NO. 1000791

SUPREME COURT
OF THE STATE OF WASHINGTON

NO. 80854-1

COURT OF APPEALS, DIVISION I
STATE OF WASHINGTON

MARI YVONNE DAVIES,

Respondent,

vs.

MULTICARE HEALTH SYSTEM, et al.,

Petitioners.

ANSWER TO PETITION FOR REVIEW

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I. INTRODUCTION

This matter stems from treatment Mari Davies received at Good Samaritan Hospital following a rollover vehicle crash. Dr. Michael Hirsig, the attending physician in the Good Samaritan emergency room, correctly diagnosed Ms. Davies with multiple neck fractures but failed to inform her of the material risks associated with such neck fractures, including a vertebral artery dissection and possible stroke, if she accepted his recommendation that she return home with no additional testing or treatment. In fact, Ms. Davies had a vertebral artery dissection and the next day suffered a debilitating stroke. Consistent with Washington law, Ms. Davies asserted a claim against Dr. Hirsig for failure to obtain informed consent. The trial court erroneously dismissed that claim on summary judgment, and the Court of Appeals correctly reversed that ruling.

Dr. Hirsig, along with Mt. Rainier Emergency Physicians, PLLC, and MultiCare Health System (collectively "defendants") wrongly claim that the Court of Appeals' ruling "conflicts with settled law," including this Court's decision in *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 331 P.3d 19 (2014). Pet. 2.[1] As discussed below, no such conflict exists because *Anaya Gomez* and the Court of Appeals decisions cited by defendants are easily distinguishable. Moreover, Ms. Davies' informed consent claim

[1] This answer uses the same abbreviations as defendants' Petition For Review ("Pet.").

closely tracks the informed consent claims that this Court upheld in *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999), and *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979). There is no conflict with settled law, nor any other issue that warrants this Court's review. Defendants' Petition For Review should be denied.

II. STATEMENT OF THE CASE

Mari Davies was involved in a single-car rollover crash and was taken by ambulance to Good Samaritan Hospital on August 23, 2017. RP 614, 733; Ex. 1 at 4. Dr. Hirsig was the attending physician in the Good Samaritan emergency room that day and saw Ms. Davies. RP 807. Dr. Hirsig's notes indicate Ms. Davies had a "high probability of sudden clinically significant or life-threatening deterioration," which required direct high-level care, "the absence of which could have resulted in further morbidity or mortality." Ex. 2 at 20.

After examining Ms. Davies, Dr. Hirsig ordered a CT scan, which revealed multiple fractures of Ms. Davies' cervical spine at the C3 level. RP 696-97, 705; Ex. 2 at 29. Following a conversation with the radiologist, Dr. Hirsig advised Ms. Davies and her recently arrived family members of the results of these scans and informed them that Ms. Davies would be transferred to the trauma unit at Tacoma General Hospital for further treatment and observation. RP 701; Ex. 2 at 22.

Dr. Hirsig then contacted Dr. William Morris, the on-call neurosurgeon, who confirmed the diagnosis of multiple neck fractures. RP 784-85. Dr. Morris recommended that Ms. Davies be placed in a cervical collar. RP 785-86. According to his progress notes, Dr. Morris was under the impression that Ms. Davies would be transferred to Tacoma General Hospital for observation by the "Trauma Team." RP 1121; Ex. 2 at 24.

Both Dr. Hirsig and Ms. Davies' expert acknowledged at trial that a vertebral artery injury is a well-documented risk following cervical spine fractures caused by trauma. RP 747, 764-65, 1232-33. A CTA scan is the only way to rule out a vertebral artery dissection. RP 762, 769. Yet Dr. Hirsig did not inform Ms. Davies of the risks associated with her (correctly diagnosed) neck fractures, including a vertebral artery dissection and possible stroke. Without that information, Ms. Davies and her family did not know to ask about further treatment or testing before discharge. Instead, Ms. Davies was placed in a neck collar, prescribed medication for pain and nausea, and sent home. Ex. 2 at 19, 27.

The next day, Ms. Davies' daughter, Melissa Bronoske, took Ms. Davies to visit her primary care physician, Dr. Andrew Larsen, to follow up on her emergency room visit. RP 1722-23, 1801. At that time, Ms. Davies was experiencing extreme neck pain (10/10 on a pain scale), which was made worse by her coughing due to pneumonia. RP 1723. Dr. Larsen

arranged for transport to Providence St. Peter Hospital for direct admission for treatment of her pain and pneumonia. RP 1725. While awaiting transport, Ms. Davies suffered a significant stroke. RP 1725, 1806-08.

The stroke was later determined to have been due to a vertebral artery dissection Ms. Davies sustained when her neck fractured during the rollover crash. RP 638. Ms. Davies' experts testified at trial that the stroke would have been prevented if defendants had performed a CTA scan and then prescribed medication (such as Plavix and aspirin) that prevents strokes. RP 994-97, 1267-68.

Over the next two days and while at Providence St. Peter Hospital, Ms. Davies' condition deteriorated significantly. RP 639. Ms. Davies is now permanently disabled: she is unable to care for herself, cannot take her medicine and manage her complicated conditions, cannot transport herself, and has cognitive issues. RP 1734. Ms. Davies lives in an assisted living facility where she receives around-the-clock assistance and will require that assistance for the remainder of her life. RP 649-51, 1734-35.

Ms. Davies filed suit against MultiCare, and Dr. Hirsig intervened as a defendant. CP 19-20, 799-800. Relevant here, Ms. Davies asserted a claim against Dr. Hirsig for failure to obtain informed consent. CP 19-20. Dr. Hirsig moved for partial summary judgment on that claim, which the

trial court granted. CP 590-92. The Court of Appeals reversed that ruling, and defendants now seek this Court's review.

III. ARGUMENT WHY THIS COURT SHOULD DENY REVIEW

A. The Court Of Appeals' Decision Does Not Conflict With Decisions Of This Court Or The Court Of Appeals (RAP 13.4(b)(1)-(2)).

1. The Court Of Appeals' Analysis Does Not Conflict With This Court's Decision In *Anaya Gomez* Or The Other Court Of Appeals Decisions Cited By Defendants.

Defendants wrongly claim that the Court of Appeals' decision "conflicts with settled law that 'a provider cannot be liable for failure to inform in a misdiagnosis case.'" Pet. 2 (quoting *Anaya Gomez*, 180 Wn.2d at 618). The Court of Appeals correctly concluded that this case is "unlike *Anaya Gomez*" (Op. ¶¶ 27, 30), and its analysis does not conflict with that decision or the additional Court of Appeals decisions cited by defendants.

In *Anaya Gomez*, a patient who suffered from uncontrolled diabetes, was immunocompromised, and was susceptible to serious infections visited the hospital complaining of urinary tract infection symptoms. 180 Wn.2d at 613. Lab results determined her cultures were positive for yeast, but her treating physician concluded that the test result was a false positive and therefore did not inform her about the lab results. *Id.* at 614. In affirming the dismissal of the plaintiff's informed consent claim, the Court explained: "Either Dr. Sauerwein knew that Mrs. Anaya had a yeast infection, giving rise to a failure to inform claim, or he failed to know she had a yeast

infection, giving rise to the negligence claim." *Id.* at 619. The Court added: "Mr. Anaya points to no choice that was available to the treating physicians or Mrs. Anaya, instead inviting this court to ignore the medical realities surrounding the circumstances of the case." *Id.* at 622.

Unlike the circumstances in *Anaya Gomez*, Dr. Hirsig was aware of Ms. Davies' multiple neck fractures (CP 504), thus "giving rise to a failure to inform claim" (*Anaya Gomez*, 180 Wn.2d at 619). And unlike the patient in *Anaya Gomez*, Ms. Davies had numerous diagnostic and treatment options including a CTA scan and medication (like Plavix and aspirin) that would prevent a stroke. CP 130, 504. As the Court of Appeals correctly noted (Op. ¶¶ 28-30) and the record confirms (CP 145, 147-48; RP 994-97, 1267-68, 1725, 1806-08), these diagnostic and treatment options would have prevented the stroke that Ms. Davies suffered following discharge. Yet Dr. Hirsig failed to inform Ms. Davies of the material risks associated with multiple neck fractures, including injury to arteries in the neck and possible stroke, if she accepted his recommendation that she return home with no additional testing or treatment rather than pursue other treatment options. On this record, the Court of Appeals' decision does not conflict with *Anaya Gomez*.

Defendants' argument regarding *Anaya Gomez* also fails because this is not a "misdiagnosis case." Pet. 2, 3, 8, 10, 11, 13, 19. As the Court

of Appeals correctly noted, Ms. Davies "was *correctly diagnosed* with a cervical fracture." Op. ¶ 27 (emphasis added). Far from showing that Dr. Hirsig misdiagnosed Ms. Davies' condition, the summary judgment record confirms that he *correctly* diagnosed Ms. Davies with multiple neck fractures. CP 504. Nor did Dr. Hirsig testify that he "ruled out" a vertebral artery dissection, as defendants also claim. Pet. 1, 4, 12, 17. He testified at his deposition only that he "*didn't suspect* that she had a dissection." CP 578 (emphasis added). Because this issue was decided on summary judgment, the Court "view[s] the facts and reasonable inferences in the light most favorable to the nonmoving party." *Meyers v. Ferndale Sch. Dist*., 197 Wn,2d 281, 287, 481 P.3d 1084 (2021). Moreover, it is undisputed that a CTA scan is the only way to rule out a vertebral artery dissection and Dr. Hirsig did not order a CTA scan. RP 762, 769, 845, 1123-24. This, too, undermines defendants' argument that the Court of Appeals' analysis conflicts with *Anaya Gomez*.[2]

[2] In addition to the informed consent claim at issue in defendant's Petition For Review, Ms. Davies also asserted a medical negligence claim. CP 19. While the negligence claim is not at issue here, defendants misleadingly state that "a jury found that Dr. Hirsig's decision not to order a CTA because he had *ruled out a vertebral artery injury* after consulting with a neurosurgeon complied with the standard of care." Pet. 1-2 (emphasis added); *see also* Pet. 5 n.2, 6-7. The jury made no such specific finding. It merely answered "no" when asked on the special verdict form "was Dr. Michael Hirsig, MD, negligent in his care of Mari Davies?" CP 823. Additionally, this Court recognized in *Backlund* that "[n]egligence and informed consent are *alternative methods* of imposing liability on a health care practitioner." 137 Wn.2d at 659 (emphasis added).

Lastly, the other Court of Appeals decisions cited by defendants (Pet. 12 n.4) are distinguishable for similar reasons: they involve health care providers who misdiagnosed a patient's principal injury whereas here Dr. Hirsig *correctly* diagnosed multiple neck fractures and failed to provide material information regarding the risks and benefits of the recommended and alternative treatment options.[3] Where, as here, a physician *correctly* diagnoses an injury and fails to inform a patient of the material facts relating to the risks and proposed course of treatment for that injury, the cases relied upon by defendants are inapposite. Because the Court of Appeals' decision does not conflict with a decision of this Court or another Court of Appeals decision, review is not warranted under RAP 13.4(b)(1) or (2) .

2. Ms. Davies' Informed Consent Claim Closely Tracks The Claims That This Court Upheld In *Backlund* and *Gates*, And The Court Of Appeals Correctly Relied On Those Decisions.

In addition to concluding (correctly) that this case is "unlike *Anaya Gomez*" (Op. ¶¶ 27, 30), the Court of Appeals concluded that the case is "like *Gates*" (*id.*). In *Gates*, as well as in *Backlund*, this Court upheld

[3] *See Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 791, 954 P.2d 319, *rev. denied*, 136 Wn.2d 1023 (1998) (failure to diagnose cancer); *Harbottle v. Braun*, 10 Wn. App. 2d 374, 390-91, 447 P.3d 654 (2019) *rev. denied*, 194 Wn.2d 1018 (2020) (failure to diagnose coronary disease); *Thomas v. Wilfac, Inc*., 65 Wn. App. 255, 260-61, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992) (failure to diagnose malathion poisoning); *Bays v. St. Lukes Hosp.*, 63 Wn. App. 876, 882, 825 P.2d 319 (1992) (physician "unaware of the thromboembolism condition"); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 168, 772 P.2d 1027 (1989) (physician "unaware of the risk of brain herniation and subsequent injury").

informed consent claims that closely resemble Ms. Davies' claim. Contrary to defendants' assertion (Pet. 2), this "settled law" strongly supports the Court of Appeals' analysis.

In *Gates*, Ms. Gates suffered from high pressure in both eyes, which placed her in the borderline area for glaucoma, but her ophthalmologist did not inform her of the abnormality or additional diagnostic procedures to determine the significance of that abnormality. 92 Wn.2d at 246. This Court held that the doctrine of informed consent extends to such facts because "[t]he 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." *Id.* at 251.

In *Backlund*, Ashley Backlund (a newborn infant) suffered from jaundice caused by elevated levels of bilirubin (a substance released into the bloodstream when red blood cells break down). 137 Wn.2d at 654. The defendant physician treated the condition with phototherapy. Another treatment alternative existed – a blood transfusion – but the physician did not believe Ashley required a transfusion because her bilirubin levels were not serious enough to warrant such treatment. *Id.* at 662. Even though the jury found in favor of the physician on the medical negligence claim (as the

jury did here (CP 823)), the Court held that the physician could be liable for failing to "sufficiently inform the patient of risks and alternatives in accordance with RCW 7.70.050," including a transfusion. *Id.* Emphasizing the importance of "patient sovereignty," the Court noted that without sufficient information regarding risks and alternatives, patients cannot properly evaluate the risks of treatment. *Id.* at 663-64.

Ms. Davies' informed consent claim closely tracks the informed consent claims in *Gates* and *Backlund*. Like the health care providers in both cases, Dr. Hirsig correctly diagnosed Ms. Davies' condition – multiple neck fractures – but did not advise her or her family that there was another treatment option – a CTA scan – that could conclusively determine the presence of a vertebral artery dissection. CP 130. Indeed, defendants effectively concede that *Backlund* directly addresses such circumstances in holding that the plaintiffs there "stated a valid claim under RCW 7.70.050 because the physician correctly diagnosed the condition but did not advise the parents of the risks and benefits of the alternative transfusion treatment." Pet. 11 (citing *Backlund*, 137 Wn.2d at 662). And like the plaintiffs in both cases, without sufficient information about material risks and treatment options Ms. Davies could not make an informed decision on the course of her future medical care, including whether to remain at the hospital for

further monitoring, testing, and treatment. On this record, the Court of Appeals correctly relied on *Backlund* and *Gates*. Op. ¶¶ 18-30.

Ignoring the facts of this case, defendants claim that *Gates* is factually distinguishable because "unlike in *Gates*, Ms. Davies did not present with an undiagnosed 'abnormal condition,' or with a 'high risk of disease.'" Pet. 16. That is an unduly narrow reading of *Gates*, which makes clear 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." 92 Wn.2d at 250. Here, Ms. Davies had multiple neck fractures and therefore had a right to know the material facts concerning that condition and any risks presented by that condition so that she could make an informed choice regarding the course of treatment. Dr. Hirsig failed to provide that information as *Gates* requires.

Defendants further argue that *Gates* is distinguishable because unlike the alternative diagnostic procedure in this case – a CTA scan – the glaucoma tests in *Gates* were "simple, inexpensive, and risk free." Pet. 17-18. Defendants ignore the record on this point, which establishes that a CTA scan is "simple" and "noninvasive" and "takes five to 20 minutes." RP 1583-84. Defendants also fail to compare the cost of a CTA scan to the alternative, which is a lifetime of cognitive issues and around-the-clock

care. This Court appropriately recognized that comparison in *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 320, 622 P.2d 1246 (1980): "when considering the alternative of death by heart attack, [the available tests] were relatively simple and risk free." Nor does it matter that Dr. Hirsig "was an emergency room physician who had no preexisting relationship with Ms. Davies." Pet. 17. Nothing in RCW 7.70.050 creates an exception for emergency room physicians, and Dr. Hirsig, as defendants concede, "took Ms. Davies' extensive medical history, performed a physical examination, and ordered CT scans of her head, cervical spine, abdomen, and pelvis." Pet. 4. Dr. Hirsig's lack of a preexisting relationship with Ms. Davies does not preclude reliance on *Gates*.

Finally, it is entirely irrelevant that "*Gates* was decided before the Legislature codified informed consent as a 'treatment-based' doctrine in 1976." Pet.16. First, as the Court of Appeals noted (Op. ¶ 26), this Court confirmed in *Anaya Gomez* that "*Gates* has not been overruled" (180 Wn.2d at 623). Second, while the informed consent statute is treatment-based, so too is Ms. Davies' informed consent claim. Addressing that precise issue, Ms. Davies' complaint alleges in relevant part as follows:

> 5.1 Defendants and/or their respective employees or agents did not explain to Plaintiff Ms. Davies the *alternative diagnostic tests and treatments* available. They did not explain that another option was a CTA or MRA test and aspirin therapy or other medication.

> 5.2 Had Defendants provided appropriate informed consent, a reasonable patient would have turned down the option of going home without having received a CTA or MRA test. A reasonable patient would have opted for *alternative testing and treatment*.

CP 19-20 (emphasis added). The informed consent claim thus focuses on the treatment options following a (correct) diagnosis of multiple neck fractures. On this record, *Gates* is directly on point. Because the Court of Appeals' analysis is consistent with this Court's precedent, review is not warranted under RAP 13.4(b)(1) or (2).

B. The Court Of Appeals' Decision Does Not Involve An Issue Of Substantial Public Interest That Should Be Determined By This Court (RAP 13.4(b)(4)).

Contrary to defendants' policy argument (Pet. 13-15), there is nothing confusing or improper about the Court of Appeals' decision. Indeed, the meaning and breadth of the Court of Appeals' analysis is clear. The court specifically states, as the above discussion confirms, that "once she was correctly diagnosed with a cervical fracture, there were additional tests available as part of her initial diagnoses – namely a CT angiography (CTA) scan – to check for vertebral artery dissection prior to discharge." Op. ¶ 27. In *Anaya Gomez*, this Court likewise held: "The duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it." 180 Wn.2d at 618-19. Here, Dr. Hirsig diagnosed Ms. Davies with multiple neck fractures. CP 504. Having done so, he was

required by Washington law to disclose information that "a reasonably prudent person in the position of the patient or his or her representative would attach significance to [in] deciding whether or not to submit to the proposed treatment." RCW 7.70.050(1)(a), (2). The applicable rules are clearly and consistently stated in the Court of Appeals' decision, *Backlund*, *Gates*, *Anaya Gomez*, and RCW 7.70.050. Dr. Hirsig simply failed to discharge this statutory duty.

In sharp contrast to the clarity of the Court of Appeals' decision, defendants here seek to marginalize and contort informed consent claims in Washington. What defendants want this Court to do is divide a patient's condition into a series of legally distinct injuries when analyzing an informed consent claim so that a health care provider can argue that he or she failed to diagnose an injury and thereby manufacture a misdiagnosis case. Here, for example, Dr. Hirsig would like to argue that a vertebral artery dissection is an alternative diagnosis that he ruled out. But Dr. Hirsig did not rule out a vertebral artery dissection, as Section III.A.1 above shows. And even if he did, a vertebral artery dissection is not an alternative diagnosis. Instead, it is a risk associated with multiple neck fractures, which Dr. Hirsig correctly diagnosed. Under RCW 7.70.050(1)(a), Dr. Hirsig is liable if he "failed to inform the patient of a material fact or facts relating to the treatment" of that condition. This legal requirement would be

meaningless if, as defendants argue, a health care provider can avoid disclosing material risks of a proposed treatment simply by recasting those risks as "other injuries" that were allegedly "ruled out." This, too, is a compelling reason to deny review. *See Thompson v. Hanson*, 168 Wn.2d 738, 753, 239 P.3d 537 (2009) (statutory provisions "should not be interpreted to undermine the purpose of the statute").

Defendants' reference to "unnecessary diagnostic testing" (Pet. 14) is similarly misguided. The issue here relates to informed consent – not unnecessary medical care – and this Court long ago held that cost and complexity are not determinative of a provider's duty to disclose:

> Although the fact that alternative diagnostic procedures are "conclusive" or "simple" may be of some importance in determining the materiality of the fact, *these characterizations of the tests in Gates were not determinative of the doctor's duty to disclose. Gates* relied on *Miller v. Kennedy*, [11 Wn. App. 272, 522 P.2d 852 (1974), *aff'd,* 85 Wn.2d 151, 530 P.2d 334 (1975)], another diagnostic procedure test case which involved neither a simple, risk free, or conclusive means of testing.

Keogan, 95 Wn.2d at 320 (emphasis added). Nor was the Court of Appeals mistaken or confused when it stated that vertebral artery dissection is a "common" and "well known" occurrence following neck fractures. Pet. 17; Op. ¶ 27. The record supports that point as well.[4] Indeed, Dr. Hirsig

[4] CP 143 ("[t]hey are commonly found together"), 145 ("It's well-known in the trauma literature that the mechanism of injury that leads to a cervical fracture is one that can also

conceded at trial that a vertebral artery dissection is one of several "associated other injuries." RP 747, 764-65. Had Dr. Hirsig shared that critical information with Ms. Davies, as Washington law requires, she would have received *necessary* diagnostic testing and treatment and avoided the stroke that she suffered following discharge.

Lastly, defendants' policy arguments are especially hollow in this case given Dr. Hirsig's repeated reliance on "shared decision-making." According to Dr. Hirsig, the decision to send Ms. Davies home without further monitoring, testing, and treatment was a "shared" decision made with her family members: "Like I said, *it has to be a shared decision when something like that happens*. The patient has to have support at home if she's going to be going home." CP 511. Defendants have never explained (nor can they explain) how Ms. Davies and her family could share such decision-making responsibility without being informed about the relevant risks and possible treatment options. Unlike defendants, the Court of Appeals appropriately recognized the importance of "patient decision-making" and "patient sovereignty" (Op. ¶ 17, quoting *Backlund* 137 Wn.2d

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lead to a cervical arterial dissection…."); RP 1060 ("hyperextension injury in [Ms. Davies'] neck" "puts her at risk for vertebral artery dissection"), 1062 ("You're more at risk in her case because she had enough force to break her neck."), 1268 (dissections "are fairly common in cervical spine fractures"), 1589-90 ("high risk factors for [blunt cervical vascular injury include] any fracture of C1, C2, or C3"). Defendants also claim that Ms. Davies' expert quantified the risk of a vertebral artery dissection at trial "at 1 in 1,000, or .1%." Pet. 17 n.6. To the contrary, she added "that percentage goes up significantly" once "you start screening for it." RP 1001. Defendants ignore that additional testimony.

at 633). There is no conflict with settled law nor any other issue that warrants this Court's review.

IV. CONCLUSION

For the foregoing reasons, defendants' Petition For Review should be denied.

DATED this 26th day of August, 2021.

PETERSON | WAMPOLD
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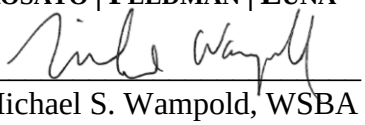

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CERTIFICATE OF SERVICE

I certify that on the 26th day of August, 2021, a copy of this document was sent as stated below.

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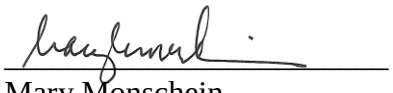

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