Supreme Court No. 94713-9

COA No. 32652-7-III

SUPREME COURT
OF THE STATE OF WASHINGTON

ESTATE OF LORRAINE P. HENSLEY, BY AND THROUGH ITS Personal Representative, JESSICA WILSON and LORRAINE HENSLEY, by and through her Personal Representative,

Petitioner,

v.

COMMUNITY HEALTH ASSOCIATION OF SPOKANE (CHAS); PROVIDENCE HOLY FAMILY HOSPITAL; SPOKANE EAR, NOSE AND THROAT CLINIC, P.S.; and MICHAEL CRUZ, M.D.,

Respondents.

ANSWER OF RESPONDENTS MICHAEL CRUZ, M.D., and SPOKANE EAR, NOSE AND THROAT CLINIC, P.S. TO PETITION FOR DISCRETIONARY REVIEW

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I. IDENTITY OF RESPONDENT

Respondents are Michael Cruz, M.D. and Spokane Ear, Nose and Throat Clinic, P.S.

II. CITATION TO COURT OF APPEALS DECISION

The Court of Appeals decision that is the subject of the Petition for Review is Estate of Hensley by and through Wilson v. Community Health Association of Spokane (CHAS), 198 Wn. App. 1036 (2017) wherein the Court upheld the trial court's dismissal of Hensley's informed consent claim.

III. ISSUE PRESENTED FOR REVIEW

The issue presented for review is whether the Court of Appeals properly affirmed the trial court's dismissal of Hensley's informed consent claim.

IV. COUNTER STATEMENT OF THE CASE

A. Introduction and Pertinent Trial Court and Court of Appeals Procedure

This is a medical malpractice case arising from the February 6, 2009, death of Lorraine Hensley. The Petitioners, and Plaintiffs below, are Ms. Hensley's estate and her two adult children ("Hensley"). The

Respondents, and Defendants below, are healthcare providers Ms. Hensley saw at various points during the approximately two months before her death, namely the Community Health Association of Spokane ("CHAS"), Providence Holy Family Hospital, Spokane Ear Nose & Throat Clinic, P.S. ("SENT") and SENT otolaryngologist Michael Cruz, M.D. ("Dr. Cruz").

The cause of death, identified at autopsy, was brain herniation resulting from cerebral meningitis – a bacterial infection of the brain. The infection developed rapidly when bacteria from Ms. Hensley's frontal sinuses leaked into her brain through an undiscovered pinpoint hole in the cranium and corresponding four millimeter hole in the dura.

The Respondents had all diagnosed Ms. Hensley with sinusitis – a sinus infection – likely related to an abscessed tooth. And, generally, in keeping with that diagnosis, their treatment consisted of antibiotic therapy, pain medications, and a recommendation that the offending tooth be extracted.

At trial, Hensley faulted Respondents for allegedly misinterpreting Ms. Hensley's signs, symptoms and imaging studies. Specifically, Hensley claimed Respondents violated their respective standards of care by: (1) not construing Ms. Hensley's signs, symptoms, and imaging studies, particularly CT scans performed on January 9, 2009, and February 1, 2009, as indicative of an aggressive, erosive infection that threatened to intrude

into the brain, and (2) not instituting immediate, aggressive therapy to address that condition, including hospitalization with IV antibiotics and surgical drainage of the sinuses. Hensley also asserted an informed consent claim, contending the defendants failed to provide her with information regarding the true nature and extent of her condition and the risk of death if the condition was not treated with the aggressive therapy advocated.

By contrast, Respondents, generally, claimed Ms. Hensley's signs, symptoms and imaging studies supported sinusitis as the appropriate diagnosis and that they complied fully with their respective standards of care by diagnosing and treating Ms. Hensley for that condition. More specifically, Respondents contended Ms. Hensley's signs, symptoms and imaging studies were not diagnostic of an aggressive infection that was eroding through bone in the sinuses and threatening cranial intrusion. And, with respect to the January 9 and February 1 CTs, Respondents argued that neither showed an intracranial infectious process or the pinpoint hole in the cranium and four millimeter defect in the dura which ultimately provided the pathway for the fatal migration of bacteria from the sinuses into the brain. Respondents objected to Hensley's informed consent claim on the grounds that Hensley's case was one of alleged violation of the standard of care, not informed consent.

At the conclusion of Hensley's case, Respondents moved for judgment as a matter of law on the informed consent claim. RP 1858-59. The trial court denied the motion. *Id.*, CP 1031-33.

After a four-week jury trial, the trial court determined that instructing on informed consent was inappropriate, RP 3355-56, and the case was submitted to the jury on the issues of standard of care and proximate cause. The jury found that Dr. Cruz (and thus SENT) did not violate the standard of care. CP 907-09. It further concluded that, while CHAS violated the standard of care, the violation was not a proximate cause of injury or damage. *Id.* Finally, the jury hung on whether Providence violated the standard of care. *Id.*

Hensley moved for a new trial, arguing, among other things, that the court erred in dismissing the informed consent claim. CP 910-935. The trial court denied the motion, CP 1015-16. Hensley appealed, CP 1017-1030, and on April 11, 2017 Division III of the Court of Appeals affirmed in *Hensley v. Community Health Associates of Spokane, et al.*, No. 32652-III. This Petition for Discretionary Review followed.

B. Dr. Cruz's Interaction With Ms. Hensley

Dr. Cruz saw Ms. Hensley only once - on February 2, 2009. RP 3031. That day, Ms. Hensley told Dr. Cruz she had been seen in the emergency room the night before for sinusitis and that they told her to see

an ENT. *Id.* Ms. Hensley also indicated she had been on Zithromax and Vioxin for the sinus infection and that the ER had put her on Clindamycin. RP 3037. Ms. Hensley further reported she was having a right posterior molar removed the next day and was still having headaches but no visual changes. RP 3038. She stated she felt like her face was swollen at times and that she did not have a previous history of chronic sinusitis or sinusitis in general. *Id.*

The existence of head CT scans done on January 9 and February 1 was relayed to Dr. Cruz by his nurse, and Dr. Cruz reviewed them before Ms. Hensley entered the exam room. RP 3038. Studies done at Inland Imaging are available to health care providers on Inland Imaging's secure website, and Dr. Cruz accessed the images on his computer. RP 3039.

Dr. Cruz looked at the January 9, 2009, CT and noted it showed opacification of the right maxillary ethmoid and frontal ethmoid areas, RP 3039-40, and bone erosion near a tooth in the maxilla. RP 3042. Dr. Cruz's impression was that this was something "very commonly seen" and directly related to Ms. Hensley's dental disease. *Id.* By the history provided, Ms. Hensley was scheduled to have the tooth extracted and was having ongoing dental issues. RP 3042. Thus, Dr. Cruz assumed she was going to be evaluated by a dentist. *Id.* Neither Dr. Cruz nor the interpreting

radiologist saw any bony erosion of the sinuses on the January 9 CT. RP 3044.

Dr. Cruz likewise did not see any bony erosion of the sinus on the February 1, CT, RP 3045. He did see opacification, but many things can produce that finding. RP 3214. All opacification means as reported on a sinus CT is that the sinuses are not full of air like they should be. RP 3214.

Dr. Cruz examined Ms. Hensley's face with a light and by palpation. RP 3204-06. He looked for swelling over the maxillary sinuses, around the orbits of the eyes, around the frontal sinuses, and found no evidence of any swelling or redness in those areas. RP 3207-10.

In addition, Dr. Cruz performed a routine diagnostic nasal endoscopy, RP 3220, and found purulent drainage or discharge in the middle meatus. RP 3223. That confirmed that the majority of what he saw on the CT was likely infection. RP 3223-24[1].

After taking a history, reviewing the imaging studies and performing an exam, including endoscopy, Dr. Cruz did not believe Ms. Hensley needed urgent or emergent sinus surgery, RP 3225-26, nor did he believe she was at risk of developing any sort of brain infection or intracranial

[1] Dr. Cruz received the culture results on 2/6/2009, and they showed strep viridians. By this time, however, Ms. Hensley had passed away. RP 3198-99. There was nothing Dr. Cruz could have done to get the culture back earlier. RP 3199.

complication. RP 3228. Such a development from sinusitis is "extremely uncommon." RP 3228. In Dr. Cruz's 14 years of practice, he has only been called twice by neurosurgeons who were seeing a patient with intracranial complications as a result of a sinus infection. RP 3228.

C. Expert Testimony at Trial

The trial featured extensive, and sharply contrasting, expert testimony[2]. Generally, Hensley's experts claimed the January 9 and February 1 CT scans, standing alone, were diagnostic of an aggressive, erosive sinus infection that threatened a potentially fatal intrusion into the brain, and that Respondents violated their respective standards of care by not interpreting the scans that way and treating Ms. Hensley with emergent hospitalization for I.V. antibiotics and surgical sinus drainage.

By contrast, Respondents' experts testified, generally, that the January 9 and February 1 CT scans showed a relatively common sinus infection, that there were no findings suggestive of an erosive process that could result in migration of bacteria from the sinuses into the brain, and that Respondents' treatment of Ms. Hensley for the condition diagnosed - a sinus infection - with antibiotics and removal of the offending tooth, was appropriate and in full compliance with the standard of care.

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[2] The contrasting testimony is set forth in the Appendix, with appropriate citations to the record.

On the issue of informed consent, specifically the risk presented by the condition they contended was present (an aggressive, erosive infection that threatened intrusion into the brain) Hensley's experts described the risk of the purported condition as "very high risk", RP 596, "extremely high risk", *Id*, "really high risk", RP 597, an "urgent medical matter", RP 600, a "smoking gun", RP 607, "complicated, dangerous and life threatening", RP 693, and potentially "lethal." RP 1113.

Conversely, Respondents' experts described the risk of the condition they diagnosed – routine sinusitis – extending into the brain, as "rare and unusual" and "extremely low" RP 2803-04.

V. ARGUMENT AND AUTHORITIES

A. The Trial Court Properly Refused to Instruct the Jury on Informed Consent

1. Standard of Review

Where the trial court refuses to instruct the jury on a theory or cause of action, that determination is the equivalent of judgment as a matter of law. See *Gomez v. Sauerwein,* 180 Wn.2d 610, 616, 331 P.3d 19 (2014). The court reviews a granted motion for judgment as a matter of law *de novo*, construing the evidence in a light most favorable to the non-moving party, and drawing all reasonable inferences in his favor. *Id.* Judgment as a matter of law is appropriate when, after construing all facts and reasonable

inferences in favor of the non-moving party, the court determines that no competent and substantial evidence exists to support a verdict. *Paetsch v. Spokane Dermatology Clinic, P.S.*, 118 Wn.2d 842, 848, 348 P.3d 389 (2015). "Substantial evidence" is evidence sufficient "to persuade a rational, fair minded person that the finding is true." *Cantu v. Department of Labor and Industries*, 168 Wn.App. 14, 21, 277 P.3d 685 (2012).

2. Based on the Evidence Produced at Trial, Dismissal of Hensley's Informed Consent Claim was Appropriate.

This case is controlled by *Gomez v. Sauerwein*, 180 Wn.2d 610, 331 P.3d 19 (2014), where this Court affirmed the fundamental incompatibility between a standard of care claim for failure to diagnose a particular condition, and an informed consent claim based on the health care providers alleged failure to inform the patient about a condition the provider did not diagnose.

Indeed, for purposes of the informed consent analysis, this case is remarkably similar to *Gomez*. There, the Defendant, Dr. Sauerwein, was confronted with a blood test result that was positive for yeast. But after considering the test result in the context of the patient's entire clinical presentation, including the patient's report that she was feeling better since the blood draw, Dr. Sauerwein concluded the lab result was a false positive

and did not consider the patient to have a serious or threatening condition. Significantly, he did not inform the patient of the test result.

As it turned out, the lab result was not a false positive. Several days later, the lab positively identified *candida glabrata* as the yeast in the patient's blood. The patient's condition worsened, the glabrata infection spread to the patient's internal organs, and she died.

The trial court dismissed the informed consent claim, concluding under *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999) that the claim against Dr. Sauerwein was one of misdiagnosis, and that *Backlund* precluded an informed consent claim in a misdiagnosis case. In affirming the dismissal, the *Gomez* court stated:

> "Simply put, a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it. In such situations, a negligence claim for medical malpractice will provide the patient compensation if the provider failed to adhere to the standard of care in misdiagnosing or failing to diagnose the patient's condition."

180 Wn.2d at 618. (Emphasis added).

Significantly, the court emphasized that because Dr. Sauerwein did not know the patient had a yeast infection (even though she did), the patient could not base an informed consent claim on Dr. Sauerwein's failure to inform the patient of the risks associated with that condition:

> "Counsel presented evidence on both the failure to inform claim and the negligence claim at trial, but based on the facts presented at trial, the judge concluded this was a misdiagnosis case. Applying the common sense rule from *Backlund*, the judge found that this was a medical negligence case and not an informed consent case. (Citation omitted). Either Dr. Sauerwein knew that Ms. Anaya had a yeast infection, giving rise to a failure to inform claim, or he failed to know she had a yeast infection, giving rise to the negligence claim. On one set of facts the two theories are mutually exclusive. Based on the evidence and expert witnesses Mr. Anaya presented, he appears to have chosen to pursue the later rather than the former."

180 Wn.2d at 619 (emphasis added).

The rule to be taken from *Gomez* and *Backlund* is that where a health care provider, after evaluating the clinical information at his/her disposal, subjectively concludes that a patient has a particular diagnosis or condition, as opposed to a different diagnosis or condition, the health care provider has no duty to provide informed consent with respect to the condition not diagnosed.

In the instant case, at the core Hensley's case was one of alleged failure to diagnose the nature and extent of the infectious process in Ms. Hensley's sinuses and to aggressively treat that undiagnosed condition[3]. Indeed, in Hensley's Complaint, it was alleged that the Defendants "jointly failed to inform Loraine Hensley of the material fact of the virulent

[3] At one point Hensley acknowledged that her claim was about medical negligence, not informed consent. RP 679-80.

infectious process and its evidenced progression via soft tissues toward intracranial areas, with bone erosion." CP 0011. But none of the Respondents regarded Ms. Hensley's condition as such. Rather, they all interpreted the relevant images and Ms. Hensley's signs and symptoms as diagnostic of a routine sinus infection.

At trial, Hensley's evidence and arguments were consistent with the Complaint. All of Hensley's experts testified that the January 9 and February 1 CT scans showed a virulent, aggressive infectious process that was eroding into the bone and threatening to intrude into the brain rather than a routine case of sinusitis. In an effort to graft an informed consent claim onto her standard of care claim based on the same facts, Hensley's experts further testified that Respondents should have recognized the actual nature of the infectious process in the sinuses and that this condition (not the one diagnosed or appreciated by the Respondents) carried with it the risk of death. But simultaneously asserting causes of action for breach of the standard of care by failing to diagnose and informed consent based on the same set of facts is precisely what *Gomez* prohibits.

Like the patient in *Gomez*, Hensley, relying on *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), argues the January 9 and February 1 CT findings constituted an abnormal bodily condition about which Respondents had an absolute duty to inform Ms. Hensley. As the *Gomez* court pointed

out, however, *Gates* does not support the proposition that every "abnormal" test result, imaging finding or bodily condition must, categorically, be reported to the patient. Indeed, the *Gomez* court flatly rejected that proposition, stating:

> "Mr. Anaya attempts to create a new duty in this case for providers to inform patients of all positive test results. But that is not the rule. (Citation omitted). Proposing this rule stems from ignorance of the medical process. A lab test is one tool among many that a healthcare provider uses to form a diagnosis. Other tools include the history of present illness, family history, social history, and past medical history, as well as findings from a physical exam. Only after the provider has used these tools to make a diagnosis can he or she inform the patient about possible treatments and the risks associated with each."

180 Wn.2d at 620.

As the *Gomez* court recognized, it is not a test result or singular abnormal bodily condition, standing alone, that matters in the informed consent rubric. What matters is how that "abnormal" test result or bodily condition fits into the overall clinical picture, and how the defendant interprets that information. Here, based on Ms. Hensley's overall clinical picture, including the January 9 and February 1 CT scans, Respondents diagnosed routine sinusitis, and did not regard Ms. Hensley's signs and symptoms and the imaging studies as indicative of an aggressive, erosive infectious process that threatened to intrude into the cranium. They had no informed consent duty to inform Ms. Hensley of the risks associated with

that undiagnosed condition, or of specific findings on imaging studies that they interpreted as supportive of their diagnoses (sinusitis).

VI. CONCLUSION

Based on the foregoing argument and authorities, Respondents Michael Cruz, M.D. and SENT respectfully submit that the trial court and the Court of Appeals were correct in rejecting Hensley's informed consent claim in this failure to diagnose case, and respectfully request that Hensley's Petition for Review be denied.

Dated this 31st day of July, 2017.

EVANS, CRAVEN & LACKIE, P.S.

By _____
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CERTIFICATE OF SERVICE

Pursuant to RCW 9A.72.085, the undersigned hereby certifies under penalty of perjury under the laws of the state of Washington, that on the 3 day of ~~July,~~ August 2017, a copy of the ANSWER OF RESPONDENTS MICHAEL CRUZ, M.D. and SPOKANE EAR, NOSE AND THROAT CLINIC, P.S. TO PETITION FOR DISCRETIONARY REVIEW was delivered to the following persons in the manner indicated:

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8-3-17 /Spokane, WA — Benjamin T. Yesland

(Date/Place)

APPENDIX

EXPERT TESTIMONY AT TRIAL

1. Hensley's Experts

a. Elliot Felman, M.D.

- He is a specialist in family medicine. RP 576.
- The January 9, 2009, CT was a "very high risk CT scan for the patient and put the patient at extremely high risk." RP 596.
- Based on the January 9, 2009, CT, it was standard of care to say to the patient, "get this done right away, you're at risk." RP 597.
- Based on the January 9, 2009, CT, the standard of care required that the health care provider "sit down with the patient and say this is a really high risk, I'm worried about you. Something really, really bad could happen to you and we don't want that to happen." RP 598.
- The symptoms don't matter at all. At this point you are "treating the [January 9, 2009] CT scan . . . it doesn't matter how the patient feels." RP 599.
- The patient's symptoms were a "red herring" in this case. "Once you get the [January 9, 2009] CT scan in the office on January 11 or January 12, this is an urgent medical matter because the patient is at risk and you have to be prudent enough to not put them at risk." RP 600.
- The "material risk" of the condition depicted on the January 9 CT scan is "that it will extend—this infection will extent into either the lining of the brain causing what we call a meningitis . . . or that it will actually exit into the tissue of the brain itself, causing cerebritis. And more likely than not, if that happens, the patient's gonna die. At least a 50%, I believe, mortality rate." RP 606-07.

- "You've got your smoking gun. You know the patient's at risk and you have to protect the patient." [Referring to the January 9, 2009 CT] RP 607.
- The CT scan of February 1, 2009, did not show any indication of an infection in the brain. RP 610.
- Likewise, the CT scan of January 9, 2009, did not show any indication of any infection in the brain. RP 631.
- Opacification as shown on a sinus CT means you cannot see through it. The opacification can be inflammation, an infection, or other things. RP 633.
- In terms of the nuances of any bony erosion or what was going on inside of the sinuses or brain [as depicted on the CT scans], that would be uniquely within the [purview] of a radiologist, neuroradiologist, neurosurgeon or maybe an ENT. RP 635.
- Opacification does not mean infection, necessarily. It means you can't see through it. RP 635. Opacification could be infection, inflammation, fluid—a number of things. RP 635.
- Sinusitis is inflammation. RP 635. You can have sinusitis without having an infectious process. RP 636.

b. <u>Paul Bronston, M.D.</u>

- He is a specialist in emergency medicine. RP 658.
- The January 9 CT "showed this extensive dangerous infection in her face that was extending and eating away at the bone." RP 692-93.
- This was a complicated, dangerous, life-threatening condition [the condition allegedly depicted on the January 9 CT]. RP 693.

- The risk to the patient of the condition as depicted on the January 9 CT is that "it's life threatening. It can kill a person." RP 698.
- The CT scan of February 1 does not show any sort of intracranial abscess. RP 700.
- Opacification can be infection, fluid, or inflammation. RP 737.
- The erosive process reported on the January 9 CT scan could be associated with the tooth. RP 737.
- PAC Hunter ordered the February 2 CT to make sure the patient did not have any bony erosions into the cranium. RP 738.
- His training does not include actually reading and interpreting an imaging study himself. RP 755.
- The CT report says, "Bony erosion is seen 'at the root of the right superior molar tooth extending through the floor of the right maxillary sinus.'" RP 779.
- The January 9 CT scan report stated specifically that there was no definite bony erosion seen at the area of the right frontal sinus. RP 781. The CT report said that the bony erosion discussed was at the maxilla. RP 782.

c. **Richard Beck, M.D.**

- He is an ENT specialist or otolaryngologist. RP 796.
- The condition depicted on the January 9 CT "is a very serious, dangerous and life-threatening condition." RP 808.
- The January 9 CT report described very severe, pan-sinusitis. RP 817.
- The risk to Ms. Hensley of the condition demonstrated by the January 9, 2009, CT was "death." RP 850.
- The risk of the condition depicted in the February 1, 2009, CT was "death." RP 850.

- The condition depicted on the 1/9 CT is a serious, life-threatening condition which can only be treated with surgery, intravenous antibiotics, hospitalized admission and multiple specialists, each providing care in their fields. RP 851.
- Generally, he agrees with the radiologist's interpretation of the January 9 CT. RP 863.
- He disagrees, however, with the radiologist's report regarding the February 1 CT. He believes the February 1 CT shows demineralization—erosion—of the bone behind the frontal sinus, posterior to the frontal sinus. That was not reported by the radiologist. RP 863-64. This was "an important finding that was not described [by the radiologist]." RP 864.[1]
- He also believes the 2/1 CT shows a fluid collection between the posterior portion of the right frontal sinus and the underlying brain. The report does not mention that important finding either. RP 865.
- The 1/9/09 CT did not show any indication of intracranial infection. RP 920-21. The CT showed erosion of bone at the base of the maxillary sinus but there was no notation of erosion at the top or superior portions of the maxillary sinus, and no indication of erosion into either the ethmoid sinus or the frontal sinus. RP 921.

d. <u>Richard Sokolov, M.D.</u>

- He is an infectious disease specialist. RP 1050.
- The risk of the condition as depicted on the January 9, 2009, CT image was there could be several potential complications. RP 1111-12. The CT was both erosive and involved multiple sinuses. *Id.* One of the complications of sinusitis is a more destructive local

[1] Dr. Beck is the only expert (including the radiologist who issued the CT report) who interpreted the February 1 CT as showing erosion of the bone behind the frontal sinus.

process that can spread into the bloodstream, at which time it becomes a more global and systemic infection. *Id.* Or it can spread to very fragile adjacent structures such as the brain or the eyes. *Id.*

- If the condition as depicted on the January 9, 2009, CT is not treated within the standard of care, the "end point" of the condition is that "a patient has an unrelenting sinus infection, progressive swelling, a brain abscess, and meningitis can be a result of such a process." RP 1112.
- If not properly treated, the "end point" of a brain abscess and meningitis is that with meningitis, they both can be fatal processes. RP 112. When he says this can be a "lethal infection," he means it would kill people. *Id.*
- The "end result" of the condition depicted on the February 1 CT scan, if not properly treated in the manner discussed, would be that the patient would be at risk of the same result he talked about with respect to the prior [January 9] scan: brain abscess or metastases or traveling of the infection to distant sites, meningitis or even a bloodstream infection. RP 1113. These are all potential consequences." RP 1113. "These are all potentially life-threatening infections and can be 'lethal.'" *Id.*
- The only bony erosion mentioned in the January 9 CT deals with the tooth. RP 1122.
- The nuances or details of the CT scan are critical in terms of assessing the magnitude of this—this patient is seriously ill." RP 1217. "The point I tried to make is the patient is seriously ill by virtue of [the] CT scan findings." *Id.*

e. **James Winter, M.D.**

- He is an emergency physician. RP 1554.

- Once the January 9, 2009, CT was obtained, regarding the risk to the patient at that point if she did not receive aggressive treatment, "the highest risk is death, which happened in this case." RP 1576-77.

2. Dr. Cruz's Experts

a. Gary Stimac, M.D.

- He is a diagnostic radiologist specializing in neuroradiology. RP 1875.
- On the January 9, 2009, sinus CT, with respect to the term "erosion," as used in the cardiologists report, the CT does show erosion around where the teeth plug in to the upper jaw. RP 1886-87.
- However, the January 9, 2009, sinus CT does not show erosion anywhere else in the maxillary sinus. RP 1887. It only shows erosion in the area of the tooth or dental abscess, which had eroded the bone of the jaw. *Id.* And because that is right below the maxillary sinus, that eroded the floor of that sinus. *Id.*
- The January 9, 2009, CT does not show a communication between the tooth abscess and the sinus cavity that was allowing oral content to enter the maxillary sinus. RP 1888-89. That was also not a finding at autopsy, which would be the "final word" on the question of whether something from the mouth itself was getting into the maxillary sinus, and the radiology [the January 9, 2009, CT scan] does not allow for that distinction. *Id.*
- The February 1, 2009, CT does not show any radiographic evidence of an infection that extended from the sinus to the brain. RP 1889-90. There were no findings of material that was extending from the sinus cavities into the brain area. *Id.*

- The 4mm hole in the dura Dr. Aiken [the pathologist] found during the autopsy is not something that showed up on the February 1, 2009, CT. RP 1981. The radiology is not capable of identifying something that small in such a dense surface. *Id.*
- He has reviewed around 3,000 sinus CTs in his career. RP 1893. Of those, a majority showed some opacification in the sinuses. *Id.* And a large number, probably hundreds, showed very significant opacification of the sinuses similar to what is seen in Ms. Hensley's case. *Id.* It is not unusual for someone to have a bad sinus disease and have the sinuses "plugged up," particularly if they are being referred by an allergy specialist or an ENT for the evaluation of chronic sinus disease. *Id.*
- He can think of only three cases in his entire career where he was able to see radiographically sinus disease extending into the cranium. RP 1893-94. One was related to a fracture. *Id.* The second was postoperative, where there had been a surgical intervention. *Id.* And the third involved sinus disease caused by a fungus in an immunocompromised patient. *Id.*
- With respect to the opinions expressed by plaintiff's expert, Dr. Beck, concerning the various findings on the February 1 CT, he disagrees with most of them. RP 1894-95.

b. <u>Timothy Smith, M.D.</u>

- He is an otolaryngologist. RP 2761.
- As an otolaryngologist, he does not consider surgery unless there are impending orbital or intracranial complications. RP 2789.
- Based on the January 9 and February 1, 2009, CT scans, he does not believe this patient had any indications for any kind of sinus surgery as of February 2, 2009. RP 2788.

- From his review of the records in this case, including Dr. Cruz's February 2, 2009, documentation, as well as the CT scans, there was no evidence of an orbital complication present on February 2, 2009, that would suggest the need for surgery. RP 2790.
- Likewise, there was no indication of an intracranial complication or process that would provide an indication for surgery. RP 2790-91.
- The standard of care did not require Dr. Cruz to take the patient to the hospital and perform a frontal sinus trephination procedure and drainage. RP 2794.
- Neither the January 9 nor the February 1, 2009, CTs show any signs of intracranial involvement or infection. RP 2795. Even after reading the deposition of an expert [Dr. Beck] who suggested the evidence was there, and with the knowledge of the final tragic outcome in this case, he did not see those findings. RP 2795.
- In his opinion, the physical examination as documented by Dr. Cruz on February 2 did not show any indication of an impending onset of either an orbital complication or an intracranial complication that might call for surgical intervention. RP 2795.
- Rather, he saw indications for the opposite. RP 2795. He saw some sense of improvement, meaning the correct antibiotics had now been given to the patient. RP 2795. And there was no forehead edema clinically and there was a radiograph the day before. *Id.* So generally, his sense is that as of February 2, things were going in the right direction or at least stabilizing. *Id.*
- It is a very common CT finding for upper molars in the maxilla to have roots that intrude or protrude into the maxillary sinus cavity. RP 2796. He sees this condition in the operating room when he opens the maxillary sinus. *Id.*

- It is not an uncommon to see a bone abnormality or a change in the maxilla associated with a dental issue when reviewing a sinus CT. RP 2797.
- Surgery is never performed based on CT scan findings alone. RP 2797-98. Decisions are made based on a lot of different data, *Id.*, including imaging, laboratory data and, most importantly, the history and physical examination from the patient. *Id.*
- He does not agree that the January 9, 2009, CT findings, in and of themselves, were indicative of a medical emergency requiring immediate hospitalization, intravenous antibiotics and emergency or urgent sinus surgery. RP 2798.
- He does not believe the standard of care required Dr. Cruz to admit the patient to the hospital on February 2, 2009, for intensive therapy, including both intravenous antibiotics as well as surgery. RP 2798-99.
- Putting all of the information together, on February 2, 2009, he saw signs of, at a minimum, stabilization, if not some degree of improvement over a 24-hour period from when the correct antibiotic had been started. So in his mind they were going in the correct direction and he would not have altered that [treatment] course. RP 2799.
- Regarding the risk to the patient as of February 2, 2009, of developing an intracranial infection or abscess or subdural empyema, thankfully these types of complications of sinusitis are very rare and unusual. RP 2803-04. So the risk of that to the patient on February 2 was extremely low. *Id.*
- The standard of care did not require a reasonably prudent otolaryngologist on February 2, 2009, to tell the patient about the extremely low or very low risk of a potential or possible brain infection arising out of this condition. RP 2804.

- He closely examined the February 1, 2009, CT scan. RP 2805. Even knowing the outcome, he looked carefully for evidence of any defect in the posterior table of the frontal sinus that would have predicted an ominous outcome for the patient. *Id.* He did not see anything in that regard. *Id.*
- Ms. Hensley did not have complicated acute frontal sinusitis. RP 2861. It is only complicated if the patient is showing clear and pending complications of the orbit or cranial activity. *Id.*
- In his opinion, Dr. Cruz complied fully with the standard of care. RP 2780.

c. <u>Eric Pinczower, M.D.</u>

- He is an otolaryngologist. RP 2897-98.
- The January 9, 2009, CT showed bony erosion in the periapical areas, or above the root of the teeth. RP 2912-13. That is quite common on a CT. *Id.* Sinuses which have been contaminated by a dental infection he sees relatively commonly. *Id.*
- Every day, as an anatomic variant, he sees the roots of molars in the right maxilla or left maxilla extending into the maxillary sinus on CT. RP 2913.
- The January 9, 2009, CT finding of erosion in the maxilla near the molar is not the type of finding that would cause a reasonably prudent otolaryngologist to immediately hospitalize the patient, put the patient on intravenous antibiotics and conduct emergency sinus surgery. RP 2913.
- The treatment of acute sinusitis is usually oral antibiotics. RP 2913. That would be the typical treatment for a prudent otolaryngologist.

- The February 1, 2009, CT did not show any evidence of acute intracranial findings. RP 2917. That means the inside of the patient's cranium appeared normal and that the infection was isolated in the sinuses. *Id.*
- As part of his work in this case he compared the January 9 and February 1 CTs to determine whether there was any difference in the presentation of the sinus disease. RP 2926-27. It seemed like there was a little more fluid or opacification of the frontal sinuses on the February 1 CT. RP 2927. But that did not change anything. *Id.* There was still air in the frontal sinuses and the walls of the frontal sinuses were intact. *Id.* So the [correct] diagnosis was still acute sinusitis. *Id.*
- In his years of experience as an otolaryngologist he has never encountered a case where sinusitis of the type described in [Ms. Hensley's] imaging and the medical records resulted in a fatality. RP 2927.
- From his review of the imaging, the sinus involvement as of February 2, 2009, was confined to the sinuses themselves. RP 2928.
- He does not agree that the condition shown on the January 9 and February 1 CTs was "extremely risky." RP 2954.
- He does not agree that any infection to the face area is a "very risky condition." RP 2954-55.

d. <u>Michael Gillum, M.D.</u>

- He is a physician, specializing in infectious disease. RP 3125.
- Chronic sinusitis is an extremely common condition—between 2% and 15% of the population have it - whereas complications of sinusitis are extremely rare. RP 3169.

- He regards Ms. Hensley's situation as an acute worsening of a chronic process. RP 3132. In that setting, these infections are notoriously polymicrobial, in other words, several different types of bacteria will cause them. *Id.*
- Clindamycin is a good antibiotic, and through the years it has maintained efficacy against the oral anaerobes and then also the oral streptococci, whereas there has been a significant increase in resistance with the macrolides. RP 3133. Like all antibiotics, Clindamycin has had some difficulties with resistance but much less so than Clarithromycin. *Id.*
- Based on his review of the records, as of February 2, 2009, Ms. Hensley had had an inadequate response to antibiotic therapy. RP 3134. So it was reasonable as of 2/2/2009 to switch to a different drug. *Id.*
- Based on his review of the materials and analysis of the patient's condition on February 2, 2009, in his opinion she did not have appropriate indications, from an infectious disease standpoint, for admission to the hospital. RP 3135-36. The usual indications for admitting somebody with a sinus infection or severe sinusitis would be a systemic infection or evidence that there is an infection throughout the system. RP 3136. That would usually be defined by low blood pressure, rapid heartbeat, rapid respiratory rate, and fever. *Id.* As of February 2, 2009, she really did not have any of those issues. *Id.*
- From an infectious disease standpoint, a tapering course of Prednisone, as prescribed by Dr. Cruz on February 2, 2009, was appropriate therapy. RP 3137-38. That is a typical medication to use in a situation where there is an acute flare-up of chronic sinusitis to decrease inflammation and enhance drainage. *Id.*

- In his opinion, based on the way Ms. Hensley's description was described in the records, she was an appropriate candidate for oral Clindamycin given her presentation on February 2, 2009, in Dr. Cruz's office. RP 3139.
- If he had been contacted by Dr. Cruz on February 2, 2009, and given the information that appears in Dr. Cruz's chart, he would not have recommended the patient be hospitalized and/or the use of intravenous antibiotics. RP 3141-42. That is because Dr. Cruz met with the patient and examined her and looked at the appropriate CT scans and saw they were going to extract the tooth the next day, that was a major part of the problem. *Id.* Dr. Cruz looked in the patient's nose, looked back in the nasal pharynx and saw it was draining. *Id.* He obtained an appropriate culture and sent it off so that a few days down the road he would know the specific bacteria or bacterias that were causing the problem. *Id.* At that point she was on a very appropriate empiric antibiotic. *Id.* He would have suggested Dr. Cruz leave her there, and told him there was no indication for intravenous therapy or hospitalization. *Id.*

EVANS, CRAVEN & LACKIE, P.S.

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