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STATE OF CALIFORNIA

Court of Appeal

SECOND APPELLATE DISTRICT

DIVISION FOUR

J. GARY HASTINGS
ASSOCIATE JUSTICE (RETIRED)

V.

ARBITRATION NUMBER 13488

ARC NUMBER 70K425D

ARBITRATION AWARD

Arbitration was conducted beginning on November 17, 2015, and concluding on November 20, 2015. The matter was presided over by Justice (Ret.) J. Gary Hastings. Appearing for claimant were and of . Appearing for respondent was of . The following witnesses were sworn and testified: Dr. ; Dr. ; Dr. ; Dr. ; Dr. ; ; ; Dr. ; Dr. ; Dr. ; Dr. ; Dr. ; Dr. ; Dr. ; Dr. ; and Dr. . Exhibits were offered and received into evidence. After final argument on Friday November 20, 2015, the matter was deemed closed.

BACKGROUND HISTORY

On April 1, 2014, presented for a wellness exam at the of where he was seen by his assigned Doctor of internal medicine, . Dr. reported that Mr. , an 84 year-old, presented with a weight loss of 32 pounds over the last 20 months and complaints of diarrhea. His report states: "He has not continued to lose weight. He has had increased frequency and looseness of his stools. He denies blood. Last fecal globin was normal. He has associated urgency of bm and has had occasional accidents. He has history of poliomyelitis with some

left side weakness. He also has chronic pain of his neck, elbows, hips and back. These issues have been addressed in the past in pain management. XR shows OA at multiple joints in his body." Dr. notes: "Discussed weight loss. No change in diet other than he stopped having a glass of wine per night. No change in exercise. With weight loss and diarrhea, hyperthyroid is a consideration. Will check TSH." (Exh. 2.) Dr. ordered tests to be run.

On April 15, 2014, Mr. was contacted with the results of tests run. There was no infection found to explain the diarrhea and he was told to let Dr. know if his diarrhea continued. (Exh. 4.)

On May 2, 2014, Mr. again saw Dr. complaining that "he 'is a prisoner' as he has constant diarrhea and his legs are swollen he has fallen multiple times and has injured his shoulder so he can't use a cane." (Exh. 5.) Dr. provided a reference to Gastroenterology and told Mr. he would be contacted.

Mr. had not been contacted by May 14, 2015, so he presented himself to the emergency room because of his continued diarrhea. The admitting notes state: "SUBJECTIVE: Is frustrated over his condition, that's been going on for so long; denies any abdominal pain, or that he's had abdominal pain along with the diarrhea." (Exh. 6.003). A diagnostic study was done. The first "impression" reported was "Pancreatic duct dilation with stones at the ampulla and in the main pancreatic duct at the junction of the neck and body. Pancreatic side branch ectasia. Atrophic pancreatic parenchyma." The report was electronically signed by Dr. on 5/20/2014 7:25 AM. (Exh. 6.001.)

Dr. learned of Mr. 's case from a telephone call. He saw a written referral of May 21, 2014, for an ERCP of Mr. . In part, it states: "ERCP for PD stones and steatorrhea. No abdominal pain. . . . MRCP showed 'Pancreatic duct is dilated measuring 10 mm in diameter. Signal voids correspond to intraductal stones seen on CT with a 12 mm stone at the junction of the neck and body of the pancreas and another poorly defined stone in the duct at the ampulla. Pancreatic parenchyma is atrophic and there is side branch ectasia.' Patient on pancreatic enzyme supplementation with improved

steatorrhea. Thanks." (Exh. 7.001-2.) Dr. referred Mr. , through Dr. , to Dr. for the ERCP. He did not know who would be doing the procedure. He never spoke with anyone about potential alternative treatments for Mr. and he never provided any other than the ERCP.

On May 28, 2014, the ERCP was performed. Dr. , a Fellow, was to perform the procedure with Dr. , an experienced gastroenterologist, supervising. Dr. discussed the procedure with Mr. and Mr. 's daughter and obtained a signed consent form. (Exh. 10.) During the procedure a dilation balloon was placed in the rear of the pancreas, past a stone, and it burst when Dr. told the nurse to inflate it. Dr. thinks the balloon may have come into contact with the stone. He told Dr. to remove the balloon but it was stuck and wouldn't come out. Dr. believed it was stuck on the stone. At this point, Dr. took over. He tried to reposition the item but part of the catheter broke and came out. It left part of the catheter curled up in Mr. 's stomach. Using a choledochoscope he went back into the pancreas and found there was a "freely mobile 5mm stone at the level of the pancreatic neck. The retained catheter was observed lodged by an intraductal stone." (Exh. 12.001) Using , Dr. was able to fracture the 5mm stone. He then used EHL to fracture the distal stone but it left an 8mm fragment behind. He put in a mechanical lithotripter in an attempt to remove the 8mm fragment but it broke and "the catheter had to be stripped. Mechanical rescue device was attempted, but failed." (Exh. 21.001-2.) It was decided to wait until the next day to try and resolve the situation. Mr. remained sedated and was moved to ICU.

On May 29, 2015, Dr. along with Dr. attempted to remove the retained devices; the Hurricane balloon and mechanical lithotripter basket. They were unable to do so. Mr. was then returned to ICU and remained sedated. The notes from that date have the following recommendations, among others: "5. Schedule extracorporal lithotripsy (ECL) as alternative modality for fragmenting the pancreatic duct stone. Discussed with Dr. from Urology this morning. His availability will need to be confirmed and ACSL transport will need to be arranged given that he (Mr.) is still intubated. 6. Discussed

with Dr. from surgery. It is reasonable to proceed with ECL at this juncture. He believes that extracorporal lithotripsy will unlikely negatively impact any anticipated surgical options. 7. Family meeting with current status and plan of care was held with , and . Drs. and were also present." (Exh. 13.002.)

ECLs are performed by Urologists and not Gastroenterologists. It is a non-invasive procedure that attempts to fracture the stones. Dr. , a Urologist, was consulted and discussed the matter with Drs. and . Dr. recalled that all agreed ECL would be appropriate and they spoke to the family about it. An ECL was not performed. Dr. changed his mind the next day. He told them he had never done an ECL on pancreatic stones. The records reflect: "After discussion Dr. (Urology), the decision was made to abandon extracorporal lithotripsy of the pancreas given lack of local expertise and experience. Appreciate Dr. and his surgical team. The likelihood of success for device removal using endoscopic instruments is low at this point. It would be reasonable to pursue surgical management after the ampullary edema has time to decrease." (Exh. 14.001)

Surgery was successfully conducted on June and the items were removed from Mr. 's pancreas. The notes of the procedure reflect: "there continued to be multiple fragments of stone in the PD. The duct was swept, using 5mm biliary fogarty catheters and irrigated multiple times to satisfactorily remove the stone fragments." (Exh. 100, pg 2282.) Mr. was discharged from the hospital in June and transferred to a skilled nursing facility from which he was discharged home on August 3, 2014.

Prior to May 28, 2014, Mr. was able to walk on his own, although with an abnormal gate and the use of one or two canes. When he was a teenager he contracted polio which affected his left leg which left it fairly useless. His ankle on that leg was fused. He also regularly drove, swam in his backyard pool and at the beach and had dates with his wife where they would drive to the beach and have picnics. Since May 28, 2014, Mr. has been wheelchair bound and can no longer walk, sit up on his own, drive a car, make his own meals or swim.

He has a care giver nine hours a day seven days a week and relies upon the care givers to help him with toiletries, food preparation, getting into and out of bed, dressing and transportation. He attributes his current condition to the treatment he received from beginning on May 28, 2014, with the ERCP which resulted in lodging of the balloon and basket in his pancreas and the follow up surgery to remove the devices.

CONTENTIONS

In "Claimant's Trial Brief" he makes claim of six "acts by that fell below the standard of care" as follows:

1. " physicians erroneously recommended an ERCP extraction of the pancreatic stones in Mr. 's pancreatic duct. Prior to performing any invasive procedures, physicians should have prescribed a *good faith* trial of pancreatic enzymes in an attempt to resolve Mr. 's health issues, which were related to pancreatic insufficiency.
2. "The physicians fell below the level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians in the gastroenterology community would have used in the same or similar circumstances when the physicians failed to provide Mr. with *informed* consent regarding all available alternatives of treatment for his chronic pancreatitis symptoms.
3. "The physicians fell below the level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians in the gastroenterology community would have used in the same or similar circumstances when the physicians scraped a pancreatic stone with a Dilation Balloon and then inflated the balloon on top of the stone.
4. "The physicians fell below the level of skill, knowledge and care in diagnosis and treatment that other reasonably careful physicians in the gastroenterology community would have used in the same or similar circumstances when the physicians chose to place a mechanical lithotripter and a rescue device inside Mr. 's pancreatic duct in the presence of a deflated, stuck balloon.

5. "The physician's [sic] decision to perform an invasive surgical extraction of the retained hardware prior to attempting an ESWL [ECL in the notes] fell below the level of skill, knowledge and care in treatment that other reasonably careful physicians in the gastroenterology community would use in the same or similar circumstances. An ESWL could have fragmented the pancreatic stone allowing the stuck equipment to be removed without the need for invasive surgery.
6. "An ESWL should not have been precluded due to a lack of local expertise, especially since there are numerous qualified gastroenterologists and urologist[s] who perform ESWL in the pancreatic duct in and around the County of Los Angeles which have the requisite skill, experience, knowledge, equipment and facilities to perform and ESWL." (Claimant's Trial Brief, pp. 14-16, italics in original.)

FINDINGS AND DISCUSSION

Dr. was claimant's medical expert on the standard of care. He testified to four items he felt were below the standard of care:

1. should not have done an ERCP without first doing a trial run of enzymes to see how Mr. reacted, at least a three to fourth month trial.
2. Dr. should not have allowed Dr. to obtain informed consent from Mr. because Dr. had never performed or seen one of these procedures within the pancreas so he would not have been able to provide all of the necessary information to obtain informed consent. Specifically, the risk of entrapment as happened here. While Mr. may have been provided with some of the risks of the procedure, he was not provided with the alternative of a trial run of enzymes so he could determine for himself whether to undergo the trial or go ahead with the ERCP.
3. It was improper to attempt to inflate the balloon on top of the stone because it will entrap the stone. This type of balloon will easily break from the potentially sharp points of the stone. He believes it was "pilot error."

4. It was below the standard of care that the physicians did not attempt ESWL [ECL] to further break up the stone which may have freed the two devices retained in the pancreas without the need for surgery.

Beginning with the last item of Dr. 's list first [Items 5 and 6 in claimant's brief], there was uncertainty what size stones, if any, remained after Dr. had performed the EHL in an attempt to break up the distal stone on May 28. Dr. testified that he believed he had been able to break up most of the stone and the items still remained stuck in the pancreas. He reasoned that an additional attempt at ECL would do nothing to free the retained items. Dr. , retained expert in gastroenterology, agreed with Dr. . He believed surgery was necessary to recover the items left behind. The surgical report from June 2 indicated that the stones had been broken up although there were multiple fragments left. And Dr. provided no reliable testimony that doing the procedure would have resulted in recovering the lost devices without surgery. I find that claimant has failed to meet his burden by a preponderance of evidence to establish that doing an ESWL [ECL] would have precluded the surgery

Turning to item 3, placement of the balloon on top of the stone causing it to break [item 3 in claimant's brief]; Dr. testified that he believed it was "pilot error" to scrape the stone with the balloon. However, he does not know what caused the rupture of the balloon. He testified there were four potential causes: 1. Over inflation; 2. Traction; 3. Contact with a stone; and 4. Damage to the balloon as it passes through the elevator. But he could not testify to a reasonable medical certainty which of these potential causes was operable. Nor could Dr. . Dr. also testified it is a known shortcoming that balloons can rupture. What was not brought up was whether a defect in the device may have caused the balloon to rupture, which seems a reasonable possibility. Given that it cannot be established with a reasonable medical certainty what caused the balloon to fail, claimant has not carried his burden on this issue.

I next turn to item 4 within claimant's trial brief; use of the mechanical lithotripter in aid of removing the burst balloon. Dr. testified that in

circumstances such that occurred here doctors must use their background, training and ingenuity to determine how to proceed. He has never seen a balloon or basket left behind in this type of procedure nor has he ever read any reports that it has happened. He is also unaware of any literature which describes what to do under the circumstances. Thus, he presented no credible evidence to establish that use of this device in aid of recapturing the balloon was below the standard of care. And no one else did. Claimant has failed to carry his burden on this issue.

Item 1 of Dr. 's testimony [and item 1 in claimant's brief], urged that an enzyme trial should have been attempted before performing an ERCP. All doctors agreed that Mr. pancreatitis was chronic, not acute, and that Mr. was not complaining of pain. Mr. was placed on enzymes when he visited May 14, and the records reflect that his symptoms were improving when he appeared on May 28 for his ERCP. Dr. testified that without pain and an obstruction, which would have indicated this was acute pancreatitis, and given that his symptoms were improving, it was below the standard of care not to continue Mr. with enzymes and to hold off on doing an ERCP. He did not believe the records reflected that an obstruction existed. And he testified the stones could be allowed to remain as long as they were not causing problems. Dr. , on cross-examination, testified that retained stones could cause problems "down the line" which could be a week or decades. Dr. testified that he believed an obstruction existed referring to the study done before the ERCP which showed a 12mm stone at the junction of the neck and body of the pancreas within a 10mm dilated pancreatic duct. He further testified that an enzyme trial would not have resolved the stones which could lead to further problems. But he didn't know what might happen if the stones were not removed. He concluded that an ERCP was necessary. Dr. testified that in his opinion all GI doctors lived up to the standard of care in this case and that he believed there was an obstruction. But on cross-examination, a portion of Dr. 's deposition was read into evidence as follows:

"Q. Okay. If a patient is improving after prescribing pancreatic enzymes, is it still appropriate to perform an ERCP to remove the pancreatic stones?

"A. You may observe the patient over a period of time. The fear is still that in time the patient's disease may progress. I think in my education, training, experience, and even in reviewing the literature, you may get a certain bang for the buck with pancreatic enzymes, but they don't necessarily resolve the problem.

"Q. If a patient is prescribed pancreatic enzymes and the - - for example, diarrhea and weight loss, the diarrhea stops and the weight starts to go up, would you then not do an ERCP?

"A. I might hold off and wait, but I would certainly observe the patient with imaging studies to see if the stones are increasing in size and if the obstruction is worsening. If I see that the pancreatic duct is dilating, my fear is just that this will cause some other problem down the road. And at that point I would certainly do an ERCP." (Pg. 60 line 22 to page 61 line 17.)

From the foregoing it is apparent that under certain circumstances an enzyme trial may have been appropriate, but with close follow-up. There is no evidence in the record to suggest that any of the doctors ever considered the alternative of an enzyme trial before proceeding with the ERCP, or offered such a course to Mr. . But it is not necessary to resolve whether this was below the standard of care or not because it merges with the next issue of informed consent.

Dr. 's opinion regarding informed consent was twofold: 1. that Dr. should not have allowed Dr. to provide informed consent; and 2 that the doctors failed to discuss with Mr. the benefits and alternatives to doing an ERCP, to wit – an enzyme trial. The law with regard to informed consent was set down clearly in *Cobbs v. Grant* (1972) 8 Cal3d 229, 242-243:

"In many instances, to the physician, whose training and experience enable a self-satisfying evaluation, the particular treatment which should be undertaken may seem evident, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards become essential.

"Therefore, we hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."

The Supreme Court also held that the issue of whether sufficient information has been provided to the patient is not controlled by the custom of what physicians within the community would tell to the patients:

"A concomitant issue is the yardstick to be applied in determining reasonableness of disclosure. This defendant and the majority of courts have related the duty to the custom of physicians practicing in the community. [Citations.] The majority rule is needlessly overbroad. Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion. [Citation] The court in *Canterbury v. Spence* [(D.C. Circuit 1972)] 464 F.2d 772, 784, bluntly observed: 'Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.' Unlimited discretion in the physician is irreconcilable with the basic right of the

patient to make the ultimate informed decision regarding the courts of treatment to which he knowingly consents to be subjected." (*Id.* at 243.)

Turning now to the evidence, I do not agree with Dr. that merely because Dr. had never done or witnessed an ERCP of the pancreas that he would not have been able to obtain informed consent. But that differs from whether informed consent was actually obtained from Mr. to begin with.

As previously noted, Dr. testified that a good faith trial using enzymes should have been tried before ERCP was instituted. At the least, he testified, this option should have been given to Mr. . And Dr. testified that under certain circumstances he would wait and do an enzyme trial prior to undertaking an ERCP. While there are consent forms in the file and the procedure notes state that the patient was provided notice of all risks, benefits and alternatives of the procedure, the evidence at the arbitration establishes otherwise. Dr. testified at the arbitration but did not testify that he told Mr. about a trial with enzymes as an alternative to ERCP. And, as previously noted, it appears from the records that the only treatment considered by the doctors was an ERCP. Mr. testified that he was given no alternative but to go ahead with the ERCP, and his daughter, , who was with him when Dr. obtained the consent, agreed. I find that Mr. was not provided sufficient information about the alternative to ERCP of an enzyme trial. But that doesn't end the discussion.

Cobb also discussed the scope of disclosure necessary to obtained informed consent:

> "The scope of disclosure required of physicians defies simple definition. Some courts have spoken of 'full disclosure' [citations] and others refer to 'full and complete' disclosure' [citations] but such facile expressions obscure common practicalities. Two qualifications to a requirement of 'full disclosure' need little explanation. First, a patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required; the

patient is concerned with the risk of death or bodily harm, and problems of recuperation. Second, there is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of low incidence. [Footnote omitted] When there is a common procedure a doctor must, of course, make such inquiries as are required to determine if *for the particular patient* the treatment under consideration is contraindicated – for example, to determine if the patient had had adverse reactions to medications; but not warning beyond such inquiries is required as to the remote possibility of death or serious bodily injury.

"However, when there is a more complicated procedure, as the surgery in the case before us, the jury should be instructed that when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under certain circumstances.

"In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision." (*Id.* at 244-245, italics added.)

Here, regarding the so-called risks attendant to an ERCP, Dr. testified that this was not a simple procedure. In fact, it was listed as Type 3 out

of four in difficulty. And Mr. , given his history of polio and other potential physical problems, was at a higher risk than others his age. Dr. testified the consent form used by Dr. [Exhibit 10] did list the "common risks" of an ERCP. He testified the risks are: bleeding, perforation, pancreatitis, damage to surrounding tissue, cardiac problems associated with anesthesia, and instrumentation issues. The consent form does not appear to list "instrumentation issues" or anything similar. Dr. did not further elucidate on what he believed should be disclosed regarding "instrumentation issues," although he did testify that it was not below the standard of care not to mention the potential entrapment of the basket as occurred here when trying to recapture the burst balloon. But Dr. testified that one of the known risks of using balloons is rupture, which he has seen on a number of occasions. He has also seen reports of balloons and baskets becoming entrapped. He testified that on one occasion while he was watching an ERCP, a basket became entrapped and the doctor performing the procedure decided that surgery should immediately be done to remove the basket. The record does not reflect that the risk of a balloon rupturing during the procedure, and the potential peril resulting therefrom, was discussed with Mr. . The absence of experience by Dr. may explain that omission.

I find that Mr. was not provided sufficient information upon which to provide an informed consent to proceed with an ERCP procedure.

The issue then turns to causation, which *Cobb* also addressed:

> "There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such causal connection arises only if it is established that had revelation been made consent to treatment would not have been given. . . .
>
> "The patient-plaintiff may testify on this subject but the issue extends beyond his credibility. Since at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may

believe so, with the 20/20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment. *Thus an objective test is preferable: i.e., what would a prudent person in the patient's position have decided if adequately informed of all significant perils.* [Citation.]" (*Id.* at 245, italics added.)

Given Mr. 's age, past history of polio and his struggles to maintain a lifestyle as normal as possible, I conclude that if he had been fully informed he would have opted in the beginning to go with the enzyme trial. Of course, we don't know how that would have turned out because the option wasn't given to him. But Dr. testified that with retained stones problems may arise down the line within weeks or decades. Evidence suggests that Mr. 's current life expectancy is between 2.5 and 5.7 years, certainly shorter than decades.

Prior to the ERCP procedure there is no doubt Mr. had various medical problems relating back to when he had polio as a teenager. But through grit and sheer determination he was able to overcome many obstacles that others may not have. Before the ERCP procedure he was walking on his own, although with aids, he was swimming and driving and preparing his own meals. He was leading as normal a life as he could under the circumstances. Respondent points to the nurse's discharge note filed 5/19/2014 which recommended that as of that date Mr. required care in a skilled nursing facility with 24 hour caregivers for his own safety, suggesting that he is no worse off today than prior to the ERCP procedure. I disagree. As pointed out in the notes, Mr. said a skilled nursing facility "will never be an option, he is determined to return home with his wife." It also points out that he argued "that he does not need help and insisted that everything is going to be fine and he will be able to return home and manage things at home safely." This demonstrates his "true grit" to borrow a phrase from the name of a movie. It also lays a foundation for his claim of emotional distress resulting from what happened later.

As a result of the surgery required by the failed ERCP procedure and the lengthy recuperation required, Mr. lost any ability to ambulate by himself or to care for himself. He is wheelchair bound and now does need caregivers 24 hours a day, although he has been getting by with them only nine hours a day.

The parties stipulated that the figures contained within the report of are undisputed and shall be admitted as accurate and reasonable life care costs. The stipulation left only Mr. 's life expectancy to be determined in application to Ms. 's figures.

Dr. , a board certified neurologist, was claimant's life expectancy expert. He testified that normal life expectancy of a person Mr. 's age would be between 5.7 and 6.2 years. He believes that Mr. lost some of that life expectancy as a result of the ERCP and resulting surgery and recuperation but he can't calculate the actual amount. He doesn't attribute any of Mr. 's current problems to post polio syndrome.

Dr. , also a neurologist, testified on behalf of respondent. He agreed with the base figures used by Dr. but reduced these by 50%, 25% because of the pre-existing polio and another 25% because of other pre-existing medical issues, although no explanation was given why. He gave a life expectancy of 2.5 years.

There is no doubt Mr. had medical issues before the ERCP procedure but because of his indomitable will he had been "getting along." I can't disagree with Dr. that Mr. has most likely lost some life expectancy from the normal range. But there is no evidence he is suffering from polio syndrome or that any discount should be given for this pre-existing condition. And to discount another 25% for re-existing problems relating to an 86 year-old man without explanation does not seem reasonable. I accept the figure of 5.4 years in the stipulation.

No evidence was presented that Mr. has not remained with . Thus, I accept the figures within the stipulation under item 2 d. "If Mr. 's

life expectancy is 5.4 years, and he continues with coverage, then the PV of the cost of his care is $860,277 . . .."

Regarding pain and suffering, there is no doubt that Mr. has suffered severely in this regard. Under MICRA the limit is $250,000 which is well-deserved in this case.

An award against and in favor of claimant shall issue in the amount of $860,277 for present value of the cost of his future care and $250,000 for pain and suffering, a total of $1,110,277.

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.

12/6/2016

Dated

Justice (Ret.) J. Gary Hastings