NO. 103635-3

SUPREME COURT OF THE STATE OF WASHINGTON

STEVEN BEARD, individually and as personal representative of THE ESTATE OF SUPAK BEARD,

Petitioners,

v.

THE EVERETT CLINIC, PLLC; OPTUM CARE SERVICES COMPANY; AND OPTUM CARE, INC; AND SHAILA H. GALA, MD,

Respondents.

RESPONDENTS' ANSWER TO PETITION FOR REVIEW

Amanda K. Thorsvig, WSBA #45354
Attorney for Respondent
FAIN ANDERSON VANDERHOEF ROSENDAHL O'HALLORAN SPILLANE, PLLC
3131 Elliott Ave., Suite 300
Seattle, WA 98121
Ph: 206.749.0094
Email: amanda@favros.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

STATE CASES **PAGE(S)**

RULES

OTHER AUTHORITIES

I. IDENTITY OF RESPONDING PARTIES

Respondents (collectively "Dr. Gala") answer Appellant Steven Beard's Petition for Review.

II. COURT OF APPEALS DECISION

Division I unanimously concluded the trial court properly exercised its discretion in giving the exercise-of-judgment pattern instruction, WPI 105.08. Contrary to Beard's assertions, Division I found ample evidence that Dr. Gala exercised reasonable care and skill consistent with the standard of care, not only in choosing among multiple alternative diagnoses and courses of treatment, but also in formulating her judgment regarding how to manage Supak Beard's complex medical presentation. This Court's decisions support giving the instruction in situations like Dr. Gala's and have rejected the arguments Beard makes concerning the instruction's propriety. No RAP 13.4(b) consideration applies. This Court should deny Beard's petition.

III. ISSUE COUNTERSTATEMENT

Did the trial court properly exercise its discretion in giving the exercise-of-judgment instruction where there was evidence Dr. Gala complied with the standard of care in formulating her judgment and making choices among alternative diagnoses and courses of treatment?

IV. CASE COUNTERSTATEMENT

A. Factual Background.

Supak Beard suffered from systemic lupus erythematosus ("lupus"), a complex, incurable autoimmune disease that attacks organ systems. RP 608, 621-22, 779. Lupus can cause flares ranging in severity, sometimes resulting in hospitalization or death. RP 622. Rheumatologists, who care for patients with autoimmune disease, cannot predict when flares will occur, their severity, or duration. RP 624-25. Flares must be treated. RP 626-29.

When first diagnosed with lupus in 1991, Supak developed nephritis (kidney inflammation)—among the most serious lupus

complications. RP 619, 624, 768. Although her kidney disease quieted two years later, she still required medications, including prednisone and hydroxychloroquine, to manage her lupus and prevent flares. RP 621, 623, 631.

Supak established care with rheumatologist Dr. Gala in 2007, continued experiencing periodic flares between 2007 and 2017, and was never able to discontinue prednisone. RP 625-26, 765, 773-74. Between November 2017 and January 2018, her flares required increasing prednisone and worsened with attempts to taper it. RP 646-779, 783-84, 795-96.

On February 5, 2018, when Dr. Gala was out of town, Supak went to a walk-in clinic with a 102.9-degree fever and chills. RP 678-81. The doctor ordered blood and urine cultures and a chest x-ray. RP 681-82. The radiologist's x-ray report indicated "[b]andlike opacity overlying the right lung apex that may represent atelectasis or artifact and less likely pneumonia. Lungs otherwise appear clear," and stated: "Consider follow-up or CT for further assessment." Ex.432 at 1-2. The walk-in clinic

doctor contacted Dr. Gala's on-call rheumatologist and informed him that the chest x-ray showed "possible pneumonia but not too convincing." RP 683. They started Supak on Levaquin, an antibiotic, to cover for possible pneumonia while awaiting blood cultures. RP 687-88.

The next day, the walk-in clinic called Supak, who reported no fever and was told if she woke up the next day with no fever, she could cancel her appointment, which she did. RP 689. Supak's blood and urine cultures were negative. Ex.431 at 7-10. Supak continued to improve after taking Levaquin, remained afebrile, and had no problems breathing, indicating the process in her lungs had resolved. RP 690-91. The walk-in clinic advised her to call back if her symptoms were not completely resolved following the 10-day Levaquin course. RP 691. Supak did not call back. RP 691-92.

At her scheduled appointment with Dr. Gala on March 1, 2018, Supak told Dr. Gala that 60mg prednisone helped, but tapering to 20mg caused a flare. RP 692-96, 812-15; Ex. 435A at

2. Dr. Gala noted Supak's fever in early February and treatment for possible pneumonia, but Supak reported feeling much better after taking Levaquin. RP 693-94; Ex. 435A at 2. The fever had resolved by February 5. RP 694. Supak travelled to Florida for a week from February 10 to 17, during which time she felt well. RP 693-94; Ex.435A at 2.

On March 1, however, Supak reported chills that morning and had a low-grade 100.3-degree fever which Dr. Gala believed could be from a lupus flare or infection. RP 695-96, 707, 816-17; Ex. 435A at 2. Supak denied cough, sore throat, or difficulty breathing. RP 695-96, 817-18. Other than the low-grade fever and an elevated pulse, Supak's vitals were normal, and her weight was stable. RP 698-99. Dr. Gala listened to Supak's chest, which was clear without findings suggesting lung infection. RP 700, 707, 818. Dr. Gala also reviewed the February chest x-ray report. Ex.435A at 7. Dr. Gala believed any infection had resolved by March because Supak's symptoms had resolved, RP 819, and that the radiologist's recommendation for follow-up

chest imaging had been directed to the ordering physician who was evaluating Supak for active symptoms in February. RP 805-06.

Dr. Gala testified that nothing in her evaluation of Supak on March 1 indicated an urgent condition or necessitated an infectious disease consult. RP 759-60. Still, she needed to evaluate Supak for possible infection. RP 819-20. Exercising her medical judgment, Dr. Gala decided not to repeat a chest x-ray because she did not "think it was indicated, as [Supak] reported no cough, no shortness of breath" and her "lungs were clear on auscultation." RP 819-20. Instead, she chose to complete blood and urine cultures over chest imaging because she was "reassured by her history of no chest pain or shortness of breath or cough … [and] examination of her lungs and chest. Her exam was consistent with an arthritis flare, but [she] did feel, with the one day of fever, that [she] needed to check blood and urine cultures…." RP 820-21. Dr. Gala accordingly ordered labs and

urine and blood cultures to investigate the fever's etiology. Ex.435A at 8.

To treat Supak's flare, Dr. Gala increased Supak's prednisone to 40mg. RP 702-03, 815. Because both a lupus flare and an infection can cause fever, RP 819-20, she closely followed Supak, watching for infection, and used the lowest prednisone dose possible. RP 780-82, 787-88. Balancing infection risk versus benefit of treating a suspected flare, Dr. Gala explained: "my concern was that the tapering went too fast and this led to the flare that she was experiencing and that I wanted to get … back under control." RP 815-16.

After the labs revealed inflammation consistent with either infection or a flare and elevated liver enzymes, Dr. Gala ordered a gastroenterology consult and abdominal ultrasound. RP 702-04, 706, 820-23, 825-26. She referred Supak to gastroenterology because Supak's liver tests were elevated. RP 821-23. She did not tell the gastroenterologist she was considering infection because she trusted the gastroenterologist to evaluate Supak, RP

826-27, 917-18, and the gastroenterologist, as "part of the same medical records system," had "access to all the records," RP 967.

The next morning, March 2, Supak called with a 100.7-degree fever. RP 912. Dr. Gala continued checking the blood and urine culture results, which remained negative, while awaiting the final results. RP 913-14. Dr. Gala's nurse gave Supak information to schedule the gastroenterology consult and abdominal ultrasound. RP 913. Dr. Gala testified that she decided to continue awaiting final culture results because nothing about a continued low-grade fever indicated the need for urgent infectious disease intervention: Supak's "cultures were negative to date, meaning every day I get results from the lab informing me if there's any growth on the culture. … I was reviewing that, and the plan … was as we stated before on the March 1st visit." RP 913-14.

On March 5, Supak called reporting blood in her stool. RP 914. The final urine culture results were negative, and the blood cultures were negative to date but still pending final. RP 915. Dr.

Gala asked her staff to facilitate getting a gastroenterology appointment with a physician. RP 915-16. Dr. Gala also ordered stool studies. RP 916-17. By March 6, Supak's stool test was negative, as were her other tests to rule out infection. RP 918-19.

Supak's gastroenterology workup revealed a nonbleeding stomach ulcer but no other abnormal findings. RP 921. Because it did not explain Supak's elevated liver enzymes, the gastroenterologist planned a liver biopsy. RP 921.

On March 22, when Supak saw Dr. Gala, Dr. Gala immediately appreciated that Supak's condition was markedly changed from prior visits. RP 922. Supak now had abdominal, epigastric, and back pain, with a 103.4-degree fever, prompting Dr. Gala to order a chest, abdomen, and pelvis CT. RP 924-25.

The abdominal CT revealed "[f]indings most consistent with terminal ileitis" that could be infectious or inflammatory, and the chest CT showed pulmonary opacities and nodules. RP 928. When Dr. Gala got the results, she instructed Supak to go to the ER and gave the ER physician advance notice of Supak's

arrival. *Id.* Dr. Gala had no further involvement in Supak's care. RP 929.

Arriving at the ER that evening, Supak was afebrile with normal blood pressure, normal respiration, and only a slightly elevated pulse. RP 854-55; Ex.453 at 3,9. She had a generally reassuring abdominal examination and appeared "nontoxic," not looking extremely ill. RP 855-58. Supak was admitted to the hospital for further evaluation. Ex.453 at 6. Early on March 23, she worsened, repeat imaging revealed free air in her abdomen, and she was taken for emergency exploratory surgery, where a perforated bowel was found and repaired. Ex.453 at 7, 28-29. Although Supak survived surgery, she suffered a cardiac arrest and died several hours later. RP, 901.

Post-mortem studies revealed that Supak died from extrapulmonary intestinal tuberculosis causing bowel perforation. RP 850-52, 876. "Extrapulmonary tuberculosis," tuberculosis that does not affect the lungs, is rare. RP 849-51.

That it also caused a bowel perforation that Supak died from after successful surgery to repair it is "rare-upon-rare." RP 851-52.

B. Procedural History.

Supak's husband, Steven Beard, sued Dr. Gala for medical malpractice. CP 562-69. Dr. Gala denied all allegations. CP 554-61. At trial, Dr. Gala testified at length, explaining her medical decision-making, judgment, and choices in caring for this complex patient. *See* pages 4-9, *supra*; RP 759-60, 779-82, 787-88, 805-06, 815-16, 819-24, 826-27, 913-14, 917-19, 967.

Dr. Brown, Beard's rheumatology expert, criticized Dr. Gala for failing to order a chest x-ray or CT in follow-up to the February imaging, which the trial court ruled he could not assert because he had failed to disclose this opinion.[1] RP 272, 276-77. He also opined the standard of care required Dr. Gala on March 1 and March 2 to urgently refer Supak to infectious disease, RP 278-79, 280, and that Dr. Gala breached the standard of care in

[1] Beard did not appeal this ruling.

increasing Supak's prednisone, RP 279, and in not informing the gastroenterologist of concern about infection, RP 287-88.

Dr. Elizabeth Volkmann, Dr. Gala's rheumatology expert, testified Dr. Gala complied with the standard of care in her decision-making and treatment. RP 612-13, 617. Dr. Volkmann explained the reasonableness of the choices Dr. Gala made during Supak's complicated course:

> [T]his patient had a number of things going on on March 1st. One … was worsening arthritis in the setting of abruptly lowering the prednisone, and … it was very reasonable to go back up to that dose of prednisone that helped control her symptoms.
>
> She also had these abnormalities on the liver test, and this resulted despite stopping the methotrexate. That could have been the cause. And so to then refer the patient to an expert to figure out what was causing the liver tests was appropriate, and also to get imaging of that organ to see how it appeared. And that type of information would be very helpful for the gastroenterologist to have when they saw the patient.
>
> And then thirdly, to try to understand, was this fever only due to the lupus flare getting worse or could there be an infection. And since there was no localizing sources of the infection, no cough, no shortness of breath, no abdominal pain, the best place to start looking for infection and the only

> places that you can really culture it easily are the urine and the blood.

RP 708-09.

Dr. Volkmann agreed with Dr. Gala's judgment regarding Supak's prednisone dosing, explaining: "[A] lot of factors … go into that decision," including what body parts are affected and how long the patient has taken prednisone. RP 632-33, 668, 674. Deciding the therapeutic dose requires balancing the risk of not treating lupus with the risk of increased infection: "it comes from years of experience in treating patients where you just have to use your best clinical judgment …." RP 634.

Dr. Volkmann also testified Dr. Gala's belief on March 1 that Supak's abrupt prednisone decrease caused her flare was reasonable, as was Dr. Gala's choice to increase prednisone: "that was the logical thing to do, because she had done better on the higher dose, and when she abruptly decreased is when the symptoms came back." RP 702, 705. "We can't just focus on the infection or focus on the lupus. We have to do both. And in this case, she was addressing the lupus flare, but then looking to see

if there was any infection, too." RP 702-03; *see also* RP 747-48 (reasonable for Dr. Gala to treat flare while investigating possible infection).

Dr. Volkmann also agreed with Dr. Gala's judgment that Supak did not need an urgent infectious disease referral on March 1, RP 641-44, confirming that a one-day, low fever would not cause a reasonable rheumatologist to believe there was an urgent infectious process, particularly when Supak's temperature was considerably lower than in February when she had possible pneumonia. RP 697-99. "There was nothing urgent about [Supak's] presentation on this day that would necessitate an urgent evaluation from infectious disease. She had a low-grade fever, and this is something that's pretty common in patients with lupus." RP 709. Because Supak's complaints centered on joint pain occurring with self-reducing prednisone, indicating a flare, it was reasonable to believe that a flare could be causing the fever. RP 640-41, 695-96.

Dr. Volkmann disagreed that the standard of care required Dr. Gala to order chest imaging on March 1 or 2 because she evaluated the lungs by listening to them and, without respiratory symptoms, reasonably chose to pursue blood and urine cultures instead. RP 707-10, 736-37, 746, 747, 751-54 (reasonable to rely on response to antibiotics regarding February x-ray findings); RP 685-86 (radiologist's February recommendation to consider follow-up imaging directed to ordering physician, not Dr. Gala). Urine and blood cultures test for the majority of infectious processes that rheumatologists encounter when patients only have low-grade fevers. RP 700-701, 704-05, 707-09, 715, 746.

Nothing on March 2 had changed. As Dr. Volkmann explained, Supak "had a fever for one day and it continued for another day, but the treatment that was prescribed, the increase in prednisone, only has one day to work, so we really wouldn't expect a change in fever at that early time point." RP 618. Additionally, "Dr. Gala had ordered studies to check for an infection in the blood and urine, and … those were still pending

that next day. So she was still looking to see whether there was an infection at that time to explain why the fever was there." *Id.*

Dr. Volkmann believed Dr. Gala reasonably chose to refer Supak to gastroenterology for elevated liver enzymes. *See* RP 703-04, 706-07. The standard of care did not require Dr. Gala to tell the gastroenterologist about possible infection because "all of the information that the consultant needs about the patient is in the electronic medical record." RP 717.

Considering the trial testimony and carefully reviewing the law, the trial court found the evidence supported giving the exercise-of-judgment pattern instruction. RP 1015-16, 1018; CP 23, which supplemented the pattern standard of care instructions to which Beard did not object, CP 17, 18, 21.

The jury returned a unanimous defense verdict, finding Dr. Gala not negligent. RP 1155-57. Beard appealed, challenging the exercise-of-judgment and no-guarantee/poor result instructions. Division I rejected Beard's arguments, concurring with the trial court that evidence supported giving the instructions. Beard

petitions for review only on the exercise-of-judgment instruction.

V. ARGUMENT WHY REVIEW SHOULD BE DENIED

No RAP 13.4(b) consideration warrants this Court's review of a pattern instruction that it has held for decades courts have discretion to give when the evidence supports the instruction, as it did here. Division I did not eliminate any requirement this Court has articulated for giving the exercise-of-judgment instruction. Division I correctly applied well-settled precedent to demonstrate that Dr. Gala satisfied each requirement for the instruction: she had choices among alternative diagnoses and treatments, and expert testimony supported that she exercised reasonable care and skill in making the choices she made. There is no conflict with this Court's decisions. Nor can Beard create an issue of substantial public interest by making arguments about the instruction's propriety this Court has previously rejected.

A. Division I's Decision Does Not Conflict with this Court's Decisions.

This Court has "consistently approved of the exercise of judgment jury instruction in appropriate medical malpractice cases." *Fergen v. Sestero,* 182 Wn.2d 794, 803, 346 P.3d 708 (2015) (citing *Miller v. Kennedy*, 85 Wn.2d 151, 151-52, 530 P.2d 334 (1975) (*Miller* II); *Miller v. Kennedy*, 11 Wn. App. 272, 280, 522 P.2d 852 (1974) (*Miller* I); *Miller v. Kennedy*, 91 Wn.2d 155, 160, 588 P.2d 734 (1978) (*Miller* III); *Watson v. Hockett*, 107 Wn.2d 158, 164-65, 727 P.2d 669 (1986); *Christensen v. Munsen*, 123 Wn.2d 234, 249, 867 P.2d 626 (1994)).

An exercise-of-judgment instruction is "justified when (1) there is evidence that the physician exercised reasonable care and skill consistent with the applicable standard of care in formulating his or her judgment and (2) there is evidence that the physician made a choice among multiple alternative diagnoses (or courses of treatment)." *Fergen*, 182 Wn.2d at 806 (citations omitted). Contrary to Beard's assertions, *Pet. at 15-16*, Division

I did not eliminate either requirement. It found Dr. Gala's evidence satisfied both. *Slip Op. at 47-59*.

First, Dr. Gala had choices. Division I found "numerous bases on which a jury could find that Dr. Gala was presented with circumstances requiring her to make a choice between methods of treatment," including:

> [I]ncreasing Supak's prednisone dosage or maintaining (or lowering) her prednisone dosage during the time in question; ordering urine and blood testing or ordering urine and blood testing as well as another chest X-ray on March 1; continuing to wait for the urine and blood test results or urgently referring Supak to an infectious disease specialist on March 2; and referring Supak to a gastroenterologist and trusting that the consultant would review the record of issuing such a referral and personally contacting the gastroenterologist ahead of the appointment.

Slip Op. at 57-58.

Second, "Dr. Gala made choices—that is, exercised her medical judgment":

> Dr. Gala adjusted Supak's prednisone dose in response to her reported symptoms, clinical observations, the laboratory test results, and imaging studies. Dr. Gala ordered blood, urine, and stool cultures in response to Supak's reported—and

> clinically observed—fever and her reported blood in her stools. Dr. Gala referred Supak to a gastroenterologist in response to ongoing abnormal liver functioning tests. And, in response to Supak's new symptoms of a second day of fever and three days of blood in her stools, Dr. Gala chose to continue to review Supak's pending urine and blood culture tests each day and order a stool pathogen panel as she waited for the test results to finalize.

Slip Op. at 58.

Finally, "the record contains expert witness testimony supporting that Dr. Gala made choices that were consistent with the rheumatological standard of care. … Dr. Volkmann, a rheumatological expert witness, testified that each of Dr. Gala's choices discussed herein were consistent with the standard of care." *Slip Op. at 58-59; see also id. at 47-59;* pages 12-16, *supra*.

Beard's contention, *Pet. at 17*, that the "bench and bar are now left uncertain whether the first requirement … is still a requirement" is wrong. Division I straightforwardly recognized, followed, and applied both requirements consistent with this Court's decisions.

Division I also properly rejected Beard's contention that evidence the physician met the standard of care in "formulating" or "arriving at" his or her judgment necessitates "testimony that—at each step along the way—the physician's thought process was consistent with the standard of care," *Slip Op. at 32*, notwithstanding having made a choice within the standard of care. Division I correctly appreciated that "the phrase a physician's 'arriving at a judgment' between competing therapeutic techniques or among medical diagnoses is merely another way Washington state appellate courts have referred to the physician's choice made between such treatments or diagnoses." *Slip Op. at 40*; *see also Slip Op. at 42-43* ("formulating his or her judgment" is an iteration of the same principle that the physician's judgment is the physician's choice).

None of this Court's decisions Beard cites, *Pet. at 11-15*, conflict with Division I's decision. None discusses let alone requires additional expert testimony that the defendant's state-

of-mind complied with the standard of care. *See, e.g., Fergen*, 182 Wn.2d at 808-09 (focusing on "choices that necessarily involved" physician's judgment); *Paetsch v. Spokane Dermatology Clinic, PS*, 182 Wn.2d 842, 851-52, 348 P.3d 389 (2015) (approving instruction where doctor chose to treat patient for one of two competing diagnoses); *Christensen,* 123 Wn.2d at 249 (approving instruction where defense experts testified that ophthalmologist's choice complied with standard of care though they would have treated patient differently).

These decisions evaluate whether the choice—objective evidence of the defendant's judgment—was reasonable and whether the defendant used "clinical judgment in diagnosis or treatment" to reach that choice. *Fergen*, 182 Wn.2d at 799. Thus, a trial court may instruct on exercise-of-judgment when the doctor made "choices that necessarily involved his judgment", and expert testimony supports that the "**choices** were within the standard of care." *Id.* at 808 (emphasis added). The test is whether evidence establishes that the doctor had a choice among

alternatives, made a choice, and the choice complied with the standard of care, as here.

Division I properly held, consistent with this Court's decisions, that "the exercise of judgment instruction may be given when there is proof that a physician was confronted with a choice between competing diagnoses or methods of treatment, each or all of which would be consistent with the standard of care, and proof that the choice made by the physician among those options was consistent with the standard of care. Affirmative evidence that the physician's reasoning underlying that choice was consistent with that standard is not required." *Slip Op. at 44*.

Beard also argues that Division I improperly relied on the emergency doctrine to justify giving the exercise-of-judgment instruction, *Pet. at 25-27*. It did not; Division I's decision was based on precedent upholding the exercise of judgment instruction. It discussed the emergency doctrine only in refutation of Beard's contention that the exercise-of-judgment

instruction was unique and therefore somehow improper: "Beard's perception of the propriety of this instruction is colored by his perception of it being unique in the law. … However, the principles underlying the exercise of judgment instruction are not at all unique in the law." *Slip Op. at 25*; *see also Fergen*, 182 Wn.2d at 811 (recognizing that elaborating instructions are commonly used in negligence law and are helpful for lay jurors).

Regardless, Beard's fixation on the reasoning underlying the choices is immaterial because Division I also recognized that "Dr. Volkmann provided cogent reasoning as to **why** each of those choices were within the standard of care." *Slip Op. at 59* (emphasis added). Even if this Court's decisions imposed a requirement that the physician's underlying reasoning comply with the standard of care, evidence confirmed Dr. Gala's did.

B. Beard's Petition Does Not Involve an Issue of Substantial Public Interest.

This Court has considered and rejected Beard's argument, *Pet. at 18*, that the exercise of judgment instruction is "incorrect, harmful, and must be overruled," instead holding it "helps juries

to understand the complexity of the legal standard that they are being asked to apply." *Paetsch*, 182 Wn.2d at 852 (citing *Fergen*, 182 Wn.2d at 811). The instruction provides "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." *Watson*, 107 Wn.2d at 167 (quotations and citations omitted). It "is a useful tool to remind juries of the fallibility of medicine." *Fergen*, 182 Wn.2d at 804 (citing *Watson*, 107 Wn.2d at 167).

"Properly given and worded, this instruction does not misdirect the jury and is not confusing;" it simply "alerts jurors that they must resolve factual issues regarding the standard of care" and still "requires the jury to find that in arriving at the diagnosis or treatment the physician exercised reasonable care and skill within the requisite standard of care." *Fergen*, 182 Wn.2d at 811 (citations omitted).

Beard fails to provide "a clear showing that an established rule is incorrect and harmful" to warrant abandoning such precedent. *Fergen*, 182 Wn.2d at 809. Beard's contention that the instruction overemphasizes defense theories and confuses juries, *Pet. at 23-30*, raises no argument distinguishable from those raised in *Fergen* that this Court rejected. *See*, *e.g.*, *Fergen*, 182 Wn.2d at 810 (rejecting argument that instruction is unnecessary, confuses jurors, emphasizes defense theory, and creates unfair advantage to defendants tantamount to directed verdict). Beard's reprise of previously rejected arguments in an attempt to invalidate the instruction is foreclosed. *Paetsch*, 182 Wn.2d at 852.

Beard nonetheless contends, *Pet. at 20*, "[this] Court's precedent approving the exercise of judgment instructions [sic] is incorrect in that it tells the jury a doctor may not be liable based on the doctor's irrelevant subjective mental state." He then cites, *Pet. at 20-21*, several out-of-state cases he claims "have abandoned this instruction as incorrect because it injects

subjectivity (the doctor's reasoning behind a choice) into the objective standard of care issue (the doctor's ultimate choice)." But, what he ignores is that the instructions injecting a subjective, rather than objective, standard that those out-of-state cases rejected contained such qualifiers as "good faith", "bad faith", "bona fide", "honest", or "mere" errors of judgment or "mistakes" in judgment, *see* cases cited *Pet. at 20-21,* including *Morlino v. Med. Ctr. of Ocean Cnty.*, 152 N.J. 563, 585-87, 706 A.2d 721 (1998); *Day v. Johnson,* 255 P.3d 1064, 1070, 1071 (Colo. 2011). This Court has already disapproved such language. *See Fergen,* 182 Wn.2d at 804 and cases cited therein. It does not appear in the pattern exercise-of-judgment instruction this Court has approved that the trial court gave in this case.

Beard, however, suggests, *Pet. at 21,* that, because the out-of-state cases he cites approving some formulation of an exercise-of-judgment instruction "do not tell juries to consider how the physician 'arrived at' the choice," the pattern exercise-of-judgment instruction this Court has approved is an outlier.

Nothing could be further from the truth. Beard's assertions that the physician's reasoning behind his or her ultimate choice is irrelevant, *Pet. at 29,* or that the "instruction's focus on how the physician 'arrived at the judgment' to select a diagnosis or treatment is misstatement of law", *Pet. at 18*, are simply not true.

By telling the jury that "[a] physician is not liable for selecting one of two or more alternative courses of treatment, if, in arriving at the judgment to follow the particular course of treatment, the physician exercised reasonable care and skill within the standard of care …," the instruction properly allows the jury to consider not only whether the choice was within the standard of care, but also whether the physician took the appropriate steps the standard of care required before making that choice. *See Fergen*, 182 Wn.2d at 810-11 (rejecting dissent's assertion that exercise-of-judgment instruction incorrectly "focuses the jury on the physician's choice rather than the plaintiff's claim that the physician failed to take the proper steps before making the choice," and "could make the jury believe it

does not need to resolve factual issues regarding the standard of care.")

Beard's position that this Court's precedent "gives no guidance to the bench or bar on when to use the instruction," *Pet. at 21*, is also incorrect. This Court has clearly mandated that "a court should give the instruction only when the physician presents sufficient evidence that they made a choice between two or more alternative, 'reasonable [and] medically acceptable' treatment plans or diagnoses" not "'simply if a physician is practicing medicine at the time.'" *Needham v. Dreyer*, 11 Wn. App. 2d 479, 490, 454 P.3d 136 (2019), *rev. denied*, 195 Wn.2d 1017 (2020) (quoting *Fergen*, 182 Wn.2d at 808). As Division I recognized, the physician must have a choice between alternative diagnoses or treatments, make a choice, and making the choice must comply with the standard of care, as in this case.

Finally, Beard repeatedly asserts without evidence, *Pet. at 10, 22, 27*, juries receiving the exercise of judgment instruction uniformly return defense verdicts. That same argument in

Fergen, 182 Wn.2d at 810, did not persuade this Court that the long-standing precedent approving the instruction was incorrect or harmful so as to warrant eliminating the instruction.

No data substantiates that every jury receiving the instruction returns a defense verdict, much less that the instruction causes them to do so. Indeed, data disproves it. For example, the instruction was given in *Woodring-Thueson v. State*, King Cty. Sup. Ct. No. 15-2-29985-9 SEA, and *Evans v. Seattle Children's Hospital*, King Cty. Sup. Ct. No. 15-2-26711-6 SEA, both of which resulted in eight-figure plaintiff verdicts. The instruction does not tell juries that judgment calls are immune from liability, and no data supports that juries interpret it that way.

Beard's rehashing of arguments that this Court has previously rejected regarding the exercise-of-judgment instruction's propriety do not create an issue of substantial public interest warranting this Court's further review.

VI. CONCLUSION

Division I's decision is not in conflict with any decision of this Court. Nor does Beard's petition involve any issue of substantial public importance. This Court should deny Beard's petition for review.

I declare that this document contains 4,996 words. RESPECTFULLY SUBMITTED this 23rd day of December, 2024.

FAIN ANDERSON VANDERHOEF ROSENDAHL O'HALLORAN SPILLANE, PLLC

s/Amanda K. Thorsvig
Amanda K. Thorsvig, WSBA #45354
Attorneys for Respondents
3131 Elliott Ave., Suite 300
Seattle, WA 98121
Ph: 206.749.0094
Email: amanda@favros.com

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that under the laws of the State of Washington that on the 23rd day of December, 2024, I caused a true and correct copy of the foregoing document, "Respondents' Answer to Petition for Review," to be delivered in the manner indicated below to the following counsel of record:

Counsel for Appellants:
Corrie J. Yackulic, WSBA #16063
CORRIE YACKULIC LAW FIRM, PLLC
110 Prefontaine Pl. S., Suite 304
Seattle, WA 98104
Ph: 206.787.1915
Email: corrie@cjylaw.com

SENT VIA:
☐ Fax
☐ ABC Legal Services
☐ Express Mail
☐ Regular U.S. Mail
☑ E-file / E-mail

Counsel for Appellants:
Brian K. Leonard, WSBA #18087
LAW OFFICES OF BRIAN K. LEONARD, P.S.
110 Prefontaine Pl. S., Suite 304
Seattle, WA 98104
Ph: 425.778.1838
Email: brian@BLeonardlaw.com

SENT VIA:
☐ Fax
☐ ABC Legal Services
☐ Express Mail
☐ Regular U.S. Mail
☑ E-file / E-mail

Counsel for Appellants:	SENT VIA:
Joshua B. Trumbull, WSBA #40992 Ben W. Wells, WSBA #19199 Brian J. Fisher, WSBA #46495 WELLS | TRUMBULL, PLLC 106 E Gilman Ave Arlington, WA 98223-1017 Ph: 425.309.7700 Email: josh@wellstrumbull.com ben@wellstrumbull.com brian@wellstrumbull.com	☐ Fax ☐ ABC Legal Services ☐ Express Mail ☐ Regular U.S. Mail ☑ E-file / E-mail

Co-counsel for Respondents:	SENT VIA:
Michele C. Atkins, WSBA #32435 Joseph V. Gardner, WSBA #53340 FAIN ANDERSON VANDERHOEF, ROSENDAHL O'HALLORAN SPILLANE, PLLC 3131 Elliott Ave., Suite 300 Seattle, WA 98121 Ph: 206.749.0094 Email: michele@favros.com joe@favros.com	☐ Fax ☐ ABC Legal Services ☐ Express Mail ☐ Regular U.S. Mail ☑ E-file / E-mail

DATED this 23rd day of December, 2024, at Seattle, Washington.

s/Carrie A. Custer
Carrie A. Custer, Legal Assistant
Email: carrie@favros.com

FAVROS LAW

December 23, 2024 - 9:24 AM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	103,635-3
Appellate Court Case Title:	Steven Beard v. The Everett Clinic, PLLC, et al.
Superior Court Case Number:	20-2-05883-0

The following documents have been uploaded:

- 1036353_Answer_Reply_20241223092103SC528506_9252.pdf
  This File Contains:
  Answer/Reply - Answer to Petition for Review
  The Original File Name was Respondents Answer to PFR.docx.PDF

A copy of the uploaded files will be sent to:

- Brian@BLeonardlaw.com
- ben@wellstrumbull.com
- brian@wellstrumbull.com
- corrie@cjylaw.com
- joe@favros.com
- josh@wellstrumbull.com
- michele@favros.com
- patricia@cjylaw.com

Comments:

Sender Name: Carrie Custer - Email: carrie@favros.com
Filing on Behalf of: Amanda Kathleen Thorsvig - Email: amanda@favros.com (Alternate Email: carrie@favros.com)

Address:
3131 Elliott Avenue
Suite 300
SEATTLE, WA, 98121
Phone: (206) 749-0094

Note: The Filing Id is 20241223092103SC528506