

[J-8-2026]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

TODD, C.J., DONOHUE, DOUGHERTY, WECHT, MUNDY, BROBSON, McCAFFERY, JJ.

MARVIN SMITH (DECEASED),
INDIVIDUALLY AND AS ADMINISTRATOR
OF THE ESTATE OF TANYA SMITH,
DECEASED,

Appellee

v.

ANNIE KANNARKATT, M.D., AND CANCER
CARE ASSOCIATES OF YORK, INC.,

Appellants

: No. 17 MAP 2025
:
: Appeal from the Order of the
: Superior Court at No. 1084 MDA
: 2022 dated March 11, 2024
: vacating and remanding the Order
: of the York County Court of
: Common Pleas, Criminal Division,
: at No. 2018-SU-002317 dated
: July 6, 2022.
:
: ARGUED: March 11, 2026
:
:
:

OPINION

JUSTICE BROBSON

DECIDED: October 29, 2026

Oftentimes, as a part of establishing liability in a medical malpractice action, a plaintiff must present expert medical testimony that a defendant's conduct fell below acceptable medical standards and that the conduct was the proximate cause of the plaintiff's harm. There are instances, however, when a plaintiff cannot meet this standard because there exists a possibility that the plaintiff's harm would have resulted irrespective of the quality of the medical treatment provided. Concluding that a defendant cannot escape liability simply based upon that statistical possibility, this Court, in *Hamil v. Bashline*, 392 A.2d 1280 (Pa. 1978), adopted a standard that relaxed a plaintiff's burden of proving causation in those circumstances.

Specifically, the *Hamil* Court held that “causation may be founded upon expert opinion testimony to the effect that [the] defendant failed to exercise reasonable care in performing an undertaking to render services to a patient which the defendant should recognize as necessary for the other’s protection, that this failure increased the risk of physical harm to the patient, and that such harm did in fact result.” *Hamil*, 392 A.2d at 1283. In this discretionary appeal, we must determine whether the Superior Court correctly applied this so-called “increased risk of harm” standard of causation in this case. For the reasons that follow, we hold that the Superior Court applied the standard correctly. Accordingly, we affirm.

I. BACKGROUND

On March 8, 2017, Tanya Smith (Decedent) presented to an oncological surgeon at WellSpan York Hospital (WellSpan) with an enlarged lymph node that was in her armpit and had been discovered during her treatment for shoulder pain. The oncological surgeon biopsied the lymph node. John Wright, M.D. (Dr. Wright), a WellSpan pathologist, reviewed the biopsy and indicated a pathological diagnosis of metastatic breast cancer.¹

In the week following Dr. Wright’s issuance of the pathology report, Decedent underwent additional testing in the form of a CT scan, PET scan, mammogram, and ultrasound. This testing did not reveal evidence of a primary tumor site or suggest that Decedent’s cancer originated in the breast. Moreover, the results of the CT and PET scans included lymphoma as a differential diagnosis.

On March 21, 2017, Decedent began treating with Annie Kannarkatt, M.D. (Dr. Kannarkatt), an oncologist at Cancer Care Associates of York, Inc. (Cancer Care

¹ More specifically, Dr. Wright provided a pathological diagnosis of “metastatic adenocarcinoma compatible with breast origin involving lymph node.” (N.T., Trial, 4/26/2022, at 234.)

Associates). Dr. Kannarkatt had access to Decedent's medical records and the competing impressions contained therein. Nonetheless, without further investigation, Dr. Kannarkatt proceeded to treat Decedent for breast cancer, which treatment included chemotherapy and radiation therapy. While the areas exposed to radiation therapy saw improvement, the chemotherapy produced little to no improvement in Decedent's condition.

On November 30, 2017, Decedent underwent another PET scan, which revealed that her cancer had spread significantly. The spread of the disease into Decedent's abdomen resulted in the removal of her gallbladder in March 2018. A biopsy of the cancerous tissue from Decedent's gallbladder led to a revised diagnosis of ALK positive large B-cell lymphoma, an incredibly rare and aggressive form of cancer. Of note, a reexamination of the tissue samples taken in March 2017 revealed that those samples were identical to the March 2018 tissue samples, indicating that Decedent was suffering from ALK positive large B-cell lymphoma—and not metastatic breast cancer—all along.

Upon receiving the revised diagnosis, Decedent transferred her care to the Milton S. Hershey Medical Center (Hershey Medical) and began treating with oncologist Seema Naik, M.D. (Dr. Naik). Decedent underwent chemotherapy directed to lymphoma-type cancers, which produced little to no response. Decedent then underwent treatment known as "salvage" chemotherapy, which reduced her cancer load to the point of enabling her to undergo a stem cell transplant. Decedent did not respond positively to the stem cell transplant, and she died on January 6, 2019.

Prior to her death, Decedent and her husband, Marvin Smith (Mr. Smith), also now deceased (collectively, the Smiths), filed suit against Dr. Kannarkatt and Cancer Care Associates (collectively, Appellants) in the Court of Common Pleas of York County (trial

court).² In the operative complaint, the Smiths asserted that Dr. Kannarkatt owed a duty of care to Decedent and that Dr. Kannarkatt acted negligently by, *inter alia*: (1) failing to properly diagnose Decedent's cancer; (2) failing to confirm that Decedent had breast cancer; (3) failing to consult with pathology for purposes of ruling out other cancers; and (4) prescribing and treating Decedent with incorrect and ineffective chemotherapy. The Smiths asserted that Dr. Kannarkatt's negligence increased the risk of harm to Decedent, was a direct and proximate cause of her injuries and death, and deprived her of the ability to survive past January 6, 2019. The Smiths claimed damages for the medical expenses that Decedent incurred and the pain and suffering that she endured as a result of Dr. Kannarkatt's negligence. The Smiths also asserted a claim of vicarious liability against Cancer Care Associates.

The matter was first tried before a jury in October 2021, but that trial ended in a mistrial caused by a hung jury. A second jury trial commenced on April 25, 2022. The Smiths presented several witnesses in support of their case-in-chief, including: (1) causation expert Robert Soiffer, M.D. (Dr. Soiffer); (2) Dr. Kannarkatt; (3) Dr. Naik; (4) Dr. Wright; (5) Mr. Smith; and (6) standard-of-care expert Gerald Goldklang, M.D. (Dr. Goldklang). Appellants also presented the expert testimony of Richard Ambinder, M.D., out of turn—*i.e.*, before the Smiths rested their case.

After the Smiths rested, Appellants moved for compulsory nonsuit. Following argument, the trial court granted Appellants' motion, concluding that the Smiths failed to present sufficient evidence to prove causation. The Smiths then sought post-trial relief, which the trial court denied. The trial court entered judgment in favor of Appellants, and

² As the caption indicates, the named plaintiff-appellee is now "Marvin Smith (Deceased), Individually and as Administrator of the Estate of Tanya Smith, Deceased." We, nonetheless, refer to plaintiff-appellee as "the Smiths" for ease of reference. Moreover, the Smiths named additional defendants in their suit, but those defendants are no longer involved in this matter as a result of proceedings not relevant to this appeal.

the Smiths appealed to the Superior Court. Relevant here, the Smiths contended that the trial court erred by granting a compulsory nonsuit, and by refusing to remove the nonsuit and award a new trial, because the Smiths presented sufficient evidence of causation under the “increased risk of harm” standard described in *Hamil* such that the case should have been submitted to the jury.

The Superior Court agreed. By the Superior Court’s account, the record evidence demonstrated that the clinical and radiological findings in Decedent’s case were inconsistent with Dr. Wright’s preexisting pathological diagnosis of metastatic breast cancer. The Superior Court added that Dr. Goldklang testified that Dr. Kannarkatt, as the medical oncologist who is “a very integral part of the process” and “who is going to be treating the patient with significant chemicals,” had an obligation to speak directly to the pathology group for purposes of questioning the diagnosis in light of the conflicting findings before her. *Smith v. Kannarkatt* (Pa. Super., No. 1084 MDA 2022, filed March 11, 2024), slip op. at 16 (quoting N.T., Trial, 4/27/2022, at 343, 347, 392). The Superior Court additionally observed that, per Dr. Goldklang, Dr. Kannarkatt’s failure to do so fell below the standard of care in the evaluation and treatment of Decedent.

The Superior Court continued by observing that “the evidence also demonstrated that the incorrect diagnosis that went unchallenged by Dr. Kannarkatt resulted in Decedent undergoing approximately one year of debilitating chemotherapy with drugs that were inappropriate to her cancer.” *Id.* (relying upon Mr. Smith’s testimony that, between March 2017 and March 2018, Decedent was always going through chemotherapy treatments, which “resulted in her not being able to do ‘hardly . . . anything’ anymore” (alteration in original) (quoting N.T., Trial, 4/27/2022, at 417)). The Superior Court additionally relied upon testimony from Dr. Soiffer that Decedent’s cancer “spread considerably” during that time and that, as a result of receiving the incorrect treatment,

“Decedent was ‘deprive[d] . . . of a substantially better opportunity for a longer life.’” *Id.*, slip op. at 17 (alterations in original) (quoting N.T., Trial, 4/26/2022, at 183, 189-90). The Superior Court also reasoned that, while Dr. Soiffer could not opine with certainty as to what Decedent’s likelihood of survival would have been, he was not required to offer such testimony under *Hamil*.

The Superior Court next distinguished *Montgomery v. South Philadelphia Medical Group, Inc.*, 656 A.2d 1385 (Pa. Super. 1995), which Appellants relied upon in support of their contrary position that the Smiths presented insufficient evidence of causation to allow the jury to decide the case. As described in more detail below, *Montgomery* involved a plaintiff’s claim that a physician’s assistant negligently failed to refer the plaintiff to a physician for pain in her breast that was ultimately diagnosed as breast cancer. The Superior Court observed, here, that the plaintiff’s expert in *Montgomery* was unwilling or unable “to state whether the plaintiff’s risk of harm was increased where ‘there was no evidence that an examination by a physician would have disclosed anything more than was discovered by the . . . physician’s assistant.’” *Smith*, slip op. at 17-18 (quoting *Montgomery*, 656 A.2d at 1393). The Superior Court reasoned that, in contrast, Dr. Soiffer’s testimony provided a basis for the jury to find that Dr. Kannarkatt’s failure to question the pathologist’s diagnosis “resulted in a significant delay in proper treatment[,] which substantially reduced Decedent’s chance for a better outcome—an outcome that could have included complete remission after proper chemotherapy modalities and, thereafter, a total cure through a subsequent bone marrow transplant.” *Id.*, slip op. at 18 (citing N.T., Trial, 4/26/2022, at 180-81 (explaining that bone marrow transplants can cure patients with Decedent’s diagnosis and that transplant outcome declines with increase in disease or when patients are “later in their course”)).

In sum, the Superior Court explained that, pursuant to *Hamil*, “medical opinion need only demonstrate, with a reasonable degree of medical certainty, that a defendant’s conduct increased the risk of the harm actually sustained, and the jury then must decide whether that conduct was a substantial factor in bringing about the harm.” *Id.* (emphasis omitted) (quoting *Jones v. Montefiore Hosp.*, 431 A.2d 920, 924 (Pa. 1981)). The Superior Court observed that the record evidence “supports a finding that Dr. Kannarkatt breached her duty of care by failing to question Dr. Wright’s pathological diagnosis in light of the incompatible clinical and radiological findings and, in doing so, increased Decedent’s risk of harm by substantially delaying her ability to receive proper treatment, while simultaneously allowing the disease time to mutate and spread further throughout her body, which was, in turn, weakened by a year’s worth of inappropriate breast cancer chemotherapy.” *Id.*, slip op. at 18-19. Concluding that the trial court, thus, erred in refusing to permit the jury to determine whether Dr. Kannarkatt’s conduct was a substantial factor in bringing about Decedent’s harm, the Superior Court vacated the trial court’s judgment and remanded the matter for a new trial.

II. ANALYSIS

At Appellants’ request, we granted allowance of appeal to consider “[w]hether the Superior Court properly applied the increased risk of harm standard established by *Hamil* . . . and its progeny as it relates to expert testimony regarding the risk and resultant harm.” *Smith v. Kannarkatt*, 333 A.3d 1263 (Pa. 2025) (per curiam). This issue presents a question of law, for which our standard of review is de novo and our scope of review is plenary. *In re Vencil*, 152 A.3d 235, 241 (Pa. 2017). Moreover, given that this case concerns the propriety of the trial court’s award of a compulsory nonsuit in Appellants’ favor and its subsequent refusal to remove that nonsuit, we note that

[t]he rules regarding a compulsory nonsuit are well established. A judgment of nonsuit can be entered only in clear cases, and a plaintiff must be given

the benefit of all evidence favorable to him, together wi[th] all reasonable inferences of fact arising therefrom, and any conflict in the evidence must be resolved in his favor. Thus[,] an order granting a nonsuit is proper only if the jury, viewing the evidence and all reasonable inferences arising from it, in the light most favorable to the plaintiff, could not reasonably conclude that the elements of the cause of action have been established.

However, it is also well settled that a jury can not be permitted to reach its verdict on the basis of speculation or conjecture, and that a judgment of nonsuit is properly entered if a plaintiff has not introduced sufficient evidence to establish the elements necessary to maintain an action. In addition, it is the duty of the trial judge to determine, prior to sending the case to the jury, whether . . . the plaintiff has met this burden.

Morena v. S. Hills Health Sys., 462 A.2d 680, 682-83 (Pa. 1983) (citations omitted).

Ordinarily, to make out a prima facie case of medical malpractice, a plaintiff must establish that: (1) the physician owed a duty to the patient; (2) the physician breached that duty; (3) the breach of duty was the proximate cause of, or a substantial factor in, bringing about the patient's harm; and (4) the patient suffered damages that were a direct result of the harm. *Mitzelfelt v. Kamrin*, 584 A.2d 888, 891 (Pa. 1990). Generally speaking, "[a] plaintiff is also required to present an expert witness who will testify, to a reasonable degree of medical certainty, that the acts of the physician deviated from good and acceptable medical standards, and that such deviation was the proximate cause of the harm suffered." *Id.* at 892. As noted, however, there are some cases in which meeting this standard would be "impossible" because the circumstances are such that a percentage of patients would suffer harm regardless of the quality of the medical treatment rendered. *Id.*

Lest a defendant be rendered immune from liability "because of uncertainties as to the consequences of his negligent conduct," this Court in *Hamil* adopted Section 323(a) of the Restatement (Second) of Torts (1965) (Restatement) to address such situations. *Hamil*, 392 A.2d at 1286-88. Section 323(a) of the Restatement provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the

other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if

(a) his failure to exercise such care increases the risk of such harm

Restatement § 323(a). In contrast to the typical case in which a plaintiff alleges that a defendant's conduct "set in motion a force which resulted in harm," Section 323(a) applies in cases where a defendant's conduct "failed in a duty to protect against harm from another source." *Hamil*, 392 A.2d at 1286. Again, this standard "relaxes the degree of certainty ordinarily required of a plaintiff's evidence to provide a basis upon which the jury may find causation." *Gradel v. Inouye*, 421 A.2d 674, 678 (Pa. 1980); *see also Hamil*, 392 A.2d at 1287-88 (explaining that Section 323(a) "permits the issue [of causation] to go to the jury upon a less than normal threshold of proof"). It requires a fact-finder to weigh probabilities and "consider not only what [d]id occur, but also what [m]ight have occurred, [i.e.], whether the harm would have resulted from the independent source even if [the] defendant had performed his service in a non-negligent manner." *Hamil*, 392 A.2d at 1287.

Thus, pursuant to *Hamil*, in medical malpractice cases falling under Section 323(a) of the Restatement, "causation may be founded upon expert opinion testimony to the effect that [the] defendant failed to exercise reasonable care in performing an undertaking to render services to a patient which the defendant should recognize as necessary for the other's protection, that this failure increased the risk of physical harm to the patient, and that such harm did in fact result." *Hamil*, 392 A.2d at 1283. As the *Hamil* Court further explained,

[o]nce a plaintiff has demonstrated that [the] defendant's acts or omissions, in a situation to which Section 323(a) applies, have increased the risk of harm to another, such evidence furnishes a basis for the fact-finder to go further and find that such increased risk was in turn a substantial factor in bringing about the resultant harm; the necessary proximate cause will have been made out if the jury sees fit to find cause in fact.

Id. at 1288 (footnote omitted).

Notably, the *Hamil* Court explained that it did “not intend to undermine the well-established standard of ‘reasonable degree of medical certainty’ as the accepted norm for medical opinions on causation.” *Id.*; *see also Gradel*, 421 A.2d at 679 (explaining that Pennsylvania law ordinarily requires expert medical opinion on causation to be stated to reasonable degree of medical certainty and “need not be unqualified and absolute”). Observing the difficulty associated with requiring a medical expert to state “what [m]ight have happened” to a reasonable degree of medical certainty, the Court explained that, “[w]here there is at issue the adequacy of medical services rendered in a fact situation to which Section 323(a) [of the Restatement] applies, . . . a [p]rima facie case of liability is established where expert medical testimony is presented to the effect that [the] defendant’s conduct did, with a reasonable degree of medical certainty, increase the risk that the harm sustained by [the] plaintiff would occur.” *Hamil*, 392 A.2d at 1288-89.

Moreover, in providing such testimony, an expert need not use the phrase “increased the risk of harm” when rendering an opinion. *Mitzelfelt*, 584 A.2d at 894. Rather, courts are to consider the substance of the testimony as a whole to determine whether a plaintiff met the relaxed standard under Section 323(a) of the Restatement. *Id.* Once the expert renders testimony consistent with these principles, “[t]he jury, not the medical expert, then has the duty to balance probabilities and decide whether [the] defendant’s negligence was a substantial factor in bringing about the harm.” *Gradel*, 421 A.2d at 679; *see also Mitzelfelt*, 584 A.2d at 894 (expressing analysis in terms of two-part test, requiring initial determination of “whether the expert witness for the [plaintiff] could testify to a reasonable degree of medical certainty that the acts or omissions complained of could cause the type of harm that the [plaintiff] suffered” and then

determination of “whether the acts complained of caused the actual harm suffered by the [plaintiff],” which is where relaxed standard applies).

To the above, we add that a plaintiff has the burden to prove causation by a preponderance of the evidence. *Hamil*, 392 A.2d at 1284. That said, a plaintiff need not exclude every possible explanation in establishing a prima facie case. *Id.* at 1285. Rather, “it is enough that reasonable minds are able to conclude that the preponderance of the evidence shows [the] defendant’s conduct to have been a substantial cause of the harm to [the] plaintiff.” *Id.*; see also *Gradel*, 421 A.2d at 678 (“Pennsylvania law has long recognized that causation may be established by evidence that [the] defendant’s negligence was a substantial factor in bringing about the harm even though it was not the only factor.”). Once a plaintiff establishes a prima facie case of causation against the defendant, “the fact that some other cause concurs with the negligence of the defendant in producing an injury does not relieve the defendant from liability unless he can show that such other cause would have produced the injury independently of his negligence.” *Gradel*, 421 A.2d at 678 (quoting *Hamil*, 392 A.2d at 1285).

Turning to the testimony proffered in the instant matter, we begin with Dr. Goldklang, a medical oncologist and Plaintiffs’ standard-of-care expert. Dr. Goldklang initially confirmed that all of his answers would be given to a reasonable degree of medical certainty. (N.T., Trial, 4/27/2022, at 341.) Dr. Goldklang agreed with the use of a three-legged stool as an analogy to describe how an overall diagnosis of a patient is made, where pathology information is viewed in conjunction with clinical and radiological information. (*Id.* at 349.) Dr. Goldklang explained that a pathologist makes the “tissue diagnosis” of cancer patients. (*Id.* at 342-43.) Dr. Goldklang also explained that oncologists rely on pathologists prior to treatment and described pathology as the “gold

standard” upon which he relies to help him diagnose and direct the appropriate therapy. (*Id.* at 357-58, 360-61, 366.)

Dr. Goldklang added, however, that pathologists “are not infallible” or “always correct” and that medical oncologists “are a very integral part” of the diagnostic process. (*Id.* at 343, 350, 386-87.) Dr. Goldklang explained that oncologists need to ensure that they are “as close to 100 percent certain as to what the diagnosis is” and are treating the correct malignancy with the correct combination of drugs because chemotherapy consists of “very toxic, strong chemicals with many side effects[a]nd there are different combinations of drugs for different cancers.” (*Id.* at 347-48.) Dr. Goldklang testified that, as such, if the clinical picture or other information does not seem to fit a patient’s presentation or pathological diagnosis, a reasonable oncologist should contact the pathologist and request a “deeper dive.” (*Id.* at 343, 346-347, 351.) Dr. Goldklang reported that it was “very important” to ask for pathology’s reexamination in those circumstances and that “both parties learn more by doing so.” (*Id.* at 347.) When asked if, in his experience and knowledge, it is an accepted practice for a medical oncologist to contact pathology to get additional help in the diagnosis of a patient, Dr. Goldklang responded, “[i]n many cases.” (*Id.* at 388.)

With respect to this case, Dr. Goldklang indicated that, if Dr. Kannarkatt had started treating Decedent with breast cancer chemotherapies following the pathology report but prior to knowing any other information about Decedent, Dr. Goldklang would not be critical of Dr. Kannarkatt’s conduct. (*Id.* at 343-44.) Dr. Goldklang explained, however, that Dr. Kannarkatt had a CT scan of Decedent’s chest, a diagnostic mammogram, a diagnostic ultrasound, and a PET scan, all of which followed the pathology report, failed to confirm that Decedent had breast cancer or a primary tumor site, and/or indicated a possibility of lymphoma. (*Id.* at 344-46, 351, 370, 390, 393.) Dr. Goldklang noted that a

primary tumor site is present in a vast majority of cases of adenocarcinoma that has spread to the lymph nodes and bones and is rarely missed by studies such as mammograms, ultrasounds, and PET scans. (*Id.* at 345-46, 365.) Dr. Goldklang also confirmed that his review of the medical records in Decedent's case revealed no evidence of breast cancer on physical examination. (*Id.* at 348.) As such, Dr. Goldklang expressed his opinion that the clinical and radiological picture was not consistent with a diagnosis of breast cancer. (*Id.* at 350-51.)

Dr. Goldklang also articulated his opinion that Dr. Kannarkatt did not meet the standard of care in the evaluation and treatment of Decedent given her lack of communication with pathology in this case. (*Id.* at 341-42, 351-52, 384.) Dr. Goldklang explained that Dr. Kannarkatt should have prompted a discussion with pathology, including pushing for additional testing and a reevaluation given: (1) pathology's diagnosis was compatible, not diagnostic, meaning that pathology was not certain in the diagnosis; and (2) the aggressive and widespread nature of the disease without a primary site and the suggestion of lymphoma in the clinical and radiological information. (*Id.* at 351-54, 365, 368, 370.) Dr. Goldklang also testified that, insofar as there was any indication that pathology initially considered and ruled out lymphoma as the correct diagnosis for Decedent, lymphoma can, nonetheless, come back into the differential diagnosis based on the clinical picture. (*Id.* at 390-91.) According to Dr. Goldklang, "[t]his is far from a clear-cut picture and it is the obligation of the . . . medical oncologist, . . . Dr. Kannarkatt in this case, to make certain she has all information, and if things don't fit the clinical picture, to speak directly with other doctors involved with the case." (*Id.* at 392.)

Dr. Soiffer, a medical oncologist with expertise in the field of lymphoma cancers and bone marrow transplants, testified as Plaintiff's causation expert. (N.T., Trial, 4/26/2022, at 158-59, 171.) Dr. Soiffer confirmed that all of his answers would be given

to a reasonable degree of medical certainty. (*Id.* at 171.) Dr. Soiffer explained that ALK positive B-cell lymphoma is very aggressive and very rare, with approximately 120-150 reported cases, and that the recurrence rate is high. (*Id.* at 165, 176-78, 191, 195.) Dr. Soiffer indicated that, given the rarity of ALK positive B-cell lymphoma, it has no standard treatment. (*Id.* at 166, 202-03.) Dr. Soiffer stated that, instead, an oncologist would look to literature and other standard lymphoma therapies and then apply similar technologies and principles to treat the disease. (*Id.*) According to Dr. Soiffer, it is desirable to treat patients with aggressive lymphomas as aggressively as possible up front given the likelihood of recurrence. (*Id.* at 191.) Dr. Soiffer explained:

[W]hen cancers are untreated or inadequately treated, they can grow, they can become resistant to chemotherapy that they've received in the past, and they can mutate. So[,] the cells are constantly growing. They can develop new mutations that make them more and more difficult to treat. That is not uncommon in patients with different malignancies that there is what's called -- the term that's used is called clonal progression. So that the tumor clones, progress[es] that is. It's actually called clonal evolution. It evolves to a more complicated state with more mutations that make it more resistant to chemotherapy.

(*Id.* at 187.)

Dr. Soiffer added that a majority of patients with lymphoma generally need chemotherapy only, but with lymphomas like ALK positive B-cell lymphoma that are aggressive and have a high rate of relapse, patients should receive more aggressive chemotherapy than routinely provided and then progress to a stem cell transplant early. (*Id.* at 191-92.) Dr. Soiffer explained that "the likelihood of a successful transplant is higher if the transplant is performed when the disease has not become resistant and when there is a small volume of disease." (*Id.* at 192.) Dr. Soiffer also indicated that there are documented complete remissions of ALK positive B-cell lymphoma with chemotherapy but that "[t]he issue . . . is the durability of that remission" and that transplants work much better and outcomes are better if the patient is in or near remission. (*Id.* at 178, 180, 186,

193, 204.) Dr. Soiffer further indicated that patients needing a transplant should have it done as early as possible because “[t]he more disease the patient has going into a transplant or the later in their course that they are when they undergo a transplant, the worse their outcome is going to be with a transplant.” (*Id.* at 180.) According to Dr. Soiffer, a bone marrow transplant can prolong survival and ultimately lead to a cure. (*Id.* at 180-81.) Dr. Soiffer also explained that a bone marrow transplant is typically not performed for breast cancer or adenocarcinoma. (*Id.* at 182.)

With respect to Decedent, Dr. Soiffer stated that there was “significant progression” of her disease between March 17, 2017, and April 19, 2018. (*Id.* at 183-84.) Dr. Soiffer explained that these circumstances make it more difficult to achieve remission and then have a successful outcome with a stem cell transplant, as the volume or bulk of the disease is higher. (*Id.* at 183-85.) Dr. Soiffer also stated that, generally speaking, the therapies Decedent received for breast cancer are not used to treat lymphoma. (*Id.* at 188.) In addition, Dr. Soiffer provided the following testimony relative to the impact that the 13-month delay in Decedent’s proper diagnosis and treatment had on Decedent’s chances for a prolonged life:

[Q.] So what difference is there, if any, of [Decedent’s] chances of having a prolonged life if this diagnosis had been made and those same treatments were given to her in 2017 instead of 2018?

A. The difference between 2017 and 2018 was that the disease had spread considerably between 2017 and 2018. It was at a later stage. She had already received considerable amounts of chemotherapy.

And in general, transplants performed in first remission yield far better results than transplants performed in subsequent remissions or when patients are in remission. So[,] the optimal time to proceed with aggressive therapy would have been earlier in her course.

. . . .

[Q.] Dr. Soiffer, do you have an opinion to a reasonable degree of medical certainty whether the 13-month delay in making the correct diagnosis and starting treatment for this aggressive lymphoma as you have

already described, did that deprive [Decedent] of a substantially better opportunity for a longer life beyond when she died on January 6, 2019?

A. I think it did, yes.

Q. And could you explain your answer?

A. I think it did because [Decedent] was subjected to chemotherapy that was -- did not address her malignancy.

And there are two aspects that are of concern. The first is that she did not get adequate therapy for the malignancy during that interval, during that period of time. She received agents that were not designed to treat lymphoma but rather designed to treat breast cancer. So that allowed the lymphoma to grow and spread to the point where it became more difficult to treat her subsequently and to treat her successfully subsequently.

In addition, during that 12-month or approximately a year period of time, she was, of course, subjected to chemotherapy. And chemotherapy had its own series of side effects that can be debilitating for a patient, debilitating on the patient and weaken that patient unnecessarily.

(*Id.* at 183, 189-90.)

Notably, on cross-examination, Dr. Soiffer further testified:

Q. And doesn't the literature say that the average life span of an individual with metastatic ALK positive B-cell lymphoma is a year, one year?

. . . .

A. There have been several small reports in the literature which looked at the average survival. One report has the average survival of these patients as low as 12 months, 11, 12 months, one at the average survival somewhere in the order of 22 months or 24 months.

Q. How many months did [Decedent] survive her cancer?

A. I think it was about 21, 22 months.

Q. So [Decedent] fell into the category of the average person with this aggressive stage 4 ALK positive B-cell lymphoma, correct?

A. Yes. Well, in [Decedent's] case, in those other cases they likely received lymphoma therapy from the beginning. So[,] she did not last for at least a year. So[,] it's unclear what her survival would have been if she had received it from the beginning.

Q. That's not my question. My question is with advanced stage 4 ALK positive B-cell lymphoma, [Decedent] statistically outlived the average person, correct?

A. Statistically, survival was better than the 11, 12 months in one report and approximately the same as the 22 months in another report that we reviewed.

(*Id.* at 195-97; see also *id.* at 205 (explaining that Decedent's survival "was in the 20-something month range," which is medium survival that is documented in some patients with ALK positive B-cell lymphoma).)

Dr. Soiffer also indicated that, in general, the breast-cancer directed chemotherapy that Decedent received was unsuccessful and that, if Decedent had been given lymphoma-directed chemotherapy from the outset, he believed her outcome would have been better. (*Id.* at 199-202.) Dr. Soiffer noted that, when Decedent transferred her care to Hershey Medical, she received chemotherapy that is used in aggressive lymphomas, which ultimately achieved "at least a partial remission, if not a near complete remission." (*Id.* at 202.) Of further note, Appellants' counsel and Dr. Soiffer had the following exchange:

Q. So you can't say with any degree of certainty that had ALK positive B-cell lymphoma treatment been provided at the outset, [Decedent's] course would have been any different. You can't say that with any certainty, can you?

A. I don't know what her survival would have been. I certainly can't predict that and how she would have as an individual responded to the drugs that would be used for ALK positive lymphoma.

I do know that she did not have the opportunity, though, to see how she would respond and basically by -- basically she went from having a possible chance at a long-term remission, making that possible opportunity impossible by not having the lymphoma-directed therapy up front.

(*Id.* at 205.) Dr. Soiffer added that, while Decedent's prognosis was poor from the outset, the literature contains documentation that anywhere from eight to twenty percent of

people with Stage III or IV ALK positive B-cell lymphoma live 5 years, regardless of age.³ (*Id.* at 206-07.)

The above testimony, viewed in the light most favorable to the Smiths, reveals that Dr. Wright initially indicated an incorrect pathological diagnosis of metastatic breast cancer for Decedent. At the time Dr. Wright made his pathological diagnosis, however, he did not have the benefit of the mammogram, ultrasound, CT scan, and PET scan that failed to confirm Dr. Wright's diagnosis and included lymphoma as a differential diagnosis or concern. Dr. Kannarkatt, on the other hand, did have the benefit of this clinical and radiological information showing inconsistencies with Dr. Wright's initial pathology

³ The Smiths also presented the testimony of Dr. Naik, provided via videotaped deposition, at trial. Dr. Naik explained that Decedent had "Stage IV localized cancer with only axillary lymph node" prior to seeing her and Stage IV widespread extensive metastatic disease when Decedent began treating with her following Decedent's change in diagnosis. (Original Record (O.R.), Item No. 54, Plaintiff's Exhibit JE-78 at 4, 10.) Dr. Naik described her treatment of Decedent, which began with a "more aggressive option[]" of chemotherapy that did not work and then proceeded to "salvage ICE chemotherapy" followed by a donor stem cell transplant. (*Id.* at 2, 4-5.) Dr. Naik explained that this path of treatment "can offer patients long-term survival" and that it was a realistic goal that, through her treatment of Decedent, Decedent would become free of cancer with the hope that it would not return. (*Id.* at 4, 6-7.) Dr. Naik, nonetheless, testified that Decedent's cancer relapsed within about one month of her stem cell transplant and that, ultimately, the cancer and related complications took her life. (*Id.* at 12-14.)

When asked if Decedent "ha[d] a better chance of beating this cancer or at least prolonging her life . . . if [Dr. Naik was] treating [Decedent] with localized Stage IV instead of widespread Stage IV" cancer, Dr. Naik responded affirmatively. (*Id.* at 14.) Dr. Naik added that Decedent's "ultimate outcome could have been way better if [she] would have seen [Decedent] at initial presentation." (*Id.* at 15; *see also id.* (explaining that chance for long-term survival "would have been way better with a localized nodal and bony tissue").) Dr. Naik also testified to how Decedent's previous treatment for breast cancer contributed to Dr. Naik's decision to avoid using "really aggressive chemotherapy" and treatment prior to Decedent's stem cell transplant given concerns regarding toxicity and increased mortality and morbidity. (*Id.* at 6.) Dr. Naik indicated that the survival rate of ALK positive B-cell lymphoma is very poor and that Decedent survived her disease within the statistical range that the medical literature indicates for similar patients with her disease. (*Id.* at 10-11, 15.)

diagnosis when she began treating Decedent. As Dr. Goldklang testified, under the present circumstances, Dr. Kannarkatt, as the treating oncologist, had the obligation to speak to the pathology team regarding the inconsistencies and the potential for a reexamination of Decedent's initial pathology diagnosis. Dr. Kannarkatt failed to do so and, instead, proceeded to administer inappropriate and debilitating chemotherapy treatments to Decedent for approximately thirteen months, at which point Decedent was discovered to have ALK positive B-cell lymphoma all along.

Decedent's cancer also progressed significantly during that time. Dr. Soiffer opined that, as a result of the delay in proper diagnosis and treatment—in which, according to the Smiths' evidence, Dr. Kannarkatt played a role—Decedent was “deprive[d] . . . of a substantially better opportunity for a longer life.” (N.T., Trial, 4/26/2022, at 189-90.) Based on the foregoing, pursuant to *Hamil* and its progeny, the Smiths provided sufficient evidence to establish a prima facie case that Dr. Kannarkatt's conduct increased the risk of harm to Decedent, thereby requiring submission of the case to the jury for a determination of whether that conduct was a substantial factor that contributed to produce Decedent's final stage metastasis and ultimate death.

Notwithstanding the above, Appellants insist that reversal of the Superior Court's judgment is warranted.⁴ Emphasizing that *Hamil* and its progeny did not obviate a plaintiff's burden to prove causation, Appellants argue that the Smiths failed to meet their burden to prove causation as to Dr. Kannarkatt under the relaxed standard established in that precedent. Specifically, Appellants submit that it was only Dr. Wright's admittedly negligent pathology misdiagnosis that was the ultimate, known cause of the complained-of harms of a delay in proper diagnosis and treatment. Appellants claim that

⁴ In support of Appellants, Hospital and Healthsystem Association of Pennsylvania has filed an *amicus curiae* brief and the American Medical Association and the Pennsylvania Medical Society have filed a joint *amici curiae* brief.

the Smiths presented insufficient expert witness testimony that Dr. Kannarkatt's conduct in failing to question Decedent's diagnosis could cause the type of harm that Decedent suffered. According to Appellants, Dr. Kannarkatt was not involved in the misdiagnosis and had no control or ability to control the underlying negligence that caused Decedent's actual harms. Appellants share that there is no evidence here that any communication with Dr. Wright might have changed the outcome of Decedent's treatment to any degree. Appellants add that the Smiths never presented a pathology expert to render an opinion in this regard and that, instead, the Smiths "presented Dr. Wright[,] who was equivocal in whether any communication from Dr. Kannarkatt would have altered the outcome, while being unequivocal in the rendering of his initial diagnosis." (Appellants' Brief at 28.)

Appellants assert that the Superior Court ignored Dr. Wright's responsibility for the misdiagnosis and employed speculation to determine that any communication from Dr. Kannarkatt would have changed Decedent's outcome. Appellants submit that the Smiths' "attempt to establish causation against Dr. Kannarkatt for nonfeasance secondary to Dr. Wright's actual malfeasance exceeds the bounds of increased risk of harm causation." (*Id.* at 19.) Appellants also criticize *Hamil* and contend that subjecting medical providers like Dr. Kannarkatt to liability under these circumstances "highlights the issues with the increased risk of harm standard adopted in *Hamil* and its progeny," as it lowers the burden of proof for plaintiffs while shifting significant costs to medical professional defendants. (*Id.* at 33-34.) It also "would eliminate any trust among providers and cause unnecessary reviews for the sole purpose of limiting liability," which would lead to patient suffering due to not receiving timely, necessary medical care or providers becoming more risk averse. (*Id.* at 33.)

As for Dr. Soiffer's testimony in particular, Appellants similarly claim that his causation opinion focused "entirely on the impact of the '13-month delay in making the

correct diagnosis and starting treatment for this aggressive lymphoma,” which fails to create the legally necessary nexus to the Smiths’ failure-to-communicate theory of negligence alleged against Dr. Kannarkatt. (*Id.* at 29 (quoting N.T., Trial, 4/26/2022, at 189).) According to Appellants, the Superior Court relied upon “magic words” and failed to look to the substance of Dr. Soiffer’s testimony, which, when reviewed in its entirety and in the light most favorable to the Smiths, was speculative, equivocal, and incapable of sustaining the Smiths’ burden of proof even under the relaxed *Hamil* standard. (*Id.* at 34-36.)

Appellants further attack Dr. Soiffer’s testimony on the grounds that Dr. Soiffer had never treated ALK positive large B-cell lymphoma, which is rare and has no established treatment regimen. Appellants also submit that Dr. Soiffer was unable to opine as to Decedent’s shortened life expectancy, and they note that Decedent lived equal to or beyond all known statistical possibilities for her rare and deadly form of lymphoma. Appellants assert that Dr. Soiffer’s opinion is based upon nothing more than a possible chance at a long-term remission with earlier lymphoma treatment but that he simultaneously conceded his inability to offer any opinion as to survivability, which is insufficient as highlighted by *Montgomery*. “Thus,” Appellants argue, “when viewing the collective substance of Dr. Soiffer’s testimony, it was clear that [the Smiths] failed to present sufficient evidence to establish any significant possibility of avoiding injuries, or even any possibility of avoiding injuries at all.” (*Id.* at 42 (internal quotation marks omitted).)

Finally, Appellants contend that any reliance by the Smiths and the Superior Court on the medical testing conducted subsequent to Dr. Wright’s misdiagnosis is a red herring. In support, Appellants argue that every oncology provider confirmed that a primary tumor site does not always exist and that radiology cannot diagnose a

malignancy; instead, radiology is used only to discern the staging and extent of the cancer. Appellants also highlight that Dr. Wright was unequivocal in his opinion as to the category of Decedent's malignancy and that subsequent challenges based upon a lack of a primary tumor site would not have impacted his decision in that respect.

As noted by the Smiths,⁵ Appellants' arguments are largely based upon a selective review of the record or otherwise go to issues such as the weight and credibility of the testimony proffered as opposed to its sufficiency. For instance, Appellants seek to attribute the harms resulting from the delay in proper diagnosis and treatment to Dr. Wright alone, to the exclusion of the evidence demonstrating Dr. Kannarkatt's involvement in that delay through her failure to confer with pathology regarding the diagnosis and the administration of improper chemotherapy treatments. Indeed, we agree with the Superior Court that "Dr. Soiffer's testimony provided a basis for a jury to find that Dr. Kannarkatt's failure resulted in a significant delay in proper treatment which substantially reduced Decedent's chance for a better outcome—an outcome that could have included complete remission after proper chemotherapy modalities and, thereafter, a total cure through a subsequent bone marrow transplant." *Smith*, slip op. at 18. As such, it is for the jury to decide whether Dr. Kannarkatt's conduct constituted a substantial factor—alongside any other factors, such as Dr. Wright's conduct or Decedent's preexisting cancer—in bringing about Decedent's harm. *See, e.g., Hamil*, 392 A.2d at 1285 (explaining that, "[i]n establishing a [p]rima facie case, the plaintiff need not exclude every possible explanation of the accident; it is enough that reasonable minds are able to conclude that the preponderance of the evidence shows [the] defendant's conduct to have been a substantial cause of the harm to [the] plaintiff"); *id.* at 1286-87 (observing that, in cases to which relaxed causation standard applies, "a fact-finder must

⁵ The Pennsylvania Association for Justice has filed an *amicus curiae* brief in support of the Smiths.

consider not only what [d]id occur, but also what [m]ight have occurred, [*i.e.*], whether the harm would have resulted from the independent source even if [the] defendant had performed his service in a non-negligent manner”).

We are likewise unpersuaded by Appellants’ criticisms of the relaxed causation standard and their position that the Smiths were required to introduce evidence that Dr. Kannarkatt contacting Dr. Wright would have changed Decedent’s diagnosis, treatment, and overall outcome.⁶ “[T]he concept of proximate cause is often ‘purely one of policy, of our inadequately expressed ideas of what justice demands.’” *Hamil*, 392 A.2d 1287 n.8 (quoting W. Prosser, *Law of Torts*, § 41, at 237 (4th ed. 1971)). More to this point, the *Hamil* Court observed:

[Cases such as this one] by their very nature elude the degree of certainty one would prefer and upon which the law normally insists before a person may be held liable. Nevertheless, in order that an actor is not completely insulated because of uncertainties as to the consequences of his negligent conduct, Section 323(a) [of the Restatement] tacitly acknowledges this difficulty and permits the issue to go to the jury upon a less than normal threshold of proof.

Id. at 1287-88 (footnote omitted). This Court continued by relying upon the following as justification for deviating from the normal requirements of proof:

When a defendant’s negligent action or inaction has effectively terminated a person’s chance of survival, it does not lie in the defendant’s mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable. Rarely is it possible to demonstrate to an absolute certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass. The law does not in the existing circumstances require the plaintiff to show to a certainty that the patient would have lived had she been hospitalized and operated on promptly.

⁶ Indeed, insofar as Appellants’ arguments in this or any other regard can be interpreted as a request to abrogate or modify the *Hamil* standard or as a suggestion that it does not apply in this case, such issues are outside the scope of the question we accepted for review.

Id. at 1288 (quotation marks omitted) (quoting *Hicks v. United States*, 368 F.2d 626, 632 (4th Cir. 1966)).

Appellants' arguments illustrate the necessity of the relaxed causation standard. It is impossible to know what would have happened if Dr. Kannarkatt had contacted Dr. Wright to discuss the additional information in Dr. Kannarkatt's possession. It is clear, however, that the Smiths have presented sufficient evidence to establish a prima facie case that Dr. Kannarkatt's involvement in the improper diagnosis and treatment of Decedent increased the risk of progression in Decedent's cancer and her premature death. This is all that the Smiths had to do to get their case to the jury. See *Mitzelfelt*, 584 A.2d at 892 (“[O]nce there is testimony that there was a failure to detect the cancer in a timely fashion, and such failure increased the risk that the woman would have either a shortened life expectancy or suffered harm, then it is a question for the jury whether they believe, by a preponderance of the evidence, that the acts or omissions of the physician were a substantial factor in bringing about the harm.”)

It is, thus, a task for the jury “to balance probabilities and decide whether [Dr. Kannarkatt's] negligence was a substantial factor in bringing about [Decedent's] harm.” *Gradel*, 421 A.2d at 679. Notably, in so doing, the jury is under no obligation to render that conclusion or otherwise find the Smiths' evidence credible or that it is entitled to any weight. Nor does the *Hamil* standard preclude Appellants from challenging the Smiths' evidence on increased risk of harm through cross-examination or by offering opposing expert medical testimony. See *Hamil*, 392 A.2d at 1288 n.9 (observing that “a defendant may present expert testimony [as to] the unlikelihood of survival even had the defendant exercised due care; as always, resolution of conflicting testimony is for the jury”).

Finally, we address Appellants' reliance on the Superior Court's decision in *Montgomery*. In that case, a patient presented to a physician's assistant for an annual physical examination. The patient notified the physician's assistant that she had been experiencing pain in her left breast. The physician's assistant noted that the patient had fibrocystic breasts and ordered a baseline mammogram, which revealed no abnormality. The patient continued to complain of pain in her left breast to the medical group that employed the physician's assistant over the next year to no avail. Upon experiencing new symptoms, the patient saw a gynecologist employed by the same medical group. The gynecologist located a suspicious mass in the patient's left breast, which was ultimately determined to be a Stage II malignancy that had spread to one lymph node. The patient underwent a modified radical mastectomy of the left breast, followed by chemotherapy.

The patient filed suit against the medical group, contending that the physician's assistant was negligent in failing to refer the patient to a physician following her complaints of left breast pain. The matter proceeded to trial, which ended when the trial court entered a compulsory nonsuit for lack of sufficient evidence on the element of causation. On appeal, the Superior Court agreed with the trial court. Analyzing the case under the relaxed causation standard, the Superior Court observed that the patient had failed to proffer any evidence as to the point at which the tumor could have been first detected such that an examination by a physician would have uncovered anything more than what the physician's assistant had discovered. *Montgomery*, 656 A.2d at 1392-93 (highlighting that there was no evidence of lump or mass and no abnormality showing on mammogram ordered by physician's assistant). The Superior Court added the following observations with respect to the patient's proffered expert testimony:

Although [the expert] testified that the failure to refer [the patient] to a physician fell below the standard of care required of a physician's assistant, he was either unable or unwilling to say that the risk of harm had been

increased thereby. He said only that it was “*very possible*” that the failure to refer her to a physician “*may have increased* her chance of having a positive lymph node” when the cancer was eventually diagnosed and that it “may have increased her risk for requiring a mastectomy with chemotherapy.” On cross-examination he said, “[H]ad the tumor been diagnosed one year earlier, it is indeed possible that if it were small enough, the breast could have been conserved and treated by lumpectomy/radiation therapy alone.” All of this was speculative, he conceded, saying “one can only speculate as to had it been diagnosed earlier what its size may have been, since we don’t know, nor will we ever know.”

Id. at 1393 (second alteration and emphasis in original). The Superior Court also explained that the patient’s tumor was removed by mastectomy and subsequent chemotherapy and that there was no record evidence of recurrence. Given that the patient’s evidence showed only that it was possible that her tumor could have been treatable by lesser means if the tumor could have been diagnosed earlier, and the lack of evidence that the tumor actually could have been diagnosed earlier, the Superior Court concluded that the trial court properly entered a compulsory nonsuit.

The circumstances of the instant matter are distinguishable from *Montgomery*. Here, the Smiths’ evidence demonstrates that Decedent was always suffering from ALK positive B-cell lymphoma, not metastatic breast cancer. Moreover, Dr. Goldklang testified, to a reasonable degree of medical certainty, that Dr. Kannarkatt breached her duty of care by failing to question Dr. Wright’s diagnosis in light of the inconsistent findings revealed by clinical and radiological testing that was in Dr. Kannarkatt’s possession and conducted after the initial pathology misdiagnosis. Additionally, in contrast to the expert testimony at issue in *Montgomery*, Dr. Soiffer testified, within a reasonable degree of medical certainty, that the delay in the proper diagnosis and treatment of Decedent deprived her “of a substantially better opportunity for a longer life beyond when she died on January 6, 2019.” (N.T., Trial, 4/26/2022, at 189-90.) In support, Dr. Soiffer explained that, during the period in which Decedent was improperly diagnosed and treated, Decedent’s cancer spread and became more difficult to treat, and she was subject to the

debilitating and weakening effects of inappropriate chemotherapy. Dr. Soiffer also emphasized that, the earlier that proper treatment is provided to a cancer patient such as Decedent, the better chance that patient has of a favorable outcome, including complete remission and a cure. As the Superior Court correctly concluded, Dr. Soiffer's testimony provided a basis for a jury to find that Dr. Kannarkatt's involvement in Decedent's delayed proper diagnosis and treatment increased Decedent's risk of harm. Lastly, unlike in the case of the patient in *Montgomery*, who achieved full recovery, Decedent's cancer spread considerably between March 2017 and April 2018 and ultimately led to her death. As such, Appellants are not entitled to relief in light of *Montgomery*.

III. CONCLUSION

Based on the foregoing, and pursuant to *Hamil* and its progeny, we conclude that the Smiths provided sufficient evidence to establish a prima facie case that Dr. Kannarkatt's conduct increased the risk of harm to Decedent, thereby requiring submission of the case to the jury for a determination of whether that conduct was a substantial factor in bringing about Decedent's harm. We further conclude that the Superior Court correctly applied this increased-risk-of-harm standard to the instant matter. Accordingly, we affirm.

Chief Justice Todd and Justices Donohue, Dougherty, Wecht, Mundy and McCaffery join the opinion.