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IN THE SUPREME COURT OF THE STATE OF WASHINGTON

RUDOLFO ANAYA GOMEZ, as Personal Representative of the Estate of
CHRISTINA PALMA ANAYA, deceased,

Plaintiff/Petitioner,

vs.

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

Defendants/Respondents.

BRIEF OF AMICUS CURIAE
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

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On Behalf of Washington
State Association for
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 ORIGINAL

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I. IDENTITY AND INTEREST OF AMICUS CURIAE

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to the Washington State Association for Justice (WSAJ). WSAJ Foundation is the new name of Washington State Trial Lawyers Association Foundation (WSTLA Foundation), a supporting organization to the Washington State Trial Lawyers Association (WSTLA), now renamed WSAJ. WSAJ Foundation, which operates the amicus curiae program formerly operated by WSTLA Foundation, has an interest in the rights of plaintiffs under the civil justice system, including an interest in the rights of plaintiffs under Ch. 7.70 RCW, governing civil claims against health care providers.

II. INTRODUCTION AND STATEMENT OF THE CASE

This case presents the Court with the opportunity to clarify the meaning and application of Washington's informed consent statute, RCW 7.70.050. Rudolfo Anaya Gomez, as Personal Representative of the estate of his wife Christina Anaya (Anaya Gomez or Estate), brought this medical malpractice action against Mark F. Sauerwein, M.D. (Sauerwein) and his employer, The Yakima Valley Farm Workers Clinic (based upon vicarious liability). The underlying facts are drawn from the Court of Appeals opinion and the briefing of the parties. See Anaya Gomez v. Sauerwein, 172 Wn.App. 370, 289 P.3d 755 (2012), *review granted*, 177 Wn.2d 1008 (2013); Estate Br. at 1-2, 4-9; Sauerwein Br. at 4-23; Estate

Reply Br. at 1; Estate Pet. for Rev. at 3-7; Sauerwein Resp. to Pet. for Rev. at 1-3; Estate Supp. Br. at 1-2; Sauerwein Supp. Br. at 1-7.

For purposes of this amicus curiae brief, the following facts are relevant: Christina Anaya (Christina) was a patient of Yakima Valley Farm Worker's Clinic (Clinic), and her primary care physician was Dr. Kyle Heisey (Heisey). Christina suffered from diabetes, leaving her immune system vulnerable. In August 2006, Christina was feeling poorly and was hospitalized and determined to have a bacterial urinary tract infection (UTI).

Following this hospitalization and additional evaluation and treatment at the hospital, Sauerwein, who was covering for Heisey at the Clinic, was advised of the result of a preliminary blood test taken at the hospital that showed Christina's blood tested positive for a serious fungal infection. Sauerwein did not share this information with Christina.

Instead, after consulting with another health care provider, Sauerwein determined that if Christina was not otherwise feeling ill, the preliminary blood test result was likely a false positive due to contamination. He had a licensed practical nurse at the Clinic contact Christina and confirm that she was not in distress. Christina told the nurse that she had returned to the emergency room the night before and had been catheterized in order to empty her bladder, and felt better afterwards. After receiving this information, Sauerwein had the Clinic move up Christina's scheduled follow-up appointment from September 5th to

August 30th, but took no other immediate action regarding the preliminary blood test result.

It turned out that the preliminary blood test result was accurate and Christina had a serious fungal infection. The subsequent course of treatment was unsuccessful and she died of fungal sepsis approximately two months later.

Anaya Gomez brought this medical malpractice action against Sauerwein and the Clinic, and the case proceeded to trial on both negligence and informed consent claims.

The trial court dismissed Anaya Gomez's informed consent claim at the close of plaintiff's case. It did so on the grounds that under these facts, Anaya Gomez was only entitled to pursue the negligence claim based upon an alleged "misdiagnosis" on Sauerwein's part. See Sauerwein Br. at 21-22 (quoting record). The trial court apparently considered the misdiagnosis to be Sauerwein's determination that the preliminary blood test result was inaccurate, when considered along with the rarity of a fungal infection in the blood and Christina's clinical picture. See id. at 22. It appears the trial court did not reach the question whether Anaya Gomez established a prima facie case of informed consent under RCW 7.70.050(1), because it concluded the statute did not apply.

The case proceeded to verdict solely on Anaya Gomez's negligence claim, and the jury found Sauerwein was not negligent in his treatment of

Christina. The jury did not reach the issue of proximate cause. The trial court denied all post-trial motions and the Estate timely appealed.

Anaya Gomez appealed dismissal of the informed consent claim, and the Court of Appeals affirmed. The court's analysis features an extended discussion of three of this Court's informed consent cases—Gates v. Jensen, 92 Wn.2d 246, 595 P.2d 919 (1979), Keogan v. Holy Family Hospital, 95 Wn.2d 306, 622 P.2d 1246 (1980), and Backlund v. University of Washington, 137 Wn.2d 651, 675 P.2d 950 (1999). The court concluded that, while the holding in Gates would support Anaya Gomez's informed consent claim, Gates has been overruled, abrogated or limited by Backlund or Keogan. See Anaya Gomez, 172 Wn.App. at 372, 385. As a result, the Court of Appeals affirmed dismissal "on the basis that Dr. Sauerwein's failure to diagnose presented a cause of action for medical negligence only." Id. at 385. In so doing, it did not explain whether or how its "failure to diagnose" conclusion related to or differed from the trial court's "misdiagnoses" analysis.

This Court granted Anaya Gomez's petition for review.

III. ISSUE PRESENTED

Under Washington's informed consent statute, RCW 7.70.050, did Sauerwein have a duty to inform Christina of a preliminary laboratory blood test result indicating a serious fungal infection, regardless of whether he believed this test result was inaccurate due to contamination?

See Estate Pet. for Rev. at 2-3.

IV. SUMMARY OF ARGUMENT

The superior court erred in dismissing Anaya Gomez's informed consent claim under RCW 7.70.050 at the conclusion of plaintiff's case. Considering the evidence as recounted in the Court of Appeals opinion and the parties' briefing in a light most favorable to Anaya Gomez, there are questions of fact whether Sauerwein is liable for breaching a duty to inform Christina of the preliminary blood test result indicating a life-threatening fungal infection. It should not matter that the test result was preliminary or that Sauerwein believed the test result was inaccurate.

Under these circumstances, it was for the jury to determine in accordance with the requirements of RCW 7.70.050 whether a) the test result was a material fact relating to treatment, b) Christina consented to the treatment—a mere follow-up Clinic visit—without being fully informed of the material fact, c) a reasonably prudent patient under similar circumstances would not have consented to this treatment if informed of the material fact, and d) the treatment was a proximate cause of Christina's death. Any other result would undermine the principle of *patient sovereignty* that is at the heart of the duty to disclose material facts and obtain informed consent, which principle is premised on a patient's right to fully participate in charting his or her own destiny.

This Court's decisional law is wholly consistent with this result, and the courts below erred in viewing this case as involving a

"misdiagnosis" or "failure to diagnose" on Sauerwein's part, and in concluding the informed consent theory of liability is inapplicable.

V. ARGUMENT

A. Overview Of Washington Law Regarding Tort Claims Against Health Care Providers For Negligence And Breach Of Duty To Obtain Informed Consent.

Beginning in 1975, tort claims against health care providers for negligence and failure to obtain informed consent have been governed by statute in Washington. See RCW 4.24.290; RCW 7.70.010-.065; see also Berger v. Sonneland, 144 Wn.2d 91, 109, 26 P.3d 257 (2001).¹ Negligence and informed consent are distinct grounds for imposing tort liability on a health care provider. See generally Backlund, 137 Wn.2d at 659. Thus, a provider may act in a nonnegligent manner, yet still be liable for failure to obtain the patient's informed consent.

Negligence claims against health care providers are principally governed by RCW 7.70.030-.040. A plaintiff must prove a violation of the standard of care. See RCW 7.70.030(1). The evidence must show that the health care provider failed to exercise that degree of skill, care and learning possessed at the time in the profession or class to which the provider belongs, in the state of Washington, acting in the same or similar circumstances. RCW 7.70.040; see also RCW 4.24.290 (imposing similar requirement for negligence claims). Expert testimony is usually required to support a negligence claim. See Harbeson, 98 Wn.2d at 468-69.

¹ The current versions of these statutes are reproduced in the Appendix to this brief. For a useful history of the common law regarding negligence and informed consent, see Harbeson v. Parke-Davis, Inc., 98 Wn.2d 460, 467-70, 656 P.2d 483 (1983).

Claims for breach of the duty of informed consent are governed by RCW 7.70.050. This statute essentially codifies preexisting common law. See Harbeson, 98 Wn.2d at 470-71; Miller v. Kennedy, 11 Wn.App. 272, 522 P.2d 852 (1974), *aff'd per curiam*, 85 Wn.2d 151 (1975) (adopting Court of Appeals informed consent analysis); Laws of 1975-76, 2nd Ex. Sess. Ch. 56 §10, Final Bill Rpt. on ESHB 1470. The duty of health care providers to secure the informed consent of patients with regard to medical treatment is fiduciary in nature. See Miller, 11 Wn.App. at 282. It is grounded in the principle of "patient sovereignty," Smith v. Shannon, 100 Wn.2d 26, 30, 666 P.2d 351 (1983), and honors the patient's "right of self-determination" to make voluntary and informed decisions regarding what happens to his or her own body, Miller, 11 Wn.App. at 282-83.

Section B discusses the elements of proof necessary for establishing an informed consent claim, and whether these elements were met in this case.

B. Considered In A Light Most Favorable To Anaya Gomez, The Evidence Recounted In The Court of Appeals Opinion And Briefing Before This Court Establishes That The Informed Consent Claim Should Have Been Decided By The Jury.

The trial court and Court of Appeals analyses of the informed consent claim primarily focus on case law and whether this is a "misdiagnosis" case or a "failure to diagnose" case. See Sauerwein Br. at 21-22 (quoting extracts from trial court rulings rejecting informed consent claim); Anaya Gomez at 385 (concluding basis for liability is "failure to diagnose," cognizable only as a medical negligence claim). Further, the

Court of Appeals analysis is influenced by its perception of discord in this Court's opinions in Gates, Keogan and Backlund, *supra*. Neither court appears to evaluate the informed consent claim with reference to the specific elements set forth in RCW 7.70.050.

This section of the brief explains why Anaya Gomez presented a justiciable informed consent claim that should have been decided by the jury. The evidence is examined with respect to each element of proof required under the informed consent statute.² If the elements are not met, this would be determinative. However, if the Court agrees that they are met, then §C, *infra*, explains how this Court's decisional law is wholly consistent with this result.

(a) Material fact related to treatment: the preliminary blood test result indicating a serious fungal infection.

The first element of an informed consent claim is that "the health care provider failed to inform the patient of a material fact or facts relating to the treatment." RCW 7.70.050(1)(a). A fact is material if "a reasonably prudent person in the position of the plaintiff...would attach significance to it [in] deciding whether or not to submit to the proposed treatment." RCW 7.70.050(2); *see also* Backlund, 137 Wn.2d at 667 n.3 (recognizing material facts are those of a "serious nature").³

² WSAJ Foundation has not reviewed the record in this case. The facts are drawn from the recitations of the parties in their briefing and the Court of Appeals opinion. Under CR 50, the facts are viewed in a light most favorable to Anaya Gomez. *See* Schmidt v. Coogan, 162 Wn.2d 488, 491, 173 P.3d 273 (2007).

³ Some material facts relating to treatment options require expert testimony. *See* RCW 7.70.050(3). The need for expert testimony does not appear to be at issue here. *See* main text.

The undisclosed material fact here is the preliminary blood test result indicating a serious fungal infection. See Estate Br. at 5; Estate Reply Br. at 1. Anaya Gomez describes this fungal infection as "potentially fatal," Estate Pet. for Rev. at 3, and Sauerwein does not appear to dispute this fact, other than wanting to place it in a larger context. See e.g. Sauerwein Resp. to Pet. for Rev. at 4-10 (focusing on preliminary nature of the result, likelihood of sample contamination, and Christina's overall clinical picture); Sauerwein Supp. Br. at 19 (similar).⁴ Sauerwein's immediate response to the test result suggests he recognized its serious nature. He was concerned, consulted with a colleague, had a nurse call Christina to ask how she was feeling, and moved up a previously scheduled appointment by approximately a week. See Anaya Gomez, 172 Wn.App. at 373-74; Sauerwein Resp. to Pet. for Rev. at 2-3. The test result was positive for a potentially life-threatening infection of the blood. This is a material fact.⁵

⁴ As explained infra at n.7, these considerations all would have been proper subjects for the discussion with Christina *after* she was apprised of the test result.

⁵ In Miller, 11 Wn.App. at 288, the court indicates that a health care provider may, as a "matter of defense," present evidence of a standard of nondisclosure based on "mental incompetence, emergencies, and potential physical trauma or mental disturbance to the patient." Miller, 11 Wn. App. at 288; see also Harbeson, 90 Wn.2d at 470 & nn.4-5 (discussing Miller). None of these circumstances appear to be present in this case. Moreover, it is not clear whether evidence regarding a standard of nondisclosure based on potential physical trauma or mental disturbance remains relevant after the adoption of Ch. 7.70 RCW. See RCW 7.70.050(4) (implying consent in emergency or when patient is incompetent, but not addressing physical trauma or mental disturbance); RCW 7.70.065 (providing for surrogate decision makers for incompetents). To the extent that a standard of nondisclosure remains relevant, it is an affirmative defense, on which the health care provider has the burden of proof. As such, it does not relate to whether the patient has presented a prima facie case. See Miller at 283-84; Harbeson at 470. In any event, the jury is entitled to reject a standard of nondisclosure defense based on the principle of patient sovereignty. See Miller at 288 (stating "it is for the jury to accept or reject whether any standard of nondisclosure should deprive a patient of his right to self-

RCW 7.70.050(a)(1) refers to “a material fact or facts *relating to the treatment.*” (Emphasis added.) Although the phrase “relating to” and the term “treatment” are not defined in the statute, given their plain and ordinary meaning, this requirement is met. See Burns v. City of Seattle, 161 Wn.2d 129, 140, 164 P.3d 475 (2007) (regarding plain meaning rule of statutory interpretation).⁶ The material fact of the test result is related to Sauerwein's treatment of Christina, and Anaya Gomez should be found to have met the burden of establishing the first element, creating a jury question on this issue.⁷

(b) Patient consent to treatment while unaware of material fact relating to treatment: Christina accepts plan for follow-up appointment without knowledge of test result.

The second element of an informed consent claim is “[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)(b). There seems to be little or no dispute that Christina accepted Sauerwein's follow-up appointment plan while unaware of the test result indicating a

determination”); Harbeson at 470 (stating “[t]he duty to impart material information is not limited by the customs or standards of other practitioners in the community”).

⁶ Sauerwein describes his actions as “a plan,” Sauerwein Br. at 8, but he also argues that this is a “misdiagnosis” case and that “diagnosis” is distinct from “treatment,” Sauerwein Supp. Br. at 14-19. This argument should be rejected. The term “diagnosis” does not appear in RCW 7.70.050, and plain common sense suggests diagnosis is related to treatment provided during the course of the physician-patient relationship. See Gates, 92 Wn.2d at 250 (stating patient’s right to know not confined to post-diagnosis stage of treatment; involving common law informed consent claim). Sauerwein's misdiagnosis argument is otherwise addressed in §C, infra.

⁷ Under RCW 7.70.050 and the underlying principle of patient sovereignty, all of the factors that Sauerwein urges were proper considerations for his determination not to tell Christina about the test result are those he should have shared with her in a conversation *after* he disclosed the test result. Understandably, he would have discussed concerns about contamination of the test, her compromised health, the dangers of immediate treatment before final verification of the blood test, and any number of other factors that he or Christina found relevant.

potentially life-threatening condition. See Estate Supp. Br. at 1; Sauerwein Supp. Br. at 16. There is nothing in the briefing to suggest otherwise. There appears to be a jury question on this element.

(c) Whether the reasonably prudent patient in Christina's circumstances would not have consented to Sauerwein's treatment if informed of the test result is a jury question.

The third element of an informed consent claim is "[t]hat a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts." RCW 7.70.050(1)(c). What the hypothetical reasonably prudent patient would do under these circumstances is ordinarily a question of fact. See Backlund at 667-68. This objective determination may include consideration of "the situation of the patient, i.e., his or her medical condition, age, risk factors, etc.," along with "the risks of the treatment and any material risks regarding treatment alternatives." Id. at 667. These latter considerations may require expert testimony. See id. at 664.⁸

The briefing before the Court reflects conflicting expert testimony on whether other treatment options existed, had Christina been told of the test result and been given the opportunity to choose what to do in response to Sauerwein's plan. Compare Estate Br. at 6-7 & Estate Supp. Br. at 4 and n.1, with Sauerwein Resp. to Pet. for Rev. at 10, 14, 16-19.

⁸ In determining what the reasonably prudent patient would have done under the circumstances, the jury is not bound to conclude a fully informed patient would have necessarily followed the treating health care provider's advice. See Backlund at 659-60, 669 n.6. This is true even when a particular health care provider's treatment is found to be within the standard of care, and he or she prevails in the negligence claim. See id. at 659-60.

Consequently, whether Anaya Gomez met the third element of the informed consent claim appears to be a matter for the jury.

(d) Whether Sauerwein's treatment of Christina proximately caused her death was a question for the jury.

The final element of an informed consent claim is "[t]hat the treatment in question proximately caused injury to the patient." RCW 7.70.050(1)(d). This question appears to be a proper subject for expert medical opinion. See RCW 7.70.050(3)(d) (requiring expert testimony regarding the anticipated benefits of alternative forms of treatment). Here, the briefing reflects a difference of opinion between medical experts on whether Christina would have lived had she chosen an alternative treatment. Compare Estate Supp. Br. at 4 and n.1, with Sauerwein Resp. to Pet. for Rev. at 10, 14, 16-19. The issue of proximate cause should be for the jury.

* * *

Anaya Gomez appears to have presented sufficient evidence to the trial court to submit the informed consent claim to the jury. If so, the question remains whether the court nevertheless was correct in dismissing the claim on grounds that Washington's decisional law exempts cases of "misdiagnosis" or "failure to diagnose" from the informed consent statute. See Sauerwein Supp. Br. at 10-20. This issue is addressed in §C.

C. The Trial Court And Court Of Appeals Erred In Concluding That Informed Consent Is Inapplicable, Based On The Characterization Of Sauerwein's Failure To Inform Christina Of Her Preliminary Blood Test Result As A "Misdiagnoses" Or "Failure To Diagnose."

The trial court and the Court of Appeals concluded that informed consent is inapplicable to a physician's misdiagnosis or failure to diagnose. Misdiagnosis and failure to diagnose are not free-standing exceptions to the informed consent statute, and there is no distinction between material facts learned during the process of diagnoses and other material facts relating to treatment. Instead, the categories of misdiagnosis and failure to diagnose represent a shorthand way of expressing the principle that *a health care provider does not have a duty to disclose facts of which he or she is unaware*. This principle is implicit in the first element of an informed consent claim, requiring proof "[t]hat the health care provider failed to inform the patient of a material fact or facts relating to the treatment[.]" RCW 7.70.050(1)(a) (brackets added); accord 6 Wash. Prac., Wash. Pattern Jury Instr. Civ. WPI 105.04-.05 & cmts. (6th ed.). This principle also explains and harmonizes this Court's decisions in Gates, Keogan and Backlund.

In Gates, the Court held that there was a jury question whether an ophthalmologist was subject to liability for lack of informed consent, based in part on his failure to disclose a test result indicating that the plaintiff was on the borderline for glaucoma. See 92 Wn.2d at 248-51. The parties in Gates did not dispute that the ophthalmologist was aware of the

test result indicating an abnormality. In rejecting the ophthalmologist's argument that the duty to disclose does not extend to diagnostic procedures, the Court stated that "[t]he physician's duty of disclosure arises ... whenever the doctor becomes aware of an abnormality which may indicate risk or danger." Id. at 251.

In Keogan, the Court held that a physician did not have a duty of disclosure, and was not, therefore, subject to liability for lack of informed consent, under circumstances where he "had become aware of no bodily abnormality in his patient." 95 Wn.2d at 330 (Hicks, J., concurring in part & dissenting in part).⁹ The physician diagnosed his patient with inflammation of the cartilage connecting the ribs to the sternum, based on the patient's complaints of chest pain and certain test results. See id. at 331. Although the physician had "[a] suspicion of a possibility of an abnormality," i.e., angina pectoris, there were no test results suggesting this diagnosis. Id. at 330. As a consequence, unlike the glaucoma test in Gates, there was nothing for the physician to disclose to his patient. See Keogan at 330 (Hicks, J., stating "when there is no diagnosis nor diagnostic procedure involving risk to the patient, there is nothing the doctor can put to the patient in the way of an intelligent and informed choice"; internal quotation omitted).¹⁰ Otherwise, the majority in Keogan

⁹ As the Court of Appeals correctly notes, the concurrence/dissent by Justice Hicks, joined by four other justices, represents the holding of the Court on the issue of informed consent. See Anaya Gomez at 383.

¹⁰ It appears from the Court of Appeals decision in Keogan that the physician was aware of "slightly abnormal" results of cardiac enzyme tests, but he discussed these results with the patient. Keogan v. Holy Family Hospital, 22 Wn. App. 366, 368, 589 P.2d 310 (1979), *rev'd*, 95 Wn.2d 306, 622 P.2d 1246 (1980).

cited Gates with approval for the proposition that "a physician has a duty of disclosure whenever he becomes aware of a bodily abnormality which may indicate risk or danger, whether or not the diagnosis has been completed." Id. at 329.¹¹

Lastly, in Backlund, this Court held that a jury determination that a physician complied with the standard of care does not, as a matter of law, preclude a claim against the physician for failure to obtain informed consent. See 137 Wn.2d at 659-63. As part of this holding, the Court describes the circumstances giving rise to a duty to obtain informed consent: "[w]henver a physician *becomes aware* of a condition which indicates risk to the patient's health, he has a duty to disclose it." Id. at 660 (emphasis in original; internal quotation omitted). The Court distinguished circumstances under which a duty to disclose is not imposed: "[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." Id. at 661 (emphasis added; footnote omitted).¹² Under the facts of Backlund, the physician treated an infant's jaundice with phototherapy, and did not disclose to the infant's parents an

¹¹ The Court of Appeals below stated "that *Gates* has either been abrogated or limited to its facts by *Keogan*[" Anaya Gomez at 385. This statement cannot be reconciled with Justice Hicks' favorable citation of *Gates* in *Keogan*.

¹² The Court of Appeals describes this part of Backlund as dicta "because the court rejected the defense argument that the negligence at issue was misdiagnosis." Anaya Gomez at 379. This is incorrect because the statement of the circumstances supporting a claim for informed consent is necessary to the holding that a finding of no negligence does not preclude such a claim.

alternate treatment involving blood transfusions. The Court held that this created a jury question whether the physician sufficiently informed the parents of the risks and alternatives of the phototherapy treatment in the absence of facts "suggesting [the physician] was *unaware* of the transfusion alternative." *Id.* at 662 (brackets & emphasis added; footnote omitted).¹³

The organizing principle of Gates, Keogan and Backlund is not some formalistic distinction between misdiagnosis or failure to diagnose and other types of cases, but rather the common sense notion, grounded in the text of the informed consent statute, that *a health care provider does not have a duty to disclose facts of which he or she is unaware.*¹⁴

¹³ Ultimately, the Court in Backlund found that there was a failure of proof regarding the third element of informed consent, i.e., whether a reasonably prudent patient under similar circumstances would have consented to treatment. See 137 Wn.2d at 669-70.

¹⁴ The Court of Appeals cases discussed by the parties and the opinion below can be reconciled with this Court's jurisprudence, with one exception. In Burnet v. Spokane Ambulance, 54 Wn.App. 162, 168, 772 P.2d 1027, review denied, 113 Wn.2d 1005 (1989), the court cited Keogan for the proposition that "[w]henver a physician *becomes aware* of a condition which indicates a risk to the patient's health, he has a duty to disclose it." (Emphasis in original.) Under the facts of Burnet, it was undisputed that the physician was unaware of the patient's condition. See 54 Wn.App. at 169.

In Bays v. St. Luke's Hosp., 63 Wn.App. 876, 880, 825 P.2d 319, review denied, 119 Wn.2d 1008 (1992), the court cited Keogan and Gates for the proposition that "[a] physician has a duty to disclose an abnormality which may indicate risk or danger in the patient's body." Under the facts of Bays, the patient claimed that the physician had a duty to disclose all possible methods of treating thromboembolism because it was one of four medical problems that were included in the physician's differential diagnosis. See 63 Wn.App. at 881. However, the X-ray ordered by the physician to confirm the diagnosis was negative, see *id.* at 879; as a result, the court applied the principle that the duty to disclose methods of treating the condition "does not arise until the physician becomes aware of the condition by diagnosing it," *id.* at 881. Presumably, the result would have been different if the X-ray had been positive and was not disclosed.

In Thomas v. Wilfac, Inc., 65 Wn.App. 255, 258-61 828 P.2d 597, review denied, 119 Wn.2d 1020 (1992), the plaintiff alleged that the physician failed to obtain informed consent relating to treatment for pesticide poisoning, even though the physician did not make that diagnosis but instead diagnosed the plaintiff with asthma. The court understandably rejected the plaintiff's contention that the physician had to disclose a diagnosis he did not make and obtain informed consent relating to treatment he did not provide. There is nothing comparable in Thomas to Christina's test result.

The dispute between the parties actually rests upon competing views of the material fact in question. Anaya Gomez views the material fact as the positive preliminary test result indicating a potentially fatal fungal infection, and argues that Sauerwein violated his duty to disclose and obtain informed consent because he was admittedly aware of the test result.

Sauerwein, on the other hand, appears to view the material fact as the actual existence of a fungal infection. He reasons that he did not breach his duty to disclose and obtain informed consent when he composed his treatment plan because the test result was preliminary and he reasonably believed that it was a false positive, based on the likelihood of contamination and Christina's condition, as reported by the nurse who spoke with her. See e.g., Sauerwein Supp. Br. at 19-20.

Sauerwein's insistence that the preliminary nature of the test result relieves him of any duty to disclose is not grounded in the text of the informed consent statute, and would appear to exempt a significant amount of material information from the ambit of the statute. If a fact is

Finally, in Gustav v. Seattle Urological Assocs., 90 Wn. App. 785, 789-90 & n.4, 954 P.2d 319, *review denied*, 136 Wn.2d 1023 (1998), the majority opinion appears to make a distinction between diagnosis and treatment, and hold that informed consent does not apply to diagnosis. However, it appears from the dissent that a biopsy performed at the physician's request was incomplete and that the physician later learned that he had misinterpreted certain lab reports. See id. at 792-96 (Becker, J., dissenting). While the physician discussed the biopsy and the lab reports with the patient, he did not disclose the limited nature of the biopsy, nor did he disclose the misinterpretation of the lab reports after he learned about it.

In sum, Burnet, Bays and Thomas are consistent with this Court's cases. To the extent Gustav is inconsistent, it should be disapproved.

material, it should not matter how it is characterized by the health care provider, whether preliminary, final or something else.

Furthermore, Sauerwein's focus on his own belief that the test result was a false positive, reasonable or not, is at odds with the patient-centered perspective that is the touchstone of an informed consent claim. See Smith v. Shannon, 100 Wn.2d at 30 (stating "[t]o allow physicians, rather than patients, to determine what information should be disclosed would be in direct conflict with the underlying principle of patient sovereignty"); Backlund at 660 (recognizing "[i]nformed consent focuses on the patient's right to know his bodily condition and to decide what should be done"; internal quotation omitted). It also seems to conflate the issue of informed consent with the separate question of whether Sauerwein was negligent. See id. at 659.

Anaya Gomez correctly focuses on the test result itself as the material fact in question under the informed consent statute. This is in keeping with the principle of patient sovereignty and the patient's right to chart his or her own destiny. See Miller, 11 Wn. App. at 282. As explained in Backlund at 663:

A patient must be given sufficient information to make an informed health care decision. *Shannon*, 100 Wn.2d at 29. Accordingly, "it is for the patient to evaluate the risks of treatment and that the only role to be played by the physician is to provide the patient with information as to what those risks are." *Id.* at 30.

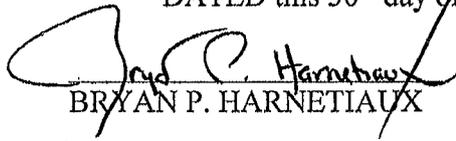
In order for the patient to participate meaningfully in health care decisions, all serious test results—and especially a preliminary test result

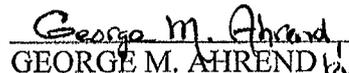
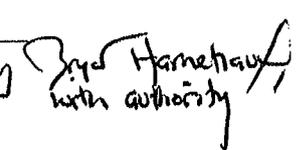
indicating a life-threatening condition—must be disclosed. It should not matter whether the test result is preliminary or whether Sauerwein believed it was accurate. The jury should have been permitted to determine whether Sauerwein breached a duty to disclose the test result to Christina in order for her to participate meaningfully in her own health care.

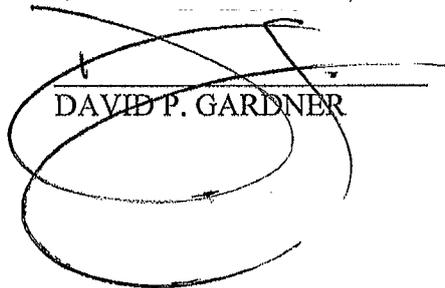
VI. CONCLUSION

The Court should adopt the analysis set forth in this brief and resolve this appeal accordingly.

DATED this 30th day of September, 2013.


BRYAN P. HARNETIAUX


GEORGE M. AHREND by 
with authority


DAVID P. GARDNER

On Behalf of WSAJ Foundation

Appendix

4.24.290. Action for damages based on professional negligence of hospitals or members of healing arts--Standard of proof--Evidence--Exception

In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts including, but not limited to, an East Asian medicine practitioner licensed under chapter 18.06 RCW, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatric physician and surgeon licensed under chapter 18.22 RCW, or a nurse licensed under chapter 18.79 RCW, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession, and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

[2010 c 286 § 12, eff. June 10, 2010; 1995 c 323 § 2; 1994 sp.s. c 9 § 702; 1985 c 326 § 26; 1983 c 149 § 1; 1975 1st ex.s. c 35 § 1.]

7.70.010. Declaration of modification of actions for damages based upon injuries resulting from health care

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in RCW 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care which is provided after June 25, 1976.

[1975-'76 2nd ex.s. c 56 § 6.]

7.70.020. Definitions

As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services including, but not limited to, an East Asian medicine practitioner, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician assistant, midwife, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care

paramedic, including, in the event such person is deceased, his or her estate or personal representative;

(2) An employee or agent of a person described in part (1) above, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

[2010 c 286 § 13, eff. June 10, 2010; 1995 c 323 § 3; 1985 c 326 § 27; 1981 c 53 § 1; 1975-'76 2nd ex.s. c 56 § 7.]

7.70.030. Propositions required to be established--Burden of proof

No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

(1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;

(2) That a health care provider promised the patient or his or her representative that the injury suffered would not occur;

(3) That injury resulted from health care to which the patient or his or her representative did not consent.

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence.

[2011 c 336 § 250, eff. July 22, 2011; 1975-'76 2nd ex.s. c 56 § 8.]

7.70.040. Necessary elements of proof that injury resulted from failure to follow accepted standard of care

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

[2011 c 336 § 251, eff. July 22, 2011; 1983 c 149 § 2; 1975-'76 2nd ex.s. c 56 § 9.]

7.70.050. Failure to secure informed consent--Necessary elements of proof--Emergency situations

(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 or her 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.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his or her representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his or her consent to required treatment will be implied.

[2011 c 336 § 252, eff. July 22, 2011; 1975-'76 2nd ex.s. c 56 § 10.]

7.70.060. Consent form--Contents--Prima facie evidence--Shared decision making--Patient decision aid--Failure to use

(1) If a patient while legally competent, or his or her representative if he or she is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and

the patient has the burden of rebutting this by a preponderance of the evidence:

(a) A description, in language the patient could reasonably be expected to understand, of:

- (i) The nature and character of the proposed treatment;
- (ii) The anticipated results of the proposed treatment;
- (iii) The recognized possible alternative forms of treatment; and
- (iv) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

(b) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in (a) of this subsection.

(2) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgment of shared decision making as described in this section, such acknowledgment shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by clear and convincing evidence. An acknowledgment of shared decision making shall include:

(a) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of meeting the informed consent requirements set forth by laws, accreditation standards, and other mandates;

(b) A brief description of the services that the patient and provider jointly have agreed will be furnished;

(c) A brief description of the patient decision aid or aids that have been used by the patient and provider to address the needs for (i) high-quality, up-to-date information about the condition, including risk and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes; (ii) values clarification to help patients sort out their values and preferences; and (iii) guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process;

(d) A statement that the patient or his or her representative understands: The risk or seriousness of the disease or condition to be prevented or treated; the available treatment alternatives, including nontreatment; and the risks, benefits, and uncertainties of the treatment alternatives, including nontreatment; and

(e) A statement certifying that the patient or his or her representative has had the opportunity to ask the provider questions, and to have any questions answered to the patient's satisfaction, and indicating the patient's intent to receive the identified services.

(3) As used in this section, "shared decision making" means a process in which the physician or other health care practitioner discusses with the patient or his or her representative the information specified in subsection (2) of this section with the use of a patient decision aid and the patient

shares with the provider such relevant personal information as might make one treatment or side effect more or less tolerable than others.

(4)(a) As used in this section, "patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the condition and treatment options, benefits, and harms, including, if appropriate, a discussion of the limits of scientific knowledge about outcomes, for any medical condition or procedure, including abortion as defined in RCW 9.02.170 and:

(i)(A) That is certified by one or more national certifying organizations recognized by the medical director of the health care authority; or

(B) That has been evaluated based on the international patient decision aid standards by an organization located in the United States or Canada and has a current overall score satisfactory to the medical director of the health care authority; or

(ii) That, if a current evaluation is not available from an organization located in the United States or Canada, the medical director of the health care authority has independently assessed and certified based on the international patient decision aid standards.

(b) The health care authority may charge a fee to the certification applicant to defray the costs of the assessment and certification under this subsection.

(5) Failure to use a form or to engage in shared decision making, with or without the use of a patient decision aid, shall not be admissible as evidence of failure to obtain informed consent. There shall be no liability, civil or otherwise, resulting from a health care provider choosing either the signed consent form set forth in subsection (1)(a) of this section or the signed acknowledgment of shared decision making as set forth in subsection (2) of this section.

[2012 c 101 § 1, eff. June 7, 2012; 2007 c 259 § 3, eff. July 22, 2007; 1975-'76 2nd ex.s. c 56 § 11.]

7.70.065. Informed consent--Persons authorized to provide for patients who are not competent--Priority

(1) Informed consent for health care for a patient who is not competent, as defined in RCW 11.88.010(1)(e), to consent may be obtained from a person authorized to consent on behalf of such patient.

(a) Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent, based upon a reason other than incapacity as defined in RCW 11.88.010(1)(d), shall be a member of one of the following classes of persons in the following order of priority:

(i) The appointed guardian of the patient, if any;

(ii) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;

- (iii) The patient's spouse or state registered domestic partner;
 - (iv) Children of the patient who are at least eighteen years of age;
 - (v) Parents of the patient; and
 - (vi) Adult brothers and sisters of the patient.
- (b) If the health care provider seeking informed consent for proposed health care of the patient who is not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:
- (i) If a person of higher priority under this section has refused to give such authorization; or
 - (ii) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.
- (c) Before any person authorized to provide informed consent on behalf of a patient not competent to consent under RCW 11.88.010(1)(e), other than a person determined to be incapacitated because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.
- (2) Informed consent for health care, including mental health care, for a patient who is not competent, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, may be obtained from a person authorized to consent on behalf of such a patient.
- (a) Persons authorized to provide informed consent to health care, including mental health care, on behalf of a patient who is incapacitated, as defined in RCW 11.88.010(1)(e), because he or she is under the age of majority and who is not otherwise authorized to provide informed consent, shall be a member of one of the following classes of persons in the following order of priority:
- (i) The appointed guardian, or legal custodian authorized pursuant to Title 26 RCW, of the minor patient, if any;
 - (ii) A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to chapter 13.32A or 13.34 RCW, if any;
 - (iii) Parents of the minor patient;
 - (iv) The individual, if any, to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; and

(v) A competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient. Such declaration shall be effective for up to six months from the date of the declaration.

(b) A health care provider may, but is not required to, rely on the representations or declaration of a person claiming to be a relative responsible for the care of the minor patient, under (a)(v) of this subsection, if the health care provider does not have actual notice of the falsity of any of the statements made by the person claiming to be a relative responsible for the health care of the minor patient.

(c) A health care facility or a health care provider may, in its discretion, require documentation of a person's claimed status as being a relative responsible for the health care of the minor patient. However, there is no obligation to require such documentation.

(d) The health care provider or health care facility where services are rendered shall be immune from suit in any action, civil or criminal, or from professional or other disciplinary action when such reliance is based on a declaration signed under penalty of perjury pursuant to RCW 9A.72.085 stating that the adult person is a relative responsible for the health care of the minor patient under (a)(v) of this subsection.

(3) For the purposes of this section, "health care," "health care provider," and "health care facility" shall be defined as established in RCW 70.02.010.

[2007 c 156 § 11, eff. July 22, 2007; 2006 c 93 § 1, eff. June 7, 2006; 2005 c 440 § 2, eff. July 24, 2005; 2003 c 283 § 29, eff. July 27, 2003; 1987 c 162 § 1.]

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Dear Mr. Carpenter,

Attached is the Washington State Association for Justice Foundation brief of amicus curiae for filing. The amicus request is pending at this time.

Electronic service is being effected by email on counsel per prior arrangement, as reflected in our letter request for amicus status.

Respectfully submitted,

Bryan Harnetiaux, WSBA #5169
On Behalf of the Washington State Association for Justice Foundation