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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,

Appellant,

v.

ORTHOPEDICS INTERNATIONAL LIMITED, P.S.; and PAUL
SCHWAEGLER, M.D.,

Respondents.

BRIEF OF RESPONDENTS

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STATUTES

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I. COUNTERSTATEMENT OF THE ISSUES

1. Did the trial court properly exercise its discretion in denying plaintiff's motions for mistrial and, post-verdict, for new trial based on defense counsel's sending of information about the trial to the attorney representing one of Brenda Smith's treating physicians, Dr. Kaj Johansen, who had been deposed and was scheduled to testify as a defense witness?

2. Did the trial court properly conclude that defense counsel's contact with the attorney representing Dr. Johansen was not misconduct or a violation of Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988) (prohibiting defense counsel from conducting *ex parte* interviews of a plaintiff's treating physicians), when defense counsel (a) did not conduct any *ex parte* interview of Dr. Johansen, (b) did not seek to obtain, or obtain, from Dr. Johansen or his lawyer any disclosure of information about Ms. Smith (except that which was obtained during Dr. Johansen's deposition and trial testimony), but (c) only provided Dr. Johansen's attorney with copies of plaintiff's trial brief and the trial testimony of one of plaintiff's experts, Dr. David Cossman, who was critical of Dr. Johansen's care (which Dr. Johansen's attorney forwarded to Dr. Johansen), and a copy of a two-page outline for defense counsel's planned direct examination of Dr. Johansen at trial (which there is no evidence Dr.

Johansen ever saw)?

3. Should the trial court's denial of plaintiff's motions for mistrial and for a new trial be affirmed not only on the grounds that there was no misconduct or violation of Loudon, but also on the grounds that plaintiffs have not shown that the contact defense counsel had with Dr. Johansen's counsel materially prejudiced plaintiff's case?

II. COUNTERSTATEMENT OF THE CASE

A. Nature of the Case and the Appeal.

In this medical malpractice, wrongful death and survival action, Jerry D. Smith, as personal representative of Brenda L. Smith's estate, on behalf of himself and Ms. Smith's children, Richona Hill and Jeremiah Hill, sued Dr. Paul Schwaegler, an orthopedic surgeon who specializes in spine surgery, Dr. Schwaegler's employer, Orthopedics International Ltd., P.S., and Swedish Medical Center. CP 3-10. Mr. Smith claimed that Dr. Schwaegler and the nurses at Swedish were negligent in their post-operative care of Ms. Smith following a spine fusion surgery Dr. Schwaegler performed on her at Swedish on December 31, 2003, and that such negligence caused Ms. Smith's leg fasciotomies, amputations, and death. CP 9. The defendants denied plaintiff's claims. CP 12-13.

Plaintiff's nursing negligence claim against Swedish settled shortly before trial. CP 550-54. Plaintiff's claims against Dr. Schwaegler and

Orthopedics International, and Dr. Schwaegler's and Orthopedic International's claims of non-party fault against Swedish were tried to a jury with the Honorable Susan Craighead presiding. CP 329-30. Following a two-and-a-half-week trial, the jury returned a special verdict, finding that Dr. Schwaegler had not been negligent. CP 278.

Plaintiff appeals from the trial court's denials of his motion for a mistrial, 11/20 RP 4, and his later motion for a new trial, CP 284-93, 320-26, both of which were based on his claim that defense counsel's contacts with the attorney for one of Ms. Smith's treating physicians, Dr. Kaj Johansen, was a violation of Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988) (prohibiting defense counsel from conducting ex parte interviews of a plaintiff's treating physicians). The trial court concluded that there had been no Loudon violation or misconduct, 11/19 RP 59-60, 74; CP 320-26, and noted that no order had been entered excluding witnesses or precluding a trial witness from being apprised of a previous trial witness's testimony, CP 321 (§ 2).

Dr. Johansen had been deposed by plaintiff's counsel, CP 354-451, and was a defense witness at trial, CP 149, 282. Defense counsel did not conduct any ex parte interview of Dr. Johansen. 11/19 RP 47-48, 51-53, 55-56, 64-65, 72. Defense counsel had "contact" only with Dr. Johansen's attorney, Rebecca Ringer, providing her, *via e-mail*, with copies of

plaintiff's trial brief (CP 104-117),¹ 11/19 RP 48, 70, and the transcript of the testimony of one of plaintiff's experts who had criticized Dr. Johansen's care (both of which she forwarded to Dr. Johansen), 11/19 RP 47, 52-53, 70; 12/19 RP 7, as well as a two-page outline of defense counsel's planned direct examination of Dr. Johansen (which there is no evidence Dr. Johansen ever saw), 11/19 RP 49-50; Post Trial Ex. 1. At no time, did defense counsel seek to obtain, or obtain (other than during the deposition and trial questioning of Dr. Johansen), any disclosure of information about Ms. Smith from either Dr. Johansen or his lawyer. 11/19 RP 47-48, 51-53, 55-56, 64-65, 72.

B. Ms. Smith's Care and Treatment.

Brenda Smith, while in her 40s, developed severe back pain. 11/6 RP 18. She underwent a discectomy, which alleviated her pain for a while. 11/6 RP 18; 11/20 RP 90. By late 2002, however, she had a recurrence of back pain and saw Dr. Paul Schwaegler, an orthopedic surgeon employed by Orthopedics International Ltd., P.S., who has specialized in lumbar spine surgery since 1990. 11/6 RP 18; 11/20 RP 70, 78. Dr. Schwaegler did an MRI scan and other tests, tried nerve blocks without success, and decided to see if another microsurgery procedure

¹ Plaintiff's "Trial Brief Re: Facts," CP 104-17, set forth in 11 pages a chronology of information from Ms. Smith's medical records and then two pages about Ms. Smith and the impact of her death on her family. It did not include any discussion of plaintiff's malpractice theory or preview the expected trial testimony of any medical witnesses.

could give Ms. Smith the kind of result she had experienced before. 11/20 RP 91. Dr. Schwaegler operated on Ms. Smith's back in February 2003 and, for about six months, her condition improved, but then it got worse. 11/20 RP 93. When an MRI and discogram showed further deterioration of her discs, fusion surgery was indicated. 11/20 RP 93-94.

On December 31, 2003, Ms. Smith, then age 46 and weighing over 270 pounds,² was admitted to Swedish for an anterior/posterior laminectomy fusion with implanted hardware. The over nine-hour surgery, which was performed by Dr. Schwaegler, with Dr. Andrew Ting, a general surgeon, assisting to provide access to the lumbar vertebrae, proceeded according to plan and was completed successfully and without complication,³ 11/19 RP 9-13; 11/20 RP 89-90, 97-99, 101; Exs. 3, 4.

Ms. Smith was transferred, per Dr. Schwaegler's order, Ex. 84, from the post-surgical recovery room to the intensive care unit rather than to a room on one of the hospital floors. Ex. 10. Dr. Schwaegler had Ms. Smith transferred to the ICU so that she would receive more intense and frequent monitoring from nursing staff as the nurse-to-patient ratio is

² According to Dr. Johansen's operative report for the clot removal surgery he performed on January 2, Ms. Smith weighed 124 kg., which is a little over 273 pounds. See Ex. 58.

³ During the anterior part of the procedure, a small tear was made in the vena cava, a major blood vessel that returns blood back to the heart from the lower body and that had to be retracted away from the vertebrae so Dr. Schwaegler could remove disc material. 11/19 RP 20-21; Ex. 3. Dr. Ting repaired the small tear with one or two small sutures, 11/19 RP 11, and did not regard the tear as a surgical complication, 11/19 RP 13. No trial witness attributed the vena cava tear to malpractice by Dr. Ting or Dr. Schwaegler.

much lower in ICU than on a regular hospital floor. 11/20 RP 103-05.

At about 8:00 p.m. (2000 hours), ICU Nurse Anna Sterner noted some numbness in Ms. Smith's feet, Ex. 10; 11/7 RP 30-36, and telephoned Dr. Schwaegler to inform him, Ex. 5; 11/7 RP 36, 39, 51-52. Dr. Schwaegler asked the nurse to check and make sure that Ms. Smith was "moving everything and that she had good perfusion, specifically pink, warm, had good pulses." 11/20 RP 111-12; see also 11/7 RP 67.

Nurse Kay Foster took over Ms. Smith's care between 11:00 p.m. and 11:30 p.m. on December 31. 11/15 RP 162. She was able to feel pulses in both of Ms. Smith's feet throughout her shift, which ended at 7:50 the next morning. 11/15 RP 166-67, 172-73, 178; Exs. 10, 11.

At 6:00 a.m. on January 1, 2004, Dr. Elias Khalfayan, an orthopedic surgeon and partner of Dr. Schwaegler, checked on Ms. Smith, and found that she could not move her feet. 11/7 RP 96. Dr. Khalfayan considered the possibility of a vascular problem, but was able to palpate a normal pulse in both feet. 11/7 RP 112. When he apprised Dr. Schwaegler of Ms. Smith's status by phone, Dr. Schwaegler said he was coming to see her himself. 11/7 RP 106, 119-20.

Phyllis Hanson was the nurse on duty from 7:00 a.m. to 7:30 p.m. on January 1. 11/7 RP 130-31. She called Dr. Joseph Bennet, an adult

hospitalist trained in internal medicine,⁴ to advise him of apparent kidney issues given Ms. Smith's low urine output and high potassium level. 11/7 RP 153. Dr. Bennet arrived at about 1:00 p.m. to evaluate Ms. Smith for renal dysfunction. 11/7 RP 154-55; 11/15 RP 123. He noted that she was having some difficulty moving her right foot, 11/15 RP 129, but had muscle function in both lower extremities, 11/15 RP 130. Ms. Smith's ability to move her right foot marked an improvement from what Dr. Khalfayan had found. 11/15 RP 144-45. Dr. Bennet found relatively normal motor function in the left foot. 11/15 RP 145. When asked by defense counsel what it tells him about the perfusion in the patient's extremity "if an experienced ICU nurse finds good pulses, good color, and good temperature in four consecutive examinations of a patient over a course of about seven hours, Dr. Bennet answered: "It's good and adequate." 11/15 RP 147.

Dr. Schwaegler came in about mid-day on January 1. 11/20 RP 113-14. Ms. Smith's foot pulses were normal, her feet were warm, and she could move both feet. 11/20 RP 117-19. As Dr. Schwaegler explained at trial, motor deficits sometimes occur after spinal surgery and

⁴ As Dr. Bennet explained, a hospitalist is a physician who works only in hospitals, providing care either to adults or children, and who directs the care of hospitalized patients, sees them daily, participates in sorting out diagnoses, organizes consultants and others, including surgeons, organizes medications, and sees to continuity of care after discharge. 11/15 RP 118.

usually fluctuate. 11/20 RP 118-19. Although Ms. Smith's right foot was weak, her left foot had normal strength, and he was comforted that her symptoms were from manipulation of the nerves during the surgery and that she had improved since 6:00 a.m. 11/20 RP 118-19, 121.

Nurse Hanson recorded normal pulses at 3:00 p.m. on January 1. 11/7 RP 165-68; Ex. 11.

Nurse Lolena Cummons, who took over when Nurse Hanson's ICU shift ended on January 1, noted in the chart that, at 7:20 p.m., Ms. Smith's left foot was cool and no pulses were present. Ex. 11. Nurse Cummons did not notify any physician. At 11:40 p.m., she noted that Ms. Smith's left foot was cold and that no pulses were present even by Doppler. Ex. 11. She called Dr. Khalfayan, who called Dr. Schwaegler at about 1:00 a.m. on January 2. 11/20 RP 124. Dr. Schwaegler consulted with Dr. Ting to confirm that the problem seemed to be a vascular one, then "put in a page" for Dr. Johansen, a vascular surgeon, who called back and agreed to meet him at the hospital. 11/20 RP 125-26. Dr. Johansen completed his initial assessment of Ms. Smith by 3:30 a.m. 11/14 RP 14-15; Ex. 55.

Dr. Johansen ordered an aortogram, which showed an obstruction at the aortic bilateral common iliac artery (a clot blocking a main artery that serves both legs). 11/14 RP 16-18. By 6:30 a.m. on January 2, Dr.

Johansen was performing clot removal surgery, removing clots first from the aorta and then from lower arterial branches at the groin and below the left knee. 11/14 RP 19-21; Ex. 58. Because Ms. Smith's legs began "pinking up," and because it was Dr. Johansen's understanding that blood flow to the legs had been blocked for no longer than eight hours, he elected not to probe into the left ankle for more clots or to perform a fasciotomy to reduce the risk of "compartment syndrome" (swelling from re-established blood flow that would reduce blood circulation to leg tissues). 11/14 RP 21-23; Ex. 58.

Ms. Smith, however, did develop compartment syndrome, and Dr. Johansen had to perform fasciotomies on both legs later on January 1, 2004. 11/14 RP 24-25; Ex. 60; CP 109. Despite further attempts, Dr. Johansen could not save Ms. Smith's lower left leg, and it was amputated, initially below the knee on January 21 and, after further operations by Dr. Johansen on January 23, 24, and 26, at the knee on February 5, 2004. CP 111-113; 11/14 RP 26-29; Exs. 61, 62.

Ms. Smith developed a serious Methicillin resistant staphylococcus aureus (MRSA) infection and, on March 1, 2005, was re-hospitalized with pneumonia. CP 114. Dr. Johansen provided care to Ms. Smith during that hospitalization, 11/14 RP 13, which ended when she died of pneumonia and pulmonary thromboembolism on March 10, 2005, Ex. 89. Dr.

Johansen, who had become close to Ms. Smith and her family, 11/14 RP 13-14, attended her funeral, CP 116.

C. Lawsuit.

In February 2006, Mr. Smith brought this medical malpractice, wrongful death and survival action against Dr. Schwaegler, Orthopedics International, and Swedish. CP 3-10. Mr. Smith did not sue Dr. Ting, Dr. Khalfayan, Dr. Bennet, or Dr. Johansen. See id.

D. The Deposition of Dr. Johansen.

Plaintiff's counsel deposed Dr. Johansen, CP 354-451, and did most of the questioning, CP 358-435, 442-48. Plaintiff's counsel asked Dr. Johansen what he could recall about how he "got to see" Brenda Smith on January 2, 2004, CP 363; what Dr. Schwaegler had told him on the phone, CP 364; what he had asked Dr. Schwaegler, CP 364-65; and whether he had obtained information as to how long Ms. Smith had gone without blood supply to her legs, CP 365. When Dr. Johansen answered that his "sense" was that she had not been without blood supply for "very long," plaintiff's counsel inquired further and was told "something like a few hours, a couple of hours." CP 365-66; see also CP 375, 408.

Plaintiff's counsel probed Dr. Johansen's willingness to opine that Ms. Smith's arterial occlusion could have been diagnosed earlier and that earlier diagnosis and surgery would have saved her leg, but Dr. Johansen

proved unhelpful in that regard. Dr. Johansen testified that, if he had been told initially that the blood supply to Ms. Smith's leg had been cut off for six hours, he would have operated without waiting for the result of an aortogram, would not have done a fasciotomy, CP 366-67, and would have saved about three hours, but did not know whether saving three hours would have been significant, CP 369-70.

Plaintiff's counsel asked what Dr. Johansen would have done had he been called in soon after 1900 hours (7:00 p.m.) on January 1 and told that Ms. Smith's previously palpable pulses had become detectable only by Doppler and that her left foot had become cool. CP 371-72. Dr. Johansen responded that he would have drawn no negative conclusion if the Doppler pulses had been of good quality, because a change in temperature with good quality Doppler pulses would signify "just a foot that's been out in the open air." CP 372. Plaintiff's counsel asked Dr. Schwaegler whether it is "fair to say" that Dr. Schwaegler "clearly had the impression that this had been only going on a couple hours," and Dr. Johansen answered "Yes, absolutely." CP 375.

Plaintiff's counsel then gave Dr. Johansen an opportunity to opine that a risk of malperfusion (poor blood circulation) is associated with prolonged back surgery, and that the type of table Dr. Schwaegler used for

the spine fusion surgery puts patients at risk of clotting. Dr. Johansen denied awareness of any such associations. CP 376-79.

Plaintiff's counsel asked Dr. Johansen whether he had an opinion as to when the clot formed in Ms. Smith's aorta, and Dr. Johansen answered that he did not, but offered that he had ruled out the possibility that retraction may have dissected (cut) the aorta during the spine surgery because he had looked inside the aorta and saw no dissection. CP 379-80. Plaintiff's counsel asked whether a vena cava tear during the spine surgery would have promoted thrombosis; Dr. Johansen answered no. CP 382. Plaintiff's counsel asked whether the embolus (clot) could have accounted for Ms. Smith's left foot "getting cold at 1900 hours the night before;" Dr. Johansen answered no, because she still had pulses. CP 391.

Deposition questioning returned to the subject of whether earlier diagnosis and treatment would have saved Ms. Smith's leg. CP 396. Dr. Johansen testified that he could not say whether surgery at midnight (January 1-2) would have made a difference. CP 396-99.

Plaintiff's counsel explored Dr. Johansen's working relationship with Dr. Schwaegler, and was told that they have known each other for 15 years and have worked together on dozens of cases. CP 415-16. He asked Dr. Johansen whether Dr. Schwaegler ever indicated that he wished he had been informed of a change in Ms. Smith's condition that had been noted

by the nurses “the night before,” and Dr. Johansen answered that he did not recall Dr. Schwaegler doing so. CP 416. Plaintiffs’ counsel asked about Ms. Smith’s course after the initial surgeries to remove the clots and try to save her leg, CP 418-27, and then asked whether, if an ankle brachial index had been ordered earlier on January 1, a developing occlusion of the aorta would have been diagnosed, CP 428-33. Dr. Johansen answered that use of an ankle brachial index would have made sense only in the absence of good Doppler signals. CP 432.

Counsel for Swedish elicited Dr. Johansen’s opinions that the emboli (clots) formed elsewhere, left the aorta and traveled to the tibial artery “early on,” and that, by the time of the loss of pulses, whenever that occurred, the clot had already moved to the tibial artery, CP 435-36, and confirmed that it had been Dr. Johansen’s clinical decision, because Ms. Smith’s foot began “pinking up,” not to proceed lower to remove clots in the tibial artery, CP 437-38. Swedish’s counsel elicited Dr. Johansen’s opinion that the leg would not have been saved even if he had operated four to six hours sooner. CP 439. Counsel for Dr. Schwaegler then asked a few questions about how Dr. Schwaegler had positioned Ms. Smith during the spine surgery. CP 440-41.

Plaintiff’s counsel, following up on Swedish’s counsel’s questioning, asked Dr. Johansen when, in his opinion, the embolization of

the tibial arteries occurred. CP 442. Dr. Johansen answered that embolization significant enough to cause occlusion had not occurred at any point while the artery had a pulse that was either palpable or “at least a diphasic Doppler signal,” CP 442-43; that the arteries had become occluded by the time the vascular lab study was done (on the morning of January 2), CP 443-44; and that the occlusion occurred between then and whenever the nurses last had detected a pulse, CP 446.

E. The Parties’ Theories of Case.

Plaintiff filed and served a trial brief a week before trial began. CP 104-16. It consisted of (1) an 11-page chronology starting with Ms. Smith’s spine surgery on December 31, 2003, CP 105, and ending with her death and ensuing autopsy, CP 115, followed by (2) a page and a half description of the Smith family and how its members were affected by Ms. Smith’s death, CP 115-16. The trial brief did not contain any legal argument or any summary of plaintiff’s liability theory, although its factual chronology highlighted the nursing and physician notes, starting on the evening of December 31, about Ms. Smith having difficulty moving her feet, numbness, a cool foot, and, eventually, no palpable pulses and then no Dopplerable pulses. CP 106-08.

Plaintiff’s counsel told the jury in opening statement that Ms. Smith lost her leg and contracted an ultimately fatal MRSA infection

because Dr. Schwaegler negligently assumed that postoperative motor-deficit symptoms in her legs were due to manipulation of nerves during the spinal fusion surgery and did not take any steps to rule out a vascular cause until it was too late to save her left leg. 11/6 RP 23-25. Plaintiff's counsel told the jury that "[t]he fact that there are some pulses present doesn't mean there isn't a clot and doesn't mean there isn't a blockage [of blood flow]," and that experts would testify that the motor loss symptoms Ms. Smith began having at 10:00 p.m. on December 31 required Dr. Schwaegler to act then, or certainly by mid-day on January 1, to rule out both a vascular and a neurological problem. 11/6 RP 25-26.

Defense counsel told the jury in opening statement that "complications don't equal malpractice," 11/6 RP 52, but that "pulses equal perfusion," such that, "[i]f you have a pulse, that means that the blood is moving through your body and the tissues are being perfused with blood," 11/6 RP 53. Defense counsel told the jury that Ms. Smith had pulses in her legs until the evening of January 1, and that her nurse did not tell any doctor until midnight that Ms. Smith had no pulses in her legs and that her left foot was cool. 11/6 RP 67-68. Defense counsel told the jury that two experienced spine surgeons would testify that Dr. Schwaegler had not been negligent. 11/6 RP 69-70.

F. The Trial Testimony.

The trial testimony as to negligence focused on what it meant that Nurses Sterner, Foster, and Hanson, and Drs. Khalfayan, Bennet, and Schwaegler all were able to feel normal pulses on December 31 and during the morning and afternoon of January 1; whether “pulses mean perfusion;” and whether Ms. Smith’s numbness and muscular problems should nonetheless have prompted Dr. Schwaegler to call in a vascular surgeon earlier and well before he was first alerted, at 1:00 a.m. on January 2, that Ms. Smith had a cold foot and no detectable leg pulses.

1. The testimony of plaintiff’s standard-of-care experts.

Plaintiff’s first standard-of-care expert was Dr. Mark Palumbo, a spine surgeon. Dr. Palumbo disclaimed any criticism of the intraoperative care that Drs. Ting and Schwaegler had provided. 11/6 RP 110, 143, 157. He also disclaimed any criticism of Dr. Schwaegler’s response to Nurse Sterner’s call on the evening of December 31. 11/6 RP 143-44. He told the jury that Ms. Smith’s leg numbness on December 31 had indeed been consistent with “surgical manipulation of the nerves,” and that, at that point, because “there were pulses present in the lower extremities, at least to some extent, and the legs seemed to be well perfused, seemed to be getting enough blood supply,” Ms. Smith required only “careful

monitoring . . . taking into consideration that if more develops, this is really something that needs to be followed up on.” 11/6 RP 115.

Dr. Palumbo contended that, by 0600 hours on January 1, the progression of symptoms from foot numbness to deterioration in lower leg motor function should have made her physicians suspect one of four causes: (1) compression of nerves due to collection of blood in her posterior wound; (2) a bilateral neurologic dysfunction; (3) a “vascular event,” meaning a “blood flow problem to the legs that shuts down the nutrition and oxygen supply . . .;” or (4) compartment syndrome, “where excessive swelling in the legs can cause the muscles to become nonfunctional.” 11/6 RP 122-24.

According to Dr. Palumbo, by the morning of January 1, an MRI was indicated to rule out collection of blood, and a detailed physical examination, palpating of the pulses throughout the lower extremity, and a Doppler exam or ankle brachial index (ABI) test should have been done, or a vascular surgeon should have been consulted, 11/6 RP 124-26, and, had those steps been taken, vascular surgery would have had a much higher probability of preserving the lower leg tissues. 11/6 RP 126.⁵ Dr.

⁵ Dr. Palumbo also opined, with respect to the hospital nursing staff, that “the standard of care was not met in several instances,” and cited inadequate documentation of a baseline neurologic and vascular examination immediately after the spinal surgery, and “a lack of providing information to the treating surgeons on the night of January 1st, around 6:00 to

Palumbo admitted that he could not say what an ABI would have shown had one been done at 6:00 a.m. on January 1. 11/6 RP 152-53.

Plaintiff's other standard-of-care expert, David Cossman, M.D., a Los Angeles vascular surgeon, 11/8 RP 44-45, contended that, by mid-day on January 1, Ms. Smith was showing symptoms that should have prompted her physicians to rule out a vascular cause or "get a vascular surgeon in there"; that the failure to do either made her care substandard, 11/8 RP 90-91; and that her leg would have been "fine" had an arterial clot been diagnosed mid-day on January 1, 11/8 RP 97-98, 113.⁶ Disagreeing with Dr. Palumbo, see 11/6 RP 114, Dr. Cossman opined that a pulse does not equate with perfusion of blood flow in the limb, so it did not matter that nurses or physicians were able to feel pulses during the evening of December 31 or as of 0600 hours on January 1, 11/8 RP 98, 108-09.⁷

7:00 p.m., when . . . Ms. Smith developed some signs in the leg that were consistent with a major vascular problem." 11/6 RP 93.

⁶ Dr. Cossman absolved Dr. Schwaegler of malpractice in Ms. Smith's preoperative or intraoperative care, 11/8 RP 113, and for not taking steps to rule out a vascular cause of the leg numbness and dark-urine symptoms that Nurse Sterner had reported at 2200 hours on December 31. 11/8 RP 85; Ex. 10.

⁷ Dr. Cossman was unable to resist criticizing other physicians as well. He disagreed with Dr. Johansen's choice of incision site for his initial surgery to try to reestablish blood flow, 11/8 RP 94-95, 129, and with Dr. Johansen's evaluation and care of Ms. Smith, 11/8 RP 127, 129-132. Dr. Cossman also opined that Dr. Ting "should have been there" on January 1, and had not met the standard of care. 11/8 RP 133-134. He opined that Dr. Khalfayan also had not met the standard of care. 11/8 RP 134. Dr. Cossman told the jury that he never relies on nurses' observations of pulses, 11/8 RP 135-136.

On cross-examination, Dr. Cossman acknowledged limits to his expertise:

Q. Can we also agree that you don't know how often these types of motor or sensory issues develop from a vascular cause or from a neurologic cause?

A. No. What I said was that I can't comment on Dr. Schwaegler's attributing this to the neurologic consequences of a spine surgery. That's something you'd have to get from a neurosurgeon or an orthopedic surgeon.

Q. So putting that together, you don't know how often these motor or sensory problems are from a vascular or a neuro cause?

A. Well, that question's vague. What I said is that these are symptoms that can be due to vascular disease. Now, if Dr. Schwaegler says they can also be due to neurologic issues after spine surgery, that – you'll have to get that from other people. I'm not an expert in that area.

11/8 RP 119.

2. The defense standard-of-care expert testimony.

In defense of the post-operative care Dr. Schwaegler provided to Ms. Smith, the defense presented his testimony, 11/20 RP 60-145, as well as the testimony of two other experienced spine surgeons, Dr. Scott Kitchell and Dr. Scott Blumenthal, 11/13 RP 104-08; 11/15 RP 25.

Dr. Kitchell told the jury that it is “important to distinguish between complications and deviations from the standard of care, and I believe Dr. Schwaegler met the standard of care in this case.” 11/13 RP 102. Dr. Kitchell explained that, as an orthopedic surgeon, “when I think

of pulses being present, then I think perfusion is present.” 11/13 RP 108-09. Dr. Blumenthal also opined that Dr. Schwaegler met the standard of care for a spine surgeon, 11/15 RP 29, and explained that spine surgeons “tend to look for problems [postoperatively], and when we get reports of good pulses, it’s kind of steady as she goes,” 11/15 RP 31, and that “it’s reasonable to assume that if someone has good pulses that the blood’s getting down there, and that would imply good perfusion,” 11/15 RP 43.

3. Dr. Ting’s testimony.

Plaintiffs did not call Dr. Ting, but the defense did. The defense called him to refute Dr. Cossman’s opinion testimony that the vena cava tear that Dr. Ting repaired during the spinal fusion surgery had been a major complication. 11/19 RP 10-14.

4. Dr. Johansen’s testimony.

Plaintiffs also did not call Dr. Johansen, but the defense did. Dr. Johansen testified on November 14, 2007. Much of his direct trial testimony was a plain-English account of what his reports said.

Dr. Johansen described being called in by Dr. Schwaegler at about 1:00 a.m. on January 2, 2004, 11/14 RP 13-14, and the findings he had noted during the initial assessment of Ms. Smith, 11/14 RP 14-15. He explained that the aortogram he ordered showed that Ms. Smith had a 30-percent-of-normal blood supply to the right leg and none to the left leg.

11/14 RP 18. He related that Ms. Smith was taken to the operating room, where he removed a clot from the aorta, and then evaluated the inside of the aorta but found no evidence of a narrowing of the aorta or a tear that might explain the clot. 11/14 RP 19-20. He testified that he probed for and found more clot in the left leg, 11/14 RP 20, closed the aorta and the incision he had made to access it, and opened the left groin and the left common femoral artery, and, using a catheter, found and removed a clot from the left femoral popliteal artery below the knee. 11/14 RP 21.

Dr. Johansen explained that Ms. Smith's left foot thereupon became "quite pink," indicating that good blood flow (perfusion) was being restored and that the limb had been salvaged. 11/14 RP 21-22. He therefore decided not to probe the artery down into the left ankle for more blood clot. 11/14 RP 22. Dr. Johansen explained that he considered whether to perform a fasciotomy to reduce the risk of compartment syndrome, but decided not to because it had been his and Dr. Schwaegler's impression that the period of inadequate blood supply had been brief, such that Ms. Smith probably was not at risk for compartment syndrome. 11/14 RP 23-24. Dr. Johansen testified that Ms. Smith went on to develop compartment syndrome anyway, and underwent fasciotomies later on January 2. 11/14 RP 24-27. Dr. Johansen testified that even then he was optimistic that she would not lose either leg or foot. 11/14 RP 27-28. Dr.

Johansen then described the process that led to the eventual loss of Ms. Smith's lower left leg. 11/14 RP 28-31.

Asked what role the small tear of the vena cava that Dr. Ting had repaired during the spinal fusion surgery on December 31 had played in Ms. Smith developing the vascular problems that he dealt with, Dr. Johansen answered, as he had in his deposition, CP 381-82, none. 11/14 RP 32. He explained, as he had in his deposition, CP 382, that it is not uncommon to have small tears in the vein during spinal fusion surgery and that the vena cava is a vein, not an artery. 11/14 RP 32. Dr. Johansen testified that it is hard for him to know whether the perfusion had been inadequate to save the left foot as of the time he first operated, or became inadequate afterward, 11/14 RP 32-33, and that, in hindsight, he might have proceeded "farther down" to get clots out of the lower and smaller arteries, or might have done a fasciotomy then, 11/14 RP 33, and certainly would have done both if he had thought the limb had been without a blood supply for several hours longer than he thought it had. 11/14 RP 33-34. Asked without objection what the significance is of a patient having pulses in the lower extremities that can be Dopplered, and warm feet that are normal in color, Dr. Johansen answered that it suggests the patient has good blood supply, that the perfusion is good. 11/14 RP 34.

Plaintiff's counsel did not object to any questions until defense counsel asked Dr. Johansen what he would have done if he had been called in to see Ms. Smith at around noon on January 1.⁸ 11/14 RP 35. The court sustained the objection as calling for speculation from a witness who was not being called as an expert. 11/14 RP 40-41. When defense counsel asked to make an offer of proof while Dr. Johansen was still on the witness stand, the court decided to wait until the end of his testimony and take the offer of proof outside the presence of the jury. 11//14 RP 42-44. Dr. Johansen then testified, without objection, that Dopplerable pulses, warm feet, and good color suggest to him that perfusion, or blood supply, is present and that, if the foot is warm, the blood supply is at least satisfactory. 11/14 RP 44.

Defense counsel next asked Dr. Johansen to explain "flow geometry," which Dr. Johansen did, without objection from plaintiff's counsel. 11/14 RP 45. He explained that, as a blockage develops, a drop in blood pressure does not occur until the artery is about 75 percent blocked, at which point "fairly quickly you'll start developing coolness or diminished . . . or even absent pulses." 11/14 RP 45-46. When defense counsel then asked Dr. Johansen if he has an opinion when that change

⁸ As noted above, at Dr. Johansen's deposition plaintiff's counsel had tried, but had been unable, to elicit testimony about earlier intervention that was helpful to plaintiff's case. CP 369-372-73, 391-93, 396-99.

occurred with Ms. Smith,⁹ the court sustained plaintiff's counsel's objection that the question sought expert testimony. 11/14 RP 46.

Asked how long it had taken, "from its very inception," for the clot he removed from Ms. Smith's aorta to get where he found it, Dr. Johansen explained at some length, without prior objection and consistent with his deposition testimony, CP 384-85, 433-34, that he thought it started during the spine operation but 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" 11/14 RP 46. At that point, plaintiff's counsel objected and moved to strike on the ground that Dr. Johansen was being asked to give expert testimony. Id. The court struck the testimony and instructed the jury not to consider it. 11/14 RP 47-48. That concluded Dr. Johansen's direct examination.

On cross-examination, plaintiff's counsel, among other things, elicited from Dr. Johansen testimony that, when he first arrived to take over Ms. Smith's care on January 2, it was his understanding that the stoppage of blood flow was only a couple of hours old. 11/14 RP 79.

⁹ As noted above, Dr. Johansen had testified in response to plaintiff's counsel's deposition questions, that embolization significant enough to cause occlusion had not occurred at any point while the artery had a pulse that was either palpable or "at least a diphasic Doppler signal," CP 442-43; that the arteries had become occluded by the time the vascular lab study was done (on the morning of January 2), CP 443-44; and that the occlusion occurred between then and whenever the nurses last detected a pulse, CP 446.

On redirect examination, the court sustained a lack-of-foundation objection to a question as to what an ankle brachial index (ABI) test administered at about 1:00 p.m. on January 1 would have found.¹⁰ 11/14 RP 83. Dr. Johansen then testified without objection and based on his own personal experience working at Swedish, that ICU nurses at Swedish hospital are competent to operate and routinely to do operate “a Doppler” to check patients’ pulses in the lower extremities. 11/14 RP 84.

The court then sustained an objection by plaintiff’s counsel, and Dr. Johansen did not answer, a question whether he would have any reason to believe that a nurse who testified she was able to either palpate or find Doppler pulses at 8:00 a.m., 10:00 a.m., 11:30 a.m. and 3:00 p.m. was not accurately reporting what she found. 11/14 RP 85-86. The court suggested that defense counsel could rephrase the question, which defense counsel did and asked Dr. Johansen whether, as a vascular surgeon practicing at Swedish, he routinely relies on the ability of ICU nurses to accurately determine whether his patients have normal pulses. 11/14 RP 86. The court overruled plaintiff’s counsel’s objection to that question, and Dr. Johansen answered yes, and went on to explain that one reason he

¹⁰ As noted earlier, plaintiff’s counsel had asked Dr. Johansen in deposition whether a developing occlusion of the aorta would have been diagnosed had an ABI been ordered earlier on January 1, and Dr. Johansen had responded that an ABI would have made sense only in the absence of good Doppler signals. CP 428-33.

relies on the nurses at Swedish is that he personally trained them in use of the Doppler and considers their findings trustworthy. 11/14 RP 87.

Dr. Johansen testified that, had there been a suggestion that a vascular deficiency had developed at 7:00 p.m. the previous day, he would have acted differently, but he did not know, and believes Dr. Schwaegler did not know, that a lack of pulses had been noted that early. 11/14 RP 89. The court sustained objections to, and Dr. Johansen did not answer, questions as to what Dr. Johansen believes Dr. Schwaegler would have done had Dr. Schwaegler been given earlier notice of a vascular problem. 11/14 RP 89-90.

Further examination by both counsel replewed old ground, after which Dr. Johansen answered six questions submitted by jurors. 11/14 RP 93-97. The jury was excused and the defense proceeded with its offer of proof, and Dr. Johansen opined that an ABI test done at 1:00 p.m. on January 1 would have been normal and explained why. 11/14 RP 99-101. Plaintiff's counsel cross-examined, and asked Dr. Johansen whether he had "some idea as to . . . what questions would be asked of you here today," asserting to the court that "if this doctor has some idea as to what questions were being asked, then there's been a violation of the law here." 11/14 RP 103. Dr. Johansen testified that he thought the questions would be "along the lines of those you had asked me in my deposition, and

also . . . I was sent a thing called a plaintiff's trial brief." 11/14 RP 103-04 (referring to CP 104-17). Dr. Johansen had his file with him, and gave it to the court to examine; the court noted that the trial brief in Dr. Johansen's file did not contain any "notations or anything that could have been from an attorney or anything like that," but that it did contain "fax information," which she let plaintiff's counsel see. 11/14 RP 105. The court informed plaintiff's counsel that Dr. Johansen's file also included letters from his counsel and a transcript of Dr. Cossman's November 8 trial testimony. 11/14 RP 107.

Plaintiff's counsel indicated that plaintiff might move "for a directed verdict on liability . . . due to attorney misconduct, and limit this case to damages." 11/14 RP 107. Further consideration was deferred until Dr. Johansen could consult his counsel. 11/14 RP 107-109. Trial proceeded; the jury heard the testimony of plaintiff's infectious disease expert Dr. John Townes, 11/14 RP 110-137, and Nurse Cummons, 11/14 RP 142 (by videotape).

5. Plaintiff's eventual motion for mistrial.

When court reconvened on November 15, Judge Craighead noted that no one had sought and she had not entered any order excluding witnesses or precluding the sharing of information about what was taking place at trial with witnesses, and then asked where the parties "want to go

from there.” 11/15 RP 3-4. During colloquy, plaintiff’s counsel referred to but did not ask the court to grant a mistrial, 11/15 RP 7, and suggested an evidentiary hearing,¹¹ and possible sanctions such as striking of defense expert testimony or a curative instruction, 11/15 RP 8-9. After hearing from defense counsel, 11/15 RP 10-14, the court asked that inquiry be made of Ms. Ringer as to Dr. Johansen’s schedule, 11/15 RP 16. Trial proceeded, and the jury heard the testimony of defense expert Dr. Scott Blumenthal, 11/15 RP 17-114; Dr. Bennet, 11/15 RP at 116-57, and Nurse Foster, 11/15 RP 158-96.

A telephone conference hearing was held on Saturday, November 17, 2007, to further explore with Ms. Ringer, Dr. Johansen’s lawyer, what communication had occurred between her and defense counsel. 12/19 RP 6-7.¹² E-mails between defense counsel and Ms. Ringer were provided to the court and ultimately became exhibits for the record, 12/19 RP 8; Post Trial Ex. 1, along with Dr. Johansen’s file, Post Trial Ex. 2. Further discussion was had during trial on November 19, 11/19 RP 43-89, after Dr. Ting testified. The hearings established that: (1) in addition to

¹¹ On November 15, plaintiff filed “Plaintiff’s Motion for an Evidentiary Hearing Re: Materials Provided to Dr. Kaj Johansen.” CP 148-54. On November 19, defendants filed “Defendants’ Opposition to Plaintiff’s Motion for Hearing Re: Materials Provided to Dr. Johansen.” CP 155-64.

¹² The November 17 hearing was not reported. At a later hearing on December 19, 2007, which was reported and is of record, the court and counsel for the parties referred to and related facts that had been established at the earlier hearing, about which there seems to have been no material dispute.

plaintiff's trial brief, defense counsel had also sent Ms. Ringer a copy of Dr. Cossman's trial testimony; (2) defense counsel had sent Ms. Ringer a two-page outline for the planned direct examination of Dr. Johansen at trial; (3) Ms. Ringer had forwarded to Dr. Johansen the trial brief and transcript of Dr. Cossman's testimony; and (4) Ms. Ringer had no substantive conversations with defense counsel. Post Trial Exs. 1 and 2; 11/19 RP 47-48, 51-53, 55-56, 64-65, 72. Plaintiff's counsel again referred to a mistrial, but did not move for one. 11/19 RP 76, 88. Trial proceeded, and the jury heard testimony from the King County Medical Examiner, 11/19 RP 89-130, and plaintiff Jerry Smith, 11/19 RP 131-44.

The next day, November 20, plaintiff formally moved, orally, for a mistrial, and Judge Craighead denied the motion. 11/20 RP 4. The court offered plaintiff's counsel the opportunity to recall Dr. Johansen and to ask him whether he and Ms. Ringer had gone over a list of questions that she expected defense counsel to ask, but plaintiff's counsel chose not to do so. 11/20 RP 14.

Having found no misconduct by defense counsel and wishing to avoid any comment on the evidence, the trial court declined to give an instruction proposed by plaintiff, 11/20 RP 3, but did instruct the jury that:

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

CP 209. Plaintiff does not assign error to the court's refusal to give his proposed instruction.

6. The defense verdict.

The jury was given a special verdict form which asked first whether Dr. Schwaegler had been negligent and, then, if he had been negligent, whether such negligence had been a proximate cause of injury to the plaintiff. CP 278-280. The jury found that Dr. Schwaegler had not been negligent, CP 278, and thus did not reach the questions of proximate causation, or damages, CP 279.¹³

7. The motion for new trial.

Plaintiff moved for a new trial based on what his counsel continued to claim was a violation of Loudon. CP 284-293; 12/19 RP 6, 11-12. Plaintiff asserted that "Dr. Johansen's supposedly unbiased testimony was a centerpiece of defendant's closing argument." CP 293. Plaintiff did not explain what made Dr. Johansen "supposedly unbiased" or what made his trial testimony biased in some way that had been unfairly prejudicial to plaintiff. Defense counsel's closing argument runs for 43 pages of the trial transcript. 11/21 RP 84-117. References to Dr. Johansen's trial testimony account for fewer than four of those pages.

¹³ Nor did the jury reach the questions of negligence on the part of Swedish or apportionment of fault. See CP 278-280.

11/21 RP 97-100.¹⁴ The centerpiece of defense counsel's closing argument was the same as the centerpiece of defense counsel's opening statement: pulses means perfusion. Compare CP 52-54, 66, 68 with CP 86, 93, 98, 109, 111. "Pulses means perfusion" was the centerpiece of defense counsel's closing argument because Dr. Schwaegler had so testified (11/20 RP 128-29); Dr. Kitchell had so testified (11/13 RP 108-09); Dr. Blumenthal had so testified (11/15 RP 31); Dr. Khalfayan had so testified (11/7 RP 112-13); Dr. Bennet had so testified (11/15 RP 147); and even Dr. Palumbo, one of plaintiff's two standard of care experts and the only one who was a spinal surgeon, had so testified (11/6 RP 115).¹⁵

Judge Craighead denied plaintiff's motion for new trial, CP 320-22; 12/19 RP 31, and entered judgment on the jury verdict for Dr. Schwaegler and Orthopedics International, CP 327-30. She admitted the e-mails between defense counsel and Rebecca Ringer as Post-Trial Ex. 1 and Dr. Johansen's file as Post-Trial Ex. 2. In her written order denying plaintiff's motion for new trial, Judge Craighead made the following findings or conclusions:

¹⁴ Counsel for Dr. Schwaegler also reminded the jury of Dr. Cossman's gratuitous criticisms of the care that Dr. Johansen, who was not being sued, provided to Ms. Smith. 11/21 RP at 107.

¹⁵ That Dr. Johansen's trial testimony was supportive of that point, see 11/14 RP 34, 44, is not surprising in light of his deposition testimony that embolization significant enough to cause occlusion had not occurred at any point while the artery had a pulse that was either palpable or "at least a diphasic Doppler signal," CP 442-43.

1. Defense counsel did not engage in any misconduct by having contacts with Rebecca Ringer, attorney for Dr. Johansen;

2. There was no order in limine excluding witnesses, thus there was no irregularity in the proceeding, misconduct or error in law that would justify a new trial;

3. To the extent that plaintiff's counsel claimed to be surprised by defense counsel's contact with Rebecca Ringer, the court addressed the issue of surprise at trial by providing plaintiff the opportunity to call Dr. Johansen back to trial for additional cross examination, as well as providing the jury with a special instruction addressing the contact;

4. Plaintiff's counsel was already aware of facts relevant to potential bias such [as] Dr. Johansen's working relationship with defendant Dr. Schwaegler, his frequent work as a defense expert, his marriage to a medical malpractice defense attorney, his awareness of the issues in malpractice cases, and that he likely knew about the facts leading up to his care of Ms. Smith because he could have been a defendant in this case given his role in the care of Ms. Smith. However, plaintiff made the strategic choice not to pursue a hostile witness cross examination of Dr. Johansen. Thus, the concern raised by plaintiff does not justify a new trial, in view of all the evidence.

CP 321-22. Plaintiff timely appealed. CP 331-39.

III. ARGUMENT

A. Standard of Review.

A trial court's denials of motions for mistrial and new trial are reviewed for abuse of discretion and whether the appellant was denied a fair trial. Kimball v. Otis Elevator Co., 89 Wn. App. 169, 178, 947 P.2d 1275 (1997) ("A trial court should grant a mistrial only when nothing the court can say or do would remedy the harm caused by the irregularity, or

in other words, when the harmed party has been so prejudiced that only a new trial can remedy the error”). The same standards apply to an order denying a motion for new trial. Aluminum Co. of America v. Aetna Cas. & Sur. Co., 140 Wn.2d 517, 537, 998 P.2d 856 (2000) (“The criterion for testing abuse of discretion [in the denial of a new trial] is: ‘[H]as such a feeling of prejudice been engendered or located in the minds of the jury as to prevent a litigant from having a fair trial?’” (quoting Moore v. Smith, 89 Wn.2d 932, 942, 578 P.2d 26 (1978) (quoting Slattery v. City of Seattle, 169 Wash. 144, 148, 13 P.2d 464 (1932))).

Plaintiff argues that, when it is not learned until during or after trial that defense counsel conducted an *ex parte* interview of the plaintiff’s treating physician, a new trial is required as a matter of law if the plaintiff loses. *App. Br. at 25-28*. Plaintiff relies for that argument on Rowe v. Vaagen Bros. Lumber, Inc., 100 Wn. App. 268, 278-279, 996 P.2d 1103 (2000), where defense counsel, claiming that the case was governed by RCW Title 51 and that Loudon therefore did not apply, had conducted *ex parte* interviews of the plaintiff’s treating physicians before deposing them. Rowe does not apply here because, as explained below, there was no *ex parte* interview, by defense counsel, of any of Brenda Smith’s treating physicians, either before deposition or otherwise.

Moreover, Rowe confirms the holding in Ford v. Chapin, 61 Wn. App. 896, 898-99, 812 P.2d 532, rev. denied, 117 Wn.2d 1026 (1991), that for a Loudon violation to require the grant of a new trial, there must not only have been *ex parte* contact with a plaintiff's treating physician, but the contact must have "materially prejudiced plaintiff's case." See Rowe, 100 Wn. App. at 280 ("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 . . . The problem, however, was [that g]iving Mr. Rowe the option of foregoing his doctors' essential evidence is not a remedy. This is grounds for a new trial by itself"). Thus, the abuse of discretion standard of review applies to the trial court's denial of plaintiff's motion for a new trial, and he must show not only that there was *ex parte* contact prohibited by Loudon but also that the contact materially prejudiced his case and denied him a fair trial.

B. Defense Counsel Did Not Do Something Prohibited By *Loudon v. Mhyre*.

1. There is no prohibition against "contact" between defense counsel and the attorney for a plaintiff's treating physician.

There was no "Loudon violation" here for a simple reason: defense counsel conducted no *ex parte* interview of Dr. Johansen. Loudon did not involve, and the Supreme Court in that case did not announce any rule prohibiting, "contact" between defense counsel and the lawyer for a

plaintiff's treating physician. The decision prohibited only defense counsel's *ex parte* interviews of a plaintiff's treating physicians. To the extent Loudon would imply other prohibitions, such prohibitions would be prohibitions of be actions by defense counsel that are designed to, or that actually do, accomplish the same thing that *ex parte* interviews had previously been routinely conducted to obtain, *i.e.*, information that the physician has about the patient/claimant. Here, defense counsel did not conduct any *ex parte* interview of Dr. Johansen, or do anything else *ex parte* that was designed to, or that did, elicit information from him about his patient, Ms. Smith. Neither Loudon, nor any other authority cited by plaintiff prohibits what occurred here -- communication between lawyers acting as lawyers.

2. There is no reason to create a prohibition against the type of "contact" that occurred here between defense counsel and the lawyer for Dr. Johansen.

When information is communicated to a treating physician through his or her personal lawyer, the concerns that prompted the Loudon court to prohibit defense counsel from conducting *ex parte* interviews of a plaintiff's treating physicians are not implicated. The Loudon rule was adopted not because the Supreme Court considered contact between

defense lawyers and treating physicians to be evil or even unethical,¹⁶ but rather because of a policy determination that it is unfair to patient and physician to ask the physician in an informal setting to figure out what medical information about the plaintiff is or is not relevant to the litigation, and may or may not be disclosed, even though the plaintiff by filing suit waived the physician-patient privilege as to medical information relevant to the litigation. Loudon, 110 Wn.2d at 677-79. At no time was Dr. Johansen put in such a position.

The Loudon court's stated primary concern was that physicians are not lawyers and, in an *ex parte* interview with defense counsel, might disclose privileged medical information about the plaintiff that should not be disclosed because it is irrelevant to the lawsuit. As the Loudon court explained:

The danger of an *ex parte* interview is that it may result in disclosure of *irrelevant*, privileged medical information. The harm from disclosure of this confidential information cannot, as defendants argue, be fully remedied by subsequent court sanctions. [Emphasis supplied.]

¹⁶ As the Supreme Court acknowledged in Loudon, *ex parte* interviews are not unethical, the Washington State Bar Association having advised its members that "[w]here no patient privilege exists or where the privilege has been declared waived by Court Order or by the express written consent of the patient, a lawyer may interview a physician in the same manner as any other witness." Loudon, 110 Wn.2d at 681 n.4 (quoting WSBA Formal Ethics Op. 180 (1985)). The court also acknowledged that "[a] number of courts have approved *ex parte* contact due to its advantages over depositions and the claimed unfair advantage given plaintiffs." 110 Wn.2d at 677 (citing decisions from a U.S. District Court and appellate courts in Alaska, Delaware, Missouri and New Jersey).

Loudon, 110 Wn.2d at 678.¹⁷ The Loudon court found persuasive an Iowa decision that expressly disclaimed mistrust of lawyers:

We do not mean to question the integrity of doctors and lawyers or to suggest that we must control discovery in order to assure their ethical conduct. We are concerned . . . with the difficulty of determining whether a particular piece of information is relevant to the claim being litigated. Placing the burden of determining relevancy on an attorney, who does not know the nature of the confidential disclosure about to be elicited, is risky. *Asking the physician, untrained in the law, to assume this burden* is a greater gamble and *is unfair to the physician*. We believe this determination is better made in a setting in which counsel for each party is present and the court is available to settle disputes. [Emphases supplied.]

Loudon, 110 Wn.2d at 678 (quoting Roosevelt Hotel Ltd. Partnership v. Sweeney, 394 N.W.2d 353, 357 (Iowa 1986)). A secondary concern behind the Loudon prohibition against *ex parte* interviews is protection of the physician:

In addition, a physician has an interest in avoiding inadvertent wrongful disclosures during ex parte interviews. We recognize, without deciding, that a cause of action may lie against a physician for unauthorized disclosure of privileged information . . . The participation

¹⁷ As the court in Rowe, 100 Wn. App. at 278-79, summarized the Loudon rule:

The primary concern is potentially prejudicial but irrelevant disclosures. The defendant's lawyer cannot make the relevance determination because he or she does not know the nature of the confidential disclosure in advance. The doctor is not a lawyer. The plaintiff's lawyer needs to be present. [Loudon, 110 Wn.2d] at 678. Moreover, the threat that a doctor might talk with a legal adversary outside the presence of plaintiff's counsel could have a chilling effect on the injured person's willingness to continue with treatment and be forthright with the physician. Id. at 679. [Emphasis supplied.]

of plaintiff's counsel to prevent improper questioning or inadvertent disclosures enhances the accomplishment of the purpose of the physician-patient privilege by also providing protection to the physician. [Emphasis supplied.]

Loudon, 110 Wn.2d at 680 (citations omitted).¹⁸

Thus, contrary to the lesson plaintiff seeks to extract or extrapolate from Loudon, that decision does not reflect judicial concern about "contact" *per se*. The decision reflects concern about protecting both patient and treating physician against the physician's disclosure of a patient's medical information that is irrelevant to the patient's personal injury claim.¹⁹ No such disclosure occurred here, nor was any such disclosure sought. Plaintiff's counsel has never identified any medical information about Ms. Smith, much less medical information irrelevant to this case, that defense counsel either tried or was able to get Dr. Johansen to disclose outside of his deposition or at trial. All that happened was that information about what had been filed or said in open court at a public trial was conveyed, through his lawyer, to a treating physician, Dr.

¹⁸ The Loudon case did not involve or prohibit lawyer-to-lawyer communications like those that occurred in this case, where the treating physician, as Dr. Johansen did, had his or her own lawyer, who *is* "trained in the law of physician liability," to watch out for the physician's interests and to protect the physician from making inappropriate disclosures of patient health care information.

¹⁹ To the extent the Loudon court expressed another secondary concern, *i.e.*, that "[t]he mere threat that a physician might engage in private interviews with defense counsel would, for some [patients], have a chilling effect on the physician-patient relationship and hinder further treatment." Loudon, 110 Wn.2d at 679, the court did not explain why that concern was pertinent to the case before it, which, like this case, was one in which the patient had died before suit was filed.

Johansen, who was scheduled to testify as a witness in that trial. No one asked Dr. Johansen to disclose medical information about his late patient, Ms. Smith, behind the scenes. Nor was Dr. Johansen tricked, or in danger of being tricked, into disclosing such information behind the scenes. Dr. Johansen disclosure of information about Ms. Smith occurred only in (a) his deposition and (b) his testimony at trial.

Plaintiff's reliance on Rowe, App. Br. 26-27, 38-39, likewise is misplaced. The issue in Rowe was whether Loudon applied in a lawsuit alleging wrongful discharge in retaliation for filing an industrial insurance claim. Rowe, 100 Wn. App. at 278-80. In Rowe, defense counsel sought to justify its *ex parte* communications with plaintiff's treating physicians on the ground that an industrial insurance claim figured in the action and the Supreme Court, in Holbrook v. Weyerhaeuser Co., 118 Wn.2d 306, 313, 822 P.2d 271 (1992), had held that Loudon did not apply, and *ex parte* interviews of treating physicians were permissible, in the context of industrial insurance claims. Id. at 279-80. The Rowe court disagreed and held that, because the Rowe lawsuit was not an industrial insurance claim governed by RCW Title 51, but rather a common law tort action for retaliation, Loudon did apply and defense counsel's *ex parte* communications with the plaintiff's treating physicians were improper. Id. Because the trial court had concluded that the *ex parte*

communications had prejudiced the plaintiff,²⁰ the trial court's grant of a new trial was affirmed. Id. at 280.

What happened in Rowe and Loudon did not happen here. Defense counsel did not seek, solicit, or receive information of any kind from Dr. Johansen or Ms. Ringer concerning Ms. Smith, except through Dr. Johansen's pretrial deposition, CP 354-451, and then at trial. Defense counsel sent Ms. Ringer a copy of plaintiff's trial brief, a public document, and a transcript of Dr. Cossman's public trial testimony. There was no order excluding witnesses who had not yet testified from the courtroom or prohibiting either side's lawyers from informing upcoming witnesses about, or showing them, testimony already given by other trial witnesses.

Defense counsel also sent Ms. Ringer a copy of a two-page outline of defense counsel's planned direct examination of Dr. Johansen, but did not seek or receive any input about, or modification of that outline from Dr. Johansen or Ms. Ringer. Nor did defense counsel seek or obtain from Ms. Ringer any indication as to how Dr. Johansen would answer any of the questions or address any of the subjects on the outline.

²⁰ In Rowe, there was concern "not only about prejudicial information inadvertently disclosed to opposing counsel, but also about what counsel might have communicated to the doctors that colored their recollection of the events and influenced their deposition testimony." Rowe, 100 Wn. App. at 279-80. Neither of those concerns are borne out in this case.

Plaintiff made no attempt below, and makes no attempt in his opening brief, to show any correlation between the outline and the testimony that defense counsel elicited from Dr. Johansen at trial. And, at the end of the day, the record discloses that, besides telling the jury what he had done and why, and what he might have done differently had he been given different information at the time of his involvement in Ms. Smith's care, Dr. Johansen was limited by the trial court to stating opinions he had formed in his role as treating vascular surgeon and/or based on his personal experience practicing vascular surgery at Swedish. Moreover, his trial testimony was wholly consistent with his deposition testimony. Plaintiff has no basis for complaining either that Dr. Johansen's trial testimony came as any surprise or that the information that defense counsel provided to Dr. Johansen's counsel and that Dr. Johansen's counsel shared with him, colored his recollection, influenced his trial testimony, or otherwise so materially prejudiced his case as to deny him a fair trial.

Judge Craighead's stated reasons for denying plaintiff's motions for mistrial and new trial were not untenable and her denials of those motions were not an abuse of discretion. Kimball, 89 Wn. App. at 178; Aluminum Co., 140 Wn.2d at 537; Ford, 61 Wn. App. at 898-99.

C. The “Contact” that Defense Counsel Had With Dr. Johansen’s Lawyer Did Not “Taint” Dr. Johansen’s Trial Testimony.

Plaintiff argues on appeal, *App. Br. at 38*, that the “contact” of which he accuses defense counsel “tainted” Dr. Johansen’s trial testimony. Yet, plaintiff has identified nothing that Dr. Johansen said as a trial witness for the defense that was different from or went beyond his deposition testimony and chart entries, or that he would not plausibly have said had he not received a copy of plaintiff’s trial brief or the transcript of Dr. Cossman’s trial testimony.

Quoting from the argument plaintiff’s counsel made at the hearing on the motion for new trial, 12/19 RP 18, 20-21, plaintiff asserts, *App. Br. at 36-38*, that Dr. Johansen, as a trial witness was “sliding in [unspecified] comments and information that go to standard of care and causation.” As Judge Craighead found, however, CP 321-22:

Plaintiff’s counsel was already aware of facts relevant to potential bias such [as] Dr. Johansen’s working relationship with defendant Dr. Schwaegler, his frequent work as a defense expert, his marriage to a medical malpractice defense attorney, his awareness of the issues in malpractice cases, and that he likely knew about the facts leading up to his care of Ms. Smith because he could have been a defendant in this case given his role in the care of Ms. Smith. However, plaintiff made the strategic choice not to pursue a hostile witness cross examination of Dr. Johansen. Thus, the concern raised by plaintiff does not justify a new trial, in view of all the evidence.

Moreover, plaintiff's counsel succeeded in limiting Dr. Johansen's opinion testimony to subjects about which he had formed opinions independently of the lawsuit, *i.e.*, that warm skin and good pulses indicate adequate perfusion; and that the Swedish ICU nurses are competent and trustworthy in checking pulses.

The specific complaints that plaintiff's counsel made at the hearing on the motion for new trial, and which he quotes, but does not further explain in his opening brief, *App. Br. at 36-38*, are without merit.

First, plaintiff complains that Dr. Johansen "talk[ed] about the following morning, . . . about a fact that occurred well before he got involved . . . , whether [the extremity] was warm or not." 12/19 RP 18, referring to 11/14 RP 34; *App. Br. at 36*. The references to the following morning, and the foot being cool or warm were in the questions, not Dr. Johansen's answers, 11/14 RP 34, and, if Dr. Johansen had not already known, he would have learned from plaintiff's counsel's questioning at his deposition that Ms. Smith's foot had become cool on January 1, before he was called in. CP 371-72.²¹

Second, plaintiff complains about Dr. Johansen's reference at trial to a 75% blockage not creating an abnormal blood supply, and with

²¹ And, as Judge Craighead noted at the hearing, 12/19 RP 19-20, Dr. Johansen may well have been moved to review the patient records out of concern that the care he provided would be questioned and/or that he would be among those sued.

coolness and diminished pulses developing as the blockage exceeds 75%, which he claimed Dr. Johansen “came up with” from Dr. Cossman. 12/20 RP 19, referring to 11/14 RP 45, *App. Br. at 36*. Nothing in Dr. Johansen’s deposition testimony was contradictory. Dr. Cossman’s testimony was public. Moreover, to the extent Dr. Johansen’s testimony was *corroborative* of Dr. Cossman’s, that hardly prejudiced plaintiff.

Third, plaintiff complains about Dr. Johansen’s trial testimony about absent pulses developing quickly, starting with the foot getting cool. 12/19 RP 19, referring to 11/14 RP 46; *App. Br. at 37*. Dr. Johansen actually testified that the embolism process had begun during the spine surgery but was not significant, in terms of blocking blood supply, until around midnight on January 2 when signs of a problem began, including a cool foot and pulses that could no longer be felt. 11/14 RP 46. That testimony was consistent with Dr. Johansen’s deposition testimony, under questioning by plaintiff’s counsel, that embolization significant enough to cause occlusion had not occurred at any point when the artery had a pulse that was either palpable or Dopplerable, CP 442-43, and that the occlusion occurred between the time of the vascular study on the morning of January 2 and whenever the nurses last detected a pulse, CP 446. And, that Ms. Smith’s foot had become cool on the evening of January 1 was a point that

plaintiff's counsel explored in Dr. Johansen's deposition, not something Dr. Johansen later learned from defense counsel on the sly. CP 371-72.

Fourth, plaintiff complains that Dr. Johansen testified "that the clot does not become significant until there's a cool foot, again referring to an event that takes place before his involvement." 12/19 RP 20, referring to 11/14 RP 47, *App. Br. at 37*. But, plaintiff ignores the fact that prior questions during his deposition and at trial had made reference to the development of a cool foot on January 1, CP 371-72; 11/14 RP 34, as well as the fact that the trial court struck this particular answer, 11/14 RP 47.

Fifth, plaintiff complains about Dr. Johansen's trial testimony that "[i]n somebody who has a pulse you can feel, a palpable pulse in the foot, it would be unanticipated to have inadequate blood supply." 12/19 RP 20, referring to 11/14 RP 61; *App. Br. at 37*. That testimony was given without any objection or motion to strike from plaintiff. 11/14 RP 60-61. It was not inconsistent with Dr. Johansen's deposition testimony. Indeed, Dr. Johansen had testified at deposition under questioning by plaintiff's counsel that embolization significant enough to cause occlusion had not occurred at any point while the artery had a pulse that was either palpable or "at least a diphasic Doppler signal," CP 442-43.

Sixth, plaintiff complains about Dr. Johansen's "no" answer at trial when asked, on cross-examination by plaintiff's counsel, "can increased

compartment pressures cause tissue damage in this case within the calf?” 12/19 RP 20, referring to 11/14 RP 66; *App. Br. at 37*. Dr. Johansen gave no contradictory testimony at his deposition, and plaintiff failed to explain either how defense counsel is responsible for the answer or how the answer was prejudicial to his case. Indeed, the question related to an issue of causation rather than negligence, and the jury did not get past the question of negligence. It relates to the compartment syndrome that Ms. Smith developed after blood flow was restored to her legs and the clinical decision not to perform a fasciotomy immediately after completing the clot-removal surgery on the morning of January 2 that Dr. Johansen (who was not the defendant at trial) had made.

Seventh, plaintiff complains that Dr. Johansen, in response to plaintiff's counsel request that he explain what is meant by monophasic, biphasic, and triphasic Doppler waves, “volunteered” that characteristic Doppler wave descriptions can help one determine whether or not there is a vascular obstruction. 12/19 RP 20, referring to 11/14 RP 73-74; *App. Br. at 37-38*. Plaintiff knew from Dr. Johansen's deposition that he places great confidence in Doppler devices to confirm the presence of pulses. CP 371-373, 432. The testimony was not inconsistent with deposition testimony, and all it did was provide a vivid description to the jury, *at the*

invitation of plaintiff's counsel, of what a practitioner hears when using a Doppler that confers a sense of confidence.²²

Eighth, plaintiff complains about Dr. Johansen's trial testimony that Swedish ICU nurses' pulse findings are trustworthy. 12/19 RP 21, referring to 11/14 RP 86-87; *App. Br. at 38*. That testimony, however, was based on his personal experience.

Finally, plaintiff complains about Dr. Johansen's testimony "of this being unpreventable." 12/19 RP 21, referring to 11/14 RP 97; *App. Br. at 38*. Dr. Johansen was asked whether the complication that developed postoperatively in Ms. Smith's case "occurred in spite of people doing the right thing," and he answered affirmatively. 11/14 RP 97. Plaintiff's counsel neither objected nor moved to strike the testimony.²³ Moreover, plaintiff's counsel was well aware from Dr. Johansen's deposition

²² Plaintiff also complains about Dr. Johansen's testimony that an ICU nurse is more likely to know about the differences in Doppler pulse wave sounds than say an orthopedic nurse, 12/19 RP 20, referring to 11/14 RP 74; *App. Br. at 38*, but ignores the fact that it was plaintiff's counsel who asked Dr. Johansen whether a regular registered nurse is trained to appreciate those differences in sound, 11/14 RP 74. To the extent plaintiff complains about redirect with respect to the vena cava tear, see 12/19 RP 20; *App. Br. at 38*, plaintiff's counsel did not object to defense counsel's questions, see 11/14 RP 81-82. And, to the extent plaintiff complains about defense counsel's questions as to what an ABI would have shown if done on January 1, plaintiff ignores the fact that his counsel's objections were sustained and Dr. Johansen did not answer those questions. See 11/14 RP 83-84

²³ The question also did not clearly refer to care provided by anyone except Dr. Ting, or to postoperative care that was provided to Ms. Smith before Dr. Johansen became involved on January 2.

testimony that he could not say that earlier intervention would have made a difference. See CP 369-70, 396-99, 439.

Plaintiff failed to show the trial court, and has not shown on appeal, that any aspect of Dr. Johansen's trial testimony was "tainted" by any of the information that defense counsel sent to Dr. Johansen's counsel that Dr. Johansen's counsel then shared with Dr. Johansen.

Plaintiff's contention that Dr. Johansen impermissibly expressed some opinions at trial even though he was presented as a "fact witness" rather than as an expert witness, *App. Br. at 24*, is unavailing, because testimony expressing opinions that a treating physician formed in that role are considered fact witness testimony rather than expert witness testimony. Kimball v. Otis Elevator Co., 89 Wn. App. 169, 175, 947 P.2d 1275 (1997) ("only opinions acquired and developed in anticipation of litigation are expert opinions; professionals who have acquired facts and opinions not in anticipation of litigation, but from some other involvement, are not expert witnesses") (citing Peters v. Ballard, 58 Wn. App. 921, 930, 795 P.2d 1158, rev. denied, 115 Wn.2d 1032 (1990)). The trial court sustained plaintiff's objections and limited Dr. Johansen's opinion testimony to opinions formed independently of the lawsuit, either as a surgeon who long has practiced at Swedish or as a vascular surgeon of considerable experience.

Plaintiff did not lose this case because of Dr. Johansen's trial testimony, much less because of any information defense counsel provided to Dr. Johansen's counsel. The jury believed Dr. Schwaegler's, Nurse Sterner's, Nurse Foster's, Dr. Khalfayan's, Dr. Bennet's and Nurse Hanson's testimony, that established that Ms. Smith had detectable pulses in her feet until the evening of January 1, and accepted the defense experts' testimony that, with pulses present, it was reasonable to infer good perfusion and that the standard of care did not require Dr. Schwaegler to call in a vascular surgeon or order tests to rule out an embolism until he was informed that pulses had been lost late on January 1 –which Dr. Schwaegler promptly did.²⁴

Because the contact defense counsel had with Dr. Johansen's counsel was not misconduct or a violation of Loudon, and because it did not materially prejudice plaintiff's case, see Rowe, 100 Wn. App. at 280; Ford, 61 Wn. App. at 898-99, no new trial is warranted.

²⁴ It may well have been helpful to the defense (a) that one of plaintiff's experts, spinal surgeon Dr. Mark Palumbo, agreed that a pulse indicates perfusion, 11/7 RP 114, and (b) that the only expert for plaintiffs who disputed that point, vascular surgeon Dr. David Cossman, went out of his way to criticize the care provided to Ms. Smith by virtually all of the nurses and doctors who saw her, including Drs. Johansen, Khalfayan, and Ting, and admitted that he is not conversant with the complications of spinal surgery and did not know whether the kinds of symptoms Ms. Smith had before the evening of January 2 can be neurologic in origin.

D. Plaintiff's Attempt to Equate the Contact that Occurred in this Case to Witness Intimidation Is Specious.

Plaintiff tries, *App. Br. at 30-34*, to analogize what occurred here – the providing of information from a public trial to the lawyer for a treating physician who had been deposed, and whose involvement in the case was extensively documented in the patient's chart – to cases from other jurisdictions in which peer pressure was brought to bear to intimidate physicians into declining to testify against other physicians. *App. Br. at 30-34*. No such thing happened here. Nobody tried to intimidate or scare off Dr. Johansen or make him think twice about criticizing another health care provider.

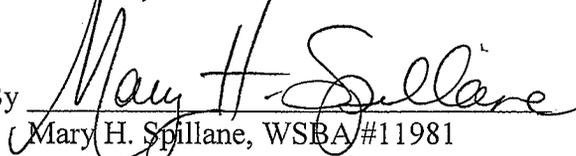
IV. CONCLUSION

For the foregoing reasons, this Court should affirm the trial court's denials of plaintiff's motions for a mistrial and for a new trial, and the judgment entered in defendants' favor on the jury's verdict finding no negligence.

RESPECTFULLY SUBMITTED this 8th day of September, 2008.

WILLIAMS, KASTNER & GIBBS PLLC

By



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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 8th day of September, 2008, I caused a true and correct copy of the foregoing document, "BRIEF OF RESPONDENTS," to be delivered by U.S. mail, postage prepaid, to the following counsel of record:

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Carrie A. Custer

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