
UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

EVELYN HEINRICH, et al.,

Plaintiffs-Appellees

v.

ELIZABETH DUTTON SWEET
and FREDERICK H. GREIN, JR.,
Representatives of the Estate of
WILLIAM H. SWEET, M.D.,

Defendants-Appellants

ON APPEAL FROM A JUDGMENT OF
THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BRIEF OF AMICI CURIAE
in Support of Defendants-Appellants
Elizabeth Dutton Sweet
and Frederick H. Grein, Jr.,
Representatives of the Estate
of William H. Sweet, M.D.

PROFESSIONAL LIABILITY FOUNDATION, LTD.,

MASSACHUSETTS MEDICAL SOCIETY,

AMERICAN MEDICAL ASSOCIATION, and

AMERICAN COLLEGE OF SURGEONS

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, the amici curiae make the following disclosures.

The Massachusetts Medical Society and the Professional Liability Foundation, Ltd. are Massachusetts corporations. Neither is held by a parent corporation and neither is a stock company.

The American Medical Association is an Illinois corporation. It is not held by a parent corporation and is not a stock company.

The American College of Surgeons is an Illinois corporation. It is not held by a parent corporation and is not a stock company.

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STATEMENT OF INTEREST AND AUTHORITY

The Professional Liability Foundation, Ltd., the Massachusetts Medical Society, the American Medical Association, and the American College of Surgeons respectfully submit this brief as amici curiae in support of William H. Sweet, M.D. They do so with the consent of the parties.

The Professional Liability Foundation, Ltd. ("PLF") is a non-profit Massachusetts corporation established in 1995. The purposes of PLF include improving the quality and affordability of patient health care, promoting reforms in the medical tort and professional liability insurance system, supporting legislation and/or administrative regulation consistent with its goals, and participating in litigation where necessary to express the views of its members. In addition to the MMS, which participates separately in this case, the members of the PLF represented by its advocacy voice include Baystate Health System, Caritas Christi Health Care System, the Massachusetts Hospital Association, New England Medical Center, ProMutual Group, and the Risk Management Foundation of the Harvard Medical Institutions Inc., The Massachusetts Medical Society ("MMS") is a non-profit corporation which was chartered by the Massachusetts General Court in 1781 to "advance medical knowledge, [and] to develop and maintain the highest professional and ethical standards of medical practice and health care." It is the oldest continuously operating medical society in the United States and currently has more than 17,000 physician and medical student members.

Founded in 1847, the American Medical Association ("AMA"), an Illinois not for profit corporation, is a professional organization of physicians and is the largest medical society in the United States. Its approximately 275,000 physician members practice in all fields of medical specialization and in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health. It is a federacy of its constituent state associations,

including MMS. The AMA submits this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies (“Litigation Center”). The Litigation Center, a coalition of the AMA and 50 state medical societies, including MMS, was established to present the views of the medical profession to the courts.

The American College of Surgeons is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The College currently has more than 56,000 members (referred to as Fellows), including more than 3,400 members in other countries, making it the largest organization of surgeons in the world. There are presently more than 3,300 associate members (Associate Fellows).

The amici curiae share an interest in the proper application of legal standards to physicians in relation to the practice of medicine. That interest includes within its scope the proper application of statutes of limitations to claims that may be asserted against physicians by patients or their representatives. In this case, the statute of limitations was deemed to be tolled by the alleged failure on the part of Dr. Sweet to inform his patients that he had acted negligently in his treatment of them. Such an application of the doctrine of fraudulent concealment rests upon a misconception of the physician-patient relationship and a misapprehension of Massachusetts law.

ARGUMENT

I. Introduction

The tolling of the statute of limitations in this case under a theory of fraudulent concealment represents a fundamental misapplication of Massachusetts law. This misapplication, if allowed to stand unchallenged, could have far reaching effects on the effectiveness of the statute of limitations as applied to medical malpractice cases. The District Court's theory of fraudulent concealment and the manner in which the fraudulent concealment statute was applied to this case, based upon a fiduciary duty theory arising from the physician-patient relationship existing between Dr. Sweet and his patients, Mr. George Heinrich and Mrs. Eileen Sienkewicz, is unreasonable, unworkable, and not supported by Massachusetts law.

The starting point for appellate review on this point is the jury verdict finding in Dr. Sweet's favor on the issue of informed consent. That finding demonstrates that the jury concluded that the patients were provided with "all significant medical information that the physician possess[ed] or reasonably should [have] possess[ed] that [was] material to an intelligent decision by the patient whether to undergo [the] proposed procedure." Harnish v. Children's Hospital Medical Center, 387 Mass. 152, 154 (1982); (16:28) (jury instructions quoting Harnish) The process of obtaining informed consent, while it has doubtless evolved over the 40 years since the events at issue occurred, is in essence a way of ensuring patient choice and self-determination. Shine v. Vega, 429 Mass. 456, 464 (1999). The physician's role is to inform the patient, so the patient may decide whether to

proceed with a treatment option, based upon a dialogue with the physician about the risks and benefits of that treatment, as well as other available options, including the decision to forgo treatment altogether. [Shine v. Vega cite] “Appropriate information may include the nature of the patient’s condition, the nature and probability of risks involved, the benefits to be reasonably expected, the inability of the physician to predict results, if that is the situation, the irreversibility of the procedure, if that be the case, the likely result of the treatment, and the availability of alternatives, including their risks and benefits....” Harnish, 387 Mass. at 154. In this case, the jury found that Dr. Sweet had obtained informed consent from Mr. Heinrich and Mrs. Sienkewicz. That finding precludes the finding, that the District Court imputes to the jury, that Dr. Sweet “failed to disclose that performing the experiments on human beings was negligent.” [citation]

As to fraudulent concealment, the district court ruled that physicians have a fiduciary duty to disclose known possible causes of actions to patients fully. Heinrich III, V at __. The judge instructed the jury that if a physician-patient relationship existed between Dr. Sweet and Mr. Heinrich and Dr. Sweet and Mrs. Sienkewicz, that Dr. Sweet was a fiduciary and “he has a responsibility to disclose data, data that he has. . . .And there isn’t that duty to inquire on your own if you’ve got a doctor-patient relationship, because the doctor, acting as a fiduciary, is supposed to tell you the data necessary for you to inquire further and take action. . . . The doctor is required, if the doctor knows that there is the data supporting a potential claim, even though it may be a claim against him or others, he’s got to disclose that. He’s got to disclose that to the people who can act on that claim. That goes with the relationship of being a fiduciary for the care of a patient.” (16:22) Given the complexity and the novelty

of the application of the fraudulent concealment statute in the context of the physician-patient relationship, this jury instruction did not provide the jury with sufficient guidance to reach a reasonable conclusion as to the proper application of that statute on the facts in this case. As set forth below, this jury instruction goes beyond the existing precedent in Massachusetts law and does so in ways that are inconsistent with the principles governing the physician-patient relationship.

II. The Jury Finding As To Informed Consent Precludes a Finding of Fraudulent Concealment.

As the District Court acknowledged, the informed consent verdict for defendants directly communicated the jury's conclusion with respect to Dr. Sweet's honesty with his patients, Mr. Heinrich and Mrs. Sienkewicz: "Implicit in the jury finding is the view, necessarily adopted by this Court, that those of Sweet's patients that are involved here were kept fully apprized [sic] of Sweet's knowledge and proceeded voluntarily in light of it." Heinrich V at 91. Despite this statement, the District Court maintained that the jury could have found that there was something that Dr. Sweet failed to disclose to the patients about the procedure. "While Dr. Sweet may have informed the Plaintiffs that the treatment was risky and uncertain, he failed to disclose that performing the experiments on human beings was negligent. That is what the jury found and it was consistent." [Citation] However, this attempt to reconcile inconsistent jury verdicts is simply unworkable given any accepted legal or medical definition/

¹ of informed consent.

As set forth in the Brief for Defendants-Appellants Elizabeth Dutton Sweet and Fredrick H. Grein, Jr., Representatives of the Estate of William H. Sweet, M.D. (“Dr. Sweet’s Brief”), pp. 31-34, a finding of informed consent means that the jury concluded that Dr. Sweet had disclosed to Mr. Heinrich and Mrs. Sienkewicz all the information material to their decision to undergo the procedure. In light of this finding, no reasonable jury could also have found that Dr. Sweet knew, but failed to disclose, “that performing the experiments on human beings was negligent.”

III. The Application of the Fraudulent
Concealment Statute to this Case Represents
an Unwarranted Extension of Massachusetts Law.

A. No Massachusetts Court Has Upheld the
Tolling of the Statute of Limitations Based

¹/ Current American Medical Association (AMA) ethical policy regarding informed consent states in part: “The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician’s obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. . . .Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.” AMA Council

could not be said to have engaged in fraudulent concealment by mere silence.”); Fowles v. Lingos, 30 Mass. App. Ct. 435 (1991) (“For some purposes (e.g., treatment) the doctor-patient relationship is a fiduciary one “ and therefore “there may be some circumstances where there is a duty to disclose a cause of action.”). See also Riley v. Presnell, 409 Mass. 239 (1991) (noting that there are fiduciary aspects to the psychotherapist-patient relationship and that failure of a psychotherapist to reveal facts relevant to a potential malpractice action will toll the statute of limitations until the plaintiff discovers the cause of action).

While the Massachusetts courts have recognized the possibility of such a situation, there is no appellate decision upholding a finding of sufficient facts to establish that a physician has fraudulently concealed a cause of action by being silent when he had a duty to speak. The Massachusetts courts have approached this theory with such caution that it remains largely undeveloped. From this sparse precedent,³ the District Court ruled that a reasonable jury could find that Dr. Sweet breached a duty to disclose his negligence to his patients more than thirty years ago -- despite the lack of evidence that Dr. Sweet himself knew or believed he was negligent (Dr. Sweet’s Brief, pp. 32-33), and in the face of a contrary jury finding that Dr. Sweet had disclosed all the known risks and benefits to the patients at the time. This expansive application of a fraudulent

³ The district court relied in part for this extension of the Massachusetts precedent upon Bourassa v. LaFortune, 711 F. Supp. 43 (D. Mass. 1989). In that case; the District Court (Harrington, J.) ruled that: “It is this court’s judgment that Massachusetts courts, if presented with this issue, would rule that, if a doctor knows or believes that a cause of action exists and fails to disclose it to the plaintiff, he will have breached his fiduciary relationship and violated his professional duty thus tolling the statute of limitations”). As the Massachusetts Appeals Court pointed out in Fowles, 30 Mass. App. Ct. at 441-442, in declining to follow Bourassa, the trial judge did not specify what evidence, if any, was

concealment theory to Dr. Sweet's conduct does just what the Massachusetts courts have declined to do thus far (i.e., to hold a physician accountable for fraudulent concealment for failing to disclose something without demonstrating that he believe it).

In Fowles v. Lingos, the Massachusetts Appeals Court correctly noted that a broad reading of section 12 would be unworkable and would put an intolerable burden on physicians. In Fowles, the Appeals Court, like the Supreme Judicial Court in Maloney, made clear that the relevant question for purposes of tolling the statute of limitations is the actual knowledge or belief of the physician himself as to whether he has been negligent, and not the opinion of a third party who concludes in retrospect that the physician had in fact been negligent. The court rejected the idea that a plaintiff could evade the statute of limitations by showing that the physician had failed to disclose evidence of a difference of opinion about the applicable standard of care or by showing that a physician has failed to divulge some adverse criticism. "To read into G.L. c. 260 § 12, a duty to disclose in such circumstances would . . . increase immeasurably the risks undertaken by physicians." Fowles, 30 Mass. App. Ct. at 441. Given these cases, which indicate the Massachusetts courts' strict evidentiary requirements and their understanding of how problematic an importation of the fiduciary duty theory of fraudulent concealment could be in the context of the physician-patient, it is inappropriate for the District Court to permit a jury finding to stand without any specific evidence that would support it. To the extent that this theory may gain any vitality in Massachusetts, it should be shaped by the Massachusetts courts, and the federal courts should approach such cases with caution rather than an expansive approach. See Burris Chemical, Incorporated v. USX

presented by the plaintiff to suggest fraudulent concealment of facts that the defendant

Corporation, 10 F.3d 243, 247 (4th. Cir. 1993) (“Under Erie Railroad v. Tompkins [304 U.S. 64, 78 (1938)], the federal courts sitting in diversity rule upon state law as it exists and do not surmise or suggest its expansion.”). See also Demars v. General Dynamics Corp., 779 F.2d 95, 101 (1st Cir. 1985) (“we are in the business of applying state law, not changing it”).⁴

⁴ In this case, the District Court applied an undeveloped line of Massachusetts cases to permit a claim to go forward on very tenuous evidence, almost forty years after the events in question, at a time when the physician himself is not even able to testify as to what he knew or believed.

B. The Ill-Advised Interpretation of a Physician’s Duty Applied in this Case is Outside the Scope of the Physician’s Professional Duty to Disclose as Defined by the Physician’s Duty to Treat the Patient.

Communication between physician and patient about the patient’s medical condition is an integral part of the treatment relationship. The physician discloses to the patient material information related to the patient’s care, whether it is for purposes of informed consent or other treatment-related purposes. Without delving into the history of differences between how these concepts were articulated in 1960-1961 as opposed to the

physician had a duty to disclose.

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The question of the proper application of the fraudulent concealment statute as a matter of Massachusetts law could have been and could still be certified to the Supreme Judicial Court pursuant to its Rule 1.03.

present day⁵, it is sufficient to say that a relationship of trust and confidence is central to the physician-patient relationship, and part of that relationship includes an expectation that the physician will act in the best interest of the patient's care when determining what information should be communicated to the patient. In that sense, amici, like the Massachusetts courts, agree that it could be said that there is a "fiduciary" aspect of the physician-patient relationship which requires the physician, in the course of his professional relationship with a patient, to communicate truthfully with the patient about the patient's medical condition and the physician's professional judgment concerning that condition. However, as the Massachusetts courts correctly note, to the extent that the physician's duty to disclose information is relevant to the fraudulent concealment analysis, it certainly does not encompass a duty to advise a patient of information that the physician himself does not know or believe to be true. Such a requirement would run contrary to the physician's duty to give his patient his best professional judgment, and serve no medical purpose. In this case, as demonstrated by Dr. Sweet's Brief, pp. 32-33, there is no evidence that Dr. Sweet knew or believed that he had been negligent in his

⁵ For example, Section 1 of the 1957 Version of the AMA Principles of Medical Ethics state in part "[p]hysicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion." A current AMA ethical policy, American Medical Association Council on Ethical and Judicial Affairs Opinion E-8.12, entitled "Patient Information," states in part: "It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care. . . . Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a

care of these patients, and the jury finding of informed consent establishes that Dr. Sweet fully informed these patients of what he knew and believed about the risks and benefits the procedure offered for their condition.

An additional issue that does not appear to have been considered by the Massachusetts courts (unsurprisingly, given the undeveloped state of the law in this area) is to what extent a duty of disclosure owed to a patient by a physician differs from the duty owed by a fiduciary in other contexts (such as a trustee-beneficiary relationship, e.g., Demoulas v. Demoulas, 424 Mass. 501, 519 (1997)). For example, given that the duty of disclosure in the case of the physician-patient relationship arises out a specific treatment relationship it is in most circumstances limited by the duration of that relationship.⁶ The District Court did not instruct the jury with respect to the termination or continuation of the physician's fiduciary duty upon the death of the patient. The Massachusetts cases do not provide much guidance on this point.

IV. The District Court's Interpretation of
Massachusetts Law Runs Contrary to the Public
Policy Underlying the Statute Of Limitations.

patient.” American Medical Association Council on Ethical and Judicial Affairs Opinion E-8.12, “Patient Information” (Issued March 1981; Updated June 1994.)

⁶ There may be some circumstances where a physician would be required to alert a patient to a condition despite the patient's termination of the relationship, when the results of treatment have not yet been conveyed to the patient, see Gray v. Kieger, 27 Mass. App. Ct. 583 (1989). However, “Nothing in Gray v. Kieger, supra, suggests that a physician who believes that the patient has reached the end of his needed treatment has some ongoing duty to that patient that it breached by failure to followup with that patient.” Harlfinger v. Martin, 435 Mass. 38, 51 (2001)

The facts in this case provide a powerful illustration of the policies underlying the statute of limitations. Dr. Sweet, who was approximately 50 years of age when he performed the procedures at issue, was approximately 85 years of age when plaintiffs filed suit against him in 1995. Dr. Sweet did not testify at trial because he was no longer competent. Dr. Sweet's Brief, pp. 21, 24. The statute of limitations should serve to provide one with security and stability at the end of one's life with respect to activity performed more than thirty years earlier. Moreover, Dr. Sweet's inability to testify shows how evidence is lost or becomes unavailable over time. The integrity of the adjudicatory process is diminished when the facts at issue occurred in the remote past.

The application of the fraudulent concealment statute to toll the period of limitations for more than thirty years in this case runs contrary to the fundamental policies underlying the statute of limitations. Such a statute balances the interests of one who has suffered a wrong against the equally important interests of the other members of society, who need security and stability in their affairs. Harlfinger v. Martin, 435 Mass. 38, 43 n.8, __ N.E.2d __, n.8 (2001); Franklin v. Albert, 381 Mass. 611, 618, 411 N.E.2d 458, 462-63 (1980); Nudd v. Hamblin, 90 Mass. 130, 132-33 (1864). Such a statute also promotes adjudication on the basis of fresh and complete evidence. Harlfinger v. Martin, 435 Mass. at 43 n.8, __ N.E. 2d at __ n.8; Franklin v. Albert, 381 Mass.at 618, 411 N.E.2d at 463. See also Riley v. Presnell, 409 Mass. at 254, 565 N.E.2d at 790 (O'Connor, J., dissenting) ("Protracted delay, with its attendant loss and staleness of evidence, results in unfair litigation."). Moreover, "[t]he problem of defending stale medical malpractice claims is further exacerbated by the fact that the standard of care is itself subject to rapid and dramatic change, fueled by advances in medical science and

technology. From a defendant's perspective, demonstrating the standard of care of many years past, and that the defendant's treatment of the plaintiff did not deviate from it, can be very difficult" Harlfinger v. Martin, 435 Mass. at 43 n.8, ___ N.E.2d at ___ n.8. As plaintiffs' claims raise the question whether Dr. Sweet conformed to the standard of care in 1960 and 1961, the statute of limitations should serve to protect Dr. Sweet from the burden of presenting testimony as to the standard of care applicable to conduct that occurred approximately 35 years before the filing of the complaint.

To permit a determination by another person (especially many years later) that conduct was negligent to establish the physician's belief at the relevant time that he was in fact negligent turns the statute of limitations on its head and could have widespread undesirable results. It would require physicians to disclose to patients the opinion of others even when the physician does not himself agree with them, just to avoid a tolling of the statute of limitations. This interpretation would not advance the policy reasons for tolling the statute of limitations --- preventing a wrongdoer from escaping liability by unfair concealment -- and would not improve the quality of the patient's care. In fact, it could have the harmful effect of discouraging peer review and other types of critical analysis that contribute enormously to the improvement of the quality of medical care.

Conclusion

For the reasons set forth above as well as those set forth in Dr. Sweet's Brief, plaintiffs may not avoid the period of limitations through reliance upon the Massachusetts fraudulent concealment statute. The Court should rule that the finding of fraudulent concealment in this case was clearly erroneous.

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