ERIC E. YOUNGER, Judge of the Superior Court (Ret.)
Neutral Arbitrator ✧ ADR SERVICES, INC.
915 Wilshire Boulevard, Suite 1900
Los Angeles, California 90017
Phone (213) 683-1600 ✧ Fax (626) 791-8996
eeyounger @ gmail.com

IN THE MATTER OF THE

ARBITRATION BETWEEN

Claimant,

vs.

, *et al.*

Respondent.

CASE NO. 11788

ARBITRATION AWARD

Award

The undersigned Arbitrator heard the cause, beginning on November 12, 2013. Having considered the evidence of the parties and argument of counsel, the Arbitrator finds in favor of respondent.

Former individual respondent , M.D., was dismissed from the case by stipulation on November 14.

A Note on Counsel

Each side was represented by able counsel, who were "at the high end of the scale" of cordiality, efficiency and courtesy. They were a joy to work with, and, no, this section does not appear in every award.

Discussion

Claimant's allegations of fact are briefly described at page 4, below.

This was not a complicated case, nor was it, ultimately, difficult to decide.

The main reason it was not complicated is that the testimony of the expert witnesses, , M.D., , M.D. and , D.D.S, M.D.[1] turned out to be unnecessary to the result. This scenario, unusual in a medical malpractice case, flowed from the Arbitrator's findings, as will be explained below, on the operative facts of claimant's care.

An additional and related element of simplicity flows from the absence of *legal* issues in the case, again because of the factual findings.

Had claimant prevailed on the facts, there would have been both expert testimonial issues and legal issues, but she did not.

Preliminary Comments

The parties are asked to bear these things in mind when reviewing the Arbitrator's thinking on the facts of the case, which will be set forth below.

Burden of Proof

California law, indeed the law of every jurisdiction in the English-speaking world, requires a plaintiff in a civil case[2] to bear a "burden of proof." This requires that he or she prove the case by a "preponderance of the evidence." In a jury trial, the judge would explain it this way:

> A party must persuade you, by the evidence presented in court, that what he or she is required to prove is more likely to be true than not true. This is referred to as "the burden of proof." After weighing all of the evidence, if you cannot decide that something is more likely to be true than not true, you must conclude that the party did not prove it. * * *
>
> (Judicial Council of California, Civil Jury Instructions ("CACI"), # 200)

This Arbitrator is guided by these same ground rules.

What does that mean, from the claimant's point-of-view, in this case? The first, and most important, thing to understand is that the result here *might* be *wrong*. This Arbitrator does not

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[1] This gentleman was a percipient witness, but the Arbitrator was advised that he was designated as an expert as well.

[2] The issue is, of course, identical for a claimant in an arbitration.

possess some God-like ability to weigh the evidence *perfectly* any more than anyone else would, and he does not promise or offer perfection. He does offer 40 years of listening carefully to evidence and he does promise he has done his best to be fair to all sides in all cases, but no trial or arbitration is a perfect process.

Credibility of Witnesses

"Credibility" is a term bandied around courthouses and television shows all the time, but we must remember that it really describes two quite different things - honesty and accuracy. Any witness can be extraordinarily conscious of his or her oath to tell the *truth*, but be utterly *mistaken* in what is heard, seen or remembered. Conversely, a witness can recall events perfectly but intentionally misstate them. Sometimes these issues overlap, as where a witness who really does not recall the answer to a question but invents one believed to be favorable.

This Arbitrator will go to almost any lengths *not* to decide any important issue by "intuition" or assessing "who *seems* more believable." Fact-finders can be fooled by liars and - perhaps more easily - by decent citizens who are "sure" what they have seen, but are wrong.

Witnesses themselves are fooled by misperceptions and memory glitches.

Proper fact-finding, accordingly, is the process of trying to line up what a witness says with non-manipulable circumstantial evidence, concentrating on that which is "objective" whenever possible.

The assessment of "bias, motive and interest" should not be *omitted* from the process, and a jury would be instructed as follows:

> . . . did the witness show any bias or prejudice or have a personal relationship with any of the parties involved in the case or have a personal stake in how this case is decided?
>
> CACI # 107(d)

But this issue is of secondary importance, first, because and its doctors also have biases and interests and, second, because people do not always act in accordance with their apparent self-interest.

Lessons Learned as a Judge

This Arbitrator had to learn the lesson that every conscientious judge learns, and that is that there are - if not *always* - at least *often*, two very different sides of the story and that each must be listened to. It is absolutely critical that one not try to decide a case before hearing *both* sides, no matter how persuasive the one who goes first may be. This case is a great example, in that claimant's case was persuasive and it seemed, at first, that she would be likely to prevail.

The Facts of the Case

Claimant's Side

Claimant's Witnesses to Facts

Claimant presented several witnesses in addition to her own testimony: is a distant relative; is claimant's daughter-in-law; is claimant's husband; is claimant's son. Each told different aspects of essentially the same story, which is that claimant, over a period of at least six visits to Dr. at offices, complained of mouth pain of varying degrees of seriousness. All of those visits also concerned other health issues, as Dr. was claimant's primary care physician ("PCP").

The witnesses' narratives were generally consistent and the scenario they described was as disturbing as it was simple: No matter how strongly Ms. complained of problems in her mouth (generally in the gums), neither she nor any of the relatives who accompanied her to visits could get Dr. to pay any attention. She very much wanted a referral to a dentist and/or a prescription for antibiotics. Each time, Dr. would "put her off" by saying she had too many other patients, that claimant had other problems requiring more attention or by making some other excuse.

Claimant's version of the events was lent credibility by her having had exostosis (a bony growth) removed from her mouth at in 2006 and diagnoses of similar conditions in 2008 (also at) and on April 26, 2011 at . The last of those diagnoses was by Dr. , who had replaced Dr. as claimant's PCP, and she referred her to , D.D.S., M.D., an oral maxillofacial surgeon, who did surgery on May 23 to correct the problem.

At first blush, then, claimant's narrative seemed sound: She had plenty of witnesses, each of whom seemed reasonably[3] credible and it certainly seemed logical that, as all the evidence showed that she had generally the same condition in 2006, 2008 and 2011, she must have had it - and surely would have complained of it - between 2009 and 2011.

While claimant had no "special damages" (doctor bills, hospitalization and the like) as all the work was performed at , she probably would have been awarded "general damages" for "pain and suffering" and related inconvenience and emotional distress, had her case held up factually.

Testimony of , M.D.

Problems for claimant actually began during her own case-in-chief, with the testimony of , M.D., her standard-of-care expert. While, as indicated above, his expert testimony was not important to the result in the case, other aspects of it began an erosion in claimant's evidence which was to become dramatic as the case went along. No one aspect of his testimony was enormous, but several were noteworthy:

The records he reviewed before testifying included a reference to a doctor back at , who saw claimant earlier in 2011, referring to an acute condition with "*intermittent* pain." This was to become a more significant issue than was understood during this November 13, 2013 testimony.

Dr. acknowledged that claimant saw a "physical medicine doctor,"[4] *unrelated to* , in connection with a traffic accident during the period in question, and that there was no reference to the mouth pain in that doctor's records either.

He also acknowledged that Dr. records, which he carefully reviewed, contained indications as to a lot of different medical problems, but nothing about mouth pain. Left unanswered was the nagging question which would remain throughout the case, which was ***why*** *Dr. would have documented - and made an effort to treat - a considerable variety of conditions all over claimant 's body, but so steadfastly refused to consider a mouth issue about which complaints were ongoing.*

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[3] No insult is intended by the word "reasonably." Please see the discussion of "credibility" above.

[4] Presumably for medico-legal work

An embarrassing admission in Dr. deposition - of the sort which excited defense counsel, perhaps excessively - was when he was asked if it isn't true that nothing did or did not do caused claimant any problems, to which he responded "with the information I have, no." He did, to be sure, later change the deposition testimony and had a not-very-persuasive explanation for it.

But the biggest problem with Dr. testimony was the return, near its end, to the issue of the *consistency* of the pain. The Arbitrator wrote out in advance and posed this question: "Given her overall situation and the work ultimately done on her in May of 2011, what is your opinion as to whether she had substantial pain most of the time between 2009 and 2011?" The doctor's answer was plainly not what claimant or her counsel wanted to hear: "It is likely she would have had intermittent pain."

These two references to "intermittent" pain, the second of which was in response to a question by the undersigned, which was worded carefully in an effort at neutrality, were to become important.

Respondent's Side

, M.D.

, M.D., then an individual respondent (but later dismissed) was an excellent witness: She is a graduate of and the at and has been a family practice physician at for fourteen years.

Not only did she exude medical knowledge and expertise, but her comprehension of the systems regarding file notations was extraordinary. The Arbitrator's contemporaneous note, during her testimony, "*her personal note-taking on the computer is almost obsessively complete and detailed*," was echoed by a later witness, Dr. (respondents' expert), who referred to Dr. note-taking as "obsessive."

The uniform practice in her office was and is for a nurse to ask a patient for his or her chief complaint, prior to taking vital signs and asking about allergies and medications, but the balance of a patient's history is taken by the doctor herself and entered simultaneously on the computer. She stated that her screen is set up so that a patient can see what is being recorded. Dr. testified "I 100% verify every complaint as if the nurse didn't put anything down," and that she makes a note of *every* complaint, not just the most important.

Dr. testified to seeing claimant eight times between 2009 and 2011 and her notes from the "new patient exam" in May 2009 are interesting in that Mrs. only told of one prior surgery (female), omitting 2006 procedure in her mouth. That initial visit included a full physical exam, which would include the checking of the mouth,[5] while, on subsequent visits, when attention was directed to specific complaints, she would not necessarily examine the whole body. Dr. treated claimant for high blood pressure, high cholesterol, back pain, depression, migraine headaches and shortness of breath (she was a smoker, which concerned the doctor). She notes, with considerable fervor, that the first reference to any mouth problem in all of voluminous records came *after* she last saw Mrs.

There is no need here to include the references in Dr. testimony to each visit, but she did make a specific point that the February 21/22,[6] 2011, "visit," testified to by Ms. ,[7] was a *telephonic* (also referred to as "automatic" or "RAR") medication refill. The word "Telephonic" appears on the first page of that record, and Dr. noted that there is no documentation of an in-person visit from a receptionist or nurse, which would be there if claimant had appeared in person. There is is a notation of a response to a pharmacy service request (for Diazepam) from Dr. who added to the record on her own and called Dr. for clarification. There was some further discussion of that prescription for Diazepam, a generic for Valium. Dr. notes that refilling it without an in-person visit by a patient, where it is being "chronically refilled" for a long-term issue, is not unusual and she also stated that this is not, contrary to the assumptions underlying claimant's counsel's questioning, a *pain* medication.

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[5]Mrs. wore full dentures, and Dr. testified that, absent some complaint or other particularized reason, she would not have been asked to remove them. Obviously, there is no way to know whether any gum problem *would have* showed in May of 2009, but, if it did, the dentures could well have hidden it.

[6]The records of this incident are from the 22nd, but Dr. refers to a refill request's having been handled "yesterday," explaining why both dates came up in testimony.

[7]This, of course, suggests that Ms. "remembered" a non-existent visit to after seeing, or being told of, a February 22 entry in the records, while failing to see the word "Telephone" at the top of the first page, but there could be other explanations for her testimony and knowing what they might be is not critical to the result.

She has no recollection of any person's ever being with claimant except for her husband, though she does not completely rule out the possibility that some other relative could have come in with her, as there would not necessarily have been a note of an accompanying friend or relative. On the other hand, given the more-than-ample displays of Dr. documenting habits, her testimony that she absolutely did not have any sort of "confrontation" in the office with any woman accompanying claimant about a pain issue and that she certainly would have documented any such "rare event,"[8] seems highly persuasive.

The Arbitrator asked Dr. about a doctor or employee's ability to go back and change computerized record entries *post hoc*, and, specifically, about her knowledge as to whether and how that could be done. The doctor stated that she chairs a committee dealing with computerized record issues, and displayed a sophisticated grasp of the system. She testified that records cannot be deleted or changed, but, when something is to be added or changed, a supplemental record is created. Her personal log-in to the computer system does not permit her to change any nurse's notes (which also contain no references to mouth issues) at all. This is significant testimony to anyone who has handled medical malpractice cases over the years, in that inadequate documentation, or medical records which appear to have been altered (often poorly), have sometimes paved a plaintiff's road to success in the courtroom.

Another contemporaneous note of the Arbitrator summarizes this testimony: "*Dr. is a simply excellent witness: Quite apart from medical issues, her knowledge of systems, protocols, computers, etc. are* [sic] *dramatic*".

Other Witnesses

Respondent's standard-of-care expert was , M.D. Well-qualified and connected with , not , his testimony ("They certainly complied with the applicable standard of care") did not wind up being critical, as claimant's own expert's testimony was rendered

[8] One cannot ignore professionals' increasing needs for "CYA" documentation in today's world, and, whether that expressly impacted the doctor's thinking or not (she did not say so), the possibility that there was an actual confrontation with third persons, which was not documented, seems nearly unbelievable. The doctor testified that confrontations were "salient events," which would surely have been documented.

moot, being foundationally based on proffered underlying facts which the Arbitrator has found were not proven.

, M.D., PhD is a long-time physical medicine and rehabilitation doctor at He saw claimant on approximately five times October 2009 through April 2011, but never heard any complaint of mouth pain. He would "definitely" have documented it in the chart, even though he was treating her for back pain, and would have referred her directly (*i.e.*, without needing to send her back to her PCP) to an oral maxillofacial surgeon.

, an LVN often assigned to work with Dr. , gave testimony consistent with hers about procedures and the degree of documentation required of everyone involved in the patient's care. His practice, assuming that a patient had called in for an appointment, was to begin by looking at the note from the call center to see why patient is there (sometimes, he testified, it is correct and sometimes not). He also always does an after-visit summary, which is printed out and given to the patient by him (even if there is nothing for the patient to do). While Mr. professed no independent memory of Mrs. visits, he does remember her face, but has no record of any mouth pain issues.

, M.D., D.D.S., an oral maxillofacial surgeon, performed the ultimately successful surgery on claimant on May 23, 2011. He is the only truly disinterested witness in the case, as he was employed at at the time of his treatment of claimant, but no longer is.

Significantly, his own notes recall claimant's speaking of "intermittent pain over a three year period," which had become substantial over the past couple of weeks (as of the time she saw him in late April).

Dr. testified that the surgery was not treated as an emergency, but was set so relatively close to the date her first saw her because he had a cancellation on May 2, permitting him to fit her in. She drank coffee with cream on the morning of the intended procedure, contrary to the pre-op instructions, and this necessitated the change to the May 23 date.

The Ultimate Problems with Claimant's Case

One of the more persuasive areas of Dr. testimony consisted of her treatment notes regarding claimant's conditions *other than* her mouth. There is, as mentioned above, the almost obsessive note-taking, which permitted the doctor to testify in remarkable detail about her care of a wide range of Mrs. ailments and conditions. This returns one to the question discussed above which will simply not go away about claimant's case: *Why* would Dr. have treated - and carefully documented - so many conditions, while steadfastly ignoring one particular part of her body? If, hypothetically, it appeared that the doctor just did not like the patient, thought her a malingerer or so non-compliant that she would just not "do her best work" for her, one would expect a more pervasive pattern of lack-of-care, yet even claimant does not suggest (and her counsel did not argue) that any other malady was ignored or even inexpertly treated.

A broader version of this issue is presented outside the bounds of Dr. own testimony, as various other doctors and professionals treated Mrs. during the subject period and documented their care, yet *none* have records of any *mouth* complaints: In addition to the "outside" doctor she saw in connection with her accident cases, Dr. , who treated her for back pain at , Dr. , who saw her for female complaints, , a physical therapist, , D.O., dealing with migraines and nausea and Dr. , treating an infection, all omit mention of mouth issues. No nurse or receptionist or call center person ever recorded any. Why and how could *all* of them - clearly even some people who do not know each other - miss the same complaint, while recording many others. Even the most elaborate conspiracy-of-silence one can imagine does not explain this.

The precise basis for this Award's being in favor of respondents is the Arbitrator's finding that claimant's evidence, taken as a whole, does not preponderate.

While not essential to the Award, one cannot escape the conclusion that claimant indeed had *intermittent*[9] mouth pain - perhaps even severe pain - during part or all of the period in question, but

[9] It cannot be ignored that claimant's own expert, Dr. , testified not only to a doctor's reference to intermittent pain, but also to his own *opinion* that she would likely have had intermittent pain.

that there was no complaint of it to Dr. or anyone else at prior to April 25, when she saw Dr. , who moved forward immediately on its treatment. Dr. , the oral maxillofacial surgeon, whom all concerned agree became the hero of claimant's care when he did the successful May 2011 surgery, also quoted her as complaining of *"intermittent* pain.

An answer to the question of why this seemingly nice lady and her pleasant and impressive family would prosecute this claim is in the realm of speculation and not necessary to the result, though, in the traditional realm of "bias, motive and interest," the fact that she was seeking money from cannot be ignored. At one point during the hearing, it was suggested that adverse results (perhaps by costs' being billed to her or deducted from a settlement) in personal injury litigation are somehow involved, but the Arbitrator has no reliable or detailed knowledge of anything like that and it plays no part in the Award.

Language Required by California Department of Managed Health Care

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: November 20, 2013

Eric E. Younger
Judge of the Superior Court (Ret.)
Neutral Arbitrator

ERIC E. YOUNGER, JUDGE OF THE SUPERIOR COURT (Ret.)
Neutral Arbitrator ✧ ADR Services, Inc
915 Wilshire Boulevard, Suite 1900
Los Angeles, California 90017
(213) 683-1600 ✧ Fax (626) 791-8996
eeyounger @ gmail.com

IN THE MATTER OF THE ARBITRATION BETWEEN

Claimant

vs.

Respondents.

ARBITRATION NO. 12281

RULING ON RESPONDENT'S MOTION FOR SUMMARY JUDGMENT

PROCEDURAL BACKGROUND

Respondent, on January 24, 2014, moved for summary judgment, supporting its Memorandum of Points and Authorities with various Declarations and a "separate statement," required by law in a Superior Court proceeding (Code of Civil Procedure §437c(b).) and useful in an arbitration.

Claimant has filed an undated "Response," together with some documents she regards as having evidentiary value.

A tentative ruling was drafted by the Arbitrator and sent electronically to the parties on April 28, 2014.

The motion was argued on May 2, 2014 by Dr. and Esq.

This Ruling follows that process.

RULING

Respondent's motion must be **GRANTED**.

DISCUSSION

Legal Standard for Summary Judgment

Unlike trial judges, arbitrators, ". . . unless specifically required to act in conformity with rules of law, may base their decision upon broad principles of justice and equity, and in doing so may expressly or impliedly reject a claim that a party might successfully have asserted in a judicial action." (*Moncharsh v. Heily & Blase* (1992) 3 Cal. 4th 1, 11, 10 Cal. Rptr.2d 183.) Having said that, when parties agree to retain an arbitrator who spent two decades on the Bench, it seems reasonable to assume that they are looking for answers to their legal issues which are grounded in California substantive law. The undersigned Arbitrator, accordingly, may proceed informally (as our law concerning arbitrations plainly encourages), but tries to base legal rulings on the statutory and case law of the state, hence being guided by the substance (if not all of the procedural wrinkles) of summary judgment law.

A summary judgment is, of course, a determination that an "action . . . has no merit." (Code of Civil Procedure §437c(a).) "[T]he party moving for summary judgment bears the burden of persuasion that there is *no triable issue of material fact* . . . ." (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal. 4th 826, 850, 107 Cal. Rptr. 2d 841; emphasis added).

Expert Evidence Issue

Claimant has proffered no "standard-of-care" expert.[1]

A lengthy discussion of the law requiring presentation of such an expert is unnecessary here. The Arbitrator regards respondent's discussion of the point (Memorandum of Points and Authorities, p. 9, l. 9) as correct and it is, in any event (as will be discussed below), unopposed by claimant.

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[1] Her failure to do so and request to designate one after the instant motion was briefed and under consideration are treated at some length in a letter "Ruling on Motion for Late Presentation of Expert Witness," also of today's date. Leave to present an expert Declaration on April 30 for the May 2 hearing was denied.

In keeping with the "broad principles of justice and equity" (*Moncharsh, supra*) an arbitrator is supposed to follow, the *reasons* contained in case law are often more important than the specific *holdings* of cases. This point is well-illustrated by respondent's cited *Willard v. Hagemeister*, 12121 Cal.App.3rd 406 (1981); Points and Authorities, p. 10, l. 2).) The Court of Appeal notes that triers-of-fact, whether jurors, judges or arbitrators operate in a world of general knowledge, but need the guidance of experts in evaluating professional competence. The instant case is certainly illustrative: The Arbitrator does not *know* whether the conduct alleged by Dr. was within the community medical standard-of-care or not and the only information he has on the point is the Declaration of M.D., who has headed the Emergency Medicine Department at for some 22 years.

The Arbitrator, not surprisingly, finds Dr. to be an appropriate expert on the standard-of-care in this case, a view unchallenged by claimant.

On this basis alone, a summary judgment in favor of respondents should be granted.

Other Issues

While not as concrete and not as dispositive as the expert evidence point, there are other bases for granting the motion. Her "Response to Respondent's Motion for Summary Judgment" is, like most other things Dr. has done in this case, articulate, charming, intelligent and completely unsuited to the task at hand. The entire 20-some pages of the document do a good job of "telling her story" and arguing her case.

What those pages do not do is to "oppose" respondent's motion. There are almost no references to the motion at all. Dr. introduces a concept referred to as "Quality of Care," not, so far as this Arbitrator knows, a term used in medical negligence[2] cases. She discusses the views of one Dr. , apparently a British doctor, in a journal article. She mentions cases in which she indicates[3] has been held liable for malpractice. But the overwhelming majority of the enormously-long (mostly single-spaced) document is the aforementioned telling-of-her story, and

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[2]This expression arises in various hospital regulatory contexts and perhaps others. (See *Smith v. Selma Community Hospital*,164 Cal.App.4th 1478 (2008.).)

[3]Because they were not necessary to the result, the Arbitrator has not reviewed them.

there is nothing about that story which points inherently to malpractice.

Articulate and well-educated as she clearly is, claimant displays a complete lack of conceptual understanding of medical negligence (often referred to as "malpractice") in her view that, because a lot went wrong with her care and she was in great pain, there *must have been* malpractice. Certainly this is not an uncommon layperson's misunderstanding, but it is nothing close to being the law.

Does her story make one sorry Dr. , a cancer survivor, has suffered? Of course.

Does it raise questions about her care? Certainly.

But does it refute Dr. very specific opinion on that care? No.

Does it remotely bring forth evidence of a breach in the standard-of-care? No.

There is no need to rule on the Statute of Limitations issue, though it should be noted that claimant brings forth no authority in opposition to respondent's assertion of it. She vaguely argues her view of "accepted guidelines of the Statute of Limitations," (p. 15) without citing any legal authority.

Conclusion

This is a sad case. It concerns a clearly able human being who has suffered greatly, as, surely, her family has, too. No one has suggested that she has not had a terrible time with her medical condition in recent years.

The granting of the summary judgment motion - universally referred to in California cases as a "drastic remedy" - is this Arbitrator's unpleasant duty.

But that decision is not a "close call."

Notice: 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 30, 2014

Eric B. Younger
Judge of the Superior Court, Retired
Neutral Arbitrator