

STATE OF MAINE
PENOBSCOT, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.:

WADE BUTLER, IN HIS
INDIVIDUAL CAPACITY AND AS
PERSONAL REPRESENTATIVE
OF THE ESTATE OF ELIZA
BUTLER,

Plaintiff,

v.

ST. JOSEPH HEALTHCARE and
ST. JOSEPH HOSPITAL,

Defendants

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COMPLAINT

Wade Butler, in his individual capacity and as Personal Representative of the Estate of Eliza Butler, by and through counsel, states as follows for this Complaint.

Introduction

1. This is a medical malpractice case arising out of a more than three-and-a-half-year delay in diagnosing breast cancer in Eliza Butler.

2. Eliza was just shy of her 38th birthday when, in December 2017, she first reported a lump in her left axilla (armpit) to her primary care provider St. Joseph Healthcare. St. Joseph Healthcare recognized the possibility of breast cancer and discussed ordering an ultrasound or mammogram, but never ordered the imaging.

3. Eliza returned to St. Joseph Healthcare with complaints of pain coming from the same site in her left axilla in in January 2019, in August 2020, and in February 2021. St. Joseph Healthcare never ordered any imaging of the axillary region during or following any of these visits.

4. In June 2021, after worsening symptoms, St. Joseph Healthcare finally ordered an ultrasound of the left axilla. The ultrasound identified a “spiculated mass” in the precise area of

Eliza's previous axillary mass. A mammogram and biopsy confirmed that this mass was breast cancer.

5. However, by the time it was finally diagnosed, the cancer was metastatic, Stage IV, had spread into her lungs, and was at an end-stage phase of breast cancer called "lymphangitic carcinomatosis," which is incurable and has an average life expectancy of around 6 months.

6. In January 2023, approximately a year and a half after her diagnosis, Eliza died of Stage IV, metastatic breast cancer.

7. At the time of her death, Eliza was 42 years old.

8. Eliza left behind her husband and the love of her life, Wade, with whom she had run a popular candy store, Specialty Sweets, in Bangor.

9. She is also survived by four young children: Jacoby, age 13, Penelope, age 9, Zachary, age 7, and Emily, age 4.



Parties

10. Plaintiff Wade Butler is the Personal Representative of the Estate of Eliza Butler. At all times relevant to this Complaint, Wade and Eliza were husband and wife and resided in Bangor, County of Penobscot, and State of Maine.

11. Defendants St. Joseph Healthcare and St. Joseph Hospital (collectively “St. Joseph” and “Defendants”) are registered Maine corporations that provide health care services, including through St. Joseph Family Medicine of Brewer, Maine.

System Failure, Agency, Direct and Vicarious Liability

12. Like all corporations, Defendants act through their employees and their agents, including medical doctors, mid-level providers, nurses and other staff and personnel who combine to create a system of health-care delivery to outpatients.

13. All references to Defendants or St. Joseph within this Complaint are intended to be inclusive of all Defendants’ employees or agents—whether specifically identified in the medical chart or not; or specifically identified by name in this Complaint or not—who participated in and collectively comprised the system of medical care relied upon by Wade and Eliza, and which Plaintiff alleges, through this Complaint, failed to comply with reasonable standards for delivery of medical care.

14. Plaintiff alleges that each and every person involved in the system of medical care upon which Eliza relied was an actual or implied agent of St. Joseph, because each person had authority conferred by St. Joseph to participate in Eliza’s medical care, and Eliza and Wade reasonably believed and relied upon the belief that Defendants would appropriately select, in both quality and quantity, sufficient personnel with the necessary qualifications, experience, training and supervision to fulfill his or her role within the system of medical care, such that the system as

a whole was safe, met the needs of Eliza as a patient, and thus complied with the standard of reasonable medical care expected of medical providers Defendants.

15. Plaintiff specifically contends that Defendants were directly negligent based upon Defendants' negligent hiring, training, staffing, supervision, policies, communication, documentation, medical record-keeping, culture and systems, as well as vicariously liable for the negligence of each and every one of its personnel whose conduct, either individually or in combination with other personnel, contributed to the failure of such individual(s) and the system to meet the standard of reasonable care to the decedent.

Background of Pertinent Medicine

16. According to the Centers for Disease Control (CDC), more than 240,000 women are diagnosed with breast cancer each year in the United States. Of those women, more than 42,000 die each year from breast cancer, making it the second most common cause of cancer death for American women.

17. The mortality rate from breast cancer has dropped dramatically since the 1980s. One of the reasons for the lower mortality rate is **because of earlier detection** through the practice of screening mammography. When breast cancer is diagnosed early, the opportunity for treatment and recovery is improved.

18. Breast cancer is staged based upon criteria published by the American Joint Committee on Cancer (AJCC) and Union for International Cancer Control (UICC). Staging is based upon assigning values to T (tumor), N (lymph node), and M (metastasis). Additionally, prognostic stages of cancer also reflect the cancer's hormone positive or negative status—Estrogen Receptor (ER) expression, Progesterone Receptor (PR) expression, and Human Epidural Growth

Factor expression (HER2)—as these are indicators of whether the cancer is treatable. Based upon these factors, an overall prognostic stage (I-IV) can be established.

19. For example, the table below shows how TNM and ER/PR/HER2 combine to produce a prognostic stage group:

T (size of primary tumor)	N (spread to lymph nodes)	M (distant metastasis?)	ER	PR	HER2	Prognostic Stage
T1: < 2cm	N1: 1-3 axillary lymph nodes	0 (none)	Pos	Pos	Neg	IB
T1	N2: 4-9 axillary lymph nodes	0	Pos	Pos	Neg	IIB
Any T (any size tumor)	N3	0	Pos	Pos	Neg	IIIB

20. The five-year disease-free survival rate for breast cancer is as follows:

Stage I: 98-100%

Stage II: 85-98%

Stage III: 75-95%

21. By contrast, stage IV, metastatic (M1), breast cancer is incurable.

22. However, even for stage IV cancer, advances in treatment with modern chemotherapy drugs and earlier diagnosis provide appreciable benefits in terms of prolonging a patient's life—in some cases, by many years. Thus, at each stage it is important that the cancer be diagnosed and treated as early as possible. Delay carries great risks of spread and progression of the cancer to a higher stage or to the point where the cancer causes secondary disease processes, like orthopedic injury, organ injury, respiratory distress, etc., that increase mortality risk.

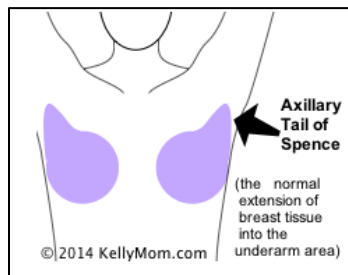
The Standard of Care for Diagnosing Breast Cancer

23. Breast cancer is most often diagnosed by imaging (most commonly, mammogram). However, it is not uncommon for a concern to first come to the attention of a medical provider from a patient's report of symptoms (e.g., a lump or pain in the breast or armpit).

24. Importantly, **when breast cancer is in the differential diagnosis, the medical provider is required to perform a physical examination (palpating the breast and axillary region) and to order imaging.**

Physical Breast Exam

25. A breast examination includes a thorough examination of the central breast tissue, as well as an examination of the axillary region. There are two reasons that the axillary region must be included in an exam. First, primary breast tissue extends into the area under the armpit—a portion of the breast tissue called the Axillary Tail of Spence (see diagram below):



26. Second, the axillary region contains regional lymph nodes to which breast cancer is known to spread.

27. Although pain in the breast or armpit pain is a less common presentation of breast cancer, it is well known that some women report pain or tenderness. Simply Googling the question, “Why does my armpit hurt?” generates a WebMD article explaining that breast cancer is one possible cause (see excerpt from article below):

Why Does My Armpit Hurt?

<https://www.webmd.com/a-to-z-guides/armpit-pain-causes>

Written by [Alyson Powell Key](#)

Medically Reviewed by [Carol DerSarkissian, MD](#) on September 01, 2021

IN THIS ARTICLE

- [Muscle Strain](#)
- [Swollen Lymph Nodes](#)
- [Breast Cancer](#)

Whether it's throbbing, aching, or sharp, everyone has been in [pain](#). The uncomfortable sensation is a red flag. Pain in your [armpit](#) could mean that you've simply strained a muscle, which is eased with ice and rest. It could also be a sign of more serious conditions, like an infection or breast cancer.

Breast Imaging

28. If breast cancer is in the differential diagnosis, a medical provider **is required** to order imaging *even if no masses are detected on physical examination*.

29. It is well recognized that a woman can have breast cancer identifiable on imaging *even if she has no palpable mass*.

30. Moreover, palpating a mass alone cannot distinguish between benign and malignant tumors, as the characteristics of a malignant mass are highly variable patient to patient: the mass can be hard or soft, fixed or mobile, painful or non-painful.

Treatment and Outcomes of Localized or Regional, Non-Metastatic Breast Cancer, With or Without Axillary Lymph Node Involvement

31. For patients with early-stage breast cancer, outcomes are typically very good, irrespective of whether the patient has axillary lymph node involvement.

32. Patients with or without clinical evidence of axillary node involvement may undergo primary breast surgery (mastectomy, lumpectomy, etc.) followed by axillary lymph node dissection (ALND) and/or adjuvant radiation therapy (RT) following sentinel lymph node biopsy. Some women may be offered hormone and/or chemotherapy.

33. The National Health Service in the United Kingdom publishes a nomogram that can be used to predict outcomes for women treated for breast cancer based upon input variables, including age at diagnosis, ER and HER2 status, tumor size, tumor grade and the number of positive lymph nodes.

34. For a 39-year-old woman, like Eliza, with an ER positive, HER2 negative, grade III tumor of approximately 2 cm, and a single positive lymph node, the 10-year survival after surgery alone is 71%.

35. That survival rate increases to 78% and 82% if hormone and chemotherapy, respectively, are also administered.

36. All other variables remaining constant, a woman with non-metastatic breast cancer would be more likely than not to survive her cancer unless there was involvement of *more than 12 lymph nodes*.

The Delay in Diagnosing and Treating Eliza Butler's Breast Cancer

December 2017

37. On December 4, 2017, Eliza called SJH, the office of her primary care doctor, Jennifer Freese. (SJHC 0033.) Eliza explained that she had a **“cord” under her left arm** for the last couple of weeks which was painful. Dr. Freese was unavailable, so the office scheduled Eliza for an appointment with nurse practitioner, Christine Nealley.

38. The following day, on December 5, 2017, Eliza was seen at SJH by FNP Nealley. FNP Nealley noted that Eliza had **“found a cord and small lumps” in her left armpit** about three weeks earlier on November 17. The nurse/MA commented: **“? nodules . . . notices this about three weeks ago.”** Eliza stated that **“it is not as noticeable now but is tender to touch.”** (SJHC 0034.)

39. At her deposition, Eliza showed the location of the mass in her left axilla:



40. FNP Nealley performed a breast and axillary exam but stated that she was unable to palpate any masses. Nevertheless, she acknowledged that based upon the patient's report of an axillary mass, breast cancer was in the differential diagnosis:

Q: Were you concerned about breast cancer?

A: **It was on the – on the differential.**

(Nealley Dep. 31:23-24.)

41. Because breast cancer was in the differential and cannot be ruled out based upon a physical examination alone, FNP Nealley was required to order imaging.

42. In her office note from the visit, Nealley documented that she **“discussed the possibility of doing “us[ultrasound] and a mammogram.”**

43. Nealley noted that Eliza stated that she was “very busy at this time of yr,” and Eliza “would like to delay the test till January given that she is scheduled for a recheck of the breasts in Jan as it has greatly improved in the last few weeks and nothing abnormal was felt on this exam.” (SJHC 0035.)

44. Following Eliza's office visit with FNP Nealley, the standard practice at SJH was that this record would be forwarded to Eliza's regular PCP, Dr. Freese, and Dr. Freese would review Nealley's note. (Freese Dep. at 71:15-72:2.)

44. Accordingly, had Dr. Freese followed standard protocol, she should have become aware of Eliza's report of an axillary mass and FNP Nealley's plan to order ultrasound or mammogram.

45. However, following the office visit of December 5, 2017, neither FNP Nealley, Dr. Freese, nor anyone else at SJH, ordered an ultrasound or mammogram—or so much as brought the issue up again—*for another 3 ½ years*.

46. Over that same 3 ½ years, no subsequent breast or axillary exam was ever performed, even though Eliza continued to report axillary pain consistent with her initial report of a mass in her axilla.

January 2019

47. On January 2, 2019, Eliza presented to SJH for a visit with Dr. Freese.

48. At that time, Eliza reported that her left arm had been hurting “for a few months” despite the fact that she had experienced “no particular injury or trauma.”

49. Eliza stated that her “**pain starts in her axilla.**” Eliza stated that the pain was somewhat better at rest, “but never really goes away.” (SJHC 0050.)

50. Dr. Freese acknowledged that if a patient presents with pain in her axilla, the standard of care requires that the doctor perform a breast exam followed by imaging:

Q. So you have pain in the breast or the armpit. You're required to, at a minimum, do a breast exam, right?

A. That would be what I would do, yes.

...

Q. [T]he way you rule out [breast cancer] is through a systemic process that involves a history, a physical examination, and radiographic imaging, right?

A. Yes, at some point all of those things need to be done.

(Freese Dep. at 49:7-10, 81:15-20.)

51. Despite Eliza's report of axillary pain following her prior report of an axillary mass, Dr. Freese did not perform a breast or axillary examination.

52. Indeed, Dr. Freese did not so much as ask Eliza to remove her shirt so that she could visually inspect the area.

53. Rather, Dr. Freese merely assumed that Eliza's pain was musculoskeletal and referred her for physical therapy.

54. Dr. Freese also failed to review Eliza's recent medical history, including the treatment record from FNP Nealley in which Eliza reported an axillary mass and FNP Nealley discussed the ultrasound or mammogram.

55. At deposition, Dr. Freese acknowledged that if she had seen the reference to the mammogram, she would have understood that the reason for this would have been to rule out breast cancer, and that as of January 2019, this imaging had still not been completed:

Q. The mammogram would be for breast cancer, wouldn't it?

A. Yes.

Q. And you would have understood as of January of 2019 that neither of those tests [ultrasound or mammogram] had ever been performed, correct?

A. If I had not got the reports on either of those, then yes.

...

Q. And now the patient is back and complaining about a condition that includes pain that starts in her left armpit, right?

A. That's - - yes.

(Freese Dep. at 76:5-12, 77:5-8.)

56. Although Dr. Freese testified that she was required to review the medical record of Eliza's December 5, 2017, office visit with FNP Nealley, Dr. Freese never reviewed that record.

57. First, Dr. Freese does not note in any of the subsequent records that she was aware that Eliza had reported an axillary mass or that Nealley had discussed ordering an ultrasound and mammogram.

58. Second, even after Dr. Freese learned that Eliza had been diagnosed with Stage IV breast cancer, Dr. Freese never recalled that her patient had first reported a lump in her axilla several years earlier or that there had been discussion as far back as 2017 about ordering an ultrasound or mammogram:

Q. [W]hen you learned that Eliza had cancer, did you remember that your colleague had suggested a mammogram as far back as December of 2017?

A. I did not remember that, no.

(Freese Dep. at 111:5-9.)

Q. When you learned that she had breast cancer, did you think back to your time treating her and reflect on the progression of her care over that time in any way?

A. No, I -- I simply recognized that she was a former patient, and that I had seen her before.

(Freese Dep. at 28:4-10.)

59. Dr. Freese never knew that Eliza had reported an axillary mass in December 2017, or that Nealley had discussed imaging, because Dr. Freese never took the time to review FNP Nealley's December 5, 2017 office note.

60. By Dr. Freese's own admission, this violated standard practice. *See* Freese Dep. at 73:9-16 ("Q. But if you didn't review [the December 2017 record], that would have been inconsistent with the typical practice of reviewing office records for your patients that were seen

by other providers in the practice, correct? A. Yes. Typically, I review notes that are forwarded to me when other providers have seen them.”).

August 2020

61. On August 21, 2020, Eliza called SJH asking to speak with a nurse.

62. She stated that she had no feeling in the back of her left arm.

63. She noted that she “**sometimes has pain in her armpit.**”

64. She stated that she “has had weird things happen with her left arm for a couple of years now.” (SJHC 0077.)

65. The note was forwarded to Dr. Freese, and she recommended that Eliza come in for an office visit. (Freese Dep. at 92:3-12.)

66. Four days later, on August 25, 2020, Eliza saw Dr. Freese.

67. Once again, Dr. Freese did not perform a breast or axillary exam. (Freese Dep. 103:6-8.)

68. Instead, as in January 2019, Dr. Freese did not follow up on or examine the issue of the axillary mass or axillary pain, because, she stated, “I would have gone by the other symptoms,” and “it seemed more musculoskeletal to me, so that’s where I was focusing on.” (Freese Dep. 104:22-25.)

69. Again, Dr. Freese seemed completely oblivious to her patient’s history of reporting an axillary mass and her colleague’s discussion of a plan for ultrasound or mammogram. (Freese Dep. at 105:1-7 (“Q. In August of 2020 -- again, do you know in August of 2020 whether you were aware of the nurse practitioner's note from December of 2017? A. I -- **I don't have recollect -- recollection of reviewing that note**, but I -- I don't know either way.”).

Jan – June 2021: Lead Up to Cancer Diagnosis

70. On January 3, 2021, Eliza reported to SJH that she had a severe onset of back pain after picking up her 18-month-old daughter. (SJHC 0104.)

71. This was the first time that Eliza had reported back pain to her PCP.

72. In February 2021, Dr. Freese left SJH to work full time at a new aesthetics medical business she founded. Responsibility for Eliza's primary care was transferred to physician assistant, Dennis Scott Simpson.

73. On February 4, 2021, Eliza was seen by PA Simpson.

74. Again, Eliza reported back pain, localized to her sacrum.

75. On examination, PA Simpson found "focal anesthesia to light touch, inferior upper arm, left." (SJHC 0107.)

76. Simpson did not review any of Eliza's prior medical records and was not aware that she had reported a left axillary mass in December 2017. (Simpson Dep at 51:23-52:2.)

77. He did not perform a breast or axillary examination. (Simpson Dep at 50:17-21.)

78. He referred Eliza for osteopathic manipulation therapy.

79. Eliza returned to SJH on February 22, 2021 complaining of back pain. She was seen by PA Simpson.

80. In addition to the ongoing back pain, Simpson noted a lump under Eliza's left armpit. (SJHC 0121.)

81. **This was the first time *anyone* at SJH had examined and palpated Eliza's left axillary area since her office visit on December 5, 2017.**

82. However, despite palpating a lump in the left armpit, Simpson did not perform a complete breast exam or order imaging.

83. In March 2021, Eliza was seen twice at SJH.

84. She reported that she was now being treated for anxiety. She had ongoing lumbar and thoracic tightness. She was fatigued and suffered from headaches.

85. Eliza was attending physical therapy and her physical therapist asked SJH to order an MRI of her left shoulder. (SJHC 0132-0134, 0153.)

86. An MRI of the left shoulder was performed on March 30, 2021. It was read as showing mild increased signal in supraspinatus tendon at its insertion into greater tuberosity which could reflect focal tendinopathy or poorly visualized partial thickness tear, as well as minimal excess fluid in the subacromial subdeltoid bursa suggesting mild bursitis. (SJHC 0155.)

87. On April 23, 2021, Eliza presented to SJH, complaining of visual disturbance in her left eye and severe headaches. She also reported tingling in her left arm.

88. Despite palpating an axillary mass in February, PA Simpson did not perform an examination of the axilla or breast to determine whether the mass had grown or changed over the past two months, and he did not order any imaging of the breast or axilla.

89. He ordered MRIs of the cervical spine and brain. (SJHC 0159.)

90. MRIs of the cervical spine and brain completed on May 17 and 18 were read as normal, except for a possible small disc protrusion in the neck unlikely to cause any symptoms. (SJHC 0188-90.)

91. On June 3, 2021, Eliza called SJH stating that she felt like she had asthma. She reported that for 3-4 weeks she had been having a hard time talking and breathing during activity. (SJHC 0192.)

92. **This was Eliza's first report of any respiratory symptoms.**

93. On June 8, Eliza sought care at an urgent care center for her difficulty breathing. They provided her with an inhaler. (NLUC 11.)

94. On June 9, Eliza returned to SJH, reporting that she was suffering from anxiety and shortness of breath for about a month. She also reported ongoing, low-level back pain. She was “educated on the use of the inhaler” and prescribed Prednisone. No breast or axillary exam was performed, and no breast or axillary imaging ordered. (SJH 0195.)

95. On June 11, Eliza called SJH stating that things were not getting better. A chest X-ray was done and came back normal. (SJHC 0211.)

96. On June 13, Eliza returned to Urgent Care, complaining of worsening shortness of breath. They suggested that she go to the hospital emergency department. (NLUC 20.)

97. Eliza was seen that same day in the emergency department at Eastern Maine Medical Center (EMMC). They noted that she had shortness of breath for four weeks. They performed a CT scan of her chest, which came back with several abnormal findings, including mediastinal lymphadenopathy; 1.2 cm subcarinal node; 1 cm left inter lobular node; multiple areas of ground glass opacity; peripheral consolidation inflammatory in nature; and septal thickening. (EMMC 2901.)

98. On June 16, 2021, Eliza returned again to SJH and PA Simpson. Her chief complaint was shortness of breath, which had started about a month ago. (SJHC 0218.) Simpson wrote: “Pt also reports a lump under her left armpit that she is concerned about and wants it to be looked at.” PA Simpson examined the lump and noted “focal swelling, one to two centimeters, left pectoral area, **no axillary nodes** noted.” (Simpson Dep. at 76:20-25.)

99. According to Simpson, this exam was “exactly the same” as his examination of the same left armpit lump in February. (Simpson Dep. at 77:1-8.)

100. Observing that there were **no involved axillary lymph nodes**, PA Simpson explained that “there tend[] to be areas where you will find nodes. And I didn’t find those in that area.” (Simpson Dep. at 78:17-24.).

101. On June 17, Eliza’s PCP spoke with the pulmonologist who reviewed the chest CT. The pulmonologist explained that the differential diagnosis **included cancer**. (SJHC 0236.)

102. On June 29, 2021, Eliza went to SJH for her ultrasound.

103. She reported that she had been coughing up blood (hemoptysis) for a week. (SJHC 0246.)

104. The ultrasound identified a “[s]olid shadowing spiculated parenchymal nodule” in the left axilla **“measuring approximately 1.8 cm in greatest dimension.”** This nodule “has appearance highly suggestive of breast malignancy.” The “remainder of the axilla demonstrates **no obvious lymphadenopathy.**” The Impression states:

Solid **spiculated fairly superficial nodule** present in the left axilla, concerning for malignancy. Interestingly, **breast malignancy can have very similar appearance. Potentially breast malignancy within the extra mammary breast tissue located in the left axilla would be in the differential diagnosis.** Further evaluation with ultrasound guided core biopsy of the lesion is warranted. Additionally, as no prior mammographic imaging was done in this patient, before biopsy, bilateral diagnostic mammogram should be obtained.

(SJHC 0264.)

July 2021: Cancer Finally Diagnosed

105. On July 1, Eliza called SJH to report that she was experiencing episodes of tachycardia (rapid heart rate) and hypoxemia (low oxygen saturation). (SJH 0269.)

106. On July 6, 2021, Eliza had a mammogram. The mammogram revealed a total of four nodules: 1 in the right breast, 2 in the left breast, and 1 in the left axilla. (SJHC 0283.)

107. On July 11, Eliza again went to the EMMC emergency department with worsening shortness of breath. They noted that she had been on antibiotics, steroids, and inhalers with no significant improvement. They also noted that she reported losing ten pounds in the last few months. They sent Eliza home with instructions to return for admission to the hospital. (EMMC 2757.)

108. On July 12, 2021, Eliza was admitted to Eastern Maine Medical Center with worsening shortness of breath. A chest CT showed Eliza's pulmonary disease was "markedly progressive" compared with the study performed a just month earlier, despite the fact that she was on antibiotics. (EMMC 2813.)

109. While admitted to EMMC, on July 14, they performed a bronchoscopy and ultrasound-guided biopsies of her breast and axillary masses. The biopsies confirmed that each of the masses identified on mammogram were malignant. The bronchoscopy demonstrated spread of her cancer to her mediastinal lymph node (station 7, subcarinal node).

110. The biopsy showed the following with respect to the four masses identified on the mammogram:

Left Breast Mass 1. Located 10 o'clock, 7 cm from the nipple. This mass measured 8 mm and was poorly differentiated ductal carcinoma. It was ER positive, PR positive and HER2 negative. Lymphovascular invasion was present with no in situ carcinoma identified.

Left Breast Mass 2. Located at 12:30, 3 cm from nipple. Measures 4mm. Poorly differentiated, ductal carcinoma. ER positive, PR positive, HER2 negative. located in situ with no lymphovascular invasion (in situ is a pre-invasive cancer because it is in the ducts and has not yet spread to surrounding tissue).

Right Breast. Located at 10 o'clock, 8cm from nipple. Measures 8mm. Ductal carcinoma, located in situ, intermediate nuclear grade, cribriform pattern, with no lymphovascular invasion present. ER positive, PR positive, HER2 negative.

Left Axillary Mass. Located in the left axilla. **Measures 1.8 cm.** ER positive, PR positive, HER2 negative. **"Soft tissue with invasive ductal carcinoma."**

(EMMC 2462.) **“The tumor is present in the fibroadipose tissue; no lymph node tissue identified.”** (EMMC 2467.)

111. On July 16, Eliza was seen in the hospital by Dr. Sigrid Berg, MD, a hematologist and oncologist. Dr. Berg noted that Eliza “had had a palpable left axillary mass since 2017, with associated pain.”

112. She documented that a bronchoscopy done July 14 showed metastatic breast cancer in mediastinal nodes. Each of the areas biopsied showed findings consistent with high grade breast cancer. Eliza was referred to Cancer Care of Maine. (EMMC 2223.)

Lymphangitic Spread to the Lungs

113. Eliza was re-hospitalized and discharged from EMMC on July 22. Upon discharge, the attending physician, Ayodeji Oduola, MD, observed that Eliza’s “dyspnea more likely secondary to progressive metastatic breast cancer.” (EMMC 2031.)

114. Likewise, her consulting oncologist, Shruti Bhandari, MD, explained that Eliza’s “dyspnea could be **related to lymphangitic spread of cancer.**” (EMMC 2043.)

115. On July 23, 2021, Eliza was seen by medical oncologist, Dr. Catherine Chodkiewicz, MD of Cancer Care of Maine. Dr. Chodkiewicz noted that Eliza had metastatic breast cancer with bilateral breast masses and lymphangitic spread to her lungs. In particular, she noted that “CTs done of 7/12/21 show **likely lymphangitic spread in the lower lungs** and patchy nodular disease in both lungs. I do not think this is infectious in nature the patient had several courses of antibiotics without improvement her CBC shows no WBC elevation.”

July 2021 – January 2023: Cancer Treatment

Taxol (Paclitaxel)

116. Eliza was started on the chemotherapy drug, Paclitaxel. However, as soon as it was infused, Eliza had a bad reaction, so it was stopped immediately.

117. Dr. Chodkiewicz noted that Eliza would be switched to Nab Paclitaxel to avoid infusion reaction. She discussed the goals of treatment with Eliza and Wade, clarifying that **“treatment is palliative in intent, meant to delay progression,”** but that treatment would not provide a cure; Eliza had an **“incurable disease.”** (CCME 1108.)

Abraxane (Nab Paclitaxel)

118. On July 26, Dr. Chodkiewicz started Eliza on Nab Paclitaxel. (CMMC 1107.)

119. In early August, Eliza again was admitted to EMMC. A chest CT showed a worsening of her lungs. (EMMC 1475.) On August 8, doctors raised a concern that the worsening pulmonary picture might be the result of “pneumonitis” from a side effect of the Nab Paclitaxel. Based upon this concern and because there were suitable alternative chemo drugs available, they made the decision to switch to a new chemotherapy agent, Xeloda.

Xeloda (Capecitabine)

120. Eliza was started on Xeloda in early August. By the end of August, Dr. Chodkiewicz was concerned that Eliza was not having a meaningful response to this drug.

121. A chest CT on August 28 described the mass in the left axillary region as measuring 3.6 cm, larger than what was measured on ultrasound in June.

122. The CT also showed bony metastases, particularly at T12, which had grown considerably as compared with the prior chest CT approximately three weeks earlier. (EMMC 892.)

123. Dr. Chodkiewicz ordered a bone scan.

124. A bone scan performed on September 7, 2021 described multiple areas of bone metastases, including the posterior thoracolumbar junction (T12/L1), ribs, iliac wing, mid-distal right femur and upper sternum. (EMMC 780.)

Ibrance (Palbociclib)

125. Toward the end of October 2021, Dr. Chodkiewicz switched Eliza's chemotherapy regime to Ibrance (along with hormone deprivation therapy).

126. The Ibrance did not have a positive impact, as she continued to have progression of her metastatic disease through March 2022.

Eribulin (Halaven)

127. On March 22, 2022, Dr. Chodkiewicz started Eliza on Eribulin.

128. Eliza completed 12 cycles of Eribulin therapy with the last one occurring on November 16, 2022.

129. Unlike the prior therapies, Eliza's cancer responded well to Eribulin.

130. By April 2022, doctors were noting that Eliza has demonstrated "**remarkable improvement** in her interstitial chest disease on this regimen." (CCME22 11.)

131. Lumbar and thoracic MRIs completed in August 2022 showed significant reduction in disease. (EMMC 3392, 3395.)

132. A chest CT performed on October 21, 2022 showed that compared with June 2022, pleural effusion and septal thickening had decreased. The radiologist noted that "[t]hese are not specific and may reflect residual changes of improving lymphangitic carcinomatosis." Additionally, other areas of subpleural airspace opacity were "**markedly improved or resolved.**" Many of the scattered areas of parenchymal nodular opacity seen on the prior study have "substantially decreased, **possibly secondary to treatment response** or decreasing coexisting pulmonary edema. **No definite new or significantly increasing pulmonary parenchymal nodules. Lymph nodes: No axillary, hilar, or mediastinal lymphadenopathy. No new or increasing bony mets.**" (EMMC 3387.)

133. Eliza's 11th cycle of Eribulin was completed on November 16. Her doctor authorized a break in the treatment through the holiday season.

December 2022 – Death on January 1, 2023

134. On December 6, 2022, Eliza went to the emergency department at EMMC with a fever and suspected pneumonia. (EMMC 3327.)

135. She was admitted to the hospital for several days. They performed a thoracentesis and removed 1.2 L of fluid from her chest and placed her on antibiotics.

136. She was discharged on December 10 with her breathing "almost back to baseline." (EMMC 3316.)

137. However, the following day she returned to EMMC having relapsed with a new fever and more fluid in her lungs. (EMMC 3195.)

138. She remained hospitalized for five days until December 16.

139. On December 30, Dr. Chodkiewicz had a long conversation with Eliza, explaining that her respiratory status was very tenuous and if she had to be placed on a ventilator there was a very low probability of recovery because they could not continue her cancer treatment on a ventilator.

140. On January 1, 2023, Eliza was pronounced dead.

141. The EMMC death summary states:

diffuse lymphangitic pulmonary disease spread with a great deal of obliteration of the right lung and nearly half of her hemithorax filled on that side as well as infiltration on the left; recurrent pleural effusions; no specific medical intervention could be done other than give supportive care; patient sustained cardiac arrest, comfort care, extubated, expired at 9:32 am." (EMMC 3164.)

COUNT I: Survival Claim for Pre-Death Damages

142. Plaintiff re-alleges the preceding allegations.

143. Defendants owed Eliza Butler a duty to practice safe and reasonable medicine within standards of acceptable medical care.

144. Defendants breached this duty by, among other things:

- a. failing to reasonably manage her medical care;
- b. failing to investigate the cord and lumps in the left axilla;
- c. failing to order and/or to follow up on the recommendation for breast ultrasound and mammogram;
- d. failing to make reasonable referrals for additional testing and treatment.
- e. failing to document the medical record accurately;
- f. failing to review pertinent medical history and information in medical chart;
- g. failing to share and communicate critical information between and among medical providers; and
- h. failing to have adequate policies, procedures, training, oversight and supervision to ensure that the standard of safe and reasonable medical care was met.

145. As a direct and proximate result of Defendant's negligence, Plaintiff suffered harm prior to her death.

146. Plaintiff, as Personal Representative of the Estate of Eliza Butler, seeks all categories of damages that would have been recoverable to Eliza Butler prior to the time of her death, and which survive her death by virtue of Maine's survival statute 18-C MRSA §3-817, including pecuniary injuries; medical expenses; loss of future wages and earning capacity; conscious pain and suffering; and emotional distress.

COUNT II: Wrongful Death

147. Plaintiff re-alleges the preceding allegations.

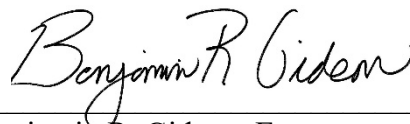
148. As a result of the negligence detailed above, Eliza Butler died of breast cancer at a date and time earlier than Plaintiff likely would have died from natural causes, or from breast cancer, had her cancer been diagnosed and treated within appropriate standards of care following a safe and reasonable approach to her medical care.

149. Plaintiff seeks the categories of damages recoverable pursuant to Maine's death act, 18-C MRSA Section 2-807, including pecuniary injuries; medical, surgical and hospital care and treatment; reasonable funeral expenses; loss of comfort, society and companionship of the deceased; and emotional distress.

Request for Judgment

WHEREFORE, Plaintiff requests judgment in his favor for damages, together with costs, interest, attorney fees, and such other and further relief as this Court finds just and appropriate.

Dated: December 8, 2023



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