Michael J. Bonesteel - Arbitrator
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IN THE MATTER OF ARBITRATION

Claimants,

v.

Respondents.

Arbitration No.: 11308

MEMORANDUM OF DECISION

Arbitrator: Michael J. Bonesteel

Case Filed: December 12, 2011

By agreement of the parties, the hearing of this matter has been bifurcated. Arbitration of the sole issue of negligence took place on July 29, 30 and 31 and August 1 and 4. The matter was then argued on August 15, 2014.

Claimant contends that Respondent is negligent in the following ways:

1. Respondent was negligent in the recommendation of a D&C and laparoscopy.

2. Defendant was negligent in his presentation with regard to the question of informed consent thereby vitiating the consent of claimant

3. Respondent Dr. was negligent in the manner in which he carried out the D&C and the laparoscopy.

4. Respondent Dr. was negligent in failing to order an inoperative pathological examination of the tissues removed from during the dilation and curettage in that, had he done so, he would have learned that there were no products of conception removed from Mrs. and he might have done further curettage to remove the products of conception.

During closing argument, claimant attorney withdrew the contention of Respondent's negligence in failing to use suction for the curettage.

During the hearing, although the issue is not the subject of evidence taken at the arbitration, Respondent's attorney withdrew his statute of limitations defense with regard to issues of wrongful birth and wrongful life. For any other issues, that defense continues.

I.

FINDINGS

The arbitrator finds that defendant Dr. was negligent in failing to consider all of the evidence available to him in making recommendation to claimant with regard to the necessity of a laparoscopy and D&C. Respondent Dr. was also negligent in his presentation to with regard to the obtaining of her informed consent. The Respondent Dr. was not negligent in the performance of the D&C or in the performance of the laparoscopy. The Respondent Dr. was not negligent in failing to obtain a frozen section or a STAT pathology report on the materials removed from Mrs. .

II.

DISCUSSION

Mrs. had her last menstrual period ending April 27, 2010. Thereafter, she used a home pregnancy test to determine that she was in fact pregnant. records Exhibits A 1, 2, 3 and 4 indicate that she went to the medical offices of Respondent on May 28, 2010 and was seen by , DO. He

took a history and reviewed her medical and surgical history as displayed on . His record indicates that the patient presented with tenderness in the right lower quadrant. He sent the patient to the laboratory and to for a STAT obstetrical ultrasound which showed mild free fluid in the pelvis, no intrauterine pregnancy, no obvious adnexal masses, appendix not seen. To ascertain what that meant, presumably, he spoke with the OB, Dr. who indicated to him that it was too early to see a gestational sac at the beta-HCG level less than 1,500. Dr. told him to repeat that level in two days. The level obtained at that time was 517.0. Two days later, further serum was collected at 12:20 p.m. That serum contained an HCG of 1,638.0. An ultrasound on that date showed a small gestational sac. No ectopic pregnancy was seen. No free fluid was seen. (Exhibit C-7) At that time, the patient was advised to repeat the ultrasound in seven to 10 days. She was apparently advised that the HCG was increasing appropriately. Record indicates the abdominal pain was improving. She returned again, this time to on June 1, 2010 where she was seen by Dr. . She presented with right lower quadrant pain which had started the Thursday before. It was a, "constant pinch", mild. At that time, Dr. indicated that he had reviewed medical/surgical, family and social history displayed in . His report on page C-9 contains the HCG levels from both the May 28 and May 30 HCG tests. Dr. progress notes indicated a threatened abortion as a primary and counter diagnosis. He indicated that the HCG had increased appropriately. He indicated that the patient had a history of pelvic pain in the past with a history of pelvic adhesions. He indicated that, should she develop heavy bleeding, severe pain or temperature greater than 101 she should go to the . Apparently, this report was contemporaneously available. The report indicates on Exhibit C-10 that the lab director: is . M.D.

There is no question that, on the morning of June 6, 2010, had severe abdominal pain in her home and contacted both her husband, who was at church, and her mother. Together, they took Mrs. to . There, she

was seen in the ER by , M.D. He ordered an ultrasound. That ultrasound indicates a single intrauterine gestational sac seen with a yolk sac and fetal pole. No cardiac activity was observed. The gestational sac was measured to a diameter of 1.75 cm corresponding to six weeks one day duration plus or minus three days. It was a tiny fetal pole measuring 2.5 mm corresponding to five weeks six days duration. There was no cardiac activity which was suggestive of embryonic demise.

A follow up beta-HCG and sonogram were suggested. Much has been made of the fact that all of this information was not available at the time that Dr. saw the patient. Presumably, the finding of a gestational sac, a yolk sac, and a fetal pole was available for review in the "quick and dirty" report sent to the ER. Dr. confirms this in his testimony and also in his deposition at page 126. Interestingly, at page 33 lines two through 24 of Volume I of his deposition, Dr. indicates that he does not recall that report locating a pole and sac when he advised Mr. and Mrs. with regard to his conclusions for the need for a D&C and a laparoscopy. At that page, he indicates that he does not know if the pole and sac were included in the handwritten version. Thereafter, at page 126 he says that they were. He confirms this again in Volume II of his deposition.

Presumably, a properly taken history of the patient on June 6, 2010 would have indicated that she had had HCG serum quantifications on May 28 and May 30, 2010. All doctors, with possible exception of Respondent Dr. , have indicated that results of these lab tests would have been available to Dr. on June 6, 2010. Further, these HCG results were contained in the June 1 report of Dr. which should have been available. If it was not available because it was Sunday, since there is no immediate threat to her health, according to Dr. , it seems that one could have waited until Monday morning to check on the HCG results. A simple graph of those results as done roughly by the arbitrator indicates that the HCG level from graphing those two points would have been expected to pass 15,000 on June 10. If anything, the doubling time was more rapid. This would not seem to indicate a falling HCG due to fetal demise.

With regard to history of Mrs. , he indicates that he did not have any information whether or not the pain had improved at the time he saw her. (Depo page 52). Mrs. indicated that her pain had improved. The emergency room doctor indicated that her pain had improved. One wonders whether Dr. took a history on this subject or not. He does indicate that when he saw her she was having bilateral pain. He does not indicate whether she had had right-sided pain followed by left-sided pain which was now bilateral. Nor do we know whether that would make any difference. He does indicate in his testimony as well as in his deposition (page 43) that she was not at risk when he saw her.

At page 38 and again at page 126 of the first deposition he indicates that the handwritten note said that the ultrasound showed a fetal pole, a yolk sac and no cardiac activity. If Dr. wanted to know whether this was an ectopic pregnancy, it would seem that he might find that out by calling the radiographer. There appears to be no reason why that could not be done.

With regard to informed consent, Dr. indicates that he did not recall any conversation with regard to the possibility of a viable fetus." He indicates that he does not recall this woman indicating that she did not want an abortion. He says at page 24/2 of Vol. II he did not know that he could have Statpath results within minutes to have an hour. He says that he had never done that with Dr. . Dr. disagrees. All this time, the witness repeats and repeats that he did not feel this patient was in dire distress. Yet, if she elected not to have the surgery, he would release her "AMA." Against medical advice means – according to Dr. – that the surgery had to be done. Despite not recalling a conversation that if there was a 1% chance that the baby was alive she did not want to have a D&C, the doctor does recall telling her that he did not believe in abortion either and that he was a practicing Catholic. In Vol. II, page 42/16-43, he reiterates that it was totally unknown whether a 3 day delay had risks but she was not at risk when he saw her.

The only thing he remembers about any conversation-presumably a history conversation-was that she told him that she had been in the office and had a positive

pregnancy test. Apparently he was totally unaware of the two prior ultrasounds. At page 30 of the second deposition he indicates that the handwritten note did not indicate the uterine yolk sac and fetal pole were present. This contradicts both page 38 of that deposition and page 126 of the prior deposition.

Dr. testified repeatedly that there was a greater than 50% chance of fetal demise than a less than fetal 50% chance that the fetus lived. Dr. indicated that, if Dr. indicated that there was no chance that the fetus lived, that was below the standard of care. He indicated that an HCG of 15,000 without a heartbeat is not necessarily indicative of fetal demise. He indicates that there was nothing life threatening to Mrs. on June 6, 2010. Dr. indicates that Dr. should never have recommended a D&C or a laparoscopy that day. He and Dr. apparently agree that there was no life threatening event that day.

Everyone other than Dr. would seem to agree that there was some chance based upon the information available on June 6, 2010 that this fetus was viable.

From the evidence, it does not appear that there is any question that Mrs. and her husband and her mother all thought that she had been told that the baby was dead and had to be removed. Dr. states that he told her that that was the case but that she could go home and wait but she would be back in four days and continue to have horrible pain. That does not sound like the possibilities of a normal pregnancy as of the afternoon of June 6 and that failure to fully inform Mrs. was negligent.

With regard to the contention that Dr. was negligent because he failed to do his curettage via suction, that the contention that that is negligent has been withdrawn.

With regard to the contention that Dr. was negligent failing to obtain an inoperative path report on the supposed products of conception, the arbitrator finds that the doctor's actions were not negligent. Dr. indicates that the tissue volume removed was roughly what you would expect to see at 6 weeks. She supports Dr. thoughts regarding a heterotrophic pregnancy because the HCG is at the high range of what you would expect to see at 6 weeks. Dr. testified that, had Dr. suspected from

his clinical experience that there might be a live pregnancy, follow up would have been appropriate. Apparently, he did not so suspect. Interestingly, Dr. testified that, if Dr. said there was no evidence of intrauterine pregnancy, he was being inaccurate.

Although this matter is not yet finished, 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: September 4, 2014

HAIGHT BROWN & BONESTEEL LLP

By: _____
Michael J. Bonesteel
Arbitrator

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IN THE MATTER OF ARBITRATION

Claimant, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Respondents.	Arbitration No.: 12697 **RULING ON RESPONDENTS' MOTION FOR SUMMARY JUDGMENT** Arbitrator: Michael J. Bonesteel Complaint Filed: January 11, 2014

The motion for summary judgment of Respondent Kaiser Foundation Health Plan, Inc. was heard on October 24, 2014. After telephone argument by both sides, the matter was submitted. Thereafter, claimant provided further information in writing. That information together with the claimants opposition to the motion was duly considered. At a further hearing on November 3, 2014, the motion for summary judgment was granted in its entirety. This matter is order to be dismissed.

The reasons for granting the motion are among others that the respondent's motion was complete. The curriculum vitae of indicates that he is a physician competent to testify in the areas in which he offered opinions. He indicated that he reviewed the entire medical record. He indicated that the prescription called Lipitor half the dosage at which it was prescribed was appropriate. He indicated that Lipitor is known to have an unusual if not rare complication of rhabeomyolysis. There is no

indication that the complication of the ingestion of Lipitor or any other statin is able to be tested for or predictable.

Claimant has no complaints about her care and treatment for the condition of rhabeomyolysis other than the fact that on admission to the hospital she was transferred to the second floor. Her complaint there is that the nurses did not give her a bedpan and did not have diaper pads for the problem of urinating. They apparently told her to urinate in the bed. As a registered nurse, she is confident to testify with regard to this problem. However, there appear to be no damages from any claim whatsoever. Additionally, there appears to be no indication that anyone was in anyway untruthful. This lasted for a very short period of time. Were it to be negligent in anyway, there are no damages falling from it.

Other than that particular testimony, claimant offers no testimony by any competent witness to challenge the conclusions of Claimant also indicates that she would not be offering any testimony by any physician were there to be an actual arbitration.

On several occasions, claimant has been urged to retain the services of an attorney. She has indicated that she has been unable to do so. She has not indicated that she has any intention of continuing to attempt to find an attorney.

Claimant agrees that she has fully recovered from the episode which took place on June 27, 2012 and from which she was discharged from the hospital on July 26, 2012. All evidence indicates that the prescription of Lipitor at the dosage at which it was prescribed was within the standard of care. There is no indication that any studies could have been undertaken to predict the rhabeomyolysis. There is no indication that any studies should have been undertaken during the time in which the claimant was taking Lipitor which would have indicated by laboratory studies that her health was failing.

Therefore, as stated above, for the reasons given, motion for summary judgment is granted. This matter is dismissed.

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

Dated: November 10, 2014 HAIGHT BROWN & BONESTEEL LLP

By:
Michael J. Bonesteel
Arbitrator

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IN THE MATTER OF ARBITRATION

, a minor, by and through her parents, and , and and , individually,,

Claimants,

v.

, M.D., , , and ,,

Respondents.

Arbitration No. 11308

THIRD *AMENDED* MEMORANDUM OF DECISION
PHASE II

This matter have been submitted to the arbitrator in several different theories on behalf of and her parents and . They are:

1. General negligence;
2. Negligent infliction of emotional distress (parents);
3. Wrongful life (parents);
4. Wrongful birth ( ); and
5. Failure to obtain informed consent.

The arbitrator has previously found that Dr. was negligent in failing to consider all of the evidence available to him in making recommendation to claimant with regard to the necessity of a laparoscopy and D&C. Respondent Dr. was also negligent in his presentation to with regard to the obtaining of her informed consent. The Respondent, Dr. , was not negligent in the performance of the D&C or in the performance of the laparoscopy. The Respondent, Dr. , was not negligent in failing to obtain a frozen section or a STAT pathology report on the materials removed from Mrs. .

Phase II of the arbitration is held to determine causation, liability if any, and damages, if any.

FINDINGS

The arbitrator finds that claimants, and each of them, have failed to prove that the negligence of the defendant was a legal cause of injury in damages to any of the plaintiffs.

Judgment is therefore for the defendant.

CAUSATION

Both claimants and defendant agree that, with regard to both general negligence and negligent infliction of emotional distress counts causation must be proven. the evidence for causation is insufficient and these causes of action fail.

Claimants urge that they need not shown legal cause under the causes of wrongful life, wrongful birth or lack of informed consent theories.

The Arbitrator disagrees:

1. As to lack of informed consent theories, the harm must have occurred because of the lack of informed consent. In other words, the doing of the procedure must have caused harm. Such harm has not been proven to a reasonable degree of medical probability.

2. With respect to wrongful life and wrongful birth, the use notes on CACI §§ 511 and 512 cite to *Gami v Mullikin Medical Center*, (1993) 18 Cal.App.4th 870 and particularly to page 877 regarding wrongful life actions:

"As in any medical malpractice action, the plaintiff must establish:

(1) The duty of the professional . . . ;

(2) A breach of that duty;

(3) A proximate caused connection between the negligent conduct and the resulting injury; and

(4) Actual loss or damage. . . ."

With regard to the wrongful birth cause of action, the language of CACI § 511 is to the affect that the abortion procedure was negligently performed. In the case at bench, it has been ruled that the performance itself was not negligent.

3. With regard to the finding of a lack of informed consent, claimant must prove that it was harmed by the result or risk that should have been explained before the procedure. Such causation has not been proven to a reasoned degree of medical probability.

DISCUSSION

The discussion hereinafter shall be limited to one of causation as it has been the sticking point for the arbitrator.

In that regard, claimants have offered the testimony of . Respondents have offered testimony from , , , , and to some extent other doctors. These witnesses, not surprisingly, disagree with Dr. assessment of causation as well as the nature and extent of 's problems.

Dr. is a well-known, well qualified pediatric neurologist. For the last 20 years or so, he has testified almost exclusively for plaintiffs. He is specially qualified in neuroradiology and has used the CT scans and MRI's from July 1, 2011 and July 13, 2011 and from radiology on February 20, 2015. These studies are apparently all read as normal by the radiologist who undertook them. They are also read as normal by Dr. . Dr. who indicates that those are very subtle changes not discernable by most experts.

He further opines that those changes constitute an organic injury to the brain. He indicates that the existence of such an injury is supported by the neuropsychological test chart of both Dr. and Dr. . Dr. says that neuropsychologists give opinions but do not diagnose. She believes that there is no way to tell whether will be limited in the future as her frontal lobes are still developing.

Dr. says the imaging studies appear normal. Minor asymmetries are within their normal limits. There is nothing pathologic.

Presuming that this frontal lobe problem exists in such a subtle way, no one, including Dr. has explained how something so subtle could have arisen from trauma occurring at 5 weeks/5 days.

Dr. found it "consistent" but did not testify as to causation here to a reasonable medical probability.

He finds hypotonia comparable with an acquired event. No other treator or expert describes hypotonia.

He says that his reasoning is inductive and mechanistic – a combination usually described at the bottom up method of scientific inquiry. It can be hypothesis raising but not hypothesis solving.

He does not go into the origins of the spinal cord injuries. Dr. , who appears from his C.V. and testimony to have a concentration in this area says that these injuries are essentially always genetic.

Each of the defense experts disagrees with Dr. 's analysis. They opine that, from the approach of genetics (2), obstetrics, and neurology one would expect that, if there is trauma from a failed D&C at this gestational age, there would be an all or nothing result. That a failed therapeutic abortion can result in no injury is shown by a reading of *Stills v Gratton*, 55 Cal.App.3d 698. (cited in the source notes for CACI 511). It is also shown in Exhibits 201, 202, and 203. In No. 203, two infants are well after failed first trimester D&C's. In Nos. 201 and 202 reports an arthrogryposis from failed terminations of pregnancies. All of these D&C's were done at a later stage of pregnancy. She reports that 67% of studied failed D&C's were 5-8 weeks or fetal age 7-10 week gestational. Only one was born and it was fine. She also opines that, if there is going to be difficulty, one would expect a lack of fetal movement. There is none reported here or at least non brought to the attention of the arbitrator.

There is no basis shown for postulating hypoxia or dehydration from the D&C as a caused effect.

In her other paper, Exhibit No. 2002, had accumulated 2500 cases of agrogryposis with 11 cases of failed therapeutic abortion all at between 7-14 weeks gestation – far later than the case at bench.

Dr. appears to be an expert in Klippel-Feil and Wildervranck phenomina for which a gene is not yet isolated. She indicates that they are to a reasonable medical probability genetic and that this child has some variant thereof. She also says that all the sonograms suggest a normally developing fetus. At the stage of 's development when the D&C was performed the brain is just cleaving into two hemispheres. Subtle injuries just to not make sense.

Dr. , an expert on spinal segmental injuries indicates that they are invariably genetic. Interestingly, Dr. , who has done a literature search, finds no segmental or scoliosis problems is any failed therapeutic abortion reports. Dr. opines that 's pattern fits a genetic disorder.

All defense experts indicate that the type of infection which causes birth defects is viral infection not bacterial. This would be an all or nothing situation for a developing fetus.

Dr. indicates, to a reasonable medical probability, that 's problems are not caused by the failed D&C. With a structure this size, any mechanical, infections or hypoxic event would be expected to cause more pervasive damage. None of those fit with the segmental injuries.

It is the conclusion of the arbitrator that claimants have failed to establish causation to a reasonable medical probability.

This matter is now closed.

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, 2015

HAIGHT BROWN & BONESTEEL LLP

By: _____
Michael J. Bonesteel
Arbitrator

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: 15027**

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

~~An arbitration hearing was held on~~ A hearing re Respondent's Motion for Summary Judgment was heard on July 25, 2018

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

____ The Claimant(s) is entitled to _____.

Or:

__✓__ The Respondent(s) is entitled to Summary Judgment.

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.

Michael J. Bonesteel Esq. Date August 4, 2018

_____ _____

Signature of Party Arbitrator Date

_____ _____

Signature of Party Arbitrator Date

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August 6, 2018

Re: vs. Arbitration No. 15027

Respondent's Motion for Summary Judgment came on regularly to be heard on July 25, 2018. Claimants appeared In Propria Persona and respondents were represented by The motion was made on basically two grounds: first, that the matter was not brought within the applicable Statue of Limitations and second, that there was no evidence of any negligence by any respondent. Turning first to the argument regarding the Statue of Limitations, claimants' child was born on March 17, 2015 and died at respondent's facility on March 18, 2015. The demand for Arbitration wasn't filed until September 1, 2017. Shortly after the death, at the request of the family, an autopsy was performed at the facility. For reasons not disclosed, the autopsy report was not prepared until December 5, 2015. Claimants are unsure when they first saw it, but Mr. spoke to the autopsy physician in January of 2016. He confirms that he was told that he should contact a neonatologist if he sought further information. This conversation, if there were any question at that time, would most certainly have placed the claimants on inquiry notice and started the running of the Statue of Limitations. Yet, no action was undertaken until the filing of the arbitration demand in September of 2017, more than a year later. No reason for the delay is given. By any calculation, the time for bringing this case was long passed. The claim must be dismissed as untimely. This decision ends this litigation. The claim is dismissed. The other grounds for the motion are moot. That part of the motion is ordered off calendar. The motion is granted as to the failure to file within the time allowed by the Statue of Limitations.

Michael J. Bonesteel, Arbitrator

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IN RE: ARBRITRATION

15209 RE: AMENDED ORDER OF DISMISSAL AFTER HEARING OF ORDER TO SHOW CAUSE RE: DISMISSAL

, individually and successor and heir of , deceased,
Claimant,
vs. , a business entity form unknown: and , a business entity form unknown;
and Does 1 through 50, inclusive,
Respondents.

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

The OSC Re: Dismissal set by the Arbitrator came on regularly for hearing on November 1, 2019 at 9:00 a.m. and of appeared on behalf of respondents. There was no appearance by claimant, , despite being served with a copy of the OSC Re: dismissal. Claimant was further advised of the call-in phone number by both the arbitrator and respondent.

After full consideration, the Arbitrator finds the following:

1. The Claimant has taken no steps to move this matter toward hearing since her counsel was relieved as counsel 90 days ago.
2. Claimant did not appear for the hearing of her counsel's motion to be relieved.
3. Claimant was advised of the ruling on that motion and of the potential of dismissal.
4. Nothing was done.
5. Claimant was advised of the pendency of the OSC Re: dismissal.
6. Claimant chose not to appear.
7. Therefore: This matter is dismissed with prejudice and is now concluded.

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

November 17, 2019 Michael J. Bonesteel, Arbitrator