No. 91374-9

SUPREME COURT OF THE STATE OF WASHINGTON

DAVID DUNNINGTON and JANET WILSON,

Petitioners and Cross-Respondents,

v.

VIRGINIA MASON MEDICAL CENTER,

Respondents and Cross-Petitioners.

ON APPEAL FROM KING COUNTY SUPERIOR COURT

No. 13-2-21191-2 SEA

BRIEF OF HEALTH CARE AMICI CURIAE WASHINGTON STATE MEDICAL ASSOCIATION, WASHINGTON STATE HOSPITAL ASSOCIATION, WASHINGTON CHAPTER—AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, WASHINGTON STATE RADIOLOGICAL SOCIETY, AND THE WASHINGTON STATE PODIATRIC MEDICAL ASSOCIATION

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Washington Cases

Other State Cases

Constitutional Provisions, Statutes and Court Rules

Page(s)

Treatises, Journals, & Articles

Other Authorities

I. IDENTITY AND INTEREST OF *AMICI CURIAE*

Health Care Amici[1] are state-wide non-profit organizations that represent Washington state medical and osteopathic physicians, emergency surgeons, radiologists, Podiatric Physicians, and physicians assistants, and the state's 107 community hospitals, as described in the motion to file this brief ("Motion"). Their collective experience is that medicine is at its best when it is a collaboration between the physician and patient, and the others on the health care team. The physician depends on the patient to accurately report her condition or perceived problem and to cooperate with developing and carrying out the treatment plan. That includes following instructions for follow-up exams to allow for the physician's assessment of progress and any need to maintain or change the treatment plan.

For many medical malpractice cases, such as diagnosis and choice of treatment cases, jury instructions must set out the mutual responsibilities of both the practitioners and the patient that are essential to determine and carry out the most effective treatment. Such instructions thus instruct the jury on the boundaries of a plaintiff's claim against a physician and the elements of his or her defenses. This includes cases alleging a "loss of chance".

[1] Health Care Amici are: the Washington State Medical Association; Washington State Hospital Association; Washington Chapter—American College of Emergency Physicians; Washington State Radiological Society; and the Washington State Podiatric Medical Association.

"Loss of chance" cases do not relieve a plaintiff of the obligation to meet the statutorily mandated and long-settled requirement of proving more probable or not, or "but for" causation for the claimed injury from health care that is a long-standing part of Washington's medical negligence law and an inherent part of the governing statutes, RCW 7.70.030(1) and .040. Proper instructions preclude strict liability for a bad result, a rule most recently reaffirmed in *Fergen v. Sestero*, 182 Wn.2d 794, 803-09, 346 P.3d 708 (2015) and *Paetsch v. Spokane Dermatology Clinic, P.S.*, 182 Wn.2d 842, 851-52, 348 P.3d 389 (2015).

II. ISSUES OF CONCERN TO HEALTH CARE AMICI

1. Should the Court reaffirm that a patient must act reasonably and non-negligently in following the physician's prescribed course of treatment–including returning for scheduled follow-up exams and treatments–and that the failure to do so entitles the defendant to an instruction on contributory negligence, particularly since the current health care environment and RCW 7.70.060 promote shared decision-making between provider and patient and co-responsibility for one's care?
2. Should the Court reaffirm that the statutory and common law causation requirement for medical negligence cases–proof of "but for" cause in fact from the physician's acts or omissions–is a required part of a "loss of chance" medical negligence case, as established by the plurality in *Herskovitz v. Group Health*, adopted in *Mohr v. Grantham*,[2] applied in numerous Court of Appeals decisions, and that is the accepted general rule throughout the country?

[2] *Herskovitz v. Group Health Co-Op*, 99 Wn.2d 609, 664 P.2d 474 (1983) and *Mohr v. Grantham*, 172 Wn.2d 844, 262 P.3d 490 (2011).

Health Care Amici emphasize that a contributory negligence affirmative defense must be available to properly instruct a jury on a physician's theory of the case and defense to a negligence claim where, as here, it directly affects whether Dr. Ngan's care negatively affected Mr. Dunnington's cancer and ultimate outcome. It informs the jury of the settled balance of responsibility between physician and patient and, consequently, of the parameters of liability in cases where the patient's action, lack of action, or failure to adhere to the recommended course of treatment, may contribute to or control the outcome—here, by precluding the caregiver from being able to provide the necessary intervention when needed. Striking the contributory negligence defense and consequent instructions under these circumstances makes the presentation of the evidence and the law to the jury materially and logically incomplete.

Health Care Amici respectfully submit this brief to also help the Court understand that the Dunningtons' proposal on "substantial step" would be a dramatic change to settled medical malpractice tort law that is not warranted and is a bad policy. If adopted as proposed it would be a major step towards imposing strict liability on physicians for a bad result, a concept the Court again rejected in the *Fergen v. Sestero* and *Paetsch v. Spokane Dermatology Clinic* decisions just 18 months ago.

III. RELEVANT FACTS

Health Care Amici accept the facts as stated by Respondent-Cross-Petitioner VMMC, particularly as to the totality of facts to be considered on whether the contributory negligence affirmative defense was properly dismissed or should be reinstated so the jury can consider that critical defense.

IV. LEGAL DISCUSSION

A. A Contributory Negligence Affirmative Defense Must Be Allowed, And Its Instructions Given, When There Is Evidence The Plaintiff-Patient Failed To Follow Or Adhere To His Physician's Instructions And Potentially Affected The Outcome.

1. This Court recognized in 1927 in *Brooks v. Herd* that patients have a duty to follow their physician or healer's course of treatment, including returning for assessment as scheduled, that remains the majority rule.

In 1927 this Court held in the case of a "drugless healer" that the patient bringing suit has a duty to follow the advice of the healer or physician if the patient wanted to later complain of the advice:

> [I]t is the duty of the patient to follow the advice of the physician, and, if he fails to follow the advice of the physician and something untoward happens to the patient which would not have happened or was not the physician's negligence, then the physician would not be liable, and, if the plaintiff failed to follow the advice of the doctor and thereby aggravated the ailment, the jury should find for the defendant.

Brooks v. Herd, 144 Wash. 173, 177, 257 Pac. 238 (1927). *Brooks* also held that the instructions should correctly state the law of the

mutual responsibilities between patient and healer and that it is a jury question whether the alleged failure to cure was the result of the healer's acts or omissions, or the patient's "willful absence from treatment or some other cause". *Id.*, 144 Wash at 178.[3]

While now a matter of contributory and comparative negligence rather than a complete bar to liability, these well-established principles at the time of *Brooks v. Herd* remain the law in Washington and around the country, as pointed out by both VMMC and the WDTL amicus brief.[4]

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[3] *Brooks* thus expressly addressed the situation here where the patient sees the physician, then fails or chooses to not adhere to the direction to return for evaluation at a specified time or interval. *Brooks* held that the matter of the patient's responsibility was a jury question:

> [An instruction providing that] if, while appellant [healer] was treating respondent [patient] and before he pronounced respondent cured, respondent failed, neglected, and refused to return to appellant for further and additional treatment, but absented himself from appellant and did not return for further treatment, the jury should find for appellant, was incorrect in law. While it would have been appropriate under the issues in this case for the court to have given some instruction along that line, [any such instruction had to include] the idea that the absenting of himself from appellant for treatment was without cause or reason and whether a reasonable time (in the absence of an agreed time, as in this case) had elapsed in which to effect a cure, and that **it would be for the jury to determine under the issues and facts whether the cause of the failure to cure respondent, if there was such failure, was due to such willful absence from treatment or to some other cause**.

Brooks v. Herd, 144 Wash. at 178 (bold added). The VMMC briefing thus understated the impact of *Brooks* and whether it addressed the situation here where the patient began a course of treatment, then "failed, neglected" or otherwise did not return for further treatment or exam as Dr. Ngan had directed.

[4] *See* VMMC Response Brief at 19-20; WDTL *amicus* brief at § IV.D. *See, e.g., Merrill v. Odiorne*, 113 Me. 424, 94 A. 753 (1915):

> But in cases of this nature a duty devolves upon the patient. In an extensive note to be found in the case of *Gillette v. Tucker* [citation omitted], upon the authority of the cases there cited, it is held that it is the duty of the patient to follow the reasonable instructions and submit to the reasonable treatment prescribed by his physician or surgeon. If he fails in his duty, and his

(Footnote continued next page)

Health Care Amici respectfully submit there is no reason to retreat from the common sense rulings in *Brooks*, and that none of the criteria are met to prompt the Court to abandon a prior precedent even had the Dunningtons made that request, which they did not. *See Fergen*, 182 Wn.2d. at 809-12 (discussing criteria for overruling prior precedent and declining to do so since the criteria, as here, were not met).

Moreover, given the increased focus on shared decision-making (discussed *infra*, §IV. A.3.) and the ready availability of health-related information on the internet in our current era, there is even a greater reason for reliance on the patient to act as a critical collaborator in his or her own treatment plan than there was in 1927. Finally, reinforcing the patient's individual responsibility is wholly consistent with this populist state's continuing recognition of the rights and autonomy of the individual to make decisions for him or herself and to be responsible for those actions, an approach that reaches back to statehood.[5]

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negligence directly contributes to the injury, he cannot maintain an action for malpractice against his physician or surgeon, who is also negligent in treating the case.

[5] The Washington Constitution's provision for freedom of speech declared in 1889 that the individual is accountable for the responsible exercise of his or her speech: "Every person may freely speak, write and publish on all subjects, ***being responsible for the abuse of that right.*** WA. CONST. art. 1 sec. 5 (emphasis added). There is no reason to think individuals are any less responsible for their own acts today than they were deemed to be in 1889.

2. **Since the jury must be instructed on the parameters of liability and the defenses that may apply, and defendants are entitled to instructions on potentially applicable defenses, striking the contributory negligence defense means the jury will never get instructed on the legal importance and consequences of a plaintiff patient's failure or refusal to adhere to a physician's advice or treatment, nor hear those critical facts.**

The purpose of jury instructions is to provide the applicable law on the elements of both claims and defenses to the twelve citizens who will decide the case.[6] This includes instructions on the parameters of liability and instructions on the potential defenses to the asserted liability for the case before them, based on the admitted evidence, as Professor Tegland explained:

> The parties are entitled to have their respective theories of the case presented to the jury in the instructions, including multiple claims and inconsistent defenses, provided there is evidence in the record to support them. . .

14A K. Tegland, WASHINGTON PRACTICE: CIVIL PROCEDURE §31:12 at 314 (2nd ed. 2009) (footnotes omitted).

This Court recently reaffirmed the basic principle that both parties are entitled to have the jury instructed on their parts of the

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[6] The instructions . . . are intended to inform the jury of the law as it relates to the case being tried. The jury is informed of applicable statutory law, ordinances, and the established principles of common law as they have been agreed upon and formally expressed in court decisions. Typically included are the elements of the plaintiff's cause of action, the burden of proof, potentially applicable defenses, the manner in which damages are to be determined, and other factual issues in the case.

4 K. Tegland, WASHINGTON PRACTICE: RULES PRACTICE § CR 51.1 at 236-37 (6th ed. 2013); 14A K. Tegland, WASHINGTON PRACTICE: CIVIL PROCEDURE §31:1 at 291-92 (2nd ed. 2009) (same).

case for which there is sufficient evidence. *See Fergen, supra,* 182 Wn.2d at 810 ¶30 (affirming trial courts' use of exercise of judgment instruction in medical negligence cases as a necessary part of the physicians' defense and rejecting arguments the instruction should be abandoned as confusing) (citing *Barrett v. Lucky Seven Saloon, Inc.,* 152 Wn.2d 259, 266-67, 96 P.3d 386 (2004) (reversing verdict for failure to give instruction because "[f]ailure to permit instructions on a party's theory of the case, where there is evidence supporting the theory, is reversible error.")).

The rationale for the rule is because the failure to instruct on an applicable defense, or on a necessary element of a defense, is both an incorrect statement of the law and prevents a defendant from arguing her defense, and thus is error as a matter of law. *Barrett,* 152 Wn.2d at 267; *Travis v. Wash. Horse Breeders Ass'n., Inc.,* 111 Wn.2d 396, 408-09, 759 P.2d 418 (1988) (reversing plaintiff verdict for failure to give instruction on reasonableness defense to CPA claim). Moreover, it is only a full explanation of the applicable law via instructions that allows each party to fairly argue their case and gives the jury the factual and legal framework for a proper decision.

Under the circumstances such as here, where there is evidence the patient did not adhere to the defendant physician's advice and denied the physician the opportunity to review the course and efficacy of the initial treatment, striking the defense and refusing to instruct on the plaintiff's responsibility and potential negligence is

error.[7] The jury thus could not be informed of a well-established principle of liability and, in these circumstances, of critical facts to the physician's defense, denying the physician the benefit of a full presentation of the facts and circumstances. It would erroneously burden the physician defendant with nearly strict liability.

3. The trial court's dismissal of the contributory negligence defense despite supporting evidence is bad public policy because it undercuts both patient responsibility and the legislatively favored approach of shared decision-making between patient and physician.

The contributory negligence defense aligns closely with the ethical and practical principles behind shared decision-making, a concept that was first adopted by the legislature in 2007 as part of the health care liability statutes in RCW 7.70.060. *See* 2007 Laws ch. 259 §3 and 2012 Laws ch. 101 §1. There is a wealth of literature on the subject, much of which addresses shared decision-making and medical negligence, as discussed *infra*.

In its first brief, VMMC correctly notes that it is "more important than ever for courts to recognize that the physician/patient relationship is a two-way street" and that the trial court's decision to

[7] *See, e.g.*, VMMC's Response Brief's counterstatement of the facts at pp. 4-12 setting out the delays caused by Mr. Dunnington's decisions, especially the summary on page 8 to the following effect: 1) Mr. Dunnington's decisions not to do the excision and biopsy at either of the first two exams in September 2011; and 2) Mr. Dunnington's decision not to return to the clinic in early October; and 3) Mr. Dunnington's decision not to do the excision and biopsy on December 27, 2011, "**all** delayed diagnosis of the lesion as cancerous." Emphasis added.

strike the affirmative defense "imposes on Dr. Ngan liability not only for his own decision making but also his patient's own personal choices." VMMC Response Brief, pp. 14-15. While on a quick review it may seem that striking the contributory negligence defense for lack of evidence was a patient-friendly ruling or neutral, it has unintended consequences. These include actively discouraging physicians from both respecting patient autonomy and from engaging in practices like shared decision-making. Further, denying the defendant physician this key legal defense is error since defendants are entitled to such instructions where, as here, the facts taken in their favor along with all reasonable inferences support it.

Shared decision-making has been characterized as "a process in which the physician shares with the patient all relevant risk and benefit information on all treatment alternatives and the patient shares with the physician all relevant personal information that might make one treatment or side-effect more or less appropriate than others. Then, both parties use this information to come to a mutual medical decision."[8]

Shared decision-making is expressly encouraged under state and federal law.[9] Yet many physicians are hesitant to fully utilize

[8] Durand, et al., *Can Shared Decision-Making Reduce Medical Malpractice Litigation? A Systematic Review*, BMC HEALTH SERVICES RESEARCH (April, 2015) 15:167.

[9] *See* RCW §7.70.060; 42 U.S.C. § 299b-36 (Program to facilitate shared decision-making).

shared decision-making out of fear of malpractice liability even though a patient's decision, *e.g.*, to defer treatment or select a less invasive test or procedure, is one that is consciously made after a full discussion of risks and benefits.[10] Such reluctance will grow if patients are insulated from the consequences of their own decisions, as the dismissal of the contributory negligence defense does here unless it is reversed.[11]

If patients are not legally responsible for their own decisions, there is a ***dis***incentive for a physician to give the patient an opportunity to make their own decision. This is contrary to both the established law[12] and also to empirically-grounded good health policy. In addition to common sense, the available evidence suggests that shared decision-making reduces health care costs while simultaneously resulting in better patient outcomes and increased patient satisfaction.[13]

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[10] Merenstein, *Winners and Losers*, 291 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 15 (Jan. 7, 2004); Jaime S. King and Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429 (2006).

[11] Durand, et al., n. 8.

[12] *See Brooks v. Herd, supra,* and § IV. A. 1, *supra.*

[13] Emanuel, E. J, et al., *Shared Decision Making to Improve Care and Reduce Costs*; 368 N. ENG. J. MED. 6 (Jan. 3, 2013); Arterburn, D, et al, *Introducing Decision Aids at Group Health Was Linked To Sharply Lower Hip and Knee Surgery Rates and Costs*, 31 HEALTH AFFAIRS 2094 (Sept. 2012).

4. **Health Care Amici's experiences reinforce that the current allocation of responsibility works effectively and fairly balances the parties' respective roles in patient care while the proposed change is inconsistent with and deleterious to the increasing role of patient participation and responsibility in the contemporary health care system.**

Health Care Amici's experience is that several kinds of cases show how a patient's diligence and responsibility factors into the quality of care provided and whether the physician is at fault for an adverse outcome. *See* Motion at 5-7. Cancer cases involving a claim of a missed or delayed diagnosis, like Mr. Dunnington's, are classic examples for loss of chance.

Although the American Cancer Society's 40-year campaign asserts that early detection means early cure, tragically, that too often is not true. Early detection only allows earlier treatment *potential*,[14] but no guarantee on outcome, particularly where, as here, the cancer has already metastasized.[15]

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[14] *See* NATIONAL CANCER INSTITUTE, *Screening and Early Detection*, http://www.cancer.gov/research/areas/screening (last visited 9/1/16):

> Some patients whose cancers are detected and treated early may have better long-term survival than patients whose cancers are not found until symptoms appear. Unfortunately, effective screening tests for early detection do not exist for many cancers. And, for cancers for which there are widely used screening tests, many of the tests have not proven effective in reducing cancer mortality.

[15] A cancer that has metastasized by definition has already spread and is difficult and, most often, impossible to control. *See, e.g.*, NATIONAL CANCER INSTITUTE, *Metastatic Cancer*, http://www.cancer.gov/types/metastatic-cancer (last visited 9/1/16) (emphasis added):

> The main reason that cancer is so serious is its ability to spread in the body. Cancer cells can spread locally by moving into nearby normal tissue.

(Footnote continued next page)

This case is a good illustration. As shown in VMMC's Response Brief, expert testimony was submitted that the cancer had ***already*** metastasized by the September 1, 2011 exam by Dr. Ngan. VMMC Response Brief, p. 11-12. Given that fact, and the nature of the cancer, "cure" was most likely not an option. Since it is now known that each primary type of cancer has numerous strains and types, treatment options and outcomes are determined in conjunction with the patient's family history and make-up. *See* NATIONAL CANCER INSTITUTE, *Metastatic Cancer supra* fn. 15 NATIONAL CANCER INSTITUTE, *Screening and Early Detection,* fn. 14.

Early detection is always the goal. But given the nature of cancer and when it can first be detected, early detection does not necessarily equate with a cure, or even a better result. *See* fn. 14. It may have an impact on the nature and type of treatment and the ***potential*** for amelioration or genuine cure. But necessarily, where

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> Cancer can also spread regionally, to nearby lymph nodes, tissues, or organs. **And it can spread to distant parts of the body. When this happens, it is called metastatic cancer.** For many types of cancer, it is also called stage IV (four) cancer. The process by which cancer cells spread to other parts of the body is called metastasis. . .
>
> # # # #
>
> **Metastatic cancer does not always cause symptoms**. When symptoms do occur, their nature and frequency will depend on the size and location of the metastatic tumors.
>
> # # # #
>
> **Once cancer spreads, it can be hard to control. Although some types of metastatic cancer can be cured** with current treatments**, most cannot**. Even so, there are treatments for all patients with metastatic cancer. The goal of these treatments is to stop or slow the growth of the cancer or to relieve symptoms caused by it. In some cases, treatments for metastatic cancer may help prolong life.

the "early" detection occurs only ***after*** the cancer has metastasized, the treatment options and cure potential are greatly limited if not eliminated. *See* fn. 15. That is the nature of both cancer and the inexact art and science of the practice of medicine, where physicians do the best they can with the information and cooperation given by the patient, and are held accountable only if they breach the standard of care rather than being strictly liable every time a bad or unwanted result occurred.[16]

Diabetes cases are another example. A diabetic patient is expected to follow up according to a physician order and if the patient does not do so it can lead to a bad outcome. For example, for diabetes-related complications like neuropathy, the doctor tells the patient to keep blood sugar within a certain set of parameters. The patient may or may not have success doing this and may be good or bad at communicating the blood sugar results to the doctor on a regular basis. *See* Motion at 6-7. Due to the patient's own neglect, the patient later suffers neuropathy, blindness, or other diabetic complications and wants to sue the physician. To what extent should the physician be solely accountable under negligence when

[16] This Court last year re-affirmed Washington's long-standing medical negligence standards, which do not impose liability for a bad result but only for a violation of the standard of care which is the cause in fact of the injury, recognizing that "the inexactness of medicine is not a basis for legal liability" since "the desired results cannot be guaranteed." *See Fergen*, 182 Wn. 2d at 803-812 (refusing to change the basic rules on liability for health care providers); *Paetsch*, 182 Wn.2d at 851-52 (recognizing unanimously that *Fergen* is the state of Washington law).

the patient is unable or unwilling to follow the suggested course of treatment? Should the doctor have done more with aggressive diabetic treatment or was it the patient's responsibility for not staying on top of the blood sugar levels and communicating with the physician? Health Care Amici submit that these questions have been, and should remain, fact-based determinations based on all the evidence and subject to the long-standing legal rules that provide for patient responsibility for their own actions and embrace the concepts of shared decision-making and a plaintiff's obligation to exercise his or her own due care.

Another example involves cases with patients who have pre-existing co-morbidities or whose underlying cardiac or vascular condition would more probably not have been diagnosed even if the disputed treatment alleged had been performed earlier. *See* Motion at 7. Under the current "but for" legal standard for causation, Health Care Amici's experiences with juries is that the potential for balanced, substantiated reasoning is heightened. *Id.*

Finally, and as appropriate to the case at hand, Health Care Amici, particularly the WSPMA, emphasize that for Podiatric Physicians, following post-op and post-exam instructions with regard to weight-bearing and wound care are critical to successful diagnosis and treatment for foot-related conditions, simply based on the nature of the area at issue: the foot, the foundation for most individuals' ability to navigate daily life. *See* Motion at 3-4.

Patients who fail to adhere to their Podiatric Physician's instructions as to either care or follow-up appointments for assessment by the trained professional risk compromising the care that was planned and short-circuiting the ability of the physician to intervene in the earliest and most efficacious way. *Id.* The total evidence in this case, as illustrated in the VMMC's two briefs and particularly its reply brief (and which, per summary judgment rules, must be assessed with all inferences in Dr. Ngan's and VMMC's favor), illustrate that this is a genuine and material point.

B. Substantial Factor Test.

Respondent VMMC thoroughly addressed the history and analytical framework of the substantial factor test, pointing out how unworkable this test would be in real life, particularly in the medical negligence context. VMMC RB at §§ V. B., and VI.B, pp. 16-17 & 21-44. The WDTL amicus brief also addresses the proposed substantial factor test in detail in §§ IV. A., B., & C. Health Care Amici strongly endorse those arguments and add these points.

First, as described by both VMMC and the WDTL amicus, the proposed substantial factor test and analysis is inconsistent with both the statute and with a proper reading of Justice Pearson's opinion in *Herskovitz* and Justice Owen's opinion in *Mohr*. The Washington analysis for loss of chance retains "but for" causation as to the alleged injury: the loss of chance. It should be re-affirmed.

Second, there is no good reason to make such a fundamental shift in tort law. Moreover, it would be inconsistent with the statute and the underlying statutory principle that the legislature has pre-empted this area of the law. The Court may not legislate.

Third, the concern raised in the dissenting opinions in *Mohr*, that the majority's test for lost chance would be seen to have abandoned "but for" causation, have not been borne out, as shown by the later Court of Appeals decisions discussed in detail by the WDTL amicus. Moreover, if *Mohr* had in fact adopted a test that was less than the traditional "but for" analysis, the Dunningtons would not be complaining that they needed a change in the law.

Maintaining the *Herskovitz-Mohr* "but for" causation test for loss of chance cases is especially important when multiple providers treat a patient for a single medical condition. Health Care Amici submit that changing the causation test to the proposed substantial factor test would have a dramatically negative effect on the concept of a medical team and coordinated care to the detriment not just of the practitioners, but to patients and the overall health care system, increasing the cost of providing care and, thus reducing access.

V. CONCLUSION

Health Care Amici ask that they continue to be held accountable only for those acts or omissions for which they are actually responsible and which, in fact, injured the patient. They are committed to helping and healing their patients. Their motto is to do

no harm. If they have, in fact, done harm, they will accept the consequences. But if the harm is, in fact, caused by the patient in whole or in part, Health Care Amici submit that each person should be held accountable for their own relative contribution as is appropriate under those particular facts. The current system with "but for" causation, including for "lost chance" cases under the established case law, provides for just such an equitable and just allocation of fault and responsibility.

Health Care Amici respectfully suggest that there is no need to change the long-established rules of the health care tort system. The governing statutes have not been changed. Nor have the Dunningtons offered a convincing rationale for creating liability not provided for by the statute or prior decisions. Instead, the Court should re-affirm Justice Pearson's plurality rule in *Herskovitz* as adopted in *Mohr*, and as applied in the many subsequent Court of Appeals decisions cited by the WDTL amicus. As part of the decision, the Court should reaffirm its 1927 decision in *Brooks* and its principle that where, as here, a health care provider has established a factual basis for a contributory negligence affirmative defense based on the patient's failure to adhere to the physician's recommendations or appear for follow-up examinations, that critical part of the physician's defense must go to the jury for decision under proper instructions so the physician can ***have*** a defense and not be subjected to strict liability for a bad result he or she did not cause.

Health Care Amici respectfully ask the Court to adhere to settled law and the existing balance of responsibility it contains for the reasons set forth above.

Respectfully submitted this 6th day of September, 2016.

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the State of Washington that I am an employee at Carney Badley Spellman, P.S., over the age of 18 years, not a party to nor interested in the above-entitled action, and competent to be a witness herein. On September 6, 2016, I electronically filed a true and accurate copy of the *Brief of Health Care Amici Curiae: WSMA, WSHA, Wa-ACEP, WSRS, WSPMA* with the Washington Supreme Court via email to supreme@courts.wa.gov; and that I caused to be served a true and correct copy of the foregoing document on the below-listed attorneys of record by the methods noted below:

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DATED this 6th day of September, 2016.

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