Supreme Court No. 93905-5

COA No. 329348

SUPREME COURT
OF THE STATE OF WASHINGTON

ESTATE OF JOAN R. EIKUM
By and through its Personal Representative, JOHN J. EIKUM, and JOAN R. EIKUM, by and through her Personal Representative,

Petitioner,

v.

SAMUEL JOSEPH, D.O.,

Respondent.

PETITION FOR DISCRETIONARY REVIEW

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I. IDENTITY OF THE PETITIONER.

The Petitioner is the Estate of Eikum and John Eikum. Both are Appellants in the Division III proceeding.

II. CITATION TO COURT OF APPEALS DECISION.

This is a petition seeking review of Division III's ruling of *Estate of Eikum v. Joseph,* No. 32934-8-III, 2016 WL 5342411 (Sept. 22, 2016), reconsideration denied Oct. 27, 2016. *Appendix A.*

III. ISSUES PRESENTED FOR REVIEW.

1) Does this Supreme Court's rulings in *Backlund v. University of Washington,*[1] and *Gomez v. Sauerwein,*[2] create an affirmative defense to an RCW 7.70.050 informed consent claim? Or do those rulings allow a dismissal by directed verdict once a defendant physician testifies that he "excluded" a high risk medical condition?

Answer: This Supreme Court's rulings in *Backlund v. University of Washington* and *Gomez v. Sauerwein* create an affirmative defense to this state's informed consent law, but like any affirmative defense, the defense must be proved to the trier of fact to result in a constitutional trial. Division III has instead authorized a trial court to enter a directed verdict once a

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[1] *Backlund v. Univ. of Washington,* 137 Wn.2d 651, 661 (1999).

[2] *Gomez v. Sauerwein,* 180 Wn.2d 610 (2014).

defendant physician testifies that he excluded a high risk medical condition. This conflicts with this court's rulings, it conflicts with Division II's ruling in *Flyte v Summit View Clinic,*[3] and it results in an unconstitutional trial.

2) Does this Court's *Gates v. Jensen*[4] ruling control over a *Backlund/Sauerwein* affirmative defense in a medical negligence case where the symptoms and test results present in the defendant physician's medical record are consistent with the disease ultimately discovered, and where objective test results verify the existence of the condition ultimately discovered?

Answer: Yes, this Court differentiates between a *Backlund/Sauerwein* defense versus a *Gates v. Jensen* claim. Division III fails to apply this distinction, it conflicts with this court's precedent, and it conflicts with Division II's ruling in *Flyte v. Summit View Clinic,* which adheres to the distinctions made by this Supreme Court. Division III's failure to apply this Court's distinction deprived John Eikum of his viable *Gates* informed consent claim, and of proper jury instruction on his claim.

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[3] *Flyte v. Summit View Clinic,* 183 Wn.App. 559, 572 (Div. II, 2014).

[4] *Gates v. Jensen,* 92 Wn.2d 246 (1979).

3) Does ER 803(a)(18)'s exception to hearsay allow medical experts to testify that they are quoting statements from articles, when the article is never present in the courtroom?

Answer: No. ER 803(a)(18) does not allow medical experts to testify to statements contained within an article while refusing to produce that article for inspection. Division III's construction of ER 803(a)(18) abrogates the constitutional trial right to meaningful confrontation of expert witnesses.

IV. SUMMARY OF PETITION FOR REVIEW.

Division III's *Eikum* ruling conflicts with this Supreme Court's precedent, and remove constitutional trial protections in a medical negligence claim brought under RCW 7.70, et seq. First, this Supreme Court's rulings in *Backlund* and *Sauerwein* create an affirmative defense that a physician may assert against an RCW 7.70.050 informed consent claim. Where genuine issues of material fact arise as to the credibility of a physician's testimony that he "excluded" a medical condition, the constitutional right to a jury trial requires that the jury make the fact findings necessary to sustain the physician's *Backlund* defense. In contravention of this fact finding, Division III's *Eikum* ruling applies *Backlund* to allow the physician a directed verdict of dismissal based purely on the physician's self-serving testimony. *Eikum* conflicts with *Backlund* and *Sauerwein,* and

Division II's ruling in *Flyte v. Summit*, and it results in constitutional error. Where the facts of an affirmative defense are in dispute, that defense must be submitted to a jury.

Second, *Eikum* also conflicts with this Supreme Court's rulings in *Backlund, Sauerwein* and *Gates,* and with Division II's *Flyte v Summit,* by failing to distinguish a *Backlund/Sauerwein* defense from an actionable *Gates v. Jensen* informed consent claim. The *Backlund* defense protects the physician from double liability when the physician actually excludes the medical condition at issue, while a permissible *Gates* claim exists where the evidence shows that the defendant physician had continuing of symptoms consistent with, and of verified test results pointing to, a high risk medical condition, but where the physician did nothing to form a diagnosis as to that or any condition, nor to exclude that or any condition. *Eikum* is in conflict with this Supreme Court and Division II because it fails to properly distinguish between the *Backlund/Sauerwein* defense and the viable *Gates* claim.

Finally, ER 803(a)(18) allows an exception to hearsay for a medical expert. But Division III applies the language of the Rule to abrogate a medical claimant's constitutional right to confront defense expert medical witnesses. This is error of a constitutional magnitude, and prejudice is presumed.

V. STATEMENT OF THE CASE.

John Eikum is the widower of Joan Eikum—his wife of nearly 55 years at the time of her death. John filed a wrongful death action based on claimed medical negligence by pulmonary physician Dr. Samuel Joseph. *CP 3*. Dr. Joseph failed to treat Joan's signs and symptom of heart disease present within the standard of care by diagnosing her symptoms and verified test results to the proper medical conclusion. *CP 10*. Joseph failed to tell Joan about his suspicion of, and test results showing, her heart dysfunction, all within the context of her pre-surgical examination. *CP 12*. Joseph "cleared" Joan for a high-risk surgery following a fifteen minute examination in his office, where she remained fully clothed, seated in a chair. *RP 1972: 20-24; 1976:2-4*. He told her only: "You're ready for surgery. We'll see you back in six months. Continue your medications. Good-bye." *RP 1984: 15-20*. Joan made the decision to go forward with knee surgery because "the doctor indicated that she was okay; ready for surgery." *RP 926: 1-7*.

Joan Eikum died from cardiac arrest within hours of her knee surgery. Following her cardiac arrest, her extensive heart dysfunction was quickly revealed by a bedside echocardiogram (ECHO) test. *RP 778:6-13*. Treating cardiologist Dr. Andrew Boulet testified that Joan had "very, very

severe coronary disease, life-threatening coronary disease, in all of her vessels." *RP 814: 16-22.*[5] "[T]he entire heart was at risk." *RP 815: 24.* She should not have been "cleared' for surgery. *RP 600: 22-24; 601:1-4; 851:18-24.*

Joseph's medical record showed extensive evidence of Joan's cardiac decline. Joan began reporting to Joseph her shortness of breath, and her new "syncope," i.e., fainting spells, months before his surgical clearance. *RP 921: 11-15; RP 898:15-18.* Both are symptoms of cardiac dysfunction—aortic valve stenosis and issues with blood flow. *RP 898:15-18 (shortness of breath or "dyspnea"); RP 341: 21-RP 343: 18 (syncope and dyspnea in connection with carotid bruit); 399:4-7(dyspnea).* Joseph heard a carotid "bruit"—also a sign of aortic stenosis and vascular disease. *Id.*[6] Joseph's medical record contained verified test results showing Joan's cardiac dysfunction. John Eikum had taken Joan to a hospital emergency

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[5] Joan's left main artery was narrowed by 98%, and her left anterior descending artery was narrowed by 95%. *RP 815: 11-15.* She had aortic valve stenosis. *RP 818: 18-20.* 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.*

[6] The carotid artery test signified a distal "stenotic" process. *RP 320: 6-9 (Plaintiff's expert).* This meant that Joan "has atherosclerotic vascular disease—a disease of the arterial system." *RP 320: 14-21.* The neck "bruit" also indicates a murmur in the heart's aortic valve. *RP 321: 3-11.*

room, where an electrocardiogram (EKG) was done. The test report states: "Abnormal EKG." *RP 235: 15-19.*[7] Joseph wrote in his medical record that he didn't know *what* was causing Joan's symptoms. He wrote himself a note that a cardiology consult should be obtained to determine the etiology of Joan's symptoms, but he never arranged for the consultation, nor did he ever tell Joan of his concerns. He did tell Joan to arrange for her own Holter monitor test—a heart rhythm test—which she did. That test also came back showing abnormalities.[8]

Plaintiff's medical expert Leslie Stricke, a pulmonologist from Cedars Sinai Hospital in Los Angeles, identified the "gold standard" for testing for the presence and degree of heart disease—this is a test called an echocardiogram (ECHO). *RP 374-375.* The test cost around $250, and would take only 10-15 minutes. Office practitioners obtain these tests easily by referral to a cardiologist. *RP. 377.* The ECHO allows ready evaluation of all facets of the heart's function. *RP 303-305.*

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[7] The January 12, 2009 EKG report identified a number of heart dysfunction conditions—tachycardia was present via a heart rate of 123 beats per minute versus a normal rate of 72 beats per minutes. *RP 352: 5-9.* The EKG showed 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 states right across its top "abnormal EKG ECG." *RP 352: 20-22.*

[8] The Holter monitor showed Joan's heart in sustained tachycardia for over nine hours, with 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.*

Dr. Sticke testified that Joseph did not exclude any cause for Joan's cardiac symptoms, nor for her abnormal cardiac test results. *RP 380: 3-7.*[9] Stricke pointed to Joseph's own record, which showed his concern for heart abnormalities, including his referral for a Holter monitor and his own note regarding a cardiology evaluation. *RP 356- RP 357.* But Joseph never excluded either aortic stenosis, ventricular dysfunction, or coronary artery disease, even though such were indicated by the testing and symptoms. *RP 380: 3-7.*[10]

Dr. Jeffrey Caren is Board-Certified in Internal Medicine and Cardiovascular Disease, and also affiliated with Cedars-Sinai Medical Center in Los Angeles. *RP 534, 536.* Dr. Caren agreed with Dr. Stricke. The first reasonable step in determining the cause of Joan's symptoms would have been to obtain an echocardiogram. *RP 591.* Instead, he testified, none of the tests that Joseph performed excluded the possibility of coronary artery disease. *RP 548: 20-23.* None of the tests Joseph performed excluded the indicated aortic stenosis, nor ventricular dysfunction. *RP 548-*

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[9] Joseph's chest x-rays and pulmonary function tests did not exclude heart disease. *RP 298: 9-11; RP 369: 13-17.* The hospital's EKG measured only the *rate* of the heart, not its valve or ventricle function. *RP 302: 17.* The Holter monitor is also associated only with the rhythm of the heart. *RP 303: 6-23.*

[10] Joseph's chest x-rays and pulmonary function tests did not exclude heart disease. *RP 298: 9-11; RP 369: 13-17.* The hospital's EKG measured only the *rate* of the heart, not its valve or ventricle function. *RP 302: 17.* The Holter monitor is also associated only with the rhythm of the heart. *RP 303: 6-23.*

49. To the contrary, Dr, Caren confirmed that those very tests Joseph *had* ordered *raised* the suspicion of the existence of those very cardiac dysfunctions. *RP 549: 12 – RP 550: 11.* Joseph's notes confirmed that he did not establish the etiology nor cause of Joan's syncope. *RP 586: 7-11.* Dr. Caren testified that Joseph's medical record confirms that he did not exclude anything. *RP 586: 2-11.*

After the close of John Eikum's case in chief, Dr. Joseph took the stand, and testified that he had excluded heart disease. The trial court thereupon dismissed John's informed consent claim by directed verdict.

Division III sustained the ruling. Because Joseph *testified* that he excluded heart disease, states Division III, "*Backlund* expressly controls." Division III went on to explain: "Here, Dr. Joseph had ruled out heart trouble as the cause of bruit or the episodes of syncope. He expressly told the jury that after the Holter monitor test in January, his 'final impression was no acute cardiopulmonary disease.' *RP at 1942.* He testified that after examining Ms. Eikum in March, there was 'no evidence of heart disease" behind the syncope incidents. RP at 1970.' " *Eikum, at *5.* Division III thus affirmed the dismissal based on Joseph's testimony alone.

Division III also affirmed the trial court's allowing defense medical experts and counsel to purportedly quote the content of what defense experts claimed was a 2007 document setting the criteria for the medical standard

of care for a presurgical evaluation. That article was never in the courtroom, no one ever saw it, and the defense refused to produce it. Defense counsel argued in closing that this article's criteria, as relayed by defense experts, listed the steps for the medical standard of care, and that Joseph adhered to it's steps.[11] This nonexistent "tool" had by then been so pervasively injected into the trial that the defense attorney told the jury in closing, "You're probably sick of it...." *RP 2318: 12-18.* Whatever the 2007 criteria were or are, they have never been seen to this date.

The jury exculpated Joseph from the Eikums' negligence claim. Division III held that there was no error in allowing this hearsay under ER 803(a)(18), and that even if error existed, John Eikum did not show material prejudice from not being able to see this article.

VI. ARGUMENT FOR REVIEW.

1) This Supreme Court's rulings in *Backlund v. University of Washington* and *Gomez v. Sauerwein* create an affirmative defense to this state's informed consent law, but, like any affirmative defense, such a defense must be proved to the trier of fact to result in a constitutional trial.

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[11] Defense argued that "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.* 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.*

Division III has instead authorized a trial court to enter a directed verdict once a defendant physician testifies that he excluded a high risk medical condition.

Washington's Constitution Art. I, § 22, and the United States Constitution, Amd. 6, guarantee the right to trial by jury. This right is guaranteed in all civil cases by the due process clause. *Tegland, 5A Wash. Prac., Evidence Law and Practice § 611.7 (6th ed.)* citing *Baxter v. Jones,* 34 Wn.App. 1 (Div. III 1983).[12] A directed verdict is only appropriate if, when viewing the material evidence most favorable to the nonmoving party, the court can say, as a matter of law, that there is no substantial evidence or reasonable inferences to sustain a verdict for the nonmoving party. *Wright v. Engum*, 124 Wn.2d 343, 356 (1994).[13]

In *Backlund,* as confirmed in *Gomez v. Sauerwein,* 180 Wn.2d 610 (2014), this Supreme Court created a fact-based affirmative defense for a physician to use against an informed consent claim when that physician is sued under two statutory alternative forms of medical provider liability—1) medical care below the standard of care, and 2) failure to inform the patient

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[12] Constitutional rights may be asserted for the first time on appeal. RAP 2.5; *Tegland, 5A Wash. Prac., Evidence Law and Practice § 611.7 (6th ed.) citing Tegland, 2A Washington Practice: Rules Practice, RAP 2.5 (8th ed.).* Division III's ruling creates this conundrum.

[13] Quoting from *Hizey v. Carpenter,* 119 Wn.2d 251, 271–72, 830 P.2d 646 (1992) (quoting *Industrial Indem. Co. of Northwest, Inc. v. Kallevig,* 114 Wn.2d 907, 915–16, 792 P.2d 520, 7 A.L.R.5th 1014 (1990)).

of material facts. *See RCW 7.70.030.*[14] The second theory, that of informed consent liability, is not actionable where a physician excludes a particular disease, or fails to diagnose it, as the physician cannot be expected to inform the patient about an unknown disease. *Sauerwein, 180 Wn.2d at 618, referencing Backlund, 137 Wn. 2d at 661.* In this "exclusion" instance, the first theory, "a negligence claim for medical malpractice will provide the patient compensation if the provider failed to adhere to the standard of care in misdiagnosing or failing to diagnose the patient's condition." *Id. at 618.* This is referred to as the *Backlund* rule. But the *Backlund* rule is premised on the physician having actually excluded the condition, or "misdiagnosed" it. In other words, *Backlund* is no more than an affirmative defense that must be proved. Here, plaintiff's experts disputed Joseph's testimony. They testified that Joseph did not exclude or diagnose *anything*, much less heart disease. The *Backlund* defense thus became a genuine issue of material fact for the jury, not Joseph's entitlement to a directed verdict.

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[14] RCW § 7.70.030, attached at *App. D*, includes the two relevant liability theories alleged here-- medical negligence, i.e. "(1) That injury resulted from the failure of a health care provider to follow the accepted standard of care," which is then further detailed at RCW 7.70.040, and "(3) That injury resulted from health care to which the patient or his or her representative did not consent," which is further detailed at RCW 7.70.050 (attached at *App. E*)

In *State v. Fry*, 168 Wn.2d 1, 18, 228 P.3d 1, 10 (2010), the dynamic is similar. This Court holds that a statutory medical use exemption to the marijuana law presents only an affirmative defense to be proved in court. It does not result in a presumed immunity simply because the defendant produces documents alleging that he falls under the statutory exemption. *Backlund* is precisely the same. *Backlund* should not allow for a directed verdict in the physician's favor solely on the word of the defendant physician when that testimony is disputed. Division II applies this principle in *Flyte*, where the defendant physician testified that he had ruled out (influenza), but other evidence showed that this may not have been the case at all. *183 Wa. App. at 579-580. Flyte* holds that when evidence is in dispute over whether a physician ruled out the condition, this presents a disputed question of fact. "If the jury believed that Marsh had not ruled out influenza, it could properly have considered Kenneth's informed consent claim under the rule articulated in *Anaya Gomez*." *Id.*

This Court should accept review and hold that *Backlund* is an affirmative defense which, where disputed, must be determined by the jury. Division III's *Eikum* ruling entitles a defendant to a directed verdict under *Backlund*, even where his testimony is disputed. *Eikum* at *5. This conflicts with *Backlund*, *Sauerwein*, and with *Flyte*. It is also error of constitutional magnitude, because *Eikum*'s holding violates a claimant's constitutional

right to trial by jury on their informed consent claim when genuine issues of material fact are in dispute.

2) This Supreme Court's ruling in *Gates v. Jensen* applies to cases where symptoms and test results are consistent with the disease ultimately discovered, and where test results verify the existence of the condition ultimately discovered. Division III fails to differentiate between *Gates* and *Backlund/Sauerwein,* it controverts this court's law, and it conflicts with Division II, which adopted the proper distinction.

Division III's *Eikum* ruling also contravenes this Supreme Court's *Gates v. Jensen* ruling, and it conflicts with Division II's ruling in *Flyte v. Summit View Clinic.* It does both by confusing the difference between a *Gates* claim and the *Backlund* affirmative defense. This Court should accept review.

In *Sauerwein*, this Supreme Court applied its *Backlund* "exclusion" defense to Dr. Sauerwein. It did so by differentiating Dr. Sauerwein's facts from its *Gates v. Jensen* facts. *180 Wn. 2d at 622-623. Gates* holds that a physician has a duty to inform the patient within the diagnostic process where the circumstances raise the suspicion of a medical condition. *Id. at 622. Sauerwein* accorded the defendant physician the *Backlund* defense, because Dr. Sauerwein had only one positive test available, he felt the test was erroneous—a false positive—he was under time constraints, and "had

no additional tests available." *Id. at 621.* His facts were thus "different from *Gates* because there was nothing else that Dr. Sauerwein could have done." *Id. at 622. Sauerwein/Backlund's* defense thus applies where a physician misdiagnoses or excludes, but with minimal contact with a patient, minimal information, and little time to act.[15] A *Gates* claim applies where a physician has possession of consistent positive tests and symptoms pointing to higher risk for the condition at issue. This is the same distinction followed by Division II in *Flyte.* In the latter, Division II applied *Gates.* The claimant "showed symptoms arguably consistent with (the condition at issue)," and this and other information warranted the right to information—a scenario "with little in common" with *Backlund. Flyte* 183 Wn.App. at 577.[16]

Division III's *Eikum* ruling fails to apply this differentiation. In *Eikum*, John Eikum's medical experts and Joseph's own medical record show Joseph's recording of consistent and multiple positive test results, along with reports of symptoms, all pointing to heart dysfunction. Joseph's

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[15] Moreover, here, as in *Gates,* plaintiff's experts testified to the ready availability of a "gold standard" test for the condition at issue—heart dysfunction—which is "simple, inexpensive, and risk free."

[16] Division II adopts *Gates* to confirm that, "The existence of an abnormal condition in one's body, the presence of a high risk of disease, and 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 which future medical care will take." *Flyte*, at 572, citing *Gates* at 250-51.

own record shows that he intended a cardiac consultation to attempt to reach conclusions, but never followed through. EKG and Holter monitor testing "positively identified" heart dysfunction. *Eikum* is plainly a *Gates* claim, not a *Backlund* defense. This Court should accept review and hold that *Gates v. Jensen* allows a claim for informed consent where symptoms and positive test results are consistent with the disease ultimately discovered, and certainly where alternative diagnostic procedures exist to conclusively determine the presence or absence of that disease, and the patient is not told.

Not only does Division III ignore this differentiation, but it does so by a gross over-generalization of *Sauerwein.* Division III holds that "an informed consent claim cannot be based on the same facts as a negligence claim." *Eikum,* at *4, erroneously citing *Sauerwein* at "617-623." This is gross misconstruction of *Sauerwein*'s language. The *Sauerwein* Court, in referencing only the facts of its misdiagnosis case, states: "On one set of facts the two theories are mutually exclusive." 180 Wn. 2d at 619. This sentence does not result in the broad generality that *Eikum* erroneously imposes. Facts for both forms of liability necessarily arise from the same series of visits between a doctor and a patient. But the facts of <u>treatment</u> differ from the facts of <u>informing</u>, even if both occur within the same visit. This is not double liability for the same act. This is the difference between the physician telling the patient what the patient needs to know, and the

physician treating the patient within or below the medical standard of care. The "same facts" ruling of *Sauerwein* relates only to a valid misdiagnosis case, not to medical cases in general. *Eikum* engages in gross error in expanding *Sauerwein's* language to the new golden rule of "[A]n informed consent claim cannot be based on the same facts as a negligence claim."

3) ER 803(a)(18), an exception to hearsay, is limited. Division III interprets this evidence rule to violate federal and state constitutional trial rights.

The right to cross examine is guaranteed in all civil cases by the due process clause. Const. art. I, § 22, U.S.; Const. Amend 6; *Tegland, 5A Wash. Prac., Evidence Law and Practice § 611.7*, citing *Baxter v. Jones,* 34 Wn.App. at 658.[17] "Whenever the right to confront is denied, the ultimate integrity of this fact-finding process is called into question." *State v. Darden*, 145 Wn.2d 612, 620 (2002).[18]

Hearsay cannot be effectively cross-examined. Hearsay is "a statement, other than one made by the declarant while testifying at the trial

[17] (holding that cross examination is an integral part of both criminal and civil judicial proceedings.").

[18] (holding that the right to confront and cross-examine adverse witnesses is guaranteed by both the federal and state constitutions, that the "primary and most important component is the right to conduct a meaningful cross-examination of adverse witnesses," that confrontation therefore helps assure the accuracy of the fact-finding process, and that the right to confront must be zealously guarded).

or hearing, offered in evidence to prove the truth of the matter asserted." *ER 801.* Hearsay is not admissible "except as provided by these rules, by other court rules, or by statute." *ER 802.* Under ER 803(a)(18), an expert receives an exception:

> "(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 (are excepted as hearsay). **If admitted, the statements may be read into evidence but may not be received as exhibits**."
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> *ER 803(a)(18), emphasis added, attached at App. C.*

Division III's *Eikum* ruling construes ER 803 (a)(18) to allow an expert to "quote statements" of an authoritative source that is never present in the courtroom.[19] This application of ER 803(a)(18) deprives a litigant of their state and federal constitutional right to confront expert witnesses. The rule plainly does not allow for such use.

In addressing the construction of ER 803(a)(18), Division III first misapprehends the record as to the identity of the claimed authoritative

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[19] An example of how this was allowed is this: Defense counsel and his defense medical expert: "Q: And in connection with that testimony, Doctor, under the revised cardiac risk index in the 2007 guidelines from the American College of Cardiology and the American Heart Association, is performing a functional capacity evaluation through testing part of the index or recommended under the index? A: No, it's not." *RP 1260:18-24.*

source.[20] But Division III ruled that even if something untoward had happened here, John made no showing of prejudice. *Eikum* thus creates a significant question of law under the state and federal Constitutions, because John showed error of constitutional magnitude, and prejudice is presumed. A trial court allowing a medical expert to "read into the record" statements that are not present, but which purportedly set the very standard of medical care, violates the confrontation right. Here, defense counsel also based his entire closing argument on this hearsay. Defense argued that since Dr. Joseph's care met this 2007 risk index's criteria, he thereby met the

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[20] The "revised cardiac risk index in the 2007 guidelines" is a document which defense claimed set the medical standard of care, and which exonerates Dr. Joseph. This 2007 risk index is not the "Harrington treatise" referred to by Division III, nor was it contained within that treatise. *See RP 1260: 18-24.* The criteria of cardiac risk indexes changes depending on the year of publication. The 2007 cardiac risk index was never in the courtroom. John Eikum found a *2009* cardiac risk index that required "heart rate control" as the standard of care, to which Dr. Joseph failed to adhere. But defense expert Dr. Jon Peterson thereupon testified that the 2009 index's heart rate control requirement didn't exist as a requirement in the 2007 index that applied here. *RP 1586: 17-24.* In another instance: "Q (By Ms. Schultz) It is now your testimony then, sir, that the schematic that we've just spent this time going through was different in 2007 and didn't have this down at the bottom?" Defense expert: "Yes." *RP 1587.* In another effort by plaintiff's counsel to use a different risk index that had surfaced, defense counsel simply asked its witness: "And is this risk index the one that was adopted by the American College of Cardiology and the American Heart Association *that we've referred to in this case as the 2007 guidelines?*" Defense expert: "It is not." *RP 1258: 7-19.* There was never a question that this 2007 cardiac risk index had never been in the courtroom. Defense counsel acknowledged this fact at a bench conference late in the trial when he told the court that he did not even "acquire" the 2007 document until the day before the bench discussion. He didn't bring it to court anyway. *RP 1835: 22 – RP 1836: 1.*[20] The trial court refused to make him produce it.

standard of care. *RP 2320.*

Division III's *Eikum* ruling misconstrues ER 803(a)(18) to hold that "**Statements contained in**" published treatises and "**statements (that) may be read into evidence...**" need not be present to allow an expert to "read (them) into evidence." This is not the language of ER 803(a)(18). This is classic hearsay. Division III erroneously construes ER 803(a)(18) to prevent the cross examination of an expert witness; absent review and correction, *Eikum* deprives medical litigants of their constitutional trial right of confrontation.

VII. CONCLUSION.

Petitioner respectfully asks this Court for review.

DATED this 25th day of **November, 2016.**

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CERTIFICATE OF SERVICE

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APPENDIX A

Eikum v Joseph

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NOTE: UNPUBLISHED OPINION,
SEE WA R GEN GR 14.1

Court of Appeals of Washington,
Division 3.

Estate of Joan R. Eikum By and through its Personal Representative, John J. Eikum, and Joan R. Eikum, By and through her Personal Representative, Appellants,
v.
Samuel Joseph, D.O., Spokane Respiratory Consultants, Respondents.

No. 32934-8-III
|
September 22, 2016

Appeal from Spokane Superior Court, 12-2-01990-2, Honorable Annette S. Plese, J.

Attorneys and Law Firms

Mary Elizabeth Schultz, Mary Schultz Law PS, Spangle, WA, for Appellant.

Edward Joseph Bruya, Bruya & Associates, P.C., James B. King, Evans, Craven & Lackie, P.S., Spokane, WA, Mary H. Spillane, Fain Anderson, et al., Seattle, WA, for Respondent.

UNPUBLISHED OPINION

Korsmo, J.

*1 The estate of Joan Eikum (Estate) appeals from an adverse jury verdict in its medical malpractice action against Dr. Samuel Joseph. Concluding that the trial court correctly refused to instruct the jury on an informed consent theory and that the Estate has not shown any prejudicial error, we affirm.

FACTS [1]

1 In light of the review standards governing the primary issue, we state the facts primarily from the Estate's view of the case, recognizing that Dr. Joseph and his experts saw them in a different light.

Upon the retirement of her primary physician, Dr. Joseph treated Ms. Eikum for the last four years of her life. She already suffered from diabetes when referred to Dr. Joseph. In October 2008, Dr. Joseph detected a bruit in Ms. Eikum's carotid artery.[2] A bruit is a sound caused by turbulence of the blood as it moves through the body. When heard in the neck, it can signify a narrowing of the carotid artery (carotid stenosis), but it can also signify narrowing of the aortic valve in the heart (aortic stenosis). Sound from the valve can be heard in the neck because the sound transmits through the artery. When aortic stenosis is heard directly from the heart it is more properly called a murmur.

2 This was the only time the bruit was detected by any doctor. In subsequent examinations, neither Dr. Joseph nor any other doctor detected a bruit.

Dr. Joseph sent Ms. Eikum for a carotid duplex examination. It revealed no evidence of stenosis (narrowing) of the carotid artery. The absence of carotid stenosis made aortic stenosis more likely. However, Dr. Joseph did not share any of this information with Ms. Eikum.

Around Thanksgiving 2008, Ms. Eikum fell while at home. Later that year, she passed out on a bed, laying back for five or six seconds and then coming up out of it. Around Christmas, Ms. Eikum slumped to the floor in the kitchen without reason, and then came up again. In January, she sprawled backwards while sitting on the toilet, coming back almost immediately. After this last incident, Ms. Eikum went to the emergency room.

The records of that visit indicated she suffered from syncope, the temporary loss of consciousness. There she underwent an electrocardiogram (EKG), a test that shows the rate of the heart, including whether there is interference with either the left or right ventricle. The EKG indicated tachycardia, which is an abnormally rapid heart rate. Following the emergency room visit, Ms. Eikum saw Dr. Joseph on January 21, 2009. Dr. Joseph was aware of the syncopal episodes, but did not know the cause of them. He ordered further pulmonary function tests, and also requested a Holter monitor.[3] His notes also indicated he planned to request a cardiology evaluation of Ms. Eikum.

3 A Holter monitor measures a person's heart rate. Ms. Eikum wore the monitor for the required 24 hour period. It showed that her heart rate exceeded 100 beats per minute for over nine hours, a sign of tachycardia. The results of the monitor were not shared with Ms. Eikum.

*2 Ms. Eikum saw Dr. Joseph again in March 2009 to obtain clearance for knee surgery. She desired to have her right knee replaced to eliminate some knee pain. She met with Dr. Joseph and he cleared her for surgery. However, Dr. Joseph did not indicate any heart-related concerns to Ms. Eikum, nor did he share that he did not know what was causing the syncope, or that he had considered ordering a cardiology consultation. He also did not discuss with her the possibility of getting an echocardiogram. An echocardiogram is a low-cost, non-invasive test that gives doctors a picture of how the heart valves are functioning and the condition of the heart muscle. With it, a doctor can assess the existence and severity of heart problems.

Dr. Joseph cleared Ms. Eikum for the elective knee surgery and she underwent the procedure in early April. The knee surgery exacerbated a pre-existing heart condition. This caused a heart attack 36 hours after the surgery, which in turn required emergency bypass surgery. Her "cascade to death" began with the heart attack, which came when she was at risk while recovering from the knee surgery. The heart attack likely was caused when a small clot (or several of them) blocked an already narrowed blood vessel. Report of Proceedings (RP) at 823-824. She died later that month.

John Eikum, on behalf of his wife's estate, sued Dr. Joseph on theories of negligence and lack of informed consent. The case ultimately proceeded to jury trial.

The estate called several doctors to testify at trial, including standard-of-care witness Dr. Leslie Stricke. During defense cross-examination of Dr. Stricke, counsel brought up the revised cardiac risk index. It considers a patient's risk of cardiac complications from noncardiac surgery. Dr. Stricke indicated familiarity with the index. Counsel then brought forward a copy of "Harrison's text on internal medicine," which contained tables involving the index. After Dr. Stricke conceded that Harrison's is a "well-recognized treatise that physicians and internists use and rely on," counsel provided Dr. Stricke with a three-page excerpt of the book, including the cover page, title page, and page 50, which contained the tables in question. The excerpt contained the "revised cardiac risk index clinical markers," which counsel used to cross-examine the doctor. During the cross-examination, the full Harrison's text was present in the courtroom.[4] After counsel finished his cross-examination, Ms. Eikum's attorney was given an opportunity to look at the book in more detail, and used other portions of the book in redirect examination.

4 "The book's right here, correct? ... Correct." RP at 442.

The cardiac risk index continued to be an issue at trial; both sides brought up the risk index with Ms. Eikum's next witness. Part way through defense cross-examination of this witness, Ms. Eikum's counsel requested to use the *Harrison's* text again. The book was no longer in the building and counsel asked Dr. Joseph's attorney to produce it. The trial court refused to order him to produce it unless he was going to use it again. At no point were additional excerpts of the book read into evidence with this witness. Instead, the cardiac risk index was discussed generally.

The cardiac risk index came up again with a defense expert, Dr. Darrel Potyk. This witness discussed the risk index generally, how it was created and how it evolved. He also discussed what the index indicates with regard to risk of a patient for surgery. The Estate did not raise a hearsay objection during Dr. Potyk's testimony.[5]

5 Ms. Eikum's counsel did object on what appears to be a relevance theory: "Your Honor, just a continuing objection to the use of the revised cardiac risk index when it's not indicated as having been used." RP at 1043-1044. Dr. Joseph's counsel immediately objected "to counsel's speaking objection," and the trial court noted Ms. Eikum's objection but overruled it. RP at 1044.

***3** After the plaintiff was done calling witnesses, Dr. Joseph moved for a judgment as a matter of law on the informed consent claim.[6] The court granted the motion, stating that "a provider cannot be liable for informed consent claims arising from the ruled out diagnosis" and that there had been "no testimony that Dr. Joseph knew of the heart condition and failed to inform her of the possible treatments." RP at 1126-1127.

6 Witnesses were heard out of order during trial and, in order to limit the inconvenience to Dr. Joseph, the Estate decided not to call him during its case in chief with the understanding that it would not face scope of direct examination objections when cross-examining the doctor. RP 1008-1014. Rather than await the testimony, the Estate asked that the motions to dismiss be heard immediately. RP at 1102.

Ms. Eikum requested, but the court declined to give, a series of five additional jury instructions. The two primary instructions were proposed instructions 10 and 14. The first proposed a "reasonable prudence" standard as an alternative basis for finding liability, while the second addressed the obligation to discuss conditions with a patient. Clerk's Papers (CP) at 28-32. Instead, the court gave the general health care negligence instruction:

> A health care professional owes to the patient a duty to comply with the standard of care for one of the profession or class to which he or she belongs.
>
> A physician who holds himself out as a specialist in internal medicine/pulmonary medicine has a duty to exercise the degree of skill, care, and learning expected of a reasonably prudent internal medicine/ pulmonary medicine in the State of Washington acting in the same or similar circumstances at the time of the care or treatment in question. Failure to exercise such skill, care, and learning constitutes a breach of the standard of care and is negligence.
>
> The degree of care actually practiced by members of the medical profession is evidence of what is reasonably prudent. However, this evidence alone is not conclusive on the issue and should be considered by you along with any other evidence bearing on the question.

CP at 138.

The Estate urged the jury to find that Dr. Joseph had violated the standard of care by failing to diagnose Ms. Eikum's heart condition and by failing to communicate with her. The doctor, in turn, told the jury that her symptoms were not indicative of heart disease. The jury sided with Dr. Joseph, concluding by a 10 to 2 vote that he was not negligent.

Judgment was entered on the verdict. The Estate then timely appealed to this court.

ANALYSIS

The Estate presents three issues for consideration that we address in the following order. First, the Estate believes the trial court erred in dismissing the informed consent claim. Second, it contends the court erred in permitting the defense to reference a learned treatise. Finally, the Estate argues the court erred in not giving its requested instructions.

Informed Consent Claim

The Estate contends the court erred in dismissing its informed consent claim, arguing that the failure to diagnose the heart problem prevented Ms. Eikum from giving her informed consent to the elective knee surgery. Assuming, without deciding, that the informed consent doctrine was available to the Estate in this "one off" circumstance, the trial court correctly determined that the evidence did not support the claim.

Well settled standards govern review of this issue. Appellate courts apply de novo review to a trial court decision to grant or deny a motion for judgment as a matter of law. *Alejandre v. Bull,* 159 Wn.2d 674, 681, 153 P.3d 864 (2007). Judgment as a matter of law is appropriate when, viewing the evidence in favor of the nonmoving party, there is substantial evidence to support a verdict for that party. *Sing v. John L. Scott, Inc.,* 134 Wn.2d 24, 29, 948 P.2d 816 (1997). "Substantial evidence" is evidence sufficient "to persuade a rational, fair-minded person that the finding is true." *Cantu v. Dep't of Labor & Indus.,* 168 Wn. App. 14, 21, 277 P.3d 685 (2012).

***4** The Estate's specific argument is that by failing to inform Ms. Eikum of the unresolved symptoms and suggest use of an echocardiogram to investigate potential heart problems, she consented to the knee surgery without awareness of material facts. Br. of Appellant at 29. Although this seems to be merely a restatement of her negligence claim that the failure to diagnose the heart problem led to the fatal heart attack following surgery she should not have undergone, we need not address that point because the evidence does not support an informed consent claim. This issue requires a review of the case law governing informed consent theories involving a failure to diagnose.

Our statute provides four elements for an informed consent claim:

> (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.

RCW 7.70.050(1).

The informed consent doctrine has its basis in common law, developing from the tort of assault and battery. The original theory was that a patient could not intelligently consent to a battery (the medical procedure) without a full understanding of any significant risks. *Keogan v. Holy Family Hosp.,* 95 Wn.2d 306, 313, 622 P.2d 1246 (1980). The doctrine was expanded to apply to situations where doctors failed to advise a patient of an abnormal condition[7] so the patient would be able to evaluate treatment options. *Miller v. Kennedy,* 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd,* 85 Wn.2d 151, 530 P.2d 334 (1975). Informed consent was applied in the context of a failure to diagnose in *Gates v. Jensen,* 92 Wn.2d 246, 595 P.2d 919 (1979). There an ophthalmologist, confronted with high pressure readings in the plaintiff's eyes, failed to advise the patient of the fact and of additional testing that might have confirmed the presence of glaucoma. *Id.* at 248. The court concluded the plaintiff had been entitled to an instruction on informed

consent in addition to the instructions on negligence that had been given to the jury. *Id.* at 250-251.

7 The failure to inform the patient of an abnormal condition presented a question of negligence. *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974). It was the need to decide on treatment options that moved this aspect of malpractice to the informed consent side of the ledger. *Id.* at 281-282.

The legislature subsequently codified medical malpractice actions, including informed consent claims. Chapter 7.70 RCW. Construing the statute, our court subsequently concluded that in a failure-to-diagnose context, an action for breach of informed consent was inappropriate. *Backlund v. Univ. of Wash.*, 137 Wn.2d 651, 661, 975 P.2d 950 (1999). "A physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent." *Id.* After *Backlund*, it was questionable whether or not *Gates* remained valid.

This court soon thereafter concluded that *Gates* either had been overruled or limited to its facts. *Anaya Gomez v. Sauerwein*, 172 Wn. App. 370, 385, 289 P.3d 755 (2012), *aff'd*, 180 Wn.2d 610, 331 P.3d 19 (2014). While affirming this court, the Washington Supreme Court concluded that *Gates* remained good law in situations where a failure to inform arises during the diagnostic process. 180 Wn.2d at 623. However, the majority[8] expressly stated that an informed consent claim cannot be based on the same facts as a negligence claim. *Id.* at 617-623. The court held that "when a health care provider rules out a particular diagnosis based on the circumstances surrounding a patient's condition, including the patient's own reports, there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis." *Id.* at 623.

8 Justice Gonzalez, writing for four justices who concurred in the result, would not foreclose the possibility of both negligence and informed consent claims arising from the same facts. 180 Wn.2d at 627-630. However, it would be "rare" that both theories were available under the same facts. *Id.* at 630-631.

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

The trial court did not err in granting judgment as a matter of law on the question of informed consent. [9]

9 The one complicating factor is that the trial testimony occurred after the motion to dismiss had been granted. As stated in footnote 6, in part this was because the Estate deferred its questioning of Dr. Joseph until the defense case as a matter of courtesy and also asked that the court rule immediately on the defense motion instead of awaiting the doctor's testimony. RP at 1008-1014, 1102. Under these circumstances, the ruling might have been premature, but it ultimately was correct.

Learned Treatise

The Estate next argues that the trial court erred in its rulings concerning defense use of the cardiac risk assessment tool discussed in the learned treatise. We need not decide whether any error occurred since the Estate has not established any harm from the alleged errors.

Trial court evidentiary rulings are reviewed for abuse of discretion. *State v. Guloy,* 104 Wn.2d 412, 429-430, 705 P.2d 1182 (1985). Discretion is abused when it is exercised on untenable grounds or for untenable reasons. *State ex rel. Carroll v. Junker,* 79 Wn.2d 12, 26, 482 P.2d 775 (1971). An appellate court will only consider the specific evidentiary objections that were presented to the trial court. *Guloy,* 104 Wn.2d at 422. An evidentiary error, like any nonconstitutional error, is harmless if, within reasonable probability, it did not affect the verdict. *State v. Zwicker,* 105 Wn.2d 228, 243, 713 P.2d 1101 (1986).

At issue is the learned treatise exception to the hearsay rule. Hearsay is a "statement ... offered in evidence to prove the truth of the matter asserted." ER 801(c). While there are numerous exceptions and exclusions, hearsay statements are typically inadmissible at trial. ER 802, 803, 804. ER 803(18) specifically provides that learned treatises may be read into evidence:

> 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.

The matter first arose when the defense brought up the index in cross-examination of Dr. Stricke. Defense counsel first asked whether Dr. Stricke was aware of "the revised cardiac risk index" and then more generally whether the doctor was aware of *Harrison's* text on internal medicine. RP at 441. Dr. Stricke answered in the affirmative to both questions. Counsel

also asked if *Harrison's* was a "well-recognized treatise that physicians and internists use and rely on in the conduct of their medical practices." *Id.* Doctor Stricke again answered in the affirmative. RP at 442. Counsel then provided two tables excerpted from *Harrison's* to Dr. Stricke and questioned him about whether the conditions indicated in the tables existed in Ms. Eikum. *Id.* at 448-449. Although counsel only provided a photocopy of three of the pages of the book (cover, title page, and page 50, containing the tables), the entire book was present in the courtroom at this time. RP at 442 ("The book's right here, correct? ... Correct."). Further, Ms. Eikum's attorney was given an opportunity to look at the book during the break and had the witness read some more information from the book during redirect. RP at 470, 508. No objection was raised to this process. There was no error.

***6** Other experts for both sides were asked about the risk index even though the *Harrison's* book was no longer in the courtroom. The plaintiff several times objected to examination of the witnesses concerning the risk index in the absence of the book, thus preserving this issue for review.[10] Even if we assume that it was erroneous to question the witnesses in the absence of the learned treatise, the Estate has not established prejudicial error. The evidence was properly admitted in accordance with the rule during the testimony of Dr. Stricke, and similar evidence came in through defense expert Dr. Potyk[11] without the Estate raising any hearsay objection.[12] The evidence was properly before the jury during the testimony of those two experts. Discussing the matter with the other witnesses, even in the absence of the treatise, did not add to or detract from to the evidence already properly before the jury. At most, even if improperly admitted, the other testimony was merely cumulative to the original evidence. Cumulative evidence is not a basis for finding prejudicial error. *State v. Todd,* 78 Wn.2d 362, 372, 474 P.2d 542 (1970).

10 Appellant never raised a "best evidence" objection at trial. ER 1002. The attempt to do so now is unavailing since we will not consider an evidentiary argument not raised to the trial court. *Guloy*, 104 Wn.2d at 422.

11 RP at 1033-1047.

12 RP at 1016-1101.

The Estate has not shown how the questioning of witnesses in the absence of the treatise affected the verdict. Accordingly, it has not demonstrated prejudicial error.

Additional Jury Instructions

Lastly, the Estate argues that the trial court erred by failing to give its five requested "additional" instructions. However, the instructions given by the trial court were proper and the Estate has not shown an entitlement to the additional instructions.[13] There was no error.

13 We agree with the Estate that it properly preserved this issue. We need not address the defense arguments that the instructions are erroneous.

The trial court has discretion in the wording and number of jury instructions; this court reviews the trial court's decision for abuse of discretion. *Fergen v. Sestero,* 182 Wn.2d 794,

802, 346 P.3d 708 (2015). Instructions are sufficient if they are supported by substantial evidence, allow the parties to argue their theories of the case, and, when read as a whole, properly inform the jury of the applicable law. *Id.* at 803. An instruction that misstates the applicable law is reversible error if it causes prejudice. *Id.* The court need not give an instruction that is erroneous in any respect. *State v. Hoffman,* 116 Wn.2d 51, 110-111, 804 P.2d 577 (1991). The discretion afforded the trial court in the wording of instructions means that it need not give additional instructions, even when they are correct, if the court's other instructions are sufficient. *Gammon v. Clark Equip.,* 104 Wn.2d 613, 617, 707 P.2d 685 (1985).

The Estate's argument founders on this latter point. Neither party contends the instructions given by the trial court were erroneous in any manner. Assuming that the Estate's proposed instructions were correct statements of the law, it has failed to establish that any of them were *necessary* in the sense that the Estate could not argue its theory of the case without them. The court's instructions did allow the Estate to argue its case. The five instructions all addressed the standard of care in one manner or another. Two of the instructions involved the failure to order additional tests, while the other three addressed alleged failures of Dr. Joseph to communicate with Ms. Eikum concerning diagnosis and treatment. The general negligence instruction given by the court allowed the Estate to make its arguments on these points. It put forth its theory of the case concerning all of these topics and the jury was able to consider them.

A party is only deprived of its theory of the case if the court's instructions do not allow it to argue the theory. *Fergen,* 182 Wn.2d at 803. The court's instructions did permit the Estate to argue its theory. Accordingly, they were adequate. The fact that some or all of the additional instructions might have been proper does not mean the trial court erred by refusing to give them.

*7 The trial court did not abuse its discretion.

The judgment is affirmed.

A majority of the panel has determined this opinion will not be printed in the Washington Appellate Reports, but it will be filed for public record pursuant to RCW 2.06.040.

WE CONCUR:

Fearing, C.J.

Lawrence-Berrey, J.

All Citations

Not Reported in P.3d, 2016 WL 5342411

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APPENDIX B

Order Denying Reconsideration

FILED
OCTOBER 27, 2016
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

ESTATE OF JOAN R. EIKUM By and through its Personal Representative, JOHN J. EIKUM, and JOAN R. EIKUM, By and through her Personal Representative,	)	No. 32934-8-III
Appellants,	)	ORDER DENYING MOTION FOR RECONSIDERATION
v.	)	
SAMUEL JOSEPH, D.O., SPOKANE RESPIRATORY CONSULTANTS,	)	
Respondents.	)	

THE COURT has considered appellant's motion for reconsideration and is of the opinion the motion should be denied. Therefore,

IT IS ORDERED, the motion for reconsideration of this court's decision of September 22, 2016 is hereby denied.

PANEL: Judges Korsmo, Fearing, Lawrence-Berrey

FOR THE COURT:

George Fearing

GEORGE FEARING
Chief Judge

APPENDIX C

ER 803 (a)(18)

West's Revised Code of Washington Annotated
Part I Rules of General Application
Washington Rules of Evidence (ER)
Title VIII. Hearsay

Washington Rules of Evidence, ER 803

RULE 803. HEARSAY EXCEPTIONS; AVAILABILITY OF DECLARANT IMMATERIAL

Currentness

(a) Specific Exceptions. The following are not excluded by the hearsay rule, even though the declarant is available as a witness:

(1) *Present Sense Impression.* A statement describing or explaining an event or condition made while the declarant was perceiving the event or condition, or immediately thereafter.

(2) *Excited Utterance.* A statement relating to a startling event or condition made while the declarant was under the stress of excitement caused by the event or condition.

(3) *Then Existing Mental, Emotional, or Physical Condition.* A statement of the declarant's then existing state of mind, emotion, sensation, or physical condition (such as intent, plan, motive, design, mental feeling, pain, and bodily health), but not including a statement of memory or belief to prove the fact remembered or believed unless it relates to the execution, revocation, identification, or terms of declarant's will.

(4) *Statements for Purposes of Medical Diagnosis or Treatment.* Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

(5) *Recorded Recollection.* A memorandum or record concerning a matter about which a witness once had knowledge but now has insufficient recollection to enable the witness to testify fully and accurately, shown to have been made or adopted by the witness when the

(13) *Family Records.* Statements of fact concerning personal or family history contained in family Bibles, genealogies, charts, engravings on rings, inscriptions on family portraits, tattoos, engravings on urns, crypts, or tombstones, or the like.

(14) *Records of Documents Affecting an Interest in Property.* The record of a document purporting to establish or affect an interest in property, as proof of the content of the original recorded document and its execution and delivery by each person by whom it purports to have been executed, if the record is a record of a public office and an applicable statute authorized the recording of documents of that kind in that office.

(15) *Statements in Documents Affecting an Interest in Property.* A statement contained in a document purporting to establish or affect an interest in property if the matter stated was relevant to the purpose of the document unless dealings with the property since the document was made have been inconsistent with the truth of the statement or the purport of the document.

(16) *Statements in Ancient Documents.* Statements in a document in existence 20 years or more whose authenticity is established.

(17) *Market Reports, Commercial Publications.* Market quotations, tabulations, lists, directories, or other published compilations, generally used and relied upon by the public or by persons in particular occupations.

(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.

(19) *Reputation Concerning Personal or Family History.* Reputation among members of a person's family by blood, adoption, or marriage, or among a person's associates, or in the community, concerning a person's birth, adoption, marriage, divorce, death, legitimacy,

APPENDIX D

RCW 7.70.030

West's Revised Code of Washington Annotated
Title 7. Special Proceedings and Actions (Refs & Annos)
Chapter 7.70. Actions for Injuries Resulting from Health Care (Refs & Annos)

West's RCWA 7.70.030

7.70.030. Propositions required to be established--Burden of proof

Effective: July 22, 2011
Currentness

No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

(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.

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence.

Credits
[2011 c 336 § 250, eff. July 22, 2011; 1975-'76 2nd ex.s. c 56 § 8.]

Notes of Decisions (60)

West's RCWA 7.70.030, WA ST 7.70.030
The statutes and Constitution are current with all laws from the 2016 Regular and First Special Sessions of the Washington legislature.

APPENDIX E

RCW 7.70.050

West's Revised Code of Washington Annotated
Title 7. Special Proceedings and Actions (Refs & Annos)
Chapter 7.70. Actions for Injuries Resulting from Health Care (Refs & Annos)

West's RCWA 7.70.050

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

Effective: July 22, 2011
Currentness

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

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

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

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

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

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

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

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

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

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

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

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

Credits

[2011 c 336 § 252, eff. July 22, 2011; 1975-'76 2nd ex.s. c 56 § 10.]

Notes of Decisions (114)

West's RCWA 7.70.050, WA ST 7.70.050

The statutes and Constitution are current with all laws from the 2016 Regular and First Special Sessions of the Washington legislature.

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