

NO. 107350-5

87811-1

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**COURT OF APPEALS FOR DIVISION I  
STATE OF WASHINGTON**

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AOLANI E. GLOVER, a single individual,

Respondent,

v.

THE STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; AND LULU M. GIZAW, PA-C,

Petitioners

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**MOTION FOR DISCRETIONARY REVIEW**

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**A. IDENTITY OF PETITIONERS**

The State of Washington d/b/a Harborview Medical Center, asks this Court to accept review of the decision set forth in Part B of this motion. Inasmuch as Harborview Medical Center is, for these purposes, a part of the University of Washington,<sup>1</sup> Petitioner will be referenced as “the University” in this motion.

**B. DECISION**

In this medical negligence action, the University requests review of a superior court order, which has been certified for RAP 2.3(b)(4) review, that prohibits University lawyers and risk managers from having “ex parte” contact with plaintiff’s treating physicians who are University employees or agents and who practice at University of Washington Medical Center (“UWMC”). This order is reproduced in the Appendix at A102-03.<sup>2</sup> The certification is A104-05.

This Court recently granted discretionary review in another case presenting the same issue, *Youngs v. PeaceHealth*, No. 67013-1-I, review granted May 26, 2011, where the trial court declined to issue a similar order. This case presents the issue under different circumstances,

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<sup>1</sup> See *Kleyer v. Harborview*, 76 Wn. App. 542, 543 n.1 (1995).

<sup>2</sup> The documents relevant to this petition are contained in the Appendix in compliance with RAP 17.3(8). The Appendix is numbered sequentially and cited as A-\_\_.

described below, which the Court should consider in formulating a decision.

**C. ISSUE PRESENTED FOR REVIEW**

Does *Loudon v. Mhyre*, 110 Wn.2d 675, 756 P.2d 138 (1988) prohibit counsel for a health organization, or its risk managers, from communicating with employees of the organization who are not personally accused of negligence regarding a medical malpractice suit against the organization where:

A. the trial court's order effectively requires the organization to waive its attorney-client and work product privileges in order to obtain relevant information from its own employees; and

B. the trial court's order prevents counsel for the organization and its risk managers from consulting with the organization's managing agents regarding defense of the matter?

**D. STATEMENT OF THE CASE**

**1. Facts**

On or about April 2, 2008, plaintiff Aolani Glover, then 28 years old, suffered a spontaneous dissection of her right coronary artery ("RCA").<sup>3</sup> The dissection was discovered during a diagnostic cardiac

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<sup>3</sup> Coronary arteries are comprised of three layers: the intima, the media, and the adventitia. Dissection of the coronary artery results in separation of the layers of the arterial wall, creating a false lumen or channel. The separation may be between the

catheterization procedure carried out at Harborview on the night of April 2, 2008. Following extensive but futile efforts to repair the dissection by placement of stents, and multiple shocks to restore normal rhythm following a ventricular fibrillation, a temporary pacemaker and an intra-aortic balloon pump were placed in order to maintain heart function and circulation, and she was transferred to the Intensive Care Unit. A29-30.

Three days later, she was transferred to UWMC, where she received further treatment including temporary placement of a ventricular assist device. She was discharged from UWMC to home on April 22, 2008, but returned on May 6, 2008 with complaints of renewed chest pain. On this occasion, she was found to have spontaneously dissected a major branch of her left anterior descending coronary artery and the entirety of her left circumflex coronary artery. The interruption of blood supply resulting from these additional dissections caused extensive damage to the left side of plaintiff's heart. Consequently, she required a heart transplant, which she received on July 27, 2008. A30.

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intima and the media, or between the media and the adventitia. Hemorrhage into the false lumen can impinge upon the true lumen of the coronary artery, impairing blood flow and causing myocardial ischemia, infarction, or sudden death. Spontaneous dissection is very rare. The cause for spontaneous dissection is unknown in this case, although it most often occurs in young women who are taking oral contraceptives, or during and shortly after pregnancy. See [http://en.wikipedia.org/wiki/Coronary\\_artery\\_dissection](http://en.wikipedia.org/wiki/Coronary_artery_dissection).

Ms. Glover's continuing care at UWMC, as well at University-affiliated clinics, has involved dozens of University physicians and other providers. Some have had extensive involvement. Others have been involved only briefly, sometimes without ever meeting the patient, such as the cardiologists and radiologists who interpreted studies, the members of the transplant committee who reviewed Ms. Glover's status, or the pathologists who examined tissue samples. *Id.*

## **2. Claims**

Ms. Glover alleges that the staff at Harborview was too slow to recognize that she was suffering a cardiac event, thereby delaying her transfer to the cardiac catheterization laboratory for diagnosis and treatment. Ms. Glover theorizes that she could have avoided extensive damage to the right side of her heart if she had undergone catheterization and been successfully stented at an earlier point. She further theorizes that, with less damage to the right ventricle, she would have been a candidate for coronary artery by-pass grafting or some other intervention that would have prevented subsequent dissections and the resultant damage to her left ventricle. A30-31.

Initially, Ms. Glover's counsel indicated that her negligence claims were confined to those providers "who had contact with Aolani Glover prior to her transfer to the coronary catheterization laboratory" at

Harborview. On this basis, her counsel asserted that *Loudon*, as well as *Smith v. Orthopedics Int'l*, 170 Wn.2d 659, 244 P.3d 939 (2010), preclude defense counsel from contacting any treating physicians (and presumably other health care providers), other than those involved in her care in the Emergency Department, except in a deposition where he is present. Subsequently, without expressly indicating that the scope of her claim has expanded, plaintiff's counsel indicated that he did not object to defense counsel's contact with any of the HMC Emergency or Cardiology staff involved in Ms. Glover's care, so long as those individuals were not shown any records of her subsequent care. A31-32, 37-43. And, again without explanation for the changed position, the order that plaintiff proposed and the trial court entered prohibits defense counsel from contacting any physicians who cared for her at UWMC, but does not restrict contacts with physicians who saw her at Harborview.

### **3. Defendant's Motion for Protective Order**

Because these purported restrictions are prejudicial and unworkable, the University brought a motion under CR 26(c), seeking a ruling from the superior court regarding the ability of its counsel to consult with University physicians involved in the case who did not treat Ms. Glover while she was hospitalized at Harborview. A16-28.

Through its School of Medicine, the University operates an integrated health system that includes hospitals and outpatient clinics and employs physicians who staff those facilities, including Harborview and UWMC. The University's "UW Medicine" system is fully integrated, such that when Ms. Glover needed a ventricular assist device, a service available at UWMC but not at Harborview, her need was accommodated by transfer to the former facility. A80-81. At all times, all of her medical records—whether generated at Harborview or UWMC—were (and are) available to doctors at both facilities. *Id.*

The University also showed that many University physicians, including the key individuals for purposes of this case, practice at both hospitals and did so at the time of the events in question. A81. In fact, at least one of the physicians who cared for Ms. Glover at Harborview on the night of April 2, 2008 subsequently cared for her at UWMC. *Id.* These physicians are all employees of the University and ultimately responsible to the Dean of the School of Medicine, who also serves as the CEO of UW Medicine.

The University further showed that the roster of "non-targeted" treating physicians includes individuals who hold management positions within UW Medicine or who have specialized expertise that the University would ordinarily and necessarily draw upon in evaluating a case of this

nature; e.g., Dr. Larry Dean, Director of the UW Regional Heart Center; Dr. Daniel Fishbein, Medical Director of the UW's Heart Failure and Heart Transplant Programs, Dr. Edward Verrier, former chief of the UW's Division of Cardiothoracic Surgery, and Dr. Charles E. Murry, Director of the University's Center for Cardiovascular Biology. A32-33.

Dr. Fishbein, who is currently one of plaintiff's attending cardiologists, is a national expert in the evaluation and treatment of end-stage heart disease and one of the people at the University best-positioned to comment knowledgeably on the cause and probable timing of plaintiff's dissections. Dr. Dean, who performed catheterization procedures on Ms. Glover in April and May 2008, is a leading interventional cardiologist and a person uniquely positioned to comment about the ability to successfully stent the dissections experienced by Ms. Glover. Dr. Verrier, who participated as a member of the committee that evaluated Ms. Glover's suitability for transplant, is one of the nation's preeminent cardiac surgeons with special expertise in coronary artery bypass and transplant procedures. Dr. Murry is a cardiovascular pathologist who is an expert on the mechanism of myocardial infarction. He examined Ms. Glover's native heart after her transplant operation. *Id.*

Plaintiff's response was to say that an identifiable boundary exists between care provided at Harborview and care provided at UWMC,

arguing that her care at UWMC should be considered as if it had “provided at Swedish Medical Center.” A61.

#### **4. Superior Court Ruling and Certification**

After hearing argument, the superior court denied defendants’ motion, and entered an order directing that

Defense Counsel and the defendant’s risk manager are prohibited from *ex parte* contact, directly or indirectly, with any of Plaintiff Aolani Glover’s treating physicians at University of Washington Medical Center.

A102-03.

The trial court also granted the parties’ joint motion for certification of the order for discretionary review to this Court. A-104-105. The University timely filed a notice of discretionary review. A-106-110.

### **E. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED**

#### **1. Summary**

Two superior court judges, while reaching differing results on the issue, have agreed that the question presented warrants discretionary review under RAP 2.3(b)(4). This Court should accept the certification in this case and grant review because the issue presented is one of first impression, important, recurring, and difficult to address on appeal from a final judgment.

More specifically, discretionary review is warranted because extension of *Loudon* is not justified under the rationale of that decision and to do so interferes with the attorney-client relationship between the University and its counsel in several material ways. First, the order forbids defense counsel and the University's risk management personnel from obtaining relevant information on a privileged basis from the University's own employees. Under the attorney-client privilege as applied in *Sherman v. State*, 128 Wn.2d 164, 190, 904 P.2d 355 (1995) and *Wright v. Group Health*, 103 Wn.2d 192, 194, 691 P.2d 564 (1984), the University's counsel otherwise would be permitted to obtain information on a confidential basis from all University employees with relevant knowledge of a matter, regardless of whether those employees are managing agents of the University or would be considered "clients."<sup>4</sup> But, under the trial court's order, the price of obtaining that information is the presence of plaintiff's counsel and, consequently, the waiver of attorney-client and work product privileges.

Second, inasmuch as the rule in *Loudon* is based on judicial assessment of appropriate public policy necessary to protect the patient-physician privilege, extension of *Loudon* is unwarranted in this case because both state and federal statutes already permit healthcare providers

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<sup>4</sup> See also RPC 1.13, Comment 2 (West 2011) (if lawyer for organization investigates a claim, lawyer's interviews with employees or other constituents are privileged).

to disclose confidential healthcare information to their lawyers, without the patient's knowledge or consent, for the purpose of obtaining legal advice regarding a liability claim. See RCW 70.02.050(1)(b) (Uniform Health Care Information Act); 45 C.F.R. § 164.506(a) and (c) (HIPAA regulations). Accordingly, disclosure to the University's lawyers does not violate public policy.

Third, even if *Loudon* has some application in these circumstances, the trial court's blanket order fails to appropriately balance the interests of the parties. In this case, the roster of physicians that defense counsel are prohibited from contacting includes several who hold key management positions within UW Medicine and who normally would be expected to contribute their knowledge, expertise and judgment in formulating the University's position in this highly unusual case. Under the trial court's order, these physicians, even those with minimal involvement, cannot carry out their normal roles relative to liability claims against the University.

An appellate ruling addressing these issues is necessary in order to guide the conduct of the parties in litigation such as this to eliminate uncertainty resulting from conflicting trial court decisions. And, because this case presents circumstances different from those presented in *Youngs*,

in which this Court has already accepted review, it is appropriate to accept this case and consolidate it with *Youngs*.

**2. Review is Warranted under RAP 2.3(b)(4)**

RAP 2.3(b)(4), provides in pertinent part that this Court may accept discretionary review where “the superior court has certified ... that the order involves a controlling question of law as to which there is substantial ground for a difference of opinion and that immediate review of the order may materially advance the ultimate termination of the litigation.” These criteria, which are borrowed from 28 U.S.C. § 1292(b),<sup>5</sup> are easily met in this case.

No Washington appellate court has decided whether *Loudon* applies when the defendant is an integrated healthcare organization that employs both targeted and non-targeted physicians, or has considered whether to prohibit confidential communications between the organization’s counsel and its employed physicians, specifically including physicians holding management positions within the organization. A “controlling question of law” is not merely one that will decide the outcome of the litigation; rather, a question is “controlling” if resolution of the issue on appeal could materially affect the outcome of the litigation. *In re Cement Antitrust Litigation*, 673 F.3d 1020, 1026 (9th Cir. 1982).

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<sup>5</sup> 2A Karl B. Tegland, *Washington Practice: Rules Practice*, at 161 (6<sup>th</sup> ed. 2004).

Here, the trial court's order interferes with the relationship between the University and its counsel in ways that materially limit the normal functioning of defense counsel and risk management personnel.

There is obvious ground for difference of opinion on the question, as evidenced not only by the differing outcomes in this case and *Youngs*, but also by out-of-state cases reaching results opposite from that of the trial court here.<sup>6</sup> And, finally, an interlocutory appellate ruling on the question will serve to advance the ultimate resolution of the case by eliminating the uncertainty and dysfunction engendered by the trial court's ruling.

**a. The policy considerations underlying *Loudon* are inapplicable in this context.**

*Loudon*'s prohibition on contact between defense counsel and non-party treating physicians is based on an "underlying ... concern for protecting the patient-physician privilege." *Smith*, 170 Wn.2d at 665. *Loudon* identified four specific concerns in this regard. See *Holbrook v. Weyerhaeuser Co.*, 118 Wn.2d 306, 822 P.2d 271 (1992) (discussing bases

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<sup>6</sup> See, e.g., *Estate of Stephens ex rel. Clark v. Galen Health Care Inc.*, 911 So. 2d 277, 283 (Fla. 2d Dist. Ct. App. 2005) (patient-physician privilege does apply to communications between counsel for hospital and employed non-party physicians); *Burger v. Lutheran General Hosp.*, 198 Ill. 2d 21, 52, 759 N.E. 2d 533 (2001) (patient information within knowledge of staff physicians is property and responsibility of hospital); *In re Med. Malpractice Cases Pending in Law Div.*, 337 Ill. App. 3d 1016, 1026, 787 N.E.2d 237, 245 (Ill. App. Ct. 2003) (patient's right of privacy did not prevent hospital counsel from consulting with non-party treating physicians on staff of hospital).

for *Loudon*). The first and primary concern was that the waiver of privilege resulting from commencement of a personal injury suit extends only to information that is relevant and discoverable under CR 26 and that, without the presence of plaintiff's counsel, a nonparty treating physician might disclose irrelevant and, therefore, privileged information. *Loudon*, 110 Wn.2d at 677-78; *see also Rowe v. Vaagen Bros. Lumber, Inc.*, 100 Wn. App. 268, 278, 996 P.2d 1103 (2000) ("The primary concern is potentially prejudicial but irrelevant disclosures").

Second, *Loudon* reflected a concern that non-party physicians may not understand the appropriate boundaries of the privilege waiver in personal injury cases, and cannot rely on defense counsel to advise them on that subject. *Loudon*, at 677-78. Third, the Court noted that, "for some," there could be a chilling effect on the patient-physician relationship if direct contact with their doctors was permitted. *Id.* at 679; *see also Rowe* at 278 ("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"). In the same vein, *Smith* indicated that the "risk that a nonparty treating physician testifying as a fact witness might assume the role of a nonretained expert for the defense ... may result in chilling communications between patients and their physicians about privileged medical information." *Smith* 170 Wn.2d at 669. Finally, *Loudon* indicated that pre-trial interviews might lead to situations where defense counsel was compelled to testify as impeachment witnesses

concerning their communications with non-party physicians. 110 Wn.2d. at 680.

None of these considerations is present here. First, with regard to the preservation of patient-physician privilege, healthcare providers have always been free to disclose privileged healthcare information to their lawyers for the purpose of obtaining legal advice.<sup>7</sup> Consistently, the Washington Uniform Health Care Information Act, Ch. 70.02 RCW,<sup>8</sup> and the Health Care Insurance Portability and Accountability Act, P.L. 104-191 (“HIPAA”),<sup>9</sup> allow disclosure of a patient’s confidential health care

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<sup>7</sup> See, e.g., *DeNeui v. Wellman*, 2008 WL 2330953 (D. S. Dakota 2008) (non-party treating physician entitled to disclose privileged information to counsel who was appointed by same insurer that provided coverage for the defendant).

<sup>8</sup> RCW 70.02.050(1)(b) provides:

1) A health care provider or health care facility may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

...  
(b) To any other person who requires health care information for ... administrative, legal, financial, actuarial services to, or other health care operations for or on behalf of the health care provider or health care facility.

<sup>9</sup> HIPAA permits the use and disclosure of protected health information without a patient’s consent for “treatment, payment and health care operations.” 45 C.F.R. § 164.506(a). This so-called “routine use” exception refers to a wide range of management functions for covered entities, including quality assessment, practitioner evaluation, and auditing services. See *Citizens for Health v. Leavitt*, 428 F.3d 167, 174 (3d Cir. 2005). The federal Department of Health and Human Services has issued official guidance expressly permitting disclosures to legal counsel. See U.S. Dept. of Health & Hum. Services, Health Information Privacy, Frequently Asked Questions (the covered entity will share protected health information for litigation purposes with its lawyer, who is either a workforce member or a business associate). In these cases, the Privacy Rule permits a covered entity to reasonably rely on the representations of a lawyer who is a business associate or workforce member that the information requested is the minimum necessary for the stated purpose. See 45 CFR 164.514(d)(3)(iii)(C.) available at <http://www.hhs.gov/ocr/privacy/faq/permitted/judicial/705.html>.

information without the patient's authorization to any person who requires that information to provide legal services to a health care provider or facility. Accordingly, there is no privilege preventing employees of a health care organization from disclosing confidential information to the organization's lawyers for the purpose of allowing the lawyers to advise the organization. *See, e.g., Manor Care of Dunedin, Inc. v. Keiser*, 611 So.2d 1305 (Fla. 2d Dist. Ct. App. 1992) (statutory exception to privacy protections for healthcare information, allowing defendants to access such information, also permitted ex parte interviews of employees and former employees).

Second, even if there is some potentially irrelevant privileged information within the possession of non-targeted University providers, the authority to disclose that information to counsel does not mean that counsel are free to use protected information for unauthorized purposes. To the contrary, the institution, its staff, and its outside counsel are all obligated under federal law to maintain appropriate confidentiality.<sup>10</sup> And, unlike the situation in *Loudon* where defense counsel owed no obligation to the non-party physicians, counsel for a health care

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<sup>10</sup> *See* 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ (“the lawyer who is a workforce member of the covered entity must make reasonable efforts to limit the protected health information disclosed to the minimum necessary for the purpose of the disclosure. Similarly, a lawyer who is a business associate [outside counsel] must apply the minimum necessary standard to its disclosures, as the business associate contract may not authorize the business associate to further use or disclose protected health information in a manner that would violate the HIPAA Privacy Rule if done by the covered entity”).

organization have an obligation to appropriately advise its providers regarding the appropriate protection of privileged information.<sup>11</sup>

With respect to the third reason for the *Loudon* rule—the potential for divided loyalty—the fact that a patient has sued a physician’s employer and colleagues creates that potential independently. And, given the limitations on patient-physician privilege and privacy of medical records previously discussed, a patient who has sued a health care organization has no legitimate expectation that the organization will not access information within its possession that is necessary to assess its liability. *See Burger v. Lutheran General Hosp.*, 198 Ill. 2d 21, 52, 759 N.E. 2d 533 (2001) (where patient seeks care in an integrated health care system, any legitimate expectation of privacy is limited to the institution, rather than any individual provider).

Further, with respect to the concern that treating physicians may become defense experts, the calculus is different when the treating physician’s role within the defendant-organization already includes consultation with the organization’s lawyers or risk managers. In these circumstances, there is no risk that contact with the organization’s lawyers will change the physician’s role. Finally, there is also no legitimate prospect that defense counsel’s contact with the client’s employees will require counsel to testify, since all of those communications are

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<sup>11</sup> *See* 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ (“the Privacy Rule permits a covered entity to reasonably rely on the representations of a lawyer who is a business associate or workforce member that the information requested is the minimum necessary for the stated purpose”).

privileged. Accordingly, none of the *Loudon/Smith* factors apply in this context.

**b. This case presents additional considerations which militate against extension of *Loudon*.**

The court's consideration of public policy in *Loudon* and *Smith* did not include the negative consequences of prohibiting counsel for an organization from obtaining information on a privileged basis from employees of the organization or providing advice to employees—including managing agents—of the organization. In this regard, it should be considered that some restrictions on communications between civil counsel and client may be unconstitutional.<sup>12</sup>

Here, it is undisputed that the scope of University counsel's engagement includes advice and representation of all of the University's involved health care providers. A36. The purpose for this scope of engagement is to allow counsel to advise both the providers and the University regarding their potential liability which, as shifting scope of the claims in this case illustrates, may change as the case progresses.

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<sup>12</sup> See *Potashnick v. Port City Const. Co.*, 609 F.2d 1101, 1118 (5th Cir. 1980) (order prohibiting counsel for corporation from consulting with president of corporation during breaks and recesses in trial infringed on due process rights); *United States v. Philip Morris Inc.*, 212 F.R.D. 418, 420 (D.D.C. 2002) (“there are clearly constitutional overtones and concerns about any interference with or limitation on the ability of counsel to confer with her witnesses (whether client or not), to strategize about the case (if the witness is the client), and to provide day-to-day commercial advice (if, for example, the witness is a commercial client).”).

Physicians may also need advice regarding their obligations in responding to discovery in the matter. Counsel's engagement anticipates that need.

It is also undisputed that the University physicians who counsel is prohibited from contacting have relevant knowledge that is likely to assist counsel in advising their client. Furthermore, several of the physicians who counsel is prohibited from contacting hold management positions within the University and would normally be expected to consult with counsel with respect to a case of this nature. Some of them have specialized knowledge relevant to issues in the case, which is not readily available from other sources.

In summary, the trial court's order materially interferes with the ability of counsel to investigate and obtain the candid views of University physicians on the matter, to consult with the University's management and in-house experts and, ultimately, to provide an appropriate level of service to their clients.

**c. Interlocutory Review Is Appropriate.**

This issue would be extremely difficult to address on appeal after final judgment because the harm that results from interference with the attorney-client relationship will not necessarily be reflected in the outcome of the trial and cannot be remedied simply by reversal of the judgment.

**F. CONCLUSION**

For the reasons set forth above, the Court should grant discretionary review under RAP 2.3(b)(4).

Respectfully submitted this 22 day of July, 2011

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**CERTIFICATE OF SERVICE**

I certify under penalty under the laws of the State of Washington that on July 25<sup>th</sup>, 2011, I caused a true and correct copy of the foregoing MOTION FOR DISCRETIONARY REVIEW to be delivered as follows:

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- Federal Express, Next Day

  
Gerri Downs

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PETITIONER'S  
APPENDIX TO  
MOTION FOR  
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Washington State  
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Acknowledged Receipt, this 6<sup>th</sup> day  
of October, 2016, Time: 12:00pm  
In Olympia, Washington.  
Signature: [Signature]  
Print Name: Matt Kernitt  
Assistant Attorney General

SUPERIOR COURT OF THE STATE OF WASHINGTON  
FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,  
  
v:  
STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,  
Defendants.

NO.  
COMPLAINT FOR DAMAGES  
[MEDICAL NEGLIGENCE]

COME NOW THE PLAINTIFF, by and through her attorneys of record, OTOROWSKI  
JOHNSTON MORROW & GOLDEN, PLLC, and for her causes of action against defendants alleges as  
follows:

**I. IDENTIFICATION OF PLAINTIFF**

1.1 Aolani E. Glover. At all times material hereto, the plaintiff, Aolani Glover  
resided in Kent, King County, Washington. At all times material hereto, Aolani Glover received  
health care services from State of Washington d/b/a Harborview Medical Center, and their  
employees, agents and/or ostensible agents, including but not limited to, Lulu M. Gizaw, PA-C,  
and there existed a fiduciary health care provider-patient relationship between Aolani Glover and  
these defendants. Ms. Glover brings her causes of action individually.

**II. IDENTIFICATION OF DEFENDANTS**

2.1 State of Washington d/b/a Harborview Medical Center. At all times material

1 hereto, the State of Washington, pursuant to RCW 28B.20.440 *et seq.*, established and authorized  
2 the University of Washington to operate a hospital and provide medical care and treatment in  
3 Seattle, King County, Washington. At all times material hereto, the defendants, State of  
4 Washington d/b/a Harborview Medical Center, and their employees, agents and/or ostensible  
5 agents, including but not limited to Lulu M. Gizaw, PA-C, provided medical care and treatment to  
6 Aolani E. Glover, which created a fiduciary health care provider-patient relationship between these  
7 defendants and Aolani E. Glover.  
8

9 2.2 Lulu M. Gizaw, PA-C. At all material times hereto, defendant Lulu M. Gizaw,  
10 PA-C, was a duly licensed Physician Assistant authorized to provide medical care and treatment in  
11 the State of Washington. At all times material hereto, Lulu M. Gizaw, PA-C, provided medical  
12 care and treatment to Aolani Glover, and there existed a fiduciary healthcare provider-patient  
13 relationship between Aolani Glover, and defendant, Lulu M. Gizaw, PA-C. At all times material  
14 hereto, defendant Lulu M. Gizaw, PA-C, was an employee, agent and/or ostensible agent of State  
15 of Washington d/b/a Harborview Medical Center.  
16

### 17 III. SATISFACTION OF ADMINISTRATIVE CLAIM REQUIREMENT

18 3.1 In January 2010, RCW 7.70.100 Notices of Intent to Sue were mailed to (1)  
19 State of Washington d/b/a Harborview Medical Center, Risk Management Division, Office of  
20 Financial Management, 300 General Administration Building, PO Box 41027; MS: 41027,  
21 Olympia, WA 98504-1027; (2) Harborview Medical Center c/o Eileen Whalen, Executive  
22 Director, 325 Ninth Avenue, Seattle, WA 98104; and (3) Lulu Gizaw, PA-C, 13213 59<sup>th</sup>  
23 Avenue West, Edmonds, WA 98026. Additionally, in February 2010, a University of  
24 Washington Claim Form was submitted as a courtesy to Office of Risk Management, 22  
25 Gerberding Hall, Box 351276, University of Washington, Seattle, Washington 98195-1276.  
26

COMPLAINT FOR DAMAGES- 2 of 8

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
ATTORNEYS AT LAW  
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BAINBRIDGE ISLAND, WASHINGTON 98110  
(206) 842-1000; (206) 842-0797 FAX

1 On February 25, 2010, attorney for plaintiff, Aolani Glover, received a letter dated February  
2 23, 2010 from Kelly Williams, Liability Claims Manager for State of Washington d/b/a  
3 Harborview Medical Center denying plaintiff's claim.

4 **IV. STATEMENT OF THE FACTS**

5 4.1 On 4/2/08 at approximately 1100, Aolani Glover presented to Harborview  
6 Medical Center Emergency Department. Ms. Glover's chief complaint was chest pain. After a  
7 substantial wait, Aolani Glover was registered at the Emergency Department at 1234.  
8

9 4.2 Aolani Glover was not seen by any emergency medicine personnel for over two  
10 and one-half hours. At approximately 1512, Aolani Glover was seen by an emergency room nurse.

11 4.3 On 4/2/08 at 1614, approximately one hour later, an EKG was obtained on Aolani  
12 Glover, which was abnormal.

13 4.4 On 4/2/08 at 1615, the first set of post triage vital signs was obtained on Aolani  
14 Glover: BP 144/101, P 81, Pain 6-7/10.

15 4.5 On 4/2/08 at approximately 1630, Aolani Glover was seen by Lulu M. Gizaw, PA-  
16 C.  
17

18 4.6 On 4/2/08 at 1640, laboratory tests were ordered for Aolani Glover. At 1643,  
19 Aolani Glover's cardiac laboratory tests revealed abnormally elevated Troponin, CK (total) and  
20 Myoglobin levels: Troponin 5.89 (Ref. Range <0.40), CK total 1,953 (Ref. Range 30-231),  
21 Myoglobin 402 (Ref. Range 14-66).  
22

23 4.8 The laboratory results listed in paragraph 4.7 above indicate that Aolani Glover  
24 experienced or was experiencing a probable myocardial infarction.

25 4.9 Notwithstanding the abnormal EKG and the elevated cardiac blood tests, Aolani  
26 Glover was discharged home by Lulu Gizaw, PA-C.

1           4.10 At no time prior to her discharge was Aolani Glover seen or examined by a  
2 medical doctor while at Harborview Medical Center's Emergency Department. At no time before  
3 discharge did Lulu Gizaw PA-C consult with a supervising or attending physician regarding his  
4 diagnosis, treatment or discharge of Aolani Glover.

5           4.11 On 4/2/08 at approximately 1900, Aolani Glover was found at the pharmacy by  
6 Lulu Gizaw, PA-C and requested to return to the Emergency Department.

7           4.12 On or about 4/2/08, Lulu Gizaw, PA-C, intentionally destroyed his original  
8 handwritten emergency room record regarding Aolani Glover's 4/2/08 Emergency Department  
9 visit.  
10

11           4.13 PA-C Gizaw's intentional destruction of his emergency room charting record  
12 regarding Aolani Glover's 4/2/08 Emergency Department visit constitutes spoliation of evidence.

13           4.14 Eight days after destroying his original Emergency Department handwritten chart  
14 note regarding Aolani Glover's 4/2/08 Harborview Emergency Department visit, Lulu M. Gizaw,  
15 PA-C, wrote the following chart note on 4/10/08:  
16

17           **My hand written ED note, dated 4/2/08, is a replacement of my original**  
18 **hand written ED note regarding this patient's treatment. My original**  
19 **hand written note reflected the fact that the patient was discharged based**  
20 **on my understanding at that time that her troponin level was normal.**  
21 **Based on this understanding I discharged the patient at approximately**  
22 **18:30 pm with prescriptions for Aspirin 81 mg and a cough syrup and**  
23 **instructions to schedule at (sic) a treadmill test. At the time of discharge the**  
**patient looked stable. Upon my realization that the pt's troponin level**  
**was 5.89, within about 5-10 minutes of the approximate time of discharge, I**  
**located the patient in the outpatient pharmacy and (sic) her return to the**  
**ED at about 18:40 pm. (Emphasis added).**

24           4.15 On 4/2/08 at 1925, the first set of vital signs were obtained since Aolani Glover's  
25 return to the ER following discharge.

26           4.16 On 4/2/08 at 1945, Aolani Glover's additional cardiac laboratory tests revealed

1 abnormally elevated Troponin 24.58 and CK (total) 2,037.

2 4.17 On 4/2/08 at approximately 2155, Aolani Glover underwent selective coronary  
3 angiography, angioplasty and stent of the proximal, mid and distal RCA with placement of a  
4 temporary pacemaker and IABP due to acute MI with unresolving chest pain. Dr. Abhishek  
5 Sinha's 4/3/08 Procedure Note indicates in part:  
6

7 Acute spiral dissection, likely spontaneous, of the entire RCA. Despite  
8 multiple angioplasties and stent placements, the RCA continued to have TIMI  
9 0 flow. Patient developed complete heart block during the procedure and  
required a temporary pacemaker. An IABP was also placed for BP  
support...numerous ventricular fibrillations requiring defibrillation...

10 4.18 On 4/2/08 at 2342, Aolani Glover's cardiac laboratory tests revealed abnormally  
11 elevated Troponin 21.88 and CK (total) 1,832.

12 4.19 On 4/5/08, Aolani Glover was transferred to the University of Washington with a  
13 discharge history/diagnoses of cardiogenic shock, right coronary artery dissection, ST elevation  
14 myocardial infarction inferior leads, metabolic acidosis, ARDS, ventilator-associated pneumonia  
15 and acute renal failure.  
16

17 4.20 On 4/5/08, Ranjini M Krishnan, MD, dictated an Admit Note for Aolani Glover  
18 that stated in part: "Given her multiorgan failure with RV infarct and failure, she was transferred  
19 here for a mechanical support and potentially a heart transplant depending on her clinical course."  
20

21 4.21 On 4/5/08, Aolani Glover underwent a cardiac catheterization by Larry Dean,  
22 MD, due to her recent myocardial infarction and congestive heart failure with cardiogenic shock.  
23 During the procedure, Dr. Dean placed a right-sided TandemHeart PVAD.

24 4.22 On 4/22/08, Aolani Glover was discharged home from the University of  
25 Washington.  
26

4.23 On 5/8/08, Aolani Glover was activated on the transplant list UNOS 1B and on  
COMPLAINT FOR DAMAGES- 5 of 8

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1 7/27/08, Aolani Glover underwent a heart transplant.

2 4.24 As a direct and proximate result of the defendants' failure to provide reasonably  
3 prudent medical care, Aolani Glover has been permanently and severely injured.

4 **V. LIABILITY AND NEGLIGENCE**

5 5.1 This is an action for professional negligence and malpractice against the  
6 defendants, and each of them, brought pursuant to the laws of the State of Washington, to include  
7 RCW 7.70 *et seq.*, and ordinary negligence. Plaintiff hereby notifies defendants that she is  
8 pleading all theories of recovery and bases for liability available pursuant to law to include  
9 negligence; lack of informed consent; and negligent failure to monitor, manage, diagnose, consult,  
10 refer, inform and treat and manage Aolani Glover's cardiac condition and otherwise render the  
11 necessary care Aolani Glover required.

12 5.2 As a direct and proximate result of the fiduciary health care provider/patient  
13 relationship that existed between the defendants and Aolani Glover, the defendants owed the duties  
14 to provide reasonably prudent medical care, including but not limited to, properly, adequately and  
15 timely monitoring, managing, diagnosis, referring, consulting, informing and treating Aolani  
16 Glover's cardiac condition; informing her of the material risks to their approach to treatment;  
17 properly obtaining her informed consent to treatment; and otherwise rendering the necessary care  
18 Aolani Glover required.

19 5.3 During the course of their relationship, the defendants breached their duties owed  
20 to Aolani Glover, including, but not limited to, failing to properly, adequately or timely monitor,  
21 manage, diagnose, refer, consult, inform and treat Aolani Glover's cardiac condition; failing to  
22 inform her of the material risks to their approach to treatment; failing to properly obtain her  
23 informed consent to treatment, and otherwise failing to render the necessary care Aolani Glover  
24  
25  
26

1 required.

2 5.4 As a direct and proximate result of the defendants' failure to provide reasonably  
3 prudent medical care, Aolani Glover has been permanently injured and damaged.

4 **VI. DAMAGES**

5 6.1 As a direct and proximate result of the defendants' negligence and breach of  
6 duties, Aolani Glover suffered permanent injury and damage including extensive damage to the  
7 right side of her heart and underwent a heart transplant, which has left her weak and fatigued,  
8 and on multiple drugs to prevent rejection, and she has had recurrent infections. Because of the  
9 heart damage, heart transplant, weakness and fatigue, she is no longer a candidate for the Kent  
10 Police Department. Aolani Glover is currently disabled.

11 6.2 Aolani Glover's damages include past and future medical expenses, loss of future  
12 earning capacity, pain and suffering and loss of enjoyment of life, all in amounts to be proven at  
13 the time of trial as reasonable and proper as determined by the trier of fact.

14 **VII. LIMITED WAIVER OF PHYSICIAN/PATIENT PRIVILEGE**

15 7.1 Pursuant to RCW 5.60.060(4)(b), plaintiff hereby waives the physician/patient  
16 privilege only insofar as necessary to place any and all alleged damages at issue at the time of trial,  
17 as might be required by statute or amended statute or case law interpreting the statutes of the State  
18 of Washington. It should be understood that plaintiff's actions do not constitute a waiver of any of  
19 her constitutional rights and that the defendants are not to contact any treating physicians without  
20 first notifying counsel for the plaintiff so that they might bring the matter to the attention of the  
21 Court and seek appropriate relief, including imposing limitations and restrictions upon any desire  
22 or intent by the defendants to contact past or subsequent treating physicians *ex parte* pursuant to  
23 the rule announced in Loudon v. Mhyre, 110 Wn.2d 675 (1988).  
24  
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COMPLAINT FOR DAMAGES- 7 of 8

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WHEREFORE, plaintiff prays for judgment against the defendants by way of damages in such amounts as might be proven at the time of trial and decided and determined by the trier of fact as reasonable and just under the evidence, as well as for costs and disbursements herein incurred, and for such other relief as the Court may deem just and equitable.

DATED this 27 day of September, 2010.

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

By Thomas R. Golden

Thomas R. Golden, WSBA # 11040  
Attorneys for Plaintiff

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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,

CASE NO. 10-2-35124-8 SEA

Plaintiff,

vs.

**ANSWER OF DEFENDANTS  
STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL  
CENTER AND LULU M. GIZAW,  
PA-C**

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,

Defendant.

COME NOW Defendants the State of Washington d/b/a Harborview Medical Center and Lulu M. Gizaw, PA-C ("defendants"), and answer plaintiff's Complaint for Damages (Medical Negligence) as follows:

**I. IDENTIFICATION OF PLAINTIFF**

1.1 Defendants admit that Aolani Glover received health care services from Harborview Medical Center and Lulu M. Gizaw, PA-C. Defendants lack knowledge sufficient to form a belief as to the truth of the remaining factual allegations in this paragraph and, therefore, deny the same. To the extent that this paragraph alleges legal conclusions, those require no answer.

**II. IDENTIFICATION OF DEFENDANTS**

2.1 Defendants admit that the University of Washington is an agency of the State of Washington, and that the University operates Harborview Medical Center in Seattle, King

ANSWER OF DEFENDANTS STATE OF  
WASHINGTON d/b/a HARBORVIEW MEDICAL  
CENTER AND LULU M. GIZAW, PA-C - Page 1

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

1 County, Washington. Defendants further admit that Lulu M. Gizaw, PA-C, is an employee of  
2 the University of Washington and provided care and treatment to Aolani E. Glover. Except as  
3 expressly admitted herein, defendants deny the remaining allegations of this paragraph.

4 2.2 Defendants admit that Lulu M. Gizaw, PA-C, is a licensed Physician Assistant  
5 authorized to provide medical care and treatment in the state of Washington. Defendants  
6 further admit that Lulu M. Gizaw, PA-C, is an employee of the University of Washington and  
7 provided care and treatment to Aolani E. Glover.

8 **III. SATISFACTION OF ADMINISTRATIVE CLAIM REQUIREMENT**

9 3.1 Defendants admit that a document titled "90-Day Notice of Intention to  
10 Commence Action Against Health Care Provider Pursuant to RCW 7.70.100" and dated  
11 January 6, 2010, was submitted to Lulu Gizaw, PA-C. Defendants further admit that a  
12 document titled "90-Day Notice of Intention to Commence Action Against Health Care  
13 Provider Pursuant to RCW 7.70.100" and dated February 2, 2010, was submitted to  
14 Lulu Gizaw, PA-C. Defendants further admit that a document titled "90-Day Notice of  
15 Intention to Commence Action Against Health Care Provider Pursuant to RCW 7.70.100" and  
16 dated January 6, 2010, was submitted to the Harborview Medical Center Risk Management  
17 Division and received on January 11, 2010. Defendants further admit that a document titled  
18 "90-Day Notice of Intention to Commence Action Against Health Care Provider Pursuant to  
19 RCW 7.70.100" and dated January 6, 2010, was received by the University of Washington  
20 Office of Risk Management on January 11, 2010. Defendants further admit that a University  
21 of Washington Claim Form dated February 2, 2010, was submitted. Defendants further admit  
22 that on February 23, 2010, Liability Claims Manager Kelly Williams corresponded with  
23 attorney Tom Golden and denied plaintiff's claim. Except as expressly admitted herein,  
24 defendants deny the remaining allegations of this paragraph.

25 ///

26 ///



1 4.10 [sic] Deny.

2 4.11 [sic] Defendants admit that on April 2, 2008, Lulu Gizaw, PA-C, located Aolani  
3 Glover at the pharmacy and requested that she return to the Emergency Department. Except  
4 as expressly admitted herein, defendants deny the remaining allegations of this paragraph.

5 4.12 [sic] Deny.

6 4.13 [sic] Deny.

7 4.14 [sic] Defendants admit that on April 10, 2008, Lulu Gizaw, PA-C, drafted a  
8 handwritten chart note regarding Aolani Glover. Except as expressly admitted herein,  
9 defendants deny the remaining allegations of this paragraph.

10 4.15 [sic] Defendants admit that the medical records for Aolani Glover reflect that  
11 vital signs were recorded at 19:25. Except as expressly admitted herein, defendants deny the  
12 remaining allegations of this paragraph.

13 4.16 [sic] Defendants admit that the laboratory results for Aolani Glover dated April 2,  
14 2008, and timed 19:45 reflect a Troponin level of 24.58 ng/mL and a Creatinine Kinase total  
15 of 2037 U/L. Except as expressly admitted herein, defendants deny the remaining allegations  
16 of this paragraph.

17 4.17 [sic] Defendants admit that Dr. Sinha's procedure note dated April 3, 2008,  
18 reflects that Aolani Glover underwent selective coronary angiography with angioplasty and  
19 stent of the proximal, mid and distal RCA with both bare metal and DES stents and placement  
20 of a temporary pacemaker and IABP. Defendants further admit that Dr. Sinha's procedure  
21 note dated April 3, 2008, states, in part, "Summary – Acute spiral dissection, likely  
22 spontaneous, of the entire RCA. Despite multiple angioplasties and stent placements, the  
23 RCA continued to have TIMI 0 flow. Patient developed complete heart block during the  
24 procedure and required a temporary [sic] pacemaker. An IABP was also placed for BP  
25 support. Complications – numerous ventricular fibrillations requiring defibrillation." Except  
26 as expressly admitted herein, defendants deny the remaining allegations of this paragraph.

1 4.18 [sic] Defendants admit that the laboratory results for Aolani Glover dated  
2 April 2, 2008, and timed 23:42 reflect a Troponin level of 21.88 ng/mL and a Creatinine  
3 Kinase total level of 1832 U/L. Except as expressly admitted herein, defendants deny the  
4 remaining allegations of this paragraph.

5 4.19 [sic] Defendants admit that Aolani Glover was discharged from Harborview  
6 Medical Center on April 5, 2008, and transferred to the University of Washington Medical  
7 Center. Defendants further admit that Aolani Glover's medical records reflect that her  
8 discharge diagnoses included cardiogenic shock, right coronary artery dissection, ST  
9 elevation myocardial infarction inferior leads, non-gap metabolic acidosis, acute respiratory  
10 distress syndrome, ventilator-assisted pneumonia, and acute renal failure. Except as expressly  
11 admitted herein, defendants deny the remaining allegations of this paragraph.

12 4.20 [sic] Admit.

13 4.21 [sic] Defendants admit that plaintiff underwent certain procedures on April 5,  
14 2008, including placement of a tandem heart RVAD, but otherwise deny the allegations of  
15 this paragraph.

16 4.22 [sic] Admit.

17 4.23 [sic] Defendants admit that Plaintiff received a heart transplant on or about July  
18 27, 2008, but otherwise lack knowledge or information sufficient to form a belief as to the  
19 truth of the matters alleged in this paragraph and, therefore, deny the same.

20 4.24 [sic] Deny.

21 **V. LIABILITY AND NEGLIGENCE**

22 5.1 Paragraph 5.1 alleges legal conclusions requiring no answer from defendants.  
23 To the extent that paragraph 5.1 may be deemed to allege facts, those allegations are denied.

24 5.2 Paragraph 5.2 alleges legal conclusions requiring no answer from defendants.  
25 To the extent that paragraph 5.2 may be deemed to allege facts, those allegations are denied.

26 5.3 Deny.

1 5.4 Deny.

2 VI. DAMAGES

3 6.1 Deny.

4 6.2 Deny.

5 VII. LIMITED WAIVER OF PHYSICIAN/PATIENT PRIVILEGE

6 7.1 This paragraph does not require an answer from defendants.

7 RESPONSE TO PLAINTIFF'S ELECTION TO DECLINE

8 VOLUNTARY ARBITRATION PURSUANT TO RCW 7.70A.020

9 Defendants acknowledge plaintiff's rejection of voluntary arbitration. Such rejection  
10 renders defendants' response moot, but these defendants reserve the right to so elect and/or  
11 stipulate at a future time after sufficient discovery has been conducted.

12 AFFIRMATIVE DEFENSES

13 By way of further answer and affirmative defense, the defendants allege:

- 14 1. Plaintiff Aolani Glover was at fault and her fault was a proximate cause of her
- 15 injuries.
- 16 2. The Complaint fails to state a claim upon which relief may be granted.
- 17 3. Plaintiff assumed the risk of injuries and damages, if any, sustained by her.
- 18 4. Any alleged injuries and damages were proximately caused by persons or entities
- 19 other than these answering defendants and/or by causes other than those for which these
- 20 answering defendants are accountable.
- 21 5. Defendants reserve the right to amend this answer, including affirmative defenses.

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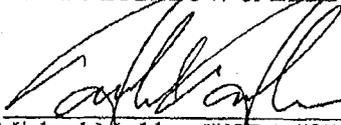
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**PRAYER FOR RELIEF**

Wherefore, having fully answered the Complaint, defendants request entry of a judgment dismissing the Complaint and action with prejudice and awarding its costs.

DATED this 27 day of October, 2010.

BENNETT BIGELOW & LEEDOM, P.S.

By   
Michael Madden, WSBA #8747  
Special Assistant Attorney General  
Attorneys for Defendants

**CERTIFICATE OF SERVICE**

I certify under penalty under the laws of the State of Washington that on this day I caused a true and correct copy of the foregoing to be delivered as follows:

Thomas R. Golden, Esq.	<input type="checkbox"/>	Hand Delivered
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/>	Facsimile
298 Winslow Way West	<input checked="" type="checkbox"/>	Email
Bainbridge Island, WA 98110	<input checked="" type="checkbox"/>	1 <sup>st</sup> Class Mail
Fax: (206) 842-0797	<input type="checkbox"/>	Priority Mail
email: <a href="mailto:trg@medilaw.com">trg@medilaw.com</a>	<input type="checkbox"/>	Federal Express, Next Day

Dated at Seattle, Washington, this 27<sup>th</sup> day of October, 2010.

  
Gerri Downs  
Legal Assistant

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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,

Plaintiff,

vs.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULUM. GIZAW, PA-C,

Defendants

CASE NO. 10-2-35124-8 SEA

DEFENDANTS' MOTION FOR A  
PROTECTIVE ORDER

**ORAL ARGUMENT REQUESTED**

**I. MOTION**

Defendants (hereinafter the University) respectfully move the Court pursuant to Civil Rules 26(c) for an order directing that its counsel are not precluded from contacting any of its employees or agents who provided health care services to the plaintiff.

**II. CR 26(i) COMPLIANCE AND REQUEST FOR ORAL ARGUMENT**

Counsel for the parties have conferred regarding the issue presented by this motion and agree that further negotiated resolution is not likely. The parties jointly request oral argument.

**III. ISSUE**

Are the lawyers for an integrated health care organization that has been sued for medical negligence precluded from discussing the case with employees or agents of the

1 defendant organization who were involved in the plaintiff's care but who have not themselves  
2 been accused of negligence?

3 **IV. EVIDENCE RELIED UPON**

4 The University relies upon the Declaration of Michael Madden filed herewith, as well  
5 as the Complaint on file.

6 **IV. BACKGROUND**

7 This motion presents a recurring and important question which has not heretofore been  
8 addressed by any Washington appellate decision. In the recent past, trial courts have split on  
9 the question. Most recently, in *Youngs v. Peacehealth*, Whatcom Cty. No. 10-2-03230-1,  
10 Judge Uhrig denied a malpractice plaintiff's motion for a protective order to prevent the  
11 defense counsel from interviewing physicians employed by the defendant who were not  
12 accused of personal negligence. The court certified the issue for immediate appeal pursuant  
13 to RAP 2.3(b)(4),<sup>1</sup> however, and the plaintiff has sought discretionary review. Two years ago,  
14 in *Jacobus v. Kraus*, King Cty. No. 08-2-03749-5, Judge Spector ruled in favor of plaintiff on  
15 the same issue. In that case, the defendants sought discretionary review, which was denied on  
16 the basis that the ruling did not constitute probable error, although the appellate court  
17 recognized that allowing defense counsel to interview the client's own employees was not  
18 facially inconsistent with *Loudon*, nor did *Loudon* involve the circumstances presented here.<sup>2</sup>

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24 <sup>1</sup> The certification order states: "There is no Washington authority addressing the specific issue of whether the  
25 rule in *Loudon v. Myhre* prohibiting defense counsel from engaging in ex parte contact with a plaintiff's  
nonparty treating physicians applies to treating physicians employed by the defendants." Madden Decl. Ex. 4.

26 <sup>2</sup> A copy of the ruling by the Court of Appeals Commissioner is attached as Exhibit 5 to the Madden Declaration.

1 **A. Plaintiff's Medical Condition and Treatment**

2 The plaintiff, 28 years old at the time, suffered a spontaneous dissection of her right  
3 coronary artery ("RCA").<sup>3</sup> The dissection became known during a diagnostic catheterization  
4 procedure carried out at Harborview Medical Center (operated by the University of  
5 Washington)<sup>4</sup> on the night of April 2, 2008. Efforts to repair the dissection by placement of  
6 stents were unsuccessful, leaving the RCA completely occluded. During attempted repair of  
7 the dissection, plaintiff's heart went into ventricular fibrillation, requiring multiple shocks to  
8 restore normal rhythm. Due to the weakened condition of her heart, a temporary pacemaker  
9 and an intra-aortic balloon pump were placed and she was transferred to the Intensive Care  
10 Unit.

11 Three days later, she was transferred to the University of Washington Medical Center  
12 ("UWMC"), where she received further treatment including temporary placement of a  
13 ventricular assist device. She was discharged from UWMC to home on April 22, 2008, but  
14 returned on May 6, 2008 with complaints of renewed chest pain. On this occasion, she was  
15 found to have spontaneously dissected a major branch of her left anterior descending coronary  
16 artery and the entirety of her left circumflex coronary artery. It was impossible to repair these  
17 dissections, and the interruption of blood supply resulting from these additional dissections  
18 caused extensive damage to the left side of plaintiff's heart. Consequently, she became a  
19 candidate for a heart transplant, which she received on July 27, 2008.

20

21

22 <sup>3</sup> Coronary arteries are comprised of three layers: the intima, the media, and the adventitia. Dissection of the  
23 coronary artery results in separation of the layers of the arterial wall, creating a false lumen. The separation may  
24 be between the intima and the media, or between the media and the adventitia. Hemorrhage into the false lumen  
25 can impinge upon the true lumen of the coronary artery, impairing blood flow and causing myocardial ischemia,  
26 infarction, or sudden death. Spontaneous dissection is very rare. The cause for spontaneous dissection is  
unknown in this case, although it most often occurs in young women who are taking oral contraceptives, or  
during and shortly after pregnancy.

<sup>4</sup> As explained in *Kleyer v. Harborview*, 76 Wn. App. 542 (1995), although HMC is owned by King County, it is  
operated by the University and all of its staff are University employees.

1 After her transfer from HMC to UWMC, dozens of University physicians and other  
2 providers have been involved in her care. Some have had face-to-face contact and extensive  
3 involvement. Others have been involved only briefly or without ever meeting the patient,  
4 such as the cardiologists and radiologists who interpreted studies, the members of the  
5 transplant committee who reviewed plaintiff's status, or the pathologists who examined tissue  
6 samples.

7 **B. Plaintiff's Liability Theory**

8 Plaintiff claims that the Emergency Department staff at Harborview, including the  
9 individual defendant Physician Assistant Lulu Gizaw, was too slow to recognize that she was  
10 suffering a cardiac event, thereby delaying her transfer to the cardiac catheterization  
11 laboratory for diagnosis and treatment. Plaintiff theorizes that she could have avoided  
12 extensive damage to the right side of her heart if she had undergone catheterization and been  
13 successfully stented at an earlier point. She further theorizes that, with less damage to the  
14 right ventricle, she would have been a candidate for coronary artery by-pass grafting or some  
15 other intervention that would have prevented the extensive damage to her left ventricle that  
16 resulted from the subsequent dissections. Accordingly, in addition to questions about whether  
17 the evaluation and care in the Emergency Department was appropriate, there are a number of  
18 causation issues; *e.g.*,

- 19
- 20 • Is it likely that earlier stenting would have succeeded or was plaintiff's RCA so  
21 weakened that stenting would not have been possible?
  - 22 • Given that blood tests prior to the catheterization indicated that plaintiff already had  
23 suffered a significant myocardial infarction, even assuming that a successful  
24 intervention was possible, how much difference would it have made?
  - 25 • Even assuming a lesser level of damage to the right ventricle, was there reason to  
26 anticipate further dissections such as those discovered on May 8, 2008? If so, would

1           there have been a means to avoid the damage that resulted from those dissections, such  
2           as by stenting or by-pass surgery, and thereby to avoid the need for transplantation?

3   **C.    Plaintiff's Position re Application of Loudon and Smith**

4           Plaintiff's counsel has indicated that her negligence claims are confined to those  
5   providers "who had contact with Aolani Glover prior to her transfer to the coronary  
6   catheterization laboratory." On this basis, plaintiff's counsel initially asserted that *Smith v.*  
7   *Orthopedics International*, 170 Wn.2d 659 (2010), and *Loudon v. Myhre*, 110 Wn.2d 675  
8   (1988) preclude defense counsel from contacting any of the subsequent treating physicians  
9   (and presumably other health care providers), even though they are employed by the  
10   University of Washington, except in a deposition where he is present. Subsequently,  
11   plaintiff's counsel has indicated that he did not object to direct contact with any of the HMC  
12   Emergency Department or Cardiology staff who were involved in his client's care, so long as  
13   those individuals were not shown any records of her subsequent care.<sup>5</sup>

14   **D.    Defendants' Position**

15           Based on an "underlying ... concern for protecting the patient-physician privilege,"  
16   *Smith* and *Loudon* prohibit defense counsel from contacting non-party treating physicians,  
17   *Smith*, 170 Wn.2d at 665. The patient-physician privilege does not prevent physicians,  
18   whether they are the targets of a suit or not, from disclosing otherwise privileged information  
19   to their lawyers in order to obtain legal advice. *See, e.g., DeNeui v. Wellman*, 2008 WL  
20   2330953 (D. S. Dakota 2008) (non-party treating physician entitled to disclose privileged  
21   information to counsel who was appointed by same insurer that provided coverage for the  
22   defendant). Here, plaintiff has sued the University, which operates an integrated health care  
23   system ("UW Medicine") that includes hospitals, physician groups, and outpatient clinics.  
24   State statute and federal regulations expressly authorize disclosure of confidential health

25           \_\_\_\_\_

26   <sup>5</sup> Madden Decl. ¶ 3 and Exs. 2-3.

1 information to the lawyers for a health care provider, without notice to or consent by the  
2 patient. RCW 70.02.050(1)(b); 45 C.F.R. § 164.506(a) and(c). Accordingly, the patient-  
3 physician privilege does not prevent disclosure of confidential health care information to  
4 counsel for a defendant health care organization when that disclosure is for the purpose of  
5 allowing the organization to receive the advice of counsel. Furthermore, the law which  
6 permits these disclosures precludes a finding that patients have a legitimate expectation that  
7 they can limit the use of relevant information that is within the possession and control of the  
8 entity that they have sued.

9       Additionally, there are countervailing considerations, not present in *Smith* or *Loudon*,  
10 which argue against extension of the bar on contact with non-party treating physicians to  
11 physicians who are employees or agents of a party. To begin with, counsel has been  
12 appointed as special assistant attorneys general to “advise and represent the University,  
13 including its health care providers, employees, and/or indemnitees involved in this matter.”  
14 Madden Decl. ¶2 and Ex. 1. The University’s attorney-client privilege extends to all  
15 communications between its counsel and its health care providers/agents, even those who are  
16 not part of management. *Sherman v. State*, 128 Wn.2d 164, 190 (1995) (citing *Upjohn v.*  
17 *United States*, 449 U.S. 383, 391-92 (1981)). In this setting, the University is permitted to  
18 confidentially provide all of its relevant information to counsel, so that counsel can provide  
19 the most informed advice and defense. *Id.* Applying *Smith* and *Loudon* in this setting would  
20 be an unprecedented and unwarranted extension of their holdings, and would require the  
21 University to waive the attorney-client privilege in order to obtain relevant information that is  
22 within the knowledge of its own employees and agents.

23       Prohibiting counsel from contacting their client’s own employees/agents also would  
24 interfere with the attorney/client relationship and hinder the University’s ability to obtain  
25 counsel’s evaluation of this case because the roster of “non-targeted” treating physicians  
26 includes individuals who hold key positions within UW Medicine and who have specialized

1 expertise that the University would ordinarily and necessarily draw upon in evaluating this  
2 unusual case; e.g., Dr. Larry Dean, Director of the UW Regional Heart Center; Dr. Daniel  
3 Fishbein, Medical Director of the UW's Heart Failure and Heart Transplant Programs, Dr.  
4 Edward Verrier, former chief of the UW's Division of Cardiothoracic Surgery, and Dr.  
5 Charles E. Murry, Director of the University's Center for Cardiovascular Biology. Dr.  
6 Fishbein, who is currently plaintiff's attending cardiologist, is a national expert in the  
7 evaluation and treatment of end-stage heart disease and one of the people at the University  
8 best-positioned to comment knowledgeably on the cause and probable timing of plaintiff's  
9 dissections. Dr. Dean, who performed two catheterization procedures on Ms. Glover in April  
10 and May 2008, is a leading interventional cardiologist and a person uniquely positioned to  
11 comment about the ability to successfully stent the dissections experienced by Ms. Glover.  
12 Dr. Verrier, who participated in a pre-transplant evaluation of Ms. Glover, is one of the  
13 nation's preeminent cardiac surgeons with special expertise in coronary artery bypass and  
14 transplant procedures. Dr. Murry is a cardiovascular pathologist who is an expert on the  
15 mechanism of myocardial infarction.

#### 16 V. ARGUMENT

##### 17 A. **Neither *Loudon* nor *Smith* Prohibits Lawyers for a Health Care Provider from** 18 **Contacting their Client's Employees and Agents.**

19 *Loudon* was based on four specific concerns about the impact of direct contact  
20 between the patient's adversaries and his/her non-party treating physicians on the patient-  
21 physician privilege. See *Holbrook v. Weyerhaeuser Co.*, 118 Wn.2d 306, 822 P.2d 271  
22 (1992) (discussing bases for *Loudon*). The first and primary concern was that the waiver of  
23 privilege resulting from commencement of a personal injury suit extends only to information  
24 that is relevant and discoverable under Civil Rule 26 and that, without the presence of  
25 plaintiff's counsel, a nonparty treating physician might disclose irrelevant, and therefore  
26 privileged, information. *Loudon*, 110 Wn.2d at 677-78; see also *Rowe v. Vaagen Bros.*

1 *Lumber, Inc.*, 100 Wn. App. 268, 278, 996 P.2d 1103 (2000) (“The primary concern is  
2 potentially prejudicial but irrelevant disclosures”).

3         Second, and closely related, *Loudon* reflected a concern that non-party physicians may  
4 not understand the appropriate boundaries of the privilege waiver in personal injury cases, and  
5 they cannot rely on defense counsel to advise them on that subject. *Loudon*, at 677-78. Third,  
6 the Court noted that, “for some,” there could be a chilling effect on the patient-physician  
7 relationship if direct contact with their doctors was permitted. *Id.* at 679; *see also Rowe* at  
8 278 (“the threat that a doctor might talk with a legal adversary outside the presence of  
9 plaintiff’s counsel could have a chilling effect on the injured person’s willingness to continue  
10 with treatment and be forthright with the physician”). In the same vein, *Smith* indicated that  
11 the “risk that a nonparty treating physician testifying as a fact witness might assume the role  
12 of a nonretained expert for the defense ... may result in chilling communications between  
13 patients and their physicians about privileged medical information.” 170 Wn.2d at 669.  
14 Finally, the *Loudon* decision indicated that pre-trial interviews might lead to situations where  
15 defense counsel was compelled to testify as impeachment witnesses concerning their  
16 communications with non-party physicians. 110 Wn.2d. at 680.

17         None of these considerations is present here. First, with regard to the preservation of  
18 patient-physician privilege, healthcare providers have always been free to disclose privileged  
19 healthcare information to their lawyers for the purpose of obtaining legal advice. Regulations  
20 under HIPAA also expressly recognize that direct contact by counsel with all of the  
21 institution’s employed healthcare providers is a normal part of healthcare operations that does  
22 not require notice to or consent from the patient.<sup>6</sup> The Washington Uniform Health Care

23 \_\_\_\_\_  
24 <sup>6</sup> HIPAA permits the use and disclosure of protected health information without a patient’s consent for  
25 “treatment, payment and health care operations.” 45 C.F.R. § 164.506(a). This so-called “routine use”  
26 exception refers to a wide range of management functions for covered entities, including quality assessment,  
practitioner evaluation, and auditing services. *See Citizens for Health v. Leavitt*, 428 F.3d 167, 174 (3d Cir.  
2005). The federal Department of Health and Human Services has issued official guidance expressly permitting  
disclosures to legal counsel. *See* U.S. Dept. of Health & Hum. Services, Health Information Privacy, Frequently

1 Information Act, Ch. 70.02 RCW, also allows disclosure of health care information about a  
2 patient without the patient's authorization to any person who requires that information to  
3 provide legal services to a health care provider or facility. RCW 70.02.050(1)(b).  
4 Accordingly, there is no privilege when a health care provider, acting through its agents,  
5 discloses information to its own lawyers. *See Estate of Stephens ex rel. Clark v. Galen Health*  
6 *Care, Inc.*, 911 So.2d 277, 282-83 (Fla. App. 2005) (patients' privacy rights were not violated  
7 when providers within a unified hospital system discussed their treatment and care with  
8 attorneys for the hospital).

9       Second, even if there potentially is some irrelevant privileged information within the  
10 possession of non-targeted University providers, the authority to disclose that information to  
11 counsel does not mean that counsel are free to use protected information for unauthorized  
12 purposes. To the contrary, the institution, its staff, and its outside counsel are all obligated  
13 under federal law to maintain appropriate confidentiality.<sup>7</sup> And, unlike the situation in  
14 *Loudon* where defense counsel owed no obligation to the non-party physicians, counsel for a  
15 health care organization have an obligation to appropriately advise its providers regarding the  
16 appropriate protection of privileged information.<sup>8</sup>

17  
18  
19 Asked Questions (the covered entity will share protected health information for litigation purposes with its  
20 lawyer, who is either a workforce member or a business associate). In these cases, the Privacy Rule permits a  
21 covered entity to reasonably rely on the representations of a lawyer who is a business associate or workforce  
22 member that the information requested is the minimum necessary for the stated purpose. *See* 45 CFR  
23 164.514(d)(3)(iii)(C.) available at <http://www.hhs.gov/ocr/privacy/faq/permitted/judicial/705.html>.

24 <sup>7</sup> 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ ("the lawyer who is a workforce member of the covered entity  
25 must make reasonable efforts to limit the protected health information disclosed to the minimum necessary for  
26 the purpose of the disclosure. Similarly, a lawyer who is a business associate [outside counsel] must apply the  
minimum necessary standard to its disclosures, as the business associate contract may not authorize the business  
associate to further use or disclose protected health information in a manner that would violate the HIPAA  
Privacy Rule if done by the covered entity").

<sup>8</sup> 45 CFR 164.514(d)(3)(iii)(C) and HIPAA FAQ ("the Privacy Rule permits a covered entity to reasonably rely  
on the representations of a lawyer who is a business associate or workforce member that the information  
requested is the minimum necessary for the stated purpose").

1 With respect to the third reason for the *Loudon* rule—the potential for divided loyalty  
2 to the patient—the fact that a patient has sued a physician’s employer and colleagues  
3 independently creates that potential. And, given the limitations on patient-physician privilege  
4 and privacy of medical records previously discussed, a patient who has sued a health care  
5 organization cannot have any legitimate expectation that the organization will be prevented  
6 from accessing all of the information within its possession that is necessary to assess its  
7 liability or defend itself in a lawsuit. See *Burger v. Lutheran General Hosp.*, 198 Ill. 2d 21,  
8 52, 759 N.E. 2d 533 (2001) (where patient seeks care in an integrated health care system, any  
9 legitimate expectation of privacy is limited to the institution, rather than any individual  
10 provider). Finally, there is also no legitimate prospect that defense counsel’s contact with the  
11 client’s own employees will require them to testify, since all of those communications are  
12 privileged. Accordingly, none of the *Loudon/Smith* factors have any force in this context.

13 Plaintiff may point, nonetheless, to the portion of Justice Fairhurst’s opinion in *Smith*,  
14 where she dissented from the majority, as confirmation that the lead opinion’s prohibition on  
15 direct contact with non-party treating physicians extends to contacts between defense counsel  
16 and employees and agents of the client. A review of the circumstances in *Smith* refutes this  
17 suggestion. In that case, a group headed by the Washington State Hospital Association  
18 (“WSHA”) filed an *amicus* brief, urging the Supreme Court to (a) affirm the Court of  
19 Appeals; and (b) avoid any unnecessary pronouncements about the application of *Loudon* to  
20 contacts between defense counsel and agents of a defendant/health care organization. The  
21 lead opinion in *Smith*, written by Justice Alexander and joined by six other justices with  
22 respect to application of *Loudon* to the facts, confirmed that “the fundamental purpose of the  
23 *Loudon* rule is to protect the physician-patient privilege.” 170 Wn.2d at 667.<sup>9</sup> Nothing in the  
24

25 <sup>9</sup> Justices Owens and J. M. Johnson joined Justice Alexander in holding that there was a *Loudon* violation, but  
26 found no resulting prejudice. Justices C. Johnson, Sanders, Chambers and Stephens agreed with the lead opinion  
on the application of *Loudon*, but would have applied a *per se* prejudice rule and reversed the judgment. Justice

1 lead opinion, or Justice C. Johnson's concurrence/dissent,<sup>10</sup> signals that the court intended to  
2 apply *Loudon* to the facts presented here. To the contrary, reading the two opinions joined by  
3 seven justices who found a *Loudon* violation, it appears that court heeded WSHA's request to  
4 avoid making a pronouncement on an issue that was not presented by the record in *Smith*.

5 In Justice Fairhurst's opinion, however, she argued that the lead opinion goes beyond  
6 the scope of the patient-physician privilege and contravenes the provisions of the Uniform  
7 Health Care Information Act allowing disclosure of privileged information to lawyers. *Id.* at  
8 677. This statement is not a part of the holding, of course, and given the close divisions  
9 among the justices and the careful phrasing of the holding so as to avoid comment on an issue  
10 not presented, it would be improperly presumptuous to expand *Smith* beyond its facts and  
11 specific holding.

12 **B. Application of *Loudon* in these Circumstances would Unduly Interfere with the**  
13 **Ability and Obligation of Defense Counsel to Represent their Client**

14 *Loudon* and *Smith* did not present or address the question of whether a prohibition on  
15 direct communications with a defendant institution's employed physicians would hinder the  
16 ability of the institution's attorneys to represent their client, or prevent the employed  
17 physicians from obtaining advice from counsel. These types of considerations weigh heavily  
18 against application of the *Loudon* rule in this case. Of particular concern is the degree of  
19 interference with the normal functions of defense counsel. Under *Upjohn v. United States*,  
20 449 U.S. 383 (1981), which has been consistently followed in Washington,<sup>11</sup> an  
21 organization's attorney-client privilege extends beyond the "control group" to include  
22 communications between counsel and lower level employees, for the purpose of gathering of

23 Fairhurst, joined by Chief Justice Madsen, found no *Loudon* violation and hence no prejudice, thus making a 5-4  
24 majority for affirmance.

25 <sup>10</sup> Justice Johnson's concurrence/dissent begins, "The lead opinion correctly concludes that *Loudon* prohibits the  
type of ex parte contact that took place in this case." (emphasis supplied).

26 <sup>11</sup> E.g., *Sherman v. State*, 128 Wn.2d 164 (1995).

1 information necessary for counsel to advise the client regarding its potential liabilities.  
2 Depositions are not a substitute for these communications because attorney-client privilege  
3 cannot be preserved in that setting, nor can providers be expected to be fully candid in the  
4 presence of opposing counsel. And, requiring counsel to conduct their internal investigation  
5 of the case, including exploration of liability theories, in the presence of opposing counsel  
6 necessarily invades the work-product privilege.

7       The impact of extending *Loudon* is particularly severe in this case because at least  
8 several of the University physicians who were subsequently involved in plaintiff's care are  
9 critical institutional resources for assisting counsel and the University with evaluating the  
10 very complicated and unusual liability issues that it presents. These include Drs. Fishbein,  
11 Dean, Verrier, and Murry. In addition, several of the non-targeted physicians likely are, by  
12 virtue of their management roles, speaking agents for the University under *Wright v. Group*  
13 *Health*, 103 Wn.2d 192, 201 (1984). *Wright* adopted a "flexible interpretation" that depends  
14 on the position and authority of the speaker and the nature of the particular statement. 103  
15 Wn.2d. at 200-01. In this regard, the court cited a series of cases applying ER 801(d)(2) (or  
16 earlier law) pertaining to the admissibility of admissions of a party-opponent, which went  
17 both ways on the question. Among the cited cases is *Young v. Group Health*, 85 Wn.2d 332,  
18 534 P.2d 1349 (1975), which *Wright* parenthetically described as standing for the proposition  
19 that a "doctor had 'speaking authority' for [a] hospital." *Id.* at 201. *Young* held that it was  
20 error to exclude an out-of-court statement, in the form of a medical opinion, by a treating  
21 physician employed by Group Health, who was not named as defendant in the case, because  
22 the statement constituted an admission of a party opponent. 85 Wn.2d at 337-38.

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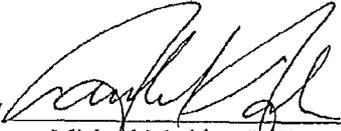
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**VI. CONCLUSION**

For these reasons, the Court should grant the University's Motion.

Dated this 16 day of May, 2011.

BENNETT BIGELOW & LEEDOM, P.S.

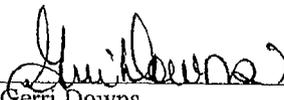
By   
Michael Madden, WSBA #8747  
Carol Sue Janes, WSBA #16557  
Special Assistant Attorneys General  
Attorneys for Defendants

**CERTIFICATE OF SERVICE**

I, the undersigned, hereby certify under penalty of perjury under the laws of the State of Washington, that I am now, and at all times material hereto, a resident of the State of Washington, over the age of 18 years, not a party to, nor interested in, the above-entitled action, and competent to be a witness herein. I caused a true and correct copy of the foregoing pleading to be served this date, in the manner indicated, to the parties listed below:

Thomas R. Golden, Esq.  Hand Delivered  
Otorowski Johnston Morrow & Golden, PLLC  Facsimile  
298 Winslow Way West  U.S. Mail  
Bainbridge Island, WA 98110  Email  
Fax: (206) 842-0797  
email: [trg@medilaw.com](mailto:trg@medilaw.com)

Dated this 17<sup>th</sup> day of May, 2011, at Seattle, Washington.

  
Gerri Downs  
Legal Assistant

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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,

Plaintiff,

vs.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULUM. GIZAW, PA-C,

Defendants

CASE NO. 10-2-35124-8 SEA

**DECLARATION OF MICHAEL  
MADDEN RE MOTION FOR  
PROTECTIVE ORDER**

1. I am one of the attorneys for the defendants in this matter and have personal knowledge of the facts stated herein.

2. I have been appointed as a special assistant attorney general to represent the defendants and the interest of the University of Washington in this matter. A copy of my appointment letter is attached as Exhibit 1. I have over 25 years of experience in handling medical negligence matters. I have represented the University of Washington and its affiliated health care providers in numerous matters during that time, including several involving cardiology, cardiac surgery, and transplant medicine.

3. Plaintiff's medical records indicate the following:

a. The plaintiff, 28 years old at the time, suffered a spontaneous dissection of her right coronary artery ("RCA"). The dissection became known during a diagnostic catheterization procedure carried out at Harborview Medical Center (operated by the

Madden Decl. in Support of  
Motion for Protective Order - Page 1

LAW OFFICES  
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1 University of Washington) on the night of April 2, 2008. Efforts to repair the dissection by  
2 placement of stents were unsuccessful, leaving the RCA completely occluded. During the  
3 repair attempts, Ms. Glover's heart went into ventricular fibrillation, requiring multiple  
4 shocks to restore normal rhythm. Due to the weakened condition of her heart, a temporary  
5 pacemaker and an intra-aortic balloon pump were placed and she was transferred to the  
6 Intensive Care Unit.

7           b. Three days later, she was transferred to the University of Washington  
8 Medical Center ("UWMC"), where she received further treatment including temporary  
9 placement of a ventricular assist device. She was discharged from UWMC to home on April  
10 22, 2008, but returned on May 6, 2008 with complaints of renewed chest pain. On this  
11 occasion, she was found to have spontaneously dissected a major branch of her left anterior  
12 descending coronary artery and the entirety of her left circumflex coronary artery. It was  
13 impossible to repair these dissections, and the interruption of blood supply resulting from  
14 these additional dissections caused extensive damage to the left side of plaintiff's heart.  
15 Consequently, she became a candidate for a heart transplant, which she received on July 27,  
16 2008.

17           c. After her transfer from HMC to UWMC, dozens of University  
18 physicians and other providers have been involved in her care. Some have had face-to-face  
19 contact and extensive involvement. Others have been involved only briefly or without ever  
20 meeting the patient, such as the cardiologists and radiologists who interpreted studies, the  
21 members of the transplant committee who reviewed plaintiff's status, or the pathologists who  
22 examined tissue samples.

23           4. Based on discovery responses and correspondence, Plaintiff appears to be  
24 claiming that the Emergency Department staff at Harborview, including the individual  
25 defendant Physician Assistant Lulu Gizaw, was too slow to recognize that she was suffering a  
26 cardiac event, thereby delaying her transfer to the cardiac catheterization laboratory for

1 diagnosis and treatment. Plaintiff theorizes that she could have avoided extensive damage to  
2 the right side of her heart if she had undergone catheterization and been successfully stented  
3 at an earlier point. She further theorizes that, with less damage to the right ventricle, she  
4 would have been a candidate for coronary artery by-pass grafting or some other intervention  
5 that would have prevented the extensive damage to her left ventricle that resulted from the  
6 subsequent dissections. Accordingly, in addition to questions about whether the evaluation  
7 and care in the Emergency Department was appropriate, there are a number of causation  
8 issues; e.g.,

- 9 • Is it likely that earlier stenting would have succeeded or was plaintiff's RCA so  
10 weakened that stenting would not be possible?
- 11 • Given that blood tests prior to the catheterization indicated that plaintiff already  
12 had suffered a significant myocardial infarction, even assuming that a successful  
13 intervention was possible, how much difference would it have made?
- 14 • Even assuming a lesser level of damage to the right ventricle, was there reason to  
15 anticipate further dissections such as those discovered on May 8, 2008? If so,  
16 would there have been a means to avoid the damage that resulted from those  
17 dissections, such as by stenting or by-pass surgery, and thereby avoid the need for  
18 transplantation?

19 5. Plaintiff's counsel has written to me, stating that her negligence claims are  
20 confined to those providers "who had contact with Aolani Glover prior to her transfer to the  
21 coronary [sic] catheterization laboratory." A true and correct copy of that letter is attached  
22 hereto as Exhibit 2. In that letter, Plaintiff's counsel has asserted that, under *Smith v.*  
23 *Orthopedics International*, 170 Wn.2d 659 (2010) and *Loudon v. Myhre*, 110 Wn.2d 675  
24 (1988), we are precluded from contacting any of the subsequent treating physicians who are  
25 employed by the University of Washington or University of Washington Physicians, except in  
26 a deposition or other setting in which he is present. Subsequently, in an e-mail message

1 attached as Exhibit 3, plaintiff's counsel has indicated that he did not object to direct contact  
2 with any of the HMC Emergency Department or Cardiology staff who were involved in his  
3 client's care, so long as those individuals were not shown any records of her subsequent care.

4         6. This purported restriction interferes with the attorney-client relationship  
5 between my firm and the University, and materially hinders my ability to represent the  
6 University's interest in this matter, in the following ways:

7             a. Precluding me from interviewing my client's employees and agents  
8 except in the presence of opposing counsel effectively obviates the attorney-client privilege.

9             b. Several of the physicians subsequently involved in plaintiff's care are  
10 persons that I would normally call upon for advice and to suggest potential consultants to help  
11 defend this extremely unusual case. These are persons, such as Dr. Larry Dean, Director of  
12 the UW Regional Heart Center, Dr. Dan Fishbein, Medical Director of the UW's Heart  
13 Failure and Heart Transplant Programs, Dr. Edward Verrier, former chief of the UW's  
14 Division of Cardiothoracic Surgery, and Dr. Charles E. Murry, Director of the University's  
15 Center for Cardiovascular Biology. Each of these individuals has relevant expertise that is  
16 unique within the University and the region; *i.e.*, Dr. Fishbein is a national expert in the  
17 evaluation and treatment of end-stage heart disease and I believe he is one of the people at the  
18 University best-positioned to comment knowledgeably on the cause and probable timing of  
19 plaintiff's dissections. Dr. Dean is a leading interventional cardiologist and a person that I  
20 would expect to have unique knowledge about the ability to successfully stent dissections  
21 such as those experienced by Ms. Glover. Dr. Verrier is one of the nation's preeminent  
22 cardiac surgeons with special expertise in coronary artery bypass and transplant procedures.  
23 Dr. Charles E. Murry is a cardiovascular pathologist whose interests focus on the mechanism  
24 of myocardial infarction. Based on plaintiff's medical records, it is my understanding that Dr.  
25 Fishbein is currently plaintiff's attending cardiologist; Dr. Dean performed two  
26 catheterization procedures on Ms. Glover in April and May, 2008; Dr. Verrier saw her very

1 briefly in connection with her evaluation for transplant; and that Dr. Murry has examined  
2 tissue samples obtained from plaintiff.

3 c. Without the ability to confidentially consult with these representatives  
4 of my client, my ability to defend the case and to identify experts is severely limited. These  
5 individuals have expertise and knowledge that is likely unique within the University.  
6 Furthermore, in efforts to identify other potential internal resources, it has become apparent to  
7 me that many of the members of the cardiology, pathology and cardiac surgery services at the  
8 University have been involved in plaintiff's care at some level, however minimal.

9 d. Drs. Dean and Fishbein, and possibly Drs. Verrier and Murry, are, by  
10 virtue of their positions in management, speaking agents for the University. They are also  
11 persons who would normally be expected to provide the University and its counsel with the  
12 benefit of their experience and judgment with regard to the evaluation and defense of this  
13 matter. It would be extremely difficult to accurately evaluate this very unique case without  
14 their input.

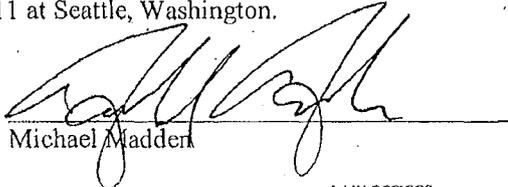
15 7. Attached hereto as Exhibit 4 is a true and correct copy of the Order granting  
16 Plaintiff's Motion to Certify in *Youngs v. Peacehealth*, Whatcom Cy. No. 10-2-03230-1.

17 8. Attached hereto as Exhibit 5 is a true and correct copy of Commissioner's  
18 Ruling Denying Discretionary Review in *Jacobus v. Kraus*, Ct. App. No. 63346-5-I.

19 9. Counsel for the parties have conferred regarding the issue presented by this  
20 motion and agree that further resolution is not likely. The parties jointly request oral  
21 argument.

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

24 Dated this 16 day of May 2011 at Seattle, Washington.

25  
26  
  
Michael Madden

Madden Decl. in Support of  
Motion for Protective Order - Page 5

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

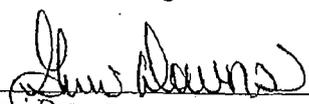
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**CERTIFICATE OF SERVICE**

I, the undersigned, hereby certify under penalty of perjury under the laws of the State of Washington, that I am now, and at all times material hereto, a resident of the State of Washington, over the age of 18 years, not a party to, nor interested in, the above-entitled action, and competent to be a witness herein. I caused a true and correct copy of the foregoing pleading to be served this date, in the manner indicated, to the parties listed below:

Thomas R. Golden, Esq.	<input type="checkbox"/>	Hand Delivered
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/>	Facsimile
298 Winslow Way West	<input checked="" type="checkbox"/>	U.S. Mail
Bainbridge Island, WA 98110	<input checked="" type="checkbox"/>	Email
Fax: (206) 842-0797		
email: <a href="mailto:trg@medilaw.com">trg@medilaw.com</a>		

Dated this 17<sup>th</sup> day of May, 2011, at Seattle, Washington.

  
 \_\_\_\_\_  
 Gerti Downs  
 Legal Assistant

{1408.00092/M0351296.DOCX; 2}

FILED  
 APPEALS DIV I  
 COURT OF APPEALS  
 STATE OF WASHINGTON  
 2011 JUL 25 PM 4:41

# EXHIBIT 1



ROB MCKENNA

**ATTORNEY GENERAL OF WASHINGTON**

University of Washington Division • Box 359475  
Seattle WA 98195-9475 • Phone (206) 543-4150 • Fax (206) 543-0779

October 8, 2010

COPY RECEIVED  
TIME \_\_\_\_\_ BY \_\_\_\_\_  
OCT 14 2010  
BENNETT BIGELOW  
& LEEDOM

Via Facsimile and U.S. Mail

Mr. Michael F. Madden  
Bennett, Bigelow & Leedom, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, Washington 98101-1397

RE: Aolani Glover v. State of Washington, et al.  
King County Superior Court No. 10-2-35124-8  
UW File No. UW10-2333

Dear Mr. Madden:

I understand you have spoken with a representative of Risk Management's claims program and have agreed to represent the University of Washington's interest in the above-entitled proceeding. Since only the Attorney General or his designee can represent state agencies, I am appointing you as a special assistant attorney general to advise and represent the University, including any of its health care providers, employees, and/or indemnitees involved in this matter.

This appointment is made under the terms of the contract we have previously signed.

Also, at your earliest convenience, please fax a conformed copy of your Notice of Appearance, reflecting receipt by the court, to the attention of Jane Warner Dukuray at (206) 543-0779. Please contact me as soon as possible if you foresee any problems complying with these conditions.

Sincerely,

Noella Rawlings  
Interim Division Chief

NAR:jwd.

cc: Kelly Williams, UW Liability Claims Manager (via email)  
Barbara Parnell

i:\groups\attysgen\saagapts\standard\m letter appts\jzwl rm madden re glover.docx

# EXHIBIT 2

# OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

ATTORNEYS AT LAW

CHRISTOPHER L. OTOROWSKI\*  
CAROL N. JOHNSTON\*\*  
JANE MORROW\*\*  
THOMAS R. GOLDEN  
SUSAN C. EGGERS\*\*

JEROME E. CARBONE, M.D., MEDICAL CONSULTANT  
ANNE HOSHIZAKI, MEDICAL RECORDS LIBRARIAN  
SHELLEY JONES, CASE MANAGER  
MELISSA SPOONER, OFFICE MANAGER

\*ALSO ADMITTED IN COLORADO  
\*\* ALSO REGISTERED NURSE

February 22, 2011

COPY RECEIVED  
TIME \_\_\_\_\_ BY \_\_\_\_\_

FEB 23 2011

BENNETT BIGELOW  
& LEEDOM

Michael Madden, Esq.  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Avenue, Suite 1900  
Seattle, WA 98101

RE: GLOVER V. HARBORVIEW MEDICAL CENTER, ET AL.

Dear Mr. Madden:

I am writing to you regarding the impact of Smith v. Orthopedics International upon the discovery in this case.

It is our position that the negligence in this action occurred within the Harborview Medical Center Emergency Room Department and its untimely triage and diagnosis of Aolani Glover's cardiac event. We are not contending any negligence on the part of the invasive cardiologist or the HMC cardiologists and intensivists, who cared for Aolani during and after the catheterization up to her transfer to the University of Washington Medical Center. Likewise, we are not contending Ms. Glover's care at the University of Washington Medical Center was negligent.

In many respects, the posture of Aolani's case is similar to your case Jacobus v. Kraus et al Court of Appeals, Division I, No. 63346-5-I. It is our position that you may contact and confer with HMC Emergency Medicine Physicians who had contact with Aolani Glover prior to her transfer to the coronary catheterization lab. We do, however, take the position that HMC physicians, who performed the catheterization and subsequently cared for Aolani, may not be contacted by you, your offices or HMC/UWMC Risk Management regarding Aolani Glover's case without our knowledge, permission or member of this firm being present. The Smith case reinforced the viability of Loudon to all subsequent treating physicians. I believe that this delineation of the period of negligence to the confines of the HMC Emergence Room Department provides a clear demarcation regarding impermissible ex parte contact.

THE ALLIANCE BUILDING • 298 WINSLOW WAY WEST • BAINBRIDGE ISLAND, WASHINGTON 98110  
TELEPHONE 206.842.1000 • FAX 206.842.0797 • WEB WWW.MEDILAW.COM

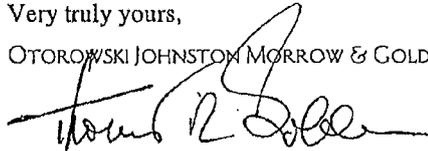
OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

Michael Madden  
February 22, 2011  
Page 2

I believe that Loudon, Smith and Jacobus are predictive of the trial courts decision on any motion for protective order. Please let me know if we can agree on a protective order or if we will need to note this matter up before Judge Eadie.

Very truly yours,

OTOROWSKI JOHNSTON MORROW & GOLDEN

A handwritten signature in black ink, appearing to read "Thomas R. Golden", written over the printed name.

Thomas R. Golden  
Attorney at Law

TRG:mka

# EXHIBIT 3

**Mike Madden**

---

**From:** Mike Madden  
**Sent:** Tuesday, May 03, 2011 12:52 PM  
**To:** 'Tom Golden'  
**Cc:** Michelle K. Apodaca; Carol Sue Janes  
**Subject:** RE: Glover depositions

Thanks for the quick response. I think that we're going end up in front of the judge on the Loudon issue regardless, but I appreciate your cooperation. Please do let me know how much time you will need with Dr. Copass.

Mike

Michael Madden  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Ave. Suite 1900  
Seattle, WA 98101  
T: 206-622-5511  
F: 206-622-8986  
[www.bbllaw.com](http://www.bbllaw.com)

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---

**From:** Tom Golden [mailto:trg@medilaw.com]  
**Sent:** Tuesday, May 03, 2011 12:44 PM  
**To:** Mike Madden  
**Cc:** Michelle K. Apodaca  
**Subject:** Re: Glover depositions

Mike: We will set up a deposition of the step mother. I will review and let you know what 30(b)(6) topics need to be addressed. As for the Loudon/Smith issues for HMC cath lab personnel and HMC cardiology, I will not object to you talking to them regarding their care and the events of April 2-5, 2008. I do object and will object to any providing of records from UWMC of subsequent cardiology care unless they were personally involved in care at UWMC. It is our position that providing medical information not known to them contemporaneously at the time of their care takes them out of the position of a subsequent treating physician. I do consider the UWMC physicians off limits until a court decision. They don't have to talk to me but they should not be meeting/talking to you either.

Tom Golden

On 5/3/11 12:06 PM, "Mike Madden" <[mmadden@bbllaw.com](mailto:mmadden@bbllaw.com)> wrote:

Tom: We are working on dates for Anne Newcombe, who will also likely end up as our CR 30b6 representative. In the latter regard, please confirm that that your CR 30b6 specification is as indicated in your email below. I don't want to be going ahead to get Ms. Newcombe ready to testify on one topic and find out that you want to add others. We will also start working on date for Dr. Copass; how much time do you anticipate?

On the flipside, we want to depose AG's step mom. I believe that you offered to set that up. If I misunderstood, please

let me know.

Finally, we probably ought to have CR 26 conference on the *Loudon/Smith* issue. I'd like to be clear on your position regarding the cardiologists who came to the ED or were consulted by the ED staff at Harborview on 4/2/08. To me, your letter of February 22 is a little vague on that topic.

Mike

Michael Madden  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Ave. Suite 1900  
Seattle, WA 98101  
T: 206-622-5511  
F: 206-622-8986  
www.bblaw.com

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**From:** Tom Golden [mailto:trg@medilaw.com]  
**Sent:** Tuesday, May 03, 2011 9:35 AM  
**To:** Mike Madden  
**Cc:** mka@mail1.medilaw.com  
**Subject:** Re: Glover depositions

Mike: Dr. Copass was to have had a meeting with Mr. Gizaw. Also. As head of the Emergency Department, Dr. Copass is most certainly a speaking agent on policies and procedures of the emergency department, any decision not to implement a chest pain protocol and EKG issues. Please advise on the status of the requested depositions. Tom Golden

On 4/28/11 12:20 PM, "Mike Madden" <mmadden@bblaw.com> wrote:  
And why would Dr. Copass have any relevant knowledge?

Michael Madden  
Bennett Bigelow & Leedom, P.S.  
1700 Seventh Ave. Suite 1900  
Seattle, WA 98101  
T: 206-622-5511  
F: 206-622-8986  
www.bblaw.com <www.bblaw.com>

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applicable protection. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you think that you have received this email message in error, please notify the sender via email or telephone at (206) 622-5511.

**From:** Tom Golden [<mailto:trg@medilaw.com>]  
**Sent:** Wednesday, April 27, 2011 11:44 AM  
**To:** Mike Madden  
**Cc:** Michelle K. Apodaca  
**Subject:** Glover depositions

Mike: For the next round of depositions, I would like to take the depositions of Dr. Copass, Ann Newcomb and a CR 30(b)(6) designee regarding te taking, reading, overreading and preservation of an EKG in 2008. Please let me know when you have dates. Tom

EXHIBIT 4

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HONORABLE IRA J. UHRIG

FILED IN OPEN COURT  
4/22/2011  
WHATCOM COUNTY CLERK  
By \_\_\_\_\_  
Deputy

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

MARC YOUNGS,  
  
Plaintiff,  
  
v.  
  
PEACEHEALTH, a Washington corporation  
d/b/a PEACEHEALTH ST. JOSEPH  
MEDICAL CENTER and d/b/a  
PEACEHEALTH MEDICAL GROUP, and  
UNKNOWN JOHN DOES,  
  
Defendants.

CAUSE NO. 10-2-03230-1.  
~~[PROPOSED]~~  
  
ORDER

This matter came before the Court upon Plaintiff's Motion for Certification of Order for Discretionary Review pursuant to RAP 2.3(b)(4). In reviewing the motion, the Court has considered:

1. Plaintiff's Motion for Certification of Order for Discretionary Review;
2. Declaration of Andrew Hoyal
3. *Defendant PeaceHealth Response to Plaintiff's Motion for Certification of Order for Discretionary Review*
4. *Order for Discretionary Review*

The Court hereby FINDS as follows:

~~[PROPOSED]~~ ORDER - 1

LUYERA, BARNETT, BRINDLEY,  
BENINGER & CUNNINGHAM,  
ATTORNEYS AT LAW  
6700 BANK OF AMERICA TOWER  
701 FIFTH AVENUE  
SEATTLE, WASHINGTON 98104  
(206) 467-6090

*and April 22, 2011*

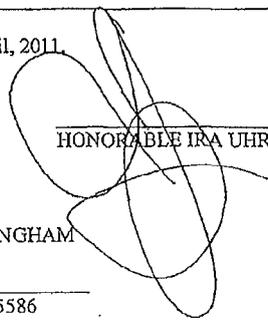
1           1.     The Court's March 25, 2011 order granting Defendant's Motion for  
2 Reconsideration involves a controlling issue of law as to which there is substantial ground  
3 for a difference of opinion. There is no Washington authority addressing the specific issue  
4 of whether the rule in *Loudon v. Mhyre* prohibiting defense counsel from engaging in ex  
5 parte contact with a plaintiff's nonparty treating physicians applies to treating physicians  
6 employed by the defendant. The question is therefore one of first impression requiring  
7 resolution by the appellate courts;

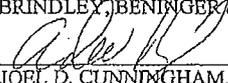
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9           2.     Immediate review of the order and resolution of this issue will materially  
10 advance the ultimate termination of this litigation.

11           The Court being fully apprised, it is hereby ORDERED, ADJUDGED AND  
12 DECREED that Plaintiff's Motion for Certification of Order for Discretionary Review is  
13 GRANTED.  
14

15  
16  
17

18           DATED this 22 day of April, 2011.

  
HONORABLE IRA UHRIG

21 Presented by:  
22 LUVERA, BARNETT  
23 BRINDLEY, BENINGER & CUNNINGHAM  
24   
25 JOEL D. CUNNINGHAM, WSBA #5586  
26 ANDREW HOYAL, WSBA# 21349  
Counsel for Plaintiff

[PROPOSED] ORDER - 1

LUVERA, BARNETT, BRINDLEY,  
BENINGER & CUNNINGHAM  
ATTORNEYS AT LAW  
6700 BANK OF AMERICA TOWER  
701 FIFTH AVENUE  
SEATTLE, WASHINGTON 98104  
(206) 467-6090

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Presented by:

JOHNSON, GRAFFE, KEAY,  
MONIZ & WICK, LLP

By   
John C. Graffe, WSBA #11835  
Heath S. Fox, WSBA #29506  
Attorneys for Defendant PeaceHealth

Approved as to form and notice of presentation waived:

LUVERA, BARNETT, BRINDLEY,  
BENNINGER & CUNNINGHAM

By:   
Joel D. Cunningham, WSBA #5586  
Andrew Hoyal, WSBA #21349  
Attorneys for Plaintiff Marc Youngs

AMENDED ORDER GRANTING MOTION FOR  
RECONSIDERATION - 3

JOHNSON, GRAFFE,  
KEAY, MONIZ & WICK, LLP  
ATTORNEYS AND COUNSELORS AT LAW  
925 FOURTH AVENUE, SUITE 2300  
SEATTLE, WASHINGTON 98104  
PHONE (206) 223-4770  
FACSIMILE (206) 386-7344

# EXHIBIT 5

COPY RECEIVED  
TIME \_\_\_\_\_ BY \_\_\_\_\_

JUN 05 2009

BENNETT BIGELOW  
& LEEDOM

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON  
DIVISION ONE

WILLIAM JACOBUS, individually and )  
as Guardian of ELLEN JACOBUS, )  
a minor, )

Respondent, )

v. )

ERIC KRAUS, M.D., and STATE OF )  
WASHINGTON d/b/a UNIVERSITY OF )  
WASHINGTON, JOHN DOES 1-50, )

Petitioners. )

No. 63346-5-1

COMMISSIONER'S RULING  
DENYING DISCRETIONARY  
REVIEW

In this medical malpractice action brought by plaintiff William Jacobus against defendants the University of Washington, Dr. Eric Kraus and other treating physicians (the University), the University seeks discretionary review of a trial court protective order that prohibits defense counsel from ex parte contact with Jacobus' treating physicians other than Dr. Kraus and two others and permits plaintiff's counsel to have ex parte contact with any of Jacobus' treating physicians other than Dr. Kraus and two others. For the reasons stated below, review is denied.

In January 2008, Jacobus filed a medical malpractice complaint against Dr. Eric Kraus, a physician employed by the University, and John Does 1-50, identified as individuals who provided health care to Jacobus. The complaint alleges that Dr. Kraus failed to properly manage the administration of an anti-epileptic drug, Lamictal, and

Commissioner's Ruling  
No. 63346-5-1/2

thereby caused Jacobus to have a severe reaction called Stevens-Johnson Syndrome. Jacobus further alleges that the University is liable for the acts of the unnamed individuals. As the case progressed, two resident physicians, Dr. Lyudmila Petruk and Dr. James Crew, were named as defendants. Jacobus asserts that he is seeking damages for all injuries resulting from the alleged negligence, including any subsequent malpractice related to the negligence.<sup>1</sup>

Jacobus has received extensive treatment within the University health care system, including University of Washington Medical Center and Harborview Medical Center, before, during, and after the episode that is the focus of the lawsuit. In his witness disclosure, Jacobus identified approximately 230 University-affiliated health care providers whom he reserved the right to call as witnesses. A dispute arose as to ex parte contact with these providers. Jacobus took the position that under Louden v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988), defense counsel could have no ex parte contact with any treating health care provider listed as a potential witness except the "targeted" physicians, Drs. Kraus, Petruk, and Crew. Jacobus also took the position that under Wright v. Group Health Hospital, 103 Wn.2d 192, 691 P.2d 564 (1984), his counsel could have ex parte contact with any of the University-affiliated health care providers except Drs. Kraus, Petruk, and Crew.

The University took the position that it should be allowed to speak directly with University employed treatment providers other than Drs. Kraus, Petruk and Crew, especially those whose testimony may involve issues regarding causation and liability. In an apparent attempt to narrow the controversy, the University provided a list of 17

<sup>1</sup> Plaintiff's Motion for Protective Order.

Commissioner's Ruling  
No. 63346-5-1/3

such individuals, which includes attending physicians who treated Jacobus, as well as those holding administrative positions such as the Director of Emergency Medicine and the Chair of the Department of Rehabilitation Medicine and Chief of Rehabilitation Medicine at Harborview. The University also took the position that Jacobus' counsel should be prohibited from having ex parte contact with hospital employee physicians and residents.

Jacobus sought a protective order, which the trial court granted:

1. Defense counsel is prohibited from *ex parte* contact, directly or indirectly, with any of plaintiff William Jacobus' treating physicians other than Dr. Eric Kraus, Dr. Lyudmila Petruk, and Dr. James Crew.
- .....
3. Plaintiffs' counsel are permitted *ex parte* contact with any of plaintiff William Jacobus' treating physicians other than Dr. Eric Kraus, Dr. Lyudmila Petruk, and Dr. James Crew.<sup>[2]</sup>

The University seeks discretionary review under RAP 2.3(b), probable error that substantially alters the status quo or substantially limits its freedom to act. Both parties renew the arguments they made below.

Regarding paragraph 1 of the order, the University argues that the trial court committed probable error in prohibiting defense counsel from having direct contact with its employees who are nonparty treating physicians. The University argues that the rule in Louden, which prohibits defense counsel from engaging in *ex parte* contact with a plaintiff's physicians, is not an absolute bar on such contact; that the considerations

---

<sup>2</sup> Paragraph 2 of the order, which required defense counsel to provide a list of all Jacobus' treating physicians with whom defense counsel had had contact, is not at issue.

Commissioner's Ruling  
No. 63346-5-1/4

underlying Louden are absent in this context; that both HIPAA<sup>3</sup> and the Washington Health Care Information Act<sup>4</sup> allow disclosure of health care information about a patient without the patient's authorization to any person who requires the information to provide legal services to a health care provider or facility; that these statutes continue to require appropriate confidentiality and prohibit unauthorized use of patient information; that courts in other jurisdictions permit defense counsel to communicate with their employed physicians in cases like this;<sup>5</sup> and that a blanket prohibition runs afoul of other interests, including interfering with the ordinary functions of University counsel.

Jacobus argues that Louden is and has been for more than twenty years an absolute bar on ex parte contact between defense counsel and treating physicians; that the policies underlying Louden remain true in this context; that the University overstates the problem because it is not prohibited from contact with treating physicians, but is only limited to having contact through formal discovery; that the law that provides the most protection for patient privacy prevails and that Louden therefore prevails over HIPAA; that Louden does not conflict with the Washington Health Care Information Act; that the out of state cases are not helpful because they rely on specific state statutes; and that the trial court order does not purport to interfere with the University's ordinary risk management activities outside of this case.

---

<sup>3</sup> Health Insurance Portability and Accountability Act, 29 U.S.C. 1181 et seq.

<sup>4</sup> Washington Health Care Information Act, RCW 70.02.050(b)(b).

<sup>5</sup> See, e.g., Burger v. Lutheran Gen. Hosp., 198 Ill.2d 21, 759 N.E.2d 533 (2001); Estate of Stephens ex rel. Clark v. Galen Health Care, Inc., 911 So.2d 277 (Fl. App. 2 Dist. 2005).

Commissioner's Ruling  
No. 63346-5-1/5

In short, the parties dispute the reach of Louden. I am not persuaded by Jacobus' argument that the University's position necessarily requires overruling Louden, and I am persuaded that this case involves multiple circumstances not present or considered in Louden, including an institutional health care provider defendant, treating physicians whose conduct is not at issue but who are employed by the defendant institutional health care provider, and the impact of HIPAA as well as Washington statutes.<sup>6</sup> Having said that, in light of current Washington case law, I cannot conclude that the trial court order prohibiting defense counsel from having ex parte contact with Jacobus' treating physicians is probable error.

Regarding paragraph 3 of the protection order, the University contends that the trial court committed probable error in allowing Jacobus' counsel to have ex parte contact with any of plaintiff William Jacobus' many treating physicians other than Drs. Kraus, Petruk, and Crew because those treating physicians may be speaking agents for the University and Wright prohibits counsel from contacting an opponent's employees who are managing or speaking agents for the employer. Jacobus contends that there was no error because the University failed to present any evidence as to the speaking authority of any particular treating health care provider. Jacobus also asserts that the trial court order has little practical effect because the treating health care providers are now represented by independent counsel and Jacobus has complied with independent counsel's request that all contact with these treating health care providers be through counsel.

---

<sup>6</sup> This case also includes the additional gloss that the Attorney General represents the named defendants as well as the University's employees and residents.

Commissioner's Ruling  
No. 63346-5-1/6

Wright is a medical malpractice case brought by a plaintiff against Group Health Hospital and an individual physician employed by Group Health. The plaintiff sought to have direct ex parte contact with nurses and other health care providers employed by the hospital. The court noted that the plaintiff sought to interview hospital employees to discover facts incident to the alleged malpractice, not privileged communications. Thus, the attorney-client privilege did not bar plaintiff's attorney from the interviews. Wright, 103 Wn.2d at 195. The question before the court was to determine which of the hospital's health care providers should be protected from approach by adverse counsel. Wright, 103 Wn.2d at 197. The court concluded that plaintiff's counsel was prohibited from ex parte contact with only those hospital employees who have managing authority sufficient to give them the right to speak for and bind the hospital, noting that this "managing-speaking agent test" is a flexible one to be applied to the circumstances of each case. Wright, 103 Wn.2d at 201-02. The court also limited its decision: "This opinion shall not be construed in any manner . . . so as to *require* an employee of a corporation to meet ex parte with adverse counsel. We hold only that a corporate party, or its counsel, may not *prohibit* its nonspeaking/managing agent employees from meeting with adverse counsel." Wright, 103 Wn.2d at 203.

To the extent the trial court order allows Jacobus' counsel to have ex parte contact with any and all treating physicians other than Drs. Kraus, Petruk, and Crew without any consideration of whether some of the treating physicians are speaking/managing agents of the hospital, it appears to be probable error. But at this point it also appears that the order does not sufficiently alter the status quo or limit the University's freedom to act so as to call for interlocutory review.

Commissioner's Ruling  
No. 63346-5-1/7

The University argues that the issues it raises are recurring and affect every hospital in the state. The court in Wright and especially Louden sought to balance the burdens of formal discovery with the problems inherent in ex parte contact. See Wright, 103 Wn.2d at 677. The effect of the protective order here is troubling. I am persuaded that the case presents issues that appear to warrant appellate review, but I am not persuaded that it is essential they be decided on interlocutory review in this case. The discovery cutoff of May 26, 2009 has passed, and trial is scheduled to commence July 13, 2009, although the parties agree that it may be continued if the trial judge is unavailable. At this point it appears that review from a final judgment is adequate. See Scavenius v. Manchester Port Dist., 2 Wn. App. 126, 127, 467 P.2d 372 (1970) (remedy by appeal from a final judgment is generally adequate and the court discourages piecemeal review).

Now, therefore, it is

ORDERED that discretionary review is denied.

Done this 14 day of June, 2009.

*Mary S. Neel*

\_\_\_\_\_  
Court Commissioner

FILED  
COURT OF APPEALS DIV. #1  
STATE OF WASHINGTON  
2009 JUN -4 PM 12:03

1  
2  
3 THE HONORABLE RICHARD EADIE  
4 HEARING DATE: JUNE 16, 2011 AT 8:30 AM  
5

6 SUPERIOR COURT OF THE STATE OF WASHINGTON  
7 FOR KING COUNTY

8 AOLANI E. GLOVER, a single individual,  
9 Plaintiff,

NO. 10-2-35124-8

10 v.  
11 STATE OF WASHINGTON d/b/a  
12 HARBORVIEW MEDICAL CENTER; and  
13 LULU M. GIZAW, PA-C,

AMENDED MEMORANDUM IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER

Defendants.

14 **I. COUNTERSTATEMENT OF ISSUE BEFORE THE COURT**

15 The issue before this court is whether the unambiguous rule that defense counsel may not  
16 have ex parte contact with a non-party treating physician established in Loudon v. Mhyre, 110 Wn.2d  
17 675, 676, 756 P.2 183, 189 (1988), and most recently Smith v. Orthopedics International, 170 Wn.2d  
18 659 (2010), is a nullity just because a treating physician is an employee at another institution operated  
19 by the corporate defendant.

20 In resolving this issue, this issue concerns only subsequent UWMC physicians whose care  
21 does not give rise to any liability. This fact is undisputed.

22 **II. SUMMARY OF ARGUMENT**

23 Aolani Glover contends that HMC was negligent in the delayed diagnosis of her cardiac  
24 condition because of the over five hour delay in being seen by a physician assistant and/or physician  
25 and that this five hour delay was further exacerbated by the negligent diagnosis when finally seen by  
26

AMENDED MEMORANDUM IN OPPOSITION TO  
DEFENDANTS' MOTION FOR PROTECTIVE  
ORDER - 1 of 12

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1 Lulu Gizaw, PA-C. All total, Ms. Glover was at the HMC Emergency Department for approximately  
2 eight hours (11:00-19:00) before Aolani's evolving cardiac condition was first recognized. This  
3 delay prevented early and controlled intervention to prevent the subsequent massive right-sided heart  
4 damage, kidney damage and also the proximate cause of her subsequent heart transplant.

5 At no time has Aolani Glover ever alleged any negligent medical care at any other institutions  
6 or at any other time than that occurring at HMC on April 2, 2008. Aolani Glover has never alleged  
7 any negligence against UWMC or its physicians who cared for her beginning August 5, 2008, and  
8 who have continuously cared for her in both inpatient and outpatient settings and continue to do so  
9 presently. The named defendants in this action are the State of Washington d/b/a Harborview  
10 Medical Center and Lulu Gizaw, PA-C. Nevertheless, defense counsel erroneously argues that he is  
11 legally entitled to have ex parte contact with any and all of Aolani Glover's nonparty treating UWMC  
12 physician as well as any other RCW 7.70 healthcare providers within the University of Washington  
13 Medical system because of a purported attorney-client privilege. Defendant's Motion, p. 6, line 14-  
14 16. This argument is a clear subterfuge to nullify the unambiguous principles and public policy of  
15 Loudon v. Mhyre, 110 Wn.2d 675, 756 P.2d 138 (1988) and Smith v. Orthopedics International, 170  
16 Wn.2d 659 (2010) prohibiting defense counsel from having any direct or indirect ex parte contact  
17 with a patient's treating physician. Any decision by this court recognizing that a patient suing a  
18 HMC physician or the institution itself for a specific negligent event creates, as a matter of law, an  
19 attorney-client relationship between defense counsel and the named defendant to every single person  
20 within the University of Washington medical system effectively nullifies Loudon and Smith and  
21 further allows the defense to convert treating physicians into expert witnesses against their own  
22 patients.  
23

24  
25 A denial of defendant's motion for a protective order does not impair counsel's ability to  
26 defend their client. Any questions that they wish to ask of Aolani's treating physician in a

AMENDED MEMORANDUM IN OPPOSITION TO  
DEFENDANTS' MOTION FOR PROTECTIVE  
ORDER - 2 of 12

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1 confidential ex parte situation, they can ask in a deposition and counsel can consult with transplant  
2 centers across the country for forensic expert witnesses, just as Ms. Glover must do. Granting the  
3 protective order would fundamentally prejudice Aolani Glover's right to a fair trial. Justice Charles  
4 W. Johnston recognized the prejudicial impact of utilizing a treating physician as a defense expert  
5 witness:

6  
7 Such testimony can wreak havoc with a plaintiff's case and possibly  
8 sound its death knell. The prejudicial impact of a treating physician's  
9 adverse expert testimony almost always outweighs the probative  
10 value of the testimony.

11 Carson v. Fine, 123 Wn.2d 206, 234, 867 P.2d 610 (1994).

12 (J. Johnson, dissent).

13 Beginning with Loudon 33 years ago and through it's progeny, and most recently the  
14 Supreme Court opinion in Smith, our Supreme Court and Court of Appeals have never recognized  
15 any exceptions to the strict prohibition by defense counsel against defense counsel having indirect or  
16 direct ex parte contact with a patients treating physician.

17 **III. ONE ADDITIONAL WASHINGTON STATE SUPERIOR COURT CASE HAS**  
18 **ADDED THIS ISSUE BESIDES JACOBUS AND YOUNGS**

19 Defense counsel correctly states this issue did arise in Jacobus v. Krause, King County Cause  
20 08-2-09749-5, in which discretionary review was denied as well as Youngs v. PeachHealth,  
21 Whatcom County Cause No. 10-2-03230-1. The Court of Appeals Division I granted discretionary  
22 review in Youngs. See Golden Declaration. In addition to these two cases, there is a third case,  
23 Small v. PeachHealth d/b/a St. Joseph Hospital, Whatcom County Cause No. 10-2-01077-3, in which  
24 the Honorable Iria Uhrig denied defendant's motion to allow ex parte contact. See Golden  
25 Declaration.

26 **IV. APPLICABLE LAW**

AMENDED MEMORANDUM IN OPPOSITION TO  
DEFENDANTS' MOTION FOR PROTECTIVE  
ORDER - 3 of 12

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1     **A.     **LOUDON UNAMBIGUOUSLY STATES THAT A DEFENSE COUNSEL MAY NOT,****  
2     **AS A MATTER OF PUBLIC POLICY, HAVE EX PARTE CONTACT WITH A**  
3     **PLAINTIFF'S TREATING PHYSICIAN, EVEN THOUGH PATIENT-PHYSICIAN**  
4     **PRIVILEGE WAS WAIVED.**

4     In a unanimous decision, our Supreme Court stated:

5             We hold that the defense counsel may not engage in *ex parte contact*,  
6             but is limited to the formal discovery methods provided by court rule.

7     Loudon at 676. The Supreme Court did not recognize or consider there to be an exceptions to  
8     this rule. Smith and Loudon are clear that prohibition on ex parte contact applies to all "non-party"  
9     treating physicians. In a key paragraph summarizing the holding in Loudon, and identifying the  
10    situation to which Loudon applies, Smith court states:

11            In Loudon, we established the rule that in a personal injury action,  
12            "defense counsel may not engage in ex parte contacts with a  
13            plaintiff's physicians." Loudon, 110 Wash.2d at 682, 756 P.2d 138.  
14            Underlying our decision was a concern for protecting the physician-  
15            patient privilege. Consistent with that notion, we determined that a  
16            plaintiff's waiver of the privilege does not authorize ex parte contact  
17            with a plaintiff's *nonparty* treating physician. In limiting contact  
18            between defense counsel and a plaintiff's *nonparty* treating  
19            physicians to the formal discovery methods provided by court rule,  
20            we indicated that "the burden placed on defendants by having to use  
21            formal discovery is outweighed by the problems inherent in ex parte  
22            contact." Id. At 667, 756 P.2d 138. We rejected the argument that  
23            requiring defense counsel to utilize formal discovery when  
24            communicating with a *nonparty* treating physician unfairly adds to  
25            the cost of litigation and "gives plaintiffs a tactical advantage by  
26            enabling them to monitor the defendants' case preparation."

20     Smith at 665 (emphasis added).

21     The Smith court also recognized the importance of prohibiting defense ex parte contact with  
22     treating physicians, and especially so in medical negligence actions:

23            Courts have recognized that, in the past, permitting "ex parte contacts  
24            with an adversary's treating physician may have been a valuable tool  
25            in the arsenal of savvy counsel. The element of surprise could lead to  
26            case altering, if not for case dispositive results." Law v. Zuckerman,  
            307 F.Supp.2d. 705, 711 (D.Md.2004) (citing Ngo v Standard Told &  
            Equi., Co., 197 F.R.D. 263 (D.Md. 2000)); see also State ex rel.

1            *Woytus v. Ruan*, 776 S.W.2d 389, 395 (Mo.1989) (acknowledging  
2            that **ex parte contact in medical malpractice cases between defense**  
3            **counsel and a nonparty treating physician creates risks that are**  
4            **not generally present in other types of personal injury litigation,**  
5            including the risk of discussing “the impact of a jury’s award upon a  
6            physician’s professional reputation, the rising cost of malpractice  
7            insurance premiums, the notion that the treating physician might be  
8            the next person to be sued,” amount others (quoting *Manion v.*  
9            *N.P.W. Med. Ctr. of N.E. Pa., Inc.*, 676 F.Supp. 585, 594-95  
10            (M.D.Pa1987)), *abrogated on other grounds by Brant v. Pelican*, 856  
11            S.W.2d 658, 661 (Mo.1993).

12            Smith, at 669 n. 2 (emphasis added).

13            Additionally, the Smith court recognized that defense ex parte contact transforms a treating  
14            physician into an expert witness advocated for the defense:

15            “Furthermore, permitting contact between defense counsel and a  
16            nonparty treating physician outside the formal discovery process  
17            undermines the physician’s roll as a fact witness because during the  
18            process the physician would improperly assume a roll akin to that of  
19            an expert witness for the defense. Fact witness testimony is limited to

20            “those opinions or inferences which are (a) rationally  
21            based on the perception of the witness, (b) helpful to a  
22            clearer understanding of the witnesses testimony or  
23            the determination of a fact in issue, and (c) not based  
24            on scientific, technical, or other special knowledge  
25            within the scope of rule 701.”

26            ER 701. Smith, *supra* at 668.<sup>1</sup>

                 In the present case, plaintiff seeks only an order prohibiting ex parte contact with nonparty  
treating physicians. Plaintiff is not suggesting or arguing that the facts and opinions of the UWMC  
treating physicians cannot be obtained. Loudon and Smith specifically provide that such factual  
testimony from treating physicians shall be done through the discovery process. Loudon at 680.<sup>2</sup>

---

<sup>1</sup> See also Peters v. Ballard, 58 Wn.App. 921, 795 P.2d 1158 (1990) [A treating physician testifies based on knowledge and opinions derived solely from factual observation and does not qualify as a CR 26(b)(4)(B) “expert.”]

<sup>2</sup> We are unconvinced that any hardship caused the defendants by having to use formal discovery procedures outweighs the potential risk involved with ex parte interviews.

1 Had Aolani Glover's follow-up cardiology care and all other care been provided at Swedish Medical  
2 Center, there would be no motion before this court and the opinions of treating physicians would be  
3 elicited by deposition. Continuing the prohibition against ex parte contact by defense counsel ensures  
4 that both counsel, and more importantly the trial court and jury, will receive untainted and impartial  
5 testimony from treating physicians based solely on their treatment.

6 **B. THE DEFENDANT SHOULD NOT BE ALLOWED TO EVADE THE HOLDINGS OF**  
7 **LOUDEN AND SMITH BY CONTENDING UWMC TREATING PHYSICIANS AND**  
8 **HEALTHCARE PROVIDERS ARE SOMEHOW A PARTY TO THE LITIGATION**

9 Aolani Glover's subsequent treating physicians at UWMC are not parties to the action when a  
10 corporation is a defendant. Aolani Glover respectfully submits that if a treating physician is not a  
11 "party", whether a named party or a person whose conduct give rise to liability, then Louden and  
12 Smith must apply. This question of who is a "party" was clearly answered in Wright v. Group  
13 Health, 193 Wn.2d 192, 691 P.2 564 (1984), which stated:

14 We hold the best interpretation of "party" in litigation involving  
15 corporations is only those employees who have the legal authority to  
16 "bind" the corporation in a legal evidentiary sense, *i.e.*, those  
employees who have "speaking authority" for the corporation.

17 Id. at 200.

18 The Supreme Court in Wright rejected a claim by Group Health that all of its employees were  
19 "parties" in a lawsuit brought against the corporation. Id. At 194. Only those employees who are  
20 speaking agents for the corporation are parties. Id. at 200-201.

21 In particular, defense counsel contends that Dr. Larry Dean, Dr. Dan Fishbein and "possibly"  
22 Dr. Edward Verrier and Dr. Charles Murray are speaking agents by virtue of their position in  
23 management. See Madden declaration, p. 5. These doctors provided care to Aolani Glover within  
24 their capacity as a direct healthcare provider. Any testimony from them is limited to their specific  
25 treatment.  
26

AMENDED MEMORANDUM IN OPPOSITION TO  
DEFENDANTS' MOTION FOR PROTECTIVE  
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1 Further, there is absolutely no evidence submitted establishing that Drs. Dean, Fishbein,  
2 Verrier and Murray are presently authorized within their alleged administrated capacity to legally  
3 bind the State of Washington and Harborview Medical Center in any issue in this case. There is no  
4 evidence that these UWMC physicians are responsible for or set any Emergency Department policy  
5 at HMC. These UWMC physicians have neither the administrative position nor day-to-day  
6 experience at HMC to be a "speaking agent" to legally bind the defendants.

7  
8 In Young v. Group Health, 85 Wn.2d 322, 534 P.2d 1349 (1975). The Supreme Court  
9 allowed the opinion of a Group Health physician on the material facts regarding the risk of a vaginal  
10 delivery with the fetus in a breech presentation as an ER 801(d)(2) admission against Group Health.  
11 In Young, the testifying physician was also the managing agent for Group Health and participated in  
12 the management of Dylan Young's birth. Id. at 337.<sup>3</sup> The admissibility of an agent's admissions are  
13 dependent upon a finding by the trial court that the declarant is qualified as an expert within the area to  
14 which his testimony pertains; that the declarant was a speaking agent for the principal at the time  
15 when the statement was made, and that the admission is otherwise necessary, reliable and  
16 trustworthy. Young at 337-338 Koninklijke Luchtvaart Maatschappij N.V. KLM v. Tuller, 292 F.2d  
17 775 (D.C. Cir. 1961). In the present case, UWMC physicians Dean, Fishbein, Verrier or Murray  
18 were not involved in Aolani Glover's care at HMC's Emergency Department, nor do they currently  
19 possess the management authority at HMC – let alone UWMC – sufficient to bind the defendants.

20  
21 **C. AN ATTORNEY-CLIENT RELATIONSHIP DOES NOT EXIST BETWEEN**  
22 **DEFENSE COUNSEL AND NONPARTY TREATING PHYSICIANS AND**  
23 **OTHER HEALTHCARE PROVIDERS MERELY BECAUSE THE STATE OF**  
24 **WASHINGTON IS A MAIN PARTY**

25 In addition to attempting to characterize four UWMC treating physicians as speaking agents"  
26 to circumvent Loudon and Smith, defense counsel also argues that "the adherence to Loudon and

1 Smith prohibiting ex parte contact with UWMC healthcare providers “interfere with the attorney-  
2 client relations between my firm and the University” and “obviates the attorney-client privilege.”  
3 Madden declaration p. 4 para. 6. Defense counsel wishes to make every University physician, nurse,  
4 therapist, medical technician or any other RCW 70.7 health care provider who cared for Aolani  
5 Glover at any time, at any location, and for any condition a “client” to permit otherwise prohibited ex  
6 parte contact. This argument was specifically rejected in Wright v. Group Health, 103 Wn.2d 192,  
7 194, 691 P.2d 564 (1984):

8  
9 Group Health argues that as a corporation represented by counsel, its  
10 current and former employees are “client” of the law firm for  
11 purposes of the attorney-client privilege. ... We disagree.

12 Id. at 194. The defense makes no attempt to distinguish Wright and its applicability.

13 From it’s own information website, the University of Washington Medicine provides medical  
14 care at HMC, UWMC, Northwest Hospital and Medical Center and multiple neighborhood clinics.  
15 See Golden declaration. In it’s 2009 report to the community, UWMC stated that it had 1,823  
16 physicians and 4,359 employees. Golden declaration. The defense cannot seriously contend that it  
17 has over five thousand clients in this action. The trial court’s recognition that a suit against the  
18 overarching medical corporation automatically establishes an attorney-client relationship is not  
19 supported by law and flouts the public policy of Loudon and Smith protecting the interest of patients  
20 and the integrity of the adversarial judicial system.

21 The cited case of Sherman v. State, 128 Wn.2d 164, 904 P.2d 355 (1995), does not create an  
22 attorney-client relationship as to all corporate employees. In Sherman, the underlying facts did not  
23 involve a medical negligence case or ex parte contact with treating physicians. The case involved a  
24 resident anesthesiologist who was terminated for diversion and use of drugs and then sought  
25

26 <sup>3</sup> “The plaintiff argues that Dr. Malan was the managing agent for Group Health”.

1 damages. Id. At 176. In Sherman, the anesthesiologist contended an attorney-client relationship  
2 existed between himself and the state attorney general's office representing the University that  
3 required disqualification of the entire Attorney General's office. The Supreme Court held there was  
4 no basis for a subjective belief that Dr. Sherman and the AAG had an attorney-client relationship. Id.  
5 at 190.

6 From the Sherman decision, defense counsel in this case seizes upon the following language  
7 as authority for extending his attorney-client relationship to every employee within the University of  
8 Washington medical system:  
9

10 In arguing that an attorney-client relationship was formed, Dr.  
11 Sherman relies almost entirely on the fact that the memorandum was  
12 headed "CONFIDENTIAL - ATTORNEY CLIENT PRIVILEGE  
13 AND WORK PRODUCT." (Clerk's Papers at 5430. However, the  
14 only reasonable interpretation of these works in this context is that  
15 correspondence between an attorney for a corporate entity and that  
16 entity's employees is subject to the attorney-client privilege of the  
17 corporate entity. See Upjohn Co. v. United States, 449 U.S. 383, 394-  
18 95, 101 S. Ct. 677, 66L. Ed.2d 584 (1981)

19 Sherman at 190 (emphasis added).

20 In Sherman, the referenced attorney-client privilege in this wrongful termination action  
21 existed between the University of Washington administrative personnel involved in the termination  
22 and who were also being sued in their individual capacity. In Sherman, there was no issue of whether  
23 the attorney-client relationship extended beyond the actual participants in the termination and to  
24 every single University employee. Aolani Glover has never contended that Mr. Madden has ever  
25 represented her interest nor has she sought his disqualification. Sherman does not establish that a  
26 medical negligence action arising out of a single discrete incident at HMC creates by operation of law  
an attorney-client relationship with all 1,823 or more physicians and over 4,000 additional employees.  
The absurd result of such a ruling would allow Mr. Madden to speak with every physician, nurse or  
therapist who has ever seen Aolani Glover, either as an inpatient or an outpatient as a neighborhood

1 clinic for whatever reason, and Ms. Glover would never be aware of such ex parte contact.

2 **D. GRANTING DEFENDANTS PROTECTIVE ORDER WOULD RESULT IN**  
3 **EXTREME AND IRREVERSABLE PREJUDICE TO AOLANI GLOVER**  
4 **WHILE DENIAL OF THE MOTION FOR PROTECTIVE ORDER DOES**  
5 **NOT IMPARE A DEFENDANTS' ABILITY TO DEFEND ITSELF.**

6 Granting of the defendant's Motion for Protective Order necessarily hinges upon the finding  
7 of an expansive definition an attorney-client relationship not withstanding its conflict with Wright.  
8 The practical results of such an order would absolutely prevent any medical negligence plaintiff from  
9 establishing the requisite prejudice from potential ex parte contact. All treating provider ex parte  
10 contacts would be cloaked within the attorney-client relationships and the patient would be unable to  
11 present to the trial court evidence of actual prejudice from ex parte contact. See Smith, supra at 672.  
12 There will be no record of what was said in these conversations. Future testimony will be shaped by  
13 ex parte communication and when heard by the trial court and jury, and cannot be remedied. Loudon  
14 and Smith establish a prophylactic rule. The rule is designed to prevent harm from ex parte contact  
15 from occurring in the first place. Attempting to engage in ex parte communication with a treating  
16 physician under the guise attorney-client relationship is merely another end-run around Loudon.  
17 Defense counsel cannot accomplish indirectly what they cannot accomplish directly. Smith at 668-  
18 669.

19 **E. RCW 70.02.050(1)(B) AND FEDERAL LAW DO NOT OVERRULE LOUDON**  
20 **AND SMITH**

21 RCW 70.02.050(1)(b) does recognize the unauthorized disclosure of patient information for  
22 legal purposes but such disclosure of medical records is done by subpoena with notice to the patient.  
23 This statute does not permit ex parte contact with treating physician.

24 RCW 70.02.050 was enacted in 1998 - ten years after the Supreme Court established the  
25 Loudon rule. There is no reference that this statute was intended to abrogate or create an exception to  
26 Loudon. Second, the title to RCW 70.02 pertains to medical records information, not ex parte

1 discussions. Third, the term "legal" with RCW 70.02.050(1)(b) is not defined. The logical  
2 interpretation is that medical records can be obtained in legal proceedings pursuant to statutory  
3 provisions. The term "legal" must be narrowly and logically construed within the meaning of the  
4 statute and not be considered an exception to Loudon and Smith to help the overall legal defense of  
5 the legal institution. Finally, RCW 70.02 requires notice to the patient of any compulsory effort to  
6 obtain medical records, and then only by subpoena and deposition. An interpretation of RCW  
7 70.02.050(1)(b), which would allow ex parte contact with treating physicians must be rejected.  
8

9 Likewise, any suggestion that federal law, such as Health Insurance Portability and  
10 Accountability Act (HIPAA) provides separate basis for allowing defense counsel ex parte contact  
11 with the treating physician is misplaced. In Moreland v. Austin, 284, Ga. 730, 670 S.E.2d 68 (2008).  
12 The Georgia Supreme Court recognized that HIPAA preempts prior Georgia law which allowed ex  
13 parte communication between defense counsel and plaintiff's treating physicians and recognized that  
14 HIPAA affords patients more control over their medical information when it comes to informal  
15 contacts between litigants and physicians. Moreland at 670 S.E.2d 71. A copy of Moreland is  
16 provided. See Golden declaration.  
17

18 Thus, to the extent that HIPAA may be an issue, it is consistent with Loudon and Smith rather  
19 than creating an exception to established state law.

20 **F. THE GRANTING OF THE PROTECTIVE ORDER PLACES TREATING**  
21 **PHYSICIANS IN A CONFLICT OF INTEREST SITUATION**

22 The protective order sought ignores the conflict situation presented to physicians if defense  
23 counsel were allowed to have ex parte contact with treating physicians. Aolani Glover continues to  
24 receive cardiology specialty care, hospitalizations and out patient care at UWMC and a neighborhood  
25 clinic. Aolani Glover has not had any care, either inpatient or outpatient, at HMC other than her  
26 April 2-5, 2008 care. Aolani's current care providers may be required to confer with defense counsel

1 anytime Aolani seeks needed medical care. There is a fiduciary duty between the physician and  
2 patient. Hunter v. Brown, 4 Wn.App. 899, 905, 484 P.2d 1162 (1971) ["The physician-patient  
3 relationship is of a fiduciary character"]. While the fiduciary physician-patient relationship does not  
4 prohibit a physician from giving potentially adverse testimony against his/her patients, Carson v.  
5 Fine, 123 Wn2d 206, 267 P.2d 610 (1994) the physician is his testimony must not become an  
6 advocate or partisan in the legal proceeding. Carson at 218. Questions arise that if the protective  
7 order is granted whether physicians would be advised and/or allowed independent counsel to discuss  
8 their proper role as a treating physician in the litigation? Can the physician be compelled to  
9 participate in ex parte contacts? The risk of prejudice and harm to the patient is too great and the  
10 treating physician must not be placed in this untenable position.

11  
12 CONCLUSION

13 For the forgoing reasons, the motion for protective order must be denied.

14 DATED this 8 day of June, 2011.

15 OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

16  
17 By   
18 Thomas R. Golden, WSBA # 11040  
19 Attorneys for Plaintiff

THE HONORABLE RICHARD EADIE  
HEARING DATE: JUNE 16, 2011 AT 8:30 AM

SUPERIOR COURT OF THE STATE OF WASHINGTON  
FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,

NO. 10-2-35124-8

v.

AMENDED DECLARATION OF  
COUNSEL IN OPPOSITION TO  
DEFENDANTS' MOTION FOR  
PROTECTIVE ORDER

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,

Defendants.

I, Thomas R. Golden, hereby declare under penalty of law: that he is of attorneys for plaintiff Aolani Glover and makes this declaration base upon his own personal knowledge and information.

Attached and incorporated herein as **Exhibit 1** is a true and correct copy of excerpted Emergency Department medical records from Aolani Glover's April 2, 2008, admission to Harborview Medical Center.

Attached and incorporated herein as **Exhibit 2** is a copy of a record prepared by Harborview Medical Center Physician's Assistant Lulu Gizaw. Their document is also Exhibit 2 to Mr. Gizaw's deposition. This exhibit is not a true and correct copy of the *original* hand written Emergency Room Record. Mr. Gizaw acknowledges that he shredded and/or destroyed his original Emergency Room record in the evening hours of April 2, 2008. Also attached as

DECLARATION OF COUNSEL IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER - 1 of 5

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
ATTORNEYS AT LAW  
298 WINSLOW WAY WEST  
BAINBRIDGE ISLAND, WASHINGTON 98110  
(206) 842-1000; (206) 842-0797 FAX

1 part of Exhibit 2 (Exhibit 3 for Gizaw deposition) is Mr. Gizaw's April 10, 2008, medical record  
2 entry acknowledging the creation of a replacement document.

3 Attached as Exhibit 3 are true and correct copies of deposition excerpts of Ms. Aolani  
4 Glover, pages 17, 23, 26, 32, 33, 34.

5 Attached as Exhibit 4 are true and correct copies of portions of University of Washington  
6 (UW Medicine) website, including sections regarding UW physicians, University of Washington  
7 Medical Center, Northwest Hospital and Medical Center and UW Neighborhood Clinics.

8 Attached as Exhibit 5 are true and correct copies of deposition excerpts of Lulu Gizaw,  
9 PA-C pages 40, 77 and deposition Exhibits 4, 5 and 6.

10 Attached as Exhibit 6 are true and correct copies of deposition excerpts of Alice  
11 Brownstein, M.D., pages 40, 41, 51.

12 Attached as Exhibit 7 is a true and correct copy of HMC medical records discharge  
13 summary.

14 Attached as Exhibit 8 are true and correct copies of the admission note of Aolani Glover  
15 from UWMC.

16 Attached as Exhibit 9 are true and correct copy of Whatcom County trial court order in  
17 Small and the Youngs v. PeaceHealth Order granting discretionary review.

18 Attached as Exhibit 10 is a true and correct copy of Moreland v. Austin, 284 Ga. 730  
19 (2008).

20 These medical records and deposition excerpts establish that Aolani Glover arrived at  
21 Harborview Medical Center at approximately 11:00 am and proceeded to the Emergency  
22 Department. She advised HMC of chest pains. Aolani Glover waited 1½ hours before she was  
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DECLARATION OF COUNSEL IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER - 2 of 5

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
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1 even registered. HMC patient registration records confirm a registration time of 12:34 pm.  
2 Aolani Glover was directed to wait and was not taken from the waiting room until 15:12 hours.  
3 Aolani Glover was not taken to an examining room, but placed on a gurney in a hallway where  
4 she waited at least another hour before being seen by defendant Physician Assistant Lulu Gizaw.  
5 Initial blood work and electrocardiogram were ordered as part of an initial treatment plan. The  
6 blood test included testing for Troponin, which a complex of proteins which are integral to the  
7 contraction of cardiac muscles. Troponin levels are used to test for heart disorders, including  
8 myocardial infarction. 16:43 hours, laboratory results of the first set of cardiac enzymes were  
9 available and indicated a Troponin-I level of 5.89 ng/ml. The HMC laboratory normal reference  
10 range is < .40 ng/ml. The HMC laboratory report indicates that a Troponin-I of 0.40 ng/ml or  
11 greater is probable myocardial infarction.  
12

13  
14 This elevated Troponin level requires immediate cardiac consultation and is indicative of  
15 cardiac muscle damage. Notwithstanding the abnormal Troponin-I level, Defendant Gizaw  
16 discharged Aolani Glover at an unknown time, believed to be approximately 18:30 hours.  
17 Aolani was advised that she was not having a cardiac event and that she was probably  
18 experiencing stress. Mr. Gizaw's purported explanation of Ms. Glover's premature and  
19 inappropriate discharge is that he reviewed another patient's laboratory test results, including  
20 Troponin levels, and wrote them on Aolani Glover's *original* Emergency Room Record. The lab  
21 values of this purported unknown patient were supposedly normal. Regardless of the credibility  
22 of Mr. Gizaw's explanation, it is undisputed that he did not ever review Aolani Glover's  
23 laboratory test prior to discharge.  
24  
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26

DECLARATION OF COUNSEL IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER - 3 of 5

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
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1 Mr. Gizaw found Aolani and her father at the outpatient pharmacy and urgently requested  
2 that Aolani return to the Emergency Department. Upon her return to the Emergency  
3 Department, Aolani was reexamined, and at 19:20 hours there was a redraw of blood for cardiac  
4 enzymes. The second Troponin level increased four fold to 24.58 ng/ml.

5  
6 At 21:22 hours, Aolani Glover was taken to the HMC Cardiac Catheterization  
7 Room, where it was first discovered that Aolani Glover had been experiencing a right coronary  
8 artery dissection. Upon admission to the cardiac catheterization room, Aolani Glover still had  
9 good vital signs but quickly experienced multiple cardiac arrests requiring cardiopulmonary  
10 resuscitation (CPR), cardioversion (electric shock) and placement of a balloon pump to maintain  
11 blood pressure. The HMC interventional cardiologists were never able to successfully stent the  
12 right pulmonary artery and reintroduce blood flow through the right coronary artery. Aolani  
13 Glover's critical medical conditions included 1) cardiogenic shock; 2) right coronary artery  
14 dissection, unsuccessfully stented; 3) acute respiratory distress syndrome; 4) ventilator assisted  
15 pneumonia; and 5) acute renal failure. On April 5, 2008, Aolani Glover was transferred to the  
16 University of Washington Medical Center (UWMC) in critical condition with multi-organ system  
17 failure and for consideration of possible heart transplant. Aolani remained hospitalized at  
18 UWMC until April 22, 2008. A subsequent dissection in a left coronary artery required  
19 hospitalization at UWMC on May 6, 2008. Aolani underwent a heart transplant on June 27, 2008  
20 at UWMC.  
21

22  
23 It is plaintiff's liability theory that Harborview Medical Center was negligent in failing to  
24 timely diagnose her cardiac condition and that the five-hour delay was compounded by the  
25 negligent diagnosis of Physician Assistant Lulu Gizaw.  
26

DECLARATION OF COUNSEL IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER - 4 of 5

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DATED this 8 day of June, 2011.

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

By 

Thomas R. Golden, WSBA # 11040  
Attorneys for Plaintiff

DECLARATION OF COUNSEL IN  
OPPOSITION TO DEFENDANTS'  
MOTION FOR PROTECTIVE ORDER - 5 of 5

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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,

vs.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULUM. GIZAW, PA-C,  
Defendants

CASE NO. 10-2-35124-8 SEA

DEFENDANTS' REPLY IN  
SUPPORT OF MOTION FOR A  
PROTECTIVE ORDER

Defendants' Reply in Support of  
Motion for Protective Order

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**I. SUMMARY OF REPLY**

The *Loudon* rule was developed “as a matter of public policy,” in order “to protect the physician-patient privilege,” based on the court’s perception of the relative balance of interests presented by the case-specific facts. *Loudon v. Mhyre*, 110 Wn. 2d 675, 677 (1988); *Smith v. Orthopedics Int’l, Ltd., P.S.*, 170 Wn. 2d 659, 667 (2010). When courts make policy, they necessarily proceed based on the particular circumstances before them, rather than a review of all of the conceivable circumstances that may bear on the question. Neither *Loudon* nor *Smith* involved circumstances or interests similar to those presented here. For example, when the *Loudon* court said it was “unconvinced that any hardship caused the defendants by having to use formal discovery procedures outweighs the potential risk involved with ex parte interviews,” it did not have occasion to consider a circumstance where application of its rule would prevent defense counsel and their clients from obtaining relevant information—evidentiary and otherwise—from employees and agents of the client, except by waiving the attorney-client privilege. Nor did it have occasion to weigh a defendant’s interest in having its counsel consult—on a privileged basis—with its own senior leadership and to receive their input relative to a matter. Likewise, *Smith* and *Loudon* did not consider the fact that the patient-physician privilege (which is purely statutory in Washington) does not apply when a physician discloses privileged or protected information to a lawyer, when that disclosure is for the purpose of allowing the lawyer to render advice to the physician or the physician’s employer. When these factors are considered, extension of *Loudon* is clearly inappropriate.

**II. FACTS IN REPLY**

Plaintiff asserts that an identifiable boundary exists between “defendant” health care providers at Harborview and other “non-targeted” providers who delivered care at University of Washington Medical Center (“UWMC”) or its affiliated clinics, arguing that her care at UWMC should be considered as if it had “been provided at Swedish Medical Center.” This

1 assertion is at odds with the reality of integrated health care systems such as UW Medicine.  
2 To begin with, plaintiff did not independently choose to seek care at UWMC following her  
3 April 2-5, 2008 care at Harborview; rather, HMC transferred her to UWMC because she  
4 needed care that UWMC was best equipped to provide. Madden Supp. Decl. ¶¶ 4, 5, and 6  
5 [April 5, 2008 discharge note; April 5 admit note; AMR transport note]. Furthermore, not  
6 only are all health care providers at Harborview and UWMC employed by the University, but  
7 many of the attending physicians practice at both hospitals, including Drs. Dean, Fishbein,  
8 Murry and Verrier. Madden Supp. Decl. ¶ 2. In the same way, residents and fellows are  
9 commonly assigned to both institutions. Thus, for example, the UWMC-based cardiology  
10 fellow (who plaintiff has agreed we can contact) who was called by the Harborview  
11 Emergency Department to assess plaintiff, drove from UWMC to Harborview for that  
12 purpose. He also treated her at UWMC after her transfer from Harborview. Supp. Madden  
13 Decl. ¶ 3. Furthermore, UW Medicine maintains an integrated medical record system that  
14 includes records from both Harborview and UWMC, so that a UW Medicine physician  
15 stationed at Harborview can review a patient's UWMC records and vice versa. These things  
16 are the essence of an integrated health care delivery system.

### 17 III. ARGUMENT

#### 18 A. *Loudon* should not be applied so as to compel a waiver of attorney-client privilege as 19 a condition of obtaining relevant information from the University's own employees.

20 Plaintiff does not dispute the proposition that *Loudon* was not intended to interfere  
21 with privileged communications between defense counsel and their clients. Instead, he argues  
22 that communications between the University's lawyers and non-targeted UWMC physicians  
23 would not be privileged because they are not "parties" to the case or "clients" of defense  
24 counsel. Both arguments miss the point, which is that the corporate attorney-client  
25 privilege—that is, the ability of a corporate entity to have its lawyers gather information from  
26 its employees and agents relevant to a legal issue and to keep those communications

1 confidential—applies regardless of whether the persons providing information to counsel are  
2 agents or managers or speaking agents of the corporation or whether those agents would be  
3 considered “clients” of the lawyer under the Rules of Professional Conduct. Thus, for  
4 example, *Upjohn Co. v. U.S.*, 449 U.S. 383 (1981), reversed a decision allowing enforcement  
5 of an IRS subpoena of records of communications between Upjohn attorneys and its non-  
6 management employees regarding an investigation of bribes to foreign officials. The Court  
7 rejected the proposition that the attorney-client privilege applies only to communications  
8 between counsel and those in the “control group” of the corporation, stating, “In a  
9 corporation, it may be necessary to glean information relevant to a legal problem from middle  
10 management or non-management personnel as well as from top executives.” *Id.* at 391-92  
11 (citations omitted). The *Upjohn* rule was adopted in Washington by *Sherman v. State*, 128  
12 Wn.2d 164, 190 (1995), where the court held that privileged communications between a  
13 University attorney and a medical resident did not make the resident a client of the attorney,  
14 such that the attorney should have been disqualified from a later lawsuit between the resident  
15 and the University. In so holding, the court concluded that communication “between an  
16 attorney for a corporate entity and that entity’s employees is subject to the attorney-client  
17 privilege of the corporate entity.” *Id.* Accordingly, all communications between defense  
18 counsel—who have been engaged to represent the interests of the University—and University  
19 personnel concerning the matter are privileged. Forcing defense counsel to communicate with  
20 University personnel in the presence of plaintiff’s counsel will compel the University to either  
21 forgo access to their information or waive the attorney-client privilege.

22 **B. *Loudon* should not be applied so as to prevent privileged communications**  
23 **between counsel and the University’s managing or speaking agents.**

24 Plaintiff acknowledges that at least some of the physicians whom he would prevent  
25 from speaking with defense counsel are managing or speaking agents for the University. In  
26 particular, Drs. Dean, Fishbein, and Murry currently manage significant University programs,

Defendants’ Reply in Support of  
Motion for Protective Order - Page 3

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1 and Dr. Verrier did at the time in question. When a case such as this is brought against the  
2 University, each of them would be expected to consult with defense counsel with respect to  
3 the medical issues in the case (including causation) and also to provide their candid evaluation  
4 of the matter, regardless of whether they were involved in the questioned care. Plaintiff has  
5 not offered any authority to support her assertion that a UW Medicine manager who provided  
6 services to her cannot participate in the case except in the role of a witness whose testimony  
7 "is limited to their specific treatment." To the contrary, nothing in *Loudon* suggests that the  
8 court intended, or has authority, to enact such an unprecedented policy.

9 **C. The proposed extension of *Loudon* has no relationship to the patient-physician**  
10 **privilege.**

11 Because the *Loudon* rule is intended to preserve and foster the patient-physician  
12 privilege, its application must be tethered to the scope and purposes of the privilege. In  
13 Washington, the privilege exists solely by virtue of RCW 5.60.060(4), which prohibits a  
14 physician from testifying in a civil action as to information acquired in attending a patient  
15 without his or her consent. *Carson v. Fine*, 123 Wn. 2d 206, 212 (1994). As a statute in  
16 derogation of common law, RCW 5.60.060(4) is strictly construed and its application is  
17 limited by the statutory purposes of facilitating full disclosure by the patient and protecting  
18 against embarrassment which may result from disclosure of medical information. *Id.*  
19 Regardless of how these purposes apply to limit interactions between independent treating  
20 physicians and defense counsel, there is no question that the privilege does not prevent  
21 physicians from disclosing confidential information to their lawyers, or to the lawyers for  
22 their employers. To the contrary, state and federal law already permit such disclosures. RCW  
23 70.02.050(1)(b); 45 C.F.R. § 164.506(a) and (c).

24 **D. The balance of interests tips in favor of the University.**

25 In *Loudon* and *Smith*, the Court expressed a concern that allowing *ex parte* contact  
26 between non-party treating physicians and defense counsel might cause a division of loyalty;

1 that out of sympathy for a colleague or a desire to tamp down malpractice suits, the non-party  
2 treating physician may be induced to shade her testimony in favor of the defendant-physician.  
3 To the extent that there is validity to the notion that contact with defense counsel will produce  
4 these effects, the logical weight of that notion largely vanishes in the present circumstances.  
5 All of the providers—whether “targeted” or not—are employees of the University and  
6 colleagues in UW Medicine and, in addition to duties to patients, each of them owes a duty of  
7 loyalty to the University, which would include a duty to cooperate in the defense of this case.  
8 This situation is far different from the circumstance where counsel may try to enlist an  
9 independent physician as a partisan for defense.

10 **E. *Loudon* does not apply to University risk management personnel.**

11 Plaintiff’s proposed order would extend *Loudon* to the University’s “risk manager.”  
12 Plaintiff cites no authority supporting such a prohibition, and it is not apparent that courts  
13 have jurisdiction to regulate the manner by which the University manages its internal affairs.  
14 Further, it is important to understand that risk management activities encompass both quality  
15 improvement and claims handling services, which are not necessarily connected to the  
16 activities of counsel, and that disclosure of confidential or protected information to risk  
17 management personnel is authorized by statute.

18 **IV. CONCLUSION**

19 For these reasons, the Court should grant the University’s Motion.

20 Dated this 15<sup>th</sup> day of June, 2011.

21 BENNETT BIGELOW & LEEDOM, P.S.

22  
23 By 

24 Michael Madden, WSBA #8747  
25 Carol Sue Janes, WSBA #16557  
26 Special Assistant Attorneys General  
Attorneys for Defendants

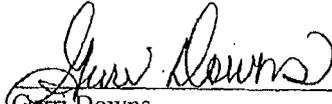
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**CERTIFICATE OF SERVICE**

I, the undersigned, hereby certify under penalty of perjury under the laws of the State of Washington, that I am now, and at all times material hereto, a resident of the State of Washington, over the age of 18 years, not a party to, nor interested in, the above-entitled action, and competent to be a witness herein. I caused a true and correct copy of the foregoing pleading to be served this date, in the manner indicated, to the parties listed below:

Thomas R. Golden, Esq.	<input type="checkbox"/>	Hand Delivered
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/>	Facsimile
298 Winslow Way West	<input checked="" type="checkbox"/>	U.S. Mail
Bainbridge Island, WA 98110	<input checked="" type="checkbox"/>	Email
Fax: (206) 842-0797		
email: <a href="mailto:trg@medilaw.com">trg@medilaw.com</a>		

Dated this 15<sup>th</sup> day of June, 2011, at Seattle, Washington.

  
 \_\_\_\_\_  
 Gerni Downs  
 Legal Assistant

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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,

Plaintiff,

vs.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULUM. GIZAW, PA-C,

Defendants

CASE NO. 10-2-35124-8 SEA

**SUPPLEMENTAL  
DECLARATION OF MICHAEL  
MADDEN RE MOTION FOR  
PROTECTIVE ORDER**

1. I am one of the attorneys for the defendants in this matter and have personal knowledge of the facts stated herein. This declaration supplements my earlier declaration dated May 16, 2011.

2. Based on my personal interactions with the University and its physicians over the last 25 years, I am aware that many UW Medicine attending physicians have privileges at both the UWMC and Harborview Medical Center. Further, I have learned through the medical director at Harborview Medical Center that Dr. Larry Dean, Dr. Dan Fishbein, Dr. Edward Verrier, and Dr. Charles E. Murry have privileges at Harborview and have since at least 2008.

3. As part of my defense of this action, I met with Dr. Abhishek Sinha, a cardiology fellow who provided treatment to plaintiff at Harborview. Plaintiff had previously agreed that I could have contact with Dr. Sinha. I learned from Dr. Sinha that, at the time in

1 question, he was working at UWMC. After he received a call from the Harborview  
2 Emergency Department requesting a cardiology assessment of plaintiff, he drove from  
3 UWMC to Harborview for that purpose. I also learned that Dr. Sinha provided further  
4 treatment for her at UWMC after her transfer from Harborview.

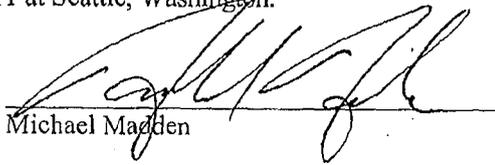
5 4. Attached hereto as Exhibit 6 is a true and correct copy of a document  
6 contained in the medical records received from defendants, entitled "Discharge Summary,"  
7 dated April 5, 2008.

8 5. Attached hereto as Exhibit 7 is a true and correct copy of a document  
9 contained in medical records received from defendants, entitled "Admit Note," dated April 5,  
10 2008.

11 6. Attached hereto as Exhibit 8 is a true and correct copy of a document  
12 contained in medical records received from defendants, dated April 5, 2008, describing  
13 plaintiff's ambulance transport from Harborview to UWMC.

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

16 Dated this 15 day of May 2011 at Seattle, Washington.

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19 Michael Madden  
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CERTIFICATE OF SERVICE

I, the undersigned, hereby certify under penalty of perjury under the laws of the State of Washington, that I am now, and at all times material hereto, a resident of the State of Washington, over the age of 18 years, not a party to, nor interested in, the above-entitled action, and competent to be a witness herein. I caused a true and correct copy of the foregoing pleading to be served this date, in the manner indicated, to the parties listed below:

Thomas R. Golden, Esq.	<input type="checkbox"/>	Hand Delivered
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/>	Facsimile
298 Winslow Way West	<input checked="" type="checkbox"/>	U.S. Mail
Bainbridge Island, WA 98110	<input checked="" type="checkbox"/>	Email
Fax: (206) 842-0797		
email: <a href="mailto:trg@medilaw.com">trg@medilaw.com</a>		

Dated this 15<sup>th</sup> day of June, 2011, at Seattle, Washington.

  
 Gerri Downs  
 Legal Assistant

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Supp. Madden Decl. in Support of  
Motion for Protective Order - Page 3

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# Exhibit 6

GLOVER, AOLANI E H2588523  
Discharge Summary Authenticated  
Service Date: Apr-05-2008  
Dictated by Hedemark, MD, Michael David on Apr-05-2008

24237

**DATE OF ADMISSION:**  
April 2, 2008

**DATE OF DISCHARGE:**  
April 5, 2008

**SERVICE:**  
Cardiology

**ATTENDING:**  
Dr. Michael Chen

**DISCHARGE DIAGNOSES:**

1. Cardiogenic shock
2. Right coronary artery dissection
3. ST elevation myocardial infarction inferior leads
4. Non-gap metabolic acidosis
5. Acute respiratory distress syndrome
6. Ventilator-associated pneumonia
7. Acute renal failure

**CONSULT:**  
Critical Care Pulmonary Medicine

**PROCEDURES:**  
April 3, 2008

- Left heart catheterization (complicated by v-fib requiring defibrillation, intubation)
- Angioplasty and stent of the proximal mid and distal RCA
- Temporary transvenous pacemaker placement (5-French bipolar pacing catheter)
- Intraaortic balloon pump placement

April 4, 2008

- Right IJ Cordis placement
- PA catheter placement

**STUDIES:**  
p CXR (4/5/08):  
Comparison: 4/4/08 Findings: Endotracheal tube tip projects approximately 2.6 cm above the carina. Other tubes and lines are grossly unchanged and in unaltered position. Right pleural fluid is unchanged. No change in appearance of the cardiomeastinal configuration.  
Single portable view of the chest obtained on April 5, 2008 at 4:55 hours shows revision of Swan-Ganz catheter with tip now projected in the proximal right main pulmonary artery. Right pleural effusion unchanged. Appearance of the pulmonary parenchyma is likewise unchanged. No new focal pulmonary abnormalities. Portable supine view of the abdomen obtained on April 4, 2008 at 18:42 hours shows distal end of esophageal catheter terminating in the gastric fundus. Other tubes and lines are unchanged. No bowel dilation. Mild attenuation of the soft tissue outlines is noted. No suspicious ectopic air is seen.

HMC	Patient: GLOVER, AOLANI E (H2588523)	Doc pg 1 of 6	Job pg 234 of 291	Req Id: 987727117	bembryb : 10/12/10 09:47:46
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HMC000234  
CONFIDENTIAL

pAbd Xray (4/5/08):

Portable supine view of the abdomen obtained on April 5, 2008 at 11:00 hours shows distal end of esophageal catheter terminating in the gastric cardia. Other tubes and lines are unchanged. No bowel dilation. Mild bowel distention. Mild attenuation of the soft tissue outlines and centralization of bowel loops may relate to fluid. No suspicious ectopic air is seen. Subtle focal increased density in the right mid hemiabdomen, unclear etiology.

Echocardiogram (4/5/08) with Bubble Study (preliminary):

Severe RV dilatation and systolic dysfunction. Underfilled LV but preserved LV function overall. Inf wall motion abnormality. No new areas of decreased function. Paradoxical septal function consistent with RV overload. Evidence of PFO but not e/o of a significant shunt.

Renal Artery Duplex (4/5/08):

Bilateral renal arteries were patent, could not rule out stenosis. The left renal artery was only visualized in the distal segment and on the right proximal to distal. The flow in the kidneys was not evaluated due to motion. Bilateral renal veins were patent. The flow in the mid to distal aorta was not obtained due to motion artifact and bowel gas. The velocity in the proximal aorta was 196 cm/s. Could not determine the level of the balloon pump due to motion and bowel gas. Right side: Proximal renal artery peak velocity is 114 cm/s, mid renal artery peak velocity is 140cm/s. Distal renal artery peak velocity is 119cm/s. Left side: distal renal artery peak velocity is 79.4 cm/s

portable CXR (4/4/08)

Impression: Feeding tube has been inserted with tip in the gastric fundus. Other tubes and lines are in unaltered position. Intra-aortic balloon pump remains in the descending aorta, several centimeters distal to the left subclavian artery origin. Increasing opacity in both lung bases is likely due to right greater than left effusions, which are new.

Echocardiogram (4/3/08):

Left ventricular cavity size is normal. Systolic function is mild to moderately reduced, EF = 41% by 2D echo. Segmental wall motion abnormalities as described above, notably the inferior wall is akinetic. Right ventricular size is mildly increased, systolic function is moderately to severely reduced. Mild to moderate tricuspid regurgitation otherwise cardiac valves are normal in structure and function. Normal pulmonary artery pressure.

PA & Lat CXR (4/2/08):

Cardiac and mediastinal contours are normal. The lungs and pleural spaces are clear. No pneumothorax or acute bony abnormality.

CTA Aorta (4/2/08):

No evidence of acute or chronic vascular injury.

EKGs

4/5/08 @ 0600: Comparison with 4/3/08 @ 1322. Accelerated Junctional rhythm at HR 77. No e/o P waves. ST elevation in II, III, AVF persist with Q wave in III, AVF. Interval development of Q wave in V3, V4 with ST elevation V3 through V6 and greater than 1mm in V3, V4.

4/4/08 @ 0607: Ventricular pacing at HR 92.

4/3/08 @ 0204: NSR with HR 82. PVCs. Significant ST elevation in II, III, AVF. Q in II, III, AVF. ST depressions in V2-V4.

4/2/08@ 1614: NSR with HR 73. Mild ST elevation, < 1mm in II, III, AVF.

**HISTORY AND PHYSICAL:**

For full details, please review the complete History and Physical by Dr. Cynthia Meier dated April 2, 2008. In brief, Ms: Glover is a 28-year-old woman with a history of migraine headaches and chronic abdominal pain who presented with a one-day history of lightheadedness and chest pressure. She had substernal chest pressure, was evaluated in the ER, given nitroglycerin, morphine, aspirin and metoprolol, and evaluated for possible aortic dissection with a CTA, which was negative. Her troponin levels were subsequently found to be elevated and she was urgently taken to the Cardiac Cath Lab where she was noted to have a right coronary artery dissection. She had v-fib arrest multiple times with shock. She subsequently was intubated and then

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transported to the Cardiac Intensive Care Unit for further care.

#### HOSPITAL COURSE:

1. Right coronary artery dissection. The patient presented with chest pain and found to have a right coronary artery dissection on catheterization. Attempts at stenting were performed during cardiac catheterization. During the cardiac catheterization, the patient became hypotensive, was bolused with normal saline and received a total of 4 liters at that time. Started on dopamine. Had several episodes of ventricular fibrillation requiring defibrillation. Was then bolused with and started on amiodarone, and continued on an amiodarone drip. An intraaortic balloon pump was placed. After the patient's coronary intervention along with a temporary pacemaker, she was transported to the CICU, continued on a heparin drip and ReoPro for 6 hours. Amiodarone was subsequently stopped without increasing times of ectopy, and she remained off amiodarone throughout her hospitalization here. Her initial cardiac enzymes had a troponin of 5.89. These subsequently peaked at 90 and continued to decline until the day of transfer her troponin again peaked at 97 and subsequent troponin levels on day of transfer have declined. At transfer, her last troponin was 76.32. On April 3, she was noted on echocardiogram to have moderately to severely reduced RV function and inferior wall akinesis. Due to her right ventricular failure, she was maintained with fluid boluses and underlying maintenance fluid. At discharge, she was approximately 24 liters up, with minimal urine output. As a result of her continued normal saline boluses and subsequent LR boluses, she became hyperchloremic, in addition had a non-gap metabolic acidosis felt secondary to her hyperchloremia, and prior to discharge, her fluids were switched to bicarb drip. Throughout her hospitalization, attempts were made to maintain a high CVP and wedge pressure. This was accomplished through continued fluid challenge with a goal of CVP greater than 20 and a MAP greater than 60. Her repeat echocardiogram was performed the day of transfer for a concern that she may have shunt resulting in poor oxygenation in her low SvO<sub>2</sub>, as her SvO<sub>2</sub> had dwindled into the 40-50 range. In addition, there were increased difficulties with oxygenation, possibly secondary to fluid that was required to maintain her RV pressures. The echocardiogram with bubble study showed evidence of PFO, but did not have significant shunt apparent, and continued to show inferior wall motion abnormalities, severe RV dilatation and systolic dysfunction, but overall preserved LV function. The patient was started on dobutamine overnight secondary to a need for increased inotrope to possibly help with SvO<sub>2</sub>. In addition, she was continued on dopamine and due to her low MAPs this was unable to be weaned. At transport, she continued to have low urine output, and on the day of transport she had concerning EKG changes in the lateral leads with ST elevation and a rising troponin, but wall motion abnormalities were not detected on echo for her left ventricular side. However, her EKG changes are concerning for a possible anterior involvement. She was maintained at a pacer setting of 90, and due to difficulty with persistent oxygenation in which her SpO<sub>2</sub> had dropped to 80s, PO<sub>2</sub> had dropped to 62 on 100% FiO<sub>2</sub>, we conferred with Critical Care Pulmonary and discussed the possibility of starting nitric oxide in inhaled in the hopes of decreasing her pulmonary vascular resistance. She was started at 5 parts per million prior to transport with excellent results; her SpO<sub>2</sub> increased to 97% from the high 80s and her SvO<sub>2</sub> increased into the 60s and 70s, along with her MAPs increasing subsequently also. Due to these difficulties with oxygenation, Dr. Chen, our attending, discussed with Dr. O'Brien, the attending at the University of Washington Medical Center with regards to future management and decided that a TandemHeart placement in the cath lab would be her next best option, and as a result, she was urgently transported to the UWMC for further care. We are uncertain as to the original etiology of her dissection and why she would have a right coronary artery dissection. It is interesting to note she does seem to take many over-the-counter medications. In addition, she is apparently in some type of migraine headache study with a medication, and it is uncertain whether that would have had an etiology or not, and uncertain if there are any underlying collagen vascular issues. The patient will be transported to UWMC on dopamine, dobutamine, intraaortic balloon pump, pacemaker, inhaled nitric oxide, and intubated.

2. Acute respiratory distress syndrome. The patient has had persistent poor oxygenation necessitating involvement with Critical Care Medicine and Pulmonary Medicine, and through their help,

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she had met criteria for ARDS with bilateral infiltrates, a low P:F ratio and a low pulmonary capillary wedge pressure. As a result, she was started one day prior to transport on lung protective ventilation (LPV) without a PEEP ladder. The morning of transport, additional PEEP was added. This was increased from a PEEP of 5 to a PEEP of 8 in the hopes of increasing oxygenation. This had little to no effect on her SvO2 or cardiac index, and seemed to drop her cardiac output just slightly. As a result, her PEEP was returned to 5, and it was at that time that the nitric oxide was attempted. She was also noted to have the non-gap metabolic acidosis, likely secondary to the rapid normal saline boluses and increased hyperchloremia. As a result of this, the ventilation rate was increased to 18 prior to transport. In addition, she was started on a bicarb drip and 1 liter D5W with 3 ampules bicarb at 150 mL/hr.

3. ID. The patient was noted to have a temperature with a T max of 38.7. She had blood cultures and urine cultures, which were no growth times one day. She also had an endotracheal tube suction that was sent for sputum, culture, and Gram stain. This had a Gram smear of 3+ white blood cells and 3+ gram-positive cocci, and in addition, a culture of 3+ *Staphylococcus aureus* coagulase positive. Sensitivities are pending. She was subsequently started on vancomycin and moxifloxacin for which she has received a dose of moxifloxacin and 2 doses of vancomycin at 1 gram. She is due to receive a third dose of vancomycin; however, she has not had a vancomycin trough, and as she does have acute renal failure, it would be prudent to obtain a vancomycin trough when she transfers over to UWMC. Hence, she likely has ventilator-associated pneumonia and will be appropriately covered with vancomycin. Uncertain if the moxifloxacin would need to be continued, but at this time, given her critical illness, will continue it. She does have allergies to **SULFA** and **PENICILLIN**.

4. Acute renal failure. She had an acute change in her creatinine today to 2.1, and her urine output has decreased. There was concern that her intraaortic balloon pump may be too low and possibly compromising her renal arteries. This necessitated us to obtain an urgent renal duplex; however, due to bowel gas, they were unable to get good flows in arteries, but did note that both left and right renal arteries were patent. The right renal artery seemed to have good flow velocity; however, the left renal artery had some decreased flow velocity. They were unable to visualize the end of the intraaortic balloon pump and tell if it is actually compromising the renal arteries. In addition, attempts were made today to decrease her ratio on the Intraaortic balloon pump from 1:1 to 1:3 to see if her urine output would increase, and this provided no change. However, it is likely that her acute renal failure is simply due to her cardiogenic shock and worsening status.

5. Abdominal distention. The patient has had increasing abdominal distention, possibly due to her right heart failure. Her lactate is also noted to rise today to 2.5. She has a soft abdomen, but it does appear distended. KUB was performed today and seemed to have a nonspecific opacity in the right mid hemi-abdomen of unknown significance. Her transaminases were initially elevated, but have improved today, and her amylase yesterday was normal. Her abdomen will continue to need to be followed.

**ALLERGIES: PENICILLIN, SULFA DRUGS, SHELLFISH**

**MEDICATIONS:**

**MEDICATIONS**

Aspirin EC 325mg tab Dose: 325 mg = 1 tab PO QDay  
 Chlorhexidine gluconate 2% topical liq Dose: 1 application Topical QHS  
 Docusate 250mg/25mL soln Dose: 250 mg = 25 mL PO Q12 Hours  
 Moxifloxacin/0.8% NaCl Dose: 400 mg = 250 mL IVPB Q24 Hours  
 Ranitidine/0.45% NaCl Dose: 50 mg = 50 mL IVPB Q8 Hours  
 Sedation Vacation Dose: 1 each MISC QAM  
 Senna syrup 5mL Dose: 10 mL PO QHS  
 Sodium Chloride 0.9% Dose: 500 mL IV Documentation  
 Sodium chloride 0.9% inj 10mL (syringe) Dose: 10 mL IV Push Q8 Hours  
 Vancomycin/Dextrose 5% Dose: 1 g = 200 mL IVPB Q12 Hours  
 Vitamin multiple, with mineral 15mL soln Dose: 15 mL Feeding Tube QDay

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**INFUSIONS**

Dextrose 5% in Water 850 mL + Sodium bicarbonate 150 mEq Dose: 850 mL IV Infusion  
 DOBUTamine 1000 mg + Dextrose 5% in Water 250 mL Dose: 250 mL IV Infusion , (currently at 4 mcg/kg/min)  
 DOPamine 800 mg + Dextrose 5% in Water 250 mL Dose: 250 mL IV Infusion ( currently at 10 mcg/kg/min)  
 Fentanyl 2500 mcg + Dextrose 5% in Water 200 mL Dose: 200 mL IV Infusion  
 Heparin 20000 units + Dextrose 5% in Water 500 mL Dose: 500 mL IV Infusion  
 Insulin REGULAR 100 units + Dextrose 5% in Water 100 mL Dose: 100 mL IV Infusion  
 Midazolam 50 mg + Dextrose 5% in Water 40 mL Dose: 40 mL IV Infusion

**PRN MEDICATIONS**

Acetaminophen 650mg (2 x 325mg) tab Dose: 650 mg = 2 tab PO Q4 Hours PRN  
 Acetaminophen 650mg/20.3mL soln Dose: 650 mg = 20.3 mL PO Q4 Hours PRN  
 Bisacodyl 10mg supp Dose: 10 mg = 1 supp Rectal QDay PRN  
 Calcium gluconate Dose: 9 mEq = 19.35 mL IVPB On Call PRN  
 Chlorhexidine gluconate 2% topical liq Dose: 1 application Topical Q24 Hours PRN  
 Dextrose 50% 50mL Inj (Emerg) Dose: 12.5 g = 25 mL IV Push On Call PRN  
 Fentanyl 100mcg/2mL inj Dose: 50-100 mcg IV Q10 Minutes PRN  
 Heparin 5,000units/mL Inj Dose: Per Bolus Protocol IV On Call PRN  
 Magnesium sulfate Dose: 16 mEq = 3.94 mL IVPB On Call PRN  
 Morphine 2mg/mL inj Dose: 2-4 mg IV Q5 Minutes PRN  
 Nitroglycerin SL 0.4mg tab #25 Dose: 0.4 mg = 1 tab Sublingual Q5 Minutes PRN  
 Potassium chloride Dose: 40 mEq = 20 mL IVPB On Call PRN  
 Potassium phosphate Dose: 40 mEq = 9.09 mL IVPB On Call PRN  
 Promethazine 25mg tab Dose: 25 mg = 1 tab PO Q6 Hours PRN  
 Promethazine 25mg/mL inj Dose: 25 mg = 1 mL IV Q6 Hours PRN  
 Sodium Chloride 0.9% Dose: 500 mL IV On Call PRN  
 Sodium chloride 0.9% inj 10mL (syringe) Dose: 10 mL IV Push On Call PRN  
 Sodium phosphate Dose: 40 mEq = 10 mL IVPB On Call PRN

**SETTINGS AT TRANSPORT:**

Date 04/05/08 09:08  
 Ventilator Mode: AMV  
 PEEP Set: 5  
 PEEP Total: 5  
 Static Pressure: 16  
 Static Compliance: 39  
 AMV Rate: 18  
 Tidal Volume - PBW: 5.96  
 Minute Ventilation - Total: 7.776  
 O2 Sat: 86  
 O2 Percent Administered: 100  
 O2 Flow Rate: 10Q  
 O2 Delivery Device: Ventilator

**Swan-Ganz Numbers**

Date 04/05/08 10:18  
 CVP: 22  
 PAS: 31  
 PAD: 23  
 PAD: 26  
 SVO2 Continuous: 50  
 CO: 3.9  
 CI: 1.95  
 SVR: 862  
 PVR: 205

**DISCHARGE CONDITION:**

Critical.

**DISPOSITION:**

University of Washington Medical Center, accepting physician Dr. O'Brien, Cardiology.

**CODE STATUS:**

Full.

The physicians listed on this summary can be reached for questions via paging operators at 206-731-3000.

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**Signature Line**

Electronically Reviewed/Signed On: 04/05/08 at 17:42

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Hedemark, MD, Michael David  
Resident, UWMC, Internal Medicine  
Box 354981  
Seattle, WA

Electronically Co-Signed On: 04/05/08 at 19:38

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Chen, MD, PhD, Michael Anthony  
Attending Physician, Div of Cardiology, Dept of Medicine  
Box 359748  
Seattle, WA

cc: O'Brien, MD, Kevin Douglas  
Attending / Associate Professor of Medicine UWMC  
Dept of Med/Cardiology, Box 356422  
Seattle, WA

MDH/LP  
DD:04/05/08  
TD:04/05/08

24237

**CC Address Information**  
none

# Exhibit 7

GLOVER, AOLANI U2645045  
Admit Note Authenticated  
Service Date: Apr-05-2008  
Dictated by Krishnan, MD, Ranjini M on Apr-05-2008

HOSPITAL DAY: 0.1

**CHIEF COMPLAINT**

Cardiogenic shock, Acute respiratory failure, Acute renal failure, Severe metabolic acidosis

**HISTORY OF PRESENT ILLNESS**

28 y.o. woman with migraine headaches and significant family history of premature CAD presented to Harborview ER for new onset chest pain radiating to back and ass. near syncope following which came to the ER when troponin was found to be elevated, had a negative CTA for dissection following which taken to the cath lab urgently. A spiral Right coronary artery dissection was found in the cath lab that was difficult to stent but eventually obtained multiple stents with poor restoration of flow. At that time patient had V Fib arrest when she was defibrillated and intubated. Also placed on a temporary pacer for complete heart block.

Her hospital course was complicated by possible aspiration pneumonia, worsening respiratory failure, acute renal failure and persistent metabolic acidosis followed by hypotension. She was volume resuscitated for RV failure and gained about 10 kg in two days. Her metabolic acidosis was nonanion gap hyperchloremic initially followed by a lactate acidosis and combined respiratory acidosis. Also required increased FIO2 on the vent for which low PPV was initiated. Could not tolerate increased PEEP and finally improved with inhaled NO at 5ppm.

Given her multiorgan failure with RV infarct and failure, she was transferred here for a mechanical support and potentially a heart transplant depending on her clinical course.

**PROBLEM LIST:**

1. Cardiogenic shock
2. Right coronary artery dissection
3. ST elevation myocardial infarction inferior leads
4. Non-gap metabolic acidosis
5. Acute respiratory distress syndrome
6. Ventilator-associated pneumonia
7. Acute renal failure

**ALLERGIES:**

penicillin  
sulfa drugs  
shellfish

**MEDICATIONS PRIOR TO ADMISSION (AT HARBORVIEW)**

Aspirin EC 325mg tab Dose: 325 mg = 1 tab PO QDay  
Chlorhexidine gluconate 2% topical liq Dose: 1 application Topical QHS  
Docusate 250mg/25mL soln Dose: 250 mg = 25 mL PO Q12 Hours  
Moxifloxacin/0.8% NaCl Dose: 400 mg = 250 mL IVPB Q24 Hours  
Ranitidine/0.45% NaCl Dose: 50 mg = 50 mL IVPB Q8 Hours  
Sedation Vacation Dose: 1 each MISC QAM  
Senna syrup 5mL Dose: 10 mL PO QHS

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Sodium chloride 0.9% inj 10mL (syringe) Dose: 10 mL IV Push Q8 Hours  
 Vancomycin/Dextrose 5% Dose: 1 g = 200 mL IVPB Q12 Hours  
 Vitamin multiple, with mineral 15mL soln Dose: 15 mL Feeding Tube QDay

**MEDICATIONS**

Aspirin 325mg tab Dose: 325 mg = 1 tab PO QDay  
 Chlorhexidine 0.12% oral top liq 10mL Dose: 10 mL Swish&Spit BID  
 Information Line Dose: >48hrs/Complex Pts MISC QDay  
 Moxifloxacin/0.8% NaCl Dose: 400 mg = 250 mL IVPB Q24 Hours  
 Ranitidine 150mg/10mL soln Dose: 150 mg = 10 mL Feeding Tube Q12 Hours  
 Vancomycin (Add-Vant) Dose: 1 g IVPB Q12 Hours

**INFUSIONS**

Bivalirudin 250 mg + Sodium Chloride 0.9% 250 mL Dose: 250 mL IV Infusion  
 DOBUTamine 1000 mg + Dextrose 5% in Water 250 mL Dose: 250 mL IV Infusion  
 DOPamine 400 mg + Dextrose 5% in Water 250 mL Dose: 250 mL IV Infusion  
 Fentanyl 5000 mcg Dose: IV Infusion  
 Insulin REGULAR 100 units + Sodium Chloride 0.9% 100 mL Dose: 100 mL IV Infusion  
 Midazolam 100 mg + Dextrose 5% in Water 80 mL Dose: 80 mL IV Infusion  
 NitroGLYCERIN 50 mg + Dextrose 5% in Water 250 mL Dose: 250 mL IV Infusion

**PRN MEDICATIONS**

See eMAR

**PAST MEDICAL HISTORY**

Migraine headaches  
 Chronic abdominal pain

**MEDICATIONS PRIOR TO ADMISSION**

Aviane PO qd  
 Phenergan PRN headache  
 Frovatriptan x1 on the evening prior to admission

**FAMILY HISTORY**

Father with MI vs vasospams in 40's. Paternal aunt with MI in her 40's. Aunt with myocardial bridge. Mother passed away of cancer.

**SOCIAL HISTORY**

Patient is currently in training to take the police fitness test. ETOH: none. Tobacco: none. Illicits: none.

**VITALS (Most recent and 24 hour range.)**

Date	Result	Last	MIN	--	MAX
04/05/08 20:00	Temp C:	36	35.8	--	38.7
04/05/08 21:44	HR:	74	69	--	90
04/05/08 21:00	RR:	20	15	--	22
04/05/08 20:01	SBP Non-Inv:	113	103	--	113
04/05/08 20:01	DBP Non-Inv:	21	21	--	46
04/05/08 20:01	MAP Non-Inv:	55	55	--	63
04/05/08 21:44	SBP-Arterial:	117	60	--	145
04/05/08 21:44	DBP-Arterial:	52	38	--	64
04/05/08 21:44	MAP-Arterial:	80	51	--	94

**HEMODYNAMICS**

(From harborview)

CVP: 13; PAS: 23; PAD: 17; PAD: 20  
 SVO2 Continuous: 73  
 CO: 4.7; CI: 2.35;SVR: 894; PVR: 259

**ORCA I&O DATA**

Height: 182.0 (cm) 5' 12" (ft/in) (04/05/2008)

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Admit Wt: 79.00 (kg) 174 (lbs) (04/05/2008)  
 Last Daily Wt: 92 (kg) 202 (lbs) (04/04/08 04:00)  
 Previous Daily Wt: 79 (kg) 174 (lbs) (04/03/08 01:00)

**CISR I&O** (Cumulative Total as of)

Result	04/01/2008	04/02/2008	04/03/2008	04/04/2008	04/05/2008	Total
Intake Total (0600)	0	1680	13596	11272	3786	30333
Output Total (0600)	0	1130	2352	911	776	5171
Net I&O Total (0600)	0	550	11244	10361	3007	25162
Daily weight				92		N/A

**RESPIRATORY DATA** (Most recent and 24 hour range.)

Date 04/05/08 20:01  
 Ventilator Mode: AMV  
 PEEP Set: 5  
 PEEP Total: 5  
 Static Pressure: 23  
 Static Compliance: 11  
 AMV Rate: 20  
 Tidal Volume - PBW: 6.90  
 Minute Ventilation - Total: 10  
 O2 Sat: 100  
 O2 Percent Administered: 30  
 O2 Flow Rate: 100  
 O2 Delivery Device: Ventilator

**REVIEW OF SYSTEMS**

[X] Unable to Obtain due to Patient Condition

**PHYSICAL EXAM**

G: Intubated and sedated  
 E: EOMI, PERRL  
 ENMT: o/p clear  
 RESP: CTAB  
 CV: JVP is flat, RRR, no m/r/g, no Edema  
 ABD: soft, minimally tender diffusely, NABS, ND  
 MS: Normal B & T, 2+ PT and radial pulses bilat  
 SKIN: no rashes  
 NEURO: moving all ext, CN grossly intact

**LABORATORY STUDIES**

**RESULTS FROM TODAY RESULTS FROM YESTERDAY**

04/05/08 20:39 04/04/08 18:05

? ICa --- ? ICa ---  
 137 115 21 ? Ca 6.9 139 116 13 ? Ca 7.7  
 -----<136 ? Mg 2.0 -----<125 ? Mg 2.0  
 4.8 20 2.4 ? Phos 4.5 4.7 18 1.2 ? Phos 3.0

**RESULTS FROM TODAY RESULTS FROM YESTERDAY**

04/05/08 19:50 04/04/08 21:00

10.6 ? PT 44.2 11.5 ? PT 18.0  
 14.39]-----[ 102 ? INR 4.8 13.99]-----[ 165 ? INR 1.6  
 33 ? PTT 129 36 ? PTT 72

**OTHER LABORATORY STUDIES**

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Date 04/05/08 18:45  
 Amylase (Total): 31  
 AST (GOT): 120  
 ALT (GPT): 80  
 Alk Phos (Total): 21  
 Bilirubin (Total): 0.6  
 Albumin: 1.9  
 CK: 2670  
 CK-MB Mass: 44  
 Troponin-I: 75.92

**LAST 6 HEMATOCRITS IN PRECEDING 24 HOURS**

04/05/08 18:45 04/05/08 16:10 04/05/08 03:52 04/04/08 21:00 04/04/08 13:00 04/04/08 03:45  
 33 36 34 36 37 37

**PROCEDURES:**

April 3, 2008 (HMC)

- Left heart catheterization (complicated by v-fib requiring defibrillation, intubation)
- Angioplasty and stent of the proximal mid and distal RCA
- Temporary transvenous pacemaker placement (5-French bipolar pacing catheter)
- Intraaortic balloon pump placement

April 4, 2008 (HMC)

- Right IJ Cordis placement
- PA catheter placement

April 5, 2008 (UWMC)

- Right Tandem Heart placement
- IABP change
- Right IJ Transvenous pacer
- Left IJ Triple lumen

**ASSESSMENT / PLAN**

28 year old female with s/p RCA dissection post stent placement to proximal, mid and distal RCA with poor restoration of distal flow, s/p V.Fib arrest, mechanical ventilation, acute respiratory failure, renal failure, persistent metabolic acidosis, hypotension now s/p tandem heart placement for the RV also has a IABP for LV support continues to be critically ill.

1) CARDIAC: Tolerated the procedure in the cath lab. No immediate complications. Accelerated junctional rhythm with back up pacing. Blood pressure improving. Has a Triple lumen on the Left IJ for SvO2 and CVP. IABP 1:1. On Dobutamine at 5mcg/kg/mn and Dopamine at 9mcg/kg/mn. Continued on ASA and Plavix for ACS and PCI 4/2/08. last ECHO from Harborview was reviewed, which showed severe RV dilatation, dysfunction, paradoxical septal motion and a PFO without significant shunting.

**PLAN:**

- 1) Wean and titrate down the dopamine.
- 2) Continue dobutamine at same rate
- 3) Transvenous pacing at back up rate of 50 bpm and output set at 10 mA, sensitivity 2 mA
- 4) Titrate tandem flows for SvO2 from TLC, as Swan not feasible with a Right heart tandem. Will use Fick Cardiac Output (125cc/mn) / (SaO2 - SvO2) x 1.36 x Hgb)
- 5) Will continue Inhaled NO and titrate upto 40 ppm for now until her hypoxia improves.

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6) Continue Aspirin. Will hold Plavix for now because of anticipation of a RVAD placement and risk of bleeding.

7) Continue Bivalirudin given she is thrombocytopenic.

B) PULMONARY: Increasing FIO2 requirements in the setting of RV infarct, aspiration pneumonia. Although a PFO was detectable, no evidence of a major interatrial shunt by TTE. CXR c/w with pulmonary edema and bilateral pleural effusions. SaO2 responded to inhaled NO. On AC rate 15, TV 450, PEEP of 5. Could not tolerate increased PEEP at harborview. On Moxifloxacin Vancomycin for ? aspiration pneumonia. Sputum positive for *S. aureus*.

PLAN:

- 1) Will continue Moxifloxacin and Vancomycin.
- 2) Continue AC but increase the rate to 20 and TV to 500 in an effort to correct acidosis, which is now a mixed respiratory and metabolic acidosis.
- 3) Continue inhaled NO for RV afterload reduction.

C) RENAL: Acute tubular necrosis mostly due to hypotension and hypoxia. UO decreased. Net positive and has gained 13 kilos in two days due to volume resuscitation. CVP at 13. Creatinine around 2 from 1

PLAN: 1) Lasix 200mg ivx 1 tonight.

2) Strict I/Os and daily weights.

3) Correct metabolic acidosis but will restrict the use of NaHCO3 due to increased volume that needs to be given. Will first correct the respiratory component of the acidosis by increasing the ventilatory rate.

D) ID: No temp spikes.

PLAN: Continue Vancomycin and Moxifloxacin.

Repeat cultures here.

E) FEN: Hyperchloremic metabolic acidosis with respiratory acidosis.

PLAN:

- 1) Correct respiratory acidosis first.
- 2) Follow ABGs every 2 to 4 hours until it improves.
- 3) NPO tonight.

F) HEME: Concerning for Heparin induced thrombocytopenia due to a significant drop in platelet.

PLAN: Start bivalirudin and titrate per protocol here.

Type and crossmatch. Patient is A positive

G) PROPHYLAXIS: On Bivalirudin as above. Will continue the ranitidine at 150 mg iv bid.

Patient is full code and is considered for a ventricular assist device placement if clinical condition continues to be the same or worse.

**Attending Statement:**

I saw and evaluated this patient today with Dr. Krishnan and the Cardiology B ICU team.

I agree with Dr. Krishnan's note for today.

I personally examined the patient today and reviewed the patient's clinical course, laboratory data, and:

radiological studies

ventilator parameters

hemodynamic data

**PERTINENT HISTORY, EXAM AND DATA:** Patient accepted in emergent transfer from HMC for progressive hypotension, hypoxemia, pneumonia, acute renal insufficiency and worsening acidosis following large RV/inferior MI on 4/2/2008. Patient managed by Dr. Michael Chen at HMC, who called me to request advice on management this AM in setting of critical worsening of clinical status. Patient was on Dobutamine 5 mcg/kg/min, Dopamine 10 mcg/kg/min at time of transfer, with inhaled NO added at 5 ppm just prior to transfer. I arranged immediate transfer to UWMC Cardiac Catheterization Laboratory for placement of right-sided Tandem Heart (percutaneous ventricular assist device), replacement of IABP, relocation of temporary transvenous ventricular pacing wire, removal of Swan-Ganz catheter, and placement of a triple-lumen central venous catheter. Patient was extremely acidotic upon arrival in Cath lab, and IABP augmentation improved slightly with administration of NaHCO<sub>3</sub>.

**DIAGNOSES, ASSESSMENT, AND PLAN:**

The following conditions contribute to complex, high-level decision-making and to the high probability of acute, clinically significant deterioration. The statements represent my decisions unless otherwise indicated.

1. Cardiogenic shock status post RV infarct - Placement of right-sided Tandem Heart resulted in slow improvement in hemodynamic status so that we were able to wean off Dobutamine over the 3-4 hours after its placement. Patient remained on Dobutamine at 5 mcg/kg/min, and IABP was a very helpful adjunct for maintaining MAP. Patient had peak CPK total elevation of almost 8700 at HMC and Cath report suggests poor reperfusion of RCA after multiple stent placement for spiral dissection. Therefore, I suspect that meaningful recovery of RV function is unlikely and intermediate plan is to try to stabilize hemodynamics, diurese to improve pulmonary function and renal function and treat infection with goal of transitioning to IVAD next week, if infectious and pulmonary status improve sufficiently
2. Respiratory - Patient had PaO<sub>2</sub> of 62 on 100% FIO<sub>2</sub> until inhaled NO added just prior to transfer. Growing *S. aureus* from lungs. Suspect patient has both aspiration pneumonia and pulmonary edema, in setting of 16 kg weight increase (from 76 to 92 kg) while at HMC. Have increased NO to 40 ppm to maximize oxygenation and minimize pulmonary vascular resistance. Increasing ventilatory rate to maintain PCO<sub>2</sub> at 40 so as not to further stimulate

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hyperchloremic metabolic acidosis.

3. ID - Continuing Vancomycin and moxifloxacin.

4. Renal - Patient almost certainly has ATN given acuity of Cr rise. Therefore, I expect Cr to continue to rise further over next few days, despite restoration of normal perfusion pressure. Will give Lasix 200 mg IV to see if kidneys respond. Might need UF.

[x] I spent a total of 240 minutes personally providing critical care and formulating a plan for the day, independent of any time spent teaching or performing any separately billable procedures.

[x] This time includes meeting with the patient's father, stepmother for data gathering, discussion of treatment options, and care planning as the patient was incapable of participating in medical decision making.

Name: Kevin O'Brien

UWP 6437

Date of Service: 04/05/2008

**Signature Line**

Electronically Reviewed/Signed On: 04/06/08 at 12:45

---

Krishnan, MD, Ranjini M  
Fellow, Dept of Medicine, Cardiology  
Box 357710  
Seattle, WA

Electronically Co-Signed On: 04/07/08 at 06:57

---

O'Brien, MD, Kevin Douglas  
Attending / Associate Professor of Medicine UWMC  
Dept of Med/Cardiology, Box 356422  
Seattle, WA

Electronically Co-Signed On: 04/06/08 at 15:53

---

Krishnan, MD, Ranjini M  
Fellow, Dept of Medicine, Cardiology  
Box 357710  
Seattle, WA

<https://mindscape.mcis.washington.edu/mindscape/java/viewDocument.htm?eventId=566...> 10/14/2010

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RMK  
DD:04/05/08

CC Address Information  
none

<https://mindscape.mcis.washington.edu/mindscape/java/viewDocument.htm?eventId=566...> 10/14/2010

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CONFIDENTIAL

# Exhibit 8





**FILED**  
KING COUNTY, WASHINGTON

**JUN 16 2011**

SUPERIOR COURT CLERK  
BY ANDREW T. HAYLS  
DEPUTY

SUPERIOR COURT OF THE STATE OF WASHINGTON  
FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,

v.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,  
Defendants.

NO. 10-2-35124-8 SEA

ORDER RE: DEFENDANTS' MOTION  
FOR PROTECTIVE ORDER

This matter came before the Court upon Defendants' Motion for Protective Order Permitting *Ex Parte* Contact with Plaintiff's Treating Health Care Providers. In reviewing the motion, the Court has considered:

1. Defendants' Motion for Protective Order;
2. Declaration of Michael Madden with Exhibits thereto;
3. Plaintiff's Memorandum in Opposition to Defendants' Motion for Protective Order;
4. Declaration of Counsel in Opposition to Defendants' Motion for Protective Order with Exhibits thereto; and
5. Defendants' Reply.
6. *Supplemental Declaration of Michael Madden* <sup>TW</sup>

ORDER RE DEFENDANTS' MOTION  
FOR PROTECTIVE ORDER - 1 of 2

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
ATTORNEYS AT LAW  
298 WINSLOW WAY WEST  
BAINBRIDGE ISLAND, WASHINGTON 98110  
(206) 842-1000; (206) 842-0797 FAX

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The Court being fully apprised, hereby DENIES Defendants' Motion for Protective Order;

It is further Ordered that Defense counsel and the defendant's risk manager are prohibited from *ex parte* contact, directly or indirectly, with any of Plaintiff Aolani Glover's treating physicians at University of Washington Medical Center.

DATED this 16<sup>th</sup> day of June, 2011.

Richard D Eadie  
HONORABLE RICHARD EADIE

Presented By:

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

Thomas R. Golden

Thomas R. Golden, WSBA # 11040  
Attorneys for Plaintiff

*Approved as to form:*

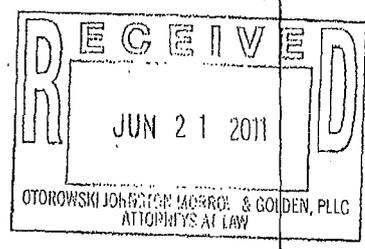
Richard D Eadie  
*Special Assistant Attorney General  
attorney for defendants*

ORDER RE DEFENDANTS' MOTION  
FOR PROTECTIVE ORDER - 2 of 2

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
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IT IS ORDERED that moving party is required to provide a copy of this order to all parties who have appeared in the case.



SUPERIOR COURT OF THE STATE OF WASHINGTON  
FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,  
v.  
STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,  
Defendants.

NO. 10-2-01077-3  
ORDER ON MOTION FOR  
CERTIFICATION

This matter came before the Court upon the parties joint Motion for Certification of Order for Discretionary Review pursuant to RAP 2.3(b)(4). In reviewing the motion, the Court has considered: the Court's Order on Defendants' Motion for Protective Order and the files and records herein and hereby finds:

I. The Court's Order on Defendant's Motion for Protective Order involves a controlling issue of law as to which there is substantial ground for a difference of opinion. There is no Washington authority addressing the specific issue of whether the rule in Loudon v. Mhyre and Smith v. Orthopedics International prohibiting defense counsel from engaging in ex parte contact with a plaintiff's nonparty treating physician applies to treating physicians employed by the defendant. The question is therefore one of first impression requiring resolution by the appellate courts;

ORDER ON MOTION FOR  
CERTIFICATION - 1 of 1

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BAINBRIDGE ISLAND, WASHINGTON 98110  
(206) 842-1000; (206) 842-0797 FAX

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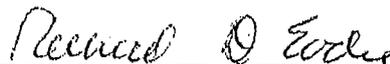
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2. Immediate review of the order and resolution of this issue will materially advance the ultimate termination of this litigation.

The Court being fully apprised, it is hereby ORDERED, ADJUDGED AND DECREED that the parties' Joint Motion for Certification of Order for Discretionary Review is GRANTED.

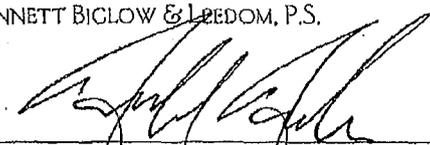
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DATED this 17<sup>th</sup> day of June, 2011.

  
\_\_\_\_\_  
HONORABLE RICHARD ADIE

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC    BENNETT BICLOW & FREEDOM, P.S.

  
\_\_\_\_\_  
Thomas R. Golden, WSBA # 11040  
Attorneys for Plaintiff

  
\_\_\_\_\_  
Michael Madden, WSBA #8747  
Attorneys for Defendants

ORDER ON MOTION FOR  
CERTIFICATION - 2 of 2

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC  
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The Honorable Richard Eadie

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,

NO. 10-2-35124-8 SEA

vs.

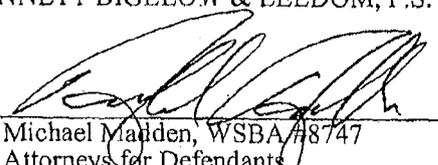
NOTICE OF DISCRETIONARY  
REVIEW TO COURT OF APPEALS  
DIVISION ONE

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,  
Defendant.

Defendants State of Washington and Lulu M. Gizaw PA-C hereby seek review by the Court of Appeals, Division I, of the Order denying defendant's motion for a protective order entered by the King County Superior Court (Honorable Richard Eadie) on June 16, 2011. A copy of the Order is attached to this notice as Exhibit A.

DATED this 11 day of July, 2011.

BENNETT BIGELOW & LEEDOM, P.S.

By   
Michael Madden, WSBA #8747  
Attorneys for Defendants

**CERTIFICATE OF SERVICE**

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I certify under penalty under the laws of the State of Washington that on July 11, 2011,  
I caused a true and correct copy of the foregoing NOTICE OF DISCRETIONARY REVIEW  
TO COURT OF APPEALS DIVISION ONE to be delivered as follows:

Thomas R. Golden	<input type="checkbox"/>	Hand Delivered
Otorowski Johnston Morrow & Golden, PLLC	<input type="checkbox"/>	Facsimile
298 Winslow Way West	<input type="checkbox"/>	Email
Bainbridge Island, WA 98110	<input checked="" type="checkbox"/>	1 <sup>st</sup> Class Mail
Fax: (206) 842-0797	<input type="checkbox"/>	Priority Mail
email: <a href="mailto:trg@medilaw.com">trg@medilaw.com</a>	<input type="checkbox"/>	Federal Express, Next Day

  
Gerri Downs

{1408.00092/M0388218.DOCX; 2}

# **EXHIBIT A**

**FILED**  
KING COUNTY, WASHINGTON

**JUN 16 2011**

SUPERIOR COURT CLERK  
BY ANDREW T. HAVUS  
DEPUTY

SUPERIOR COURT OF THE STATE OF WASHINGTON  
FOR KING COUNTY

AOLANI E. GLOVER, a single individual,  
Plaintiff,

v.

STATE OF WASHINGTON d/b/a  
HARBORVIEW MEDICAL CENTER; and  
LULU M. GIZAW, PA-C,  
Defendants.

NO: 10-2-35124-8 SEA

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FOR PROTECTIVE ORDER

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3. Plaintiff's Memorandum in Opposition to Defendants' Motion for Protective Order;
4. Declaration of Counsel in Opposition to Defendants' Motion for Protective Order with Exhibits thereto; and
5. Defendants' Reply.

6. *Supplemental Declaration of Michael Madden* <sup>TMA</sup>

ORDER RE DEFENDANTS' MOTION  
FOR PROTECTIVE ORDER - 1 of 2

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The Court being fully apprised, hereby DENIES Defendants' Motion for Protective Order;

It is further Ordered that Defense counsel and the defendant's risk manager are prohibited from *ex parte* contact, directly or indirectly, with any of Plaintiff Aolani Glover's treating physicians at University of Washington Medical Center.

DATED this 16<sup>th</sup> day of June, 2011.

*Richard D Eadie*  
HONORABLE RICHARD EADIE

Presented By:

OTOROWSKI JOHNSTON MORROW & GOLDEN, PLLC

*Thomas R Golden*

Thomas R. Golden, WSBA # 11040  
Attorneys for Plaintiff

*Approved as to form:*

*Richard D Eadie*  
Special Assistant Attorney General  
attorney for defendants

ORDER RE DEFENDANTS' MOTION  
FOR PROTECTIVE ORDER - 2 of 2

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