In The
Court of Appeals
Sixth Appellate District of Texas at Texarkana

No. 06-17-00056-CV

ELLEN S. WAKEFIELD, INDIVIDUALLY, AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF GEORGE WINSTON WAKEFIELD, DECEASED, AND VANN DOYLE WAKEFIELD, INDIVIDUALLY, Appellants

V.

PINNACLE ANESTHESIA CONSULTANTS, P.A., Appellee

On Appeal from the 348th District Court
Tarrant County, Texas
Trial Court No. 348-278566-15

Before Morriss, C.J., Moseley and Burgess, JJ.
Memorandum Opinion by Chief Justice Morriss

MEMORANDUM OPINION

Two days after breaking his ankle by falling while on a fishing trip, seventy-one-year-old George Wakefield underwent surgery in Tarrant County[1] for repair of the ankle fracture. George, who had a complicated medical history and was not in good health, was administered anesthesia by means of a laryngeal mask airway (LMA). Following the surgery, George was diagnosed with aspiration pneumonia, which led directly to acute respiratory failure and, ultimately, to his death some days later. The resulting lawsuit against the anesthesia group alleged that negligence in choosing to use the LMA caused George's aspiration and death. The trial court granted a defense summary judgment after excluding the plaintiff's medical expert's testimony. We affirm the judgment of the trial court.

George's wife, Ellen S. Wakefield, individually and as personal representative of George's estate, together with George's son, Vann Doyle Wakefield,[2] sued Pinnacle Anesthesia Consultants, P.A., among others.[3] The plaintiffs claimed that Pinnacle was responsible, under the doctrine of respondeat superior, for the negligence of its employee, Steve I.O. Wilson, M.D., in using the LMA rather than an endotracheal tube with an inflatable cuff (ETT) when administering anesthesia in order to protect George's airway and lungs from aspiration during the surgery. Wakefield not

[1]Originally appealed to the Second Court of Appeals, this case was transferred to this Court by the Texas Supreme Court pursuant to its docket equalization efforts. *See* TEX. GOV'T CODE ANN. § 73.001 (West 2013). We are unaware of any conflict between precedent of the Second Court of Appeals and that of this Court on any relevant issue. *See* TEX. R. APP. P. 41.3.

[2]We refer to the appellants collectively as Wakefield.

[3]Various other defendants were nonsuited in the trial court.

only claimed negligence from using the LMA, but also the lack of informed consent regarding the risks and hazards associated with the LMA procedure.

In support of its negligence claim against Pinnacle, Wakefield offered the testimony of its designated expert, Steven Schrenzel, M.D. According to Schrenzel, use of the LMA was contraindicated in light of George's high risk for aspiration, and its use proximately caused George's death. Schrenzel further opined that Wilson improperly offered an LMA for George's surgery and failed to advise George that the LMA was not safe or effective to prevent aspiration.

On Pinnacle's motion, the trial court excluded Schrenzel's testimony as scientifically unreliable.[4] The trial court then entered a no-evidence summary judgment in favor of Pinnacle, followed by a final take-nothing judgment in its favor.

On appeal, Wakefield contends that the trial court erred in striking Schrenzel's testimony, in granting Pinnacle's no-evidence motion for summary judgment on its negligence claims, and in granting Pinnacle's no-evidence motion for summary judgment on its informed-consent claim. Although we find that (1) Schrenzel's opinion on the medical standard of care is scientifically reliable, we conclude that (2) Schrenzel's opinion on medical causation is not scientifically reliable and, therefore, that (3) the trial court did not err in granting summary judgment denying Wakefield's negligence claims. We also conclude that (4) the trial court did not err in granting summary judgment denying Wakefield's informed consent claim.

[4]Pinnacle claimed that Schrenzel's testimony on the medical standard of care, medical causation, and informed consent was scientifically unreliable. Without specifying the precise basis of its order, the trial court granted Pinnacle's motion to strike and the *Daubert/Robinson*, *see infra* p. 8, challenge to Schrenzel's testimony.

(1) Schrenzel's Opinion on the Medical Standard of Care Is Scientifically Reliable

Wilson, who was asked to provide anesthesia for George, learned of George's medical history, which included lung cancer, chronic obstructive pulmonary disease, and esophageal cancer for which he had an esophagectomy[5] and a gastric pull-up procedure.[6] Essentially, George was left with no esophagus and no esophageal sphincter.[7] Consequently, George could not lie flat, as there was nothing to keep gastric acids from leaking into his trachea. George also had a history of aspiration[8] pneumonia and was taking three different medications to control stomach acids. Due to this history, George was at a very high risk for aspiration during surgery, a risk of which Wilson was aware.[9] Due to George's systemic disease, Wilson rated George as a classification three under the American Society of Anesthesia classifications. Wilson explained to George that a classification three meant that he was at high risk for anesthesia and that he was also a surgical risk.

Wilson discussed with George his options for delivery of anesthesia. He explained that placement of the ETT required paralyzation and that the ETT usually results in more airway trauma

[5]A surgery to remove the esophagus.

[6]A procedure whereby the stomach is pulled up to the chest.

[7]A ring of muscle surrounding and serving to close an opening of the stomach.

[8]According to Schrenzel, "Aspiration is defined as the inhalation of foreign material into the airways beyond the vocal cords. Aspirate can be liquids, blood, and food particles."

[9]Wilson testified that he knew that George was a 71-year-old male. He continued,

> I remember seeing his height and weight. I remember reading that he had a history of recurrent aspiration pneumonia after he had a gastric pull-up for esophageal cancer. I remember that he had a right lower lobectomy for right low -- right lower lobe carcinoma. I remember that he had coronary artery stints put in for coronary artery disease. He had a right popliteal artery stint put in for right popliteal artery stenosis which, you know, lies behind the right knee. He had hyper cholesterol

than the LMA. He explained that, with the LMA, there is less chance of laryngeal spasm and more hemodynamic stability. Wilson told George that both techniques could be done safely and that his airway could be safely protected with either technique. Wilson also told George that once the protection of the LMA or the ETT was removed, he would be at high risk for aspiration. Wilson testified that, once the LMA was well placed, it would cover the inlet to the trachea and provide protection. Consequently, Wilson did not feel as though the LMA posed a greater risk of aspiration. Because George did not want to undergo paralysis required with an ETT, he elected to use the LMA.

Before surgery, the head of George's bed was elevated to approximately thirty degrees to reduce the risk of aspiration. George was given Bicitra to neutralize stomach acid, and he had fasted for almost twelve hours before the surgery. General anesthesia was administered and the LMA was placed. The tip of the LMA was placed posterior to the trachea, the cuff was inflated, and there was a good seal. Wilson heard equal, bilateral breath sounds after placement of the LMA.[10]

During surgery, Wilson monitored George's volume, respiratory rate, and oxygen saturation. Wilson also checked for any signs of aspiration during the procedure. More

> anemia, severe COPD from 45 years or more of smoking. Of course, he came in with the right ankle fracture from a boating trip. He reported that he had twisted -- fell and twisted his right ankle. I also remember he had benign prostatic hypertrophy. And I read some of the other procedures that he had. He had some minor procedures like colonoscopy, tonsillectomy, T and A. And from the records he had diffuse interstitial disease on his chest x-ray. And from his medication information, he was on Plavix and some antidepressants. He was on anti-hypertensive for his high blood pressure. So from the record, that's the general information I got.

[10]Wilson repositioned the LMA before determining there was a proper seal.

specifically, Wilson checked for fluids in the tubular portion of the LMA. Every fifteen to twenty minutes—approximately three times—Wilson listened over the trachea for "any gurgling sound coming from his airway or any slushing of fluid back and forth through the tube, and leakage of air around the LMA." The surgery lasted for approximately fifty-one minutes. Wilson testified that it was highly improbable that George aspirated during surgery. George's oxygen saturation never dropped, and he never coughed or hiccupped. Wilson did not see any signs of aspiration throughout the surgery or at any other ime. Even so, Wilson could not say that he was 100 percent sure that George did not aspirate during surgery.

Following surgery, George was placed on 100 percent oxygen and was taken to the post-anesthesia care unit (PACU) at 12:55 p.m. Wilson assessed George in the PACU and determined that he was easily aroused, but drowsy. His vital signs were good,[11] and his oxygen saturation was 100 percent. The LMA was in place, and the cuff was inflated. Wilson spoke with George and told him that he was going to leave the LMA in place until he was more fully awake and alert. Wilson did not, however, listen to George's chest with a stethoscope. After he completed his assessment, Wilson advised the PACU nurse to keep the head of the bed elevated and to make sure that George was fully awake before she removed the LMA.

At 1:20 p.m., the PACU nurse removed the LMA, as George was awake, but drowsy. George was placed on a nasal cannula for the delivery of oxygen. Approximately eleven minutes after the LMA was removed, George experienced some weak coughing. At approximately

[11]George's blood pressure was 139 over 65, his pulse rate was 115, and his temperature was 98.2.

1:33 p.m., George's oxygen saturation had decreased from 99 to 92 percent while on the nasal cannula. The PACU nurse reported that George sounded congested. George was given Albuterol, after which his oxygen saturation level was somewhat improved. Shortly thereafter, George's oxygen saturation level dropped again, and he was placed on a Bilevel Positive Area Pressure (BiPAP) machine. His oxygen saturation level gradually increased to 100 percent, but George was unable to maintain his oxygen saturation level without the BiPAP machine. At 2:30 p.m., George was admitted to the Intensive Care Unit (ICU) for observation and respiratory care. Wilson assumed that George may have aspirated or have had a silent aspiration after the LMA was removed.

Subsequent chest x-rays revealed aspiration pneumonia with acute respiratory failure. George was intubated in the ICU, and his condition improved. After George was extubated, he developed new difficulty breathing and required re-intubation, but he declined treatment. George passed away March 22, 2013.

(a) Standards of Review and Law Regarding Expert Testimony

An expert witness "may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue." TEX. R. EVID. 702. Consequently, in order for expert testimony to be admissible, the expert must be qualified, and his testimony must be relevant and

based on a reliable foundation. *E.I. du Pont de Nemours & Co. v. Robinson*, 923 S.W.2d 549, 556 (Tex. 1995)[12] (adopting *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 591–92 (1993)).

The *Robinson* factors are, however, "non-exclusive, and they do not fit every scenario." *TXI Transp. Co. v. Hughes*, 306 S.W.3d 230, 235 (Tex. 2010) (citing *Gammill v. Jack Williams Chevrolet, Inc.*, 972 S.W.2d 713, 726 (Tex. 1998)). In cases where not all of the *Robinson* factors are applicable, it is proper for the trial court to consider the expert's knowledge, training, and experience in assessing the reliability of his testimony. *Id.*; *Gammill v. Jack Williams Chevrolet, Inc.*, 972 S.W.2d 713, 726–27 (Tex. 1998).

However, expert testimony that is based on the expert's knowledge, training, and experience is unreliable when "there is simply too great of an analytical gap between the data and the opinion offered." *Gammill*, 972 S.W.2d at 726–27 (citing *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997)). As explained in *Gammill*, an expert's observations must support his conclusions. *Id*. at 727. Stated differently, the expert's observations must be connected to his conclusions by a

[12]In making the threshold determination of admissibility under Rule 702, *Robinson* set out the following list of nonexclusive factors:

> (1) the extent to which the theory has been or can be tested;
>
> (2) the extent to which the technique relies upon the subjective interpretation of the expert;
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> (3) whether the theory has been subjected to peer review and/or publication;
>
> (4) the technique's potential rate of error;
>
> (5) whether the underlying theory or technique has been generally accepted as valid by the relevant scientific community; and
>
> (6) the non-judicial uses which have been made of the theory or technique.

Robinson, 923 S.W.2d at 557.

reasoned explanation. *See Earle v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999) ("An expert's simple *ipse dixit* is insufficient to establish a matter; rather, the expert must explain the basis of his statements to link his conclusions to the facts."); *Gen. Motors Corp. v. Burry*, 203 S.W.3d 514, 533 (Tex. App.—Fort Worth 2006, pet. denied). "In ensuring that the testimony rests on a reliable foundation, the trial court is not to determine whether an expert's conclusions are correct, but only whether the analysis used to reach those conclusions is reliable considering all the evidence." *Wiggs v. All Saints Health Sys.*, 124 S.W.3d 407, 410 (Tex. App.—Fort Worth 2003, pet. denied) (citing *Gammill* 972 S.W.2d at 728; *Marvelli v. Alston*, 100 S.W.3d 460, 474–75 (Tex. App.—Fort Worth 2003, pet. denied)). "[I]f no basis for the opinion is offered, or the basis offered provides no support, the opinion is merely a conclusory statement and cannot be considered probative evidence, regardless of whether there is no objection." *City of San Antonio v. Pollock*, 284 S.W.3d 809, 818 (Tex. 2009).

"The proponent of the expert testimony bears the burden of showing both tests have been met." *Wiggs*, 124 S.W.3d at 410 (citing TEX. R. EVID. 104(a), 702; *Robinson*, 923 S.W.2d at 557). "The decision whether to admit evidence rests within the discretion of the trial court." *Robinson*, 923 S.W.2d at 558. Consequently, we will reverse only if there is an abuse of that discretion. A trial court abuses its discretion when it acts without reference to any guiding rules or principles. *Id.*

(b) The Evidence

Schrenzel is board certified in anesthesiology by the American Board of Anesthesiology and is a Fellow of the American College of Anesthesiologists.[13] Schrenzel has been actively and continually engaged in practicing medicine as an anesthesiologist since 1981.[14] He has administered anesthesia to approximately 2,000 to 3,000 patients at risk of aspiration and at least 1,000 patients at high risk of aspiration. Schrenzel has extensive experience in using both ETTs with cuffs and LMAs, and he has used thousands of LMAs in administering anesthesia to patients. Over the years, he has personally witnessed one patient experiencing aspiration in the operating room and was present and witnessed patients experiencing aspirations in approximately twelve other patients. Schrenzel testified that he is familiar with the proper procedures to be followed in diagnosing or assessing and treating patients with aspirations in the operating room or PACU or even outside the PACU. Schrenzel testified that, because the standard of medical care required Wilson to select and recommend or offer indicated anesthesia procedures to maximize or best

[13]Schrenzel's formal education and training include graduation from the University of Pennsylvania with a Bachelor of Arts degree in 1975, and in 1978, he received a Medical Doctor (M.D.) degree from Chicago Medical School. He completed his internship training at Presbyterian Hospital in Philadelphia from 1978 to 1979 and received residency training in anesthesiology at Hospital of the University of Pennsylvania in Philadelphia from 1979 to 1981.

[14]Schrenzel testified by deposition and by affidavits dated August 4, 2016, and October 7, 2016. The August 4 affidavit was included in Wakefield's response to Pinnacle's no-evidence motion for summary judgment. Schrenzel's October 7 affidavit was included in "Plaintiffs' Response to Defendant Pinnacle Anesthesia Consultants, P.A.'s Motion to Strike Testimony of Plaintiffs' Expert Steven Schrenzel, M.D." After having considered Pinnacle's Motion to Strike and *Daubert/Robinson* Challenge, Renewed Motion to Strike and *Daubert/Robinson* Challenge and No Evidence Motion for Summary Judgment and Renewed No-Evidence Motion for Summary Judgment, together with Wakefield's responses to those motions, and after a hearing and the submission of additional briefing, the trial court granted Pinnacle's Motion to Strike and *Daubert/Robinson* Challenge and Renewed Motion to Strike and *Daubert/Robinson* Challenge, No-Evidence Motion for Summary Judgment and Renewed No-Evidence Motion for Summary Judgment.

protect George's airway during general anesthesia, Wilson should have selected an ETT rather than an LMA.[15] Schrenzel explained that George was at a very high risk of aspiration during surgery or even post-operatively because of his medical history and conditions. Wilson was aware of George's medical history of esophagectomy and the gastric pull-up procedure and aspiration pneumonia and that, as a result, George was at high risk of aspiration. He was also aware that George should never lie flat on his back and that George was taking three medications to control stomach acids.

Schrenzel testified that, because of George's high aspiration risk, use of the LMA was contraindicated. Schrenzel explained that, although a correctly placed LMA could block the airway (trachea) from blood, secretions, and surgical debris from above the level of the mask, it was not effective in protecting George's airway from aspiration. Schrenzel explained that, because

[15]Schrenzel testified,

> [T]he standard of medical care required Dr. Wilson to select and recommend or offer indicated anesthesia procedures to maximize or best protect Mr. Wakefield's airway during general anesthesia and refrain from selecting, recommending, or offering contraindicated anesthesia methods to Mr. Wakefield even though he preferred to avoid endotracheal extubation, paralysis, and ventilation during surgery and possibly postoperatively for a period of time.
>
> Further,
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> According to the applicable standards of medical care, Dr. Wilson should have correctly used an endotracheal tube with an inflatable cuff to administer anesthesia to Mr. Wakefield during his lower right leg and ankle surgery, because it was an indicated and safest method to protect Mr. Wakefield's airway and lungs from aspiration, in view of his very high risk of aspiration.
>
> And,
>
> According to the standards of medical care, it was or should have been reasonably foreseeable to a reasonably prudent anesthesiologist that selecting, recommending, or offering the LMA method, rather than endotracheal tube with inflatable cuff method, for Mr. Wakefield's anesthesia could lead to or result in aspiration of his stomach acid or contents and eventual aspiration pneumonia and death.

the LMA stays outside of the trachea, it could not have prevented aspirated fluids or gastric contents from entering George's airway. Conversely, he explained, an ETT with an inflatable cuff would have blocked off the trachea. He further testified that the ETT was ninety-five percent effective in protecting the patient's airway from aspiration.[16]

Schrenzel supported his opinion that the standard of medical care in this case required use of an ETT rather than an LMA with information contained on the LMA package insert and medical literature, as well as his experience in the administration of anesthesia to patients at high risk of aspiration. Schrenzel concluded that, because an LMA was contraindicated due to George's very high risk of aspiration, Wilson fell below the standard of care in failing to select, recommend, or offer an ETT to administer anesthesia to George. Schrenzel further opined that, because the LMA failed to protect George from aspiration, George probably experienced aspiration during surgery, resulting in aspiration pneumonia and eventual death. The parties dispute the scientific reliability of Schrenzel's opinions on the medical standard of care and on proximate cause.

[16]Schrenzel clarified this statement in his deposition. He explained,

> My statement that the endotracheal tube is 95 percent effective at preventing aspiration is really based on a study that was at least 35, maybe 40 years old, that involved injecting dye into the patient's mouth after they were intubated, and seeing if any of that dye made it past the cuff. And if they saw any of this blue dye whatsoever below the cuff, that was considered a failure, but this was minuscule quantities. In my experience, having taken care of thousands of patients who are at risk of aspiration, I never saw the endotracheal tube fail to protect the patient.

(c) Opinion on the Medical Standard of Care

Pinnacle contends that Schrenzel's opinion on the medical standard of care is unreliable because Schrenzel has no personal experience, literature, or other support for his opinion that the risk of aspiration is greater with the LMA than with the ETT.[17] We disagree.

In support of its contention that Schrenzel's experience is insufficient to lend reliability to his opinion on the medical standard of care, Pinnacle relies on *Wiggs v. All Saints Health System*, 124 S.W.3d 407 (Tex. App.—Fort Worth 2003, pet. denied). In that case, the expert, Watkins, opined that the cause of Wiggs' loss of vision following back surgery was due to ischemic optic neuropathy (ION). The trial court excluded Watkins' testimony as scientifically unreliable. On appeal, our sister court evaluated the quantity and quality of Watkins' experience and concluded that his "lack of personal experience with patients having ION amount[ed] to no experience at all." *Id*. at 413. Watkins had no special training regarding ION and its causes and had never treated anyone for ION or even made a diagnosis of ION. *Id*. Consequently, Watkins' experience was insufficient to support his opinion. *Id*. The medical literature—two articles "pulled" by Watkins—did not render his opinion reliable. Watkins did not explain how the articles supported his opinion

[17]Schrenzel opined that, "[a]ccording to the applicable standards of medical care, after Dr. Wilson made his preoperative assessment of George Wakefield, he should have become aware of Mr. Wakefield's very high risk of aspiration during surgery or even postoperatively because of his medical history and conditions." Further, he indicated that "Dr. Wilson should have recognized and assessed that use of the endotracheal tube with ventilation for administration and maintenance of Mr. Wakefield's anesthesia was indicated, and that use of a laryngeal mask airway (LMA) for administration and maintenance of his anesthesia was contraindicated due to Mr. Wakefield's high risk of aspiration during surgery." In essence, Schrenzel's opinion was not that the risk of aspiration is greater with the LMA than with the ETT, but that the risk of aspiration is greater with an LMA than with the ETT in a person—like George—with a very high risk of aspiration.

and did not point to specific passages supporting his opinion. *Id*. In fact, both articles seemed to conclude that the cause of ION was unknown in the scientific community. *Id*.

In this case, unlike *Wiggs*, Schrenzel testified as to his extensive experience in the administration of anesthesia to thousands of patients at risk of aspiration and at least 1,000 patients at high risk of aspiration. He further testified to his experience using thousands of LMAs in administering general anesthesia to patients and his early use of LMAs in this country. Schrenzel further testified that he has used ETTs in administering general anesthesia to patients from 1979 to the present. While it is true that Schrenzel has never used an LMA in a patient at high risk for aspiration and that he has not seen a colleague use an LMA in a patient at high risk for aspiration, we cannot conclude that Schrenzel's level of experience in this arena renders his opinion on the medical standard of care unreliable. Schrenzel demonstrated that he has more than general experience in anesthesia. The evidence demonstrates that he has extensive experience in administering anesthesia to patients at high risk of aspiration.

Beyond that, however, Schrenzel supported his standard of care opinion with package insert information provided by the LMA manufacturer as well as medical literature on the subject. The package insert for the LMA states:

> **Contraindication**
>
> Due to the potential risk of regurgitation and aspiration, do not use the LMA™ airway as a substitute for an endotracheal tube in the following elective or difficult airway patients on a non-emergency pathway:
>
> 1. Patients who have not fasted, including patients whose fasting cannot be confirmed.
> 2. . . . any condition associated with delayed gastric emptying.

Caution

The LMA™ airway does not prevent regurgitation or aspiration.

Schrenzel relied on additional literature that stated, "[L]aryngealMask airways . . . should not be used in anesthetized patients who are at increased risk of pulmonary aspiration. Patients will be at risk if the stomach is not empty. . . . Several diseases and symptoms, such as . . . hiatus hernia . . . are known to delay gastric emptying." Additionally, "Gastric emptying may also be delayed in patients who have previously undergone upper gastrointestinal surgery . . . ."[18] The same article states, however, "We often do not know whether the predisposing factors described above really do increase the incidence of aspiration." Schrenzel conceded that there is no quantification of risk using the LMA in high-risk patients like George, because "the study can never be done. No one would ever get consent to do that study."

Schrenzel testified that anesthesiologists have long recognized that patients with conditions which delay or prevent the stomach from emptying should normally be regarded as "full stomachs." Further, based on George's esophagectomy and gastric pull-up surgery, Schrenzel testified that he should have always been regarded as a non-fasting patient. Schrenzel explained that, as a result of those surgeries, George's esophagus had been removed and replaced with what was a total hiatal hernia. He further testified that George's inability to lie flat was indicative of delayed gastric emptying.

[18]T. Asai, Editorial II, *Who is at Increased Risk of Pulmonary Aspiration?* 93 BRIT. J. ANAESTHESIA 497, 497–500 (2004).

Schrenzel also relied on literature that stated, "The primary contraindication to elective use of the LMA is a risk of gastric-contents aspiration (e.g., full stomach, hiatus hernia with significant gastroesophageal reflux, intestinal obstruction, delayed gastric emptying, poor history)."[19] Further, "Cuffed endotracheal intubation is the mainstay of prevention of regurgitated material from reaching the trachea and lungs. . . . The LMA reduces barrier pressure at the LES with an increased incidence of reflux in comparison with the cuffed endotracheal tube."[20] *Morgan and Mikhail's Clinical Anesthesiology*, on which Schrenzel relied, indicates that "[c]ontraindications for the LMA include patients with pharyngeal pathology (eg, abcess), pharyngeal obstruction, full stomachs (eg, pregnancy, hiatal hernia) or low pulmonary compliance (eg, restrictive airway disease) requiring peek inspiratory pressures greater than 30 cm H2O."[21] Further, "Tracheal intubation is the gold standard in protecting the airway from aspiration in anesthetized patients."[22]

Schrenzel further relied on literature stating, "The primary limitation of the laryngeal mask airway (LMA) is that it does not reliably protect the lungs from regurgitated stomach contents, although it may act as a barrier at the level of the upper esophageal sphincter if it is correctly positioned."[23] The incidence of aspiration with the LMA "has been estimated at 0.02%, which is

[19]PAUL G. BARASH, BRUCE F. CULLEN, ROBERT K. STOELTING, MICHAEL K. CAHALAN & M. CHRISTINE STOCK, CLINICAL ANESTHESIA 760 (6th ed. 2009).

[20]*Id.* at 1224.

[21]JOHN F. BUTTERWORTH, DAVID C. MACKEY & JOHN D. WASNICK, MORGAN & MIKHAIL'S CLINCAL ANESTHESIOLOGY 97 (5th ed., McGraw-Hill Comps. 2013) (1992).

[22]Alexander Ng & Graham Smith, *Gastroesophageal Reflux and Aspiration of Gastric Contents in Anesthetic Practice*, 93 ANESTHESIA & ANALGESIA 494, 494–513 (2001).

[23]C. Keller, J. Brimacombe, J. Bittersohl, P. Lirk & A. von Goedecke, *Aspiration and the Laryngeal Mask Airway: Three Cases and a Review of the Literature*, 93 BRIT. J. ANAESTHESIA 579, 579–82 (2004).

similar to tracheal intubation in elective patients."[24] Schrenzel testified that the similarity of the estimated incidence of aspiration with the LMA and the ETT is based on the understanding that the LMA was not studied on patients at high risk for aspiration. In fact, one article on which Schrenzel relied concluded that the use of the LMA did not increase the risk of incurring signs or symptoms of pulmonary aspiration compared with an ETT. That same article, however, indicated that the LMA was not used on patients at high risk for aspiration.[25]

The substance of Schrenzel's standard of care opinion was that, in patients at high risk of aspiration, the best protection against aspiration is an ETT. Consequently, in his opinion, the medical standard of care requires use of an ETT in such patients. The medical literature on which Schrenzel relied, together with his experience as outlined above, render his standard of care opinion scientifically reliable.[26]

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[24]*Id.* Additional literature on which Schrenzel relied also recognizes that "A known disadvantage of the [LMA] is its inability to protect against pulmonary aspiration and regurgitation of gastric contents." CARIN HAGBERG, BENUMOF'S AIRWAY MANAGEMENT 1186 (2nd ed. 2007).

[25]This particular article stated, "Our choices for excluding the LMA were based upon documented risk factors and reflected our opinions as to which were most important. We are confident that the contraindications were well known by anesthetists and were strictly observed . . . . This is supported by the almost universal use of tracheal tubes in surgical procedures where there were contraindications to the LMA." A. Bernardini & G. Natalini, *Risk of Pulmonary Aspiration with Laryngeal Mask Airway and Tracheal Tube: Analysis on 65 712 Procedures with Positive Pressure Ventilation*, 64 ANAESTHESIA 1289, 1289–94 (2009). Consequently, the article continued, "in the clinical setting, the LMA was not used for high-risk patients. The odds ratio for aspiration in patients in whom the LMA was used was < 1 in the univariate analysis, which is consistent with selection of patients with a lower risk of aspiration." *Id.*

[26]Pinnacle claims that the literature cited by Schrenzel in support of his opinion that the LMA was contraindicated in a patient at high risk for aspiration does not take into account patient positioning and the administration of Bicitra. We do not believe that the efficacy of these measures in conjunction with the use of the LMA renders Schrenzel's standard of care opinion unreliable. The record reflects that George could not lay in a prone position and that he was on three medications for acid reduction prior to the surgery. We address the issue of patient positioning and the administration of Bicitra as those measures impact Schrenzel's opinion on proximate cause.

(2) Schrenzel's Opinion on Medical Causation Is Not Scientifically Reliable

"Recovery in a medical malpractice case requires proof to a reasonable medical probability that the injuries complained of were proximately caused by the negligence of a defendant." *Columbia Rio Grande Healthcare, L.P. v. Hawley*, 284 S.W.3d 851, 860 (Tex. 2009) (citing *Park Place Hosp. v. Estate of Milo*, 909 S.W.2d 508, 511 (Tex. 1995)). "The proximate cause element has two components: cause-in-fact and foreseeability." *LMB, Ltd. v. Moreno*, 201 S.W.3d 686, 688 (Tex. 2006). Proof that negligence was a cause-in-fact of injury requires proof that the act or omission was a substantial factor in causing the injury and that, without the act or omission, the harm would not have occurred. *Id.*

Generally, expert testimony based on reasonable medical probability is required to establish proximate cause. *See Jelinek v. Casas*, 328 S.W.3d 526, 533 (Tex. 2010). In other words, the expert must, "to a reasonable degree of medical probability, explain how and why the negligence caused the injury." *Id.* at 536. "'Reasonable medical probability' is established, in the absence of other reasonable explanations, when it becomes 'more likely than not' that the condition or injury complained of resulted from the event." *Marvelli*, 100 S.W.3d at 480.

It is undisputed that George aspirated and that he died from aspiration pneumonia and acute respiratory failure. There are three time frames during which George could have aspirated: before, during, or after surgery. Schrenzel opined that George's aspiration happened during surgery. Pinnacle claims, though, that Schrenzel did not properly rule out other plausible causes of George's injury. *See Wal-Mart Stores v. Merrell*, 313 S.W.3d 837, 839–40 (Tex. 2010) (expert's failure to explain or adequately disprove alternative theories of causation makes his or her own theory

speculative and conclusory). In other words, it complains that Schrenzel's proximate cause opinions were unreliable because "he lacked any factual basis for his opinion on the timing of the aspiration so as to link use of an LMA to the aspiration event,"[27] and, therefore, failed to rule out other plausible causes of George's aspiration pneumonia, acute respiratory failure, and subsequent death.

"When the evidence demonstrates that 'there are other plausible causes of the injury or condition that could be negated, the plaintiff must offer evidence excluding those causes with reasonable certainty.'" *Bustamante v. Ponte*, 529 S.W.3d 447, 457 (Tex. 2017) (quoting *Merrell Dow Pharm., Inc. v. Havner*, 953 S.W.2d 706, 720 (Tex. 1997)). In *Jelinek*, the court held that, when "circumstantial evidence is consistent with several possible medical conclusions, only one of which establishes that the defendant's negligence caused the plaintiff's injury, an expert witness must explain why, based on the particular facts of the case, that conclusion is medically superior to the others," based on "verifiable medical evidence, not simply the expert's opinion." *Jelinek*, 328 S.W.3d at 529, 536. We examine the evidence to determine whether this standard was met.[28]

Schrenzel explained that George

[27]If George aspirated before the LMA was placed, there could be no causal link between the use of the LMA and George's demise. Likewise, if George aspirated after the LMA was removed, there can be no causal link between the use of the LMA and George's demise.

[28]In *Jelinek*, the expert testified that "the Hospital's negligence 'in medical probability' caused Casas additional pain and suffering." *Jelinek*, 328 S.W.3d at 535. This opinion was based on the presence of an intra-abdominal infection that could have been treated with certain antibiotics. Circumstantial evidence of infection existed, but there was no direct evidence of an infection. The expert conceded that the circumstantial evidence, on which he relied to form the opinion the patient suffered from an infection, was equally consistent with two other infections cultured from the patient's incision and blood—neither of which were treatable by the antibiotics in question. *Id*. The court held, "When the only evidence of a vital fact is circumstantial, the expert cannot merely draw possible inferences from the evidence and state that 'in medical probability' the injury was caused by the defendant's negligence." *Id*. at 536.

> probably experienced aspiration during the surgery because he was at a very high risk of aspiration into his trachea and lungs, the LMA did not protect him against such aspiration, and either Dr. Wilson did not recognize or assess the aspiration, because, as he conceded in his deposition testimony, he did not perform auscultation of his chest after the initial intubation procedures on Mr. Wakefield, and he only auscultated his neck maybe three times during the surgery, or Mr. Wakefield experienced a silent aspiration that went unrecognized at the time of its occurrence during surgery. As of March 2013, many cases of aspiration, particularly under anesthesia, were silent and unrecognized at the time of occurrence, when such aspirations were witnessed, it was common to see a delay in the onset of clinical deterioration, and such deterioration could continue over four to six hours.

(a) Pre-operative Aspiration

Pinnacle complains that this explanation fails to exclude a pre-operative aspiration event, given that George was at high risk to aspirate based on his anatomy and his history. Pinnacle points out that Schrenzel testified that it can take up to six hours for clinical manifestations of an aspiration event to appear. As such, there was a window of time starting in the morning, hours before the LMA was placed, during which George could have aspirated.

Schrenzel testified that there is no factual event demonstrating evidence of a pre-operative aspiration, a time period during which George was in control of his protective airway reflexes. In fact, Schrenzel concurs with Pinnacle's experts, Amir Baluch, M.D.,[29] and Jonathan Weissler, M.D.,[30] that there is no medical evidence to indicate that George aspirated preoperatively because

[29]Baluch, an anesthesiologist licensed to practice in Texas, testified that he was not aware of any medical evidence to indicate that George had aspirated from the time that he was admitted to North Hills Hospital until the time Wilson began administering general anesthesia and inserting the LMA. There was no change in his vital signs or oxygen saturation level, and he did not receive any breathing treatments preoperatively.

[30]Weissler, a pulmonary and critical care physician, testified that, preoperatively, George's respiratory drive and reflexes to protect his airway were intact, and there is no medical evidence to the contrary. In his opinion, George did not experience aspiration before he was taken to the operating room, given an LMA, and administered general anesthesia. According to Weissler, George was exposed to the greatest risk of aspiration when his airway was removed.

there was no change in his vital signs or oxygen saturation levels. Moreover, there are no medical records to indicate that George received pre-operative breathing treatments for aspiration. Schrenzel therefore opined that "it is not possible that [George] aspirated pre-operatively while his protective airway reflexes were intact," and he, therefore, "ruled that possibility out as not being probable or likely."

Even assuming that pre-operative aspiration was a plausible cause of George's aspiration pneumonia and respiratory failure, we believe this evidence, based on a reasonable degree of medical probability, rules out a pre-operative aspiration.

(b) Intra-Operative versus Post-Operative Aspiration

It is undisputed that there were no clinical signs of aspiration during surgery. Wilson testified that George's oxygen saturation levels were "pretty steady throughout the procedure," there were no signs of bronchospasm, and there was "no difficulty in maintaining his ventilation throughout." On arrival in the PACU, the LMA was still in place. George's oxygen saturation was 100 percent, his blood pressure was 139 over 65, his pulse was 115, his respiratory rate was "about 15," and his temperature was 98.2. Although drowsy, George was able to obey commands, and according to Wilson, "he was breathing well. His exertion, everything, very good air entry." Schrenzel conceded that he could not find any factual basis from the anesthesia or intra-operative records that would indicate that the aspiration happened during surgery.

Baluch testified to his belief that, most likely, George aspirated in the PACU around the time the LMA was removed. He further opined that it is possible that George could have experienced a very small aspiration during the surgery. A large aspiration, however, would result

in oxygen saturation decline, bronchospasm, and elevated peak airway pressures. In this case, he could not state the quantity of aspiration, but observed that it was "enough to eventually put [George] in the ICU." He further explained that George was completely stable during the operation and that there was no change in vital signs, no elevated peak pressures, no elevated blood pressure, and no signs of bronchospasm or laryngospasm. When George was taken to the PACU, the LMA was removed and coughing ensued. Shortly thereafter, his oxygen saturation declined. Baluch testified that patients "cough when something goes into the trachea. When they have their airway reflexes, they're going to cough, so that tells me that's when the aspiration happened. That's the most likely based on the time course."

In support of his opinion that George experienced an intra-operative aspiration, Schrenzel testified that George's protective airway reflexes "were suppressed and obtunded by the anesthesia" during surgery and that the LMA did not protect against aspiration in this high-risk patient. In George's case, however, the head of the bed was elevated thirty degrees during surgery, and George was given Bicitra to reduce the impact of an aspiration, should one happen. Although Schrenzel is not aware of any data which indicates that elevating the head of the bed lowers the risk of aspiration under anesthesia, he agrees that it is a reasonable step to help minimize the risk of aspiration. Schrenzel has no personal experience with the efficacy of bed positioning and medication such as Bicitra as factors that mitigate against the risk of aspiration with an LMA.

Schrenzel also posits that, because Wilson did not auscultate George's lungs during surgery and auscultated his neck only three times, he did not recognize or assess the aspiration. The medical records indicate, though, that, after George arrived in the PACU, his lungs were

auscultated by the nurse, and they were clear; there were no adventitious sounds. Schrenzel explained that the anesthetic agents Desflurane and Decadron are powerful bronchodilators and that the combination of these agents, based on a reasonable degree of medical probability, masked the lung sounds of the intra-operative aspiration.

Schrenzel agreed, though, that the first evidence of a drop in George's oxygen saturation levels happened in the PACU approximately eleven minutes after the LMA was removed. On removal of the LMA, George experienced a weak cough and attempts to cough. At that time, oxygen saturation levels were ninety to ninety-two percent. Schrenzel acknowledged that patients can aspirate "during what looks like coughing efforts" and agreed that George's cough and/or coughing effort was the "first factual time [he saw] anything in vital signs or the patient's action demonstrating something consistent with aspiration." Within thirteen minutes after the LMA was removed, the PACU nurse notified Wilson that George's oxygen saturation level had dropped. George was given Albuterol, and that briefly improved his saturation level. Approximately twenty minutes later, though, his oxygen saturation level dropped to between eighty-six and eighty-eight percent. At that time, George was on mask oxygen and continued to cough. After George was placed on a BiPAP, his oxygen saturation level improved to ninety-six percent.

Although Schrenzel could not exclude the documented coughing spell after removal of the LMA as a time that George aspirated, he testified that it was unlikely that George aspirated when he coughed. This was an unlikely time for George to have aspirated, explained Schrenzel, because the LMA was not removed until George demonstrated to the PACU nurse that he was fully awake and alert. The coughing happened at a time when George's protective airway reflexes were intact

and were no longer anesthetized. Because George was able to protect his own airway at the time he coughed, Schrenzel opined, it is unlikely that he aspirated.

According to Schrenzel, the course of events leading to aspiration pneumonia instead resulted from a "silent aspiration that went unrecognized at the time of its occurrence during surgery." A "silent aspiration," Schrenzel testified, would not immediately affect oxygen saturation levels, because lung pathology resulting from aspiration is an ongoing process. Schrenzel opined that, having witnessed a number of aspirations, a patient's clinical status often does not deteriorate "until a period of time has passed."[31] The full impact of the inflammatory response to an aspiration could take, according to Schrenzel, from "one to four hours, or even up to six hours." He further explained that "the fact that the patient's vital signs looked acceptable during the anesthetic may just mean that this was too early in the aspiration for substantial deterioration to have taken place."

In his own experience, Schrenzel has personally been present in the operating room on approximately thirteen occasions during or after which patients aspirated. Approximately half of those aspirations were silent. He became aware of these silent aspirations because the patients deteriorated while in the operating room. Schrenzel does not, however, specifically remember being called into the PACU when a patient deteriorated after an aspiration event. In 100 percent of Schrenzel's personal experience with either silent or witnessed aspirations, the patient

[31]In support of this proposition, Schrenzel relied on a single piece of scientific literature, which stated, "The course of pneumonitis can be broadly differentiated into 2 clinical phases. Phase 1 involves intense coughing or bronchospasm that occur immediately following the aspiration event whereas the second phase characterized by the onset of inflammation in the pulmonary occurs over the next 4–6 hrs. . . ." Krishnan Raghavendran, Jean Nemzek, Lena M. Napolitano & Paul R. Knight, *Aspiration-Induced Lung Injury*, 39 CRITICAL CARE MED. 818, 818–26 (2011).

deteriorated sufficiently during the operation that it was evident the patient had aspirated in the operating room. Schrenzel has never personally seen a patient who aspirated in the operating room in which there were no clinical signs of deterioration and in which deterioration was evident later in the PACU.

In the six or seven cases in which Schrenzel witnessed an aspiration in the operating room, there were no immediate changes in the patient's vital signs. The aspirations appeared to be clinically insignificant. However, over the course of a few hours, the condition of these patients worsened as they deteriorated. With respect to the silent aspirations, Schrenzel could not recall how long the patients had been under anesthesia, or the time between the silent aspiration and the deterioration of vital signs.

Schrenzel agreed that one of two conclusions can be drawn from the fact that George's vital signs were acceptable during the operation. Stable vital signs during the surgery indicate that either it was too early in the course for substantial deterioration to have taken place following a silent aspiration or the aspiration had not yet happened. Schrenzel opined that it is more likely than not that the aspiration took place during "a period of almost two hours in which [George]" had lost "all of his protective reflexes due to anesthetic agents, nothing had been done to add protection to his airway," and he was "completely vulnerable" and "totally defenseless for two hours." He contrasts this with a time during which "he's relatively awake, has much or all of his airway protective reflexes back."

Applying the above stated legal standards, we cannot say that Schrenzel explained why, based on the particular facts of this case, his conclusion that George experienced an intra-operative

aspiration is medically superior to the conclusion that the aspiration happened post-operatively. The verifiable medical evidence indicates that George was stable throughout the surgery and showed no clinical signs of aspiration during surgery. The evidence further indicates that the first clinical sign of aspiration happened post-operatively. Although Schrenzel explained the reason for his opinions based on the time course of George's post-operative deterioration, he was unable to support this opinion with his own clinical experience or with a broad reading of medical literature.

Schrenzel's experience relating to the time course of patient deterioration in intra-operative aspirations revealed that, in each of those cases, clinical evidence of aspiration was apparent during the operation. Schrenzel testified that he has no experience in treating a patient who aspirated intra-operatively, but who had no clinical signs of aspiration until they were transported to the PACU. In short, Schrenzel has never been involved in a case in which a patient experienced a silent, intra-operative aspiration in the absence of clinical signs of that aspiration during the course of the surgery. Schrenzel could not recall the time at which clinical signs of aspiration became evident in the cases of silent aspiration about which he testified.

The literature on which Schrenzel relied to support his opinion that clinical signs of aspiration do not appear for four to six hours after the fact broadly supports the proposition that pulmonary inflammation does not happen immediately. That same literature, however, speaks of "intense coughing or bronchospasm that occur immediately following the aspiration event," later followed by pulmonary inflammation. It makes no mention of a silent, intra-operative aspiration, as Schrenzel opined happened here. This literature also indicates that the coughing or

bronchospasm follows the aspiration event. This is counter to Schrenzel's opinion that the "weak coughs and attempts to cough" were evidence that George was protecting his airway and did not aspirate. Schrenzel failed to support his opinion of intra-operative aspiration in the absence of clinical evidence with a broad reading of the medical literature. *See Wiggs*, 124 S.W.3d at 413 (if medical expert seeks to support causation opinion with medical literature, he must base opinion on "broad reading of the medical literature"). A "'Broad reading of the medical literature' means that the expert must 'point to specific passages in varied and different sources that are generally accepted as support for his conclusion.'" *Id*. (quoting *Minn. Min. & Mfg. Co. v. Atterbury*, 978 S.W.2d 183, 193 (Tex. App.—Texarkana 1998, pet. denied).

An expert's opinions on causation must deal in reasonable medical probabilities. That is, an expert opinion must illustrate that the ultimate harm "more likely than not" resulted from the purported misconduct. *Jelinek*, 328 S.W.3d at 532–33. Based on the record evidence, an intra-operative aspiration cannot be proved or disproved. It is equally plausible that George experienced a post-operative aspiration. Consequently, Schrenzel's causation testimony is not based on reasonable medical probability. *See Bustamante*, 539 S.W.3d at 457; *Jelinek*, 328 S.W.3d at 536, 539. We therefore conclude that the trial court acted within its discretion in striking Schrenzel's testimony.

(3) The Trial Court Did Not Err in Granting Summary Judgment Denying Wakefield's Negligence Claims

A no-evidence motion for summary judgment is essentially a motion for a pretrial directed verdict. TEX. R. CIV. P. 166a(i); *Timpte Indus., Inc. v. Gish*, 286 S.W.3d 306, 310 (Tex. 2009). A party is entitled to a no-evidence motion for summary judgment if, "[a]fter adequate time for

discovery . . . there is no evidence of one or more essential elements of a claim or defense on which an adverse party would have the burden of proof at trial." TEX. R. CIV. P. 166a(i); *Fort Worth Osteopathic Hosp. v. Reese*, 148 S.W.3d 94, 99 (Tex. 2004). The trial court must grant the motion unless the non-movant produces more than a scintilla of evidence raising a genuine issue of material fact on the challenged elements. *Zapata v. The Children's Clinic*, 997 S.W.2d 745, 747 (Tex. App.—Corpus Christi 1999, pet. denied). More than a scintilla of evidence exists when the evidence supporting the finding, as a whole, "rises to a level that would enable reasonable and fair-minded people to differ in their conclusions." *Havner*, 953 S.W.2d at 711.

We review the trial court's grant of summary judgment de novo. *Valence Operating Co. v. Dorsett*, 164 S.W.3d 656, 661 (Tex. 2005). In most medical malpractice cases, "expert testimony is necessary" to establish or preclude summary judgment. *Blan v. Ale*, 7 S.W.3d 741, 744 (Tex. App.—Houston [14th Dist.] 1999, no pet.); *see Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 880 (Tex. 2001). We review the evidence in the light most favorable to the non-movant, disregarding all contrary evidence and inferences. *Timpte Indus., Inc.*, 286 S.W.3d at 310. Where, as here, a trial court's order granting summary judgment does not specify the ground or grounds relied on for its ruling, we affirm the summary judgment if any theory advanced is meritorious. *Carr v. Brasher*, 776 S.W.2d 567, 569 (Tex. 1989).

Pinnacle's no-evidence motion for summary judgment was predicated on the premise that the opinions of Wakefield's sole expert should be struck. The motion claims that "Schrenzel offers no evidence . . . that Dr. Wilson fell below the standard of care or that Defendant proximately caused the damages claimed by Plaintiffs" and that, therefore, its no-evidence motion for summary

judgment on Wakefield's negligence claims should be granted. Once the trial court excluded Schrenzel's testimony, Wakefield did not have reliable, admissible testimony from an expert to support its negligence case.

Although we conclude that the trial court erroneously excluded reliable evidence on the standard of medical care, we also conclude that it properly excluded unreliable evidence on proximate cause. In the absence of the properly excluded testimony on proximate cause, Wakefield did not produce more than a scintilla of evidence that Pinnacle's negligence proximately caused George's death. We therefore affirm the trial court's summary judgment on Wakefield's negligence claims.

(4) The Trial Court Did Not Err in Granting Summary Judgment Denying Wakefield's Informed Consent Claim

Among the allegations leveled at Pinnacle was the claim that Wilson failed to obtain George's informed consent "to the LMA procedure or treatment for administration of anesthesia during the . . . surgery . . . and Wilson improperly failed to inform [George] of the risks and hazards associated with the LMA procedure." Pinnacle moved for summary judgment on this claim on the basis that there is no evidence to rebut the List A presumption on informed consent. Wakefield contends that the trial court erred in its entry of summary judgment on that basis.

Chapter 74 of the Texas Civil Practice and Remedies Code governs informed consent claims. "Chapter 74 creates the Texas Medical Disclosure Panel (the 'Panel') and charges the Panel with responsibility for identifying those medical and surgical procedures that do and do not require disclosure of risks and hazards to the patient or the person authorized to consent for the patient." *Vaughn v. Nielson*, 274 S.W.3d 732, 736 (Tex. App.—San Antonio 2008, no pet.) (citing TEX.

CIV. PRAC. & REM. CODE ANN. §§ 74.102–.103 (West 2017)). "The Panel creates lists of procedures that require specific disclosures, which are referred to as 'List A' procedures, and those that require no disclosure, which are referred to as 'List B' procedures."[32] *Id*. Consent "in writing, signed by the patient . . . and by a competent witness," is effective for a List A procedure if the consent "specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the disclosure panel under Section 74.103." TEX. CIV. PRAC. & REM. CODE ANN. § 74.105 (West 2017). Disclosure "made as provided in Section 74.104" creates "a rebuttable presumption that the requirements of Sections 74.104" (duty of physician to provide disclosure of risks and hazards of List A procedure) "and 74.105" (manner of disclosure) "have been complied with . . . ." TEX. CIV. PRAC. & REM. CODE ANN. § 74.106 (West 2017).

Although it is undisputed that George signed an anesthesia consent form which disclosed the List A risks required to be disclosed to a patient undergoing general anesthesia, Wakefield contends that his informed consent claim should be permitted to proceed because (1) the procedure here—use of an LMA for a patient with high aspiration risk and a greater risk of aspiration with an LMA versus an ETT—is not a procedure that appears on Lists A or B and (2) George's consent was invalidated by Wilson's misrepresentation that the LMA and the ETT were equally safe. We disagree.

[32]These lists are published in the Texas Administrative Code. 25 TEX. ADMIN. CODE § 601.2 (List A), § 601.3 (List B) (2016).

The provision of general anesthesia is a List A procedure.[33] This list does not differentiate based on the type of airway used. Section 601.2(a)(2) is intended to cover all situations in which general anesthesia is provided and lists the risks which must be disclosed when general anesthesia is provided. George was informed of these risks and consented to them. *See* 25 TEX. ADMIN. CODE § 601.2. We find no merit to the argument that this case involved a unique procedure not covered by List A.

The Texas Supreme Court has rejected the idea that an expert witness can rebut the presumption of informed consent in List A cases by claiming additional risks which, in the expert's opinion, should have been disclosed. *Earle v. Ratliff*, 998 S.W.2d 882, 891 (Tex. 1999). In that case, the claimant attempted to rebut the List A presumption through expert testimony that risks

[33]Section 601.2, Title 25 of the Texas Administrative Code, captioned "Procedures Requiring Full Disclosure of Specific Risks and Hazards -- List A" requires the disclosure of the following risks inherent in general anesthesia care:

(a) Anesthesia.

(2) General.

(A) Permanent organ damage.

(B) Memory dysfunction/memory loss.

(C) Injury to vocal cords, teeth, lips, eyes.

(D) Awareness during the procedure.

(E) Brain damage.

25 TEX. ADMIN. CODE § 601.2.

other than those identified by the Panel should have been disclosed. The court observed that the Panel, which prepares List A, was charged with identifying what risks must be disclosed and the form in which disclosure must be made. *Id*. "[A] physician who discloses to a patient the risks of a List A procedure in the substance and form prescribed by the Panel 'shall be considered to have complied' with the Act, and a patient's consent to a List A procedure obtained as prescribed 'shall be considered effective.'" *Id*. (footnotes omitted). A physician cannot, therefore, be found negligent for not disclosing other risks associated with a procedure when the physician made the disclosures as prescribed by the Texas Medical Disclosure Panel. *Id*.

Wakefield also contends that George's consent was invalidated by Wilson's misrepresentation that the LMA and the ETT were equally safe. *Earle* likewise disposes of this claim. There, the court determined that, although the presumption of proper disclosure can be rebutted only by showing the invalidity of consent, a showing of invalidity is limited to showing the "invalidity of the consent form, such as by proof that the patient's signature was forged, or that the patient lacked capacity to sign." *Id*. at 891–92. Such claims of invalidity have not been alleged here. And, except in those rare cases when a misrepresentation is actionable under the Texas Deceptive Trade Practices Act, such claims arise out of the provision of medical care and are governed by what is now Chapter 74. *See id*. at 893. Consequently, obtaining informed consent in compliance with List A satisfies the requirements of Chapter 74, and the claimed misrepresentations do not rebut the presumption. The trial court did not err in granting summary judgment on Wakefield's informed consent claim.

We affirm the trial court's judgment.

Josh R. Morriss, III
Chief Justice

Date Submitted: December 5, 2017
Date Decided: February 8, 2018