Attorneys for Respondent,
, M.D.

IN THE MATTER OF ARBITRATION

, an individual and , an individual, Claimants, vs. , M.D., an individual, Respondent.	OIA NO.: 11815 ~~[PROPOSED]~~ **ORDER GRANTING RESPONDENT , M.D.'S , MOTION FOR SUMMARY JUDGMENT, OR IN THE ALTERNATIVE SUMMARY ADJUDICATION** DATE: **June 11, 2013** TIME: **10:00 a.m.** [Via Telephonic Appearance]

Respondent's Motion for Summary Judgment, or alternatively, for summary adjudication, was heard before this Court on June 11, 2013. NO APPEARANCE BY ~~appeared for~~ Claimants. , ESQ., appeared for Respondent. After full consideration of the evidence, the separate statements submitted by both parties, the notice of lodgement of exhibits, the declarations of the experts, the authorities cited by counsel, as well as oral argument at the hearing of this matter, the Court finds there is no triable issue of material fact in this action for medical malpractice and loss of consortium and that the moving party is entitled to summary judgment for the following reasons:

The claimants have failed to present any evidence regarding two of the essential elements of a cause of action for medical malpractice - breach of the standard of care and causation. Claimants are unable to establish that the treatment and care provided to

by Dr. , M.D., fell below the standard of care. Based on Mrs. presenting symptoms and past diagnoses, it was reasonable to diagnose her with cataracts in her left eye and to recommend a phacoemulsification surgery to address her symptoms. The phacoemulsification procedure performed on December 10, 2010, was performed in accordance with the applicable standard of care. The development of post-operative corneal edema is not indicative of negligence during surgery as this is a common and well known complication associated with this procedure. After Mrs. developed corneal edema and Descemet's membrane detachment, following the cataracts procedure, Dr. provided post-operative care which complied with the applicable standard of care. The treatment provided by Respondent in December of 2010, complied with the applicable standard of care

Furthermore, the claimants are unable to demonstrate that any action, or inaction, by Dr. resulted in injury to as Mrs. cannot demonstrate, to a degree of medical certainty, that receiving different medical treatment would have resulted in a better outcome. The post-operative care provided by Dr. was one of several options open to him, within the applicable standard of care. It would be speculative to state that following another treatment option would have resulted in a better outcome.

IT IS THEREFORE ORDERED that Respondent's Motion for Summary Judgment is GRANTED and that judgment shall be entered forth with in favor of Respondent and against Claimants.

Nothing in this arbitration decision (or settlement agreement) prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision (or settlement agreement) to the Department of Managed Health Care.

DATED: 6/11/13

Hon. David H. Brickner

HON. DAVID H. BRICKNER (RET.)
JAMS
500 N. State College Blvd.
14th Floor
Orange, CA 92868
Telephone: (714) 939-1300
Fax: (714) 939-8710

ARBITRATOR

IN RE: THE MATTER OF

Claimants,	**ARBITRATION No. 12192**
vs.	JAMS Ref. No. 1200047411
Respondents.	**FINAL AWARD**

This arbitration was conducted under the Rules for , including Rule 15 a. The hearing was held on April 28, 29 and 30 and May 1, 2014 at the JAMS offices in Orange, California.

The following is a statement of facts found by the Arbitrator. If they differ from the parties' views of the facts, that difference stems from the Arbitrator's determination of witness credibility, the relevance and weight of the evidence, and from applying the burden of proof.

INTRODUCTION

This is an action by and her husband, , against the entities and their surgeon, , M.D., for medical malpractice. They allege Dr. failed to properly implant a hernia repair mesh in Ms. , and failed to secure

Ms. informed consent for her hernia repair surgery. Mr. sues for loss of consortium.

CLAIMANTS' CONTENTIONS

In January 2012, Ms. , a patient, consulted with her primary care physician, M.D., about a possible hernia. Dr. examined the small bulge at Ms. waistline and immediately diagnosed a hernia, referring her to the surgical department for possible hernia repair.

After consultation with surgeon, Dr. , Ms. elected a procedure wherein Dr. would inspect the hernia laparoscopically (using a camera with a fiber optic lens in the abdominal cavity) and then decide whether to suture it or cover it with a polyester mesh.

On January 26, 2011, the hernia was surgically repaired, Dr. having opted for placement of mesh.

Ms. testified that after the surgery, and until removal of the mesh some 12 months later, she suffered virtually continual stabbing, debilitating pain behind her navel. In January of 2013, to find relief from this pain, previous treatments and medications having been unavailing, she consulted , M.D., a surgeon in , who removed the mesh on January 15, 2013, which he preserved in a formalin solution. He claims, on inspection of the mesh during and after the surgery, the mesh was placed incorrectly, causing Ms. pain.

Since the February 2013 surgery, Ms states her pain has been reduced by 80%.

DISCUSSION

WAS THE MESH IMPLANTED CORRECTLY?

The evidence on this question comprises three elements: (1) The direct testimony of Dr. , describing her habits, custom and practices in performing this surgery; (2) the opinions of Claimants' experts derived from their examination of the mesh, offered in support the theory of improper placement; (3) the opinion of Respondents' expert, offered to support proper placement.

Before discussing this evidence, some background information is necessary.

Umbilical Hernias- The abdominal structures of the human body (from the outside to the inside) comprise epidermis (skin), fat, muscle, fascia, peritoneum, omentum, and bowel. The fascia is a fibrous membrane which holds the viscera (internal organs) in place; the peritoneum is a membrane behind the fascia; the omentum is a fatty apron which hangs down in front of the bowel, behind the peritoneum.

A hernia is a hole in the *fascia*, through which peritoneum, omentum and bowel may extrude. There are various types of hernias, depending on where in the fascia the defect is located; Ms. suffered from an *umbilical* hernia, meaning a hole in the fascia behind the navel.

Umbilical Hernia repair methods- An umbilical hernia can be repaired by Laporotomy, which is an incision through the skin to the fascia where the hernia is closed by sutures, or by another method, where a polyester mesh is placed over the hernia, known as an "anterior (front) on-lay." Another technique, the "posterior (back side) in-lay", is done laparoscopically where the mesh covers the defect from the *posterior* of the fascia, lying between the peritoneum and the fascia. This method was used to repair Ms. hernia.

The Mesh- The mesh used to patch Ms. umbilical hernia was a polyester mesh disc, like a little window screen, 4 inches in diameter, *coated on one side with transparent layer of absorbable collagen,* and known as the Parietex Optimized Composite Mesh. When implanted as intended, the mesh side is fastened over the fascia, covering the hernia, and facing *outward* toward the *abdominal wall.* The collagen side then faces the *inside* of the body, facing the peritoneum, omentum, and viscera (bowel and other organs).

Mesh is a foreign element, and the body's natural reaction to it is to build tissue into and around it. The mesh side is therefore placed over the fascia and hernia, toward the abdominal wall, to *encourage* that integration of tissue, which secures the mesh. The *collagen side* is placed facing the inside of the body and, until it is absorbed by the body and disappears, *discourages* tissue integration on the *inside* of the body, reducing potentially harmful tissue integration (or adhesions) which can damage the bowel and other nearby organs.

It is crucial that the mesh be implanted correctly, with the mesh facing the abdominal wall and the collagen facing the omentum.

Claimants contend the mesh was implanted backward, with the collagen side facing the abdominal wall and the mesh side facing the omentum.

Dr. TESTIMONY

The surgical plan- Dr. examined Ms. quickly diagnosing a hernia, advising surgery. She told Ms. she would examine the hernia laparoscopically at the outset of the procedure, then chose whether to do "primary" or "in-lay" repair. Dr. prefers mesh repair, as it does not entail the "tension" caused by pulling tissues together through suturing, with concomitant greater risk of recurrence. The election of "in-lay" was almost a foregone conclusion.

Ms. surgery- The proper method of hernia repair by the "in-lay" method using the Parietex Optimized Composite Mesh, comprises these steps, which, according to Dr. , were scrupulously followed in Ms. case:[1]

1) Patient is sedated with general anesthesia lying supine on operating table;
2) A small incision is made a few inches either to the left or right of the navel, through which is placed a device into the abdominal cavity;
3) Gas is passed through this device, inflating the abdominal cavity, creating space for surgical tasks;
4) A tube, called a trocar, is then inserted through this incision and a laparoscope is inserted.
5) Several TV screens in the operating room display the laparoscope's view of the abdominal cavity;
6) Dr. examines the hernia, finding a defect of approximately one cm;
7) She decides against a "primary" repair, choosing "in-lay."
8) The Parietex Optimized Composite Mesh is now produced and handled in this manner:
    a) A nurse in the operating room opens the sealed box containing the mesh and extracts a sealed envelope, which she hands to Dr. ;
    b) Dr. opens the sealed envelope and retrieves a sealed inner box;
    c) This box is a small tray covered by a paper sheet;
    d) Dr. peels back the paper sheet;

[1] Dr. relied on her notes and her customary practices and habits in describing the procedure on Ms. , since she does not actually recall this patient.

e) The mesh, as always, lies mesh side up in the tray;
f) Dr. pours an anti-bacterial solution in the tray, wetting the mesh;
g) With a hooked needle, she then threads two "stay sutures" through opposing edges of the webbing on the mesh side;
h) She then rolls the mesh into a cylindrical shape with the collagen side on the inside, inserts it into the trocar and places it in the abdominal cavity, where it unfolds, collagen side up;
i) Dr. then reaches into the abdominal cavity with two gripping type devices placed through two small incisions near the navel;
j) While watching the TV screen, she grasps the two "stay sutures," pulling them toward the abdominal wall, guiding the mesh into place over the hernia, the mesh side toward the abdominal wall, and collagen side toward the omentum;
k) Dr. then ties off the "stay sutures" in a manner which holds the mesh in place;
l) With the mesh now secured against the abdominal wall and covering the hernia, Dr. then inserts a tack gun, tacking the mesh into place against the abdominal wall with approximately 20 tacks around the outer and inner circumference of the mesh. These tacks are tiny titanium spirals, with points at one end and fattened heads at the other;
m) The "stay sutures" and equipment are removed and incisions sutured.

DR. AND DR. EXAMINE THE MESH

, M.D.- Dr. , who removed the mesh, is a key witness for the Claimants, as it was he who first raised the possibility the mesh had been placed incorrectly.[1]

Dr. performed a Laporotomy, by incising the skin above the stomach, through subcutaneous fat, to the fascia, locating the hernia. He saw the mesh, noting extensive dense adhesions of the omentum on the inner surface of the mesh. He also noted "the rough side of the mesh" was facing the omentum and "the smoother side" of the mesh was facing the abdominal wall. He removed the mesh, preserving in place several of the tacks used by Dr. The tacks are important. Based on the visible points and heads, every viewer of this mesh knows *which side* of the mesh was against the abdominal wall and which against the omentum.

Dr. perceived "rough" and "smooth" sides, apparently based on his seeing exposed mesh fibers on the "rough" side and feeling the smooth texture on the "smooth" side. He opined

[1] Dr. did not appear at the hearing; his video deposition was played in his absence.

the mesh had been put in "upside down," because the "rough" side was toward the omentum.[1] "The composite mesh has two sides that have different properties. One side is rough, which is meant to form adhesions and is not supposed to be turned intraperitoneal [toward the omentum.] There is a smooth side on the other side, which is meant to reduce the adhesions...and that is meant to be exposed to the intraabdominal wall..." deposition, pages 20 -21, lines 24-25, 1– 9.)

"The rough side [is] facing the intraabdominal viscera." (Page 22, Lines 12-14.)

When pulling the mesh halfway out of the body he observed the side facing intraabdominally was in fact the "rough" side.

When asked to examine the mesh he did so, testifying he could discern which side was "rough" and which was "smooth." He stated "...the rough side, which I can see best right now in the jar the way its oriented, it appears to have [observable] mesh configuration, that is with weaving, with pore size, its about 1 ½ millimeters, and on the opposite side, it's a smooth side where you don't see any fabric, no weaving, no pores." (Page 42, Lines 18-24.) When handling the mesh he stated "You have to feel it to really appreciate how smooth it is because there's a lot of ad[hesions] that's still stuck to it from the abdominal wall..." (Page 53, Lines 4-6.)

Dr. has not used Parietex mesh. When asked if he knew whether the mesh has different materials on each side or how one side is "rough" and the other "smooth," Dr. replied, "My understanding of the differences in the sides is based on my examination of the material. One side feels smooth, the other side feels rough." (Page 95 Lines 9-12.)

When asked if he knew if the smooth side has any type of covering or material over it to make it smooth, Dr. replied (after several objections, which were overruled) "I don't know." (Page 96, Line 2.)

In response to the question "Okay, so you don't know what makes one side smooth and one side rough?" Dr. replied (after several objections, which were overruled) "No. I don't know how it's manufactured. I know one side is smooth and one side is rough." (Page 96 Lines 4-24.)

[1] In fairness to Dr. , since the mesh is a disc, it can't be upside down; I assume he meant "backward."

When asked if he knew whether the properties of either side change over time in the human body, Dr. replied (after several objections, which were overruled) "I don't know." (Page 97, Line 5.)

When asked how long it takes for adhesions [integration of the surrounding tissue] to form after placement of a mesh inside the body, Dr. answered (after several objections, which were overruled) "I don't have that kind of knowledge." (Page 97, Line 12.)

, M.D.- Dr. , who is familiar with collagen-coated mesh, testified as Claimants' expert. In examining the mesh itself, he noted the direction of the tacks show the "smooth" side identified by Dr. is the side that was against the abdominal wall, which supports, in his view, Dr. opinion that the mesh was installed backward because the "smooth" side must have been the collagen side.

He also said peritoneum will grow on a properly placed collagen-coated mesh, covering the mesh, but not integrating into it. Peritoneum, however, will *not* grow on or cover the bare mesh. Since Dr. saw no peritoneum covering *either side* of the mesh, he inferred the collagen side had been placed against the abdominal wall and the omentum (and peritoneum) were exposed to the non-collagen side. Hence, no peritoneum layer on either side.

DR. AND DR. EXAMINE THE MESH

Dr. - Dr. was called as Respondents' expert. He observed the omentum side has little tissue adhered to it, whereas the abdominal wall side has muscle thoroughly entwined in it. This demonstrated the mesh side, not the collagen side was properly against the abdominal wall, where muscle is found. He further noted the collagen dissolves over approximately two months, leaving bare mesh next to the omentum into which the omentum will naturally grow, a desired result.

Dr. - Dr. examined the mesh, noting, as did the other witnesses, the heads of the tacks, identifying the omentum side, and the points of the tacks, identifying the abdominal wall side. She observed the abdominal wall side is completely covered with tissue, the omentum side has less, which follows her having placed the collagen against the omentum, meaning the collagen "did its job" by inhibiting adhesion.

ANALYSIS

All agree, based on the tacks left in the mesh, how the mesh was oriented in the abdomen, but that fails to establish *which* of the two sides was originally coated with the now, long-gone, collagen.

Dr. described the mesh as having "smooth," and "rough" sides, concluding, *because* one side was "smooth," it must have been intended for the omentum, but was mistakenly placed against the abdominal wall. The "rough" side being against the omentum reinforced his opinion. Apparently, though never specifically questioned on this point, Dr. believed the mesh consisted only of "rough" and "smooth" sides, which led to his conclusion it had been installed backward. The problem with this theory is that Dr. was unaware the Parietex mesh does not rely on a "rough" versus "smooth" sides for its efficacy. Instead, as we know, it uses a re-absorbable collagen coating to inhibit adhesions to the omentum and bare mesh for integration into the abdominal wall. The two sides of the Parietex mesh are *identical,* except for the collagen coating; no evidence of any other difference in the two sides was offered. Once the collagen disappears, this Parietex mesh has no "rough" or "smooth" sides.

Therefore, because the location of the long-gone collagen is unrelated to the perceived texture of the mesh's two sides, Dr. "rough/smooth" theory does not prove which side of the mesh originally was coated with collagen. [1]

Dr. opinion is based largely on Dr. . While Dr. believes that peritoneum would coat a properly placed collagen layer, Dr. noted that the perceived absence of such a visible layer is explained because the peritoneum is only one cell thick.

Dr. and Dr. point out that deeply embedded abdominal muscle tissue, typical of that tissue's reaction to exposed mesh, is found on the abdominal wall side of this mesh.

After examining the mesh, the Arbitrator notes the abdominal wall (Dr. "smooth" side) is completely coated with tissue, consistent with the abdominal wall having been exposed

[1] When discussing and demonstrating the "smooth" side of the mesh, Dr. was actually touching only tissue on the fully coated surface of the mesh, not mesh fibers.

to the bare mesh side, while the omentum (Dr. "rough" side) is only intermittently coated with tissue, consistent with its having been exposed to the growth-inhibiting collagen-coated side.

CONCLUSION

After careful consideration of all the testimony of the various expert witnesses, and repeated examination of the mesh itself, the Arbitrator has concluded, because Dr. testimony does not support improper implant theory, and because the abdominal wall side of the mesh is covered with tissue, whereas the omentum side is not, that the mesh was probably installed correctly.

This conclusion is supported by Dr. detailed description of this surgery, which the Arbitrator finds entirely credible. To conclude otherwise, the Arbitrator would have to find the commission of a sequence of consecutive, compounding mistakes at almost every step of Ms. procedure: Neither Dr. , nor the nurses, nor the anesthesiologist noticed the mesh was upside down in the box, or upside down while wetting it in the box with antibiotic solution, or when stitching the two "stay sutures," or when watching its placement over the hernia on the TV screens, or when tacking it in place. This scenario is inherently improbable.

The Arbitrator therefore concludes by the preponderance of the evidence that Dr. placed the Parietex mesh appropriately in Ms.

INFORMED CONSENT

Claimants' original theory, as enunciated in opening statement and pursued through part of the hearing, was the alleged failure of Dr. to inform Ms. of the possibility of chronic pain resulting from umbilical in-lay hernia repair. This theory, however, was not supported by Claimants' expert, Dr. , and was abandoned.

Dr. said, with little elaboration, that Dr. fell below the standard of care by not informing Ms. of "all options" and their "benefits and drawbacks." Counsel has argued this means Dr. should have informed her of the variety of other umbilical hernia repair possibilities, such as "on-lay" or "primary" by Laparotomy.

He further urges Ms. was not properly informed of the possibility of adhesions with mesh and of surgical complications.

The evidence clearly shows Dr. told Ms. about laparoscopic "primary" and "in-lay," the only procedures the doctor intended to use. The Arbitrator sees no need to advise the patient of procedures the surgeon has no intention of undertaking. As to risks, Ms. was provided a helpful booklet that explained, in understandable language, pictures, and detail, many kinds of hernia repairs, including her own. She was referred to pages 14 and 19 of the booklet which described her surgery and which advised of the risks of bleeding, infection, numbness or pain in the groin or leg, risk of hernia recurrence, anesthesia risks, mesh complications, inability to urinate and bowel or bladder injury.

The Arbitrator finds Ms. was given sufficient information regarding her surgery and foreseeable risks, to allow her to make an informed decision on whether to proceed.

JUDGMENT

The Arbitrator has found Dr. implanted the mesh properly and adequately advised Ms. of the risks. Thus, the entities and Dr. have prevailed in the matter and Claimants shall take nothing by their complaint. The Respondents shall have judgment in their favor. Costs to be borne by

NOTHING IN THIS ARBITRATION AWARD PROHIBITS OR RESTRICTS THE EMROLEE FROM DISCUSSING OR REPORTING THE UNDERLYING FACTS, RESULTS, TERMS AND CONDITIONS OF THIS DECISION TO THE DEPARTMENT OF MANAGED HEALTH CARE.

DATED: May 23, 2014

Hon. David H. Brickner (Ret.)

HON. DAVID H. BRICKNER (RET.)
JAMS
500 N. State College Blvd.
14th Floor
Orange, CA 92868
Telephone: (714) 939-1300
Fax: (714) 939-8710

ARBITRATOR

IN RE: THE MATTER OF

Claimant, vs. Respondents.	**ARBITRATION No. 12626** JAMS Ref. No. 1200048384 **RULING ON MOTION FOR SUMMARY JUDGMENT**

Claimant brings a medical malpractice action against Respondents alleging certain of Respondents' Doctors falsely, and with fraudulent intent, informed him he suffered from prostate cancer and needed appropriate medical treatment. This fraudulent action, according to Claimant, was motivated by the pecuniary desires of the doctors in question as well as the fact that he is African American.

Claimant further alleges that at no time did he believe the entreaties of the doctors and he eschewed their advice to seek medical treatment. Instead, Claimant asserts, he does not have prostate cancer and will never seek treatment with the subject physicians.

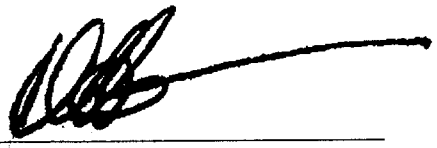
Respondents have brought a motion for summary disposition of this action, fashioned as a motion for summary judgment. Claimant appeared at telephonic oral argument, but filed no papers in response to the motion.

Assuming, for the moment, the subject physicians falsely reported to Claimant that he was suffering from prostate cancer, and did so for nefarious reasons, Claimant has repeatedly and emphatically pointed out he did not believe them and took no steps or action whatsoever in reliance on their advice. Thus, he has suffered no injury.

Respondents' motion for summary disposition is granted.

NOTHING IN THIS ARBITRATION AWARD PROHIBITS OR RESTRICTS THE ENROLEE FROM DISCUSSING OR REPORTING THE UNDERLYING FACTS, RESULTS, TERMS AND CONDITIONS OF THIS DECISION TO THE DEPARTMENT OF MANAGED HEALTH CARE.

DATED: September 11, 2014



Hon. David H. Brickner (Ret.)

HON. DAVID H. BRICKNER (RET.)
JAMS
500 N. State College Blvd.
14th Floor
Orange, CA 92868
Tel: 714-939-1300
Fax: 714-939-8710

Arbitrator

IN THE MATTER OF

JAMS No. 1200052829

Claimant,

vs.

Respondents.

AMENDED RULING ON RESPONDENT'S SECOND MOTION FOR SUMMARY JUDGMENT

Respondent, brings its second motion for summary judgment against Claimant, action for professional negligence.

FACTS (as reprised from the first motion)

Ms. underwent right knee replacement surgery on November 11, 2014 performed by Dr. of the an entity which renders medical care under contract with

Notwithstanding severe post-op pain, she was discharged from the hospital. She suspects she might have been discharged prematurely.

Although the severe pain abated somewhat, in her post-operative visits to Dr. she reported serious, chronic, disabling pain. Dr. said "... it takes a year to recover."

On the first anniversary of the surgery the pain, though somewhat improved, was still beyond bearable limits, compromising ability to do her job as activity director at a facility known as She eventually found employment elsewhere at reduced pay.

Due to persistent pain and a loss of faith in her prescribed physical therapy protocol, Ms. consulted on December 4, 2015. Her physical therapist there opined that her post-operative therapy prescribed by Dr. was inadequate.

In May of 2016 Ms. underwent meniscus repair on her *left* knee at but with a different orthopedic surgeon. Before that surgery, she asked if, while she was under anesthetic, they would manipulate her *right* knee in the hope it might relieve her still-constant pain. The surgeon consulted with Dr. who advised against it, as it "might break a bone."

In August, 2016, Ms. went outside the network and consulted Dr. an orthopedic surgeon. After x-rays and consultation, Ms. underwent surgery on September 27, 2016 to implant a thinner polyethylene liner and manipulate the knee. The effect of these procedures greatly reduced pain. Improvement continues to this day.

Ms. filed her demand for arbitration on January 25, 2017.[1]

THE PRESENT MOTION FOR SUMMARY JUDGMENT

This is a motion brought under Code of Civil Procedure 437c, which provides, in relevant part,

> (c) The motion for summary judgment shall be granted if all papers submitted show that there is no triable issue as to any material facts and that the moving party is entitled to a judgment as a matter of law.

moves for judgment, arguing there are no triable issue of fact as to this material issue: medical services and treatment of Ms. were within the standard of care.

bases its motion on the un-rebutted declaration of M.D. Dr. upon an examination of the entirety of the medical files, has opined the entire

[1] In her informal papers Ms. states she "filed papers with " regarding the physical therapy on February 2016, which would have been timely. However, because this statement was not made under oath, I must disregard it. Since Ms. was on notice in 2015 of the purported inadequacy of her physical therapy in 2015, and because there is no competent evidence before the Arbitrator as to the filing of her action for physical therapy before 2017, her action for the physical therapy is barred.

treatment of Ms. from pre-op, to surgery, to post-op to physical therapy, was within the standard of care. That is to say, without legal negligence, the basis of Ms. claim.

Faced with this evidence, Ms. must now rebut the opinion of Dr. with competent expert medical statements under oath in opposition to this motion, which she has failed to do. Thus, Dr. testimony exonerating stands as the only evidence on the issue of medical negligence, which is fatal to Ms. defense of this motion.

She has filed papers detailing her experience and told the Arbitrator in good faith that she has "experts who can testify at the hearing" and that she has "given all the appropriate papers to " but, in opposition to this summary judgment motion, this is not enough.

Absent expert medical declarations from Ms. at least raising a *question* of whether fell below the standard of care, the Arbitrator has no choice but to grant motion.

RULING

motion for summary judgment is GRANTED.

Nothing in this arbitration decision prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision to the Department of Managed Health Care.

DATED: January 26, 2018

It is So Ordered

Hon David H. Brickner (Ret.)
Arbitrator

HON. DAVID H. BRICKNER (RET.)
JAMS
500 N. State College Blvd.
14th Floor
Orange, CA 92868
Tel: 714-939-1300
Fax: 714-939-8710

Arbitrator

IN THE MATTER OF

JAMS No. 1200054196

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and , Heirs of , Deceased,

Claimants,

vs.

and

Respondents.

AMENDED RULING ON MOTION FOR SUMMARY JUDGMENT

Respondents move for summary judgment, which is unopposed.

FACTS

On May 8, 2016, reported to with certain urinary complaints. After several examinations, it was determined that Mr. suffered from bladder cancer. He was informed the best treatment was chemotherapy followed by surgery involving removal of the bladder and the prostate gland.

After a regimen of chemotherapy, Mr. underwent surgery on November 15, 2016, which was successful. During recuperation in the hospital, Mr. experienced some atrial fibrillation, which was treated with Metoprolol.

He was discharged from the hospital on November 25, 2016. On November 28, 2016 he died as a result of multiple pulmonary emboli.

M.D., a medical doctor licensed to practice in California reviewed the entire record of Mr. treatment and opined that every aspect of his treatment was within the standard of care. He further opined Respondents' treatment did not cause or contribute to Mr. death.

RULING

In an action against a medical provider for professional negligence, the testimony of an expert in the field is necessary for the Claimant to prove his/her case (*Willard v Hagemeister* (1981) 121 Cal. App. 3 406). This is even more compellingly necessary in the face of an opposing opinion which, as here, tends to vindicate the Respondent,

Since this motion is unopposed and no expert has been offered in support of Claimants' case, the motion for summary judgment must be, and hereby is, GRANTED.

Dated: December 13, 2018

It is So Ordered

Hon. David H. Brickner (Ret.)
Arbitrator

Nothing in this arbitration decision prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this decision to the Department of Managed Health Care.