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COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

TERESA HARBOTTLE, individually and as Personal Representative of
the Estate of JOHN F. HARBOTTLE, III, deceased,

Appellants,

v.

KEVIN E. BRAUN, M.D. and JANE DOE BRAUN, and their marital
community,

Respondents.

BRIEF OF RESPONDENTS

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. COUNTERSTATEMENT OF ISSUES PRESENTED FOR REVIEW 2

III. COUNTERSTATEMENT OF THE CASE 2

 A. Factual Background 2

 1. Mr. Harbottle first saw Dr. Braun for painful ear bumps 2

 2. Mr. Harbottle next saw Dr. Braun for complaints of burning in his chest, which Dr. Braun believed most likely due to gastroesophageal reflux disease 3

 3. Mr. Harbottle’s symptoms resolved with Prilosec treatment..... 4

 4. Mr. Harbottle next saw Dr. Braun with complaints of exertional shortness of breath during allergy season 5

 5. Mr. Harbottle did not see or contact Dr. Braun again..... 6

 6. Mr. Harbottle died of an irregular heart rhythm 6

 B. Procedural History 7

 1. Dr. Braun’s motion for summary judgment dismissal of the informed consent claim..... 7

 2. Discovery relating to Dr. Braun’s employment history and patient complaints 10

 3. Dr. Braun’s motion to exclude evidence of past grievances..... 14

 4. The jury’s verdict..... 16

IV. ARGUMENT.....	16
A. The Trial Court Properly Dismissed the Informed Consent Claim	16
1. The standard of review is de novo	17
2. Washington courts have repeatedly held that failure to diagnose a condition is a matter of medical negligence, not of informed consent.....	18
3. Because Dr. Braun had no duty to inform of possible treatments for a disease he did not believe Mr. Harbottle had, the informed consent claim was properly dismissed	21
4. Mrs. Harbottle’s reliance on <i>Gates v. Jensen</i> , <i>Keogan</i> , <i>Flyte v. Summit View Clinic</i> , and the <i>Anaya Gomez</i> concurrence is misplaced.....	25
5. Mrs. Harbottle’s informed consent claim was also properly dismissed because she failed to make out a prima facie case	35
B. The Trial Court Properly Exercised Its Discretion in Excluding Evidence of Past Unrelated Grievances Against Dr. Braun.....	37
1. The standard of review is abuse of discretion	38
2. Mrs. Harbottle’s incantation of “perjury” is inaccurate and does not render the trial court’s exclusion of evidence as to other patient’s complaints an abuse of discretion.....	38
3. The trial court did not abuse its discretion in excluding evidence of other patients’ unrelated complaints	40

4. Mrs. Harbottle’s discussion of sanctions for discovery violations has nothing to do with the propriety of the trial court’s evidentiary ruling and ignores that she never moved the trial court for any such sanctions 47

5. Mrs. Harbottle’s discussion of RCW 70.41.200 also has nothing to do with the propriety of the trial court’s exclusion of evidence of other patients’ unrelated complaints 48

6. Mrs. Harbottle has not provided a record of the trial proceedings and thus cannot establish prejudice resulting from the trial court’s exclusion of evidence of other patients’ complaints..... 49

V. CONCLUSION 50

TABLE OF AUTHORITIES

	Page(s)
STATE CASES	
<i>Allemeier v. Univ. of Wash.</i> , 42 Wn. App. 465, 712 P.2d 306 (1985)	49
<i>Anaya Gomez v. Sauerwein</i> , 180 Wn.2d 610, 617, 331 P.3d 19 (2014) 17, 19-20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35	35
<i>Backlund v. Univ. of Wash.</i> , 137 Wn.2d 651, 975 P.2d 950 (1999)	19-20, 21, 26, 32, 33
<i>Bays v. St. Luke’s Hosp.</i> , 63 Wn. App. 876, 825 P.2d 319, <i>rev. denied</i> , 119 Wn.2d 1008 (1992).....	20, 24, 34, 35, 37
<i>Brown v. Spokane County Fire Prot. Dist. No. 1</i> , 100 Wn.2d 188, 668 P.2d 571 (1983)	49
<i>Burnet v. Spokane Ambulance</i> , 54 Wn. App. 162, 772 P.2d 1027, <i>rev. denied</i> , 113 Wn.2d 1005 (1989).....	21
<i>Cantu v. Seattle</i> , 51 Wn. App. 95, 752 P.2d 390 (1988)	38
<i>Flyte v. Summit View Clinic</i> , 183 Wn App. 559, 333 P.3d 566 (2014).....	25, 29, 30, 31, 32
<i>Gates v. Jensen</i> , 92 Wn.2d 246, 595 P.2d 919 (1979)	25, 26, 27, 28, 29
<i>Gustav v. Seattle Urological Assocs.</i> , 90 Wn. App. 785, 954 P.2d 319 (1998)	17, 18, 20, 24, 35, 37
<i>Holt v. Nelson</i> , 11 Wn. App. 230, 523 P.2d 211, <i>rev. denied</i> , 84 Wn.2d 1008 (1974).....	19

<i>Keogan v. Holy Family Hosp.</i> , 95 Wn.2d 306, 622 P.2d 1246 (1980)	23, 25, 29, 31, 34
<i>LaMon v. Butler</i> , 112 Wn.2d 193, 770 P.2d 1027, <i>cert. denied</i> , 493 U.S. 814 (1989)	17
<i>Loeffelholz v. C.L.E.A.N.</i> , 119 Wn. App. 665, 82 P.3d 1199 (2004).....	40
<i>Minehart v. Morning Star Boys Ranch, Inc.</i> , 156 Wn. App. 457, 232 P.3d 591 (2010).....	38
<i>Smith v. Shannon</i> , 100 Wn.2d 26, 666 P.2d 351 (1983)	36
<i>State ex rel. Carroll v. Junker</i> , 79 Wn.2d 12, 482 P.2d 775 (1971).....	38
<i>State v. Benn</i> , 120 Wn.2d 631, 845 P.2d 289 (1993)	44
<i>State v. Kunze</i> , 97 Wn. App. 832, 859 P.2d 977 (1999)	44
<i>State v. O'Connor</i> , 155 Wn.2d 335, 119 P.3d 806 (2005)	38, 43, 44-45
<i>State v. Olson</i> , 92 Wn.2d 134, 594 P.2d 1337 (1979)	39
<i>State v. Stump</i> , 73 Wn. App. 625, 870 P.2d 333 (1994)	39, 40
<i>State v. York</i> , 28 Wn. App. 33, 621 P.2d 784 (1980)	40, 41-43
<i>Thomas v. Wilfac, Inc.</i> , 65 Wn. App. 255, 828 P.2d 597, <i>rev. denied</i> , 119 Wn.2d 1020 (1992).....	20, 24
<i>Volk v. DeMeerleer</i> , 187 Wn.2d 241, 386 P.3d 254 (2016)	17

STATUTES AND RULES

RCW 7.70.040 7, 18

RCW 7.70.050 7, 8, 9, 22, 26, 33, 35

RCW 7.70.050(1)..... 18

RCW 7.70.050(2)..... 19

RCW 9A.72.020 39

RCW 9A.72.060 39

RCW 43.70.150 48

RCW 70.41.200 48

ER 401..... 14

ER 402..... 14

ER 403..... 14, 37, 38, 47

ER 608..... 43

ER 608(b) 14, 15, 37, 38, 39, 41, 43, 44, 49

ER 609(a)(2)..... 39

RAP 9.2(b)..... 49

I. INTRODUCTION

In this wrongful death action, Teresa Harbottle asserted a medical negligence claim against Dr. Kevin Braun, alleging that her husband John Harbottle died from coronary artery disease that Dr. Braun negligently failed to diagnose, having instead diagnosed and provided treatment for gastroesophageal reflux disease (GERD). On the same facts, she also tried to assert an informed consent claim, which the trial court dismissed on Dr. Braun's motion for partial summary judgment. At trial of the medical negligence claim, Dr. Braun contended that, based on Mr. Harbottle's clinical presentation and positive response to treatment for GERD, he complied with the applicable standard of care in his diagnosis and treatment of Mr. Harbottle's symptoms, and that Mr. Harbottle died not from coronary artery disease, but from asymptomatic hypertrophic cardiomyopathy, an untreatable and likely genetic condition, that predisposed him to fatal arrhythmias. The jury found Dr. Braun not negligent.

On appeal, Mrs. Harbottle challenges the dismissal of her informed consent claim, as well as exclusion of evidence of unrelated, unsubstantiated past grievances other patients had made against Dr. Braun. Because the trial court did not err in dismissing the informed consent claim or abuse its discretion in excluding the evidence of those past grievances, the judgment on the jury verdict should be affirmed.

II. COUNTERSTATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Did the trial court properly dismiss the informed consent claim because: (a) under Washington law, Dr. Braun's failure to diagnose coronary artery disease, a condition he believed was an unlikely cause of Mr. Harbottle's symptoms based on the facts and circumstances surrounding Mr. Harbottle's condition and his positive response to treatment for gastroesophageal reflux disease (the condition Dr. Braun believed was the most likely cause), potentially gave rise only to a medical negligence claim, not an informed consent claim; and/or (b) because Mrs. Harbottle failed to present expert testimony establishing material facts relating to any treatment or evidence that any treatment provided proximately caused Mr. Harbottle's death?

2. Did the trial court properly exercise its discretion under ER 401-403, and 608(b), in excluding evidence of unrelated, unsubstantiated, remote-in-time complaints other patients had made against Dr. Braun?

III. COUNTERSTATEMENT OF THE CASE

A. Factual Background.

1. Mr. Harbottle first saw Dr. Braun for painful ear bumps.

Mr. Harbottle first saw Dr. Braun in January 2010 for painful bumps on his ear. CP 256, 259. Dr. Braun diagnosed actinic keratosis and prescribed liquid nitrogen treatment, and Mr. Harbottle was to return for

follow up and a preventative health maintenance exam. CP 256, 262.

2. Mr. Harbottle next saw Dr. Braun for complaints of burning in his chest, which Dr. Braun believed most likely due to gastroesophageal reflux disease.

Having seen his naturopath for a physical exam, Mr. Harbottle did not see Dr. Braun again until June 2011, when he complained of “burning” in his chest “five minutes in duration” for two months “occurring more frequently and now daily” and not associated with food or exercise. CP 45, 258, 262-63. He reported taking “Pepcid without benefit.” CP 45, 263. He denied loss of consciousness, lightheadedness or nausea, and described acid reflux, or gastroesophageal reflux disease (GERD), symptoms. CP 45, 263-64. He also reported taking niacin, on his naturopath’s recommendation, for a possible elevated lipid in the past. CP 45, 258, 263.

Based on “an in-depth history” and “thorough physical examination” that revealed Mr. Harbottle was not overweight, did not smoke, and did not have diabetes, high blood pressure, or a family history of heart disease, and therefore had a low risk of heart disease, Dr. Braun believed his clinical picture indicated GERD as the likely cause of his symptoms. CP 45, 263-65. He engaged in “shared decision-making” with Mr. Harbottle, discussing his symptoms, concerns and options for further testing. CP 263-65. Mr. Harbottle had “particular concerns about respiratory problems” and wanted his testosterone levels checked on

advice of his naturopath, even though Dr. Braun found “no symptoms of low testosterone.” CP 263, 265. Ultimately, Mr. Harbottle agreed with the options Dr. Braun presented, including Prilosec treatment to try to relieve his apparent symptoms of GERD, as well as lab testing (including testosterone levels per Mr. Harbottle’s request), a chest x-ray, an electrocardiogram, and an exercise tolerance (or stress) test. CP 45, 263-64.

Dr. Braun ordered the lab tests, referred Mr. Harbottle to a cardiologist for the stress test (which Mr. Harbottle initially scheduled, but later cancelled), and had his nurse perform the electrocardiogram, which Dr. Braun reviewed and found “unremarkable,” without “signs of significant cardiovascular abnormality.” CP 264-65. Mr. Harbottle was to follow up in a month for “ongoing care for his symptoms.” CP 265-66.

3. Mr. Harbottle’s symptoms resolved with Prilosec treatment.

Mr. Harbottle returned to see Dr. Braun on July 27, 2011, and reported no recurrence of chest burning or chest pressure that “was well resolved” with Prilosec, that he had no complaints of chest pain, and that he had discontinued alcohol and caffeine. CP 48, 266. Because the Prilosec had resolved Mr. Harbottle’s symptoms, Dr. Braun believed that a cardiac issue, that “had been a very unlikely potential cause of his symptoms,” “was even less likely.” CP 266. Dr. Braun suggested continuing Prilosec as needed rather than every day. *Id.* Mr. Harbottle

agreed to return for a preventive health maintenance exam. *Id.*

When Mr. Harbottle returned for a full physical on August 22, 2011, he reported that, since his last appointment, “acid foods seemed to cause” symptoms of “heartburn” that were well treated with Prilosec. CP 49-50, 267-69. He also reported resuming alcohol, one or two servings every other night, and exercising five to seven days a week. CP 269. On exam, Dr. Braun found no abnormalities, but persuaded Mr. Harbottle to stop taking niacin because his cholesterol was not high and it could increase the risk of gout, which ran in his family. CP 258, 268-69.

On December 12, 2011 Mr. Harbottle returned for a toenail fungus, and Dr. Braun suggested an over-the-counter treatment, but also prescribed Lotrimin in case it was more convenient or cost-effective. CP 269.

4. Mr. Harbottle next saw Dr. Braun with complaints of exertional shortness of breath during allergy season.

Mr. Harbottle returned to see Dr. Braun on March 14, 2012, with a complaint of “dyspnea on exertion,” or shortness of breath with exercise, for twelve days. CP 51, 269. He reported cold symptoms, including a minimal cough, post nasal drip, and sore throat, for which he had taken Sudafed, but “no radiating chest symptoms or lightheadedness,” fever or muscle aches. CP 269-70. Although he typically had seasonal allergies that time of year, he had not been using his inhaler. CP 270. After

examination, and given Mr. Harbottle's "history of bronchial reactive airway disease" and recent "upper respiratory infection," Dr. Braun gave him samples of Symbicort, an asthma medication, and Mr. Harbottle agreed to follow up to assess whether his symptoms had resolved. CP 270.

5. Mr. Harbottle did not see or contact Dr. Braun again.

Rather than returning to Dr. Braun, Mr. Harbottle saw his allergist, Dr. Andrade, in May 2012 for hay fever symptoms, "seasonal esophagitis" that resolved with heartburn medication, and "a history of tightness in his chest." CP 62-63. He denied chest pain, irregular heartbeat, or other pain or weakness, and did not describe shortness of breath. CP 62-63. Mr. Harbottle denied wheezing when lying in bed or exercising, but Dr. Andrade noted "mild" wheezing "with moderately forceful exhalation." CP 62, 64. Tests revealed allergic reactions to a number of things. CP 65. Dr. Andrade offered as options avoidance, medication, and allergen immunotherapy via injections and Mr. Harbottle "elected conservative therapy with medication and avoidance" and agreed to return to consider immunotherapy if medication did not adequately control his symptoms. CP 65.

6. Mr. Harbottle died of an irregular heart rhythm.

On May 24, 2012, while traveling for business in California, Mr. Harbottle went for a massage. The masseuse left him alone on the table for five minutes and returned to find him unresponsive and not breathing.

CP 67, 69. He could not be revived and was pronounced dead after arrival at a nearby emergency room. CP 67-69. After a limited autopsy that did not include microscopic examination of relevant tissue samples, the coroner classified the death as natural and due to atherosclerotic heart disease. CP 71. A pathologist the defense hired, after microscopic review of tissue blocks retained from the autopsy, concluded that Mr. Harbottle did not have clinically significant coronary artery disease, but had asymptomatic hypertrophic cardiomyopathy, an untreatable, likely genetic, condition that predisposed him to fatal arrhythmias and caused his death. CP 1077-78.

B. Procedural History.

Teresa Harbottle, individually and as personal representative of her husband's estate, sued Dr. Braun, alleging medical negligence under RCW 7.70.040 and lack of informed consent under RCW 7.70.050. CP 4-5. She claimed: (1) that Dr. Braun misdiagnosed Mr. Harbottle with GERD and bronchial reactive airway disease and failed to diagnose "significant coronary artery occlusion" that caused his death, CP 3-4; and (2) that, if "fully and properly informed of the true nature of his condition" and "the alternative of having a cardiology consult," Mr. Harbottle would not have consented to treatment for GERD and reactive airway disease, CP 5.

1. Dr. Braun's motion for summary judgment dismissal of the informed consent claim.

Dr. Braun moved for summary judgment to dismiss the informed

consent claim, arguing that (1) a failure to inform a patient of the risks associated with a certain condition based on a misdiagnosis or failure to diagnose gives rise to a medical negligence claim, not an informed consent claim, CP 19-22; (2) Mrs. Harbottle failed to present expert testimony regarding any material risks of treatment that Dr. Braun failed to disclose as required to support a prima facie informed consent claim, CP 23; and (3) as RCW 7.70.050 informed consent claims are limited to treatment situations and Mrs. Harbottle's experts opined only that Dr. Braun failed to inform of risks associated with a diagnosis of coronary artery disease, not risks of any proffered treatment, the informed claim was nothing more than a disguised medical negligence claim, CP 23-24.

In response, Mrs. Harbottle, describing the diagnostic process as a "phase of treatment," argued that Washington recognizes an informed consent claim based on failure to inform about a diagnostic test available to rule out a particular condition. CP 194-200. She claimed Dr. Braun had a duty to inform Mr. Harbottle of both the risks of coronary artery disease and the availability of a diagnostic test (an exercise treadmill test by a cardiologist) to "rule out heart disease as a possible cause" of his symptoms. CP 189-90. While acknowledging that Dr. Braun made a referral for an exercise treadmill test, she claimed her expert's testimony that he "should not have allowed the exercise treadmill test to be cancelled" and "should

have followed-up with Mr. Harbottle” as to “the need for the test (and the obvious fact that it had not yet been completed),” instead of continuing “with a course of treatment targeted exclusively at heartburn,” was sufficient to establish an informed consent claim. CP 191-93, 200-201.

In reply, Dr. Braun pointed out that (1) Mrs. Harbottle had erroneously confused and conflated her negligence claim with an informed consent claim, CP 508-512; (2) she could not convert a medical negligence failure to diagnose claim into an informed consent claim simply by asserting that it is based on the “diagnostic phase of treatment,” CP 511; (3) an informed consent claim under RCW 7.70.050 is concerned with disclosure of material risks of treatment, CP 510-12; (4) Dr. Braun had no duty to disclose the risks of treatment for a condition he did not diagnose or believe Mr. Harbottle likely had, CP 512-16; and (5) Mrs. Harbottle failed to present expert testimony establishing the existence of any material facts relating to treatment or any evidence that the treatment given proximately caused injury and, thus, had not made out a prima facie informed consent claim, CP 510, 512, 516. At the summary judgment hearing, Dr. Braun also explained that no informed consent claim existed because Mr. Harbottle did not sustain any injury from the treatments given, Prilosec and Symbicort. 9/16/16 RP 4-5. He also clarified that he was not seeking to limit or preclude any arguments Mrs. Harbottle might

have as to violations of the standard of care, but sought dismissal only of any informed consent claim. 9/16/16/ RP 5.

After considering the parties' submissions and arguments, the trial court granted summary judgment dismissing the informed consent claim. 9/16/16 RP 11; CP 526-27.

2. Discovery relating to Dr. Braun's employment history and patient complaints.

In response to interrogatories in April 2015 asking if he had (1) "ever been the subject [of] an allegation, claim, complaint, or lawsuit (including any civil claims, criminal claims, and/or professional complaints) alleging inappropriate conduct or improper and/or negligent or substandard treatment," or (2) "ever been under disciplinary review by any medical board," Dr. Braun initially answered "no." CP 716. In deposition in April 2016, in response to questions about complaints against him while employed by MultiCare and the reasons he left employment there, Dr. Braun responded as follows, CP 276:

Q Okay. Were you subject to any complaints while you were an employee of MultiCare?

A There's always complaints.

Q Okay. What complaints do you remember being subject to when you were employed with MultiCare?

A There were patients who didn't get the prescriptions that they were looking for.

Q Any other complaints that you remember being subject to when you were with MultiCare?

A I'd have to go back and look through.

Q What would you go back to look through?

A I don't know.

Q Do you have a personnel or credentialing file at MultiCare?

A I don't know.

Q In terms of your departure from MultiCare, was that a decision that you made for yourself or is that one that MultiCare made for you?

A It was made mutually.

Q Okay. Did you write a letter saying you were going to terminate your relationship with MultiCare or did they write you a letter saying that your relationship might be terminated?

A I don't recall. We had to work out a noncompete so that they would allow me to practice locally.

In March, 2017, even though Dr. Braun had ended his employment there five years before he began to treat Mr. Harbottle, Mrs. Harbottle issued a subpoena to MultiCare, seeking his employment file, his credentialing file, and any "complaints, grievances, or investigations" pertaining to him. CP 590-92. Dr. Braun moved to quash and the trial court ordered MultiCare to produce "an index of responsive materials" identifying with specificity any privileges it was asserting. CP 1373-78, 1416-17. After MultiCare produced the indices, CP 594-96, 630-32, Dr. Braun moved for a protective order. CP 528-38. The trial court ordered MultiCare to produce its non-privileged records subject to a protective order, *see* CP 674-76, and to identify the number of pages contained in each document for which it asserted a privilege. CP 664-65. The non-privileged records

MultiCare produced included a letter to Dr. Braun indicating that three female patients had made grievances, alleging inappropriate flirtatious behavior and untoward touching. CP 732. The index of privileged records MultiCare produced identified a letter from MultiCare to the Department of Health presumably concerning those three grievances. CP 749-50.

In July 2017, Dr. Braun provided supplemental interrogatory answers regarding other patients' allegations (1) listing several objections, including lack of relevance and risk of undue prejudice; (2) stating that he initially interpreted the questions "to exclude unsubstantiated allegations that related to topics other than the provision of medical treatment"; (3) admitting that there had been "complaints about his demeanor or actions while he was practicing at MultiCare many years prior" to his "treatment of Mr. Harbottle at a different clinic"; and (4) stating that the Medical Quality Assurance Commission had investigated the complaints, found them to be unsubstantiated, and did not file any charges or take any disciplinary action against him. CP 852-54.

Thereafter, claiming that Dr. Braun had lied and committed "perjury" when responding to interrogatories and deposition questions regarding other complaints, Mrs. Harbottle moved for *in camera* review of certain portions of the records MultiCare had withheld as privileged, CP 702-09, which the trial court granted, CP 880-81. The trial court's *in*

camera review did not result in production of further documents.

Ultimately, documents MultiCare produced and documents the Department of Health produced pursuant to the parties' respective Public Records Act requests showed that: (1) between June 2003 and April 2005, MultiCare received three complaints "alleging inappropriate flirtatious behavior involving verbal advances and untoward touching of an unaccompanied female patient" against Dr. Braun; (2) MultiCare placed Dr. Braun on administrative leave on April 27, 2005 as a result of the three complaints; (3) Dr. Braun resigned his employment with MultiCare by letter dated May 2, 2005; (4) the Medical Quality Assurance Commission (MQAC) investigated the three complaints but closed the file based on insufficient evidence; (5) in November 2005, the spouse of a patient complained to the MQAC that Dr. Braun would not provide a prescription for a narcotic over the phone and instead advised the patient to go to an urgent care clinic; (6) the MQAC investigated that complaint and closed the file without disciplinary action because the "[c]are rendered was within standard of care"; and (7) Dr. Braun held credentials as an active staff member in good standing at two MultiCare hospitals between October 1999 and October 2011, during which time he was not the subject of any disciplinary actions. CP 732, 734, 739, 846-47, 857, 859-60, 862.

3. Dr. Braun's motion to exclude evidence of past grievances.

Dr. Braun filed a motion to exclude any evidence of allegations against him unrelated to his care of Mr. Harbottle as irrelevant and inadmissible under ER 401, 402, and 403, as well as ER 608(b). CP 751-62, 767-819. He argued that: (1) the fact that other patients made unsubstantiated complaints against him six or more years earlier had no bearing on the central issue for trial – whether his diagnosis and treatment of Mr. Harbottle in 2011 and 2012 complied with the applicable standard of care; (2) allowing the jury to hear evidence of other patients' unsubstantiated complaints would be unduly prejudicial, confuse the issues, mislead the jury, waste time on collateral issues, and require presentation of extensive additional explanatory evidence; (3) the risk of undue prejudice resulting from the inflammatory nature of allegations of sexual misconduct that have nothing to do with diagnosis of coronary artery disease far outweighed any minimal probative value; and (4) because his discovery responses did not demonstrate a lack of credibility or conceal any prior allegations by other patients under circumstances even remotely similar to the allegations in this case, admission under ER 608(b) would be unwarranted due to the risk of undue prejudice. CP 757-62.

In response, Mrs. Harbottle characterized Dr. Braun's discovery responses as "untruthful testimony" and "perjury," and argued that evi-

dence of past patient complaints was admissible under ER 608(b) as relevant to credibility, which she claimed was “paramount” based on assertions that Mr. Harbottle’s death gave Dr. Braun “free reign to supplement the medical record with his self-serving testimony” and that the jury “should be entitled to know” that his “word cannot necessarily be trusted.” CP 822-26. Claiming that Dr. Braun’s schedule was “extremely busy,” she asserted that evidence he was “lingering” and spending time “coming-on[sic] to” female patients was relevant to explain why he “failed to review Mr. Harbottle’s chart” “during the three office visits prior to his untimely death.” CP 826-27. She also claimed that his failure to remember “multiple complaints of sexual misconduct” was relevant to show a “self-serving and highly selective memory loss” or to impeach his claim of memory of “key conversations with his now-deceased patient.” CP 827.

In reply, Dr. Braun noted that (1) Mrs. Harbottle’s claimed need to impeach his versions of specific conversations lacked a reasonable basis given his testimony that he had no “independent recollection,” generally or specifically, of conversations with Mr. Harbottle, but had to rely on medical records, chart notes, and habit and practice, CP 255, 864-65; (2) her assertion that Dr. Braun neglected Mr. Harbottle to focus on female patients lacked evidentiary support and was nothing more than an attempt to present inflammatory, irrelevant, and prejudicial innuendo at trial, CP

865-66; (3) admission of other patients' complaints would be unduly prejudicial and require a mini-trial on collateral issues so that Dr. Braun could offer his explanation, CP 865-66; and (4) the authorities Mrs. Harbottle cited did not support denial of the motion to exclude, CP 866-67.

After hearing argument before and after ordering MultiCare to produce records it claimed were privileged for in camera review, 8/25/17 RP 3, 5-7, 9-10, 12-13; 9/8/17 RP 8-36, and reviewing additional case law, 9/8/17 RP 31-36, the trial court granted the motion to exclude. CP 956-57.

4. The jury's verdict.

After a three-week trial, the jury returned a verdict answering "No" to the question "Was the Defendant, Kevin Braun, MD, negligent?" CP 1359-60. Judgment was entered on the jury's verdict. CP 1361-62.

IV. ARGUMENT

A. The Trial Court Properly Dismissed the Informed Consent Claim.

Mrs. Harbottle's argument, *App. Br. at 7-22*, that the trial court erred in dismissing her informed consent claim is ultimately based on her erroneous assertions, *App. Br. at 21*, that "Washington cases only foreclose a claim for failure to obtain informed consent in a situation where a physician misdiagnoses a condition if the physician's misdiagnosis meant he/she was unaware of the patient's possible condition" and that "where the physician knows of a condition but misdiagnoses it believing another

condition is present, the physician must advise the patient of the possible conditions known to him or her and inform the patient of them” Because Washington courts, including the Washington Supreme Court most recently in *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 613, 617, 331 P.3d 19 (2014), have repeatedly held otherwise, the trial court’s summary judgment dismissal of the informed consent should be affirmed. Moreover, because Mrs. Harbottle failed to present expert testimony establishing the risks of any treatment that Dr. Braun allegedly failed to disclose, or evidence that the Prilosec or Symbicort treatment he provided proximately caused injury to Mr. Harbottle, so as to make out a prima facie informed consent case, the trial court’s summary judgment dismissal of the informed consent claim should be affirmed.

1. The standard of review is de novo.

Appellate courts review summary judgment decisions de novo, engaging in the same inquiry as the trial court, to determine if there is any genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Volk v. DeMeerleer*, 187 Wn.2d 241, 254, 386 P.3d 254 (2016). An order granting summary judgment may be affirmed on any basis supported by the record. *LaMon v. Butler*, 112 Wn.2d 193, 200-01, 770 P.2d 1027, *cert. denied*, 493 U.S. 814 (1989); *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 789 n.3, 954 P.2d 319 (1998).

2. Washington courts have repeatedly held that failure to diagnose a condition is a matter of medical negligence, not of informed consent.

Standard of care and informed consent claims are two distinct claims; allegations supporting one normally will not support the other. *Gustav*, 90 Wn. App. at 789. The two claims have different foci, evident from their differing necessary elements of proof.

Under RCW 7.70.040, the necessary elements of proof of a medical negligence claim – that injury resulted from the failure of a health care provider to follow the accepted standard of care – are:

- (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.

Under RCW 7.70.050(1) the necessary elements of proof of an informed consent claim – that injury resulted from the failure to secure the patient's informed consent – are:

- (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.

Under RCW 7.70.050(2), a fact is considered “material” if “a reasonably prudent person in the position of the patient ... would attach significance to it in deciding whether or not to submit to the proposed treatment.”

“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 Wash.*, 137 Wn.2d 651, 659, 975 P.2d 950 (1999). Thus, if a physician fails to obtain the patient’s informed consent to a treatment before proceeding with the treatment and the patient is injured by the treatment, the patient has a cause of action for damages for failure to obtain informed consent even though the physician complied with the standard of care in performing the treatment. *Id.* at 660 (citing *Holt v. Nelson*, 11 Wn. App. 230, 237, 523 P.2d 211, *rev. denied*, 84 Wn.2d 1008 (1974)). But,

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

Backlund, 137 Wn.2d at 661. “In misdiagnosis cases, this rule is necessary to avoid imposing double liability on the provider for the same

alleged misconduct.” *Anaya Gomez*, 180 Wn.2d at 618 (citing *Backlund*, 137 Wn.2d at 661-62 n.2).

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

Anaya Gomez, 180 Wn.2d at 618 (affirming dismissal of informed consent claim against physician who did not inform patient who later died of sepsis of a blood culture positive for yeast, because based on patient’s clinical condition, physician believed the blood culture was a false positive); *see also Gustav*, 90 Wn. App. at 789 (informed consent claim properly dismissed where physician failed to diagnose prostate cancer believing instead that patient’s elevated PSA tests were due to chronic prostatitis or bacterial infection); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 260-61, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992) (informed consent claim properly dismissed because emergency room physician owed no duty to inform patient of time frame to treat condition he did not diagnose); *Bays v. St. Luke’s Hosp.*, 63 Wn. App. 876, 881-82, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992) (informed consent claim properly dismissed because physician owed no duty to discuss possible methods for treating thromboembolism where physician was “unaware of the thromboembo-

lism condition”); *Burnet v. Spokane Ambulance*, 54 Wn. App. 162, 168-69, 772 P.2d 1027, *rev. denied*, 113 Wn.2d 1005 (1989) (informed consent claim properly dismissed as physician had no duty to disclose risk of brain herniation and subsequent injury of which he was unaware).

Where a physician arguably misdiagnoses the patient’s condition and recommends a course of treatment for the patient based on that misdiagnosis, the physician is properly liable in negligence for the misdiagnosis if such diagnosis breaches the standard of care. But the physician should not be additionally liable under RCW 7.70.050 for a condition unknown to the physician. For example, a physician who misdiagnosed a headache as a transitory problem and failed to detect a brain tumor may be guilty of negligence for the misdiagnosis, but it seems anomalous to hold the physician culpable under RCW 7.70.050 for failing to secure the patient’s informed consent for treatment for the undetected tumor.

Backlund, 137 Wn.2d at 661 n.2 (citation omitted).

3. Because Dr. Braun had no duty to inform of possible treatments for a disease he did not believe Mr. Harbottle had, the informed consent claim was properly dismissed.

The problem of double liability for the same alleged misconduct arises when a plaintiff alleges that a health care provider (1) misdiagnosed the patient’s condition, and (2) failed to inform the patient about possible treatments for a particular disease of which the provider may have been aware but believed that the patient did not have. *Anaya Gomez*, 180 Wn.2d at 617. Thus, “when a health care provider rules out a particular diagnosis based on the patient’s clinical condition,” which includes “test results, medical history, presentation upon physical examination, and any

other circumstances that are available to the provider,” “the provider may not be liable for informed consent claims arising from the ruled out diagnosis under RCW 7.70.050.” *Id.* at 613.

In *Anaya Gomez*, after learning that the patient who had initially presented complaining of a urinary tract infection was feeling better, the physician did not inform the patient, who had uncontrolled diabetes that made her susceptible to infections, of a concerning lab result he received suggesting a yeast infection of the blood because, given the improvement in her condition, he concluded that the lab result was most likely a false positive due to contamination rather than reliable evidence of a very dangerous infection. *Id.* at 613-14. The physician moved up the patient’s next appointment, but when the patient’s condition worsened, she returned to the hospital, where she was diagnosed with a rare yeast infection in the blood that caused fungal sepsis and death. *Id.* at 614-15.

The patient’s husband proceeded to trial against the physician on both medical negligence and failure to obtain informed consent claims, but at the close of the husband’s case the trial court, concluding that this was a medical negligence misdiagnosis case and not an informed consent case, dismissed the informed consent claim. *Id.* at 614-15, 619. The Supreme Court affirmed, agreeing that “[o]n one set of facts the two theories are mutually exclusive” – either the physician “knew” the patient had a yeast

infection, “giving rise to a failure to inform claim,” or “he failed to know she had a yeast infection, giving rise to the negligence claim.” *Id.* at 619.

The Court rejected the husband’s claim that providers must inform patients “of all positive test results,” recognizing “the importance of taking the patient’s condition into account while making a diagnosis” and that lab tests are just “one tool among many that a health care provider uses to form a diagnosis.” *Id.* “[T]he duty to disclose does *not* arise ‘whenever [the provider] becomes aware of a bodily abnormality which may indicate risk or danger’ ... but rather turns on whether or not ‘the diagnosis has been completed.’” *Id.* at 620 n. 4 (emphasis in original) (quoting five-justice concurrence/dissent in *Keogan v. Holy Family Hosp.*, 95 Wn.2d 306, 329, 622 P.2d 1246 (1980)). Because “there is no duty to inform the patient on treatment options pertaining to a ruled out diagnosis,” and to hold the opposite “would require health care providers and patients to spend hours going through useless information that will not assist in treating the patient,” the Court concluded as a matter of law that the husband could only state a cause of action for medical negligence based on the misdiagnosis. *Anaya Gomez*, 180 Wn.2d at 623.

Here too, Mrs. Harbottle’s claims are mutually exclusive -- either Dr. Braun knew Mr. Harbottle’s symptoms had a cardiac cause giving rise to an informed consent claim, or he failed to know the condition of Mr.

Harbottle's heart giving rise to a medical negligence claim. Like the allegations in *Ayana Gomez*, the factual allegations here support only a medical negligence cause of action, because based on the circumstances surrounding Mr. Harbottle's condition, including his response to treatment for GERD, Dr. Braun did not believe coronary artery disease was a likely cause of Mr. Harbottle's symptoms. *See also Bays*, 63 Wn. App. at 883 ("A failure to diagnose a condition is a matter of medical negligence. We decline to create a second or alternate cause of action on informed non-consent to a diagnostic procedure predicated on the same facts necessary to establish a claim of medical negligence"); *Thomas*, 65 Wn. App. at 261 ("[f]ailure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform a patient"); *Gustav*, 90 Wn. App. at 790 ("While a physician has a duty to disclose an abnormality in the patient's body which may indicate risk or danger, a physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform. The duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it").

Based on Mr. Harbottle's clinical condition in June 2011, including his symptoms, history, physical exam, and EKG, Dr. Braun believed it was unlikely that his symptoms were due to heart disease. CP 263-65. When Mr. Harbottle returned a month later and reported resolution of his

symptoms with Prilosec, a treatment expectably effective for GERD but not cardiac problems, Dr. Braun was convinced that his initial diagnosis of GERD was correct and a cardiac cause was even less likely. CP 266. When Mr. Harbottle returned in March 2012 complaining of shortness of breath, Dr. Braun believed based on his clinical condition, including his allergy history and his low risk for cardiac-related causes, his symptoms were most likely due to an asthma-like condition and recommended treatment with Symbicort. CP 270. Because the Prilosec resolved his symptoms in 2011, CP 267-69, and Mr. Harbottle did not return to report whether the Symbicort prescribed in March 2012 resolved his symptoms, CP 270, Dr. Braun, like the physician in *Anaya Gomez*, was left with “nothing further to diagnose” and had no information to “put to the patient in the way of an intelligent and informed choice” about possible treatment, *Anaya Gomez*, 180 Wn.2d at 622 (quoting five-justice concurrence/dissent in *Keogan*, 95 Wn.2d at 330).

4. Mrs. Harbottle’s reliance on *Gates v. Jensen*, *Keogan*, *Flyte v. Summit View Clinic*, and the *Anaya Gomez* concurrence is misplaced.

Relying primarily on *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979), the three-person lead opinion in *Keogan*, 95 Wn.2d at 320-21; *Flyte v. Summit View Clinic*, 183 Wn App. 559, 333 P.3d 566 (2014), and the concurring opinion in *Anaya Gomez*, 180 Wn.2d at 627-31, Mrs.

Harbottle contends, *App. Br. at 20*, that (1) the duty to disclose may arise before a health care provider reaches a “conclusive” diagnosis, and (2) an informed consent claim is only unavailable when a the physician is “entirely unaware” of the patient’s condition. Her contentions are incorrect.

First, with regard to Mrs. Harbottle’s reliance on *Gates*, she ignores what the court in *Anaya Gomez* had to say about it. *App. Br. at 10-12*. While the Court in *Anaya-Gomez*, citing *Gates*, 92 Wn.2d at 250-51, recognized that “[i]n certain circumstances [it had] held that the right to informed consent can include the process of diagnosis,” it also recognized that *Gates* predated RCW 7.70.050’s codification of informed consent and its clear use of the word “treatment.” *Anaya Gomez*, 180 Wn.2d at 617. Also, the *Anaya Gomez* court recognized that “[t]he *Gates* court allowed the informed consent claim based on a unique set of facts,” *id.* at 623, that “*Backlund* clarifies that *Gates* is the exception and not the rule with regard to the overlap between medical negligence and informed consent, and that “[g]iven the unique factual situation in *Gates*, it is unlikely we will ever see such a case again,” *id.* at 626.

This case is not such a case and does not involve the unique factual situation present in *Gates*. In *Gates*, 92 Wn.2d at 247, the Court considered whether an informed consent claim existed when a physician failed “to inform a patient of a bodily abnormality discovered during a

routine examination and of diagnostic procedures” available “to determine the significance of that abnormality.” A patient “in a high risk group for glaucoma” complained to an ophthalmologist of symptoms consistent with glaucoma, submitted to a pressure test that indicated she was in the borderline area for glaucoma, as well as another test that was inconclusive, and then asked the doctor about the results. *Id.* at 247, 250. Rather than inform the patient of the high pressure readings, her high risk for glaucoma, and the availability of two “simple, inexpensive, and risk free” diagnostic tests for glaucoma he could have performed during the visit, he told her that “he had checked for glaucoma but found everything all right” and diagnosed her problem as difficulty adjusting to contact lenses. *Id.* at 247-48. Over the next two years as her condition worsened, the patient returned twelve times, but doctors at the eye clinic did not administer the simple tests. *Id.* at 248. Ultimately, the patient was diagnosed with glaucoma that left her functionally blind. *Id.* at 248-49.

The *Gates* court held that when a physician is aware of “[t]he existence of an abnormal condition in [the patient’s] body,” “the presence of a high risk of disease,” as well as “the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease,” the physician’s duty of disclosure arises and the physician must inform the patient of those facts to allow the patient to “make an informed

decision on the course which future medical care will take.” *Id.* at 251. According to the *Anaya Gomez* court, while *Gates* has not been overruled, it “stands for the proposition that patients have a right to be informed about a known or likely condition that can be readily diagnosed and treated.” *Anaya Gomez*, 180 Wn.2d at 626. The Court in *Anaya Gomez* distinguished *Gates*, however, because the doctor in *Anaya Gomez* may have suspected a yeast infection in the blood but had no reason to believe that the patient actually had the particularly dangerous kind of infection that ultimately caused her death based solely on his knowledge of “one blood test that was inconsistent with her physical condition and other tests, rendering the positive blood test more likely to be a false positive resulting from contamination.” *Id.* at 621 & n.5. The Court in *Anaya Gomez* also noted that even if the doctor had a “duty to follow up” with the lab, the parties had not raised the issue, and such an argument would be relevant only to medical negligence claim, not informed consent. *Id.* at 622 n.6.

Here, unlike in *Gates*, Dr. Braun was not aware of any abnormality in Mr. Harbottle’s body and, like in *Anaya Gomez*, believed that a cardiac cause of Mr. Harbottle’s symptoms was “very unlikely” in June 2011 and “even less likely” in July 2011 when Mr. Harbottle returned and reported that Prilosec had resolved his symptoms. CP 266. Similarly, in March 2012, when Dr. Braun’s evaluation of Mr. Harbottle’s clinical condition

suggested a respiratory-related cause of his symptoms, he had no reason to believe that a cardiac cause was any more likely than before. Moreover, to the extent Mrs. Harbottle's experts opined that the standard of care required Dr. Braun to "follow up" regarding referral to a cardiologist, as the *Anaya Gomez* Court recognized, such a duty to "follow-up" is only relevant to a medical negligence claim. In sum, *Gates* does not support an informed consent claim on the facts of this case.

Second, as for Mrs. Harbottle's reliance on *Keogan*, she cites, *App. Br. at 12-13*, the three-justice lead opinion, rather than the five-justice concurring/dissenting opinion that is the controlling opinion on informed consent in that case, as the Court in *Anaya Gomez*, 180 Wn.2d at 620-21 n.4, made clear. As the *Anaya Gomez* court recognized, the five justices dissenting from the lead opinion on the informed consent issue in *Keogan* held that "the duty to disclose does *not* arise 'whenever [the provider] becomes aware of a bodily abnormality which may indicate risk or danger,' as stated in *Gates*, but rather turns on whether or not 'the diagnosis has been completed.'" *Id.* (quoting *Keogan*, 95 Wn.2d at 329) (emphasis by the court). Thus, Mrs. Harbottle's claim, *App. Br. at 12-13*, that the *Keogan* court held the opposite is incorrect.

Third, as for *Flyte*, Mrs. Harbottle's reliance on it, *App. Br. at 18-21*, is also misplaced if for no other reason than *Flyte* did not involve a

negligent failure to diagnose claim. In *Flyte*, a woman who was seven months pregnant visited a clinic for symptoms consistent with the H1N1 virus, causing “swine flu,” about which the clinic had received public health alerts reporting a global pandemic and recommending prophylactic treatment of pregnant women with the drug Tamiflu. 183 Wn. App. at 562-63. The clinic staff did not inform the patient about the pandemic or the available Tamiflu treatment. *Id.* at 563. After the patient and her baby died, her husband sued the clinic, alleging a medical negligence claim for not considering the possibility of H1N1 and administering Tamiflu prophylactically and an informed consent claim for failing to inform the patient of the pandemic and the available Tamiflu treatment. *Id.*

Flyte did not involve a negligent failure to diagnosis claim. The husband did not contend that the clinic breached the standard of care by failing to diagnose H1N1; it was undisputed “that no test could detect H1N1 within the time that Tamiflu could most effectively treat the disease.” *Id.* at 576. Thus, unlike the claims in *Anaya Gomez* and Mrs. Harbottle’s claims here, the claims in *Flyte* were not mutually exclusive – the patient was pregnant and “showed symptoms arguably consistent with H1N1,” giving rise to a duty to inform her of the public health alerts and availability of Tamiflu, and the standard of care required offering Tamiflu prophylactically before confirming a diagnosis, giving rise to a medical

negligence claim regardless of the ultimate diagnosis. *Id.* at 577.

At issue on appeal in *Flyte* was whether the trial court erred in instructing the jury that “[a] physician has no duty to disclose treatments for a condition that may indicate a risk to the patient’s health until the physician diagnosis that condition.” *Id.* at 572. Citing the five-justice concurring/dissenting opinion that was controlling on the informed consent issue in *Keogan*, 95 Wn.2d at 329-30, that recognized that, even if no diagnosis had been made, a duty to disclose existed if the patient was to undergo a diagnostic procedure involving risk to the patient, the *Flyte* court concluded that applicable case law did not sweep so broadly as to support the proposition that no duty to disclose arises until a diagnosis has been made and the trial court’s instruction thus contained a clear misstatement of the law that was prejudicial. *Flyte*, 183 Wn. App. at 578.

Moreover, rejecting the Clinic’s claim that *Anaya Gomez*’s holding, 180 Wn.2d at 623, that “when a health care provider rules out a particular diagnosis based on the circumstances surrounding a patient’s condition ..., there is no duty to inform the patient on treatment options pertaining to the ruled out diagnosis” foreclosed Mr. Flyte’s informed consent claim, the *Flyte* court held that there was a disputed question of fact as to whether the clinic doctor had actually ruled out influenza. *Flyte*, 183 Wn. App. at 579-80. Although the doctor said he had ruled it out, he

admittedly had no independent memory of seeing the patient and based his testimony on chart notes that actually supported a contrary inference. *Id.*

Here, Dr. Braun was not aware of any abnormality in Mr. Harbottle's body and, based on the circumstances surrounding his condition, including Mr. Harbottle's symptoms, his history, his physical exam, his EKG, and his response to Prilosec treatment, did not believe it very likely that there was a cardiac cause of Mr. Harbottle's symptoms. CP 266. *Anaya Gomez*, rather than *Flyte*, controls here. As the *Anaya Gomez* court recognized, 180 Wn.2d at 618, "a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it."

Fourth, as for Mrs. Harbottle's reliance, *App. Br. at 16-17*, on the concurrence in *Anaya Gomez*, it does not support her argument that she has both a misdiagnosis medical negligence claim and an informed consent claim on the facts here. Beside the obvious reason that the majority opinion, rather than the concurrence, in *Anaya Gomez* is the binding opinion, the concurrence does not go as far as she suggests. In particular, the concurrence agreed that the example set out in *Backlund*, specifically, a misdiagnosis of "a headache as a transitory problem, resulting in a failure to detect a brain tumor," "would not support both a negligence claim and an informed consent claim," observing that it is "certainly true" that the

physician could not be “culpable under RCW 7.70.050 for failing to secure the patient’s informed consent for treatment for the undetected tumor.” *Anaya Gomez*, 180 Wn.2d at 629 (Gonzalez, J., concurring in result only). The concurrence, however, then posited “the potential claim the patient would have if the provider had also failed to secure informed consent before treating the transitory headache and an injury resulted,” opining that that scenario would support both types of claims “regardless of whether diagnosis rose to the proper standard of care.” *Id.*

Mrs. Harbottle’s claim is like the *Backlund* example rather than the potential claim posited in the concurrence. Mrs. Harbottle claimed that Dr. Braun’s misdiagnosis of GERD resulted in a failure to diagnose coronary heart disease. Even the concurring justices agreed that such a claim would not also support an informed consent claim for failing to provide information regarding treatment, or diagnostic procedures, for coronary heart disease. Mrs. Harbottle did not claim that any injury resulted from the Prilosec or Symbicort treatments Dr. Braun provided for Mr. Harbottle’s apparent GERD and respiratory ailment.

Finally, Mrs. Harbottle seems to suggest, *App. Br. at 19-20, 22*, that it is only when a physician conclusively or definitively rules out a particular diagnosis that there is no duty to inform, but that is not what *Anaya Gomez* or any of the other cases rejecting an informed consent

claim hold. Indeed, were that the rule, a plaintiff would always have an informed consent claim in a misdiagnosis or failure to diagnose case, as a physician obviously could not have conclusively ruled out a condition that the patient had, but the physician failed to diagnose.

Mrs. Harbottle also seems to suggest, *App. Br. at 15, 21*, that whenever a physician demonstrates awareness of a possible condition by including it in a differential diagnosis, the physician must inform the patient of diagnostic tests available to rule out the condition, no matter how rare or unlikely it is, but that too is not what the applicable case law holds. *See, e.g., Bays*, 63 Wn. App. at 881-83 (physician's inclusion of thromboembolism in differential diagnosis did not give rise to duty to disclose diagnostic tests and treatment for that condition); *Anaya Gomez*, 180 Wn.2d at 623 n.8 (“[T]here are] 200 different things that might cause chest pain, only 3 of which related to the heart.’ ... A health care provider cannot possibly inform a patient about every disease that might be causing each of his or her symptoms”) (quoting *Keogan*, 95 Wn.2d at 331, (Hicks, J., concurring in part, dissenting in part)).

If Dr. Braun misjudged the likelihood of a possible cardiac cause for Mr. Harbottle's symptoms, erroneously believed there was insufficient reason to suspect cardiac dysfunction, or failed to recognize a need to insist upon additional tests, that would give rise to a medical negligence

claim if it violated the standard of care (which the jury found it did not), but it would not give rise to a failure to secure informed consent claim. That is what cases such as *Anaya Gomez*, 180 Wn.2d at 623 n.8, *Gustav*, 90 Wn. App. 790-92, and *Bays*, 63 Wn. App. 881-83, make clear.

5. Mrs. Harbottle's informed consent claim was also properly dismissed because she failed to make out a prima facie case.

Under RCW 7.70.050, the necessary elements of an informed consent claim include (1) a failure to disclose “a material fact or facts relating to the treatment,” (2) the patient consented to treatment without knowing such material facts, (3) a reasonable patient would not have consented to the treatment if informed of such material facts, and (4) “the treatment in question proximately caused injury to the patient.” RCW 7.70.050 (emphasis added). As the court in *Anaya Gomez* observed, 180 Wn.2d at 617, “[t]he statute clearly uses the word ‘treatment,’ demonstrating the intent to limit informed consent claims to treatment situations.” Because Mrs. Harbottle failed to raise a genuine issue of material fact as to any failure to disclose any “material fact relating to the treatment” or that “the treatment in question proximately caused injury to the patient,” she failed to establish the first and fourth elements of an informed consent claim and the claim was properly dismissed.

With regard to the fourth element – that the treatment in question

proximately caused injury to the patient – Mrs. Harbottle has not presented any evidence that any treatment Dr. Braun provided proximately caused any injury to Mr. Harbottle. Thus, she failed to establish that necessary element of an informed consent claim warranting its dismissal.

With regard to the first element – failure to disclose material facts relating to the treatment – expert testimony is necessary to prove materiality. *Smith v. Shannon*, 100 Wn.2d 26, 34, 666 P.2d 351 (1983). “Specifically, expert testimony is necessary to prove the existence of a risk, its likelihood of occurrence, and the type of harm in question.” *Id.*

Here, Mrs. Harbottle failed to present expert testimony establishing the existence or likelihood of occurrence of any risk relating to the treatment Dr. Braun provided. Rather, she claims Dr. Braun “should have informed [Mr. Harbottle] of the risk of a cardiac cause” for his symptoms and “the need for further testing” and points only to her experts’ testimony that Dr. Braun “breached the standard of care in failing to treat [his] heart disease and in not securing performance of a stress test by a cardiologist,” and that Dr. Braun “should not have allowed the exercise treadmill test to be cancelled” and “should have followed-up” “regarding the need for the test.” *App. Br. at 4-5, 21-22.*

While such expert testimony was sufficient to support a medical negligence claim (a claim tried to but rejected by the jury), it was not

sufficient to establish the existence or likelihood of occurrence of any risk “relating to the treatment” Dr. Braun provided so as to support an informed consent claim. The trial court properly rejected Mrs. Harbottle’s attempts “to disguise a medical negligence issue as a failure to obtain an informed consent issue,” *Bays*, 63 Wn. App. at 882, and “to merge two distinct and logically separate causes of action,” *Gustav*, 90 Wn. App. at 791-92. The trial court’s summary judgment dismissal of the informed consent claim should be affirmed.

B. The Trial Court Properly Exercised Its Discretion in Excluding Evidence of Past Unrelated Grievances Against Dr. Braun.

Chastising the trial court for failing to sanction Dr. Braun for what she inflammatorily, but erroneously, characterizes as perjury and willful nondisclosure of past incidents of misconduct, Mrs. Harbottle asserts, *App. Br. at 22-39*, that the trial court erred in refusing to admit evidence of or impeachment as to past unsubstantiated and unrelated complaints other patients made against him. In so doing, Mrs. Harbottle gives at most lip service to the broad discretion afforded to the trial court in ruling on evidentiary matters, including those under ER 403 and 608(b), and ignores the fact that Dr. Braun has never been charged with, much less convicted of, perjury, and that she never moved the trial court for sanctions against Dr. Braun for his discovery responses. Because the trial court properly

exercised its discretion under ER 403 and ER 608(b) in excluding evidence or cross-examination as to other patients' unrelated complaints, its evidentiary ruling should be affirmed.

1. The standard of review is abuse of discretion.

Exclusion of evidence under ER 403 or ER 608(b) is within the discretion of the trial court. *Cantu v. Seattle*, 51 Wn. App. 95, 100, 752 P.2d 390 (1988) (ER 403); *State v. O'Connor*, 155 Wn.2d 335, 349-51, 119 P.3d 806 (2005) (ER 608(b)). A discretionary ruling "will not be disturbed on review except on a clear showing of abuse of discretion, that is, discretion manifestly unreasonable, or exercised on untenable grounds, or for untenable reasons." *State ex rel. Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971). Even if the appellate court disagrees with the trial court, "it may not substitute its judgment for that of the trial court unless the basis for the trial court's ruling is untenable." *Minehart v. Morning Star Boys Ranch, Inc.*, 156 Wn. App. 457, 463, 232 P.3d 591 (2010).

2. Mrs. Harbottle's incantation of "perjury" is inaccurate and does not render the trial court's exclusion of evidence as to other patient's complaints an abuse of discretion.

Mrs. Harbottle's counsel's use of inflammatory language, such as "perjury," "patently false testimony," "attempt to fool the tribunal," is not a substitute for an accurate description of the record and properly supported legal argument. In Washington, perjury is a felony that may be

charged by the prosecutor when, “in any official proceeding,” a person “makes a materially false statement which he or she knows to be false under an oath required or authorized by law.” RCW 9A.72.020. Aside from treason charges, the burden of proof necessary to sustain a perjury conviction is the strictest known to the law. *State v. Olson*, 92 Wn.2d 134, 136, 594 P.2d 1337 (1979). To prove perjury, the questions and answers supporting the allegation, when interpreted in context, must demonstrate that the speaker was fully aware of the actual meaning behind the examiner’s questions and knew that his or her answers were not the truth. *State v. Stump*, 73 Wn. App. 625, 628-29, 870 P.2d 333 (1994). “Precise questioning” is required for perjury; unresponsive answers to ambiguous questions do not raise an inference of perjury and cannot be submitted to a jury. *Id.* Moreover, a person cannot be convicted of perjury in certain circumstances “if he or she retracts his or her false statement in the course of the same proceeding in which it was made.” RCW 9A.72.060.

Mrs. Harbottle is obviously aware that Dr. Braun has not been convicted of perjury as she sought to cross-examine him on his initial interrogatory responses and deposition testimony not under ER 609(a)(2), which applies to “*conviction* evidence,” but under ER 608(b), which applies to “*nonconviction* evidence” and allows the trial court broad

discretion to admit or exclude evidence. *Loeffelholz v. C.L.E.A.N.*, 119 Wn. App. 665, 707-08, 82 P.3d 1199 (2004) (italics in original).

Based on the record before this Court, Dr. Braun could not even be charged with perjury, let alone convicted. To the extent his initial answers to overly broad interrogatories could be considered inaccurate in light of the unsubstantiated patient complaints made between 2003 and 2005, Dr. Braun filed supplemental responses explaining his misunderstanding of the full breadth of the questions. As for his answers to deposition questions, Dr. Braun admitted that there were “always complaints” and testified as to his general memory of complaints regarding prescriptions and his lack of memory of any other kinds of complaints. Mrs. Harbottle’s counsel’s *assumptions* as to whether Dr. Braun actually interpreted the interrogatory questions in the manner he claimed or actually remembered details of other kinds of complaints would be insufficient to support charges as perjury defendants “may not be assumed into the penitentiary.” *Stump*, 73 Wn. App. at 629 (citations and quotations omitted).

3. The trial court did not abuse its discretion in excluding evidence of other patients’ unrelated complaints.

Relying primarily on *State v. York*, 28 Wn. App. 33, 621 P.2d 784 (1980), Mrs. Harbottle argues, *App. Br. at 36-39*, that the trial court’s decision to foreclose impeachment of Dr. Braun’s trial testimony under

ER 608(b) with his discovery responses was reversible error. She asserts, *App. Br. at 37-38*, that her view of his “truthfulness” in discovery responses was “key” evidence for impeachment and germane to the issues at trial because Mr. Harbottle’s absence from trial would allow Dr. Braun “free reign to supplement the medical record with his self-serving testimony” and because defense experts relied on his testimony to support their opinions as to whether he met the standard of care. Contrary to Mrs. Harbottle’s assertions, the trial court did not abuse its discretion in excluding evidence or cross-examination as to other patients’ unrelated and unsubstantiated complaints.

Mrs. Harbottle’s description of *York* is an oversimplification; it does not require admission of the evidence at issue here. Before trial in *York*, the trial court granted the State’s request to exclude as “a collateral matter” cross-examination of an undercover investigator, who would testify that he had purchased two bags of marijuana from the defendant, about the fact that he had been fired from a previous job as a trainee in a Montana county sheriff’s office doing similar undercover drug bust work because of paperwork irregularities and unsuitability for the job. *York*, 28 Wn. App. at 34-35. At trial, the State presented evidence of the investigator’s military service and his other jobs doing undercover work, initially for the military and then for a city police department in a

neighboring county. *Id.* at 34. The defense presented “a substantial number of alibi witnesses” who testified that the defendant was not at the location where the alleged drug buy occurred. *Id.* at 34-35. The defense also sought to show that the investigator had a motive to fabricate the sale based on evidence that he was unemployed and penniless when he arrived in the county and that the county sheriff’s office paid him \$20 per successful drug buy for a total of \$740 during his brief tenure. *Id.* at 35. In closing argument, the prosecutor argued that there was “[a]bsolutely no reason at all” to doubt the investigator’s testimony; that he had “no axe to grind” and “no stake in the outcome”; that he was no longer working for the county sheriff; and that he’d “done a good job, just like he’s done in the past in his prior jobs.” *Id.* at 35.

The appellate court considered two questions: (1) whether evidence of the investigator’s Montana job difficulties was “merely collateral to the questions presented in [the] case”; and (2) if not, whether the judge properly limited cross-examination. *Id.* at 35. The court concluded that the evidence was not merely collateral because the State had argued that “there was nothing negative” in the investigator’s background, which “may have been the single factor” causing “the jury to believe him rather than the other witnesses.” *Id.* at 35-36. Because the investigator’s credibility as an undercover drug buyer was “the very

essence of the defense,” the evidence was “germane to the issue” at trial. *Id.* And, because a criminal defendant has a fundamental constitutional right to cross-examination, and thus should be given extra latitude to show motive or credibility, and because the trial court’s limitation of cross-examination of the undercover investigator called “into question the integrity of the fact-finding process,” particularly where the State had introduced the investigator’s extensive positive employment history while minimizing and obtaining suppression of the only negative employment history, the *York* court concluded that “fundamental fairness” required a new trial. *Id.* at 36-37.

In *State v. O’Connor*, 155 Wn.2d at 348-53, the Supreme Court discussed the *York* Court’s analysis of whether evidence sought to be explored during cross-examination under ER 608(b) is “merely collateral” or actually germane – that is, whether it is “relevant to facts at issue in [the] case” and to veracity on the stand. As the Court observed in *O’Connor*, 155 Wn.2d at 350, “[p]rohibiting the trial court from considering” “germaneness to the issue” “could result in a system under which the trial court is constitutionally *required* to admit *any* instance of a key witness’s prior misconduct.” Because the language of ER 608 “clearly” “grants trial courts discretion to make such determinations” and “Washington courts have been clear that not every instance of a witness’s

(even a key witness's) misconduct is probative of a witness's truthfulness or untruthfulness under ER 608(b)," trial courts have broad discretion to consider the relevance of such evidence. *Id.* at 350-51 (citing *State v. Benn*, 120 Wn.2d 631, 651, 845 P.2d 289 (1993) (witness's drug dealing did not impact his ability to testify as to discussions with defendant); *State v. Kunze*, 97 Wn. App. 832, 859 P.2d 977 (1999) (admission of instances of lying, either sworn or unsworn, is "highly discretionary"))).

In *O'Connor*, the State charged O'Connor with malicious mischief for allegedly slashing the tires on Rachel Bologna's car. 155 Wn.2d at 337. Investigators discovered that O'Connor gave Bologna money to replace the tires in addition to funds she received from her insurance company. *Id.* at 339-40. When the State moved to exclude evidence that she kept the difference between the total amount she received and the amount she paid to replace the tires, O'Connor asserted that that fact "goes to her credibility, her ability to tell the truth on the stand," and was a proper subject for cross-examination under ER 608(b). *Id.* at 339. The trial court disagreed, concluding that the evidence may have some relevance to her character, but was not materially relevant to the issue for trial – whether O'Connor committed the crime. *Id.* at 340.

The Supreme Court affirmed, noting "there were other avenues for challenging Bologna's credibility," including "inconsistencies" between

her statements, and that the retention of the money may reflect dishonesty but did not involve a lie under oath. *Id.* at 351-52. Moreover, the Court held that the trial court “acted within its discretion when it determined” that the evidence “was not probative of Bologna’s truthfulness on the stand because it was simply too attenuated from her testimony regarding the events on the night in question.” *Id.* at 352-53.

Here, the trial court properly exercised its discretion to determine whether the evidence at issue was relevant both to Dr. Braun’s truthfulness on the stand as well as to the factual issues for trial. Even if the trial court had interpreted Dr. Braun’s failure to disclose the other patients’ complaints in his initial answers to certain interrogatories or in response to certain deposition questions as evidence of an unwillingness to admit to remembering unsubstantiated allegations of sexual misconduct or a lack of memory, the trial court still, in the proper exercise of its discretion, could have concluded that such evidence was too attenuated from his testimony regarding the medical care he provided to Mr. Harbottle to be germane to the issues in the case.¹

¹ In a footnote, *App. Br. at 38 n. 20*, Mrs. Harbottle tries to claim, as she did below, CP 820-21, that evidence of three patients’ complaints of sexual misconduct was admissible to show that Dr. Braun was spending excessive amounts time with female patients and thus had limited time to spend working-up or reviewing charts of his male patients. But, even Mrs. Harbottle’s counsel agreed with the trial court that there “would never ... be a reveal to the jury” as to the claims of sexual misconduct, as that would be “way too prejudicial.” 9/8/17 RP 26. The trial court even told counsel for Dr. Braun that he did not need to argue against that claim. 8/25/17 RP 9.

First, Dr. Braun's testimony about his medical care was based on his chart notes and his general practice habits, not his memory. Second, the central issue for the jury – whether Dr. Braun met or breached the standard of care – did not turn on Dr. Braun's truthfulness regarding his memory of patient complaints occurring years before the treatment at issue, but on his explanation, and both sides' experts' interpretation, of his chart notes and Mr. Harbottle's other medical records. Third, Mrs. Harbottle has not shown that Dr. Braun's testimony at trial differed from the chart notes or medical records, or that he claimed that his memory at trial was more trustworthy than the chart notes or medical records he relied upon for his defense. Fourth, contrary to Mrs. Harbottle's repeated mischaracterizations, Dr. Braun's discovery responses and deposition answers did not involve any lies under oath, as he supplemented his interrogatory answers and explained his misunderstanding as to what kind of information the interrogatories sought, and there is no evidence, beyond assumption, that he was inaccurate at his deposition in his description of his memory. Fifth, although Mrs. Harbottle repeatedly asserts that Dr. Braun purposely concealed his real reason for leaving MultiCare, there is no evidence establishing that he did not genuinely believe that his main reasons for leaving were those stated at his deposition.

Moreover, the trial court, in the exercise of its discretion, properly

could conclude that any limited probative value the evidence of past complaints might have with regard to Dr. Braun's credibility was substantially outweighed by the danger of unfair prejudice, confusion of the issues, waste of time, or misleading of the jury under ER 403. *See* 9/8/17 RP 26-28 (where trial court expressed concerns that evidence of prior sexual misconduct complaints would be far too prejudicial, as would simply allowing Mrs. Harbottle's counsel to cross-examine Dr. Braun about his discovery responses and the existence of some of unspecified patient complaints that he did not initially disclose, leaving the jury to wonder what those complaints were and letting those complaints detract from the real issue in the case).

Under such circumstances, the trial court's exclusion of evidence and cross-examination as to other patients' complaints was not an abuse of discretion and should be affirmed.

4. Mrs. Harbottle's discussion of sanctions for discovery violations has nothing to do with the propriety of the trial court's evidentiary ruling and ignores that she never moved the trial court for any such sanctions.

Mrs. Harbottle devotes multiple pages of her opening brief regarding the trial court's exclusion of evidence of other patients' complaints to discussion of case law concerning sanctions for discovery violations and repeatedly suggests that the trial court should have sanctioned Dr. Braun

so that he would “not be allowed to benefit from his lack of candor in discovery” or “rewarded” for “his misconduct.” *See App. Br.* at 22-26, 29, 39. But, Mrs. Harbottle did not move for sanctions or ask the trial court to admit evidence of other patients’ unsubstantiated and unrelated complaints as a discovery sanction. Nor does she cite any authority suggesting that admission of otherwise highly prejudicial and excludable evidence is an appropriate sanction for a discovery violation. Thus, this Court need not consider her discovery sanctions arguments on appeal.

5. Mrs. Harbottle’s discussion of RCW 70.41.200 also has nothing to do with the propriety of the trial court’s exclusion of evidence of other patients’ unrelated complaints.

In her opening brief, Mrs. Harbottle also devotes several pages to a discussion of RCW 70.41.200, regarding the privilege applicable to quality improvement materials prepared by hospitals. *App. Br.* at 29-33. Her reason for including this discussion is unclear, as Dr. Braun did not assert any privilege under RCW 70.41.200 as a basis for excluding the evidence,² nor does the record suggest that the trial court excluded the evidence on the basis of any such privilege.

² To the extent MultiCare withheld certain records (that it later produced for in camera inspection) on the basis of privilege, it did so on the basis that such records were prepared for purposes of peer review and quality improvement under the MultiCare Medical Group’s Coordinated Quality Improvement Program under RCW 43.70.150 and RCW 70.41.200. *See* CP 594.

6. Mrs. Harbottle has not provided a record of the trial proceedings and thus cannot establish prejudice resulting from the trial court's exclusion of evidence of other patients' complaints.

Even if the trial court had abused its discretion in preventing impeachment under ER 608(b), which it did not, such “error without prejudice is not grounds for reversal” and is considered harmless unless it affects the outcome of trial. *Brown v. Spokane County Fire Prot. Dist. No. 1*, 100 Wn.2d 188, 196, 668 P.2d 571 (1983). Without the trial record, however, this Court cannot determine whether the excluded evidence affected the outcome of the trial. *See Allemeier v. Univ. of Wash.*, 42 Wn. App. 465, 472-73, 712 P.2d 306 (1985).

Although Mrs. Harbottle claims she was prejudiced by the trial court's evidentiary ruling, *App. Br. at 33, 37, 39*, and she bears the burden of providing a sufficient trial record for review, *Allemeier*, 42 Wn. App. at 472; RAP 9.2(b), she chose not to provide a transcript of the trial to allow this Court to evaluate the effect, if any, of the trial court's challenged evidentiary ruling on the outcome of the case. For this reason alone, this Court should not reach the merits of her claim and should affirm the trial court's evidentiary ruling. *Allemeier*, 42 Wn. App. at 472-73.

V. CONCLUSION

For the foregoing reasons, the trial court's summary judgment dismissal of the informed consent claim, exclusion of evidence of other patients' unrelated complaints, and entry of judgment on the jury's verdict should be affirmed.

RESPECTFULLY SUBMITTED this 11th day of June, 2018.

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