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NO. 61226-3-1

COURT OF APPEALS, DIVISION I  
OF THE STATE OF WASHINGTON

JERRY D. SMITH, as Personal Representative of the ESTATE OF  
BRENDA L. SMITH, Deceased, and on behalf of JERRY D. SMITH,  
RICHONA HILL, JEREMIAH HILL, and the ESTATE OF BRENDA L.  
SMITH,

Appellants,

v.

ORTHOPEDICS INTERNATIONAL LIMITED, PS; and PAUL  
SCHWAEGLER, MD,

Respondents.

**BRIEF OF APPELLANTS**

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## ASSIGNMENTS OF ERROR

The Trial Court Erred in Four Respects:

1. The Trial Court erred in failing to determine there was a violation of Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988), where counsel for Defendant Paul Schwaegler, MD, provided Plaintiffs' Trial Brief, court transcript testimony of plaintiffs' vascular surgery expert and defense counsel's outline for defendant's direct examination of treating physician Dr. Kaj Johansen, through the treating physicians personal lawyer.

2. The Trial Court erred in ruling that a Motion in Limine or an ER 615 Motion to Exclude Witnesses is a necessary requirement for a Loudon violation where defense counsel has provided a treating physician witness trial documents and trial testimony.

3. The Trial Court erred in failing to grant Plaintiff Smith's Motion for Mistrial.

4. The Trial Court erred in failing to grant Plaintiff Smith's CR 59 Motion for New Trial with exclusion of Dr. Johansen's testimony at retrial.

## ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. May defense counsel evade a violation of Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988), prohibiting any contact with

a treating physician, when defense counsel sent Plaintiffs' Trial Brief, trial testimony of plaintiffs' vascular surgery expert and defense counsel's proposed questions and outline of direct examination of the testifying treating physician to the treating physician through the treating physician's personal attorney? (*Assignment of Error 1*)

2. Whether a violation of a pretrial motion in limine or an ER 615 Motion to Exclude Witnesses is a requirement for a Loudon v. Mhyre violation where defense counsel provides trial testimony to a testifying treating physician? (*Assignment of Error 2*)

3. What is the appropriate remedy for an in-trial Loudon v. Mhyre violation? (*Assignments of Error 3 & 4*)

## **STATEMENT OF THE CASE**

### A. INTRODUCTORY FACTS.

Jerry Smith is the surviving spouse and personal representative of the estate of Brenda Smith. He brings this action in his representative capacity on behalf of Brenda Smith's estate, her surviving children, Richona Hill and Jeremiah Hill, and himself. Defendant Paul Schwaegler, MD, is a board-certified orthopedic surgeon specializing in back surgery and is a member and/or partner of Orthopedics International Limited, PS. Orthopedics International Limited, PS, maintains medical offices in

Seattle, Washington.<sup>1</sup> The plaintiff alleges Dr. Schwaegler was negligent in his post-operative care of Brenda Smith and that this negligence was a proximate cause of Brenda's fasciotomies, amputations and death.

B. MEDICAL FACTS.

The basic medical facts concerning Brenda Smith's multiple surgeries and death are not in dispute. Brenda Smith underwent a repeat back operation by Dr. Paul Schwaegler on December 31, 2003. The surgery that was carried out at Swedish Hospital at the Cherry Hill (Providence) Campus was a two stage procedure which lasted a total of 9.5 hours. (RP 11/06/07, p. 106.) The first stage of the procedure was an anterior (abdominal) approach to remove disc material at L3-4 and L4-5. During this first part of the surgery, in order to gain access to the lumbar discs, the vena cava and aorta need to be retracted. (RP 11/08/07, p. 63.) Here, during this part of the procedure, the vena cava was actually torn and had to be repaired by the access surgeon, Dr. Andrew Ting (not a defendant in the case). (RP 11/06/07, p. 106; RP 11/20/07, p. 98.) Even further retraction of the aorta is required for the repair of the vena cava. (RP 11/08/07, p. 72.)

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<sup>1</sup> Swedish Health Systems d/b/a Swedish Medical Center/Providence Campus was previously named as a party and settled prior to trial. Dr. Kaj Johansen, a treating vascular surgeon of Brenda Smith, was never a party to this action.

The second part of the procedure involved moving Brenda to a position where she lay flat on her stomach. During this part of the surgery, Dr. Schwaegler removed additional disc material and placed a metal supportive device to stabilize the three vertebrae. (RP 11/20/07, p. 99.)

After emerging from surgery, Brenda Smith was taken to the post-anesthesia care unit (PACU or recovery room). (RP 11/20/07, p. 102.) Dr. Schwaegler's handwritten operative note listed no complications. (RP 11/20/07, pp. 108, 109.) Brenda was taken to the intensive care unit (ICU) at 1925. (RP 11/20/07, p. 102.)

At 2200 that evening, ICU Nurse Anna Sterner called Dr. Schwaegler because of her concern over a new finding that Brenda Smith had bilateral foot numbness. (RP 11/07/07, pp. 52, 53; RP 11/20/07, p. 111.) Dr. Schwaegler advised Nurse Sterner that this numbness was expected. (RP 11/07/07, pp. 51-53; RP 11/20/07, p. 112.) The ICU nurse also told Dr. Schwaegler that the urine was dark with blood. (RP 11/20/07, pp. 111, 112.) Dr. Schwaegler did not come in to see his patient. (RP 11/20/07, pp. 110, 113.)

At 0600 the next morning, Dr. Elias Khalfayan, an orthopedic surgeon and partner covering for Dr. Schwaegler, came in to see Brenda Smith. Dr. Khalfayan noted a questionable neurologic exam. (RP

11/07/07, pp. 92, 93; Ex. 5.) Brenda was less able to flex her feet with weak knee movement. Brenda had decreased sensation on the dorsum of her left foot and had no active deep tendon reflexes, plantar flexion or extensor hallucis longus (muscle which extends the great toe). (RP 11/07/07, p. 92.) These deficits represented change from Brenda Smith's motor function 1.5 hours earlier. (RP 11/07/07, p. 92.)

Later that morning, Dr. Khalfayan rechecked Brenda Smith and called Dr. Schwaegler at home to advise him that Brenda was still exhibiting signs of weakness, had elevated potassium and that Dr. Khalfayan had requested a consult from the Swedish staff hospitalist. (RP 11/07/07, pp. 51-53.) Dr. Schwaegler advised Dr. Khalfayan that he would be coming in to see Brenda. (RP 11/07/07, p. 53; RP 11/20/07, p. 115.) Dr. Schwaegler acknowledges a vascular problem should be considered. (RP 11/20/07, p. 149.)

Dr. Bennet, a hospitalist, sees Brenda on January 1<sup>st</sup> and notes she is having difficulty with her right ankle plantar flexion and dorsiflexion, has difficulty moving her legs bilaterally and that her right leg is becoming more difficult to move and has less sensation. (RP 11/15/07, pp. 135-137, 149; Ex. 14; Ex. 6.) Dr. Schwaegler sees Brenda in conjunction with Dr. Bennet, but Dr. Schwaegler does not make any medical chart entry. (RP 11/08/07, p. 90.)

At 1500, ICU Nurse Hanson evaluates Brenda and finds that she has bilateral lower extremity pulses present. Nurse Hanson goes off shift at 1900 and Nurse Lolena Cummons begins her shift carrying out an evaluation at 1920 noting that Brenda's left foot is cool. (Ex. 11; RP 11/06/07, pp. 153, 155.) Nurse Cummons notes that there are no pedal (foot) pulses present. (Ex. 11.) At 2340, Nurse Cummons notes the left foot is cold and there are no pulses present by Doppler examination. (Ex. 11.) Nurse Cummons first contacts the staff hospitalist, Dr. Sachdeva, and then calls Dr. Khalfayan at approximately 1:00 am. (Ex. 11; RP 11/07/07, p. 114.) Dr. Sachdeva was unable to feel either the femoral, popliteal or dorsalis petal pulses and diagnosed an arterial out-flow problem. (RP 11/20/07, p. 126.) Brenda's left foot was cooler than her right. The left foot was cold and blue. (RP 11/20/07, p. 126.) Dr. Schwaegler considered Brenda's exam to be "grossly different" from the afternoon. (RP 11/20/07, pp. 126, 127.)

Dr. Khalfayan called Dr. Schwaegler, who came down to see Brenda. (RP 11/07/07, p. 114.) Dr. Schwaegler called Dr. Kaj Johansen for a vascular surgery consult. (RP 11/20/07, p. 125.) Dr. Schwaegler's early morning progress note states:

Pt /c [with] new findings of cool & dusky L foot & absent pulses distally B [bilaterally]...Does feel numbness is greater in L foot region...minimal motor fxn [function]

distally B [bilateral] LE [lower extremities]. Trace plantar flxn [flexion] & dorsiflxn [dorsiflexion] toes. Trace plantar flxn foot, min [minimal]/dorsiflxn R. Ø appreciable dorsiflxn L. Sensation intact R, absent/diminished greatly L LE [lower extremity] (foot). L foot cyanotic looking. Ø pulses distally in either LE [lower extremity]...Appears to have some component of vasc compromise...consulted Dr. Johansen...Will defer decision making to him re vasc status...

Dr. Kaj Johansen performed a left retroperitoneal transaortic thrombectomy. (Ex. 58; RP 11/14/07, p. 76.) Dr. Johansen's post-operative diagnosis included: "terminal aortic thrombosis, left femoral-popliteal embolization." (Ex. 58). Dr. Johansen's operative report provides, in part:

...This...woman underwent an extensive anterior/posterior spinal fusion and stabilization 36 hours previously. In the early postoperative period, she had some bilateral distal lower extremity neurologic findings, which were thought likely secondary to intraoperative traction on nerve roots. However, she subsequently developed a cool left foot, which was pulseless by Doppler, and a vascular laboratory examination in fact demonstrated substantial reduction of blood supply on both side (right and left ankle-arm Doppler arterial pressure indices of 0.31 and 0.0). Arteriography was performed, revealing complete occlusion of the infrarenal aorta, approximately 3 cm distal to the renal arteries. The iliac arteries reconstituted bilaterally.

...The patient is brought urgently to the operating room for aortic reconstruction with the presumption that an intimal flap raised at the time of traction on the aorta during anterior cage fusion or thrombus formation because of her nearly 6 hours in the prone position with her heavy weight resulted in aortic occlusion, either by dissection or thrombosis.

EXHIBIT 58.

Later that afternoon and evening, Dr. Johansen performed a second surgery to relieve compartment pressures within the muscles of the calf. Dr. Johansen performed a bilateral four compartment fasciotomy and excision of nonviable anterior compartment musculature on Brenda Smith secondary to bilateral lower extremity compartment syndrome. (Ex. 59; RP 11/14/07, p. 76.) His operative report provided, in part:

...This...woman suffered an unfortunate distal aortic thrombotic occlusion, with embolization of the left lower extremity, subsequent to an extended spine reconstructive procedure. She underwent aortic thrombectomy and patch angioplasty, as well as left femoral-popliteal embolectomy earlier in the day. The decision was made at that time not to carry out four compartment fasciotomy because of what was believed to be the relatively brief (6-12 hours) period of time of ischemia, as well as the patient's preserved (albeit diminished) motor and sensory function of both lower extremities prior to operation. Following the first operation, the patient had significant problems with rising creatinine levels and potassium, and received large amounts of volume. The patient demonstrated firm, although not tense, moderately tender calves bilaterally and had sensation and motor function which, as it was prior to the first operation, intact, but substantially diminished. However, a vascular laboratory examination demonstrated loss of calf vein phasicity. The patient is brought urgently to the Operating Room for four compartment fasciotomy....

...The muscle in all four compartments of both lower extremities bulged significantly. The anterior compartment musculature was clearly nonviable bilaterally. The right lateral compartment showed a flicker of twitch, but looked mostly nonviable. On the left side the lateral compartment seemed viable. The superficial and deep posterior compartments were viable (viability in all cases noted by twitch to galvanic stimulation).

EXHIBIT 59.

The fasciotomies were not successful. As a result of the aortic occlusion, Brenda underwent multiple and repeated surgical procedures during January and February of 2004. Additionally, Brenda contracted Methicillin Resistant Staphylococcus aureus (MRSA), a very difficult infection to treat. (RP 11/08/07, pp. 55, 176, 177.)

On 01/05/04, Dr. Johansen performed an inspection under anesthesia, irrigation and debridement, excision of right lateral compartment muscle on Brenda Smith. (RP 11/14/07, p. 76.) On 01/07/04, Dr. Johansen performed irrigation, debridement, second closure of open fasciotomy wounds bilaterally on Brenda Smith. (RP 11/14/07, p. 76.) On 01/12/04, Dr. Johansen performed a thromboembolectomy of the left posterior tibial artery and left peroneal artery secondary to a severely ischemic, pre-gangrenous left mid and forefoot due to tibial artery emboli. (RP 11/14/07, p. 76.)

On 01/21/04, Dr. Johansen performed a left below the knee amputation on Brenda Smith secondary to a necrotic left forefoot. (RP 11/14/07, p. 77.)

On 01/23/04, Dr. Johansen performed an examination under anesthesia, re-amputation and debridement and irrigation of Brenda Smith's non-healing, pre-gangrenous left transtibial amputation wound.

(RP 11/14/07, p. 77.) The following day, Dr. Johansen performed an examination under anesthesia, irrigation and application of a wound-VAC device secondary to her open non-healing left below the knee amputation (BKA). (RP 11/14/07, p. 77.) A blood culture was obtained, which revealed Methicillin Resistant Staphylococcus aureus. (RP 11/08/07, p. 178.)

On February 5, 2004, Brenda underwent a re-amputation of the left below the knee amputation. (RP 11/14/07, p. 77.) On 02/07/04, Dr. Johansen performed a re-amputation of the tibia and fibula. (RP 11/14/07, p. 77.) On 02/13/04, Dr. Johansen performed a through knee (TK) left amputation. (RP 11/14/07, p. 78.) Brenda Smith was continuously in the hospital from December 31, 2003 through April 24, 2004.

After her discharge, Brenda Smith continued to have MRSA infection complications. (RP 11/08/07, p. 178.)

On March 1, 2005, Brenda Smith was admitted through the emergency room to Swedish-Cherry Hill campus for multilobar pneumonia. Brenda had MRSA pneumonia. (RP 11/08/07, pp. 179, 189.) Brenda Smith died of MRSA pneumonia. (RP 11/08/07, p. 179.) The MRSA infection at the time of her death was contracted at her 2004 hospitalization at Swedish/Providence. (RP 11/08/07, pp. 180, 181.) Brenda Smith had osteomyelitis from MRSA. (RP 11/08/07, p. 187.)

C. DR. JOHANSEN'S TRIAL TESTIMONY.

On November 14, 2007, Dr. Kaj Johansen testified. He was called as a witness for the defense and was examined by attorney Clarke Johnson. (RP 11/14/07, p. 9.) Dr. Johansen acknowledged his first involvement was at approximately 1 am on January 2, 2004. (RP 11/14/07, p. 14.) Dr. Johansen went through in detail his initial consultation note (Ex. 55). (RP 11/14/07, p. 15.) Dr. Johansen's initial plan was to perform an aortogram. (RP 11/14/07, p. 16.) Dr. Johansen described and explained his embolectomy procedure. (RP 11/14/07, pp. 19-20.) Dr. Johansen described a fasciotomy and testified that a fasciotomy was not performed at this initial procedure because it was his understanding that the arterial occlusion had been for a relatively short period of time. (RP 11/14/07, pp. 22-23.) Dr. Johansen testified that, in hindsight, he would not have performed the aortogram and would have performed the fasciotomy earlier in the morning on January 2, 2004. (RP 11/14/07, pp. 33, 34.) Dr. Johansen was then asked a hypothetical question regarding his course of action had he been called at noon on January 1, 2004. Plaintiffs' counsel objected. A sidebar conference was held and the court requested that the sidebar be put on the record. *See* Transcript 11/14/07, pp. 35-44. Mr. Otorowski argued that the question posed was an expert question where he had not been designated as an

expert witness to answer such questions, especially in the present case where defendants have identified Dr. Samer Saiedy, who, unlike Dr. Johansen, would have performed a fasciotomy earlier in the morning and would have been able to save Brenda Smith's leg. (RP 11/14/07, pp. 37-38.) The court reasoned that it was not helpful to the jury to hear a treating physician speculate about what he would have done at a point in the case when he actually was not called in. (RP 11/14/07, pp. 40-41.) The court sustained plaintiffs' objection. (RP 11/14/07, p. 44.)

Dr. Johansen was then immediately asked about arterial flow dynamics, a topic specifically addressed by plaintiffs' expert, Dr. Cossman. When asked a question regarding the timing of the aortic thrombus in Brenda Smith, Dr. Johansen greatly expanded his answer by adding the additional statement:

I believe that it was not significant, in terms of blocking blood supply, until there started being signs at the bedside of a problem, for example, a cool foot, pulses which initially could be felt with the fingers but no longer could be felt, it was still at that point, I believe that the blockage became really significant.

(RP 11/14/07, p. 47.) Plaintiffs' counsel again immediately objected to seeking expert opinions prior to Dr. Johansen's involvement. (RP 11/14/07, p. 47.) The court sustained the objection and struck the quoted portion of the answer. (RP 11/14/07, p. 48.)

On cross-examination, Dr. Johansen described the Ankle Brachial Index (ABI) and the significance of the vascular flow study and ankle brachial index performed on Brenda Smith after his initial involvement. (RP 11/14/07, pp. 58-60.) Dr. Johansen also described his multiple surgeries performed on Brenda Smith. (RP 11/14/07, pp. 76-77.).

On redirect, Dr. Johansen was again asked his opinion regarding an ABI performed midday on January 1, 2004. (RP 11/14/07, p. 84.) This question was again objected to and the court sustained the objection. (RP 11/14/07, p. 84.) Dr. Johansen was again asked to comment on the believability of the ICU nurses checking Brenda Smith's pedal pulses on January 1<sup>st</sup> prior to Dr. Johansen's involvement:

Q. So if a nurse in this case testified that she was able to either palpate or find Doppler pulses at eight a.m., 10:00 a.m., 11:30, and 3:00, based on your experience with trained ICU nurses at Swedish Hospital, would you have any reason to believe that they were not accurately reporting what they were finding?

MR. OTOROWSKI: Your Honor, I object. First of all, there's no reference in the medical records to good pulse, good color, normal temperature, as we've already established. Again, this witness has no factual information as to what went on then, he doesn't know what the nurses' testimony was. One of the nurses, Nurse Hanson, says she does not have any idea what monophasic, biphasic, and multiphasic even meant.

MR. JOHNSON: Your Honor, the specific testimony of Nurse Hanson is that she's trained to check –

THE COURT: I recognize that. We're talking about what this witness can testify about. Sustained, but it may be because you can rephrase.

Q. (BY MR. JOHNSON) Doctor, do you routinely rely on your practice as a vascular surgeon at Swedish Hospital on the ability of the nurses in the ICU to accurately be able to determine whether your patients have normal pulses?

MR. OTOROWSKI: Objection, asked and answered, Your Honor.

THE COURT: He may answer.

A. I do.

Q. (BY MR. JOHNSON) Can you explain that for us, please.

A. Yes. I think your question was can I count on the nurses' expertise, training and expertise and understanding, to give me dependable information, information that I can trust, in terms of decision-making. The answer is yes, and it is because, among other things, I have personally trained them in the use of the Doppler, and the reasons that it needs to be used, in addition to physical examination, feeling for pulses, and so forth. So it is because I – personally, I and other vascular surgeons have trained them, and because our body of experience over years has suggested that the – their findings are trustworthy, that I myself look upon them as being trustworthy.

(RP 11/14/07, pp. 85-87.)

Defense counsel also made an offer of proof regarding a hypothetical question of the Ankle Brachial Index (ABI) performed earlier in the day on January 1<sup>st</sup>. (RP 11/14/07, p. 99.) During the cross-examination phase of the Offer of Proof, Dr. Johansen confirmed that at the time of his deposition he had not reviewed the inpatient record, and was represented by counsel at the deposition. (RP 11/14/07, p. 102.) Dr.

was represented by counsel at the deposition. (RP 11/14/07, p. 102.) Dr. Johansen specifically denied that anyone from defense counsel's office had been in contact with him.

When asked the type of questions Dr. Johansen believed he was going to be asked in court, he replied: "I thought the questions would be along the lines of those you had asked me in my deposition and also if I may look – I was sent a thing called a plaintiffs' trial brief." [Emphasis added.] (RP 11/14/07, pp. 103-104.) It was also determined that the trial brief had been faxed to Dr. Johansen. (RP 11/14/07, p. 105.) The court also confirmed that Dr. Cossman's November 8, 2007 testimony transcript was also in the possession of Dr. Johansen. (RP 11/14/07, p. 107.)

D. NOVEMBER 19, 2007 HEARING.

Following Dr. Johansen's testimony, plaintiff requested an evidentiary hearing to investigate the circumstances of Dr. Johansen's being provided Plaintiffs' Trial Brief, Dr. Cossman's trial testimony and any other pre-testimony contact between Dr. Johansen and defense counsel. (ER 148-153.) Over the weekend the parties' counsel hired counsel, and the trial court conducted telephone conferences with all counsel, including counsel for Dr. Johansen. On November 19, 2007, the

trial court conducted a hearing regarding Dr. Johansen's testimony.<sup>2</sup> The court declined a full evidentiary hearing as requested by plaintiffs, but through the weekend conference calls and representations of counsel at the November 19, 2007 hearing, it was established that:

- Plaintiffs' Trial Brief was sent at Mr. Graffe's request to Rebecca Ringer for forwarding to Dr. Johansen (RP 11/19/07, p. 48);
- Mr. Graffe took the initiative to send the trial testimony of Dr. Cossman to Ms. Ringer for Dr. Johansen's review (RP 11/19/07, pp. 47, 50, 51);
- An undisclosed item, which was claimed to be attorney work product, was also sent to Ms. Ringer for Dr. Johansen's review (RP 11/19/07, p. 48). After the December 19, 2007 denial of Plaintiffs' Motion for New Trial, plaintiff first became aware that this "undisclosed" item was Clarke Johnson's outline for his direct examination of Dr. Johansen.

The trial court expressed serious concerns regarding the candor of defense counsel, but did not consider there to be a Loudon violation "as the law currently stands." The court stated:

So it may be that an appellate court will see fit to expand Louden [sic] to cover any contact, whether it's in the

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<sup>2</sup> Attorney Charles Wiggins appeared specially for plaintiffs; attorney Elizabeth Leedom appeared specially for defendant.

discovery context or not, but heretofore it does not appeal to me that Louden [sic] goes that far, and so I am sympathetic to and I think that I need to address the plaintiffs's, I think, genuine surprise, under these circumstances, about Dr. Johansen having received that testimony.

But I do not think that it was misconduct, under these circumstances, to share the transcripts with Dr. Johansen, or his counsel, I should say, and it was not a violation of a court order, and at least as the law currently stands, I don't believe it was a violation of the law. So I think some of the more drastic remedies that have been suggested by the plaintiffs, such as striking Dr. Johansen's testimony, are not appropriate under those circumstances. However, I do recognize that they were completely surprised by Dr. Johansen having read Dr. Cossman's testimony, presumably, and there was a discussion during his testimony at sidebar, in chambers, where Mr. Otorowski made it very clear that he was quite concerned that Dr. Johansen had information and had had contact with defense counsel in some way, and he was told that defense counsel had not spoken to Dr. Johansen, which was technically true, but I think that it certainly led the court to believe that there hadn't been any communication between defense counsel and Dr. Johansen in his – and/or his attorney, and at least for the time being I think it led plaintiffs counsel to believe that, and that really wasn't the situation.

This information had been transmitted, and I think, in all candor, probably should, under those circumstances, have been disclosed to the plaintiffs.

In light of that, I think we have to figure out what is the most appropriate way to be fair to the plaintiffs under these circumstances, and I've thought about a couple of different remedies. One would be calling Dr. Johansen back for further cross-examination, and there are some probably parameters that we would have to devise. Another would be a jury instruction.

(RP 11/19/07, pp. 61-63.)

On November 20, 2007, the trial court denied Plaintiffs' Motion For Mistrial (RP 11/20/07, p. 4); declined plaintiffs' proposed curative jury instructions (RP 11/20/07, pp. 8, 12); and, fashioned the Court's Instruction No. 8 (ER 209). Plaintiffs properly and timely objected to the giving of Instruction No. 8 (RP 11/21/07, pp. 132-133).

The jury found for Dr. Schwaegler and Orthopedics International Limited.

E. CHRONOLOGY OF DEFENSE COUNSEL'S CONTACTS WITH DR. KAJ JOHANSEN AND/OR HIS ATTORNEY.

From emails produced (Exhibit 2, Post Trial Exhibits) this sequence of events occurred:

1. October 29, 2007, Francesca Kerr, paralegal to John C. Graffe, sends an email to Rebecca Ringer, Dr. Johansen's attorney, attaching Plaintiffs' Trial Brief. Ms. Kerr states: "John asked that I send this to you as attorney for Dr. Johansen. He would like Dr. Johansen to read it."
2. November 5, 2007, trial begins.
3. Day/time unknown. John Graffe leaves a voicemail for Rebecca Ringer. Contents of the voicemail unknown.
4. November 10, 2007, 2:17 pm, Rebecca Ringer sends email to John Graffe thanking him for his voicemail regarding plaintiff's

expert's criticism of Kaj. Rebecca Ringer requests that John Graffe send anything to her assistants (Celeste and Seija) so that "someone will be able to print and get the transcript up to Kaj."

5. November 11, 2007, 3:30 pm, defense counsel John Graffe emails Rebecca Ringer confirming Dr. Johansen's scheduled testimony on Wednesday morning [11/14] and that his legal assistant, Francesca, "will send the testimony of Dr. Cossman, their vascular surgery expert. Clarke [Clarke Johnson] will be handling Kaj. I suspect that he will send areas of inquiry. Thanks. John"

6. November 12, 2007, 8:35 am, Francesca Kerr sends Rebecca Ringer the trial testimony of Dr. Cossman for Dr. Johansen's review.

7. November 13, 2007, 10:41 am, Francesca Kerr sends Clarke Johnson's notes for his direct examination of Dr. Johansen to Rebecca Ringer. Defense attorney Clarke Johnson's notes identify defendant's trial theme, defendant's illustrative trial exhibit, i.e. diagram, and specific expert questions.

8. November 14, 2007, Dr. Johansen testifies.

9. November 19, 2007, court hearing.

10. November 20, 2007, court denies Motion for Mistrial.

## SUMMARY OF ARGUMENT

*Ex parte* communications with a treating physician who testifies not as an expert but as a fact witness is prohibited as a matter of public policy. Rowe v. Vaagan Bros. Lumber, Inc., 100 Wm. App. 268, 996 P.2d 1103 (2000) *citing* Loudon v. Mhyre, 110 Wn. 2d. 675, 677, 756 P.2d 138 (1988).

Neither party identified Dr. Johansen as a CR 26(b)(5) expert witness; each party had identified other individuals as an expert vascular surgeon.<sup>3</sup>

Defense counsel violated Loudon and Rowe when they sent treating physician Dr. Kaj Johansen plaintiffs' trial brief, the transcript of trial testimony of Dr. David Cossman and defense counsel's outline of direct examination questions for Dr. Johansen's testimony. These materials were sent to Dr. Johansen through his private attorney. *Ex parte* contact by defense counsel with a treating physician is improper; the same *ex parte* contact through the treating physician's counsel is still prohibited *ex parte* communications. What is prohibited directly must not be permitted indirectly.

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<sup>3</sup> Plaintiff identified Dr. David Cossman, who testified on November 8, 2007. Dr. Samer Saiedy, identified by defendant Schwaegler as a vascular surgeon for the defense, was identified but did not testify.

The appropriate remedy for the Loudon violations and defense counsel's lack of candor regarding the forwarding of trial information and proposed questions for the treating physician require reversal of the defense just verdict, granting a new trial and exclusion of Dr. Johansen's testimony at retrial.

### ARGUMENT

DEFENSE COUNSELS' PROVIDING TREATING PHYSICIAN DR. KAJ JOHANSEN PLAINTIFFS' TRIAL BRIEF, TRIAL TRANSCRIPT OF DR. DAVID COSSMAN, AND AN OUTLINE OF DEFENSE COUNSEL'S PROPOSED DIRECT EXAMINATION OF DR. JOHANSEN TO THIS TREATING PHYSICIAN VIOLATES LOUDON V. MHYRE, 110 WN. 2D 675 (1988).

A. STANDARD OF REVIEW.

The Standard of Review for a motion granting or denying a new trial is abuse of discretion. Lockwood v. AC&S, Inc., 44 Wn. App. 330, 363, 722 P.2d 826 (1986); Gardner v. Malone, 60 Wn.2d 836, 846, 376 P.2d 651, 379 P.2d 918 (1962). However, if the court's reasons are based on issues of law, the appellate court review for error of law only. Lyster v. Metzger, 68 Wn.2d 216, 226, 412 P.2d 340 (1966); Rowe v. Vaagen Bros. Lumber, Inc., 100 Wn. App 268, 278, 996 P.2d 1103 (2000).

B. LOUDON V. MHYRE, 110 WN.2D 675, 756 P.2D 138 (1988).

It is well established that an adverse party is not permitted to engage in an *ex parte* interview with a treating physician. Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988). Loudon was a wrongful

death case where defense counsel moved for an order permitting *ex parte* communication with the deceased's healthcare providers in Oregon. The Loudon court analyzed many years of legal decisions that followed Kime v. Niemann, 64 Wn.2d 394 (1964) and the concept of *ex parte* communications with healthcare providers. The Loudon court stated at page 677:

We hold that ex parte interviews should be prohibited as a matter of public policy. [Emphasis added.]

The Loudon court stated at page 680:

We note also that permitting *ex parte* interviews could result in disputes at trial should a doctor's testimony differ from the informal statements given to defense counsel, and may require defense counsel to testify as an impeachment witness.

What has happened here with regard to Dr. Johansen is clearly one of the situations contemplated by the Loudon court. The final words of the court were:

We hold that defense counsel may not engage in *ex parte* contacts with a plaintiff's physicians. The trial court's order is affirmed.

The Loudon court did not restrict the prohibited *ex parte* contact to "conversation" or "correspondence" or "messages" but "**contacts**". This is a very pertinent concept since in this case, defense counsel utilized attorney Rebecca Ringer as a conduit through which to pass trial

information and previously unknown testimony and opinions to Dr. Johansen in hopes of more favorable testimony.

Contrary to the concerns of this trial court, the Supreme Court did not specifically limit its Loudon holding to only pre-trial discovery. The public policy reasonings continue throughout the litigation process. There is no logic to prohibit defense counsel *ex parte* contact prior to a deposition, but then allow subsequent *ex parte* contact prior to trial, during trial or immediately prior to testimony. The Loudon court said:

The unique nature of the physician-patient relationship and the dangers which *ex parte* interviews pose justify the direct involvement of counsel in any contact between defense counsel and a plaintiff's physician.

Loudon v. Mhyre, *supra*. at 681 [emphasis added].

Mr. Graffe's sending plaintiffs' trial brief and the trial testimony of Dr. Cossman and Mr. Johnson's sending of his direct examination testimony outline for Dr. Johansen were all intentional and deliberate *ex parte* contacts with a treating physician. These *ex parte* contacts were without our Supreme Court's intended protective "direct involvement of counsel in any contact between defense counsel and a plaintiff's physician." *Id.* At 681.

At the time the trial court denied Plaintiffs' Motion for Mistrial, the court stated:

...There may be very good reasons why Loudon should be expanded to prohibit this kind of conduct, but I don't think that that's the state of the law at the moment, so I don't think that I can say the law was violated here. ...

RP 11/20/07, p. 8.

Plaintiff respectfully submits that this Court of Appeals specifically and unequivocally hold that the Loudon prohibition of against defense counsel having *ex parte* contact with a treating physician apply throughout the trial process. *Ex parte* contact abuse can occur at any time throughout the litigation process. The potential threat to the trial process by *ex parte* contact can and does occur subsequent to discovery – as shown in the present case. It should be noted that the more recent decision of Rowe v. Vaagen Bros. Lumber, Inc., 100 Wash. App. 268, 996 P.2 1103 (2000) noted the prohibited *ex parte* contact occurred during discovery as well, but analyzed the improper conduct and remedy under its “Trial Procedure” section of its opinion. The Court of Appeals stated the unambiguous, bright-line rule:

*Ex parte* communication with a treating physician who testifies not as an expert but as a fact witness is prohibited as a matter of public policy.

Rowe v. Vaagen Bros. Lumber, Inc., *supra.* at 278, *citing Loudon v. Mhyre*, 110 Wn.2d 675, 677, 756 P.2d 138 (1988). Dr. Kaj Johansen is such a treating physician testifying as a fact witness.

Any suggestion or concern that Loudon is confined to pre-trial depositions is not a sufficient basis for this trial court's reluctance to find a Loudon violation for defense counsel's *ex parte* contacts with a treating physician. The bright-line rule of Rowe encompasses prohibited defense *ex parte* contact with treating physician witnesses from the pre-trial deposition through trial.

Plaintiff respectfully submits that this Court of Appeals specifically and unequivocally hold that the Loudon and Rowe prohibition against defense counsel having *ex parte* contact with a treating physician apply throughout the trial process.

C. ROWE V. VAAGEN BROS. LUMBER, INC., 100 WASH. APP. 268, 996 P.2D 1103 (2000).

In 2000, Division III of the Court of Appeals decided Rowe v. Vaagen Brothers Lumber, Inc., 100 Wash. App. 268 (2000). Rowe involved a wrongful termination claim and a situation where defense counsel conducted *ex parte* interviews with two treating physicians prior to their depositions. The jury returned a defense verdict. The court, in analyzing the facts stated at page 278:

***Ex Parte Contact.*** We hold that, as a matter of law, defense counsel's violation of the discovery rules required the trial judge to grant a new trial.

During the depositions of Drs. Cooke and Adams, it became apparent to Mr. Rowe's counsel that the defense must have

talked to them. Counsel put his objection on the record. Defense counsel admitted the contact. When the depositions were offered at trial, the court deleted some portions of the testimony that obviously reflected information acquired after the events. On Mr. Rowe's post-trial motion for a new trial, the court considered that this did not cure the inherent prejudice.

[25]**Court Rule.** Ex parte contact with an opposing party's expert medical witness is prohibited by court rule. CR 26(b)(5); \*\*1110In re Firestorm 1991, 129 Wash.2d 130, 137, 916 P.2d 411 (1996). Ex parte communication with a treating physician who testifies not as an expert but as a fact witness is prohibited as a matter of public policy. Loudon v. Mhyre, 110 Wash.2d 675, 677, 756 P.2d 138 (1988).

The issue in Rowe is strikingly parallel to the case at bar. There was no knowledge of the *ex parte* contact by plaintiffs counsel until the deposition. In the present case, the situation was worse; it came during the middle of the trial and was apparently instigated by defense counsel.

The court went on to state at page 279: "The ex parte contact was a clear and, we believe, inexcusable violation of the discovery rules."

The court went on to discuss the remedies and the court held that a new trial was granted with instructions to prohibit testimony by the physicians who were "tainted".

[28]**Remedy.** If, as the court concluded here, the ex parte communication prejudiced Mr. Rowe, the remedy is to ban the use of the evidence by the defense, in whole or in part. See, e.g., Marek v. Ketyer, 733 A.2d 1268, 1270 (Pa.Super.Ct.1999) (defense counsel precluded from calling plaintiff's treating physicians as expert witnesses at trial); Porter v. Fieldcrest Cannon, Inc., 133 N.C. App. 23, 514

S.E.2d 517, 523 (1999) (portions of deposition related to *ex parte* communication should be excluded).

Vaagen Brothers suggests that Mr. Rowe invited the error because he, not the defense, called the doctors to the stand and put their deposition testimony before the jury. The problem, however, was defense counsel's discovery violation. Giving Mr. Rowe the option of foregoing his doctors' essential evidence is not a remedy.

This is grounds for a new trial by itself.

[29]Objectionable Questioning. Finally, the record is replete with plaintiff's objections to the form of defense counsel's questions and the answers elicited. The court found the defense's "persistent objectionable method of questioning" witnesses requiring numerous unnecessary bench conferences and objections prejudiced Mr. Rowe. Our reading of the trial record suggests no reason for this court to substitute its judgment for that of the trial court on the prejudicial effect of this conduct.

The trial court's order granting a new trial is affirmed. The case is remanded for a new **\*\*1111** trial with instructions that the defense is precluded from using the testimony of Dr. Adams and Dr. Cooke.

SCHULTHEIS, J., and KATO, J., concur.

The Rowe case is nearly on all fours with the present case with the exception that the "contact" here went from lawyer to lawyer to physician rather than direct counsel defense counsel to physician.

Rowe also establishes the dual nature of the appropriate remedy for *ex parte* communication with the treating physician. The *ex parte* contact

“is grounds for a new trial by itself.” Id. at 278. Second, the testimony of the treating physician may be stricken at time of retrial. Id. at 278.

D. UTILIZATION OF THE TREATING PHYSICIAN’S PERSONAL ATTORNEY TO TRANSMIT DEFENSE COUNSEL MATERIALS TO THE TREATING PHYSICIAN DOES NOT EXCULPATE DEFENSE COUNSEL FROM A LOUDON AND ROWE VIOLATION.

From the November 19, 2007 court hearing, it is undisputed that Mr. Graffe and Mr. Johnson took the initiative to forward Plaintiffs’ Trial Brief, trial testimony transcript of Dr. Cossman and defense counsel’s direct testimony outline for Dr. Johansen to his personal attorney for transmittal to Dr. Johansen. For purposes of Loudon and Rowe, this Court of Appeals should clearly and unequivocally prohibit such conduct. When both Loudon and Rowe are both premised upon public policy, the court should not condone such a transparent end run around Loudon and Rowe. The Loudon court envisioned the plaintiff’s lawyer as being the all important buffer to prohibit *ex parte* contacts between defense counsel and a treating physician. Mr. Graffe’s and Mr. Johnson’s *ex parte* contacts before and during trial intentionally avoided plaintiffs’ counsels’ involvement until after the fact.

Both Loudon and Rowe prohibit “contacts” between defense counsel and the treating physician. While face-to-face contacts are potentially most egregious, the undisputed facts remain that Mr. Graffe

and Mr. Johnson intended these indirect *ex parte* contacts with Dr. Johansen. Such behavior should not be permitted or condoned; it must be prohibited.

Another reason for prohibiting any intermediary or conduit for transmitting information from defense counsel to a treating physician is that such efforts lead to lack of candor to the court and opposing counsel. In the present case, when Mr. Otorowski, at a sidebar conference, raised the question of whether trial testimony and trial information had been provided to Dr. Johansen, it was represented that there had been no direct contact with Dr. Johansen. The court stated:

...I do recognize that they were completely surprised by Dr. Johansen having read Dr. Cossman's testimony, presumably, and there was a discussion during his testimony at sidebar, in chambers, where Mr. Otorowski made it very clear that he was quite concerned that Dr. Johansen had information and had contact with defense counsel in some way, and he was told that defense counsel had not spoken to Dr. Johansen, which was technically true, but I think that it certainly led the court to believe that there hadn't been any communication between defense counsel and Dr. Johansen in his – and/or his attorney, and at least for the time being I think it led plaintiffs' counsel to believe, and that really wasn't the situation.

This information had been transmitted, and I think, in all candor, probably should, under those circumstances, had been disclosed to the plaintiffs. ...

RP 11/19/07, p. 62.

E. OTHER JURISDICTIONS HAVE FACED SIMILAR ISSUES WHERE THIRD PARTIES HAVE HAD CONTACT WITH A TREATING PHYSICIAN.

Courts in other jurisdictions have dealt with situations where either defense counsel or the defendant himself went through a “conduit” in the form of professional colleagues of the treating physician to accomplish the same end as a direct contact would. In McCool v. Gehret, 657 A.2d 269 (1995), a subsequent treating physician agreed with plaintiff to testify that the defendant physician was negligent. The defendant physician called a professional colleague and asked that he then call the physician who was going to be critical of his care in an effort to dissuade him from testifying. The court found the attempt to be “reprehensible” and allowed a jury instruction based on McCormick and Wigmore that the defense, by resorting to wrongdoing, is presumed to have a weak case. The court stated at page 276:

This Court has held that "attempts to improperly influence a witness' testimony are fundamentally unfair and pervert the truth-seeking function of trial." Weber v. State, Del. Supr., 457 A.2d 674, 679 n. 6 (1983). Similarly, the second trial judge condemned Dr. Gehret's conduct:

[Dr.] Gehret's behavior in vicariously conveying insinuating messages to [Dr.] Dein by way of [Dr.] Krell was reprehensible. Surely this conduct is not within the scope of acceptable means to defend a suit properly before the Court.

Thus, Dr. Gehret was undoubtedly correct that the jury may have reacted adversely to the evidence of his efforts to

intimidate Dr. Dein.

Nevertheless, it is precisely because of the egregious nature of such conduct that the law expressly permits the jury to make adverse inferences from a party's effort to intimidate witnesses or otherwise suppress probative evidence against him. According to McCormick:

[W]rongdoing by the party in connection with its case ... is also commonly regarded as an admission by conduct. By resorting to wrongful devices, the party is said to provide a basis for believing that he or she thinks the case is weak and not to be won by fair means.... Accordingly, the following are considered under the general category of admissions by conduct ... undue pressure by bribery, intimidation, or other means to influence a witness to testify favorably or to avoid testifying; ...

McCormick on Evidence § 265 (John W. Strong, et al. eds., 4th ed. 1992). *Accord* 2 John H. Wigmore, *Wigmore on Evidence* § 278(2) (Chadbourn Rev.1979). [FN7]

Here there can be little question that the delivery of Dr. Cossman's trial testimony was an improper attempt to influence the testimony of Dr. Johansen who testified in his deposition that he had never read the chart that preceded his involvement in Brenda Smith's care. The McCool court went on to say at page 277:

Having heard [Dr.] Gehret's testimony and observed his demeanor at trial, the Court finds that [Dr.] Gehret's characterization of his discussions with [Dr.] Krell was disingenuous. The Court concludes that the defendant's act of calling Dr. Krell was an **intentional attempt to relay a message to [Dr.] Dein** and to influence him concerning his participation in Mrs. McCool's case.

Once a sufficient showing is established, the evidence of interference is presented to the jury, along with appropriate instructions from the trial judge. The jury can then either reject or accept that evidence. If the evidence is accepted by the jury, it may support an inference that the party charged with interference is conscious of the weakness or unjust nature of his or her case. Accordingly, it may be considered as substantive evidence in support of the other party's claim, e.g. negligence in this case. [Emphasis supplied.]

Applying the McCool facts, an indirect relay through an intermediate person is the same as a direct ex parte contact and is therefore sanctionable. A new trial was granted there; this court unfortunately is now set up by defense counsel actions to be virtually required to grant a new trial.

McCool followed the seminal case of Meyer v. McDonnell, 392 A.2d 1129 (1978). The Meyer case involved attempts by a defendant physician to intimidate two other physicians who were testifying against him in a medical malpractice action. In that case the defendant directed his secretary to call an intermediary physician to let him know that another physician would be testifying and he would distribute the testimony to the American Academy of Orthopedic Surgeons. While not specifically stated, the telephone call had its intended effect and the intermediary physician then called the expert to dissuade him from testifying. The court stated at page 533:

[2] Under the view taken by Wigmore, McCormick, and the cases cited above, which view we here adopt, the conduct of appellee in attempting to intimidate Doctors Nystrom and Pizzi is admissible as tending to show his consciousness of the weakness of his case and a belief that his defense would not prevail without the aid of such improper and unfair tactics as those in which he engaged. This, in conjunction with the other evidence in the case, may lead to the further inference that appellee considers his case to be weak because he, in fact, is guilty of the negligence which appellant asserts he committed. Such inferences are, of course, merely permissible and the jury is free to either accept or reject them as it sees fit.

A new trial was granted based on the misconduct. As stated by the court there at page 525:

Whatever merit the medical profession may have in its current outcry against malpractice suits, the remedy does not lie in polluting the streams of justice by tampering with witnesses.

In Petrillo v. Syntex, 499 NE.2d 952 (1986), the Illinois Supreme Court went through an exhaustive analysis of *ex parte* contacts by defense counsel with treating physicians. It held:

We believe that this issue, namely, whether defense counsel may properly engage in *ex parte* conferences with a plaintiff's treating physician, is best decided by relying on principles of public policy, obligations created by confidential and fiduciary relationships, and the ethical responsibilities of modern day professionals.

Accordingly, for the reasons set forth above, we rule today that discussions between defense counsel and a plaintiff's treating physician should be pursuant to the Rules of discovery only. That being the case, the decision of the circuit court of Cook County finding Tobin to be in

contempt of court is affirmed.

F. THE ABSENCE OF ANY FORMAL MOTION IN LIMINE OR ER 615<sup>4</sup> MOTION EXCLUDING WITNESSES DOES NOT LESSEN THE LOUDON VIOLATION.

In its oral rulings, the Court noted that neither party sought a motion in limine to exclude witnesses from trial. The Court then stated that the absence of such a motion in limine somehow lessened the seriousness of defense counsel's contact with Dr. Johansen. Such an argument or legal requirement is erroneous.

The prohibition against any *ex parte* contacts with treating physicians by defense counsel based upon decisional law and strong public policy. The prohibition against *ex parte* contact exists throughout the litigation process and is no way dependent upon any trial motions in limine. Nowhere in Loudon is there any prerequisite for an additional motion in limine prior to the Loudon prohibition to exist. A motion in limine excluding witnesses provides a second and separate basis for sanctions, but it should not and must not ameliorate a Loudon violation.

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<sup>4</sup> ER 615 EXCLUSION OF WITNESSES provides, in part:

At the request of a party, the court may order witnesses excluded so that they cannot hear the testimony of other witnesses, ....

G. CR 59.

Defense counsel's improper contacts with Dr. Johansen and his court testimony fall within CR 59(a)(1) being an irregularity in the proceedings of the court by which a party was prevented from having a fair trial; CR 59(a)(2) involving misconduct of a prevailing party; CR 59(a)(3) accident or surprise which ordinary prudence could not have guarded against; CR 59(a)(4) newly discovered material evidence which plaintiff could not, with reasonable diligence, have discovered produced at trial; CR 59(a)(8) error in law occurring at the trial and objected to by plaintiff; and CR 59(a)(9) substantial justice has not been done.

Providing the trial brief, Dr. Cossman's trial testimony and an outline of proposed questions was a designed plan to utilize Dr. Johansen as defendant's vascular surgery expert instead of the designated expert, Dr. Samer Saiedy.<sup>5</sup> Providing these materials to Dr. Johansen was clearly an improper "contact" to have Dr. Johansen prepared for cross-examination. Further, as expected, Dr. Johansen's supposedly unbiased testimony was a centerpiece of defendant's closing argument.

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<sup>5</sup> Any suggestions that providing Dr. Johansen the plaintiff's trial brief, trial transcript of Dr. Cossman's testimony and an outline of questions as part of witness preparation is disingenuous. It is curious that Mr. Gaffe did not provide Dr. Johansen the deposition of defendant's vascular expert, Dr. Saiedy, who also was critical of Dr. Johansen, unless a decision had already been made to use Dr. Johansen as the only vascular surgeon witness.

At the December 19, 2007 CR 59 Motion for New Trial, Mr.

Otorowski argued<sup>6</sup>:

MR. OTOROWSKI: Okay. In terms of, gee, did it really make a difference? In a medical malpractice case you've got Dr. Johansen's testimony in this case as a treating doctor, that's what he was supposed to be for all the world, but every different little point he is sliding in comments and information that go to standard of care and go to causation.

Defense wants to say, well, the jury decided this on standard of care. Well yes, they did, but after hearing Dr. Johansen's testimony and them not calling Dr. Saiyed [sic], which we told the court we kind of predicted this is what was going to unfold. I would direct the court's attention to certain parts of Dr. Johansen's trial testimony, including page 27 [RP 11/14/07, p. 34], where he talks about the following morning, and he's talking about a fact that occurred well before he got involved, in terms of the extremity, whether it was warm or not.

He talked at page 37 [RP 11/14/07, p. 44], again, this is on direct questioning, that – it's a question about the pulse and flow geometry. At page 38 [RP 11/14/07, p. 45] he brings up the 75 percent. If the court will remember, there was testimony about, you know, until you have a 75 percent blockage, you don't feel any change in the pulse. Where did he come up with that? He came up with that from Dr. Cossman.

Page 39 [RP 11/14/07, p. 46] he's talking about absent pulses developing fairly quickly, starting with the foot getting cool, and he only knows that because he's been given all this information.

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<sup>6</sup> The pages referenced by Mr. Otorowski are to the interim daily transcript and do not correspond to the same numbered pages in the filed transcript. The bracketed references are to the official Report of Proceedings.

THE COURT: Now, he's been represented for some time, right?

MR. OTOROWSKI: Correct.

THE COURT: And it would have appeared to me that perhaps but for the plaintiffs' close relationship with Dr. Johansen and Brenda Smith's close relationship with Dr. Johansen, he might have been a defendant in this lawsuit, is that a fair characterization?

MR. OTOROWSKI: No, actually.

THE COURT: Well, I mean, I was listening to the testimony and I was thinking, gosh, of all the doctors I've been hearing about, he's got some issues, and I guess my thought would be, wouldn't he have likely become familiar with a lot of the hospital records and the issues pertaining to the vascular issues in this case in anticipation of possibly being a defendant?

MR. OTOROWSKI: Well, but he didn't. I think he testified that he did not look at any records prior to when he got into the picture, and I think that held true at the time of the deposition.

At page 40 [RP 11/14/07, p. 47] of Dr. Johansen's trial testimony he talks about that the clot does not become significant until there's a cool foot, again referring to an event that takes place before his involvement.

On my cross-examination, I'm basically walking into the wolves den at this point, not knowing what he had been given. He talks about you can't anticipate a bad blood supply, that's at page 54 [RP 11/14/07, p. 61]. At page 59 [RP 11/14/07, p. 66], increased pressure does not necessarily cause tissue damage to the calf, again, an issue that was a plaintiffs' issue.

At page 67 [RP 11/14/07, pp. 73, 74] – and at this point I think we're in cross-examination, he volunteers that

characteristic wave descriptions can help you determine whether or not there's an obstruction. Again, at page 67 he says that in the ICU a registered nurse is more likely to know about the pulses, again talking about things that occurred before he got involved. It goes into the risk of the vena cava tear, on the redirect, and then again and again, even on redirect, Mr. Johnson's asking, well, what about the ABI? I'm standing up, having to object, and the court sustained most of those objections, and he volunteers, ell, in terms of whether or not a nurse could feel a pulse, he says, I count on the RNs, repeating the defense theme.

He says at page 80 [RP 11/14/07, p.87] that their findings are trustworthy. These are standard of care comments. Mr. Johnson has multiple opportunities to do the right thing and avoid some of those questions, but he doesn't because he knows what the answer's going to be from this defendant.

He talks about, at page 90 [RP 11/14/07, p. 97], of this being unpreventable, again a standard of care concept, and then the offer of proof is when it unfolds, and as I said before, when I asked to see the paperwork, that's when Clarke Johnson jumps in and asserts work product privilege on behalf of Rebecca Ringer.

(RP 12/19/07, pp. 18-21.)

Reasonable minds must conclude that Dr. Johansen's testimony was tainted by the defense counsels' multiple *ex parte* contacts such that a new trial is required.

Rowe v. Vaagan Bros. Lumber, Inc., supra. makes it abundantly clear that a new trial is required:

Ex parte contact. We hold that as a matter of law, defense counsel's violation under discovery rules required the trial court judge to grant a new trial.

Rowe v. Vaagan Bros. Lumber, Inc., *supra.* at 278. The Rowe trial court attempted to redact certain portions of testimony, but these attempts did not cure the inherent prejudice. *Id.* at 278.

In the present case, the trial court merely instructed the jury that:

Dr. Johansen was provided a copy of Dr. Cossman's trial testimony by defense counsel. Plaintiffs' counsel was unaware of this fact.

This is Instruction No. 8, Court's Instructions to the Jury (ER 209). Such a curative instruction is wholly inadequate. This supposed curative instruction reflects the trial court's unwillingness to specifically find a Loudon violation of prohibited defense counsel *ex parte* communication with a treating physician. Such an instruction or the redaction of testimony as in Rowe are inadequate remedies when there has been a Loudon and Rowe violation.

### **CONCLUSION**

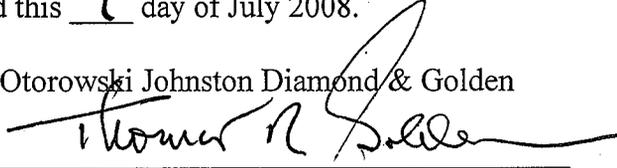
Defense counsel's sending of Plaintiffs' Trial Brief, the trial testimony of plaintiffs' vascular surgery expert, Dr. Cossman, and an outline of intended direct testimony to a treating physician witness through the physician's personal attorney must be viewed as *ex parte* contact. The Loudon and Rowe decisions evince strong public policy against any defense counsel-treating physician contact. Plaintiff Smith requests that this Court of Appeals unambiguously hold that the Loudon and Rowe

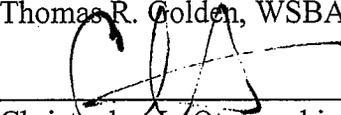
prohibitions against defense counsel- treating physician *ex parte* contact exist throughout the litigation. Further, the use of a third person to facilitate an *ex parte* contact must also be prohibited.

Dr. Johansen's testimony was "tainted" by his review and knowledge of the additional trial materials and information he received as a result of the improper *ex parte* contacts. The judgment on the verdict and the trial court's denial of plaintiff Smith's CR 59 Motion for New Trial must be reversed, the case remanded for a new trial and Dr. Johansen's testimony prohibited at retrial.

Respectfully submitted this 9 day of July 2008.

Otorowski Johnston Diamond & Golden

  
Thomas R. Golden, WSBA #11040

  
Christopher E. Otorowski, WSBA #8248

**CERTIFICATE OF SERVICE**

I certify that on the 9<sup>th</sup> day of July 2008, I caused a true and correct copy of the foregoing document to be served on the following counsel of record by ABC Legal Messenger Services:

Co-Counsel for Defendants/Respondents

John C. Graffe, WSBA #11835  
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925 Fourth Avenue, Suite 2300  
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601 Union Street, Suite 4100  
Seattle, WA 98101  
(206) 628-6600

Dated this 9<sup>th</sup> day of July 2008, at Bainbridge Island, Washington.



Brandi R. Patsfield  
Legal Assistant to Thomas R. Golden, Esq.

FILED  
COURT OF APPEALS DIV. #1  
STATE OF WASHINGTON  
2008 JUL -9 AM 11:37

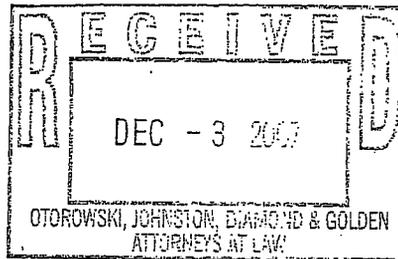
Superior Court of the State of Washington  
For the County of King

SUSAN J. CRAIGHEAD  
Judge

(206) 296-9211  
King County Courthouse  
Seattle, Washington 98104-2312  
E-mail: susan.craighead@kingcounty.gov

November 29, 2007

John Graffe  
Clarke Johnson  
925 Fourth Avenue, Suite 2300  
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Liz Leedom  
1700 Seventh Avenue, Suite 1900  
Seattle, WA 98101

Re. Smith v. Orthopedics International  
No. 06-2-05818-6 SEA

Counsel,

As you are aware, the jury has returned a defense verdict in this case. The court has in its possession (1) copies of e-mail correspondence between defense counsel's firm and Ms. Ringer and (2) items from Dr. Johansen's file that he brought to court. I am writing to seek your views on what should happen with these items.

The court examined the e-mail correspondence and discussed it generally with the parties, but I did not allow plaintiffs' counsel to see the e-mails during trial. It would

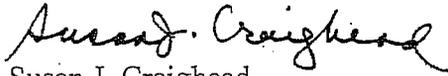
Page 2  
11/29/07

appear to me that this correspondence should be included in the record (as an exhibit) for appeal, as I viewed these documents. It would also appear to me that plaintiffs' counsel should be permitted to see the correspondence now that trial is over, in order to allow them to evaluate the merits of filing a notice of appeal and, of course, to litigate such an appeal. If defense counsel objects to this course of action, they should inform the court and counsel in writing by December 5.

The court has held on to the items in Dr. Johansen's file, but all parties have examined those items. It does not appear to me necessary to include this material in the record on appeal, and I propose to return these items to Dr. Johansen via his attorney, Ms. Ringer. Once again, if any party objects to this course of action, they should inform the court and counsel in writing by December 5.

Thank you for your prompt attention to this matter. It has been a pleasure working with all of you.

Sincerely,



Susan J. Craighead  
Judge

**Francesca Kerr**

---

**From:** Francesca Kerr  
**Sent:** Monday, October 29, 2007 4:29 PM  
**To:** 'Rebecca Ringer'  
**Cc:** Liz Mitchell; Jackie Schaffrath  
**Subject:** Smith v. Schwaegler

**Attachments:** DOC071029.pdf



DOC071029.p  
df (433 KB)

Hi Rebecca: John asked that I send this to you as attorney for Dr. Johansen. He would like Dr. Johansen to read it. Thank you.

Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104

Phone: (206) 223-4770  
Fax: (206) 386-7344  
francesca@jgkmw.com

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-----Original Message-----

From: Johnson Graffe Keay Moniz & Wick [mailto:sandra@jgkmw.com]  
Sent: Monday, October 29, 2007 4:48 PM  
To: Francesca Kerr  
Subject: Scanned from e-4511 10/29/2007 15:48

Scanned from e-4511.  
Date: 10/29/2007 15:48  
Pages:14  
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HONORABLE SUSAN CRAIGHEAD  
TRIAL DATE: 11/05/2007

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF KING

JERRY D. SMITH, as Personal  
Representative of the ESTATE OF BRENDA  
L. SMITH, Deceased, and on behalf of  
JERRY D. SMITH, RICHONA HILL,  
JEREMIAH HILL, and the ESTATE OF  
BRENDA L. SMITH,

Plaintiff,

v.

ORTHOPEDECS INTERNATIONAL,  
LIMITED, P.S.; PAUL SCHWAEGLER,  
M.D.; and SWEDISH HEALTH SERVICES  
d/b/a SWEDISH MEDICAL  
CENTER/PROVIDENCE CAMPUS,

Defendants.

NO. 06-2-05818-6SEA

PLAINTIFF'S TRIAL BRIEF RE: FACTS

COMES NOW THE PLAINTIFF and does hereby submit Plaintiff's Factual Trial  
Brief.

**I. NATURE OF THE CASE**

This office represents Jerry Smith as Personal Representative of the Estate of Brenda  
Smith and on behalf of the heirs of Brenda Smith's estate. This case involves the unnecessary  
and hideously painful suffering and subsequent death of Brenda Smith, age 47, as the result of  
negligent medical care by her surgeon, Dr. Paul Schwaegler.

**MEDICAL FACTS**

**A. DECEMBER 31, 2003**

Brenda Smith underwent a repeat back operation by Dr. Paul Schwaegler on New Years Eve, 2003. The surgery that was carried out at Swedish Hospital at the Cherry Hill (Providence) campus was a two stage procedure which lasted a total of 9.5 hours. The first stage of the procedure was an anterior (abdominal) approach to remove disk material at L3-4 and L4-5. This part of the procedure lasted four hours and required Brenda Smith, who was morbidly obese at 123 kgs (270 lbs.), to be in a kneeling position with her torso laying flat on the operating table. This position on what is known as an Andrews table, can kink and thereby impede blood flow and facilitate clot formation of the vessels in the lower extremities. Because of the positioning, blood tends to pool in the legs.

The second part of the procedure involved moving Brenda to a position where she lay flat on her back for a period of five and one-half hours. During the first part of the surgery, in order to gain access to the disks, the vena cava and aorta need to be retracted out of the way, which can cause clots to form. Here, the vena cava was actually torn and had to be repaired during this part of the procedure by the vascular surgeon, Dr. Andrew Ting (not a defendant in this case).

During the second part of the surgery with Brenda Smith in a supine position on her back, Dr. Schwaegler removed more disk material and placed a metal support device in to stabilize the three vertebrae.

After emerging from the surgery, Brenda Smith was taken to the post anesthesia recovery unit (PACU or Recovery Room). Dr. Schwaegler's handwritten operative note indicated no [Ø] complications. She was seen by Dr. Schwaegler there as well as by PACU

1 nurses. The PACU nurses did not record any baseline observations for Brenda Smith's feet or  
2 lower extremities in terms of sensation, strength or quality of pulses. Dr. Schwaegler did note  
3 that she had normal sensation and there were no problems as of approximately 1745. Brenda  
4 was taken to the ICU at 1925 after being discharged from the recovery room.

5 At 2200 that night, New Year's Eve Night, nurse Anna Sterner, concerned over a new  
6 finding that Brenda had bilateral foot numbness, called Dr. Schwaegler. He told the nurse  
7 that this was expected. The nurse also told Dr. Schwaegler that the urine was dark with  
8 blood. Dr. Schwaegler did not come in to see his patient.  
9

10 Through the night Brenda had foot numbness.

11 **B. JANUARY 1, 2004**

12 At 0600 when Dr. Khalfayan, an orthopedic surgeon and partner covering for Dr.  
13 Schwaegler, came in to see Brenda, he noted a questionable neurologic exam. She was less  
14 able to flex her feet with weak knee movement. She had decreased sensation on the dorsum  
15 of her left foot and had no active deep tendon reflexes, plantar flexion or extensor hallucis  
16 longus (muscle which extends the great toe) which represented a change from when she had  
17 motor function 1.5 hours prior. She in essence had developed a "drop foot" which was a  
18 significant change from her normal functions post op in the lower extremities. At this time  
19 there is no documentation of a peripheral vascular exam or any concern about the vascular  
20 system.  
21

22 At 0630 Nurse Sterner states that while Brenda can lift her legs slightly, it is "not as  
23 good as before." Three persons, Dr. Khalfayan, Nurse Sterner and Brenda Smith, all note  
24 decreased motor function. Dr. Khalfayan rechecks Brenda and calls Dr. Schwaegler at home.  
25  
26

1 Dr. Schwaegler advises Dr. Khalfayan that he will be in to see Brenda. Dr. Schwaegler  
2 testified:

3 2 A Yes, it was a deficit, there's no question. I mean  
4 she couldn't move as well as she could previously,  
5 that's correct.

6 5 Q Did this ever improve after 6:00 in the morning?

7 6 A Yes.

8 7 Q And when and where?

9 8 A Uh, when I came in at noon it had improved somewhat,  
10 uh, not completely, but at the time I came in she had  
11 most of her strength back in her left lower extremity  
12 but she was still somewhat weak in her right lower  
13 extremity. And...

14 13 Q Did you ever have a, a face-to-face conversation with  
15 Doctor Kalfayan?

16 15 A No.

17 16 Q Why don't you tell us as best you can and complete as  
18 possible the substance of your conversation.

19 18 A Doctor Kalfayan called me late morning and informed  
20 me that he was concerned about Brenda. And I asked  
21 him what he was concerned about. He said he was  
22 concerned that her motor strength was decreased and  
23 since he didn't know what it was preoperatively other  
24 than from looking through the notes, he, he was  
25 wanting me to know that that was the case.

26 25 I believe he was calling me mid to late morning  
1 because he had checked back to see if there was any  
2 change in that, and apparently she was still showing  
3 signs of weakness. So he indicated to me that she  
4 was weak. He also indicated to me that, uh, her  
5 urine output was down and she was, umm, getting a  
6 high potassium. He told me what she, what he had  
7 done but that that had not rectified things, uh, that  
8 her potassium had still, was still rising and so he

9 had taken it upon himself to call the inpatient team  
10 and he wanted to make sure that I was okay with that.

11 And, uh, I recollect asking him, Well, who,  
12 who's on for the inpatient team? And he said, Oh,  
13 Doctor Bennett. And I said, Okay, great, he's very  
14 competent and that sounds, that sounds good. And I  
15 informed Doctor Kalfayan that I was going to be  
16 coming in that day anyway so that I would take a look  
17 at her probably within an hour or two and reassess  
18 the situation.

Schwaegler Deposition, pgs. 102-103.

Dr. Bennett, a hospitalist who sees Brenda at 1350 on January 1<sup>st</sup>, notes that she is having difficulty with her right ankle plantar flexion and dorsiflexion, has difficulty moving her legs bilaterally and her right leg is becoming more difficult to move and has less sensation. Dr. Schwaegler sees Brenda in conjunction with Dr. Bennett but fails to note anything in the chart.

At 1500, Nurse Hanson evaluates Brenda, finding that she has bilateral pulses present. Nurse Hanson goes off shift at 1900 and Nurse Cummons comes on shift carrying out an evaluation at 1920 noting the left foot is cool and notes no pulses present.

At 2340, Nurse Cummons notes the left foot is cold and there are no pulses present by Doppler.

**C. JANUARY 2, 2004**

After contacting the hospitalist, Dr. Sachdeva, she then calls Dr. Khalfayan at approximately 1:00 am. Dr. Schwaegler, who was called by Dr. Khalfayan, comes down to see Brenda and calls in Dr. Johansen for a vascular surgery consult which takes place at about 0300. After evaluating Brenda and obtaining an aortogram, Brenda is taken to surgery to

1 remove a clot in the aorta which had blocked off all blood to her lower extremity. Another  
2 clot was found in the knee at the popliteal artery.

3 At approximately 0100, the AHT progress note indicates that the physician was  
4 "unable to feel either FA, PA, DP. [Left] foot cooler than [right]. Ø obvious cyanosis but  
5 somewhat dusky...Has sensation only over inner side of L [left] foot. Able to wiggle L [left]  
6 toes but not R [right]." At approximately 0200, it is documented that a vascular study was  
7 performed, and that Dr. Johansen and Dr. Schwaegler were in with Brenda Smith. Dr.  
8 Schwaegler's progress note provides in part as follows:  
9

10 Pt /c [with] new findings of cool & dusky L foot & absent pulses distally B  
11 [bilaterally]...Does feel numbness is greater in L foot region...minimal  
12 motor fxn [function] distally B [bilateral] LE [lower extremities]. Trace  
13 plantar flxn [flexion] & dorsiflxn [dorsiflexion] toes. Trace plantar flxn  
14 foot, min [minimal]/dorsiflxn R. Ø appreciable dorsiflxn L. Sensation  
15 intact R, absent/diminished greatly L LE [lower extremity] (foot). L foot  
16 cyanotic looking. Ø pulses distally in either LE [lower  
17 extremity]...Appears to have some component of vasc  
18 compromise...consulted Dr. Johansen...Will defer decision making to him  
19 re vasc status...

20 At approximately 0330, a nurse documented that Brenda Smith's left foot was cold  
21 and dusky with no pulses.

22 At approximately 0510, an aortogram was performed on Brenda Smith.

23 At 0550, a nurse noted a "Late Entry" in the Progress Record:

24 Late Entry Nsg 01/02/03 0550 2340 Pt L foot dusky, cold to touch, Ø  
25 pulses by Doppler. Pt unable to wiggle toes as in prev. assessment at 1940.  
26 AHT MD notified. Stat Vascular Study ordered. Dr. Khalfayan notified of  
Δ's [changes]. Will continue to monitor...

Surgery was carried out beginning at around 0600 to remove the two clots in the left  
lower extremity. About 12 hours later, a second surgery was carried out to relieve  
compartment pressure in the calves. Compartment pressure occurs from the death of muscle

1 tissue and subsequent expansion within the closed compartments of the calf. The  
2 compartment syndrome surgery essentially relieves the pressure by performing slices in the  
3 calf compartments. This failed to cure the situation and later Brenda's leg was amputated  
4 since her lower leg had died. She underwent multiple revisions of this surgery and during her  
5 stay in the hospital she contracted methicillin-resistant Staphylococcus aureus (MRSA) which  
6 is often contracted by patients who spend too long in the hospital.

7  
8 Between 0625 and 1057, Vascular Surgeon, Kaj Johansen, M.D., performed a left  
9 retroperitoneal transaortic thrombectomy, Bovie and pericardium patch angioplasty; and a left  
10 femoral-popliteal thromboembolectomy, leg incisions on Brenda Smith secondary to an  
11 occluded aorta. Dr. Johansen's postoperative diagnosis included "[t]erminal aortic  
12 thrombosis, left femoral-popliteal embolization." His operative report provides in part as  
13 follows:

14  
15 ...This...woman underwent an extensive anterior/posterior spinal fusion  
16 and stabilization 36 hours previously. In the early postoperative period,  
17 she had some bilateral distal lower extremity neurologic findings, which  
18 were thought likely secondary to intraoperative traction on nerve roots.  
19 However, she subsequently developed a cool left foot, which was pulseless  
20 by Doppler, and a vascular laboratory examination in fact demonstrated  
21 substantial reduction of blood supply on both side (right and left ankle-arm  
22 Doppler arterial pressure indices of 0.31 and 0.0). Arteriography was  
23 performed, revealing complete occlusion of the infrarenal aorta,  
24 approximately 3 cm distal to the renal arteries. The iliac arteries  
25 reconstituted bilaterally.

26 ...The patient is brought urgently to the operating room for aortic  
reconstruction with the presumption that an intimal flap raised at the time  
of traction on the aorta during anterior cage fusion or thrombus formation  
because of her nearly 6 hours in the prone position with her heavy weight  
resulted in aortic occlusion, either by dissection or thrombosis.

Between 1742 and 1916, Dr. Kaj Johansen performed a bilateral four compartment  
fasciotomy and excision of nonviable anterior compartment musculature on Brenda Smith

1 secondary to bilateral lower extremity compartment syndrome. His operative report provides  
2 in part as follows:

3 ...This...woman suffered an unfortunate distal aortic thrombotic occlusion,  
4 with embolization of the left lower extremity, subsequent to an extended  
5 spine reconstructive procedure. She underwent aortic thrombectomy and  
6 patch angioplasty, as well as left femoral-popliteal embolectomy earlier in  
7 the day. The decision was made at that time not to carry out four  
8 compartment fasciotomy because of what was believed to be the relatively  
9 brief (6-12 hours) period of time of ischemia, as well as the patient's  
10 preserved (albeit diminished) motor and sensory function of both lower  
11 extremities prior to operation. Following the first operation, the patient had  
12 significant problems with rising creatinine levels and potassium, and  
13 received large amounts of volume. The patient demonstrated firm,  
14 although not tense, moderately tender calves bilaterally and had sensation  
15 and motor function which, as it was prior to the first operation, intact, but  
16 substantially diminished. However, a vascular laboratory examination  
17 demonstrated loss of calf vein phasicity. The patient is brought urgently to  
18 the Operating Room for four compartment fasciotomy....

19 ...The muscle in all four compartments of both lower extremities bulged  
20 significantly. The anterior compartment musculature was clearly nonviable  
21 bilaterally. The right lateral compartment showed a flicker of twitch, but  
22 looked mostly nonviable. On the left side the lateral compartment seemed  
23 viable. The superficial and deep posterior compartments were viable  
24 (viability in all cases noted by twitch to galvanic stimulation).

25 **D. JANUARY 5 - FEBRUARY 13, 2004**

26 On 1/5/04 between 1350 and 1524, Dr. Johansen performed an inspection under  
anesthesia, irrigation and debridement, excision of right lateral compartment muscle on  
Brenda Smith, and noted in his operative note in part as follows:

...A large proportion of the lateral compartment musculature on the right  
was dead and was debrided. There was a small component of this  
compartment that was still viable distally. The remainder of the muscle in  
all three compartments on the left and the remaining two compartments on  
the right appeared viable. The skin edges could not be apposed without  
significant tension, so primary closure was not carried out.

1 On 1/7/04, Dr. Johansen performed irrigation, debridement, second closure of open  
2 fasciotomy wounds bilaterally on Brenda Smith, and noted in part in his operative report that  
3 "[t]he wounds could be closed without tension. All muscle was viable (lateral and posterior  
4 compartments on the left side, posterior compartments only on the right side).

5 On 1/12/04, Dr. Johansen performed a thromboembolectomy of the left posterior tibial  
6 artery and left peroneal artery secondary to a severely ischemic, pre-gangrenous left mid and  
7 forefoot due to tibial artery emboli.

8 On 1/21/04, Dr. Johansen performed a left below the knee amputation on Brenda  
9 Smith secondary to a necrotic left forefoot, and noted in part as follows in the operative  
10 report:  
11

12 ...This...woman suffered distal left lower extremity embolization at the  
13 time of an acute aortic thrombosis following spine surgery. She underwent  
14 thrombectomy, including of the tibial arteries, with restoration of flow  
15 down to the midfoot, but demarcation at that level. She has been observed  
16 for approximately 10 days with the hopes that she would salvage enough  
17 midfoot tissue to enable an open transmetatarsal or Chopart amputation...a  
18 useful left foot could not be salvaged.

19 On 1/23/04, Dr. Johansen performed an examination under anesthesia, re-amputation  
20 and debridement and irrigation of Brenda Smith's nonhealing, pre-gangrenous left transtibial  
21 amputation wound.

22 On 1/24/04, Dr. Johansen performed an examination under anesthesia, irrigation and  
23 application of a wound-VAC device secondary to her open nonhealing left below the knee  
24 amputation (BKA). A blood culture was obtained, which revealed Methicillin Resistant  
25 Staphylococcus aureus.

26 On 1/26/04, Dr. Johansen performed an extensive debridement and harvest of skin  
graft (300 sq cm) secondary to a massive left below knee amputation and 4-compartment

1 fasciotomy of her open wound. Dr. Jourdan Gottlieb performed a split-thickness skin graft  
2 600 square centimeters on her open wound, left below the knee stump.

3 On 2/5/04, Dr. James Watson performed a re-amputation of the left below the knee  
4 amputation, and noted in part in his operative report that "[e]ssentially all the below knee  
5 muscles were dead..." On 2/6/04, a blood culture was obtained, which revealed Vancomycin  
6 Resistant Enterococci. On 2/7/04, Dr. Johansen performed an examination under anesthesia,  
7 irrigation and reamputation of the tibia and fibula and application of the wound VAC  
8 secondary to an open, Pseudomonas-in contaminated wound in the left below the knee  
9 amputation. On 2/10/04, Dr. Watson performed a wound dressing under anesthesia on the  
10 open left below the knee amputation. On 2/13/04, Dr. Johansen performed a through knee  
11 (TK) left amputation secondary to a nonhealing, dysfunctional left below the knee amputation  
12 with open wound. Brenda Smith was continuously in the hospital from December 31, 2003  
13 through April 24, 2004.  
14

15 After her discharge, Brenda Smith continued to have MRSA infection complications.  
16 On June 3, 2004, Dr. David Tempest, Brenda's rehabilitation medicine physician, reported  
17 that her wound culture "came back MRSA." Brenda had previously had an infected left  
18 stump hematoma, which had been drained and probed by Dr. Johansen. On October 30, 2004,  
19 Brenda was again seen by infectious disease physician, Dr. Martin Siegel. Dr. Siegel was  
20 concerned that she had osteomyelitis in the tip of the left femur from the previous MRSA  
21 infections. Dr. Siegel also considered Brenda Smith to be a "MRSA carrier."  
22

23 On December 22, 2004, Brenda Smith had a new ulcer on her amputation stump. Dr.  
24 David Judish found purulent drainage and was able to probe the sinus tract approximately  
25 three centimeters near bone. A deep wound culture was obtained and the wound was packed  
26

1 with gauze dressing. Brenda was referred back to Dr. Siegel pending wound culture results.  
2 The final wound culture came back as methicillin-resistant Staphylococcus aureus (MRSA).  
3 When seen again on December 28, 2004, by Dr. Judish's associate, Dr. Michael Myint, it  
4 again diagnosed as soft tissue infection with MRSA. It was unclear at that point in time  
5 whether this is a primary infection secondary to underlying deep infection such as  
6 osteomyelitis versus a new MRSA infection. Regardless, Brenda Smith was started on a  
7 course of doxycycline and rifampin. By January 4, 2005, Brenda Smith was again admitted to  
8 the Swedish Cherry Hill facility for intravenous vancomycin therapy and an MRI and bone  
9 scan. Brenda Smith's intravenous vancomycin was to continue until February 2, 2005.

10  
11 On March 1, 2005, Brenda Smith was again admitted through the emergency room to  
12 Swedish-Cherry Hill campus for multilobar pneumonia. A March 1, 2005 chest x-ray showed  
13 patchy pulmonary infiltrates. A CT scan with contrast confirmed pulmonary infiltrates and  
14 ruled out any pulmonary embolism. Upon admission, Brenda was considered to be certainly  
15 at risk for MRSA pneumonia and was given vancomycin intravenously. Brenda was admitted  
16 to the intensive care unit.

17  
18 Notwithstanding episodic periods of improvement, a March 7, 2005 follow-up CT  
19 scan showed "interval increase in the extensive interstitial infiltrates" throughout both lungs.  
20 On March 6, 2005, Dr. John Huseby performed a bronchial alveolar lavage in which 300 cc.  
21 of puss and aspirates were removed and sent to the lab for culture. Dr. Huseby's procedure  
22 report stated:

23  
24  
25 The lab culture of the bronchial alveolar lavage showed many methicillin-resistant  
26 Staphylococcus aureus. Rare candida (fungal) was also identified. The gram stain also

1 showed many positive cocci, which were presumed to be staph. A viral respiratory screen for  
2 possible viral causes of the pneumonia were negative.

3 Late on March 9, 2005, Brenda was transferred from the ICU to the regular medical  
4 floor. Brenda still required supplemental oxygen. She had an episode of desaturation and two  
5 respiratory therapy treatments, which improved her oxygen saturations. Brenda experienced  
6 heartburn and agitation in the early morning hours and was given a "GI cocktail" and Ativan  
7 was ordered at approximately 6 am. By 8 am, Brenda was noted to be lethargic and within a  
8 couple of minutes suffered a respiratory arrest, which required prolonged resuscitation.  
9 Brenda did not receive sufficient oxygenation to her brain during this resuscitation and the  
10 family later chose to disconnect Brenda from life support.  
11

12 An autopsy was performed by Washington Pathology Consultants. The principle  
13 diagnosis on autopsy was clinical multilobar acute pneumonia (methicillin-resistant  
14 Staphylococcus aureus by antemortem bronchial alveolar lavage culture 3/6/05). The autopsy  
15 was also consistent with pre-existing conditions of chronic obstructive pulmonary disease, i.e.  
16 emphysematous changes. The autopsy also noted that Brenda Smith had a stenotic abdominal  
17 aorta at the previous aortic thrombectomy site. Evidence of lack of oxygenation of the brain  
18 was confirmed by early acute ischemic-hypoxic changes of cerebral cortex with mild cerebral  
19 edema and central herniation.  
20

### 21 BACKGROUND OF PLAINTIFFS

22 Brenda Smith was a dump truck driver-heavy equipment operator, as is her husband,  
23 Jerry Smith. Brenda has two adult children, Richona and Jeremiah. Their family is very  
24 close, and they all assisted in Brenda's home healthcare needs. Jeremiah was a field EMT  
25 and is now an emergency dispatcher. Brenda enjoyed sculpture and stone carving.  
26

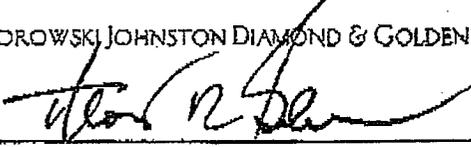
1 Brenda Smith agreed to this major surgery because she believed this fusion would  
2 allow her to return to her beloved profession as a truck driver. Dr. Schwaegler confirmed in  
3 his deposition that the goal of the surgery was to return Brenda to work in this job. Instead of  
4 her hope of returning to work, Brenda wound up helpless in a 15-month odyssey through  
5 more than a dozen major surgical procedures, including three amputation procedures.  
6 Throughout the ordeal, Brenda tried to remain optimistic. Family friends, Tina Borelan and  
7 LeAndre Tyler, saw the toll it took on Brenda and the family. Tina characterizes Jerry,  
8 Brenda, Jeremiah and Richona as a "very tight" family with Brenda as the strength of the  
9 family unit. Brenda made everyone around her feel good. Tina characterizes the impact of  
10 Brenda's death on the family as "devastating." Jerry has lost both his soul mate and his will  
11 to live. LeAndre Tyler has seen Jerry return to alcohol consumption. Richona has lost her  
12 best friend and is no longer considering pursuing a Jeremiah career. Jeremiah remains highly  
13 emotional about the loss of his mother. He lost not just his mother, but his closest confident.

14  
15  
16 Dr. Kaj Johansen and even Dr. Schwaegler will testify that Brenda was a remarkable  
17 woman to whom they both became attached. Dr. Johansen even attended Brenda's funeral.  
18 Brenda Smith was a special person who died an unnecessary death at the early age of 47. For  
19 15 months, Brenda struggled to maintain her sense of identity and self worth even after  
20 undergoing multiple mutilating surgeries. In the end, she could not beat back her medical  
21 complications from Dr. Schwaegler's negligent surgery.

22 RESPECTFULLY SUBMITTED this 29 day of October, 2007.  
23  
24  
25  
26

OTOROWSKI JOHNSTON DIAMOND & GOLDEN

By:

  
Thomas R. Golden, WSBA #11040  
Attorneys for Plaintiff

**CERTIFICATE OF SERVICE**

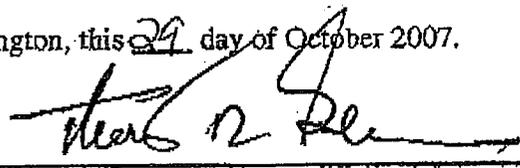
I, the undersigned, hereby certify under penalty of perjury under the laws of the State of Washington, that I am now, and at all times material hereto was a citizen of the United States, a resident of the State of Washington, over the age of 18 years, not a party to, nor interested in, the above-entitled action, and competent to be a witness herein.

I caused to be served this date a copy of the foregoing pleading, in the manner indicated to the parties listed below:

John C. Graffe, Esq.  
Johnson Graffe Keay Moniz & Wick  
925 Fourth Avenue, Suite 2300  
Seattle, WA 98104

- Legal Messenger
- Hand Delivered
- Facsimile
- First Class Mail
- UPS, Next Day Air
- Email

DATED at Bainbridge Island, Washington, this 29 day of October 2007.

  
~~Brandi R. Patfield~~  
Legal Assistant to Thomas R. Golden

**Francesca Kerr**

---

**From:** Francesca Kerr  
**Sent:** Monday, November 12, 2007 8:35 AM  
**To:** 'Rebecca Ringer'  
**Cc:** 'Celeste Delostrinos'; 'sperry@kingmanpeabody.com'; Clarke Johnson; John Graffe  
**Subject:** RE: Kaj Johansen  
**Attachments:** COSSMAN-TT 11-8-07.pdf

Rebecca: Here is the trial testimony of Dr. Cossman for Dr. J's review.

Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104

Phone: (206) 223-4770  
Fax: (206) 386-7344  
[francesca@jgkmw.com](mailto:francesca@jgkmw.com)

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---

**From:** John Graffe.  
**Sent:** Sunday, November 11, 2007 3:30 PM  
**To:** Rebecca Ringer; Liz Mitchell  
**Cc:** Celeste Delostrinos; sperry@kingmanpeabody.com; Clarke Johnson; Francesca Kerr  
**Subject:** RE: Kaj Johansen

Rebecca: He is scheduled for Wednesday morning. Francesca will send the testimony of Dr. Cossman, their vascular surgery expert. Clarke will be handling Kaj. I suspect that he will send areas of inquiry. Thanks. John

---

**From:** Rebecca Ringer [mailto:[rringer@kingmanringer.com](mailto:rringer@kingmanringer.com)]  
**Sent:** Sat 11/10/2007 2:10 PM  
**To:** John Graffe; Liz Mitchell  
**Cc:** Celeste Delostrinos; sperry@kingmanpeabody.com  
**Subject:** Kaj Johansen

11/10/07

Hi John,

Thanks for your voicemail re plaintiff's expert's criticisms of Kaj. Yes, I'm sure Kaj would appreciate knowing the issues. Because I'll be out of state again starting tomorrow, could you please be sure and send anything to both Celeste and Seija as well as me? That way, someone will be able to print and get the transcript up to Kaj. When is Kaj scheduled to testify?

Let me know if there is anything else I can do. Good luck!

Rebecca

11/15/2007

**Rebecca Ringer**

**Kingman Ringer & Horne**

505 Madison Street, Suite 300

Seattle, WA 98104

Tel: (206) 622-1264

Fax: (206) 292-2961

E-Mail [rringer@kingmanringer.com](mailto:rringer@kingmanringer.com)

Web: [www.kingmanringer.com](http://www.kingmanringer.com)

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**Liz Mitchell**

---

**From:** Patricia J. Andrews [patti@fsav.com]  
**Sent:** Tuesday, March 20, 2007 8:44 AM  
**To:** Liz Mitchell  
**Subject:** RE: SMITH: DR. JOHANSEN DEP

Apparently your office requested this dep. so you should note it.

*Patti Andrews*  
*Legal Assistant*  
*Fain Sheldon Anderson & VanDerhoef, PLLC*  
*(206) 749-2387*  
[patti@fsav.com](mailto:patti@fsav.com)

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---

**From:** Liz Mitchell [mailto:liz@jgkm.com]  
**Sent:** Monday, March 19, 2007 7:22 PM  
**To:** Brandi Patsfield; Patricia J. Andrews  
**Subject:** SMITH: DR. JOHANSEN DEP

Am I noting this Patti or are you?

**Liz Mitchell**

---

**From:** Brandi Patsfield [bp@medilaw.com]  
**Sent:** Tuesday, March 20, 2007 12:26 PM  
**To:** Liz Mitchell; Patricia J. Andrews  
**Subject:** Re: SMITH: DR. JOHANSEN DEP

Actually, I am. He's a treater that we want to depose.  
Brandi

On 3/19/07 7:22 PM, "Liz Mitchell" <liz@jgkm.com> wrote:

Am I noting this Patti or are you?

**Liz Mitchell**

---

**From:** John Graffe  
**Sent:** Tuesday, April 24, 2007 3:10 PM  
**To:** Liz Mitchell  
**Subject:** Re: DR. JOHANSEN

Ok

----- Original Message -----  
**From:** Liz Mitchell  
**To:** John Graffe  
**Sent:** Tue Apr 24 14:41:18 2007  
**Subject:** DR. JOHANSEN

His dep has moved from this Thursday to May 7th and it's on your calendar. Do you still want to attend Nurse Phyllis Hanson at 12:30 pm on Thurs..?

**Liz Mitchell**

---

**From:** John Graffe  
**Sent:** Tuesday, April 24, 2007 3:38 PM  
**To:** Liz Mitchell  
**Subject:** RE: DR. JOHANSEN

yes

---

**From:** Liz Mitchell  
**Sent:** Tue 4/24/2007 3:14 PM  
**To:** John Graffe  
**Subject:** RE: DR. JOHANSEN

Ok, meaning you want to attend the nurse's dep? Johansen is now moved to May 2nd.

-----Original Message-----

**From:** John Graffe  
**Sent:** Tuesday, April 24, 2007 3:10 PM  
**To:** Liz Mitchell  
**Subject:** Re: DR. JOHANSEN

Ok

----- Original Message -----

**From:** Liz Mitchell  
**To:** John Graffe  
**Sent:** Tue Apr 24 14:41:18 2007  
**Subject:** DR. JOHANSEN

His dep has moved from this Thursday to May 7th and it's on your calendar. Do you still want to attend Nurse Phyllis Hanson at 12:30 pm on Thurs.?

**Liz Mitchell**

---

**From:** Heather Polz [heather@jgkmw.com]  
**Sent:** Monday, April 30, 2007 11:09 AM  
**To:** Liz Mitchell  
**Subject:** Smith - Johansen dep

Is it this Wed and is John covering it? thanks.

Heather L. Polz  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
2115 North 30th #101  
Tacoma, WA 98403  
(253) 572-5323  
heatherp@jgkmw.com

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**Liz Mitchell**

---

**From:** Heather Polz [heather@jgkmw.com]  
**Sent:** Tuesday, May 08, 2007 3:40 PM  
**To:** Liz Mitchell  
**Subject:** Smith - Dr. JOhansen's dep

Please let me know if any dates have been thrown out yet for Dr. J's dep. Thanks.

Heather L. Polz  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
2115 North 30th #101  
Tacoma, WA 98403  
(253) 572-5323  
heatherp@jgkmw.com

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**Liz Mitchell**

**From:** Jackie Schaffrath  
**Sent:** Thursday, June 21, 2007 2:13 PM  
**To:** Liz Mitchell  
**Subject:** RE: SMITH V. SCHWAEGLER - Return of Johansen's subfile to Liz

I am returning Dr. Johansen's subfile to you in tomorrow's pouch.

**From:** Liz Mitchell [mailto:liz@jgkm.com]  
**Sent:** Monday, June 18, 2007 2:47 PM  
**To:** Jackie Schaffrath  
**Cc:** Clarke Johnson  
**Subject:** SMITH V. SCHWAEGLER

Hi Jackie. Two deps Clarke will cover are Kai Johansen, MD (set for Wed. 6/27 @ 9:30am. Dep notice is in the subfile.) I am going to send you Dr. Johansen's subfile in the pouch.

And Scott Blumenthal, MD set for August 16 @ 9am in Plano. Below is his contact information. His assistant is going to send me his updated fee schedule which I will forward to you.

<p>Scott Blumenthal, M.D.  Texas Back Institute  6020 W. Parker Rd., Ste. 200  Plano, TX 75093  Assistant: Nancy McCord  (972) 608 5114  nmcord@texasback.com</p>	<p>Dep: August 16, 2007, 9 a.m.   Dr. Blumenthal is available at 8am for prepdep   I am working on location for dep.</p>
---	--

Thanks  
Liz

*Liz Mitchell*  
*Legal Assistant*  
*Johnson, Graffe, Keay, Moniz & Wick, LLP*  
*925 Fourth Ave, Ste 2300*  
*Seattle WA 98104*  
*Phone: (206) 223-4770*  
*Fax: (206) 386-7344*

*liz@jgkmw.com*

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11/16/2007

**Liz Mitchell**

---

**From:** Christy Reynolds [cr@medilaw.com]  
**Sent:** Wednesday, October 31, 2007 12:26 PM  
**To:** Liz Mitchell  
**Subject:** Re: SMITH: KAJ JOHANSEN

Yes, we have the exhibits - #s 0-27.

Christy

On 10/31/07 11:02 AM, "Liz Mitchell" <liz@jgkm.com> wrote:

Did you get a copy of the exhibits to his dep. We did not. I'll ask Ringer also.

*Liz Mitchell  
Legal Assistant  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104  
Phone: (206) 223-4770  
Fax: (206) 386-7344*

*[liz@jgkmw.com](mailto:liz@jgkmw.com) <<mailto:liz@jgkmw.com>>*

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**Liz Mitchell**

---

**From:** Rebecca Ringer [rringer@kingmanringer.com]  
**Sent:** Saturday, November 10, 2007 2:11 PM  
**To:** John Graffe; Liz Mitchell  
**Cc:** Celeste Delostrinos; sperry@kingmanpeabody.com  
**Subject:** Kaj Johansen

11/10/07

Hi John,

Thanks for your voicemail re plaintiff's expert's criticisms of Kaj. Yes, I'm sure Kaj would appreciate knowing the issues. Because I'll be out of state again starting tomorrow, could you please be sure and send anything to both Celeste and Seija as well as me? That way, someone will be able to print and get the transcript up to Kaj. When is Kaj scheduled to testify?

Let me know if there is anything else I can do. Good luck!

Rebecca

**Rebecca Ringer**  
**Kingman Ringer & Horne**  
505 Madison Street, Suite 300  
Seattle, WA 98104  
Tel: (206) 622-1264  
Fax: (206) 292-2961  
E-Mail [rringer@kingmanringer.com](mailto:rringer@kingmanringer.com)  
Web: [www.kingmanringer.com](http://www.kingmanringer.com)

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---

11/16/2007

**Liz Mitchell**

---

**From:** John Graffe  
**Sent:** Sunday, November 11, 2007 3:30 PM  
**To:** Rebecca Ringer; Liz Mitchell  
**Cc:** Celeste Delostrinos; sperry@kingmanpeabody.com; Clarke Johnson; Francesca Kerr  
**Subject:** RE: Kaj Johansen

Rebecca: He is scheduled for Wednesday morning. Francesca will send the testimony of Dr. Cossman, their vascular surgery expert. Clarke will be handling Kaj. I suspect that he will send areas of inquiry. Thanks. John

---

**From:** Rebecca Ringer [mailto:rringer@kingmanringer.com]  
**Sent:** Sat 11/10/2007 2:10 PM  
**To:** John Graffe; Liz Mitchell  
**Cc:** Celeste Delostrinos; sperry@kingmanpeabody.com  
**Subject:** Kaj Johansen

11/10/07

Hi John,

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Let me know if there is anything else I can do. Good luck!

Rebecca

**Rebecca Ringer**  
**Kingman Ringer & Horne**  
505 Madison Street, Suite 300  
Seattle, WA 98104  
Tel: (206) 622-1264  
Fax: (206) 292-2961  
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---

11/16/2007

Liz Mitchell

---

From: Francesca Kerr  
Sent: Thursday, November 15, 2007 9:19 AM  
To: 'leedom@bblaw.com'; 'Rebecca Ringer'; 'Hosford, Bradley'; 'chris@fsav.com'  
Cc: John Graffe; Clarke Johnson; Liz Mitchell  
Subject: Smith: Pif Motion for Evidentiary Hearing Re Materials Provided to Johansen

Attachments: DOC071115.pdf



DOC071115.  
pdf (188 KB)

Please see attached and reply to all. Thank you.

Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle, WA 98104

Phone: (206) 223-4770  
Fax: (206) 386-7344  
francesca@jgkmw.com

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-----Original Message-----

From: Johnson Graffe Keay Moniz & Wick [mailto:sandra@jgkmw.com]  
Sent: Thursday, November 15, 2007 9:12 AM  
To: Francesca Kerr  
Subject: Scanned from e-4511 11/15/2007 09:11

Scanned from e-4511.  
Date: 11/15/2007 09:11  
Pages: 7  
Resolution: 200x200 DPI

-----

## Liz Mitchell

---

**From:** Rebecca Ringer [rringer@kingmanringer.com]  
**Sent:** Thursday, November 15, 2007 11:07 AM  
**To:** Francesca Kerr; eleedom@bblaw.com; 'Hosford, Bradley'; Chris Anderson  
**Cc:** John Graffe; Clarke Johnson; Liz Mitchell  
**Subject:** RE: Smith: Plf Motion for Evidentiary Hearing Re Materials Provided to Johansen

Chris KNOWS that I provided the trial brief and testimony to Kaj because I told him that last evening when I called him back.

I'm starting a trial Monday so am not available to appear or really to do much of a response - a fact Chris also knows since I told him that last evening also.

Is there any plan? What about having the Court conduct a brief conference call with me this afternoon so I can again confirm that I am the only one who has had contact with my client?

RR

Rebecca Ringer  
Kingman Ringer & Horne  
505 Madison Street, Suite 300  
Seattle, WA 98104  
Tel: (206) 622-1264  
Fax: (206) 292-2961  
E-Mail rringer@kingmanringer.com  
Web: www.kingmanringer.com

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**From:** Francesca Kerr [mailto:francesca@jgkm.com]  
**Sent:** Thursday, November 15, 2007 9:19 AM  
**To:** eleedom@bblaw.com; Rebecca Ringer; Hosford, Bradley; chris@fsav.com  
**Cc:** John Graffe; Clarke Johnson; Liz Mitchell  
**Subject:** Smith: Plf Motion for Evidentiary Hearing Re Materials Provided to Johansen

Please see attached and reply to all. Thank you.

Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104

Phone: (206) 223-4770  
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francesca@jgkmw.com

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Sent: Thursday, November 15, 2007 9:12 AM

To: Francesca Kerr

Subject: Scanned from e-4511 11/15/2007 09:11

Scanned from e-4511.

Date: 11/15/2007 09:11

Pages:7

Resolution:200x200 DPI

-----

**Francesca Kerr**

---

**From:** Francesca Kerr  
**Sent:** Tuesday, November 13, 2007 10:41 AM  
**To:** 'Rebecca Ringer'; 'Celeste Delostrinos'; 'sperry@kingmanpeabody.com'  
**Cc:** Clarke Johnson; John Graffe  
**Subject:** Smith v. Schwaegler: Dr. Johansen Direct Exam Notes  
**Attachments:** DirectExam Johansen.doc

Hi Rebecca, Celeste and Seija: Attached are Clarke Johnson's notes for direct examination of Dr. Johansen.

*Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104*

*Phone: (206) 223-4770  
Fax: (206) 386-7344  
[francesca@jgkmw.com](mailto:francesca@jgkmw.com)*

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**Smith v Schwaegler**

Dr. Johansen  
Direct Examination

Defendant's Theme - (good) pulses = perfusion

1. His background/training

2. Take him through the events of 1/2

What he did

Why he did it

What he found

3. Diagram

- a. clot in aorta
- b. clot embolizing to LE including TA
- c. when foot pinked up it showed adequate perfusion (mottled and cool)  
(OP p.2 at top)

4. 20/20 Hindsight

Training and years of experience as VS?

Tell us in your opinion what happened to Brenda Smith from a vascular standpoint (overview in this case).

5. Blood Flow Geometry

What happens to blood flow as an occlusion slowly develops?

Where did the clot found in Brenda Smith's pop. artery originate?

Where did the clot formed in the TA originate?

When in your opinion did the clot likely break off and travel to the TA?

7. Did the minor tear and repair of the VC have any role in the arterial problems that BS experienced?

8. Please tell us what role the embolus to the T. artery played in Brenda Smith losing her leg (p. 66)

9. Was there another major factor in causing that loss? (p. 82)
10. If you had known how this would ultimately turn out, what would you have done differently?
11. Is this a situation where you provided appropriate care but the patient still experienced a poor outcome (bad result)?
  - a. Did you provide appropriate care to BS?
  - b. BS experienced a poor outcome in spite of your best efforts?

12. As a vascular surgeon:

What do palpable/Doppler-able pulses, warm feet and good color tell you about perfusion in the lower extremities?

(The interstate is open) – R. Cossman (p. 53)

13. If you were called about BS mid-day on 1/1 and came in and examined her and found:

Good pulses and warm feet w/ good color, would further testing have been indicated?

**Possible Questions:**

Dr. J – Do you have an opinion whether it was reasonable for Dr. Khalfayan (ortho) to conclude (at 6 am on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet w/ good color?

Dr. J – Do you have an opinion whether it was reasonable for Dr. Bennett (AHT) to conclude (at 11-12 am on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet, w/ good color?

Dr. J – Do you have an opinion whether it was reasonable for Dr. Schwaegler to conclude (at 12-1 p.m. on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet, w/ good color?

Limit our questions to January '04.

If compartment syndrome had never developed, would BS still have lost her leg?

Please explain

Message

**Rebecca Ringer**  
Kingman Ringer & Horne  
505 Madison Street, Suite 300  
Seattle, WA 98104  
Tel: (206) 622-1264  
Fax: (206) 292-2961  
E-Mail: [rringer@kingmanringer.com](mailto:rringer@kingmanringer.com)  
Web: [www.kingmanringer.com](http://www.kingmanringer.com)

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**Clarke Johnson**

**From:** Francesca Kerr ([francesca@igkm.com](mailto:francesca@igkm.com))  
**Sent:** Monday, November 12, 2007 8:35 AM  
**To:** Rebecca Ringer  
**Cc:** Celeste Delostinos; sperry@kingmanpeabody.com; Clarke Johnson; John Graife  
**Subject:** RE: Kaj Johansen  
**Attachments:** COSSMAN-IT 11-9-07.pdf

Rebecca: Here is the trial testimony of Dr. Cossman for Dr. J's review.

*Francesca Kerr*  
*Paralegal to John C. Graife*  
*Johnson, Graife, Keey, Moniz & Witek, LLP*  
*920 Fourth Ave, Ste 2300*  
*Seattle WA 98104*

*Phone: (206) 223-4770*  
*Fax: (206) 386-7344*  
*[francesca@igkm.com](mailto:francesca@igkm.com)*

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**From:** John Graife  
**Sent:** Sunday, November 11, 2007 3:30 PM  
**To:** Rebecca Ringer; Liz Mitchell  
**Cc:** Celeste Delostinos; sperry@kingmanpeabody.com; Clarke Johnson; Francesca Kerr  
**Subject:** RE: Kaj Johansen

Rebecca: He is scheduled for Wednesday morning. Francesca will send the testimony of Dr. Cossman, their vascular surgery expert. Clarke will be handling Kaj. I suspect that he will send areas of inquiry. Thanks. John

**From:** Rebecca Ringer ([rringer@kingmanringer.com](mailto:rringer@kingmanringer.com))  
**Sent:** Sat 11/10/2007 2:10 PM  
**To:** John Graife; Liz Mitchell  
**Cc:** Celeste Delostinos; sperry@kingmanpeabody.com  
**Subject:** Kaj Johansen

11/10/07

El John,

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Let me know if there is anything else I can do. Good luck!

Rebecca

11/17/2007

11/17/2007

**Clarke Johnson**

---

**From:** Francesca Kerr [francesca@jgkm.com]  
**Sent:** Tuesday, November 13, 2007 10:41 AM  
**To:** Rebecca Ringer; Celeste Delostrinos; sperry@kingmanpeabody.com  
**Cc:** Clarke Johnson; John Graffe  
**Subject:** Smith v. Schwaegler: Dr. Johansen Direct Exam Notes  
**Attachments:** DirectExam Johansen.doc

Hi Rebecca, Celeste and Seija: Attached are Clarke Johnson's notes for direct examination of Dr. Johansen.

*Francesca Kerr  
Paralegal to John C. Graffe  
Johnson, Graffe, Keay, Moniz & Wick, LLP  
925 Fourth Ave, Ste 2300  
Seattle WA 98104*

*Phone: (206) 223-4770  
Fax: (206) 386-7344  
[francesca@jgkmw.com](mailto:francesca@jgkmw.com)*

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## Smith v Schwaegler

Dr. Johansen  
Direct Examination

Defendant's Theme - (good) pulses = perfusion

1. His background/training

2. Take him through the events of 1/2

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Why he did it

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a. clot in aorta

b. clot embolizing to LE including TA

c. when foot pinked up it showed adequate perfusion (mottled and cool)  
(OP p.2 at top)

4. 20/20 Hindsight

Training and years of experience as VS?

Tell us in your opinion what happened to Brenda Smith from a vascular standpoint (overview in this case).

5. Blood Flow Geometry

What happens to blood flow as an occlusion slowly develops?

Where did the clot found in Brenda Smith's pop. artery originate?

Where did the clot formed in the TA originate?

When in your opinion did the clot likely break off and travel to the TA?

7. Did the minor tear and repair of the VC have any role in the arterial problems that BS experienced?

8. Please tell us what role the embolus to the T. artery played in Brenda Smith losing her leg (p. 66)

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9. Was there another major factor in causing that loss? (p. 82)
10. If you had known how this would ultimately turn out, what would you have done differently?
11. Is this a situation where you provided appropriate care but the patient still experienced a poor outcome (bad result)?
  - a. Did you provide appropriate care to BS?
  - b. BS experienced a poor outcome in spite of your best efforts?

12. As a vascular surgeon:

What do palpable/Doppler-able pulses, warm feet and good color tell you about perfusion in the lower extremities?

(The interstate is open) – R. Cossman (p. 53)

13. If you were called about BS mid-day on 1/1 and came in and examined her and found:

Good pulses and warm feet w/ good color, would further testing have been indicated?

Possible Questions:

Dr. J – Do you have an opinion whether it was reasonable for Dr. Khalfayan (ortho) to conclude (at 6 am on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet w/ good color?

Dr. J – Do you have an opinion whether it was reasonable for Dr. Bennett (AHT) to conclude (at 11-12 am on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet, w/ good color?

Dr. J – Do you have an opinion whether it was reasonable for Dr. Schwægler to conclude (at 12-1 p.m. on 1/1) that BS did not have a significant occlusion when he found good pulses, warm feet, w/ good color?

Limit our questions to January '04.

If compartment syndrome had never developed, would BS still have lost her leg?

Please explain