Arbitration Award

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Instructions: Use of this form is optional. Within fifteen business days of the date of the closing of most arbitration hearings, the Neutral Arbitrator must serve the Arbitration Award on the Parties and the Independent Administrator. If there were three arbitrators, this Award must be signed by at least two of them. See Arbitration Rules 37 - 39. Return to:

Office of the Independent Administrator
3580 Wilshire Boulevard, Suite 2020
Los Angeles, California 90010
Fax: 213-637-8658

Arbitration Name: _____ **Arbitration Number:** 10568

Cary Miller, the Arbitrator(s) selected to determine the dispute between the Parties in the above referenced action, find(s):

An arbitration hearing was held on _____.

It is the decision of the Arbitrator(s) that the prevailing Party in this Arbitration is **Check one:**

_____ The Claimant(s) is entitled to _____.

Or:

√ The Respondent(s) is entitled to judgment in its favor.

The reasons for this decision are attached.
(Arbitration Rule 38 requires that the Award provide findings of fact and conclusions of law, consistent with California Code of Civil Procedure Section 437c(g) or Section 632.)

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.

Cary M. Miller — 12/4/12
Signature of Neutral Arbitrator — Date

_____ — _____
Signature of Party Arbitrator — Date

_____ — _____
Signature of Party Arbitrator — Date

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Arbitrator

IN THE MATTER OF THE ARBITRATION

BETWEEN

Claimant,

and

KAISER FOUNDATION HEALTH PLAN, KAISER FOUNDATION HOSPITALS, SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP,

Respondents.

JAMS Ref. No.: 1240020465
KAISER ARBITRATION No.: 10568

Final Ruling re Respondent's Motion for Summary Judgment

Respondent submitted a Motion for Summary Judgment on June 22, 2012. Respondent's moving papers contained admissible declarations of two medical experts to the effect that (1) Respondent's care and treatment of met the standard of care, and (2) no act or omission by Respondent caused or contributed to death. The submission of these declarations shifted the burden to Claimant to submit an expert declaration that rebutted the opinions on both issues.

After several extensions, Claimant opposed the motion by submitting a one page letter from dated November 19, 2012. In his letter, set forth his opinion that Respondent violated the

standard of care in failing to work up a right lung lesion that was detected on an MRI of the thoracic and lumbar spine in summer of 2005. The lung lesion was reevaluated in September 2009 when presented with widely metastatic disease involving the brain, lung and soft-tissue in the abdomen.

Upon receiving Claimant's opposition, Arbitrator issued a tentative decision in favor of Respondent and advised the parties that either party could request oral argument by December 3, 2012 at 5pm. Neither party requested oral argument although Claimant submitted supplemental documents at the deadline. These documents included Claimant's signed declaration which set forth a number of factual statements, opinions and conclusions regarding various aspects of medical chart.

In his letter, set forth his opinion that Respondent violated the standard of care in failing to work up a right lung lesion that was detected on an MRI of the thoracic and lumbar spine in summer of 2005. The lung lesion was reevaluated in September 2009 when presented with widely metastatic disease involving the brain, lung and soft-tissue in the abdomen. This opinion is sufficient to create a triable issue of fact as to whether Respondent's care and treatment of met the standard of care.

letter failed to establish a triable issue of fact as to whether any act or omission by Respondent caused or contributed to death. simply stated that "no one can predict the patient's prognosis from 2005 (without complete radiology work-up) and the effect of the failure to work-up the lung nodule." Claimant's supplemental documents did not contain any admissible opinions bearing on the issue of causation. Arbitrator finds that Claimant's opposition is insufficient to rebut the opinions of Respondent's two experts on the issue of causation.

For reasons set forth above, Arbitrator grants Respondent's Motion for Summary Judgment.

DATED: 12/4/12

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Arbitrator

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Arbitrator

IN THE MATTER OF THE ARBITRATION

BETWEEN

ARBITRATION No.: 11615

Claimant,

FINAL AWARD

and

Respondents.

I. INTRODUCTION AND PROCEDURAL BACKGROUND

Claimant is , an incompetent adult, by and through his conservator and mother, . He brings this action for professional negligence against Respondents, , , and .

This Arbitration Hearing began on June 18, 2013. Cary W. Miller served as the sole Arbitrator. After eight evidentiary hearing sessions, the

Arbitrator declared the hearing closed on June 27, 2013. At the close of the hearing, the parties stipulated that the Arbitrator had until July 31, 2013 to issue this Interim Award.

Claimant was represented by and of the . Respondents were represented by and of . All proceedings were reported by Court Reporting.

The following witnesses were called to testify: , R.N.; , R.N.; ; R.T.; , M.D.; , M.D.; , M.D.; , M.D. (Claimant expert); , M.D. (Claimant expert); , R.N.; , R.N. (Claimant expert); , M.D. (Respondents Expert); (Claimant expert); , M.D.; , R.N.; ; (Claimant expert); , R.N.; , M.D. (Respondents expert); (Respondents expert); , M.D. (Respondents expert); (Respondents expert); , R.N. (Respondents expert); , M.D. (Respondents expert); . testified via videotape deposition. Claimant appeared but did not testify.

At the beginning of the Arbitration, the parties presented three binders that contained approximately 175 exhibits. A Joint Arbitration Exhibit Index sets forth the exhibits that were referred to in the Arbitration. The parties stipulated that all exhibits contained in the Joint Arbitration Exhibit Index could be considered by the Arbitrator in reaching his decisions.

On July 19, 2013, the Arbitrator issued an Interim Award that, among other things, asked the parties to advise no later than July 25, 2013 whether any further hearings were required before the Interim Award is converted

to a Final Award. Counsel for Respondents timely indicated a desire to file a Motion for Reconsideration. To allow time for the motion to be heard, the parties stipulated that the Arbitrator had until August 30, 2013 to issue the Final Award. The Motion for Reconsideration was filed on August 7, 2013. Both sides submitted extensive briefs and oral argument was held on August 20, 2013. The oral argument was reported by Court Reporting. Upon conclusion of oral argument, the parties agreed that this Final Award would contain all final findings and conclusions without the need to submit a separate ruling on the Motion for Reconsideration.

II. GENERAL FACTUAL OVERVIEW

The following discussion is a summary of those facts found by the Arbitrator to be true and relevant to the issuance of this Interim Award. Any differences between the recitation and any party's position or contention is the result of the Arbitrator's determination as to witness credibility, relevance, burden of proof consideration, and the weighing of evidence, both oral and written.

A. Events Prior to Admission

was 17 years of age when he was stabbed multiple times in the chest and left flank on May 12, 2011. He was taken to Medical Center where he was found to be hypotensive and tachycardic. Mr. was also noted to be awake, alert and able to follow commands. Examination revealed a pericardial effusion without tamponade. Mr. underwent an emergency sternotomy, exploratory laparatomy, partial colectomy, left nephrectomy, left iliac vein ligation, left thoracostomy tube placement, and temporary abdominal closure. He required pressor support after this operation. Mr. was returned to surgery for abdominal

washout, colostomy and abdominal closure. He stabilized after this procedure and pressors were stopped. He remained hemodynamically stable although he was tachycardic throughout this hospitalization. A left thoracostomy tube and two mediastinal drains were removed on May 17.

Mr. was intubated before the initial operation. He was placed on a propofol drip for sedation. He could not be weaned from the ventilator following the second operation. He was very agitated when his sedation was weaned, and he required wrist restraints. He failed multiple sprint trials. Mr. was extubated on May 18, but he required reintubation a few hours later secondary to tachypnea, increased work of breathing, and respiratory failure. He was able to communicate and follow commands while extubated.

Mr. was transferred to on May 20. At the time of transfer, he remained in serious condition, but was hemodynamically stable. He was sedated with propofol drip and was noted to be unable to follow commands at the time of transfer.

B. Events at Prior to Extubation Event

Upon arrival at , Mr. was admitted to the General Surgery Trauma Service Team under the care of Dr. (General Surgery and Vascular Surgery). He was placed in room 3123 in the ICU. Mr. was noted to be sedated and ventilator dependent. Soft wrist restraints were maintained and he was kept on propofol drip and fentanyl drip.

Dr. (Pulmonary and Critical Care Specialist) examined Claimant on May 21. Dr. decided to continue him on mechanical ventilatory support with sedation to help with patient-ventilator synchrony since he was not a candidate for weaning that day. She ordered a Spontaneous Awakening Trial (SAT) and Spontaneous Breathing Trial (SBT) the following

day to determine whether Mr. could be weaned from the ventilator. Her order instructed the nurses to call the physician to reassess analgesia and sedation strategies if Mr. failed the SAT.

Mr. was appropriately sedated while on propofol. Dr. decided to stop the propofol and start Mr. on versed (also referred to as midazolam in the records) because of a persistent fever that Dr. thought might be in reaction to the propofol. At 1115, Dr. ordered continuous versed IV drip to increase by 1mg/hr until a -2 RASS target ("light sedation") was achieved. Dr. further ordered bolus dosing of 2mg every five minutes until the RASS target was achieved. The nurses were ordered to "Call physician for midazolam infusion rate = 10 MG/HR or breakthrough midazolam dose = 10 MG and RASS target not achieved." Dr. also continued the order for soft wrist restraints.

Dr. (Cardiologist) saw Mr. at approximately 1515. He noted that Mr. was intubated and sedated. A bedside echocardiogram confirmed the continued presence of a moderately large traumatic pericardial effusion without tamponade.

The continuous versed drip was steadily increased over the course of the afternoon and evening until the maximum dose was reached at 2240. At 1952, Mr. RASS score was noted to be 0 ("alert and calm"). Ms. noted at 2250 that Mr. was "agitated/restless, able to sit up, trying to get out of bed, moving all over the bed. Mom at bedside helping to calm down patient. Midazoam is now at 10 mg/hr, Fentanyl 200mcgs, still pt wakes up intermittently and tries to pull out ETT." Ms. did not administer any versed boluses and did not tell Dr. about Mr. agitation or sedation level before her shift ended at 2300.

Ms. took over for Ms. at 2300 and was with Mr. until May 22 at 0700. She testified that Ms. told her that

there had been issues of agitation during her shift that required her to turn up the continuous versed. Ms. encountered four or five bouts of agitation beginning at 0100. One bout required her to hold Mr. chest down to keep him from pulling away from the ventilator and putting strain on the endotracheal tube. Ms. noted that Mr. was sitting up, his feet were coming off the side of the bed, and he was trying to bring his hands in toward his chest like a "superhero" move. During this time, Ms. recorded RASS scores of +2 and +3 ("very agitated").

Ms. did not record the sedatives that she administered to Mr. during her shift. She testified that she administered 2mg boluses by using the IV drip rather than the PYXIS mediation control system. She further testified that the boluses relieved Mr. agitation and that he was well sedated between episodes of agitation. Ms. did not notify Dr. or any physician about Mr. agitation because he reached the target level of sedation after boluses were given and boluses totalling 10mg/hr were never given to Mr. .

At the change of shift at approximately 0700, Ms. expressed concern about the potential risk of extubation to Mr. . She did this with the expectation that Mr. would tell the physicians when they came in. Ms. does not recall telling Mr. that she had notified a physician during her shift.

Mr. began his nursing care of Mr. at 0700. Mr. was a 4 year nurse who had worked in the ICU since 2008. At the hand-off, he recalled Ms. telling him about some bouts of agitation that were resolved by boluses of versed. He further recalled her saying that she had notified the physician about the bouts of agitation. Mr. testified that it was very important to him that the physician was up to speed. Mr. recalled that Ms. was very anxious

about the evening's events. She expressed relief that Mr. was taking over because he was a man closer in size to Mr.

Mr. stayed with Mr. almost continuously because he was concerned with his safety. Mr. first observed an episode of agitation at 0800. He saw Mr. thrashing and attempting to climb down the bed. He testified that he gave three boluses of versed that resolved the agitation after approximately 15 minutes.

A second bout of agitation occurred during the SAT/SBT that had been ordered by Dr. the previous day. Mr. (Respiratory Therapist) performed the SBT between 0845 and 0859. Mr. sedation did not need to be lightened because he was already awake. At the beginning of the SBT, Mr. was able to breathe on his own although he was overbreathing the ventilator. He was able to slow his breath on request.

Mr. noted that Mr. became agitated during the test, and his 02 Sat rate dropped to 92%. Accordingly, Mr. stopped the trial after only 14-15 minutes. Mr. gave two boluses of versed to resolve Mr. agitation.

A third bout of agitation occurred at approximately 0943. This bout lasted approximately 15 minutes and, according to Mr. , was worse than the previous episodes. He wrote a note at 0948 which states: "Patient continues to be agitated and restless. On 200mcgfentanyl and 10mg versed drips. Patient continues to climb and trying to pull tubes and lines. Continue to observe and monitor." To resolve this episode of agitation, Mr. gave 3 boluses of Versed.

During his shift, Mr. did not record any RASS scores or the amount of sedation that he administered to Mr. . He testified that

the level of agitation that morning was a +3 and that the episodes of agitation got worse.

Mr. did not contact Dr. regarding the failed SAT/SBT. However, he recalled talking to Dr. as she was walking through the ICU sometime that morning. He asked Dr. if the Versed should be adjusted because of bouts of agitation that boluses had resolved. He did not mention the bouts of agitation during Ms. shift because he assumed Dr. already knew. Mr. does not recall Dr. response. Dr. does not recall this discussion. She testified at hearing that she would have evaluated Mr. and considered an adjustment to his medications if she was aware of the information in Mr. 0948 note. At her deposition, Dr. testified that she would have adjusted Mr. medications.

Dr. came to the ICU to see Mr. between 0930 and 1030. Dr. spent 5-10 minutes with Mr. and noted that he was restrained and comfortably sedated. Dr. testified that he did not review Mr. record. He spoke with Mr. who said that Mr. had been taken off propofol due to a reaction and had been started on versed. Mr. described a few brief episodes of agitation that were manageable. Mr. did not mention the specific number of boluses needed to control Mr. bouts of agitation. Dr. recalls that Ms. expressed concerns regarding her son's agitation. Dr. told Mr. that he would write an order if the patient required more sedation. Mr. declined. At 1117, Dr. wrote a note that Mr. was "more active so was sedated during the night. Pulling at tubes."

Dr. also saw Mr. for approximately 30 minutes, during which he performed a bedside echocardiogram. Dr. was in the room

with him and they discussed the echocardiogram which showed no change in the moderately large pericardial effusion without tamponade. Dr. recalled that Mr. displayed no agitation while he was in the room.

C. Extubation Event

Mr. was at the monitor in Mr. room when he heard the alarm of Mr. ventilator sound sometime after 1041. The events from this point forward are difficult to reconstruct. The recollections of the involved witnesses vary considerably and the Patient Resuscitation Record (Exhibit 23) is admittedly inaccurate and incomplete as to time and details. Ms. , the author of Exhibit 23, acknowledged that some of her entries are inaccurate.

Dr. testified that she entered the room shortly after the alarm sounded. While she was at the foot of the bed, concern was expressed that the tube might be dislodged. She told the family to leave the room, asked that the tube be removed, and asked the nurses to call anesthesia. Efforts were made to bag the patient but resistance was met. Mr. then began to vomit profusely, after which he went into cardiac arrest. A Code Blue was called while Dr. was attempting to suction the patient's airway. Dr. , Anesthesiologist, arrived and intubated the patient without problem. Dr. testified that she would have intubated Mr. if Dr. had not arrived after the airway was cleared. After these events, Dr. wrote a note that included the following information: patient self-extubated; vomited; bradycardic followed by asystole; total time pulseless 6min.; total resuscitation time about 14 min.

Dr. testified that he was completing his charting in the ICU when he heard the alarm. Dr. saw Dr. run into the room. He followed Dr. into the room within one minute. Mr. was tachycardic with

normal blood pressure at that time. The Code Blue was called while Mr. was being bagged. Dr. arrived and rapidly, smoothly intubated the patient. Dr. testified that an ultrasound during the code demonstrated P.E.A. (electrical activity without a pulse), and that Mr. did not have any blood pressure during the entire code. Mr. heart rate returned within a minute or so after he was reintubated. Dr. described this as more smooth than the hundreds of other codes he had seen. It was "a routine code, not unduly long". Dr. was not surprised that the Patient Resuscitation Record was inaccurate due to the "controlled chaos" that is typical of most Code Blues.

Mr. heard the alarm go off sometime between 1035 and 1040. He went straight to the room where he saw that Mr. was agitated with his head and shoulders moving side to side. Mr. suctioned the airway with no problems. Mr. gave Mr. a bolus that settled him down. Mr. heard a hissing sound shortly before Dr. came into the room. Dr. examined Mr. and asked that a call be placed to anesthesia. Mr. estimates that 1 – 1 ½ minutes had elapsed from the time the alarm went off to when one of the clerks in the unit called anesthesia. Someone proceeded to remove the tube, after which Mr. began to bag Mr. He met resistance, the patient was repositioned, and another effort was made to bag him. Mr. got a new bag by calling out to the nursing station. When it was brought in, Dr. took over this function. Mr. does not recall any vomiting. Dr. arrived after anesthesia was called. While applying a portable, hand-held ultrasound device on Mr. chest, Dr. announced "no pulse, call code blue." Mr. noted that Mr. O2 Sat was down and his color was not good. Mr. called the Code Blue and began chest compressions. Dr. arrived and reintubated Mr.

with no problems. The Code Blue ended 1 ½ minutes later when the heart rate returned. Mr. estimates that five minutes had elapsed from the time he entered the room.

Mr. testified that Mr. and Mr. responded quickly to the alarm. Dr. arrived within 30-45 seconds after the alarm went off. Upon hearing the alarm, Mr. went to the patient to see that the tube was still at 22 cm. However, he heard a hissing sound which indicated the tip of the tube had dislodged above the vocal cords. A call went out to anesthesia and Dr. asked him to remove the tube. Mr. began to suction and bag the patient within 1 ½ minutes of the alarm. He met resistance twice. He does not recall changing the bag nor does he recall seeing Mr. vomit. Dr. arrived and put Mr. aside to intubate.

Mr. testified that he arrived in the room within seconds of the alarm. He noticed low tidal volumes. He recalled that Mr. was awake, distressed, thrashing around with his head going side to side. He was also trying to sit up. The tube was loose and dislodged so that it was no longer at a depth of 22cm and the holder was dangling. He recalls that Dr. tried to ventilate the patient with an ambu bag that had to be replaced once. Mr. does not know how much time elapsed until intubation was completed.

Dr. was in the PACU when he received the call from ICU. He took less than one minute to gather his equipment and was en route to ICU when he heard the Code Blue. He quickened his pace and arrived in Mr. room 1 minute 50 seconds after he received the call. He saw that the patient was being bagged. He couldn't recall if chest compressions were being administered. He gave Mr. two breaths with the bag before intubating him with no difficulty. Dr. testified that he was on call to

intubate or reintubate patients. Intensivists at are asked to page anesthesiologists to do this. He would not have expected Dr. to intubate Mr. , although there was nothing to prevent an intensivist from intubating a patient before the anesthesiologist arrives. According to Dr. , this would have been a difficult intubation for Dr. because the vocal cords could not be visualized.

D. Subsequent Events/Claimant's Status

Dr. and the other healthcare providers who were present during the resuscitation efforts believed that Mr. responded well from the self-extubation and resuscitative efforts. However, on May 26, Mr. began posturing, a reflex response by brain damaged individuals. Subsequent imaging studies demonstrated damage consistent with anoxic encephalopathy. Mr. remained in a vegetative state after the Code Blue and it was initially believed that his prognosis was dismal. However, he began to improve and eventually regained some ability to speak and ambulate. On January 3, 2012, Mr. was transferred to , a transitional care facility in Pomona, California, where he currently resides. Ms. lives in a home adjacent to in order to be close to Mr. .

Mr. has irreversible brain damage from which he will never fully recover. He will never be employable and he will require 24-hour attendant care the rest of his life. He has fully recovered physically from the stabbing and it is anticipated that his colostomy will be reversed at some time in the future.

III. FINDINGS AND CONCLUSIONS

A. STANDARD OF CARE (PRE-EXTUBATION)

Claimants Position: Mr. claims that the nurses attending him violated the standard of care in several significant respects: failure to adjust his medications in the face of severe bouts of agitation; inadequate communications and miscommunications between nurses and with treating physicians; failure to take reasonable steps to keep Mr. safe; failure to follow physician's orders. Mr. called two experts to support these claims.

Dr. is a Board Certified Pulmonologist and Critical Care Specialist with extensive experience treating intubated patients in the ICU setting. He testified that the ICU has the most unstable group of patients in the hospital. With regard to ventilator-dependent patients like Mr. , bouts of agitation are particularly dangerous and "fraught with hazard". The primary goal is to eliminate agitation with appropriate levels of sedation along with constant monitoring and reassessments. Communication among the treatment team is vital to assure that the attending physicians are kept apprised of the patient's condition and can adjust the patient's level of sedation.

According to Dr. , the pattern of escalating bouts of severe agitation during the shifts of Ms. and Mr. put Mr. at significant risk for pulling out his life support. Although Dr. agreed that self-extubation is a known risk, the results of an unplanned extubation are unpredictable and potentially dangerous for the patient. In Dr. opinion, Mr. most likely dislodged the tip of the tube above the level of the vocal cords with his tongue. Although "tonguing" can occur in the absence of negligence, Dr. opined that Mr. self-extubation would have been avoided if he were appropriately sedated.

Dr. set forth the following specific criticisms of the nurses attending Claimant:

1. Ms. violated the standard of care for failing to call Dr. or the physician on duty when Mr. experienced his second bout of agitation on May 22 at 0100. The first episode of agitation at 2255 was a change in status in the face of maximum doses of Versed. The second episode at 0100 represented a pattern that required a physician to be notified in order to assess whether additional sedation was required to keep Mr. safe.

2. Miscommunication between Ms. and Mr. regarding whether Ms. had contacted Mr. physicians about Mr. agitation during her shift. As a result of this miscommunication, neither nurse contacted Dr. prior to Mr. self-extubation. If Dr. had been notified, the standard of care would have required her to assess Mr. .

3. Mr. violated the standard of care in failing to notify Dr. regarding the three episodes of agitation during his shift and the amount of medication that he administered. These episodes represented a dangerous worsening of Mr. condition. Dr. is also critical of Mr. for failing to notify Dr. that Mr. sedation did not have to be lightened for the SBT and that Mr. failed the SBT after only 14 minutes due to agitation.

4. Mr. failed to adequately inform Dr. of Mr. agitation. As a result, Dr. responded on inadequate information. Dr. is also critical of Mr. for failing to document this important interaction.

Ms. is an experienced Critical Care Clinical Specialist who essentially reiterated Dr. standard of care criticisms. In addition, Ms. criticized the nurses who attended Mr. for failing to appropriately record RASS scores, and for failing to record the boluses of Versed that were administered to Mr. .

Respondents' Position: Respondents argue that Claimant's position is based on a retrospective approach, and they ask the Arbitrator to apply a prospective view. In essence, Respondents assert that there was no reason to believe Mr. couldn't be masked or ventilated successfully if he self-extubated. Mr. did not have a mechanical airway obstruction and he had demonstrated an ability to breathe on his own for more than four hours at and for 14 minutes immediately prior to the incident in question. In further support of its position that Mr. event was unpredictable, Respondents cite multiple witnesses who testified that they had never seen this result before in their many years of cumulative experience with ventilator patients. Finally, Respondents assert that agitation is expected and that the care providers must exercise their judgment in deciding the delicate trade-off between sedation and liberation from the ventilator.

In support of its standard of care defense, Respondents called two witnesses.

Dr. is an experienced Pulmonologist and Critical Care Specialist at . His opinions are summarized as follows:

1. Mr. was not ventilator dependent. There was no indication of pulmonary issues, lung disease or upper airway issues. Mr. had

adequate respiratory drive and had demonstrated that he could breathe for himself for some period of time. If Mr. tube became dislodged, there was no foreseeable risk that he could not breathe on his own. To wean the patient off the ventilator, the treatment team must accept some amount of agitation which is not unexpected. On cross-examination, Dr. agreed that extubation was possibly a time sensitive and life-threatening event.

2. Unintended extubation is a well recognized risk (a "fact of life") in the ICU.

3. Tonguing is very uncommon. In Dr. opinion, it is not reasonable to sedate to avoid this.

4. The periods of agitation from May 22 at midnight to 1030 were managed by boluses of versed. Mr. was sedated most of the time. Accordingly, there was no duty on the part of the nurses to notify Dr. until she made rounds.

5. The SBT was terminated after 14 minutes due to agitation, and Mr. was put back on respiratory support. The expectation was that the test would be repeated in 24 hours. This test failure was not a predictor of increased risk upon self-extubation. Rather, it indicated that it may be easier for Mr. to breathe if the tube were removed. On cross-examination, Dr. agreed that Mr. was "ventilator dependent" after failing the SBT.

6. The standard of care did not require Dr. to increase Mr. sedation following his discussion with Mr. .

Ms. is an experience Critical Care Clinical Specialist with the Hospital in La Jolla. Her opinions are as follows:

1. Ms. disagrees with the opinions of Claimant's experts that Ms. and Mr. violated the standard of care. It was appropriate to resolve Mr. bouts of agitation with versed boluses and wait until morning rounds to apprise Dr. of his condition.

2. Unplanned extubations are not predictable or preventable. There was no reason to believe Mr. would lose his airway if he self-extubated.

3. Failure to record RASS scores and the administration of sedatives is a documentation issue rather than a standard of care violation.

Findings and Conclusions: In the face of an appropriate sedation order, Mr. bouts of agitation grew progressively worse on May 22 from 0100 to 1030. Ms. was so concerned with Mr. risk of extubation that she advised Mr. with the expectation that he would notify a physician. The Arbitrator finds that Ms. should have either contacted the physician herself after the second episode of agitation or made sure that Mr. did so. Mr. episodes of agitation grew worse during the course of Mr. shift in the face of a continuous dose of versed and multiple boluses. Mr. should have notified Dr. after each of the three episodes of agitation that occurred on his shift and especially after the failed SAT/SBT. These findings are supported by Dr. testimony that she would like to have been notified that Mr. was exhibiting the behaviors set forth in Mr. 0948 progress note. If Dr. or Dr. had learned the

true state of Mr. condition anytime before 1030, one or both of them would have promptly increased Mr. sedation and thereby avoided the self-extubation event that occurred sometime after 1041. Accordingly, the Arbitrator finds that Claimant met his burden of proof that Respondents violated the standard of care.

In evaluating all the evidence relevant to this issue, the Arbitrator finds the testimony of Claimant's experts to be more credible than Respondents' experts. Dr. brought far more hands-on ICU experience to the table than Dr. , who only spends 6-8 weeks per year on the clinic services in the Medical Service at and he cannot recall the last time he was responsible for an ICU patient. The Arbitrator further finds that Dr. testimony was more straight forward and credible. Dr. change in testimony that Mr. sustained a cardiac arrest totally independent of ventilation undermined his credibility. Although both nursing experts have extensive ICU experience, the Arbitrator finds Ms. opinions were more credible than those of Ms. .

The Arbitrator has considered Respondents' position that a prospective view of this case should be taken. Most of Respondents' witnesses gave testimony in support of this position. The Arbitrator agrees with Respondents' evidence that it is necessary to accept some amount of agitation as efforts are made to wean a patient off the ventilator. However, the Arbitrator believes that the attending nurses, Mr. in particular, did not appreciate the dangerous worsening of Mr. bouts of agitation. By failing to adequately inform Dr. or Dr. , the nurses deprived the physicians of the opportunity to adjust Mr. level of sedation before his self-extubation.

B. STANDARD OF CARE (POST-EXTUBATION)

Claimant's Position: Claimant claims that Dr. violated the standard of care by attempting to bag Mr. while waiting for Dr. to arrive instead of immediately reintubating him. Claimant relies on the expert testimony of Dr. to support this position. Dr. testified that Mr. airway had to be reinstated as quickly as possible. Dr. could have accomplished this in less than a minute whether or not Mr. vomited, and Mr. anoxic brain damage would have been avoided. While Dr. and the response team were waiting for Dr. to arrive, Mr. lost his airway and became hypoxic for 3 to 5 minutes leading to loss of consciousness. The decreased oxygen then led to a cardiac arrest. Although one can not be sure how long Mr. was hypoxic and pulseless because of the poor record, Mr. may have been pulseless and without spontaneous circulation for as long as 13 – 16 minutes. This resulted in a significant insult to the brain, which begins to lose cells at about 4 minutes.

Respondents' Position: Respondents deny that Dr. violated the standard of care as asserted by Claimant. This was a witnessed event with Dr. at the door, according to Ms. , or nearby in the ICU. She immediately responded and promptly put out a call to anesthesiology in conformance with practice for anesthesiologist to perform intubations and reintubations. Dr. responded within 1minute and 45 seconds of the call and reintubated Mr. within one minute of arrival. According to Dr. , a spontaneous heart rate resumed within one minute of the reintubation. Respondents assert that the evidence establishes that the entire time from alarm to the end of the Code Blue took less than the

national standard of five minutes. Finally, Respondents assert that it was not foreseeable that Mr. would have a bad outcome from this event.

Dr. (Cardiologist) and Dr. provided expert testimony on behalf of Respondents. Dr. found this to be a smooth code with an appropriate, efficient response. In his opinion, the time from extubation to reintubation was four minutes. He attributed the poor outcome to the following factors: (1) the presence of pericardial effusion which affects filling after blood ejection from the heart; (2) vomiting which likely caused a vassal-vagal response that slowed Mr. heart rate; and (3) a possible pre-existing neurological insult at the time of the stabbing incident. Dr. testified that the response was very fast and that reintubation occurred within three minutes. He agreed with Dr. that the result was unexpected and unanticipated. Neither expert was critical of Dr. for the way in which she responded to this emergency.

Findings and Conclusions: Upon considering all relevant evidence, the Arbitrator finds that Claimant failed to prove that Dr. violated the standard of care. When the alarm went off, Dr. quickly went to Mr. room and promptly asked staff to contact an anesthesiologist upon learning that the tube may be dislodged. Despite the contents of the inaccurate and incomplete code record and Dr. own post-event estimate of the timing of post-alarm events, the weight of evidence supports Respondents' position that the entire episode lasted less than the national standard of five minutes. Under these circumstances, the Arbitrator finds that Dr. judgment call to suction and bag the patient until Dr. arrived was reasonable and within the standard of care. The Arbitrator agrees with Dr. that the pre-existing pericardial effusion and vomiting probably contributed to the outcome. As discussed below, there is

insufficient evidence to find that Mr. had a pre-existing neurological insult that was contributory to the outcome.

C. CAUSATION

Positions: On behalf of Claimant, Dr. and Dr. testified that Mr. anoxic brain damage is the direct result of the self-extubation that caused a lack of oxygen for an extended period of time that led to a cardiac arrest. Respondents' experts testified that they would have expected a good outcome based on the quick response to the self-extubation. Dr. was the only expert to testify that Mr. cardiac arrest was totally independent of poor ventilation. However, he testified in his deposition, which was taken one month prior to the start of arbitration, that Mr. suffered an anoxic or hypoxic event that set off a chain of events that led to a cardiac arrest. He specifically admitted in his deposition that the extubation was a substantial factor in causing Mr. cardiac arrest.

Respondents further allege that there is no medical basis to rule out brain injury from the stabbing and initial resuscitation. Dr. and Dr. addressed this defense during their testimony. They opined that Mr. did not have brain injury prior to the self-extubation. They based their opinion on the following factors: (1) The physicians did not believe Mr. needed a head CT or neuro assessment; (2) Mr. Glasgow Coma scores were not suggestive of a major traumatic injury; and (3) Mr. was able to communicate and follow commands at and prior to the self-extubation. Dr. further testified that Mr. agitation is common in young ventilator patients and is not indicative of brain injury.

On behalf of Respondents, Dr. , Dr. and Dr. testified that there is no medical basis to rule out brain injury from the initial stabbing and resuscitation. It was noted that Mr. sustained significant blood loss, his aorta had to be clamped during surgery, and his blood pressures were in the 30's, 40's and 50's in the initial post-insult period. They further opined that Mr. confusion and agitation could be caused by hypo-perfusion. However, all three experts acknowledged that it is only possible that Mr. had pre-existing brain damage.

Findings and Conclusions: The overwhelming evidence supports a finding that the self-extubation was a substantial factor in causing Mr. cardiac arrest. The testimony of Dr. and was convincing on this point, and Dr. agreed in his deposition. The Arbitrator also finds that Claimant proved by a preponderance of the evidence that Mr. anoxic brain damage did not precede the extubation. Dr. and Dr. were convincing on this issue. While the Arbitrator agrees with Respondents' experts that pre-existing brain damage cannot be ruled out, the existence of a possibility is not legally sufficient to prevail on this issue. Accordingly, the Arbitrator finds in favor of Claimant on the issue of causation.

D. DAMAGES

Having found in favor of Claimant on the issues of standard of care and causation, the Arbitrator hereby addresses the components of Claimant's damages.

1. Non-Economic Damages

Claimant sustained catastrophic injuries as a result of Respondents' negligence. In view of the statutory limitation set forth in California Civil Code Section 3333.2, the Arbitrator awards non-economic damages in the amount of $250,000.

2. Loss of Earning Capacity

At the time of his injury, Mr. was a 17-year-old who had not established an earnings history. Accordingly, the economic experts base their calculations of future lost earnings on the level of education that Mr. would have likely attained but for the event in question. This approach is consistent with legal authority that allows Mr. to recover damages for lost earning capacity without proof of actual loss of earnings.

Mr. presented two scenarios on behalf of Claimant. The first assumes Mr. would have attended post-secondary education to become certified as a Nursing Aide, Orderly or Attendant. This results in a present value loss of $748,060. The second scenario assumes Mr. would have earned a bachelor's degree in nursing and obtained a position as a Registered Nurse. This results in a present value loss of $2,047,106.

Mr. presented three scenarios on behalf of Respondents. The first assumes less than high school education, which results in a present value loss of $587,907. The second assumes that Mr. would have graduated from high school. This results in a present value loss of $894,097. The third assumes some college education, which results in a present value loss of $1,124,068,068. In all three scenarios, Mr. includes a set-off in the amount of $190,284 for potential SSI benefits over the course of Mr. life.

Ms. testified that a college education is important to her and her family, and that Mr. wanted to go to college to become a registered nurse. She also testified about Mr. unsuccessful high school career. Mr. started at as a 9th grader in 2008. She transferred him to School. Fearing that Mr. may flunk out, Ms. enrolled him at in January 2010. Ms. testified that Mr. was in 11th grade at the time of his accident and was working toward graduation.

Mr. academic records, as summarized by Mr. , paint a much different picture of Mr. high school career. Mr. withdrew from 9th grade at in 2009 with a 0.6 average. At Charter School, Mr. took six classes and received 4 F's. The records reflect that Mr. was still a 9th grader at in December 2010. Rather than working toward graduation, the records reflect that Mr. had significant absences in the spring of 2011 and did not attend school at all in April.

The weight of the evidence on this issue strongly suggests that Mr. was not on a course to graduate from high school. Any award based on an assumption that Mr. would have turned things around but for his accident would be speculative at best. Accordingly, the Arbitrator finds that Mr. first scenario best represents the present value of Mr. lost earning capacity. The Arbitrator declines to apply a set-off for potential SSI benefits because it is unlikely Mr. will qualify for such benefits once Respondents satisfy the final award in this matter. Accordingly, Claimant is awarded loss of earning capacity in the amount of $587,907.

3.

Respondents have been paying for Claimant's stay at as a covered benefit under his grandfather's membership. Respondents have also been paying rent in the amount of $1200 per month for a house adjacent to , although this is not a covered benefit. By living in this house, Ms. can be actively involved in Claimant's care and activities at .

During the arbitration hearing, Ms. testified that Respondents will continue to pay for Claimant's stay at until Claimant's attending physician determines that his continued stay is no longer medically necessary. Neither side presented further evidence at the arbitration hearing with regard to the anticipated length of stay. Based on this limited information, the Interim Award included an order that Respondents shall continue to pay for the Claimant's stay at and for the rent on the house adjacent to until Claimant's attending physician opines that it is no longer medically necessary for him to stay at .

Having received more information after issuing the Interim Award, the Arbitrator hereby makes the following conclusions and findings:

In Opposition to the Motion for Reconsideration, Claimant submitted a declaration from , M.D. According to the declaration, Dr. is Claimant's treating physician at where claimant continues to make therapeutic progress as a patient. It is medically necessary for Claimant to remain as a patient at until he can be discharged to a safe, permanent home which accommodates Claimant's disability needs. Claimant also submitted a declaration from , which sets forth the necessary steps to establish a safe, permanent home for Claimant. This consists of the formation of a trust, locating and selecting an appropriate trustee for the trust, a court order approving the disbursal of funds to

purchase a home, locating a suitable home, obtaining an appraisal on it, and making required renovations on the home before it can be occupied. Ms. estimates this process will take six to twelve months. Based on this information, the Arbitrator finds that Claimant is entitled to damages to cover the cost of his stay at for one year ending on July 14, 2014.

The full rate for a year at is $569,932. Respondents assert that they should only be required to pay the contracted rate of $328,500. In Opposition to the Motion for Reconsideration, Claimant's counsel represented that Claimant is no longer a dependent of his grandfather. Respondents' counsel responded by submitting a letter questioning whether Claimant is or has ever been entitled to health coverage benefits with Respondents. This exchange of information raises the distinct likelihood that Respondents are not obligated to pay for Claimant's stay at on a going-forward basis. In that event, Claimant would be required to pay the full rate unless offers him a discount. In the absence of any evidence that Claimant would receive a discounted rate from , Claimant is entitled to damages in the amount of $569,932.

The Arbitrator further finds that Claimant is entitled to damages in the amount of $18,000 for payment of rent on the home adjacent to through July 14, 2014.

4. Future Life Care Costs

Two Life Care Planners, Ms. and Ms. , testified about the costs of care that Mr. will require for the rest of his life. The only material differences in the two life care plans are the following: (1) Ms. plan includes an electric wheelchair and the costs of care at , and (2) Ms. plan includes various potential sources of payments of Mr. costs other than attendant care.

The parties agree that attendant care is the biggest future cost. The Life Care Planners also agree on the general range of annual attendant care costs. They further agree that there are no sources of third-party payment for these costs.

The parties disagree on two issues that significantly impact the present value of attendant care costs: (1) Mr. life expectancy; and (2) the appropriate discount rate to be applied.

Life Expectancy: Both Rehabilitation Experts testified that Mr. life expectancy is lower than normal due to his physical and mental disabilities. Dr. believes Mr. life expectancy is 45-50 years, based on some ability to walk and feeding ability. According to Dr. there is some room for improvement as Mr. has not yet reached a plateau. Dr. initially testified that Mr. life expectancy is 38.6 years, based on tables of individuals whose impaired mobility results in a lack of exercise. On cross-examination, Dr. acknowledged that he misread the tables. Mr. life expectancy, according to an accurate reading of the tables, relied upon Dr. , is 42.5 years.

The Arbitrator hereby finds that Mr. life expectancy is 45 years. This number is at the lower end of Dr. range and is higher than Dr. revised number. However, Dr. opinion assumes that Mr. cannot ambulate independently. Mr. has demonstrated a limited ability to independently ambulate and the Arbitrator agrees with Dr. that his ability to ambulate has not yet reached a plateau.

Discount Rate: Two economists, Mr. and Mr. , testified on this issue. Mr. uses a -.66% discount rate based on 30 years of historical data demonstrating a 6.75% rate of inflation for attendant care costs and a discount rate of 5.8%. Mr. uses a historical

relationship between interest rates (U.S. Government Bond Yields) and inflation (CPI), resulting in a 3% net discount rate. Mr. reached similar results when comparing interest rates with medical care inflation and when comparing interest rates with wage growth of home health aides (although the latter statistics were for only a 20-year period).

The Arbitrator recognizes the recent trend of increasing healthcare costs and extremely low interest rates. The Arbitrator further recognizes that no one can predict with confidence how this trend will play out over the course of Mr. life. However, interest rates will undoubtedly rise and there will be continued efforts to reign in the costs of healthcare services. Looking at the issue from a long-term historical perspective, the Arbitrator agrees with Mr. opinion that a 3% net discount rate is the appropriate rate to apply over the course of Mr. life.

Mr. reports offer a menu of options to arrive at a present value for Mr. future care needs. Most of the options involve various sources of third-party payments. The Arbitrator declines to apply a set-off for potential payments by third-party payers for two reasons: (1) it is unlikely that Mr. will qualify for such benefits once Respondents satisfy the final award in this matter; and (2) the future of the Affordable Care Act and its application to Mr. is too speculative to consider at this point in time. The other option is "Direct Hire" v. "Agency Hire" for attendant care. The Arbitrator believes Agency Hire is the appropriate option as it provides more flexibility to the family in deciding how best to care for Mr. .

For these reasons, the Arbitrator adopts Mr. present value number under "Private Pay, Agency Hire". Mr. initial calculations under this heading did not take into account the Arbitrator's findings regarding Claimant's life expectancy and the date of Claimant's discharge from

. Taking these findings into consideration, Mr. calculated the present value of Claimant's future care needs to be $3,524, 688. The Arbitrator hereby finds that the present value of Mr. future care needs, based on a life expectancy of 45 years and beginning on July 14, 2014, is $3,524,688.

In his Motion for Reconsideration, Claimant submitted the Declaration of Ms. which set forth a variety of life care costs that will be incurred by Claimant while he remains at . The Arbitrator declines to include these costs as part of Claimant's damages for several reasons: (1) they were not raised by Claimant until after the Interim Award was issued; (2) they are inconsistent with Mr. report that served as the basis for her hearing testimony; and (3) they were not mentioned in Ms. life care plan (which, as noted above, was identical in most respects to Ms. plan).

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IV. FINAL AWARD

Arbitrator hereby finds in favor of Claimant against Respondents and awards damages as follows:

Non-economic Damages	$ 250,000.00
Loss of Earning Capacity (Present Value)	$ 587,907.00
Future Life Care Costs (Present Value)	$3,524,688.00
	$ 569,932.00
Rent	$ 18,000.00
Total	$4,950,527.00

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: August 26, 2013

Cary Miller, Esq.
Arbitrator

Cary W. Miller, Esq.
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IN THE MATTER OF THE ARBITRATION BETWEEN

Claimant,

v.

Respondents.

ADRS CASE No. 13-3303-CWM

ARBITRATION AWARD

This matter was heard on March 16, 18, 19 and 20, 2015 in the San Diego office of ADR Services, Inc. Claimant was represented by Esq. and Esq. Respondents were represented by Esq. Cary W. Miller, Esq. served as the Arbitrator.

Both parties submitted prehearing briefs. After both sides gave opening statements, the following witnesses were called to testify under oath: ; ; M.D. (Claimant's Expert); CPA; ; M.D.; M.D. (Respondent's Expert). The parties also submitted a binder of joint exhibits. After the parties gave oral summations, the Arbitrator declared the Arbitration Hearing closed on March 20, 2015.

Claimant claims that she suffered significant and life altering injuries as the result of Respondents' negligent failure to timely diagnose and treat sepsis that developed following bowel surgery on November 28, 2011.

Having reviewed and considered all testimony and documentary evidence, the Arbitrator makes the following findings of fact and conclusions of law:

STANDARD OF CARE

Claimant failed to prove that Respondents violated the standard of care before approximately 3:22 p.m. on December 2. Until that time, Ms. did not have evidence of sepsis and her signs and symptoms were appropriately attributed to a post-operative ileus. She was noted to be doing well when assessed by Dr. and Dr. on December 1 at 5:39 p.m. and on December 2 at 8:43 a.m. The Arbitrator agrees with the testimony of Dr. that there was insufficient evidence of infection during either visit to require the ordering of tests (CBC with differential and/or acute abdominal series) or antibiotics.

Furthermore, neither expert testified that the nurses should have contacted Dr. or Dr. at any time before they returned to assess Ms. on December 2 at approximately 3:22 p.m.

Respondents violated the standard of care on December 2 at approximately 3:22 p.m. At this time, Ms. demonstrated a dramatic change in condition including lethargy and dusky digits. These were the first observed signs of sepsis and multi-organ breakdown. The Arbitrator agrees with the testimony of both experts that the standard of care required the institution of antibiotics at this time. It was appropriate for Dr. to institute IV fluids with bolus and order a chest x-ray and abdominal series to look for free air which would indicate an anastomotic breakdown or leakage. However, the Arbitrator agrees with Dr. that it was below the

standard of care to wait as long as three or four hours to review the test results and recheck Ms.

CAUSATION

Claimant failed to meet her burden of proof that Ms. 's damages were caused by the delay in diagnosing her condition on or soon after December 2 at 3:30 p.m. The Arbitrator agrees with Dr. 's testimony that the institution of antibiotics at that time would not have reversed Ms. 's sepsis or altered her outcome. The Arbitrator also agrees with the testimony of Dr. , a Gyn-Oncologist with far more experience and expertise than Dr. with regard to the handling of bowel perforations, that Ms. 's surgery would have been no different if it had occurred earlier. On the issue of causation, Claimant only presented evidence that early treatment of sepsis is generally preferred and the outcome is generally better. This is insufficient to prove that an earlier transfer to ICU, which occurred at 5:45 p.m., and earlier surgery would have altered Ms. 's damages or resulted in a different surgical procedure. Accordingly, the Arbitrator would be required to engage in speculation in order to determine the damage, if any, suffered by Ms. as a result of the delay in diagnosis.

DECISION

Respondents are the prevailing parties and Claimant is not entitled to an award of monetary damages.

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: 3/26/15

Cary W. Miller, Esq.
Arbitrator

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IN THE MATTER OF THE ARBITRATION BETWEEN

KAISER FOUNDATION HEALTH PLAN, INC.,

Claimant,

v.

, AN INDIVIDUAL; AND DOES 1 TO 10 INCLUSIVE,

Respondents.

ADRS CASE No. 16-0426-CWM

ARBITRATION AWARD

The undersigned Arbitrator, having been selected for the purpose of conducting a binding arbitration on all claims alleged by the parties and having examined the submissions and exhibits offered and received, now FINDS, CONCLUDES and AWARDS as follows:

THE PARTIES AND THE CLAIM

Claimant Kaiser Foundation Health Plan, Inc. ("Kaiser") is a medical benefits plan. Respondent was at all relevant times a Kaiser member. The claim at issue is a single claim for recovery of medical expenses paid by Kaiser in connection with an automobile accident on October 1, 2013. Respondent did not participate in the arbitration despite notice thereof.

STATEMENT OF FACTS

Based upon Kaiser's Arbitration Brief and supporting documents, the following is a summary statement of those facts found by the Arbitrator to be true. The standard of proof applied by the Arbitrator is that of a preponderance of the evidence, i.e. that which is more likely true than untrue. The facts presented by Kaiser are undisputed.

Respondent was an insured under a Kaiser Permanente Individual Member Plan ("Plan"). The Plan provided for payment of Respondent's medical expenses in the event of injury, subject to Respondent' right to recover sums received by Respondent from a third party. Respondent was involved in an automobile accident caused by another driver on October 1, 2013. Respondent received medical benefits paid for by the Plan after the accident. The reasonable value of these medical benefits was $23,651.20.

After the accident, Kaiser made repeated requests of Respondent as to whether she was pursuing a claim against a third party. Respondent did not respond to Kaiser's first four requests for information about her claim. On April 28, 2014, Respondent responded that she was not making a claim and had not hired an attorney. In this time frame, Respondent learned from the insurance adjuster for the third party that Respondent had in fact retained an attorney and received a settlement in the amount of $30,000.00 in January 2014. Kaiser sent Respondent a Notice of Lien on May 1, 2014. Kaiser initiated this action because Respondent has failed to provide reimbursement.

DISCUSSION

Under the Plan, Kaiser was obligated to pay any medical expenses Respondent incurred in the event of an injury caused by a third party. The Plan further provides that, if Respondent obtained a settlement from a third party who allegedly caused an injury for which she received Covered Services, Respondent must pay Kaiser its charges for those Services, except that the amount she must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Under the Plan, Respondent was obligated to send written notice to Kaiser's

representative within 30 days after submitting a claim against a third party. The language of the Plan satisfies the case law that in order to vitiate the "made-whole" rule of reimbursement, the contractual provision must clearly and specifically give the insurer priority out of any proceeds regardless of whether the insured is first made whole. See Progressive West Ins. v. Yolo County Superior Court (Preciado) (2005) 135 Cal. App. 4th 263.

The undisputed evidence is that Respondent's lawsuit was settled for $30,000. One third of that amount is $10,000, which is the maximum amount that Civil Code Section 3040 allows Kaiser to recover. Kaiser secured its rights by submitting a Notice of Lien on May 1, 2014. Any arguable delay in asserting the lien is the result of Respondent's failure to timely notify Kaiser of her claim and her false representations that she had not retained an attorney and received a settlement from a third party.

AWARD

1. Kaiser shall take $10,000 from Respondent.
2. The costs of this arbitration shall be borne by Kaiser.

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

Dated: 4/26/16

Cary W. Miller, Esq.
Arbitrator

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IN THE MATTER OF THE ARBITRATION BETWEEN

Claimant,

v.

Respondents.

ADRS CASE No. 15-9013-CWM

RULING GRANTING RESPONDENTS' MOTION FOR SUMMARY JUDGMENT

Respondents submitted their Motion for Summary Judgment on June 9, 2016. Respondents argued that the undisputed facts warrant Summary Judgment on Claimant's only cause of action for medical negligence because (1) there is no admissible expert opinion testimony critical of the Respondents' care and treatment of Claimant, and (2) no act or omission by Respondents caused or contributed to Claimant's damages.

In support of their motion, Respondents' submitted the Declaration of M.D. Dr. is a Board Certified Orthopedic Surgeon who specializes in hand surgery. Dr. reviewed the medical records and imaging studies pertaining to the care and treatment of Claimant's left hand and wrist injury by and M.D. Upon doing so, Dr. set forth his professional opinions that (1) Respondents' treatment and care

of Claimant was appropriate and within the standard of care; and (2) no act or omission by Respondents caused or contributed to any of the damages that Claimant alleges to have sustained.

Claimant failed to submit any opposition to the Motion for Summary Judgment. More specifically, Claimant failed to present an expert declaration that contradicts the opinions of Dr.

In California, the standard of care for physicians in a medical negligence case may be established only by qualified expert testimony. Unless the matter at issue is a matter of common knowledge, expert testimony is conclusive and cannot be disregarded. California courts have incorporated the expert medical requirement into their standard for summary judgment in medical malpractice cases. When a defendant moves for summary judgment and supports his motion with expert declarations that his conduct fell within the community's standard of care, he is entitled to summary judgment unless the plaintiff comes forward with conflicting evidence. Munro v. Regents of the University of California (1989) 215 Cal. App. 3s 977, 984; Willard v. Hagemeister (1981) 121 Cal. App.3d 406, 412.

Claimant must also prove that Respondents' negligence was a cause-in-fact of injury. This must be proven within a reasonable medical probability upon competent expert testimony. Based on the undisputed medical opinions of Dr. the Arbitrator hereby grants summary judgment in favor of Respondents on both asserted grounds. Claimant's claim is dismissed.

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.

DATE: 9/20/14

Cary W. Miller, Esq.
Arbitrator