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Case Number 548,2013

IN THE SUPREME COURT OF THE STATE OF DELAWARE

BARBARA A. MAMMARELLA,	)	
	)	
Appellant,	)	
	)	
v.	)	No. 548,2013
	)	
ALAN B. EVANTASH, M.D.,	)	
ALL ABOUT WOMEN OF	)	
CHRISTIANA CARE, INC., and	)	
CHRISTINE W. MAYNARD, M.D.,	)	
	)	
Appellees.	)	

Appeal from the Superior Court of the State of Delaware,
In and For New Castle County, C.A. No. N11C-12-242 VLR

APPELLANT'S AMENDED OPENING BRIEF

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Dated: December 30, 2013

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NATURE AND STAGE OF PROCEEDINGS

Appellant, Barbara A. Mammarella (hereafter "Plaintiff" or "Mrs. Mammarella"), commenced this medical negligence action on December 28, 2011, with supporting Affidavits of Merit later held to be in compliance with 18 *Del. C.* §6853, alleging that All About Women of Christiana Care, Inc. and Christine W. Maynard, M.D., Appellees (hereafter "Dr. Maynard" or "Defendant All About Women"), and Alan B. Evantash, M.D., Appellee (hereafter "Defendant Evantash"), were negligent in failing to diagnose a malignant breast lump. (A 1). She further alleged that by the time the correct diagnosis was made she had been injured as a result of the lump growing from 6mm in largest dimension to 8mm as seen on imaging studies.

Trial was scheduled to begin on September 23, 2013. (A 8). Defendants presented a joint motion for summary judgment on July 18, 2013, predicated on the ground that Plaintiff did not present evidence of a *prima facie* case on the issue of harm causation. (A 21-24). That motion was denied by the trial judge[1] at the pretrial conference on August 22, 2013. (A 31).

[1] This case was initially assigned to the Honorable Jerome O. Herlihy. (A 4). Following his retirement, it was reassigned to the Honorable Vivian L. Rapposelli who conducted the pretrial conference. Due to a scheduling conflict, it was anticipated that the Honorable Charles E. Butler would try the case; however, that conflict was resolved and Judge Rapposelli planned to conduct the trial.

On September 3, 2013, Plaintiff took the trial deposition testimony of her treating medical oncologist, David D. Biggs, M.D. (A 56). On September 6, 2013, Defendants filed a letter request to file a Motion for Judgment as a Matter of Law pursuant to Superior Court Civil Rule 50(a)(1) (A 46), again repeating their earlier contention. That request was denied on September 9, 2013. The e-mail read:

> Dear Counsel:
>
> Judge Rapposelli received and reviewed the September 6, 2013 letter submitted by Counsel for Defendants All About Women of Christiana Care Inc., and Christine W. Maynard, M.D., Ryan T. Keating, Esq., requesting the opportunity to present a motion for judgment as a matter of law. The dispositive motion deadline has passed according to the Trial Scheduling Order and both Judge Rapposelli and Judge Butler are currently in trials. As a result, the Defendants are not permitted to file a motion at this late date and trial will go forward on Monday, September 23, 2013. Thank you.
>
> Susan Judge
> Chambers of Judge Vivian L. Rapposelli

(A 47).

Thereafter, on September 18, 2013 Defendants renewed their request for judgment (A 104-109), which was discussed at an information telephone conference on that day (A 18,110) and then formally argued and ruled on the following day (A 112-163).

The Motion for Judgment as a Matter of Law was granted. (A 162).

Plaintiff docketed this Appeal on October 10, 2013. (A 19). This is Plaintiff's Opening Brief.

SUMMARY OF ARGUMENT

Plaintiff presented expert evidence sufficient to establish a *prima facie* case that Defendants' medical negligence allowed a malignant breast tumor to increase in size from 6mm to 8mm over a six-month period. The growth of the tumor caused her harm. The *prima facie* case was established in two ways: (a) the record evidence of the treating oncologist, and (b) through Affidavits of Merit held compliant under 18 *Del. C.* §6853 which this Court's ruling in *Dishmon v. Fucci*, 32 A.3d 338 (Del. 2011) declared to constitute a *prima facie* case. The Trial Court erred when it ruled as a matter of law under Superior Court Civil Rule 50(a)(1) that no reasonable jury could find in favor of Plaintiff on the medical causation issue.

STATEMENT OF FACTS

Plaintiff, a 56 year-old post-menopausal woman, was noted as having two "new solid nodules" on breast imaging in October, 2009. (A 165-166). The radiology technologist advised her that day "it's a benign fibroadenoma", a condition that does not become malignant. (A 83, 102). The radiologist, Dr. Evantash, then mailed a standard form letter advising her that there was no evidence of cancer, and, as for all women over 40, was further advised to return for routine mammography in one (1) year. (A 169). Simultaneously, the ultrasound report, describing two (2) new nodules with largest dimension of six (6) millimeters, was forwarded to Mrs. Mammarella's obstetrician-gynecologist, Christine W. Maynard, M.D. (A 165-166).[2]

Mrs. Mammarella, a registered nurse, was "uncomfortable" about the new finding of "benign"[3] and initiated a discussion with Dr. Maynard who advised her to have another imaging study in six (6) months. (A 87, 170). That was done and showed the nodule had grown to eight (8) millimeters. (A 171-172). A biopsy was performed which disclosed a malignancy. (A 173).

[2] Later evidence from the radiologist defendant established that there was only a single nodule and the "technologist" had erred in describing two, albeit the dimensions were "quite accurate." (A 97).

[3] "Benign" or "Malignant" is not a diagnosis that can be reached from an imaging study. That diagnosis can only be made after a biopsy and pathologic examination. (A 74).

After the finding of the malignancy the "oncology team" at the Cancer Center convened a meeting with Mrs. Mammarella and her husband on May 13, 2010. (A 173-176). David D. Biggs, M.D., an obstetrician-gynecologist oncologist was present as part of a multidisciplinary clinic to get a picture of what the treatment options are. (A 173-176). The Mammarellas were advised what they might expect as far as further treatment options (A 176), and specifically, that if the size of the tumor on excision proved to be eight (8) millimeters (or less), she would be eligible to have it treated by radiation. (A 70, 176). He also indicated that it was the type of breast cancer that has a "high-grade histology [and] is a very small primary tumor". (A 174). When excised on May 27, 2010, the tumor proved to be 1.1 centimeters in largest dimension, which then led to chemotherapy, as the recommended treatment. (A 59-60).

Although the thirty-three (33) percent increase in tumor size on imaging study did not alone indicate metastasis of the malignancy, it did require a more drastic and debilitating treatment regimen (A 60-64), increased the risk of a shortened survival period (A 60), and became a source of dread and anxiety to the patient. (A 92, 129).

During his discovery deposition, Dr. Biggs said that he advised Mrs. Mammarella at the time of their first meeting that radiation would be an option in the event the lesion proved to be 8mm or less. (A 70).

He reaffirmed that testimony at his trial deposition when he testified:

> A: You want me to read the whole thing?
> Q: Your answer, yes. And do it slowly for her benefit.
> A: Okay. "I think looking back at our initial consultation note, I indicated that if the tumor was no larger than it appeared on ultrasound, which I think was, what, 8 millimeters, that I would likely feel that she would not take chemotherapy. I would like to underline the word likely, though, because it's really a gray zone.
> "And when you are in that gray zone, you really have to have a patient who" – and then I said "you have to suss out," what I meant was "you have to try to understand the desires of the patient to be aggressive and try to help them understand the risks and potential benefits within the level of uncertainty that we have. So it's not quite as exact as that. Do you know what I'm trying to say?"
> Q: And is that still your testimony?
> A: Yes. I mean, I would stand by this. I can try to elaborate, but...
> Q: I'm going to ask a few more questions. When you refer to 8 millimeters on ultrasound, you're referring to the April 2010 ultrasound?
> A: Yes. Right.
> Q: And the history that you had taken earlier indicated that on ultrasound in October of 2009 the measurement was 6 millimeters. Is that correct?
> A: Yes.
> Q: Okay. To the extent that you've stated any views or opinions here in terms of your treatment of Mrs. Mammarella or advice that you gave her or these comments, does that represent your best medical judgment?
> A: Yes.

(A 71-70).

In describing a partial breast radiation treatment trial at his center Dr. Biggs said it's done through a series of catheters that involve high-energy particles twice a day over five days to get the same therapeutic effort in less time.

Dr. Biggs met with the Mammarellas on June 8, 2010 when he had the final biopsy results showing the size of the tumor to be 1.1 centimeters. (A 59). He then told her that the "risk of death from metastatic disease over the next years was 17 percent." (A 60). They "talked about how adjuvant chemotherapy would reduce that risk by approximately one-third, which for her, as you know, one third of 17 is about 6 to 8 percent ... so we talked about the options for chemotherapy regimens." (A 60). He said he was recommending chemotherapy "at that point." (A 60).

Mrs. Mammarella described the chemotherapy and her emotional reaction in this way:

> Q: If you could briefly explain to me the side effects that you felt as a result of the chemotherapy?
> A: Well, after the first chemo treatment I lost all my hair after two weeks. It's called hitting the wall where you feel – the best I can describe it is aches and pains of the flu times a thousand. You can barely move. You hurt so bad. Extreme, extreme fatigue like you've never experienced before.
>
> Lack of motivation to do anything. Slight nausea, I didn't have bad nausea, just slight. I had medication for that. Headache. It gets worse as each treatment went on. Need I continue or do you want me to stop here?
> Q: It sounds like you have explained all of the general side effects.
> A: I haven't explained them all, there is more. Do you want the rest?

Q: Sure.
A: Okay. With Taxotere which I was on and it was called a dense dose so I had a dense dose of Taxotere. Dense dose of Cytoxan. As a result it causes brown lines to form on your fingernails and they become deformed. I lost maybe two or three fingernails on each hand. My fingers, the tips, throbbed so badly that the pain was intense. I could not sleep. So I was put on a medication to help that. That's called neuralgia which is pain and tingling in the extremities so I had all of that.

The inside of my mouth felt like sandpaper. It was not smooth if you feel the inside of your checks [sic] they are smooth and mine were tough. My tongue, the tip, was partially almost numb. It was real rough feeling. I had a metallic taste in my mouth that I used a special spray for. Sore throat, diarrhea.
Q: Let me ask you this, you were on chemotherapy you said for 12 weeks?
A: Yes.
Q: And you had various side effects for those 12 weeks?
A: Yes.
Q: How much longer did those side effects last?
A: Two to three weeks. But that being said, I've never been the same since.
Q: Why don't you explain to me basically what effects you felt during chemotherapy and what effects you still feel today that you relate to the chemotherapy treatment?
A: Psychological impact and results. Fatigue continues. I seem to be short of breath when I go up and down steps. I don't seem, I do. I am. My GI tract is not the same.
Q: What about your GI tract is not the same?
A: Okay this is a little embarrassing but I go from either constipation to diarrhea which I never did before. I would say about half of my hair has grown in. Not all of my hair will ever grow back in. That continues.

(A 89-92).

ARGUMENT

I. The Trial Court Erred When It Ruled As A Matter Of Law Under Superior Court Civil Rule 50(a)(1) That No Reasonable Jury Could Find In Favor Of Plaintiff On The Medical Causation Issue.

A. QUESTION PRESENTED

Whether the Trial Court abused its discretion in ruling that no reasonable jury could return a verdict for the Plaintiff on the evidence of record. The question was preserved at pages A 110-111, during oral argument at A 125-138 and the Court ruled at A 162.

B. SCOPE OF REVIEW

Trial Court's ruling that Defendants were entitled to judgment as a matter of law under Superior Court Civil Rule 50(a)(1) is reviewed for an abuse of discretion. *Dishmon v. Fucci,* 32 A.3d 338 (Del. 2011).

C. MERITS OF ARGUMENT

The evidence of record, according to expert testimony, categorizes at least the following harms caused by the negligent delay in diagnosis:

1. a 33% increase in size of a malignant tumor;

2. a risk of death over the next years at 17% based on the size and characteristics of the tumor;

3. the disqualification of radiation therapy as a practical mode of treatment[4];

4. the rigors and debilitating effects of the recommended chemotherapy regimen;

5. the accompanying "psychological impact" on the patient (A 92) of fear, dread and apprehension.

Delaware law supports the proposition that this evidence is sufficient to withstand a motion for summary judgment or a motion for judgment as a matter of law.

One issue raised in *Strauss v. Biggs*, 525 A.2d 992, 997 (Del. 1987), at the appellate level after a verdict for the plaintiffs, was whether a negligently delayed referral to a specialist caused harm to the patient. The Court stated:

> With respect to causation, Dr. Centrella described the discomfort caused by a heel spur. The jury could readily infer that the failure to make a referral for proper treatment prolonged Mrs. Biggs' discomfort. Although direct testimony linking the alleged negligence to the prolonging of discomfort would have been helpful, under the circumstances of this case the expert testimony was sufficient to allow this claim to go to the jury.

Green v. Weiner, 766 A.2d 492 (Del. 2001) reversed a Superior Court's grant of judgment as a matter of law on the grounds that a proffered medical expert's opinion did not meet the requirements of 18 *Del. C.* §6853. Although the

[4] Theoretically, a patient in that situation could opt for radiation instead of chemotherapy, a choice that would not be in her best health interest.

expert's opinion did not explicitly state that the standard of care was breached and that breach caused injury, this Court reversed, holding:

> Section 6853 does not require medical experts to couch their opinions in legal terms or to articulate the standard of care with a high degree of legal precision or with "magic words." Similarly, to survive a motion for judgment as a matter of the law, the Greens are not required to provide uncontradicted evidence of the elements from which a reasonable jury could find in their favor. So long as Dr. Kahn's testimony provides this minimal evidence, any inconsistencies in Dr. Kahn's testimony must be resolved by a jury and are thus irrelevant for purposes of ruling on a motion for judgment as a matter of law.

Id. at 495.

In *Barriocanal v. Gibbs*, 697 A.2d 1169, 1172-73 (Del. 1997), this Court reversed a Superior Court decision interpreting 18 *Del. C.* §6852, the informed consent statute, saying "the statute does not require an expert to articulate certain 'magic words' because this interpretation would exalt form over substance."

Reviewing the *prima facie* evidentiary requirements for a viable Affidavit of Merit as mandated by 18 *Del. C.* §6853, this Court held: "Again, we acknowledge that although the expert's statement does not mirror Section 6853 exactly, his statement is the functional equivalent of the statutory language, and thus, satisfies the requisite proximate cause standard." *Dishmon v. Fucci*, 32 A.3d 338, 344 (Del. 2011).

These holdings, we submit, encompass the circumstances of the case at bar and warrant reversal even though "a more straightforward explanation of the standard of care [causation here] undoubtedly would have simplified matters, [the doctor's] testimony provides a sufficient basis for a permissible inference of negligence." *Id.*

The instant case also implicates the increased risk of harm issue which was addressed in *U.S. v. Anderson*, 669 A.2d 73 (Del. 1995). The United States District Court for the District of Delaware certified questions to the Delaware Supreme Court whether an "increased risk of harm" stemming from a failure to diagnose caused a plaintiff to become more likely to suffer a recurrence of cancer, and, if so, whether that was compensable. This Court conducted a careful analysis of pertinent authorities and said: "We hold that increased risk of harm accompanied by physical injury is a compensable element of damages under Delaware law." I*d.* at 2.

The Court noted the "...increased risk doctrine has been employed in cases involving late diagnoses which allowed cancer to spread. (Citation omitted; emphasis provided.)" *Id.* Quoting *U.S. v. Cumberbatch*, 647 A.2d 1098, 1103 (Del. 1994), the Court repeated: "If an injury is suffered in the loss of chance situation, it is the reduced possibility of survival which is the basis of the claim, not the death itself."

Here, the evidence is straightforward that the malignant nodule grew from 6mm in size to 8 mm (physical injury), and in Dr. Biggs' view, the Plaintiff's risk of death, based on the size and characteristics of the tumor, was 17%. This testimony fits the increased risk of harm doctrine and defeats the Defendants' argument.

The Minnesota Supreme Court recently considered a "loss of chance" claim in the context of a negligently delayed cancer diagnosis case. *Dickhoff v. Green,* 836 N.W.2d 321 (Minn. 2013). In doing so, the Court conducted an extensive review of the case law on this subject.[5] *Id.* at 326-327. The Court concluded that Minnesota recognizes a loss of chance claim, saying: "...we agree with those courts that treat the reduction of a patient's chance of recovery or survival as a distinct injury. It should be beyond dispute that a patient regards a chance to survive or achieve a more favorable medical outcome as something of value." *Id.* at 334 (Emphasis added). In the present case, the opportunity lost as a result of negligent delay was the chance to qualify for a less punishing treatment regimen as well as the 17% risk of death.

[5] Interestingly, the court did not mention Delaware's jurisprudence on "increased risk of harm" claims. *c.f. U.S. v. Cumberbatch, supra.*

Finally, we point out that this Court has ruled that an Affidavit of Merit which meets the requirements of 18 *Del. C.* §6853 established a *prima facie* case. *Dishmon v. Fucci*, 32 A.3d 338 (Del. 2011). In the case at bar, the veracity of the Affidavits of Merit filed with the Complaint was challenged and found to be in compliance with the statutory requirements. (A 3, 4). Although the Affidavits of Merit did not delve into the factual intricacies discussed here, the *Dishmon* precedent would seem sufficient to withstand a summary judgment under Civil Rule 56 or a motion for judgment as a matter of law under Civil Rule 50(a)(1). The statutory language in 18 *Del. C.* §6853(a)(1) governing the Affidavit of Merit ("there are reasonable grounds to believe that the applicable standard of care was breached ... and that the breach was a proximate cause of injury claimed in the complaint") is virtually the same as the language in §6853(e) ("No liability ... unless the alleged deviation from the applicable standard of care in the specific circumstances of the case and as to the causation of the alleged personal injury...") (Emphasis added). The *Dishmon* decision, we respectfully submit, precludes a judgment as a matter of law in a medical negligence lawsuit when the Affidavit of Merit has been held to comply with 18 *Del. C.* §6853.

As the nonmoving party, Mrs. Mammarella is entitled to the benefit of the following principles:

1. Delaware's longstanding policy favoring the final disposition of civil disputes on their merits. *Christian v. Counseling Res. Assocs., Inc.*, 60 A.3d 1083 (Del. 2013).

2. To have the case examined in the light most favorable to her. *Green* 766 A.2d at 493 (Del. 2001); *Burkhart v. Davies*, 602 A.2d 56, 58-59 (Del. Super. 1991).

3. To all favorable inferences to be drawn from the evidence of record. *Russell v. Kanga*, 571 A.2d 724, 731 (Del. 1990)

4. That summary judgment motions are especially disfavored in negligence cases because the fact patterns are usually susceptible to more than one interpretation. *Price v. Saylor*, C.A. No. 10C-12-220 PLA, 2012 Del. Super. LEXIS 360.

5. She is not required to provide "uncontradicted evidence of the elements of [her] negligence claim." *Green v. Weiner*, 766 A.2d at 495 (Del. 2001).

The court below placed heavy reliance on *Kardos v. Harrison*, 980 A.2d 1014 (Del. 2009). (A 162). The scenario there was somewhat different. In that case, the treating oncologist was unable to express an opinion on causation because the patient "had not been on [hormone therapy] long enough to decide" whether she would respond before she died. Here, the evidence is clear that the malignancy

grew (A 74) during the period of negligent delay and as a result: (1) made Mrs. Mammarella ineligible for radiation therapy, and (2) raised her risk of death to 17% without chemotherapy. This scenario is tantamount to a diabetic with an untreated gangrenous toe that months later leads to foot amputation rather than toe amputation. We respectfully submit the heavy reliance on *Kardos*, *supra.*, was not warranted here.

Plaintiff respectfully submits she is entitled to have the merits of her allegations of negligence and harm decided by a jury.

CONCLUSION

For the reasons herein stated, Appellant respectfully requests this Court to reverse the Decision and Order of the Trial Court dated September 19, 2013, and remand for further proceedings.

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Dated: December 30, 2013

So, again, we're back to square one, the issue is Dr. Biggs and that's it.

THE COURT: All right.

MR. KEATING: Thank you.

THE COURT: Mr. Ferri.

MR. FERRI: Your Honor, I concur, with just the added statement that Mr. Castle has had two opportunities to question Dr. Biggs to ask direct, clear questions, he chose not to do so. He also could have retained a forensic expert to testify to what he believes -- what he himself believes and he did not do it. What is in the record now remains nothing but speculation. And if this is presented to a jury, they would have nothing but speculation upon which to decide a case and it's the plaintiff's burden to provide that evidence to a reasonable medical probability. Thank you.

THE COURT: Thank you, Mr. Ferri.

All right. Title 18, Section 6853 provides that before liability can be established in a medical negligence action, a plaintiff must present expert testimony as to the applicable standard of care, the alleged deviation from that standard or the breach of

the standard of care and the causal link between the breach and the alleged injury.

And as I understand it from the defendants, that there has always been -- although not conceding any position on standard of care, but the crux of the defendant's position has always been whether that causal link between the breach and the alleged injury could be established in this case. The medical testimony that has to come in in order to support that liability is via expert and that is to a degree of reasonable medical probability as to all three elements. The plaintiff is required to provide expert testimony as to the standard of care, causation and credible evidence of each of these elements from which a reasonable jury could find in favor. And in the absence of credible medical testimony that establishes negligence, defendant would be entitled to a judgment as a matter of law.

Again, Dr. Biggs, as I understand it, is the oncologist and plaintiff's treating physician was identified as plaintiff's sole expert who could testify as to causation. That was confirmed various times through the communication with counsel and confirmed as

early as yesterday that Dr. Biggs was the expert on causation. It's my understanding that at the discovery deposition, Dr. Biggs did not state that the alleged delay in diagnosis resulted in any change of prognosis, which I know we've ruled on at the -- we excluded that evidence with respect to prognosis because there had been no change in prognosis. Dr. Biggs did not state that the alleged delay in diagnosis resulted in any change in treatment either or any diminished chance of survival. And that was at his discovery deposition at 25 through 27, 29, 36 to 38, 62, and 63 to 64.

Dr. Penman, the breast surgeon who treated plaintiff, agreed with Dr. Biggs. And that was at deposition -- her -- that deposition at 14 through 15 and then 21, 23.

Both doctors, Penman and Biggs, testified that the growth of the tumor did not have any effect on plaintiff's prognosis. Dr. Powers defers to Dr. Biggs, the treating oncologist, and his causation opinions in his deposition at 166 and 167.

Previously on defendant's motion for summary judgment, I denied the motion because the representations from counsel -- plaintiff's counsel --

was that Dr. Biggs would be able to establish at trial that the breach in the standard of care was the proximate cause of the injuries to include the change in treatment from radiation to chemotherapy and, specifically, the change in treatment from a partial breast radiation to chemotherapy.

With this rule 50 motion, under 50(a)(1), I did have -- having previously read it, I'm looking at it now, based on the fact that the basis for consideration of this cause -- of this motion is that the causation expert has now been deposed and his trial deposition of September the 3rd now closes the record with respect to the issue of causation and that is the information that is going to be submitted to the jury. And the basis, obviously, of this Rule 50 motion for judgment as matter of law didn't arise until after September 3rd, after the trial deposition of Dr. Biggs had been taken.

The plaintiff indicated that Dr. Biggs would state that plaintiff had undergone a different treatment plan but for the delay in diagnosis. And that was -- that's what's stated in the pretrial stipulation and that those are the representations that had previously been made. So a timely diagnosis in October of 2009 after

the first ultrasound, therefore, would have resulted in a treatment plan that would have been different than the chemotherapy that she ultimately underwent. Again, partial breast radiation versus chemotherapy.

The deposition, however, of Dr. Biggs was taken on September the 3rd. This testimony doesn't appear to comport with what was anticipated. And it's very much like the Kardos versus Harrison decision and what happened in that particular case.

I want to highlight what I think Dr. Biggs is saying as to the issue of causation. First off, I highlight what has been presented from the defense attorneys, which is:

"QUESTION: And so if one were to ask you what this patient's treatment would have been or what treatment she would have required in October of 2009, you couldn't state that; correct?"

And the answer is:

"ANSWER: Correct.

"QUESTION: Okay. You would be speculating if you gave that information; correct?

"ANSWER: Correct."

Dr. Biggs further testified:

"QUESTION: I just want to make sure that we all understand your testimony today. You can't tell the jury to a reasonable degree of medical probability what Mrs. Mammarella's treatment would have been in October 2009; is that correct?

"ANSWER: Correct.

"QUESTION: And do you have any opinions as to how big Mrs. Mammarella's tumor would have been in October 2009 based on the imaging studies alone?

"ANSWER: God -- I mean, no.

"QUESTION: So you can't tell the jury how big Mrs. Mamarella's tumor was in October of 2009?

"ANSWER: Correct."

When I referenced Dr. Biggs' deposition, page 16, question on line 7:

"QUESTION: And I take it the patient or the typical patient, at least, would prefer the partial radiation approach to the whole --"

And then the question stops. And then the answer is:

"ANSWER: Well, I don't know, you know, if I say typical, I mean there's -- you have to put a catheter into the breast. It stays in for about a week to ten

days. They have to walk around with this catheter in their breast."

And then he goes on to say:

"ANSWER: And then people are naturally, you know, concerned about participating in clinical trials. A lot of people are uncomfortable with that, so I don't know if it's the typical patient."

The question is:

"QUESTION: Okay. At this stage --"

And this is on direct:

"QUESTION: The meeting on May 13th, were you and the team in a position to recommend whole breast radiation versus partial breast or was that still an open issue at that point?"

The answer is:

"ANSWER: I think that was still an open issue."

And then he goes on to say:

"ANSWER: So, no, it was not a decision that was going to be made that day, as I recall."

On page 18, the question was:

QUESTION: Just one other point on radiation. I gather from what you told us before that that's not something you do but another member of the team is in

charge of?"

And his answer was:

"ANSWER: Yes."

On page 19, he answers about a June 8th, 2010 visit, which is the visit that he has with her and he states:

"ANSWER: So at this time we had the final biopsy results. It did show that the size of the tumor was 1.1 centimeters and so we talked about I was -- once I have the final pathology, I'm able to be a little bit more specific as far as the risk of distant metastatic disease and the benefits of adjuvant chemotherapy."

And on line -- page 20, line 16 -- I'm sorry, line 21 the question was:

"QUESTION: And at that time, was radiation no longer a consideration?"

His answer is:

"ANSWER: No, radiation would still be given if you want to pursue breast conservation, but the radiation would be delayed until the completion of chemotherapy."

I don't see anything in the direct that asks questions about whether his treatment would have been

radiation in October 2009 had she been properly diagnosed in October 2009.

Then I do see on line 18 of page 28, the question is:

"QUESTION: And there were questions about when to opt for radiation treatment initially versus chemotherapy and the conversation dealt with the size of the tumor; do you recall that?"

His answer is:

"ANSWER: Sort of."

And then on line 29 -- I'm sorry, page 29, line 3:

"QUESTION: Mrs -- "

I'm sorry, line 1:

"QUESTION: Mrs. Mammarella was under the impression that if the tumor on biopsy turned out to be less than 8 -- 8-centimeters or less in size, that she was a candidate for radiation treatment instead of chemotherapy first; is that a correct statement?"

And the answer is:

"ANSWER: You'd have to ask her what her impression was. My goal in that initial meeting is to try to provide a general framework for understanding how we make decisions and so that was my goal. If that

came across as being very specific, that was unintentional."

Then we get to I think what plaintiff's crux is, which is where I think they -- the focus of where they believe they establish certainty or some opinion here within a reasonable degree of medical probability. And that's at page 30. And at that point on direct, the doctor is asked to read pages from his testimony that was given at a prior deposition and his -- so he rereads and he says, quote:

"ANSWER: I think looking back at our initial consultation note, I indicated that if the tumor was no larger than it appeared on ultrasound, which I think was what, 8-millimeters, that I would likely feel that she would not take chemotherapy. I would like to underline the word 'likely' though because it's really a gray zone. And when you are in that gray zone you really have to have a patient who --"

Then he goes on and on and says:

"ANSWER: You have to try to understand the desires of the patient to be aggressive and to try to help them understand the risks and potential benefits within the level of uncertainty that we have, so it's

not quite as exact as that."

Then the answer -- the question -- and he says:

"ANSWER: Do you understand -- do you know what I'm trying to say?"

That was the end of his comment or his quote, I should say.

And then on Page 31, the question on direct is:

"QUESTION: And is that still your testimony?

And his answer is:

"ANSWER: Yes. I mean, I would stand by this. I can try to elaborate, but. . ."

And then the question on line 15:

"QUESTION: To the extent you stated any views or opinions here in terms of treatment of Mrs. Mammarella or advice that you gave her or these comments, does that represent your best medical judgment?"

The answer is:

"ANSWER: Yes.

"QUESTION: And do we translate that then to reasonable probability? Would you --"

Let me state the question properly. The question on line 21, Page 31 on direct is:

"QUESTION: And for our legal purposes, we

translate that to reasonable medical probability. Would you accept that?"

His answer is:

"ANSWER: I don't begin to understand what your legal interpretations are. I just -- I stand by what I said.

"QUESTION: It's your best medical judgment?"

And his answer is:

"ANSWER: Yeah."

And that was it.

Now that plaintiff has been fully heard on the issue of causation via Dr. Biggs, the plaintiff has no other causation expert. This is the evidence via trial deposition. As in Kardos versus Harrison at 980 Atlantic 2d 1014, the trial Court sees no point in waiting or impaneling a jury under these circumstances since the facts are not going to change.

In his deposition, the treatment or course of treatment in October that he gets into, especially on cross-examination -- and I failed to get into the details of the cross because I felt that there was -- it was insufficient on direct.

On page 33, the question is:

"QUESTION: So -- "

On cross-examination:

"QUESTION: -- any discussions you had with the patient prior to that June 18th, 2010 consultation would have been tentative or speculative terms; is that fair to say?"

His answer is:

"ANSWER: Yes, correct.

"QUESTION: Is it fair to say that you have no opinion as to what this patient's treatment regimen would have been prior to receiving that definite pathology on June 8th, 2010? Do you have any opinion as to what this patient's treatment would have been at any point in time prior to June 8, 2010?"

His answer is:

"ANSWER: Well, I guess it depends on what you mean by that. I would have my -- I would -- I would have my own opinion as to what I think is likely, but I wouldn't render an official opinion as to what I would recommend until I had all the facts."

On page 35:

"QUESTION: If one were to ask you in your medical opinion what this patient's treatment would have been

prior to her definite diagnosis, could you give an opinion to that effect?"

His answer is:

"ANSWER: No.

"QUESTION: And so if one were to ask what this patient's treatment would have been or what treatment she would have required in October 2009, you couldn't state that; correct?

"ANSWER: Correct.

"QUESTION: Okay. You would be speculating if you gave that information; correct?

"ANSWER: Correct."

Page 36:

"QUESTION: And do you have any opinion as to how big Mrs. Mammarella's tumor would have been? I think I covered this before."

His answer was:

"ANSWER: No."

He also states he can't tell how big the tumor was in October of 2009.

On page 39, the question -- the question was:

"QUESTION: When you had testified at your deposition that to a reasonable degree of medical

probability you could not determine what risks of metastatic disease was at 6-millimeters as opposed to 1.1 centimeters, do you stand by that testimony?"

His answer is:

"ANSWER: Yes."

And he says:

"ANSWER: And that's what I was trying to get at. When you start, like, trying to dissect it down to millimeters of difference, you're asking more of the data than is there and so, no, I don't think anybody can tell you that."

The question is:

"QUESTION: So is it fair to say when you're talking about differences of a few millimeters here and there, determining the risk of metastatic disease is sort of speculative -- a speculative endeavor, it's guesswork? Is that a yes?"

And his answer is:

"ANSWER: Yes."

Question on page 41:

"QUESTION: And you had testified at your deposition that to your knowledge, Mrs. Mammarella hasn't sustained any permanent side effects as result

of the chemotherapy treatment. Do you stand by that testimony today?"

His answer is:

"ANSWER: Yes."

And a question is:

"QUESTION: You can't tell the jury to a reasonable degree of medical probability what Mrs. Mammarella's treatment would have been in October 2009; is that correct?"

His answer is:

"ANSWER: Correct."

At no point is the doctor ever able to say within a reasonable degree of medical probability that the prognosis for treatment would have changed had she been diagnosed in October of 2009. He indicates that the call would have been speculative, at least from what -- my reading of his deposition. I don't think this is sufficient for plaintiff to establish proximate cause.

Mr. Castle indicated that there's an inference when he says -- when the doctor says, "I likely feel her. . ." and I think that an inference is certainly not enough to establish proximate cause. The basis -- plaintiff's only evidence on causation by Dr. Biggs is

speculative and I think plaintiff fails to make a prima facia case on the issue of causation. He is unable to state with a reasonable degree of medical probability whether plaintiff -- I'm sorry, defendant's failure to diagnoses in October had caused her a different treatment option. Plaintiff fails to prove causation is an element of her case on which she does carry the burden of proof and given that no other expert is going to testify as to causation, I'm going to grant defendant's motion as a matter of law.

I want to also state that I'm not happy about what -- with having to dismiss a trial like this and I think that the trial Court in Kardos was faced with the same sentiment. But given that the testimony is what it is and it won't change, it seems appropriate to follow the law that guides me in this decision.

Do the parties have anything else? Counsel, anything else?

MR. KEATING: No, Your Honor.

MR. FERRI: No, Your Honor.

MR. CASTLE: No, Your Honor.

THE COURT: Thank you. So ordered.

(Court in recess.)