**Patricia A. Law (SBN 163661)**
**LAW OFFICES OF PATRICIA A. LAW**
4371 Latham Street, Suite 205
Riverside, CA 92501
(951) 683-8320
Fax: (951) 683-8321

Attorneys for Plaintiff



SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF RIVERSIDE

JOSHUA TUCKER AND LISA TUCKER,

Petitioners,

vs.

KAISER FOUNDATION HOSPITALS, and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP; and DOES 1 through 100, inclusive,

Respondents.

CASE NO: RIC 1218828

**PETITION TO VACATE ARBITRATION AWARD**

Date: 1-8-2013
Time: 830
Dept: 12



Petitioners hereby move this Court for an order vacating a Binding Arbitration Award issued by Harrison Sommer, Esq. of Judicate West pursuant to Code of Civil Procedure §1286.2. The Petition will be made on the grounds that Mr. Sommer violated the Kaiser Arbitration Rules in place for the underlying Arbitration and violated Code of Civil Procedure §1283.4 and §1283.5. Particularly, Petitioners will show that the Arbitrator failed to decide all issues presented to him at the Arbitration of this matter. This petition will be based on the Kaiser Arbitration Rules, the Code of Civil Procedure, Case law, Trial transcripts attached hereto, arguments of Counsel and such further evidence as may be necessary to rule on the issues raised in this petition.

## TABLE OF CONTENTS

## TABLE OF AUTHORITIES

CASES:



## STATUTES

## I

## ARBITRATION PROCEEDINGS

The underlying matter arose out of a series of medically negligent acts committed by Physicians and staff at the Kaiser Riverside facility. Pursuant to the terms of the Kaiser Insurance plan, of which Claimants were members, they were required to demand and participate in a Binding Arbitration as opposed to bringing suit in a Civil Court. On July 23, 24, 25, 26 and 27 and August 1st and 2nd of 2012, the matter was heard by mutually chosen Arbitrator, Harrison Sommer, Esq. pursuant to the Kaiser Rules. On September 17, 2012, Mr. Sommer issued his Arbitration Decision, a true and correct copy of which is attached hereto as Exhibit "A". A number of issues presented to the Arbitrator were not addressed or decided in the Award. Further, the Arbitration Decision fails to comply with Kaiser's own rules relating to the content and form of the Arbitration Award.

## II

## STATEMENT OF FACTS AND LIABILITY IN THE UNDERLYING MATTER

At 11:30 p.m. on May 16, 2009 William Joshua Tucker, then 46 years old, presented to the emergency department at Kaiser Riverside with severe abdominal pain. He reported that the pain had come on suddenly at about 3:00 p.m. that day while he was engaged in yard work. Dr. Can Tamkoc, emergency physician, examined the patient and took a history and physical shortly after midnight on the 17 th and found that Mr. Tucker was experiencing severe, constant abdominal pain which Mr. Tucker felt had been increasing in severity since its onset. He also complained of nausea. Dr. Tamkoc appropriately ordered lab tests. He also ordered a CT without contrast to rule out Kidney stones based on the severity of the patient's pain. Dr. Tamkoc clearly noted that Mr. Tucker did not have peritoneal signs as of that point in time.

Mr. Tucker continued to experience severe pain, despite significant administration of narcotic pain medication. Upon receipt of the CT scan results and realizing that the patient was still in severe pain, Dr. Tamkoc called the surgical service for consultation around 4 a.m.. **Dr. Michael Lawrence** was on call. Dr. Lawrence asked Dr. Tamcok to get another CT in follow

up.

That CT was accomplished at 6:30 a.m. Dr. Lawrence examined Mr. Tucker at or about 7:30 a.m. and dictated his history and physical at 7:44 a.m., sixteen minutes prior to going off shift. Dr. Lawrence came to the conclusion that it was a partial small bowel obstruction and admitted the patient for "observation". He ordered an NG tube placement for decompression presuming that would relieve his pain symptoms. The NG tube placement was delayed by the Kaiser staff for almost 3 hours and then made no difference whatsoever and the patient remained very symptomatic despite significant pain medication administration. The patient was transferred up to his hospital room at about 9:30 a.m.

Over the next 9 hours Mr. Tucker's condition continued to deteriorate. Dr. Lawrence never once called back to check on this patient, in fact he was unreachable until 4:30 p.m. By 10 a.m., Mr. Tucker no longer was getting even short term relief from the narcotic pain medication. The nursing notes indicated that he was writhing in pain. The nurse's notes also indicated that he was agitated and restless.

He was requiring oxygen, his pulse and respirations and blood pressure were skyrocketing. By noon he had developed a fever, was tachycardic and hyperventilating. **Dr. Sonny Wang** was the on-call surgeon that came on duty when Dr. Lawrence left at 8:00 a.m. Dr. Lawrence had contacted Dr. Wang about this patient however, the information communicated was substandard as was the plan related to who's patient this patient really was. That constituted a poor hand-off of the patient.

Dr. Wang never checked on this patient between 8 a.m. and noon. At Mr. Tucker's nurse's insistence, Dr. Sonny Wang finally evaluated Mr. Tucker shortly before noon for the first time. Mr. Tucker had not been seen by a surgeon for over 4 hours at that point.

Dr. Wang cursorily evaluated Mr. Tucker and left orders to "hydrate him aggressively" and "observe him closely". Between 12:00 p.m. and 2:30 p.m., despite 3 separate administrations of morphine and dilaudid, Mr. Tucker remained at a 10 out of 10 pain scale. During that same time period, no less than 5 attempts were made to get Dr. Wang back up to re-evaluate Mr. Tucker. He refused.

Mr. Tucker's nurse, Fabian Ballasteros, was so concerned about him and the fact that he could not get Dr. Wang to respond, he called the Rapid Response Team and ICU nurse Christopher Burke responded. Christopher Burke attempted to intervene in order to get Dr. Wang to re-evaluate Mr. Tucker. Dr. Wang refused. Finally, after Christopher Burke contacted the house supervisor, Dr. Wang returned at 2:30 p.m. By that time, Dr. Wang found that the patient had developed peritoneal signs and that he needed to be taken to the operating room. Dr. Wang noted in his dictation of 2:31 p.m. that he had "attempted to contact the patient's primary surgeon Dr. Lawrence several times by pager and at his home with no success". Dr. Wang all along knew the patient needed to go to surgery, he just didn't want to do it himself. Mr. And Mrs. Tucker testified about the excruciating pain that he was in during the delay.

Even after Mr. Tucker was found to have peritoneal signs, (a life and death situation), it was almost 3 hours before Mr. Tucker got to surgery. Why? Because Dr. Wang still refused to take the patient to surgery on his own and waited for Dr. Lawrence's arrival. Dr. Lawrence dictated a note at 4:46 p.m. that he had come at Dr. Wang's insistence and "he will take the patient to surgery "now"".

At surgery a clot was found occluding the Superior Mesenteric Artery, the main blood vessel to the small intestine. It had caused an occlusion at that point because there was a stenosis in the area as a result of Mr. Tucker's radiation in his young age.

At surgery, Dr. Lawrence removed two segments of bowel. One of the segments was described as pale pink signifying that it was viable bowel and should not have been removed. At pathology, the Kaiser pathologist found that many portions of the longer segment of bowel that was removed had only superficial injury. The pathology performed by the Kaiser pathologist showed that much of the bowel that Dr. Lawrence removed only had superficial necrosis into the mucosa or the submucosa, indicating that the likelihood of survival was very high. Of eight representative sections of bowel that were studied, six were potentially still viable according to Dr. Salcedo, the Kaiser pathologist.

At surgery, Drs. Wang and Lawrence removed clearly dead bowel, but they also removed viable bowel. In fact, they removed 35 cm of bowel that all experts and the Kaiser

pathologist agree was likely viable.

Because of the delay in taking Mr. Tucker to surgery, he languished in excruciating pain for 10 hours and developed peritonitis. More and more of his bowel was dying as the hours went along.

Because of the extent of bowel resection necessary as a result of the delay in taking Mr. Tucker to surgery and as a result of the removal of viable bowel, he is fed Total Parenteral Nutrition (TPN) through a PICC line for 12 hours every night and will be fed in that fashion for the rest of his life. He also has a colostomy as a result of strictures that occurred following these events. Each little segment of bowel that could have been saved would have afforded Mr. Tucker a better quality of life and increased his chances of adapting and coming off of the TPN.

## III

## THE ARBITRATOR'S DECISION

The Arbitrator was required under the Kaiser Arbitration Rules to determine all issues presented to him and make findings of fact and conclusions of law as to those issues. He was required to compose an Arbitration Award that set forth those findings of fact and conclusions of law as if Ruling on a motion For Summary Judgment in the Superior Court. (See a true and correct copy of the Kaiser Rules attached hereto as Exhibit "B", particularly page 15, paragraph 38)

The Arbitrator fell well short of deciding all of the issues presented to him and decided only that the conduct of Dr. Lawrence at or about 7:44 in the morning complied with the standard of care. He failed to address Kaiser's 3 hour delay in placing the NG Tube between 7:30 and 10:30, he failed to address the substandard hand-off from Dr. Lawrence to Dr. Wang and he failed to determine whether Dr. Wang's conduct over a 9 hour period of time met or fell below the standard of care. He makes a comment that Drs. Lawrence and Wang's conduct "was very troublesome" and "left a lot to be desired" and then made no finding regarding Dr. Wang in negligence or causation. Dr. Wang was the patient's surgeon from approximately 8:00 a.m. until he was finally taken to surgery after 5 p.m. and the Arbitrator did not rule on his conduct. A significant portion of the 7 days of Arbitration was spent on Dr. Wang's conduct

and the causative effect of his delay, yet Dr. Wang's conduct was **never** addressed in the Decision. And lastly, the Arbitrator did not even mention the issue of whether the removal at surgery of pale pink viable bowel was below the standard of care, even though Defendant's own expert admitted that it was below the standard of care.

The Claimant put on four witnesses relating to the segments of bowel that could have been saved had the surgery occurred even two hours earlier. Those witnesses agreed that any additional bowel that could have been saved would have afforded the Claimant a better quality of life. That testimony was uncontroverted, yet the Arbitrator failed to even consider that or rule on it. The claimant put on a witness that testified that viable bowel had been removed at surgery. The Defendant's surgery expert, Preston Flanigan, testified that removal of viable bowel was below the standard of care, yet the Arbitrator did not even mention this issue in the award.

The record is replete with testimony setting forth the benefit to the Claimant with additional centimeters of bowel. There was testimony that if a mere additional 30 centimeters of bowel had been salvaged, the likelihood was that the Claimant would have adapted over the years to that and eventually been weaned from the TPN. There is no mention of the fact that there was uncontroverted testimony that 60 centimeters of pale pink viable bowel had been removed negligently.

Further, there was no mention of the 9 hours of excruciating pain Claimant had to endure while in the care of Dr. Wang and the fact that he developed peritonitis during that period of time. Further, during that time, his wife looked on in horror as her husband deteriorated before her eyes. Lastly, although the Arbitrator touched upon Dr. Lawrence's decree that Claimant "could be woken up for them to say goodbye as he was going to die", he failed to rule on the negligence of that act or the injury to Mrs. Tucker, who was also a claimant.

## IV

## KAISER ARBITRATION RULES

After filing of the Demand for Arbitration to Kaiser in this matter, Claimant's Counsel

was served, by the Office of the Independent Administrator, with a document entitled:

"Rules for Kaiser Permanente Member Arbitrations Administered by the Office of the Independent Administrator Amended as of April 1, 2011"

In most pertinent part to this Petition, the Rules state at page 15:

38. Form of Award

a. A majority of the arbitrators shall sign the award. The award shall specify the prevailing party, the amount and terms of the relief, if any, and the reasons for the decision. In setting forth the reasons, the award, or **any decision deciding an arbitration, shall provide findings of fact and conclusions of law, consistent with California Code of Civil Procedure Section 437c(g) or Section 632.** The reasons for the decision will not become part of the award nor be admissible in any judicial proceeding to enforce or vacate the award. The arbitrator may use the arbitration award form. The neutral arbitrator shall be responsible for preparing the written award." (Exhibit "B")

## V

## APPLICABLE CODE SECTIONS

The Kaiser Rules are clear on the form which the Award should take and refer specifically to the following Sections of the California Code of Civil Procedure:

"Upon the denial of a motion for summary judgment, on the ground that there is a triable issue as to one or more material facts, the court shall, by written or oral order, specify one or more material facts raised by the motion as to which the court has determined there exists a triable controversy. This determination shall specifically refer to the evidence proffered in support of and in opposition to the motion which indicates that a triable controversy exists. Upon the grant of a motion for summary judgment, on the ground that there is no triable issue of material fact, the court shall, by written or oral order, specify the reasons for its determination. The order shall specifically refer to the evidence proffered in support of, and if applicable in opposition to, the motion which

indicates that no triable issue exists. The court shall also state its reasons for any other determination. The court shall record its determination by court reporter or written order." Code of Civil Procedure §437c(g).

"In superior courts, upon the trial of a question of fact by the court, written findings of fact and conclusions of law shall not be required. The court shall issue a statement of decision explaining the factual and legal basis for its decision **as to each of the principal controverted issues at trial** upon the request of any party appearing at the trial. The request must be made within 10 days after the court announces a tentative decision unless the trial is concluded within one calendar day or in less than eight hours over more than one day in which event the request must be made prior to the submission of the matter for decision. The request for a statement of decision shall specify those controverted issues as to which the party is requesting a statement of decision. After a party has requested the statement, any party may make proposals as to the content of the statement of decision.

The statement of decision shall be in writing, unless the parties appearing at trial agree otherwise; however, when the trial is concluded within one calendar day or in less than 8 hours over more than one day, the statement of decision may be made orally on the record in the presence of the parties." Code of Civil Procedure §632.

Petitioners bring this Petition pursuant to the following Code of Civil Procedure Sections:

"The award shall be in writing and signed by the arbitrators concurring therein. **It shall include a determination of all the questions submitted to the arbitrators the decision of which is necessary in order to determine the controversy.**" Code of Civil Procedure §1283.4 (emphasis added).

"Any party to an arbitration in which an award has been made may petition the court to confirm, correct or vacate the award. The petition shall name as respondents all parties to the

arbitration and may name as respondents any other persons bound by the arbitration award." Code of Civil Procedure §1285.

"(a) Subject to Section 1286.4, the court shall vacate the award if the court determines any of the following: . . .

(4)The arbitrators exceeded their powers and the award cannot be corrected without affecting the merits of the decision upon the controversy submitted.

(5)The rights of the party were substantially prejudiced by . . . **other conduct of the arbitrators contrary to the provisions of this title.**" Code of Civil Procedure §1286.2 (a)(4), (emphasis added).

## VI

## APPLICABLE CASE LAW

The case law on this issue has held over and over that an Arbitrator's failure to decide all claims and issues presented to him at the hearing on the Arbitration "exceeds their powers" or constitutes "other conduct of the arbitrators contrary to the provisions of this title."

For example, *Rodrigues v. Keller* (1980) 113 Cal.App.3d 838, 170 Cal.Rptr. 349, reached the conclusion that the party attacking the Award "must demonstrate that a particular claim was expressly raised at some time before the award and that the arbitrator failed to consider it". That case goes on to say at pages 840 and 841 that "Code Civ.Proc., §1283.4 provides that (the award) shall include a determination of **all the questions submitted to the arbitrators** the decision of which is necessary (841) in order to determine the controversy."; such failure may constitute "other conduct of the arbitrators contrary to the provisions of this title" justifying vacation of the award under section 1286.2. (emphasis added)

*National Union Fire Insurance Company v. Superior Court* (1967) 252 Cal.App.2d 568, 60 Cal.Rptr.535 and *Banks v. Milwaukee Ins. Co.* (1966) 247 Cal.App.2d 34, 55 Cal.Rptr. 139, both held that in the event that there is an affirmative showing that certain issues were submitted to the Arbitrator and he failed to consider them and rule on them, that constitutes misconduct such that the award should be vacated. "If the record actually shows that the issue

(of general damages) had been submitted to the Arbitrator and that he totally failed to consider it, the Court could and should have vacated the award. It is provided in §1283.4 that: The award shall ....include a determination of all the questions submitted to the Arbitrator, the decision of which is necessary in order to determine the controversy. Failure to find on all issues submitted is, thus, a statutory ground for vacating an award." *(Banks*, supra, at pages 142, 143).

Federal Cases have followed suit in determining when it is appropriate to vacate an award which does not address all issues put before the arbitrator. For example:

In the case of *Western Employers Ins Co v. Jefferies & Co. Inc.* (9th Cir. 1992) 958 F. 2d 258, Western challenged the award on the ground that the arbitrators failed to make findings of fact and conclusions of law as required by the agreement; Western's counsel responded that the contract required the panel to make such findings; On December12, 1989, the arbitrators rendered an award in favor of Jefferies on all disputed issues. The panel did not include any findings of fact and conclusions of law in its award; The court below did not expressly consider Western's basic contractual right to arbitrate according to the specific terms contained in its arbitration agreement; Under these traditional principles, Western had a right to receive what it bargained for – arbitration according to the terms of its contract with Jefferies.

Further, in that case, the Claimant argued that the Arbitrators failed to abide by the terms of the Arbitration Agreement by virtue of their failure to provide Western with findings of fact and conclusions of law, the NASD panel clearly failed to arbitrate the dispute according to the terms of the arbitration agreement. In so doing, the panel exceeded its authority under 9 U.S.C. §10(d).

## VII

## EXPERTS CALLED AT ARBITRATION

Claimant called the following experts ( as well as others) in support of his position on liability and causation:

**1. Willis Wagner, M.D., Vascular Surgeon**

• Graduated University of Southern California/M.D.

• Board Certified in General and Vascular Surgery

• Fellowship trained at University of North Carolina in Vascular Surgery

• Chief, Division of Vascular Surgery, Cedars-Sinai Medical Center (2004-Present)

• Clinical Associate Professor of Surgery, Keck School of Medicine, (2002-Present)

**2. Leo Gordon, M.D., General Surgeon**

• Graduated Northwestern University Medical School/M.D.

• Fellowship trained at Scripps Clinic and Research Foundation in General Surgery

• Certified by the American Board of Surgery

• Associate Director of Surgical Education, Cedars-Sinai Medical Center (2001-Present)

**3. Marvin Ament, M.D., Gastroenterologist, Nationally Recognized TPN Expert**

• Graduated University of Minnesota Medical School/M.D.

• Residencies at University of Washington Hospitals and U.C.L.A.-C.H.A. Los Angeles

• Gastroenterology fellowship at University of Washington

• Board Certified in Pediatrics, Pediatric Gastroenterology and Nutrition

• Medical Director of Pediatric Gastroenterology, Specialty Medical Group Central California, Children's Hospital Central California (2011-Present)

• Professor of Pediatrics, U.C.L.A. Medical Center/Mattel Children's Hospital (1973-Present)

• Distinguished Professor of Pediatrics, U.C.L.A., Los Angeles (2004-Present)

**4. John Vallone, M.D., Pathologist with a Sub-Specialty in Gastro pathology**

• Graduated from Jefferson Medical College/M.D.

• Residencies at University of California Irvine/Pathology

• Fellowships: University of California Irvine/Gastrointestinal/Hepatic Pathology and University of California Los Angeles/NIH-Early Detection Research Network

• Board Certified in Anatomical Pathology

**5. David B. Stanton, M.D., Gastroenterologist**

• Graduated Tufts University Boston, Ma/M.D.

• Residency at University of California San Francisco/Internal Medicine

• Fellowship at University of California San Francisco/Gastroenterology

• Has Clinical Practice, Gastroenterology and Liver Disease, Orange County, Ca (1986-Present)

• Medical Director, GastroDiagnostics Endoscopy Center, Orange, Ca (1993-Present)

• Medical Director, Community Clinical Trials, Orange, Ca (1998-Present)

## VIII

## IDENTIFICATION OF ISSUES PRESENTED AT ARBITRATION AND ANALYSIS OF THE ARBITRATION AWARD

It is Petitioner's position that Dr. Lawrence's conduct after 0744 in the morning was never addressed nor determined by the Arbitrator to be within or below the standard of care although there was substantial testimony on those issues. Dr. Wang's conduct was not addressed or determined at all although there were three witnesses called for that specific purpose.

The Claimant tried the matter addressing primarily the following issues in terms of standard of care and causation:

**Issue #1:**

Dr. Lawrence's FAILURE TO RECOGNIZE SURGICAL ABDOMEN at 0744 and take him to emergent or urgent surgery was below the standard of care.

**Finding of fact:** The Arbitrator determined that conduct was not below standard of care. See Exhibit "A", Arbitration Decision, page 6 beginning at line 13.

**Issue #2:**

Dr. Lawrence's DIAGNOSIS OF SMALL BOWEL OBSTRUCTION at 0744 during his initial consultation and instituting treatment with NG Tube was below the standard of care.

**Finding of Fact:** The Arbitrator determined that was not below standard of care. See Exhibit "A", Arbitration Decision, page 6 beginning at line 13.

**Issue #3:**

Dr. Lawrence's Poor hand-off, i.e. failure to clearly communicate with Wang what to be assessing in the patient and who was in charge, was below the standard of care.

**Finding of Fact:** None.

Pertinent Testimony of Claimant's expert, Dr. Leo Gordon not referred to anywhere in the

Arbitration Decision. Not identified as an issue, No finding of Fact.

Dr. Leo Gordon testified on this issue as follows at page 27 of his Trial testimony: (A true and correct copy is attached hereto as Exhibit "C")

**Page 27**

Q. There is, however, there was a hand off from Dr. Lawrence to Dr. Wang?
A. Yes, that's correct.
Q. You understand that Dr. Lawrence dictated this note

**Page 28**

about 16 minutes before he went off shift that morning?
A. As I understand it.
Q. Do you have some understanding -- let me ask you this. In order to comply with the standard of care, what should have been the quote, unquote, "hand off" from Dr. Lawrence to Dr. Wang?
A. Well, the hand off would be based on the same analysis of the surgical consultation that I reviewed earlier. 46-year old guy with a scar on his abdomen, intense pain and all the other data. The standard of care would dictate this patient be explored with the assumption he has a closed loop bowel obstruction.
Q. If Dr. Lawrence was about to get off duty in 16 minutes and felt this patient needed to go to surgery, he would either, one, have to take the patient to surgery himself to comply with the standard of care or engage an oncoming surgeon to take the patient to surgery?
A. That's my opinion. I think that's correct.

**Page 29**

Q: .....I want to try to carefully write down the quote that he said. Dr. Wang said, "My recollection of what Dr. Lawrence said to me was 'Dr. Wang, if you don't mind at some point looking in on this patient.'"
Let's assume for the moment that that was the type of hand off that occurred between Dr. Lawrence and Dr. Wang.

What are your comments on that?
MR. DEHAAS: I object to the question. It's assuming facts not in evidence. It's a limitation of what was discussed and what Dr. Wang actually testified to. It's extraction from some of his testimony without his full explanation of what was discussed between him and Dr. Lawrence.
THE ARBITRATOR: It may be an incomplete hypothetical. I'll have to judge his response on that basis. Go ahead.
THE WITNESS: Well, one of the big issues in medicine today are these hand offs because of work hour restrictions and people going off call and people coming on call. That seems to me, with respect, a rather leisurely and somewhat cavalier request given the facts that are present in the consultation that occurred some 16 minutes prior to that comment if that's what occurred. In other words, when you say "Would you mind please stopping by," to me it didn't convey the immediacy or the potential seriousness of the underlying surgical problem. That's what I'd say to that particular phrase.

**Issue #4:**

Almost 3 hours passing before placement of the NG Tube was below the standard of care as admitted by Dr. Lawrence in his testimony.

**Finding of Fact:** None

Not identified as an issue, No finding of Fact.

One of the defendants, Dr. Lawrence testified as follows: ( a true and correct copy of the testimony of Michael Lawrence, M.D. is attached hereto as Exhibit "D")

Q. You did, in fact, order an NG tube decompression?
A. I'd have to go back in my notes. I have every reason to believe I did.
Q. You anticipated the NG tube would be placed in what kind of a time frame?
A. As soon as someone can carry out the orders.
Q. You've been working for the Kaiser system for a very long time. Been at the Kaiser Riverside center for a long time and had been in May of 2009 when you placed an order for an NG tube placement for a patient who you believe has a partial small bowel obstruction. How long does it take to get the NG tube placed?
A. It can vary. That's the real answer. There have been times that I'm down, and there is a nurse who is with

me at the time down there, and I've seen them place them before they even go up to the floor. I know at times that it doesn't get taken off until they get to the floor and put in when they hit the floor.
Q. When you've made the order for the NG tube placement for Mr. Tucker, when did you anticipate the NG Tube would be placed? In what time frame?
A. I have no independent recollection. If I was to -- and I hate to assume. If I'm not talking to an RN down in the emergency room at that time, my anticipation would be it would be done when he hits the floor.
Q. Doctor, if I told you that the NG tube was not placed for two hours after you ordered it, would you be concerned about that?
A. Yeah, I would.
Q. If I told you it was not placed for an hour after you ordered it, would you be concerned about that?
A. I'd be disappointed.
Q. If I told you it wasn't inserted for more than three hours after you order it, would you be concerned about it?
A. I'd be ticked.
Q. Did anybody tell you it wasn't until 10:35 that the NG tube was placed?
A. No one told me.

**Issue #5:**

Dr. Wang's Failure to recognize pain out of proportion to a partial small bowel obstruction was below the standard of care.

**Finding of Fact:**

Identified as an issue by Arbitrator, but failed to make a finding of fact. See Exhibit "B" Arbitrator's Decision, page 6 beginning at line 18. Dr. Leo Gordon, Claimant's General Surgery Expert testified as follows, Trial testimony (Exhibit "C"), beginning at page 31 line 16:

**Page 31**

Q. Let's talk about whether this patient continued to exhibit symptoms consistent with a surgical emergency. If you look at 20-001, Doctor, that is an internal medicine note of Dr. Nicholas Nguyen at 9:31 in the morning. If we flip over to 20-002, second page of his note under physical examination, he finds the patient to be in acute distress due to pain.
Again, what we were talking about earlier in your testimony about the patient's presentation not being consistent with a partial small bowel obstruction, what information does

this comment lend us?

**Page 32**

A. Well, most patients with a run of the mill incomplete bowel obstruction due to adhesions usually get better with a nasogastric tube and intravenous fluids. So when you read a note later on in the day, after the patient's admitted, that the general view of the patient is a patient in acute distress due to pain, it plays into the previous mention I made of the severe and continuous nature of a closed loop obstruction or some obstruction like that.

Q. You understand, and we've had testimony in this arbitration, that Chris Burke, the rapid are response team nurse, he testified earlier this week and you read his deposition?

A. Yes.

Q. And Chris Burke was called to the patient's bedside why?

A. I think there was concern on behalf of the nursing staff about this patient and that set in motion some type of rapid response team or some other mechanism within the facility to which he responded.

Q. The particular complaint to which Chris Burke responded was that the patient was in pain and not responding to pain medication?

A. As I understand it, yes.

Q. If a patient has a simple run of the mill partial small bowel obstruction, does the patient respond to pain

**Page 33**

medication?

A. Patient usually responds to pain medication if the other modalities have been used such as a nasogastric tube and intravenous fluids. That's why it's called an incomplete bowel obstruction. It's incomplete. Stuff is getting through.....

**Page 36**

Q. Let's go back to Dr. Wang's initial dictation which is 20-0003. At that time -- by the way, he dictates at 12:01 -- we know that the patient had been admitted, had the nasogastric tube inserted. We know that because we have its output listed by Dr. Wang.

At that point in time, Dr. Wang described to us that he did an examination of the patient, asked him some short questions is what Dr. Wang said, and then found in the abdomen that the patient was guarded. Do you see that under his impression?

A. I do.

Q. So Dr. Wang found at sometime before noon that the patient was guarded. We read the dictation by nurse Ballesteros of 10:35, indicating that Dr. Wang was made aware

**Page 37**

of what the patient's status was.

I want you to assume for the moment that Dr. Wang testified that, when he came to see the patient, the patient was in discomfort. He was uncomfortable is what Dr. Wang continued to say. First of all, in terms of looking at the nursing notes and looking at the pain scales and other information that's in the medical record, did you see any other location at or about this time, noon, where the patient indicated that he was not in severe pain?

A. No. There are certainly notes of decreased pain after administration of the pain medicine. But there is rapid recurrence of the pain within a short time after that.

Q. And by the time the patient gets admitted and gets to noon, was there even any indication at all at that point that the patient was even getting short-term relief from the pain medication?

A. I don't believe so because this is a note around that time that now describes the guarding, and part of guarding is pain when you examine the patient.

Q. And part of guarding is an indication of what?

A. It's an indication of peritonitis.
Q. If a patient is examined by a surgeon and guarding is found, is that a surgical emergency?
A. Well, you have to put the whole thing --
Q. I asked my question poorly. In the context of this

**Page 38**

patient, knowing what we know about this patient's presentation and the events leading up to noon, when Dr. Wang does the examination and finds that the patient's abdomen is guarded, do you believe in order to comply with the standard of care, the patient should have been taken to surgery?
A. I do.
Q. You know that there was no arrangement or suggestion made for surgery at that point in time?
A. That's correct.

**Page 41**

Q. Are you of the opinion that Dr. Wang breached the standard of care at the time of his second evaluation of this patient?
A. That is my opinion.

**Issue #6:**

Dr. Wang's failure to respond to the patient's deteriorating condition was below the standard of care. Rapid Response Team Nurse, Chris Burke's testimony not referenced. Chris Burke's note was introduced into Evidence at the Arbitration. It is attached hereto as Exhibit "J".

**Finding of Fact:**

Alluded to at the Arbitrator's Decision (Exhibit "B") page 6 line 39, but no finding of fact determined by the Arbitrator. Chris Burke's testimony not even mentioned. Dr. Leo Gordon testified (Exhibit "C") beginning at page 38 of his Trial testimony as follows:

**Page 38**

Q. There are events that occur between this examination and the examination done later which is dictated at 2:31 P.M. I want you to assume for the moment that Dr. Wang testified

here two days ago that he thinks he may have examined the patient as early as 1:30 maybe up until 2:00 P.M. and didn't dictate this note until 2:31. I want you to assume that's what he testified to. All right?
A. Okay.
Q. Looking at this note 20-05 -- let's start with 20-04. Dr. Wang testified that and dictated that he sent the patient for another KUB, a flat x-ray of the kidneys, ureters and bladder and found that there was dilated small bowel. No gross free air was seen. What does that signify, no gross free air?
A. It means nothing is perforated yet.
Q. He lists blood pressure, pulse, temperature, etc. By the way, if you look across the blood pressure, pulse,

**Page 39**

temperature and respirations, those are all elevated, are they not?
A. They are. The patient in severe pain with overt peritoneal signs. Patient has a rather rigid abdomen in the setting of a right renal mass and known right inguinal hernia. Under his abdominal examination, he lists that the patient has peritoneal signs, is very guarded and has a rigid abdomen. Okay.
Under his impression and plan, indicates patient has an acute abdomen in the setting of a right renal mass, right inguinal hernia. Recommendation would be for exploration right now for possible closed loop small bowel obstruction likely due to adhesion.
I want you to assume that this information and these findings were made at some point in time between 1:30 P.M. and 2:30 P.M. If the patient did not go to surgery until 4:45 that afternoon, is that below the standard of care?
A. It is.
Q. Why?
A. The same parameters apply throughout the day as applied with the data available at 7:30 in the morning. In this circumstance though, even though you don't need it, you

have the added immediacy of peritonitis and what was described as a rigid abdomen.
The evidence of peritonitis was described by the

**Page 40**

surgeon as overt. I took that to mean easily noticeable or quite clearly demonstrable. I mean, now you have an elevated temperature, an elevated respiratory rate and an elevated pulse. So the standard of care is essentially the same.
Q. I understand the standard of care is the same, but you just mentioned something. You now have the added immediacy of peritonitis. Tell me what you mean by that?
A. Well, this note is a clear cut description of a patient that has something severely inflamed or dead within his abdomen. That as much immediacy as you can quantify it there was at 7:30 is now multiplied by the fact that the patient has developed signs typically associated with advanced inflammation, death of tissue or an ongoing serious intraabdominal problem.
Q. If in fact the testimony in this case has been and is accurate that, even after the team was assembled, the operating room was ready, the patient was in the O.R. holding area, even after all of that was accomplished, that Dr. Wang indicated that he was still waiting for Dr. Lawrence, is that below the standard of care?
MR. ERICKSON: Misstates the testimony.
THE ARBITRATOR: It's asked in terms of a hypothetical. If you can show that is not accurate, it impacts the force of his answer, but he can answer that hypothetical.
THE WITNESS: Well, I assume that Dr. Wang had the

**Page 41**

same skills Dr. Lawrence had in terms of the ability to open up the human abdomen. Yes, under these circumstances it would certainly be below the standard of care to wait if you had the expertise to do the job.
Q. BY MS. LAW: Are you of the opinion that Dr. Wang

fell below the standard of care at the time of his initial examination of this patient?

A. I am.

**Issue #7:**

Dr. Wang's Failure to recognize the impact and significance of peritoneal signs was below the standard of care.

**Finding of Fact:**

Not identified as an issue by the Arbitrator, and failed to make a finding of fact. See Leo Gordon's testimony (Exhibit "C") beginning at page 25 line 13:

**Page 25**

Q. We also know that Dr. Wang did not schedule the patient for surgery until after Dr. Wang discovered peritoneal signs, true?

A. That's correct.

Q. You also read the deposition of Dr. Alexander, the defendant's general surgery expert in this case. What is it that Dr. Magdee Alexander said about when the appropriate time to take this patient to surgery would have been?

A. As I understand Dr. Magdee's testimony in his deposition, the theme of his comments was to wait for the patient to develop these peritoneal signs or peritonitis before deciding to go to surgery. I think part of the testimony was something to the effect that we were taught by

**Page 26**

his mentors to -- the term is sit on the patient which is a global term for watching and observing the patient until peritoneal signs develop. I believe that's what he testified to.

Q. We had Dr. Willis Wagner here yesterday. You know Dr. Wagner?

A. Yes.

Q. In fact, it was at Dr. Wagner's suggestion that you became involved in this case or at least look at the file?

A. Right. He wrote initially, asked if I would be

involved in this case.
Q. And Dr. Wagner testified to us yesterday that the development of peritoneal signs is consistent with evidence of irreversible bowel injury. So let me ask you this. Do you agree with that, first of all?
A. I think that's reasonable. I do agree with that.
Q. So basically the theme of Dr. Alexander's deposition and of course what we know from what happened with Dr. Lawrence and Dr. Wang was to wait until the patient developed peritonitis before taking him to surgery.
The question then is is it within the standard of care to wait until the patient shows signs of irreversible bowel injury before taking him to surgery?
A. That is below the standard of care since the whole effort to get someone to surgery is to identify and correct

**Page 27**

whatever problems are going on in the abdomen. In other words, if you have sufficient data and suspicion to proceed to surgery, you certainly don't wait for the development of peritonitis to justify taking the patient to surgery.
Q. So you've told us that you think Dr. Lawrence fell below the standard of care by failing to schedule this patient for surgery at or about 7:30 in the morning, correct?
A. Right. Or just out of fairness in calling another surgeon to do the same.
Q. And that gets me to my next point. Dr. Lawrence admitted the patient for the plan that we've just outlined that's reflected in his initial dictation. Did Dr. Lawrence follow this patient at all after that moment?
A. Not until later on in the afternoon when he was called back and the patient was taken to surgery.

**Issue #8:**

Dr. Wang's refusal to proceed to the surgery without Dr. Lawrence, which delayed the surgery for almost 3 hours was below the standard of care.

///

**Finding of Fact:**

Identified as an issue by the Arbitrator, but failed to make a finding of fact, other than, "It was very troublesome". See testimony listed in evidence for issues 5, 6, 7 and 8 above.

**Issue #9:**

Lawrence's removal of "pale pink" viable bowel at surgery was below the standard of care.

**Finding of Fact:**

Not even identified as an issue by the Arbitrator, nor a finding of fact made. One item of evidence that was admitted at the Trial was the pathology report of the Kaiser pathologist, Dr. Salcedo identifying a 60 cm portion of the bowel that was removed as "pale pink and mottled." (A true and correct copy of this report is attached hereto as Exhibit "E". Further, see testimony of **Defendant's** expert, Preston Flanigan, a true and correct copy of which is attached hereto as Exhibit "F", beginning at page 11 of his testimony.

> Q. Because you look at the bowel and you determine based on the gross observation of the bowel whether it's dead, whether it's viable, alive or whether it's questionable; correct?
> A. Exactly.
> Q. And when you do that, you leave in the questionable bowel and you plan to come back and take a second look; correct?
> A. Yes.
> Q. How do you know what bowel to take out; how do you know what bowel is dead?
> A. Because we have seen it so many times. And we just know based on the characteristics which you asked me about before.
> And we talked about that it's black. It's thinned. It may be perforated. It's nonparasitic. The muscles are not working in it.
>
> **Page 12**
> You may see clotted arteries that are close to the bowel and in the bowel wall where you know it cannot survive that.
> So, those are the characteristics that we look at and we make a decision based on that.
> And to some degree it's based on, you know, my mentors telling me and their mentors telling them and on and on. And that's clinically how it's done.
> If there's any question in your mind about whether something is dead or alive, you leave it in. That's the whole basis for the mandatory second-look operation.

Q. So, if you see pink bowel, if you see pale pink bowel, if you see mottled or patchy bowel that is pink in color, you leave it with the idea that you will come back 24 hours later?
A. Right.
Q. Because it would be below the standard of care to remove pink, pale pink or questionable viable bowel on the first operation; correct?
A. It would below the standard of care to remove bowel which you did not believe was frankly necrotic at that point in time.
Q. What would lead you to the conclusion that it was frankly necrotic is that it would be black, thinned,

**Page 13**
perforated?
A. It wouldn't have to be all of those things, but a combination of various characteristics.
Q. The earlier that the patient is taken to surgery and the bowel revascularized, the lower the mortality and the lower the morbidity?
A. I haven't actually seen that study, but from a logical standpoint I would have to say that that makes sense.

**Page 24**
Q. What you do is you remove the thrombus from the S.M.A. and you put the intestine back in the belly and you let it sit there; don't you?
A. Other than dead stuff, yes.
Q. Well, you let it sit there before you cut into it, if you have dead areas and questionable areas and viable areas, you don't start cutting around and taking pieces out until you've reprofused the area; do you?
A. Normally, that's true.
Q. So, you reprofuse the area, you take the clot out and you reprofuse the area and you stick it back in the belly and you wait and look at it; correct?
A. Yes.
Q. Because with the devastating consequences of the removal of a significant portion of bowel, you've got to give the patient the benefit of the doubt; true?
A. True.
Q. And it's your opinion and it's well-established in the literature that you wait a period of 30 to 40 minutes after you've removed that thrombus to see if you have lines of demarkation between viable, questionable and obviously dead bowel; true?
A. Yeah, 30 in a patient.
Q. Do you know how long they waited in this case before they began removing bowel?

**Page 25**
A. I don't.
Q. It would be below the stand of care not to wait

a period of time; true?
A. Not necessarily. If you looked at a certain part of the bowel and you've got a couple surgeons standing there both saying this bowel is as black as this chair here and it's dead.
You may as well do something during the 30 minutes that you're waiting because you're going to take that bowel anyway.
Something that looks like that is not going to turn back to normal pink bowel. It's those marginal areas that you're waiting to see what's going to happen with.
Q. So, you leave the marginal areas in for 30 minutes. And if they look at the end of the same of 30 or 40 minutes, you would make the decision whether you're going to leave them for the second cut?
MR. DEHAAS: And you keep saying 30 to 40 minutes. And he said around 30 minutes.
MS. LAW: Okay. I apologize. I'll re-ask my question.
BY MS. LAW:
Q. So then you would leave the marginal areas in the bowel for a period of, approximately, 30 minutes and

**Page 26**

watch what happened to those areas; true?
A. You would or you might also say we're going to do a second look tomorrow and so we'll look then. We will give it more than 30 minutes. We will give it 24 hours.
Q. That would be the standard of care; would it not, Doctor?
A. It would be, either one.
Q. Either, given 30 minutes --
A. If you waited 30 minutes and nothing changed, but if it was still marginal looking, you still would not take it out.
Q. So, marginal means just that; marginal means that we're coming back for a second look?
A. We're coming back anyway.



**CAUSATION ISSUES:**

1) The Claimant was in excruciating pain for 10 hours after seeing Dr. Lawrence, yet the Arbitrator never mentioned that as a recoverable damage.

2) Each hour that passed leading up to the surgery caused further damage to the bowel.

3) Every centimeter of bowel that could have been saved would have afforded the Claimant a better quality of life.

4) The less TPN needed, the better off for the Claimant. The more bowel, the less TPN

needed.

5) Surgery at 2pm or 3pm or 4pm would have saved more bowel.

Although the Arbitrator refers to the fact that the "earlier the reperfusion, the likelihood of increased functional bowel is greater", the Arbitrator never made a finding of fact as to whether or not the conduct after 7:44 a.m. caused any injury to the Claimant. That is a fatal omission on causation.

The testimony on the causation issues presented at Arbitration was as follows:

Dr. David Stanton, Claimant's Gastroenterologist testified as follows: (A true and correct copy of his testimony is attached hereto as Exhibit"G"):

**Page 8**

Q. Okay. What are your opinions in that regard?
A. Well, that he's T.P.N. dependant. That's Total Parenteral Nutrition. I'm sure that that abbreviation has been used a lot here. And highly likely will be for life.

**Page 9**
That he has significant disabilities associated with the many surgeries and insults we'll say that his body has been through. And that he's likely to need extensive care medically going forward.
And I should also say that his life expectancy is somewhat shortened. I believe that I said 10 years was my estimate from the expected figure of 77 or 78 years of age for a Caucasian man.
Q. All right. Let's take those one at a time. The first one is T.P.N. dependent and highly likely will be for life; on what do you base that opinion?
A. On the basis that he, during the surgeries that he underwent, and especially the first two surgeries that he had in '09, he lost the majority of his small intestine.
It was resected and that he's left with something like 50 centimeters of small bowel. He was on Total Parenteral Nutrition from a period shortly after the surgeries until the present time.
He has had two attempts of weaning from the T.P.N. which both resulted in profound weight loss and weakness and those were both abandoned.

**Page 36**
Q. All right. In terms of your experience of caring for patients that have short gut syndrome or are T.P.N. dependent, do you have an opinion with respect to

**Page 37**
if Mr. Tucker had an additional 30 centimeters of bowel, what effect that would have on his T.P.N. dependence?
A. Potentially, it could limit it or even reverse it.
MR. ERICKSON: You know what, I'm going to object that it's accumulative. We've heard from the doctor on this extensively.
THE COURT: Overruled.
BY MS. LAW:
Q. And in terms of if Mr. Tucker had an additional 60 centimeters of bowel, what in your opinion would that effect be on his need for T.P.N.?
A. If it was properly functioning, he would more likely than not be T.P.N. free.

Dr. Marvin Ament who is widely regarded as one of the World's experts on TPN testified as follows: (A true and correct copy of which is attached hereto as Exhibit "H")

**Page 14**
Q. Just do it as briefly as you can so that we can explain what the difference should be if you had more or less bowel.
A. Well, your intestine looks like a carpet. If you would look at it microscopically, it truly – it looks like a carpet. These are your absorptive fingers. They're called villi, absorptive villi. And again, the – just to make you aware, you need about – if you're a normal person, 50 percent of your intestinal is what you need to really have normal digestion and absorption. The body has a lot of reserve. The body has a lot of reserve. So that's why you can lose 50 percent and not get into trouble. Okay.
Let's say you lose more than 50 percent. The – what's left has got to try to do the job of the part that you've resected. What happens is these absorptive villi grow. That's what happens when you ger a resection. The bowel that's left – the villi try – they grow to try to make up for what's been resected. That's what adaptation

**Page 15**
really is. So the part of the intestine that's left grows so it can improve – absorb better. But again, it can only do so much. And so that's – and then right now – I mean, I don't have the earliest figures. I just know where he is right right now. That he's obviously absorbing a third of what he needs from eating and drinking.
Q. Is there, Doctor, a quote unquote magic number in terms of the number of centimeters of bowel that an adult needs to generally not be TPN dependent?
A. Well, it's really quite variable. I mean, I can tell you that you're going to see various things. If you have – if you have more than, you know, I would say, 38 to

50 centimeters of the small intestine – okay. This is the small intestine – and you have an ileocecal valve – and I'll talk about all of these things in a minute – plus the colon – okay. I'm going to give you another little bit of a lesson.
In an adult – in a typical –
MR. ERICKSON: Hold on. If the lesson is outside of the call of the question, I'm going to object.
JUSTICE SOMMER: I think that we can break it up a little bit. So let her lead you through it.
Q. BY MS. LAW: The question is, is there a magic number that you can look at or that's in the literature that tells us when a patient will be TPN independent?

**Page 16**
A. Yes. If you have 38 to 50 centimeters of small intestine and you've got an ileocecal valve and you have the whole colon functioning, this is an adult who should be able to come off of TPN and become independent, either by eating and drinking or by infusing, feeding through a gastrostomy tube. But this will – in the year 2012, a patient who has all of these has probably a 90 percent chance of fully adapting.
Q. Does Mr. Tucker have that much small intestine?
A. You know, he may have 24 – I've seen various numbers in there. I saw 24 centimeters of small intestine, plus the ileocecal valve. He does not have the whole colon. He is using only half of his colon. He has a transverse colostomy.

**Page 19**
Q. In terms of what you know about him, about how much colon he has left, about how much small intestine he has left, about how he's been able to adapt at least to a third of his calories by PO intake, do you have an opinion as to what would be the likelihood of his TPN independence or dependence if he had an additional 30 centimeters of bowel that had been saved?
A. I think it would be substantially better.

Claimant's Vascular surgery Expert, Willis Wagner, testified beginning at page 31 of his Trial testimony as follows: (A true and correct copy is attached hereto as Exhibit "I")

Q. Okay. So let's work backwards in terms of this case in particular.
We know that not the entire bowel died in this case. We know that?
A. Correct.
Q. Okay. And we know that the occlusion occurred at or very near 3:00 p.m. the day before?
A. Correct.
Q. Okay. So we have the onset of the occlusion at 3:00 p.m. the day before and we have the resection at

approximately 6:00 p.m. the next day. So now we have 27 hours; correct?
A. Yes.
Q. Okay. So we have 27 hours up until the time that the surgery occurs. And even at 27 hours there is a portion of the bowel that was salvaged; correct?
A. Yes.

**Page 32**
Q. Okay. There are other portions of the bowel, based on the pathologist's deposition – and you read the respondent's pathologist Dr. Fishbein's deposition; true?
A. Yes.
Q. Okay. And Dr. Fishbein opined in his deposition that a number of the representative sections that he looked at in terms of the segments of bowel that were removed, that many of them only had mucosal or submucosal involvement. You recall that testimony?
A. Yes.
Q. Okay. And so then again, so we have 27 hours between onset and resection, and we still have, on the sections, evidence of only mucosal or submucosal involvement; true?
A. Yes.
Q. Okay. And by the way, death of the bowel is death through the bowel wall into the muscularis propria; true?
A. Yes.
Q. Okay.
A. You can have death of the inner lining of the bowel and it can regenerate. It sluffs. That occurs not uncommonly with various shock states – trauma, heart disease – where the blood flow transiently is diminished. Blood flow to the inner lining of the bowel is compromised. the inner lining of the bowel sluffs and it regenerates as

**Page 33**
long as the remainder of the bowel stays alive. It's not an all or none process.
Q. So all the mark or the line on the sand of irreversibility is that line of the muscularis propria; true?
A. It's the outer layer of the bowel.

**Page 41**
Q. All right. And then in terms of the patient's presenting symptoms, do they lend us any information related to whether the bowel was dead before Mr. Tucker presented to the emergency department?
A. Well, as physicians refer to both signs and symptoms. Signs meaning the examination, and the symptoms are what the patient complains of. He was complaining of constant severe pain. And as I said earlier in my testimony, a dead organ doesn't hurt. If the bowel was dead and there was no segment that was still viable, he would have no pain. Dead bowel doesn't have pain. Just as

a dead leg doesn't have pain. It's anesthetic. The nerves that go to that area don't feel anything. They don't send

**Page 42**

a signal. The way the brain perceives pain is the signal comes from the nerves in the area where the insult is occurring. That's how pain is perceived. If the nerves going to the bowel are dead because the bowel is dead, the brain would not perceive pain. The brain perceives pain because the stimulus is there, the bowel is screaming out, whatever triggers the nerve fibers for pain is going on. So he was complaining. So we had — the symptom of pain is not consistent with irreversible dead bowel. And the physical findings of no peritoneal signs also indicate that it was not irreversibly dead. If he had irreversibly dead bowel on presentation, he would have peritonitis. And we have the testimony of both the emergency room physician who initially examined him, as well as Dr. Lawrence who examined him the next morning, that he did not have peritoneal signs. And it was only in the early afternoon that Dr. Wang identifies peritoneal signs. So clearly there was an evolution occurring. It did not come to completion prior to his admission.

**Page 43**

Q. In terms of your – finishing out your causation opinions in this case. Have you reached opinions and conclusions with respect to what difference, if any, a surgery earlier in the day – the discovery earlier in the day of this occlusion and thrombectomy performed earlier in the day, what difference that would have made for Mr. Tucker?
A. Yes. It's my opinion that every hour earlier this operation occurred would have resulted in salvage of more bowel. I know you as attorneys like to say, "Okay, at what point did this percentage of bowel" – and I think I've made it pretty clear we can't say that. We can't predict that. There are just too many variables in the human body to say that at this period of time this amount of bowel would have been saved.
What I can say very definitively is that every hour prior to the operation that was undertaken would have resulted in salvage of additional portions of the bowel.
Q. In terms of taking the testimony of the

**Page 44**

pathologists in this case who have basically dissected all of the levels of the bowel and looked at all of the slides in this case, can we correlate what portions of the bowel would more likely have been saved at what time based on the level of necrosis that's seen in the slides?
A. Well, that also is hard to say. Because even segments that were clearly dead, if they had been revascularized four hours before, may have been alive. Clearly there were segments on the bowel that there was not

transmural death. And those segments likely would have been salvaged. But in the segments – even the segments that had complete death, even those segments might have survived. Yes, they might have sluff the epithelium of the lining of the intestine, and it might have had – might have been ill and had required some regeneration of that lining in the intestine. But even some of the frankly necrotic bowel could have survived.
Q. So when we look at – when we listen to the pathologist testify that there were areas that only had necrosis of the villi – we heard a little bit yesterday about the villi. What are the villi?
A. Villi are the infoldings and outpuches of the lining of the intestine that snatch up the nutrients as it goes through the intestine. It increases the surface area so that you don't have just a straight pipe. If you have

**Page 45**
little inlets kind of like you have at a pier, little inlets sticking out, all that entire surface is capable of absorbing nutrients as opposed to just a straight river with two banks on it. The villi are projections that contain cells that can snatch up nutrients.
Q. And the villi are the top layer, basically, the inner most layer of the bowel; true?
A. Yes.
Q. All right. So areas on pathology that show only necrosis of the villi, those are the ones that are least injured by the ischemic event; correct?
A. Correct. And are capable – even if the villi completely die, are capable of regenerating. That surface of the bowel is very able to regenerate. There are different organs in the body that have different regenerative capacity. Some organs don't regenerate well. Some organs heal and regenerate very well. For instance, the liver, the lungs do regenerate very well. The intestinal lining does as well.
Q. Then underneath the villi is the level of the bowel that's known as the mucosa?
A. Yes.
Q. The submucosa?
A. Um-hm.
Q. And then the bowel wall?

**Page 46**
A. Yes.
Q. Okay. So is it fair to say – let me ask you, the areas that have the least invasion of necrosis or show the least necrotic tissue, are those the areas that are most likely to have survived had it been reperfused?
A. Yes.
///
///

**Re-Direct**

**Page 6**
Q. The fact -- there's a very detailed description of what that additional 45 centimeters looked like and why Dr. Lawrence left it in; true?
A. Yes.
Q. Okay. And the descriptor by Dr. Lawrence of what it looked like and why he left it in were what in your recollection?
A. Because it was patchy and it looked like it potentially was salvageable.
Q. What does that mean in terms of the ischemic event to that area of the bowel?
A It means that that portion of the bowel, which is sort of in the cusp between the SMA and the IMA circulation, it's just teetering on the edge. It's just teetering on the edge. It might die, it might not.
Q. So bowel that is just teetering on the edge, can you say to a reasonable degree of medical probability what the outcome for that bowel would have been had it been reperfused five hours early?
A. I believe more likely than not it would have survived.

Dr. John Vallone, Clinical Pathologist, testified on causation as follows (a true and correct copy of his testimony attached hereto as Exhibit "K":

**Page 37**
Q. If you were to get the patient -- if the patient were to get to surgery, have the thrombosis removed and the area at the S.M.A. opened, and the distribution of the S.M.A. reperfused, two hours before this patient developed peritoneal signs, what is your opinion with respect to what portion of the bowel would have been salvageable based on what you see in these slides?
A. So, this goes to the clinical pathologic correlation which is in, I would say, all pathologist's mind is critical, is that prior to this time, prior to the peritonitis, two hours prior to that this bowel probably was not showing this degree of necrosis. So,

**Page 38**
it would have been significantly less.
And I would say that there is a, that there is a high degree of likelihood that this bowel would have been viable at that point.
Page 42
Q. So now let's go to the shorter segment of the bowel.
First of all, tell us how Dr. Sacedo, the Kaiser pathologist, described the shorter segment of the

bowel.
A. This is in quotes. The shorter segment of bowel is pale pink and mottled in appearance, period. It's intact, period.
No perforation is seen, period.
The ends are also stapled shut, period.
The external diameter of the bowel ranges from two point zero to four point zero centimeters, period.
Q. Okay. In terms of gross observation of a segment of bowel and calling it pale pink and mottled, what does that mean to you?
A. It means that there's some ischemic injury.
Q. Pale pink and --
A. Now if I can just clarify that. It's ischemic. So, it's still being perfused. That's why it's pink. It becomes pale in areas where the blood flow is decreased. It's different from dusky.
So, she's saying pale pink and mottled, there's variability in the pink and in the paleness. It's

**Page 43**
different than the larger segment where she used the term dusky brown.
Q. Dusky brown connotes to you in terms of a gross observation that it is dead bowel?
A. It connotes to me that there's a greater likelihood of it being dead bowel.
Q. On the other hand, pale pink and mottled connotes to you what?
A. A viable bowel.

**Page 46**
Q. All right. So, in terms of the four representative sections of the shorter segment of the bowel, the 60-centimeter segment of the bowel; in terms of looking at all four sections, and you don't have to take us through all four sections, but in terms of looking at all four sections of the shorter segment of the bowel, the 60 centimeters that was pale pink and mottled, do those four distinct sections show viable

**Page 47**
bowel?
A. Yes.
Q. And that's viable bowel just before it's resected at, approximately, 6:00 p.m.?
A. Yes.

**Page 48**
Q. Now, in terms of gross appearance, we've looked at the microscopic appearance. And we've heard what Dr. Sacedo called was the gross appearance, but I want to ask you, what difference would reperfusing this bowel have made, say, it was two hours before the resection or four or six hours before the resection, what difference

would that earlier reperfusion have made in gross observation of the bowel?

**Page 49**
A. It would look more pink. And, you know, in talking about the timing of events, I think that it's really quite important the development of the patient's peritonitis as a sign as to what's happening inside.

**Issue # 10:**

Did Dr. Lawrence's pronouncement of the imminent death of the Claimant, which was clearly erroneous, cause injury to Claimant, Lisa Tucker?

**Finding of Fact:**

The Arbitrator identified that conduct as "very troublesome" and "leaving much to be desired", but never made a finding of fact as to whether that was negligent or caused injury.

Although Lisa Tucker's testimony is not ready as of the time of the filing of this Petition, Claimant's Counsel's declaration sets forth as an offer of proof, the testimony that was elicited on this issue.

## IX

## CONCLUSION

Based on the foregoing evidence cited from the Arbitration transcripts and the Declaration of Patricia A. Law attached hereto, it is respectfully requested that the Arbitration Decision be vacated because of its failure to address and decide the majority of the issues submitted to the Arbitrator. It is further requested that the matter be remanded to the Arbitration forum for selection of a Neutral Arbitrator and the re-hearing on the matter so that all issues of negligence and causation may be decided.

Dated: December 21, 2012

LAW OFFICES OF PATRICIA A. LAW

BY: _____
PATRICIA A. LAW
Attorneys for Claimants