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	No. 52586-1-II UNPUBLISHED OPINION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.