Office of the Independent Administrator
Arbitration Tribunal

CLAIMANT

VS

RESPONDENTS

FINAL AWARD

I, the undersigned Arbitrator, having been designated in accordance with the Arbitration Agreement entered into by the above-named parties, and having been duly sworn and having heard and considered the evidence submitted in connection with the hearing in the above-entitled matter, find that FINAL AWARD IN FAVOR OF RESPONDENTS is warranted, based upon the following analysis:

1. **Facts**

In April 2010, Claimant had a mechanical valve placed in her heart, leading to the need to use Coumadin to minimize a resulting risk of life threatening clots. The use of Coumadin complicated other surgical procedures Claimant would need, because patients on that drug are far more vulnerable to the bleeding that can result from surgical complications. For such patients, a small surgical "nick" to a vessel, ordinarily inconsequential, can become a serious problem.

It is for this reason that when Claimant faced the need for kidney stone removal in August 2010, the surgeon scheduled to perform that removal, Respondent M.D., needed to address the question whether or not to take Claimant off Coumadin for the duration of the surgery. ***If*** a patient is to be taken off Coumadin for surgery, the preferred method is to undertake a regime making use of the drug Heparin. That regime permits the surgeon to limit to a few hours the period of time the patient is off Coumadin, but it involves the additional complication of a ten day stay in the hospital (five days before, and another five days after, the surgery). Both courses involve risk: without the regime, the patient faces a significantly greater risk of serious bleeding; with the regime, the patient faces the increased risk of clotting, and the inherent risks of a longer hospital stay.

It is not disputed that Claimant knew that there was a risk of excessive bleeding if she underwent surgery while on Coumadin. Whatever ordinary concerns she would have

had would have been enhanced by the discouragement of her brother, a close confidante, who held, and expressed to her, the strong feelings on the issue he had acquired as a result of his own experience with another family member who had had an adverse experience with a serious Coumadin-aggravated surgical complication. Nor is there a contention that it was an act of negligence for Dr. to have nicked the vessel – such events are an inherent risk of this type of surgery. Nor is there a serious dispute that Dr. raised the issue with Claimant before the surgery. Finally, there is no dispute that Dr. conferred with Claimant's cardiologist as part of his surgical planning, and that the cardiologist at least acquiesced in the use of the Heparin regime.

Beyond those items of substantial agreement, there is this dispute: Claimant contends that she expressed at least a willingness to be taken off Coumadin for the limited period of the surgery, but that she deferred to the judgment of the surgeon, who preferred to proceed without doing so. Dr. , for his part, contends that his own preference would have been to take the patient off of Coumadin, using Heparin, that that is the course recommended by the patient's cardiologist, but that he did not take that course in deference to the patient only, who, having been fully informed of the alternatives and their consequences, strongly insisted on remaining on Coumadin.

During the surgery, there was, in fact, a small, unintended perforation of a vessel, causing a bleed. Exercising caution, Dr. did not then continue to pursue removal of the kidney stones, and they have not to date been removed. (The manner in which the unremoved stones stopped being problematic was not presented by either side as part of the evidence.) The patient suffered an extended stay in the hospital (ten to eleven days), the majority of that time being in the ICU, while her bleeding condition was treated through blood transfusions and other procedures. During her post operative hospital stay, she recalls experiencing two adverse incidents: on one occasion she awoke to find herself on the floor, for what she concluded had been a substantial period of time; on another occasion, while still hooked up to the ambulatory IV device, she walked outside the hospital, with the exit door closing and locking behind her, and found herself unable to reenter for a substantial period of time. Claimant exercised her right to depart from the hospital before Respondents were prepared to discharge her.

The evidence is that the decision to transport Claimant to the ICU was precautionary only; that she was consistently hemodynamic and otherwise stable; and that although there was pain, anxiety, dislocation and additional risk associated with the needed corrective treatment, there were no known permanent injuries.

2. Analysis

Dr. account of his interactions with both the cardiologist and with the patient appears, on the evidence, to put him in an implausibly passive role. While it is not implausible to conclude that the cardiologist may have expressed her professional opinion of the magnitude of the risk of clotting without Coumadin, and may have advised that if one were to take the patient off Coumadin, one should do so as temporarily as possible, using the Heparin regime, it is unlikely should would have expressed an ultimate opinion on the comparative risk of bleeding versus clotting. The assessment of

the risk and consequences of bleeding during surgery without Coumadin is the province of the surgeon, not the cardiologist. It is unlikely the purported process of concluding that Heparin was the preferred course was that of simply adopting the recommendation of the cardiologist. The more likely event is that otherwise suggested by Respondents' expert, Dr. specifically, that the surgeon obtained clearance to proceed with the Heparin procedure if, in his judgment as a surgeon, an undue risk of bleeding necessitated that course. This is also consistent with Dr. recordation of his own conversation set forth in his own pre-operative assessment plan: "I spoke to the cardiologist, [who] prefers iv Heparin in the hospital [as opposed to an alternative drug, lovenox] if anti-coag [sic, if coagulant] is needed." (Hearing Exhibit 2.)

It also appears unlikely that in his conversation with Claimant, the patient, Dr. strongly urged the Heparin course, but acquiesced to the insistence of the patient that she remain on the Coumadin. That account is inconsistent with both the Claimant's credible testimony and with the contextual evidence that she would have at least been seriously open the risk of a surgical bleed. Moreover, it is not entirely consonant with Dr. notes in the chart memorializing the conversation. The chart cannot be read to say, in effect, "I recommended X, but was unsuccessful persuading the patient, who insisted on Y, and I reluctantly proceeded with Y out of deference to the patient's preference, despite my own ongoing belief that Y remained the less preferred of the two medically acceptable choices." The notes state, instead: "We discussed higher risk of stroke with lovenox. I offered to do procedure on full anti-coagulation." (Id.) The purported adamancy of the patient was anomalous enough in this case that one would ordinarily expect some express reference to "proceeding on the basis of patient preference" had that in fact been the primary reason for the course Dr. took. But no such reference exists.

The question thus becomes whether Dr. conduct is medically defensible without the ultimate recommendation (one way or the other) of the cardiologist and without the factor of patient insistence. Does the decision to avoid the Heparin route and proceed with surgery in the face of the increased inherent risk of creating an uncontrolled bleed fall below the standard of care?[1]

The arbitrator concludes, on the basis of the evidence, that it does not. The issue is comparative risk assessment, viewed from vantage point of the Respondent physician at the time he made the assessment – i.e., before the adverse event took place. There is risk with either course. The magnitude of the risk for either course cannot be precisely measured. The risk of clotting without Coumadin can be minimized through the use of Heparin, but only by means of limiting the time the patient is exposed to the clotting risk. That risk cannot be eliminated. And one material consequence of that risk is death. The incidence of excessive bleeding resulting from surgery with Coumadin is probably higher

[1] We do need to reach the "standard of care issue." Respondents' contention, which was urged more at the summary judgment hearing than at the evidentiary hearing, that there was no ***causal connection*** between the uncontrolled bleed and the decision operate on the Coumadin affected patient, is not even arguably supported by the evidence.

than the incidence of clotting without Coumadin, but the consequences of such bleeding is less severe – they can almost always be controlled, as they were in this case, without permanent injury, let alone death. This became particularly true within the last decade, when the problem of contracting disease through blood transfusion was largely conquered.

Board certified urologist, M.D., testified as an expert witness, and provided an unqualified opinion that Dr. decision to take the calculated risk of a controllable surgical bleed, and thereby avert the more serious (albeit small) risk of a clot, is not only consistent with the ordinary practice within the medical field, but also the better option, and the one that he, Dr. consistently has resorted to in at least the last decade of his own busy surgical practice. He was, in the opinion of the Arbitrator, a very credible witness. His conclusion was both plausible and unchallenged by any contrary expert testimony. For these reasons, the Arbitrator finds that Dr. met the standard of care when he elected to proceed to operate on Mr. without taking her off Coumadin.

The Arbitrator refrains from reaching the analysis of the circumstances surrounding the two undesirable incidents Claimant allegedly experienced during her hospital stay – sleeping on the floor and exiting a locked door. The consequences of those events, however regrettable, do not rise to the level of cognizable injury warranting a damage award.

Accordingly, the Arbitrator finds in favor of Respondents, and each of them.

3. Award

For the reasons stated above, the Arbitrator awards as follows:

a. Respondents, and each of them, are determined to be the prevailing party, and Claimant shall recover nothing from Respondents.

b. All costs and fees shall be borne as incurred.

c. This Award constitutes full resolution of all claims submitted to this Arbitration.

d. 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: July 9, 2013

John (Jay) McCauley
Arbitrator