More than Just a Breast Cancer Misdiagnosis Case

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Leann and Steve were friends of a friend. Leann worked in a plant where they print the veneers used in the production of kitchen cabinets and laminate floors. She was a bookkeeper in the office and made a modest wage. Steve worked in a plumbing supply house. They lived in a suburban Atlanta town, the kind that has a quaint courthouse square but has been overrun with strip malls and chain restaurants, not far at all from where they had both grown up. They had known each other a lifetime ago, when they were teenagers. Steve would sneak over to Leann's house and they'd watch movies and make plans about the future. They had their whole lives in front of them.

But, like most high school couples, they grew up and they grew apart. Each went on to marry and have kids. From time to time their orbits would intersect, briefly, long enough to say hello and catch up before going back to their lives. It would be almost twenty years before they would reconnect in earnest, both divorced, with five children between them. Leann would say that something was different that time. They had both grown up, but it was like they were back in high school and no time had passed. They knew they were supposed to be together. It was like they just had to get some things out of their respective systems first.

In time, I would see the wedding video. Leann wore a casual white dress and Steve a short-sleeved linen shirt and slacks on a beautiful summer day. Tesla played at the reception of just close friends and family and cold beer flowed. They were two people who bore the scars of life and the passage of time, but to anyone watching, were exactly where they were meant to be—together. Leann would say that Steve was her best friend, but as they danced and laughed at the reception, neither knew how much Leann would come to need Steve by her side.

"SOMETHING IS NOT RIGHT"

By the time either of them had any real health issue, Leann and Steve had been married six years. Their oldest child was 20 and their youngest eight. Things were as they expected, until one morning, Leann began feeling discomfort in her breast. That was soon followed by discharge from her nipple. They didn't waste any time getting it checked out, and after a physical examination and a mammogram and ultrasound, Leann was sent to a breast surgeon on the other side of Atlanta. When I asked them later how they ended up at that hospital system, with no less than three other hospitals between their house and the office of the breast surgeon, they said they were told "these people are the best."

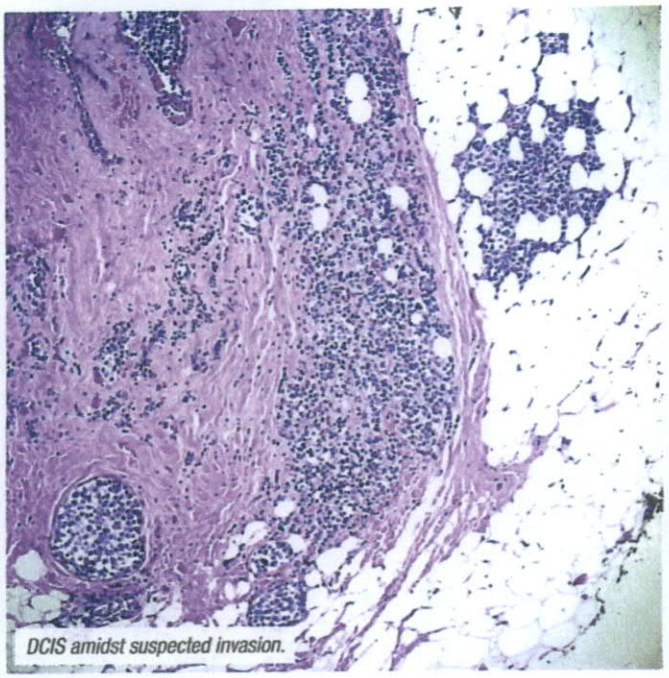
Soon, Leann was scheduled for a lumpectomy. She tolerated the procedure well. Unbeknownst to Leann and Steve, the tissue samples were then reviewed by a pathology group employed by the hospital system with which the breast surgeon was affiliated. The specimens were to be reviewed by Pathologist 1, a well-credentialed, single man in his early 50s. I later learned the details of how a pathology technician prepared the slides for his review. Pathologist 1 examined the slides and found what he believed to be Ductal

Even though I explain to clients that settlement value is vastly different from verdict value, it is sometimes very difficult for plaintiffs to separate emotion from the process. At one point, Leann told me she was disappointed at what appeared to be the final offer. "We are talking about my life. That just doesn't seem like it is enough."

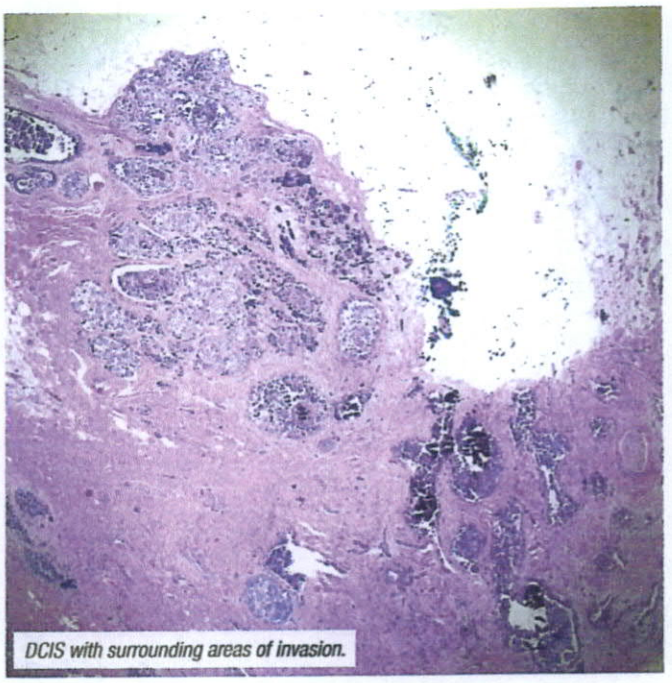
Carcinoma In Situ, ("DCIS"). Because this constituted a first diagnosis of malignancy, a fellow pathologist, Pathologist 2, was required to review the case. In this instance, Pathologist 2 also happened to be the lab director.

Pathologist 2 agreed with Pathologist 1 that it was DCIS, but it was determined that the margins of the specimen were not clear, meaning that there was not a perimeter of cancer-free tissue surrounding the malignant specimen from the lumpectomy, indicating that more tissue needed to be taken to ensure that all of the cancer had been removed.

Leann underwent a second lumpectomy about a month later. She tolerated the procedure well. This time, the specimen was read by Pathologist 3, a married, well-credentialed pathologist in her early 40s. She, too, confirmed the diagnosis of DCIS and also noted the margins may not have been clear. About six weeks later, after considering family history and wanting to be as prudent as possible, Leann underwent double mastectomy and sentinel lymph node biopsy. While the surgery was traumatic, with Steve by her side, she



DCIS amidst suspected invasion.



DCIS with surrounding areas of invasion.

got through the procedure and the recovery the best she could. The tissue from the mastectomy was examined, coincidentally, by Pathologist 1. His findings were again DCIS and that the lymph node biopsies were negative. He noted in his pathology report for the mastectomy that Leann had a history (the lumpectomy specimens) of "extensive DCIS."

Based on the diagnosis solely of DCIS, Leann was told that the margins were now clear and that she was cured.

COMPLETELY BLIND-SIDED

The next eleven months flew by. Leann and Steve went to work, raised their kids and lived their lives together. Then, suddenly one morning, Leann started experiencing abdominal pain that wouldn't go away. An MRI showed lesions on her liver. A biopsy showed "breast origin." Everything was turned upside down.

Leann was seen by the oncologist she had met only a few times the year before. The one who, along with the other doctors on whom she'd depended, had told her she had nothing to worry about.

It was one sentence that got their attention. One sentence that gave them the distinct impression a mistake had been made: "If I had only known it was *this* kind of cancer, I would have treated you completely differently..."

More just looking for someone to hear her story, Leann confided in a friend, who happened to be a paralegal, and a friend of mine.

THE INITIAL MEETING

Leann was exactly 19 days older than me. Steve was a couple of years older than us, but we all spoke the same language: hair bands and pinch-rolled jeans. We hit if off immediately. They told me the story of what Leann had been through and what the oncologist had said. They had a few medical records, including some recent pathology reports from another local hospital system. The reports showed cancer of a breast origin in her liver. They told me how when Leann was diagnosed, they sold their house and with the proceeds from the equity they had built, they moved to a cabin in North Georgia. Leann had always wanted to do that when they retired and they thought there was no good reason why they couldn't do it now. Leann's story had certainly gotten my attention and I liked them. It didn't add up and I needed to help.

After our meeting, I was left with two lingering questions: She'd had a double mastectomy. Her nodes were clear. How could she, almost a year later, develop lesions in her liver caused by breast cancer- when she no longer had breasts? And, how could three, well-credentialed, assumingly good-intentioned pathologists miss the kind of cancer that caused it?

FORREST FOR THE TREES

My first call was to a pathologist at a prestigious academic institution on the West Coast. I had never used her before. She, too, was about my age. She had an incredible pedigree. I would believe whatever she told me about the case, good or bad, but would she look at it? I obtained and sent to her, what we believed to be, the original pathology slides. I gave her no indication as to what I thought may or may not be on the slides.

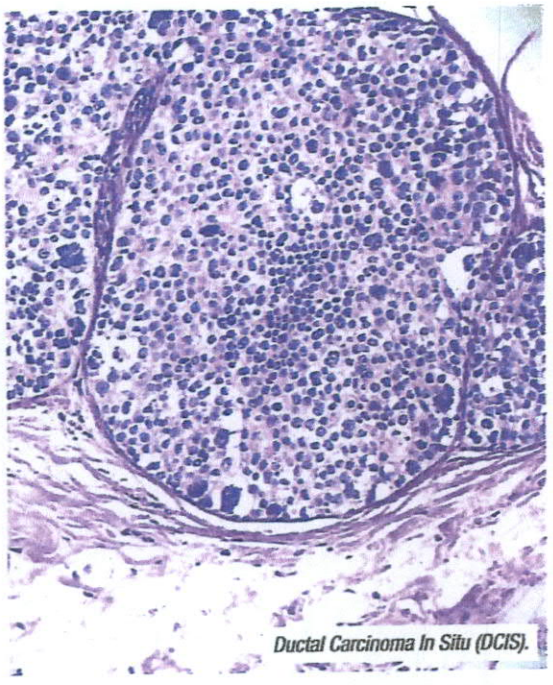
Not long after, she called me. "They missed it. It's right there, invasive carcinoma."

"What do you mean?" I asked. "Are you saying she didn't have DCIS?"

"No- she had both! There's a whole lot of DCIS, but there's invasive there too. They just missed it."

I asked her what was the best book on breast pathology. She recommended one and I bought a copy. I also bought a plane ticket to California and with my new book, I flew out to look at the slides with her. I read the book on the plane and when I arrived at her office, she had a microscope with two viewing ends. She sat on one side of the scope and I on the other and we looked at the slides together. I told her not to give me any help and I managed to identify exactly what she was talking about. Granted, there was bias—I knew that she'd found invasive carcinoma and I just had to pick it out. But there it was. At least what looked like it.

I asked her *how* they could have missed it. She believed it was a classic "not seeing the forest for all of the trees," situation. There was obvious, extensive DCIS. That much was true, but there were also areas



Ductal Carcinoma In Situ (DCIS).

that were subtle but very suspicious for, and believed to be, invasion.

FILING SUIT

The pathologist and I crafted an affidavit and we filed suit against Pathologists 1, 2 and 3, as well as their group and the hospital system. It turned out, as we suspected, that the group was owned by the hospital system and the Pathologists were therefore hospital system employees. Over the years, I'd had dealings with the two law firms that usually handled claims for this system, but, neither was given the case to defend. Instead, it was assigned to another large Atlanta malpractice defense firm and the lead attorney on the case was a stalwart of our business. I've had dozens of cases with this firm as well, and one time when I was at their offices for a deposition in another case, I mentioned to a friend, who was one of the partners at that firm, that I also had this new breast cancer case and that I was surprised it was assigned to them. He replied that the lawyer on the case was now handling the "bigger" cases for that hospital system. Needless to say, I was encouraged by his comment.

Whenever I file suit, I also notice the depositions of the defendants in the case for 50 days out from the date of the Complaint. Rarely do we conduct the depositions on the dates I notice, but I treat the notice as a placeholder, so I can depose the defendants before they have heard from any of my witnesses and have had a chance to discern my real theory of the case. We began in this case with the deposition of Pathologist 1.

As this was a pathology case, and what the pathologists saw–or didn't see–was at the heart of the case, I had asked my expert to take photomicrographs of the slides that were produced to us and that she had reviewed. I then had about twenty-eight, high quality prints made of the micrographs. I have had cases in which opposing counsel has allowed my use of the micrographs in the deposition(s) and others when they have not. As the deposition of Pathologist 1 approached, I prepared for either contingency.

A FEW TWISTS AND TURNS...

Less than two weeks before the deposition, I was notified that one of the firms I had originally expected to handle the case was making an entry of appearance. With this development, Pathologists 2 and 3 were now going to be represented by other counsel. To me, that meant only one thing: there must be some conflict in the defendants' views of the case. More encouraging news for us.

We proceeded with the deposition of Pathologist 1, as planned. He did not seem to make a very good witness. He was defensive and argumentative. I had asked my expert what she thought he might say in his defense. He tried to invoke each excuse just as she had predicted. I left the deposition not dissuaded of any of our theories.

The next deposition was to be of Pathologist 2. As it approached, I got a call from the lawyer for Pathologists 2 and 3. He told me that his partner would be handling the deposition of Pathologist 2. I asked why and he told me it was because he was "very busy" and needed help covering the deposition. I was not sure what to make of this development. His partner had a reputation of being aggressive in the defense of his clients and was no stranger to controversy in our area of practice. I had handled and resolved a number of cases with him in the past, but could not help but think that maybe this was an attempt by the defense to stymie any momentum we were building. My suspicions were only magnified when he announced to me that, after an exhaustive search that began as

he took over representation of Pathologist 2, he, "had found the *original* pathology slides" deep in the "bowels of the hospital!"

Original slides? You mean our case has been based on re-cuts? Let me guess, I thought, these *original* slides don't contain any invasive carcinoma? I cannot say that I did not feel on some level that this was classic gamesmanship. As the deposition of Pathologist 2 (the lab director) approached, I could not wait to hear how no one on the defense side but the latest lawyer to enter the case had noticed, not even Pathologist 1's counsel, that we had not been looking at the original slides.

Sometimes in the business of representing patients and injured parties, it can seem like the odds are always against you. Like you are David and the defense is Goliath, armed with public sentiment, favorable case law and unforgiving statutory law. It is hard not to assume that every twist in a case is not the result of defense chicanery. But I'm glad to say that in this instance, my instincts in that regard were wrong.

Apparently, it had been Pathologist 2's position all along that when he performed the review of the slides from Pathologist 1's first interpretation, he never saw a slide that contained invasion. According to him, and confirmed by Pathologist 3, the lab policy during the time period of this case was that he was only required to look at one representative slide from the first series of lumpectomy slides. To prove this, he insisted that his initials would be on the actual slide he reviewed, and when they were not, he insisted the slides we had all exchanged at the beginning of the case were re-cuts. When his new lawyer entered the case, he began searching for the original slides and eventually found a set with one slide containing Pathologist 2's initials.

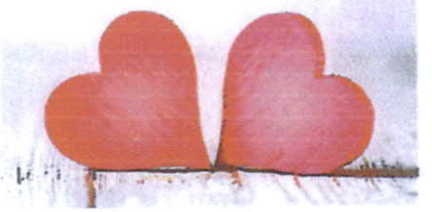
I asked Pathologist 2 why he did not note anywhere on the pathology report that he had only looked at selected slides. He responded that it was not policy then, but that he did it every time now, as a direct result of this lawsuit.

Of course, I asked my expert to examine the *original* slides and her opinion remained unchanged. She did confirm, however, that the slide that Pathologist 2 had examined did not contain any invasion. I deposed Pathologist 2, confirmed he had no liability and dismissed him from the case.

HIDING IN PLAIN SIGHT OF A ROOM FULL OF DOCTORS

Since the time that our pathologist expert had first reviewed the slides, (before suit was filed), as expected, I had received discovery responses from all Pathologist defendants. Contained in Pathologist 3's responses was information about a "Tumor Board" at which she had spoken about a month after her examination of the slides in this case and about a month before Leann's double mastectomy.

It was one sentence that got their attention. One sentence that gave them the distinct impression a mistake had been made: "If I had only known it was this *kind* of cancer, I would have treated you completely differently..."



Tumor Board, in this case, was a meeting of oncologists, surgeons, pathologists and other clinicians with the purpose of discussing particularly challenging or novel cancer cases for educational purposes. Pathologist 3 had presented Leann's case to the Board as an example of straightforward, extensive DCIS. The irony was inescapable.

Also contained in Pathologist 3's responses were PowerPoint slides from her presentation at that Tumor Board. Our expert reviewed the materials and was shocked to find that invasion was present on at least one of the slides that Pathologist 3 had presented!

I was again pleasantly surprised in the case when I deposed Pathologist 3. She was polite and professional and it was clear to me she felt badly about what had happened. Of course, no amount of decorum excuses deviating from the standard of care, but it was nice to actually depose someone who showed some contrition, however subtly. She explained that when she examined the set of slides from the second lumpectomy, she already expected they would show DCIS, as that had been the diagnosis of Pathologist 1 and then confirmed by Pathologist 2. When I showed her the photomicrographs of the slides she had examined, she admitted some were suspicious for invasion. When I showed her the ones Pathologist 1 had examined, she also admitted some were suspicious of invasion. She also testified that the standard of care required Pathologist 1 to further investigate what he should have appreciated as suspicious findings.

THE EXPERTS

Despite these developments, of course, the defendants wanted to depose my standard of care and causation experts. I could only guess that they also wondered how if Leann's nodes were negative, she could develop lesions in her liver almost a year after the mastectomy. How would my experts explain that?

I found the answer fascinating. Before filing suit, I wanted to shore up our causation theory and better understand how this had all happened. I met with Leann's treating oncologist on two different occasions during the litigation. I also hired an expert in the Pacific Northwest who is at the forefront of breast cancer research and treatment. He, too, is in his mid-forties. I had two main questions for him: first, if the invasive carcinoma had been diagnosed at the same time as the DCIS, would Leann's outcome have been different; and secondly, how could she have clean nodes but then develop metastasis to her liver almost a year later?

The answer to the first question was yes, her outcome would have been different. Leann had a hormone receptor positive cancer, so Tamoxifen therapy would have been indicated. If it had been diagnosed earlier, an Oncotype DX recurrence score could have been determined and a specific chemotherapy cocktail could have been tailored to her. Instead, she received no treatment and the cancer metastasized to her liver and bones before she knew what was happening. The efficacy of chemotherapy is somewhat paradoxical: chemo kills rapidly replicating cells. The faster the cells are replicating, the more effective the chemo, so more aggressive cancers are more susceptible to treatment with chemo. That is why it is important to obtain Oncotype DX and Ki-67 (a test that measures cellular proliferation) scores, as early as possible.

But what about the negative nodes? The expert explained that with invasive cancer, "micro-metastases" develop and enter the circulatory and/or lymphatic system, if not eradicated through chemotherapy. He explained that the micro-metastases were subclinical, meaning undetectable, and therefore could not necessarily be monitored. In other words, if there is any invasion, chemotherapy is crucial. In Leann's case, these very small groups of cancer cells were allowed to float about her body and eventually take up residence in her liver and then bones. While this explained the negative nodes, it made the case even more tragic. Leann thought she was cancer free, when all along she had these insidious cells living inside her.

Our causation expert just happened to be in Atlanta for a conference at a time that everyone could attend a deposition. He gave testimony without incident and I was pleased at how well he communicated the issues. Not long after, we flew to the West coast and our standard of care expert was deposed. Pathologist 2's lawyer did his best on her, but she held up well. She's a pretty remarkable woman. She is an invasive breast cancer survivor herself. At the conclusion of her deposition, we all agreed to mediate the case. We set if for the first of the month, two months out. In the meantime, the defense threw up one last Hail Mary and identified a causation expert in New England. I took his deposition the Friday before the mediation on Tuesday, and, as I expected, his testimony could be

distilled to, "cancer kills and she was going to die anyway." We were not dissuaded.

RESOLUTIONS

We hired, by all accounts, one of the more popular and effective medical negligence mediators. Consent did not appear to be an issue, especially since the pathologists worked for the hospital system and therefore did not have private insurance. The month before the mediation, I brought a producer and camera crew to Leann and Steve's cabin and we shot a "day in the life" video. Leann told their story, how they had found each other after all of those years. Steve talked about how incredibly stoic Leann was to the outside world and how fragile she would be when no one was around. They talked about the impact on the children and their families and they talked about how much they needed each other. I played the video at the mediation and Pathologist 3, the only individual defendant to attend, cried. She thanked Leann and Steve for sharing the video and said how much she hoped the case could get resolved that day.

The defendants eventually put real money on the case, but at one point, Leann and Steve were frustrated. Even though I explain to clients that settlement value is vastly different from verdict value, it is sometimes very difficult for plaintiffs to separate emotion from the process. At one point, Leann told me she was disappointed at what appeared to be the final offer.

"We are talking about my life. That just doesn't seem like it is enough."

And then she asked me, "Are you disappointed, too?"

I thought for a minute. "Not as disappointed as I would be if we spent another eighteen months trying to get to trial only to have a jury give you *less* or *no* money. Or if we got a big verdict and the defense tied us up in appeals," I said.

Before I could finish my thought, Leann said softly, "Or if we keep going with the case and I'm not here to see it through to the end..."

SEEING AND FEELING THE IMPACT

Leann and Steve settled the case that day for a significant number. It was not as much as they had hoped, but it was far more than enough to accomplish some of the goals Leann had set in the short term. We met with a structured settlement specialist and I referred them to financial planners. Leann wanted to do something for each of the kids. For two of them, she paid off some debt. For another, she bought a practical car. For the others, college funds. For the whole family, she bought a house with plenty of room. Not a mansion on the north side of Atlanta as some more cynical might expect, but a nice five-bedroom home in the same town they'd been living in before the diagnosis. She bought Steve an SUV. When she was done, they still had about 75 percent of the recovery.

For herself, she bought a convertible. In the few months following the settlement, I spoke with both Leann and Steve a number of times. Leann had a peace I had not seen before, but I knew from Steve that she was in decline. I asked how the resolution of the case had affected her. He gave me an example. He told me that before the case was over, when she would get bad news, she would ball up in the corner and hide from the world, sad and depressed, for sometimes a week. After the settlement, when she got bad news, she'd

jump in her car, put the top down and drive down the highway until she felt better.

Almost four months to the day after the mediation, on a Tuesday, I got a phone call from Steve. Leann had awoken that morning confused and unable to get herself out of bed. Steve had called an ambulance and they had been at the ER most of the day. When I got to the hospital around 7pm, there were dozens of people, Leann's family and friends, in the hallways and waiting areas. I didn't really know anyone except Steve and the kids, so I waited quietly until I could talk to him and say good bye to Leann. As I was walking out, an older woman stopped me,

"I don't mean to be rude, but everyone here has been trying to figure out who the guy in the orange sweater is. Who are you?"

"My name is Brandon Taylor, ma'am."

As soon as I said my name, the woman, who I learned was Steve's mother, began to cry and turned to her husband and told him I was Leann's lawyer. She hugged me and thanked me for everything I had done for Leann and Steve and for helping make Leann's last few months peaceful. She told me that she and her husband had been helping Leann and Steve financially as all of the treatment had exhausted their savings. She told me that she and her husband were also on the brink of financial collapse because of this and that had the settlement not come when it did, they were afraid they would lose everything. I thanked them for the kind words and slipped out the side door. Steve told me Leann passed away later that night.

EPILOGUE

A few months after Leann passed, I was having lunch with Steve. He was telling me how the kids were doing and how hard he was finding it to be alone after being at Leann's side for so long and through such emotional times. I knew that Leann had always wanted a pool, so I asked Steve if the new house had one. He told me that it didn't but that they had broken ground on a pool in the back yard on a Monday. He said it had been a tough weekend for her and that she had been spending most of her time in bed. But that Monday, she got out of bed, walked downstairs, pulled a chair up to the sliding glass door and sat there and watched the backhoe dig the hole for the pool all day long. He said she had a smile from ear to ear the whole day. It was the happiest he had seen her in months. Then when the crew left, she went back up to bed but never got out of bed again under her own power. The next night, she was gone.

As plaintiffs lawyers, we sometimes represent people that we may not like. We sometimes represent people that we know were harmed and need our help, but we wish were more fiscally responsible, more appreciative, kinder. But in this case, maybe better than in most, I saw the impact the results we work so hard for can make. I saw an incredibly brave woman be able to live out her last days knowing her family would be ok–and that felt more satisfying than I can describe. ●

ABOUT THE AUTHOR

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