IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

DIANE KERN, as next friend of SAMANTHA KERN,	)	
Plaintiff,	)	
v.	)	C.A. NO.: 02C-05-001-FSS
THE ALFRED I. DUPONT INSTITUTE OF THE NEMOURS FOUNDATION a/k/a A.I. DUPONT HOSPITAL,	)	
Defendant.	)	

Preliminary Ruling: February 26, 2004
Submitted: April 9, 2004
Decided: July 30, 2004

OPINION AND ORDER

Upon Defendant's Motion for Summary Judgment - - ***GRANTED***.

Kenneth M. Roseman, Esquire, Ciconte Roseman & Wasserman, 1300 King Street, P.O. Box 1126, Wilmington, Delaware, 19899. Attorney for Plaintiff.

Joseph S. Naylor, Esquire, Pepper Hamilton, LLP, 1313 Market Street, Suite 5100 P.O. Box 1709, Wilmington, Delaware, 19899. Attorney for Defendant.

SILVERMAN. J.

This medical negligence case involves a 2-month old child who underwent throat surgery to widen her trachea. Post-operative complications developed and the surgery failed. Plaintiff has sued the hospital, alleging that nurses negligently monitored an intravenous tube inserted in the child's head.

Plaintiff tacitly acknowledges that the surgery was dicey. Even so, Plaintiff contends that Defendant's post-operative negligence increased the risk that the throat surgery would fail. Furthermore, Plaintiff seeks to call the surgeon to testify not only about the surgery and other treatment she rendered, but also to serve as Plaintiff's medical expert on the standard of post-operative care and causation. Plaintiff, however, has not retained the treating physician, the surgeon, as an expert. If called, the treating physician would testify as a fact witness about the care she rendered, but she does not agree to offer expert opinions about the hospital's treatment. Moreover, if forced to testify as an expert, the treating physician would not opine that negligence by Defendant proximately caused injury to Plaintiff.

The court, therefore, must decide two questions: First, will the "increased risk doctrine" be expanded to cover Plaintiff's claim? Second, can the Plaintiff force the child's treating physician to testify as an expert on the hospital's standard of care and causation? The court also will address whether the treating physician's opinions adequately support Plaintiff's cause of action.

I.

The parties submitted a pre-trial stipulation including the facts below. On September 8, 2000, Samantha Kern was born at Christiana Hospital in Newark, Delaware. She was eleven weeks premature, weighing only two pounds, eight ounces. Samantha was unable to breathe on her own, and an endotracheal tube was inserted into her throat to improve airflow to her lungs.

On November 1, 2000, Samantha transferred from Christiana Hospital to the Alfred I. duPont Hospital for Children in Wilmington. At the duPont Hospital, Ellen Deutsch, M.D., evaluated Samantha's airway and diagnosed her with subglottic stenosis, or a narrowing of the airway above the vocal cords. Dr. Deutsch works for the hospital as a pediatric otolaryngologist.

Dr. Deutsch performed a cricoid split on Samantha on November 2, 2000. This involved splitting the main cartilage in Samantha's trachea and inserting a graft from her hyoid bone in the incision. The procedure was meant to widen Samantha's airway to allow unassisted breathing. Following the cricoid split, Samantha was sedated and paralyzed per Dr. Deutsch's post-operative instructions.

While Samantha was still sedated and paralyzed on November 8, 2000, a nurse discovered that an intravenous line in Samantha's scalp had leaked into the tissue surrounding the vein in which it was inserted. Instead of going into the vein,

I.V. fluid was collecting under the skin near the child's head and neck, causing swelling. The I.V. was removed, and Dr. Deutsch placed a drain in an incision she made in Samantha's neck during the cricoid split. Over the next 24 hours, the I.V. fluid drained and the swelling subsided.

On November 9, 10 and 13, 2000, Samantha's endotracheal tube was removed to determine whether she could breathe autonomously. Each time, she experienced difficulty breathing and the endotracheal tube was replaced. On November 13, Dr. Deutsch performed a tracheotomy on Samantha, a procedure where the trachea is cut and a tube is inserted into the trachea so that the patient breathes directly through the tube. Samantha will need the help of a tracheotomy tube to breathe for years into the future, at the least, and possibly for the rest of her life.

Plaintiff argues that Samantha suffered two distinct injuries from the I.V. leak: the resulting swelling and draining procedure were painful, and the leak caused spontaneous movement of Samantha's neck. The swelling and movement increased the risk, to an unknown extent, that the cricoid split would fail. Although Plaintiff has not hired her as an expert, Plaintiff contends that Dr. Deutsch, as treating physician, is available and the perfect witness to opine about Defendant's alleged negligence.

Defendant counters that Plaintiff's proof fails in several ways. Dr.

Deutsch, who is employed by Defendant, cannot be compelled to offer opinions against her will. Therefore, Plaintiff has failed to identify an expert to establish Defendant's negligence. Delaware's medical negligence statute, as presented below, requires medical expert testimony on standard of care and causation. In addition, were she to testify, Dr. Deutsch would not adequately support Plaintiff's "increased risk" claim. While she would allow that any negligence by Defendant *could* have increased the risk that the surgery would fail, Dr. Deutsch would not hazard a guess as to the specific percent by which the risk of failure was increased, much less that any negligence probably caused the failure.

II.

Procedurally, on May 1, 2002, Plaintiff filed a complaint for alleged injuries to her daughter. Defendant answered on June 3, 2002. Defendant moved for summary judgment on November 26, 2003, and oral argument was held on February 5, 2004. The court announced this decision, without elaboration, at the pre-trial conference on February 26, 2004. Plaintiff conceded that in light of the court's decision, Plaintiff had no medical expert. Furthermore, she declined to attempt to find one. Accordingly, it is undisputed that the court's and Plaintiff's decisions mean that this case is over. This opinion explains and finalizes the court's informal, February 26, 2004 ruling.

III.

Summary judgment is proper where there are no genuine issues of material fact, thus entitling the moving party to judgment as a matter of law.[1] A court deciding a summary judgment motion must identify disputed factual issues whose resolution is necessary to decide the case, but not to decide the issues.[2] As mentioned, for present purposes the facts are not in dispute. The court, therefore, must apply the undisputed facts to the law, as the court finds the law to be, and in that way decide the motion.

IV.

A. Increased Risk Doctrine

As mentioned, there are two issues here. First, Plaintiff argues the "increased risk doctrine." Essentially, Plaintiff's stance is:

> The I.V. infiltrate caused swelling and spontaneous movement of Samantha's neck. The swelling and spontaneous movement caused an increased risk that the cricoid split [would] fail and that Samantha was at an increased risk of further injury and damages.[3]

Plaintiff further says:

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[1] *Johnson v. Bowman*, 1997 WL 719354, at *1 (Del. Super. Ct.)(citing *Merrill v. Crothall-American, Inc.*, 606 A.2d 96, 99-100 (Del. 1992)).

[2] *Merrill*, 606 A.2d at 99.

[3] Plaintiff's Answering Brief, at 4.

> [T]he sworn testimony and the statement of Dr. Deutsch could lead to a conclusion that the swelling and neck movement caused by the I.V. infiltrate increased the risk that the cricoid split performed on Samantha would fail.[4]

Ten years ago, while answering certified questions in *United States v. Cumberbatch*,[5] the Supreme Court of Delaware introduced the "increased risk doctrine" to Delaware, in a footnote. *Cumberbatch* explains that "[t]he increased risk doctrine provides that a person may recover damages if the person's risk of suffering a negative medical condition is increased because of medical malpractice."[6] In *Cumberbatch*, actually a "lost chance" case, it was given that absent defendant's malpractice, the patient had a forty-five percent chance of surviving. But the malpractice had reduced the patient's chances to twenty-five percent. *Cumberbatch* rejected the "lost chance" claim, but only because the claim in *Cumberbatch* was for wrongful death. In dicta, *Cumberbatch* suggested that Delaware would adopt the then-emerging, "proportional approach" to compensation for loss of chance.

A year after *Cumberbatch*, the other shoe fell. In another case presenting

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[4] Id., at 5.

[5] 647 A.2d 1098 (Del. 1994).

[6] *Id.* at 1100 n.3.

certified questions, *United States v. Anderson*,[7] Delaware's Supreme Court formally adopted the "increased risk of future harm" doctrine. *Anderson* involved a late diagnosed cancer. There, the patient's chance of avoiding recurrence of cancer dropped from 100 percent to 85 percent, due to the negligence. *Anderson* holds that the increased risk doctrine is recognized in Delaware, mentioning that "[t]he increased risk doctrine has been employed in cases involving late diagnoses which allowed cancer to spread. . .[t]he doctrine has also been employed in cases involving skull fractures and resulting future susceptibility to meningitis."[8] Plaintiff relies entirely on *Anderson.*

Cumberbatch and *Anderson* cite with approval the federal District Court for Delaware's *Cudone v. Gehret*,[9] which also involved a late diagnosed cancer. There, the medical negligence caused the plaintiff-patient's chance of recurrence to increase from 25-30% to 50-60%. *Cudone* held the increased risk doctrine applied. *Cudone,* however, also referred to dicta in *Shively v. Klein,*[10] which involved a loss of chance. *Shively* warned against using the loss of chance doctrine for other than

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[7] 669 A.2d 73 (Del. 1995).

[8] *Id.* at 76 (citations omitted).

[9] 821 F.Supp. 266 (D. Del. 1993).

[10] 551 A.2d 41 (Del. 1988).

its intended purpose. *Cudone,* referring to *Shively*, explained:

> [T]he Court determined that the application of the concept sought by plaintiffs, i.e., one which relaxed the standard of causation, "would have been a drastic departure from the causation standards consistently applied in Delaware."[11]

Other authorities also apply the increased risk doctrine.[12] One example is *Petriello v. Kalman*,[13] a Connecticut case cited with approval in *Anderson.* The patient, Ann Petriello, experienced a difficult pregnancy. A doctor, Roy E. Kalman, negligently perforated Petriello's uterus while performing a dilatation and curettage on her. A different doctor then had to resect Petriello's bowel in order to repair the damage. But because of resulting adhesions "there was between an 8 and 16 percent chance that [Petriello] would suffer a future bowel obstruction as a result of the bowel resection necessitated by [Dr. Kalman's] actions."[14] The increased risk doctrine led to a damages award that was sustained on appeal.

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[11] 821 F.Supp. at 269 (quoting *Shively*, 551 A.2d at 44).

[12] See generally *Edwards v. Family Practice Associates, Incorporated*, 798 A.2d 1059 (Del. Super. Ct. 2002) (although called "loss of chance," increased risk doctrine applied where failure to diagnose stomach cancer hastened plaintiff's death); Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981).

[13] 576 A.2d 474 (Conn. 1990).

[14] *Id.* At 481.

Regardless of whether the increased risk or lost chance doctrines were applied or not, a common element of the cases presented above is that every plaintiff proffered expert opinion specifically quantifying the increased risk or loss of chance caused by the medical negligence. Here, no expert will state with reasonable probability and precision what the chances were that the surgery would have worked, much less offer any opinion as to the percentage by which Defendant's alleged negligence reduced the chance of success. The percentages are vital because they form the basis for any damages calculation by the jury. Without them, the jury would be left to speculation. Furthermore, it is unclear whether Plaintiff's current condition, using a tracheotomy tube, is permanent. Thus, regardless of the court's willingness to apply the increased risk doctrine and force the treating physician to testify, Plaintiff's proof falls short.

In passing, the court reiterates the concern in *Shively* about the relaxed, proportional causation standard's impact on Delaware's entrenched approach to proximate cause. Unlike Connecticut, Delaware is a so-called "but for" jurisdiction. Typically, if a defendant's negligence merely is a substantial factor in causing injury, a plaintiff cannot recover in Delaware. The increased risk doctrine seems to compromise that standard where a treatment's chance of success was less than fifty percent at the outset. In such a situation, can it be said that any negligence which

further reduced plaintiff's chances was more than a substantial factor in causing injury? In other words, if a defendant's negligence indisputably increased the likelihood of failure, but the surgery probably was doomed anyway, can it be said that but for the negligence the surgery probably would have succeeded? Those are questions for another case because, as presented above, no one can quantify the harm, if any, caused by Defendant's alleged negligence here.

B. Expert Witness

Delaware law requires expert medical testimony in medical negligence cases such as this one.[15] Instead of retaining an expert, Plaintiff merely would call Samantha's surgeon as her expert on the hospital's standard of care and causation. Plaintiff would question the treating physician about the throat surgery she performed and try to elicit the opinion that the I.V.'s placement violated the standard of care and caused the surgery to fail, which made the tracheotomy necessary.

The first problem is that the treating physician has little or no factual knowledge about Samantha's post-operative care. More importantly, the treating physician is employed by Defendant. She has not been offered as an expert for

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[15] DEL. CODE ANN. tit. 18, § 6853 (1999)("No liability shall be based upon asserted negligence unless expert medical testimony is presented as to 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 or death. . .").

Defendant. Nor has she performed an "independent medical examination" at either party's request.[16]

In Delaware, a witness generally cannot be forced to offer expert opinions. Nor can defendant's employee be compelled to testify as plaintiff's expert witness.[17] This prevents a form of involuntary servitude,[18] with employees and experts being made to "serve without remuneration and without [their] consent."[19] It is no answer here, as Plaintiff argues, that the treating physician gave a deposition on which Plaintiff is willing to rely. The physician appeared as a fact witness. When Plaintiff asked the physician for her expert opinion, that drew an objection and the answer was given over the objection.

Moreover, as mentioned, when the physician offered an opinion about standard of care, it was not helpful to Plaintiff. Most significantly, the physician

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[16] Cf. *Pinkett v. Brittingham*, 567 A.2d 858 (Del. 1989) (rule preventing one party from compelling opposing party's employee from testifying inapplicable to doctor who performs independent medical examination and testifies strictly from own report).

[17] *Montecinos v. Dickinson Medical Group, P.A.*, Del. Super., C.A. No. 94C-07-027, Ridgely, J. (Aug. 21, 1996)(ORDER); *Horne v. Kent General Hospital, Incorporated*, Del. Super., C.A. No. 85C-AP-29, Bifferato, J. (Aug. 28, 1990).

[18] See *State v. McLaughlin*, 514 A.2d 1139, 1142 (Del. Super. Ct. 1986)(citations omitted).

[19] *Montecinos* at *1.

attributed the surgery's failure to the extensiveness of Plaintiff's congenital problem. And the physician did not see the swelling or Plaintiff's movement, whether caused by negligence or not, as even a significant factor in the surgery's outcome.

At most, the treating physician testified in deposition that along with several other possibilities, "motion of the neck . . . can detract from the success of the surgery." As to the possibility of excessive motion and its effect on the surgery in this case, the physician testified:

> Q: Is there any physical finding that you can rely upon to support a conclusion that excessive motion did not cause the failure of the surgery?
> A: No.
> Q: If you assume that subsequent to the massive edema there was motion, could that motion have affected the success of the surgery? And if not, why not?
> A: It depends on how much motion. And I cannot say that didn't have an effect.

Referring to this case's facts rather than theoretical possibilities, however, the treating physician further testified, "There's nothing in the notes about excessive motion, and I don't recall whether there was excessive motion." And, as mentioned above, the treating physician attributed the surgery's failure to Plaintiff's congenital condition, not Defendant's treatment.

As to the swelling caused by the I.V. infiltrate, the physician allowed that "if [Plaintiff] had significant swelling, that could cause airway obstruction with

failure of the cricoid split and an inability to breathe adequately and comfortably after extubation." Along the same line, giving Plaintiff the benefit of several inferences, the treating physician testified the swelling had an impact on the timing of Plaintiff's extubation. And the physician further testified that following the physician's schedule for extubation "decreases the complications, which are often pulmonary, and increases the chance of success."

Plaintiff's complications, of course, were not pulmonary. Moreover, the physician did not opine that any change in the extubation schedule had a bearing on the surgery in this case, much less that it increased the risk of failure here. She also testified, "I don't think anybody knows the precise duration of intubation that's optimal . . . There are sometimes circumstances about an individual patient that would encourage delay of the extubation." Again, the physician made no effort to tie the theory to this case's facts. The only reasonable way to read the treating physician's explanation for what happened in this case is that the surgery failed because it failed.

Finally, as to the expert testimony issue, the court appreciates that there is a scintilla of evidence that the child experienced pain due to the swelling and the minor surgery she underwent to correct it. Nevertheless, Plaintiff's proof establishes neither liability nor causation. All of the above assumes that the physician can be

forced to testify in the first place, which the court cannot do. As it stands, Plaintiff has no medical expert witness and, as mentioned, she declines to find one.

V.

For the foregoing reasons, it appears that Plaintiff can present no medical expert testimony as to the deviation from the applicable standard of care by Defendant and as to causation of any injury to Plaintiff. Thus, Defendant's motion for summary judgment is ***GRANTED***.

IT IS SO ORDERED.

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Judge

oc: Prothonotary (Civil Division)