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OFFICE OF THE INDEPENDENT ADMINISTRATOR

KAISER PERMANENTE MEMBER ARBITRATIONS

CHRISTINA FLACH, DYLAN FLACH, MADISION FLACH, NOAH FLACH AND HANNAH FLACH,

Claimants

vs.

KAISER FOUNDATION HEALTH PLAN, INC, KAISER FOUNDATION HOSPITALS AND KAISER PERMANENTE MEDICAL GROUP, INC.,

Respondents

OIA: Arbitration Case No. 15721

Judicate West: Case No. A254706-53

STATEMENT OF DECISION AND AWARD

Hearing on Zoom: 10-05-21 to 10-15-21

Decision of February 9, 2022

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I. INTRODUCTION

The Arbitration Hearing in this matter came on regularly for hearing on the Zoom platform on October 4, 5, 6, 7, 8, 11,12,13,14 and 15, 2021, before the duly appointed Arbitrator in this case, the Honorable Donald J. Sullivan, Judge of the Superior Court (Ret). The live testimony concluded on October 15, 2021. The Arbitration Hearing remained open for post Arbitration evidentiary submissions on November 1, 2021 (where the Parties submitted over a thousand pages) and also remained open for post Arbitration Briefings (over 200 pages) until November 29, 2021. After a cursory review of the Post Arbitration Briefs, the Arbitrator noted that Claimants were requesting non-economic damages in excess of the $250,000.00 cap imposed by Civil Code Section 3333.2. The Arbitrator was surprised by this Request because it had not been made prior in the litigation nor during the live Arbitration Hearing. Since Respondents (understandably) had not responded to this issue in their Post Arbitration Hearing Briefs, the Arbitrator gave them until December 7, 2021 to submit additional briefing on this issue, which they did. Thereafter, the Arbitrator gave Claimants an opportunity to Reply, which they did on December 20, 2021.

The Reporters' transcript from this proceeding runs 2,609 pages. Approximately 10,000 pages of Briefings and Exhibits had been submitted as pre-Arbitration filings. More than a thousand pages of Briefings, Testimony and Exhibits were submitted after the close of the Arbitration Hearing. Based upon Stipulation, the Arbitration Award in this case is due on February 11, 2022.

Attorney Scott Righthand of the Law Office of Scott Righthand appeared on behalf of Claimant Christina Flach, the surviving spouse of decedent Kenneth E. Flach. Attorneys William A. Levin, Maria Ramos, Angela Nehmens and Samira Bokaie of Levin Simes

Abrams LLP appeared on behalf of Claimants Dylan Flach, Madison Flach, Noah Flach and Hannah Flach, the adult children of decedent, Kenneth E. Flach.

Attorneys Brian Davies and Ryan Snyder of Hayes, Scott, Bonino, Ellingson, Gustani, Simonson & Clause LLP appeared on behalf of Respondents Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and The Permanente Medical Group, Inc., sued herein as "Kaiser Permanente Medical Group."

This is a medical malpractice, wrongful death action. Claimants are pursuing claims against the Kaiser entities listed above based upon "institutional" negligence by such entities. Claimants are also claiming that the Kaiser entities are liable under the theory of Respondeat Superior for the negligent acts or omissions of their employees, Cynthia Girtz, RN and John Culbertson, MD. The Arbitrator notes that these two individuals were the employees of Respondent The Permanente Medical Group, Inc., sued herein as Kaiser Permanente Medical Group.

An alleged party Respondent named "Kaiser Permanente Insurance Company" was dismissed from this litigation by Stipulation in May of 2019 because no such entity exists. [See Arbitration Management Conference Order of May 22, 2019.] In addition, by written Stipulation of September 5, 2019, previously named Respondents, John Culbertson, M.D. and Jason Bateman, M.D., were dismissed without prejudice from this case, subject to agreement that Respondents produce them for depositions; agree that they were acting within the course and scope of their employment with the remaining Respondents, while they provided care and treatment to decedent, Kenneth Flach; and agreed that, if either of them was negligent and such negligence was a substantial factor in causing Mr. Flach's death, the remaining Respondents will respond to and satisfy the award and judgment. (Respondeat Superior). It is the Arbitrator's

understanding that Respondents accepted these conditions for the dismissal of Doctors Bateman and Culbertson from this litigation.

In addition, at the commencement of the arbitration hearing, claimants stated that they were no longer pursuing any negligence claims relating to the care and treatment of decedent Ken Flach at the Kaiser Hospital in San Rafael on March 8, 2021.

Opening Statements, Testimony, Exhibits, Arguments and all Briefings submitted by the Parties were considered. The Arbitrator has included many quotes and excerpts from the submissions in this Award. The Arbitrator is familiar with the CACI jury instructions in general, including the ones pertaining to this matter, including Medical Negligence (the 500 series). The Arbitrator considered the Briefings submitted by the Parties and consulted the CACI jury instructions in applying the law in this case.

The following individuals testified, either by way of live testimony, deposition testimony or by Declaration:

1. Cynthia D. Girtz, RN
2. Mark I. Langdorf, MD
3. John David Culbertson, MD
4. Mary Marshall "Molly" Cooke, MD
5. Shelley Gordon, MD
6. Christina Flach
7. Robert Seguso
8. James Dana Leo, MD
9. Perry Rogers
10. Jonathan Calvin Tobias

11. Madison Flach

12. Hannah Flach

13. Dylan Flach

14. Blythe Basich, RN

15. Jerome Barakos, MD

16. Phillip Hugh Allman, PhD

17. Gordon Scott Drysdale

18. Steven Fugaro, MD

19. Brenda Danner, RN

20. Michael J. Bresler, MD

21. William Patrick Joseph, MD

22. Mark Cohen, M.S.

23. Thomas Shaughnessy, MD

24. Aleco Preovolos

25. Trey Welke

26. William Hoddick, MD

27. Michael Jacobs, MD

28. Patricia Padilla, MD

29. Sarah Puryear, MD

30. Richard Stevens, CPA

31. Dave Stockton, Jr.

32. Hugh West, MD

33. Noah Flach

34. Robert W. Johnson, MBA

35. Windy Chavez

II. STATEMENT OF FACTS

A. Flachs' Telephone Call with The Permanente Medical Group, Inc. Appointment and Advice Call Center

At all relevant herein, Kenneth Flach and Christina Flach, residents of Novato, California, were both enrollees in the subject health plan administered by Kaiser Foundation Health Plan, Inc. On Wednesday, March 7, 2018, Claimant Christina Flach attempted, unsuccessfully, to directly call John Culbertson, MD, an employee of The Permanente Medical Group, Inc. [Medical Group], the primary care physician of Kenneth Flach. Mr. Flach was very sick. Dr. Culbertson's office was located at the Kaiser Permanente Clinic in Novato, California. Mrs. Flach was unable to directly reach Dr. Culbertson or his office assistant due to the Medical Group's communication policies and was required to go through the Kaiser Advice Nurse system. At 1:42 PM on March 7, 2021, Mrs. Flach, with Mr. Flach at her side, called the required Kaiser help number and the system routed the Flachs to Windy Chavez, a Medical Group Teleservice Representative or TSR,

As an employee of The Permanente Medical Group, Inc., Ms. Chavez was not medically trained. However, she received several weeks of training on how to handle incoming calls. She was trained that as soon as someone called-in with a emergent complaint, such as chest pain (she had a list of 15 "emergent" complaints), she was to immediately contact, depending on the circumstance, either the "CCMD" [Critical Care MD] or the Advice Nurse at the call center [AACC], relay the "emergent" complaint to the responding CCMD or Advice Nurse and "warm transfer" the call (stay on the line while the caller and CCMD or Advice Nurse are connected).

During the portion of the call with TSR Windy Chavez, Christina Flach relayed to Ms. Chavez that "my husband has bronchitis really, really bad; *his chest is killing him*; he has a fever. I have never seen him so sick. Stuff is coming out of his chest. His chest is really in pain. He is tired." [This call is recorded.]

After talking with Christina Flach, Windy Chavez placed the Flachs on hold and then spoke with advice nurse Cynthia Girtz, RN, also an employee of The Permanente Medical Group, Inc. Ms. Chavez told Nurse Girtz that "He's got really bad bronchitis, his chest is in pain, hacking up stuff and a bunch of different other things." Ms. Girtz answered, "cold symptoms" and Ms. Chavez answered "Yeah. She said he's got bronchitis" and Ms. Girtz commented "Oh, yeah, they call them lots of things. It doesn't mean they've been diagnosed with it though." Ms. Chavez then told the Flachs that she had the advice nurse on the line and connected the Flachs to Nurse Girtz. This portion of the call began at 1:44 PM and lasted for 13 minutes. The entire telephone call, which lasted about 15 minutes, was recorded and played at the Arbitration Hearing and entered into evidence, along with a transcript of the call. The chart note made by Windy Chavez was timed 01:42 PM and stated: "Emergent Symptom: Chest Pain-discomfort, pressure, tightness or pain in chest."

At the outset of their conversation, Christina Flach told Nurse Girtz that she was calling on behalf of her husband, Kenneth Flach, and that he was sitting there with her. Mrs. Flach stated: "My husband's got, I think, bronchitis really, really badly. He – I've never seen him so sick. He's coughing up stuff out of his chest, he feels nauseous, really weak." Nurse Girtz says: "nauseated and week, lots of cough." And, Mrs. Flach says "achy" and "no energy at all. Cold." Nurse Girtz asks if Mr. Flach is having "chills like he might have a fever" and Mr. Flach says "mild fever maybe" and Mrs. Flach adds: "mild fever, yeah. He took a hot bath in salt a few

hours ago." Nurse Girtz asks if they have a thermometer and Mrs. Flach responds in the negative, to which Nurse Girtz replied "Bummer." Nurse Girtz asks Mrs. Flach to put her hand on Mr. Flach's head, which she does and reports that "it's a little bit warm but it doesn't feel like anything." Mrs. Flach also notes that Mr. Flach has a sore throat.

Nurse Girtz asks early-on in the conversation how long Mr. Flach has been sick. Mr. Flach answers "ever since – two days ago." Mrs. Flach also answered "Two days. But today it got significantly worse. " Nurse Girtz observed: "Oh, and they do, unfortunately. These first couple days are really, really rough until they pass that – the one week point, actually." When asked by Nurse Girtz if there was any color to any of the mucus [sputum] that he had been coughing up, Mr. Flach told Nurse Girtz: "Yeah, yellowish orange." When asked by Nurse Girtz if there was any night when he had been "chilled to the bone," Mr. Flach offered that "he broke in a sweat one time, you know, when your fever breaks." Nurse Girtz then asked Mr. Flach if he had been taking anything for his symptoms and Mr. Flach said "Mucinex DM" and Mrs. Flach added "Advil." When asked by nurse Girtz if he was able to cough-up "more stuff" more easily and have less dry coughing with the Mucinex, Mr. Flach responded: "It seems like it, yeah, but it hurts so bad like broken glass in my chest." And Nurse Girtz responded: "You're sore, yeah, in your throat and stuff." When asked by nurse Girtz if he gets sharp pains in his throat or chest or both, Mr. Flach answered: "Just like fire, yeah, just burning in my chest." To which Nurse Girtz stated: "Burning in the chest. I was going to say usually the burning comes after we're had a cough for a while and have done a bunch of dry coughing, but have you been doing a bunch of dry coughing to start using the Mucinex DM." Mr. Flach indicated that he had been sick for a while and then he "played golf on Friday morning," (which was March 2nd) and that put him "over the edge." Nurse Girtz responded: "So things have been worse in the last couple of days.

And how many days where you sick before that" and Mr. Flach responded that "I mean, it was like a mild cold, not (unintelligible) and stuff. Like four days." Nurse Girtz said to Mr. Flach: "Okay. Let's see. When things kind of started back four days ago, did you feel more tired like you were coming down with something" and Mr. Flach replied "Yeah." Mr. Flach mentioned that his kids had been sick and so had people at work. Nurse Girtz commented: "So we've actually been at this about six days now total" and Mr. Flach replied: "Probably, yeah, I don't know (unintelligible)." Nurse Girtz said: "Yeah. Hopefully things will turn around here."

Nurse Girtz also inquired if Mr. Flach had any chronic medical problems and Mrs. Flach said "no" and "he's fine." Nurse Girtz then asked if Mr. Flach was on any daily prescriptive medicines and Mrs. Flach said Mr. Flach is on Wellbutrin and Adderall. Nurse Girtz asked if Mr. Flach was taking the Wellbutrin to try and quit smoking or for depression. There was an inaudible answer from Mr. Flach. However, Nurse Girtz concluded that Mr. Flach was on Wellbutrin for depression and, based upon input from Mrs. Flach, that Mr. Flach is a non-smoker. Nurse Girtz asked about Mr. Flach's recent medical history of taking prednisone and Mr. Flach answered that he had a really bad sinus infection a month ago and could not hear out of his right ear. Nurse Girtz calculated that Mr. Flach had taken Prednisone for 9 days total and commented that this drug, which Mr. Flach had taken in the beginning of February, could suppress the immune system and make it harder to "to fight that stuff off."

Nurse Girtz then returned to the issue of mucus and sputum and asked Mr. Flach if "any of the mucus that you're blowing from the nose or been coughing up and looking really bloody" and both Mr. and Mrs. Flach answered "no." Nurse Girtz responded: "Let's (sic - Lots) of yellow. Okay. Any history of asthma for you ever, sir" and Mrs. Flach said "no." When Nurse Girtz asked "Since you've had congestion here, have you noticed there's (sic) episodes where

you can hear a wheeze or a whistle when you breathe in and out that won't clear if you cough or blow your nose." Mrs. Flach answered in the affirmative, indicating that it had just started the "last day" and, further, that Mr. Flach had never needed to use an asthma inhaler for a cold in the past with wheezing. Nurse Girtz noted that wheezing "makes the cough a lot less effective generally if we can't cough it away kind of thing." Nurse Girtz also inquired if Mr. Flach had any episodes of shortness of breath and both Mr. and Mrs. Flach said "no." When Nurse Girtz asked if Mr. Flach had any episodes of any extreme chest tightness, both Mr. and Mrs. Flach answered "no." Thereafter, Nurse Girth further asked if Mr. Flach "could walk from one end of the home to the other without getting short of breath here lately." Mrs. Flach answered "yes" but added that Mr. Flach is a "little lightheaded" when doing so. Nurse Girtz replied "A little lightheaded. That might be not enough fluids." Mrs. Flach answered; "Yeah, I was trying to get him to drink more – start to drinking (unintelligible). Nurse Girtz said: "Yeah, just got to keep him drinking." The Flachs then confirmed that Mr. Flach did not have any confusion in the previous 24 hours, did not recently feel any severe panic or anxiety over his breathing and that Mr. Flach had never ever been hospitalized for any kind of breathing issues in the past. Toward the end of the conversation, Nurse Girtz (again) inquired: "And is there a feeling of like a constant tightness or heaviness in the chest at all" and Mr. Flach said, "just burning" and Nurse Girtz responded: "Just burning. Burning's enough. And, let's see. Cough is definitely getting worse here." She then confirmed that they usually get their medical care through the Kaiser Novato facility.

At the end of the call, Nurse Girtz told the Flachs: "I'll try and set him up for a telephone appointment to talk to a doctor today. If they want him to come in, you know, for an x-ray or to get his lungs listened to, then they'll make arrangements for that. But will start (in) this

direction. Mrs. Flach said "Okay." And Nurse Girtz added: "Because we're trying to keep people from commingling and getting more germs on top of everything they've got already. Okay," to which Mrs. Flach said "Okay" and Nurse Girtz said: "So Dr. Colson (phonetic - Culbertson) has got a first telephone appointment with him at four - or excuse me, 3:40. Will that work for you? Mrs. Flach responded: "Yeah. Fine, yeah." Nurse Girtz confirmed the telephone number for the Flachs and asked them if they wanted a text message or email confirmation and Ms. Flach confirmed that "A text would be good." There was further discussion about the timing of the call and Nurse Girtz then mentioned: "And definitely anything worsens further, or new symptoms come up, or things don't get better in the time the doctor says they should, just pick up the phone, call us anytime. OK? Mrs. Flach said: "Okay, thank you. Bye" and then the call thereafter ended at 1:57 PM.

After this call with Mrs. Flach and Nurse Girtz, TSR Windy Chavez created her Encounter Record Note, showing "Call Outcome" as "Consult" and under "Emergent Symptom" wrote: "Chest Pain – discomfort, pressure, tightness or pain in chest."

After this call with the Flachs, Nurse Girtz created her chart note at 2:01 PM. It shows under "Call Outcome: Telephone Appointment" and under "Call Notes", the following:

"KEY SYMPTOMS: uri (Upper Respiratory Infection) sx (symptoms) w/ freq (with frequent) congested cough, yellow mucus, stuffy/runny nose, nausea, fatigue, low-grade fever, int (intermittent) wheezing w/o (without) chest tightness or sob (shortness of breath), burning in chest during and following cough

ONSET/DURATION: 6 days - cough getting worse

PERTINENT HISTORY: was on prednisone for 9 days in last mo (month)

TRIED (BETTER/WORSE) Mucinex dm and Advil w/ (with) some temporary improvement in sx (symptoms)."

Under "Protocols," Nurse Girtz wrote:

1. Medicine – ASTHMA/WHEEZING

The chart notes of Windy Chavez and Nurse Girtz were in The Permanente Medical Group, Inc.'s record system maintained for Mr. Flach and available for Dr. Culbertson's later review for his telephone call with Mr. Flach, scheduled by Nurse Girtz for 3:40PM later that same day. The recording of the Windy Chavez/Nurse Girth/Flachs' telephone call, starting at 1:42PM, and the written transcript thereof, all in the Medical Group's record system, were apparently not available to, nor accessible by, Dr. Culbertson at the time of his call, per his testimony.

B. Dr. Culbertson's call to Mr. Flach

Dr. Culbertson called Mr. Flach at 3:37 PM on March 7, 2018. [Mrs. Flach was present with Mr. Flach and listening-in on the call.] The duration of the call was about three minutes. There is no telephone recordation of this call.

The Kaiser Encounter Record for this Telephone Appointment Visit with Dr. Culbertson shows the "Diagnoses" as "URI (UPPER RESPIRATORY INFECTION) – Primary"

The "Progress Notes" section of this Encounter Record show John David Culbertson, MD as the "Author" and "Editor" and that he signed the Progress Notes that day at 4:55PM. Further, the Progress Notes show the "Creation Time" on March 7, 2018 at 4:54 PM and that the Progress Notes were "filed" on March 7, 2018 at 4:55 PM.

The body of the Progress Notes are as follows:

“I called at the number provided and asked for this specified patient. The patient confirmed that I was indeed speaking with the correct person; name and date of birth confirmed. I discussed with the patient limitations and risks of management over the phone without physical exam.

Patient expressed understanding and agreed to proceed with the care and treatment as necessary.

Patient complains of URI symptoms one week

Cough, chest congestion,? wheezing

+ laryngitis

No fever

No chest pain

No shortness of breath

URI (UPPER RESPIRATORY INFECTION) (primary encounter diagnosis)

Note:

see patient instructions.

- Supportive care (cough suppressant of choice, nasal saline rinse, fluids, rest, decongestants)

- Return if worsening (fever > 100.4, chills, cough with streaks of blood, shortness of breath, or chest pain.

- Patient agreeable with plan.

- advised appointment before end-of-the-week if needed

Discussed codeine cough syrup. Advised that this is a narcotic medication. Advised to not operate heavy machinery or drink alcohol within 6 hours of taking this medication. Patient agreeable

Plan: Codeine-guaiFENesin (guaiFENesin AC) 10–100 mg/5mL Oral Liqd - TAKE 1-2 TEASPOONSFUL (5–10 ML) ORALLY AT BEDTIME AS NEEDED FOR COUGH

Albuterol (VENTOLIN HFA) 90 mcg/actuation Inhl HFAA – INHALE 2 PUFFS ORALLY EVERY 4 HOURS AS NEEDED FOR SHORTNESS OF BREATH. 100 DAYS SUPPLY IS 1 CANISTER

INHALER, ASSIST DEVICES (AEROCHAMBER Z-STAT PLUS-FLW SG) Misc. Spacer - Use as directed with inhaler"

The orders for this medication were timed at 3:42 PM, about two minutes after the call ended.

C. Photo of Mr. Flach's Sputum

Mr. Flach took a photograph on his cell phone of his sputum about 37 minutes after his discussion with Dr. Culbertson and about 2.5 hours after his call with Nurse Girtz.

D. Email exchange between Mr. Flach and Dr. Culbertson on March 8th.

At 8:20 AM the next morning (on March 8, 2021), Mr. Flach wrote this email to Dr. Culbertson: "I had the worst night, sweating and coughing up blood, my chest is really tight and sore, can't breathe very well. So weak and dizzy. Can I come in this morning?" At 8:29 AM Dr. Culbertson wrote back: "You need to see me today." Sometime after receiving Dr. Culbertson's email timed at 8:29AM, Mrs. Flach decided to drive Mr. Flach to the Kaiser ER and hospital in San Rafael, California.

E. Kaiser Hospital in San Rafael

Mr. Flach arrived at the Kaiser San Rafael Hospital Emergency Room at 9:19 AM. At 9:31 AM, he had a respiratory rate of 26, pulse of 92, blood pressure of 61/43 and blood oxygen of 99%. At 9:50AM he had a respiratory rate of 32, a pulse of 91, blood pressure of 88/59 and blood oxygen of 91%. His chief complaints were Shortness of Breath, Chest Discomfort and Cough. By mid-morning, the ER physicians found acute respiratory failure, renal failure, septic shock, hemoptysis and neutropenia, all presumed from severe community-acquired pneumonia.

Dr. Bateman ordered a chest x-ray at 9:37 AM. The results were "timed" at 10:04 AM and received by the ER physicians at 10:18 AM. The Findings of the Radiology Report were: "Dense consolidation of the mid to lower left lung and the lower aspect of the right upper lobe and more patchy within the right lower lobe compatible with diffuse infiltrates bilaterally. Follow-up until complete resolution. Normal heart size. No pneumothorax" The "Impression" part of this report stated "Dense consolidation of the mid to lower left lung and the lower aspect of the right upper lobe and more patchy within the right lower lobe compatible with diffuse infiltrates bilaterally. Follow-up until complete resolution."

Even before the Chest X-Ray results had been sent from the Radiology Department to the Emergency Department [or any gram stain results (showing gram positive bacteria in tetrads) had been sent to the ER], Dr. Bateman ordered Levofloxacin and Zosyn, both antibiotics, at 9:50 AM, and they were both started intravenously at 10:00 AM. In addition, Dr. Bateman ordered Vancomycin, also an antibiotic, at 9:59 AM (likewise before any gram stain results were known). Infusion of Vancomycin followed the other two infused antibiotics and it was started at 12:49 PM.

Kaiser ER physician Jason Bateman, MD recognized that Mr. Flach was in septic shock as early as 9:55 AM that day. His ER note reads as follows:

"Sepsis Documentation

9:55 AM 3/8/2018

Suspected site(s) of infection: pulmonary

A - SIRS criteria: Heart rate >90 and Respiratory rate >20

B - End organ dysfunction due to sepsis present: Lactic Acid > 2 mmol/L (Cardiac)

C - Hypotension (systolic BP < 90 mmHg or MAP <65 mmHg after 30 mL/kg fluid bolus) and/or initial

lactic acid >=4 mmol/L? yes

Patient meets Criteria A and C.

Patient has septic shock."

Within one minute of receiving the Chest X-ray results, and about an hour after Mr. Flach's arrival in the ER, Dr. Bateman ordered, at 10:19AM, that Gram Stain testing and Cultures be done of Mr. Flach's sputum. The sputum sample taken served as the source for both a Culture study, which would take several days to yield results, and a Gram Stain that would take about 90 minutes to obtain results. The purpose of the Gram Stain and Culture Growth study was to determine if Mr. Flach was suffering from a bacterial infection.

At 11:50AM, the Gram Stain results were recorded. They showed:

* Few White Blood Cells
* < than 10 squamous epithetical cells

- Many gram positive cocci in pairs, tetrads and chains. Few gram-negative coccobacilli and gram negative rods. No apparent oropharyngeal flora seen."

Gram positive cocci in pairs and chains may suggest Streptococcus. Gram positive cocci in tetrads may suggest Staphylococcus. The result of the Sputum Culture Study came in three days later on March 11, 2018 at 1:46 PM. The Findings were "Heavy Growth Methicillin-Resistant Staphylococcus Aureus [MRSA]."

Physical examination of Mr. Flach's chest on March 8th showed "rales/rhonchi noted diffuse bilaterally."

Once the bacteria was identified in the Culture Growth Study, the lab performed sensitivity studies. Such studies revealed that the bacteria Mr. Flach had in his lung - Methicillin Resistant Staphylococcus Aureus [MRSA] - was sensitive to two of the very antibiotics empirically ordered by Dr. Bateman for Mr. Flach soon after he arrived in the ER Department, namely Vancomycin and Levofloxacin. This bacteria was also sensitive to other antibiotics, including Clindamycin, Doxycycline and Gentamicin.

At 10:05 AM on March 8, 2021, Sheryl Hickey, a Kaiser medical assistant, left a telephone message for Mr. Flach on his phone. Her Encounter Record note entry for this contact reads: "Left msg (message) w/ (with) first available app't (appointment) – tomorrow am (March 9th). Per pcp (Primary Care Provider, presumably Dr. Culbertson) should be seen today (March 8th). Then per HC, pt is in ED"

The Discharge Summary from Kaiser Hospital (and Transfer Summary to Another Acute Hospital) authored by Nirupam Singh, M.D. at 3:26 PM. on March 9, 2018, states in part:

"**Hospital Course and Significant Findings**

“54-year-old otherwise healthy (only past history of ADHD), presented 3/8/18 with sudden onset of cough, respiratory distress and hemoptysis. In ED found to be in severe septic shock, acute respiratory failure, hemoptysis, acute renal failure and neutropenia all presumed from severe community acquired pneumonia. Underwent Endotracheal intubation and needed pressors with bicarb the same day.”

ICU course:

Broad-spectrum antibiotics with vancomyosin, Zosyn and levofloxacin. Clindamycin added along with IV lg 3/9/2018 given severe worsening

. . .

ID:

Pneumonia: Continue levofloxacin, Zosyn, vancomycin. Cultures pending but gram-positive cocci on strain

…

The UCSF Extracorporeal Membrane Oxygenation [ECMO] team arrived at 5:00 PM on March 9th and Mr. Flach was on ECMO at 6:10 PM.

F. Transfer from Kaiser Hospital to UCSF

On the evening of March 9, 2018, Mr. Flach was transferred from Kaiser Hospital in San Rafael to the University of California at San Francisco Medical Center [UCSF] in San Francisco, with the following diagnoses: (Principal) Septic Shock, Neutropenia due to infection, thrombocytopenia, adult respiratory distress syndrome, pneumonia, acute renal failure, hemoptysis and acidosis. The UCSF hospital record shows that Mr. Flach had been receiving Levofloxacin and Vancomycin while a patient at UCSF.

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The Culture Study results at UCSF were virtually identical to those done at Kaiser Hospital: Methicillin Resistant Staphylococcus Aureus (MRSA). Several physicians at UCSF commented on Mr. Flach's respiratory decline. UCSF physician Monica Moy, MD said: "Microbiological data supports respiratory viral infection subsequently leading to bacterial super-infection (MRSA). UCSF physician Jennifer M. Babik, MD said "RVP here now positive for metapneumovirus, and so the most likely scenario is that Mr. Flach has a metapneumovirus infection complicated by a severe bacterial superinfection with MRSA. UCSF physician Sarah Puryear, M.D. stated: "Mr. Flach presents with an aggressive and rapidly progressive clinical course most consistent with metapneumovirus with MRSA pneumonia superinfection." Mr. Flach's final principal diagnosis was "sepsis due to methicillin resistant Staphylococcus aureus." An Attendant diagnoses was "Pneumonia due to methicillin resistant Staphylococcus aureus". Mr. Flach expired at UCSF on March 12, 2018. After his death, the UCSF Discharge Summary stated:" Respiratory failure 2/2 ARDS 2/2 to + metapneumovirus, superimposed + Staph aureus PNA requiring VA ECMO."

Mr. Flach's death certificate lists pneumonia leading to respiratory failure as the cause of death.

III. ALLEGATIONS AND RESPONSES

Claimants: (taken from their Submissions)

"The allegations are derivative of Kaiser's failure to arrange an in-person physician appointment with decedent, Kenneth Flach on March 7, 2018, that would have resulted in an examination, objective testing and successful, life-saving treatment for Mr. Flach on that date.

The claims here arise out of Christina and Ken Flach's interactions with Kaiser on March 7, 2018, when Mr. Flach had undiagnosed and untreated community acquired pneumonia (CAP). It is alleged, inter alia, that Kaiser was contacted by decedent for his medical condition but Kaiser entities themselves and Kaiser employees failed to examine or treat him.

The evidence in this case established that there was medical negligence on the part of Nurse Cynthia Girtz, RN and John Culbertson, M.D. in failing to have 54-year-old Kenneth Flach seen and examined. It further established that Kaiser's HMO policies designed to reduce costs by way of minimizing the ability of patients to see their physicians through 'advice nurse triaging' and Kaiser's directive to advice nurses to set "telephone appointments only" interfered with Mr. Flach being seen and examined by a physician. After three telephone interactions with Kaiser health care providers on March 7, 2018, who chose not to see or examine him then, Mr. Flach and his wife could wait no longer to be seen and went to the emergency room on their own on March 8. By then, Ken Flach was in septic shock with organ failure. Despite belated efforts to treat him, he could not be successfully resuscitated and treated and passed away on March 12, 2018, due to CAP caused sepsis"

Respondents: (taken from their Submissions)

The Kaiser entities responded that the Nurse Advice System does not breach the standard of care and such systems play a crucial role in a healthcare system. These systems are used by Respondents and other medical providers alike. The benefits of a nurse advice system include improved overall care access, better coordination of care and scheduling, a substantial decrease in unnecessary urgent care and emergency room visits, and a higher satisfaction and appreciation for a free source of guidance and information. In addition, Mr. Flach was aware of

the functionality of the Advice Nurse System, as well as the option that he could go to the emergency department or urgent care at any time if he desired.

The Respondents also contend that they have no policy discouraging patients, who are infectious and need to be seen in person, from going to the ER or the Clinic.

Further, Respondents contend that Nurse Girtz adhered to the nursing standard of care in that her selection of Nursing Protocols was appropriate, the history she took from the Flachs was appropriate and the same day telephone appointment she made for Mr. Flach with his treating physician, Dr. Culbertson, was likewise appropriate.

With respect to Dr. Culbertson, Respondents contend that he adhered to the standard of care in that he properly assessed Mr. Flach over the phone, that Mr. Flach did not require an in-person visit.

Finally, Respondents contend that they did not cause Mr. Flach's death in that the Assessment done over the telephone did not result in Injury to Mr. Flach, who willingly accepted a telephonic appointment with Dr. Culbertson and never requested an in-person visit. In addition, Dr. Culbertson followed the standard of care in diagnosing Mr. Flach with Bronchitis and not Community Acquired Pneumonia [CAP], which was low on Dr. Culbertson's differential diagnosis. Even if Dr. Culbertson had diagnosed CAP, the standard of care would have been oral antibiotics and the same would not have influenced Mr. Flach's outcome. On March 8, 2018, Mr. Flach had a viral precipitated illness with multi-organ dysfunction syndrome. He had a fatal disease on arrival to the hospital and no amount of MRSA sensitive antibiotics would or could save him. Therefore, Dr. Culbertson's conduct on March 7th did not cause or contribute to Mr. Flach's death.

Additionally, Respondents contend that Claimants cannot establish that Mr. Flach died from MRSA. Respondents state that the gram stain taken at Kaiser Hospital on March 8, 2018 was unreliable and that no accurate conclusion can be drawn from the sputum culture. Such culture may or may not be correct. Also, Respondents contend that Mr. Flach did not have a bacterial infection prior to him entering the Kaiser Hospital in San Rafael on March 8th, and, if Mr. Flach did develop a MRSA infection, it happened after Mr. Flach was admitted to the hospital. Further, the blood cultures never grew-out bacteria, suggesting Mr. Flach had primarily a viral infection with some degree of superinfection, perhaps, of bacteria. In addition, Respondents contend that, as of March 8th, no physician, reviewing Mr. Flach's chest X-rays, could accurately say that such X-rays affirmatively establish that either a viral or bacterial process was causing Mr. Flach's lung infection. According to Respondents, treatment for MRSA on March 7th would have had no impact on the ultimate outcome, because Mr. Flach decompensated from the metapneumovirus beyond the ability for him to recover.

Respondents also contend that, even if Mr. Flach had been treated as an Outpatient on March 7th, his outcome would not have changed. Even if Mr. Flach had been diagnosed with pneumonia on March 7th, the treatment that he would likely have received [oral antibiotics] would not have treated his viral pneumonia, and it would have had no impact on any alleged MRSA lung infection. Mr. Flach's condition would not have improved from March 7th forward, if he had been treated as an out-patient. Even if Mr. Flach had been treated in the ER on March 7th for pneumonia, he would not have been given antibiotics [per the standard of care] that would have covered a MRSA infection. Also, he would have been given oral antibiotics. And, Mr. Flach did not have MRSA at that time. Lastly, he was not septic on March 7th.

/ / /

IV. STANDARD OF CARE – MEDICAL NEGLIGENCE

A. Nurse Girtz

A registered nurse is negligent if she fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful registered nurses would use in similar circumstances. This level of skill, knowledge and care is sometimes referred to as "the standard of care." You must determine the level of skill, knowledge, and care that other reasonably careful registered nurses would use in similar circumstances based only on the testimony of expert witnesses. CACI 504

1. Claimants' Perspective per their Submissions

Claimants offered multiple expert witnesses [Dr. Langford, Dr. Cooke, Dr. Leo and Nurse Basich] on the issue of whether Nurse Girtz complied with the required nursing standard of care. The common thread in their testimony was that Mr. Flach needed to be seen *in person* that afternoon, March 7, 2018, preferably in the ER, but, at an absolute minimum, by a qualified physician.

They opined about the significance of the content of the telephone call between the Flachs and Nurse Girtz on March 7, 2018 in these terms:

a. Mark Langdorf, MD

* He is a long-time Professor of Clinical Emergency Medicine at UC Irvine and is Board Certified in the field of Emergency Medicine. He was responsible for setting-up a managed care demand system and qualified as an expert on the subject of use and management of nursing advice systems and their content; as an expert in Emergency Medicine; as an expert in the applicable Nursing Standard of Care; and an expert in Causation.

* Nurse Girtz breached the standard of care by misapplying and using the wrong algorithms and directed Mr. Flach to a lower cost setting telephone appointment, instead of an in person visit with his doctor or an emergency department visit immediately. Her failure in this regard prevented Mr. Flach from immediately seeing a physician in person and allow such a physician to properly evaluate Mr. Flach to determine whether he had pneumonia and, if so, to what extent. The constellation of symptoms communicated by Mr. and Mrs. Flach to Nurse Girtz on March 7th placed pneumonia clearly in the differential diagnosis. Pneumonia is an infection that can get worse very fast and needs to be treated with antibacterial antibiotics as soon as possible to avoid outcomes like the one that happened here with Mr. Flach. In addition, where one receives information from the patient who advises he had a fever, a fever sweat, still has a mild fever, feels very weak, gets lightheaded walking across the house yet was able to play golf only days before, was having severe pain in his chest (like glass in my chest) and the mucus (sputum) color of yellow-orange, these are all features that suggest that the patient has pneumonia, until proven otherwise. And proven otherwise would mean a chest x-ray, laboratory tests and empirical treatment with antibiotics.

b. Blythe Basich, RN

*She is a registered nurse with a BS degree, is a Board-Certified Emergency Nurse and a Mobile Intensive Care Nurse. She currently works as an emergency room nurse and previously worked as an Advice Nurse Supervisor on an advice line that received 200-250 daily calls. She qualified to testify on the applicable Nursing Standard of Care.

* Nurse Girtz failed to follow the Kaiser Chest Pain Protocol, which states that a patient with chest pain, who complains of sustained burning, must be immediately sent to the emergency department for evaluation. The failure to follow this protocol was below the standard

of practice, because the protocols were set up to evaluate and rule out the most dangerous symptoms, if used correctly. In this case, chest pain was the symptom that should have led to the use of the Chest Pain Protocols. Nurse Girtz' failure to use the Chest Pain Protocol was below the standard of care; and, several Chest Pain Protocols would have yielded the same result, namely a referral to the emergency room.

* The goal of an advice triage nurse is to decide what the most urgent symptom is and whether it is life-threatening. The triage process could lead to catastrophic injury or death, if not done properly. If there is a decision to be made as to the level of care and the nurse has information that might suggest either a serious illness requiring emergency medical care or a less serious illness, a nurse must always err on the side of treatment for the most serious illness, as her job is to rule out the most life-threatening issue. If a nurse is unable to rule out a life-threatening issue the nurse must assume that it is, in fact, life threatening.

* Nurse Girtz breached the standard of practice by failing to appropriately triage Mr. Flach, in that Nurse Girtz used the wrong protocol for triaging this patient. She should have used the Chest Pain Protocol, but instead used Cough Cold Sinus Flu Protocol. Had she used the Chest Pain Protocol with Mr. Flach; the disposition would have been "emergent" to the emergency room. The Kaiser Advice Protocols for Nurses instructed Nurse Girtz to identify the protocol to use, based upon what the most urgent symptom was, along with her nursing judgment. Use of the most urgent symptom to find a proper protocol is standard practice in an Advice Nurse system and has significant triage implications. Based upon the information exchanged during the subject phone call, chest pain was the most urgent symptom that Mr. Flach had.

*Nurse Girtz breached the standard of care by not reasonably using her nursing judgment. She failed to triage Mr. Flach appropriately. Her reasonable nursing judgment would require that she recognize these signs and symptoms of progressive worsening and potential sepsis and use her judgment to have Mr. Flach be seen emergently. Nurse Girtz blatantly ignored the dispositions she was supposed to be following by arranging just a phone call with Mr. Flach's primary care physician. Setting up a telephone appointment, rather than sending the patient to the emergency room, was a disposition that was a breach of the nursing standard of care by nurse Girtz.

* Although Mr. Flach had qualifying chest pain, and the Chest Pain Protocol was intended to be used for chest pain of all types, Nurse Girtz did not use it. Use of the Chest Pain protocol would have provided Mr. Flach an emergent disposition by way of the emergency room. Mr. Flach had chest pain with sustained burning and, in the event there was inadequate information about whether the chest pain was cardiac-like or not, the disposition would be to send him to the emergency room. It is not always clear-cut or easy for a nurse to determine whether chest pain is cardiac-like or noncardiac like and, if there were any doubt about whether the chest pain was cardiac-like, a nurse is to err on the side of sending the patient to the emergency room.

*There is a Chest Pain protocol that focuses on the symptom complex of chest pain (noncardiac-like) with profound weakness. As to whether Mr. Flach was "profoundly weak" or not, Mrs. Flach told Nurse Girtz that Mr. Flach was "really weak"; that several days earlier he was able to play golf; and, that currently he was unable to hold a conversation on the phone, requiring his wife to initiate the contact for him. Mr. Flach fit within this category of chest pain with profound weakness for which the disposition was emergency room.

* There is a third category under the Kaiser Chest Pain Protocol with the title, "Chest pain Not now but within 72 hours." That protocol provides for chest pain occurring at any point within the last 72 hours, along with sustained burning, even if it was not currently happening. If that is the case, the patient should have a disposition to the emergency room. This protocol required only that there be chest pain and sustained burning. It did not require cardiac-like chest pain.

* It was not simply Claimants' experts that concluded Nurse Girtz breached the standard of care. Defense expert Brenda Danner, RN agreed that Mr. Flach's chest pain complaints could have been cardiac-like and, along with his complaints of sustained burning, a fair reading and proper use of the Chest Pain protocol obligated Nurse Girtz to send Mr. Flach to the emergency department. Here, Respondent's expert, Nurse Danner, reiterated the very same conclusion as Claimants' expert, Nurse Basich, when the Chest Pain protocol was evaluated within the category of "Chest pain Not now, but within 72 hours." Nurse Danner clearly testified that it was a breach of the standard of care for Nurse Girtz not to send Mr. Flach to the emergency room under that particular protocol, which she concluded applied in this case.

* Nurse Girtz breached the standard of care by not sending Mr. Flach to the emergency room given the entirety of the communications Nurse Girtz had with the Flachs, the protocols she used and failed to use and her inability to locate the most urgent symptom upon which to base protocol selection.

* What Nurse Girtz was told by the Flachs and how Nurse Girtz wrote the same in her notes was "misleading."

c. Molly Cooke, MD

Dr. Cooke is a long time Full Professor of Medicine at UCSF in the field of Internal Medicine, is Board Certified in the field of Internal Medicine and is a Master of the American College of Physicians. She has been working with triage nurses throughout her entire career. She qualified as an expert in the Standard of Care for Internal Medicine and the applicable Nursing Standard of Care and Causation.

* The standard of care required a disposition by Nurse Girtz of an immediate visit to the ER or an emergent in-person physician visit by 2:30 p.m. that day. The seriousness of this presentation militated for an in-person visit within hours of the conversation with Nurse Girtz.

* Either by way of protocol or use of a nurse's clinical judgment, the standard of care required of Nurse Girtz was for her to get Mr. Flach seen in person by a physician that afternoon and Nurse Girtz' failure to do so the afternoon of March 7, 2018, was a breach of the standard of care. The reason the standard of care required that Mr. Flach be seen in person is that the differential diagnosis includes conditions, namely pneumonia, that cannot be adequately evaluated without a face-to-face visit. So, what Mr. Flach needed at the end of Nurse Girtz' evaluation was an arrangements of a face-to-face visit with a physician that afternoon and really as soon as possible.

* When someone does phone triage and hears the first thing out of the family member's mouth about the patient is "I have never seen him so sick," the listener should be thinking that this patient needs to be seen in order to assess his general appearance, get vital signs, do a chest exam, and based on the chest exam, a chest x-ray.

* The symptom complex conveyed by telephone was a lower respiratory infection rather than an upper respiratory infection. With an upper respiratory infection, the symptoms involve the common cold; where, with a lower respiratory infection, the symptoms are

pneumonia. The symptoms she considered dispositive, necessitating that the patient be seen by a physician in person, include a productive cough with yellow-orange sputum, weakness, fever and subjective illness, significantly worse over the past two days.

*The description of orange tinted sputum indicates that there is sufficient inflammation in the lung tissue that is causing some bleeding and the blood mixed with phlegm or sputum causes it to turn an orange-ish hue. The implication of that clinical finding is alarming, and it alone required that Mr. Flach he be seen that afternoon.

* When she wrote her chart note, Nurse Girtz significantly degraded the information she obtained from the Flachs during the course of their March 7, 2018 call. Some important precision was lost going from the interview that Nurse Girtz did, to what she put in her note. Nurse Girtz dropped the descriptive 'orange' as it related to the color of Mr. Flach's sputum; and the word "fatigue" in Nurse Girtz' note was used to replace a description of Mr. Flach as 'very weak' by Mrs. Flach. The expression "really weak" is different from "fatigue." There was also a failure to note in her chart and advise that, although Mr. Flach had a reported low-grade fever, he did not have a thermometer. In addition, Nurse Girtz made an effort to link Mr. Flach's chest pain to his cough, when there was no basis in the conversation to do so. Further, the fact that Nurse Girtz did not use the word 'pain' to describe the sensation felt by Mr. Flach in his chest, which was clearly conveyed to her during the phone call, was also a degradation of information given to her. The chart note by Nurse Girtz clearly understated the condition of Mr. Flach, of which she had been apprised by the Flachs in the call.

d. James Leo, MD

*Dr. Leo is Board Certified in Internal Medicine, Emergency Medicine and Critical Care Medicine and was qualified as an expert in all three of these fields, and also as an

expert in the management and evaluation of patients, including nursing care. He qualified to discuss the applicable Standards of Care and Causation in this case. He is the Chief Medical Officer for Memorial Care Health System, a complex of four hospitals and 230 outpatient sites in the Long Beach area.

* With the symptoms of 6-day history of illness, with its worsening in the prior two days, with Mrs. Flach commenting, 'it is the sickest she has ever seen her husband', with his chest in severe pain, with yellow-orange sputum, the standard of care required that Nurse Girtz refer Mr. Flach to see a physician within hours of her call on March 7th, in-person and in a setting that would allow for a chest X-ray and physical examination. Since Nurse Girtz never set-up an in-person face to face meeting with Dr. Culbertson or any other physician, nor did she advise Mr. Flach to be seen in the emergency room, it was below the standard of care on her part.

* The reason the standard of care required Nurse. Girtz to have the patient examined on March 7th and x-rayed on March 7th was because the history of illness was worsening, which was classic for secondary bacterial infection, often manifesting as pneumonia; the presence of subjective fever notwithstanding the use of Advil; the presence of chest pain raising the potential for pneumonia; and the distinctly unusual yellow-orange sputum, all suggesting that Mr. Flach did not have a standard respiratory infection and Nurse Girtz' own recognition (thoughts in the back of her mind) that Mr. Flach likely needed a physical exam, chest x-ray and antibiotics.

* Nurse Girtz had a variety of options available to her but chose a low level of care leading to Mr. Flach's death. She could have called a critical care emergency medicine physician or sent Mr. Flach to the emergency room at that time or scheduled an in-person visit with a physician. Nurse Girtz admitted that pneumonia was in her differential assessment

(diagnosis); the problem here is that she did not put it high enough on her list. She knew that the telephone encounter itself, several hours later with a physician, would not include any kind of a physical examination, a chest X-ray or antibiotic therapy. Yet, she knew or suspected that a physician would want to listen to Mr. Flach's chest and probably order antibiotics. The standard of care for pneumonia in patients with complaints like those described in the call is a physical examination, chest x-ray, timely diagnosis of the pneumonia, typically in the emergency medicine department and proper, timely treatment including antibiotic therapy.

* Nurse Girtz' documentation/note of her call was inaccurate and misleading vis-à-vis the information that was relayed to her by the Flachs. Her notation of the call was beneath the standard of care. Her decision to omit the word 'orange' from a description of "yellowish orange," because she considered it nothing of concern, along with the unwarranted change of a report of "burning in the chest" to "burning in the chest during and following cough" was below the standard of care for nurse Girtz. Mr. Flach had significant, constant pain in his chest and there was constant burning in his chest.

2. **Respondents' Perspective per their Submissions**

a. Selection of the Nursing Protocols was Appropriate

* Nurse Girtz has worked in a number of emergency sectors as a medical provider. She has worked in intensive care units, critical care units, the general emergency room, and heart catheterization lab. She also worked as an advice nurse for 15.5 years. She has been called upon to use her nursing judgment for her entire career. Her breadth of experience makes her the most qualified nurse testimony in this case.

* Ms. Girtz listened to the decedent's entire report of symptoms to evaluate the particular assessment to be performed. Picking one symptom out from the constellation that are

given was not Ms. Girtz's typical practice. When asked in this case:" All right. So, if we are going to prioritize these symptoms, which of these symptoms had the potential to cause serious and emergent harm to Mr. Flach? Was it nausea, or was it –" She answered: " You can't really separate out. It's a whole entity of the disease process or the pathophysiology, and you don't necessarily just pick out one symptom here and there." In addition, chest pain was not the problem Ms. Girtz identified. She identified Mr. Flach's cough, cold, and flu-like symptoms. Then, she moved onto assessing his chest pain as part of that protocol. When asked: " Okay. And wouldn't you agree that the most urgent symptom that you were told about was that this man had chest pain so bad that it felt like he had glass in his chest?" She responded: " The way we were instructed, like I said, that chest pain was not considered the most -- you're looking at where the problem is identified. His problem was he had a cough and cold and those kind -- and a runny nose and those types of symptoms. So, I identified the problem, then I was -- then I went into assessing the chest pain part of it a bit." She did not use the chest pain protocol, because Mr. Flach's "burning in his chest" was part of the cough and congestion protocol. In talking to Mr. Flach, it did not sound like his chest pain was cardiac-like, so Ms. Girtz chose the cough protocol due to Mr. Flach's emerging symptoms.

*Respondents' nursing expert, Brenda Danner, RN's testimony at trial provided credible support the conduct of Ms. Chavez and Ms. Girtz. She was asked: "And why was it appropriate for her to utilize that protocol at the initial part of the call?" to which she answered: " Because the way it presented. That was the problem. He had what they thought was bronchitis and a lot of congestion and coughing." Question: "Was Ms. Girtz required under the standard of care to use the chest pain protocol at the initial part of the interaction with Mr. and Mrs. Flach?" Answer "No. Because that wasn't -- that wasn't his main complaint. He said he had burning, and

– but the -- and that was the complaint. And that would be part of the congestion questions. You know, do you have pain? Well, yes, he has pain in the chest as well. But is it cardiac or not? At this point it doesn't sound like it."

*Dr. Padilla testified that she trains the advice nurses that work at Respondents' call center to listen to the entire story of a patient. Ms. Girtz did exactly that during her conversation with Mr. Flach and did not let any particular symptom control her review. If a patient reports cough, fever, and chest pain, nurses are trained to suspect an upper respiratory infection. This question was posed to Dr. Padilla: "If a patient were to call in to the call nurse and ask about a constellation of symptoms that involved fever and chest pain and wheezing and a cough, would you expect that the nurse might consider what all of those symptoms together might yield in the days ahead to pick out the most urgent clinical symptom?" Dr. Padilla answered: " In that scenario we train our nurses to listen to the story. And in that scenario, cough, fever and chest pain could be the constellation of an upper respiratory infection. Those symptoms in and of themselves do not lead one to think of a cardiac outcome. We train our nurses to ensure they differentiate that so that we can get those that are cardiac to the appropriate outcome."

*The chest pain protocol is appropriate when chest pain is the only presenting complaint. In his call with Ms. Girtz on March 7, 2018, Mr. Flach complained of a number of symptoms, and did not call specifically for chest pain, therefore the assessment was directed towards a different protocol. Dr. Padilla was asked: And this is a protocol that is appropriate where the patient calls and says he or she is experiencing chest pain at the time of the call. Is that true?" She answered: "Only if that is the one and only presenting complaint." Question: "You

1 mean, there can be no other complaints that the patient has other than chest pain now –" Answer:
2 Correct."
3 *Burning chest pain was part of the myriad of symptoms presented with Mr.
4
5 Flach's cough and cold. Dr. Padilla states that burning chest pain is a common symptom of a
6 cold due to the coughing. Therefore, Dr. Padilla would not consider the burning sensation as an
7 urgent symptom and feels that Mr. Flach was properly evaluated over the phone by Ms. Girtz.
8 Dr. Padilla was asked: "Are you saying that in Mr. Flach's case his most urgent symptom was
9
10 something other than his burning chest pain? She answered: " It was part of the constellation of
11 symptoms that were being presented with his cough/fever/sputum production. And in cases
12 where people have been coughing, they get chest pain. So, in that scenario, it's not necessarily an
13 urgency, it is a part of all of the symptoms in cough/cold/flu. Question: "And so your assessment
14 of the phone call in this case was that the burning chest pain that Mr. Flach complained of was
15
16 not his most urgent symptom?" Answer: "It wasn't an urgent symptom." Question: "It wasn't
17 even an urgent symptom?" Answer: "It was part of the whole constellation of symptoms that
18 were being presented. And the nurse took that information to do -- to make sure that he had a
19 higher level of care by booking a phone appointment within the hour and 40 minutes, I don't
20 remember exactly, with his primary care physician rather than giving advice which is normally
21 what our nurses would do for a cough/cold/flu. She recognized there was some urgency that
22 needed to be spoken to with a physician and that happened within the hour and 40 minutes,
23
24 whatever the time of appointment was." Question: "Based on your assessment of the phone call,
25 did you consider Mr. Flach's complaint of chest pain that was of a burning nature and felt like he
26 had glass in his chest to be an urgent symptom, or no?" Answer: "Urgent to the point where he
27 needed to speak to a physician which is what happened. He needed to be evaluated by a
28

physician. The nurse got him an appointment with a physician in a very short period of time." Question: "Did you consider the burning chest pain that Mr. Flach complained of to be an emergent symptom?" Answer: "Not in the way that it was described in the scenario that he was coughing and had a fever. He definitely needed to be evaluated for sure. It was not a simple nurse advice call. It needed evaluation which is what our nurse did."

*From an emergency doctor's point of view, and using the benefits of hindsight, Claimants' expert Dr. Langdorf agrees that the information in Ms. Girtz' note, the transcription of the call with Mr. Flach, and the recording of the call, there was nothing that showing cardiac chest pain. Dr. Langford was asked: "So, Doctor, you would agree that even with the benefit of hindsight and having all of this material available to you, Nurse Girtz's note, the transcription of the call, the recording itself, there was nothing in there that you understood to be a description showing cardiac-like chest pain, correct?" He responded: "I would agree with that. It didn't look like cardiac chest pain to an emergency doctor."

* Dr. Cooke, also one of Claimants' experts, similarly agrees that cardiac chest pain can be assessed over the phone, and that while Mr. Flach had chest discomfort, it was not cardiac-based pain. She made this conclusion based upon Ms. Girtz' phone call assessment with Mr. Flach, Dr. Cooke was asked: "Okay. And until that chest pain is necessarily evaluated, can anyone on the telephone vet out whether that chest pain is cardiac, or chest pain called from – caused from some other purpose? She answered: " So what I would say here is that the chest pain protocol, you can tell from the questions, is really oriented to cardiac chest pain. And based on doctor – Nurse Girtz's interview, this pain does not sound like cardiac chest pain to me. The patient still has chest pain, but the characteristics are not at all typical of cardiac chest pain. The

1 characteristics are - - and the associated symptoms are much more consistent with a diffuse
2 pulmony process."

characteristics are - - and the associated symptoms are much more consistent with a diffuse pulmonary process.”

*Another one of Claimants’ experts, Dr. Leo, after his review of the phone call, the recording, and the transcript, also does not believe that there were any signs or symptoms indicating cardiac chest pain. He was asked: “During that phone call, the recording and in your review of the transcript, you never saw any signs or symptoms indicating that there was chest pain from a cardiac condition; true?” He answered: “Correct.”

*The majority of claimants’ own expert physicians agree that Mr. Flach did not have cardiac chest pain on March 7th or any time prior to his passing.

*Regardless of this testimony from Claimants other experts, Claimants’ nursing expert, Ms. Basich, in her arbitration testimony went against the great weight of the record. At best, her testimony represents sloppiness and a failure to understand the evidence and record. At worst, it is a display of bias and opinion with no value. Despite testimony to the contrary from the other experts in this case, Ms. Basich believes that the decedent had cardiac-like chest pain. Furthermore, Ms. Basich understands that Mr. Flach was able to walk across the house but opines that he was profoundly weak. When asked: “Did he have cardiac-like chest pain now, though?” She answered: “Yes.” Question: “Why do you say that?” Answer: “ He had a subsequent amount of cardiac-like chest pain equivalence to go along with it, as well as, right here in the protocol, where he has what they suggest is cardiac-like chest pain, sustained burning.” Question: “And this says, ‘profound weakness.’ With the information that this nurse had, was there any way she could rule out that Mr. Flach had a profound weakness?” Answer: “ She could have asked him questions.” Question: “And did she?” Answer: “She did not.” Question: “With the information that she had, assuming that's all she was able to get, did

this particular requirement of "Chest pain now with profound weakness" fit in this situation?" Answer: " Yes, it did." Question: "And from the perspective of Nurse Girtz, could any of that have happened had she set that up as she did with just a telephone call with a doctor? Answer: "No, not with a telephone call. In fact, when she ended her phone conversation with the Flachs, she made comment of the fact that she believed that Mr. Flach was going to require to be seen in person with -- for a chest x-ray and for someone to listen to his lungs, but she still proceeded with this disposition anyways." Question: "So then if I understand you correctly, if a patient reports some type of chest pain, any type, within another constellation of symptoms, it would be proper to only focus on the chest pain then; true?" Answer. "Yes, that's true. So, I can tell you that, during his phone call, it is my opinion that he was suffering from cardiac-like chest pain." Question: "Well, but you would understand from the call with Ms. Girtz that he was able to walk across the room, true?" Answer: "Yes, yes." Question: "But yet, you still believe he was profoundly weak?" Answer: "Yes." Question: "Well, they denied that. But they also, on separate occasion, denied shortness of breath directly; true?" Answer: "I don't believe the actual phrase 'Are you short of breath' was ever said." Question: "So it's your opinion that the questions that Ms. Girtz asked were not designed in any way to determine whether pleuritic chest pain was present; true?" Answer: "They were not designed to assess the type of chest pain; correct."

*The testimony of the other experts is not necessary to discredit the testimony of Ms. Basich, as a review of the contents of the call between Ms. Girtz, Mr. Flach, and Christina Flach on March 7th directly conflicts with her opinions. The Call Transcript – page 10, lines 2 to 4 reflects: Question: "Any episodes of shortness of breath?" Answer: (Mr. Flach) " No." Answer: (Mrs. Flach) " No." Lastly, Ms. Basich has only worked as an advice nurse for a short period of time, less than half a year, and is no longer working in that position. Thus, not only are her

opinions an outlier from the other experts in this matter, so is the amount of experience she has had. It appears that Claimants were aware of this defect due to them asking many of their physician experts to opine on nursing subjects, something that Respondents did not do. However, this move only serves to globally weaken the opinions of those other experts who agree to provide opinions outside of their medical specialty. Given the evidence that was received in this matter, Claimants cannot meet their burden of proof on the claims that Ms. Girtz deviated from the standard of care, and that theory should fail.

b. History of Mr. Flach Taken by Ms. Girtz was Appropriate.

*The experts in this case all testified that the history taken by Nurse Girtz was adequate and within the standard of care.

*On Wednesday, March 7, 2018 at 1342, Mr. Flach and his wife called Respondents' advice nurse call center. In speaking with telephone service representative Windy Chavez, it was explained that they believed the Mr. Flach had bronchitis and was experiencing chest pain and had a productive cough. Mr. Flach and his wife were immediately transferred to speak with Ms. Girtz and proceeded to have an approximately 13-minute conversation regarding Mr. Flach's symptoms. Mr. Flach had not been well for the past two days, had been taking Advil and Mucinex, but that his symptoms worsened after playing 36 holes of golf in the rain over the Weekend. Ms. Girtz asked whether Mr. Flach was experiencing any sharp chest pain, but he denied that and described it as "burning" and "broken glass" sensations. When asked about Mr. Flach's sputum, it was described as "yellowish orange", with denials that it contained any blood. Mr. Flach denied he had any shortness of breath or episodes of extreme chest tightness. As to a fever, Mrs. Flach told Ms. Girtz that Mr. Flach might have a fever, but a thermometer was not readily available to check, and Mrs. Flach did not subjectively feel that the decedent had a fever

upon a touch test. Based on these reported symptoms, Ms. Girtz utilized the cough/sinus/cold/flu and asthma/wheezing protocols, which suggest the patient undergo a telephone evaluation with a primary care physician that turned out to be Dr. Culbertson, the decedent's primary care physician.

*At the end of the call, Ms. Girtz offered a telephone appointment with Dr. Culbertson later that afternoon, which was an agreeable option to both the decedent and his wife. It was further explained that the physician would arrange for an in-person appointment and x-ray if they desired, and that this practice avoided infectious patients from spreading their condition at the facility. Ms. Girtz took an adequate history of the decedent, as she listened to his story of symptoms and asked follow up questions when necessary. Ms. Girtz was asked: "When you were talking about Mr. Flach's burning in his chest that he reported and you suggested it was related to his cough, what do you recall his response being to that? She answered: "He, like I said, he started with the glass. Then he kind of went to the burning. And I may be picking here, but when I was thinking about that comment about the yellow or the pain with the cough or whatever, I seem to recall that in the background when he was coughing that he would kind of moan right after the cough, and then he would be fine for a while, and then cough again, and then there would be a moan. I don't know if those things get picked up on a transcription or not . . ." Question: "Sure. How did you at least interpret, you know, his moans, if at all, in regard to your conversation?" Answer: "That the cough made his chest more uncomfortable." Ms. Girtz did not hear anything during her call with the Mr. Flach that suggested his "burning in chest" symptom was related to anything other than coughing. She was asked: "During the entirety of that call, did you ever take anything said by either Mr. or Mrs. Flach to suggest that the burning

in the chest that was being reported was related to anything other than coughing?" Answer: "No."

* In addition, Ms. Girtz sufficiently pursued Mr. Flach's chest pain in that she asked follow up questions to see if he had any chest tightness, and whether he was anxious or panicked about his breathing to assess if he was short of breath. She was asked "At some point, you asked Mr. Flach about the presence of chest tightness. What was the significance of his denial of that particular symptom?" She answered: "Chest tightness, if it comes and goes with activity, could be cardiac in nature. If it's a constant tightness with wheezing, that could be the onset of some pretty significant asthma symptoms or significant inflammation to the bronchials." Question: "What was your purpose in asking Mr. Flach if he had any panic or anxiety regarding his breathing?" Answer: "Sometimes they can't say or judge really well whether they're short of breath or not. It can be on the borderline. If they're starting to get really anxious or panicky kind of stuff, feel like they're smothering when they lay down, things like that, that can be significant shortness of breath. Plus, it can also show a decrease in the oxygen levels to the brain."

*Ms. Girtz followed her typical practice, as an experienced advice nurse of 15.5 years, to assess Mr. Flach, and she followed the standard of care at all times. She was asked: "In regard to your call with Mr. Flach, did you follow your typical practice in assessing him? She answered: "Yes."

*Following her review, Ms. Danner agreed that Mr. Flach did not describe symptoms associated with profound weakness. She is supportive of Ms. Girtz' history of Mr. Flach and opined that Ms. Girtz followed the standard of care. Ms. Danner was asked: "Based on your review of the call, the transcript and the recording, is it your understanding that the

descriptions of Mr. Flach were such that he would be assessed as having profound weakness?" She answered: "Not if you could walk around your house. That's not profound." Question: "Okay. How would you -- at least in your own practice -- describe a patient's abilities if they did have profound weakness?" Answer: "You can't get out of bed."

*In her own assessment of Ms. Girtz, Dr. Padilla testified that Ms. Girtz properly applied the advice nurse protocols after Mr. Flach denied two or more episodes of blood in his sputum. Dr. Padilla was asked: "Perfect. So, if we were to start there and the nurse were to get through the first question, which is that she asked the patient if there had been two or more episodes of bright red sputum containing one tablespoon or more of blood, and the answer was no." She answered: "Correct." Question: "At that point under that protocol the nurse is no longer considering emergent conditions. Is that right?" Answer: "That's how the protocol is written by the physicians, yes."

*Dr. Cooke also testified that Ms. Girtz took an adequate history of Mr. Flach, and there was nothing further that was required. She said: "So the history that Nurse Girtz took I thought was perfectly acceptable.

c**. Same Day Appointment with Physician was Appropriate**.

*Prior to the relevant events in this matter, Mr. Flach had used Respondents' advice system to get guidance regarding health concerns and to schedule appointments. He also understood that he could request an in-person appointment over a telephone appointment, if that is what he desired. Both Dr. Cooke and Ms. Basich were unaware that Mr. Flach had used Respondents' advice nurse system on many occasions before the subject matter of this case. Mr. Flach knew that even if an advice nurse advised a telephone appointment, he could still be seen

in person by requesting a visit. Ultimately, a same-day telephone appointment to address Mr. Flach's symptoms was well within the standard of care.

*Ms. Girtz was aware that Mr. Flach was taking medicine to treat his symptoms. She was asked: "You also knew that – well, it was conveyed that he was taking Advil, right? An antipyretic? She answered: "Yes." Question: "So you knew that would bring the fever down, right?" Answer: "That it should, yes."

* Furthermore, Ms. Girtz did not think that the decedent was profoundly weak because he could walk across the house. She was asked: "Okay. You're just saying you don't think it was – fit in the category of profound weakness?" She answered: "Correct." Question: "What does 'profound' mean in this context?" Answer: "Generally, that they can't walk more than a few steps without collapsing or can't even get out of a chair under their own power."

*Ms. Girtz' job is not to medically diagnose patients over the phone. That is the job of a physician. She defers to the physicians for a diagnosis in her typical practice. She was asked: "Among your thoughts that afternoon during this phone call was that Mr. Flach needed a chest x-ray and someone to listen to his chest, right? She answered: "I don't tell doctors how to treat their patients or how to assess them. " Question: "That wasn't my question. I was asking about your thoughts. "Answer: "That he may possibly." Question: "You were also thinking that Mr. Flach could stand a round of antibiotics, right?" Answer: "Like I said, that's medical judgment, not mine." Question: "So, you know, at any time during your telephone call and assessment of Mr. Flach, did you use your nursing judgment and conclude that he had pneumonia?" Answer: "No. It's a medical diagnosis. I don't make medical diagnoses." Question: "That's not something you do in your typical practice?" Answer: "No. We can surmise that it's

possible, but, no, I do not make medical diagnoses. That's not within my scope of practice as a registered nurse.” Question: “At any time during your assessment with Mr. Flach, did you use your nursing judgment and conclude that he needed antibiotics?” Answer: “No.” Question: “At any time during your assessment Mr. Flach, did you use your nursing judgment and conclude he needed an X-ray?” Answer: “No.” Question: “In your typical practice, did you defer to a physician to determine whether a patient needed an x-ray or a diagnosis of pneumonia?” Answer: “Always.”

* Ms. Girtz was able to schedule Mr. Flach for a same day telephone appointment, which was noteworthy because it was already late in the afternoon. She was asked: “Okay. You eventually selected an option for a telephone appointment with Dr. Culbertson that afternoon. Do you recall having any thoughts about the fact that there was a telephone encounter available with Dr. Culbertson later that afternoon?” she responded: “I was thrilled.’ Question:” Why were you thrilled?” Answer: “Usually at that time of the day, there were usually no appointments available any longer, and we usually end up sending messages, and I don't like having patients hanging in the lurk waiting for a call back just for an appointment time, particularly when they weren't feeling real good. “

*According to Respondents’ internal medicine expert, Steven Fugaro, MD, Mr. Flach was well aware of how the telephone advice system worked. He was asked: “And based on your review of those prior calls, in what ways did you understand Mr. Flach was familiar with the use of the Kaiser advice nurse system? He answered: “Well, he understood that they had telephone appointments, because I know that one of them was offered to him. And then he asked for an appointment. I think he was offered a telephone appointment, and he said he preferred a face-to-face appointment because he, quote, did not think he could get care or -- I

think what he meant by that was maybe I think he just wanted to see someone face to-face to do a more direct, hands-on evaluation."

*Respondents' nursing expert Ms. Danner also knew that the decedent accepted a telephone appointment with Dr. Culbertson without any hesitation or displeasure. She was asked: "You know, at least as far as you're aware, after having listened to the call and reviewed this transcript, was there any indication that you're aware of that a telephone appointment was not acceptable to either Mr. or Mrs. Flach? She answered: "No. I think it's acceptable with him saying, 'No, I'm not short of breath,' and Mrs. Flach saying, 'No, he's not short of breath.' 'No, there's not chest pain.' And her speaking on his behalf, 'No, there was not.' It's, like, two answers by each person. And he's talking. He has no anxiety or concerns about his breathing. Now, if he said yes to any of those, it would be emergency room."

*Given the history obtained by Ms. Girtz, Ms. Danner does not believe Ms. Girtz was not required to send Mr. Flach immediately to the emergency department. She was asked: "Based on the symptoms that were reported while Ms. Girtz used that particular protocol, was there a requirement that Ms. Girtz instruct Mr. Flach to be seen immediately in the emergency department?" Answer: "No. Because of the answers to the questions not short of breath, no chest pain unknown fever. You wouldn't necessarily send someone to the ER for a fever. So, at that point, it was not sounding critical enough to go to the ER."

*If Mr. Flach wanted to be seen in person, Ms. Danner expected him to express his wishes to be seen, like he had during previous advice nurse calls. Mr. Flach did not request an in-person appointment. She was asked: "I mean, they said thank you, and that meant that they were happy they weren't going to see the doctor? Answer: "Thank you. It was the tone that you heard. That -- okay, thank you. I mean, if I was unhappy with something, I would have been

speaking up saying, no, I am not happy with this. He had said it before in one of the conversations when he was making an appointment, I don't want a telephone appointment; I want to be seen face-to-face."

*Dr. Cooke also understood that Respondents did not prevent its' patients from requesting in person appointments, and that Mr. Flach knew that he could request an in-person appointment. She said: "But I believe he probably understood that he could request an in-person visit."

*Thus, providing Mr. Flach with a telephone appointment with his primary care physician, when he knew that was a possibility and did not request otherwise, was an appropriate decision, and Ms. Girtz did not deviate from the standard of care in doing so.

d. Nurse Girtz' Preparation of the Chart was Proper

*Ms. Girtz' chart note was discussed extensively at trial. She uses her nursing judgment to craft the narrative for her chart note. The standard of care does not require her to write everything discussed with the patient. Ms. Girtz' typical practice includes writing chart notes that determines will be most informative to the treating doctor. Ms. Girtz did not put down "orange" in her chart note because orange is not used as a descriptive term for sputum. Therefore, she believed charting the decedent's sputum as "yellow" would be more informative to the physician. She was asked: "Why didn't you put down yellow orange? Answer: "Because orange is usually not a very descriptive symptom. Very often that can be due to food or something they drank." Question: "It could be –"Answer: "Or medicines or . . ."
While claimants want to turn this difference in color into something more than it is, it is obvious that Ms. Girtz reported an abnormal color indicating an infection, and allowed the physician to conduct their own assessment of the color. As most experts in this matter reported never having

heard sputum being described as "orange", it was reasonable for Ms. Girtz to not focus on the specificity of the color, but what it represented the decedent needed for his treatment. Thus, no breach occurred regarding this issue.

B. Dr. Culbertson

An internal medicine specialist is negligent if he fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful internal medicine specialists would use in similar circumstances. This level of skill, knowledge and care is sometimes referred to as "the standard of care." You must determine the level of skill, knowledge, and care that other reasonably careful internal medicine specialists would use in similar circumstances based only on the testimony of expert witnesses. CACI 502

1. Claimants' Perspective per their Submissions

*Dr. Culbertson was in the course and scope of his employment as a Kaiser employee at all times during which he provided care for Mr. Flach on March 7, 2018. He contends that he did not know about Mr. Flach's chest pain or yellow-orange sputum on March 7th, but if he had known about these issues, he would have recommended that Mr. Flach see him that day or go to the emergency room at that time. Exhibits 6 and 7 establish that Mr. Flach had both chest pain and yellow-orange sputum less than two hours before Mr. Flach's 3-minute call with him and so advised Nurse Girtz. There is no question that Kaiser, by and through its Advice Nurse Girtz knew about these symptoms. (Exhibits 6 and 7). If the degradation of information (see testimony of Dr. Cooke and Dr. Leo), or the Kaiser system denigrating this problem to telephone call disposition, was such that the information did not get to Dr. Culbertson, that is Kaiser's institutional negligence and Nurse Girtz' negligence as well, but it is also, nonetheless,

Dr. Culbertson's negligence for not learning the details of Mr. Flach's illness and acting in accord with what he has described as his own standard of practice.

*With the testimony that Dr. Culbertson did not know, but if he had known, of symptoms conveyed to Nurse Girtz, he would have seen Mr. Flach on March 7th and that would have saved Mr. Flach's life, Kaiser cannot prevail in this case. Kaiser designed and managed its advice nurse system and whether the reason Dr. Culbertson did not get the information is because 1) Nurse Girtz failed to include it and degraded information in her note; 2) Nurse Girtz set up a telephone appointment suggesting to Dr. Culbertson that Mr. Flach's illness was 'less emergent'; 3) Kaiser's policy to shunt Cough Cold Flu cases to telephone dispositions; 4) Dr. Culbertson's failure to read Nurse Girtz' note; 5) Dr. Culbertson's failure to devote sufficient time to take a complete history from Mr. Flach; 6) Kaiser's failure to provide Dr. Culbertson with the recorded advice nurse interactions, the negligence of Kaiser is at the root of it all. If it is true that Dr. Culbertson did not learn of the crucial symptomatology conveyed in the recorded call, and that Dr. Culbertson otherwise would have seen Mr. Flach or sent him to the emergency room on March 7th, had he known Mr. Flach had chest pain or yellow-orange sputum, then the information breakdown is unquestionably the fault of both the Kaiser providers and the Kaiser system itself.

*Focusing on Dr. Culbertson's actions alone, it is noteworthy that Dr. Culbertson's' own expert witness, Dr. Bresler, who had testified for defense counsel no less than 10 times before, and had read Dr. Culbertson's testimony, testified: Question: "You're a medical doctor? True?" Answer: "Of course." Question: "And you have offered one opinion that you thought that the nurse did not breach the standard of care, right?" Answer: "Correct." Question: "But with respect to Dr. Culbertson, you're not saying that Dr. Culbertson did not breach a

standard of care here, are you?" Answer: "I'm not coming to a conclusion about Dr. Culbertson." … Question: "And you read - you obviously read Dr. Culbertson's deposition; correct?" Answer: "Correct." Question: "But yet, you elected or somebody elected not to express any standard of care opinions with respect to Dr. Culbertson. And that's the preface to this question: Did you tell the lawyers for Kaiser that you did not think you could be helpful to them in that area?" A: "Yes."

*In this case, the advice nurse scheduled Dr. Culbertson for a phone call with Mr. Flach at 3:40 p.m. on March 7, 2018. The time the call was scheduled and the fact that it was a phone call was also suggestive to Dr. Culbertson that the medical issues were not very serious. Dr. Culbertson had no access to the earlier telephone interaction with the advice nurse. His only information preceding the telephone call may have been the notes from the TSR and the misleading and incomplete notes from the advice nurse (Girtz). But there is no evidence Dr. Culbertson ever read them.

*Molly Cooke, MD, was quite candid in opining about Dr. Culbertson's care. She testified that the note and the discrepancy between his note, Nurse Girtz' note and the actual phone call two hours earlier, "…makes me wonder if he did anything in terms of taking a history." …. "I don't know how this note came about, but I have no confidence in it." She testified unequivocally that the history taken by Dr. Culbertson was a breach of the standard of care. She was asked: "You would agree that there are times that you take patient histories in telephone encounters that are around three minutes, right?" She replied: "Not for presentations like this. I mean if the patient says, 'I'm confused whether I'm supposed to take my medicine in the morning or the evening,' that's a three-minute encounter. But sussing out, you know, how

sick is this guy really and what's the appropriate next step in his care is a longer process than three minutes, simply can't be done in three minutes."

*Although it is far from clear that Dr. Culbertson ever looked at Nurse Girtz' note and he certainly never had access to the Girtz-Flach telephone recording, Dr. Cooke testified that it was striking how the quality of clinical information was degraded with each phone call, note and communication. She noted that "orange" indicates there is inflammation in the lung tissue that is causing some bleeding and blood mixed with phlegm. This, according to Dr. Cooke, it was an alarming symptom of hemoptysis and would be an indication of a serious lower respiratory infection inclusive of diffuse pulmonary inflammation (the lungs are bleeding) for which the patient needs to be seen. When Dr. Culbertson only took three minutes to determine how sick Mr. Flach was, having no prior information, Mr. Flach's fate was sealed.

*Dr. Cooke testified that Dr. Culbertson breached the standard of care that required Mr. Flach be seen within one hour of the 3:40 p.m. Culbertson telephone call. She was asked: "And once that call was in play, what …should Dr. Culbertson have derived from that call and what disposition did the standard of care require at that time? Answer: "Well, the standard of care still requires that the patient she (sic – 'be') seen. I feel strongly that the patient should have been seen as a result of Nurse Girtz' telephone interaction with the patient. And had Dr. Culbertson taken a proper history, he would have been obliged by standard of care to have the patient seen." THE ARBITRATOR: When? THE WITNESS (Cooke): "Well, I wish the patient had been seen at 2:30, but clearly by 3:40, this patient should have been told, 'You need---you have a serious illness and you need to be seen by a physician in person within the next hour or so.'"

*A referral by Dr. Culbertson to the emergency department at the conclusion of that telephone call would have been the most obvious disposition that would have complied with standard practice. Instead, Dr. Culbertson did not see Mr. Flach or advise him to be seen-that day at all.

*Dr. Leo - who also practices internal medicine - concluded Dr. Culbertson's actions were substandard. He stated: "I did conclude Dr. Culbertson fell below the standard of care in a number of ways." He testified that Dr. Culbertson breached the standards of care in his taking of an inadequate history, in his failing to document the history adequately, and in his documentation of his telephone visit with Mr. Flach that was simply not credible, given the recorded conversation with Nurse Girtz. Dr. Culbertson was required to elicit the true facts evident by virtue of the earlier recording and the standard of care was then to see Mr. Flach or have him seen.

*Dr. Leo opined that Dr. Culbertson failed to learn that Mr. Flach's sputum color was reported as yellow-orange two hours before his call and likely, at the time of his call, was rust colored, as it was 45 minutes post call. Dr. Culbertson fell beneath the standard of care in either failing to access the note written by Nurse Girtz or, to the extent he did so, in failing to note discrepancies between the history that Nurse Girtz obtained and what Dr. Culbertson recorded as the absence of fever or chest pain. Most importantly, given all of the information that Dr. Culbertson either obtained or was available to him, the standard of care required of Dr, Culbertson was that Mr. Flach be examined and x-rayed that day in order to rule out pneumonia.

*Dr. Langdorf, also testified that Dr. Culbertson took an inadequate history- one that was too brief a history to discriminate between pneumonia and other diagnoses. He stated that this treatment was a breach of the standard of care. Dr. Langdorf also opined that Dr.

Culbertson breached the standard of care by failing to see Mr. Flach in person or choosing to send him to the emergency room. Furthermore, Dr. Langdorf testified that Dr. Culbertson breached the standard of care in failing to order a chest X-ray that would have led to the diagnosis of bacterial pneumonia. This failure delayed the administration of antibiotics for 16 hours.

*As for Dr. Culbertson's practice, he was on the phone a total of three minutes with Mr. Flach on March 7th. (Exhibit 9.) This was two minutes less than his average five-minute-long telephone appointment. Perhaps he was distracted or had other pressing issues. The note was likely typed after three more in-person patient visits, because it was timed more than an hour later and just before Dr. Culbertson was to leave for the day. We will never know. What we do know is the history he took bears no relation to the information conveyed over the telephone just two hours earlier. (Exhibits. 6, 7) Further, Nurse Girtz' note that was available to him was irreconcilable with his own. The evidence is clear that Mr. Flach's illness was not improving-he was in septic shock by the time he was admitted to the emergency room on March 8th. It is unlikely that Mr. Flach would have conveyed to Dr. Culbertson anything suggesting he was improving.

*The standard of care was to take a careful history and to learn the details of the problem Mr. Flach was experiencing. Mr. Flach's condition warranted an in-person appointment on March 7th to take place no later than 4:40 p.m. per Dr. Cooke to include examination and objective testing. None of that happened. If it was too late in the day for Dr. Culbertson, the standard of care was for him to send Mr. Flach to the emergency room.

* Michael Jacobs, MD, a longtime Professor of Medicine at Standard University Medical Center and an expert in the field of Internal Medicine opined:

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*Within the bounds of reasonable medical certainty that based upon the information provided by the Flachs on March 7, 2018, the standard of care required Dr. Culbertson to either immediately have seen Mr. Flach in the (Medical Group) clinic the afternoon of March 7, 2018 or to have directed Mr. Flach to go to the emergency room no later than the afternoon of March 7th.

* From the recorded call earlier that day, there is no dispute that Mr. Flach already advised Nurse Girtz that he had chest pain and a fever. He also reported yellowish orange sputum that likely became that color, because it was sputum mixed with blood. There also is no question that Mr. Flach's illness was getting worse, not better. He was in septic shock by 9:21am on March 8, 2018. His sputum was certainly blood-stained by 4:17pm on March 7, 2018, according to the photograph taken by Mr. Flach himself. Further, he had already advised Nurse Girtz that the illness was getting worse and Nurse Girtz became properly concerned about the trajectory of the disease. For these reasons, it is my opinion that Mr. Flach never advised Dr. Culbertson that he had no fever or chest pain. It is much more likely that Dr. Culbertson assumed a telephone appointment was not for a serious illness, his three minutes of a telephone appointment with Mr. Flach was inadequate to obtain the full story which would have elicited the information time Nurse Girtz already had and that in the three patients that he saw since the phone call, the true information was not retained. To comply with the standard of care, Dr. Culbertson was obligated to ask his patient questions that would have elicited that Mr. Flach had recently (less than two hours earlier) been experiencing, and likely was then experiencing, serious chest pain and a mild fever. He should have also learned that he was taking Advil to reduce his fever.

* In a context like this one, for a patient as sick as Mr. Flach was, three minutes is not an adequate time for a reasonably careful physician to take a sufficient history to decide that Mr. Flach did not have severe pneumonia or some other major disease entity, including sepsis. Dr. Culbertson's note of that interaction supports this conclusion. It records no probing for pertinent facts or symptoms, no history of the trajectory of the disease process and no indication that the sputum color was discussed. It includes the wording "no fever" and " no chest pain" that directly contradicts what is known, with certainty, that was conveyed by Mr. Flach to Advice Nurse Girtz a few hours earlier that same day.

* The constellation of information and symptoms described during the Flach's call with Nurse Girtz, including Mrs. Flach describing this illness as at a level where she had "never seen her husband so sick, coughing up stuff, nauseous, really weak, achy, no energy, with a mild fever," provides actual symptoms that warrant Mr. Flach be seen that day. This information also provides a perspective from someone who best knows the patient and can provide insight to the clinician about the degree of illness. This in unique and important information that provides a clinician insight as to how ill a patient may look if seen. Further, the information that this illness has continued over six days and is not improving, as one would expect of an illness such as this, but rather has gotten worse in the two days preceding the March 7th call, is another major factor that the standard of care required that Mr. Flach be evaluated in a face to face examination, followed by a chest x-ray, in the afternoon of March 7, 2018.

*The standard of care required that Dr. Culbertson take a complete history from Mr. Flach that would enable Dr. Culbertson to determine if Mr. Flach required being seen that afternoon. Within reasonable medical probability, Dr. Culbertson took an incomplete, inadequate and truncated history from Mr. Flach that was inaccurate in critical part and breached the

standard of care. Having only a three minute call with a patient having Mr. Flach's symptoms is inadequate to learn the nature and extent of the problem. Given the symptoms conveyed to Nurse Girtz earlier that day, it is certain that Mr. Flach's symptoms, when he spoke to Dr. Culbertson, were the same or worse than they were at 1:44pm. The standard of care required Dr. Culbertson to elicit the history of severe chest pain and to characterize this in detail; to inquire about sputum production and fully describe the sputum; to inquire about fever, chills, and sweats; and to elicit the progression of the illness, especially starting as a viral illness for several days, but then abruptly worsening the two days before the call. Had this been done, Dr. Culbertson would have learned of Mr. Flach's symptoms, at which time the standard of care would have required that he or another physician see Mr. Flach immediately, or instruct Mr. Flach to go to the emergency room immediately. In either instance, a physical exam, including chest exam, a chest x-ray, and blood test would have been done and a diagnosis of pneumonia made. Furthermore, the instruction Dr. Culbertson made in his chart note to Mr. Flach to "return" if he had a "cough with streaks of blood …. or chest pain" was misleading and made no sense, since Mr. Flach already had severe chest pain and sputum that, unbeknownst to Mr. Flach, was already tainted with blood and was an emergent symptom. Mr. Flach was not told by Dr. Culbertson to return if his sputum turned to a pink or a rust color. Most likely, his sputum did not become blood streaked until the following morning.

*There was but one physician who rendered an opinion on whether Dr. Culbertson's care met the standard of practice. That was Dr. Fugaro. Dr. Shaughnessy, a critical care physician, did not practice internal medicine on an outpatient basis and he had no opinion. Dr. Bresler advised Kaiser Attorneys that he could not support Dr. Culbertson's care. Dr. Joseph was an infectious disease expert who gets cases after admission to the emergency room on

referral, unlike Dr. Culbertson. So only Dr. Fugaro provided testimony that potentially could assist Dr. Culbertson.

*Dr. Fugaro has testified in deposition between 400 and 500 times and has earned over $3 million dollars testifying in malpractice cases. He has testified for Mr. Simonson or his office 15-20 times.

*Dr. Fugaro is a concierge physician. He sees just 3-5 patients daily and has for 15 years. He gives his patients his cell phone number. If Dr. Fugaro had been Mr. Flach's physician, he would have been called directly by Mr. Flach.

*Dr. Fugaro conceded he would have likely spent more than three minutes on the phone with Mr. Flach. What's more, he acknowledged the photo of the sputum Mr. Flach took showed hemoptysis and that he regularly gets photos from patients of 'various things' and ailments on his cell phone.

*Dr. Fugaro also conceded that he would have verbally elicited the orange tint to the sputum and once he was able to see the photo (Ex. 8 taken on March 7, 2018, at 4:17 p.m.), the standard of care would have been to either see the patient emergently or send him to the emergency room. Of course, he agreed that if Dr. Culbertson had seen Mr. Flach in person, Dr. Culbertson would have seen Mr. Flach's blood tainted sputum. Dr. Fugaro also conceded that if Dr. Culbertson had seen Mr. Flach on March 7th, he likely would have obtained a chest x-ray and, if Dr. Barakos was correct that the x-ray probably would have shown a multilobar pneumonia, the standard of care would have been to send Mr. Flach to the emergency room.

*The information from which a diagnosis should have been, and would have been made, was available and in the hands of Kaiser; and, if Dr. Culbertson had taken the time to access it, Mr. Flach would be alive today.

*On March 7, 2021, the standard of care required that Mr. Flach be seen and examined by a qualified physician. Despite three separate telephone interactions with Kaiser health care providers, including a TSR, a registered nurse and an internal medicine physician, Mr. Flach was never seen in person and examined by anyone. Kaiser never requested that he come in to be examined.

2. **Respondents' Perspective per their Submissions**

a. Dr. Culbertson Properly Assessed Mr. Flach Over the Phone

*Dr. Culbertson enjoys seeing and connecting with his patients every year. He loves caring for his patients. His love and joy for his patients is what keeps him going. He has even received peer-voted awards as the physician his co-workers would most like to send their family members to. The long hours are part of the territory for a doctor in his role tasked with caring for thousands of patients. Due to the large number of patients, Dr. Culbertson treats patients in a wide variety of settings: in person, over the phone, and on video. Regardless of the medium to which Dr. Culbertson treats his patients, he always does so with the highest level of care.

*Dr. Culbertson followed his typical standard of practice at all times during his interaction and phone appointment with the decedent. He was asked: "So just as a kind of cleanup question, in regard to your telephone encounter with Mr. Flach and your preparation of your note afterwards, did you do anything outside of the typical practice you've described for us here today? He answered: "No."

*Dr. Culbertson followed up with his medical assistant to make sure the decedent was seen. He was asked: "Do you know whether or not your medical assistant was successful in reaching Mr. Flach? He answered: "I did not find out immediately, but it was, I

don’t know, maybe – it might have – I don’t recall the next episode of when I talked to her again. But when I found out that he hadn’t come into my schedule, then I got a little bit more panicked, and I was like, ‘You got to get him in now. We need to get him in.’”

*Respondents’ expert internist Dr. Fugaro opines that the standard of care for a telephone visit is different than an in-person appointment and that Dr. Culbertson’s care should be reviewed and weighed accordingly. Dr. Fugaro said: “And I would say that the standard of care of a telephone visit is just different than the standard of care of an in-person visit because of the inherent fact you're seeing a person, and you're able to examine them. And that's just something we all accept, and we know.

*Claimants’ expert internist, Dr. Cooke, agrees with Dr. Fugaro that the standard of care for a telephone appointment is different than an in-person appointment. She was asked: “You would agree that the standard of care is not exactly the same for a telephone visit as a telephone encounter, true? She answered: “I would agree with that.”

*Not only does Dr. Langdorf testify as to the nurse standard of care, he also discusses Dr. Culbertson’s care. However, once again, Dr. Langdorf is neither a nurse or primary care physician and only sees patients in the emergency medicine setting. Therefore, his opinions regarding Dr. Culbertson’s care in the primary care setting should be given little weight. Dr. Langdorf was asked: “So you agree that Dr. Culbertson’s practice is vastly different in scope both in patients and treatment and methodologies than your own practice, true? . . . He responded: “Office practice is different than emergency practice.”

*An adequate history can be taken in three minutes. Especially after a nurse has prescreened the patient with a 13-minute phone conversation. Dr. Culbertson received and reviewed a chart note describing the decedent’s problems. Dr. Leo agrees that Dr. Culbertson

could screen Mr. Flach's symptoms in about three minutes. He was asked: "Is that an adequate time within which to take a history of a patient like this with these complaints?" He replied: "Is it possible to obtain a standard of care history with these complaints in three minutes? I would say that's within the realm of possibility, but that has to include asking the right questions. And in this case, given recordation by Dr. Culbertson of no pain and no fever in the face nurse Girtz' contradictory documentation, three minutes would not be enough time to be able to sort out those discrepancies."

*As such, Dr. Culbertson's interaction with the decedent in all aspects met the standard of care, and based on the reported symptoms, properly diagnosed him with an upper respiratory infection and advised him to come in or call back of those symptoms worsened or new ones developed. Claimants' focus on Dr. Culbertson's imperfect memory is immaterial, as he is entitled to rely upon not only his custom and habit to inform his memory, but also his chart note to supplement it as well.

*Experts cannot pick and choose what information fits with their theory and criticize what does not fit, but must base their assessments on all information to appear objective. Since claimants cannot identify a deviation from the standard of care by Dr. Culbertson without disregarding his chart note and/or testimony shows that the opinions of their experts are not credible, and cannot meet the burden of proof.

b. Mr. Flach did not Require an In-Person Appointment

* Mr. Flach's reported symptoms did not require him to be seen immediately. Dr. Culbertson informed the decedent of warning signs that his condition was getting worse. In the scenario of worsening, Dr. Culbertson instructed Mr. Flach to be seen. But understanding that Mr. Flach did not have shortness of breath, chest pain, or coughing up blood, Dr. Culbertson did

not believe he needed to be seen that day. He was asked: "As I mentioned in my note, he did not have – when I asked him if he had chest pain, irrespective of what was said to Nurse Girtz, when he didn't – he said he did not have chest pain, he said he did not have shortness of breath. For the type of symptoms, he had and the duration of the time that he had without a fever, these are all very consistent with bronchitis. So, at that particular time, without having signs of coughing up blood, anything like that, this all sounds like very common bronchitis that we see innumerable times throughout the year. There was nothing in our conversation there that indicated she though he needed to go to the ER, and there was nothing in my conversation at the time when I talked to him that indicated he needed to go to the ER.

*An important part of taking the history of a patient is believing what the patient is reporting and answering to the questions asked. Dr. Culbertson was asked: "Understanding some patients know themselves better than others, would you generally believe what a patient reports to you in response to your questions? He answered: "Yeah, absolutely. I meant, there – yes, I would say absolutely, in most cases."

*When a patient describes symptoms that require them to be seen, Dr. Culbertson would make sure the patient receives an appointment. He was asked: "Q. So in the situation where a patient has described symptoms and you think it's reasonable for them to be seen in person and there's a request that they do, is there ever a circumstance where you would reject that request?" He responded: "Never, never, not – yeah, no."

*Dr. Culbertson understands that patients are familiar with what a fever is and isn't. Furthermore, he knows that most people have an objective measure at home to determine a fever. So, when a patient tells him that they don't have a fever, he believes it. He was asked: "Do you assume that if a patient says that they don't have a fever, they have found

some objective way to determine that, such as with a thermometer? He replied: “I would think so.”

*Finally, during the phone call with Mr. Flach, there was no indication that he had pleuritic chest pain. Dr. Culbertson was asked: “Is your notation here “no chest pain” in your understanding a statement that there is no pleuritic chest pain that he’s reported? He answered: “Absolutely. There’s – there’s no indication of pleurisy.”

*Dr. Fugaro testified that Dr. Culbertson reviewed the symptoms of pneumonia with Mr. Flach. He was asked: “Just in your experience, what are the array of symptoms that an internist looks for in order to diagnose a potential case of pneumonia?” He said: “We certainly look for cough. We look for shortness of breath. We look for a particular kind of chest pain that's a sharp, pleuritic-type of chest pain. That's because the pleura, which is the lining of the lungs, actually have nerve endings, while the vast majority of the lungs do not have nerve endings. We would look for someone who is having significant fever, certainly. And we would look for someone who is having some degree of difficulty walking, difficulty ambulating in terms of breathing.”

* Without the presence of pleuritic chest pain, which the decedent denied, Dr. Fugaro would be substantially less worried about lobar pneumonia. He was asked: “So if a patient doesn't report that pleuritic chest pain, what impact would that have on the placement of pneumonia in an internist's differential diagnosis?” He responded: “Again, you take a lot of other factors into account. But if the patient is simply having severe chest discomfort, this burning or broken glass sensation, but not sharp pleuritic pain, that makes the concern about a lobar pneumonia which is associated with bacteria substantially less. And everything is probability,

and so it reduces in an internist's mind the probability somewhat that such a patient has a concerning lobar pneumonia.

*Furthermore, patients with pneumonia symptoms do not always need to be treated in the office. Pneumonia symptoms can be treated just as effectively through outpatient methods. Dr. Fugaro was asked: “But the vast majority of patients who have such symptoms, who have that in the differential, don't need to be seen in the office, can be treated effectively as an outpatient, often get better. He answered: “So that did not a priori, in my opinion, necessitate him being seen, meaning Mr. Flach.”

*Dr. Culbertson’s differential diagnosis was entirely reasonable given the history taken. His differential diagnosis was within the standard of care. Dr. Fugaro was asked: “Was it appropriate under the standard of care for Dr. Culbertson to have that assessment following his call with Mr. Flach? He answered: “Prospectively, that was entirely reasonable and within the standard of care in my medical opinion.”

*Dr. Culbertson has stated throughout this case that he approached the phone call with Mr. Flach like any other telephone appointment in his typical practice. Claimants’ expert internist Dr. Cooke testified that this typical practice for telephone encounters was consistent with the standard of care. She was asked: “Q. Right. At his deposition when Dr. Culbertson described his typical practice for when he would have a telephone encounter with a patient, he descried that process, and when you reviewed that, your opinion was that his description was consistent with the standard of care in those circumstances, right? She replied: “Well, if that’s what I said before, I’ll stick with it.”

*Dr. Cooke also believes that for Dr. Culbertson to assess a patient and create his differential diagnosis, he must consider the information given to him from the patient.

She was asked: “You would agree that Dr. Culbertson is entitled to consider the information he receives in a patient history during a conversation with the patient, true? She said: “Of course.”

*Dr. Cooke agrees that pneumonia would not be high on her differential diagnosis if a patient reported a cough with no fever, no chest pain, and no shortness of breath. She said: “So, as a hypothetical, I would agree that a patient who only has a productive cough with no fever and no chest pain and no shortness of breath, pneumonia would certainly be lower on my differential diagnosis than other less dangerous conditions.”

*Claimants must prove that Dr. Culbertson was deceitful or inaccurate in his chart note and recollection of the telephone appointment with the decedent in order for the opinions of their experts to be reasonable and credible. However, even Dr. Cooke agrees, that if you believe the history taken by Dr. Culbertson, his consistent testimony throughout deposition and trial, and the breadth of his typical practice, then her opinions are unsupported. She was asked: “Right. But if – if that information was correct, your opinions would not be supported here today, right? She answered: “If it was correct, yeah.”

c. Dr. Culbertson Properly Prepared his Chart Note

*Dr. Culbertson testified that he uses shorthand chart abbreviations to describe and assess his telephone appointments within the patient’s medical chart. In addition, he will customize the chart note to the individual patient’s symptoms and concerns. Dr. Culbertson’s chart noting during Mr. Flach’s telephone appointment followed his typical standard practice and did not breach the standard of care.

*Dr. Culbertson wrote “yellow sputum” in his chart note because that it is what he was told. Yellow sputum is a common symptom in patients with an upper respiratory

infection. He was asked: “Why would you assume he said he had yellow sputum? He answered: “ You know, I would usually if there is something different, I’d have reflected it in my note.”

*Dr. Culbertson reviewed Ms. Girtz’ note to prepare for his telephone appointment with Mr. Flach. Dr. Culbertson also interviewed Mr. Flach and assessed his symptoms to further determine the medical care and treatment necessary. He was asked: “Is the internist required to accept as absolutely true all of the information in the other provider's chart notes? He replied: “Not at all. You would take it into account, but then you would also derive your own information from your own interview and discussion with the patient.”

*In the opinion of Respondents’ expert emergency medicine provider, Hugh West, MD, Dr. Culbertson is entitled to rely on his own medical history, in conjunction with the notes received from the advice nurse. Dr. West was asked: “Okay. And you heard in that telephone call that the Flachs’ said he had a mild fever; right? Dr. West responded: “Well, that doesn't mean he had a fever. I mean, when you have a history taken by a nurse and a medical student and a resident and an attending, those histories are often different. And if a physician is managing the patient as Dr. Culbertson is, he's entitled to rely on his own history. And if he says, did you have a fever and the patient says no, then he's entitled to rely on that information. Doesn't make any difference what he told the medical student or the nurse or the triage nurse or the paramedic in the field, he's entitled to rely on his own stuff.

*Dr. Culbertson’s chart note reflects information he gathered while asking Mr. Flach questions. A chart note that reads “no chest pain” means that the patient reported no chest pain. Dr. West was asked: “So did Dr. Culbertson say to him, you know, are you -- first of all, do you believe that the patient said, "I have no chest pain" to Dr. Culbertson?” Dr. West replied:

"Sure. That's what that entry in the chart means. No chest pain means I asked the patient do you have chest pain and the patient said no."

*In line with claimants' other experts, Dr. Cooke outright states her belief that Dr. Culbertson's note is a work of fabrication, intentional or not. She was asked; "And you would agree that there's only one note that you are not accepting as truthful and that's Dr. Culbertson's from March 7th, right? She answered: "As not truthful, that's correct."

*Likewise, Claimants' infectious disease expert, Shelley Gordon, MD shares the opinion that Dr. Culbertson's chart note is inaccurate and deceitful, and indicates she paid little attention to his testimony explaining his chart note. She was asked: "Are you taking that patient history obtained by him as truthful? She responded: "I'm saying it's inaccurate." Question: "You understood Dr. Culbertson to have explained himself, that when he said, "no chest pain," that was in reference to sharp, pleuritic type chest pain associated with pneumonia, right?" Answer: "I did not recall that from the deposition."

*Similarly, Dr. Leo's opinion regarding Dr. Culbertson's credibility is not rooted in fact. His opinions are subjective, circumstantial, and should be given little weight. He was asked: "I think the way you phrased it earlier is you don't find Dr. Culbertson's documentation to be credible. Did I get you correctly?" Dr. Leo answered: "That is my subjective impression on reading that in light of the patient's prior history and presentation in the phone call."

*Claimants realize they must attack the accuracy of Dr. Culbertson's in order to have a chance of showing that there was a deviation from the standard of care, as the alternative narrative cannot incorporate Mr. Flach's report of symptoms that show he did not require to be seen immediately.

*Dr. Culbertson came to the arbitration, testified truthfully under oath as to the history he took of the decedent, and that he correctly noted the symptoms in his charting. These facts destroy claimants' theory of liability, and thus liability must fail for lack of a deviation of care.

C. Institutional Negligence

1**. Claimants' Perspective per their Submissions**

Negligence is the failure to use reasonable care to prevent harm to oneself or to others. A person can be negligent by acting or by failing to act. A person is negligent if that person does something that a reasonably careful person would not do in the same situation or fails to do something that a reasonably careful person would do in the same situation. You must decide how a reasonably careful person would have acted in Respondents situation.

*The Kaiser Entities were negligent in the promulgation and directive for the use of its policy that disposition of 'Flu' 'Cough' 'Cold' patients was by telephone. In this regard the Kaiser Entities also bears responsibility for the death of Mr. Flach, due to its negligence in the use of its Advice Nurse System as a conduit for directing its nursing staff that infectious patients should be seen only by telephone appointments. Kaiser established a patient contact system that required screening of all patients seeking care by an Advice Nurse, combined with a protocol administered through that system, limiting patient-physician face to face examination. The policy placing a barrier between physician and patient was not medical care and had no medical purpose. The protocol was a directive to nurses to book only telephone appointments for patients with cough, cold, flu, sinus, including those patients with symptoms of pneumonia.

*The first issue is whether promulgation of the protocol by Kaiser for use by Kaiser nurses was professional negligence, defined as "a negligent act or omission to act by a

‘health care provider’ in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

*There is no evidence that the Kaiser Defendants, who promulgated the subject policy where “healthcare providers”. Certainly Dr. Culbertson and Nurse Girtz were licensed providers, and Kaiser is vicariously liable for their negligence. However, with respect to the relevant policy issue here, there is no evidence that any of the Kaiser entities who promulgated the protocol or policy were licensed under the provisions set forth above. Furthermore, the evidence in the case is that the promulgation of the subject policy was for economic purposes, not medical purposes. An HMO is not considered a health care provider. In the Knox-Keene Act, a distinction is made between "health care service plans," such as an HMO, and the licensed "providers" who are professional persons or organizations who deliver or furnish health care services. In the definitions section of the Knox-Keene Act, Health and Safety Code section 1345, subdivision (f), "health care service plans" are defined as either of the following: "(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees. By definition, Kaiser is not a health care provider. Kaiser physicians and nurses are health care providers but as a matter of law, Kaiser entities do not qualify under the definition. Kaiser is an HMO.

*In promulgating policies and procedures Kaiser owed a duty to subscribers who were patients and would foreseeably be impacted by it. That included Kenneth Flach.

*The evidence in this case supports the conclusion that the promulgation of the subject 'telephone appointment only' policy was negligence. Since policy promulgation is institutional by definition, there is no health care provider responsible for policy issuance.

*One primary reason Nurse Girtz did not book an in-person appointment was Kaiser's policy that she considered to be a directive to her to set up only telephone appointments with patients expressing pneumonia symptoms and this policy alone was a substantial factor in causing Mr. Flach's death.

*There is no Respondent expert who defended the policy of Kaiser's in directing its nurses to shunt possible pneumonia patients to telephone appointments. The only defense evidence is testimony that the Advice Nurse System as a whole may not be substandard. However, that testimony does not address the subject Kaiser policy/directive and its impact here.

*Nurse Girtz was asked: "So it was your directive from Kaiser to try to keep infectious patients out of the clinic and to set up telephone calls with doctors instead; true?" She answered: "Generally speaking, yes."

*Dr. Langdorf, who had previously been tasked with designing and setting up an Advice Nurse System, testified that Kaiser's policy of demand management and advising nurses to avoid sending potentially infectious patients to see a doctor in-person is institutional negligence primarily promulgated for economic purposes. He testified that it was a breach for the system to have a goal of trying not to send patients to see a doctor in person.

*Dr. Langdorf testified that the purpose of the nurse advice line in the Kaiser managed care system is "very specifically economic". The intent is to set up an intermediary or barrier between the patient requesting care and the physician to manage and limit the care of the patient to lower cost settings with lower cost providers. In this case, it keeps the patients from

seeing a doctor in the emergency department which is admittedly an expensive site of care. The system reduces diagnostic testing and costs, because there is no X-ray or lab work or CT available by telephone. Per Dr. Langdorf: "Kaiser accepts this patient risk cost reduction tradeoff in the interest of economics and profit."

*Nurse Girtz chose a protocol that was entitled "Cough Cold Sinus Flu" that she knew had no potential emergent resolution to it, unless the patient was coughing up spoonfuls of blood. (Exhibit 11C). Short of that symptomatology, the protocol was designed only for telephone resolution. In other words, Kaiser had decided that its "cough cold sinus flu" symptom patients under virtually all circumstances would receive a telephone appointment. According to Dr. Langdorf, and as is apparent, the reason is to limit the need for more doctors and health care providers who cost Kaiser more money. In this particular case, Nurse Girtz expressed her understanding that the trajectory of this disease was very abnormal, that likely Mr. Flach was going to need a chest x-ray, antibiotics and an in-person examination, but nevertheless chose a disposition that she considered her 'directive' by Kaiser. That directive was to refer Mr. Flach to a telephone appointment consistent with the protocol she chose.

*Dr. Langdorf was asked: "Sort of to summarize it, Mr. Flach was never sent to see a physician face-to-face, correct? He answered: "Yes, and that was the fundamental failing of the system that Kaiser set up for Nurse Girtz and Dr. Culbertson."

*Dr. Leo recognized Kaiser's overall directive that advice nurses set up phone calls instead of in-person appointments with patients who might be contagious. Dr. Leo testified that a general policy of keeping people with respiratory infection out of the clinical setting to avoid contagion is beneath the standard of care when those patients have a clinical indication to be seen physically in person as was the case here. He addressed the influence of that policy and

testified that Nurse Girtz' acceding to the policy that Mr. Flach should be scheduled for a telephone appointment visit in order to avoid bringing him into a clinical area because of that policy was beneath the standard of care.

2. Respondents Perspective per their Submissions

Respondents' assert that there is no institutional negligence. They incorporate their previous arguments in the Section found above entitled "Nurse Advice System does not Breach Standard of Care." In addition, the Protocols are written by a committee of physicians and nurses employed by The Permanente Medical Group, Inc. There is no policy to keep infectious patients from coming into a clinic or emergency room. While Claimants assert that Nurse Girtz operated under a policy to keep all infectious patients out of the clinic or hospital by scheduling telephone appointments with physicians, the actual practice was to offer telephone appointments only in the event that the provider had already determined that the patient did need to be seen. If there is a reason for a patient to seen in-person, there is no policy preventing the same. The cough/cold/flu" protocol allows the nurse to use his/her clinical judgment in deciding for a higher level of care than a telephone call with the physician. The nurse can arrange for an infectious patient to go to the ER or see a physician in-person. Both Nurse Girtz and Dr. Padilla made that clear. At the Arbitration Hearing, Nurse Girtz was asked: "We heard a statement in the tape and the statement was: 'We are trying to keep people from commingling and getting more germs.' Do you remember that statement?" She answered: "Yes" and said that was something she had told the Flachs. The follow-up question was: "And you told them that was the reason why you were setting up a telephone, not an in-person appointment: true?" Nurse Girtz answered: "One of the reasons." When thereafter asked: "Did Kaiser tell you that it was their policy for you to attempt to set up a telephone call with the patient rather than set up an in-person

examination and meeting with the doctor for a patient?" Nurse Girtz answered with a question: "When there was something infectious?" Followed by another question stating "yes" and Nurse Girtz then answering: "Yes. *And if there was not an immediate call for some sort of intervention that required them to be into the – – in the clinic*." This question followed: "So it was your directive from Kaiser try to keep infectious patients out of the clinic and to set up telephone calls with doctors instead; true?" Nurse Girtz said: "Generally speaking, yes" In other words, if the infectious patient needed to go to the clinic and be seen in-person than such patient would be told to do so by the Advice Nurse or CCMD.

Dr. Padilla, who works for Respondent The Permanente Medical Group, Inc. and was Respondents' PMK on a variety of topics, including the Scripts used by the TSRs, Protocols used by the Advice Nurses and the Workflows was asked:" Right. You are aware that Mr. Flach was advised by the advice nurse in this case to not go into a facility and to connect with Dr. Culbertson by telephone. Right?" Answer: "That's our normal workflow. Question: "That's what you understand occurred in this case. Right?" Answer: "Yes." Question: "Okay. And the reason for that is that you don't want that patient to give his or her virus germs, flu, whatever it is, bacterial infection, to other people by coming to the clinic or going to the hospital?" Answer: "*That's if we deem it appropriate for a telephone appointment. Again, the nurses have the ability to use their clinical judgment. If we do determine that an in-person visit is needed, we advise the patient to come in wearing a mask back in those days in 2018 when this happened***.** "

Further, with regard to the Cough/Cold/Sinus/Flu Protocols in question, this advisory was contained in capital letters at the top of *each* page: "This protocol is intended to be used by a registered nurse (RN) in the assessment and triage of KP members calling on the

telephone. *It is expected that the content of the protocol will be adapted to the unique issues and needs of each caller by the RN, using his/her clinical judgment.* In addition, on the specific exhibit page [PEX 11.053] that pertains to the "Emergent Condition" re episodes of bright red sputum, there is this additional proviso near the middle of the page: **"***Member does not meet the criteria but in RNs judgment should be seen in this category***."** In the subject telephone call with Mr. Flach, Nurse Girtz was free to elevate his case to "Emergent," if her clinical judgment led her to do so, which, in her view, it did not.

The AACC received about 55,000 calls per day during the Cold/Cough/Flu season in 2018, of which about 30% or approximately "18,000" [actually ~16,500] calls involved Cold / Cough/ Flu /URI matters. The vast majority of these callers do not require an immediate "emergent" referral to the CCMD or an in-person same day urgent appointment with a physician. The calls that require emergent or urgent reference are properly handled by the CCMD or the Advice Nurse. To schedule all "18,000" callers with an urgent in-person physician visit for the same day would create and impossible burden on the physicians and be a workplace disaster.

IV. CAUSATION – SUBSTANTIAL FACTOR

A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm. It must be more than a remote or trivial factor. It does not have to be the only cause of the harm. The substantial factor test is used in a medical negligence case. CACI 400 and 500 and Directions for Use Notes. CACI 431 on "Causation: Multiple Causes" also applies.

A. Claimants' Perspective per their Submissions

*Kaiser's Institutional Negligence and the Breaches of the Standards of Care of Its Health Care Providers were each a Substantial Factor In Causing the Death of Kenneth Flach.

*There are very clear links in the chain of causation here. By all accounts, Mr. Flach had a treatable illness on March 7, 2018. Even according to defense infectious disease expert, Dr. Joseph, Mr. Flach was not in septic shock on March 7th.

*Kaiser's institutional negligence and breaches of the standard of care here are that Mr. Flach's reported illness and symptoms required that he be examined in-person by a physician within hours of his call to Nurse Girtz and again within an hour of Dr. Culbertson's telephone appointment. This would have occurred if Nurse Girtz had contacted a CCMD who advised her to advise Mr. Flach to go the emergency room or if Nurse Girtz, herself, had simply advised Mr. Flach, to go to the emergency room, as the standard of care required. Alternatively, she could have booked an appointment that day with Dr. Culbertson or another physician or Dr. Culbertson himself could have had Mr. Flach come in to see him in clinic. But that did not happen.

*Nurse Girtz was asked: "We heard a statement in the tape and the statement was this: 'We are trying to keep people from commingling and getting more germs.' Do you remember that statement? "She answered: "Yes" Question: "That's something that you told Mr. and Mrs. Flach; right?" Answer: "Yes." Question: "And you told them that was the reason why you were setting up a telephone appointment, not an in-person appointment, true?" Answer: "One of the reasons." Question: "…And an in-person appointment in this particular instance was never set up with Dr. Culbertson or anyone else; right? Answer: "Not that I was—not that I made up." Question: "You did not advise the patient to go to the emergency room did you? Answer: "No."

*Nurse Girtz has admitted that the Kaiser policy was a "directive" and that was why she did not set up an in person visit with Mr. Flach.

* Dr. Langdorf spoke at length about the fundamental failing of this policy: He stated: "And so there's a fundamental disconnect between the reasonable at-times judgment of the advice nurse and her action to send him for phone advice based on their directive from Kaiser to make phone advice appointment or phone appointments with doctors for upper respiratory infection/cough/cold/sinus algorithm. That's a fundamental disconnect." Dr. Langdorf advised that the fact that Mr. Flach was never sent to see a physician face to face was the fundamental failing of the system that Kaiser set up for Nurse Girtz and Dr. Culbertson.

*First, Kaiser's economic choice and directive to the advice nurses was for them to set up telephone appointments. That was emphasized in the "Cold Cough Sinus Protocol," where it was spelled out that it was a telephone appointment protocol, unless the patient was spitting up at least two teaspoons of frank blood. The advice nurses were Kaiser's employees, and pressured by this policy, Nurse Girtz viewed it as a directive. The policy was clear and in writing, to do exactly what Nurse Girtz did—set up a telephone appointment.

* Kaiser's own telephone-appointment-only policy was not the sole component of the negligence here. Nurse Girtz, notwithstanding the Kaiser policy, owed a duty of care to provide a reasonable nursing assessment, nursing diagnosis, nursing notes and disposition that was standard of care to her patient. That duty required her to get Mr. Flach seen by a physician on March 7th within hours and required her to provide a complete and accurate note to a physician reading it, to completely apprise the doctor of the entirety of the symptoms conveyed in the telephone call.

*Third, Dr. Culbertson owed a duty of care to Mr. Flach to obtain a complete history (that would have included the information conveyed in Exhibits 5, 6, 7) and be sure Mr.

Flach was seen on March 7th, examined and x-rayed in order to diagnose the problem. If Dr. Culbertson was too busy, he needed to refer his patient to the emergency room.

Dr. Culbertson, himself, admitted he would have seen Mr. Flach on March 7th or referred him to the emergency room, if he had known about his chest pain or yellow-orange sputum.

*Shelley Gordon, MD is an infectious disease specialist. She is central to the infectious disease committees at CPMC in San Francisco and board certified in internal medicine and infectious disease. She also has a PhD in immunology. She did a fellowship in infectious disease at NYU. She was on the committee that wrote the infectious disease boards and voluntarily took them and passed to be recertified.

* Dr, Gordon testified that at the time of the phone call with Nurse Girtz at 1:44 p.m., Mr. Flach had pneumonia due to MRSA. It was a multilobar pneumonia at that time. Had Mr. Flach been seen in the emergency room on March 7, 2018, the pneumonia would have been diagnosed. She offered that more likely than not, had Mr. Flach been seen by a physician on March 7th, an x-ray would have been ordered, it would have shown multilobar pneumonia, if taken as early as 1:44 p.m. Similarly, a physician examining the patient on March 7th would have most likely seen rapid breathing and heard chest crackles coming from phlegm indicating infection. She stated that a physician seeing this patient on March 7th would likely have referred Mr. Flach to the emergency room and/or admitted him to the hospital. Either way Mr. Flach, more likely than not, would have been admitted to the hospital, if he had seen on March 7, 2018.

*Dr. Leo testified that if Mr. Flach had been seen by a physician on March 7th, the examination would have included, within reasonable medical probability, a physician listening to Mr. Flach's lung sounds, which would have been abnormal breath sounds consistent with pneumonia. According to Dr. Cooke, they would have likely yielded crackles or rales. Per

Dr. Leo and Dr. Gordon, a chest x-ray was clinically indicated based upon Mr. Flach's history and what the physical exam, to a reasonable degree of medical probability would have shown; and the chest x-ray would have shown multilobar infiltrates or abnormal findings consistent with pneumonia in multiple lobes of the lung.

*Dr. Cooke was asked: "…The x-rays that were taken the next day at Kaiser Hospital which you say you saw can you comment on those based upon what you believe Mr. Flach had the day before, what you think the x-rays would have shown if they were taken on March7th?" She responded: "Yes. So, as I said, the X-rays that were taken early in the morning of March 8th showed bilateral multilobar infiltrates. And given the symptoms that the Flachs described to Nurse Girtz, I believe that had an X-ray been taken on the 7th, it would have looked very similar to the X-ray early in the morning on the 8th. …Now, he clearly changed between the 7th and the 8th. But what changed, in my opinion, was not the pulmonary disease; it was the development of the sepsis."

* Per Dr. Jacobs, had Mr. Flach been seen and examined on March 7, 2018, the physical examination would have included a stethoscope examination of his chest. Most likely, crackles would have been heard and this would have led to a chest x-ray, which either would have been done at Dr. Culbertson's office or at the emergency room in the afternoon of on March 7, 2018. Given the appearance of Mr. Flach's chest x-ray at 9:50am on the morning of March 8, 2018, showing multilobar pneumonia and consolidated infiltrates, it likely would have had a similar appearance during the afternoon of March 7, 2018 at 1: 44pm. This is likely since it is known that Mr. Flach's illness was becoming progressively worse, his chest was in significant pain and that his sputum had a bloody component to it. This opinion is based both upon his

description of the mucus to nurse Girtz as yellow orange and based upon a photograph Mr. Flach had taken of it at 4:17 PM on March 7th.

*The breaches of the standard of care as outlined above were a substantial factor in the death of Mr. Flach. Had Mr. Flach been seen and examined by a physician on March 7, 2018, he would have been diagnosed with severe pneumonia based upon his symptoms described to nurse Girtz, including his discolored sputum, his probable vital signs, chest pain, his overall condition in the appearance of his chest x-ray the next day that likely would have shown similar pneumonia on March 7th. (Dr. Jacobs)

*Once Mr. Flach was in the Kaiser emergency room on March 8th, the diagnosis of community acquired pneumonia and septic shock was made quite early. His history is recorded as having chest pain and cough for two days. His chest x-ray showed severe pneumonia and likely would have shown the same or similar infiltrates during the afternoon of March 7th. In the hospital, Mr. Flach was prescribed and administered Levofloxacin, Zosyn and Vancomycin before the gram stain came back at 11:50am. The bacteria culture from Mr. Flach's sputum was susceptible to Levofloxacin and Vancomycin. In my opinion, within reasonable medical probability, Mr. Flach would have received these same antibiotics administered via IV had he been seen March 7, 2018. There are two reasons I believe this to be true. First, Kaiser's use of these drugs on March 8, 2018 for treating the same patient for a bacterial infection suggests this was a standard Kaiser choice for community acquired pneumonia presenting in the matter Mr. Flach did - the disease he was treated for on March 8, 2018. Second, had other antibiotics been used for some reason on March 7th, Mr. Flach, nevertheless, would have been treated for severe pneumonia by way of IV antibiotic therapy. A gram stain would have been done on admission as had been done on March 8th. Results would have come back within two hours. The gram stain

1 likely would have shown the same bacteria classification shown on the March 8th gram stain.
2 Coverage for gram positive bacteria including Staph Aureus and MRSA would have led to the
3 use of the same antibiotics used on March 8, 2018 for treating this patient. Further, if Mr. Flach
4 continued to deteriorate while being closely monitored in the hospital, the antibiotics would have
5 been adjusted until he began to improve. (Dr. Jacobs)

6 *It is my opinion, with reasonable medical certainty, that had Mr. Flach been seen
7 on March 7, 2018 by an emergency medicine physician or Internist or other reasonably astute
8 clinician, he would have been timely treated with fluids, antibiotics and other care as appropriate
9 and would have recovered from the illness entirely intact. Is my opinion, with reasonable
10 medical certainty, that Dr. Culbertson's breaches of the standards of medical care were a
11 substantial factor in causing the death of Mr. Flach. (Dr. Jacobs)

12 *More likely than not, had the standard of care been complied with and Mr.
13 Flach been seen by a physician on March 7th, according to both Dr. Leo and Dr. Gordon , Mr.
14 Flach would have been sent to the emergency room without delay, where he would have been x-
15 rayed, evaluated and treated. Per Claimants' experts, had Mr. Flach been seen in person by Dr.
16 Culbertson, his physical examination on March 7th would have been suggestive of pneumonia in
17 the form of crackles heard on auscultation of the lungs. The chest x-ray would have shown
18 multilobar infiltrates all of which, along with the history, would have necessitated immediate
19 referral to the emergency department. The presence of multilobar pneumonia with hemoptysis is
20 an indication under which patients must be admitted to the hospital.

21 *Dr. Leo testified that once in the emergency department on March 7th, the
22 probable findings of multilobar infiltrates on chest x-ray, combined with Mr. Flach's history, the
23 photo showing the appearance of blood tainted sputum, whether evident in real time or by the

photo Mr. Flach himself took on March 7, 2018 at 4:17 p.m. (Ex.8), would have been indicative of a high likelihood of MRSA pneumonia which would have required, in addition to broad spectrum antibiotics, the use of intravenous Vancomycin, an antibiotic that is specific to MRSA. According to Dr. Leo, "So once the chest X-ray is done and you've seen the description or heard the description of the sputum, you're giving Vancomycin."

*Virtually all witnesses [Joseph, Leo, Langdorf and Bresler] testified that physician examination and chest X-ray would have resulted in admission to the hospital on March 7th. There, empiric antibiotics would have been started. They likely would have been the same as those used on March 8th empirically that were begun before the gram stain was back at 11:50 AM on March 8th. The bacteria Mr. Flach had would have been susceptible to those antibiotics had treatment begun on March 7th. That is not in dispute. PEX 1A.007.

*Dr. Leo indicated that once Mr. Flach got to the emergency room, a full history would have been obtained reflecting the details of illness including 6 days of illness, worse the past two days, yellow orange sputum, the presence of fever and chest pain, all of which would have resulted in an expeditious evaluation for pneumonia, inclusive of a chest x-ray, which would have revealed multilobar infiltrates. Upon the history provided, with either the suggestion of hemoptysis, with reported yellow-orange sputum, or the sputum that was evident in Exhibit 8, that would have served as a clear indication that Mr. Flach was at risk for MRSA pneumonia, which would also have had his care providers ordering intravenous antibiotics inclusive of Vancomycin and admitting Mr. Flach to the hospital.

*Defense expert, Dr. Joseph, testified that based upon the results of the March 8th gram stain, a test available to treating physicians in about an hour, which revealed likely pneumococcus, staphylococcus (MRSA is a staphylococcus bacteria) and streptococcus for Mr.

Flach, it would have shown exactly the same thing on March 7th. If this patient were admitted on March 7th at any time from 1:44 p.m. to midnight on March 7th, the results of the gram stain would have been the same, inclusive of gram-positive bacteria, and treatment with Vancomycin would have begun.

*With both gram positive and gram-negative bacteria showing in the gram stain, physicians needed to cover MRSA in their antibiotic treatment—which is just what they did., as stated by Dr. Bresler. Even according to this defense expert, it is the gram stain that generates the only information - for days - about what the bacteria might be and that is what physicians rely upon to select antibiotics. The bacteria that Mr. Flach had per the March 8th gram stain, was the same as what would have been seen on March 7th, and according to Dr. Bresler as well, this bacteria was susceptible to both Vancomycin and Levofloxacin - the drugs Mr. Flach was receiving empirically upon admission to the emergency department on March 8th.

*If for some reason, the antibiotics initially chosen on a March 7th hospital admission were not the same as those used on March 8th, or did not cover MRSA, they would have been changed within hours to cover MRSA as soon as the gram stain was available, or the patient was deteriorating, according to Dr. Gordon. Had Mr. Flach been treated with antibiotic therapy on March 7th, within reasonable medical probability he would have survived. Whatever antibiotics were begun as his initial therapy, within hour's care, providers would have been alerted to his illness and the correct therapy. The statistics show that of 100 people with MRSA pneumonia, 87% survive. Per Dr. Gordon, within several hours of collecting samples on March 7th, providers would have begun treatment for MRSA, regardless. As Dr. Gordon states: "If your patient is really sick and you think it may be staph, you treat for MRSA….In our community, …of our staph aureus isolates, one-third were MRSA…. So, in this case, you wouldn't from that

gram stain, know it was MRSA but you would know it was staph….And if he's really sick you treat him for the worst case scenario and then you deescalate later if it turns out not to be MRSA."

*If Mr. Flach had been seen in the emergency room, even according to defense expert Dr. Joseph, he would have had a chest x-ray and pneumonia would have been diagnosed and treated. Mr. Flach was harboring a treatable bacterial infection that had begun as a metapneumovirus or, essentially, a cold virus. According to Dr. Leo, the entire course of Mr. Flach's illness in the two days prior to his death was completely consistent with and typical of MRSA and atypical of metapneumovirus. According to Dr. Gordon, the trajectory of the illness gives the clinician an indication as to whether this is a viral or bacterial illness. Someone who putters along for a few days and then gets worse with these symptoms is classic for staph pneumonia. The treating physicians at UCSF came to the same conclusion. See Declaration of Sarah Puryear, MD.

*Mr. Flach had been ill for four days and the illness was getting worse in the last two days, not better. As stated by Dr. Leo, this is classic for a history obtained by patients with a secondary bacterial infection. Secondly, the purulent sputum evidenced on Exhibit 9 is unusual to see with a viral infection especially with blood in the sputum. The finding of blood in the sputum or hemoptysis, is classic for MRSA pneumonia but rarely seen in human metapneumovirus patients. Only two cases in the world literature on hemoptysis have been reported from metapneumovirus alone. The third factor uniquely indicative of an MRSA bacterial infection is the rapid course of the illness which is atypical of the human metapneumovirus that is more indolent, gradually progressive and typically resolving. This was the diagnosis of UCSF physicians as well. Declaration of Sarah Puryear, MD.

*Had the in-person exam occurred after 4:15 p.m. on March 7th, 2018, the physicians and health care providers would have been shown a photo of the sputum showing hemoptysis that is Exhibit 8. In any event, the physicians would have seen the rust or orange color of Mr. Flach's sputum by photo or in real time.

*Mr. Flach likely had a bacterial pneumonia by March 7, 2018, as of 1:42 p.m., the time of the initial contact with the TSR and then Nurse Girtz. Dr. Leo stated that the history alone by way of worsening disease trajectory presented to the advice nurse is classic for a secondary bacterial infection. The illness that began as a "Metapneumovirus" evolved from a cold/virus to a superimposed bacterial infection by March 7th. All of the criteria support this conclusion, including the trajectory of the disease worsening two days prior, the presence of hemoptysis, the low white blood cell count and the X-ray infiltrates. This was a well-known process to all experts in this case.

*Claimants experts all testified that there was evidence of the superimposed bacterial process ongoing by March 7th that included, the worsening of the illness and the hemoptysis described as a yellowish orange sputum (Ex. 6, 7) and appearing by 4:17 p.m. to be pink or rust colored (Ex. 8).

*Mr. Flach had a MRSA bacteria that was treatable on March 7th with Levofloxacin and Vancomycin, which more likely than not he would have received, according to Dr. Leo. But failing to treat Mr. Flach on March 7th resulted in his demise. As noted by Dr. Leo, by the time Mr. Flach was seen on March 8, 2018, he was in septic shock. Septic shock is a condition in which an infection has precipitated a significant impairment of at least one organ system causing hypotension (low blood pressure) that does not normalize with fluid administration. Mr. Flach was not in septic shock on March 7th at 4:00 p.m. or 1:00 p.m. when

Kaiser had the opportunity to treat him. By the time that Mr. Flach arrived at the hospital on the morning of March 8th, no antibiotic treatment would have been able to change the course.

*The evidence here from the perspective of internal medicine specialist Molly Cooke, MD, was that a reasonable physician, upon taking a reasonable history and learning of the symptoms experienced by Mr. Flach, would have sent him on to the emergency room along with the physician's note for evaluation by 3:40 p.m. on March 7th. Once there, Mr. Flach would have been examined with vital signs taken that would have revealed crackles in his lungs indicating fluid or pus in the alveoli. Then a chest x-ray would have been ordered. At that point, Mr. Flach would have been admitted to the hospital.

*James Leo, MD, testified that had the patient been seen within the standards of care, the physical examination of the chest would have been suggestive of the presence of pneumonia, most likely in the form of crackles heard on auscultation of the lung. The chest x-ray would have demonstrated multilobar infiltrates that would have been a clear indication for immediate referral to the emergency department. Had the standard of care been complied with and the patient been seen by a physician, that is what would have transpired.

* Dr. Cooke similarly testified that had an x-ray of Mr. Flach's chest been taken on March 7, 2018, it would have shown bilateral multilobar infiltrates much like the x-ray taken on March 8th in the emergency room. According to Dr. Cooke, although Mr. Flach's condition changed between March 7th at 1:44 p.m. and March 8th upon admission to the emergency room, what changed was not the pulmonary disease but rather the development of sepsis.

*Jerome Barakos, MD, Claimants' radiology expert was in accord. The only radiologist to testify live, described the chest x-ray findings taken on March 8th as "severe multilobar pneumonia." He compared the appearance of a normal chest film with what he

described as the appearance of a snowstorm. According to Dr. Barakos, had this x-ray been taken 24 hours earlier, it would obviously be abnormal as this kind of disease does not spring up on you all of a sudden. It would have been an abnormal multilobar pneumonia then. He also advised that the chest x-ray taken on the morning of March 8th, correlated clinically with bacterial pneumonia as opposed to a viral pneumonia.

*Had Mr. Flach been seen by any reasonable physician on the 7th of March he would also have been examined. His vital signs would have been taken and the examination would have included an examination by stethoscope and chest x-ray. The examiner would have heard crackles upon exam and the chest x-ray would have shown severe bilateral multilobar pneumonia. This diagnosis results in hospitalization and intravenous antibiotic therapy. The same or similar antibiotics he received on March 8th -Levofloxacin and Vancomycin, that were susceptible to the MRSA, would have been administered on March 7th. Had these antibiotics been started the afternoon or evening of March 7, Mr. Flach would have survived, and gone on to live a normal life, according to Dr. Cooke.

*Dr. Leo testified that had Mr. Flach been treated in accord with the standard of care on March 7th, he would have survived, and he would be with us today and would not be a pulmonary cripple. His lungs would have recovered from this such that he would be able to breathe normally.

*The opinion of the Claimants' experts universally was that had Mr. Flach received treatment for his pneumonia on March 7th, he more likely than not would have survived and gone on to live a normal life. Even Dr. Shaughnessy stated that were this a bacterial infection that led to community acquired pneumonia that led to sepsis, earlier antibiotic administration would have made a difference.

V. Respondents' Perspective per their Submissions

Respondents did not cause the death of Mr. Flach. Regardless of the particular theory relied upon by claimants, they have not met their burden of establishing the causation element of their wrongful death medical negligence claims against Respondents, thus liability cannot attach.

1. Assessment Over Telephone Did Not Result in Injury to the Decedent.

While the evidence does not support a finding that either Dr. Culbertson or Ms. Girtz deviated from the standard of care in either of their interactions with the decedent, the decision to have a physician evaluate him by telephone on March 7th did not cause or contribute to any injury. Foundationally, a telephone appointment with Dr. Culbertson was accepted by the decedent, and there is no argument that he ever requested to be seen in-person. Even still, whether in-person or over the telephone, the decedent was going to describe his condition accurately to his medical providers, as supported by the testimony of Christina Flach as follows: "My husband had a very big personality and had no problem expressing himself."

At the arbitration, Respondents' internal medicine expert Dr. Fugaro testified, in a global capacity following his review of the material in this matter, that Dr. Culbertson did deviate from the standard of care and did not injure the decedent. He was asked: "Following your review, was there anything that Dr. Culbertson did that caused or contributed to the death of Mr. Flach?" He opined: "Prospectively, no. I thought he absolutely met the standard of care. He did the appropriate triage that his clinical judgment that this was bronchitis seemed entirely reasonable."

Additionally, in his deposition testimony, Dr. West explained as follows how nothing about a telephone appointment inappropriately impacted Dr. Culbertson's ability to

assess the decedent. He was asked: “All right. Was pneumonia in the differential diagnosis for someone considering that complex of symptoms? He answered: “Yes.” Question: “Would you agree that the only way to rule out pneumonia for a patient like that would be an in-person examination? Answer: “No.” Question: “Would you agree that the only way to rule out pneumonia for a patient like that would be with a chest x-ray?” Answer: “No.” Question: “Would you agree that the only way to rule out pneumonia for a patient like that would be to listen to his chest through a stethoscope?” Answer: “Okay. So, again, we've run into this in the last two questions and now in this question and it came up earlier in the deposition. You're using "rule out" in a way that's a little bit unfamiliar to me. That is to say, if pneumonia is in the differential diagnosis, how do you address it. And the answer is you might not be able to rule it out without a CT scan of the chest, but you don't get a CT scan of the chest on everybody who has these complaints. So in terms of ruling out pneumonia, is it necessary to go down that, got to see the patient, got to listen to the chest with a stethoscope and so forth, the answer is, no, you don't have to do those things if the likelihood of community-acquired pneumonia is low enough on your differential diagnosis.”

Later in his deposition, Dr. West further explained his causation opinion, such that no act or omission on behalf of Respondents resulted in Mr. Flach’s death. He was asked: “Okay. What is your opinion?” He opined: “And the opinion is that no one at Kaiser took any actions that caused or contributed to his death. And we've covered some of that in the deposition by way of saying, on the 7th, if he had been prescribed an antibiotic by Dr. Culbertson or if he had been seen by a physician who had come to a diagnosis of community-acquired pneumonia and they had taken the accepted approach to community-acquired pneumonia and prescribed an oral antibiotic, that no antibiotic administration on the 7th would have influenced the outcome.

Because when he came in on the 8th in septic shock, that was a viral septic shock and not a bacterial septic shock. And then the second piece of that was when he came in on the 8th with a blood pressure in the 60s, as sick as could be, he had an elevated creatinine for renal dysfunction. He had a white count of 2 for leucopenia so his white count defenses were wiped out. And so, he had multi-organ dysfunction syndrome, which is a more severe type of septic shock, and that was a viral-precipitated illness. So, it was a fatal disease on arrival. And the administration of Levoflox, even though the subsequent MRSA was sensitive to Levoflox or a more rapid administration of vancomycin, which the MRSA was also sensitive to, would not have changed the outcome. That is to say, from a causation point of view, nothing anybody did after the patient came into the emergency department on the 8th made any difference in the outcome. It was a fatal disease."

This sentiment is also held by Respondents' infectious disease expert Dr. Joseph, in that he does not feel there was reason for Dr. Culbertson to suspect pneumonia based on the history he obtained from the decedent. He was asked: "Thank you. Given that constellation of symptoms, were those symptoms in and of themselves dispositive for the presence of pneumonia on March 7th? He stated: "No, not particularly. They strongly suggest an upper respiratory tract infection, but they could represent the beginning of a lower respiratory tract infection."

Lastly, it should be noted that Christina Flach initially described her husband as getting sicker after talking with Dr. Culbertson, before changing her answer. She was asked: "And when you got back, did you give Ken the medicine?" She answered: "Yes. First thing." Question: "When you got back, was there any change in Ken's condition that afternoon?" Answer: "He was – I mean, it seemed like he was getting worse, actually, to me." Question: ". So was he getting –"Answer: "Not worse, but the same. I'll say that. The same." Clearly, staying

with the answer that he was getting worse opens the decedent up to criticism that he did not follow Dr. Culbertson's instructions to contact him or come in if he developed any of the symptoms that he had denied. Thus, if the decedent did not develop a fever, shortness of breath, or pleuritic chest pain, or bloody sputum before he went to bed, and only reported it in the morning, then the evidence establishes that no treatment could have saved his life at that time. As such, being offered an assessment over the telephone on March 7th did not cause or contribute to the decedent's death, and cannot support the claim for liability.

2. Claimants Cannot Establish that Mr. Flach Died from MRSA.

Similarly, the burden of proof is not met showing that the decedent died from MRSA pneumonia. The only way that claimants do so is by having employing experts who do not consider the evidence in its totality, as well as by misunderstanding the principles of infectious disease.

In his arbitration testimony, Respondents' infectious disease expert Dr. Joseph started by explaining how he determined that the gram stain was unreliable based on its results. He was asked: "What do you understand the result of that gram stain to have been?" He replied: "Well, the gram stain showed very few white blood cells and very few epithelial cells and a plethora of bacteria, all of which have shapes that are found in the normal mouth and throat. So, the gram stain was not diagnostic and not conclusive that the results of the sputum specimen would be reliable." Question: "What is your understanding of what the white cell count was around the time the sputum sample was obtained?" Answer: "The total white blood count was 2,000, and the neutrophils were approximately 1,500. Question: "So do those results have an impact on the reliability of the gram stain that was conducted?" Answer: "I think they don't. Any time the white blood count is over a thousand, then there will be the presence of white blood

cells at the site of the infection. And that's what we're looking for in the sputum. So, I -- I don't want to imply that the sputum culture was inaccurate. What I do want to imply is that no statement can be made about its accuracy. It could be correct, and it could be incorrect."

An anticipated criticism of Dr. Joseph is that he did not consider the effect of Panton-Valentine leucocidin ("PVL") on the decedent's blood stream, a supposed by-product of MRSA, which supposedly impacted the level of white blood cells in the decedent's system on March 8th. However, Dr. Joseph notes that this the medical literature regarding this phenomenon is something that has only been replicated in a laboratory setting, and that PVL has never been shown to have a provable impact on a patient's white blood cell count. He was asked: "And if this patient did have a necrotizing pneumonia, that enzyme would likely kill -- would exist and kill white blood cells; right?" He opined: "You know, I don't know that that's ever – I may be way off base, but I don't know that there's ever any clinical importance to the effect on white cells from that enzyme. It sounds like Dr. Leo has information that there is an effect on white blood cells because of a laboratory phenomenon. But I've never seen it have any clinical effect on white blood cells." Question: "Okay. And do you know if the Panton-Valentine leukocidin impacted the number of white blood cells in this gram stain?" Answer: "You know, I never in my career have heard anything like that. Never. I -- I mean, you have intrigued me to want to go back and see if there is such a thing. . . . The leukocidin part is a laboratory phenomenon. To the best of my knowledge, it has no clinical importance."

Further, Dr. Joseph's testimony cannot be attacked with arguments that he is contradicting the findings of the infectious disease providers for the decedent at UCSF subsequent to his treatment by Respondents. Rather, his opinions are in line with the findings at UCSF, shown by his opinions regarding the meaning of said findings. He was asked: "Q. In your

review, did you come across medical records from UCSF from a Dr. Puryear in her management of Mr. Flach while at that institution?" He replied: "Yes." Question: "And can you give me any opinions you have one way or the other whether you agree with the conclusions she arrived at in her treatment?" Answer: "Well, I believe she said the exact same thing that I did." Question: "Okay." Answer: "That is, that the presentation, the laboratory results, the clinical course, is consistent with MRSA pneumonia complicating viral pneumonia. We just don't have enough information to say for sure that that's what it was."

Dr. Joseph also disproves claimants' theory that the color of the decedent's sputum at all times is consistent only with an MRSA pneumonia. He was asked: "Okay. And the color of the sputum makes no difference either to you in terms of whether we're dealing with a pneumonia or a severe pneumonia or anything; right?" He answered: "Well, the color of the sputum, there's only two infections of which I ever heard in four decades where the color of the sputum is suggestive of a particular bacterial etiology. It just doesn't apply to this case. One is the color of rust, and the other is the color of currant jelly. Other than that, as a clinician, I think one sees and hears many different descriptors, but they're not diagnostic or suggestive of a cause or the need for a specific treatment."

In agreeing with Dr. Joseph's opinions, Respondents' emergency medicine expert Dr. West reviewed not only the information given on March 7th to provider, but also the decedent's condition when he presented to the emergency department the following morning. Dr. West concurs that the decedent did not have a bacterial infection prior to that time, and if he did develop an MRSA infection, it was after he was admitted to the hospital, He was asked: "So did Mr. Flach have a bacterial infection before he showed his face in the emergency medicine department on March 8th, 2018?" He stated: "I believe no is the answer to that one." Question:

1 “Okay. So, do you think he acquired the bacteria in the hospital?” Answer: “No. I think the
2 explanation for that is that he had two blood cultures when he came in on the 8th that showed no
3 growth, which is to say he did not have MRSA in his bloodstream when he arrived septic. But he
4 did have a nasal culture -- a nasal swab, done sometime later that showed MRSA. So, I believe,
5 to a medical probability, that his nares, his nasal passages, were populated with MRSA and that
6 was probably the cause of the MRSA superinfection, which happened later.”
7
8 Likewise, Respondents’ emergency medicine expert Dr. Bresler also supports the
9 absence of evidence that an MRSA infection was likely present at the time that the decedent was
10 admitted to the hospital, including because he is not the typical patient who is expected to have
11 such a condition. He was asked: “What is the significance of the absence of bacteremia? He
12 stated: “It's extremely surprising in this case. Not all pneumonia has bacteremia, but most -- most
13 do. And in a patient in septic shock from -- from pneumonia, I think it's very surprising that
14 multiple blood cultures never grew out a bacteria. That makes me wonder if in fact this was
15 primarily viral with some degree of superinfection perhaps of bacteria. But the main culprit may
16 have been viral. But I think it's extremely surprising that a guy this sick with pneumonia never
17 grew out a bacteria in his blood.” . . . . “But there's no -- there were no risk factors for MRSA.
18 Usually the skin is the portal of entry. We don't have MRSA floating around our body. I mean,
19 we have all kinds of bacteria inside, but usually other than the nasal and oral cavities, we don't
20 usually have MRSA in those areas. I mean, our gut has, you know, innumerable numbers of -- E.
21 coli for example, not toxigenic like you hear about in, you know, epidemics.”
22
23 In another specialty, Respondents’ radiology expert Dr. Hoddick concurs that the
24 evidence available to them does not permit a finding as of March 8th to establish affirmatively
25 that either a viral or bacterial process was causing the decedent’s lung infection. He was asked:
26
27
28

“Again, looking at the entirety of the chest films taken on March 8th, is it correct to say that based on the totality of the evidence those films show to you, that it is not possible for you to say more likely than not that the generating problem was viral or bacterial or something else? He said: “No one can say that with any degree of medical confidence. No one. Accurately, anyway.” Question: “Okay. So, as a radiologist, you can't take it farther than that, right? Once you get that wide differential, it gets -- it's back to the clinicians to make their determination, right?” Answer: “No. It's back to me with the clinicians to get other pieces of the puzzle to try to sort out what's going on.”

Even though Dr. Joseph explained that the decedent’s white blood cell count was abnormally low, but not low enough to impact the number of cells that would be contained in a sputum sample, claimants’ infectious disease expert Shelley Gordon, MD failed to show that she understood this distinction. She was asked: “Right. And what did it show?” She opined: “And it showed, - you don’t have it up there, but it was gram positive cocci and I think tetrads in pairs and chains and a few other organisms. It showed – one of the comments was, I believe, few white cells, but no epithelial cells, so suggesting that it was a reasonably good-quality sample.” Question: “You would agree that the amount of the white blood cells that were found in the gram stain taken on March 8th makes the samples inadequate to diagnose an MRSA infection, true? Answer: “False. No. I disagree with that. First of all, he was leukopenic, and the number of bacteria that get into, you know, any infected body fluid is going to be proportional to what you have in the periphery. And the other factor which I had forgotten in my deposition but was reminded of, which I’m going to raise here, is the significance of the MRSA Panton-Valentine leukocidin, which is white-cell destructive, and so the sputum with a florid PVL-infected MRSA

is going to have less white cells. So, no, this was a valid gram stain. It was not contaminated with oral flora. It was a good sample."

As she shows by her own admission, Dr. Gordon adopted the theory regarding PVL being significant at the arbitration and after her deposition was taken. Since she was not the source of this theory, but one of claimants' other experts, she deferred to those other specialties on the area of her own expertise in order to make her testimony consistent with theirs. Were this a credible theory within the realm of infectious disease, she would not have had to clarify her position as she did.

Based on the foregoing, claimants did not present credible expert testimony that showed the decedent experienced an MRSA infection prior to March 8th. While it is not contested that his condition at UCSF supported the conclusion of a MRSA superinfection, treatment for that condition on March 7th would have had no impact on the ultimate outcome, as the decedent decompensated from his pneumonia from metapneumovirus beyond the ability for him to recover.

3. Treated as Outpatient on March 7th Would Not Have Changed Outcome

Assuming that Mr. Flach had been seen on March 7th by Dr. Culbertson or another internal medicine provider, as claimants argue should have happened, there would have been no change in the outcome for the decedent. Even if he had been diagnosed with pneumonia, the treatment that he was likely to have received in such circumstances would not only have not treated his viral pneumonia but would have had no impact on any alleged MRSA lung infection. In his arbitration testimony, Respondents' internal medicine expert Dr. Fugaro explained what would have likely happened in the hypothetical scenario that the decedent was seen on March 7th. He was asked: "And so not specifically regarding any strain of MRSA that Mr. Flach was

tested for or, you know, any susceptibility were run on, but just in general, do you know whether those typical antibiotics, under the standard of care you described, would likely have been effective in treating MRSA? He opined: “They would not have, and I'll say that for several reasons. One, although the ultimate MRSA that was documented on March the 8th was sensitive to doxycycline, if that was causing pneumonia – and I'm not sure -- certainly, oral doxycycline does not produce anywhere near the tissue levels of antibiotics that one needs. That has to be done intravenously. And, certainly, neither azithromycin nor the beta-lactam antibiotics would have had any impact whatsoever if the pneumonia was being caused by either metapneumovirus or by the methicillin-resistant staph aureus.

Thus, the only conclusion is that Mr. Flach’s condition would not have been improved from treatment in the outpatient setting on March 7th, and would have still decompensated as he did even with standard of care antibiotic treatment.

Moreover, it would not have mattered had the decedent presented to the emergency department on March 7th for evaluation there instead of by an internist. Both of Respondents’ experts on this specialty agree regarding the standard of care for treatment had the decedent been seen in that setting on that day, and been diagnosed with pneumonia, and would not have covered MRSA infections. Dr. Bresler was asked: “So let's say that a patient had been diagnosed with pneumonia and given one of the antibiotics, one of the oral options that didn't typically cover an MRSA infection and then was sent home with the antibiotic, what would you expect that patient's clinical course to be following taking that medication?” He opined: “If the patient has staph pneumonia?” Question: “Correct.” Answer: “And they were given an antibiotic that did not cover staph?” Question: “Correct.” Answer: “It would be as if they weren't treated with an antibiotic. They would get sicker.” Question: “So had Mr. Flach gone to the emergency

department on March 7th, what, under the standard of care, was required, if anything, in regard to the antibiotics to be given?" Answer: "Well, it depend -- it depends on what they found. If, on the 7th, he came to the emergency department and if the history and the physical exam suggested a strong possibility of pneumonia, and he got a chest X-ray, and it showed pneumonia, he would have -and at that time -- obviously he wasn't in septic shock, or he'd have probably been dead by the next day. So, at that time, he would have gotten probably single coverage with a fluoroquinolone or perhaps the double antibiotic choice of the other two, as I said." Question: "Would the same X-ray essentially, perhaps not as advanced but similar, on March 7th have shown pretty close to the same type of pneumonia?" Answer: "No, I disagree with that." Question: "Are you –"Answer: "The gentleman on the 8th was a totally different patient than on the 7th. I agree that it's a fairly good chance it would have shown pneumonia, but I don't think it would have been in the ballpark of what we're seeing the next day."

Further, Dr. West was asked: "Do you have an opinion if whether Mr. Flach had been seen in the emergency medicine department on March 7th and -- or by Dr. Culbertson on March 7th and been prescribed levofloxacin at that time whether that would have been effective in treating his MRSA?" He opined: "Remember, he didn't have an MRSA infection when he came in on the 8th. He had a viral infection. And the answer is, absolutely, Levoflox on the 7th would not have touched the viral infection. It would have made no difference at all in terms of him getting into septic shock on the 8th."

In line with both of these opinions, Respondents' critical care expert Dr. Shaughnessy opined that, based on the available information as of March 7th, the decedent's condition was not one that would have resulted in consultation by a critical care specialist.

Crucially, Respondents' infectious disease expert Dr. Joseph confirms the standard of care antibiotic treatment that the decedent would have received had he been seen by his specialty on March 7th, which would not have included coverage for MRSA, even the particular strain identified from the decedent's samples. He was asked: "And, you know, in your opinion, what antibiotic would an infectious disease specialist have started Mr. Flach on March 7th, had he been seen by one?" He opined: "From my review of the records, it would have been outpatient management. I don't see that Mr. Flach would have met the criteria for admission. And that typically means that the chance of a serious complication or death is 1 in 10,000 or less. But I - if I had seen Mr. Flach on March 7th, I would have started azithromycin." Question: "And would that have been oral administration?" Answer: "Yes." Question: "Would that antibiotic at that time have been effective in treating an MRSA infection?" Answer: "No." Question: "What would have had to have happened on March 7th for an infectious disease specialist to give Mr. Flach the same antibiotics that he eventually ended up receiving on March 8th?" Answer: "I don't think it would have occurred under any circumstances." Question: "Okay. Go ahead, please." Answer: "On March 7th, in order for Mr. Flach to have received antibiotics that are active against MRSA would have required a sequence of events that is extremely uncommon. But each of these events would have had to have occurred. First, he would have had to have been personally examined by a physician. That typically would mean being referred to the outpatient clinic or the emergency department. Then, he would have had to have met criteria for admission. And I don't see that at all being likely on March 7th. Third, the managing physicians would have to conclude that the guidelines published by the Infectious Diseases Society and the American Thoracic Society for the treatment of pneumonia are inadequate, because none of them would include giving a drug that is active against MRSA pneumonia. And

then fourth, the cause of the disease would have had to have been MRSA. All of those -- even if Mr. Flach met the criteria for severe pneumonia, vancomycin or drugs active against MRSA are not part of the recommended treatment. So, any pneumonia requiring hospitalization, including severe pneumonia, is not an indication for a drug that would treat MRSA pneumonia. That's how rare it is." Question: "Okay. Pneumonia is less frequent than that?" Answer: "Very few. Very few -- MRSA is a recognized cause of pneumonia, but so few that the treatment for MRSA is not even in the current pneumonia guidelines, the most recent update. That's how rare it is."

As to what the decedent's chest x-ray was likely to have shown on March 7th, had one been done either in the outpatient or emergency setting, Respondents' radiology expert Dr. Hoddick was asked: "Are you able to tell from that film whether the pneumonia was generated by bacteria or generated by a virus?" He opined: "Or inflammation from aspiration. There are any numbers of possibilities. To tell you what organism it is would be a fool's errand. It may be multiflora, if you will, which can occur with aspiration. It is diffuse and how it became so diffuse suggests an inhalational process or hematogenous spread or aspiration, but to tell you what organism it is or what organisms, plural, are present would be a fool's errand and cannot be done. It cannot even be said with certainty that this is an infectious process, let alone what organism is causing it."

A review of the evidence submitted on behalf of claimants shows that in order for them to meet their burden on this issue, they have to also have met their burden showing that that the decedent had MRSA, which as discussed above, cannot be accomplished. In order to do this, claimants rely on uncredible expert opinion from their experts, including Dr. Gordon, who agrees with Respondents' experts that MRSA antibiotic coverage is not required under the standard of care for outpatient treatment. She said: "But, no, for the run-of-the-mill CAP during flu season,

there's no requirements to treat for MRSA, but clinical judgement really comes in as to when you have to add treatment for MRSA." She was asked: "And so if a doctor, in receiving certain pieces of information and then making recommendations, did so in compliance with the stated standard of care in this document or the guidelines, at least, you would agree that they were acting within the standard of care?" She replied: "Yes. Yes, I would."

Finally, claimants are not able to meet their burden of proof in establishing that, more likely than not, the decedent would have been admitted to the hospital had he been seen by any physician on March 7th. Specifically, claimants' radiology expert Dr. Jerome Barakos was asked: "Okay. Do you have an opinion going backwards in time from the call with Nurse Girtz as to when it would have been first detectable that Mr. Flach had abnormal findings on a chest x-ray? He said: "No, I don't have an opinion in that regard." And, he was also asked: "Here it says, 'The findings of community-acquired MRSA pneumonia are nonspecific and difficult to distinguish from other infections.' So, is that, you know, similar to the descriptions you've given earlier in your opinions?" he answered: "Yes, sir, precisely. The non-specific – the non-specificity of medical imaging and the need to correlate with clinical history."

A review of Dr. Barakos' testimony shows that the only way that he is able to opine, with any specificity, regarding the type of infection that the decedent had at any time is based on information that would be obtained outside his specialty. As displayed by Respondents' radiology expert, Dr. Hoddick, it is only appropriate to describe what is found on the imaging, and not for the radiologist to gather information like an internist and come up with a diagnosis. Thus, claimant can only rely on expert testimony outside the bounds of qualification in order to at all show that action would have been taken in contradiction with the standard of care treatment.

V. DECISION ON (MEDICAL) NEGLIGENCE

On March 7, 2018, Kenneth Flach, age 54 [DOB: 05-24-1963] at the time and a retired professional tennis player, and his wife Christina Flach, were subscribers/members of The (Kaiser) Permanente Medical Group, Inc. [Medical Group] health plan. That day, Mr. Flach was quite ill. Christina Flach tried to directly call Mr. Flach's primary care physician [Dr. Culbertson at the Novato Clinic], but she was unable to directly communicate with him. The Medical Group's patient contact system required all patients to contact a Teleservice Representative (TSR) and/or an Advice Nurse before they would be allowed to have a visit with a Medical Group physician. In particular, due to the Medical Group's communication policies, the Flachs were required to go through the Medical Group's Appointment and Advice Nurse Call Center [AACC]. They called the Medical Group's AACC on March 7, 2018, at 1:42pm and the Medical Group system routed the Flachs to a TSR named Windy Chavez and, soon thereafter, to Advice Nurse Cynthia Girtz.

In this case, the TSR (Chavez) was physically located in the Sacramento area AACC and the Advice Nurse (Girtz) was physically located at the Vallejo AACC. There were approximately 200 to 300 Advise Nurses in Vallejo, all who were stationed behind a computer. No patients were ever medically seen in the Call Center building with Nurse Girtz in Vallejo. The Advice Nurses are provided protocols from the Medical Group on their computers and asked to manage patients by virtue of use of those protocols.

The Medical Group asked the Advice Nurses, including Nurse Girtz, to identify the protocol to use, based upon what the patient's most urgent symptom was, along with her/his nursing judgment. The most urgent symptom was intended by the Medical Group to be the focus of any decision to select a protocol. The Medical Group explains to its nurses that the protocol is

selected and used as a resource and guide "as soon as the most clinically urgent symptom or problem is identified." Patricia D. Padilla, MD testified in this case as the Medical Group's Person Most Qualified. She testified on a variety of subjects, including TSR and Advice Nurse Training, and Instructions to the Advice Nurses on how to triage patients by use of the Medical Group's algorithms (protocols) as they existed on March 2018. Dr. Padilla was asked how a nurse should ferret out the most urgent clinical symptoms from a constellation of symptoms. She stated: "Those that would have the worst outcomes are the ones that would be advised to ferret out and use that protocol, again within the context of what the patient is saying. In your example, fever and chest pain, there may be an assessment for both of those things." Dr. Padilla was further asked: "And so did you say the most urgent clinical symptom is the symptom that has the worst outcome in the context of the constellation?" She answered: "Yes."

A. Nurse Girtz

In their initial telephone call to the AACC on March 7, 2018, Mrs. Flach told the TSR, Ms. Chavez, "My husband has bronchitis really, really bad; *his chest is killing him;* he has a fever. I have never seen him so sick. Stuff is coming out of his chest. His chest is really in pain. He is tired." The initial note by Windy Chavez indicates the call started at 01:42 p.m. and she wrote as the "Emergent Symptom": Chest Pain-discomfort, pressure, tightness or pain in chest."

As noted, Ms. Chavez considered the complaint of chest pain an emergent complaint and immediately transferred the call (called a 'warm transfer' since the TSR stays on the line) to an Advice Nurse, in this instance, to Advice Nurse Cynthia Girtz. From 1:44pm - the time the call was transferred from the TSR – the call thereafter lasted about 13 minutes and Nurse Girtz signed her chart note at 2:01 p.m. Nurse Girtz was in the course of her employment with Respondent The Permanente Medical Group, Inc. on March 7, 2018, when she had the

subject telephone conversation with the Flachs, and in particular, when she was advising Mr. Flach, providing care for him, making a decision to set-up a physician telephone visit for him and writing her chart note.

Ms. Chavez told Nurse Girtz that she was advised by Mrs. Flach that Mr. Flach had "really bad bronchitis, his chest is in pain, hacking up stuff…" Nurse Girtz's immediate response was "Cold symptoms."

Once the TSR had completed the transfer of the call to Advice Nurse Girtz with the Flachs on the line, Mrs. Flach told Nurse Girtz immediately: "I've never seen him so sick. He's coughing up stuff out of his chest, he feels nauseous, really weak."

Mrs. Flach also told Nurse Girtz that her husband was cold, had no energy at all and both Mr. and Mrs. Flach mentioned to her that Mr. Flach had a slight or "mild fever." Mrs. Flach also told Nurse Girtz that the Flachs did not have a thermometer. Mr. Flach additionally recounted to Nurse Girtz that he had an episode of night sweats, like "when your fever breaks." Nurse Girtz inquired about his medications and Mr. Flach replied that he was taking Advil and Mucinex. Nurse Girtz knew that Advil was an antipyretic and should have reduced a fever.

Mr. Flach advised Nurse Girtz that he was "coughing-up stuff out of his chest" (sputum) that looked yellowish-orange. This raised a slight concern with Nurse Girtz that blood might be tainting his sputum orange. She was aware that some "…people with pneumonia can go through a process where their sputum becomes darker, where it changes color from yellow to yellowish-orange to pink, to all of a sudden full of blood." Nurse Girtz asked Mr. Flach if he had been coughing-up mucus that looked "really bloody" and Mr. Flach answered in the negative. Because she asked him this question about his sputum, and knowing all his other symptoms and the worsening trajectory of his disease, it is clear that she was thinking about a lower respiratory

bacterial infection and possibly had pneumonia in her nursing assessment or differential diagnosis. She did not advise Mr. Flach to pay particular attention to sputum that was pink, or red currant jelly colored, or rust-colored, or blood-tinged colored and how important this sign or symptom was in this disease process. As the evidence shows, more likely than not, Mr. Flach was in the middle of that infectious disease process, where the sputum darkens, suggesting a bacterial infection and pneumonia. In her chart note, she described the sputum as "yellow mucus," not yellowish orange, coughed-up sputum. Although Nurse Girtz recognized that Mr. Flach had an infectious disease, she did not think that adding the word "orange" to the word "yellow" in her chart note "added anything," because the descriptor "yellow" indicated Mr. Flach had an infectious disease. Nurse Girtz knew that her chart note would potentially be seen by a physician later that day. She recognized that it was her job to tell the doctor what specific symptoms the patient was complaining about and not to change what the patient told her.

Mrs. Flach initially told Nurse Girtz that Mr. Flach had been sick just two days and was "significantly worse" today. However, upon further questioning, Mr. Flach advised Nurse Girtz that he had "been sick for a while", that he had a 'cold' for four days, that he played golf on Friday (March 2th), which was four days prior to the call, and that this experience "put me over the edge." Nurse Girtz noted that usually the first two days are the most difficult and illnesses of this type get better by the seven day mark.

Nurse Girtz knew the implications of a worsening trajectory of the disease process. She testified that when she learned Mr. Flach had been sick for six days, she recognized he needed intervention soon. Of all the symptoms conveyed to her on the phone by the Flachs, at the end of her Assessment, the one that she considered the most urgent was the fever. "Once we figured-out the duration of how long Mr. Flach had been ill, that was one of my biggest

indicators that there was a problem, because six days into an illness of this sort, he should not be running a fever. He should not be getting worse overall with a viral – if it were a viral illness or whatever it was. Basically, six days into it, hopefully, you would be turning the corner and getting better instead of getting worse. So that was - it's the conglomeration of all those symptoms together they told me that there was a problem here." She further stated that she knew: "It wasn't just a normal viral cold, whatever process was going on. A(t) the weekend (sic – 'week's end') of a cold, you should be turning the corner. There shouldn't be any possible fevers. You should be feeling a little stronger. You should be starting on the road to recovery, at least. And he was getting worse. That's not---that's abnormal. That's very abnormal."

Mr. Flach, a former professional athlete, described the pain in his chest: "It hurts so bad like broken glass in my chest." When asked if he got sharp pains in the chest, he stated: "Just like fire, yeah, just burning in my chest." When asked if the feeling in his chest was constant tightness or heaviness, he stated: "Just burning."

Nurse Girtz could hear Mr. Flach cough over the phone. He had a deep, productive cough, full of phlegm, which he could not completely clear, because of the same-day onset of wheezing. She wrote in her chart note that Mr. Flach had burning in his chest "during and following cough." In trying to determine the temporal relationship of the burning in Mr. Flach's chest to Mr. Flach's cough, Nurse Girtz admitted that and she did not ask Mr. Flach: "When is his chest pain? Does it hurt when you breathe in, you know, take a deep breath, or does it hurt when you move side to side? Or does it hurt when you cough? Or does it hurt after you cough? Or does it hurt all the time? Did you do any of that? Nurse Girtz' answer: "I guess not." Since the context of Mr. Flach's burning in his chest to the timing of his cough was not found in the transcript of the call, but only in Nurse Girtz' chart note, she acknowledged at the Arbitration

Hearing that her description in her notes, viz., "burning in his chest during and following cough" was "inaccurate" in that regard. Nevertheless, she said at the Arbitration Hearing that she related the burning in Mr. Flach's chest to Mr. Flach's coughing, because she thought that she heard a kind of "moan" right after the cough and then Mr. Flach would be fine for a while or cough again and then he would moan again. "You can't cough and moan at the same time." She was not sure if the recording of the call reflected these moans. However, she never asked Mr. Flach any questions about such moaning. When asked: "Was there anything keeping you from asking Mr. Flach the details about his cough? In other words, could you have said to him, 'Hey, sounds like you're moaning or groaning when you cough? Is that when it hurts, or does it hurt all the time?' Any reason you could not have asked him that question?" Her response was "I guess there's no reason I couldn't ask any question." The Arbitrator listened carefully to the recording of this call and could not hear any moaning by Mr. Flach at all, in particular, no moaning during or after a cough on the recording.

Nurse Girtz wrote in her chart note that Mr. Flach's cough was getting worse, which, may or may not have been the case, but the accurate statement would have been to state that his entire illness had gotten much worst (not just his cough) in the past two days. Clearly, Nurse Girtz thought the same when she realized that the trajectory of his sickness or illness had gotten much worse in the past two days, which she characterized as "very abnormal."

On the call, Nurse Girtz posed some questions to Mr. Flach to evaluate the nature of the chest pain. However, one important question would have been whether or not Mr. Flach experienced pain on inspiration. That question was never asked nor answered.

At the highest level of advice nurse triage, Nurse Girtz was authorized and could advise a patient to go to an emergency room or contact an emergency medicine physician, known

as a Critical Care Medicine Doctor or CCMD. Other hierarchical choices for patient disposition include appointment within four hours, appointment today, appointment for today or tomorrow, within a week, and so forth. The Protocols described both specific complaints from which a disposition would be directed, and each protocol also included the statement that the nurse could use her nursing judgment for patient disposition.

Nurse Girtz used the Medical Group protocols, combined with her Nursing Judgment, to decide on the type of care the patient requires. She also agreed with the statement: "Your goal here, at the end of the day, was not to follow necessarily a protocol to whatever end that you agree with or disagree with. Wasn't your goal here to provide treatment – – care and treatment for a patient who is sick and get him the care he needed."

Nurse Girtz described the advice nurse assessing process, protocols and appointments for patients as follows:"[A]ll the protocols started with emergent outcome, and then it will go down to same-day outcome, and then today, tomorrow, generally, and then anything (a) week or longer. So, whatever was the first question that you clicked a "yes" answer to, then that would automatically pop you into whatever your outcome was, whether it be advice or appointment, ER - - if it was ER, it would populate a screen then informed that you needed to consult with the CCMD." If the option selected was ER and consult with the CCMD, she would ask the patient exactly where they are, what number they could be reached at in case you got disconnected, where their nearest Kaiser ER was, if they had anybody who could drive, was there a car available or transportation of some sort.

If Nurse Girtz used the protocol to click on something and it took her to the scheduling portion, she could then determine what appointments to recommend to a patient. There would be a pop up box at the bottom of the screen, and it would start listing appointments

that were available and she could click a button to accept the appointment. In deciding whether an appointment should be scheduled for the same day, or the next day or some other day, the "outcome" day was determined by the protocol and the computer would list the corresponding appointments. For example, if it was a same-day outcome, the computer would not offer appointments for the next day, only that day. If the computer schedule did not offer her appointment on or by the given day, she would have to call the clinic.

When asked which one of Mr. Flach's symptoms had the potential to cause serious and emergent harm to Mr. Flach, Nurse Girtz answered that she couldn't really separate it out, because "it's a whole entity of a disease process or the pathophysiology" and "you don't necessarily just pick out one symptom here and there." She agreed that one of the Kaiser training documents for advice nurses tells them to "listen actively to the patient's story to identify the most urgent clinical symptom" and that is what she was told to do when using the Kaiser protocols. She also testified that the "urgent symptom or chief complaint is determined through synthesizing the assessment data." She remembers from her training that she was to select the protocol based on the most urgent symptom; but for cold and flu symptoms, Kaiser did not want them to go directly to the chest pain protocol. Also, in regard to complaints of chest pain, Nurse Girtz said:" [A]nd they wanted, you know, particularly like under the chest pain protocol, they would want you to think of it a certain way versus if you had chest pain, but it was accompanied with, say, G.I. symptoms or something. You know they would try to help us differentiate what was going on in that particular protocol" In the subject case, she also could not determine that "chest pain was not the most urgent symptom, because she has to look at the whole picture and you don't just look at one symptom. "When you're talking possible viral or, you know, respiratory infection of some sort, you have to look at the whole constellation of symptoms."

When Nurse Girtz was asked "As far as choosing protocols, do you recognize that the Kaiser system of choosing protocols is based upon what we saw in Exhibit 11A, the most urgent symptom? She replied "Or the problem. I was going to say it isn't always the most urgent symptom that's …" (No further answer) And then an immediate follow-up question: "But the design of the protocol system is designed for you to be able to pick out the most urgent symptom to give you the protocol that you're supposed to be working off of; right? As you understood it" Nurse Girtz further replied: "Well and you read off that it says the chief complaint, whatever the - - what was that part that you - - brought up? It said the chief symptom or – – and then there was something about – – I don't know, whatever that second part was. And that's where they went with us when anybody had colds or flu issues. We started with those kind of – – that protocol first, and then there was – – if you look in their protocol, there's a million things you can transfer to once you have got some background."

Nurse Girtz initially used the Cough/ Cold/ Sinus/ Flu Protocol in this case. Such Protocol was designed for telephone appointment disposition only, unless nursing judgment was used to override it. Under "General Instructions," the Protocol states in the very first sentence: "This protocol offers the option of TELEPHONE TREATMENT for Flu Symptomatic Antiviral Medication for members who meet certain criteria. Thereafter, it states: "If the outcome is an APPOINTMENT offer TAV (telephone appointment visit) first, if appropriate (see MSL in appropriate outcome box). It further states: "Recommended TAV MSL- 'Our clinicians recommend that members with cough, cold or flu symptoms are offered a Telephone Appointment for your convenience and to reduce the spread of viruses.'"

As between cough and cold symptoms and chest pain, Nurse Girtz chose the Cough/Cold/Sinus/Flu protocol, based upon Mr. Flach's Cough/Cold/Sinus/Flu symptoms and

thought those were more urgent than Mr. Flach's chest pain. The Cough/ Cold/ Sinus/ Flu protocol had only one emergent symptom that would prompt an emergency room referral or CCMD referral: two or more episodes of bright red sputum containing one tablespoon or more of blood. During the Cough/Cold/Flu season, the Medical Group's three AACCs received, per Dr. Padilla, a combined total of around 55,000 calls per day, of which about 30% or "18,000" calls pertained to cough or cold or flu. Nurse Girtz had been an advice nurse at the Vallejo AACC from 2002-2018 (16 years) and was intimately familiar with the Medical Group's protocols, especially the Cough/ Cold /Flu/ Sinus protocol. She obviously knew, when she chose to use that protocol, that Mr. Flach would not merit a visit to the ER or an urgent in-person physician visit that day, unless one of two things happened: Mr. Flach was spitting-up a noticeable quantity of frank (red) blood per the protocol (which he was not at that time); or, she could use her Nursing Judgment to override the telephone disposition (which was specifically allowed by the protocol).

The Flachs clearly told Nurse Girtz that Mr. Flach had pain in his chest and burning in his chest. Nurse Girtz recognized that people can have a heart attack during cold and flu season. She admitted that she could not "say for sure," prospectively, whether Mr. Flach was having cardiac-like pain or not. She thought he did not have cardiac related chest pain, because Mr. Flach did not say he had extreme tightness in his chest or shortness of breath and she presumed his chest pain was not worse with activity, although she never asked him if chest pain was worse with activity. Had Nurse Girtz suspected or believed that Mr. Flach's chest pain – described as "so bad" and felt like "fire" and as "burning" and "broken glass" – was *cardiac-like*, the protocol "Chest Pain NOW, Cardiac-like Chest Pain NOW, described as . . . *sustained burning"* would have required that Mr. Flach be immediately referred to a CCMD or emergency room. [Exhibit PEX 11E.002].

In addition, Nurse Girtz recognized that if she had used the protocol "Chest Pain NOW, Chest Pain NOW with *Profound Weakness*," such Chest Pain protocol would have required an immediate review by the CCMD or instructions to the patient to go to the emergency room." [Also found in Exhibit PEX 11E.002]. This protocol did not include a cardiac component. Here, Nurse Girtz knew that Mr. Flach had chest pain with significant weakness, since Mrs. Flach mentioned at the very beginning of the call that Mr. Flach was "really weak." However, Nurse Girtz did not think Mr. Flach's weakness was "profound," which, in her view, meant that a patient cannot walk more than a few steps without collapsing. During the call, she asked the Flachs if Mr. Flach had any "episodes of shortness of breath" and they both answered in the negative. She asked if Mr. Flach could walk across the house without having shortness of breath and Mrs. Flach said "yes," but it made Mr. Flach a little "lightheaded." However, Nurse Girtz did not pose any pointed questions regarding the reason or reasons why Mrs. Flach had said at the very beginning of the call that her husband was "really weak." Nurse Girtz never asked "how" or "in what way" is your husband "really weak," or what do you mean by describing your husband as "really weak." Despite the fact that Mrs. Flach told Nurse Girtz that Mr. Flach was "really weak," Nurse Girtz used the word "fatigue" in her chart note, as opposed to words "really weak", because that is how she describes "really weak."

Finally, the Chest Pain protocol provided still another avenue for Mr. Flach to be seen, had it been seriously considered. Under the category, "Chest pain NOT now but within 72 hours" a patient must be referred to a CCMD or an emergency room, if the patient had recent "Chest pain described as:….*sustained burning*." [Exhibit 11.E.003]. There was no cardiac component necessary to satisfy this protocol. According to Dr. Padilla, who was on the committee that approved the Chest Pain Protocol, this particular Chest Pain protocol was

intended to include disease processes beyond simply cardiac pain. Nurse Girtz was familiar with the Chest Pain Protocol; however, the evidence shows that she never seriously considered the Chest Pain protocol at all for Mr. Flach.

As referenced, Mr. Flach described his chest pain as “it hurts so bad” as a “burning pain” like “fire” and as “broken glass in his chest.” Although he also described a constellation of symptoms, there was no other individual sign or symptom that potentially had a worse outcome than chest pain - that could be caused by pneumonia or have a cardiac etiology. Dr. Padilla testified that chest pain can be the most urgent clinical symptom with the worst outcome.

There was no protocol for pneumonia. Some of the symptoms of pneumonia may have been embedded in other protocols. Nurse Girtz opted not to use a Chest Pain Protocol that certainly embedded one pneumonia symptom, i.e., chest pain. Along with the symptom of intense chest pain, Mr. Flach had, as Nurse Girtz stated many times, a “constellation of symptoms.” These included fever, nausea, burning in the chest, significant weakness, productive cough (phlegm/sputum), that is yellowish-orange in color, and an illness that has gotten significantly worst the last two days out of six. The outcome of this Chest Pain protocol, accompanied by appropriate nursing judgment, would have been a recommendation for immediate referral to the emergency room for Mr. Flach. Or, at an absolute minimum, the scheduling of an urgent in-person visit that afternoon with Dr. Culbertson or another physician. Even though Nurse Girtz never opened the Chest Pain Protocol for this call, as stated, she was familiar with it.

When Nurse Girtz decided that Mr. Flach would only have a telephone appointment with a physician, she also advised the Flachs: “If they want him to come in, you know, for an x-ray or to get his lungs listened to, then they’ll make arrangements for that.”

At the Arbitration Hearing, Nurse Girtz mentioned that Mr. Flach had a lower respiratory infection, probably bronchitis, and that she had certain “thoughts” in the back of her mind about this patient, Mr. Flach, at the time of the call that day. Recognizing that Mr. Flach had a lower respiration, her “thoughts” were that Mr. Flach possibly had pneumonia, may need a chest exam, may need a chest x-ray and may need antibiotics. Yet, she did not tell Mr. Flach to go to the ER or set-up an in-person urgent visit with a physician for him that afternoon. There is no communication she made, either by her chart note, or in some other fashion, to let Dr. Culbertson or another physician know about these particular “thoughts” and why she had them. Her chart note was silent about her “thoughts.” Yet, she knew that her chart note, and the chart note by the TSR were all that Dr. Culbertson would have available to him for the later telephone visit with Mr. Flach, if he decided to look at them. [Apparently, neither the recording of the call, nor the transcript of the call, was available to Dr. Culbertson for his review.]

It is apparent she was contemplating that Mr. Flach possibly had pneumonia, but never let Dr. Culbertson know the same by virtue of her note or in any other manner. She knew that a telephone visit with a physician would not give the physician the benefit of actually seeing how sick Mr. Flach was. She knew that during a telephone visit, a physician would not be able to take Mr. Flach’s vital signs. She knew that neither a chest x-ray nor chest exam could occur during a telephone visit. She knew all of these actions would only happen, if there was a face-to-face examination. She also knew that the chest x-ray and exam would both probably happen, if she had sent Mr. Flach to the emergency room.

Nurse Girtz testified that she generally understood that pneumonia was a lung infection, the symptoms of which could include fever, including a low grade one, chest pain and a feeling of burning in the chest. As noted previously, she was considering pneumonia as a possible cause for the symptoms that Mr. Flach was describing, because he had a fever, chest pain and a feeling of burning in his chest. This critical analysis was part of her nursing assessment (or nursing diagnosis). [The Medical Group protocol documents include a “TPMG AACC Workflow” chart (Exhibit PEX 11.325), which clearly refers to “Nursing Diagnosis” as part of the nursing workflow. It shows “Assessment > *Nursing Diagnosis* > Outcome Identification > Planning > Implementation > Evaluation]. Once again, thinking about possible pneumonia was, undoubtedly, the reason why Nurse Girtz told the Flachs that Mr. Flach may later in the day have his chest examined and have x-rays taken of his chest. Although she had pneumonia in the back of her mind, Nurse Girtz did not elevate the possibility of pneumonia to a level that caused her to take action, i.e., contact the CCMD or schedule an urgent in-person physician appointment for that afternoon. Her failure to take one of these options significantly affect Mr. Flach’s outcome.

During the call, Nurse Girtz eventually switched from the cough/cold/sinus/flu protocol to the asthma/wheezing protocol, because Mr. Flach was wheezing, and it was a brand new symptom that he never had prior and “that can be significant of more a part of the infectious process.” She asked Mr. Flach whether he had chest tightness, because, if it comes and goes with activity, that could be cardiac in nature. If it’s a constant tightness with wheezing that could be the onset of some pretty significant asthma symptoms or significant inflammation to the bronchials.

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Nurse Girtz was informed by the asthma/wheezing protocol that Mr. Flach needed to have an appointment with a physician that day. In order to get to the next recommendation for Mr. Flach's evaluation, she responded: "That's on the second page after the nurse's note. It says, 'appoint during office hours today, appropriate for TAV [telephone advice visit], video, or *office appointment,* worsening cough, wheezing, or chest congestion not improving with inhaler or nebulizer or does not have inhaler/nebulizer.' That's what I clicked 'yes' to." This was one of the options within the asthma/wheezing protocol that was available to Nurse Girtz during her assessment of Mr. Flach. She used her nursing judgment, based on the information she gained during the call, to select that option to learn what further assessment was recommended – over and above what she had done as a nursing assessment. She does not know if there were any *in-person* appointments available for Dr. Culbertson that same day because "those things flash by so fast, there's no way I would have that memorialized or remember this far down the line." She eventually selected an option for a telephone appointment for Mr. Flach that afternoon with Dr. Culbertson and she was "thrilled' to get an afternoon telephone encounter for Mr. Flach with Dr. Culbertson, since there usually are no longer appointments available that time of day. Under this protocol, she could have and should searched or looked for an in-person visit with Dr. Culbertson or another physician for Mr. Flach that afternoon, but did not do so, because "those things flash by so fast." This explanation is not acceptable.

Nurse Girtz did not properly use the "nursing judgment" provision in the protocols, when she failed to send Mr. Flach to the ER, when she failed to call a CCMD and when she failed to arrange an urgent in-person face to face meeting with a physician that afternoon. She had the ability and the authority to take all these actions and did not.

As noted, Nurse Girtz told the Flachs: "I'll try and set him up for a telephone appointment to talk to a doctor today." She added: "If they want him to come in, you know, for an x-ray or go get his lings listened to, then they'll make arrangements for that. But we'll start (in) this direction." And, then she said: "Because we are trying to keep people from commingling and getting more germs." She did not ask the Flachs if they would prefer to see a physician in person. The telephone arrangement Nurse Girtz made was essentially a directive to the Flachs to take a telephone visit without asking them their preference. She did not candidly tell the Flachs that Mr. Flach's case did not merit or warrant an in-person physician visit per the Medical Group's protocols and her own nursing judgment. Implicitly, she told the Flachs that the reason she was setting up a telephone appointment, instead of an in-person appointment, was because the Medical Group was trying to keep people from commingling in the clinic and getting more germs. In reality, it was the Medical Group's guidance per protocol to Nurse Girtz to limit almost all Cold/Cough/Sinus/ Flu patients from being seen in-person, unless there was an "override" of the protocol based on nursing judgment (which she did not properly exercise that day). By telling the Flachs, without any input of discussion, that she was setting-up a telephone appointment "because we are trying to keep people from commingling and getting more germs," she was sending a message to the Flachs, discouraging them from "speaking-up" and requesting an in-person physician visit. Under these circumstances, the Arbitrator rejects Respondents' argument that it was the Flachs' fault in not obtaining an in person visit for Mr. Flach.

With the symptoms of 6-day history of illness, with its worsening in the prior two days, with Mrs. Flach commenting, 'it is the sickest she has ever seen her husband', with his chest in severe pain, with yellow-orange sputum, the standard of care required that Nurse Girtz refer Mr. Flach to see a physician within hours of her call on March 7th, in-person and in a

setting that would allow for a chest x-ray and physical examination. Since Nurse Girtz never set-up an in-person face to face meeting with Dr. Culbertson or any other physician, nor did she advise Mr. Flach to be seen in the emergency room, it was below the standard of care on her part.

The nursing standard of care required Nurse Girtz to have Mr. Flach examined on March 7th and x-rayed on March 7th for these reasons: the history of illness was worsening, which was classic for secondary bacterial infection, often manifesting as pneumonia; the presence of subjective fever notwithstanding the use of Advil; the presence of chest pain raising the potential for pneumonia; and the distinctly unusual yellow-orange sputum, all suggesting that Mr. Flach did not have a standard respiratory infection and Nurse Girtz' own recognition (thoughts in the back of her mind) that Mr. Flach likely needed a physical exam, chest x-ray and antibiotics.

Nurse Girtz had a variety of options available to her but chose a low level of care leading to Mr. Flach's death. She had the authority to send Mr. Flach to the ER, or to call a critical care emergency medicine physician or send or schedule an in-person visit with a physician. She admitted that pneumonia was in her differential assessment (diagnosis). The problem in this case is that she did not put it high enough on her list. She knew that the telephone encounter itself, several hours later with a physician, would not include any kind of a physical examination, a chest x-ray or antibiotic therapy. Yet, she knew or suspected that a physician might want to listen to Mr. Flach's chest, order an x-ray and start him on antibiotics. The standard of care for pneumonia, for patients with complaints like those described in this call, is a physical examination, chest x-ray, timely diagnosis of the severe pneumonia, and an immediate referral to the emergency medicine department (if the patient is not there already) and proper, timely treatment including empiric antibiotic therapy.

Nurse Girtz' documentation/note of her call was inaccurate and misleading vis-à-vis the information that was relayed to her by the Flachs. Her notation of the call was beneath the standard of care. Her decision to omit the word 'orange' from a description of "yellowish orange," because she considered it added nothing; along with her misreporting "really weak "as "fatigue," because that is her terminology; along with the unwarranted change of a report of "burning in the chest" to "burning in the chest during and following cough," was below the standard of care for Nurse Girtz. Mr. Flach had significant, constant pain in his chest and there was constant burning in his chest.

In conclusion, the Arbitrator finds that Nurse Girtz breached the Nursing Standard of Care, and in so doing, was negligent in her care, diagnosis and treatment of Mr. Flach. And, the Arbitrator so finds.

B. Dr. Culbertson

Based upon the information provided by the Flachs on March 7, 2018, that was known or knowable by Dr. Culbertson, the standard of care required Dr. Culbertson to either immediately have seen Mr. Flach in the Medical Group clinic the afternoon of March 7, 2018 or to have directed Mr. Flach to go to the emergency room no later than the afternoon of March 7th

When Dr. Culbertson called Mr. Flach on March 7, 2018 at 3:37 PM, and thereafter provided advice, care and treatment for Mr. Flach, he was in the course and scope of his employment with Respondent The Permanente Medical Group, Inc. The call lasted three (3) minutes. Typically, Dr. Culbertson's phone appointments last less than five (5) minutes. The Medical Group's standards allowed Dr. Culbertson to take ten (10) minutes for a telephone appointment. The typical length of Dr. Culbertson's in-person appointments are about twenty (20) minutes and there is a twenty (20) minute allotment in the Medical Group's standard for in-

person patient visits. Dr. Culbertson did not recall if he did anything to prepare for the telephone appointment with Mr. Flach, although, by custom and practice, he usually reviews the chart notes before an appointment, if he has time. Unlike the call between the Flachs and the AACC, there was no recording of this three (3) minute call between Dr. Culbertson and Mr. Flach.

Dr. Culbertson stated he recalled "little bits" of the phone call between himself and Mr. Flach that transpired between 3:37 PM and 3:40 PM on March 7th. He does not remember the details of the conversation, because it was so long ago. He remembers the call, but he does not remember the details. He remembers the call itself and parts of the call, what he called the "gist" of the call. He remembers content without a great bit of detail. He definitely remembers talking to Mr. Flach that day. When his deposition was taken in this case about 18 months after Mr. Flach's death, Dr. Culbertson was asked about his recall of the subject telephone conversation with Mr. Flach and he stated: "You know, a year and a half later, I am going by my notes." This excerpt was read into the record at the Arbitration Hearing. In the course of a few years, Dr. Culbertson deals with thousands of patients with very similar symptoms, so that over time, his patients all tend to run together. He does not remember the details of every three (3) minute call he's had with every patient and that's why he relies on his notes.

Dr. Culbertson's chart note of the 3:37 PM phone call is timed at 4:55 PM, which electronically means he did not 'sign' or close his note until 4:55PM, one hour and 15 minutes after the call ended with Mr. Flach and 5 minutes before the typical end of the day (seeing patients) at 5:00 PM. As noted, according to Dr. Culbertson, his in-person appointments usually last about 20 minutes and, therefore, he would likely have seen three patients between Mr. Flach's 3:37 PM telephone call and the time he left his note about the call. [Dr. Culbertson could

not say how many patients he may have seen after his call with Mr. Flach and before he started his note.]. He does not recall, if he began typing his note during the time he was talking to Mr. Flach or whether that occurred later. In particular, he could not say if he began writing his note at 4:00pm, 4:30 PM or 4:50 PM on March 7, 2018. Dr. Culbertson's Orders for Mr. Flach's Medications were timed at 3:42 PM – 2 minutes after the call ended.

Dr. Culbertson's chart notes of the call are brief, beginning with four prepopulated lines that are entered automatically as soon as Dr. Culbertson opened his note, and, per Dr. Culbertson, this part of the note did not correctly reflect his initial interaction with Mr. Flach. For instance, he did not ask Mr. Flach to confirm who he was, or his date of birth, although that is what his note states. Also, he does not recall whether he and Mr. Flach discussed the risks of management over the phone without physical exam, although the prepopulated note states that to be the case.

The substance of Dr. Culbertson's note totals six very abbreviated lines in the middle of the first page of his note. These 23 words, abbreviations and symbols were not prepopulated, and Dr. Culbertson personally typed them: "Patient complains of URI symptoms one week, cough, chest congestion? wheezing + laryngitis. No fever. No chest pain. No shortness of breath." Dr. Culbertson ordered a cough suppressant, nasal saline rinse, fluids, rest and decongestants. He prescribed Codeine -Guaifenesin AC to be taken at bedtime. He prescribed Ventolin HFA, 2 puffs orally every 4 hours for shortness of breath. Also, the note shows that the patient should "return" (to the clinic) for temperature (fever) over 100.4, blood-streaked sputum and chest pain. His Primary Diagnosis was "URI (UPPER RESPIRATORY INFECTION) – PRIMARY"

Dr. Culbertson's knew that a treating physician must learn as much as possible about the history of the illness that the patient has. He also knew that the progression of an illness is critically important in assessing its acuity and severity. He knew that if the patient made a complaint of cough, then pneumonia must be in the differential diagnosis. He stated that if a patient also complains of fever and chest pain, such patient must be seen. He stated that if there were blood in a patient's sputum, that patient must be seen. Dr. Culbertson knew or should have known all of the symptoms pertaining to Mr. Flach's illness. But he failed to obtain the whole story about Mr. Flach's illness. Consequently, he did not appreciate the severity of Mr. Flach's illness and, therefore, did not examine Mr. Flach or send him to the emergency room. This was below the applicable standard of care.

From the recorded call earlier that day, there is no dispute that Mr. Flach already advised Nurse Girtz that he had chest pain and a fever. He also reported yellowish orange sputum that likely became that color, because it was sputum mixed with blood. There also is no question that Mr. Flach's illness was getting worse, not better. [He was in septic shock by 9:21am the next day.] His sputum was certainly blood-stained or blood-tinged by 4:17pm on March 7, 2018, as reflected in the photograph taken by Mr. Flach himself, approximately 37 minutes after the call ended with Dr. Culbertson. Further, Mr. Flach had already advised Nurse Girtz that the illness was getting worse and Nurse Girtz became properly concerned about the trajectory of the disease. For these reasons, more likely than not, Mr. Flach never advised Dr. Culbertson that his sputum was merely "yellow" in color, or that he was "getting better," or that he had "no fever" or that he had "no chest pain," and the same is verified by Mrs. Flach, who was listening-in on the call that day with Dr. Culbertson. It is much more likely that Dr. Culbertson assumed that this non-urgent telephone appointment was not for a serious illness,

because, if it was otherwise, the advice nurse would have scheduled an in-person visit. Apparently, it was just a fairly routine call for him about a URI, as he so reported in his chart note and labelled the Primary Diagnosis as an URI.

At the Arbitration Hearing, Dr. Culbertson said that URI was **not** his primary encounter diagnosis, because he really thought Mr. Flach had both an upper respiratory infection, followed by a lower respiratory infection, despite what he wrote in his chart note (URI). He testified that "URI" is used interchangeably by him for both types of infection. He said it would have been more accurate, if he had written in his chart note that Mr. Flach had complained of LRI (lower respiratory infection) symptoms, or URI symptoms that became LRI symptoms, because that is what he thought. He believed Mr. Flach was having an episode of bronchitis (a viral syndrome), but the word "bronchitis" is not found in his chart. He was very aware that any indication of a respiratory infection can always proceed to pneumonia and, specifically, knew that patients with bronchitis sometimes have pneumonia. Therefore, according to him, he did consider if Mr. Flach had pneumonia and pneumonia was in his differential diagnosis.

He also testified that Mr. Flach stated that he had no fever, when he asked him that question. He did not follow-up and ask Mr. Flach if he had a mild fever two hours earlier when he talked to Nurse Girtz and, further, he did not ask if Mr. Flach was taking an antipyretic, to reduce his fever, which Mr. Flach was. He testified that he asked Mr. Flach about spitting-up mucus or sputum and he assumes Mr. Flach said his mucus was yellow or, otherwise, he would have made a note in his chart, which he did not. Since he thought Mr. Flach had been coughing-up yellow mucus, he did not ask him any other questions about the color of his mucus. [From the recording earlier in the day, Mr. Flach had been coughing-up yellowish – orange sputum just two

hours before when he talked to Nurse Girtz.] With respect to the trajectory of Mr. Flach's illness, he thought Mr. Flach was getting better and not getting worse.

Additionally, Dr. Culbertson testified that he knew Mr. Flach complained of "glass" in his chest. He does not recall Mr. Flach telling him "my chest hurts so bad" nor telling him that "it's like a burning, like fire in my chest." However, he wrote "no chest" pain in his chart, because that is what Mr. Flach allegedly told him, when he asked Mr. Flach, if he had pain in his chest with "wheezing" or "overt chest pain." Respondents contend that Dr. Culbertson was really referencing "no '*pleuritic'* chest pain" in his chart note. However, his chart note does not include the word "pleuritic" between the words "no" and "chest pain" or anywhere else. For such an extremely important, critical detail, his chart note should have clearly and unambiguously reflected his thinking and his finding in this regard. It did not. Also, it completely disregards the severe chest pain Mr. Flach actually had. When Dr. Culbertson was answering questions under CCP section 776 (cross) examination at the Arbitration Hearing, he never used the word "pleuritic" in any answer during this cross-examination. The word only arose near the tail end of his Redirect examination, when Dr. Culbertson was asked if he had ever "heard" of the word "pleuritic" used with chest pain and he said he had. [At the Arbitration Hearing, during Respondents' cross-examination of Claimants' expert witness, Dr. Gordon, she was asked: "You understood Dr. Culbertson to have explained himself, that when he said, 'no chest pain' that was in reference to sharp, pleuritic type pain associated with pneumonia, right?" Dr. Gordon answered: "I do not recall that from the deposition."] It would have been a straightforward and easy (and exacting) for Dr. Culbertson to write the word "pleuritic" between the words "no" and "chest pain" in his chart, if that is what he thought. Or, it would have been a simple task to otherwise qualify the "no chest pain" entry in another way. Additionally, there is absolutely

nothing in Dr. Culbertson's chart note that suggests he made a diagnosis of a Lower Respiratory Infection, much less identify a specific type of Lower Respiratory Infection, such as Bronchitis, as his 'Primary Diagnosis." In particular, there is nothing in the "body" of his chart note that reflects he did actually diagnose Mr. Flach with bronchitis or that he had pneumonia in his differential diagnosis and how he "ruled out" pneumonia. The Arbitrator does not find Dr. Culbertson's explanation for the chart note entry "no chest pain" as credible.

As noted previously, the call between Mr. Flach and Dr. Culbertson lasted three (3) minutes. In a context like this one, for a patient as sick as Mr. Flack was, three minutes is not an adequate time for a reasonably careful physician to take a sufficient history to decide that Mr. Flach did not have severe pneumonia or some other major disease. Dr. Culbertson's note of that interaction supports this conclusion. It records no probing for pertinent facts or symptoms, no history of the trajectory of the disease process and no indication that the sputum color was discussed. It includes the wording "no fever" and " no chest pain" that directly contradicts what is known, with certainty, that was conveyed by Mr. Flach to Advice Nurse Girtz a few hours earlier that same day. Dr. Culbertson's three minute call with Mr. Flach was inadequate to obtain the full history and extent of Mr. Flach's illness. A substantive call would have elicited the information Nurse Girtz had already obtained from the Flachs earlier that afternoon. Dr. Culbertson fell beneath the standard of care in either failing to access the note written by Nurse Girtz, or, to the extent he did so, in failing to note discrepancies between the history that Nurse Girtz obtained and what Dr. Culbertson recorded as the absence of fever or chest pain. Most likely, Dr. Culbertson never solicited the detailed, significant history from Mr. Flach; or, if he did, after he had finished his three, in-person patient visits that day, subsequent to the call with Mr. Flach, he did not retain the true information given to him by Mr. Flach. To comply with the

standard of care, Dr. Culbertson was obligated to ask Mr. Flach questions that would have elicited that Mr. Flach had recently - less than two hours earlier - been experiencing, and likely was then experiencing, severe chest pain, had a mild fever (and that Mr. Flach was taking Advil to reduce his fever), was nauseas, very weak, and had been coughing-up yellowish orange sputum and was getting progressively worse, not better. Dr. Culbertson's history was far too brief, and he failed to discriminate between pneumonia and other diagnoses.

Mr. Flach described his sputum as having a yellowish orange color. This description tells a clinician, such as Dr. Culbertson (had he asked), that the sputum very likely has some blood in it or, at the very least, there is something the patient finds odd about its color. This suggests hemoptysis (coughing-up blood) and any patient calling with this symptom amidst a constellation of symptoms described by the Flachs, must be seen promptly. Dr. Culbertson admitted at the Hearing that had he known Mr. Flach had chest pain and yellowish-orange colored sputum, he would have personally seen Mr. Flach that afternoon or sent him to the emergency room. In this case, Mr. Flach's symptoms included hemoptysis by 4:17 PM and likely before that time. Had a physician seen Mr. Flach, in accord with the standard of care, such a physician would have seen evidence of that sputum color either by the photograph taken by Mr. Flach or with direct expectoration. Evidence of that sputum was evidence of a bacterial pneumonia. Once seen by physician, the standard of care required confirmation of a presumptive pneumonia diagnosis by chest x-ray. So, had Mr. Flach been seen and examined on March 7, 2018, the physical examination would have included a stethoscope examination of his chest. Most likely, crackles would have been heard and this would have led to a chest x-ray, which either would have been done at Dr. Culbertson's office or at the emergency room on March 7,

2018. The x-ray would have suggested severe pneumonia. Coupled with all his symptoms, including hemoptysis, under all circumstances, Mr. Flach would have been sent to the ER.

The history that Dr. Culbertson took was below the standard of care for his patient, Mr. Flach. It was incomplete, inadequate, incorrect, inexplicable and not credible, yet, in a significant way, it served as a basis for Dr. Culbertson's not sending Mr. Flach to the emergency room nor seeing Mr. Flach in person.

Had Dr. Culbertson taken an adequate history, he would have noted that Mr. Flach already had significant symptoms, which required him be seen that afternoon. Rather, Dr. Culbertson's chart note reads: "Appointment before the end of week if needed." This shows that Dr. Culbertson did not understand the gravity of Mr. Flach's illness, largely because he took an inadequate history. Furthermore, in the "Instructions," Dr. Culbertson put in his note for Mr. Flach to "return" if he had a "cough with streaks of blood …. or chest pain." This was misleading, since Mr. Flach already had severe chest pain and sputum that, unbeknownst to a lay person like Mr. Flach, already was tainted with blood and was an emergent symptom. Since Dr. Culbertson assumed Mr. Flach's sputum was yellow in color (which was incorrect) and did not learn the color previously described by Mr. Flach as "yellowish orange," and because he took an inadequate history, Dr. Culbertson placed himself in a position of not being able to advice, and, therefore, did not tell, Mr. Flach to "return" to the clinic, if his sputum turned from yellowish orange to pink or red currant jelly color or rust color. Most likely, Mr. Flach's sputum did not become blood streaked until the following morning, when it was too late for Mr. Flach to go to the clinic. [At that time, Mr. Flach remembered Dr. Culbertson's instruction "to return" and sent the Email to Dr. Culbertson, asking to come-in and see Dr. Culbertson that morning.] The

instructions listed in Dr. Culbertson's note of his visit with Mr. Flach were, therefore, misleading to Mr. Flach and explain why he did not go the ER the day before (March 7th).

During the night, Mr. Flach was very uncomfortable, he was shaking, was achy and had a continuing fever. Prior to and after the phone call, he continued to cough-up blood tinged sputum, although he likely did not recognize the darker color as blood. He was spitting into tissues, the sink and a wastepaper basket. The sputum he described on the phone call to Nurse Kurtz, as yellowish orange appeared reddish orange in the photo recovered from Mr. Flach's phone taken at 4:17PM on March 7th. Upon reviewing the photo, Dr Culbertson testified at the Arbitration Hearing that this photo showed blood in the sputum and, had he known about it, he would have been very concerned. He would have seen Mr. Flach that day in his clinic or sent him to the emergency room. To a lay person, the photo does not show sputum with frank blood nor blood streaks in it. On the morning of March 8th, however, Mr. Flach was coughing-up frank blood.

At 8:28 AM on March 8, 2018, Mr. Flach wrote the following Email to Dr. Culbertson: "I had the worst night, sweating and coughing up blood, my chest is really tight and sore, can't breathe very well. So weak and dizzy. Can I come in this morning?" At 8:29 AM, Dr. Culbertson wrote back: "You need to see me today." He did not tell Mr. Flach that he needed to go to the emergency room right that minute nor did he tell Mr. Flach that he needed to come see him in the clinic immediately. This response (not telling Mr. Flach to go to the emergency room right now or come immediately to the clinic) demonstrates, unfortunately, Dr. Culbertson's complete lack of understanding and appreciation of the seriousness of the disease process that afflicted Mr. Flach and which eventually took his life.

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The constellation of information and symptoms described during the Flachs' call with Nurse Girtz, including Mrs. Flach describing Mr. Flach's illness at a level where she had "never seen her husband so sick, coughing up stuff, nauseous, really weak, achy, no energy, with a mild fever," was all discoverable by Dr. Culbertson, if he had used the time allocated for the call (10 minutes) and taken an appropriate history. These actual symptoms warranted that Mr. Flach be seen that day. This information also provided a perspective from someone who knows the patient best and provided insight to the clinician about how ill the patient looked and the degree of illness. Further, the information that this illness has continued over six days and is not improving, as one would expect of an illness such as this, but rather has gotten worse in the two days preceding the March 7th call, is another major factor that the standard of care required that Mr. Flach be evaluated in a face to face examination, followed by a chest x-ray, in the afternoon of March 7, 2018.

In summary, the standard of care required Dr. Culbertson to take a complete history from Mr. Flach that would enable Dr. Culbertson to determine if Mr. Flach required being seen that afternoon. Dr. Culbertson took an incomplete, inadequate and truncated history from Mr. Flach that was inaccurate in critical part and breached the standard of care. Having only a three (3) minute call with a patient having Mr. Flach's symptoms is inadequate to learn the nature and extent of the problem. Given the symptoms conveyed to Nurse Girtz earlier that day, it is certain that Mr. Flach's symptoms, when he spoke to Dr. Culbertson, were the same or worse than they were at 1:44 PM. The standard of care required Dr. Culbertson to elicit the history of severe chest pain and to characterize this in detail; to inquire about sputum production and fully describe the sputum; to inquire about fever, chills, and sweats; and to elicit the progression of the illness, especially starting as a viral illness for several days, but then abruptly

worsening the two days before the call. Had this been done, Dr. Culbertson would have learned of Mr. Flach's symptoms, at which time, the standard of care would have required that he see Mr. Flach that afternoon or instruct Mr. Flach to go to the emergency room now. In any instance, a physical exam, including chest exam, a chest x-ray, and blood test would have been done and a diagnosis of severe pneumonia made. Mr. Flach would have sent to the ER. Dr. Culbertson's failure in this respect also delayed the administration of intravenous antibiotics for 18 hours.

In conclusion, the Arbitrator finds that Dr. Culbertson breached the required standard of care for an internal medicine specialist and was, thus, negligent in his care, diagnosis and treatment of Mr. Flach. And, the Arbitrator so finds.

C. Institutional Negligence

Claimants assert that the evidence submitted in this case proved that the Kaiser entities were negligent in the promulgation, direction and usage (in all cases) of this policy: That the disposition for 'Flu' 'Cough' 'Cold' patients (infectious patients) is by telephone and not by in-person visits. In particular, Claimants argue that Kaiser established a patient contact system that required screening of all patients seeking care by an Advice Nurse, combined with a protocol administered through that system that limited patient-physician face to face examinations. The protocol was (allegedly) a directive to nurses to book only telephone appointments for patients with cough, cold, flu, sinus, including those patients with symptoms of pneumonia. Claimants state this policy placed a barrier between physician and patient was not medical care and had no medical purpose.

Respondents assert that there is no institutional negligence. They argue that the Nurse Advice System employed by Respondent The Permanente Medical Group, Inc. [Medical Group], sued herein as "Kaiser Permanente Medical Group" is essential and invaluable in

dispensing health care and is used by many other major health care systems. The Protocols are written by a committee of physicians and nurses employed by the Medical Group. There is no policy to keep infectious patients from coming into a clinic or emergency room. While Claimants assert that Nurse Girtz operated under a policy to keep all infectious patients out of the clinic or hospital by scheduling telephone appointments with physicians, the actual practice was to offer telephone appointments only in the event that the provider had already determined that the patient did need to be seen. If there was a reason for a patient to seen in-person, there was no policy preventing the same. The Cough/Cold/Flu" protocol allows the nurse to use his/her clinical judgment in deciding for a higher level of care than a telephone call with the physician. The nurse can arrange for an infectious patient to go to the ER or see a physician in-person.

The Arbitrator find that both Nurse Girtz and Dr. Padilla made it clear that if an infectious patient needed to be seen in the ER or clinic, the Cough/Cold/Flu" protocol allowed the Advice Nurse to use his/her clinical judgment in deciding for a higher level of care than a telephone call with the physician. The Advice Nurse can arrange for an infectious patient to go to the ER or see a physician in-person. In this case, Nurse Girtz had the authority to do so, had she wanted to exercise her authority. [The Arbitrator has found that she did not properly exercise her nursing judgment and practiced below the standard of care.]

At the Arbitration Hearing, Nurse Girtz was asked: "We heard a statement in the tape and the statement was: 'We are trying to keep people from commingling and getting more germs.' Do you remember that statement?" She answered: "Yes" and said that was something she had told the Flachs. The follow-up question was: "And you told them that was the reason why you were setting up a telephone, not an in-person appointment: true?" Nurse Girtz answered: "One of the reasons." When thereafter asked: "Did Kaiser tell you that it was their

policy for you to attempt to set up a telephone call with the patient rather than set up an in-person examination and meeting with the doctor for a patient?" Nurse Girtz answered with a question: "When there was something infectious?" Followed by another question stating "yes" and Nurse Girtz then answering: "Yes. **And if there was not an immediate call for some sort of intervention that required them to be into the – – in the clinic**." This question followed: "So it was your directive from Kaiser try to keep infectious patients out of the clinic and to set up telephone calls with doctors instead; true?" Nurse Girtz said: "Generally speaking, yes" In other words, if the infectious patient needed to go to the clinic and be seen in-person than such patient would be told to do so by the Advice Nurse or CCMD.

Dr. Padilla, who works for Respondent Medical Group and was Respondents' PMK on a variety of topics, including the Scripts used by the TSRs, and the Protocols and Workflows used by the Advice Nurses was asked:" Right. You are aware that Mr. Flach was advised by the advice nurse in this case to not go into a facility and to connect with Dr. Culbertson by telephone. Right?" Answer: "That's our normal workflow. Question: "That's what you understand occurred in this case. Right?" Answer: "Yes." Question: "Okay. And the reason for that is that you don't want that patient to give his or her virus germs, flu, whatever it is, bacterial infection, to other people by coming to the clinic or going to the hospital?" Answer: **"That's if we deem it appropriate for a telephone appointment. Again, the nurses have the ability to use their clinical judgment. If we do determine that an in-person visit is needed, we advise the patient to come in wearing a mask back in those days in 2018 when this happened. "**

Further, with regard to the Cough/Cold/Sinus/Flu Protocols in question, this advisory was contained in *capital letters* at the top of each page: "This protocol is intended to be

1 used by a registered nurse (RN) in the assessment and triage of KP members calling on the
2 telephone. **It is expected that the content of the protocol will be adapted to the unique issues**
3 **and needs of each caller by the RN, using his/her clinical judgment**. In addition, on the
4 specific exhibit page [PEX 11.053] that pertains to the "Emergent Condition" re episodes of
5 bright red sputum, there is this additional proviso near the middle of the page: **"Member does**
6
7 **not meet the criteria but in RNs judgment should be seen in this category."** In the subject
8 telephone call with Mr. Flach, Nurse Girtz was free to elevate his case to "Emergent" or
9 "Urgent," if her clinical judgment led her to do so, which, in her view, it did not. [The Arbitrator
10 has found that she did not properly exercise her nursing judgment and practiced below the
11
12 standard of care.]
13 The AACC received about 55,000 calls per day during the Cold/Cough/Flu
14 season in 2018, of which about 30% or approximately "18,000" [actually ~16,500] calls involved
15 Cold / Cough/ Flu /URI matters. The vast majority of these callers do not require an immediate
16
17 "emergent" or "urgent" referral to the CCMD or an in-person same day urgent appointment with
18 a physician. The calls that require emergent or urgent reference are to be appropriately handled
19 by the CCMD or the Advice Nurse. To refer all 16,500 callers to the ER (emergent cases) or to a
20 physician (for an in-person urgent visit) for the same day would create an undue, unnecessary
21 and impossible burden on the physicians, nurses and staff. Or, as Dr. Padilla said: "a workplace
22
23 disaster."
24 Therefore, the Arbitrator does not find that Respondent The Permanente
25 Medical Group, Inc., sued herein as "Kaiser Permanente Medical Group," nor any Respondent,
26 had a policy as perceived and described by Claimants and, therefore, the Arbitrator finds no
27 Institutional Negligence in this case.
28

V. DECISION ON CAUSATION – SUBSTANTIAL FACTOR

A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm. It must be more than a remote or trivial factor. It does not have to be the only cause of the harm. CACI 430

More likely than not, had the standard of care been complied with, i.e., Mr. Flach had been seen by a physician in person in the afternoon of March 7, 2018, Mr. Flach would have been sent to the emergency room without delay, where he would have been evaluated, had a chest exam, had an x-ray taken of his chest, and received appropriate treatment for his bacterial pneumonia infection. Had Mr. Flach been seen in person by Dr. Culbertson, his physical examination on March 7th would have been suggestive of pneumonia in the form of crackles heard on auscultation of the lungs. The chest x-ray would have shown multilobar infiltrates all of which, along with the history, would have necessitated immediate referral to the emergency department. The presence of multilobar pneumonia with hemoptysis is an indication under which patients must be admitted to the hospital.

Once in the emergency department on March 7th, the probable findings of multilobar infiltrates on chest x-ray, combined with Mr. Flach's history, the photo showing the appearance of blood tainted sputum, whether evident in real time or by the photo Mr. Flach himself took on March 7, 2018 at 4:17 PM (Ex.8), would have been indicative of a high likelihood of MRSA pneumonia, which would have required, in addition to broad spectrum antibiotics, the use of intravenous Vancomycin, an antibiotic that is specific to MRSA.

Given the appearance of Mr. Flach's chest x-ray at 9:50AM on the morning of March 8, 2018, showing multilobar pneumonia and consolidated infiltrates, a chest x-ray taken in the afternoon of March 7, 2018 likely would have had a similar appearance to the one taken on

March 8th. This is likely, since Mr. Flach's illness was becoming progressively worse, his chest was in significant pain and his sputum had a bloody component to it. This conclusion is based both upon Mr. Flach's description of the coughed-up sputum given to Nurse Girtz as yellowish orange and based upon a photograph Mr. Flach had taken of it at 4:17 PM on March 7th. The chest x-ray taken on the morning of March 8th correlated clinically with bacterial pneumonia as opposed to a viral pneumonia. This diagnosis results in hospitalization and the administration of empiric intravenous antibiotic therapy.

More likely than not, at the time of the phone call with Nurse Girtz at 1:44PM on March 7, 20218, Mr. Flach had multilobar pneumonia (due to MRSA). The history alone, by way of worsening disease trajectory presented to the advice nurse, is classic for a secondary bacterial infection. The illness that began as a "metapneumovirus" evolved from a cold/virus to a superimposed bacterial infection by March 7th. All of the criteria support this conclusion, including the trajectory of the disease worsening two days prior, the presence of hemoptysis (described by a lay person as a yellowish orange sputum at 1:44 PM and appearing rust colored by 4:17 PM that day), the low white blood cell count and the x-ray infiltrates.

Mr. Flach was harboring a treatable bacterial infection that had begun as a metapneumovirus or, essentially, a cold virus. The entire course of Mr. Flach's illness in the two days prior to his death was completely consistent with, and typical of, MRSA and atypical of metapneumovirus. The trajectory of the illness gives the clinician an indication as to whether this is a viral or bacterial illness. A person who putters along for a few days and then gets worse with these symptoms is classic for staphylococcus aureus pneumonia. The uniquely indicative feature of a MRSA bacterial infection is the rapid course of the illness, which is atypical of the human

metapneumovirus, the latter being more indolent, gradually progressive and typically resolving. The metapneumovirus did not kill Mr. Flach. The MRSA superimposed infection did.

Mr. Flach had been ill for four days and the illness was getting worse in the last two days, not better. This is the typical history obtained from patients with a secondary bacterial infection. The purulent sputum evidenced in Mr. Flach's photo of his sputum (Exhibit 8) is unusual to see with a viral infection, especially with blood in the sputum. The finding of blood in the sputum, or hemoptysis, is classic for MRSA pneumonia, but rarely seen in human metapneumovirus patients. Only two cases in the world literature on hemoptysis have been reported from metapneumovirus alone

Once Mr. Flach was in the Emergency Room at Kaiser Hospital in San Rafael on March 8th, the diagnosis of community acquired pneumonia and that of septic shock were made early-on. His history is recorded as having chest pain and cough for two days. His chest x-ray showed severe pneumonia and likely would have shown the same or similar infiltrates during the afternoon March 7th. As noted, the presence of multilobar pneumonia with hemoptysis is an indication under which patients must be admitted to the hospital.

What clearly changed between March 7th and March 8th, was not Mr. Flach's pulmonary disease itself, but the development of the sepsis.

In the hospital, Mr. Flach was prescribed broad spectrum antibiotics, Levofloxacin and Zosyn, at 9:50 AM. A few minutes later, at 9:59 AM, the broad spectrum antibiotic, Vancomycin, that specifically targets and MRSA, was prescribed. All three of these antibiotics were ordered almost two hours before the gram stain results came back at 11:50 AM. [The ER physicians ordered a gram stain on Mr. Flach's sputum at 10:19 AM, with the intention of discovering what type of suspected bacteria it was. With both gram positive and gram-

negative bacteria showing in the gram stain, the ER physicians needed to cover MRSA in their antibiotic treatment—which is what they anticipated and what they did.] Levofloxacin, and Zosyn were started intravenously at 10 AM and Vancomycin at 12:49 PM. The bacteria culture from Mr. Flach's sputum was susceptible to Levofloxacin and Vancomycin. More likely than not, Mr. Flach would have been hospitalized on March 7, 2018 and received these same antibiotics administered intravenously to him on March 8th. There are two reasons this is probable. Firstly, Kaiser Hospital in San Rafael's use of these drugs on March 8, 2018, for treating the same patient for a severe bacterial infection, suggests this was a standard choice at that hospital for a severe case of community acquired (bacterial) pneumonia. Secondly, had other antibiotics been used for some reason on March 7th, Mr. Flach, nevertheless, would have been treated for severe pneumonia by way of intravenous antibiotic therapy. A gram stain would have been done on admission, as had been done on March 8th. Results would have come back within two hours. The gram stain likely would have shown the same bacteria classification shown on the March 8th gram stain. Coverage for gram positive bacteria including Staphylococcus Aureus and MRSA would have led to the use of the same antibiotics used on March 8, 2018 for treating Mr. Flach. Further, if Mr. Flach continued to deteriorate while being closely monitored in the hospital, the antibiotics would have been adjusted until he began to improve. This illness started as a respiratory viral infection (metapneumovirus), which subsequently led to a bacterial pneumonia superinfection (MRSA). Early antibiotic administration was crucial and would have made a significant difference in this case. It would have saved Mr. Flach's life.

Statistics show that of every 100 people afflicted with MRSA pneumonia, 87% survive. In the San Francis Bay Area, if a patient is really sick and a physician thinks it may be Staphylococcus Aureus infection, the physician treats for MRSA. In this community, of the

Staphylococcus Aureus isolates, one-third were MRSA in this timeframe. As in the case of Mr. Flach, a physician would know from that gram stain that it was a Staphylococcus Aureus infection, but the physician would not know from the gram stain that it was MRSA. So, if the patient is really sick, the physician would treat him for the worst case scenario (MRSA) and then deescalate later, if it turns out not to be MRSA. Here, the sputum cultures showed Mr. Flach had MRSA. Although blood cultures, done in the hospital on Mr. Flach's blood, revealed no bacteremia (presence of bacteria in the bloodstream), up to 60% of bacterial infections do not get into the bloodstream, or are not detected, for a variety of reasons.

Mr. Flach had a MRSA bacterial pneumonia infection that was treatable on March 7th with Levofloxacin and Vancomycin, which, more likely than not, he would have received. The failure by both Nurse Girtz and Dr. Culbertson in not having Mr. Flach seen by a physician in person on the afternoon of March 7th resulted in Mr. Flach's demise. By the time Mr. Flach was seen on March 8, 2018, he was in septic shock. Septic shock is a condition in which an infection has precipitated a significant impairment of at least one organ system, causing hypotension that does not normalize with fluid administration. Mr. Flach was not in septic shock on March 7th at 1:44 PM nor at 3:37 PM when both Nurse Girtz and Dr. Culbertson had a duty to have him seen by a physician in person. They did not do so. By the time Mr. Flach arrived at the hospital on the morning of March 8th, no antibiotic treatment would have been able to change his course.

The breaches of the standard of care by Nurse Girtz and Dr. Culbertson were each a substantial factor in causing the death of Mr. Flach. Had Mr. Flach been seen and examined by a physician on March 7, 2018, he would have been diagnosed with severe pneumonia based upon his symptoms described to Nurse Girtz, including his discolored sputum,

his probable vital signs, his chest pain, his overall condition, and, a chest x-ray showing bilateral multilobar infiltrates suggesting severe pneumonia. The chest x-ray on March 7th would have had a similar appearance to the chest x-ray taken the next day on March 8th. Had Mr. Flach been seen on March 7, 2018 by an emergency medicine physician or Internist or other reasonably astute clinician, more likely than not, he would have been timely treated with fluids, antibiotics and other care as appropriate and would have recovered from the illness entirely intact. He would have gone on to live a normal life. He would not be a pulmonary cripple. His lungs would have recovered from this illness such that he would be able to breathe normally.

Respondents contend, on one hand, that Mr. Flach was too healthy in the afternoon of March 7, 2018 to merit an in-person visit with a physician that afternoon. Yet, on the other hand, Respondents contend that Mr. Flach was deathly ill on the afternoon of March 7, 2018 and no in-person physician visit could have saved him. The Arbitrator disagrees with Respondents on both counts.

The Arbitrator previously found that Nurse Girtz was negligent when she breached the required standard of nursing care. The Arbitrator now finds that such negligence was a substantial factor in causing the harm, to wit, the death of Mr. Flach.

The Arbitrator previously found that Dr. Culbertson was negligent when he breached the required standard of care for an Internal Medicine Specialist. The Arbitrator now finds that such negligence was a substantial factor in causing the harm, to wit, the death of Mr. Flach.

Since Nurse Girtz and Dr. Culbertson were in the course and scope of their employment with Respondent The Permanente Medical Group, Inc. (sued herein as “Kaiser Permanente Medical Group”) at the time of their advice and treatment of Mr. Flach on March 7,

2018, the findings of negligence and causation (substantial factor) on the part of Nurse Girtz and the findings of negligence and causation (substantial factor) on the part of Dr. Culbertson are imputed to their employer, Respondent The Permanente Medical Group, Inc., under the doctrine of Respondeat Superior. The Arbitrator makes such findings against Respondent The Permanente Medical Group, Inc. in this action.

IX. DAMAGES

Nurse Girtz was clearly in the course and scope of her employment with The Permanente Medical Group, Inc., when she treated and cared for Mr. Flach on March 7, 2018 and Respondent The Permanente Medical Group, Inc. never denied that she was an employee and defended her actions (and omission) at the Hearing. Based on the findings made that she breached the nursing standard of care and was thereby negligence, and that such negligence was a substantial factor in causing Mr. Flach's death, these findings were imputed to her employer, Respondent The Permanente Medical Group, Inc. and such Respondent is vicariously liable for the harm caused by the negligence of Nurse Girtz.

Dr. Culbertson was clearly in the course and scope of her employment with The Permanente Medical Group, Inc., when he treated and cared for Mr. Flach on March 7, 2018 and Respondent The Permanente Medical Group, Inc. never denied that he was an employee and defended his actions (and omission) at the Hearing. Based on the findings made that he breached the standard of care for an Internal Medicine Specialist and was thereby negligence, and such negligence was a substantial factor in causing Mr. Flach's death, these findings were imputed to his employer, Respondent The Permanente Medical Group, Inc. and such Respondent is vicariously liable for the harm caused by the negligence of Dr. Culbertson.

The rule of Respondeat Superior is familiar and simply stated: an employer is vicariously liable for the torts of its employees committed within the scope of the employment. CACI 3701 and CACI 3703.

Based upon the findings made against both Nurse Girtz and Dr. Culbertson noted above, and such findings having been imputed to their employer, Respondent The Permanente Medical Group, Inc., and Respondent The Permanente Medical Group, Inc. having been found to be vicariously liable for the negligence of both Nurse Girtz and Dr. Culbertson, and such negligence of each of them having played a substantial factor in causing Mr. Flach's death, therefore, Respondent The Permanente Medical Group, Inc. must pay for the harm (damages) resulting from the death of Mr. Flach.

CACI 3921 is the main governing wrongful death damage instruction and provides guidance in this case. With the "fill-ins" completed and the instruction otherwise tailored for this case, it states:

"If you decide that Claimants Christina Flach, Dylan Flach, Madison Flach, Noah Flach and Hannah Flach have proved their claims against Cynthia Girtz, RN, John Culbertson and The Permanente Medical Group, Inc., for the death of Kenneth Flach, you also must decide how much money will reasonably compensate Claimants for the death of Kenneth Flach. This compensation is called "damages." Claimants do not have to prove the exact amount of these damages. However, you must not speculate or guess in awarding damages. The damages claimed by Claimants fall into two categories called economic damages and noneconomic damages. You will be asked to state the two categories of damages separately on the verdict form. Christina Flach, Dylan Flach, Madison Flach, Noah Flach and Hannah Flach claim the following economic damages: 1. The financial support, if any, that Kenneth Flach would have contributed to the

family during either the life expectancy that Kenneth Flach had before his death or the life expectancies of Claimants, whichever is shorter; 2. The loss of gifts or benefits that Claimants would have expected to receive from Kenneth Flach; 3. Funeral and burial expenses; and 4. The reasonable value of household services that Kenneth Flach would have provided. Your award of any future economic damages must be reduced to present cash value. Claimants also claim the following noneconomic damages: 1.The loss of Kenneth Flach's love, companionship, comfort, care, assistance, protection, affection, society, moral support; 2. The loss of the enjoyment of sexual relations (re Christina Flach); and 3. The loss of Kenneth Flach's training and guidance. No fixed standard exists for deciding the amount of noneconomic damages. You must use your judgment to decide a reasonable amount based on the evidence and your common sense. For these noneconomic damages, determine the amount in current dollars paid at the time of judgment that will compensate Claimants for those damages. These damages should not be further reduced to present cash value, because that reduction should only be performed with respect to future economic damages. In determining Claimants' loss, do not consider: 1. Claimants' grief, sorrow, or mental anguish; Kenneth Flach's pain and suffering; or 3. The poverty or wealth of Claimants. In deciding a person's life expectancy, you may consider, among other factors, the average life expectancy of a person of that age, as well as that person's health, habits, activities, lifestyle, and occupation. According to the CACI Life Expectancy Table 2 (male) and Table 3 (female), the average life expectancy of a 54 year-old male is 26.5 years, such as Kenneth Flach, and the average life expectancy of a 52 year-old female, such as Christina Flach, is 31.6 years. [The Arbitrator recognizes that the Claimant adult children all have much longer life expectancies than 26.5 years.] This published information is evidence of how long a person is likely to live but is not conclusive. Some people live longer, and others die

sooner. ***In computing these damages, consider the losses suffered by all Claimants and return a verdict of a single amount for all Claimants. The judge will divide the amount among the Claimants.***

Recovery for wrongful death is not restricted to only elements of an ascertainable economic value, such as loss of household services or earning capacity, but also includes the monetary value of such factors as lost comfort, society, companionship, care and protection. Under Code of Civil Procedure section 377.61, damages for wrongful death are measured by the financial benefits the heirs were receiving at the time of death, those reasonably to be expected in the future, and the monetary equivalent of loss of comfort, society, and protection and so forth.

In an action for the death of a person caused by the wrongful act or neglect of another, damages may be awarded that, under all the circumstances of the case, may be just. The damages in a wrongful death action may include compensation for the financial benefits plaintiff was receiving from the decedent at the time of death and those reasonably to be expected in the future, such as loss of earning capacity or loss of household services.

As a general matter, damages for wrongful death are measured not only by the financial benefits the heirs were receiving at the time of death, but those reasonably to be expected in the future. An acceptable way to show how much money would have been available for the support of a decedent's wife and children is to show what the decedent probably would have earned during the remainder of his life and to deduct from that amount his personal maintenance expense and the amount he would have spent on other things.

CACI Instruction 3903D defines the loss of earning capacity in a personal injury, rather than wrongful death, case but is helpful in measuring damages in a wrongful death case, *as long as there is an application of personal consumption of the decedent*. 3903D states:

"The loss of ability to earn money as a result of the injury, the plaintiff must prove: 1) that it is reasonably certain that the injury plaintiff sustained will cause him to earn less money in the future than he otherwise could have earned; and 2) the reasonable value of that loss to him. In determining the reasonable value of the loss, compare what is reasonably probable that plaintiff could have earned without the injury to what he or she can still earn with the injury. Consider the career choices that plaintiff would have had a reasonable probability of achieving. It is not necessary that he/she have a work history."

This instruction would be modified to deduct the decedent's personal consumption from the future earnings.

A. Claims made by Christina Flach

In this action, **Claimant Christina Flach**, as the Surviving Spouse of Kenneth Flach, claims **Noneconomic** damages based on the following losses:

1. The loss of Kenneth Flach's love, companionship, comfort, care, assistance, protection, affection, society and moral support;

2. The loss of the enjoyment of sexual relations;

3. The loss of Kenneth Flach's training and guidance.

In this action, **Claimant Christina Flach,** as the Surviving Spouse of Kenneth Flach claims the following **Economic** damages:

1. The financial support, if any, that Kenneth Flach would have contributed to her during either the life expectancy that Kenneth Flach had before his death or the life expectancy of Christina Flach, whichever is shorter;

2. The loss of gifts or benefits that Christina Flach would have expected to receive from Kenneth Flach;

3. The reasonable value of household services that Kenneth Flach would have provided.

B. Claims made by the four Adult Children of Kenneth Flach

In this action, the four **Claimant Adult Children** of Kenneth Flach, each claim **Noneconomic** damages based on the following losses:

1. The loss of Kenneth Flach's love, companionship, comfort, care, assistance, protection, affection, society and moral support;

2. The loss of Kenneth Flach's training and guidance.

In this action, the four **Claimant Adult Children** of Kenneth Flach each claim the following **Economic** damages:

1. The financial support, if any, that Kenneth Flach would have contributed to each of them during either the life expectancy that Kenneth Flach had before his death or the life expectancies of each Adult Child, whichever is shorter;

2. The loss of gifts or benefits that each of the Adult Children would have expected to receive from Kenneth Flach;

C. Non-Economic Damages

The Arbitrator found that there was no Institutional Negligence. However, the Arbitrator found professional negligence on the part of Nurse Girtz and Dr. Culbertson, licensed health care providers, employed on March 7, 2018 by Respondent The Permanente Medical Group, Inc., which is responsible for their conduct and is liable herein for damages caused by their professional (medical) negligence. California Civil Code Section 3333.2, in effect since 1975, and unsuccessfully challenged in the California Supreme Court many times, limits the total

amount of noneconomic damages in this professional negligence medical malpractice wrongful death action to a combined total for all Claimants in the amount of $250,000.00.

Kenneth Flach and Christina Flach were happily married and expecting to spend the rest of their natural lives together. They were married for eight years and were true soul mates. They were deeply in love, enjoyed each other's company and kept each other young. They had a beautiful, wonderful relationship as evidenced by the testimony of Christina Flach, as well as photos exhibits submitted at the Hearing. They had a deep appreciation for one another. Christina Flach testified that her husband was her best friend; was fun, smart and supportive; and was amazing with his kids and her kids. Kenneth Flach always brought a smile to her face and a twinkle in her eye. They traveled the world together. They both had a strong interest in tennis. They attended tennis tournaments all over, including the Davis Cup, Wimbledon, ATP Tournaments and other tennis venues. Kenneth Flach was a former world champion tennis player and Mrs. Flach was a very good tennis player in her own right, so their interests strongly overlapped.

As for the four Claimant Adult children of Kenneth Flach, namely, Dylan Flach, Madison Flach, Noah Flach and Hannah Flach, they all were very close to their father. They all moved from the Midwest to be with him in Marin County. Each enormously enjoyed his company and spent countless hours with him, talking, listening to music together, going to concerts and sporting events, playing sports together, celebrating birthdays and holidays together, watching TV and just being, otherwise, together. He was kind, thoughtful, welcoming, understanding and very generous to them with both his advice and his financial support. He was their hero, their model, their north star, their counselor, their best cheer leader and their confidant. As with his spouse, Christina Flach, the Adult Children's father, Kenneth Flach, was

everything to them. They deeply loved him, as he deeply loved them. They each had a very special relationship with him.

Based on the evidence, the Arbitrator determines that Claimants, as a group, are entitled to the maximum amount of noneconomic damages as allowed by law in this action, i.e., the sum of $250,000.00. **The Arbitrator divides this amount as follows:**

1. **To Claimant Christina Flach the sum of $125,000.00;**
2. **To Claimant Dylan Flach the sum of $31,250.00;**
3. **To Claimant Madison Flach the sum of $31,250.00;**
4. **To Claimant Noah Flach the sum of $31,250.00;**
5. **To Claimant Hannah Flach the sum of $31,250.00;**

D. Economic Damages

Christina Flach claims she has sustained economic damages for loss of support, loss of household services, loss of gifts and loss of benefits. She and the Adult Children claim that Mr. Flach had signed a contract in mid-February 2018 with the Charles Window and Door Company and that he would have had steady income from this job. Mrs. Flach also claims loss of support stemming from loss profits of the San Rafael restaurant Lil' Best Porkhouse, stating that she had to close the restaurant upon the death of her husband. In addition, Mrs. Flach and the Adult Children claim Mr. Flach would have had significant earnings as a golfer on the senior tour, if he chose to do so. Also, Mrs. Flach and the Adult Children claim that Mr. Flach was a former tennis champion and tennis great and would have been a sought-after commodity in the tennis world. They claim Mr. Flach would have earned significant amounts of money through endorsements, clinics, exhibitions, appearances, teaching, coaching and through other tennis endeavors, generally.

These Economic Damages include loss of financial support to each of them and loss of gifts and benefits to them. They also include damages for Loss of Household Services to Mrs. Flach.

***Charles Window and Door Company**

On February 18, 2018, three weeks before his death, Mr. Flach signed an employment agreement with Charles Window & Door Company as a project manager. At the time of his death, he was working full time with an annual base salary of $60,000.00, plus a bonus that would be no less than an additional 10% annually. In addition, he was receiving health insurance benefits and other benefits. Mrs. Flach indicated that this job was a "temporary measure," as the two of them needed a positive income flow to stabilize their finances until more permanent changes could be made. Nevertheless, this was good job with benefits.

***Restaurateur and Restaurant Business**

In 2011, Mr. Flach and Mrs. Flach decided to become owners and partners together in a restaurant business Best Lil' Porkhouse, which they owned through an LLC [Best Lil Porkhouse, LLC]. They created this LLC on July 15, 2011 for that purpose of operating a restaurant. It was Mr. Flach's concept and derived from his love of barbecue. For a while Mr. Flach devoted time to both his Rolling Hills tennis position and to opening a restaurant. Thereafter, he left Rolling Hills to devote full time to their restaurant business, which soon became three restaurants. Apparently, Mr. Flach did everything for the first restaurant: he created the menu and the recipes; he built the restaurant out; he hired the people; he got the vendors and so on.

The first location for the Best Lil' Porkhouse restaurant was in San Rafael, California. It opened in July 2012. Mr. Flach's son, Dylan, came from the mid-west to help

manage it. Despite Mrs. Flach's statement that it performed well, that was not the case. Based upon the testimony for the Hearing by a CPA, the Best Lil' Porkhouse restaurant had a net loss of $98,214.00 for 2012.

The Flachs then open a restaurant in 2013 in Corte Madera, California in the former space of Max's restaurant and bar.

In 2014, the Flachs opened their third restaurant in Alameda, California.

Mrs. Flach supported the restaurant venture with moral support, financial investment and interior decorating. She was not involved in the management of the restaurants, hiring or firing of employees or doing any of the accounting or /tax return tasks. Mr. Flach ran the restaurants and made the decisions related to running them.

At some point in the operation of the restaurant in Corte Madera, the Flachs hired a consultant to advise them as to what improvements could be made. The consultant thought the space was too large, there were too many employees, the restaurant was only half-full with customers and the costs of the supplies (food) were too high and so forth. When their lease ended after two years, the Flachs did not search for another location and closed this restaurant in Corte Madera in 2016 for good. That left the Alameda and San Rafael Restaurants in operation.

Apparently, the Flachs hired a manager for the Alameda restaurant who, unbeknownst to them, embezzled large sums of money, stopped paying the rent, stopped paying the payroll taxes and forged false weekly reports. The Flachs were unaware of the manager's dishonesty until Mr. Flach received a call that the rent had not been paid. The news shocked and devastated Mr. Flach and precipitated the closing of the Alameda restaurant in 2017. The Flachs found another restaurant group to assume the 10-year lease for the Alameda restaurant site.

As noted, the tax returns for the Best Lil Porkhouse LLC **in 2012** showed Gross Sales of $200,150 and a **net loss of $98,214**. Although the tax returns for the business in 2014 Gross Sales of $2,016,064.00, the returns showed the business only had a **net profit of $1,723**. In **2015**, the amended tax returns showed Gross Sales for the business of $2,789,565.00, yet the business showed a **net loss of $57,153.** In **2016**, the tax returns showed Gross Sales for the business of $450,750.00 and the business showed a **net loss of $8,390**. These figures do not reflect the unremitted sales taxes that had not been paid during this period. Had those taxes been paid, the losses would have been greater for 2015 and 2016 and there would not have been any profit for 2014. In reality, the LLC was losing money. The tax returns for 2017 and 2018 were not produced. A CPA who reviewed the financial data for the business for those years opined that the LLP was losing money.

It is the Arbitrator's view that, at least by February of 2018, and probably sooner, Mr. Flach became disenchanted about being a Restauranteur and maintaining this business. The San Rafael restaurant was probably losing money or, at best, showed only a very meager profit. As noted above, on February 18, 2018, three weeks before his death, Mr. Flach signed an employment agreement with Charles Window & Door Company as a project manager, to help Mr. Flach and Mrs. Flach "create a positive income flow." It is the Arbitrator's view that, at this time, both Mr. and Mrs. Flach were also quite concerned and worried about their LLC and the restaurant operation, because they knew or anticipated that the State of California, California Department of Tax and Fee Administration, had filed, or was in the process of filing, a tax lien against their LLC in the amount of $557,142.67, for unpaid sales taxes stemming back to 2013. The LLC (restaurant) would have been subject to ongoing levies and scrutiny and it would have taken an enormous effort by the LLC (restaurant) to satisfy this lien. In the Arbitrator's view,

more likely than not, by the time Mr. Flach was searching for a new job in the early part of 2018, both Mr. and Mrs. Flach were thinking of closing the restaurant in San Rafael, due to its history of losing money, the prospects of pumping more their money into the operation and the intimidating huge tax lien. In the Arbitrator's view, and the Arbitrator so finds, more likely than not, had Mr. Flach survived his illness in March of 2018, Mr. and Mrs. Flach would have closed the Best Lil' Restaurant in San Rafael in the spring of 2018 due to its financial burden and their emotional distress. Claimant Christina Flach admits as much in her Closing Brief: "the combination of inexperience in managing restaurants and an embezzler wounded the business to the point where it failed." Therefore, more likely than not, there would no longer have been a restaurant for Mr. Flach to manage or Dylan Flach to manage and the Arbitrator so finds. Had Mr. Flach survived his illness, there would not have been any "lost profits" from this restaurant business, only losses, and the Arbitrator so finds. [The tax lien still existed at the time of the Arbitration Hearing; the amount due had increased - the sum due was $634,071.09. The Statue of Limitations on this lien had not run, and will not run, anytime soon. See California Revenue & Taxation Code section 19255. In addition, the Arbitrator does not find, as credible, the documents submitted for the two month period of March and April 2018 for the San Rafael restaurant. (Exhibits 305 and 306.) These isolated, unaudited, informally prepared, one page each "Sales and Expenses" documents submitted by Claimants Adult Children are not reliable in predicting the success of the restaurant. For the month of March, there is no entry for "Sales Tax Payments" or 'Insurance.' For April, there is a handwritten note "Adan, myself and Luis not paid." This remark indicates that the operation did not have sufficient funds to pay its employees. In addition, there were no tax returns submitted for 2017 and 2018. As noted, the

only CPA who reviewed the financial records indicated this restaurant business lost money practically the entire time it was in existence.]

***Touring Golfer on Senior Tour**

For many years prior to his death, Mr. Flach enjoyed playing golf. He was very passionate about it. He hoped to improve his golf game to the point where he would be able to join the senior tour, known now as the Tour of Champions, and earn money in professional golf. He allegedly would have needed only a year of intense practice to do so. There is no doubt that Mr. Flach was an excellent tennis player and his many important championships reflect the same. In considering all the evidence, more likely than not, Mr. Flach would not have achieved the level of play necessary to earn money on the Senior (golf) Tour, despite his enthusiasm and athletic prowess. More likely than not, Mr. Flach would have practiced for a year and come to the realization that his potential golf earnings were illusory and that he would not have sufficient golf winnings to sustain himself. The recorded golf scores for his 170 rounds of golf, between 2011 through 2018, showed that his average score per round was 80.11. His average score per round over the years had not improved. His handicap was a consistent 8. The average PGA Tour of Champion Scoring Average was 71.5 in 2018. Although Mr. Flach was a good golfer, and might have become a very good golfer with a few years of practice, in the Arbitrator's view, Mr. Flach would not have become an elite golfer. More likely than not, he would not have become eligible to play in the Tour of Champions. After a year of intense training and playing golf, more likely than not, Mr. Flach would have seen that he could not make money playing golf and would have changed his focus. Along with working at Charles Window and Door, he would have likely returned to tennis, where he had been a world champion, professional tennis player, tennis teacher, tennis coach, tennis director and T.V tennis commentator.

***Tennis**

The evidence showed that Mr. Flach attended Southern Illinois University from 1981 to 1983 as a physical education major. While at Southern Illinois University, he was a three-time NCAA Division II singles and doubles tennis champion. In 1983, he was a Division I singles and doubles All American. At Southern Illinois he was the number one player in the country in Division II in singles with also with his partner in men's doubles, Robert Seguso.

Mr. Flach and Mr. Seguso were the number one team in the country in 1983 in college and turned pro in late 1983.

By any measure, Mr. Flach had a brilliant pro tennis career. By 1985 Mr. Flach was ranked number one in the world in Men's Doubles. He and Mr. Seguso won both the Italian Open and US Open in 1985. That same year they won eight tournaments and became ranked number one in the world. Mr. Flach also won championships in mixed doubles with partner Kathy Jordan at Wimbledon in 1986 and at the French Open in 1986. Mr. Flach and Robert Seguso won the Men's championship at Wimbledon in 1987, came in as runners-up at the US Open in 1987, were the champions again in Men's Double at Wimbledon in 1988, won an Olympic Gold Medal in the 1988 at the Seoul Olympics in Korea and were the runners-up in the US Open in 1989. With a new doubles' partner, Rick Leach, Mr. Flach won the US Open in 1993.

Mr. Flach and his partner, Robert Seguso, were very popular in England and won a number of 'warmup tournaments' for all top ranked double players. From 1984 to 1991 they were by far the most popular team in the world. They were on television regularly, winning events around the world. During that period, they were on television about twenty to twenty-five times annually, playing in the finals.

In the midst of their careers, Mr. Flach and Mr. Seguso played not only major tournaments, but also played on the ATP Tour in tournaments in Rome, Boston, Indianapolis, Los Angeles, Hong Kong, Taipei and many more world ATP tournament stops.

Mr. Flach and Mr. Seguso were members of the United States Davis Cup team from 1985 to 1991 under Captain Arthur Ashe and went undefeated throughout the world in Davis Cup play. Mr. Flach was also a member of the US World Team Cup from 1985 to 1989 and, as noted, a member of the US Olympic team in 1988.

Mr. Seguso retired in 1992 but Mr. Flach continued to play well in competitive competition.

Throughout the 1990s, both Mr. Flach and Mr. Seguso participated in many tennis corporate events. Mr. Flach participated in these events longer than Mr. Seguso did.

Together they participated in ex-champions' reunions, the Grand Slam activities, competed in the "over-35" and "over 45 tournaments" and participated in clinics, outings and other tennis related events.

At the end of his competitive tennis career, Mr. Flach became the USTA National Coach in 1996 and 1997, developing young players and running training camps for the top USTA juniors.

Mr. Flach became Vanderbilt University's head men's tennis coach in 1997. Under his tutelage, Vanderbilt University won its first ever SEC championship and Vanderbilt reached the NCAA team championship finals in 2003. That same year, Mr. Flach was named the SEC Coach of the year. Mr. Flach also had the responsibility for managing the budget and running Nike summer tennis camps while coaching at Vanderbilt.

1 Mr. Flach left Vanderbilt University in 2005 to accept another tennis position at
2 the Naples Bath and Tennis Club in Naples, Florida. In eventually oversaw the entire club,
3 including the tennis operations. He left the Naples Bath and Tennis Club in 2007 to become the
4 tennis Director at the Highlands in St. Louis, Missouri in 2008, where he remained through 2009.
5
6 Mr. Flach and Mrs. Flach married in 2010 and remained husband and wife until
7 his death on March 12, 2018. Once moving to California in 2010, Mr. Flach continued to teach
8 tennis and was the teaching pro at Rolling Hills Club in Novato California, where he was able to
9 earn directly from those he taught there. Thereafter, he also taught and held clinics at the Harbor
10 Point Tennis Club in Tiburon California. The manager of that club estimated that Mr. Flach
11 earned about $75,000.00 annually, the money coming directly from the members he taught.
12
13 *Based upon the evidence, the Arbitrator finds, more likely than not, Mr. Flach
14 would have abandoned his quest to become a pro golfer on the Tour of Champions after one
15 year, despite his passion, intensive training and practice. Had he lived, he would have been only
16 working for the Charles Window and Door Company during this first year [April 1, 2018 to
17 March 31, 2019] and earning $60,000 per year with a 10% bonus. He would not have been
18 giving tennis lessons this first year, due to his devotion toward becoming a golfing pro. In his
19 second year [April 1, 2019 to March 31, 2020] and third year [April 1, 2020 to March 31, 2021],
20 he would still have been working for the Charles Window and Door Company fulltime. More
21 likely than not, his earnings in his second year at the Charles Window and Door Company
22 would have been $61,878 (base salary) plus a 10% bonus and his earnings in his third year at the
23 Charles Window and Door Company would have been $63,487 (base salary) plus a 10% bonus.
24 During his second year, he would have restarted giving tennis lessons, while working fulltime for
25 Charles Window and Door Company. He also would have done so in his third year. He would
26
27
28

have worked approximately 10 hours per week and earned $150.00 per hour. In addition, during his second year and third year, he would have also been laying the groundwork to enter the more lucrative part of the tennis world, thereby boosting his income. As he entered his fourth year [April 1, 2021], he would have quit his job with the Charles Window and Door Company and, more likely than not, embarked on a career doing work as a former tennis pro, world champion and tennis legend. Based upon the persuasive evidence presented at the Hearing, Mr. Flach, more likely than not, would have made appearances in exhibitions and given tennis clinics at the United States Tennis Association's high profile tennis tournaments on behalf of the corporate sponsors of those events. He would have also played exhibition sets of tennis and played "fun" sets with those chosen by the sponsors. In addition, he would have participated in "meet and greet" sessions with the clients of the corporate sponsors and given advice on playing tennis and how to improve one's game. He would have given private tennis lessons and coaching lessons to a select clientele who were willing to pay a significantly (high) rate ($250 per hour) for his services. He would have returned as a TV commentator for tennis events. All of this work would have continued at least through his entire working life expectancy.

*Considering all of the evidence, the Arbitrator is using Group Exhibit 42 as a reference and guide for Past Loss of Income, less consumption, as a Project Manager for Charles Window and Door Company for the period April 1, 2018 through April 1, 2021 (three years). The Arbitrator calculates and finds this amount to be $119,016. Using the same Group Exhibit 42 for Past Loss of Income, less consumption, as a Tennis Instructor for the period April 1, 2019 through April 1, 2021 (two years), the Arbitrator calculates and finds this amount to be $89,740. Using the same Group Exhibit 42 for Past Loss of Income, less consumption, as a former tennis pro and world champion doing corporate appearances, exhibitions, clinics, other corporate

events, TV commentating, high-end paying tennis lessons and the like, for the period April 1, 2021 through the date of the Arbitration Hearing on October 4, 2021 (approximately six months and 12 days), the Arbitrator finds the loss to be $117,000.

*The total amount of **Pass** Lost Income available for Claimants' support, gifts and benefits is **$325,756** [$119,016 + $89,740 + $117,000]. This amount is stated in, and as, present value.

Using Group Exhibit 42 as a reference and guide for Future Loss of Income, i.e., Future Loss of Earning Capacity, less consumption, the Arbitrator finds the total (undiscounted) amount of Future Loss of Income, i.e., Future Loss of Earning Capacity, less consumption, from October 1, 2021 (date of Arbitration hearing) to July 28, 2031 (end of life work expectancy) to be $2,047,764. The Present Day Discounted Future Value of such Future Loss of Income, i.e., Future Loss of Earning Capacity, less consumption, is **$1,786,544.**

The Arbitrator finds that Mr. Flach, had he lived, would have had a life expectancy of 26.5 years (from March of 2018), and have lived until year 2044. The Arbitrator also finds that Mrs. Flach and each of the Adult Children have life expectancies of more than 26.5 years.

Claimant Christina Flach's Amount for Past Loss of Support, Gifts and Benefits is $325,756 minus the total amount allocated to the Claimant Adult Children for Past Support, Gifts and Benefits as determined by the Arbitrator

Claimant Christina Flach's Amount for Future Loss of Support (Loss of Economic Capacity) Gifts and Benefits is $1,786,544 minus the total amount allocated to the Claimant Adult Children for Future Loss of Support (Loss of Economic Capacity), Gifts and Benefits as determined by the Arbitrator

. The Arbitrator now determines the loss of financial support, gifts and benefits to each Adult Child Claimant.

1. Financial Support, Gifts and Benefits to the Adult Children

a. Dylan Flach

Dylan Flach (Dylan) is the oldest child of Mr. Flach's previous marriage. He turned 30 years old just before Mr. Flach's death. He had been working as the manager or co-manager of the San Rafael Lil' Best Porkhouse restaurant for a number of years. He was earning about $40,000.00 per year at the time of Mr. Flach's passing in March of 2018. His basic claim is that Mr. and Mrs. Flach promised him that, if this restaurant was showing profits, he would benefit from any future profitability of this restaurant. If Mr. and Mrs. Flach reaped profits from the restaurant, then they would share such profits with him, by increasing his salary as manager to $80,000 per year. The problem with Dylan's claim is that the San Rafael restaurant was largely unprofitable, and Mr. and Mrs. Flach would have closed it in the spring of 2018, as fully described above. At that time, Dylan would have had to seek new employment at market rate for a restaurant manager. Since the San Rafael Lil' Best Porkhouse restaurant would have closed and such closure would have meant no future profits to Mr. and Mrs. Flach from this restaurant, they would have had no "benefits" in the form of an increased salary, much less any salary, to pass on to Dylan. Thus, the claim of loss of an increased salary for Dylan cannot be sustained and the Arbitrator makes such a finding.

In addition, Dylan claims that he put in "sweat equity" into the San Rafael Lil' Best Porkhouse restaurant business, in that he had been working as a manager of the restaurant at a salary below market. He expected, should the restaurant close in 2018, he would be compensated for such "sweat equity." One problem with this claim is that there is no legal basis

for it. Another problem is that, more likely than not, the LLC was broke in 2018 and there was no money to pay any such "sweat equity."

The Arbitrator finds that Dylan did not sustain any Past Loss of Support, Benefits or Gifts.

However, the evidence showed that Mr. Flach was very generous with his children. Based upon the evidence, the Arbitrator finds, more likely than not, had he survived, Mr. Flach would have given each child as gifts or benefits, including Dylan, the sum of $5,000 per year for twenty years, starting on October 1, 2021 to October 1, 2041. The Arbitrator selects the commencement date of October 1, 2021, because Mr. Flach would have been earning significant amounts of money by that time - 3.5 years from the date of his recovery from his illness (April 1, 2018), had he not died. Mr. Flach would have had the financial capability to make such gifts or benefits. The total accumulated sum would have been $100,000 over these twenty years. The present day (date of the Hearing – October 4, 2021), discounted value of such amount, using a discount rate of 1.75%, is $70,487.

Summary of Damages for Dylan Flach:

*** The Arbitrator does not find a Past Loss of Support for Dylan Flach.**

*** The Arbitrator finds that Dylan's discounted Present Day Value of his Future Loss of Benefits and Gifts is $70,487.** [The Arbitrator recognizes that the future periodic benefits of $100,000 most likely would have been paid by Mr. Flach over a 20 year period of time.]

***The Arbitrator finds Dylan Flach's total loss for both Past Loss of Support, Benefits and Gifts and the discounted Present Day Value of his Future Loss of Support, Benefits and Gifts is $70,487.**

b. Madison Flach.

Madison Flach is the second child of Kenneth Flach from his first marriage. She was 27 years old when Mr. Flach died. Mr. Flach had been paying her automobile insurance premiums for many years and there is an implied expectation that these payments would not abruptly end had Mr. Flach survived his illness. More likely than not, Mr. Flach, had he lived, would have continued to pay these car insurance premiums for two more years. Her car insurance premiums were $1,320 per year. **Her loss of Past Support is, therefore, $2,640 and the Arbitrator so finds**. There is no loss of future support and the Arbitrator so finds**.**

As with the other Adult Children, and as explained above, Madison would likely have also received from Mr. Flach, had he lived, the sum of $5,000 per year for twenty years in gifts and benefits, starting October 1, 2021 and ending October 1, 2041.

Summary of Damages for Madison Flach:

*****The Arbitrator finds that Madison Flach's Loss of Past Support is $2,640**.

***The Arbitrator finds that Madison Flach's discounted present day value of her Future Loss of Gifts and Benefits is $70,487.** [The Arbitrator recognizes that the future periodic benefits of $100,000 most likely would have been paid by Mr. Flach over a 20 year period of time.]

*****The Arbitrator finds Madison Flach's total loss for both Past Loss of Support, Benefits and Gifts and the discounted Present Day Value of her Future Loss of Support, Benefits and Gifts is $73,127 [$2,640 + $70,487]**

c. Noah Flach

Noah Flach ("Noah") is the third child of Kenneth Flach from his former marriage. He was 26 years old at the time of Kenneth Flach's passing.

In 2013 Noah moved from Tennessee to Marin County, California to be with his father and siblings. Before coming west, he had completed two years of studies at the University of Tennessee [UT] in Knoxville. He applied for and signed student loan agreements to obtain the funds necessary to pay his tuition for these two years, apparently in the total sum of $32,000 [$8,000 per semester for 4 semesters]. His father co-signed these loans. Noah also took out a student loan for $8,000 for a 5th semester at UT and his father co-signed that loan too. Noah did not complete this 5th semester at UT. His transcript record for that semester showed he had withdrawn from the school.

Once Noah had moved to Marin County, he worked full-time for about three years. At some point, he was required to start making payments on his student loans for semesters 1 through 4 at UT. Whatever amount he could not pay on these loans, his father paid the difference. He had an understanding with his father, that his father would help him pay all of these loans over time.

In 2016, Noah thought he would like to return to college and complete his degree. His father strongly encouraged him to do so. He told his father that he could not afford to pay the tuition or for living expenses and would need to take out student loans and get help with his living expenses. His father told him to return to school, that he would help him with the living expenses and that they would work something out in the future ("down the road"), when the loans became due. Noah decided to go to San Francisco State University in fall of 2016 to complete his 3rd and 4th years of college. San Francisco State told him that in order to enroll, he needed to obtain his transcript from UT. When Noah contacted UT and asked it to release his transcript to San Francisco State, UT advised him that he needed to repay his 5th semester loan $8,000), because he had withdrawn (and not received credit). His father immediately paid the

$8,000 necessary to release his transcript from UT to San Francisco State. Noah enrolled at San Francisco State and obtained student loans for the next two years to pay the tuition in the sum of $8,400 per year (total of $16,800). As before at UT, his father co-signed these student loans for San Francisco State.

While at San Francisco State, Noah was working from time to time at the family restaurants and using the car to drive for Uber. His father had leased the car for him. His father made the lease payments and paid for the car's insurance. His father also helped pay for his university required books, his rent, his cell phone and other living expenses. He graduated from San Francisco State University in May of 2018, about two months after his father died. In one of the last conversations he had with his father, he had mentioned to him that he was considering going to graduate school, also at San Francisco State University, that coming fall and obtaining a Master of Science Degree in Business Analysis. His father was happy for him. He did not have a specific conversation with his father about any student loans for graduate school, but he expected that his father would assist him in repaying any such student loans. He did obtain the loans for his Master's program, which amounted to $44,000 [$22,000 per year]. The two year program was intense, requiring approximately 60 hours a week of his time, and the business school advised the students not to engage in any outside employment. He lived in a flat close to the university. Apparently, he had to borrow money for his living and car expenses, approximately $2,000 per month for his 1st year of graduate school. During his 2nd year, he had an internship with the County of Marin. He worked about 25 hours per week and received about $18.00 per hour. He lived with his biological mom in San Rafael during his 2nd year. When he graduated from San Francisco State with his Master's degree in May of 2020, he sought and received

employment with the County of Marin and his salary was $78,000 per year with significant benefits. He is now financially independent.

In this litigation, Noah indicates that he will be satisfied if he just receives financial support (or benefits) that he is seeking in the form of repayment of his graduate school student loans in the amount of $44,000 and his two years of living expenses while in grad school amounting to $52,647, for a total of $96,674. If he receives this support (benefits) for graduate school, he will not seek support in the form of repayment of his $65,000 in outstanding and mostly unpaid student undergraduate loans, for which his father was a co-signer.

The evidence does show that Mr. Flach was the co-signer of Noah's student undergraduate loans in the sum of $65,000 and that Mr. Flach indicated to Noah that he would help Noah pay these loans "down the road." Mr. Flach did immediately pay UT for a loan in the sum of $8,000 in 2016, when Noah did not have the money. Mr. Flach also helped Noah, when Noah could not pay the entirety of his student loan installment payments, when they were due. Mr. Flach paid the difference that Noah could not pay.

More likely than not, if Mr. Flach had been alive, he would have paid for Noah's living expenses during his 1st year of graduate school in the amount of **$26,323** [2,194 per month] and the Arbitrator so finds. Noah was not working that year and the school discouraged it.

More likely than not, Noah would have lived with his father or biological mother during his 2nd year of graduate school. He was working as an intern for the County of Marin and was making about $1,800 per month. His father would, more likely than not, have made-up the difference of $394 per month or **$4,728** for that year and the Arbitrator so finds.

The Arbitrator finds that Noah's Past Loss of Support (re Living Expenses) is $31,051 [$26,323 + $4,728].

With respect to the $65,000 in unpaid interest bearing *undergraduate* student loans, more likely than not, Mr. Flach, had he been alive, would have *helped* Noah make these loan payments, when due, over the years. More likely than not, over the life of these loans, Mr. Flach would have paid 50% of the total amount, or **$32,500** (present day value).

With respect to the $44,000 in unpaid interest bearing *graduate* student loans, more likely than not, Mr. Flach, had he been alive, would have *helped* Noah make these loan payments, when due, over the years. More likely than not, over the life of these loans, Mr. Flach would have paid 50% of the total amount, or **$22,500** (present day value)

The present day value of Mr. Flach's 50% (reimbursement) payment of these periodic, interest bearing student loans is **$55,000** [$32,500 + $22,500.] If these loan payments (reimbursements) were paid overtime, the accumulative amount of periodic payments over the life of the loans would be much greater than $55,000 today. And the amount of $55,000 is needed today to pay these interest bearing loans over ten years. More likely than not, the amortized monthly payment for a $55,000 loan at 3.75 % over ten years would be $66,040.80 or $550.34 per month for 10 years. **The Arbitrator finds the present day discounted value of Noah's Future Loss of *Support* (re Student Loan Reimbursement) is $55,000.**

As with the other Adult Children, and as explained above, Noah would likely have also received from Mr. Flach, had he lived, the sum of $5,000 per year for twenty years as Gifts and Benefits, starting October 1, 2021 and ending October 1, 2041. **The discounted present day value of this Future Loss of Gifts and Benefits is $70,487.**

*** The Arbitrator finds that Noah Flach's Past Loss of Support (re Living Expenses) is $31,051 [$26,323 + $4,728].**

*** The Arbitrator finds the present day discounted value of Noah's Future Loss of Support (re Student Loan Reimbursement) is $55,000.** [The Arbitrator recognizes that the future periodic payments for the Student Loans most likely would have been paid by Mr. Flach over a 10 year period of time.]

*** The Arbitrator finds the present day discounted value of Noah's Future Loss of Gifts and Benefits is $70,487.** [The Arbitrator recognizes that the future periodic benefits of $100,000 most likely would have been paid by Mr. Flach over a 20 year period of time.]

***The Arbitrator finds Noah Flach's Total Loss for Past Loss of Support, Benefits and Gifts and the discounted present day Value of his Future Loss of Support, Benefits and Gifts is $156,538** [$86,051 + $70,487]

d. Hannah Flach

Claimant Hannah Flach (Hannah) was born on March 26, 1997. She is the fourth child of decedent Kenneth Flach. He died two weeks before her 21st birthday. Hannah claims $195,224 in loss of support, gifts and benefits.

Hannah first came to live in Marin County in 2011 at age 14 and lived with her father. She attended Tamalpais High School in Mill Valley, California. In 2013 she returned to the St. Louis, Missouri area and lived with her mother. She graduated early from a high school in St. Louis in 2014. She returned to California in 2016 in order to be with her father and her siblings. She lived with one of her brothers when she arrived and then eventually found her own apartment in San Rafael, within walking distance of the family's restaurant in that city. She

enrolled at the College of Marin in Kentfield, California in 2016. Her Father personally encouraged her to attend college and even went with her to the registrar's office at the College of Marin to pay the tuition on her behalf. She was working part-time at the family's San Rafael restaurant while attending classes at the College of Marin. Her father paid her in cash for her work at the restaurant in San Rafael and she also received tips from the customers. She used the tips and cash to pay for some of her general living expenses, but her father essentially paid for all of her major expenses, including living expenses (rent at $1,000 per month), car ($276 per month), car insurance ($200 per month), health insurance ($225 per month), tuition at College of Marin ($670 per semester, equivalent to $150 per month), books for college ($225.00 per semester, equivalent to $56 per month) and cell phone expenses ($110 per month). All these major expenses totaled $2,017 per month. She had a reasonable expectation that her father would continue to pay her tuition in college and a major part her living expenses. Her father was the one who encouraged her go beyond an AA degree from the College of Marin and to get a bachelor's degree. He knew of her plan to eventually transfer from the College of Marin to San Francisco State University. She had specifically talked to him about this transfer before he unexpectedly died. He was very supportive of her desire to get a university degree. After her father's death in March of 2018, she took a break from her studies.

There is no evidence when Hannah completed her break. The record is silent on this point. Had her father been alive, more likely than not, Hannah would have finished her spring semester at the College of Marin in June of 2018 and her father would have continued to pay her major expenses. Hannah did not testify that she was attending the College of Marin (or another college) during the period from September of 2018 to August of 2020. There is no evidence what she was doing. Presumably, she was living in Marin County this entire time and

working full-time, making at least the average minimum wage of $14.75 per hour. This would have translated to $2,500 per month. She claimed her major monthly expenses in this timeframe, including tuition and books, for which her father was paying, was $2,117. Therefore, her own earnings during this two year period would have covered her own expenses and she would not have needed help from her father.

More likely than not, had her father been alive, he would not have been providing any support to Hannah in the timeframe of September 2018 to September 1, 2020, since she was not attending college and probably was working fulltime from September 1, 2018 to September 1, 2020.

However, more likely than not, had her father been alive, he would have paid for her living expenses for the months of April, May, June, July and August of 2018, since she was still in college. This amount is $10,585. **Hannah's Past Loss of Support re Living Expenses for the period from April 1, 2018 to September 1, 2018 is $10,585**.

After Hannah had taken a significant break in her studies for two years, she enrolled at San Francisco State University in August of 2020 and will graduate in 2024 with a Bachelor of Art's degree in Communications. Hannah will be 27 years old at the time of her graduation in the spring of 2024. The tuition at San Francisco State is $11,000 per semester or $22,000 per year. Hannah expected her father to pay for her university tuition and living expenses, because her father knew that she would not be able to afford those expenses. And, he had fully paid for her tuition at the College of Marin and was a co-signor of Noah's university student loans. So far, toward her tuition of $11,000 per semester at San Francisco State, she has received $8,000 per semester in student loans and $3,000 per semester in grants. She has to pay back the student loans but does not have to pay back the grants. She will continue to pay tuition

through loans and grants and incur living expenses until she obtains her BA degree in the spring of 2024.

For about a year or so prior to the arbitration hearing, seemly around the time she entered San Francisco State, *and 2.5 years after her father's death*, she was working 25 hours per week as a nanny. She is currently living with her biological mom in San Rafael. She previously had her own apartment.

In September of 2020, when she entered San Francisco State University, had her father been alive, more likely than not, he would have *helped* her by paying her major expenses: tuition, books, rent, car, car insurance, health care, cell phone and other major living expenses. Hannah's major living expenses during the period of September 1, 2020 to October 3, 2021 (Hearing date), while she was attending San Francisco State, were probably $1,923 per month or **$25,191** for these 13 months and three days. Had her father been alive at this time, she probably would have continued renting an apartment and incurred other major expenses, yet worked part-time to pay the balance of the expenses.as she had done, when she attended College of Marin. **Hannah's Past Loss of Support re Living Expenses for the period from September 1, 2020 to October 4, 2021 is $25,191.**

Hannah's Total Past Loss of Support re Living Expenses is $35,776 [$10,585 + $25,191].

Hannah's major living expenses during the period of October 4, 2021 (Hearing date) to October 3, 2022, while she is attending San Francisco State, will probably be $2,015 per month or $24,180 for that period. **The discounted present day value of her Living Expenses during this year from October 4, 2021 to October 3, 2022 is likely $23,764.**

Her major living expenses during the period of October 4, 2022 to October 2023 will probably be $2,116 per month or $25,392 for the year. **The discounted present day value of the living expenses during this year from October 4, 2022 to October 3, 2023 is likely $24,526.**

Her major living expenses during the period of October 4, 2023 to June 4, 2024 will probably be $2,201 per month or $26,412 for the year. **The discounted present day value of the living expenses during this year from October 4, 2023 to June 4, 2024 (completion of school) is likely $25,073.**

The present day value of her major living expenses while at San Francisco State University from October 4, 2021 (Hearing Date) to June 1, 2024 (Graduation Date) is $73,363 ($23,764 + $24,526 + $25,073). More likely than not, based upon the evidence, **Hannah would have been paying more of her expenses, but her father would have continued to pay 65% of her major expenses or $47,686**. **The Arbitrator finds that the present day discounted value of Hannah's Future Loss of Support re Living Expenses to be $47,686.**

Based upon the entirety of the evidence, Mr. Flach would have co-signed student loans for Hannah, while she was at San Francisco State University for four years (September of 2020 to June of 2024). Based upon the evidence, her tuition was $11,000 per semester, or $22,000 per year. She already has received, and probably will receive in the future, student grants in the amount of $3,000 per semester ($6,000 per year), thus lessening the amount per semester that she has needed to borrow, and will need to borrow in the future, in order to pay her tuition. This means that her student loan each semester is $8,000, or $16,000 per year (tuition minus grants). Over four years, her student loans will amount to $64,000 ($16,000 times 4). At the time of the Arbitration Hearing in October of 2021, she had already taken out loans to pay for

1 three semesters at San Francisco State University. This amount is $24,000 ($8,000 times 3).
2 From January 2022 through June of 2024, she will have taken out another $40,000 in student
3 loans to cover the five remaining semesters toward her degree ($8,000 times 5). Her father, had
4 he lived, more likely than not, would have co-signed these student loans. Although there may be
5 some increase in the tuition each year, there likely would also be a concomitant increase in the
6 grants. The differential between tuition and grants would probably remain constant, viz. at
7 $8,000. Accordingly, her student loans per semester will likely remain at $8,000.

9 As noted, more likely than not, had he been alive, Mr. Flach would have *helped*
10 Hannah pay for her San Francisco State University student loans, when due. These loans total
11 $64,000. This is the amount that is needed today to pay these interest bearing loans. If these
12 loans were paid overtime, the accumulative amount of periodic payments over the life of the
13 loans would be much greater than $64,000 today. More likely than not, the amortized monthly
14 payment for a $64,000 loan at 3.75 % over ten years would be $76,847 or $640.39 per month for
15 10 years. Based on all the evidence, more likely than not, had Mr. Flach been alive, he would
16 have contributed 50% toward payment of these loans, or **$32,000** (present value) and the
17 Arbitrator so finds.

20 **The Arbitrator finds the discounted value of the Total Future Loss of**
21 **Support for Hannah Flach is $$79,686 [$47,686** (living) + **$32,000** (student loans)**] and the**
22 **Arbitrator so finds.**

24 As with the other Adult Children, and as explained above, Hannah would likely
25 have also received from Mr. Flach, had he lived, the sum of $5,000 per year for twenty years as
26 Gifts and Benefits, starting October 1, 2021 and ending October 1, 2041. The discounted present
27 day value of this Future Loss of Gifts and Benefits is $70,487.
28

Summary of Damages for Hannah Flach:

*** The Arbitrator finds Hannah Flach's Past Loss of Support re Living Expenses is $35,776** [$10,585 + $25,191].

*** The Arbitrator finds that the present day discounted value of Hannah's Future Loss of Support re Living Expenses to be $47,686.** [The Arbitrator recognizes that the future payments for living expenses most likely would have been paid by Mr. Flach over a 2.65 year period, had Mr. Flach survived.

*** The Arbitrator finds that the present day discounted value of Hannah Flach's Future Loss of Support re Student Loans to be $32,000.** [The Arbitrator recognizes that the future periodic payments for the Student Loans most likely would have been paid by Mr. Flach over a 10 year period of time.]

*** The Arbitrator finds the present day discounted value of Hannah Flach's Future Loss of Gifts and Benefits is $70,487.** [The Arbitrator recognizes that the future periodic benefits of $100,000 most likely would have been paid by Mr. Flach over a 20 year period of time.]

***The Arbitrator finds Hannah Flach's Total Loss for Past Loss of Support, Benefits and Gifts and the discounted present day value of her Future Loss of Support, Benefits and Gifts is $185,949** [$35,776 + $47,686 + $32000 + $70,487]

2. Christina Flach.

* **Loss of Household Services**.

Considering all of the evidence, the Arbitrator is using Group Exhibit 42 as a reference and guide for Past and Future Loss of Mr. Flach's Household Services, less consumption, to Mrs. Flach. Mr. Flach would have performed Household Services until October

5, 2043. The Arbitrator finds the past loss of Household Services (from April 1, 2018 to October 4, 2021) to be to be **$46,344**. This amount is stated as present value. The Arbitrator finds the future loss of such Household Services to be **$483,157**. The present day, discounted value of such services is **$330,495**.

The sum total of the Past Loss of Household Services ($46,344) and the present day value of the Future Loss of Household Services) is **$376,839**. This is Mrs. Flach's loss of Household Services.

***Loss of Support, Loss of Benefits and Loss of Gifts**

Claimant Christina Flach's Past Loss of support, loss of gifts and loss of benefits is $325,756 minus the total sum of the amounts allocated to the Children Adult Children for Past Loss of Support, Gifts and Benefits as determined by the Arbitrator. Christina's amount is = $325,756 – [$0 + $2,640 +$31,051 + $35,766), which = $325,756 --$69,467= **$256,289**

Claimant Christina Flach's present day value of her Future Loss of Income, Gifts and Benefits is $1,786,544 **minus** the total sum of the present day value of the Loss of Future Support, Gifts and Benefits, of the four Adult Children Claimants as determined by the Arbitrator is $1,786,544 – [$70,487 +$70,487 +$125,487 + 149,093] which = $1,786,544 -- $315,554 = **$1,470,590**

Mrs. Flach's Past Lost of Support, Gifts and Benefits is $256,289

Mrs. Flach present day value of her Future Loss of Support is $1,470,590 .

IX. AWARD

A. Christina Flach

The Arbitrator awards to Claimant Christina the following amounts:

1. Noneconomic Damages in the amount of **$125,000**;

2. Past Economic Damages for Loss of Support, Gifts and Benefits plus Loss of Household Services in the sum of **$302.633** [$256,289 + $46.344]
3. Future Economic Damages for the present day value of Future Loss of Support, Gifts and Benefits plus Future Loss of Household Services in the sum of **$1,847,429** [$1,470,590 + $376,839]

Total Award = $2,275,062

The Arbitrator awards to Claimant Dylan Flach following amounts:

B. Dylan Flach

1. Noneconomic Damages in the amount of **$31,250**;
2. Future Economic Damages for the present day value of Future Loss of Gifts and Benefits in the sum of **$70,487**

Total Award = $101,737

The Arbitrator awards to Claimant Madison Flach following amounts:

C. Madison Flach

1. Noneconomic Damages in the amount of $31,250;
2. Past Economic Damages for Loss of Support in the amount of **$2,640;**
3. Future Economic Damages for the present day value of Future Loss of Gifts and Benefits in the sum of **$70,487**

Total Award = $104,377

The Arbitrator awards to Claimant Noah Flach following amounts:

D. Noah Flach

1. Noneconomic Damages in the amount of **$31,250**;
2. Past Economic Damages for Loss of Support in the amount of **$31,051**;

3. Future Economic Damages for the present day value of Future Loss of Support, Gifts and Benefits in the sum of **$125,487.**

Total Award = $187,788

The Arbitrator awards to Claimant Hannah Flach following amounts

E. Hannah Flach

1. Noneconomic Damages in the amount of **$31,250**
2. Past Economic Damages for Loss of Support, in the amount of **$35,776**;
3. Future Economic Damages for the present day value of Future Loss of Support, Gifts and Benefits in the sum of **$149,093**.

Total Award = **$216,119**

IT IS SO ORDERED

The Arbitrator Reserves Jurisdiction

February 9, 2022

Hon. Donald J. Sullivan
Judge of the Superior Court (Ret)
Neutral Arbitrator

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

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE:

I am employed in the County of Orange, State of California. I am over the age of 18 and am not a party to the within action. My business address is 1851 East First Street, Suite 1600, Santa Ana, California 92705.

On 2/11/2022 I served the **STATEMENT OF DECISION ISSUED FEBRUARY 9, 2022** on the following parties in the matter of **Christina Flach, et al. vs. Kaiser Foundation Health Plan, Inc., et al.** placing a true copy to all parties as follows:

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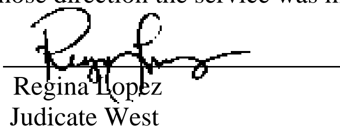
( )	BY U.S. MAIL:	I caused such envelope(s), with postage fully prepaid, to be placed in the U.S. Mail at Santa Ana, California.
( )	BY FACSIMILE:	I caused such document to be sent via facsimile to each person on the attached mailing list.
(X)	BY ELECTRONIC MAIL:	I caused such document to be sent via electronic mail to each person.
( )	BY PERSONAL SERVICE:	I caused such envelope to be delivered by hand to the office of the addressee.
(X)	STATE:	I declare under penalty of perjury under the laws of the State of California that the above is true and correct.
( )	FEDERAL:	I declare that I am employed in the office of a member of the bar of this Court at whose direction the service was made.

Executed on 2/11/2022 at Santa Ana, California.



Regina Lopez
Judicate West