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NO. 88307-6

IN THE SUPREME COURT  
OF THE STATE OF WASHINGTON

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RODOLFO ANAYA-GOMEZ, as Personal Representative of the Estate of  
Christina Palma-Anaya, deceased,

Petitioner,

vs.

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

Respondents.

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APPEAL FROM YAKIMA COUNTY SUPERIOR COURT  
Honorable C. James Lust, Judge

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SUPPLEMENTAL BRIEF OF RESPONDENTS

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## TABLE OF CONTENTS

	Page
I. NATURE OF THE CASE.....	1
II. ISSUES PRESENTED .....	1
III. STATEMENT OF THE CASE .....	1
A. STATEMENT OF RELEVANT FACTS .....	1
B. STATEMENT OF PROCEDURE .....	5
IV. ARGUMENT .....	7
A. THERE IS NO PROXIMATE CAUSE .....	7
B. INFORMED CONSENT DOES NOT APPLY IN MISDIAGNOSIS SUITS .....	10
1. A Doctor Need Not Disclose What Is Not Diagnosed .....	10
2. <i>Gates</i> Does Not Apply .....	17
V. CONCLUSION .....	20
APPENDIX A RCW 7.70.050	

## TABLE OF AUTHORITIES

### Washington Cases

	Page
<i>Anaya Gomez v. Sauerwein</i> , 172 Wn. App. 370, 289 P.3d 755 (2012), <i>rev. granted</i> , 177 Wn.2d 1008 (2013) .....	7
<i>Augerson v. Seattle Electric Co.</i> , 73 Wash. 529, 132 P.222 (1913).....	7
<i>Backlund v. University of Washington</i> , 137 Wn.2d 651, 975 P.2d 950 (1999) .....	10, 11, 12, 17, 19
<i>Bays v. St. Luke's Hospital</i> , 63 Wn. App. 876, 825 P.2d 319, <i>rev. denied</i> , 119 Wn.2d 1008 (1992).....	12, 13
<i>Burnet</i> , 54 Wn. App. 162, 772 P.2d 1027 (1989).....	11, 12
<i>Cregan v. Fourth Memorial Church</i> , 175 Wn.2d 279, 285 P.3d 860 (2012) .....	15
<i>Faust v. Albertson</i> , 167 Wn.2d 531, 222 P.3d 1208 (2009).....	9
<i>Gates v. Jensen</i> , 92 Wn.2d 246, 595 P.2d 919 (1979).....	17, 18
<i>Guijosa v. Wal-Mart Stores, Inc.</i> , 144 Wn.2d 907, 32 P.3d 250 (2001) .....	9
<i>Gustav v. Seattle Urological Associates</i> , 90 Wn. App. 785, 954 P.2d 319, <i>rev. denied</i> , 136 Wn.2d 1023 (1998).....	13, 14
<i>Keogan v. Holy Family Hosp.</i> , 22 Wn. App. 366, 589 P.2d 310 (1979), <i>aff'd in part, rev'd in part on other grounds</i> , 95 Wn.2d 306, 622 P.2d 1246 (1980) .....	11, 16
<i>Keogan v. Holy Family Hospital</i> , 24 Wn. App. 583, 601 P.2d 1303 (1979), <i>aff'd in part, rev'd in part on other grounds</i> , 95 Wn.2d 306, 622 P.2d 1246 (1980) .....	18, 19
<i>Keogan v. Holy Family Hospital</i> , 95 Wn.2d 306, 622 P.2d 1246 (1980) .....	12, 16, 18
<i>Matsyuk v. State Farm Fire &amp; Cas. Co.</i> , 173 Wn.2d 643, 272 P.3d 802 (2012) .....	18

<i>Miller v. Kennedy</i> , 11 Wn. App. 272, 522 P.2d 852 (1974), <i>aff'd per curiam</i> , 85 Wn.2d 151, 530 P.2d 334 (1975) .....	15, 16
<i>Rains v. State</i> , 100 Wn.2d 660, 674 P.2d 165 (1983).....	13
<i>State v. Carroll</i> , 81 Wn.2d 95, 500 P.2d 115 (1972).....	7
<i>Truck Insurance Exchange v. VanPort Homes, Inc.</i> , 147 Wn.2d 751, 766, 58 P.3d 276 (2002) .....	7

### Other Jurisdictions

<i>Block v. McVay</i> , 80 S.D. 469, 126 N.W.2d 808 (1964), <i>overruled</i> <i>in part on other grounds by Shamburger v. Behrens</i> , 380 N.W.2d 659 (S.D. 1986).....	11
<i>Brown v. Armstrong</i> , 713 S.W.2d 725 (Tex. App. 1986).....	11
<i>Glover v. Griffin Health Servs.</i> , 2006 Conn. Super. LEXIS 1841 (Jun. 15, 2006).....	11
<i>Hall v. Frankel</i> , 190 P.3d 852 (Colo. App. 2008).....	11
<i>Linquito v. Siegel</i> , 370 N.J. Super. 21, 850 A.2d 537 (2004).....	11
<i>Pratt v. University of Minn. Affiliated Hosps. &amp; Clinics</i> , 414 N.W.2d 399 (Minn.1987) .....	11
<i>Rich v. Foye</i> , 51 Conn. Supp. 11, 976 A.2d 819 (2007).....	11
<i>Roukounakis v. Messer</i> , 63 Mass. App. Ct. 482, 826 N.E.2d 777 (2005) .....	11
<i>Townsend v. Turk</i> , 218 Cal. App.3d 278, 266 Cal. Rptr. 821 (1990)..	11, 12
<i>Vandi v. Permanente Med. Group</i> , 7 Cal. App.4 <sup>th</sup> 1064, 9 Cal. Rptr.2d 463 (1992).....	11, 19, 20
<i>Wheeler v. Wise</i> , 133 Ohio App.3d 564, 729 N.E.2d 413 (1999) .....	12

### Statutes

DEL. CODE ANN. tit. 18, § 6801(6) .....	15
---	----

GA. CODE ANN. § 31-9.6.1.....	15
N.Y. PUB. HEALTH LAW § 2805-d .....	15
RCW ch. 7.70 .....	14, 18
RCW 7.70.010 .....	18
RCW 7.70.040 .....	14
RCW 7.70.050 .....	7, 9, 10, 11, 14, 15, 18
RCW 7.70.050(1)(a).....	14
RCW 7.70.050(1)(d).....	7
RCW 7.70.050(3) .....	15
RCW 18.64.011(11)(b).....	15
RCW 71.24.025(8) .....	15
RCW 71.24.061(3) .....	15
RCW 70.24.110 .....	15
RCW 79.96A.020 .....	15
VT. STATE. ANN. tit. 12, § 1909.....	15

**Other Authorities**

<a href="http://dictionary.reference.com/browse/misdiagnose?s=t">http://dictionary.reference.com/browse/misdiagnose?s=t</a> .....	17
WASHINGTON PRACTICE <i>Washington Pattern Jury Instructions</i> 105.04 (6 <sup>th</sup> ed. 2012).....	14
16 D. DeWolf & K. Allen, WASHINGTON PRACTICE <i>Tort Law &amp; Practice</i> § 15:19, at 474 (3d ed. 2006 & 2012-13 Supp.) .....	10
WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 2435 (1993).....	15

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## **I. NATURE OF THE CASE**

A jury exonerated Dr. Sauerwein, a family practice doctor, for misdiagnosing and not treating a rare yeast in the blood condition. Plaintiff has not appealed from that result. Instead, he claims the jury should have decided whether the doctor was liable for not advising the patient about the condition he did not diagnose. There was no evidence, however, of proximate cause.

## **II. ISSUES PRESENTED**

A. Did any failure to inform proximately cause plaintiff's loss, where even had defendants disclosed the information plaintiff claims they should have disclosed, the loss would have occurred anyway?

B. If "yes", can a physician be liable for not advising a patient of a condition the physician mistakenly does not diagnose?

## **III. STATEMENT OF THE CASE**

### **A. STATEMENT OF RELEVANT FACTS.**

On August 24, 2006, defendant/respondent Mark Sauerwein, M.D., the on-call family practice doctor at defendant/respondent Yakima Valley Farm Workers' Clinic, received a message that a preliminary lab report on another clinic doctor's patient—plaintiff/petitioner's decedent, Christina Anaya (the patient)—preliminarily showed an unidentified yeast in the blood. (6/7 RP 35, 41, 44, 46-49, 52; 6/9 RP 144)

Dr. Sauerwein learned the patient had been admitted to Toppenish Community Hospital on August 20 and discharged on August 21. To get more information and discuss the preliminary yeast report, he called Dr. Moran, the internal medicine physician who had treated the patient at the hospital. Since Dr. Moran had more infectious disease experience and training and had actually seen the patient, Dr. Sauerwein felt he was the best expert available. (6/7 RP 53-55, 71; 6/10 RP 77, 81-82)

Dr. Moran advised the patient had bacteria in the urine, indicating a urinary tract infection (UTI). He said she had been given IV fluids, insulin for her diabetes, and an antibiotic for the UTI. (6/7 RP 55-57)

The doctors discussed the preliminary yeast report. Everyone has yeast in the body, but not in the blood. The average family practitioner would never see the condition; Dr. Sauerwein had not since his medical training some 20 years before. Indeed, none of the parties' family practice experts, with more than 100 years' combined practice, had ever attended a patient with yeast in the blood. (6/7 RP 36, 58, 79, 102; 6/8 RP 20-21, 56; 6/9 RP 76, 90, 136; 6/10 RP 79, 109-10, 113)

Yeast in the blood is usually nosocomial—most people who get it do so while in the hospital for weeks, seriously ill with another condition. Because their immune systems are so compromised from such things as leukemia or cancer, yeast can enter the blood, typically causing fever and

making the patient even sicker. Hence, in discussing the preliminary lab report, the two doctors agreed that unless the patient was now ill and not responding to treatment, the yeast was likely a contaminant. In Dr. Sauerwein's experience, blood test contamination and inaccurate preliminary lab test results were common. (6/7 RP 58-60; 6/9 RP 109, 114, 135; 6/10 RP 80, 82-83, 98, 110-12, 124-25; 6/13 RP 12-13, 32-35)

Accordingly, a clinic nurse contacted the patient, who said she had gone to the ER on August 23 because she thought she still might have blood in her urine and was unable to urinate. The ER drained the bladder and sent her home, still on the UTI antibiotic. The patient reported she no longer had a fever and was feeling much better, albeit a bit tired. Hence, Dr. Sauerwein felt there was no medical emergency. Had the patient said she had a fever, was not feeling well, or wanted to come in, he would have had her come to the clinic. (6/7 RP 62-63, 65; 6/10 RP 83, 86-87, 94-95)

On August 26 the lab finally identified the type of yeast from the blood sample the Toppenish hospital ER had collected on August 20. It was *Candida glabrata*. Neither Dr. Sauerwein nor anyone else at defendant clinic ever received or otherwise learned of this final lab report. (Ex. 6; 6/9 RP 52-53; 6/10 RP 70-71)

Meanwhile, the patient began to feel unwell. On August 29, instead of contacting defendant clinic as its patients are told to do if they

feel ill, this patient decided to go to a Yakima hospital. The admitting doctor noted she presented "an extremely confusing picture of multiple abnormalities, including low sodium, anemia, renal failure, and urine which was positive for yeast." (Ex. 3A, p. 4) The hospital doctors initially did not know what the yeast was. Upon learning 24 hours later that it was an unspecified type of *Candida*, they started a broad spectrum antifungal, Fluconazole<sup>1</sup> aka Diflucan. (6/7 RP 140; 6/9 RP 50-52; 6/10 RP 94; 6/13 RP 24)

*Candida glabrata* is resistant to Fluconazole. On August 31, an infectious disease doctor discontinued it and began Amphotericin B, a toxic antifungal so harmful to the kidneys that most infectious disease doctors will not use it without knowing the specific yeast the patient has. This patient had significant kidney damage even before she was hospitalized: her kidneys were operating at 20% of normal. One expert explained that "infectious disease physicians [are] the only ones that should take the risk of further harming the patient[']s kidneys while they're trying to cure that [yeast] infection" by using Amphotericin B. (6/7 RP 95, 98; 6/9 RP 51; 6/10 RP 33, 39, 116, 118-19; 6/13 RP 19)

The treatment did not work. The patient died. Her death certificate

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<sup>1</sup> This brief corrects many of the misspellings contained in the VRP including this drug.

listed diabetes as the underlying cause of death. (6/10 RP 43; Ex. 8)

In fact, the patient had long had uncontrolled diabetes due to noncompliance with her doctor's recommendations. By August 2006 she had diabetes-related advanced neuropathy, amyotrophy, and kidney damage. Her hemoglobin A1c, measuring average blood sugar, was more than twice the normal reading. One of plaintiff's experts called it "alarmingly high." The one endocrinologist to testify had never seen such a reading in 31 years of practice. He testified that because of her long high blood sugar history, even had Amphotericin B been started on August 26, she would have died. (6/7 RP 103; 6/9 RP 32; 6/10 RP 21-34, 42-43)

**B. STATEMENT OF PROCEDURE.**

Plaintiff/petitioner Rodolfo Anaya Gomez, personal representative of his wife's estate, sued Dr. Sauerwein and the Clinic. (CP 1-25) The complaint alleged the following medical negligence claim (CP 5):

Defendant Sauerwein breached [the] standard of care by dismissing the blood culture containing the *Candida Glabrata* as a "probable contaminant," and in not immediately seeing Christina, and also in not immediately placing her on antifungal medications on the day that defendant Sauerwein was advised of the laboratory results for Christina's blood.

Just 17 days before trial, plaintiff sought to raise an informed consent claim, namely, that defendants had failed to inform the patient "[t]hat blood drawn from her ... on August 20 ... was reported to the

defendants on August 24 ... to contain yeast ....”<sup>2</sup> Over objection, the trial court allowed the claim. (CP 34-35, 112, 282-87)

At trial, plaintiff’s two family practice experts said Dr. Sauerwein should have advised her of the yeast in her blood and immediately started administering a broad form antifungal. Plaintiff’s infectious disease expert testified that family practice doctors such as Dr. Sauerwein should use Fluconazole. (6/7 RP 87; 6/8 RP 41; 6/9 RP 27, 48-50)

No one disputed, however, that—

- the Yakima hospital doctors did not begin Amphotericin B for 52 hours after admission, a delay that plaintiff’s infectious disease expert said did not violate the standard of care (6/9 RP 50-52); and
- Fluconazole does not work on *Candida glabrata*, so even had Dr. Sauerwein begun Fluconazole on August 24 when he learned of the preliminary lab result, it would have been ineffective. (6/9 RP 58; 6/10 RP 116-18) Plaintiff’s infectious disease expert testified (6/9 RP 58):

Q: ...you acknowledge that [D]iflucan [Fluconazole] would not have been adequate or effective to treat the Candida, correct?

A: The, the Candida Glabrata, correct.

Q.: [T]he use of [D]iflucan [Fluconazole] would not have changed the outcome for the patient, would it?

A: Ultimately no.

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<sup>2</sup> The August 24 lab report did not identify the yeast as *Candida glabrata*. (6/7 RP 104)

The trial court dismissed the informed consent claim. The jury found no medical negligence. Judgment for the defense was entered. Plaintiff's postjudgment motions were denied. (CP 103-10, 112, 114-15, 312-14; 6/9 RP 69) A unanimous Division III affirmed. *Anaya Gomez v. Sauerwein*, 172 Wn. App. 370, 289 P.3d 755 (2012). As plaintiff appealed only the dismissal of his informed consent claim, the verdict that defendants were not negligent is the law of the case. *Augerson v. Seattle Electric Co.*, 73 Wash. 529, 531, 132 P.222 (1913).

#### IV. ARGUMENT

##### A. THERE IS NO PROXIMATE CAUSE.

This Court has a duty to affirm if the judgment can be sustained on any ground, even on granting a petition for review. *State v. Carroll*, 81 Wn.2d 95, 101, 500 P.2d 115 (1972); *Truck Insurance Exchange v. VanPort Homes, Inc.*, 147 Wn.2d 751, 759, 766, 58 P.3d 276 (2002). Because there is no proximate cause, this Court must affirm.

To prove an informed consent claim, plaintiff must show the treatment for which there was no informed consent proximately caused the patient's injury. RCW 7.70.050(1)(d) (copy of RCW 7.70.050 in appendix). Even if there were such treatment here, plaintiff failed to show that "treatment" proximately caused the patient's death.

Plaintiff claimed that if Dr. Sauerwein had told the patient of the

preliminary yeast result, additional cultures would have been taken and immediate antifungal treatment started, at either defendant clinic or an ER. Plaintiff's infectious disease expert testified she would have lived had an antifungal been administered starting August 24, the day Dr. Sauerwein learned of the preliminary yeast finding. (6/7 RP 86-87; 6/9 RP 25-29) There is no substantial evidence to support this conclusory statement.

First, plaintiff's infectious disease expert testified the standard of care for a family practice doctor like Dr. Sauerwein was to use Fluconazole, which was also the most likely drug an ER doctor acting within the standard of care would have used. But the expert admitted Fluconazole would not have changed the outcome. (6/9 RP 27, 48-50, 58; *and see* 6/10 RP 127)

Second, even had two cultures been taken on August 24, as plaintiff advocated, the result would not have changed. It took 6 days for the lab to specifically identify the yeast. There was *no* evidence the patient would have lived if *Candida glabrata* had been identified on August 30, rather than August 31. (6/7 RP 25-26, 105; 6/10 RP 42, 120, 127, 141)

Third, even had the patient been told her blood contained yeast and she had gone to an ER on August 24, Amphotericin B would not have been started then, since no one knew she had *Candida glabrata*. The undisputed evidence—primarily from plaintiff's own experts—was that

most doctors would not prescribe Amphotericin B without knowing the specific yeast involved, especially with a patient whose kidneys were already damaged. An ER doctor acting within the standard of care would likely use Fluconazole. (6/7 RP 98; 6/9 RP 27, 49-50; 6/10 RP 33, 118-19)

Fourth, plaintiff claimed Amphotericin B should have been started on August 26, the day the lab identified *Candida glabrata*. But the lab never conveyed the *Candida glabrata* finding to Dr. Sauerwein or his clinic. Since the patient never told defendants she was feeling worse, and they never knew she had *Candida glabrata*, they could not have known Amphotericin B was required. (6/7/ RP 105; 6/9 RP 52-53; 6/10 RP 70-71)

Fifth, even had Amphotericin B been started on August 26, the only endocrinologist to testify opined the outcome would have been the same due to the patient's uncontrolled diabetes. (6/10 RP 42-43)

Thus, had the jury heard the informed consent claim, jurors would have had to use mere theory, speculation, or conjecture to find proximate cause. This is impermissible. *Guijosa v. Wal-Mart Stores, Inc.*, 144 Wn.2d 907, 922, 32 P.3d 250 (2001). Absent competent, substantial evidence or reasonable inferences therefrom that telling the patient she had yeast in her blood would have changed the outcome, this Court must affirm. *See Faust v. Albertson*, 167 Wn.2d 531, 537, 222 P.3d 1208 (2009).

**B. INFORMED CONSENT DOES NOT APPLY IN MISDIAGNOSIS SUITS.**

Even if the alleged failure to obtain informed consent had proximately caused the patient's death, this Court must affirm because—

The failure to inform a patient of potential risks for a condition that the physician has not yet diagnosed does not violate the duty to obtain informed consent; instead, the patient must demonstrate that the failure to diagnose constituted an act of professional negligence. *The duty to disclose risks associated with a condition arises only when the physician becomes aware of a condition by diagnosing it.*

16 D. DeWolf & K. Allen, WASHINGTON PRACTICE *Tort Law & Practice* § 15:19, at 474 (3d ed. 2006 & 2012-13 Supp.) (emphasis added) (footnotes omitted).

**1. A Doctor Need Not Disclose What Is Not Diagnosed.**

In the typical informed consent situation, a physician diagnoses the patient's condition and recommends a treatment. The physician can be liable under RCW 7.70.050 if he or she fails to advise the patient of other treatment options or the risks of the treatment recommended. *Backlund v. University of Washington*, 137 Wn.2d 651, 661 n.2, 975 P.2d 950 (1999).

This is not a typical informed consent situation. Dr. Sauerwein non-negligently, but mistakenly, believed the patient did not have yeast in her blood. Plaintiff seeks to hold defendants liable for not telling the patient about a condition the doctor reasonably believed she did not have.

In *Backlund* a newborn had jaundice. The defendant doctor

administered phototherapy, but knew blood transfusions, albeit risky, were the treatment in severe cases. The parents were not told about the transfusion alternative. The baby suffered brain damage. A jury found the doctor not negligent. The trial court dismissed the informed consent claim.

This Court said the defense verdict on the negligence claim did not require, “on these facts,” dismissing the informed consent claim,<sup>3</sup> 137 Wn.2d at 659. But this Court explained what will be referred to “the *Backlund* rule”:

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

*Id.* at 661; *see also id.* n.2. This rule is not an anomaly. Courts in several other jurisdictions follow it, many citing *Backlund* with approval.<sup>4</sup>

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<sup>3</sup> An informed consent claim could exist, for example, where a high risk treatment or diagnostic procedure (assuming *arguendo* RCW 7.70.050 includes diagnostic procedures) is provided, negligently or not, but without informed consent. *See Burnet*, 54 Wn. App. 162, 169, 772 P.2d 1027 (1989); *Keogan v. Holy Family Hosp.*, 22 Wn. App. 366, 369, 589 P.2d 310 (1979), *aff’d in part, rev’d in part on other grounds*, 95 Wn.2d 306, 622 P.2d 1246 (1980).

<sup>4</sup> Cases citing *Backlund* include *Hall v. Frankel*, 190 P.3d 852 (Colo. App. 2008); *Rich v. Foye*, 51 Conn. Supp. 11, 976 A.2d 819 (2007) (citing *Glover v. Griffin Health Servs.*, 2006 Conn. Super. LEXIS 1841 (Jun. 15, 2006) (citing *Backlund*)); *Roukounakis v. Messer*, 63 Mass. App. Ct. 482, 826 N.E.2d 777 (2005). *See also Pratt v. University of Minn. Affiliated Hosps. & Clinics*, 414 N.W.2d 399 (Minn.1987); *Block v. McVay*, 80 S.D. 469, 126 N.W.2d 808 (1964); *Vandi v. Permanente Med. Group*, 7 Cal. App.4<sup>th</sup> 1064, 9 Cal. Rptr.2d 463 (1992); *Liquito v. Siegel*, 370 N.J. Super. 21, 850 A.2d 537 (2004); *Brown v. Armstrong*, 713 S.W.2d 725 (Tex. App. 1986); *cf. Townsend v. Turk*,

*Backlund* traces its roots to *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 622 P.2d 1246 (1980), and *Bays v. St. Luke's Hospital*, 63 Wn. App. 876, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992). See *Burnet v. Spokane Ambulance*, 54 Wn. App.162, 772 P.2d 1027, *rev. denied*, 113 Wn.2d 1005 (1989). In *Keogan* the patient had chest pain, which could have been due to 200 different conditions. The defendant doctor considered, *inter alia*, angina pectoris, but diagnosed sternum cartilage inflammation. The patient later died of a heart attack. His estate claimed the doctor should have disclosed other diagnostic tools.

The 5-justice majority, denominated the concurrence/dissent, ruled there could be no informed consent claim:

If [defendant doctor] was negligent because he should have discovered [the patient's] diseased heart and failed to do so, that is what should be alleged and proved in this case. It was alleged. The jury did not find that it was proved.

95 Wn.2d at 331.

In *Bays* the defendant doctor diagnosed a dislocated shoulder and mild vertebral compression fractures. A few days later, the patient's temperature soared. Concerned about various conditions including thromboembolism, the doctor ordered a chest X-ray, which was negative.

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218 Cal. App.3d 278, 266 Cal. Rptr. 821 (1990) (no duty to disclose what physician did not believe, even if erroneous). See generally *Wheeler v. Wise*, 133 Ohio App.3d 564, 729 N.E.2d 413 (1999).

A few days later, the patient died of pulmonary embolism.

The patient's estate claimed the doctor should have disclosed thromboembolism treatments since the doctor had considered that condition as a possibility. Division III affirmed, explaining:

[T]he duty to disclose does not arise until the physician becomes aware of the condition *by diagnosing it*.

A physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform the patient...Here, it is undisputed [defendant] did not diagnose the condition of thromboembolism...[Plaintiff's] action for medical negligence is based on [the] failure to diagnose the thromboembolism which manifested itself in the early morning hours [of the day the patient died]. ...Before then, [defendant] was unaware of the thromboembolism condition. Thus, [plaintiff] is unable to establish the first element of the informed consent cause of action.

63 Wn. App. at 881-82 (emphasis added).

In *Gustav v. Seattle Urological Associates*, 90 Wn. App. 785, 954 P.2d 319, *rev. denied*, 136 Wn.2d 1023 (1998), plaintiff had a suspicious prostate nodule and elevated PSA. Defendant doctor performed several biopsies over the years, but did not find cancer. The last biopsy, however, was not completed. Another doctor found metastasized cancer. Plaintiff sued for medical negligence and failure to inform of the risk of not completing the last biopsy.

Division I affirmed summary judgment on the informed consent

claim. Noting that both the medical negligence and informed consent claims were based on the failure to diagnose cancer, the court explained:

While a physician has a duty to disclose an abnormality in the patient's body which may indicate risk or danger, a physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform. *The duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it. ....*

*Id.* at 790 (emphases added) (footnotes omitted).

The *Gustav* doctor was aware of possible cancer since he did the biopsies and knew the last was incomplete. But “the physician [must] become[] aware of the condition *by diagnosing it*” *Id.* (emphasis added); 6 WASHINGTON PRACTICE *Washington Pattern Jury Instructions* 105.04, at 604-05 (6<sup>th</sup> ed. 2012) (hereinafter “WPI”). Dr. Sauerwein considered but did not diagnose yeast in the blood. Thus, he had no duty to disclose it.

The foregoing cases are consistent with RCW ch. 7.70. RCW 7.70.040 permits medical negligence claims when a health care provider fails to follow the standard of care. Thus, the jury was allowed to decide whether Dr. Sauerwein's misdiagnosis fell below the standard of care (they decided it did not).

But unlike RCW 7.70.040, the informed consent statute, RCW 7.70.050, is limited to “treatment.” RCW 7.70.050(1)(a); 6 WPI 105.04, at 603-04. RCW ch. 7.70 does not define “treatment,” so its plain, ordinary

meaning applies. *Cregan v. Fourth Memorial Church*, 175 Wn.2d 279, 285, 285 P.3d 860 (2012). The dictionary distinguishes between diagnosis and treatment: “treatment” means “the action or manner of treating a patient medically or surgically <diagnosis and [treatment] of tuberculosis>.” WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 2435 (1993).

Indeed, RCW 7.70.050(3) refers to “treatment proposed and administered” and “alternative forms of treatment.” Neither could mean “possible diagnosis” or “alternative diagnosis”. Thus, the failure to advise of a condition the doctor did not diagnose cannot violate RCW 7.70.050.

The Legislature knows the difference between diagnosis and treatment—it has frequently referred to both. *E.g.*, RCW 18.64.011(11)(b), 70.24.110, 71.24.025(8), 71.24.061(3). When the Legislature intended to include diagnosis in “treatment”, it expressly said so. *E.g.*, RCW 79.96A.020. If the Legislature had intended “treatment” in RCW 7.70.050 to include diagnosis, it would have said so, as do statutes in many states. *Rains v. State*, 100 Wn.2d 660, 668, 674 P.2d 165 (1983); *e.g.*, DEL. CODE ANN. tit. 18, § 6801(6); GA. CODE ANN. § 31-9.6.1; N.Y. PUB. HEALTH LAW § 2805-d; VT. STATE. ANN. tit. 12, § 1909.

In any event, the purpose of informed consent is to enable a patient to make an intelligent choice. *Miller v. Kennedy*, 11 Wn. App. 272, 282,

522 P.2d 852 (1974) (Div. I), *aff'd per curiam*, 85 Wn.2d 151, 530 P.2d 334 (1975). If Dr. Sauerwein had told the patient about the yeast he did not believe she had, he would have recommended Fluconazole, which does not work on *Candida glabrata*. He would not have recommended Amphotericin B, since the yeast species was unknown. More cultures could have been suggested, but they would have taken 6 days, which would have been too late. (6/7 RP 52-53, 98; 6/9 RP 49-50, 58, 142-43; 6/10 RP 120, 127) As *Keogan's* majority said, if ““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.” 95 Wn.2d at 330 (quoting *Keogan*, 22 Wn. App. at 370).

Plaintiff claims this is not a misdiagnosis case as Dr. Sauerwein knew of the preliminary lab result. But the doctor also knew this patient, unlike most with yeast in their blood, had not been seriously ill for weeks in the hospital and was feeling better. He and Dr. Moran—who had greater infectious disease experience and training—jointly decided that if she was feeling better, the yeast must be a contaminant. Contrary to plaintiff's claim that Dr. Sauerwein acted unilaterally and without justification, the doctors' decision was medically reasonable. Indeed, the jury found Dr. Sauerwein not negligent. (CP 312; 6/7 RP 58-59, 71; 6/10 RP 77-78, 80-82; 6/13 RP 32-33)

“Misdiagnose” means “to make an incorrect diagnosis.” <http://dictionary.reference.com/browse/misdiagnose?s=t>. Dr. Sauerwein concluded the preliminary lab result must have been due to a contaminant because the patient did not have a fever and was feeling much better. In retrospect, he made an incorrect diagnosis by misdiagnosing a contaminant rather than yeast in the blood.

Plaintiff also claims *Backlund* supports his informed consent claim since the informed consent claim there was remanded for trial. But *Backlund* was not a misdiagnosis case—defendant knew the baby had jaundice. Instead, defendant misjudged the condition’s severity, failing to order treatment he knew was available for the condition he had diagnosed.

Nor does *Backlund*’s dissent aid plaintiff. The majority held the informed consent claim failed because plaintiff had not shown a reasonably prudent patient would have chosen alternative treatment had it been disclosed. 137 Wn.2d at 668-70. The dissent would have had a jury decide what a reasonably prudent patient would have done. *Id.* at 674. Far from disagreeing with the *Backlund* rule, the dissent recognized the majority had “state[d] the correct legal standards.” *Id.* at 675.

## **2. Gates Does Not Apply.**

Plaintiff relies primarily on *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979). There defendant doctor examined plaintiff for failing

eyesight several times over two years. Each time he found high eye pressure, indicating borderline glaucoma, but did not dilate her eyes or tell her about her high pressure. Plaintiff ended up with glaucoma. This Court ruled she was entitled to a trial on her informed consent claim.

*Gates* does not apply. First, it is inconsistent with the later *Keogan* and *Backlund* decisions, which tacitly abrogated it. See *Matsyuk v. State Farm Fire & Cas. Co.*, 173 Wn.2d 643, 659, 272 P.3d 802 (2012) (later holding directly contrary to earlier holding overrules it *sub silentio*).

Second, *Gates* involved health care provided *before* June 25, 1976. 92 Wn.2d at 247-48. RCW ch. 7.70, which governs this case, applies only to health care provided *after* June 25, 1976. RCW 7.70.010. As discussed *supra* at p. 14, RCW 7.70.050 is limited to “*treatment*” (emphasis added).

Third, even if still valid, *Gates* is factually dissimilar. In *Gates*, the high eye pressure indicated but one possibility—glaucoma. *Keogan v. Holy Family Hospital*, 24 Wn. App. 583, 601 P.2d 1303 (1979), *aff'd in part, rev'd in part on other grounds*, 95 Wn.2d 306, 622 P.2d 1246 (1980). Here, as discussed *supra* at 16, a jury found Dr. Sauerwein had good reason to disbelieve the preliminary lab report. In *Gates*, simple, risk-free tests would have been conclusive. 24 Wn. App. at 585. Here, as discussed *supra* at 16, additional cultures would have made no difference. Here, Dr. Sauerwein had, via his nurse, one-time phone contact with the

with the patient; in *Gates*, the doctor saw plaintiff a dozen times over 2 years. 24 Wn. App. at 585.

Plaintiff's claim that unless this Court reverses, doctors will have a license to withhold test results ignores that this case is about misdiagnosis. The *Backlund* rule does not apply to non-misdiagnosis cases.

More importantly, Dr. Sauerwein was not looking at just a test result (and a preliminary one at that), but was looking at the result in conjunction with information the patient was afebrile and feeling much better. By focusing on the preliminary lab result while discounting clinical evidence, plaintiff engages in the luxury of hindsight for a situation both parties' expert witnesses agreed was rare. Indeed, not one expert said he had ever seen a patient with non-nosocomial yeast in the blood. (6/8 RP 29; 6/9 RP 90-91; 6/10 RP 42,112; 6/13 RP 35)

Plaintiff would have this Court require Dr. Sauerwein to have disclosed a condition he reasonably believed did not exist. Requiring physicians to inform patients of non-medically indicated conditions they might have would cause needless confusion, wasted time, increased costs, and potentially harmful, unnecessary testing and treatment. In holding that all available diagnostic tests need not be disclosed, one court explained:

After a medical condition has been discovered it may be relatively easy to look back and identify a diagnostic procedure which would have revealed the condition but

which was not medically indicated at the time. But in treating a patient a physician can consider only what is known at the time he or she acts. At the time of treatment there may be dozens, perhaps even hundreds, of diagnostic procedures which could reveal a rare and unforeseen medical condition but which are not medically indicated. Under plaintiff's proposed theory the doctor would be required to explain each and every possible diagnostic procedure regardless whether he or she believes it to be medically indicated....

*Vandi v. Permanente Medical Group, Inc.*, 7 Cal. App.4<sup>th</sup> 1064, 9 Cal.Rptr.2d 463, 467 (1992). The same is true here—a doctor should not need to divulge a condition he or she does not believe the patient has.

**V. CONCLUSION**

This is not an informed consent case. A cause of action for failure to obtain informed consent does not exist where the doctor is claimed to have been negligent in misdiagnosing a condition. Further, even if a cause of action for informed consent did exist, there is no evidence of proximate cause. This Court should affirm.

DATED this 14<sup>th</sup> day of August, 2013.

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*per 8/14/13  
phone  
authorization*

## RCW 7.70.050

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

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

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) That the treatment in question proximately caused injury to the patient.

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

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

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

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

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

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

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

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

## Notes:

**Severability -- 1975-'76 2nd ex.s. c 56:** See note following RCW 4.16.350.

## APPENDIX A



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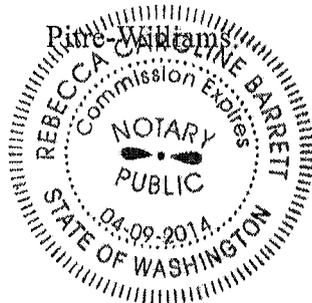
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DATED this 19<sup>th</sup> day of August, 2013.

\_\_\_\_\_  
Jessica Pitre-Williams

SIGNED AND SWORN to before me August 19, 2013 by Jessica



Print Name: REBECCA BARRETT  
Notary Public residing at: LYNNWOOD, WA  
My appointment expires: 4-9-2014

069237,094030/418042

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Attached for filing in case no. 88307-6, Anaya v. Sauerwein please find the following:

- Supplemental Brief of Respondents
- Affidavit of Service

Pamela A. Okano, WSBA #7718, e-mail: [pokano@rmlaw.com](mailto:pokano@rmlaw.com)

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