CASE # 14751
Judicate West Case #A233477-39

, an individual,	)
	)
Claimant,	)
	) ARBITRATION AWARD
vs.	)
	) Hearing Dates: April 17, 18, 2018
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,	)
Respondent.	)
	)

The Parties & Counsel

Claimant, ("Claimant"), is represented by her attorney of record Esq., Respondent, ("Respondent"), is represented by its attorneys of record, Esq., Esq., and Attorney at Law, of Worthy of note here is the exemplary, highly professional, effective representation afforded the Parties in this proceeding by all counsel. This matter was thoroughly briefed, efficiently presented, and argued at the highest level of professional competence.

Introduction

The Parties seem to concur that this case arose from Claimant's complications after the laparoscopic ventral hernia repair surgery on 6 June 2016 (the "June 6th Surgery"). The June 6th Surgery was performed by Dr. Claimant was 64 at the time.

One additional undisputed fact was confirmed by the evidence and by agreement of Counsel. Though Claimant was throughout her procedures a " patient," Exhibit 204 shows that the California Department of Health Care Services has asserted a MediCal lien totaling $352,250.05.

Witness Testimony

This matter was arbitrated in an evidentiary hearing over the course of two days. Live testimony was received from Claimant and her daughter, " "
Dr. M.D. ("Dr. "), Board Certified general surgeon at Respondent's also testified. Additionally, the Parties offered expert witness testimony from the following physicians[1], all of whom were accepted as duly qualified expert witnesses:

- Dr. M.D.: Dr. served as Claimant's pathology expert.
- Dr. M.D.: Dr. was offered as Claimant's general surgery expert.
- Dr. M.D.: Dr. testified as Respondent's pathology expert.
- Dr. M.D.: Dr. Board Certified general surgeon and Fellow of the American Society of Metabolic & Bariatric Surgery, was Respondent's general surgery expert.

Documentary Evidence

Though the Parties submitted two large three-ring binders of documents, the documents upon which the Parties have relied were culled down to fit within one large binder[2]. Most of these were Claimant's medical records pre- and post- the June 6th Surgery, the June 12th surgical repair of the delayed onset perforation, and the complications that followed.

The documentary evidence included the Curriculum Vitae of the medical experts. It also contained declarations by Drs. and apparently arising from Respondent's Motion for Summary Judgment.

The Parties also presented very informative anatomical illustrations to graphically show the intestinal/bowel areas on which Dr. performed surgery on Claimant's ventral hernia. There were also photos of an exemplar of the

[1] Discussion of the relevant portions of the physicians' testimony and the affect on the weight of that testimony follows below.
[2] Rather than list each of the exhibits admitted into evidence at the hearing, a general summary should suffice.

instrumentation used during the surgery and of the pathology slides. All of the culled-down exhibits were admitted into evidence by agreement.

ISSUE PRESENTED

Distilled to its essence, the question presented to the Arbitrator in this Arbitration is:

> Whether to a reasonable degree of medical probability Dr. breached the standard of care by failing to see that Claimant's small bowel was sufficiently injured during the June 6th Surgery to bring about, five days later, what was surgically determined to have become a serious delayed onset full thickness perforation?

There did not seem to be any dispute that, had Dr. seen an injury that could become a full thickness tear requiring repair, she could have and would have, rather simply, been able to repair it.

Discussion

Stating the obvious, we know that, in order to recover any compensation, Claimant must prove by a preponderance of the evidence that Dr. fell below the standard of care in doing the June 6th Surgery. As will be explained in the succeeding paragraphs, for this trier of fact, despite the exemplary presentation by Mr. on her behalf, Claimant was unable to meet her burden of proof.

The preponderance of the evidence established that Claimant suffered a "delayed onset" perforation of her small bowel, manifest five days after the June 6th Surgery. Counsel seemed to concur on this foundational fact, which was supported by the medical experts' testimony . There was also agreement that Claimant's medical history (that is, her history before the June 6th Surgery) includes abdominal surgeries, at least one of which was performed by Dr. and various "co-morbidities"[3].

[3] There was significant discussion by counsel and by witnesses about Claimant's co-morbidities. The most significant of them appeared to be: "morbidly obese"; a-pack-a-day cigarette smoker for more than 30 years; atherosclerosis. From Respondent's perspective, these co-morbidities were a significant factor in the delayed onset perforation and Claimant's inability to heal on her own without further action by Dr. during the June 6th Surgery. Had it been a close call, the consideration of these co-morbidities would have added a modicum of weight to the evidence tipping the scales to the result here. While considered by this Arbitrator, Claimant's co-morbidities did not affect the decision reached.

During the June 6th Surgery, Dr. had to separate a small amount of small bowel which had adhered to the abdominal wall, a procedure that required cutting adhesions that were the result of Claimant's prior abdominal procedures. Dr. testified that she had performed hundreds of laparoscopic ventral hernia repairs and thousands of other laparoscopic procedures. She was found by this Arbitrator to have been eminently qualified to perform the June 6th Surgery. Dr. was also seen to have been unabashedly candid in her testimony and unquestionably credible.

Dr. explained the June 6th Surgery in great detail. Given Claimant's medical history, Dr. fully expected this to have been a difficult operation to repair two large holes and multiple smaller holes in the abdominal wall[4]. It turned out that she encountered less adhesions between the abdominal wall and the small bowel. She candidly and credibly testified that she had no difficulty taking down the adhesions. This was confirmed in her operative report (Exhibit 9).

The operative report and Dr. testimony also explained critical procedural aspects of the June 6th Surgery. The medical experts also confirmed that these standard of care aspects require that the surgeon continuously keep watch for any signs of injury to the small bowel during the surgery. These injuries are a known risk. The evidence also showed that the surgeon is required to inspect the surgical field before closing. Dr. credibly testified that this is exactly what she did during the June 6th Surgery, taking extra care because of Claimant's medical history specifically known to her[5].

The uncontroverted evidence also established that Dr. had two other experienced surgeons assisting her during the June 6th Surgery – Dr. a surgical

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[4] According to Dr. one of the holes was so large that it had colon in it. The testimony showed that this was a potentially dangerous medical situation as the bowel could have been crimped to the point of strangulation or bursting, or both, leading to life threatening consequences. Apparently this risk is among the reasons this type of surgery is done "voluntarily" rather than on an emergent basis.

[5] Dr. testified that she carefully checked for bruising, for signs of bleeding, and for other harmful intrusions. She recounted, for example, specifics about removal of the trocars and her careful, continuous inspections to assure there was no bleeding. The trocar/inspection is documented in Exhibit 9, the operative report. To some extent, if one saw the expert testimony as having equal weight, Dr. credible testimony alone would suffice to support the result here – she did not breach the standard of care.

resident, and Dr. another Board Certified general surgeon. The evidence conclusively showed that the June 6th Surgery was conducted under direct visualization – described as HD transmission – with all three surgeons continuously viewing Dr. surgical procedure. Direct visualization, according to the testimony, is a standard of care requirement, which was met here during the June 6th Surgery.[6]

The consensus among the experts and argued by counsel was that there was an insult to the small bowel during the June 6th Surgery. The extent and visibility of that small bowel injury during this adhesiolysis procedure are in dispute. The expert testimony suggested that what set in motion what became the perforation *may* have been from the "grasper" either applied too tightly or when used to pull the bowel to extend the adhesions that needed to be cut[7]. None of the experts, however, opined that Dr. did anything wrong in using the grasper.

Without getting into the credibility challenges asserted by Respondent during cross-examination, Dr. did opine that the injury he believed occurred during the June 6th Surgery "would have been visible" and "would have been apparent" to a surgeon such as Dr. He also stated that a surgeon would be able to see on the HD monitor an injury that would have affected the serosa. Dr. concludes that Dr. simply missed the serious injury here. Dr. conclusions, though offered in an effort to help the trier of fact, are insufficient to overcome the greater weight of the evidence, including Dr. testimony and the testimony from Dr. . The evidence leads us to a conclusion contrary to the view held by Dr.

As argued by Claimant, Dr. gave testimony about what he would have done *had he encountered* a serosal injury. His practice, and that of many of his colleagues, would have been to suture the injury rather than allow for the likely self healing that would occur. Dr. however, did not opine that he saw any evidence of an injury during the June 6th Surgery needing repair. Like the other medical testimony, Dr. concurred that injury to the small bowel that could become a delayed onset perforation is a known risk of this surgery, especially when presented

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[6] Claimant argued that "common sense" should lead to the correct conclusions and outcome in this proceeding. Respondent, to some extent concurred (though arguing that burdens of proof must be the basis of the final decision). This Arbitrator agrees with Claimant: given the weight of the credible evidence, including the fact that three sets of highly trained surgical eyes were carefully watching the June 6th Surgery on a high definition screen, common sense would lead us to conclude that the injury must not have been visible to the highly trained surgical eye.

[7] There was also discussion that the "scissors" used to cut the adhesions may have also cut the small bowel.

with a patient with Claimant's medical history. He saw no reason to question that Dr. did not see any injury that would require attention – further procedures, repair, or otherwise – during the June 6th Surgery. Instead, Dr. credible testimony[8] pushes the scales heavily in favor of a finding that Dr. did not breach the standard of care during the June 6th Surgery.

Testimony provided by Drs. and the two competing pathology experts, did not help to move the balance in Claimant's favor. While informative, neither could provide persuasive evidence that could lead to a reasonable conclusion that Dr. did something below the standard of care that brought about Claimant's terrible journey that began five days after the June 6th Surgery.

It seems that your Arbitrator would be remiss if nothing was said about Claimant's suffering. The evidence was clear that Claimant suffered severe, life threatening complications brought about by the delayed perforation. She spent 100 days in hospital; she was in a coma; she had additional surgeries including one on June 12, 2016 to repair the perforation. She suffered DVT, pulmonary emboli, and an IVC filter placement procedure; an abdominal fistula; and, other complications. There was no dispute that Claimant's parade of horribles following the delayed perforation were painful, scary and debilitating. These undisputed facts are what makes the decision required by the preponderance of the evidence the subject of very careful, deliberative analysis. Unfortunately for Claimant, that analysis compels the outcome reached in this Award. As a result, there is no need to discuss how this lien may have affected Claimant's recoverable damages.

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[8] It is perhaps instructive if not important to note here the credibility attributed to Dr. testimony. His credentials are above reproach. He was candid, professional, unassuming, and believable. His experience as a surgeon dealing with the anatomy in question here is perhaps unsurpassed. Dr. testimony weighed heavily in the decision reached in this case and greatly outweighed the expert testimony offered by Claimant.

Conclusion

For the reasons discussed above, Claimant must be found to have not met her burden to prove that Dr. breached the standard of care in performing the June 6th Surgery.

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: 15 May 2018

Robert N. Dobbins, LL.M., Arbitrator