Kalat v Bickford RN et al

8 Parties Associated with Docket: WOCV1988-01567 | Click last name to view contact information

No.	Last Name:	First Name:	Party Role:	Party Status:
1	Bickford RN	Gail	Defendant	Dismissed by Court Order
2	Caponi RNCNP	Karen	Defendant	Dismissed by agreement of parties
3	Fleming RN	Karen	Defendant	Dismissed by agreement of parties
4	Kalat	Joan O	Plaintiff	Active
5	Planned Parenthood Clinic Ma		Defendant	Active
6	Planned Parenthood League Ma		Defendant	Active
7	Thiebe RN	Elizabeth	Defendant	Active
8	Walsh MD	Brian W	Defendant	Dismissed by agreement of parties

185 Great Road
Bolton, Ma. 01740
June 10, 1989

Edward M. Swartz
Swartz & Swartz
10 Marshall Street
Boston, Ma. 02108

RE: Elise Kalat

Dear Mr. Swartz,

I have reviewed the medical records of Elise Kalat from the Planned Parenthood Clinic of Central Massachusetts and Worcester Memorial Hospital and the incident reports from Bay State Ambulance by James M. Halacy, E.M.T. and Pier M. Plazeski, E.M.T.. My opinion is based upon the content of these documents.

Elise Kalat was a twenty two year old woman who was undergoing her third first trimester abortion on February 10, 1987 at the Planned Parenthood Clinic. This was her second abortion at this clinic. She had developed hives after her first therapeutic abortion in 1982. She had no unusual sequela after her second therapeutic abortion in 1986. Her medical history was remarkable for asthma, which was controlled by Ventolin and cromolyn sodium inhalers, and venereal diseases which were successfully treated in January and February of 1986.

On the day of her admission for the abortion, Ms. Kalat stated that she had used her Ventolin inhaler that morning. She was given a paracervical block using 20 cc. of lidocaine, with 2 cc. of atropine and 1 cc. of Fentanyl intravenously. The procedure was uneventful and Ms. Kalat was brought to the recovery room via wheelchair. Upon her arrival in the recovery room at 11:50 a.m., Ms. Kalat complained of trouble breathing and asked to use her inhaler. At 11:53 a.m. she used her inhaler again, became increasingly anxious and tried to stand up. At 11:55 a.m., she stopped breathing and a pulse could not be found. Ms. Kalat was placed on the floor and cardiopulmonary resuscitation was started by K. Fleming, R.N.. An oral airway was placed by K. Caponi, R.N.C./N.P. and Ms. Kalat was ventilated with 100% oxygen via a ventimask attached to an ambu bag. According to the nursing note written by K. Fleming, R.N., "Assessment of perfusion done per Dr. Walsh through palpation of femoral arteries with compressions." Ms. Fleming also wrote that, "Chest expansion present with ventilation done by K. Caponi, R.N.C./N.P. - neck hyperflexed." An ambulance had been called at 11:55 a.m.. The ambulance arrived at 12 noon and at 12:02 p.m., Ms. Kalat was transferred to the ambulance. According to the notes written by G. Bickford, R.N. and K. Fleming, R.N., cardiopulmonary resuscitation was continued during the transfer to the stretcher and the ambulance.

The ambulance arrived at the Planned Parenthood Clinic at 11:58 a.m. and two Emergency Medical Technicians, James M. Halacy, E.M.T. and Pier M. Plazeski, E.M.T., brought a stretcher into the room where Ms. Kalat was being resuscitated. According to the statement written by Mr. Halacy, E.M.T., "I noticed that the facility employee who was doing the compression phase of CPR was administering the compression approx. 1" above the navel - the pt was cyanotic at this time and an employee of the facility was administering ventilations to the patient via bag valve mask. I noticed that with each ventilation the patients cheeks would puff out indicating that she was not receiving adequate ventilations. At this point with my partner at the head and I at the feet we lifted the patient to the stretcher - before doing so I looked up to make sure someone had the IV which had been inserted prior to our arrival. With a three count we lifted the patient and the IV was pulled from the patient's arm. We then brought the patient to the elevator and placed the patient in the ambulance at 12:05 and proceeded to Memorial Hospital with a male and a female employee of Planned Parenthood."

Mr. Halacy's partner, Pier M. Plazeski, E.M.T., observed in his incident report, "As we entered the room where the patient was located I observed a person doing compressions on this patient later known as Elsie Kalat. The compressions were being done incorrectly, approximately 1" above the navel. I observed another person doing ventilations with an Ambu-bag. I at this point began to demand the patient with our equipment. After a minute or so, my partner and I transferred the patient to our stretcher the I.V. was pulled out of her arm that another person had been holding. The I.V. site began to bleed. As my partner and I attempted to strap the patient onto the stretcher, personnel of Planned Parenthood began to run with the stretcher down the corridor. There appeared to me to be much confusion with no organization among the staff of Planned Parenthood. Once in the elevator I was able to strap in the lower extremities of the patient. The patient was loaded into the ambulance by my partner and me. During transport to Memorial Hospital I continued with ventilations on the patient and a nurse from Planned Parenthood continued to do compressions properly. A Doctor that also accompanied us during transport kept feeling for a pulse."

According to nursing notes written by K. Fleming, R.N., once in the ambulance, the ambulance attendant and K. Fleming, R.N., continued the CPR and Dr. Walsh assessed the perfusion via femoral and carotid pulses. The patient arrived at Worcester Memorial Hospital at 12:08 p.m. without regaining consciousness, with no palpable pulse and no spontaneous respirations.

Upon arrival at the hospital, Ms. Kalat was intubated and defibrillated with success. She was admitted to the Coronary Care Unit and placed on a ventilator. A neurological assessment by Dr, Markley on the second day of her hospitalization showed that she now had decerebrate posturing with decreased tone and that he felt she was slowly deteriorating neurologically. A second consult by Dr. Bazemore of the Neurology Service was sought. His impression was that, "the patient was in a deep coma, thought secondary to hypoxic encephalopathy due to her initial respiratory and cardiac arrest at the Planned Parenthood." Ms. Kalat continued to do poorly and on the third hospital day, Dr. Markley again evaluated the patient. His testing showed nonintact brain stem functioning. Later in the day. Ms. Kalat became hypotensive and went into ventricular tachycardia. Cardiopulmonary resuscitation and defibrillation were started but were unsuccessful. Ms. Kalat was pronounced dead at 4:54 p.m. on February 12,1987.

On the basis of the information contained in her medical records and the incident reports from Bay State Ambulance Service, it is my opinion that Elise Kalat did not receive an acceptable level of nursing care from the nurse administering cardiac compressions, K. Fleming, R.N. or the nurse administering pulmonary resuscitation, K. Caponi, R.N.C./N.P. while Ms. Kalat was being resuscitated at the Planned Parenthood Clinic. It is reasonable to expect that any nurse working at a state licensed health care facility would be able to carry out cardiopulmonary resuscitation. All registered nurse education programs include training in cardiopulmonary resuscitation. The Massachusetts' Department of Public Health requires that health care facilities provide cardiopulmonary resuscitation review at least annually in order to be licensed to provide patient care.

A cardiac arrest occurs when a patient's heart stops beating and breathing ceases. Quick intervention is essential. Within four to six minutes after cardiac arrest, serious damage to the brain and heart can occur as a result of oxygen depletion.[1] The goal of cardiopulmonary resuscitation is to produce a flow of oxygenated blood to vital organs in order to minimize this damage. Oxygen can be supplied to the lungs using mouth to mouth resuscitation or via an airway with mechanical assistance. The flow of blood is maintained by external cardiac massage applied to the lower third of the sternum.[2] Evaluation is an important part of a cardiopulmonary resuscitation effort "for it provides the nurse with information on the

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1 F.L.Blower, E.O.Bevis, Fundamentals of Nursing Practice: Concepts, Roles, and Functions, C.V.Mosby Company: St. Louis, 1979. Page 478

2 Ibid. Pages 481-2

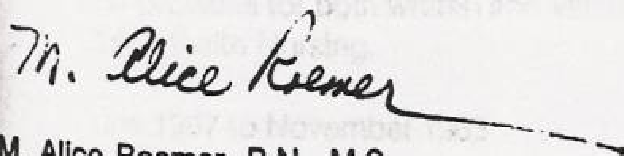
effectiveness of or need for continuation and refinement of the process."[3] Chest expansion is the criterion used to evaluate successful air flow to the lungs and the presence of a carotid pulse with a cardiac compression is the criterion used to evaluate successful cardiac massage.[4]

Although the nursing note written by K. Fleming, R.N. stated that there was "chest expansion present with ventilation," when James M. Halacy, E.M.T. arrived with the ambulance, he noted that the patient was cyanotic and that with each ventilation, the patient's cheeks would puff out. This would indicate that air was not reaching the lungs. Ongoing evaluation is the key to a successful resuscitation effort. The person who was using the ambu bag, K. Caponi, R.N.C./N.P., should have been evaluating the patient's chest expansion more carefully, especially since she was not giving mouth to mouth resuscitation and was in a position to observe the patient's chest continually. It only takes a small change in the patient's head position to block the airway and if the patient's cheeks puff out it indicates that the airway needs to be checked immediately.

Both James M. Halacy, E.M.T. and Pier M. Plazeski, E.M.T. noted that cardiac compressions were being administered about one inch above the navel and not to the lower third of the sternum. The nurse's note written by K. Fleming, R.N. states that compression was being evaluated through palpation of femoral arteries. Abdominal compression one inch above the umbilicus could cause one to palpate a femoral pulse due to compression of the abdominal blood vessels. The femoral pulse does not allow one to properly evaluate successful cardiac compression and a carotid pulse should have been taken. According to the notes written by K. Fleming, R.N. and B. Walsh, a carotid pulse was not taken until Ms. Kalat was in the ambulance, about ten minutes after her cardiac arrest. The incident report written by Pier M. Plazeski, E.M.T. notes that the staff member from Planned Parenthood did do the cardiac compressions properly once they were in the ambulance.

Cardiac arrest is a life threatening event and can occur without warning. Any nurse working in a state licensed health care facility would be expected to know basic cardiopulmonary resuscitation techniques and how to evaluate those techniques. Elise Kalat entered the Planned Parenthood Clinic assuming that, should she experience a life threatening situation, the staff would know what to do. On the basis of the information contained in her medical records and the Bay State Ambulance incident reports, the nursing staff at the Planned Parenthood Clinic failed to give Elise Kalat the standard of nursing care that she had a right to expect. They failed to use proper resuscitation techniques and because of their failure to evaluate those techniques properly, failed to refine their techniques during those critical first minutes after Elise Kalat experienced her cardiac arrest. It is my opinion that the failure of the nurses to properly evaluate their resuscitation efforts, thereby failing to change their efforts appropriately, contributed to the untoward outcome experienced by Elise Kalat.

Signed,



M. Alice Roemer, R.N., M.S.

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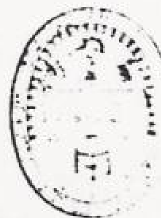
[3] Ibid. Page 479

[4] Ibid. Page 484

The University of Vermont



COLLEGE OF MEDICINE, DEPARTMENT OF MEDICINE
CARDIOLOGY UNIT, MARY FLETCHER UNIT
MEDICAL CENTER HOSPITAL OF VERMONT
BURLINGTON, VERMONT 05405
(802) 656-3734

July 26, 1990

John O'Neill
Swartz and Swartz
10 Marshall Street
Boston, MA 02108

RE: Elise A. Kalat

Dear Mr. O'Neill:

This communication is in response to your letter of July 20, 1990.

1. As I had indicated in my letter of 12/28/89, Mr. James Halacy states in his report that when he arrived on the arrest scene, a Planned Parenthood facility employee was "performing CPR with compressions being administered too low (approximately one inch above the naval)." The Planned Parenthood records include a nursing note by K. Fleming indicating that CPR was initiated by K. Fleming, R.N., the oral airway was placed by K. Caponi, R.N., and ventilation performed by her as well. Assuming that it was K. Fleming (Karen Fleming) that was performing the "chest" compressions at the level of the naval, then it is my opinion that she deviated from good and accepted standards of care for CPR.

2. Based on available information, and as the only physician on the scene, I assume that Dr. Walsh was in charge of the CPR efforts. Assuming that Dr. Walsh was in charge of running the CPR, then it is my opinion that Dr. Walsh deviated from good and accepted standards of care by failing to have the nurse who was performing the chest compressions use the correct hand position.

3. The notes of Dr. Walsh as well as Nurse Gail Bickford and Nurse Karen Fleming all indicate that the patient was unresponsive and pulseless without spontaneous respirations. Initial steps for CPR in these circumstances include not only administration of chest compressions and ventilation but in addition attempts at defibrillation with and without cardiac medications. The protocol recommended by the American Heart Association (which is very similar to the algorithm listed in the Quality Assurance Program of Planned Parenthood) calls for immediate precordial thump and three attempts at defibrillation as soon as possible if no pulse is present. Then epinephrine is recommended followed by a repeat defibrillation attempt, lidocaine, and repeat defibrillation, and then Bretylium, and then repeat defibrillation. As best I can tell from the records, no defibrillation was attempted. If none was available, then this

represents a gross deviation from the standard of care on the part of Planned Parenthood. If one was available but was not used by Dr. Walsh, then this represents a deviation from good and accepted standards of care on the part of Dr. Walsh. Furthermore, the CPR medication and administration log indicates only that aminophylline and Narcan were given. It is my opinion that the failure to administer epinephrine in conjunction with defibrillation as well as lidocaine or Bretylium if defibrillation were unsuccessful also represents a deviation from good and accepted standards of care on the part of Dr. Walsh.

4. Regarding Dr. Walsh's decision to perform the abortion in a clinic (as opposed to a hospital) concerning the patient's history of asthma, it is my opinion that this does not necessarily represent a deviation from good and accepted standards of care. It would depend on the availability of emergency services at the clinic. As I indicated in my previous letter, it is my opinion that a decision to perform any surgery requiring anesthesia in a medical facility which does not have appropriate resuscitative equipment and personnel would represent a deviation from good and accepted standards of care.

If I can answer any further questions, please feel free to contact me.

Sincerely,

Kenneth A. Brown, M.D., F.A.C.C.
Associate Professor of Medicine
Attending in Cardiology

KAB/mr

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, SS.

SUPERIOR COURT
C.A. NO: 88-1567

JOAN O. KALAT,
Administratrix of the
Estate of ELISE A. KALAT,
and Individually,
Plaintiff

v.

PLANNED PARENTHOOD LEAGUE OF
MASSACHUSETTS, INC., et al
Defendants

4/23/91
Filed In County (Tribunal)
Butler J.
attest: E. G. [illegible]
Deputy asst Clerk

30

DEFENDANTS' OPPOSITION TO PLAINTIFFS' OFFER OF PROOF

Now come the defendants and oppose Plaintiffs' Offer of Proof. This is a medical malpractice action brought on behalf of the decedent, Elise A. Kalat, arising out a first trimester abortion she received on February 10, 1987.

I. The Parties

1. Plaintiff Joan O. Kalat is the mother and administratrix of the estate of Elise Kalat.

2. Defendant Planned Parenthood League of Massachusetts, Inc. allegedly provided the subject abortion service to Elise Kalat through the Defendant Planned Parenthood Clinic of Central Massachusetts.

3. Defendant Brian W. Walsh, M.D. is the physician who allegedly

performed surgery and provided pre-operative and post-operative care to Elise Kalat on February 10, 1987.

4. Defendants Elizabeth Thiebe, R.N, Karen Fleming, R.N., Karen Caponi, R.N. and Gail Bickford, R.N. allegedly provided pre-operative, operative and post-operative nursing care to Elise Kalat.

A. The Facts

On February 10, 1987, Elise Kalat underwent a first trimester abortion procedure. This was her third abortion. According to the clinic record, the patient's first abortion was performed by a private physician in 1982, and she developed hives after this procedure. Her second abortion was performed at the Planned Parenthood Clinic on January 14, 1986. The Clinic record indicates this procedure was routine in all respects with no complications.

On February 10, 1987, Ms. Kalat arrived a the Planned Parenthood Clinic of Central Massachusetts for a first trimester abortion. She signed the abortion consent form which includes a consent for administration of local anesthesia and a consent for administration of augment anesthesia. Prior to the abortion, Ms. Kalat's vital signs were taken and recorded. Her blood pressure was 110/50 and pulse was 88. Laboratory tests were performed and the results recorded in the record. Dr. Walsh performed a physical

examination of Ms. Kalat as well as a pelvic examination. All of the findings made by Dr. Walsh were normal with the exception of the patient's uterus. In this regard, he noted the uterus to be enlarged consistent with an 8 week pregnancy.

Following the pelvic examination, Dr. Walsh proceeded with the abortion procedure. He first inserted a speculum into the patient's vagina, and he obtained both Pap smear and a gonorrhea culture. Nurse Fleming administered the augment anesthesia. Following this, Dr. Walsh administered a paracervical three point block local anesthesia, and then dilated the patient's cervix up to a #25 Pratt dilator. The uterine contents were evacuated with a 8 mm. suction cannula, and this was followed by sharp curettage. Dr. Walsh performed visual examination of the tissue, and he noted it consisted of products of conception. The patient was then taken to the recovery room.

Ms. Kalat was received in the recovery room at 11:50 a.m. She was placed on one of the recliners, and her vital signs were taken and noted to be normal (blood pressure - 110/50; pulse - 88). Then, she indicated she was having trouble breathing, and she asked for her asthma inhaler. This was immediately retrieved. At 11:53 a.m., Ms. Kalat was anxious and used her inhaler. She said she could not breath and used her inhaler again. She became more anxious. Dr. Walsh and Karen Caponi, R.N. were present to assist

the patient. At 11:55, Ms. Kalat's color turned cyanotic. She immediately was given oxygen and an interveneous line was started. An ambulance was called. Then, Elise Kalat became breathless and pulseless. She was immediately placed on the floor, CPR was initiated and an air way was inserted. Dr. Walsh administered both Aminophyllin and Narcan through the intravenous line. The ambulance arrived at the Clinic at 11:58. CPR was continued. She was placed in the ambulance at 12:05 and arrived at the Worcester Memorial Hospital at 12:07. According to the Worcester Memorial Hospital discharge summary, on arrival at the emergency room, Ms. Kalat was intubated and shocked with 360 joules after the EKG monitor revealed asystole. She then developed slow idioventricular rhythm which converted to normal sinus rhythm at 80 beats per minute after she was treated with Isopril (intratracheally), one amp of Epinephrine and three amps of sodium bicarbonate. Later that day she was admitted to CCU. On February 11, 1987, Ms. Kalat suffered a second cardiac arrest from which she was resuscitated. On February 12, 1987, she suffered a third arrest from which she could be not resuscitated.

B. The Standard of Review for a Medical Practice Tribunal <u>Pursuant to M.G.L. c. 231, Section 60B</u>

Under M.G.L. c. 231, section 60B, every action for medical malpractice must be screened by a tribunal composed of a single justice of the Superior Court, a physician licensed to practice

PROGRESS NOTES

PATIENT # 10-138 DATE: 2/10/87

PATIENT NAME: Kalat, Elise

Pt. transferred to ambulance. cont during transfer to be minus pulse and resp.s. CPR maintained by ambulance attendant and KFleming RN. Dr. Walsh present assessing perfusion via femoral and carotid pulses & CPR continued through arrival to hospital. Pt. did not regain consciousness, pulse or spontaneous respirations. Care referred immediately to E.R. staff upon arrival to Memorial E.R..

KFleming RN
Flow

Addendum: location of family members unknown. Dr. Walsh and KFleming RN attempted to notify pts. mother until 2:30pm s̄ success.

KFleming
Flow

The University of Vermont

COLLEGE OF MEDICINE, DEPARTMENT OF MEDICINE
CARDIOLOGY UNIT, MARY FLETCHER UNIT
MEDICAL CENTER HOSPITAL OF VERMONT
BURLINGTON, VERMONT 05405
(802) 656-3734

December 28, 1989

Joan M. Fahey
Swartz & Swartz
10 Marshall Street
Boston, MA 02108

RE: Elise A. Kalat

Dear Ms. Fahey:

This communication will summarize my opinions based on a reasonable degree of medical certainty regarding the case of Elise A. Kalat. I have reviewed medical records including those of the Planned Parenthood Clinic of Worcester, Massachusetts; Worcester Memorial Hospital records of February 10, 1987; and Bay State ambulance records.

Ms. Kalat was a 22-year-old woman who was at the Planned Parenthood clinic on February 10, 1987, for an elective abortion. She had a history of two prior elective abortions in 1982 and in January of 1986. The first was apparently complicated by hives. Her other past medical history was significant for asthma which apparently was well controlled on Ventolin and Cromolyn inhalers. Her pre-operative blood pressure was 110/50 mmHg with a pulse of 80. Her physical examination was unremarkable. According to the Planned Parenthood clinic records, she arrived from the procedure room into the recovery room at 11:50 a.m. with a blood pressure of 110/50 mmHg with a pulse of 88. She complained of difficulty breathing, asking for an inhaler. At 11:53 she was described as anxious using the inhaler (Ventolin). Dr. Walsh arrived at 11:55 a.m., the patient was described as cyanotic, given oxygen and an ambulance was called. The patient became breathless and pulseless at that time and CPR was initiated. Her airways were reported to be obstructed, aminophylline was given, 250 mg i.v. push by Dr. Walsh. No blood pressure or pulse was able to be obtained. She also received one ampule of Narcan by Dr. Walsh. The ambulance was described as arriving at 12:00 noon. The Bay State ambulance records indicate that they were dispatched to the scene at 11:55 a.m., arrived at the scene at 11:58 a.m., departed from the scene at 12:05 p.m., and arrived at the Worcester Memorial Hospital at 12:07 p.m. An incident report filed by James Halacy indicates that when the ambulance team arrived, they found that the Planned

Parenthood facility employee who was administering the compression phase of CPR was "performing CPR with compressions being administered too low (approximately one inch above navel)". In addition, Mr. Halacy observed that "an employee of the facility was administering ventilations to the patient via bag valve mask. I noticed that with each ventilation, the patient's cheeks would puff out indicating that she was not receiving adequate ventilations". The patient was transported to a stretcher by an ambulance team and then to Memorial Hospital. The incident report filed by Pier M. Plazeski (Mr. Halacy's partner) corroborated Mr. Halacy's observations that "the compressions were being done incorrectly, approximately one inch above the navel." He also indicated that the patient was then transported via ambulance to Memorial Hospital. During this transportation, Mr. Plazeski indicates that "I continued with ventilations on the patient and a nurse from Planned Parenthood continued to do compressions properly". When she arrived at Worcester Memorial Hospital, she was rapidly intubated and shocked with development of initially a slow idioventricular rhythm and then a normal sinus rhythm at 80 per minute after she was treated with Isuprel, epinephrine, and sodium bicarbonate. Her blood pressure after cardioversion was 110/70 mmHg. Her cardiovascular status initially was stable but her neurologic status was consistent with severe hypoxic brain damage. Her subsequent course was complicated by fever, diabetes insipidus, deterioration of neurological status, and ultimately a cardiac arrest from which she was not resuscitated. An autopsy was performed. It indicated normal coronary arteries, smooth epicardial surface without injuries, and no evidence of myocardial infarction. There was severe brain edema. Dr. Vernard Adams, the forensic pathologist, based on the medical history, information supplied by Dr. Fielding, autopsy findings, and a consultation with Dr. Gary Welch, chief of anesthesiology at the University of Massachusetts Medical Center, Dr. Adams concluded that Elise Kalat died of "asthmatic bronchospasm following therapeutic abortion." He noted that the anesthetic agents used would not expected to be allergenic and that although there was a temporal relationship of the surgical procedure to the asthmatic attack, a causal relationship was not demonstrable. He concluded that the manner of death was natural.

I would like to make the following observations/opinions:

1. Regardless whether the etiology was an allergic reaction or due to a spontaneous asthmatic bronchospasm episode, it is clear that the patient's death was a direct result of a cardiopulmonary arrest suffered at approximately 11:55 a.m. on February 10, 1987.

2. Based on the observations of both Mr. Halacy and Plazeski, it is clear that the person administering chest compressions as part of the CPR for Ms. Kalat was compressing at a position inappropriately too low. Chest compression should be administered at a point on the sternum approximately two-thirds of the way from the sternal notch to the xiphoid process. When performed

Date of call (MM DD YY) 02 10 87

Complaint: Cardiac / Respiratory Arrest

Last name: Kolat — first name: Elise — m.i.

Age: 022 — INFANT AGE (1 to 24 months) — NEWBORN AGE (1 to 31 days) — SEX ☐ M ☒ F

Patient's physician: Dr Corbett

TRIP TIMES (24-hour clock, hours:minutes)

Dispatched	Arrived scene	Departed scene	Arrived destination	Back in service
1155	1158	1205	1207	1216

Location: Worc. Office
Address: 340 Main St. - Worc.
Destination: Memorial Hosp.
Medications, history, comments

VITAL SIGNS ☐ Unable to obtain ☐ Not attempted

Blood pressure	Respiration	Pulse	Time taken
Cardiac Arrest			

PATIENT STATUS
- ☐ Conscious
- ☐ Confused
- ☐ Stuporous
- ☐ Convulsing
- ☒ Unconscious
- ☐ Apparent death

PULSE
- ☐ Normal
- ☐ Rapid, weak
- ☐ Rapid, bounding
- ☐ Slow
- ☒ Absent

RESPIRATION
- ☐ Normal
- ☐ Rapid, shallow
- ☐ Labored
- ☒ Absent

BLEEDING
- ☐ None
- ☐ Minor
- ☐ Serious
- ☐ Poss. internal

PUPILS (L / R)
- ☐ Normal ☐
- ☐ Dilated ☐
- ☐ Mid-point ☐
- ☐ Constricted ☐
- ☒ Unreactive ☐

SKIN CONDITION
- ☐ Normal
- ☒ Cool, clammy
- ☐ Cool, dry
- ☐ Hot, moist
- ☐ Hot, dry

SKIN COLOR
- ☐ Normal
- ☐ Flushed
- ☐ Pale, ashen
- ☒ Cyanotic

PATIENT COMPLAINTS
- ☒ None
- ☐ Pain
- ☐ Fever
- ☐ Faintness
- ☐ Nausea
- ☐ Paralysis
- ☐ Numbness
- ☐ Slurred speech
- ☐ Visual loss

PROBABLE CONDITION
- ☐ No apparent medical problem
- ☐ MEDICAL
- ☐ TRAUMA
- ☒ CARD. ARREST
- ☐ CARDIAC
- ☒ RESPIR. ARREST
- ☐ OBSTRUCT. AIRWAY
- ☐ SHOCK
- ☐ Allergic reaction
- ☐ Asphyx./drowning
- ☐ Seizure
- ☐ CVA
- ☐ Diabetic state
- ☐ Respiratory
- ☐ DRUGS
- ☐ ALCOHOL
- ☐ POISON
- ☐ OBS/GYN
- ☐ PSYCHIATRIC
- ☐ OTHER

TYPE OF INJURY
- ☐ None
- ☐ Possible internal
- ☐ Abrasion
- ☐ Amputation
- ☐ Avulsion
- ☐ Blunt trauma
- ☐ Bruise/contusion
- ☐ Burns
- ☐ Concussion
- ☐ Dislocation
- ☐ Electric shock
- ☐ Fracture-closed
- ☐ Fracture-open
- ☐ Laceration
- ☐ Puncture
- ☐ Sprain/strain
- ☐ Other:

Mark suspected injury site with X

Front — Back

TYPE OF CALL
- Motor vehicle acc.
- Non-motor veh. injury
- Emergency illness
- Emergency maternity
- Transfer of previous
- Emergency transfer
- Scheduled transport

PATIENT OUTCOME
- 1 ☐ Transport not needed
- 2 ☐ Refused transport
- 3 ☐ Moved by other
- 4 ☒ Transported
- 5 ☐ Round trip
- 6 ☐ Cancelled
- 7 ☐ False alarm
- 8 ☐ Patient DOA

INITIAL AID REC'D. FROM
- ☐ None
- ☐ Untrained bystander
- ☐ Trained bystander
- ☐ Police/Fire
- ☒ CPR started

EMERGENCY CARE
- ☐ None
- ☐ Aid refused
- ☐ Extrication
- ☒ CPR
- ☐ Airway cleared
- ☐ Airway used
- ☐ Artificial vent.
- ☐ Suction used
- ☒ Oxygen given — L/M demand
- ☐ Dressing/bandage
- ☐ Heat/cold applic.
- ☐ Neck-spine immob.
- ☐ Traction splints
- ☐ Fixed splints
- ☐ Vomiting induced
- ☐ Obstetric delivery
- ☐ Part elevated
- ☐ Patient restraints
- ☐ Other

BLEEDING CONTROL
- ☐ Direct pressure
- ☐ Pressure point
- ☐ Elevation
- ☐ Tourniquet

Comments and ...

CONDITION PATIENT WAS FOUND: pt supine on floor of clinic - upon [arriv]ing, we were informed pt is "in arrest" - 2240 f pt was cyanotic [pu]lse, ⊖ resp. - clinic staff was performing CPR c̄ compressions [be]ing administered too low (app. 1" above navel) - clinic staff [ha]d oropharyngeal airway in place. Upon lifting pt to litter c̄ nurse [ho]lding I.V. d5 IV was pulled loose c̄ minor bleeding - pt [illegible] c̄ 2 clinic personnel and CPR continued en-route. [illegible]

BAY STATE AMBULANCE INCIDENT REPORT

DATE OF INCIDENT: 02/10/1987 TIME: 11:55 hrs.

TYPE OF INCIDENT Cardiac Arrest

LOCATION OF INCIDENT Planned Parenthood, 340 Main Street, 6th floor, Worcester

INVOLVED PARTIES Planned Parenthood - patient: Elsie Kalat

WITNESSES

IMMEDIATE SUPERVISOR (PERSON IN CHARGE) Alan S. Dean, Regional Director

DATE AND TIME SUPERVISOR NOTIFIED

DETAILED DESCRIPTION OF INCIDENT (ATTACH ADDITIONAL SHEETS IF NEEDED)

On the above date and time, my partner (James Halacy) and I were dispatched to Planned Parenthood for a patient with difficulty breathing. Upon our arrival three minutes later (11:58 am) we were met at the back doors by a person named Lois Counselor (according to name tag). As we entered the offices of Planned Parenthood, a woman said to us ".we've got an arrest here". As we entered the room where the patient was located I observed a person doing compressions on this patient later known as Elsie Kalat. The compressions were being done incorrectly, approxiamtely 1" above the navel. I observed another person doing ventillations with an Ambu-bag. I at this point began to demand the patient with our equipment. After a minute or so, my partner and I transferred the patient to our stretcher the I.V. was pulled out of her arm that another person had

PERSON REPORTING (NAME): Pier M. Plazeski

(TITLE): EMT-A

(SIGNATURE): Pier M. Plazeski

WORKMANS COMPENSATION DISCLAIMERS

Employee Responsibility: Under the Occupational Safety and Health Act of 1970 each employee shall comply with all occupational and health standards, rules and regulations, and orders under the Act that apply to their own actions and conduct on the job.

EMPLOYEE SIGNATURE:

****

DATE OF REVIEW:

ACTION SUGGESTED TO PREVENT RECURRENCES:
(ATTACH REPORT)

ACTION TAKEN TO PREVENT RECURRENCES:
(ATTACH REPORT)

PERSON PREPARING REPORT DATE

L·A·N·N·E·D
.RENTHOOD
.E. OF MASSACHUSETTS

ard of Directors
n D. Pratt
ident
nie S. Burnes, Esq.
President
Kimball Faulkner
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on K. Bennett
n A. Bowditch
edish Bradford, Jr., Esq.
Corlette
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ry B. Faulkner, Ph.D.
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Reve. E. Spencer Parsons
n M. Rashba, M.D.
ge S. Richardson, M.D.
A. Scott, M.Ed.
est Van B. Seasholes
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Honorable James M. Shannon
ar E. Smith, Ph.D.
Reed Smith, Ed.D.
abeth Bell Stengle
lip G. Stubblefield, M.D.
d E. Van Allen
le T. Wisotzky
lia Zervas

i Nichols Gamble, Ed.D.
utive Director

IN OFFICE
Bishop Allen Drive
nbridge, MA 02139
7) 492-0518

nned Parenthood Clinic
entral Massachusetts
Main Street
rcester, MA 01608
7) 799-5307

April 21, 1987

Massachusetts Department of
Public Health
Health Care Quality Division
80 Boylston Street
Boston, MA 02116

RE: Report Pursuant to Regulation 105 CMR 140.611

Dear Gentlepersons:

Please be advised that on February 10, 1987, a complication arose following a first trimester abortion procedure at this clinic. The procedure was routine in all respects. Following the procedure, the patient, Elise Kalat, complained of shortness of breath while in the recovery room. An ambulance was called and the patient was transported to Worcester Memorial Hospital. It was subsequently learned that the patient died on February 12, 1987, at that hospital.

This report is sent in accordance with the requirements of the above referenced Department of Public Health Regulation, (Section 140.611, Reports on Surgery and Anesthesia Related Complications). If you have any questions, please contact the undersigned directly.

Very Truly Yours,

Elizabeth a Thiebe R.N.

Elizabeth Thiebe, R.N.
Clinic Director
Planned Parenthood League of MA
340 Main Street
Suite 645
Worcester, MA 01608
(617) 799-5307

LIST OF ALL STAFF ON FEB. 10, 1987

Arello, Lisa	Medical Assistant
Baskin, Ellen	Receptionist
Belton, Marlyn	Medical Assistant
Bennet, Roz	Volunteer
Bickford, Gail, R.N.	Recovery Room Nurse
Bourassa, Brenda P.A.	Physican Assistant
Bowman, Beth	Counselor
Bromley, Elizabeth	Medical Assistant
Caponi, Karen R.N.C., N.P.	Medical Coordinator
Crum, Lois	Counselor
Fleming, Karen, R.N.	Flow Nurse
Forsythe, Vanessa, R.N.	Recovery Room Nurse in training
Garceau, Lisa	Counselor
Sinman, Lisa	Secretary/Office Manager
Thiebe, Elizabeth, R.N.	Clinic Director
Tomailo, Maria	Lab Tech
Underwood, Judy	Counselor
Walsh, Brian, M.D.	Physican

Address for all staff, 340 Main Street, Suite 645, Worcester, Ma. 01608

LIST OF ADMINISTRATIVE STAFF 1987

Stanton Goldstein M.D.	Medical Director
Elizabeth Thiebe R.N.	Clinic Director
Karen Caponi R.N.C.,N.P.	Medical Coordinator

Address for all 340 Main Street, Suite 645, Worcester, MA. 01608

III. PATIENT FLOW

A. Sample Patient Flow (One Visit)

TIME	FUNCTION	STATION	STAFF
8:00 - 8:30 a.m.	Check in, pay fee and complete history.	Reception/ Waiting Room	Receptionist
	Lab tests	Lab	Lab Technician
	Height and weight		
8:30 - 9:10 a.m.	Review of medical history Counseling Consent forms Contraceptive counseling Vital Signs	Interview Room	Counselor
9:10 - 9:30 a.m.	Review of lab results Final chart check Change to exam gown Pre-medication, if indicated	Patient Waiting Area/Dressing	Clinic Supervisor
9:30 - 9:45 a.m.	Procedure	Procedure Room	Physician Procedure Nurse
9:45 - 10:45 a.m.	Recovery/post-op monitoring Post-op instructions Contraception discussed, review instructions. Post-op appointment made or referral letter arrangements to own M.D.	Recovery Room	Recovery Room Nurse Counselor or Recove Room Volunteer ~~Clinic Supervisor~~

[UNI]T NUMBER
19709

BAY STATE AMBULANCE SERVICE
P.O.Box N
Malden, MA

176293

RETURNED

[DAT]E 2-10-87 DRIVER Halacy ATTENDENT Plazeski AMBULANCE 720 CHAIR CAR

[PA]TIENT Elise Kalat PHONE 798-3819

[ADD]RESS 495A Mill St DATE OF BIRTH 10-14-64 AGE 22

[CI]TY Worc STATE Mass ZIP 01602 MALE (FEMALE)

[EM]PLOYED BY PHONE

[ME]DICARE - - - MEDEX

[WE]LFARE - - - - - -
reg office cat suffix

[BL]UE CROSS # OTHER INSURANCE bill Planned Parenthood 340 Main St Worcester MA 01608

[CA]RD HOLDER NAME IF DIFFERENT: MEDICAID

[DO]CTOR Dr. Corbett BLUE CROSS

[DI]AGNOSIS: Resp. Arrest - Card. Arrest

TRANSFER / (EMERGENCY) / AUTO ACCIDENT

[EQU]IPMENT USED Litter - O_2 OXYGEN demand MONITOR

[CA]LL SOURCE (specify) Planned Parenthood MILES 2 CALL TIME 1155

[FRO]M 340 Main St.-Worc Time: 1158 TO Memorial Hosp. E.R. Time: 1207

[ME]DICARE PATIENTS ONLY: I request that payment under the Medical Insurance Program be made [di]rectly to Bay State Ambulance Service on any unpaid bills for services furnished to me by [Ba]y State Ambulance. I permit a copy of this authorization to be used in place of original.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

[OTH]ER The Signer of this form agrees to pay Bay State Ambulance for all services rendered [to] the patient. I also understand it is my responsibility to notify Bay State Ambulance [of] any or all insurance information.

SIGNATURE: x Cathy J Jewell

[AU]TO ACCIDENT: TAX ID 04-2399909 REGISTRATION YEAR MAKE

[PA]TIENTS NAME AND ADDRESS:

[OWN]ERS NAME AND ADDRESS:

[INSU]RANCE AGENT COMPANY

[INSU]RANCE ADDRESS PHONE

[I HER]EBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO BAY STATE AMBULANCE SERVICE, INC. FOR [AL]L SERVICES RENDERED.

SIGNATURE: DATE

ounseling report counselor: Jenny Y.

ographical data:
21 y.o. Baker/waitress, single, lives w/roommate
1 previous AB - 121 Lincoln summer '82.

cumstances surrounding pregnancy:
Unprotected intercourse. Pt states she has been successfully using rythm method past 3yrs - suprised pg. Did have prescription for pill - regrets not using.

lings about abortion/consideration of options:
Pt aware of all options. Feels AB best due to lack of finances, also not ready for a child now. ~~Had Roommate~~ Freind offered to adopt child - pt states she could not do this. Feels embarrassed that she is going thru another AB.
Viewed AB fact sheet - no concerns

ly/significant other involvement:
Boyfreind with her today - supportive - Doesn't Know about previous AB
Several supportive freinds
Mother Knows about previous AB but not this one. Pt states she ashamed to tell mom it happened again.

aceptive information:
Pt wants O.C.s. Gave fact sheet.

al impressions/counselor concerns:
Pt seems sure of decision, but feels badly that she's going through this again. Had hives after past procedure - local anesthesia or [illegible] may have caused. Should tolerate procedure well.

lor checklist: ✓
nsent signed: ✓
ve consent signed ✓
ne and recorded ✓

Signature: Jennifer Blais Date: 1/14/86

unseling report counselor: [illegible]

raphical data:
is 22 y.o., single, unemployed at present, is looking for job. lives w/ mother
3rd preg., 3rd AB

mstances surrounding pregnancy:
partner had u.s.i.

gs about abortion/consideration of options:
states she has considered all options and that AB is decision at this time, she states she could not financially [s]ort a child at this time - pt. states this is her decision that she is sure - AB fact sheet read and reviewed - ∅ serious quest./concerns

significant other involvement:
amily involvement
ner in preg. knows and is supportive of decision

eptive information:
will begin pill today
yeast infection on ON 1/35

impressions/counselor concerns:
ugh pt. did not want to fully discuss her decision ng process, she should cope adequately w/ dure

r checklist:
nt signed: ✓
consent signed ✓
and recorded ✓
al ...... judicial ...

ature: Lisa M. Garceau Date: 2/10/87

the incident, plaintiff was 22 years old and in good health. She had a medical history of asthma. On February 10, 1987, plaintiff presented to the defendants at Planned Parenthood Clinic of Central Massachusetts for an elective abortion. Immediately following the procedure, according to Planned Parenthood records, plaintiff went into cardiac arrest. Defendants commenced CPR on the plaintiff, who was subsequently transferred to Worcester Memorial Hospital.

The defendants, Brian Walsh, physician; Elizabeth Thiebe, R.N., Clinic Director; Karen Fleming, R.N., Flow Nurse; Karen Caponi, R.N.C.P.N., Medical Coordinator; and Gail Bickford, R.N., Recovery Room Nurse, fell below the acceptable standard of care of the average, qualified physician or nurse by failing to properly administer CPR and by failing to follow acceptable standards of care in this emergency situation, which should have included defibrillation and the administration of epinephrine to the plaintiff. The defendants Planned Parenthood League of Massachusetts, Inc., and Planned Parenthood Clinic of Central Massachusetts, actually the same entity, are responsible for failure to ensure that their employees have current CPR certification, failure to have properly trained nurses and doctors on staff, by

administer a precordial thump, and failure to administer epinephrine in conjunction with defibrillation as well as lidocaine or Bretylium if defibrillation was unsuccessful.

These deviations from the requisite standard of care resulted in plaintiff's severe hypoxic brain damage and ultimately, her death.

Karen Fleming, R.N.

On February 10, 1987, Karen Fleming, R.N., rendered nursing care, including administration of CPR, to plaintiff. In doing so, they entered into a nurse-patient relationship with attendant duties.

Nurse Fleming had a duty to exercise that degree of care and skill of the average qualified nurse, taking into account advances in the profession.

Specifically, in February of 1987, the standard of care for the average qualified nurse working in a state-licensed health care facility would have included:

1. Knowledge of cardiopulmonary resuscitation techniques, including how to administer adequate cardiac compressions, and;

2. up-to-date certification in basic life support and cardiopulmonary resuscitation.

Nurse Fleming fell below the standard of care of the average qualified nurse practicing in a state-

licensed facility in 1987 through her failure to correctly administer adequate cardiac compressions and failure to maintain up-to-date certification in basic life support and cardiopulmonary resuscitation.

These deviations from the requisite standard of care resulted in plaintiff's severe hypoxic brain damage and ultimately, her death.

Karen Caponi, R.N.C.P.N.

On February 10, 1987, Karen Caponi, R.N.C.P.N., rendered nursing care, including administration of CPR, to plaintiff. In doing so, they entered into a nurse-patient relationship with attendant duties.

Nurse Caponi had a duty to exercise that degree of care and skill of the average qualified nurse, taking into account advances in the profession.

Specifically, in February of 1987, the standard of care for the average qualified nurse working in a state-licensed health care facility would have included:

1. Knowledge of cardiopulmonary resuscitation techniques, including how to administer adequate pulmonary resuscitation.

Nurse Caponi fell below the standard of care of the average qualified nurse practicing in a state-licensed facility in 1987 through her failure to correctly administer adequate pulmonary resuscitation.

3. Training in adequate emergency procedures. The facts of this case disclose that the employees of PPCCM were inadequately trained for emergency procedures.

PPLM/PPCCM fell below the standard of care of the average licensed healthcare facility through its failure to have adequately trained personnel with current CPR certifications, with knowledge of how to handle a life-threatening emergency, through its failure to have defibrillation equipment on hand, and through its failure to promulgate adequate emergency procedures.

Planned Parenthood's own rules pertaining to Emergency Procedures for Complications in the Clinic require that at least one staff member have current CPR certification. Despite this rule, the person who actually administered the chest compressions did not have current certification. As the evidence has demonstrated, the chest compressions were done improperly.

These deviations from the requisite standard of care resulted in plaintiff's severe hypoxic brain damage, and ultimately her death.

PPLM/PPCCM is also negligent by reason of respondeat superior. PPLM/PPCCM employed the named defendants as their agents/servants as evidenced by the named defendants' titles and their corresponding job

Specifically, in February of 1987, the standard of care for the average qualified nurse-clinic director working in a state-licensed health care facility would have included:

1. The overall development and management skills necessary to ensure that proper emergency systems were in place.

2. Recruiting and evaluation skills necessary to ensure that hired staff was trained to handle emergency situations.

3. Adherence to compliance with licensing and regulatory schemes.

These standards were in fact the job requirements of the clinic director as set forth by Planned Parenthood in its job description.

Nurse Thiebe fell below the standard of care of the average qualified nurse-clinic director in a state-licensed facility in 1987 through her failure to ensure that adequate emergency systems and protocols were in place, failure to ensure that all staff members were adequately trained in how to handle emergency situations, and failure to ensure that all staff members were up-to-date on their certifications in CPR and Basic Life Support.

These deviations from the requisite standard of care resulted in plaintiff's receiving inadequate CPR,

Kalat v Bickford RN et al

Docket Entry Details for Docket: WOCV1988-01567

No.	Docket Entry:
1	Nisi dismissal; agrmnt or stip to be filed by 10/19/95 (Donohue,RAJ)
2	Notice mailed 9/29/95

Docket Details: Parties Attorneys Docket Entries Calendar Events Print Docket