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Appellate Court No. 52586-1-II

THE SUPREME COURT OF THE STATE OF WASHINGTON

PHYLLIS COOLEN as Personal Representative of the Estate of PATRICK COOLEN, and Individually as Surviving Spouse,

Petitioner,

v.

GROUP HEALTH COOPERATIVE,

Respondents.

PETITION FOR DISCRETIONARY REVIEW

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TABLE OF CONTENTS

APPENDIX A - Superior Court Order

APPENDIX B - Division II Court of Appeals opinion,

Coolen v. Grp. Health Coop., 52586-1-II, 2020 WL 4784849

(Wash. Ct. App. Aug. 18, 2020)

TABLE OF AUTHORITIES

Cases

WACS

Other Authority

I. IDENTITY OF PETITIONER

The Petitioner is PHYLLIS COOLEN as Personal Representative of the Estate of PATRICK COOLEN, and Individually as Surviving Spouse.

II. CITATION TO COURT OF APPEALS' DECISION

Division II Court of Appeals opinion, *Coolen v. Grp. Health Coop.*, 52586-1-II, 2020 WL 4784849 (Wash. Ct. App. Aug. 18, 2020). The Motion for Reconsideration was denied on September 15, 2020.

III. ISSUES PRESENTED FOR REVIEW

1. Did the Appellate Court err by (a) excluding the Plaintiff from introducing any evidence of Defendant's failure to provide Patrick Coolen informed consent and (b) removing Plaintiff's cause of action for informed consent and (c) not instructing the jury on informed consent? YES.

2. Did the Appellate Court err by (a) removing Plaintiff's corporate negligence cause of action at trial and (b) not instructing the jury on corporate negligence? YES.

3. Did the Appellate Court err by (a) removing the Plaintiff's shared decision-making cause of action at trial and (b) not instructing the jury on shared decision-making? YES.

IV. STATEMENT OF THE CASE.

The Appellate Court's decision conflicts with this Court's decisions in *Gates v. Jensen,* 92 Wash. 2d 246, 595 P.2d 919,(1979), *Backlund v. Univ. of Washington,* 137 Wash. 2d 651, 975 P.2d 950 (1999),*Osborn v. Public Hospital Dist. I, Grant County,* 80 Wn.2d 201, 492 P.2d 1025 (1972), *Pedroza v. Bryant,* 101 Wash. 2d 226, 229, 677 P.2d 166 (1984), *Douglas v.*

Freeman, 117 Wash. 2d 242, 253, 814 P.2d 1160 (1991). The issues in this petition are of substantial public interest, as they affect patient rights.

INFORMED CONSENT

A. A protein-specific-antigen test is a simple, risk-free screening for a life-threatening cancer.

Prostate specific antigen ("PSA") is protein made by cells that line the prostate. A process for diagnosing **prostate cancer** is to conduct a PSA test and then a biopsy. A PSA test is a simple blood test that can pick up if PSA is leaking into the blood. *VRP 129.*

If the PSA level is elevated, one of the only three conditions it could possibly be is prostate cancer. *id.* Conducting a PSA test is the first step to ruling out prostate cancer – as you don't biopsy without a PSA. *VRP 181.*

B. GH never ruled out prostate cancer as a diagnosis.

On September 13, 2010, Patrick Coolen presented to Group Health Cooperative ("GH") with complaints of a few months of urinary frequency/urge, some urethral discomfort and an urge to urinate about every hour while awake. *VRP 132.* He was found to have an enlarged prostate. *id.*

GH failed to discuss with Mr. Coolen the potential of having cancerous tissue as part of the enlargement of the prostate. GH did not have any discussion with Mr. Coolen informing him of the alternative diagnostic procedure (PSA testing and biopsy) that would rule in-or-out prostate cancer.

Dr. Peter Bretan, a Urologist, Transplant Surgeon and the President of the California Urological Association, testified that to make a complete diagnosis, prostate cancer screening by way of PSA should be performed. *VRP 134-135.* Dr. Bretan testified that Mr. Coolen had classic prostate irritation and deserved **diagnosis and follow-up**. *VRP 106, 134, 219.*

PSA testing is part of the "alternative diagnostic procedures" about which GH was required to inform Mr. Coolen. PSA testing is the precursor to a biopsy and diagnosis. "[N]ot do that [PSA] test at that time or at least talk to him [Mr. Coolen] and say that's part of the workup" failed to meet the standard of care. *Dr. Staben testimony at VRP 255:21-256:5-18.*

C. The failure to rule in or out a diagnosis of prostate cancer is fundamental to an informed consent cause of action.

A PSA test and biopsy are **part of the procedure for arriving at a conclusive diagnosis** in the face of the urinary conditions and enlarged prostate Mr. Coolen presented with in 2010. *See above.*

Mr. Coolen had abnormal conditions putting him at high risk for prostate cancer. There were diagnostic procedures that existed to determine the presence or absence of prostate cancer (PSA followed by a biopsy). *VRP 118-119, 120-121, 131, 133-134, 143, 214, 267, 269-270, 272-273, 304-305.* Mr. Coolen could have made, had he been informed.

GH deprived Mr. Coolen of the information pertaining to available

alternative procedures that could have been taken and that he could have chosen to undergo to obtain a diagnosis. GH failed to inform Mr. Coolen with the information necessary for him to make a life-saving decision pertaining to the work-up of his condition.

This is based on and supported by the evidence that was presented to the jury at trial. *See Dr. Staben testimony at VRP 256:5-18, and VRP 266:14-18, and VRP 267:1-6, and VRP 267:22-268:1, and VRP 268:4-10, and VRP 269:21-270 __, and VRP 273, and VRP 270, and VRP 304-305. See Dr. Bretan testimony at VRP 118.*

Mr. Coolen was going to leave the September 13, 2010 GH office visit thinking that his urinary problems are caused by alcohol, caffeine, and a benign enlargement of his prostate, and he was not going to go home with the fact that this could be cancer, because that was not documented **or discussed** on that visit. *See Dr. Staben testimony at VRP 272-273.* "[, , ,] he never had a PSA done, ever." *Dr. Staben testimony at VRP 263.*

D. The failure to inform Mr. Coolen was fatal.

GH's failure to present Mr. Coolen with critical information of procedures to lead to a diagnosis was fatal to Mr. Coolen. This is supported by the evidence at trial. *See e.g. VRP 121, 136, 138, 139-140, 143, 184, 225.*

Dr. Bretan testified that, "I think this is something that should have

been done, could have been done, low toxicity, **and it would have ended up with Mr. Coolen still alive today**." [bold added]. *VRP 225:8-11.* The PSA test to screen for prostate cancer was not offered to Mr. Coolen when the disease was confined to his prostate and he was symptom-free, and thus when it was in a very curable state if it was found at that time. *See Dr. Bretan testimony at VRP 118.*

The standard of care for working up this problem would be to do a PSA test. *Dr. Staben testimony at VRP 269.* When the cancer was curable GH failed to inform Mr. Coolen of the additional procedure (PSA and biopsy) as part of the process for obtaining a diagnosis (to rule in/out cancer).

E. The Superior Court removed the informed consent cause of action. The Appellate Court affirmed.

The trial court incorrectly excluded the informed consent cause of action and failed to instruct the jury on informed consent. *VRP 9.10.18, 59-60; VRP 830; CP 2275-2296.* The Court applied the *Backlund* rule to this case, even though this case falls directly within the exception set forth in *Backlund v. Univ. of Washington,* 137 Wash. 2d 651, 659, 975 P.2d 950 (1999). The Appellate Court affirmed.

SHARED DECISION MAKING

A. The Superior Court failed to instruct the jury on shared decision making. The Appellate Court affirmed.

The trial court also failed to instruct the jury on shared decision making. *See CP 2275-2296; VRP 1394-1395.* The Appellate Court affirmed.

The evidence supported the giving of the shared decision making instruction. *See e.g. VRP* 331:23-332:4; *455:15-19; 485:15-16.* GH admitted that shared decision-making in screening improves outcome. *VRP 487.*

CORPORATE NEGLIGENCE

The trial court denied GH's CR 50 motion at the end of Coolen's case-in-chief (*VRP 833, 834),* but on the last day of trial the court removed Coolen's corporate negligence cause of action and failed to give any corporate negligence jury instructions. *VRP 1361-1368; CP 2275-2296.* The Appellate Court affirmed.

A. GH failed to exercise reasonable care to adopt policies and procedures for men's prostate health.

At trial, GH was asked: "Does Group Health have any men's health policies for prostate cancer" and GHC answered: "We do not." *VRP 577.* The court stopped the jury from deciding if GH's failure to adopt a single policy or procedure pertaining to the entire subject of men's prostate health breached GH's duty to exercise reasonable care to adopt policies and procedures for health care of its patients pursuant to *Osborne, id,* and WAC 246-320-226. The trial court misapplied the law and removed Coolen's corporate negligence claim against GH. The Appellate Court affirmed.

B. GH failed to exercise reasonable care to periodically monitor and review the competency of its providers.

At trial, GH's admitted that GH does not put in place any system, any audit, or any control regarding whether GH's providers were actually giving patients information about prostate cancer and PSA testing. *VRP 534-536.*

Dr. Bretan's testimony established that corporations need to implement tracking of physicians, using an electronic medical record system, and inform physicians of monitoring to get compliance. *VRP 222:1-7.*

There was evidence before the jury to allow the jury to find that GH's failure to put in place any policy, procedure, system, audit, or control that would **monitor** whether GH's providers were actually implementing preestablished patient care guidelines relative to prostate cancer, caused Mr. Coolen's death. *See e.g. VRP 139-140 VRP 222.*

Failure to screen and implement an electronic medical record tracking of physicians was evidence of "failure to monitor" under corporate negligence. *See Dr. Bretan testimony at VRP 221:23-25; 222:1-7.*

GH's failure to supervise and monitor its doctors resulted in GH failing to inform Mr. Coolen of PSA testing at a time when it would have saved his life. *VRP 608.* Dr. Bretan testified that "All I know is, more likely than not, greater than 50 percent chance of having it confined in 2010. [. . .] And then it basically grew out of the prostate and became metastatic, as we saw it in 2014. [. . .] The earliest that you could estimate that he could have still been saved would possibly be early 2013, late 2012." *VRP 142-143.*

IV ARGUMENT

INFORMED CONSENT/SHARED DECISION MAKING

The Appellate Court's ruling conflicts with this Court's rulings in Gates, *id*, Backlund, *id* and *Gomez v. Sauerwein,* 180 Wash. 2d 610, 623, 331 P.3d 19 (2014). These issues are of substantial public interest because they affects patient rights. This Petition is pursuant to RAP 13.4(b)(1)(2)and(4).

Whether GH obtained informed consent is not the issue on this appeal. That question should have been for the jury to decide, but the lower court incorrectly excluded Coolen's informed consent cause claim based on its incorrect conclusion that the *Backlund* rule applied. This case falls directly within the exception set forth in *Backlund v. Univ. of Washington,* 137 Wash. 2d 651, 975 P.2d 950 (1999), which derives from Gates, *id.*

The *Baklund* rule is that a provider cannot be liable for failure to inform in a misdiagnosis case. There is an exception to this rule. The *Backlund* case states: "There are situations where a provider could be liable for failure to inform without negligence. The most obvious example would be a provider who knows about two alternative treatments but informs the patient of only one treatment, which is subsequently performed perfectly." *Id at* 619.

The exception applies here. GH failed to inform Mr. Coolen as to alternative procedures (PSA testing followed by biopsy) that could have been

taken to rule in or out prostate cancer. The facts of this case drive directly through the opening left by this Court in *Backlund* to maintain *both* a failure to diagnose cause of action and an informed consent cause of action.

In *Gomez v. Sauerwein,* 180 Wash. 2d 610, 623, 331 P.3d 19, 25 (2014), the Supreme Court held that when a health care provider **rules out** a particular diagnosis based on the circumstances surrounding a patient's condition, including the patient's own reports, there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis.

In Coolen's case, GH **never ruled out prostate cancer** as a diagnosis. GH claimed his condition was "benign prostatic hyperplasia". Because GH did not share information with and inform Mr. Coolen of the option and existence of procedures to determine a prostate cancer diagnosis, Coolen did not know if his condition was "benign".

Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919, (1979) illustrates a situation not excluded by the "*Backlund* rule". In *Gates,* this Court stated, "Important decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures **leading to** a diagnosis, [. . .]." [bold added]. *Gates,* at 250-251. "These decisions must all be taken with the full knowledge and participation of the patient." *Id at 251.*

"Under *Gates,* there may be instances where the duty to inform arises

during the diagnostic process, [. . .]" [bold added]. *Gomez, id.,* at 623. The determining factor is whether the **process of diagnosis** presents an informed decision for the patient to make about his or her care. *id.*

Backlund, id., does not stand for a blanket abolition of an informed consent action where failure to diagnose is also pursued. Rather, *Backlund* confirms that *Gates, id,* is an exception with regard to the overlap between medical negligence and informed consent. *See Gomez, id.* at 626.

1. The appellate Court's attempt to distinguish this case from *Gates* is a distortion of *Gates.*

The Appellate Court attempts to distinguish this case from *Gates, id.,* by: (a) determining that a PSA test is not conclusive - *Opinion, at 18;* (b) determining that "Patrick's providers informed him on several occasions that he had two methods available for prostate cancer screening, a DRE and a PSA." - *id, at 19;* © determining that a PSA test is not risk free. - *id, at 18;* and (d) determining that here a DRE was performed in 2009 and 2010 Gates "[r]eceived no screening at all for glaucoma" - *id at 19.*

The Appellate Court's ruling conflicts with and misconstrues *Gates, id.* In *Gates, id.,* the Supreme Court rejected conclusiveness as a requirement: "The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed." *Gates, id., at* 250. The Supreme Court proceeded to note that "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." [bold added]. *id.*, at 250–51.

The physician's duty is to provide information needed in order to make an informed choice regarding the course which the patient's medical care will take. *See Gates, id., at* 250. A patient must know 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 in order to make an informed decision on the course which future medical care will take. *id., at* 251.

"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." *Gates, id., at* 251.

"Less" is what occurred in the present case. The lower court attempts to distinguish *Gates, id.,* by noting that, "Patrick's providers informed him on several occasions that he had two methods available for prostate cancer screening, a DRE and a PSA." *Opinion, at 19.* This is inconsistent with the relevant facts in this case. *For example, see Dr. Staben testimony at VRP 267, and Dr. Bretan's testimony at VRP 118.*

The Appellate Court steps into a fact-finder role when it states that, "A PSA test is known for its risk of false positives and overtreatment." *Opinion, at 19.* That would only be correct if the Appellate Court gave no weight to conflicting evidence at trial (e.g. Dr. Bretan's testimony that a PSA test is "far more sensitive and accurate" compared to a DRE. *VRP 138.* and Dr. Bretan's testimony that **the way** Urologists, find this localized prostate cancer in this setting is to have a discussion and order PSA, "[. . .] in this exact same setting." *VRP 121.*

The Appellate Court's attempt to distinguish *Gates., id.,* (when the COA determined that a PSA test is not risk free) is inconsistent with the GH speaking agent's admission that the harm of a PSA test is trivial. *VRP 491.* A PSA test is a very simple, quick test – a simple screening for a life-threatening cancer. *See Dr. Bretan testimony at VRP 129-130.*

The Appellate Court's fourth attempted distinction of *Gates., id.,* inconsistent with the relevant facts in *Gates, id.* In *Gates, id,* "Dr. Hargiss examined Mrs. Gates' optic nerves with a direct ophthalmoscope to determine whether the discs, or surfaces, of the nerves showed the exacerbated "cupping" which is characteristic of glaucoma." *Gates, id, at* 247. Shortly after Gates' first visit, "Dr. Hargiss made another pressure reading and found pressures in both eyes to be within the high range of normal." *id., at* 248.

The Supreme Court also noted that other evidence tended to show Dr. Harris "complied with the applicable professional standard of care by examining Mrs. Gates' optic nerve discs with a direct ophthalmoscope." *id., at* 253.

Here, the Appellate Court asserts that "Neither provider [who performed the DREs in 2009 and 2010] thought that Patrick had prostate cancer after performing the DRE." *Opinion, at 19.* This is analogous to *Gates, id,* where after examining Gates and performing tests, Dr. Hargriss "[c]ould see no evidence of abnormality and made no further tests for glaucoma." *Gates, id., at* 247. Dr. Hargriss diagnosed Gates problem as difficulties with the contact lenses she wore. *id, at* 248.

Despite those facts, the Supreme Court noted in *Gates, id,* that there was evidence at trial that if glaucoma had been detected when Gates first visited the Eye Clinic, the condition could have been stabilized and a great part of her vision saved. *id., at* 250.

Here, the Appellate Court contends that the duty to obtain informed consent does not arise whenever the provider becomes aware of a bodily abnormality which may indicate risk or danger but rather turns on whether or not the diagnosis has been completed.

In Coolen's case, the diagnosis had not been completed. The standard in working up Mr. Coolen's condition, given his presented conditions, was

to perform a PSA (and then biopsy) – which is a critical part of the diagnostic process. Dr. Bretan opined that if GHC had given Mr. Coolen PSA testing in 2010, that would have "absolutely" provided a basis for further evaluation between 2010 and 2014. *VRP 121.* PSA testing should have been done, could have been done, is low toxicity, and it would have saved Mr. Coolen's life. *See Dr. Bretan testimony at VRP 225:8-11.*

The Appellate Court cites Gomez, id, for the proposition that there is no duty to inform the patient of treatment options for a ruled out diagnosis. This is wrong because **GH never ruled out** prostate cancer as a diagnosis.

A PSA test is directly on point with the types of patient-decisions this Court in *Gates, id.,* recognized as important and to be taken with full knowledge and participation of the patient.

> 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.

Gates, id., at 250–51.

Just as here, where GH made a non-prostate cancer diagnosis (BPH), in *Gates, id,* the doctor gave a non-glaucoma diagnosis (difficulties with the contact lenses Gates wore.) *id., at* 248. Despite having made that diagnosis, the Supreme Court held that the trial court erred in refusing the requested jury

instruction regarding informed consent. *See Gates, id., at* 251. The Supreme Court held, "It is respondents' contention, however, that the doctrine of informed consent does not apply to questions of appropriate diagnostic procedures and the requested instruction was properly rejected. **We do not agree.**" [bold added]. *id, at 250.*

Here, the Court of Appeals also stated, "Under RCW 7.70.060, "shared decision making" is a means of fulfilling the duty to obtain informed consent."

CORPORATE NEGLIGENCE

The Appellate Court's ruling conflicts with *Osborn v. Public Hospital Dist. I, Grant County*, 80 Wn.2d 201, 492 P.2d 1025 (1972), *Bennett v. Dep't of Labor & Indus.*, 95 Wash. 2d 531, 533, 627 P.2d 104, 105 (1981), *Pedroza v. Bryant,* 101 Wash. 2d 226, 229, 677 P.2d 166 (1984), and *Douglas v. Freeman, 117 Wash. 2d 242, 253, 814 P.2d 1160 (1991).*This issue also is of substantial public interest because it affects patient rights. This Petition is made pursuant to RAP 13.4 (b)(1)(2)and(4).

"Hospitals are in a superior position to monitor and control physician performance." *Pedroza id., at* 231. The Supreme Court adopted corporate negligence in *Pedroza, id,* and held that doing so was consistent with the *Pederson* and *Osborn, id,* decisions. Quoting Koen, a Rutgers Law Review article, the Washington Supreme Court stated in *Pedroza, id.:*

> **Early detection also enables the hospital to institute informal procedures which may adequately correct a problem** before more formal sanctions are necessary.

[Bold added]. *Pedroza, id.,* at 232. The Supreme Court determined that, "**[t]he doctrine is justified by the policy reasons already discussed.**" [Bold added]. *id., at 233.* The underlying purpose for the duty of care under corporate negligence is patient safety and welfare. *id.,* at 236.

A. Corporate Negligence is distinct from medical malpractice.

Here, the Appellate Court commingles corporate negligence with a claim under chapter 7.70 RCW. Corporate negligence and medical malpractice are different theories of liability based on different standards of care. *See Douglas, id., at 253.*

Neither the enacting of chapter 7.70 RCW nor the 1985 amendment to RCW 70.41.180 (on both of which the Appellate Court relies) hinder Coolen's corporate negligence claim and more specifically GH's duty under WAC 246-320-226 to adopt patient care policies and procedures designed to guide staff that address criteria for patient admission to general and specialized service areas, use of preestablished patient care guidelines or protocols and discharge planning.

The amendment to RCW 70.41.180 in 1985 pertains to "professional services rendered by any physician" -- while the requirements under WAC

246-320-226 to adopt policies and procedures govern and apply to **hospitals.** Corporate negligence is a legal theory against GH, not its physicians.

GH's liability is based on a duty of care **owed by the institution** directly to patients to ensure their safety and welfare while within its confines. *See Pedroza, id.,* at 236.

In *Douglas, id.,* the Supreme Court noted that in *Schoening v. Grays Harbor Comm'ty Hosp.,* 40 Wash.App. 331, 698 P.2d 593, review denied, 104 Wash.2d 1008 (1985), a plaintiff's settlement with doctors did not relieve the hospital of liability because the **hospital could still** be liable for any breach of its **separate duties** owed to plaintiff. *See Douglas, id., at* 252–253.

B. *Douglas* did not create an exhaustive list of duties.

The Appellate Court states that to the extent *Osborn, id.,* held that chapter 70.41 RCW may establish a health care institution's duty of care, *Osborn's* logic does not survive the Supreme Court's express adoption of corporate negligence in *Douglas,* which listed other specific duties but not the duty to establish policies and procedures for patient care. *Opinion, at 11.* Respectfully, this is incorrect.

Corporate negligence was not adopted in the *Douglas* case, it was expressly adopted seven years earlier in *Pedroza, id* at page 233. In *Douglas, id.,* when this Court documented four duties for corporate negligence, it was not creating an exhaustive list of duties. For example, the duty of the hospital

to intervene in the pattern jury instruction was adopted in *Schoening v. Grays Harbor Cmty. Hosp., 40 Wash. App.* 331 698 P.2d 593 (1985), and discussed in *Alexander v. Gosner,* 42 Wash. App. 234, 240, 711 P.2d 347 (1985).

In *Schoening, id.,* the Appellate Court held, "Under the cases cited, the hospital clearly has a duty to monitor the treatment of its patients and intervene if there is obvious negligence." *id.,* at 335. In *Alexander, id.,* the Court stated: "Corporate negligence has been extended to include placing a duty on the hospital to "intervene in the treatment of its patients if there is obvious negligence"." *id., quoting* the *Schoening, id,* case. *Douglas, id.,* did not overturn *Osborn, Schoening or Alexander, id.*

In *Douglas, id.,* when this Court referenced four corporate negligence duties, it did so in the context of noting what one commentary found (a law review article). *See Douglas, id.,* at 248. This is not an exhaustive list. For example, the duty to exercise reasonable care to adopt policies and procedures is not specifically listed in *Douglas,* but, "[i]s discussed in *Osborn v. Public Hospital Dist. I, Grant County*, 80 Wn.2d 201, 492 P.2d 1025 (1972)." *See comment to WPI 105.02.02.*

C. Statutes and Regulations addressing specific men's prostate policies are not required.

The Appellate Court asserts that: "[. . .] Phyllis presented no evidence that any regulation imposed an obligation on Group Health to adopt *specific*

policies and procedures relating to *particular methods* for diagnosing, screening, or treating prostate cancer or any other illness, which is what Phyllis claims Group Health failed to do. *Opinion, at 12.* That is conflicts with *Osborne, id.,* and the corporate negligence jury instruction that flows from *Osborne, id.* It conflicts because GH's conduct with respect to adopting policies and procedures is not dependent on specifics and particulars, but is measured against "reasonable care." The jury should have been permitted to decide if adopting **zero** policies and procedures pertaining to the entire subject of men's prostate health breached its duty to exercise reasonable care to adopt policies and procedures for health care of its patients pursuant to *Osborne, id,* and WAC 246-320-226.

The GH speaking agent admitted that it did not have **any** men's health policies for prostate cancer. *VRP 577.* The exercise of reasonable care in a negligence action is a question of fact for the jury. *Gordon v. Deer Park Sch. Dist. No. 414,* 71 Wash. 2d 119, 122, 426 P.2d 824 (1967)

WAC 246-320-226, "[g]uides the development of a plan for patient care. This is accomplished by supervising staff, **establishing, monitoring, and enforcing policies and procedures** that define and outline the use of materials, resources, and promote the delivery of care." [bold added]. *WAC 246-320-226*

Under this WAC, GH was required to **adopt and implement policies and procedures designed to guide staff** that address: (1) Use of preestablished patient care guidelines or protocols; (2) Conditions that require patient transfer within the facility, to specialized care areas and outside facilities; and (3) Patient safety measures. *See WAC 246-320-226(c)(d)&(g).*

Group Health had patient care "guidelines" (not policies according to GH) but GH did not even have policies or procedures to implement those guidelines. Group Health completely failed to exercise reasonable care to **adopt** and **implement** policies and procedures.

D. The evidence showed that failure by GH to monitor and review its providers proximately caused Coolen's death.

The Appellate Court incorrectly determined that "there was no evidence that a failure to monitor and review caused Patrick's death." This is incorrect and conflicts with this Court's rule in *Bennett v. Dep't of Labor & Indus.,* 95 Wash. 2d 531, 533, 627 P.2d 104, 105 (1981) that, "If, from the facts and circumstances and the medical testimony given, a reasonable person can **infer** that the causal connection exists, the evidence is sufficient."

In the present case, there was considerable evidence for the jury to find that GH's failure to monitor whether GH's providers were actually implementing preestablished patient care guidelines relative to prostate

cancer, were providing patients information about prostate cancer, or were even offering PSA testing – caused Mr. Coolen's death.

Proximate cause is generally a question of fact for a jury. *Bowers v. Marzano,* 170 Wash. App. 498, 506, 290 P.3d 134 (2012).

VI. CONCLUSION

The Supreme Court should accept review and reverse the Court of Appeals' decision because the appellate Court's decision misapplies case law and conflicts with case law on issues of great importance.

DATED: October 15, 2020

RON MEYERS & ASSOCIATES PLLC

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APPENDIX A

Filed
Washington State
Court of Appeals
Division Two
September 15, 2020

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

PHYLLIS COOLEN, as personal representative of the estate of PATRICK COOLEN, and individually as surviving spouse, Appellant, v. GROUP HEALTH COOPERATIVE, a Washington business entity doing business in Thurston County, Respondent, GROUP HEALTH OPTIONS, INC., a for profit Washington corporation doing business in Thurston County; GROUP HEALTH OF WASHINGTON, a Washington business entity doing business in Thurston County; JOHN AND/OR JANE DOES 1-3, providers of health care services in Thurston County; and BUSINESS ENTITIES 1-3, providers of health care services in Thurston County, jointly and severally, Defendants.	No. 52586-1-II ORDER DENYING MOTION FOR RECONSIDERATION

Appellant has filed a motion for reconsideration of the court's decision filed August 18, 2020. The court having reviewed appellant's motion and supporting documents, it is hereby

ORDERED that appellant's motion for reconsideration is denied.

PANEL: Jj. Maxa, Sutton, Glasgow

FOR THE COURT:

Sutton, A.C.J.

APPENDIX B

Filed
Washington State
Court of Appeals
Division Two

August 18, 2020

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

PHYLLIS COOLEN, as personal representative of the estate of PATRICK COOLEN, and individually as surviving spouse, Appellant, v. GROUP HEALTH COOPERATIVE, a Washington business entity doing business in Thurston County, Respondent, GROUP HEALTH OPTIONS, INC., a for profit Washington corporation doing business in Thurston County; GROUP HEALTH OF WASHINGTON, a Washington business entity doing business in Thurston County; JOHN AND/OR JANE DOES 1-3, providers of health care services in Thurston County; and BUSINESS ENTITIES 1-3, providers of health care services in Thurston County, jointly and severally, Defendants.	No. 52586-1-II UNPUBLISHED OPINION

GLASGOW, J.—Patrick Coolen, a patient at Group Health Cooperative, died of prostate cancer in 2016. His wife, Phyllis Coolen, sued Group Health on behalf of herself and Patrick's

estate. Phyllis[1] appeals the trial court's decisions effectively removing from the jury's consideration her claims based on corporate negligence and informed consent.

Phyllis argues that the trial court erred by not instructing the jury that Group Health had a duty to adopt policies and procedures for prostate cancer screening, by not instructing the jury that Group Health had a duty to monitor and review its providers, and by granting Group Health's motion in limine removing her breach of informed consent/shared decision-making claim from the jury's consideration. Phyllis requests attorney fees on appeal.

We affirm. The trial court was not required to instruct the jury on the duty to adopt policies and procedures because Group Health did not have a duty to adopt specific policies and procedures for particular methods of screening illnesses. The trial court was also not required to instruct the jury on the duty to monitor and review claim because substantial evidence did not support that claim. We affirm the trial court's decision to grant Group Health's motion in limine effectively removing Phyllis's informed consent/shared decision-making claim from the jury's consideration because, absent particular facts not applicable here, a plaintiff may not bring an informed consent claim in a misdiagnosis case. We deny Phyllis's request for attorney fees.

FACTS

A. Background

Patrick was a patient at Group Health between 2003 and 2014. Dr. Jennifer Williams, a family practice physician, was Patrick's primary care physician.

In January 2003, Patrick had a routine well-adult visit with Dr. Williams. Because Patrick was a 54-year-old male, he received paperwork that included a question asking whether he wanted

[1] For clarity, we refer to Patrick Coolen and Phyllis Coolen by their first names.

written information about prostate cancer screening. Patrick checked the "'yes'" box and Dr. Williams wrote "'done'" next to that section on the form. Verbatim Report of Proceedings (VRP) (Sept. 19, 2018) at 852. She did not specifically remember her conversation with Patrick, but testified that she would normally give the patient a brochure about prostate cancer screening and might also have a conversation about it.

There are two ways to screen for prostate cancer. One is a physical prostate examination called a digital rectal examination (DRE). The other is a prostate specific antigen (PSA) test. The PSA test involves drawing blood to check for elevated PSA levels, which can indicate the presence of prostate cancer but can also be caused by benign inflammation or enlargement of the prostate. If PSA levels are elevated, providers typically biopsy the prostate to determine whether the elevated PSA levels are caused by prostate cancer.

In September 2006, Patrick had another well-adult visit with Dr. Williams. They discussed prostate cancer screening and the risks and benefits of both tests, including that the PSA test is associated with false positives, which can result in overtreatment. According to Dr. Williams's chart notes, Patrick understood "'the limitations of this screening test and wishe[d] not to proceed with prostate cancer screening.'" VRP (Sept. 19, 2018) at 856-57.

In March 2009, Patrick had a well-adult visit with Randy Weiler, a physician assistant with Group Health. Weiler discussed prostate cancer, the screening controversies, and prostate cancer outcomes. Weiler's chart notes did not indicate whether Patrick declined the PSA test, but Weiler testified he was sure Patrick declined it, because if Patrick had not declined the PSA test, he would have ordered it. Weiler did perform a DRE, finding a normal prostate.

In September 2010, Patrick saw Laurie Rogers, a Group Health physician assistant, for an acute visit. Patrick complained of urinary issues and discomfort. Rogers performed a DRE to check for prostate cancer. Rogers's chart notes indicate that Patrick's "prostate [was] enlarged, symmetrical, smooth, elastic, [and] nontender." VRP (Sept. 20, 2018) at 976. Although Patrick's prostate was enlarged, Rogers did not think he had prostate cancer.

Rogers developed a working diagnosis of benign prostate hypertrophy (BPH). Both BPH and urinary issues are very common in men over 50 years old, and about half of men at age 61 have BPH. Rogers did not place her BPH diagnosis on Patrick's "problem list," an electronic record of chronic diagnoses kept for continuity of care. VRP (Sept. 13, 2018) at 252-53. Rogers ordered tests to rule out sexually transmitted infections and they were negative. Rogers instructed Patrick to return for follow up if his symptoms persisted or worsened.

Phyllis's expert, Dr. Peter Bretan, testified that a PSA test would have been appropriate at this time to rule out prostate cancer. But he also acknowledged that according to American Urological Association guidance, if a patient did not continue to have BPH symptoms over time, further testing was unnecessary.

Patrick saw Group Health providers for unrelated issues several times over the next two years but did not mention ongoing prostate problems. In May 2012, Patrick had a routine colonoscopy, and he indicated at that appointment that he was not experiencing urinary issues or pain.

In April 2013, Patrick saw Dr. Williams for an acute visit. He complained of testicular and scrotal pain. Dr. Williams diagnosed him with epididymitis (testicular irritation). He did not have low back pain. Dr. Williams testified that testicular pain was not a symptom of prostate cancer.

Dr. Williams also ordered a urinalysis and noted that Patrick had a scant amount of blood in his urine. Dr. Williams did not think that this was a sign of prostate cancer, in part because Patrick was on blood thinners that could cause blood in his urine.

In March 2014, Patrick saw Dr. Rebecca Brandt, also a Group Health physician, for an acute visit. He complained of urinary problems. Dr. Brandt performed a DRE, which revealed an enlarged, nontender prostate. Dr. Brandt again diagnosed Patrick with BPH and dysuria and suggested a urology referral. Patrick and Phyllis were about to move to Hawaii, and he planned to follow up with the urology referral once he arrived in Hawaii.

In June 2014, Patrick established a new primary care relationship with a Kaiser Permanente doctor in Hawaii. Patrick had low back pain, a fever, and was losing weight. The Kaiser doctor ordered a PSA test and prostate biopsy. The PSA test and biopsy revealed high-grade, high-volume malignancy. Patrick and Phyllis moved back to Washington where he received chemotherapy and experimental cancer treatments. However, Patrick's cancer was advanced and metastatic, and he died in June 2016, at 66 years old.

B. Procedural History

Phyllis sued Group Health in her individual capacity and as the personal representative of Patrick's estate. Her complaint included claims for negligent failure to diagnose under RCW 7.70.040 and failure to obtain informed consent or engage in shared decision-making under RCW 7.70.050.[2] Phyllis sued Group Health under a vicarious liability theory for the negligence of its employees. Phyllis's complaint also included claims for corporate negligence. Phyllis asserted that

[2] Under RCW 7.70.060, "shared decision making" is a means of fulfilling the duty to obtain informed consent under RCW 7.70.050, so it is not an independent basis of a claim itself, contrary to what Phyllis suggests in her briefing to this court.

Group Health breached duties it owed to Patrick to monitor and review its providers and to adopt policies and procedures for prostate cancer screening.

Group Health filed a pretrial motion to exclude Phyllis from presenting evidence, arguing, or submitting jury instructions about her lack of informed consent claim. The trial court granted Group Health's motion, finding that Phyllis's case was a negligent failure to diagnose case and agreeing with Group Health that under Washington law, a failure to diagnose case generally cannot also support a failure to obtain informed consent claim.

After the plaintiff's case in chief, Group Health moved for judgment as a matter of law on Phyllis's corporate negligence claims. The trial court denied Group Health's motion at that time, concluding that substantial evidence supported Phyllis's corporate negligence claims.

Both parties presented expert testimony on the issue of when the standard of care required a provider to recommend and perform a PSA test. Experts on both sides agreed that prostate cancer often develops slowly and is often not fatal. They also agreed that PSA testing has both risks and benefits because it can lead to overdiagnosis and cause men to seek treatment that is not medically necessary. Testimony at trial revealed that as of 2013, most medical associations, including the American Urological Association, to which both Phyllis's and Group Health's expert witnesses belonged, did not recommend routine PSA testing, but recommended instead that providers engage in shared decision-making with their patients about the risks and benefits of PSA tests.

The parties' experts disagreed about when, if ever, Patrick's prostate cancer could have been both detectable and curable. Dr. Bretan, testifying for the plaintiff, believed that even if Patrick's prostate cancer was a fast-growing, high-grade cancer, it would have been confined to his prostate and still "very curable" if detected in 2010. VRP (Sept. 12, 2018) at 139-40. Dr. Bretan

testified that Patrick's cancer would likely have been survivable even if detected in early 2013. Conversely, Dr. Michael Brawer, an expert for Group Health, believed Patrick's cancer would not have been curable even if discovered in 2010 and that it had the capacity to metastasize throughout his body "very, very early on" in its development. VRP (Sept. 24, 2018) at 1195.

Phyllis's proposed jury instructions included instructions on corporate negligence. She proposed that the jury receive the following instruction:

> Group Health owes an independent duty of care to its patients. This includes the duty to:
>
> Exercise reasonable care to periodically monitor and review the competency of all health care providers who practice medicine at [Group Health].
>
> . . . .
>
> Exercise reasonable care to adopt policies and procedures for health care provided to its patients.

Clerk's Papers at 2207 (quoting 6 WASHINGTON PRACTICE: WASHINGTON PATTERN JURY INSTRUCTIONS: CIVIL 105.02.02 (2018) (WPI)).

Before closing arguments, the trial court ruled that it would not instruct the jury on corporate negligence under either theory. Phyllis argued that the trial court's decision was improper.

The remaining claim was based on the negligent failure to diagnose. The jury returned a verdict in favor of Group Health, finding it was not negligent. Phyllis appeals.

ANALYSIS

I. CORPORATE NEGLIGENCE JURY INSTRUCTIONS

A. Jury Instructions

The decision whether or not to give a particular jury instruction is typically "within the trial court's discretion." *Taylor v. Intuitive Surgical, Inc.*, 187 Wn.2d 743, 767, 389 P.3d 517 (2017).

But "[w]here substantial evidence supports a party's theory of the case, trial courts are required to instruct the jury on the theory." *Id.* "'Substantial evidence' is evidence sufficient to persuade a fair-minded person of the truth of the matter asserted." *In re Marriage of Chandola*, 180 Wn.2d 632, 642, 327 P.3d 644 (2014). Substantial evidence must go beyond speculation and conjecture. *Estate of Dormaier v. Columbia Basin Anesthesia, P.L.L.C.*, 177 Wn. App. 828, 852, 313 P.3d 431 (2013). Whether a jury instruction was required or proper is "governed by the facts of the particular case." *Fergen v. Sestero*, 182 Wn.2d 794, 803, 346 P.3d 708 (2015).

We review a trial court's decision to give a jury instruction de novo if it is based on a matter of law and for abuse of discretion if based on a matter of fact. *Taylor*, 187 Wn.2d at 767. The issues here involved whether certain claims were properly removed from the jury's consideration entirely. These are matters of law that we review de novo. We view the facts and reasonable inferences in the light most favorable to the nonmoving party. *See Woodward v. Lopez*, 174 Wn. App. 460, 468, 300 P.3d 417 (2013).

The fact that a jury instruction quotes a WPI does not mean it is a correct statement of the law. The pattern instructions "are not the law; they are merely persuasive authority." *State v. Hayward*, 152 Wn. App. 632, 645, 217 P.3d 354 (2009).

B. Corporate Negligence

Washington law recognizes the doctrine of corporate negligence in medical negligence cases. *See Pedroza v. Bryant*, 101 Wn.2d 226, 233, 677 P.2d 166 (1984). Corporate negligence "imposes on the hospital a nondelegable duty owed directly to the patient, regardless of the details

of the doctor-hospital relationship."[3] *Id.* at 229. "The standard of care to which the [institution] will be held is that of an average, competent health care facility acting in the same or similar circumstances." *Ripley v. Lanzer*, 152 Wn. App. 296, 324, 215 P.3d 1020 (2009).

In *Douglas v. Freeman*, the Washington Supreme Court articulated four duties that health care institutions owe patients under corporate negligence:

> (1) [T]o use reasonable care in the maintenance of buildings and grounds for the protection of the [institution's] invitees; (2) to furnish the patient supplies and equipment free of defects; (3) to select its employees with reasonable care; and (4) to supervise all persons who practice medicine within its walls.

117 Wn.2d 242, 248, 814 P.2d 1160 (1991). The *Douglas* court did not include under corporate negligence a duty to adopt particular policies and procedures governing patient care.

To prevail on a corporate negligence claim, the plaintiff must prove duty, breach, injury, and proximate cause by a preponderance of the evidence. *Id.* National standards developed by accreditation organizations may be relevant to defining the standard of care, but expert testimony is generally required to establish the standard of care and causation. *Pedroza,* 101 Wn.2d at 234; *Frausto v. Yakima HMA, LLC*, 188 Wn.2d 227, 232, 393 P.3d 776 (2017).

C. Duty to Adopt Policies and Procedures

Phyllis argues that the trial court erred by not instructing the jury that Group Health owed its patients a duty to adopt policies and procedures for patient care. She contends that Group Health breached this duty because it did not have "men's health polic[ies] for prostate cancer." Reply Br.

[3] Group Health is a "hospital" for purposes of this doctrine. *See* chapter 7.70 RCW, specifying that "'health care provider'" includes "[a]n entity, whether or not incorporated, facility, or institution employing one or more persons" licensed to provide health care services. RCW 7.70.020(3); *see also Douglas v. Freeman*, 117 Wn.2d 242, 253, 814 P.2d 1160 (1991) (dental clinic subject to corporate negligence).

of Appellant at 13. She acknowledges that *Douglas* does not impose a duty to adopt policies and procedures, but asserts that RCW 70.41.030 and WAC 246-320-226 do impose that duty. We disagree.

RCW 70.41.030 required the Department of Social and Health Services to "establish and adopt . . . minimum standards and rules pertaining to the . . . operation of hospitals" and "for the establishment and maintenance of standards of hospitalization required for the safe and adequate care and treatment of patients." WAC 246-320-226(3)(g) in turn provides that for licensing, health care institutions must have patient care guidelines or protocols.

In 1972, in *Osborn v. Public Hospital District I*, the Washington Supreme Court held that a hospital owed patients a duty of care under chapter 70.41 RCW. 80 Wn.2d 201, 205, 492 P.2d 1025 (1972). *Osborn* cited a WAC provision adopted under chapter 70.41 RCW that required hospitals to "'establish safety policies and procedures for the care of the patients who because of their age or condition are not responsible for their acts.'" *Id.* (quoting former WAC 248-18-200(7) (1960)). When the court decided *Osborn,* hospitals could only be held liable under a vicarious liability theory. *See id.* The court's reliance on chapter 70.41 RCW offered recourse to an injured patient where negligence was not the fault of individual providers, but the result of a hospital policy that instructed employees to "blindly follow" the attending physician's orders, even if the patient's condition had changed and the orders no longer made sense. *Id.*

Then, in 1976, the legislature enacted chapter 7.70 RCW, making it the exclusive statutory basis for medical negligence actions. *See* RCW 7.70.010; *Branom v. Univ. of Wash.*, 94 Wn. App. 964, 969, 974 P.2d 335 (1999). In 1985, the legislature amended RCW 70.41.180 to provide, "[n]othing contained in this chapter shall in any way authorize the department to establish

standards, rules and regulations governing the professional services by any physician." LAWS OF 1985, ch. 213, § 26.

To the extent *Osborn* held that chapter 70.41 RCW may establish a health care institution's duty of care, *Osborn*'s logic does not survive the Supreme Court's express adoption of corporate negligence in *Douglas*, which listed other specific duties but not the duty to establish policies and procedures for patient care. Similarly, *Osborn*'s reliance on chapter 70.41 RCW does not survive the enactment of chapter 7.70 RCW, which created the exclusive statutory claim for medical negligence, or the amendment of chapter 70.41.180 RCW, which prevented the department from establishing standards for physicians.

Here, in deciding not to instruct the jury on Phyllis's policies and procedures claim, the trial court explained that RCW 70.41.030 does not apply to patient care because that statute applies only to the planning and construction of medical facilities. It also stated that WAC 246-320 does not require hospitals to adopt policies and procedures regarding patient care, because that regulation has "nothing to do . . . with establishing policies, programs, requirements of the health care portion of hospital care . . . [or] a hospital's . . . obligation to establish policies and procedures with respect to a particular area of care, in this case, . . . prostate screening." VRP (Sept. 26, 2018) at 1367.

The trial court was correct when it found that RCW 70.41.030 does not apply here. As explained above, chapter 7.70 RCW now exclusively governs health care related negligence claims, and RCW 70.41.030 can no longer be used as the basis for an institution's duties with regard to patient care. *See Branom*, 94 Wn. App. at 969; *see also* RCW 70.41.180. To the extent the trial court held that WAC 246-320 was not relevant to whether an institution breached the

standard of care for patient care services, this was not entirely correct. WAC 246-320-226 is entitled "[p]atient care services" and WAC 246-320-226(3)(g) requires hospitals to "[a]dopt, implement, review, and revise patient care policies and procedures . . . that address . . . [u]se of preestablished patient care guidelines or protocols." And under RCW 5.40.050, "[a] breach of a duty imposed by . . . administrative rule shall not be considered negligence per se, but may be considered by the trier of fact as evidence of negligence." However, the trial court properly recognized that WAC 246-320-226 says nothing about "a hospital's . . . obligation to establish policies and procedures with respect to a *particular* area of care," such as prostate cancer screening. VRP (Sept. 26, 2018) at 1367 (emphasis added).

We affirm the trial court's ruling. Even if a jury could find that Group Health had a legal duty to adopt some policies and procedures to ensure patient safety and medical care, Phyllis presented no evidence that any statute or regulation imposed an obligation on Group Health to adopt *specific* policies and procedures relating to *particular methods* for diagnosing, screening, or treating prostate cancer or any other illness, which is what Phyllis claims Group Health failed to do.

We acknowledge that the proposed instruction was based on WPI 105.02.02, which contemplates a duty to "exercise reasonable care to adopt policies and procedures for health care provided to its patients." But this instruction was not supported in this case by the Supreme Court's articulation of the corporate duty doctrine in *Douglas*, and it is also no longer supported by statute.

The trial court properly decided not to instruct the jury on Phyllis's policies and procedures claim because Group Health did not have a duty to adopt particular policies for screening prostate cancer.

D. Duty to Monitor and Review Providers

Phyllis argues that the trial court erred by deciding not to instruct the jury on corporate negligence based on Group Health's alleged failure to monitor and review its health care providers. She contends the trial court erred when it found that an institution only owes a duty to monitor and review its providers if it is aware of obvious negligence. Under *Taylor*, we review this basis for the decision de novo because it was a matter of law. 187 Wn.2d at 767.

We agree that a health care institution's duty to monitor and review its providers is not limited to instances where the institution was aware of obvious negligence. No reversible error occurred, however, because a reasonable jury could not have found that any failure by Group Health to monitor and review its providers proximately caused Patrick's harm.

The duty to intervene in treatment is the only corporate negligence duty that is limited to situations where the institution is aware of obvious negligence. *See Schoening v. Grays Harbor Cmty. Hosp.*, 40 Wn. App. 331, 335, 698 P.2d 593 (1985); *see also Alexander v. Gonser*, 42 Wn. App. 234, 240, 711 P.2d 347 (1985). Group Health had a duty to supervise the providers who cared for Patrick under the corporate negligence doctrine even absent obvious error. *Douglas*, 117 Wn.2d at 248.

Phyllis presented evidence from which a jury could infer that Group Health breached a duty to monitor and supervise its providers, but even viewing the facts and reasonable inferences in Phyllis's favor, there was no evidence that a failure to monitor and review caused Patrick's death.

Although the parties offered competing evidence about the standard of care, we conclude that through Dr. Bretan's expert testimony, Phyllis presented substantial evidence that the standard

of care required Group Health to monitor and review its providers' electronic medical records to make sure they were discussing prostate cancer screening and PSA testing with their patients and documenting those discussions in their records. Dr. Bretan testified that at Kaiser, where he worked, the institution monitored electronic medical records to make sure providers were discussing prostate cancer screening and to prevent individual doctors from exercising a personal bias against PSA tests. Based on Dr. Bretan's testimony, the jury could reasonably infer that the standard of care required institutions such as Group Health to adopt monitoring policies like those used at Kaiser.

Even so, Phyllis did not provide evidence that Group Health's failure to monitor and review proximately caused Patrick's injury. RCW 7.70.040(2).

Even if Group Health audited its providers' records in compliance with the articulated standard of care, there was no evidence that the monitoring would have led to different offers of testing for Patrick, that Patrick would have chosen to receive a PSA test where he had not done so in the past, that his cancer would have been detectable, or that it would have been curable once detected. A jury could only have speculated that additional monitoring by Group Health would have saved Patrick's life. According to Phyllis's expert, Dr. Bretan, the cancer would have spread beyond the prostate by early 2013. Thus, in Bretan's opinion, the 2009 and 2010 visits with Weiler and Rogers are the two visits that could have altered the course of the disease but, in both cases, the providers performed DREs and found no sign of cancer. There is no evidence that monitoring providers' prostate cancer screening practices would have prompted more testing in light of Weiler's and Rogers's conclusions after the DREs and the American Urological Association's recommendations. Finally, another expert for Phyllis, Dr. Jonathan Staben, acknowledged that if

the 2009 and 2010 symptoms were caused by prostate cancer they would not have abated, and Patrick did not return for urological issues until 2014.

The evidence suggested that even if Group Health had monitored its providers more thoroughly, it would not have found that its providers fell short of their obligation to offer prostate cancer screening to and discuss PSA testing with Patrick. At each of his visits between 2003-2009, Patrick received information about prostate cancer screening, including PSA tests, and Dr. Weiler performed a DRE in 2009. From 2010-2013, Patrick did not receive information about PSA testing or prostate cancer, but his visits were for acute issues that his health care providers believed were unrelated. Phyllis's experts did not testify that providers generally should discuss PSA testing at acute visits for unrelated issues.

Dr. Bretan testified that Rogers should have offered Patrick a PSA test in 2010 when he had acute urological symptoms, but Dr. Bretan also acknowledged that the American Urological Association's recommendations would not have been for further testing at that time unless symptoms persisted. Even if Dr. Williams should have discussed prostate cancer screening or PSA testing during Patrick's April 2013 visit for testicular pain, Dr. Bretan testified that the cancer would likely have been incurable by early 2013, and this visit occurred in April 2013.

Additionally, to the extent Phyllis argues that Group Health's failure to put Patrick's BPH diagnosis on his problem list breached Group Health's duty to monitor and review and caused Patrick's injuries, Phyllis also did not explain how this oversight stemmed from Group Health's failure to monitor and review its providers' records. She also did not present evidence of causation with regard to this assertion.

We hold that the trial court did not err by deciding not to instruct the jury on a health care institution's duty to monitor and review its providers. Even if the jury believed that Group Health had a duty to exercise reasonable care to monitor and review, no evidence established causation beyond speculation and conjecture.

II. INFORMED CONSENT/SHARED DECISION MAKING CLAIM

Phyllis argues that the trial court erred by dismissing her informed consent claim. She asserts that the general rule that a health care provider cannot be liable for failure to obtain informed consent in a misdiagnosis case does not apply. We disagree.

A. Informed Consent Cause of Action

RCW 7.70.050(1) governs a health care provider's failure to secure informed consent. It requires the plaintiff to prove, among other things, "[t]hat the health care provider failed to inform the patient of a material fact or facts relating to the treatment," and "[t]hat the patient consented to the treatment without being aware of or fully informed of such material fact or facts." RCW 7.70.050(1)(a)-(b). Under RCW 7.70.060, "shared decision making" is a means of fulfilling the duty to obtain informed consent. RCW 7.70.040 governs medical negligence claims, which arise when a health care provider's conduct falls below the accepted standard of care.

In *Gates v. Jensen*, the Supreme Court held that an informed consent cause of action may sometimes arise from a provider's prediagnosis conduct. 92 Wn.2d 246, 250-51, 595 P.2d 919 (1979). The patient showed signs of glaucoma, but her ophthalmologist never informed her that she could have glaucoma and never performed simple, inexpensive diagnostic tests. *Id.* at 247-28. The court held the doctor liable under the doctrine of informed consent because "[t]he 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." *Id.* at 250-51.

Later, in *Backlund v. University of Washington*, the Supreme Court held that where the plaintiff alleges the medical provider misdiagnosed the patient's condition, the plaintiff cannot also bring a failure to obtain informed consent claim. 137 Wn.2d 651, 661, 975 P.2d 950 (1999). The court explained, "[a] physician who misdiagnoses the patient's condition, and is therefore unaware of . . . treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but . . . not . . . an action based on failure to secure informed consent." *Id.*

More recently, in *Anaya Gomez v. Sauerwein*, the Supreme Court clarified that *Backlund* did not overrule *Gates*. 180 Wn.2d 610, 626, 331 P.3d 19 (2014). Rather, "*Gates* stands for the proposition that patients have a right to be informed about a known or likely condition that can be readily diagnosed and treated." *Id.* at 626. The court held that *Backlund* sets forth the general rule that a plaintiff may not claim failure to obtain informed consent regarding a particular condition when the provider misdiagnosed the patient and determined that the patient did not have that condition. *Id.* at 623. Although cases resembling *Gates* should be excepted from the *Backlund* rule, the court predicted that "[g]iven the unique factual situation in *Gates*, it is unlikely we will ever see such a case again." *Id.* at 626.

The most important factor in determining whether a plaintiff may bring an informed consent claim in a misdiagnosis case is "whether the process of diagnosis presents an informed decision for the patient to make about [their] care." *Id.* at 623. "The ophthalmologist [in *Gates*]

had available 'two additional diagnostic tests for glaucoma which are simple, inexpensive, and risk free,'" but the doctor in *Anaya Gomez* "had no additional tests available . . . [and Anaya Gomez's] symptoms indicated that she did *not* have a blood infection." *Id.* at 621-22.

In *Harbottle v. Braun*, this court held that the trial court did not err in granting a summary judgment motion to dismiss an informed consent claim where a doctor negligently misdiagnosed the patient's coronary artery disease as acid reflux and did not inform the patient about the possibility of heart disease or caution him against canceling a stress test. 10 Wn. App. 2d 374, 377, 393, 447 P.3d 654 (2019), *review denied*, 194 Wn.2d 1018, 455 P.3d 140 (2020). Citing *Anaya Gomez*, this court concluded that the *Gates* exception to *Backlund* arises when the diagnostic process involves decisions the patient needs to make about their care, and it did not apply in Harbottle's case. *Id.* at 384-87, 393. The doctor's misdiagnosis led him to believe that Harbottle did not have heart disease, so there was no further informed decision for the patient to make. *See id.* at 392-93.

In sum, *Gates* is a very narrow exception to *Backlund*, and only a case that very closely resembles the "unique factual situation in *Gates*" qualifies for the exception. *Anaya Gomez*, 180 Wn.2d at 626.

B. Dismissal of Informed Consent Cause of Action[4]

Two significant differences exist between this case and *Gates*. First, unlike a glaucoma test, a PSA test is not "conclusive and risk free." *Gates*, 92 Wn.2d at 253. The PSA blood test is

[4] As an initial matter, Group Health argues that Phyllis waived this argument on appeal, but we disagree. Her lawyer appears to have cited some case law in opposition to the defense's motion in limine. Even if Phyllis's lawyer did not cite authority below, the issues and arguments are sufficiently clear in her briefing to this court to permit appellate review.

not conclusive on its own because elevated PSA levels are often not caused by cancer, and only a biopsy of the prostate can conclusively diagnose prostate cancer. A PSA test is known for its risk of false positives and overtreatment. Evidence at trial suggested that as of 2013, medical providers no longer recommended PSA testing.

Second, the ophthalmologist in *Gates* never told the plaintiff about "the existence of . . . simple procedures" for diagnosing glaucoma. 92 Wn.2d at 248. By contrast, Patrick's providers informed him on several occasions that he had two methods available for prostate cancer screening, a DRE and a PSA. Unlike the plaintiff in *Gates* who received no screening at all for glaucoma, Weiler performed a DRE in March 2009 and Rogers performed a DRE in September 2010. Neither provider thought that Patrick had prostate cancer after performing the DRE.

The duty to obtain informed consent "does not arise 'whenever [the provider] becomes aware of a bodily abnormality which may indicate risk or danger' . . . but rather turns on whether or not 'the diagnosis has been completed.'" *Anaya Gomez*, 180 Wn.2d at 620 n.4 (emphasis omitted) (quoting *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 329, 622 P.2d 1246 (1980)). Although some of Patrick's symptoms were abnormal, such as Dr. Williams's finding in 2013 that he had blood in his urine, his Group Health providers had already diagnosed him with BPH in 2010. Patrick's symptoms were consistent with BPH, and they seemed to improve after his visit in 2010. Dr. Williams testified that resolution of his symptoms during that time was not consistent with prostate cancer. Patrick's overall clinical picture between 2010 and 2013 was consistent with BPH, which limited the amount of information his providers needed to disclose under their informed consent obligations.

Once Patrick's providers diagnosed him with BPH—regardless of whether or not they were correct—there was no further diagnostic decision for him to make, and "there is no duty to inform the patient [of] treatment options [for] a ruled out diagnosis." *Id.* at 623. As in *Harbottle*, Patrick's providers did not have a duty to disclose alternative diagnostic measures once they diagnosed him with BPH in 2010. Because this case does not present the unique fact pattern of *Gates*, a pattern that the Supreme Court characterized as rare, the trial court did not err in removing this issue from the jury. Phyllis could properly bring a negligent misdiagnosis claim, but she was precluded under *Backlund* and *Anaya Gomez* from bringing an informed consent claim.

We affirm the trial court's decision to grant Group Health's motion in limine eliminating the informed consent cause of action.

III. ATTORNEY FEES

Phyllis requests attorney fees under RCW 7.70.070 and RAP 18.1, but provides no further argument. RCW 7.70.070 does not create an independent right to attorney fees, but rather describes factors the court is to consider in determining how much to award a party who is entitled to attorney fees. Moreover, Phyllis has not prevailed. *See Young Soo Kim v. Choong-Hyun Lee* 174 Wn. App. 319, 327, 300 P.3d 431 (2013). Phyllis has not established a basis for an award of attorney fees.

CONCLUSION

The trial court properly declined to instruct the jury on Phyllis's claims that Group Health had a duty to adopt policies and procedures and a duty to monitor and review. The trial court properly granted Group Health's motion in limine removing Phyllis's informed consent claim from the jury's consideration. We affirm. We also deny Phyllis's request for attorney fees.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Glasgow, J.

We concur:

Maxa, J.

Sutton, A.C.J.

RON MEYERS & ASSOCIATES PLLC

October 15, 2020 - 4:17 PM

Filing Petition for Review

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	Case Initiation
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