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Superior Ct. No. 12-2-00325-9

COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

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

Appellants,

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.

**BRIEF OF RESPONDENTS / CROSS APPELLANTS
MICHAEL CRUZ, M.D., and
SPOKANE EAR, NOSE AND THROAT CLINIC, P.S.**

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I. STATEMENT OF THE CASE

A. Introduction and Pertinent Trial Court Procedure

This is a medical negligence case arising from the February 6, 2009, death of Lorraine Hensley. The Appellants, 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 involved healthcare providers had all diagnosed Ms. Hensley with sinusitis – a sinus infection – likely related to an abscessed tooth. And, generally, consistent with that diagnosis, their treatment consisted of antibiotic therapy, pain medications, and a recommendation that the offending tooth be extracted.

Hensley faulted the Defendants for misinterpreting Ms. Hensley's signs, symptoms and imaging studies. Specifically, Hensley claimed the Defendants were negligent for: (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 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. Ms. 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.

The Defendants, 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, Defendants 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. With respect to the January 9 and February 1 CTs, Defendants 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. Defendants also 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, and that, in any case, Hensley's experts provided insufficient testimony regarding the nature of any specific risk and the likelihood of its occurrence.

At the conclusion of Hensley's case, all Defendants moved for judgment as a matter of law on the informed consent claim. RP 1858-59. Dr. Cruz also moved for judgment as a matter of law on the standard of care claim on the ground that none of Hensley's experts expressed their standard of care opinions against Dr. Cruz in terms of reasonable medical certainty or probability. *Id.* The trial court denied the motions. *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 and that the jury's verdict was the result of juror misconduct. CP 910-935. The trial court denied the motion, CP 1015-16, and this appeal followed. CP 1017-1030. Dr. Cruz cross-appealed the trial court's denial of his motion for dismissal of Hensley's standard of care claim¹.

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.*

¹ The Notice of Cross Appeal was not included in the Clerks Papers and is the subject of a pending Supplemental Designation of Clerks Papers.

Before Ms. Hensley entered the exam room Dr. Cruz was aware of and reviewed head CT scans done on January 9 and February 1 because the existence of the scans was relayed to him by his nurse. 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 erosions of the sinuses on the January 9 CT. RP 3044.

During his visit with Ms. Hensley, Dr. Cruz also evaluated the February 1, CT, RP 3045, and did not see any bony erosion. RP 3045.

Many things can produce opacification of the sinuses as shown on a CT. 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 3223-24².

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 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.

² Dr. Cruz received the culture results on 2/6/2009, and they showed strep viridians. But 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 sooner. RP 3199.

C. Pertinent Expert Testimony

The trial featured extensive, and sharply contrasting, expert testimony. 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 the Defendants 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, Defendants' 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 Defendants' 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.

Pertinent contrasting expert testimony provided by Hensley's experts and Dr. Cruz's experts is set forth below:

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. Paul Bronston, M.D.

- 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 864.³
- 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. Richard Sokolov, M.D.

- 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

³ 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.

of the complications of sinusitis is a more destructive local 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. Timothy Smith, M.D.

- 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. **Eric Pinczower, M.D.**

- 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. **Michael Gillum, M.D.**

- 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.*

II. ARGUMENT AND AUTHORITIES

A. Because Hensley's Experts Did Not Give Their Respective Standard of Care Opinions in Terms of Reasonable Medical Certainty, The Trial Court Erred By Not Dismissing Hensley's Standard Of Care Claim Against Dr. Cruz

1. Standard of Review

Under CR 50(a), after a party has been fully heard with respect to an issue, the court may grant a motion for judgment as a matter of law

against that party if there is “no legally sufficient evidentiary basis for a reasonable jury to find . . . for that party with respect to that issue . . .” On a CR 50(a) motion at the close of Plaintiffs’ case, the court must view the evidence in the light most favorable to the non-moving party and determine whether the proffered result is the only reasonable conclusion. *Esparza v. Sky Reach Equipment, Inc.*, 103 Wn. App. 916, 926-27, 15 P.3d 188 (2000). An appellate court reviews a trial court’s denial of a motion for judgment as a matter of law in a jury trial *de novo*, engaging in the same inquiry as the trial court. *Gorman v. Pierce County*, 176 Wn. App. 63, 74, 307 P.3d 795 (2013).

2. **The Standard of Care Testimony of Hensley’s Experts Did Not Meet the Legal Standard for Expert Testimony in Medical Negligence Case**

Unless the standard of care and its violation would be obvious to a layman, in a medical negligence case expert testimony is necessary to prove whether a particular practice is reasonably prudent under the applicable standard of care. *McLaughlin v. Cook*, 112 Wn.2d 829, 836-37, 774 P.2d 1171 (1989). “In addition, medical expert testimony must be based upon ‘a reasonable degree of medical certainty.’” *McLaughlin* at 836-37, *citing cases*.

In the instant case, none of Hensley’s five expert witnesses (Elliot Felman, M.D., Richard Beck, M.D., Paul Bronston, M.D., Richard Sokolov,

M.D. or James Winter, M.D.)⁴ expressed their standard of care opinions against Dr. Cruz in terms of a reasonable degree of medical certainty, as required by Washington law. Accordingly, the trial court erred in denying Dr. Cruz's CR 50(a) motion on Hensley's standard of care claim(s).

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

1. Standard of Review

Where the trial court refuses to issue a jury instruction on a theory or claim because of a determination there are insufficient facts to support the requested instruction, the standard of review is abuse of discretion. *See, Kappelman v. Lutz*, 167 Wn.2d 1, 6, 217 P.2d 286 (2009).

Here, the trial court determined the facts did not support instructing the jury on informed consent. Accordingly, the standard of review is abuse of discretion.

2. The Trial Court Did Not Abuse Its Discretion By Refusing to Instruct on Informed Consent

Defendants moved *in limine* to exclude any claim of or reference to informed consent on the ground that Hensley's case was essentially one of misdiagnosis in violation of the standard of care and that, in any case, none

⁴ Dr. Felman's testimony on direct is at RP 576-614. Dr. Bronston's testimony on direct is at RP 657-725. Dr. Beck's testimony on direct is at RP 791-861. Dr. Sokolov's testimony on direct is at RP 1049-1117. Dr. Winters' testimony on direct is at RP 1553-1592.

of Hensley's expert witnesses had been identified in pretrial discovery as having opinions supportive of an informed consent claim, specifically the nature of a particular risk and the likelihood of its occurrence. RP 108-110; CP 490-517. The Court reserved ruling, RP 111, and at trial gave Hensley great leeway in offering expert testimony to support an informed consent claim, overruling Defendants' non-disclosure objections. *See, e.g.*, RP 676, 790, 1044, 1552. At the conclusion of Hensley's case, the Court denied Defendants' CR 50 motion to dismiss the informed consent claim. RP 1031-33. Ultimately, however, the Court refused to instruct on informed consent, determining Hensley's case was essentially one of alleged violation of the standard of care, not informed consent, and that, in any event, Hensley failed to provide sufficient expert testimony to support an informed consent claim. RP 3355-56.

The trial court's refusal to instruct on informed consent was entirely appropriate. In the relatively recent case of *Gomez v. Sauerwein*, 180 Wn.2d 610, 331 P.3d 19 (2014)⁵, the Washington Supreme Court affirmed the fundamental incompatibility between a standard of care claim for alleged misdiagnosis and an informed consent claim for failing to inform the patient with respect to risks and complications of a condition not diagnosed. There,

⁵ Hensley cites *Flyte v. Summit View Clinic*, 183 Wn. App. 559, 333 P.3d 566 (2014), a post *Gomez* case from Division 2 of the Court of Appeals. With all due respect to Division 2, the Court's holding seems irreconcilable with *Gomez*.

the deceased plaintiff presented to providers with what was believed to be a urinary tract infection. Blood was drawn, and the results revealed a culture positive for yeast. The culture, however, had not grown to the point where the strain could be determined.

The family practitioner defendant decided to hold off on further treatment so long as the patient was not ill, on the mistaken belief that the presence of yeast was simply a contaminant. The yeast was not a contaminant. As it turned out, a rare fungal infection was growing. The inaction delayed the administration of antifungal medication. The infection spread to the decedent's internal organs, she developed fungal sepsis, and died. The decedent's estate made an informed consent claim which was dismissed on a directed verdict because the cause of action was not applicable to the facts of the case. The Court of Appeals affirmed. The Washington State Supreme Court granted certiorari, and affirmed the decisions below. In doing so, the Supreme Court emphasized and confirmed prior informed consent law:

Informed consent and medical negligence are distinct claims that apply in different situations. While there is some overlap, they are two different theories of recovery with independent rationales. In determining which theory of recovery is available, the issue is whether this is a case of misdiagnosis subject only to negligence or if the facts also support an informed consent claim.

...

The doctrine of informed consent has been distinguished from malpractice as applying to fundamentally different situations. As we stated in *Backlund*, 137 Wash.2d at 661, 976 P.2d 950 (1999):

A physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent.

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 with compensation if the provider failed to adhere to the standard of care in misdiagnosing or failing to diagnose the patient's condition.

In misdiagnosis cases, this rule is necessary to avoid imposing double liability on the provider for the same alleged misconduct. *Id.* at 661-62 n.2, 975 P.2d 950. The proposition that a provider cannot be liable for failure to inform in a misdiagnosis case has been referred to as "the *Backlund* rule." *Id.* at 661, 975 P.2d 950. *Backlund* followed several Court of Appeals opinions applying the same rule. See, *Thomas v. Wilfac, Inc.*, 65 Wash. App. 255, 261, 828 P.2d 597 (1992) ("Failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform a patient."); *Burnet v. Spokane Ambulance*, 54 Wash. App. 162, 168-69, 772 P.2d 1027 (1989) ("[T]he issues presented were confined to negligence and misdiagnosis rather than a violation of the informed consent law."); *Bays v. St. Luke's Hosp.*, 63 Wash. App. 976, 881, 825 P.2d 319 (1992) ("[T]he duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it."). This court cited

all of these cases when it decided *Backlund*. See 137 Wash.2d at 659-60, 975 P.2d 950.

180 Wn.2d at 617-19

After this review of the informed consent law, the court held:

. . . that when a health care provider rules out a particular diagnosis based on the circumstances surrounding a patient's condition, including the patient's own reports, there is no duty to inform the patient on treatment options pertaining to the ruled out diagnosis. To hold otherwise would require health care providers and patients to spend hours going through useless information that will not assist in treating the patient. Corrected Br. Of Amici Curiae Wash. State Med. Ass'n & Wash. State Hosp. Ass'n at 13. The provider may be liable for negligence in failing to diagnose the condition if the mistaken diagnosis otherwise meets the elements of a medical malpractice claims.

This is a misdiagnosis case. Accordingly, the *Backlund* rule applies and the trial court properly dismissed the informed consent claim as a matter of law. Therefore, we affirm the Court of Appeals but point out that *Gates* has not been overruled. See, *Anya Gomez*, 172 Wash. App. at 385, 289 P.3d 755. *Backlund* and *Keogan* state the general rule of when a plaintiff can make an informed consent claim. The *Gates* court allowed the informed consent claim based on a unique set of facts that are distinguishable from this case. Under *Gates*, there may be instances where the duty to inform arises during the diagnostic process, but this case does not present such facts. The determining factor is whether the process of diagnosis presents an informed decision for the patient to make about his or her care. Dr. Sauerwein's knowledge of the test result provided no treatment choice for Mrs. Anya to make.

180 Wn.2d at 623.

Additional authority is found in *Thomas v. Wilfac, Inc.*, 65 Wash. App. 255, 828 P.2d 597, *review denied*, 119 Wash.2d 1020 838 P.2d 692 (1992) (court rejected informed consent claim based upon emergency room doctor's alleged failure to inform patient of time frame to treat condition that he did not diagnose); *Bays v. St. Lukes Hosp.*, 63 Wash. App. 876, 881-82, 825 P.2d 319, 322 (1992), *review denied*, 119 Wash.2d 1008 (1992) (physician owed no duty to discuss possible methods of treatment for thromboembolism where the physician was "unaware of the thromboembolism condition").

Here, Hensley's case was essentially and fundamentally 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.⁶ This is evinced by the manner in which Hensley set forth her claim in her Complaint, where her informed consent claim was described as follows:

- "All Defendants individually and jointly failed to inform Lorraine Hensley of the material fact of the virulent infectious process and its evidenced progression via soft tissues towards

⁶ At one point Hensley acknowledged that her claim was about medical negligence, not informed consent. RP 679-80.

intracranial areas, with bone erosion." *Complaint*, pg. 9, Paragraph 2.48.

- "Lorraine Hensley continued to seek treatment from defendants for a worsening condition without being aware of, or fully informed of, the material facts of her precarious condition." *Id. at 2.49.*
- "A reasonably prudent patient under Lorraine Hensley's circumstances would not have consented to continued discharges from care, steroid uses, saline rinses, and neti pots if informed of the material facts of her progressively worsening condition and infectious processes." *Id. at 2.50.*

Hensley's trial evidence and argument were consistent with the Complaint. The essence of Hensley's case, and the thrust of all Hensley's supporting expert testimony, was that the involved health care providers failed to interpret Ms. Hensley's signs, symptoms and test results, particularly the January 9 and February 1 CT scans, as showing not a routine case of sinusitis, but, instead, a virulent, aggressive infectious process that was eroding into the bone and thus threatening to intrude into the brain. And, to the extent Plaintiffs' experts testified with regard to "risks," the testimony had essentially the same theme: 1) That Defendants should have recognized the true nature of the infectious process in

Ms. Hensley's sinuses; 2) if they did not comply with the standard of care by recognizing and aggressively treating the true condition with hospitalization, IV antibiotics and surgical drainage of the sinuses, the "endpoint" was death, and; 3) because Defendants failed to comply with the standard of care by recognizing the true nature of the infectious process and treating it aggressively with hospitalization, IV antibiotics and surgical drainage of the sinuses, there was a "risk" of death. This was simply couching the standard of care claim in informed consent terms, in order to take advantage of both causes of action. But this is precisely the conflation of standard of care and informed consent prohibited by *Gomez*.

3. **In addition to the above, the trial court properly refused to instruct on informed consent because Hensley failed to provide expert testimony on the nature of a particular risk and the likelihood of its occurrence.**⁷

The rule of expert testimony relative to an informed consent claim was established in *Smith v. Shannon*, 100 Wn.2d 26, 666 P.2d 351 (1983), where the court explained:

The determination of materiality is a two step process. Initially, the scientific nature of the risk must be ascertained,

⁷ Hensley argues at length that the trial court erroneously required that expert testimony on risk be expressed in terms of "probability." The trial court did use that term in its ruling. *See* RP 3356. However, given the argument and briefing presented to the court, it is likely the court was simply trying to convey that it is incumbent upon the plaintiff to present expert testimony on the statistical likelihood of a risk's occurrence. Dr. Cruz does not believe the court was attempting to convey that a particular risk must be "probable," i.e., 51% or higher, before the risk can be considered material, and Dr. Cruz is certainly not making that argument here.

i.e., the nature of the harm which may result and the probability of its occurrence. (Citations omitted). The trier of fact must then decide whether that probability of that type of harm is a risk which a reasonable patient would consider on deciding on treatment.

While the second step of this determination of materiality clearly does not require expert testimony, the first step almost as clearly does. (Citations omitted). Only a physician (or other qualified expert) is capable of judging what risks exist and their likelihood of occurrence. A central reason for requiring physicians to disclose risks to their patients is that patients are unable to recognize the risks by themselves. Just as patients require disclosure of risks by the physicians to give an informed consent, a trier of fact requires description of risks by an expert to make an informed decisions.

Some expert testimony is necessary to prove materiality. Specifically, expert testimony is necessary to prove the existence of a risk, its likelihood of occurrence, and the type of harm in question. Once those facts are shown, expert testimony is unnecessary. (emphasis added).

100 Wn.2d at 33-34.

See also, Adams v. Richland Clinic, Inc., P.S., 37 Wn. App. 650, 681 P.2d 1305 (1984); *Seybold v. Neu*, 105 Wn. App. 666, 681-82, 19 P.3d 1068 (2001).

Given the requirement of expert testimony on the nature of a risk and the likelihood of its occurrence, courts have found immateriality as a matter of law where the likelihood of occurrence was sufficiently small. *See e.g. Ruffer v. St. Francis Caprini*, 56 Wn. App. 625, 784 P.2d 1288 (1990) (one in 20 to 50,000 risks of colon perforation resulting from

sigmoidoscopy immaterial as a matter of law); *Luke v. Family Care & Urgent Medical Clinics*, 2007 WL2461850 (one in 25,000 to one in 40,000 chance of fulminant liver failure immaterial as a matter of law); *Mason v. Elsworth*, 3 Wn. App. 298, 474 P.2d 909, 919-20 (1970) (concluding .75 chance not material as a matter of law); *Smith v. Shannon*, 100 Wn.2d 26, 666 P.2d 351 (1983) (affirming directed verdict on an 8.6 in one million to zero to .05% chance of phlebitis).

Here, none of Hensley's experts gave testimony with respect to the nature of a specific risk and the likelihood of that risk's occurrence. Rather, her experts testified in general terms as follows:

- The January 9, 2009, CT was a “very high risk CT scan for the patient” (RP 596) and that it was “standard of care to say to the patient, ‘get this done right away, you’re at risk’” (RP 597).
- The standard of care required the health care provider to “sit down with the patient and say this is a really high risk, I’m worried about you. Something really bad could happen to you and we don’t want that to happen.” RP 598.
- Symptoms are a red flag in this case. They have nothing to do with it. Once you get the 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 risks of the condition as depicted on the January 9 CT scan is that “this infection will extend 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 going to die. At least a 50% percent mortality rate.” RP 606-07. (Dr. Sokolov)
- The risk to the patient of the condition that is presented in the CT report on January 9, 2009, is that the condition is “life threatening. It can kill a person.” RP 698. (Dr. Bronston)
- The CT of January 9, 2009, shows “a very serious, dangerous and life-threatening condition.” RP 808. (Dr. Beck) “The patient needs to know the status of their condition.” RP 808. The risk to the patient of the condition as demonstrated in the January 9, 2009, CT report is “death.” RP 850.
- The risk of the condition depicted in the February 1 CT scan is “death.” RP 850.
- Death is the “end point” of the condition depicted on the January 9, 2009, CT because the CT shows 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.”

- The risk of the condition as depicted in the January 9, 2009, CT is that there could be “several potential complications.” RP 1111. (Dr. Sokolov) One of the complications of sinusitis is that “a more destructive local process can spread into the bloodstream, at which time it becomes a more global and systemic infection. Or spread to a very fragile adjacent structure; the brain, the eyes, you know, structures that are very fragile and can be tenuous in the immediate vicinity.” *Id.*
- The “end point” of the condition depicted on the January 9, 2009, CT, if the condition is not treated within the standard of care is that “brain abscess and meningitis can be a ‘you know, results of such processes.’” (RP 1112) and that, if not properly treated, the “end point” of brain abscess and meningitis is that “meningitis, they both can be fatal processes.” When he says this can be a “lethal infection” he means it would kill people. RP 1112.
- The “end result” of the condition depicted in the February 1, 2009, CT scan, if not properly treated, is that “I would say you are at risk of the same results that I talked about with the prior scan; brain abscess, or what we said before, metastases or traveling of the

infection to distant sites, meningitis, or even bloodstream infections. These are all potential consequences.” RP 1113. And the potential consequences are that “these are all potentially life-threatening infections and that they are ‘lethal.’” RP 1113.

- “The gravity of the illness is not apparent in the note [Dr. Cruz’s note of February 2, 2009] because obviously the CT scan is – and the nuances of the details of the CT scan are critical in terms of assessing the magnitude of this – this patient is seriously ill.” “The point I tried to make is the patient is seriously ill by virtue of this CT scan finding.” RP 1213, RP 1217.
- Dr. James Winter testified in response to the following question, “In terms of risk to the patient, once the January 9, 2009, CT is obtained, what is the risk to the patient at that point if she does not receive aggressive treatment?” RP 1576. The answer was, “Well, the highest risk is death, which happened in this case.” RP 1577.

As the above testimony reveals, none of Hensley’s experts identified a specific risk of a particular treatment, or non-treatment, and then gave legally sufficient corresponding testimony about the likelihood of that risk occurring. While Dr. Sokolov did testify, with respect to the January 9 CT scan, that there was “at least a 50% mortality rate” if infection migrated into

the lining of the brain or in to the brain tissue itself, he never identified the risk of the infection migrating into the brain in the first instance.

C. There Was No Juror Misconduct Warranting a New Trial

1. Standard of Review, Deference to Trial Court Discretion and Matters that Inhere in Verdict

Deciding whether juror misconduct occurred and whether it affected the verdict are matters for the discretion of the trial court, and will not be reversed on appeal unless the court abused its discretion. *Breckenridge v. Valley General Hospital*, 150 Wn.2d 197, 203, 75 P.3d 944 (2003). “A strong affirmative showing of misconduct is necessary in order to overcome the policy favoring stable and certain verdicts, and secret, frank and free discussion of the evidence by the jury.” *Breckenridge* at 203, quoting *State v. Balinsok*, 123 Wn.2d 114, 117-18, 966 P.2d 631. A trial court abuses its discretion when its decision is “manifestly unreasonable, or exercised upon untenable grounds, or for untenable reasons.” *Breckenridge* at 203, quoting *State ex Rel, Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971).

Even if the trial court determines the existence of jury misconduct, an appellate court must “give great deference to the trial court’s determination of whether juror misconduct affected the verdict because the trial court ‘observed all the witnesses and the trial proceedings and had in

mind the evidence which had been presented.”” *Halverson v. Anderson*, 82 Wn.2d 746, 752, 513 P.2d 827 (1973).

When determining whether misconduct occurred, the trial court must consider whether the alleged conduct "inheres in the verdict." If it does, the evidence cannot, as a matter of law, be considered by the trial court. *Turner v. Stime*, 153 Wash. App. 581, 589, 222 P.3d 1243, 1247 (2009). The purpose of this rule was described in *State v. Hatley*, 41 Wash. App. 789, 706 P.2d 1083 (Div.1, 1985):

The need for finality in litigation requires a public policy making inadmissible evidence that inheres in a jury verdict. If every verdict were subject to impeachment if the losing side could obtain an affidavit indicating that in making up his or her mind, the juror reached certain critical conclusions prior to commencement of deliberations, disregarded some evidence, misunderstood an instruction, misapplied the rules of law, or completely misunderstood the testimony of one or more witnesses, then a jury verdict would simply be the first round in an interminably prolonged trial process. We hold that the evidence in this case should not have been considered because it directly involved Hamernik's thought processes and therefore inhered in the verdict. *Gardner v. Malone, supra*.

41 Wash. App. 789, 794, 706 P.2d 1083, 1087.

In *Cox v. Charles Wright Academy, Inc.*, 70 Wash.2d 173, 422 P.2d 515 (1967), the Supreme Court described the critical nature of the rule as follows:

Our judicial system rests upon the idea of finality in judgments given by the courts. Lacking the principle that

every action will one day terminate in a final adjudication, subject no longer to re-examination, the judicial system would likely disappear. For that reason and other good reasons, the courts have long accepted the premise that jurors may not impeach their own verdict -a salutary principle contributing greatly to the finality of judgments and stability of the courts.

Thus, courts may consider only such facts asserted in the affidavits of jurors which relate to the claimed misconduct of the jury and do not inhere in the verdict itself. The mental processes by which individual jurors reached their respective conclusions, their motives in arriving at their verdicts, the effect the evidence may have had upon the jurors or the weight particular jurors may have given to particular evidence, or the jurors' intentions and beliefs, are all factors inhering in the jury's processes in arriving at its verdict, and, therefore, inhere in the verdict itself, and averments concerning them are inadmissible to impeach the verdict.

A different rule, one permitting jurors to impugn the verdicts which they have returned by asserting matters derogatory to the mental processes, motivations and purposes of other jurors or purporting to explain how and why a juror voted as he did in arriving at his verdict, would inevitably open nearly all verdicts to attack by the losing party and thwart the courts in achieving a long held and cherished ambition, the rendering of final and definitive judgments.

Cox, 70 Wash. 2d 173, 179-80, 422 P.2d 515, 519-20 (1967) (internal citations omitted).

The contours of the rule were defined by the Supreme Court in

Gardner v. Malone as follows:

The crux of the problem is whether that to which the juror testifies (orally or by affidavit) in support of a motion for a

new trial, inheres in the verdict. If it does, it may not be considered; if it does not, it may be considered by the court as outlined in *State v. Parker, supra*. One test is whether the facts alleged are linked to the juror's motive, intent, or belief, or describe their effect upon him; if so, the statements cannot be considered for they inhere in the verdict and impeach it. If they do not, it then becomes a matter of law for the trial court to decide the effect the proved misconduct could have had upon the jury. Another test is whether that to which the juror testifies can be rebutted by other testimony without probing a juror's mental processes.

60 Wash.2d 836, 376 P.2d 651 (1962).

The *Gardner* court also recited examples which relate to a juror's motive, intent, belief, or their effect on a juror:

The distinction between motive and irregularities may sometimes be shadowy and difficult to perceive, but it is today universally agreed that on a motion to set aside a verdict and grant a new trial the verdict cannot be affected, either favorably or unfavorably, by the circumstances:

‘that one or more jurors *misunderstood* the judge's *instruction*;

‘or were influenced by . . . an *improper remark* of a fellow juror;

‘or *assented* because of *weariness* or illness or importunities;

...

‘*or had been* influenced by inadmissible evidence;

...

'or had omitted to consider important evidence or issues;

....

'or had by any other motive or belief been led to their decision.'

Gardner, 60 Wash.2d 836, *quoting*, 8 Wigmore, Evidence (McNaughton Rev. 1961) § 2349, p. 681 (footnotes omitted).

Consistent with the above, a court may not consider a juror's post-verdict statements that explain the reasoning behind the verdict. *Breckenridge v. Valley Gen. Hosp.*, 150 Wash.2d 197, 206 (2003). The trial court abuses its discretion if it considers statements that inhere in the verdict. *Id.* at 206-207.

2. Alleged Undisclosed Bias of Juror "Jay"

It is misconduct for a juror to fail to disclose material information when asked during voir dire. *Hill v. GTE Directories Sales Corp.*, 71 Wn. App. 132, 104, 856 P.2d 746 (1993). However, to obtain a new trial in a situation of material non-disclosure during voir dire, the party alleging juror misconduct must first demonstrate that the juror failed to answer honestly a material question, and then further show that a correct response would have provided a valid basis for a challenge for cause. *Hill, supra.* at 141.

In the instant case, Hensley has made no showing that any juror, particularly "Jay," failed to honestly answer a material question during voir

dire and that a correct response would have supported a challenge for cause. Accordingly, there was no actual bias on the part of this juror warranting a new trial.

3. **Allegation That Jurors Advocated Other Jurors Not Follow Instructions.**

Hensley claims the foreman and juror “Jay” advocated that the jury “disregard” the trial court’s instruction on proximate or “more probable than not” cause. This argument should be rejected for at least three reasons. First, Ms. Phillips, in her declaration, did not say that the foreman and juror “Jay” instructed other jurors to ignore the court’s instructions. Rather, she stated:

...

h. This theme went to disregarding the more probable than not instruction. The foreman and Jay said that the “more probable than not” instruction only applied to the standard of care, but not to causation. I and others tried to point out that the court’s instruction said that “more probable than not” applied to causation as well. Jay said “yeah, she sure could spin it couldn’t she?” He then said that the “more probable than not” standard as to causation was Ms. Schultz’s “spin” and not the court’s instruction.

CP 939.

Second, Ms. Phillips’ claims were rebutted by the declaration of the foreman, Mark Kinney, wherein he stated:

...

15. Neither I, as presiding juror nor the jury came up with a different instruction on causation than that provided

by the court. I made every effort to insure that the court was familiar with all of the court's instructions and that each juror had those instructions in mind before any vote was taken. As presiding juror, I did not provide the jury with any instruction on causation, but instead read the court's instructions and asked each juror to read the instructions on all aspects of the case.

...

CP 948.

Third, and finally, "a juror's failure to follow the court's instructions inheres in the verdict, and affidavits relating to such alleged misconduct may not be considered." *Ayers v. Johnson & Johnson Baby Products*, 117 Wn.2d 747, 769, 818 P.2d 1337 (1992). That some jurors believed that causation had to be proven by "direct" evidence instead of on a more probable than not basis, is the very definition of information which "inheres in the verdict" as that concept has been defined by Washington Courts.

4. Alleged Injection of Extrinsic Evidence

Hensley claims that juror "Jay's" revelation, during deliberations, that he took his mother to the ER, that they gave her dilaudid and her speech was slurred, but they sent her home and she was "fine" amounted to injection of extrinsic evidence, warranting a new trial. This, however, is precisely the "life experience" information jurors are allowed to bring to their deliberations, and is not misconduct warranting a new trial. *See*,

Breckinridge v. Valley General Hospital, 150 Wn.2d 197, 75 P.3d 944 (2003).

Moreover, even if the alleged “extrinsic evidence” did not amount to a personal experience as described in *Breckinridge*, and even if it did not inhere in the verdict, Hensley would still be required to show that reasonable grounds exist to conclude the alleged “misconduct” deprived the plaintiff of a fair trial. *See, Halverson v. Anderson*, 82 Wn.2d 746, 513 P.2d 827 (1973). Even if misconduct is found, “great deference is due the trial court’s determination that no prejudice occurred.” *Richards v. Overlake Hospital & Medical Center*, 59 Wn. App. 266, 271, 796 P.2d 737 (1990). Here, Ms. Phillips’ declaration does not show that the information about “Jay” taking his mother to the ER had a prejudicial impact on the jury.

III. CONCLUSION

Based on the foregoing argument and authority, Dr. Cruz respectfully requests that the trial court’s denial of Hensley’s motion for new trial be affirmed.

Dated this 25 day of February, 2016.

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 26 day of February, 2016, a copy of the BRIEF OF RESPONDENT MICHAEL CRUZ, M.D. was delivered to the following persons in the manner indicated:

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2/26/2016 /Spokane, WA
 (Date/Place)

Carol L. Myers
 Carol L. Myers