogueras JJ, Wexner SD. Is early oral feeding safe after elective colorectal surgery? World Congress of Gastroenterology, Los Angeles, California, October 2-7, 1994. (Poster presentation by P. Reissman, M.D.)
 10. Weiss EG, Reiver D, Reissman P, Cohen SM, Nogueras JJ, Wexner SD. Septic complications of ileal pouch anal anastomosis (IPAA). Southern Medical Association 88th Annual Scientific Assembly, Orlando, Florida, November 2-6, 1994. (Presentation by Eric G. Weiss, M.D.)
 11. Pfeifer J, Reissman P, Weiss EG, Cohen SM, Nogueras JJ, Wexner SD, Teoh TA. Is early oral feeding safe after elective colorectal surgery? Southern Medical Association 88th Annual Scientific Assembly, Orlando, Florida, November 2-6, 1994. (Presentation by Johann Pfeifer, M.D.)
 12. Weiss EG, Kmiot WA, Reiver D, Cohen SM, Reissman P, Lucas FV, Nogueras JJ, Wexner SD. Outcome after restorative proctocolectomy for ulcerative colitis compared with indeterminate colitis. Southern Medical Association 88th Annual Scientific Assembly, Orlando, Florida, November 2-6, 1994. (Presentation by Eric G. Weiss, M.D.)

ONGOING CLINICAL RESEARCH

Retrospective Evaluation of Veritas® Collagen Matrix used Prophylactically and in Parastomal Hernia Repair (REPAIR)
Protocol Number: 11-001 - Complete

An Extended Pain Relief Trial Utilizing the Infiltration of a Long Acting Multivesicular Liposome Formulation of Bupivacaine, EXPAREL: A Phase 3b Health Economic Trial in Adult Patients Undergoing Open Colectomy.
Protocol Number: MA402S23B303 - Complete

The PARSC trial, a prospective study for the assessment of recurrence risk in stage 11 colon cancer patients using ColoPrint.
Protocol Number: 11-056 - Complete

Veritas® In Non- Bridging Ventral Hernia Repair (VIBE)
Protocol Number: 09-004 - Complete