

FILED

JAN 10 2013

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 88307-6

IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

Court of Appeals No. 30098-6-III

RODOLFO ANAYA-GOMEZ,
as personal representative of the estate of Christina Palma-Anaya,
deceased,

Petitioner,

v.

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

Respondents.

FILED
JAN 16 2013
CLERK OF THE SUPREME COURT
STATE OF WASHINGTON

PETITION FOR REVIEW

Richard R. Johnson, WSBA #6481
DELORIE-JOHNSON, P.L.L.C.
917 Triple Crown Way #200
Yakima, Washington 98908
Telephone: (509) 469-6900

Ian S. Birk, WSBA #31431
Benjamin Gould, WSBA #44093
Isaac Ruiz, WSBA #35237
Harry Williams IV, WSBA #41020
KELLER ROHRBACK L.L.P.
1201 Third Avenue, Suite 3200
Seattle, Washington 98101
Telephone: (206) 623-1900

Attorneys for Petitioner

ORIGINAL

TABLE OF CONTENTS

IDENTITY OF PETITIONER..... - 2 -

CITATION TO COURT OF APPEALS DECISION..... - 2 -

ISSUE PRESENTED FOR REVIEW - 2 -

STATEMENT OF FACTS AND PROCEDURE..... - 3 -

 I. Facts - 3 -

 A. Christina Anaya’s blood tests positive for fungus, but Dr. Mark Sauerwein does not share that test result with her. - 3 -

 B. Ms. Anaya’s fungal infection leads to her death..... - 5 -

 II. Procedural history - 6 -

SUMMARY OF ARGUMENT - 7 -

ARGUMENT..... - 9 -

 I. The Court of Appeals’ decision, by its own admission, conflicts with this Court’s decision in *Gates v. Jensen*. - 9 -

 A. Under *Gates*, Ms. Anaya has a valid claim for lack of informed consent. - 9 -

 B. Only the Supreme Court, not the Court of Appeals, has the authority to determine that Supreme Court precedent is no longer binding. - 10 -

 II. The decision below raises issues of substantial public interest by diverging from *Gates*’s central holding: that physicians must disclose material test results of which they are aware. - 12 -

III. The Court of Appeals' decision conflicts
with this Court's decision in *Backlund*.- 14 -

IV. The other cases on which the Court of
Appeals relied do not call *Gates* into
question or support the Court of Appeals'
decision.- 17 -

CONCLUSION.....- 19 -

TABLE OF AUTHORITIES

State Cases

<i>1000 Va. Ltd. P'ship v. Vertecs Corp.</i> , 158 Wn.2d 566, 146 P.2d 423 (2006).....	11
<i>Archer v. Galbraith</i> , 18 Wn. App. 369, 567 P.2d 1155 (1977).....	16
<i>Backlund v. University of Washington</i> , 137 Wn.2d 651, 975 P.2d 950 (1999).....	passim
<i>Bays v. St. Lukes Hospi</i> , tal, 63 Wn. App. 876, 825 P.2d 319, review denied, 119 Wn.2d 1008, 833 P.2d 387 (1992).....	18
<i>Burnet v. Spokane Ambulance</i> , 54 Wn. App. 162, 772 P.2d 1027, review denied, 113 Wn.2d 1005, 777 P.2d 1050 (1989).....	19
<i>Davis v. Microsoft Corp.</i> , 149 Wn.2d 521, 70 P.3d 126 (2003).....	3
<i>Gates v. Jensen</i> , 92 Wn.2d 246, 595 P.2d 919 (1979).....	passim
<i>Gustav v. Seattle Urological Associates</i> , 90 Wn. App. 785, 954 P.2d 319, review denied, 136 Wn.2d 1023, 969 P.2d 1064 (1998).....	19
<i>Keogan v. Holy Family Hospital</i> , 95 Wn.2d 306, 622 P.2d 1246 (1980).....	7, 17, 18
<i>Matia Contractors, Inc. v. City of Bellingham</i> , 144 Wn. App. 445, 183 P.3d 1082 (2008).....	11
<i>Smith v. Shannon</i> , 100 Wn.2d 26, 666 P.2d 351 (1983).....	12, 13
<i>State v. Studd</i> , 137 Wn.2d 533, 973 P.2d 1049 (1999).....	11

Stewart-Graves v. Vaughn,
162 Wn.2d 115, 170 P.3d 1151 (2007)..... 12

Thomas v. Wilfac, Inc.,
65 Wn. App. 255, 828 P.2d 597, review denied, 119
Wn.2d 1010, 838 P.2d 692 (1992)..... 18, 19

State Statutes

RCW 7.70.050(1)..... 12

RCW 7.70.050(2)..... 12

IDENTITY OF PETITIONER

Rodolfo Anaya-Gomez, Plaintiff below, is the personal representative of the estate of his widow, Christina Palma-Anaya. He seeks review of a published decision of the Court of Appeals, Division Three, dismissing his informed-consent claim as a matter of law.

CITATION TO COURT OF APPEALS DECISION

The published decision of the Court of Appeals was filed on December 11, 2012, and is attached as Appendix A to this Petition.

ISSUE PRESENTED FOR REVIEW

Defendant Mark Sauerwein, M.D., learned that Plaintiff Christina Anaya's blood tested positive for a fungal infection. Dr. Sauerwein did not inform Ms. Anaya of the test result. He decided not to treat Ms. Anaya for a fungal infection because of his belief that the test could be a false positive. But the test was correct. Because of the delay in treatment, Ms. Anaya died of preventable fungal sepsis.

Gates v. Jensen, 92 Wn.2d 246, 595 P.2d 919 (1979) holds—on indistinguishable facts—that a patient who is not informed of a positive test result has a valid claim for lack of informed consent. Here, the Court of Appeals erred by declining to follow *Gates* and granting Dr. Sauerwein judgment as a matter of law even though he had excluded Ms. Anaya from participating in the decision to delay treatment of her life-threatening

illness. The decision of the Court of Appeals violates the principle that patients must be informed of facts material to their health care.

The issue presented is:

Must a patient be informed of a medical test result showing that the patient may have a serious—in this case, potentially fatal—condition?

STATEMENT OF FACTS AND PROCEDURE

I. Facts

The relevant facts are largely undisputed.¹

A. Christina Anaya's blood tests positive for fungus, but Dr. Mark Sauerwein does not share that test result with her.

Christina Anaya, a married mother of two, came to Toppenish Community Hospital in late August 2006, complaining of urinary tract symptoms. (6/7/11 RP 49:990–93, 126:2473–80.) A urine culture was taken, and her blood was drawn for laboratory testing. The urine culture tested positive for bacteria. (*Id.* at 56:1116–18.) Ms. Anaya was treated for a bacterial infection and discharged the next day. (*Id.* at 48:971–72, 56:1119–57:1141.) Two days later she was back in the Hospital, not feeling well and unable to urinate. (*Id.* at 62:1238–45.) She was catheterized, which allowed her to empty her bladder. (*Id.*)

¹ When reviewing a judgment granted as a matter of law, the court views the evidence in the light most favorable to the nonmoving party. *See, e.g., Davis v. Microsoft Corp.*, 149 Wn.2d 521, 531, 70 P.3d 126 (2003).

On August 24, four days after Ms. Anaya's blood was taken for testing, the laboratory reported the results to the Yakima Valley Farm Workers Clinic, where Ms. Anaya usually received primary care. (*Id.* at 44:891–92; 48:962–70.) The blood test was positive for yeast, a type of fungus. (*Id.* at 48:962–70, 52:1047–52.) The positive result was relayed to Defendant Dr. Mark Sauerwein. (*Id.* at 53:1056–59.)

Dr. Sauerwein testified that the positive test result for yeast made him “concerned.” (6/10/11 RP at 76:1514.) Because Ms. Anaya suffered from poorly controlled diabetes, her immune system was compromised and she was more vulnerable to infection. (6/7/11 RP 74:1470–75:1477, 88:1742–49.) Dr. Sauerwein learned of her diabetes on the same day that he received the positive blood test. (*Id.* at 65:1298–301.)

Dr. Sauerwein called Dr. John Moran, an internist who had treated Ms. Anaya at the Hospital. (*Id.* at 55:1094–1113; 6/10/11 RP 78:1557–79:1569.) The doctors discussed the test result and came up with a plan. Dr. Sauerwein would have a nurse contact Ms. Anaya. (6/10/11 RP 79:1565–80:1584, 83:1641–47.) If she did not report feeling sick, Dr. Sauerwein would treat the positive result for yeast as a “probable contaminant”—a false positive—even though false positives for yeast are almost nonexistent. (6/7/11 RP 58:1154; 6/8/11 RP 29:552–59; 6/10/11 RP 80:1581–84.) But if she *did* report feeling sick, Dr. Sauerwein would

have her come into the clinic and would take “further action.” (6/10/11 RP 80:1584.)

When the nurse called Ms. Anaya, she told the nurse what had taken place the night before: she had visited the Hospital a second time, had been catheterized, had emptied her bladder, and had felt much better after that. (6/7/11 RP 62:1243–63:1246, 64:1271–74.) This information was reported back to Dr. Sauerwein. (*Id.* at 65:1300–01.) Sticking to his plan, he took no further action at that time. He evidently remained concerned, though, for after learning that Ms. Anaya’s next appointment was scheduled for September 5—in about two weeks—he concluded that date was “too far out.” (*Id.* at 66:1305–10.) He had the Clinic contact her and reschedule her appointment for the next week. (*Id.*)

At no time, however, did Dr. Sauerwein inform Ms. Anaya of the positive blood test. (*Id.* at 67:1336–1348.) Nor did he ask anyone else to inform her of the positive blood test. (*Id.* at 68:1349–69:1369.)

B. Ms. Anaya’s fungal infection leads to her death.

By the next week, the symptoms of Ms. Anaya’s fungal infection had worsened. (6/7/11 RP 139:2726–29.) After being admitted to the hospital on August 29, her urine tested positive for yeast. (App. B at 4.) She was treated with antifungal medication. (6/7/11 RP 142:2775–79.)

At first, her condition seemed to improve, but she soon went into respiratory failure and was transferred to the intensive care unit. (*Id.* at 142:2780–144:2814; App. B at 4.) There she was diagnosed with fungal sepsis, which is the body’s reaction to an overwhelming fungal infection. (6/7/11 RP 73:1473–43; App. B at 4.) As a result of her fungal sepsis, Ms. Anaya suffered cardiac arrests and lack of oxygen to her brain. (6/7/11 RP 73:1447–49; App. B at 4.) Starved of oxygen, her brain died. Ms. Anaya passed away on November 17, 2006, at the age of 32. (App. B. at 4; App. C.)

II. Procedural history

Rodolfo Anaya, Christina Anaya’s widower and the personal representative of her estate, filed this action against Dr. Sauerwein and the Clinic. He asserted medical negligence, and, by trial amendment, asserted a claim that Defendants had violated Ms. Anaya’s right to informed consent by failing to inform her about the positive blood test for yeast. (CP 34–35.) At the close of evidence, however, the trial court granted the defense’s motion to dismiss the informed-consent claim as a matter of law. (6/9/11 RP 69:1343–49.) The jury returned a special verdict in Defendants’ favor on the negligence claim, finding that they had not breached the standard of care, without reaching the other elements of the claim. (CP 108–10.)

Mr. Anaya appealed the dismissal of his informed-consent claim, and the Court of Appeals affirmed in a published opinion. It agreed with Mr. Anaya that under *Gates v. Jensen*, 92 Wn.2d 246, a doctor who is aware of test results suggesting a dangerous bodily abnormality must inform the patient of those results. (App. A at 17.) Thus, under *Gates*, Mr. Anaya had a valid informed-consent claim, since Dr. Sauerwein was aware of the positive blood test for yeast—a test that indicated a fungal infection—but failed to tell Ms. Anaya about it. (*Id.*) But the Court of Appeals concluded that *Gates* had been “abrogated” or “overruled sub silentio” by two later cases, *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980), and *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999). (App. A at 18.) The Court of Appeals also believed that three lower court decisions foreclosed the informed-consent claim. (*Id.* at 11–13, 18.) According to the Court of Appeals, the Supreme Court’s “denial of review” of those three decisions showed that *Gates* had been silently overruled. (*Id.* at 18.)

SUMMARY OF ARGUMENT

The Court of Appeals held that Dr. Sauerwein had no duty to disclose the positive test result when determining a course of treatment. For four reasons, that erroneous conclusion merits this Court’s review.

First, to reach that conclusion, the Court of Appeals had to hold that this Court's indistinguishable decision in *Gates v. Jensen* has been silently overruled. The lower court's nullification of one of this Court's decisions cries out for review.

Second, in deeming *Gates* a nullity, the Court of Appeals undermined the principle that patients are entitled to control their own treatment decisions. Under Washington's informed-consent law, a doctor must disclose any fact that a reasonably prudent patient would consider material. The Court of Appeals' decision is erroneous because it allows a doctor to withhold a positive test result even when a patient would consider it material, based simply on the doctor's unilateral judgment that the test result might be wrong.

Third, the Court of Appeals erred by relying on this Court's decision in *Backlund*, a case that actually *supports* the informed-consent claim here. The Court of Appeals' decision conflicts not only with *Gates* but also with *Backlund*.

Fourth, none of the other precedents on which the Court of Appeals relied abrogate *Gates* or support the decision below. No Washington court has ever held that a physician aware of an alarming test result may withhold it based solely on his subjective judgment that the result may be incorrect.

ARGUMENT

I. The Court of Appeals' decision, by its own admission, conflicts with this Court's decision in *Gates v. Jensen*.

The Court of Appeals acknowledged that this case was indistinguishable from *Gates v. Jensen* but held that *Gates* had been overruled by implication. (App. A at 17–18.) Review of this holding is warranted under RAP 13.4(b)(1).

A. Under *Gates*, Ms. Anaya has a valid claim for lack of informed consent.

In *Gates*, the patient visited an ophthalmologist, complaining of difficulties with her vision. The ophthalmologist measured the pressure in her eye, which was high enough to be “in the borderline area for glaucoma.” *Gates*, 92 Wn.2d at 247. While there were two other simple and inexpensive diagnostic tests for glaucoma, the ophthalmologist did not tell the patient about them; he instead treated the patient for problems with her contact lenses. *Id.* at 247–48. Without telling the patient about the high pressure in her eyes, he told the patient that he had “checked for glaucoma but found everything all right.” *Id.* at 248. The patient turned out to be in the early stages of glaucoma, which left her blind. *Id.* at 248–49.

In a unanimous decision on this issue, this Court stated that the patient had an informed-consent claim. The ophthalmologist should have informed her that she had high pressure in her eyes, putting her at risk for

glaucoma, and that there were “alternative diagnostic procedures” to determine whether she had glaucoma. *Id.* at 250–51. “The physician’s duty of disclosure arises,” said the Court, “whenever the doctor becomes aware of an abnormality which may indicate risk or danger.” *Id.* at 251; *see also id.* (patient has a right to know of the “presence of a high risk of disease”).

The Court of Appeals was right to say that *Gates* is precisely on point: both the ophthalmologist in *Gates* and Dr. Sauerwein here were “aware of test results suggesting an abnormality,” so under *Gates* Dr. Sauerwein had a duty to disclose the test results. (App. A at 17.) Yet the Court of Appeals concluded “that *Gates* has either been abrogated or limited to its facts by *Keogan*, or has been overruled sub silentio in light of the Supreme Court’s decision in *Backlund* and its denial of review of” three other Court of Appeals decisions. (*Id.* at 18.)

B. Only the Supreme Court, not the Court of Appeals, has the authority to determine that Supreme Court precedent is no longer binding.

The Court of Appeals was wrong to suggest that *Gates* had been silently overruled. No later precedent—other than the decision below—has called *Gates* into question. *See infra* Argument Parts III–IV. More fundamentally, though, the Court of Appeals should not have engaged in this inquiry at all.

Only the Supreme Court, and not the Court of Appeals, has authority to overrule Supreme Court precedent. The Supreme Court's decisions are "binding on all lower courts in this state," and the Court of Appeals errs when it "fails to follow directly controlling authority by this court." *1000 Va. Ltd. P'ship v. Vertecs Corp.*, 158 Wn.2d 566, 578, 146 P.2d 423 (2006). The Court of Appeals lacks the authority to hold that one of this Court's precedents has been silently overruled, *see id.*—especially since this Court will normally announce when it is overruling a precedent: "We will not overrule such binding precedent *sub silentio.*" *State v. Studd*, 137 Wn.2d 533, 548, 973 P.2d 1049 (1999). The Court of Appeals erred when it refused to follow *Gates*, a decision that it acknowledged was indistinguishable.

Even more troubling was the Court of Appeals' belief that this Court had overruled *Gates* merely by denying review in three cases. (App. A at 18.) Denial of discretionary review "has never been taken as an expression of the court's implicit acceptance of an appellate court's decision." *Matia Contractors, Inc. v. City of Bellingham*, 144 Wn. App. 445, 452, 183 P.3d 1082 (2008) (citing cases). If denials of review had precedential effect, this Court would be forced to give plenary review to every petition, lest denial of review create bad law. That result would be

contrary to the purpose of discretionary review, which is designed to allow the Court to give plenary review only to a select group of cases.

It has been half a decade since this Court has heard any informed-consent case, *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 170 P.3d 1151 (2007), and more than a decade since this Court has heard an informed-consent case that did not involve a medical emergency, *Backlund*, 137 Wn.2d 651. The Court of Appeals' decision presents an ideal vehicle for this Court's voice to be heard on informed consent once again. Review under RAP 13.4(b)(1) is warranted.

II. The decision below raises issues of substantial public interest by diverging from *Gates*'s central holding: that physicians must disclose material test results of which they are aware.

Gates held that an ophthalmologist who knew of test results indicating a risk of glaucoma had a duty to disclose those results. *Gates* holds that a positive test result indicating a serious health condition must be disclosed.

The patient's right to be informed of a test result turns on whether that result is "material." See RCW 7.70.050(1). Whether a fact is material, and thus required to be disclosed, is an objective test, see *Backlund*, 137 Wn.2d at 665–67, and is measured by the views of a reasonably prudent patient, and not a reasonable physician, RCW 7.70.050(2); *Smith v. Shannon*, 100 Wn.2d 26, 30, 666 P.2d 351 (1983). Any other rule would

undermine “patient sovereignty,” the “underlying principle” of Washington’s law of informed consent. *Smith*, 100 Wn.2d at 30. Because this principle holds that patients, and not physicians, are entitled to control their own treatment, *see Backlund*, 137 Wn.2d at 663, it is patients, and not physicians, who must “determine what information should be disclosed,” *Smith*, 100 Wn.2d at 30.

Here, the blood test results were material: Anaya’s test results indicated an objectively high level of risk that would have caused a reasonably prudent patient to seek different treatment.² (6/8/11 RP 29:552–59 (false positives rare); *id.* at 30:573–80 (expert testimony on importance of test result).) Under the Court of Appeals’ decision, however, Dr. Sauerwein’s unilateral judgment that the test could be a false positive exempted him from the duty to disclose. The decision measures informed consent not by the reasonably prudent patient, but by what a particular doctor, on his own, subjectively judges to be material. That is a novel rule with startling consequences. Because every test has a chance of being incorrect, the decision of the Court of Appeals would logically entitle physicians in Washington to withhold *any* test result. This threat to

² Contrary to an argument Dr. Sauerwein made to the Court of Appeals, there was also expert testimony that Dr. Sauerwein’s decision to treat the blood test as a false positive was the proximate cause of Ms. Anaya’s death. (6/7/11 RP 40:780–82 (“I think it’s pretty easy to say on a more probable than not basis, had she been treated on the 24th, like she should have been, that she would have survived.”).)

patient sovereignty raises issues of substantial public interest, and so warrants review under RAP 13.4(b)(4).

III. The Court of Appeals' decision conflicts with this Court's decision in *Backlund*.

To hold that *Gates* had been silently overruled, the Court of Appeals relied on *Backlund v. University of Washington*. (App. A at 18.) But it is the decision below, and not *Gates*, that conflicts with *Backlund*.

In *Backlund*, the infant patient suffered from elevated bilirubin. 137 Wn.2d at 654. The defendant physician elected to treat the patient with phototherapy, but did not inform the infant's parents of an alternative, more aggressive, and riskier treatment, blood transfusion. *Id.* at 655. Phototherapy was unsuccessful and the infant suffered severe brain damage from the elevated bilirubin. *Id.* A jury returned a verdict finding no negligence but deadlocked on the issue of informed consent. *Id.* The parties agreed to a bench trial on informed consent, after which the court entered judgment for the defendant on the merits. *Id.* at 655–58.

On appeal, the defense contended that the jury's finding of no negligence precluded the informed consent claim as a matter of law. The defendant relied on Washington cases holding generally that when a physician, through misdiagnosis, is unaware of a condition, the physician is not liable under the informed-consent law for failing to tell the patient

about that condition. The defendant in *Backlund* tried to characterize his failure to inform the plaintiffs of the blood transfusion alternative as a “misdiagnosis”—i.e., as a “decision that [the patient’s] condition was not so serious as to require transfusion instead of phototherapy.” *Id.* at 659.

This Court unanimously rejected this argument. Writing for the majority, Justice Talmadge summarized Washington law as holding that “[a] physician who misdiagnoses the patient’s condition, and is therefore unaware of an appropriate category of 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. While the defendant physician, “in his professional judgment, . . . did not believe [the patient] required a transfusion,” *id.* at 662, that did not turn *Backlund* into a misdiagnosis case. What mattered was whether the physician was *aware* of the alternative of transfusion but stayed silent about it—there were “no facts” in the case “suggesting [the physician] was unaware of the transfusion alternative.” *Id.* at 662. Hence a reasonable trier of fact could have found that the defendant violated the informed-consent law by failing to sufficiently inform the patient of risks and alternatives. *Id.*

Then-Justice Madsen, though in dissent, agreed with the majority’s “legal principles.” *Id.* at 670 (Madsen, J., dissenting). In particular, the

dissent agreed that the duty to disclose must be gauged from a reasonably prudent patient's point of view, and not from the doctor's. As the dissent noted, "even if a doctor's assessment of a particular risk is accurate, that does not mean that a reasonably prudent patient would not choose alternate treatment despite the risk." *Id.* at 672 (citing *Archer v. Galbraith*, 18 Wn. App. 369, 378, 567 P.2d 1155 (1977)).

The *Backlund* Court unanimously agreed that the doctor could not evade liability by characterizing his failure to disclose as a misdiagnosis. It reaffirmed *Gates*'s holding that a doctor's unilateral judgment about facts cannot shield him from the duty to disclose those facts so long as they would be material to a reasonably prudent patient.

The Court of Appeals' decision in this case cannot be squared with *Backlund*. Dr. Sauerwein is making the same argument that this Court rejected in *Backlund*. He is arguing that he cannot be liable for failing to inform Ms. Anaya of the positive test because his unilateral judgment about the test amounted to a "misdiagnosis." What Dr. Sauerwein ignores is that he was not "unaware" of the positive test result, just as in *Backlund* the defendant physician was not "unaware" of the alternative treatment.

Indeed, Dr. Sauerwein's own testimony demonstrates that he was aware of the test result: he testified that he was "concerned" about the positive test and actively exercised his professional judgment about the

course to take in response. (6/10/11 RP 76:1514.) Dr. Sauerwein asked for, and was given, the exercise-of-judgment instruction (6/14/11 RP 9:171–74), which is appropriate “only when the doctor is confronted with a choice among competing therapeutic techniques or among medical diagnoses.” 6 Washington Practice: Washington Pattern Jury Instructions: Civil 105.08 note on use (6th ed. 2012). The jury found that Dr. Sauerwein’s exercise of judgment was within the standard of care, but it does not follow that he was entitled to exercise that judgment unilaterally without telling his patient first.

This case presents a much more compelling informed-consent claim than did *Backlund*. Dr. Sauerwein admitted that he was aware of the positive blood test for yeast, and yet he did not merely fail to tell Ms. Anaya about “the risks associated with” a positive blood test for yeast, or about alternative treatments, *Backlund*, 137 Wn.2d at 655—he failed to tell her about the results of the test at all. Because the decision below conflicts with *Backlund*, review is warranted under RAP 13.4(b)(1).

IV. The other cases on which the Court of Appeals relied do not call *Gates* into question or support the Court of Appeals’ decision.

The Court of Appeals also erred in holding that *Gates* had been undermined by this Court’s decision in *Keogan v. Holy Family Hospital*, and by three other Court of Appeals decisions.

In *Keogan*, the patient's estate based its informed-consent claim on the fact that the physician had *not* performed any tests for angina. See *Keogan*, 95 Wn.2d at 312. The physician in *Keogan*, unlike Dr. Sauerwein, had no knowledge of a positive test result. So *Keogan* neither justifies Dr. Sauerwein's nondisclosure nor abrogates *Gates*'s holding that a positive test result indicating a serious health condition must be disclosed. *Keogan* was, after all, decided just a year after *Gates*, and all of the Justices who signed *Keogan*'s majority opinion on the informed-consent claim also joined the informed-consent holding of *Gates*. Compare *id.* at 329–32, with *Gates*, 92 Wn.2d at 254, 257.

The Court of Appeals also cited three lower court precedents, but none of these three decisions conflict with *Gates* or hold that a doctor may withhold a material test result based simply on the doctor's unilateral judgment about the result. In *Bays v. St. Lukes Hospital*, 63 Wn. App. 876, 825 P.2d 319, *review denied*, 119 Wn.2d 1008, 833 P.2d 387 (1992), the court simply held that a doctor had no duty to tell the patient about the risks of a medical condition when a test had come back *negative* for that condition. See *id.* at 879, 881-82. The patient did not contend that the doctor had failed to tell him about that negative test. Similarly, in *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 828 P.2d 597, *review denied*, 119 Wn.2d 1010, 838 P.2d 692 (1992), the doctor did not disclose the possibility that

the patient was suffering from pesticide poisoning rather than asthma—but the doctor had not become aware of any facts that suggested pesticide poisoning, and indeed had ruled out that possibility entirely. *See id.* at 258. Likewise 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 doctor was wholly unaware of the risks that he failed to disclose. *See id.* at 169 (“It is undisputed Dr. Graham was unaware of Tristen’s condition which implicated risk to her . . .”).³ None of these cases hold—indeed, no Washington case has ever held—that when a physician consciously learns of an objectively material test result, the physician may withhold that result based solely on the chance that the result may be incorrect.

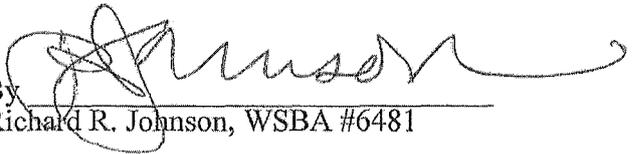
CONCLUSION

The Court of Appeals’ decision conflicts with two of this Court’s decisions, threatens patient sovereignty, and finds no support in the rest of this State’s case law. This Petition should therefore be granted.

Respectfully submitted this 9th day of January, 2013.

³ The Court of Appeals also briefly cited to *Gustav v. Seattle Urological Associates*, 90 Wn. App. 785, 954 P.2d 319, *review denied*, 136 Wn.2d 1023, 969 P.2d 1064 (1998). There, the urologist had disclosed the patient’s elevated levels of PSA, a possible indicator of cancer, but had simply concluded that those test results did not point to cancer. Here, Dr. Sauerwein did not disclose the test results to Ms. Anaya.

DELORIE-JOHNSON, P.L.L.C.

By 
Richard R. Johnson, WSBA #6481

KELLER ROHRBACK L.L.P

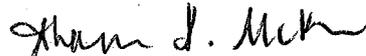
By 
Ian S. Birk, WSBA #31431
Benjamin Gould, WSBA #44093

Attorneys for Petitioner

CERTIFICATE OF SERVICE

I certify under penalty of perjury of the laws of the State of Washington that on January 9, 2013, I caused a true and correct copy of the foregoing PETITION FOR REVIEW to be delivered via federal express as follows:

Mr. David A. Thorner
Ms. Megan Murphy
Thorner, Kennedy & Gano P.S.
The Chestnut Legal Building
101 South 12th Avenue
P.O. Box 1410
Yakima, WA 98907-1410



Shannon McKeon, Legal Assistant
Keller Rohrback L.L.P.

APPENDIX A

Court of Appeals Decision

FILED

December 11, 2012

In the Office of the Clerk of Court
WA State Court of Appeals, Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

RODOLFO ANAYA GOMEZ, As)	No. 30098-6-III
Personal Representative of the Estate of)	
Christina Palma Anaya,)	
)	
Appellant,)	
)	
v.)	
)	
MARK F. SAUERWEIN, M.D., and THE)	
YAKIMA VALLEY FARM WORKER'S)	
CLINIC, A Washington Corporation,)	
)	PUBLISHED OPINION
Respondents.)	
)	

Siddoway, A.C.J. — Thirty-two-year-old Christina Palma Anaya died of fungal sepsis. Her estate appeals the trial court's dismissal of its claim that Mark Sauerwein, M.D., failed to obtain Ms. Anaya's informed consent to the doctor's decision to await a final blood test before acting on a preliminary test, identifying yeast in her blood, which the doctor concluded must be in error. The estate's alternative claim of medical negligence, asserting misdiagnosis by Dr. Sauerwein, was rejected by a jury.

At the heart of the parties' disagreement is whether the decision in *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979) represents a continuing exception to the

statement in *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999) that when a doctor misdiagnoses a patient's condition, the patient can bring only an action for medical negligence, not one for failure to secure informed consent. We hold that it does not. *Gates* must be regarded at this point as having been abrogated or limited to its facts by the five-member concurring opinion in *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980) or overturned, sub silentio, by later decisions of the Supreme Court. We affirm.

FACTS AND PROCEDURAL BACKGROUND

Christina Anaya was diagnosed with type two diabetes when she was 19 or 20 years old and by 2006, at age 32, had been a long-standing patient of the Yakima Valley Farm Worker's Clinic. Her blood sugar was poorly controlled, leaving her immunocompromised. Kyle Heisey, M.D., a physician employee of the defendant clinic, was her primary physician.

On Sunday, August 20, 2006, Ms. Anaya traveled to the emergency department of Toppenish Community Hospital, complaining of symptoms consistent with a urinary tract infection (UTI). She was admitted to the hospital, a urine culture was taken, and blood was drawn and forwarded to a laboratory for routine testing. She was discharged from the hospital the next day with a diagnosis of UTI, after the urine culture showed she was growing Gram-negative rods. The culture was verified to be the bacterial organism

No. 30098-6-III

Anaya Gomez v. Sauerwein

Klebsiella pneumoniae on August 22. Ms. Anaya returned to the hospital on Wednesday, August 23, because she was not feeling well and could not empty her bladder. She was evaluated and treated, but not admitted to the hospital. Dr. Sauerwein was not involved in any of these events.

On Thursday, August 24, a microbiologist in the laboratory at the Yakima Regional Medical Center, to whom Ms. Anaya's August 20 blood culture had been sent for analysis, telephoned the Farm Worker's Clinic and told Sarah Gott, a registered nurse, that a preliminary report indicated that Ms. Anaya's blood culture was positive for yeast. The culture had not grown out to a point where the strain could be determined. Ms. Gott relayed what she had been told to Dr. Sauerwein, a family practitioner, who was covering for Dr. Heisey.

Dr. Sauerwein was puzzled by what was conceded by all of the experts to be a rare test result. He consulted with Dr. John Moran, who was board certified in internal medicine and had treated Ms. Anaya in the hospital the prior weekend. Dr. Sauerwein would later testify that he regularly consulted with Dr. Moran about patients, that he trusted him, and that he knew that Dr. Moran had seen Ms. Anaya only days before, which Dr. Sauerwein characterized as "a big advantage." Report of Proceedings (RP) (June 10, 2011) at 78. Together, they arrived at a plan to find out how Ms. Anaya was doing and, if she was ill, to take further action. If she was not ill, they agreed that they

would wait, because in that event, it was probable that the yeast was a contaminant. The consultation and agreed course of action were reflected in Dr. Sauerwein's clinic note.

Dr. Sauerwein directed Ms. Gott to contact Ms. Anaya to determine how she was doing. Mary Sifuentes, a licensed practical nurse at the clinic, called Ms. Anaya, who told the nurse that she had returned to the emergency room the prior night, emergency department personnel had catheterized and emptied her bladder, and she felt much better after that. She was continuing to be treated for a bacterial infection.

Based on that information, Dr. Sauerwein did not take further immediate action on the blood test result, although upon being told that Ms. Anaya's next scheduled follow-up appointment at the clinic was on September 5, he responded, "have her come in next week please, 9/5 is too far out." Ex. 7. Ms. Anaya was contacted and rescheduled to return to the clinic on the following Wednesday, August 30. There was no evidence that Dr. Sauerwein or anyone else at the clinic informed Ms. Anaya of the results of the microbiology test.

It turned out that the blood test was not contaminated; Ms. Anaya did have a fungal infection. It took six days, until Saturday, August 26, for the fungus to grow out and be identified as *Candida glabrata*. No report of that final finding was received by the clinic.

On August 29, Ms. Anaya's husband, Rodolfo Anaya-Gomez, who was working in

Alaska but had learned of his wife's persisting illness, returned to Washington to see to her care. He drove her to Yakima Memorial Hospital on the day he arrived home. Upon being admitted, her urine tested positive for yeast—something it had not done when she was admitted to the Toppenish hospital nine days earlier. Approximately 24 hours after her admission to Yakima Memorial, a consulting nephrologist learned of her fungal infection with *Candida*, although the strain was not yet identified. He began treating Ms. Anaya with fluconazol, an antifungal medication, but one that does not eliminate *Candida glabrata* from the blood stream. It was not until a day later, when Ms. Anaya was seen by an infectious disease specialist who learned that her blood culture had grown *Candida glabrata*, that the fluconazol was discontinued and she began receiving amphotericin B intravenously.

Ms. Anaya felt better the next day and was transferred out of the intensive care unit (ICU), but only temporarily. The fungus had invaded her internal organs and she had developed fungal sepsis. Despite her return to the ICU and aggressive treatment, she eventually fell into a vegetative state, was transferred to a nursing home in Toppenish, and died on November 17, 2006. The cause of death was fungal sepsis.

Mr. Anaya-Gomez, as personal representative of Ms. Anaya's estate, brought suit against Dr. Sauerwein and the clinic for medical negligence, alleging that the doctor had "deviated from the accepted standard of care in the community" in his "evaluation and/or

non-treatment” of Ms. Anaya. Clerk’s Papers (CP) at 7.

Three weeks before trial, the estate submitted a notice of trial amendment, adding a claim for failure to obtain informed consent. The defendants objected to the amendment as untimely and because, they argued, an informed consent theory was inapplicable, given the facts of the case. A few days before trial, the court heard defense arguments against permitting the amendment and for an order in limine excluding evidence supporting the informed consent theory. The court entered an order denying the defense motion to exclude evidence in support of the theory “at this time.” CP at 296.

At the close of the estate’s case, the defendants renewed their objection to the informed consent claim and moved the court to dismiss it as a matter of law. The court granted the motion. It later denied the estate’s request for reconsideration.

In support of its medical negligence claim, the estate presented expert testimony that the standard of care required that Dr. Sauerwein contact Ms. Anaya upon receipt of the preliminary report, tell her that her blood culture had tested positive for yeast, and advise her to return to the emergency room for evaluation and to have a new blood culture taken and tested.

Defense experts disagreed, testifying that yeast infections in the blood are so rare that the appropriate standard of care was to contact the patient to determine her clinical condition and, if she was feeling better, to await the final report before administering

treatment. The infectious disease expert for the defense also testified that amphotericin B is the only antifungal medication effective against *Candida glabrata*, is itself toxic, and is especially damaging to the kidneys. He testified that even an infectious disease specialist would not ordinarily put a patient on the drug without having a final identification of *Candida glabrata* as the infectious organism.

At the conclusion of the trial on the medical negligence claim, the jury returned a defense verdict. The estate's motions for reconsideration, judgment notwithstanding the verdict (JNOV), and/or for new trial were denied. The estate timely appealed.

ANALYSIS

I

Dr. Sauerwein presents two threshold arguments that the estate has failed to comply with rules of appellate procedure and we should, for that reason, refuse to entertain its arguments.

He argues, first, that the estate makes arguments not identified in its notice of appeal. A notice of appeal must "designate the decision or part of decision which the party wants reviewed." RAP 5.3(a)(3). However, we review an order or ruling not designated in the notice if it "prejudicially affects the decision designated in the notice" and "is made[] before the appellate court accepts review." RAP 2.4(b). An order "prejudicially affects" the decision designated in the notice of appeal where its designated

No. 30098-6-III
Anaya Gomez v. Sauerwein

decision would not have occurred in the absence of the undesignated ruling or order.

Right-Price Recreation, LLC v. Connells Prairie Cmty. Council, 146 Wn.2d 370, 380, 46 P.3d 789 (2002).

The estate's notice of appeal requests review of the judgment and the order on the estate's posttrial motions (for reconsideration, for JNOV, or for a new trial). Its appeal from the final judgment and posttrial motions brings up for review the trial court's oral ruling dismissing its informed consent theory as a matter of law and refusing to instruct the jury on that theory.

Second, Dr. Sauerwein argues that the estate has failed to provide us with argument demonstrating how the cases that it cites bear on the facts and circumstances of this case, in violation of RAP 10.3(a)(6). That rule requires that an appellate brief contain "argument in support of the issues presented for review, together with citations to legal authority and references to relevant parts of the record." RAP 10.3(a)(6). Dr. Sauerwein's principal objection is to the estate's asserted overreliance on extensive block quotes from Washington cases, without articulating why those cases control or bear on the outcome of this appeal.

The crux of this appeal has almost nothing to do with any dispute over the facts of this case, and turns almost entirely on reconciling a handful of reported Washington decisions. A detailed discussion of the key cases is a logical presentation of the estate's

argument. We had no problem following the estate's argument on appeal and find no violation of our rules.

II

Washington's Supreme Court first recognized the doctrine of informed consent in *ZeBarth v. Swedish Hospital Medical Center*, 81 Wn.2d 12, 499 P.2d 1 (1972) and the legislature thereafter codified the prima facie elements of an informed consent claim in RCW 7.70.050 in 1975. *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007). Under the doctrine, a health care provider has a fiduciary duty to disclose relevant facts about the patient's condition and the proposed course of treatment so that the patient may exercise the right to make an informed health decision. *Id.* at 122-23 (citing *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd*, 85 Wn.2d 151, 530 P.2d 334 (1975)). A provider may be liable to an injured patient for breaching this duty even if the treatment otherwise meets the standard of care. *Id.* at 123. "The doctrine of informed consent is based on 'the individual's right to ultimately control what happens to his body.'" *Id.* (quoting *Keogan*, 95 Wn.2d at 313-14).

The legal issue presented by this appeal is whether the trial court correctly dismissed the estate's informed consent claim on the basis that a health care provider's failure to diagnose, or its misdiagnosis, presents a cause of action for medical negligence only, because no informed consent requirement is triggered.

We review a decision on a motion for judgment as a matter of law de novo, applying the same standard as the trial court. *Davis v. Microsoft Corp.*, 149 Wn.2d 521, 530-31, 70 P.3d 126 (2003). Judgment as a matter of law is not appropriate if, after viewing the evidence and reasonable inferences in a light most favorable to the nonmoving party, substantial evidence exists to sustain a verdict for the nonmoving party. *Schmidt v. Coogan*, 162 Wn.2d 488, 491, 173 P.3d 273 (2007). “An order granting judgment as a matter of law should be limited to circumstances in which there is no doubt as to the proper verdict.” *Id.* at 493.

In successfully moving for judgment as a matter of law, Dr. Sauerwein relied on an extended discussion of whether misdiagnosis can constitute failure to provide informed consent in *Backlund*. The Washington Supreme Court stated in that case:

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.

137 Wn.2d at 661. It continued, in a footnote,

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.

Where a physician arguably 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 the undetected tumor.

Id. at 661-62 n.2 (citations omitted).

This discussion of informed consent in *Backlund* was dicta, because the court rejected the defense argument that the negligence at issue was misdiagnosis. The action had been brought by the parents of a newborn who suffered brain damage when phototherapy treatment proved ineffective for her hyperbilirubinemia, or jaundice, and who had not been told that only a higher risk treatment—blood transfusion—might be effective in serious cases. Because the neonatologist diagnosed the newborn's hyperbilirubinemia and was aware of the alternative treatments, the Supreme Court held that it was not a case of misdiagnosis, and the plaintiffs were entitled to pursue their theory of lack of informed consent.

Although dicta, *Backlund's* discussion of whether misdiagnosis is actionable as a failure to obtain informed consent relies on several reported decisions of this court in which the issue was squarely presented.

In *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 828 P.2d 597, *review denied*, 119

Wn.2d 1020 (1992), cited by *Backlund*, 137 Wn.2d at 659, this court rejected an appellant's argument that the trial court erred in refusing to rule, as a matter of law, that an emergency room doctor failed to secure her informed consent when he failed to inform her of a rejected diagnosis. She had suffered breathing problems after exposure to Malathion. In providing treatment, the doctor did not tell her that he had rejected poisoning by Malathion as the cause of her complaints, and did not explain the risks of Malathion poisoning or its treatment. This court held:

Dr. Plumley diagnosed Ms. Thomas as suffering from asthma, not Malathion poisoning. He did not treat her for Malathion poisoning. Therefore, he did not have a duty to inform her of the timeframe for administering an antidote or her future risk of developing organophosphate-induced delayed neurotoxicity. . . .

Failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform a patient. Informed consent and medical negligence are alternate theories of liability. Here, it is undisputed Dr. Plumley did not diagnose Malathion poisoning. Ms. Thomas has not established that Dr. Plumley failed to inform her of a material fact relating to treatment.

65 Wn. App. at 260-61 (citations omitted). The Supreme Court denied review of this court's decision in *Wilfac*.

The *Backlund* court's discussion of the proper theory for presenting a claim of misdiagnosis also cited this court's decisions in *Bays v. St. Luke's Hospital*, 63 Wn. App. 876, 825 P.2d 319, *review denied*, 119 Wn.2d 1008 (1992) and *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 772 P.2d 1027, *review denied*, 113 Wn.2d 1005 (1989).

In *Burnet*, the plaintiffs had themselves presented expert testimony that the defending doctor was unaware of a condition of the patient implicating risk to her. The Supreme Court in *Backlund* quoted portions of this court's decision agreeing with the trial court that "the issues presented were confined to negligence and misdiagnosis rather than a violation of the informed consent law," and this court's holding that because of the doctor's lack of awareness, "he had no duty to disclose. The Burnets' claim relates solely to issues of failure to meet the standard of care and diagnosis." *Backlund*, 137 Wn.2d at 661 (quoting *Burnet*, 54 Wn. App. at 169). The Supreme Court denied review of this court's decision in *Burnet*.

Finally, the *Backlund* court cited to this court's decision in *Bays*. The Supreme Court characterized *Bays* as involving "[a] patient's attempt to disguise a negligence issue as a failure to obtain an informed consent issue." 137 Wn.2d at 661. It pointed out that in *Bays*, this court held that "[a] failure to diagnose a condition . . . is a matter of medical negligence," adding that "[w]e 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." *Id.* (second alteration in original) (quoting *Bays*, 63 Wn. App. at 883). The Supreme Court denied review of this court's decision in *Bays*.

Against this authority, the estate relies on several older Washington decisions, but

principally on *Gates* and *Keogan*. *Gates* involved a plaintiff who suffered substantial loss of her eyesight over her two-year treatment by the defending ophthalmologist. After diagnostic pressure tests, the ophthalmologist found that Ms. Gates was in the borderline area for glaucoma in each eye. He made no further tests for glaucoma, although more definitive tests were readily available. He diagnosed her problem as difficulties with her contact lenses, because he could see no evidence of abnormality. He rejected later readings of high pressure in her eyes as misleading, attributing them to Ms. Gates' tension at being subjected to the pressure testing procedure. The trial court refused to instruct the jury on a theory of failure to obtain informed consent.

The ophthalmologist defended by challenging Ms. Gates' basic assumption that her vision loss was due to glaucoma. Defense evidence suggested it was caused by a stroke or series of strokes. The jury found against Ms. Gates on her medical negligence claim. *Gates v. Jensen*, 20 Wn. App. 81, 83, 579 P.2d 374 (1978), *rev'd*, 92 Wn.2d 246.

The Court of Appeals rejected Ms. Gates' complaint on appeal that her theory of failure of informed consent should have been submitted to the jury, holding, "The doctrine of informed consent should not be enlarged so as to include problems of mistaken diagnosis. The claim of negligent conduct appropriately covers the fault of a mistaken diagnosis and is sufficient to afford a fair trial on the issue." 20 Wn. App. at 87.

But the Supreme Court accepted review and clearly disagreed. Relying on the reference in *Miller v. Kennedy* to the duty of a physician “to inform a patient of abnormalities in his or her body,” the *Gates* court held:

The patient’s right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. Important decisions must frequently be made in many nontreatment situations in which medical care is given, including procedures leading to a diagnosis, as in this case. These decisions must all be taken with the full knowledge and participation of the patient. The physician’s duty is to tell the patient what he or she needs to know in order to make them. The existence of an abnormal condition in one’s body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease are all facts which a patient must know in order to make an informed decision on the course which future medical care will take.

92 Wn.2d at 250-51. It went on to state that “[t]he physician’s duty of disclosure arises, therefore, whenever the doctor *becomes aware of an abnormality which may indicate risk or danger*” and that “[t]he facts which must be disclosed are all those facts the physician knows *or should know* which the patient needs in order to make the decision.” *Id.* at 251 (emphasis added).

Keogan, decided a year and a half later, similarly involved a claim by the personal representative of a deceased patient that the treating physician—a general practitioner who had administered a resting electrocardiogram (EKG) and took cardiac enzyme tests after his patient complained of chest pain—should have told the patient about the

No. 30098-6-III

Anaya Gomez v. Sauerwein

possibility of an angiogram and a treadmill EKG. This was despite the fact that neither test was used extensively by general practitioners at the time, and the patient's symptoms were inconclusive. *Keogan v. Holy Family Hosp.*, 24 Wn. App. 583, 601 P.2d 1303 (1979), *rev'd*, 95 Wn.2d 306. Even upon reconsideration, following the Supreme Court's decision in *Gates*, the Court of Appeals held:

In a situation involving simple, risk-free procedures which would conclusively determine the presence or absence of glaucoma, the court's comment [in *Gates*] is apropos. But as we noted in *Keogan v. Holy Family Hosp.* [, 22 Wn. App. 366, 589 P.2d 310 (1979)], the symptoms which Keogan exhibited ranged from gastrointestinal problems to heart disease. Dr. Snyder conservatively treated both, but he had neither made a diagnosis nor pursued a course of treatment involving a risk to his patient. Under these circumstances, no duty to inform had yet arisen and no instruction was required.

Keogan, 24 Wn. App. at 585-86.

The Washington Supreme Court accepted review of *Keogan*, and the estate mistakenly asks that we rely on *Keogan's* lead opinion as support for its position in this case. But the Supreme Court's decision in *Keogan* was split on the several issues presented in that appeal. The lead opinion spoke for a majority only on the issue of whether the trial court should have found negligence as a matter of law for the defendant's failure to administer an EKG to Mr. Keogan upon his presentation at the hospital emergency room. *See* 95 Wn.2d at 331-32 (Hicks, J., concurring in part, dissenting in part).

On the informed consent issue, it was Justice Hicks' opinion that spoke for a five-member majority of the court. That opinion held:

By . . . focusing on the diseased heart to the exclusion of everything else, the majority seizes upon a suspicion by Dr. Snyder of a possibility that Keogan may have angina pectoris to decree that the informed consent doctrine as applied in *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), controls here. In *Gates*, the court held 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.

The Court of Appeals held that no duty to inform had yet arisen in this case because 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." *Keogan*[, 22 Wn. App. at 370]. Under the circumstances of this case, I agree with the Court of Appeals.

95 Wn.2d at 329-30 (Hicks, J., concurring in part, dissenting in part).¹

Dr. Sauerwein argues that *Gates* does not apply to this case because it is distinguishable; according to Dr. Sauerwein, Ms. Gates' ophthalmologist was aware of an abnormality and Dr. Sauerwein was not. In our view, however, both physicians were aware of test results suggesting an abnormality. But based on other information from or about the patient, both concluded that the test results could reasonably be discounted as inconclusive, supporting no diagnosis and no immediate risk. We do not agree with Dr. Sauerwein that *Gates* is clearly distinguishable from the present case.

¹ We note that the Supreme Court granted reconsideration in the matter on April 9, 1981. The case was thereafter dismissed by stipulation of the parties on June 23, 1981. See 95 Wn.2d at 332.

We conclude, however, that *Gates* has either been abrogated or limited to its facts by *Keogan*, or has been overruled sub silentio in light of the Supreme Court’s decision in *Backlund* and its denial of review of *Wilfac*, *Burnet*, and *Bays*. A later holding overrules a prior holding sub silentio when it directly contradicts the earlier rule of law. *Lunsford v. Saberhagen Holdings, Inc.*, 166 Wn.2d 264, 280, 208 P.3d 1092 (2009). And see *Gustav v. Seattle Urological Associates*, 90 Wn. App. 785, 790, 954 P.2d 319, review denied, 136 Wn.2d 1023 (1998), in which a two-member majority—over a dissent on this issue—held that “a physician’s failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform,” and “[t]he duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it.” Once again, the Supreme Court denied review in *Gustav*.

Accordingly, the trial court properly dismissed the estate’s informed consent claim on the basis that Dr. Sauerwein’s failure to diagnose presented a cause of action for medical negligence only.

Affirmed.

Siddoway, A.C.J.

WE CONCUR:

No. 30098-6-III

Anaya Gomez v. Sauerwein

Sweeney, J.

Kulik, J.

APPENDIX B

**Trial Exhibit 3A:
Discharge Summary from Yakima Valley
Memorial Hospital**

DATE OF ADMISSION: 08/29/06
DATE OF DISCHARGE: 11/07/06

ADMITTING DIAGNOSIS
Acute renal failure

FINAL DIAGNOSIS
Candida sepsis

OTHER DIAGNOSES

1. Septic shock
2. Acute renal failure
3. Posttraumatic pulmonary insufficiency
4. Cardiac arrest
5. Anoxic brain damage
6. Defibrillation syndrome
7. Congestive heart failure
8. Pleural effusion
9. Iatrogenic pneumothorax
10. Iron deficiency anemia
11. Hypoosmolality
12. Cardiac rhythm disorder
13. Diabetes mellitus type 2, controlled
14. Decubitus ulcer
15. Diarrhea

OPERATIVE PROCEDURES: Tracheostomy on 09/28/06, exploratory thoracotomy on 09/26/06, insertion of intercostal catheter for drainage on 09/13/06, percutaneous gastrostomy tube on 09/22/06, upper endoscopy with biopsy on 10/10/06, percutaneous endoscopic gastrojejunostomy, cardiopulmonary resuscitation on 09/06/06, cardiac resuscitation on 10/10/06, cardiac resuscitation on 10/12/06, and cardiac resuscitation on 10/28/06.

CONSULTATIONS: Dr. N. C. Chowdhury, Dr. V. C. Kamath, Dr. C. E. Mandanis, Dr. P. I. Menashe, Dr. L. E. Urrutia, Dr. P. Vathesatogkit, Dr. S. C. Yang, Dr. N. L. Barg, Dr. M. Jorgensen, Dr. J. H. Licht, and Dr. W. F. Von Stubbe.

SUMMARY OF ADMISSION HISTORY AND PHYSICAL: The patient is a 32-year-old married housewife and mother of 2 who had been diabetic for about 10 years. The family noticed pallor for about two weeks before this admission. She began to feel bad at about that time with some back pain.

1 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTIN/A
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A - 0000001

She was diagnosed with a renal infection and with anemia. She was admitted on antibiotics and was discharged 24 hours later. She said she felt fine when she left the hospital but had a sensation of a full abdomen. She returned to the emergency room within the next day or two with the sensation of a full bladder. A catheter was placed and the bladder was drained. Again, she was discharged home. During this time, she developed sore, swollen legs, fevers, back pain, and weakness. Because of the deterioration, she said she wanted to be out of Toppenish and came here to our hospital. She was evaluated in the emergency room, noted to have multiple problems, and admitted to my service as a medical backup patient.

Physical examination revealed a youthful and extremely pale 32-year-old lady who was in no apparent distress when first seen. She does appear to be weak and complained of being cold. Examination showed edema of both legs at about 3/10. Otherwise, her examination was remarkably unremarkable.

DATABASE: The patient's blood type was O positive. She was transfused 27 units of packed cells. She received 29 units of fresh frozen plasma. She had 3 units of platelets. The initial blood gas on 08/31/06 revealed pH of 7.39, pCO₂ 21 and pO₂ 68 with a saturation of 95% on 2 liters. Her CO₂ at that time was 13. Approximately 50 to 70 blood gases were done during her hospital stay during the process of adjusting the oxygen saturation. Details are in the chart on those numbers. The CMP on her admission had a calcium of 7.7, glucose 237, BUN 54, creatinine 3.7, protein 6, albumin 1.7, alkaline phosphatase 287, sodium 121, CO₂ 10. Her amylase was 26 with a troponin of 0.06 and a lipase of 16. Her CK was 110. The patient had a BMP or CMP at least daily and many times several times during the day throughout her hospital stay. As would be imagined, there was a tremendous amount of variability. It showed that her renal function deteriorated after admission, her proteins declined, and her liver functions became elevated. She remained acidotic for a long period of time. Eventually, her renal function improved and stabilized while her other factors did not change much. Her initial BNP was 282. The TSH was 2.25 with a hemoglobin A_{1c} of 9.2 hemoglobin, and estrogen level of 250. The patient's initial 24-hour protein was 2000 with a derived and not calculated creatinine clearance of 16. Her serum creatinine was 2.8 at that time. The patient had a series of titers from Dr. J. H. Licht to exclude vasculitis of her kidneys. These were negative or only slightly abnormal. The initial CBC had a white count of 14.1, hemoglobin 7.5, hematocrit 22.2, with an MCV of 83 and platelets of 393,000. Similar to the CMP, the patient had a CBC or variation at least once a day and many times several times a day throughout her 2-1/2-month hospital stay. These numbers varied. As would be expected, she improved following transfusions and then would gradually decline again. An RA test was negative. Her initial INR was 1.56 with an initial APTT of 46.6 and a D-dimer of 2800. The fibrinogen was 660. Serial INRs and APTTs were done and were frequently elevated. The initial urinalysis had 2+ leukocytes, 3+ blood and 3+ yeast. A repeat in late October was negative with no yeast or white cells noted. Stool for occult blood showed some initial bleeding on 09/11/06 but were otherwise negative.

2 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Helsey, MD
Richard B. Boyd, MD

3A - 0000002

Twenty-seven blood cultures were done during her stay. Initially she grew *Candida glabrata*. After several days this cleared. At times her cultures would show contaminated organisms, but otherwise they were negative. The initial urine culture also grew *Candida glabrata*. A repeat culture in September was negative times two. A final culture in early November grew *Klebsiella*. Eight sputum cultures were obtained during her stay and grew *Staphylococcus aureus*, respiratory flora or *Acinetobacter baumannii*. Her central line was cultured at least four times and grew *Acinetobacter baumannii*. Stool cultures times two were negative for bacteria, but the initial stool culture grew *Candida glabrata*. Stool for *C. difficile* toxin was negative on five occasions. Stool for ova and parasites on 10/19/06 was negative.

RADIOLOGY STUDIES: Similar to the lab reports, enumerable studies were done during this admission. The initial chest x-ray was negative. The initial ultrasound from 08/29/06 showed an enlarged left kidney without a mass or hydronephrosis. The left kidney was edematous and was felt to be either infected or ischemic. A CT scan done on 08/30/06 again showed an enlarged left kidney again consistent with edema or inflammation. By 09/03/06, her chest x-ray had bilateral alveolar infiltrates. By 09/08/06, the infiltrates were continuing to worsen. A venous ultrasound of the lower extremities did not show any signs of thrombi on 09/12/06. A CT on 09/18/06 showed bilateral lower lobe pneumonia, as well as ascites and anasarca. The kidneys at that time were read as being fairly unremarkable. A CT of the head on 09/18/06 was read as a normal study. On 09/18/06, the patient was noted to have a chest tube. Again, she had bilateral infiltrates. Over the next few weeks, she continued to have diffuse pulmonary densities in both lung fields on her multiple chest x-rays. By in large, there was little change. A repeat CAT scan of the abdomen on 10/09/06 again had little change from a prior CAT scan. An MRI of her brain done on 10/31/06 showed diffuse changes consistent with ischemia or toxicity. This was most consistent with anoxic encephalopathy. She was noted to have sinusitis of her maxillary sinuses and mastoiditis.

CARDIOLOGY STUDIES: An echocardiogram done on 09/01/06 showed a left ventricular size which was small and hyperdynamic. She had moderate pulmonary hypertension. By 09/15/06, there was little change. The chambers were perhaps more normal in size. No thrombus was identified. Her initial EKG had a sinus tachycardia with a rate of 115, as well as rightward axis. The patient was monitored at great length throughout her hospital stay, and multiple tracings are on the chart. By in large, she is most frequently in a sinus rhythm or a sinus bradycardia noted at times.

HOSPITAL COURSE: As the reader can already tell from the notes above, this was a very lengthy and complicated hospital stay, lasting for parts of four months. The chart itself is 9 inches thick. In order to make this a true summary, multiple significant events will be touched on only briefly. The reader is referred to the chart for the details they wish to find.

3 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A - 0000003

This patient was admitted by myself on medical backup in late August. She presented with an extremely confusing picture of multiple abnormalities, including low sodium, anemia, renal failure, and urine which was positive for yeast. She was transfused that evening and started on antibiotics. The following day, Dr. M. Jorgensen was consulted, as well as Dr. Licht. By that time, the patient was going into respiratory failure and was transferred to the ICU. Dr. L. E. Urrutia took over the case from that point for basically the duration of the hospital stay. The patient was seen very shortly thereafter by Dr. N. L. Barg, who diagnosed Candida sepsis, including a Candida pyelonephritis. He immediately said that her prognosis was probably extremely grim. In spite of that, the entire ICU team, both the doctors and the nurses, treated this case with great heroism over the next several weeks. The patient was not stable hemodynamically for a long period of time. She had cardiac arrests. She had a collapsed lung. She required a tracheostomy. Throughout all this, she developed anoxia, which led to an advanced cerebral anoxia. She was seen by the neurologist, who felt the patient was brain dead by that time. The family was informed of this at great length by Dr. Urrutia. In spite of that news, they asked us to keep going and make every effort to help her survive. Eventually, she was transferred to the telemetry unit. She was there for barely a day or two when she had another cardiac arrest. She went back to the intensive care unit for several more weeks. She was transferred out again. After about five days on the medical floor, she had another respiratory arrest and was transferred back to the unit again. By this point, the patient's family was able to understand the case. They were convinced by Dr. Urrutia that the patient was not stable enough to survive on her own, since she was unable to handle any of her secretions or her own breathing. They agreed that the patient could be sent to a nursing home. They understood that if she had a further cardiac arrest in the nursing home it would probably be fatal.

By this time, the patient had developed significant breakdown of her skin with large decubitus ulceration. She was anoxic and had little or no purposeful movements, even of her eyes. She had no vocalization of any significance.

DISPOSITION: The patient was discharged to a nursing home in the lower valley. At that time, she was on Isosource VHN at 75 ml per hour per J-tube. She was receiving tracheostomy care, as well as G-tube care. She was on oxygen. She had an RC in place. She had braces for her legs.

Blood sugars were being checked BID with a sliding scale of aspart insulin. She had NPH insulin at 15 units BID.

Other medications included esomeprazole 40 mg PO daily, cholestyramine 4 g BID, Lomotil 5 ml Q4H, medroxyprogesterone 10 mg daily, prednisone 5 mg daily, and Cipro 500 mg BID for 10 days.

4 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A- 00000004

The patient was to have weekly lab work to include a CMP, magnesium and phosphorous.

RBB:tc

D: 11/24/2006 7:45 P

T: 11/27/2006 12:10 P

000031866

cc: Neil L Barg, MD
Richard B. Boyd, MD
Nepal C. Chowdhury, MD
Kyle Heisey, MD
Maria Jorgensen, MD,PhD
Voderbet C. Kamath, MD
J. Hamilton Licht, MD
Christos E. Mandanis, MD
Phillip I. Menashe, MD
Luis E. Urrutia, MD
Pratan Vathesatogkit, MD
William F. Von Stubbe, MD
S. Chris Yang, MD

Signature

Richard B. Boyd, MD

5 of 5

YAKIMA VALLEY MEMORIAL HOSPITAL
Yakima, Washington

DISCHARGE SUMMARY

ANAYA, CHRISTINIA
DOB: 06/14/1974
MEDICAL RECORD # 49-60-02
ADMIT 08/29/2006 DISCHARGE 11/07/2006
BILLING # 25388968
PCP: Kyle Heisey, MD
Richard B. Boyd, MD

3A- 0000005

APPENDIX C

**Certificate of Death
Christina Palma-Anaya**

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH**

Local File Number: 1536 Washington State Certificate of Death State File Number: _____

1. Legal Name (include AKA's if any): First Middle LAST <u>Christina Palma ANAYA</u>			2. Death Date <u>11-17-2006</u>		
3. Sex (M/F) <u>Female</u>	4a. Age - Last Birthday <u>32</u>	4b. Under 1 Year Months Days <u> </u>	4c. Under 1 Day Hours Minutes <u> </u>	5. Social Security Number <u> </u>	6. County of Death <u>Yakima</u>
7. Birthdate <u>6-14-1974</u>	8a. Birthplace (City, Town, or County) <u>Toppenish</u>	8b. (State or Foreign Country) <u>Washington</u>	9. Decedent's Education <u>11th grade</u>		
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. <u>Yes - Mexican</u>			11. Decedent's Race(s) <u>Hispanic</u>		12. Was Decedent ever in U.S. Armed Forces? <u>NO</u>
13a. Residence: Number and Street (e.g., 824 SE 5 th St.) (include Apt. No.) <u>42 E. 3rd Street</u>				13b. City or Town <u>Toppenish</u>	
13c. Residence: County <u>Yakima</u>	13d. Tribal Reservation Name (if applicable) <u>N/A</u>	13e. State or Foreign Country <u>Washington</u>	13f. Zip Code #4 <u>98948</u>	13g. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
14. Estimated length of time at residence. <u>3 years</u>		15. Marital Status at Time of Death <u>Married</u>	16. Surviving Spouse's Name (Give name prior to first marriage) <u>Rodolfo Anaya</u>		
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED)) <u>Homemaker</u>			18. Kind of Business/Industry (Do not use Company Name) <u>Own Home</u>		
19. Father's Name (First, Middle, Last, Suffix) <u>Ascension C. Palma</u>			20. Mother's Name Before First Marriage (First, Middle, Last) <u>Alma Silva</u>		
21. Informant's Name <u>Rodolfo Anaya</u>		22. Relationship to Decedent <u>Spouse</u>	23. Mailing Address: Number and Street or RFD No. City or Town State Zip <u>42 E. 3rd Ave. Toppenish, WA 98948</u>		
24. Place of Death, if Death Occurred in a Hospital: <u>N/A</u>			Place of Death, if Death Occurred Somewhere Other than a Hospital: <u>Nursing Home</u>		
25. Facility Name (if not a facility, give number & street or location) <u>Toppenish Nursing and Rehab</u>		26a. City, Town, or Location of Death <u>Toppenish</u>	26b. State <u>WA</u>	27. Zip Code <u>98948</u>	
28. Method of Disposition <u>Burial</u>		29. Place of Final Disposition (Name of cemetery, crematory, other place) <u>Elmwood Cemetery</u>		30. Location-City/Town, and State <u>Toppenish, WA</u>	
31. Name and Complete Address of Funeral Facility <u>Colonial Funeral Home 228 S. Alder; Toppenish, WA 98948</u>				32. Date of Disposition <u>11-21-2006</u>	
33. Funeral Director Signature X <u>[Signature]</u>					

Cause of Death (See instructions and examples)

34. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. <u>Cardiac arrhythmia</u>	Interval between Onset & Death
Sequentially (list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. <u>Anoxic/Ischemic encephalopathy</u>	Interval between Onset & Death <u>2 months</u>
	c. <u>Fungal sepsis</u>	Interval between Onset & Death <u>2 months</u>
	d. <u>Type II Diabetes mellitus</u>	Interval between Onset & Death <u>years</u>

35. Other significant conditions contributing to death but not resulting in the underlying cause given above: _____

36. Autopsy? Yes No

37. Were autopsy findings available to complete the Cause of Death? Yes No

38. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending	39. If female <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	40. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown
41. Date of Injury (MM/DD/YYYY)	42. Hour of Injury (24hrs)	43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)
45. Location of Injury: Number & Street: City or Town: _____ County: _____ State: _____ Zip Code + 4: _____		44. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
46. Describe how injury occurred		
47. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)		
48a. Certifying Physician: <u>[Signature]</u>		48b. Medical Examiner/Coroner: <u>[Signature]</u>
49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Print) <u>Kyle Heisey, M.D., 518 W 1st, Toppenish, WA 98948</u>		50. Hour of Death (24hrs) <u>1:30</u>
51. Name and Title of Attending Physician (if other than Certifier) (Print) <u>[Signature]</u>		52. Date Signed (MM/DD/YYYY) <u>11/17/06</u>
53. Title of Certifier: <u>Medical Doctor</u>	54. License Number: <u>MD 8160</u>	55. ME/Coroner File Number
57. Registrar Signature <u>Mary Mordue, Deputy Registrar</u>		56. Was case referred to ME/Coroner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
59. Amendments		58. Date Received (MM/DD/YYYY) <u>11-20-2006</u>

DOP 001-003 (5/05)