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No. 68479-5-I

DIVISION I, COURT OF APPEALS
OF THE STATE OF WASHINGTON

JEFFREY BEDE, as Personal Representative
of the Estate of LINDA SKINNER, Deceased,

Plaintiff/Respondent,

v.

OVERLAKE HOSPITAL MEDICAL CENTER,
a Washington corporation, and
PUGET SOUND PHYSICIANS, PLLC,
a Washington corporation,

Defendants/Appellants.

ON APPEAL FROM KING COUNTY SUPERIOR COURT
(Hon. Beth Andrus)

APPELLANTS' REPLY BRIEF

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I. SUMMARY OF REPLY

The Estate repeatedly invokes the abuse of discretion standard. That standard, however, is a standard of review, not a formula whose recital automatically excuses whatever decision a trial court has made, simply because that decision is deemed "discretionary." Moreover, the contours of that standard are well established, and place limits both legal and factual on discretionary trial court decisions which, if transgressed, mandate a finding by the appellate court of error by the trial court.[1]

Here, the trial court made a series of discretionary decisions, and the result was a series of errors -- of law and fact -- that prejudiced the Defendants in a closely contested medical malpractice jury trial. The Defendants believe that when this Court reviews the record, it will be convinced that the Defendants are right, and that a new trial must be ordered on standard of care and causation.

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[1] The Estate's approach to review of discretionary decisions is redolent of the approach of some Washington appellate decisions which this Court rejected in *Coggle v. Snow*, 56 Wn. App. 499, 784 P.2d 554 (1990). In holding that a trial court abused its discretion in denying a continuance requested by new counsel for a plaintiff in a medical malpractice case, who needed additional time to prepare a response to the defendant's summary judgment motion, this Court emphatically rejected the idea that discretionary decisions should be upheld unless an appellate court could say that no reasonable trial judge would have made such a decision. This Court emphasized that "the proper standard is whether discretion is exercised on untenable grounds or for untenable reasons, considering the purposes of the trial court's discretion." 56 Wn. App. at 507. Thus, discretion is abused when a trial court applies the wrong legal standard, and also when a trial court's findings are not supported by substantial evidence. *E.g.*, *Washington State Physicians Ins. Exch. & Ass'n v. Fisons Corp.*, 122 Wn.2d 299, 339, 345, 858 P.2d 1054 (1993) (holding trial court erred by applying the wrong legal standard and by making findings not supported by substantial evidence).

II. ARGUMENT IN REPLY

A. The Erroneous Exclusion of the Autopsy Photos and Related Expert Testimony Mandates a New Trial.

1. The Failure to Timely or Correctly Balance the *Burnet* Factors.

The trial court did not timely or correctly balance the *Burnet*[2] factors, and the Estate's *Burnet* defense fails to salvage this error.

First, the Estate claims *Burnet* only applies to sanctions "imposed under CR 37(b)." Estate's Brief ("EB") 35. The Estate ignores the Supreme Court's subsequent application of *Burnet* to sanctions imposed under authority other than CR 37(b). *See Rivers v. Washington State Conference of Mason Contractors*, 145 Wn.2d 674, 677, 41 P.3d 1175 (2002) (sanctions for violating scheduling order deadline subject to *Burnet*).[3]

Second, the Estate claims *Burnet* does not apply because exclusion of the autopsy photos was not a sanction that affected the Defendants' ability to present its case, given that they were still "free to use a diagram, free to use an illustration, in order to support [their]...defense experts'

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[2] *Burnet v. Spokane Ambulance*, 131 Wn.2d 484, 933 P.2d 1036 (1997).

[3] The Estate claims *Mayer v. Sto Industries, Inc*, 156 Wn.2d 677, 132 P.3d 115 (2006) held *Burnet* does not apply to sanctions imposed under CR 26(g). EB 35. This reading of *Mayer* was rejected by the Supreme Court in *Blair v. TA-Seattle East No. 176*, 171 Wn.2d 342, 254 P.3d 797 (2011). *See* 171 Wn.2d at 349-50.

testimony." EB 36 (quoting the trial court, at RP (12/20/11) 286:9-12).[4] The Estate does not explain how a diagram or illustration could substitute for the actual evidence of the photos and expert testimony explaining how those photos support the Defendants' theory of the case, ***both*** of which the trial court excluded. Exclusion of photographic evidence and expert testimony based on such evidence is *precisely* the kind of "harsh sanction" that may not be imposed without first balancing the *Burnet* factors.

Third, the Estate claims the trial court did balance the *Burnet* factors during trial, not just in the court's supplemental post-trial order. EB 38. The Estate first cites the court's initial ruling on December 19, 2011,when the court actually said *nothing* about willfulness, prejudice, or a lesser sanction, and the only reference to prejudice was by *the Estate's counsel*. *See* RP (12/19/11) 11:5-14:3 (court says *only* that the photos are excluded because they were produced "too late"). The Estate then cites the court's ruling on December 20, 2011, denying the Defendants' initial motion for reconsideration, when the court again said nothing about the *Burnet* factors, and instead grounded its decision on the Defendants'

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[4] The trial court's statement about diagrams and illustrations actually was made during the course of the court's ruling excluding the photos *under ER 403*, and had nothing to do with whether the photos should be excluded as a sanction. The statement's merits will also be addressed in Section II.A.3.

supposed failure to show "good cause" for relief under King County Local Civil Rule 4. *See* RP (12/20/11) 282:22-286:12.[5]

These are the *only* citations offered to prove the trial court complied with the requirement that the *Burnet* factors be balanced on the record *when a court is deciding whether to impose a sanction*, and not by "backfilling" the record with an order issued after the sanction has already been imposed. *See Blair*, 171 Wn.2d at 350 (a sanction must be supported at the time it is entered, not in hindsight). These citations actually confirm the trial court did *not* balance the *Burnet* factors on the record during the trial, which under *Blair* is fatal to the trial court's belated balancing set forth in its supplemental post-trial order.

Fourth, the Estate claims the trial court's exclusion of the photos reflected a proper balancing of the *Burnet* factors. EB 40-41. Yet the Estate ignores that the trial court, when it did balance, erroneously conflated the concepts of willfulness and good cause, a legal error in the application of the first *Burnet* factor which fatally taints what balancing the trial court did do. *See* Defendants' Opening Brief ("DOB") 34-35 (discussing the distinction between willfulness and good cause). The

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[5] The Estate states that the trial court on December 20 "describe[ed] defendants' willful discovery violations[.]" EB 38. The word "willful" is the Estate's, not the court's. A search of the transcript will confirm that the trial court *never* during the trial said the Defendants willfully violated their discovery obligations. The court did not level that charge until its post-trial supplemental order addressing the *Burnet* factors.

Estate also repeats, as if it were a verity on appeal, the trial court's statement that the photos were "easily accessible to Defendant PSP" throughout the pendency of the lawsuit, EB 41, ignoring -- as did the trial court -- that PSP could not gain access to the photos except through the formal process of discovery, *see* DOB 35, n.33, and that PSP had been diligent in seeking access to the photos through that process. *See* DOB 36, n.34.

Most fundamental, however, is *the* key fact, whose import the trial court never grasped -- that the photos became irrelevant after expert witness depositions disclosed agreement on whether pus was present at the acoustic neuroma surgical site. *See* DOB 21-23 (describing deposition testimony). Only when the Estate changed its disclosed theory of the case, and began to dispute whether pus was present[6] -- starting with Dr. Loeser's supplemental deposition on December 5, and culminating with the striking of Dr. Cummins as a witness on December 12[7] -- did the

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[6] The Defendants will address the Estate's assertion that it did not change its theory, and that its experts agreed at trial that pus was present at the site, when the Defendants discuss in Section II.A.6 how they were prejudiced by the exclusion of the photos and related expert testimony.

[7] The Estate states it withdrew Dr. Cummins as a witness on November 28, after deciding not to pursue a standard of care violation claim against Dr. Trione, and cites Clerk's Papers pages 359 and 1245 as supporting this statement. EB 13, 15. CP 359 is a copy of an e-mail trail dated November 28, in which the Estate's counsel informed PSP's counsel that no standard of care claim would be pursued against Dr. Trione; *the document says nothing about withdrawing Dr. Cummins*. CP 1245 is a page from a brief submitted by the Estate during trial, which does state that Dr. Cummins was withdrawn because no claim would be pursued against Dr. Trione. But the brief does not assert Dr. Cummins

(footnote continued on next page)

photos become relevant; PSP promptly contacted Overlake about PSP's outstanding discovery request for the photos and Overlake just as promptly produced them.[8] To find the Defendants willfully violated their discovery obligations in the face of these facts *is* a manifest abuse of discretion.

2. King County Local Civil Rule 4 Cannot Save the Exclusion Ruling.

Under *Burnet*, a party requesting the sanction of exclusion has the burden to show (1) a willful violation of discovery obligations by its opponent (2) prejudice to the requestor's trial preparations, and (3) no sanction short of exclusion will suffice. The Estate does not deny that, if these requirements for exclusion derive from the Civil Rules, then King County Local Civil Rule 4(j)'s requirement --- that a party must show good cause in order to qualify for relief from the rule's automatic exclusion of an exhibit or witness not identified by the deadline for such

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was withdrawn on November 28. In fact, Dr. Cummins was withdrawn no earlier than December 12. CP 2038 (McIntyre Dec. at 3, ¶9); CP 1824 (Joint Statement of Evidence, filed 12/13/11, at 2) (omitting Cummins from the Estate's expert witness list); *see* DOB 23 (discussing Cummins's withdrawal as of December 12).

[8] The Estate criticizes the Defendants for presuming to decide what is relevant, while ignoring that its counsel evidently had come to the same conclusion about the photos' relevance, as counsel never bothered to make a specific discovery request for the photos. DOB 21, n.21 (discussing the Estate's failure to actively pursue production of the photos). Moreover, the notion that the Defendants made some sort of collective decision about whether and when to produce the photos has no support in the record. PSP pursued production of the photos through discovery, and PSP's decision to press Overlake for the photos, pursuant to PSP's outstanding discovery request for them, was made in response to the Estate's change in its disclosed theory of its case, after the Local Rule 4 exhibit and witness deadlines had passed ***and less than two weeks before the start of trial***.

identification -- cannot be enforced because it conflicts with *Burnet*. *See* DOB 38, n. 37.[9] Yet in its argument for why *Burnet*'s requirements do not apply in this case, ***the Estate implicitly concedes that those requirements are derived from the Civil Rules***, disputing only *from which rules* they derive. The Estate thus effectively admits that Local Rule 4 cannot sustain the trial court's ruling in the face of error under *Burnet*.[10]

The Estate's defense of the merits of the trial court's Local Rule 4 ruling rests first on the claim that the Defendants' good cause argument "was vastly different at trial than it is now on appeal." EB 24. The claim rests on a supposed distinction between "abscess" and "pus" which the parties in fact did not make. Both sides' experts described an abscess as a

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[9] The Defendants reiterate that they warned the trial court of precisely this problem, when the court based its denial of the first motion for reconsideration on Local Rule 4 instead of addressing whether exclusion could be sustained under *Burnet*. RP (12/20/11) 289:6-14 (statement of PSP counsel immediately following ruling) ("This evidence is material to the search for the truth, and my client is being sanctioned because Overlake didn't produce the documents. I don't think that's fair, I don't think that's sustainable under *Blair* and *Burnet*, **nor do I think a King County local rule can displace the obligations to facilitate the search for the truth that is mandated by the overall civil rules as explicated in *Burnet* and *Blair***. .... [T]hat's all I'm going to say on that point for now, and we will try to develop this further as the trial proceeds." (emphasis added)); *see* DOB 24, n.23 (noting this statement of counsel challenging whether the local rule could displace *Burnet*).

[10] As part of its argument that *Burnet* does not apply in this case, the Estate brings up this Court's 2005 decision in *Lancaster v. Perry*, 127 Wn. App. 826, 113 P.3d 1 (2005), making much of the decision's focus on the predecessor to Local Rule 4. EB 37, n.6. *Lancaster*'s precedential value, however, has been substantially undermined by the Supreme Court's subsequent overruling of this Court's decision in *Blair v. TA-Seattle East No. 176*, 150 Wn. App. 904, 210 P.3d 326 (2009). Moreover, *Lancaster* cannot correctly be read as holding that basing an exclusion decision on the local rule automatically exempts the decision from complying with *Burnet*, given the Supreme Court just three years before reversed sanctions based in part on a King County local rule, because the trial court failed to balance the *Burnet* factors. *See Rivers*, *supra*, 145 Wn.2d at 677.

collection of pus, and it is the rupture of that pus into the surrounding area which is so damaging when an abscess bursts. *Compare* RP (12/22/11) 801:6-7 (Dr. Talan) ("[A]n abscess is pus surrounded by tissue") *with* RP (12/29/11) 1480:10-11 (Dr. Riedo) ("an abscess is a collection of pus in a confined space"); *see* RP (12/22/11) 799:9-18 (Dr. Talan) (describing how the rupture of pus from a burst brain abscess is so damaging). Thus, when PSP referred, in its first motion for reconsideration, to Dr. Cummins' deposition testimony about an "abscess" in the acoustic neuroma surgical site, PSP was not drawing a distinction between an abscess at the site and pus at the site, *because by definition an abscess at the site meant pus was* ***also*** *at the site*. In short, the Defendants' argument to the trial court on good cause is exactly the same as its argument on appeal, save that now that argument is made to demonstrate why the trial court should be reversed because the court erred in its good cause determination.

The Estate also claims that the withdrawal of Dr. Cummins did not constitute good cause for adding the autopsy photos. The Estate asserts there was "*always* a conflict regarding Dr. Riedo's testimony that Ms. Skinner had an abscess or abscess-like formation near her brain[,]" and that Drs. Siegel and Talan "rejected that contention" during their depositions, citing Clerk's Papers pages 1080-81, 1194, 1196, and 1198 as supporting this assertion. EB 24-25 (emphasis the Estate's). CP 1080 and 1081 are pages from Dr. Siegel's deposition, but he says *nothing* about an

abscess or abscess-like formation, whether in or near Ms. Skinner's brain. CP 1194, 1196 and 1198 are pages from Dr. Talan's deposition, but he also says *nothing* about an abscess or abscess-like formation *near* Ms. Skinner's brain, only testifying that he rejected the contention that Ms. Skinner had an abscess *in* her brain.

In fact, until Dr. Loeser's supplemental deposition on December 5, the parties, through the testimony of their experts, were in agreement that (as Dr. Cummins testified, and as Dr. Riedo agreed) (1) Ms. Skinner had an abscess (a collection of pus and bacteria) at the acoustic neuroma surgical site, and (2) this abscess broke through into Ms. Skinner's brain. Of course, the Estate was within its rights later to withdraw Dr. Cummins as a witness. But the Estate having disclosed, through the process of expert witness discovery, a theory of the case *upon which the Defendants were entitled to rely in preparing their case for trial*,[11] there was no good cause for excluding evidence that the Estate's eleventh-hour change of theory made relevant.[12]

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[11] Neither the Estate now, nor the trial court then, have grasped that the Defendants never claimed the right to rely on Dr. Cummins' testimony being introduced into evidence. Instead, the Defendants claimed the right to rely on what the deposition testimony of Dr. Cummins and the Estate's other experts disclosed about the Estate's theory of its case, in preparing the Defendants' case for trial, a right that is no less true for what deposition testimony discloses than for any other disclosure made during discovery.

[12] The Estate's other good cause arguments -- that it agreed at trial that pus was present at the site, and that the trial court was merely enforcing a pre-trial *in limine* ruling -- will be addressed in Sections II.A.5 and .6, respectively.

3. ER 403 Cannot Save the Exclusion Ruling.

The Estate's defense of the trial court's ER 403 ruling ignores several key points. The Estate does not deny (1) the trial court made its ruling *sua sponte*, (2) before the taking of evidence had begun, and (3) without giving the Defendants a chance to show why the photos were probative and whether the introduction of the "shocking" photos (showing the skull with hair attached) could be avoided. The Estate also does not deny (1) the trial court ignored the Defendants' prompt motion for reconsideration, and never addressed the issue again until its order denying the Defendants' post-trial motion for new trial, and (2) the court's assertion in that order, that the Defendants never submitted evidence of probativeness until after trial, ignored Dr. Riedo's declaration ***submitted on December 22, just two days after the court's initial ruling***, in which Dr. Riedo explained why the photographs were highly probative. CP 963-65 (First Riedo Dec.) (reflecting filing date of 12/22/11); *see* RP (12/22/11) 871:3-16 (court acknowledges receipt of motion for reconsideration, including Riedo Declaration).

The Estate does attack Dr. Riedo's qualifications to testify about what the photos show. EB 28. The trial court, however, never based its ruling on Dr. Riedo's supposed lack of qualifications. Nor did the Estate challenge those qualifications during the course of the trial. When confronted with Dr. Riedo's declaration opining about the photos'

probativeness, the Estate's *only* response was to demand that Dr. Riedo be excluded as a witness as a sanction (because showing Dr. Riedo the photos somehow violated the court's exclusion ruling). *See* CP 1911-1918 (Estate's Request for Contempt and Sanctions, filed 12/23/11). The Estate *never* suggested that Dr. Riedo was not competent to give opinions about what the photos showed (e.g., about whether they showed pus in the vicinity of the acoustic neuroma surgical site).[13] The Estate may be entitled to make such a challenge on remand,[14] but having failed to raise the issue at trial, and thereby give the Defendants an opportunity to respond, the Estate is not entitled to an affirmance on that ground.[15]

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[13] The Estate certainly knew *how* to make such a challenge, having sought to exclude several of the Defendants' experts' opinions (including Dr. Riedo's) by a pre-trial motion *in limine*, which the trial court denied on December 9. *See* CP 381-388 (Estate's Motions *in Limine* at 12-19, Motion No. 9); RP (12/9/11) 8:14-19 (ruling denying motion).

[14] The odds of such a challenge succeeding seem rather long, if the Estate's citations from Dr. Riedo's trial testimony are any indication. All go, at most, to the *weight* a trier of fact might give to his testimony. *See* RP (12/29/11) 1446:13-1450:12, cited by the Estate at page 28 of its brief. The Estate also ignores that its criticism of Dr. Riedo's qualifications cannot apply to Dr. Wohns, who agreed with Dr. Riedo, and strongly criticized Dr. Loeser's contrary views, in a declaration supporting the Defendants' motion for new trial. *See* CP 1337-1341 (Wohns Dec.).

[15] Relatedly, the Estate criticizes the Defendants for not calling Dr. Thoroughgood, the author of the Overlake pathology report, as a witness. EB 28. Besides ignoring that Dr. Thoroughgood was not listed as a witness, and therefore subject to exclusion on the same basis as the photos themselves, the Estate is wrong to imply that courts won't allow anyone but pathologists to interpret autopsy photos for a trier of fact; in fact, no Washington court has ever held that only pathologists are qualified to interpret autopsy photos. Moreover, this argument is just a variation on the theme of the supposed incompetence of the Defendants' proffered expert interpreter of the photos, and (as stated) that argument was not raised by the Estate at trial and is not available as a ground for affirmance of the decision to exclude the photos.

The Estate also asserts the trial court correctly excluded the photos because the information they represented could be conveyed to the jury by the use of a diagram or illustration, *see* EB 29, an argument the Estate also made to justify the trial court's sanction ruling. The argument has no more merit when advanced to defend the trial court's ER 403 ruling than it did when advanced to support the sanctions ruling. A diagram or illustration is an illustrative exhibit, at best. The photos, and the expert testimony explaining their import, are *evidence*, and the cases make clear that such evidence cannot be excluded unless their probativeness is substantially outweighed by their prejudicial effect.

Here, any prejudicial effect was entirely avoidable because the prejudicial photos (those showing the skull with hair attached) would not have to be shown to the jury.[16] Moreover, any prejudicial effect could only redound to the Estate's benefit. The Estate complains that the Defendants cite no case holding that someone in the Estate's position has no standing to invoke ER 403. Yet the Estate does not even try to explain how it could possibly have been prejudiced by the introduction of the

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[16] The Estate complains that the Defendants never told the trial court exactly which photos would not need to be shown to the jury. EB 30-31. The Estate ignores that *the trial court itself identified* which photos were "shocking" (those showing hair attached to the skull), RP (12/20/11) 286:5-8, *and the Defendants then told the court that* ***none*** *of those photos would have to be shown to the jury.* CP 961 (PSP supp. memo. at 9) ("PSP has determined that no more than six of the 17 photos are necessary. While they graphically depict the brain and sections of the brain in question, none of them reflect what the Court was most concerned about. ***None depict Ms. Skinner's scalp, her hair, or show the skull in connection with her body***." (emphasis added)).

photos, when it would have been *the Defendants* forcing the jury to look at pictures of the deceased's brain and taking the risk of a jury backlash. It makes no sense to allow a party who cannot be harmed to benefit from the exclusion of evidence based on a rule whose sole purpose is to prevent that harm.[17]

Finally, the Estate asserts the jury would have found the photos themselves to be incomprehensible, and would have been unable to sort out the ensuing dispute between Drs. Riedo and Loeser over whether the photos showed pus or surgical debris in the vicinity of the acoustic neuroma surgical site. Yet juries in medical malpractice trials *routinely* resolve such disputes, and it is no defense of a trial court ruling excluding evidence in such a case that the ruling spared the jury having to make another such decision.[18]

4. Sanctioning for a Supposed *in limine* Violation During the Trial Cannot Save the Exclusion Ruling.

The Estate's defense of the mid-trial sanctions ruling gets off on the wrong foot by claiming the trial court found PSP's trial counsel in "contempt of court" (EB 31), when in fact the trial court could not have

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[17] The expressed concern about prejudice also makes the highly dubious assumption that a jury in the era of "CSI" and related crime shows is likely to be offended by someone showing them such photographs.

[18] The Defendants again point out that they will respond in Section II.A.5 to claims that the Estate did not dispute the presence of pus in the acoustic neuroma surgical site, or that somehow the Defendants were otherwise not prejudiced by the exclusion of the photos and expert testimony explaining to the jury what those photos show.

done so because -- as the trial court itself recognized -- questioning Dr. Talan about the fact of autopsy photos did not violate the terms of the court's order. *Compare* RP (12/22/11) 928:4-9 (trial court's acknowledgement) *with Johnston v. Beneficial Management Corp.*, 96 Wn.2d 708, 712-14, 638 P.2d 1201 (1982) (vacating finding of contempt for violating protective order; "[t]he facts found must constitute a *plain violation* of the order" (emphasis added) (citation omitted)).

The Estate then responds to the Defendants' contention, that the trial court based its sanction ruling on erroneous notes of what questions PSP's trial counsel had asked Dr. Talan, by dismissing as "immaterial" whether counsel asked about "the" autopsy photos or autopsy photos generally. EB 32. The Estate ignores that this difference *was material to the trial court*. The Estate does not deny that the trial court said that questions about autopsy photos generally would not have been objectionable. *See* RP (12/27/11) 984:22-985:3. The Estate also does not deny that PSP's trial counsel only asked questions about autopsy photos generally. *See* RP (12/22/11) 910:18-22. Yet if (as here) a court says that Action X by a party would not have been objectionable, then sanctions that party when all they did was what the court said was not objectionable, how can the sanction be anything other than an abuse of discretion?

To this basic question the Estate has no answer, yet the question is dispositive of whether the mid-trial sanctions ruling can sustain the

exclusion of the photos and expert testimony about what those photos show. The Estate's point about counsel not being at liberty to violate a ruling just because the trial court should by now recognize that the earlier ruling was error, when the trial court has not yet announced that it has come to that conclusion (EB 33), is a fair one.[19] But in this case counsel did not violate the ruling. According to the trial court itself, the questions asked of Dr. Talan were not objectionable. The only reason the trial court proceeded to impose a sanction was because *the trial court's notes misreported what was actually asked.* No reasonable theory of deference to discretion can sustain a decision based on so basic an error.

5. The December 9 Pre-Trial *in limine* Ruling is a Red Herring.

The Estate makes much of the Defendants not mentioning the trial court's grant on December 9 of Overlake's motion to exclude any evidence requested but not produced during discovery. *See, e.g.*, EB 23 (claiming it is "surprising, yet telling," that the ruling is not mentioned). Yet why should the Defendants mention a ruling *that was not a basis for the trial court's exclusion of the photos*? It is true that the Estate's counsel did invoke the ruling, when he moved on the morning of December 19 to

[19] A fair one, but in and of itself not sufficient to sustain the exclusion of the photos. If PSP's trial counsel had in fact asked improper questions, the proper course of action would have been to (1) sanction counsel with a punishment sufficient to deter any further violations, while (2) vacating the exclusion ruling itself. Punishing counsel by excluding evidence the court by now should realize cannot properly be excluded (either under Local Rule 4 or ER 403) would be an impermissibly disproportionate sanction.

exclude the photos, but the trial court did not exclude the photos on that basis. After ruling that morning to exclude the photos because producing them the previous Friday was "too late," RP (12/19/11) 14:2, the trial court the next day clarified that it considered the production of the photos to have been "too late" because it occurred after the November 28 deadline for designating exhibits and witnesses established by Local Rule 4, and because the Defendants had failed to show good cause for being relieved from the automatic exclusion provision of that rule. RP (12/20/11) 283:17-284:4. Why would the trial court have bothered to say *any* of this, and make no reference to the December 9 *in limine* ruling, if the court believed the *in limine* ruling could properly dispose of the matter?

Obviously the court did *not* believe the *in limine* ruling could properly dispose of the matter, and the court was correct as a matter of law in that belief. When Overlake made its motion, and when the matter was before the court on December 9, the Estate's shift in its theory of the case was only just underway. Dr. Loeser had given his supplemental deposition testimony on December 5, but Dr. Cummins would not be struck until December 12. Is the Estate suggesting the Defendants somehow waived their right later to introduce the photos into evidence, and have an expert testify about what they showed, because they did not bring the matter up on December 9?

That would seem to be the argument, yet Washington waiver law requires *much* more before such a finding could be sustained here. *See*, *e.g.*, *Wagner v. Wagner*, 95 Wn.2d 94, 102, 621 P.2d 1279 (1980) (waiver other than by express agreement must be by "unequivocal acts or conduct evidencing an intent to waive" and cannot be inferred from "doubtful or ambiguous factors" (citations omitted). In sum, the Estate's discursion about the December 9 *in limine* ruling seems best treated as a red herring dragged across the Court's path in an attempt to distract from the true issues; it should be summarily tossed aside, and given no further consideration.

6. The Defendants Were Prejudiced.

The Estate denies the Defendants were prejudiced by denying its experts disputed whether pus was present in the acoustic neuroma surgical site. This denial misstates the record:

- The Estate claims Dr. Talan answered "yes" when asked if pus was present at the site, and cites in support of this claim a portion of his trial testimony appearing at RP (12/22/11) 811:2-812:8. *See* EB 26 (second bullet point). The pages cited by the Estate are at the beginning of the cross-examination of Dr. Talan by PSP's trial counsel; contrary to the Estate's claim, Dr. Talan did *not* concede anywhere on those pages that pus was present at the site. Moreover, when counsel repeatedly returned to what she characterized as Dr. Talan's deposition testimony that pus was

present at the site, Dr. Talan continued to refuse to concede the point. The climax of this battle came in the following exchange:

> Q. All right. And you believe that this fluid collection of white blood cells and bacteria was able to communicate or get into the fluid and the brain because of a defect in the area due to her old surgery, don't you?
>
> A. Yeah, if I may, I just want to be perfectly accurate with my previous testimony and not take one part in exclusion of all of it, and I'll make the point again if I may -- is that all right?
>
> I made clear throughout the deposition, later, that this area definitely had bacteria, because we know pneumococcus has to come from there, and it probably had white cells because there were certainly white cells, ultimately, in the spinal fluid and they were in communication.
>
> ***But it may not have represented true pus in a primary site of infection***. It may only have represented a fluid collection that was colonized with the normal bacteria.
>
> In your question you keep stressing this part which, indeed, I will acknowledge was one part of the questioning of the deposition but was not -- doesn't represent my opinion in totality, which I have an obligation to be truthful about.

RP (12/22/11) 820:13-821:11 (emphasis added); *see* DOB 46, n.45 (noting Dr. Talan's testimony about the absence of "true pus" at the site).[20]

- The Estate claims Dr. Loeser "likewise agreed" that pus was present at the surgical site, and cites in support of this claim RP

[20] As previously stated, Dr. Talan testified that an abscess is by definition a collection of pus. Had he admitted pus was present in the surgical site, he would have all but conceded Dr. Riedo's contention that an abscess had formed there, and the rupture of this abscess was the source of the infection. The record is clear, however, that Dr. Talan made no such admission. (A copy of Dr. Talan's full cross examination is attached as App. A.)

(1/3/12) 1707:14-18 and 1708:19-25. *See* EB 26 (third bullet point). These citations are taken from PSP's trial counsel's cross-examination of Dr. Loeser, and if this were all Dr. Loeser had said on the subject, a case could at least be made that Loeser *disagreed with Talan* about whether pus was present at the surgical site. Such a contradiction *within* the Estate's case, however, does not prove the Estate *agreed with the Defendants* that pus was present at the site. Moreover, the Estate ignores Dr. Loeser's testimony that what the pathologist had observed could have been surgical debris and not pus. *See* RP (1/3/12) 1671:3-13.[21]

The Estate also makes much of the fact that Dr. Riedo was able to testify to his opinions without relying on the autopsy photos, EB 42, ignoring that Dr. Reido was not allowed to *strengthen* those opinions with the *additional* evidence of the photos. The Estate also asserts that the photos and Dr. Riedo's testimony based on them would have been "cumulative" of the Defendants' illustrative exhibits, EB 43, *again* ignoring that the illustrative exhibits were not substantive evidence and could not substitute for the photos and Dr. Reido's testimony based on the photos. Ultimately, the Estate cannot deny that in this closely contested case, in which the jury deliberated for four days only to render a divided

[21] This testimony also undercuts the Estate's claim that its introduction of the autopsy report manifested agreement that pus was present in the surgical site. *See* EB 26 (first bullet point). The Estate did introduce the report, but then through Dr. Loeser took issue with the report's finding that pus was present at the site.

verdict on standard of care and causation, there is a reasonable probability that the autopsy photos and Dr. Riedo's testimony based on those photos would have changed the outcome. *See Magana v. Hyundai Motor America*, 123 Wn. App. 306, 319, 94 P.3d 987 (2004) (ordering a new trial where there was a reasonable probability that the failure to instruct the jury about stricken evidence changed the outcome).

B. The Erroneous Allowance of Rebuttal Testimony and Denial of Surrebuttal Testimony Mandates a New Trial.

In defense of the trial court's rebuttal and surrebuttal rulings, the Estate offers little more than the expected plea for deference to discretion.

1. Standard of Care.

The trial court's error in allowing Dr. Loeser to testify in rebuttal on standard of care so clearly compels a new trial on that issue that any reply is virtually superfluous. The controlling facts are few, beyond reasonable dispute, and their legal implications equally incontrovertible.

First, the trial court erred in adopting the philosophy that a plaintiff in a civil damages action gets "the last word." Trials are not debates (or appeals, for that matter), and the law is *clear* that, if all a plaintiff has to offer in rebuttal is cumulative evidence, repeating what has already been said during the plaintiff's case-in-chief, the plaintiff has no right to present that rebuttal. But the trial court ruled otherwise when, on December 9, 2011, it denied PSP's motion *in limine* to bar Dr. Loeser as a

rebuttal witness, and that fundamental error infected the future course of proceedings on this issue.

Second, the trial court erred in failing to recognize that it needed to probe exactly what Dr. Loeser was going to say on standard of care. Having accepted the notion that because the Defendants had said many things in their case bearing on standard of care, the Estate's supposed right to "the last word" had been triggered, the court made no attempt to find out if what Dr. Loeser was going to say was truly responsive in a way that Dr. Siegel and Talan had not already addressed. The door thus was opened to rebuttal on standard of care that would prove overwhelmingly cumulative of what Drs. Siegel and Talan had already said.

The Estate, tacitly admitting that cumulative testimony from Dr. Loeser would have been improper rebuttal, claims that Dr. Loeser was doing nothing more than "provid[ing] the necessary context for rebuttal testimony by reference to earlier testimony." EB 45. The Estate cites to nothing in the trial transcript of Dr. Loeser's testimony to support this assertion. That transcript shows that Dr. Loeser did not reference either Dr. Siegel or Dr. Talan, to provide context for his own opinions. Starting on line 1, page 1660 of the transcript (Volume VIII, 1/3/12), and continuing through line 12, page 1665, Dr. Loeser was taken through his

standard of care opinions by the Estate's counsel,[22] and during this examination Dr. Loeser ***made no reference whatsoever to the testimony of Dr. Siegel or Dr. Talan***. Instead, he gave opinions that turned out -- as the trial court later agreed[23] -- to be cumulative of the opinions to which Drs. Siegel and Talan and already testified.[24]

Third, as a result of the trial court's error, the Estate was able in closing argument to invoke repeatedly the powerful image of three impressively credentialed experts indicting Dr. Anderton's care of Ms. Skinner, and contrast that image against the one expert who testified that Dr. Anderton had complied with the standard of care.[25] This exploitation

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[22] Copies of these pages of the transcript are attached as App. B.

[23] CP 1358 (new trial denial order at 5) ("[T]he Court *agrees with Defendants* that many of [Dr. Loeser's] ... opinions ***were cumulative of those previously expressed by Plaintiff experts Drs. Siegel and Talan***" (emphasis added)). Later in its order the trial court listed six examples of Loeser rebuttal testimony that the court felt constituted "genuine rebuttal." *See* CP 1360-62 (order at 7-9). Only *one* pertained to standard of care. *See* CP 1361 (order at 8) (bullet point no. 5) (Loeser testimony rebutting contention that meningeal enhancement shown on MRI test result could reasonably have been attributed to a prior lumbar puncture); *see* DOB 47-48, n.48 (discussing trial court's finding of cumulativeness of Loeser testimony on standard of care).

[24] Besides claiming that Dr. Loeser was referencing Drs. Siegel and Talan to give context for his own opinions, the Estate also accuses the Defendants of contradicting themselves on the issue of cumulativeness. *See* EB 45 ("Attempting to fit this case into that prohibition [i.e., the prohibition against cumulative rebuttal testimony], defendants suggest that Dr. Loeser's testimony was cumulative of the testimony of plaintiff's other experts, Drs. Talan and Sigel...But earlier in their brief, defendants complain that Dr. Loeser 'went substantially beyond Drs. Siegel and Talan.'"). In fact, the Defendants' complaint about Dr. Loeser going beyond Drs. Siegel and Talan concerned Dr. Loeser's opinions *about causation, **not standard of care***. *See* DOB 30 (erroneously cited by the Estate as showing a complaint about Loeser going beyond Siegel and Talan on standard of care).

[25] *See* DOB 49, n.50 (citing to the record of the closing argument showing how the Estate's counsel repeatedly exploited the fact of Dr. Loeser's rebuttal testimony on

(footnote continued on next page)

of error in closing argument establishes prejudice compelling a new trial on standard of care. *See Anfinson v. FedEx Ground Package System, Inc.*, 174 Wn.2d 851, 876-877 (¶45), 281 P.3d 289 (2012) (finding a misleading jury instruction was prejudicial because "the incorrect statement was actively urged upon the jury during closing argument. *No greater showing of prejudice from a misleading jury instruction is possible without impermissibly impeaching a jury's verdict*" (citation omitted) (emphasis added)).[26]

2. Causation.

The trial court's errors in this issue area which implicate whether to grant a new trial on causation, as well as on standard of care, involve both rebuttal and surrebuttal. As to whether Dr. Loeser should have been allowed to testify in rebuttal on causation, the Estate responds to the Defendants' primary point -- that the trial court erroneously gave the Estate the benefit of a new expert seeming to offer the final, definitive

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standard of care). It is vital to understand that, Dr. Loeser's testimony having been admitted over the Defendants' objection, there was nothing objectionable about this argument *and therefore nothing the Defendants could do about it at the time.* Counsel was accurately characterizing the evidence in telling the jury that the Estate had presented three experts to indict Dr. Anderton's care, against only one expert who defended that care.

[26] The Estate claims the error of allowing Dr. Loeser's cumulative rebuttal testimony on standard of care was harmless because the erroneous admission of cumulative evidence is always harmless. EB 47 (citation omitted). This argument, if accepted, would render the prohibition against cumulative rebuttal evidence a legal dead letter. In addition, the Estate ignores that here, it went beyond inducing the erroneous admission of such evidence -- the Estate (through counsel) exploited that error in closing, which, under *Anfinson*, independently entitles the Defendants to a new trial.

word on causation -- by asserting that "[c]learly, *someone* has to have the last word." EB 46. But in a trial without surprises during the course of the Defendants' case, the plaintiff does *not* have the right to a last word. That is the point of the prohibition against cumulative rebuttal testimony. If there have been no surprises, the plaintiff's case-in-chief will already embody all of the evidence necessary to deal with the defendant's contentions, and no rebuttal is needed nor should it be allowed.

The Estate does not dispute that there were no surprises in the Defendants' causation case, and in fact Dr. Riedo's testimony was consistent with his deposition. *See* DOB 50, n.51. Accordingly, the Estate should have been required to call Dr. Loeser in its case-in-chief, and present his causation opinions then. And because the Estate was allowed to call Dr. Loeser in rebuttal to present those opinions in rebuttal, and because those opinions went well beyond the scope of what either Dr. Siegel or Talan had testified to on causation, the Defendants should have been allowed to present surrebuttal testimony to answer those opinions. This is particularly so for opinions (e.g., that there was an empyema but no abscess located at the acoustic neuroma surgical site) that had not previously been disclosed.[27]

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[27] The Estate now argues that the Defendants were obligated to anticipate Dr. Loeser's causation rebuttal in the Defendants' case. DB 46. It is rather difficult, however, to preemptively address an opinion that is not disclosed until the witness is on the witness stand. (e.g., empyema not abscess).

III. CONCLUSION

This Court should vacate the judgment, and remand for a new trial on standard of care and causation.

RESPECTFULLY SUBMITTED this 19th day of November, 2012.

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Case No. 68479-5-I

APPENDIX	DOCUMENT
A	Excerpt from *Verbatim Report of Proceedings*, Volume IV, December 22, 2011: Cross examination of David A. Talan, M.D. by Ms. McIntyre, pp. 811-856
B	Excerpt from *Verbatim Report of Proceedings*, Volume VIII, January 3, 2012: Direct examination of John D. Loeser, M.D. by Mr. Wampold, pp. 1645-1680

APPENDIX A

NO. 68479-5-I
COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION I

JEFFREY BEDE, as Personal Representative of the Estate of LINDA SKINNER, Deceased,
Respondent.
vs.
OVERLAKE HOSPITAL CENTER, a Washington corp., and PUGET SOUND PHYSICIANS, PLLC, a Washington corp.,
Appellants.

King County Superior Court
No. 10-2-24387-9 SEA

TRANSCRIPT OF THE TRIAL PROCEEDINGS BEFORE

THE HON. BETH M. ANDRUS

VOLUME IV

December 22, 2011
516 Third Avenue
Seattle, Washington

DATE REPORTED VIA FTR: May 13, 2012
REPORTED BY: Mary A. Whitney, CCR

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ALSO PRESENT: MARCUS TRIONE, M.D.

-o0o-

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EXHIBIT INDEX

-o0o-

Note: "*" denotes phonetic spelling.
"..." denotes brief inaudible portions of the audio recording.

SEATTLE, WASHINGTON; THURSDAY, DECEMBER 22, 2011

TRANSCRIPT OF THE TRIAL PROCEEDINGS

BEFORE THE HON. BETH M. ANDRUS

VOLUME IV

8:58 A.M.

-o0o-

THE COURT: All right. Issues this morning we need to address before bringing out the jury.

Mr. King.

MR. KING: I understand, your Honor, that the defense ... yesterday because of some motions that I was primarily responsible for. I just wanted to do two things; one, to assure the court I'm not trying to waste your time or tie you up. As you know, the Court of Appeals is rather fussy about preservation of error, and so we have to do what we have to do.

Second, especially in light of your concern about time being spent on reconsideration, I want to reply to the court that indeed we are going to follow up on the autopsy pictures issue.

When last we discussed that matter, you had expressed some concern that we were asking you to do something based on a brief asserting the relevance of the evidence and where was the proof, and

I promised that we would address this with our experts.

We are now in a position, shortly, by this afternoon, to provide you with a declaration on that point and a short supplemental discussion, and I will keep my oral presentations on this to an absolutely minimum.

THE COURT: All right. Thank you very much, Mr. King.

MR. KING: Thank you, your Honor.

THE COURT: All right. Next issue.

MR. WAMPOLD: Your Honor, a couple of things. One is we handed up to the court and we gave to opposing counsel a proposed instruction we indicated in line with what your Honor talked about giving to the jury.

THE COURT: All right.

MR. WAMPOLD: And the only other issue is that I marked four illustrative exhibits that I plan on using with Dr. Talan -- I've provided opposing counsel -- and wanted to know if your Honor wanted to take up any objections outside the presence of the jury, if there are any.

THE COURT: All right. Let's start with the limiting instruction, proposed language.

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Mr. Anderson's colleague, Ms. Griffith, on a case with Mr. Anderson?
A. I am.
MR. ANDERSON: Well --
Q. Thank you.
MR. WAMPOLD: I have nothing further at this time.
MR. ANDERSON: That's true.
THE COURT: All right.
Ladies and gentlemen, let's take our midmorning recess at this time. You may take your notepads with you. We'll take a 15-minute recess.
Again, I ask that you abide by the court's previous instruction. Please don't discuss the case with each other or with any third parties -- please don't discuss your notes with each other, either -- please don't do any independent research, and we'll see you back in 15 minutes.
THE BAILIFF: Please rise.
(Jury excused.)
THE COURT: Please be seated everyone.
MR. ANDERSON: Your Honor, I take issue with that last comment. I promise you. There is not a single file that is my file where Dr. Talan is an expert.

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THE COURT: Well, I mean, this is --
MR. ANDERSON: If I need to swear to the court, I'll get up and testify.
THE COURT: This is clearly a factual issue that can be ferreted out, and I'm going to leave it to Mr. Wampold and Dr. Talan and Mr. Anderson to ferret this issue out. And it's a legitimate area of cross-examination if he is mistaken, if there's --
MR. ANDERSON: Okay.
THE COURT: If he's working with someone else in your firm, that's something you'll need to figure out and we can deal with it on cross.
MR. BARNS: And your Honor, it would just be one of those instances where we may cross him on that issue, Mr. Anderson may cross him.
THE COURT: Definitely --
MR. BARNS: Okay.
THE COURT: -- but as I said, you guys choose how you divide your time up.
MR. BARNS: Okay.
MR. ANDERSON: Thank you.
THE COURT: All right. We'll be in recess.
MR. WAMPOLD: Thank you.
THE BAILIFF: Please rise.

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(Recess taken.)
THE BAILIFF: Court is again in session.
THE COURT: Please be seated, everyone.
Do I understand that there may have been some additional objections towards the Wohn deposition?
MR. BARNS: And we're going to try to work it out, your Honor.
THE COURT: All right.
MS. McINTYRE: (Indicating.)
THE COURT: All right. I have provided the parties with my rulings on those --
MR. BARNS: Right.
THE COURT: -- that were highlighted in green, so let me know if you have any more.
All right. Any other issues before we bring the jury out?
MR. WAMPOLD: No. The only thing I'd -- just to give your Honor fair warning, we, after Dr. Talan, our next witness will appear by videotape.
THE COURT: All right.
MR. WAMPOLD: Yes.
THE COURT: All right. Then we can bring the jury in.
(Pause in the proceedings.)

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(Jury re-enters proceedings.)
THE COURT: Please be seated, everyone.
Cross-examination, Ms. McIntyre.
MS. McINTYRE: Thank you, your Honor.
-o0o-
CROSS-EXAMINATION
BY MS. McINTYRE:
Q. Good morning, Dr. Talan.
A. Good morning.
Q. Welcome to Seattle.
A. Thank you.
Q. You believe that Ms. Skinner had a collection of fluid containing pus and bacteria in the mastoid area on her right side, correct?
A. Yeah, I -- I think what I testified to was that she may have had that, or just a fluid collection that was colonized with pneumococcal bacteria.
Q. Right.
A. Yes.
Q. You believe that she had this collection of pus and bacteria in her old acoustic neuroma surgery site, correct?
A. Again, same answer as I gave you.
Q. And you also believe that that collection of

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pus and bacteria in the old surgical site for the acoustic neuroma was the source of the meningitis. True?
A. Yes. And again, you're repeating one portion of my answer, not the entire part, but I think the source, as I explained before, was entry of bacteria from the outside colonizing, or infecting, that area into the brain, yes.
Q. And at your deposition you were actually kind enough to draw a diagram for us of the area that you believe contained the pus and bacteria. Do you recall that?
A. Actually, I don't, but I'll trust that you're right.
Q. Well, let me hand you, first of all, defendants' Exhibit-142.
MS. McINTYRE: I've provided a copy to counsel, and I would move for its admission for illustrative purposes.
THE COURT: Let's have him ID it first.
MS. McINTYRE: Sure.
MR. WAMPOLD: I actually have no idea what we're looking at.
THE COURT: If you could just show a copy to Mr. Wampold.

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THE CLERK: It's Exhibit-14- -- defendants' Exhibit-142 ...
MR. WAMPOLD: All right. That's fine.
MS. McINTYRE: May I approach the witness?
THE COURT: You may.
MS. McINTYRE: Thank you.
Q. Dr. Talan, handing you defendants' Exhibit-142, do you recognize that as the drawing that you diagrammed for us at your deposition?
A. I honestly don't remember it, but I may have.
Q. Sure.
A. I'm happy to go over it again with you.
Q. Okay. Thank you.
MS. McINTYRE: I would move for admission of -142 for illustrative purposes.
MR. WAMPOLD: No objection, your Honor.
THE COURT: All right. -142 will be admitted for illustrative purposes only.
(Defendants' Exhibit-142 received in evidence for illustrative purposes.)
THE COURT: And ladies and gentlemen of the jury, the same instruction to you applies; that it is for illustrative purposes only. The evidence will be the testimony, not the document itself.

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Q. (By Ms. McIntyre) And Dr. Talan, what I'd like to do is put this exhibit up so that the jury can see it and look at it with us.
A. (Nods affirmatively.)
Q. It would help if I put it on the right side. Okay.
So why don't you orient us, if you would, to the anatomy here. Is this the outer ear.
A. Do you want me to come up there? Do you have a pointer? Or how should I do it?
MS. McINTYRE: Do we have a pointer?
A. Thank you.
Q. There you go, Dr. Talan.
A. Okay.
Q. So is this the outer part of the ear?
A. Yes, it is.
Q. All right. And then is this the canal running from the outer part of the ear in towards the eardrum?
A. Yeah. So this is what's called the "external auditory canal" (indicating). That's where you're not supposed to put Q-tips.
Q. Yes.
A. And there's your -- this is (indicating) -- it looks like what they're trying to draw there is the

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eardrum.
Q. Okay.
A. Yeah.
Q. Now, this drawing shows a tumor on the inside of the ear. Is this representative of an acoustic neuroma?
A. It could be, yeah, sure.
Q. And this is the kind of tumor that Ms. Skinner had removed in 2006; is that right?
A. Yes.
Q. Then there is a circled area here, and it says, down at the bottom of this exhibit, "Talan Exhibit No. 3 - 10/24/2011." Do you remember that from your deposition now?
A. I don't, but, again --
Q. You don't dispute it.
A. I don't dispute it.
Q. Okay. All right.
So, at your deposition, then, did you draw a circle for me around the area of the ear and right mastoid where you felt there was this collection of pus and bacteria.
A. Yeah, I don't remember the context you asked me to draw it. It looks like -- looks like one of my circles, maybe.

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Q. Okay.
A. So -- and I think I indicated that area. I don't remember if -- you know, if it was in the context that we were talking about, the CT scan findings, because we did discuss that -- well, I guess we could look back.
But, yeah, it -- this is -- this is some of the area where there was, on the CT scan, some destruction or removal of bone, and there was some fluid.
And I think you -- that's what we were talking about --
Q. Yes.
A. -- and you said, "Well, about where was it?" and if I recall, I said, "Well, gee, I wish, you know, I had the CT scan here, but I'll do the best I can."
Q. And this is the area where you believe there was the collection of fluid and that it contained the pus and bacteria, right?
A. Again, to be very clear, because it was a long deposition and I -- I mentioned this in my previous answer -- there may have been pus or bacteria, but there was definitely fluid that was colon- -- at least colonized with bacteria.
The reason I made the distinction later in

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my deposition, I think, was to make it clear that I -- the patient -- we had to explain why Mrs. Skinner didn't really have symptoms there --
Q. Uh-huh.
A. -- so if she had a rip-roaring infection there, I would have expected, logically, symptoms.
So she may not have had a -- you know, pus and bacteria there, and/or she may have just had fluid that collected because of congestion -- and I do describe that later in the deposition -- that was colonized with these bacteria, as everybody has, pneumococcus in that area of the ear.
MS. McINTYRE: May I open and publish Dr. Talan's deposition?
THE COURT: The deposition of Dr. David Talan, taken October 24, 2011, is published.
MS. McINTYRE: Thank you.
(Deposition of David A. Talan M.D. published.)
MS. McINTYRE: May I hand the deposition to Dr. Talan, your Honor?
THE COURT: You may.
MS. McINTYRE: Thank you.
Q. Dr. Talan, would you please turn to page 27 of your deposition, at line 24.

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A. Yes -- which page? I'm sorry.
Q. Page 27.
A. Okay. (Witness complies.) All right.
Q. All right. So at line 24, did I ask you these questions -- this question: "Let's turn to the pus and fluid collection that was in the mastoid area. I think you said that you found there were white blood cells present there. Is that correct?"
Read your answer, please.
A. Yeah, I -- it doesn't say that on my page 27, and my lines aren't numbered 1 through 24, either, so I think we're on the wrong page. Page 27?
Q. Yes, page 27.
A. About how far down?
Q. Lines 24 --
MS. McINTYRE: May I --
THE COURT: You may.
MS. McINTYRE: -- approach the witness.
A. Yeah. See, there's no --
Q. There's these numbers -- oh, you're right. Okay. Well, let's look at these last two down here.
A. Okay.
Q. All right?
So, now --
COUNSEL: Mary, I've got another mini.

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Q. This might be easier, Dr. Talan.
THE COURT: If you would show that to Mr. Wampold first just to make sure --
MS. McINTYRE: Sure.
THE COURT: -- he has no objection.
MR. WAMPOLD: That's fine.
THE COURT: All right.
MR. WAMPOLD: That's fine.
Q. If you could look at page 27 on this document, Dr. Talan, it might make it easier for you.
A. (Witness complies.)
Q. There you go.
Okay. So, page 27, lines 24 and 25.
A. Okay.
Q. Now, did I ask you this question: "Let's turn to the pus and fluid collection that was in the mastoid area. I think you said that you found there were white blood cells present there. Is that correct."
Would you read your answer.
A. Uh -- oh, darn. Where it says, "Let me back up"?
Q. No. Your answer would go on to page 28.
A. Oh, I see, 28, okay. It's a "Yes." "Yes."
Q. And then I asked you this question: "And

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there -- and would there also be bacteria present?"
And would you read your answer.
A. "Yes."
Q. Now, you believe that this collection of white blood cells and bacteria in the old acoustic neuroma site actually was able to communicate or get into the spinal fluid surrounding Ms. Skinner's brain, do you not?
A. I think that the ear, as I testified many times previously, was -- the external ear and the structures between that and the brain were in communication, correct.
Q. All right. And you believe that this fluid collection of white blood cells and bacteria was able to communicate or get into the fluid and the brain because of a defect in the area due to her old surgery, don't you?
A. Yeah, if I may, I just want to be perfectly accurate with my previous testimony and not take one part in exclusion of all of it, and I'll make the point again, if I may -- is that all right?
I made clear throughout the deposition, later, that this area definitely had bacteria, because we know pneumococcus has to come from there, and it probably had white cells because there were certainly

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white cells, ultimately, in the spinal fluid and they were in communication.
But it may not have represented true pus in a primary site of infection. It may only have represented a fluid collection that was colonized with the normal bacteria.
In your question you keep stressing this part, which, indeed, I will acknowledge was one part of the questioning of the deposition but was not -- doesn't represent my opinion in totality, which I have an obligation to be truthful about.
Q. Would you turn to page 33 of your deposition, Dr. Talan.
A. Certainly.
(Witness complies.) Okay.
Q. All right. Let's look at line 12. Did I ask you this question: "All right. Now, you believed that the old acoustic neuroma surgical site was the locus or the initial site of the infection; is that correct?"
Read your answer, please.
A. "Yes ... " -- let's see, "... or it's a place where the infection came through to cause meningitis."
Q. And then I asked you this question: "And is this the place where there was the fluid collection in

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the mastoid area which you believe contained white blood cells and bacteria?"
Read your answer, please.
A. And I said, "I think at some point it did, yes. "
Q. And I asked you: "Do you believe that there was communication, then, from the old acoustic neuroma surgical site into the brain?"
Read your answer.
A. "Yes."
Q. And I asked: "And is this your opinion to a reasonable degree of medical certainty?" And what was your answer?
A. "Yes."
Q. And Dr. Talan, those were your answers to my questions under oath on October 24, 2011, correct?
A. I'm still under oath, and they're still my answers to your questions.
Q. All right. Right.
Now, Ms. Skinner could have had a small amount of the fluid collection in this area for a period of time, couldn't she.
A. Yes, she could have.
Q. And you don't know for how long she could

Page 823

have had the fluid collection there, do you?
A. No.
Q. And you also are not sure when the bacteria began to multiply in this area, are you?
A. Well, I -- your question contains an assumption that I don't completely acknowledge, so I don't know how to answer your question.
Q. All right. Then --. Let's look at your answer on page 31.
A. Okay.
Q. And I had just asked you a follow-up question at line 8, and then would you read the answer.
A. "But then the question would be, you know, when that became a site that bacteria multiplied and then communicated into the brain."
Q. All right. And you're not sure when that was, correct?
A. Let's see -- well, whatever -- I mean, I don't know if you want to get -- me to look at what I testified to or reiterate again what I believe.
Q. Okay.
A. I'm happy to do either.
Q. All right. Let's move on.
You talked about the mass in Ms. Skinner's ventricle that was seen on CT. Do you recall that?

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A. Yes.
Q. And that mass of material was kind of the fuzzy, white -- I think you called it a "glob" -- glob of material that we saw initially in the left ventricle, correct?
A. It was always in the left ventricle.
Q. Well, we'll see.
A. Yeah.
Q. Now, that is abnormal, to have a mass of pus and bacteria in the ventricle, isn't it?
A. Yes.
Q. Now, you, I think, said that -- just now, that the mass always remained in the left ventricle.
A. Yeah.
Q. Is that your understanding?
A. It was on the left side of the brain. It moved from sort of the middle or front towards the occipital horn, yes.
Q. Well, Dr. Talan, didn't you read the CT report done the following day, the 27th, where the radiologist stated that there was now a soft tissue mass in the dependent portion of the right lateral ventricle, and that this could be redistribution from that prior debris and mass in the left?
A. That's not what was on the CT scan.

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Q. Well, let's put it up here, then.
MS. McINTYRE: This is defendants' -103, and it's 00148.
Q. And I know that you're not a radiologist, Dr. Talan, but, in fact, this CT report done on the 27th does talk about there being a "small amount of nodular soft tissue attenuation in the dependent portion of the right lateral ventricle." Do you see where I read that?
A. You read it accurately, but it's --
Q. And that's on the opposite side of the left ventricle, isn't it?
A. Right and left are opposite, but if we have the scans, I'll be happy to show you and the jury why that's not correct.
Q. The radiologist says that this could be "redistribution" -- uses the word "redistribution -- correct?
A. Yes.
Q. All right.
Let's talk about the term "pyogenic ventriculitis," and you've heard that term before, haven't you?
A. Yes.
Q. Now, there's a term "ventriculitis," and that

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means inflammation of the lining of the ventricle, doesn't it?
A. Yes.
Q. "Pyogenic ventriculitis" means something different, doesn't it?
A. Well, it's an adjective for "ventriculitis," and "pyogenic" usually means there's white blood cells.
Q. Well, neuroradiologists, for example, refer to "pyogenic ventriculitis" as meaning the presence of pus and bacteria in the ventricle, or do you know that?
A. It's a complicated answer. I do know it, but radiologists cannot see pus and bacteria, so this is a -- this is an association that's been made with what radiologists see on CT scans and what they learn about the case.
Q. Do you agree with the literature that says that pyogenic ventriculitis represents an "uncommon but severe intracranial infection that can lead to serious sequelae and even death"?
A. It depends, and in my previous answer with Mr. Wampold, I describe the condition where it is extremely serious, a rupture of an abscess into the ventricle, yes.

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Q. Well, pyogenic ventriculitis isn't just caused by a rupture of an abscess into the ventricles, is it?
A. Well, it depends how that's defined. But pyogenic ventriculitis, as I testified to before and -- is a finding that occurs in virtually now every case that we can do an MRI of bacteria meningitis. Bacterial meningitis is a pyogenic infection.
There are other types that -- if I can -- that aren't pyogenic -- they don't demonstrate as many white blood cells, like, due to certain viruses and other types of organisms -- but in purulent and bacterial meningitis, that -- those are pyogenic causes of meningitis, and with every case you will get inflammation of the lining of the ventricle.
Q. Do you agree with this statement --
MR. WAMPOLD: I'm sorry -- I'm sorry to interrupt, Judge Andrews. There was a hand-up from juror No. 2.
MS. McINTYRE: Oh, I'm sorry.
JUROR #2: Your Honor, I can't hear counsel at all.
MS. McINTYRE: Oh.
THE COURT: All right. What we may also do is, if you wouldn't mind, is we may get you --

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JUROR #2: It's only when she touches her neck to her chin.
THE COURT: Ms. McIntyre --
MS. McINTYRE: ...
THE COURT: Ms. McIntyre --
MS. McINTYRE: Yes.
THE COURT: -- if you wouldn't mind trying to speak up a little more.
MS. McINTYRE: I will.
JUROR #2: Thank you --
MS. McINTYRE: I will.
JUROR #2: -- very much.
Q. Would you agree with this additional statement from the literature: "Pyogenic ventriculitis is an uncommon manifestation of severe intracranial infection that may be clinically obscure"?
A. No.
Q. Would you agree that pyogenic ventriculitis is uncommonly reported in adults?
A. Yeah. It probably is, yes.
Q. And you mentioned MRI scans, looking at the ventricles. The people doing that would be radiologists and neuroradiologists, primarily, correct?

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A. Yes.
Q. All right.
Now, let's talk about your opinions on the standard of care. You're board-certified in both emergency medicine and in infectious disease, correct?
A. Yes.
Q. Most emergency physicians are not also board-certified in infectious disease, are they?
A. No.
Q. In fact, your experience is pretty rare, isn't it?
A. That training is very rare.
Q. Now, you actually take call for the infectious disease service at your medical center, don't you?
A. Yes, I do.
Q. And when you take call, you're actually working as an infectious disease doctor for one to two months out of the year, aren't you?
A. Yes, I am.
Q. And your average, reasonable emergency physician isn't doing that, true?
A. No.
Q. You're not licensed to practice medicine in the state of Washington, are you?

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A. No.
Q. And you've never practiced medicine here, have you?
A. No.
Q. Turning to the ACEP, the American College of Emergency Physicians, expert witness oath, on No. 3 it says: "I will provide evidence or testify only in matters in which I have reason, clinical experience, and knowledge in the areas of medicine that are the subject of the case or proceeding." And you agree with that, don't you, Dr. Talan?
A. I do.
Q. And does this mean that if a person is going to testify as an expert witness on the standard of care for an emergency physician, that they should have recent clinical experience in that area?
A. Yes.
Q. And does it mean that they should have knowledge of the practice of medicine pertinent to that area, meaning emergency medicine?
A. Yes.
Q. So, in this American College of Emergency Physicians oath, an emergency doctor who hadn't practiced for 30 years wouldn't meet this criteria.
A. No.

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Q. And a physician who didn't practice as an emergency doctor -- had never practiced as an ED doctor -- wouldn't meet this criteria, either, correct?
A. No, I don't think so.
Q. They wouldn't, correct?
A. I mean, I agree with you.
Q. The usual triad for bacterial meningitis is fever, nuchal rigidity, and altered mental status. Do you agree with that?
A. The classic triad, yes.
Q. Okay.
A. Not the -- by "usual," if you mean to imply the most common symptoms, they are not.
Q. I meant classic triad, so thank you for pointing that out.
And Ms. Skinner had pneumococcal meningitis, correct?
A. Yes, she did.
Q. Patients with pneumococcal meningitis are much more likely to have all three of the classic triad features on presentation, aren't they?
A. More likely than?
Q. Than patients with other types of meningitis.
A. It kind of depends on what the other types

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are. I'm not exactly sure I can answer you exactly on that --
Q. Okay.
A. -- unless you tell me what other types.
Q. Doesn't the literature state that 58 percent of patients with pneumococcal meningitis will have all three features of the classic triad for bacterial meningitis?
A. I'm not sure what literature you're referring to. Nothing that I brought. It might be true at the time that they're all diagnosed. I don't know what you're looking at.
Q. Well, I'm referring to --
A. I hope you're not making it up. I presume you're quoting something.
Q. I'm referring the literature, for example, in Up to Date, and I'm also referring to literature by van de Beek, "Clinical Features and Prognostic Factors in Adults with Bacterial Meningitis," published in the New England Journal of Medicine.
A. Okay. I'm --
Q. You're familiar with both of those --
A. Yeah, I --
Q. -- sources, aren't you?
A. Not up to date, but I'm very familiar with

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Dr. van de Beek's article.
Q. All right. And Dr. van de Beek points out that the single most significant factor in surviving meningitis is whether the patient has pneumococcal meningitis or not, correct?
A. When comparing the organisms that he did -- these are bacterial organisms in that paper --
Q. Uh-huh.
A. -- that was a significant association. It wasn't the only association.
Q. But he found that to be the most statistical -- statistically significant association with survival, didn't he?
A. I think in that paper he did.
Q. And he also found that the risk of dying from pneumococcal meningitis was 30 percent, correct?
A. Yes.
Q. And you agree with that, the risk of death from pneumococcal meningitis is around 30 percent, true?
A. Well, that's what I testified to. I did refine that answer a little bit in my previous testimony, because since then there have been more recent published data, around the time of this case, that suggests for pneumococcal etiology, the --

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I think the mortality is -- it's about 18 percent, or 82 percent survive.
Q. As of October 24, 2011, when I took your deposition, it was your opinion that the mortality rate with pneumococcal meningitis was 30 percent, correct?
A. As I said, that is what I testified to --
Q. All right.
A. -- based on, actually, that paper.
Q. And most patients with bacterial meningitis have an elevated temperature, don't they?
A. They -- most have a -- either a history of a fever or a measured elevated temperature.
Q. And you define a "fever" as 38 degrees Celsius, which is 100.4 in Fahrenheit, correct?
A. Yes.
Q. And you agree that Ms. Skinner never had a documented fever on any emergency department visit or when she was in the hospital, right?
A. I agree with that.
Q. Okay. Now, the only health-care provider you are critical of in this case is Dr. Anderton; is that right?
A. Yes.
Q. So let's talk about that.

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You do believe that Dr. Anderton obtained an appropriate history from Ms. Skinner, don't you?
A. I do.
Q. And Dr. Anderton did a physical examination, including examining Ms. Skinner's neck, and found that she had full range of motion. Do you recall that?
A. Yes.
Q. And you also believe that that constituted an appropriate physical exam, don't you?
A. I do.
Q. And you're not critical of Dr. Anderton for ordering the tests, the white blood cell count, are you?
A. No.
Q. Have you determined that -- or is it your opinion that Ms. Skinner had nuchal rigidity when she was in the ER from 7:00 a.m. to 1:30 p.m. on January 26th?
A. If by "nuchal rigidity" you mean that her neck was immobile and rigid, I don't believe she did.
Q. All right.
Now, earlier you testified that a nurse observed nuchal rigidity and that Ms. Skinner could not touch her chin to her chest. Do you recall that testimony?

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A. I need to correct you. I did not testify that the nurse demonstrated the finding of nuchal rigidity, but I did reiterate what -- the second part of your question, or what was in your question, that the nurse did say that Mrs. Skinner could not touch her chin to her chest.
Q. All right. Now, are you aware that the nurse never had Ms. Skinner even attempt that maneuver?
A. No.
Q. Now, we can agree that Dr. Anderton was there. She got the history and she did the physical exam. She was there, she saw this patient, talked to the patient, felt how warm the patient was or wasn't. She did all of those things, correct?
A. Well, I don't know if she felt how warm the patient was, but she was there. We can't -- I'm certainly not disputing that.
Q. She was there and you were not, true?
A. True, as is the case in every one of these cases --
Q. Yes.
A. -- which have to be looked back and expert testimony is given. The experts are not there.
Q. Right. But when you talk about whether

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nuchal rigidity was present or not, Dr. Anderton is the person who was there who assisted Ms. Skinner in moving her neck, who made those observations, correct?
A. She was there.
Q. And Dr. Anderton documented that Ms. Skinner did not have nuchal rigidity, didn't she?
A. She didn't document rigidity. She said that Mrs. Skinner had "pain with range of motion and spasm," and she described neck pain that persisted despite administration of Dilaudid, an analgesic, and a benzodiazepine, kind of related to Valium, which is a muscle relaxer.
Q. Dr. Anderton documented that there were no meningeal signs, correct?
A. Yes.
Q. What does that mean?
A. Well, there were meningeal signs, but what it means to Dr. Anderton, you should talk with her.
Q. All right.
A. Maybe it would -- it would imply that a "meningeal sign" is any type of pain on motion of the neck, and certainly any limitation of motion. A meningeal sign would be the finding of meningitis on an MRI.

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Q. Dr. Anderton concluded, based on her physical exam with Ms. Skinner, that there was no meningismus or nuchal rigidity, didn't she?
A. She -- I think she did conclude that.
Q. All right.
You mentioned the x-ray or the MRI. When you're caring for a patient, you don't just blindly rely on a radiology report, do you.
A. It depends on what it is.
Q. Well, when you're caring for a patient and you get a radiology report, isn't it your obligation as the patient's doctor to synthesize the information, to consider the radiology report, but also consider the history you have from the patient, your exam of the patient? As the treating doctor, have to synthesize all of that information and then utilize your judgment, don't you?
A. I agree with that.
Q. Okay. And the difference here -- and Dr. Anderton did that. The difference here is that you have come to a different judgment than she did, correct?
A. No -- I mean, I'm not testifying, Ms. McIntyre, to my standard of care, I'm testifying to what I think a reasonable emergency physician

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did based on 25 years of experience in teaching people from the time they are students up through residents.
So it's not only that I would do something different, it is I'm --
Q. Mm-hmm.
A. -- I think what's at issue here is what a reasonable doctor would do.
Q. All right. It's your opinion that a reasonable doctor would have made a different judgment than Dr. Anderton did --
A. Yes.
Q. -- correct?
A. Yes.
Q. All right. And you would agree that it is a judgment call in this situation, isn't it?
A. There's -- but there's good and bad judgment.
Q. Yeah --
A. It's not just any judgment. The question is, in the -- in the face of everything that was there, was the judgment reasonable? Was it a good and reasonable judgment or was it the wrong judgment?
Q. Mm-hmm. And you would have made a different judgment.
A. I think reasonable emergency physicians would

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have made a much different judgment.
Q. Okay. All right.
Now, you talked about the cervical MRI, and you showed us -- you explained some areas from the MRI up here on the screen earlier --
A. Yes.
Q. -- correct?
A. Yes.
Q. Now, there were some highlighted areas in red on that MRI going up and down the spinal canal and so forth. Do you recall that?
A. Yes.
Q. Now, that highlighting and the red markings, that was added by Mr. Wampold, wasn't it?
A. Yes. I didn't --
Q. I mean, that's not --
A. It wasn't me.
Q. Okay. But my point is, that's not the way the original MRI looked --
A. No.
Q. -- correct?
A. No.
Q. Now, you were also asked if you would review an MRI or x-ray, yourself, or whether you would rely on a radiologist, and I think you said emergency

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room physicians often rely on the radiologists, correct?
A. Yes.
Q. So, an emergency physician could meet the standard of care by relying on information from the radiologist, they wouldn't have to go review the film themselves, correct?
A. No. If the only issue about the standard of care is whether the emergency physician should look at and read an x-ray differently, then, no, I -- I don't think they need to do that to meet the standard of care.
Q. Now, as I understood your earlier testimony, it's your opinion that Dr. Anderton would have met the standard of care of a reasonably prudent emergency physician if she had given Ms. Skinner antibiotics by noon on January 26th, correct?
A. Yes.
Q. And then it's your opinion that Ms. Skinner should have received steroids thereafter, correct?
A. Exactly what I testified to, is that the issue of steroids is controversial.
Q. Okay.
A. Personally, I think they are best administered. Many of my colleagues expert in this

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area would say they're not so sure.
Q. Yes.
A. So I think it is within the standard of care to do either.
Q. Okay.
A. And my criticism, before and now, is not that steroids were not administered in a timely fashion --
Q. Okay.
A. -- it's that antibiotics were not.
Q. All right. So let's be real clear on this, then, for the jury. Your criticism of Dr. Anderton is that she didn't give antibiotics by noon, correct?
A. Yes.
Q. And you are not critical of the failure to give steroids around that time, correct?
A. I don't -- it's a personal preference --
Q. Mm-hmm.
A. -- but I don't think -- I've not seen that really be -- be a -- I don't think that's a standard of care violation.
Q. Yeah. And you mentioned there's some controversy about steroids. Is there controversy about whether or not they're really very effective in situations like this?
A. That's the issue.

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Q. Okay. All right.
Now, let's talk about some of your opinions about survival. You do agree that some patients do succumb to meningitis even if they receive the right treatment and they receive it promptly, correct?
A. Yes.
Q. And that's because of the virulence of the -- or the strength of the bacteria, comorbidities of the health of the patient, the patient's own immune response, and their inflammatory response, correct?
A. And -- I think you left one thing out --
Q. Okay.
A. -- that I stressed, which is their condition at the time that the diagnosis and treatment is --
Q. Sure.
A. -- administered.
Q. All right. Now, you said that you thought Ms. Skinner was "relatively healthy." Do you recall that testimony?
A. I -- yes, I -- it was my testimony.
Q. All right. Now, as of the time of your deposition, the documents that you reviewed for this case were the records from Overlake Hospital, and then the acoustic neuroma surgery report from 2006,

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correct?
A. Yes.
Q. And so that then forms the basis for your conclusion that Ms. Skinner was relatively healthy --
A. Right.
Q. -- correct?
A. I think you left out -- well, she had two autopsies.
Q. All right. And the autopsies. Okay.
It's your opinion that even if Mrs. Skinner -- Ms. Skinner had received antibiotics at 8:00 o'clock, 8:00 p.m., on the 26th rather than about four hours later, at midnight, you still don't believe Ms. Skinner would have survived, do you.
A. Well, the way you stated it, I still don't think she would have survived. I think my -- previously -- previously we -- I made it clear that I think she would have survived had she been administered antibiotics at noon on the 28th.
So I'm not quite sure of your --
Q. Okay.
A. -- of your --
Q. All right.
A. -- conditional "still" in there, but --
Q. Right, to clarify --

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A. -- I think just to -- no, we're on the same page here. The later you roll the time forward towards when she now has evidence of nerve damage, the less likely she is to survive, and to survive without complications, and that was my testimony.
Q. All right. And so, for example, you believe that even if she'd received antibiotics by 8:00 o'clock that night, she would not have survived, correct?
A. Yes.
Q. And for you, the determining factor is really when the patient begins to exhibit altered mental status; is that right?
A. Well, it's not only when one begins, but the degree of it --
Q. Okay.
A. -- so, you know, again, as I make clear, biology is a continuum, and so your chance of coming out of bacterial meningitis once in coma is very low.
Q. Mm-hmm.
A. When you're fully alert it's very high, when you're slightly confused, it's a little lower, and when you're -- you have a stroke syndrome, it's -- it -- you're -- you might survive, but you'll wind up with a stroke. You won't be able to move one side of your body.
Q. All right. With respect to Ms. Skinner, you believe that at the point that she became confused, it was too late to save her, correct?
A. No, I don't think at the very point she became confused for the reasons I just sort of alluded to in the previous answer.
Q. Would you turn.
A. Her chance starts -- excuse me -- her chance starts to go down as she becomes more obtunded and lethargic, and ultimately comatose.
Q. Would you turn to your deposition at page 88, please, Dr. Talan.
A. Yes. (Witness complies.) Okay.
Q. Okay. Line 17, I asked you this question: "If she ..." -- and that was referring to Ms. Skinner -- "... had antibiotics at 6:00 p.m. instead of at midnight, would that have changed her, likely changed, her outcome?"
Would you read your answer for us.
A. Sure. "You mean, you are asking me at what point was it more likely or less likely than not, and I think I can't tell exactly, but I think at the point that she started to get altered mental status, that's very consistently the most important prognostic factor

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in studies of bacterial meningitis, so I think at the point she became confused, probably the ball game was over."
Q. "... at the point she became confused, probably the ball game was over." That was your sworn testimony under oath on October 24, 2011, was it not?
A. Will you allow me to read what I continued saying?
Q. Would you answer my question first, please.
A. Of course. That was my testimony. I read it into the record.
Q. Thank you.
MR. WAMPOLD: Your Honor, under ER 106, I'd like to ask that Dr. Talan be allowed to read the rest of his testimony.
MS. McINTYRE: I have no objection to that --
THE COURT: Okay.
MS. McINTYRE: -- if he wants to.
THE COURT: All right.
THE WITNESS: Thank you.
A. "Now, biology is continuous." We've heard that before. "The law is not. You asked me -- you asked -- the law is not [continuous]. You asked me to

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draw a line at the 50 percent hashmark. Sorry. Did you get that, the 50 percent mark? And so, I don't know. Somewhere in between the 12 and the period she became confused, the chances increase, and -- but I think at 12 hours, you have sufficient time, and she did look good. I mean, that's the whole point --

Q. Okay.

A. -- on the negligence side." So that's, I think, consistent with my testimony before.

Q. All right.

Now, let's talk about the incidence of morbidity or complications that patients who are able to survive. First of all, the complications for a patient like Ms. Skinner would be neurologic complications, wouldn't they?

A. Yes.

Q. And the complications -- well, strike that.

Patients who have pneumococcal meningitis and survive, probably 50 percent of them will have neurologic complications, correct?

A. Yes.

Q. And those complications can range from something mild to something disastrous and irreversible, true?

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A. Yes.

Q. And the neurologic complications could include hearing loss, stroke, cognitive impairment, coma, persistent vegetative state. Those are all of the complications that a patient surviving pneumococcal meningitis could have.

A. Those are many of them, yes.

Q. All right. And with Ms. Skinner, all you can tell us is that had she survived, she would have had a 50 percent chance of having some complication along that spectrum, correct?

A. No.

Q. Okay. Would you turn to page 96 of your deposition.

A. (Witness complies.)

Q. And let's actually back up to page 95 so we get the whole question-and-answer sequence.

Looking at line 14 did I ask you that: "What is the average morbidity incidence for patients with pneumococcal meningitis?"

A. And I answer later, down: "Probably, of those that survive, 50 percent have some complications."

Q. And then I asked you: "And what kind of complications?"

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Would you read your answer.

A. "Well, it's neurological. I mean, it could be -- it could be hearing loss, especially in the young, it could be strokes, it could be cognitive dysfunction, it could be persistent vegetative state and coma."

Q. And then go ahead and read your additional answer on page 96 at line 2.

A. "Anything from something mild and recoverable to something disastrous and irreversible."

Q. And then I asked you this question: "Do you have an opinion regarding whether Ms. Skinner would have had some of the neurologic deficits that you have described if she had survived?"

Would you read your answer starting at line 8.

A. I said, "I don't know. She didn't -- her course looked like -- I don't recall that she was described at autopsy or from her imaging to have a stroke, like a big acute stroke or something like that, so probably she wouldn't have had that, I guess, but you can have ... I don't know.

"I would just say there is a 50 percent chance on surviving she'd have some complications along the spectrum. She might be at slightly lower

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risk of a major one if she didn't demonstrate that before she died."

So that was my answer.

Q. All right. And that was your testimony under oath on October 24, 2011, correct?

A. Yes.

Q. Just a couple of questions about lumbar puncture, since you discussed that earlier.

Did Ms. Skinner have increased intracranial pressure on January 26th, when she was in the emergency department.

A. Yeah, all patients with bacterial meningitis have increased intracranial pressure.

Q. What is "increased intracranial pressure"?

MR. WAMPOLD: Would you say that again.

THE WITNESS: I'm sorry.

A. All patients with bacterial meningitis have increased intracranial pressure. Sorry.

Q. And what is that condition? Would you define it for the jury.

A. Yes. The brain and its contents -- that includes the spinal fluid -- have a pressure, and there's a normal pressure, and when there's crowding inside the cavity that houses the spinal cord and the brain, inflammation causes more expansion, edema,

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and the pressure inside goes up.
Q. And there can be some risks in doing a lumbar puncture on a patient that has increased intracranial pressure, correct?
A. Not all patients. Not a patient like Mrs. Skinner.
Q. Other risks associated with doing a lumbar puncture include pain, infection, nerve irritation, nerve damage, or actually severing a nerve, correct?
A. Yes.
Q. These are all things that a doctor would discuss with a patient before doing a lumbar puncture, correct?
A. Yes.
Q. I'd like to finish up by asking you a few questions about -- a few more questions about the medical-legal work that you have done.
MS. McINTYRE: And I have Exhibit-143, your Honor, which I have marked, and I've given a copy to counsel. I would like to hand it to the witness simply in case he needs it to refresh his memory.
THE COURT: Any objection. Mr. Wampold?
MR. WAMPOLD: No.
THE COURT: All right.
You may approach.

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MS. McINTYRE: Thank you.
Q. Dr. Talan, you have given several hundred depositions, haven't you?
A. Over my career, yes.
Q. And you've testified at trial at least 40 times, haven't you?
A. Yes.
Q. You charge $500 an hour to review records, correct?
A. Yes.
Q. And you charge $850 an hour for depositions, correct?
A. Yes.
Q. You're charging $8500 today for your testimony here in court, aren't you?
A. I am.
Q. Did you arrive in Seattle last night?
A. Yes.
Q. So are you charging for two days of time here or one?
A. Two days.
Q. Two days. So that will be a charge of $17,000, then, for your trial testimony, correct?
A. That's right.
Q. And when we add up the time that you have

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spent in reviewing this case and meeting with Mr. Wampold, and charges for your deposition, and $17,000 here today, we're in excess of $30,000, aren't we?
A. I don't think so. What you handed me here was about $5,000 -- $4- or $5,000.
Q. Well, we can do the math, then.
On May 7, 2010, you charged the plaintiffs $2500, right.
A. Yes.
Q. And that was at a rate of $500 per hour, correct, for reviewing records?
A. Yes.
Q. On July 15, 2011, you charged another $750, correct?
A. Yes.
Q. And on December 27, 2010, your charge was for $1,000, right?
A. Yes.
Q. And then on October 17 and October 18 you charged an additional $1,000 regarding this case, correct?
A. Right.
Q. And then you were paid $2,000 by the plaintiff for travel regarding your deposition.

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Do you recall that?
A. Yes.
Q. And then I took your deposition at the rate of $850 an hour -- right? -- and it took about three hours, so that was $2500, right?
A. Yes.
Q. And you have done additional work on that -- on this case since then, haven't you?
A. Yes.
Q. And how much additional work have you done on the case since I took your deposition on October 24, 2011?
A. Let's see, I've reviewed a couple more depositions and met with Mr. Wampold, so maybe three or four hours.
Q. So if we take four times five, that would be an additional $2,000?
A. Okay.
Q. Okay. And then we have your charge for two days of trial testimony, and that would be $17,000 right?
A. Yes.
Q. Okay.
Your income from the medical-legal work that you do is anywhere between $150,000 to $200,000

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a year, isn't it?
A. Yes.
Q. And that's almost as much as what you make in your job as a doctor, isn't it?
A. From my primary employment at the County of Los Angeles, yes.
Q. And you spend far less time on the medical-legal work, don't you?
A. Yes.
Q. I have no more questions. Thank you.
A. You're welcome.
THE COURT: Mr. Wampold, redirect?
MR. WAMPOLD: Thank you, your Honor.
-o0o-
REDIRECT EXAMINATION
BY MR. WAMPOLD:
Q. Doctor, one of the things that we heard yesterday was that part of a physician's role is to try to "find a unifying theory" for a patient's symptoms. Are you familiar with that concept?
A. Yes.
Q. Could you tell us a little bit about that.
A. Well -- so, you know, we're going through our differential diagnosis, we're -- we have a list of different things, and it's always more likely that

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when someone comes in with a bunch of different symptoms and findings, that it's caused by one disease, not many.
Now, it's not impossible that it couldn't be many, but if you find yourself, you know, putting three diagnoses together in order to explain all of these things when one made more sense, you're taught in medicine certain logic.
It's actually called "Occam's razor," and, I don't know, there must be some fable around Occam and its razor, but the basic idea was you try to find one unifying diagnosis, if it makes sense, and you don't ignore the clues that could point in that direction if they exist.
Q. Okay. Let's take a look at a list of symptoms here, signs and symptoms, that Ms. Skinner had.
Well, maybe on the board, on the -- do you mind getting up.
A. No, it's okay.
THE COURT: Just take the microphone with you.
MR. WAMPOLD: Okay.
THE WITNESS: All right.
THE COURT: That's all I ask.

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THE WITNESS: A microphone and a marker, I guess.
MR. WAMPOLD: Yeah.
THE WITNESS: Where's the marker?
THE COURT: The marker's up there on the counter.
THE WITNESS: All right.
THE COURT: And if you could turn that easel, orient it a little bit more towards the jury.
THE WITNESS: (Complies.)
THE COURT: Thank you.
THE WITNESS: Is that better?
Q. (By Mr. Wampold) Doctor, if you could write down "MRI."
A. All right.
Q. "WBC." "Stiff neck." "Headache." "Vomiting."
A. (Witness complies.) Okay.
Q. Would -- those five signs and symptoms in this particular case, the MRI that shows enhancement of the meninges, the elevated white blood cell count, the stiff neck, the headache, and the vomiting, what is the disease process that a reasonably prudent physician is going to think is the unifying cause of all those five signs and

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symptoms?
A. Again -- sorry -- in this case, these all point towards meningitis.
Q. And Dr. Anderton, what did she attribute the MRI finding to?
A. She thought that that might be due to a past lumbar puncture.
Q. Okay. Could you -- do you mind writing that down, "prior LP"?
A. Okay. (Witness complies.)
Q. And what did she attribute the white blood cell count to?
A. She said it was a mystery.
Q. Okay.
A. She wasn't sure.
Q. What did she attribute the stiff neck to?
A. I'd have to look at her diagnosis. I think maybe a cervical strain or --
Q. Okay. Let's write down "cervical" -- write down "strain."
A. "Strain."
Q. And the headache, what did she attribute that to?
A. Oh, I think -- and again, I'm confused between the 25th and the 26th. At least someone

APPENDIX B

NO. 68479-5-I
COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION I

JEFFREY BEDE, as Personal Representative of the Estate of LINDA SKINNER, Deceased,
Respondent.
vs.
King County Superior Court
No. 10-2-24387-9 SEA
OVERLAKE HOSPITAL CENTER, a Washington corp., and PUGET SOUND PHYSICIANS, PLLC, a Washington corp.,
Appellants.

TRANSCRIPT OF THE TRIAL PROCEEDINGS BEFORE

THE HON. BETH M. ANDRUS

VOLUME VIII

January 3, 2012
516 Third Avenue
Seattle, Washington

DATE REPORTED VIA FTR: May 21, 2012
REPORTED BY: Mary A. Whitney, CCR -

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(Cont'd)

EXHIBIT INDEX

(Cont'd)

INDEX - (Cont'd)

Note: "*" denotes phonetic spelling.
"..." denotes brief inaudible portions of the audio recording.

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SEATTLE, WASHINGTON; TUESDAY, JANUARY 3, 201
TRANSCRIPT OF THE TRIAL PROCEEDINGS
BEFORE THE HON. BETH M. ANDRUS
VOLUME VIII
9:05 A.M.
-o0o-

THE BAILIFF: King County Superior Court is now in session, the Honorable Beth Andrus presiding.

THE COURT: Please be seated everyone.

MR. WAMPOLD: Happy New Year, your Honor.

THE COURT: Good morning.

MS. McINTYRE: Good morning, your Honor.

THE COURT: Happy New Year to everyone.

MS. McINTYRE: Thank you.

THE COURT: If we can all just remember now to use 2012 on everything that we write and sign.

I understand that the parties have been fairly busy over the holiday weekend. I want to let you know I did receive Puget Sound Physicians' objection to the rebuttal standard-of-care testimony of Dr. Loeser. I received the plaintiff's response to that pleading.

I also then received a memorandum from Puget Sound Physicians on rebuttal and

surrebuttal, and I received a response from the plaintiff on that, as well, and I have had an opportunity to review all of that material.

I also had a chance to go over all of my notes of the trial testimony of Drs. Dobson, Maravilla, Riedo, and Wohns in order to try to refresh my recollection as to what each of the respective experts testified in order to evaluate the positions that the parties have taken.

Ultimately, I believe that the plaintiff has the stronger position on this particular issue. I understand rebuttal should be limited to things that are new and not just a repetition of the plaintiff's case in chief, but there seems to be a fairly clear -- well, perhaps not clear -- disagreement on standard of care that I think Loeser is probably going to address in some way.

I am going to allow Loeser to testify in rebuttal in the plaintiff's case, and I am going to allow him to opine as to the standard of care.

I do think that there was enough in Dr. Riedo's testimony about the atypicality of her presentation that seems to be the guts of where the disagreement is on the experts; whether or not she did in fact exhibit enough signs to warrant an LP.

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-o0o-
JOHN D. LOESER, M.D., witness herein, having been first duly sworn on oath by the Court, was examined and testified as follows:

THE COURT: Please have a seat.
THE WITNESS: Thank you.
-o0o-
DIRECT EXAMINATION - (Rebuttal)
BY MR. WAMPOLD:
Q. Good afternoon, Dr. Loeser. Could you please state and spell your name for the record.
A. My name is John David Loeser; L-o-e-s-e-r.
Q. Your work address?
A. Department of Neurological Surgery, University of Washington, Seattle, Washington.
Q. Dr. Loeser, you are a neurosurgeon and a professor of neurosurgery at the University of Washington, correct?
A. That is true.
Q. And you've been a neurosurgeon for about 50 years?
A. That is true.
Q. And as a neurosurgeon, you have to know

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about infections of the brain and the surrounding tissues, like the spinal cord.
A. Yes.
Q. And all neurosurgeons have to be familiar with bacterial meningitis and its signs and symptoms, true?
A. Yes.
Q. Okay. And you're here -- as the judge has told the jury, you're here to respond to some of the testimony of some of the defense experts. Is that fair?
A. That's true.
Q. Before we get to those topics, I want to walk through your educational background. Dr. Loeser, could you tell us about your educational background.
A. I graduated from Harvard College in 1957, magnum cum laude and Phi Beta Kappa. I then went to NYU School of Medicine, graduated in 1961, and was elected to the honorary society there of Alpha Omega Alpha.
I then did an internship in surgery at the University of California in San Francisco in '61-62, and then did a residency in neurosurgery at the University of Washington from '62 to '67.
Q. And after you were done with

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your residency in neurosurgery, did you then go into the Army?
A. I had a job for six months at the University of California, Irvine, and then got an invitation to join the Army that I couldn't refuse.
Q. And was that to go to fight in Vietnam?
A. I spent a year in Vietnam, and then a second year at Fitzsimmons in Denver.
Q. And tell us what it was that you were doing in the military.
A. I was doing neurosurgery for soldiers and a certain number of civilians who were wounded in some way in that conflict.
Q. Were you decorated for your time?
A. I received several decorations for my time in Vietnam and for my activities there.
Q. After Vietnam, why don't you walk us through -- first of all, did you sit for the board certification?
A. Yes. After Vietnam, I spent a second year in the Army because the standard term was two years in my era, and then a position opened up at the University of Washington. I returned to the University of Washington in 1969.
The neurosurgery board requirements

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are that you can't take the oral boards until two years after you finish your residency, and I took and passed the neurosurgery oral boards in 1970.
Q. Okay. And then have you been at the University of Washington medical school since that time?
A. I have.
Q. Why don't you walk us through what a professor of neurosurgery and a neurosurgeon -- what you do at the University of Washington, what you've done over the course of your career.
A. Well, I joined the faculty as assistant professor of neurological surgery, and I was recruited to come back because they needed a neurosurgeon interested in pediatric neurosurgery and pain, and so those were my specialty assignments.
But there were a group of four of -- four other people at the university at the time, and we all rotated taking call, and all did a certain amount of general neurosurgery that was not in anyone's particular specialty area.
I also had a laboratory and did neurophysiological research in the first decade or so that I was at the university.
In 1977, I became the curriculum dean at

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the University of Washington and spent the next five years half-time in the dean's office and half-time doing neurosurgery when I --

Q. So you were the curriculum dean for the whole med school?

A. That's correct.

Q. Okay.

A. When I finished that, I was asked to be director of the pain center, which I directed from 1982 -- 1983 until I retired from that in 1998.

During this time, I split my time between the university and Children's, because in 1974 the university merged with Children's and all the pediatrics that had been done at the university was moved to Children's.

I was associate chief of neurosurgery at Children's from '74 to '85, and then I was chief of neurosurgery at Children's from '86 to about '93.

Q. And during the time that you were assistant chief and then chief of neurosurgery at Children's, did you continue to do surgery on adults at the University of Washington?

A. I did.

Q. Okay.

A. About half-time in each institution.

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Q. And tell us -- we know that you have these subspecialties of pediatrics and pain, but you also -- you mentioned that every fourth or fifth -- there were four or five of you. Then had to be on call. What does that mean, when a neurosurgeon is "on call"?

A. Well, you took care of any neurosurgical problems that came into the hospital. You were likely, in the wintertime, to be the only guy in town -- everyone else was off skiing -- and so you took care of whatever came in and needed to be done on an urgent or emergent basis.

There were some areas of neurosurgery that no one of us specialized in, and then we just all shared with that area of neurosurgical activities.

Q. Okay. So I think we've sort of talked about your clinical work. I'd like to -- tell us a little bit about the other duties and responsibilities you have as a professor of neurosurgery at the U; the writing, the teaching, that type of thing.

A. Well, I actually ran a neurophysiology lab for the first decade, roughly, of my tenure and spent a significant part of my time doing research involving neurophysiology, related mainly to pain and to epilepsy. When I went into the dean's office, that

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wet lab research had to go. I couldn't do everything.

All along, I have been responsible for teaching residents in neurological surgery, both at the bedside and the clinic, in the operating room, medical students who rotate through the neurosurgery clerkship.

I lecture in the MEDEX program for the PAs. I've lectured in the nursing school and the dental school. I've done a lot of lecturing and a lot of seminars and -- both formal and informal types of teaching, for medical students, residents, fellows, trainees, visitors from abroad, et cetera.

Q. And then at one point were you named Fulbright scholar?

A. I got a Fulbright senior fellowship in 1989, and spent the year '89 through '90 in Adelaide, Australia, doing research and teaching.

Q. Okay. And are there actually some lectureships named after you at the University of Washington and elsewhere?

A. Yes. The University of Washington has an annual continuing medical education course in the pain center that they named the "John Loeser Pain Course."

The American Association of Neurological Surgeons, which is the union for all neurosurgeons in

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the United States, has a lectureships in its pain section and a John D. Loeser lectureship on neuromodulation.

And the International Association for the Study of Pain, which has been an organization that I've helped found and have been involved in, has a meeting at -- a lecture at its biannual meeting entitled, "The John D. Loeser Lectureship."

Q. And Doctor, because of your research and writing, have you actually published articles in the peer-reviewed journals?

A. I guess about 250.

Q. And have you also written books and book chapters?

A. An equal number of book chapters, and I have written or edited eight books.

Q. Doctor, tell us, in 2008, did you stop actually performing surgery on patients?

A. Yes. I retired from clinical practice in 2008, and I work part-time at the university now, doing research, teaching, a little bit of administration, but no patient care.

Q. But are you still involved with patient care? And I wonder if you could tell us a little bit about the Tuesday conferences and the Wednesday conferences.

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A. Yeah. I don't provide any direct patient care -- I don't do any surgery anymore, I don't see patients in clinic -- but in an academic service such as ours, we have a variety of conferences, predominantly for resident education, that the department runs.

So, for example, at 7:00 o'clock on Tuesday mornings, there is a spine conference where the orthopedists and the neurosurgeons at the university discuss the planned cases for the week.

On Tuesday at 5:00 o'clock, there's a pain center conference where interesting cases or lectures are given by various faculty members.

On Wednesday mornings, from 7:00 to 9:00 a.m. at Harborview, the entire neurosurgery department gets together for different functions each week of the month, so to speak.

So it will be a morbidity and mortality conference one week. It will be a lecture of some sort another week. It will be presentation of research from the department another week. It will be invited guest speakers. A hodgepodge of didactic activities.

And then Wednesday at 5:00 o'clock at the university is our case conference for the university,

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only, where the planned cases for the week are discussed, the pictures -- the imaging studies reviewed, and we have -- the resident has to produce a weekly brief didactic session, because we're trying to teach people how to make presentations and so forth.

So those are the conferences I go to now.

Q. Okay. And Doctor, tell us, just very briefly, what this looks like if people are "presenting" on a case -- and I assume you mean a surgery that's going to take place -- and all of the neurosurgeons are there. Tell us a little bit about what that's like.

A. Well, one of the junior residents is tasked with the job of presenting a brief synopsis of the patient's history and findings, and then the imaging studies -- x-rays, CT, MR, occasionally other kinds of studies -- are presented and discussed by all of the faculty and the residents who are there, and we sort of informally criticize or agree with the management plan that the attending surgeon is proposing.

Usually we all agree about how to go about doing things, but sometimes there are heated debates about "I'd do it this way" or "I'd do it that way" or something like that.

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So it's a very open and easy give-and-take amongst a group of colleagues. It's not criticism. It's trying to produce an environment where the residents and fellows can learn most efficiently.

Q. And you also mentioned these meetings up at Harborview of all the neurosurgeons --

A. Uh-huh.

Q. -- and you said that they rotate, but that sometimes there are morbidity and mortality discussions. Tell us a little bit about those -- I think they're referred to as "M & M conferences." Tell us a little bit about that.

A. Yeah, "M & Ms" are sweeter than "morbidity and mortality," perhaps. But it is a requirement of the neurosurgery boards -- and they get it from the Graduate Council on Medical Education -- that every academic service have a monthly morbidity and mortality conference in which all of the trainees and the faculty are present.

Any case where there was an unexpected death or unexpected complication is presented and discussed with the goal of trying to decide: Is this a result of an act of nature? I mean, did this patient have a disease that was going to kill them no matter what happened? Or was this because of an error

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in judgment? Or was this because of an error in technique?

Because the only way you get better is by finding out what went wrong, and it's not an accusatory experience, it's everybody saying, "Well, how can we do it better next time."

This is a requirement of all training programs in the United States, and it's religiously held, and notes are taken, and it's all documented. It's very serious formal activity.

Q. For neurosurgery?

A. Well, for every specialty, but, yes, neurosurgery.

Q. So, Doctor, in terms of the work that you still do -- you still attend all of these conferences, you still do teaching -- are you still doing writing and research?

A. Yes.

Q. And you have been since 2008?

A. I have.

Q. All right.

Doctor, I want to turn to another issue, and that is whether you know a couple of the experts who have testified before this jury.

Do you know Dr. Wohns?

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A. Yes. He was once a resident in our system.
Q. Okay. And he was a resident in your system. Were you the attending when he was a resident?
A. Yes.
Q. And Dr. Wohns testified that he was a "chief resident." Is that some sort of honor, to become a chief resident?
A. You can't become a board-certified neurosurgeon unless you have served a year as chief resident in your training program, so every neurosurgeon in practice in the United States who is board-certified has served as chief resident.
Q. And Dr. Maravilla is someone who has testified. Is that somebody that you've worked with for many years at the University of Washington?
A. Yes.
Q. Okay.
A. He is a colleague at the University of Washington.
Q. And could you tell a little bit about, in cases where you've worked with Dr. Maravilla, what sort of his role is versus your role.
A. Well, Dr. Maravilla is a neuroradiologist. He is administratively responsible for neuroradiology,

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which means any kind of imaging done of the nervous system and its surrounding tissues at the university.
He reads, interprets, any imaging study of the brain or spinal cord. He can be consulted, and we consult with him when we have a diagnostic problem and we need to know what's the best way of imaging this.
But he does no patient care. He does not provide any continuity of care. He simply is a neuroradiological expert, and a good one, whom I enjoy working with and have for 20 years.
Q. Okay. Okay.
Now, Doctor, I want to talk a little bit, before you get to the conclusions that you've reached in this case, about the things that you have reviewed.
One of the things that you reviewed is, we actually provided you with a transcript of the testimony of Dr. Riedo, right?
A. Yes.
Q. And the testimony, partial testimony, of Dr. Maravilla?
A. Yes.
Q. And we provided you with the trial testimony of Dr. Wohns.

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A. Yes.
Q. We also provided you with all of the records of Ms. Skinner from Overlake Hospital?
A. Yes.
Q. The pretrial testimony of Dr .Anderton and the other health-care providers who provided care to Ms. Skinner on the 26th?
A. Yes.
Q. And you also read the pretrial testimony of Chris Bede and Courtney Bede?
A. I did.
Q. And you looked at films that were Taken at Overlake Hospital and the reports of those films?
A. I did.
Q. You looked at the autopsy that was performed by Overlake Hospital and by Johns Hopkins?
A. Yes.
Q. And you read the records from the acoustic neuroma surgery and the subsequent surgery to repair the leak from back East for Ms. Skinner?
A. I did.
Q. Did you feel that you had the information you needed to form some conclusions in this case?
A. I did.
Q. Okay.

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Doctor, I want to start with this question, and in all the questions I'm going to ask you, I want you to assume that I'm asking you for your conclusion to a reasonable degree of medical probability, more right than wrong, unless I tell you otherwise.
Do you believe that Ms. Skinner had bacterial meningitis on January 26, 2010, when she was in the emergency department with Dr. Anderton?
A. Yes.
Q. Why do you believe that?
A. She had the history and physical findings compatible with meningitis, or suggestive of meningitis, she had a white count of 19,000, which is almost certainly indication of a serious infection, and she had an MR scan that showed enhancement of the meninges, the coverings of the spinal cord, which is always meningitis until proven otherwise, and that combination, to me, says this woman had meningitis.
Q. Doctor, do you believe that had an LP been performed on Ms. Skinner in the emergency department when she was there with Dr. Anderton on the 26th, that it would have showed that she had bacterial meningitis?

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A. Absolutely certainly.
Q. And tell us why you believe that.
A. Because she had meningeal enhancement, because she had an elevated white count, and because she had clinical signs and symptoms suggestive of meningitis, and, to finish, because we know that she did have meningitis ten hours later, and the meningitis certainly didn't start when she got admitted to the hospital that night.
Q. Now, Doctor, I want to talk about your conclusions about whether the standard of care was met on the 26th, but I want to understand from you -- you're not an emergency room doctor, right?
A. Correct.
Q. -- why is it that you believe you have the qualifications to talk about whether the standard of care was met on the 26th in the emergency department.
A. I guess I'd start to answer that by saying my experience as a medical educator tells me that every medical student who graduates from our school, at least -- and I suspect all of American medical schools -- is taught what the signs of meningitis are, the emergent need for establishing the diagnosis, and treatment.

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And I don't think it has anything to do with what specialty you have gone into. It is something that every physician needs to know and was taught at some point during their medical school or internship years.
I don't think there's a different standard of identifying a patient with meningitis for a neurosurgeon or a neurologist, or an emergency room doctor or a family practice doctor. It's just one of those diagnoses where we know that the outcome is primarily determined by the prompt -- excuse me, the promptness of treatment, and delay in establishing diagnosis, and therefore delay in establishing treatment, is the single largest adverse outcome predictor.
Q. Doctor, have you also had involvement with emergency departments over the course of your career?
A. I certainly have.
Q. Okay. And tell us a little bit about how it is that you've had involvement with emergency departments.
A. It works in two ways. One of them is the emergency room physician is faced with a diagnostic problem that has something to do with the

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nervous system and might call us to come see a patient who is a new patient for us.
The other is an established patient comes to the ER, and the neurosurgery service is called, and we go down and see the patient and discuss the management with the ER physicians at the time.
Q. And so what are the emergency rooms that you've had heavy involvement with throughout your 50 years of being a neurosurgeon?
A. Well, in all the hospitals I've worked in: the VA, Harborview, United States Public Health Service hospital -- which is now not used for that purpose -- Children's Hospital, and the University of Washington hospital.
Q. In your experience, are emergency room doctors supposed to be more in tune with the signs and symptoms of bacterial meningitis or less in tune than other physicians?
A. More in tune.
Q. Why is that?
A. Because they're so often the front line of health care, particularly in our country today where so many people use the ER as their primary care facility. Patients come to the ERs with symptoms just like Ms. Skinner did, and the ER physician has got to

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be able to say, "This may be meningitis. I have to pursue this."
Q. Doctor, do you believe that the standard of care was met by Dr. Anderton on January 26, 2010?
A. I do not believe she met the standard of care.
Q. And tell us why you believe that.
A. Because the standard of care for any physician, including an ER physician, when confronted with a patient with the story that Ms. Skinner had when she was brought to the hospital for the second time, mandates that the diagnosis of meningitis be considered, and the standard of care mandates if you consider the diagnosis of meningitis as a possibility, you have got to do an LP at that time to rule in or rule out your concern.
Q. And what was the significant history and findings that you think meant that Linda Skinner was required by the standard of care to get an LP?
A. She had a history of fever, although it is clear she did not have fever at the time. She complained of neck pain and headache that radiated up and down the spine and over the top of her head.
She had a history of nausea and vomiting,

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she had a white count of 19,000, and she had an MR scan that showed meningitis. What else do you need to say the patient has meningitis and to act accordingly?

Q. And Doctor, do you believe -- well, what do you believe was the treatment that was required by the standard of care for Ms. Skinner on the 26th?

A. Two things were required: a lumbar puncture to prove the diagnosis, and the prompt initiation of triple antibiotic therapy until the organism was determined and the therapy could be modified as appropriate.

Q. And Doctor, do you believe, to a reasonable degree of medical probability, had Ms. Skinner gotten a lumbar puncture and the antibiotics in the emergency department on the 26th, that she would be alive today?

A. I do.

Q. Okay. Why?

A. Well, I guess it's based on both my personal experience over the years and on what I can read in the literature where people have directly addressed the question: What is the morbidity and mortality of pneumococcal meningitis in adults? I have cared for some number of patients -- I'm guessing less than ten -- over my 50 years who had pneumococcal

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meningitis, and they all survived.

I could tell from the literature that I was able to glean on the subject, that if you look at surveys of all comers -- that is, they didn't just pick the six ones or the not sick ones; they just took anybody who came to the hospital with meningitis, with pneumococcal meningitis, adult -- the survival rate is up around 80 to 90 percent.

And so my experience is similar to that that is in the published literature. Pneumococcal meningitis is not a fatal condition, in most patients, if it is appropriately treated.

Q. Okay. How does Ms. Skinner's clinical picture at the time contribute to your opinions that she would have survived had she been given timely treatment?

A. Well, ironically, it contributes relatively little, because she had a white count. She had a shift to the left indicating infection. Almost exclusively, 19,000 white cells with a shift to the left means bacterial infection. And then she had an MR scan that showed she had meningeal enhancement.

Other causes of meningeal enhancement are so rare that most people have never seen it.

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It can occur in somebody who has had a spinal fluid leak, but even if it occurs then, when the leak is stopped, it goes away in days, weeks, maybe a month or so.

This lady's lumbar puncture was five years before. It is absolutely -- there is absolutely no basis for saying her meningeal enhancement was due to an LP or a CSF leak that she had five years before with no evidence that it was continuing to leak.

So, to me, the real proof of the pudding is the white count and the MR scan, and the history and findings should have been suggestive to a prudent physician. But even if the patient was mute, having the white count and the MR scan is meningitis until you've proven that it's not.

Q. And I had a slightly different question that I was asking. The fact that she was lucid and not hypertensive and not having seizures, how does that play into your conclusions about the fact that she would have survived?

A. Well, the literature says, very clearly, the better the patient's condition when you initiate therapy, the more likely you are to have a good outcome, and the reciprocal is also true, the poorer the condition, the less likely you are to have a good

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outcome.

Q. Okay. I want to switch gears here for a minute, and I want to talk about Dr. Riedo's conclusion.

You read his trial testimony, and saw that what he says is that she really didn't have meningitis, but she had this abscess outside of her ear that ruptured.

Dr. Loeser, do you agree with Dr. Riedo, that she had some sort of abscess in her ear.

MS. McINTYRE: Objection, your Honor, to the characterization of testimony by Dr. Riedo, that he said Ms. Skinner never had meningitis.

THE COURT: I'll overrule the objection. I think the jury will decide what the prior testimony was.

But can you ask your question again.

MR. WAMPOLD: I will. I'll rephrase. I didn't mean to misspeak.

Q. Dr. Loeser, do you agree that Ms. Skinner had some sort of abscess that ruptured when she was in the emergency department on the 26th, as Dr. Riedo has testified to?

A. I do not.

Q. Explain to us why you don't agree with

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Dr. Riedo.
A. There are several reasons why I do not. First of all, it relates to the definition of "abscess." An abscess is a collection of dead white cells -- pus -- surrounded by the body's attempt to isolate that infection, which we call a "capsule."
The capsule consists of fibroblasts and new, tiny little blood vessels. That's how the body tries to fight the infection; wall it off and bring in blood vessels to bring in white cells to fight the infection.
Abscesses occur in tissue, meaning that you can have an abscess in the brain. Abscesses can occur in the liver, or in the spleen. It occurs in something, and the abscess sort of looks like tennis ball, except instead of having air in the middle, it has pus in the middle and this dense, fibrous, and bloody capsule around it.
Ms. Skinner had an infection in a space that was created by the neurosurgeons who wanted to get access to where her acoustic neuroma was, in the beginning, and in the second operation to where the dural leak was.
They removed a large amount of the bone in -- what's called the "temporal bone" here on the side

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(indicating), they completely removed all of the bones and the canals, the semicircular canals, in the middle ear, they tied off her eustachian tubes so there was no drainage down into the nose, and they completely obliterated her external canal so it was just a blind, dead-end sac, and they made this big space.
In order to make sure that the dural repair didn't break down again, they put Duragen, a synthetic material, over the dura, they put some collagen matrix -- another synthetic material -- and they took a fat graft from her thigh and packed it into this area.
I think she probably at some point after this second operation developed a low-grade infection in that area. The infection was occurring in a space that was already created by the surgeons. If you want to argue she had an infection there, it's an empyema. It's not an abscess.
Furthermore, if an abscess ruptures, which is what Dr. Riedo claimed happened, the capsule stays there, and so when you do an autopsy or an imaging study of the region, you see the capsule.
The pus has ruptured out -- that's true -- but there's a capsule there, and the autopsy report -- and I think it was a good, thorough

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autopsy -- did not mention anything that looked like a capsule.
Indeed, the report's a little funny to me because it says there was purulent material in the middle ear, so you couldn't see the bones of the -- the little, tiny bones in your ear. Well, guess what? They were removed by the surgeon. That's why you couldn't see them.
And whether she had any kind of rip-roaring, serious infection in her ear I think is open to question. The debris seen in that space could be the remnants of the fat graft, and the collagen and the Duragen, and things that were packed in there.
However, I do think the most likely cause of her meningitis was a leak from this empyema in the ear that contaminated the subspinal fluid spaces, but I see no evidence whatsoever to support the idea that there was an abscess in her ear.
Furthermore, we know what an ear infection looks like, clinically, especially an "abscess" in that area, which, as I said, is the wrong term, but then let's say an "empyema" in that area.
The patient has excruciating pain on that side of the head, on that ear -- it's not on the other ear, it's unilateral pain -- and if this woman had

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a serious infection in her right ear, she would have had right-sided ear pain.
It could radiate up towards the top of the head or down into the neck, but it wouldn't radiate to the other side, and it wouldn't give her nuchal rigidity and things like that.
So I think, clinically, there's absolutely no evidence to support the idea that she had an "abscess" -- I don't like using the word, but he used it -- okay. -- an "abscess" in her right ear. Not feasible, in my opinion.
Q. Okay. And so, Doctor -- okay. And so if there was no abscess, there was no rupture while she was in the emergency department on the 26th, either.
A. That is correct.
Q. Okay.
Doctor, the theory that he -- that Dr. Riedo postulates about there being some sort of abscess that ruptures on the 26th, and then that was when all of her symptoms really started, how does that square with the MRI finding of meningitis, that was taken?
A. Well, as I recall Dr. Riedo's testimony, is that the reason why she got better in the ER

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was that her abscess ruptured at that time, but we know that her meningeal enhancement was already there. Consequently, it's backwards. Okay.

If there had been a ruptured abscess and the subarachnoid space was flooded with bacteria and white blood cells, you could develop meningeal enhancement, but the timing he proposed is absolutely wrong. The patient's enhancement was there before the time that he proposed her abscess ruptured.

Infection in the middle ear on one side is not likely, in my opinion, to give you completely 360-degree, around-the-spinal-cord enhancement that runs from the bottom of the skull down to the low cervical region. I just don't think that that's a reasonable hypothesis.

Q. Doctor, part of Dr. Riedo's conclusion is based on the fact that Ms. Skinner showed some improvement in the emergency department. He said that's totally inconsistent with someone who has bacterial meningitis. You've been an expert in pain and pain drugs over the course of your career. Is he right?

A. No.

Q. Tell us why.

A. First of all, the amount of pain a person has

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is so variable that you just can't make any meaningful prediction on this pathology will cause that amount of pain.

Mrs. Skinner said her head pain when she came to the hospital was 10 out of 10. To me that means she's got serious pain. That's as big a number as you can give, is 10 out of 10. That's excruciating pain.

She was given some analgesics, and her pain gradually came down, first to a 9, and then a couple hours later a 6. Well, I don't know about you, but a 6 is still a lot of pain, to me. I wouldn't want to have a 6-level pain.

And I think the course of somebody with meningitis, particularly early in the meningitis, can be quite fluctuating. It's not just a straight projection, people fluctuate around a mean, and I think that's not uncommon.

Q. Doctor, can you make statement that the amount of Dilaudid that she was given -- first of all, what kind of drug is Dilaudid?

A. Dilaudid is a narcotic, like morphine or methadone.

Q. Okay.

A. It's a very powerful opiate.

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Q. Can you make a statement that, you know, one milligram of Dilaudid wouldn't affect somebody like Ms. Skinner's pain?

A. No, you cannot.

Q. Why not?

A. Because you don't know what Mrs. Skinner's response to a milligram of Dilaudid will be. People vary. She's not tolerant of narcotics; that is, her medical record doesn't indicate she was used to taking narcotics.

Some people are exquisitely sensitive to narcotics and get dramatic pain relief from relatively low doses, and some do not. You just can't make an ex cathedra statement: One milligram of Dilaudid isn't enough to give somebody pain relief. That's just nonsense.

Q. Doctor, now, we know that Mrs. Skinner had ventriculitis when she came back at about 10:30 from the CT scan.

Do you believe -- the fact that she had ventriculitis late that evening when she came back to Overlake, does that somehow mean that she wasn't saveable back at around 10:00 to noon in the emergency department on the 26th?

A. It does not.

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Q. And tell us why that's your opinion.

A. Ventriculitis is not a uniformly fatal disease for anyone. Indeed, in my pediatric experience where we put spinal fluid shunts into people --

Q. What's a "shunt"?

A. The tube that goes from the hollow space inside your brain into your vein or into your abdominal cavity to drain spinal fluid.

All operations have a risk of inflection, and every once in a while -- like about 10 percent of the time -- a shunt gets infected, and when it gets infected, the primary source of infection is in the ventricle, and that patient has ventriculitis, and with appropriate treatment they all survive.

In adults with meningitis, there are not any really good studies that tell you what the incidence of ventriculitis is. First of all, you couldn't tell somebody had ventriculitis until we had MR scans and CT scans, and that's relatively recently, even in my career. You could tell at autopsy, but we don't do many autopsies today.

The best I can tell, from reading the available literature and my own experience, is that a significant fraction of the people with meningitis

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do have ventriculitis and most of them survive, so I think that ventriculitis -- well, let me go back a second.

Meningitis is a relatively rare disease. I mean, you know, how many cases of meningitis occur in a year, of pneumococcal meningitis, and are seen by an emergency room or a specialist in infectious disease or a neurosurgeon? A couple a year. It's not common in our society at this time.

Ventriculitis, because as a concept it follows meningitis, is even rarer, so many people may never see any, but I think the best evidence we have is that a sizable fraction -- a third to a half of the people with meningitis -- do have ventriculitis, and the vast majority of those survive with appropriate, prompt treatment.

Q. And the appropriate treatment of ventriculitis, is it any different than the treatment for bacterial meningitis?

A. Not with pneumococcal meningitis. There are some exceptions where you have an organism that is not susceptible to the standard antibiotics, because if you think about it a second, you put the antibiotic into somebody's vein, and it goes into their bloodstream, and the heart pumps it up to the brain,

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and it gets out of the blood vessels into the tissues that are infected.

Well, some antibiotics don't get across into the brain, and then you'd have to put the antibiotic directly into the ventricle. But that's not relevant to pneumococcal meningitis.

Q. So the treatment for Ms. Skinner would have been the same.

A. Absolutely.

Q. Okay. Okay.

Doctor, I want to talk about the medical-legal work like this, testifying in a medical-legal case like this. In the course of your 50-year career, how much medical-legal work have you done?

A. Probably around 50 cases, 50 to 60 cases I would think.

Q. So about one a year, something like that, on average?

A. Well, recently, a little more. In the very beginning of my career, I didn't want to talk to lawyers at all, and so I just didn't get involved to any degree --

Q. Okay.

A. -- but in recent years I've done three to

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five cases a year, maybe.

Q. And in 2007, were you doing a case for one of my law partners, Brian Putra?

A. Yes. I was a treating physician in that case --

Q. Okay.

A. -- and had little choice about getting involved.

Q. And then Mr. Putra passed away and we worked together on that particular case.

A. That is true.

Q. And then in 2008, did you testify in a case where I put you on the stand?

A. That is true.

Q. Okay. And what was that case about?

A. Well --.

Q. I'll give you a hint.

A. You'd better.

Q. It was an oral surgery malpractice case ...

A. Oh, that was the case of the woman who was going to have an impacted molar removed, and the dental surgeon missed the molar and took a big bite out of her jaw, which got her mandibular nerve that runs down the jaw and gave her numbness and a terrible pain problem in her jaw and cheek and teeth.

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Q. And were you her treating doctor in that case?

A. I'm not sure.

Q. Okay.

A. I may have been. I don't -- because -- my confusion is because one of the things I specialized in was seeing people with crazy face pain. I saw lots of them.

In fact, because there's one defense attorney who defends all of the dentists who get sued for malpractice, I ran into this guy at least a half-dozen times in cases, and I'm not sure I can recall who said what to who, about it.

Q. That's fine.

A. I can't tell you.

Q. That's fine.

MR. WAMPOLD: Your Honor, could I just have a moment to confer.

THE COURT: Yes.

(Discussion off the record.)

MR. WAMPOLD: I don't have any further questions at this time. Thank you, your Honor.

THE COURT: Cross?

MS. McINTYRE: Your Honor, may we have a brief side-bar?