

FILED

AUG 22 2012

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

NO. 30523-6-III

COURT OF APPEALS, DIVISION III
OF THE STATE OF WASHINGTON

DANI FERGEN, individually and as Personal Representative of the
ESTATE OF PAUL J. FERGEN, and minors, BRAYDEN FERGEN and
SYDNEY FERGEN, individually,

Appellants,

v.

JOHN D. SESTERO, M.D., individually, and as an
employee/shareholder/agent of Defendant Spokane Internal Medicine, and
SPOKANE INTERNAL MEDICINE, P.S., a Washington corporation,

Respondents.

BRIEF OF RESPONDENTS

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Daniel W. Ferm, WSBA #11466
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I. INTRODUCTION

Paul Fergen consulted his doctor, internist John Sestero, M.D., on November 17, 2004, about a small lump on his ankle that had appeared a week before and that was causing slight discomfort. Dr. Sestero's assessment was that the lump was a (benign) ganglion cyst. Mr. Fergen had a seizure on December 8, 2005, and was diagnosed with metastatic cancer that was determined to be Ewing's sarcoma, a rare, aggressive malignancy that proved chemotherapy-resistant. Mr. Fergen died January 18, 2007. After it was determined that the ankle lump was the primary site from which the sarcoma metastasized, Mr. Fergen's widow blamed Dr. Sestero for failing to reach the correct diagnosis within a few weeks of the November 17, 2004 visit.

Prejudicial error does not occur when a trial court gives an instruction that correctly states applicable law. Mrs. Fergen claimed that Dr. Sestero underestimated the possibility of and did not rule out malignancy and thus arrived at his diagnosis negligently. The "exercise of judgment" instruction correctly framed the issue as whether Dr. Sestero *arrived at* his diagnosis in a way that met the standard of care. It helped prevent the jury from finding negligence simply because, in retrospect, Dr. Sestero's diagnosis had been incorrect. There was no instructional error.

II. COUNTERSTATEMENT OF ISSUE PRESENTED FOR REVIEW

1. Did the trial court properly exercise its discretion in giving, as a supplement to a proper standard of care instruction, its Instruction No. 18, WPI 105.08,¹ which stated that “[a] physician is not liable for selecting one of two or more alternative diagnoses, if, in arriving at the judgment to make the particular diagnosis, the physician exercised reasonable care and skill within the standard of care the physician was obliged to follow,” where there was evidence that Dr. Sestero was confronted with a choice among diagnoses and that, in arriving at his judgment to make the particular diagnosis he made, he exercised reasonable care and skill within the standard of care he was obliged to follow?

2. Has Mrs. Fergen failed to meet her burden of establishing prejudice in the giving of the “exercise of judgment” instruction, WPI 105.08, when it is a correct statement of the law concerning a legal principle that has long been accepted in this state² and provides “useful watchwords” to remind juries “that medicine is an inexact science where desired results cannot be guaranteed, and where professional judgment may reasonably differ as to what constitutes proper treatment?”³

¹ 6 WASHINGTON PATTERN JURY INSTRUCTIONS: CIVIL 105.08 at 612 (6th ed. 2012) (“WPI”)

² See *Watson v. Hockett*, 107 Wn.2d 158, 165, 727 P.2d 669 (1986).

³ *Id.* at 167.

III. COUNTERSTATEMENT OF THE CASE

A. Mr. Fergen's Medical Care.

On November 14, 2004, Paul Fergen consulted John Sestero, M.D., an internal medicine physician, at Spokane Internal Medicine, P.S., concerning a nickel-sized, RP 1214, lump on the outside of his right ankle. Ex. P-1A. Taking a history, Dr. Sestero learned that Mr. Fergen had noticed the lump "in the last week" and had a small amount of discomfort but had no erythema,⁴ swelling, or other abnormalities. Dr. Sestero examined and palpated the lump; it was smooth and soft and was not tender. Ex. P-1A; RP 606, 2040. Dr. Sestero considered malignancy an exceedingly unlikely possibility in his differential diagnosis, and thus did not mention that remote possibility to Mr. Fergen. RP 609-10.

Dr. Sestero's chart note for the November 17, 2004 visit indicates that he assessed the lump as a ganglion cyst, and ordered an x-ray of Mr. Fergen's ankle to look for any "other structural abnormalities in the ankle." RP 2033-34; Ex. P-1A. As his plan, Dr. Sestero referred Mr. Fergen to either Dr. Sanwick or Dr. Padrta at Northwest Orthopedics and suggested that he otherwise follow up as needed with "us." Ex. P-1A; RP 2045-46. Mr. Fergen had previously seen Dr. Sanwick and others at

⁴ Erythema – redness – would have suggested infection, or trauma, or some sort of inflammatory disease. RP 2037-38.

Northwest Orthopedics in late 1998, 2000, and 2002. RP 2045-46; Ex. P-9, pp. 00015-23, 000031-32. Dr. Padrta specialized in orthopedic medicine of the foot and ankle. RP 611, 2046.

The x-ray Dr. Sestero ordered was taken the same day. The radiologist reported the following findings and conclusion to Dr. Sestero:

FINDINGS

There is no bony abnormality. No erosion destruction. No fractures. No foreign body is seen. There does appear to be some soft tissue swelling laterally and anteriorly.

CONCLUSION

No bony abnormality identified. No erosion or destruction. If a soft tissue cyst is felt an ultrasound might be of help.

Ex. P-3. Dr. Sestero did not order an ultrasound. RP 2034-35. Two board-certified internists and an orthopedic oncologist called by the defense opined that the applicable standard of care did not require Dr. Sestero to order an ultrasound, biopsy, or other test to rule out cancer, RP 1130-31, 1153, 1138-47, 1313, 1316, 1320, 1324, 1402-04, or to make a referral to a specialist, RP 1153, 1314-15, 1412, or even to order the x-ray, RP 1192-93, 1309-10, 1405-06.

Dani Fergen, Mr. Fergen's wife, who is a registered nurse, RP 1103, denied that Dr. Sestero mentioned Dr. Sanwick or Dr. Padrta to her husband at the visit on November 17, 2004. RP 1212. She also testified that, during that visit, she suggested that Dr. Sestero order an MRI, but

that Dr. Sestero responded that one cannot just order an MRI for any lump, which sounded reasonable to her at the time, but ordered the x-ray, which she also considered reasonable.⁵ RP 1114. Mrs. Fergen testified that Dr. Sestero told them that he believed Mr. Fergen had a ganglion cyst and that ganglion cysts are benign. RP 1214. In light of what she read when she looked up ganglion cysts on the internet, Dr. Sestero's diagnosis made sense. RP 1214. She testified that Dr. Sestero called the Fergen home the next morning and left a message saying the x-ray was negative and that Mr. Fergen should call if the lump got bigger or painful and he would lance it or refer Mr. Fergen to someone who would. RP 1213.

Mrs. Fergen testified that her husband's ankle lump did not change during the ensuing year.⁶ RP 1213. Mr. Fergen did not consult any physician at Northwest Orthopedics about the lump and did not seek follow-up or additional care of any kind from Dr. Sestero or any other physician with Spokane Internal Medicine. November 17, 2004 apparently was his last visit to any physician anywhere until December 2005.

⁵ Dr. Sestero did not recall such a request for an MRI that day and did not recall Mrs. Fergen being present. RP 1989. He testified that, according to his clinic's records for Mrs. Fergen, who also had been his patient, she had requested, and he had declined to order, an MRI when she had a neck strain in 2003. RP 1989-93. Mrs. Fergen recalls only once requesting an MRI from Dr. Sestero. RP 1819-20.

⁶ Mr. Fergen's treating oncologist, Dr. Hewlett, who first saw him in January 2006, RP 824-25, testified that the lesion even then was "very small" and consistent in appearance with a cyst. RP 836. By MRI done January 9, 2006, the ankle lesion measured 2.8 x 2.1 x 1.8 cm. RP 831; Ex. P-12, page 000490. An inch is about 2.4 c.m. RP 831.

On December 8, 2005, Mr. Fergen had a seizure and went to Deaconess Hospital in Spokane. RP 1217-19; Ex. P-12, page 000456. A CT scan revealed a brain bleed that initially was thought to be from a stroke. Ex. P-12, pages 000456 and 463. When his temperature spiked, a chest x-ray was done, and then a CT angiogram of the chest, and then a lung biopsy that resulted in a tentative diagnosis of lymphoma. *Id.* at pages 000456-57. Mrs. Fergen told his physicians he had been in his usual state of health until he began having neurological changes a few weeks before. *Id.* at page 000456; *see also* Ex. P-12, page 000489. On December 12, an MRI imaging study of Mr. Fergen's brain revealed right frontal metastases. Ex. P-12, page 000489.

Mr. Fergen was discharged from Deaconess Hospital on December 18, 2005, with his seizures seemingly controlled with Dilantin, Ex. P-12, page 000489, but he seized again and returned on December 25. Ex. P-12, pages 000464 and 489; RP 1222. A CT scan showed an increase in blood at the site of the earlier brain bleed in December. Ex. P-12, pages 000463 and 465-66. By December 28, a biopsy of lung tissue had revealed that he had a high grade undifferentiated carcinoma. Ex. P-12, page 000473. On January 20, 2006, pathologists at the University of Washington diagnosed Ewing's sarcoma. Ex. P-12, page 000486.

Mr. Fergen responded positively to chemotherapy during early 2006, RP 503-07, 513; RP 1251-52, 1257-61, but then the cancer came “roaring back,” RP 1062, and the Fergens learned in November that Mr. Fergen had more brain tumors, RP 1260-63. Plaintiffs’ experts agreed that Mr. Fergen’s Ewing’s sarcoma was, or became, chemotherapy-resistant. RP 506-07, 1032-33, 1039, 1048, 1061-62, 1066, 1071-73; RP 1522-23; RP 581-90; *see* CP 2656-62 (deposition of Dr. Butrynski). Mr. Fergen died January 18, 2007. RP 1384.

B. This Litigation.

On December 31, 2007, Mrs. Fergen filed this wrongful death action, alleging that Dr. Sestero committed malpractice for which Spokane Internal Medicine is vicariously liable. CP 3-9. Plaintiffs’ theory, described before trial, was (1) that the ankle lump was Ewing’s sarcoma that metastasized to Mr. Fergen’s lungs, brain, lymph nodes and bones, CP 1530; (2) that Dr. Sestero violated the standard of care by not ordering an ultrasound or some other diagnostic test, which would have disclosed that the ankle lump was a solid mass, and which would have led to further testing and diagnosis of Ewing’s sarcoma within a few weeks of the November 17, 2004 visit, CP 1530; and (3) that, with diagnosis at that stage, Mr. Fergen would have had “an excellent prognosis for recovery,” CP 1530, of 50 to 60 percent instead of the 15 to 20 percent chance he had

at the time the actual diagnosis of metastatic cancer was made, CP 1532.

The case was tried to a jury from November 7 to December 1, 2011. CP 2511-13. Each side called multiple medical experts to opine as to whether Dr. Sestero met the standard of care in arriving at his diagnosis of ganglion cyst and whether and how the claimed delay in diagnosis of the sarcoma affected Mr. Fergen's prognosis and outcome.⁷ Defense experts defended Dr. Sestero's diagnosis as appropriate based on the history of a one-week-old lump that was not painful and the fact that soft-tissue tumors on the ankle are exceedingly rare. RP 1137-38, 1150-53, 1309-15, 1323-24, 1330, 1332, 1399-1404, 1412-13. A defense pathologist opined that, given how aggressive Mr. Fergen's Ewing's sarcoma was even though the ankle lump itself did not grow, the sarcoma probably had already metastasized to his lungs by November 2004.⁸ RP

⁷ Concerning causation and prognosis, the oncologists and pathologists who testified at trial did not dispute three general propositions: (1) Ewing's sarcoma is very aggressive and Mr. Fergen's sarcoma had probably begun metastasizing at least microscopically through his bloodstream by the time he noticed the lump and consulted Dr. Sestero, RP 1058, 1077, 1160 (Ewing's sarcoma "is everywhere pretty quick"), 1500, 1619-21; (2) patients with Ewing's sarcoma automatically get chemotherapy whether or not, at the time of diagnosis, there is evidence of metastasis to organs detectable by imaging studies (macrometastasis), because some degree of micrometastasis is presumed to be occurring, RP 581-90, 837, 1026-27, *see* CP 2624, 2636 (deposition of Dr. Butrynski); and (3) patients diagnosed with Ewing's sarcoma who begin chemotherapy before the disease becomes macrometastatic have a survival rate of better than 50 percent and as high as 65 percent but patients diagnosed with macrometastatic Ewing's sarcoma – which would include Paul Fergen – have a survival rate of no better than 15%, RP 492-93, 1055-56, 1171, 1206-07, 1489, 1537.

⁸ At trial, plaintiffs presented testimony from a pathologist, Dr. Irby Cossette, and four oncologists: Dr. James Butrynski, Dr. Brian Samuels, Dr. Andrew Howlett, and Dr. Mark Goodman. Of those experts who addressed the point, Dr. Samuels (RP 510-11),

1673-75.

C. Malpractice Issues.

Whether Dr. Sestero was negligent involved two related issues: whether, in context, he arrived at his assessment (diagnosis) in a way that met the standard of care, and whether he adopted a plan, based on his assessment of ganglion cyst, that properly took into account the fact that ganglion cysts usually appear on the wrist and rarely appear on the ankle or foot.

1. Plaintiffs' Expert's Standard of Care Testimony.

Plaintiffs called an internist, Dr. Bernard Michlin, who was critical of how Dr. Sestero arrived at his assessment (diagnosis) of ganglion cyst:

Q. And can you tell the jury what opinions, if any, you formed with respect to the manner in which this note was charted, specifically whether the history, the physical, the findings, and conclusions were in line with what you would expect to see.

* * *

A. . . . I have no problem with the standard of care of his history or his physical exam. Then we move on to the assessment. His [Dr. Sestero's] assessment is a ganglion

Dr. Howlett (RP 837) and Dr. Goodman (RP 1500) acknowledged that, by November 17, 2004, when Mr. Fergen saw Dr. Sestero, the Ewing's sarcoma probably had already metastasized at least *microscopically* to other parts of his body through his bloodstream. Drs. Cossette (RP 563) and Butrynski (RP 581-90 (*see* CP 2640, 2674-75, 2679)) disclaimed any opinion as to whether Mr. Fergen's sarcoma was or was not *macrometastatic* by November 2004. Dr. Goodman presumed that sarcoma *was not* macrometastatic in November 2004 because there is no evidence that it *was* macrometastatic. RP 1500. Plaintiffs were able to avoid dismissal for lack of evidence of causation because Dr. Samuels, alone among the experts testifying on the point, opined affirmatively that the sarcoma was probably *not* yet macrometastatic in November 2004. RP 510-13, 1070.

cyst of the right ankle. So that's his assessment. Everything after that is a plan. *So I do have an issue with the assessment of a ganglion cyst of the right ankle since it wasn't a ganglion cyst of the right ankle, but the assessment shouldn't have been, because I've never seen a ganglion cyst of the right ankle in that location. I don't believe he has ever seen a ganglion cyst of that location. So, therefore, it should be a lump or bump at that location, etiology to be determined.* The problem with calling this a ganglion cyst of the right ankle is that everything that followed was the assumption of the care, treatment, and diagnosis of a ganglion cyst. It wasn't the care, treatment, and diagnosis of a lump or bump of unknown etiology. And that's what caused the ball to go in the wrong direction, because now you get to the plan based on an erroneous assessment, which is why the assessment is so important, because everything in your plan is based on your assessment. So his assessment was a ganglion cyst and everything he did concerned a ganglion cyst . . .

Q. So based upon what's in this record, do you believe that there is more that should have been done as required by the standard of care?

A. Yes. It should not have been a ganglion cyst because that was an erroneous assumption. It was a bad assumption. It wasn't a bad guess. It was an impossible guess. Because if I haven't seen it -- when I have patients that come in and say, "Could it be this," and I turn to them and I say, "Well, I guess it could be, but I've never seen it in 30 years," well, then the patient says, "Well, what do you think it is?" And I say, "Well more likely it's something else and let's pursue that."

RP 409-413 (emphasis added). And, later, Dr. Michlin opined:

Q. Can you tell the jury what your opinions are, your standard-of-care opinions are in that regard.

A. In regards to the?

Q. What his obligations were and whether or not it included an obligation to diagnose Ewing sarcoma.

A. He did not have an obligation to diagnose Ewing sarcoma. His obligation was to determine that he had a lump or bump that he didn't know what it was and then to proceed to find out what it was. He was not to pre-presume what the lesion was and then base all of his actions following based on a presumption. To presume and then base your actions on that presumption falls below the standard of care. In order for him to have been within the standard of care, he should have recognized that he didn't know what it was and that he needed to find out what it was. He certainly had no obligation to think or consider or even dream this would ever be a Ewing sarcoma.

RP 440.

Plaintiffs also called a family practice physician, Dr. Peter McGough, who opined that, because ganglion cysts rarely occur at the ankle, Dr. Sestero should have been more suspicious and concerned about alternative diagnoses, including malignancy, than he was.

Q. Can you explain to the jury, if a patient such as Mr. Fergen came in to you with the lump where it was, can you take them through the thought process of what you would expect to happen.

A. Well, as I think I mentioned earlier, we start with, you know, asking about the lump, how long it had been there and whether it was changing in size, whether it was causing symptoms. On examination we would essentially take a look at the size and whether, you know, it was movable. So a fixed lump might be more concerning, for example. Something that was movable might be less concerning. In the lateral ankle it would be my belief and practice that you would have to do more. And in this case, and based on my personal experience, I would refer it to a specialist, likely for biopsy.

Q. Is the fact that the lesion itself is in an area where you have never seen it before, does that atypical aspect or

presentation have anything to do with the way you would evaluate the lump?

A. Yes. As I mentioned before, we're not required to evaluate every lump. And so it's the unusual location that makes this more concerning.

Q. In this particular case Dr. Sestero in his note referred to it as a ganglion cyst. Do you recall looking at that note?

A. I do.

Q. Do you believe that it was a violation of the standard of care to call it a ganglion cyst?

A. No, I don't.

* * *

Q. Can you explain to the jury why.

A. Again, ganglion cysts are very, very common causes for lumps near joints. Most commonly – in fact, the vast majority that I might see are on what we call the extensor surface of the wrist. And so having – you know, just presuming that it might be a ganglion cyst I believe is within the differential, but because there are other things it could be and because of the unusual location, you have to make sure it's a ganglion cyst.

Q. And can you tell the jury the steps that you would take, if any, with respect to determining or proving that this is a ganglion cyst.

A. In this case, because of the location of the lump, as I mentioned before, I would have referred for biopsy.

RP 875-77. And, later in his direct testimony, Dr. McGough opined:

Q. So can you explain to the jury, please, what you believe the standard-of-care violations were in this case, if any.

A. It's my opinion that ***the violation was related to not proceeding to get a definitive diagnosis based on the atypical location of the lump.*** Again, in many locations you don't need to do additional workups, but in an atypical location like this, it's my opinion that you do.

Q. And what type of workup do you believe should have been employed in this case?

A. Had he decided to proceed with an ultrasound and had it showed that it was cystic, I believe that would have been within the standard of care. Not doing an ultrasound, I think the next step would have been likely to, again, refer to an orthopedist to make sure you knew what the diagnosis was.

Q. Would an MRI, in your opinion, have shown the characteristic of this lump?

A. It would have shown whether it was solid or cystic, but, again, an ultrasound would be a much more inexpensive way with less radiation to get the diagnosis of cyst.

Q. And, Doctor, there has been a lot of discussion throughout the course of this case about the rarity of this tumor which is called a Ewing sarcoma. Is it your opinion that Dr. Sestero should have diagnosed the Ewing sarcoma?

A. No.

Q. Does rarity have anything to do with your standard-of-care opinions?

A. Not in terms of trying to guess what a diagnosis is ultimately. ***So what we try and do is say how we would approach problems that are atypical or abnormal.***

RP 889-90 (emphases added).

On cross-examination, Dr. McGough was asked about the application of medical judgment when deciding whether to refer, for biopsy, a patient with what a physician believes is a cyst on the wrist:

Q. Okay. So in connection with what you've seen that you thought were ganglion cysts at the wrist, did you send those all out for biopsies?

A. As I mentioned before, because ganglion cysts commonly occur in the wrist, I believe that monitoring that expectantly is fine. Since I've never seen one associated with the

lateral ankle, my opinion is that monitoring that would not be acceptable.

Q. And that may be a question that somebody else may ask you, but the one that I asked you is whether you have sent out ganglion cysts at the wrist for biopsy.

A. Yes, I have.

Q. Okay. Have you sent them all out, all the tons that you have seen?

A. No.

Q. All right. So how did you know when you arrived at your diagnosis that it was a ganglion cyst, that this lump or bump wasn't really concealing a primitive neuroectodermal tumor?

A. I did not know.

Q. Okay. *It was a judgment you made, fair?*

A. *That's fair.*

RP 911 (emphasis added). Defense counsel then went on to ask Dr. McGough a series of questions using the word "judgment," and although there were occasional interruptions for objections, none of plaintiffs' counsel's objections concerned use of the word "judgment." RP 912-15.⁹ Dr. McGough acknowledged on cross-examination that benign cyst would have been "at the top" of his own differential diagnosis. RP 918.

Both Dr. Michlin and Dr. McGough opined that Dr. Sestero should either have (a) ordered an ultrasound and, if necessary, further diagnostic

⁹ Defense standard of care expert, Long Beach, California internist Dr. James Leo, also testified concerning the medical judgment involved in making a diagnosis, RP 1329-33, as did Yakima internist Dr. Daniel Doorninck, on direct examination, RP 1401, on cross-examination, RP 1422-23, and on redirect, RP 1433.

tests, which would have produced a definitive diagnosis of Ewing's sarcoma, RP 440, 875-77, 888, which would have taken less than three weeks, RP 547, or (b) referred Mr. Fergen to an orthopedic surgeon for further evaluation, RP 414, 889-90, 904. Plaintiffs' medical experts acknowledged that Ewing's sarcomas are extremely rare, and occur in only one out of several million people per year. RP 439, 442, 468, 535, 820, 909-910, 1023-24, 1506-07.

2. The Defense Experts' Standard of Care Testimony.

The defense presented expert testimony on the standard of care from a board-certified orthopedic surgeon specializing in musculoskeletal oncology, Dr. Daniel Flugstad, RP 1120, 1123, and two board-certified internists, Dr. James Leo, RP 1301, and Dr. Daniel Doornick, RP 1393-95, all of whom testified that Dr. Sestero complied with the applicable standard of care in his care and treatment of Mr. Fergen. RP 1137-38, 1309-12, 1399-1401. All three testified that, in arriving at his diagnosis or assessment that the lump on Mr. Fergen's ankle was most likely a ganglion cyst, Dr. Sestero complied with the applicable standard of care. RP 1150-54, 1310-13, 1332-33, 1400-02. As Dr. Doornick explained, the assessment that the bump was a ganglion cyst "was a reasonable assessment, and it's the assessment I would have made." RP 1400. And,

as Dr. Leo testified, the judgment Dr. Sestero made was a reasonable judgment under the standard of care based on Mr. Fergen's presentation:

Q. Yes. I would like you to explain to the jury whether you think the judgment made at that time was a reasonable judgment under the standard of care based on the presentation.

A. The answer is yes, I do believe that it was reasonable. I believe that, in this young man presenting with a joint-associated nodular swelling, that Dr. Sestero, upon listening to the history and conducting the examination, reasonably concluded that this joint-associated swelling was overwhelmingly likely a ganglion cyst, and therefore, did not require further evaluation at that point. I think he saw something which presented precisely like something that is very common and reasonably concluded that it was just that and required nothing more.

Q. Is your assessment of that judgment based on what was known at this time as opposed to what was known in January of 2006?

A. Correct.

Q. Why is that?

A. Again, the standard of care is prospective. It's what you know at the time, not what you know in retrospect. At the time, Dr. Sestero did not know that this patient had a less-than-one-in-a-million soft tissue tumor. He knew that this patient was presenting with a swelling that is a very common presentation of a ganglion cyst. So given that information, that presentation, that knowledge at the time, Dr. Sestero had no reason to conclude other than he did.

RP 1332-33.

All three experts defended Dr. Sestero's diagnosis as appropriate based on the history of a one-week-old lump that was not painful and the fact that soft-tissue tumors on the ankle are exceedingly rare. RP 1137-38,

1150-53, 1309-15, 1323-24, 1330, 1332, 1399-1404, 1413. Moreover, they testified that the applicable standard of care did not require Dr. Sestero to order an ultrasound, biopsy, or other test to rule out cancer, RP 1131, 1153, 1138-47, 1313, 1316, 1320, 1324, 1402-04, or to make a referral to a specialist, RP 1153, 1314-15, 1412, or even to order the x-ray, RP 1192-93, 1309-10, 1405-06. As Dr. Leo put it, the standard of care does not require a physician to “hunt for exceedingly rare conditions which are so far down the list of possibilities for something that has – that is presenting in a very common manner.” RP 1323-34; *see also* RP 1312-13. As he also explained:

In the case of a cystic swelling that is associated with a joint, ganglion cysts are far and away the most likely diagnosis, and other considerations are far less likely. The other considerations that would come into play here are things that are equally benign, equally not harmful to the patient.

. . . The possibility of something more dangerous that you would have to do more advanced studies to rule out in [a] case of this kind of presentation is so minisculely small, the standard of care does not require the internist to try to chase down every theoretical possibility by doing more advanced diagnostic testing.

RP 1312-13; *see also* RP 1402-03 (Dr. Doornick’s testimony that the standard of care does not “require an internist to definitively rule out, ensure himself and the patient that this bump is not a cancer, primary or metastatic tumor”).

Dr. Sestero was the final trial witness. Plaintiffs' counsel cross-examined him aggressively, challenging the process by which he discounted the possibility of cancer and arrived instead at the assessment (diagnosis) of ganglion cyst.

Q. Doctor, if you considered for one second that this could be cancerous, why didn't you tell the Fergens?

MR. KING: Objection. Lacks foundation that he did, Your Honor.

MR. KAMITOMO: He's testified he didn't.

THE COURT: Overruled.

BY MR. KAMITOMO:

Q. Why didn't you tell the Fergens?

A. Based on my examination, the history of this being present for one week, what I found on the examination, it would be such a remote, unlikely possibility, it wasn't felt to be something you would mention even at that point.

Q. But if cancer is one of the differential possibilities for a lump in an area you have never seen before, don't you think that ought to be the patient's choice?

MR. KING: Objection. Argumentative.

MR. KAMITOMO: It's a question directly to the heart of this case.

THE COURT: Overruled.

MR. KING: Your Honor, may we approach?

THE COURT: Yes.

[Colloquy omitted]

BY MR. KAMITOMO:

Q. Doctor, do you remember the question?

A. Can you repeat it, please.

Q. Sure. If cancer was a possibility for this particular lump on a lump that you have never seen in that area before, don't you think you ought to have told the Fergens that and let them make the choice as to what they would like done with this lump?

A. The problem that comes up is, anytime I see a patient with any symptom whatsoever, whether they come in with a headache, whether they come in with a sore throat, whether they come in with a cough, whether they come in with a lump on their wrist, cancer could always be a potential explanation for any symptom any human being has. And I presume when you see the doctor you don't come in and have them say, "Well, your sore throat's probably a strep throat, but it could be cancer." It's just not the way we do things.

Q. That's what you were taught in medical school, that one of the differential possibilities for a sore throat is cancer?

A. It could be a laryngeal cancer, sure.

Q. And so you were taught in medical school that lumps in an area you've never seen before where one of the actual differentials that's listed is sarcoma is something you should disregard if it's remote?

A. Again, I think you're mischaracterizing, saying that I've never seen a lump in that area before. But, again, *we come to our conclusion. We do our exam. The lump's there for a week. We do the exam of the lump and we come to what we think is the most likely explanation.* We put a plan in place, where, if it had been followed through on, it would have greatly increased the chance of finding out that it was something else.

RP 2061-65 (emphasis supplied). And:

Q. Your diagnosis that this was not cancer was based upon your knowledge and experience? I believe you just testified to that.

A. Correct.

Q. And so you actually did consider cancer on that day and you ruled it out, correct?

A. No, I didn't say I ruled it out that day.

Q. Well, at that time you were considering it was not cancer, correct?

A. I would not have considered cancer as the most likely explanation for this, no.

RP 2069.

D. Dispute Over Whether a Referral Was Really Made.

In light of plaintiffs' experts' testimony that Dr. Sestero would have satisfied the standard of care by making a referral to an orthopedist, RP 413-14, 877, 885-90, 921-22, and of Dr. Sestero's chart note saying "refer to Dr. Sanwick or Dr. Padrta," Ex. P-1A, plaintiffs' counsel challenged the chart note as false. Plaintiffs' counsel offered testimony of several witnesses – including Mrs. Fergen, who denied that Dr. Sestero mentioned Dr. Sanwick or Dr. Padrta to her husband on November 17, 2004, RP 1212 – in an attempt to attack the chart note's credibility.

Over objection, RP 417-19, the trial court permitted plaintiffs' counsel to elicit, from Dr. Michlin, the first standard-of-care expert, testimony noting that Dr. Sestero had obtained pre-authorizations from Mr. Fergen's health insurer, Cigna, when making referrals for Mr. Fergen in 1998, 1999, 2000, 2001, 2002, and 2003, RP 428-31, 438; Exs. P4A-F, but had not sought any pre-authorization in November 2004, and that Dr.

Sestero's clinic staff had made referral appointments for Mr. Fergen on some prior occasions but did not do so in November 2004, RP 427-31, 436-38.¹⁰ Plaintiffs' counsel also was permitted, over objection, to show the jury videotaped deposition testimony of Kelly Nelson, a client service employee of Cigna, CP 241 (¶ 2), for the purpose of trying to show that Cigna required pre-authorization for any referral. CP 237-28; RP 577 (see CP 237-39. Plaintiffs' counsel made the departure-from-pattern argument a centerpiece of his adverse examination of Dr. Sestero, RP 610-25, and of his later cross-examination of Dr. Sestero, RP 2052-57.¹¹

¹⁰ In seeking permission to elicit such testimony, plaintiffs' counsel argued to the court at sidebar that to exclude it would:

... hamstringing our ability to defend what they're going to put up in their case in chief, that the referral occurred. And the only people, the two people who will say that is Dr. Sestero and Dani Fergen because nobody else was there. An expert witness can look at the medical records and say, "I know what the referral process is because here it is in your own medical records. You didn't follow your own medical records; and, therefore, I don't believe the referral occurred." The jury still has to decide whether they believe that witness or not believe that witness. But you have to ask the evidence to combat what the defense is going to put up in their case. It significantly prejudices us on their defenses. That is their defense. He can cross-examine him [Dr. Michlin] on his credibility on whether he's relying on the right things . . . There's all kinds of evidence in their own documentation they've produced that establish that a referral likely didn't occur. [Dr. Michlin should be permitted to] express an opinion based upon what he sees in the evidence as to whether or not the referral occurred. If you don't allow that, then it goes unchallenged.

RP 420-21.

¹¹ Committing what manifestly was error, the court permitted plaintiffs' counsel, over objection, to elicit from a Fergen family friend, Tina Olson, testimony as to what Mrs. Fergen had told her Dr. Sestero had said to the Fergens on November 17, 2004, RP 750-58, 763-65, which plaintiffs' counsel argued was subject to the "state of mind" exception to the hearsay rule, RP 753 and 755, and was relevant because it "goes to Dr. Sestero's credibility," RP 757, and which the court ruled was admissible as an ER 802(d)(2)

Dr. Sestero's testimony was that, as of November 2004, Cigna no longer was requiring pre-authorization for referrals to specialist providers, and that his staff did not make an appointment because they did not routinely do so and Mr. Fergen had been to Northwest Orthopedics and Dr. Sanwick before. RP 1994, 2002, 2004-05, 2019-21, 2045-46.

E. Jury Instructions.

Defendants proposed, CP 2275-76; 1601-04, and the trial court gave as its Instruction No. 18, over plaintiffs' objection, CP 1535-38; RP 2109-12, WPI 105.08, which stated:

A physician is not liable for selecting one of two or more alternative diagnoses, if, in arriving at the judgment to make the particular diagnosis, the physician exercised reasonable care and skill within the standard of care the physician was obliged to follow.

CP 3198; RP 2144-45. The court had explained its decision to give the pattern instruction after hearing from defense counsel:

MR. KING: Your Honor, *Ezell*¹² says: "Our Supreme Court has approved error of judgment instruction, and we are constrained to follow the principles established under state decision. *Ezell* has failed to establish the instruction is a misstatement of the law or that it is ambiguous or misleading." Error in judgment instruction still requires the physician to comply with the standard of care. And the testimony from both Dr. McGough and Dr. Michlin is that, when he failed to pursue with definitive testing and imaging, which is the judgment call, his diagnosis of

admission by Dr. Sestero, RP 778. The court struck, but the jury heard, testimony by another friend of Mrs. Fergen that Mrs. Fergen is trustworthy. RP 988.

¹² *Ezell v. Hutson*, 105 Wn. App. 485, 20 P.3d 975, rev. denied, 144 Wn.2d 1011 (2001).

ganglion cyst, that he deviated from the standard of care. Likewise, the testimony of Dr. Sestero is that he considered when you see a bump, it's atypical, but the differential list, the likelihood of this being cancer is so far down the list that you don't go any further in terms of weighing that alternative. That's a judgment call. The determination of the treatment, the referral, the X ray, et cetera, is a judgment call. Watson tells us that, when there are alternative diagnostic considerations, it is entirely appropriate, and I believe in this case it cries out for an error of judgment instruction. This was a diagnostic issue from the get-go. And under these circumstances, and particularly the way the plaintiffs have tried the case, I can argue as an error in judgment that he was within the standard of care, and they can argue that he was outside of the standard of care for the judgment he made. And, in fact, that's the way they've tried the case. That's what the instruction says. He still has to comply with the standard of care. And their proof is that the judgments he made were wrong; they were outside the standard.

THE COURT: Okay. Counsel, I am giving the instruction. And I would incorporate the recitation made by Mr. King in support of my determination that it is appropriate in this instance to use the instruction. I am certainly mindful of the directive from the appellate courts that the instruction is to be used with caution. An excerpt from *Ezell* sets out the familiar rule on jury instruction's sufficiency, and that is, that they, (1) allow parties to argue theories of the case; (2) do not mislead the jury; and (3) inform the jury properly on what the law is to be applied. And the Court of Appeals Division III says right almost at the beginning that *Ezell's* asked us to disregard precedent when deciding this issue. Further, the Court recalls that defendant, Dr. Sestero, throughout the case has been vigorously attacked for his decision to simply use an X ray and not do anything further. And albeit the cancer diagnosis was way down the list, that was a part of the differential diagnosis, and it was indicated to be an appropriate differential diagnosis by other defense experts, names of which I can't instantly recall. Nonetheless, there was an assertion that the choice of diagnosis of ganglion cyst was precipitous and wasn't

appropriate. So, again, in *Ezell* the Court goes through the history in the state of Washington. They talk about cases in, in fact, other jurisdictions that have rejected this type instruction. I note that the instruction in our case does not have the offending language such as the word – use of the word “honest.” And with those comments, Counsel, that’s the Court’s reasoning, in essence. So I would – that’s the reason I won’t [sic, will] give the instruction.

RP 2112-15.

In closing argument, plaintiffs’ counsel urged the jury to reject Dr.

Sestero’s reliance on his medical judgment:

You have to ask yourself, is it reasonable when it comes to the potential for cancer to say that feeling the cancer and looking at the lump is good enough, and if I think that cancer is so far down the list of possibilities, I don’t have to do anything more than that. And if I’m going to be held accountable in a courtroom in front of people like you, I’m going to say I exercised my clinical judgment, and that was good enough no matter what the harm that flowed from that.

RP 2154.

Plaintiffs’ counsel also argued that Mrs. Fergen was more credible than Dr. Sestero regarding the making of a referral on November 17, 2004,

RP 2156-58, after telling the jury that:

When I first met Dani I believed in her from the time I first talked to her. And as this case went through, I continue to believe in the case and believe in this family.

RP 2149.

F. Jury's Finding of No Negligence.

The trial court gave the jury a verdict form that asked whether Dr. Sestero had been negligent and then, if the answer was yes, whether his negligence had proximately caused Mr. Fergen's death or loss of chance of survival. CP 3200-02. The jury found that Dr. Sestero had not been negligent, CP 3200, and thus answered no further questions. The court entered judgment on the defense verdict. CP 4336-37.

G. Single-Issue Appeal.

Plaintiffs appealed. CP 4338-40. Her only claim of error on appeal is to the giving of WPI 105.08.

IV. STANDARD OF REVIEW

When a jury instruction correctly states the law, a trial court's decision to give it will not be disturbed absent an abuse of discretion. *Micro Enhancement Intern'l, Inc. v. Coopers & Lybrand, L.L.P.*, 110 Wn. App. 412, 430, 40 P.3d 1206 (2002); *see also Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 264, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992); *Petersen v. State*, 100 Wn.2d 421, 440, 671 P.2d 230(1983). The trial court's decision constitutes an abuse of discretion only if it is "manifestly unreasonable" or was based on "untenable grounds" or "untenable reasons," *State ex rel. Carroll v. Junker*, 79 Wn.2d 12, 26, 482 P.2d 775 (1971), or if no reasonable person would have decided the way the judge

did, *Howell v. Spokane & Inland Empire Blood Bank*, 117 Wn.2d 619, 629, 818 P.2d 1056 (1991).

Jury instructions challenged on appeal are reviewed to determine whether they permit the parties to argue their theories of the case, whether they are misleading, and whether when read as a whole they accurately inform the jury of the applicable law.

Adcox v. Children's Orthop. Hosp., 123 Wn.2d 15, 36, 864 P.2d 921 (1993). Jury instructions which permit the parties to argue their theories of the case, are not misleading, and, when read as a whole, accurately inform the jury of the applicable law are sufficient and not erroneous. *Brown v. Spokane Cty. Fire Prot. Dist. No. 1*, 100 Wn.2d 188, 194, 668 P.2d 571 (1983); *Caruso v. Local Union No. 690*, 107 Wn.2d 524, 529, 730 P.2d 1299, *cert. denied*, 484 U.S. 815 (1987). Even if an instruction is misleading or erroneous, it will not require reversal unless prejudice is shown. *Brown*, 100 Wn.2d at 196; *Caruso*, 107 Wn.2d at 530. The party challenging an instruction bears the burden of establishing prejudice.¹³ *Griffin v. West RS, Inc.*, 143 Wn.2d 81, 91, 18 P.3d 558 (2001); *Miller v. Yates*, 67 Wn. App. 120, 125, 834 P.2d 36 (1992).

¹³ Prejudice is presumed if an instruction contains a clear misstatement of law; prejudice must be demonstrated if an instruction is merely misleading. *Keller v. City of Spokane*, 146 Wn.2d 237, 249-50, 44 P.3d 845 (2002).

V. ARGUMENT

A. Washington Courts Have Long-Recognized the Propriety of Giving an “Error of Judgment” Instruction in Medical Malpractice Cases.

The Washington Supreme Court and the Court of Appeals have long held that the giving of an “error of judgment” or, as it is now titled in WPI 105.08, an “exercise of judgment” instruction is proper and within the trial court’s discretion in medical malpractice cases where there is evidence that the defendant was confronted with a choice among competing therapeutic techniques or among medical diagnoses. See *Christensen v. Munsen*, 123 Wn.2d 234, 248-49, 867 P.2d 626 (1994); *Watson v. Hockett*, 107 Wn.2d 158, 164-67, 727 P.2d 669 (1986); *Housel v. James*, 141 Wn. App. 748, 760, 172 P.3d 712 (2007); *Ezell v. Hutson*, 105 Wn. App. 485, 488-92, 20 P.3d 975, *rev. denied*, 144 Wn.2d 1011 (2001); *Gerard v. Sacred Heart Med. Ctr.*, 86 Wn. App. 387, 388-89, 937 P.2d 1104, *rev. denied*, 133 Wn.2d 1017 (1997); *Thomas*, 65 Wn. App. at 263-64; *Vasquez v. Markin*, 46 Wn. App. 480, 487-89, 731 P.2d 510 (1986), *rev. denied*, 108 Wn.2d 1021 (1987).¹⁴

¹⁴ See also *Miller v. Kennedy*, 11 Wn. App. 272, 280, 522 P.2d 852 (1974) (approving the “*honest* error of judgment” instruction); *Miller v. Kennedy*, 85 Wn.2d 151, 152, 530 P.2d 334 (1975) (approving and adopting the reasoning of the Court of Appeals in *Miller*, 11 Wn. App. 272); *Miller v. Kennedy*, 91 Wn.2d 155, 160-61 588 P.2d 734 (1978) (reaffirming previous approval of the “*honest* error of judgment instruction” in cases where the physician was called upon to exercise professional judgment).

In *Miller v. Kennedy*, 11 Wn. App. 272, 280, 522 P.2d 852 (1974), *aff'd*, 85 Wn.2d 151 (1975), the Court of Appeals first approved the giving of an “error of judgment” instruction which read:

A physician is not liable for an honest error of judgment if, in arriving at that judgment, the physician exercised reasonable care and skill, within the standard of care he was obliged to follow.

In approving the use of the instruction, the Court of Appeals in *Miller*, 11 Wn. App. at 280, reasoned:

The efforts of a physician may be unsuccessful or the exercise of one’s judgment be in error without the physician being negligent so long as the doctor acted within the standard of care of his peers. *Dinner v. Thorp*, 54 Wn.2d 90, 338 P.2d 137 (1959). A doctor is liable only for misjudgment when he arrived at such judgment through a failure to act in accordance with the care and skill required in the circumstances. A mistake is not actionable unless it is shown to have occurred because the doctor did not perform within the standard of care of his practice. *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34, 29 A.L.R.2d 485 (1951); *Norden v. Hartman*, 134 Cal. App. 2d 333, 285 P.2d 977 (1955); *Skeffington v. Bradley*, 366 Mich. 552, 115 N.W.2d 303 (1962); *Marsh v. Pemberton*, 10 Utah 2d 40, 347 P.2d 1108 (1959). This instruction also was appropriate as an abstract statement of the law.

The Washington Supreme Court, in a *per curiam* opinion, affirmed, approved, and adopted the Court of Appeals’ decision in *Miller*, concluding that it could “add nothing constructive to the well considered opinion of that court.” *Miller v. Kennedy*, 85 Wn.2d 151, 152, 530 P.2d 334 (1975). In a subsequent appeal in the same case, *Miller v. Kennedy*,

91 Wn.2d 155, 160-61, 588 P.2d 734 (1978), the Washington Supreme Court reiterated its approval, and the Court of Appeals' previous approval, of the "error of judgment" instruction in cases where the physician was called upon to exercise professional judgment.

Eight years later, in *Watson*, 107 Wn.2d at 164-67, the Washington Supreme Court again examined the "error of judgment" instruction, made changes to its wording, and delineated the circumstances in which its use is proper. The Court of Appeals in *Watson v. Hockett*, 42 Wn. App. 549, 555-57, 712 P.2d 855 (1986), had rejected the "error of judgment" instruction approved in *Miller*, concluding that it was confusing, unnecessary, and an improper statement of the law which altered the standard of care set forth in RCW 7.70.040 as enunciated in *Harris v. Groth*, 99 Wn.2d 438, 663 P.2d 113 (1983). The Washington Supreme Court disagreed with the Court of Appeals, and concluded that, when "given in connection with a proper standard of care instruction" and when "used in the manner and form approved herein," the error of judgment instruction supplements and clarifies the standard of care and serves an important purpose to:

provide useful watchwords to remind judge and jury that medicine is an inexact science where the desired results cannot be guaranteed, and where professional judgment may reasonably differ as to what constitutes proper treatment. [Italics in original.]

Watson, 107 Wn.2d at 166-67 (quoting J. Perdue, *Texas Medical Malpractice*, ch. 2, “Standard of Care”, 22 Hous. L. Rev. 47, 60 (1985)).

Reaffirming that the “error of judgment” instruction is proper and reflects an accepted principle of law in this state and elsewhere, the Washington Supreme Court changed the wording of the instruction approved in *Miller* to delete the word “honest.” *Watson*, 107 Wn.2d at 164-65. The court reasoned that use of the word “honest” imparted an argumentative aspect and could cause jury confusion as to whether plaintiff had to prove a “dishonest” mistake in order to prevail. *Id.* By eliminating the word “honest” from the instruction, the court removed the basis for the concerns expressed by the Court of Appeals in *Watson*, 42 Wn. App. at 555-57, and by courts in other jurisdictions which had disapproved “honest,” “good faith,” “mere,” or “bona fide” error of judgment instructions.

The Washington Supreme Court in *Watson* also delineated the circumstances in which the “error of judgment” instruction properly may be given, stating:

This “error in judgment” instruction is, however, to be given with caution. In the first place, as its terms make clear, it applies only where there is evidence that in arriving at a judgment, “the physician or surgeon exercised reasonable care and skill, within the standard of care he [or she] was obliged to follow.” Secondly, its application will ordinarily be limited to situations where the doctor is con-

fronted with a choice among competing therapeutic techniques or among medical diagnoses. [Footnote omitted.]

Watson, 107 Wn.2d at 165; *see also Thomas*, 65 Wn. App. at 263-64.

The *Watson* court also rejected the argument that the “error of judgment” instruction alters the standard of care set forth in RCW 7.70.040 as enunciated in *Harris*, reasoning:

In the case before us, both the trial court and the Court of Appeals were of the view that the change in the standard of care, as enunciated in *Harris*, affected the instructions we had approved in *Miller*. This is incorrect. The “no guarantee”, “bad result” and “error in judgment” instructions discussed above, to use the phraseology of *Miller*, “supplement” the standard of care; while they may clarify it, they do not change it. Thus, these instructions can only be given in connection with a proper standard of care instruction. The instructions approved in *Miller* were not mentioned in *Harris* and are unaffected by it. [Footnote omitted.]

Watson, 107 Wn.2d at 166-67; *see also Gerard*, 86 Wn. App. at 388-89 (rejecting a contention that the error of judgment instruction conflicts with the objective standard of care set forth in RCW 7.70.040).

In *Christensen*, 123 Wn.2d at 248-49, the Washington Supreme Court again reaffirmed the propriety of giving the “error of judgment” instruction (as approved in *Watson*), held that it accurately stated the law and was not a comment on the evidence, and reiterated the circumstances set forth in *Watson* for the proper use of the instruction.

In *Ezell*, 105 Wn. App. at 488-92, the Court of Appeals declined an invitation to disregard precedent and find the “error of judgment” instruction misstates the statutory standard of care and is ambiguous and misleading. The court concluded:

In sum, our Supreme Court has approved the “error of judgment” instruction and we are constrained to follow the principles established under stare decisis. The *Ezells* have failed to establish that the instruction is a misstatement of the law, or that it is ambiguous and misleading. As such, the trial court did not err in giving the instruction.

Id. at 492. Focusing on an Oregon Supreme Court decision, *Rogers v. Meridian Park Hosp.*, 307 Ore. 612, 772 P.2d 929 (1989), critical of the use of the word “error” in the instruction, the *Ezell* court indicated its agreement that “it may be confusing to suggest that a physician who has exercised his or her judgment within the standard of care may have committed a ‘error of judgment,’” but recognized that it seems “unlikely the instruction would be understood that way,” as “in context, the term ‘error’ is used in the limited sense of a physician making a decision that, in hindsight, did not achieve the desired result.” *Id.* at 490-91. And, while the *Ezell* court further noted that “[i]f the Supreme Court to chooses to revisit the line of cases that bind us, it seems fair to add that we see no independent reason for giving a separate ‘error of judgment’ instruction”

that “adds little while risking unnecessary confusion,” *id.* at 491, the Supreme Court denied review. *Ezell*, 144 Wn.2d at 1011.

Sharing the concerns expressed in cases like *Rogers* and *Ezell* over use of the word “error” in the instruction, “while also recognizing the wisdom of the *Watson* court’s conclusion that it can sometimes be helpful to remind jurors that “medicine is an inexact science where the desired results cannot be guaranteed and where professional judgment may reasonably differ,” *see* Comment to WPI 105.08, the Washington Pattern Jury Instruction Committee re-titled the instruction as an “Exercise of Judgment” instruction and rewrote it to read:

A physician is not liable for selecting one of two or more alternative [*courses of treatment*][*diagnoses*], if, in arriving at the judgment to [*follow the particular course of treatment*] [*make the particular diagnosis*], the physician exercised reasonable care and skill within the standard of care the physician was obliged to follow.

WPI 105.08. The Court of Appeals in *Housel*, 141 Wn. App. at 760, has since approved that formulation of the instruction (also used in this case).

Here, there was evidence that Dr. Sestero was confronted with a choice among diagnoses and that, in arriving at his diagnosis, he exercised reasonable care and skill within the standard of care he was obliged to follow. The error of judgment instruction closely followed the court’s standard of care instruction and was appropriately worded. *See* CP 3185;

RP 2138-39; WPI 105.08. In light of *Christensen, Watson, Miller, Housel, Ezell, Gerard, Thomas, and Vasquez*, the trial court had ample tenable grounds and reasons for giving the “exercise of judgment” instruction, WPI 105.08. It cannot be said that no reasonable judge would have given the instruction under the circumstances of this case. Thus, the giving of “error of judgment” instruction was not an abuse of discretion.

B. When Missed Diagnosis Is Alleged, the Issue of the Physician’s Negligence Is Properly Framed as Whether the Physician Arrived At His or Her Diagnosis in a Way that Complied with the Standard of Care, Not Whether the Diagnosis Stands up under Hindsight.

A doctor examining a patient is not like a factory turning out a fungible product, and a doctor’s liability for medical malpractice is not strict, as a product manufacturer’s liability is. Compare RCW 7.70.040 and RCW 7.72.030. Diagnosis is “the *art* of distinguishing one disease from another.” *Dorland’s Illus. Med. Dict.* (27th Ed. 1998), p. 461 (italics supplied). That a physician misassessed the patient with a benign condition that was actually malignant does not make the physician liable. To be held liable for a wrong diagnosis, the physician must have *arrived at* the assessment in a way that fell below the applicable standard of care. Because this was an incorrect diagnosis case, in which the plaintiffs would have benefited unjustly if the jury had not understood that point of law, and because WPI 105.08 correctly stated the law, it was not an abuse of

discretion to give the pattern instruction; it would have been error *not* to give it.

Dr. Sestero was criticized by plaintiffs' standard of care experts for the thought process by which he *arrived at* his diagnosis. *Christensen*, 123 Wn.2d at 249, holds that, even worded in terms of *error* of judgment, the instruction is not an impermissible comment on the evidence in a medical malpractice case "when there is evidence that *in arriving at* a judgment, the physician exercised reasonable care and skill within the standard of care he or she was required to follow [emphasis supplied]." The alleged malpractice in this case consisted of arriving at the diagnosis of ganglion cyst even though ganglion cysts more commonly appear on the wrist and rarely appear on the foot or ankle. RP 410-13, 889-90.

Plaintiffs' counsel framed questions of his experts in terms of Dr. Sestero's diagnostic process. Plaintiffs' first standard of care expert, Dr. Michlin, was asked whether he believed "there is more that should have been done as required by the standard of care." RP 412. Plaintiffs' other standard of care expert, Dr. McGough, was asked to explain to the jury "the thought process of what you would expect to happen" when a patient presents with a lump like the one Mr. Fergen had, RP 875, and "the steps that you would take, if any, with respect to determining or proving that this is a ganglion cyst," RP 877.

Without an exercise of judgment instruction, the risk is unacceptably high in a missed diagnosis case that the jury may fail to focus properly on the issue of whether the defendant physician complied with the standard of care in *arriving at* the diagnosis he or she made at the time he or she made it.¹⁵ No real-life physician should be put at risk of being compared by jurors to the fictional protagonist on the TV show *House*, who manages to diagnose, with uncanny accuracy, exceedingly rare conditions that have baffled his colleagues. But it was at just such a risk that plaintiffs' counsel sought to put Dr. Sestero when he argued in closing that clinical judgment should not excuse a diagnosis that was fatally incorrect and that Dr. Sestero's diagnostic process was inadequate:

... we had testimony from Dr. Peter McGough – he's at the University of Washington, teaches other doctors that are going to go out in the medical community – and Dr. Bernard Michlin who is affiliated with Stanford and teaches other doctors to go out into the community. And their testimony was, if somebody comes into your office, you have to look at the problem that they have and look at it based upon your experience and knowledge. And in this particular case, when Paul walked into Dr. Sestero's office, he had a lump in a place that Dr. Sestero in his collective

¹⁵ Appellants allude, *App. Br. at 24, fn. 14*, to the gratuitous comment in *Ezell* that “the ‘error of judgment’ instruction adds little while risking unnecessary confusion,” *Ezell*, 105 Wn. App. at 491, while implicitly inviting the Supreme Court to revisit the appropriateness of giving the “error of judgment” instruction in any case. The Supreme Court denied review. *Ezell*, 144 Wn.2d 1011 (2001). Moreover, even if the *Ezell* court's comment that use of the word “error” may be confusing because it is contradictory if “judgment” refers to choosing between acceptable courses of treatment, *Ezell*, 105 Wn. App. at 491, was valid, it no longer is, because the pattern instruction no longer uses, and Court's Instruction 18 in this case did not use, the phrase “error of judgment.”

experience had never seen before. Now, in his office, we know from the chart, he felt it, we know he looked at it, and we know that's all he did in his office visit. And based upon what he claims was his clinical judgment or his medical judgment, even though on cross-examination he conceded that cancer could be a possibility, he opted not to do any further testing. Now, Drs. Michlin and McGough said that's not enough. We'll give it to you that you called it a ganglion cyst, all right. We don't have a problem with that. Unlikely, but call it a ganglion cyst. But if the other potential is that this could be a cancer, then you have an obligation to your patient to make sure it is a ganglion cyst and make sure it's not cancer.

RP 2152-53. And, in rebuttal closing, plaintiffs' counsel asserted:

It's not okay to stand before you and say clinical judgment is everything. Clinical judgment is certainly important. I would never say doctors can't use their clinical judgment. And there are of plenty of times when they do it. But if you are arguing that, if the choices are cancer or something benign and you do nothing more than feel it and then say, "In my clinical judgment the cancer was so far down the list I can't be held responsible for that," well, I can't buy that.

RP 2218.

Dr. Sestero was entitled to the protection against such Monday morning quarterbacking that WPI 105.08 provides. The pattern instruction was called for in this case, so it was not error for the trial court to give its Instruction No. 18, the "exercise of judgment" instruction.

C. There Is No Merit to Plaintiffs' Argument that Dr. Sestero Was Not "Confronted with a Choice Among Medical Diagnoses."

Plaintiffs base their appeal on the statement in *Watson*, 107 Wn.2d at 165, which was reiterated in *Christensen*, 123 Wn.2d at 249, that an

error of judgment instruction will “ordinarily be limited to situations in which the doctor is confronted with a choice among competing therapeutic techniques or among medical diagnoses.” Plaintiffs effectively take the position that, when a physician has a high level of confidence in the diagnosis at which he or she arrives, and regards other *possible* diagnoses as too unlikely to warrant a plan different from the one he or she adopts, the physician is not choosing or distinguishing between or among “competing” possible diagnoses. That is nonsense. Neither case law nor the Note on Use for WPI 105.08 say the “*exercise of judgment*” pattern instruction may be given only when the defendant physician was “confronted” with a choice between the wrong diagnosis and a strongly competitive alternative.

As the trial court correctly recognized, plaintiffs’ theory was that Dr. Sestero exercised substandard medical judgment in diagnosing an aggressive Ewing’s sarcoma as a benign ganglion cyst, and in basing his plan on the diagnosis of cyst instead of (a) ordering more tests to get a more definitive diagnosis (which Dr. Sestero admits he did not do), or (b) referring Mr. Fergen to an orthopedic surgeon for evaluation (which Dr. Sestero’s chart says he did, but which Mrs. Fergen claims he did not do). It distorts the record for plaintiffs now to argue that Dr. Sestero was not confronted with, and thus made no choice at all between, more than one

possible diagnosis. Dr. Sestero testified that he did consider malignancy as at least a *possibility*, RP 609, but that it was an extremely unlikely one – which is true, as plaintiffs’ experts, RP 442, 488, 535, 555, 910, 919, 1023-24, 1506-07, Mr. Fergen’s treating orthopedic oncologist, RP 820, and the defense experts, RP 1150, 1157, 1506-07, 1609, all agreed. Plaintiffs’ contention nonetheless was that, because Ewing’s sarcoma is so terrible a disease, Dr. Sestero was confronted with a diagnostic choice that he failed to fully appreciate and act on.

Plaintiffs ignore what the jury heard concerning the medical judgment that is involved in making any diagnosis. For example, without objection from plaintiffs’ counsel as to the form of the questions, plaintiffs’ standard of care expert Dr. Michlin was cross-examined at length about the judgment a physician exercises when making any diagnosis. RP 912-15. As another example, the jury heard about diagnostic judgment from Dr. James Leo, an internist called by the defense, who testified as follows without objection by plaintiffs’ counsel:

Q. Doctor, the assessment or diagnosis arrived at by Dr. Sestero on 11-17-04 was ganglion cyst. And you’ve already talked about that. My question is a little different. Would you explain to the members of the jury what role medical judgment plays in arriving at an assessment such as ganglion cyst in a presentation like this.

A. What the internist brings to bear in a situation like this is the accumulation of their training in medical school, their training in internship and residency, and their experience

during practice in looking at and assessing patients who present with whatever the kinds of signs and symptoms are that are taking place at that visit. In this case it's the diagnosis of a soft tissue nodule. That involves putting together the history, the physical examination, what you're seeing with your eyes, what you're feeling with your hands, what's been going on with the patient in arriving at a conclusion that is based on one's clinical judgment. It is, in turn, based upon all that knowledge and experience. Your judgment is always a key piece of everything we do in gaining a sense in evaluating a patient of what it is that they actually have. There is literally not an interaction that goes on in the office on a daily basis that doesn't involve some degree of physician judgment, some choice of saying, "I'm going to think about these things. I'm not going to think about these because they're so unlikely."

* * *

Q. Can you tell us whether or not there's a requirement for the internist to record every potential thing he's thinking about that this bump might represent in November of '04 in order to comply with the standard of care.

A. There is no such requirement.

Q. Tell us why.

A. Well, once again, documentation is separate from standard of care. The standard of care requires a physician to think about the appropriate considerations based upon whatever the patient's presentation is, but there is no standard that says the physician has to write down all of those considerations in the chart. Physician is, in standard documentation, supposed to write down what your impression of what's going on. There is simply no teaching in medical school, especially in residency when we learn to write notes that aren't 20 pages long, that says you've got to write down every possibility that you're thinking of.

RP 1329-31.

The "*exercise of judgment*" pattern instruction serves to make it clear that medicine is not an exact science, and that a physician *may* guess

wrong on a diagnosis *without* having violated the standard of care, and that a wrong guess is something for which a physician is liable only if, in arriving at it, he or she failed to comply with the standard of care applicable to him or her at the time. As the Supreme Court explained in *Watson v. Hockett*, 107 Wn.2d at 167, such an instruction – it has since undergone some editing – serves “to remind judge and jury that medicine is an inexact science where . . . professional judgment may reasonably differ as to what constitutes proper treatment.”¹⁶ The pattern instruction supplements, and must be given with, a proper standard of care instruction, *id.* at 166-67, which was done in this case. CP 3185, 3196.¹⁷

Although it was not a point plaintiffs’ counsel or expert witnesses chose to make, defense experts explained at trial that whether a physician meets the standard of care in making a diagnosis has to be evaluated *prospectively* – as of the time the diagnosis was made and arrived at, based on what the physician knew – not retrospectively, with the benefit of more and often better information. RP 1323, 1333, 1413. Otherwise, liability for a missed diagnosis would be strict, and it is not. *See* RCW 7.70.040 and RCW 4.24.290. Plaintiffs’ fulminations about the instruction are simply expressions of frustration at having been required to prove

¹⁶ Quoting J. Perdue, *Texas Medical Malpractice*, ch. 2, “Standard of Care,” 22 *Hous. L. Rev.* 47, 60 (1985).

¹⁷ Court’s Instruction Nos. 6 and 16 were WPI 105.02 and 21.02, respectively.

violation of a standard of care and at having failed to persuade a jury that missing a diagnosis of an extremely rare disease is malpractice if the disease is a terrible one.

D. There Was No Prejudice in the Giving of the “Exercise of Judgment” Instruction.

Earlier versions of the “*error of judgment*” instruction used the term “*honest error*.” *Watson* disapproved of the use of the word “honest,” 107 Wn.2d at 164-65, and the “*exercise of judgment*” pattern instruction, WPI 105.08, given in this case did not include the word “honest.” The *error of judgment* instruction at issue in *Ezell* prompted the Court of Appeals, while finding no abuse of discretion in the giving of the instruction, to suggest that use of the word “error” could risk unnecessary confusion. The “*exercise of judgment*” pattern instruction, which was given in this case, no longer uses the word “error.” Thus, the “exercise of judgment” instruction does not “prejudice” a plaintiff by implying that dishonesty or contradictory propositions must be proven. All the “*exercise of judgment*” pattern instruction does is make it clear that, if a physician exercises skill and care according to the standard he or she is expected to follow, the physician is not liable for arriving at a diagnosis that turns out to be incorrect. Medical malpractice liability is not strict,

and medical negligence cannot be proved simply by deploying a retrospectoscope.

Plaintiffs' "prejudice" argument reduces to a claim that the exercise of judgment instruction must have prejudiced her because she lost. To the contrary, plaintiffs lost not because of an instruction that correctly stated the law but rather because the jury was unpersuaded that Dr. Sestero failed to comply with the standard of care in diagnosing a cyst and not ordering more tests to rule out a one-in-millions soft-tissue sarcoma, and/or because the jury was unpersuaded by plaintiffs' counsel's campaign to discredit Dr. Sestero's chart note saying he referred Mr. Fergen to an orthopedist. The jury understood Dr. Sestero's reasoning, the expert testimony, and the statistics. It rightly declined to blame Dr. Sestero for the fact that, after November 17, 2004, Mr. Fergen's ankle lump neither changed in size or appearance nor discomfited him enough to prompt him (or his registered nurse wife) to seek further medical attention for it from, or even to mention it to, any kind of health care provider until after he was diagnosed with cancer in late 2005. As the jury was entitled to and did find, Ewing's sarcoma killed Paul Fergen; malpractice by Dr. Sestero did not.

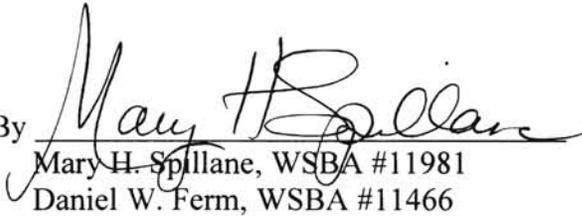
Because the “exercise of judgment” instruction given in this case was a correct statement of applicable law, and not erroneous, it cannot be prejudicial. *See Ezell*, 105 Wn. App. at 489.

VI. CONCLUSION

For the foregoing reasons this Court should affirm the judgment entered on the jury’s defense verdict.

RESPECTFULLY SUBMITTED this 20th day of August, 2012.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 20th day of August, 2012, I caused a true and correct copy of the foregoing document, "Brief of Respondents," to be delivered in the manner indicated below to the following counsel of record:

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