THE COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss

Board of Registration in Medicine,
Petitioner

v.

Darius M. Ameri, M.D.,
Respondent

Division of Administrative Law Appeals
14 Summer Street, 4th Floor
Malden, MA 02148
(781) 397-4700
www.state.ma.us/dala

Docket No. RM-22-0051

Appearance for Petitioner:

Rachel N. Shute, Esq.
Board of Registration in Medicine
178 Albion Street, Suite 330
Wakefield, MA 01880

Appearance for Respondent:

Megan Grew Pimentel, Esq.
Daniel Wu, Esq.
Adler Cohen Harvey Wakeman Guekguezian, LLP
75 Federal Street, 10th Floor
Boston, MA 02110

Administrative Magistrate

James P. Rooney

Summary of Decision

Board of Registration in medicine entitled to summary decision on charge that doctor had been grossly negligent in his surgical treatment of a patient when a jury in a civil suit over this patient's treatment had already found the doctor grossly negligent.

RECOMMENDED DECISION

On February 3, 2022, the Board of Registration in Medicine issued a Statement of Allegations seeking to discipline Darius M. Ameri, M.D. based on a jury verdict finding him grossly negligent in the manner in which he performed hiatal hernia surgery on a patient who

subsequently died. The Board followed up by filing a motion for summary decision in which it argues that the doctor is precluded from relitigating whether he was grossly negligent. The doctor opposes the motion contending that the doctrine of issue preclusion is inapplicable here and that the doctor has obtained new evidence that calls into question whether his actions during surgery injured the patient.

In ruling on these motions, I consider the motion papers filed by the parties, the Statement of Allegations and the five exhibits attached to it (Bd. Exs. 1-5), and an exhibit submitted by the doctor (Dr. Ex. A). The exhibits are listed in an appendix.

Findings of Fact

Based on the Statement of Allegations, the exhibits presented, and the reasonable inferences drawn from them, when viewed in the light most favorable to the non-moving party, I make the following findings of fact:

1. Darius Ameri has been licensed to practice in Massachusetts since 1987. He is board-certified in surgery and is affiliated with Winchester Hospital. (Statement of Allegations.)

2. Patient A "was referred to defendant Dr. Darius Ameri for treatment of a hiatal hernia in her diaphragm. The diaphragm separates the chest cavity from the abdomen; the hiatus is an opening in the diaphragm that permits the esophagus to travel down through the chest into the stomach. A hiatal hernia is an abnormality in which the stomach protrudes up through the hiatus into the chest. [Dr.] Ameri determined that hiatal hernia repair surgery was necessary to restore Parsons's stomach to its proper anatomical position." (Bd. Ex 5, *Parsons v. Ameri*, 97

Mass. App. Ct. 96, 97 (2020).)[1]

3. "[Dr.] Ameri performed [laproscopic] surgery [on Patient A], assisted by . . . Louise Pothier, a registered nurse first assistant. [Dr.] Ameri chose to repair the hiatal hernia by attaching a mesh closure to [Patient A's] diaphragm with a medical device called the Ethicon Securestrap, which is used during hernia repair surgery to attach prosthetic materials to soft tissue. Commonly referred to as a 'tacker,' the device attaches absorbable 'tacks' (also called 'straps' or 'fasteners') through mesh into tissue. On their own, the tacks are approximately five millimeters in length, but at the time of insertion, the tacker presses them as much as 6.7 millimeters into the tissue." *Parsons*, 97 Mass. App. Ct. at 97.

4. "After the surgery, [Patient A's] vital signs were stable. Two days after the surgery, however, she complained that her heart was racing and that she had abdominal pain. An echocardiogram showed the presence of excess fluid in [Patient A's] pericardium near where the tacks were placed; her heart rate was very elevated and irregular. She was administered blood-thinning medication and morphine. Approximately one hour later, [Patient A] went into cardiac arrest. She made 'raspy, guttural sounds,' her breathing became labored, and she was unresponsive except for moaning. Cardiopulmonary resuscitation (CPR) was performed, but efforts to resuscitate her were unsuccessful.

The provisional autopsy report [performed by Mark Zuckerman, M.D.] stated that [Patient A's] cause of death was 'cardiac in nature,' caused by blood in the pericardial sac resulting in tamponade -- or compression of the heart due to excess fluid in the pericardium --

[1] For ease of reference, from here on I will cite to the published Appeals Court decision.

likely occurring from prolonged CPR. The medical examiner produced the provisional autopsy report based on external and internal examinations of [Patient A's] body.

The final autopsy report, produced after microscopic evaluation of [Patient A's] heart, noted 'puncture marks on the posterior aspect of the heart with hemorrhage just below the level of the cardiac valves,' and the presence of 250 cubic centimeters (about eight ounces) of blood in the pericardium. The report noted both 'acute and chronic' pericarditis, or inflammation of the pericardium, with 'the acute inflammation and hemorrhage likely occurring at the time of hiatal hernia repair.' 'Although trauma was considered as a potential cause of the pericarditis, unequivocal evidence of surgical trauma . . . could not be demonstrated.' [Patient A] did not have a pulmonary embolism, or blood clot, in her lungs, the presence of which could have contributed to irregular heartbeat. The report concluded, 'The final cause of death is ascribed to a combination of pericarditis, myocarditis and hemopericardium' -- that is, inflammation of the pericardium, inflammation of the heart muscle, and bleeding within the pericardial sac -- 'with tamponade leading to cardiac arrest.'" *Parsons*, 97 Mass. App. Ct. at 99-100; Dr. Ex. A.

5. Patient A's estate, on behalf of her husband and children sued Dr. Ameri, Louise Pothier, a nurse who assisted him, and the surgical association that employed them. (Bd. Ex. 1.) The case was tried to a jury. The trial lasted six days. (Ex. 3.) The jury was "led through the preliminary and final autopsy reports in detail." *Parsons*, 97 Mass. App. Ct. at 104.

6. The estate maintained that Dr. Ameri negligently caused Patient A's death by inappropriate use of the tacker, which punctured Patient A's pericardium, leading to excess fluid in the pericardium, acute pericarditis, and Plaintiff's A's heart attack and death. (Bd. Exs.

3 and 5.) It relied on expert testimony and a warning by the manufacturer of the tacker of the circumstances in which it should not be used. [Patient A's] expert, Dr. Brian Carmine, was "a general surgeon who had performed nearly 1,000 hiatal hernia surgeries. Carmine testified to a reasonable degree of medical certainty that [Dr.] Ameri and [nurse] Pothier's treatment of [Patient A] was below the standard of care expected from the average qualified surgeon and registered nurse first assistant and was a substantial contributing factor to [Patient A's] death. Specifically, based on his review of the final autopsy report and the photographs from the surgery, Carmine opined that it was more likely than not that [Dr.] Ameri pierced [Patient A's] pericardium and punctured her heart with the tacker, resulting in her cardiac arrest and death.

Carmine was familiar with the tacker [Dr.] Ameri used in the laparoscopic procedure performed on [Patient A] as well as other techniques for hiatal hernia repair. Injury to the pericardium or any part of the heart muscle should not have occurred if proper surgical techniques were used, and causing such injury during hiatal hernia surgery would violate the applicable standard of care. The average qualified surgeon would have been aware of the risks of using a tacker: 'the concern is that when you fire one of these pressure-loaded fasteners, that it can penetrate through and hit structures on the other side of the diaphragm that you can't see, and cause life-threatening injury.' Once the stomach was moved down into its correct anatomical position and the hernia was closed or reduced, the back of the heart was just 'the thickness of a diaphragm away' from where the tacks were placed; this distance could be as little as three to five millimeters. When asked whether [Dr.] Ameri used the tacker to place tacks on [Patient A's] diaphragm 'in the vicinity of the pericardium,' Carmine answered, 'Yes.

There were some that were concerningly anterior,' that is, too close to the front of the chest, near the back of the heart. In Carmine's opinion, [Dr.] Ameri's choice to use the tacker directly on the diaphragm, when it was very close to the pericardium, was below the standard of care.

Moreover, Carmine testified that [Dr.] Ameri's use of the tacker was directly contraindicated by the manufacturer's instructions, which stated that the tacker should not be used in a 'diaphragmatic hernia repair' where tacks are inserted 'in the diaphragm in the vicinity of the pericardium.' The average qualified surgeon would know or should have known this information, and [Dr.] Ameri's use of the tacker in [Patient A's] surgery violated the standard of care.

Carmine further testified that it was the surgical tacks that caused the puncture marks on [Patient A's] heart, not CPR as the defendants contended. The puncture marks in the autopsy reports were not consistent with an injury related to CPR but, rather, were consistent with an injury occurring during the surgery. Carmine also noted that [Patient A] went into cardiac arrest before CPR was performed." *Parsons*, 97 Mass. App. Ct. at 100-101.

7. Dr. Ameri testified in his own defense and also presented expert testimony. "The defendants' theory of the case was that [Patient A] died of long-standing damage to her heart caused by the hiatal hernia, aggravated by prolonged CPR. [Dr.] Ameri emphatically denied 'enter[ing]' [Patient A's] heart with the tacks during the performance of the surgery." *Parsons* 97 Mass. App. Ct. at 101. The doctor testified that he "had used the tacker in many hernia repair surgeries. He preferred to fasten mesh with the tacker because the tacks were less likely than sutures to tear, which could potentially raise the risk of hernia recurrence. [Dr.] Ameri

used the tacker to affix mesh to [Patient A's] diaphragm crura, that is, the muscular edge of the diaphragm closest to the esophagus. Although he understood the contraindications associated with the tacker, [Dr.] Ameri stated that the tacker was nonetheless 'almost always' used to affix mesh to the diaphragm, 'unless the thickness of it is not enough.' In this regard, he distinguished between the diaphragm and the crura, stating that 'crura is always thicker than the actual muscle layer of the diaphragm,' and that because the crura is so thick the tacks were 'not going to get anywhere beyond this thickness.' Used in this way, the tacker was 'nowhere close to,' 'did not have any relationship whatsoever, or a proximity or getting close,' and was 'far away from any major vessel or heart or any part of the pericardium.' He admitted that he did not measure the thickness of [Patient A's] diaphragm crura at the time of the surgery, but he 'ballpark[ed]' its thickness to be ten millimeters, thick enough to withstand the five millimeter tacks without allowing them to pierce through the diaphragm. He agreed that puncturing the pericardium or the myocardium, the heart muscle itself, during hiatal hernia repair surgery would be below the standard of care expected of the average qualified general surgeon." (*Parsons*, 97 Mass. App. Ct. at 98-99.)

8. "The defense's expert witness, Dr. David Brooks, a general and gastrointestinal surgeon, opined that [Dr.] Ameri's actions and conduct were appropriate and in accord with the accepted practice of the average qualified general surgeon. He believed that [Patient A's] death was caused not by an injury during the hiatal hernia repair surgery but rather by the use of blood-thinning medication and attempts to resuscitate her through CPR.

Brooks testified that the tacks did not enter [Patient A's] heart. He believed it highly

unlikely that the tacks could have injured [Patient A's] pericardium because the puncture marks were 'miles away' from where the tacks were placed. Like [Dr.] Ameri, Brooks estimated the thickness of the crura to be approximately ten millimeters. He stated that the location of the hemorrhaging, the location of the tacks, and the technique used to close the hernia and move the stomach back to its proper position all indicated that [Patient A's] pericardium was not injured during surgery. He also pointed to a sentence in the provisional autopsy report stating that 'no surgical penetration of the pericardium was identified.' He suggested that [Patient A's] initially stable postoperative condition was not consistent with someone who suffered a pericardium injury during surgery. He believed that the echocardiogram performed on the second day after surgery would have revealed more fluid in the pericardium if it had been injured during surgery. He also pointed to the autopsy findings of chronic pericarditis and stated that he believed that [Patient A's] hiatal hernia was responsible for that condition. In his opinion, the prolonged CPR caused an injury 'that led to bleeding into the pericardial sac.' He stated that the evidence that the CPR broke [Patient A's] second rib supported his conclusion that it also injured the heart.

Brooks too was familiar with the tacker and the contraindications for its use. He stated that despite the warnings, he used it routinely in laparoscopic hiatal hernia surgery. Based on his personal experience and review of the medical records, he opined that [Dr.] Ameri's use of the tacker was appropriate for [Patient A's] procedure 'if used wisely and safely.' In his opinion, 'the warnings that are on the package insert are largely a defensive maneuver' by the manufacturer so 'it would not be involved in litigation.'" *Parsons*, 97 Mass. App. Ct. at 101-

102.

9. The jury was asked to complete a special verdict form. It answered yes to questions relating to whether Dr. Ameri acted negligently in his treatment of Patient A, and whether his negligence was a substantial contributing factor in both causing her pain and suffering and contributing to her death. It awarded Patient A's husband and children substantial sums as compensation. The jury also answered yes to a question asking whether Dr. Ameri has acted with gross negligence. It then awarded $2.5 million in punitive damages. (Bd. Ex. 2.)

10. Dr. Ameri filed a number of post-trial motions, one of which objected to the issue of gross negligence being presented to the jury. Dr. Carmine had not testified that Dr. Ameri's conduct was a gross deviation from the standard of care, evidently because he had not been asked. Following the doctor's testimony, the trial judge, Edward P. Leibensperger, asked the parties to address whether the jury could nonetheless be asked to consider whether Dr. Ameri was grossly negligent. Judge Leibensperger decided to allow the issue to go to the jury because of the evidence that Dr. Ameri used the tacker near the pericardium in evident violation of the manufacturer's explicit warning not to do so. He then gave the "standard [gross negligence] charge" to the jury describing "gross negligence as 'substantially and appreciably' greater than ordinary negligence. Among other measures, gross negligence includes voluntary incurring of obvious risk and persisting in a palpably negligent course of conduct over a period of time." He denied Dr. Ameri's motion that evidently asked the gross negligence finding be set aside, ruling that:

> the jury's finding of gross negligence was reasonably justified by the evidence that Dr. Ameri proceeded to use the tacker in this surgery despite the explicit contraindication.

> It could reasonably be found that he voluntarily subjected [Patient A] to an obvious risk when there were alternatives to the use of the tacker. There was evidence that use of the tacker in hiatal repair surgery to fasten tacks to the diaphragm was negligent. A jury, having concluded that use of the tacker was negligent, could find that Dr. Ameri's testimony that he regularly uses the tacker for similar hiatal repair surgery suggests that Dr. Ameri was indifferent to the risks and persistently engaged in negligent conduct. Consequently, the jury's finding of gross negligence should not be disturbed.

(Bd. Ex. 3.)

11. Judge Leibensperger denied all of Dr. Ameri's post-trial motions, including a motion for a new trial, except for a motion concerning prejudgment interest on the punitive damage award. Consequently, the judge issued an amended judgment striking such interest but otherwise leaving the compensatory and punitive damage awards unchanged. (Bd Exs. 3 and 4.)

12. Dr. Ameri appealed and raised a number of issues related to gross negligence, including once again his objection to that issue having been left for the jury to decide in the absence of expert testimony that he had been grossly negligent. The Appeals Court, in a February 26, 2020 decision, rejected this argument and affirmed the jury verdict. It held:

> Conceding that the plaintiff's expert would not have been permitted to opine that his conduct amounted to "gross negligence," see Puopolo v. Honda Motor Co., 41 Mass. App. Ct. 96, 98, 668 N.E.2d 855 (1996), [Dr.] Ameri nonetheless contends that the jury could not permissibly reach a verdict on the issue without expert testimony, based on "factual and medical consensus," that [Dr.] Ameri's conduct was not just below the applicable standard of care, but also was "a flagrant and egregious departure." We disagree. The evidence, including the plaintiff's expert's testimony, provided the jury with a reasonable basis to distinguish ordinary negligence from gross negligence in this case. It was uncontested that injuring the patient's pericardium or heart muscle during hiatal hernia repair surgery would violate the standard of care for the average qualified surgeon. The evidence as a whole permitted the jury to find that [Dr.] Ameri's use of the tacker in [Patient A's] surgery manifested many of the common indicia of gross negligence. See Rosario v. Vasconcellos, 330 Mass. 170, 172, 112 N.E.2d 243 (1953), quoting Lynch, 294 Mass. at 172, 200 N.E. 914 ("some of the more common indicia of

> gross negligence are set forth as 'deliberate inattention,' 'voluntary incurring of obvious risk,' 'impatience of reasonable restraint,' or 'persistence in a palpably negligent course of conduct over an appreciable period of time' ").

Parsons, 97 Mass. App. Ct. at 108-109.

13. On August 13, 2020, Pathologist Mark Zuckerman, M.D. of Winchester Hospital, sent a letter to Dr. Ameri's then counsel. In the letter, he made the following comments on his autopsy of Patient A:

> At the time of the autopsy, I found the tacks were in the appropriate position for the intended surgery and found no evidence of surgical trauma to the pericardium or heart. There were puncture marks to the back (posterior) aspect of the heart, which were due to the cardiac compressions of CPR in which the heart pressed against the underlying spine.
>
> An abundance of tissue samples were taken of these areas for microscopy. I found no evidence of surgical trauma to the pericardium or heart microscopically. I found severe and long standing medical pericarditis of uncertain origin.
>
> I consulted CV PATH[2] in Virginia which was directed by Dr. Renu Virmani who was the former Director of Cardiovascular Pathology at the Armed Force Institute of Pathology. In their report, they state: "Although the trauma was considered as a potential cause of the pericarditis, unequivocal evidence of surgical trauma in the submitted histologic sections could not be demonstrated."
>
> Although the surgery had taken place two days prior to the patient's passing, it would not be possible for surgical trauma to heal in the interval.

(Dr. Ex. A.)

14. On February 3, 2022, the Board of Registration in Medicine issued a Statement of Allegations charging Dr. Ameri with malpractice and gross negligence in connection with his surgery on Patient A. It averred the jury verdict of gross negligence in the civil case precluded

[2] The CV Path Institute describes itself as "designed to provide expert translational bench-to-bedside research services utilizing state-of-the-art technology." https://www.cvpath.org/#ConsultationServices.

the doctor from relitigating that issue and that the jury verdict of negligence in the care and treatment of Patient A combined with the jury finding that his negligence caused her pain and suffering precluded the doctor from relitigating whether he had committed malpractice. (Statement of Allegations.)

Discussion

The Board of Registration in Medicine has now moved for summary decision on the basis that the jury verdict established that Dr. Ameri was grossly negligent and that he is collaterally estopped from relitigating the issue in this proceedings.[3]

"The doctrine of collateral estoppel, also known as issue preclusion, does not require mutuality of parties, so long as there is an identity of issues, a finding adverse to the party against whom it is being asserted, and a judgment by a court or tribunal of competent jurisdiction." *Miles v. Aetna Casualty & Surety Co.*, 412 Mass. 424, 427 (1992). The main factor that the party espousing estoppel must establish is that "the issue on which preclusion is sought has been 'the product of full litigation and careful decision.'" *Id.* (citation omitted.) The Supreme Judicial Court has held that, if an issue is decided in a civil case, issue preclusion can apply in a subsequent disciplinary proceeding. It observed in a case involving attorney discipline that:

[3] The Board in it motion made brief reference to the malpractice charge contained in the Statement of Allegations, but did not present a fully developed argument. Consequently, the doctor's response did not focus on the malpractice charge either. Although the argument might ultimately be similar regarding this charge, I reach no conclusion as to malpractice. Rather, it would appear that Board counsel has decided that a decision based solely on the gross negligence charge is sufficient to allow the Board to discipline the doctor. Thus, I am issuing a recommended decision on the merits, rather than a partial decision on one charge alone.

> We see no basis for withholding preclusive effect of civil findings in a subsequent disciplinary action against an attorney. To do so would cause to be relitigated issues previously examined and decided. Such relitigation would not comport with the judicial goals of finality, efficiency, consistency, and fairness, thought to be effectuated through the invocation of collateral estoppel.

Bar Counsel v. Board of Bar Overseers, 420 Mass. 6, 10-11 (1995). The Court noted, however, that the "fact finder [in the disciplinary proceeding] should be afforded wide discretion in determining whether to [grant preclusive effect] would be fair to the defendant," and should consider, for example, "whether disparate burdens of proof existed in the two proceedings." *Id.* at 11-12.

There is no obvious reason why, if collateral estoppel may apply in bar disciplinary proceedings, it should not also apply in proceedings to discipline doctors.[4] I have recited the evidence presented at the six day trial of Dr. Ameri to show that he had a full and fair opportunity to present his defense to the charge of gross negligence and to make any arguments he had to the trial court and the Court of Appeals on the gross negligence issue. In the end, after this full and fair opportunity, both the trial court and the Court of Appeals affirmed the jury verdict on that issue. The judgment entered against Dr. Ameri after the six day trial and the affirmance of the verdict by the Appeals Court suffices to show "a finding adverse to the party against whom it is being asserted, and a judgment by a court or tribunal of competent

---

[4] Board regulations allow it to discipline a doctor for "[h]aving been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those [for which a doctor may be disciplined in Massachusetts] set forth in M.G.L. c. 112, § 5 or 243 CMR 1.03(5)." 243 CMR 1.03(5)(a)12. The Supreme Judicial Court has affirmed that the Board may by regulation give collateral estoppel effect to a another state's disciplinary actions "for reasons substantially the same" as those for which physicians may be disciplined in Massachusetts. *Haran v. Board of Registration in Medicine*, 398 Mass. 571 (1986).

jurisdiction."

The burden in the civil trial was on Patient A's estate to show by a preponderance of the evidence that Dr. Ameri was grossly negligent. Similarly, in this proceeding that burden is on the Board of Registration in Medicine to prove by a preponderance of the evidence that Dr. Ameri was grossly negligent. *Board of Registration in Medicine v. Carcamo-Sanabria*, Docket No. RM-11-310, Recommended Decision at 7 (Div. of Admin. Law App., Oct. 5, 2012). Thus, there is no disparate standard of proof that ought preclude application of collateral estoppel.

The doctor makes a number of arguments as to why issue preclusion should nonetheless not apply to him. He resumes the argument that he tried unsuccessfully in the prior litigation, namely that the estate's expert did not specifically opine that Dr. Ameri had been grossly negligent. Both the trial court and the Appeals Court directly addressed this issue and held that the issue of gross negligence was properly placed before the jury because the evidence included facts from which a jury could find that the doctor had acted with gross negligence. These rulings appear correct and there is no reason to revisit them here, even if we had the authority to do so.

The doctor also objects that the jury did not make a specific finding as to what actions of his amounted to gross negligence. It is true that all the jury did in the civil action by way of explanation of its conclusion that the doctor was grossly negligent was check a box to that effect. It offered no written description of exactly which pieces of evidence led it to this conclusion. But this is universally true of jury verdicts. In civil cases, juries determine liability and, in criminal cases, they determine guilt, rarely with any particular explanation as to their

reasoning. What that means is that the doctor is essentially arguing that issue preclusion is unavailable if the prior case was decided by a jury. That is not the law. For example, when asked to determine whether a verdict in a criminal case tried to a jury should be given preclusive effect, the Supreme Judicial Court held that "a party to a civil action against a former criminal defendant may invoke the doctrine of collateral estoppel to preclude the criminal defendant from relitigating an issue decided in the criminal prosecution." *Aetna Cas. & Surety Co. v. Niziolek*, 395 Mass. 737, 742 (1985). The supposed lack of clarity of the jury's verdict was not a barrier to the trial court or the Appeals Court resolving whether the jury had a basis for determining that Dr. Ameri had acted with gross negligence. These courts simply looked at the evidence and concluded that the evidence that would have been sufficient to find the doctor grossly negligent was the evidence on which the jury relied. This is a standard approach to the analysis of jury verdicts. What it means for present purposes, is that I will assume that the facts described by the courts as the proper bases of the jury's finding are the bases to be considered here when addressing the discipline of Dr. Ameri for gross negligence.

In a somewhat related argument, the doctor claims that there is a lack of identity of issues between the civil case on and this disciplinary proceeding because the gross negligence issue in the civil case related to whether the estate was owed punitive damages while the issue here is whether the doctor should be disciplined in order to protect the public health generally. Dr. Ameri cites a decision holding that a private citizen may maintain an action against a tobacco company and seek punitive damages even after the Attorney General had settled a prior suit with the tobacco company because the interests of the individual and the Attorney General

were different. *See Laramie v. Philip Morris USA Inc.*, 488 Mass. 399 (2021).

That decision is inapposite. The dispute in *Laramie* was over claim preclusion, not issue preclusion. The Massachusetts Attorney General had sued Philip Morris and other tobacco companies over their manufacture and sale of tobacco products and sought treble damages under the state's consumer protection law, M.G.L. c. 93A. In 1998, Massachusetts and most other states settled with the tobacco companies. The settlement agreement "released Philip Morris from liability for punitive damages to persons acting as private attorneys general seeking relief on behalf of the general public, but preserved claims for individual relief for separate and distinct injuries." 488 Mass. at 404. Years later, Pamela Laramie sued Philip Morris for the wrongful death of her husband, Fred Laramie, who died of lung cancer after decades of smoking. A jury awarded her both compensatory and punitive damages. On appeal, Philip Morris argued that the settlement agreement precluded an award of punitive damages. The Supreme Judicial Court disagreed. It observed that "'[c]laim preclusion makes a valid, final judgment conclusive on the parties and their privies, and prevents relitigation of all matters that were or could have been adjudicated in the action'" and that "[t]hree elements must be established to show claim preclusion: '(1) the identity or privity of the parties to the present and prior actions, (2) identity of the cause of action, and (3) prior final judgment on the merits." *Id.* at 405. The Court noted that the Attorney General had pursued relief on behalf of the citizenry generally, while Laramie was seeking damages relating to a personal injury. It also noted that the punitive damages she was seeking were under the wrongful death statute, while the Attorney General had relied on the very different punitive provisions of the consumer protection law.

Comparing the different claims, the Court observed that "[t]he 'wrong' the plaintiff sought to remedy was the loss she and her daughter sustained due to Laramie's death, caused by Philip Morris's malicious, willful, wanton, reckless, or grossly negligent conduct, see G. L. c. 229, § 2 [while] [t]he 'wrong' the Attorney General sought to remedy, by contrast, was the Commonwealth's increased medical expenditures caused by Philip Morris's commission of unfair or deceptive acts or practices in violation of G. L. c. 93A, § 2." *Id.* at 411.

Dr. Ameri insists that *Laramie* applies here because the distinction the Court made between punitive damages and a government remedy should apply because the civil suit brought by the estate involved punitive damages while the disciplinary hearing involves a different public concern. That misses the point of *Laramie*. Philip Morris was arguing that Mrs. Laramie's claim for punitive damages was precluded by a similar claim for damages by the Attorney General. The distinctions the Court made in its *Laramie* decision were to show that the two damages claims were not the same. The issue here is not whether the damage claims are the same. The estate's effort to seek punitive damages is different than the Board's effort to seek to discipline Dr. Ameri, which means that, per *Laramie*, the Board's action seeking discipline of the doctor is not precluded by the prior damages verdict. However, in both instances the underlying issue was whether Dr. Ameri had acted with gross negligence. On that score, the issue is exactly the same. The jury was charged in the civil case with the standard jury instruction that defines "gross negligence as 'substantially and appreciably' greater than ordinary negligence." (Finding 10.) This is the definition of gross negligence that applies to Board of Registration in Medicine disciplinary proceedings. *See Hellman v. Board of*

Registration in Medicine, 404 Mass. 800, 804 (1989) ("Gross negligence is substantially and appreciably higher in magnitude than ordinary negligence.") Thus, there is an identity of issues.

The doctor still insists, based on a 1994 Board decision, that a "civil jury verdict and judgment in a medical malpractice case are not given any preclusive effect at DALA." The decision, *In re Jacob Goldberg*, D.O., 87-73-TR, Final Decision (Bd. of Regis. In Medicine, Dec. 28, 1994) concerned a psychiatrist who had previously been sued by his patient for malpractice. The Board declined to give the jury's verdict preclusive effect because a "review of the record from the civil trial . . . was inconclusive insofar as determining what issues of fact were actually litigated and necessarily determined in that case." Final Decision at 34 n. 25. This result is consistent with the SJC's opinion that the "fact finder [in the disciplinary proceeding] should be afforded wide discretion in determining whether to [grant preclusive effect] would be fair to the defendant," *Bar Counsel*, 420 Mass. at 11, but it does not mean that DALA must in every case refuse to grant preclusive effect to a civil jury verdict. As I have explained above, I believe preclusive effect is warranted in this instance.

Finally, Dr. Ameri maintains that Dr. Zuckerman's letter presents new evidence that "raises serious questions about whether [he] was negligent in the performance of the surgery" and thus calls "into question the finding of gross negligence." The Board makes the obvious rejoinder that the Massachusetts Rules of Civil Procedure allow relief from a final judgment based on new evidence only for "newly discovered evidence which by due diligence could not have been discovered in time to move for a new trial." Mass. R. Civ. P. 60(b)(2). There is no evidence that the doctor has returned to court and sought a new trial based on the Zuckerman

letter. Such relief would, in any event, seem unlikely. Dr. Zuckerman worked for Winchester Hospital in 2020 when he wrote his letter. Although the record before me does not reflect where he worked in 2013 when he wrote the autopsy report, I presume he worked at Winchester Hospital then as well because Patient A's surgery was performed at that hospital. Thus, there is nothing to suggest that his opinion, as expressed in his recent letter, would have been unavailable to Dr. Ameri's then counsel in the civil trial if thought to be useful. Moreover, his opinion seems hardly new. In his autopsy report, he stated that he did not find "unequivocal evidence of surgical trauma." (Finding 4.) In his letter, he stated that he "found no evidence of surgical trauma to the pericardium or heart." He added that he consulted with a pathologist in Virginia who also found that "unequivocal evidence of surgical trauma in the submitted histologic sections could not be demonstrated." (Finding 13.) As it is, the autopsy report played a significant role in the civil trial. The jury was "led through the preliminary and final autopsy reports in detail" (Finding 5) and the doctor's expert witness relied, in part, on the autopsy as he "pointed to a sentence in the provisional autopsy report stating that 'no surgical penetration of the pericardium was identified.'" (Finding 8.) Dr. Ameri had a full and fair opportunity to rely on the autopsy report in the civil trial. Dr. Zuckerman's subsequent letter is not reason to discard the jury's verdict and start again from scratch.

I therefore grant the Board's motion for summary decision. I note that the doctor has an opportunity to present mitigating evidence before the Board makes its decision on discipline. I have described the evidence in the civil trial in some detail partly because it shows how close a case this was and offers evidence that might be considered mitigating. The doctor had

performed similar surgeries in the past without harming his patients. Based on this experience and his estimation of the thickness of the tissue to be tacked, he had a good faith belief that using a tacker as part of Patient A's surgery would not harm her. He also had the opinion of another practicing surgeon that he did not harm the patient let alone cause her death. If he has other mitigating evidence, he may present it to the Baord.

Conclusion

Based on the foregoing, the Board may impose such discipline on Dr. Ameri for gross negligence as it deems appropriate in light of the facts and conclusions of law that can be drawn from the civil verdict of gross negligence in the doctor's treatment of Patient A.

DIVISION OF ADMINISTRATIVE LAW APPEALS

James P. Rooney

James P. Rooney
First Administrative Magistrate

Dated: NOV 30 2022

APPENDIX

Board Exhibits

1. Complaint of Estate of Laura Parsons versus Dr. Ameri
2. Special verdict form
3. Trial judge's ruling on Dr. Ameri's motion for a new trial (June 6, 2018)
4. Amended judgment on jury verdict
5. *Parsons v. Ameri*, 97 Mass. App. Ct. 96 (2020)

Dr. Ameri Exhibit

A. Letter of Mark Zuckerman, M.D. (August 13, 2020)