# Arbitration Award

**Instructions:** Use of this form is optional. Within fifteen business days of the date of the closing of most arbitration hearings, the Neutral Arbitrator must serve the Arbitration Award on the Parties and the Independent Administrator. If there were three arbitrators, this Award must be signed by at least two of them. See Arbitration Rules 37 - 39. Return to:

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**Arbitration Name:** , **Arbitration Number: 12230**

Barbara Reeves Neal, the Arbitrator~~(s)~~ selected to determine the dispute between the Parties in the above referenced action, find(s):

An arbitration hearing was held on February 10 - 14, 2014

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

✓ The Claimant~~(s)~~ is entitled to $25,000.00

**Or:**

____ The Respondent(s) is entitled to _____

**The reasons for this decision are attached.**
(Arbitration 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.**

Barbara Reeves Neal
Signature of Neutral Arbitrator

2/25/2014
Date

_____
Signature of Party Arbitrator

_____
Date

_____
Signature of Party Arbitrator

_____
Date

JAMS ARBITRATION NUMBER REF #1210031029
( Arbitration No. 12230)

Claimant,

And

and

**Respondents.**

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**AWARD**

**Parties and Counsel:**

| | |
|---|---|
| , Pro se | , Esq. |
| Claimant | Counsel for Respondents |

**Arbitrator:**
Barbara Reeves Neal
JAMS
1601 Cloverfield Ave., Suite 370-S
Santa Monica, CA 90404

**Place of Arbitration:** Santa Monica, CA

**Date of Award:** March 9, 2014

The undersigned Arbitrator, having been designated in accordance with Agreement to Arbitrate between Claimant and Respondents , , and (the " Respondents") and the Rules for Member Arbitrations, and having examined the submissions, proof and allegations of the parties, finds, concludes and issues this Award as follows:

## I. INTRODUCTION AND PROCEDURAL STATEMENT

Claimant saw her primary care physician, , M.D., at the Clinic on May 7, 2012. She had been suffering from a cold with headache, cough and fever symptoms. While there she was administered two medications, Toradol and Zofran, and shortly thereafter experienced hallucinations and was transferred to the Emergency Room. Thereafter she experienced continuing adverse effects, including tremors, mental impairment, slowed speech and acute personality change. After pursuing her options with Member Case Resolution Center, she submitted a Demand for Arbitration, dated May 5, 2013.

The Demand for Arbitration named three entities and twenty-four individuals who are identified as employees. The Arbitrator requested counsel for Respondents to clarify which of the entities were properly responsible for the employees and for the conduct alleged in the Demand. Respondents' counsel stated that each entity had different responsibilities, one entity being the plan, one being the employer of the nurses and one being responsible for the doctors.

The undersigned was appointed Arbitrator on June 12, 2013. An initial Case Management Conference was held on July 19, 2013. Thereafter various discovery and case management orders were issued.

Prior to the arbitration hearing Claimant dismissed the following nine individual Respondents:

1. (M.D.)

2. (M.D.)

3. (M.A.)

4. (M.A.)

5. (M.D.)

6. (Sr. Consultant, Expedited Review)

7. (Sr. Case Manager)

8. (Case Manager, Complaint Office)

9. (Administrative Assistant to Dr )

This leaves the following eighteen Respondents in the arbitration:

1.

2.

3.

4. (M.D.)

5. (M.D.)

6. (M.D.)

7 (M.D.)

8 (R.N.)

9. (L.V.N)

10. (M.D.)

11. (L.V.N.)

12. (M.D.)

13. (N.P.)

14. (M.D.)

15. (M.D.)

16. (R.N., TCC)

17. (M.D., Medical Director, Internal Medicine)

18. (M.D., Supervisor to Dr )

The above remaining individual fifteen Respondents are referred to as the "individual Respondents." Respondents numbered 1-3 are referred to as the " Respondents."

The Arbitration Hearing was held on February 10-14, 2014. The following witnesses testified:

, M.D., , Ph.D., , M.D., and , M.D.

The evidence closed at the conclusion of the hearing and the parties thereafter agreed that the Arbitrator would have until March 10, 2014 to issue an Award.

## II. FACTS

The following is a statement of those facts found by the Arbitrator to be true and necessary to the Award. To the extent that this recitation differs from any party's position, that is the result of determinations as to credibility, determinations of relevance, burden of proof considerations, and the weighing of the evidence, both oral and written.

On May 7, 2012, Claimant saw her primary care physician, , M.D., at the Clinic on May 7, 2012. She had been suffering from a cold with headache, cough and fever symptoms. Dr. prescribed fluid replacement, Toradol for the headache and Zofran to prevent nausea. The Toradol was given by IM by , LVN, at 11:28 a.m.; the IV for the fluids was initiated by , RN, at 11:50 a.m. and Zofran was given at 12:47 p.m. The medical records also state that Claimant was given an IV administration ofToradol on the same date.

Shortly thereafter Claimant began hallucinating and seeing spots and lights running up and down the wall. She was transferred to the Emergency Room, but her chart did not immediately accompany her. She continued to experience hallucinations and was shaking uncontrollably. There was some confusion in the ER as the staff repeatedly asked her why she was there and seemed to believe that she had taken drugs. Claimant overheard a nurse comment that she (Claimant) had been administered an overdose of medication in the clinic. Dr. , the ER physician, noted in Claimant's medical records on May 7, 2012 that Claimant had been administered Toradol "iv with Zofran;" earlier in the medical records , LVN, noted that Claimant had received Toradol 30mg IM. Eventually the hallucinations and tremors ended and Claimant was released to go home.

Claimant returned to the ER the following day, May 8, 2012, because she was experiencing confusion, was unable to keep still and was still suffering from slow cognition and speech. The diagnosis was "Psychosis, most likely drug induced." She was

admitted, spent the night in the hospital, and was dismissed with a diagnosis "disturbance of consciousness." No mention was made of the fact that the chart reflected that Toradol had been administered twice, once IM and once IV, during the same visit.

On May 9, 2012, Claimant sought a second opinion from . M.D., a neurologist at . Dr prescribed several tests, which Claimant thereafter had performed at . All of the tests were negative.

During the next several months, Claimant was seen once again by Dr , and at some point thereafter (times are confusing inasmuch as the medical records, as produced by , contain inconsistencies and are not chronological) Dr. withdrew as Claimant's primary care physician. Claimant was thenpassed among a series of different physicians, including Dr , Dr. , Dr. , Dr. Dr , and Dr. , as well as a number of nurses at . Several of the professionals recommended that Claimant consult a psychiatrist, which she declined to do.

Dr ,although diagnosing Claimant as "mentally slowed" andinstructing Claimant not to drive or work until cleared by herself and a neurologist,nonetheless refused to fill out the forms that Claimant needed for authorized sick leave from work, including work release and work status forms necessary to qualify under the Family Medical Leave Act ("FMLA"). Other professionals likewise refused to provide Claimant with work release forms unless and until she had a psychiatric follow-up. During this time her medical records included erroneous diagnoses ("head injury" and "TMJ") and one doctor (Dr. ) made light of her symptoms and recommended that she rub Ben Gay on her temples and the back of her neck. Only one entry in her medical records, by Dr on May 16, 2012, made reference to the fact that her hallucinations and altered mental status arose after being administered Torodol and Zofran, although noting "(may not be causal)."

Claimant was able to obtain a work absence note from Dr , and was able thereafter to get work slips from various doctors that covered her for a few weeks at a time. However, Dr. , to whom Claimant had provided the FMLA forms, refused to complete and submit those FMLA forms, and no other doctor would do so either, preventing Claimant from ever getting FMLA leave. Instead Claimant had only work release forms with various diagnoses: "mental status, disturbance of consciousness,

viral syndrome" (June 8, 2012); "migraine" (July 6, 2012); "stuttering, adult onset, extrapyramidal gait" (August 23, 2012); "mental status, disturbance of consciousness, ataxia, stuttering, adult onset" (December 5, 2012); "mental status, disturbance of consciousness" (February 3, 2013); "mental status, disturbance of consciousness, anxiety, stuttering, adult onset" (May 7, 2013). None of these diagnoses referenced her adverse reaction to medication (or a possible medication overdose), which concerned Claimant and caused her emotional distress.

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for up to twelve work weeks for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Claimant's condition qualified her for FMLA leave, yet no physician ever authorized FMLA leave, even though authorizing her work absences. Her work supervisor frequently questioned her as to why she had not submitted her FMLA forms, and Claimant feared that she would lose her job.

As mentioned above, between May 2012 and December 2013, when Claimant was finally cleared to return to work full time, referred Claimant to different physicians at . Each of the physicians refused to address the fact that she felt she had experienced an adverse reaction to an overdose of Toradol and/or Zofran, but rather continued to try to send her to a psychiatrist.

During this time Claimant obtained her medical records and noted that there was a reference to Claimant having received 30 mg. IV Toradol in addition to the 30 mg. of IM Toradol. The order for the Toradol does not specify IM or IV, rather just "injectable solution," which could have been given IM or IV, or, as Claimant alleges, both ways. In addition, Claimiant noted that although the medical records prescribed "2mg/mL IV Soln" of Zofran, the records also stated that she had been administered 4 mg of Zofran. However, the uncontradicted testimony of Dr. established that 4 mg is the lowest standard dose of Zofran, and it is recorded as being of a 2mg/ml strength, which is the proper way to prescribe and administer Zofran.

The two nurses who administered the Toradol and the Zofran did not testifyat the arbitration hearing.

For several months Claimant's condition required her to be cared for by her mother inasmuch as she was unable to care forherself, and was not authorized to drive or

work. She received medical authorization to drive in February 2013, she returned to work part-time in March 2013, and returned to work full time in December 2013

pharmacology expert. , Pharm.D., a clinical pharmacist and a pharmacologist, acknowledged that hallucinations are a known side effect of Toradol, although very rare. Dr testified that he found only six cases of hallucinations as a Toradol side effect in the FDA database that he reviewed. (However, it was noted that did not report Claimant's incident to the FDA, leading one to question the completeness of that database.) Dr testified that pharmacologically Toradol and Zofran would have been excreted by a patient's body completely within 25 hours, and would not be having an effect on a patient's body after about five to six hours. He acknowledged that it was "very possible", although not probable, that drugs such as Toradol and Zofran could have an impact on a patient even after their half life and after having been excreted from the body if the drugs interacted with and changed neuro-receptors in such a way that the neuro-receptors did not revert back to their original state, thus leaving the patient with longer lasting neurological effects.

Dr. opined that if the Toradol was given both IM and IV, that action was below the standard of care. He noted that inasmuch as the chart states that Toradol was given both IV and IM, one must assume that it was. He also opined that the chart was below the standard of care in that it did not state that another medication listed there (Levoflox) was not in fact given. Further, he opined that if Toradol had not been given both IM and IV, then the chart was in error and that was below the standard of care. He also testifiedthat any unforeseen reaction to medication should be documented in the chart, as well as any change in behavior, to comply with the standard of care.

second witness. , M.D., testified that every doctor and nurse at who had anything to do with Claimant's care acted appropriately and did nothing below the standard of care. He further opined that other than the administration of Toradol and Zofran, no other action by any physician was a substantial factor in causing the injury. He testified that he had reviewed the entire set of claimant's medical records, but could not identify with specificity what he had reviewed and, when he was shown the records that had produced to Claimant he did not recognize them as anything that he had reviewed. He further stated that the Claimant's set of records were

incomplete because only the electronic set at would be complete, and Claimant's printed set did not contain all of the relevant records. When asked about whether the fact that the medical records showed both an IM and IV administration of Toradol reflected either a medical error or an error in the medical records, he evaded the question and stated that the records that had provided to Claimant were not accurate or complete.

Claimant did not offer any expert witnesses.

## III. DISCUSSION

As confirmed by Respondents' expert, Dr. , something occurred on May 7, 2012, that was below the standard of care: either (a) two nurses interpreted Dr. order for "Ketorolac (Toradol) 30 mg/mL (1 mL) Inj Soln" inconsistently and erroneously administered the Toradol both IM and IV, or (b) the entry later that day by Dr stating "Toradol (Ketorrolac Tromethamine) ...given this iv with zofran" was erroneous. Although Claimant was seen by physicians in two follow up visist, on May 8-9, 2012 when she returned to the ER and was then admitted overnight for observation, and on May 16, 2012 when she was seen both by Dr. and Dr. , no one noted after Claimant had become aware of that her medical records indicated that she had received two doses of Toradol. Dr. denied that she had received two doses but took no steps to confirm exactly what had occurred or to correct or update the medical records

As confirmed by the testimony of Claimant and Dr , as well as the medical records, Claimant suffered hallucinations following the administration of the Toradol and Zofran on May 7, 2012, and continued to suffer from mental impairment for months thereafter. However, Claimant has failed to meet her burden of proof that even a double dose of Toradol along with a dose of Zofran was the cause of her medical problems. Claimant offered no expert testimony on the subject. Respondents' expert, Dr. , testified although it was possible, indeed very possible, that those medications could be a cause of longer lasting medical problems, it was not probable that there were the cause, and that an accidental double, triple or even quadruple dosageof Toradol, while possibly causing Claimant's hallucinations was not likely to cause Claimant's longer-term symptoms. Expert testimony is required to establish breach of

the standard of care in a medical malpractice case, unless the breach is of such a nature that it can be said to be within the realm of common knowledge. Not only did Claimant fail to produce an expert to address the issue whether Toradol and Zofran (single or double doses) were the probable cause of her injuries, she did not rebut the testimony of Dr. on the issue. The arbitrator concludes that the question whether Toradol and/or Zofran caused Claimant's longer-term injuries is not a matter that can be said to be within the realm of common knowledge.

However, the existence of mistakes in the medical records as detailed above, the errors in documenting what drugs were and were not administered and in what quantity as well as the errors in recording diagnosis as "TMJ" or "head injury" is something as to which the arbitrator is competent to find as below the standard of care without the need for expert testimony. Claimant produced policies and procedures and demonstrated that the records as produced to Claimant did not comply with own policies. This was demonstrated by a comparison of the records to the policies and procedures. In addition, this was supported by the testimony of Respondents' experts. Not only were the medical records incomplete, as testified to by Dr. , they were below the standard of care as not accurately reporting which medications had and had not been administered, as testified to by Dr. .

As a result of these errors in the medical records, the physicians never focused on whether there had been a mistake in the administration of Toradol and/or Zofran, but instead concluded that Claimant's on going problems were psychiatric. This in turn led Dr to refuse to authorize FMLA leave unless and until a psychiatrist saw Claimant. Claimant refused to consult a psychiatrist and as a result refused to provide her with the documentation necessary for her to obtain FMLA leave from work.

Claimant did not meet her burden of proof that but for the errors in medical charting she would not have suffered from the longer-term adverse mental and cognitive problem. She offered no testimony that had recognized and immediately addressed the issue that she may been administered an overdose of Toradol and/or Zofran, she would have received different treatment and would not have suffered from the ongoing mental and cognitive problems.

Claimant did meet her burden of proof that she suffered emotional distress as a result of fearing that she would lose her job because failed to provide her with the

necessary authorization for protected FMLA leave. acknowledged that Claimant could neither work nor drive, and provided her with numerous, short-term "release from work" forms. However, those non-FMLA work releases left her exposed to losing her job and were no substitute for the FMLA release to which she was entitled. As a result of not having the FMLA release, Claimant was at risk of losing her job for what should have been three months of FMLA-protected leave, and suffered emotional distress. This liability falls upon the entities inasmuch as no one doctor or nurse was responsible, but rather resulted from charting errors and the resulting interaction among the doctors, administrators, and the relevant policy and procedures.

There is no objective yardstick for determining the dollar value to be attributed to suffering months of emotional distress. The evidence established that Claimant had had a stable and long-term job as a registered nurse job at a salary of $101,000 for the year 2012. Her distress at the thought of losing that job, as her supervisor continually asked her for her FMLA leave paper work that she was unable to supply due to refusal to provide it to her, is understandable. The Arbitrator awards Claimant $25,000 in general damages for emotional distress against the Respondents

## IV. CONCLUSION AND AWARD

1. Claimant is entitled to an award of general damages for emotional distress in the amount of $25,000 payable by jointly and severally by Respondents

, and

2. Claimant shall take nothing from the named individual Respondents.

3. Both parties shall bear their own attorney fees and costs.

This Award resolves all issues submitted for decision in this proceeding.

Dated: March 9, 2014

Barbara Reeves Neal

Barbara Reeves Neal, Arbitrator