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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.

**PETITIONER'S BRIEF IN ANSWER TO BRIEF OF AMICI
CURIAE WASHINGTON STATE MEDICAL ASSOCIATION
AND WASHINGTON STATE HOSPITAL ASSOCIATION**

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INTRODUCTION AND SUMMARY

Under the plain language of Washington's informed-consent law, a physician who becomes aware of a material test result during the diagnostic process must inform the patient of that result. This is the position that Petitioner Rodolfo Anaya has taken throughout this litigation.

The brief of the Washington State Medical Association and Washington State Hospital Association ("Amici") makes it necessary to restate that position. Amici say that Mr. Anaya asks for a "strict liability" standard under which physicians would have to report "every preliminary test result for every patient." (Corrected Br. of Amici Curiae Wash. State Med. Ass'n & Wash. State Hosp. Ass'n ("Amici Br.") at 14.) That is false. Consistent with the plain language of RCW 7.70.050, Mr. Anaya maintains only that *material* test results need to be disclosed—those results to which a "reasonably prudent" patient would "attach significance" in "deciding whether or not to submit to the proposed treatment." RCW 7.70.050(2) (defining "material").

Once Amici's straw man of strict liability blows away, only three other arguments remain.

First and foremost, Amici argue that a physician who is consciously aware of a material fact need not disclose that fact as long as he also commits what Amici call a "misdiagnosis"—i.e., as long as he

draws the wrong inference from the material fact, just as Dr. Sauerwein drew the wrong inference from the positive blood test. This proposed rule conflicts with the informed-consent statute's plain language, and finds no basis in precedent.

Next, Amici argue that the informed-consent law does not apply when the health care provider recommends no course of treatment. Dr. Sauerwein, however, *did* recommend treatment, and even if he had not, Amici's narrow definition of "treatment"—under which "treatment" is limited to an "invasive procedure"—conflicts with the statutory language and patient sovereignty. (Amici Br. at 7 n.4.)

Finally, Amici suggest that the informed-consent statute does not apply before the health provider makes a final diagnosis. But this again conflicts with the statute's language.

ARGUMENT

I. Because the informed-consent statute imposes liability for failing to disclose test results only when those results are objectively material, the statute does not impose strict liability.

As one of the elements of an informed-consent claim,¹ RCW 7.70.050 requires a plaintiff to show "[t]hat the health care provider failed to inform the patient of a material fact or facts relating to the treatment."

¹ The evidence supporting all four statutory elements is discussed in Mr. Anaya's Answer to the Brief of Amicus Curiae Washington State Association for Justice Foundation.

RCW 7.70.050(1)(a). Under the statute, a “material fact” is defined as one to which “a reasonably prudent person in the position of the patient . . . would attach significance” in “deciding whether or not to submit to the proposed treatment.” RCW 7.70.050(2).

Because the blood test result was “material” as defined by the statute, Dr. Sauerwein is liable for withholding it. Here, Ms. Anaya’s positive blood test for yeast was material. Three experts testified that a yeast infection in the blood is extremely serious—indeed, life-threatening. (6/7/11 RP 85:1673–76; 6/8/11 RP 30:573–78; 6/9/11 RP 21:400–03, 21:406–07.) In addition, undisputed testimony established that a false positive for yeast in the blood is almost nonexistent; it just “doesn’t happen.”² (6/8/11 RP 29:552–59; 6/9/11 RP 21:397–98.) Indeed, Mr. Anaya’s experts testified that the positive blood test urgently required the alternative treatment of immediate antifungal therapy. A reasonably prudent patient would have attached significance to the blood test in

² Amici cite an article about blood culture contamination, but fail to note that the article does not say that all microorganisms are equally likely to contaminate a culture. (Amici Br. at 17 n.11.) Indeed, as the article itself notes, a blood culture that tests positive for *Candida*, as Ms. Anaya’s did, “almost always represent[s] a true infection.” Keri K. Hall & Jason A. Lyman, *Updated Review of Blood Culture Contamination*, 19 *Clinical Microbiol. Rev.* 788, 790 (2006), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1592696/pdf/0062-05.pdf>; *see also id.* at 789 (“Often, the identity of the microbe that grows from a blood culture is a very helpful clue that the results may or may not represent contamination.”).

deciding on treatment, so Dr. Sauerwein had a duty to disclose the test to Ms. Anaya.

Amici insist that Mr. Anaya seeks “strict liability for failure to immediately disclose” a test result, but that is false. (Amici Br. at 2.) If a test result is not material, the informed-consent statute imposes no duty of disclosure. Thus, a physician need not “immediately report every preliminary test result for every patient,” or disclose “all potential ramifications and outcomes of the test result.” (*Id.* at 14.) But a physician who knows of a material test result, as Dr. Sauerwein knew here, must disclose it before unilaterally committing the patient to the physician’s chosen treatment. Far from being a “strict liability” rule, this is a straightforward application of RCW 7.70.050’s patient-centered standard for disclosure. *Backlund v. Univ. of Wash.*, 137 Wn.2d 651, 665–66, 975 P.2d 950 (1999).³

II. Statutory language, precedent, common sense, and the facts of this case all refute Amici’s insistence that a physician can withhold an objectively material blood test result simply because he subjectively believes it to be a false positive.

Amici claim that this is a case of “misdiagnosis,” and purely for that reason cannot be the subject of an informed-consent claim. (Amici Br.

³ In a related vein, Amici proclaim that Mr. Anaya wants a “[b]right [l]ine [r]ule.” (Amici Br. at 13.) Mr. Anaya has never used that term, and argues only that RCW 7.70.050’s standard for materiality be followed.

at 18.) According to Amici, Dr. Sauerwein's failure to disclose the blood test is excused because he wrongly believed that it was a false positive and that Ms. Anaya did not have a fungal infection. In that sense, they argue, this case is about a "claim of nondisclosure from a misdiagnosis." (*Id.*) And, say Amici, when a physician's withholding of a material fact stems from this kind of "misdiagnosis," an informed consent claim cannot lie—even if, as in this case, the physician is aware of the material fact.

Amici's argument is flawed on every level. First and most importantly, it conflicts with the language of RCW 7.70.050, the informed-consent statute. Second, it conflicts with *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), and finds no support in any other precedent. And third and last, it defies common sense.

A. Amici's position conflicts with the statutory language.

The plain language of the statute requires a plaintiff to prove "[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). A "fact" is "material," under the statute, "if a reasonably prudent person in the position of the patient or his or her representative would attach significance to it [in] deciding whether or not to submit to the proposed treatment." RCW 7.70.050(2).

Two aspects of this statutory language refute Amici's position that a physician may stay silent about an alarming blood test so long as he believes the blood test is a false positive.

First, the statute requires the disclosure of a "fact or facts," rather than disclosure of a physician's subjective state of mind. RCW 7.70.050(1)(a). A blood test is no less a "fact"—and no less subject to disclosure under the statute—simply because a physician subjectively deems it a false positive.

Second, a fact is "material," and therefore must be disclosed, if "a reasonably prudent person in the position of the patient" would attach significance to it. RCW 7.70.050(2). This standard is objective: it makes the duty to disclose turn not on what the particular plaintiff would have done, but on what a reasonably prudent patient in the plaintiff's position would have done. *Backlund*, 137 Wn.2d at 665. Thus, contrary to Amici's argument, a physician's subjective belief about a blood test cannot possibly affect whether that blood test is "material" under the statute, both because it is the *physician's*, and not the *patient's*, belief, and because it is the physician's *subjective* belief.

Amici's argument does not merely contradict the plain language of the informed-consent statute, though—it is also contradicts the statute's purpose. The statute makes the reasonably prudent patient the standard for

whether a fact is “material,” RCW 7.70.050(2), because that is the only standard consistent with patient sovereignty. Without this patient-centered standard, physicians could “determine what information should be disclosed,” which “would be in direct conflict with the underlying principle of patient sovereignty.” *Smith v. Shannon*, 100 Wn.2d 26, 30, 666 P.2d 351 (1983).

Under Amici’s approach, however, Dr. Sauerwein owed Ms. Anaya no duty to disclose her blood test simply because Dr. Sauerwein drew the wrong inference from the blood test and deemed it a false positive. Under that approach, the physician’s subjective views, and not the reasonably-prudent-patient standard, governs disclosure. Likewise, the physician’s subjective views would allow the physician to make treatment decisions alone; the patient would not have to be consulted. This approach conflicts not only with the statute language’s explicitly patient-centered standard for disclosure, *see* RCW 7.70.050(2), but the deeper *reason* for that standard: patient sovereignty.

B. Amici’s position conflicts with precedent.

1. *Gates* remains binding precedent.

Gates presents an insuperable barrier to Amici’s argument. In that case, the ophthalmologist was aware of the patient’s borderline test for glaucoma, but did not disclose it because he did not believe that the patient

had glaucoma. 92 Wn.2d at 247–48. The ophthalmologist, like Dr. Sauerwein here, drew the wrong inference from the test for glaucoma. If Amici are right about the law, the ophthalmologist would not have been required to disclose the test result. But the *Gates* Court held otherwise.

Recognizing that *Gates* defeats their position, Amici argue that *Gates* is no longer good law because it was decided under the common law instead of RCW 7.70.050. In *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 170 P.3d 1151 (2007), however, the Court rejected this argument. In *Stewart-Graves*, the plaintiffs argued that *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980), which applied the common law’s emergency exception to an informed-consent claim, was “inapplicable because it was decided under the common law duty of informed consent, not RCW 7.70.050.” *Stewart-Graves*, 162 Wn.2d at 125. The Court disagreed, noting that “[i]n adopting RCW 7.70.050, the legislature codified the common law doctrine of informed consent.” *Id.* “Thus,” the Court reasoned, “*Keogan*’s holding has continuing application.” *Id.* The same goes for *Gates*: it remains good law.

Quite apart from what this Court said in *Stewart-Graves*, Amici’s argument that *Gates* has been abrogated is illogical. *Gates* itself makes clear that it is applying the standard of *Miller v. Kennedy*, 11 Wn. App. 272, 522 P.2d 852 (1974), *aff’d*, 85 Wn.2d 151, 530 P.2d 334 (1975).

See Gates, 92 Wn.2d at 251 (“[A]pplication of the doctrine of informed consent to circumstances other than treatment of a diagnosed disease is nothing new. *Miller v. Kennedy* itself involved evaluating the risks of a diagnostic procedure . . .”). And, as everyone agrees, the standard of *Miller* was codified in RCW 7.70.050. (Amici Br. 8 n.5.) Because *Gates* applied the law codified in RCW 7.70.050, it is binding precedent with respect to RCW 7.70.050.

Amici cite *Smith* to support their argument that *Gates* has been abrogated, but *Smith* was not addressing RCW 7.70.050, the informed-consent statute. Instead, it addressed the negligence standard of RCW 7.70.040. *Smith*, 100 Wn.2d at 38. That statutory standard of care, unlike the law governing informed-consent claims, was intended to depart from, rather than incorporate, the prior common-law standard. *See McKee v. Am. Home Prods. Corp.*, 113 Wn.2d 701, 723, 782 P.2d 1045 (1989). *Gates* is still binding law, and *Smith* does not show otherwise.

The fact that *Gates* is still binding law also refutes Amici’s assertion that Mr. Anaya wants to “dramatically change the settled law of the past 35 years.” (Amici Br. at 1.) Mr. Anaya wants to restore the law to what it was before the Court of Appeals issued the decision under review. Under that law, physicians must disclose material test results of which they were aware.

2. *Backlund provides no support to Amici.*

Fleeing from *Gates*, Amici appeal to *Backlund* to support their view that physicians aware of a material fact need not disclose it if, like Dr. Sauerwein, they draw the wrong inference from that fact. Amici misread *Backlund*.

Contrary to Amici, *Backlund* did not hold that a so-called misdiagnosis, without more, immunizes a physician from an informed-consent claim. Rather, it held that a physician who is *ignorant* of a material fact *because of* a misdiagnosis cannot be subject to an informed-consent claim. *Backlund* chose its language carefully when it described the circumstances in which a patient cannot bring an informed-consent claim: namely, circumstances in which a physician “misdiagnoses the patient’s condition *and is therefore unaware* of an appropriate category of treatments or treatment alternatives.” 137 Wn.2d at 661 (emphasis added). Such a physician is exempted from disclosing a fact because she is unaware of the fact, not merely because of the presence of a “misdiagnosis.” It does not follow from *Backlund* that when a physician is actually aware of a material fact, the additional presence of “misdiagnosis” would excuse nondisclosure.

Indeed, *Backlund* itself focused on *whether* the physician was aware, as opposed to the *reason* for the physician’s awareness or lack

thereof. *Backlund* held that even though the physician had concluded, in his professional judgment, that the infant patient's condition did not call for the alternative treatment of blood transfusion, nothing "suggest[ed]" that the physician "was unaware of the transfusion alternative." *Id.* at 662. And, precisely because the physician *was* aware, "a trier of fact might still have found he did not sufficiently inform the patient of risk and alternatives in accordance with RCW 7.70.050." *Id.* What mattered in *Backlund* was not the talismanic label of "misdiagnosis," but the practical question whether the doctor was actually aware of the material fact. (*See* Pet. for Review at 15–16.) Here, because Dr. Sauerwein was aware of the blood test, he is subject to an informed-consent claim for failing to disclose it.

Amici nevertheless seek to draw support from a hypothetical discussed in *Backlund*, if not from *Backlund*'s facts or reasoning. In that hypothetical, the Court said that a physician who misdiagnoses a patient's headache as transitory, when in fact it is caused by a brain tumor, cannot be subject to an informed-consent claim "for failing to secure the patient's informed consent for treatment for the undetected tumor." *Backlund*, 137 Wn.2d at 661 n.2. But that hypothetical is not this case. The physician in the hypothetical would not have to discuss an "undetected tumor" with the patient. But if the physician performed a test that was positive for a

tumor, *that* fact would have to be disclosed. In other words, the *Backlund* hypothetical does not help Dr. Sauerwein because he had a positive, material test result that he failed to disclose.⁴

C. Even under Amici's view of the law, this cannot be a "misdiagnosis" case.

On Amici's view, whether a case involves a "misdiagnosis" depends on the health provider's subjective state of mind. Because Dr. Sauerwein did not subjectively believe that the blood test was correct, he "misdiagnosed" Ms. Anaya and did not have to disclose the blood test.

Even on this view, however, this case is not about a "misdiagnosis." A reasonable jury could easily find that Dr. Sauerwein was aware that the blood test might well be correct. In his testimony, he continually emphasized how much the blood test "concerned" him. (6/10/11 RP 76:1514–16, 85:1671–76, 98:1930.) He was "uncertain about what it meant." (6/7/11 RP 71:1399.) And he noted in his contemporaneous notes that even if Ms. Anaya was *not* "currently ill," the blood test was merely "a *probabl[e]* contaminant." (*Id.* at 58:1154, 59:1171, 59:1174 (emphasis added).) Most telling of all, he concluded that

⁴ Amici's discussion of *Bays v. St. Lukes Hospital*, 63 Wn. App. 876, 825 P.2d 319 (1992) suffers from the same flaw as their discussion of the *Backlund* hypothetical. In *Bays*, the court held that a physician did not have to disclose potential medical problems where an x-ray, to quote Amici's squib, "did not appear to indicate any of the four medical problems." (Amici Br. at 15.) Again, Mr. Anaya agrees. But if the x-ray was *positive* for a problem, *that* fact would have to be disclosed.

Ms. Anaya's currently scheduled appointment in two weeks was "too far out," and asked the nurse to reschedule that appointment for the next week. (*Id.* at 66:1308–09.) There is substantial evidence that Dr. Sauerwein knew that deeming the blood test a false positive was risky.

On Amici's view of the law, Dr. Sauerwein's subjective state of mind determines whether this is a "misdiagnosis" case. Even on that view, this is not such a case. Dr. Sauerwein was far from certain that the blood test was a false positive. He knew that there were risks in deeming it a false positive. Thus, even if Amici's incorrect view of the law were accepted, Dr. Sauerwein still owed Ms. Anaya duty to inform her that the positive blood test for yeast might well be correct.

III. Because the blood test related to the treatment that Dr. Sauerwein recommended to Ms. Anaya, the informed-consent statute required Dr. Sauerwein to disclose the blood test to her.

Amici argue that the informed-consent claim here fails as a matter of law because Dr. Sauerwein had not recommended any treatment to her. (Amici Br. at 14.) As a result, say Amici, there is no evidence to support the first or second elements of an informed-consent claim: first, that Dr. Sauerwein withheld a material fact "relating to the treatment"; and second, that Ms. Anaya "consented to the treatment without being aware of or fully informed of such material fact." RCW 7.70.050(1)(a), (b).

Amici's argument depends on a strained interpretation of "treatment" that has no support in the statute or in Washington decisions. Amici seek to limit treatment to an "invasive procedure." (Amici Br. at 7 n.4.) Interpolating this theory into the statute, they reason that because the statute requires disclosure of facts "relating to the treatment," RCW 7.70.050(1)(a), the duty to disclose can only apply to an "invasive procedure." And, under this construct, if a physician has not yet proposed an invasive procedure, there is no "treatment" for which the patient's consent is needed.

The argument finds no support in the facts or the law. The facts show that Dr. Sauerwein did recommend an affirmative intervention—i.e., treatment. Amici's narrow interpretation of "treatment" also conflicts with the language of RCW 7.70.050, leaves patient sovereignty unprotected, and cannot be squared with the doctrinal foundations of Washington's law of informed consent.

A. Dr. Sauerwein recommended affirmative "treatment" to Ms. Anaya.

Even if "treatment," under the statute, required some kind of affirmative intervention, Dr. Sauerwein *did* recommend treatment to Ms. Anaya. He did not do nothing after receiving the positive blood test. Instead, concerned about the test, he consulted a colleague, formed a plan,

directed a nurse to contact Ms. Anaya to learn how she was feeling, and rescheduled her follow-up appointment from two weeks out to one week out. (6/7/11 RP 66:1308–16; 6/10/11 RP 76:1514–85:1690.) This affirmative intervention in Ms. Anaya’s life satisfies even a narrow interpretation of “treatment.”

B. Amici’s narrow definition of “treatment” conflicts with the language of Washington’s informed-consent statute, as well as the fundamental principles that animate it.

Amici not only ignore the facts, however; they also ignore the law. They read “treatment,” under RCW 7.70.050, to reach only a doctor’s affirmative actions or interventions. That reading of “treatment” conflicts with the statutory language. For when RCW 7.70.050 gives a list of those “[m]aterial facts . . . which must be established by expert testimony,” it gives this list:

- (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.*

RCW 7.70.050(3)(a)–(d) (emphasis added). Thus, under the last category of “material facts” that must be established by expert testimony, the statute

lists risks, complications and benefits related to “possible alternative forms of treatment, including nontreatment.” RCW 7.70.050(3)(d). This unambiguous language make it clear that “nontreatment” is just another “form[] of treatment.” To put it differently, the statute includes nontreatment—i.e., a doctor’s decision *not* to make an affirmative intervention—within the larger category of treatment. Thus, for purposes of the informed-consent statute, a decision not to make an affirmative intervention is treated as simply another form of “treatment.” The very premise of Amici’s argument—that only affirmative interventions count as “treatment” under the informed-consent statute—is incorrect.⁵

It only makes sense that the Legislature decided that “nontreatment” is just another “form[] of treatment,” RCW 7.70.050(3)(d), since any other decision would not have protected patient sovereignty. When a doctor unilaterally elects nontreatment without telling the patient what the patient needs to consent to that nontreatment intelligently, it invades a patient’s “right to chart his own destiny . . . with dignity” just as much as recommending affirmative treatment without full disclosure.

Miller, 11 Wn. App. at 282.

⁵ The Court should look to RCW 7.70.050(3) to inform the meaning of RCW 7.70.050(1). “When the same words are used in different parts of the same statute, it is presumed that the Legislature intended that the words have the same meaning.” *Timberline Air Serv., Inc. v. Bell Helicopter-Textron, Inc.*, 125 Wn.2d 305, 313, 884 P.2d 920 (1994); *see also Medcalf v. Dep’t of Licensing*, 133 Wn.2d 290, 301, 944 P.2d 1014 (1997)).

Extending the protections of informed consent *only* to situations where the physician recommends affirmative intervention would also conflict with the doctrinal foundation of Washington's informed-consent law. In contrast to some states, Washington's informed-consent law has outgrown the connection it may once have had with the law of battery, under which an informed-consent violation is conceptualized solely as a kind of nonconsensual touching. *See Miller*, 11 Wn. App. at 281–82; *see also Bundrick v. Stewart*, 128 Wn. App. 11, 17, 114 P.3d 1204 (2005). Rather, our law of informed consent has grown into a branch of the law of fiduciary duty. “The duty of the doctor to inform the patient is a fiduciary duty.” *Miller*, 11 Wn. App. at 282. Thus, it makes no sense in Washington to require that the doctor propose an affirmative intervention, since a health provider's duty to disclose arises not out of an act of “touching,” but out of the fiduciary duty of candor: to tell the patient all of those material facts of which the physician is aware.

IV. As the statutory language makes clear, the informed-consent statute applied to Dr. Sauerwein even though he had not yet made a conclusive diagnosis.

At certain points in their brief, Amici appear to hint that Dr. Sauerwein was under no duty to disclose the blood test simply because he

had not yet made a conclusive diagnosis.⁶ (See Amici Br. at 2, 9.) The plain language of the statute does not require a conclusive diagnosis. The four elements of an informed-consent claim are laid out in RCW 7.70.050(1). None of them require the plaintiff to show that the physician has already made a conclusive diagnosis. To require proof of only four elements is, by implication, *not* to require proof of any other elements. See, e.g., *State v. Ortega*, 177 Wn.2d 116, 124, 297 P.3d 57 (2013).

If, Amici are arguing that the blood test was not a fact “relating to the treatment,” RCW 7.70.050(1)(a), because the test was diagnostic, they are incorrect for three reasons.

First, diagnosis is not distinct from treatment; it is part and parcel of treatment. Treatment *includes* diagnosis, for without diagnosis, the rest of treatment could not occur. See *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 648 (Wis. 2012) (“[D]iagnosis is an essential component of modes of treatment . . .”). Because the blood test was a fact relating to diagnosis, it was necessarily a fact “relating to the treatment.”

⁶ Amici, however, do not really seem to believe that a conclusive diagnosis is necessary before a duty to disclose can arise. They concede, for example, that “an invasive procedure done” during the process of diagnosis, “such as the biopsy in *Miller v. Kennedy*,” requires informed-consent. (*Id.* at 7 n.4.) A kidney biopsy could not trigger the duty to inform if, as Amici appear to maintain, the physician must make a conclusive diagnosis before the duty to disclose is triggered. The biopsy is necessary only because the doctor has *not* made a conclusive diagnosis.

Second, even if, *arguendo*, treatment and diagnosis are distinct, the blood test here was nevertheless a fact “relating to the treatment.” That is true for the simple reason that the blood test affected the treatment decisions that Dr. Sauerwein made: it prompted him to consult with a colleague, to inquire into how Ms. Anaya was currently feeling, and to reschedule her appointment from two weeks out to one week out. The treatment decision that Dr. Sauerwein made was thus “relat[ed] to” the blood test. RCW 7.70.050(1)(a).

Third, excluding decisions made during diagnosis from statute’s ambit would undermine patient sovereignty, the ability to learn the “material facts the patient” must know “to intelligently chart [his or her] destiny with dignity.” *Miller*, 11 Wn. App. at 282. Instead, a physician would have exclusive control over the management of a patient until the physician condescended to render a conclusive diagnosis. That result would be inconsistent with the physician’s status as a fiduciary who must let the patient know the material facts they learn both before a conclusive diagnosis and after it.

CONCLUSION

All of Amici’s arguments should be rejected. First, Mr. Anaya does not ask for a strict-liability standard. Second, a physician cannot withhold an objectively material blood test result simply because he subjectively

believes it to be a false positive. Third, Dr. Sauerwein did recommend treatment. Fourth and last, the informed-consent statute applied to Dr. Sauerwein even though he had not yet made a conclusive diagnosis.

Patients should not be kept in the dark about important test results. They are partners in their own care, including what is arguably the most crucial phase of that care, the diagnostic process. For these reasons and the others that Mr. Anaya has stated elsewhere, the Court of Appeals should be reversed and this case remanded for trial.

Respectfully submitted this October 18, 2013.

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

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CERTIFICATE OF SERVICE

I certify under penalty of perjury of the laws of the State of Washington that on October 18, 2013, I caused a true and correct copy of the foregoing PETITIONER'S BRIEF IN ANSWER TO BRIEF OF AMICI CURIAE WASHINGTON STATE MEDICAL ASSOCIATION AND WASHINGTON STATE HOSPITAL ASSOCIATION to be delivered via email and U.S. Mail postage prepaid.

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Attached for filing is Petitioner's Brief in Answer to Brief of Amicus Curiae Washington State Medical Association and Washington State Hospital Association

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