

A Primer on Defending Breast Cancer Litigation*

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Introduction

Breast cancer is the second leading cause of cancer deaths in American women.¹ One out of eight American women will develop breast cancer in her lifetime.² Given these statistics, it is no surprise that the leading cause of lawsuits against physicians involves delay in the diagnosis of breast cancer.³ These statistics highlight the need for any attorney practicing in the private sector to be familiar with the issues surrounding the defense of a breast cancer action.

It is often inviting, but strategically unwise, to approach the defense of a breast cancer misdiagnosis case as simply another injury or death action. Because many issues peculiar to cancer-related matters do not arise in everyday trial work, the defense practitioner would do well to be apprized of potential traps and pitfalls. Since new issues arise with some frequency in this area, this Article does not attempt to be all-inclusive or present itself as an end-all solution for the trial lawyer.

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¹ Nat'l Cancer Inst., *Lifetime Probability of Breast Cancer in American Women*, at cis.nci.nih.gov/fact/5_6.htm (last visited June 3, 2002); Imaginis Corp., *Breast Cancer: Statistics on Incidence, Survival, and Screening*, at www.imaginis.com/breasthealth/statistics.asp (last modified Mar. 6, 2001).

² See sources cited *supra* note 1.

³ Steven D. Frankel & R. James Brenner, *Legal Issues Related to Interventional Breast Procedures*, *APPLIED RADIOLOGY* (Aug. 2001), at 34 (citing a 1995 Physician Insurer's Association of American Breast Cancer Study); see also Samuel Zylstra et al., *Defense of Breast Cancer Malpractice Claims*, 7 *BREAST J.* 2, 77 (2001).

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Rather, an effort is made to address basic and common, but often overlooked, issues that arise and must ultimately be considered by defense attorneys handling trial-bound, breast cancer lawsuits.

I. What Are the Salient Medical Issues?

In order to properly defend a failure-to-diagnose-breast-cancer case, defense counsel must become conversant with a number of different medical issues that are peculiar to a breast cancer action. Those medical issues include a detailed understanding of precisely what cancer is, the growth rate of tumors, medical diagnosability, treatments, and survivability rates. This Article discusses each issue in turn.

A. Definition of Cancer

In general, cancer is a medical term used to indicate various types of malignant neoplasms that are usually the result of the continuous proliferation of abnormal cells.⁴ “A malignant neoplasm has the property of uncontrolled growth and dissemination or recurrence after removal or both. Cancer spreads throughout the body because of the ability of cells from the primary tumor to migrate to other sites and establish new-growing foci (metastasis).”⁵

“Cancers are classified by the type of tissue in which they arise and the cell type that constitutes the tumour.”⁶ Over 150 types of cancers with different behaviors have been classified in human beings.⁷ These types of cancers are classified by two major types: carcinoma and sarcoma.⁸

Carcinoma, the larger category, refers to cancers of epithelial tissues, which cover the external body (the skin) and line the inner cavitory structures of organs such as the breasts; the respiratory and gastrointestinal tracts; the endocrine glands, such as the pituitary, thyroid, and adrenals; and the genitourinary system, which includes the prostate, testes, ovaries, fallopian tubes, uterus, kidneys, and urinary bladder. Sarcoma refers to cancers of the various elements that constitute the

⁴ Harvey F. Wachsmann, *Medical Malpractice-Failure to Diagnose and Treat Cancer*, TRIAL LAW. Q., Fall 1982, at 15.

⁵ *Id.*

⁶ *Types of Cancer*, ENCYCLOPEDIA BRITANNICA ONLINE, available at search.eb.com/eb/article?eu=108742&tocid=59365#59365.toc (last visited June 3, 2002).

⁷ *Id.*

⁸ *Id.*

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connective tissues, such as fibrous tissues, muscle, blood vessels, bone, and cartilage.⁹

“Carcinomas of the breast are generally formed from the epithelium or lining of the mammary ducts or lobules” contained within the breast.¹⁰ “These cancers are divided into two main groups: carcinomas of ductile epithelial origin” and carcinomas of lobular epithelial origin.¹¹ “Although both types fall under the category of breast cancer, ductile and lobular carcinomas are two distinct histopathologic entities, having different clinical characteristics that may affect how they are treated.”¹²

B. Staging

Breast cancer is classified into stages for purposes of prognosis and treatment.¹³ Identifying the cancer stage is one of the most important factors since it usually plays a vital role in selecting treatment options.¹⁴ However, until surgery or a biopsy is conducted, staging is merely presumptive.¹⁵

Stage 0: Stage 0 cancer is divided into two types of cancer.¹⁶ Ductile carcinoma in situ (DCIS) breast cancer is a very early stage of cancer that may develop into an invasive type of cancer.¹⁷ Lobular carcinoma in situ (LCIS) breast cancer is not cancer but rather a marker that identifies a woman at increased risk to develop invasive breast cancer.¹⁸

Stage I. At this stage, the tumor is two centimeters or less in diameter and has not spread outside the breast.¹⁹

⁹ *Id.*

¹⁰ Irwin M. Ellerin, Mia I. Frieder & Gary R. Hillerich, *Handling a Failure to Diagnose Breast Cancer Case*, TRIAL, May 1996, at 31 [hereinafter *Handling a Failure to Diagnose Breast Cancer Case*]; see Gary R. Hillerich, Irwin M. Ellerin & Mia I. Frieder, *Selecting and Presenting a Failure to Diagnose Breast Cancer Case*, 20 AM. J. TRIAL ADVOC. 253, 255 (1996-97) [hereinafter *Presenting a Failure to Diagnose Breast Cancer Case*].

¹¹ *Handling a Failure to Diagnose Breast Cancer Case*, *supra* note 10, at 31.

¹² *Id.*

¹³ See Univ. of Pa. Cancer Ctr., *Breast Cancer*, at www.oncolink.com/templates/types/article.cfm?c=3&s=5&ss=33&id=923 (last reviewed Nov. 1, 2001).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Breast Cancer*, *supra* note 13.

¹⁹ *Id.*

Stage II. Stage II is broken into two substages: Stage IIA and Stage IIB.²⁰ Stage IIA breast cancer is defined by a tumor no larger than two centimeters in diameter that has not spread to the lymph nodes.²¹ Stage IIB breast cancer is defined by tumors between two and five centimeters in diameter that have spread to the lymph nodes or cancer with tumors that are larger than five centimeters in diameter that have not spread to the lymph nodes.²²

Stage III. Stage III breast cancer is also divided into two substages: Stage IIIA and Stage IIIB.²³ Stage IIIA cancer has spread to the lymph nodes or to axillary tissues.²⁴ Stage IIIB includes all sizes of tumors and cancer that has attached itself to tissues near the breast or chest wall or spread to lymph nodes inside the chest wall.²⁵

Stage IV. Stage IV breast cancer is cancer that has metastasized, spread out of the breast to other organs of the body, most often the bones, lung, liver, or brain.²⁶

“Inflammatory breast cancer is a special class of breast cancer that is very rare.”²⁷ The breast is inflamed, red and exhibits ridges or wheals.²⁸ Although rare, inflammatory breast cancer tends to spread quickly to other parts of the body.²⁹

C. Medical Diagnosability

Most failure-to-diagnose-breast-cancer cases begin with an exploration of the timing and sufficiency of the initial physical breast examination by the primary care physician, family practitioner, internist, or clinic physician.³⁰

It is important for all women to perform monthly breast self exams, beginning at age twenty, to detect any changes that may occur in their

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Breast Cancer, supra* note 13.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Breast Cancer, supra* note 13.

²⁹ *Id.*

³⁰ *Presenting a Failure to Diagnose Breast Cancer Case, supra* note 10, at 255.

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breasts.³¹ “The most common type of breast cancer cases involves a small, painless lesion or mass that is found first by the patient.”³² If a woman finds a lump and it does not disappear after the menstrual cycle, then the lump should be evaluated by a physician as soon as practicable.³³

The clinical visit should begin with a detailed history taking that includes questioning as to when any breast and axially symptoms first appeared and how they evolved, including the existence of a single discrete mass or multiple masses, bloody nipple discharge and its characteristics, nipple or skin retraction, and breast or arm pain.³⁴ The history should also explore the patient’s prior reproductive history, the patient’s family history of cancer, and the patient’s breast-related medical care (such as biopsy and mammography).³⁵

The history should be followed by a thorough clinical breast examination which “includes inspection (looking) and palpation (feeling) of the entire breast/chest area including the lymph node areas above and below the collarbone and under each arm.”³⁶ During the remainder of the exam, “the physician will check for any skin dimpling, nipple retraction, or other visual changes.”³⁷ Any masses detected during the breast examination must be recorded in the patient’s medical record.³⁸ “A small percentage of breast cancers are not detected by mammography but can be felt during a clinical breast examination.”³⁹

If the examining physician detects any lumps or unusual changes, a mammogram should be suggested.⁴⁰ There are essentially two

³¹ Imaginis Corp., *Breast Cancer Screening/Prevention, Evaluating a Breast Lump*, at www.imaginis.com/breasthealth/lump.asp (last updated June 12, 2001) [hereinafter *Evaluating a Breast Lump*].

³² *Handling a Failure to Diagnose Breast Cancer Case*, *supra* note 10, at 32.

³³ *Evaluating a Breast Lump*, *supra* note 31.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Imaginis Corp., *Breast Cancer Screening/Prevention, Guidelines Women Should Follow for Early Detection of Breast Cancer*, at www.imaginis.com/breasthealth/earlydetection.asp (last visited June 3, 2002) [hereinafter *Early Detection of Breast Cancer*].

³⁷ *Evaluating a Breast Lump*, *supra* note 31.

³⁸ *Handling a Failure to Diagnose Breast Cancer Case*, *supra* note 10, at 31.

³⁹ *Early Detection of Breast Cancer*, *supra* note 36.

⁴⁰ Univ. of Pa. Cancer Ctr., *NCI/PDQ-Physician Statement: Screening for Breast Cancer*, at www.oncolink.com/templates/types/article.cfm?c=3&s=5&ss=35&id

different types of mammograms: screening mammography and diagnostic mammography.⁴¹ Screening mammograms evaluate women for breast cancer in the absence of signs or symptoms of disease.⁴² Diagnostic mammograms are performed on women with physical breast abnormalities or abnormal screening mammograms.⁴³

Screening mammography should consist of two different views of each breast: the mediolateral oblique (MLO) and the craniocaudal (CC).⁴⁴ The MLO is taken from the side and the CC is taken from the top.⁴⁵ Both views should include all breast tissue.⁴⁶ Since diagnostic mammography is used to evaluate specific breast masses or symptoms, a variety of views can be used.⁴⁷ In both cases, care should be taken to obtain quality films that adequately depict the pertinent breast tissue.⁴⁸

It is impossible for even the most experienced physician to rule out breast cancer by palpation or mammography.⁴⁹ As a result, when a persistent mass is either detected by palpation or confirmed by mammography, other steps such as aspiration, biopsy, or ultrasound are required to rule out cancer.⁵⁰

A breast mass that is suspected of being a cyst should be aspirated.⁵¹ Aspiration involves inserting a needle into the mass and withdrawing any fluid that is present.⁵² If the lump is a cyst, the fluid should be clear or straw colored, and the mass should go away immediately.⁵³

= 6597 (last modified Nov. 21, 2001). “Mammography is the best way to detect breast cancer in its earliest, most treatable stage—an average of 1–3 years before a woman can feel the lump.” The Nat’l Breast & Cervical Cancer Early Detection Program, *Breast Cancer and Mammography Information*, at www.cdc.gov/cancer/nbccedp/info-bc.htm (last reviewed May 31, 2002) [hereinafter *Mammography Information*].

⁴¹ Sharon S. Lutz, *Breast Cancer Litigation: When is the Physician Liable?*, TRIAL, Dec. 1995, at 47.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Lutz, *supra* note 41, at 47.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.* at 48.

⁵⁰ *Id.*

⁵¹ Lutz, *supra* note 41, at 48.

⁵² *Id.*

⁵³ *Id.*

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If the mass remains after aspiration, a breast biopsy must be performed.⁵⁴ In a needle biopsy, tissue is removed from the lump via a needle and sent for pathological review and interpretation. In an open biopsy, the physician removes the entire mass and sends it to the pathology lab for evaluation.⁵⁵ One of the newer diagnostic procedures being used by examining physicians is the ultrasound breast biopsy.⁵⁶ During this procedure, the doctor uses an ultrasound machine to find the suspicious area and then takes five tissue samples with a spring-loaded biopsy gun.⁵⁷ The material that is removed using the biopsy gun is then subject to microscopic pathological examination.⁵⁸

The National Cancer Institute has published guidelines for screening breast examinations for women:

Screen Tests for Women of Different Ages ⁵⁹		
AGE	RECOMMENDATION	BENEFIT
Under age 40	Breast exam by doctor	No data
Age 40 to 49	Breast exam by doctor Mammogram every one to two years	May reduce her chances of dying from breast cancer by about seventeen percent
Age 50 to 74	Breast exam by doctor Mammogram every one to two years	May reduce her chances of dying from breast cancer by about thirty percent
Age 75 and over	Breast exam by doctor Mammogram every one to two years	No data

These recommendations may or may not represent the standard of care, depending on the dates and physician specialties at issue. Regardless of whether these recommendations actually create the standard of care, they can provide reference sources for plaintiffs' attorneys and experts in establishing various standards.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ Lutz, *supra* note 41, at 48.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Mammography Information*, *supra* note 40 (citing National Cancer Institute).

Defense attorneys who handle failure-to-diagnose cases must be familiar with the foregoing factors affecting diagnosability and must carefully review the records for evidence that the defendant practitioner followed the foregoing procedures. Any evidence to the contrary will certainly be emphasized by plaintiff's counsel when making a case for the defendant's breach of the standard of care in failing to diagnose the plaintiff's cancer.

D. Treatment

Cancer is a disease of individual cells, and even one cancerous cell can divide hundreds of times to produce a new cancer mass.⁶⁰ As a result, a cure can only be accomplished by removing or killing all of the cancerous tissue.⁶¹ The four generally accepted ways of killing or removing cancer cells are surgery, radiation, chemotherapy, and hormone therapy.⁶² Sentinel lymph node biopsy followed by surgery, bone marrow transplantation, and peripheral blood stem cell transplantation are treatments being tested in clinical trials.⁶³

In regard to breast cancer, surgery can consist of limited surgical intervention, such as localized lymph node removal or lumpectomy (which involves the removal of limited portions of breast tissue) all the way up to the more invasive single or double mastectomy (which involves the complete removal of one or both breasts).⁶⁴ Surgery may also involve the removal of lymph nodes in surrounding tissue, such as lymph nodes located in the armpit, neck or chest.⁶⁵

If the cancer has advanced beyond stage one and spread to distant organs, surgery alone will not suffice; the patient will have to undergo radiation treatments, chemotherapy, or hormone therapy.⁶⁶ Many forms of cancer are quite susceptible to radiation, which can be given repeatedly and to several different parts of the body.⁶⁷ Even in those instances where radiation cannot completely eliminate a particular type of cancer, radiation can be quite effective in reducing the size of the

⁶⁰ *Types of Cancer*, *supra* note 6.

⁶¹ *Id.*

⁶² Nat'l Cancer Inst., *Breast Cancer (PDQ): Treatment*, at www.cancer.gov/cancer_information/doc_pdq.aspx?version=patient&viewid=53d97cba-89a2-45d4-b55d-b7b5ad7dc2dd#5 (last modified Feb. 2002).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Breast Cancer (PDQ): Treatment*, *supra* note 62.

tumor, thereby reducing or relieving the patient of the symptoms of the disease.⁶⁸

Chemotherapy is the term used to describe the drug treatment of cancer.⁶⁹ Chemotherapy enters the bloodstream of the body through the mouth or by inserting a needle into a vein or muscle.⁷⁰ Since each drug attacks cancer cells in a different way, the use of as many as four or five different drugs may be used in a precise combination in order to increase the effectiveness of the treatment.⁷¹ Chemotherapy is not used only in those cases where the cancer can be cured; it is often also used in combination with surgery or radiation.⁷²

Hormone therapy may be given if tests reveal that cancer cells have estrogen receptors and progesterone receptors.⁷³ Hormone therapy is used to change the way hormones in the body help cancers grow by using drugs that change the way the hormones work or by surgery to take out organs that make hormones, such as the ovaries.⁷⁴ Hormone therapy with Tamoxifen is often given to patients with early stages of cancer.⁷⁵

E. Impact of Delayed Diagnosis

A delayed diagnosis of breast cancer impacts not only a patient's chance of survival but also the amount of pain they will suffer and the invasiveness of the treatment they will require.⁷⁶ The following table highlights the extreme impact a delay in diagnosis of breast cancer can have on a patient's life and, consequently, her damages.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Types of Cancer, supra* note 6.

⁷² *Id.*

⁷³ *Breast Cancer (PDQ): Treatment, supra* note 62.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Imaginis Corp., *Staging and Survival Rates of Cancer*, at www.imaginis.com/breasthealth/staging.asp?mode=1 (last modified Mar. 21, 2001) (citing American Cancer Society figures).

Numerical Stages of Breast Cancer⁷⁷

STAGES	FIVE-YEAR RELATIVE SURVIVAL RATE	TREATMENT
Stage 0	100%	DCIS cancer—Breast-conserving surgery and radiation therapy; lumpectomy followed by radiation treatment; or total mastectomy with or without hormone therapy.
Stage I	98%	LCIS cancer—Hormone therapy (to reduce the risk of developing breast cancer) or mastectomy if the patient is at high risk for breast cancer. Breast conserving therapy such as removal of only the cancerous tissues followed by radiation therapy if necessary; or lumpectomy/modified radical mastectomy followed by radiation if necessary.
Stage IIA	88%	Same as Stage I although radiation therapy is often necessary.
Stage IIB	76%	Same as Stage I although radiation therapy is often necessary.
Stage IIIA	56%	Modified radical mastectomy with or without breast reconstruction; lumpectomy (if the tumor is removable with one incision); radiation and systemic therapy (chemotherapy or hormone therapy) often follow surgery.
Stage IIIB	49%	Radiation therapy to reduce the tumor size; then, either a lumpectomy or a radical mastectomy; then, chemotherapy, radiation or chemotherapy plus hormonal therapy.
Stage IV	16%	Chemotherapy, hormone therapy or both. Treatment focuses on extending survival time and relieving symptoms.

After seven years, survival rates decrease for each stage: Stage I – 92%; Stage II – 71%; Stage III – 39%; and Stage IV – 11%.⁷⁸

⁷⁷ *Id.*

⁷⁸ *Id.*

II. What Are the Theories of Liability Pursued by the Plaintiff?

Perhaps the most prevalent theory of liability pursued in breast cancer cases is the failure-to-diagnose theory. Under this theory, the plaintiff attempts to prove that a negligent delay in the diagnosis of the plaintiff's breast disease was a departure from acceptable medical practice and the delay was a proximate cause of the alleged injury (that is, it resulted in a significant alteration of the prognosis, outcome, or treatment). The failure-to-diagnose theory can be founded on a variety of medical activities or, as the case may be, inactivity.

The factual predicate necessary to plead and prove a failure-to-diagnose case may be laid during the very first visit with the plaintiff's family physician or gynecologist. As previously discussed, it is vitally important for both the patient and the physician that a complete and thorough medical history be obtained from the patient.⁷⁹ The history should include not only a detailed exploration of the patient's present complaints and previous breast-cancer-related treatment, but also a discussion of family medical history.⁸⁰ "[A] family or racial history of certain cancers is important in evaluating asymptomatic patients for cancer screening" and "in obtaining certain medical tests in symptomatic patients."⁸¹ The history should also include exposure to occupational hazards, such as asbestos, and any social habits like alcoholism or smoking. Failure on the part of the examining physician to elicit such information during the taking of the history could be an important factor in establishing negligence.⁸²

A failure-to-diagnose case can also be based on failure to perform a physical examination, performance of an inadequate examination, or over-reliance on a negative examination. Examples of these mistakes include a physician's failing to recognize a tumor that the patient had discovered, failing to detect an obvious tumor "while treating the patient for an unrelated disease, [m]istaking a carcinomatous tumor

⁷⁹ Heredity breast cancer makes up only approximately 5% to 10% of all breast cancer cases. Cancer Info. & Support Int'l, *Breast Cancer*, at www.cancer-info.com/breast.htm (last visited Mar. 4, 2002).

⁸⁰ Martin B. Flamm, *Cases of Failure to Diagnose Cancer: When Misdiagnosis and Delay Violate Accepted Standards of Care*, TRIAL, Sept. 1986, at 82, 84.

⁸¹ *Id.* at 84; see also *Beckcom v. United States*, 584 F. Supp. 1471, 1478-79 (N.D.N.Y. 1984) (finding that liability for a breast cancer misdiagnosis is based in part on the failure to take a complete history).

⁸² Corrine P. Parver, *Defense of Delayed Diagnosis and Treatment of Breast Cancer*, 30 MED. TRIAL TECH. Q. 34, 39 (1984).

of the breast for a breast infection, or a benign lesion [d]isregarding a definite retraction sign”; failing to determine the cause of nipple discharge; or ordering a diagnostic test in lieu of a physical examination.⁸³

A physician’s failure to monitor the patient or perform follow-up evaluations can serve as a basis for liability.⁸⁴ In the case of *Truan v. Smith*, the defendant doctor’s working diagnosis of the plaintiff’s condition included the possibility of breast cancer, but the doctor did not tell the plaintiff this fact.⁸⁵ The doctor decided to take a wait-and-see approach but failed to perform follow-up tests or have the plaintiff return for further care following the expiration of the doctor’s self-imposed observation period.⁸⁶ The doctor’s negligence in failing to monitor the plaintiff or perform follow-up evaluations was held to have either materially increased the chances of or accelerated the plaintiff’s death.⁸⁷

Liability also can result from an examining physician’s failure to refer the plaintiff for further tests or failure to perform additional diagnostic tests, such as biopsies or mammograms.⁸⁸ A physician’s failure to follow another physician’s or a specialist’s recommendation for additional diagnostic testing when cancer is suspected may amount to professional malpractice. Other courts have held that a physician’s failure to repeat a test, perform additional studies, or refer a patient for a biopsy when an initial test is negative may be malpractice when clinical suspicion is, or should be, high that cancer may still be present.⁸⁹

Plaintiffs may prove malpractice by pointing to the examining physician’s failure to follow recommended protocols. As previously

⁸³ *Beckcom*, 584 F. Supp. at 1478 (finding liability for a breast cancer misdiagnosis based in part on the failure to follow-up a physical examination with more diagnostic testing or a sooner return visit); *Blanchette v. Barrett*, 229 Conn. 256, 261–62, 640 A.2d 74, 78 (1994) (holding that, under some circumstances, the failure to follow-up after a negative mammogram would be sufficient for liability in an ongoing doctor-patient relationship).

⁸⁴ See *Truan v. Smith*, 578 S.W.2d 73, 77 (Tenn. 1979) (holding that the doctor’s negligence in monitoring the patient may have increased the risk of death).

⁸⁵ 578 S.W.2d 73, 76–77 (Tenn. 1979).

⁸⁶ *Truan*, 578 S.W.2d at 75.

⁸⁷ *Id.* at 76.

⁸⁸ *Blanchette*, 640 A.2d at 78; *Hollingsworth v. Shenandoah Med. Imaging, Inc.*, 38 Va. Cir. 324 (Cir. Ct. 1996) (finding the physicians failed to follow-up after a negative mammogram).

⁸⁹ *Flamm*, *supra* note 80, at 85.

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discussed, several professional organizations have developed and published guidelines regarding the timing and frequency of physical and radiographic breast examinations. Although these recommended protocols are not mandatory and are usually not considered binding, they have been widely disseminated and are common knowledge in the medical community. Oftentimes, plaintiffs' attorneys attempt to portray these guidelines and recommended protocols as the standard of care and argue that an examining physician deviated from the standard of care when her examinations did not comport with the guidelines.

Failure-to-diagnose cases can also be founded on improper or inadequate record keeping. Frequently, examining physicians do make recommendations to patients, but for a variety of reasons—including haste, patient overload, forgetfulness or carelessness—these recommendations are not properly recorded in the patient's chart. Some of the more common charting errors include

- failing to record recommendations for follow-up or consultation with a specialist;
- failing to record whether the patient has a family history of cancer or has been exposed to known toxins or carcinogens;
- failing to document the circumstances under which the patient should return for further evaluation;
- failing to record the size, shape, character, or location of lumps or suspicious abnormalities and their alleged duration; and
- failing to chart the reasons for the patient's failure to follow a consultant's recommendations regarding diagnosis or treatment.⁹⁰

If charting errors are present, defense counsel can anticipate the plaintiff's counsel attempting to introduce evidence of the charting errors or omissions in support of the plaintiff's failure-to-diagnose claim.

Some states allow a plaintiff to proceed under a failure to inform theory. In the seminal case of *Truman v. Thomas*, the examining physician told his patient that she should have a pap smear test, but she refused.⁹¹ The physician failed to inform his patient concerning what could result from her refusal to have the test done and she later

⁹⁰ *Id.* at 86.

⁹¹ 27 Cal. 3d 285, 289–90, 611 P.2d 902, 904, 165 Cal. Rptr. 308, 310 (1980).

developed cancer.⁹² The court held that when a patient indicates a refusal to undergo a risk-free test or treatment, the physician must advise that patient of all material risks of which a reasonable person would want to be informed before deciding not to undergo the test or treatment.⁹³ Based on this case law, a plaintiff could argue that her physician's failure to inform her of the risk of developing undetected breast cancer after refusing to undergo a mammogram should give rise to liability on the part of the examining physician.

In addition to the foregoing, breast cancer cases can also be predicated on more traditional malpractice theories such as a failure to remove the entire cancerous lesion or all of the affected lymph nodes; improper radiation therapy that was not indicated or that was administered in improper doses, timing, or frequencies; or contraindicated chemotherapy.⁹⁴ Finally, breast cancer cases can be based on a misdiagnosis of cancer (when, in fact, none existed), thereby needlessly subjecting the plaintiff to unnecessary surgery, radiation, or chemotherapy.⁹⁵

III. What Are the Defenses Available to the Defendant?

A. Statute of Limitations

Most jurisdictions in the United States have enacted statutes of limitations that are designed to limit the amount of time that a tortfeasor can expect to answer for his own negligence. Determining when the statute of limitations expires in a medical malpractice action can be a daunting task, but one which should be immediately undertaken by defense counsel once the defendant has been served with the summons and complaint.

The legislatures in many states have recognized that great difficulties exist in applying traditional personal injury statute of limitations principles to medical malpractice actions. For this reason, many states

⁹² *Truman*, 611 P.2d at 904.

⁹³ *Id.* at 906.

⁹⁴ See generally *Jones v. Montefiore Hosp.*, 494 Pa. 410, 431 A.2d 920 (1981) (involving a doctor who was negligent in not removing full cancerous mass).

⁹⁵ Steven E. Pegalis & Harvey F. Wachsman, *Negligence and Cancer: What the Lawyer Needs to Know*, TRIAL, May 1986, at 49–50; see generally *Solomon v. Hall*, 767 S.W.2d 158 (Tenn. Ct. App. 1988) (involving defendant doctors who were sued for misdiagnosing the plaintiff as having breast cancer); *Wyatt v. Longoria*, 33 S.W.3d 26 (Tex. App. 2000) (involving defendant doctors who were sued for misdiagnosing the plaintiff as having terminal cancer).

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have enacted special statutes of limitations that apply specifically to medical malpractice actions.⁹⁶ Some of these states have also enacted special statutes of repose that apply in medical malpractice cases.⁹⁷ Defense counsel must become intimately familiar with these statutes and begin an assessment of any cancer case by reviewing their applicability to the case at hand.

There are some special considerations that defense counsel should be aware of when dealing with these special statutes of limitations for medical malpractice actions. For example, under Illinois law, the two-year statute of limitations period applies—even if the four-year statute of repose has not elapsed since the time of the alleged injury—if the plaintiff knows or through the use of reasonable diligence should have known of the existence of the injury.⁹⁸ In addition, the activating event, in terms of the statute of limitations, is the time when the plaintiff knows or reasonably should have known of the injury and the plaintiff knows or reasonably should have known that the injury was negligently caused.⁹⁹ Where no medical malpractice is initially suspected, the plaintiff is not required to investigate the possibility of malpractice immediately following a traumatic injury to avoid the limitations period in case medical negligence is subsequently discovered.¹⁰⁰ Moreover, defense counsel should keep in mind that a statute of limitations does not serve to extend a statute of repose period; the statute of repose period is an absolute limit.¹⁰¹

⁹⁶ See, e.g., 735 ILL. COMP. STAT. 5/13-212 (West 2001); MD. CODE ANN. CTS. & JUD. PROC. § 5-109 (2001); MICH. COMP. LAWS § 600.5838a (2001); MISS. CODE ANN. § 15-1-36 (2001); N.M. STAT. ANN. § 41-5-13 (Michie 2001); S.C. CODE ANN. § 15-3-545 (Law. Co-op. 2001).

⁹⁷ See, e.g., 735 ILL. COMP. STAT. 5/13-212 (West 2001); MD. CODE ANN. CTS. & JUD. PROC. § 5-109 (2001); MISS. CODE ANN. § 15-1-36 (2001); S.C. CODE ANN. § 15-3-545 (Law. Co-op. 2001); see PATRICK E. MCGANN ET AL., ILLINOIS PERSONAL INJURY 5–19, 5–20 (1997).

⁹⁸ MCGANN ET AL., *supra* note 97, at 5–21; see also *Seale v. Gowans*, 923 P.2d 1361, 1364 (Utah 1996) (finding that the defendants failed to establish a legal harm that would begin the running of the statute of limitations); *Weidman v. Wilkie*, 277 Ill. App. 3d 448, 453, 660 N.E.2d 157, 160, 213 Ill. Dec. 900, 903 (Ct. App. 1995).

⁹⁹ MCGANN ET AL., *supra* note 97, at 5–21; see also *Snyder v. Judar*, 132 Ill. App. 3d 116, 118, 477 N.E.2d 47, 48, 87 Ill. Dec. 446, 447 (App. Ct. 1985) (finding that plaintiffs do not have to investigate the possibility of medical malpractice at the moment an injury is discovered).

¹⁰⁰ MCGANN ET AL., *supra* note 97, at 5–21.

¹⁰¹ See *Cronin v. Howe*, 906 S.W.2d 910, 913 (1995) (discussing placing an absolute limit on the time during which malpractice actions can be brought).

Many states also adhere to a “continuous treatment” rule when it comes to allowing plaintiffs to file and pursue malpractice actions.¹⁰² Under the continuous treatment rule, the applicable statute of limitations or statute of repose is tolled until the end of the physician-patient relationship, so long as there has been continuous treatment. A plaintiff will be able to prevail under a theory of a continuous course of negligent treatment if she can show that there was a continuous and unbroken course of negligent conduct, and that the treatment was so related as to constitute one continuous wrong. Once treatment has been discontinued, the statute begins to run, regardless of whether the patient is aware of the negligence at the time the treatment is terminated.¹⁰³

One other point deserves mention when discussing statutes of limitations. Most states will allow for the tolling of the statute of limitations whenever the plaintiff alleges that the defendant fraudulently concealed facts which would have led her to discover a potential cause of action.¹⁰⁴ However, if at the time the plaintiff discovers the fraudulent concealment, a reasonable time remains to file the action within the statute of limitations, this provision does not toll the running of the limitations period.¹⁰⁵ To take advantage of the discovery rule for fraudulent concealment of a cause of action, the plaintiff must specifically plead the facts necessary to explain why the discovery of the cause of action did not occur sooner.¹⁰⁶ Generally, when the plaintiff alleges fraudulent concealment, “it is necessary to show affirmative acts by the defendant which were designed to prevent, and in fact did prevent, the discovery of the claim.”¹⁰⁷ Mere silence on

¹⁰² See *McCoy v. United States*, 264 F.3d 792, 795 (8th Cir. 2001) (discussing the use of the continuous treatment doctrine in the Eighth Circuit); see also *Wilshire v. Richey*, No. 90-6542, 1991 U.S. App. LEXIS 29784, at *7 (6th Cir. Dec. 10, 1991) (noting that Kentucky is the only state in the Sixth Circuit that has not adopted the continuous treatment rule).

¹⁰³ See *Anderson v. Wagner*, 79 Ill. 2d 295, 323, 402 N.E.2d 560, 573, 37 Ill. Dec. 558, 571 (1979); *Voeytlin v. Perryman*, 977 S.W.2d 806, 810–11 (Tex. App. 1998); *McGANN ET AL.*, *supra* note 97, at 5–13.

¹⁰⁴ See, e.g., *Hagney v. Lopeman*, 147 Ill. 2d 458, 464, 590 N.E.2d 466, 469, 168 Ill. Dec. 829, 832 (1992).

¹⁰⁵ *McGANN ET AL.*, *supra* note 97, at 5–13; see also *Hagney*, 590 N.E.2d at 469; *Zagar v. Health & Hosps. Governing Comm’n of Cook County*, 83 Ill. App. 3d 894, 898, 404 N.E.2d 496, 499–500, 39 Ill. Dec. 112, 114–15 (App. Ct. 1980).

¹⁰⁶ *McGANN ET AL.*, *supra* note 97, at 5–14; see also *Foster v. Plaut*, 252 Ill. App. 3d 692, 699, 625 N.E.2d 198, 203, 192 Ill. Dec. 238, 243 (App. Ct. 1993).

¹⁰⁷ *Foster*, 625 N.E.2d at 203.

the part of the defendant and the mere failure of the plaintiff to learn of a cause of action does not constitute fraudulent concealment. The plaintiff must be able to show that the defendant said or did something to lull or induce the plaintiff into delaying the filing of her claim after the limitations period has run.¹⁰⁸

B. Causation

Defense counsel should work to have the causation question focus not on what caused the delay in diagnosis, but whether the delay made a difference in the end result or prognosis.¹⁰⁹ The argument is that no damages, or only minimal damages, resulted from the delay. The incurable nature of the breast cancer might be proved by the expert testimony of a physician to the effect that, although a certain course of treatment might have been somewhat helpful, there was no way to conclude that the patient would have survived even if she would have received the more helpful treatment.¹¹⁰ This approach relies on a predetermined strategy of framing the cancer at issue as highly aggressive and incapable of clinical detection until it had accomplished such wide spread invasion that the outcome for the plaintiff would not be significantly impacted by any known treatment regimens. Successful use of this argument requires a thorough review of biological markers and pathological studies.

A major part of the causation argument is the “doubling time” theory.¹¹¹ A defense expert will explain to the jury that the cancer in question started as one cell and underwent subsequent binary division to become two cells and so on. The defense expert will usually assume cells double for the average breast cancer every 100 to 120 days. Therefore, the minimal palpable mass of a tumor approximately one centimeter in diameter is in its thirtieth doubling and has been growing in the patient for approximately eight years. Consequently,

¹⁰⁸ *Hagney*, 590 N.E.2d at 468 (stating the necessity of showing affirmative acts intended to prevent discovery).

¹⁰⁹ Faye E. Luppi et al., *Feature: Legal Issues in Breast Cancer*, 12 MAINE BAR J., May 1997, at 138, 144. The courts in the following cases held that a failure to diagnose an incurable disease was not a proximate cause of a decedent’s death in a wrongful death action, precluding any action of that type against the party who failed to make the diagnosis. *Bromme v. Pavitt*, 5 Cal. App. 4th 1487, 1499, 7 Cal. Rptr. 2d 608, 614 (Ct. App. 1992) (colon cancer); *Williams v. Bay Hosp., Inc.*, 471 So. 2d 626, 630 (Fla. Dist. Ct. App. 1985) (lung cancer).

¹¹⁰ See *Burke v. Miners Mem’l Hosp. Ass’n*, 381 S.W.2d 758, 759 (Ky. Ct. App. 1964).

¹¹¹ Parver, *supra* note 82, at 35, 40.

by the time the tumor has become detectable, regional or distant metastasis is likely to have occurred, thereby greatly reducing or extinguishing the patient's life expectancy. Accordingly, the argument is that the physician's delay, either in diagnosis or treatment of the breast lesion, did not proximately cause a significant impact on the patient's ultimate prognosis.

However, the theories and science regarding tumor proliferation and growth are changing all the time. At a minimum, defense counsel should be familiar with the evolving theories of tumor growth, as well as the growing body of information on the biology of breast cancer and the effect of delay on diagnosis, which continue to be controversial in the medical literature.¹¹²

C. Contributory Negligence

After all is said and done, failure-to-diagnose cases are usually complicated by questions of the patient's lack of compliance, either in returning to the primary care physician for follow-up, obtaining recommended testing such as mammograms or ultrasounds, or not making or keeping an appointment for a recommended general surgical referral for biopsy.

Many reasons have been advanced for these failures, including a failure by the doctor to stress compliance or to give a firm date for re-examination, or the doctor painting too rosy a picture and basically discouraging concern and follow-up. Defense arguments tend to suggest natural denial by the patient, other overriding concerns like family tragedy or illness, or the patient's own fear of facing mortality. Whatever the reason for the lack of compliance, an argument can be made that such actions contributed to the patient's damages and may have been so extreme as to warrant a finding of contributory negligence.¹¹³

These circumstances inevitably place the defense in the unenviable position of casting blame on the naturally sympathetic patient who

¹¹² Luppi et al., *supra* note 109, at 145.

¹¹³ King v. Clark, 709 N.E.2d 1043, 1048 (Ind. Ct. App. 1999) (holding evidence that the patient delayed seeking treatment in obtaining recommended diagnostic tests and had rapidly growing cancer warranted contributory negligence instructions in a failure to timely diagnose breast cancer case); Roers v. Engebretson, 479 N.W.2d 422, 424 (Minn. Ct. App. 1992) (upholding a finding that a breast cancer patient was thirty percent contributorily negligent where, after patient first consulted a physician about a lump in her breast, he told her to return in six months and she did not return for fifteen months).

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(with the possible exception of the chronic smoker-lung cancer patient) has had a devastating disease process thrust upon her through no fault of her own. The plaintiff is nearly always a partial victim in a cancer case. While the facts of every case should allow the defense to avoid the blame game, it is important from a jury dynamic standpoint to formulate a defense theory that places blame as subtly as possible.

From a practical standpoint, the defense would like to avoid bearing the burden of proof at trial. The assertion of an affirmative defense of contributory fault carries with it the burden of establishing, through expert testimony, that the patient's delays or failures proximately resulted in the claimed damage.¹¹⁴ This type of defense tends to overwhelm a case and may well detract from the main thrust of the defendant's argument, which should focus on the defendant's compliance with the applicable standard of care.

Perhaps a more effective use of contributory fault evidence is to forego the possibility of a percentage reduction in the verdict or a greater than fifty percent attribution of fault and use the evidence of a plaintiff's failure to obtain prompt and proper follow-up care in support of a failure to mitigate damages instruction or argument. Another alternative is to argue that, although the plaintiff's failures and delays were unfortunate and basically tied the hands of the defendant physicians or health care providers, in the end, these failures were of no consequence since no intervention, however heroic or aggressive, would have changed the outcome.

IV. What Damages Can the Plaintiff Recover?¹¹⁵

A. Compensatory Damages for Medical Expenses, Lost Time or Future Earnings, Pain and Suffering, Future Medical Expenses, and Others

Obviously, the plaintiff will make a claim for compensatory damages. Those damages will include damages for past and future medical

¹¹⁴ See, e.g., *Barenbrugge v. Rich*, 141 Ill. App. 3d 1046, 1054–55, 490 N.E.2d 1368, 1373–74, 96 Ill. Dec. 163, 168 (App. Ct. 1986).

¹¹⁵ Before conducting an analysis of the plaintiff's damages, defense counsel should familiarize herself with any applicable statutes capping medical malpractice damages in the relevant jurisdiction. See, e.g., *Turner v. Massiah*, 656 So. 2d 636, 641 (La. 1995) (a \$408,000 judgment for a breast cancer misdiagnosis action reduced in part for being above the cap set by the Louisiana Medical Malpractice Act); see generally Carol A. Crocca, Annotation, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245 (2001) (discussing statutory recovery caps).

expenses. If the plaintiff has had a long course of treatment, or if the plaintiff's treating physicians expect that a lengthy course of chemotherapy, radiation, or other medical treatment is necessary to prolong or save the plaintiff's life, one can expect the plaintiff's attorney to ask for hundreds of thousands—or even millions—of dollars as compensation to cover past and future medical bills.

In addition, the defense can expect to encounter claims for past and future lost wages, bonuses, or benefits. If the plaintiff has missed a substantial amount of time from work, or is expected to miss a great deal of time in the future, the lost wage claim can be a substantial part of the plaintiff's prayer for damages.

Apart from the *hard* monetary damages outlined above, the plaintiff may also ask for compensation for a number of intangible damages. One such type of damages is compensation for pain and suffering. There is almost nothing as sad as a young wife and mother dying of metastatic breast cancer. In those cases where the plaintiff has already died prior to trial, if the plaintiff's attorney has had the foresight to videotape the testimony of the plaintiff, the defense will have a formidable task ahead in attempting to overcome the natural sympathy in favor of the deceased. Left unchecked, damages for pain and suffering may climb into the millions of dollars.

B. Loss of Consortium or Companionship

Loss of consortium is a term of art used to describe damages for loss of society, companionship, comfort, love, affection, and sexual relations. The courts of some states, such as Texas, have held that loss of consortium damages are recoverable solely for sentimental losses.¹¹⁶ The law regarding loss of consortium damages, and who may recover them, varies a great deal from state to state. Defense counsel would be well advised to carefully review the law of the jurisdiction in which the action is pending in order to gain an understanding of this potentially explosive element of damages.

Anyone who doubts that loss of consortium damages can be substantial in failure-to-diagnose-cancer cases should review the case of *Wheat v. United States*.¹¹⁷ In *Wheat*, a woman died after her physicians failed to diagnose cervical cancer.¹¹⁸ The district court held that the decedent's teenage daughter was entitled to \$1 million for

¹¹⁶ Whittlesey v. Miller, 572 S.W.2d 665, 667 (Tex. 1978).

¹¹⁷ 630 F. Supp. 699 (W.D. Tex. 1986).

¹¹⁸ *Wheat*, 630 F. Supp. at 701.

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loss of consortium, the decedent's older daughter was entitled to \$500,000 for loss of consortium, the decedent's husband was entitled to \$1.8 million for loss of consortium, and also the decedent's parents were each entitled to \$200,000 for loss of consortium damages.¹¹⁹

C. Emotional Distress

When a doctor initially tells a patient that she has cancer, the news itself is devastating. The patient may experience weight loss, depression, vomiting, nausea, or other physical responses to the news of cancer. In those cases where the physician misdiagnosed cancer, a very real potential exists for the plaintiff's counsel to add a count for intentional or negligent infliction of emotional distress. In addition, in those cases where a plaintiff has been subjected to unnecessary chemotherapy or other treatment as a result of the misdiagnosis, defense counsel can expect to see a prayer for relief requesting compensation for the suffering caused by the unnecessary therapy.¹²⁰

D. Survival and Lost Chance of Survival

Many states allow a plaintiff to recover damages for the defendant's failure to adequately diagnose or treat the cancer when that failure results in the loss of a chance of survival.

For example, in Texas, the plaintiff must prove that in reasonable medical probability the ultimate harm would not have occurred but for the [physician's] negligence. This means that a plaintiff whose cancer is terminal or who is suing for wrongful death must show that the cancer . . . was, more likely than not, curable—the patient would have had at least a [fifty-one] percent chance of surviving with adequate treatment. . . .

Other states have adopted the loss of chance doctrine, which allows a plaintiff to prove that her chances for long-term survival have been reduced by some percentage. States that have adopted this theory may require a plaintiff to show she had a greater than [fifty] percent chance of surviving before the defendant's negligence, while other states

¹¹⁹ *Id.* at 722.

¹²⁰ In *Hume v. Bayer*, 178 N.J. Super. 310, 428 A.2d 966 (1981), a doctor diagnosed a young boy as having a rare cancerous disease when he in fact only had an infected appendix. According to the court, the plaintiffs could have stated a viable claim against the defendant doctor for intentional infliction of emotional distress if they had included allegations that the doctor intentionally communicated the misinformation or that the plaintiff patient suffered severe emotional distress. *Hume*, 428 A.2d at 974.

merely require proof that a “substantial chance” of survival—usually defined as less than [fifty] percent—was lost.¹²¹

E. Fear of Developing Cancer

“Fear of illness” is a phrase generally used by the courts to describe a present anxiety over developing cancer in the future or the present fear of contracting other types of serious physical illness. In practice, fear of illness is a shorthand phrase for a wide range of mental disturbances—anxiety, shock, depression, despair, anguish, nervousness, as well as fear—that may arise out of the apprehension associated with the possibility of contracting a future illness or disease. As such, fear-of-illness claims are simply a type of legal action for the recovery of emotional distress damages.¹²²

Fear-of-illness cases should not be confused with cases involving a claim for an enhanced risk of future disease. In the latter type of case, the plaintiff claims that the defendant’s negligence caused her to incur an increased risk of developing the illness in the future. The court is asked to award damages despite the fact that no one can know with certainty whether the dire consequences the plaintiff believes may happen will ever come to pass. Increased risk of illness claims differ from fear-of-illness claims in that plaintiffs are not seeking compensation under the former for present-day fears. Rather, they are looking for recovery for the full value of a future disease, even if they never contract that disease, if they are able to show a sufficiently enhanced risk of contraction through competent expert testimony.¹²³

¹²¹ Clay Miller, *Misread Pap Smears-Taking a Closer Look*, TRIAL, June 1997, at 36 (citations omitted); see also *Kramer*, 858 S.W.2d at 407 (rejecting the lost chance of survival doctrine as part of the Texas common law where the adverse result would probably have occurred anyway); see, e.g., *Kilpatrick v. Bryant*, 868 S.W.2d 594, 596 (Tenn. 1993) (declining to recognize a cause of action for loss of chance); see also, e.g., *Kroll v. United States*, 708 F. Supp. 117, 118 (D. Md. 1989), *aff’d*, 900 F.2d 253 (4th Cir. 1990) (discussing the recognition of a “loss of a substantial chance of survival as an element of damage”).

¹²² A claim for fear-of-illness differs from a claim for cancerphobia. First, the term “cancerphobia” refers to an unreasonable fear that the individual asserting the claim knows to be unreasonable, whereas “fear of illness” is a phrase that generally applies to fears which are deemed to be reasonable. In addition, cancerphobia refers to a recognized psychiatric illness that must be proved through expert testimony. A fear of illness claim may be established simply through the plaintiff’s own testimony to the effect that she is afraid, preoccupied, and distressed because of an enhanced risk of illness.

¹²³ Although the language differs from court to court, generally, in order for a plaintiff to recover under an increased risk of illness claim, the plaintiff must establish

States that have been confronted with fear-of-illness claims generally impose one of three requirements in determining whether to allow plaintiffs to recover for fear of illness: (1) physical injury resulting in mental anguish, (2) mental anguish resulting in physical injury, or (3) mental anguish that neither results from nor causes physical injury. Each of these requirements for recovery in fear-of-illness cases will be addressed *seriatim*.

1. Physical Injury or Impact Resulting in Mental Anguish

The majority of jurisdictions in the United States confronted with fear-of-illness claims require, as a prerequisite to recovering damages for fear of developing illness at a later date, proof of a physical injury or impact resulting in mental anguish. One of the often cited cases requiring such proof is *Gideon v. Johns-Manville Sales Corp.*¹²⁴ Howard Gideon handled asbestos products daily as a major part of his twenty-five years of work for Standard Insulation, Inc.¹²⁵ At the time of trial, Gideon was suffering from asbestosis, and he presented medical testimony that he had a greater than fifty percent chance of contracting mesothelioma or some other type of asbestos-related cancer.¹²⁶ Gideon sought damages for, among other things, his increased fear of contracting cancer, as well as his increased risk of developing cancer.¹²⁷ The jury returned a verdict against seven of the seventeen defendants sued by Gideon and assessed damages at \$500,000.¹²⁸ The defendants appealed and argued that Gideon's enhanced risk of cancer claim should have been excluded and that the district court erred in not instructing the jury that Gideon could not recover for his fear of cancer.¹²⁹

that there is a greater than fifty percent chance that the illness will occur at some point in the future. *See, e.g.,* Jackson v. Johns-Manville Sales Corp., 781 F.2d 394, 413 (5th Cir. 1986) (allowing recovery for an asbestosis plaintiff where evidence indicated a greater than 50% chance of contracting cancer); Rabb v. Orkin Exterminating Co., 677 F. Supp. 424, 426 (D.S.C. 1987) (disallowing recovery where plaintiffs could provide no testimony indicating that there was a greater than 50% chance of developing cancer); Johnson v. Armstrong Cork Co., 645 F. Supp. 764, 769 (W.D. La. 1986) (holding that recovery was possible where toxic exposure more probably than not will lead to cancer; requiring evidence that indicates the increased risk is greater than fifty percent).

¹²⁴ 761 F.2d 1129 (5th Cir. 1985).

¹²⁵ *Gideon*, 761 F.2d at 1134.

¹²⁶ *Id.* at 1138.

¹²⁷ *Id.*

¹²⁸ *Id.* at 1134.

¹²⁹ *Id.* at 1139.

The Fifth Circuit Court of Appeals held that Gideon was entitled to recover for his fear of cancer. The court stated:

Given the testimony that Gideon was likely to develop and die from cancer, the district court did not err in refusing to charge the jury that Gideon could not recover for his fear of future injury and death. Texas law permits the recovery of damages for mental anguish at least when there is actual physical injury. It does not appear that recovery for anxiety must be limited to concern about the injury that is already manifest. Gideon may, therefore, recover for the fear of future conditions that will, in medical probability, develop from presently existing injuries.¹³⁰

In essence, because Gideon was currently suffering from a physical injury (asbestosis), the court of appeals held that Gideon should be permitted to recover damages for his fear of cancer.¹³¹ Based on the same rationale that guided the *Gideon* court, several other jurisdictions require some form of bodily injury before submitting the question of damages for fear of cancer to the jury.¹³²

Some courts have gutted the requirement of a physical injury or impact resulting in mental anguish by characterizing the mere exposure to cancerous materials as being a physical injury or impact.¹³³ However, the Supreme Court refused to equate mere exposure with physical impact in *Metro North Commuter Railroad Co. v. Buckley*.¹³⁴ In *Buckley*, the United States Supreme Court declined to follow cases that held a plaintiff could recover for emotional distress based on exposure to asbestos in the absence of physical symptoms. Instead, the Court held that Buckley could not recover emotional distress

¹³⁰ *Gideon*, 761 F.2d at 1138 (citations omitted).

¹³¹ *Id.*

¹³² *Boryla v. Pash*, 960 P.2d 123, 127 (Colo. 1998); *Payton v. Abbott Labs*, 386 Mass. 540, 547, 437 N.E.2d 171, 175 (1982); *Ferrara v. Galluchio*, 176 N.Y.S.2d 996, 999, 152 N.E.2d 249, 252 (N.Y. 1958); *Eagle-Picher Indus. v. Cox*, 481 So. 2d 517, 538 (Fla. Dist. Ct. App. 1985).

¹³³ *Dartez v. Fibreboard Corp.*, 765 F.2d 456, 468 (5th Cir. 1985) (holding that the plaintiff's mere ingestion of asbestos fibers, despite his lack of illness, was sufficient to allow for recovery of fear-of-cancer damages); *see also Herber v. Johns-Manville Corp.*, 785 F.2d 79, 84 (3d Cir. 1986) (discussing a claim for emotional harm based on fear and future illness); *Wetherill v. Univ. of Chicago*, 570 F. Supp. 1124, 1560 (N.D. Ill. 1983) (stating that fear of future injury linked to the "physical impact (as distinct from injury) of defendant's tortious conduct" is required for recovery).

¹³⁴ 521 U.S. 424, 437, 117 S. Ct. 2113, 2121, 138 L. Ed. 2d 560, 573 (1997).

damages unless, and until, he manifested symptoms of a disease.¹³⁵ In refusing to follow those cases holding that mere exposure to asbestos satisfied a physical injury or impact requirement, the Court noted that “physical impact” does not equate with “physical contact” and does not

include a contact that amounts to no more than an exposure—an exposure, such as that before us, to a substance that poses some future risk of disease and which contact causes emotional distress only because the worker learns that he may become ill after a substantial period of time.¹³⁶

2. Mental Anguish Resulting in Physical Injury

A few jurisdictions have departed from the majority rule and allowed plaintiffs to recover damages pursuant to fear-of-illness claims only if their fear or mental anguish results in a physical injury.¹³⁷ The general sentiment of these courts is that a physical manifestation corroborates allegations of mental anguish and, therefore, legitimizes the plaintiff’s claims.

In *Stites v. Sundstrand Heat Transfer, Inc.*, the plaintiffs, residents of Dowagiac, Michigan, filed suit against the defendant “alleg[ing] that they . . . suffered severe injuries from exposure to various toxic chemicals [that had] leaked from [the defendant’s] manufacturing plant . . . [s]ince the [early] 1950s.”¹³⁸ The plaintiffs claimed to suffer from “severe depression over a fear of cancer, as well as humiliation, anxiety, mortification, anguish, emotional distress [and] outrage.”¹³⁹ The defendant filed a motion for partial summary judgment in regard to the plaintiffs’ fear-of-cancer claim. In ruling on the defendant’s motion for summary judgment, the district court stated that,

[t]o recover on their fear of cancer claim, plaintiffs must establish (1) that they have suffered emotional distress as a proximate result of defendant’s negligent conduct; (2) that this emotional distress has manifested itself in definite and objective physical injury; and (3) that

¹³⁵ *Buckley*, 521 U.S. at 432.

¹³⁶ *Id.* at 432; *accord* *Temple-Inland Forest Prods. Corp. v. Carter*, 993 S.W.2d 88, 91 (Tex. 1999) (discussing the recovery of damages for reasonable fear of disease without current physical injury).

¹³⁷ *Watkins v. Fibreboard Corp.*, 994 F.2d 253, 259 (5th Cir. 1993); *In re Moorenovich*, 634 F. Supp. 634, 637 (D. Me. 1986).

¹³⁸ 660 F. Supp. 1516, 1517 (W.D. Mich. 1987).

¹³⁹ *Stites*, 660 F. Supp. at 1517.

their emotional distress is not about a completely fictitious, vague, fanciful or imagined consequence, having no reasonable basis.¹⁴⁰

3. Mental Anguish That Neither Results From Nor Causes Physical Injury

Recently, some jurisdictions have retreated from the traditional approach of requiring a prior physical injury, impact, or a physical manifestation of the fear and have allowed plaintiffs to proceed with claims for fear of cancer when they have neither suffered a physical injury or impact nor manifested any physical conditions as a result of their claimed distress. One such case is *Potter v. Firestone Tire & Rubber Co.*¹⁴¹ In *Potter*, four landowners living adjacent to a waste disposal site filed suit against the defendant, alleging that their water supply had been contaminated by toxic chemicals negligently dumped by the defendant.¹⁴² None of the plaintiffs manifested any cancerous or pre-cancerous conditions, nor did any of the plaintiffs suffer from any conditions of physical ill-being at the time they filed suit.¹⁴³ Each plaintiff claimed to face an enhanced, unquantifiable risk of developing cancer in the future as a result of their exposure to the toxic chemicals carelessly discarded by the defendant.¹⁴⁴

At a bench trial, the plaintiffs were awarded several million dollars in damages, including \$800,000 for their fear-of-cancer claims.¹⁴⁵ The defendant appealed, and the California Court of Appeals affirmed the award of damages for the plaintiffs' fear of cancer.¹⁴⁶ An appeal was taken to the California Supreme Court, which also upheld the award of damages for the plaintiffs' fear of cancer.¹⁴⁷

In holding that the plaintiffs were entitled to recover for their fear of cancer, the California Supreme Court held that the plaintiffs did not have to establish a present physical injury, impact, or a resulting

¹⁴⁰ *Id.* at 1526; *see also* Bass v. Nooney Co., 646 S.W.2d 765, 772–73 (Mo. 1983) (replacing the old impact rule in Missouri with a two-prong test requiring the plaintiff to prove that “(1) the defendant should have realized. . .an unreasonable risk of causing the distress; and (2) the emotional distress . . . must be medically diagnosable and . . . of sufficient severity”).

¹⁴¹ 6 Cal. 4th 965, 986, 863 P.2d 795, 808, 25 Cal. Rptr. 2d 550, 563 (1993).

¹⁴² *Potter*, 863 P.2d at 801–02.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 814.

¹⁴⁵ *Id.* at 803.

¹⁴⁶ *Id.* at 804.

¹⁴⁷ *Potter*, 863 P.2d at 810.

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physical manifestation of their anguish in order to recover emotional distress damages for the fear of developing cancer in the future.¹⁴⁸ The supreme court held that, in order for plaintiffs who have not suffered either a physical injury or impact, and who are not suffering from a physical manifestation of emotional distress to recover damages engendered by a fear of cancer, they must

plead[] and prove[] that (1) as a result of the defendant's negligent breach of a duty owed to the plaintiff, the plaintiff [was] exposed to a toxic substance which threaten[ed] cancer, *and* (2) the plaintiff's fear stems from a knowledge, corroborated by reliable medical or scientific opinion, that it is more likely than not that the plaintiff will develop the cancer in the future [because of] the toxic exposure. Under [the *Potter*] rule, a plaintiff must do more than simply establish knowledge of a toxic ingestion or exposure and a significant[ly] increased risk of cancer. The plaintiff must further show that, based upon reliable medical or scientific opinion, the plaintiff harbors a serious fear that the toxic ingestion or exposure was of such magnitude and proportion as to likely result in the feared cancer.¹⁴⁹

Other courts have followed the *Potter* rationale and some have even allowed recovery despite evidence showing that the plaintiff does not and will not have cancer.¹⁵⁰

F. Punitive Damages

In some states, plaintiffs may be able to obtain punitive damages in a failure-to-diagnose-or failure-to-treat-breast-cancer case.¹⁵¹ Such damages would normally be available only if the plaintiff can prove that the defendant or defendants engaged in conduct which demonstrated an utter indifference to the plaintiff's health or well-being, or that the defendant or defendants engaged in willful and wanton misconduct. This is a heavy burden for the plaintiff to carry and, in those cases where the plaintiff is seeking punitive damages, every effort must be made to require the plaintiff to meet every element of the claim. Defense counsel should move the court in limine to bar any reference to punitive damages until such time as the plaintiff has presented evidence to warrant an award of punitive damages.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 816.

¹⁵⁰ See *Watkins v. Fibreboard Corp.*, 994 F.2d 253, 259 (5th Cir. 1993); *In re Moorenovich*, 634 F. Supp. 634, 637 (D. Me. 1986); *James v. Lieb*, 221 Neb. 47, 59, 375 N.W.2d 109, 117 (1985).

¹⁵¹ See, e.g., ALA. CODE § 6-11-21 (2001).

Some state legislatures have expressed a fear that punitive damages in medical malpractice cases will result in ever increasing health care costs, the elimination of some medical specialties, and a dangerous decrease in practicing physicians within given areas. In order to help alleviate these problems, the legislatures have passed statutes specifically prohibiting the imposition of punitive damages in medical malpractice cases.¹⁵² Defense practitioners must be aware of these statutes, and invoke them, if the plaintiff expresses an interest in obtaining punitive damages.

V. Which Experts Does the Defense Choose and Where Does the Defense Find Them?

It may be impossible to defend (or prosecute) a failure-to-diagnose breast cancer case without the services of at least one expert witness. The types of experts retained by the defense will be dictated, to a certain extent, by the claims being made by the plaintiff and the nature and extent of the plaintiff's alleged damages. What follows is a summary of the types of experts that are often used in these types of cases and how they can be utilized to build a strong defense to the plaintiff's claims.

Oncologist. An oncologist is “[a] medical doctor who specializes in the treatment of cancer.”¹⁵³ This witness will be an expert in the origins and causes of a particular cancer and should possess the experience in pathology or histology (the science which deals with the microscopic structure of tissues and organs) required for maximum effect at trial.¹⁵⁴ An oncologist can make or break the case for the defense and should be used to educate the jury about cancer and provide credible testimony regarding the defenses to the plaintiff's case.¹⁵⁵

Obstetrician-Gynecologist. An obstetrician-gynecologist is a medical doctor who specializes in the administration of health care to women with a special emphasis on the care of women during and after

¹⁵² See, e.g., 735 ILL. COMP. STAT. ANN. § 5/2-1115 (West 2001) (stating that, “[i]n all cases, whether in tort, contract or otherwise, in which the plaintiff seeks damages by reason of legal, medical, hospital, or other healing art malpractice, no punitive, exemplary, vindictive or aggravated damages shall be allowed”).

¹⁵³ Haskell H. Shelton, *Defending Cancer Litigation: The Causation Defense*, 24 FOR THE DEFENSE, Jan. 1982, at 8, 15.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

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pregnancy.¹⁵⁶ Most women who seek regular healthcare consult with an obstetrician-gynecologist for pelvic exams, breast exams, Pap smear tests, pregnancy tests, prenatal care, and other health issues related exclusively to women.¹⁵⁷ If the defendant in the case is the plaintiff's obstetrician-gynecologist, an obstetrician-gynecologist should be consulted, especially in regard to charting issues, standard of care issues, and examination techniques.¹⁵⁸

Pathologist. A pathologist is a medical doctor concerned with the "analysis of tissues, either before or after death."¹⁵⁹ A pathologist should be consulted to confirm the existence of the particular cancer at issue and perhaps provide testimony regarding the nature and extent of the invasiveness and cellular makeup of the plaintiff's cancer.¹⁶⁰ If the pathologist retained by the defendant has a subspecialty in histology, she may be the single best witness to be called at the time of trial.¹⁶¹

Epidemiologist. Literally speaking, an epidemiologist is "an individual who studies epidemics and epidemic diseases."¹⁶² In recent years, "the designation has come to mean an individual who devotes himself to identification of the causes of disease in humans."¹⁶³ An epidemiologist may be a medical doctor or a person who has been scientifically trained in the particular discipline.¹⁶⁴ An epidemiologist would be familiar with the techniques used to analyze large numbers of people with known diseases.¹⁶⁵ Through the use of various analytical techniques, the epidemiologist can identify common substance exposures in an effort to identify the cause of the plaintiff's cancer.¹⁶⁶

Toxicologist. A toxicologist is an individual who devotes her life to the study of poisons, including their effects on the human body.¹⁶⁷ Toxicology is divided into four different fields, including clinical

¹⁵⁶ See generally TABER'S CYCLOPEDIA MEDICAL DICTIONARY (18th ed. 1993).

¹⁵⁷ *Id.*

¹⁵⁸ See *id.* (defining obstetrician and gynecologist).

¹⁵⁹ Shelton, *supra* note 153, at 8, 15.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ Shelton, *supra* note 153, at 8, 15.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 14.

toxicology, environmental toxicology, forensic toxicology, and industrial toxicology.¹⁶⁸ Any toxicologist hired by the defense should be certified by the American Board of Toxicology and should have a basic familiarity with the area of risk assessment.¹⁶⁹ A toxicologist should not be retained as the sole expert in the case, especially when the plaintiff has disclosed a medical doctor as an expert witness.¹⁷⁰

Industrial Hygienist. An industrial hygienist is usually “concerned with the control of health hazards in the workplace.”¹⁷¹ An industrial hygienist will often be hired to analyze air quality information and help quantify exposure levels.¹⁷² In addition, such an expert can explain, from a technical standpoint, what may have occurred within a particular plant at a particular time and provide valuable assistance in checking the supporting data of opposing air modeling experts.¹⁷³ Moreover, this expert will be able to pinpoint whether factors such as changes in the manufacturing process or equipment would materially affect substance exposures.¹⁷⁴

Economist. An economist is a person specially trained in economic theory and principles.¹⁷⁵ Oftentimes an economist will be hired by the plaintiff’s attorney to reduce any verdict in favor of the plaintiff to present cash value. Undoubtedly, the figures presented by the plaintiff’s economist will be skewed in favor of the plaintiff. Defense counsel may need to hire an expert economist in order to refute the numbers advanced by the plaintiff’s financial expert.

Once defense counsel has identified the type of expert or experts that will help to support the theories of defense, she must then find the expert. Inquiries regarding expert witnesses can be made to other members of defense counsel’s firm or to other defense counsel in the jurisdiction where the case is pending. The names of potential experts can also be obtained from defense counsel’s other clients, including other physicians or hospitals. Experts can sometimes be located through cancer support groups or the American Cancer Society. In addition, defense counsel can obtain the names of potential experts

¹⁶⁸ *Id.* at 15.

¹⁶⁹ Shelton, *supra* note 153, at 14.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 14.

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ Shelton, *supra* note 153, at 14–15.

¹⁷⁵ WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 395 (9th ed. 1983).

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through expert witness indices (such as the DRI expert witness bank), professional search firms (such as the Technical Advisory Service for Attorneys), or the Internet.

The authors are in favor of retaining experts, no matter where they come from, at the very beginning of the case. The insight and guidance an expert can provide in framing defenses, refuting the plaintiff's claims, formulating deposition questions, and tailoring discovery can be invaluable and can make the difference between winning and losing the case.

The first contact with the expert should be by telephone. Defense counsel should have a brief conversation with the expert regarding the facts of the case and the possible theories of liability and defense. The expert should be provided with a copy of all of the information and documents in defense counsel's possession. Defense counsel should find out what documents the expert wants to review and what additional information the expert would like defense counsel to obtain. The initial consultation should be followed by a formal letter indicating the expert's retention, an admonition that all conversations with defense counsel are confidential and should be treated as such, and an outline for completion of the expert's initial analysis.¹⁷⁶

After the expert has received the materials sent by defense counsel, but before the expert has arrived at her conclusions and opinions, defense counsel should contact the expert to determine whether any further materials should be sent to the expert for review. Every effort should be made to provide the defense expert with all materials available in the case and to supplement the expert's file when additional information or documents become available. Defense counsel should be especially vigilant in providing all defense experts with copies of the reports generated by the plaintiff's expert witnesses.¹⁷⁷

Once the defense expert or experts have reviewed all of the available materials and information, and have arrived at their opinions and conclusions, defense counsel will be in a position to better prepare answers to plaintiff's discovery and, possibly, some well-crafted requests for admissions of facts. Counsel should also use the expertise of opinion witnesses to fashion appropriate affirmative defenses to the

¹⁷⁶ John F. Romano, *The Classic Case of Medical Mismanagement: Litigation of the Failure to Diagnose Malignant Disease Cases*, 7 AM. J. TRIAL ADVOC. 217, 251 (1984).

¹⁷⁷ *Id.*

plaintiff's complaint at law. In addition, defense counsel should use the expert witness or witnesses as the architects of discovery. Every effort should be made to find out precisely what information the expert wants defense counsel to ascertain during the course of discovery. Defense counsel should not engage in discovery without having definite goals in mind—and those goals should be ones that are shared by the defendant's experts.¹⁷⁸

As the dates for the depositions of the defendant's experts approach, defense counsel will need to have lengthy pre-deposition conferences with the experts. All aspects of the possible direct and cross-examinations must be covered in detail. The deposition is the last place the expert and defense counsel want to be surprised. Once the depositions are completed, defense counsel must be sure to provide copies to his experts so that the experts can review their testimony prior to trial.¹⁷⁹

Just prior to trial, defense counsel should discuss possible trial exhibits with his experts. Counsel should find out what the experts want to work with in the courtroom in terms of anatomical models, charts, and medical illustrations depicting such items as tumor growth, cancer staging, or cell development or destruction.¹⁸⁰ In addition, a great deal of time should be spent preparing the defense experts for trial. Defense counsel should conduct a sample direct and cross-examination of each expert, covering all aspects of the expected trial testimony.¹⁸¹ Remember, "prior preparation prevents a pitiful, poor performance."

VI. Source Material

Cancer cases are fact intensive. In order to properly handle the defense of a breast cancer case, the defense attorney must become an expert on cancer. There are several very good sources for defense attorneys to rely on for vital information regarding cancer and the defense of cancer cases. Among that source material is the following:

- *Cancer: Principles & Practice of Oncology*, V. DaVita, et al.
- *Disease of the Breast*, C.D. Haagensen
- *Growth Kinetics of Tumors*, G. Gordon Steel

¹⁷⁸ *Id.* at 252.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ Romano, *supra* note 176, at 252.

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- *Manual for Staging of Cancer*, Oliver H. Beahrs, et al.
- *Clinical Oncology*, Horton & Hill, ed.
- *Origins of Human Cancer*, Hiatt, et al.
- *Breast Health*, Charles B. Simone
- *Breast Cancer: What You Should Know (But May Not Be Told) About Prevention, Diagnosis, and Treatment*, S. Austin & C. Hitchcock

At least one of these fine reference books should find its way into defense counsel's personal library for use during the preparation and trial of breast cancer cases.

Conclusion

Breast cancer litigation is intense. Oftentimes, the cases revolve around individuals who lost their battle with the dreaded disease and died. Emotions run high and so do the stakes. There are no guarantees in life (except the guarantees of death and taxes) and the authors do not guarantee that following the advice detailed above will result in a defense verdict. However, heeding the advice contained herein may go a long way toward eliminating specious claims and containing the legitimate ones.