COA No. 329348

IN THE COURT OF APPEALS, DIVISION III

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,

Plaintiffs/Appellants,

v.

SAMUEL JOSEPH, D.O,

Defendant/Respondent.

APPELLANTS' OPENING BRIEF

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I. ASSIGNMENTS OF ERROR/ISSUES.

Issue # 1: Sufficient evidence was presented of two statutory alternative theories of liability to prove a single claim of injury by medical negligence, and the Eikums were deprived of a jury on their informed consent theory.

Error #1: The trial court erred in dismissing John Eikum's informed consent claim at the close of Eikum's case.

Issue # 2: In order to qualify for an ER 803(a)(18) exception to hearsay, the content of "statements contained in a learned treatise" must be present in the courtroom.

Error # 2: The trial court abused its discretion by allowing defense counsel and defense experts to testify as to the content of "statements contained in a learned treatise" under ER 803(a)(18), when the alleged treatise was never in the courtroom, and which defense and its experts either would not, or could not, produce.

Issue #3: A physician has a well-established duty to perform alternative tests where risk conditions arise, and a duty to communicate options for alternative tests. The jury must be so instructed, even though the remaining claim is one related only to the standard of care.

Error # 3: The court erred in declining to instruct the jury on the duty of a physician to involve the patient in the patient's diagnostic process as part of the standard of care, when the evidence placed the existence of this established duty into dispute.

II. STATEMENT OF CASE

A. Procedure.

John Eikum, the widower and personal representative of the Estate of Joan Eikum, his wife of nearly 55 years, on behalf of Joan and her estate, filed a complaint for medical negligence and wrongful death against pulmonary physician Dr. Samuel Joseph. *CP 3.* "The Eikums" alleged medical care below the standard of care, and violation of Joan's right to informed consent.

The trial court dismissed Mrs. Eikum's informed consent claim after her case in chief. *RP 1127: 12-15.* The jury deliberated for four days before returning a verdict finding that Samuel Joseph did not violate the standard of care in his treatment of Joan Eikum. *CP 153* at Question 1. The jury was charged on October 3, 2014. *See* RP at 2341. The verdict was returned four days later on October 7th. *CP 154.* The Eikum estate files this appeal.

B. Evidence Presented.

A. John Eikum:

John and Joan Eikum married in September 1955. *RP 193.* Mrs. Eikum, hereafter "Joan," had been treated by a physician who had retired and recommended defendant Dr. Samuel Joseph as his successor. *RP 214-15.* John Eikum ("John") and Joan went along with this: "Well, when somebody recommends a doctor, you say 'Okay, that's fine, we'll do that,'

so we did." *RP 217: 11-12.* John and Joan depended on a doctor's advice. "The doctor told us what to do—we do it." *RP 218: 17.* Appointments which John attended consisted of Dr. Joseph communicating very briefly and doing chest x-rays, but he and his wife would never hear anything about the x-rays. *RP 223: 1 – RP 224: 15.* There were no (test) results provided. "No results. No communication." *RP 224: 15.* John remembered Joan performing a test where she was to blow into a tube, but she was unable to blow properly. *RP 225: 2-8.* Dr. Joseph had the results, but never discussed them. John stated, "I assumed that if there was something wrong, the doctor will tell you." *RP 225: 11-16.*

John and Joan never saw the results of Joan's October 2008 "carotid duplex exam." *RP 227: 18-24; RP 229: 5-6.* Dr. Joseph never talked with the Eikums about any aspects of the test, or its suggesting the possibility of a "stenotic process." *RP 229: 5-12.*

In and around Thanksgiving 2008 and Christmas 2008, Joan began fainting, a symptom known as "syncope." *RP 229: 17 – RP 231: 10.* When yet another syncope incident occurred in the first part of January, John took Joan to the Emergency Room. *RP 231-32.* The hospital's electrocardiogram (EKG) states on its face: "Abnormal EKG." *RP 235: 15-19.* The EKG report identified tachycardia with unusual paroxysmal,

rate 123, a right axis deviation, a right bundle branch block, and an inferior Q wave. *RP 235: 22 – RP 236: 8.* No one discussed the results with him. *RP 236: 9-11.* The ER visit was reviewed by Dr. Joseph by January 21, 2009. *RP 237: 9-14; RP 238: 9-13; RP 239: 20-21.*

Dr. Joseph's January 21, 2009 office notes of his visit with Joan reflect his knowledge of Joan's multiple bouts of syncope. *RP 237: 15-24; RP 238: 9-13.* She reported three such syncopal episodes since Christmas 2008. *RP 237: 19-24.* Dr. Joseph was aware of her Emergency Room visit on January 12th. *RP 238: 9-13.* He offered Joan no information. *RP 238: 21-23.* Dr. Joseph never discussed with the Eikums what is reflected in his notes; that is, that he was unable to determine the cause of her syncope. *RP 239: 25 – RP 240: 3.* He did not tell the Eikums that he planned to have Joan undergo a cardiac evaluation. *RP 240: 5-6.* Dr. Joseph did refer Joan for a Holter monitor test. *RP 240: 11-13.* Dr. Joseph explained that this test was cardiac related, and dealt with the heart's rhythm. *RP 240: 15-17.* Joan participated in the Holter monitor process. *RP 240-41.* The Eikums never received the results from that test. *RP 241: 20-21.*

After Joan began experiencing syncope, John told Dr. Joseph what he had noticed at home – i.e., that Joan was fatigued and experienced

shortness of breath. *RP 921: 11-15.* Dr. Joseph responded, "Well, it's shortness of breath. That's got to be her lung function; her lungs aren't functioning properly." They were not told of any heart dysfunction suspicions. *RP 921: 18-21.* Joan was not offered any tests other than the "blow" test and the Holter monitor. *RP 923: 19-21.*

In March 2009, John and Joan returned to Dr. Joseph. *RP 243: 9-24.* Joan was considering whether to consent to an elective right knee replacement surgery. *RP 243: 21-24.* John Eikum could not remember the actual office visit in March 2009. *RP 243: 9-15.* But the appointment was identified in Dr. Joseph's notes as being an appointment for a surgical clearance. *RP 243: 16-24.* It was also characterized as a "routine follow-up." *RP 243: 16-20.* No concerns or risks of knee surgery were discussed with Joan Eikum. *RP 244: 24 – RP 245: 6.*

Dr. Joseph never discussed with the Eikums that Joan's symptoms and tests raised the potential of heart disease and dysfunction, and that he had been unable to identify the cause of those symptoms and abnormalities, or that he had intended a cardiac evaluation for her to further investigate. John Eikum never did see the Holter monitor test report. *RP 924: 16-18.* Dr. Joseph did not suggest in any form that Joan had any kind of issue with her heart before the knee surgery. *RP 924: 12-*

15. Joan made the decision to elect knee surgery because "the doctor indicated that she was okay; ready for surgery. Joan had a knee problem and needed fixing, so we said, 'Okay, that's fine.'" *RP 926: 1-7.* There was no discussion beyond that. *RP 926: 3-7.*[1] He testified: "If a doctor has cleared someone to do something, you expect that everything is fine. Had we known at the time of—had we been informed of the EKG and maybe the possibility that something was wrong, I'm sure we would have asked for a second opinion to make sure that it was safe for Joan to have the surgery." *RP 980: 24 – RP 981: 15.* John testified that had he known of Joan's abnormal cardiac tests—the abnormal EKGs and the Holter monitor—"she would never have had a knee replacement." *RP 923: 24 – RP 924: 11.*

B. Dr. Leslie Stricke:

Los Angeles pulmonologist Dr. Leslie Stricke is Board certified in

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[1] After the dismissal of the Eikums' informed consent theory of liability, Dr. Joseph would confirm this description of Joan's "consent" to Dr. Joseph's "ready for surgery" conclusion. After the Eikums' informed consent theory of liability was dismissed, Dr. Joseph would testify that his presurgical cardiac evaluation with Mrs. Eikum lasted15-minutes. *RP 1972: 20-24.* He told Joan Eikum—"You're ready for surgery. We'll see you back in six months. Continue your medications. Good-bye." *RP 1984: 15-20.* That was all he told her—"Ready for surgery. Come back in six months." *RP 1985: 13-22.* An echocardiogram could have been done "in a heartbeat." *RP 2063: 9-12.* All he had to do was to direct his staff to get Joan set for a referral. *RP 2063.* An echocardiogram was "an incredibly valuable tool," and he used it often. *RP 2076: 10-11.* But in Dr. Joseph's opinion, "[T]here was no reason to do any further testing, or any further instructions needed from me at that time." *RP 1985: 23 – RP 1986: 1.*

Internal Medicine and in Pulmonary Medicine. *RP 276-77.* Dr. Stricke testified that Dr. Joseph first violated the medical standard of care because he had notice of heart abnormalities and failed to pursue proper testing to reach a diagnosis—"there were symptoms and physical findings that needed to be investigated to their conclusion, which would require certain minimum numbers of standardized testing." *RP 291: 23-25.* That didn't happen. *RP 292: 1-3.*

Second, Dr. Joseph violated the medical standard of care by failing to share with Joan his plan for, and then his rejection of, a cardiology consultation. *RP 292: 4-20.* Even if Dr. Joseph felt it was unnecessary, that decision, testified Dr. Stricke, was Joan's decision to make. *RP 292: 14-20; RP 292: 24 – RP 293: 5.* It is "the right of the patient to hear what is available to the patient, why (the doctor) may think it's not necessary … at the end of the day, it is the decision of the patient whether to have cardiology consultation, as in this case, or whatever testing is being explained to the patient, and that I may choose to feel is unnecessary." *RP 292: 4-20.* The patient "needs to be part of the decision, especially when one rejects tests that may have a significant impact on the patient." *RP 292: 21-23.* The phrase "reasonable prudence" within the definition of the standard of care means in part that any assessment that a physician makes

includes the risks and benefits of the surgery, and this must be communicated to the patient so that the patient (and often family) can make a decision whether they agree with the assessment that the physician would make. *RP 288: 22 – RP 289: 4.*

Dr. Stricke testified that the phrase "informed consent" is used in the medical sense; it is part of the medical duty of care. *RP 292: 24 – RP 293: 4.* In advancing the standard-of-care management of the patient, medical decisions which are not always clear-cut have to be made. This duty of communication and discussion with the patient are important, not just because it is the patient's right to know why tests are going to be done or *not* done, but because it assists the physician's own medical decision-making in his carrying out the standard of care. *RP 293: 11-20.* Communication and the patient's opinion can change the physician's position itself. *RP 293: 9-20.* Such a communication has a "major bearing on the outcome of what happens." *RP 295: 7-9.*

Third, Dr. Joseph also violated the standard of care because he did not exclude the very heart conditions he was tasked with identifying. Dr. Joseph's pulmonary function tests did not exclude heart disease. *RP 298: 9-11.* His EKG measured the *rate* of the heart. *RP 302: 17.* The Holter monitor also is associated only with the rhythm of the heart. *RP 303: 6-*

23.

Dr. Joseph possessed abnormal test results, and was aware of symptoms and tests which showed the presence of heart dysfunction. The standard of care required an echocardiogram, and that standard was violated. *RP 318: 4-11.* An echocardiogram test does a number of things, including examining heart valves, and the ejection force of the heart muscle. When a heart starts failing, "the echocardiogram can tell that information." *RP 304: 3 – RP 305: 16.*

a) Dr. Joseph possessed a carotid duplex exam test, which showed the presence of *both* an atherosclerotic condition of the blood supply, and an aortic stenosis, and mandated an alternative test—an echocardiogram.

In October 2008, just months before her fatal surgery, Dr. Joseph heard a "bruit" in Joan's neck. *RP 313: 16-19.* Such a bruit in the neck may signify aortic valve stenosis. *RP 315: 1-3.* The bruit could be a heart murmur. A competent physician would know this—"This is one thing that I think every person who has gone through cardiology is taught, and is aware of." *RP 315: 4-10.* Dr. Joseph himself had sent Joan Eikum for a "carotid duplex exam." *RP 318-19.* The carotid artery test did not show significant narrowing or obstruction of the carotid artery. *RP 319: 7-16.* What it *did* show was the possibility of a distal "stenotic" process. *RP 320: 6-9.* This meant that Joan "has atherosclerotic vascular disease—a

disease of the arterial system." *RP 320: 14-21.* The neck "bruit" was now revealed to be a heart murmur in the aortic valve. *RP 321: 3-11.* The standard of care now required an echocardiogram test. *RP 316: 6-10; RP 321: 3-18*; *RP 318: 4-7.* More specialized care was also now warranted. It would now be unfair for Joan to have to rely on a pulmonary physician for heart issues. *RP 322: 17-25.* Joan now needed a referral to a cardiologist or a vascular surgeon. *RP 321: 16-18.*

b) Dr. Joseph was aware of Joan's syncope and shortness of breath symptoms, which also raised the risk of heart dysfunction and mandated an alternative test—an echocardiogram.

Dr. Stricke testified that syncope stands on its own as a symptom of an aortic valve stenosis. Syncope in conjunction with a carotid bruit mandates that the physician be thinking of an aortic stenosis. *RP 341: 21 – RP 342: 10.* Dr. Joseph was aware that Joan was experiencing syncope. *RP 341: 16-20.*

Dr. Joseph's records reflected both his carotid exam results, which raised the risk of aortic stenosis and vascular disease, and the reports of syncope, which also raised the risk of aortic valve stenosis and issues with blood flow. *RP 342: 12 – RP 343: 18.* With four bouts of syncope, the situation was dangerous and had to be taken seriously. *RP 344: 3-13.* Based upon Dr. Joseph's own notations in January 2009, the standard of

care required an echocardiogram and a referral to a cardiologist. *RP 350: 17 – RP 351: 3.*

c) Dr. Joseph was aware of the Sacred Heart EKG taken on January 12, 2009, which was also abnormal.

The EKG taken at Sacred Heart Medical Center in January 2009 also signified the existence of cardiac dysfunction. *RP 351: 14 – RP 352: 19.* This Jan. 12, 2009 test depicted tachycardia—a heart rate of 123 beats per minute versus a normal rate of 72 beats per minutes. *RP 352: 5-9.* The same EKG showed that Joan had heart conduction abnormalities, right ventricle blockage, and fascicular blocks. *RP 352: 10-11.* The EKG describes "conducting bundles within the conducting system that are not working," as well as an "inferior Q wave," which means that damage existed to the heart muscle. *RP 352: 10-19.* The EKG itself states right across its top that the electrocardiogram is abnormal: "abnormal EKG ECG." *RP 352: 20-22.* Dr. Stricke agreed that the test results were abnormal. *Id.* Even when Joan was in Dr. Joseph's office on January 21st, her heart again showed her in significant tachycardia at 120 beats per minute. *RP 355: 25 – RP 356: 7.*

d) Dr. Joseph did not resolve the cause of Joan's symptoms or exclude heart disease. He wrote in his record that he did not know the cause of Joan's syncope: "syncope? etiol." *RP 356: 8-18.*

Dr. Joseph did not exclude any cause for Joan's syncope. *RP 356: 12-18.* But he clearly suspected heart abnormalities. He planned on both a Holter monitor, and on referring Joan for a cardiology evaluation. *RP 356: 19 – RP 357: 17.* Although the Holter monitor was obtained, he did not refer her for the planned cardiology evaluation. *RP 357: 16-17.*

e) Dr. Joseph possessed Holter monitor tests, which also showed heart abnormalities and which test did not exclude heart disease.

The Holter monitor thereafter taken did not exclude valvular disease, ventricular dysfunction, *or* coronary artery disease. *RP 358: 13-19; RP 360: 16-18.* Such a test does not reflect what is going on in the heart valves, or show the actual function of the heart. *RP 360: 20-24.* What the Holter monitor *did* show was Joan's heart in tachycardia for over nine hours, and at an even higher level of tachycardia for over an hour. *RP 358: 20 – RP 359: 7.* It also showed "PVCs" – extra beats – which can become very serious. *RP 359: 19-25.* PVCs are not diagnostic, but of concern. *RP 360: 8-10.* The Holter did not exclude any of the risks already presented—valvular disease, coronary artery disease, or ventricular dysfunction—because it cannot reflect these conditions. *RP 360: 11-24.* Dr. Joseph had these results in his medical record. *RP 361: 1-6.*

f) Pulmonary function tests excluded asthma or COPD as the cause of Joan's shortness of breath, thus again raising the risk of heart dysfunction.

The "blow" tests performed on Joan by Dr. Joseph excluded the existence of asthma as potentially the cause of her breathing issues. *RP 364: 7-13*. The test results showed no evidence of significant asthma, and no evidence of significant COPD. *RP 365: 16-17; RP 366: 13-14*.

g) Chest x-ray.

Dr. Joseph also had chest x-rays of Joan Eikum. They did not exclude heart disease. *RP 369: 13-17*.

h) "Ready for surgery" without using the gold standard alternative test—an echocardiogram.

On March 12, 2009, Dr. Joseph evaluated Mrs. Eikum for presurgical clearance for her right knee replacement as requested by the orthopedic surgeon. *RP 368: 1-12*.

The primary issue for a presurgical clearance is heart health. *RP 373: 18-20*. This is because of stressors that are placed on the heart attendant to such surgeries, including not just that of the surgery itself, but the rehabilitation involved after the surgery. *RP 372-73*.

Dr. Joseph's presurgical clearance violated the standard of care. *RP 373: 21 – RP 374: 2*. Joan's symptoms and test results were all left

unexplained, and they needed further investigation. *RP 374: 5-7.* An alternative test—an echocardiogram—was indicated. *RP 374: 10-12.* Such a test would clearly show Joan Eikum's aortic stenosis, and a cardiology referral/evaluation would thereupon address the issue. "No cardiologist ... would assess severity of an aortic stenosis without an echocardiogram." *RP 374: 10-17.*

Had Dr. Joseph simply referred Joan Eikum for the echocardiogram himself, not only would the aortic stenosis have been diagnosed, "but as well, the abnormal functioning of the left ventricle would be evidenced, leading to a cardiologist's involvement and a decision made as to further testing, including cardioangiogram to determine the severity or the presence of coronary artery disease. *RP 375: 2-12.* An echocardiogram here was "absolutely essential." *RP 376: 17-24.* The echocardiogram "is pretty much the gold standard." *RP 374: 18.*

An echocardiogram is easily obtained, and inexpensive. It is only about $250, and the test would have taken 10-15 minutes. The tests are readily available. *RP 377: 14-23.* Any practitioner can obtain such an echocardiogram. *Id.* The patient can either be referred out, or the service will come directly to a physician's office. *RP 378: 1-3.*

Dr. Joseph violated the standard of care by telling Mrs. Eikum she

was ready for surgery. *RP 377: 7-13*; *RP 378: 4-9*. He had failed to reach any resolution of any of the symptoms and test signs Joan had displayed. *RP 379: 18-20*. There was no exclusion of the known potential of aortic stenosis, ventricular dysfunction, or coronary artery disease. These investigations still needed to be done. *RP 380: 3-7*.

Dr. Joseph also had a duty to communicate the information in his possession, and he violated that duty. *RP 378: 22- RP 379: 5*. No evidence existed that any of Joan's test results, or concerns raised by such, were ever discussed with her. *RP 379: 13-17*.

C. <u>Dr. Jeffrey Caren:</u>

Dr. Jeffrey Caren is affiliated with Cedars-Sinai Medical Center in Los Angeles, and Board-certified in Internal Medicine and Cardiovascular Disease. *RP 534, 536*. Dr. Caren testified that pulmonologists are not the ones who should be performing cardiology consults for patients. *RP 546, 547*. That is to be done by a cardiologist. *RP 547*.

Dr. Caren testified that Dr. Joseph violated the standard of care in his treatment and his presurgical evaluation of Mrs. Eikum. *RP 547: 12-19*. Dr. Joseph's medical duty in the presurgical evaluation was "to *identify her surgical risk* from a medical point of view, and he failed to do that." *RP 547: 24 – RP 458: 3, emphasis added.* Findings existed that

were not properly pursued, including Joan's multiple episodes of syncope and shortness of breath/dyspnea. *RP 548: 1-9.* Her carotid bruit, which turned out to be something different, was "just dropped there." *RP 548: 12-15.* Her abnormal EKG was not further evaluated. *RP 548: 17-19.* These symptoms and tests were consistent with coronary artery disease, but the existence of this disease was not further evaluated. *RP 548: 12-19.* None of the tests that Dr. Joseph performed excluded the possibility of any coronary artery disease in his presurgical clearance. *RP 548: 20-23.* None of the tests he performed excluded the possible aortic stenosis, or ventricular dysfunction. *RP 548-49.* The tests he *had* ordered raised the suspicion of the existence of those cardiac dysfunctions. *RP 549: 12 – RP 550: 11.*

Dr. Caren explained that the January 12, 2009 EKG performed on Joan Eikum was "unequivocally an abnormal EKG." *RP 579: 9.* It evidenced a prior heart attack in areas supplied by the right coronary artery. *RP 577: 16 – RP 578: 10.* The 2009 EKG suggested the presence of a left ventricular dysfunction. *RP 578: 15-21.* The EKG did not exclude the presence of coronary artery disease or aortic stenosis. *RP 578: 6-10.* The "most benign" requirement of the standard of care for an Internal Medicine physician such as Dr. Joseph on seeing Joan's EKG

would be to get an echocardiogram. *RP 580: 1-6.* Other tests, such as a myocardial infusion study, could also be done with a deferral to an expert in the field – i.e., a cardiologist. *RP 580: 1-6.*

The Holter test Dr. Joseph ordered in January 2009 did not exclude cardiac disease. *RP 569: 24-25.* That January 2009 test showed Joan's heart beating at a maximum heart rate of 146, with her heart rate beating in excess of 100 for nine hours. *RP 567 4-5.* It was not known why. *RP 567: 16-23.* It would have been below the standard of care for Dr. Joseph to presume that Joan had been exercising for those 9 hours and 19 minutes. *RP 568: 4-17.*

Dr. Joseph's notes confirmed that he did not ever establish the etiology or cause of Joan's syncope. *RP 586: 7-11.* Its own medical record confirms that the "etiology" or cause of Joan's syncope was not determined. And, in fact, it never *was* determined. *RP 586: 2-11.* The syncope bouts being reported to Dr. Joseph were significant, because they had happened multiple times—from three to five times. The cause needed to be determined, and the first step of the standard of care would have been to get an echocardiogram. *RP 591: 8-13.* It was below the standard of care for Dr. Joseph to have told Dr. Dunlap that the patient was ready for surgery, *and* it was below the standard of care to report the same

conclusion to Joan. *RP 592; and RP 580: 14-19.* This was because Dr. Joseph did not know the cause of her symptoms, and he had reason to suspect that she might not be ready for surgery. *RP 592: 13-15.*

Joan's syncope was likely caused by a combination of moderate aortic stenosis, coronary artery disease, and left ventricular dysfunction. *RP 598: 12-16.*[2]

The material risk, and the echocardiogram as the definitive test.

The known risk of sending a patient with Joan's heart condition into a knee replacement surgery was that she would suffer a cardiac event – a "demand myocardial infarction" – meaning that her heart would not be able to get sufficient blood and nutrients through the structure of that heart in that condition. *RP 593: 8-13.*[3] The physician's purpose in a presurgical cardiac evaluation is to assess the risks, and weigh them. *RP 594: 22-24.*[4]

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[2] At the time Joan Eikum was cleared for surgery, she had already experienced a heart attack in the bottom of her heart supplied by the right coronary artery, *RP 553: 24 – RP 554: 5.* She had a weakened right ventricle, 80% - 90% blockage in the right coronary artery, 95% blockage at the end of the left main and the origin of the left anterior descending, and at the origin of the circumflex coronary artery, as well as either a thickening or a stenosis of the aortic valve. *RP 554: 6-22.* She had critical blockage of all three heart valves. *RP 554: 21-22.* She was "on a banana peel." *RP 554: 23.*

[3] The most dangerous time for those with coronary atherosclerosis usually occurs about 48 hours after the surgery. *RP 594: 8-13.*

[4] The presurgical clearance focused on heart health, and is not the responsibility of the orthopedic surgeon who was to perform the knee surgery. *RP 580: 20-22.* That orthopedic surgeon must rely on the consultant with respect to a patient's cardiac health prior to such a surgery. Dr. Joseph was Dr. Dunlap's consultant. *RP 581: 4-9.*

Joan had a preexisting cardiac condition on March 12, 2009 which included a high-degree, three-vessel coronary artery disease with moderate aortic stenosis, a prior inferior myocardial infarction, and right ventricular dysfunction. *RP 608: 4-12.* Dr. Joseph's pronouncing Joan Eikum "ready for surgery" reduced Joan's life expectancy from 12 years to 3-5 years, or somewhere between 60% - 75%. *RP 608: 13-25.*

An echocardiogram would have shown aortic stenosis. *RP 601: 5-7.* Following proper investigation, Joan Eikum would have alternatively had heart bypass surgery, not an elective knee surgery. *RP 600: 12-21.* The standard of care would have required heart bypass surgery. *RP 600: 17-21.* She should not have gone into a knee surgery with her heart in that condition. *RP 600: 22-24.* Her necessary treatment, and her option for treatment, was bypass surgery and, possibly, aortic valve replacement. *RP 601: 1-4.*

Had Mrs. Eikum had the appropriate bypass surgery, her chance of survival from her preexisting cardiac condition would have been 99%. *RP 602: 10-25.*

Following her elective knee surgery, Joan Eikum's "downward spiral" was triggered. *RP 599: 2-22.* She had an infarction of her left ventricle—a heart attack. Her heart simply couldn't keep up with the

demands made. *RP 599: 21 – RP 600: 11.*

D. Dr. Andrew Boulet:

Dr. Andrew Boulet was Joan's treating cardiologist at Providence Hospital in April 2009 following her post-surgical heart attack. *RP 764-66.* Joan died in the hospital after her elective knee replacement surgery from respiratory failure following multiple organ failure, including sepsis and a stroke with a brain injury, and kidney and liver failure after having undergone an emergency bypass surgery, combined with an aortic valve replacement. *RP 767: 21-24.* Dr. Boulet concluded that Joan's knee replacement surgery contributed to her death. *RP 767: 25 – RP 768: 14.* Her "cascade to death" started with her heart attack after surgery. *RP 769: 8-15.* It was not until that heart attack that physicians would discover that Joan had preexisting life-threatening coronary disease. The bypass was an emergency salvage surgery. *RP 770: 5-14.* Joan was starting to die before the bypass surgery was able to get underway. *RP 770: 15-19.*

Dr. Boulet agreed that where syncope exists, an echocardiogram test can identify heart valve structure or myocardial structure as the reason. *RP 776: 15-19.* Syncope can be caused by a weak heart or valve issue. About 80% of the time, the cause of syncope is cardiovascular. *RP 791: 6-14.* Valve structure is identified through an echocardiogram, along

with a variety of other heart function information. *RP 776: 20 – RP 777.* The echocardiogram can reveal the reasons for syncope. *RP 776: 5-19.*

Dr. Boulet also heard Joan's heart murmur. *RP 779: 21-24.* A murmur signifies a possible aortic valve stenosis, or valve sclerosis. *RP 781: 6-11.* Stenosis is a process that develops over years. *RP 781: 16-23.* The aortic valve stenosis would have been present 60-90 days before he heard the murmur. *RP 781: 12-17.*

When Joan experienced her heart attack, the extent of her heart dysfunction was discovered. Dr. Boulet described her disease as critical, severe three-vessel coronary disease, including left vein disease and hemodynamic compromise. *RP 812: 5-7.* This was "very, very severe coronary disease, life-threatening coronary disease, in all of her vessels." *RP 814: 16-22.* The left main artery was narrowed to 98%, and her left anterior descending artery was 95% narrowed. *RP 815: 11-15.* The level of plaque in her arteries was life-threatening. *RP 828: 22-24.* Her left anterior descending artery was heavily diseased and calcified all the way out to the apex, so there was no soft spot for cardiac surgeons even to graft during her bypass surgery. *RP 833: 10-17.* This "very, very severe coronary disease" was "coupled with a low cardiac output, in the setting of a moderately tight aortic valve which required more blood." *RP 809: 15-*

18. She had aortic valve stenosis. *RP 818: 18-20*. "Basically, the entire heart was at risk." *RP 815: 24*.

Dr. Boulet confirmed that post-operative cardiac events are a known phenomena. *RP 849: 22-25*. Using the phrase "cleared for surgery" does not allow for a patient's informed consent; instead, it signifies to a patient that they are low risk, "and people tend to interpret that as 'no risk' for your elective surgery." *RP 849: 5-8*. A patient must instead be told a degree of risk – i.e., low risk, some risk, etc. *RP 849: 9-19*.

Joan Eikum would not have been a proper candidate for knee surgery until after her cardiac dysfunction was addressed—meaning a bypass surgery. *RP 851: 18-24*. Dr. Boulet testified that had a coronary arterial bypass treatment been done in a non-emergent situation, then even someone who had cardiac disease as severe as Mrs. Eikum had a survival rate, following such a bypass, of 94%. *RP 852: 10-24*. Survival rates for a bypass plus aortic valve surgery were 94%. *RP 852: 25 – RP 853: 10*. But without that surgery, given her heart condition, Joan's life expectancy would have been less than two years. *RP 910: 19-25*. Once she had her heart attack and prior to bypass surgery, Joan's chances of survival dropped to zero percent. *RP 821: 25 – RP 822: 5*. Her only chance of

survival was to be generated from the surgery itself. *RP 822: 4-11.*

III. ARGUMENT

Issue # 1: Sufficient evidence was presented of two statutory alternative theories of liability to prove a single claim of injury by medical negligence, and the Eikums were deprived of a jury on their informed consent theory.

A. Standard of review.

The Appellate court reviews de novo a trial court's CR 50 order granting a defense motion for judgment as a matter of law. The Appellate court must apply the same standard as the trial court. *Goodman v. Goodman*, 128 Wn.2d 366, 371, 907 P.2d 290, 293 (1995)*(applying Rule 50 to a judgment notwithstanding a the verdict following verdict)*. Civil Rule 50 allows for judgment as a matter of law (JMOL) at any time, including at the close of a party's case in chief, at the close of evidence, or even following entry of the verdict itself, when there is "no legally sufficient evidentiary basis for a reasonable jury to find or have found for that party with respect to that issue." *CR 50*. Such judgments are proper only when, "as a matter of law, there is neither evidence nor reasonable inference therefrom sufficient to sustain the verdict." Goodman, 128 Wn.2d at 371. But a Rule 50 motion admits the truth of the opponent's evidence and all inferences that can be reasonably drawn therefrom, and requires the evidence be interpreted most strongly against the moving

party and in the light most favorable to the opponent. No element of discretion is involved." *Id.*

It is only where, in viewing the evidence in a light most favorable to the non-moving party, the court can say there is no substantial evidence or reasonable inference to support a verdict for the non-moving party, that the motion may be granted. *Carlson v. Lake Chelan Community Hospital*, 116 Wn.App. 718, 729, 75 P.3d 533 (2003).

B. The trial court's dismissal of one theory of liability contravenes CR 50.

The trial court dismissed one of the Eikums' theory of medical negligence liability, that theory being on Dr. Joseph's violation of Joan Eikum's right to informed consent, at the close of the Eikum's case. But the Eikums presented sufficient evidence of Dr. Joseph's violation of Joan Eikum's right to informed consent as one theory of the medical negligence alleged. The trial court's dismissal contravened CR 50, failed to properly assess the evidence, and misapplied the law of *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979); *Backlund v. Univ. of Washington,* 137 Wn. 2d 651, 660, 975 P.2d 950 (1999); *Anaya-Gomez v. Sauerwein*, 180 Wn.2d 610 (2014); *and Flyte v. Summit View Clinic,* 183 Wn.App. 559, 575, 333 P.3d 566 (2014). The Eikums are entitled to a new trial on that theory of liability.

C. Alternate theories are available to prove medical negligence in the same case.

RCW Chapter 7.70 allows "Actions for Injuries Resulting from Health Care." An injured patient may establish medical negligence liability in "one or more" of three specific ways.[5] Negligence and informed consent are "alternative methods of imposing liability" on a health care practitioner. Informed consent allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent. *Backlund v. Univ. of Washington*, 137 Wn.2d at 659. Alternate theories allow a jury to reject one form of liability, but find another, or find both. *See, e.g., Brown for Hejna v. Yamaha Motor Corp. USA,* 38 Wn.App. 914, 917-18, 691 P.2d 577 (1984) (holding that strict liability and negligence are separate non-exclusive theories equally available to a plaintiff in the same case).

Two of these alternative avenues of medical negligence liability are further defined by ensuing statutory elements. RCW 7.70.040

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[5] RCW § 7.70.030 states as liability theories:

"(1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;

(2) That a health care provider promised the patient or his or her representative that the injury suffered would not occur;

(3) That injury resulted from health care to which the patient or his or her representative did not consent."

(violation of standard of care);[6] RCW 7.70.050 (violation of right to informed consent).[7]

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[6] RCW § 7.70.040 states as follows;

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

RCW 7.70.040.

[7] RCW 7.70.050 states in relevant part:

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 non-treatment.

Both negligence and informed consent theories were at issue here.

D. The Eikums evidenced both alternative theories of medical negligence liability under the plain language of RCW 7.70.040 and .050.

The Eikums presented sufficient evidence to show that Dr. Joseph failed to follow the accepted standard of care under RCW 7.70.030(1). That avenue was never in question and went to the jury. The Eikums evidenced that Dr. Joseph failed to act on abnormal test results, failed to investigate, failed to refer Joan Eikum to a cardiologist or to obtain an echocardiogram in the fact of her symptoms and abnormal test results, and negligently pronounced her "ready for surgery," which caused her damage. This was sufficient to establish a standard of care violation.

The Eikums' second theory of liability was that of injury through medical treatment to which Joan did not consent, per RCW 7.70.030(3), and defined in RCW 7.70.050. "The treatment" at issue was Dr. Joseph's diagnostic process and his conclusion of "ready for surgery." John Eikum evidenced that Dr. Joseph failed to inform Joan of material facts relating to his diagnostic process and that "ready for surgery" conclusion. Dr.

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(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.

Wash. Rev. Code Ann. § 7.70.050 (West).

Joseph never communicated to Joan Eikum the cardiac risk demonstrated by her symptoms or her known abnormal cardiac test results, he failed to reach any diagnosis from either her reported cardiac symptoms or her multiple test results, he failed to tell Joan Eikum that he had been unable to reach any conclusions as to the etiology of her syncope or her symptoms, he failed to tell her that he had not investigated further to reach any conclusion, nor that he himself had written "cardiology consult" in her record but then failed to pursue that consult or discuss it with her, and in the absence of any diagnosis, and in the presence of existing cardiac dysfunction, symptoms and abnormal test results, he failed to advise her even of the availability of a simple, inexpensive gold standard test – the echocardiogram – that could have allowed resolution. He thus violated her right to informed consent by telling her she was "ready for surgery"—a conclusion he made entirely by himself, for her, with no explanation.

But the trial court dismissed the Eikums' informed consent theory, holding: "You can't use the same evidence to prove a negligence standard as an informed consent standard … If the doctor doesn't know about it, he can't inform the patient." (RP 1117: 1-6). These are two different holdings, and both contravene the law and ignore the evidence presented.

Within the medical profession, indifference to the patient during

that patient's diagnostic process is a violation of the standard of care. But within the *law,* it can be both negligence and a violation of informed consent. Negligence, because it prohibits the doctor himself from getting it right; violation of informed consent, because it prevents the patient from being able to make meaningful choices for their own care. Nothing in RCW 7.70.030 limits what evidence can be used to support either alternative theory. What is necessary is simply that each theory be evidenced.

The Eikums met their burden of showing all "necessary elements of proof" of an informed consent claim. RCW 7.70.050(1) (a)-(d). Per the statute, Dr. Joseph a) failed to inform Joan Eikum of the material fact of her unresolved symptoms, her abnormal test results and the ready availability of a simple test (an echocardiogram) that would have revealed extensive heart disease and dysfunction—all of these material fact or facts relating to the treatment; b) she consented to Dr. Joseph's "ready for surgery" conclusion, without being aware of or fully informed of these material facts; c) a reasonably prudent patient under similar circumstances would not have consented to "ready for surgery" if informed of such material fact or facts; and d) her accepting Dr. Joseph's course of diagnostic treatment and his "ready for surgery" conclusion proximately

caused her injury and death. RCW § 7.70.050.

A material fact for purposes of section (1)(a) in RCW 7.70.050 is statutorily defined: 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, the fact is material. Within a diagnostic procedure relating to a condition that involves risk to the patient, a health care provider has a duty to disclose material facts relating to that diagnostic procedure. *Flyte v. Summit,* 183 Wn.App. at 577. This situation presented an "intelligent and informed choice" to be put to Joan Eikum—whether to proceed to the surgery or not when there had been no diagnosis from her cardiac symptoms, where abnormal test results which suggested the risk of heart valve disease and disease of the arterial systems of the heart, where heart disease had never been excluded, and when Joan Eikum had a readily available gold standard alternative diagnostic treatment available before agreeing to Dr. Joseph's "ready for surgery" conclusion. RCW 7.70.050(3)(c) itself defines as "material facts" which must be disclosed: "c) The recognized possible alternative forms of treatment."

The Eikums' expert testimony thus not only established that Dr. Joseph was doing a diagnostic procedure, that he possessed abnormal test

results and symptoms raising the risk of a multifactorial heart dysfunction, that he himself noted that a cardiology consultation was warranted because he could not identify the cause of Joan's syncope, but that well-recognized possible alternative form of treatment, i.e., echocardiogram, was readily available, inexpensive, simple, and non-invasive for a conclusive diagnosis. This alternative treatment option was not just available, it was *indicated* as part of the standard of care given the continued unresolved symptoms. Joan Eikum was not informed of any of this. This expert testimony allowed Joan Eikum's second theory of negligence liability to go to the jury. It satisfied all prongs of RCW 7.70.050(3)(c).

Joan Eikum also established through medical expert testimony an alternative prong of informed consent liability under RCW 7.70.050(3)(d). Her experts established "(d) ... recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including non-treatment." Dr. Caren testified that by sending Joan Eikum to a knee surgery with her symptoms and abnormal test results indicating the existence of heart disease, and with no further testing or resolution, Dr. Joseph reduced Joan Eikum's chances of survival by over 50%. This is a material risk from a non-conclusive diagnosis in the face of symptoms and

tests.

Joan Eikum's treating physician, Andrew Boulet, evidenced that had Joan been allowed the alternative proper testing, it would have led to the resultant necessary cardiac bypass surgery, with her chances of survival thereby in excess of 90%. *See Andrew Boulet, RP 852: 10-24.*

The Eikums sufficiently evidenced a violation of informed consent, and were entitled to have that theory go to the jury. The trial court erred in dismissing the Eikums' informed consent liability theory.

E. The Eikums evidenced both theories of liability under existing precedent.

In the recent appellate decision of Flyte v. Summit View Clinic, 183 Wn.App. at 92 Wn.2d at 250-51, 572, the *Flyte* court reinvigorates *Gates v Jensen*, 92 Wn.2d 246. Applied here, *Flyte* would hold that Joan Eikum had the right to know how Dr. Joseph was "diagnosing" her for surgical clearance and drawing his conclusions, or not drawing conclusions. Joan's right was not confined to being told of *his* choice for her treatment—"ready for surgery." And this would apply even had Dr. Joseph c*onclusively* diagnosed her. *Flyte*, 183 Wn.App. at 572. Even with a conclusive diagnosis, Joan's right to information and choice was attendant to the diagnostic process itself – i.e., before Dr. Joseph reached his ultimate conclusion. *Flyte*, 183 Wn.App. at 574, 575, citing *Gates v.*

Jensen, and *Anaya-Gomez*, 180 Wn.2d at 37. Here, Dr. Joseph did not share his diagnosis process at all, nor the fact that he had not investigated sufficiently to achieve any diagnosis, nor exclude heart disease. Both are material facts.

As explained in *Flyte* at 183 Wn.App. at 572, quoting *Gates v. Jensen*, 92 Wn.2d at 250-51, "[I]mportant decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures leading to diagnosis. Those decisions must all be taken with "the full knowledge" and participation of the patient." *Id.*, *emphasis added.* The "physician's duty is to tell the patient what he or she needs to know in order to make them." *Id.* The existence of alternative *diagnostic* procedures to "conclusively determine the presence or absence of that disease are all facts which a patient must know in order to make an informed decision on the course of her future medical care." *Flyte* at 572, citing *Gates v. Jensen*, 92 Wn.2d at 250-51.

Joan Eikum's right to information and choice was attendant to the diagnostic process itself – i.e., before any ultimate conclusion is reached. *Flyte* at 574. The duty of a physician is to allow patients to choose their own medical treatment, instead of taking that choice away from them. *Flyte* at 574, citing *ZeBarth v. Swedish Hospital and Medical Center*, 81

Wn.2d 12, 23, 499 P.2d 1 (1972).

The trial court ruled that Dr. Joseph "didn't know" about Joan Eikum's heart disease. "If the doctor doesn't know about it, he can't inform the patient." *RP 1117: 1-6.* This hearkens to *Backlund v. University of Washington.* A physician can't inform the patient of the risks of a condition that the physician had excluded as being present. *See Flyte*, 183 Wn.App. at 576, citing *Backlund*, 137 Wn.2d at 661, n.2. But that was not what was evidenced here. The Eikums' evidence was that Dr. Joseph *did* know about Joan's cardiac dysfunction signs and symptoms, her abnormal test results from cardiac testing he had himself requested, and his own plan for a cardiology consult as a result. Dr. Joseph *did* know of the likely presence of heart disease or the high suspicion of such. He simply failed to investigate it to any diagnostic or exclusion process. Backlund also establishes that whenever a physician *becomes aware* of a condition which indicates risk to the patient's health, he has a duty to disclose it. 137 Wn.2d at 660. It is only when a health care provider *rules out* a particular diagnosis that there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis. Here, Dr. Joseph never ruled out heart disease. "Ready for surgery" is *not* a diagnosis, nor a misdiagnosis. It is not an exclusion, nor an inclusion, of any medical

condition or health information. "Ready for surgery" says, and shares nothing with Joan Eikum.

The trial court's finding that Dr. Joseph "didn't know" of heart disease is a finding that could only be gleaned from taking evidence in a light most favorable to the *defense*, which contravenes CR 50. The Eikums' evidence established that Dr. Joseph *did* know of the high risk of heart dysfunction. The finding contravenes CR 50, and the evidentiary record itself. The Eikums sufficiently evidenced a viable claim of violation of informed consent under RCW 7.70.050(3)(c) and (d), and under *Backlund*, *Anaya-Gomez*, and *Flyte*.[8]

Both *Backlund* and *Anaya-Gomez* also support that one "significant fact" here is that Dr. Joseph had available an additional gold standard diagnostic test for Joan's heart dysfunction symptoms and testing. The test was inexpensive and risk free. *Anaya-Gomez* at 622, citing *Gates v. Jensen,* 92 Wn.2d at 248. In *Anaya-Gomez,* Dr. Sauerwein

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[8] After the Eikums' informed consent theory of liability was dismissed, Dr. Joseph would testify that his presurgical cardiac evaluation with Mrs. Eikum lasted 15-minutes. *RP 1972: 20-24.* He told Joan Eikum—"You're ready for surgery. We'll see you back in six months. Continue your medications. Good-bye." *RP 1984: 15-20.* That was all he told her—"Ready for surgery. Come back in six months." *RP 1985: 13-22.* He also confirmed that an echocardiogram could have been done "in a heartbeat." *RP 2063: 9-12.* All he had to do was to direct his staff to get Joan set for a referral. *RP 2063.* He agreed that an echocardiogram was "an incredibly valuable tool," and he used it often. *RP 2076: 10-11.* But in Dr. Joseph's opinion, "[T]here was no reason to do any further testing, or any further instructions needed from me at that time." *RP 1985: 23 – RP 1986: 1.*

had no additional tests available, but here, such tests were available. The very choice available to Joan Eikum was whether to do the additional testing in light of her test results, and "[G]iven the small cost and effort of those tests, the decision was relatively easy." *Anaya-Gomez* at 621, referencing *Gates*. As to the trial court's concern over which alternative liability applied, that was for the jury to determine. A jury may properly uphold a physician's professional judgment as to what that physician decided to disclose or not disclose as the standard of care for treatment, but "a trier of fact might still have found he did not sufficiently inform the patient of risks and alternatives in accordance with RCW 7.70.050." *Backlund*, 137 Wn.2d at 662-63.[9]

The Eikums were entitled to have the jury determine if that approach violated Joan Eikums' right to informed consent. They met their burden of showing a prima facie case of Dr. Joseph's withholding of material facts in Dr. Joseph's conclusion of "ready for surgery." The trial court's dismissal of this informed consent theory of liability requires retrial on this avenue of liability.

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[9] The *Anaya-Gomez* court uses the phrase "imposing double liability" when discussing alternative theories, *Id.*, 180 Wn.2d at 618. But "double liability" is meaningless where there is only one injury and one requested recovery. The Eikums weren't seeking the same recovery imposed twice. The jury could find one, reject the other, find both or find neither; but the recovery was the same recovery from one single claim of medical negligence.

Issue # 2: In order to qualify for an ER 803(a)(18) exception to hearsay, the content of "statements contained in a learned treatise" must be present in the courtroom.

A. Standard of review.

A trial court's evidentiary rulings are reviewed for abuse of discretion. *Hickok-Knight v. Wal-Mart Stores, Inc.*, 170 Wn.App. 279, 313, 284 P.3d 749 (2012), *citation omitted.* A trial court abuses its discretion if it bases its decision on untenable grounds or reasons, or if its decision is manifestly unreasonable. *Id. citing Yousoufian v. Office of Ron Sims,* 168 Wash.2d 444, 458, 229 P.3d 735 (2010). Here the trial court abused its discretion because the grounds for its decision were untenable. It misapplied ER 803(a)(18)'s plain language and the Rule's implicit requirements. Questions of law are reviewed de novo. *Hickok-Knight* at 313.

B. ER 803(a)(18) was violated.

Here, defense counsel James King repeatedly asserted that it was not an echocardiogram that was the standard of care in Washington, but instead, it was for presurgical clearance what he represented to be the *content* of a writing he called the "2007 cardiac risk test index" allegedly promulgated either by the American College of Cardiology or American Heart Association, or both. Defense counsel purported to quote this

article's content both during cross examination of the Eikums' experts, and during the direct examination of his own defense expert witnesses. His defense experts also quoted this alleged article. But neither defense counsel, nor his experts, could produce the content of that 2007 writing they all purported to quote. The pervasive nature of this ongoing representation and testimony is such that the record cites are laid out in ***Appendix A***.

Representations made as to a writing that is not present is classic hearsay. *ER 801, 802.* If the content of a writing is intended to be introduced through an expert under ER 803(a)(18)'s exception as a "learned treatise" or authoritative article, the Rule necessarily requires that the writing be present in the courtroom for admission, *and* this same premise is likewise required under ER 1000, et seq.

(i) ER 803(18)(a) requires that any article referenced be present in the courtroom.

ER 803(18)(a)allows an exception to hearsay called "statements contained in published treatises."[10] Through it, an expert witness is thus

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[10] ER 803(a)(18) states in relevant part as follows:

> **"RULE 803. HEARSAY EXCEPTIONS; AVAILABILITY OF DECLARANT IMMATERIAL**
>
> **(a) Specific Exceptions.** The following are not excluded by the hearsay rule, even though the declarant is available as a witness:
>
> .....

allowed to testify about, and to read to the jury, statements that contained in a writing. But the only way to meet the rule is to have the article present in the courtroom. *See State v. Rangitch*, 40 Wn.App. 771, 780, 700 P.2d 382 (1985)(where an expert read from certain texts). ER 803(a)(18)'s "admission" requirement prior to reading ensures that the statements allegedly contained within those treatises are necessarily present in the courtroom, and the content thus able to be verified before it is admitted and read. Questions and answers which purport to represent the actual content of such an article thus refer to "statements contained within" the article, and are hearsay absent this verification. Under ER 803(a)(18), such a document is admitted, but simply not entered as an exhibit. *See, e.g., Miller v. Peterson*, 42 Wn.App. 822, 714 P.2d 695 (1986).

In *Rangitch*, a physician testified as to the reliability of specific statements in an article present, thereby "qualifying the textual statements under ER 803(a)(18)." *Rangitch* at 780. In *Larson v. City of Bellevue*, an

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(18) *Learned Treatises.* To the extent called to the attention of an expert witness upon cross examination or relied upon by the expert witness in direct examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence but may not be received as exhibits."

RR 803, emphasis added.

expert was allowed to read an article's statements into evidence if the expert testified as to their reliable authority. *Larson v. City of Bellevue*, __P.3d__, 2015 WL 4204116. Again, the article was in the courtroom. *Id.*

Here, defense never produced the 2007 document they purported to quote, and the content of which was repeatedly "applied" without being present.

Throughout trial, the Eikums' counsel repeatedly objected to the defense representations of the content of this alleged 2007 article that was not present in the courtroom. *Appendix A in total.* Throughout trial, the trial court consistently allowed these representations as an exception to hearsay under ER 803(a)(18). *Id.*

The confusion was profound. Defense counsel at one point implied that the 2007 "guidelines" were contained within a textbook known as "Harrison's 17th Edition," which turned out to not contain those guidelines at all—the textbook simply referred to the 2007 guidelines. *App. A 2, n.1, referencing RP 486: 6-10.* The 2007 article was never in the courtroom throughout trial. After repetitive defense claims as to its content, and late in the trial, the Eikums' counsel ultimately presented what she found on the Internet, believing it to be the defense referenced 2007 guidelines,

whereupon defense counsel announced that that document was not the 2007 guidelines he and his experts had been referring to. *App. A 24-26; RP 1858: 18-20.* At no time during the trial did the defense thus ever produce *their* 2007 article, the content of which they continuously represented and alleged was the specific standard of care in Washington for presurgical clearance. Defense counsel centered his closing argument on this nonexistent 2007 article.[11]

This error was pervasive, and the Eikums are entitled to a new trial. "Statements contained in a learned treatise" must be present in the courtroom to be allowed through ER 803(a)(18). This is implicit in the Rule's language, and in its requirement of admission before being allowed to be read. The trial court's allowing continued representations of the alleged content of an article that was never present in the courtroom was error in the application of ER 803(a)(18).

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[11] He argued "this tool ... is more accurate than any single test. This tool is predictive and is used to predict risk for non-cardiac surgery, and multiple studies support its reliability." *RP 2318: 19-22.* He referred to the nonexistent 2007 guidelines as a "well validated, well established tool with exhaustive scientific research and exhaustive scientific underpinnings in effect in 2009" when Joan Eikum's presurgical clearance was performed. *RP 2318: 12-18.* The testimony as to the content of this "tool" was so extensive "you're probably sick of it...." *RP 2318: 12-18.* He argued that physicians used the 2007 "tool" to evaluate or clear a patient for non-cardiac surgery, "and here it is. This tool ... is more accurate than any single test. This tool is predictive and is used to predict risk for non-cardiac surgery, and multiple studies support its reliability." *RP 2318: 12-22.* Dr. Joseph's "using this risk index" met the standard of care. *RP 2320: 16-21.*

(ii) ER 1000, et seq. was violated.

The Eikums also continuously requested the production of this alleged 2007 writing because its content was repeatedly being represented without it being present. *App. A, e.g., A-2, citing RP 444: 6-7; A-3, citing 445: 10-17; A 7-8, referencing RP 620; A 9-10, citing RP 623, 624, etc.* They were entitled to the production. ER 1000 et seq., is known as the "best evidence rule." *See, e.g., In re Adolph*, 170 Wn.2d 556, 568, 243 P.3d 540, 546 (2010). ER 1000 et seq. is consistent with ER 803(a)(18), and was also violated. Even if ER 803(a)(18) would allow reference to an article, and even were its terms not terms requiring the production of the article (as they clearly are), ER 1001 would still entitle the Eikums to review the actual document being represented.

An alleged treatise or article is a writing. ER 1001(a). It is "words…set down by handwriting, typewriting, printing,…or other form of data compilation." *ER 1001(a)*. The "2007 article" referenced could be easily reproduced, as it was allegedly a set of published guidelines. *ER 1001 (c) and (d)*. ER 1002's best evidence rule required that the contents of that 2007 writing be proved by presentation of the writing. *ER 1002, 1003*. The trial court abused its discretion in refusing the Eikums that right.

The trial court also violated ER 1006 by allowing a defense expert to fashion a "chart" in court as an alleged "summary" of their nonexistent 2007 article. Summaries are permitted for the contents of "voluminous writings.... which cannot conveniently be examined in court," and such summaries may be presented in the form of a chart. *ER 1006*. But to be allowed, "[T]he originals, or duplicates, shall be made available for examination or copying, or both, by other parties at reasonable time and place. The court may order that they be produced in court." *Id.* ER 1006 was also violated. Here, the original 2007 article allegedly being quoted was never present to verify any summary.

Even the "Harrison's 17th" textbook that plaintiffs' counsel had access to on a five-minute break was not the 2007 guidelines underpinning "the chart." But even that textbook was removed from the courtroom by defense counsel. The trial court's requiring the Eikums to go out, find, and *buy* the treatise for themselves if they wanted to verify anything, violated ER 1000 et seq., and mandates a new trial on both theories of liability.

Issue #3: A physician has a well-established duty to perform alternative tests where risk conditions arise, and a duty to communicate options for alternative tests. The jury must be so instructed, even though the remaining claim is one related only to the standard of care.

A. Standard of review

Legal errors in jury instructions are reviewed de novo. *Fergen v. Sestero,* 182 Wn.2d 794, 803, 346 P.3d 708, 713 (2015).

B. Supplemental instructions in medical negligence cases are favored to help jurors understand the complexity of the cases.

This state's Supreme Court recently reaffirmed the need for jury instructions which supplement "basic standard of care instruction in medical malpractice cases." Supplemental instructions "help juries understand the complexity of the legal standard they are being asked to apply." *Fergen v. Sestero*, 182 Wn.2d at 811. "[I]f a party's theory of the case is supported by substantial evidence, he or she is entitled to have the court instruct the jury on it." *Id.* at 810. "Elaborating instructions" are "commonly used in negligence law and are helpful for lay jurors to understand the complexities of a malpractice case." *Id.,* at 811. I When evidence supports that the judgment issue is in dispute, then the entitlement arises. *Id.* at 811.[12] The trial court also has a duty to ensure that the testimony and argument made is not misleading as a matter of law. *Gammon v. Clark Equip. Co.*, 104 Wn.2d 613, 616-17, 707 P.2d 685 (1985). If the trial court does not like the plaintiffs' proposed instructions

[12] In all reported cases where the instruction was used, a defense verdict resulted. *Id. at 810.*

on an issue, it has considerable discretion in deciding how such an instruction should be worded. *Id.*

Here, two duties of standard of care negligence arose as a matter of law. Both were in dispute. Here, the Eikums proposed jury instructions embodying both the physician's duty of administering additional diagnostic tests, and the duty to communicate to the patient the option of available, additional administrative tests, as standard of care negligence duties.

A physician has a duty to disclose treatment options to a patient for a condition that may indicate a risk to the patient's health, even before a conclusive diagnosis. In *Flyte*, the appellate court reversed a trial court that affirmatively instructed a jury that a physician had "no duty" to disclose treatment options for a condition that may indicate a risk to the patient's health until the physician diagnosed the condition. 183 Wn.App. at 572. Such a duty exists as a matter of law, and a trial court's instructing a jury that no such duty existed contravened the law. *Id*, citing *Gates*, 92 Wn.2d at 250-51; *Anaya-Gomez*, 180 Wn.2d at 37. Likewise, in *Gates*, "jury questions were raised as to whether (the physician) disclosed all the facts which he had a duty to disclose and, if not, whether (the patient) was injured thereby." 92 Wn.2d at 251. The trial court in *Gates* erred in

refusing a requested supplemental instruction. *Gates*, 92 Wn.2d at 251.[13] Here, the Eikums fashioned their proposed instructions 13 and 14, later 26 and 27, *CP 104-105*, on the duty of disclosure of abnormalities as part of the medical standard of care on the same *Gates* instruction language already determined by this state's Supreme Court to be proper. *See infra.* Proposed instruction 14, and amended 27, even though referencing the duty of *advising* a patient, were presented as duty of care, i.e., standard of care negligence instructions: "Failure to so advise the patient is negligence." *CP 32, 105.* Proposed instruction 15 also began as an elements instruction for a theory of informed consent, based on WPI 105.04 and 105.05, but it was later amended to a negligence instruction at proposed Instruction No. 28 because of defense physicians' testimony.

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[13] In *Gates*, the proposed supplemental instruction at issue reads as follows:

"You are instructed that an ophthalmologist has a duty to advise his patient of all relevant, material information concerning the condition of the patient's eyes that the patient will need to make an informed decision respecting the alternative methods of examination for eye disease, of the reasonably foreseeable risks of each alternative, and of no such examination at all. Failure to so advise the patient is negligence."

"The plaintiff-patient must prove the following elements to establish a case of negligence against the ophthalmologist for failing to impart information so the course of examination could be chosen intelligently: (1) The defendant-doctor failed to inform the plaintiff-patient of the condition of the patient's eyes, of the availability of alternative examination procedures for detecting eye disease, of the reasonably foreseeable material risks of each alternative, and of no examination at all. (2) A reasonable person in the plaintiff-patient's position would have chosen a different course of examination had the alternatives and the material risks of each been made known. (3) The plaintiff has been injured as a result of submitting to the course of examination proposed by the physician."

Gates v. Jensen, 92 Wn.2d at 250, n.2, *emphasis added.*

CP 33 (Proposed Instruction 15) v. CP 106 (Proposed Instruction 28).

The Eikums' request to incorporate the legal duty to *advise* a patient properly as part of the *medical standard of care* was raised throughout trial. See RP 1385-1391.[14] Because of this, the trial court initially ruled that if the plaintiff's experts testified that the duty to disclose was "part of the standard of care," and if the defense experts said it was not, "then at the end of the trial when we instruct the jury, that's how I'll instruct them." *RP 1390: 24-1391:4.* But it never did so. The trial court gave only one negligence instruction. *CP 138, Instruction No. 5.*

Moreover, proposed instructions 10 and 11 (amended 23 and 24) were pure negligence instructions. If reasonable prudence required the *administration* of additional diagnostic tests before clearing Joan Eikum for elective surgery, and Dr. Joseph failed to administer those tests, then such would suffice as negligence. *CP 28-29, 101-102.* This comported with *Gates v. Jensen.* Symptoms and test results showed the risk of a

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[14] The Eikums' argued that even though the informed consent theory had been dismissed, plaintiffs' experts had established that the duty to communicate with the patient was a part of the medical standard of care, and could continue to be addressed in testimony. *RP 1385: 2-23.* Defense counsel objected to that theory, claiming that dismissal of the informed consent theory prevented any questioning or testimony on the duty to communicate. The Eikums were simply "repackaging" an informed consent claim, defense claimed. *RP 1387: 10-17.* Defense argued, "regardless of what Dr. Stricke says...."our Supreme Court and our Appellate Courts have disposed of that notion...and its immaterial when someone says the standard of care is with respect to disclosure." *RP 1388: 14-19.*

certain condition, or the diagnostic procedures are inconclusive, and "reasonable prudence requires the use of the alternative tests." 92 Wn.2d at 252-53.

The Eikums' instructions were correct statements as a matter of law. And by not instructing the jury on the existence of either legal duties, whether or not as informed consent or standard of care, the court created a fact issue as to whether either duty existed at all. The jury could not apply the evidence they heard to established duties; they had to resolve whether the duties existed at all. By failing to instruct, the single negligence instruction given misled the jury. *Gammon*, 104 Wn.2d at 616-17. The jury's role was to apply the evidence to the existent duties. The court's material instructional error requires retrial.

IV. CONCLUSION

John Eikum is entitled to a new trial on his medical negligence claim under both theories of liability. This court should so hold.

DATED this 14th day of September, 2015.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that she is a person of such age and discretion as to be competent to serve papers; and that on **September 14, 2015**, she served a copy of the foregoing document to the following individuals in the manner indicated below:

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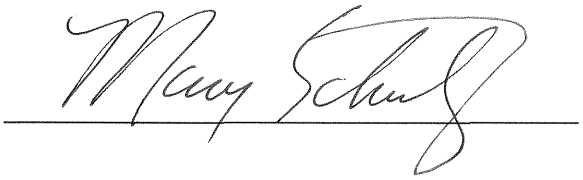
DATED this 14th day of **September, 2015**.



APPENDIX A

ER 803(a)(18) evidence and rulings

A. Cross Examination of Plaintiff's expert Dr. Leslie Stricke.

On cross examination, defense counsel began making reference to "the revised cardiac risk index." *RP 441: 12-14.* Defense Counsel referenced a "Seventeenth Edition of Harrison's Text on Internal Medicine." *RP 442: 2-6.* Dr. Stricke confirmed that the "Harrison's" text on internal medicine was authoritative, *RP 441: 20 – RP 442:1*, but Dr. Stricke did not have the "17th Edition." *RP 442: 6.* Defense counsel now handed the witness, not the Harrison's itself, but a document he claimed he had made for the witness's "review" allegedly from the text. *RP 442: 13-25.* Defense counsel stated that the document contained "the first page of what I've handed you is simply the cover from Harrison's. The book's right here, correct?" *RP 442:13-17.*

Yet defense counsel stated "I've made a copy for your review and I have some questions for you from page 50 of Harrison's, and I've attached that to the document that you're looking at…and *that Page 50 contains the revised cardiac risk index clinical markers, correct*? .." *RP 442: 18-25.* Dr. Stricke could only look at the defense's copied excerpt. In response to the defense question, "And that Page 50 contains the revised cardiac risk index clinical markers, correct?" the witness responded, "I see that." *RP*

442: 25.[1] The document was never marked for admission by the defense or identified for the record beyond this. *RP 442-443.*

Plaintiffs' counsel objected to the document's use absent the original or copy of the complete document. She requested that defense provide her "the book," which was sitting on defense counsel's table, because "[T]here's a lot of stuff missing in the defense exhibit," and she requested the ability to "see where this is coming from." *RP 443: 19-23.* The court denied the request, stating that plaintiffs' counsel had received a copy of what the witness was looking at, and "that's all he has to provide at this point." *RP 444: 2-3.*

Plaintiffs' counsel thereupon made request for the *complete* document, "which I have a right to." *RP 444: 6-7.* The court denied review of the document. Plaintiffs' counsel objected. Admission of the document was required because "he's testifying from it." *RP 444: 10-12.* The complete document was at issue: "He's testifying from it, and I'd like to see where he's pulling this from." *RP 444: 10-13.* The court again overruled the objections, holding: "at some point you can cross examine

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[1] The actual document handed to the witness was not described until redirect. Plaintiffs' counsel described on the record that it consisted a three page document, with the first page being a copy of the cover of a book, the second page being the publisher, and the third page being "pieces." *RP 484: 1-7.* The pieces were "a couple of tables" from a chapter called "Medical Evaluation of the Surgical Patient." *RP 485: 21-24.* The document piece copied was not the cardiac risk index; it simply referenced the index—" Evaluation of such patients....should always begin with a thorough history...and with a 12 lead resting EKG *in accordance* with the American College of Cardiology, American Heart Association guideline recommendations." *RP 486: 6-10*, emphasis added.

him (plaintiff's own witness)." *RP 444: 15-16.* Only the witness could request the document: "If you need to see the entire, or if the witness needs to see it, I'll allow *him* to look at it, but specifically for the questions he is asked at this time." *RP 444: 14-19, emphasis added.* Defense counsel began questioning Dr. Stricke on this document which was neither marked as an exhibit, nor admitted. *RP 444: 8-25.*

Plaintiffs' counsel requested a bench conference. The document she had received was incomplete, and its source could not be verified—"All we have are two little tables here," that could not be addressed without context. *RP 445: 10-17.* The court overruled the objection again, and held that it was the witness alone who was in control of asking for the complete document, not counsel. *RP 445: 18-24.*

Defense counsel continued to proceed to cross examine the plaintiffs' expert with this incomplete document, reading from it. *RP 446.* Dr. Stricke testified only, "I'm agreeing with what you're reading," (i.e., on the exhibit he had been handed). *RP 446: 10-11.* When defense counsel attempted to get Dr. Stricke to confirm that his excerpt "comes right out of Harrison, you know that?" – i.e., that it quoted the text verbatim, Dr. Stricke requested a chance to answer that question, but the court interrupted him upon defense objection. *RP 446: 16-25.* Defense counsel continued to insist on cross examining from his document alone,

and Dr. Stricke stated: "There is such conflicting information in different literature. *Yours* says this, I agree, but that's not necessarily what all the literature says." *RP 447: 11-13.*

Defense counsel continued to assert that "Harrison's" was the source of his excerpt, and read his document to the witness. *RP 447: 19 – RP 448: 12.* Dr. Stricke was likewise asked to read, from not the text, but the excerpted table provided him. *RP 447: 19 – RP 448: 15.* Plaintiffs' counsel again objected to the process. The document the witness was given was incomplete, and nothing could be verified—what it was, or where it came from. "There's no indication that Table 8.4 follows 8.1—there's a big hole in the middle of it." *RP 448: 16-18.* The trial court again overruled the objection. *RP 448: 19-21.* Defense counsel again insisted that the doctor answer questions based on the purported content of his excerpt. *RP 448: 22 – RP 449: 51.* Defense counsel continued to ask questions, reading from his document. *RP 451: 22-25.*

Defense counsel began representing "the literature." *RP 466: 23-25.* Defense now represented that "the American Heart Association and the American College of Cardiologists" had studied and "published" certain material. *RP 467: 3-10.* Dr. Stricke answered that he was unsure of what defense counsel was referring to. *RP 467: 13-14.* Defense counsel represented alleged "figures published by the ACC and the AHA."

The witness stated "I will accept that you have reviewed this in great length and you've got the information, but I'm not sure that I can agree with that because...," and again asked to explain. *RP 468: 5-9; 11-13.* He stated "I don't know whether (what counsel was representing) is correct." *RP 468: 11-16.*

On a five minute break during cross examination, Plaintiffs' counsel again asked the court to allow her a "look at the book," (Harrison's text) so that she could appropriately redirect. The court inquired of defense counsel as to whether he would "allow" it. *RP 470: 8-14*: Defense counsel "allowed" it. *RP 469: 15-17.* Following this five minute break, Defense counsel again referenced, not his Harrison's text, but "the revised cardiac risk index," and objection was now also made. "It presumes only one cardiac risk (index)." *RP 471: 11-23.*

Plaintiff's counsel had retained the "Harrison's" book from the break and attempted to use it for redirect. Defense objected to Plaintiff's counsel being allowed to use the "Harrison's" book to do her redirect, but the court allowed it. *RP 485: 13-20.* Defense counsel would later object that because there was only the one book, he could not follow the testimony without having the book in front of him. *RP 506: 22-25.* Defense counsel complained that, as he "did not have the benefit of the book," he could not "make his record or ask appropriate questions." *RP*

506: 22-25; RP 507: 15-19. At the end of the redirect, the court directed the plaintiffs' counsel to return the book to defense counsel. *RP 509: 5.*

Similarly, on the cross – examination of Plaintiff's expert Dr. Jeffrey Caren, Defense counsel again raised the "American College of Cardiology guidelines for evaluating patients for perioperative cardiac risk that were published in 2007." *RP 610:11-15.* These 2007 guidelines were not provided. Dr. Caren testified that he knew "of" them but could not quote them. *RP 610: 14.* Defense counsel then stated that those 2007 guidelines "were in effect in 2009, were they not?" *RP 610: 15-16.* The witness stated, "I'll accept that, yes." Defense counsel stated: "Do you know one way or another?" The witness stated: "Not for sure." *RP 610: 19.* Objection continued to be posed to defense representing the alleged content of the guidelines, and the objection continued to be overruled. *RP 611: 23 – RP 612: 7.*

Defense would continue to assert "the American College of Cardiology and the American Heart Association guidelines for cardiac clearance of patients preoperatively," as the "standard of care" criteria. *RP 612: 15-25.* Because all objections to the existence of alleged "guidelines" had been overruled, "the" alleged 2007 guidelines were now taken as existent, but the content was not in the courtroom. *RP 612: 20-21.* These 2007 guidelines discussed were now represented to be the ones

allegedly in effect existent at the time of Joan Eikum's surgery in early 2009. *RP 612: 15-25; RP 613: 4-9.* Dr. Jeffrey Caren testified that he did not use, know the elements of, nor committed to memory those 2007 guidelines allegedly in effect. *RP 613: 1-14.*

Now Defense counsel raised two different documents: "either the American College of Cardiology, AHA guidelines *or* the incorporated revised cardiac risk index in clearing patients for surgery." *RP 613:10-14, emphasis added.* Defense counsel now asked whether a doctor would be complying with the standard of care if they were "using those guidelines." *RP 613: 15-22.* But to that point, "those" guidelines had never been shown to anyone, and did not appear to be present in the courtroom.

On a break during Dr. Caren's testimony, an extensive objection and colloquy again occurred regarding defense's continued purported reference to a 2007 "cardiac risk index" which was not present in the courtroom. *RP 620-629.* Defense counsel had brought "this large book that we played with" the day prior, and had presented "a couple tables." *RP 620: 13-17.* The continuing allowance of this was at issue: "there are some issues arising with the cardiac risk index—this whole concept." *RP 620: 13-17.* Since the court earlier declined to "admit" the Harrison's textbook on request by Plaintiff, defense counsel had now taken the Harrison's book back to his office to make it unavailable, and refused to

produce it on request. *RP 620: 18-25.* Objection was taken—the text had to be present in the courtroom to allow for redirect or for any other witness intended to be presented with it. *RP 620: 24-621: 1-2.*

The court refused this request as well. "It's not evidence, which is why the court didn't admit it under the court rules or the evidence rules." *RP 621: 2-7.* The court referred to either the Harrison's text, or the "pieces" of the three-page excerpt, alleged to be from the Harrison's text, as themselves being "an article." *RP 621: 7-8.* The court stated that "your doctor testified that he's well aware of *it*, familiar with it, relies on it, doesn't have the 17th edition, but does know about it." *RP 621: 7-12.* It held that "it" was not evidence, and can't be admitted under the court rules. *RP 621: 11-13.*

Plaintiff's counsel argued that the defense's excerpted document and the textbook *had* been admitted "it is evidence because they were reading from it, and that is admitting it into evidence." *RP 621: 14-16.* It "was being offered as evidence. It is in evidence. It has been attested to as in evidence, but I don't have it here, and the court is going to hear some different variations off the risk index and that's why I'm raising this now." *RP 621: 14-21.*

Defense counsel confirmed that all plaintiff's counsel had received was a copy of the defense's excerpted document—"a copy of the front

piece of the treatise, the publication date and copyright date, and the two tables that I used in my examination of Dr. Stricke yesterday to Ms. Schultz—so she has that." *RP 622: 20-25.* Defense counsel did not want to bring back the Harrison's text into the courtroom. He stated he did not intend to use the actual book-the treatise from which this excerpt was allegedly taken: he was "not intending to use *Harrison's* with this witness at all." *RP 623: 4-5.* He again represented content—there was only *one* single revised cardiac risk index. *RP 623: 6-7.* He did this by asserting the content of yet another document, or perhaps several: "Not according to the American College of Cardiology, not according to the 2009 ACHAA focused update on perioperative beta incorporated into the ACHAA 2007 guidelines on perioperative cardiovascular care for noncardiac surgery." *RP 623: 6-12.* None of these documents were in the courtroom. Dr. Stricke did not testify that he actually used *anything* the defense had showed him. He testified that there were different indexes. *RP 621: 22-25.*

Plaintiffs' counsel objected--if someone was using evidence to impeach witnesses, the evidence needed to be in the courtroom. *RP 623: 14-16.* Defense had produced a document showing only two tables of something, then "(took the book) back and locked it up in their office...that is not allowed." *RP 623: 14-20.* If defense was going to

continue to ask about "a" singular cardiac risk index and make assertions of fact as to what the index is, "[W]e're entitled to have that book over here." *RP 623: 23 – RP 624: 2.* Plaintiffs objected to the court's use of ER 803(18) to allow what was happening. If the textbook is what was allegedly being quoted, that could not be verified, and it was not proper to allow defense to intentionally remove that textbook from the courtroom while claiming to quote it. *RP 624: 3-15.*

The court again overruled the objection. It held that since only one piece of paper was used, the "front of it and the middle page," *RP 624:25-625: 1-2*, that document could be read to the jury without admission. *RP 625: 7-11.* Since defense was only intending on using the alleged "one page he copied off"...from the textbook, "[Y]ou have just as good ability to go get a book and use it if you wish to use it ... if you want the book, you have just as much ability. They don't have to go get the book for you." *RP 625: 11-13, 22-25.* Counsel's being able to "look at the book" over the five-minute break, that was sufficient. *RP 625: 14-19.* The court then apparently held that this defense excerpt from something was a treatise. *If admitted,* it could be read into evidence. *RP 625: 14-19.* The court again then held: "So it's not going to be admitted." *RP 625: 20-22.* The court reiterated that plaintiff's counsel could go buy her own book if she wanted one. *RP 625: 22-25.* "They don't have to get the book for

you." *Id.*

Plaintiffs' counsel again clarified that the excerpt document the defense handed the witness was not a treatise: "Two clips out of something is not the treatise." *RP 626: 4-5.* "He has excerpted from something, and we established that with Dr. Stricke. He gave us Table 8.1 and Table 8.4, and all the stuff in between was removed, and I objected to that yesterday. This is not in accord with the rule to take two paragraphs out, stamp them, and say 'that's a learned treatise.'" *RP 626: 4-12.* Plaintiff again requested the complete document, and argued that it was required. *RP 626: 13-19.* The trial court rejected production.

The court again ruled that Plaintiff's counsel could go buy the book defense was wielding: "We were at lunch time. You could have left to go get,..." *RP 626: 25-627: 1.* The court held: "I'm not going to make his office go get something *you want to use." RP 627: 19-20, emphasis added.* "You had a copy of it, you could have gotten it. Everybody can Google, get online, go to the bookstore—but he gave you a copy of the front of the book of what it was." *RP 627: 18-24....* "At this point, you could have gotten it yourself if you wanted to see it. I gave you a chance to look at it at the break yesterday." *RP 627: 25 – RP 628: 2.* The court thus refused to allow plaintiff to verify even that the excerpted, non-admitted document being used by defense, if it was the "2007 cardiac risk

index," was correctly represented.

Plaintiffs' counsel told the court that a *Harrison's* medical treatise cannot be obtained over the lunch hour. It has to be ordered. There is no physical ability to go get such a book. *RP 628: 3-9.* [2] "The only book we're going to be able to get before this trial concluded is the one that's sitting in counsel's office." *RP 628:10-12.*

The trial court agreed that Plaintiff's expert did *not* testify that the excerpt defense counsel was presenting was "the" risk index "that everyone has to use." *RP 628: 24-25.* But it then also ruled that the "Seventeenth Edition" of *Harrison's* had been referenced, and accepted that the defense's excerpt *was* "the cardiac risk index." Defense had "handed a portion (to the witness) that he would like him to talk about." *RP 628: 20 – RP 629: 6.*

Plaintiffs' counsel would not be given further access to the actual learned treatise, the textbook, or article within the textbook, from which the tables were allegedly excerpted. No "risk index" was presented from either "the American College of Cardiology, AHA guidelines," *or* "the incorporated revised cardiac risk index in clearing patients for surgery." *RP 613:10-14, emphasis added.*

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[2] Plaintiff's counsel could not simply go out and buy such a medical treatise. *RP 626: 21-22.*

On redirect, Dr. Caren again clarified that there are several cardiac risk indexes out there. *RP 724: 2-8.* Dr. Caren could not tell which index defense counsel was referring to, or what year. *RP 724: 15-16. RP 725: 15-21.* He didn't know what risk factors "they list in the cardiac." *RP 728: 16-25.* Defense counsel's question to Dr. Caren implied that Dr. Caren had told the jury that the 2007 guidelines, "were in force in 2009." *RP 728:24-25.* Plaintiffs' counsel objected to the question, and the court again overruled the objection. The witness stated that he could not answer the question. *RP 729.*

On redirect, plaintiffs' counsel put up on the screen "something" illustrative that the defense had provided her. *RP 729: 21-25.* On the defense graphic, it stated: *"2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Non-Cardiac Surgery." RP 729: 21-25.* But the graphic stated that the document had a publication date of July 10, 2009. *RP 730: 9-11.* Counsel offered the graphic as a Plaintiff's exhibit, and the court rejected it. *RP 730: 12 – RP 731: 4.* Defense would continue to represent and testify to the alleged content of statements they claim were contained in a "2007 cardiac risk index" which was never produced. This unproduced, unseen "2007 cardiac risk index," would thereafter be quoted by all of the defense experts as the standard of care.

Defense expert Dr. Daryl Potyk practiced Internal Medicine. *RP*

1016. Dr. Potyk was asked to explain "the" Revised Cardiac Risk Index. *RP 1032: 14-21.* Dr. Potyk also explained that there were "several iterations of this, beginning in the 70s, 80s, and 1999." *RP 1032: 19 – RP 1033: 2.* "The" index was published in 1999. *RP 1033: 13.*

Defense counsel now referenced the year *2009* and asked if the American College of Cardiology in 2009 "issue(d) a publication with guidelines for assessing preoperative risk." *RP 1037: 20 – RP 1038: 1.* Dr. Potyk testified that it did. But he also testified that there were different guidelines; "the revised cardiac risk index is the simpler of the guidelines." *RP 1039: 12-15.*

Defense counsel then asked that Dr. Potyk explain the content of this "simpler" guideline. He was to "go through what the revised cardiac risk index is." *RP 1043: 21-24.* Over continuing objection, Dr. Potyk began discussing the content what he represented to be "the" revised cardiac risk index. *RP 1043: 25 – RP 1044: 23.* He testified to the documents' "six variables." *RP 1044: 9-11.* He testified as to how the article assigned points, or risk bullets. *RP 1047: 12-16.* Dr. Potyk testified that "the" revised cardiac index is a "well accepted tool … the tool that both assesses and predicts risk under the scientific studies that underpin it." *RP 1048: 25 – RP 1049: 5.*

Defense applied "the" revised cardiac risk index to Mrs. Eikum's

situation as the standard of care. *RP 1095: 5-25.* Dr. Potyk testified: "There's no replacement for this multifactorial risk index," and he elevated the risk index even beyond the usefulness of an echocardiogram or other testing. *RP 1100: 12-22.* "This" multifactorial risk index "is more predictive than any particular study, in and of itself." *RP 1101: 1-3.*

Over objection, Dr. Potyk now drew a self-made chart representing "the" still nonexistent risk index during his direct exam. *RP 1043: 8 – RP 1044: 6.* His drawing allegedly represented "the revised cardiac index." *RP 1131: 2.* He referred to his drawing as the "six variables" allegedly contained within the index. *RP 1044: 9-23.*

On cross examination, Plaintiff's counsel thereupon produced an actual article which the witness identified as the "2009 American Heart Association Focused Update On Perioperative Beta Blockade Incorporated Into the ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Care for the Non-Cardiac Surgery," and moved to admit it at P-68. *RP 1134: 13-17.* The court rejected its admission "based on prior rulings," i.e. ER 803. *RP 1138: 5-7.* On a bench conference, the court refused to "admit" the document under ER 803(a)(18): "You can talk about it, but I'm not going to admit it." *RP 1136: 20-22.*

Dr. Potyk now agreed on cross examination that the Plaintiffs' "2009" article incorporated into the 2007 guidelines required a physician

to use heart rate control during the type of surgery Joan Eikum had undergone. Alternatively, it required the physician to consider non-invasive testing, and an echocardiogram was such a non-invasive test. *RP 1142: 16 – RP 1143: 17.* This 2009 article about the 2007 guidelines thus "impeached" defense representations about the claimed content of "the" risk index of 2007.

Another 2009 article was presented to Dr. Potyk showing that risk models identified severe aortic stenosis as a major clinical predictor of adverse outcomes. *RP 1175: 3-7, 17.* Dr. Potyk also agreed that as of the time of Dr. Joseph's deposition, Dr. Joseph had brought a 2010 article that he referred to as "the revised cardiac risk index." *RP 1166: 22-25; RP 1167: 1-5.* The 2010 risk index described markedly increased complications in patients with significant aortic stenosis. *RP 1168: 8-11.* The 2010 risk indexes explained that aortic stenosis was actually an increased risk for major complications, such that such patients now rarely had elective non-cardiac surgery. *RP 1331: 12 – RP 1332: 8.*

Dr. Potyk also clarified that the guidelines he had used in an article he wrote were in 2005. *RP 1155: 1-5.* He began referring to his own article as "this outdated guideline." *RP 1157: 22.* He clarified that his 2005 "outdated guideline" also recommended non-invasive testing prior to surgical "clearance." *RP 1159: 6-7.*

Various versions of this cardiac risk index had been actively produced by the Eikums except for the defense's alleged 2007 version, which they were quoting.

Dr. John Peterson now testified for the defense. Dr. Peterson is a cardiologist. *RP 1392-93.* During his testimony, Dr. Peterson offered that: "We sort of have guidelines," and testified that they were published in 2007. *RP 1454: 20-25.* This 2007 "guidelines publication" was published by the American College of Cardiologists/American Heart Association and the publication contained "[T]he revised cardiac index." *RP 1455: 1-6.* Again, this 2007 document was not present. Again, Plaintiffs objected to the testimony about this alleged 2007 "standard of care" publication without the document present: "I have an objection unless we see those guidelines. He's testifying to guidelines that aren't present." *RP 1456: 12-18.* At this point, the court sustained the objection *RP 1456: 19;* but Dr. Peterson continued to refer to the content of testimony as "[T]he 2007 guidelines." *RP 1457: 19; and see RP 1460: 24 – RP 1461: 10* (claiming categories and risk levels from the "clinical guidelines," and the guidelines' recommendation). The trial court would thus variously sustain objection to the form of the question, then capitulate and allow the questioning to proceed on the alleged content of what had now morphed from the alleged 2007 cardiac risk index to a different

document entirely, the "revised cardiac risk index *incorporated in* the 2007 ACC AHA guidelines that you referred to here in your testimony today." *RP 1467: 18- 1468:13, emphasis added.* Objection continued: "Your Honor, same objection. Unless we have it, because there's no ability to cross examine a witness unless I have what he is talking about." *RP 1468: 9-20.* Defense counsel then claimed he had "multiple" copies of "it," but didn't bring them: "I didn't see the necessity of bringing it back today." *RP 1468: 22 – RP 1469: 3.* Defense counsel now claimed that plaintiff's counsel had "gone through it yesterday to some extent with Dr. Potyk." *RP 1468: 22-25.* This was not a true statement—the 2007 version had never been present, only the 2005 article, a 2009 article and a 2010 version.

The trial court now sustained reference to the guidelines, but defense counsel went back to it. Now, Dr. Peterson testified that there was only one revised cardiac risk index which had been "incorporated into the ACC 2007 guidelines." *RP 1471: 14-16.* Dr. Peterson was no longer referring to the referenced 2007 guidelines, he was discussing some other document "incorporated into" the 2007 guidelines.

Counsel now directed Dr. Peterson's attention to the hand-drawn chart that defense expert Dr. Potyk had created. *RP 1471: 17-20.*

Plaintiffs' counsel again placed objection on the record: "I'm

going to renew my objection to all of this unless and until we see these 2007 guidelines that counsel keeps referring to." *RP 1471: 21-24.* Another extended colloquy ensued. Plaintiff's counsel continued to object to defense's continued reference to an allegedly published document that had never been present: "I'm not able to cross examine this witness. He's testifying from something and it isn't here." *RP 1472: 12-14.*

Extensive colloquy again took place regarding the objection. *RP 1473-1482.*

Defense counsel confirmed that the guidelines he continued to quote were the ones that had never been in the courtroom. The 2007 version was the only one that could apply to Joan Eikum, given the date of her surgery: "there's only one set of guidelines, the '07 guidelines that apply to the issues in this case." *RP 1475: 19-23.* Defense counsel claimed that the 2009 guidelines that Plaintiffs' counsel had used to impeach his earlier defense experts' testimony were different from the 2007 version he and his witnesses were *actually* discussing. The 2009 version "reincorporated" the 2007 version, and *"added beta blocker therapy post surgically." RP 1475: 19-23.* But "[T]here's only one cardiac risk index." *RP 1475: 19-24.* Defense now confirmed that material differences existed between the 2007 version in effect at the time of Joan Eikum's surgery, and the 2009 "update" in effect after her surgery.

But defense still did not present the 2007 version.

Defense also argued, in the same objection colloquy, that Plaintiff's counsel had been provide the "risk index" because at the deposition, Dr. Joseph had brought in an article dated in *2006*, a year before the 2007 index being referenced. *RP 1482: 18-21.* A page later, defense counsel again reiterated: "There is only one revised cardiac risk index." "This is it," claiming that "it" was an unspecified document "disclosed some time ago." *RP 1483: 8-9, referring Plaintiff's Exhibit 55, which is the 2006 version.*

Plaintiff's counsel continued to object, describing all of the numerous risk indexes that had been present, except for the 2007 version the defense was claiming to quote from. "If it's so obvious and so well used, and it was discussed at these depositions, then where is it? And that's what I'm objecting to ... the defense objects to everything we do with these schematics and other years, and yet it's not producing the 2007 one." *RP 1476-79; RP 1479: 6-10.*

Recognizing that by then various defense witnesses themselves had referred to different print dates and updates, the trial court again ordered that if defense counsel was to refer to "it," the testimony was conflicting as to whether there was only one, and, in fact, the evidence was that there were updates. *RP 1483: 22 – RP 1484: 8.* The court held that: "If we

don't have it, I'm not going to let him refer to it because of the confusion." *RP 1484: 4-8.* But it also held that "statements that are contained in published treatises, articles ...are admissible for publication by talking about them...and the publication can be established as reliable authority....[T]hey can talk about it. It can be referred to. They can read from it." *RP 1484:25-1485: 12.*

On defense resumption of testimony on direct, defense counsel now presented his expert with a document the witness reported was the 2009 ACC/AHA focus update on perioperative beta blockade incorporated into the ACC/AHA 2007 guidelines for perioperative cardiovascular evaluation and care for noncardiac surgery. *RP 1486: 5-8.* The witness again testified as to the content of the 2007 guidelines. He attested that the guidelines were "revised completely in 2007," and as to the 2009 document he now had—"this is the original 2007 guidelines." *RP 1486: 11-18.* This directly controverted all testimony and colloquy just held. The article he pointed to itself was not the 2007 guidelines, but a 2009 revision. This 2009 version was approved in July 2009, *after* Joan Eikum's surgery, by the American College of Cardiology Foundation, Board of Trustees and by the American Heart Association Science Advisor and Coordinating Committee. *RP 1486: 24-1487:3; RP 1487: 4-9.* Again, Plaintiff objected. "This is the 2009 revision of 2007. We don't

have the 2007, so the issue remains the same." *RP 1487:25-1488: 2.*

The court overruled the objection. *RP 1488: 3-4.* It did not require production of the 2007 guidelines as it had just held that it would.

Defense again read what they claimed to be content of the 2007 guidelines by reading a 2009 update not yet published when Joan Eikum went to surgery. *RP 1488: 1-17.* The content of the "2007 guidelines... in effect at the time of Mrs. Eikum's surgery" was again alleged. *RP 1488: 8-17.* The prior defense expert's chart was compared to this new 2009, alleged 2007, risk index. The chart was "very similar," but there were differences. *RP 1489: 3-14.* They were "very, very close," but there were exceptions. *RP 1489: 20 – RP 1490: 4.* The expert continued to testify about the 2007 guidelines not present in the courtroom. *RP 1491: 21 –RP 1492: 13.*

During cross examination, Dr. Peterson then divulged that the actual 2007 cardiac risk index identified aortic stenosis as a risk factor. *RP 1556: 22-1557: 13.* The 2007 article placed it in a different area than where the 2009 document than did the defense tables and articles being shown. *RP 1557: 2-13.* The 2009 guideline's recommendation of beta blockers also became a new section in 2009. *RP 1579: 15-19.*

Dr. Peterson now agreed with plaintiffs' counsel—without the 2007 guidelines present, "all we know is that ... they say these are the

updated guidelines, so it says the perioperative beta blockade is updated." *RP 1582: 21-24.* Now, Dr. Peterson did not "remember" sentences in the 2007 guidelines dealing with heart control remedies. *RP 1585: 8-20.* Now, he didn't believe that the 2007 index included the heart rate control requirement. He testified: "I don't believe that it did ... I believe that it was updated in 2009." *RP 1586: 17-24.* Now, he agreed that the 2009 schematic the parties had just spent all the time going through was in fact different from the 2007 risk index, including in its conclusions for treatment at the bottom of the chart. *RP 1587: 12-19.* He claimed that the requirements now pointed out to him in the 2007 article were not in the 2007 article—the one in place when Joan Eikum underwent surgery. *RP 1628: 10-12.* Dr. Peterson now was not sure what was in the 2007 guidelines. *RP 1647: 8-16.* He testified "I don't believe it was down there. I mean, I read the guidelines. I took a look at them. I don't have them in front of me, but to my knowledge, they were never in the guidelines in 2007." *RP 1647: 7-16.* But, Dr. Peterson testified, the 2007 risk schematic was a "gold standard." *RP 1647: 17-25.* Later guidelines then "added the beta blocker back." *RP 1647: 25 – RP 1648: 4.* The "pivotal" 2007 guidelines, allegedly establishing the standard of care in Washington, allegedly supportive of Dr. Joseph, and allegedly not including the requirements of the 2009 version that Dr. Joseph now plainly failed to do,

remained missing.

Dr. Daniel Doornink then testified for the defense as a doctor of Internal Medicine. *RP 1731.* The same process ensued, Dr. Doornink was also asked by defense about the alleged "American College of Cardiology/American Heart Association 2007 guidelines for perioperative—for evaluation of patients before cardiac surgery." *RP 1785: 21-25.* Again, objection was taken to questioning witnesses on direct without that alleged 2007 document being produced. *RP 7186: 6-7.* The court again overruled the objection. Dr. Doornink was allowed to testify to the content of the missing 2007 revised cardiac risk index. *RP 1786: 11-14.* He testified, among other things, that the "2007 standards were the guidelines, were the standard of care..." *RP 1787: 11-13.*

On cross examination, Plaintiffs' counsel believed she had now independently found these "2007 guidelines." She first asked Doornink if he had the 2007 "guidelines" with him, and he did not. *RP 1833: 14-15.* Plaintiffs' counsel asked to project what she believed were the 2007 guidelines. *RP 1833: 16-22.*[3] She asked that the schematic and article be marked as exhibits P-70 and P-71. There were two document—one a power point pullout and one "the article, itself." *RP 1834: 11-1835: 9.*

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[3]The article was entitled: "2007 Guidelines, American College of Cardiology/American Heart Association Task Force (Shortened Version)."[3] *RP 1864: 8-16.* And see Court's Exhibit List identifying P-70 as "2007 evaluations scamatic (sic) 2 page document," and P-70 as "Accompanying article of P-70" both rejected.

Dr. Doornink stated that the plaintiffs' 2007 document was not complete: "I'm not sure this is the full document." *RP 1835:14-18.* Defense counsel now objected to the plaintiffs' 2007 guidelines because they were not the 2007 guidelines *he* was referring to. *RP 1835: 22-25.* He now stated that he had "acquired the document yesterday," meaning, impliedly, the 2007 document, but Plaintiffs' counsel, he said, needed to get it herself. *RP 1835: 22-1836: 1.* The court "rejected" the plaintiffs' document, but allowed counsel to "ask them about it..." *RP 1836: 2-5.* Dr. Doornink continued to assert Plaintiffs' version was "not the full document." *RP 1836: 21-24.* The witness stated, e.g.: "That full text guideline is quite extensive, and is not in here." *RP 1847: 21-22.*

In the plaintiffs' "non-applicable" set of 2007 guidelines, Dr. Doornink agreed that Dr. Joseph would indeed be required to consider a perioperative beta blockade as heart protection for any non-elective surgery to proceed. *RP 1847: 5-22.* The plaintiffs' non-applicable 2007 guidelines allowed surgery to proceed, but only using "heart rate control," i.e., beta blockers. *RP 1847: 15-22.*

This 2007 document, if it were the actual 2007 guidelines, would show that both defense counsel and defense had been plainly either speculating as to or flat out misrepresenting the alleged content of the 2007 guideline document. Defense counsel thus objected to Plaintiffs'

2007 guideline document, claiming it to not be what he had been referring to as his own version of the 2007 guidelines. He stated: "Your Honor, again, counsel's referring to what she's reading as a risk index, and it is not. Objection." *RP 1858: 18-20.* The objection was sustained. *Id.* Dr. Doornink again testified "these are not a part of the guidelines...*these are not the guidelines. RP 1859: 10-12, emphasis added.* He testified that Plaintiffs' 2007 document "isn't a guideline. This part is not a guideline." *RP 1863: 20 – RP 1864: 7.*

And in spite of defense counsel's earlier apparent claim that he "acquired the document yesterday, *RP 1835: 22-1836: 1,* he didn't produce it. The "defense" 2007 guidelines remained missing.

Dr. Samuel Joseph then testified for the defense. *RP 1910.* Dr. Joseph testified that he was used the revised cardiac risk index in his practice while doing preoperative evaluations. *RP 1965: 15-20.* He also claimed to use the 2007 guidelines—the ones that weren't in the courtroom. *RP 1965: 21-23.*

On cross-examination, he clarified that he could only presume that the 2007 index would have been available to him online from 2007 - 2009. *RP 2006: 25 – RP 2007: 3.* He didn't see it online, actually, so this was only a presumption. *RP 2007: 7-8.* At the time of his deposition, he did not have the 2007 document. *RP 2007: 12-14.* He did not see the alleged

2007 risk index until the trial. *RP 2008: 4-8.*

APPENDIX B

Appendix B

Record: Dispute regarding a physician's duty to inform and the duty to administer alternative tests before surgical clearance in the presence of evidence suggesting the risk of or existence of heart disease.

Dr. Joseph agreed that his purpose was to evaluate Joan Eikum's heart and lungs prior to surgery. *RP 1969: 14-15.* He acknowledged that he never reached any diagnosis as to why Joan had lost consciousness; he had only "working proposals." *RP 1969: 21-24.*

Dr. Joseph acknowledged that surgeries were a known cause of heart attacks, including the known risk of such occurring while recovering post-operatively from non-cardiac surgery. It had occurred to his patients every six months. *RP 2001: 8 – RP 2002: 17.* He had had substantial experience with such events happening. *RP 2003: 4-6.*

Dr. Joseph acknowledged that Joan had shortness of breath with exertion. *RP 2039: 13-20.* He agreed that her Holter results were not normal. *RP 2051: 21.*

Dr. Joseph testified that it was his decision as to what information he would share with Joan, and why, and what tests he would administer, and why. He evaluated all of her concepts of risk on his own. *RP 2010: 23 – RP 2011: 13.* He "absolutely" considered the use of preoperative beta blockers, but he eliminated it. *RP 2015: 3-17.* As to evidence that

surgery should be done with heart rate control "if indicated," he decided heart rate control was not indicated. He considered beta blockers, but felt that there were contraindications to their use. *RP 2015: 22 – RP 2016: 5.* He did not tell Joan this. *RP 2015: 18-21.* There was "no need to." *RP 2015: 19.*

Dr. Joseph considered non-invasive testing and decided himself that that there was no reason to do so. *RP 2016: 20-23.* He felt such tests would not change *his* management, so "therefore, I felt she was ready for surgery." He went through all the steps of his evaluation. *RP 2016: 20 – RP 2017: 2.* He discussed none of this with Joan. *RP 2017: 3-7.* It wasn't necessary. *RP 2017: 4-7.*

He decided against sending Joan to the cardiologist as he had planned because he decided that there was no indication for it either, nor any need to involve another physician. *RP 2018: 25 – RP 2019: 3.* There was no reason for a cardiology consultation. *RP 2021: 12.* He was not doing a "cardiac clearance." *RP 2021: 7-8.* He was doing an "internal medicine" clearance. *RP: 2021: 7-9.* But he also agreed that it was his duty to assess Mrs. Eikum from a cardiologic standpoint prior to her going into surgery. *RP 2022: 24 – RP 2023: 2.* He simply did not feel that it was his duty to explain his reasoning to her. *RP 2023: 17-20.* Dr. Joseph decided no further evaluation was necessary *for* Joan, and that there were

no other options; therefore, he wouldn't present any options to her. *RP 2020: 7-10.*

Dr. Joseph would not send his patients their test results. He would give them only his assessment of the results. *RP 1987: 1-12.* Nothing in Dr. Joseph's file showed that he forwarded any of her cardiac testing in late 2008 or early 2009 to Joan. Dr. Joseph testified that on March 12, 2009, he discussed "issues" with Joan. *RP 1948: 8-11.* No evidence of any such discussion was in his notes. *See RP 1946: 8-17.* He testified, "It's totally implicit ... it's not required by me or any practitioner to further justify that." *RP 1991: 4-12.* He interpreted the results of Joan Eikum's Holter monitor test for the orthopedic surgeon, and did not send even that orthopedic surgeon the test because he would not expect an orthopedic surgeon to understand the nuances of a Holter monitor. *RP 2053: 9-12.*

In fact, Dr. Joseph's presurgical cardiac evaluation with Mrs. Eikum lasted 15-minutes. *RP 1972: 20-24.* He agreed that the only thing he told Joan Eikum was this: "You're ready for surgery. We'll see you back in six months. Continue your medications. Good-bye." *RP 1984: 15-20.* He reiterated this. All he would have said is this: "Ready for surgery. Come back in six months." *RP 1985: 13-22.* In Dr. Joseph's opinion, "[T]here was no reason to do any further testing, or any further

instructions needed from me at that time." *RP 1985: 23 – RP 1986: 1.*

Dr. Joseph agreed that an echocardiogram could have been done "in a heartbeat." *RP 2063: 9-12.* All he had to do was to direct his staff to get Joan set for a referral. *RP 2063.* An echocardiogram was "an incredibly valuable tool," and he used it often. *RP 2076: 10-11.*

Dr. Potyk:

Defense expert Dr. Potyk also agreed that Dr. Joseph never came to any conclusion as to the cause of Joan's syncopal episodes. *RP 1209: 5-7.*

Dr. Joseph knew that Mrs. Eikum was having dyspnea on exertion. *RP 1209: 8-23; 1210: 19-24.* Dr. Potyk confirmed that the Q wave in Joan's January 2009 EKG could be indicative of aortic stenosis or coronary artery disease. "It can be, but it can also be something that is insignificant." *RP 1213: 2-5.*

Dr. Potyk confirmed that Joan's EKG of January 12, 2009 showed a conduction disorder. *RP 1220: 2-4.* Mrs. Eikum was tachycardic on the EKG, and was "still tachycardic when she appeared in Dr. Joseph's office on January 23rd. *RP 1222: 20 – RP 1224: 5.* The circumstances of *why* she would still be tachycardic were unknown. "There are a lot of reasons." *RP 1224: 3-10.* The January 2009 EKG report itself said that its results were abnormal. *RP 1230: 16-18.*

On the Holter monitor, Mrs. Eikum reached her maximum heart rate at 9:08 a.m. There was no information about what she would have been doing. *RP 1225: 1-11.* Dr. Joseph did not get the diary or the time sheets. *RP 1225: 17-19.* Given Mrs. Eikum's age, that 145 heart rate would be her maximum heart rate, and she would be at her maximum heart without Dr. Joseph knowing what was causing this. *RP 1226: 13-15.* It could not be told from the tests for how long she was at that rate. *RP 1226: 15-18.* Her heart rate exceeded 100 for over nine hours and nineteen minutes. *RP 1227: 5-8.* This is a "prolonged" tachycardia. *RP 1227: 8.* Her heart rate was greater than 120 for an hour and twelve minutes. *RP 1227: 2-4.* The Holter monitor demonstrated prolonged, sustained tachycardia. *RP 1229: 16-19.*

Dr. Joseph did not determine any cause for all of the elevated heart rates as far back as January 12, 2009. *RP 1231: 17-21.* He never excluded coronary artery disease, or aortic stenosis. *RP 1232: 2-7.* Dr. Joseph did not resolve the symptoms presented. "As to Mrs. Eikum's syncope, it was unclear what was going on with her." *RP 1078: 17-23.* "I don't know exactly what was causing her syndrome." *RP 1079: 3.* "I don't think I can come up with a unified diagnosis," but he was "less concerned," testifying that her condition was "resolving rather than getting worse." *RP 1079: 8-10.*

Dr. Potyk also testified that the standard of care did not require Dr. Joseph to share the patient's test results from her Holter monitor. *RP 1235: 4-13.* Her tests, including the January 12, 2009 EKG, Holter monitor, or duplex exam report—all went to Dr. Joseph, but never to Joan Eikum. *RP 1235: 20 – RP 1236: 12; RP 1238: 13-16.*

Dr. Potyk testified that it was the standard of care to just say, "ready for surgery." *RP 1244: 12-16.* Dr. Potyk also agreed that the purpose of a preoperative evaluation is to identify patients at high risk for cardiac complications after surgery, because such surgery predisposes the patient to a risk of cardiac events. *RP 1251: 6-25.* For some people, that risk is catastrophic. *RP 1252: 3-8.* This is known. *RP 1252: 8.* That risk is elevated if a person going into a surgery has a diseased heart. *RP 1252: 9-12.* The worse the condition of the heart, the less likely that patient is to be able to get through a post-operative cardiac event. *RP 1252: 13-16.*

Dr. Potyk also testified that "based on my review of the records, I saw no indication to pursue an echocardiogram." *RP 1057: 18-19.* Dr. Potyk testified: "I don't see how it was going to add to the clinical picture." *RP 1058: 9-13.* "I think not getting an echocardiogram was appropriate." *RP 1059: 4-6.* He testified: "There was just no reason to do it." *RP 1059: 18.* As physicians, "We can do a lot of things, but one of the guiding principles we have is: 'what are you going to do with the

information?' If it's not going to change anything you do, why do a test? Why do it? You're just spending people's money and wasting their time subjecting them to tests, and then there are always downstream consequences of tests." *RP 1059: 20 – RP 1060: 1.* "So unless it's going to change something you do, we generally don't do—and we think through this process whenever we order a test. It's: 'What is this going to do for me? Is this going to change what I do? If it's not going to change what I do, then why order it?'" *RP 1060: 8-12.*

Dr. Doornink:

Defense's Dr. Doornink testified in similar fashion. He also agreed that abnormalities were present on the EKG. *RP 1890: 10 – RP 1891: 20.* They included evidence of an electrical conduction disturbance. *RP 1891: 14-15.* Joan's dyspnea on exertion was an anginal equivalent, and could also be a symptom of both aortic stenosis *and* symptomatic of coronary disease. *RP 1795: 21 – RP 1796: 4.* In fact, syncope could be caused by a "severe or critical aortic stenosis." *RP 1796: 7-9.*

A murmur could also be indicative of an aortic stenosis. *RP 1804: 6-9.* An echocardiogram would pick up an aortic stenosis. *RP 1804: 10-11.*

Mrs. Eikum's pulmonary function test and blood gas tests also had slight abnormalities in them. *RP 1802: 2-5.*

Dr. Doornink agreed that a critical role of the consultant is to determine the stability of the patient's cardiovascular status. *RP 1852: 3-8.* Dr. Doornink agreed that Dr. Joseph did not ever determine the actual cause of the syncope. *RP 1796: 14-16.*

Dr. Doornink testified that he had no obligation to tell his patient about the decisions he was making for that patient. *RP 1887: 17-25.* He would have no obligation to talk to his patient about a test that said: "abnormal EKG" if *he* decided it was not abnormal. "That would be a little too complex for me to try to explain to a patient the intricacies of an EKG like this." *RP 1888: 1-6.* He would not send the test to the patient, nor discuss it with them. *RP 1888: 10-12.* As well, the only obligation a physician had to discuss the Holter monitor tests with the patient would be to tell them there was nothing unusual about it. The patient would not be sent the report. *RP 1888: 13 – 1889: 1.*