Thank you for taking the time to share information for the article on Page 3.
Sincerely,

Leslie Nicholson

To Sue or Not to Sue Doctors in Implant Cases

SEVERAL possible strategies have emerged in the proliferating silicone breast implant litigation, and one concerns whether to name the implanting/treating physician as a defendant along with the implant manufacturer. Reaction to the strategy has been mixed. However, a report earlier this month in *The Wall Street Journal* may convert some skeptics; it suggests surgeons were given many reasons to be concerned about the implants' safety long before the recent explosion of scrutiny and disclosure of potentially incriminating documents from manufacturers.

An obvious reason for suing a physician in breast implant litigation is for substantive malpractice — e.g., failing to treat infections following implantation or performing the wrong procedure. Another basis for doing so involves informed-consent/failure-to-warn issues — especially, some attorneys say, if it will avoid an "empty chair" if an implant maker raises a "learned intermediary" defense.

However, there is some disagreement over what constitutes malpractice in this area, and even more disagreement on the extent of doctors' liability for not informing patients of the risks. Furthermore, there may be procedural bars that make filing malpractice claims impractical.

"Doctors are a responsible party for patients' injuries and should be held responsible for their share of the problem," says Karen Koskoff of Bridgeport, Conn., who has named doctors as co-defendants in most of the implant suits she has filed in state court.

In two of her cases, the women went in for breast lifts and ended up with implants they didn't know they would be getting; in another, the surgeon removed so much during a breast reduction that he had to insert an implant. Additionally, in every case, "there is clearly a lack of informed consent," she says; although the implant package inserts were "by no means adequate," none of the plaintiffs even received the information the inserts contained. She also believes many doctors may have minimized the fact that implants interfere with mammograms for breast cancer.

Some attorneys contend that reliance on the closed-capsulatomy technique of breaking up scar tissue that can form around the implants (it can cause the implant to rupture) may be malpractice. However, it may be difficult to prove that the procedure constitutes substandard care. Ernie Hornsby of Dothan, Ala.'s Farmer, Price, Smith, Hornsby & Weatherford and Ralph Knowles of Atlanta's Doffermyre, Shields, Canfield & Knowles discovered this when a doctor they were suing for rupturing both the plaintiff's implants during a closed capsulatomy was exonerated at trial.

Ms. Koskoff also has included doctors in product liability claims because of their role as "distributors" of a product. If suing a physician under the product statute is upheld as proper, "it's unlikely his malpractice insurer will cover a claim against him (this isn't malpractice for the care and treatment of a patient)," says Ms. Koskoff, explaining her rationale. "Thus, it makes the doctor vulnerable and may get him to force the insurer to settle."

Another reason cited for suing doctors is to head off the possibility that the manufacturer will raise a learned-intermediary defense. Ms. Koskoff confronted such a situation in an earlier suit involving a polyurethane-coated breast implant. Messrs. Hornsby and Knowles saw how it resulted in a defense victory in a California case tried two months before their's. Richard B. Garrett of Montgomery, Ala.'s Rushton, Stakely, Johnston & Garrett, who defended the doctor in the Hornsby/Knowles suit, said the co-defendant implant company did argue, albeit unsuccessfully, that it had indeed warned doctors against closed capsulatomies.

Skeptics' Reservations

Skeptics contend that based on the revelations in documents that are just now being disclosed by implant manufacturers, it is likely that informed-consent claims won't wash. "Doctors just didn't know," says Kenneth B. Moll of Chicago. "These could be seen as frivolous lawsuits." And although former implant maker Heyer-Schulte Corp. sent a letter to doctors in 1976 cautioning against performing closed capsulatomies, "the medical literature was actually recommending doing the non-invasive procedure," he points out.

However, a March 12 *Wall Street Journal* article — "Informed Consent? Plastic Surgeons Had Warnings on Safety of Silicone Implants" — reveals evidence that "over the past two decades, plastic surgeons...saw and ignored red flags in this lucrative branch of their speciality...[and] failed to alert women to possible health risks reported by several sources, including professional journals, manufacturers and some of their own patients." Among the experts who reportedly warned surgeons about possible problems with the implants, only to be "rejected and condemned," are Frank Vasey, a Florida rheumatologist; Melvin Silverstein, an oncologist at the Breast Center in Van Nuys, Calif.; and James Rudy, an engineer and former president of Heyer-Schulte.

Clearly, a lot of research must be done before a surgeon can be named as a defendant, proponents acknowledge. Furthermore, "In most states, there are lots of roadblocks to suing doctors," says Mr. Knowles —e.g., special pleading requirements, statutes of limitations, caps on compensatory and punitive damages, and mandatory review panels. — *Leslie Nicholson*

Thank you for taking the time to share information for the article on Page 5.
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May Be Covered by Insurance

Most courts have been reluctant to extend insurance coverage to claims involving physician-patient sexual contact that do not arise out of the psychotherapy setting, typically finding that sex between the doctor and patient is not part of the rendering of professional services. See *Smith v. St. Paul Fire & Marine Ins. Co.*, 353 N.W.2d 130 (Minn. 1984). However, just as there has been broadening of coverage for sexual conduct within the therapeutic relationship, there have also been some attempts by certain courts to broaden coverage in the non-therapeutic context.

In *St. Paul Fire & Marine Ins. Co. v. Asbury*, 720 P.2d 540 (1986), the Arizona Court of Appeals found that there was insurance coverage for a gynecologist's intentional and improper "manipulations" of his female patients (apparently he massaged their clitorises) during the gynecological examination. It reasoned that the sexual act took place "in the course of" and was an "inseparable part" of the provision of professional services — i.e., a gynecologist gives pelvic examines and routinely touches this part of the female anatomy in the course of his professional service.

Few courts have followed the unusual rationale of *Asbury*. Indeed, predicating coverage on the fact that the sexual contact occurred within the scope of the physician's particular specialty area would produce some strange results inconsistent with the purpose of professional liability insurance. Would a cosmetic surgeon involved in a breast augmentation procedure be afforded coverage for sexual contact with the patient during the course of a physical exam or post-surgery follow-up? Would a physical therapist be covered for intentional sexual acts performed during the course of therapeutic massage?

Of course, other bases have been advanced for either finding or denying coverage for sexual-misconduct claims. Recently, some insurers have added provisions specifically excluding coverage for claims arising out of "sexual acts" performed by the physician.

In *Govar v. Chicago Ins. Co.*, 879 F.2d 1581 (8th Cir. 1989), the court found that no coverage existed for a licensed psychologist charged with malpractice for having sexual relations with his patient. The physician-defendant claimed that there should be coverage, despite the fact that there was a sexual-acts exclusion, since there were other claims of malpractice beyond the sexual acts. However, the court held that the sexual acts were an essential element of the patient's cause of action and that the exclusion was therefore applicable.

Public Policy Issues

Public policy has also been used as a rationale for finding coverage in the sexual misconduct situation. In *Aetna Life and Cas. Co. v. McCabe*, 556 F.Supp. 1342 (E.D.Penn. 1983), the court found coverage for the defendant-doctor even though the testimony clearly indicated that the sexual activity with the patient was not part of the therapy. The insurance policy in question had an exclusion for intentional torts. The court found that the sexual contact was, in fact, intentional, and although there were some elements of the transference/countertransference phenomenon, it appeared to be simply sexual abuse of a patient by a doctor.

However, in applying Pennsylvania law, the court found coverage, stating "Although Pennsylvania has a policy interest in deterring intentional torts by barring insurance recovery for them by the tortfeasor, it also has a strong interest in compensating Pennsylvania victims of malpractice for injuries suffered at the hands of Pennsylvania physicians."

A similar rationale resulted in a finding of coverage in *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382 (1982). The Michigan Court of Appeals found coverage for psychiatric sexual misconduct because it would not be the insured psychiatrist who would benefit from the coverage but the innocent victim who would be compensated for her injuries. The court held that there was great public interest in protecting the injured party in this type of situation.

It appears likely that courts will continue to find coverage in the situation involving the mishandling of the transference/countertransference phenomenon. The real issue is whether the courts will broaden the definition of the transference/countertransference phenomenon to include all emotional and/or dependent relationships between physicians and patients and find coverage.

The issue also may be whether courts will extend the definition of professional services, as in *Asbury*, and find that certain other types of sexual misconduct may be covered within a broad definition of professional services.

Although there may be public policy reasons to find coverage to benefit the innocent victim in these situations, it would not seem well-reasoned to extend coverage to sex between a patient and physician outside of the narrowly defined transference/countertransference context.

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