Schulner

Arbitration Award

Instructions: 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:

Arbitration Name: Arbitration Number: 11834

Keith Schulner, the Arbitrator selected to determine the dispute between the Parties in the above referenced action, finds the following in this arbitration which concluded on July 17, 2014.

Claim against , M.D.

Dr. board certified in family practice, saw , a 25 year old woman, in on July 23, 2011. He relied on verbal history and chose not to look at her past records as he felt her history was sufficient. Dr. reviewed records later and concluded that had he seen them on July 23, 2011, he would not have treated any differently.

As reasonable doctors do, Dr. used a differential diagnosis with , where he took a history, examined , considered the possible causes of the presenting symptoms, attempted to rule out possible causes, and determined how to proceed accordingly. Specifically at the visit, blood pressure was 113/58, and her heart rate was recorded at 137 beats per minute with a temperature of 101.3 degrees. looked well developed, and well nourished, with no distress. She was oriented to person, place, and time.

stated she was vomiting after coughing for 3 days, had been feeling warm for a week, had night sweats, chills, and congestion. was feeling some weakness. did not look pale and no one advised Dr. that looked pale. Because was not too weak to walk, was not pale or disoriented, and did not have back pain, Dr. did not think had anemia.

Dr. instructed to hydrate for her complaint of congestion. Based on Dr. exam of and history, Dr. concluded did not have a sore throat, though he

did notice an enlarged lymph node. Dr. concluded that the enlarged lymph node was caused by an upper respiratory infection (URI).

Dr. concluded that the nurse's note that was vomiting for a week was incorrect, as that is not what told him. Doctors typically rely on their own findings over a nurse's history, if there are conflicts.

Dr. ordered thyroid blood tests after examining , to make it easier for an endocrinologist. Dr. ordered the two tests that are ordinarily the only ones needed for this to start, the TSH and T4 test.

Dr. did not think had Leukemia at this visit, as she did not have bone pain, or bleeding, or other symptoms of Leukemia not explained by hyperthyroid or a URI.

Dr. did not think had thyroid toxic crisis as he saw no evidence of neurological symptoms such as headaches, saw no acute distress, walked into the clinic (as opposed to being taken in on a wheelchair) and was able respond to questions.

Dr. prescribed an albuterol inhaler for to open her airways to reduce her vomiting caused by coughing. He did not believe the temporary increase in heart rate that can result from using the inhaler was a problem. He also advised to take Motrin and Tylenol intermittently for her fever. Dr. referred to an endocrinologist and gynecologist as requested.

Dr. did not believe had sepsis, considering with sepsis one would expect an elevated breathing rate, and was breathing 18 beats per minute which is lower than the average of 20 for someone of age.

Conclusion

Dr. treatment of was typical for a doctor in the area seeing a patient in Urgent Care who presented as did. It was not proven that damages resulted from actions or inactions below the standard of care of Dr. related to and there is no award for the claimants against Dr.

Claim against M.D.

Dr. saw the morning of July 27, 2011, at .
He relied on verbal history and chose did not review her past records as he felt her history was sufficient and he does not normally review charts unless chronic conditions are presented. As part of the history Dr. takes, he asks patients about their complaints and how long the complaints have been occurring. Dr. saw

records later and concluded that had he seen them on July 27, 2011, he would not have treated any differently.

Dr. used a differential diagnosis with where he took a history, examined considered the possible causes of the presenting symptoms, attempted to rule out possible causes, and determined how to proceed accordingly. Specifically he did not see evidence that was pale. stated she was vomiting for three days and was coughing. Her blood pressure was 104/57, pulse was 122, and temperature was 98.4. did not indicate chills, shortness of breath, or any trouble breathing, nor did she exhibit sweating, bleeding, bruising, fatigue, or weight loss. Her blood pressure was in the normal range.

Dr. concluded the 122 pulse was consistent with a URI, and was not a concern. Dr. did not send a report for to primary care as he does not do that routinely as otherwise primary care would not have time to do their own work.

Dr. refers patients out for a complete blood count test (CBC) about two to three times a week on average. He uses the CBC to test for anemia or blood infections, but not viral infections. He did not believe that a CBC was called for during this visit based on history and the examination. He ordered cough syrup for cough, Zofran as needed for vomiting, Keflex for infection and advised to follow up with her own doctor or return to Urgent Care if her problems persisted. was not on birth control, was tested for pregnancy, and was not pregnant. The exam and history did not indicate was anemic at the time of the visit.

Conclusion

Dr. treatment of was typical for a doctor in the area seeing a patient in Urgent Care who presented as did. It was not proven that damages resulted from actions or inactions below the standard of care of Dr. related to and there is no award for the claimants against Dr.

Claim against M.D.

Dr. saw at approximately 8 p.m. July 28, 2011, at Urgent Care. was with her mother, who typically waited in the waiting room, but this time, because she was very concerned about the escalation and seriousness of symptoms, accompanied into the examination room. Dr. reviewed the records from July 23, and July 27, 2011. He also examined .

chief complaint was body swelling, for a few days. had a fever, diaphoresis (sweating), no chills, cardiovascular palpitations and leg swelling. Neurologically she was positive for tremors. Her temperature was 100 degrees with a blood pressure of 118/43. Her pulse was 140 beats per minute, up from 122 the day before when she was at Urgent Care. had diffuse non-pitting edema (swelling where the dent from pushing on one's skin disappears after letting go). stated she had numbness and tingling in her limbs.

Dr. concluded that symptoms were likely attributed to untreated hyperthyroidism. Dr. referred to Dr. M.D. if symptoms did not improve or for any other concerns.

On July 29, 2011, was taken to by the Los Angeles Fire Department. They took a history, finding family was awakened by screaming. was sitting on a couch with a relative at home with a chief complaint of abdominal pain and a complaint of her legs feeling tingly. She was actively moving and A&Ox3 (alert and oriented to person, place, and time.) The fire department found to be anxious, with an unlabored normal breathing rate.

vital signs were within normal limits on the scene and during transport. was uncooperative during transport and not tolerating any type of treatment. On arrival to the hospital, suddenly became unresponsive and had agonal respirations (shallow breathing pattern that is often related to cardiac arrest and death). The crew and hospital staff initiated CPR (cardiopulmonary resuscitation) and life supporting measures.

At the hospital it was determined that had Acute Myeloid Leukemia (AML) with 80% blasts, and post cardiopulmonary arrest. If found and treated earlier, would have been expected to live about 1.5 years, with approximately half of that time in remission. Instead, she passed away at the hospital.

The autopsy revealed in the lungs, intra-alveolar edema and congestion; in the liver, sinusoids with blasts, morphologically consistent with myeloblasts, microsteatosis, and congestion; in the bone marrow, diffuse infiltration by blasts, morphologically consistent with myeloblasts, increased myeloid erythroid ratio, and decreased megakaryocytes; in the spleen, infiltration by blasts, morphologically consistent with myeloblasts, foci of necrotic cellular debris; in the periportal lymph, sinusoidal infiltration by blasts, morphologically consistent with myeloblasts, foci of necrotic cellular debris; in the thyroid, follicular hyperplasia with focal papillary infolding, sparse chronic inflammation without germinal center formation; in the CNS, cortex with edema.

The autopsy diagnosis was:

1. Infiltration of bone marrow, spleen, liver sinusoids, and periportal lymph node with blasts, consistent with diagnosis of acute myelogenous leukemia.
2. Cerebral and pulmonary edema
3. Thyroid with follicular hyperplasia
4. Liver with microsteatosis

The cause of death was acute myelogenous leukemia (AML).

When saw Dr. on July 28, 2011, she was in Urgent Care for the third time in approximately one week. presented with a pulse of 140 beats per minute, up from 122 on July 27. Her chief complaint was swelling, a condition she did not have at the previous two visits. had a fever, diaphoresis, cardiovascular palpitations, tremors, numbness and tingling in her limbs. Her mother, , voiced concerns that more was wrong than the doctor indicated, and more should be done to determine what was wrong with . A reasonable doctor in this situation, would have taken the concerns of more seriously, and ordered a CBC test, which is simple, inexpensive, can be completed in less than a couple of hours, and has the possibility of finding many causes for symptoms that had.

Dr. failure to order the CBC was below the standard of care, was malpractice, and reduced the chances of survival. The CBC may have led to other tests and an earlier diagnosis of AML. Considering everything including the extent of problems, and the late hour and shortness in time between last Urgent Care visit and her death, the malpractice did not reduce life expectancy by the full 1.5 years one would expect with an early diagnosis, but to a lesser uncertain degree.

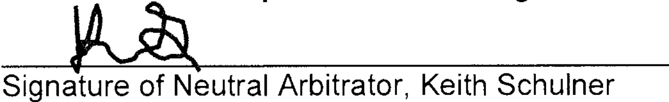
Economic damages to the claimants were not proven considering the funeral was going to occur regardless of Dr. actions or inactions and it was not proven that would have worked again and paid off the student loan.

Conclusion

The prevailing Party in this Arbitration is the claimants, and who are entitled to $100,000 for non-economic damages against M.D., and his employer, .

(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.



Signature of Neutral Arbitrator, Keith Schulner

7/31/14

Date