SUPREME COURT

OF THE

STATE OF CONNECTICUT

_____

S.C. 19879

JANE DOE,

PLAINTIFF

V.

CHARLES COCHRAN, M.D.,

DEFENDANT

_____

BRIEF OF AMICI CURIAE
AMERICAN MEDICAL ASSOCIATION
CONNECTICUT STATE MEDICAL SOCIETY

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STATEMENT OF ISSUE TO AMICI CURIAE

Under the facts of this case, did the trial court correctly conclude that the plaintiff, Jane Doe, did not have a legally cognizable claim against the defendant, Charles Cochran, M.D., for negligently informing Doe's boyfriend that he had tested negative for a sexually transmitted disease, when Doe relied on that representation in deciding to be sexually intimate with her boyfriend and, in so doing, contracted such a disease?

INTEREST OF AMICI CURIAE

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA policy-making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all states and in all areas of medical specialization.

The Connecticut State Medical Society ("CSMS") is one of the oldest state medical societies in the country, and is comprised of physicians, residents and medical students who practice in the State of Connecticut. CSMS is represented in the AMA House of Delegates and shares the objective of the AMA to promote the science and art of medicine and the betterment of public health. The primary purpose of CSMS is to enhance the delivery of high quality medical care to all Connecticut residents in the most safe, efficient, and economical manner, and to promote and maintain high standards in medical education. CSMS also represents the interests of physicians in the practice of medicine in an effort to ensure that quality medical care is available to the public. Together, Amici represent tens of thousands of physicians throughout Connecticut and across the country.[1]

[1] The AMA and CSMS join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

ARGUMENT[2]

This appeal raises the issue of whether physicians and other health care professionals and hospitals owe a duty of care to a plaintiff such as Jane Doe, an unidentified member of the public, who is not a patient of the defendant, Dr. Charles Cochran. On March 18, 2016, the Superior Court ruled that under Connecticut law, as currently framed, the defendant owed no such duty of care. The plaintiff now asks this Court to reverse the ruling of the trial court and hold that the defendant does, in fact, owe a duty of care to the plaintiff.

The American Medical Association ("AMA") and the Connecticut State Medical Society ("CSMS") (collectively, the "Amici") use this brief to express their concern over the possibility of this court expanding the scope of potential plaintiffs who could bring lawsuits founded on medical malpractice allegations against physicians. Amici adopt the Statement of Nature of Proceedings and Facts set forth by defendant in its brief filed with this Court, as well as the standard of review set forth therein. Given that this Court has requested that the parties appearing as amicus curiae provide their respective positions on the aspects of law and policy pertaining to the circumstances surrounding this case,[3] Amici filing this brief will devote most of the space allocated for that purpose.

A. There Is No Duty of Care Owed by Dr. Cochran to Plaintiff

1. Connecticut Precedent Mitigates Against Expansion of a Healthcare Provider's Duty to Non-Patients

[2] No counsel for any party has written this brief either in whole or in part. No counsel for any party, and no party, has contributed to the cost of its preparation or submission. See P.B. § 67-7.

[3] See Letter from Carolyn C. Ziogas, Chief Clerk, to Connecticut State Medical Society (Nov. 29, 2017) (on file with author).

As the defendant sets forth thoroughly in his brief, Connecticut precedent does not support extending a health care provider's duty of care to persons other than his or her patients. This point was made clear in Jarmie v. Troncale, 206 Conn. 578 (2012), wherein this Court discussed how

> [t]he established rule is that, absent a special relationship of custody or control, there is no duty to protect a third person from the conduct of another. . . . Thus, physicians owe an ordinary duty to their patients not to harm them through negligent conduct and an affirmative duty to help them by providing appropriate care. . . . There is no well established common-law rule that a physician owes a duty to warn or advise a patient for the benefit of another person. . . . Consistent with the purpose of [General Statutes § 52-190] and the limited duty of health care providers under the common law, this court has exercised restraint when presented with opportunities to extend the duty of health care providers to persons who are not their patients.

Id. at 592 (citations omitted) (internal quotation marks omitted).

As a result, this Court has concluded in the past that a nurse and an emergency medical technician owed no duty of care to a patient's sister, who fainted while observing a medical procedure performed on the patient; Murillo v. Seymour Ambulance Assn., Inc., 264 Conn. 474, 477-78 (2003); that a psychiatrist owed no duty to a patient's former spouse for any direct injury to the marriage caused by the allegedly negligent treatment of the patient for marital difficulties; see Jacoby v. Brinckerhoff, 250 Conn. 86, 88 (1999); and that a psychotherapist owed no duty to a patient's father, who was arrested for sexual abuse based on the psychotherapist's report to the police. Zamstein v. Marvasti, 240 Conn. 549, 550-51, 559-61 (1997). See also Marsala v. Yale-New Haven Hosp., Inc., 166 Conn. App. 432, 447-51 (2016) (no duty owed by hospital to patient's family for injuries sustained when patient was removed from life support against family's wishes). As explained in Jarmie, the only time this Court has even contemplated enlarging the duty of a health care provider to a non-patient was in Fraser v. United States, 236 Conn. 625, 627-

30, 634(1996) (concluding that no duty was owed by psychotherapist to third party to control patient "in the absence of a showing that the victim was either individually identifiable or, possibly, was either a member of a class of identifiable victims or within the zone of risk to an identifiable victim").

In light of the foregoing case law, it is clear that Connecticut precedent, as currently developed, does not support extending the duty of care in the present case, as this Court repeatedly has declined to extend the duty of health care providers to persons who are not their patients.

2. Foreseeability Analysis Precludes Expansion of Dr. Cochran's Duty of Care to Include Plaintiff

Amici also submit that it would be unfeasible for this Court to use the present case as a basis for articulating a new rule extending foreseeability[4] to third-party claimants in the context of patient-provider care. There are no facts presented to the Court indicating that this particular plaintiff was known to the defendant at the time that he was providing care to the patient-boyfriend. While it may be the case that the defendant knew that his patient intended to commence a sexual relationship with a woman—a woman who is now the plaintiff— that woman was not known by the defendant. The narrow facts of this single case are insufficient to establish foreseeability for a new class of persons exposed to injury

[4] "Although it has been said that no universal test for [duty] ever has been formulated . . . [the Connecticut Supreme Court's] threshold inquiry has always been whether the specific harm alleged by the plaintiff was foreseeable to the defendant. The ultimate test for the existence of the duty to use care is found in the foreseeability that harm alleged by the plaintiff was foreseeable to the defendant. . . . [T]he test is, would the ordinary [person] in the defendant's position, knowing what he knew or should have known, anticipate that harm of the general nature of that suffered was likely to result. . . ." Pelletier v. Sordoni/Skansa Const. Co., 286 Conn. 563, 594 (2008).

from such care because this class, and this particular plaintiff, could not be identified at the time that care was rendered.

This Court previously emphasized in Jarmie that "although many harms, in hindsight, may be foreseeable . . . the foreseeability test as applied by this court in the context of health care providers has . . . required an *identifiable* victim because we have deemed the effect of a physician's conduct on third parties as too attenuated to extend liability beyond the patient." Jarmie, 306 Conn. at 595-96 (emphasis added). Here, the universe of persons potentially exposed to injury as a result of Dr. Cochran's alleged failure to diagnose or warn his patient regarding a sexually transmitted disease includes anyone with whom the patient may have sexual contact in the future, which, theoretically, is an infinite number of potential victims. Thus, it logically cannot follow that this class of persons was defined and knowable—i.e., identifiable—at the time care was rendered. This point is further strengthened by the fact that the patient in the present case was unmarried. Given the potential for infidelity and divorce, however, Amici submit that this argument would apply equally to married patients.

Moreover, how long a period of time would a duty exist by the defendant to an unknown class of plaintiffs? According to a study done in connection with the New York City Department of Health, 88% of people testing positive for herpes have no symptoms because the herpes virus can remain dormant in one's body for years. J.A. Schillinger et al., *Seroprevalence of Herpes Simplex Virus Type 2 and Characteristics Associated with Undiagnosed Infection: New York City, 2004*, 35 SEXUALLY TRANSMITTED DISEASES (2008). The defendant's patient might have carried the herpes virus for months, or even years, infecting many potential plaintiffs following the defendant's testing. Accordingly, one must

consider how any statute of limitations would be tolled under such circumstances, and where a line limiting the defendant's liability would be drawn.

Ultimately, the notion that "any person with whom this patient may have sexual contact" would constitute an identifiable class of individuals that a health care provider must consider when providing patient care is a completely unworkable concept. In order to best engage in risk-management and to provide optimum care to a patient, health care providers must be afforded a clear understanding of which persons are considered legally foreseeable victims to whom they may be liable; they cannot reasonably be expected to procure a list of current and potential sexual partners from a patient in order to accomplish this. For these reasons, foreseeability analysis precludes an expansion of the defendant's duty of care to include the third-party plaintiff.

3. Public Policy Considerations Should Preclude Expansion of Dr. Cochran's Duty of Care to Plaintiff

The likely impact on medical malpractice insurance rates, patient care, and patient trust in the confidentiality of physicians dictates that any expansion of the class of plaintiffs who can sue physicians be evaluated in much greater detail than is capable in this proceeding. A guiding principle for the court in this matter should be the same guiding principle applicable to physicians: "First do no harm."[5] The repercussions of an expansion of the rule which currently limits the right to bring a medical malpractice case to someone

[5] The Hippocratic Oath is an oath historically taken by physicians. It is one of the most widely known of Greek medical texts. In its original form, it requires a new physician to swear to uphold specific ethical standards. The Hippocratic Oath is the earliest expression of medical ethics in the Western world, establishing several principles of medical ethics which remain of paramount significance today. These include the principles of medical confidentiality and non-maleficence. See U.S. Nat'l Lib. of Med., Greek Medicine, https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last updated Feb. 7, 2012).

who is a patient of the physician being sued cannot be known by this court, and, in such a circumstance, an expansion of the potential class of plaintiffs should not be undertaken, even when the current plaintiff presents such a sympathetic case.[6]

a. Impact on Medical Malpractice Insurance Rates

Amici first urge this Court to consider how a dramatic expansion of the potential class of plaintiffs could have a significant effect on medical malpractice insurance rates for health care providers. In Connecticut, health care professionals are not permitted to obtain a license to practice medicine unless they demonstrate that they have adequate malpractice insurance at a prescribed minimum level of $500,000. See General Statutes § 20-11b. As a result, if physicians in this state were to find that their insurance premiums have increased to such a degree as to become unaffordable, they may be forced to cease performing the services that create the unquantifiable risk or to leave the practice entirely.[7] Such serious concerns and consequences should not be left up to the court system to determine; rather, the legislature is the proper body to consider whether Connecticut should recognize a new exception to the general rule that health care providers do not owe a duty of care to non-patients.

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[6] As the trial court stated in its memorandum of decision below, "while the goal of the tort system may be to provide remedies to those who have been wronged, appellate-level decisions repeatedly have stated that not every wrong is remediable through the tort system." Doe v. Cochran, 62 Conn. L. Rptr. 33 (2016).

[7] Compare this to the crisis concerning the practice of obstetrics that became apparent in the early 2000s, in which "soaring malpractice insurance costs led the closings of trauma and maternity wards across the country . . . [and] forced many obstetricians to give up obstetrics, restrict services, deny certain high-risk patients, become consultants relocate, retire early, or abandon their practices all together." Sarah Domin, Where Have All the Baby-Doctors Gone? Women's Access to Healthcare in Jeopardy: Obstetrics and the Medical Malpractice Insurance Crisis, 53 CATH. U. L. REV. 499, 499-500 (2004).

In the early 2000s, medical malpractice insurance rate levels and their increases became a prominent state and national issue. As a result, the state legislature began taking action in order to remedy this "crisis." For example, during the 2003-2004 Legislative Session, the Connecticut General Assembly's Legislative Program Review and Investigations Committee conducted hearings into the issue, and ultimately offered a number of findings and recommendations toward reform. See LEG. PROGRAM REVIEW & INVESTIGATIONS COMM., CONN. GENERAL ASSEM., MEDICAL MALPRACTICE INSURANCE RATES FINAL REPORT (2003), available at https://www.cga.ct.gov/2003/pridata/studies/medical_ mal_final _report.htm.

Notably, these findings concluded that a significant contributing factor to rising insurance rates in Connecticut was the lack of a cap on non-economic damages and the growing number of medical malpractice cases brought against physicians. See id. More specifically, the Connecticut Medical Insurance Company ("CMIC") provided written testimony that a $250,000 cap on non-economic damages in Connecticut would lead to a 10% reduction in medical malpractice premiums. See id. Conversely, in the present case, adding a potential class of tens of thousands of plaintiffs will undoubtedly have a profound effect on the underwriting of medical malpractice rates, at a time of significant reductions in reimbursements to physicians who pay those premiums.

With respect to the Committee's recommendations, it suggested several statutory changes directed toward the judiciary, including the now well-known requirement that an opinion letter issued by a similar health care provider be attached to a medical negligence complaint, as codified by General Statutes § 52-190a. Indeed, the legislative history behind this statutory provision reveals that it was designed to, inter alia, "put some measure

of control on what was perceived as a crisis in medical malpractice insurance rates," "discourage frivolous or baseless medical malpractice actions," and "reduce the incentive to health care providers to practice unnecessary and costly defensive medicine because of the fear of such actions." Jarmie, 306 Conn. at 591. More to the point, however, Amici emphasizes that all of these recommendations came about after much deliberation and study, as well as commentary from all the stakeholders involved in the Committee's work. This Court should not, with the stroke of a pen, supplant its decision-making for that of comprehensive legislative process.

b. Impact on Patient Care

Amici next urge this Court to consider the impact that the expansion of a physician's duty to non-patient third parties would have in terms of the large volume of people to which this new duty would apply. Given the large number of patients in this state who are affected by sexually transmitted diseases ("STD"s) and HIV/AIDS each year, the effect that such a new rule would have on Connecticut health care professionals providing such care is certainly not de minimus.

In 2015, the last year for which the Connecticut Department of Public Health ("DPH") published statistics for STD and AIDS/HIV rates, there were reported to be roughly 2,092 reported case of Gonorrhea, 13,269 reported case of Chlamydia, 99 reported cases of Syphilis, and roughly 10,727 people reportedly living with HIV/AIDS. See DPH, *STD Statistics in Connecticut*, http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388500 (last visited Dec. 21, 2017); DPH, EPIDEMIOLOGICAL PROFILE OF HIV CONNECTICUT, 2016 (2016), available at http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/epiprofile.pdf. Importantly, these numbers do not include the numbers of people diagnosed and/or treated

for what is commonly referred to as Herpes type 1 and 2, which the Centers for Disease Control and Prevention ("CDC") estimates to be one out of six individuals between the ages of 14 and 49 years of age. CDC, GENITAL HERPES-CDC FACT SHEET (2017), available at https://www.cdc.gov/std/herpes/herpes-feb-2017.pdf.

These numbers represent a population of over 26,000 identifiable people, as well as many more estimated by the CDC, being diagnosed and cared for by physicians, who potentially pose a new risk to physicians for liability and litigation. How will physicians and patients react if the Court adopts a rule that physicians' duty of care extends to lovers, spouses, and sex partners of these 26,000 people? Will physicians require that each patient seeking a diagnosis for an STD disclose the names and addresses of the people with whom these patients have had or could have a sex with? Will patients be unwilling to submit to STD testing if their physician requires such disclosure? What will the effect be on physicians' willingness to test for these diseases? All of these unanswered questions reflect why this Court should not be taking it upon itself to create a new rule that would have such a large impact on patient care when there is so much more research and deliberation to be done on the topic first.

c. Impact on Patient Confidentiality

Amici finally urge this Court to contemplate the ethical implications of expanding physician liability to a new class of non-patient plaintiffs. More specifically, the present case raises serious concerns concerning the ethical principles of patient-provider confidentiality and privacy.

Confidentiality between the physician and patient is a key concept in medical ethics. The American Medical Association Code of Medical Ethics ("Code") recognizes this and states:

> Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient.

AMA CODE OF MEDICAL ETHICS, Op. 3.2.1 (2016). The concept has been further recognized in law, as courts "have held physicians liable for failing to protect a patient's confidentiality" and "legislatures have imposed a legal requirement upon physicians to maintain patient confidentiality." Jake Taylor, Sex, Lies, and Lawsuits: A New Mexico Physician's Duty to Warn Third Parties Who Unknowingly May be at Risk of Contracting HIV from a Patient, 26 N.M.L. REV. 481, 488 (1996). Preserving trust between patient and physician is a guiding force in medical ethics, as greater trust in the relationship fosters better medical outcomes because the patient is more likely to confide key information to their physician. With more information, the physician can better treat the patient. If trust in the relationship breaks down, then the physician is more likely to get less relevant information from the patient or the patient may choose to not see the physician, further undermining medical care.

Along with confidentiality, patient privacy is also an important ethical concept and value. The Code states:

> Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

AMA CODE OF MEDICAL ETHICS, Opinion 3.1.1 (2016).

Specific exceptions allowing breaches of these principles do exist, in both the Code and in the law. For example, the Code says that "physicians may disclose personal health information without . . . consent of the patient . . . to mitigate the threat when in the physician's judgment there is a reasonable probability that . . . the patient will inflict serious physical harm on an identifiable individual or individuals." AMA CODE OF MEDICAL ETHICS, Opinion 3.2.1 (2016). This is the well-known Tarasoff exception, wherein the California Supreme Court broadened a behavioral health doctor's duty to a non-patient—specifically, the duty to warn— when the doctor knows that the patient is a threat to a non-patient individual. Tarasoff vs. Regents of the University of California, 17 Cal. 3d 425 (Cal. 1976).

Tarasoff is a key benchmark when deciding when to expand a physician's duty and "many jurisdictions have adopted its reasoning in one form or another." Jeffrey W. Burnett, A Physician's Duty to Warn a Patient's Relatives of a Patient's Genetically Inheritable Disease, 36 HOUS. L. REV. 559, 564 (1999). Tarasoff requires that the plaintiff be readily identifiable and that a "special relationship" exist between the physician and patient or physician and third-party. Id. at 564. The Tarasoff court explained that "courts have carved out an exception to this rule in cases where the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct." Tarasoff, 17 Cal. 3d at 435.

Exceptions like Tarasoff are the most ethically sound, as the third-party is readily identifiable, there is an emergency risk of serious physical bodily harm or death, and a special relationship exists. The disclosure of confidential medical information is discrete in nature and limited to exigent circumstances where immediate public safety concerns outweigh confidentiality principles. In contrast, should this Court in the present case

reverse the trial court and rule in favor of the plaintiff, physicians would then potentially have a duty to notify, either directly or indirectly, the sexual partners of their patients concerning the results of the patient's STD test. Given that this potential class of plaintiffs is so broad and unclear, any breach of privacy and confidentiality of the physician-patient relationship is much more significant and its potential impact on the physician-patient relationship much more profound. Accordingly, the weighing of these ethical concerns demands that non-expansion of the physician's duty in such cases is the most ethical outcome.

CONCLUSION

Amici have long advocated for reasonable limits on the ability of those persons harmed by the professional conduct of physicians to seek recourse against the physician who allegedly caused the harm. To that end, Amici express their grave concern with the expansion of a health care provider's duty of care to a non-patient under the facts of this case.

Connecticut precedent is clear that this Court favors the exercise of restraint when presented with opportunities to extend the duty of health care providers to persons who are non-patients. Moreover, it is nearly impossible to articulate a bright-line rule of foreseeability for the benefit of health care providers when, like here, the class of persons potentially exposed to injury from such care is so broad and cannot be readily identifiable at the time care is rendered. Most importantly, Amici are troubled that the creation of an entirely new class of potential plaintiffs, arising out of circumstances such as the ones set forth in this case, as well as under other circumstances that cannot be contemplated until the time a clever plaintiff's lawyer analogizes them to those in this case, will result in

several negative public policy consequences regarding the impact on medical malpractice insurance rates, patient care, and patient confidentiality. The potential negative effect on the willingness of physicians to engage in a type of practice where the extent of liability extends to both a class of plaintiffs unknown to the physician, and temporally into the future far beyond the current statute of limitations for medical malpractice claims, must weigh into the Court's considerations in this matter.

Although it is true that the courts are the principle vehicle for interpreting case law and precedent, time and again the critical nature of how physicians provide care to patients has required that the legislature act when deciding the scope of how that care is to be provided, and how disputes are resolved, when a patient, or non-patient, is dissatisfied with the care. The resources at the legislature's disposal include the ability to conduct investigations and public hearings into a number of issues confronting physicians and the public in the ways that medical care is delivered, and to oversee healthy debate regarding those very issues. The legal issues confronting this Court are inextricably intertwined with those that go to the heart of the practice of medicine. When such a confluence of issues come before any court, any decision which contemplates the changing of the status quo of the law should be evaluated carefully.

Ultimately, despite the sympathetic nature of the plaintiff's plight in the present case, Amici have to agree wholeheartedly with the trial court's quoting of Lawrence v. O & G Industries, Inc., 319 Conn. 641 (2015) in its memorandum of decision below: "While it may seem that there should be a remedy for every wrong, this is an ideal limited perforce by this world." Id. at 666. In light of the foregoing, Amici strongly urge this Court to hold that the trial court was correct in concluding that the plaintiff did not have a legally cognizable claim

against the defendant in the absence of a patient-provider relationship between the two parties.

Respectfully submitted,

December 28, 2017

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CERTIFICATION

Pursuant to Practice Book § 62-7 and 67-2, the undersigned certifies that the attached brief is a true copy of the electronically submitted brief, and that true copies were emailed and mailed first class postage prepaid on December 28, 2017, to:

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It is also certified that the brief complies with all the provisions of Practice Book § 67-2.

The undersigned attorney hereby certifies that this brief does not contain any name or other identifying information that is prohibited from disclosure by rule, statute, court order, or case law; and that the brief complies with all provisions of this rule pursuant to Practice Book § 67-2.

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