

Supreme Court No. 91374-9

SUPREME COURT
OF THE STATE OF WASHINGTON

DAVID DUNNINGTON and JANET WILSON,
Appellant and Cross-Respondent

v.

VIRGINIA MASON MEDICAL CENTER,
Respondent and Cross-Appellant.

REPLY BRIEF OF RESPONDENT/CROSS APPELLANT

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I. INTRODUCTION

Plaintiffs start their brief by restating the issues. That restatement has two flaws. First, it confuses the burden of proof at trial with the standards for defeating summary judgment. At this stage, the Dunningtons have the burden under CR 56, as the moving party, to demonstrate that there are no genuine issues as to any material fact. *Babcock v. Mason County Fire Dist.*, 144 Wn.2d 774, 784, 30 P.3d 774 (2001); *Lamon v. McDonnell Douglas Corp.*, 91 Wn.2d 345, 349, 588 P.2d 1346 (1979).

Second, plaintiffs improperly restrict their review of evidence to that produced by VMMC. The correct inquiry is whether, considering *all* of the evidence, not just that provided by one party, genuine issues exist as to any material fact. *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998) (“An appellate court would not be properly accomplishing its charge if the appellate court did not examine *all* the evidence presented to the trial court, including evidence that had been redacted.”) (emphasis in original).

The initial incorrect statement of issues carries forward to the remainder of the Dunningtons’ brief. An accurate understanding of the evidence before the trial court establishes that genuine issues of material

fact preclude summary judgment on all elements of the comparative negligence defense.

II. ARGUMENT

A. Under CR 56, VMMC is entitled to all reasonable inferences from all available evidence on the issue of contributory negligence and causation.

Tellingly absent from the Dunningtons' response brief is any significant identification, analysis, and/or application of the correct inquiry on review of summary judgments. 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. *See, e.g., Magula v. Benton Franklin Title Co., Inc.*, 131 Wn.2d 171, 930 P.2d 307 (1997); *Anica v. Wal-Mart Stores, Inc.*, 120 Wn. App. 481, 84 P.3d 1231 (Div. I 2004); *Roger Crane & Associates v. Felice*, 74 Wn. App. 769, 875 P.2d 705 (Div. II 1994). Any doubts as to the existence of a genuine issue of material fact should be resolved against the moving party. *See, e.g., Ely v. Hall's Motor Transit Co.*, 590 F.2d 62, 66 (3d Cir. 1978). "The trial court is not permitted to weigh the evidence in ruling on summary judgment." *Fleming v. Smith*, 64 Wn.2d 181, 185, 390 P.2d 990 (1964). If the testimony and counter-testimony submitted by the parties on a motion for summary judgment conflict on material facts, the court is essentially presented with an issue of credibility, and summary judgment

should be denied. *See, e.g., Meadows v. Grant's Auto Brokers, Inc.*, 71 Wn.2d 874, 881-82, 431 P.2d 216 (1967); *Riley v. Andres*, 107 Wn. App. 391, 398, 27 P.3d 618 (Div. II 2001).

The response brief skips over these rules. Starting with their restatement of the issues, the response attempts to shift the burden of proof to VMMC. That error is then compounded by the choice to ignore the totality of the record before the trial court, most specifically, that evidence originating from the causation opinions of plaintiffs' own experts. Review of the entire record demonstrates that the question of comparative negligence must be determined by a jury.

B. The Dunningtons' own experts establish that the time period encompassing Mr. Dunnington's failure to return was proximately related to the ultimate lost chance. Genuine issues of material fact thus exist on the question of causation.

In a particularly egregious misstatement of the record, Dunningtons' brief states: "Ngan did not submit any evidence that the period of time necessary to obtain a second opinion affected Dunnington's chance of a better outcome." *Reply/Response Brief at 20*. To the contrary, VMMC submitted the declaration¹ of plaintiffs' expert, Dr. Dean Felsher, and summarized² his deposition testimony. In his deposition, Dr. Felsher

¹ This declaration appears as Appendix A. *CP 740-46*.

² As noted in the declaration, the actual transcript was not available at the time the responsive pleadings were being submitted. *CP 736-37*.

specifically addressed the issue of the one-month delay, contending that the one-month delay between Mr. Dunnington's first visit to former co-defendant, Dr. Ryan Bierman, and the date of the biopsy reduced Mr. Dunnington's chances of survival. *CP 736.*

The declaration that Dr. Felsher produced at his deposition sets out in detail the timing of events. *CP 745, Appendix A.* Dr. Felsher asserted that during the interval between Dr. Ngan's first and second visits and the biopsy, the tumor acquired an invasive character, spread locally into deep tissues, and became distantly metastatic. *Id.* Dr. Felsher identified this four-month delay as directly responsible for the advancement of the cancer.

Of those four months, Mr. Dunnington's failure to return consumed two and a half months, or 62%³ of the total delay. During this time, Mr. Dunnington precluded Dr. Ngan from acting on his behalf by dropping all contact with him and choosing not to return for follow-up care.

Two other experts hired by plaintiffs affirmed that this delay caused a poorer outcome. Like Dr. Felsher, Dr. Frank Baron pointed to

³ Mr. Dunnington was scheduled to return on or about October 1, 2011. *CP 407; 732.* Instead, he next contacted Dr. Ngan on December 16, 2011 about scheduling an MRI before the year's end. *CP 407.* An argument can be made that Mr. Dunnington's actions delayed the diagnosis for a full three months, as his contact on this date was simply to arrange for an MRI. *Id.*

the delays allegedly associated with the conduct of both Dr. Ngan and Dr. Bierman. He concluded that both doctors “caused significant delay in diagnoses” of the malignancy. *CP 500*. Dr. Brad Naylor, echoed these comments, *see CP 515-16, 656-57*, and added that “delay in diagnosis and treatment allowed this lesion...to likely grow and metastasize.” *CP 516*. Multiple experts thus point directly to delays into January 2012 as proximate causes of injury.

Moreover, the response brief omits important testimony contained in Dr. Ngan’s declaration. The complete declaration appears as Appendix B. Missing from the selected quotations is Dr. Ngan’s explanation that he asked Mr. Dunnington to return so that he (Dr. Ngan) could evaluate whether the treatment succeeded. *CP 732, Appendix B*. Also omitted from the summary of Dr. Ngan’s declaration is Dr. Ngan’s statement that:

Had Mr. Dunnington followed my direction to return within two weeks of September 15, 2011, and agreed to the surgical excision that I offered as early as September 15th, *the melanoma would have been discovered much earlier.* The fact that melanoma was not in my differential would not have changed my standard practice of ordering biopsies for tissue which has been surgically excised.

CP 733, Appendix B (emphasis added.)

The Dunningtons’ brief also does not discuss Dr. Ngan’s statement that Mr. Dunnington further delayed the diagnosis by not accepting the December 27, 2011 recommendation for surgical excision. *CP 733*. Had

Mr. Dunnington accepted this recommendation, the melanoma would have been discovered in late December or early January. *Id.* Dr. Ngan's statement combined with Dr. Felsher's opinion that the one-month delay between January 2012 and the February biopsy caused a reduction in Mr. Dunnington's chance at a better outcome establishes causation. *CP* 736.

A jury is entitled to consider evidence of all causes of delay into January 2012, including Mr. Dunnington's own delay in returning to Dr. Ngan for the surgical excision of the lesion and his decision to seek a second opinion. This rule is specifically contained in WPI 1.02 which provides in pertinent part:

In order to decide whether any party's claim has been proved, you must consider all of the evidence that I have admitted that relates to that claim. Each party is entitled to the benefit of all of the evidence, whether or not that party introduced it.

WPI 1.02. The testimony proffered by the Dunningtons' own experts establishes genuine issues of material fact on causation and thus precludes summary judgment.

C. The argument that Mr. Dunnington's failure to return to the clinic had no impact on the care he would have received ignores Dr. Ngan's actual testimony, conflicts with Dr. Ngan's declaration establishing that an earlier return to the clinic would have resulted in earlier discovery of the cancer, and conflicts with the well-established rule that medical facts must be established through medical testimony.

- 1. The narrow reading of Dr. Ngan's declaration and testimony conflicts with the rule that the non-moving party is entitled to have the facts, and all inferences from those facts, construed in their favor.**

In an effort to eliminate a genuine issue of material fact on causation, the original motion for summary judgment started with the premise that Dr. Ngan could not prove causation because he had testified that melanoma would not have been on his differential diagnosis even *if* Mr. Dunnington had returned as requested. *Reply/Response Brief at 19.* The Dunningtons cite to this testimony, and to Mr. Dunnington's testimony regarding temporary improvements, as proof that Mr. Dunnington's conduct could not have caused his injury because Dr. Ngan would have acted in the very same way, hence the diagnosis would still have been delayed.

In response to plaintiffs' motion for summary judgment, Dr. Ngan explained that questions about differential diagnoses are different than questions about treatment plans. *CP 733.* Dr. Ngan stated that had Mr. Dunnington returned in October 2011, he "***would have explored other options***, especially if Mr. Dunnington's lesions had not responded to

conservative treatment.” *Id.* Emphasizing the second half of the sentence, the Dunningtons’ Response brief argues that Dr. Ngan never stated that he would have pursued other options if the lesion had responded to conservative treatment. *Reply/Response Brief at 19; 23.* This narrow reading of the declaration is not permitted. Dr. Ngan’s declaration clearly states that had Mr. Dunnington returned, he would have pursued other options. *CP 733.* Moreover, even if there is an ambiguity, Dr. Ngan’s testimony and all inferences from that testimony must be interpreted in the light most favorable to VMMC. *See, e.g., Mountain Park Homeowners Ass’n v. Tydings*, 125 Wn.2d 337, 341, 883 P.2d 1383 (1994).

Contrary to plaintiffs’ interpretation, Dr. Ngan would have investigated other options regardless of improvement, and a surgical excision/biopsy would have been performed much sooner. *Id.* Mr. Dunnington’s failure to return to the clinic deprived Dr. Ngan of this opportunity, thereby contributing to the delay which allowed the cancer to advance, and materially altering his own outcome in this case. The flaws in this argument will be discussed below.

2. **The argument that Mr. Dunnington's delay had no effect because Dr. Ngan would not have acted differently rests on Mr. Dunnington's lay person appraisal of medical facts and ignores Dr. Ngan's testimony concerning the reason he needed to return for evaluation.**

It is important to note at the outset that this entire argument rests on Mr. Dunnington's lay testimony concerning the condition of his foot and the dubious proposition that a cancerous lesion "improved" with cryo therapy treatment. This testimony comes from Mr. Dunnington's "explanation" for his failure to return:⁴

Q: Why did you wait three months to come back, when the note on the 15th says "Return to clinic in two weeks?"

A: The instructions for Dr. Ngan was to observe the—the wound—the PG and to just---that it should dry; that it might be getting better as long as I off-load it and I use the silver nitrate sticks to cauterize it.

So I did those things very, very carefully. *So I followed his orders, and it began to dry up. It looked like it was improving. So I didn't return because it was improving.* I was able to stop using the Velcro shoe, and I could wear a regular shoe.

And for those reason, I felt like I didn't need to see the doctor because it was behaving the way he described it should behave when a PG begins to heal itself.

Q: That was a decision you made?

⁴ There is actually no medical proof that melanoma would improve based on the cryo therapy Dr. Ngan administered in September. None of the Dunningtons' experts suggested that the lesion would have responded in the manner that Mr. Dunnington reported and counsel is unaware of any medical literature which supports this position.

A: Yes.

Q: Okay.

A: It was—it was a decision I made, based on Dr. Ngan's description what to look for.

Q: Did he tell you to come back in two weeks, on the 15th

A: I don't remember him specifically saying that.

CP 482 (emphasis added).

Contrary to the inference left by Mr. Dunnington's testimony, Dr. Ngan flatly denies conditioning the duty to return on the condition of Mr. Dunnington's foot.

Q: If this note did not exist and I asked you that question, you could recall actually saying that to David Dunnington, "Come back in two weeks"?

A: Yes.

Q: Did you say, "*Come back if -- in two weeks if your foot is not better*"?

A: *No.*

Q: Did you say that, "*If this treatment works and it's all healing up and you're staying off of it, don't worry about coming back*"?

A: *No.*

CP 479 (emphasis added). This testimony is consistent with

Dr. Ngan's declaration:

I did not tell Mr. Dunnington that he did not have to return if his condition improved. When I performed a procedure, I instruct my patients to return so that I may evaluate whether the procedure or treatment worked. I expect my patients to follow my instructions.

CP 732.

Apart from the shaky scientific foundation for the claim that a cancerous lesion improved with cryo therapy, the fact is that the Dunningtons cannot negate causation by substituting the lay testimony of a patient for that of a qualified medical provider. There is no evidence that just because Mr. Dunnington thought the lesion had reacted properly to the treatment, that Dr. Ngan also would have concluded no additional treatment was necessary. Dr. Ngan possesses medical training and skills necessary to evaluate the physical response to the therapy that Mr. Dunnington does not have. The fact of improvement thus had to be established by Dr. Ngan or the testimony of some other physician.⁵ Mr. Dunnington's lay testimony cannot establish the fact of improvement in the medical sense Dr. Ngan was concerned about.

Mr. Dunnington simply made the choice to ignore his physician's advice and then attempted to rationalize why he did not come back. Having chosen not to accept the September 15 and December 27

⁵ In reply, plaintiffs could have produced expert testimony, assuming their experts agreed, that the lesion would have responded as Mr. Dunnington described.

recommendations for surgical excision, he now wants to blame only Dr. Ngan, not himself, for his actions. Having failed to return when instructed, he deprived Dr. Ngan of the opportunity to utilize his medical skills to evaluate whether the treatment had in fact succeeded.

While Mr. Dunnington may believe that his decision is justified, his rationalizations alone cannot defeat a comparative negligence defense. The underlying fact of response to the treatment need to be established by a physician because it involves an analysis of medical facts that are beyond a layperson's knowledge. *See, e.g., Douglas v. Freeman*, 117 Wn.2d 242, 252, 814 P.2d 1160 (1991); *McLaughlin v. Cooke*, 112 Wn.2d 829, 837, 774 P.2d 1171 (1989); *Harris v. Groth*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983). The trial court erred in basing the order granting summary judgment on this testimony.

3. The focus on the differential diagnosis ignores the real issue, which is when a surgical excision and biopsy would have been ordered.

In addition, the entire argument is a red herring because it focuses upon the differential diagnosis rather than the real issue, *when* would Dr. Ngan have advanced his treatment to surgical excision and biopsy. Dr. Ngan began discussing surgical options at the first visit. *CP 406*. He advanced his recommendations to surgical intervention on September 15, 2011. *CP 733, 407*. It is undisputed that a surgical excision would have

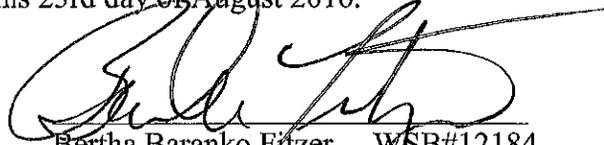
resulted in a biopsy that, in turn, would have revealed the cancer. *CP 733*. Dr. Ngan's differential diagnoses or reasons for recommending the surgical excision are thus irrelevant, as it is the *biopsy*, not the differential diagnosis that would have revealed the melanoma. Focusing on the differential, rather than when an excision and biopsy would have occurred, confuses the issue. What is important for purposes of the comparative fault analysis is when in time Dr. Ngan recommended an excision and biopsy, whether or not there was a delay in obtaining the excision and biopsy, and who was responsible for the delay in obtaining the recommended excision and biopsy. As the evidence shows, and the briefing in this case highlights, these are hotly contested issues that preclude summary judgment.

III. CONCLUSION

The allegation that VMMC failed to contest causation ignores the record before the trial court. VMMC simply relied upon the plaintiffs' own experts who linked the delay to the advancement of the cancer. Nothing more is required. The trial court erred in taking this issue away

from the jury. VMMC respectfully requests that this order be reversed
and that the jury be instructed on comparative fault at trial.

Respectfully submitted this 23rd day of August 2016.



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Jennifer Merringer Veal, WSB#41942
Attorney for Virginia Mason Medical
Center as Respondent/Cross
Appellant

CERTIFICATE OF SERVICE

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

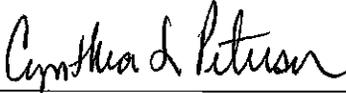
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Signed on August 23, 2016 at Tacoma, Washington


Cynthia Petersen Paralegal

Appendix A

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IN THE SUPERIOR COURT OF WASHINGTON STATE
FOR KING COUNTY

DAVID DUNNINGTON and JANET
WILSON,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE;
VIRGINIA MASON MEDICAL
CENTER; ALVIN T. NGAN, DPM;
RYAN BIERMAN, DPM; ANKLE &
FOOT SPECIALISTS OF PUGET
SOUND, P.S.; UNKNOWN JOHN
DOES AND JOHN DOE CLINICS,

Defendants.

NO. 13-2-21191-2 SEA

DECLARATION OF
DEAN FELSHER, M.D., PH.D.

I, DEAN W. FELSHER, M.D., PH.D., declare under penalty of perjury under the
laws of the State of Washington that the following is true:

I am of legal age and in all respects competent to testify to the statements
contained in this Declaration.

I am a physician licensed to practice medicine in the State of California and I am
Professor of Medicine in the Division of Oncology at Stanford University School of
Medicine, California.

DECLARATION OF DEAN FELSHER, M.D., Ph.D. - 1

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1 I received my medical degree in 1992 from the University of California, Los
2 Angeles. I completed my residency in Internal Medicine at the Hospital of the University
3 of Pennsylvania in 1994. I completed my fellowship in Hematology-Oncology at
4 University of California, San Francisco in 1999. I received board certification in Internal
5 Medicine in 1996 and Medical Oncology in 1998. My curriculum vita is attached hereto
6 as Exhibit 1.
7

8 I have been asked by James L. Holman, the attorney for David Dunnington, to
9 review medical records from the following facilities, in addition to all depositions taken
10 to date, as well as photos:

- 11 • Virginia Mason Medical Center
- 12 • Ankle & Foot Specialists of Issaquah
- 13 • University of Washington Medical Center
- 14 • Grays Harbor Community Hospital
- 15 • MD Anderson Cancer Center
- 16 • Seattle Cancer Care Alliance
- 17 • Group Health Cooperative

18 I hold the following opinions to a reasonable degree of medical probability.
19

20 **SUMMARY OF PERTINENT CLINICAL DETAILS:**

21
22 Mr. Dunnington has a history of metastatic melanoma. He first presented with a
23 lesion on the plantar surface of his left foot as seen by Dr. William Kirshner on
24 09/01/2011. This was presumed to be a foreign body reaction or a pyogenic granuloma.
25 Notably, no skin lesions or lymph nodes are noted and no mention of ulceration. Then,
26

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1 he was seen by Dr. Ngan for further examination of this left foot lesion that was
2 described as having a history of bleeding with physical activity. On the first exam of
3 9/01/2011, "two spots" were noted, one more proximal was described as "tender". On
4 physical exam, there was evidence for a 6-8 mm diameter lesion ulceration with
5 proliferating granulomatous tissue thought to be consistent with pyogenic granuloma.
6 The lesion was cleaned and treated with silver nitrate. On 9/15/2011, Dr. Ngan still did
7 not perform a biopsy or refer Mr. Dunnington for biopsy. He again treated with
8 cryogenic therapy. On 12/26/2011, an MRI was performed that showed:

10 "There is abnormal enhancement of the dermal tissues. The region of
11 abnormal enhancement measures approximately 16mm transverse x 8mm
12 in depth, image 13 of series 11. At least 3 individual nodules are seen as
13 seen on sagittal image 8-11 of series 10. This abnormal skin thickening
14 and abnormal enhancement is largely confined to the dermis and
15 immediate subcutaneous fat. It does not extend into the deeper muscular
16 and tendinous structures of the foot."

17 Dr. Ngan saw Mr. Dunnington the day following, December 27, 2011, and stated,
18 "This appears benign, but is clearly painful to walk on. I recommend surgical excisional
19 biopsy and closure. Closure could prove difficult and would likely entail skin
20 plasty...Meanwhile I will check with my colleagues to get their impression as well upon
21 his request."

22 Mr. Dunnington then scheduled an appointment with a second podiatrist, Dr.
23 Bierman, and saw him on three occasions in January 2012. Again, no biopsy was
24 performed. The patient was then seen by Dr. Miller on 01/31/12, who considered that the
25 lesion was more "wart-like" but "malignancy was a consideration" and recommended a
26 punch biopsy. The pathology returned as consistent with invasive melanoma, acral
lentiginous melanoma, depth of 3.7 mm Clark Level IV with positive vertical growth and

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1 ulceration. In February of 2012, the patient was found to have evidence for metastasis.
2 Pathology revealed Breslow thickness of 1.1cm with a minimum pathologic stage of
3 pT4N1aMX. The one lymph node that was positive was the left inguinal sentinel lymph
4 node which was found positive for metastatic melanoma (0.2 mm in greatest dimension).
5 Subsequently, further metastatic disease was found higher up Mr. Dunnington's leg.
6

7 **SUMMARY OF PERTINENT CONCLUSIONS:**

8 Mr. David Dunnington presented to Virginia Mason Hospital with a history of a
9 bleeding lesion on the sole of his left foot that was associated with a growing mass and
10 subsequently with ulceration. This initial clinical presentation is highly suspicious for a
11 diagnosis that includes malignancy and is a particularly notable presentation for
12 melanoma. There was a delay of four months in the diagnosis of melanoma because this
13 lesion was managed medically before performing a simple skin biopsy. Subsequently,
14 the patient, at the time of diagnosis, was found to already have metastatic disease.
15

16 Based upon the clinical examination and presentation, Mr. Dunnington initially
17 presented with nonulcerated acral lentiginous melanoma that was in the "superficial
18 spreading phase of the disease" that was much more medically likely than not, less than 1
19 mm in depth and without any evidence for distant invasion. Then, by February when the
20 tumor was biopsied and diagnosed, it had clearly microscopically ulcerated and was now
21 growing and had progressed to the phase of "spread with deep invasion" and was greater
22 than 4 mm in depth. Subsequently, it was found that there was evidence in the patient for
23 local and distant metastasis.
24
25
26

DECLARATION OF DEAN FELSHER, M.D., Ph.D. - 4

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PROGNOSIS OF MELANOMA:

Melanoma is a curable disease with early detection. However, metastatic melanoma is almost always fatal (Garbe et al, The Oncologist, 2010; Tuong et al Dermatology Clinics, 2012). The American Cancer Society, the National Institute of Health and the American Society of Clinical Oncology have a major effort into informing physicians and patients of the importance of the detection of early detection of melanoma (NIH, 2010). There is no physician who is not aware of the importance of detecting melanoma early.

The prognosis of melanoma is largely determined by the depth of invasion that is described as the Breslow Thickness. In addition, the presence of ulceration, number of mitotic cells (dividing cells), presence of satellite lesions (cancer cells migrating away from the primary tumor), perineural invasion can be associated with worse prognosis.

Melanoma can be subtyped into different pathologies including: superficial spreading (70%), lentigo maligna, acral lentiginous melanoma (2-3%) and nodular melanoma. Importantly, acral lentiginous melanoma is well known to typically occur on the soles of feet or hands, grow generally more quickly, but with an initial phase of superficial spreading growth before transiting to a vertical spread with deep invasion.

For acral lentiginous melanoma, it is particularly important to diagnose early because of the two distinct clinical stages. After deep invasion the prognosis is dismal.

The prognosis of distinct types of melanoma, and in particular, acral lentiginous melanoma, is almost entirely dependent upon the depth of invasion at initial presentation (Bradford et al, Arch Dermatol, 2009). Based upon SEER data from 1986-2005 of 1,413

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1 cases of acral lentiginous melanoma, the prognosis for a Stage I (<1mm lesion) is 98.8%
2 survival for 5 year and 91.8% survival for 10 years based upon the SEER database
3 (Bradford et al, Arch Dermatol, 2009). A Stage IIb (8mm deep acral lentiginous
4 melanoma without ulceration staged to be) would have an expected 5 year and 10-year
5 survival of 85.8% and 68.2.0%, respectively. A Stage III (11mm deep acral lentiginous
6 melanoma with ulceration) would have an expected 5-year and 10-year survival of 61.2%
7 and 40.9%.

9 SUMMARY ANALYSIS OF THE CASE:

10 Mr. Dunnington presented to his primary care physician with a growing but
11 superficial mass in the sole of his left foot that was highly suspicious for malignancy.
12 This lesion was not biopsied for several months, instead treated with silver nitrate and
13 other medical therapy. During this time, the tumor acquired an invasive character, had
14 spread locally into the deep tissues and had become distantly metastatic.
15

16 Notably, the cancer is an acral lentiginous melanoma that is well known to have
17 two distinct phases of growth: superficial spreading and then deep invasion. Mr.
18 Dunnington presented with what is much more medically likely than not a curable
19 melanoma in the superficial spreading phase that would have been expected
20 conservatively to have a long-term survival of greater than 91.8%. Instead, there was a
21 four month delay in his diagnosis because the tumor mass was not biopsied and instead
22 treated medically. At the time of his diagnosis, he had a melanoma that had transitioned
23 to invasive cancer with an expected 5 year and 10 year survival of 61.2 % % and 40.9%,
24 respectively.
25
26

DECLARATION OF DEAN FELSHER, M.D., Ph.D. - 6

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In my expert opinion, the delay in the diagnosis of Mr. Dunnington much more likely than not had led him to being diagnosed with what would have been a curable cancer, with an inoperable and incurable cancer that is associated with a dismal outcome, significant morbidity and pain and the requirement of long term and highly toxic therapy.

I reserve the right to review additional information as it becomes available and to amend this declaration.

DATED this 20th day of May, 2014, at Stanford, California.



DEAN W. FELSHER, M.D., PH.D.

DECLARATION OF DEAN FELSHER, M.D., PH.D. - 7

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Appendix B

FILED

14 SEP 29 AM 9:47

Honorable Barbara Linde

Trial Date: 10/1/2014

Hearing Date: October 30, 2014

E-FILED

CASE NUMBER: 13-2-21191-2 SEA

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

DAVID DUNNINGTON and JANET
WILSON,

Cause No: 13-2-21191-2 SEA

Plaintiffs,

v.

DECLARATION OF ALVIN T. NGAN,
D.P.M., IN OPPOSITION TO
PLAINTIFFS' MOTION FOR PARTIAL
SUMMARY JUDGMENT

VIRGINIA MASON MEDICAL CENTER;
ALVIN T. NGAN, DPM; RYAN BIERMAN,
DPM; ANKLE & FOOT SPECIALISTS OF
PUGET SOUND, P.S.; UNKNOWN JOHN
DOES AND JOHN DOE CLINICS,

Defendants.

Alvin T. Ngan, D.P.M., states under penalty of perjury, pursuant to the laws of the State of Washington, that I am competent to testify, that I have personal knowledge of the following facts and the testimony which appears below is true and correct:

I am one of the individually named defendants in the above entitled action. I treated Mr. Dunnington on September 1, 2011, September 15, 2011, and December 27, 2011.

On September 15, 2011, as documented by my contemporaneous medical record, I discussed surgical excision and a biopsy as an alternative to the conservative treatment used at

1 the first visit. Also documented in the medical record is the fact that I asked the plaintiff to
2 return for a follow-up appointment within two weeks.

3 I did not tell Mr. Dunnington that he did not have to return if his condition improved.
4 When I perform a procedure, I instruct my patients to return so that I may evaluate whether
5 the procedure or treatment worked. I expect my patients to follow my instructions.
6

7 The plaintiff did not have any additional contact with my office until mid-December
8 2011. At that time, he called, stated that the soreness in the ball of his foot had come back,
9 and requested an MRI. He stated further that he wanted the MRI to occur before the end of
10 the year for insurance purposes. On December 20, 2011, my office staff faxed over to Group
11 Health, the plaintiff's insurance, a request for authorization for an MRI. The MRI was done
12 on December 26, 2011. I saw Mr. Dunnington the next day for what turned out to be his final
13 visit with me. At that visit, I reviewed the MRI with Mr. Dunnington and advised him that
14 the next step was to surgically excise the lesion and biopsy it.
15

16 Mr. Dunnington informed me that he wanted to think about it and discuss the matter
17 with his family. Again, both the recommendation for the surgical incision and biopsy and the
18 plaintiff's response are documented in my medical records of that visit. Mr. Dunnington
19 never returned for the surgical excision and biopsy. I subsequently learned that he had saw a
20 different podiatrist who treated him during January 2012 and that he ultimately had a biopsy
21 at the end of January 2012.

22 I have reviewed my depositions taken on December 13, 2013 and January 24, 2014.
23 Mr. Holman asked me whether I included melanoma in my diagnosis on December 27, 2013.
24 I responded that I had not. He then also asked whether, based on that, I would have included
25

1 melanoma on my differential diagnosis had the plaintiff returned on or about October 1, 2011.

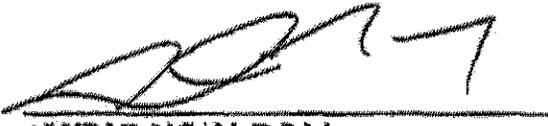
2 I answered that I would not have included melanoma in the differential.

3 At no time did Mr. Holman inquire as to what treatment or course of action I would
4 have recommended had Mr. Dunnington returned in October 2011. Had he asked this
5 question, I would have explained that I would have explored other options, especially if Mr.
6 Dunnington's lesion had not responded to conservative treatment. I would have thus reached
7 the conclusion that we should surgically excise the granuloma and obtain a biopsy at an
8 earlier date. This is the same recommendation I made in December.

9 Had Mr. Dunnington followed my direction to return within two weeks of September
10 15, 2011, and agreed to the surgical excision that I had offered as early as September 15th, the
11 melanoma would have been discovered much earlier. The fact that melanoma was not in my
12 differential would not have changed my standard practice of ordering biopsies for tissue
13 which has been surgically excised.

14 Mr. Dunnington further delayed his diagnosis by not agreeing to the surgical excision
15 and biopsy I recommended on December 27, 2011. Had he acted on my recommendation for
16 surgical excision and biopsy, the melanoma would have been discovered in late December or
17 early January at the latest. Instead, Mr. Dunnington went to another doctor apparently for a
18 second opinion about my recommendation for surgical excision of the lesion.

19 Executed this 26th day of September 2014 at Seattle, Washington.

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ALVIN T. NGAN, D.P.M.

CERTIFICATE OF SERVICE

I certify under penalty of perjury of the laws of the State of Washington that on the date set forth below, I caused a true and correct copy of the foregoing document be served on the following in the manner indicated below:

Counsel for Plaintiff: James L. Holman Jessica F. Holman 4041 Ruston Way, Suite 101 P O Box 1338 Tacoma WA 98401-1338 ilh@theholmanlawfirm.com jhm@theholmanlawfirm.com	<input type="checkbox"/> Via First Class Mail <input type="checkbox"/> Via Hand Delivery <input checked="" type="checkbox"/> Via Electronic Mail
Counsel for Def. Bierman/Foot & Ankle Philip M. deMaine Johnson Graffe Keay Moniz & Wick LLP 2115 North 30 th Street, Suite 101 Tacoma WA 98403 phil@igkmw.com	<input type="checkbox"/> Via First Class Mail <input type="checkbox"/> Via Hand Delivery <input checked="" type="checkbox"/> Via Electronic Mail

SIGNED at Tacoma, Washington this 29th day of Sept., 2014.


 Dawne Shotsman, Legal Assistant
 FITZER, LEIGHTON & FITZER, P.S.