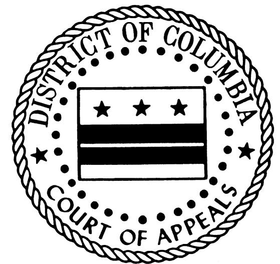

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IN THE
DISTRICT OF COLUMBIA COURT OF APPEALS

Appeal No. 22-CV-532

WASHINGTON HOSPITAL CENTER CORPORATION d/b/a WASHINGTON WOMEN'S WELLNESS CENTER AT WASHINGTON HOSPITAL CENTER,

Appellant

v.

SHANAYE BATEY, et al.

Appellee

Appeal from the Superior Court for the District of Columbia
(The Honorable Juliet McKenna)
Case No. 2019 CA 006716 M

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Counsel for Washington Hospital Center Corporation certifies that no other parties or counsel appeared in the Superior Court in this action. *See* D.C. Court of Appeals Rule 28 (a)(2)(B). Counsel further certifies that no individual has filed an amicus brief in connection with this appeal.

These representations are made so that the judges of this Court may evaluate possible disqualification or recusal.

Dated: December 23, 2022

Respectfully submitted,

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RULE 28(a)(2) CORPORATE DISCLOSURE STATEMENT

Washington Hospital Center Corporation is a not-for-profit corporation with no corporate subsidiaries. It is wholly owned by MedStar Health, Inc. *See* D.C. Court of Appeals Rule 28 (a)(2)(B).

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STATEMENT OF JURISDICTION

This appeal is from a final judgment that disposes of all parties' claims. *See* D.C. Court of Appeals Rule 28 (a)(5).

ISSUES PRESENTED

1. Medical patients have a well-established tort duty to cooperate with healthcare providers and follow their instructions during treatment. The patient here was told that she was pregnant with an abnormal ultrasound and instructed to return for further testing. Despite *twice* agreeing to comply, she never did. Following instructions either time would have prevented her death from a ruptured ectopic pregnancy. Did the trial court erroneously preclude the Hospital's contributory-negligence defense and jury instructions?

2. The District of Columbia has never found a healthcare provider's failure to warn a patient of the risks of not following instructions actionable under the informed-consent doctrine. The jury here was allowed to find the Hospital liable for not providing such a warning. Does such evidence support informed-consent liability?

3. As District of Columbia wrongful-death beneficiaries, children can recover for lost parental income and services including lost parental guidance, care, support, and education—but not for sentimental loss or grief. Here, the jury awarded Ms. Dunbar's three children $692,000 for lost parental services before awarding them $15 million more for lost parental guidance. Given the evidence and statutory limitations on recoverable damages, is the $15 million award excessive?

STATEMENT OF THE CASE

Plaintiffs filed survival and wrongful-death claims against Defendant Washington Hospital Center Corporation (the Hospital) alleging negligent treatment and failure to obtain decedent's informed consent. In April 2022, a jury found the Hospital liable under both theories and awarded Plaintiffs more than $17 million. On June 16, the Superior Court denied the Hospital's post-trial motions for a new trial and remittitur. App. 832-842. The Hospital timely noted its appeal.

RELEVANT FACTS

A. Relevant Medical History

Nurse Practitioner Sarah Belna provided gynecologic consultation to the decedent Tiffaney Dunbar on February 7, 2018, for her annual examination at the Hospital's Women's Wellness Center. Nurse Belna told Ms. Dunbar, an adult with three children, that her pregnancy test was positive but that her transvaginal ultrasound was abnormal and that she needed to return for further testing in two days. App. 280; App. 411-412, 419; App. 289-290. Ms. Dunbar agreed to do so but did not return. *See* App. 418, 465.

Upon realizing this, Nurse Belna reached Ms. Dunbar by phone, on February 13, and instructed her to appear the *next day* for the testing. App. 281. Ms. Dunbar again agreed to do so but again failed to appear. *Id.*; App. 431. Tragically, Ms. Dunbar had an ectopic pregnancy that ruptured on February 17, causing her death.

Appearing for follow-up testing, as instructed by Nurse Belna, on either February 9 or February 14 would have identified the ectopic pregnancy, prompted immediate treatment, and prevented the injury completely. *See* App. 463-464.

B. Litigation, Trial, and Verdict

Ms. Dunbar's estate and wrongful-death beneficiaries (her children) sued the Hospital for not diagnosing the ectopic pregnancy sooner and not emphasizing to Ms. Dunbar the risks of failing to follow Nurse Belna's instructions, including the risk of death. Their complaint alleged medical negligence both in the treatment that the Hospital provided and its purported failure to obtain Ms. Dunbar's informed consent. App. 15-23.

In the parties' Joint Pretrial Statement, the Hospital requested D.C. Standardized Civil Jury Instruction 9.11, Patient's Contributory Negligence. App. 59. In response, Plaintiffs moved in limine to preclude evidence that Ms. Dunbar twice failed to appear, as instructed, for follow-up testing. App. 6. Erroneously viewing the pre-trial record as uncontested that "Nurse Belna never informed Ms. Dunbar . . . that her ultrasound was abnormal," the court precluded the Hospital from arguing contributory negligence in its opening statement, pending further development of the factual record at trial. App. 107, 109-110.

The court did not categorically rule out the "possibility" of instructing the jury on contributory negligence if the trial evidence created "a contested issue as to

what a reasonable person in Ms. Dunbar's position would have done in the exercise of reasonable care for her own safety." App. 108. But it warned that it was "unlikely" to allow the Hospital to argue contributory negligence in closing unless the evidence showed that Ms. Dunbar had been informed that an ectopic pregnancy could be fatal. App. 108, 110.

The evidence at trial was clear—even undisputed—that Nurse Belna explicitly told Ms. Dunbar that her sonogram was abnormal and then instructed her, twice in six days, to return for additional testing.

Nurse Belna testified about her standard practice for patients with abnormal sonograms. During the test, she speaks constantly with the patient about what she sees. When the sonogram is abnormal, she discloses ectopic pregnancy as one of four possible scenarios. App. at 419-410, 453-454. She testified that she would never tell a patient in these circumstances that she could defer follow-up testing. App. at 433-434. Instead, Nurse Belna instructed Ms. Dunbar to have additional testing in follow-up to her abnormal sonogram to be completed on February 9. App. at 463. After Ms. Dunbar failed to appear on February 9, Nurse Belna spoke with Ms. Dunbar on February 13 and again instructed her to be tested the next day on February 14. App. at 431. Ms. Dunbar did not object to further testing yet did not follow Nurse Belna's instructions either time. *Id.*; *see also* App. at 857-875.

Nurse Belna's testimony and the medical records were corroborated by a second witness. Nurse Belna's medical assistant unambiguously testified that she heard Nurse Belna directly telling Ms. Dunbar that she needed to return for testing on February 9. App. at 289-290. Although the Court erroneously thought that contributory negligence should be implicated only if Nurse Belna explicitly told Ms. Dunbar that an ectopic pregnancy could rupture or be fatal, Nurse Belna did not believe it was necessary to frighten the patient. App. at 466. Nurse Belna was satisfied that the patient would return for testing, as she had twice agreed to do.

When the evidence closed, the Hospital renewed its request to argue contributory negligence. App. at 664-665. The court recognized that Nurse Belna had testified that it was her habit and practice to speak constantly with the patient about what she was seeing while performing a sonogram. App. at 668. Thus, a reasonable factfinder could infer that Nurse Belna told Ms. Dunbar that she saw a questionable gestational sac, her ultrasound was abnormal, and an ectopic pregnancy was possible. App. at 671. But the court improperly disregarded the testimony when noting that (1) "at no time did [Nurse Belna] utter words ectopic pregnancy or rupture" and (2) "beyond the standard spontaneous abortion precautions" she did not "[g]ive her any other reason to believe that returning back to the clinic in 48 or even 96 hours was imperative because of the potential risk it posed to her health." App. at 669.

Relying on a "higher hurdle to put a contributory negligence defense in a medical malpractice case," the court concluded that the evidence was insufficient to even raise the question and precluded the Hospital from arguing contributory negligence to the jury in its closing. App. at 672. The next day, during arguments on jury instructions, the court noted its "continued ruling on contributory negligence" and affirmed that it had "precluded a contributory negligence defense." App. at 698-699, 733. The court prepared the final jury instructions, which omitted the Hospital's requested instruction on contributory negligence. *See* App. at 747-767.

After hearing the parties' arguments about permissible closing argument on non-economic damages under the evidence, the court compounded its error by allowing Plaintiffs to make an improper "*Colston* argument." It warned Plaintiffs that they needed to "tow a very fine line," advising them not to usurp the role of the jury or the evidence when "making the arguments about the appropriate award of damages." App. at 694.

With this seam opened, Plaintiffs argued in closing:

> Loss of parental guidance is exactly what the instruction tells you. Its loss of what a parent does . . . So these are things like, for [TJD], who's going to be the tooth fairy. Not her mom. For [JD] when he wins his first baseball tournament. Is he going to turn around to see his mom cheering him on in the stands? No.
>
> For [TAD] when she got her period her mom wasn't there. When [TAD] goes to a special dance routine and wants to have help with

> her costume she doesn't have her mom there to help her out. When [JD] needs help with his anger and his tutoring after school when he's tired. You heard Shanaya say Tiffaney had a way of singing his special song. Something that a mother would do.
>
> How about holidays, first dates, driving a car, getting married, having a baby, holidays. That's what we're trying to replace. We can't get Tiffaney back. 'She was taken but we can balance the harm. And as I said, that number is completely up to you.
>
> Some of you might think $3 million for each child would be fair. Some of you might think $10 million might be fair. Some of you might think more. That's completely up to you ladies and gentlemen. I would just ask you to use your collective wisdom about what it's like to have a parent and what's it's like not to have a parent. Because for [TAD], [JD] and [TJD] they can't get her back.

App. at 802-803.

On April 6, 2022, the jury returned its verdict awarding Plaintiffs more than $17 million. The verdict included $5,000,000 to *each* of the three minor children for lost parental guidance, care, support, and education. This was added to awards of $915,000 for lost wages, $692,000 for loss of services, and $500,000 for Ms. Dunbar's pain and suffering. App. at 825-827. In other words, the $15 million was awarded *only* for lost "parental guidance, care, support, and education"—not for lost wages, not for lost services, and not for Ms. Dunbar's own pain and suffering related to her ruptured ectopic pregnancy. Although instructed *not* to render an award for the children's grief or sentimental loss of their mother, the jury plainly did so with the $15 million award for lost "parental guidance, care, support, and education."

C. Post-trial Motions and Rulings

After the verdict, the Hospital moved for a new trial or remittitur. *See* Def.'s 5-4-22 Mot. for new trial and Mot. for new trial or remittitur. Plaintiffs opposed the motions, and the Hospital filed a combined reply. Pls.' 5-18-22 Omnibus Opp.; Def.'s 5-25-22 Combined Reply. On June 16, the Superior Court issued its eleven-page opinion denying every argument in the Hospital's post-trial motions. App. at 832-842.

In its June 16 opinion, the court recognized that "whether the Defendant was permitted to present a defense of contributory negligence during trial was the subject of exhaustive pretrial briefing, argument, and a detailed oral ruling" on March 17. App. at 835. The court explained that it "initially precluded the Defendant from opening on a theory of contributory negligence and reserved ruling on whether the Defendant would be permitted to submit this theory to the jury following full development of the factual record at trial." App. at 835-836. At the close of the evidence, the Hospital renewed its request to argue contributory negligence. The court denied it, "concluding as a matter of law that the evidence remained insufficient for a reasonable juror to find that the decedent knew or should have known of the risk of ectopic pregnancy or the potential consequences of not returning for a further blood test, including death." App. at 836. For these reasons, "the Court declined to instruct the jury on this affirmative defense." *Id.*

On informed consent, the "Court overruled Defendant's objection to the informed consent instruction and a separate informed consent finding on the verdict form" because the complaint leveled an informed-consent claim. App. at 836-837. The court noted that the Hospital had not challenged the "validity or sufficiency" of the informed-consent claim during the trial and suggested that the time for doing so had passed. App. at 837. It found that the "evidence elicited at trial was more than sufficient to submit this claim to the jury." *Id*.

On damages, the court was "satisfied that nothing about the jury's verdict shocks the conscience, and that no improper arguments by counsel or erroneous evidentiary or instructional rulings by the court warrant reduction of damages or a new trial." App. at 833-834. Plaintiffs' post-trial brief ironically justified the $15 million award as reflecting that "the jury's findings flow[ed] from the grievous loss" suffered by the decedent's children—exactly the type of recovery that the Act does not allow. *See* Pls.' Opp. at 38 (emphasis added). The court disagreed that Plaintiffs had invited the jury to award damages for grief, mental anguish, or sentimental loss. It reasoned that the jury did not do so because it was instructed not to award such damages. App. at 839-840. On the excessiveness of the record-setting award, Judge McKenna found that the verdict did not shock the conscience but that it was merely "near the top of the acceptable range." App. at 841-842.

ARGUMENT SUMMARY

First, the Hospital was improperly prevented from presenting its defense of contributory negligence. In wrongful-death and survival actions, Plaintiffs cannot recover if the decedent was contributorily negligent. The uncontested facts of this medical-negligence action show contributory negligence as a matter of law. Patients have a well-recognized duty to follow medical instructions and cooperate with treatment. But the patient here repeatedly failed to follow clear medical instructions—even after being reached by phone and agreeing to comply—resulting directly in her death.

The trial court erroneously held that this evidence does not even *raise a triable question* of contributory negligence unless the patient subjectively knew the risks of noncompliance, and it refused to instruct on the issue. These fundamental legal errors denied the Hospital a fair trial. They require, at minimum, a new trial on liability and damages where the Hospital can fairly defend itself.

Second, the informed-consent claim should not be re-tried because no evidence supports it. Plaintiffs fault the Hospital for not warning the patient that not following medical instructions is risky. But the informed-consent doctrine has never required such warnings, especially for patients who agree to comply. At most, Plaintiffs' theory would support the claim of negligent medical treatment.

Third, the $15 million award for lost parental guidance, care, support, and education is excessive as a matter law. The jury, after awarding the decedent's three children $692,000 for lost parental services, inexplicably added three $5 million awards, ostensibly for each child's lost parental guidance, care, support, and education. The D.C. Wrongful Death Act has never supported such extreme awards for lost parental guidance. And no evidence supports the $15 million award here. The jury, inflamed by improper arguments, awarded damages for grief and sentimental loss. Yet, such non-pecuniary losses are not compensable under the Act, which is in derogation of common law and strictly construed.

The entire award should be vacated with orders for a new trial limited to the negligent-treatment claims.

ARGUMENT

I. The trial court denied the Hospital a fair trial by precluding its arguments on contributory negligence and refusing to instruct the jury on the defense.

A. Medical patients have a duty to cooperate and follow their healthcare providers' instructions.

It is well-settled in the District that a medical "patient has a **duty to cooperate** with her doctor in proper diagnosis and treatment."[1] Patients owe this duty of cooperation to *themselves* for their own health and safety. This Court's *Stager* (1985) and *Nelson* (1997) precedents explain that patients cannot reasonably be expected to know what their professionally trained health care providers would know.[2] So they are reasonably expected to listen to their healthcare providers and *follow their instructions*.[3] Injured patients are contributorily negligent—at times even as a matter of law—when they do not follow medical instructions that, if followed, would have prevented their injuries. That is plainly the case here.

Plaintiffs' post-trial briefing has already quoted the holdings that defeat their argument that the evidence at trial raised no triable question of Ms. Dunbar's contributory negligence. They concede—as they must—that, "in the District of

[1] *See Stager v. Schneider,* 494 A.2d 1307, 1312 (D.C. 1985).

[2] *See id.*; *Nelson v. McCreary*, 694 A.2d 897 (D.C. 1997).

[3] *See Stager*, 494 A.2d at 1312.

Columbia, [1] patients are under a duty to themselves to follow their doctors' instructions and provide information requested by their doctor to facilitate their health care" and (2) "a patient has a duty to cooperate with her doctor in proper diagnosis and treatment." Pls.' Opp. to Post-Trial Motions at 3 n.11.[4] The trial court similarly recognized at its pre-trial hearing that, in "the District of Columbia, patients are under a duty to themselves to follow their doctor's instructions and provide information requested by their doctors to facilitate their health care." App. at 106.

The rule is fair and reasonable. For ordinary people, rejecting or ignoring doctors' instructions is *per se* "unreasonable conduct" that naturally increases health risks. It undeniably did so here.

Despite recognizing the holdings that doom their appellate arguments, Plaintiffs want to muddy the analysis with inapt arguments and case law. Plaintiffs argued to the trial court that Ms. Dunbar—after being directly instructed on February 7 that she needed to return on February 9, and then reached by phone on February 13 and told to return on February 14—somehow had "**no inducement** to return promptly." Pls.' Opp. to Post-Trial Motions at 5 (emphasis added).

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[4] Quoting *Burton v. United States*, 668 F. Supp. 2d 86, 108 (D.D.C. 2009); *Stager v. Schneider*, 494 A.2d 1307, 1312 (D.C. 1985).

The argument fails on many levels. First, an instruction *is* an inducement. Even if one accepts the false premise that contributory negligence requires evidence of "inducement," a jury could reasonably find that a professional healthcare provider's repeated instructions to return for testing on fixed dates are, in fact, an inducement to return on those dates. More fundamentally, no authority holds or even suggests that a patient's duty to follow instructions does not arise unless the instructions are sweetened with some extra "inducement."

Defeated by controlling law on a patient's duties to cooperate and follow instructions, Plaintiffs argue against inapt, nonexistent duties. No one disputes that the patient's duty to follow instructions does not extend to a duty to self-diagnose complex medical conditions or anticipate remote complications that no lay person would be expected to understand on their own. No one is trying to impose these nonexistent duties on Ms. Dunbar. Only her well-established duties to cooperate with her healthcare provider and follow medical instructions are at issue.

Controlling precedents establish the reasonable boundaries of a patient's duty to cooperate and follow instructions and show that Ms. Dunbar breached her duty. The *Stager* decision affirmed that patients have a duty to cooperate with their doctors. It then rejected—as a "quantum leap" of logic—the medical defendant's argument that a patient's duty to follow instructions includes a purported duty to call a radiologist to confirm that chest x-rays taken in preparation for her *foot*

surgery did not indicate lung cancer.[5] *Stager* distinguished the defendant's argument, which had no legal basis, from the controlling precedents and its other cited cases that "deal with patients' failure to follow instructions."[6] The cases with patients who—like Ms. Dunbar and unlike the *Stager* plaintiff—did not follow medical instructions required a contributory-negligence instruction.

Similarly, the *Nelson* decision found no basis for a contributory-negligence instruction when the surgical patient, unaware that a colostomy would be safer if placed on his right side, had merely "requested . . . that the colostomy remain on the left side, so that only one side of his abdomen would be disfigured."[7] The *Nelson* patient's innocent request formed no legal or factual basis for a contributory-negligence instruction when serious complications later arose from the left-side placement. Nothing in these cases casts doubt on Ms. Dunbar's unambiguous duty to *follow Nurse Belna's instructions* to return for testing.

Instead, the precedents stand for the unremarkable proposition that healthcare providers' expertise may impose on them a duty that, in some respects, may exceed even the patient's duty to herself.[8] So, for example, a patient's

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[5] *Stager*, 494 A.2d at 1312.

[6] *Id*.

[7] *Nelson*, 694 A.2d at 904.

[8] *See Morrison v. McNamara*, 407 A.2d 555, 567-68 (D.C. 1979).

seemingly innocuous symptoms (e.g., temporary headaches or dizziness) might impose a duty on the doctor—but not the patient—to act. But, here, the patient *did not follow clear instructions* from her nurse practitioner or do what she told her nurse practitioner she would do—twice in a matter of days. Such actions epitomize contributory negligence by a patient.

A patient's fundamental duty to cooperate and follow medical instructions or be deemed contributorily (or comparatively) negligent is enforced beyond the District, in Maryland (and many other jurisdictions). *Chudson v. Ratra* and other influential Maryland decisions have expressly "adopted the principle expressed in 70 C.J.S. *Physicians and Surgeons* § 80(c)" that a "patient who, after receiving treatment, fails to return to the physician or surgeon for further treatment, as instructed, is *guilty of contributory negligence preventing recovery* for injurious consequences from such failure."[9] But Plaintiffs' post-trial briefing resisted this relevant case law with the uncontested point that Maryland law is not binding precedent in the District. This deflection ignores the special relevance of Maryland law to this Court.

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[9] *See Smith v. Pearre*, 96 Md. App. 376, 393-94 (1993) (emphasis added); *Chudson v. Ratra*, 76 Md. App. 753, 773-74 (1988); *see also Thomas v. Wash. Indus. Med. Ctr., Inc.*, No. 98-1652, 1999 U.S. App. LEXIS 16771, at n.5 (4th Cir. July 19, 1999) (affirming judgment as a matter of Maryland law against patient who failed to return for follow-up care as instructed by nurse).

When D.C.'s common law is silent on a legal question, relevant common-law decisions from Maryland appellate courts are "authoritative." The "District derives its common law from Maryland and decisions of Maryland courts on questions of common law are authoritative in the absence of District authority."[10] This Court's 1993 *C.A.P.* opinion explains that, although Maryland appellate decisions are not binding precedent in the District of Columbia, Maryland common-law jurisprudence is "the most authoritative body of law other than our own precedent."[11]

B. The patient's duty to follow instructions is not conditioned upon the patient's subjective belief that non-compliance is dangerous.

The trial court fundamentally erred by adding a new pre-condition to patients' common-law duty to follow their doctors' instructions and cooperate with diagnosis and treatment: subjective knowledge of the risks of non-compliance. It found contributory negligence irrelevant because "the evidence remained insufficient for a reasonable juror to find that the decedent knew or should have known of the risk of ectopic pregnancy or the potential consequences of not returning for a further blood test, including death." App. at 836. But that is simply not the standard required to raise a contributory negligence defense when the

[10] *Solid Rock Church v. Friendship Pub. Charter Sch., Inc.*, 925 A.2d 554, 560-61 (D.C. 2007) (citing *In re C.A.P.*, 633 A.2d 787, 790 (D.C. 1993)).

[11] 633 A.2d at 790.

patient does not cooperate in her treatment or follow her healthcare provider's clear instructions. The patient's subjective knowledge of risk is relevant only to an assumption-of-the-risk defense—which is not at issue here.

Plaintiffs' post-trial briefing proposed two nonexistent exceptions to a patient's duty to cooperate and follow a healthcare provider's instructions. First, they argued that a patient has no duty to follow medical instructions, even crystal-clear ones, when she merely receives them without also subjectively believing that she is in danger or that non-compliance is risky. *See* Pls.' Opp. to Post-Trial Motions at 2-6. Second, Plaintiffs argued that a patient's duty to follow instructions arises only if she is told that compliance is "urgent." *See id*. at 4.

No case recognizes either exception. A patient's duty to cooperate and follow her professional healthcare providers' instructions is unconditional. It does not require the patient's subjective belief that noncompliance risks her life or an express warning that ignoring her doctors' instructions would be dangerous. Ms. Dunbar had a duty to cooperate and follow Nurse Belna's instructions during pregnancy, even without knowing the particular risks of ectopic pregnancies.[12]

Nor does a patient's self-duty arise only when she is told that compliance is "urgent." As Plaintiffs see it, instructing a patient that she has an abnormal sonogram and "needs to return" one or two days later means nothing, even if she

[12] *See Stager v. Schneider,* 494 A.2d 1307, 1312 (D.C. 1985).

agrees to comply, unless she is instructed that there is an "*urgent* need to comply." *See id*. at 4. That is not the law. Only a jury could decide whether an instruction that she "needs to return" was sufficient.

So how did the trial court get it so wrong? Both the trial court and Plaintiffs concede that patients have a duty to follow medical instructions. And the trial court recognized that it could keep contributory negligence from the jury "only if . . . no reasonable finder of fact could find contributory negligence" by Ms. Dunbar. App. at 99. But the court misconstrued the *Durphy* precedent as authorizing the court to *reject* contributory-negligence instructions unless evidence also showed that the patient knew that non-compliance was risky.[13] App. at 107-110.

Durphy does not stand for that; it *favors* jury instructions on contributory negligence and having the jury decide the question. It reversed the trial court's judgment as a matter of law for the defendant primarily because of *causation*; it was disputed whether the patient's negligence had even *contributed* to his injury. The *Durphy* Court explained that whether "any negligence on Mr. Durphy's part proximately resulted in the amputation of his foot was the subject of conflicting evidence, **requiring the jury to weigh it**, draw reasonable inferences from it, and

[13] *See Durphy v. Kaiser Found. Health Plan of Mid-Atlantic States*, 698 A.2d 459 (D.C. 1997).

resolve the disputed issues."[14] Here, no one can dispute that Ms. Dunbar would be alive today if she had followed Nurse Belna's instructions either time.

Nothing in *Durphy* justifies rejecting a contributory-negligence instruction when a patient with an "abnormal" pregnancy twice failed to follow her healthcare provider's instructions for follow-up testing. Besides recognizing that conflicting causation evidence precluded summary judgment, the *Durphy* court explained that evidence that Mr. Durphy was sometimes non-compliant with medical instructions did not require judgment for the hospital as a matter of law because (1) he denied receiving some of the instructions and (2) there was "substantial evidence that Mr. Durphy made a significant effort to be treated."[15] It explained that Mr. Durphy saw his doctors twenty times over a three-month period, including a five-day hospitalization. He had also lost confidence in his care providers because months of regular appointments and treatments had yielded no relief.[16] He testified that his doctors did not listen to him and did not explain the risks that he faced.[17] The *Durphy* court reasoned that, under such circumstances, it was *for the jury* to decide

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[14] 698 A.2d at 466 (emphasis added).

[15] *Id.* at 468.

[16] *Id.* at 464.

[17] *Id.* at 468.

whether Mr. Durphy acted unreasonably in declining his doctors' instructions to continue seeing them for additional treatment.[18]

Plaintiffs are left with one line of dicta from *Durphy*, which relies on *Morrison v. McNamara* and conflates the doctrines of contributory negligence and assumption of the risk. *Durphy's* dicta states that a patient's limited knowledge "may negate the critical elements of the defense of contributory negligence, specifically the knowledge and appreciation of the risks and dangers associated with certain medical treatments."[19] But that misstates the reasoning of *Morrison*—an assumption-of-the-risk case—and ignores *Morrison's* explanation that patients generally "cannot *assume the risk* of negligent treatment."[20]

This Court's precedents in *Rotan v. Egan* and *Morrison* also do not support the argument that Ms. Dunbar's presumed ignorance of the risk of ectopic pregnancy (despite Nurse Belna's testimony and Ms. Dunbar's three prior completed pregnancies) so completely negates her contributory negligence that jurors cannot even consider it. *Morrison* addressed the propriety of a jury instruction on assumption of the risk—contributory negligence was not even at issue on the appeal. It recognized, among other things, that a patient's ignorance of

[18] *Id.* at 467.

[19] 698 A.2d at 465 (citing *Morrison v. McNamara*, 407 A.2d 555 (D.C. 1979)).

[20] *See Rotan v. Egan*, 537 A.2d 563, 567 (D.C. 1988) (emphasis added); *Morrison*, 407 A.2d at 567.

risks that his doctors knew of "negates the critical elements" of the *assumption-of-the-risk* defense, "i.e., knowledge and appreciation of the risk."[21]

The confusion all stems from ill-considered dicta in footnote 11 of the *Morrison* decision. The footnote cited a 1972 student Note in the Cleveland State Law Review for the ambiguous one-sentence proposition that the "same principles are equally valid with respect to the defense of contributory negligence in medical malpractice."[22] *Morrison* never defines what these "same principles" are. Nor does the 1972 Note. Add. at 1-8. The citation leads nowhere.

The trial court apparently misread the *Morrison* footnote to mean that patients, who generally "cannot assume the risk of negligent treatment," also cannot *negligently contribute* to negligent treatment. The error is profound and fundamental. That is *exactly* what a contributorily negligent patient does.

Although the *Rotan* decision addresses contributory negligence, it still does not help Plaintiffs. Affirming a defense verdict for Ms. Rotan's physicians, the *Rotan* appeal addressed contributory-negligence jury instructions and arguments in a medical-negligence action involving an infected heart valve.[23] There was no evidence (or even proffer) that Ms. Rotan had not followed her physicians'

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[21] 407 A.2d at 567.

[22] *Id.* at 568 n. 11.

[23] 537 A.2d. at 564.

instructions, and it was undisputed that she had told her doctors that she had a heart murmur.[24] The trial court properly precluded arguments that Ms. Rotan was contributorily negligent for not self-diagnosing her heart-valve infection and contacting her physicians even earlier than she had. And the court held that any erroneously admitted testimony that had "raised the spectre of contributory negligence" was harmless.[25]

Here, no evidence would support any remotely comparable argument by Ms. Dunbar. And, if it did, it would create only a jury question on contributory negligence—not a bar to jurors even considering the question. Although Plaintiffs may have had an evidentiary basis to argue that Ms. Dunbar was not aware of the risk of having an ectopic pregnancy, Nurse Belna's testimony gave jurors a sound basis to find that she was aware.

More important, Ms. Dunbar's awareness level is ultimately immaterial because the jury had clear evidence that Ms. Dunbar (1) was twice instructed to return for testing and (2) never objected to further testing. Nor was there any evidence that she had lost confidence in Nurse Belna such that declining her instructions to undergo additional pregnancy testing would have been *per se* reasonable. The failure to follow instructions creates a jury question by itself.

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[24] *Id.* at 566.

[25] *Id*. at 567.

The court's ruling erroneously made it *per se* reasonable for Ms. Dunbar to not follow clear medical instructions to promptly return for testing after twice agreeing to do so. It failed to follow its own pre-trial ruling that contributory negligence would be relevant if the evidence created "a contested issue as to what a reasonable person in Ms. Dunbar's position would have done in the exercise of reasonable care for her own safety." App. at 108. Not following instructions for follow-up testing—even after Nurse Belna called her directly to remind her to do so—if not a breach as a matter of law, certainly creates a jury question of whether it was reasonable for Ms. Dunbar to do so in exercise of self-care.

C. The Hospital was entitled to present its evidence and argument on contributory negligence.

The fundamental legal error of precluding evidence or argument on contributory negligence requires a new trial. Even after extensive post-trial briefing, Plaintiffs have yet to present a case where a court held—as a matter of law—that harmful non-compliance with medical instructions *during* a course of treatment created no factual question of contributory negligence for jurors. The relevant cases show that the court cannot decide for itself that Ms. Dunbar's decision not to follow Nurse Belna's instructions—twice in six days—even after agreeing to do so, was *per se reasonable* conduct. *See* Pls.' Opp. to Post-Trial Motions at 5-8. That factual determination belongs to the jury, especially given the low threshold for jury questions.

Plaintiffs' only cited D.C. appellate decision that rejects a defendant's argument for a contributory-negligence instruction because the plaintiff's conduct was *per se* reasonable involved a pedestrian struck *in a crosswalk* by the defendant's car. The *Asal* pedestrian entered the crosswalk only after (1) looking both ways, (2) waiting for cars to stop, and (3) making eye contact with and waving to the driver of the fully stopped car. *See id*. at 11 n.28[26] *Asal's* facts simply did not implicate contributory negligence when a second car passed the stopped car and hit the pedestrian.[27] *Asal* does not immunize Ms. Dunbar's contributory negligence from fair scrutiny by the jury.

Nor can Plaintiffs get any traction from case law that finds no contributory negligence when a patient is non-compliant only *after* treatment has ended. The timing of a patient's non-compliance with instructions is crucial because Ms. Dunbar failed to follow Nurse Belna's instructions *during* a course of treatment and case law recognizes that (1) patient non-compliance *after* treatment has ended goes to mitigation of damages rather than contributory negligence. *See* Pls.' Opp. to Post-Trial Motions at 13 n.33.[28] The *Durphy* court explained that most "courts

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[26] Citing *Asal v. Mina*, 247 A.3d 260, 276 (D.C. 2021).

[27] *See* 247 A.3d at 275-77.

[28] Citing *Andrews v. Carr*, 135 N.C. App. 463, 521 S.E.2d 269 (1999) ("Assuming the post-surgery activities of Plaintiff did contribute to his injuries, they cannot constitute contributory negligence because these activities occurred *subsequent* to Dr. Carr's negligent treatment. Any injuries Plaintiff caused to himself as a result

appear to hold that contributory negligence for a patient's non-compliance with medical treatment decisions will bar recovery completely only if the patient's negligent acts are contemporaneous with the physician's negligent acts."[29]

To date, the only case that either party has found that finds no contributory negligence for non-compliance *during* a course of treatment is the 1987 *Lauderdale* decision from Alabama.[30] But *Lauderdale* was a "nonjury trial" where the judge—as the factfinder—found that the injured veteran who was mistreated in an overcrowded V.A. hospital was not contributorily negligent. The Federal Tort Claims Act claim was resolved based "upon the evidence presented at a nonjury

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of his failure to follow Dr. Carr's post-negligence treatment advice are properly considered in mitigation of his damages and cannot constitute a bar to the claim. The trial court, therefore, properly allowed Plaintiff's motion for directed verdict on Defendants' defense of contributory negligence and properly instructed on mitigation of damages."); *Sawka v. Prokopowycz*, 104 Mich. App. 829, 306 N.W.2d 354 (1981) (rejecting smoking as contributory negligence in failure-to-diagnose lung cancer case); *Dunn v. Catholic Med. Ctr., Inc.*, 55 A.D.2d 597, 389 N.Y.S.2d 123 (App. Div. 2nd Dept. 1976) ("the alleged improper professional treatment occurred *prior to* the patient's own negligence"); *Heller v. Medine*, 50 A.D.2d 831, 377 N.Y.S.2d 100 (App. Div. 2nd Dept. 1975) (holding that when "the alleged improper professional treatment occurred prior to the patient's own negligence," the "damages are reduced to the degree that the plaintiff's negligence increased the extent of the injury").

[29] 698 A.2d at 467.

[30] *Lauderdale v. United States*, 666 F. Supp. 1511 (M.D. Ala. 1987).

trial."[31] None of this supports the trial court's decision barring argument and instructions on contributory negligence.

Exploring every legal theory possible to absolve the trial court of its error, Plaintiffs have also strained to cast Ms. Dunbar's injury as unforeseeable as a matter of law or not proximately caused by her non-compliance. But, again, Plaintiffs' argument comes apart when they disclose the controlling legal standard. They necessarily concede that contributory negligence requires evidence only that Ms. Dunbar's negligence was "a *substantial factor* in causing [her] injury, *and* that the injury or damage was *either* a direct result or a reasonably probable consequence of the negligent act or omission." Pls.' Opp. at 2 (emphasis added).[32]

That is exactly what the Hospital's evidence showed. Ms. Dunbar's non-compliance with Nurse Belna's instructions was (1) a substantial factor in her injury, which (2) directly resulted from her non-compliance. Ignoring the repeated instructions of her nurse practitioner for monitoring of her pregnancy led directly to a pregnancy-based injury. The injury would have been prevented by compliance with the pregnancy-related instructions. That is not "unforeseeable" harm or harm unrelated to Ms. Dunbar's breach of her duty to follow instructions for managing her pregnancy.

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[31] *Id*.

[32] Quoting *Durphy*, 698 A.2d at 465.

D. The Hospital was entitled to a jury instruction on contributory negligence.

The Hospital's right to defend itself with evidence and argument on contributory negligence also entitled it to a jury instruction on contributory negligence. The threshold evidentiary showing is whether the patient was instructed by her healthcare provider to return for further treatment and failed to return or even object to returning—not whether the patient understood the medical risks that flowed from her decision. By denying the jurors any opportunity to consider Ms. Dunbar's contributory negligence, the trial court essentially found it *per se* reasonable for a patient to *not* follow repeated instructions to return for treatment if the patient does not subjectively believe that failing to follow instructions may harm her. The decision to deny a jury instruction on contributory negligence was prejudicial error that, at minimum, requires a new trial.

The Court of Appeals has been clear on this point: "Generally a party is entitled to a jury instruction upon the theory of the case if there is sufficient evidence to support it."[33] The *Waas* decision warned that, "when the meaning of a request for an instruction is reasonably apparent, and its subject-matter is important and not sufficiently covered by the general charge, a court would not be justified in

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[33] *George Washington Univ. v. Waas*, 648 A.2d 178 (D.C. 1994); *see Scoggins v. Jude*, 419 A.2d 999 (D.C. 1980); *Hall v. Carter*, 825 A.2d 954 (D.C. 2003).

ignoring the request."[34] Citing the "widely recognized" and "general principle of a patient's duty to cooperate in medical treatment," *Waas* saw "no reason why trial courts should be reluctant in instructing a jury to incorporate this principle in appropriate cases."[35]

The *Waas* trial court withstood appellate scrutiny by giving jurors a three-paragraph instruction on contributory negligence that correctly stated the law. The Court of Appeals affirmed the plaintiff's verdict because, in part, the jury instructions included the doctrine's crucial elements:

> Contributory negligence is negligence on the part of the person injured which combined in some degree with the negligence of another proximately causes the injury of which the injured party complains. A person is contributorily negligent if he fails to act with the reasonable prudence which would [be] exercised by an ordinary, reasonable person under the circumstances. *Any degree of contributory negligence bars a plaintiff's recovery*.[36]

The same reasoning controlled in *Dennis v. Jones*, which also affirmed a plaintiff's verdict because the trial court had instructed the jury on contributory negligence in terms that "clearly conveyed the essence of the defense," namely that patient was

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[34] 648 A.2d at 183 (cleaned up) (citing *Montgomery v. Virginia Stage Lines, Inc.,* 191 F.2d 770, 772 (D.C. Cir. 1951)).

[35] *Id.* at 185.

[36] 648 A.2d at 183-84 (emphasis added).

responsible for her own injuries because she failed to comply with her surgeon's instructions to quit smoking.[37]

Both before and after issuing *Waas*, the Court of Appeals has repeatedly affirmed a party's right to a jury instruction on contributory negligence when *any* evidence supports the instruction.[38] The landmark *Scoggins* decision reversed a plaintiff's verdict for a tenant injured by a falling ceiling because the trial court had declined the defendant's request for a contributory-negligence instruction. Denying the instruction was reversible error because there was evidence that the tenant had hung a plant from the part of the ceiling that fell.

The same principle applies in medical-negligence cases. *Hall* squarely rejected the patient's argument that the trial court should not have instructed the jury on her contributory negligence for smoking while trying to heal from surgery. The plaintiff considered the instruction unwarranted because her physician did not tell her to stop smoking but had only "casually inform[ed]" her "that he preferred she stop smoking, and that she at least should cut back for the surgery because smoking was not good for wound healing."[39]

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[37] 928 A.2d 672, 679 (D.C. 2007).

[38] *See Scoggins v. Jude*, 419 A.2d 999 (D.C. 1980); *Hall v. Carter*, 825 A.2d 954 (D.C. 2003).

[39] 825 A.2d 954 (D.C. 2003).

Plaintiffs and the trial court have yet to cite a case where the defendant had evidence that the patient did not follow medical instructions and thereby suffered harm but the jurors properly received no instruction on contributory negligence. The cases repeatedly go the other way or hold that the defendant is entitled to judgment in its favor. Besides the District of Columbia cases cited above, cases from across the country reaffirm that this case presented, at minimum, a jury question on contributory negligence and the refusal to instruct the jury on contributory negligence requires a new trial:

> *Maryland*: "Maryland law requires 'the submission of *even meager* evidence [of contributory evidence] to the jury'"[40]

> *California*: "It is hornbook law that each party to a lawsuit is entitled to have the jury instructed on all of his theories of the case that are supported by the pleadings and the evidence. It is incumbent upon the trial court to instruct on all vital issues involved. Contributory negligence is a basic defense in a personal injury action. A trial court, where there is evidence to support such a defense, may not, by refusing to instruct on it, deprive a party of this defense. If it does, the error in refusing to instruct on it is **obviously prejudicial** in any case where the evidence admitted in support of the defense, if believed, would support a verdict in favor of the complaining party. Where the evidence on the issue of contributory negligence is conflicting, and would support a finding either way, the question is one of fact and not of law, and must be decided by the trier of the facts. Thus, the basic question presented in this case is whether or not there was evidentiary support for the defense of contributory negligence. If there was such support, it was **prejudicial error not to have given the proffered instructions**."[41]

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[40] *Hopkins v. Silber*, 141 Md. App. 319, 785 A.2d 806 (2001) (emphasis added) (quoting *Chudson v. Ratra*, 76 Md. App. 753, 769-770, 548 A.2d 172 (1988)).

[41] *Schliesman v. Fisher*, 97 Cal. App. 3d 83, 158 Cal. Rptr. 527 (1979) (emphasis

Florida: "The defendant raised the issue of comparative negligence by asserting that the plaintiff violated her physician's instructions, given in the course of treatment, and that such noncompliance with her physician's instructions played a part in her ultimate injury."[42]

Georgia: "It is proper to charge contributory and comparative negligence in a medical malpractice case where, as here, there is evidence indicating that the procedure complained of was negligently not performed would have been performed had [the patient] followed Nurse Staten's instructions . . . ."[43]

New York: "In the case at bar the trial court declined to charge the jury, as requested by appellant, that it should consider, in mitigation of damages, whether negligence on the part of the plaintiff subsequent to the alleged malpractice contributed to her injuries. That **error is so prejudicial that reversal would be required in the interests of justice** even if appellant had not timely excepted. While a patient is justified in disregarding instructions which are improper, the patient has the duty to exercise reasonable care. On this record, the appellant physician was entitled to have the jury consider, in mitigation of damages, whether there was any negligence on the part of plaintiff or her doctors subsequent to the alleged malpractice."[44]

Pennsylvania: "Thus, the evidence of Zieber's comparative negligence was the testimony of Dr. Bogert that he had recommended the C-T scan and that Zieber had refused to undergo the test. Because **even minimal evidence** of comparative negligence **requires** a charge on the issue when requested, and Appellants had requested such an instruction, we hold that the trial court should have given an appropriate jury instruction on comparative negligence and that its **failure to do so is**

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added) (without internal citations).

[42] *Nordt v. Wenck*, 653 So. 2d 450 (Fla. Dist. Ct. App. 1995); *see also Musachia v. Rosman*, 190 So. 2d 47, 49 (Fla. 3d DCA 1966).

[43] *DeVooght v. Hobbs*, 265 Ga. App. 329, 593 S.E.2d 868 (2004).

[44] *Dunn v. Catholic Med. Ctr., Inc.*, 55 A.D.2d 597, 389 N.Y.S.2d 123 (App. Div. 2nd Dept. 1976) (emphasis added) (without internal citations).

> **reversible error**. [citation] Accordingly, we are constrained to reverse and remand for a new trial."[45]

The overwhelming weight of authority holds that, when a patient is harmed by failing to follow her healthcare provider's instructions for follow-up testing, the court's denial of a contributory-negligence instruction is prejudicial error that requires a new trial.

II. The evidence at trial does not support informed-consent liability.

A. The informed-consent doctrine does not require warnings of the risks of non-compliance with medical instructions.

The informed-consent doctrine requires healthcare providers to inform their patients of the risks, benefits, and likelihood of success of both (1) the *treatment* that the patient agrees to undergo and (2) the other reasonable *treatment* options that the patient does not pursue. Informed-consent liability arises if a physician's negligent failure to do so harms the patient. But the informed-consent doctrine has limits. It cannot be inserted into every medical-negligence case that criticizes the quality of doctor-patient communication about health risks. And it certainly does not require warnings of the risks of *non-compliance* with medical instructions. That is the unprecedented step that Plaintiffs ask this Court to take.

Despite repeated challenges to do so, Plaintiffs have produced no case that finds the informed-consent doctrine applicable to a patient's failure to appear for

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[45] *Zieber v. Bogert*, 2000 PA Super 24, 747 A.2d 905 (2000) (emphasis added).

follow-up medical testing that she (1) was instructed to have and (2) had agreed to undergo without objection. Apparently, no state or federal court has ever construed informed-consent liability to encompass a healthcare provider's duty to warn a patient of the risks of non-compliance with medical instructions. *Cf.* Pls.' Opp. at 15. If such a claim is viable, it alleges negligent medical treatment—not a negligent failure to obtain the patient's informed consent to treatment.

To be clear, physicians should, and do, tell their patients the risks of forgoing a medical procedure when doing so is one of the patient's *reasonable treatment options*. And 'doing nothing' is often a reasonable treatment option. For example, a surgeon who recommends spinal-fusion surgery for chronic disc pain and properly discloses the procedure's risks to the patient should also disclose any reasonable non-surgical treatment options and attendant risks as well as the option and risks of having no treatment at all. Or a woman with a high-risk pregnancy whose fetus is viable but not yet full-term often can choose between an immediate cesarean delivery, induction of labor with a plan for vaginal delivery, or continued gestation. Before she chooses, her physician would advise her of the risks, benefits, and likelihood of success of each reasonable treatment option, including the risks of just waiting.

But that is not the scenario here. Not being re-tested was never offered or presented as one of Ms. Dunbar's treatment options—and no one argues that it

should have been. Instead, Nurse Belna twice instructed Ms. Dunbar to have the necessary testing, and Ms. Dunbar agreed both times to have it without objecting or even requesting postponement. Given the patient's agreement to comply, Nurse Belna saw no reason to frighten Ms. Dunbar with the prospect of dying from an ectopic pregnancy. Not showing up for an agreed-upon medical test is simply not a "treatment alternative" that would require a recitation of risks, benefits, and likelihood of success.

Even with every inference in Plaintiffs' favor, the trial evidence does not support an informed-consent claim. If, as Plaintiffs argue, Nurse Belna negligently harmed Ms. Dunbar by not giving a more frightening warning about her potential ectopic pregnancy, that would state a negligent-*treatment* (i.e., traditional, garden-variety medical negligence) claim—not an informed-consent claim.[46] Not disclosing to a patient the risks of not following agreed-upon instructions to show up for testing does not fall under the umbrella of the informed-consent doctrine, which has never required such warnings to patients.

The Court of Appeals has repeatedly instructed courts that "informed consent" is not a catch-all claim for *any* allegation that a healthcare provider harmed a patient by inadequately communicating risk information. Rejecting plaintiffs' efforts to frame injuries caused by negligent medical advice as both

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[46] *See*, *e.g.*, *Cleary v. Group Health Ass'n*, 691 A.2d 148, 155 (D.C. 1997).

negligent treatment and failure to obtain informed consent, it has explained that what "the law calls 'informed consent' is more accurately characterized as informed consent to medical *treatment*."[47] "The risk of harm must inhere in the treatment itself."[48] In other words, in "the context of medical malpractice cases based on a lack of informed consent, a physician's breach of duty to disclose is actionable in negligence only if 'it induces a patient's uninformed consent to a risky operation from which damages actually result.'"[49] That did not happen here.

The *Cleary* court's lengthy analysis shows that the doctrine is confined to treatment alternatives.[50] It held that "to prevail in an action based on a theory of informed consent, the plaintiff must prove that if he had been informed of the material risk, he would not have consented to the procedure and that he had been injured as a result of submitting to the procedure."[51] It explained that, although the plaintiff claimed harm from inadequately communicated risk information, he did not state a claim for failure to obtain informed consent.[52] In 2007, the Court aptly

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[47] *Cauman v. George Washington Univ.*, 630 A.2d 1104, 1108 (D.C. 1993).

[48] *Id*.

[49] *Jones v. Howard Univ., Inc.*, 589 A.2d 419 (D.C. 1991) (quoting *Gordon v. Neviaser,* 478 A.2d 292, 295-96 (D.C. 1984)); *Kelton v. District of Columbia*, 413 A.2d 919 (D.C. 1980) (same).

[50] 691 A.2d 148, 154-55 (D.C. 1997).

[51] *Id.* at 155 (cleaned up).

[52] *See id.*

summarized *Cleary* as “distinguishing allegations of negligence in conveying inaccurate medical information from a claim of failure to obtain informed consent.”[53] The claims here do not implicate the informed-consent doctrine.

B. The issue cannot be waived before a new trial has even started.

Without a meritorious substantive argument to support even a prima facie informed-consent claim, Plaintiffs will likely retreat to procedural arguments. They may emphasize the portion of the court’s order noting that the Hospital did not move for summary judgment on the informed-consent claim before or during the first trial. But that ultimately would not help them. First, precluding the Hospital’s argument, evidence, and requested jury instruction on contributory negligence (Arg. I, *supra*, at 12-33) will require a new trial on *both* the negligent treatment and informed-consent claims because both are forms of medical negligence.

Second, the Hospital repeatedly objected at trial to the informed-consent claim as legally insufficient. In the parties’ Joint Pretrial Statement, Plaintiffs requested standardized instruction 9.09,[54] Disclosure of Medical Risks – Informed Consent. App. at 73. The Hospital objected to the entirety of the instruction being given and to the court’s proposed edits. App. at 58. It argued that the instruction was improper because Plaintiffs presented only a claim for negligent treatment, not

[53] *Miller-McGee v. Wash. Hosp. Ctr.*, 920 A.2d 430, 435 (D.C. 2007).

[54] Plaintiffs misnumbered the standardized instruction, which is 9.08.

informed consent. App. at 684. Yet, the court reasoned that the instruction was appropriate because Nurse Belna testified that she "engages her patients along the way" and Plaintiffs' Complaint pled lack of informed consent. *Id.* Ultimately, the jury heard Plaintiffs' proposed instruction. App. at 758-761.

The Hospital renewed its objections to the informed-consent questions on Plaintiff's proposed verdict form. App. at 769-770. It again argued that informed-consent evidence did not merit a separate jury question. *Id.* Over the Hospital's objection, the court determined that a separate question was not prejudicial but, instead, beneficial for appellate purposes. App. at 771. The Hospital also raised the more fundamental problem, objecting that "just because there is an assertion in the complaint of lack of informed consent doesn't make it so." App. at 684.

The trial court erred by instructing the jury on informed consent without evidence or even a theory of the case that could sustain informed-consent liability alongside the negligent-treatment claim. If this Court remands this case for a new trial, it should not require re-trial of a fundamentally flawed informed-consent claim that lacks necessary evidence.

III. The jury returned an excessive verdict that included impermissible solatium damages.[55]

After awarding Ms. Dunbar's three children $692,000 for "loss of services," the jury awarded each child an additional $5 million for "loss of parental guidance, care, support and education." App. at 825-827. The massive award for such discrete damage is unprecedented—by several multiples. It shocks the conscience.

The Hospital cannot find a remotely comparable award for such circumscribed loss in any State that—like the District—limits wrongful-death recovery for a parent's death to pecuniary loss for lost parental income and services. Awarding $15 million for lost parental guidance—separate from any lost parental services—is either a monstruous anomaly or a still-excessive award for grief and sentimental loss, which wrongful-death beneficiaries cannot recover under the D.C. Act. Either way, the staggering award cannot stand.

A. The Wrongful Death Act is in derogation of common law and bars awards for grief, mental anguish, or sentimental loss.

At common law, a cause of action died with the decedent, whose heirs could not recover anything from the tortfeasor. In the 1800s, most American jurisdictions adopted wrongful-death acts (modeled on Britain's Lord Campbell Act of 1846) to

[55] If the Court accepts the Hospital's contributory-negligence argument in Argument Part I and will vacate the judgment and order a new trial, it need not address Argument Part III, which addresses the excessiveness of the original verdict.

allow a decedent's family members to recover certain types of damages.[56] In 1963, the District enacted its own Wrongful Death Act, now codified at D.C. Code §16-2701. Because wrongful-death statutes are in derogation of common law, they "must be strictly construed" to provide only recoveries that the Act allows.[57]

In its influential *Runyon* decision, the D.C. Circuit recognized that the "proper recovery under the Wrongful Death Act is *principally* the amount of *financial loss* to the spouse and next of kin."[58] The D.C. Wrongful Death Act lets statutory beneficiaries recover only "the pecuniary benefits that [they] might reasonably be expected to have derived from the deceased had [s]he lived."[59] It limits recoverable damages to two types of pecuniary benefits: "(1) the loss of financial support the decedent could have expected to provide the next of kin"; and "(2) the value of lost services (e.g., care, education, training, and personal

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[56] *See McKeon v. State, Use of Conrad*, 211 Md. 437, 442, 127 A.2d 635 (1956); *Wittel v. Baker*, 10 Md. App. 531, 533-34, 272 A.2d 57 (1970).

[57] *See Waldon v. Covington*, 415 A.2d 1070, 1075 n.17 (D.C. 1980); *Pitts v. District of Columbia*, 391 A.2d 803, 807 (D.C. 1978).

[58] *Runyon v. District of Columbia*, 463 F.2d 1319, 1322 (D.C. Cir. 1972) (emphasis added).

[59] *See also Semler v. Psychiatric Inst. of Washington, D.C.*, 575 F.2d 922, 924-25 (D.C. Cir. 1978).

advice)."[60] It forbids recovery for any "non-pecuniary losses, such as grief, mental anguish, or sentimental loss."[61]

The D.C. Wrongful Death Act also expressly contemplates the remittitur of excessive verdicts. It authorizes both trial and appellate courts to remit excessive verdicts: "If, in a particular case, the verdict is deemed excessive, the trial judge or the *appellate court, on appeal* of the cause, may order a reduction of the verdict."[62] In light of this provision, courts construing the D.C. Act have repeatedly remitted excessive awards, sometimes even *sua sponte*.[63]

Besides awarding Ms. Dunbar's three children $915,000 for their mother's lost future wages, the jury awarded them $692,000 for the loss of their mother's services. These include the countless services that a dedicated loving parent might provide: not only cooking, cleaning, laundry, and transportation, but also care, education, training, and personal advice, among other things.[64]

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[60] *Himes v. MedStar Georgetown,* 753 F. Supp. 2d 89, 94 (D.D.C. 2010) (internal quotations omitted). *See also Herbert v. District of Columbia*, 808 A.2d 776, 778 n.2 (D.C. 2002); *District of Columbia v. Hawkins*, 782 A.2d 293, 303 (D.C. 2001).

[61] *Himes*, 753 F. Supp. 2d at 94.

[62] D.C. Code § 16-2701(b) (emphasis added).

[63] *See*, *e.g.*, *District of Columbia v. Jackson*, 810 A.2d 388, 397-98 (D.C. 2002); *District of Columbia v. Hawkins*, 782 A.2d 293 (D.C. 2001); *Thomas v. Potomac Elec. Power Co.*, 266 F. Supp. 687, 694-97 (D.D.C. 1967); *Graves v. United States*, 517 F. Supp. 95 (D.D.C. 1981).

[64] *Id.*

Although such pecuniary loss cannot be precisely calculated, jurors must assign a dollar figure, based on the hours that the decedent spent providing these parental household services and an economist's expert testimony on the services' monetary value. Here, Plaintiffs' economist, Dr. Linsley told jurors that Ms. Dunbar provided 76 hours per week—10.8 hours per day with no days off—of services to her children, including "care of children" and working with "homework" (i.e., care, support, and education), at the time of her death when she was also working part-time. App. at 364. He valued Ms. Dunbar's parental household services at $689,702. App. at 368. And the jury awarded the children $692,000 for "loss of services." App. at 827.

B. The excessive verdict was spawned in part from Plaintiffs' improper *Colston* argument.

This Court's opinion in *District of Columbia v. Colston* allows a plaintiff's attorney to ask the jury to award *non*-economic damages—pain and suffering—based on the value of a personal injury.[65] In *Colston*, the plaintiff lost his healthy eye and was blinded. In closing arguments, his attorney asked the jury to award non-economic damages by rhetorically asking how much an eye is worth:

> Consider the loss of that eye as the major element of damages. How much is an eye worth? How much is a healthy eye worth? You cannot restore his vision but you can compensate him for the loss. Is an eye worth five hundred thousand? Eight hundred

[65] 468 A.2d 954 (D.C. 1983).

> thousand? A million? That is for you to say. That is for you to decide. But, ask yourself this question. If Johnny Colston on February the fifth had been offered one million dollars for his healthy eye, you ask yourself if he would have accepted? You decide what that eye is worth.[66]

The *Colston* precedent allows such arguments in the context of personal injury.

But no District of Columbia case has ever allowed a *Colston* argument for a wrongful-death beneficiary's losses, which are strictly pecuniary and must be based on the economic evidence presented at trial. Here, over defense objection, the Plaintiffs' attorney here made a similar *Colston* argument to elicit an improper award of solatium damages. Such arguments are impermissible in wrongful-death cases because they necessarily seek damages (grief, mental anguish, or sentimental loss) that are not recoverable in a wrongful-death case. The jury should not have been asked to award damages based on the *value of a mother*, but rather based on the pecuniary losses that her children suffered because of her death.

C. The excessive lost-parental-guidance awards shock the conscience.

After recovering $915,000 for lost future wages and $692,000 for lost parental services, there should be virtually nothing left for a D.C. wrongful-death beneficiary to recover under an Act that forbids recovery for any "non-pecuniary losses, such as grief, mental anguish, or sentimental loss."[67] Yet, the jury here

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[66] *Id.* at 956.

[67] *Himes*, 753 F. Supp. 2d at 94.

inexplicably dwarfed the already sizable $692,000 loss-of-parental-services award with $5 million *per child* for "loss of parental guidance, care, support and education." Besides being largely, if not completely, redundant of the loss-of-parental-services award, the $15 million award for loss of parental guidance, care, support, and education has no evidentiary basis. It is the "shocking or monstruous" award that is excessive as a matter of D.C. law and should be vacated.[68]

The $15 million award bears no reasonable relationship to the damage testimony that either economist presented to the jury or any other evidence. Although expert economic testimony in a wrongful-death case represents only a guideline that cannot reach mathematical certainty, a verdict more than **22 times** greater than the largest number in evidence for lost parental services must be among the prohibited "extravagant verdicts for grief and injury to feelings."[69] This Court emphasizes that, despite "the jury's broad discretion in assessing damages, there must be substantial evidence upon which the award is predicated."[70] What "substantial evidence" supports the additional $15 million recovery?

The only plausible explanation for the $15 million award (besides mistake) is that the jury, primed by Plaintiffs' appeals to sympathy in closing arguments,

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[68] *See Louison v. Crockett*, 546 A.2d 400 (D.C. 1988).

[69] *See Hord v. Nat'l Homeopathic Hosp.*, 102 F. Supp 792, 794 (D.D.C. 1952) *aff'd* 204 F.2d 397 (D.C. Cir. 1953).

[70] *Doe v. Binker*, 492 A.2d 857, 860 (D.C. 1985).

compensated the children for their emotional distress, grief, and sentimental loss. Plaintiffs closed by telling jurors to envision future weddings, births, holidays, and other deeply sentimental milestones without their mother. They asked jurors to imagine JT winning his first baseball tournament but then being unable to see his mom cheering him on in the stands.

These emotional appeals have nothing to do with the advice, guidance, and education that a parent may give. But they worked, provoking jurors to award $15 million for sentimental loss and grief, completely untethered from the evidence at trial. Courts applying the D.C. Act recognize that although "such emotions are righteous and commendable, they should not be permitted to influence the verdict."[71] These excessive awards cannot stand.

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[71] *Thomas v. Potomac Elec. Power Co.*, 266 F. Supp. 687, 696 (D.D.C. 1967).

CONCLUSION

For these reasons, the Hospital asks the Court to vacate the judgment below and order a new trial that is limited to deciding liability, if any, for negligent treatment and any resulting damages.

Dated: December 23, 2022 Respectfully submitted,

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District of Columbia Court of Appeals

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4. Information about protection orders, restraining orders, and injunctions that "would be likely to publicly reveal the identity or location of the protected party," 18 U.S.C. § 2265(d)(3) (prohibiting public disclosure on the internet of such information); *see also* 18 U.S.C. § 2266(5) (defining "protection order" to include, among other things, civil and criminal orders for the purpose of preventing violent or threatening acts, harassment, sexual violence, contact, communication, or proximity) (both provisions attached).

5. Any names of victims of sexual offenses except the brief may use initials when referring to victims of sexual offenses.

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Signature

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22-CV-532
Case Number(s)

12/23/22
Date

IN THE
DISTRICT OF COLUMBIA COURT OF APPEALS

Appeal No. 22-CV-532

WASHINGTON HOSPITAL CENTER CORPORATION d/b/a WASHINGTON WOMEN'S WELLNESS CENTER AT WASHINGTON HOSPITAL CENTER,

Appellant

v.

SHANAYE BATEY, et al.

Appellee

Appeal from the Superior Court for the District of Columbia
(The Honorable Juliet McKenna)
Case No. 2019 CA 006716 M

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Contributory Negligence in Medical Malpractice

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Contributory Negligence In Medical Malpractice

*Diane Shelby**

THE PREFIX "MAL" means "bad". Medical malpractice, simply stated, is the bad practice of medicine. To the law, it is unskilled or negligent practice of medicine, as a profession, which causes injury.[1]

The best and most complete defense to a charge of malpractice is the allegation and proof of the absence of negligence.[2] It is also the most often used defense.[3] Of the less popular defenses, contributory negligence[4] on the part of the patient is probably the least attractive and the most difficult to maintain,[5] even though it has been held to be a complete bar to recovery in several cases difficult to categorize.[6]

Probably the main reason contributory negligence is not a popular defense is a monetary one. In a true malpractice action, even if sustained, contributory negligence is just that—negligence which proximately contributes to the injury.[7] The defendant doctor is still left liable for whatever part of the injury it is determined was caused by his negligence alone. This exception to the general rule, that an injured party cannot recover damages for an injury which he helped, even in the slightest degree, to create,[8] is the factor which lends much of the confusion to the cases. The rule for malpractice cases is very clearly stated in *Morse v. Rapkin,*[9] a New York case decided in 1965.

> There are situations in actions loosely labeled malpractice where the charge of dereliction is undistinguishable from the ordinary charge of negligence. The bulk of these actions are against hospitals, but it is conceivable that one could arise against a doctor. In such a case, applying the rule that contributory negligence defeats the action would be entirely proper. (Cite omitted.) But where the gravamen of the action is the improper professional treatment, the patient's failure to follow

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[1] 41 AM. JUR. *Phys. & Sur.*, § 78 (1942); 70 C. J. S. *Phys. & Sur.*, § 40 (1951); 42 OHIO JUR. 2d *Phys. & Sur.*, § 110 (1960).

[2] J. WALTZ and F. INBAU, MEDICAL JURISPRUDENCE 139 (1971).

[3] *Id.* at 139.

[4] For a discussion of the development and history of contributory negligence as a defense in malpractice cases, see Alderson, *Contributory Negligence in Medical Malpractice,* 12 CLEV.-MAR. L. REV. 455 (1963).

[5] See comments of the court as to common problems of deciding malpractice cases in Flynn v. Stearns, 52 N.J. Super. 115, 145 A.2d 33 (1958); See also discussion of sociological and practical considerations in the handling of this type of case discussed in Friedman, *Handling the Unique Problems of Medical Malpractice Actions,* 10 S.D. L. REV. 137 (Spring 1965); Coleman, *Malpractice and Contributory Negligence,* 60 J. NAT'L MED. ASSOC. 164 (March 1963).

[6] The distinction between ordinary negligence and negligence in the practice of a profession appears not to be made by many courts. The rules of law of negligence and malpractice are often interchanged, intermingled or ignored.

[7] W. PROSSER, LAW OF TORTS, § 64 (3rd ed. 1964).

[8] Hunter v. United States, 236 F. Supp. 411 (M. D. Tenn. 1964).

[9] 24 App. Div. 24, 263 N.Y.S. 2d 428, 430 (1965).

instructions does not defeat the action. If the failure increases the extent of the injury, damages would be reduced to that degree. (Cites omitted.)

A second reason is that, generally, a defense of contributory negligence admits or implies negligence on the part of the party raising the defense.[10] Although studies have shown that, contrary to the belief held by most medical professionals, there is no appreciable loss of professional standing or monetary income after involvement in civil malpractice litigation, most are loath to admit to a charge of negligence.[11]

In the area of proof, a defense of contributory negligence is particularly difficult to maintain because of the unique features of the malpractice case—the usually long period of time (course of treatment) covered by the case, and the fact that the patient is assumed to put himself completely under the charge of the doctor or hospital and is in no position to harm himself.[12] The difficulty with the time aspect is that contributory negligence must be a direct cause, and exist contemporaneously with the negligent acts of the physician in the creation of the injury.[13] If a course of treatment lasts for three years, the difficulty in pinpointing and matching the specific actions of the defendant and plaintiff which together produced the injury becomes evident.

Disregarding for the moment the relatively small number of malpractice cases where true contributory negligence is found, and the cases where only malpractice is found, the remainder of the cases divide themselves into two distinct groups. In one category are the cases where the doctor was not negligent at all in his practice of medicine, the injury complained of occurring through some wilful and negligent conduct of the patient. In the other cases, the alleged contributory negligence occurred subsequent to the doctor's alleged negligence. In the second group, it is interesting to note the number of "bad result" cases. In these cases the doctor never expected a complete cure. The patient is discharged with instructions for self-help or referred to another physician. He fails to take advantage of either, and, consequently, the final results of the treatment are even less than the doctor expected. The patient sues, and, because medicine is not an exact science and juries are not always ruled by logic or the weight of the evidence, in a surprising number of suits, wins.

Undeniably, the patient has a right to recover damages for injury and to have a judicial decision as to the extent or existence of such injury, but the potential for corruption of sound legal principles is

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[10] 39 OHIO JUR. 2d *Negligence*, § 85 (1959).

[11] LEVINE, *Medical Malpractice*, LEGAL ESSAYS OF THE PLAINTIFF'S ADVOCATE 127 (1961); SANDOR, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459 (1957).

[12] *See* authorities cited at note 3 *supra*.

[13] *Cf.*, Annot. 50 A. L. R. 2d 1046 (1956).

evident. Here, as in no other area of the law, the plaintiff is allowed to have money damages despite the fact that his disability has been increased or even created by his own actions.

Judging from the rise in the number of articles in professional journals and symposia on the subject, it appears that the "bad result" case is becoming a disturbing area for several professions.[14] For doctors and insurance men, it is disturbing because it is becoming a growing proportion of the increasing number of malpractice cases and awards in malpractice cases have been reaching unprecedented heights.[15] The legal profession is concerned because the cases are often inconsistent.

The discussion which follows will highlight developments in the major areas of malpractice litigation brought in the past ten years where contributory negligence was raised as a defense.

Proximate Cause

The plaintiff in *Somma v. U. S.*[16] failed to correctly fill in a form. Consequently X-ray films which showed active tuberculosis were not sent to his family physician. The disease went untreated for years. During the months after it was discovered that the disease was in active state, the defendant made no effort to advise the plaintiff of the urgency of his condition or to urge him to see his personal physician. In deciding the case for the government, the court, applying Pennsylvania law, said:

> . . . Plaintiff is not entitled to recover if any negligence of his with regard to his health contributed, in even slight part to the incident of May 29, 1956, and the damages resulting therefrom.

Although this is labeled a malpractice case, it would appear from the decision that the rules for ordinary negligence had been applied.

An opposite result was reached the same year in *Wheatley v. Heidemann.*[17] The parents of a two-year-old girl took the child to an osteopath. The doctor failed to correctly diagnose an infection of the eye, and the eye was later removed. The parents, suing as next friends for their daughter, were charged with contributory negligence in knowing the osteopath's limitations and still continuing with him. The court declared:

> Of course if the parents' negligence were the sole proximate cause . . . it would be a good defense. But if defendant's negligence

[14] THE MEDICO-LEGAL READER 235 (S. Polsky ed. 1956).

[15] R. LONG, THE PHYSICIAN AND THE LAW, 240 (2nd ed. 1959); Shindell, *A Survey of the Law of Medical Practice,* 193 J.A.M.A. 1108 (September 1965), *cont'd* 194 J.A.M.A. 527 (October 1965); STAFF OF SENATE SUBCOMMITTEE ON EXECUTIVE REORGANIZATION, 91ST CONGRESS, 1ST SESSION, REPORT ON MEDICAL MALPRACTICE: "THE PATIENT VERSUS THE PHYSICIAN" (1969).

[16] 180 F. Supp. 519, 525 (E.D. Pa. 1960).

[17] 251 Iowa 695, 102 N. W. 2d. 343 (1964).

. . . was a substantial factor in causing the injury, negligence of either parent would not be a defense.[18]

Florida has consistently held that contributory negligence is a complete bar to recovery. In 1964 in the case of *General Hospital of Greater Miami, Inc. v. Gager*[19] it so held, and in 1966, in *Musachia v. Rosman*[20] the court said:

> It is only when negligent acts on the part of the plaintiff have a direct and proximate causal relation, or contribute in some appreciable degree, to the injury that recovery is precluded.

Two "bad result" cases in juxtaposition show that the law is still developing in some states on the question of contributory negligence as a proximate cause and complete bar to recovery. In 1966, in *Paull v. Zions First National Bank*,[21] the plaintiff's arm was manipulated by surgical procedure. Alleged infection at the site of the incision, severing of a nerve, and formation of scar tissue caused loss of mobility. The court decided that the failure to exercise the arm, as directed, was the cause of the injury, i.e., that at the time of the suit mobility of the arm was still not restored.

The Kentucky court, which has been consistent in its holdings that contributory negligence will only mitigate damages, held, under a similar fact pattern, in *Blair v. Eblen*:[22]

> Negligence on the part of the patient, which occurs wholly subsequently to the physician's malpractice which caused the original injuries sued for, is not a complete defense to any recovery against the physician, but serves to mitigate the damages, preventing recovery to the extent the patient's injury was aggravated or increased by his own negligence . . . sustained prior to his contributory negligence.

Finally, in the 1970 case of *Germann v. Matriss*,[23] everyone except the court seemed to be confused. Plaintiff's wife had died of tetanus which, it was alleged, had entered her mouth on an improperly sterilized denture and been deposited in the open socket of a recently extracted tooth. The defendant dentist charged contributory negligence in that the patient had removed the dentures against his instructions. In commenting on the defense's charge of contributory negligence, the court ruefully said in deciding for the defendant:

> If the fatal spore entered a tooth socket because the denture was removed, such fact would establish only that the proximate cause of the fatal disease was not the allegedly negligent steriliza-

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[18] *Id.* at 712, 102 N. W. 2d at 353. If the parents' negligence were the "sole proximate cause" it would appear that contributory negligence would *not* be a good defense to the child's right to recover; rather, the showing of the defendant's freedom from negligent action would be a better defense.

[19] 160 So.2d 749 (Fla. Ct. App. 1964).

[20] 190 So.2d 47, 50 (Fla. Ct. App. 1966) quoting Bessett v. Hackett, 66 So.2d 694 (Fla. 1953).

[21] 18 Utah 2d 183, 417 P.2d 759 (1966).

[22] 461 S.W.2d 370 (Ky. Ct. App. 1970).

[23] 55 N. J. 193, 260 A.2d 825 (1970).

> tion which permitted a spore to be on the denture when Dr. Matriss . . . inserted it . . . Such fact would demonstrate that the efficient producing cause of the tetanus was a cause for which the doctor was not responsible.[24]

Patient's Duty To Use Ordinary Care To Protect Himself

Corresponding to the doctor's duty to use care and skill in his practice of medicine[25] is the patient's duty to use ordinary care in protecting himself from obvious or foreseeable injury.[26]

The court in *Fleishmann v. Richardson-Merrill, Inc.*[27] refused to extend the doctor's duty beyond the patient's voluntary termination of treatment.[28] The plaintiff had taken drugs by prescription to control high blood pressure. When the prescription ran out, she called the physician's office and obtained the trade name of the drug. For two years she purchased and took the drug without prescription. The drug was subsequently found to cause blindness. Although, upon learning of the harmful effect of the drug, she immediately stopped taking it, she suffered blindness and sued the doctor. The court decided that the doctor had no continuing duty to warn patients of possible harmful treatment after the patient had terminated the doctor-patient relationship. Further, if the patient and doctor learned of the harmful effects at the same time (which they did), it was as incumbent on the patient to protect herself as it was on the doctor to warn her.

The court in *Ambur v. Zim Israel Navigation Co.*[29] stated:

> Under the . . . circumstances, I find that there was no malpractice by Dr. Yaulus . . . since plaintiff failed to acquaint Dr. Yaulus with the full history of his ailment sufficient to enable the physician adequately to treat him.

In that case, a 51-year-old rabbi failed to give his complete history of heart trouble to the ship's doctor who was attending him to treat a seizure the plaintiff had sustained before the ship had come into port. The doctor allowed him to disembark and tour Israel, where he suffered more seizures with resulting damage to his heart.

A 1970 case, *Ray v. Wagner*,[30] upholds the patient's duty to protect himself but also seems to extend the physician's duty to warn the patient of possible harm even after the patient has indicated termination of the doctor-patient relationship. Plaintiff had a positive result on the Pap smear test for uterine cancer. The doctor was unable to contact her to tell her the results of the test as she had given false information about her address, her place of employment, and her

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[24] *Id.* at 210, 260 A.2d at 834. This flaw in the reasoning of the defense had passed unnoticed by the trial judge and attorneys for both sides.

[25] R. LONG, *supra* note 15, at 1; 70 C. J. S. *Phys. & Sur.*, § 41 (1951).

[26] R. LONG, *supra* note 15, at 75; 65 C. J. S. *Negligence*, § 4 (3) (1966).

[27] 94 N. J. Super. 90, 226 A.2d 843 (Super. Ct. App. Div. 1967).

[28] R. LONG, *supra* note 15, at 7.

[29] 310 F. Supp. 1033 (S. D. N. Y. 1969).

[30] 286 Minn. 539, 176 N.W.2d 101, 103 (1970).

husband's place of employment. As a result, treatment was delayed many months and plaintiff was rendered sterile. On appeal of a decision for the doctor, the court said in regard to the doctor's trying to contact the plaintiff even after she had ceased consulting him and had not paid her bill:

> While it seems clear that defendant had a duty to take whatever steps were reasonable to notify plaintiff of the results of the test she took in August, *it was for the jury to decide whether the failure to reach plaintiff was the result of negligence on the part of the doctor,* and, if so, whether such negligence proximately caused the condition which resulted from her ultimate condition. (Emphasis supplied.)

Patient's Right To Rely On Physician's Competence

Concurrent with the patient's duty to save himself from obvious harm is his right to rely on the competence of his doctor.[31] He is not required to suspect every act of his physician, or to get a second opinion, and, even though the results of the treatment may be unsettling, he may reasonably rely on assurances from his doctor. The principle has been adhered to in most of the recent cases, even though in a few cases the right seems to have been extended to the very edge of reasonableness.

In *Favalora v. Aetna*,[32] a 71-year-old woman was admitted to hospital for tests to determine why she was experiencing fainting spells. Her physician did not indicate to the hospital the fact of the spells and no medical history was taken. During the taking of X-rays, she fell from the table and broke her leg. Contributory negligence was charged in that she failed to inform the radiologist that she was subject to fainting spells. The court said:

> She was under no duty to reiterate her entire medical history to each of the hospital personnel with whom she came in contact but was entitled to rely upon the skill of her personal physician and the competence of the specialists into whose care and keeping she had been committed for examination.
>
> ... [C]onformity with the standard of care observed by other medical authorities of good standing in the same community cannot be availed of as a defense in a malpractice action when the criterion relied upon is shown to constitute negligence in that it fails to guard against injury to the patient from a reasonably foreseeable contingency.[33]

Rahn v. U. S.[34] decided in 1963, awarded $75,000 damages to the plaintiff. The defendants, military physicians, had not been able to correctly set plaintiff's broken wrist. This fact had been noted in the medical records. Therapy was recommended to the plaintiff and she accepted it. The immobility and misalignment of her wrist, how-

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[31] Favalora v. Aetna Cas. & Surety Co., 144 So.2d 544 (La. Ct. App. 1962).

[32] *Id.*

[33] *Id.* at 550.

[34] 222 F. Supp. 775 (S.D. Ga. 1963).

ever, were not improved. All during the course of treatment, the plaintiff had been reassured by the doctors that everything was all right. She did not discover the truth until she requested her medical records. The court noted:

> The plaintiff had a right to rely upon the defendant for her treatment without her calling others in to determine whether the defendant's agent were (sic) properly treating her, and she was not bound to consult other doctors unless she was fully aware that the defendant's agents were not properly treating her.[35]

A later case, *Johnson v. U. S.*[36] decided in 1967, came to the conclusion that even though the plaintiff had been in constant pain and had been unable to use his arm, he was not required to consult another physician who might have discovered the fact that a nerve had been sutured to the wrong tendon and thus have prevented the plaintiff's long period of lost wages. He was permitted damages for the entire period.

CONCLUSION

One writer has suggested that contributory negligence is a good defense and should be used more frequently.[37] This area, however, as the preceding has attempted to show, is still developing. Some states have instituted malpractice screening committees composed of both lawyers and physicians.[38] Their purpose is to stem the increase in the "nuisance suit", if possible, and to clarify the law in the area of malpractice by seeing that truly justiciable cases come to trial.[39] Perhaps, when the cases are clarified before trial the defense of contributory negligence, properly applied in the correct cases, will be more frequently seen.

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[35] *Id.* at 780.

[36] 271 F. Supp. 205 (W.D. Ark. 1967).

[37] Trostler, *Contributory Negligence as It Applies to Medical Malpractice*, 34 RADIOLOGY 76 (1940).

[38] Karcher, *Malpractice Claims Against Doctors: New Jersey's Screening Procedure*, 53 A.B.A.J. 328 (1967).

[39] Similar committees have been set up in Arizona, Idaho, New Mexico, Virginia, New York, Nevada, Pennsylvania, California, and Utah. The California and Utah plans have panels of doctors advised in the law by members of the local bar association.

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