NOTICE: Summary decisions issued by the Appeals Court pursuant to M.A.C. Rule 23.0, as appearing in 97 Mass. App. Ct. 1017 (2020) (formerly known as rule 1:28, as amended by 73 Mass. App. Ct. 1001 [2009]), are primarily directed to the parties and, therefore, may not fully address the facts of the case or the panel's decisional rationale. Moreover, such decisions are not circulated to the entire court and, therefore, represent only the views of the panel that decided the case. A summary decision pursuant to rule 23.0 or rule 1:28 issued after February 25, 2008, may be cited for its persuasive value but, because of the limitations noted above, not as binding precedent. See Chace v. Curran, 71 Mass. App. Ct. 258, 260 n.4 (2008).

COMMONWEALTH OF MASSACHUSETTS

APPEALS COURT

19-P-1829

BRIAN LACORAZZA, personal representative[1]

vs.

JULIEN PHAM & others.[2,3]

MEMORANDUM AND ORDER PURSUANT TO RULE 23.0

After Richard Lacorazza (Lacorazza) died while under the care of the defendants, the plaintiff filed a complaint seeking damages based on claims of medical malpractice. See G. L. c. 231, § 60B. A medical malpractice tribunal concluded that the plaintiff's offer of proof was insufficient to present a triable claim of malpractice against any of the defendants, and a judgment of dismissal entered in the Superior Court. On the plaintiff's appeal, we reverse.

The factual background appearing in the record is extensive and detailed, and the parties are well familiar with it; we do

[1] Of the estate of Richard Lacorazza.
[2] Alina Fernandez, Syed Quadri, Vishal Patel, Trent Hiles, and Veronica Darling.
[3] We note that a suggestion of death of one of the defendants, Syed Quadri, was filed prior to oral argument.

not recite or summarize it here, but will include pertinent elements in our discussion of the parties' arguments on appeal.

We begin with a statement of the applicable legal standard. "A plaintiff's offer of proof shall prevail before a medical malpractice tribunal (1) if the defendant is a health care provider as defined in G. L. c. 231, § 60B, . . . '(2) if there is evidence that the [health care provider's] performance did not conform to good medical practice, and (3) if damage resulted therefrom.'"[4] Feliciano v. Attanucci, 95 Mass. App. Ct. 34, 37 (2019), quoting Kapp v. Ballantine, 380 Mass. 186, 193 (1980). The tribunal must apply a directed verdict standard to the evidence presented by the plaintiff, with some allowance to be made for the nascent stage of the litigation. See Feliciano, supra at 38-39. If any one of the plaintiff's theories meets this standard, the offer survives the statutory screening test. Kapp, supra at 192. Moreover, "[t]he standard for admission of expert testimony before a medical malpractice tribunal is an extremely lenient one." Feliciano, supra at 39, quoting Halley v. Birbiglia, 390 Mass. 540, 543 n.4 (1983). See Heyman v. Knirk, 35 Mass. App. Ct. 946, 947-948 (1993). "[T]he tribunal should give consideration to the proffered opinion of an expert if the offer of proof is sufficient to show that a trial judge

[4] The first element of the Kapp test is uncontested.

in his discretion might properly rule that the qualifications of the witness are sufficient." Kapp, supra at 192.

In simplest terms, the plaintiff's expert, Dr. Michael Stanley Drew, stated that Lacorazza suffered complete bowel infarction and death because of the "significant" delay in the diagnosis and treatment of his ischemic bowel. In Dr. Drew's opinion, to a reasonable degree of medical certainty, each of the defendants failed to conform to good medical practice in several respects. As for Hiles, Dr. Patel, and Dr. Pham, Dr. Drew opined that they deviated from the standard of care by failing to do the following: recognize and appreciate signs and symptoms of an ongoing acute abdominal process;[5] "offer, order, and/or perform" a nasogastric tube (NGT) insertion; and order a surgical or gastroenterology consult.[6] As for Darling and Dr. Quadri, Dr. Drew opined that they deviated from the standard of care by failing to assess Lacorazza at bedside after being

[5] The signs and symptoms of an acute abdominal process include, but are not limited to, "abdominal distension/firmness, diarrhea/loose stool, indigestion, nausea, vomiting, metabolic acidosis, renal failure, and abdominal/pelvic CT scan findings of pneumatosis." Dr. Drew further explained that "[a]cute conditions of the abdomen are produced by inflammatory, obstructive, or vascular mechanisms."

[6] Dr. Drew further opined that Hiles also deviated from the standard of care by failing to order radiology imaging including a kidney, ureter, or bladder or abdominal CT scan. He also faulted Dr. Pham and Dr. Patel for failing to order abdominal imaging on an emergency basis (and for failing to follow up with the results), as required by the standard of care.

informed of his worsening condition, and by failing to order a transfer to the intensive care unit (ICU) after it was clear Lacorazza needed closer monitoring. Dr. Drew also faulted Dr. Quadri for failing to order an immediate central line or PICC placement. Dr. Drew faulted the care and treatment provided by Dr. Fernandez because she failed to recognize and appreciate the signs and symptoms of an acute abdominal process (as well as the CT scan findings reporting colonic distension and pneumatosis as consistent with such a process), and because she failed to "offer, order, and/or perform" an NGT insertion. Dr. Drew specifically opined, to a reasonable degree of medical certainty, that Lacorazza's premature and preventable death was the direct result of the substandard care rendered to him by the defendants. In Dr. Drew's professional opinion, if the defendants had provided care and treatment consistent with the standard of care, Lacorazza's acute abdominal process would have been diagnosed and treated as early as January 16 or 17, preventing, more likely than not, Lacorazza's bowel infarction, cardiac arrest, and death on January 18.

We address the defendants' various challenges to the sufficiency of the plaintiff's offer of proof in turn.

Standard of care. There is no merit to the defendants' contention that Dr. Drew's opinion was insufficient because it was silent on the standard of care for certain medical

subspecialties. The record shows that Dr. Drew is a board-certified surgeon licensed to practice medicine in New York, a fellow of the American College of Surgeons, a member of four medical and surgical societies (including the American Society of Abdominal Surgeons), and a faculty member of two universities.[7] In his opinion letter, he stated that he was familiar with the accepted standard of care owed by the average qualified physician assistant and internal medicine physician to postoperative patients with signs and symptoms of an acute abdominal process in Massachusetts in 2014. Dr. Drew's credentials and extensive experience sufficiently established his familiarity with the standard of care owed by the defendants. See Lambley v. Kameny, 43 Mass. App. Ct. 277, 287 n.18 (1997) ("plaintiff's medical expert need not be practicing in the same area as the defendant, let alone be a specialist in that area"); Heyman, 35 Mass. App. Ct. at 948 (podiatrist qualified to give opinion on orthopedic surgeon). Moreover, internal medicine is a medical "specialty" requiring board certification. See Palandjian v. Foster, 446 Mass. 100, 103 n.5

[7] In addition, he holds appointments as the codirector of bariatric surgery and the chairman of the operating room committee at North Shore LIJ-Forest Hills Hospital. In addition, he has maintained a private practice treating adult patients since 1981.

(2006).[8] Though the defendants may have "subspecialties," they indisputably remain either physician assistants with internal medicine backgrounds or board-certified internal medicine physicians. Dr. Drew was qualified to render an opinion regarding the care and treatment they provided.

To the extent the defendants contend that Dr. Drew failed to address their specific roles, Dr. Drew acknowledged each of the defendants' different titles, roles, and many of their specialties, in his detailed chronology of the medical facts and events upon which his opinion was based.[9] The authorities cited

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[8] Indeed, Dr. Pham and Dr. Patel requested that the medical member of the tribunal specialize in internal medicine. Hiles and Darling requested that the medical member be a physician assistant. Dr. Quadri and Dr. Fernandez requested a hospitalist.

[9] We note that there are some factual issues that cannot be resolved on the present record regarding the nature and extent of the defendants' roles and responsibilities. Such questions, however, are "not amenable to disposition by the tribunal." Feliciano, 95 Mass. App. Ct. at 39 n.11. For example, according to his own note, Dr. Patel assessed Lacorazza not only for possible critical care admission, but also for his shortness of breath. Moreover, although Dr. Pham and Dr. Patel claim their involvement was limited to one-time consultations, their notes establish that they would continue to monitor and follow Lacorazza. To the extent that Dr. Patel suggests that his doctor-patient relationship with Lacorazza ended when he "went off service" on January 17, the medical record does not show when or if that occurred. In fact, on the record before us, there is no evidence that Dr. Patel transferred Lacorazza's care to Dr. Fernandez. Contrast St. Germain v. Pfeifer, 418 Mass. 511, 520 (1994). The defendants dispute among themselves whether the orthopedic service remained as Lacorazza's attending physicians and physician assistants during his postoperative care, or whether the hospitalist service assumed that role.

by the defendants to support their arguments to the contrary are unpublished opinions that are, in any event, distinguishable. On this record, any claimed shortcomings in Dr. Drew's knowledge, experience, and familiarity regarding the limited roles or subspecialties of any individual defendant go to the weight and credibility of the evidence, matters beyond the purview of the tribunal. See Feliciano, 95 Mass. App. Ct. at 37.[10]

Factual support for expert opinions. The defendants' contention that Dr. Drew's opinions were not "rooted in the record evidence," Washington v. Cranmer, 86 Mass. App. Ct. 674, 675 (2014), fares no better. Dr. Drew's opinions were supported by information in the hospital records before the tribunal. See Blood v. Lea, 403 Mass. 430, 434 (1988). At this stage of the proceedings, the plaintiff was entitled to inferences not only that the nurses' notes relied upon by Dr. Drew were available to the defendants at the time they rendered care, but also that the standard of care required them to read them before rendering care. See Goudreault v. Nine, 87 Mass. App. Ct. 304, 309 (2015) ("standard requires the tribunal to draw all reasonable

[10] The defendants' arguments that Dr. Drew applied the "wrong" standards of care are just that, arguments of counsel and not proof supported by appropriate expert testimony. If the standard of care in any instance is in fact different than averred by Dr. Drew, the issue is one for trial.

inferences favorable to the plaintiff and prohibits the tribunal from drawing any unfavorable inferences"). Several signs and symptoms of an acute bowel process were in fact documented not only by the nurses, but also by the defendants themselves (though they may have attributed them to another cause). "[A] factually based statement by a qualified expert, without more, is sufficient to meet the tribunal standard." Booth v. Silva, 36 Mass. App. Ct. 16, 21 (1994). See Feliciano, 95 Mass. App. Ct. at 39. Dr. Drew's opinion was consistent with this principle.[11]

Causation opinions. For similar reasons, we are unpersuaded by the defendants' contention that Dr. Drew's causation opinions were speculative, conjectural, and conclusory. See Washington, 86 Mass. App. Ct. at 675. The opinions instead were grounded on information in the hospital records showing, if substantiated, a classic course of worsening ischemic bowel that was missed by the defendants. Dr. Drew essentially found that if the defendants had timely recognized

[11] Nor was Dr. Drew's opinion based on assumed facts contradicted by the medical record. Contrast Cooper v. Cooper-Ciccarelli, 77 Mass. App. Ct. 86, 92-93 (2010) (where expert failed to account for defendant's consultation with two specialists with more expertise, opinion was based on assumed facts not rooted in evidence); LaFond v. Casey, 43 Mass. App. Ct. 233, 237-238 (1997) (expert's assumption that baby suffered from hypoxia during birth process not rooted in evidence where hospital records showed delivery of a normally functioning infant).

the potential danger, performed the appropriate tests, called in an appropriate expert, or sent Lacorazza to the ICU where he belonged for closer monitoring, Lacorazza's ischemic bowel would have been diagnosed earlier, more likely than not, before it progressed to an irreversible bowel infarction, cardiac arrest, and death. This opinion connecting deviations from the standard of care and harm was sufficient at the tribunal stage. See Joudrey v. Nashoba Community Hosp., Inc., 32 Mass. App. Ct. 974, 976 (1992) ("'Not a great deal is required to fend off a directed verdict on the issue of causation. It is enough to adduce evidence that there is a greater likelihood or probability that the harm to the plaintiff flowed from conduct for which the defendant was responsible.' . . . 'The plaintiff is not required to show that the physician's negligence is the exact cause of the harm nor is the plaintiff required to exclude all possibility that the harm would not have occurred absent the physician's negligence'" [citations omitted]).

The defendants fault Dr. Drew for failing to explain how the acute abdominal process could have been reversed if discovered earlier; for not addressing when the bowel infarction occurred or how it could have been prevented and successfully treated; for failing to explain how quickly an emergency CT scan and surgery could have been safely performed on the evening of January 17; and for not addressing how an NGT placement,

surgical consult, emergency CT scan, and follow-up by Dr. Patel "would have avoided the outcome." These arguments go to the weight and credibility of Dr. Drew's opinion, matters beyond the purview of the tribunal. See Feliciano, 95 Mass. App. Ct. at 37.[12]

Conclusion. The judgment of dismissal is vacated. The findings and decision of the medical malpractice tribunal in favor of the defendants are vacated and new findings and a decision shall be entered for the plaintiff stating that the evidence presented, if properly substantiated, is sufficient to raise a legitimate question of liability appropriate for

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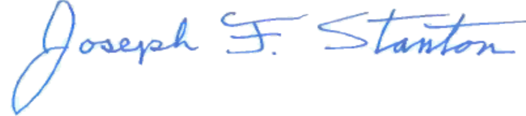
[12] We acknowledge that Dr. Drew's causation opinion leaves many questions unanswered. That is permissible under our case law. See Blood, 403 Mass. at 434 (medical expert's opinion regarding "probable" causal link between negligence and injury is sufficient to take issue to jury); Berardi v. Menicks, 340 Mass. 396, 402 (1960) ("[w]here the relation of cause and effect between two facts has to be proved, the testimony of an expert that such relation exists or probably exists is sufficient"). We conclude that Dr. Drew's causation opinion falls comfortably within the line of cases finding the requirement adequately addressed. See Bradford, v. Baystate Med. Ctr., 415 Mass. 202, 208-209 (1993); Kopycinski v. Aserkoff, 410 Mass. 410, 418 (1991); Blood, supra at 434; Berardi, supra at 401-402; Goudreault, 87 Mass. App. Ct. at 309-311; Washington, 86 Mass. App. Ct. at 680-681; Thou v. Russo, 86 Mass. App. Ct. 514, 519 (2014); Nickerson v. Lee, 42 Mass. App. Ct. 106, 111-112 (1997); Delicata v. Bourlesses, 9 Mass. App. Ct. 713, 719-720 (1980).

We reject the plaintiff's argument that the tribunal applied an incorrect legal standard for the reasons stated in Cooper, 77 Mass. App. Ct. at 91-92.

judicial inquiry. The case is remanded to the Superior Court for further proceedings.

So ordered.

By the Court (Green, C.J., Milkey & Wendlandt, JJ.[13]),



Clerk

Entered: November 3, 2020.

[13] The panelists are listed in order of seniority.