COMMONWEALTH OF MASSACHUSETTS

HAMPDEN, SS

SUPERIOR COURT DIVISION
CIVIL ACTION NO.: 2179CV00559

SARA MIROLLI,
PLAINTIFF

v.

HEATHER LOVE, M.D., ET AL.
Defendants

PLAINTIFF'S OFFER OF PROOF

This action involves a claim by Sara Mirolli who suffered injuries as a direct result of the negligent and unacceptable care provided by Defendants Health Love, M.D., Kimberly Marakovits, M.D., Nada Kawar, M.D. Nichole Thompson, M.D., Donald Kirton, M.D., Laurie A. Friedman, CNM and Lauren Jammallo, M.D. as it relates to care provided by the Defendants between November 16, 2018 and December 1, 2018 at Baystate Medical Center, a/k/a Baystate Health.

Plaintiff underwent two critical admissions, the first between November 16, 2018 through November 21, 2018; and the second between November 25, 2018 through December 1, 2018. The procedures undertaken by the Defendant(s) included the following: (1) total abdominal hysterectomy; (2) exploratory laparotomy; (3) bilateral salpingectomy; (4) Cystoscopy; (5) wound debridement; and (6) Broad ligament dissection.

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The Plaintiff alleges that the doctor(s) and midwife were negligent in their treatment of her by deviating from the standard of recognized care. The standard of care is discussed in Plaintiff's Expert Report of Dr. Elizabeth Moore, See Exhibit A. The treatment provided to Ms. Mirolli had the cumulative effect of seriously damaging her reproductive organs. There was first a delay in performing the cesarean section. Secondly, there was a delay in starting triple antibiotics in the second admission. Lastly, there was a delay in starting the second surgery. This missed opportunity would have been an ideal time to empty the infected contents of Ms. Mirolli's uterus. The resulting deviations resulted in a rupture of the uterine wall. This resulted in spillage of the pus into the abdomen and allegedly destroying the uterine wall. The delay in care and deviations from the standard of care collectively contributed to the permanent tissue damage and loss of Ms. Mirolli's reproductive capacity. See Ex. A, p. 2-9.

The Plaintiff's Offer of Proof includes the following:

A. Expert Report of Dr. Elizabeth Moore, including exhibits, and curriculum Vitae[1].

B. Affidavit of Sara Mirolli.

C. Appendix of Medical Records contained within Appendix (USB Drive).

ARGUMENT

Massachusetts General Laws, Chapter 231, § 60B, explicitly sets forth both the scope and the limits of this tribunal's function in reviewing a claim of medical malpractice. In the first paragraph of §60B, the tribunal is instructed to review the Plaintiff's Offer of Proof to:

> determine if the evidence presented, if properly substantiated, is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result.

[1] See Ex. A, p. 46-49.

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

The Supreme Judicial Court held in Little v. Rosenthal, 382 N.E.2d 1037, 1039, (1978), that in evaluating evidence submitted by the Plaintiff in a medical malpractice claim, "the tribunal's task should be compared to a trial judge functioning in ruling on a defendant's motion for direct verdict." Under this standard, a finding for the defendants in a medical malpractice case should be entered "only when [in] construing the evidence most favorable to the plaintiff, it is still insufficient to support a verdict in his favor". DeMarzo v. S. & P. Realty Corp., 306 N.E.2d 432 (1974). For the purpose of such a motion, all evidence favorable to the Plaintiff must be accepted as being true.

The Plaintiff's evidence before this tribunal clearly would not entitle the defendant to a directed verdict. Certainly, if a jury were to accept the testimony of Dr. Elizabeth Moore as true, as the tribunal must for the purpose of this hearing, it would be warranted in returning a verdict for the Plaintiff. Additionally, the tribunal does not have to weigh the issue of vicarious liability for the doctor. "Vicarious liability of a hospital for acts of an emergency room physician was a question which a medical malpractice tribunal was not jurisdictionally competent to decide". Kilmartin v. Lowell General Hospital, 23 Mass. App. Ct. 901 (1986).

In order to establish liability in a medical malpractice case, the Plaintiff must present evidence to establish: 1) the breach of duty owed by the Defendants; and 2) a casual relationship between that breach and damages allegedly suffered. Civitarese v. Gorney, 358 Mass. 652 (1971), Bernard v. Menicks, 340 Mass. 296 (1960). The Plaintiff's Order of Proof, including the

expert report of Elizabeth Moore, M.D. clearly satisfies both of these requirements. In treating the Plaintiff, the standard of care required of the Defendant is to:

> exercise the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. Brune v. Belinkoff, 354 Mass. 1012, 109 (1968).

The Plaintiff has raised sufficient issues as to each Defendant in this case.

The limited discovery, to date, discloses that Dr. Marakovits and resident Dr. Love failed to interpret the clinical findings as noted in the photograph of November 26, 2018 at 10:21 Hours at readmission. Imaging of the abdomen and pelvis on re-admission was a mandatory and necessary component to avoid delay of care and catastrophic outcome. Had the doctors correctly interpreted the abdominal exam and the putrid secretion from the vagina, they would have understood the gravity of the situation, ordered imaging, and promptly intervened with surgical drainage before the uterus ruptured with pus into the abdomen proper. The record supports that the patient was not taken to surgery until 12 hours after the temperature elevated/spiked to 102.9 degrees. This dramatic temperature spike typically occurs when a structure ruptures and spills purulent material into the abdominal cavity. The record supports that the uterus ruptured at the time the patient spiked the 102.9 temperature and at this point the uterus was severely damaged. See Ex. A, p. 4-5.

Drs. Marakovits and Love failed to stratify this patient's high-risk factors based on:

- BMI
- Anemia
- Post op uterine hematoma
- Fetal head impaction at cesarean section with contamination of the surgical field

These risk factors, in addition to a white count of 30,000, warranted triple antibiotic coverage despite the patient's allergies. With a penicillin allergy, this patient could have received Vancomycin, Gentamicin and Clindamycin or a regimen determined appropriate by an

infectious disease physician consultant. The combined lack of triple antibiotic coverage and surgical delay ultimately resulted in severe tissue damage/degradation and hysterectomy. The description above demonstrates a downward deviation in the standard of care and a failure of due diligence to follow/pursue a differential diagnosis in a timely manner.

As to Dr. Thompson and Dr. Kirton, the record demonstrates a deviation from the standard of care. The record supports a deficiency in surgical judgment when there is necrotic tissue noted on the left broad ligament and left pelvic sidewall that impair visualization during surgery. At this time, there was no hypotension or other acute events such as hemorrhage that would cause a surgical emergency and require rapid surgical technique. The appropriate intervention would have been to get the gynecological oncologist to dissect the critical urologic structures from the left side prior to the hysterectomy. This also would have given an opportunity for collaboration and opinion regarding salvage of the uterus.

GYN cancer surgeons, on a regular basis, must intra-operatively inspect diseased tissue margins and decide what must be resected and what structures can be saved. The pathology report does not contain any photos of the structures removed. Typically, one would find the images of the structures in the gross pathology section of the report and be able to inspect the uterine tissue margin that had ruptured. This combined with a lack of dictation or commentary from the GYN oncologist further supports that the Defendants deviated from the standard of care. Another item in support of this position is the pathology report which indicates that the cervix was relatively unaffected.

The record supports a deficiency in surgical judgment, and decision making that placed the patient at unnecessary risk for serious intraoperative injury. The record does not support the surgeon's decision to remove the uterus. There is a downward deviation in the standard of care

as it relates to patient safety in the operating room. The appropriate due diligence in this situation was to collaborate in the determination of whether or not the uterus could be salvaged. The appropriate due diligence, in light of impaired visualization, was to suspend surgical effort until the left renal collecting system could be dissected, therefore allowing the surgery to safely proceed after collaborating with the gyn oncologist.

Dr. Kawar never consulted with Ms. Mirolli or obtained her informed consent. See Exhibit B, Affidavit of Mirolli. Despite this, we have no medical records of Dr. Kawar to review other than the operative note which lists the doctor as a surgical assistant to the procedure performed on Ms. Mirolli. As discussed, infra, Ms. Mirolli contends that the procedure performed with Dr. Kawar deviated from the standard of care. The consulting gynecological oncologist was requested to dissect the left broad ligament structures due to impaired visualization at the time of hysterectomy. The purpose at this point was to delineate the ureter and drainage from the left kidney and confirm via cystoscopy that the structures were not injured during hysterectomy. The urinary collecting system is at particular risk of injury during conditions of pelvic infection and swelling (edema). This description is given in the operative note from the hysterectomy itself, however, there is no dictation from this consulting surgeon. The standard of care dictates that a consulting surgeon dictates a separate surgical dictation and documents their findings and documents their procedure and impressions. The record does not contain this document. There is an institutional component as well in that most institutions will have bylaws and policy that operative reports are dictated within 24 hours. This is a logistical opinion and a failure of due diligence on the part of the consulting surgeon.

Dr. Jammallo deviated from the standard of care by allowing labor induction to continue in the setting of severe pre-eclampsia with maternal renal failure. A bolus of magnesium in the

setting of anuria placed this patient at risk for "code" or acute respiratory failure due to magnesium toxicity.

The standard of care dictates that for labor induction to continue there must be reassuring maternal fetal testing. The appropriate intervention was for the doctor to do a cesarean section and collaborate with the critical care unit either personally or in conjunction with MFM (maternal fetal medicine).

Dr Jammallo failed to deliver the patient when it was clinically indicated. This was part of several delays in her care that cumulatively resulted in the morbidities contributing to life threatening infection and hysterectomy (hemorrhage, hematoma, and atony of the uterine walls).

Midwife Friedman intentionally and knowingly practiced outside her scope of care when she made the management decision to restart labor induction in the setting of:

1. Sever Preeclampsia with elevated creatine and renal failure remote from delivery at 5 cm dilation.
2. Recurrent late decelerations at 5 cm dilation.
3. Meconium with moderate variable decelerations without address of amnio infusion or physician input.
4. The plaintiff stating that "I can't do this anymore".

Fifteen percent of patients become high risk in labor, as was the case with Ms. Mirolli. A delay of appropriate care further lengthens time of intervention and placed the patient at greater risk for obstetrical and medical complications (hematoma, bleeding, atomy, hysterectomy). Oliguria, acute tubular necrosis of the kidney, met criteria for operative delivery by 1935 hours. There is an intuitional component and obligation to enforce provider compliance

with one's scope of practice. These are all downward deviations in the standard of care compounded by institutional due diligence failure.

Under the recognized standard of care, there has been sufficient facts raised as to each Defendant's liability in this case and Ms. Mirolli should not have to post bond as to any defendant.

CONCLUSION

The standard that this tribunal is bound to follow requires that all rational inferences are in the Plaintiff's favor and that this tribunal accept as true all evidence favorable to the Plaintiff. Under this standard, " the defendant, in fact, is taken to have conceded the truth" of the Plaintiff's evidence. See Smith & Zobel, Rules Practice, 8 Mass. Prac., Series, p. 203. Based upon the Offer of Proof submitted by the Plaintiff, and in light of the foregoing standards, the Plaintiff should be allowed to proceed further without the imposition of a statutory bond.

FOR THE PLAINTIFF
Sara Mirolli
By her Attorney

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CERTIFICATE OF SERVICE

I certify that a true copy pf the above document was served upon (each party appearing pro se and) the attorney of record for each party by email and mail this 6th Day of January 2021.

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