DAWN MARIE SCHOFF, in her capacity as the Personal Representative of the Estate of **BARBARA A. FOOTE,** and in her **PERSONAL CAPACITY** as the daughter of Barbara A. Foote, deceased.

CALVIN J. FOOTE, JR., as Use Plaintiff,

Plaintiffs,

v.

CIVISTA MEDICAL CENTER, INC. t/a UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER
5 Garrett Avenue
La Plata, Maryland 20646,

&

ROBYN ANDERSON, M.D.
5 Garrett Avenue
La Plata, Maryland 20646

&

DAVID FROMBERG, M.D.
16 Stream Court
Owings, Maryland 21117,

Defendants.

IN THE

CIRCUIT COURT FOR

CHARLES COUNTY

Case No. C-08-CV-20-000614

SECOND AMENDED COMPLAINT

Dawn Schoff, in her capacity as the Personal Representative of the Estate of Barbara A. Foote, her mother, and in her individual capacity as the daughter of Barbara A. Foote, and Calvin J. Foote, Jr., as Use Plaintiff, by and through their attorneys, Robert D. Schulte and Schulte Booth, P.C., and Michelle J. Dickinson and the Law Office of Michelle J. Dickinson, LLC, and pursuant to Md. Code Ann. (2015), §§ 3-2A-01 and §§ 3-

901, *et seq*. of the Courts and Judicial Proceedings Article, brings this claim against Civista Medical Center, Inc. t/a the University of Maryland Charles Regional Health, Inc. d/b/a University of Maryland Charles Regional Medical Center, Robyn Anderson, M.D., and David Fromberg, M.D. As cause, Plaintiffs state as follows:

PARTIES

1. Dawn Marie Schoff ("Ms. Schoff" or "Plaintiff") is a natural person who resides in Baltimore County, Maryland and who has been duly appointed as the Personal Representative of the Estate of her beloved late mother, Barbara A. Foote, and who brings this suit in that capacity and as required by Md. Code Ann. (2015), § 17-113(5)(c) of the Estates and Trust Article, as well as in her personal capacity.

2. Calvin Foote, Jr. is the natual soon of Barbara A. Foote whose whereabouts are unkown.[1]

3. Defendant, Civista Medical Center, Inc. is a corporation formed and existing under the laws of the State of Maryland and which is otherwise a health care organization that owns and operates that facility known and trading as the University of Maryland Charles Regional Medical Center where Defendants Robyn Anderson, M.D. and David Fromberg, M.D. rendered medical services to Barbara A. Foote.

4. The University of Maryland Charles Regional Medical Center is situated in La Plata, Maryland and is colloquially known as "Charles County Hospital" (hereinafter referred to as "CCH").

[1] Plaintiffs incorporate herein by reference their Amendment by Interlineation filed on September 14, 2021.

JURISDICTION AND VENUE

5. Insofar as all Parties are residents of the State of Maryland, jurisdiction would otherwise be proper in the Circuit Court for Charles County pursuant to Md. Code Ann. (2012), §§ 6-102 & 6-103, and 3-2A of the Courts and Judicial Proceedings Article.

6. Venue too would be proper in that Court pursuant to Md. Code Ann. (2012), § 6-201(b) of the Courts and Judicial Proceedings Article, because the Defendant CCH's principal offices are situated in that County and the events prompting this claim occurred there.

NATURE OF CLAIMS/FACTS

7. This Complaint arises out of the Defendants' utter and admitted failure to honor the express wishes of Ms. Foote to control her own fate and in direct contravention of her health care instructions as expressly reflected in the orders issued by her attending physician(s) and Defendants' failure to properly care for and treat Ms. Foote which led to multiple cardiac and respiratory arrests and Defendants' efforts to conceal their wrongdoing.

8. Specifically, and on or about March 7, 2020 and following treatment at CCH after presenting with a suspected gastro-intestinal bleed, Ms. Foote, a woman of Seventy-Seven (77) years, suffered cardiac and respiratory arrest while in that Facility.

9. Prior thereto, on March 15, 2019, Ms. Foote had suffered a cardiac arrest and was administered CPR and intubated.

10. After enduring these excruciating life sustaining procedures in 2019, and after discussing the matter with her religious counsel, her physician Defendant Robyn Anderson, M.D., and immediate family – including her daughter, Dawn Schoff – Ms. Foote

had decided that if she were to suffer cardiac arrest again at any point in the future, she did not want to be resuscitated and again suffer through that pain and agony.

11. Ms. Foote therefore decided to issue instructions to her health care providers to ensure that her health care wishes were known and followed – especially as they related to her end-of-life decisions.

12. Accordingly, and on or about March 20, 2019, Ms. Foote, among other things, specifically instructed her health care providers and Defendant's staff, employees, and agents, including Robyn Anderson, M.D., that in the event that she "coded" – was found in cardiac arrest and/or not breathing – no resuscitation should be attempted, that is to say, no CPR, no defibrillation, no intubation, and no drugs designed to stimulate heart activity and/or breathing.

13. In accordance with her express wishes, CCH through its agent, Dr. Robyn Anderson, duly executed a Maryland Medical Orders for Life Sustaining Treatment (MOLST) Form on or about March 20, 2019.

14. That MOLST form executed by Dr. Robyn Anderson became a part of Ms. Foote's electronic medical record with Defendant CCH.

15. Ms. Foote's MOLST Form provides in pertinent part:

> This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is

discharged or transferred.

16. In Section 1 of the Form, the following language is set forth:

> ***No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally***.
>
> _____ Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation.
>
> _____X__ Option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilator support by CPAP or BiPAP, but do not intubate.
>
> _____ No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

(Emphasis added.)

17. When Defendant CCH admitted Ms. Foote into its emergency department on March 3, 2020 – almost a year later – for a suspected gastro bleed, Defendant CCH was aware of and, indeed, confirmed her DNR/DNI "code status" pursuant to her MOLST that had been duly executed by Dr. Robyn Anderson.

18. DNR is medical parlance for "Do Not Resuscitate."

19. DNI is medical parlance for "Do Not Intubate."

20. In fact, Defendant CCH prepared a new MOLST Form upon her admission confirming Ms. Foote's continued wish not to be resuscitated or intubated. Defendant CCH further recorded Ms. Foote's code status as "Do NOT Intubate, No CPR (MOLST A2)" and/or the existence of the MOLST in her medical records no less than seven (7) times between her admission on March 3, 2020 and her cardiac arrest on March 7, 2020.

Any provider who accessed Ms. Foote's electronic medical record on a computer workstation at CCH would see her DNR/DNI code status prominently displayed immediately below her name.

21. Thus, and as of March 7, 2020, there existed no ambiguity, no doubt, no confusion, and no justifiable reason why anyone employed by Defendant CCH attending to the care of Ms. Foote, including but not limited to Dr. Robyn Anderson and Dr. David Fromberg, did not understand that her "code status" was anything other than "DNR/DNI"; indeed, her code status was specifically indicated on her admission record(s) and throughout her medical records.

22. This foregoing exercise is not only sanctioned by Maryland Law, it is encouraged by it to ensure that healthcare providers and family members are properly, fully, and without ambiguity instructed as to an individual's wishes in advance of any condition that in the absence of it would render their wishes opaque and so that individuals and/or their health care surrogates can make the highly personal decision to die without unwanted medical intervention and interference and to avoid being subjected to unwanted medical treatment during the final moments of life.

23. In that regard, the MOLST Form was developed and adopted by the Maryland Legislature almost a decade ago after input from patient advocacy groups, religious leaders, healthcare professionals, legal professionals, academics and the Maryland Attorney General's Office.

24. Following the adoption of the MOLST Form in March of 2011, over seventy (70) interested parties/stakeholders, developed MOLST training tools for consumers and professionals, including flyers, written guides, slide presentations, and videos.

25. In short, the adoption of the Maryland MOLST Form was an enormous undertaking designed to fully apprise Maryland's health care community of the propriety, if not necessity, of the MOLST Form to ensure complete clarity of a patient's wishes in their final hours and was designed to be an enduring and portable document to effect those ends.

26. Ms. Foote's MOLST Form and DNR/DNI code status were conspicuously present in and referenced throughout her medical records.

27. Ms. Foote's DNR/DNI code status, however, was not identified on her wristband, as required by CCH's own written policy. Indeed, upon information and belief, CCH failed to train or otherwise properly inform its employees and agents, including members of its Code Blue Team and Defendant Robyn Anderson, of its policy for identifying DNR/DNI patients with color-coded snaps on patients' wristbands to avoid medical errors.

28. On March 7, 2020 and before 3:53 p.m. that day, Ms. Schoff had been visiting with her mother who was then complaining of – among other things – back pain.

29. Ms. Foote was expected to be released in short order.

30. Despite being a geriatric patient with COPD, she had previously been given and was then under the pharmacological effect of numerous drugs, including Flexeril, Decadron, Protonix, Ferrous Sulfate, Mucinex, Oxycodone, Atarax, and Benadryl.

31. Prior to Ms. Schoff's departure from the Hospital, she was advised by an attending nurse that her mother would be given medication "for pain."

32. At approximately 3:31 p.m., Valium and a higher dose of Flexeril were ordered by Civista agent or employee Physician's Assistant Chelsea Hughes to be given

to Ms. Foote.

33. At approximately 3:42 p.m., Valium was administered to Ms. Foote.

34. Ms. Foote was "Valium naïve."

35. Valium is contraindicated for pain management and depresses respiration.

36. At 3:53 p.m., Ms. Schoff left the Hospital.

37. At 4:00 p.m., Ms. Foote's vital signs were normal.

38. Although various and in some cases conflicting accounts have been given about how and when she was discovered, medical records indicate that by approximately 4:18p.m., Ms. Foote "was found to be" or was observed to have become unresponsive and without spontaneous respiration or heartbeat.

39. Despite her express instructions, against her wishes, in contravention of her MOLST Form and in violation of Maryland law, Supervising Nurse Wright called a "code blue."

40. Dr. Robyn Anderson, who had executed Ms. Foote's MOLST Form and knew of her DNR/DNI code status, and other hospital personnel performed CPR upon Ms. Foote, gave her a dose of epinephrine, gave her bag-mask ventilation, and then Dr. Anderson intubated her – placing a breathing tube into her airway, a very invasive and profoundly painful event – procedures specifically authorized by Dr. David Fromberg, Ms. Foote's code status notwithstanding.

41. As a result, Ms. Foote awoke, attempting to sit up, kicking along the way and pulling at the breathing tube in her throat.

42. Hospital personnel restrained Ms. Foote by tying restraints around her wrists and the sides of the hospital bed to prevent her from pulling out the tube they had

just forcibly thrust down her throat against her express wishes.

43. Shortly thereafter, members of Ms. Foote's family arrived to find their mother and grandmother in the ICU in great distress, tied to her bed with restraints, battered by the violent cardio-pulmonary resuscitation, with a tube in her throat, and attached to a mechanical ventilator that was breathing for her.

44. Ms. Foote's family reminded her medical providers – who had been caring for her for five (5) days as a DNR/DNI patient and, indeed in Dr. Anderson's case, who had executed the original MOLST A2 Form – that she was a "DNR/DNI" patient.

45. Ms. Foote's daughter – the Plaintiff herein – observed her mother in great discomfort, precisely what Ms. Foote had so thoughtfully and carefully sought to avoid ever experiencing again by directing Dr. Robyn Anderson to execute a MOLST Form designating her code status as DNR/DNI, and requested that the ETT (intubation) tube be removed.

46. Consistent with that request and the wishes of her mother, Respiratory Therapist "Clifford" removed Ms. Foote's breathing tube and instead placed her upon a nasal cannula for oxygen.

47. Neither Ms. Foote nor her family were advised by Defendants or any other Hospital personnel, however, that this act likely may contribute to or result in Ms. Foote's death.

48. Upon extubation, Ms. Foote suffered difficulty breathing, wheezing upon exhaling and an extremely low oxygen saturation rate, which required treatment with a nebulizer.

49. Over the next Sixteen (16) hours, Ms. Foote was conscious and

communicative, but had increasing oxygen flow requirements.

50. Unbeknownst to Ms. Foote and her family, before the decision was made to extubate her, Dr. Anderson had previously signed various orders withdrawing all medical care from Ms. Foote save for "comfort care"– that is to say – palliative care only.

51. Indeed, Dr. Anderson began withdrawing all life-sustaining care and treatment from Ms. Foote even before the medical provider signed the "palliative care only" order – about which neither Ms. Foote nor her family had any knowledge.

52. No one authorized Dr. Anderson, and Dr. Anderson was without legal authority, to do so.

53. Ms. Foote was not in a terminal or end stage condition and no physicians certified that she was.

54. In short, Dr. Anderson had made the unilateral decision to let Ms. Foote die and falsified one or more MOLST Orders to justify her actions, claiming in the medical records that she discussed the matter with the patient at a time when doing so admittedly would have been impossible.

55. Beginning at approximately 5:30 a.m. on March 8, 2020, Ms. Foote became increasingly anxious, attempting to pull off her gown and oxygen mask, despite attempts by Hospital personnel to reorient her to time and place.

56. She was given Ativan to ease her anxiety.

57. At around 10:30 a.m. that same morning, Ms. Foote's hospital bed was cleaned, as it was found to be heavily soaked in urine.

58. For her part, Ms. Foote was "agitated," resisting all care, "breathing agonally" and screaming "I can't breathe," according to her ICU nurse, Lizbeth Cortez,

RN.

59. Hospital personnel administered morphine in an attempt to alleviate her agony.

60. Thereafter, her agitation decreased given morphine's pharmacological properties.

61. Within thirty (30) minutes, however, her heart and breathing had ceased.

62. Ms. Foote was dead – again.

63. This time, however, she died in agony – as the direct and undeniable result of: (1) express healthcare wishes being ignored by Hospital Personnel, including the very physician who executed the original MOLST Form that designated her code status as DNR/DNI, Dr. Robyn Anderson; (2) Hospital personnel having failed to property extubate her and monitor her vital signs and ensure proper oxygenation during the intervening period; and (3) without permission of patient or her family, all medically necessary and appropriate treatment being withdrawn from Ms. Foote leading directly to her death.

64. Ms. Foote ultimately was charged for medical services that she specifically advised Defendants that she did not want or were otherwise occasioned by Defendant personnel having ignored her express healthcare wishes.

65. In so doing, the Defendants broke the law.

66. On March 17, 2020, nine (9) days after her mother's death, Ms. Schoff received correspondence from CCH employee, Nurse Kelli Forbes, where she admitted, among other things, that Defendant's internal review had determined that Supervising Nurse Christy Wright, who called the code blue, and others, presumably including Dr. Robyn Anderson and Dr. David Fromberg, were not aware of Ms. Foote's code status

even though her medical records clearly indicated that she was a "DNR/DNI" patient because CCH failed to follow its own policy and properly affix a purple DNR "snap" to her wristband.

67. This, despite Dr. David Fromberg having been Ms. Foote's admitting physician in the emergency department on March 3, 2020 when her DNR/DNI code status was first confirmed and having treated her as her attending physician throughout her stay at CCH.

68. This, also, despite Dr. Robyn Anderson having executed Ms. Foote's MOLST Form indicating her DNR/DNI status.

69. This, also, despite Ms. Foote's DNR/DNI code status being identified and confirmed in her medical records by Defendant CCH and its physician-agents at least once each day during the five (5) days leading up to her cardiac arrest – including just hours earlier by Nurse Lina de Castro, who was Ms. Foote's nurse and who witnessed and/or participated in the resuscitation.

70. The March 17, 2020 letter provides, in pertinent part:

> [t]he Performance Improvement Department, with the assistance from the Nurse Manager of 2 East, interviewed staff and completed a review of your mother's medical record. As a result of our conversation and the completed investigation, we are working on implementing changes to ensure a patient's code status is identified and communicated in a timely manner to all members of the health care team. In your mother's situation, staff who were unfamiliar with her code status observed her health declining [] and identified [that] she required CPR to prevent death. Out of concern for your mother, they immediately initiated resuscitation efforts. Unfortunately, they were informed of her code status moments later, nearly consecutively with her initiation of mechanical ventilation.

71. This communication to Ms. Schoff was, at best, misleading and omitted numerous facts including why Ms. Foote coded in the first place and why she ultimately

passed.

COUNT I – BATTERY
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE v. ALL DEFENDANTS

72. Plaintiff incorporates herein by reference paragraphs 1-71, above.

73. At all times relevant, Ms. Foote not only did not wish to be touched by Defendant, its agents or employees in the event that she "coded," she specifically ordered Defendant, its agents and employees to administer no CPR, no intubation, no chemical stimulants, and no defibrillation in her final moments of life.

74. Despite her wishes and Dr. Robyn Anderson's and others' orders reflecting her express instructions, Defendant CCH, its agents and employees, including Dr. Anderson, intentionally administered to Ms. Foote and against her will, violent chest compressions and forced down her throat a breathing tube which again, were procedures authorized by Dr. David Fromberg, according to Hospital medical records.

75. These actions, which were harmful and offensive to Ms. Foote, were undertaken deliberately in an effort to conceal the cause of Ms. Foote's arrest, were occasioned in whole or in part by Defendants' failure to properly train employees and agents regarding CCH's color-coded wristband policy identifying DNR/DNI patients, and, to the extent that they violated the express wishes of Ms. Foote, with actual malice.

76. As a result of Defendant CCH's and its agents' and employees' conduct, including Dr. Robyn Anderson and Dr. David Fromberg, Ms. Foote has suffered substantial damages, including but not limited to extreme pain and suffering, physical injury, mental distress, monetary losses and an agonizing death.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

COUNT II –NEGLIGENCE
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE v. ALL DEFENDANTS

77. Plaintiff incorporates herein by references paragraphs 1-76, above.

77. At all times relevant, Defendants owed to Ms. Foote a duty of reasonable care to properly monitor and avoid administering a combination of medications that would otherwise cause respiratory and cardiac arrest in a geriatric patient with COPD;

78. Defendants further owed Ms. Foote a duty of reasonable care to assess, determine and effectuate her end-of-life planning requirements and desires and abide by her Maryland Medical Orders for Life Sustaining Treatment (MOLST). Defendants' duty of care included the responsibility to ensure that those requirements and desires as expressed through Ms. Foote's MOLST Form were honored, respected and complied with by Defendant CCH's staff, agents and employees as well as by all medical personnel who might foreseeably encounter Ms. Foote while in the care of Defendant CCH.

79. Defendants breached their duty of care to Ms. Foote by, without limitation:

a. Failing to alert attending medical personnel that she was a "DNR/DNI" patient;

b. Failing to properly train staff, agents, and employees to take reasonable steps to ensure the end of life planning documents are prominently noted in her chart;

c. Failing to properly train and ensure that staff, agents, and employees follow Hospital policies for identifying DNR/DNI patients with color-coded snaps on their Hospital wristbands;

d. Failing to properly train staff, agents, and employees to take reasonable steps to ensure that Ms. Foote's end of life planning requirements and desires were honored;

e. Failing to take the simple step of banding or otherwise identifying Ms. Foote as a DNR/DNI patient in accordance

with their own Hospital policies; and

f. In the case of Dr. Robyn Anderson and Dr. David Fromberg, failing to properly educate/re-educate themselves and their staff as to Ms. Foote's code status and/or comply with her MOLST Form.

g. And in the case of Defendant CCH, failing to properly monitor and administering a combination of medications which caused Ms. Foote to suffer respiratory and cardiac arrest.

80. As a direct and proximate result of the negligence of the Defendants, Ms. Foote suffered respiratory and cardiac arrest and then (in Defendants' effort to conceal their negligence) suffered unwanted, violent and painful medical intervention at the end of her life in violation of her express wishes to the contrary and had to watch her family endure her tremendous suffering in the final hours of her life.

81. But for the negligence of Defendants, Ms. Foote would not have suffered respiratory and cardiac arrest in the first place or at the very least would have experienced a natural and peaceful death, as she had desired.

82. However, due to Defendants' negligence, Ms. Foote suffered respiratory and cardiac arrest, unwanted resuscitation, and then an agonizing death otherwise witnessed by both her beloved Daughter and granddaughter.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

COUNT III – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS
DAWN SCHOFF, INDIVIDUALLY AND AS PERSONAL REPRESENTATIVE
v. ALL DEFENDANTS

83. Plaintiff incorporates herein by reference paragraphs 1-82, above.

84. At all times relevant, Defendant CCH, and its agents' and employees' conduct, including that of Dr. Robyn Anderson and Dr. David Fromberg, was intentional

and/or reckless.

85. At all times relevant, Defendant CCH, and its agents' and employees' conduct, including that of Dr. Robyn Anderson and Dr. David Fromberg, was extreme, outrageous, and performed with malice, insofar as it violated the express wishes of Ms. Foote and even the least trained among Defendant CCH's agents and employees should have known of Ms. Foote's DNR/DNI status, as it was there to be seen and prominent in her medical records.

86. Indeed, Dr. Robyn Anderson – who participated in the code blue response team along with Dr. David Fromberg, performed the violent cardio-pulmonary resuscitation, and intubated Ms. Foote – actually executed Ms. Foote's original MOLST Form declaring her code status as DNR/DNI.

87. At all times relevant, Defendants knew or reasonably should have known that failing to honor Ms. Foote's end-of life requirements and desires as expressed through her duly executed Maryland Order(s) for Life Sustaining Treatment (MOLST) would create an unreasonable risk of severe emotional distress to Ms. Foote and others, including and especially her daughter, Dawn Marie Schoff.

88. Indeed, such severe emotional distress was virtually guaranteed, knowing that despite her strong desire to forego unwanted medical intervention at the hour of her death, she would be revived against her wishes only to later suffer an agonizing death otherwise occasioned by the needless and unauthorized withdrawal of life-sustaining medical care which the Defendants had an affirmative duty to provide.

89. Needless to say, there exists a causal connection between Defendants' wrongful conduct and Ms. Foote's and Ms. Schoff's emotional distress that is of a severe

nature, as it would be for anyone in their position.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

COUNT IV – BREACH OF CONTRACT
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE v.
CHARLES COUNTY HOSPITAL

90. Plaintiff incorporates herein by reference paragraphs 1-89, above.

91. At all times relevant, there existed a contract between Ms. Foote and Defendant CCH, express and/implied.

92. Pursuant to that contract, Ms. Foote was charged thousands of dollars for the services rendered by Defendant CCH to her and, as such, consideration supported the aforementioned contract.

93. Among other things, the contract between Defendant CCH and Ms. Foote required that Defendant CCH and its agents and employees honor the orders of her treating health care professionals, including doctors and certified nurse practitioners as well as Ms. Foote's own express health care wishes.

94. Defendant CCH materially breached its contract with Ms. Foote by failing to honor her express health care wishes, end-of-life requirements, and desires as expressed through her Maryland Order(s) for Life Sustaining Treatment (MOLST) duly executed by Dr. Robyn Anderson; by failing to honor her treating health care professional's express orders; by withdrawing life-sustaining treatment without consent or legal authority; and by administering and charging Ms. Foote for health-care services that she expressly stated she did not want.

95. As a result of Defendant CCH's breach of its contract with Ms. Foote, she

suffered both economic and non-economic damages.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), plus interest and costs.

COUNT V – BREACH OF FIDUCIARY OBLIGATION
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE v. All DEFENDANTS

96. Plaintiff incorporates herein by reference paragraphs 1-95, above.

97. At all times relevant, Ms. Foote was a patient of Defendant CCH's health care facilities and, as such, was entirely dependent upon Defendant CCH's staff, employees and health-care professionals for her daily needs, including, food, housing, and the administration of the health care for which she had contracted.

98. At all times relevant, Ms. Foote's personal needs were under the control and supervision of Defendant CCH and its employees and agents, including Dr. Robyn Anderson and Dr. David Fromberg and, because Ms. Foote was receiving medical care from Defendant CCH, this included the time and manner in which Ms. Foote would pass.

99. As a result of this highly-dependent relationship, there existed by necessity a relationship of trust and confidence between Defendants and Ms. Foote.

100. Because of this relationship of trust, there existed between Ms. Foote and Defendants a fiduciary relationship.

101. That fiduciary relationship burdened Defendants with the obligation to assess, determine and effectuate Ms. Foote's end-of-life planning requirements and desires which, through Defendant CCH's staff, agents, employees and business records were well-known or should have been well-known to Defendants.

102. This duty of care included the responsibility to ensure that those requirements and desires as originally expressed through Ms. Foote's Maryland Medical

Order(s) for Life Sustaining Treatment (MOLST) by Dr. Robyn Anderson were honored, respected and complied with by Defendants' staff as well as all medical personnel who might foreseeably encounter Ms. Foote while in the care of Defendant CCH, including Dr. Robyn Anderson and Dr. David Fromberg.

103. Defendants utterly ignored their respective fiduciary obligations that they owed to Ms. Foote by failing to honor her express health care wishes, end-of-life requirements and desires as expressed through her Maryland Medical Order(s) for Life Sustaining Treatment (MOLST); by failing to honor her treating heath care professional's express orders; and by administering and charging Ms. Foote for health care services that she expressly stated she did not want; and by withdrawing life-sustaining medical care from her at the time she needed it the most without her informed consent or the proper legal authority.

104. In breaching their fiduciary duty to Ms. Foote, Defendants placed their own interests above those of Ms. Foote and concerned themselves more with concealing their wrongdoing and delivering expensive health care to their patients rather than respecting end-of-life decisions made for the purpose of avoiding the very difficult and tragic circumstances Ms. Foote and her family ultimately suffered.

105. Defendants' breach of its fiduciary obligations to Ms. Foote (and to her family) directly and proximately caused Ms. Foote the damages that she alleges herein.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), plus interest and costs, inclusive of punitive damages, plus interest and costs.

COUNT VI – LACK OF INFORMED CONSENT
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE v. ALL DEFENDANTS

106. Plaintiff incorporates herein by reference paragraphs 1-105, above.

107. At all times relevant, Ms. Foote enjoyed the unqualified right to make her own health care decisions and to control her own body and destiny especially with regard to the time and manner at which she would pass.

108. At all times relevant, Defendants ignored the express wishes of Ms. Foote, that is to say, she specifically advised Defendant CCH, its staff, agents, and employees that she desired no CPR, no chemical stimulants, and no intubation during her final moments of life to artificially prolong it.

109. Defendants ignored those wishes by administering to Ms. Foote CPR and intubating her during her final hours of her life – *albeit,* in an effort to conceal their role in causing her arrest – and thereby artificially prolonging it for at least Sixteen (16) additional agonizing hours and during which time they withdrew the very care that would have saved her life.

110. As a result, Defendants deprived Ms. Foote of her healthcare autonomy, of the right to determine what will and will not be done to her own body, of the opportunity for a dignified and peaceful death or otherwise the opportunity to survive an otherwise survivable condition.

111. Defendants' administration of CPR and other resuscitative efforts to Ms. Foote on March 7, 2020 were done without, and in express contravention of, Ms. Foote's informed consent as was the withdrawal of medical care from her after the unwanted resuscitation.

112. All damages suffered by Ms. Foote as alleged herein are a direct and

proximate result of Defendant's act(s) in that regard.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

COUNT VII – WRONGFUL DEATH
DAWN SCHOFF, INDIVIDUALLY v. CIVISTA MEDICAL CENTER AND ROBYN ANDERSON, M.D.

113. Plaintiff incorporates herein by reference paragraphs 1-112, above

114. Shortly after the resuscitation of Ms. Foote on March 7, 2020, CCH and Dr. Anderson began withdrawing all life-sustaining medical care from Ms. Foote, effectively abandoning her to the fate that which she ultimately suffered.

115. Ms. Foote had not previously appointed a medical power of attorney and no doctors had certified in writing that Ms. Foote was in a terminal or end-stage condition.

116. Ms. Foote did not authorize Dr. Anderson or any other person to withhold life-sustaining medical care.

117. Ms. Foote did not consent to nor was she then capable of providing "informed consent" to the entry of a "comfort and care only" or palliative care order.

118. As a result of Dr. Anderson's unilateral decision to withhold and withdraw all life-sustaining medical care from Ms. Foote, Ms. Foote's condition rapidly deteriorated and she passed again within a day even though she was suffering from no clinical condition that would not have responded to treatment.

119. In short, Dr. Anderson's decision in that regard caused and/or substantially contributed to the death of Ms. Foote.

120. In an effort to conceal her cause of death, Ms. Foote's Death Certificate, conspicuously signed by a CCH executive, identifies her cause of death as a

"gastrointestinal bleed."

121. Ms. Foote did not have an active gastrointestinal bleed at the time of her death, and a gastrointestinal bleed was not the cause of her death.

122. The cause of Ms. Foote's death was the improper administration of oxygen which resulted in hypoxemia and subsequent respiratory failure and the withdrawal of all life-sustaining care otherwise not authorized.

123. In addition, Defendants have either destroyed and/or secreted documents in order to stave off a malpractice claim and otherwise pretend lack memory of events that any any reasonable person in their position would remember.

124. As a direct and proximate result of Defendant CCH and Robyn Anderson's negligence in causing Ms. Foote's death, Ms. Schoff sustained pecuniary loss, mental anguish, emotional pain and suffering, loss of society, loss of companionship, loss of consortium, loss of comfort, loss of protection, loss of parental care, loss of attention, loss of advice, loss of counsel, and loss of guidance.

125. This complaint is timely filed within three (3) years after the death of Ms. Foote pursuant to Section 3-904(g) of the Courts and Judicial Proceedings Article of the Maryland Code Annotated.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

COUNT VIII – SURVIVAL ACTION
DAWN SCHOFF, AS PERSONAL REPRESENTATIVE, v. ALL DEFENDANTS

126. Plaintiff incorporates herein by reference paragraphs 1-125, above

127. At all times relevant, Defendants owed to Ms. Foote a duty of reasonable care to properly monitor and avoid administering any combination of medications that

would otherwise cause respiratory and cardiac arrest in a geriatric patient with COPD.

128. Defendants further owed Ms. Foote a duty of reasonable care to assess, determine and effectuate her end-of-life planning requirements and desires and abide by her Maryland Medical Orders for Life Sustaining Treatment (MOLST). Defendants' duty of care included the responsibility to ensure that those requirements and desires as expressed through Ms. Foote's MOLST Form were honored, respected and complied with by Defendant CCH's staff, agents and employees as well as by all medical personnel who might foreseeably encounter Ms. Foote while in the care of Defendant CCH.

129. Defendants breached their duty of care to Ms. Foote by, without limitation:

a. Failing to alert attending medical personnel that she was a "DNR/DNI" patient;

b. Failing to properly train staff, agents, and employees to take reasonable steps to ensure the end of life planning documents are prominently noted in her chart;

c. Failing to properly train and ensure that staff, agents, and employees follow Hospital policies for identifying DNR/DNI patients with color-coded snaps on their Hospital wristbands;

d. Failing to properly train staff, agents, and employees to take reasonable steps to ensure that Ms. Foote's end of life planning requirements and desires were honored;

e. Failing to take the simple step of banding or otherwise identifying Ms. Foote as a DNR/DNI patient in accordance with their own Hospital policies; and

f. In the case of Dr. Robyn Anderson and Dr. David Fromberg, failing to properly educate/re-educate themselves as to Ms. Foote's code status and/or comply with her MOLST Form.

g. And in the case of Defendant CCH, failing to properly monitor and administering a combination of medications which caused Ms. Foote to suffer respiratory and cardiac arrest.

130. As a direct and proximate result of the negligence of the Defendants, Ms.

Foote suffered respiratory and cardiac arrest and then (in Defendants' effort to conceal their negligence) unwanted, violent and painful medical intervention at the end of her life in violation of her express wishes to the contrary.

131. But for the negligence of Defendants, Ms. Foote would not have suffered respiratory and cardiac arrest in the first place or at the very least would have experienced a natural and peaceful death, as she had desired.

132. However, as a proximate result of Defendants' negligence, Ms. Foote suffered respiratory and cardiac arrest, unwanted resuscitation, and then an agonizing death after Defendants' intentional and wrongful withdrawal of all life-sustaining treatment from her without legal authority.

133. Ms. Foote suffered severe conscious pain and suffering between the time of the initial respiratory and cardiac arrest occasioned by polypharmacy and unwanted and violent resuscitation, the withdrawal of life-sustaining treatment, which began shortly thereafter, and her ultimate death the following day.

134. Indeed, according to the Hospital's medical records, Ms. Foote was screaming "I can't breathe" in her final hours of life.

WHEREFORE, Plaintiff demands judgment for damages in excess of Thirty Thousand Dollars ($30,000.00), inclusive of punitive damages, plus interest and costs.

Respectfully submitted,

SCHULTE BOOTH, P.C.

By: /s/

Robert D. Schulte, # 9512140133
14 N. Hanson Street
Easton, Maryland 21601

(410) 822-1200
(410) 822-1299 fax

rschulte@schultebooth.com

LAW OFFICE OF
MICHELLE J. DICKINSON, LLC

By: /s/
Michelle J. Dickinson, # 9812160003
5850 Waterloo Road, Suite 140
Columbia, Maryland 21045
(443) 325-7225 (t)
(866) 211-2673 (f)

Counsel for Dawn Marie Schoff
Personal Representative, Estate of
Barbara A. Foote

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 16th day of March, 2022, a copy the foregoing First Amended Complaint was served upon the following counsel of record via this Court's electronic filing system:

Gregory L. VanGeison, Esq.
Kristina L. Miller, Esq.
Anderson, Coe & King, LLP,
Seven Saint Paul Street, Suite 1600
Baltimore, Maryland 21201

Attorney for Defendant Civista Medical Center, Inc.
t/a University of Maryland Charles Regional Medical Center

G. Branch Taylor, Esq.
Diane M. Uhl, Esq.
Taylor & Uhl, LLC
2 Wisconsin Cr., Suite 700
Chevy Chase, Maryland 20815

Counsel for Defendant Robyn Anderson, M.D.

Natalie C. Magdeburger, Esq.
Gregory K. Kirby, Esq.
Pessin Katz Law, P.A.
901 Dulaney Valley Road, Suite 500
Towson, Maryland 21204

Attorney for Defendant David Fromberg, M.D.

/s/
Robert D. Schulte