

FILED

JAN 19 2012

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

NO. 300986

COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

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

Appellant (Plaintiff),

v.

MARK F. SAUERWEIN, M.D. and THE YAKIMA VALLEY
FARM WORKERS CLINIC, a Washington Corporation,

Respondents (Defendants).

BRIEF OF RESPONDENTS

David A. Thorer WSBA 4783
Megan K. Murphy WSBA 31680
Thorer, Kennedy & Gano P.S.
Attorneys for Respondents
101 S. 12th Ave.
Yakima, WA 98902
509-575-1400
Fax: 509-453-6874

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I. INTRODUCTION

Informed consent is not applicable in this case. The facts alleged by the Plaintiff gave rise to a medical liability claim in which the defendant-doctor allegedly was negligent in misdiagnosing a condition. Given the facts and circumstances, and evidence presented at trial, it was clearly proper for the Trial Court to dismiss the claim that there was a failure to obtain informed consent.

The Plaintiff claimed that Mark F. Sauerwein, M.D., a primary care physician at Yakima Valley Farm Workers Clinic, negligently misdiagnosed a laboratory result that stated there was a positive blood culture for yeast as a probable contaminant. The Plaintiff also asserted a failure to obtain informed consent claim. At the close of the Plaintiff's case, the Honorable C. James Lust concluded Defendants successfully argued that the informed consent claim had no place in this lawsuit. Later, the jury returned a verdict in favor of Dr. Sauerwein, finding that he was not negligent. Because the jury answered "no" to the question on negligence, the jury did not address the question of proximate causation.

The basis of this appeal, as stated by Plaintiff-Appellant in the Brief of Appellant, is that the Trial Court erred in four ways that all related to the assertion that the failure to obtain informed consent was an applicable theory of liability. However, as held by the Washington

Supreme Court in *Backlund v. University of Washington*, 137 Wn.2d 651, 661, 975 P.2d 950 (1999), informed consent is not an applicable theory of law in a case like this that involves a claim of medical negligence based on the misdiagnosis of a condition. The holding in *Backlund* states:

A physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent. (Emphasis added.)

The Washington Supreme Court provided an example of a failure to obtain informed consent not being applicable as a cause of action in a case involving misdiagnosis with the following:

For example, a physician who misdiagnosed a headache as a transitory problem and failed to detect a brain tumor may be guilty of negligence for the misdiagnosis, but it seems anomalous to hold the physician culpable under RCW 7.70.050 for failing to secure the patient's informed consent for treatment for the undetected tumor. Cf. *Thomas [v. Wilfac, Inc.]*, 65 Wn. App. [255] at 261, 828 P.2d 597 [(1992)]. (Emphasis added).

Backlund, at 661, FN2.

Plaintiff alleged that medical malpractice occurred because a condition was misdiagnosed. With this underlying claim, informed consent was not an applicable alternative theory of law in this matter, and the Trial Court properly dismissed that claim.

II. THE TRIAL COURT DID NOT ERR

In the Notice of Appeal to Division III of the Court of Appeals, it is stated that “Rodolfo Anaya – Gomez, plaintiff, seeks review by the designated appellate court of the Judgment For Defendant On Special Verdict, entered on June 24, 2011, and of the Order on Plaintiff’s Motion for Reconsideration And For JNOV or For A New Trial, entered on July 18, 2011.” *See*, CP 116; *and see*, CP 116-127. The Assignments of Error, at pages 2 – 3 of Brief of Appellant, request review of four claims of error. The first three of these four claims, were not identified by the Notice of Appeal. Defendant-Respondent objects to the Assignments of Error that are beyond those listed in the Notice of Appeal. *See*, RAP 5.3(a)(3). All Assignments of Error are addressed in the Brief of Respondent, but in addressing all Assignments of Error, Defendants-Respondents are not waiving their objection and request that the Court of Appeals only review those issues on appeal properly designated in the Notice of Appeal.

Contrary to the Plaintiff-Appellant’s Assignments of Error, in this case:

1. The Trial Court properly granted the Defendants’ Motion for Dismissal of the informed consent claim at the close of the Plaintiff’s case.

2. The Trial Court properly excluded instructions to the jury on an informed consent claim.

3. The Trial Court properly held that the Defendants should not be strictly liable for the dismissed informed consent claim. The Trial Court properly applied the applicable law in its determination.

4. The Trial Court properly denied Plaintiff's post-trial Motions for Reconsideration, Motion for a New Trial and/or for Judgment Notwithstanding the Verdict.

As will be argued below, the record and evidence presented in this case prove that the Trial Court carefully and thoughtfully considered Plaintiff's motions and theories, and made a deliberate and well-reasoned analysis of the law, applying the facts presented to the legal arguments. In proceeding as it did, the Trial Court properly determined that the informed consent claim did not have a place in this case.

III. COUNTER STATEMENT OF THE CASE

A. Counter Statement of Facts

The "Statement of the Case" in the Brief of Appellant does not reflect the actual testimony of the witnesses at trial. Instead, there are generalized facts that do not accurately portray the testimony of the

witnesses, with interlineations of editorialized statements of Plaintiff-Appellant's counsel.

For example, at the bottom of page 5 of the Brief of Appellant, the Plaintiff-Appellant misquotes a question posed by Plaintiff's counsel to a witness, and then incorrectly attributed the quoted language to the witness, which is inaccurate and wrong. In addition, the quote at the top of page 6 of the Brief of Appellants is not correctly stated from the record. The trial testimony from the witness, Dr. Sauerwein, was, "[w]ould be, it's good to share information." That quote of Dr. Sauerwein was manipulated into "good information to share" in the Brief of Appellant. *See*, RP 6/7/11, page 69, line 1377.

At the penultimate paragraph on page 5 of the Brief of Appellant, it is claimed that Defendant Dr. Sauerwein "dismissed the lab result of fungus", which is not the testimony of any trial witness. As will be described below, Defendant Dr. Sauerwein took multiple actions in handling the information of the positive blood culture for yeast and was not dismissive in his considerations.

The "Statement of the Case" in the Brief of Appellants is an inaccurate reflection of the evidence presented to the Trial Court and jury.

For background, on Sunday, August 20, 2006, Christina Anaya was seen at the Emergency Department of Toppenish Community

Hospital and admitted to the hospital. During this hospital admission, a blood sample was taken and sent to a laboratory for analysis. Christina Anaya was discharged from the hospital on Monday, August 21, 2006, with the diagnosis of a urinary tract infection. A urine culture taken on August 20, 2006 showed she was growing Gram-negative rod, which was verified to be the bacterial organism *Klebsiella pneumoniae*, on August 22, 2006. She returned to the Emergency Department of Toppenish Community Hospital on Wednesday, August 23, 2006 because she was not feeling well and could not empty her bladder. She was evaluated and treated, but not admitted to the hospital, and was released to go home. Dr. Sauerwein was not involved in any of these events.

On Thursday, August 24, 2006, the Yakima Valley Farm Workers Clinic received a telephone call (not a piece of paper or document) from the laboratory at Yakima Regional Medical Center that Christina Anaya's blood culture was positive for yeast. *See*, RP 6/10/11, page 70, lines 1394-1398. This was a "preliminary" culture, rather than a "final" culture, which requires additional information be generated by the laboratory. *See*, RP 6/10/11, page 70, lines 1387-1393. This preliminary information was relayed to Dr. Sauerwein. *See*, RP 6/10/11, page 75, lines 1482-1487.

DR. SAUERWEIN: Well we've, we've seen this before. But Sara informed me that she had a phone call from Yakima Regional Lab. They were looking for somebody to talk to, to make

this report. She answered the phone and as we know she told me that the patient's blood culture was positive for yeast.

RP 6/10/11, page 75, lines 1484-1487.

Dr. Sauerwein was not this patient's regular doctor. The doctor Christina Anaya regularly saw at the Yakima Valley Farm Worker Clinic was Kyle Heisey, M.D. (misspelled in the Report of Proceedings as Dr. Hesie). *See*, RP 6/10/11, page 93, lines 1839-1842.

Dr. Sauerwein's reaction to the positive blood culture for yeast was that of concern:

MS. MURPHY: Ok. On that day when you saw a positive blood culture for yeast, what was your initial reaction?

DR. SAUERWEIN: Um, I was concerned about that. Um, I was concerned about that result, I was puzzled by it. I did, I did not, I wasn't sure what it meant or what the implications of it were.

MS. MURPHY: Ok. And so what did you do when you were puzzled and concerned? What was your reaction?

DR. SAUERWEIN: Well when I understood that she, this was generated from the hospital and that she had been admitted, and then in front of me I had the records of the history and physical and some of those lab reports are in part of Exhibit 7A, um, I, I had several thoughts. One was I need to find out how this patients [sic] is doing and I also um, felt that I needed to speak to a trusted colleague to help me understand the situation.

MS. MURPHY: Ok. And in looking at the history and physical, who authored that?

DR. SAUERWEIN: That was John Moran, Dr. John Moran.

MS. MURPHY: K. And who is John Moran?

DR. SAUERWEIN: He's a hospitalist and internal medicine doc that has worked with us in Toppenish Hospital for quite a few years. I consider him to be um, very sharp and does an excellent job helping us take care of our patients in hospital

settings.

MS. MURPHY: Is he board certified in internal medicine?

DR. SAUERWEIN: Yes.

MS. MURPHY: And um, when you say that you trust him, have you dealt with him on other patients?

DR. SAUERWEIN: On a regular basis.

MS. MURPHY: Ok. Um, and did you factor that into why you wanted to call Dr. Moran? The fact that you trust him and that you've known [sic – him] for a long period of time and that he um, authored this history and physical?

DR. SAUERWEIN: Yes.

MS. MURPHY: Ok. Why else did you decide to call Dr. Moran?

DR. SAUERWEIN: Well, he had the advantage of putting eyes on the patient which is a big advantage.

MS. MURPHY: Ok. And what is [sic – does] that mean? Why is that an advantage?

DR. SAUERWEIN: Um, he would be able to give me the best information and have the best recent hands on and eyes on point of view cause he took care of her in the hospital.

RP 6/10/11, page 76-78, lines 1512-1544.

After receiving the information from the laboratory that there was a positive blood culture for yeast, Dr. Sauerwein reviewed that preliminary test result with Dr. Moran, who had treated Christina Anaya on August 20 and 21 at Toppenish Community Hospital. *See*, RP 6/10/11, page 79, 1565-1571. Dr. Sauerwein and Dr. Moran engaged shared decision making, and came up with a plan. *See*, RP 6/10/11, pages 79-80, lines 1575-1579. They jointly decided to find out if the patient was sick, and if she was, then further action would be taken; if she was not sick, then they would wait because this was a probable contaminant. *See*, RP 6/10/11,

pages 79-82, lines 1581-1629. Dr. Moran had more experience and training than Dr. Sauerwein with infectious disease:

DR. SAUERWEIN: It's by the nature of what internists do who have a lot more hospital time and spend a long lengths [sic] of time during their residency programs in those areas of specialty or discipline.

MS. MURPHY: Ok. And so in that regard, you were contacting an expert to consult with regard to this lab, lab data?

DR. SAUERWEIN: I felt I was getting the advice of a respected colleague with more experience than my own.

MS. MURPHY: Ok. And it was the shared decision that if the patient was not currently ill, then is [sic – this] was a probable contaminant?

DR. SAUERWEIN: Ya, I, I would characterize my medical decision making and my frame of mind after the records and, and speaking to my colleague and understanding what I knew at the time about Ms. Anaya, that I did not have enough tipping point at that moment to prompt me to do more at that time.

RP 6/10/11, page 82, lines 1617-1629.

Dr. Sauerwein then had his nurse contact the patient. *See*, RP 6/10/11, page 83, lines 1641-1647. After the patient was contacted, Dr. Sauerwein learned that the patient had been to the Emergency Room the previous day, August 23, 2006, because she could not empty her bladder and had been catheterized, but not admitted to the hospital. *See*, RP 6/10/11, page 85, lines 1683-1688. Dr. Sauerwein also knew that the patient was feeling better from the patient's own self report to the nurse, that she had been taking her antibiotics as prescribed from August 21, and that she did not have a fever. *See*, RP 6/10/11, page 85, 1689-1690; page

86, lines 1691-1692; *and see*, page 86, lines 1706-1707. Dr. Sauerwein summed this information up as follows:

DR. SAUERWEIN: Well as I said, um, we had reassuring indications from her that she was feeling better, we had um, all the materials that you have in Exhibit 7A. None of those which seemed to indicate that she was in any degree of trouble. And I was overall reassured, I felt reassured after I reviewed that information and I felt reassured after she gave us the report she did.

RP 6/10/11, page 87, lines 1712-1715.

MS. MURPHY: Ok. Dr. Sauerwein um, if any of these clinical symptoms had been different, what would you have done?

DR. SAUERWEIN: Um, well as I talked about before, I was, as I thought about this, this question in my mind, and I was looking for some kind of tipping point to me one way or the other, and if she'd had a fever I would have asked her to come in. If she had said I'm not feeling well, I would of have [sic] asked her to come in. If she, if she said I wanna [sic] be seen, I would have [sic - had] her come in. So I just didn't, there was none of those, those tipping points for me present to prompt me to consider herself [sic] as being in any kind of danger.

RP 6/10/11, pages 94-95, lines 1858-1865.

With this information and joint plan, Dr. Sauerwein determined that the positive blood culture for yeast was a probable contaminant and directed a nurse to contact the patient to schedule her for an appointment earlier than the appointment that had previously been made (August 30, rather than September 5). *See*, RP 6/10/11, page 93, lines 1831-1842.

The final culture report from the laboratory that the species of

yeast was *Candida glabrata* was not known until Saturday, August 26, 2006. *See*, RP 6/10/11, page 70-71, lines 1401-1406. However, the final culture was not reported to or received by the Yakima Valley Farm Workers Clinic. *See*, RP, 6/10/11, page 71, lines 1407-1421. The only report received by the Yakima Valley Farm Workers Clinic was the telephone call of the preliminary result from the Yakima Regional Medical Center laboratory on August 24, 2006. *See*, RP 6/10/11, page 71 lines 1419-1421.

B. Counter Statement of Procedural History

The Plaintiff-Appellant cited error on behalf of the Trial Court, but failed to give specific instances from the record identifying where the claimed error occurred.

In this case, the Clerk's Papers and Report of Proceedings are replete with proof of the careful and thoughtful manner in which the Honorable C. James Lust reviewed the motions, objections, and arguments of counsel relative to the informed consent claim. The record also demonstrates the careful deliberation that resulted in Judge Lust's determination that failure to obtain informed consent was not an applicable claim in a case, in which the claimed medical liability was based on facts asserting that the defendant-doctor was negligent for misdiagnosing a condition.

Below, Respondents present a summary of the procedural record that shows the Trial Court went to great effort to review the Plaintiff-Appellant's claim that a failure to obtain informed consent was a legal theory upon which a jury needed to render a verdict.

Trial in this matter was scheduled to proceed on March 7, 2011. *See*, CP 219. Shortly before the commencement of trial, however, on February 7, 2011, Plaintiff moved to continue the trial date, which was objected to by Defendants. *See*, CP 213-214 (Defendants' Response to Plaintiff's Motion for a Continuance of Trial Date); *and see*, CP 239-244 (Memorandum of Points and Authorities in Support of Defendants' Response to Plaintiff's Motion for a Continuance of Trial Date); *and see*, CP 215-238 (Declaration of Megan K. Murphy in Support of Defendants' Objection to Plaintiff's Motion for a Continuance); *and see*, CP 245-247 (Declaration of David A. Thorner in Support of Defendants' Objection to Plaintiff's Motion for a Continuance).

The outcome was that the Trial Court granted a continuance as requested by the Plaintiff, with the provision in the Order on Plaintiff's Motion to Continue Trial Date that "[a]ll discovery in this matter is completed and no additional discovery shall occur." CP 279. The trial was rescheduled to commence on June 6, 2011.

On May 17, 2011, three weeks before trial that had been re-scheduled was set to begin, Plaintiff submitted a Notice of Trial Amendment adding a claim alleging failure to obtain informed consent. *See*, CP 34-35. The Motion to amend was objected to by Defendants as untimely under CR 15, and because the informed consent theory was inapplicable given the facts of this case. *See*, CP 282-278. In addition to the objection to the amendment, Defendants also filed Defendants' Second Supplemental Motion in Limine – Informed Consent, along with a Memorandum in Support of Defendants' Second Supplemental Motion in Limine – Informed Consent. *See*, CP 288 and 289-295, respectively.

On June 3, 2011, among other arguments, the Trial Court heard argument on the Defendants' objection to the amendment adding the informed consent claim, as well as Defendants' Second Supplemental Motion in Limine to prohibit the presentation of the informed consent theory at trial. Plaintiff's argument are stated at RP 6/3/11, pages 7-13, lines 134-262. In summary, the thrust of Mr. Johnson's argument with regard to Plaintiff's motion to amend and add the informed consent claim was as follows:

And so um, the evidence of the case, our evidence in the case on the standard of care is that it's below the standard of care for Dr. Sauerwein to have concluded that the blood sample was a contaminate [sic] and just said well I think it's a contaminant, have her come in next week. Our evidence is that if he thought it was a

contaminant he should have had the patient either come to the clinic to have her blood redrawn on the 24th or maybe the next day, 24 hours at the most to check to see if really it was a contaminated sample. To you know I think it's [sic - a] contaminant and we better check it. That's the standard of care.

RP 6/3/11, page 10, lines 188 -194.

So, the evidence of I guess that the defense wants to present in the case about [sic - the] suggestion of contributory negligence, I guess is that she had non compliant [sic] on her diabetes. Diabetes is not what killed her. Diabetes kinda [sic] set her up to have this fungal infection for it to be a bad deal. What killed her, according to the death certificate is fungal sepsis which sets up the respiratory arrest and the anoxic brain damage. I mean that, that's what killed her. So, she, she went to the hospital two times, she was taking the medication. She did whatever they told her to do on this illness and I, I don't know, what did she do wrong? How do you have contributory negligence on Christina in this case. She, she didn't even know that she had the yeast or the fungus in her blood. It isn't like she turned down that treatment. She wasn't given the option. She wasn't told what was wrong with her. There's your informed consent, cause of action. I mean it just dawned on me, just what, these guys must think I'm a dope. I mean what [sic - when] is this dope gonna [sic] finally figure out that this is an informed consent case.

RP, 6/3/11, pages 11-12, lines 221-231.

In response, Defendants argued, in part, as follows:

Some facts that were not brought out by Mr. Johnson's statements to the Court and also bring up the Informed Consent and why it's not applicable in this case. That's one reason I defiantly [sic - definitely] don't think Mr. Johnson's a dope, cause it's not applicable. It does not apply here in this case. This is a Wrongful Death action in which Dr. Sauerwein has been charged by the Plaintiff's with causing this lady's death. This is a lady who for ten years did not take medical advice. She did not take her medication for her diabetes. She did not follow through with

treatments. She was recommended in July of 2006 to go to the emergency room immediately, she declined, said I won't go. This is a, for ten years she had been building up her body such that by the time August of 2006 rolls around, she has neuropathy in her legs, and she has an inability to stand up. She has an A1C if [sic – of] 16 which is a recording of your hemoglobin and all doctors, Plaintiff's doctors, and our expert doctors all say they have never seen an A1C result that high.

She has gotten to the point in August of 2006, where she is, [sic – to] put it bluntly, a very yeasty lady. She has yeast everywhere. When she went in on Sunday, August 20th to the Toppenish Community Hospital, she would [sic – was] diagnosed with yeast infection, polynafritous [sic – pyelonephritis], she had yeast growing all over. And they thought it was the run of the mill yeast, so they put her on antibiotics. The next day, she was doing so much better, significantly better based on her own comments to health care providers, she was discharged from the hospital.

On Wednesday the 23rd, she couldn't empty her bladder. She was not even admitted to the emergency room. They simply drained her bladder, it was clear urine, which the experts will describe for the Jury why that's significant and she was released to go home. This report that there was a positive blood culture for yeast came to doctor [sic – Dr.] Sauerwein. He contacted Dr. Moran. There was a reasonable basis to think that it was a contaminant. Had Dr. Moran said get her into the emergency room, do a repeat blood clot culture [sic – blood culture], come, have her come into [sic – the] clinic, put her on anti-fungals, which in this case I believe the evidence will show, based on testimony through depositions of both Plaintiff's experts and our experts, that Floconizol [sic – Fluconazole] or Diflucan would not have help [sic – helped] combat Candida Glabrata, which was not known what specie [sic – species] of yeast it was until Saturday.

Mr. Johnson brought up Yakima Memorial and this is what was left out. When Christina Anaya when [sic – went] to Yakima Memorial Hospital, they didn't know what to do with her, she was [sic – an] extremely complex patient. She didn't immediately die of sepsis. They actually got Dr. Neil Barg involved, the one and only infectious disease doctor in this community, all of Yakima Valley, and it took him a while to find out what was going on. It took days to figure out what was going [sic – on]. But Dr. Barg did figure out that she had Candida Galbrata and he treated it and

her body became clear of all yeast, [sic – and] all bacterial infections.

RP 6/3/11, pages 13-15, lines 269-303.

We believe that the evidence will show that those issues were resolved. She did not die immediately. She did then go into a multi system organ failure. Whether that was attributed to the Candida Glabrata, whether it was attributed to the fact that she had uncontrolled diabetes for ten years running, or other factors, the, the autopsy report does not just list one item as the cause of death. It lists many. And unfortunately I cannot list them off for you because I don't remember them all. But that is not the sole basis of why she died. We have hired an Endocrinologist, an infectious disease doctor, an [sic – and] a family practice physician and an internal medicine doctor to all testify as to the actions of Dr. Sauerwein as well as what Christina Anaya had done to her body as of August of 2006. And that's mostly going to come from our endocrinologist who will discuss what happens when your body is ravaged by diabetes. This was a 32 year old woman, very young to end up in the situation that she was. But she contributed to her own health status and [sic] in defense of Dr. Sauerwein; we have a right under ER 402 and ER 403 to present that evidence.

RP 6/3/11, page 15, lines 305-316.

But to segway [sic – segue] into Informed Consent, the reason we don't think RCW 7.70.030 and 050 apply, is that under Case Law, and I'm citing Baze [sic – Bays] v. St. Lukes Hospital at 63 Wn. App. 876 a 1992 case as well as Burnette [sic – Burnet], B U R N E T T E [sic] v. Spokane Ambulance at 54 Wn. App. 162 a 1989 case, and a Washington Supreme Court [sic – case], which I happily found, called Backlund, B A C K L U N D v. University of Washington at 737 [137] Wn.2nd 651 1999 case, and the Backlund case is wonderful in describing when Informed Consent applies. There are alternative theories, events to help health care practitioners. There is negligence and there's a violation of [sic – not] informing your patient of a material risk. It's totally possible that you medically did not commit any acts of negligence but you failed to inform them of a material risk, that's possible. But what [sic – what] the Buckland [sic – Backlund] case says is that when

you don't know the diagnosis, a misdiagnosis case, is a medical negligence issue. It is not a violation of informed consent issues. What the Plaintiff's are essentially saying is that Dr. Sauerwein called this a probably [sic – probable] contaminant. Whether that was right or wrong, whether that met the standard of care or not, that's a question of medically [sic – medical] negligence. That is not a question of informed consent. And [sic – in] the Backlund case there's a footnote, footnote 2, goes through exactly what's required. But essentially Baze [sic – Bays], Burnette [sic – Burnet], and Backlund all stand for the principal [sic – principle] that the duty of a doctor to disclose a material risk does not arise until a doctor becomes aware of the condition by diagnosing it. A failure to diagnose is negligence, there is no violation of a duty to inform when they do not know the diagnosis.

So in this case, if Plaintiff's are going to proceed on the fact pattern, that this is medical negligence for thinking it was probably [sic – a probable] contaminant, then they cannot say that this was also a violation of informed consent. And in Backlund um, the language that I also wanted to direct Your Honor to is that they were going to decline to create an alternative cause of action for informed non consent to the same facts that would show medical negligence. So do we think Mr. Johnson is a dope not bringing this up earlier? No, because it doesn't apply in this case. We're asking you too [sic – to] um, throw [sic – enter] a Motion in Limine disallow [sic – disallowing] any commentary by the Plaintiff's on the theory on informed consent. In our briefing, we also cited CR 15(b) and when this issue came up and we're objecting on that basis. But similarly just on the legal theory alone we believe that [sic – it] should be precluded from coming [sic – in].

RP 6/3/11, pages 16-17, lines 336-361.

At the June 3, 2011 hearing, the Trial Court held

The informed consent I wanna [sic] take a little bit more [sic – of a] look at. I wanna, wanna [sic] read some of these cases again based upon what I heard in oral argument. So I'll defer on that and, and, and give you a decision later on, ok.

RP 6/3/11, page 20, lines 422-424. Thereafter, the Trial Court determined that evidence would be heard before a ruling on whether the informed consent claim was applicable to the case, and an Order on Defendants' Second Supplemental Motion in Limine Re: Informed Consent was entered stating the Defendants' Motion was "denied at this time." CP 296.

At the close of the Plaintiff's case, Defendants then moved to dismiss the informed consent claim.

This Motion was argued to the Trial Court as follows:

Your Honor, we are moving to dismiss, at this point, the informed consent aspect of this case. We cite back to the cases that we previously referenced in, in this case in particular the Baze [sic – Bays] v. St. Lukes at 63 Wn. App. 876, a 1992 case is relevant [sic] in that case there was apparently a spool of wire that fell on the patient. The attending doctor diagnosed four potential medical problems having to do with pulmonary functions. The doctor there [sic – then] ruled out those four potential medical, potential reasons for problematic pulmonary function but the patient thereafter died of a pulmonary embolism. The plaintiff was trying to insert [sic – assert] a duty against the doctor that in these four possible differential diagnosis's [sic] there should have been additional rule outs, even though it was not known that here [sic – there] was a medical condition that would result in a pulmonary embolism. The Baze [sic – Bays] Court held and cited to Burnette [sic – Burnet] and Burnette is Burnette v. Spokane Ambulance at 54 Wn. App. 162 it's a 1989 case that a duty to disclose by a physician does not arise until a condition is known by diagnosing it. The Baze [sic – Bays] Court held that failure to diagnose is a medical negligence issue and not a violation of the duty to inform.

In the evidence that is [sic – has] been presented to you, to the jury, excuse me during the course of this trial, they are using the same set of fact [sic – facts] to allege a medical negligence case to also allege a failure to inform. But it's a different cause, it's, it's, there is a difference in those theories, in those theories of law.

And in this case the informed consent aspect does not apply. The Baze [sic – Bays] Court held and I'm quoting "a failure to diagnose a condition as we have indicated above is a matter of medical negligence. We decline to create a second or alternate cause of action on informed non consent to a diagnostic procedure predicated on the same facts necessary to establish a claim of medical negligence.

This was the same theory that was brought up in Burnette [sic – Burnet] v. Spokane Ambulance with that [sic – which] I've referenced [sic.] in the [sic – that] case, a baby had [sic – a] seizure disorder and [sic – the] expert for the plaintiff's said that the defendant doctor was unaware of the risk of brain herniation and the subsequent injury. Thus, everyone agreed that the doctor didn't know of the potential risks but the underlying holding of that [sic – case] is that the duty to disclose does not arise um, if the claim is only related to medical negligence. And it doesn't arise unless the doctor is able to diagnose something.

These two cases which are on point, particularly the Baze [sic – Bays] Court, Baze [sic – Bays] decision being on point, um, those, both of those cases were cited in Buckland [sic – Backlund] v. University of Washington, Buckland [sic – Backlund] v. University of Washington had, had more of a burden of proof question but those two cases were cited by our Washington Supreme Court um, as authoritative. Burnette [sic – Burnet] and Baze [sic – Bays] um, don't have negative history with regard to this principal [sic – principle]; as to when a duty arises and in this case um, the theory that has been presented to the jury, by the plaintiff's [sic] is not of a negligent failure to diagnose um, and the claim that this, Dr. Sauerwein's interpretation that this was a probable contaminant is negligence as opposed to an informed consent. Um, this probably makes most sense with thinking of yourself going to a doctor and informed consent comes up in the context of treatment. When a diagnosis is made the next step is to talk about treatment. That's when informed consent triggers up of oh [sic], ok, well the possible risks of going thru [sic] surgery are you know Anastasia [sic – anesthesia] which include a whole host of issues. That is not the case we're dealing with here. This is a diagnosis issue. Diagnosis not treatment. We're in the precursor stage unless [sic – and] informed consent does not apply.

RP 6/9/11, pages 66-67, lines 1275-1313.

In response to the Defendants' CR 50 motion, Plaintiff cited the *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) case, and argued:

And how that applied in this case Your Honor, is this; Dr. Sauerwein is advised that the laboratory reports a fungal blood infection. There's no need to make any diagnosis. He's informed about the result. And the treatment course that he undertook for that was to have the nurse contact her to see how she felt and then have her come back in on August 30, that was the treatment course. So, by law, then the physician has a duty to tell the patient about a material risk, if it's a material risk. And in this case it certainly was, the fungus in her blood killed her. So the law, as a matter of law, he's required to tell her about this risk and he didn't do so. There's no question about it. And the evidence before you is that, that failure resulted in her demise. So we submit that the Court should deny this motion and the case proceeds both on um, the, the department [sic- departure] from the standard of care and informed consent.

RP 6/9/11, page 68, lines 1323-1332.

To Plaintiff's response, Defendants' replied:

The Gates case was a 1979 case. Um, the Buckland [sic – Backlund] case is from 1999. Gates is an old case. The case that we feel is most pertinent um, to the facts of this case and what's being presented is the Baze [sic – Bays] Case, that was a 1992 case. So um, the cases that we are citing are closer in proximately [sic – proximity] and were at least support but the [sic – supported by], the Supreme Court in 1999. And then in Buckland [sic – Backlund]. And finally the, the one point that, that I need to emphasize is, is the holding from Buckland [sic – Backlund]. A physician who misdiagnosis's [sic] the patient's condition and therefore [sic – is] unaware of the appropriate category of treatment or treatment alternatives, may properly [sic – be] subject to a negligence action where such misdiagnosis reaches the standard of care but may not be subject to an action based on failure to secure informed consent.

RP 6/9/11, pages 68-69, lines 1334-1342.

The Trial Court held:

Well at this time I have the benefit of hearing the testimony presented by Plaintiff which is different from when the Court actually made the, it's ruling earlier. Recognizing the Court's responsibility here is to consider everything in the like [sic – light] most favorable to the plaintiff. Nevertheless, it would appear to me that the case should proceed only on the medical negligence portion and not on informed consent, informed consent. Quite frankly everything I've heard deals with medical negligence and I understand Mr. Johnson's argument but disagree with respect to his argument. With that in mind, the motion is granted.

RP 6/9/11, page 69, lines 1343-1349.

After a recess, the Plaintiff was permitted to present further argument to the Trial Court to reconsider its ruling. Plaintiff argued that informed consent is statutorily based at RCW 7.70.030 and 7.70.050. *See*, RP page 70, lines 1371-1372, and 1380. Plaintiff again cited the *Gates v. Jensen* case, as well as *Miller v. Kennedy*, 11 Wn. App. 272, 522 P.2d 852 (1974). Plaintiff summed up the argument by stating:

So with all respect Your Honor, we're asking the Court to reconsider. We think we have established the evidence in the case to proceed in the case on both informed consent and failure to reach the standard of care and that the Court should not rule as a matter of law under the facts of this case that we don't have a right to proceed on informed consent.

RP 6/9/11, page 72, lines 1420-1423.

In response, Defendants argued that when a physician arguably misdiagnoses a condition, then the potential liability is that of medical

negligence. In a misdiagnosis case, a physician cannot be liable under RCW 7.70.050 for a condition unknown to that doctor. *See*, 6/9/11, RP page 72-73, lines 1427-1445.

In this case the evidence is that this, this possible, this, this, um, positive blood culture for yeast came in and it was determined, diagnosed to be a probably [sic- probable] contaminant based on the clinical presentation of the patient. If that's the theory of the plaintiff's case, then it is a misdiagnosis case. And they have an argument of medical negligence for misdiagnosing this condition.

They do not have the informed consent aspect however. Because a duty does not arise until there is a known condition. And that condition was not known by Dr. Sauerwein on the 24th.

RP 6/9/11, page 73, lines 1436-1445.

The Trial Court held:

Well it seems to me that based upon the testimony that's come in so far which is the plaintiff's testimony and the defense case hasn't come in yet. But the testimony of any [sic – in any] case that Dr. Sauerwein misdiagnosed, that's the conclusion this Court would take if the Court was sitting on the jury certainly and based on the, the plaintiff's evidence. Um, the Court agrees Ms. Murphy with you that it is a misdiagnoses [sic] and that's [sic] it's medical negligence. I understand from Mr. Johnson was [sic – what] he's telling me. I think he's right. That these are alternative but not alternative, they, they can both be brought in as, as theories. However, the Court does agree with you that at the time of the misdiagnoses [sic] and for a period after, there was, there was no need for informed consent because the proper diagnosis had not been made at that time, it wasn't made until later. Therefore the Court will stand by its ruling.

RP page 73-74, lines 1446-1454.

As a dismissed claim, the jury was not instructed on the informed consent claim. For the convenience of the Court, the exceptions that were

taken by the Plaintiff-Appellant relative to the instructions on informed consent are located at RP pages 57-58, lines 1133-1146; and at CP 84, 88, 89, and 99.

The Special Verdict Form filed with the Court on June 14, 2011, found Mark F. Sauerwein, M.D. not negligent. *See*, CP 312-314. Thereafter, a Judgment for Defendant on Special Verdict was filed with the Court on June 24, 2011. *See*, CP 103-110.

Thereafter, the Trial Court reviewed briefing and heard oral argument on Plaintiff's Brief in Support of Motions for Reconsideration, JNOV and/or for New Trial (CP 315-337) and Sworn Statement of Richard R. Johnson in Support of Plaintiff's Post Trial Motions (CP 111-113). The Trial Court also reviewed the Response to Plaintiff's Motion for Reconsideration and for JNOV or for a New Trial. CP 338-353. The Trial Court heard oral argument on this issue (RP 7/15/11, pages 3-11) and denied Plaintiff's Motion for Reconsideration and for JNOV or for a new trial, entering an Order of denial on July 18, 2011. *See*, CP 114-115.

IV. ARGUMENT

A. Standard of Review

Issues of law are reviewed de novo. A trial court's decision on a motion for judgment as a matter of law is reviewed on appeal by applying the same standard as the trial court, which considered the evidence in the

light most favorable to the nonmoving party. *See, Columbia Park Golf Course, Inc. v. City of Kennewick*, 160 Wn. App. 66, 79, 248 P.3d 1067 (2011), *citing Goodman v. Goodman*, 128 Wn.2d 366, 371, 907 P.2d 290 (1995).

A motion for a new trial is reviewed de novo. *See Id.*, at 80, *citing Cox v. General Motors Corp.*, 64 Wn. App. 823, 826, 827 P.2d 1052 (1992).

B. Authority and Argument on Informed Consent

Informed consent usually occurs in the context of a patient who is participating in a decision about treatment. In this case, there was unclear data with unknown significance relative to the positive blood culture for yeast. The ambiguity of the positive blood culture for yeast was confounding information given the clinical presentation of the patient. The patient was “better” and did not have a fever.

By statute, to impose liability on a physician for a violation of RCW 7.70.030, a plaintiff must prove all of the elements itemized in RCW 7.70.050. The necessary elements of proof in RCW 7.70.050 are:

- (1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

- (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
- (b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;
- (c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
- (d) That the treatment in question proximately caused injury to the patient.

RCW 7.70.050 (sections (2) and (3) not produced above).

The application of an informed consent claim was analyzed by the Washington State Supreme Court in *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950. With regard to an informed consent claim, the Supreme Court held:

A physician who misdiagnoses the patient’s condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent. FN2

FN 2. In the traditional informed consent case, a physician diagnoses the patient’s condition and recommends a course of treatment. The physician is liable under RCW 7.70.050, however, if the physician fails to disclose the attendant risks of such treatment. Similarly, the physician is liable if the physician fails to disclose other courses of treatment, including no treatment at all, as options upon which the patient makes the ultimate choice. *See, e.g., Brown v. Dahl*, 41 Wn. App. 565, 570, 705 P.2d 781 (1985) (“duty to disclose similarly attaches to recognized possible alternative forms of treatment and the anticipated results of the

treatment proposed and administered” (quoting *Adams v. Richland Clinic, Inc.*, 37 Wn. App. 650, 656-59, 681 P.2d 1305 (1984)).

Where a physician arguable misdiagnoses the patient’s condition and recommends a course of treatment for the patient based on that misdiagnosis, the physician is properly liable in negligence for the misdiagnosis if such diagnosis breaches the standard of care. But the physician should not be additionally liable under RCW 7.70.050 for a condition unknown to the physician. For example, a physician who misdiagnosed a headache as a transitory problem and failed to detect a brain tumor may be guilty of negligence for the misdiagnosis, but it seems anomalous to hold the physician culpable under RCW 7.70.050 for failing to secure the patient’s informed consent for treatment for the undetected tumor. Cf. *Thomas [v. Wilfac, Inc.]*, 65 Wn. App. [255] at 261, 828 P.2d 597 [1992]. (Emphasis added).

Backlund, at 661.

In coming to this holding, the *Backlund* Court specifically referenced and cited as authoritative two cases: *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 772 P.2d 1027 (1989), *review denied*, 113 Wn.2d 1005, 777 P.2d 1050 (1989), and *Bays v. St. Luke’s Hospital*, 63 Wn. App. 876, 825 P.2d 319 (1992), *review denied*, 119 Wn.2d 1008, 833 P.2d 387 (1992). These two cases stand for the proposition that treatment choices for a patient may fall solely within the “classic professional negligence situation requiring the patient to prove the physician breached the standard of care” and that the treatment choice was not a matter related to a theory of informed consent. *Backlund*, at 660.

As argued to the Trial Court, the *Burnet* and *Bays* cases were cited

favorably by the *Backlund* opinion. These two cases hold that a claim of failure to obtain informed consent is inapplicable to the facts presented in this case, a misdiagnosis case.

In *Burnet*, a minor child suffered from a seizure disorder that resulted in multiple hospitalizations. *Burnet*, at 163. During three hospitalizations, the minor child had prolonged seizures that developed into extensive brain damage. *Id.* Plaintiffs claimed that the defendant-doctor failed to inform the parents of his decision not to provide diagnostic tests or treatment. *Id.*, at 168. The defense offered expert testimony that the defendant-doctor was unaware of the risk of brain herniation and subsequent injury. *Id.*

The trial court in *Burnet* determined that the “issues presented were confined to negligence and misdiagnosis rather than a violation of the informed consent law.” *Id.*, at 168-169. The *Burnet* Court affirmed the trial court and held that the defendant-doctor “was unaware of Tristen’s [minor’s] condition which implicated risk to her, so he had no duty to disclose.” *Id.*, at 169. In determining this holding, the *Burnet* Court referenced *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 314, 622 P.2d 1246 (1980), and *Gates v. Jensen*, 92 Wn.2d 246, 251, 595 P.2d 919 (1979), which are cited as authoritative by Plaintiff-Appellant, but are each distinguished in the sections below.

In regard to the analysis of the informed consent claim, the *Burnet*

Court held:

Informed consent focuses on the patient's right to know his bodily condition and to decide what should be done. RCW 7.70.050; *Alexander v. Gonser*, 42 Wn. App. 234, 237, 711 P.2d 347 (1985), *review denied*, 105 Wn.2d 1017 (1986) (*citing Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 314, 622 P.2d 1246 (1980)). Whenever a physician *becomes aware* of a condition which indicates risk to the patient's health, he has a duty to disclose it. *Keogan*, at 314, 622 P.2d 1246; *Gates v. Jensen*, 92 Wn.2d 246, 251, 595 P.2d 919 (1979); *Alexander*, 42 Wn. App. at 237, 711 P.2d 347; *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd*, 85 Wn.2d 151, 530 P.2d 334 (1975).

In response to Dr. Graham's liability, Thomas T. Reiley, M.D., an expert called on behalf of the Burnets, stated Dr. Graham was unaware of the risk of brain herniation and subsequent injury. The trial court determined that the issues presented were confined to negligence and misdiagnosis rather than a violation of the informed consent law. We agree; informed consent is an alternative method to impose liability. Thus, a high risk method of treatment rendered in a non-negligent manner, but without an informed consent of the patient, may result in liability. That is not the situation here. It is undisputed Dr. Graham was unaware of Tristen's condition which implicated risk to her, so he had no duty to disclose. See *Nicholson [v. Deal]*, 52 Wn. App. [814], 821, 764 P.2d 1007 [(1988)]. The Burnets' claim relates solely to issues of failure to meet the standard of care and diagnosis. (Emphasis added)

Burnet, at 168-169.

Similar to the facts in *Burnet*, in the case before the Court, Dr. Sauerwein had preliminary information from the laboratory that was ambiguous. See, RP 6/10/11, pages 94-95, lines 1858-1865. He was therefore unaware of the condition that implicated a potential risk to

Christina Anaya. *See, Burnet*, at 168-169. From the standpoint of the clinical presentation, the patient was improving based upon her own assessment of her status. *See*, RP 6/10/11, page 87, lines 1712-1715. She had a known bacterial infection (*Klebsiella pneumoniae*) that explained all of the symptoms she had experienced. *See*, RP 6/13/11, page 20, lines 278-382. Moreover, the treatment that was being provided, which was specific to treating a bacterial infection, had every appearance of working to make the patient better. *See*, RP 6/13/11, page 23, lines 442-455. The fact that the patient was clinically doing better, and that she had been released from the Toppenish Community Hospital Emergency Department less than 24 hours from the time the preliminary blood culture report was received, made it probable that this preliminary laboratory result was a contaminant. *See*, RP 6/10/11, page 87, lines 1712-1715. Thus, on August 24, 2006, there was no duty imposed upon Dr. Sauerwein to disclose the result of the test. *See*, RP 6/9/11, page 115, lines 2308-2314; *and see*, RP 6/13/11, page 26, lines 510-514.

In *Bays v. St. Lukes Hospital*, 63 Wn. App. 876, 825 P.2d 319 (1992), the patient was injured when an 800-pound spool of wire strapping fell on him. *Bays*, at 878. At the Emergency Room, the patient was diagnosed with a dislocated right shoulder that was reduced (relocated) and mild compression fractures of his 12 vertebrae. *Id.* On September 3,

1983, a concern regarding the patient's pulmonary function arose and the defendant-doctor made a differential diagnosis listing four potential medical problems that were thereafter ruled out. *Id.*, at 879. On September 6, 1983, the patient had symptoms of a pulmonary embolism and died shortly thereafter. *Id.* The estate-plaintiff claimed that the defendant-doctor had an obligation to disclose all methods of treatment of conditions because there were additional methods of treatment for thrombophlebitis, thromboembolism, and pulmonary embolism within the differential diagnosis of thromboembolism. *Id.*, at 881. In this regard, the *Bays* Court held:

Ms. Bays interprets RCW 7.70 as imposing upon physicians the duty to disclose material facts relating to treatment of conditions which have not been diagnosed by the physician. She argues Dr. DeWitt had a duty to disclose to Ms. Bays all possible methods of treatment for thrombophlebitis, thromboembolism and pulmonary embolism on September 3 because Dr. DeWitt's differential diagnosis included thromboembolism. This is not the law in Washington. As clearly stated in *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 772 P.2d 1027, *review denied*, 113 Wn.2d 1005, 777 P.2d 1050 (1989), the duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it.

A physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform the patient. Informed consent and medical negligence are alternate methods to impose liability. *Burnet*, 54 Wn. App. at 168-169, 772 P.2d 1027; *see* RCW 4.24.290. (Emphasis added.)

Bays, at 881-882.

The plaintiff in *Bays*, also argued that her motion for a directed verdict and new trial on the issue of informed consent should have been granted. *Id.*, at 882. The *Bays* Court held that “[t]he assertion and argument is a transparent attempt to disguise a negligence issue as a failure to obtain informed consent issue on both the diagnostic test and the medical treatment.” *Id.* In that regard, the *Bays* Court held:

A failure to diagnose a condition, as we have indicated above, is a matter of medical negligence. **We decline to create a second or alternate cause of action on informed nonconsent to a diagnostic procedure predicated on the same facts necessary to establish a claim of medical negligence.** (Emphasis added)

Bays, at 883.

In the case before the Court, Plaintiff claim Dr. Sauerwein was negligent in failing to properly diagnose yeast in the blood. The facts submitted to support the medical liability claim were the same facts Plaintiff was transparently using in an attempt to claim a failure to obtain informed consent. As held in *Bays*, a cause of action on informed nonconsent, predicated on the same facts necessary to establish a claim of medical negligence, does not exist.

In the case before the Court, the allegations are that Dr. Sauerwein did not correctly interpret the preliminary report of a positive blood culture for yeast. However, based on the circumstances presented, which

include a patient who had a known infection of the urinary tract with a bacterial organism called *Klebsiella pneumoniae*, as well as the fact that the patient was doing better and did not have a fever, the positive blood culture for yeast was unclear information that was confounding information given the clinical presentation. *See*, RP 6/10/11, page 87, lines 1712-1715; and page 94-95, lines 1858-1865. Therefore, the preliminary report of a positive blood culture for yeast had unclear and unknown significance. *See*, RP 6/13/11, page 26, lines 497-505. The ambiguity of the preliminary laboratory results did not impose a duty upon Dr. Sauerwein under the informed consent statute RCW 7.70.050.

As held in *Bays*, a duty to inform does not exist in a case in which there is a claim of a failure to properly diagnose a condition, which is a claim of medical negligence, not a claim of a violation of the duty to secure informed consent. *See, Id.*, at 883. Moreover, as held in *Bays*, the Court declined creating a second or alternate cause of action on “informed nonconsent”. *See, Id.*

The cases cited as authoritative by the Defendants-Respondents are not distinguished by the Plaintiff-Appellant in the Brief of Appellant. These cases and their significance to the facts and evidence herein are therefore undisputed.

Finally, the Plaintiff-Appellant has not addressed the issue of proximate causation. The fourth element of RCW 7.70.050 requires that the plaintiff establish that the treatment in question proximately caused injury to the patient. At trial, there was no presentation of evidence on the issue of proximate causation. The record is void on this subject. In addition to no witness testifying on this statutory element, there was no offer of proof on proximate causation. The Plaintiff-Appellant's claim on informed consent fails for this reason as well.

C. Counter to Cases Cited by Plaintiff

RAP 10.3(a)(6) states that the brief of appellant or petitioner should contain, under appropriate headings: "*Argument*. The argument in support of the issues presented for review, together with citations to legal authority and references to relevant parts of the record." In the Brief of Appellant, there is a lack of argument between the cases cited and relied upon by the Plaintiff-Appellant, and the connection that allegedly exists to the facts and circumstances presented in the case before the Court. The application of the cases referred to by Plaintiff-Appellant in the Brief of Appellant are not self evident. Below are arguments as to why these cases, relied upon by Plaintiff-Appellant, are distinguishable from the case being reviewed on appeal.

In the Brief of Appellant, an argument is not made as to how and why the legal analysis of the Trial Court was wrong. The reasoning of the referenced cases was never applied and argued by Plaintiff-Appellant in the Brief of Appellant. As extensively outlined in the paragraphs above, this was not a situation in which the Trial Court discarded, dismissed or ignored facts, evidence, or the applicable law. Rather, this was a carefully and thoughtfully considered situation in which the facts and evidence were applied to the law as it exists in the State of Washington with regard to informed consent claims.

1. **Distinguish: *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979)**

Plaintiff-Appellant cites *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) and then cuts and pastes direct and nearly-direct quotes (not citing to *Gates* page numbers) from page 11 through the top of page 17 of the Brief of Appellant. Despite the extensively quoted language from *Gates*, there is no argument made by Plaintiff-Appellant as to how the facts or holding of *Gates* apply to the evidence and legal analysis presented in this case.

Gates was decided in 1979. In comparison, the *Backlund* case was decided twenty years later, in 1999.

Gates is distinguishable from the case before the Court because in *Gates* the defendant-ophthalmologist took eye pressure readings and the results of that test indicated the patient was borderline for glaucoma. *Gates*, at 247. The evidence in *Gates* was that despite high pressure in both of the patient's eyes, when questioned by the patient, the defendant-ophthalmologist told the patient she was "all right" rather than telling her of the problem. *Id.*, at 247. Thereafter, the defendant-ophthalmologist did not follow through on additional diagnostic tests that were simple and inexpensive, and that held little risk to the patient. *Id.* Moreover, the availability of these diagnostic tests was not discussed with the patient. *Id.*, at 247-248.

The *Gates* Court held that "[t]he physician's duty of disclosure arises, therefore, whenever the doctor becomes aware of an abnormality which may indicate risk or danger." *Id.*, at 251.

The facts in *Gates* are distinguishable from the case before the Court. Dr. Sauerwein was not aware of an abnormality that may indicate risk or danger. Instead, Dr. Sauerwein was presented with a preliminary blood culture that was positive for yeast. However, the clinical picture of the patient indicated that this preliminary blood culture was a contaminant and that the patient was not at risk or in danger. *See*, RP 6/10/11, page 87, lines 1712-1715, *and see*, RP 6/10/11, pages 94-95, lines 1858-1865.

The holding in *Gates* is not applicable to the facts and circumstances presented in relation to this case because Dr. Sauerwein was not aware of an abnormality that may indicate a risk or danger to the patient.

2. **Distinguish: *Smith v. Shannon*, 100 Wn.2d 26, 666 P.2d 351 (1983)**

Without citing *Smith v. Shannon*, 100 Wn.2d 26, 666 P.2d 351 (1983), the briefing in Plaintiff-Appellant's Brief of Appellant, between pages 17 through 23, are almost exclusively direct quotes from the *Smith* opinion.

As with other cases quoted in the Brief of Appellant, Plaintiff-Appellant did not argue how the facts and law in *Smith* apply to the facts in the case before the Court.

It is odd that Plaintiff-Appellant would extensively quote from *Smith*, given the fact that in *Smith*, the plaintiff at the trial court level argued causes of action involving: 1) negligent treatment, and 2) failure to obtain informed consent. *Smith*, at 27. In *Smith*, the trial court, sitting as the fact finder, found in favor of the defendant-doctor on both causes of action, which was affirmed. *Id.*, at 27 and 38. Perhaps that is why Plaintiff-Appellant did not cite *Smith v. Shannon* for the 6 pages of direct, and nearly-direct quoted language from that opinion. Despite not citing

the pages of quoted opinion from *Smith*, that does not diminish the fact that *Smith* does not support the conclusory claimed errors purported by Plaintiff-Appellant in this case.

In *Smith*, the patient contacted her attending physician regarding a possible kidney complication. *Id.*, at 28. She was referred to a radiologist where intravenous pyelogram (a radiopaque contrast agent) was injected and then x-rays were taken of her kidneys and ureters. *Id.* The patient-plaintiff was informed that she may feel nauseous or become unconscious as a result of the administration of the IVP. *Id.* The *Physicians' Desk Reference* (a book describing the uses, effects and dangers of drugs) mentioned 10 other risks potentially caused by the IVP injection. *Id.*

At trial, the court, weighing all of the evidence as trier of fact, dismissed Ms. Smith's cause of action for negligence on the ground that she had not demonstrated any deviation by Dr. Shannon from the established standard of medical practice. The court also rejected Ms. Smith's claim that Dr. Shannon had failed to obtain her informed consent, on the ground that Dr. Shannon had informed Ms. Smith of all material risks. While the court recognized that Dr. Shannon had not informed Ms. Smith of all of the risks described in the PDR, it concluded that Ms. Smith had failed to prove that any of these "were in fact medically significant or recognized risks." Clerk's Papers, at 94, 102. In so concluding, the court noted in particular that Ms. Smith had failed to produce sufficient expert testimony on this issue and indicated that it considered such testimony necessary.

Id., at 29. The Supreme Court in *Smith* affirmed the decision of the trial court. *Id.*, at 38. The issue in *Smith* was a delineation of what were

medically significant risks and whether expert testimony was required as part of the burden of proof. *Id.*

In the case before the Court, Plaintiff-Appellant did not argue why or how *Smith* supported its position on appeal, and therefore it is unknown what to respond to relative to the *Smith* case.

In the 6 pages of the Brief of Appellant in which the *Smith* case is quoted, the only briefing that is not from *Smith* is the bottom two paragraphs of page 18. At page 18 of the Brief of Appellant, it is stated that three of the defense experts, without providing their quoted testimony, testified that it was not the standard of care for a family practice physician to inform a patient of an undiagnosed issue. This is an apparent agreement by Plaintiff-Appellant that it should not prevail on its Assignment of Error claiming that this case should be deciding in favor of Plaintiff as a matter of law.

For the convenience of the Court, Respondent has provided the quoted testimony of the witnesses referenced in the Brief of Appellant.

First, Walter Balek, M.D., a family practitioner (Dr. Balek's name is misspelled throughout the Report of Proceedings):

MR. THORNER: Alright. And do you believe that Dr. Sauerwein met the standard of care, [sic – of] a reasonably prudent family practitioner in his actions, as, as recorded in the record and reflected in this document on Thursday, August, excuse me. Thursday, now you got me doing it. Thursday, August 24, 2006,

that's our military background getting in our way here. Is that correct?

DR. BALICK [SIC]: That's correct, I, I, believe he, he acted in a prudent and, and appropriate manner. You know difficult situation, bits and pieces of data, a patient who apparently was not getting sicker, one culture with high risk of contamination, false positives on one culture. So I think that you know it is, he didn't ignore this. He took you know called the doctor who took care of her, I mean there, there were a number of steps that he took and, and did it I think very appropriately.

RP 6/9/11, page 110, lines 2198 – 2206.

MR. THORNER: Ok. The question is this, I'll try to restate it. Did Dr. Sauerwein based upon, re, restate myself [sic]. Under the circumstances of the information that Dr. Sauerwein had, as reflected in the records, require under these circumstances to meet the standard of care, was he required to tell the patient or have the nurse tell the patient on his behalf that she had yeast infection on this date?

DR. BALICK [SIC]: Ok. Given the information that he had I thing that the, I guess once he had made the determination this is a contaminated sample and therefore not a valid tests [sic – test], I, I don't think it's a [sic] required to, to give a patient what you have now come to the clinical conclusion is that it is an invalid test before the result. Um, so I would say that, that it wouldn't have been required based on, on the information at that point and, and knowing or not knowing, I'll just say making the decision, that this is a, a contaminated sample because she is better.

MR. THORNER: K. Now, does a reasonably prudent family practitioner tell a patient of all abnormal lab results that he or she receives during the course of caring for a patient?

DR. BALICK [SIC]: I would say that almost never happens. And the, the reason for that is because there's a lot of abnormal lab results that really are not pertinent not only to the patient's care but just plain aren't pertinent.

RP 6/9/11, pages 111-112, lines 2233-2247.

Next, the testimony of Peter Hashisaki, M.D., an infectious disease specialist (Dr. Hashisaki's name is misspelled throughout the Report of Proceedings):

MS. MURPHY: Alright. And um, in this situation that you evaluated, um, with us, would Dr. Sauerwein have been or a family practice physician have been obligated to tell the patient of a positive blood culture for yeast?

DR. HUSHISAKI [SIC]: At that point, they didn't know whether it was real or contaminant. So I would not. I mean it's kinda [sic] like why worry the patient needlessly.

RP 6/10/11, page 142, lines 2817-2821.

Finally, Dr. Daniel Doornink, an internist:

MS. MURPHY: Did the standard of care require Dr. Sauerwein to inform the patient of a positive blood culture for yeast?

DR. DOORNINK: This was, the clinical significance of this was still in question and so he wasn't required to notify the patient regarding this, no.

RP 6/13/11, page 26, lines 502-505.

Plaintiff assigned error in that Defendant Dr. Sauerwein was not held liable as a matter of law for allegedly not obtaining informed consent. Plaintiff is essentially asserting that this is a strict liability case, which is not an applicable theory of law to the facts of this case. Plaintiff-Appellant agrees that this is not an applicable theory of law by reciting facts that concede three defense experts testified that there was no obligation to inform the patient of the preliminary blood culture results,

given the totality of the facts and circumstances. Similarly, in *Smith*, the Supreme Court held that “liability cannot per se be predicated on Dr. Shannon’s failure to inform Mrs. Smith of all of the risks described in the PDR.” *Smith*, at 31.

It is the position of Respondents, as argued above, that failure to obtain informed consent was not an applicable theory of law to the facts of this case. The Trial Court properly dismissed that claim after hearing the Plaintiff’s case-in-chief. However, on appeal, Plaintiff-Appellant is claiming error against the Trial Court relative the Trial Court’s denial of Plaintiff’s post-trial Motion for Reconsideration, JNOV and/or for New Trial. (As cited in the Counter Statement of Procedural History at page 23 of this Brief, the written arguments on this motion are located at CP 315-337, CP 11-113, CP 338-353, and CP 114-115.)

At the time of the post-trial hearing, July 15, 2011, the Trial Court had the benefit of having heard all of the evidence, including the above-quoted testimony of Drs. Balek, Hashisaki, and Doornink. As can be seen from the record, at the hearing on the Motion for Reconsideration, JNOV and/or for New Trial, Plaintiff did not present any new or different information that had not previously been considered by the Trial Court. *See*, RP 6/15/11, pages 3-6, lines 45-121; and pages 10-11, lines 196-229.

In addition to no new or different facts being argued, Plaintiff also did not cite to or argue case law different from the opinions that had previously been cited to and argued to the Trial Court. *See, Id.* At this hearing, Plaintiff referred in oral argument to *Keogan v. Holy Family Hospital*, 85 Wn.2d 306, 622 P.2d 1246 (1980), which is a case discussed in the paragraphs below, rather than focusing on the *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) as was done when Defendant's moved for dismissal of the claim at the conclusion of the Plaintiff's case, but, no new cases were cited to the Trial Court for consideration that had not previously been cited and considered. *See, Id.*

The Trial Court properly denied Plaintiff's Motion for Reconsideration, JNOV and/or for New Trial. The Trial Court had the benefit of having heard all of the trial testimony, include the testimony of defense experts that a reasonably prudent family practice practitioner did not have to inform the patient of the positive blood culture for yeast. *See*, RP 6/9/11, pages 110-112, lines 2198-2206 and lines 2233-2247; *and see*, RP 6/10/11, page 142, lines 2817-2821; *and see*, RP 6/13/11, page 142, lines 502-505.

3. **Distinguish: *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980)**

In the Brief of Appellant, between pages 32 and 40, there is, again, un-cited direct quotes or almost direct quotes from *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980). The *Keogan* opinion is quoted, but no analysis, applications, or arguments are offered as to the applicability of the *Keogan* to the case before the Court.

Keogan was decided in 1980, the *Backlund* case was decided in 1999. Therefore, *Keogan* is an older decision, nineteen years older, than *Backlund*. *Keogan* is also a split decision. The majority opinion in *Keogan*, issued by three justices of an eight-member panel, cite *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) in their holding that a physician had a duty to disclose information whenever he or she becomes aware of a bodily abnormality that may indicate a risk or danger, whether or not the diagnosis is completed. *Id.*, at 315. Thereafter, five justices concurred in part, and dissented in part, in an opinion in which it was stated that a negligence theory was adequate to give plaintiffs a remedy for a treating doctor's inaction, and there was no duty imposed on a doctor to inform a patient of something that had not been diagnosed. *Id.*, at 331.

Keogan is factually distinguishable from the case currently before the Court. In *Keogan*, the treating defendant-doctor obtained test results

that suggested that the patient had heart disease. *Id.*, at 307. The defendant-doctor testified that he thought the patient had angina, although he failed to confirm this and the patient was not treated for angina. *Id.* As described, despite the suspicion of angina, the defendant-doctor concluded that other causes made the patient ill and did not disclose to the patient the possibility of heart disease and did not disclose to the patient other tests that were available to diagnose heart disease. *Id.*, at 308-309. The patient died of a heart attack, and the estate-plaintiff sued the defendant-doctor for medical malpractice and lack of informed consent. *Id.*, at 311.

In *Keogan*, the majority opinion cited *Gates v. Jensen*, and held

... the duty to disclose with regard to Dr. Snyder had arisen. Dr. Snyder testified that Keogan's mid-chest pain constituted an abnormality, and that he suspected angina as the cause of the pain. Instead of fulfilling his duty to disclose, as set forth in the following section, Dr. Snyder began treating Keogan for a stomach ailment and for mild heart trouble through the prescription of an antacid and Sorbitrate without allowing Keogan to determine for himself if additional diagnostic procedures should be pursued to determine the cause of his chest pain. (Emphasis added).

Id., at 315. This is a different set of circumstances than those presented with regard to Dr. Sauerwein. In the case before the Court, Dr. Sauerwein did not suspect that the patient had yeast in her blood as a result of his conference with Dr. John Moran, the hospitalist physician who treated Christina Anaya earlier in the week. *See*, RP 76-78, lines 1512-1544. It

was their joint decision that if Christina Anaya was not currently ill, then this preliminary laboratory report of a positive blood culture for yeast was a probable contaminant. *See*, RP 82, lines 1617-1629. Therefore, when Dr. Sauerwein gained additional information that the patient was not currently ill, he concluded that the yeast was a probable contaminant. *See*, RP 6/10/11 page 87, lines 1712-1715; and page 94-95, lines 1858-1865.

Plaintiff at trial asserted a claim that Dr. Sauerwein misdiagnosed the preliminary report of a positive blood culture for yeast, and that this misdiagnosis was medical negligence. This alleged misdiagnosis did not, however, create a valid claim of lack of informed consent. The Court properly and appropriately dismissed the informed consent claim after the presentation of the Plaintiff's case-in-chief. This ruling of the Trial Court should be upheld.

4. **Distinguish: *Estate of Lapping v. Group Health Cooperative of Puget Sound*, 77 Wn. App. 612, 892 P.2d 1116 (1995)**

Plaintiff-Appellant again offers direct cut and paste quotes from the *Estate of Lapping v. Group Health Cooperative of Puget Sound*, 77 Wn. App. 612, 892 P.2d 1116 (1995) case without offering any argument as to its applicability to the facts in the case before the Court. At pages 40 through 45 of Brief of Appellant, direct and almost direct quotes are stated.

The *Estate of Lapping* case is inapplicable to the case before the Court for the same reasons the *Gustav* Court held that the *Estate of Lapping* was inapplicable to the fact pattern in *Gustav*. See, *Gustav v. Seattle Urological Associates*, 90 Wn. App. 785, 954 P.2d 319 (1998). The *Gustav* Court held that “[i]n *Lapping*, where the plaintiff’s decedent died while undergoing a diagnostic procedure, the court considered a physician’s duty to inform regarding risks inherent in the diagnostic procedure itself.” *Gustav*, at 792.

In *Estate of Lapping*, an endometrial biopsy was performed to remove a sample of tissue from the lining of the uterus for later examination. See, *Estate of Lapping*, at 614. A consent form was signed, but the defendant-doctor did not discuss the effects of the patient’s seizure history with the patient or that the biopsy could be performed at a hospital, rather than at the clinic, which would allow for additional precautions regarding the administration of anesthesia. See, *Id.*, at 615. The patient had a seizure during the biopsy procedure and died. See, *Id.*, at 616. The *Estate of Lapping* Trial court declined to instruct the jury on informed consent. See, *Id.*, at 622. On appeal, the *Estate of Lapping* Court held that informed consent was a matter for the jury to decide:

Because Lapping was epileptic and taking dilantin, there is a reasonable inference that a reasonable person in her shoes would have wanted to know of and consider having the biopsy done in the

hospital, with the additional equipment and precautions there available.

Id., at 626.

Estate of Lapping is not applicable to this case because the patient in *Estate of Lapping* needing to participate in the determination of whether or not the recommended procedure was the treatment choice she wanted to make. In *Estate of Lapping*, a procedure was going to be performed and the patient had to choose whether the risks outweighed the benefits of going forward with the procedure. In Dr. Sauerwein's case, there was no procedure that was going to be performed. Therefore, there was no decision that was to be made by Christina Anaya. Thus, there was no duty that arose relative to any obligation of Dr. Sauerwein to inform her.

V. CONCLUSION

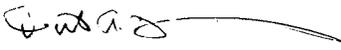
For the reasons cited above, the Trial Court properly granted a dismissal of the informed consent claim at the close of the Plaintiff's case-in-chief. The Trial Court also properly excluded jury instructions on an informed consent claim. The Trial Court also properly denied Plaintiff's post-trial Motion for Reconsideration, and Motion for a New Trial and/or for JNOV. In so doing, the Trial Court properly did not find Dr.

Sauerwein liable as a matter of law for a claim alleging failure to obtain informed consent.

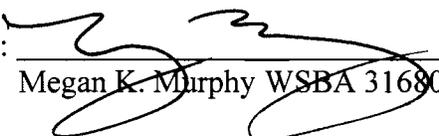
Defendants Mark Sauerwein, M.D. and the Yakima Valley Farm Workers Clinic respectfully request the Court of Appeals affirm the rulings of the Trial Court in this matter.

Respectfully submitted this 18th day of January 2012.

THORNER, KENNEDY & GANO P.S.
Attorneys for Defendants

By: 

David A. Thorner WSBA 4783

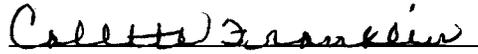
By: 

Megan K. Murphy WSBA 31680

PROOF OF SERVICE

I, Colette Franklin, declare under penalty of perjury of the laws of the State of Washington that on January 18th, 2012, I placed a copy of the Brief of Respondent to which this document is attached in the United States mail, postage prepaid and by Attorney Messenger Service to:

Mr. Richard R. Johnson
Delorie Johnson PLLC
917 Triple Crown Way, Suite 200
Yakima, WA 98908


Colette Franklin
Secretary to Megan K. Murphy