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No. 68924-0

Court of Appeals
Division 1
Washington State

LEONARDO C. MARIANO, *pro se*
Plaintiff/Appellant

v.

SWEDISH CARDIAC SURGERY
Defendant/Appellee

BRIEF OF APPELLANT

Leonardo C. Mariano, *pro se*

1123 Rainier Av. # 415
Everett, WA 98201
(425) 317-0854
mariano.leonardo@ymail.com

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TABLE OF CONTENTS

Table of Authorities	i
I. <u>Introduction.</u>	1
II. <u>Errors and Issues.</u>	1
III. <u>Facts of the Case.</u>	2
IV. <u>Arguments.</u>	
Summary and Terms of Reference	3
A. Medical Evidence.	
1. Doctrine of <i>res ipsa loquitur.</i>	4
2. Legal Citations.	5
B. Wrong Diagnosis.	
1. Admission	7
2. Reliance	7
3. Multiple Treatments	7
4. Contemporary Studies	8
C. Unnecessary Bypass.	
1. Appropriateness	9
2. Consent	10
3. Suppression of Evidence	13
4. Under Duress	13
D. Summary Judgment.	13
E. Statute of Limitations.	14
F. Full and Fair Trial Denied	15
1. From Dependant	16
2. From trial court	16
G. Damages.	19
1. Absence of Damage?	19
2. Bypass A Success?	19
V. <u>Conclusions.</u>	20
Appendix.	21

TABLE OF AUTHORITIES

COURT DECISIONS

1. Atwood v. Albertson's Food Ctrs., 92 Wn.App. 326,330,966 P.2d 351(1998)
2. Bell v. State, 147Wn2d 166, 181, 52 P.3d 502 (2002).
3. Douglas v. Freeman, 117 Wn2d 242, 250, 814 P.2d 1160 (1991).
4. Estate of Sly v. Linville, 75 Wn.App. 431, 436, 878 P.2d 1241 (1994).
5. Estelle, Correction Director, et al v. Gamble 29 U.S. 97.
6. Guile v. Ballard Community Hospital, 70 Wn.App. 18.21,851 P.2d 689 (1993)
7. Hill v. Parker, 12 Wn.2d 517, 529, 122, P.2d 476 (1942).
8. Malilia v. Holder, Jr. , No. 05-77397, February 3, 2011.
9. McLaughin v. Cooke, 112 Wn.2d 829, 838, 774, P.2d 1171 (1989).
10. Pacheco v. Ames, 149 Wn.2d 431, 436, 69.P.39,324 (2003).
11. Rendon v. Holder, Jr., N0. 06-70301, May 3, 2010.
12. Shellenbarger v. Brigman, 101 Wn.App.339, 347, 3 P.3 211 (2000).
13. Webb v. Nuereducation, Inc., 121 Wn.App. 336, 343,, 88 P.3d 417 (2004).
14. Winbun v. Moore, 143 Wn.2d 206, 214, 18 P.3d 576 (2000).
15. Young v. Key Pharmaceutical, Inc., 112 Wn.2d 216, 226,776, P.2d 182(1989).

STATUTES

1. RCW 4.16.350; 350(3)
2. RCW 4.24.290
3. RCW 5.45.020.
4. RCW 7.70.030; 040; 050(1); 060
5. CR 56(c)

I. INTRODUCTION

Leonardo C. Mariano is the plaintiff/appellant in this medical malpractice case. A naturalized American citizen, he came to the United States in 1991, after retiring as a career economist with the Congress of the Philippines. He was a patient at the Swedish Cardiac Surgery/

Swedish Cardiac Surgery, defendant/appellee, is a member of the Swedish Medical Center. Swedish is the largest non-profit health-care provider in the Greater Seattle Area. Defendant conducted a cardiac diagnostic test and performed a bypass surgery on Plaintiff.

II. ERRORS AND ISSUES

In granting Defendant's Motion for Summary Judgment, the trial court ruled that Plaintiff did not have the required expert supports for his claims of a) wrong diagnosis and b) unnecessary heart bypass. The trial court erred when it did not consider the reports of medical tests/procedures and related evidence as expert supports. **ISSUES ARE:**

A. Reports of major medical tests and procedures and related materials are considered expert supports and admissible in court.

B. The right artery was wrongly diagnosed as diseased and needed a bypass. However, that right artery was already completely damaged and harmless a long time ago and no treatment was required..

C. A bypass surgery was unnecessarily performed on the left artery which is relatively healthy.

D. Summary judgment is not appropriate when there are genuine issues of

materials facts still to be resolved.

E. The Statute of Limitation starts, not when the event occurred, but when the malpractice was discovered.

F. Full and fair hearing denied.

G. Irreparable damages resulting from the highly invasive bypass surgery ..

III. FACTS OF THE CASE

1. Medical Evidence.

Plaintiff depended on the following, among 26 exhibits, to support the claims but were completely ignored by the Defendant and by the trial court.

- a). Cardiac catheterization/coronary angiography. (CP p. 124)
- b). Coronary artery bypass graft/CABG. (CP p. 116)
- c). NM myocard spect multi studies rest/stress/adenosine plus walk dual isotope test. (CP p. 108)
- d) Two-dimensional, M-mode echocardiogram with color Dopler. (CP p. 106)
- e) Stress echocardiogram. (CP p. 104)
- f). Rest/stress echocardiogram. (CP p. 102)
- g). Cardiac CT angiography. (CP p. 110)

2. Wrong Diagnosis.

In its diagnosis (cardiac catheterization), Defendant categorically identified the right artery as the source of Plaintiff's chest discomfort. In his summary letter, Dr. John Petersen stated:

“... now that I know the anatomy with the critical lesion in his right coronary artery that I suspect is the culprit lesion the best approach in this case is with direct coronary revascularization (bypass).... (CP p. 115)

However, no surgery was done on the diagnosed right artery since there was nothing to operate on. Dr. John Gartman, cardiac surgeon who did the bypass, reported that

“... right coronary artery were so hard throughout their length, there was nothing I could do with those...” (CP p. 116)

3. Unnecessary Bypass.

Dr. David Gartman performed an unplanned heart bypass surgery in the LEFT artery:

“... Coronary artery bypass graft x 4 with IMA (left internal mammary artery) to LAD (left anterior descending, to left ventricular extension branch.” (CP p. 116)

However, according to Dr. John Petersen, the left artery was not diseased and not a candidate for any surgery, unlike the right artery.

Left Main: *Moderate calcification in its lumen but no critical stenosis.*

.....

Right coronary artery: *Heavily calcified throughout its coursing and an 85 to 90 % stenosis beyond the acute marginal.” (CP p. 124)*

IV. A R G U M E N T S

SUMMARY AND TERMS OF REFERENCE.

The subject matter of this case is medical evidence or expert supports which absence was the reason for the grant of summary judgment. Specifically, Plaintiff will argue that the medical evidence submitted have a direct bearing and relevancy to the two claims of wrong diagnosis and unnecessary bypass. In joining evidence with the two claims, the trial court is being asked to resolve this case on its merit, not thru the

abbreviated trial of summary judgment.

In their arguments, Defendant focused on the words “expert witness” and “expert testimony” while the trial court adopted the words “expert supports” and “expert opinion. For this brief, Plaintiff uses the words “medical evidence”, defined for this purpose as anything which supports or rejects a prior conclusion or finding and is backed by an experienced doctor or reputable organization.

Plaintiff is not assisted by a lawyer, nor by a medical consultant. Unemployed due to poor health since the bypass operation seven years ago Plaintiff cannot afford to hire any.

A. MEDICAL EVIDENCE.

1. Res ipsa loquitor. Claims of wrong diagnosis and unnecessary bypass are supported by three major reports: a) cardiac catheterization/coronary arteriogram (diagnosis) by Dr. John Petersen (CP p. 124), b) coronary artery bypass graft by Dr. David Gartman (CP p. 116) and c) letter summarizing the diagnosis by Dr. Petersen (CP p. 115)Exh.

I). These three documents have two things in common.

- a). All are owned by the Defendant itself, who is under estoppel from issuing any challenge or objection for their admissibility in court.
- b). All speak for themselves in a straight-forward manner, with no room for different interpretations.

“..... The res ipsa loquitor doctrine allows the jury to infer negligence where three elements are met: (1) the accident or occurrence producing the injury is of a kind which ordinarily does not occur absent someone’s negligence; (2) the injuries were caused by an agency or instrumentality within the control of the dependant; and (3) the injury-causing accident or occurrence was not due to any voluntary action or contribution on the part of the Plaintiff.
Pacheco v. Ames, 149 Wn.2d 431, 436, 69.P.39, 324 (2003)

Since all elements are met, the doctrine of *res ipsa loquitur* is applicable to the claim of wrong diagnosis. On the 2nd and 3rd elements, the injury was caused solely by Defendant while Plaintiff had no part at all. On the 1st element, the issue is not HOW but WHY regarding the diagnosis and bypass. Even with negligence, it is not usual for a diagnosis to be way off the mark and for an operation to be done on an artery which is not a candidate for a bypass. These events do not ordinarily occur and they were reported by Defendant's Dr. Petersen and Dr. Gartman themselves

Defendant evaded the issue concerning the three above three elements of the doctrine with this passing general comment:

“ there is no evidence that the injuries claimed by Mr. Mariano are of the type that ordinarily does not happen without negligence. Without knowing the professional standard of care for the health care provider performing cardiac bypass surgery, or diagnosing a heart condition, a layman would not be capable of determining, that Mr. Mariano's claimed injury would have occurred absent negligence.” (CP p. 11 - 12).

2. Legal citations. Plaintiff will show how the submitted medical evidence play a convincing role in supporting the claims of wrong diagnosis and unnecessary bypass. Firstly, the trial Court's rejection of all the medical evidence presented by Plaintiff is not supported by the following:

“The Plaintiff may obtain from the Defendant, testifying as an adverse witness, the required expert testimony” Douglas v. Freeman, 117 Wn.2d 242, 250, 814 P.2d 1160 (1991).

“Medical records are generally are relevant and admissible in a medical malpractice trial.” Bell v. State, 147Wn2d 166, 181, 52 P.3d 502 (2002).

“Reports of lab test results contained in the physician's medical file are admissibleRCW 5.45.020.

Defendant further held that the testimony of an expert witness is a must requirement in any medical malpractice case:

“... Court Rule (CR 11), together with the statutory requirements under RCW 7.70, compel you to have supporting testimony from a qualified medical expert witness PRIOR to filing a medical malpractice lawsuit.”
Defendant’s Email to Plaintiff dated October 12, 2011

After examining said CR 11 and RCW 7.70, also Rules 26 to 37. on deposition and discovery and parallel LCR’s, Plaintiff found no such injunctions.

A similar message is shown in another email:

“ ... if you provide me with the name of an expert witness supporting your claim at any time before the hearing, I will likely strike the hearing (on the summary judgment motion”. Defendant’s Email to Plaintiff dated January 13, 2012.

Defendant narrowly defined expert support as the testimony of a person, a witness, to the exclusion of any written materials. The undue importance Defendant gives to this testimony is understandable as a matter of court strategy. Plaintiff simply cannot pay the fee of an expert witness who usually charges \$ 450 an hour, over at least 7 hours, two hours to review the case file and five hours to attend the hearings. As shown in two court citations below, the expert testimony is overrated:

“(Expert testimony) is not required when medical facts are observable by a layman’s senses and describable without medical training.” McLaughlin v. Cooke, 112 Wn.2d 829, 838, 774 P.2d 1171 (1989).

“A malpractice case may be proved without the aid of expert testimony by a chain of circumstances from which an ordinary layman may reasonably and naturally infer the ultimate fact required to be established”. Shellenbarger v. Brigman, 101 Wn. App. 339, 347, 3 P.3 211 (2000)

B. WRONG DIAGNOSIS.

1. Admission. In its attempt to justify its action, Defendant inadvertently admitted the error with these words in Defendant's Answers to Plaintiff's First Set of Interrogatories, October 4, 2011, p.2:

" coronary right artery were so damaged that they could not be salvaged or used in connection with the bypass procedure to establish coronary revascularization." (Appendix E)

The quotation is also incriminating for the Defendant if the intention was to use part of the right artery to serve as a graft vessel for the bypass in the unplanned left artery. That would have been unusual. The primary sources for any graft are the saphenous vein from the leg and the internal mammary artery from the inner wall of the chest. As diagnosed, the right artery was targeted for surgery because it was diseased. It was not meant to supply a graft for the bypass in the left artery.

2. Reliance. Defendant used coronary angiography as a diagnostic tool which, however, was not reliable in determining the cause of Plaintiff's heart problems:

" ... While angiography is an accurate test that provides extensive information, it doesn't always provide the specific information your physician is looking for. For example abnormalities in the coronary arteries may be found in the coronary angiogram, but these abnormalities may not be the cause of your chest pain..." Mayo Clinic Heart Book, p. 262 (2000). (Appendix A)

3. Multiple Treatments. Defendant did not consider whether Plaintiff's other medical ailments had contributed to his heart problems. The wake-up symptom for an impending heart attack was intense pain which radiates to other parts of the body which Plaintiff did not experience. (CP p.113) Rather his symptoms were basically shortness of breath and chest discomfort. Thus, Plaintiff was referred to other

doctors: Dr. George Cox on acid reflux and hiatal hernia, Dr. Michael Tamber on thyroid nodules, Dr. Ronald Green on lung lesions, Dr. Michael Millie on gallstone Dr. Frank Sheridan on the heart, Dr. Neale Smith on the heart and Dr. John Lank on diabetes and blood pressure.

4. Contemporary Findings. Defendant ignored other studies by several veteran cardiologists, discussed below, that Plaintiff's right artery was relatively healthy which contradict the dire assessment of Defendant. Essentially, there was free flow of blood in the arteries of the heart. Defendant violated a major provision of RCW 7.70.040:

*“ exercise that degree of care, skill, and learning expected of a reasonably prudent health care at that time in the profession or class to which he belongs, in the State of Washington, **acting in the same or similar circumstances.**”*

a). In the Nuclear Scan Myocard Spect Rest/Stress done on August 11, 2005 (eight months before the bypass), Dr. Neale Smith of Western Washington Medical Group reported:

“ no ischemia is identified. nuclear medicine portion showed normal left ventricular systolic function.... ” (CP p. 108)

b). In the Stress Test done January 20, 2003, Dr. Frank Sheridan of the Everett Clinic reported:

“ patient was able to exercise for 9 minutes without any chest pain.... this test is interpreted as negative for ischemia. ” (CP p. 103)

c). In the echocardiogram test done January 19, 2000, Dr. Kirk Prindle of the Everett Clinic reported:

“ No evidence of reversible coronary artery blood flow

*abnormalities He falls into the lowest possible risk group....
the likelihood of having a normal life expectancy is superb.”*
(CP p. 102))

C. UNNECESSARY BYPASS.

1. Appropriateness. According to Mayo Clinic (Appendix A, p.), coronary bypass surgery is an option if:

- “* *You have severe chest pain caused by narrowing of several of the arteries*
- * *You have more than one diseased coronary artery and the heart’s main pump - the left ventricle - is not functioning well.*
- * *Your left main coronary artery is severely narrowed or blocked. This artery supplies most of the blood to the left ventricle.*

The unplanned bypass on the left artery done by Defendant was unnecessary because none of the above conditions were met.

Re main left artery above. In the coronary angiography Dr. John Petersen stated that this artery had only “*moderate calcification in its lumen but no critical stenosis*”. (CP p. 124)

Re left ventricle above. In the echocardiogram , Dr. Neale Smith of the Western Washington Medical Group stated: “... *The left ventricle is normal in size....There are no wall motion abnormalities.*” (CP p. 106)

Re chest pain above. Plaintiff had no severe chest pain, only shortness of breath. In his evaluation report dated March 21, 2006, Dr. John Petersen stated: “... *It has not been a radiating pain. It does not go t the jaw or down the arms.* (CP p. 113))

None of the three conditions above were met. Meaning, the left artery is not a

candidate for a bypass.

2. Consent. Two Washington State laws expressly prescribe that medical procedures, such as bypass artery, angioplasty, among others, cannot proceed without the informed consent of the patient:

“... in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.” RCW 4.24.290.

Medical liability can be established if “... *the injury resulted from Health care to which the patient or his representative did not consent.*” RCW 7.70.030

Plaintiff signed the consent form for a bypass which is worded in the assigned blank spaces as follows:

Blocked heart blood vessels. (coronary artery disease).....coronary artery bypass graft.” (CP p. 132)

The above citation is not a blanket mandate for Defendant to operate in all arteries of the heart. It must be stressed that the diagnostic test identified only the right artery needing treatment. (CP p. 115). The left artery could not be included because it was relatively normal. (CP p. 124) Further, in the topic bypass protocol immediately above, the left artery did not meet all the conditions for a bypass surgery.

Printed in the consent form, not in a blank space, two pieces of advice are directed to Plaintiff before signing:

“Washington State law guarantees that you both have the right and obligation and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process.” (CP p. 132)

“I (Plaintiff) have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known” (CP p. 132, back side of form.)

A brief background will clear such wishes. Defendant was approached for a second opinion due to two contrasting findings. Dr. Neale Smith reported the absence of ischemia. (CP p. 108) while Dr. Frank Sullivan recommended angioplasty/stent for the damaged right artery. (CP p. 110) Plaintiff made known in no uncertain term decision to exclude the highly invasive bypass surgery due to a higher risk from old age (76 years old at that time). Moreover, the less invasive angioplasty (PTCA) or stent was preferred in case treatment was necessary.

There has been a running debate on which is the better procedure - bypass or stent. The Everett Clinic (where Plaintiff is a patient) has long been an advocate of the latter (CP p. 137) As pointed out by Mayo Clinic (CP p. 134), the extremely invasive bypass operation is appropriate only in cases of severe and multiple blood blockages. The No. 1 ranked heart hospital in the United States, John Hopkins, has pointed out several advantages of stent over bypass as shown in Appendix C.

In the consent form to perform diagnosis, the treatment tool was described in the following words:

“Coronary Arteriogram.....Possible Angioplasty/Stent. (CP p. 133)

For reasons detailed with expert supports/opinion in two topics below, Plaintiff's wishes were not carried out.

3. Suppression of Evidence. Defendant failed to comply with the provision of RCW 7.70.050 (1) which will be cited in full because of its importance in establishing

informed consent:

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

- (a) That the health care provider failed to inform the patient of a material fact or facts related to the treatment;*
- (b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;*
- (c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;*
- (d) That the treatment in question proximately caused injury to the patient.*

The fact suppressed was the final report on the diagnostic cardiac catheterization done by Dr. John Petersen on March 30, 2006. (CP p. 124) After numerous demands for its release, this report was received only on April 27, 2011 or five years later, precisely because of its incriminating content. As stated earlier, the left main artery had “*moderate calcification in its lumen but no critical stenosis.*” In sharp contrast, the right main artery was found to be “*heavily calcified throughout its coursing and an 85 to 90 % stenosis.*” Meaning, there was a good reason to target the right artery for a bypass but no reason at all to subject the left artery to an unnecessary surgery.

4. Under Duress. Plaintiff signed the consent form under duress on March 30, 2006, while still groggy from his diagnostic cardiac catheterization. The diagnosis started on 12:24 pm and ended a few hours later. (CP p. 124) At the 3:45 pm of the same

afternoon, Plaintiff signed the form. . (CP p. 132)

D. SUMMARY JUDGMENT

This case was dismissed with the grant of Defendant's Motion for Summary Judgment. This issue is now being revisited since it is becoming more and more clearer that the court still has to resolved several controversial issues already extensively discussed in this Brief. These are the following:

1. Statute of Limitation
2. Informed Consent
3. *Res ipsa loquitor*
4. Wrong Diagnosis.
5. Unnecessary Bypass

CR 56 (c) allows summary judgment only in the total absence of genuine issues of material facts. This is elaborated by this court decision”

“Summary Judgment is not appropriate in a medical malpractice action, however, a reasonable person could infer, from the facts, circumstances, and medical testimony, that a casual connection exists.” Shellenbarger v. Brigman, 101 Wn.App. 339, 348, 3 P.3d 211 (2000)

Defendant has the burden to challenge the facts described by Plaintiff on the above five controversial issues

“ ...To support a motion for summary judgment, the moving party is required to at least set out its version of the facts and allege that there is no genuine issue as to the facts as set out.” Guile v. Ballard Community Hospital, 70 Wn.App. 18, 21, 851 P.2d 689 (1993)

In evaluating the respective arguments of both parties, the trial court is enjoined

to give preferential treatment to Plaintiff as the nonmoving party.

“ ... The evidence and inferences therefrom presented by the nonmoving party must be examined in the light most favorable to that party.” Young and Key Pharmaceutical, Inc., 112 Wn.2d 216, 226,770 P.2d 182 (1989)

E. STATUTE OF LIMITATIONS

The basic law governing the period within which a person can file a lawsuit is RCW 4.16.350:

“ ... imposes a three-year statute of limitations on medical malpractice action.” Webb v. Nueroeducation, Inc., 121 Wn.App. 336, 343, 88 P.2d 417 (2004)

The same law and court decisions, however, provides an exception to the general rule.

“ ... allows the action to be brought no later than one year after the time the patient of his representative discovered or reasonably should have discovered that the injury or condition was caused by such act or omission.” RCW4.16.350(3)

‘ ... provides a discovery rule that can allow a medical malpractice action to be brought later than the three-year period.’
Winbun v. Moore, 143 Wn.2d 206,214, 18 P.3d 576 (2000)

The discovery happened just after April 27, 2011 when Plaintiff's follow-up letter asking questions about the bypass remained unanswered, after numerous demands:

“An answer to the issue is all I need to erase my doubt about the bypass. During the many years of my recovery, I had been at peace with the outcome. However, lately after reading all the available reports on the operation, I am now uneasy. (CP p. 122).

Earlier, in the October 30, 2009, letter, Plaintiff asked why the left artery was operated on when the diagnosis identified the right artery needing surgery.

“...purpose of this letter is to seek your opinion... ..what major damages in the left side of the heart did you find and fix during the operation?” (CP p. 121).

Not having received any answer from the two letters discussed above may be interpreted as admission. Consequently, the Complaint was filed on May 2, 2011, well within the period prescribed by the Statute of Limitations.

Before the follow-up letter of April 24, 2011, Plaintiff considered the bypass operation a success (CP p. 121) and no misgivings about the operation was contemplated. When Defendant continued to refuse to answer a simple question of WHY a bypass was done on the left artery, doubts about the operation emerged.

:

When Defendant argues that the statute was violated, it carries assuming the burden of proof.

“ ... Violation of a statute of limitations period is an affirmative defense and the burden of proof to establish a violation is on the Party asserting the violation. Estate of Sly v. Linville, 75 Wn.App. 431, 436, 878 P.2d 1241 (1994)

F. FULL AND FAIR HEARING DENIED

Plaintiff was denied his day in court. The decision to dismiss the medical malpractice case was rushed in only one session, lasting about 18 minutes. Also, no special consideration was given to Plaintiff's hearing problem. Worst, the proceeding was not recorded.

1. By Defendant

a). Plaintiff served notice that Dr. John Petersen (cardiac diagnostician) and Dr. David Gartman (cardiac surgeon) would be deposed as hostile witnesses. Their testimonies, through deposition, were crucial because they have personal knowledge of the case. Earlier Plaintiff received only vague and general answers from two sets of interrogatories. However, the depositions were aborted with the filing of the summary judgment motion.

b). Defendant demanded the deposition of a witness but later changed its mind because his testimony was incriminating.. Dr. Harold Dash is chair of the Cardiology Department of Everett Clinic; he was Plaintiff's attending cardiologist. Long before the Complaint was filed, Dr. Dash was ready to answer why the diseased right artery was already harmless and needed no treatment. (CP p. 137) and that, Plaintiff had a silent heart attack decades ago which completely damaged the right arteries. After which, corollary arteries took over the function of the diseased right artery, thus ensuring the free flow of blood. Defendant changed its mind about deposing Dr. Dash.

B. By Trial Court.

As stated earlier, Plaintiff was not given his day in court. The 18-minute trial was mostly consumed by the trial judge after both parties summarized their respective stands on the issues. The trial judge did not pose any question at all, but instead gave a long explanation of his thinking about the case. Plaintiff had the impression then that it was only the period for opening statements and that the arguments and counter-arguments would come next. It was the Defendant's attorney who called to the attention

of Plaintiff that the trial was over. A very recent decision of the U.S. Court of Appeals, Ninth Circuit, holds:

*“ we agree that the I J denied a full and fair hearing In violation of the **Due Process Clause**.and that this prejudiced(his) ability to present evidence..... ” Rendon v. Holder, Jr., No. 06-70301, May 3, 2010.*

The trial judge emphasized the absence of not only expert medical testimonies but also of legal representation. One option mentioned was to hire a lawyer on a contingency basis. Plaintiff did contact several earlier and most declined to take medical malpractice and discrimination cases. The trial judge pointed out the handicaps a pro se litigant has to carry in a court case because of legal technicalities. Since the court subtly ruled that a medical malpractice case is too complex for a layman, Plaintiff assured the court the fear was misplaced in view of Plaintiff's vast experience in legal research and analysis in the Congress of the Philippines as head of its economic planning office.

Below is a decision of the **U.S. Supreme Court** which is reassuring:

“ As the Court unanimously held in Haines v. Kerner, 404 U.S. 519 (1972), a pro se complaint, 'however in artfully pleaded' must be held to 'less stringent standards than formal pleading drafted by lawyers'”
Estelle, Correction Director, et al. v. Gamble 29 U.S. 97

Because of his hearing impediment, Plaintiff was unable to understand the rulings of the trial judge who spoke in a hurried pace. Plaintiff did not dare interrupt for clarification for fear of sanctions, hoping for an opportunity at a later stage. But, the trial ended abruptly

The courtroom was a mess. Two cases were scheduled on the same day and at the

and time. This may be the reason why the trial judge conducted the hearing in a rush manner. The lawyers of the other case were already seated in the table reserved for litigants. The Mariano/Swedish parties presented their arguments, standing up, in front of the rostrum.

Worst, the 18-minute hearing was not recorded. Plaintiff, with a hearing problem, was banking on the transcript to understand fully the words spoken by the trial judge. In an appellate case, the reasons for the decision of the trial judge, should be subjected to full disclosure.

Plaintiff sought a continuance of Defendant's Motion for Summary Judgment for two good reasons, among others. During the discovery period, potential evidence were identified but suppressed by Defendant. One was the crucial testimonies of Dr. Petersen and Dr. Gartman as stated earlier, because of their personal knowledge of the issues. This may not be allowed in a summary judgment proceeding but an exception to the rule would be sought. As stated above, the final report on the diagnostic cardiac catheterization which was released only five years after the procedure. The left artery was shown to be healthy but underwent an unnecessary bypass. Another recent decision of the U.S. Court of Appeals, Ninth Circuit reads:

" we conclude that the I J abused his discretion in denying continuance request because the I J failed to follow theguidelines when considering the request. Malilia v. Holder, Jr., No. 05-77397, February 3, 2011.

G. DAMAGES

This issue of Damages is given special treatment in this brief as a strong reaction to the contention of Defendant that “ .. *Plaintiff Has No Damages Related to Alleged Negligence*”, asserting a) “... *He has no demonstrable damages.*” and that he admits that b) “ ...the bypass operation was a success.” CP p. 32 In contrary response, Plaintiff summarizes what are already presented earlier.

On item a) above: The effects of the heart bypass on Plaintiff are glaringly Described in Complaint (CP p.6) This will be confirmed by anyone of the millions of Americans who had this kind of operation. It is extremely invasive as described in an excerpt from a book by Mayo Clinic, the number one ranked Heart Hospital in the United States (Appendix A) As experienced by Plaintiff, the chest was opened wide and the sternum realigned. Worst, the chest was opened a second time several hours after the main operation due to complications. While the newly-harvested clean artery/vein grafts were being attached to the diseased artery, the flow of blood continued with the installation of a mechanical heart. Expected interruptions in the blood flow during the operation, even by few seconds, impacted on every organs of the body.

On item b) above, Plaintiff's words “ ... the bypass operation was a success.” were taken out of context. The reference was on WHY, not on HOW. Defendant was challenged to answer the question in Plaintiff's letter dated October 30, 2009 why the bypass was done on the left artery when, based on the diagnosis, the target (culprit) was

the right artery. (CP p. 121). Without a medical consultant, Plaintiff merely stipulated the operation was a success because no death occurred. More discussions on item b) are found on pages 110 to 113 of this Brief.

V. CONCLUSIONS

Plaintiff seeks compensation for all kind of legal damages, punitive, exemplary and others resulting from economic losses, emotional stress, mental anguish and health deterioration.

Plaintiff prays, at least, for the reversal of the grant of Defendant's Motion for Summary Judgment and remand the case back to the King County Superior Court.

Plaintiff prays, as a better option, for the Court of Appeal to resolve with finality this case of medical malpractice (wrong diagnosis and unnecessary bypass), based on merits.

APPENDIX

A P P E N D I X

- A. Mayo Clinic Heart Book. Excerpt on Diagnostic Angiography.
- B. Mayo Clinic. Article on Protocol for Heart Bypass.
- C. Johns Hopkins White Paper. Bypass Surgery v. Angioplasty.
- D. Cleveland Clinic. Article on Less Invasive Bypass Surgery.
- E. Interrogatory. Dependant's Answer to Right Heart Diagnosis.

Alvin C. Marino

MAYO CLINIC

A

HEART BOOK



Why not use angiography first to diagnose heart disease?

Angiography, which allows you to see inside blood vessels, cannot be the first step in diagnosing heart disease. Your coronary arteries are the blood vessels. So why isn't it the first-line test used to diagnose heart disease? And why do physicians recommend it after angiography is performed?

Some of the answers to these questions have already been discussed. Angiography is expensive. It requires special equipment and specially trained medical staff, and it carries some risk, even if the risk is not very small. There are other reasons, however. While angiography is an accurate test that provides extensive information, it doesn't always provide the specific information your physician is looking for. For example, abnormalities of the coronary arteries may be found on the coronary angiogram, but these abnormalities may not be the cause of your chest pain.

What the coronary angiogram does best is provide a road map to your blood vessels. Simply looking at a road map of a city doesn't necessarily tell you what the traffic patterns in the area are. To find out where the bulk of the traffic is, perhaps a satellite view of city exhaust pipes would be useful. Similarly, a catheter can be inserted into the artery, and the amount of oxygen and blood steps in the artery can also provide more valuable information. In some cases, the catheter needs to be used as an additional investigation to complete the whole picture of your heart's health.

Of course, it isn't really the coronary artery that is being seen, but the image of the contrast material in the hollow part (lumen) of your artery. If there are partial or total blockages of the coronary arteries by atherosclerotic plaque or blood clots, these show up as irregularities or places where the image of the contrast material cuts off.

Left ventriculography

At the same time you undergo coronary angiography, you may often have a contrast agent injected into your left ventricle. This procedure, called left ventriculography, shows how well your left ventricle is pumping. This also reveals its shape and internal structures and whether there is any back leakage (regurgitation) through the mitral valve. If leakage is present, the contrast material can be seen flowing backward into the left atrium.

Angiography in peripheral blood vessels

Angiographic techniques can be used to see blood vessels in other parts of your body—even those in your brain. It also can be used in the blood vessels to your legs or arms (performed there, it's called arteriography), the aorta and its main branches (aortography), and selected blood vessels to specific organs. Angiography in your brain is performed by neuroradiologists. Specialists called vascular radiologists perform angiography in many other areas.

Cardiac catheterization for congenital defects

Other uses of cardiac catheterization include examining congenital malformations of the heart. It can be used to assess the degree of shunting of the blood through a septal defect (a hole in your heart) or through abnormal connections of the arteries (see page 66). It does this by measuring the oxygen in the blood in your heart.

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By Mayo Clinic staff

Definition

Coronary bypass surgery is a procedure that restores blood flow to your heart muscle by diverting the flow of blood around a section of a blocked artery in your heart. Coronary bypass surgery uses a healthy blood vessel taken from your leg, arm, chest or abdomen and connects it to the other arteries in your heart so that blood is bypassed around the diseased or blocked area. After a coronary bypass surgery, normal blood flow is restored. Coronary bypass surgery is just one option to treat heart disease.

Coronary bypass surgery can help reduce your risk of having a heart attack. For many people who have coronary bypass surgery, symptoms such as chest pain and shortness of breath are reduced after having the surgery.

Select a button to view the process of a coronary bypass



Why it's done

You and your doctor can consider whether coronary bypass surgery or another artery-opening procedure, such as angioplasty or stenting, is right for you.

Coronary bypass surgery is an option if:

- You have severe chest pain caused by narrowing of several of the arteries that supply your heart muscle, leaving the muscle short of blood during even light exercise or at rest. Sometimes angioplasty and stenting will help, but for some types of blockages, coronary bypass surgery may be the best option.
- You have more than one diseased coronary artery and the heart's main pump — the left ventricle — is not functioning well.
- Your left main coronary artery is severely narrowed or blocked. This artery supplies most of the blood to the left ventricle.

- You have an artery blockage for which angioplasty isn't appropriate, you've had a previous angioplasty or stent placement that hasn't been successful, or you've had stent placement but the artery has narrowed again (restenosis).

Coronary bypass surgery may also be performed in emergency situations, such as a heart attack, if your doctor sees that you're not responding to other treatments.

Coronary bypass surgery doesn't cure the underlying heart disease that caused blockages in the first place. This disease is referred to as atherosclerosis or coronary artery disease. Even if you have coronary bypass surgery, lifestyle changes are still a necessary part of treatment after surgery. Medications are routine after coronary bypass surgery to lower your blood cholesterol, reduce the risk of developing a blood clot and help your heart function as well as possible.

Risks

Because coronary bypass surgery is an open-heart surgery, you may have complications during or following your procedure. The most common complications of coronary bypass surgery are:

- Bleeding
- Heart rhythm irregularities (arrhythmias)

Less common complications include:

- Heart attack, if a blood clot breaks loose soon after surgery
- Kidney failure
- Infections of the chest wound
- Memory loss or troubles with thinking clearly, which often go away within six to 12 months
- Stroke

Your risk of developing these complications depends on your health before the surgery. Talk to your doctor to get a better idea of the likelihood of experiencing these risks.

If you're having a scheduled coronary bypass surgery, your risk of complications is usually low, but still depends on your overall health. The risk is higher if the operation is done as an emergency or if you have other medical conditions such as emphysema, kidney disease, diabetes or blocked arteries in your legs (peripheral artery disease, or PAD).

THE JOHNS HOPKINS WHITE PAPERS

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JOHNS HOPKINS MEDICINE
BALTIMORE, MARYLAND

Bypass Surgery vs. Angioplasty

Angioplasty has several advantages over bypass surgery. Angioplasty is a relatively simple procedure, there is no need for general anesthesia, and the risks of open heart surgery are avoided. In addition, after only a 1-night stay in the hospital, patients can resume their normal activities almost immediately. Angioplasty is also less expensive than bypass surgery.

As described earlier, restenosis is a possibility with angioplasty, and patients who undergo this procedure must accept the risk that a repeat angioplasty or, ultimately, bypass surgery may become necessary. In comparison, bypass surgery may keep coronary arteries open longer and may produce better blood flow through these arteries. Bypass surgery generally provides good relief of angina for at least 5 years. Bypass surgery is usually favored over angioplasty for people with 1 or more of the following:

- **Narrowing of the left main coronary artery.** This vessel is the main artery supplying blood to the heart. Even a brief period of blockage of blood flow through this artery could damage the heart muscle and be fatal.
- **Narrowing of several vessels.** Bypass surgery is a better option than angioplasty when the buildup of plaque has caused multiple obstructions in an artery or has narrowed several arteries. This is because angioplasty is a more complex procedure to perform when the affected area is large and requires the implantation of several stents.
- **Narrowing at an arterial branch.** An arterial branch is where 1 artery meets another. Because angioplasty to remove plaque at this site may shift the plaque into an adjacent artery, causing a new blockage, bypass surgery is sometimes preferred.
- **Diabetes.** In a study conducted in the mid-1990s—the Bypass Angioplasty Revascularization Investigation (BARI)—the 7-year survival for people with diabetes was significantly better in those who underwent bypass surgery (76%) than in those undergoing angioplasty (56%). A more recent study (published in 2001) confirmed the advantage of bypass surgery over angioplasty in people with diabetes, with increased survival in the bypass group. However, these studies were conducted before drug-eluting stents were available, and the results may be different in future studies using such stents.

Among the drawbacks of bypass surgery are longer hospital stays and longer rehabilitation time than with angioplasty. In addition, a recent study of 261 bypass surgery patients found that about 40%

had a decline in their mental abilities that persisted 5 years after surgery. (It's possible, however, that this decline was caused by underlying vascular disease and not the surgery itself.)

Except in an emergency situation, you have time to get a second opinion when deciding between angioplasty and bypass surgery. Getting that second opinion will help you feel more confident that you've made the right decision. For advice on finding a second opinion, see the feature on pages 54–55.

Other Procedures To Improve Blood Supply to the Heart

Besides bypass surgery and angioplasty, other newer procedures such as atherectomy, laser ablation, and enhanced external counterpulsation (EECP) are used in certain circumstances to improve blood flow through the coronary arteries.

Atherectomy. This procedure removes plaque from the inside of arteries. It involves the use of a high-speed rotary blade or drill to shave away portions of plaque that are narrowing a coronary artery. Using a catheter, the blade or drill is delivered to the site of the blockage. Atherectomy works best on large, straight arteries. The blade is usually used when the plaque is limited to 1 side of the artery wall; the drill typically produces better results than angioplasty for very long obstructions.

An atherectomy is often done prior to balloon angioplasty to remove some of the plaque; angioplasty then follows to compress or crush the remaining plaque against the walls of the arteries. Serious complications are rare, but may include unexpected vessel closure or a heart attack.

Laser ablation. This procedure is similar to angioplasty, but instead of a balloon at the tip of the catheter there is a probe. The probe is heated with a beam of laser light that cuts through the plaque and virtually burns it away. However, there are potential complications associated with laser ablation—most notably, accidentally making a hole in the artery wall. The procedure may one day prove useful in reopening completely blocked arteries, as well as in destroying plaques that cannot be treated with angioplasty, either because the plaques are too long or are too hardened by calcium deposits. At present, the procedure is rarely used.

Enhanced external counterpulsation. Some people with angina do not get sufficient pain relief from medication or angioplasty, and can't undergo bypass surgery because of poor health. For these individuals, a noninvasive procedure called enhanced external counterpulsation (EECP) may improve angina symptoms and quality of life.

MORE PATIENTS ARE HAVING LESS INVASIVE BYPASS SURGERY

For people who need coronary artery bypass surgery, the chance of having a minimally invasive procedure rather than an open-chest operation is increasing. Advances in techniques and instrumentation are making the less intrusive operation a possibility for many more patients, regardless of age, gender, extent of disease and whether they have had prior bypass surgery.

Minimally invasive cardiac surgery (MICS) eliminates the most traumatic and painful aspect of conventional coronary artery bypass surgery (CABG, pronounced "cabbage"): the need for a median sternotomy, in which doctors split apart the breastbone and spread open the rib cage to reach the heart. Minimally invasive surgery usually means a shorter recovery, less pain and a quicker return to normal activities than with CABG.

MICS, which represents one of the biggest changes in heart surgery since the introduction of CABG 35 years ago, refers primarily to two different procedures: minimally invasive direct coronary artery bypass (MIDCAB) and port-access coronary artery bypass.

Until recently, MICS was available only to patients with one or maybe two blocked arteries. Patients requiring triple or quadruple bypass usually had a conventional procedure. All that is changing. "The technology and equipment are evolving very rapidly," says Cleveland Clinic cardiothoracic surgeon Joseph Sabik, M.D.

MIDCAB

MIDCAB is most suited for men and women who have single-vessel disease in an artery located on the front side of the heart, either the left anterior descending artery or the right coronary artery. The surgery is performed on a beating heart, and as a result does not require the use of a heart-lung machine. It is therefore a good option for patients with peripheral vascular disease, who are at increased risk during cardiopulmonary bypass with the heart-lung machine.

The surgeon makes a small incision in the left side of the chest between the ribs to expose the heart, as well as the internal mammary (chest) artery that will be used to bypass the blockage. The area of the heart to be operated on is stabilized to make the procedure easier to perform. (Bypassing an artery on a beating heart has been likened to trying to stitch together two moving pieces of well-cooked, thin spaghetti.)

One stabilizer, called the Octopus, uses suction cups to lift and stabilize the area of the heart around

the artery to be grafted. Another stabilizing system uses a device that looks like a two-tined fork, which immobilizes the area by applying pressure to the heart muscle on either side of the artery.

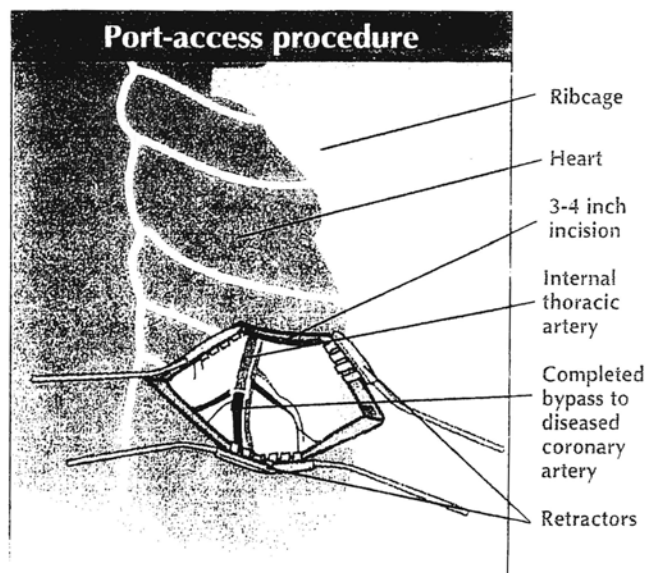
When the area is stable, the surgeon connects the mammary artery to the blocked artery, completing the bypass. The procedure generally takes about two hours.

Although it is too soon to evaluate long-term results, early studies of patients undergoing MIDCAB — including high-risk patients — report clinical outcomes comparable to standard CABG. Because the heart-lung machine is not used, MIDCAB avoids the risks associated with it, including the possibility of impaired cognitive function. Some physicians believe it is the use of the heart-lung machine that accounts for the 6% or so of bypass patients who are left with neurological damage.

Port-access

Patients requiring multivessel bypasses or second bypasses (which doctors call reoperations) may be candidates for the port-access procedure, a technique that allows surgeons to operate through a small, three-to-four-inch incision in the chest. As with conventional CABG, the heart is stopped and protected with special drugs. But a different method is used to connect the heart to the heart-lung machine.

Rather than hooking up the heart directly to the bypass machine, the surgeon performing port-access will insert thin, flexible tubes (cannulas) into blood vessels in the thigh (femoral artery) and neck and



thread them to the heart. The tubes are then used to connect the patient to the heart-lung machine.

Once the patient's pumping activity is taken over by the heart-lung machine, the surgeon performs the bypasses through the small incision. Because the heart is "at rest" and filled with blood, the surgeon can operate on the front, side and back of the heart by lifting and turning the heart as necessary to get access to the blocked arteries. In women, port-access incisions are usually made beneath the breast to conceal the resulting scar.

One advantage to port-access is a decreased risk of developing atrial fibrillation, an irregular heart rhythm that occurs in approximately 25–30% of patients following conventional bypass surgery. "Although medication is effective in restoring normal rhythm to the heart, atrial fibrillation does increase the risk of stroke," Dr. Sabik notes. "So any decrease in this risk is a plus."

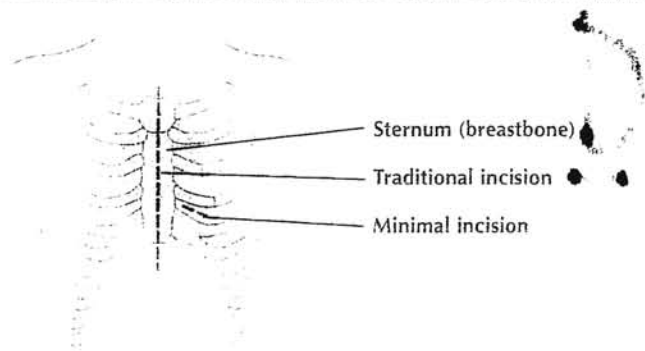
Approximately 20% of Dr. Sabik's patients requiring multivessel bypasses or reoperations have undergone port-access.

Early in 1998, the first report from the Port-Access International Registry (PAIR) study, which included data from more than 1,000 patients at 121 medical centers, revealed that the procedure is safe, with a low incidence of complications, equivalent to standard open-chest surgery. Further research is being done to measure long-term efficacy, recovery time and the impact of the procedure on a patient's quality of life.

Of course, port-access and MIDCAB procedures are still serious surgery. Both techniques are being carefully monitored by the American Heart Association, the American College of Cardiology and the American College of Surgeons, whose positions reflect cautious optimism until more data on the procedures' effectiveness are obtained and analyzed. No one yet knows whether the long-term results will prove to be as good as those with conventional open-chest coronary artery bypass surgery.

What are the benefits?

Patients undergoing minimally invasive bypass surgery experience reduced trauma and less pain during the recovery period. "Postoperative pain can be one of the hardest things for patients to deal with following conventional bypass surgery," says Dr. Sabik. After traditional open-chest surgery, patients may experience difficulty breathing because of the pain associated with the sternotomy. (This can be aggravated if the patient is a smoker.) MICS procedures also eliminate the need for a ventilator (breathing tube) during recovery, and seem to reduce the risk of other complications associated with CABG. The percentage of patients who have to contend with postsurgical infections is far lower when MICS is done.



The smaller incisions also reduce the risks of other postoperative complications such as bleeding. "Overall, patients go home sooner and enjoy a more rapid recovery," notes Dr. Sabik.

At The Cleveland Clinic, patients typically stay in intensive care 24 hours or less. Their hospital stay is often reduced to three or four days, compared to five to seven days following conventional surgery. Postoperative recovery may be two to four weeks, compared to six to eight weeks with traditional open-heart surgery.

Older patients with other health problems may require a longer hospital stay after a minimally invasive procedure than younger patients, but nonetheless it will probably be shorter than it would have been after conventional bypass surgery. "We originally believed these techniques would be most appropriate for younger, relatively healthier patients," Dr. Sabik says. "However, experience has taught us that the opposite is often true. With port-access or other minimal techniques, the physical toll on the body is less, which may actually make it a better choice for some older patients."

Who is a candidate?

There are no hard and fast rules when deciding who can have minimally invasive bypass surgery. "We tailor the procedure to the patient, not the other way around," says Dr. Sabik. For example, an 80-year-old patient who requires a reoperation may be a good candidate because of the location of his blockages, and because he is otherwise in good health. Conversely, a younger patient may not be a candidate because of obesity or an enlarged heart. Minimally invasive techniques are equally suitable for men and women.

If you are facing coronary bypass surgery, your surgeon will make a recommendation based on how best to treat your particular blockages with the least risk to you. In many patients, that may dictate a conventional procedure. If your surgeon is more comfortable performing the conventional procedure, you may be better off sticking with the tried-and-true method. Currently, only a small percent of open-heart surgeries are performed using MICS procedures. But as technology continues to evolve and improve, that number is likely to keep growing.

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

LEONARDO C. MARIANO, pro se,

Plaintiff,

v.

SWEDISH CARDIAC SURGERY,

Defendants.

NO. 11-2-15733-4 SEA

DEFENDANT SWEDISH CARDIAC SURGERY'S[sic] ANSWERS TO PLAINTIFF'S FIRST SET OF FOUR INTERROGATORIES TO DEFENDANT

DEFENDANT'S ANSWERS AND OBJECTIONS
TO PLAINTIFF'S INTERROGATORIES

GENERAL OBJECTION

Defendant Swedish Cardiac Surgery [sic] objects to these interrogatories to the extent it is clear that plaintiff has not obtained expert review and does not have the required expert testimony to continue to pursue his ongoing claim. RCW Ch. 7.70, *et. seq.* It is further clear that without competent, qualified expert input, plaintiff is not able to properly interpret or comprehend the medical records in his possession. Based on plaintiff's medical chart, it is clear that he had cardiovascular disease in his right and left coronary arteries.

Plaintiff's Right Coronary Artery was found to be "heavily calcified throughout its coursing" with an 85-90% stenosis beyond the acute marginal. Proximally, that artery had about an 80% stenosis within the first 2 cm of its coursing. See attached March 30, 2006 Procedure Report on Selective Coronary Arteriogram.

Plaintiff's Left Anterior Descending Coronary Artery had a 50-60% narrowing right at its origin. In the midsection of the left anterior descending artery, there was a section that was "almost aneurysmal" followed by an 85-90% midsection stenosis. The diagonal system, specifically the

DEFENDANT SWEDISH CARDIAC SURGERY'S[sic]
ANSWERS TO PLAINTIFF'S FIRST SET OF FOUR
INTERROGATORIES TO DEFENDANT - 1

Andrews • Skinner, P.S.
645 Elliott Ave. W., Ste. 350
Seattle, WA 98119
Tel: 206-223-9248 • Fax: 206-623-9050

1 superior branch, had an 85-90% stenosis over about a 1.5-2 cm length. See attached March 30,
2 2006 Procedure Report on Selective Coronary Arteriogram.

3 Without the appropriate and necessary coronary artery bypass grafting procedure performed on
4 April 4, 2006, plaintiff was at significant risk for a cardiac event which would potentially have
5 been fatal or rendered him significantly incapacitated.

6 **INTERROGATORY NO. 1:** In attached Exhibit K, Dr. David Gartman (Defendant's
7 surgical doctor) stated: ". . . . *The patient was returned to the operating room later that evening for*
8 *post-operative sternal bleed.*" Please elaborate in detail why and how Plaintiff had to undergo a
9 post-operation.

10 **Answer:** As plaintiff's medical records reflect, plaintiff was returned to the operating room
11 following his coronary artery bypass procedure on April 4, 2006, to address and control
12 postoperative bleeding. Copies of the relevant records are attached.

13 **INTERROGATORY NO. 2:** In attached Exhibit J, Dr. David Gartman (Defendant's
14 surgical doctor) stated: ". . . . *The PDA and distal **right** coronary artery were so hard throughout*
15 *their length, there was nothing I could do with those.*" Does this not contradict the diagnosis of
16 Defendant's Dr. John Peterson (in attached Exhibit I) who targeted the hardened **right** coronary
17 artery as the culprit or reason why Plaintiff was suffering from chest pains and shortness of breath?

18 **Answer:** No. The quoted chart entry indicates that portions of plaintiff's right coronary
19 artery were so damaged that they could not be salvaged or used in connection with the by-pass
20 procedure to establish coronary revascularization. Defendant provided good and appropriate care
21 for all of plaintiff's cardiac issues.

22 **INTERROGATORY NO. 3:** Referring to Interrogatory No. 2 above: Since Defendant
did not do anything with the hardened right coronary artery, was it already harmless?

PROOF OF SERVICE

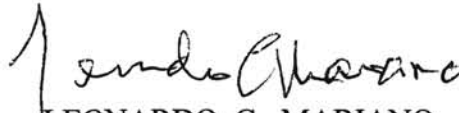
On January 7, 2013, Appellant mailed a copy of a report dated January 5, 2013 to Hon. Richard Johnson, Court Administrator of the Court of Appeals, regarding the Appellant's Brief.. Copies were mailed to:

Hon. Richard D. Johnson
Court of Appeals
600 University St.
Seattle, WA 98101

Pamela Marie Andrews
Andrews Skinner PS
645 Elliot Ave W Ste 350
Seattle, WA 98119-3911

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED January 7, 2013 at Everett, Washington State.


LEONARDO C. MARIANO
Appellant