Arbitration Award

Instructions: The Neutral Arbitrator must serve the Award form on the parties and the within fifteen business days of the date of the closing of most arbitration hearings. (If there are three arbitrators, this Award must be signed by at least two of them.) See Rules 37 - 39.

Arbitration Name: **Arbitration Number: 14184**

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

An arbitration hearing was held on April 3, 4, & 5, 2017.

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

✓ The Claimant(s) is entitled to: $250,000.00.

Or:

____ The Respondent(s) is entitled to __________.

The hearing was conducted **(check one):**
✓ in person ____ by telephone ____ video conference ____ by documents only

Were attorney's fees awarded? ____ yes ✓ no
If yes, how much and to whom? __________

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

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

Carl West Anderson [signature]
The Honorable Carl West Anderson (Ret.)

4/27/17
Date

____
Signature of Party Arbitrator

Date

____
Signature of Party Arbitrator

Date

AWARD

Because most of the pertinent facts are not disputed and are well known to the parties and counsel they will be recited here only when critical to a finding or an expert opinion. This case is a classic battle of the experts. Whether is liable depends upon which expert is to be believed.

It should be noted at the outset that there were numerous allegations of improper record keeping throughout this arbitration, such as the following: using 5 year old templates, not omitting the use of "peribulbar anesthesia" from the Long Operative Notes (LON) template, etc. While indicative of "sloppy reporting," to quote Dr. , most of these mistakes did not result in any injury to Mr. , and require no further analysis. One, however, is troublesome. That is Dr. 's mention in the LON that "The chamber was filled with Viscoat" [Ex. 5: top of page 2]. Dr. noted that the "All Meds" Note does not mention "Viscoat," but does report that "Sodium Hyaluronate" (Helon) was administered for two minutes from 1700 to 1702 [Ex. 6: last page]. Dr. opined that Dr. should have used Viscoat, and he opined it was beneath the standard of care to use a less viscous medicine. Thus, if Dr. is to be believed, she should have done so. It appears from her note that she recognized that he is correct. If she asked for Viscoat, but was given Helon, and if Dr. is correct, would be at fault for not providing her with what she ordered.

The opinions of Claimant's Expert, Dr. and Respondent's expert, Dr. concerning whether Dr. 's treatment during and after the cataract surgery was either within or beneath the standard of care are diametrically opposed in several critical aspects. They contradict each other with regard to Dr. 's performance of each of the following: (1) appropriately securing the head before and during surgery; (2) use of the correct viscoelastic medication in placing the lens, i.e., Healon or Viscoat; (3) attempting to place the lens in the capsule, after it had been ruptured, instead of immediately attempting to place it in the sulcus; (4) failure at end of procedure to administer proper medication to prevent intraocular pressure (IOP) from spiking and to prevent inflammation of the cornea; (5) failure to give Mr. specific instructions concerning the complications and symptoms to be concerned about on discharge; and (6) failure to call Mr. the evening of surgery. The determination of which opinion is correct necessarily involves determining which expert has the most expertise in this particular area of ophthalmology practice. Both are Board Certified in Ophthalmology.

Dr. first opinion that Dr. treatment of Mr. failed to meet the standard of care to a reasonable medical probability was in her failure to properly secure his head for the surgery. Dr. "Long Operative Note" [Ex. 5] omitted any discussion of placement or taping of the head, but did record that when the lens was fractured into fragments, "...the patient got restless and kept lifting his head off the gourney (sic) a number of times." When asked at her deposition whose responsibility was it in this case to see that the patient is adequately secured so he can't move his head, Dr. responded "It's not a

responsibility that's assigned to anybody." [Depo: 34/11-12]. She testified likewise at the arbitration, but conceded that "I'm captain of the ship," "used paper tape to secure the head," "it's easy to come out of," "head positioning by myself or nurse," and "always have it secured."

Dr. 's "opinion No. 1" at deposition and at arbitration was that "Dr. didn't have him restrained in such manner to keep him safe during the surgery..." [Depo.: 35/16-17]. He explained that "...she did not adequately take responsibility to make sure that the head was sufficiently taped and restrained. Whether it be by multiple layers of paper tape or cloth tape or some other method. [Depo.: 38/23—39/2]. Because of this the capsule was ruptured, and lens fragments and ultimatey the IOL were lost to the posterior.

Dr. opined that not securing the head, or improperly using paper tape to do so, was not beneath the standard of care because it is "not possible to restrain" the head, and "I never tape head," and "I don't find it helps" on the table and finally, "there is no standard of care that head needs to be taped." His testimony was consistent with his deposition where he opined it was not beneath the standard of care to tape the head, "but certainly not below the standard of care to not tape the head with paper or whatever type of tape." [Depo.: 76/19-21]. Interestingly, when Dr. was asked what caused the posterior capsule rupture, he replied "From the operative report, it sounds like most likely the movement of the patient caused the posterior capsular rupture." [Depo.: 61/3-5]. Conversely, when asked that question in her deposition Dr. testified otherwise: "Sometimes as we are using the phacoemulsifier it —the energy runs across the posterior capsule and it causes it to rip." [Depo: 41/8-10].

Dr. 's testimony and curriculum vitae indicate he has performed between 5000 and 6000 of the same procedures which Dr. performed here—primary cataract removal and lens implant surgery. And he continues to impart his expertise to students at . Dr. , on the other hand, last performed this surgery during his residency, years ago, and now specializes in diseases of the retina. He testified that sometimes he does remove a cataract in his treatment of the retina. There is no question that Dr. is better qualified to testify concerning the duty to secure the head before surgery. Dr. 's demeanor in dismissing Dr. 's opinion with the remark that he, himself, never tapes the head (when he doesn't even do this kind of surgery) was almost flippant. It certainly renders his opinion with regard to standard of care less worthy of belief. Even Dr. when asked about whose responsibility it was to secure the patient, appeared to recognize the importance of doing so.

Dr. next criticized Dr. for not actually using Viscoat and "Her dictation also indicates that she only filled the chamber with the, quote, Viscoat, and it didn't list if she put anything in the actual capsular bag or sulcus. The standard of care would require you to use that material in the posterior aspect of the eye to protect and create a space to put that implant in safely." [Depo: 44/9—16]. He also criticized her for trying to place it in the capsular bag first. Dr. contradicted this opinion: "Again, there are problems with all of these techniques and one, most (sic) rely on the clinical judgment at the time and to say that to fail to

use Viscoat in that way in this case is a breach of the standard of care, I think is simply inaccurate." [Depo: 80/9—13]. Again, because of his greater familiarity with this procedure at this juncture Dr 's testimony is the more credible.

Dr. next opined that Dr. should not have attempted to place the lens in the capsular bag, because she knew at that point that the capsular bag was ruptured and probably not stable: "What's my experience with doing these procedures, the status of the capsule in general is such that I would believe a reasonably prudent ophthalmologist would go for a direct ciliary sulcus placement;" [Depo.: 49/22—50/1]. Dr. opined this was a matter of judgment and thus should not be criticized. There does not seem to be any harm to the patient by trying the capsular bag first, but the lens was lost in transferring it from the bag to the sulcus. No one specifically opined that losing the lens was below the standard of care. But, as set forth above, Dr. believed the failure to use Viscoat prevented Dr. from being able to retrieve the lens as it was falling into the posterior. Even Dr. conceded that using Viscoat "...it is possible that it would buy the surgeon a little bit of time to grab the falling lens." [Depo.: 804-6]. While Dr. did specifically say "the only cases I've heard of where it's lost is when someone would attempt to put it in a bag, so you shouldn't lose the lens if you put it properly in the sulcus," [Depo.: 50/17—20] he did not specifically opine that attempting to put it in the capsular bag was itself beneath the standard of care.

Dr. was, however, very critical of how Dr. handled the complications after nucleus pieces had fallen into the vitreous as well as the IOL. He further opined "...this type of complication is a red flag in a sense for increased intraocular pressure..." [Depo.: 51:16-17]. He explained that at this point in the surgery (after the complications have arisen) the surgeon's responsibility is to keep the eye stable, "And I didn't see that any measures at all were taken to do anything to try to keep the pressure from spiking to the level that it did. So, that's another opinion that the standard of care was violated." [Depo.: 53: 3-7]. He then listed the medications that should have been considered and administered, and concluded: "And I do believe to a reasonable degree of medical probability that the use of those medications would have been effective in keeping the pressure at least low enough that the cornea would not have had the degree of edema that prevented the retina doctor from doing a treatment on an urgent basis." [Depo.:53: 11-16].

Dr , on the other hand, when asked whether he agreed with Dr. that after the complications it was the duty of the surgeon to medicate the eye replied: "I disagree. I've honestly rarely seen that done." [Depo.: 84:8-9]. He made his opinion absolutely clear at hearing: "It is not the standard of care to administer them in a case such as this." Here again we have a clear difference of opinion between the experts, and we are getting closer to Dr. 's area of expertise. Dr. did agree that it was OK for Dr. to administer these medications on the next day, and although agreeing that lens fragments and the IOL entering the posterior could be a cause of a rise in IOP, he inferred that it didn't occur that quickly and they could actually lower the pressure, which would be as bad. He explained that "Typically, in

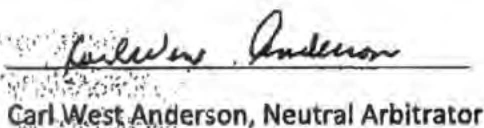
the immediate postoperative period, the eye is, to start with, not making much by way of aqueous and therefore arising (sic) intraocular pressure is not very common immediately." [Depo.: 85: 2-5]. The situation here refutes that opinion. Less than 24 hours after his release Mr. s IOP was 62. Apparently his eye did make much aqueous. He recognized as much when he testified "these medications can drop 15...his went to 62...no way to prevent it."

Dr. was also critical of other postoperative conduct such as Dr. s failure to advise Mr. specifically what happened during surgery, the danger of spikes in pressure, and the symptoms which should prompt him to call the hospital. He further criticized giving him the standard instruction sheet upon departure; it should have been tailored to the complications developed in his case. And Dr. opined it was the duty of the surgeon, especially in a case like this, to call the patient in the evening to check on his condition. These criticisms seem very reasonable.

In short, in the battle of the experts, Dr. opinions were more credible than those of Dr. . His qualifications are superior, his testimony was very impressive and well-reasoned, and his opinions that Dr. s performance of this surgery fell beneath the standard of care in several aspects is found to be true. These violations more probably than not prevented the IOL from being placed properly and caused Mr. 's eye to develop conditions which prevented the retinal specialist, Dr. , from performing reparative surgery to save the eye.

No evidence was introduced regarding economic damages, although Mr. may incur future medical expenses to relieve his eye pain. Only pain and suffering damages are sought, and limited by Civil Code Sec. 3333.2 to $250,000.00; that amount is sought. While actual damages far exceed that amount, because there is no comparative negligence on the part of Mr. actual damages need not be calculated and will be ordered to pay $250,000.00 to Mr. on account of its negligence in treating him. [Claimant and Counsel have signed the Waiver of Party Arbitrator Form, allowing an award in excess of $200,000.00.]. Both Claimant and Counsel having signed the Waiver of Objection to Payment of Fees, Respondent will be responsible for payment of all the Arbitrator's Fees.

April 26, 2017



Carl West Anderson, Neutral Arbitrator