IN THE MATTER OF THE ARBITRATION BETWEEN

Claimants

and

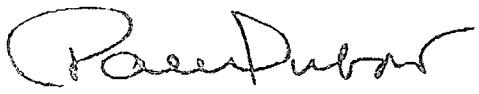
FINAL AWARD

CASE NO. 11232

Respondents

On March 6, 2013 the arbitrator issued an interim ruling in which he granted Respondents' motion for summary judgment, primarily because of Claimants' failure to submit any expert declarations relative to claimant medical condition. However, on account of allegations made by Claimants that their then attorney had misled them with respect to his efforts to find experts, the arbitrator extended the time within which to find expert(s) until April 12, 2013. The arbitrator advised that if Claimants failed to file expert declaration(s) by April 12, he would issue a final ruling granting Respondents' motion for summary judgment. If, on the other hand, Claimants did file such declarations, the arbitrator would give time for Respondents to respond, and then would revisit the ruling.

Claimants have failed to file any expert declarations by the April 12 deadline. Consequently, Respondents' motion for summary judgment is granted and a final award is herewith rendered in favor of Respondents.



Paul J. Dubow
Arbitrator

Dated: April 15, 2013

Arbitration Pursuant to the Arbitration Program
Arbitration Number 12193

Claimant

vs.

RULING ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT AND FINAL AWARD

DR. and DR.

Respondents

Procedural History

Following medical treatment by Respondents during 2009 and 2010, Claimant filed a notice to sue for professional negligence on February 7, 2012. A complaint was filed in the Superior Court of California for Alameda County on May 4, 2012 followed by a first amended complaint filed on May 9, 2012. The latter document asserted claims for medical malpractice, medical errors and negligence, emotional distress, loss of income, loss of consortium, and punitive damages. Claimant asserted therein that respondent Dr. negligently prescribed excessive dosages of medicine designed to control Claimant's blood pressure, ignored Claimant's requests to adjust the dosages, and failed to inform Claimant that adherence to the prescribed dosages would lead to severe health risk and major organ failure. Claimant further alleged that Dr. negligently inserted a catheter for dialysis that punctured his lung and caused him to suffer congestive heart failure, fluid in his lungs, and breathing problems which in turn led Claimant to being placed on oxygen and contributed to his kidney failure.

Respondents' motion to compel arbitration was granted on April 26, 2013. Paul J. Dubow was appointed as the arbitrator and executed an agreement to serve on August 29, 2013. The arbitrator provided the parties with his disclosures on September 25, 2013 and neither party filed an objection to his appointment.

On October 29, 2013, two motions for summary disposition were filed, one by Dr. and the respondents and the other by Dr. and the respondents. The motions were accompanied, *inter alia,* by declarations executed by expert witnesses

, M.D., , M.D. and , M.D. Claimant's opposition was due on November 29, 2013. On November 7, 2013, Claimant moved for an extension of time to file his opposition. The motion was granted and Claimant's time within which to file his opposition was extended to December 27, 2013. Claimant did not file an opposition by the due date. On December 28, 2013, the arbitrator sent an email to Claimant asking when he intended to file the opposition. Claimant did not respond to the email. On January 9, 2014, the arbitrator received an email from Claimant in which he stated that "the week before the opposition was due I was in contact with attorneys and believed that one of the attorneys was in contact with [the arbitrator] and [Respondents' attorney] to represent me". However, no attorney contacted the arbitrator to inform him that he or she represented Claimant. In addition, Respondents' counsel averred that he had not been in contact with an attorney who purportedly represented Claimant. In an email sent later on January 9, Claimant asserted that he had filed the opposition at 9 am that morning. At 10:20 am on January 10, the arbitrator notified Claimant that he had not received the opposition. It was later determined that Claimant had filed the opposition in Superior Court rather than with the arbitrator. The arbitrator is now in possession of the opposition brief and has read it. The brief makes reference to photographs but they were not attached to the arbitrator's copy nor does it contain medical records or any expert declarations.

Treatment by Dr.

Claimant was diagnosed as a diabetic in 1997. In the months before he began to be treated by Dr. , he had been treated by physicians for hypertension, diabetic gastroparesis, and high blood pressure. Dr. began to see Claimant as his primary care physician on June 29, 2009. Claimant complained of nausea, fatigue, and difficulty walking. Recently prescribed medications were controlling his blood pressure and Dr. recommended that he continue on these medications. Dr. also prescribed medicine to control the nausea and vomiting that accompanied gastroparesis. The nausea and vomiting nevertheless continued. Claimant asserts that the nausea and vomiting occurred because Dr. either prescribed the wrong medications or prescribed a dosage that was too high for Claimant to tolerate. In particular, Claimant questions the prescription of metroprolol, which he asserts to be an allergy medicine and to captopril, which he alleges would cause kidney failure if used on a long term basis.

On July 15 after a spell of vomiting and nausea, Claimant was referred to the emergency department. On July 24, Claimant visited Dr. for a gastroenterology consultation. During the interview with Dr. , Claimant revealed that he had stopped taking the medications prescribed by Dr. in the apparent belief that these medications were causing the nausea and vomiting. Claimant asserted in his brief that, prior to visiting Dr. , his wife had reduced his pill intake by half and then half again and that during this period his vomiting and nausea stopped. The vomiting and nausea returned, according to Claimant, after he followed the instructions of Drs. and to resume taking the medications.

On September 24, Dr. noted that Claimant had not taken metoprolol for a month and that his blood pressure had increased to 166/96. Claimant avers that he stopped taking metroprolol because he was allergic to it.

In January 2010, Dr. noted that Claimant had stopped taking amlodipine because of leg swelling.[1] His blood pressure was down a bit, but was still unsatisfactory. On July 1, 2010, Dr. noted that Claimant was not taking the fully prescribed dosages of captopril and clonidine. His blood pressure had increased to 170/98. His instructions to Claimant were:

> Your blood pressure is very high. It is very important to take all blood pressure medicines every day and as prescribed. If not, dangerous complications, including but not limited to, bleeding in the breain (sic) or stroke can occur. (Ex. B to declaration, p. 128).

On September 1, in response to Claimant being overdue for blood pressure and diabetes testing, nurse sent a note to Claimant, reminding him to take all of his medications, inviting him to come in for a free blood pressure check, and suggesting that, if he found it difficult to adhere to his prescription regimen, that he contact the Behavior Medicine Department. The letter concluded with the following statement:

> If you choose to do nothing, you need to know that you are at high risk for fatal heart attack and debilitating stroke as well as the complications of uncontrolled diabetes that affect the eyes, kidneys, and nerves. (Ex B to declaration, p. 143).

Between October 2010 and January 2011, Dr. tried to contact Claimant to set up an appointment but did not receive any response. On January 30, 2011, Claimant appeared at in Antioch and was diagnosed with acute renal failure, hypertensive urgency, and fluid overload. Dr. ordered a renal biopsy which showed that Claimant's condition was caused by diabetes and hypertension. Ultimately, dialysis was required.

In May 2011, Claimant saw Dr. again. His blood pressure was stable. Claimant attributes this to the fact that Dr. and another physician, Dr. , had prescribed the correct medications. But by August, Claimant's blood pressure had risen to 160/90 because Claimant was not taking all of the medications prescribed.

Dr. opined that the care provided to Claimant by Dr. related to his kidneys, diabetes, and hypertension, including medications prescribed, met the standard of care and did not contribute to Claimant's injuries. Rather, his diabetes, hypertensive neuropathy, and noncompliance with medications caused his kidneys to fail. Dr. agreed with Dr. 's analysis of the reason for Claimant's kidney failure and also noted that his non-

[1] Claimant asserts that the leg swelling occurred subsequent to January 2010.

compliance with the medication regimen prescribed by Dr. was a factor. Dr. further stated that blood pressure medications do not correlate with nausea and vomiting. It was Dr. ' opinion that the gastroparesis was the source of the nausea and vomiting.

Dr. also opined that the prescription of captopril met the standard of care because Claimant's blood pressure was difficult to control. He testified in his declaration that it was proper to include captopril in Claimant's medication regimen because it serves a double function---it both lowers blood pressure and protects the kidneys by lowering creatinine levels, which rise when the kidneys are functioning poorly. He further averred that captopril is particularly necessary for individuals with diabetes. Finally, Dr. noted that had Claimant taken the medicines as prescribed, he would not have experienced kidney failure as early as he did, but that even if he diligently adhered to the medication regimen, kidney failure would have eventually occurred because of Claimant's diabetes and hypertension which are, respectively, the number one and number two leading causes of kidney failure.

Claimant did not provide any expert testimony that contradicted Drs. and .

Treatment by Dr.

As noted above, Claimant was diagnosed with acute renal failure when he was treated at on January 30. His kidney function continued to decline after the diagnosis and Dr. prescribed dialysis treatment. In anticipation of such treatment, Dr. , an interventional radiologist, placed a dialysis catheter in Claimant's chest on February 9 after explaining the risks to and obtaining consent from Claimant's wife. Those risks included bleeding and infection. After the catheter was inserted, Dr. ordered an x-ray to check its position. The x-ray revealed that the catheter had entered the right internal jugular vein and exited the central right subclavian vein and into the right medial pleural space. The tip of the catheter was situated outside of the vascular system with a right hemothorax. Dr. left the tube in place and immediately requested surgical assistance from surgeons Dr. and Dr. , who repaired the perforation. Claimant stated in his opposition that he was in surgery for more than six hours and that he required surgery on the left side of his chest two weeks later. He was discharged from the hospital on February 23.

Dr. testified in his declaration that the care provided by Dr. was within the standard of care for an interventional radiologist. The procedure performed by Dr. was medically indicated and performed appropriately. The perforation suffered by Claimant was a recognized risk and a known complication of the procedure and, most importantly, can occur without negligence. Dr. commended Dr. for immediately recognizing the situation and requesting surgical assistance. That response was also within the standard of care.

Claimant did not provide any expert testimony that contradicted Dr. .

Disposition

The arbitrator, having carefully reviewed all of the evidence, makes the ruling set forth below.

The standard of care in a professional negligence is a matter peculiarly within the knowledge of experts and can only be proven by their testimony unless the conduct required by the particular circumstances is within the common knowledge of a layperson. *Landeros v. Flood,* (1976), 17 Cal. 3d 399, 410, 131 Cal. Rptr, 69; *Osborn v. Irwin Memorial Blood Bank,* (1992) 5 Cal. App. 4th 234, 273, 7 Cal. Rptr. 2d 101; *Williamson v. Prida,* (1999) 75 Cal. App. 4th 1417, 1424, 89 Cal. Rptr. 2d 868.

In this matter, Claimant asserts that Dr. both provided him with the wrong blood pressure medications and prescribed over-dosages of the medications. He asserts that this regimen led to nausea and vomiting in the short term and ultimately caused his kidney failure. The only evidence that he has presented to support his theory was that the nausea and vomiting subsided during a short period of time when he stopped taking the medications. But Claimant is a layperson and while the course of conduct that he chose appeared, at least temporarily, to achieve the result that he desired, a reason for the cessation of nausea and vomiting is not within the common knowledge of a layperson. On the other hand, Respondents' experts testified in their declarations that blood pressure medications are not normally associated with nausea and vomiting and that gastroparesis, a condition that is associated with diabetes and for which Claimant was also being treated, is associated with nausea and vomiting. Most importantly, Claimant provided no expert testimony linking his medications with kidney failure while Respondents' experts testified in their declarations that diabetes and hypertension, two conditions which afflicted Claimant, are the primary sources of kidney failure. Claimant therefore failed to meet his burden of proof that Dr. did not adhere to the proper standard of care when he prescribed the medications in controversy.

With respect to Dr. , Claimant asserts that "complications were so that I was in surgery for more than six hours" and that he needed another surgery two weeks later. However, Dr. testified in his declaration that the procedure performed by Dr. was performed appropriately, that the perforation suffered by Claimant was a recognized risk and a known complication of the procedure, and that this type of injury can occur absent any negligence. Claimant did not offer any expert testimony to refute Dr. ' opinion. Clamant therefore failed to meet his burden of proof that Dr. did not adhere to the proper standard of care when he performed the surgery.

Respondents' motion for summary judgment is granted and a final award is herewith rendered in favor of Respondents.

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

Paul J. Dubow
Arbitrator

Dated: January 15, 2014

MEMBER ARBITRATION

Case No. 11961

Claimant

FINAL AWARD

v.

Respondent

Procedural History

The demand for arbitration in this medical malpractice action was filed on behalf of Claimant on December 11, 2012 by his wife, . In essence, two claims are asserted. First, the complaint alleges that Respondent was negligent because on several occasions in October and November 2010, Claimant was served chopped food instead of pureed food while in Respondent's care, causing him to aspirate, delaying his recovery from a fractured hip, and beginning a downhill course in his health which culminated in his death in November 2013. Second, the complaint alleges that Claimant was denied Medicare benefits pursuant to the Advantage program after he was transferred from Hayward to , an assisted living provider not associated with in November 2010. Total damages claimed are $215,170.

The undersigned was appointed as the arbitrator and executed an agreement to serve on January 14, 2013. The arbitrator provided the parties with his disclosures on the same day and neither party filed an objection to his appointment.

On September 3, 2013, Respondent filed a motion for a separate trial on the issue of whether the case should be dismissed based on expiration of the statute of limitations. The motion was granted and the hearing on this issue was held on November 12, 2013. The motion to dismiss was denied by order dated December 26, 2013.

Trial on the merits occurred at the office of Respondent's counsel on January 7, 2014. ( ), Claimant's son, appeared in pro per on behalf of his father pursuant to Member Arbitration Rule 54. of appeared on behalf of Respondent. Claimant did not call any expert witnesses and his sole witness was . Respondent's witnesses were ,

M.D., called as an expert, and , a medical social worker employed by Respondent.

Factual History

Claimant, then aged 75, was hospitalized on September 17, 2006. During Claimant's hospital stay, a CT scan of the head was taken which indicated, *inter alia,* the presence of mild periventricular white matter hypodensity. However, Dr. testified that this was normal for people in Claimant's age group. Claimant was discharged on September 24, 2006 with a diagnosis indicating periods of agitation secondary to underlying dementia exacerbated by significant alcohol intake. Dr. testified that, although Claimant could enjoy normal activity at that time, the dementia was irreversible.

On June 17, 2010, Claimant was hospitalized again. He was diagnosed with alcohol withdrawal delirium, atrial fibrillation, cardiomyopathy, memory disorder, peripheral neuropathy, and hypertension. Another CT scan of his head was taken and Dr. testified that there had been a big change since 2006. The brain showed generalized atrophy and Dr. stated that Claimant was on "an inexorable downhill course with respect to dementia". He estimated that Claimant's projected life span at that time was from three to five years. He believed that a return to independent living was impossible although there could be periods of normal activity because of medical care and the care and attention that he could receive from family members.

Claimant's family and his physicians decided that it would be best to transfer Claimant to an assisted living facility following his discharge from the hospital and he was admitted to Assisted Living Center, which was close to the family home in Antioch. testified that Claimant did well at . In his pretrial brief, wrote that Claimant's "physical condition was good, he was walking and able to be social with the other residents, and was able to feed and dress himself. He took care of his own hygiene and was looking forward to going back home soon and resume his active lifestyle".

On or about October 1, 2010, Claimant fell and fractured his hip. He was taken to Hospital, operated by Respondent, and underwent surgery. Following surgery, it was ordered that Claimant be given pureed meals. testified that the very first meal served to Claimant after surgery was not a pureed meal, but a hamburger. testified that Claimant choked on the meal and was aspirated. It was opinion that this event delayed Claimant's physical therapy and set him on the downhill course that culminated in his death three years later. The episode also required Claimant to be transferred from to the Post Acute Care Center ( ) where observed at least three other choking episodes, all presumably the result of being served non pureed food.

The medical records introduced in this matter make reference to serving of non pureed food only once, to wit, on November 17. (Exhibit 7). They do make it clear, however, that

Claimant suffered from aspiration but the cause and extent of that condition is in dispute. , who is a lay person, asserts that it was the direct effect of serving Claimant the wrong food. But Dr. testified that choking is quite common for dementia patients because they sometimes forget how to eat and are easily distracted. He also suggested that the aspiration may have been caused by unsuccessful efforts to insert an NG tube to help Claimant's caloric intake.

On November 19, Claimant was discharged from Hayward. Before the discharge, Ms. met with Claimant's wife. Ms. testified that Mrs. wanted Claimant to return to an assisted living center near their home. Ms. told her that Medicare would not cover the care that Claimant would receive at the assisted living center and she believed that Mrs. understood this. Claimant thereupon returned to and was not reimbursed for the cost of care at that facility.

The Choking Episodes

testified that Claimant was able to fend for himself and in general good spirits prior to breaking his hip in October 2010. also testified that, during Claimant's first meal following surgery, he observed Claimant being fed a hamburger rather than pureed food and choking immediately thereafter.

was a credible witness and his testimony was not refuted by Respondent. Dr. testified that Claimant's physician did indeed order that he be served only pureed food and that serving of a non-pureed hamburger violated that order. Consequently, the arbitrator finds that Respondent was negligent when it served the non-pureed hamburger to Claimant on October 1 and when it again served him non pureed food on November 17.

It is not clear from the record that Claimant's choking episodes other than on October 1 and November 17 were the result of being fed non-pureed food but, even if that were the case, it does not end the inquiry. In order to prevail, Claimant must show that service of the non pureed food was the cause of his deteriorating health.

In order to recover in a medical malpractice case, it is necessary to prove that an alleged failure to exercise the care and skill required under the circumstances was a proximate cause of the condition about which the complaint is made. In the absence of a showing that such result was a matter of common knowledge, expert testimony is required. *Keen v. Prisinzano,* (1972) 23 Cal. App. 3d 275, 279, 100 Cal. Rptr. 82; *Landeros v. Flood,* (1976), 17 Cal. 3d 399, 410, 131 Cal. Rptr, 69; *Osborn v. Irwin Memorial Blood Bank,* (1992) 5 Cal. App. 4th 234, 273, 7 Cal. Rptr. 2d 101; *Williamson v. Prida,* (1999) 75 Cal. App. 4th 1417, 1424, 89 Cal. Rptr. 2d 868.

See also *Jones v. Ortho Pharmaceutical Corp.,* (1985) 163 Cal. App. 3d 396, 402-03, 209 Cal. Rptr. 456, where the court held:

> The law is well settled that in a personal injury action causation must be proven within a reasonable medical probability upon *competent expert testimony.* Mere possibility alone is insufficient to establish a prima facie case..[citing cases]..That there is a distinction between a reasonable medical "probability" and a medical "possibility" needs little discussion. There can be many possible "causes", indeed, an infinite number of circumstances which can produce an injury or disease. A possible cause only becomes "probable" when, in the absence of other reasonable causal explanations, it becomes more likely than not that the injury was a result of its action. This is the outer limit of inference upon which an issue may be submitted to [the trier of fact]. (*Emphasis supplied.)*

Here, there could have been another reason for Claimant's deteriorating condition, to wit, the hip surgery. Surgery for a hip fracture is an extremely invasive procedure, particularly for an elderly person suffering from the onset of dementia. Thus, Claimant had to establish that Respondent's negligent serving of non pureed food was the cause of his condition. This cannot be proven through the common knowledge of a lay person. Claimant needed to provide expert testimony. He did not and Respondent did.

Dr. , Respondent's expert, testified that half of the patients in Claimant's age group who survive hip surgery do not regain full use of the hip. If the patient has underlying dementia, the chance of full recovery is lower because it is difficult for the patient to remember how to walk with this disability. He further testified that choking on food is quite common for patients with dementia. Pureed food reduces the occurrence somewhat but does not eliminate it. There is evidence that Claimant suffered from aspiration pneumonia, which may have resulted from choking which in turn may have resulted from being served non pureed food but also could have resulted from the failed insertion of the NG tube. In any event, when Claimant was discharged from Hayward on November 19, Dr. noted that while Claimant may have suffered from aspiration during his hospital stay, there was no definite pneumonia at that point. (Exhibit E). It would appear therefore that Claimant's condition was not caused by the service of non pureed food.

Failure to Pay Benefits

Dr. , an expert in geriatric medicine, testified that Medicare rules are very strict. Medicare will not pay benefits to a patient who is transferred from care by his or her primary care physician to an assisted living facility. The general rule is that the patient must have spent at least three days in a hospital, there is an assessment that transfer to another facility can result in an improvement in the patient's condition, and that such care must be provided in a skilled nursing facility not an assisted living facility.

When Claimant was discharged from Hayward, Ms. discussed the next step with Mrs. . The latter did not want Claimant to return to because of her

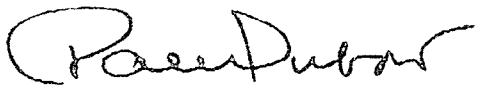
belief that he would again be subject to being served the wrong diet. She wanted Claimant to be sent to a rehabilation facility near the family home and he ultimately returned to . Ms. told Mrs. that Claimant's stay at would not be a covered benefit and she recorded this in his medical records. (Exhibit F).

The family's decision to return Claimant to was not an irrational one. The family regularly visited and was attentive to Claimant during his previous stay at and during his stays at Respondent's various facilities. They continued to do so when he returned to and such activity no doubt prolonged his life. But they did so at a cost of giving up his right to Medicare benefits.

Disposition

Claimant did not meet his burden to establish that he is entitled to damages and Respondent shall prevail.

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



Paul J. Dubow
Arbitrator

Dated: January 17, 2014