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WASHINGTON STATE  
SUPREME COURT

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No. 91374-9

SUPREME COURT  
OF THE STATE OF WASHINGTON

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DAVID DUNNINGTON and JANET WILSON,  
Petitioner and Cross-Respondent

v.

VIRGINIA MASON MEDICAL CENTER,  
Respondent and Cross-Petitioner.

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BRIEF OF RESPONDENT/CROSS PETITIONER

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## I. INTRODUCTION

Petitioners David Dunnington and Janet Wilson (“Dunningtons”) claim that Dr. Alvin Ngan, a podiatrist employed by Respondent Virginia Mason Medical Center, failed to timely diagnose Mr. Dunnington’s melanoma causing a lost chance at a better outcome. This claim raises two issues on appeal. First, whether Mr. Dunnington’s failure to follow Dr. Ngan’s instructions breached the patient’s duty to take responsibility for his own care such that he was comparatively negligent for the alleged delay. Second, whether this Court should abandon traditional tort principles and hold that “substantial factor” should replace “but for” as the proximate cause standard in lost chance claims.

This brief first presents a competing version of the facts and then addresses the trial court’s disposition of the Dunningtons’ motion for summary judgment on comparative fault. As argued in Part VI.A, the trial court’s dismissal of the defense of comparative negligence resolved disputed issues in favor of the Dunningtons, and ignored the well-established proposition that as a partner in his healthcare, Mr. Dunnington had a duty to follow his physician’s instructions. Based on the disputed issues, a jury could find that Mr. Dunnington’s failure to follow instructions was not reasonable and that he therefore contributed to the

delay in diagnosis. The trial court therefore erred in granting the motion for partial summary judgment.<sup>1</sup>

Part VI.B addresses the Dunningtons' arguments that the trial court erred in rejecting their request to apply the substantial factor test for causation contained in WPI 15.02. By its terms, WPI 15.02 is inapplicable to medical negligence cases. Extension of the substantial factor test to negligence actions is ill-advised and not supported by sound public policy. "But for causation is the first, essential element of proximate cause, cause-in-fact. Cause-in-fact is not a mere technicality but the "*sine qua non*"<sup>2</sup> of legal liability."<sup>3</sup> *Eckerson v. Ford's Prairie Sch. Dist.*, 3 Wn.2d 475, 482, 101 P.2d 345 (1940).

This Court has already struck the appropriate balance between competing policy interests by recognizing that "a loss of chance of better

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<sup>1</sup> This case comes to the Court to resolve two potentially case determinative issues before either party incurs the expense of a jury trial. The parties' statements of facts are therefore, by necessity, incomplete and have not been tested for veracity. In evaluating plaintiffs' motion for partial summary judgment, the defendant is entitled to have all facts and all inferences drawn from those facts viewed in the light most favorable to the defense. See *Millson v. City of Lynden*, 174 Wn. App. 303, 309, 298 P.3d 141 (Div. I 2013) ("This court reviews a summary judgment order de novo, viewing the facts and reasonable inferences in the light most favorable to the nonmoving party."); *Lam v. Global Med. Sys. Inc.*, 127 Wn. App. 657, 661, n. 4, 111 P.3d 1258 (Div. I 2005).

<sup>2</sup> "Something absolutely indispensable or essential." <http://www.merriam-webster.com/dictionary/sine%20qua%20non>

<sup>3</sup> This case was cited by the Dunningtons at page 9 of their brief for the proposition that the standard of proximate cause employed in a given case reflects policy considerations. This argument skips over the above analysis that before getting to proximate cause, the plaintiff must first establish cause-in-fact. By skipping this vital first step, the Dunningtons reduce the issue of causation to an evaluation of competing public policies.

outcome” is a distinct, compensable injury. No important policy arguments support eviscerating traditional causation doctrine by removing cause-in-fact from medical malpractice lost chance cases. The Dunningtons’ arguments to the contrary rest on faulty reasoning and an incomplete understanding of the complexity of traditional causation principles and should therefore be rejected.

## **II. ASSIGNMENTS OF ERROR ON CROSS-PETITION**

The trial court improperly removed comparative negligence from the jury’s consideration given evidence that Mr. Dunnington’s failure to follow his physician’s instructions contributed to the delayed diagnosis and the reduction in his chance of a better outcome.

## **III. STATEMENT OF CROSS-PETITION ISSUE**

1. Did Mr. Dunnington breach his duty to exercise ordinary care for his own health when he returned 87 days later than instructed, thus depriving Dr. Ngan of the opportunity of a much earlier diagnosis?

2. Did Mr. Dunnington breach his duty to exercise ordinary care for his own health when he ignored Dr. Ngan’s recommendation for excision and biopsy in December 2011?

#### IV. COUNTERSTATEMENT OF THE CASE

**A. Consistent with pyogenic granuloma, not the much rarer plantar surface melanoma, Mr. Dunnington presented to Dr. Ngan with a clinical history of distant trauma.**

On September 1, 2011, Mr. Dunnington saw his primary care provider, Dr. William Kirshner, at a Virginia Mason outpatient clinic. *CP 405*. Mr. Dunnington reported that “all summer” he had had a “lesion on the plantar surface<sup>4</sup> of the left foot.” *Id.* He also indicated that he believed that there was a foreign body there. *Id.*

Dr. Kirshner observed a granulomatous lesion on the plantar surface “which could be a foreign body reaction.” *CP 405*. He offered to arrange an appointment with Dr. Alvin Ngan, a podiatrist also employed by Virginia Mason. *Id.*

Dr. Ngan promptly saw Mr. Dunnington, working him in to the clinic schedule that same day. *Id.* Consistent with his description to his family practice doctor, Mr. Dunnington told Dr. Ngan that the lesion “arose after a puncture wound months ago.” *Id.* Based on the

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<sup>4</sup> Sole of foot. <http://www.medilexicon.com/medicaldictionary.php?t=86981>

granulomatous appearance<sup>5</sup> and the history of trauma, Dr. Ngan diagnosed a pyogenic granuloma.<sup>6</sup> *CP 406.*

**B. Dr. Ngan offered treatment options that would have resulted in the discovery of the melanoma months before the actual diagnosis had Mr. Dunnington followed Dr. Ngan's recommendations.**

Dr. Ngan offered Mr. Dunnington both conservative and more aggressive options, including surgical excision and biopsy. *CP 406.*

Mr. Dunnington opted for conservative treatment. *Id.* Dr. Ngan administered a silver nitrate treatment and three cycles of liquid nitrogen. *Id.* Dr. Ngan instructed Mr. Dunnington to return in 10 days for follow-up. *Id.*

Mr. Dunnington returned on September 15, 2011. *Id.* He reported that the initial treatment seemed to help but that the lesion had de-roofed and was now about the same as before. *Id.* Dr. Ngan again informed Mr. Dunnington of his options--including surgical excision and biopsy of the lesion. *CP 733.* Dr. Ngan favored surgical intervention but, recognized that it was Mr. Dunnington's decision. *CP 407.* Surgical excision and biopsy would have revealed the presence of melanoma

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<sup>5</sup> Without factual support, the Dunningtons state at page four of their brief, that Dr. Ngan recognized the "ABCD rule" for determining when a podiatrist should suspect a lesion is cancer. There is no "ABCD rule." There are guidelines. *CP 601.* The material the Dunningtons provided to the Court is actually a patient handout. *See CP 77-78.* The same source refers to malignant melanomas as "The Great Masquerader." *CP 78.*

<sup>6</sup> An acquired small rounded mass of highly vascular granulation tissue, frequently with an ulcerated surface, projecting from the skin or mucosa; histologically the mass resembles a capillary hemangioma. *Stedman's Medical Dictionary*, p. 744 (26th ed.).

whether or not Dr. Ngan suspected it because Dr. Ngan's standard practice is to order biopsies for tissue that has been surgically excised. *CP 733*. Once again, the patient opted for conservative treatment in the form of a repeat of the cryotherapy. *Id.* As documented in the medical record, Dr. Ngan instructed Mr. Dunnington to return to the clinic in two weeks. *CP 407; 732*. This would have required Mr. Dunnington see Dr. Ngan by approximately October 1, 2011.

Instead, Mr. Dunnington dropped all contact with Dr. Ngan for months. *CP 84*<sup>7</sup>. Dr. Ngan did not tell Mr. Dunnington that this return was optional. *CP 732*. He did not tell him that if the condition improved he need not return. *Id. Anytime* he does a procedure, Dr. Ngan instructs his patients to return so that he can evaluate whether or not the procedure or treatment worked. *Id.* Despite these instructions, Mr. Dunnington waited until late on Friday, December 16, 2011, to next contact Dr. Ngan. *CP 407*.

On that date, he called and reported the soreness in his foot had returned and that he now wanted an MRI.<sup>8</sup> *Id.* Dr. Ngan complied with this request and ordered an MRI. *Id.* The MRI indicated that the lesion was consistent with a vascular malformation/pyogenic granuloma.

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<sup>7</sup> The Dunningtons' own timeline documents both the instructions to "RTC" and the fact that they did not contact Dr. Ngan again until December 16, 2011. *CP 82*.

<sup>8</sup> For insurance purposes, he wanted this done before the end of the year. *Id.*

*CP 408.* Dr. Ngan discussed the MRI findings with Mr. Dunnington when he came into the clinic on December 27, 2011. *Id.* This date is 87 days after Mr. Dunnington was supposed to return for follow-up care. *CP 407-08.*

Mr. Dunnington told Dr. Ngan that the lesion had scabbed over for a “few weeks” but re-opened and started bleeding. *CP 408.* It continued to be painful. *Id.* Dr. Ngan observed that the lesion was notable for three islands of pyogenic granuloma that all appeared enlarged from the previous visit. *Id.* Dr. Ngan’s records document that he recommended “surgical excisional biopsy” at that time. *Id.*

Mr. Dunnington again balked at surgical excision. He responded that he wanted to discuss the issue with his family. *Id.* That was the last time Dr. Ngan saw or heard from Mr. Dunnington. *CP 408; 732.* Instead, Mr. Dunnington went to a different podiatrist, Dr. Ryan Bierman,<sup>9</sup> for another opinion regarding the surgical excision. *CP 415-16.* Like Dr. Ngan, Dr. Bierman diagnosed the lesion as trauma-induced pyogenic granuloma. *CP 416, 605.* Dr. Bierman testified that the physical appearance of the lesion was consistent with benign pyogenic granuloma:

Q. And can you tell me what your assessment is?

A. It's a plantar first metatarsal head pyogenic granuloma.

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<sup>9</sup> Mr. Dunnington also initially sued Dr. Bierman, but non-suited the claim in the fall of 2014.

Q. Can you tell me all the reasons why you thought this was a pyogenic granuloma?

A. Because it was easy to bleed, uniformly hemorrhagic, had a -- like a friable layer, which is a very unstable layer, that made it very easy to bleed. And was recurrently trauma-based.

Q. Recurrently what?

A. Trauma-based. There was the initial trauma and then the second trauma.

Q. Yeah. Anything else that you can recall as to why you thought there was a granuloma?

A. It looked very similar to many other granulomas I had seen.

*CP 277 (Deposition of Dr. Bierman at 58:19-59:9).*

Like Dr. Ngan, Dr. Bierman discussed all options, including surgical excision and biopsy with Mr. Dunnington. *CP 86-87; 416.* Mr. Dunnington again chose conservative treatment, including debridement and cauterization. *Id.* Dr. Bierman also instructed Mr. Dunnington to return in two weeks. *Id.* He saw Dr. Bierman on January 12, 2012 and January 30, 2012. *CP 86-87.* On January 30, 2012, Mr. Dunnington decided to consult a dermatologist at Virginia Mason. *CP 87.* Dr. Arlo Miller did a punch biopsy on January 31, 2012 which resulted in a positive finding of melanoma. *CP 87-88.* He underwent surgical excision of the lesion on February 16, 2012. *CP 89.*

Mr. Dunnington's decision not to do the excision and biopsy in September, not to return to the clinic in early October, and not to do the excision and biopsy on December 27, 2011 all delayed diagnosis of the lesion as cancerous. *CP 733.*

Upon diagnosis, Mr. Dunnington's cancer was classified as stage IIIC. *CP 159*. Within a few short months, the melanoma reappeared. *CP 92-93*. He received treatment at the Seattle Cancer Alliance and MD Anderson Cancer Center in Houston, Texas. *CP 94-96*. His disease took a turn for the worse and Mr. Dunnington was on course to succumb from his disease. *CP 152*.

Now a stage IV, Mr. Dunnington became eligible for an experimental clinical trial that was restricted to stage IV patients, or those stage III patients whose tumors could not be resected. *CP 159-60*. As a result of that clinical trial, Mr. Dunnington is cancer free, and his prognosis of living a normal life expectancy is good. *CP 147*.

Alleging failure to timely diagnose and treat his cancerous foot lesions, the Dunningtons filed this medical negligence suit.

**C. The parties dispute both the contention that Dr. Ngan breached the standard of care and the conclusion that an earlier diagnosis would have resulted in a different outcome.**

Petitioners' Brief fails to provide the fair statement of the case contemplated by RAP 10.3(a)(5). For instance, while Mr. Dunnington argues that Dr. Ngan breached the standard of care, he fails to inform the Court that the doctor who knows the most about his cancer, Dr. John

Thompson,<sup>10</sup> *refused* to criticize Dr. Ngan's care. *CP 158* (Thompson Deposition at 56:14-22).

Petitioners' Brief also fails to discuss the defense experts who support Dr. Ngan's care. One of the best cancer doctors in the nation, Dr. Mark Garnick of Harvard Medical School, testified that, given the history the patient provided, all the doctors involved met the standard of care. *CP 270*. Dr. Garnick's testimony established further that melanoma lesions on the bottom of the foot are relatively rare, less than 2 or 3 percent of the total number of melanomas. *Id.* Finally, Dr. Garnick testified that Dr. Ngan did the appropriate work-up and analysis. *CP 274-75*.

Similarly, Dr. John Schuberth, a board certified foot surgeon, agreed that Dr. Ngan met the standard of care. *CP 278*. While the Dunningtons frequently rely on a picture of the foot<sup>11</sup> taken in December to establish the standard of care and/or the existence of cancer, Dr. Schuberth identified the extreme difficulty of eliminating hindsight bias in cancer cases. *CP 279*. Dr. Schuberth noted that it is not fair to simply show a picture and ask the question "Does this look suspicious?"

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<sup>10</sup> Dr. Thompson is the medical director of Seattle Cancer Care Alliance and a national expert on the issues arising from this case. *See, CP 124-142*.

<sup>11</sup> *See* Petitioners' Brief at 3.

*Id.* Instead, the physician's conclusions must be judged in the context of the history and the clinical picture. *Id.*

The Dunningtons fail to tell this Court that there is substantial dispute about whether Mr. Dunnington actually had a 40 percent chance of a better recovery. This figure came from Dr. Thompson's testimony. *CP 122.* However, Dr. Thompson also testified that when Mr. Dunnington first saw Dr. Ngan, he had stage IIIB, ulcerated melanoma, with a transit lesion. *CP 121.*

Dr. Mark Garnick explained the significance of these findings. He testified that by Mr. Dunnington's first visit with Dr. Ngan on September 1, 2011, the disease had already metastasized at the microscopic level:

A. Okay. So the concept that metastases occurs quote-unquote late in the quest of a disease is what I was taught in medical school, and every piece of information that we have now suggests that the metastatic process of cancers that have the genetic capability to metastasize do so well before the primary lesion is ever diagnosable. There is not one piece of evidence that we have to suggest that a metastasis to go through all of its iterations and all of its molecular steps to become a metastatic focus can do so in a short period of time from September until December. So the metastatic process that occurs in patients with microscopic metastatic disease *occurs well before the primary is even diagnosable.*

CP 273 (Deposition of Dr. Garnick at 60:22-61:11)(emphasis added). He concluded that Mr. Dunnington had metastatic cancer when he first saw Dr. Ngan on September 1, 2011. CP 272.

A second defense oncologist, Dr. Dennis Willerford, agreed, noting that the 40 percent survival rate did not take into account the fact that Mr. Dunnington's lesion was ulcerated when he first presented to Dr. Ngan. CP 282. For those individuals who present with ulcerated lesions, the survival statistics are "approximately 25% worse than for patients with non-ulcerated melanomas." *Id.* Looking at the photograph contained in the Dunningtons' brief, Dr. Willerford concluded that it showed a primary tumor and one or two satellite lesions, which were undoubtedly present at his initial presentation on September 1, 2011.<sup>12</sup> CP 283. That "information demonstrates that Mr. Dunnington's melanoma had a propensity to spread via lymphatic channels in the foot, and that this process *was already well established at the time of his initial presentation* in September 2011." CP 283 (at lines 22-25).

**D. Procedural history related to contributory negligence defense.**

On December 13, 2013 and January 24, 2014, counsel for the Dunningtons deposed Dr. Ngan and asked whether Dr. Ngan had included

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<sup>12</sup> In fact, Dr. Ngan's records document a satellite lesion on this first visit. CP 406.

melanoma in his differential diagnosis on December 27, 2011. *CP 732-33*. Dr. Ngan responded that he had not included it. *CP 733*.

Counsel did not ask Dr. Ngan what his recommendation would have been had Mr. Dunnington returned to the clinic as instructed. *Id.* Had he been asked, Dr. Ngan would have responded that he would have explored the other options, including surgery that he discussed with Mr. Dunnington in December. *Id.* This would have resulted in early surgical excision of the lesion, a biopsy, and a much earlier diagnosis. *Id.*

The Dunningtons sought summary judgment on the issue of contributory negligence. *CP 432-443*. The trial court granted the Dunningtons' motion and struck Dr. Ngan's affirmative defense. *CP 798*.

Subsequently, the parties agreed to attempt final resolution of both the lost chance causation instruction and comparative negligence issues before incurring the expense of trial. The parties joined in the motion to the trial court to certify these issues, the motion for discretionary review, and the motion for direct review.

## V. ARGUMENT SUMMARY

### A. Arguments for reversal of summary judgment on comparative negligence.

In an era of “shared decision making”<sup>13</sup> it is more important than ever for courts to recognize that the physician/patient relationship is a two-way street. A physician has a duty to exercise “that degree of care, skill, and learning expected of a reasonably prudent health care provider<sup>14</sup>” in the care of his patient. When his breach of that duty proximately causes a patient’s injury,<sup>15</sup> he may appropriately be held responsible for the patient’s injury.

A patient, in turn, is charged with a duty to exercise ordinary<sup>16</sup> care for his own well-being. He will be found to be negligent if he fails to act as a reasonably careful person would have acted under the same or similar circumstances.<sup>17</sup>

Mr. Dunnington’s failure to return on or about October 1, 2011, deprived Dr. Ngan of the opportunity to evaluate the lesion’s response to conservative treatment and to move forward to surgical excision and biopsy, a course that would have rapidly led to discovery of the

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<sup>13</sup> RCW §7.70.060.

<sup>14</sup> RCW § 7.70.040(1).

<sup>15</sup> RCW § 7.70.040(2).

<sup>16</sup> 6 WASHINGTON SUPREME COURT COMMITTEE ON JURY INSTRUCTIONS, WASHINGTON PRACTICE, WPI 10.01 (6th ed. 2012). *See also, id.* at WPI 11.01.

<sup>17</sup> *Id.* at WPI 10.01.

melanoma. *CP 733*. Where the patient delays diagnosis by dropping out of care, he has breached his duty to exercise reasonable care for his own healthcare. Here, Mr. Dunnington removed himself from Dr. Ngan's care for a period of time that represents *more than half* of the five and one-half months<sup>18</sup> he now alleges caused him to lose a chance of a better outcome. Mr. Dunnington cannot have it both ways. He cannot on one hand, assert that the delay caused him to lose his chance of avoiding a recurrence of his cancer and then, on the other hand, argue that his own role in the delay is irrelevant. The trial court's decision ignores Mr. Dunnington's role in this delay. It imposes on Dr. Ngan liability not only for his own decision making but also his patient's own personal choices, which clearly played a major role in contributing to the delay. Equity demands that the jury be allowed to consider this fact in determining who bears responsibility for Mr. Dunnington's outcome. Dr. Ngan therefore asks this Court to reverse the trial court's order granting partial summary judgment and remand this case with instructions to let the jury determine the relative fault of Dr. Ngan and Mr. Dunnington.

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<sup>18</sup> Mr. Dunnington was asked to return in two weeks, or about October 1, 2011. *CP 84*. He actually returned 87 days later, on December 27, 2011. *Id.*

**B. Arguments for the inapplicability of WPI 15.02 to lost chance claims.**

The Dunningtons request that this Court adopt the substantial factor test. In doing so, they ignore the significance of their request to the doctrine of proximate causation. Proximate cause has two elements: cause-in-fact and legal causation. *Hartley v. State*, 103 Wn.2d 768, 777, 698 P.2d 77 (1985). Our courts recognize:

The doctrine of proximate cause in Washington entails the two elements of cause in fact and legal causation. Cause in fact refers to the "but for" consequences of an act; it is the physical connection between an act and an injury. Cause in fact is generally a question for the jury, but it may become a question of law for the court when the facts are undisputed and the inferences therefrom are plain and incapable of reasonable doubt or difference of opinion.

The legal causation prong of proximate cause involves policy considerations of how far the consequences of a defendant's acts should extend. It concerns whether liability should attach as a matter of law given the existence of cause in fact.

*Christen v. Lee*, 113 Wn.2d 479, 507-08, 780 P.2d 1307 (1989) (citations omitted). The request to jettison the but for test is therefore essentially a request to eviscerate traditional tort law by removing the plaintiff's burden of proving cause-in-fact.

Adoption of WPI 15.02 for medical negligence cases involving lost chance is neither necessary nor desirable. *Herskovits v. Group Health Cooperative*, 99 Wn.2d 609, 619-636, 664 P.2d 474 (1983) and *Mohr v.*

*Grantham*, 172 Wn.2d 844, 262 P.3d 490 (2011), which adopted the *Herskovits* plurality decision, correctly balanced the need for a compensable injury with traditional tort law. By recognizing that the loss is the injury, these decisions eliminate the need to destroy existing tort law rules regarding causation.

Cause-in-fact is an essential element of a proximate cause as that phrase is used in medical negligence actions brought pursuant to RCW §7.70.040. Drawing inaccurate parallels between intentional tort cases and cases involving true multiple causes, the Dunningtons ignore the role cause-in-fact plays in proximate cause doctrine and the resultant destruction of the doctrine adoption of WPI 15.02. Dr. Ngan therefore asks this Court to affirm the trial court's ruling that the standard proximate cause instruction should be given when this matter proceeds to trial.

## VI. ARGUMENT

**A. By failing to return as instructed, Mr. Dunnington breached his duty to exercise ordinary care for his own health. The trial court therefore erred in striking the affirmative defense of comparative negligence.**

### 1. Standard of review.

“In reviewing a grant of summary judgment, an appellate court engages in the same inquiry as the trial court.” *Degel v. Majestic Mobile Manor*, 129 Wn.2d 43, 48, 914 P.2d 728 (1996) (citing *Wilson v. Steinbach*, 98 Wn.2d 434, 437, 656 P.2d 1030 (1982)). Summary

judgment is properly granted only when the pleadings on file demonstrate that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *CR 56(c); Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998); *Hutchins v. 1001 Fourth Avenue Associates*, 116 Wn.2d 217, 220, 802 P.2d 1360 (1991). When ruling on a motion for summary judgment, the court must view the evidence, and all reasonable inferences from the evidence, in the light most favorable to the nonmoving party. *Van Dinter v. City of Kennewick*, 121 Wn.2d 38, 44, 846 P.2d 522 (1993).

**2. Comparative negligence is generally an issue of fact that must be determined by the jury.**

“Whether there has been negligence or comparative negligence is a jury question unless the facts are such that all reasonable persons must draw the same conclusion from them, in which event the question is one of law for the courts.” *Hough v. Ballard*, 108 Wn. App. 272, 279, 31 P.3d 6 (Div. II 2001).

Washington Pattern Instruction 11.01 defines contributory negligence as “negligence on the part of a person claiming injury or damage that is a proximate cause of the injury or damage claimed.” 6 WASHINGTON PRACTICE, *supra* note 16, at WPI 11.01. RCW § 4.22.005 provides that any contributory fault chargeable to the claimant in an action

based on fault, diminishes proportionately the amount awarded as compensatory damages for an injury attributable to the claimant's fault, but does not bar recovery. *See, id.* at Comment, p. 134. Our courts have recognized that the issues of negligence and contributory negligence are intertwined and usually cannot be separated with "scalpellic precision." *Bordynoski v. Bergner*, 97 Wn.2d 335, 341, 644 P.2d 1173 (1982).

In determining whether a person was contributorily negligent, "[T]he inquiry is whether or not he exercised that reasonable care for his own safety which a reasonable man would have used under the existing facts and circumstances, and, if not, was his conduct a legally contributing cause of his injury." *Rosendahl v. Lesourd Methodist Church*, 68 Wn.2d 180, 182, 412 P.2d 109 (1966).

**3. A jury must determine if Mr. Dunnington's decision to forgo care for 87 days was consistent with his obligation to exercise ordinary care for his own health.**

The general principle that a patient has a duty to follow the instructions of his or her physician is widely recognized by appellate courts. *See e.g., George Washington University v. Waas*, 648 A.2d 178, 183 (D.C. 1994); *Smith v. Hull*, 659 N.E.2d 185, 192 (Ind. Ct. App. 1995) *trans. denied*; *Merrill v. Odiorne*, 113 Me. 424, 425, 94 A. 753 (1915); *Walker v. Maine General Medical Center*, 2002 Me. 46, 792 A.2d 1074

(2002) ; *Zak v. Riffel*, 34 Kan. App. 2d 93, 102, 115 P.3d 165 (Ct. App. 2005) (citing *Cox v. Lesko*, 263 Kan. 805, 819-20, 953 P.2d 1033 (1998)).

Consistent with this rule, Washington law has long imposed on patients the duty to follow his or her physician's instructions and to return for care as instructed. *Brooks v. Herd*, 144 Wash. 173, 177, 257 P. 238 (1927). In *Brooks*, the Court approved an instruction stating that the patient has a duty to follow the advice of the physician. *Id.*

Appellate courts also recognize that a patient who, after receiving treatment, fails to return to see the physician for further treatment as instructed, is contributorily negligent for any harm caused by his or her failure to return to the clinic. Although no published Washington cases address this concept, it is a well-recognized concept in other jurisdictions. *See e.g. Bayless v. Boyer*, 180 S.W.3d 439, 450 (Ky. 2006) (holding that, in an alleged failure to diagnose and timely treat a wrist fracture case, a comparative negligence instruction was warranted where the plaintiff waited 66 days between treatment in the emergency room and his decision to seek follow-up care); *Pietrzyk v. City of Detroit*, 123 Mich. App. 244, 248-49, 333 N.W.2d 236 (Ct. App. 1983) (holding comparative negligence instruction proper where plaintiff was instructed to return for evaluation of a gunshot wound in three weeks but failed to do so.); *Faulk v. Northwest Radiologists, P.C.*, 751 N.E.2d 233, 239 (Ind. Ct. App. 2001), *trans.*

*denied* (holding sufficient evidence exists to support contributory negligence instruction where plaintiff failed to follow otolaryngologist's instruction to return for a series of follow-up visits after cancer treatment.)

Genuine issues of material fact exist as to whether a reasonably careful patient would have returned as instructed and/or accepted Dr. Ngan's December 2011 recommendation that the lesion be excised. As established by Dr. Ngan's declaration, had Mr. Dunnington followed the directions to return, the melanoma would have been discovered much earlier. *CP 733*. Similarly, had he accepted Dr. Ngan's December 2011 recommendation for biopsy, the melanoma would have been discovered at least a month earlier. *Id.* Because defendant presented ample evidence that Mr. Dunnington's failure to follow Dr. Ngan's instructions resulted in a delay in his diagnosis, the trial court erred in removing the issue of contributory negligence from the case.

**B. Adoption of WPI 15.02's substantial factor test eviscerates traditional tort law by removing cause-in-fact from Petitioners' burden of proof. Where the courts have already balanced the right to compensation by designating lost chance as a cognizable injury, this change is neither warranted nor desirable.**

**1. Unlike WPI 15.02, the substantial factor test contained in §431 of Restatement (Second) of Torts requires consideration of but for causation.**

A favorite topic of legal academics and philosophers, a simple, understandable test for causation remains elusive. *See, e.g.*, Richard

Wright, *Causation, Responsibility, Risk, Probability, Naked Statistics and Proof: Pruning the Bramble Bush by Clarifying the Concepts*, 73 IOWA L. REV. 1001 (1988); Erik Knutsen, *Ambiguous Cause-in-Fact and Structured Causation: A Multi-Jurisdictional Approach*, 38 TEX. INT'L L.J. 249 (2003). The struggle has not been limited to the academic sphere. Courts around the country have wrestled with what "cause" should or does mean. *See, e.g., Gerst v. Marshall*, 549 N.W. 810, 816 (Iowa 1996); *Callahan v. Cardinal Glennon Hospital*, 863 S.W.2d 852, 861-62 (Mo. 1993). These courts point out that the Restatement formulation of the "substantial factor" test, properly read, actually incorporates cause-in-fact or but for causation. The Missouri Supreme Court explained:

One reason for the confusion as to when a "but for" test is required is because the Restatement (Second) of Torts uses "substantial factor" in a different way than **Prosser**. Section 430 of the Restatement (Second) requires "legal cause" for liability. Section 431 provides that legal cause is present if the defendant's conduct is a substantial factor in bringing about the harm. Section 432 provides that the conduct is not a substantial factor unless it meets the "but for" test, which is *always* required except for the very narrow exception where there are two independent torts, either of which by itself would have caused the injury.

*Callahan*, 863 S.W.2d at 861 (emphasis added). Professor Richard Wright identified this same disconnect in his 1985 article on causation in torts. *See, Richard Wright, Causation in Tort Law*, 73 CAL. L. REV. 1735, 1781-82 (1985).

This is further established by Section 432 of the Restatement which provides: “the actor’s negligent conduct is not a substantial factor in bringing about harm to another if the harm would have been sustained even if the actor had not been negligent.” Restatement (Second) Torts § 432(1) (1965). Comment (a) further explains that this test refers to cases where the actor’s conduct is the *necessary antecedent* to the harm:

If, without the actor’s negligent conduct, the other would have sustained harm, the same in character and extent as that which he receives, the actor’s conduct, except in the situation dealt with in Subsection (2), is not even its *necessary antecedent*, and so is not a *substantial factor* in bringing it about.

Restatement (Second) Torts §432 cmt. a (emphasis added). The phrase “necessary antecedent,” in turn, refers to but for causation, the *sine qua non* of legal liability:

An actual cause, or cause in fact, exists when the act of the defendant is a *necessary antecedent* of the consequences for which recovery is sought, that is, when the injury would not have resulted "*but for*" the act in question. But a cause in fact, although it is a *sine qua non* of legal liability, does not of itself support an action for negligence.

Considerations of justice and public policy require that a certain degree of proximity exist between the act done or omitted and the harm sustained, before legal liability may be predicated upon the "cause" in question. It is only when this necessary degree of proximity is present that the cause in fact becomes a legal, or proximate, cause.

*Eckerson*, 3 Wn.2d at 482 (first and second emphasis added, third emphasis in original).

*Blasick v Yakima*, 45 Wn.2d 309, 314, 274 P.2d 122 (1954), an early Washington case discussing substantial factor, referred only to the pertinent language in §431<sup>19</sup>. In resolving whether to adopt the “materially contributed” test for causation, the Court noted that this test was “synonymous with the ‘substantial factor’ test proposed by Restatement, Torts, 1159, §431.” *Id. Blasick, supra*, was then cited by the Pattern Jury Committee as rejecting “this approach” apparently referring to the Restatement. The Comment, however, fails to appreciate that the Restatement test for substantial factor is much more complex than the simple formula set forth in WPI 15.02.

*Seward v. Minneapolis Street Railway Company*, 222 Minn. 454, 458, 25 N.W.2d 221 (1946), a case *Blasick* cites with approval, has the more complete analysis of the Restatement’s substantial factor test. This case recognizes that § 431 is just a partial definition of legal cause:

The error in the instruction of the court below was emphasized by its use of the "material element or substantial factor" theory in defining proximate cause, a theory wholly inadequate where issues such as we have here are involved. Proximate cause (called "legal cause" in Restatement, Torts, § 431) is not adequately defined by merely telling a jury that a "material element or substantial factor" in causation is a proximate cause. It was not intended by the American Law Institute to be an adequate or complete definition.

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<sup>19</sup> This is the likely source of the confusion between the Restatement test for substantial factor and the looser formulation adopted by subsequent Washington cases discussed the comment to WPI 15.02.

*Id.* at 457-58. The *Seward* court commented that to give § 431 without the qualifying rules contained in §§ 435-453 was inappropriate, because to do so “leaves the jury afloat without a rudder.” *Id.* at 458. On the other hand, “[t]here are so many qualifying rules to §431 that if they were given or those were given which might apply to the various aspects of a negligence case a jury would be hopelessly confused.” *Id.* at 459.

Reliance on the Restatement as the support for simple substantial factor definitions such as that contained in WPI 15.02, is thus inappropriate. The Restatement, by its terms, only supports substantial factor tests that contain but for or cause-in-fact causation formulas.

**2. WPI 15.02’s application is restricted to cases where but for causation cannot be proved and/or certain intentional torts.**

WPI 15.02 differs from the Restatement in that this instruction eliminates but for causation entirely. This results in the traditional two prong inquiry for proximate cause (cause-in-fact plus legal causation) being reduced to a single, policy driven inquiry as to how far the consequences of a defendant’s acts should extend. *See*, 6 WASHINGTON PRACTICE, *supra* note 16 at WPI 15.01, Comment (citing *Colbert v. Moomba Sports, Inc.*, 163 Wn.2d 43, 176 P.3d 497 (2008) (discussing elements of proximate cause). Because the simple substantial factor test contained in WPI 15.02 jettisons the physical connection requirement

between the act and the injury, its application to medical negligence cases dramatically changes traditional tort causation principles.

WPI 15.02 states:

The term “proximate cause” means a cause that was a substantial factor in bringing about the [injury][event] even if the result would have occurred without it.

6 WASHINGTON PRACTICE, *supra* note 16 at WPI 15.02. This instruction mirrors the language of § 431(a) of the Restatement (Second) of Torts. The Note on Use then states that this instruction is to be used instead of WPI 15.01 “in the narrow class of cases (discussed in the Comment below) for which the ‘but for’ test of causation is inapplicable.” *Id.* at WPI 15.02, p. 198.

While WPI 15.02 cites generally to the Restatement of Torts, as established above, the Restatement did not intend for the substantial tort language of §431(a) to either stand alone or exclude but for causation. The Restatement cannot therefore be used to support use of WPI 15.02. Consequently, except in those “narrow” cases discussed in the comment, WPI 15.02 is inapplicable. As discussed below, lost chance cases do not raise either the policy or complex causation issues which are the distinguishing features of cases where Washington courts apply the simple substantial factor test.

**3. Lost chance cases do not fall within the narrow class of cases where the but for test cannot be applied.**

**a. Lost chance cases do not involve the identical harm or the other unique causation scenarios discussed in *Daugert* and WPI 15.02.**

Citing *Daugert v. Pappas*, 104 Wn.2d 254, 704 P.2d 600 (1985)

the Dunningtons assert that the substantial factor applies because either Dr. Ngan's negligence or the cancer "could have produced the identical harm, even if the harm is properly conceived in terms of the lost chance of avoiding the recurrence of cancer." Brief at 16. They conclude that these multiple causes make it impossible for them to satisfy the but for standard of proximate cause. *Id.* This argument is unsound.

The *Daugert* test provides:

As noted by Dean Prosser, the substantial factor test aids in the disposition of three types of cases. First, the test is used where either one of two causes would have produced the identical harm, thus making it impossible for plaintiff to prove the "but for" test. In such cases, it is quite clear that each cause has played so important a part in producing the result that responsibility should be imposed on it. Second, the test is used where a similar, but not identical, result would have followed without the defendant's act. Third, the test is used where one defendant has made a clearly proven but quite insignificant contribution to the result, as where he throws a lighted match into a forest fire. W. Keeton, D. Dobbs, R. Keeton & D. Owen, *Prosser and Keeton on Torts* § 41 (5th ed. 1984).

*Daugert*, 104 Wn.2d at 262.

The Dunningtons attempt to force their lost chance case into this analytic framework, by arguing:

This means that Dunnington still would have had a 60% chance of the outcome that ultimately occurred. *Either one of these two causes, Ngan's negligence or cancer, could have produced the identical harm, even if the harm is properly conceived in terms of the loss of chance of avoiding the recurrence of cancer.*

Petitioners' Brief at 16 (emphasis added). The Dunningtons' argument fails because it is based on the faulty premise that lost chance cases involve two causes of an identical injury.

First, Dr. Ngan did not *cause* Mr. Dunnington's cancer. He cannot therefore be held responsible for the fact it exists. He can only be held responsible to the extent that his alleged negligence deprived Mr. Dunnington of the opportunity to have a better outcome than he did.

The chances of having a better outcome are reduced to a 60/40 ratio. If, as Dr. Thompson testified, Mr. Dunnington had a 40 percent chance of avoiding the recurrence of cancer on September 1, 2011, the flip side of that conclusion is that he had a 60 percent chance that it would recur and that the outcome would have been the same.

Focusing only on the 40 percent aspect of the ratio, the Dunningtons confuse how cancer and the alleged negligence relate to the 40 percent chance of a better outcome. Their argument fails because

Mr. Dunnington's cancer is responsible for him having a 60 percent chance of recurrence, but it plays *no role* in denying Mr. Dunnington the 40 percent chance of a better recovery. Analyzed correctly, each "cause" relates to different portions of the 60/40 ratio.

This conclusion is consistent with the analysis performed by the court in *Daugert*. In *Daugert*, the court concluded that two causes, the attorney's negligence and the weakness of the underlying claim would *not* necessarily have produced the "identical" harm. Here, Dr. Ngan's alleged negligence, if it exists, caused only the reduction in the lost chance of a better outcome. It is nonsensical to say that the cancer "caused" Mr. Dunnington to lose the 40 per cent chance of a better outcome. Mr. Dunnington's preexisting condition, the cancer, caused the 60<sup>20</sup> percent risk of recurrence. It bears no causal relationship to the chances of better recovery. The cancer only acts on the flip side of the ratio, the 60 percent.

Accordingly, the lost chance of a better outcome here can only be attributed to conduct that "caused" the delay in diagnosis and treatment. The two actors whose conduct arguably "caused" the delay are Dr. Ngan

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<sup>20</sup> Ironically, the failure to diagnose the cancer may actually have improved Mr. Dunnington's prognosis. If he had presented with stage III cancer in September 2011, he would not have been eligible for the clinical trials which ultimately led to him being cancer free. *CP 147; 152; 159-60.*

(by not diagnosing melanoma) and Mr. Dunnington (by failing to follow the instructions to return and waiting 87 days to come back to his physician.)

This conclusion demonstrates a further issue with the Dunningtons' request to adopt WPI 15.02. Following their reasoning that the substantial factor test is appropriate where two actors cause the identical harm, necessarily leads to the conclusion that the substantial factor test must be applied to any claim of comparative negligence. Here, that means that if the Court reverses on comparative negligence and authorizes the substantial factor test, the jury should also be allowed to consider whether Mr. Dunnington's own negligence was a substantial factor in the delayed diagnosis. If Mr. Dunnington's failure to return to care was unreasonable, than he too caused the delay in diagnosis and contributed to his loss of the 40 percent chance of a better outcome. His comparative negligence and Dr. Ngan's negligence would have then caused the identical harm and would have to be evaluated using the same test for causation.

Dr. Ngan is fairly certain that plaintiffs generally would object to a reduction in the defendant's burden of proof on comparative negligence. But *if* the rationale for the change is that two causes work on the *identical* harm, the logical extension of the

rule the Dunningtons advocate requires that the same test for causation be applied to each party that causes the identical harm.

This conclusion illustrates the folly in the Dunningtons' position and their request to fundamentally change tort law. Rather than changing burdens of proof on causation, or confusing the jury with two different tests for the identical harm, the better option is to continue to apply traditional cause-in-fact analysis equitably so that the jury evaluates the conduct of all actors using the same test for causation.

- b. The substantial factor test frequently is applied to claims involving bad actors in order to enforce strong legislative prohibition on intentional misconduct. Simple negligence claims do not raise comparable policy considerations.**

Citing *Wilmot v. Kaiser Aluminum and Chemical Corporation*, 118 Wn.2d 46, 821 P.2d 18 (1991), the Dunningtons argue that lost chance cases fall within the narrow class of case where but for causation is not applied because of strong public policies. Citing the need to hold defendant's "accountable" and "difficulties of proof result from the defendant's conduct" as the public policies they seek to jettison but for causation in favor of WPI 15.02. Petitioners' Brief at 18-19.

This reasoning is unsound. Medical negligence cases do not implicate legislatively mandated prohibitions on intentional misconduct such as those described in *Wilmot, supra* and its progeny. In *Wilmot*, the

Court held that in worker compensation discharge cases the substantial factor test was preferable in order to enforce RCW 51.48.025's prohibition on retaliatory discharge. *Wilmot*, 118 Wn.2d at 72.

The Supreme Court applied the substantial factor test to retaliatory discharges based on age discrimination in *Allison v. Housing Authority of Seattle*, 118 Wn.2d 79, 85-86, 821 P.2d 34 (1991). The Court observed: RCW 49.60.210 "condemns retaliation even more forcefully" than the statute involved in *Wilmot, supra. Id.* at 96.

In *MacKay v. Acorn Custom Cabinetry*, 127 Wn.2d 302, 898 P.2d 284 (1995), the Court again commented on the need to protect the strong public policy against discrimination:

Washington's disdain for discrimination would be reduced to mere rhetoric if this court were to require proof that one of the attributes enumerated in RCW 49.60.180(2) was a 'determining factor' in the employer's adverse employment decision. This court will not render its own words, and those of the Legislature, hollow.

*Id.* at 310.

Negligence cases involve no comparable legislatively mandated public policies. They are simple negligence claims. While the Dunningtons argue that there is a need to hold the doctor "accountable" and that the right to compensation weighs in favor of adopting the substantial factor test, they do not explain how lost chance cases differ in

kind from other negligence cases. All negligence cases implicate the need for accountability and compensation to the injured party. Balanced against that in every negligence case, however, is defendant's right to only have to pay for the harm he or she actually caused. Following the Dunningtons' logic results in removal of cause-in-fact from *all* negligence cases.

The Dunningtons also argue that application of the substantial factor test is appropriate because, like *Wilmot*, "difficulties of proof result from the defendant's conduct in lost chance cases, creating the potential for the defendant to avoid responsibility for that conduct, thereby subverting the compensatory and deterrent functions of tort law." Petitioner's Brief at 19. This argument misconstrues the proof problems presented in *Wilmot*. *Wilmot* is based on the fact that the employee must prove the wrongful conduct "without the benefit of the employer's own knowledge of the reason for the discharge, and generally without the access to proof which the employer has." *Wilmot*, 118 Wn.2d at 47.

Unlike employment cases, the Dunningtons are not required to prove motive in order to prevail on a medical negligence claim. The Dunningtons need only prove that the conduct fell below the applicable standard of care, not why the doctor did or did not do something. *RCW §7.70.040*.

The Dunningtons incorrectly argue that, like the employment cases, lost chance cases create difficulties of proof based on the defendant's conduct. Petitioners' Brief at 19. The difficulties of proof associated with lost chance cases are not related to the doctor's conduct, but rather directly attributable to the uncertainties associated with medicine and the treatment of cancer in particular.<sup>21</sup> Because medicine is an inexact science, both sides are forced to rely on clinical studies and statistics to prove their case. For instance, Dr. Thompson, both in advising Mr. Dunnington and in offering statistical evidence in this case, relied on the 2009 AJCC Melanoma Staging and Classification, *Journal of Clinical Oncology*. CP 121. Had Dr. Ngan diagnosed the cancer in September 2011, he would have referred Mr. Dunnington to an oncologist such as Dr. Thompson who would have used the same study and given the same advice at that time.

The Dunningtons' argument that the doctor's conduct deprived the victim from knowledge of what would have happened had there been no negligence misconstrues the type of control over proof discussed in the

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<sup>21</sup> Reliance on *Herskovits* to support this proposition is misplaced. Justice Pearson's statement was made in the context of discussing the equities of the all or nothing approach. "Fourth, the all or nothing approach gives certain defendants the benefit of an uncertainty which, were it not for their tortious conduct, would not exist." *Herskovits*, 99 Wn.2d at 634. This sentence refers to allowing defendants to escape responsibility for their negligence by denying a cause of action for the loss of chance injury and is an argument in favor of recognizing the doctrine, not an argument justifying modification of the standard for causation.

employment cases. A doctor has no comparable control over the actual injury (here cancer) or special knowledge of why the cancer returned.

In addition, this argument fails to differentiate lost chance cases from other negligence cases. At some level, a negligent act always changes what would have occurred but for the negligence. This argument cannot therefore support the Dunningtons' requested change in traditional tort law.

**4. Further reduction in the plaintiff's burden of proof is not desirable or necessary because in recognizing lost chance this Court has wisely elected to focus on redefining the harm instead of changing traditional causation analysis.**

The Washington doctrine of lost chance originates with *Herskovits*, *supra*. Because no opinion obtained the required five signatures, there has been confusion regarding the precedential value of the two opinions recognizing a right to recover for lost chance. Justice Dore's opinion, signed by only one other justice, advocated the position that the Dunningtons advance here--that lost chance cases be allowed to go forward whenever the physician's conduct was a substantial factor in diminishing the patient's chance of survival. *Herskovits*, 99 Wn.2d at 610-19.

The second opinion, by Justice Pearson, was influenced heavily by an article by Joseph King, *Causation, Valuation, and Chance in Personal*

*Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981). Professor King advocated looking at the issue of what caused a loss separately from the question of what “the nature and extent of the loss are.” *Herskovits*, 99 Wn.2d at 633. Justice Pearson adopted this approach, noting that he was persuaded to this conclusion by King’s thoughtful discussion of the issues that the best course was to look at lost chance as the actual injury. *Id.* at 632.

Justice Brachtenbach wrote a strong dissent, arguing that “[m]alpractice suits represent a class of controversies where extreme caution should be exercised in relaxing causation requirements.” *Herskovits*, 99 Wn.2d at 637-38. He believed that a physician serves a vital function in our society, but the “profession affords him only an inexact and often experimental science by which to discharge his duty.” *Id.* at 638.

Justice Brachtenbach noted that the temptation to place blame on a physician who failed is great, and concluded, “Thus policy considerations do not, on balance, weigh in favor of abandoning the well established requirements of proximate cause.” *Id.*

Justice Brachtenbach went to comment on the application of the substantial factor test, noting that it is applied “only in situations where there are two causes, either of which could have caused the event alone,

and it cannot be determined which was the actual cause.” *Herskovits*, 99 Wn.2d at 638. Discussing the classic example of two people who separately start fires which burn a third person’s house, Justice Brachtenbach observed that the substantial factor test is used to prevent exoneration of both culpable individuals. Justice Brachtenbach opined that the “defendant’s act cannot be a substantial factor when the event would have occurred without it.” *Id.* (citing WILLIAM PROSSER, TORTS § 41, at 244 (4th ed. 1971)).

*Mohr v. Grantham*, *supra*, officially adopted Justice Pearson’s plurality decision in *Herskovits*, characterized lost chance as a legally recognizable injury, and extended the lost chance doctrine to those cases where the lost chance was for a better recovery or outcome. In recognizing a cause of action for lost chance of a better outcome, the Court ruled that:

[a] plaintiff making such a claim must prove duty, breach, and that there was an injury in the form of a loss of a chance caused by the breach of duty. To prove causation, a plaintiff would then rely on established tort causation doctrines permitted by law and the specific evidence of the case.

*Mohr*, 172 Wn.2d at 862.

While some authors assert that *Mohr* created additional confusion,<sup>22</sup> its adoption of the injury approach to lost chance cases effectively answers many of the horrors<sup>23</sup> the Dunningtons argue arise from but for causation.

**5. Traditional causation rules do not create a risk of a de facto directed verdict nor do they confuse the jury.**

The Dunningtons argue that the traditional but for causation test is “tantamount to directing a verdict in favor of the defendant,” that the but for standard requires the jury to make a “categorical choice” as to whether the injury would have occurred in the absence of negligence and that there is a “conceptual disconnect” that makes it difficult for the jury to follow and understand the instructions. Petitioners’ Brief at 14-15.

The Dunningtons cite no authority for the proposition that the but for standard is “tantamount to directing a verdict in favor of the defendant.” *Id* at 19. In fact, it does not. While these authors have not tracked all the cases which resulted in a plaintiffs’ verdict, plaintiffs have certainly prevailed in these cases. *See, e.g., Estate of Dormaier v. Columbia Basin Anesthesia, PLLC*, 177 Wn. App. 828, 313 P.3d 431 (Div. III 2013) (jury

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<sup>22</sup> Matthew Wurdeman, Comment, *Loss-of-Chance Doctrine in Washington: From Herskovits to Mohr and the Need for Clarification*, 89 WASH. L. REV. 603 (2014).

<sup>23</sup> *See* Part VI.B.5, *infra*.

verdict in excess of 1.3 million); *Matsuyama v. Birnbaum*, 452 Mass 1, 890 N.E.2d 819 (2008) (jury verdict in favor of plaintiffs on lost chance).

Nor is the proposition logically supportable. The *Herskovits/Mohr* adoption of lost chance as the injury focuses the jury on two different inquiries, what is the injury and did the defendant more likely than not cause it? This focus allows counsel to argue that Mr. Dunnington had something of value, a 40 percent chance of a better outcome and that Dr. Ngan's alleged negligence, "in a direct sequence" produced the loss of that 40 percent chance. Simply put, but for Dr. Ngan's negligence, Mr. Dunnington would have had the 40 percent chance of avoiding the recurrence of cancer and the loss of his leg.

The evidentiary support for this argument comes from Dr. Thompson, who clearly opines, based on a reasonable degree of medical probability, that Mr. Dunnington would have had a better outcome had his cancer been discovered in September 2011. *CP 122*.

Contrary to the Dunningtons' unsupported arguments, the jury is not faced with any different challenges in evaluating a less than 50 percent loss of chance than they are in any other case. Jurors face "categorical choices" in every case, just as they must apply the burden of proof in every case. Segregating injury from causation, as required by

*Herskovits/Mohr*, avoids the adverse outcomes the Dunningtons predict will occur.

**6. The “added” protections to the defendant are illusory and cannot compensate for the dramatic reduction in the plaintiffs’ burden of proof.**

The Dunningtons’ argue that this Court should adopt the test to “place the balance in equipoise.” Petitioners’ Brief at 19. This argument rests on the faulty conclusion that removal of the but for test will not harm defendants because the defendant “remains protected by the requirements to prove that his/her conduct was negligent, and that his/her conduct played a substantial and proximate role in the plaintiff’s injury, as well as the proportional reduction of damages that occur in loss of chance cases.” Petitioners’ Brief at 15.

These alleged protections are illusory. Negligence is a separate prong of the plaintiff’s burden of proof. *RCW §7.70.040*. The fact plaintiffs must prove negligence does not constitute a “protection” which compensates for the reduction in the plaintiffs’ burden of proof. Defendants are *entitled* to a defense verdict if a plaintiff fails to prove *either* of these elements. *See, e.g., Estate of Stalkup v. Vancouver Clinic, Inc., PS, 145 Wn. App. 572, 589-90, 187 P.3d 291 (Div. II 2008); RCW § 7.70.040*. The fact that the Dunningtons have to prove negligence

thus offers no “protection” to compensate for the removal of the plaintiff’s burden of proof to prove cause-in-fact.

Nor does the term “proximate” add protection. WPI 15.02 *defines* proximate cause as a cause that was a substantial factor. The term “proximate” is not additive, but under WPI 15.02 is the same as “substantial cause.” By removing the but for or cause-in-fact test, the requirement of proximity is also removed. The jury is no longer required to examine the sequence of events nor the issue of whether the injury would have happened without the defendant’s negligence.

Finally, the proportional reduction in damages does not “protect” the defendant on issues of causation, but rather reflects the true value of the Dunningtons’ loss. *Herskovits*, 99 Wn.2d at 635.

**7. By recognizing lost chance as the injury, this Court crafted a rule of law consistent with RCW § 7.70.040, ensured that all medical negligence plaintiffs have equal access to the courts and correctly balanced competing public policies.**

**a. Preserving the traditional but for causation test is most consistent with RCW § 7.70.040.**

RCW § 7.70.040 provides:

The following shall be *necessary* elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to

which he or she belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

RCW § 7.70.040 (emphasis added). While the statute does not define “proximate cause” or “injury,”<sup>24</sup> as argued above, WPI 15.02’s substantial factor test eliminates cause-in-fact, an essential element of proximate cause. The traditional test for proximate cause, consisting of both cause and fact and legal cause, has been applied consistently to medical malpractice actions. *See, e.g., Herskovits, supra; Mohr, supra; Harbeson v. Parke-Davis, Inc.*, 98 Wn.2d 460,475, 656 P.2d 483 (1983).

The Dunningtons’ proposal ignores that cause-in-fact has always been essential to finding liability. *Eckerson*, 3 Wn.2d at 482. Removing an element that the Legislature has labeled as “necessary” is inconsistent with the statute’s mandate.

This is in fact the conclusion of *Rash v. Providence Health & Services*, 183 Wn. App. 612, 635-36, 334 P.3d 1154 (Div. III 2014), *review denied*, 182 Wn.2d 1028 (2015). Noting that proximate cause is one essential element required by the statute, the court observed that

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<sup>24</sup> *Mohr*, 172 Wn.2d at 856.

“[n]othing in the statute suggests that a substantial factor standard of causation should be employed in a medical malpractice suit.” *Id.* at 636.

**b. Adoption of WPI 15.02 for lost chance of better recovery is neither necessary nor consistent with the need for clear rules that can be equitably applied to all individuals in a rational manner.**

Glaringly absent from the Dunningtons’ brief is a cogent discussion of when and how the new standard of causation would be applied to the multiple scenarios which arise in complex medical malpractice actions. The present case is an outlier in that, at this juncture, it involves only a single defendant and a single plaintiff with one distinct claim. This Court has enough experience with medical malpractice cases to take judicial notice that they more frequently involve multiple defendants, multiple theories, and multiple affirmative defenses. That very complexity weighs against any deviation from the statute or the traditional concepts of causation that arises from litigating hundreds of these matters.

Contrary to the Dunningtons’ arguments, adopting the substantial factor test contained in WPI 15.02 solves no existing problems. Instead, its adoption creates a level of confusion and complexity, especially in cases where the jury must analyze causation and allot fault amongst multiple parties. Which medical malpractice cases would receive the

benefit of eliminating the burden of proving cause-in-fact and, which would not? Does this reduced standard apply only to lost chance of a better outcome or also lost chance of survival? If plaintiffs want to bring both a lost chance claim and a claim for the entire injury, will the jury be given both WPI 15.01 and WPI 15.02? How would the rule apply when the jury has to decide both negligence and comparative negligence? Will the jury be instructed on both traditional proximate cause for the defendant's affirmative defense and substantial factor for the plaintiff's burden of proof? What policy considerations justify that distinction?

The rule urged by the Dunningtons has no logical or legal limits and is inconsistent with traditional tort law and the plaintiffs' burden of proof under RCW §7.70.040. It has the potential to devolve into a confusing mix of competing definitions of causation and fault. The far better rule is to maintain the clear distinction between lost chance as theory of injury. Adoption of a radical change in tort law, by eliminating cause-in-fact solves no real deficiency. There is thus no reason to deviate from traditional tort concepts.

## **VII. CONCLUSION**

For over thirty years, the courts in this state have understood that a patient who proves that, more likely than not, medical negligence resulted in a substantial reduction in their chance of a better outcome can recover

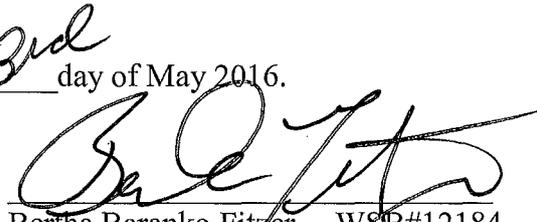
for that loss. This Court has wisely refused to abandon traditional tort principles on two prior occasions and correctly elected to recognize lost chance as a theory of injury, not as a theory of causation. In redefining the injury as the lost chance of survival or a more favorable medical outcome, this Court appropriately struck the balance between recognizing that a lost chance of a better outcome was not valueless, while at the same time acknowledging that the defendant should only be responsible for the injury he caused.

Should this Court reject precedent and adopt the Dunningtons' arguments, plaintiffs in lost chance cases will have a different, and lower, burden of proof than other medical malpractice plaintiffs. This results in the elimination of an essential element of the plaintiff's burden of proof, in contravention of RCW § 7.70.040. For these reasons, and because applying a substantial factor test only to lost chance cases will result in confusion and inequity, Dr. Ngan asks this Court to reject the Dunningtons' request to eliminate cause-in-fact in favor of a substantial factor test. The trial court's ruling on this issue should be affirmed.

Conversely, Dr. Ngan asks this Court to reverse the entry of summary judgment on comparative fault. Mr. Dunnington had a duty to share in his care and follow his physician's directions. Instead, he voluntarily chose to ignore Dr. Ngan's instructions and recommendations.

Drawing all inferences in favor of Dr. Ngan, Dr. Ngan presented sufficient evidence to require that this important issue be decided by the jury, not the court. Dr. Ngan respectfully requests that this ruling be reversed and the case remanded for trial.

Respectfully submitted this 3rd day of May 2016.



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## CERTIFICATE OF SERVICE

The undersigned does hereby declare the same under oath and penalty of perjury of the laws of the State of Washington:

On May 3, 2016, I served the document to which this is annexed by email and First Class Mail, postage prepaid, as follows:

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Signed on May 3, 2016 at Tacoma, Washington



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