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Arbitrator

IN THE MATTER OF BINDING ARBITRATION

BETWEEN

Claimants,	**ARBITRATION AWARD**
vs.	Judicate West No. A189405-3 Arbitration No. 12249
Respondents.	

This is a binding arbitration between the Claimants, and , and the Respondents, and , based upon claims of medical negligence or medical malpractice asserted by the Claimants against the Respondents. The matter was arbitrated before the undersigned as the agreed upon Arbitrator from August 11 to August 15, 2014, and from August 18 to August 22, 2014. During the Arbitration Hearing, the Claimants were represented by attorney and the Respondents were represented by attorneys, and .

At the Arbitration Hearing, the following individuals were sworn and testified: ; , M.D.; ; , M.D.; ; ;

1 , PhD; , PhD; , RN;

2 , PhD; , M.D.; , PhD; , CPA; ;

3 , M.D.; , Sr.; , PhD and AuD; , M.D.;

4 , PhD; , M.D.; , M.D.; , M.D.;

5 , M.D.; , R.N.; and , J.D., CPA. also

6 testified via an offer of proof authenticating emails obtained from computer at his

7 former employer, . At the conclusion of the hearing, all counsel reviewed all the

8 documentary evidence offered during the hearing and stipulated to the admissibility of various Exhibits

9 left with the Arbitrator. The Arbitrator now renders his award as hereinafter set forth.

10 The subject of this Arbitration is certain medical care and treatment Claimant,

11 (hereinafter,) received from Respondents (hereinafter,) during the period from July 29,

12 2011, through September 9, 2011. contends that was negligent in their care and treatment

13 of an ear infections suffered shortly before July 29, 2011, resulting in his becoming infected with

14 "strep-pneumonia bacteria, which in turn infected the honeycombed, bony structure adjacent to the

15 middle ear known as the mastoid, which eroded to the point that the infection breached the skull and, in

16 turn, released strep-pneumonia bacteria into his brain, causing a meningitis infection" which left him

17 severely brain damaged or impaired. (Quoted from Claimant's Arbitration Brief). wife,

18 (hereinafter,) alleges a claim for loss of consortium as a result of the brain injury

19 suffered as set forth above. denies Claimant's contention and contends that they were not

20 negligent in the care and treatment of .

21 testified that shortly before July 29, 2011, he attended a business convention in Atlanta,

22 Georgia, and that during the flight to Atlanta his left ear began to hurt. He further testified that he called

23 his wife and had her arrange an appointment for him with a doctor at upon his return from

24 Atlanta. The medical records indicate that saw doctors at on July 29, 2011; August 10,

25 2011; August 24, 2011; and September 9, 2011, for his left ear problem. These visits are as set forth

26 below.

27 According to the medical records, saw , M.D. on July 29, 2011. Dr.

28 chart notes (Exhibit 1) indicate the reason for visit was "left ear pain x 5 day". The

1 notes further indicate that told Dr. that he had gone "on a trip to Atlanta by plane and
2 just returned with severe pain in his left ear, started after swimming 5 days ago. Patient cannot hear
3 from his left ear." According to Dr. testimony and his chart notes he physically examined
4 and noted "Left ear: There is tenderness. A foreign body is present. Erythema, cerumen
5 impaction, exostosis of the external auditory canal pain on pulling the pinna." Except as noted above
6 Dr. physical exam was basically normal. Dr. assessment was "OTITIS
7 EXTERNA". Following his exam, Dr. issued the following orders, "PERFORM EAR
8 WASH - Premed with auralgan if possible" and prescribed the following medications: "Neomycin-
9 Polymyxin (CORTISPORIN); Antipyrine-Benzocaine (AURAL GAN/AUROTO); Cephalexin
10 (KEFLEX); and VICODIN". Dr. chart notes that he told to contact him in 2-3 weeks
11 if not better and that he should follow up or call if he is worse in 2-3 days with Dr. or
12 "available provider, or urgent care". testified that he does not recall Dr. telling him the
13 foregoing. also testified that at the time of his visit with Dr. he was "having balance
14 issues" but he believes he did not tell Dr. about them.
15 next saw Dr. on August 10, 2011, (Exhibit 3) and noted "persistent ear pain,
16 hearing decreased on Lt ear since end of July, not improving with cortisporin otic, keflex, worsening
17 symptoms, travels by plane recent." Dr. examined and noted "He is oriented to person,
18 place, and time and well-developed, well-nourished, and in no distress. No distress". Dr.
19 continued his diagnosis of OTITIS EXTERNA and changed medications, including adding
20 prednisone, and issued orders for an INSERTION OF EAR WICK, and CULTURE, NON STERILE
21 SITE. It is noted that one of the medications Dr. prescribed was for Mucus Relief Sinus
22 which the testimony indicated was to address any middle ear problems.
23 On August 24, 2011, returned to where he was seen by ,
24 M.D., who was a physician resident at the time. Dr. noted in her chart notes that "
25 is a 49 year old male who developed otalgia and decreased hearing a month ago following
26 swimming and surfing. Also flew to Atlanta. Developed dysequilibrium as well. Was treated with
27 keflex and topical drops. Did not follow dry ear precautions, but stopped surfing. Would try to remove
28 ear drops with Kleenex so they wouldn't drain out. Currently has pulsatile tinnitus and decreased

1 hearing in his left ear. No vertigo or otorrhea other than drops. No prior ear surgeries. Has known
2 exostoses, but no prior ear infections. Has known septal perforation - history of recreational drug use
3 and trauma in college. Asymptomatic." (Exhibit 4). It appears Dr. physical examined and
4 noted "No acute distress". She also noted "No fever or chills." The notes also indicate that she used an
5 otomicroscope to examine left ear and she observed that it was "75% occluded by exostoses
6 circumferentially. Edema and erythema. White drop debris suctioned. Tympanic membrane barely
7 visible centrally. Not mobile with Valsalva, but slightly mobile with pneumotoscopy." Dr.
8 assessment was that had otitis externa, possibly otitis media and she counseled him on proper dry
9 ear precaution and drop administration. She prescribed Ciprodex drops for 2 weeks and told him to
10 return in 3 weeks for an audiogram. (Exhibit 4).
11 On the morning of September 9, 2011, went to the
12 where he was given an audiogram test administered by Audiologist, , PhD,
13 AuD. Upon the conclusion of the test Dr. impression was: "AD: normal hearing; AS: normal
14 to severe mixed hearing loss." (Exhibit 5) Dr. testified that prior to administering the test she
15 looked in both of ears with an otomicroscope and he did not complain of any ear pain. She also
16 testified she performed a bone conduction test on mastoid bone and that his mastoid transmitted
17 sound to his inner ear through the mastoid bone. She further testified that when she examined
18 left ear, his ear drum did appear to be "moving in and out".
19 Later on September 9, 2011, saw Dr. again for a second time (Exhibit 6).
20 , who is mother, testified that she drove her son to his afternoon appointment with Dr.
21 . Dr. noted that told her "His hearing slightly improved, but a week ago he
22 developed severe rotatory vertigo that lasted for 24 hours. Nausea but no vomiting. Started getting
23 better after 24 hours. Has constant dysequilibrium now." She also noted on physical exam that
24 was in "No acute distress" and that when she examined left ear under otomicrospope she
25 observed "80% occluding exostoses, No otorrhea. TM visible through central slit in exostoses. Mobile
26 with pneumatic otoscopy. No effusion. No vertigo with pneumatic otoscopy. Fistula test negative. No
27 nystagmus" She then prescribed a "trial of Prednisone" and some other medications.
28

, M.D. testified that Dr. contacted him on September 9th to discuss case. He testified that based upon the information Dr. gave him, he did not believe had any sign of an "acute" infection. As is stated in the chart notes for the September 9th visit (Exhibit 6) he understood was in no "acute" distress, that the Fistula test was negative and had no nystagmus, all of which, together with the other information Dr. gave him indicated that did not have an inner ear infection.

, who is wife, testified that she tried to wake up in the morning of September 14, 2011, so he could go to work, but was unable to wake him. She further testified that she initially tried to reach mother but was unable to do so and then called her sister-in-law who told her to call 911, which she did. According to her testimony, was transported by ambulance to . was admitted to on September 14, 2011, where after a number of tests were performed, he was diagnosed with "Acute bacterial meningitis" and transferred to the intensive care unit (Exhibit 8). The Arbitrator notes that in Exhibit 10 there is a notation of "No history of alcohol or illicit drug abuse", which as testified to by at the Arbitration Hearing appears to be incorrect.

According to the medical records (Exhibit 12) surgery was performed on on September 14, 2011, resulting in a postoperative diagnosis of: "Acute left otomastoiditis, and Meningitis". remained at for treatment until September 21, 2011, when he was transferred to at the request of (Exhibit 21). The transfer notes state that "Clearly at this time, the patient appears to be significantly improved, although he is still felt to be critically ill" (Exhibit 21). While at was examined by a number of doctors and administered a series of tests (Exhibits 27, 28, 29, 30, 31, 32, 36, and 37). Subsequently, was transferred to the for further treatment on October 4, 2011 (Exhibit 49), and then transferred again to the , also known as on October 21, 2011 (Exhibit 47). was discharged home from on November 5, 2011 (Exhibit 49) and ultimately discharged from any further care from on January 18, 2012 (Exhibit 54).

and both testified that prior to his contracting meningitis he had been working for his father at earning a substantial income. They also both testified that was off

work from shortly before September 14, 2011, until January 2012, when he went back to work for his father. , and all testified that employment with was terminated in March 2013. , who is brother, and both testified that went to work for a company partially owned and run by in March or April, 2013, essentially doing the same kind of job he had been doing at also testified that he is still working at however, his brother is providing him with assistance from other individuals concerning his job duties.

The Arbitrator believes that all of the foregoing fairly accurately sets forth the chain of events that transpired between July 29, 2011, and the present time and which form the basis of this litigation. As set forth in the third paragraph of this award, Claimant's contend that negligent care and treatment of during the period in question caused him to develop meningitis and his resultant brain issues. The Arbitrator believes that all the evidence clearly indicates that has suffered some mental impairment as a result of the meningitis. There may be some disagreement between the parties concerning the nature and extent of that impairment, but it is clear that it exists to at least some extent. The Arbitrator will now address the issues of liability, causation and damages in the balance of this award.

California law is clear that the Claimants have the burden of proof to prove that was negligent in their care and treatment of medical condition, that is that their conduct fell below the "standard of care" and that such negligence caused harm to for which he is entitled to compensation according to proof. In determining whether Claimant's burden has been met, California law provides, among other things that:

> "A medical practitioner is negligent if he or she fails to use the level of skill, knowledge, and care in diagnosis and treatment that another reasonably careful medical practitioner would use in the same or similar circumstances. This level of skill, knowledge and care is sometimes referred to as the "standard of care."
>
> CACI 501

The law further requires that the standard of care be based solely on the testimony of expert witnesses. CACI 501 states:

"He must determine a level of skill, knowledge, and care that other reasonably careful medical practitioners would use in the same or similar circumstances, based only on the testimony of the expert witnesses who have testified in this case."

CACI 505 tells us:

"A medical practitioner 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. A medical practitioner is negligent only if he or she was not as skillful, knowledgeable, or careful as other reasonable medical practitioners would have been in similar circumstances."

Lastly, CACI 506 provides that:

"A medical practitioner is not necessarily negligent 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."

With the foregoing in mind, let us look at the testimony of the various experts who have testified in this case.

, M.D., who is Board Certified in otolargngology and head and neck surgery, and who also performs cosmetic plastic surgery on patients, testified on behalf of the Claimants' on the issue of Standard of Care. Dr. offered opinions that both , M..D.'s and , M.D.'s care and treatment of fell below the standard of care. As to Dr. , Dr. opined that his care and treatment fell below the standard of care because the chart notes (Exhibit 1) had a "prompt" indicating that was in a "pneumococcal high risk group" and that Dr. should have addressed that issue, including determining whether the pneumococcal vaccine should have been given to at the July 29, 2011, visit. Dr. also opined that he believed Dr. misdiagnosed ear problem. Dr. opined that he believed had Otitis Media on his first visit not Otitis Externa as Dr. diagnosed but he did not seem to indicate what more Dr.

1 should have done since he testified that ordering an "ear wash" as Dr. did was
2 within the standard of care as was prescribing Keflex for (although Dr. said may not
3 have been the best antibiotic to give, he did opine that using it was not below the standard of care).
4 Presumably, Dr. would have had the same complaint regarding the failure to address the
5 "pneumococcal high risk" prompt on second visit with Dr. on August 10,2011
6 (Exhibit 3), although Dr. did not raise that issue in his testimony concerning the August 10th
7 visit.

8 Dr. had several opinions regarding Br. care and treatment of , beginning
9 with her first visit with him on August 24, 2011 (Exhibit 4). He opined that symptoms on that
10 date were consistent with an inner ear problem, not otitis externa. For example, he sites references to
11 currently having "pulsatile tinnitus" and "dysequilibrium" which he contends are inconsistent with
12 otitis externa but are consistent with an inner ear infection. Based upon the foregoing, Dr. opined
13 that Dr. fell below the standard of care in not ordering a CT Scan of ear on that date and
14 or at a minimum prescribing antibiotics and directing him to come back in a week. Dr. opined
15 that had a CT Scan been ordered it would have shown fluid in the inner ear and in the mastoid which
16 would dictate "aggressive antibiotic treatment". Dr. was also critical of Dr.
17 recommended treatment on August 24th in that he opined the recommended treatment only treated the
18 outer ear (i.e. otitis externa), not the middle ear where he believed the problem lay. In support of his
19 position he cited the portion of Dr. chart notes where she reported that the left ear was
20 examined "under otomicroscope" and found that the "tympanic membrane barely visible .... not mobile
21 with valsalva, but slightly mobile with pneumotoscope" which he believed meant there was a problem in
22 the inner ear, not the outer ear.

23 Dr. opined that Dr. continued treatment of during his visit with her on
24 September 9, 2011 also fell below the standard of care. He opined that Dr. did not perform a
25 "thorough exam" of ear on that date and had she done so the standard of care would require her
26 to order a CT Scan and to hospitalize , neither of which happened on that date. Dr. further
27 testified that in his opinion the destruction of mastoid near the left ear had been going on for
28 several weeks. He believed that there was fluid in mastoid on September 9th and also probably

on August 24th and that a CT Scan performed on either of those dates would have shown the fluid which in turn would have dictated, as set forth above, an aggressive treatment with antibiotics. Dr. opined that had such a course of treatment been undertaken on either of those dates, would not have developed meningitis.

Dr. testified that after seeing on September 9th, she spoke to , M.D., who was her "attending physician" about condition, but she disagreed with Dr. diagnosis. Dr. opined that Dr. was not in a position to offer any diagnosis since he did not see the patient, however, Dr. did not opine that speaking to Dr. fell below the standard of care.

In summary, it appeared to the Arbitrator that Dr. believed both Dr. and Dr. misdiagnosed ear problem and failed to properly treat it, including ordering a CT Scan, all of which were below the standard of care.

, M.D., who is an infectious disease physician, testified on behalf of the Claimants'. Dr. opined that at some point it was "more likely than not" that mastoid bone became infected leading to mastoiditis which in turn lead to meningitis. He further opined that bacterial meningitis progresses rapidly and that it probably started on September 13, 2011. He also opined that giving a patient an antibiotic could help in such a situation, however, he could not say with any certainty if there was sufficient evidence in this case to have given it to following his September 9th visit with Dr. . Dr. did testify on cross examination that there was some doubt as to exactly what was going on with left ear on September 9th and that his belief may have had mastoiditis on September 9th is based upon "looking back", i.e. looking at the evidence after the fact. While the Arbitrator believes Dr. was an "honest" witness it is noted that in many of his opinions and comments he used words like "possibly", "probably", "maybe" and "may" all of which cause some concern whether those opinions or beliefs rise to the level of proof necessary in a medical malpractice action.

, M.D., who is a Board Certified Internal Medicine physician, testified on behalf of and opined that Dr. care and treatment of on the July 29, 2011 visit met the standard of care and that Dr. was not in any way negligent in his care and

1 treatment of on that date. She further opined that the standard of care did not require Dr.
2 to give the pneumococcal vaccine on July 29, 2011, and in fact if did have some
3 kind of ear infection whether it be otitis externa or otitis media giving the vaccine to would have
4 been contraindicated since it potentially could make the condition worse. She stated that you simply do
5 not give vaccine to someone who may already be sick; you give it before they get sick. She agreed with
6 Dr. that ordering the ear wash was not below the standard of care. She also agreed with Dr.
7 that prescribing an antibiotic on the July 29th visit was appropriate and not below the standard of
8 care.
9 Referencing the August 10th visit, Dr. again testified that Dr. care and
10 treatment of did not fall below the standard of care. According to her, had normal vital
11 signs on that date and there was no evidence of any serious illness. In addressing the pneumococcal
12 vaccine issue again, Dr. opined again that the standard of care did not require Dr. to
13 administer the vaccine at that time for all the same reasons she stated concerning the July 29th visit. She
14 also noted that when was offered the vaccine on September 9th, he refused or declined to have it
15 administered to him. The Arbitrator believes it is reasonable to assume that if refused the vaccine
16 on September 9th, he would have refused it on any of his prior visits to referenced in this award.
17 As to both visits with Dr. , that is the one on July 29th and again on August 10th, Dr.
18 opined that there was no reason to believe had otitis media, as Dr. believed,
19 based upon his vital signs. She also stated that otitis media is uncommon in adults, you usually see it in
20 children.
21 , M.D., who is Board Certified in otolaryngology and head and neck surgery and
22 who is Chairman of the Head and Neck
23 Department, testified on behalf of concerning the standard of care. Prior to his testimony, Dr.
24 reviewed all of the medical records at issue in the case and reviewed depositions of the various
25 parties and other witnesses. Dr. testified that mastoiditis is extremely rare today due to the
26 wide use of antibiotics. He further testified that those individuals who do get mastoiditis are usually
27 very sick, have high fevers, lots of ear pain with redness and swelling behind the ear, nausea and
28 vomiting, and puss draining from the ear. Dr. opined that had pneumococcal disease

1 which in turn caused the mastoiditis. He further opined that this process occurred over a 48 to 72 hour
2 time period prior to admission to on September 14, 2011.
3 Dr. went on to opine that both Drs. and complied with the standard of
4 care at all times when they were treating . He further believed that did not have a
5 pneumococcal infection on September 9, 2011. He testified that Dr. diagnosis on August 24th
6 of otitis externa was consistent with the symptoms had on that date. He believed did not
7 have otitis media on that date, as testified to by Dr. , because ear drum was slightly
8 mobile, while if he had had otitis media it would not have been mobile. Dr. further disagreed
9 with Dr. that Dr. should have thought about "mastoiditis" on her August 24th visit with
10 because he, according to Dr. , did not have any symptoms of mastoiditis at that time. He
11 noted that based on the chart notes was not in "acute distress" at that time nor was there any
12 evidence of redness or swelling behind left ear and he was not in "great pain", all of which are
13 symptoms he would have had if he had mastoiditis at that time.
14 As noted above, Dr. had opined that a CT Scan should have been ordered for
15 following the September 9th visit, or following any of his earlier visits at . Dr. disagreed
16 with Dr. opinion on the basis that did not have any of the signs or symptoms on those
17 visits which would have indicated a need for a CT Scan. Dr. also testified that he believed
18 had an active infection in his mastoid on September 9th. Dr. testified that this contention is
19 "impossible" because if he did he would have been extremely sick, have a temperature of 104 plus,
20 might not be conscience, would not be able to walk or stand and would have a "dead" ear. Dr.
21 believed that none of these symptoms were present on September 9th. He further opined that
22 developed a pneumococcal infection within 24 to 72 hours prior to September 14th which caused
23 to develop mastoiditis which in turn caused his meningitis. In support of his theory, Dr.
24 pointed to the fact that went to Legoland with his family on either September 11th or 12th and if
25 he had been as sick as Dr. believes at that time he simply would not have been able to go with the
26 family.
27 In further support of his opinions, Dr. refers to the CT Scan taken of left ear area
28 on September 14, 2011, (Exhibit 102) which he testified showed some of the air cells in the mastoid are

1 "intact" and not completely eroded away as Dr. believed. In Dr. opinion this CT Scan
2 shows a "very acute situation" not something going on over a long period of time as opined by Dr.
3 . Dr. also sites to the pathology report (Exhibit 116) which shows that had
4 "pneumococcal disease" which developed over a 24 to 72 hour period, not something that "brewed or
5 simmered" for several days or weeks as Dr. opined. In summary, Dr. opined that Dr.
6 "time line" as to what happened to and how he wound up with meningitis just "doesn't
7 work" for the reasons set forth above.
8 Dr. was critical of Dr. for not reviewing medical chart before the
9 September 9th visit, in fact he opined that Dr. breached the standard of care in not doing so,
10 however, he further opined that this breach had no bearing on the outcome of this case.
11 , M.D., who specializes in Internal Medicine and Infectious Diseases and who
12 is Board Certified in those areas, testified on behalf of . She opined that no one at
13 breached the standard of care regarding not administering a pneumococcal vaccine to on any of
14 the visits in question because the standard of care does not require or mandate the administration of the
15 vaccine to someone like , it is only a recommendation. She further opined that in this case
16 administering the vaccine may very well have been contraindicated because if in fact had some
17 kind of infection when he went to , the vaccine could have made the condition worse, for the
18 reason that you don't give someone who is already sick the vaccine. Dr. further opined and
19 agreed with Dr. that pneumococcal infection started after his last visit with Dr.
20 on September 9th. She also believed he did not have otitis media before September 9th. Dr.
21 also considered the fact that went to Legoland a day or two after September 9th, which he would
22 not have been able to do if he had a pneumococcal infection at that time.
23 medical experts also raised an issue concerning the prescribing of prednisone back on
24 August 10th by Dr. , which in their opinion, might have suppressed his immune system further
25 causing the later problems with ear. Dr. and Dr. testified that they did not
26 believe based on the dose of prednisone given to , that it would have in any way suppressed his
27 immune system.
28

Let us now turn the initial question: Were any of the Respondents negligent in their care and treatment of starting with his visit with Dr. on July 29, 2011, and ending with his visit with Dr. on September 9, 2011? After a very careful review and consideration of all of the evidence received in this Arbitration, and after considering the applicable law as set forth above, the Arbitrator, reluctantly, finds that the Claimants' have not met their burden of proof as to the foregoing question for the reasons hereinafter set forth.

First, as set forth in CACI 501, we must look to the testimony of the experts who testified on each side in this matter to determine whether or not any of physicians breached the applicable standard of care concerning their care and treatment of . Drs. and testified on behalf of the Claimants that did breach the applicable standard of care and therefore they were negligent in the care and treatment of . Drs. , , and testified that none of physicians breached the applicable standard of care and that it was not negligent in its care and treatment of .

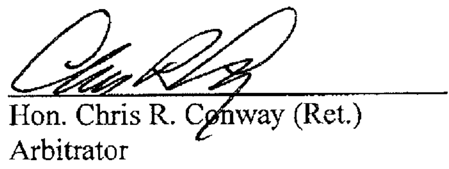
In reviewing Dr. testimony concerning Dr. it appears his main criticisms were that: Dr. failed to address an issue of whether he should have either discussed or administered a pneumococcal vaccine to on the visit of July 29, 2011: that he (Dr.) had misdiagnosed illness, calling it "otitis externa" when in fact it was "otitis media": and that Dr. should have ordered a CT Scan or given antibiotics and have him come back in a week. The Arbitrator notes that Dr. did prescribe an antibiotic for on the July 29th visit. The Arbitrator found Dr. testimony as to any negligence or breach of the standard of care by Dr. to be somewhat confusing or unclear. Dr. commented on the fact that he did not feel Dr. was in any position to offer a diagnoses as to since he didn't see the patient. It is unclear if Dr. is saying that in talking to Dr. , Dr. was somehow negligent or did he just make his remark as a general comment? It does not appear to the Arbitrator that Dr. comments regarding Dr. rise to the level of saying he breached the standard of care in some regard and therefore was negligent. Lastly, most of Dr. criticism seemed directed toward Dr. for failing to properly treat illness and for failing to order a CT Scan.

1 As to Dr. , the Arbitrator finds that the Claimants have not met their burden of proof
2 concerning any negligence on his part. The greater weight of the evidence shows that administering a
3 pneumococcal vaccine to someone like is not mandatory and failure to do so does not breach the
4 applicable standard of care. The Arbitrator further notes, as set forth above, that was offered the
5 vaccine on September 9th and refused to have it given to him. It is reasonable to assume that since he
6 declined the vaccine on September 9th he would have declined it if offered earlier. The Arbitrator finds
7 Dr. to be the more creditable witness concerning any issue related to an "alleged" failure to
8 make a proper diagnosis on the part of Dr. as to on either July 29th or August 10th. Dr.
9 testified that there was no breach by Dr. of the standard of care in treating
10 With regard to Dr. , the Arbitrator again finds that the Claimants' have not met their
11 burden of proof concerning any negligence on her part. When weighing the testimony of Dr.
12 against that of Dr. , and to some extent that of Dr. , the Arbitrator believes the sequence
13 of events as set forth by Dr. is the more reasonable and creditable. The Arbitrator set forth
14 above in greater detail the testimony of Dr. and that of Dr. , including where they
15 differed from that of Dr. , and does not feel it necessary to do so again. The greater weight of the
16 evidence indicates that the pneumococcal infection which had on September 14th did not develop
17 until sometime after September 9th, which was the last time he saw any of the physicians.
18 In conclusion, the Arbitrator wishes the Claimants to know that this was a very difficult case to
19 decide. The Arbitrator has a great deal of empathy and sympathy for Mr. and Mrs. , however,
20 as all the attorneys know empathy and sympathy cannot form the basis of any decision in this matter.
21 The Arbitrator spent countless hours reviewing all the evidence, both oral and documentary, before
22 arriving at his decision after much thought and deliberation. The Arbitrator also wishes to compliment
23 all counsel. The Arbitrator believes that the case was tried in a very professional and ethical fashion,
24 which unfortunately does not always happen. All counsel were well prepared and courteous to each
25 other, which was much appreciated by the Arbitrator.
26 By reason of the foregoing the Arbitrator finds in favor the Respondents,
27 , , and the ,
28 and against the Claimants, and , in light of this finding any finding as

to the issues of causation and damages are moot. The Arbitrator does reserve jurisdiction over any other issues in this matter that may arise subsequent to the issuance of this Arbitration 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 HEALTHCARE.

Dated: September 17, 2014



Hon. Chris R. Conway (Ret.)
Arbitrator