COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, SS.

SUPERIOR COURT
CIVIL ACTION
NO.: 1879CV00474

LEANNA LEWIS, PERSONAL REPRESENTATIVE OF THE ESTATE OF SERENA LEWIS,
Plaintiff,

V.

EILEAN ATTWOOD, M.D.,
DANIELLE GRANIERI, D.O.,
ASRA JAWED, M.D.,
HEATHER SANKEY, M.D.,
RENEE THIBODEAU, M.D., AND
BAYSTATE HEALTH, INC., D/B/A WESSON WOMEN'S CLINIC,
Defendants.

HAMPDEN COUNTY
SUPERIOR COURT
FILED
AUG 28 2018
CLERK OF COURTS

PLAINTIFF'S OFFER OF PROOF

Respectfully submitted,
The Plaintiff,
By her attorneys,

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Defendants.

PLAINTIFF'S OFFER OF PROOF

In this medical malpractice and wrongful death action, the plaintiff seeks to recover for the severe and permanent personal injuries and premature and preventable death of Serena Lewis, which she suffered as a direct result of the negligent and careless treatment rendered to her by the defendants, Eilean Attwood, M.D., Danielle Granieri, D.O., Asra Jawed, M.D., Heather Sankey, M.D., Renee Thibodeau, M.D., and Baystate Health, Inc., D/B/A Wesson Women's Clinic, by its agents, servants, and employees.

More specifically, the plaintiff alleges that the defendants were negligent in their care and treatment of Leanna Lewis during her pregnancy with her daughter, Serena Lewis, when they failed to properly diagnose, manage, and treat her placental abruption, which resulted in intrauterine fetal demise at thirty-two (32) weeks or eight (8) months gestation.

This written portion of the Plaintiff's Offer of Proof consists of the following items which will be offered at the trial of this action:

A. BayState Medical Center Records (2/24/16-8/26/16)

B. Fetal Monitor Tapes and Correspondence with Wesson Women's Clinic

C. Expert Letter and Curriculum Vitae of Joshua Holden, M.D.

This written portion of the Offer of Proof also contains an argument that the plaintiff has satisfied the requirements of M.G.L. c. 231 §60B in that this action presents a legitimate question of liability appropriate for further judicial review.

STATEMENT OF FACTS

Serena's mother, Leanna Lewis, was a 22-year-old G1, P0 expecting the birth of her first child. **(A7)** Her estimated date of confinement (EDC) was 10/17/16. **(A16)**

On 5/17/16 at 18 weeks gestation, an ultrasound revealed an echogenic focus in the fetal left cardiac ventricle. **(A34)** Amniocentesis was discussed, offered, and declined. **(A35)**

On 7/28/16 at approximately 28 weeks gestation, laboratory studies revealed a hemoglobin of 9.7 (normal: 12.0-16.0), a hematocrit of 26.6 (normal: 37.0-47.0), and a red blood cell (RBC) count of 3.25 (normal: 4.20-5.40). **(A48)** Ms. Lewis's next prenatal visit took place on 8/11/16 at 30 weeks gestation. **(A50)** Ms. Lewis was diagnosed with anemia in pregnancy. **(A52)** She had previously been given iron pills but was not taking them regularly as they were making her feel sick. **(A52)** She was instructed to try taking them at different times of day. **(A52)**

On 8/18/16 at 1:32 p.m., at 31 weeks gestation, Ms. Lewis was admitted to Baystate Medical Center. **(A55)** She reported generalized abdominal pain starting at 9:00 that morning. **(A55)** It hurt to touch her abdomen. **(A55)** She denied vaginal bleeding. **(A55)** She reported two

episodes of vomiting and denied diarrhea. (**A55**) She was having irregular contractions. (**A55**) A plan was made to rule out preterm labor. (**A55**)

Laboratory studies revealed a Hgb of 9.6 and a Hct of 27. (**A56**) A fetal fibronectin test was negative. (**A57**) A random total urine protein resulted as 26. (**A94**) The total protein (TP)/creatinine (CR) ratio was 0.16 (normal: 0.0-0.2). (**A94**) Ms. Lewis' urine creatinine level was 159.1. (**A94**)

A midwife was called to see Ms. Lewis. (**A60-61**) She noted that Ms. Lewis was complaining of severe, unremitting abdominal pain located primarily on the right side of her abdomen in both the upper and lower quadrants. (**A60**) Ms. Lewis was found to be in bed curled around her abdomen crying and rocking herself. (**A60**) A physical examination was within normal limits (WNL) with the exception of the abdomen, which was taut on her right side with guarding and no rebound. (**A60**) The fetal heart tracing (FHT) was in the 150's to 160's. (**A60**) No bleeding was noted and Ms. Lewis was afebrile. (**A60**) The midwife's assessment included abruption, acute appendicitis, and preterm labor (PTL). (**A60**) She paged the resident to examine Ms. Lewis. (**A60**) Obstetrician Eilean Attwood, M.D. examined Ms. Lewis and agreed with the plan. (**A61**)

Around the time of admission, Ms. Lewis was examined by a resident who noted that she reported sudden onset abdominal pain. (**A59**) The pain initially was a strong lower abdominal cramp and it progressed to involve her whole abdomen, particularly in the middle. (**A59**) She stated that it was constant but intermittently became stronger. (**A59**) She was unable to tolerate anything by mouth (PO). (**A59**) She reported fetal movement and denied loss of fluid or vaginal bleeding. (**A59**) Her blood pressure was 142/85. (**A59**) She was found to be writhing in bed, visibly in pain. (**A59**) An abdominal examination revealed tenderness with palpation of her

uterine fundus, and moderate contractions palpated with mild firmness in between contractions. **(A59)** Her abdomen was otherwise soft. **(A59)** A sterile vaginal examination (SVE) revealed 1 cm dilatation, 60% effacement, and a -3 station (1/60/-3) with a posterior cervix. **(A59)** Bedside ultrasound revealed vertex (VTX) presentation, a globular placenta, and evidence of calcifications. **(A59)** The fetal heart tracing was noted to be in the 150's with moderate variability and accelerations. **(A59)** Ms. Lewis was contracting every two to three minutes and had uterine irritability. **(A59)** The resident was concerned for abruption versus preterm labor (PTL). **(A59)** Given her uterine irritability, level of pain, and abnormal appearance on ultrasound, the concern for placental abruption was high. **(A59)** It was noted that maternal/fetal status was reassuring. **(A59)** The resident planned for continuous electronic fetal monitoring (CEFM), magnesium for neuroprotection, steroid course, penicillin (PCN) for Group B Strep (GBS) prophylaxis, and neonatal intensive care unit (NICU) and anesthesia consultations. **(A59-60)** The resident felt that Ms. Lewis was not stable enough to leave for a formal scan. **(A60)** Hemolysis, elevated liver enzymes, and low platelet count (HELLP) labs were drawn to rule out hypertensive etiology. **(A60)** Two units of packed red blood cells (PRBC) were on hold for her anemia. **(A60)**

Betamethasone was administered at 1:59 p.m. and Magnesium Sulfate was administered at 2:02 p.m. **(A62)** Penicillin was administered at 2:26 p.m. **(A63)**

At 2:05 p.m., nursing noted that the tracing was Category 2 due to a possible late deceleration. **(A63)** The baseline was 155. **(A63)** At 3:18 p.m., Ms. Lewis complained of pain in her back returning intermittently. **(A63)** She denied active abdominal pain at that time. **(A63)** Ms. Lewis was dozing intermittently, resting on her right side. **(A63)**

At 3:42 p.m., a maternal fetal medicine physician noted that a bedside ultrasound was being performed at the house's request. **(A63)** The placenta appeared to be grade II, with isoechoic collection behind the placenta consistent with abruption and also consistent with the patient's maximum pain. **(A63)** The placental cotyledons appeared very well organized and possibly calcified in part, grade III. **(A63)** In my professional opinion to a reasonable degree of medical certainty, these findings are consistent with abruption requiring the patient be managed accordingly. The findings were discussed with Dr. Attwood. **(A63)** There is no indication that Dr. Attwood requested a full consultation by maternal fetal medicine physician or input on the plan of management, as was required by the standard of care. **(TAB A)**

At 4:00 p.m., Ms. Lewis was reevaluated by obstetrics resident Asra Jawed, M.D., who noted that she continued to have abdominal pain. **(A64)** A VE revealed 1/60/-3 and Dr. Jawed noted that this was a Category 1 strip. **(A64)** Dr. Jawed planned to continue to evaluate for abruption versus PTL. **(A64)**

At 4:27 p.m., Ms. Lewis complained of intermittent abdominal pain. **(A64)** At 5:08 p.m., Dr. Jawed was notified that Ms. Lewis had requested pain medication. **(A64)** At 5:44 p.m., Ms. Lewis vomited a large amount and requested an epidural or intravenous pain medication. **(A64)** The nurse called the resident. **(A64)**

At 6:01 p.m., obstetrics resident Danielle Granieri, D.O. noted that she was called to Ms. Lewis's room for increased abdominal pain and a request for pain medication. **(A64)** On arrival, Ms. Lewis reported that her pain had actually gotten better temporarily and that she was doing alright. **(A64)** She reported that her pain was intermittent. **(A64)** She continued to feel intermittent abdominal tightening. **(A64)** The tracing was Category 1 per Dr. Granieri's assessment. **(A64)** Dr. Granieri discussed a plan to administer Tylenol and also given Stadol if

the pain worsened. (**A64**) Dr. Granieri noted that placental abruption remained highest on the differential. (**A64**)

At 7:15 p.m., Dr. Granieri noted that Ms. Lewis's pain was well controlled with Stadol. (**A65**) The tracing was Category 1 and a SVE was deferred. (**A65**)

At 7:24 p.m., Ms. Lewis was having irregular contractions. (**A65**) The fetal tracing showed no significant change in fetal status per nursing. (**A65**)

At 8:00 p.m., it was noted that Ms. Lewis complained of a mild headache for which she was medicated with Tylenol. (**A65**) Over the course of that evening, nursing noted that the tracing reported no significant change in fetal status. (**A66-67**)

On 8/19/16 at 12:14 a.m., an obstetrics resident examined Ms. Lewis and a VE revealed 1/60/-3. (**A67**) The Magnesium was stopped. (**A67**) Per the resident's note, the FHT revealed a baseline (BL) of 130 with moderate variability, accelerations, and no decelerations. (**A68**) Ms. Lewis was contracting once every ten minutes and described the contractions as mild cramping. (**A68**) The resident planned for a Kleihaur Betke (KB) test the following day. (**A68**) She discussed her plan with another resident and Dr. Attwood. (**A68**)

Ms. Lewis was examined again at 6:50 a.m. (**A69**) She reported that her abdominal/uterine pain had completely resolved. (**A69**) She denied contractions or pressure. (**A69**) She reported positive fetal movement. (**A69**) She requested Tylenol for a mild headache. (**A69**) The FHT was noted to reveal a BL of 140 with moderate variability, accelerations, and intermittent nonrecurrent variable decelerations with 0-1 contractions per ten minutes. (**A69**) An ultrasound was to be obtained that morning to evaluate the placenta. (**A70**)

At 8:06 a.m., nursing noted that the monitor revealed irregular weak contractions. (**A70**) Nursing documented a FHR baseline of 140 with moderate variability, accelerations, and variable decelerations which were non-recurrent and featured a rapid return to baseline. (**A70**)

At 8:41 a.m., an obstetrician noted that Ms. Lewis was doing well and was feeling occasional tightening. (**A71**) Her abdomen was soft and non-tender. (**A71**) The obstetrician planned for a formal ultrasound to assess placenta and growth, and a NICU consultation. (**A71**) She also planned to monitor Ms. Lewis' BP closely. (**A71**)

At 9:12 a.m., nursing noted that the fetal tracing showed no significant change in fetal status. (**A71**)

At 9:22 a.m., a neonatal consultation was conducted and Ms. Lewis was advised of the possible problems associated with an early delivery. (**A77**)

An ultrasound timed 10:50 a.m. and reviewed by a maternal fetal medicine physician revealed adequate fetal growth and amniotic fluid volume within normal limits. (**A83-84**) The placenta appeared thick, calcified, and abnormal, consistent with an abruption. (**A84**) A collection measuring 6.0 x 5.0 x 7.4 cm was seen behind the fundal aspect of the placenta and this was felt to be a hematoma. (**A84**) In my professional opinion to a reasonable degree of medical certainty, this finding is consistent with a large abruption. Peak systolic flow of the middle cerebral artery was measured to be within normal limits by Doppler, suggesting absence of significant fetal anemia. (**A84**) A biophysical profile (BPP) score of 8/8 was given. (**A84**) There is no indication that a full maternal fetal medicine consultation was requested and hence one was not conducted. (**TAB A**)

At 11:56 a.m., nursing again noted that the tracing showed no significant change in fetal status. (**A71**)

At 1:43 p.m., the second dose of Betamethasone was administered. **(A71)**

Later that day at 3:54 p.m., the EFM was removed per Dr. Jawed and a plan was made to obtain non-stress tests (NST). **(A72)** It was a deviation from the standard of care to discontinue continuous monitoring in this patient with a known, large abruption.

At 8:59 p.m., obstetrics resident Renee Thibodeau, M.D. noted that the FHR was reactive. **(A73)** At 9:00 p.m., obstetrician Heather Sankey, M.D. noted that Ms Lewis's NST was reactive with accelerations and variable decelerations. **(A79)** She planned for a repeat NST in 24 hours. **(A80)**

On 8/20/16 at 8:44 a.m., Ms. Lewis reported that she was not feeling the baby move. **(A73)** She was placed on the monitor and at 9:30 a.m., the tracing was noted to be reactive with variable decelerations. **(A73)**

Dr. Sankey reviewed the NST and noted that it revealed variable decelerations. **(A82)** She agreed that the NST was reactive and her recommendation was for a repeat NST in 24 hours. **(A82)** Ms. Lewis was taken to ultrasound at 10:43 a.m. **(A73)** Dr. Granieri noted that if her abruption appeared stable, she would be discharged to home. **(A74)**

The ultrasound report, timed 10:47 a.m. and interpreted by maternal fetal medicine revealed a placenta with well-defined cotelydons, with echogenic periphery that could represent calcifications. **(A85)** The retrochorionic area of mixed echogenicity near the fundus, suspected to be an abruption, appeared smaller now measuring 7.5 x 2.7 x 5.8 cm. **(A85)** Peak systolic flow of the middle cerebral artery measured within normal limits by Doppler, again suggesting absence of significant fetal anemia. **(A85)** A BPP score of 8/8 was given. **(A85)**

Dr. Granieri later noted that the ultrasound revealed an abruption with no interval growth. **(A74)**

Ms. Lewis was then discharged to home and discharge instructions were provided at 12:29 p.m. **(A74)** Ms. Lewis was advised to watch for increased contractions and fluid loss. **(A74)** She was also advised to present for a follow up NST on Monday, 8/22/16 at 9:00 a.m. **(A76, A161)** This is inconsistent with Dr. Sankey's recommendation for a repeat NST in the morning of 8/21/16. **(A82)** The discharge summary was signed by both Dr. Granieri and Dr. Attwood. **(A162)**

Following Ms. Lewis's discharge, Dr. Granieri sent an email to the Wesson Women's (WW) Clinic indicating that Ms. Lewis had an NST scheduled for Monday morning. **(A165)** Ms. Lewis was not seen as ordered by Dr. Granieri. **(A188)** Instead of conducting the NST as ordered, WW Clinic emailed Dr. Granieri to inform her that the clinic had been closed over the weekend and there was no staff available to coordinate the scheduling of the appointment. **(A165)** An NST was instead scheduled by the office for Wednesday, 8/24/16 at 10:00 a.m., which was the next available appointment. **(A165)** There is no indication that Dr. Granieri reached out to Ms. Lewis or instructed her to present to the hospital for the NST since she would not be seen in the office. **(TAB A)** Further, there is no indication that the staff at the WW Clinic consulted a physician prior to sending Ms. Lewis away. **(TAB A)**

Later that evening, on 8/22/16 at 5:16 p.m., Ms. Lewis was readmitted to Baystate Medical Center. **(A167)** She had last felt fetal movement at 3:00 p.m. **(A171)** She developed severe, constant abdominal pain at 4:00 p.m., along with nausea, vomiting, and decreased fetal movement. **(A171)** On examination, her abdomen was hard to palpation. **(A171)** BSUS confirmed fetal demise with lack of fetal heart rate. **(A171-172)** Intrauterine fetal demise (IUFD) was diagnosed. **(A172)**

Laboratory studies subsequently revealed a Hgb of 9.5 and a Hct of 26.4. **(A174)** Ms. Lewis' white blood cell (WBC) count was elevated at 14.4 (normal: 4.0-11.0). **(A175)**

Ms. Lewis began to experience contractions at 7:40 a.m. on 8/23/16. **(A178)** She delivered her baby at 11:21 a.m. **(A178)** The amniotic fluid was blood tinged. **(A178)** The baby, Serena Lewis, weighed 1445 grams (3 pounds, 2.971 ounces) and was 15.5 inches long. **(A178)** Serena appeared normal and there was no evidence of any issues with her umbilical cord. **(A183)**

On gross examination, the placenta was found to have a large abruption. **(A183)**

LIABILITY OF DEFENDANTS

Medical expert, Joshua Holden, M.D., was consulted regarding the care and treatment rendered to Leanna Lewis and her daughter, Serena Lewis. Dr. Holden is a physician licensed to practice medicine in the state of New York. He is Board Certified in Obstetrics and Gynecology. He is a clinical assistant professor at Columbia Presbyterian Medical Center in New York, NY. He is a member of the Generalist Division in the department of Obstetrics and Gynecology and supervises the residents on the labor floor and maintain a private practice, as well. Dr. Holden is familiar with the accepted standard of care as it pertains to the average qualified obstetrician, obstetrics resident, and agent, servant, and employee of an obstetrics practice practicing in Massachusetts from 2016 to the present. His curriculum vitae and expert report are attached hereto at **TAB C.**

It is Dr. Holden's professional opinion that placental abruption is a premature separation of the placenta off of the uterus. Signs and symptoms of placental abruption include pain, decreased blood counts/anemia, and vaginal bleeding. Ultrasound can be a useful tool in diagnosing abruption and characterizing its size, so that the patient can be treated accordingly. Patients with small abruptions can be monitored and may not require imminent delivery;

however, if the abruption progresses or grows, the patient and her infant will be at risk for massive blood loss and death. In a patient with a known large abruption for whom bleeding is not an indicator, continuous fetal heart rate monitoring and delivery for any sign of fetal heart rate instability is indicated.

It is Dr. Holden's professional opinion, to a reasonable degree of medical certainty, that for these reasons, the accepted standard of care in Massachusetts from 2016 through the present requires the average qualified obstetrician caring for a patient with a known, large abruption and no vaginal bleeding to: 1) order and/or obtain a full maternal fetal medicine consultation and neonatal intensive care unit (NICU) consultation; 2) initiate steroids in anticipation of an early delivery; 3) keep the patient in the hospital for monitoring; 4) order and maintain continuous monitoring of the fetal heart rate; and 5) deliver the patient in the presence of any instability in the fetal heart rate.

It is Dr. Holden's professional opinion, to a reasonable degree of medical certainty, that the standard of care in Massachusetts from 2016 through the present requires the average qualified obstetrics resident caring for a patient with a known large abruption and no vaginal bleeding to: 1) order and/or obtain a full maternal fetal medicine consultation and NICU consultation; 2) initiate steroids in anticipation of an early delivery; 3) keep the patient in the hospital for monitoring; 4) order and maintain continuous monitoring of the fetal heart rate; and 5) ensure that any further testing is scheduled and conducted within the policies and limitations of the hospital and/or any affiliated practice groups.

It is Dr. Holden's professional opinion, to a reasonable degree of medical certainty, that the standard of care in Massachusetts from 2016 through the present requires the average

qualified agent, servant, and employee of an obstetrics practice to conduct testing as ordered by physicians, to consult an obstetrician to evaluate the patient or approve sending the patient to the hospital prior to her departure from the practice, and to refer patients to the hospital's obstetric triage department if they do not have the ability to conduct the ordered testing.

LIABILITY OF DEFENDANT EILEAN ATTWOOD, M.D.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Leanna Lewis and her daughter Serena by Eilean Attwood, M.D. from 8/18/16 to 8/20/16 deviated from the accepted standard of care at the time for the average qualified obstetrician when Dr. Attwood failed to: 1) order and/or obtain a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed; 2) keep Ms. Lewis in the hospital for monitoring; and 3) order and maintain continuous fetal heart rate monitoring.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, as a direct result of Dr. Attwood's deviations from the accepted standard, as outlined above, Ms. Lewis suffered intrauterine fetal demise of her daughter Serena. Had Dr. Attwood rendered care in accordance with the accepted standard, she would have ordered and/or obtained a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, she would have kept Ms. Lewis in the hospital for monitoring and not discharged her to home, Ms. Lewis would have been maintained on continuous fetal heart rate monitoring in the hospital and would have remained in the hospital on 8/22/16, her child would have been delivered at the first sign of instability in the fetal heart rate pattern and prior to the evening hours of 8/22/16, and more likely than not, Serena would have survived and survived well.

LIABILITY OF DEFENDANT DANIELLE GRANIERI, D.O.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Leanna Lewis and her daughter Serena by Danielle Granieri, D.O. from 8/18/16 to 8/20/16 deviated from the accepted standard of care at the time for the average qualified obstetrics resident when Dr. Granieri failed to: 1) order and/or obtain a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed; 2) keep Ms. Lewis in the hospital for monitoring; 3) order continuous fetal heart rate monitoring of Ms. Lewis's infant; and 4) ensure that any further testing was scheduled and conducted within the policies of the hospital and/or any affiliated practice groups.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, as a direct result of Dr. Granieri's deviations from the accepted standard, as outlined above, Ms. Lewis suffered intrauterine fetal demise of her daughter Serena. Had Dr. Granieri rendered care in accordance with the accepted standard, she would have ordered and/or obtained a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, she would have kept Ms. Lewis in the hospital for monitoring, instead of discharging her for fetal testing which would not be conducted, Ms. Lewis would have been maintained on continuous fetal heart rate monitoring in the hospital and would have remained hospitalized on 8/22/16, her child would have been delivered at the first sign of instability in the fetal heart rate pattern and prior to the evening hours of 8/22/16, and more likely than not, Serena would have survived and survived well.

LIABILITY OF DEFENDANT ASRA JAWED, M.D.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Leanna Lewis and her daughter Serena by Asra Jawed, M.D. on

8/18/16 and 8/19/16 deviated from the accepted standard of care at the time for the average qualified obstetrics resident when Dr. Jawed failed to order and/or obtain a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, and when Dr. Jawed discontinued the continuous fetal heart rate monitoring.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, as a direct result of Dr. Jawed's deviations from the accepted standard, as outlined above, Ms. Lewis suffered intrauterine fetal demise of her daughter Serena. Had Dr. Jawed rendered care in accordance with the accepted standard, she would have ordered and/or obtained a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, she would have maintained Ms. Lewis on continuous fetal heart rate monitoring, Ms. Lewis's child would have been delivered at the first sign of instability in the fetal heart rate pattern and prior to the evening hours of 8/22/16, and more likely than not, Serena would have survived and survived well.

LIABILITY OF DEFENDANT RENEE THIBODEAU, M.D.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Leanna Lewis and her daughter Serena by Renee Thibodeau, M.D. on 8/19/16 deviated from the accepted standard of care at the time for the average qualified obstetrics resident when Dr. Thibodeau failed to order and/or obtain a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, and when Dr. Thibodeau failed to reorder continuous fetal heart rate monitoring after it had been discontinued by Dr. Jawed.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, as a direct result of Dr. Thibodeau's deviations from the accepted standard, as outlined above, Ms. Lewis suffered intrauterine fetal demise of her daughter Serena. Had Dr. Thibodeau rendered

care in accordance with the accepted standard, she would have ordered and/or obtained a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, she would have reordered continuous fetal heart rate monitoring after it had been discontinued by Dr. Jawed, Ms. Lewis would have undergone continuous fetal heart rate monitoring and would have been remained in the hospital on 8/22/16, Ms. Lewis's child would have been delivered at the first sign of instability in the fetal heart rate pattern and prior to the evening hours of 8/22/16, and more likely than not, Serena would have survived and survived well.

LIABILITY OF DEFENDANT HEATHER SANKEY, M.D.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, the care and treatment rendered to Leanna Lewis and her daughter Serena by Heather Sankey, M.D. on 8/19/16 and 8/20/16 deviated from the accepted standard of care at the time for the average qualified obstetrician when Dr. Sankey failed to order and/or obtain a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, and when Dr. Sankey failed to reorder continuous fetal heart rate monitoring after it had been discontinued by Dr. Jawed.

In Dr. Holden's professional opinion, to a reasonable degree of medical certainty, as a direct result of Dr. Sankey's deviations from the accepted standard, as outlined above, Ms. Lewis suffered intrauterine fetal demise of her daughter Serena. Had Dr. Sankey rendered care in accordance with the accepted standard, she would have ordered and/or obtained a full maternal fetal medicine consultation after Ms. Lewis's abruption was diagnosed, she would have reordered continuous electronic fetal heart monitoring after it had been discontinued by Dr. Jawed, Ms. Lewis would have undergone continuous fetal heart rate monitoring and would have been remained in the hospital on 8/22/16, Ms. Lewis's child would have been delivered at the

first sign of instability in the fetal heart rate pattern and prior to the evening hours of 8/22/16, and more likely than not, Serena would have survived and survived well.

LIABILITY OF DEFENDANT WESSON WOMEN'S CLINIC

The plaintiffs allege that Wesson Women's Clinic, through its agents, servants, and employees, is vicariously liable in this matter. Determination of this matter of vicarious liability is beyond the scope of authorized inquiry of the medical malpractice tribunal. See DiGiovanni v. Latimer, 454 N.E.2d 483 (Mass. 1983); Flagg v. Scott, 397 N.E.2d 1300, 1301 (Mass. App. 1980). In other words, the Medical Malpractice Tribunal should only evaluate the medical aspects of the malpractice claim, and the issue of whether the defendant, Wesson Women's Clinic, is liable, is beyond the legislatively granted purview of the Medical Malpractice Tribunal.

ARGUMENT

Massachusetts General Laws, Chapter 231, §60B, explicitly sets forth both the scope and the limits of this tribunal's function in reviewing a claim of medical malpractice. In the first paragraph of §60B, the tribunal is instructed to review the Plaintiff's Offer of Proof to "[D]etermine if the evidence presented, if properly substantiated, is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result."

If the Plaintiff's Offer of Proof is sufficient to raise a legitimate question of liability, the plaintiff can proceed further without bond. If not, the plaintiff may pursue his or her claim only by posting bond of Six Thousand ($6,000.00) Dollars.

The Supreme Judicial Court held in Little v. Rosenthal, 382 N.E.2d 1037, 1041 (1978), that in evaluating evidence submitted by plaintiffs in a medical malpractice claim, "the tribunal's task should be compared . . . to a trial judge's function in ruling on a defendant's motion for a

directed verdict." Under this standard, a finding for the defendants in a medical malpractice case should be entered "only where, construing the evidence most favorable to the plaintiff, it is still insufficient to support a verdict in his favor." DeMarzo v. S. & P. Realty Corp., 306 N.E.2d 432, 435 (1974) (quoting Deleo v. Jefferson, 118 N.E.2d 875 (1954); Kelly v. Railway Exp. Agency, Inc., 52 N.E.2d 411 (1943)). For the purpose of such a motion, all evidence favorable to the plaintiff must be accepted as being true.

The plaintiff's evidence before this tribunal clearly would not entitle the defendants to a directed verdict.

The Plaintiff's Offer of Proof consists of the following documents:

A. BayState Medical Center Records (2/24/16-8/26/16)

B. Fetal Monitor Tapes and Correspondence with Wesson Women's Clinic

C. Expert Letter and Curriculum Vitae of Joshua Holden, M.D.

Certainly, if a jury was to accept the testimony of Dr. Holden as true, as the tribunal must for the purpose of this hearing, it would be warranted in returning a verdict for the plaintiff.

In order to establish liability in a medical malpractice case, the plaintiff must present evidence to establish: (1) the breach of duty owed by the defendant; and (2) a causal relationship between that breach and the damages allegedly suffered. Civitarese v. Gorney, 266 N.E.2d 668 (1971); Bernard v. Menicks, 163 N.E.2d 920 (1960). The Plaintiff's Offer of Proof, including the expert report of Dr. Holden, clearly satisfies both of these requirements.

First, in treating the plaintiff, the standard of care required of the defendant is to: "[E]xercise the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession." Brune v. Belinkoff, 235 N.E.2d 793, 798 (1968).

Dr. Holden's report states that the defendants did not meet the standard of care due to the plaintiff. It is the expert's professional opinion that the plaintiff's decedent sustained severe and permanent personal injuries and an otherwise premature and preventable death as a direct result of the defendants' negligence.

CONCLUSION

The standard that this tribunal is bound to follow requires that all rational inferences be resolved in the plaintiff's favor and that this tribunal accept as true, all evidence favorable to the plaintiff. Under this standard, the tribunal "must accept as true all evidence favorable to plaintiff, indeed, defendant, for this purpose, concedes the truth." 7 James W. Smith, Hiller B. Zobel, Rules Practice, §50.6 (2d ed. 2011).

Based upon the Offer of Proof submitted by the plaintiff and in light of the foregoing standards, the plaintiff respectfully submits that there is a legitimate question of liability presented and that the plaintiff should be allowed to proceed further without the imposition of a statutory bond.

Respectfully submitted,
The Plaintiff,
By her attorneys,

Andrew C. Meyer, Jr.

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