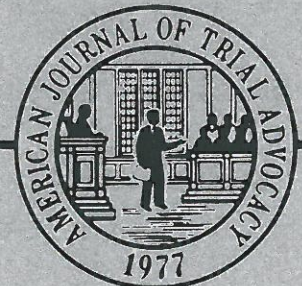


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SELECTING AND PRESENTING A FAILURE  
TO DIAGNOSE BREAST CANCER CASE

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# Selecting and Presenting a Failure to Diagnose Breast Cancer Case

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"They may carry me away, but they won't scare me away."<sup>1</sup>

Frank E. Haddad, Jr.

"Experience is a great teacher, but she sends in terrific bills."<sup>2</sup>

Minna Antrim

"I hate quotations. Just tell me what you know."<sup>3</sup>

Ralph Waldo Emerson

Breast cancer is currently the leading cause of death in America for women between ages 40 and 55.<sup>4</sup> According to the American Cancer Society, in 1996 alone, 184,300 women will have been diagnosed with breast cancer, and another 44,300 women will die from the disease.<sup>5</sup> The incidence of breast cancer and our ability to cure it have risen steadily since the 1930's.<sup>6</sup> Each year, one in every four American women will seek medical attention for a breast-related problem.<sup>7</sup>

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1. Frank E. Haddad, Jr. (1928-95).

2. *Quotes*, International Institute of Speakers and Speechwriters.

3. HENRY EHRLICH, SPEAKER'S IDEA FILE, PUT A FRESH SPIN ON AN OLD CLICHÉ.

4. David Plotkin, *Good News and Bad News About Breast Cancer*, THE ATLANTIC MONTHLY, June 1996, at 55, 58 (also recommended reading as an overview of breast cancer generally); see also John Rennie & Ricki Rusting, *Making Headway Against Cancer*, SCIENTIFIC AM., Sept. 1996, at 57.

5. Plotkin, *supra* note 4, at 55-56.

6. See *id.* at 55.

7. *Id.*

Failure to diagnose breast cancer is the basis for more medical malpractice claims than any other disease.<sup>8</sup> Consequently, one of the most critical factors in winning such a case is careful case selection. The first section of this Article addresses several factors which a lawyer should consider before determining whether to accept or refuse a particular case. The discussion of these issues is intended to be used only as a reference for forming an ultimate decision and should not be considered all-inclusive. Of course, the merits of any case must be based upon early, sound, expert review of the standard of care and causation.<sup>9</sup>

Cases are won or lost on the relative strengths and weaknesses of their respective facts. Why is it, then, that some cases are lost which our intellect and instincts tell us should have been won? Conversely, why are some cases won when it appears, on the facts, they should have been lost? Trial technique obviously plays a significant role in dissecting and displaying the salient facts to the jury. The second section of this Article discusses specific trial strategies which may prove helpful in preparing and presenting a failure to diagnose breast cancer case. Lastly, section three contains a broad overview of some general duties which have been identified in the context of breast cancer litigation by the appellate courts.

## I. Selecting the Case: Know the Medicine

In order to conduct a thorough and accurate review of any case involving a failed or delayed diagnosis of breast cancer, a lawyer must have a basic, fundamental knowledge of the disease itself. This is especially difficult when dealing with the various kinds of breast cancers, since they are extremely diverse. The following description is only an introduction to some of the basic concepts, and it is strongly urged that the practitioner become fully acquainted with the specific type of breast cancer involved in his particular case through a thorough review of the leading medical texts.<sup>10</sup>

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8. Physician Insurers Association of America (PIAA) Study (1995).

9. The authors are not physicians but are simply sharing information encountered during case investigations.

10. See generally STEVE AUSTIN & CATHY HITCHCOCK, BREAST CANCER: WHAT YOU SHOULD KNOW (BUT MAY NOT BE TOLD) ABOUT PREVENTION, DIAGNOSIS, AND TREATMENT

The female breast evolved from sweat glands primarily to provide milk to infants.<sup>11</sup> The breast provides milk to infants via a complex system of ducts, or small tubes, running "several inches back from the nipple . . . [and] milk-producing lobules which stick out from the ducts like clusters of tiny grapes."<sup>12</sup> These ducts and lobules are surrounded by fat and connective tissue and encased within a skin pouch shaped like a teardrop.<sup>13</sup> Breast cancer generally forms in the epithelium, or lining, of these mammary ducts and lobules and is divided into two main groups: carcinomas of ductal epithelial origin and carcinomas of lobular epithelial origin.<sup>14</sup> These two main groups are divided into invasive and non-invasive cancers.<sup>15</sup> For example, carcinomas of ductal origin are either invasive (invasive ductal cancers, or IDC) or non-invasive (ductal cancer in situ, or DCIS).<sup>16</sup>

Simply put, the strength of a failure to diagnose breast cancer case depends upon proving that the physician had the opportunity to timely diagnose the cancer and that the physician's failure or delay in diagnosis deviated from the standard of care in a way that worsened the patient's prognosis and ultimate chance of survival. Generally, the length of the delay between the date the cancer should have been diagnosed and the date it was actually diagnosed, as evidenced in the medical records, is critical. The longer the delay the stronger the inference that the cancer could have been treated successfully at an earlier stage.<sup>17</sup>

These seemingly simple issues require an understanding of breast cancer itself, specifically, its origin, its development and its progressive

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(1994); JAY R. HARRIS ET AL., DISEASES OF THE BREAST (1996) (a comprehensive medical text concerning breast cancer); CHARLES B. SIMONE, BREAST HEALTH: WHAT YOU NEED TO KNOW ABOUT DISEASE PREVENTION, DIAGNOSIS, TREATMENT, AND GUIDELINES FOR HEALTHY BREAST CARE (1995) (offering a comprehensive review of breast cancer for the non-physician); Plotkin, *supra* note 4.

11. Plotkin, *supra* note 4, at 60.

12. *Id.*

13. *Id.*

14. SIMONE, *supra* note 10, at 232; *see also* Irwin M. Ellerin et al., *Handling a Failure to Diagnose Breast Cancer Case*, TRIAL, May 1996, at 31.

15. SIMONE, *supra* note 10, at 231.

16. *Id.* at 232, 236; HARRIS, *supra* note 10, at 229, 245.

17. According to the PIAA study, the average delay in diagnosis is 14 months after the patient first discovers the mass. *See supra* note 4, at 1.

path of destruction once it has obtained a foothold within a patient's system. Accordingly, in order to assess the true significance of any particular delay by the physician, one must understand the technical prognostic factors relating to the cancer, i.e., histology, hormone receptor status, tumor size, metastasis, degree of nodal involvement and clinical and pathological staging.<sup>18</sup>

### A. Histology

Histology relates to the characteristics of the tumor viewed under the microscope.<sup>19</sup> In the past, this classification was based on a subjective interpretation by the examining oncological pathologist, but now there is a universally recognized pathological grading system.<sup>20</sup> Breast cancer cells are analyzed and graded on a scale of one to three based upon a subjective interpretation by a pathologist.<sup>21</sup> Basically, the scale indicates how much the breast cancer cells resemble normal duct or lobule cells.<sup>22</sup> Breast cancer cells which bear no resemblance to ordinary tissue are termed "poorly differentiated," and given a Grade 3, while breast cancer cells which look like normal cells are termed "well differentiated," and given a Grade 1.<sup>23</sup> The prognoses for these well differentiated cancers are generally considered better than those of Grades 2 and 3.<sup>24</sup>

### B. Hormone Receptor Status

Hormone receptor status is an indication of whether the cancer cells have receptors capable of attaching to the molecules of estrogen and progesterone;<sup>25</sup> that is, whether the cancer cells still retain the biochemical equipment which enables the cancer cells to physically link with

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18. SIMONE, *supra* note 10, at 226.

19. TABER'S CYCLOPEDIA MEDICAL DICTIONARY (F.A. Davis 17th ed. 1993).

20. HARRIS, *supra* note 10, at 248.

21. SIMONE, *supra* note 10, at 240.

22. HARRIS, *supra* note 10, at 248.

23. *Id.*

24. *Id.*

25. *Id.* at 301.

molecules of these hormones.<sup>26</sup> If the cancer is sensitive to these hormones, it is said to be “estrogen- or progesterone-receptor-positive.”<sup>27</sup> These tumors tend to grow more slowly and have generally better prognoses than their “estrogen- or progesterone-negative” counterparts.<sup>28</sup>

### C. Tumor Size

Tumor size is one of the most important prognostic factors. Generally, the larger the tumor, the worse the prognosis. A tumor is generally given a “T” value based upon its size.<sup>29</sup> For example, no presence of tumor is designated as T0.<sup>30</sup> Tumors less than or equal to two centimeters are assigned the value of T1.<sup>31</sup> A tumor classified as T1 is about the size of a dime.<sup>32</sup> A tumor greater than two centimeters and less than or equal to five centimeters is classified as T2; a tumor greater than or equal to five centimeters and less than or equal to ten centimeters is T3, and larger than ten centimeters, T4.<sup>33</sup> As will be discussed later, these T values are critical in properly determining the severity of the cancer.

Tumor size alone is not the only prognostic factor to be considered. Nevertheless, in assessing your case, it is imperative to ascertain if there was a tumor, mass, lump or thickening present, and what size it was when the patient first presented it to her doctor. A significant increase in size between presentation and diagnosis will strengthen your case.

### D. Metastasis

Metastasis is the spread of the cancer from the primary site in the breast to adjacent tissue or other distant parts of the body including

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26. *Id.* at 248.

27. HARRIS, *supra* note 10, at 304.

28. *Id.* at 319-20.

29. *Id.* at 328.

30. *Id.*

31. *Id.*

32. Ellerin, *supra* note 14, at 32; *see also* HARRIS, *supra* note 10, at 301-12.

33. HARRIS, *supra* note 10, at 328.

the actual skeleton itself.<sup>34</sup> Metastasis is probably the most significant factor bearing upon prognosis.<sup>35</sup> Cancers without metastasis, classified as M0, have better prognoses than cancers where metastasis has already occurred, classified as M1-M4.<sup>36</sup> Cancer can spread throughout a body in different patterns. One belief is that once a tumor reaches the size of 10,000 cells a blood supply starts to the tumor; this is called angiogenesis.<sup>37</sup> Once a blood supply to the malignant tumor is established, the cancer cells can spread throughout the body.<sup>38</sup> The different schools of thought on how cancer cells survive outside of the tumor must be understood to rebut the common defense of "the patient was doomed by the time she found the lump."

### E. Nodal Involvement

Nodal involvement occurs when the cancer spreads to the lymph nodes.<sup>39</sup> This is another important prognostic factor since a patient's chances of survival may decrease when the cancer is found to have metastasized from the primary lesion in the breast to the lymph nodes. Nodal involvement, like tumor size and metastasis, is also broken down into categories depending upon the degree and proximity of regional lymph node involvement. A cancer with no regional lymph node metastasis, classified as N0, generally has a better prognosis for the patient. Also, some physicians and researchers believe that if a sentry node can be isolated and removed along with the rest of the malignant tissue the spread of the cancer can be stopped.<sup>40</sup> However, there may also be a component of chemotherapy or radiation that is needed to effect a cure.<sup>41</sup>

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34. Ellerin, *supra* note 14, at 32.

35. Some researchers believe that metastasis only occurs when the cancer spreads beyond the affected breast tissue. See THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 446 (1987).

36. HARRIS, *supra* note 10, at 329.

37. Angiogenesis is the development of new capillaries (blood supply) from preexisting blood vessels to the tumor. HARRIS, *supra* note 10, at 284-90.

38. SIMONE, *supra* note 10, at 314-15.

39. HARRIS, *supra* note 10, at 329.

40. *Id.* at 362.

41. *Id.* at 385.

## F. Staging

The classifications for tumor size, nodal involvement and presence or absence of metastasis combine to form the basis for “staging” the cancer, or determining its severity.<sup>42</sup> Generally, cancer can be staged two ways, either clinically or pathologically. Clinical staging is based solely upon the attending physician’s physical examination of the patient.<sup>43</sup> Especially when it comes to nodal involvement and histology, clinical staging is not as accurate as pathological staging which involves the actual, microscopic and scientific analysis of the tissue.<sup>44</sup>

Both clinical and pathological staging conform to the T-N-M classification system, where “T” relates to tumor size, “N” relates to the degree of nodal involvement and “M” relates to the presence or absence of metastasis.<sup>45</sup> Based upon the factors previously discussed, the cancer is given a T, N, and M value, which corresponds to Stages I through IV.<sup>46</sup> For example, Stage I cancers—a tumor less than two centimeters in size (T1), no nodal involvement (N0) and no identifiable metastasis (M0)—have the best prognosis.<sup>47</sup>

It is critical to your case to determine what stage of cancer the patient had when she first presented it to her physician, or when it should have first been suspected or diagnosed. For example, a patient presenting a breast abnormality about the size of a dime (T1) and no other associated symptoms may have had a clinical Stage I cancer.<sup>48</sup> These cancers have the highest rate of patient survival, and coupled with chemotherapy have a five-year survival rate higher than ninety percent.<sup>49</sup> If this same cancer was diagnosed later as a Stage II, III or IV cancer, you have a compelling argument that the physician’s delay decreased the patient’s ultimate chance of survival.

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42. *Id.* at 327.

43. *Id.*

44. HARRIS, *supra* note 10, at 332.

45. *Id.* at 328.

46. *Id.* at 328-30.

47. *Id.*

48. *Id.*

49. MARC E. LIPPMAN ET AL., *DIAGNOSIS AND MANAGEMENT OF BREAST CANCER* 164-67 (1988).



Look in the medical records for careful documentation of the patient's chief complaint and for records of the physical examination. This should include a chronology of the chief complaint, along with an indication of how long the mass or lesion was present in the breast, when the patient first discovered the lesion and a diagram or narrative discussion demonstrating the location of the breast lesion and any associated features such as possible nodal involvement.

If the abnormality is described as a *lump* or a *mass*, or is measured or drawn, the patient, by definition, has a dominant three-dimensional mass which must be resolved by further diagnostic studies.<sup>50</sup> In a premenopausal female, the attending physician must conduct additional testing to rule out the possibility of cancer when a breast mass does not resolve itself within one menstrual period.<sup>51</sup> In a postmenopausal female, or in the case of a male with a recognized lesion, the standard of care may even be more stringent.

Further diagnostic studies include, but are not limited to, one or more of the following: aspiration, fine needle aspiration, open biopsy, mammography or referral to another surgeon.<sup>52</sup> In some instances, resolution may include a plan of action, such as re-examination after a menstrual period or other stated intervals. If a plan of action is recorded, look for documentation that the patient complied fully with all the physician's orders regarding return appointments, self examination, etc. Any deviation or failure by the patient to follow-up with the doctor must be carefully explored since it will be extra grist for the defense mill.

### G. Other Factors

Along with the medical aspects of the case, there are a number of additional factors to address before deciding to take a failure to diagnose breast cancer case. Although a complete discussion of the various issues

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50. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PRECIS V: AN UPDATE IN OBSTETRICS AND GYNECOLOGY (1994) [hereinafter PRECIS V].

51. See generally *DeBurkate v. Louvar*, 393 N.W.2d 131, 133 (Iowa 1986) (doctor testifying that a physician should not allow a persistent lump to remain undiagnosed even where a negative mammogram result is obtained).

52. *Id.*

is beyond the scope of this Article, the following questions should be considered before making a final decision regarding representation:

- What is the age of the patient? Breast cancer is harder to diagnose in younger women who have denser breast tissue. However, these women generally make a greater emotional impact on a jury since they have been deprived of a greater portion of their average life expectancy and expected income.
- Was the patient at an increased risk of developing cancer due to a family history of breast cancer or nulliparity, having never borne children?
- Does the patient's medical chart contain a comprehensive, documented health history and personal breast history?
- Was the patient exposed to any environmental factors linked to breast cancer?
- Did the patient seek a second opinion, and if not, why?
- Did the patient see her physician regularly and practice routine self-examinations?
- Did the patient follow all of the doctor's instructions, and do the medical records document any compliance or non-compliance?
- Were additional studies such as mammogram, X-rays, ultrasounds or bone scans ordered, and if so, have copies been obtained?

Diagnostic errors can be alleged at any point in the evaluation process. Consequently, all potential defendants such as the obstetrician/gynecologist, radiologist or surgeon must be carefully identified.<sup>53</sup>

## II. Trying the Case

### A. Selecting and Presenting a Theme

When presenting a complex case involving breast cancer, it is crucial to develop and maintain a simple, straight-forward theme. This theme

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53. See Ellerin, *supra* note 14, at 32 (comprehensive discussion of how to select a failure to diagnose breast cancer case).

must be factually correct, and easily retained. The theme should be introduced in jury selection, continued in opening statements, strengthened in trial testimony, and hammered-home in closing statements. In short, the whole of your case should be reduced to one sentence.

Such themes vary from lawyer to lawyer and may be governed by the litigator's personality as well as the particular facts of the case. The following are several examples:

- A 34-year-old woman had a 1.2 cm breast mass when she first visited her OB/GYN. The doctor allowed the mass to go unresolved for 18 months, at which point the mass had grown to 5.6 cm. In this case, "before and after" models of the tumor were constructed, demonstrating the exact size of the tumor when it was first presented to the doctor and the size when it was finally removed. The two models were referred to in jury selection and displayed in opening statements by holding one in each hand. The theme was "this is life" (the before model) and "this is death" (the after model).
- In a more egregious case in which the deviation seemed particularly clear, we claimed without hesitation, "He killed her. . . ." <sup>54</sup> We certainly caution use of this theme and respectfully suggest it be reserved for the most outrageous of circumstances under very careful and experienced use.
- In a case involving a young wife and mother whose lesion went untreated for a period in excess of one year, we argued that the plaintiff was "too young to walk through the valley of the shadow of death, too young to *needlessly* walk through the valley of the shadow of death." <sup>55</sup>

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54. In this case, a 32-year-old woman went to her OB/GYN for a checkup and pointed out a 1.5 CM palpable mass. The OB/GYN noted the mass in the breast but did nothing about it. He told her to come back in one year for her annual checkup. She presented the mass to him again, complaining that it had increased in size. The physician again did nothing but told her not to worry. The mass began to dramatically increase in size, and finally she went to another physician. *Wiegel v. Kirtley*, Jefferson Circuit Court, Division Nine, No. 94-CI-01886.

55. In this case a 24-year-old woman presented a palpable thickening to her OB/GYN. A mammogram was ordered which came back negative. One year later, she complained to the physician that the thickening had become a palpable mass which the physician noted on the chart by size and location. The physician told her that she did not need another mammogram

## B. Practical Considerations for Jury Selection

Volumes have been written on jury selection and approaches to use in particular cases. It is not the purpose of this section to address jury selection techniques in medical negligence cases generally, but to share a basic framework to utilize in the voir dire portion of a breast cancer case.

In practice, this process is not so much one of selection, but rather of *exclusion* and education. To successfully achieve these objectives, your theme must be planted with the prospective jurors as early as possible. Immediately after your greeting, the panel should be impressed with the ominous nature of the case and the candor with which you will address it. For example, you might say:

“Thirty-four year old Jane Doe found a lump in her breast and went to the defendant for help. He did nothing. Jane is now dead.”

Although this example states the basis of the case, it also does more. It impacts each member of the jury with the serious nature of the case and the straightforward style of your approach. In a breast cancer case, perhaps more so than in any other case, it is essential to continuously educate your jury and develop your theme. Consequently, it is necessary to follow up general questions during jury selection, with numerous questions geared to elicit specific information. If these follow-up questions do not clearly meet your objectives, do not belabor the point, but professionally and gracefully move on.

The following is a basic framework for questioning during jury selection:

- **General:** I know this is a delicate question, but I must ask. Have you or any member of your immediate family or a friend had breast cancer?  
**Specific:** (a) If so, when? Who treated you for it? What type of treatment was involved? How is he or she

doing? In any of these instances, did it involve a *delay* in the physician's diagnosis of the cancer?

- (b) Who discovered the lump, the patient or the doctor? Was a mammogram performed? Why? Was a biopsy performed? Why? Was a needle aspiration performed? Why?
- Have you or any member of your family or a friend had any type of cancer—not just breast cancer? If so, when? Who treated you for it? What type of treatment was involved? How is he or she doing? In any of these instances, did it involve a delay in the physician's diagnosis of the cancer?
  - If a delay was involved in the diagnosis of cancer, what did the doctor do? Why?
  - Did you or your relative or friend go to see the doctor as soon as possible? Why?
  - Did the doctor take fast action? Why? What did the doctor do?
  - Does anyone believe that just because a person has breast cancer, they are going to die from it?
  - Does anyone on the panel believe that once a person is diagnosed with breast cancer, there is no hope?
  - This case involves several diagnostic tools: biopsy; needle aspiration; mammography. Has anyone on the panel or a member of your family or friend ever had one of these tests? Why?
  - Did your physician request the test?
  - This case also involves several types of treatment which were belatedly given: chemotherapy, radiation, bone marrow transplant. Is anyone familiar with these types of treatment? How so?
  - Does anyone have any opinion about the effect that starting these treatments as early as possible has upon the chance of cure and survival?
  - Has anyone or a member of your family or friend ever had a worrisome lump that was brought to the attention of a physician? If so, what was done?
  - Has anyone on the panel or a member of your immediate family or friend ever brought a lump to the attention of a physician who did nothing? When? How did you feel about that?

- Is there anyone on the panel who has an opinion about the effect that early detection of breast cancer has upon the chance of survival? Does anyone believe that early detection does not make a difference?
- Has anyone received any literature from the American Cancer Society? Is anyone a member of the American Cancer Society? Does anyone donate money to the American Cancer Society?

Each of these simple questions is designed to enhance the theme and educate the panel about what to expect. Other questions will also address other areas of jury selection, such as exposing the dominant juror, humanizing your client, minimizing any case weaknesses, *breaking the ice* on damages, resolving any confusion concerning the burden of proof, debunking the malpractice crisis, and numerous others. While these aspects of jury selection should not be ignored, a discussion of those factors is beyond the scope of this Article.

### C. The Opening

The stage has been set. Your theme has been selected and planted with the jury. You have begun the education process with your jurors in voir dire and have identified, and hopefully, excluded those who appear biased. You must now make sense out of this complex set of circumstances and medical jargon. The opening is a tremendous opportunity to do this; however, it is also a tremendous burden.

In a breast cancer case, the opening of the trial can be approached as if it were two openings, or at least one opening with two distinct parts. The first part involves a frank and simple discussion of the nuts and bolts of medical negligence, including the medical terminology you expect jurors to encounter during the presentation of your case. The second portion deals with the particular facts of the case you are presenting, including the reason you are there—damages.

Try to avoid relying upon notes in jury argument at all costs. Because this can be an especially daunting task in medical negligence cases, where the medical terminology can be a challenge to the lawyer's mental acumen as well as the jury's, one suggestion is to incorporate a technique which allows the lawyer to share his/her notes with the jury. This tactic

gives a lawyer an easy, accessible reference to key terms while creating an instant dialogue with the jury by allowing the lawyer to speak *with* the jury rather than *to* them or, even worse, *down to* them. This type of method involves creating a glossary or list of terms that will be discussed in the case. An example of such a list is as follows:

- Standard of Care
- Deviation from Standard of Care
- Lymph Nodes/Nodal Involvement/Axilla
- Chemotherapy
- Autologous Bone Marrow Transplant
- T N M Staging System
- Early Detection
- Detection is Protection
- Mastectomy
- Lumpectomy
- Estrogen/Progesterone Receptors
- Invasive vs. Noninvasive
- S Phase
- Ill-defined Borders vs. Defined Borders
- Chance of Survival/Cure
- Lobular vs. Ductal
- Delay in Diagnosis/Delay in Treatment
- Window of Opportunity
- Stage 0, Stage 1, Stage 2, Stage 3, Stage 4

Each term on this list should be printed on a separate page in very large, bold type and enlarged to poster size. Each one of these pages, each containing a single term, should then be arranged on a flip chart. The enlargements need not be mounted but can simply be held by an easel and flipped as needed for easy reference. Note that each term should appear in the order in which it will be discussed in your opening. During your opening, as you discuss each term, you can display the term to the jury. This permits you to speak easily and knowledgeably about the most important aspects of the case.

If your jurisdiction permits note taking, rest assured that jurors will take notes during your opening statement. A thorough discussion of these terms will take some time—and it should. Take your time and

explain each term; however, avoid attempting to impress the jury with your knowledge. Remember, your purpose is to educate. If you present the information simply, the jury will intuitively recognize your understanding of the material.

In the second phase of the opening, the discussion of the facts of your particular case should include demonstrative aides to successfully communicate the issues of the case to the jury. The demonstrative aides should focus on the failure to diagnose breast cancer, although other demonstrative aides will be needed to effectively communicate damage issues. The following demonstrative aides should be considered:

- Enlarged *exact* copy of relevant portions of the defendant's office notes
- Enlarged *typed* copy of the relevant portions of the defendant's office notes
- Enlarged cutaway diagram of breast physiology—lobules & ducts
- Before and after models of the lesion(s)
- Model of the breast
- Chart depicting needle aspiration (where appropriate)
- X-rays and view box or positives of x-rays (where appropriate)
- Enlargement of xeromammograms (where appropriate)
- Enlarged appropriate American Cancer Society literature regarding early detection (to underscore its significance)

Each aide used must be organized for easy reference.

One of the most important pieces of evidence in the case will be the defendant's records since they are the evidence of the defendant's own negligence. Through these records, you will demonstrate to the jury that the defendant had the opportunity to help by diagnosing the cancer at an earlier stage, the opportunity to do something by ordering further diagnostic studies, and the opportunity to cure the patient and to increase the patient's chances of survival. Make enlargements of the relevant portions of the original records. If the original records are difficult to read, consider having portions typed and similarly enlarged for display. This will attest to your accuracy and allow the jury to read critical portions of the testimony. Enlargements should be displayed so that the jury can see them throughout the trial.



In presenting a breast cancer case, it is extremely important to demonstrate as early as possible the difference in the size of the lesion when the patient first presented it to the doctor, and when the lesion was actually diagnosed and something was finally done. Your demonstrative aides should clearly show the defendant's opportunity to help, and the difference in the size of the lesion as a direct result of the defendant's failure to do something. For example, in a case involving a lesion that is undetected by the radiologist after a mammography, a view box should be used to display the mammogram. Enlarged positives of the mammogram may be helpful in fairly depicting the affected breast. Similarly, to demonstrate the relative ease with which a skilled physician could have performed a needle biopsy or needle aspiration, consider using an enlarged diagram depicting the procedure. This will help establish early on that the defendant had the opportunity to do something to help the patient.

Certainly, there are other matters to address in the opening, including but not limited to, a presentation of what the law permits and what the law requires: damages. This area of the case is highly individualistic and applies to medical negligence and personal injury cases generally. Nonetheless, the ominous effects of treatment, including (where appropriate) breast removal, chemotherapy, radiation, and bone marrow transplantation must be addressed in a manner sufficient to educate. However, the full impact of such treatment should be reserved for trial testimony and closing argument.

#### D. The Closing

If there is an ingredient that will turn a loser into a winner, or a boring, complex morass into a case of simple, straightforward negligence, it is passion. When the case becomes a cause, it can be won. Passion permits us to fulfill, as Melvin Belli so succinctly stated, "our terrible responsibility."<sup>56</sup>

As with any case, argue a breast cancer case with honesty, humility, and humanity. Use simple words. Do not rely upon notes. Speak from the heart as well as the head, and impress upon the jury the true justness

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56. MELVIN BELLI, *READY FOR THE PLAINTIFF* 261 (1956).

of the cause. The purpose of this section of the Article is not to offer a framework for an all-inclusive closing, but to share some of the authors' experiences and insights as to the closing argument phase of a breast cancer case. To do this, we describe the manner in which we construct the closing. Although seemingly elementary, we nonetheless believe it to be crucial.

Many trial lawyers prepare the closing before trial and modify it as the trial develops. We maintain a list entitled "Points for Closing," which provides the framework for the closing argument. Obviously, the list starts long before the date of trial; however, the closing should not be prepared prior to trial. As the trial begins and continues, the list grows. Near the trial's conclusion, the list will be considerable in length and should be organized as follows: "B" - beginning, "L" - liability, "D" - damages, and "E" - end. The appropriate letter is then placed next to its corresponding point. The points within each subdivision are then numerically ranked in the order to be addressed. This should produce a flowing, comprehensive and orderly list of significant points to address. A new list should then be constructed consisting of these significant points. This new list should contain the entire argument, hopefully in one page, and consist of a key word or key phrase relating to the significant point. Once completed and reviewed, you no longer need the list, and the argument will flow in a logical and sensible manner.

In a breast cancer case, there are typical defense inconsistencies that must be addressed in the closing. For example, the defense will probably argue that the cancer was present in the plaintiff's body for years prior to the date the defendant examined her. Yet the defense will also probably argue, or intimate, that the lump was not cancerous at the time the defendant palpated the lump or viewed the mammogram. The defense will also argue, or intimate, that even if the lesion had been cancerous and even if the defendant had diagnosed it, it would have made no difference. In the case of death, the defense will argue in a subtle way that the plaintiff "was dead" when she was first examined. You must emphasize that the physicians nevertheless proceeded to remove her breast, proceeded with radiation, proceeded with high dose chemotherapy, or proceeded with a bone marrow transplant. You must emphasize that the defendant cannot have it both ways. He cannot argue that the plaintiff was "dead" and then remove her breast. He cannot argue that she was "dead" and then give her high dose chemotherapy or a bone marrow

transplant. He cannot say she was "dead" and then give her radiation, causing her to incur hundreds of thousands of dollars in medical expenses. These inconsistent defenses on causation must be addressed and highlighted.

The demonstrative aides used in opening, as well as exhibits admitted into evidence, will of course be utilized where appropriate in closing. It is extremely important to have these exhibits placed in the order you intend to address them. The flow of the argument may be tremendously interrupted, as may your train of thought, by searching for or fumbling with exhibits.

Remember to hammer-home the theme. Your client went to the defendant for help. The defendant did nothing. Again, show the size of the lesion when the defendant could have done something and the size of the lesion when something was finally done. Convince the jury that the difference in size is a direct result of the defendant's failure to do what should have been done.

### **E. An Important Aside: Prohibiting and Dealing with Ex Parte Contact**

Suppose that in preparing your case you make an appointment to speak with one of your client's attending physicians. In the course of this meeting, you learn for the first time that defense counsel has already met with the physician and has discussed at length his treatment of your client, as well as the physician's opinions about the case. The doctor tells you, "I'm surprised to see you since I told the other lawyer everything I know." You ask, "What other lawyer?" The doctor responds, "You know, Dr. Smith's lawyer. The one you filed this frivolous lawsuit against." What should you do in response to learning this information? What can be done to prevent this type of ex parte contact?

The Hippocratic oath provides as follows:

Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.<sup>57</sup>

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57. Reprinted in BERNARD S. MALOY, *THE SIMPLIFIED MEDICAL DICTIONARY FOR LAWYERS* 372 (3d ed. 1960).

The Code of Professional Responsibility of the American Medical Association, provides, in pertinent part, as follows:

The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law, or by the need to protect the welfare of the individual or the public interest.<sup>58</sup>

With respect to confidentiality, the American Medical Association Council on Ethical and Judicial Affairs provides as follows:

The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.<sup>59</sup>

The AMA ethical guidelines do, however, provide an exception to the confidentiality rules under certain conditions: "The patient's history, diagnosis, treatment, and prognosis may be discussed with the patient's lawyer with the consent of the patient or the patient's lawful representative."<sup>60</sup>

Some jurisdictions maintain a physician-patient privilege. However, whether or not a physician-patient privilege exists, it is clear that medical ethics require that patient information remain confidential.

When confronted with an ex parte communication, the defense will, in all likelihood, maintain several positions. First, the defense may maintain there is no physician-patient privilege, depending upon the jurisdiction. Second, the defense may argue that the commencement of the litigation waived any such privilege. Third, the defense may argue that it is entitled to speak to and interview any witness who has

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58. AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, CURRENT OPINIONS 71 (1994).

59. AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS § 5.05 (1994).

60. *Id.* § 5.06.

material and relevant knowledge of the issues to be addressed at trial. Finally, the defense may argue that you supplied medical authorization; therefore, the interview was conducted with the knowledge and consent of the plaintiff.

The defense will almost always request a medical authorization to obtain medical records. Attorneys should generally agree to such requests, but under very specific conditions. These conditions are two-fold. First, only records may be obtained and no ex parte contact with any of plaintiff's attending physicians may be conducted. Second, a copy of all records obtained pursuant to the authorization should be provided. If there is an agreement as to the language of this authorization, you can be relatively certain that no ex parte contact will occur. Conversely, if there is an objection to the language of this authorization, you can be relatively certain that either ex parte contact has already occurred or that it is being contemplated by the defense.

The prohibition against ex parte contacts is an emerging court-created effort to preserve the treating physician's fiduciary responsibilities during the litigation process.<sup>61</sup> The prohibition against ex parte contacts "regulates only how defense counsel may obtain information from a plaintiff's treating physician, i.e., it affects defense counsel's methods, not the substance of what is discoverable."<sup>62</sup> Courts have recognized that improper pressure could be placed upon the plaintiff's attending physician. In *Manion v. N.P.W. Medical Center*,<sup>63</sup> the court noted,

[a]n unauthorized ex parte interview could disintegrate into a discussion of the impact of a jury's award upon a physician's professional reputation, the rising cost of malpractice insurance premiums, the notion that the treating physician might be the next person to be sued, and other topics which might influence the treating physician's views. The potential for impropriety grows even larger when defense counsel represents the treating physician's own insurance carrier and when the doctor, who typically is not represented by his personal counsel at the meeting, is unaware that he may become subject to suit by revealing the plaintiff/patient's confidences which are not pertinent to the pending litigation.<sup>64</sup>

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61. See *Crist v. Moffatt*, 326 N.C. 326, 333, 389 S.E.2d 41, 45 (1990).

62. *Id.* (quoting *Manion v. N.P.W. Med. Ctr.*, 676 F. Supp. 585, 593 (M.D. Pa. 1987)).

63. 676 F. Supp. 585, 594-95 (M.D. Pa. 1987).

64. *Manion*, 676 F. Supp. at 594-95.

We are not debating the discovery of such information but are suggesting that such information only be sought by the defense after providing plaintiff or plaintiff's counsel with notice and opportunity to be heard. Notice is the key.

When *ex parte* contact has already occurred, several remedies exist. A motion in limine to exclude any damaging opinions formed as a result of the *ex parte* contact can be filed; however, it may be difficult to prove which opinions were the result of the improper contact. Therefore, a motion to strike the entire testimony of the witness should be considered. On occasion, however, this remedy may prove inadequate since the attending physician's testimony regarding care and treatment may be needed at trial. Another potential remedy is to request extensive freedom in cross-examining the physician regarding the *ex parte* contact. That is to say, the physician should be confronted with American Medical Association Guidelines regarding confidentiality, the Hippocratic Oath, as well as the Code of Professional Responsibility for the particular physician's specialty. However, even this remedy is insufficient since you will be attacking a physician that the jury will believe to be neutral. Although the remedies are inadequate, they do provide a means to reduce the highly prejudicial and damaging testimony which may have developed as a direct result of the *ex parte* contact.

It should be noted that the physician is generally an unwitting participant in such interviews. Our experience indicates that physicians do not wish to be involved in such matters and have neither the familiarity nor the time to contemplate the ramifications of such contact. Simply put, many physicians do not understand that such contact with defense counsel may be a breach of medical ethics and may expose them to potential liability from their patient. Thus, an additional reason to notify plaintiff's counsel of such *ex parte* contact would be to insulate the physician from liability.

### III. Appellate Decisions

The physician has a general duty to utilize all available scientific means and facilities to aid in the diagnosis of cancer.<sup>65</sup> This can include

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65. *Wilkinson v. Vesey*, 110 R.I. 606, 615-16, 295 A. 2d 676, 683 (1972).

the duty to take a complete history from the patient,<sup>66</sup> the duty to properly perform visual examination and palpation of the breasts,<sup>67</sup> the duty to direct the patient to return for follow-up examinations within an appropriate period,<sup>68</sup> and the duty to make an effort to determine the cause of any changes in a lump or mass noticed by the patient.<sup>69</sup> At least one court has found that, in addition to the duty to diagnose, a physician has the duty to advise a patient with breast cancer to consult with a specialist or other physician qualified in a method of treatment that the physician is not competent to give if the patient might enjoy better results by such a referral.<sup>70</sup>

Referral must be done as expeditiously as the circumstances require.<sup>71</sup> A gynecologist has been found to have a duty to refer a patient with a complaint of breast soreness to a specialist, either a surgeon or a radiologist, for mammography.<sup>72</sup> Once a physician, whatever his practice specialty, advises a patient to seek an additional consultation, the referring physician is rarely found liable for any negligence by the recommended physician absent some showing of partnership or other employment relationship between the two doctors.<sup>73</sup> Furthermore, after the referral of the patient to a specialist, it is generally the specialist and not the referring physician who is liable for any subsequent negligent care.<sup>74</sup> However, the referring physician may still have a duty to supervise the patient's care, particularly if the referral is only for a limited purpose.<sup>75</sup>

The type of treatment undertaken by the physician for the management of the cancer is another area of possible concern. For example, a physician who prescribes or administers drugs to a breast cancer patient

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66. *Beckom v. United States*, 584 F. Supp. 1471, 1478 (N.D.N.Y. 1984).

67. *Id.* at 1478; *Livengood v. Kerr*, 391 S.E.2d 371, 375 (W. Va. 1990).

68. *Beckom*, 584 F. Supp. at 1478; *Livengood*, 391 S.E.2d at 375.

69. *Truan v. Smith*, 578 S.W. 2d 73, 76 (Tenn. 1979).

70. *Harris v. Gallaher*, 375 A.2d 456, 458 (Del. 1977).

71. *Id.* at 458.

72. *Grippe v. Momtazee*, 705 S.W.2d 551, 553 (Mo. Ct. App. 1986).

73. *Steinberg v. Dunseth*, 631 N.E.2d 809, 810-11 (Ill. App. Ct. 1994), *cert. denied*, 642 N.E.2d 1304 (1994).

74. *Id.*

75. *See Harris*, 375 A.2d at 458.

must do so with reasonable skill and care for the safety and well-being of the patient. Printed literature from the drug manufacturer regarding the drug's proper use, limitations and contraindications may be considered objective evidence of the applicable standard of care.<sup>76</sup> Also, a physician using radiation therapy to treat breast cancer is required to do so properly as to avoid overexposing the patient or causing undue harm.<sup>77</sup>

When the allegation of malpractice involves surgery, the majority of cases contend that the surgery was performed negligently. However, some cases allege that the surgery should not have been performed at all.<sup>78</sup> In these cases, the claim is usually based upon some evidence that the surgery itself was not in accord with accepted medical practice in light of the nature of the patient's symptoms, that the surgery should not have been performed absent adequate non-surgical testing, that the doctor incorrectly diagnosed the condition and subjected the patient to unnecessary surgery, that the doctor failed to inform the patient of the risks involved or that alternative non-surgical procedures were available.<sup>79</sup>

## Conclusion

Failure to diagnose breast cancer is a rapidly expanding area of medical malpractice litigation. Practitioners seeking to successfully pursue their cases in this burgeoning arena need to maintain a competitive edge through careful and thorough case selection and presentation. In order to properly assess a potential claim, practitioners will need to be familiar with the basic medical terminology and have a fundamental knowledge of the disease itself. This does not, however, supplant review by a medical expert in oncology, radiology or other associated field. In

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76. *Mulder v. Parke Davis & Co.*, 288 Minn. 332, 339, 181 N.W.2d 882, 886 (Minn. 1970); *see also DaRoca v. St. Bernard Gen. Hosp.*, 347 So. 2d 933, 934 (La. Ct. App. 1977) (holding that physician must be able to justify a departure from warnings or recommendations of the manufacturer).

77. *See, e.g., Davis v. Moran*, 735 P.2d 1014, 1016 (Idaho 1987) (involving harm caused from overlap of dual beam radiation).

78. *See, e.g., Jennings v. Burgess*, 917 S.W.2d 790, 794 (Tex. 1996).

79. *See, e.g., Davis v. Caldwell*, 429 N.E.2d 741-43, 445 N.Y.S.2d 63-65 (1981); *Goodard v. Hickman*, 685 P.2d 530, 531-33 (Utah 1984).



addition, because of the complexity of the issues and emotions involved in these cases, trial strategy and presentation take on an added edge of importance. As people become more informed about breast cancer generally, they may become less forgiving of a potential plaintiff who allows a breast complaint to go unresolved. Nevertheless, through preparation and diligence, these cases can be maintained to a successful outcome.