NO. 32934-8-III

COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

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

Appellants,
v.

SAMUEL JOSEPH, D.O.,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

In this medical malpractice action, John J. Eikum, on behalf of the estate of his deceased wife, Joan R. Eikum, sued Dr. Samuel Joseph for failing to diagnose Mrs. Eikum's heart condition and pronouncing her ready for an elective knee surgery. After the elective knee surgery, Mrs. Eikum had a heart attack, and several weeks later died.

Although Mr. Eikum asserted and tried to prove claims for both medical negligence and failure to obtain informed consent, the trial court dismissed the informed consent claim at the close of Mr. Eikum's case. The trial court concluded that Mr. Eikum's claim was one for negligent failure to diagnose Mrs. Eikum's underlying heart condition, not one for failure to obtain informed consent, as Dr. Joseph had no duty to warn of a heart condition of which he was unaware. If the jury found that he should have been aware of Mrs. Eikum's heart condition, then Mr. Eikum would be entitled to recover under his medical negligence claim.

Mr. Eikum's medical negligence claim was submitted to the jury. The jury returned a verdict in favor of Dr. Joseph, finding that he did not violate the standard of care in his treatment of Mrs. Eikum.

On appeal, Mr. Eikum claims that the trial court erred (1) in dismissing his informed consent claim; (2) allowing information from a learned treatise to be read to the jury; and (3) refusing certain of his

proposed jury instructions. Because the trial court correctly dismissed the informed consent claim, properly allowed information to be read from a learned treatise, and properly refused to give Mr. Eikum's proposed jury instructions, this Court should affirm the trial court's entry of judgment on the jury verdict in favor of Dr. Joseph.

II. COUNTERSTATEMENT OF ISSUES PRESENTED

(1) Did the trial court properly dismiss Mr. Eikum's informed consent claim on grounds that the failure to diagnose a condition gives rise to a claim of medical negligence if the physician violated the standard of care, but not an informed consent claim?

(2) Did the trial court properly allow experts to testify about, and pursuant to ER 803(a)(18) read excerpts from an admittedly authoritative medical treatise concerning, a revised cardiac risk index, without requiring that the entire treatise remain present, or that authorities cited or referenced in that treatise be present in the courtroom?

(3) Did the trial court properly exercise its discretion in not giving certain of Mr. Eikum's proposed jury instructions, where the instructions did not accurately state the applicable law, were not necessary, were slanted and argumentative, would have impermissibly commented on the evidence and/or attempted to infuse his dismissed informed consent claim back into the case?

III. COUNTERSTATEMENT OF THE CASE

Dr. Joseph, an osteopathic physician, board-certified in internal, pulmonary, and critical care medicine, received his D.O. degree from the Philadelphia College of Osteopathic Medicine in 1979, completed his internship and internal medicine residency at Letterman Army Medical Center in 1982, and then did a two-year pulmonary and critical care medicine fellowship at Walter Reed Army Medical Center. RP 1342-45. After completing his Army obligation, he moved to Spokane, practiced at Rockwood Clinic for 12 years, and then, in 2001, joined Spokane Respiratory Consultants, where he saw Mrs. Eikum. RP 1346-48.

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

Mrs. Eikum developed diabetes in 1958 and became insulin dependent in about 1962. RP 210. Dr. Joseph first saw her in April 2005, after her previous physician, Dr. Klock, retired. RP 214, 216-17. She had a three-month history of chronic cough with phlegm. RP 1920. Her diabetes was not well-controlled and Dr. Joseph urged her to comply with her diet and exercise and considered changing her medications. RP 1913.

When Mrs. Eikum's cough persisted despite antibiotics, Dr. Joseph ordered breathing tests and a chest x-ray in September 2005. RP 1922-23. The x-ray was normal, with normal heart size, no evidence of pneumonia or of fluid around the lungs, and no obvious signs of infection. RP 1927.

The pulmonary function tests though showed mild air flow obstruction and very mild reduction in lung size. RP 1923-24. Dr. Joseph diagnosed asthma, RP 1929, and prescribed Advair, a combination inhaled steroid and bronchodilator, RP 1924. By November 2005, Mrs. Eikum's cough resolved, with Advair providing good results. RP 1928.

In April 2006, Mrs. Eikum reported that her "breathing [was] good using Advair only at night," even though Dr. Joseph had prescribed its use twice daily. RP 1929-30. He reduced her Advair dosage to use up to twice daily, but gave her the option to use it as she felt necessary. RP 1930. As of April 2006, Dr. Joseph's diagnoses for Mrs. Eikum were: (1) asthma; (2) diabetes mellitus; (3) question irritable bowel syndrome; and (4) hypertension. RP 1930.

By November 2006, Mrs. Eikum's breathing reportedly was not a problem and she had discontinued Advair, although Dr. Joseph recommended that she remain on it. RP 1931-33. He referred her to a diabetic clinic to assist in managing her diabetes, but she did not go. RP 1915-16.

In February 2007, Mrs. Eikum called Dr. Joseph's office complaining of a cough for ten days, with bowel or bladder incontinence while coughing. RP 1932. Dr. Joseph prescribed an anti-cough medication, but, by March, despite the medication, the cough persisted with occasional white phlegm. RP 1932-33. Mrs. Eikum was still not using the Advair,

and Dr. Joseph recommended she use it twice daily. RP 1933.

In April 2007, Mrs. Eikum reported that her "breathing was better using Advair" and did not report a cough. RP 1934. In February 2008, she complained of increased cough for two weeks. RP 1934. She was only using Advair intermittently, despite Dr. Joseph's recommendations. RP 1934-35. He again advised her to use it once to twice daily. RP 1935.

In September 2008, Mrs. Eikum was coughing with associated urinary incontinence, though her breathing was doing well. RP 1936. She continued to report breathing well in October 2008. RP 1936. In October 2008, Dr. Joseph detected bruits, a sound of blood rushing, RP 1741, in Mrs. Eikum's carotid arteries. RP 1970. He ordered an ultrasound to make sure there was no significant blockage in the artery and it did not show blockage. RP 1742.

From November 2008 to early January 2009, Mrs. Eikum had some falling or fainting spells at home. RP 230-31. When she fell off the toilet in early January, her husband took her to the emergency room. RP 231-32. Dr. Joseph saw Mrs. Eikum on January 21, 2009, after her visit to the emergency room for her falls. RP 1937-38. She reported no breathing problems, and was using Advair, but not regularly. RP 1937. Dr. Joseph's assessment was asthma with self-nihilism, *i.e.*, not taking medications (Advair) as prescribed. RP 1937. He ordered additional

pulmonary function tests, in follow up to the tests done in 2005, to see how Mrs. Eikum was doing with her asthma. RP 1938.

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

Dr. Joseph also obtained a chest x-ray in January 2009 that he compared to the x-ray taken in March 2007. RP 1942. The 2009 x-ray was unremarkable, as the heart size was normal, and there were no indications of blood vessel engorgement or pneumonia. Dr. Joseph's impression was that Mrs. Eikum had no acute cardiopulmonary disease. RP 1942. In January 2009, he also did arterial blood gas testing that was normal, and laboratory studies that had no results of clinical significance. RP 1943-45.

In March 2009, Dr. Joseph did a physical examination, in part

because of Mrs. Eikum's need for a pre-surgical evaluation for an elective knee surgery.[1] RP 1951-58, 1963-65. Her pulse rate and rhythm, respiratory rate, and blood pressure were all normal. RP 1951. Her veins were not distended, indicating a normal pressure in the right side of her heart. RP 1953. Dr. Joseph listened to her lungs and performed a cardiac exam, listening for a regular rhythm and checking for murmurs, gallops or other abnormal heart sounds. RP 1954. The cardiac exam was normal and Mrs. Eikum had no breathing difficulties. RP 1953-55. She had no abnormalities on physical examination. RP 1955. Dr. Joseph saw no need to repeat the EKG, as he had seen the recent EKG from the emergency room visit, he had the Holter monitor rhythm demonstration, and all of her tests showed no indication of any cardiac or respiratory problems. RP 1963.

Dr. Joseph concluded that Mrs. Eikum was "ready for surgery," meaning he "found no reason not to proceed with the surgeon's further evaluation to see if she was a surgical candidate from a surgical point of view, and that there was no medical reason to halt them in any way." RP 1964. His "ready for surgery" conclusion was also based on the revised cardiac risk index, which is predictive of cardiac complications after non-cardiac surgery. RP 1032-33. Using that index, Mrs. Eikum had only one risk factor – diabetes, RP 1965-66, which did not preclude her from

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

having the surgery. RP 2015-18. Dr. Joseph did not believe a cardiology referral was indicated. RP 2018-19. He "[a]bsolutely" did not suspect that Mrs. Eikum had any cardiac dysfunction. RP 2066-67.

B. The Lawsuit.

Mrs. Eikum underwent elective knee surgery on April 6, 2009, CP 9, and suffered a heart attack the early morning of April 8, 2009, RP 768, 1415. An angiogram done after her heart attack showed severe three-vessel coronary artery disease, RP 812, and an echocardiogram showed moderate aortic stenosis, weakened heart muscle, and coronary artery disease, RP 793. Mrs. Eikum underwent emergency coronary artery bypass surgery, RP 770, but died on April 27, 2009, RP 767. Mr. Eikum sued Dr. Joseph for failing to properly diagnose Mrs. Eikum's heart condition and clearing her for elective knee surgery, alleging both medical negligence and lack of informed consent claims. CP 3-15.

C. The Defense Theory of the Case and Expert Testimony.

The defense theory of the case was that (1) Dr. Joseph fully complied with the applicable standard of care and, based upon his physical examinations and work-up of Mrs. Eikum, had no reason to suspect that she had any cardiac dysfunction or needed any further cardiac assessment; (2) had an echocardiogram been done prior to her knee surgery, it would have revealed only moderate aortic stenosis, which is not a

contraindication for that surgery; (3) Mrs. Eikum had not had a previous heart attack; (4) more likely than not, Mrs. Eikum did not have significant blockage of her coronary arteries prior to her knee surgery; and (5) her heart attack after the surgery was due to a sudden thrombus that occluded the left main coronary artery. Dr. Joseph called four experts, Dr. Potyk, Dr. Doornick, Dr. Davidson, and Dr. Peterson, who, consistent with the defense theory of the case, testified as follows.

1. Defense expert Darrell Potyk, M.D.

Dr. Potyk, a board-certified internal medicine physician, RP 1019, and full-time UW School of Medicine residency program faculty member, RP 1016-17, testified that Dr. Joseph complied with the standard of care in his care of Mrs. Eikum, RP 1101, and that there was no reason to suspect heart disease or do further testing. RP 1087-89.

According to Dr. Potyk, the January 2009 EKG was not concerning, did not have worrisome characteristics, and was basically the same as the 2007 EKG. RP 1053-54. Even comparing the prior EKGs to the April 2009 pre-surgical EKG, all of the EKGs were benign and did not require further action. RP 1055-56. Nor was an echocardiogram required after Mrs. Eikum's October 2009 carotid duplex ultrasound. RP 1058. The ultrasound was done because of the bruit Dr. Joseph heard and a concern whether there was narrowing of a carotid artery, but "the ultra-

sound did not show any narrowing of those arteries that supply the brain," RP 1058, or any atherosclerotic disease. RP 1088. In Dr. Potyk's opinion, Mrs. Eikum's syncope, fainting and falling episodes in December 2008 and January 2009 were not caused by a cardiac condition. RP 1082-85. He "did not see symptoms that were diagnostic of coronary disease" as of March 12, 2009, the last visit with Dr. Joseph. RP 1087-88. Because Mrs. Eikum did not have symptoms of coronary artery disease, Dr. Joseph did not need to perform a specific work up for heart issues. RP 1087-89.

2. Defense expert Daniel Doornick, M.D.

Dr. Doornick a board-certified internal medicine physician, RP 1734, who practices in Yakima, RP 1732, concurred that Dr. Joseph met the standard of care in treating Mrs. Eikum. RP 1741. As he explained, the medical records from multiple physicians did not detect any heart murmurs. RP 1756-57. Mrs. Eikum's syncope episodes in December 2008 and January 2009 were not due to her aortic stenosis, but were more likely related to low blood pressure as a result of having been on a diuretic, and having a viral illness, diarrhea and low potassium. RP 1775-76. The results of her Holter monitor showed no worrisome signs or electrical issues with the heart. RP 1774-75. The January 2009 x-ray showed nothing abnormal or concerning. RP 1793-94. Dr. Doornick concurred that Mrs. Eikum was ready for surgery. RP 1791. Based on her

presentation and test results, there was no need to refer Mrs. Eikum to a cardiologist for further work-up or get an echocardiogram. RP 1776-77.

3. Defense expert John Peterson, M.D.

Dr. Peterson, a board-certified cardiologist practicing in Spokane, also testified that Dr. Joseph complied with the standard of care. RP 1453. At the time of Mrs. Eikum's surgery, the stenosis in her coronary arteries was less than 50%. RP 1422. Had an echocardiogram been done in January of 2009, it would have been diagnostic of coronary artery disease only if she had previously suffered a heart attack, RP 1437, but there is no evidence of heart attack on either the October 2007 or the January 2009 EKGs. RP 1445-51. Even the April 6, 2009 EKG was not diagnostic of any heart disease and would be considered benign. RP 1451. There was no indication to send Mrs. Eikum for a cardiology consultation or for an echocardiogram. RP 1455-56. Even if an echocardiogram had been done, it only would have shown moderate aortic valve stenosis, which is not a contraindication for knee surgery. RP 1457. Moreover, the Holter monitor and EKG results did not show any significant abnormalities. RP 1447-49; 1463-64. Pursuant to the revised cardiac risk index, Mrs. Eikum was considered "low risk" for her knee surgery. RP 1491-92.

4. Defense expert Charles Davidson, M.D.

Dr. Davidson, an interventional cardiologist at Northwestern

University in Chicago, RP 1671, testified that there was no evidence that, before her knee surgery, Mrs. Eikum had a previous heart attack, RP 1702, and that her heart attack after the knee surgery was caused by a plaque rupture causing a thrombus (clot) into the left main coronary artery, and extending to the left anterior descending and circumflex arteries, leading to hypotension and heart attack. RP 1688, 1692.

Mrs. Eikum, who had no angina symptoms, most likely had a sudden rupture of soft plaque forming a clot and impairing blood flow, rather than a fibrous hardened calcified blockage. RP 1688-91. Most sudden soft plaque ruptures occur in areas where there is insignificant plaque, less than 50%, which was most likely the scenario for Mrs. Eikum. *Id.* Thus, an angiogram done a month prior Mrs. Eikum's surgery would not have shown significant blockage. RP 1690, 1702-03. While discovery of a 40-50% blockage might have led to medical therapy (such as changes in diet, exercise, and blood pressure management), it would not have led to mechanical intervention, such as bypass surgery or stent, which does not occur until there is 70% or more blockage. RP 1724-26.

D. Mr. Eikum's Theory of the Case and Expert Testimony.

Mr. Eikum's theory of the case was that (1) Mrs. Eikum had signs and symptoms of cardiac disease; (2) the tests Dr. Joseph ordered did not rule out cardiac disease; (3) Dr. Joseph violated the standard of care by

failing to order additional tests, such as an echocardiogram, and by failing to refer Mrs. Eikum to a cardiologist, or at least discuss with her why he decided against referring her to a cardiologist; and (4) additional testing and referral would have revealed Mrs. Eikum's severe coronary artery disease, the knee surgery would have been postponed, and a non-emergent bypass surgery would have been done with a success rate of 94%. In his case-in-chief, Mr. Eikum called two experts, Dr. Stricke and Dr. Caren as well as Mrs. Eikum's treating cardiologist in April 2009, Dr. Boulet, who, consistent with his theory of the case, testified as follows.

1. Mr. Eikum's expert Leslie Stricke, M.D.

Dr. Stricke, a board-certified pulmonologist, RP 277, from Los Angeles, RP 274, testified that Dr. Joseph violated the standard of care by failing to investigate symptoms and physical findings, RP 291-92, failing to do additional testing, RP 291-92, and by failing to communicate with the patient regarding a possible cardiac consultation. RP 292-95. According to Dr. Stricke, Mrs. Eikum's symptoms were not explained by a diagnosis of chronic obstructive pulmonary disease, and the pulmonary function tests Dr. Joseph ordered did not rule out heart disease. RP 298. He testified that other tests and evaluations Dr. Joseph performed revealed abnormal results, such as the bruit he heard, RP 313, the January 2009 EKG, RP 352, and the Holter monitor, RP 358-60. In his view, those

results required an echocardiogram and a referral to a cardiologist or vascular surgeon. RP 316, 321. According to Dr. Stricke, Dr. Joseph, by failing to do those additional referrals or tests, and by declaring Mrs. Eikum "ready for surgery" without them, violated the standard of care. RP 291-92. Moreover, in his view, Dr. Joseph violated the standard of care when, after considering a cardiac consultation, to rejected getting one without discussing it with Mrs. Eikum. RP 291-93.

According to Dr. Stricke, an echocardiogram would have diagnosed Mrs. Eikum's aortic stenosis and likely would have shown that her left ventricle was not functioning normally. RP 375. In his view, a cardiologist should have been involved "to make a decision whether the patient needed to have a cardiac stress test before surgery." *Id.*

2. Mr. Eikum's expert Jeffrey Caren, M.D.

Dr. Caren, board-certified in internal medicine and cardiovascular disease, RP 536, testified that Dr. Joseph violated the standard of care in that "his obligation was to identify her surgical risk from a medical point of view, and he failed to do that, and there were findings prior to surgery that were not properly pursued that would have identified that risk." RP 547-48. He believed Mrs. Eikum's episodes of syncope, shortness of breath and dyspnea should have been further evaluated. RP 548. In his view, she had abnormal EKGs consistent with coronary artery disease,

necessitating further testing, as none of the tests Dr. Joseph ordered ruled out coronary artery disease, aortic stenosis or ventricular dysfunction. RP 548-49, 578. According to Dr. Caren, the standard of care required the ordering of an echocardiogram, RP 579-80, and Dr. Joseph violated the standard of care in pronouncing her ready for surgery without ruling our cardiac disease. RP 592. In his view, before her knee surgery, Mrs. Eikum had three vessel coronary artery disease, moderate aortic stenosis, and ventricular dysfunction, and the failure to diagnose those conditions reduced her chance of survival by more than 50%. RP 608-10.

Dr. Caren, however, agreed that EKGs are not diagnostic of coronary artery disease, RP 548, that the carotid artery ultrasound showed no obstruction, RP 550, and that moderate aortic valve stenosis can be asymptomatic. RP 653. He also agreed that Mrs. Eikum never had symptoms of chest pain before April 2009. RP 682.

3. Mrs. Eikum's treating cardiologist Andrew Boulet, M.D.

Dr. Boulet, Mrs. Eikum's treating cardiologist at Providence Hospital in April 2009, testified that an angiogram and echocardiogram after Mrs. Eikum's heart attack showed moderate aortic stenosis and severe coronary artery disease. RP 793-94, 812-14. In his view, these conditions take years to develop and would have been present before Mrs. Eikum's knee surgery. RP 781, 851. If these conditions had been

discovered before Mrs. Eikum's surgery, Mrs. Eikum would not have been an appropriate candidate for knee surgery until she had cardiac bypass surgery. RP 851. If a non-emergent bypass surgery had been done before Mrs. Eikum's heart attack, her survival rate would have been 90-94%. RP 852-53. According to Dr. Boulet, Mrs. Eikum's death was caused by "[r]espiratory failure as a result of multiple organ failure, including sepsis and stroke with brain injury, kidney and liver failure after having undergone a bypass surgery with the aortic valve replacement." RP 767. In his view, her knee replacement and post-operative heart attack, along with her obesity, contributed to her death. RP 767-68.

Dr. Boulet, however, admitted that moderate aortic valve stenosis may not cause any symptoms, RP 862, and agreed that EKGs are not diagnostic for coronary artery disease. RP 869. During his consult on April 8, 2009, the Eikums did not say anything suggestive of congestive heart failure or prior chest pain, RP 873-74, and Mrs. Eikum had no evidence of previous shortness of breath, RP 877-78. Dr. Boulet agreed that it would be very unusual for a person to have critical blockages in her coronary arteries and yet have none of these symptoms. RP 877-78.

E. The Motion for Directed Verdict on the Informed Consent Claim.

At the close of Mr. Eikum's case, Dr. Joseph moved for a directed verdict. His attorney argued that "[t]his is a failure to diagnose or

misdiagnosis case, and I think our authorities make it abundantly clear that if you don't know or are unaware of a condition, you're not obliged to inform of risks or treatment options associated with it." RP 1103. Mr. Eikum's counsel disagreed, and, referring to *Gates v. Jensen*, argued that "the conditions exist in here that were symptomatic were never excluded." RP 1107. Thus, she argued, Dr. Joseph had a duty to explain the test results and offer additional tests. RP 1108-09.

After taking the weekend to consider the arguments of counsel, the trial court issued its ruling, RP 1126-27:

> The testimony presented is that Dr. Joseph didn't inform Mrs. Eikum about her heart condition when he cleared her for the knee surgery. Yet, there's been no testimony that Dr. Joseph knew of the heart condition and failed to inform her of the possible treatments. It's clear from the case law that a provider cannot be liable for informed consent claims arising from the ruled out diagnosis under 7.70.050.
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> At this point based on all that case law, the Court is going to grant the defendant's motion and dismiss the informed consent claim and just go forward with the negligence claim at this point.

F. The Jury Verdict and Judgment.

Mr. Eikum's medical negligence claim was submitted to the jury. The jury returned a verdict in favor of Dr. Joseph, finding that he did not violate the standard of care in his treatment of Mrs. Eikum, CP 153, and the trial court entered judgment on that verdict. CP 155-56.

IV. ARGUMENT

A. The Trial Court Did Not Err in Dismissing Mr. Eikum's Informed Consent Claim.

Contrary to Mr. Eikum's assertions, *App. Br. at 23-36*, the trial court correctly ruled that the failure to diagnose Mrs. Eikum's heart condition gave rise to claim for medical negligence, not a claim for failure to obtain informed consent, as Dr. Joseph could not be expected to inform about a condition he was unaware Mrs. Eikum had.

1. Standard of review.

Under CR 50(a)(1), judgment as a matter of law (or a directed verdict) may be granted if "a party has been fully heard with respect to an issue and there is no legally sufficient evidentiary basis for a reasonable jury to find or have found for that party with respect to that issue …." A trial court's ruling on a motion for judgment as a matter of law (or directed verdict) is subject to de novo review with the evidence being considered in the light most favorable to the nonmoving party. *Commw. Real Estate Servs. v. Padilla*, 149 Wn. App. 757, 762, 205 P.3d 937 (2009.

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 causes of action; allegations supporting one normally will not support the other. *Gustav v. Seattle Urological Assoc.*, 90 Wn. App. 785, 789, 954

P.2d 319, *rev. denied*, 136 Wn.2d 1023 (1998). 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 claim of medical negligence – that injury resulted from the failure of a health care provider to follow the accepted standard of care – are that:

> (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 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 it and the treatment injures the patient, the patient has a claim for damages for failure to obtain informed consent even if the physician complied with the standard of care in performing the treatment. *Id.* at 660 (citation omitted). But:

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

Backlund, 137 Wn.2d at 661.

> 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 v Sauerwein, 180 Wn.2d 610,618, 331 P.3d 19 (2014) (affirming dismissal of informed consent claim against physician who did

not inform patient who subsequently died of sepsis that she had a blood culture positive for yeast, because, based on patient's clinical condition, the physician believed the 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, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992) (informed consent claim properly dismissed because emergency room physician owed no duty to inform patient of time frame to treat condition that he did not diagnose); *Bays v. St. Luke's Hosp.*, 63 Wn. App. 876, 881-82, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992) (informed consent claim properly dismissed because physician owed no duty to discuss possible methods for treating thromboembolism where the physician was "unaware of the thromboembolism 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).

3. Because Dr. Joseph concluded that Mrs. Eikum did not have heart disease, he had no duty to disclose related to that condition.

Here, based on his assessment of Mrs. Eikum, including x-ray,

arterial blood gas testing, EKGs, laboratory tests, Holter monitoring and presurgical physical examination, Dr. Joseph concluded that she had no acute pulmonary disease, and did not suspect that she had any cardiac dysfunction RP 1942-45, 1951-58, 1969-70; 2066-67. He thus concluded that she was "ready for surgery." RP 1964. Dr. Joseph was unequivocal about his conclusion that "[a]bsolutely," there was no reason to suspect that Mrs. Eikum had any cardiac dysfunction. RP 2066-67.

Defense experts Dr. Potyk, Dr. Peterson, and Dr. Doornick agreed with Dr. Joseph's assessment, and testified that Dr. Joseph complied with the applicable standard of care, RP 1100-01, 1453. 1741, and that there was no need for him to get further testing, RP 1087-89, 1455-56, 1776-77.

Because Dr. Joseph did not suspect, based on his examinations and testing, that Mrs. Eikum had any cardiac dysfunction, and thus was not aware of her heart condition, he had no risks or alternative treatments to disclose with respect to that condition. *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."); *Anaya Gomez*, 180 Wn.2d at 613 ("We hold that when a health care provider rules out a particular diagnosis based on the patient's clinical condition – including test results, medical history, presentation upon physical examination, and any other circumstances surrounding the patient's condition that are available to the provider – the provider may not be liable for informed consent claims arising from the ruled out diagnosis under RCW 7.70.050.").[2]

That Mr. Eikum's experts believed that the examinations and tests Dr. Joseph performed showed abnormalities and did not conclusively rule out cardiac dysfunction, and that further testing was needed before Dr. Joseph could pronounce Mrs. Eikum "ready for surgery," is a matter of medical negligence, not of failure to secure informed consent. Thus, when Mr. Eikum's experts assert that Dr. Joseph should have suspected a heart

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[2] Mr. Eikum appears to suggest, *App. Br. at 34*, that it is only when a physician conclusively rules out a particular diagnosis that there is no duty to inform. That is not what *Anaya Gomez* or any of the other case Dr. Joseph relies upon state. Indeed, if that were the rule, a plaintiff would always have an informed consent claim in a negligent misdiagnosis or negligent 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.

condition and should have referred Mrs. Eikum for additional tests, those assertions support a negligence claim, not an informed consent claim. If Dr. Joseph misjudged the significance of the results of the tests he performed, failed to recognize a need for additional tests, or erroneously believed that there was no reason to suspect cardiac dysfunction, that would give rise to a medical negligence claim if it violated the standard of care, but would not give rise to a failure to secure informed consent claim.

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

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

As the *Gustav* court further explained, *id.* at 791-92:

> The question whether Dr. Gottesman should have known of the difference between the two assays earlier and whether he unreasonably failed to recognize the significance of the pattern he observed raised the question of negligence and the applicable standard of care, not informed consent. If Dr. Gottesman never became aware of the condition and should have, he was negligent. But there was no allegation that he failed to disclose a material fact related to treating that condition. To hold otherwise would be to merge two distinct and logically separate causes of action. The trial court properly dismissed the informed consent claim.

See also Bays, 63 Wn. App. at 881-83 (physician's inclusion of thrombo-

embolism in differential diagnosis did not give rise to duty to disclose diagnostic tests and treatments for that condition). "A health care provider cannot possible inform a patient about every disease that might be causing each of his or her symptoms." *Anaya Gomez*, 180 Wn.2d at 623, n.8.

4. Mr. Eikum's attempts to disguise his medical negligence claim as an informed claim should be rejected.

Just as the plaintiff's assertion in *Bays* that a physician's inclusion of a condition in a differential diagnosis, that he did not test for and thus did not diagnose, required the physician to inform the patient of the available diagnostic tests and treatment for that undiagnosed condition was "a transparent attempt to disguise a negligence issue as a failure to obtain an informed consent issue," *Bays*, 63 Wn. App. at 882, so is Mr. Eikum's claim that Dr. Joseph had a duty to inform Mrs. Eikum of tests and treatments for a cardiac condition that he did not believe she had. And, just as the plaintiff in *Bays*, 63 Wn. App. at 882, was unable to establish the first element of an informed consent cause of action – that the physician "failed to inform the patient of a material fact or facts relating to the treatment," RCW 7.70.050(1)(a) – so was Mr. Eikum unable to do so.

As the *Anaya Gomez* court noted, 180 Wn.2d at 617, "[t]he statute clearly uses the word 'treatment,' demonstrating the intent to limit informed consent claims to treatment situations." Apparently recognizing

this, Mr. Eikum, *App. Br. at 27* (emphasis added), asserts that the "'[t]reatment at issue' was Dr. Joseph's ***diagnostic process and his conclusion of 'ready for surgery.'***" Yet, he cites no authority supporting such an attenuated definition of "treatment" and such an attenuated definition is hardly consistent with the courts' analyses of why the plaintiffs in *Burnet*, *Bays*, *Thomas*, *Gustav*, and *Anaya Gomez* had no claims for failure to obtain informed consent. And, to suggest that the conclusion "ready for surgery" constitutes "treatment" makes no sense.

While the Washington Supreme Court in *Anaya Gomez*, citing *Gates v. Jensen*, 92 Wn.2d 246, 250-51, 595 P.2d 919 (1979), 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. Moreover, 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," *id.* at 626, and that "[g]iven the unique factual situation in *Gates*, it is unlikely we will ever see such a case again," *id.*

The court in *Anaya Gomez* concluded that "*Gates* stands for the

proposition that patients have a right to be informed about a known or likely condition that can be readily diagnosed and treated." *Id.* at 626. But in *Gates*, there was no question that the patient's consistently high eye pressure readings over a two-year period pointed to a higher risk for glaucoma and that the ophthalmologist was well aware of those consistently high readings. Here, Dr. Joseph, based on his evaluation and testing, did not know, and believed he had no reason to suspect, that Mrs. Eikum had cardiac dysfunction. If he should have known or suspected it, that was a matter of possible medical negligence, not of informed consent.

Mr. Eikum, *App. Br. at 32-33*, nonetheless cites *Flyte v. Summit View Clinic*, 183 Wn. App. 559, 333 P.3d 566 (2014), claiming that it somehow reinvigorates *Gates* and supports his claim of error with respect to the dismissal of his informed consent claim. He is incorrect. *Flyte* did not involve a negligent failure to diagnose claim, but rather claims that the Clinic failed to provide informed consent by not telling a pregnant patient with flu-like symptoms about the H1N1 epidemic and public health alert recommendations for treating pregnant women prophylactically with Tamiflu, and breached the standard of care by not considering the possibility of H1N1 and offering Tamiflu prophylactically. The issue was whether the trial court erred in instructing the jury that a physician who misdiagnoses a patient's condition may not be subject to an action based

on failure to secure informed consent. Citing the five-justice concurring/ dissenting opinion that was controlling on the issue of informed consent in *Keogan*, 95 Wn.2d 329-30, which recognized that, even if no diagnosis had been made, a duty to disclose existed if the patient was to undergo a diagnostic procedure involving risk to the patient, the *Flyte* court concluded that the 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. Nothing in *Flyte* alters the holdings of cases like *Burnet*, *Bays*, *Thomas*, *Gustav*, and *Anaya Gomez*, which factually are more closely aligned with this case.

To hold an informed consent claim exists under the facts of this case not only would violate the holdings and rationale of those cases, but also would turn nearly every alleged misdiagnosis or failure to diagnose case into an informed consent case. Here Dr. Joseph, based on his evaluation and testing, did not believe Mrs. Eikum had any cardiac dysfunction. If he violated the standard of care in coming to that conclusion, which the jury found he had not, then he could be held liable for medical negligence. But, he had no obligation to inform Mrs Eikum of treatments for, or further means of diagnosing, a cardiac condition he did not believe she had so as to impose failure to secure informed consent liability.

B. The Trial Court Did Not Abuse Its Discretion in Allowing Testimony from a Learned Treatise Concerning the Revised Cardiac Risk Index Pursuant to ER 803(a)(18).

Mr. Eikum argues, *App. Br. at 37-43*, that the trial court abused its discretion in allowing questioning and testimony from a learned treatise concerning a "revised cardiac risk index," claiming that the learned treatise being referenced had to be, but was not, present in the courtroom,[3] and that the testimony as presented violated ER 803(a)(18), ER 1002, and ER 1006. Even if one ignores the fact that Mr. Eikum made no arguments below with respect to ER 1002 or ER 1006, and thus failed to preserve such arguments, Mr. Eikum is incorrect.

1. Standard of review.

A trial court's admission of evidence is reviewed for abuse of discretion, which occurs if "discretion [is] manifestly unreasonable, or exercised on untenable grounds, or for untenable reasons.". *City of Kennewick v. Day*, 142 Wn.2d 1, 5, 11 P.3d 304 (2000).

2. The trial court properly allowed testimony from a learned treatise concerning the revised cardiac risk index pursuant to ER 803(a)(18).

ER 803(a)(18) provides that:

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[3] In support of this argument, *App. Br. at 38*, Mr. Eikum references Appendix "A" to his brief, which is nothing more than 27 pages of argument added to his already 48-page brief. This Court should not condone such use of an appendix to circumvent the page limits for opening briefs, and thus should disregard Mr. Eikum's Appendix A. *See also* footnote 6, *infra*.

> 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***. [Emphasis added.]

The cardiac risk index was first drafted in the 1970s, was revised in the 1990s, and was published in a journal called "Circulation." RP 1032-33. The index looks at variables in a patient predictive of cardiac complications after non-cardiac surgery. RP 1032-33. "It is a standalone predictive index of complications after noncardiac surgery" and has "been incorporated into a larger algorithm" – the 2007 American College of Cardiology (ACC)/American Heart Association (AHA) guidelines. RP 1132-33. The index is now incorporated by physicians into their pre-operative evaluations. RP 1033.

At trial, the revised cardiac risk index was first addressed with Mr. Eikum's expert, Dr. Stricke, who testified, RP 441:

> Q Okay. Doctor [Stricke], you're familiar with the revised cardiac risk index; are you not?
>
> A I am.
>
> Q And revised cardiac risk index is a system devised to allow physicians to identify conditions that may make surgery contraindicated, noncardiac surgery; is that correct?
>
> A Correct.

Dr. Stricke then identified Harrison's Principles of Internal Medicine as an authoritative treatise, RP 441-42, and was handed a copy of the revised cardiac risk index, as printed in Harrison's. RP 442-43; *see also* RP 620-29.

Although Mr. Eikum's counsel had a copy of what was presented to the witness, she objected to not having "the complete document," RP 444, and argued that it should be admitted into evidence. RP 444. The trial court, referencing pre-trial motions,[4] denied that request.[5] RP 444.

All of the questions Dr. Stricke was asked about the revised cardiac risk index were based on the excerpts from Harrison's that were presented to him. *See* RP 445-71. Despite Mr. Eikum's counsel's claim that she did not have the entire Harrison's book, the book was given to her after Dr. Joseph's counsel completed his cross-examination of Dr. Stricke. RP 485. During her re-direct examination, Mr. Eikum's counsel read excerpts and asked Dr. Stricke questions from the book. RP 485-91; 506-09. Pursuant to ER 803(a)(18), the trial court denied Mr. Eikum's counsel's request to show any portion of the book to the jury. RP 484.

The next day, Dr. Joseph's counsel asked Mr. Eikum's expert, Dr.

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[4] During argument on motions in limine, Mr. Eikum's counsel had agreed that, under ER 803(a)(18), statements from learned treatises could be read to the jury, but that the documents were not to be admitted as exhibits. RP 94.

[5] The court noted that, if Dr. Stricke needed additional information, such as an additional document, he could ask for it. RP 445.

Caren, about his knowledge and use of the revised cardiac risk index. RP 610-13. Dr. Caren testified that he knew of the index, RP 610, agreed that it was within the standard of care to use the index, RP 612, but that he did not know the elements of it and did not use it in clearing patients for surgery. RP 613. Dr. Joseph's counsel asked Dr. Caren no further questions about the index and did not present a copy of it to him.

Mr. Eikum's counsel then again asked for the entire Harrison's book, which defense counsel no longer had in the courtroom, and for it to be admitted into evidence. RP 621, 24. The court declined to require defense counsel to retrieve the book for plaintiff's counsel, and noted that defense counsel's obligation was to provide the portions of it that he used in cross-examination, which he had done, and that, while statements contained in learned treatises can be read to the jury, the documents themselves could not be admitted as exhibits. RP 625-26.

Mr. Eikum's arguments that the trial court somehow violated ER 803(a)(18) are not well taken. First, defense counsel established that Harrison's was an authoritative treatise and that the revised cardiac risk index was a valid tool for evaluating patients. RP 441-42. As such, it was permissible under ER 803(a)(18) for defense counsel, in cross-examining Mr. Eikum's experts, to use excerpts from that learned treatise about the index, and have statements from them read to the jury, without the learned

treatise or the copies of excerpts being admitted as exhibits.

Mr. Eikum argues, *App. Br. at 38-41*, that the entire learned treatise must be present in the courtroom, but cites no authority that so states. *State v. Rangitsch*, 40 Wn. App. 771, 780, 700 P.2d 382 (1985), cited by Mr. Eikum, does not state that, when excerpts of a large treatise are used, the entire treatise must be available in the courtroom. Rather, it only repeats the general exception to the hearsay rule stated in ER 803(a)(18), which refers to "***statements*** contained in published treatises." ER 803(a)(18)(emphasis added). While it makes sense that "statements contained in published treatises" being read to the jury would have to be in front of the witness, that does not mean that the entire treatise, as opposed to the pertinent excerpts of it need to be present in the courtroom. Indeed, even Mr. Eikum ultimately acknowledges, *App. Br. at 41*, that: '"Statements contained in a learned treatise' must be present in the courtroom to be allowed through ER 803(a)(18)."

Factually, Mr. Eikum is also incorrect as the learned treatise at issue was in the courtroom. Both the portion specifically used and the entire Harrison's treatise were in the courtroom when Dr. Stricke was examined. RP 442-43; *see also* RP 620-29. Indeed, during her redirect of Dr. Stricke, RP 485, Mr. Eikum's counsel requested, and defense counsel provided her with the entire book:

> MS. SCHULTZ: And I'm going to ask if I can use the book from counsel, Harrison's Internal Medicine.
>
> THE COURT: Mr. King.
>
> MR. KING: Your Honor, the problem is I'm not going to be able to have it, and we're going to run into a witness not having copies nor counsel nor the Court, so.
>
> THE COURT: I'm going to allow her to use it. You can look at it. It seems to be an issue.

The next day, when Mr. Eikum's counsel complained that Harrison's was no longer in the courtroom, defense counsel responded, RP 622:

> The material that was used in the examination of Dr. Stricke yesterday was provided to counsel. I gave a copy of the front piece of the treatise, the publication date and copyright date and the two tables that I used in my examination of Dr. Stricke yesterday to Ms. Schultz [Mr. Eikum's counsel]. So she has that.

And, as the trial court also noted, RP 624-25:

> One, yesterday he [Dr. Joseph's counsel Mr. King] used the one page, the front of it and the middle page, which he gave the Court a copy. I still have it. You got a copy of it, and he had a copy that he, also, gave the witness. I do not believe he has to provide you the book. He has to provide you what he uses in cross examination while you were here in court.

That day, when Dr. Caren was on the stand, defense counsel did not present him with any printed material regarding the revised cardiac risk index. Despite this Mr. Eikum's counsel again wanted to see the entire book, which Dr. Joseph's counsel had not brought to the courthouse. RP 620-28. The court ruled, RP 629:

> ... then today you're saying well, if he's going to talk about it with this witness, I think he should provide the

> book. If you make an objection and he doesn't have something to provide to the witness, then I'll let you object, and I'll rule on that objection, ***but I'm not going to order him to give you a book that, one, we haven't talked about today that he isn't trying to admit or trying to ask about.*** I'm not going to order his office to go get a book for you. So at this point, I've made my ruling. [Emphasis added.]

Moreover, multiple physician witnesses were asked about their knowledge and use of the revised cardiac risk index, a commonly used and well known tool. Mr. Eikum cites no authority suggesting that counsel must present some document to the witnesses before counsel may ask them about their knowledge and use of such an index. To the extent that anything was read, consistent with ER 803(a)(18) and with the portion being read made available to the witness, the court and all counsel. The trial court did not abuse its discretion in ruling as it did with respect to the use of the learned treatise at issue.

3. Mr. Eikum waived any objection based on the best evidence rule, which is not implicated in any event.

Mr. Eikum argues, *App. Br. at 42*, that ER 1002 (the best evidence rule) was violated because the underlying 2007 article about the revised cardiac risk index that was referenced in the excerpts from Harrison's was not produced in the courtroom. Mr. Eikum, however never made any best evidence rule objection at trial, and thus any such objection has been waived. *State v. McKinney*, 50 Wn. App. 56, 66, 747 P.2d 1113, *rev. denied*, 110 Wn.2d 1016 (1987) ("A party may only assign error on appeal

based on the specific ground of the evidentiary objection made at trial."). Second, Mr. Eikum cites no authority suggesting that, before a party may ask a witness to read from an admittedly authoritative learned treatise, the party must make sure that any other authorities referenced in that learned treatise are in the courtroom.

4. Mr. Eikum also waived any objection based on ER 1006

Finally, Mr. Eikum argues, *App. Br. at 43*, that the trial court violated ER 1006 by allowing a defense expert to make a chart as he testified about the revised cardiac risk index. *App. Br. at 43*. Although Mr. Eikum does not identify in the text of his brief what chart he is referring to or provide any reference to the record, it appears from searching his Appendix A that he is referring to a chart drawn by Dr. Potyk discussed at RP 1043-44, and RP 1131.[6] *See* Mr. Eikum's Appendix A at A-15. But, Mr. Eikum does not cite any authority suggesting that it violates ER 1006 for a physician to make a chart illustra-

[6] "According to RAP 10.3(a)(5), citations to legal authority and reference to relevant portions of the record must be included in support of issues raised on appeal." *Schmidt v. Cornerstone Invest.*, 115 Wn.2d 148, 160, 795 P.2d 1143 (1990). "Without adequate, cogent argument and briefing, this court should not consider an issue on appeal." *Id.* In much the same way that an appellate court is not required to search the record to find support for appellant's arguments, *In re Estate of Lint*, 135 Wn.2d 518, 532, 957 P.2d 755 (1998); *Fishburn v. Pierce County Planning & Land Servs. Dep't*, 161 Wn. App. 452, 468, 250 P.3d 146, *rev. denied*, 172 Wn.2d 1012 (2011), so this court should not be required to search Mr. Eikum's 27-page Appendix narration of contents of the record to find support for his arguments. Even if requiring the Court to search his Appendix A to find references to relevant portions of the record somehow suffices, he still has not provided adequate, cogent argument and briefing concerning his Rule 1006 argument, which he makes for the first time on appeal.

ting his testimony about how a revised cardiac risk index works or is used. Perhaps even more importantly, at the time Dr. Potyk drew his chart, Mr. Eikum did not make any objection based on ER 1006, and thus waived any such objection. *McKinney*, 50 Wn. App. at 66.

C. The Trial Court Did Not Abuse Its Discretion in Declining to Give Mr. Eikum's Proposed Jury Instructions.

Mr. Eikum argues, *App. Br. at 44-47*, that the trial court erred in not giving five of his proposed instructions – Amended Proposed Instruction Nos. 23 (CP 101), 24 (CP 102), 26 (CP 104), 27 (CP 105), and 28 (CP 106-07), the full texts of which are set forth as Appendix A to this brief. The trial properly exercised its discretion in declining to give these proposed jury instructions, as they did not accurately state the applicable law, were not necessary, were slanted and argumentative, would have improperly commented on the evidence, and/or sought to infuse Mr. Eikum's dismissed informed consent claims back into the case.

1. Standard of review.

"Parties are entitled to jury instructions that accurately state the law," *Barnett v. Sequim Valley Ranch, LLC*, 174 Wn. App. 475, 488, 302 P.3d 500, *rev. denied*, 178 Wn.2d 1014 (2013), and jury instructions must be sufficient to allow the parties to argue their theories of the case, *Havens v. C&D Plastics, Inc.*, 124 Wn.2d 158, 165, 876 P.2d 435 (1994). "Jury instructions are generally sufficient if they are supported by the evidence,

allow each party to argue its theory of the case, and when read as a whole, properly inform the trier of fact of the applicable law." *Fergen v. Sestero*, 182 Wn.2d 794, 803, 346 P.3d 708 (2015) (citations omitted).

"Whether to give a certain jury instruction is within a trial court's discretion and so is reviewed for abuse of discretion."[7] *Id.* at 802-03 (citations omitted). The trial court has considerable discretion as to the wording, choice and number of instructions needed for the parties to present their theories fairly, making the abuse of discretion standard of review applicable to those decisions. *Hue v. Farmboy Spray Co.*, 127 Wn.2d 67, 92 n.23, 896 P.2d 682 (1995).

"[A] 'trial court need never give a requested instruction that is erroneous in any respect." *Crossen v. Skagit County*, 100 Wn.2d 355, 360-61, 669 P.2d 1244 (1983) (citation omitted). Nor should a trial court give slanted or argumentative instructions, as "[m]odern jury instruction practice ... is aimed at avoiding slanted or argumentative instructions ...." *Watson v. Hockett*, 107 Wn.2d 158, 161, 727 P.2d 669 (1986). And, under Const. art. IV, §16, a trial court may not comment on the evidence, and thus may not give instructions that tell the jury what weight to give certain

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[7] Although Mr. Eikum correctly notes, *App. Br. at 44*, that "[l]egal errors in jury instructions are reviewed de novo," he makes no claim on appeal that any of the jury instructions the trial court gave were legally erroneous. The abuse of discretion standard of review, not the de novo standard of review, applies to his claims of error with respect to the trial court's failure to give certain of his proposed instructions.

evidence. *See Detention of R.W.*, 98 Wn. App. 140, 145, 988 P.2d 1034 (1999) ("The instruction was an impermissible comment on the evidence because it instructed the jury on the weight to give certain evidence.").

2. Mr. Eikum did not properly preserve his claim of error as to the failure to give any of his proposed instructions.

Under CR 51(f), to properly object to giving of or the refusal to give a jury instruction, "[t]he objector shall state distinctly the matter to which counsel objects and the grounds of counsel's objection, specifying the number, paragraph or particular part of the instruction to be given or refused and to which objection is made." "An appellate court may consider a claimed error in a jury instruction only if the appellant raised the specific issue by exception at trial." *Van Hout v. Celotex Corp.*, 121 Wn.2d 697, 702, 853 P.2d 908 (1993). The trial court must have been sufficiently apprised of any alleged error to have been afforded an opportunity to correct it. *Id.* at 703.

Here, Mr. Eikum's counsel did not comply with the dictates of CR 51(f) or object with any specificity to the trial court's failure to give his Amended Proposed Instructions 23, 24, 26, 27, and 28. All Mr. Eikum's counsel stated by way of exception to the trial court's failure to give any of his proposed instructions was: "Just to shorten this, I would take exception to the Court's failure to use any instructions that we have

presented that have not been incorporated as a whole." RP 2198. That exception was not sufficient to preserve any claim of error. "A mere exception to the refusal [of the instruction] without more, as is the case here, is not enough." *State v. Myers*, 6 Wn. App. 557, 573, 494 P.2d 1015, *rev. denied*, 80 Wn.2d 1009, *cert. denied*, 409 U.S. 1061, 93 S. Ct. 562, 34 L. Ed.2d 513 (1972).

Even if Mr. Eikum's claim of error with regard to the failure to give his proposed instructions were properly preserved for review, the trial court did not abuse its discretion in refusing to give those instructions.[8]

3. The trial court did not abuse its discretion in refusing Mr. Eikum's Proposed Instruction Nos. 23 and 24 on negligence as they did not accurately state the law, were confusing, commented on the evidence, and were unnecessary.

Proposed Instruction Nos. 23, CP 101, and 24, CP 102, which Mr. Eikum claims comport with *Gates v. Jensen*, 92 Wn.2d 246, 252-53, 595 P.2d 919 (1979), *App. Br. at 47-48*, and which would have allowed the

[8] Characterizing his proposed instructions as supplemental instructions, Mr. Eikum, *App. Br. at 44*, cites *Fergen*, 182 Wn.2d at 811, for the broad propositions that "[s]upplemental instructions 'help juries understand the complexity of the legal standard they are being asked to apply,'" and "'[e]laborating instructions' are 'commonly used in negligence law and are helpful for lay jurors to understand the complexities of a malpractice case.'" But, even under those broad propositions, the trial court was not required to give his proposed instructions. *Fergen* dealt with the giving of the "exercise of judgment" instruction, the propriety of which in appropriate cases has been repeatedly reaffirmed. *Fergen* by no means stands for the proposition that any supplemental or elaborating instruction a party might propose needs to be given. Indeed, as the *Fergen* court emphasized, when the "exercise of judgment" instruction is "[p]roperly given and worded, it does not misdirect the jury and is not confusing," but "helps juries understand the complexity of the legal standard they are being asked to apply." *Id.* at 811. The same cannot be said of the proposed instructions Mr. Eikum claims the trial court should have given.

jury, even if it found no violation of the applicable standard of care, to find Dr. Joseph negligent if it found that "reasonable prudence under the circumstances," CP 101, or just "reasonable prudence," CP 102, "required the administration of additional diagnostic tests," did not correctly state the law, as the Washington Supreme Court made clear in *Harris v. Groth*, 99 Wn.2d 438, 448, 663 P.2d 113 (1983), a case Mr. Eikum fails to cite or acknowledge. In *Harris*, an ophthalmology case, the court held that the trial court properly rejected an instruction Ms. Harris had proposed based on *Gates* that was virtually the same as Mr. Eikum's Proposed Instruction No. 23 in this case, because the instruction:

> stated only that the jury should consider whether "reasonable prudence under the circumstances" required additional tests and failed to specify what skill and training the jury should assume in making this judgment. ... The instruction should have been framed in the language of RCW 7.70.040(1) and RCW 4.24.290, *i.e.*, whether a reasonably prudent ophthalmologist, possessing the degree of skill, care, and learning possessed by other ophthalmologists in the state of Washington, and acting in the same or similar circumstances as the defendant, would have performed an intraocular pressure test.

Harris, 99 Wn.2d at 448 (citations omitted). Mr. Eikum's Proposed Instruction Nos. 23 and 24 suffer not only from that same deficiency, but also more erroneously suggest that, even if the jury found no violation of the standard of care as framed in the language of RCW 7.70.040(1) and RCW 4.24.290, *see* Court's Instruction No.5, CP 138, the jury could still

find Dr. Joseph negligent under some unbridled notion of "reasonable prudence under the circumstances." That is not the law in Washington.

Moreover, Proposed Instruction No. 23, CP 101, confuses the standard of care applicable in this failure to diagnose cardiac disease case when it refers to "the applicable standard of care ***in the diagnosis of a pulmonary disease.***" And, Proposed Instruction No. 23 comments on the evidence when it states that: "if you find that Joan Eikum had heart disease, and that ***in the presence of symptoms indicating heart disease, where the statistical risk of death from heart disease was serious enough that reasonable prudence under the circumstances require the administration of additional diagnostic tests*** ...," effectively equating "the presence of symptoms indicating heart disease" with a statistical risk of death from heart disease serious enough that reasonable prudence requires additional diagnostic tests.

A trial court is not required to give a proposed jury instruction that is erroneous in any respect. *Crossen*, 100 Wn.2d at 360-61. Nor is it obliged to revise a proposed instruction if the one a party submitted was improper.[9] *Watson*, 99 Wn.2d at 447. And, a trial court may not, under Const. art. IV, §16, give an instruction that comments on the evidence.

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[9] Mr. Eikum suggests, *App. Br. at 44-45*, that "[i]f the trial court does not like the plaintiffs' proposed instructions on an issue, it has considerable discretion in deciding

Finally, Proposed Instruction Nos. 23 or 24 were not necessary for Mr. Eikum to argue his negligent failure to diagnose theory, as the jury was properly instructed on the applicable standard of care,[10] CP 138, and he was fully able to argue, and in fact argued, to the jury that Dr. Joseph violated the standard of care in failing to communicate with Mrs. Eikum, conduct further tests, and exclude certain conditions under the trial court's standard of care instructions. Mr. Eikum's counsel argued in closing that:

> our argument here is that the defendant violated the standard of care because ***he failed to investigate and to ultimately exclude the most dangerous conditions that were symptomatic and are assigned here***. That he failed to investigate and exclude the most dangerous conditions, cardiac disease. ***That he left all of the signs and symptoms unresolved, and that he did not exclude the dangerous condition of progressive heart disease, and that violated the standard of care.***

RP 2238-39 (emphasis added). Mr. Eikum's counsel reiterated:

> ***The standard of care in order to detect and diagnose these issues is to investigate, the symptoms, the signs***. You try to clarify the information, when did it happen, how did it happen, what was going on at the time. ***You communicate with the patient to get these things clarified***, to understand

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how such an instruction should be worded," but ignores the fact that the trial court is not obligated to revise a party's proposed instructions. *Watson*, 99 Wn.2d at 447.

[10] The trial court's standard of care instruction, CP 138, consistent with RCW 7.70.040(1), RCW 4.24.290, and WPI 105.02, correctly told the jury that Dr. Joseph had a duty "to exercise the degree of skill, care, and learning expected of a reasonably prudent internal medicine/pulmonary medicine [physician] in the State of Washington acting in the same or similar circumstances at the time of the care or treatment in question." Mr. Eikum asserts no claim of error with respect to the giving of that or any other of the jury instructions the trial court gave. An appellant's failure to assign error or argue a claim of error in its brief waives the claim of error. *Jackson v. Quality Loan Serv. Corp.*, 186 Wn. App. 838, 846, 347 P.3d 487 (2015).

> what they're saying to you because they don't know what's important. [Emphasis added.]

RP 2252. Mr. Eikum's counsel further referenced specific test results and argued that the standard of care required Dr. Joseph to do more:

> What has happened in this case is that in spite of all the signs and symptoms of heart dysfunction, Dr. Joseph did not only not exclude electrical, he had the electrical problems looking him in the face, and he did not exclude the electrical disturbances at no point, and he couldn't because that's what all the tests showed. The Holter monitor, the ECG, all of them was a problem with the electricity in that heart. He didn't even get to assessing these. Not only did he not exclude electrical, but he didn't even come down to this part of the heart. Below the standard of care.

RP 2270; *see also* RP 2268.

Jury instructions are sufficient if supported by the evidence, allow the parties to argue their theories of the case, and when read as a whole, properly inform the trier of fact of the applicable law. *Fergen*, 182 Wn.2d at 802-03. The trial court's negligence instructions in this case met those standards and the trial court did not abuse its discretion in declining to give Mr. Eikum's Proposed Instruction Nos. 23 and 24.

4. The trial court did not abuse its discretion in refusing Mr. Eikum's Proposed Instruction Nos. 26, 27, and 28 on informed consent, which were unnecessary as his informed consent claims had been dismissed, and which, in any event, did not accurately state the law, were slanted and argumentative, and commented on the evidence.

Mr. Eikum's Proposed Instruction Nos. 26, CP 104, 27, CP 105,

and 28, CP 106-07, are informed consent instructions that were unnecessary and inappropriate given the trial court's dismissal of the informed consent claim. RP 1126-27. Each of them refers to informed consent concepts such as a patient's "right to know" of abnormal conditions and risks presented by such conditions and right to make decisions, CP 104, a physician's "duty to inform" or "to tell" or "to advise" a patient, CP 104, 105, and 106. These proposed instructions were just an attempt to reinfuse the dismissed informed consent claim into the case.

Contrary to Mr. Eikum's assertions, *App. Br. at 46*, the fact that Mr. Eikum engrafted onto two of those instructions language that the "[f]ailure to advise [or so advise] the patient is negligence," does not convert the instructions to "standard of care" or "negligence" instructions. Nor does Mr. Eikum's claim, *App. Br. at 45-46*, that "defense physicians' testimony,"[11] or any other expert testimony as to a physician's duty to disclose or communicate certain information to the patient, convert what would otherwise be an informed consent claim into a "breach of the standard care for disclosure" negligence claim. Breach of the standard of care claims and failure to obtain informed consent claims are "two distinct

[11] Although the text of Mr. Eikum's opening brief does not set forth what "defense physicians' testimony" he is referring to, it likely was intended to refer to what is set forth as his Appendix B. Like his Appendix A, however, *see* footnote 3, *supra*, his Appendix B is nothing more than additional argument – this time only another eight pages of argument – added to his already 48-page brief. Again, this Court should not condone such use of an appendix to circumvent the page limits for opening briefs.

causes of action," and "allegations supporting one normally will not support the other." *Gustav*, 90 Wn. App. at 789. Moreover, under informed consent law in Washington, expert testimony is not proper or necessary to establish the "duty to disclose" or the "standard of care" for advising a patient as to risks or alternatives. *See Miller v. Kennedy*, 11 Wn. App. 272, 284-86, 522 P.2d 852 (1974), *aff'd*, 85 Wn.2d 151 (1975); *Smith v. Shannon*, 100 Wn. 2d 26, 31-34, 666 P.2d 351 (1983). Mr. Eikum cites no authority supporting the giving of instructions like his Proposed Instruction Nos. 26, 27, and 28 in connection with an RCW 7.70.040(1) claim that the physician failed to follow the accepted standard of care.

Moreover, Proposed Instruction Nos. 26, 27, and 28 do not accurately state the applicable law. For example, Proposed Instruction No. 26 states that a physician must inform of "***any*** risks presented by that abnormal condition." CP 104 (emphasis added). Even if there was a valid informed consent claim, a physician is only required to disclose "material risks." RCW 7.70.050. Moreover, Proposed Instruction No. 26, CP 104, states that it is the physician's duty "to tell the patient what ***he or she needs to know***" to make decisions intelligently," and Proposed Instruction No. 28, CP 106, states that "the Defendant had a duty to advise the Plaintiff of ...all material information the Plaintiff would need to know to make an intelligent and informed decision," improperly suggesting that the

duty to inform is based on the patient's subjective need to know. Yet, under Washington law, an objective, rather than a subjective, standard applies in informed consent cases, thus circumscribing to some extent the patient's power to choose. *Backlund v. Univ. of Wash.* 137 Wn.2d 651, 664-66, 975 P.2d 950 (1999) (citations omitted); *see also* RCW 7.70.050(1) and (2) (making clear that a physician's duty is to disclose material facts relating to the treatment, which are those facts a reasonably prudent person in the position of the patient would attach significance to in deciding whether or not to submit to the proposed treatment). As previously noted, a trial court is not required to give proposed instructions that are erroneous in any respect. *Crossen*, 100 Wn.2d at 360-61.

In addition, Proposed Instruction Nos. 26, 27, and 28, are argumentative, slanted, and inappropriately comment on the evidence. Proposed Instruction No. 26, CP 104, goes so far as to state that "the existence of an abnormal condition, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of disease, are all facts which a patient must know ...." Proposed Instruction No. 27, CP 105, states that a medical provider has a duty to inform of "any abnormal condition of the patient's heart that a reasonably prudent patient would need in order to make an intelligent and informed decision on whether to consent to ... a

proposed surgery for which the patient is being cleared." And, Proposed Instruction No. 28, CP 106, would have told the jury that:

> where the Defendant took on the responsibility of a presurgical evaluation himself, and where unresolved symptoms exist which could indicate heart disease, then the Defendant had a duty to advise the Plaintiff of all relevant material information related to her "clearance" for such surgery, including the unresolved issues regarding the condition of her heart, alternative tests or treatment for detecting the presence of heart disease, the risk of not getting such tests or treatment prior to her upcoming surgery ...."

That proposed instruction went even further to describe the claim as one "of negligence against this pulmonary physician for failing to impart information so the course of examination could be chosen intelligently" and stated as the first element of proof that:

> The Defendant doctor failed to inform the patient of the condition of her heart, of the availability of alternative examination procedures or tests for detecting heart disease, of the reasonably foreseeable material risks of each alternative, and of the risk of not further examination at all.

Even if Mr. Eikum had a viable informed consent claim, which he did not, a trial court should not give such slanted, argumentative instructions that overemphasize one party's theories of the case, and come perilously close, if not cross the line, to improperly commenting on the evidence in contravention of Const. art. IV, §16. As the Court explained in *Watson*, 107 Wn.2d at 165 (citation omitted), modern practice is:

> to avoid slanted or argumentative instructions. A jury instruction should be a statement of the law only. It is the function of argument by the lawyers to persuade the jury that the legal principle fits their version of the evidence or their theory of the case.

To the extent that Mr. Eikum suggests, *App. Br. at 46, n. 13*, that his Proposed Instruction No. 28 is modeled after a proposed supplemental instruction discussed in *Gates*, 92 Wn.2d at 249-50 n.2, just because an instruction was given (or properly could or should have been given in one case) "does not compel its use in a different case." *Terrell v. Hamilton*, __ Wn.2d __, __, 358 P.3d 453, 462 (2015). Nor does the fact that certain language may have been used in an appellate opinion mean that it can properly be incorporated into a jury instruction. *Adair v. Weinberg*, 79 Wn. App. 197, 203, 901 P.2d 340 (1995) (citing *Turner v. Tacoma*, 72 Wn.2d 1029, 1034, 435 P.2d 927 (1967). Indeed, "such language may sound argumentative or may even distort the law if taken out of context." *State v. Summers*, 107 Wn. App. 373, 388, 28 P.3d 780 (2001).

V. CONCLUSION

For the foregoing reasons this Court should affirm the trial court's dismissal of Mr. Eikum's informed consent claim and the trial court's entry of judgment on the jury's verdict.

RESPECTFULLY SUBMITTED on December 11, 2015.

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APPENDIX A

PLAINTIFFS' PROPOSED INSTRUCTION NO. 23
(Replaces Proposed Instruction No. 10)

Even if you find that the actions of Dr. Joseph met the applicable standard of care in the diagnosis of a pulmonary disease, if you find that Joan Eikum had heart disease, and that in the presence of symptoms indicating heart disease, where the statistical risk of death from heart disease was serious enough that reasonable prudence under the circumstances required the administrations of additional diagnostic tests before the April 6, 2009 elective knee surgery, then you are instructed that Dr. Joseph's failure to perform those tests constitutes negligence.

In determining whether the tests in question should have been given, you should consider, among other facts, the cost ease or difficulty of the administration of said tests, the risk to the patient of the tests, and/or the ensuing treatment and the reliability of the testing.

Gates v. Jensen, 92 Wn.2d 246, 253-54, 595 P.2d 919 (1979) (as to "reasonable prudence," holding that it was error for the trial court to not have given the instruction, and reversing and remanding for a new trial), and *Gomez v. Sauerwein*, 180 Wn.2d 610 at 8 (2014)(holding that *Gates* is not overruled).

PLAINTIFFS' PROPOSED INSTRUCTION NO. 24
(Replacing Proposed Instruction No. 11)

In connection with the plaintiff's claims of injury resulting from failure to follow the standard of care, the plaintiff has the burden of proving each of the following propositions:

First, that the Defendant failure to follow the applicable standard of care, or that Mrs. Eikum had heart disease before her knee surgery, and that even where the defendant's actions were within the standard of care for pulmonology conditions, the presence of symptoms indicating heart disease, and the statistical risk of death from heart disease was serious enough, that reasonable prudence required administration of additional diagnostic tests before April 6, 2009, and he failed to perform those tests;

Second, that the plaintiff was injured; and

Third, that the negligence of the defendant was a proximate cause of the injury to the plaintiff.

If you find from your consideration of all of the evidence that each of these propositions has been proved, your verdict should be for the plaintiff. On the other hand, if any of these propositions has not been proved, your verdict should be for the defendant as to this claim.

6 Wash. Prac., Wash. Pattern Jury Instr. Civ. WPI 105.03 (6th ed.)
Gates v. Jensen, 92 Wn.2d 246, 253-54, 595 P.2d 919 (1979) (as to "reasonable prudence," holding that it was error for the trial court not to have given the instruction, and reserving and remanding for a new trial), and *Gomez v. Sauerwein*, 180 Wn.2d 610 at 8 (2014)(holding that *Gates* is not overruled).

PLAINTIFFS' PROPOSED INSTRUCTION NO. 26
(Replacing Proposed Instruction No. 13)

A patient has a right to know material facts about any abnormal condition of his or her body, and any risks presented by that abnormal condition, before making an informed and intelligent choice regarding the course of treatment which her medical care will take. A physician has a duty to inform a patient of such abnormalities in her body.

The patient's right is that of making decisions during, regarding and including the procedures leading to a diagnosis, with full knowledge and participation. The physician's duty is to tell the patient what he or she needs to know in order to make those decisions intelligently.

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 intelligent and informed decision on the course which her future medical care will take.

Smith v. Shannon, 100 Wn.2d 26, 29 (1983).

Gates v. Jensen, 92 Wn.2d 246, 250-51, 595 P.2d 919 (1979)(patient's right: holding that the trial court erred in refusing to give the instruction regarding patients' rights, and reversing and remanding for a new trial); H *Gomez v. Sauerwein*, 180 Wn.2d 610 (2014)(reaffirming ⊳ *Gates*).

PLAINTIFFS' PROPOSED INSTRUCTION NO. 27
(Replacing Instruction No. 14)

A medical provider has a duty to inform a patient or a patient's representative of all relevant and material information concerning any abnormal condition of the patient's heart that a reasonably prudent patient would need in order to make an intelligent and informed decision on whether to consent to or reject a proposed course of treatment, including a proposed surgery for which the patient is being cleared. Failure to so advise the patient is negligence.

Smith v. Shannon, 100 Wn.2d 26, 29 (1983).

Gates v. Jensen, 92 Wn.2d 246, 250, 595 P.2d 919, 922 (1979)(physician's duty: holding that the trial court's failure to give a similar instruction regarding physician's duty of informed consent was error, and reversing and remanding for trial).

PLAINTIFFS' PROPOSED INSTRUCTION NO. 28
(Replacing Proposed Instruction No. 15)

You are instructed that where the Defendant took on the responsibility of a presurgical evaluation himself, and where unresolved symptoms exist which could indicate heart disease, then the Defendant had a duty to advise the Plaintiff of all relevant material information related to her "clearance" for such surgery, including the unresolved issues regarding the condition of her heart, alternative tests or treatment for detecting the presence of heart disease, the risk of not getting such tests or treatment prior to her upcoming surgery, and all material information the Plaintiff would need to make an intelligent and informed decision regarding whether to go forward without such alternative testing or treatment. Failure to advise the patient is negligence.

The Plaintiff must thus prove the following elements to establish a cause of negligence against this pulmonary physician for failing to impart information so the course of examination could be chosen intelligently:

(1) The Defendant doctor failed to inform the patient of the condition of her heart, of the availability of alternative examination procedures or tests for detecting heart disease, of the reasonably foreseeable material risks of each alternative, and of the risk of no further investigation at all.

(2) A reasonable person in Joan Eikum's position would have chosen additional testing and an alternative course of treatment had the alternative testing and treatment, and the material risks of proceeding without such, been made known.

(3) Joan Eikum was injured as a result of submitting to the course of examination and recommendation/clearance of the physician.

If you find from your consideration of all of the evidence that each of these propositions has been proved, your verdict should be for the plaintiff. On the other hand, if any of these propositions has not been proved, your verdict should be for the defendant on the claim of informed consent.

Smith v. Shannon, 100 Wn.2d 26, 30 (1983)

Gqtes v. Jensen, 92 Wn.2d 246, 250-51, 595 P.2d 919, 922 (1979).

H *Gomez v. Sauerwein*, 180 Wn.2d 610 (2014)(reaffirming ⚑ *Gates v. Jensen*, 92 Wn.2d 246, 595 P.2d 919 (1979).

KCWPI 105.05 Burden of Proof—Informed Consent—Health Care Provider *(Modified in "first...")*

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on December 11, 2015, I caused a true and correct copy of the foregoing "Brief of Respondent" to be delivered in the manner indicated below to the following counsel of record:

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DATED this 11th day of December, 2015, at Seattle, Washington.

Carrie A Custer

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