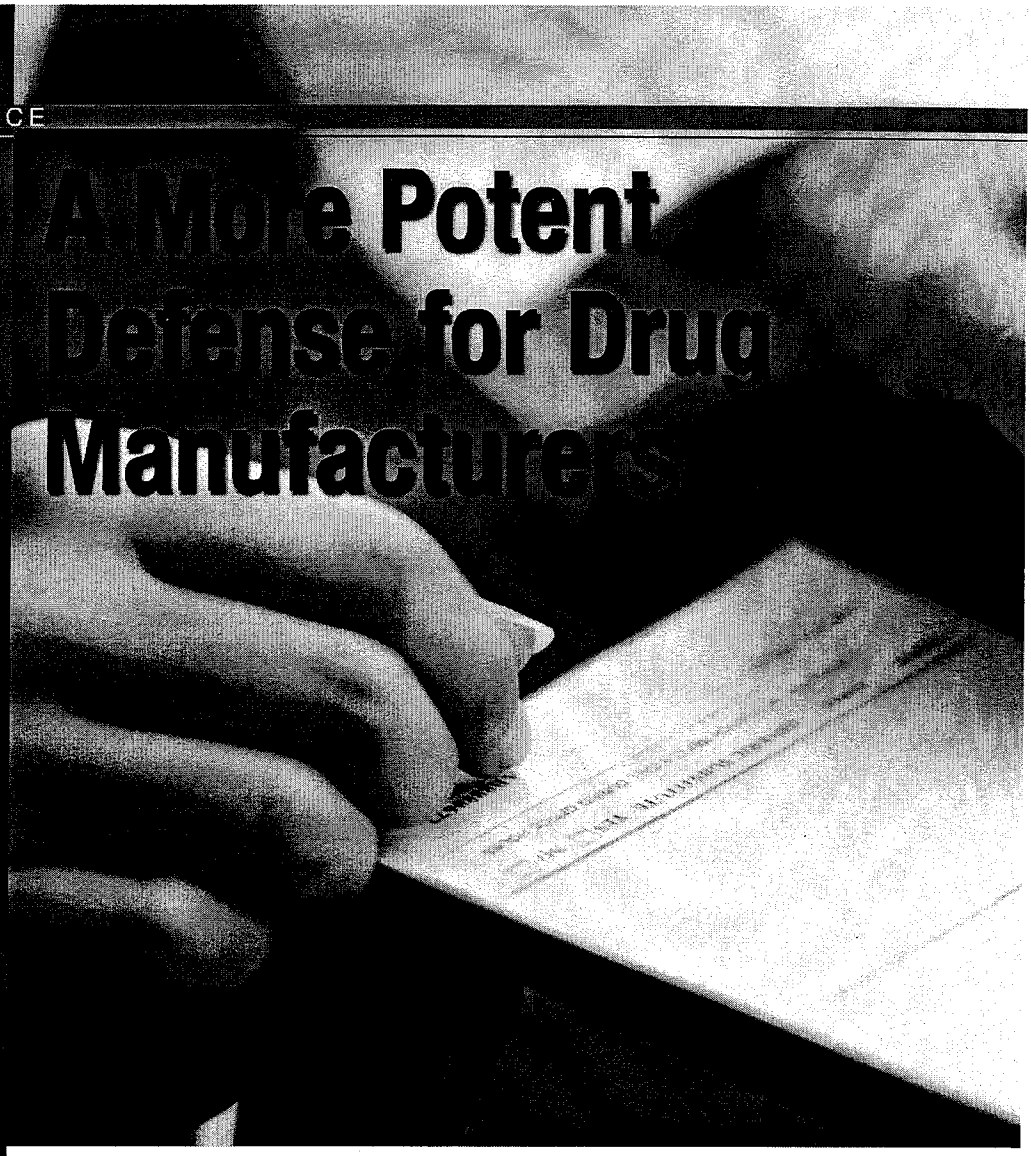
The Learned Intermediary

A More Potent Defense for Drug Manufacturers

By Matthew D. Keenan



Would a physician's prescribing preferences be influenced by a different warning?

Defense counsel knows well the important role that treating doctors can play in any case. Sometimes the treating doctor is a prominent member of the local community. In smaller venues these physicians may be health care providers to members of the jury or their families, and just one witness' views on such issues as causation and prognosis can singlehandedly dictate the outcome. Juror interviews often describe the testimony of such witnesses as one that "breaks the tie" between the battle of the experts.

And in those cases where the treating doctor doubles as the prescribing doctor, the importance of this witness is even greater. According to the laws of all 50 states, he or she is now the Learned Intermediary, the individual to whom the drug maker's legal duty to warn runs. This places the treating doctor—a witness who, in theory, has no axe to grind—in the unique position of endorsing the adequacy of the warning. His or her view of the warning can potentially trump the testimony of the plaintiff's warning expert. *See, e.g., Stahl v. Novartis*, 283 F.3d 254 (5th Cir. 2002) (Summary adjudication appropriate

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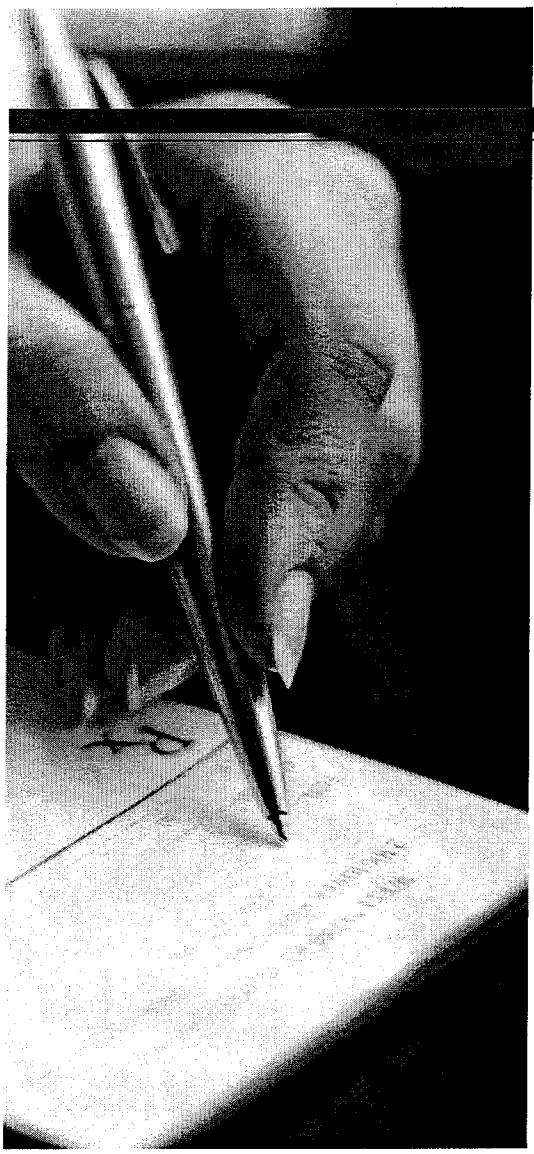

where plaintiff's prescribing physician testifies unequivocally that the warning was adequate to inform him or her of the risks involved in prescribing the drugs.)

But perhaps most importantly, the prescribing doctor can defeat a central element of plaintiff's case—proximate cause—by testifying a different warning would not have changed his conduct. When that happens, in most jurisdictions, this witness can single-handedly support a dismissal as a matter of law on warnings claims.

This article examines the current state of the law in this area, with an eye toward the FDA's long awaited and much anticipated pronouncements on new drug labeling. It also provides some practical ideas and suggestions to practitioners in navigating this ever-changing landscape.

The Learned Intermediary

This legal concept has a simple predicate—the physician "through education, experience and specialized training is in the best position to make a benefit/risk analysis in making the determination to prescribe a particular drug for a specific patient." *Doe v. Alpha Therapeutic Corp.*, 3 S.W.3d 404, 419–21 (Mo. App. 1999).

Consequently, "[t]he physician acts as a 'learned intermediary' between the manufacturer and the patient" in prescribing drugs and medical devices and passing on information about those treatments in his or her discretion. Therefore, "any warning given to the physician is deemed a warning to the patient." *Id.*

Restatement (Second) 402B, comment k gives additional support to the role of the learned intermediary. The unavoidably unsafe drug is insulated from liability typically so long as the warning is adequate. Most courts convert strict liability and negligence claims into failure to warn actions. For example, in *In re Norplant Contraceptive Prod. Liab. Lit.*, 955 F. Supp. 700, 709 (E.D. Tex. 1997), the court held that "the learned intermediary doctrine applies to all of Plaintiffs' causes of action" because the "gravamen" of each claim was the defendant's "failure to adequately warn of or disclose the severity of Norplant's side effects."

Why It Matters: Proximate Cause

In order to recover in a warnings case, the plaintiff must not only demonstrate the warning was inadequate, plaintiff must also prove the failure to warn produced—or was the legal cause of—the plaintiff's injury. *Porterfield v. Ethicon*, 183 F.3d 464, 468 (5th Cir. 1999). As an affirmative element in plaintiffs' case, plaintiffs must carry this burden. *See, e.g., Thomas v. Hoffman-La Roche, Inc.*, 731 F. Supp. 224, 229 (N.D. Miss. 1989). ("A plaintiff in a prescription drug products liability case has the burden of proving that an adequate warning to the prescribing physician would have altered the physician's conduct."). *Demmler v. SmithKline Beecham Corp.*, 448 Pa. Super. 425, 434, 671 A.2d 1151, 1155, *allocatur denied*, 546 Pa. 655, 684 A.2d 557 (1996). Even if the jury finds the warning inadequate, "*proximate cause is not presumed.*" *Id.* (emphasis added).

Some courts create a rebuttable presumption of proximate causation. In *Williams v. Lederle*, 591 F. Supp. 381, 387 (S.D. Ohio 1984), for example, the court noted that "Plaintiff is aided by a rebuttable presumption that the failure to provide adequate warnings was a proximate cause." Nevertheless, the court held that "evidence that an adequate warning would have made no difference in the physician's decision to prescribe a drug has rebutted the presumption."

Testimony by a prescribing physician that his or her prescribing conduct would be unchanged by a different warning typically presents itself in two ways. *First*, it may be demonstrated that the physician knew of the risk from sources other than the package insert. *See Wheat v. Pfizer*, 31 F.3d 340, 343 (5th Cir. 1994); *Tatum v. Schering Corp.*, 795 F.2d 925, 928 (11th Cir.1986). (The causal link between a patient's injury and the alleged failure to warn is broken when the prescribing physician had "substantially the same" knowledge as an adequate warning from the manufacturer should have communicated to him.) *Second*, it may be demonstrated that a new risk, not disclosed in the label but learned later, would not have changed the prescribing decision. *See Odom v. G.D. Searle*, 979 F. 2d 1001, 1003 (4th Cir. 1992) ("the burden remains on plaintiff to demonstrate that the additional non-disclosed risk was sufficiently high that it would have changed the treating physician's decision to prescribe the product for the plaintiff.")

There are other instances where the actions—not the opinions—of the prescriber defeats proximate cause. For example, where the prescriber did not read the package insert. In these cases, testimony by the prescribing physician that he or she did not read the warning label or rely on information provided by the manufacturer, the adequacy of warning cannot be the moving cause of the injury. *Motus v. Pfizer*, 358 F.3d 659, 660 (9th Cir. 2004).

Likewise when the physician is unavailable, there may be another basis for a motion. For example, in a Court of Common Pleas of Pennsylvania case, *Berry v. Wyeth*, 2005 WL 1431742 (June 13, 2005), the plaintiff chose not to depose her primary prescriber and received equivocal testimony from her dermatologist, who wrote one prescription for Pondimin, to establish that a different warning would have altered his behavior. *Berry*, 2005 WL 1431742 at *4. There, the court concluded, properly, that the plaintiff could not satisfy

her burden of proof under Pennsylvania law because there was no testimony from her prescribing physicians that they would not have prescribed Pondimin had Wyeth issued a different warning. *See id.* at *5.

Challenges to the Learned Intermediary

Not surprisingly, the plaintiffs' bar has little fondness for this defense. They have repeatedly challenged its appropriateness, with their most recent argument being that conventional physician/patient relationships have changed over the last decade. They cite to the explosion of direct-to-consumer advertising, the advent of lifestyle drugs, and Internet pharmacies as facilitating prescriptions with minimal physician interaction. Their contention is that the decision maker is less the physician and more the patient. Therefore, the drug maker owes the patient, not the physician, the duty to provide an adequate warning.

If a physician had independent knowledge of a risk not in the label, this defeats the proximate cause.

Plaintiff's legal journals have lent support to this argument, suggesting that "the pharmaceutical industry's attempts to influence the physician-patient relationship are paving the way for the rule's demise." Gerald D. Jowers Jr., *Drug Advertising and Accountability*, Trial Magazine, July 2003, p. 76.

Law reviews have joined the fray. One author, for example, argued "the learned intermediary rule in its current form does not adequately reflect the realities of the modern health care system and I propose reworking the Rule to better regulate today's pharmaceutical marketplace and better accomplish the main goals of tort law: compensation, deterrence, and cost allocation." T. Hall, *Reimagining the Learned Intermediary Rule for the New Pharmaceutical Marketplace*, Seton Hall Law Rev. 2004; 35(1):193–261.

Along the way, a few courts have recognized exceptions. The most prominent court to so hold is the New Jersey Supreme Court in *Perez v. Wyeth*, 734 A.2d 1245 (N.J. 1999). For that case, plaintiff's sought damages from the use of Norplant. There, the New Jersey Supreme Court adopted a narrow exception to the Learned Intermediary rule, applicable to "lifestyle" or non-therapeutic drugs and that may "cause significant side effects without any curative effects and... which are not medically necessary." *Id.* at 1257. Other exceptions are reserved for special cases such as mass vaccinations. *See Brazzell v. U.S.*, 788 F.2d 1352 (8th Cir. 1986). The vast majority of courts, however, have rejected these efforts.

Strategies for Defense Counsel

While every case turns on its own facts, more often than not defense counsel should take a hard look at initiating prescriber testimony. Certainly there may be a reason to avoid this deposition altogether if, for example, the doctor is outside the court's subpoena power and the court will enforce a discovery cut-off.

However, plaintiff's counsel should not be expected to overlook deposing such an important witness. Here are some things to consider when contemplating this discovery. At one time, the prescriber believed that your client's drug was an appropriate choice for the plaintiff. Ideally, this suggests some favorable clinical experience with your client's product including a weighing of risks—including unknown risks (and benefits)—yet deciding it was a logical choice.

Do Your Homework

Learn the physician's prescribing history. Explore his or her track record with the drug, how long he or she prescribed it, did the doctor's prescribing habits change in the face of new warnings, did the doctor receive Dear Doctor letters, or other new information about the drug. This information is normally maintained either by your client or third parties. Physicians know and understand that the risk-benefit equation is a moving target. Peer review journals will report new studies or even case reports that might alter the risk/benefit equation. Do their prescribing habits change?

Contact the Doctor

Individual state rules may differ on the issue of *ex parte* contacts with treating physicians, but all concern the patient records and patient issues. Generic, non-patient-specific interviewing is not generally restricted or prescribed. *See, e.g., Steinberg v. Jensen*, 534 N.W. 2d 361 (Wisc. 1995). ("Defense counsel may communicate *ex parte* with a plaintiff's treating physician so long as the communication does not involve the disclosure of confidential information.") Suggestions include the following: "I cannot speak to you about her medical records and anything I ask you should not be considered in that way. Do you understand?" Such a tactic should permit questions such as: "Would you consider using the drug today?" or "What was your prescribing practice, generally?" The downside risk is that you potentially tarnish the independent perception of the witness by first contacting him or her. But knowing his or her generic views of your product can be very useful in advance of the deposition.

Go First

Setting the tone of the questioning can go a long way to dictating the substance of the testimony. All of us recognize the inherent benefits to creating the first record in a deposition, *e.g.*, "Did you have a good clinical experience with this drug?" (Some would argue that there is an equal if not greater benefit to going second or asking leading questions. This should be weighed against the potential upside.)

Putting the Prescriber at Ease

In these days of mass torts, prescribers can naturally feel vulnerable. Litigation involving their patients is one step removed from litigation involving them. In terms of setting the tone, this can help improve the prospects for testimony favorable to the manufacturer. "Do you understand my client is not second guessing your clinical judgment?" "Do you understand my client has no criticisms of your care?"

Sources of Information beyond the Label

Physicians rely on many sources of information, going beyond simply the label. This is perhaps the most important aspect of the Learned Intermediary Doctrine. Physicians are well read, or if not, often don't wish to admit that they aren't. If a physician had independent knowledge of a risk not in

the label, this defeats the proximate cause. *Wheat v. Pfizer, Inc.*, 31 F.3d 340, 343 (5th Cir. 1994) (plaintiffs who claim that a package insert is inadequate must demonstrate that a proper warning would have changed the decision of the treating physician).

Experience with a Class of Drugs

Drug types fall into classes of drugs, often with class warnings. Whatever the physician's experience with your drug—good or bad—you may be able to elicit favorable testimony first with his or her experience with the class of drugs, *e.g.*, SSRIs, statins, oral contraceptives. Then you can address more specific questions as to your own client's product.

Drugs Withdrawn from the Market

Often, withdrawn drugs are those that physicians have had a good experience with, or have a subset of patients who do well with them. The high efficacy and rare risk of side effects still may make it a good choice, despite the manufacturer's decision of product removal. "Even in the face of new information, would you consider using it for the appropriate patient." "Is this a drug you would like to have available as an option for the right patient?"

FDA Expertise

The physician's specialty is in clinical care, not knowledge of FDA regulations. Questions about labeling content are best made by the FDA. Give the doctor an opportunity to side step this minefield. "Would it be fair to say that identifying what risks should be included in the label is best left to the FDA?" "The FDA and its staff, and not you, is in a better position to determine what risks should be on the label?"

"Would it be helpful to know...?"

These are difficult questions because some physicians will agree that "more information is always better." On the other hand, physicians rely on the FDA to make the determination about what rises to the level of inclusion in the label. In other words, it is not simply quantity but quality that is important to a physician. Indeed, more information, alone, can potentially be counter productive. For example, knowledge of Adverse Event Reports—without any indication of causality—may not be useful to a clinician. Similarly, numbers of reports, alone, say little about the risk/benefit profile without information about the denominator—the total number of prescriptions. As described below, recent changes in labeling regulations should preclude prescribers from opining on an inadequate warning because they are not qualified to do so. Only the FDA can do that.

New FDA Rules

In the face of all these developments, the FDA announced new substantive rules governing FDA labels. 21 C.F.R. parts 201, 314, and 601. These are the first substantive revisions to drug labels in 25 years. These new rules go into effect on June 30 for new drugs. Medications approved in the lat five years will be phased in gradually. Manufacturing of older drugs are not required to change their labels, unless there is a major change in prescribing information. Notably, these rules will change matters in new and helpful ways for both manufacturers and their counsel. They will reinforce the important role of the Learned Intermediary, and make the discovery of these witnesses a safer bet for defense counsel.

As the preamble to the regulations states: "These revisions will make it easier for health care practitioners to access, read, and use information in prescription drug labeling. The revisions will enhance the safe and effective use of prescription drug products and reduce the number of adverse reactions resulting from medication errors due to misunderstood or incorrectly applied drug information." The medical community has uniformly praised these changes. One physician journal observed that the old labels "have become largely a legal document aimed at protecting drug makers." *New Drug Labels: Easing Information Overload*, Editorial, American Medical News (amednews.com), March 13, 2006. The new format, the writer observed, "will help doctors out of the swamp of drug data and will equip them better to assist patients in traversing this difficult terrain." *Id.* The advent of these rules once again underscores the importance of the Learned Intermediary in the litigation landscape.

There are at least five significant aspects of this language.

A Stronger Learned Intermediary

These changes invigorate the Learned Intermediary by making the physician the centerpiece for receiving and imparting product information.

More Information, More Timely

The FDA is dictating an electronic labeling initiative. "The agency believes that an electronic version of labeling in the new format, particularly Highlights and Contents, will significantly expand health care practitioners' ability to access information in prescription drug labeling, enable them to rapidly obtain answers to questions for a range of drug products and ultimately facilitate the development of a comprehensive repository for drug labeling."

New Information Highlighted

Clinicians will be able to quickly identify "what's new" in the label. This obviously advances patient safety. At the same time, this facilitates the communication of new warning language in labels, thereby defeating the plaintiff's argument that new warning language was "buried in the back."

More Patient—and Jury—Friendly

The label features a new highlights section, which summarizes the most important prescribing information, including boxed warnings. The FDA considers this "highlights" section to be the most important change of all these new regulations.

The Use of an Inverted Black Triangle

This new labeling icon is to call attention to drugs that have been on the market less than three years. It underscores an important defense theme—that new drugs have unknown side effects. In effect, the new labeling rules take an existing defense theme and give it the FDA's endorsement.

Preemption

These new rules include the FDA's statement on federal preemption. An extensive discussion of preemption is beyond the scope of this article. Nevertheless, the FDA's preamble underscores that preemption remains a viable defense, and indeed defendants are pursuing this with more support then ever before.

The preemption language was not codified as part of the labeling rule making. It is not therefore part of the rule. That aside,

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the preamble expressly rejects the notion that the regulations are the minimum standards. "In fact, FDA interprets the act to establish both a 'floor' and a 'ceiling,' such that additional disclosures of risk information can expose a manufacturer to liability under the act if the additional statement is unsubstantiated or otherwise false and misleading."

New Plaintiff Strategies

While one cannot predict all the ways that plaintiffs will respond to these changes, it seems certain that they will plead legal theories to avoid the learned intermediary defense. They will prosecute manufacturing and design defect claims more aggressively. In most states, design defect claims represent "risk over benefit" and permit an argument that there is no benefit to the drug. In cases of drug withdrawals, this strategy may become more popular than in the past, while avoiding the risk of being converted into a warnings claim.

Plaintiffs will attempt to plead consumer fraud actions, thereby circumventing the Learned Intermediary defense. Most courts have rejected plaintiffs' attempts to use consumer protection statutes in this way. *See Wyeth-Ayerst Laboratories v. Medrano*, 28 S.W.3d 87 (Tex. Ct. App. 2000) (Texas Appellate Court reversed a judgment for a plaintiff who alleged DTPA claim in effort to circumvent Learned Intermediary Doctrine.)

Plaintiffs will continue to assert claims of FDA nondisclosure. Now, however, plaintiffs may attempt to turn this electronic label initiative to their benefit by contending that mechanisms are in place for rapid changes to product labels. Defendants have always had available the option of making label changes under the "changes being effected" (CBE) supplement to 21 C.F.R. 314.70, which permits label changes without first obtaining FDA approval. Expect greater scrutiny on this aspect of failure to warn claims.

Summary

In short, now more than ever, the defense of Learned Intermediary remains a powerful weapon to pharmaceutical manufacturers. With the FDA's sweeping changes to product labeling, product information will be easier for physicians to access and understand. These changes will increase patient safeguards and reduce the potential for adverse drug reactions and interactions. At the same time they empower defense counsel with renewed options to elicit favorable prescriber testimony on the essential tort element of proximate cause. **FD**