NO. 93905-5

SUPREME COURT OF THE STATE OF WASHINGTON

ESTATE OF JOAN R. EIKUM,
by and through its Personal Representative, John J. Eikum, and
JOAN R. EIKUM, by and through her Personal Representative,

Petitioner,

v.

SAMUEL JOSEPH, D.O.,

Respondent.

ANSWER TO PETITION FOR REVIEW

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II. COURT OF APPEALS DECISION

On October 27, 2016, Division III of the Court of Appeals denied the Estate of Joan R. Eikum's motion for reconsideration of the court's September 22, 2016 unpublished opinion, affirming the trial court's grant of judgment as a matter of law dismissing the Estate's informed consent claim, and finding no prejudice from alleged errors in the trial court's rulings concerning use of a learned treatise, *Estate of Eikum v. Joseph*, No. 32934-8-III, 2016 Wash. App. LEXIS 2382, (Sept. 22, 2016), *reconsideration denied*, 2016 Wash. App. LEXIS 2599 (Oct. 27, 2016).

III. ISSUES PRESENTED FOR REVIEW

1) Did the Court of Appeals properly affirm the trial court's dismissal of the Estate's informed consent claim on the ground that, where the defendant physician had ruled out heart disease, his failure to diagnose that condition gives rise to a medical negligence claim if he violated the standard of care, but not an informed consent claim?

2) Did the Court of Appeals, without deciding that there was any error, properly conclude that the Estate failed to establish prejudice from any alleged errors in the trial court's rulings allowing experts to

testify about, and under ER 803(a)(18) read excerpts from an admittedly authoritative medical treatise concerning, a revised cardiac risk index?

IV. STATEMENT OF THE CASE

A. Dr. Joseph's Care of Ms. Eikum.

Dr. Joseph, an osteopathic physician board-certified in internal, pulmonary, and critical care medicine, RP 1342-45, began seeing Ms. Eikum in 2005, after her previous physician retired. RP 214, 216-17. When Ms. Eikum, an insulin-dependent diabetic, RP 210, first saw Dr. Joseph in April 2005, she had a three-month history of chronic cough with phlegm. RP 1920. Her diabetes was not well-controlled and Dr. Joseph urged her to comply with diet and exercise and considered changing her medications. RP 1913.

When Ms. Eikum's cough persisted despite antibiotics, Dr. Joseph ordered breathing tests and a chest x-ray in September 2005. RP 1922-23. The x-ray was normal, with normal heart size, and no obvious signs of infection. RP 1927. The pulmonary function tests, though, showed mild airflow obstruction. RP 1923-24. Dr. Joseph diagnosed asthma and prescribed Advair, a combination inhaled steroid and bronchodilator. RP 1924, 1929. By November 2005, Ms. Eikum's cough resolved. RP 1928.

Over the next couple of years, Ms. Eikum had occasional cough and breathing issues that Dr. Joseph addressed with medication, including

recommending regular use of Advair. RP 1929-35. In September/October 2008, Ms. Eikum had coughing with associated urinary incontinence, though her breathing was doing well. RP 1936. In October 2008, Dr. Joseph detected bruits, a sound of blood rushing, RP 1741, in Ms. Eikum's carotid arteries. RP 1970. He ordered an ultrasound to make sure there was no significant artery blockage and it showed no blockage. RP 1742.

From November 2008 to early January 2009, Ms. Eikum had some fainting spells at home and went to the ER. RP 230-32. Dr. Joseph saw Ms. Eikum on January 21, 2009, after her visit to the emergency room. RP 1937-38. Dr. Joseph ordered additional pulmonary function tests, in follow up to the tests done in 2005. RP 1938.

The results of the January 2009 pulmonary function tests were inadequate, as Ms. Eikum refused to finish the tests. RP 1939. In his January 21, 2009 note, Dr. Joseph listed syncope with uncertain etiology, and sent Ms. Eikum for a Holter monitor study to evaluate heart rhythm, to see if that would explain her loss of consciousness or falling. RP 1941. Depending on the Holter monitor results, Dr. Joseph would then determine whether to send her for a cardiology consult. RP 1941-42. Dr. Waggoner, the cardiologist who interpreted the Holter study, did not recommend further studies by way of echocardiogram or further cardiologic evaluation. RP 656-57.

Dr. Joseph also obtained a chest x-ray in January 2009 that he compared to the x-ray taken in March 2007. RP 1942. The 2009 x-ray was unremarkable. Dr. Joseph's impression was that Ms. Eikum had no acute cardiopulmonary disease. RP 1942. In January 2009, he also did arterial blood gas testing that was normal, and laboratory studies that showed no clinically significant results. RP 1942-45.

In March 2009, Dr. Joseph did a physical examination, in part because of Ms. Eikum's need for a pre-surgical evaluation for elective knee surgery.[1] RP 1951-58, 1963-65. Her pulse rate and rhythm, respiratory rate, and blood pressure were all normal. RP 1951. Her veins were not distended, indicating a normal pressure in the right side of her heart. RP 1952-53. Dr. Joseph listened to her lungs and performed a cardiac exam, listening for a regular rhythm and checking for murmurs, gallops or other abnormal heart sounds. RP 1954. The cardiac exam was normal and Ms. Eikum had no breathing difficulties. RP 1953-55. She had no abnormalities on physical examination. RP 1955. All of her tests showed no indication of any cardiac or respiratory problems. RP 1963.

Dr. Joseph concluded that Ms. Eikum was "ready for surgery," meaning he "found no reason not to proceed with the surgeon's further evaluation to see if she was a surgical candidate from a surgical point of

[1] Her surgeon was to perform a further evaluation, including reviewing the risks of the surgery. RP 1964-65.

view, and that there was no medical reason to halt them in any way." RP 1964. Using the revised cardiac risk index, Ms. Eikum had only one risk factor – diabetes, RP 1965-66 – which did not preclude her from having the surgery. RP 2015-18. Dr. Joseph did not believe a cardiology referral was indicated. RP 2018-19. He "[a]bsolutely" did not suspect that Ms. Eikum had any cardiac dysfunction. RP 2066-67.

B. The Lawsuit and the Parties' Theories of the Case.

Ms. Eikum underwent her elective knee surgery on April 6, 2009, CP 9, and suffered a heart attack the morning of April 8, 2009, RP 768, 1415. An angiogram revealed severe three-vessel coronary artery disease, RP 812, and an echocardiogram showed moderated aortic stenosis, weakened heart muscle, and coronary artery disease. Ms. Eikum underwent emergency coronary artery bypass surgery, RP 770, but died on April 27, 2009, RP 767. Her husband, on behalf of her estate, sued Dr. Joseph for failing to properly diagnose her heart condition before clearing her for elective surgery, alleging both medical negligence and failure to obtain informed consent.

The Estate's theory of the case, supported by testimony from its experts, Drs. Leslie Stricke, and Jeffrey Caren, and treating cardiologist, Dr. Andrew Boulet, was that (1) Ms. Eikum had signs and symptoms of cardiac disease; (2) the tests Dr. Joseph ordered did not rule out cardiac

disease; (3) Dr. Joseph violated the standard of care by failing to order additional tests, such as an echocardiogram, and by failing to refer Ms. Eikum to a cardiologist, or at least discuss with her why he decided against referring her to one; and (4) additional testing and referral would have revealed Ms. Eikum's severe coronary artery disease, leading to postponement of the knee surgery, and a non-emergent bypass surgery with a success rate of 94 percent. *See* RP 291-95, 298, 313, 316, 321, 352, 358-60, 375 (Stricke); 547-49, 578-80, 592, 608-10 (Caren); 767-68, 781, 793-94, 812-14, 851-53 (Boulet).

The defense theory of the case, supported by the testimony of Dr. Joseph and defense experts Drs. Darrell Potyk, Daniel Doornick, John Peterson, and Charles Davidson, was that (1) Dr. Joseph fully complied with the applicable standard of care and, based upon his physical examinations and work-up of Ms. Eikum had no reason to suspect that she had any cardiac dysfunction or needed further cardiac assessment; (2) had an echocardiogram been done before the knee surgery, it would have revealed only moderate aortic stenosis, which is not a contraindication for that surgery; (3) Ms. Eikum had not had a previous heart attack; (4) more likely than not, she did not have significant blockage of her coronary arteries prior to her knee surgery; and (5) her heart attack after the surgery was due to a sudden thrombus that occluded the left main coronary artery.

See RP 1053-56, 1058, 1082-85, 1087-89, 1101 (Potyk); 1437, 1445-51, 1453, 1455-57, 1463-64, 1491-92 (Peterson); 1688-92, 1702-03, 1724-26 (Davidson); 1741, 1756-57, 1774-77, 1791, 1793-94 (Doornick).

C. The Motion for Direct Verdict on Informed Consent, the Jury Verdict, the Judgment, and the Court of Appeals Decision.

At the close of the Estate's case, Dr. Joseph moved for directed verdict on informed consent, RP 1103, which the trial court granted on grounds that a physician cannot be liable for an informed consent claim under RCW 7.70.050 arising from a ruled out diagnosis, RP 1126-27. On the Estate's medical negligence claim, the jury found that Dr. Joseph did not violate the standard of care. CP 153. The trial court entered judgment on that verdict, CP 155-56, and the Court of Appeals affirmed.

V. ARGUMENT WHY REVIEW SHOULD BE DENIED

This Court should deny review, as none of the considerations governing acceptance of review under RAP 13.4(b)[2] are present in this case. The Court of Appeals' decision is based upon and is not inconsistent with decisions of this Court, including *Anaya Gomez v Sauerwein*, 180 Wn.2d 610, 618, 331 P.3d 19 (2014), this Court's most recent decision on the viability of informed consent claims in failure to diagnose cases. Thus review is not warranted under RAP 13.4(b)(1). Nor is the Court of Appeals' decision inconsistent with any decision of the Court of Appeals,

[2] The Estate does not even cite RAP 13.4(b) in its Petition.

including *Flyte v. Summit View Clinic*, 183 Wn. App. 559, 333 P.3d 566 (2014), so as to warrant review under RAP 13.4(b)(2). Although the Estate makes passing reference to constitutional issues, this case does not present any significant question of law under the state or federal constitutions, to justify review under RAP 13.4(b)(3).[3] And, the Estate has not argued that this case involves some issue of substantial public interest that should be determined by this Court so as to warrant review under RAP 13.4(b)(4).

A. The Court of Appeals' Affirmance of the Trial Court's Dismissal of the Informed Consent Claim Is Not in Conflict with Any Decision of this Court or of the Court of Appeals.

Standard of care and informed consent claims are two distinct causes of action; allegations supporting one normally will not support the other. *Gustav v. Seattle Urological Assoc.*, 90 Wn. App. 785, 789, 954 P.2d 319, *rev. denied*, 136 Wn.2d 1023 (1998). In a medical negligence claim under RCW 7.70.040, the issue is whether injury resulted from the failure of a health care provider to follow the accepted standard of care. In an informed consent claim under RCW 7.70.050, the issue is whether the

[3] Although the Estate asserts, *Pet. at 11 n.12*, that "[c]onstitutional rights may be asserted for the first time on appeal, the Estate ignores that "naked castings into the constitutional sea are not sufficient to compel judicial consideration and discussion." *State v. Johnson*, 119 Wn.2d 167, 171, 829 P.2d 1082 (1990) (quoting *In re Rosier*, 101 Wn.2d 606, 616, 717 P.2d 1353 (1986) (further citation omitted). The Estate has cited no authority supporting its claims that the trial court's or the Court of Appeals' rulings as to the legal viability of its informed consent claim violated state or federal constitutional rights to trial by jury or that the trial court's or Court of Appeals' ruling concerning use of medical treatise violated its constitutional right to confront witnesses.

health care provider informed the patient of the material facts relating to a proposed course of treatment.

The different foci of the claims are evident in that "[i]nformed consent allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent." *Backlund v. Univ. of Wash.*, 137 Wn.2d 651, 659, 975 P.2d 950 (1999). Thus, a physician who injures a patient through treatment without obtaining informed consent is potentially liable on informed consent claim, even if the physician complied with the standard of care in performing the treatment. *Id.* at 660 (citation omitted). But:

> 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.

Backlund, 137 Wn.2d at 661.

As this Court confirmed more recently in *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 618, 331 P.3d 19 (2014):

> Simply put, a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it. In such situations, a negligence claim for medical malpractice will provide the patient compensation if the provider failed to adhere to the standard of care in misdiagnosing or failing to diagnose the patient's condition.

See also Gustav, 90 Wn. App. at 789 (informed consent claim properly dismissed where physician failed to diagnose prostate cancer, believing patient's elevated PSA tests were due to chronic prostatitis or bacterial infection); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992) (informed consent claim properly dismissed because emergency room physician owed no duty to inform patient of time frame to treat condition that he did not diagnose); *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 881-82, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992) (informed consent claim properly dismissed because physician owed no duty to discuss possible methods for treating thromboembolism where the physician was "unaware of the thrombo-embolism condition"); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 168-69, 772 P.2d 1027, *rev. denied*, 113 Wn.2d 1005 (1989) (informed consent claim properly dismissed as physician had no duty to disclose risk of brain herniation and subsequent injury of which he was unaware).

1. The Court of Appeals' decision is consistent and not in conflict with *Backlund* and *Anaya Gomez*.

Here, the Court of Appeals correctly analyzed *Backlund* and *Anaya Gomez* and concluded that they applied to bar the Estate's informed consent claim, because Dr. Joseph had, based on his evaluation of Ms. Eikum over time and the results of the tests he had run, ruled out heart

trouble as the cause of Ms. Eikum's bruit and episodes of syncope. As the Court of Appeals correctly explained:

> [Dr. Joseph] expressly told the jury that after the Holter monitor test in January, his "final impression was no acute cardiopulmonary disease." RP at 1942. He testified that after examining Ms. Eikum in March, there was "no evidence of heart disease" behind the syncope incidents. RP at 1970. Whether or not Dr. Joseph erroneously ruled out heart disease was properly placed before the jury as a question of medical negligence. Both sides addressed the problem from that perspective and the jury rendered its verdict in favor of the doctor. Since the doctor had concluded that there was no heart disease, the trial court correctly applied *Backlund* and took the informed consent issue from the jury. While Dr. Joseph had not yet determined what had caused the incident, he had ruled out a heart condition as the cause.

Slip Op. at 11. Thus, the Court of Appeals, consistent with *Backlund* and *Anaya Gomez*, correctly concluded that the trial court did not err in granting judgment as a matter of law on the question of informed consent.

The Estate's claim, *Pet. at 10-14*, that all *Backlund* and *Anaya Gomez* did was create a "fact-based affirmative defense" to an informed consent claim that could not be resolved on motion for directed verdict, is patently incorrect. Neither *Backlund* nor *Anaya Gomez* (nor any other case) states that its holding concerning the legal viability of an informed consent claim in a failure to diagnose or misdiagnosis case is an affirmative defense to be determined by the jury. To the contrary, as the Estate acknowledges, *Pet. at 12* (citing *Anaya Gomez*, 180 Wn.2d at 618, and

Backlund, 137 Wn.2d at 661), both *Backlund* and *Anaya Gomez* hold that an informed consent claim "***is not actionable*** where a physician excludes a particular disease, or fails to diagnose it, as the physician cannot be expected to inform the patient about an unknown disease." [Emphasis added.] As this Court held in *Anaya Gomez*, 180 Wn.2d at 613:

> [W]hen a health care provider rules out a particular diagnosis based on the patient's clinical condition – including test results, medical history, presentation upon physical examination, and any other circumstances surrounding the patient's condition that are available to the provider – the provider may not be liable for informed consent claims arising from the ruled out diagnosis under RCW 7.70.050.

The Estate nonetheless argues, *Pet. at 12*, that "the *Backlund* rule is premised on the physician having actually excluded the condition, or 'misdiagnosed' it," and asserts that its experts disputed whether Dr. Joseph had actually excluded or misdiagnosed Ms. Eikum as having heart disease. But testimony from the Estate's experts that Dr. Joseph missed the signs of coronary artery disease and did not rule it out goes to whether he was negligent in failing to recognize such signs and do further testing, not to whether he could be liable for an informed consent claim arising out of a diagnosis of heart disease that he believed he had ruled out and a condition that he "[a]bsolutely" did not suspect Ms. Eikum had. RP 2066-67. Neither *Backlund* nor *Anaya Gomez* holds that it is only when a physician has conclusively ruled out, or all experts agree that a physician has

conclusively ruled out, a particular diagnosis that there is no duty to inform. Indeed, were that the rule, a plaintiff would always have an informed consent claim in a misdiagnosis or failure to diagnose case, as no physician can ever conclusively have ruled out a condition that it turns out the patient had, but the physician failed to diagnose.

Contrary to the Estate's assertions, the Court of Appeals decision is not in conflict with either *Backlund* or *Anaya Gomez.*

2. The Court of Appeals' decision is not in conflict with *Flyte.*

Contrary to the Estate's claims, *Pet. at 13-15*, the Court of Appeals' decision also is not in conflict with Division II's decision in *Flyte v. Summit View Clinic*, 183 Wn. App. 559, 333 P.3d 566 (2014). *Flyte* ***did not*** involve a negligent failure to diagnose a specific condition (swine flu), but rather a claim that the Clinic failed to provide informed consent by not telling a pregnant patient with flu-like symptoms about the H1N1 epidemic and public health alert recommendations for treating pregnant women prophylactically with Tamiflu. Indeed, the undisputed testimony was that no test could have determined whether the patient had H1N1 in a timely manner. *Id*. at 576.

The issue in *Flyte* was whether the trial court erred in instructing the jury that a "physician has no duty to disclose treatments for a condition

that may indicate a risk to the patient's health until the physician diagnoses that condition." *Id*. at 572. Citing the five-justice concurring/ dissenting opinion that was controlling on the issue of informed consent in *Keogan v. Holy Family Hosp*ital, 95 Wn.2d 306, 329-30, 622 P.2d 1246 (1980), which recognized that, even if no diagnosis had been made, a duty to disclose existed if the patient was to undergo a diagnostic procedure involving risk to the patient, the *Flyte* court concluded that, given the extreme danger posed by H1N1 and the availability of prophylactic measures, it was error to instruct the jury that no informed consent claim could exist unless the defendant physician had conclusively diagnosed influenza, especially when that was not the allegation. *Id*. at 580.

In *Flyte*, the physician testified that he had excluded influenza as a diagnosis. *Id*. at 577. However, Division II concluded that the defendant physician's testimony was based solely on his records (as he had no independent memory) and those records were equivocal on the issue of whether he had ruled out influenza, thus creating an issue of fact. *Id*. The question of fact in *Flyte* was not based on after-the-fact expert testimony that the defendant had not, but should have, ruled out influenza, but rather was based on internal contradictions in the physician's own records and testimony about whether he had ruled it out.

Here, based on his assessment of Ms. Eikum, including x-ray, arterial blood gas testing, EKGs, laboratory tests, Holter monitoring and pre-surgical physical examination, Dr. Joseph concluded that Ms. Eikum had no acute pulmonary disease, and did not suspect that she had any cardiac dysfunction RP 1942-45, 1951-58, 1969-70; 2066-67. Dr. Joseph was unequivocal about his conclusion that "[a]bsolutely," there was no reason to suspect that Ms. Eikum had any cardiac dysfunction. RP 2066-67. In other words, Dr. Joseph ruled out coronary artery disease. That Mr. Eikum's experts were of the opinion that the examinations and tests Dr. Joseph performed showed abnormalities and did not conclusively rule out cardiac dysfunction is a matter of medical negligence, not a failure to secure informed consent.

Indeed, that is exactly what cases such as *Gustav*, *Bays*, and *Anaya Gomez* make clear. As the court held in *Gustav*, 90 Wn. App. at 790:

> Whether Dr. Gottesman and Lilly misjudged "the appropriate frequency of diagnostic testing, the dangers involved in not testing more frequently, and the consequences of not completing the 1991 biopsy," i.e., whether they negligently failed to diagnose Gustav's cancer, are issues that implicate negligence in diagnosis falling below the standard of care, not informed consent about the risks of treating the diagnosed condition.

Ultimately, this case is very similar to cases such as *Backlund*, *Burnet*, *Bays*, *Thomas*, *Gustav*, and *Anaya Gomez*, which all hold that no informed

consent claim exists. Nothing about the *Flyte* case changes that analysis.

3. The Court of Appeals' decision is also not in conflict with *Gates v. Jensen*.

The Estate further argues, *Pet. at 14-16*, that the Court of Appeals' decision "contravenes" this Court's decision in *Gates v. Jensen*, 92 Wn.2d 246, 250-51, 595 P.2d 919 (1979). It does not.

Gates was a pre-RCW 7.70.050 case involving informed consent. While this Court in *Anaya Gomez*, citing *Gates*, recognized that "[i]n certain circumstances [it had] held that the right to informed consent can include the process of diagnosis," it also recognized that *Gates* predated RCW 7.70.050's codification of informed consent that "limit[s] informed consent claims to treatment situations." *Anaya Gomez*, 180 Wn.2d at 617. Moreover, the *Anaya Gomez* court recognized: (1) that "[t]he *Gates* court allowed the informed consent claim based on a unique set of facts," *id.* at 623; (2) that "*Backlund* clarifies that *Gates* is the exception and not the rule with regard to the overlap between medical negligence and informed consent," *id.* at 626; and (3) that "[g]iven the unique factual situation in *Gates*, it is unlikely we will ever see such a case again." *Id.*

The *Anaya Gomez* court concluded that "*Gates* stands for the proposition that patients have a right to be informed about a known or likely condition that can be readily diagnosed and treated." *Id.* at 626. But

in *Gates*, there was no question that the patient's consistently high eye pressure readings over a two-year period pointed to a higher risk for glaucoma and that the ophthalmologist was well aware of those consistently high readings. Here, based on his evaluation and testing, Dr. Joseph did not know, and believed he had no reason to suspect that Mrs. Eikum had cardiac dysfunction. If he should have known or suspected it, that was a matter of possible medical negligence if he violated the standard of care, but not a matter of informed consent.

To hold that an informed consent claim exists under the facts of this case not only would violate the holdings and rationale of *Backlund*, *Burnet*, *Bays*, *Thomas*, *Gustav*, and *Anaya Gomez*, but also would turn nearly every alleged misdiagnosis or failure to diagnose case into an informed consent case. Nothing in *Gates* stands for such a proposition.

B. The Court of Appeals Properly Concluded that Error, if Any, in Allowing Under ER 803(a)(18) Expert Testimony from a Learned Treatise About the Revised Cardiac Risk Index Was Harmless.

The Estate argues, *Pet. at 17*, that the trial court, in allowing use of portions of a learned treatise referencing a revised cardiac risk index, violated its constitutional right to cross-examine the witness. The Estate, however, cites no case supporting its argument that an alleged missing document, as opposed to a missing witness, creates a constitutional infirm-

ity regarding the right to cross-examine. As previously noted, "naked castings into the constitutional sea are not sufficient to compel judicial consideration and discussion." *State v. Johnson*, 119 Wn.2d 167, 171, 829 P.2d 1082 (1990); *see* footnote 3, *supra*.

ER 803(a)(18) permits statements in learned treatises to be read into evidence, but not received as exhibits. Here, after the Estate's expert, Dr. Stricke identified Harrison's Principles of Internal Medicine as an authoritative treatise, RP 441-42, the trial court allowed defense counsel to hand Dr. Stricke a copy of the revised cardiac index as printed in Harrison's and ask him questions concerning it, RP 442-43, 445-71, *see also* RP 620-29. Although the Estate argues that the entire treatise from which the referenced portion about the revised cardiac index was read was not present in the courtroom, the trial court found otherwise. RP 442-71; 620-29. Indeed, during her re-direct examination, the Estate's counsel was handed the entire treatise, read excerpts, and asked Dr. Stricke questions from it. RP 485-91; 506-09. The Estate cites no authority suggesting that it violates a litigant's constitutional right to cross-examine witnesses if a party questions an expert about a portion of an admittedly authoritative treatise, without making sure that the entire treatise or every cited authority in the portion of the treatise being read is physically present in the courtroom.

As the Court of Appeals correctly noted, even if it were to assume, which it did not find, that it was error to question witnesses in the absence of the treatise in the courtroom, the Estate did not establish any harm from the alleged error. Indeed, even in its Petition for Review, the only harm the Estate claims, *Pet. at 19*, is its unsubstantiated claim that it has shown "error of constitutional magnitude and prejudice is presumed." As the Court of Appeals correctly held, *Slip Op. at 14*, the evidence concerning the revised cardiac risk index:

> was properly admitted during the testimony of Dr. Stricke, and similar evidence came in through defense expert Dr. Potyk without the Estate raising any hearsay objection. The evidence was properly before the jury during the testimony of those two experts. Discussing the matter with the other witnesses, even in the absence of the treatise, did not add to or detract from … the evidence already properly before the jury. At most, even if improperly admitted, the other testimony was merely cumulative to the original evidence. Cumulative evidence is not a basis for finding prejudicial error. [Footnote and citation omitted.]

The evidence complained of, then, even if improperly admitted, was cumulative and not prejudicial.

Finally, the Estate's argument, *Pet. at 19*, that the entire defense closing argument was based on the cardiac risk index is untrue. The defense closing begins at RP 2294, and the first reference to the index is at RP 2317, some 23 pages into the closing. Out of a closing argument that spanned 33 pages in the record, there are only six references to the index.

VI. CONCLUSION

Because the Estate has not shown that any of the RAP 13.4(b) considerations governing acceptance of review are present in this case, this Court should deny review of the Court of Appeals' decision, which properly affirmed the trial court's rulings in this case.

RESPECTFULLY SUBMITTED this 21st day of December, 2016.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 21st day of December 2016, I caused a true and correct copy of the foregoing document, "Answer to Petition for Review," to be delivered in the manner indicated below to the following counsel of record:

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DATED this 21st day of December 2016, at Seattle, Washington.

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