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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.

SUPPLEMENTAL BRIEF OF PETITIONER

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INTRODUCTION AND SUMMARY

Under Washington's informed-consent law, physicians must disclose all material "facts relating to the treatment." RCW 7.70.050(1)(a). A fact is material if a reasonably prudent patient would "attach significance" to it in making a decision about treatment. RCW 7.70.050(2).

Despite learning that Christina Anaya's blood had tested positive for yeast, Defendant Dr. Mark Sauerwein decided on his own that the test was a false positive and did not tell her about it. But a reasonably prudent patient in Ms. Anaya's position, being advised of the undisputed fact that false positives for yeast are almost nonexistent, would have attached significance to the positive test for yeast. (6/8/11 RP 29:552-59.) Because the test result was material, Dr. Sauerwein violated the informed-consent law by withholding it from Ms. Anaya.

Our informed-consent law gives a clear answer to this case, and a jury should have heard and decided the informed-consent claim of Ms. Anaya's estate. Understandably, Defendants seek to evade the informed-consent law altogether by characterizing Dr. Sauerwein's decision to withhold the test result as a "misdiagnosis" that is actionable solely under a negligence theory. But *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), which remains good law, forecloses Defendants' creative characterization. In doing so, *Gates* establishes the only applicable rule

that is consistent with the fundamentals of Washington's informed-consent law. *Gates* upholds the animating principle of Washington's informed-consent law—the principle that patients are entitled to make their own health care decisions. Equally important, it is faithful to the text and history of the informed-consent statute, RCW 7.70.050.

ISSUE PRESENTED FOR REVIEW

Under Washington's informed-consent law, must a patient be informed of a medical test result showing that the patient may have a serious—and, in this case, potentially fatal—condition?

STANDARD OF REVIEW

The trial court granted Defendants judgment as a matter of law. (6/9/11 RP 69:1343–49.) The Court reviews that decision de novo, applying the same legal standard as the trial court. *Davis v. Microsoft Corp.*, 149 Wn.2d 521, 530–31, 70 P.2d 126 (2003). In its review, the Court views the evidence in the light most favorable to Ms. Anaya's estate and draws all reasonable inferences in its favor. *Sing v. John L. Scott, Inc.*, 134 Wn.2d 24, 29, 948 P.2d 816 (1997). Viewing the evidence in that manner, a court can grant judgment as a matter of law only if it can say that there is no substantial evidence to sustain a verdict for Ms. Anaya's estate—only if no “rational, unbiased person” could return a verdict in the estate's favor on the informed-consent claim. *Davis*, 149 Wn.2d at 531.

ARGUMENT

I. *Gates v. Jensen* is indistinguishable and requires reversal.

Gates v. Jensen held that a patient stated a valid informed-consent claim against an ophthalmologist for failing to inform her of abnormal test results. It determined that a “duty of disclosure arises . . . whenever the doctor becomes aware of an abnormality which may indicate risk or danger.” *Gates*, 92 Wn.2d at 251. “To require less,” the Court said, would deprive patients of their sovereign right “to choose the course [their] life will take.” *Id.*

In *Gates*, a patient consulted an ophthalmologist, who measured the pressure in her eyes and found it to be in the “borderline area for glaucoma.” *Id.* at 247. The ophthalmologist did not tell the patient about the high pressure in her eyes or about the two other simple and inexpensive tests for glaucoma. Instead, he said he had checked for glaucoma and “found everything all right.” *Id.* at 248. In fact, the patient had early-stage glaucoma and eventually went blind. *Id.* at 248–49.

Indistinguishable facts are presented here. On August 24, 2006, Christina Anaya’s blood tests came back positive for yeast. (6/7/11 RP 48:962–70.) After receiving the test result, Dr. Sauerwein testified, he was “puzzled” and “concerned.” (6/10/11 RP 76:1514–15.) He consulted with another doctor and decided to treat the test as a false positive if Ms. Anaya

did not report feeling sick. (*Id.* at 78:1557–79:1569, 80:1581–84; 6/7/11 RP 58:1154–56.) Ms. Anaya had just visited a hospital because she had been unable to urinate, had been catheterized, and had finally been able to empty her bladder—so she told Dr. Sauerwein’s nurse that she felt “better.” (6/7/11 RP 64:1271–74.) Dr. Sauerwein told his staff to contact Ms. Anaya to move up her next appointment. (*See* 6/10/11 RP 93:1826–27 (after hearing from the nurse who spoke with Ms. Anaya, “I still wanted her to come back sooner than her original appointment was for.”)) But neither Dr. Sauerwein nor his staff ever told Ms. Anaya that her blood tested positive for yeast—an omission that caused her death. (6/7/11 RP 67:1336–69:1369.) She did in fact have a yeast infection. Plaintiff’s evidence was that the broad-spectrum antifungal Amphotericin B, as well as other antifungal medicines, were effective treatments for that infection, and that if timely treated, she would have lived. (6/9/11 RP 27:517–20, 27:526, 29:560–66; 6/8/11 RP 40:775–82.)¹

¹ In their Answer to the Petition for Review, Defendants argued that Mr. Anaya had not presented sufficient evidence of proximate cause. This is not correct. Plaintiff’s expert testified that it is “pretty easy” to say that Ms. Anaya would have lived if antifungal treatment had been given timely. (6/8/11 RP 40:780–82.) Defendants’ proximate-cause arguments fail for two reasons. First, on review of judgment as a matter of law, the Court must accept plaintiff’s evidence as true. *Douglas v. Freeman*, 117 Wn.2d 242, 247, 814 P.2d 1160 (1991). Second, proximate cause is not before the Court. The issue was not included in the Petition for Review, and Defendants did not cross-petition on it. Proximate cause was omitted from Defendants’ list of issues presented to the Court of Appeals. (Br. of Respondents at 3–4.) The Court of Appeals did not reach the issue. This Court, whose review is “limited to questions presented before and determined by” the Court of Appeals “and to claims of error directed to that court’s resolution,” should

The similarities between this case and *Gates* are unmistakable. Dr. Sauerwein, like the ophthalmologist in *Gates*, learned of a test result suggesting that his patient had a “high risk of disease.” *Gates*, 92 Wn.2d at 251. Indeed, Dr. Sauerwein learned of a test result that came back unambiguously positive for yeast, rather than merely being “borderline,” as the test result was in *Gates*. *Id.* at 247–48. Because the ophthalmologist in *Gates* had a duty to disclose the borderline test result for glaucoma, Dr. Sauerwein also had a duty to disclose the positive blood test for yeast. By withholding the test result and deciding unilaterally what treatment Ms. Anaya would receive, he violated the informed-consent law. Under *Gates*, Ms. Anaya’s estate is entitled to a jury trial on its informed-consent claim.

II. *Gates* correctly states the law.

The Court of Appeals recognized that *Gates* is controlling and yet declined to follow it. But *Gates* correctly states the law.

A. Later decisions have not overruled *Gates*.

In arguing that the Court has silently overruled *Gates*, Defendants rely on *Backlund v. University of Washington*, 137 Wn.2d 651, 975 P.2d 950 (1999), and *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980). Defendants’ reliance is misplaced. *Backlund* actually reaffirms *Gates*, and *Keogan* neither questions nor limits *Gates*.

not reach proximate cause. *Peoples Nat’l Bank of Wash. v. Peterson*, 82 Wn.2d 822, 830, 514 P.2d 159 (1973).

1. Backlund reaffirms Gates on the key point here: physicians cannot evade their duty to disclose known facts just by making their own judgment about the importance of those facts.

Defendants say that Dr. Sauerwein had no duty to disclose Ms. Anaya's blood test because, in the exercise of professional judgment, he deemed the test to be a false positive. *Backlund* warns against this kind of conflation of negligence and informed consent. It holds that physicians cannot immunize themselves from the duty to disclose known facts simply because, in the exercise of professional judgment, they deem those facts to be immaterial.

In *Backlund*, the physician treated an infant's jaundice with phototherapy rather than the alternative, riskier treatment of blood transfusion. *Backlund*, 137 Wn.2d at 655. He did not tell the patient's parents about the transfusion treatment "because he did not believe [the patient's] condition was sufficiently serious to warrant such a treatment." *Id.* at 656. Phototherapy ultimately failed, and the infant suffered brain damage. The parents sued the physician for negligence and lack of informed consent. The jury returned a defense verdict on the negligence claim. The physician then argued that—as a matter of law—the jury's negligence verdict exonerated him from the parents' informed-consent claim. *See id.* at 659. The trial court agreed, reasoning that the physician's

“non-negligent recommendation” about phototherapy meant that he had no duty to disclose any alternative to phototherapy. *Id.*

This Court rejected that mode of analysis as “confusing negligence and informed consent claims.” *Id.* An informed-consent claim, the Court explained, allows a patient to recover damages “even though the medical diagnosis or treatment was *not* negligent.” *Id.* (emphasis added). Thus, the mere fact that a physician’s professional judgment is upheld cannot exempt the physician from an informed-consent claim. Thus, the Court acknowledged that the physician, in his professional judgment, did not believe that the patient required a transfusion. *Backlund*, 137 Wn.2d at 662. “The jury upheld his professional judgment on that issue,” the Court continued, “but a trier of fact might still have found he did not sufficiently inform the patient of risks and alternatives in accordance with [the informed-consent statute].” *Id.* In other words, because negligence and informed consent are distinct legal theories, a physician’s professional judgment about a fact—whether or not that judgment is correct—cannot itself exempt a physician from the duty to disclose that fact.

In holding that a physician’s professional judgment about a fact does not negate the duty to disclose the fact, *Backlund* reaffirmed *Gates*. The ophthalmologist in *Gates*, after learning the “borderline” results of a test for glaucoma, had made a professional judgment that the patient likely

did not have glaucoma. *Gates*, 92 Wn.2d at 248. *Gates* nevertheless held that the ophthalmologist had to disclose the results of that test. Under both *Backlund* and *Gates*, a physician's unilateral judgment about material facts—such as troubling test results—cannot exempt the physician from disclosing them.

The informed-consent claim in *Backlund* ultimately failed, but only because the parents did not prove that a reasonably prudent patient in the parents' position would have attached significance to the blood transfusion alternative in making a treatment decision. *Backlund*, 137 Wn.2d at 668–69; *see also* RCW 7.70.050(2) (a fact is material if a reasonably prudent patient “would attach significance to it”). That result stemmed not from the *physician's* judgment that blood transfusion was immaterial, but from a total failure of proof by the plaintiffs. According to the Court, “The record indicates the Backlunds simply did not bear their burden of proof with respect to the reasonableness of a *patient's* consideration of alternatives.” *Backlund*, 137 Wn.2d at 669 (emphasis added).

2. ***In dicta, Backlund states that the duty to disclose does not extend to information unknown to the physician—a statement entirely consistent with Gates.***

In dicta, *Backlund* said that a plaintiff cannot base an informed-consent claim merely on a “misdiagnosis,” since a physician cannot tell a patient that the patient has a disease that the physician believes he lacks:

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.

Backlund, 137 Wn.2d at 661 n.2. This passage envisions a situation in which a physician fails to disclose facts relating to a patient’s true condition, but only because, through misdiagnosis, the physician did not become aware of those facts.

The situation envisioned by the *Backlund* dicta is distinct from both *Gates* and this case. For in both *Gates* and this case, physicians violated the inform-consent law not by failing to tell their patients about treatments for glaucoma or fungal infection, but by failing to tell their patients about test results of which the physicians were concededly aware.

In its dicta, *Backlund* also noted three decisions that had rejected informed-consent claims: *Bays v. St. Lukes Hospital*, 63 Wn. App. 876, 825 P.2d 319 (1992), *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 772

P.2d 1027 (1989), and *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 828 P.2d 597 (1992). None of these cases undermines *Gates*.

In *Bays* and *Burnet*, the physicians were not aware of a concrete fact or test suggesting the high risk of a particular disease. The plaintiffs' claim, rather, was precisely that the physicians were *not* aware of a disease but should have become so—and then should have disclosed how to treat the disease. See *Bays*, 63 Wn. App. at 879, 881–82; *Burnet*, 54 Wn. App. at 168–69. Here, Dr. Sauerwein was well aware of Ms. Anaya's positive blood test. That is enough to make *Bays* and *Burnet* inapplicable, but there is more. Dr. Sauerwein was also aware that there were risks in deeming the test result a probable false positive. The result “concerned” him, and he remained concerned even after his nurse contacted Ms. Anaya to learn how she was feeling—he rescheduled her next appointment to the following week rather than two weeks out. (6/10/11 RP 76:1514–15, 93:1825–27.) As this persistent concern shows, Dr. Sauerwein consciously knew that the positive blood test result might well be correct.

Thomas, the third case cited by *Backlund*, is even further removed from *Gates* and this case. In *Thomas*, the physician examined a patient, ruled out pesticide poisoning, and *correctly* diagnosed the patient as suffering from asthma rather than pesticide poisoning; the physician was not accused of withholding the results of his examination. See *Backlund*,

137 Wn.2d at 661; *Thomas*, 65 Wn. App. at 258, 260–61. Of course a physician need not disclose a condition that a patient lacks and that test results have ruled out—but that fact neither casts doubt on *Gates* nor helps Dr. Sauerwein, who received a test result indicating that Ms. Anaya *did* have a fungal infection.

Thus, neither *Backlund* nor the appellate decisions it cites—indeed, no Washington decision other than the one under review—holds that when a physician learns of an abnormal test result, the physician may withhold the result based on a unilateral decision that the test may be reporting a false positive. When those cases say that “misdiagnosis” cannot give rise to an informed consent claim, they have simply been pointing out that physicians have no duty under the informed-consent law to disclose any facts that they do not know, regardless of whether the physician’s ignorance comes about through negligence or otherwise. The informed-consent claim here, by contrast—just like the informed-consent claim in *Gates*—has always been about information that a physician admittedly knew and yet withheld.

3. *Keogan rejects an informed-consent claim in a case where—unlike Gates—the physician had no facts to disclose.*

A year and a half after *Gates*, this Court decided *Keogan v. Holy Family Hospital*. There, Timothy Keogan, complaining of chest pain,

made two office calls to Dr. Kenneth Snyder within a two-week period. *Keogan*, 95 Wn.2d at 330 (Hicks, J., concurring in part and dissenting in part). While angina “did cross Dr. Snyder’s mind as a possible cause of Keogan’s chest pain,” Dr. Snyder concluded that cartilage inflammation was the “probable cause” after “taking a history and examining Keogan.” *Id.* Not long after, however, Keogan collapsed at home, was taken to the emergency room, and eventually suffered cardiac arrest. *Id.* at 309–11 (opinion of Horowitz, J.). Keogan’s survivors asserted an informed-consent claim against Dr. Snyder for failing to tell Keogan about the possibility that he was suffering from angina or about three tests that could diagnose angina.

Keogan rejected this claim because the physician had not become aware of any material facts that he withheld from the patient. The opinion of the Court on the informed-consent claim summarized *Gates* as holding 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.” 95 Wn.2d at 329 (Hicks, J., concurring in part and dissenting in part). Without expressing any criticism of that holding, Justice Hicks explained that the facts in *Keogan* were different. The physician in *Gates*, like Dr. Sauerwein here, had test results indicating an abnormality. In contrast, in *Keogan*, the physician had learned of no

diagnostic result that suggested the risk of disease. *See id.* at 330 (agreeing that there was “no diagnosis nor diagnostic procedure involving risk to the patient” (quotation marks and citation omitted)). Thus, the physician had learned of no dangerous bodily abnormality that he could disclose to the patient. *Id.*

Here, though, there *was* a diagnostic result, and Dr. Sauerwein was consciously aware of it. He knew that Ms. Anaya’s blood test had come back positive. Nothing in *Keogan* suggests that the Court would have approved a refusal to give informed-consent instructions if the physician had *withheld* worrisome test results. Indeed, it taxes credulity that Justice Hicks intended to overrule *Gates*, whose informed-consent analysis he had joined.² Under *Keogan*’s own summary of the *Gates* holding, Dr. Sauerwein is subject to an informed-consent claim because he had become “aware of a bodily abnormality which may indicate risk or danger, whether or not the diagnosis has been completed.” *Id.* at 329.

4. *Out-of-state courts have cited Gates with approval.*

Finally, *Gates* has been cited with approval by other courts— citations that speak strongly against the notion that *Gates* has somehow been overruled. In *Jandre v. Wisconsin Injured Patients & Families*

² *See Gates*, 92 Wn.2d at 254 (Dolliver, J., joined by Hicks, J., concurring in part and dissenting in part) (“I do not quarrel with the analysis and result of the majority on the issue of informed consent.”).

Compensation Fund, a patient reported to the emergency room with facial paralysis. 813 N.W.2d 627, 640 (Wis. 2012) (plurality opinion). The physician diagnosed Bell's palsy, and a jury concluded that the diagnosis was not negligent. But the physician did not tell the patient about a simple test, which she did not perform, that would have ruled out or ruled in a blocked artery, a condition posing "imminent, life-threatening risks." *Id.* at 635. The defense there argued what is also urged here: that the case simply involved a "misdiagnosis" that was not actionable under an informed-consent theory. *Id.* at 649. The Wisconsin Supreme Court looked to *Gates* to support its conclusion that the patient's informed-consent claim should proceed where the physician never told the patient about the possibility of a dangerous condition and the inexpensive tests available to rule it out. *Id.* at 665. In *Moore v. Preventive Medicine Medical Group, Inc.*, a physician examined a mole on a patient's ear and, without making any final diagnosis, recommended follow up. 223 Cal. Rptr. 859, 861 (Ct. App. 1986). But the physician did not inform the patient of the risk of not following up, which was that the mole could be cancerous. The Court cited *Gates* (and *Keogan*) in support of its holding that "Mason had a duty to disclose to Moore all material information which would enable Moore to make an informed decision whether to see the specialist or not." *Id.* at 863-64.

Of course, comparisons with other states can sometimes fail to enlighten. Informed-consent claims in Washington are governed by RCW 7.70.050, a statute that sets forth the elements to be proven, the test for materiality, and the circumstances in which disclosure is required. Other states' laws of informed consent are often based on common law and statutory provisions that differ from RCW 7.70.050. Other courts' approving citations to *Gates*, however, belie any argument that *Gates* has been overruled.

B. *Gates* establishes the only rule applicable to this case that is consistent with patient sovereignty and the informed-consent statute.

No Washington precedent calls into question *Gates*'s holding that when physicians become aware of test results that suggest a risk of disease, they must disclose them. The rule of *Gates* is not merely mandated by *stare decisis*, though. *Gates* also establishes the only rule that is consistent with the fundamentals of our informed-consent law.

1. *Gates* preserves patient sovereignty by making the patient, and not the physician, the measure of what must be disclosed.

Patient sovereignty—the right of patients to make their own health care decisions after being fully informed—is the “underlying principle” of Washington’s informed-consent law. *Smith v. Shannon*, 100 Wn.2d 26, 30, 666 P.2d 351 (1983). And because it is patients who control their own

health care decisions, it is patients, and not physicians, who are entitled to “determine what information should be disclosed.” *Id.*

Under the law, therefore, if a “reasonably prudent patient,” after being “fully advised of the material known risks,” *Backlund*, 137 Wn.2d at 665 n.4, would “attach significance” to a fact in making a treatment decision, the fact is “material” and so must be disclosed. RCW 7.70.050(2). A reasonably prudent patient in Ms. Anaya’s position would have attached significance to the positive blood test for yeast. (*See supra* p. 1; *see also* Pet. for Review at 13.) The test was thus material, and Ms. Anaya should have been told about it.

But, for Defendants, what matters is not that the test would have been material to a reasonably prudent patient in Ms. Anaya’s position, but that the test was not material to Dr. Sauerwein. After all, they take the position that by tentatively determining that the blood test could be a false positive, Dr. Sauerwein “misdiagnosed” Ms. Anaya and so was allowed to withhold the test from her. That line of reasoning makes Dr. Sauerwein’s personal views about the test, and not the views of a reasonably prudent patient, the measure of what must be disclosed. That is not permitted by the informed-consent law’s patient-centered definition of “material fact,” or by the motivating force behind that definition, patient sovereignty. *See Smith*, 100 Wn.2d at 30.

If physicians' personal views about test results could allow them to withhold those results, patient rights would be radically undermined. *Any* test result could be withheld so long as the physician unilaterally determined that the result did not indicate a disease. A physician could, for example, withhold a borderline mammogram³ from a patient out of a paternalistic desire not to worry her. Even if it fell within the standard of care to conclude that the patient likely did not have breast cancer, a reasonably prudent patient would still want to know about the test result and the resulting risks and alternatives. Defendants' position would deprive patients of that information.

2. *Gates recognizes that the informed-consent law applies to the diagnostic process, just as to the rest of medical treatment.*

By arguing that Dr. Sauerwein had nothing to disclose to Ms. Anaya, Defendants take the position that the diagnostic process is off-limits to the informed-consent law. *Gates* rightly rejects this position as incompatible with patient sovereignty.

According to Defendants, Dr. Sauerwein did not know that Ms. Anaya had any risky abnormality, and thus had nothing to disclose to her,

³ See Margaret M. Eberl et al., *BI-RADS Classification for Management of Abnormal Mammograms*, 19 J. Am. Bd. Fam. Med. 161, 162 & n.† (2006) (explaining the standard radiological classification of abnormal mammograms, including a category that is not classified as negative for a malignancy, but that also is not positive), available at <http://www.jabfm.org/content/19/2/161.full>.

because her “clinical picture” was so “confusing and puzzling.” (Answer to Pet. at 7, 19.) They say that while a patient with a fungal infection would normally be sick, Ms. Anaya had reported she was “better” after visiting the hospital and emptying her bladder. (*Id.* at 8.) In other words, because Dr. Sauerwein had no conclusive evidence of a fungal infection—and thus had settled on no conclusive diagnosis—he was exempted from the duty of disclosure. Under that approach, as long as the diagnostic process continues, no duty of disclosure can arise.

Under *Gates*, though, a physician may not withhold a test result suggesting a high risk of disease just because there is no *conclusive* evidence of disease and no conclusive diagnosis: “The patient’s right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed.” *Gates*, 92 Wn.2d at 250; *see also id.* at 247 (the pressure in the patient’s eyes was in the “borderline area for glaucoma”). *Gates* explains that clinical uncertainty only makes disclosure *more* important, since some of the most important medical decisions are made before there is a conclusive diagnosis. *See id.* at 250–51 (“Important decisions must frequently be made in many non-treatment situations . . . , including procedures leading to a diagnosis . . .”).

Gates was correct that a patient’s right to know and to choose is just as important during diagnosis as after a conclusive diagnosis is made.

Diagnosis determines the entire course of subsequent treatment. While withholding material facts about a procedure performed after diagnosis affects only the patient's right to know about that discrete procedure, withholding material facts unearthed during the process of diagnosis affects the patient's right to know about an entire course of possible treatment. Without a patient's intelligent participation during diagnosis, a patient cannot "make an informed decision on the course which future medical care will take." *Id.* at 251.

3. *Only the rule of Gates is faithful to the statute.*

In holding that informed-consent doctrine applies just as much to the process of diagnosis as it does to procedures performed after diagnosis, *Gates* establishes a rule that is faithful to our informed-consent statute. A rule that exempts diagnosis from informed consent conflicts with statutory text and history.

The informed-consent statute requires physicians to inform patients of "a material fact or facts *relating to the treatment.*" RCW 7.70.050(1)(a) (emphasis added). This language easily encompasses facts that a physician learns during the process of diagnosis.

The informed-consent statute, moreover, was intended to codify *Miller v. Kennedy*, 11 Wn. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wn.2d 151, 530 P.2d 334 (1975), and *Miller* applied the informed-consent

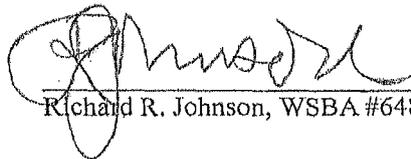
doctrine to a kidney biopsy that was part of a diagnostic process. *See* Final B. Rep. on Substitute H.B. 1470, 44th Leg., 1st Ex. Sess., at 23 (Wash. 1976) (explaining that RCW 7.70.050 incorporates the standard of *Miller*). As this history shows, the Legislature intended that the diagnostic process be subject to normal informed-consent rules.

CONCLUSION

This case asks whether a physician may unilaterally determine not to share a material test result with a patient. The answer given by both precedent and principle is “no.” This Court’s decisions, as well as the underlying principle of patient sovereignty, give patients and not physicians the right to determine the information they need to make an intelligent health care decision. The Court should therefore reverse the Court of Appeals.

Respectfully submitted this August 19, 2013.

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



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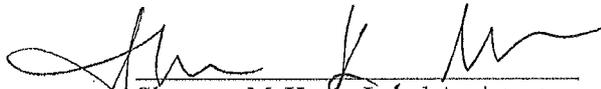
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CERTIFICATE OF SERVICE

I certify under penalty of perjury of the laws of the State of Washington that on August 19, 2013, I caused a true and correct copy of the foregoing SUPPLEMENTAL BRIEF OF PETITIONER to be delivered via e-mail and federal express as follows:

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Dear Clerk:

Please find attached for filing the Supplemental Brief of Petitioner. Below is the case information:

- **Case name:** *Rodolfo Anaya Gomez v. Mark F. Sauerwein, MD, et al*
- **Case number:** 88307-6
- **Name, phone number, bar number and email address of person filing the Supplemental Brief of Petitioner**

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Thank you.

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