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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUFFOLK SUPERIOR COURT
CIVIL ACTION NO. 1984CV119

AMANDA DAVIS,
Plaintiff

vs.

ALICE MARK, MD, 2146499
PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, INC.,
JOSHUA M. MULARELLA, MD, 2141711
CAMBRIDGE PUBLIC HEALTH COMMISSION d/b/a CAMBRIDGE HEALTH ALLIANCE and CAMBRIDGE HEALTH ALLIANCE PHYSICIANS ORGANIZATION,
Defendants

RECEIVED
MAR 13 2019
SUPERIOR COURT-CIVIL
MICHAEL JOSEPH DONOVAN
CLERK/MAGISTRATE

PLAINTIFF'S OFFER OF PROOF
AS TO THE DEFENDANTS ALICE MARK, MD & JOSHUA MULARELLA, MD

The instant offer of proof is made in accordance with Massachusetts General Laws, Chapter 231, Section 60(B). Attached to this offer of proof, and made a part hereof, are the following Exhibits:

Exhibit 1 – Affidavit of plaintiff's expert, Makunda Abdul-Mbacke, MD, MPH (3 pages), reciting pertinent facts of case and providing opinions on deviations from the applicable standards of care, & *curriculum vitae*;

Exhibit 2 - Medical records from Planned Parenthood ("PP");

Exhibit 3 – Medical records from Cambridge Health Alliance ("CHA");

Exhibit 4 – Medical records from Massachusetts General Hospital ("MGH");

Exhibit 5 – Medical record from Duffy Health Center; and

Exhibit 6 – Affidavit of Amanda Davis.

This is a medical malpractice action arising out of the care and treatment of the plaintiff, Amanda Davis, by her physicians, the defendants Alice Mark, MD, and Joshua Mularella, MD.[1]

As confirmed in her MGH records (Ex. 4), about two (2) months following a February 4, 2016 abortion procedure by Dr. Mark at PP, Ms. Davis was determined to have significant retained products of conception ("RPOC"). What is more, due to the RPOC she had suffered debilitating pain and continuous heavy bleeding over the preceding weeks and months, up until her presentation at MGH. [Ex. 4]. The plaintiff contends, based upon expert medical testimony, that Dr. Mark negligently failed to confirm the removal of products of conception during and/or after the abortion procedure, and also negligently failed to follow-up with Ms. Davis in any way, and/or respond to her phone calls, and that Dr. Mularella negligently failed to properly diagnose Ms. Davis' condition upon her presentation at Cambridge Hospital on March 15, 2016.

As explained in further detail below, as a result of the defendants' negligence, Ms. Davis was caused to suffer pain and morbidity, unnecessary hospitalization and expense, and emotional injury.

[1] Both Dr. Mark and Dr. Mularella admit in their Answers to the Plaintiff's Complaint, Paragraphs 2 and 4 respectively, that they are licensed physicians practicing in Massachusetts.

STATEMENT OF FACTS

Ms. Davis presented at PP on February 4, 2016, for a first-trimester surgical abortion performed by Alice Mark, MD. [Ex. 2, PP records]. An initial transvaginal ultrasound ("US") performed that day confirmed a 10-week gestational age. [Ex. 2]. The PP intake form indicates that Ms. Davis' phone number was recorded correctly in the chart. [Ex. 2]. The procedure performed by Dr. Mark was by way of "paracervical suction" and was aided by "ultrasound guidance" due to "difficulty with dilation." [Ex. 2]. The procedure took about fifteen minutes and was reported as "complete". [Ex. 2]. The pregnancy was declared "terminated". [Ex. 2]. The PP records indicate only that Dr. Mark performed a "gross tissue exam" by viewing the removed contents before declaring the pregnancy terminated, and that nothing further was done to confirm the absence of RPOC. [Ex. 2].

There is no indication in Ms. Davis' PP chart that a post-procedure follow-up was scheduled for her with PP. [Ex. 2]. Ms. Davis affirms that PP verbally advised her on the day of her procedure that they would call her to schedule a follow-up appointment. [Ex. 6 – Davis Aff., ¶ 3]. However, she testifies that no one from PP ever did and there is nothing in the chart indicating otherwise. [Ex. s 2, 6]. Nor is there any record in the PP chart that Ms. Davis was specifically advised to contact PP in the event that she experienced significant bleeding and/or abdominal pain/cramping following the procedure, and/or that such symptoms could be indicative of RPOC. [Ex. 2]. Ms. Davis further testifies that she was never so advised by Dr. Mark or anyone else. [Ex. 6, Davis Aff., ¶ 5].

Following the February 4, 2016 procedure, Ms. Davis experienced debilitating abdominal pain and heavy bleeding. She called PP on several occasions to speak with Dr. Mark, but on each occasion she was directed to leave a voice message for someone to return her call. [Ex. 6,

Davis Aff. ¶ 6]. Neither Dr. Mark nor anyone else from PP ever returned her calls. [Ex. 6, Davis Aff. ¶¶ 7-9].

After about thirty (30) days of hearing nothing from PP, Ms. Davis presented to the CHA Cambridge Hospital Emergency Department on March 15, 2016, where she was seen by Joshua M. Mularella, MD. Ms. Davis presented with symptoms of "heavy vaginal bleeding" and "lower abdominal cramping". [Ex. 3]. Dr. Mularella confirmed vaginal bleeding and blood clots *via* a pelvic exam. [Ex. 3]. Dr. Mularella also noted that Ms. Davis was "status post abortion at Planned Parenthood last month." [Ex. 3]. Notwithstanding her symptoms, Dr. Mularella incorrectly diagnosed Ms. Davis with "dysfunctional uterine bleeding" "most likely due to the change in hormones following the abortion last month," and discharged her from the hospital. [Ex. 3].

Finally, on or about April 6, 2016, her symptoms/condition having not resolved, Ms. Davis presented at MGH where an immediate gynecological consultation advised the need for a pelvic US which revealed the RPOC. [Ex. 4, MGH records]. She was thereafter treated medically and discharged the following day. [Ex. 4]. In addition to the unnecessary pain, morbidity and expense suffered by Ms. Davis during the period from February 4, 2016 to April 6, 2016, Ms. Davis suffered, and continues to suffer, emotional injury. [Ex. 5, Duffy records]; see, also, Payton v. Abbot Labs, 386 Mass. 540 (1982) (Massachusetts recognizes a claim for negligent infliction of emotional distress against a physician); see, also, Ferrara v. Bernstein, 613 N.E.2d 542 (N.Y.2d 1993) (plaintiff's emotional distress resulted from negligently performed abortion).

EXPERT OPINION

As previously indicated, the plaintiff has retained Dr. Abdul-Mbacke as a medical expert in this case. Dr. Abdul-Mbacke is a graduate of both Yale University School of Medicine and Harvard University School of Public Health, as well as a board-certified practicing Obstetrician-Gynecologist ("OB/GYN") who has personally performed hundreds of first-trimester abortions. [Ex. 1, Aff. of Dr. Abdul-Mbacke & *curriculum vitae*]. She is familiar with the standards of care applicable in this case. As described in detail below, Dr. Abdul-Mbacke testifies that, to a reasonable degree of medical certainty, both Dr. Mark and Dr. Mularella deviated from applicable standards of medical care in their treatment of the plaintiff, causing her to unnecessarily suffer pain, bleeding, morbidity and hospitalization due to RPOC. [Ex. 1].

I. DEVIATIONS BY ALICE MARK, MD

A. Failure to Confirm Removal of RPOC

As related in her attached affidavit [Ex. 1], Dr. Abdul-Mbacke opines that, given the 10-week gestational age of the pregnancy in this case, the standard of medical care applicable to the average qualified OB/GYN, assuming PP to be a clinical setting where cost is a permitted consideration for reduced standards, required at the very least that Dr. Mark confirm the removal of all products of conception *via* an examination employing the flotation of tissue and back lighting following the abortion procedure (Ex. 1, ¶ 6). However, given the difficulty with dilation presented in Ms. Davis' case, and the necessity for ultrasound ("US") guidance during the procedure, and the risk of, e.g., a "false passage", the standard of medical care applicable to the average qualified OB/GYN required Dr. Mark to confirm removal of all products of

conception *via* US (already employed in the procedure), and/or other heightened diagnostic testing (¶ 7).

As previously related, the PP records indicate only that Dr. Mark performed a "gross tissue exam" by viewing the removed contents before declaring the pregnancy terminated, and that nothing further was done to confirm the absence of RPOC. Dr. Abdul-Mbacke opines that the fact that US was not employed, given the specific circumstances here, to confirm the absence of RPOC, is a deviation from the applicable standard of care (Ex. 1, ¶ 8). Moreover, given the reported use and availability of US during the procedure, there appears to be no compelling reason, medical or otherwise, for Dr. Mark's not utilizing US to confirm that all products of conception were removed and that the abortion procedure was successful (¶ 11).[2]

Dr. Abdul – Mbacke further opines that (¶ 10):

> "Had Dr. Mark not deviated from the applicable standards of medical care and confirmed the removal of products of conception *via* the available US, she would have likely discovered Ms. Davis' RPOC and been able to take remedial action, e.g., immediately performing a second procedure that same day or shortly thereafter, and/or treating Ms. Davis medically."

Dr. Abdul-Mbacke concludes (¶ 11) that "[a]s a result of Dr. Mark's deviations, Ms. Davis was caused to unnecessarily suffer significant pain, bleeding, morbidity and hospitalization due to RPOC." See, also, Shirk v. Kelsey, 617 N.E.2d 152 (Ill. App. 1993) (jury verdict for plaintiff sustained where evidence indicated that Dr. failed to utilize ultrasound or otherwise confirm that abortion was complete); see, also, generally Margaret Vroman, Medical

[2] There is similarly no express indication in the PP records that flotation of tissue/back lighting was employed (Ex. 1, ¶ 9). Dr. Abdul-Mbacke opines that such would be a deviation(s) from the general standard of care applicable to the average qualified OB/GYN in a clinical setting in a case without the incidents attendant to Ms. Davis' case (¶ 9).

Malpractice in Performance of Legal Abortion, 69 ALR4th 875, 880 (West Supp. 2017) ("courts have recognized potential liability where the abortion was performed incompletely and all of the products of conception were not removed").

B. Failure to Follow Up with Patient & Return Phone Calls

With respect to Dr. Mark's failure to follow-up with Ms. Davis, Dr. Abdul-Mbacke opines as follows:

> "At all times material hereto, the standard of medical care applicable to the average qualified OB/GYN required that the OB/GYN schedule a follow-up appointment with a patient following a first-trimester abortion within one to two weeks following the procedure, or at least contact the patient to ascertain her condition, and, of course, return her calls. Moreover, the standard of medical care applicable to the average qualified OB/GYN required that an OB/GYN examine a patient who presents post-procedure with heavy bleeding, cramping and/or abdominal pain for retained POC. [Ex. 1, ¶ 15].
>
> Considering Ms. Davis' representations, Dr. Mark deviated from the applicable standards of medical care in failing to cause a follow-up appointment to be scheduled for Ms. Davis, for failing to cause a follow up phone call to be placed with her within one to two weeks, and/or failing to cause Ms. Davis' calls to be returned. Had a follow-up examination been scheduled, or if Dr. Mark had caused Ms. Davis to be contacted by PP and/or her calls to be returned, Dr. Mark would have been advised that Ms. Davis was suffering symptoms consistent with RPOC and could have confirmed the diagnosis by way of exam and taken early remedial action." [Ex. 1, ¶ 16].

Dr. Abdul-Mbacke concludes that "[a]s a result of these additional deviation(s), Ms. Davis was caused to continue to suffer unnecessary pain, bleeding, morbidity, and hospitalization due to RPOC." [Ex. 1, ¶ 17].

II. DEVIATIONS BY DR. MULARELLA – FAILURE TO DIAGNOSE

Dr. Abdul-Mbacke further discusses Ms. Davis' presentation to Dr. Joshua Mularella at the CHA hospital on or about March 15, 2016, affirming that (¶¶ 19-21):

> "Given Ms. Davis' confirmed symptoms and known recent medical history, the differential diagnosis for her condition on her presentation at CHA Cambridge plainly included retained POC, and in fact suggested the same. The standard of medical care applicable to the average qualified emergency medicine physician called for confirmation/ruling out of this diagnosis by way of US, and/or ordering a gynecological consultation. According to its website (https://wwww.challiance.org/location/cambridge-hospital), the hospital has an US/Imaging department on its campus at 1493 Cambridge Street, and it offers on-site Gynecological and Women's Health services there.
>
> Dr. Mularella deviated from the applicable standard of care when he failed to order a US and/or a gynecological consultation, instead misdiagnosing Ms. Davis with "dysfunctional uterine bleeding" "most likely due to the change in hormones following the abortion last month," and discharging her from the hospital. The chart further reveals that Dr. Mularella specifically advised and educated Ms. Davis of this [wrong] diagnosis. Although he advised her to follow up with "Women's Health" (without setting an appointment), he should have confirmed her diagnosis by US or OB/GYN consultation prior to her discharge.
>
> As a result of Dr. Mularella' s deviations and misdiagnosis, Ms. Davis was caused to continue to suffer unnecessary pain, bleeding, morbidity, and hospitalization due to RPOC."

SUMMARY OF APPLICABLE LAW

In this proceeding before the Medical Malpractice Tribunal, the sufficiency of the plaintiff's offer of proof is viewed in the light most favorable to her. Blake v. Avedkian, 412 Mass. 481, 484 (1992), quoting Kobycinski v. Asercoff, 410 Mass. 410, 415 (1991). This standard is comparable to that of the directed verdict. Id. A "preliminary trial is not called for, nor is a consideration of 'evidence' in the full sense of the term," as long as there has been a

presentation of acceptable documentation. Kapp v. Ballantine, 380 Mass. 186, 190 n.4 (1980). Moreover, under G.L. c. 231, Section 60B, this tribunal should not appraise the weight and credibility of the evidence, and every allowance should be made for the fact that the tribunal hearing precedes full development of the case through discovery. Gugino v. Harvard Community Health Plan, 380 Mass. 464 (1980); see also Delicata v. Bourlesses, 9 Mass. App. Ct. 713 (1980); Blood v. Lea, 403 Mass. 430, 433 n.5 (1988).

Additionally, although the burden is on the plaintiff to show causation, it is "enough to adduce evidence that there is a greater likelihood or probability that the harm to the plaintiff flowed from the conduct for which the defendant was responsible." Held v. Bail, 28 Mass. App. Ct. 919, 921 (1989). The plaintiff is not required to exclude all evidence that the harm would not have occurred absent the physician's negligence. Joudrey v. Nashoba Community Hospital, 32 Mass. App. Ct. 974, 976 (1992); Samii v. Baystate Medical Center, Inc., 8 Mass. App. Ct. 911, 912 (1979). Nor is it necessary that the plaintiff explain how the harm should have been avoided. Mataitis v. Goar, 416 Mass. 325, 327 (1993); Heyman v. Knirk, 35 Mass. App. Ct. 946, 948 (1993). The issue is primarily whether the defendant's conduct "fell below the standard of good medical practice ...." Blood v. Lea, 403 Mass. at 433 n.5.

In presenting this offer of proof, the "plaintiff's expert need not state [her] opinion in formulaic terms. Moreover, the tribunal may not refuse to accept an expert's opinion unless the plaintiff's offer of proof is so deficient that as a matter of law it would be improper for any judge to admit it." Nickerson v. Lee, 42 Mass. App. Ct. 106, 111 (1997) (citing Rahilly v. North Adams Regional Hospital, 36 Mass. App. Ct. 714, 718 n. 6 (1994) and Kapp v. Ballantine, 380 Mass. at 192). What is more, the expert opinion(s) contained in the affidavit attach hereto (Ex. 1) are more than sufficient to pass muster. Kapp v. Ballantine, 380 Mass. at 192 ("the wrongs to

which language of the expert opinion letter speaks implicitly show how the defendant committed a breach of the standard of care owed to his patient"). This would be the case even if the professional specialties of the expert were not precisely and narrowly related to the medical issues of the case. Id. at 192 n.7 (1980); Samii v. Baystate Medical Center. Inc., 8 Mass. App. Ct. 911. In this instance, however, the plaintiff's expert is a board-certified OB/GYN who has personally performed hundreds of first-term abortions.

Lastly, although the plaintiff has also brought counts against Planned Parenthood League of Massachusetts, Inc., the Cambridge Public Health Commission d/b/a Cambridge Health Alliance, and Cambridge Health Alliance Physicians Organization, such vicarious liability claims are beyond the purview of this tribunal. DiGivoanni v. Latimer, 390 Mass. 365 (1983).

CONCLUSION

In light of the foregoing, the plaintiff respectfully submits that, pursuant to G.L. c. 231, § 60B, and based on the medical evidence and expert opinions supplied, she has presented a legitimate question of liability appropriate for judicial inquiry.

Respectfully submitted,
The Plaintiff,
By her attorney,

Filed: March 13, 2019

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CERTIFICATE OF SERVICE

I hereby certify that copies of this offer of poof, and the exhibits attached thereto, have been served upon the counsel of record for the defendants in this action, *via* first-class mail, this 13th day of March, 2019.

Røss E. Schreiber

AFFIDAVIT OF MAKUNDA ABDUL-MBACKE, MD, MPH

I, Makunda Abdul-Macke, MD, MPH, hereby declare and certify the following:

1. The following is a review of the care provided to Ms. Amanda Davis by Alice Mark, MD, at Planned Parenthood in Boston, Massachusetts, and by Joshua M. Mularella, MD, at CHA Cambridge Hospital, back in February and March of 2016. All opinions contained herein are expressed to a reasonable degree of medical certainty.

2. I am a graduate of Yale University School of Medicine and a board-certified practicing OB/GYN who has personally performed hundreds of first-trimester abortion procedures. A copy of my current *curriculum vitae* is attached hereto and incorporated herein by this reference.

3. I have reviewed medical records provided to me concerning the care of Ms. Davis at Planned Parenthood ("PP") in Boston, Massachusetts, on or about February 4, 2016, as well as records of her care thereafter at Cambridge Health Alliance Hospital(s) ("CHA") and at Massachusetts General Hospital ("MGH").

4. Based on my review of these records, Ms. Davis presented at PP on February 4, 2016, for a first-trimester surgical abortion performed by Alice Mark, MD. An initial transvaginal ultrasound performed that day confirmed a 10-week gestational age. The PP intake form indicates that Ms. Davis' phone number was recorded in the chart.

5. The procedure performed by Dr. Mark was by way of "paracervical suction" and was aided by "ultrasound guidance" due to "difficulty with dilation." The procedure took about fifteen minutes and was reported as "complete". The pregnancy was declared "terminated".

6. Given the 10-week gestational age of the pregnancy, the standard of medical care applicable to the average qualified Obstetrician-Gynecologist ("OB/GYN"), assuming a clinic setting where cost/accessibility is a permitted consideration, required at the very least that Dr. Mark confirm the removal of all products of conception *via* an examination employing the flotation of tissue and back lighting following the abortion procedure.

7. However, given the difficulty with dilation presented in Ms. Davis' case, and the necessity for ultrasound ("US") guidance during the procedure, and the risk of, e.g., a "false passage", the standard of medical care applicable to the average qualified OB/GYN required Dr. Mark to confirm removal of all products of conception in Ms. Davis' case *via* US (already employed in the procedure), and/or other heightened diagnostic testing.

8. The PP records here indicate that Dr. Mark only performed a "gross tissue exam" by viewing the removed contents before declaring the pregnancy terminated, and that nothing further was done to confirm the absence of retained products of conception ("RPOC"). The fact that US was not employed in Ms. Davis' case to confirm the absence of RPOC is a deviation from the applicable standard of medical care.

9. There is similarly no express indication in the PP records that flotation of tissue/back lighting was employed in connection with the gross tissue exam. Such would be a deviation(s) from the standard(s) of medical care applicable to the average qualified OB/GYN in a clinic setting where cost/accessibility is a permitted consideration, in a straightforward case without the incidents attendant to Ms. Davis' case.

10. As was confirmed at Ms. Davis' presentation at MGH about 2 months after the procedure at PP, the abortion procedure at PP was revealed to have allowed significant RPOC to remain. Had Dr. Mark not deviated from the applicable standards of medical care and confirmed the removal of products of conception *via* the available US, she would have likely discovered Ms. Davis' RPOC and been able to take remedial action, e.g., immediately performing a second procedure that same day or shortly thereafter, and/or treating Ms. Davis medically.

11. Moreover, given the reported use and availability of US during the procedure, there appears to be no compelling reason, medical or otherwise, for Dr. Mark's not utilizing US to confirm that all products of conception were removed and that the abortion procedure was successful.

12. As a result of Dr. Mark's deviations, Ms. Davis was caused to unnecessarily suffer significant pain, bleeding, morbidity and hospitalization due to RPOC.

13. In addition, there is no indication in Ms. Davis' PP chart that a post-procedure follow-up was scheduled for her with PP. My understanding is that Ms. Davis represents that PP verbally advised her on the day of her procedure that they would call her to schedule a follow-up appointment. It is my further understanding that the phone number that appears for Mr. Davis in the PP chart is her correct contact number. It is also my understanding that, according to Ms. Davis, neither Dr. Mark nor anyone else from PP ever called her after the procedure.

14. There is similarly no record in the PP chart that Ms. Davis was advised to contact PP in the event that she experienced significant bleeding and/or abdominal pain/cramping following the procedure, and/or that such symptoms could be indicative of RPOC. It is my understanding that Ms. Davis represents that she called PP several times after she had continuously suffered such symptoms during the two weeks immediately following the procedure, but that she was directed by the person(s) answering the phone at PP to leave a voicemail on each occasion, and that neither Dr. Mark nor anyone else at PP returned her calls.

15. At all times material hereto, the standard of medical care applicable to the average qualified OB/GYN required that the OB/GYN schedule a follow-up appointment with a patient following a first-trimester abortion within one to two weeks following the procedure, or at least contact the patient to ascertain her condition, and, of course, return her calls. Moreover, the standard of medical care applicable to the average qualified OB/GYN required that an OB/GYN examine a patient who presents post-procedure with heavy bleeding, cramping and/or abdominal pain for RPOC (i.e., *via* US).

16. Considering Ms. Davis' representations, Dr. Mark deviated from the applicable standards of medical care in failing to cause a follow-up appointment to be scheduled for Ms. Davis, for failing to cause a follow up phone call to be placed with her within one to two weeks, and/or failing to cause Ms. Davis' calls to be returned. Had a follow-up examination been scheduled, or if Dr. Mark had caused Ms. Davis to be contacted by PP and/or her calls to be returned, Dr. Mark would have been advised that Ms. Davis was suffering symptoms consistent with RPOC and could have confirmed the diagnosis by way of exam and taken early remedial action.

17. As a result of these additional deviation(s), Ms. Davis was caused to continue to unnecessarily suffer pain, bleeding, morbidity, and hospitalization due to RPOC.

18. My further understanding is that after about thirty (30) days of hearing nothing from PP, Ms. Davis presented to the CHA Cambridge Hospital Emergency Department on March 15, 2016, where she was seen by Joshua M. Mularella, MD. Ms. Davis presented with symptoms of "heavy vaginal bleeding" and "lower abdominal cramping". Dr. Mularella confirmed vaginal bleeding and blood clots *via* a pelvic exam. Dr. Mularella also noted that Ms. Davis was "status post abortion at Planned Parenthood last month."

19. Given Ms. Davis' confirmed symptoms and known recent medical history, the differential diagnosis for her condition on her presentation at CHA Cambridge plainly included RPOC, and in fact suggested the same. The standard of medical care applicable to the average qualified emergency medicine physician called for confirmation/ruling out of this diagnosis by way of US, and/or ordering a gynecological consultation. According to its website (https://wwww.challiance.org/location/ cambridge-hospital), the hospital has an US/Imaging department on its campus at 1493 Cambridge Street, and it offers on-site Gynecological and Women's Health services there.

20. Dr. Mularella deviated from the applicable standard of care when he failed to order a US and/or a gynecological consultation, instead misdiagnosing Ms. Davis with "dysfunctional uterine bleeding" "most likely due to the change in hormones following the abortion last month," and discharging her from the hospital. The chart further reveals that Dr. Mularella specifically advised and educated Ms. Davis of this [wrong] diagnosis. Although he advised her to follow up with "Women's Health" (without setting an appointment), he should have confirmed her diagnosis by US or OB/GYN consultation prior to her discharge.[1]

21. As a result of Dr. Mularella's deviations and misdiagnosis, Ms. Davis was caused to continue to suffer unnecessary pain, bleeding, morbidity, and hospitalization due to RPOC.

22. Finally, on or about April 4, 2016, her symptoms/condition having not resolved, Ms. Davis presented at MGH where a gynecological consultation advised the need for a pelvic US which revealed the RPOC. She was thereafter treated medically. In brief, the providers at MGH acted in accordance with the applicable standards of care as Dr. Mularella should have done in March.

23. I reserve the right to amend this affidavit should any further information become available.

Signed under the pains and penalties of perjury this 22 day of January, 2019.

Makunda Abdul-Mbacke, MD, MPH

[1]Ms. Davis' CHA chart indicates that she similarly presented at the CHA Cambridge ER a month later on 04/13/2016, with vaginal bleeding, and the ER physician in fact ordered an OB/GYN consultation before her discharge.

Makunda Abdul-Mbacke, MD, MPH

130 Chatmoss Crossing Way

Axton VA. 24054

Phone-276-224-5593

Place of Birth Detroit, Michigan

Education:

Yale University School of Medicine, New Haven, CT.
MD received May 1998

Harvard University School of Public Health, Boston, MA
Major: Public Management and Community Health
MPH received June 1998

Yale University, New Haven, CT.
Major: Biology
BS received May 1992

Postgraduate Training:

University of Pittsburgh/Magee-Women's Hospital, Pittsburgh, PA
Residency in Department of Obstetrics, Gynecology & Reproductive Sciences, 1998-2002

Hospital Appointments:

Martinsville Memorial Hospital, Martinsville, VA.
Attending Staff 2007-present

Morhead Memorial Hospital, Eden, NC
Attending Staff 2007-present

Our Lady of Lourdes, Camden, NJ.
Attending Staff 2005-2007

Capital Health System, Trenton, NJ.
Attending Staff 2002-2005

University Medical Center at Princeton, Princeton, NJ
Attending Staff 2002-2005

Employment:

Piedmont Preferred Women's Healthcare Associates,
Ridgeway, VA and Eden,NC
Obstetrics and Gynecology practice specializing in high risk pregnancy, urinary incontinence, and minimally invasive surgical approaches. Office

procedures include colposcopy, hysteroscopy, endometrial ablation, urodynamics, and leep. 2007-present

Lourdes Medical Associates, Camden, NJ.

Attending physician in high volume clinic practice, responsible for management of high-risk pregnancies, complex gynecologic cases, and resident and medical student education. 2005-2007

Delaware Valley Obstetrics, Gynecology and Infertility Group, P.C., Lawrenceville, NJ and Plainsboro, NJ. 2002-2005

Private Practice Obstetrician Gynecologist in high volume practice with two locations.

Certifications & Licensure

Medical License: North Carolina, Virginia, Pennsylvania, and New Jersey
Board Certified in Obstetrics and Gynecology 2004, Recertification in 2010, 2011
National Board of Medical Examiners 1998

Research

Researcher, 2001-2002
Magee-Women's Hospital Research Supervisor-Richard Guido, MD
Primary investigator in randomized controlled trial studying the use of vasopressin at the time of vaginal hysterectomy to decrease blood loss.

Researcher, 1995-1998
Yale University School of Medicine Research Supervisor-David L. Katz, MD, MPH
"Psychosocial factors associated with high-risk behavior among New Haven public school adolescents." Final Results presented in MD thesis, nominated for honors.

Policy Consultant Intern, Winter-Spring 1997
Boston Public Health Commission Research Supervisor-Lilliane Shirley
Conducted a strategic audit of the Healthy Baby/ Healthy Child program, including an analysis of the external healthcare environment, internal management recommendations, and the calculation of a cost-per-unit service.

Researcher, Spring 1997
Harvard School of Public Health Research Supervisor-Dan Moriarity, MBA
Developed, researched, and co-authored case report on the future of academic medical centers. Case report was published and integrated into the curriculum of the Harvard School of Public Health.

Research Assistant, Spring 1994

University of Medicine and Dentistry of New Jersey Research Supervisor-Michael Lewis, PhD
Conducted research on the response to stress of infants exposed to cocaine in utero.

Research Assistant, Summer 1994
United States Agency for International Development Research Supervisors-Charles Finch, MD and Mark Wilson, PhD
"Patient perceptions of modern and traditional approaches to healing in Fatick, Senegal." Results presented at the International Health Research Symposium.

Research Assistant, Winter 1992-Spring 1993
L'Institut Pasteur, Senegal Research Supervisor-Christopher Rogier, MD
Conducted intensive field research on the duration and predictive value of malarial symptoms n children.

Honors & Awards

Virginia Museum of Natural History
Board of Trustees, July 2015-June 2020
Appointed by Governor McAuliffe to Board

The Clinical Training Fellowship Program in Substance Abuse Research and Treatment, 1998

Pew Charitable Trust-Urban Health Initiative Grant, 1997

The Betty Ford Center Fellowship for Medical Students, 1996

National Medical Association Merit-Scholar, 1995

National Medical Fellowships/Bristol-Myers Squibb Academic Medicine Fellow, 1995

Society for Pediatric Research Fellowship, 1994

Yale Disadvantaged Merit Scholarship, 1993-1998

Roosevelt L. Thompson Prize, 1992
Awarded to a graduating senior for commitment to and capacity for public service.

Herbert and Jean Cahoon Prize, 1992

Awarded for commitment to community service.

Memberships

American College of Obstetrics and Gynecology-Fellow

Leadership & Community Service

Clinical Adjunct Assistant Professor in the Division of Obstetrics & Gynecology Liberty University College of Osteopathic Medicine March 2016-February 2018

Proctor and mentor students during their clinical rotation in Obstetrics and gynecology

Preceptor Duke University School of Nursing 2010-2014
Work with Nurse Practitioner students in their women's health clerkship.

New Jersey State Maternal Mortality Case Review Team 2004-2007
Appointed to serve as Public Health Physician on state committee that investigates and reviews all maternal deaths.

Association of Yale Alumni 2002-present
Assist in interviewing local applicants for undergraduate admission and speaking at college fairs.

Advisor to The Urban League of Pittsburgh 1999-2000
Assisted in developing health policy initiatives to improve the lives of African-Americans in Pittsburgh.

President and Delegate of American Medical Association (Yale Chapter) 1994-1995
Authored first AMA policy advocating syringe and needle exchange programs to decrease the transmission of HIV.

Student Representative 1994-1995
Served on committee that plans the Yale School of Medicine's Martin Luther King Jr. symposium

Coordinator for Adolescent Substance Abuse Prevention Program 1993-1994
Conducted intervention program with seventh graders at the Roberto Clemente Middle School.

Site Coordinator for Children's Defense Fund Summer 1992
Established a Freedom School in Hartford, Ct., responsibilities included recruiting children for this educational summer program, training teachers, and coordinating fundraising efforts.

Co-Chair of the New Haven AIDS Memorial Quilt Committee Summer 1991
Coordinated community outreach projects to build support and raise money to display the Quilt

Big Sibling 1988-2000
Serve as friend and mentor to children from a troubled family in New Haven

Lectures & Seminars

Talk Show Host-"The Doctor Is In"
Hosted a call in show featuring local doctors and highlighting public health concerns. 2007-2009

Panelist "Women, Race, Health and Public Policy"
Yale University Feb. 2003
Lecturer "Taking Care of Sisters"
A discussion of breast and cervical cancer screening
University Medical Center at Princeton Oct. 2003

Lecturer "What you need to know about urinary incontinence"
Monroe Senior Center March 2004

Lecturer "Taking Care of Sisters: Time to wake up: HIV/AIDS in our Community"
University Medical Center at Princeton May 2004

Lecturer "Speak up when your down: perinatal mood disorder, psychiatric illnesses during pregnancy/postpartum"
Involved in statewide campaign to educate healthcare providers on the prevalence and importance of screening and treating perinatal mood disorders. Oct. 2005-present

Essence magazine advisor
Invited to dialogue with the editorial board on the important health issues facing African-American women. June 2004

Specialties & Interest

Cancer Screening, Healthcare Disparities, Adolescent medicine, Sexually Transmitted Infections and Minimally Invasive Surgery.

References available upon request

2

Planned Parenthood
Care, No matter what

Planned Parenthood League of Massachusetts pplm.org - (800) 258-4448

PATIENT: Amanda Davis
DATE: 01/11/2018
PROVIDER: Planned Parenthood League Of Mass
PRACTICE: PPLM BOSTON
RE: Lab Results History

Lab Results History

All Lab Results

ORDER: Chlamydia/Gonorrhea Final Signed Off
CT/GC by the APTIMA Combo2 Assay 02/04/2016 13:30

Description	Result	Flags	Range
Chlamydia	Not Detected		Not Detected
GC	Not Detected		Not Detected
Source	Urine		

Comments
Chlamydia:
\X0D0A\
GC:
A positive or negative CT or NG Nucleic Acid Amplification Test (NAAT) result should be interpreted in conjunction with other laboratory and clinical data available to the clinician. A new sample is recommended for invalid or indeterminate results. If clinically indicated, further testing can be performed on a new sample. \X0D0A\\X0D0A\Test performed at:\X0D0A\PPLM Main Lab\X0D0A\1055 Commonwealth Ave\X0D0A\Boston MA. 02215

Provider: Planned Parenthood League Of Mass 01/11/2018 02:02 PM

Document generated by: 01/11/2018

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Care. No matter what.

Planned Parenthood League of Massachusetts pplm.org · (800) 258-4448

PATIENT:	Amanda Davis
DATE OF BIRTH / AGE:	06/28/1994 / 21 Years
MEDICAL RECORD:	426027
DATE:	02/04/2016 1:30 PM
VISIT TYPE:	First Trimester Abortion

Subjective

Pregnancy History

A 21 Years old G:1 P:0 female presents for First Trimester Abortion 10 weeks 0 days
First date of menstrual period by LMP: 11/23/2015,
Patient reported LMP date as approximate (month known) and
Estimated gestation age: 10 weeks 3 days by LMP

Symptoms Since LMP

-No spotting/bleeding since LMP

Intake

Day: (857)261-1884

Pregnancy History

Currently pregnant: yes
Vaginal deliveries: 0
Caesarean sections: 0
Abortions: 0
Miscarriages: 0
Ectopic (tubal) pregnancies: 0
Stillbirths: 0
Total number of times pregnant:: 1

Breastfeeding: Not breastfeeding
IUC in place: no
History of uterine abnormality: no
During your previous pregnancies, have you ever had any complications? no

Current Medications

Currently taking medications: no
Current medications: IBUPROFEN, AZITHROMYCIN

Family History

Has a parent, brother, or sister had a heart attack before age 55? yes - father, 45 yrs old, 5 yrs ago
Has a parent, brother, or sister had a stroke before age 55? yes - brother, 5 yrs ago
Has a parent, brother, or sister with a blood clots or a blood clotting disorder? No

Asthma History

Have you ever been told that you have asthma? yes
Have you had an asthma attack in the last 30 days? no
Have you been in the hospital for your asthma in the past 3 months? no
Has exercise or stress ever triggered an asthma attack? Yes
Have you taken Ibuprofen before? yes
Did Ibuprofen trigger an asthma attack? no
Do you have an inhaler? yes
Do you have your inhaler with you today? no
How often do you use your inhaler? more than twice a week

Past Medical History

Lung problems: No
Heart problems: No
Stroke: no
A blood clotting disorder or take blood thinners: no
Blood clots in legs of lungs: no
High blood pressure: no
Cancer: no
Diabetes: no
Epilepsy or seizures: no
Steroid medication in past year: No
Lupus: No
Migraine headaches: no
High cholesterol: no
Chronic anemia: no
Crohn's disease / ulcerative colitis: no
Liver disease: no
Gallbladder disease: no
Kidney disorder: no
Adrenal gland disorder: no
Thyroid disease: no
Have you been hospitalized in the past year? no
Are you planning any major surgery that will require long-term bed rest? no

Reference Lab History

Date and result of your last pap test? 08/04/2015 normal
Abnormal pap smear? no
Treatments /surgery to the cervix: no
Sexually transmitted diseases: no
HIV/AIDS: no

Social History

Tobacco Use:
Smoking status: Current every day smoker.
Encouraged smoking cessation

Date	Counseled By	Order	Status	Description/Code	Tobacco Cessation Information
02/04/2016	Dolly Shen	Tobacco cessation counseling	completed		Smoking cessation education

Do you drink alcohol? no
Have you used street drugs in the last 24 hours? - cocaine, opiates, last use 1 yr ago
Are you now or have you ever been an IV drug user? yes
Any difficulty when having blood drawn/IV placed? no

Surgical Eligibility
NPO status per protocol
Do you have an escort: yes
Escort in building: yes
No history of problems with sedation/anesthesia
Do you have a tongue ring? no
Is there anything else we should know about you? no

Birth Control
Desired birth control method: none, other reason
Additional Problems/Concerns: Will see own doctor for BC, no partner currently

Assessment of Decision Making and Emotional Support

How is the client feeling about her decision?

Confident and clear about decision to have the abortion

Support System

- Client support system - friend supports patient in her decision

Client Questions/Answers

- Client demonstrates understanding and is prepared for the abortion
- All questions answered

Intake performed by: Dolly Shen
RN review by: Amelia Coyle RN
Clinician review by: Alice Mark MD

Objective

Vital Signs

Time	BP	Ht in	Wt lb	Temp	Pulse	Resp	BMI	Rhythm
2:06 PM	108/59	61.75	101.00	98.00	62	16	18.62	

Office Labs (completed this visit)

Lab Study	Results	Comments
Hemoglobin	12.50 gm/dL	
Rh Factor	Positive	

Pelvic Ultrasound

Order	Results	Comments	Complete Date	Complete Time	Completed By
Transvaginal Ultrasound	Probe: Transvaginal Ultrasound. Findings: yolk		02/04/2016		Lyna Tan HCA

sac, cardiac motion, fetal pole, single. Gestational age: 10 weeks.

Primary purpose: Pre-op TAB
Patient informed that US is for gestational dating only
No history of scarred uterus
Patient does not desire to see ultrasound image
Patient does not desire to know if multiple gestations are identified
Exam satisfactory
Patient informed of US findings

Clinical Impression: Definite intrauterine pregnancy

Fetus Measurements

Date	Fetus	CRL	HC	BPD	FL	AC	HL	Wd	Dp	GA Wks	GA Days
02/04/2016										10	0

Physical Exam
GU Vagina:
Comments: Normal
GU Cervix:
Comments: Normal
GU Uterus:
Uterine Size: 9-10 weeks Uterine orientation: Ant

Cervical Prep
0
0

Assessment

Dx Code	Dx Description	Chronic?	Note
Z3A.10	10 weeks gestation of pregnancy	N	
Z11.3	Encntr screen for infections w sexl mode of transmiss	N	
Z33.2	Encounter for elective termination of pregnancy	N	

Eligibility
Patient is eligible for surgical abortion procedure

IVCS
Malampati score: class 1
ASA PS Classification: 2.) Healthy Pregnancy and/or mild systemic disease
Patient has asthma: yes

Lungs CTA, no wheezing
Heart normal
Patient is eligible for IVCS
IV sedation - moderate
IV Location: left antecubital
IV inserted by: Julie Brodeur RN
Catheter: angiocath 20g.
IV assistant: Julie Brodeur RN

Anesthesia

Date & Time	O2	Fent	Versed	Meth	Pit	Atro	Nalo	Narc
02/04/2016 3:04 PM								
02/04/2016 3:06 PM		100mcg	2mg					
02/04/2016 3:14 PM			1mg					
02/04/2016 3:19 PM								

Procedure Details

Start Time: 3:06 PM
End Time: 3:20 PM
Paracervical Block with sodium bicarb 1% Lidocaine at multiple sites: 20ml.
Cervix dilated to 27 Pratt
9 mm canula used
Electromechanical suction
EBL: < 25cc
Ultrasound guidence reason: difficulty w/ dilation

Impression

Procedure complete

Gross Tissue Exam

Decidua
Villi
Sac
Placenta
Fetal Parts
Evaluation of products of conception: 10 weeks

Plan

Discharge patient from recovery room per protocol
Co-signature for verbal order: Alice Mark MD

IUC Insertion

Assessment

Not pregnant status determined by
- Pregnancy terminated today

Plan

Instructions/Counseling

- Patient informed of US findings

Implant Insertion

PLAN

Meds Prescribed during this visit

Drug Name	Dose	Qty	Sig	Refills
AZITHROMYCIN	500 mg	1	1 tab PO administered in clinic	0
IBUPROFEN	600 mg	1	1 tab PO administered to pt in clinic	0

Recovery Room
Recovery intake time: 3:26 PM.

Recovery Room Vitals

Time	BP	Pulse	Resp	Pain	O2 Sat	Bleeding	Aldrete	Taken By	Comments
3:26 PM	116/76	85	16	7/10	97		10	Amanda King RN	
3:42 PM	106/62	75	16	4/10	98		10	Amanda King RN	
3:47 PM	119/53	63	16	3/10		light-2	10	Amanda King RN	

Aldrete Details

Vitals Time	Activity	Circulation	LOC	O2%	Respiration	Score
3:26 PM	2 - Moves all extremities voluntarily/on command	2 - Is 20 mm Hg > preanesthetic level	2 - Is fully awake	2 - Has level >90% when breathing room air	2 - Breathes deeply and coughs freely	10
3:42 PM	2 - Moves all extremities voluntarily/on command	2 - Is 20 mm Hg > preanesthetic level	2 - Is fully awake	2 - Has level >90% when breathing room air	2 - Breathes deeply and coughs freely	10
3:47 PM	2 - Moves all extremities voluntarily/on command	2 - Is 20 mm Hg > preanesthetic level	2 - Is fully awake	2 - Has level >90% when breathing room air	2 - Breathes deeply and coughs freely	10

Recovery Room Discharge
Bleeding: Light
IV removed at 3:51 PM.
Patient condition: Stable and ambulatory
Verbalizes understanding of discharge instructions and medications.
Comments: planning copper IUC
Time Discharged: at 3:51 PM
Discharge RN: Amanda King RN

Medications (dispensed/written/discussed)

Medication Name	Dose	Quantity	Sig/Dose	Refills
azithromycin 500 mg tablet	500 mg	1	1 tab PO administered in clinic	0
ibuprofen 600 mg tablet	600 mg	1	1 tab PO administered to pt in clinic	0

Birth Control Method at end of visit: condoms, male.

Reference Labs

Status	Description

Ordered Chlamydia/Gonorrhea

Education Materials

CI Abortion Options
CI What to Expect after In-Clinic Abortion or Suction Procedure
CI What to Expect after Sedation
CIIC In Clinic Abortion
CIIC Moderate Sedation
How Much Am I Bleeding
MA DPH 1st Trimester Surgical Abortion Consent
Request for Medical Services
Reproductive Coercion Safety Card
Request for Surgery or Special Procedures

Surgeon: Alice Mark MD

Document generated by: Amanda King RN

Encounter location recorded at:
PPLM BOSTON
1055 Commonwealth Ave
Boston, MA 02215-1001
Proprietary and Confidential
Version 5.9.1.3 EHR (5.8/8.3)

Patient Education (continued)

Transcribed Date/Time: 01/06/17 1356 by PTRANDR
Printed Date/Time:
Report #: 0106-0298
Addendum Transcribed Date/Time: /
Addendum Signed Date/Time
CC:

Encounter Number

Meditech Account #
800227571

ED Provider Notes by Joshua M. Mularella at 3/15/2016 5:07 AM

Author: Joshua M. Mularella | Service: Emergency | Author Type: Physician
Filed: 3/15/2016 5:11 AM | Creation Time: 3/15/2016 5:07 AM | Status: Signed
Editor: Joshua M. Mularella (Physician)

CHA Emergency Medicine Attending Note

History of Present Illness:

Patient was seen during downtime, referred to scan her charts for more information such as vital signs.

Amanda Davis is a 21 year old G1P0010 status post abortion at Planned Parenthood last month at a gestational age around 7 weeks, who came to the ED with heavy vaginal bleeding and some lower abdominal cramping is getting worse throughout the day. She has gone through 3-4 tampons. Positive blood clots. She is not currently on birth control.

She denies any chest pain, shortness of breath, lightheadedness, syncope, or dysuria. Her pain now is currently 7 out of 10. She took some Motrin earlier today.

Amanda Davis
MRN: 0000336643
PCP: Ira Mintzer, MD

Arrived to the ED by: Self

History provided by: the patient
Other: Reviewed nursing notes

Review of Systems:
As per HPI. All other systems were reviewed and are negative

Past Medical Hx:

Past Medical History

Palpitations		06/24/2004
Comment:	Referred to pedi card but dnk'd 6/21/04	
Chicken pox		3yo
Asthma		
Bell's palsy		11/13/2007
Asthma		

Meds:

No current facility-administered medications for this encounter.
No current outpatient prescriptions on file.

Patient Education (continued)

ED Provider Notes by Joshua M. Mulatella at 3/15/2016 5:07 AM (continued)

NO KNOWN PROBLEMS
PID (acute pelvic inflammatory disease) 9/24/2012
Comment: 9/12- chlamydia. Treated.

Past Surgical Hx:

Past Surgical History
TONSILLECTOMY ONE-HALF AGE 12/>

Allergies:
Review of Patient's Allergies indicates:
Penicillins — Hives, Swelling

Social Hx:

Smoking status:	Current Every Day Smoker	1.00 Packs/Day
Types:	Cigarettes	
Smokeless tobacco:	Never Used	
Alcohol Use:	No	

Immunizations:
Immunization History

Administered	Date(s) Administered
• DTP	10/05/1994, 01/12/1995, 04/28/1995
• DTaP age 2 MO to <7 Yrs	12/13/1997, 03/04/1999
• Depo Provera	06/02/2010, 08/26/2010, 11/18/2010, 02/11/2011
• HIB 4 Dose Schedule	10/05/1994, 01/12/1995, 04/28/1995, 12/03/1997
• Hep B Pedi/Adol 3 Dose Less than age 20	05/30/1994, 08/30/1994, 03/04/1999
• IPV	03/04/1999
• MMR	09/01/1995, 03/04/1999
• OPV	10/05/1994, 01/12/1995, 04/28/1995, 12/03/1997
• Td	09/06/2005

Physical Examination:

ED Triage Vitals		
Enc Vitals Group		
BP	--	
Pulse	--	
Resp	--	
Temp	--	

Patient Education (continued)

ED Provider Notes by Joshua M. Mularella at 3/15/2016 5:07 AM (continued)

Temp src	--	
SpO2	--	
Weight	--	
Height	--	
Head Cir	--	
Peak Flow	--	
Pain Score	--	
Pain Loc	--	
Pain Edu?	--	
Excl. in GC?	--	

General: Patient is in minimal distress, cooperative with exam

Eyes: PERRL, no conjunctival pallor.

Head, ears, nose, and throat: Normocephalic and atraumatic. Moist mucous membranes, Normal phonation.

Respiratory/chest: No respiratory distress, speaks in full sentences. Breath sounds are clear and equal bilaterally.

Cardiovascular: Heart rate is regular in rate and rhythm. Pulses are 2+ and symmetric.

Gastrointestinal: Abdomen is soft, no tenderness or distension.

GU: Pelvic exam shows moderate vaginal bleeding protruding through the cervical os with a blood clots in the os, no tissue. No CMT. Os is closed.

Musculoskeletal: Normal muscle tone, moving all extremities, normal gait.

Skin: Warm and well perfused, no rashes or erythema/ecchymosis.

Neurologic: Alert and oriented x 3, no focal deficits.

Medications Given in the ED:	Radiology and ECG:
Medications - No data to display.	No orders to display
Lab Results:	**Vital Signs:**
Urine pregnancy test is negative	There were no vitals filed for this visit.

ED Course and Medical Decision Making:

Patient Education (continued)

ED Provider Notes by Joshua M. Mularella at 3/15/2016 5:07 AM (continued)

Patient reassured, most likely due to the change in hormones following the abortion last month. She is not currently pregnant. Reassured, told to follow-up at the woman's Center here at bridge health Alliance.

Patient/family educated on their diagnosis, she verbalizes understanding and agrees with plan of care. She was told to follow up with her primary care physician. I reviewed with her reasons to return to the Emergency Department, all questions were answered.

ED Disposition:

Impression(s):
Dysfunctional uterine bleeding

Disposition: Discharged home

Signed by Dr. Joshua M. Mularella, DO
Emergency Medicine Attending
Cambridge Health Alliance

Electronically signed by Joshua M. Mularella, DO on 3/15/2016 5:11 AM

Encounter Number

Meditech Account #
70649807.8

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM

Author: Karen T Haessler | Service: Emergency | Author Type: Physician Assistant
Filed: 4/14/2016 12:49 PM | Creation Time: 4/13/2016 3:15 PM | Status: Attested
Editor: Karen T Haessler (Physician Assistant) | Cosigner: Brian P Lyngaas, MD at 4/22/2016 10:13 AM

Attestation signed by Brian P Lyngaas, MD at 4/22/2016 10:13 AM

I saw this patient with the ED PA. She is 21-year-old female who presents with vaginal bleeding that has been gone going for several weeks. On exam her abdomen is benign. Hemoglobin shows a drop from 11.8-8.2. Gynecology was consulted. They recommend outpatient follow-up as waiting is now minimal and vital signs are stable.

EMERGENCY DEPARTMENT PHYSICIAN ASSISTANT NOTE

The ED nursing record was reviewed.
The prior medical records as available electronically through Epic were reviewed.
The mode of arrival was Self on 4/13/2016 2:51 PM.

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

This patient was seen with Emergency Department attending physician Dr.Lyngaas

CHIEF COMPLAINT

Patient presents with:
VERIFY CHIEF COMPLAINT: VAG BLEED EXPECT

HPI

Amanda Davis is a 21 year old female who reports today with vaginal bleeding since February. She states she had an abortion in February and had been bleeding ever since. She presented to MGH 1 week ago with severe abdominal cramping and bleeding and was found to have some retained fetal parts. They gave her misoprostol. She had cramping the next day and the expulsion of some clots and has been bleeding since. This morning she reports severe cramping and expelling large amounts of clots as well as going through one large hospital pad per hour. She reports on her way here the bleeding slowed down.

Pt denies HA, fever, dizziness, sore throat, stiff neck, cough, SOB, CP, Abd pain, N/V/D/C, changes in urination, urinary discharge, changes in stool, black/tarry stool, numbness, weakness, or new lower extremity edema.

PAST MEDICAL HISTORY

Past Medical History

Palpitations	06/24/2004
Comment: Referred to pedi card but dnk'd 6/21/04	
Chicken pox	3yo
Asthma	
Bell's palsy	11/13/2007
Asthma	
NO KNOWN PROBLEMS	
PID (acute pelvic inflammatory disease)	9/24/2012
Comment: 9/12- chlamydia, Treated.	

PROBLEM LIST

Patient Active Problem List:
- Asthma, mild intermittent
- PTSD (Post-Traumatic Stress Disorder)
- Depressive disorder
- Contraception
- Alcohol intoxication
- Spondylisthesis
- Anxiety
- Vaccination not carried out for other reason

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

Heartburn
Current smoker
Opioid dependence
Palpitations
Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
Breast cyst
Hepatitis C carrier

SURGICAL HISTORY

Past Surgical History
TONSILLECTOMY ONE-HALF AGE
12/>

CURRENT MEDICATIONS

No current outpatient prescriptions on file.

ALLERGIES

Review of Patient's Allergies indicates:
Penicillins Hives, Swelling

FAMILY HISTORY

Family History
Cancer - Lung Father
Gyn Sister
Comment: endometriosis

SOCIAL HISTORY

Social History
Marital Status: Single Spouse Name:
Years of Education: Number of children:

Social History Main Topics
Smoking Status: Current Every Day Smoker Packs/Day: 1.00 Years:
Types: Cigarettes
Smokeless Status: Never Used
Alcohol Use: No
Drug Use: No
Sexual Activity: Yes Partners with: Male

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

Birth Control/Protection: Contraceptive Patch

REVIEW OF SYSTEMS

The pertinent positives are reviewed in the HPI above. All other systems were reviewed and are negative.

PHYSICAL EXAM

Vital Signs: BP 98/45 mmHg | Pulse 82 | Temp(Src) 98.2 °F | Resp 18 | SpO2 100% | LMP 11/25/2015 (LMP Unknown) | Breastfeeding? Unknown

Constitutional: Well-developed, Well-nourished, Non-toxic appearance. Speaking full sentences.

Distress: moderate

HEAD: Without signs of trauma. No soft tissue swelling or tenderness.

NECK: No C-spine tenderness; No tenderness, swelling, or step-off. Full range of motion without discomfort. Supple with no meningismus.

EYES: Pupils are equal and reactive. Extraocular movements are intact. No scleral icterus.

ENT: Clear. Mucus membranes are moist.

LYMPHATICS: No palpable cervical lymphadenopathy.

CV: RRR, No MRG, radial pulses 2+ B/L

PULMONARY: CTAB, No WRR, No stridor, accessory muscle use or tripoding

ABDOMINAL: Soft, NTND, No rebound, guarding or masses, No murphy's, mobumey's or rovsing's.

GENITOURINARY: No CVA tenderness.

Pelvic: Performed with chaperone
External: Mons pubis, labia, clitoris, urethral meatus, introitus, perineum and anus w/o erythema, edema, ulcerations, lesions, nodules, d/c or odor;
Vagina: mucosa pink w/o ulcers or lesions, scant blood in the vaginal vault.
Cervix: centered, pink; OS null parious & w/o ulcers, nodules, d/c or odor. No frank bleeding from os.
Bimanual: OS closed; adnexae w/o masses, NT B/L; No cervical motion tenderness

MUSCULOSKELETAL : Moving all 4 extremities. Ambulatory w/ a steady gait.

SKIN: Warm and dry, no rash . The skin color and turgor are normal.

NEUROLOGIC: Normal mental status. Cranial nerves, motor, sensor, DTRs, and cerebellum are grossly intact.

PSYCHIATRIC: Normal affect

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

RESULTS

Results for orders placed or performed during the hospital encounter of 04/13/16 (from the past 24 hour(s))

CBC+Plt with Diff

Collection Time: 04/13/16 3:27 PM

Result	Value
WHITE BLOOD CELL COUNT	5.9
RED BLOOD CELL COUNT	2.61 (L)
HEMOGLOBIN	8.2 (L)
HEMATOCRIT	23.7 (L)
MEAN CORPUSCULAR VOL	90.8
MEAN CORPUSCULAR HGB	31.4
MEAN CORP HGB CONC	34.6
RBC DISTRIBUTION WIDTH STD DEV	39.8
RBC DISTRIBUTION WIDTH	12.2
PLATELET COUNT	336
MEAN PLATELET VOLUME	9.6
NEUTROPHIL %	40.0
IMMATURE GRANULOCYTE %	0.2
LYMPHOCYTE %	51.0
MONOCYTE %	6.6
EOSINOPHIL %	2.0
BASOPHIL %	0.2
ABSOLUTE NEUTROPHIL COUNT	2.4
ABSOLUTE IMM GRAN COUNT	0.01
ABSOLUTE LYMPH COUNT	3.0
ABSOLUTE MONO COUNT	0.4
ABSOLUTE EOSINOPHIL COUNT	0.1
ABSOLUTE BASO COUNT	0.0
Narrative	
Current Anticoagulant->None	

Basic Metabolic Panel

Collection Time: 04/13/16 3:27 PM

Result	Value
SODIUM	141
POTASSIUM	4.1
CHLORIDE	105
CARBON DIOXIDE	29
ANION GAP	7
CALCIUM	8.3 (L)
Glucose Random	97
BUN (UREA NITROGEN)	13
CREATININE	0.8
ESTIMATED GLOMERULAR FILT RATE	> 60

Prothrombin Time

Collection Time: 04/13/16 3:27 PM

Result	Value
PROTHROMBIN TIME	11.1
INR	1.0
Narrative	

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

Current Anticoagulant->None

Hepatic Function Panel

Collection Time: 04/13/16 3:27 PM

Result	Value
TOTAL PROTEIN	6.4
ALBUMIN	3.4
BILIRUBIN TOTAL	0.3
BILIRUBIN DIRECT	0.1
INDIRECT BILIRUBIN	0.2
ALKALINE PHOSPHATASE	73
ASPARTATE AMINOTRANSFERASE	21
ALANINE AMINOTRANSFERASE	24

Type and Screen

Collection Time: 04/13/16 3:30 PM

Result	Value
SAMPLE EXPIRATION DATE:	04/16/16 1530
ABO/RH INTERPRETATION	O POS
ANTIBODY SCREEN SOLID PHASE	NEGATIVE

Narrative

Pt been pregnant/transfused in the previous 3 months?->No

Pt, been preg/transfused in previous 3 months?^N

RADIOLOGY

EKG:

PROCEDURES

MEDICATIONS ADMINISTERED ON THIS VISIT

Medication Orders Placed This Encounter

sodium chloride 0.9 % IV bolus 2,000 mL

Sig:

ED COURSE & MEDICAL DECISION MAKING

I reviewed the patient's past medical history/problem list, past surgical history, medication list, social history and allergies.

Arrival: Pt arrived in stable condition and required no immediate interventions.

Patient Education (continued)

ED Provider Notes by Karen T Haessler at 4/13/2016 3:15 PM (continued)

ED Decision Making & Course: Pt is a 21 year old female with one week of heavy vaginal bleeding with clots. One week ago she was given misoprostol at Mass General for retained products of conception. She has been bleeding ever since with passing of multiple large clots this morning. Last week and Mass General her hemoglobin was 11.8. Today it is 8.2.
Given her vital signs stable, and she is asymptomatic, it was felt that a transfusion was not necessary at this point. Pelvic exam revealed scant clots and blood in her vaginal vault but her os was closed and there is no frank bleeding.
She also reports that she just changed her pad and her bleeding is minimal at this point.
ObGyn was consulted and given that the bleeding has largely stopped, they advised she follow up with them in one week.
Pt remained hemodynamically stable during their stay in the emergency department.

Follow Up: With ObGyn in one week

Electronically signed by Brian P. Lyngaas, MD on 4/22/2016 10:13 AM

Encounter Number

Meditech Account #
706551470

Progress Notes by Kathleen Harney at 4/21/2016 12:17 PM

Author: Kathleen Harney | Service: (none) | Author Type: Physician
Filed: 4/22/2016 6:17 PM | Encounter Date: 4/21/2016 12:17 PM | Status: Signed
Editor: Kathleen Harney (Physician)

21 yo G1P0
S/p TAB at PP on 2/4/16 under sedation
No antibiotics. Reports uncomplicated at the time.

She subsequently bled heavily two weeks post TAB. Went to Whidden ED, 3/15/16. ED provider felt to be a heavy menses after TAB, no further studies done, and patient was discharged home.

She was then seen at MGH 4/6/16 with persistent bleeding for > 1month. Had ultrasound revealing retained POC. Took misoprostil. Had regular bleeding.

Then seen in Cambridge ED 4/13/16 for large blood clots. At the time she was seen, no bleeding

Patient Education (continued)

Progress Notes by Kathleen Harney at 4/21/2016 12:17 PM (continued)

was noted
Hct 23.7. Discharged home with instructions for iron supplementation and f/up CBC.

Patient Active Problem List:
Asthma, mild intermittent
PTSD (Post-Traumatic Stress Disorder)
Depressive disorder
Contraception
Alcohol intoxication
Spondylisthesis
Anxiety
Vaccination not carried out for other reason
Heartburn
Current smoker
Opioid dependence
Palpitations
Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
Breast cyst
Hepatitis C carrier

Past Medical History

Palpitations	06/24/2004
Comment: Referred to pedi card but dnk'd 6/21/04	
Chicken pox	3yo
Asthma	
Bell's palsy	11/13/2007
Asthma	
NO KNOWN PROBLEMS	
PID (acute pelvic inflammatory disease)	9/24/2012
Comment: 9/12- chlamydia, Treated.	

PSH
Tonsillectomy
TAB

Meds:
Iron daily
Ritalin 10 mg BID
Gabapentin 300mg TID
Clonidine 0.1mg BID

Patient Education (continued)

Progress Notes by Kathleen Harney at 4/21/2016 12:17 PM (continued)

SH
Lives with Mom
H/o street opiod use. States she is not interested in suboxone/Methadone, which she has used in the past.

Exam
Appears well
BP 101/59 mmHg | Temp(Src) 97.8 °F (36.6 °C) | Wt:43.999 kg (97 lb) | LMP 11/25/2015 (LMP Unknown) | Breastfeeding? No
Abdomen soft, thin, nontender
Pelvic
External genitalia clear
Cx/vag no blood
Bimanual small axial nontender uterus, no masses or tenderness

UCG negative

A/P 21yo s/p TAB 2/2016 complicated by retained POC, s/p misoprostil. Bleeding now resolved. Significant anemia.
Plan repeat CBC today.
Continue iron supplementation
Counseled on birth control options. Interested in Nexplanon.
F/up for insertion.
Instructed to call for heavy or prolonged bleeding or fever.
Check repeat CBC today.
Again discussed h/o opioid abuse. States she is avoiding friends who use drugs. Declines referral to addiction program.
States she is seeking a new PCP in Somerville

Kate Harney,MD

4

MASSACHUSETTS GENERAL HOSPITAL

MEDICAL RECORD CERTIFICATION
Pursuant to M.G.L. C. 233 S. 79G

I hereby certify that to the best of my knowledge, the enclosed is a true and complete copy of the medical record of the Massachusetts General Hospital (less flow sheets), as of this date, concerning the treatment of:

DAVIS, AMANDA
MRN: 3357879
DOB: 06/28/1994

Dates of Treatment: 02/04/2016 – 08/30/2017

Signed under the pains and penalties of perjury this day:

August 30, 2017

I agree that a digital reproduction of this signed certification be accepted with the same authority as the original.

For questions regarding this medical record copy please contact Bactes Imaging @ 978-922-0016

Health Information Services
121 Innerbelt Rd.
Somerville, MA 02143

Notes

ED Notes

Author: Michael V Grasso, RN | Service: Emergency Medicine | Author Type: Registered Nurse
Filed: 4/6/2016 2:56 PM | Date of Service: 4/6/2016 2:54 PM | Note Type: ED Notes
Status: Signed | Editor: Michael V Grasso, RN (Registered Nurse)

ED Rapid Assessment Nursing Note

S: Pt with vaginal bleeding s/p abotion February 4th

O: Pt on arrival curled up in ball with pained expression

A: Vaginal bleed, abd pain, back pain

P:EM

Electronically signed by Michael V Grasso, RN at 4/6/2016 2:56 PM

Notes

ED Provider Notes

Author: Daniel J Corrigan, MD | Service: Emergency Medicine | Author Type: Resident
Filed: 4/6/2016 6:13 PM | Date of Service: 4/6/2016 3:54 PM | Note Type: ED Provider Notes
Status: Signed | Editor: Daniel J Corrigan, MD (Resident)

EMERGENCY DEPARTMENT NOTE
BRIGHAM AND WOMEN'S HOSPITAL

Chief Complaint

Chief Complaint

Patient presents with

- Vaginal Bleeding
- Back Pain
- Abdominal Pain

HPI

Amanda E Davis is a 21 y.o. female with history of D&C on Feb 4th at planned parenthood, no presenting with vaginal bleeding for the past 2 weeks and now pelvic pain for the past 2 days. She notes passage of clots from the vagina, with intermittent diffuse weakness. The pain started in the bilateral pelvic region approximately 2 days ago, comes in waves and is sharp/ stabbing in nature. She denies fevers, chills, chest pain, SOB, vomiting, diarrhea, or dysuria.

REVIEW OF SYSTEMS

Review of Systems
Constitutional: Negative for fever, chills, activity change, appetite change and fatigue.

ED Provider Notes (continued)

Eyes: Negative for visual disturbance.
Respiratory: Negative for cough, chest tightness, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Positive for nausea and abdominal pain. Negative for vomiting and diarrhea.
Genitourinary: Positive for vaginal bleeding, vaginal pain and pelvic pain. Negative for dysuria, urgency, frequency, hematuria and vaginal discharge.
Musculoskeletal: Negative for myalgias, back pain, neck pain and neck stiffness.
Neurological: Negative for dizziness, speech difficulty, weakness and headaches.

PAST MEDICAL HISTORY

Past Medical History

Diagnosis	Date
• Asthma	

Patient Active Problem List

Diagnosis
• Vaginal bleeding
• Back pain

PAST SURGICAL HISTORY

No past surgical history on file.

FAMILY HISTORY

No family history on file.

SOCIAL HISTORY

History

Substance Use Topics	
• Smoking status:	Not on file
• Smokeless tobacco:	Not on file
• Alcohol Use:	No

HOME MEDICATIONS

Patient's Medications

New Prescriptions	
No medications on file	
Previous Medications	
CLONIDINE HCL (CATAPRES) 0.1 MG TABLET	
GABAPENTIN (NEURONTIN) 300 MG CAPSULE	Take 300 mg by mouth.
METHYLPHENIDATE (RITALIN) 10 MG TABLET	Take 10 mg by mouth.
Modified Medications	
No medications on file	
Discontinued Medications	
No medications on file	

ALLERGIES

Allergies as of 04/06/2016

- (Not on File)

PHYSICAL EXAM

Vital Signs:

Filed Vitals:

	04/06/16 1456	04/06/16 1523
BP:	138/81	122/73
Pulse:	60	60
Temp:	37.1 °C (98.8 °F)	36.7 °C (98.1 °F)
TempSrc:	Temporal	Temporal
Resp:	18	20
Weight:	54.432 kg (120 lb)	
SpO2:	99%	98%

Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.

Eyes: EOM are normal. Pupils are equal, round, and reactive to light. No scleral icterus.

Neck: Normal range of motion. Neck supple. No tracheal deviation present.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She exhibits no tenderness.

Abdominal: Soft. Bowel sounds are normal. She exhibits no distension. There is tenderness **(in the pelvic region)**.

Genitourinary:

Dark blood in the vaginal vault. Dark blood oozing from close cervical OS. No CMT

Musculoskeletal: Normal range of motion. She exhibits no edema or tenderness.

Neurological: She is alert and oriented to person, place, and time.

Skin: Skin is warm and dry.

LABS/IMAGING

Please see Electronic Medical Record. Pertinent results noted below in MDM/Course/Results

MDM

ASSESSMENT/PLAN

ED Provider Notes (continued)

Amanda E Davis is a 21 y.o. female pt with a pmhx significant for D&C on Feb 4th at planned parenthood, no presenting with vaginal bleeding for the past 2 weeks and now pelvic pain for the past 2 days as described above. Exam is notable for TTP in the lower abdomen/pelvic region, without rebound or guarding. Dark blood in the vaginal vault with slow oozing from the closed cervical OS. At this time, the DDx includes: retained products of conception, endometrial bleeding, active miscarriage, and ovarian cyst. Plan for basic labs including LFTs, type/screen, Uhcg, and Plevic U/S

ED Course:
-Pt signed out to Megan O'Connor PA-C at 4:30 pm. Labs and ultrasound pending at the time of sign out.

ED Medications Ordered
Medications
sodium chloride (NS) 0.9 % syringe flush 3 mL (not administered)
sodium chloride 0.9% bolus 1,000 mL (not administered)

ED Consults Ordered
No consults were ordered.

DISPOSITION/CONDITION

Daniel Corrigan MD, MS
Emergency Medicine
#34548

Daniel J Corrigan, MD
Resident
04/06/16 1813

Electronically signed by Daniel J Corrigan, MD at 4/6/2016 6:13 PM

Notes

ED Progress/Update Note

Author: Megan K O'Connor, PA-C
Filed: 4/7/2016 2:38 AM
Status: Signed

Service: Emergency Medicine
Date of Service: 4/6/2016 4:08 PM
Editor: Megan K O'Connor, PA-C (Physician Assistant)

Author Type: Physician Assistant
Note Type: ED Progress/Update Note

Assumed care at 04/06/2016 4:08 PM

Briefly, Amanda E Davis is a 21 y.o. female with h/o D&C on 2/4 at 9 weeks gestation. Afterward had small amount of expected bleeding which increased after two weeks and is now much heavier and passing clots. Over past 2-3 days having bilateral lower pelvic pain. No change in bleeding with intercourse. No fevers, chills, n/v/d.

Vitals:

ED Progress/Update Note (continued)

BP 122/73 mmHg | Pulse 60 | Temp(Src) 36.7 °C (98.1 °F) (Temporal) | Resp 20 | Wt 54.432 kg (120 lb) | SpO2 98%

Pertinent Physical Exam Findings: VSS, abd soft and bilateral pelvic tenderness. Pelvic exam:

Labs:

Labs Reviewed

CBC AND DIFFERENTIAL
BASIC METABOLIC PANEL
LFTS (HEPATIC PANEL)
MAGNESIUM
PHOSPHORUS
PT-INR
URINALYSIS
HCG, URINE
LACTIC ACID (LACTATE)
TYPE AND SCREEN

Imaging:

US Pelvis (Results Pending)

Interventions:

Medications

sodium chloride (NS) 0.9 % syringe flush 3 mL (not administered)
sodium chloride 0.9% bolus 1,000 mL (not administered)

Plan: Labs, pelvic US, pain control

Continued Course Updates:
[x] Labs - Wbc 12.7
[x] PUS - Retained POC

US Pelvis

Final Result
IMPRESSION:
Complex heterogeneous endometrial echocomplex measuring up to 2 cm with internal vascular flow. Differential considerations include retained products of conception with a component of hemorrhage.

Complex cyst in the left ovary measuring up to 2.8 cm which may represent a corpus luteal cyst or a hemorrhagic cyst.

Labs Reviewed

CBC AND DIFFERENTIAL - Abnormal; Notable for the following:

WBC	12.73 (*)
RBC	3.76 (*)
HGB	11.8 (*)
HCT	34.4 (*)
NEUTS	74.2 (*)
LYMPHS	20.8 (*)
ABSOLUTE NEUTS	9.45 (*)

All other components within normal limits

URINALYSIS - Abnormal; Notable for the following:

BLOOD	3+ (*)
Protein-UA	1+ (*)

All other components within normal limits

URINE SEDIMENT - Abnormal; Notable for the following:

SQUAMOUS CELLS	Present (*)
MUCIN	Present (*)

All other components within normal limits

CHLAMYDIA TRACHOMATIS AND NEISSERIA GONORRHOEAE NUCLEIC ACID DETECTIO
BASIC METABOLIC PANEL
LFTS (HEPATIC PANEL)
MAGNESIUM
PHOSPHORUS
PT-INR
LACTIC ACID (LACTATE)
URINE HCG
HCG (QUANTITATIVE BLOOD)
TYPE AND SCREEN

8:20 PM
PUS shows retained POC. Benign gyn unavailable for paging. Paged gyn onc to attempt to contact.

9:39 PM
Pt with gynecology, recommend Misoprostol 600mg buccal and discharge with instructions to f/u in Gyn Clinic in two weeks. Pt discharged and given return and f/u instructions.

Electronically signed by Megan K O'Connor, PA-C at 4/7/2016 2:38 AM

Notes

ED Provider Notes

ED Provider Notes (continued)

Author: Pierre Borczuk, MD
Filed: 4/10/2016 9:16 AM
Status: Signed

Service: Emergency Medicine
Date of Service: 4/6/2016 4:24 PM
Editor: Pierre Borczuk, MD (Physician)

Author Type: Physician
Note Type: ED Provider Notes

History

Chief Complaint

Patient presents with:

- Vaginal Bleeding
- Back Pain
- Abdominal Pain

HPI

21-year-old female G1 P0 status post therapeutic abortion on February 4 at bleeding and discomfort after the abortion that improved but now presenting with 2 weeks of lower abdominal pain vaginal bleeding she states increasing in the amount of bleeding she thought she had a fever a days ago. She's had no prior abdominal surgery went through 3 pads today she occasionally feels lightheaded
She has a history of PTSD and ADHD she is on clonidine and Ritalin
Is a history of asthma she uses when necessary inhalers
She has a prior history of IV drug use
She has a allergy to penicillin

Past Medical History

Diagnosis	Date
• Asthma	

No past surgical history on file.

No family history on file.

History

Substance Use Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: No

Review of Systems
Constitutional: Negative for activity change and appetite change.
HENT: Negative for nosebleeds.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for vomiting, blood in stool and abdominal distention..
Genitourinary: Positive for vaginal bleeding and pelvic pain.
Musculoskeletal: Negative for joint swelling, arthralgias and gait problem.
Skin: Negative for rash.
Neurological: Positive for dizziness.
All other systems reviewed and are negative.

ED Provider Notes (continued)

Physical Exam

BP 122/73 mmHg | Pulse 60 | Temp(Src) 36.7 °C (98.1 °F) (Temporal) | Resp 20 | Wt 54.432 kg (120 lb) | SpO2 98%
She's awake alert and oriented her heart rate and blood pressure normal
Is no signs of head trauma her neck is supple
bilLateral breath sounds are clear
Regular rate and rhythm he has no murmur
She is mild lower abdominal discomfort abdomen is not distended she has normal bowel sounds no paraspinal megaly she has a text tattoo on her lower abdomen is no CVAT
There is no edema there is no petechiae
Physical Exam

ED Course

No consults were ordered.

If consults were ordered, refer to the consult documentation for additional information.

Clinical Impression

Final diagnoses:
None
will plan for screening labs including hematocrit coags beta-hCG will plan for pelvic ultrasound concern for retained products of conception or ectopic pregnancy. Low probability of heterotopic pregnancy

MDM:
Clinical Data Review:
Assessment and Plan:
Us c/w retained products
hcg neg
Gyn consulted

Attestation: I have personally seen and examined the patient and reviewed the resident's and PA's findings and plan. As necessary, I have appended the note with my suggestions, comments or clarification to their findings and plan in the note above. This is a shared visit with the PA.

Pierre Borczuk, MD
04/10/16 0916

Electronically signed by Pierre Borczuk, MD at 4/10/2016 9:16 AM

Notes

Consults

Consults (continued)

Author: Kaitlin J Hanmer, MD
Filed: 4/6/2016 11:31 PM
Status: Signed
Cosigner: Naima T Joseph, MD at 4/10/2016 10:36 PM

Service: OB/GYN
Date of Service: 4/6/2016 10:01 PM
Editor: Kaitlin J Hanmer, MD (Resident)

Author Type: Resident
Note Type: Consults

Consult Orders:
1. IP Consult to Gynecology [174000341] ordered by Megan K O'Connor, PA-C at 04/06/16 2047

GYNECOLOGY CONSULT INITIAL

Pt name: Amanda E Davis
MRN: 3357879

SERVICE DATE: 4/6/2016

REQUESTING PHYSICIAN: Pierre Borczuk, MD
PRIMARY CARE PHYSICIAN: Dawn Marie Peters, MD

Contact number: 857-261-1884

REASON FOR CONSULT: Vaginal bleeding s/p D&C

HPI
Patient is a 21 y.o. female G1P0010 9wks s/p TAB via D&C at 9wks GA (on 2/4/16)who presents with a 6 week history of vaginal bleeding and a 2 day history of lower abdominal pain. Amanda reports that she underwent an uncomplicated TAB at an outside hospital. After the TAB she experienced 1 week of vaginal bleeding. After 2 weeks of no bleeding, she started to bleed again. She initially thought that it was just her period returning however the bleeding persisted until now (total of 6 weeks). She is unsure of how many pads or tampons she uses per day but she does endorse passing clots. She has also been feeling quite fatigued. In addition to the bleeding, she started to experience some intense lower abdominal cramping with occasional sharp pains in the LLQ over the past 2 days. She thought that she may be constipated and so took an over the counter stool softener but this did not help with her discomfort. She rates the pain anywhere from a 3-10/10 on the pain scale (currently 3 or 4 out of 10). The sharp pains are worst in the LLQ but occasionally radiate to the right side. She has not taken any analgesics for the pain.

Amanda denies dizziness, lightheadedness, fever, chills, nausea, vomiting and urinary symptoms.

ED Course: VSS. Labs notable for HCG quant < assay, Hct 34.4. PUS shows complex heterogeneous endometrial echocomplex measuring up to 2 cm with internal vascular flow concerning for retained POCs.

OB History:
G1P0010
TAB at 9wks

Menstrual History:
Menarche: age 14
Irregular cycles, flow for 3 days at most

Sexual History:
Sexually active? yes

Consults (continued)

Patient on Hormone Replacement Therapy? no
Hx of STD's: yes - chlamydia, treated
Hx of PID: no
Last Pap results: has never had a pap

PMH:
Asthma
PTSD
Depression
ADHD
Back pain

PSH:
Tonsillectomy
D&C

Meds:
Ritalin
Clonidine
Gabapentin

All:
Penicillin - Patient has a family history of anaphylaxis to penicillin, she has never had penicillin herself

Social History:
Current every day smoker 1/2 pack per day
Current every day marijuana use. Denies other illicit substances. Per records has history of IV drug use
Drinks 8-10 units of alcohol up to 2 times per week
Denies domestic abuse. Reports feeling safe at home.

Family History:
Non-contributory

ROS
Pertinent items are noted in HPI.

Exam
Last vitals 36.6 °C (97.8 °F) | P 64 | BP 99/75 mmHg | RR 18 | SpO2 98 % | | FiO2 | 54.432 kg (120 lb)

General: healthy, alert, no distress, cooperative
Lungs: Breathing unlaboured
Cardiac: Well perfused
Abdomen: Soft, non-tender, no guarding or rebound
Pelvic:external genitalia normal, no vulvar lesions, no cervical lesions; 2 scopettes of dark blood in the vault. No active bleeding from the os. No discharge.
Bimanual: Small, anterverted uterus. No CMT. No fundal tenderness. No left adnexal tenderness. Mild right adnexal discomfort.
Extremities: Normal exam of the extremities.
Neuro: Alert, oriented X 3

Data/Results

Data:

CBC:

Lab Results

Component	Value	Date/Time
WBC	12.73*	04/06/2016 1624
RBC	3.76*	04/06/2016 1624
HGB	11.8*	04/06/2016 1624
HCT	34.4*	04/06/2016 1624
MCH	31.4	04/06/2016 1624
MCV	91.5	04/06/2016 1624
PLT	337	04/06/2016 1624
RDW	12.1	04/06/2016 1624

BMP:

Lab Results

Component	Value	Date/Time
NA	142	04/06/2016 1624
K	4.2	04/06/2016 1624
CL	104	04/06/2016 1624
CO2	25	04/06/2016 1624
BUN	9	04/06/2016 1624
CRE	0.73	04/06/2016 1624
CA	9.6	04/06/2016 1624
GLU	105	04/06/2016 1624

Coagulation:

Lab Results

Component	Value	Date/Time
PT	13.2	04/06/2016 1624
INR	1.0	04/06/2016 1624

Pregnancy:

Lab Results

Component	Value	Date/Time
HCGQT	<6	04/06/2016 2049
UCG	Negative	04/06/2016 1938

US Pelvis	Status: Final result

Procedure	Abnormality	Status
US Pelvis		

PACS Images	Encounter
Show images for US Pelvis	View Encounter

Study Result

TECHNIQUE:

Consults (continued)

Transabdominal and transvaginal ultrasound imaging of the pelvis was performed.
COMPARISON: None available.
FINDINGS:
KIDNEYS: Unremarkable.
UTERUS: The uterus measures 8.1 x 4.3 x 4.4 cm. The endometrial echocomplex demonstrates a complex heterogeneous echotexture and measures approximately 2 cm. There is internal vascular flow to the endometrial echocomplex on color Doppler.
OVARIES/ADNEXA: The left ovary measures 3.3 x 2.4 x 3.2 cm and demonstrates the presence of a complex cyst within it measuring approximately 2.4 x 1.8 x 2.8 cm. The right ovary measures 2.4 x 1.2 x 2.6 cm and is unremarkable in appearance.
PELVIS: No free fluid.
IMPRESSION:
IMPRESSION:
Complex heterogeneous endometrial echocomplex measuring up to 2 cm with internal vascular flow. Differential considerations include retained products of conception with a component of hemorrhage.
Complex cyst in the left ovary measuring up to 2.8 cm which may represent a corpus luteal cyst or a hemorrhagic cyst.

Impression/Recommendations

21 y.o. female G1P0010 9wks s/p TAB via D&C at 9wks GA (on 2/4/16)who presents with a 6 week history of vaginal bleeding and a 2 day history of lower abdominal pain. PUS and history of vaginal bleeding concerning for retained products of conception. Overall the patient is well-appearing with stable vital signs and physical exam notable only for a small amount of blood in the vaginal vault and mild left adnexal discomfort. Counseled patient about medical vs surgical management of retained products of conception and given overall stability recommended medical management with a one-time dose of misoprostol (600mcg buccally). Patient will receive dose in the ED and then will be fine for discharge home. Advised patient that she likely will experience heavier bleeding and stronger cramping within 30min - 4hrs of taking the medication and that this would be a sign that her body is passing the left over tissue. Reviewed bleeding precautions and advised patient to call or present to ED if she saturates more than 2 pads in an hour for 2 hours in a row or if she becomes symptomatic with the bleeding. Advised ibuprofen and a heating pad for cramping discomfort.

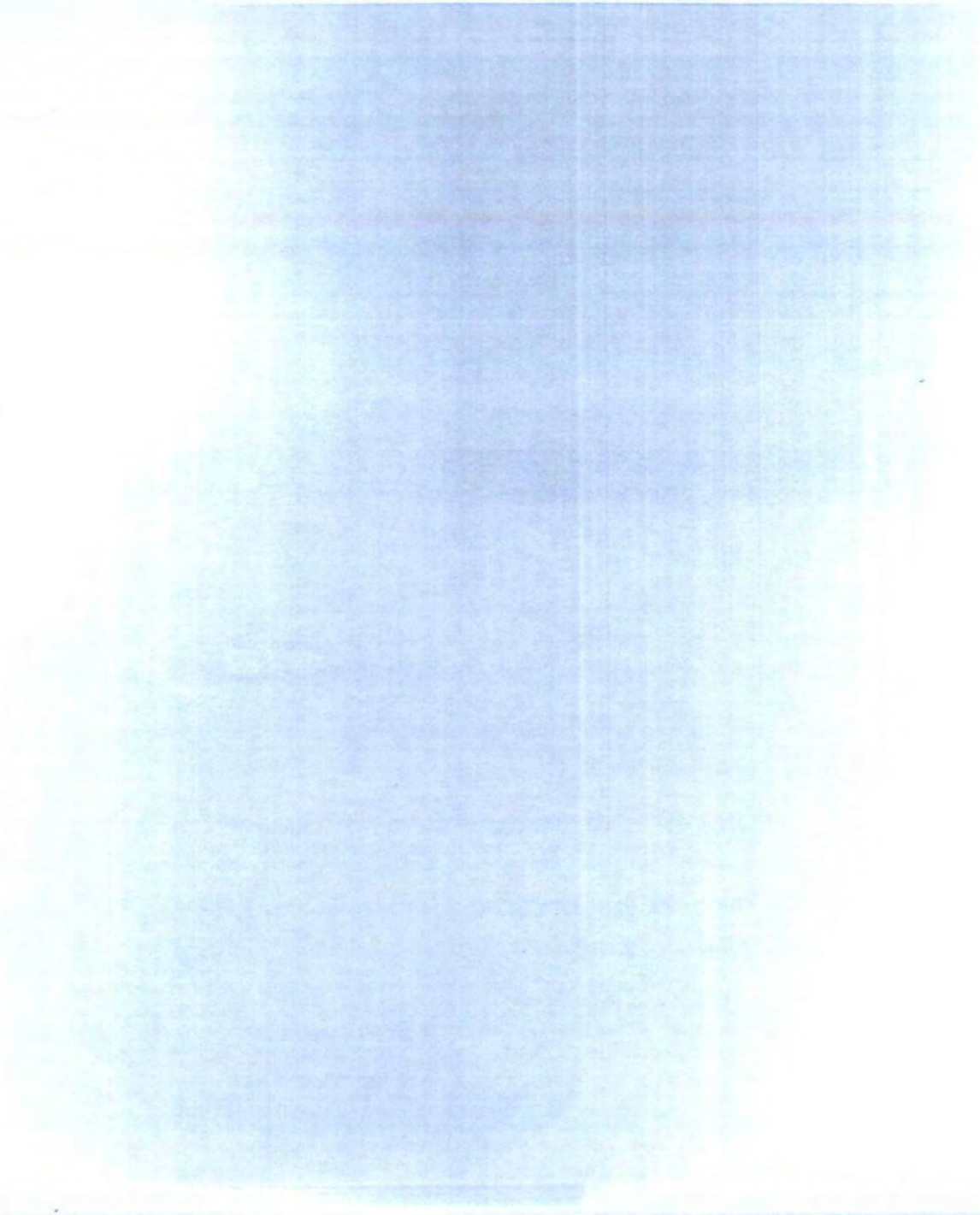
Patient will follow-up in GYN Outpatient clinic in 2 weeks' time with repeat PUS to confirm passage of products of conception. Clinic contact information provided to patient.

Patient and her mother verbalized understanding and agreement with the plan.

Patient discussed with GYN Chief Resident, Dr. Naima Joseph.

Kaitlin Hanmer, MD
OBGYN, PGY2
p35669

Electronically signed by Kaitlin J Hanmer, MD at 4/6/2016 11:31 PM
Electronically signed by Naima T Joseph, MD at 4/10/2016 10:36 PM



Duffy Health Center

94 Main Street
Hyannis, MA 02601
(508) 771-9599
(508) 771-1986, fax
www.duffyhealthcenter.org

Partners on the road to health, hope and home.

January 3, 2018
To Whom It May Concern:

Amanda Davis, date of birth 6/28/1994, receives her current behavioral health counseling services with me, at Duffy Health Center. She began to meet with me on 3/23/2017. Amanda reports having sustained a traumatic history, throughout the course of her childhood and into her adulthood. As a result, she has been and is currently being treated for, having met the criteria for, a diagnosis of Post-Traumatic Stress Disorder.

This diagnosis is described in the DMS-V (Diagnostic Statistical Manual of Mental Disorders, Fifth Edition), which is the standardized assessment manual, currently used in medical and behavioral health, to determine diagnostic criteria, in order to assess, evaluate and diagnose mental health disorders. The descriptions states that people who are diagnosed with this disorder, may exhibit behaviors and symptoms that include : " 1. Intrusive thoughts, Nightmares, Flashbacks, Emotional distress after exposure to traumatic reminders, Risky or destructive behavior, Hypervigilance, Heightened startle reaction, Difficulty concentrating, Difficulty sleeping, Decreased interest in activities." (American Psychiatric Association, 2013). As well as : "2. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events(s)." And/or "3. Avoidance of or efforts to avoid external remainders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)" (American Psychiatric Association, 2013). "4. Commonly, the individual has recurrent, involuntary, and intrusive recollections of the event (Criterion B1). "(American Psychiatric Association, 2013). Amanda has exhibited all of these symptoms at various times throughout her treatment with me. There are various other symptoms listed in the DSM-V, which Amanda also has exhibited at times throughout her course of treatment.

Amanda also is being treated currently for substance use disorder, in remission. Research indicates that these two co-occurring morbidities have potential to negatively impact one another, meaning that when one is worsening or resurging, it can trigger an increase in the symptoms of the other

Amanda has shared in sessions with me, her history regarding her traumatic experience with complications from her terminated pregnancy in 2016. These sessions have given way to discussions regarding a multitude of difficulties and life stressors that resulted from this experience. These issues have further complicated her existing trauma history. Following her experience with this terminated pregnancy, Amanda reports having had a lapse with her substance use disorder; thereby incurring more life stressors, which then compounded her traumatic experiences with a cumulative outcome. Subsequently, in sessions now, as I cannot speak to prior to 3/23/2017, she suffers with significant, intermittent, yet at times extreme symptoms of Post-Traumatic Stress Disorder. These symptoms seem to have been exacerbated by both this experience and secondarily by then triggering both increased symptoms of Post-Traumatic Stress Disorder and a lapse in her recovery from substance use disorder, cumulatively. Consequently, combined with other issues, she has also then sustained many further life complications and setbacks.

Sincerely,

Louisa Gould, MSW, LICSW
Behavioral Health Clinician
Duffy Health Center
(508) 771-9599 Extension 170

6

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUFFOLK SUPERIOR COURT
CIVIL ACTION NO. 1984CV119

AMANDA DAVIS,
Plaintiff

vs.

ALICE MARK, MD,
PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, INC.,
JOSHUA M. MULARELLA, MD,
CAMBRIDGE PUBLIC HEALTH COMMISSION d/b/a CAMBRIDGE HEALTH ALLIANCE and CAMBRIDGE HEALTH ALLIANCE PHYSICIANS ORGANIZATION,
Defendants

AFFIDAVIT OF PLAINTIFF AMANDA DAVIS

I, Amanda Davis, hereby certify the following to be true under the pains and penalties of perjury:

1. I presented at Planned Parenthood in Boston, Massachusetts for an abortion procedure on or about February 4; 2016, that was performed by Dr. Alice Mark;
2. I provided Planned Parenthood with my correct phone number and address information;
3. At the time of my discharge from Planned Parenthood, on February 4, 2016, I was advised verbally by the people at Planned Parenthood that they would call me to set up a follow-up appointment;
4. Shortly after the procedure, I began suffering debilitating abdominal pain and very heavy bleeding;
5. Neither Dr. Mark or anyone else at Planned Parenthood had advised me that abdominal pain and very heavy bleeding could be symptoms of retained products of conception;

6. Nevertheless, I called Planned Parenthood several times during the weeks following my procedure to speak with Dr. Mark or others there about my symptoms, but the persons who answered the phone at Planned Parenthood would not provide me with any assistance – instead they would always direct me to a leave voicemail for a someone who would get back to me, and I would do so;

7. Neither Dr. Mark or anyone else from Planned Parenthood ever called me to set up a follow-up appointment or to inquire as to how I was doing after the surgery;

8. Neither Dr. Mark or anyone else from Planned Parenthood ever returned any of my phone calls or responded to any of my voicemails;

9. After I was discharged from Planned Parenthood on February 4, 2016, no one from Planned Parenthood ever called me or responded to my phone calls;

10. This Affidavit does not contain everything known to me concerning the treatment I received at Planned Parenthood, and is prepared solely in connection with the plaintiff's Offer of Proof.

Signed under the pains and penalties of perjury this 12th day of March, 2019.

Amanda Davis.

THE SCHREIBER LAW FIRM LLC
BOSTON

8 FANEUIL HALL MARKETPLACE
3RD FLOOR
BOSTON MA 02109
T: 617.973.5120
F: 617.973.6406

ATTORNEY ROSS E. SCHREIBER
DIRECT LINE 617.742.1981
res@schreiberlawboston.com

Delivered by Hand

March 13, 2019

Suffolk Superior Court
Civil Clerk
Room 1216
3 Pemberton Square
Boston, MA 02108

Re: AMANDA DAVIS vs. ALICE MARK, MD, et. al,
Suffolk Superior Court C.A. No. 1984CV119

Dear Sir or Madam:

Please find enclosed herein for filing, in accordance with Superior Court Rule 73, the **PLAINTIFF'S OFFER OF PROOF**.

Thank you for your attention to this matter.

Very truly yours,

ROSS E. SCHREIBER

encs.

cc: Donna M. Marcin
Hamel, Marcin, Dunn Reardon
& Shea, PC
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Boston, MA 02110

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