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IN THE MATTER OF THE ARBITRATION OF

Arbitration No. 11386

ARBITRATION AWARD

Dates of Hearing – January 14 – 22, 2013

Claimants,

vs.

Respondents.

_____/

The matter came before the Arbitrator, Judge Bonnie Sabraw (Ret.) for Arbitration Hearing on January 14 – 22, 2013 at the San Francisco offices of ADR Services, Inc. Present at the hearing for Claimants was , Esq. and , Esq. of the of Present for Respondents was , Esq. of the law offices of At the conclusion of the hearing on January 22, 2013, the Arbitrator ordered counsel to submit post-hearing briefs. Upon receipt of the Reply briefs on February 26, 2013, the matter was taken under submission. Thereafter, it was agreed that the case should be reclassified as complex under Rule 24.b of the OIA Arbitration Rules, extending the time for the submission of this Arbitration Award to April 9, 2013.

FACTUAL BACKGROUND

Mr. had been a patient of for several years prior to presenting himself at the Emergency Department in , California, on January 25, 2011. At that time his symptoms were described in the hospital record as "sore throat, chest pain and diarrhea." According to the medical record notes Mr. described his symptoms as being awakened around 1:00 a.m. with some pain in this throat and pain in his left chest. He indicated he had had diarrhea for the past three days and took an Imodium without water right before bed and is not sure if the pill is stuck in his throat or caused a scrape. He indicated that the pain in his throat radiated from his throat to his chest, but couldn't be sure. He did indicate that he hit his head lightly on the door when going to the bathroom, but did not pass out.

wife, testified that prior to coming to the hospital Mr. had got out of bed and then she heard a thud. She believed that had passed out and she yelled for her daughter, crawled out of the bathroom and was in excruciating chest pain and had pain in his throat. He was very pale and he was ashen. An ambulance was called and he was transported to the hospital.

Upon arrival at the Emergency Department, Dr. ordered a chest X-ray, EKG, and blood tests to evaluate Mr. for a possible heart attack. This was ruled out as these tests came back within normal range. The chest pain subsided and the throat pain was minimal so he was discharged from the hospital and instructed to follow up with a physician in a few days. Dr. emphasized the need for the follow up evaluation and noted that due to his history of high blood pressure he was at risk for aortic dissection.

The next day, January 26, 2011, Mr. woke up from a nap with a burning sensation and spasms in his throat, chest, and abdomen. He was nauseous. He returned to and saw his primary care physician, Dr. and told her that he

could not eat, and that he felt "fluish." Dr. diagnosed Mr. with gastro esophageal reflux disease, which he had not suffered from in the past, and prescribed Famotidine. Mr. advised Dr. that he had been in the emergency room the day before with chest pain and she scheduled him for a treadmill stress test. His blood pressure on that visit was 133/84.

Two days later, on the morning of January 28, 2011, Mr. was at home when he broke into a sweat, felt light headed and dizzy, and felt like he was losing the ability to stand up and move. His family drove him to the hospital emergency room where he was seen by emergency room physician, Dr. . He denied chest pain at that time. His blood pressure was very low, 61/36. A bedside EKG was performed as ordered by Dr. , which revealed that Mr. was in atrial fibrillation. Mr. was given Cardizem in hopes of slowing down his heartbeat and bringing up his blood pressure. This was not effective and Dr. performed a synchronized cardioversion, using pads to shock his heart to get his heart into a regular rhythm again. His blood pressure did come up for a period of time, but then went back down. Dr. obtained another EKG, and, based on the results, felt he might be suffering from a heart attack. A heart alert was called. Mr. was immediately sent for a cardiac catheterization with cardiologist Dr.

Each of the EKG printouts for the EKGs ordered at on January 28, 2011 had a notation of "Widespread ST elevations, consider Pericarditis," an inflammation of the pericardium, which is the fibrous sac surrounding the heart.

The catheterization ordered by Dr. showed that Mr. was not suffering from a heart attack, but his notes reflect "can also consider pericarditis." As the focus was on the possible heart attack there was no follow up with respect to consideration of pericarditis at that time. During Dr. catheterization he did find a small blockage in the left main coronary

artery, which concerned him, and he ordered that Mr. be transferred to for a second cardiac catheterization with ultrasound technology. Dr. at performed this catheterization also on January 28, 2011. This catheterization revealed that Mr. was suffering from mild coronary artery disease, but the blockage was too small to be significant and was not found to be the cause of his symptoms. Mr. was monitored overnight at the hospital, given fluids and discharged from the hospital on January 29, 2011 with instructions to follow up with a cardiologist. No further testing was done at that time and no further consideration was given to following up on Dr. note or the EKG printout notes to consider pericarditis.

On February 1, 2011, Mr. was seen at the clinic by cardiologist Dr. for a follow up visit. Dr. testified that he had reviewed Mr. medical history, but it does not appear from his notes that he was aware of the emergency room visit on January 25, 2011 when he presented with chest pain and throat pain radiating into his left chest. There is also no mention of his office visit with Dr. on January 26. Dr. treated Mr. for atrial fibrillation, prescribing the blood thinner Warfarin. His blood pressure on this visit was 114/68. He was in normal sinus rhythm, and his vital signs were stable. No other tests were ordered at that time.

On February 2, 2011 Mrs. spoke to Dr. advice nurse by phone, reporting that Mr. had developed a cough and sore throat. After consulting with Dr. , the advice nurse indicated to Mrs. that the symptoms were related to his acid reflux. The next day, February 3, 2011, Mr. developed other respiratory symptoms, including wheezing, congestion, and phlegm. He returned to that day and was examined by Dr. who noted in the records that his blood pressure was 88/58. Dr. attributed his symptoms to asthma, although he had no history of this condition.

Mrs. called the advice nurse again on February 4, 2011, expressing continuing concern about Mr. low blood pressure, which in her view had been uncharacteristically low since his first emergency room visit on January 25, 2011. The nurse consulted with Dr. who advised Mr. to hold off on the lisinopril medication for the next few days, and advised that he continue taking his metoprolol unless his systolic blood pressure dropped under 90.

On February 6, 2011, Mr. spoke with a Dr. at 3:30 p.m. because his wife was concerned with his blood pressures in the 70's that morning. Later that same day, at 5:05 p.m., Mr. presented at the emergency room because while at home he had another dizzy episode and indicated to his wife, "I need to go to the hospital now." Upon arriving at the hospital his chief complaints were "dizziness and mild CP [chest pain]." Although his atrial fibrillation was at a normal sinus rhythm, he was admitted to the hospital for observation and seen by several hospital based specialists. Mr. continued to have low blood pressure and another chest X-ray and EKG were ordered, neither of which provided any new information.

By this point, with the third trip to the emergency department in three weeks, feeling that Mr. was not getting better, and believing the cause of his medical problems was not being addressed, the family spoke to a nurse, wanting to have answers to their questions and concerns. The nurse told them that cardiologist would be out to see them shortly. Unfortunately, rather than having their questions heard, let alone answered, Dr. put her hand up and said, "I'm the doctor. I'll do the talking." Dr. then explained that Mr. diagnosis was the same, atrial fibrillation and mild coronary artery disease. Dr. said that Mr. medications were causing the lower blood pressure, and that his blood pressure was not that low depending on what time of day it was taken. The medical records indicate, however, that Mr. had stopped taking the blood pressure medications metoprolol and lisinopril in

the days leading up to this hospital admission due to his blood pressure already being low. Mr. remained in the hospital until February 9, 2011 and was administered medication for atrial fibrillation and coronary artery disease. No other diagnosis was explored and no tests for other conditions were conducted.

On February 11, 2011, Mrs. called Dr. advice nurse again expressing concern about Mr. low blood pressure. Dr. told her that if the systolic blood pressure was less than 88 to give half the dose of Sotolol.

Also on February 11, 2011 Mr. spoke to , the pharmacist running the anticoagulation clinic, regarding Warfarin. At that time Mr. denied symptoms of bleeding or bruising and she gave him a follow-up date of February 15, 2011.

On February 14, 2011 Mr. saw Dr. for a follow-up visit due to his continuing low blood pressure, which was 88/59, and then on recheck was 98/60. Dr. discussed this with Dr. , who felt that the Sotolol was probably lowering the blood pressure and that he would get used to it. At this visit Mrs. was very emotional, began to cry, and said that she did not feel that her husband's diagnosis was correct. She felt his blood pressure was uncharacteristically low. Dr. indicated that she felt he would be fine, and when said, "We need to do more tests," Dr. indicated that Mr. was fine and did not need additional tests.

Ten days later, on February 24, 2011, Mr. had a follow-up appointment with Dr. . Both Mr. and Mrs. expressed concern over Mr. low blood pressures. His blood pressure on that date was 106/63. His pulse was 68. Mrs. questioned Dr. again about the fact that they had never received a satisfactory diagnosis as to why Mr. was having fainting episodes, dizziness, weakness and low blood pressure for almost a

month. Dr. reassured Mrs. that she need not be concerned. He instructed Mr. to reduce his medications to three times a week and cleared him to return to work.

Two days later, on February 26, 2011, Mr. came to the emergency room at 2:26 p.m. having suffered an acute onset of chest pain. His blood pressure was 61/35. An echocardiogram was performed which showed large pericardial effusion. A CT scan was ordered to rule out aortic dissection. Mr. became unresponsive and in an effort to save him Dr. and Dr. opened his chest wall to start the heart manually. An epinephrine shot was administered to Mr. heart. Mr. was pronounced dead at 5:27 p.m.

ANALYSIS

Under California law, the essential factual elements for a case of medical negligence require that the Claimants show that (1) that was negligent; (2) that the were harmed; and (3) that medical negligence was a substantial factor in causing the harm. (CACI 400.) A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm. It must be more than a remote or trivial factor. It does not have to be the only cause of the harm. CACI 430.

A physician is not necessarily negligent just because he or she chooses one medically accepted method of treatment or diagnosis and it turns out that another medically accepted method would have been a better choice. [Alternative Methods of Care] CACI 506.

Also, a physician is not necessarily negligent just because his or her efforts are unsuccessful or he or she makes an error that was reasonable under the circumstances. He or she is negligent only if he or she was not as skillful, knowledgeable or careful as other reasonable physicians would have been in similar circumstances. [Success Not Required] CACI 505.

STANDARD OF CARE

Claimants have the burden of proof to establish that it is more likely to be true than not true that conduct in treating from January 25, 2011 to February 26, 2011 fell below the standard of care. This must be established by the testimony of an expert witness.

In Claimants' Closing Reply Brief they describe the breach of the standard of care as "creating a system where its doctors are overworked and have little time to spend with each patient." (Reply Brief 2:6-8.) None of the doctors, nor any expert, testified that the doctors were overworked and did not have sufficient time to spend with Mr. or any other patient. While the were justifiably upset that Dr. did not spend the few minutes it would have taken to explain to them his role in Mr. treatment, or that Dr. was abrupt and insensitive to their obvious anxiousness and concern about Mr. treatment, this conduct does not establish that these or any of the other doctors treating Mr. were overworked or felt they didn't have sufficient time to spend with him. If that argument is the basis for a finding of liability, Claimants have failed to present sufficient evidence to support such a finding.

Claimants also present the argument that if one simple test, an echocardiogram, had been performed prior to Mr. death on February 26, 2011, the doctors treating him would have likely discovered fluid in the pericardium, which would have lead to a CT scan to further investigate, which would have lead to the diagnosis of a rare form of aortic dissection – intramural hematoma (IMH). (Claimants' Closing Brief, 2:6-10.) Claimants do not suggest that the doctors should have been looking for this rare condition, or even suspected it, but argue that if the echocardiogram had been done it would have lead the doctors to discover the IMH in time to repair the problem and he would not have died on February 26, 2011.

Claimants' argue that the IMH manifested itself through several concerning signs and symptoms in the month leading up to Mr. death and that doctors didn't know what was causing these symptoms and took no steps to find out.

Putting it another way, Claimants argue that during the four weeks of care the doctors had *a* picture of Mr. condition; i.e., atrial fibrillation and medication adjustments, and that this diagnosis was adopted by each doctor seeing him thereafter without any of them "thinking outside the box" to determine whether there was another explanation for his continuing distress and symptoms.

The Arbitrator has reviewed in great detail the testimony of the experts called by each side as well as the medical records and other medical evidence presented. While fault is not found with the care of any individual doctor, it is correct that each of the doctors treating Mr. after his original diagnosis of hypotension and atrial fibrillation treated him only for these conditions. No one went beyond this diagnosis even though the medication adjustments were not correcting the continuing problems and his condition was not stabilizing. He had several returns to the emergency room, the clinic, and telephone calls to the advice nurse. Considering all of the evidence presented, the Arbitrator finds that Claimants have met their burden of proof establishing that fell below the standard of care by failing to further investigate the cause of these concerning symptoms, including performing an echocardiogram in January or February of 2011.

CAUSATION

In addition to establishing that care and treatment fell below the standard of care, Claimants must also establish that it is more likely to be true than not that this breach of the standard of care was a substantial factor in causing Mr. death on February 26, 2011. In other words, Claimants must prove *to a reasonable degree of medical certainty* through the

testimony of expert witnesses that Mr. was suffering from an intramural hematoma (IMH), a rare condition, when he presented at the emergency room on January 25 or 28, 2011. If he was not, then although there has been a finding that the standard of care was breached by a failure to investigate his symptoms further between January 28 and his death on February 26, 2011, such tests would not have found an IMH to be present. These tests may have ruled out an IMH or found other conditions present that could have been treated, but Claimants' entire argument is premised on the presence of an IMH that slowly caused his death a month later. No one disputes that when Mr. came to the emergency room on February 26, 2011 he was suffering from a Type A aortic dissection. The issue is whether that was a result of an IMH having been present for the four weeks preceding that event.

Claimants' cardiology expert, Dr. , testified that it was his opinion it was a "likely possibility" and a "probable conclusion" that Mr. suffered a sub acute dissection starting on January 25, 2011. He believes that the dissection was not occurring all in one step, but rather over a period of "a few days at least," with a "little bit of stuttering." Blood accumulated over time in his pericardium and stretched it until there was no room left for his heart. Dr. did acknowledge that on January 25, 2011 Mr. vital signs were normal and there was no atrial fibrillation. He also acknowledged that the chart notes on February 1, 2011, 25 days before his death, are "P[patient] felling well, no chest pain, no shortness of breath, paroxysmal and nocturnal dyspnea, edema, palpation or dizziness." Dr. also agreed that Mr. symptoms of weakness, shortness of breath, feeling poorly, and low blood pressure could have been caused by atrial fibrillation.

Claimants' emergency room expert, Dr. , testified that he believes that somewhere between January 25 and January 28, 2011, blood leaked into the pericardial sac and on February 26, 2011, the date of his death the "flood gates opened up even further than they had up until that

point" and the dissection leaked more, bled more into his pericardium. He believes that this occurrence had been on a "stuttering course" over the preceding four weeks when he was on anticoagulants and a number of other antiplatelet medications, all of which would have favored ongoing bleeding, ongoing leaking, and ultimately a catastrophic tear or rupture into the pericardium.

Dr. , Respondent's emergency room expert, testified that in his opinion there was no aortic dissection on January 25 or 28, 2011 and that Mr. low blood pressure was not caused by an aortic dissection. He does not believe this was a "chronic dissection" because chronic fluid in the pericardium is caused by disease processes, not an aortic dissection putting blood into the pericardium. He believes that blood going into the pericardium is a terminal event, and that blood could not possibly be going into the pericardium from the aorta for 30 days during the time Mr. was anticoagulated.

Dr. , Respondent's cardiologist expert, testified that in his opinion 98% of patients with an aortic dissection have either chest pain or back pain. While Mr. did complain of chest pain at the emergency room visit on January 25, 2011, he was discharged later that day with a notation that his chest pain had subsided. On several of his other visits he did not complain of chest pain.

Dr. , Respondent's cardiac surgeon expert, testified that in his opinion it is more likely than not that this aortic dissection occurred within 72 hours of Mr. death on February 26, and that no testing such as an echocardiogram or CT scan prior to this occurrence would have shown any type of aortic dissection that could have been repaired. He agrees that it is "possible" that Mr. had an IMH where a small hole occurs and blood gets between the layers and the force of subsequent heart beats isn't enough to drive blood between layers and separate them, ending up with a glob of blood between the two layers of the aorta that doesn't go

anywhere, and particularly does not go into the pericardium. When that happens blood gets out and forms a hematoma. If this had occurred during the January 25 – 28 time frame, the echocardiogram would not have shown fluid in the pericardium, and a CT scan would most likely not have been ordered.

Dr. also testified that if Mr. had lost enough blood by it going into a hematoma to have an effect on his blood pressure, he would have exhibited a low hematocrit. In his experience he has never seen an aortic dissection in a patient with blood leaking into the pericardium with a hematocrit of 40, which is a normal hematocrit. Patients with aortic dissections have hematocrits in the low 30s or high 20s. When Mr. came to the hospital with his terminal event on February 26 his hematocrit was 33. There were only two other times during the months of January and February that his hematocrit was near the high 30s, and that was after he was transfused with saline, which would have lowered his hematocrit. His hematocrit was tested on several occasions between January 28 and February 26, 2011, and at no other time did he have sufficient blood loss to lower his hematocrit. He believes that the theory that his hypotension was related to blood loss is not supported as a result of his higher hematocrit levels. It is Dr. opinion that it was much more likely that he was a hypertensive man taking antihypertensive medications and went into atrial fibrillation, resulting in the common result that his blood pressure, especially initially, went down.

As stated above, Claimants argue the IMH occurred on or before January 28, 2011 and would have been detected by an echocardiogram showing fluid in the pericardium, leading them to do a CT scan and the finding of the IMH. Dr. testified that blood would not leak into the pericardium "a little," clot, and stop, especially if the patient was on anticoagulants as Mr. was. He does not believe it would clot because there is enough pressure so that the

entire ascending aorta is full of blood and that would be a pre-lethal situation, causing a rupture within 24 to 48 hours, not three to four weeks.

The Arbitrator finds, after careful consideration of the testimony of the several well-qualified experts, albeit with differing opinions, that Dr. testimony is the most persuasive. The Arbitrator finds that Claimants have failed to establish to a degree of reasonable medical certainty that Mr. was suffering from an IMH beginning on January 25 or 28, 2011. As a result, the failure to conduct an echocardiogram, which may have lead to additional testing, at that time, or in the three to four weeks prior to his death was not a substantial factor in causing his death.

CONCLUSION

The Arbitrator is mindful that Claimants have suffered a devastating loss by the death of their husband and father. As was discussed at the conclusion of the arbitration hearing, this case is not about where the sympathies lie -- of course they are with the family. Rather the Arbitrator must view this case through the lens of the facts presented and what is required under the law in a medical malpractice case. As noted above, the Arbitrator finds that although breached the standard of care by not conducting further tests on Mr. , Claimants have not met the burden of proof required for proving causation. As a result the Arbitrator finds in favor of Respondent and against the Claimants.

Dated: March 28, 2013

Judge Bonnie Sabraw (Ret.), Arbitrator

Hon. Bonnie Sabraw (Ret.)
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IN THE MATTER OF THE ARBITRATION OF

Claimant,

vs

Respondents.
_____/

Arbitration No. 11207
ADR Services Case No.
ARBITRATION AWARD

Date of Hearing –3/26/13

Judge Bonnie Sabraw (Ret.)
Arbitrator

The matter came before the Arbitrator, Judge Bonnie Sabraw (Ret.), for Arbitration Hearing on March 26, 2013 at the offices of DeMichelle Deposition Reporters, 700 Webster Street, Fairfield, California. Present at the hearing for Claimant was Esq.. Present for Respondents was Esq. of the law offices of

The matter was submitted for decision at the conclusion of the hearing.

FACTUAL BACKGROUND

Claimant presented at Hospital for a surgical procedure on September 14, 2010. M.D., a urologist, who had been treating Mr.

for approximately 20 years for various reasons, performed this procedure. Unfortunately, during the procedure a fiberoptic lamp was left resting on Mr. right supra-pubic area while he was under general anesthesia, which resulted in a second-degree burn in that location.

This burn was cleaned and dressed in the operating room. Dr. went out to the waiting area immediately following the procedure and spoke with Mr. daughters about what happened. The doctor drew pictures to help the daughters understand the procedure and the location of the burn. (See Exhibits 1-A through 1-C). A follow-up visit was scheduled for Mr. to see Dr. following the procedure. Dr. testified that Mr. did not keep that appointment.

For a week or so post surgery, Mr. was under the care of his daughter in , , and was complaining about the pain from the surgery as well as the burn. His brother visited him while he was at his daughter's house and encouraged him to contact his doctor because of his discomfort, but he did not so, deciding to treat the burn himself.

There was a conflict in the testimony as to whether or not Mr. returned to to have his catheter removed. The medical record indicates that he returned to on September 20, 2010 for the removal and did not raise any questions about the burn. Mr. recalls that he removed the catheter himself, as he had done with a prior surgery performed by Dr. . The record also indicates that Mr. was also told to return to the urology department that afternoon for a follow up visit, but that his daughter had called to indicate that he was not coming in because he was urinating without difficulty. Again, the record does not reflect any mention of the burn.

Thereafter Mr. went to stay with his brother in for a couple of weeks before returning to to care for his aged father. While staying with his brother he did go to

the facility and saw a Dr. in the emergency department regarding the burn. The doctor dressed the burn and prescribed an ointment to be applied to the area. When Mr. arrived in he also went to see a Dr. to discuss the condition of the burn, which now had discoloration, blood and pus oozing from it. Dr. prescribed a salve to be applied to the area. The cost of these visits to Dr. was $110, which Mr. paid. Thereafter, in the latter part of November or early December 2010 Mr. went to the VA Hospital and the doctor there told him to take the bandage off and quit using the salve he was using. Some time later Mr. began applying Gold Bond powder to the area, which he believed was helping it to heal.

It is not disputed that before leaving to go back to neither Dr. nor Mr. attempted to contact the other to discuss Mr. post surgery condition or the condition of the burn.

Mr. testified that he damaged some clothing that had a value of $200.00 as a result of the seepage from the burn while it was healing.

ANALYSIS

Claimant's Cause of Action for Professional Negligence Based on Abandonment

Claimant argues that he has met the burden of proof with respect to his abandonment cause of action and that no expert witness testimony was required.

Respondent filed a Motion in Limine, raising the issue that Claimant was required to present expert testimony to support this cause of action, and since no expert witness was expected to testify, the cause of action should be dismissed. The Arbitrator denied the Motion in Limine, allowing Claimant to present evidence on the claim,. At the conclusion of Claimant's

case, the Respondent renewed the motion. The Arbitrator reserved ruling on the motion and now addresses the issue as part of the Arbitration Award.

Jury instruction CACI 509 (Abandonment of Patient) sets out Claimant's burden in connection with this cause of action. It provides:

"[Mr.] claims [ ] was *negligent* because it did not give Mr. enough notice before withdrawing from the case. To succeed Mr. must prove both of the following:

1. That withdrew from Mr. care and treatment; and
2. That did not provide sufficient notice for Mr. to obtain another medical practitioner.

However, was not negligent if it proves that Mr. consented to the withdrawal or declined further medical care." (Emphasis added.)

To determine whether or not Claimant has met the burden of proof required to establish that , through its agent, Dr. , a urologist, was "negligent," the Arbitrator looks to CACI No. 502 (Standard of Care for Medical Specialists). This instruction provides:

"A urologist is negligent if he fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful urologists would use in similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care." The instruction also includes a paragraph which states: "You must determine the level of skill, knowledge, and care that other reasonably careful urologists would use in similar circumstances based only on the testimony of the expert witnesses who have testified in this case." This paragraph of the instruction is to be used except in cases where the court determines that expert testimony is not necessary to establish the standard of care.

Claimant argues that this is a case where expert testimony is not required to show that agent's treatment fell below the standard of care because the conduct required of Dr. is within the common knowledge of the layman. The Arbitrator disagrees.

Case law gives guidance on when the testimony of an expert witness is required in a professional negligence case to establish the standard of care, whether that standard was breached by the defendant, and whether any negligence by the defendant caused the Plaintiff's damages. As a general rule such expert testimony is required. *Flowers v. Torrance Memorial Hosp. Med. Ctr.* (1994) 8 Cal.4th 992, 1001. A narrow exception to this rule exists where "the conduct required by the particular circumstances is within the common knowledge of the layman. This exception is, however, a limited one. It arises when a foreign object such as a sponge or surgical instrument, is left in a patient following surgery and applies only when the plaintiff can invoke the doctrine of res ipsa loquitur. The common knowledge exception is generally limited to situations in which a layperson can say as a matter of common knowledge that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised. *Scott v. Rayhrer* (2010) 185 Cal. App.4th 1535, 1542.

In this case, the Arbitrator does not find that it is within the common knowledge of a layperson to determine what the standard of care requires of a urologist post surgery when there has been an unexpected occurrence such as the burn in this case. Was it sufficient for the doctor to provide a detailed explanation, including drawings, to the family waiting at the hospital? Was it sufficient for the doctor to also explain what happened to the patient immediately post surgery while the patient may still have been under the effects of the general anesthesia? Does the doctor breach the standard of care if he fails to contact a patient after leaving the hospital when there was a burn incident as occurred here? Is it sufficient for the doctor, or his or her staff, to schedule a post surgery follow up appointment with the doctor? If the patient does not appear for the scheduled follow up appointment, is it a breach of the standard of care if the doctor does not follow up telephonically with the patient? If the burn injury is outside the area of expertise of the doctor performing the surgery, is it a breach of the standard of care if the patient is not

referred to another specialist, such as a dermatologist? All of these questions require expert testimony.

As to the cause of action for abandonment, the Arbitrator finds that the Claimant has not met his burden of proof, and finds for the Respondent.

Claimant's Claim Based on Professional Negligence Resulting in the Burn Mr. Suffered During the Surgery

Respondent admits liability on this claim. As a result, Claimant is not required to prove that the Respondent's care and treatment of the patient fell below the standard of care, and that this breach caused injury to the Claimant. The only question remaining for determination by the Arbitrator on this claim is the issue of damages.

In determining the amount of damages to be awarded, the Arbitrator has considered the testimony related to the pain and suffering caused by the burn during the healing process, the existing scar in the abdomen area, the loss of clothing, the expense to see the doctor in Texas, and the cost for continuing topical medication for depigmentation and itching in the area of the scar.

The Arbitrator awards Claimant the sum of $510 as special damages -- $110 for the treatment by the doctor in $200 for future treatment by way of creams, and $200 for damaged clothing.

The Arbitrator awards Mr. the sum of $10,000 for pain and suffering experienced as a result of the burn, which took approximately five months to heal, as well as for the cosmetic appearance of the affected area on his abdomen.

Claimant total award against Respondents et al. is $10,510.00.

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: April 6, 2013.

Judge Bonnie Sabraw (Ret.), Arbitrator

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ARBITRATION IN THE MATTER OF

Claimant,

v.

Respondents.
_____/

ADR Services Case No. 12-3717-BLS

Hearing Dates: April 15 – 19, 2013
Judge Bonnie Sabraw (Ret.), Arbitrator

OIA No. 11497

The matter came on for Arbitration Hearing before the Arbitrator, Judge Bonnie Sabraw (Ret.), on April 15 through April 19, 2013 at the San Francisco offices of ADR Services, Inc., 100 First Street, 27th Floor, San Francisco, CA 94105. Claimant was represented by , Esq. of the . Respondents were represented by , Esq. of the . The parties submitted post-arbitration briefing and the matter was taken under submission on May 1, 2013.

Witnesses who testified at the hearing were , M.D. (treating physician); , M.D. (Claimant's expert); (Claimant's mother); , M.D. (treating physician); , M.D. (Respondents' expert); , M.D. (treating physician); (Claimant); and , M.D. (Respondents' expert).

The Arbitrator has reviewed the medical records, all of which were received into evidence, along with other items of evidence used to assist in understanding the evidence presented.

FACTUAL BACKGROUND

Claimant, , who was 34 years of age at the time of the surgery at issue, had been experiencing left upper quadrant pain for some time. Her treating physician considered gall bladder disease, and an ultrasound showed gallstones. Ms. was referred to general surgeon, , M.D., for possible removal of her gall bladder. Ms. met with Dr. and they discussed a laparoscopic removal of her gall bladder. It is undisputed that Dr. discussed the risks and benefits of this surgery with Ms. ; i.e., usually a shorter hospital stay, often going home that same day; significantly less scarring; and shorter recovery time. Ms. signed the informed consent form, which indicated that the risks of this surgery included "bleeding, infection, duct injury, retained stone, bile leak, need for open surgery, and stress of surgery." Despite being made aware of these risks, Ms. testified that when she left her meeting with Dr. she had the impression that the laparoscopic cholecystectomy was a somewhat routine and common procedure, albeit with the same risks as are true with any surgery. The procedure went forward on April 5, 2011.

Dr. had performed hundreds of such surgeries prior to this time without complication to the common bile duct. While Dr. , claimant's expert, testified that Dr. did not completely dissect the area known as Calot's Triangle before clipping and cutting the cystic duct, Dr. testified that he believed the extent of his dissection was sufficient for him to dissect out all the structures. Respondent now concedes, however, that at some point during surgery Dr. placed a surgical clip across, or in some way impacted, the common bile duct. (Resp. Closing Brief 6:11-12.) Respondent maintains that this judgment

call on the part of Dr. was not negligence, and that he did not intend this result. Dr. testified that during surgery he encountered bleeding when he severed the cystic artery at the posterior branch of the artery. After watching the vessel bleed for a short time, he grasped the area of the bleeding with a grasper, and placed a clip behind the grasper to control the bleeding, and the bleeding stopped.

After the surgery, it was decided that Ms. would stay in the hospital overnight. She was discharged on April 6, 2011 and went home with a discharge note that at that time her abdominal pain was a 3 to 4 on a scale of 10.

Once home, Ms. pain intensified and the pain medication she had been prescribed (Percocet), although helpful, was not sufficiently controlling what was becoming significant pain. On April 14, 2011, Ms. emailed Dr. informing him about the pain. Dr. responded, advising Ms. that it was unusual for her to "have this much pain after surgery," and arranged a CT scan to rule out any surgical complications. Prior to the time the CT scan was scheduled, Ms. had severe nausea and vomiting, in addition to severe pain, and presented at the Emergency Department at . She was admitted to the hospital at that time. After X-rays and CT scan were performed, it was decided by Dr. that a surgical ERCP procedure was necessary to rule out a retained stone or stricture. Dr. impression was "Proximal common bile obstruction likely related to surgical clips." A high-grade stenosis and possible complete obstruction of the common hepatic duct just above the level of the remnant of the cystic duct was noted. Dr. was, however, able to snake a catheter through the site of the obstruction, indicating that the clip had not completely blocked the hepatic duct. It was also noted that the right and left hepatic ducts were demonstrably dilated above the obstruction.

As a result of finding the blockage, and the lack of improvement in her symptoms and liver function, Dr. performed another ERCP under anesthesia for the placement of a biliary stent on April 21, 2011. This stent provided a temporary opening of the duct to allow passage of bile from the liver to the bowel, with the understanding that a more permanent solution would be required.

Ms. remained in the hospital for several more days and plans were made to have her see Dr. at regarding the long-term repair of the occlusion.

After considering the options presented to her by Dr. , and weighing the risks and benefits as to each, Ms. elected to have a hepaticojejunostomy procedure, a surgical bypass whereby the common bile duct is anastomosed to the duodenum. This procedure was performed on May 23, 2011. As a result of this surgery, Ms. now has a large surgical scar that is below her rib cage and across her abdominal area. Ms. required an eight-day hospital stay post surgery and testified that she experienced extreme pain during this time. While hospitalized, she used an epidural anesthetic for pain and was discharged with narcotics to be taken every four hours as needed for pain control. After several weeks, this pain and discomfort eventually subsided, but at her postoperative visit with Dr. in June 2011 she was still experiencing some pain. She did appear to be healing well, and her liver function tests in November 2011 were normal.

Ms. has experienced right upper quadrant abdominal pain, nausea and diarrhea on occasion since the surgery, but insufficient evidence was presented to connect these symptoms to the claims of medical negligence in this case.

LIABILITY

At issue here is whether Dr. placement of a hemo clip during the laparoscopic cholecystectomy was below the standard of care required of a physician in the field of general surgery, and, if so, did this breach of the standard of care cause injury to Ms.

The basic standard of care in performing a laparoscopic cholecystectomy requires:

- Correct identification of the anatomy;
- The surgeon must positively identify all structures before placing a clip on the tissue;
- A clip is never to be placed on the common hepatic duct;
- When using clips a surgeon must see the end of the clip when placing it on a structure;
- The end of the clip must not contain tissue; the surgeon must see the end of it and determine it is closed;
- Because of the proximity of critical structures, the surgeon must inspect the clip and determine it is only on the structure intended; and
- The surgeon encountering a bleeding vessel must grasp the vessel, free up the tissue until the vessel end is mobilized, and only then place a clip across the end of the vessel.

To determine whether the standard of care was breached in this case, the Arbitrator must base that determination on the testimony of expert witnesses. All of the expert witnesses testifying in this case are well-qualified, knowledgeable experts with respect to the medical procedure at issue.

Respondent presented , M.D. as an expert in the field of gastroenterology and argues that his testimony is persuasive evidence that the alleged "injury" which occurred to Ms. bile duct was caused not by a surgical clip, but by claimant's very active inflammatory reaction to the dissection and suturing of the blood vessels in and around the common hepatic duct during the cholecystectomy or to a "foreign body." The Arbitrator finds that the weight of

the evidence does not support this theory and will be addressing the liability issue as it relates to the placement of the hemo clip as testified to by the treating physicians and the testimony of experts , M.D and , M.D.

Claimant's expert, Dr. , testified that in his opinion there are two explanations for the injury to Ms. , both of which were below the standard of care. Dr. testified that in his opinion the first scenario was that Dr. failed to do a complete dissection and exposure of both the cystic duct and cystic artery prior to clipping and cutting the cystic duct; that he lateralized the common hepatic duct ("CHD") and mistook the CHD for the cystic duct. Dr. testified that a complete dissection and exposure of the structures within the critical view of safety would have prevented this error, and that a complete dissection would make mistakenly clipping the CHD entirely preventable.

Dr. second scenario is based on Dr. testimony that he encountered a posterior cystic artery bleed after dissecting and cutting the cystic artery. Dr. opinion is that in the course of clipping the vessel, Dr. negligently clipped the CHD, breaching the standard of care which requires the surgeon to carefully free up the end of the vessel from the tissue immediately surrounding it, and place a clip only on the end of the vessel.

Dr. criticizes Dr. clipping of the vessel to stop the bleeding because, in his opinion, Dr. did not adequately tease out the end of the vessel before applying the clip. Instead he grasped tissue, including the vessel, and put a clip on it. Dr. , Respondent's expert, contends that if this scenario is correct, the inclusion of the CHD within the vessel clip was inadvertent and was not below the standard of care, but rather was a risk and complication recognized for this particular surgery.

While Dr. testified that he agrees that non-negligent injury to the ducts may occur, he maintains that when there is a normal anatomy as was present with Ms. , and no

distortion of the anatomy existed, injuries to the ducts are preventable if the surgeon follows the standard of care and completes a complete dissection of the structures before clipping and cutting the CHD, or mobilizing a bleeding vessel. It is below the standard of care to put a clip on a tissue without adequately identifying the structures clipped.

Respondent also maintains because injury to the CHD is a known risk of this procedure, and that the injury that resulted was not caused by a breach of the standard of care. The fact that Dr. chose not to go further with the dissection, as Dr. maintains he should have, is simply a disagreement among the experts as to methods to complete the procedure, both of which are recognized methods of treatment, and neither of which is used exclusively and uniformly by all practitioners of good standing.

Claimant argues that even if a complication is a known risk of the procedure, knowledge of it does not absolve the physician if the complication is a result of negligence. "Inadvertence" or "error" causing a complication of surgery is still negligence, and when the known complication is preventable and the surgeon breaks the rules of surgery by failing to take the necessary steps to avoid causing the injury, that conduct is below the standard of care and the injured party is entitled to recover damages.

The Arbitrator finds the more persuasive testimony to be that of Dr. and finds that Claimant established that it is more likely to be true than not that Dr. breached the standard of care, and that this breach caused injury to Ms. .

DAMAGES

Ms. suffered pain and discomfort well beyond the normal expected pain that would be anticipated from a laparoscopic cholecystectomy procedure. This pain became more severe and after one week she presented at the Emergency Room due to severe pain, nausea, and vomiting, resulting in her being re-hospitalized through the Emergency Department. While at

the hospital she underwent two surgical ERCPs, each requiring her to be placed under anesthesia. During the second ERCP a temporary plastic stent was placed traversing the area of the blockage to provide a temporary opening of the duct to allow passage of bile from the liver to the bowel and would be a lesser impediment to any future repair of the duct injury. She continued to suffer pain. She remained in the hospital for several more days for symptom control and normalizing of her liver function tests. The placing of the stent lessened the pain, but it was understood that a third surgical procedure would be required and she was referred to M.D. at to consider permanent options for Ms. . The choices were a metal stent that would last longer than the plastic stent, but still would likely require replacement more than once during Ms. lifetime due to her being in her mid-thirties. The other option was a major six to eight-hour surgical procedure that would provide a permanent solution, with the risks attached to all major surgeries, and the further risk that it could fail, again requiring additional surgery.

Ms. opted for the major surgical procedure, a Roux-en-Y jejunostomy, hoping for the more permanent solution. This surgery took place on May 23, 2011, almost two years ago, and was successful and without complication or failure. The surgery left a large scar from below her rib cage and down and across her abdomen. This lengthy scar causes Ms. embarrassment because it is, in her opinion, unsightly and can be seen when wearing a bathing suit or when she is not fully dressed. She testified that people make negative comments about it. It also can be itchy, numb, and at times becomes raised and inflamed.

After this major surgical procedure, Ms. had an eight-day hospital stay, and was required to use an epidural to control what she described as extreme pain. Once she left the hospital she still had significant pain, and was discharged with narcotics to be taken every four

hours as needed for pain control. The pain eventually subsided and she is now able to exercise three days a week and does not have dietary restrictions.

Following this surgery the greatest risk was of recurrent bile duct stricture occurring in the first one to two years post surgery. After the two-year mark, which will take place in ten days from the date of this Award, the risk decreases to a 5 to 10 percent chance of recurrent stricture during her lifetime. Ms. testified that even with this minimized risk she is anxious when she has abdominal discomfort for any reason, fearful that it might be due to a potential stricture requiring further surgery. To date, although Ms. has had episodes of some abdominal distress, there is insufficient evidence to establish that it is due to a recurring stricture that could lead to further surgery.

CONCLUSION

The Arbitrator finds for Claimant, and against Respondents,

and

Inc., and awards damages to Ms. in the amount of $250,000.00. Claimant is also entitled to costs as allowed by law.

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: May 13, 2013

Judge Bonnie Sabraw (Ret.), Arbitrator

Hon. Bonnie Sabraw (Ret.)
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ARBITRATION IN THE MATTER OF

ADR Case No. 12-4516-BLS

Claimants,

v.

Hearing Dates: April 17 – 21, 2014
Judge Bonnie Sabraw (Ret.), Arbitrator

No. 11665

Respondents.
_____/

This matter came on for hearing before the Arbitrator, Judge Bonnie Sabraw (Ret.), on March 17 through March 21, 2014 at the San Francisco offices of ADR Services, Inc., 100 First Street, 27th Floor, San Francisco, CA 94105. Claimants were present, represented by and of . Respondents were represented by of appeared on March 19, 2014 as counsel for witness .

The parties submitted post-arbitration briefing and the Arbitrator took the matter under submission on April 4, 2014.

Witnesses who testified at the hearing were ; ; ; ; ; ;

.; and .

All medical records provided to the Arbitrator, along with other items of evidence used to assist in understanding the evidence presented, were received in evidence and considered by the Arbitrator in rendering this Arbitration Award.

INTRODUCTION

Claimant ("Ms. ") brings this medical malpractice action against . (" ") alleging that her treatment by two of 's physicians, . and ., fell below the standard of care required, causing her injury and damages. ("Mr. "), Ms. 's husband, brings an action for loss of consortium.

The basis for the claim is that:

(1) On March 16, 2013, physician a retinal specialist, administered intravitreal Kenalog injections to both of Ms. 's eyes simultaneously; and

(2) On March 17, 2013, physician ., the on-call comprehensive ophthalmologist, failed to recognize symptoms deserving of an in-person evaluation and to properly respond to Ms. 's telephone call for help.

FACTUAL BACKGROUND

Ms. is currently 38 years old, married to , and the mother of two children, and , now ages 6 and 4 respectively. Both Mr. and Ms. are high school graduates. Prior to receiving the Kenalog injections at issue in this litigation she was employed by as a flight dispatcher and fuel logistics operator, helping to

manage and coordinate flights for personal aircraft, develop quotes for aircraft leases and services, and occasionally acted as a flight attendant. Ms. presented as a very intelligent, attractive, engaging, hard working, and organized person. She is a dedicated mother and wife. While employed at she was proud of her work and was committed and dedicated to the needs of the company. The evidence indicates that Ms. was the person in the marriage who primarily handled the household duties as well as paying the bills and overseeing the mechanics of the household finances.

Mr. is currently and has been employed as a union electrical Superintendent for . He is a dedicated husband and father, doing his best to cope with the changes in his life and the lives of family members due to the loss of the sight of Ms.

.

In late 2010, Ms. was referred to the ENT clinic for evaluation because she was experiencing right-sided jaw pain, right posterior throat pain and the feeling of a mass in her throat. She was eventually referred to where she was diagnosed with "pseudo-tumor" jaw pain, and other symptoms generally believed to be related to an autoimmune disorder, which eventually resolved. While being treated at Ms. developed eye symptoms of blurry vision, which Dr. at diagnosed as iritis and referred Ms. to Dr. , a ophthalmologist specializing in uveitis, an inflammation of the middle layer of the eye where a majority of the blood vessels in the eye are located. Dr. began treating Ms. in April 2011 for this condition.

While treating Ms. , Dr. noted severe inflammation of Ms. 's iris and macula ("cystoid macular edema – CME"). To treat this condition Dr. tried oral progesterone, injections of steroids, intraocular injections of Avastin and also prescribed CellCept. These treatments were not successful in addressing the inflammation inside Ms.

's eyes. Dr. then referred Ms. to Dr. , a retinal specialist, seeking her evaluation of the patient, and whether or not she was a candidate for Kenalog injections. Kenalog is a steroid that is administered by intravitreal injection; i.e., directly into the eye, versus outside the eye, which is how the Avastin injections were administered. The Kenalog injections are considered to be a greater risk to the patient than the Avastin injections.

Ms. met with Dr. who described to her the procedure and explained the risks and benefits. The risks identified were an increased risk of developing glaucoma and cataracts and that she may have "floaters" as a result of the injections.

At the time Dr. administered the Kenalog injections, she had completed her residency at and had been employed at for approximately five months. Dr. acknowledged that as of the date of the injections she had never administered bilateral Kenalog injections on a patient. Dr. testified that she "left it up" to Ms. to choose whether or not to have the injections done in both eyes at the same time or do them one at a time on different dates. Ms. checked the box on the consent form for bilateral injections.

On Friday afternoon, March 16, 2013, Dr. administered the bilateral intravitreal Kenalog injections. After the procedure was completed, Ms. was discharged with written instructions, which stated in part in bold print:

> **"You may resume your normal activity tomorrow.**
>
> **If any of the following symptoms occur before your next appointment:**
>
> 1. **Your eye becomes extremely red or painful.**
> 2. **You experience a sudden loss of vision**
> 3. **You develop a yellow or green discharge form (sic) the eye.**
> 4. **Your eye becomes sensitive to light**
>
> **It is very important that if ANY of these symptoms occur you need to contact the Department of Ophthalmology.**
>
> **During normal business hours (8:30 to PM M-F) call .**

If it is after hours of operation or on the weekend or holiday you are to call and ask for the ophthalmologist on call.

Remember, Do Not wait until your next appointment to notify of these concerns."

Exhibit 28

Ms. went home to rest and was experiencing a "little soreness and sensitivity to light," but was not feeling worse than before the injections.

The next morning, Saturday, March 17, 2013, Ms. testified that her eyes were sore, very sensitive to light, "hurting real bad," cloudy with a feeling that her eyes were full with something covering her eyes. She testified that this was a big change from when she had gone to bed the night before. She was scared, was in bed, and kept the room dark, with everything closed. She testified that her experience was very different from her experience with the Avastin injections a month earlier.

On Saturday morning, following the directions on the discharge instructions, Mr. and Ms. called the advice line, and spoke with advice nurse , reporting that the day after the injections she was experiencing severe sensitivity to light with loss of vision, almost like looking through a cloud. "I can see a little bit, but it is so fuzzy I can barely make things out." There was no discharge or drainage, but when she opened her eyes and light hit them they were "much more painful." The eyes were bloodshot all the way around the eye.

Nurse then spoke with Dr. . Dr. was the on-call ophthalmologist. Dr. was not a retina specialist, but such a specialist was available to him if he wished to consult with one. Dr. spoke with nurse , who described Ms. as a 36-year old female who had had bilateral intravitreal Kenalog injections in both eyes the day before due to iritis and CME and was now complaining of "a lot of pain, extreme light sensitivity, and her vision is extremely cloudy."

Dr. asked Mr. if the discomfort was the same as it was from her iritis, but Mr. had not asked Ms. that question and didn't know the answer. Dr. did not request Mr. get this information from Ms. . Mr. did tell Dr. that the light sensitivity and the cloudy vision were new symptoms. Dr. told Nurse that Kenalog injections sometimes obscure your vision for a few days until it funnels out at the bottom of the eye and that the irritation and cloudiness can result in the eyes being a little irritated the next day or so because of the Betadine used to prep the eye. Dr. 's advice was to "just keep an eye on it."

Dr. did not ask to speak directly with either Ms. or her husband, and did not request that she come to the emergency department for an in-person evaluation. In essence, Dr. indicted to Nurse that she appeared to be experiencing a normal reaction, and that unless her symptoms changed or worsened, particularly if there was a discharge, she did not need to be seen in the ER. The nurse then got back on the line with Ms. , and told her that Dr. , the on-call ophthalmologist, had said that this reaction is normal and that the Kenalog injection is a murky substance which when injected can cause some cloudiness for a few days until it might settle at the bottom, so she can expect this reaction. He also told her that with respect to the discomfort and sensitivity, that this was most likely caused from the Betadine prep to the eye. He told her that that she should "wait it out," and if not improving throughout the day or getting worse, especially if there is redness or a discharge she should give them a call or have someone drive her to the ER for evaluation. (See Exhibit 70 – transcript of taped phone call.)

Believing that her symptoms were a normal reaction to the injections that did not require immediate attention, Ms. stayed at home and continued to try to rest.

On Sunday morning Ms. was experiencing severe pain, more severe than the day before, and was nauseous and vomiting. Her husband took her to the emergency room at where Dr. , who was still the on-call ophthalmologist, met her. At that time she had extraordinarily high intraocular pressure, requiring a centeses (essentially a puncture to relieve the pressure), which Dr. performed. Despite the attempts to relieve the pressure perfusion to her optic nerves and retina were interrupted, resulting in ischemic nerve injury, blind spots in both eyes, and permanent profound loss of vision in the central visual field of each eye.

LIABILITY

1. Liability Due to the Treatment by Dr. :

Claimants' expert, , M.D., a retinal surgical specialist, opined that it was below the standard of care for Dr. to have performed simultaneous intravitreal Kenalog injections on Ms. due to the increased risk inherent in such injections. In Dr. 's opinion the greatest increase in risk with Kenalog injections is that problems with intraocular pressure can develop.

It is also Dr. 's opinion that if Kenalog injections are used at all, it should only be done one eye at a time. He believes that if both eyes had not been injected simultaneously that it is within a reasonable medical probability that one of the eyes would still be functional, preventing Ms. from being legally blind and allowing her to have a far greater visual function than she currently possesses. See Ex. 8-A (Dr. 's report)

, M.D., also a retinal specialist and Respondent's expert on the standard of care issues, opines that the standard of care does not require unilateral injections. He administers Avastin and Kenalog injections, and does acknowledge that Kenalog is less common now due to new medications available – which were tried and did not work on Ms. . In his extensive experience, he is only aware of specific medical reasons that would require the Kenalog

injections to be one at a time; i.e. if patient is a steroid responder, which Ms. was not; if there is a history of glaucoma, which Ms. did not have; and if the patient was steroid naïve, which Ms. was not. While the result here was not a successful one, he does not believe that it resulted from a breach of the standard of care, and that Dr. used the level of skill, knowledge and care in administering the injections that other reasonably careful ophthalmologists would use in the same or similar circumstances.

The Arbitrator finds that Dr. 's administering of the bilateral Kenalog injections was not below the standard of care. While each expert who testified on this issue was very well qualified, and had differing opinions on whether or not the bilateral injections should have been administered, the Arbitrator does not find that administering bilateral Kenalog injections was not an accepted method of treatment. A physician is not necessarily negligent just because she chooses one medically accepted method of treatment or diagnosis and it turns out that another medically accepted method would have been a better choice. CALJIC 506.

As a result, the Arbitrator finds that Claimants cannot meet their burden of proof to establish that Dr. 's decision to inject both eyes simultaneously was below the standard of care.

2. Liability with Respect to the Medical Advice of , M.D.

Claimants' expert, Dr. , testified it is his opinion that it was below the standard of care for Dr. to not have Ms. evaluated at the emergency room when she called the morning after the procedure complaining of what he testified were classic symptoms for increased intraocular pressure.

Dr. testified that if Ms. had been directed to come in to the emergency room for evaluation that Saturday, the examination would have provided Dr. with the ability to talk with the patient directly (which he chose not to do over the phone), allowing him

to receive more detail about her condition; receive a better history and ability to review her records; and, perhaps most importantly, he would have been able to measure and quantify the magnitude of any change in pressure in her eyes. In addition, the optic nerve would have been examined and migration of the Kenalog could have been spotted.

Dr. believes that it is within a reasonable medical probability that if the evaluation had been done on Saturday, rather than waiting until the next day, that the ischemic optic neuropathy could have been avoided and vision loss would have been prevented. By the time she was finally seen the next day on Sunday, March 18, 2012 it was too late.

When Ms. arrived at the emergency room on Sunday morning she was nauseous and vomiting, which are symptoms of very high intraocular pressure. Dr. testified this rise in pressure resulted from strokes in the optic nerves of both eyes, preventing sufficient blood flow and oxygenation, killing the macula. All experts agreed that Ms. 's resulting vision impairment is not expected to improve in the future.

Dr. also testified that although Ms. would have had continued problems with CME and uveitis if this situation had not occurred, he believes that this would have been a waxing and waning condition, manageable with medication.

Respondent's expert, Dr. testified as to the standard of care and its expert , M.D., testified as to the issues of causation and damages. Dr. testified that he did not believe that at the time Ms. made the phone call that there was "clear evidence" of a rise in intraocular pressure. While that may be correct, it is not required that there be "clear evidence" of such a rise in pressure, but that there be a reasonable medical probability that a rise in pressure could be the reason for her symptoms, which could be determined if she had been instructed to go to the ER. The Arbitrator finds that the evidence supports a finding that such a reasonable medical probability existed.

's causation and damages expert, retina specialist , M.D., testified that if Ms. had been directed by Dr. to go to the ER and be examined, it is more likely than not that a rise in intraocular pressure would not have been detected at that time. Dr. acknowledges that a known risk for Kenalog injections is a rise in intraocular pressure, but, in his experience, if such a rise in pressure occurs it usually takes weeks or months to develop. He has never seen it develop within a 20-hour time frame after the injections as occurred in this case.

Although he acknowledges that it is not possible to tell what a patient's pressure is without an examination, he believes that the symptoms described by Ms. in her phone conversation with the advice nurse were common complaints after such a procedure, probably due to an irritation on the surface of the eyes.

Dr. also testified that if she had come to the ER on Saturday and been given medication designed to lower the intraocular pressure, that would not have prevented the high rise in pressure that was present on Sunday morning, and would have done very little to "stem the tide" of the ultimate high rise in pressure. As a result, he maintains that Dr. 's failure to have her be seen on Saturday did not cause her ultimate loss of vision.

Dr. testified that if this spike in pressure had not occurred she would have needed treatment for her CME condition, but he cannot say what that treatment would be. He testified that he could not say that she would likely have become legally blind, lose her ability to drive, or read normal print if this situation had not occurred.

The Arbitrator finds that the weight of the evidence supports a finding that Dr. was negligent by failing to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful ophthalmologists would use in the same or similar circumstances when he did not advise Ms. to come to the ER on Saturday morning and that this

that this conduct was below the standard of care required. When Ms. called, she was doing precisely what she had been directed to do as stated in bold print on her discharge instructions. The Arbitrator also finds that the weight of the evidence supports a finding that a rise in the intraocular pressure would have been discovered on Saturday, could have been treated and reduced, eliminating, or at least reducing, her loss of vision that resulted in her becoming legally blind.

DAMAGES

The Arbitrator has spent considerable time reviewing the testimony of each of the experts called by the parties in assessing damages, including the deposition and charges submitted by who was unable to personally appear at the arbitration. The Arbitrator agrees with Respondents that Ms. had a duty to mitigate her damages, but also recognizes that the resulting injury in this case was not one that was an easy adjustment for Ms. , as would be true for anyone. The fact that she did not return to work at and seek their assistance in accommodating her vision limitations during the period of time they held the job open for her was not a failure to mitigate her damages, but was justified by the depression, fear, anxiety and need to adjust and be trained in coping that she experienced as a result of her loss of vision. This is especially so when a physician had advised her that she was unable to accurately and safely perform the job she so enjoyed due to her vision loss.

The Arbitrator awards damages to Ms. as follows:

1. Economic Loss

Lost past wages: $

Future lost earnings if had not injured: The Arbitrator awards Ms. full wages and bonus for a period of four years, offset by social security benefits she will receive. During this

period of time Ms. is expected to receive training and an education sufficient to bring her back into the work force; albeit not necessarily at her prior job at .

Lost future earnings for Four Years: (Present discounted value)

First year:	$ 85,189.00
Second year:	$108,872.00
Third year:	$107,619.00
Fourth year:	$106,085.00
Total:	$407,765.00
Plus bonus amount for four-year period:	$ 66,873.00
Total:	$474,638.00
Less social security disability benefits expected to be received for these four years:	- $ 114,313.00
Net Lost Future Earnings:	$360,325.00

The total award for lost earnings, past and future, is $559,253.00

Life Care Costs:

The life care costs testified to by Claimants' experts in this case involve expenses for medical treatment, medications, pre-vocational rehab services, adaptive equipment and aides, and support services. Those considered by 's experts were transportation assistance and orientation and mobility training such as use of a cane, use of other devices, home support types of training such as organization of home and labeling, and equipment at home. After considering all of the testimony and evidence presented on these issues, the Arbitrator awards life care costs as follows:

Allowed Life Care Plan Expenses

Future medical treatment	$2400.00 (for counseling – it is anticipated that due to Ms. 's medical condition prior to her injury she would

	have had some future medical expenses that would have been an offset to additional amounts claimed.)
Medications	$18,239.00 (There was no evidence presented for the cost of medications if she had not been injured)
Pre-vocational rehab services	$3600.00 for transportation costs to the training. Training expense and child care expense (which would have been necessary if she was not injured and still working) are not allowed
Adaptive equipment/aides	$100,000.00
Support services	
Reader/driver	$100,000.00
Household services	125,000.00

TOTAL LIFE CARE PLAN - $349,239.00

2. Non-economic Loss

The Arbitrator awards Ms. the amount of $250,000 pursuant to Civil Code Sec. 3333.2 for her non-economic loss.

Mr. 's claim for Loss of Consortium

Economic loss: The Arbitrator makes no award to Mr. , for economic loss.

Non-Economic loss: Mr. testified that as a result of Ms. 's injuries he has observed changes in her that have affected their ability to communicate and share the intimacy of their marriage as they once did. He acknowledges that he was suffering from depression and anxiety before this incident, but testified that because of the impact her injury has had on their household and family relationships, his depression and anxiety became worse, and it was necessary to increase the dose of his medication as a result. The are in counseling to help them communicate and work together better, which does seem to be helping. The Arbitrator awards Mr. $25,000 for non-economic damages for his claim.

CONCLUSION

The Arbitrator finds for Claimants, Mr. and Mrs. and against Respondents, and . The amount awarded to Ms. for economic damages is $908,492.00. The amount awarded to her for non-economic damages is $250,000.00. The amount awarded to Mr. for non-economic damages is $25,000.00 The 's are also entitled to costs as allowed by law.

As requested by Respondent's counsel, if an award of damages is rendered, the Arbitrator orders that Respondent has 14 days to issue a check to Claimants in satisfaction of this award.

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: April 17, 2014

Bonnie Sabraw

Judge Bonnie Sabraw (Ret.), Arbitrator