No. 98118-3

COA No. 78574-5-I

SUPREME COURT OF THE STATE OF WASHINGTON

JAMES NEEDHAM, Individually,

Respondent,

v.

SHERYL DREYER, Individually, and her marital community, and DAVITA EVERETT PHYSICIANS, INC. P.S. d/b/a The Everett Clinic,

Petitioners.

ON APPEAL FROM SNOHOMISH COUNTY SUPERIOR COURT

BRIEF OF WASHINGTON STATE MEDICAL ASSOCIATION, WASHINGTON STATE HOSPITAL ASSOCIATION, AND AMERICAN MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF GRANTING REVIEW

Gregory M. Miller, WSBA No. 14459
Randolph J. Johnson, WSBA No. 50129

CARNEY BADLEY SPELLMAN, P.S.
701 Fifth Avenue, Suite 3600
Seattle, Washington 98104-7010
(206) 622-8020

Attorneys for Amici Curiae Washington State Medical Association, Washington State Hospital Association, and the American Medical Association

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Statutes and Constitutional Provision

I. IDENTITY AND INTEREST OF *AMICI*

Amici Curiae, the Washington State Medical Association, the Washington State Hospital Association, and the American Medical Association ask the Court to take review of the Court of Appeals decision ("Decision") due to three issues of deep concern that affect their members' potential liability as they provide health care throughout Washington State every day.

In 2015 this Court decided three medical malpractice appeals addressing the exercise of judgment instruction in two decisions filed the same day in *Fergen v. Sestero,* 182 Wn.2d 794, 346 P.3d 708 (2015) and *Paetsch v. Spokane Dermatology Clinic, P.S.*, 182 Wn.2d 842, 348 P.3d 389 (2015), in order to settle the issue. Both upheld the instruction: *Fergen* 5-4, with a dissent; *Paetsch*, 9-0, ruled that *Fergen* resolved the issue and, because it was unanimous, the dissent's arguments were put to rest. But, the Decision ignored *Paetsch* and followed Respondent's analysis based on the *Fergen* dissent. It misconstrued the *Fergen* majority's ruling to hold the instruction applies in such a narrow range of circumstances that it guts the instruction. This conflicts with *Fergen* and *Paetsch*.

The appellate court also disregarded much of the medical evidence presented by Dr. Dreyer and her medical experts which had been accepted by the jury. This usurped the jury's role and got the medicine wrong. By ignoring and reweighing the evidence on appeal, the panel strayed from its appellate role, infringed on the

constitutional right of the jury to decide the facts, and misunderstood the medical practice. By choosing who to believe and what the meaning of their medical testimony was – and thus, what occurred *medically* – it usurped the role of the jury. Our jurors have had the exclusive right to decide the facts since adoption of the Constitution in 1889. The ban on judicial infringement on the jury's authority to decide the facts applies no less to appellate judges than trial judges.

Medical malpractice cases are driven by the medicine and the facts. If appellate judges choose or reject medical trial testimony and decide what the "correct" medical practice is in a case, they can be wrong, and were here. The Decision disregarded Dr. Dreyer's "observational exam" of Respondent as if such exams are of no value or it did not occur, which was wrong on both counts. This is clear medical error as to what a physician takes into account when making clinical decisions. It was also factually wrong, as seen *infra*.

The Court should address whether admission of Respondent's admitted consumption of alcohol, and the expert testimony as to its possible effect on his injury was, as the trial court believed, relevant evidence to help the jury decide if medical negligence was to blame for his injury (particularly in light of each person's responsibility for their own actions, *e.g., Dunnington v. Virginia Mason Medical Center,* 187 Wn.2d 629, 638-639, 389 P.3d 498 (2017) (whether patient's actions may contribute to or cause the harm complained of is a jury question)), or reversible error per the Decision.

II. STATEMENT OF THE CASE

Respondent was found by friends "shivering and incoherent" on New Year's Day 2013, "passed out in the snow" outside his cabin after what he called "a 7 day drinking binge and [when] he was too weak to get himself up." PRV p. 5, referencing 4 RP (Smith) 555-56 and defendant's trial exhibit 103-458. His frostbite injuries required his legs to be amputated below the knees. PRV, p. 6.

Respondent sued his primary care physician Dr. Dreyer for alleged negligence in causing his injuries. *Amici* agree with Petitioners' statement that Respondent "sued Dr. Dreyer, claiming that her failure to diagnose *pneumonia* at the December 28 visit caused his frostbite injuries when he went into the snow with bare feet to find a cat and collapsed in the snow for the night." PRV, p. 6. The jury found for Petitioners after a trial with extensive evidence from both sides to tell their stories fully, but the panel reversed.

Even a cursory review of the Decision's recitation of Mr. Needham's visits to Dr. Dreyer in 2012 and his medical history shows he was a very complex patient medically, with multiple continuing and chronic issues, including alcohol abuse and HIV. These are the sort of complicated circumstances that ill-behooves an appellate court to second-guess the jurors who heard all the testimony, lived through the cross-examinations, considered the exhibits. *See* Petitioners' RB below, pp. 21-30 (detailing the extensive expert testimony).

III. LEGAL DISCUSSION

A. The Court of Appeals Decision Conflicts with *Fergen v. Sestero* and *Paetsch v. Spokane Dermatology*.

The Court of Appeals Decision conflicts with *Fergen v. Sestero* and its companion case, *Paetsch v. Spokane Dermatology Clinic, P.S., supra.*[1] The Decision ignored *Paetsch,* which affirmed that the *Fergen* majority's analysis on the exercise of judgment instruction[2] is the law going forward. That analysis states:

> …***evidence of consciously ruling out other diagnoses is not required;*** a defendant need only produce sufficient evidence of use of clinical judgment in diagnosis or treatment to satisfy a trial judge that the instruction is appropriate.

Fergen, 182 Wn.2d at 799 (emphasis added). Despite the fact that such evidence was produced, and that the trial judge was satisfied the instruction was appropriate, the Decision ruled that giving the instruction was error because "Dr. Dreyer did not select one of two or more alternative courses of treatment". Slip Op., pp. 2; 11-14.

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[1] In *Fergen,* this Court consolidated two medical malpractice appeals after trials which raised the exercise of judgment instruction and heard argument in January, 2014. After *Fergen* was argued, the Court took review in a third medical malpractice case, *Paetsch,* raising the same instructional issue, and had argument in September, 2014. Both cases were decided March 12, 2015, and both upheld the instruction, *Fergen* by a 5-4 vote. *Paetsch,* upheld the instruction issue unanimously on the basis it was resolved in *Fergen,* and all agreed there was no reason to revisit whether to abandon the instruction. *Paetsch,* 182 Wn.2d at 852.

[2] The point of the instruction is to insure health care providers are not held liable beyond the limits of statutory negligence, *i.e.,* proof that a breach of the standard of care proximately caused the injury; but that when practitioners make medical decisions within the standard of care, they are not held negligent if there is a bad result. *Fergen,* 182 Wn.2d at 798-99. It distinguishes statutory "fault-based liability" from liability for "the mere fact" an injury resulted from therapy. *Watson v. Hockett,* 107 Wn.2d 158, 162, 727 P.2d 669 (1986) (cited in *Fergen*).

The Decision misapplied *Fergen,* ignored *Paetsch,* and ignored key evidence in its analysis.[3] It reduces health care defendants' ability to defend against negligence claims, contrary to settled law as stated in *Fergen* and *Paetsch*. Review is warranted.

B. The Court of Appeals' *De Novo* Treatment of the Jury Trial Record Conflicts With Appellate Decisions on the Role of the Appellate Court And Usurps The Jury's Constitutional Role As the Sole Finder of Fact.

This issue is of particular importance to health care providers and the medical profession because it requires them to not only prove their case to the jury at trial, but again to a panel of judges on a paper record *after* trial. The Decision usurped the role of the jury to decide the facts, including who to believe, whose testimony to credit, what evidence to ignore. Such *de novo* treatment of the record disregards the jury's role as the sole finder of fact, a settled

[3] For example, while the Decision asserts Dr. Dreyer did not make a choice between diagnoses or treatments, her trial counsel asked the defense experts specifically about such contentions made by the plaintiff experts: that Dr. Dreyer should have investigated the medical assistant's note of breathing trouble despite Needham's explicit denial of a breathing problem, and that his vital signs established that his condition was urgent or emergent and needed immediate action. *See, e.g.*, 1 RP (Starr) 34:22-36:2 (testimony from defense expert Dr. Veal that the combination of Mr. Needham's breathing complaint and vitals was not indicative of pneumonia or infection); 80:23-81:1 (testimony from Dr. Veal that Dr. Dreyer appropriately followed up on breathing complaint to medical assistant by asking him about it in real time); 2 RP (Starr) 249:11-251:5 (testimony from Dr. Harrington that it was appropriate for Dr. Dreyer to "focus" on Mr. Needham's chief complaints made to her, rather than what he told the medical assistant).

Their opinions and Dr. Dreyer's lengthy testimony regarding her physical exam of Mr. Needham, 2 RP (Starr) 305:14-311:25, ignored in the Decision, show that Dr. Dreyer was confronted with choices and made choices.

principle universally recognized by our courts.[4]

Article 4, section 16, of the Washington Constitution prohibits judges from commenting on the evidence presented at trial:

> Judges shall not charge juries with respect to matters of fact, nor comment thereon, but shall declare the law.

The underlying purpose of the prohibition safeguards and preserves the jury's role as the sole finder of fact without being influenced by the judge's opinion of the evidence, since that is for the *jury* to decide. *State v. Jacobsen,* 78 Wn.2d 491, 495, 477 P.2d 1 (1970).

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[4] Three examples show this disregard of the evidence at trial. ***First,*** regarding the factual conclusion that Dr. Dreyer failed to address or ignored Mr. Needham's breathing problems, implying cursory care inconsistent with the record (*e.g.,* Slip Op. at 3 first full paragraph, and Slip Op. at 4, first paragraph), *see* Ex. 101 pp. 238-243, *esp.* p. 101-240, App. A-3 (Dr. Dreyer's objective assessment of his chest was "clear, no wheezes or rales"); 1 RP (Starr) 208:19-22 (Dr. Dreyer testimony: "his chest exam was normal"); Dr. Veal's expert testimony regarding the Oct. 12 visit, 1 RP (Starr) 28:4-7 (opining no active lung infection); Dr. Harrington's expert opinion re the Oct. 12 exam and pain, 2 RP (Starr) 242-45; Dr. Starnes' testimony that chest x-ray/follow-up was not needed, 5 RP (Smith) 794:22-795:20, and that his lower blood pressure was not from undiagnosed pneumonia, 5 RP (Smith) 884:24-8-85:10. These pages from the record are at App. A-1 to A-16, attached hereto in the order cited in fn. 4.

Second, the Decision's disregard and dismissal of Dr. Dreyer's observational exam at Slip Op. at 5, first full paragraph, ignores the medical record, Dr. Dreyer's testimony, and testimony from the experts. *See* record cites *supra*, *esp.* Ex. 101 p. 240, and record cites in fn. 3, *supra.* As to the Decision's statement finding fault because "Dr. Dreyer did not complete a chest exam", in fact defense experts testified that the standard of care did not require an additional chest exam, and Dr. Dreyer testified she was close to him when examining his back and that – ***per her observations*** – he was breathing fine. 2 RP (Starr) 355:4-9 (testimony from Dr. Shalit that a chest exam was not indicated in light of Dr. Dreyer's documentation and because "that wasn't what Mr. Needham was complaining about"); 1 RP (Starr) 38:18-39:3 (Dr. Veal testifying the same).

Third, as to the statements at Slip Op. pp. 13-14 of no evidence Dr. Dreyer "even discussed Needham's present breathing difficulties," *see* 2 RP (Starr) 305:17-22; 309:9-15; 384:1-385:7; 391:11-12. Dr. Dreyer testified she asked about breathing, he denied problems, and she noted that in her record. She did not have a specific recollection of more discussion of the medical assistant note, but that did not mean she did not discuss it with him. 2 RP (Starr) 384:13-23.

Consistent with this constitutional prohibition, the function of an appellate court is to review the action of the trial courts, but not to "hear or weigh evidence, find facts, or substitute their opinions for those of the trier-of-fact." *Quinn v. Cherry Lane Auto Plaza, Inc.*, 153 Wn. App. 710, 717, 225 P.3d 266 (2009), *rev. den.*, 168 Wn.2d 1041 (2010). Appellate courts "must defer to the factual findings made by the trier-of-fact." *Quinn*, 153 Wn. App. at 717, citing *Thorndike v. Hesperian Orchards, Inc.*, 54 Wn.2d 570, 572, 575, 343 P.2d 183 (1959). This is because "judgment as to the credibility of witnesses and the weight of the evidence is the exclusive function of the jury." *Id.*, citing *State v. Smith,* 31 Wn.App. 226, 228, 640 P.2d 25 (1982).[5] Accordingly, the law gives a strong presumption to the adequacy of a jury's verdict. *Cox v. Charles Wright Acad., Inc.*, 70 Wn.2d 173, 176–77, 422 P.2d 515, 518 (1967) (where evidence is conflicting, it is for the jury to decide the facts). *See McUne v. Fuqua,* 45 Wn.2d 650, 651-653, 277 P.2d 324 (1954) (reversing trial court's grant of new trial where strongly conflicting evidence

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[5] *Accord, Washington Belt & Drive Sys., Inc. v. Active Erectors*, 54 Wn. App. 612, 616, 774 P.2d 1250 (1989) (reviewing courts will not reweigh the evidence or the credibility of witnesses on appeal). As stated in *Quinn*, 153 Wn. App. at 717 (emphasis added):

> ...where a [fact finder] finds that evidence is insufficient to persuade it that something occurred, **an appellate court is simply not permitted to reweigh the evidence and come to a contrary finding**. It invades the province of the [fact finder] for an appellate court to find compelling that which the [fact finder] found unpersuasive. Yet, that is what appellant wants this court to do. **There was conflicting evidence...The [fact finder] weighed that conflicting evidence and chose which of it to believe. That is the end of the story.**

supported the jury's decision). This applies even if a reviewing court believes the jury reached an incorrect verdict. *Burnside v. Simpson Paper Co.,* 123 Wn.2d 93, 108, 864 P.2d 937 (1994).[6]

The Decision's approach threatens the finality of jury verdicts rendered after full and fair trials. This affects ***all*** litigants. The jury here rendered its decision based on the evidence and medical testimony presented over the course of a three-week trial. In our judicial system, it is the jury that weighs such evidence and makes a determination thereon; it is not for a reviewing court to elevate its view of certain portions of the record over that of the jury's. By doing so in cases involving complex medical testimony and evidence, appellate courts risk misinterpreting both the factual and technical evidence and testimony presented at trial.

Appellate courts are in no position to second-guess the trier of fact from a three-week trial based on a review of the paper record before it. Review should be granted because the panel here did just that.

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[6] This Court held in *Burnside,* (citations omitted) (bold added):

> [the] court will not willingly assume that the jury did not fairly and objectively consider the evidence and the contentions of the parties relative to the issues before it. The inferences to be drawn from the evidence are for the jury and not for [the] court. The credibility of witnesses and the weight to be given to the evidence are matters within the province of the jury and even if convinced that a wrong verdict has been rendered, **the reviewing court will not substitute its judgment for that of the jury, so long as there was evidence which, if believed, would support the verdict rendered**.

C. Review Should Be Granted Because the Decision Conflicts With *Colley v. PeaceHealth* and *Dunnington v. Virginia Mason Medical Center*.

Petitioners pointed out below they were entitled to defend Needham's negligence claim by attacking his experts' premise as to causation: that he collapsed on January 1 from a serious pneumonia infection that compromised his mental state. RB at 45-46, discussing *Colley v. PeaceHealth*, 177 Wn.App. 717, 312 P.3d 989 (2013). That defense included Needham's admissions of his heavy drinking up to and on the January 1 holiday and his collapse. There was no abuse of discretion in admitting the evidence to attack his experts' theory, "not to prove what actually caused his injuries." RB at 45.

The Decision, however, imposed a full causation requirement on a defendant in order to offer evidence that challenges a plaintiff's theory of causation. The Petition correctly points out that the Decision conflicts with *Colley* for, in effect, requiring defendants to only attack causation with "other 'known potential causes of plaintiff's injury' that are sufficient to 'make a determination' as to causation." PRV at 18, quoting Slip. Op. at 17.

Given the ubiquity of evidence from Mr. Needham in the medical records of his alcohol consumption, the trial court was within its discretion to admit it because, as Judge Becker correctly observed, "the defendant does not have the burden to prove causation or lack of causation." *Colley* at 728-729 (relying on Supreme Court decisions and RCW 7.70.040 for the premise it is the

plaintiff who has the burden to establish the statutory elements, including causation). Moreover, the alcohol evidence was also appropriately admitted because a patient is responsible for his own actions or inactions and how they may have affected or led to his injury. *Dunnington, supra.*

There was ample cross-examination of the defense experts' testimony as to Respondent's actions and their potential effects on the injury, and also expert testimony on behalf of Respondent's position as to what effect, if any, his actions had on his injury. It is for the jury to decide what weight to give the patient's admissions as to his own actions. Reversing because of the admission of the alcohol evidence which was well within the trial court's discretion was inconsistent with both *Colley* and *Dunnington,* meriting review.

IV. CONCLUSION

Amici Curiae WSMA, WSHA, and AMA respectfully ask the Court to grant review for the reasons given above.

Respectfully submitted this 30th day of March, 2020.

CARNEY BADLEY SPELLMAN, P.S.

By/s/ *Gregory M. Miller*
Gregory M. Miller, WSBA No. 14459
Randolph J. Johnson, WSBA No. 50129

Attorneys for Amici Curiae Washington State Medical Association, Washington State Hospital Association, and the American Medical Association

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington that I am an employee at Carney Badley Spellman, P.S., over the age of 18 years, not a party to nor interested in the above-entitled action, and competent to be a witness herein. On the date stated below, I caused to be served a true and correct copy of the foregoing document on the below-listed attorney(s) of record by the method(s) noted:

Philip J. Buri, WSBA #17637 Tom Mumford, WSBA #28652 BURI FUNSTON MUMFORD PLLC 1601 F Street Bellingham, WA 98225-3011 philip@burifunston.com Tom@BuriFunston.com	☐ U.S. Mail, postage prepaid ☐ Messenger ☐ Fax ☐ email ☒ Other – Court's Portal Filing System
Levi S. Larson, WSBA #39225 Nabreena Chatterjee Banerjee, WSBA #44724 Floyd Pflueger & Ringer, PS 200 W Thomas St Ste 500 Seattle, WA 98119-4296 llarson@floyd-ringer.com nbanerjee@floyd-ringer.com	☐ U.S. Mail, postage prepaid ☐ Messenger ☐ Fax ☐ email ☒ Other – Court's Portal Filing System
Mark B. Melter, WSBA #46262 Fain Anderson VanDerhoeff Rosendahl O'Halloran Spillane, PLLC 500 701 Fifth Ave. Ste. 4750 Seattle, WA 98104-7089 mark@favros.com	☐ U.S. Mail, postage prepaid ☐ Messenger ☐ Fax ☐ email ☒ Other – Court's Portal Filing System

DATED this 30th day of March, 2020.

Elizabeth C. Fuhrmann
Elizabeth C. Fuhrmann, PLS,
Legal Assistant/Paralegal to
Gregory M. Miller

APPENDIX A

Page(s)

Office Visit

11/14/2012 **James Needham** | MRN [redacted]

Encounter Information

	Provider	Departme	Encounter #	Center
11/14/2012 1:00 PM	Dreyer, Sheryl Ann, MD	Hp Internal Med	37028814	HARBOUR POIN

Reason for Visit

Advice Only uti sx x one week.

Reason for Visit History

Vital Signs - Last Recorded

BP	Pulse	Temp(Src)	Resp	Ht	Wt
90/50 mmHg	104	98 °F (36.7 °C)	16	5' 9" (1.753 m)	132 lb (59.875 kg)

BMI
19.48 kg/m2

Body Mass Index
19.48 kg/m ^{2}

Tobacco use as of 11/14/2012

Smoking Status	Amount
Current Some Day Smoker	1 pack/day for 0 years
Types: Cigarettes	

Smokeless Tobacco Status
Never Used

Tobacco Cessation Intervention

Tobacco cessation	Responses	Comments
Is the patient interested in quitting smoking?	**Yes**	
Was the patient given smoking cessation materials?	**Yes**	

All Flowsheet Templates (all recorded)

Encounter Vitals

Screening Results

None

Previous Results

None

No pregnancy episode available.
Current View: Showing all answers Show Only Relevant Answers
Legend: **Scores,** Non-relevant Questions

Questionnaire Answers

No questionnaire available.

Progress Notes

Dreyer, Sheryl Ann, MD at 11/14/2012 1:02 PM

Status: Signed

Subjective:

James Needham is a [redacted]y.o. male comes in for:

1. Back pain: he is having mid back pain. This has been present for 1 week. He is concerned that it is his kidneys because of the location and slight dysuria. He is having trouble starting his stream but no

discharge or fever. He has been spending a lot of time in his room and his bed. Frequency/urgency and then no stream. Dysuria.
2. Health maintenance/up to date.
3. HIV: he is taking his medications.
4. Pneumonia: he was discharged from the hospital 10/28 and is slowly feeling better.

Patient Active Problem List

Diagnoses	Date Noted
• Preventative health care *Priority: High* A. Physical examination	08/22/2011
• HIV (human immunodeficiency virus infection) *Priority: High* A. Dx: 1987 B. Hep A: negative 9/10, borderline 6/12 C. Hep B: HsAg negative 9/10, HbcAb positive 9/10, titer positive 6/12 D. Hep C: negative 9/10, 2/12, 6/12 E. RPR: negative 9/10, 2/12 F. PO4: 2/12 G. Anal pap H.Eye exam: I. Baseline exam: J. Genotypic resistance: possible M184V, K103N mutations from note Test: negative mutations 9/10 K. Pneumovax: 4/05 L. CMV Ig G:pos 2/12 M. Toxo Ig G: negative 9/10 N. Travel hx: O. Pets: cats, dogs, birds, fish P. G6PD: n/a	08/22/2011
• DNR (do not resuscitate) A. Note of 10/12/2012	10/12/2012
• Palliative care patient - Harbour Pointe 425-493-6092, p 10250	10/12/2012
• OSA (obstructive sleep apnea) Nocturnal polysomnogram sleep study on 1/10/12 revealed apnea/hypopnea index = 32.8/hr, REM apnea/hypopnea index=47.8/hr, supine apnea/hypopnea index=41.1/hr, supine/REM apnea/hypopnea index=70/hr and low oxygen saturation = 90%.	01/18/2012
• Restless legs syndrome	11/11/2011
• Seborrheic dermatitis	08/22/2011
• Allergic rhinitis	08/22/2011
• Chronic back pain	08/22/2011
• Fibromyalgia syndrome	08/22/2011
• Dental caries	08/22/2011
• Tobacco use disorder	08/22/2011
• Depression, recurrent	08/22/2011

- Hyperlipidemia LDL goal < 130 08/22/2011

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• zolpidem 10 MG PO TABS	Take 1 tablet by mouth at bedtime as needed for Insomnia (for sleep). Must last 30 days.	30 Tab	0
• pramipexole (MIRAPEX) 0.5 MG PO tablet	Take 1 tablet by mouth at bedtime.	30 Tab	1
• diazepam 5 MG PO tablet	Take 1 tablet by mouth 2 times daily. Must last 30 days.	60 Tab	0
• oxycodone 5 MG PO capsule	Take 2 capsules by mouth 2 times daily. Must last one month.	120 Cap	0
• Abacavir Sulfate-Lamivudine (ABACAVIR-LAMIVUDINE) 600-300 MG PO per tablet	Take 1 Tab by mouth every day.	30 Tab	prn
• Darunavir Ethanolate (PREZISTA) 400 MG PO TABS	Take 2 Tabs by mouth every day.	60 Tab	prn
• Ritonavir (NORVIR) 100 MG PO TABS	Take 1 tablet by mouth every day.	30 Tab	prn
• Tenofovir Disoproxil Fumarate (VIREAD) 300 MG PO tablet	Take 1 Tab by mouth every day.	30 Tab	prn
• doxepin 150 MG PO capsule	Take 1 Cap by mouth at bedtime.	30 Cap	prn
• Venlafaxine HCl 150 MG PO TB24	Take 1 tablet by mouth every day.	30 Tab	5
• albuterol-ipratropium (COMBIVENT) 18-103 MCG/ACT INH inhaler	Take 2 Puffs by mouth as needed.	1 Inhaler	prn

Objective:

BP 90/50 | Pulse 104 | Temp 98 °F (36.7 °C) | Resp 16 | Ht 5' 9" (1.753 m) | Wt 132 lb (59.875 kg) | BMI 19.49 kg/m2
General: In no apparent distress
Affect: Normal
Heart: S1 and S2 normal, no murmurs, clicks, gallops or rubs. Regular rate and rhythm.
Lungs: Chest is clear; no wheezes or rales.
Back: Pain to palpation of his paraspinal muscles.

Component *Latest Ref Rng*	11/14/2012
Type	Voided
Color	Yellow
Clarity	Hazy
Specific Gravity *1.000 - 1.030*	1.015
pH *5.0 - 8.0*	5.0
Leukocytes Esterase *Negative*	Trace (A)
Nitrites *Negative*	Negative
	Negative

Protein *Negative mg/dl*	
Glucose *Negative mg/dL*	Negative
Ketones *Negative mg/dL*	Negative
Urobilinogen *0.2 mg/dL*	0.2
Bilirubin *Negative*	Negative
Blood *Negative*	Negative
Urine Microscopic	Spun
WBC *None Seen /HPF*	0-2
RBC *None Seen /HPF*	None seen
EPITHELIAL CELL-WTMT *None Seen /LPF*	None Seen
Mucous	2+
Crystals *None Seen /LPF*	Few CaOx
Casts *None Seen /LPF*	None Seen
Bacteria *None Seen /HPF*	Occ

Imp/Plan:

Patient Instructions
1. Health care maintenance: up to date

2. HIV: continue on your medications. Labs next month

3. Pain: is from your back. Continue on your medications. Ice for 20 minutes 3-4 times a day to help decrease inflammation which is contributing to the pain.

4. Depression: agree with plan to visit sister.

Follow up in 1 month and as needed.

Revision History

Diagnoses

Back pain - Primary 724.5

Selected Pharmacy

CHERRY STREET PHARMACY - SEATTLE, WA - 1120 CHERRY STREET

Medications at Start of Encounter

	Disp	Refills	Start	End
zolpidem 10 MG PO TABS (Taking)	30 Tab	0	11/11/2012	12/11/2012
Sig - Route: Take 1 tablet by mouth at bedtime as needed for Insomnia (for sleep). Must last 30 days. - oral				
Class: Phone In				
pramipexole (MIRAPEX) 0.5 MG PO tablet (Taking)	30 Tab	1	11/11/2012	1/13/2013
Sig - Route: Take 1 tablet by mouth at bedtime. - oral				
Class: e-Prescribe				
diazepam 5 MG PO tablet (Taking)	60 Tab	0	11/11/2012	12/11/2012
Sig - Route: Take 1 tablet by mouth 2 times daily. Must last 30 days. - oral				
Class: Phone In				
oxycodone 5 MG PO capsule (Taking)	120 Cap	0	11/6/2012	12/11/2012
Sig - Route: Take 2 capsules by mouth 2 times daily. Must last one month. - oral				
Class: Print				
Notes to Pharmacy: Please mail or Cherry Street pharmacy				
Abacavir Sulfate-Lamivudine (ABACAVIR-LAMIVUDINE) 600-300 MG PO per tablet (Taking)	30 Tab	prn	10/12/2012	
Sig - Route: Take 1 Tab by mouth every day. - oral				
Class: e-Prescribe				
Darunavir Ethanolate (PREZISTA) 400 MG PO TABS (Taking)	60 Tab	prn	10/12/2012	
Sig - Route: Take 2 Tabs by mouth every day. - oral				
Class: e-Prescribe				
Ritonavir (NORVIR) 100 MG PO TABS (Taking)	30 Tab	prn	10/12/2012	
Sig - Route: Take 1 tablet by mouth every day. - oral				
Class: e-Prescribe				
Tenofovir Disoproxil Fumarate (VIREAD) 300 MG PO tablet (Taking)	30 Tab	prn	10/12/2012	
Sig - Route: Take 1 Tab by mouth every day. - oral				
Class: e-Prescribe				
doxepin 150 MG PO capsule (Taking)	30 Cap	prn	9/25/2012	
Sig - Route: Take 1 Cap by mouth at bedtime. - oral				
Class: e-Prescribe				
Venlafaxine HCl 150 MG PO TB24 (Taking)	30 Tab	5	8/13/2012	
Sig - Route: Take 1 tablet by mouth every day. - oral				
Class: e-Prescribe				
Notes to Pharmacy: Please ignore previous prescription sent in today for 75 mg.				
albuterol-ipratropium (COMBIVENT) 18-103 MCG/ACT INH inhaler (Taking)	1 Inhaler	prn	1/19/2012	
Sig - Route: Take 2 Puffs by mouth as needed. - oral				
Class: e-Prescribe				
Number of times this order has been changed since signing: **4**				
Order Audit Trail				

Level of Service

OFFICE/OUTPT VISIT,EST,LEVL III (15MINS) [99213]

Tobacco cessation

Questions	Responses
Is the patient interested in quitting smoking?	Yes
Was the patient given smoking cessation materials?	Yes

Preventive Care Handout

Questions	Responses
Date Preventive Care Handout last reviewed:	

Routing History

There are no sent or routed communications associated with this encounter.

Encounter Information

	Provider	Department	Encounter #
11/14/2012	Dreyer, Sheryl Ann, MD	Hp Internal Med	37028814

Encounter Status

Closed by Dreyer, Sheryl Ann, MD on 11/14/12 at 2:07 PM

After Visit Summary

AVS

Patient Instructions

1. Health care maintenance: up to date

2. HIV: continue on your medications. Labs next month

3. Pain: is from your back. Continue on your medications. Ice for 20 minutes 3-4 times a day to help decrease inflammation which is contributing to the pain.

4. Depression: agree with plan to visit sister.

Follow up in 1 month and as needed.

CC'd/ROUTING

None

Encounter-Level Documents - 11/14/2012:

Scan on 11/15/2012 9:27 AM by Dreyer, Sheryl Ann, MD : DISABILITY

Order-Level Documents:

There are no order-level documents.

refer to the records at any time, you can. It looks like in the United General records that you had received a report from him that his T cells had fallen below 200 and had prescribed this prophylactic, Bactrim. Does that refresh your recollection?

A Right. It was that September visit is when we got labs and then his T cells dropped below 200 and that was before the hospitalization.

Q Okay. So tell us what are you thinking when Mr. Needham presents to you in October 2012 after he's had the United General pneumonia presentation?

A Well, I think it was just a follow-up to see -- it's not uncommon when people are in the hospital that they get discharged and they say follow-up with your primary care doctor. So it was a visit to see how things were going since his discharge.

Q Okay. Did you think Mr. Needham had kind of an active pneumonia infection when you saw him on October 12th, 2012?

A No. Again, he -- his blood pressure was fine. Respirations were normal. His O_2 sat was 98. His -- again, didn't have a temperature. No cough, no sputum production, and his chest exam was normal.

Q We heard earlier some questions of Dr. Veal about, you know, why didn't you update his active problem list in October 2012 with pneumonia. Why didn't you update his active

reviewed Dr. Dreyer's October 12th, 2012, visit. Here, if you could explain, did Mr. Needham have an active pneumonia infection based on Dr. Dreyer's October 12, 2012, visit?

A I don't believe he had continued bacterial infection, that is, pus in little alveolar sacs on that date. He certainly had ongoing and resolving inflammation in the right base at that time.

Q Is there an analogy that you could provide for the jury so they could understand about infection versus inflammation and how that pneumonia process feels?

A Sure. Well, you know, like if you spill, you know, boiling water on your arm, it's going to hurt. It's going to get red. It's going to blister up and say the blisters get infected. You put antibacterial ointment on there. The germs are gone, but the arm is going to be red for quite a while until it looks like normal skin again. So any time we have an injury to the body, be it to the skin, the lungs, the gut, there's -- the heart -- inflammatory response after the initial insult.

Q Let's go ahead and turn to Mr. Needham's October 23rd hospitalization at Providence. So here we're looking at the emergency room physician's note on October 23rd, 2012. Did the emergency room physician who saw Mr. Needham believe that he had this active pneumonia infection when he was hospitalized for C. diff on October 23rd?

infection or persistent infection with C. diff and I think if Mr. Needham was complaining of diarrhea, then it would require looking for C. diff to see if he had a persistent or relapsed infection and then treat it if that was found.

Q We're going to look at -- this is the October visit of Dr. Dreyer when she saw Mr. Needham. So she saw him on October 12th. She indicates that he had pneumonia, recent hospitalization, having right shoulder pain and right rib pain made worse with egress and then she did a lung exam on October 12th. And what does this indicate to you if Mr. Needham has a clear lung exam on October 12th after being hospitalized for pneumonia on October 1st through the 5th?

A Um-hmm. It suggests that his pneumonia was appropriately treated and that he has physical exam evidence that it's resolving. She doesn't hear any persistent abnormal sounds when she listens to his lungs. He doesn't have any crackles. He doesn't have any wheezing. All those are suggesting that he's improving.

Q So there was some mention of kind of rib pain, of this chest pain. Is lower lumbar pain, is lower lumbar back pain a classic pain complaint of pneumonia?

A Not lower lumbar back pain. It would be upper, called the chest -- the thoracic region. So back pain in the thoracic region can be due to pneumonia. It can be due to a lot of

other things, but pneumonia is one of them. But lower lumbar pain is below the anatomical area of your lungs. That is typically related to a mechanical back issue rather than a lung issue.

Q Okay. So we've heard this theory from the plaintiff's family medicine expert that, you know, he had pneumonia in October. It was a bad case of pneumonia and Mr. Needham basically had this kind of necrotizing pneumonia that never went away and that's evident by the patchy space on the CT scan. And we had -- this is the CT abdomen from his October 23rd hospitalization and I will highlight this. Do you think that this CT scan that references patchy air space consolidation in the right lower lobe, no pleural effusion, does that mean that Mr. Needham had this kind of simmering necrotizing pneumonia that no one was catching?

A No, I don't think so. One of the things about CT scans is they're so exquisitely sensitive that they will identify abnormalities that before we had CT scans we never even knew about.

People that have pneumonia will often have radiographic evidence of abnormalities. They can persist for weeks or even months or even permanently after people have recovered from their pneumonia. I think if Mr. Needham had ongoing pneumonia at that time, he would have more classic symptoms of a progressive necrotizing -- and necrotizing means a

falling apart of the tissue. So some chronic cough. It's typically caused by mixtures of bacteria, some of which are anaerobic. That means they give off a foul smell. So people that have a chronic necrotizing pneumonia will have a chronic hacking cough. They will often cough up streaks of blood and sometimes even lung tissue.

I think the expression, coughing up a lung, comes from people that have a chronic necrotizing pneumonia that goes on for months and makes people very ill and I just don't think that's what Mr. Needham had in those intervening weeks and months.

I believe he had a chest x-ray done and follow-up at one point. It was clear.

Q This is actually from the October 23rd hospitalization, the same C. difficile hospitalization. It says negative 1 view chest. If they performed a chest x-ray and it was negative on October 23rd, was Dr. Dreyer required to order a chest x-ray later to get another clear chest x-ray?

A No. In fact, I think -- I don't think that it's the standard of care to get follow-up chest x-rays in people who have had pneumonia. The only reason to do that would be if they had new symptoms or persistent symptoms that made you worry that something else might be going on. But I think simply because you can often have x-ray evidence of abnormalities that persist for weeks or sometimes even

months after people recover from pneumonia, if you get follow-up imaging, I don't know what you do with it, because if you see something there, it might just be that it's taking a long time for those changes to resolve completely and they may never resolve completely.

Q Okay. So I want to move into the November -- this is the Defense Exhibit 101-238. This is the November 14th, 2012, visit. And here we have Mr. Needham presenting with a blood pressure of 90 over 50. Do you think that Mr. Needham's shift from in pre-September he had these higher systolic pressures that were above 110, now in September he has a 90 over 60. November, he has a 90 over 50. Is this 90 over 50 indicative that he has a lung infection?

A No, I don't think so. I think his blood pressure is on the lower side again, but, again, there is other reasons for people that have low blood pressure and I think we find out later that he actually had had persistent diarrhea going on for weeks. So he may have had a low blood volume related to chronic diarrhea that is responsible for that low blood pressure.

He's also taking some medication that might lower your blood pressure depending upon the timing of the medication.

So, again, I think you have to interpret the blood pressure in the context of what the patient is complaining of and how they appear. If they're not complaining of

history of C. diff, and she sent a stool sample, she checked the blood test, and she encouraged hydration.

That is how she managed the patient. She also ordered a gastroenterology consult. She was focused on the C. diff. There aren't too many things that raise your white blood cell count that high, but C. diff is definitely at the top of the list.

Q. So I want to talk a little bit about his prior hospitalization so we can unpack this a little bit.

In October 1st through the 4th he presented to United General, and he was hospitalized with pneumonia. Then he was rehospitalized in -- on October 23rd for C. diff.

Do you know what his -- his white blood cell count was on October 23 for his C. diff hospitalization?

A. I'd have to go back and check, but I think it was seven. Am I correct? I haven't memorized all of his white counts. But it wasn't --

Q. Well, we can --

A. I can't remember.

Q. We can refresh your recollection.

The Providence hospitalization on October 23rd, they have a chest X-ray that was clear. There's criticism that Dr. Dreyer, based on the CT that showed some patchy space in the abdomen, that that was a

continuation of the pneumonia, and that she should have reordered the chest X-ray in November.

Do you agree with that opinion?

A. No, I don't agree with that.

Q. Can you explain for the jury why you do not feel that Dr. Dreyer needed to order an X-ray in November of 2012?

A. I think it's very simple. We treat patients. We don't treat X-rays. We don't treat vital signs. Sometimes patients who have had -- who have been chronically ill, who have a history of pneumonia, will have abnormal findings on their chest X-ray or specifically on their CT scan because a CT scan is much more specific. It will show some scarring in the area where that pneumonic or pneumonia process was.

And so we don't really waste our time trying to order imaging studies to make ourselves feel better that the patient is doing well. If the patient is doing well clinically, there is no reason to order a follow-up study.

Q. Can C. diff cause a patient to have low blood pressure, such as a 90/50 or an 80/50 over from a period from November into December time frame?

A. Absolutely, yes. The reason that is is because C. diff is a bacteria that causes watery, profuse diarrhea. So

Can you have a baseline shift in your blood pressure?

A. You can.

Q. Do you believe that Mr. Needham had a baseline shift in his blood pressure in the fall of 2012?

A. I do.

Q. And can you explain for the jury why you believe that Mr. Needham had a baseline shift in his blood pressure in the fall of 2012?

A. After he was treated for his pneumonia in October of 2012, he began taking antibiotics, and he developed C. diff colitis, and that led to profuse diarrhea. C. diff colitis can be very difficult to get rid of, and it can come back and come back, and it can be treated and come back.

I believe that he developed this C. diff in late October/early November and was treated for that. When he presented on November the 14th of 2012, he had the blood pressure of 90/50, which would imply that he was somewhat dehydrated. The same thing on December 28th.

And, in fact, he had a blood pressure lower than both of those values in a subsequent follow-up visit in March.

Q. Okay. I want to take a look at that because I believe that there's testimony, you know, if you're running

with this hypo -- if you're hypotensive and your blood pressure is this low, that you're not going to be able to have good cognition.

Do you agree with that?

A. No.

Q. Okay. So in this time period, between November 14th and December 28th, do you believe that he had a lower baseline shift in his blood pressure because he had an undiagnosed pneumonia?

A. No.

Q. Okay. We'll finish with this. We've marked -- we will mark this as the next exhibit in order. We've heard a lot about Mr. Needham's blood pressure of 80/50, and in the vital signs it goes from -- when it goes from 90 down into 80 it turns red.

Do you think that the fact that the blood pressure, 80/50, that that red blood pressure alone meant that he needed to be hospitalized?

A. Not at all.

Q. Okay. So you had mentioned earlier that you were aware of a subsequent blood pressure taken from Mr. Needham, where he was found to have a blood pressure lower than 80/50, and I'll just -- this is a subsequent progress note from his current primary care provider, and this is taken from March of 2013. I'll just zoom here on

CARNEY BADLEY SPELLMAN

March 30, 2020 - 1:36 PM

Transmittal Information

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Appellate Court Case Number:	98118-3
Appellate Court Case Title:	James Needham v. Sheryl Dreyer, et al.
Superior Court Case Number:	16-2-20189-8

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