

COURT OF APPEALS
DIVISION III
OF THE STATE OF WASHINGTON

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DIVISION III
1000 N. WASHINGTON ST.
YAKIMA, WA 98908

RODOLFO ANAYA – GOMEZ,
As Personal Representative of the
Estate of Christina Palma – Anaya, Deceased

Appellant,

v.

MARK F. SAUERWEIN, M.D. and
THE YAKIMA VALLEY FARM WORKER’S CLINIC,
A Washington Corporation,

Respondents.

BRIEF OF APPELLANT

Cause No. 09 – 2 - 02034 – 4

Appeal No. 30098 – 6 - III

Richard R. Johnson
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ANAYA – GOMEZ V. SAUERWEIN, ET.AL.

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Brief of Appellant

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INTRODUCTION

Christina Anaya was ill in August, 2006. She was admitted to the hospital at Toppenish, Washington on August 20, 2006. At that time and place, blood was taken from her for laboratory analysis. She was diagnosed and treated there for a bacterial infection, and placed on antibiotics.

Christina continued to be ill, and returned to the emergency department at the Toppenish hospital on August 23, 2006. She was again diagnosed and treated there for a bacterial infection.

The results of the August 20, 2006 blood draw were reported by telephone by the microbiology laboratory to Christina's family practice clinic (the defendant clinic) on August 24, 2006. The lab reported that she had fungus in her bloodstream. The defendant physician in attendance at the defendant clinic that day dismissed the result as a "probable contaminant." Christina / her spouse / her family were never told of the lab result. The taking of a new blood sample for lab analysis was never suggested, nor carried out, to either confirm or to rule out a fungal blood infection. The defendants never referred Christina to any other physician(s) for consultation and / or for administration of appropriate and available treatment, including antifungal medication(s).

Christina was admitted to Yakima Valley Memorial Hospital the following week, where it was independently determined that the August 20, 2006 lab report was indeed correct. Christina did, in fact, have a fungal blood infection. Unfortunately, it was too late for Christina. The fungus coursing through her blood stream had invaded her internal organs.

Christina passed away in November, 2006 as a result of fungal sepsis, leaving behind her spouse of over ten years, and her two young children.

Despite these essentially undisputed facts, the trial judge in this case refused to allow the jury to consider failure to obtain Christina's informed consent on the presence of the abnormality in her blood identified by the lab as a basis for recovery. A Yakima County jury decided to exonerate the defendants on the sole theory the court allowed to proceed, professional negligence. This appeal followed after the trial judge denied plaintiff's post – trial motions for relief.

ASSIGNMENTS OF ERROR

The assignments of error in this appeal all center on the trial court's determination that plaintiff would not be allowed to seek recovery against the defendants on the basis of their liability for failure to obtain Christina Anaya's informed consent. Specifically:

The trial court erred in granting defendants' motion for judgment of dismissal of plaintiff's informed consent claim as a matter of law at the conclusion of plaintiff's case in chief. Plaintiff submits that court should have denied that motion under the facts of this case, and the law of this state.

The trial court erred in declining to allow the plaintiff's informed consent claim to go to the jury / the trier of fact for determination. Plaintiff proposed proper jury instructions and a verdict form on the basis of lack of informed consent, took appropriate exceptions to the court declining to give plaintiff's informed consent instructions and verdict form, and properly excepted to the Court's Instructions to the Jury.

The trial court erred in not determining and ruling that the defendants are, in fact, liable to the plaintiff **as a matter of law** for the failure to obtain Christina's informed consent on the abnormality in her blood identified by the lab. The court should have so ordered on the basis of *Keogan v. Holy Family Hospital*.

The trial court erred in denying plaintiff's post-trial motions for reconsideration, a new trial and / or for J.N.O.V. on the basis of the defendants' liability herein for failure to obtain Christina Anaya's informed consent on the abnormality in her blood identified by the lab.

STATEMENT OF THE CASE

The liability of the defendants in the Christina Anaya case is based upon the following evidence introduced at the trial of her case:

Christina was a long - standing patient of the defendant clinic (R.P. 6/7/2011, p. 43).

She had been diagnosed to have Diabetes Mellitus for at least ten years, and her blood sugars were not under control in 2006. This made her somewhat immunocompromised / more susceptible to infections (R.P. 6/7/2011, pp. 84 & 85).

Kyle Heisey, M.D., a physician employee of the defendant clinic, was Christina's usual attending physician (R.P. 6/7/2011, p. 44).

Christina had been ill and had a two day admission at Toppenish Community Hospital – August 20 and 21, 2006 (R.P. 6/7/2011, pp. 48 & 49). She was diagnosed and treated there as having a bacterial infection (R.P. 6/7/2011, p. 55).

Christina continued to be ill, and was treated in the Emergency Department at Toppenish Community Hospital the evening of August 23, 2006. She continued to be diagnosed and treated there as having a bacterial infection (R.P. 6/7/2011, pp. 62 – 64).

Defendant Sauerwein, also a physician employee of the defendant clinic, was covering for Dr. Heisey at the defendant clinic on August 24, 2006 (R.P. 6/7/2011, pp. 42, 45).

The defendant clinic and defendant Sauerwein was / were informed by telephone by the microbiologist of the laboratory at Yakima Regional Medical Center on August 24, 2006 that the blood drawn from Christina at the Toppenish Community hospital on August 20, 2006 had cultured out in the lab to show / contain yeast / fungus (Ex. 7 & R.P. 6/7/2011, pp. 48 – 53).

The laboratory analysis showing the presence of fungus in Christina's blood was / is a material fact / a fact that Christina / a reasonably prudent person / patient in Christina's position would attach significance to in deciding whether or not to submit to a proposed course of medical treatment (R.P. 6/7/2011, p. 86 & 6/9/2011, pp. 21 & 61).

Defendant Sauerwein dismissed the lab result of fungus on the August 20, 2006 blood sample as being "a probable contaminant." (Ex. 7 & R.P. 6/7/2011, pp.58 & 59).

Defendant Sauerwein had no follow – up with Dr. Heisey, or anyone else, about Christina's lab result. It "fell between the cracks." (R.P. 6/7/2011, p. 57 and 6/10/2011, pp. 94 – 101).

The defendants never told Christina about the lab result showing fungus in her blood. Defendant Sauerwein never spoke with Christina, although he testified that would have been “good information to share.” (R.P. 6/7/2011, pp. 67 – 69).

Christina / her family members didn’t know about the lab report that she had fungus in her blood (R.P. 6/7/2011, p. 70).

The defendants never gave Christina the option of having her blood re-drawn and re-cultured on or after August 24, 2006, which could have / should have been done (R.P. 6/7/2011, p. 70).

The defendants never gave Christina the option of consultation and / or treatment of the fungal blood infection with any other physician(s), which could / have should have been done (R.P. 6/7/2011, p. 71 and 6/9/2011, p. 25).

The defendants only gave Christina a follow – up appointment at the defendant clinic on August 30, 2006 because she’d had the Toppenish hospital admission on August 20, 2006 (R.P. 6/7/2011, p. 66).

Christina became increasingly more ill after August 24, 2006 (R.P. 6/7/2011, p. 139).

Rudy Anaya got off a commercial fishing boat in the Gulf of Alaska to come home to take care of his ill wife (R.P. 6/7/2011, p. 138 – 140).

When Christina and Rudy arrived at Yakima Valley Memorial Hospital on August 29, 2006, they were not able to tell the physicians there that she had fungus in her blood, because they didn't know that information (R.P. 6/7/2011, pp. 70 & 140 & 7/9/2011, p. 61).

Physicians at Yakima Valley Memorial Hospital independently discovered the fungus in Christina's blood and began giving her anti – fungal medications on August 30, 2006 (Ex. 3A, and R.P. 6/7/2011, p. 142).

By the time Christina began receiving anti – fungal medication, the fungus had invaded her internal organs / had turned in to fungal sepsis (Ex. 3A & R.P. 6/9/2011, p. 33).

Christina died on November 17, 2006 as a direct result of fungal sepsis (Ex. 8 & R.P. 6/9/2011, p. 28). Defendant Sauerwein admitted that was the case (R.P. 6/7/2011, p. 73).

Administration of antifungal medication beginning on August 24, 2006 would have prevented not only the prolonged hospitalization at Yakima Valley Memorial Hospital, but would have also prevented Christina's death (R.P. 6/9/2011, pp. 28 & 29).

The case proceeded to a jury trial in Yakima County Superior Court on June 6, 2011, on recovery theories against the defendants of

professional negligence, and failure of informed consent (C.P. 3 – 6 & 34 & 35).

At the conclusion of the plaintiff's case in chief, the presiding judge, C. James Lust, granted the defendant's C.R. 50 motion for judgment of dismissal of the plaintiff's informed consent claim as a matter of law (R.P. 6/9/2011, pp. 70 – 74).

The case was argued to the jury on June 14, 2011 (R.P. 6/14/2011, pp. 15 – 44). Plaintiff had proposed jury instructions to the court consistent with Washington law / Washington pattern instructions, and an appropriate form of verdict, on the theory of informed consent (C.P. 74, 84,88 – 90 & 99 & 100).

The trial judge declined to give the jury any instructions, or a verdict form, on informed consent as a basis for plaintiff to recover (C.P. 43 – 73).

The plaintiff took appropriate exceptions to the court declining to give the jury instructions, or an appropriate form of verdict, that would have allowed informed consent as a basis of recovery from the jury (R.P. 6/13/2011, pp. 56 – 58).

The case proceeded to deliberations by the jury on June 14, 2011 on the sole remaining basis for recovery against the defendants of

professional negligence (R.P. 7/14/2011, pp. 4 – 16). The jury returned a ten to two verdict for the defendants (C.P. 108 – 110).

Plaintiff filed and argued appropriate post – trial motions for new trial / reconsideration / JNOV (C.P. 111 – 113). Plaintiff's motions were heard by the court on July 15, 2011, and were denied by the court (R.P. 7/15/2011, pp. 3 – 11 & C.P. 114 – 115).

Plaintiff filed his Notice of Appeal herein to this court on July 20, 2011 (C.P. 116 – 127).

ARGUMENT

1. STANDARD OF REVIEW – C.R. 50 MOTIONS

This court held in *Mega v. Whitworth College*, 138 Wn.App. 661, 158 P.3d 1211 (2007) (Rev. Den'd. 163 Wn.2d 1008, 180 P.3d 1292 (2008) that:

“We review a trial court's decision on a motion for judgment as a matter of law using the same standard as the trial court. *Sing v. John L. Scott, Inc.*, 134 Wash.2d 24, 29, 948 P.2d 816 (1997). A motion for judgment as a matter of law admits the truth of the opponent's evidence and all inferences that can reasonably be drawn from it. *Queen City Farms, Inc. v. Cent. Nat'l Ins. Co.*, 126 Wash.2d 50, 98, 882 P.2d 703 (1994).

"Granting a motion for judgment as a matter of law is appropriate when, viewing the evidence most favorable to the nonmoving party, the court can say, as a matter of law, there is no substantial evidence or reasonable inference to sustain a verdict for the nonmoving party." *Sing*, 134 Wash.2d at 29, 948 P.2d 816. If any justifiable evidence exists on which reasonable minds might reach conclusions consistent with the verdict, the issue is for

the jury. *Queen City Farms*, 126 Wash.2d at 98, 882 P.2d 703.” 138 Wn.App. at p. 668.

2. INFORMED CONSENT IN WASHINGTON

The court correctly allowed amendment of the Complaint to add the cause of action for liability of the defendants on the basis of failure to obtain informed consent of Christina Anaya regarding the fungus the Yakima Regional laboratory microbiologist found in her blood, and reported to the defendants.

The court then erred, we submit, when it ruled as a matter of law, at the close of plaintiff’s case in chief, pursuant to CR 50, that the informed consent cause of action should be dismissed, and should not / could not go to the jury.

In order to have granted the defendants motion for judgment as a matter of law, according to CR 50, the court had to find and conclude that “...there is no legally sufficient evidentiary basis for a reasonable jury to find ... for that party with respect to that issue... .”

Failure of informed consent of the patient is a statutory basis for liability of a health care provider in this state. *See*, RCW 7.70.030 (3) and RCW 7.70.050. This is the subject of pattern jury instructions in this state. *See*, 6 Washington Practice – Civil WPI 105.04 (2011) and WPI 105.05.

The leading Washington cases on informed consent are *Miller v. Kennedy*, 11 Wn.App.272, 522 P.2d 852 (1974), *Aff’d.* at 85 Wn.2d 151,

530 P.2d 334 (1975); *Smith v. Shannon*, 100 Wn.2d 26, 666 P.2d 351 (1983) and *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979).

Gates v. Jensen, supra, was a medical negligence case regarding disclosure to a patient, and the rules of law which apply when a physician is alleged to have breached that duty. One of the questions was whether the doctrine of informed consent requires a physician to inform a patient of a bodily abnormality discovered during a routine examination, and of diagnostic procedures which may be taken to determine the significance of that abnormality.

Mrs. Gates consulted James Hargiss, M.D., an ophthalmologist, complaining of difficulty in focusing, blurring, and gaps in her vision. Mrs. Gates was 54 years old at the time and had a severe myopia which doubled her risk of glaucoma. Dr. Hargiss took eye pressure readings and found the pressure in each eye registered 23.8 on the Goldman scale. This reading indicated Mrs. Gates was in the borderline area for glaucoma. Dr. Hargiss then examined Mrs. Gates' optic nerves to determine whether the surfaces of the nerves showed "cupping," which is characteristic of glaucoma. There was evidence at trial that observation of the nerve discs in Mrs. Gates' case was particularly difficult with a direct ophthalmoscope when her pupils were not dilated. Dr. Hargiss didn't dilate Mrs. Gates' pupils. He didn't see evidence of abnormality and made

no further tests for glaucoma. In response to Mrs. Gates' inquiry about the pressure test, he said he had checked for glaucoma, but found everything all right. He diagnosed her problem as difficulties with the contact lenses she wore, and treated her accordingly.

The significant facts in *Gates* are that Dr. Hargiss neither told Mrs. Gates he had found high pressure in both eyes which put her in a borderline glaucoma area, nor that her risk of glaucoma was increased considerably by this high pressure and her myopia. Furthermore, Dr. Hargiss had available to him two additional diagnostic tests for glaucoma which are simple, inexpensive, and risk free. The first was to use the standard drops for dilating the pupils to obtain a better view of the optic nerve discs. The second was to have Mrs. Gates take a visual field examination to determine whether she had suffered any loss in her field of vision. Dr. Hargiss did not tell Mrs. Gates of the existence of these simple procedures, and he did not administer the tests.

Over the next two years Mrs. Gates revisited Dr. Hargiss' clinic 12 times complaining of blurring, fog, and gaps in her vision, as well as loss in visual acuity. Shortly after her first visit Dr. Hargiss made another pressure reading and found pressures in both eyes to be within the high range of normal. There was evidence at trial that in the early stages of

glaucoma pressures can vary drastically from normal to positive glaucoma readings within a 24-hour period. Dr. Hargiss concluded, however, that the first high readings were misleading because they were caused by Mrs. Gates' tension at being subjected to the pressure testing procedure, which requires placing an instrument directly on the eye. Adhering to Dr. Hargiss' initial diagnosis of difficulty adjusting to contact lenses, the doctors at the clinic did not dilate the pupils nor administer a visual field test over the next two years. Mrs. Gates' symptoms gradually worsened.

In April 1974 doctors at the clinic diagnosed Mrs. Gates as having open angle glaucoma. This diagnosis was confirmed by other specialists outside the clinic. The clinic's own glaucoma expert suggested that part of Mrs. Gates' vision loss was attributable to an acute nerve disease which is untreatable and could not have been detected before it occurred. This finding was made at a time when Mrs. Gates' glaucoma had already been diagnosed and the clinic's expert had access to the records indicating that dilation and field examinations had not been previously made. The diagnosis of nerve disease was contested at trial by other expert testimony. By the time Mrs. Gates' glaucoma was discovered her vision had deteriorated from near 20/20 with glasses to 20/200 with glasses. Mrs. Gates is now functionally blind.

At trial, Mrs. Gates requested instructions on the doctrine of informed consent. The court refused those instructions. The jury reached a verdict for the doctors and the court entered judgment accordingly. The Court of Appeals affirmed. The Washington Supreme Court granted Gates' petition for review of the trial court's refusal to give the instructions and reversed the Court of Appeals and the trial court.

At trial, Mrs. Gates requested instructions that the doctors at the Eye Clinic failed to inform her that she had high pressures in her eyes, that she was in a high risk group for glaucoma, or that there were alternative diagnostic procedures available to determine conclusively whether she had glaucoma. She contended that the doctors had a duty to tell her these facts so she could make an informed choice about treatments she would undergo, and that if she had been informed of these facts she would have requested the additional tests and glaucoma would have been discovered.

There was evidence at trial that if glaucoma had been detected when Mrs. Gates first visited the Eye Clinic, the condition could have been stabilized and a great part of her vision saved.

The doctors in *Gates* contended, however, that the doctrine of informed consent didn't apply to questions of appropriate diagnostic

procedures and the requested instructions were properly rejected. The Supreme Court disagreed.

The Supreme Court in *Gates* cited *Miller v. Kennedy, supra*. The court said that the basis of the duty of informed consent is that the patient has a right to know the material facts concerning the condition of his or her body, and any risks presented by that condition, so that an informed choice may be made regarding the course which the patient's medical care will take. The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. Important decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures leading to a diagnosis, as in the *Gates* case. These decisions must all be taken with the full knowledge and participation of the patient. The physician's duty is to tell the patient what he or she needs to know in order to make them. The existence of an abnormal condition in one's body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease are all facts which a patient must know in order to make an informed decision on the course which future medical care will take.

Application of the doctrine of informed consent to circumstances other than treatment of a diagnosed disease is nothing new. *Miller v. Kennedy, supra*, involved evaluating the risks of a diagnostic procedure, a kidney biopsy.

In *Young v. Group Health Cooperative of Puget Sound*, 85 Wash.2d 332, 534 P.2d 1349 (1975), the doctrine of informed consent was applied to a determination whether childbirth should take a natural course, where this question again was not one of treatment of a known disease. *See, also, Holt v. Nelson*, 11 Wash.App. 230, 523 P.2d 211 (1974).

The physician's duty of disclosure arises, therefore, whenever the doctor becomes aware of an abnormality which may indicate risk or danger. *Betesh v. United States*, 400 F.Supp. 238 (D.D.C.1974). The facts which must be disclosed are all those facts the physician knows or should know which the patient needs in order to make the decision. To require less would be to deprive the patient of the capacity to choose the course his or her life will take.

In *Gates*, the Supreme Court held that jury questions had been raised as to whether Dr. Hargiss disclosed all the facts which he had a duty to disclose and, if not, whether Mrs. Gates was injured thereby. The trial

court erred in refusing informed consent instructions requested by Mrs. Gates.

The doctrine of informed consent refers to the requirement that a physician inform the patient of the attendant material risks. The doctrine is premised on the fundamental principle that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body". *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92 (1914) (Cardozo, J.), overruled on other grounds, *Bing v. Thunig*, 2 N.Y.2d 656, 667, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). A necessary corollary to this principle is that the individual be given sufficient information to make an intelligent decision. See *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir.1972).

The court in *Miller v. Kennedy*, *supra*, emphasized that it is for the patient to evaluate the risks of treatment, and that the only role to be played by the physician is to provide the patient with information as to what those risks are.

Once it has been established by expert medical testimony that a risk existed, then the existence of the risk is the patient's business; and it is not for the medical profession to establish criterion for the dissemination

of information to the patient based upon what doctors feel the patient should be told. *Miller* at pp. 285-86.

To allow physicians, rather than patients, to determine what information should be disclosed would be in direct conflict with the underlying principle of patient sovereignty. *Canterbury v. Spence, supra*, at p. 784.

Despite this being the well – settled law in this state, three of the defense expert witnesses in the Christina Anaya case stated that the “standard of care” didn’t require the defendant doctor in this case to tell Christina that the lab had reported that she fungus in her blood! (R.P. 6/9/2011, p. 110; 6/10/2011, p. 142 & and 6/13/2011, p. 26). Dr. Hashasaki even stated that “I mean its kinda like why worry the patient needlessly.” (R.P. 6/10/2011, p. 142).

Talk about missing the point on patient sovereignty / patient right to know what is happening to his / her body! Certainly, Christina had a right to know, as a matter of law. What she had in her blood is what ended up killing her! The usual conduct of doctors is irrelevant to the establishment of the liability, which is imposed by law in this state.

A physician "need not disclose every risk which could be disclosed, if only because of the time required to disclose every remote risk." Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw.U.L.Rev. 628, 635 (1970).

The informed consent doctrine "does not place upon the physician a duty to elucidate upon all of the possible risks, but only those of a serious nature." *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wash.2d 12, 25, 499 P.2d 1 (1972). See also *Gates v. Jensen, supra*, ("high risk"); *Meeks v. Marx*, 15 Wash.App. 571, 578, 550 P.2d 1158 (1976) ("grave risks"); *Miller*, at 293, quoting American Hosp. Ass'n, *Statement of a Patient's Bill of Rights* (1972) ("medically significant risks"); *Mason v. Ellsworth*, 3 Wash.App. 298, 313, 474 P.2d 909 (1970) ("physician [does not] ha[ve] an obligation to detail all risks of a given procedure" but only "reasonably foreseeable" risks).

The guide for disclosure is materiality. *Miller* at 287. The test of materiality is an objective one incorporating the underlying concept of patient sovereignty.

The patient is endowed with the right to know each hazard which the usual person would utilize in reaching his decision. When a reasonable

person in the patient's position probably would attach significance to the specific risk in deciding on treatment, the risk is material and must be disclosed. *Miller* at p. 287.

One important practical issue in informed consent cases is whether expert testimony is necessary to show materiality. Problems inherent in requiring such testimony include lack of a uniform community standard, relegation of the patient's rights to secondary importance, and the oft-described "conspiracy of silence". *Mason v. Ellsworth*, supra 3 Wash.App. at 308-09, 474 P.2d 909; *Wilkinson v. Vesey*, 110 R.I. 606, 623-24, 295 A.2d 676 (1972); Comment, A New Standard for Informed Consent in Medical Malpractice Cases--The Role of the Expert Witness, 18 St. Louis U.L.J. 256, 260-63 (1973). On the other hand, expert testimony is generally of great assistance, and very often necessary, in enabling a lay trier of fact to make a reasoned decision. 51 Wash.L.Rev. 167, 177 (1975).

The jury is capable of deciding whether the doctor did not tell the patient about something that should have been revealed. The jury does not need testimony from physicians about the norm of disclosure in the community. The usual conduct of doctors in this matter is not relevant to the establishment of the liability which is imposed by law. The jury, as lay people, are equipped to place themselves in the position of a patient and

decide whether, under the circumstances, the patient should have been told. *Miller* at pp. 288-89. *See, also, Keogan*, 95 Wash.2d at 318, 622 P.2d 1246.

Miller does not completely obviate the need to present expert testimony. While the court generally stated that "[t]he testimony of medical experts is not necessary to establish the duty to disclose" (*Miller* at p. 285), its reasoning indicates that it was simply applying general rules regarding expert testimony.

A trier of fact does not require expert testimony to determine whether a reasonable patient would consider a given risk material. On the other hand, expert testimony is necessary, for example, to establish the existence of a risk, and this was expressly recognized in *Miller* at p. 288 n. 10. The *Miller* analysis of expert testimony requirements in informed consent cases is simply a particular application of the general rule that expert medical testimony is required on only those matters "strictly involving medical science". 2 J. Wigmore, *Evidence* § 568, at 779 (rev. 1979).

The basic question is whether the particular fact sought to be proved is such as is "observable by [a layperson's] senses and describable

without medical training". *Bennett v. Department of Labor & Indus.*, 95 Wash.2d 531, 533, 627 P.2d 104 (1981). Whether a reasonable patient would want to know of a given risk is such a fact; however, the existence, magnitude, and other scientific characteristics of the risk are not.

The determination of materiality is a two -step process. Initially, the scientific nature of the risk must be ascertained, i.e., the nature of the harm which may result and the probability of its occurrence. *See, Canterbury v. Spence, supra*, at 787-88; Comment, Informed Consent in Medical Malpractice, 55 Cal.L.Rev. 1396, 1407 n. 68 (1967). The trier of fact must then decide whether that probability of that type of harm is a risk which a reasonable patient would consider in 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. King, The Standard of Care and Informed Consent Under the Tennessee Medical Malpractice Act, 44 Tenn.L.Rev. 225, 288 (1977). Only a physician (or other qualified expert) is capable of judging what risks exist and their likelihood of occurrence. The 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 their

physicians to give an informed consent, a trier of fact requires description of risks by an expert to make an informed decision.

Some expert testimony is thus 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.

Defendants rely on *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999) as authority to dismiss plaintiff's informed consent claim. This reliance is misplaced, we submit.

In *Backlund*, Ashley Backlund was born a week prematurely. She was taken to Children's Hospital Medical Center for respiratory distress, and came under the care of Craig Jackson, M.D., a neonatologist. Ashley had high billirubin which caused her to be jaundiced, which is not uncommon in newborns. However, greatly elevated billirubin can cause brain damage. Jaundice is typically treated by phototherapy (light), but more serious cases are treated with blood transfusion. Dr. Jackson treated Ashley with phototherapy, but he did not discuss transfusion with Ashley's parents. Even though the billirubin level in her blood grew quite high, Dr. Jackson didn't tell the Backlunds about the risks associated with

high bilirubin. The phototherapy treatment was unsuccessful, and Ashley suffered brain damage.

The Backlunds instituted suit alleging causes of action of both negligence and failure to obtain informed consent. The case went to the jury on both legal theories. The jury exonerated the defendants on negligence, but it failed to reach a verdict on the informed consent claim. By agreement of the parties, the informed consent claim was then tried to the bench / Judge Downing. The court filed a memorandum opinion on the informed consent issue finding that a transfusion was a recognized possible alternative form of treatment, that the possibility of a transfusion was a “material fact” of which the Backlunds were not aware, and that not performing a transfusion on Ashley caused the brain damage.

However, in the *Backlund* case, Judge Downing ruled in favor of the defense on the informed consent claim finding that the Backlunds had failed to sustain their burden of proving that “a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts.” RCW 7.70.050 (1) (c). Judge Downing emphasized that the jury had found for the defendants on the negligence claim. The judge then reasoned that Dr. Jackson would appropriately express his preferred course of treatment was phototherapy and not blood transfusion. The judge concluded that a reasonably prudent

patient would, or should, accept Dr. Jackson's recommended treatment – the phototherapy.

The Court of Appeals affirmed the trial court in the *Backlund* case in an unpublished opinion, sustaining the trial judge's determination that a reasonably prudent patient would not have chosen blood transfusion for Ashley. The Washington Supreme Court then granted review.

The defendants in *Backlund* urged the Supreme Court to conclude that the Backlunds had no cause of action for failure to obtain informed consent under RCW 7.70.050 *as a matter of law* (emphasis added) where the jury exonerated the defendants on the negligence claim for alleged misdiagnosis of Ashley's condition. The Supreme Court declined to do. The court said:

“The trial court's emphasis on the patient's likely following of the non-negligent recommendation of a physician goes too far in confusing negligence and informed consent claims. Negligence and informed consent are alternative methods of imposing liability on a health care provider. Informed consent allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent. (Citations omitted). The Court of Appeals in *Holt* aptly explained that if a doctor breaches the duty to obtain an informed consent from the patient before proceeding with treatment, the patient has a cause of action for damages against the doctor even if the doctor has performed the treatment properly within the standard of care of the profession. Thus, the cause of action can arise against a doctor for failing to obtain the patient's knowledgeable permission to the treatment even though the doctor's actions have not been negligent and would not give rise to a cause of action in any other way.”
135 Wn.2d at 955

...

“A physician who misdiagnoses the patient’s condition, and is therefore *unaware* (emphasis added) 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.

We have no facts in this case, however, suggesting that Dr. Jackson was unaware of the transfusion alternative. Rather, in his professional judgment, he did not believe Ashley required a transfusion because her billirubin levels were not serious enough to warrant such treatment. A jury upheld his professional judgment on that issue, but a trier of fact might still have found he did not sufficiently inform the patient of risks and alternatives in accordance with RCW 7.70.050. The University’s contention, that an informed consent action is not present here as a matter of law because the patient’s injury was not caused by the practitioner’s actual treatment, fails.” 137 Wn.2d at 956.

What the majority in *Backlund* concluded on the informed consent claim was this, “The real question here is whether the Backlunds proved the third element of informed consent: whether a reasonable patient under similar circumstances would not have consented to the treatment if informed of the materials fact or facts associated with such treatment.” 137 Wn.2d at 958. The Supreme Court emphasized in *Backlund* that this element is measured objectively – what a reasonable patient would do – not subjectively. The court held as follows:

“When determining whether a reasonably prudent patient would have declined treatment if informed of material facts regarding his or her treatment a trial court looks to the situation of the patient, i.e., his or her medical condition, age, risk factors, etc., and then the court makes findings of fact regarding the risks of the treatment and any material risks regarding treatment alternatives. Based on these findings along with any other

relevant evidence, *the trier of fact* (emphasis added) will ordinarily determine whether a reasonably prudent patient in the plaintiff's situation would have chosen a different treatment option." 137 Wn.2d at 959.

What the Supreme Court concluded in *Backlund* is this:

"Under the statutory test, the trial court correctly ruled that Backlunds failed to establish the third element of the prima facie case of informed consent. This is essentially a case of failure of proof. A reasonably prudent patient would not have opted for transfusion, even if the reasonably prudent patient had been informed of all the pertinent risks of no treatment, phototherapy, and the alternative treatment of double transfusion. We seriously doubt the Backlunds would have chosen no treatment for Ashley. The record below indicates there was a 1 in 10,000 chance the phototherapy treatment course employed by Dr. Jackson would result in the kind of permanent brain damage Ashley Backlund suffered.

On the other hand, evidence also indicated there was a 1 in 300 to 1 in 100 chance of death if Ashley Backlund had been treated with a double transfusion of her blood. [5]. Under these circumstances, in the absence of proof from the Backlunds to the contrary, no reasonably prudent patient / representative would prefer a treatment with a 1 in 100 chance of death to their baby to the more conservative course of treatment within the standard of care that bears a 1 in 10,000 chance of permanent brain damage. The record indicates the Backlunds imply did not bear their burden of proof with respect to the reasonableness of a patient's consideration of the treatment alternatives. [6]. On this basis, the trial court's judgment dismissing the Backlunds' informed consent claim is affirmed." 137 Wn.2d at 959.

The *Backlund* case was decided five to three by the Washington Supreme Court. Justice Madsen (currently the Chief Justice of the Court) authored a rather spirited dissenting opinion, joined in by Justices Alexander and Sanders. The first paragraph of the dissent in *Backlund* reads as follows:

“After correctly identifying the legal principles applicable in this case, the majority then unaccountably departs from appellate review and steps into the role of the trial court and becomes the trier of fact. The majority decides that the facts do not support plaintiffs’ claim. Unfortunately, the majority’s decision to act as trial judge is improper. First, this court’s role is not that of finder of fact. Second, the majority’s ‘findings of fact’ are incomplete and one-sided. Adding the appellate errors on to the trial court errors compounds the miscarriage of justice which occurred in this case – the trial court applied the wrong legal standard and refused to enter findings of fact, and now this court inappropriately and wrongly determines the facts. Plaintiffs are entitled to more.” 137 Wn.2d at 960.

...

“The trial court incorrectly applied the ‘reasonably prudent person’ standard to mean that a reasonably prudent person would, and should, accept his or her physician’s recommended treatment when the treatment conforms to the standard of care. ... This view is wrong because it conflicts with the principle of patient sovereignty upon which the informed consent doctrine is based. The question is not what the physician thinks is best or what the physician thinks should be revealed. The trial court’s reasoning is also wrong because compliance with the standard of care for treatment actually given has nothing to do with the question of whether a reasonably prudent person would have consented to treatment if informed of undisclosed material facts. RCW 7.70.050 (1)(c). As the majority recognizes, it is improper to inject a negligence requirement into the informed consent cause of action.” 137 Wn.2d at 961.

...

It is, however, the patient’s decision, not the physician’s. ‘There is no room for paternalism or for over protectiveness.’ *Miller v. Kennedy*, 11 Wn.App. 272, 286, 522 P.2d 852 (1974), *Aff’d*. 85 Wn.2d 151, 530 P.2d 334 (1975).

Moreover, even if the doctor's assessment of a particular risk is accurate, that does not mean that a reasonably prudent patient would not choose alternate treatment despite the risk. See, *Archer v. Galbraith*, 18 Wn.App. 369, 378, 567 P.2d 1155 (1977). 137 Wn.2d at 961.

...

"Finally, the majority's decision in this case prompts the question: Of what use is the statutory cause of action for lack of informed consent if it cannot be maintained in this case? The cause of action for lack of informed consent is intended to assure that patients have the right to make decisions about their medical treatment. Absolutely essential to that right is the requirement that the patient be given the information necessary to make informed decisions. Plaintiffs' infant daughter Ashley suffered brain damage after being given phototherapy treatment for jaundice. Other treatments were available, but Ashley's parents were never advised of alternatives. Contrary to the majority's limited view of the evidence offered, plaintiffs presented sufficient evidence from which *a trier of fact* (emphasis added) could conclude that reasonably prudent people in their position would have selected the alternative treatment. Plaintiffs are entitled to a trial on their informed consent claim under correct legal standards." 137 Wn.2d at 962.

The defense in the Christina Anaya case also rely upon *Burnet v. Spokane Ambulance*, 54 Wn.App. 162, 772 P.2d 1027 (1989), and *Bays v. St. Lukes Hospital*, 63 Wn.App. 876, 825 P.2d 319, *Rev. Den'd.*, 119 Wn.2d 1008, 833 P.2d 387 (1992).

In the *Burnet* case, plaintiffs minor child, Tristen, had a seizure disorder and had multiple hospitalizations. The child sustained a prolonged seizure and suffered cerebral edema and extensive brain damage. Dr. Graham was Tristen's neurologist. The Burnets claimed Dr. Graham had a duty to inform of his decision not to provide any diagnostic

tests or treatment. The evidence in *Burnet* was that Dr. Graham did not know of the risk of brain injury in Tristen's case.

The court in *Burnet* recognized that whenever a physician becomes aware of a condition which indicates risk to the patient's health, he has a duty to disclose it, citing *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980), and *Gates v. Jensen*, 92 Wn.2d 246, 251, 595 P.2d 919 (1979) and the *Miller v. Kennedy* case, *supra*. The court concluded in *Burnet* that:

"Thus a high risk method of treatment rendered in a non-negligent manner, but without an informed consent of the patient, may result in liability. That is not the situation here. It is undisputed that Dr. Graham was unaware of Tristen's condition which implicated risk to her, so he had no duty to disclose. See *Nicholson*, 52 Wn.App. at 821, 764 P.2d 1007. The Burnets' claim relates solely to issues of failure to meet the standard of care and diagnosis." 54 Wn.App. at 169.

In the *Bays v. St. Lukes* case, Mr. Bays was injured when a heavy object fell on him. An emergency department doctor referred Mr. Bays to Harvey DeWitt, M.D., an orthopedic surgeon. Dr. DeWitt admitted Bays to the hospital, diagnosing a dislocated shoulder, which was reduced, and some vertebral body fractures. Dr. DeWitt put Bays at bed rest and IV fluids, advised him to move his legs to prevent blood clots from forming, and put him in anti-embolism hose. Bays began having knee pain. DeWitt examined Bays and didn't find anything, even on x-ray, and diagnosed a knee sprain. Bay's temperature spiked. DeWitt got a chest x-ray because

one concern was thromboembolism. Bays subsequently developed pulmonary embolism and died.

At the close of plaintiff's case in *Bays*, the trial court dismissed plaintiff's informed consent claim. The Court of Appeals affirmed, citing *Burnet*, that the duty to disclose does not arise until the physician becomes aware of the patient's condition. DeWitt did not diagnose thromboembolism. The court recognized that Bay's estate had a claim for negligent misdiagnosis, but if DeWitt didn't know about thromboembolism, he couldn't inform Bays of that condition, and treatment alternatives. So, the court determined in *Bays* that DeWitt didn't know the material fact of the embolism, so he couldn't disclose that.

The doctor may be negligent for not knowing of the patient's condition, but it makes clear sense that the doctor can't tell a patient about a condition the doctor doesn't know of. In the Christina Anaya case, the laboratory told the defendant doctor of the presence of the fungal blood infection. Unfortunately, he just chose to ignore it, and, even far worse, he chose not to tell Christina Anaya about it. That is where liability attaches to the defendant doctor Sauerwein – his failure to obtain informed consent for a treatment course here which basically involved setting up an appointment for Christina to come in to the defendant clinic the following

week, solely in follow – up to the hospital admission of August 20 – 21, 2006, and nothing more.

Keogan v. Holy Family Hospital, supra, clearly supports Rudy Anaya’s informed consent claim in this case. Tim Keogan, age 37, consulted his family physician, Dr. Snyder, regarding chest pain. Dr. Snyder did a clinical exam, got chest and abdominal x-rays, took a resting ECG and cardiac enzyme tests. Dr. Snyder testified at trial that he suspected angina pectoris as the cause of the chest pain, but he didn’t tell Keogan that, nor did he tell him of tests readily available to diagnose angina – nitroglycerine, an exercise, exercise ECG or angiography. Dr. Snyder didn’t do any of those tests on Keogan, and diagnosed sternum cartilage inflammation. Snyder told Keogan to rest, and he scheduled a return clinic visit.

Keogan returned to Dr. Snyder with worsening chest pain. By the subsequent visit, Dr. Snyder had received the result of the cardiac enzyme tests, which were abnormal. Snyder did another resting ECG, and took further enzyme samples. Dr. Snyder prescribed an antacid and a long-acting nitrate similar to nitroglycerine. Snyder told Keogan the nitrate was for chest pain, but Snyder didn’t tell Keogan he suspected angina and heart disease. Dr. Snyder didn’t tell Keogan that the nitrate was for angina pectoris, nor did he tell him of the other tests that could be done for

angina. Mrs. Keogan testified at trial that Tim Keogan called Snyder at his office three times in the week following the last clinic visit saying he had worsening chest pain. Snyder denied receiving those calls when he testified at trial.

At about 3:00 a.m. of March 6, 1972, Keogan collapsed at home and an ambulance took him to the E.D. at Holy Family Hospital. Keogan saw an E.D. doctor there, Anthony Appel, M.D., at about 4:00 a.m. The evidence at the trial of the *Keogan* case was that if the man had been appropriately treated at that time he had a 90 percent chance of survival. Dr. Appel was told that Dr. Snyder had done some tests because Keogan complained to Snyder of chest pain. Dr. Appel said Keogan pointed to his upper abdomen to show where the pain was located, not his chest. Dr. Appel thought Keogan had anxiety and prescribed Valium. Keogan became nauseous, and was in so much pain that he was on his hands and knees on the bed in the E.D.

At about 4:45 a.m., Dr. Appel telephoned Dr. Snyder. Snyder didn't tell Appel about the abnormal cardiac enzyme test results, or about the drugs Snyder had prescribed for Keogan. Appel didn't tell Snyder that Keogan had been brought to the E.D. by ambulance, nor did he tell Snyder what tests Appel had done. After talking to Snyder, Appel told Keogan he was releasing him from the E.D. However, the Keogans insisted that Dr.

Snyder be contacted again, and Keogan was admitted to the hospital at about 5:30 a.m. A nurse on the medical floor called Dr. Snyder to tell him that Keogan was deteriorating. Dr. Snyder prescribed a non-narcotic pain reliever, and a tranquilizer used for nausea, neither of which helped. By 7:50 a.m., Keogan was saying he had severe chest pain. Dr. Snyder was telephoned again, and prescribed morphine and oxygen.

Dr. Snyder's medical partner happened to be in the hospital on the morning in question, saw Keogan, and ordered him admitted to the cardiac care unit of the hospital at about 8:35 a.m. An ECG done in the CCU that time showed substantial heart muscle death. Keogan got worse, his heart stopped, he was resuscitated two times, but died at about 1:35 p.m.

Keogan's wife and children sued Snyder, Appel and Holy Family Hospital (Appel was an employee of the hospital). The trial which resulted in 10-2 defense verdict. The trial court denied motions for J.N.O.V., or for a new trial. Division III originally affirmed the trial court at 22 Wn.App. 366, and Keogans' motion for reconsideration was stayed pending the decision of the Washington Supreme Court in *Gates v. Jensen, supra*. Division III denied Keogans' reconsideration motion after the Supreme Court's decision in *Gates* was filed (24 Wn.App. 583). The Washington Supreme Court then granted the Keogans' P.F.R.

The Washington Supreme Court reversed the trial court and Division III in the *Keogan* case. The court held that the trial court erred in refusing to instruct the jury that Dr. Synder had a duty to disclose proposed treatment and alternatives to Keogan, including diagnostic procedures readily available to determine angina pectoris. However, the court affirmed the trial court in not instructing on informed consent as to the E.D. physician, Dr. Appel and held that Dr. Appel was negligent as a matter of law for not doing an ECG in the E.D. The court would not find Dr. Synder negligent as a matter of law.

Citing *Gates*, the Supreme Court in *Keogan* held that a physician's duty to disclose arises whenever the doctor becomes aware of an **abnormality** (emphasis added) which may indicate risk or danger. The facts that must be disclosed to the patient are all those facts the doctor knows, or should know, which the patient needs in order to make the decision regarding the course of treatment that will be carried out.

In *Keogan*, the Washington Supreme Court reaffirmed that once it has been established by expert medical testimony that a medical risk existed, then the existence of the risk is the patient's business. It is not for the medical profession to establish a criteria for the dissemination of information to the patient based upon what doctors feel the patient should be told. The patient has a right to know, and the doctor has the duty to

inform the patient, whether the doctor wants to, or not. *The fiduciary duty of the doctor requires disclosure.* (emphasis added) 95 Wn.2d at 314.

The duty to disclose material facts arises as "... to each item of information which the doctor knows or should know about the patient's physical condition... ." *Miller v. Kennedy, supra*, at p.282. The Supreme Court in *Keogan* held that:

"The physician's duty requires him to alert the patient of medical abnormalities whatever the stage of treatment. The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. Important decisions must frequently be made in many non treatment situations in which medical care is given, including procedures leading to a diagnosis, as in this case. These decisions must all be taken with the full knowledge and participation of the patient." 95 Wn.2d at 315, citing *Gates* at 92 Wn.2d at 250.

In *Keogan*, the Supreme Court held that Dr. Snyder's duty to disclose had arisen. The chest pain was an abnormality, and Snyder suspected angina was the cause. Dr. Snyder had a duty to disclose that, rather than treating Keogan for stomach problems. Keogan, therefore, was not allowed to determine for himself if additional diagnostic tests should have been done for the chest pain. "The fact that Keogan's symptoms were 'inconclusive' ... does not prevent the doctrine of informed consent from applying. It merely points out the duty to inform the patient of potentially fatal causes of his abnormality, and the means of ruling out or confirming this source of illness." 95 Wn.2d at 315.

However, in *Keogan* the court distinguished Dr. Appel's duty to disclose in the hospital emergency department from that of Dr. Snyder. As to Dr. Appel, the *Keogan* court held that:

"However, the uncontroverted fact that this was a true emergency prevented the duty to disclose alternative diagnostic techniques from applying. It is generally agreed that the doctrine of informed consent does not apply in emergency situations requiring immediate action, and we are unaware of the doctrine's application in any case in which disclosure would be made useless by the medical emergency presented." 95 Wn.2d at 316.

...

"These factors Keogan's intense pain, the need for immediate diagnosis of his condition, and the fact that his condition actually was such that it could lead to irremediable disability and quick death created a medical emergency in which the emergency room physician could not be held to the physician's duty to disclose that is applicable to non-emergency medical care." 95 Wn.2d at pp. 316-17.

In *Keogan*, Dr. Snyder asserted that his duty to disclose had not arisen because "...there was no evidence that a reasonably prudent physician in the medical community in the exercise of reasonable care, would disclose." citing *ZeBarth v. Swedish Hospital Medical Center*, 81 Wn.2d 12, 23, 499 P.2d 1 (1972) to the effect that duty to inform must be established by expert medical testimony. The *Keogan* court made quick work of that position, saying that the holding in *ZeBarth* "... is clearly no longer the law in this state. *Miller v. Kennedy, supra.*" 95 Wn.2d at 317. The patient's right to self-determination cannot be solely dependent on

expert medical testimony. “The defendant’s arguments are not well taken. The duty to disclose arose in this case when Dr. Snyder became `aware of an abnormality which may indicate risk or danger.” 95 Wn.2d at 318.

What must be disclosed? The court in *Keogan* stated, “This depends on the `materiality’ of facts concerning the patient’s condition. Only those facts which an individual would want to know in choosing a course of his treatment need be disclosed.” (citing *Miller v. Kennedy*). These facts generally include the risks of a course of treatment and the feasible alternatives to the proposed treatment. It is clear from the discussion of the patient / physician fiduciary relationship that the `treatment’ encompasses all aspects of patient care, including the doctor’s resolve to do nothing about medical abnormalities in the patient’s condition. (Citing *Miller and Gates*). With regard to Dr. Snyder and informed consent, the court in *Keogan* held that:

“In the case at bar, Dr. Snyder’s proposed and actual course of treatment constituted no additional tests and conservative prescription drug treatment of two possible sources of Keogan’s symptoms. This course of treatment entailed certain risks, e.g., the failure to diagnose a heart condition that Dr. Snyder himself testified he suspected as the cause of Keogan’s discomfort. The diagnostic techniques available to establish whether Keogan’s chest pain was due to angina and heart disease were feasible alternatives to the proposed course of treatment.

Dr. Snyder failed to inform Keogan of either the risks of the treatment undertaken or the alternatives thereto, thus violating the duty to disclose under the informed consent doctrine (emphasis added):

The existence of an abnormal condition in one's body, the presence of a high risk disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease are all facts which a patient must know in order to make an informed decision on the course which future medical treatment will take. *Gates v. Jensen, supra*, 92 Wn. 2d at 251, 595 P.2d 919." 95 Wn.2d at pp. 319-20.

The Supreme Court in *Keogan* then went on to say and conclude that:

"A general analogy between the alternative diagnostic procedures available in *Gates* and in the instant case will further demonstrate the applicability of the doctrine to Dr. Snyder's failure to disclose the existence of the tests. In *Gates*, the defendant ophthalmologist, upon being presented with borderline readings on preliminary tests for glaucoma, did not inform his patient of the tests available to determine if the abnormality was due to glaucoma, a highly serious, blinding disease. Instead, he treated her for a lesser possible cause of the abnormality difficulty with her contact lenses. In this case, Dr. Snyder, upon being presented with symptoms of angina and borderline readings on cardiac enzyme tests for heart disease, did not inform Keogan of the tests available to determine if the condition was due to rapidly progressing heart disease, a highly serious, potentially lethal illness.

Instead, he treated Keogan for lesser probable causes of the abnormality indigestion and mild, drug-controllable angina. ***The failure to inform of alternative diagnostic procedures, as in Gates, violated the duty to disclose within the scope of the doctrine of informed consent. Dr. Snyder WAS NEGLIGENT AS A MATTER OF LAW IN HIS UNCONTROVERTED FAILURE TO INFORM KEOGAN OF THE MATERIAL FACTS REGARDING HIS FUTURE MEDICAL CARE.*** See, *Miller v. Kennedy*, 11 Wn.App. at 284-85, 289, 522 P.2d 852. 95 Wn.2d at 320-21. (Emphasis added).

The Supreme Court in *Keogan* then went on to hold that the failure of the trial court to instruct the jury on informed consent "... ***was clearly***

error.” (emphasis added). 95 Wn.2d at 321. The result / the holding of the Supreme Court in the *Keogan* case was as follows:

“We reverse the Court of Appeals and remand the case for further proceedings consistent with this opinion. ***On remand, trial will be necessary only on the issue of the damages that may have been proximately caused by Dr. Snyder’s failure to inform Keogan of alternative diagnostic techniques*** and by Dr. Appel’s failure to administer an EKG and thus earlier diagnose Keogan’s condition.” (emphasis added). 95 Wn.2d at 329.

In *Estate of Lapping v. Group Health Cooperative of Puget Sound*, 77 Wn.App. 612, 892 P.2d 1116 (1995) Joyce Lapping, age 48, was having irregular menstruation. She saw her Group Health physician, Daniel Dugaw, M.D. She had a history of seizures, but had not had one for nine years. She was taking Dilantin, which Dr. Dugaw prescribed for her. He had been her physician for many years. Dr. Dugaw was concerned about cancer, so recommended an endometrial biopsy to obtain uterine tissue for laboratory analysis. Dr. Dugaw did a biopsy in his clinic, but he didn’t get a sufficient amount of tissue. So, a second biopsy was set in November, 1987.

When Ms. Lapping arrived at the Group Health clinic for the second biopsy, she was placed in a treatment room. Her blood pressure was normal.

Dr. Dugaw went over a consent form for the biopsy, in the same form as for the first biopsy. It stated, in part, "I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure." "I understand that all anesthetics involve risks of complications and ... in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes."

Dr. Dugaw didn't talk to Ms. Lapping about any risks associated with the history of seizures, or about Ms. Lapping being on Dilantin. He didn't tell her that the biopsy could be performed in a hospital, with more precautions than were available in the clinic. Ms. Lapping signed the consent form. No equipment was used to monitor breathing, blood pressure or pulse. The nearest "crash cart" was in the room next door. No one checked the level of Dilantin in Mrs. Lapping's bloodstream.

Ms. Lapping was injected with Lidocaine. After waiting a short time for the drug to take effect, Dr. Dugaw started the biopsy. After several passes with a curette to obtain uterine tissue, Ms. Lapping had what appeared to be a seizure, which lasted 15 to 30 seconds. When it was over, Ms. Lapping didn't have a pulse or blood pressure. She had irregular

gaspings respirations consistent with respiratory arrest. Dr. Dugaw attempted CPR, and a "code" was called. Three doctors and several nurses responded, and the crash cart was brought in from the next room. An endotracheal tube was inserted, a cardiac monitor was put in place, an IV was started, and efforts at CPR continued. Paramedics arrived and found Ms. Lapping's pupils showed effects of prolonged lack of oxygen to the brain. Ms. Lapping was taken to a hospital, where she was pronounced dead.

The personal representative of Ms. Lapping's estate instituted suit against Dr. Dugaw and Group Health alleging negligence and lack of informed consent. At the end of the evidence at trial, the defendants moved to dismiss the informed consent claim, and the trial court granted that motion. The jury was instructed solely on negligence, and returned a defense verdict. The trial court denied post - trial motions, and entered judgment on the verdict.

At the trial in *Lapping*, an anesthesiologist testified for plaintiff that, in light of Lapping's history of seizures, she should have been informed that she could undergo the biopsy as an outpatient at a hospital where oxygen would have been immediately available, an IV would have been in place, a blood pressure cuff would have been in place, a cardiac

monitor would have been used, and there would have been close visual scrutiny. The anesthesiologist testified that Ms. Lapping died because it was not recognized in time that she had had cardiac respiratory collapse, and she was not resuscitated in time to avoid irreparable hypoxic brain damage. The anesthesiologist testified that Ms. Lapping would not have died if she had received timely intubation and CPR, and medical personnel closely monitoring the patient would have noticed a slowing of the pulse, a drop in blood pressure, and a change in the level of consciousness three to four minutes before the seizure occurred.

Another physician testified for plaintiff that Ms. Lapping died because of a lack of oxygen to the brain, to the point where it produced irreversible brain damage. Findings of the paramedics showed there had been a severe lack of oxygen to the brain for more than five minutes. He said that Ms. Lapping probably would not have died if she had received timely intubation and CPR.

In *Lapping*, plaintiff claimed the trial court erred in directing a verdict for defendants on her cause of action for informed consent because the medical testimony showed there was a reasonable alternative to the procedure as performed, and Dr. Dugaw didn't advise Ms. Lapping of that alternative.

Materiality presents a jury question if any rational trier of fact could find, based on a preponderance of evidence, that a reasonably prudent person in the position of the patient, when deciding whether to submit to the proposed treatment, would have attached significance to the fact in issue. *Brown v. Dahl*, 41 Wn.App. 565, 574, 573, 705 P.2d 781 (1985); *Archer v. Galbraith*, 18 Wn.App. 369, 376, 567 P.2d 1155 (1977), *Rev. Den'd.*, 90 Wn.2d 1010 (1978). Immateriality is shown as a matter of law if no rational trier could find, based on a preponderance of evidence, that a reasonably prudent person in the position of the patient, when deciding whether to submit to the proposed treatment, would have attached significance to the fact in issue.

In the *Brown* case, the trial court dismissed as a matter of law, even though there was expert testimony explaining that the doctor had failed to tell the patient of the risks of general anesthesia and of the available alternatives. Division II reversed, holding that in light of the evidence presented, a rational trier could have found that a reasonable person in the patient's shoes would have attached significance to the omitted information.

In *Archer*, a surgeon failed to advise the patient of various risks associated with a hemi-thyroidectomy. He also failed to advise of the

possibility of observing the affected gland, without surgery, to see if it changed over time. The trial court removed informed consent from the jury's consideration. Division One reversed, holding that a rational trier could have found that a reasonable person in the patient's shoes would have attached significance to the omitted information. *Archer*, 18 Wn.App. at 378.

In the *Lapping* case, the question was whether a rational trier of fact could have found that a reasonably prudent person in Ms. Lapping's position would have attached significance to the fact that the endometrial biopsy could have been done in a hospital with more equipment and greater precautions than were available in the clinic setting. In the view of Division II, the answer was "yes." The court pointed out that Ms. Lapping was not a normal patient. She had a history of seizures, and was taking Dilantin because of that. Accordingly, Division II held in *Lapping* that the trial court erred by not submitting the plaintiff's cause of action for informed consent to the jury.

CONCLUSIONS

Plaintiff submits that errors of law were made by the trial court. Substantial justice had not been done here. At the very least, we submit that this court should reverse and order a new trial in this case. That new trial should, we submit, be limited to damages proximately caused by Dr. Sauerwein, as we submit that this court should rule that he was / is liable herein, as a matter of law, for failure to advise Christina of the material fact of the *known abnormality* of the fungus in her blood which ultimately killed her. As in the *Lapping* case, Christina was not a “normal patient.” She was a diabetic who had very high blood sugars. She was immunocompromised. She was set up for a bad result – here her death – by the fact that she was not told she had the fungus in her blood so that she could have known that and have been in position to make informed decisions about her medical care, which should have / would have saved her life. She had viable health care options which she never had a chance to exercise because she thought she only had a bacterial infection.

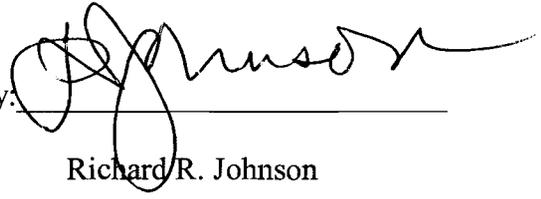
DATED this 20th day of December, 2011.

Respectfully submitted,

DELORIE – JOHNSON, PLLC

Lawyers for plaintiff / appellant

By: _____

A handwritten signature in black ink, appearing to read "Richard R. Johnson", is written over a horizontal line. The signature is stylized and cursive.

Richard R. Johnson

WSBA #6481

APPENDIX

Exhibit 3 A – Discharge Summary from Yakima Valley Memorial Hospital

Exhibit 6 – Microbiology Laboratory Report

Exhibit 7 – Defendant’s Clinical messages for Christina Anaya

Exhibit 8 – Washington State Certificate of Death

Exhibit 3 A – Discharge Summary

Yakima Valley Memorial Hospital

DATE OF ADMISSION: 08/29/06
DATE OF DISCHARGE: 11/07/06

ADMITTING DIAGNOSIS

Acute renal failure

FINAL DIAGNOSIS

Candida sepsis

OTHER DIAGNOSES

1. Septic shock
2. Acute renal failure
3. Posttraumatic pulmonary insufficiency
4. Cardiac arrest
5. Anoxic brain damage
6. Defibrillation syndrome
7. Congestive heart failure
8. Pleural effusion
9. Iatrogenic pneumothorax
10. Iron deficiency anemia
11. Hypoosmolality
12. Cardiac rhythm disorder
13. Diabetes mellitus type 2, controlled
14. Decubitus ulcer
15. Diarrhea

OPERATIVE PROCEDURES: Tracheostomy on 09/28/06, exploratory thoracotomy on 09/26/06, insertion of intercostal catheter for drainage on 09/13/06, percutaneous gastrostomy tube on 09/22/06, upper endoscopy with biopsy on 10/10/06, percutaneous endoscopic gastrojejunostomy, cardiopulmonary resuscitation on 09/06/06, cardiac resuscitation on 10/10/06, cardiac resuscitation on 10/12/06, and cardiac resuscitation on 10/28/06.

CONSULTATIONS: Dr. N. C. Chowdhury, Dr. V. C. Kamath, Dr. C. E. Mandanis, Dr. P. I. Menashe, Dr. L. E. Urrutia, Dr. P. Vathesatogkit, Dr. S. C. Yang, Dr. N. L. Barg, Dr. M. Jorgensen, Dr. J. H. Licht, and Dr. W. F. Von Stubbe.

SUMMARY OF ADMISSION HISTORY AND PHYSICAL: The patient is a 32-year-old married housewife and mother of 2 who had been diabetic for about 10 years. The family noticed pallor for about two weeks before this admission. She began to feel bad at about that time with some back pain.

1 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTIN/A
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A - 0000001

She was diagnosed with a renal infection and with anemia. She was admitted on antibiotics and was discharged 24 hours later. She said she felt fine when she left the hospital but had a sensation of a full abdomen. She returned to the emergency room within the next day or two with the sensation of a full bladder. A catheter was placed and the bladder was drained. Again, she was discharged home. During this time, she developed sore, swollen legs, fevers, back pain, and weakness. Because of the deterioration, she said she wanted to be out of Toppenish and came here to our hospital. She was evaluated in the emergency room, noted to have multiple problems, and admitted to my service as a medical backup patient.

Physical examination revealed a youthful and extremely pale 32-year-old lady who was in no apparent distress when first seen. She does appear to be weak and complained of being cold. Examination showed edema of both legs at about 3/10. Otherwise, her examination was remarkably unremarkable.

DATABASE: The patient's blood type was O positive. She was transfused 27 units of packed cells. She received 29 units of fresh frozen plasma. She had 3 units of platelets. The initial blood gas on 08/31/06 revealed pH of 7.39, pCO₂ 21 and pO₂ 68 with a saturation of 95% on 2 liters. Her CO₂ at that time was 13. Approximately 50 to 70 blood gases were done during her hospital stay during the process of adjusting the oxygen saturation. Details are in the chart on those numbers. The CMP on her admission had a calcium of 7.7, glucose 237, BUN 54, creatinine 3.7, protein 6, albumin 1.7, alkaline phosphatase 287, sodium 121, CO₂ 10. Her amylase was 26 with a troponin of 0.06 and a lipase of 16. Her CK was 110. The patient had a BMP or CMP at least daily and many times several times during the day throughout her hospital stay. As would be imagined, there was a tremendous amount of variability. It showed that her renal function deteriorated after admission, her proteins declined, and her liver functions became elevated. She remained acidotic for a long period of time. Eventually, her renal function improved and stabilized while her other factors did not change much. Her initial BNP was 282. The TSH was 2.25 with a hemoglobin A_{1c} of 9.2 hemoglobin, and estrogen level of 250. The patient's initial 24-hour protein was 2000 with a derived and not calculated creatinine clearance of 16. Her serum creatinine was 2.8 at that time. The patient had a series of titers from Dr. J. H. Licht to exclude vasculitis of her kidneys. These were negative or only slightly abnormal. The initial CBC had a white count of 14.1, hemoglobin 7.5, hematocrit 22.2, with an MCV of 83 and platelets of 393,000. Similar to the CMP, the patient had a CBC or variation at least once a day and many times several times a day throughout her 2-1/2-month hospital stay. These numbers varied. As would be expected, she improved following transfusions and then would gradually decline again. An RA test was negative. Her initial INR was 1.56 with an initial APTT of 46.6 and a D-dimer of 2800. The fibrinogen was 660. Serial INRs and APTTs were done and were frequently elevated. The initial urinalysis had 2+ leukocytes, 3+ blood and 3+ yeast. A repeat in late October was negative with no yeast or white cells noted. Stool for occult blood showed some initial bleeding on 09/11/06 but were otherwise negative.

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YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A - 0000002

Twenty-seven blood cultures were done during her stay. Initially she grew *Candida glabrata*. After several days this cleared. At times her cultures would show contaminated organisms, but otherwise they were negative. The initial urine culture also grew *Candida glabrata*. A repeat culture in September was negative times two. A final culture in early November grew *Klebsiella*. Eight sputum cultures were obtained during her stay and grew *Staphylococcus aureus*, respiratory flora or *Acinetobacter baumannii*. Her central line was cultured at least four times and grew *Acinetobacter baumannii*. Stool cultures times two were negative for bacteria, but the initial stool culture grew *Candida glabrata*. Stool for *C. difficile* toxin was negative on five occasions. Stool for ova and parasites on 10/19/06 was negative.

RADIOLOGY STUDIES: Similar to the lab reports, enumerable studies were done during this admission. The initial chest x-ray was negative. The initial ultrasound from 08/29/06 showed an enlarged left kidney without a mass or hydronephrosis. The left kidney was edematous and was felt to be either infected or ischemic. A CT scan done on 08/30/06 again showed an enlarged left kidney again consistent with edema or inflammation. By 09/03/06, her chest x-ray had bilateral alveolar infiltrates. By 09/08/06, the infiltrates were continuing to worsen. A venous ultrasound of the lower extremities did not show any signs of thrombi on 09/12/06. A CT on 09/18/06 showed bilateral lower lobe pneumonia, as well as ascites and anasarca. The kidneys at that time were read as being fairly unremarkable. A CT of the head on 09/18/06 was read as a normal study. On 09/18/06, the patient was noted to have a chest tube. Again, she had bilateral infiltrates. Over the next few weeks, she continued to have diffuse pulmonary densities in both lung fields on her multiple chest x-rays. By in large, there was little change. A repeat CAT scan of the abdomen on 10/09/06 again had little change from a prior CAT scan. An MRI of her brain done on 10/31/06 showed diffuse changes consistent with ischemia or toxicity. This was most consistent with anoxic encephalopathy. She was noted to have sinusitis of her maxillary sinuses and mastoiditis.

CARDIOLOGY STUDIES: An echocardiogram done on 09/01/06 showed a left ventricular size which was small and hyperdynamic. She had moderate pulmonary hypertension. By 09/15/06, there was little change. The chambers were perhaps more normal in size. No thrombus was identified. Her initial EKG had a sinus tachycardia with a rate of 115, as well as rightward axis. The patient was monitored at great length throughout her hospital stay, and multiple tracings are on the chart. By in large, she is most frequently in a sinus rhythm or a sinus bradycardia noted at times.

HOSPITAL COURSE: As the reader can already tell from the notes above, this was a very lengthy and complicated hospital stay, lasting for parts of four months. The chart itself is 9 inches thick. In order to make this a true summary, multiple significant events will be touched on only briefly. The reader is referred to the chart for the details they wish to find.

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YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A - 0000003

This patient was admitted by myself on medical backup in late August. She presented with an extremely confusing picture of multiple abnormalities, including low sodium, anemia, renal failure, and urine which was positive for yeast. She was transfused that evening and started on antibiotics. The following day, Dr. M. Jorgensen was consulted, as well as Dr. Licht. By that time, the patient was going into respiratory failure and was transferred to the ICU. Dr. L. E. Urrutia took over the case from that point for basically the duration of the hospital stay. The patient was seen very shortly thereafter by Dr. N. L. Barg, who diagnosed Candida sepsis, including a Candida pyelonephritis. He immediately said that her prognosis was probably extremely grim. In spite of that, the entire ICU team, both the doctors and the nurses, treated this case with great heroism over the next several weeks. The patient was not stable hemodynamically for a long period of time. She had cardiac arrests. She had a collapsed lung. She required a tracheostomy. Throughout all this, she developed anoxia, which led to an advanced cerebral anoxia. She was seen by the neurologist, who felt the patient was brain dead by that time. The family was informed of this at great length by Dr. Urrutia. In spite of that news, they asked us to keep going and make every effort to help her survive. Eventually, she was transferred to the telemetry unit. She was there for barely a day or two when she had another cardiac arrest. She went back to the intensive care unit for several more weeks. She was transferred out again. After about five days on the medical floor, she had another respiratory arrest and was transferred back to the unit again. By this point, the patient's family was able to understand the case. They were convinced by Dr. Urrutia that the patient was not stable enough to survive on her own, since she was unable to handle any of her secretions or her own breathing. They agreed that the patient could be sent to a nursing home. They understood that if she had a further cardiac arrest in the nursing home it would probably be fatal.

By this time, the patient had developed significant breakdown of her skin with large decubitus ulceration. She was anoxic and had little or no purposeful movements, even of her eyes. She had no vocalization of any significance.

DISPOSITION: The patient was discharged to a nursing home in the lower valley. At that time, she was on Isosource VHN at 75 ml per hour per J-tube. She was receiving tracheostomy care, as well as G-tube care. She was on oxygen. She had an RC in place. She had braces for her legs.

Blood sugars were being checked BID with a sliding scale of aspart insulin. She had NPH insulin at 15 units BID.

Other medications included esomeprazole 40 mg PO daily, cholestyramine 4 g BID, Lomotil 5 ml Q4H, medroxyprogesterone 10 mg daily, prednisone 5 mg daily, and Cipro 500 mg BID for 10 days.

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YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A- 00000004

The patient was to have weekly lab work to include a CMP, magnesium and phosphorous.

RBB:tc

D: 11/24/2006 7:45 P

T: 11/27/2006 12:10 P

000031866

cc: Neil L Barg, MD
Richard B. Boyd, MD
Nepal C. Chowdhury, MD
Kyle Heisey, MD
Maria Jorgensen, MD, PhD
Voderbet C. Kamath, MD
J. Hamilton Licht, MD
Christos E. Mandanis, MD
Phillip I. Menashe, MD
Luis E. Urrutia, MD
Pratan Vathesatogkit, MD
William F. Von Stubbe, MD
S. Chris Yang, MD

Signature

Richard B. Boyd, MD

5 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A- 0000005

Exhibit 6

Microbiology Laboratory Report

3

Toppenish Community Hospital
502 W 4th Avenue, Toppenish, WA, 98948
Harold McCartney M.D., Medical Director

PATIENT: ANAYA, CHRISTINA
I.D.#: 05005344
DISCHARGED: 08/21/06

MRN: 00000329427 LOC: TMED-0105-1
DOB: 06/14/1974 AGE: 32 SEX: F
ORDERED BY: JEROME, JEROME

M I C R O B I O L O G Y

SOURCE: Blood Left Arm
ORDER#: 44200226

COLLECTED: 08/20/06 12:20
RECEIVED : 08/20/06 12:49

ANTIBIOTICS AT COLLECTION :
ORDER ENTRY COMMENTS: VOMITING AND DIARRHEA--ADULT (MILD)

----- C O M M E N T S -----

VOMITING AND DIARRHEA--ADULT (MILD)

Culture Blood

* FINAL 08/26/06 13:54 Site: 0

08/21/06 .

08/24/06 ** Aerobic Bottle: POSITIVE after 3.3 days incubation.
** Patient discharged.

** Report called to Sara RN at Farmworkers Toppenish taking calls
** for Dr.K.Heisey 08/24/2006 11:27 rb/tb

08/26/06 ** Anaerobic Bottle: No growth after 5 days.

Organism 01 Candida glabrata (T. glabrata) 08/26/06 13:54 CJL

KEY FOR RESULTS: * - NEW RESULT ** - RESULT WAS MODIFIED AFTER FINAL STATUS SET SITE CODE M-YAKIMA O-TOPPENISH

ATT.PHYS.: MORAN, JOHN
ADM.DATE: 08/20/06

MRN: 00000329427 LOC: TMED-0105-1
PATIENT : ANAYA, CHRISTINA

M I C R O B I O L O G Y

PRINTED 08/27/2006 03:15

Page: 1 of 2

Exhibit 7

Defendants' Clinical Messages for

Christina Palma Anaya

Patient: Anaya, Christina

Pat ID: 14852

DOB: 6/14/1974 33.5 yr F

Clinical Message

Anaya, Christina Pat ID: 14852 DOB: 6/14/1974 33.5 yr F

[NKA]

MRN: 14852

Home Phone: (509) 985-5659

Work Phone:

Category: Clinical Message

Send To:

Priority: Routine

Copy To:

Received By: Sarah Gott, RN

Received Date: 08/24/2006 11:54 AM

Caller:

Provider: TOPPENISH, FP NURSE

Return Phone:

Messages: Sarah Gott, RN 8/24/2006 11:57:49 AM
received Uo from Yak Reg microbiology. Pts blood cultures positive for yeast. Pt was discharged on 8/21/06. Obtained hospital information but discharge summary not available. Information placed on your workstation.

Mark Sauerwein, MD 8/24/2006 2:33:51 PM
please call patient to see how she is,
unless she is currently ill, it is a probable contaminant
I reviewed the case with dr moran who took care of her in the hospital

Mary Sifuentes, LPN 8/24/2006 2:53:58 PM
spoke to christina she said went to er last nite was not feeling well at all was not to empty out her bladder so they cath her she said
feels much better now she is taking abx and has f/u appt on 8/5 not fever just a little tired pt is a diabetic.

Mark Sauerwein, MD 8/24/2006 6:50:40 PM
have her come in next week please , 8/5 is too far out

Sarah Gott, RN 8/25/2006 11:00:27 AM
Will contact.

Mary Sifuentes, LPN 8/25/2006 12:13:28 PM
APPT GIVEN FOR WED 8/30

Entered By: Sarah Gott, RN

8/24/2006 11:57:49 AM

Closed By: Mark Sauerwein, MD

8/25/2006 1:17:39 PM

Approved: Mark Sauerwein, MD

8/25/2006 1:17:00 PM

Exhibit 8

Certificate of Death

Christina Palma Anaya

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH**

Local File Number: 1536 Washington State Certificate of Death State File Number: _____

| | | | | | |
|---|--|--|---|---|---|
| 1. Legal Name (include AKA's if any): First Middle LAST Christina Palma ANAYA | | | 2. Death Date 11-17-2006 | | |
| 3. Sex (M/F) Female | 4a. Age - Last Birthday 32 | 4b. Under 1 Year Months Days | 4c. Under 1 Day Hours Minutes | 5. Social Security Number | 6. County of Death Yakima |
| 7. Birthdate 6-14-1974 | 8a. Birthplace (City, Town, or County) Toppenish | 8b. (State or Foreign Country) Washington | | 9. Decedent's Education 11th grade | |
| 10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. Yes-Mexican | | | 11. Decedent's Race(s) Hispanic | | 12. Was Decedent ever in U.S. Armed Forces? NO |
| 13a. Residence: Number and Street (e.g., 824 SE 5th St.) (Include Apt. No.) 42 E. 3rd Street | | | | 13b. City or Town Toppenish | |
| 13c. Residence: County Yakima | | 13d. Tribal Reservation Name (if applicable) N/A | | 13e. State or Foreign Country Washington | 13f. Zip Code #4 98948 |
| 14. Estimated length of time at residence. 3 years | | 15. Marital Status at Time of Death Married | | 16. Surviving Spouse's Name (Give name prior to first marriage) Rodolfo Anaya | |
| 17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED). Homemaker | | | 18. Kind of Business/Industry (Do not use Company Name) Own Home | | |
| 19. Father's Name (First, Middle, Last, Suffix) Ascension C. Palma | | | 20. Mother's Name Before First Marriage (First, Middle, Last) Alma Silva | | |
| 21. Informant's Name Rodolfo Anaya | | 22. Relationship to Decedent Spouse | | 23. Mailing Address: Number and Street or RFD No. City or Town State Zip 42 E. 3rd Ave. Toppenish, WA 98948 | |
| 24. Place of Death, if Death Occurred in a Hospital: N/A | | | 25. Place of Death, if Death Occurred Somewhere Other than a Hospital: Nursing Home | | |
| 25. Facility Name (if not a facility, give number & street or location) Toppenish Nursing and Rehab | | | 26a. City, Town, or Location of Death Toppenish | | 26b. State WA |
| 27. Zip Code 98948 | | 28. Method of Disposition Burial | | 29. Place of Final Disposition (Name of cemetery, crematory, other place) Elmwood Cemetery | |
| 30. Location-City/Town, and State Toppenish, WA | | | 31. Name and Complete Address of Funeral Facility Colonial Funeral Home 228 S. Alder; Toppenish, WA 98948 | | |
| 32. Date of Disposition 11-21-2006 | | | 33. Funeral Director Signature X <i>[Signature]</i> | | |

Part 1 completed by Funeral Director

Part 2 completed by Certifier

Cause of Death (See instructions and examples)

34. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Add additional lines if necessary.

| | | |
|---|--|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrhythmia | Interval between Onset & Death |
| Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST | b. Anoxic/Ischemic encephalopathy | Interval between Onset & Death 2 months |
| | c. Fungal sepsis | Interval between Onset & Death 2 months |
| | d. Type II Diabetes Mellitus | Interval between Onset & Death years |

35. Other significant conditions contributing to death but not resulting in the underlying cause given above

36. Autopsy? Yes No

37. Were autopsy findings available to complete the Cause of Death? Yes No

38. Manner of Death

| | | | | |
|---|---------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> Natural | <input type="checkbox"/> Homicide | 39. If female | <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death | 40. Did tobacco use contribute to death? |
| <input type="checkbox"/> Accident | <input type="checkbox"/> Undetermined | <input type="checkbox"/> Not pregnant, but pregnant within 43 days to 1 year before death | <input type="checkbox"/> Not pregnant, but pregnant within the past year | <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Pending | <input type="checkbox"/> Pregnant at time of death | | |

41. Date of Injury (mm/dd/yyyy): _____ 42. Hour of Injury (24hrs): _____ 43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) _____ 44. Injury at Work? Yes No Unk

45. Location of Injury: Number & Street: _____ Apt. No. _____
City or Town: _____ County: _____ State: _____ Zip Code # 4: _____

46. Describe how injury occurred _____

47. If transportation injury, specify:
 Driver/Operator Pedestrian
 Passenger Other (Specify) _____

48a. Certifying Physician: *[Signature]* 48b. Medical Examiner/Coroner: _____

49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (if Physician or PMH)
Kyle Heisey, M.D. 518 W 1st Ave Toppenish, WA 98948

50. Hour of Death (24hrs) **13:00**

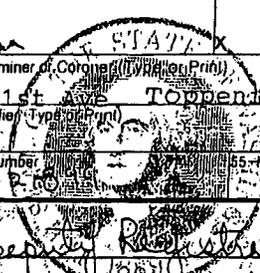
51. Name and Title of Attending Physician (if other than Certifier) (Type PMH)
[Signature]

52. Date Signed (mm/dd/yyyy) **11/17/06**

53. Title of Certifier **Medical Doctor** 54. License Number **MD 6100** 55. ME/Coroner File Number _____ 56. Was case referred to ME/Coroner? Yes No

57. Registrar Signature *[Signature]* 58. Date Received (mm/dd/yyyy) **11-20-2006**

59. Amendments _____



DDF01-003 (5/99)