The Use of Litigation Screenings in Mass Torts: A Formula for Fraud?

Lester Brickman

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The Use of Litigation Screenings in Mass Torts: A Formula for Fraud?

Lester Brickman*

I. Introduction

Mass tort litigation\(^1\) has grown dramatically in the past several decades,\(^2\) facilitated by changes in social, industrial, economic and legal conditions, practices and structures.\(^3\) Perhaps the most critical factor accounting for the rise of mass tort litigation is the enormity of the financial rewards in the form of contingency fees available to lawyers who successfully initiate or otherwise participate in such actions.\(^4\) Mass tort claims sharing similar factual issues and

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\(^*\) Professor of Law, Benjamin N. Cardozo School of Law of Yeshiva University. My research assistants, Tim Yip, Alisa Levien and Steven Keslowitz, have made important and substantial contributions to this article for which I am grateful.

\(^1\) The term “mass tort” refers to claims of injury by large numbers of persons allegedly caused by the ingestion, inhalation or implantation of a particular product or substance into the body which is harmful. The injuries suffered may be latent and not manifest for years or decades after the contact with the product or substance. See generally, Richard A. Nagareda, Mass Torts in a World of Settlement (2007) [hereafter, Nagareda, Mass Torts].

\(^2\) See e.g., Karen A. Geduldig, Casey at the Bat: Judicial Treatment of Mass Tort Litigation, Note, 29 Hofstra L. Rev. 309 at 310 (2000) (citations omitted) (noting that “[b]y 1990, [mass tort claims] encompassed seventy-five percent of all new federal product liability filings,” and that “in some jurisdictions, mass tort claims stemming from exposure to products or toxins accounted for over twenty-five percent of the entire civil caseload. In fact, mass tort litigation has evolved into the single largest category of personal injury litigation in the United States today.”) See also Advisory Committee on Civil Rules and the Working Group on Mass Torts to the Chief Justice of the United States and to the Judicial Conference of the United States, Report on Mass Tort Litigation 9 et seq. (Feb. 15, 1999).

\(^3\) See Deborah R. Hensler & Mark A. Peterson, Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis, 59 Brook. L. Rev. 961, 1013-14 (1993). Among these trends are increases in product marketing that have led to mass consumption of goods and services and therefore greater exposure to their potentially dangerous effects, advances in medical technology that enable medical experts to connect injury with exposure to products or chemical substances, epidemiological studies, increased mass media reporting of potentially dangerous products or circumstances including the increased role of television journalism shows—productions that are sometimes assisted by lawyers who are financially interested in sensationalizing coverage of an issue in order to affect public opinion or generate a client base.

\(^4\) The Korien Tillery firm has amassed over $1.8 billion in settlements of class actions filed mostly in Madison County, Illinois against such companies as IBM, AT&T, Ameritech, Xerox, MCI, GlaxoSmithKline, Allstate and SBC, generating an estimated $600 million in fees. See Braggin’ Rights, The (Madison County) Record, Dec. 16, 2007 at 9:45 a.m., available at [www.madisonrecord.com](http://www.madisonrecord.com) (last accessed on Dec. 17, 2007).
causation\textsuperscript{5} can be litigated individually or aggregated into class actions or large consolidations.\textsuperscript{6} The paradigm mass tort personal injury litigation alleges that a widespread injury was caused by exposure to or use of, defectively produced products ingested, inhaled or implanted into the body.\textsuperscript{7} The “mass” in mass torts refers to the fact that thousands -- even tens and hundreds of thousands of persons -- are alleged to have been injured by contact with or use of the product, causing bodily injury which can, \textit{in toto}, amount to hundreds of millions and even billions of dollars and contingency fees of a comparable magnitude.

The key to successfully initiating a mass tort litigation is gaining the critical “mass.”\textsuperscript{8} Once having identified a potential mass tort, plaintiffs’ lawyers must satisfy two burdens. First, they must present evidence that exposure to a substance can cause a particular disease; and second, they must produce additional evidence that an individual litigant’s disease was caused by

\textsuperscript{5} Similar factual issues and legal questions will arise in all claims in a mass tort litigation, or at least in a significant subset of claims. The same injuries will involve similar causation issues. Liability issues will be similar among claims alleging similar exposures to a particular defendant’s products.” Hensler & Peterson, \textit{supra} note 3, at 966.

\textsuperscript{6} Mass tort litigation is often in the form of a class action, mass consolidation or other aggregative form but also may simply involve thousands of substantially similar individual claims. See Howard Erichson, \textit{Informal Aggregation: Procedural and Ethical Implications of Coordination Among Council in Related Lawsuits}, 50 DUKE L.J. 381 (2000).

\textsuperscript{7} Other personal injury mass torts may be generated by a calamity, improperly designed or constructed vehicles or components of vehicles, or improper design of materials or structures. Some mass tort litigations allege only economic injury. Typically, for the latter, the economic injury to each claimant is small, but in the aggregate, the loss alleged is substantial. In actions based upon fraud, allegations are made that a bank, insurance company, credit issuer, airline or other goods seller or service provider, in the course of selling the service or product, defrauded thousands or even hundreds of thousands of consumers. While such actions, if brought individually, would usually be denominated as breach of contract suits, and attempts to convert the claims into tort actions would usually be rejected by courts, the sorcerer’s elixir of class action aggregation magically transforms them into tort claims replete with demands for punitive damages. For an account of several class actions based upon economic injury, see DEBORAH HENSLER ET AL., RAND INST. FOR CIVIL JUSTICE, \textit{CLASS ACTION DILEMMAS: PURSUING PUBLIC GOALS FOR PRIVATE GAIN} 139 (2000).

\textsuperscript{8} Increased litigation activity is facilitated by: widespread solicitation of potential claimants by use of mass advertising use of: “800” phone numbers, and websites which are ostensibly for information purposes but which steer potential claimants to the sponsoring law firm; formation of victim support groups that are underwritten by lawyers; close association with union officials in a position to steer large numbers of claimants to specific lawyers; the formation of networks of lawyers specialized to particular product claims; rising corporate wealth; judicial decisions expanding the scope of insurance coverage; and procedural rules that facilitate litigation against manufacturers.
a specific exposure of that type. The first requirement is referred to as “general causation” and the second as “specific causation.”

In some cases, general causation is established by clear epidemiological data; for example, that smoking causes lung cancer, or that exposure to asbestos causes several diseases including mesothelioma and asbestosis. In some mass tort litigations, where at least initially there is no epidemiology, plaintiffs rely on expert testimony based on scientifically untested or invalid theories to establish general causation. A leading example is silicone breast implant litigation where a cadre of scientific and medical experts testified that the silicone in breast implants entered the blood stream and caused auto immune diseases. Though this testimony was later discredited and epidemiological evidence would show that women with silicone breast implants had the same level of auto immune disease as women without such implants, the litigation was highly successful. Approximately $4 to $5 billion has been paid out to women claiming that silicone breast implants caused their alleged auto immune disease or an atypical form not identified in medical literature, of which the lawyers’ share is approximately one to two billion dollars.

Entrepreneurial experts are virtually always available to provide the general causation testimony needed for a mass tort litigation to proceed. However, that expert is subject to challenge in a Daubert proceeding. While federal judges have excluded numerous scientific or

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10 See infra section VI.
11 See infra notes 200 - 203.
medical experts who were to have testified in support of general causation, \ref{note:13} general causation expert testimony that lacks scientific validity continues to be advanced. \ref{note:14} A modest insight into this phenomenon is provided in an Appendix describing how mold litigation proceeds on the basis of testimony of a small number of experts who have been paid millions of dollars to advance theories that have been rejected by medical science.\ref{note:15}

A substantial body of literature addresses the use of “junk science” in expert testimony on general causation. Little has been written, however, about medical records generated to support specific causation in toxic tort litigation -- records which are commoditized and sold in wholesale quantities by a comparative handful of doctors who are not engaged in good faith medical practice. In this article, I address that subject in the context of the entrepreneurial technique that plaintiffs’ lawyers have devised to generate largely specious evidence of specific causation on a “mass” basis: the litigation screening.

In a litigation screening, potential litigants are solicited by lawyers or their agents by use of mass mailings, television and newspaper advertisements providing “800” telephone numbers, and by use of web sites purporting to provide medical information about toxic exposures, drugs or specific diseases but which are, in fact, “fronts” for law firms to whom the web site visitor is

\begin{footnotesize}
\begin{enumerate}
\item See, e.g., Ruggiero v. Warner-Lambert Co., 424 F. 3d 249 (2d Cir. 2005) (excluding expert medical testimony that the diabetes drug, Rezulin, was capable of causing or exacerbating cirrhosis of the liver); General Electric Co. v. Joiner, 522 U.S. 136 (1997) (affirming exclusion of physicians’ opinions that PCB exposure can cause small cell lung cancer); see also, David Klingsberg & Bert L. Slonin, Physicians’ Differential Diagnoses as Causation Proof: Recent Case Law Holds the Line in Requiring Daubert Reliability, 33 PRODS. SAFETY & LIAB. REP. 1129 (Nov. 14, 2005) (discussing courts’ rejection of differential diagnoses as not satisfying the Daubert reliability requirement with regard to general causation). In 1996, in an MDL proceeding, U.S. District Court Judge Robert E. Jones appointed independent advisors for the court on scientific issues and on the basis of their reports, held that testimony of plaintiffs’ experts that certain alleged diseases were caused by silicone breast implants was not based on accepted scientific evidence and would therefore be excluded. Hall v. Baxter Healthcare, Corp. et al., 947 F. Supp. 1387 (1996).

\item See e.g., the bogus theories advanced in the silicone breast implant litigation, infra note 246.

\item See Appendix, Mold Litigation.
\end{enumerate}
\end{footnotesize}
referred.  These solicitations may be reinforced by lawyer-facilitated articles in news media or television journalism, alerting the public to the danger posed by the product and by consumer advocacy groups closely aligned with mass tort lawyers. The potential litigants are invited to a strip mall, motel room, union hall or lawyer’s office, where a doctor or medical technician will administer tests and, in some cases, perform a cursory physical examination for the purpose of generating medical evidence of the existence of an injury to be attributed to exposure to or ingestion of the defendant’s products.

To prepare the tens of thousands of medical reports required by this wholesale massing of claimants, lawyers or the screening companies hire doctors who are willing to mass produce mostly unreliable and arguably fraudulent diagnoses for fees ranging into the millions of dollars. These litigation doctors often provide thousands, even tens of thousands, of the medical reports that are required to advance the scheme to mass produce litigants.

Litigation screenings, an “entrepreneurial” response to highly profitable opportunities that arise in certain mass tort litigations should not be confused with medical screenings. Litigation screenings have no intended health benefits. The sole objective of such screenings is to identify litigants and generate the medical reports that will qualify the litigants for compensation. To process the thousands of potential litigants that have been attracted to attend,

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16 See The Center for Medicine in the Public Interest, INSTA-AMERICANS: THE EMPOWERED (AND IMPERILED) HEALTH CARE CONSUMER IN THE AGE OF INTERNET MEDICINE 5-6, Jan. 2008 (reporting that a study of web sites providing medical information showed that this “online real estate was dominated by Websites paid for and sponsored by either class action law firms or legal marketing sites searching for plaintiff referrals” and that the information provided were often “overwhelmingly biased and misleading.”).
17 See, e.g., infra note 215-216.
most screenings use an assembly line procedure in which the tasks to be performed are divided into component parts. Dividing the screening tasks among multiple providers serves to insulate each from liability for fraud since no one thereby takes full responsibility for the medical reports and each provider can claim that he had no reason to doubt the validity or veracity of the work of others that he relied on. Each of the providers who profit from the screening -- paralegals, litigation doctors, medical technicians (taking X-rays, administering echocardiograms or pulmonary function tests), the owners and employees of the screening companies, and the lawyers who have contracted for the screenings -- are motivated by substantial and even enormous financial incentives. They are acutely aware that if the screenings do not generate a sufficiently high percentage of litigants, the lawyers will simply hire others who can do the job more effectively. Indeed, the market for litigation screenings is highly competitive and only those doctors and screening companies that produce the “right” results can expect to have the volume of business that generates substantial fees.

U.S. District Court Judge Janis Jack, presiding over a multi-district litigation involving 10,000 silicosis claims that were all generated by screenings, concluded on the basis of the testimony of the screening company principals, doctors who rendered the diagnoses upon which the claims were based and the lawyers for whom the screenings were done, that “it is apparent that truth and justice have very little to do with these diagnoses. . . [Indeed] it is clear that lawyers, doctors and screening companies were all willing participants” in a scheme to

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19 See In re Silica Prods. Litig., No. MDL 1553, 398 F. Supp. 2d 563, 635 (2005) [hereafter, MDL 1553]. “By dividing the diagnosing process among multiple people, most of whom had no medical training and none of whom has full knowledge of the entire process, no one was able to take full responsibility over the accuracy of the process. This is assembly line diagnosing. And it is an ingenious method of grossly inflating the number of positive diagnoses.” Id. at 633-634.
21 Silicosis is a scarring of the lungs (“pulmonary interstitial fibrosis” or “fibrosis”) caused by inhalation of crystalline silica (sand) dusts. See infra note 52.
“manufacture... [diagnoses] for money.” Judge Jack’s opinion sounds a clarion call to examine the use of litigation screenings in mass tort litigations -- a call that to date has been consistently ignored by torts scholars.

The litigation screening was invented by Richard “Dickie” Scruggs, who parlayed millions of dollars in asbestos litigation fees generated by screenings into the tobacco litigation which netted him a reported one billion dollars. Scruggs saw an opportunity to improve upon the traditional litigation model in which an injured person is diagnosed by his treating doctor and then retains a lawyer to sue the company that produced the product that caused the harm. To replace this retail model, Scruggs created a method to amass claims by the hundreds and later by the thousands. He advertised that he was offering free X-rays and medical examinations by doctors to workers occupationally exposed to asbestos; in return those who tested positive agreed to retain him. Scruggs’ entrepreneurial approach hit pay dirt and attracted large numbers of potential litigants who sought to claim a piece of the pie. Soon other lawyers began hiring screening companies which sprang up to meet the demand to mass produce litigants with nonmalignant asbestos disease claims.

In the 1988-2006 period, litigation screenings have been responsible for generating at least 90% of the 585,000 claims of nonmalignant asbestos related disease filed with the Manville

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22 MDL 1553, 398 F. Supp. 2d at 635.
23 For ruminations on why the subject of mass tort fraud is studiously avoided by most torts scholars, see Lester Brickman, On the Theory Class’s Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality, 31 PEPP. L. REV. 33, 166-170 (2004) [hereafter, Brickman, Asbestos Litigation].
24 See Frontline: Inside The Tobacco Deal (PBS Television Broadcast) interview available at www.pbs.org/wgbh/pages/frontline/shows/settlement/interviews/scruggs.html (last accessed May 27, 2008). Scruggs’s core role in the welding fume litigation is examined at infra note 391.
The enormous profits realized from asbestos screenings have led lawyers to use screenings in other mass tort litigations to manufacture diagnoses on a mass production basis.

Screenings have been responsible for nearly 100% of the 20,000 claims of silicosis filed mostly in state courts in Mississippi in the 2002-2004 period. In addition, litigation screenings have also accounted for the vast majority of the claims filed in the silicone breast implant, fen-phen diet drug and welding fume litigations.

I estimate that lawyers have spent at least $500 million and perhaps as much as $1 billion to conduct litigation screenings that have generated over 1,000,000 claimants, most of whose claims are specious, and contingency fees well in excess of $13 billion dollars.

In this article, I examine the mechanics of litigation screenings and review the evidence that litigation screenings in the asbestos, silica, silicone breast implants, fen-phen and welding

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26 The Manville Personal Injury Settlement Trust (“Manville Trust”) is the entity created as a consequence of the bankruptcy of the Johns-Manville Corp. in 1982 to which all claims against Johns-Manville relating to asbestos exposure are channeled. Brickman, Disparities, supra note 12, at 519 n. 12. For a fuller description of the Manville Trust, see Brickman, Asbestos Litigation, supra note 23, at 54, 128.

27 No accurate count of the number of silicosis claims that were filed in state courts in the 2002-2004 period exists in any published form. My rough estimate is based on conversations with lawyers involved in silica litigation.

28 Lawyers’ payments are mostly directed to the screening companies and to the doctors who provide the X-ray readings and diagnoses in support of the claims generated by the screenings. N&M, Inc., a screening company that generated as many as 50,000 claims of asbestosis and silicosis, had gross receipts of over $25 million between July 1996 and April 2005. Certain Defendants’ First Amended Supplemental Brief in Response to Plaintiff’s Challenge to the Constitutionality of Florida’s Asbestos and Silica Compensation Fairness Act at 4 (citing to an N&M record, Income by Customer Summary). Dr. Jay Segarra, one of the litigation doctors used frequently in asbestos and silica screenings, is reported to have been paid $10 million for this work. Wade Goodwyn, Silicosis Ruling Could Revamp Legal Landscape, March 6, 2006, All Things Considered, Nat’l Public Radio, 2006 WLNR 22951933.

Fees charged by doctors in the fen-phen screenings are described in the text at infra note 174. One fen-phen screening company that administered echocardiograms grossed $15 million in less than two years. See infra note 168. A lead counsel for Wyeth in the fen-phen litigation estimated that lawyers spent $100 million dollars for fen-phen screenings. See Summary of Statements by Peter Zimroth in Minutes of Task Force on Contingent Fees, Aug. 05, 2005 at 162 reprinted in 42 TORT TRIAL & INS. PRAC. L.J. 105 at 131 (2006) [hereafter, Zimroth, Task Force Minutes]. One of the doctors involved in the silicone breast implant screenings stated that his income rose from about $300,000 in 1993 to $2 million in 1999 when he focused on breast implant screening diagnoses. See infra note 273. Some of the screening doctors charged $6000 per examination and tests, while diagnosing more than 90% of the women as eligible for compensation. See infra note 277-278.
fume litigations have been designed to and did generate specious if not fraudulent claims. If litigation screenings do, in fact, generate tens of thousands of specious claims, one would expect that those who profit from this process, most especially the doctors who have been paid hundreds of millions of dollars for their medical reports and services, would face at least civil if not criminal sanctions. With rare exception, this has not occurred. Both the criminal and civil justice systems appear largely incapable of detecting or deterring, let alone sanctioning, the actions of medical and scientific experts who, in exchange for hundreds of millions of dollars in fees, provide specious if not fraudulent medical reports and testimony in support of mass tort claims. Lawyers are even more insulated from sanctions than are the experts they hire as part of a scheme to manufacture diagnoses for money. In this article, I will also examine the reasons for the persistence of the phenomenon of prosecution-less mass tort fraud.

II. Conditions Conducive To Litigation Screenings

While most mass tort litigations have not involved the use of litigation screenings, the impact of litigation screenings has nonetheless been considerable. Trying to identify why litigation screenings are used in some mass tort litigation but not others is a formidable task. Indeed, there does not appear to be a single set of conditions that triggers their use. Nonetheless, certain features or conditions which are present in the mass torts which appear conducive to lawyers conducting litigation screenings can be identified.

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29 I am limiting the scope of this statement to the mass production of medical reports by doctors and technicians which are “manufactured for money,” that is, specious if not fraudulent claim generation on a wholesale basis. There have been instances of prosecution for alleged fraudulent conduct in a relatively small numbers of cases, usually involving forged prescriptions or other records. For example, lawyers and others have been indicted for allegedly participating in a scheme to create false prescriptions, pharmacy records and medical records in order to qualify for compensation in the fen-phen diet drug settlement. See Jammie E. Gates, Vicksbury Attorney Indicted in Scam, CLARION-LEDGER, May 27, 2006. See also infra note 155.
The first and foremost condition is that the lawyers who will fund the screenings must conclude that they can generate substantial profits from the venture. Profitability is a function of the cost of a screening which can range from as little as $500 to upwards of $10,000 for each qualified litigant versus the settlement value of the cases generated. In addition, it must appear that there are at least thousands of potential litigants who can be attracted to attend screenings.

The critical mass volume is not only necessary for the requisite profit calculation but also independently operates to assure the success of the venture. The purpose of most screenings is to identify litigants and to generate medical reports that will enable the claims to be profitably settled, preferably *en masse*. A diligent defense can expose the fact that the medical reports generated by screenings at least lack reliability. But litigation screenings enable plaintiffs’ lawyers to overwhelm defendants by filing hundreds and thousands of suits thus making it a practical impossibility for the defendants to take any significant percentage of the cases to trial and coercing defendants into entering large scale settlements of at best dubious claims. Added to the pressure that screenings can generate is the availability of jurisdictions where judges and sometimes juries have a strong disposition to favor the interests of litigants and their lawyers and a track record of awarding substantial punitive damages.

Adding further to the pressure is the legal regime that existed in two of the most forum-shopped states, Mississippi and West Virginia, at the time when tens of thousands of mass tort

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30 *See infra* note 473. The “clear motivation” for this scheme to mass manufacture diagnoses is, as noted by Judge Jack:

to inflate the number of plaintiffs and claims in order to overwhelm the Defendants and the judicial system. This is apparently done in hopes of extracting mass nuisance-value settlements because the Defendants and the judicial system are financially incapable of examining the merits of each individual claim in the usual matter.

MDL 1553, 398 F. Supp. 2d at 676.

claims were generated by litigation screenings. Both jurisdictions had liberal joinder rules allowing nearly unlimited numbers of litigants to be joined to a litigation so long as there was at least one properly venued plaintiff. Frequently, the one or more properly venued litigants were selected because they had compelling cases such as a malignancy coupled with extensive occupational exposure. The scores and even hundreds of others joined to that litigation often, if not mostly, had specious diagnoses generated by screenings. Defendants virtually always settled the entire group of cases, including the specious ones, because they feared that a local jury would award compensatory and punitive damages that would threaten the company’s viability. The threat level was further raised by the fact that a company could not stay a massive judgment pending appeal unless it could post a bond in the amount of the entire judgment. But few companies could immediately come up with the hundreds of millions and even billions of dollars required to post such a bond. The only way to avoid a bet-the-company scenario was to settle all of the cases. Thus, the mass production of claims led to the mass settlement of claims.

If the basis for a mass tort litigation is the ingestion or inhalation of a product, and it has been shown that that product does cause serious injury, even death, as has been the case in the asbestos, silica and fen-phen litigations and perhaps in some welding fume cases, then the purpose of a litigation screening is to generate thousands of additional claimants who can assert a colorable claim of injury. “Colorable” in the litigation screening context does not mean that there is actual injury but only that a doctor participating in the screening is willing to provide a medical report attesting to the existence of an injury. Thus, in asbestos and silica litigation, litigation doctors find that the majority of the X-rays they read indicate radiographic evidence of

\footnote{See infra notes 344, 356.}
lung scarring (fibrosis) which can then be attributed to the claimed exposure. Clinical studies indicate, however, litigation doctors’ error rates are mostly in the 90% range.\textsuperscript{33}

Based on data I have compiled, an average screening of 1000 individuals occupationally exposed to asbestos will result in 500-600 being diagnosed with asbestosis; if these same individuals were examined in a clinical setting, however, approximately 30-40 would be diagnosed with asbestosis.\textsuperscript{34} The value of a nonmalignant claim in the 1988-2000 period ranged mostly from $50,000 to $150,000. Thus screenings coined money as surely as if the lawyers had access to the government’s printing press.

A circumstance that heightens the likelihood of lawyers’ sponsoring litigation screenings is a medical condition that, though pre-existing, can nonetheless be attributed to the exposure or ingestion of the subject of the mass tort. As already indicated, in asbestos and silica litigation, litigation doctors frequently attribute any scarring of the lungs, however mild and whatever the cause, as resulting from asbestos or silica exposure. In the fen-phen litigation, the fact that millions of persons were born with or had developed a mild mitral valve regurgitation, once referred to by doctors as a “murmur,” provided fertile ground for litigation doctors to find not only that the condition was more severe than in reality, i.e., “moderate” regurgitation instead of “mild” or trace but also that the condition was caused by ingestion of fen-phen.

Another condition associated with litigation screenings is a claim of injury that is not capable of objective verification. Thus, in silicone breast implant litigation, litigation doctors attributed women’s unverifiable claims of fibromyalgia, joint pain and similar unmeasurable symptoms to the silicone implants. Indeed the more unverifiable, the greater the leeway afforded the doctors to make the “right” diagnoses and attributions. In welding fume litigation, the

\textsuperscript{33} Brickman, \textit{Disparities, supra} note 12, at 531-556.
\textsuperscript{34} \textit{Id.} at 562-563.
screening diagnoses is based on “signs” such as tremor (uncontrollable shaking) that are easily fabricated and, indeed in some instances, there is clear evidence of such fabrication.\footnote{See infra notes 449-451.}

Even if objective medical tests may be required as a basis for a diagnosis of injury, litigation screenings can overcome this hurdle by using technicians with the requisite financial incentives to manipulate the test to produce outcomes which qualify the litigants for compensation. Thus, in asbestos litigation, hundreds of thousands of pulmonary function tests have been maladministered in order to show a lung function impairment that increases the value of claims.\footnote{See Brickman, Asbestos Litigation, supra note 23, at 111.} In the fen-phen litigation, there is a considerable body of evidence that medical technicians maladministered thousands of echocardiograms in order to produce specious evidence of heart valve injury.\footnote{See infra notes 170-171, 180, 185-192.}

One condition that is a \textit{sine qua non} for litigation screenings is the availability of a cadre of doctors willing to “manufacture diagnoses for money” -- that is, willing, for a fee, to provide whatever medical reports are required to qualify a substantial percentage of those screened for compensation from bankruptcy trusts or defendants in the tort system. A mere handful or two of doctors willing to engage in this commerce, however, is sufficient since each of these doctors can produce hundreds, thousands and even tens of thousands of the requisite medical reports. For example in asbestos litigation, approximately 25 doctors account for hundreds of thousands of medical reports.\footnote{See Brickman, Disparities, supra note 12, at 521.} In the welding fume litigation, a single doctor accounts for the vast majority of claims produced by the screenings.\footnote{See infra note 335.} In the fen-phen litigation, a handful of cardiologists are responsible for thousands of specious claims of heart valve disease.\footnote{See infra note 174.}
Finally, a condition that is especially conducive to the use of litigation screenings is a large aggregate settlement of a mass tort such as the settlements in the fen-phen and silicone breast implant class actions where the medical and exposure criteria for qualification for payment are insufficiently rigorous. There, lawyers took advantage of this laxity in both settlements to institute litigation screenings to generate medical reports that qualified tens of thousands of potential litigants who attended the screenings for payment though they had not been contemplated as potential claimants at the time of the settlements.

III. “Entrepreneurial” Asbestos Litigation Screenings

A. The Mechanics of Asbestos Litigation Screenings

A year before Judge Jack issued her report in the silica MDL, I detailed the existence of similar if not identical process of specious generation of hundreds of thousands of nonmalignant asbestos claims.\(^{41}\) I concluded that an illegitimate “entrepreneurial” model had come into use to generate massive numbers of specious nonmalignant asbestos claims.\(^{42}\) The core of the “entrepreneurial” model of nonmalignant asbestos litigation is an unprecedented-in-scale litigant recruitment effort: the litigation screening.\(^{43}\) Entrepreneurial screening companies are hired by lawyers to seek out persons with occupational exposure to asbestos. Mobile X-ray vans are brought to local union halls, motel rooms, or strip mall parking lots where X-rays are taken on an assembly line rate of one every five to ten minutes. In addition to the X-rays, most screening companies also administer pulmonary function tests (PFTs) to determine the existence and

\(^{41}\) See generally, Brickman, Asbestos Litigation, supra note 23.

\(^{42}\) For discussion of the “entrepreneurial” model, see Lester Brickman, On The Applicability of the Silica MDL Proceeding To Asbestos Litigation, 12 CONN. INS. L.J. 289 (2006) [hereafter, Brickman, Silica/Asbestos Litigation]. For a review of the evidence that hundreds of thousands of medical reports generated by asbestos and silica litigation screenings have been “manufactured for money,” see generally, Brickman, Disparities, supra note 12.

\(^{43}\) For a more detailed description of litigation screenings for asbestos-related diseases, see Brickman, Asbestos Litigation, supra note 23, at 62.
degree of any lung impairment since that can materially increase the value of a nonmalignant claim.\footnote{44 See Brickman, Asbestos Litigation, supra note 23, at 111 (describing pulmonary function tests); see also Brickman, Disparities, supra note 12, at 574-575.}

The sole object of these screenings is to generate medical reports to be used to support claims of asbestosis, a scarring of the lung tissue caused by extensive exposure to asbestos.\footnote{45 Prolonged exposure to scores of different dust particles which penetrate the lung’s forward line of defenses results in the accumulation of macrophages and inflammatory cells in the alveoli (the air exchange sacks of the lung), which can lead to a scarring of lung tissue. See generally Ken Donaldson & C. Lang Tran, Inflammation Caused by Particles and Fibers, 14 INHALATION TOXICOLOGY 5 (2002). When that occurs, the condition is termed interstitial or parenchymal fibrosis. If the fibrosis is the result of exposure to silica (sand dust), the condition is termed “silicosis”; if it is the result of exposure to asbestos, it is called “asbestosis.” W. RAYMOND PARKES, OCCUPATIONAL LUNG DISORDER 285, 411 (3d ed. 1994). Fibroses caused by exposure to different dusts encountered in occupational settings, as well as by numerous other causes, may manifest differently on an X-ray. See infra notes 82-86. While the determination of the cause of a fibrosis may have a medical purpose, the principal reason for determining that the cause is asbestos exposure is a function of the compensation system. Whereas a diagnosis of one cause of fibrosis may yield no compensable claim, a diagnosis of asbestosis may enable the subject to be eligible for substantial compensation. In its mildest form, asbestosis may cause no breathing impairment and is detectable only by chest X-ray or high resolution CAT scan. In more severe cases, significant fibrosis can decrease the elasticity of the lungs, and “interfere with the lung’s ability to oxygenate the blood.” AMERICAN BAR ASSOCIATION COMMISSION ON ASBESTOS LITIGATION, ABA REPORT TO THE HOUSE OF DELEGATES, RECOMMENDATION & RESOLUTION 7 (2003) [hereafter, ABA Report] (“Asbestotic lungs are characterized by reduced capacity, i.e., they can process only a reduced volume of air compared to normal lungs. Workers who suffer from significant asbestosis generally have shortness of breath on exertion.”). In its most severe form, asbestosis is progressive and debilitating and can lead to death. See supra note 17.}

In the 1988-2006 period, approximately 700,000 potential litigants who had been occupationally exposed to asbestos were screened. These litigation screenings accounted for more than 90% of the approximately 585,000 nonmalignant claims for compensation filed with the Manville Trust\footnote{46 Stephen Carroll, et al., ASBESTOS LITIGATION, RAND Institute for Civil Justice (2005), at 75; see also Lester Brickman, Ethical Issues In Asbestos Litigation, 33 HOFSTRA L. REV 833, 834 (2005);THE FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT OF 2003, S. Comm. on the Judiciary, 108th Cong., Report on S. 1125 (2003) (citing Hearing on Asbestos Litigation, Before the Senate Comm. On the Judiciary, 107th Cong. (2002) (statement of David Austern)).} in that period.\footnote{47 In its mildest form, asbestosis may cause no breathing impairment and is detectable only by chest X-ray or high resolution CAT scan. In more severe cases, significant fibrosis can decrease the elasticity of the lungs, and “interfere with the lung’s ability to oxygenate the blood.” AMERICAN BAR ASSOCIATION COMMISSION ON ASBESTOS LITIGATION, ABA REPORT TO THE HOUSE OF DELEGATES, RECOMMENDATION & RESOLUTION 7 (2003) [hereafter, ABA Report] (“Asbestotic lungs are characterized by reduced capacity, i.e., they can process only a reduced volume of air compared to normal lungs. Workers who suffer from significant asbestosis generally have shortness of breath on exertion.”). In its most severe form, asbestosis is progressive and debilitating and can lead to death. See supra note 17.}
plaintiffs’ lawyers and the screening companies have hired a comparative handful of doctors
selected because of their apparent willingness to enter into business transactions with the lawyers
for the sale of tens of thousands of X-ray readings and diagnoses in exchange for the payment of
millions of dollars in fees. The X-ray readers, usually radiologists and pulmonologists, have been
certified by NIOSH as B Readers\textsuperscript{48} which is an indication of special competence in reading chest
X-rays and classifying them on the International Labour Organization (ILO) scale.\textsuperscript{49} A

\textsuperscript{48} The National Institute for Occupational Safety and Health (“NIOSH”) of the Centers for Disease Control and Prevention (“CDC”) award B Reader approvals to individuals who meet a specified level of proficiency in classifying chest X-rays according to the ILO scale; these B Readers must be re-certified at 4 year intervals, and are usually, but not always, licensed doctors. ABA REPORT, supra note 45, at 14.

\textsuperscript{49} The degree of fibrosis appearing on a chest X-ray is graded according to a classification system developed by the International Labour Office (ILO). INTERNATIONAL LABOUR OFFICE, GUIDELINES FOR THE USE OF ILO INTERNATIONAL CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSIS (Rev. ed. 1980) [hereafter, ILO Guidelines]; see also William S. Cole, M.D., THE CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSIS, in A STUDY SYLLABUS FOR CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSIS (W.J. Tuddenham, M.D. ed. 1983) (a study guide for the application of the ILO radiographic classification system; prepared by the Division of Respiratory Disease Studies, NIOSH Centers for Disease Control and Prevention, Morgantown, W.V.). The system uses a scale that was developed to systematically record the radiographic abnormalities in the chest provoked by the inhalation of dusts.’ ILO Guidelines, id. at 1, 2. According to the ILO:

The object of the Classification is to codify the radiographic abnormalities of pneumoconiosis in a simple reproducible manner. The Classification does not define pathological entities, nor take into account working capacity. The Classification does not imply legal definitions of pneumoconiosis for compensation purposes, nor set nor imply a level at which compensation is payable.

The Classification is based on a set of standard radiographs, a written text and a set of notes. In some parts of the scheme the standard radiographs take precedence over the text for the definitions; the text makes it clear when this is so.

\textit{Id.}

On the ILO scale, chest X-rays are classified, usually by B Readers, according to the number of abnormalities (termed “opacities”) in a given area of the chest film. A zero corresponds to no abnormalities, one to slight, two to moderate, and three to severe. “Since this process is to some degree inherently subjective, readers give two classifications, the category that they think most likely and next most likely. The result is a 12 point scale, with results ranging from 0/0 (normal [X-ray] appearance) to 3/3 (severe abnormalities).” In re Joint East & South. Dist. Asbestos Litigation, 237 F. Supp. 2d. 297, 308. (E.D.N.Y. 2002). “The vast majority of screening x-rays (for which asbestosis is claimed) are read as “1/0”, which means the x-ray on first impression is at the lowest level of abnormality (“1”), but may be normal (“0”).” A reading of 1/1 is stronger than a 1/0 and means that the reader found clear evidence of irregularities. ABA REPORT, supra note 45, at 13. For purposes of identifying and locating opacities, the ILO form divides the lungs into six zones, upper, middle and lower, left and right. For a diagnosis of
comparative handful of B Readers, ranging from 4-6% of all certified B Readers, are regularly selected by plaintiffs’ lawyers to read most of the hundreds of thousands of X-ray films generated by screenings. These B Readers read the majority of these X-rays as indicating pulmonary fibrosis graded as 1/0 on the ILO scale and issue findings that the fibrosis is “consistent with asbestosis.” Along with a comparative handful of other doctors, they diagnose the vast majority of litigants thus found to have profusions of 1/0 or greater as having mild asbestosis (or silicosis -- if that is the purpose of the screening, or both asbestos and silicosis.)

This small number of B Readers and other doctors have accounted for a dramatically disproportionate number of the total number of X-ray readings and medical reports that have been submitted as evidence in support of nonmalignant asbestos personal injury claims.

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*asbestosis*, the opacities should be found bilaterally in the lower zones. Nonetheless, a B Reader may assign a 1/0 grade even if he finds irregular opacities in only one of the six zones.

As of December 15, 2005, NIOSH listed 387 B Readers on its website; on July 22, 2003, it listed 431; on April 25, 2002, it listed 535; and on February 20, 1998, NIOSH listed 627 B Readers.

A diagnosis of asbestosis, when done in a medical rather than a litigation setting, is based on a chest X-ray, physical exam including a medical and occupational history and a measurement of lung function. American Thoracic Society, *Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos*, 170 AM. J. RESPIR. CRIT. CARE MED. 691, 695-697 (2004).

Silicosis is a disease of the lung caused by the inhalation of silica dusts. Silica is the common name for minerals containing a combination of the elements silicon and oxygen and is one of the most common substances in the Earth. Extensive exposure to silica dusts, can cause severe damage to the lung, even death, depending on the dose and duration of exposure. See Andrew P. Morriss & Susan E. Dudley, *Defining What to Regulate: Silica and the Problem of Regulatory Categorization*, 58 Admin. L. Rev. 269, 272-73, 288-89 (2006). Historically the highest exposures to silica dust occurs among sandblasters working in the construction, refinery and shipyard trades, foundry workers, industrial painters and miners. GR Wagner, *Asbestosis and Silicosis* 349 LANCET 1311 (1997). Exposure during mining operations is a function of (1) the quartz content of overlying rock which is made respirable by drilling and (2) the use of dust-control equipment. (Quartz is a crystalline form of silica).

The Manville Trust has reported that of 199,533 claims it processed in the period January 1, 2002 to June 30, 2004, just twenty B Readers accounted for sixty-two percent of the total B Readings. See Power Point Presentation at 8, David T. Austern, President, Claims Resolution Management Corporation, “2004 Asbestos Claim Filing Trends.”
the reliance on a comparative handful of B Readers and diagnosing doctors is a defining characteristic of the “entrepreneurial” model.\textsuperscript{54}

B. A Comparison of the Prevalence of Fibrosis And Diagnoses of Asbestosis Found By Asbestos Litigation Screenings With the Results of A Review of Clinical Studies

1. Prevalence As Found By Litigation Screenings

My research indicates that the comparative handful of B Readers employed by screening companies and plaintiffs’ lawyers find pulmonary fibrosis in 50\%-90\% of the X-rays generated by litigation screenings, grading them as 1/0 or higher and issue findings that the opacities on the X-rays are “consistent with asbestosis.”\textsuperscript{55} Because of the economics of litigation screenings, X-rays not read as positive, i.e., 1/0 or higher on the ILO scale, are typically sent, on multiple occasions, if necessary, to other B Readers who similarly find a very high prevalence of pulmonary fibrosis, for re-reading.\textsuperscript{56} As a consequence, the actual percentage of positive X-ray readings of those screened is more likely well above the low end of the 50\%-90\% range.\textsuperscript{57}

\textsuperscript{54} In the silica MDL, Judge Jack noted that “the over 9,000 plaintiffs who submitted fact sheets were diagnosed with silicosis by only 12 doctors . . . affiliated with a handful of law firms and mobile X-ray screening companies.” MDL 1553, 398 F. Supp. 2d at 580. A study of a stratified sample of claims submitted to Owens Corning before its bankruptcy filing indicated that just five B Readers (Drs. Raymond Harron, Jay Segarra, Richard Keubler, Philip H. Lucas and James W. Ballard) had read over eighty percent of the X-rays, with Dr. Harron alone accounting for forty-six percent of the X-ray readings. Report of Dr. Gary K. Friedman at 11, 18, 21, Owens Corning Impaired Nonmalignant Claim Submissions 1994-1999 (approx.), (circa 2002). The Manville Trust reported that of 199,533 claims it processed in the period January 1, 2002 to June 30, 2004, just twenty B Readers accounted for sixty-two percent of the total B Readings. \textit{See} Power Point Presentation at 8, David T. Austern, President, Claims Resolution Management Corporation, “2004 Asbestos Claim Filing Trends.” The Trust further reported that as of December 31, 2005 of the many hundreds of B readers in its files, the top 25 who authored B reads in support of claims submitted to the Trust accounted for 66\% (89,092) of the 135,235 B reads in its records. CRMC Response, \textit{supra} note 18, at Exh. B. Of the thousands of doctors who submitted diagnoses, the top 25 who were identified in the Trust’s records as the primary diagnosing doctor accounted for 46\% (255,928) of the total of 552,045 claims that permitted such identification. \textit{Id.} at Exh. C.

\textsuperscript{55} Brickman \textit{Disparities}, \textit{supra} note 12, at 526.

\textsuperscript{56} \textit{Id.} at 531.

\textsuperscript{57} \textit{Id.} at 531-532.
addition, I estimate that these same B Readers and other doctors regularly selected diagnose approximately 80% or more of those whose X-rays are graded 1/0 or higher with asbestosis “within a degree of medical certainty.” Here too, a negative diagnosis for asbestosis -- representing a loss of potential revenue of $60,000-$100,000 in the 1990-2000 period and a lesser sum thereafter -- also results in recirculation of the file to another diagnosing doctor for re-diagnosis. Taking this practice into account, I estimate that the diagnosis rate of asbestosis for those with X-rays read as 1/0 or higher is well above 80%. Moreover, based upon the data I have assembled, I conclude that there is a significant likelihood that each of these B Readers and diagnosing doctors as well as the screening companies that hire them, have a predetermined “signature” percentage of positive X-ray readings and diagnoses in the 50%-90% range.

Indeed the “product” that these doctors and screening companies appear to be selling to lawyers is a high fixed percentages of “positive” X-ray readings and diagnoses of silicosis and asbestosis.

2. Clinical Studies of the Prevalence of Fibrosis

There have been over eighty medical studies of workers occupationally exposed to asbestos to determine the prevalence of fibrosis in these populations. A review of these clinical studies indicates a prevalence of fibrosis among a wide range of occupationally exposed workers of 11.56%.

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58 Id. at 529-530.
59 Id. at 530-531.
60 Id. at 530.
61 These studies are reviewed in Brickman, Disparities, supra note 12, at 531-544.
62 See, id. at 543. In this review, I have adjusted the results of five insulators’ studies because they have a substantial and disproportionate impact on the results of the review and thus result in overstating the prevalence. If these studies are not adjusted, the prevalence percentage is 14.18%. For
A simple comparison of the prevalence of fibrosis generated by asbestos litigation screenings with the results of a review of clinical studies, while providing compelling evidence of systemically erroneous if not fraudulent medical report generation, understates the degree of disparity. This is so because most of the clinical studies fail to distinguish between different shapes and locations of the opacities that are determined to be fibrosis whereas the litigation B Readers always find that the opacities are “consistent with asbestosis.” If the clinical studies were to have limited their X-ray readings to only opacities of the shape and location that are “consistent with asbestosis,” their findings of fibrosis would have been appreciably reduced.63

Second, there are some conditions that manifest on pulmonary X-rays which are not actually fibrosis but are sufficiently similar to fibrosis as to be easily misinterpreted as fibrosis.64 In addition, certain abnormalities of the lung that are the result of aging and smoking and which are not due to asbestos exposure are “indistinguishable from occupationally related pulmonary fibrosis.”65

A third reason why a simple comparison may understate the disparity is that there is a “background” prevalence of opacities graded as fibrosis in unexposed populations. A review of eleven clinical studies indicates a prevalence of fibrosis in the general population of

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63 Id. at 544-546.
64 Chest radiographic interpretations have been read as positive, when in fact they were negative, with the misinterpretation resulting from “increased basilar linear markings caused by emphysema or pleural changes that overlay the parenchyma.” A.C. Friedman, et al., Computed Tomography of Benign Pleural and Pulmonary Parenchymal Abnormalities Related to Asbestos Exposure, 11 Seminars in Ultrasound, CT and MR 399, 399-400 (October 1990). [hereafter, Friedman, Computed Tomography]. Prominent vessels, chronic obstructive pulmonary disease, bronchiectasis, scarring from surgery, old tuberculosis, obscuration of the lung by plaques en face, and walls of bullae (emphysema) have also been misread as parenchymal asbestosis. A.C. Friedman, et al., Asbestos-Related Pleural Disease and Asbestosis: A Comparison of CT and Chest Radiography, 150 AJR 269 (1988).
approximately 3%. This background prevalence of fibrosis in the general population may have resulted in elevated finding of fibrosis in the clinical studies of occupationally exposed workers.

3. **Clinical Re-readings of Litigation B Readers’ Results**

Beyond the results of the review of the clinical studies, there is additional evidence to support the conclusion that the B Readers most frequently selected by plaintiffs’ lawyers for litigation screenings are manufacturing B readings for money. In eight clinical studies or their equivalent, X-rays read as 1/0 or higher and “consistent with asbestosis” were re-read by independent B Readers. These studies indicate that the litigation B Readers’ error rates range from 60-97% with most in the 90% range.67

In one of these studies in 1986, the United Rubber Workers’ International Union (“URW”) requested that NIOSH conduct an evaluation of the occurrence of pneumoconiosis among tire workers to determine if the union/industry-operated medical surveillance program, which failed to detect any excess asbestosis or other pneumoconiotic conditions among tire workers, had missed cases of asbestos-related disease.68 The basis for this concern was a very high rate of pneumoconiosis generated by asbestos screenings. Information distributed to tire workers by plaintiffs’ lawyers stated that at one screening location, 64 percent of those screened tested positive for asbestosis, and at a second screening location, 94 percent tested positive for...
asbestosis.\textsuperscript{69} Focusing on workers with the greatest potential for disease, NIOSH had an
independent panel evaluate 987 X-rays from the surveillance program of workers greater than
forty years of age. The NIOSH panel found that only two (0.2\%) showed physical changes
consistent with the mildest form of asbestosis.\textsuperscript{70}

In another one of these studies done in 1990, four medical professors and radiologists
reexamined the X-rays of 439 tire workers who filed suit after a mass screening, and found that
realistically, at most, only eleven of the claimants (2.5\%) had lung conditions consistent with
asbestos exposure -- a 97.5\% error rate.\textsuperscript{71}

In a third study done in 2004, 492 X-rays read by litigation B Readers that were used to
support asbestos lawsuits were re-read by a panel of six consultant B Readers.\textsuperscript{72} The consultant
B Readers were blinded to the source of payments, source of x-rays, the attorneys involved, the
status of films in litigation, the identity of the B Readers, the individuals’ names, and the results
of their cumulative findings. All of the films originally came from plaintiffs’ counsels and had
been filed in support of plaintiffs’ asbestos lawsuits.\textsuperscript{73}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{69} See Raymark Industries, Inc. v. Stemple, No. 88-1014K, 1990 WL 72588 at *10 (D. Kan.
\item \textsuperscript{70} Jancovic & Reger, 1989, supra note 68, at 12-14.
\item \textsuperscript{71} R.B. Reger et al., Cases of Alleged Asbestos-Related Diseases: A Radiologic Re-
\item \textsuperscript{72} The study was designed and conducted by Dr. Joseph N. Gitlin, an associate professor at
Johns Hopkins, who designed and directed the National X-ray Exposure Studies in the United States for
the U.S. Public Health Service, and his co-author Mr. Otha Linton, a senior executive of the American
College of Radiology where he managed the Task Force on Pneumoconiosis for NIOSH and was
involved in the development of the B Reader program. See Joseph N. Gitlin et al., Comparison of “B”
Readers’ Interpretations of Chest Radiographs for Asbestos Related Changes, 11 ACADEMIC RADIOLOGY
843 (Aug. 2004) [hereafter, Gitlin Study].
\item \textsuperscript{73} Joseph N. Gitlin, et al., Response to Letters on B-readers Study, 11 ACAD. RAD. 1402
(Dec. 2004). The B Readers on the panel included one who had consulted primarily for plaintiffs, two
who consulted for plaintiffs and defendants, two who consulted primarily for defendants, and two who
had no previous participation in reading films for litigation. The total is seven because one of the
consultant B Readers died during the course of the study and was replaced. For a response to criticisms
of this study, see Lester Brickman, A Response to Bryan O. Blevins, Jr., Dec. 20, 2006, available at
LesterBrickman.com, then “Publications.”
\end{itemize}
\end{footnotesize}
While plaintiffs’ B Readers had found 95.9% of the 492 X-rays to be “consistent with asbestosis” and have a profusion of 1/0 or higher on the ILO scale, the six consultant readers found that only 4.5% of the same X-rays had a profusion of 1/0 or higher. Even these readings did not mean that 4.5% of the 492 had asbestosis. Rather, the re-readings only indicated that 4.5% of the X-rays had small opacities of 1/0 or greater. These opacities could have been the result of old age, obesity, smoking and more than 100 other causes, other than exposure to asbestos.

Another study, done in 2006, confirmed the results of the 2004 study. Using a randomized sample and a control group, the 2006 study reviewed 471 X-rays previously read by plaintiffs’ B Readers who found that 383 (81.31%) had a profusion of 1/0 or greater on the ILO scale. Upon re-reading by a panel of three B Readers, who were blinded as to the source of the X-rays, the purpose of the study or the identity of the entity on whose behalf the readings were being done, only 33 X-rays (7%) were found to evidence such profusions. The overall error rate found for the litigation doctors of 91% was virtually identical to the error rate found in the 2004 study.

Finally, 1,795 X-rays taken in a hospital and read by one of fifty different hospital radiologists in the normal course of reading X-rays administered in the hospital were also read by a litigation doctor in the 2003-2005 period. Using the hospital radiologists’ readings as a

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74 Report of X-ray Study by Dr. Daniel Henry, In re W.R. Grace & Co., No. 01-1139 (JFK) (Bankr. D. Del.) (June 11, 2007) [hereafter, “Henry Report”]. This unpublished study was undertaken by W.R. Grace, the debtor in a bankruptcy proceeding, and was of a cohort of claimants who alleged a non-mesothelioma malignancy caused by W.R. Grace exposure and who were relying on X-ray evidence to support the attribution of their cancer to asbestos exposure. Id. For a more complete description of the study, see Brickman, Disparities, supra note 12, at 554-556.
75 Henry Report at 5-6.
76 Id. at 5.
77 Id. at 8.
78 See Gitlin Study, supra note 72.
standard, the litigation doctor had an 89% error rate in reading the X-rays for interstitial fibrosis.\textsuperscript{79}

4. The Disparity Between Clinical Diagnoses of Asbestosis and Those Generated by Screenings

Approximately 80% or more of litigants whose screening-generated X-rays are graded as 1/0 or higher are then diagnosed with asbestosis “within a reasonable degree of medical certainty” by the litigation doctors.\textsuperscript{80} Only a few clinical studies include a diagnosis of the cause of the fibrosis identified in the studies. Two studies that did and a clinical-study equivalent found that the prevalence of asbestosis among occupationally exposed workers whose X-rays were graded as 1/0 or higher was 15%, 18.5% and 23.2%.\textsuperscript{81}

A principal reason why 77%-85% of those workers in whose X-rays were read as 1/0 or higher in the clinical studies were not diagnosed with asbestosis is that there are well over 100 possible causes of fibrosis besides asbestos exposure\textsuperscript{82} including aging,\textsuperscript{83} smoking, obesity and the use of certain medications.\textsuperscript{84} In addition, a condition called idiopathic pulmonary fibrosis,\textsuperscript{85}

\textsuperscript{79} See infra note 589.
\textsuperscript{80} See Brickman, Disparities, supra note 12, at 529.
\textsuperscript{81} Id. at 561-562.
\textsuperscript{82} Marvin I. Schwartz, Approach to the Understanding, Diagnosis and Management of Interstitial Lung Disease, in INTERSTITIAL LUNG DISEASE 1, 4-5 tbl. 1-1 (Marvin I. Schwartz & Talmadge E. King, eds. 1998).
\textsuperscript{83} “Age and smoking habits have been postulated to produce radiographic parenchymal abnormalities in unexposed populations indistinguishable from occupationally related pulmonary fibrosis.” Dr. John D. Meyer, et al., Prevalence of Small Lung Opacities in Populations Unexposed to Dusts. A Literature Analysis, 111 CHEST 404 at 404 (1997).
\textsuperscript{84} In addition to aging, commonly found “conditions/diseases not related to asbestosis which appear as interstitial lung disease on X-rays include… smoking history, obesity, lupus, silicosis, or numerous other medical conditions.” Aff. Of Dr. Robert Steiner re: Medical Standards of Care for Diagnosing Asbestos-Related Diseases, Mot. For Case Mgmt Order Concerning Litigation Screenings at 3, In re: Asbestos Prods. Liability Litig. (No. VI), Civ. Action Nos. MDL 875 (E.D. Pa. 2001). See also Tatsuji Enomoto, MD, et al., Diabetes Mellitus May Increase Risk for Idiopathic Pulmonary Fibrosis, 123 CHEST 2007 (2003) (discussing the correlation between prevalence of idiopathic pulmonary fibrosis and age, smoking history, and lifestyle-related diseases, such as obesity and diabetes mellitus). Pulmonary fibrosis is also known to be caused by certain medications, radiation, connective tissue or...
that is, fibrosis with no known cause, is indistinguishable on radiographs from the fibrosis caused by asbestos exposure and has been misread as asbestosis.\(^{86}\)

Accordingly, it is probable that the substantial disparity between the X-ray readings of the litigation doctors and the results of the medical studies would be exceeded by the disparity between the diagnoses of asbestosis by the litigation doctors and the results that medical studies would have produced had they, as did two clinical studies referenced,\(^{87}\) also undertaken to provide diagnoses.

C. The Number of Annual Hospitalizations Due to Asbestosis

Further evidence of the lack of reliability of the hundreds of thousands of medical reports produced by litigation screenings is provided by data on the number of hospitalizations for asbestosis. In the period 1990-2004, approximately 470,000 claims were filed with the Manville Trust alleging a nonmalignant disease caused by asbestos exposure.\(^{88}\) The majority of these claims, 376,000, alleged asbestosis and included medical diagnoses.\(^{89}\) Given the pandemic

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\(^{85}\) Idiopathic pulmonary fibrosis, also known as cryptogenic fibrosing alveolitis, is a “chronic lung condition of uncertain etiology… characterized histologically by the presence of usual interstitial pneumonia, and often has typical radiological appearances.” O.J. Dempsey, et al., Idiopathic Pulmonary Fibrosis: An Update, 99 Q.J. MED. 643 (2006).

\(^{86}\) Friedman, Computed Tomography, supra note 64, at 399-400.

\(^{87}\) See supra note 81.

\(^{88}\) See 2006 End MT Historical Injury Worksheet, provided to Lester Brickman by CRMC, 1/16/07, on file with the author.

\(^{89}\) Id.
proportions of claims of asbestosis, one would expect that patients hospitalized in that time frame would reflect, at least in some measure, the asbestosis claim pandemic. In fact, however, the hospitalization data does not support the existence of asbestosis in the prevalence proportions indicated by asbestos litigation screenings. The National Center for Health Studies conducts an annual survey of approximately 500 hospitals, randomly sampling the hospital records of approximately 300,000 persons discharged annually. Based on these hospital records, using ICD-9 codes, the NCHS identifies the disease primarily responsible for each patient’s hospitalization as well as up to six additional disease conditions that the hospital record reflects. In the 15 year period 1990-2004, approximately 4,500,000 hospital records (15 x 300,000) were surveyed. Of these, there were a total of 57 hospitalizations where the primary cause for the hospitalization was asbestosis.⁹⁰

D. Pulmonary Function Tests

Most screening companies also administer a battery of pulmonary function tests⁹¹ ("PFTs") to determine whether there is any lung impairment and, if so, to what degree. A

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⁹⁰ See Brickman, Disparities, supra note 12, at 567. Each discharged patient included in the survey can be assigned up to seven diagnoses. The first listed diagnosis is the primary cause of the hospitalization. In the same 15 year period, asbestosis was listed as one of seven diagnoses per patient as few as 53 times in a year to a maximum of 158 times. Projections based on this raw data, however, are of low validity. See id. at 570.

⁹¹ Pulmonary function is determined by a series of tests comparing an individual’s measurements to a set of predicted values for that individual based on age and other physical characteristics. These tests includes spirometry which measures the total expiratory volume of the lung and forced expiratory volume during the first second of expiration, total lung capacity and diffusing capacity of the lung. For more detail on PFTs, see Brickman, Asbestos Litigation, supra note 23, at 111-14. In asbestos litigation, a person is usually considered impaired if his test values fall below 80% of the predicted value. However, the more appropriate medical impairment assessment, used by the American Medical Association for example, involves a statistical determination of the lower limits of normal (based on 95% confidence interval). AMERICAN MEDICAL ASSOCIATION, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 87 (5th ed. 2001).
finding of impairment materially increases the value of a nonmalignant claim.\textsuperscript{92} The screening companies that administer PFTs find that a substantial proportion of those tested, probably a majority, have lung impairment -- findings which are inconsistent with medical science.\textsuperscript{93} Indeed, the evidence that screening companies which administer PFTs, generate false findings of impairment, \textsuperscript{94} is at least as compelling as is the evidence that the X-ray readings and diagnoses of the litigation doctors are being “manufactured for money.”

IV. The Silica MDL \textsuperscript{95}

My conclusions regarding the elements of the illegitimate “entrepreneurial” model of litigation screenings were substantially corroborated by Judge Jack’s findings in the silica MDL. To be sure, Judge Jack’s findings were based on claims of silicosis -- a fibrosis caused by exposure to crystalline silica.\textsuperscript{96} However, she was examining the identical “entrepreneurial”

\textsuperscript{92} See Manville Trust 2002 Trust Distribution Process, available at http://www.claimsres.com/DocumentsMT.html (last accessed 11/24/06) (indicating that the scheduled value for an asbestosis claim with lung impairment (Level III) is about 2 1/2 times as great as an asbestosis claim without any lung impairment (Level II)). The PI Settlement TDP of Armstrong World Industries provides that the scheduled value for a bilateral asbestos-related nonmalignant disease with impairment was more than two and a half times the scheduled value for a bilateral asbestos-related nonmalignant disease without impairment. Exhibit 1.24 (Form of Armstrong World Industries, Inc. Asbestos Personal Injury Settlement Trust Distribution Procedures), In re Armstrong World Industries Inc., Chapter 11, Case No. 00-4471 (RJN) (Bankruptcy Court of Delaware). A typical Settlement Agreement with Owens Corning and its subsidiary, the Fibreboard Corporation indicates that a non-malignant claimant who was impaired was scheduled to receive compensation of $10,000. No compensation, however, was provided for a non-malignant claimant without impairment. See e.g., Settlement Agreement with Owens Corning and Fibreboard Corporation with the law firm Climaco, Climaco, Lefkowitz & Garofoli Co., L.P.A. (1998) (on file with the author). See also, David M. Setter & Jeanette S. Eirich, Medical Criteria Legislation: A Response to Screening Scandals, 21 Mealey’s Litigation Report: Asbestos 7 (May 3, 2006).

\textsuperscript{93} See Brickman, Disparities, supra note 12, at 574-577.

\textsuperscript{94} See Brickman, Asbestos Litigation, supra note 23, at 117-128 describing a “scheme to generate false medical test results” that resulted in false PFT results; Brickman, Disparities, supra note 12, at 576-577 (analyzing the results of tens of thousands of PFTs administered by the N&M screening company).

\textsuperscript{95} For a more detailed analysis of the silica MDL and the evidence in support of the statements in this paper, see Brickman, Silica/Asbestos Litigation, supra note 42. See supra note 52.
claim generation process, including some of the same screening enterprises and the same doctors who had engaged in the identical practices with regard to the generation of claims of asbestosis and the production of medical evidence in support of those claims.

Judge Jack found the “epidemic” of silicosis as manifested by filings of upwards of 20,000 claims in the 2002-2004 period, mostly in state courts in Mississippi and Texas, was, in fact, a “phantom epidemic” from the point of view of public health -- one which was confined to a small number of state courts. Among the evidence that Judge Jack considered was the revelation that 60%-70% of the 10,000 silica claimants that were in the MDL had previously filed claims of asbestosis. However, the clinical experience of pulmonologists is that having dual diseases – both asbestosis and silicosis – is exceedingly rare and virtually never encountered.

When confronted with the implications of having filed dual disease claims, one of the lead plaintiffs’ counsels in the silica MDL sought exoneration by arguing to Judge Jack that the previous diagnoses of asbestosis rendered for his clients were “wrong” and that his firm did not file asbestosis claims and was therefore not culpable. A careful recitation of the record, however, reveals that the firm had formed an affiliate firm which did file asbestosis claims and then shared any fees generated with the parent firm. In screenings sponsored by the firm, a litigation doctor would make a diagnosis of silicosis which was forwarded to the firm and, at the same

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97 MDL 1553, 398 F. Supp. 2d at 572. For discussion of the reasons for this outbreak of silicosis filings, see Brickman, Disparities, supra note 12, at 577-578.
98 MDL 1553, 398 F. Supp. 2d at 628.
99 Id. at 594-96. These “beat the clock” filings were not limited to welding fume claims. Judge Jack noted that most of the silica claims that were part of the “phantom epidemic” of silicosis, see supra note 97, “were filed just prior to the effective dates of recent ‘tort reform’ measures in Mississippi.” Silica Prods. Liab. Litig., 398 F. Supp. 2d at 620.
100 A full recitation of the facts is set forth in Brickman, Disparities, supra note 12, at 581-582.
time and for the same litigant, make a diagnosis of asbestosis and forward that to the affiliate firm.  

The evidence that Judge Jack reviewed, including the testimony by doctors and screening companies and the records produced in response to subpoenas enforced by threats of contempt, led her to conclude that “it is apparent that truth and justice had very little to do with these diagnoses . . . [Indeed] it is clear that the lawyers, doctors and screening companies were all willing participants” in a scheme to “manufacture. . . [diagnoses] for money.”

V. Fen-phen Litigation

A. Diet Drug Use And Heart Valve Regurgitation

The practice of using “entrepreneurial” screenings to generate specious medical evidence for use in asbestos and silica litigation have been replicated in another mass tort litigation based on the use of a tandem of diet drugs: Pondimin (fenfluramine) and Redux (dexfenfluramine), a chemically similar drug. These drugs were sold to approximately six million users, mostly middle aged women, by American Home Products which in March 2002, changed its corporate name to Wyeth.  

Sales of Pondimin took off after it was reported that significant appetite suppression was realized when it was taken in tandem with another prescribed drug, phentermine, 

\[\text{Id. at 635. Referring specifically to Dr. Ray Harron, who has done over 80,000 B-reads for asbestos litigation, Judge Jack found that with regard to his silicosis diagnoses, “Dr. Harron [found] evidence of the disease he was currently being paid to find.” Id. at 577. \]  

\[\text{Id. at 636. }\]

\[\text{See Wyeth Pharmaceuticals Company History, } \text{available at } \text{http://www.wyeth.com/aboutwyeth/history} \text{ (last accessed 08/06/07). All further references to the drugs’ seller will refer to Wyeth.}\]
(the “phen” in what became known as fen-phen”). Redux, however, was taken alone. While it was known at the time of FDA approval that Pondimin and Redux raised the risk of pulmonary artery hypertension in a small number of users, data accumulated after widespread use of the drugs indicated that, for an indeterminate number of users, fen-phen use raised the risk of an injury to heart valves that allowed blood to flow back -- regurgitated -- into the chamber from which it was pumped. This condition can lead to deterioration of heart function. The initial

105 See Brown v. Am. Home Prods. (In re Diet Drugs Prods. Liab. Litig.), MDL Docket No. 1203 Pretrial Order No. 1415, 2000 WL 1222042 (U.S.D.C., E.D. Pa., Aug. 28, 2000) at *1 [hereafter, PTO 1415]. See also, David Faigman et al., 4 MODERN SCIENTIFIC EVIDENCE § 39-1.1 (2002). Redux was taken by approximately 2,000,000 users and was usually not combined with phentermine. PTO 1415, id. at 2.

106 Pulmonary arterial hypertension (PAH) (also known as PPH) is continuous high blood pressure in the pulmonary artery. Three types of changes may occur in the pulmonary arteries in individuals diagnosed with PAH. These changes include: (1) The muscles within the walls of the arteries may tighten up, making the inside of the arteries narrower; (2) the walls of the arteries may thicken and scar tissue may form in the walls of the arteries. This causes the arteries to become increasingly narrow; or (3) small blood clots might form within the smaller arteries, which causes blockages. The narrowing of the arteries causes the right side of the heart to work harder to pump blood through the lungs. This weakens the heart muscle and causes the heart muscle to lose its ability to pump a sufficient amount of blood to support the body’s requirements. This condition is known as right heart failure, and is the most common cause of death in persons diagnosed with PAH. U.S. Department of Health and Human Services, National Heart Lung and Blood Institute, What is Pulmonary Arterial Hypertension?, (August 2006) available at http://www.nhlbi.nih.gov/health/dci/Diseases/pah/pah_what.html (last accessed 08/06/07). A relatively small number of lawsuits against Wyeth alleged PAH. See Robert Lenzner and Michael Maiello, The $22 Billion Gold Rush, FORBES, April 10, 2006 at 86, 90 [hereafter, Gold Rush].

107 Two investigative reporters stated that several thousand fen-phen users suffered serious heart-valve injuries requiring surgery in 1205 cases as of February 2005. They reported that the drugs may have killed several hundred people and that 88,000 users had claimed to have had serious heart valve injury. Gold Rush, supra note 106, at 92. A review of published literature indicates little data that provides a sound basis for concluding the number of serious injuries. The discrepancy between the number of persons claiming serious heart valve disease and the number that had surgical intervention may be accounted for by the effects of litigation screenings, discussed infra at notes 166 et seq.

108 The vast majority of the fen-phen cases allege heart valve injury. Heart valves keep blood flowing in a forward direction through the heart. Heart valve disease is a condition in which some of the blood being pumped flows backward into the chamber from which it was pumped and most commonly affects the mitral and the aortic valves, both of which are located on the left side of the heart. Mitral regurgitation occurs as the heart’s left ventricle contracts and expels blood into the aorta. During this process, blood leaks backward, or regurgitates through a defective mitral value, into the left atrium. As a result of this reverse flow, the heart must work harder to pump the needed blood throughout the heart and into the body. Aortic regurgitation is a similar process that occurs when blood flows backward from the aorta into the left ventricle through the aortic valve. See Mitral Valve Regurgitation, Mayo Clinic, http://www.mayoclinic.com/health/mitral-valve-regurgitation/DS00421 (Sep. 20, 2007) (last visited
data and subsequent studies have predominantly shown that while there is an increased risk for fen-phen users of mild mitral valve regurgitation and aortic insufficiency, there is little

04/22/08); Aortic Regurgitation, American Heart Association, http://www.americanheart.org/presenter.jhtml?identifier=4448 (last visited 04/22/08).

There are four levels of mitral valve regurgitation. Trace and slight mitral valve regurgitation generally cause few, if any, problems. Indeed, many persons with trace or mild-to-moderate chronic mitral valve regurgitate never develop symptoms of any sort and thus are unaware of having this condition. Those with moderate-to-severe mitral valve regurgitation may not experience symptoms for decades. For those with more severe mitral valve regurgitation, such as acute mitral valve regurgitation, symptoms develop speedily, and cause patients to be critically ill. See Eugene Mark et al., Fatal Pulmonary Hypertension Associated with Short-Term Use of Fenfluramine and Phentermine, 337 New Eng. J. Med. 602, 602 (1997), available at The New England Journal of Medicine, http://content.nejm.org/cgi/reprint/337/9/602.pdf (last accessed 08/06/07); see also Mitral Heart Valve Disease – Overview, (April 3, 2006) available at http://www.webmd.com/heart-disease/tc/Mitral-Valve-Regurgitation-Overview (last accessed 08/06/07) [hereafter, webmd.com].

Regurgitation must be distinguished from artifacts, phantom jets, and backflow. Backflow is “a backward displacement of blood into the left atrium that is due to the closure of the valve leaflets.” Arther E. Weyman, PRINCIPLES AND PRACTICE OF ECHOCARDIOGRAPHY 431 (2d ed. 1994). This is a “normal phenomenon that exists in virtually everyone” and is “of no medical concern.” See Pretrial Order No. 2640, Nov. 14, 2002 at 12 , In re: Diet Drugs Products Liability Litigation, MDL No. 1203 (U.S.D.C. E.D. Pa.) [hereafter, Order No. 2640]. “Backflow is not mitral regurgitation. It does not result from any leakage through the valve. Instead, it is the normal movement of blood that is behind the mitral valve in the left atrium when the valve snaps shut.” See Joint Proposed Findings of Fact and Conclusions of Law of the AHP Settlement Trust, Wyeth, and Class Counsel Concerning the Law Firms of Hariton & D'Angelo, LLP and Napoli, Kaiser, Bern & Associates, LLP, September 23, 2002 at 12, In re: Diet Drugs Products Liability Litigation, MDL Docket No. 1203, U.S.D.C. E.D. Pa. [hereafter, Joint Proposed Findings of Fact], citing Trans. V. at 124:13-126:1 (Dent). Mitral regurgitation has greater velocity and lasts longer than backflow.

There are several causes of heart valve disease. In the past, rheumatic fever – an inflammatory condition that often starts with strep throat - was a common cause of heart valve disease, but this disease is uncommon today. Infective endocarditis, an infection of the endocardio gram (the lining that covers the inner walls of the heart’s chambers and valves) is another cause. In elderly people, common causes of heart valve disease include myxomatous degeneration, a condition which generally affects the mitral valve that connects the left atrium and ventricle; and calcific degeneration, a condition in which calcium deposits build up on the valve. Other causes include congenital abnormalities (i.e., problems that are present at birth, such as a misshapen aortic valve, or malformation of the mitral valve). Heart valve disease may also result from other heart disease, specifically coronary artery disease or a heart attack. Jeffrey R. Bender, Yale Medical Library, Chapter 13: Heart Valve Disease, available at http://www.med.yale.edu/library/heartbk/13.pdf (last accessed 08/06/07) [hereafter, www.med.yale.edu]. Additionally, the mitral valve can deteriorate with age or a mitral valve prolapse may occur. Mayo Clinic Foundation, Mitral Valve Regurgitation, available at http://www.mayoclinic.org/mitral-valve-disease/mitral-regurgitation.html (last accessed 08/06/07) [hereafter, www.mayoclinic.org/mitral-valve].

The phrase “aortic insufficiency” refers to mild or greater aortic valve regurgitation. See Kip A. Petroff and M. Raphael Levy, Fen-Phen: A Primer For The Second Round, 5 Mealey’s Litigation Report: Fen-Phen/Redux 7 (May 2002) [hereafter, Mealey’s, Petroff & Levy].
increased risk of moderate or severe mitral valve regurgitation.\textsuperscript{111} To determine the extent of a heart valve injury,\textsuperscript{112} medical technicians called “sonographers” administer echocardiograms, basically sonograms of the heart, which are then interpreted by cardiologists.

In September 1997,\textsuperscript{113} Wyeth decided to withdraw the drugs in response to a request from the FDA for such action, based, in part, on an article published in a medical journal reporting the Mayo Clinic’s observation of an association between use of the diet drugs and valvular heart disease.\textsuperscript{114} Subsequent studies, however, have raised doubts about some of the initial conclusions drawn from the FDA and Mayo Clinic reports as to the relationship between fen-phen use and heart valve disease. One set of studies found that fen-phen users had an increased

\textsuperscript{111} Clinical studies do not show an increased risk of moderate or severe mitral valve regurgitation for fen-phen but rather only an increased risk of mild mitral valve regurgitation and only if used for three to six months or more. PTO 1415, supra note 105, at 35-36. It is generally accepted that valvular heart disease from causes other than diet drugs is potentially progressive in nature; once a significant valvular regurgitation exists, it tends to become more severe over time. Mild forms of regurgitation tend not to progress, while moderate and severe regurgitation do tend to progress. For fen-phen users, studies have also indicated that heart valve injury may improve after cessation of the drugs and echocardiograms may then indicate normal valve function. \textit{See infra} note 118.

\textsuperscript{112} To diagnose heart valve disease, doctors can choose to have a chest x-ray administered, an electrocardiogram, or an echocardiogram. Sometimes doctors may perform an extra procedure known as a cardiac catheterization if the aforementioned tests have not provided sufficient information about the valve disease or if surgery is being planned as treatment. \textit{See www.pdrhealth.com}, supra note 108 (last accessed 07/31/07).


\textsuperscript{114} The 1997 Mayo Clinic report involved clinical observations of 24 patients who had taken the fen-phen drug combination for approximately one year. The patients’ symptoms were found to be related to valvular insufficiency, and five of the patients required valve replacement or repair (four patients had mitral valve surgery, while one patient had combined mitral, aortic, and tricuspid valve surgery. \textit{See} Richard W. Asinger, \textit{The Fen-Phen Controversy: Is Regression Another Piece of the Puzzle?}, 74 Mayo Clinic Proceedings 1302-1304 (1999), Mayo Foundation for Medical Education and Research, \textit{available at} http://www.mayoclinicproceedings.com/inside.asp?AID=2792&UID=#bib1 (last accessed 07/16/07). The Mayo Clinic report can also be found at H.M. Connolly et al., \textit{Valvular Heart Disease Associated With Fenfluramine-Phentermine}, 377 N. ENG. J. MED. 581-588 (1997) [published correction in 337 N. Eng. J. Med. 1783 (1997). \textit{See also} Chari Y. Teramae, MD, \textit{Diet Drug-Related Cardiac Valve Disease: The Mayo Clinic Echocardiographic Laboratory Experience}, 75 Mayo Clinic Proceedings 456-461 (2000), Mayo Foundation for Medical Education and Research, Division of Cardiovascular Diseases and Internal Medicine.
risk relative to control groups of elevated levels of severe mitral valve regurgitation and aortic insufficiency, which was related to the duration of use of the diet drugs; other studies have found that while fen-phen use is associated with an increase in aortic regurgitation if the drugs were taken for a “threshold duration” of three to six months, diet drug use is not associated with an increased prevalence of moderate or greater mitral valve regurgitation regardless of the duration of use. Moreover, a number of studies determined that those who took the diet drugs

115 See Mealey’s, Petroff and Levy, supra note 110; Mahmood A. Kahn et al., The Prevalence of Cardiac Valvular Insufficiency Assessed by Transthoracic Echocardiography in Obese Patients Treated with Appetite-Suppressant Drugs, 339 NEW ENGL. J. MED. 713 (1998) (23% of 233 patients who took the diet drug for an average duration of 20.5 months were diagnosed with mild or greater aortic insufficiency or moderate or greater mitral valve regurgitation as compared with 1.3% of the control group); Hershel Jick et al., A Population-based Study of the Appetite-suppressant Drugs and the Risk of Cardiac-valve Regurgitation, 339 NEW ENG. J. MED. 719 (1998) (finding that those patients who took diet drugs for periods exceeding four months experienced the greatest risk for valvular heart disease relative to both unexposed patients and those who had taken phentermine); D.H. Ryan et al., Serial Echocardiographic and Clinical Evaluation of Valvular Regurgitation Before, During, and After Treatment with Fenfluramine or Dexfenfluramine and Mazindol or Phentermine, 7 OBESITY RE. 313 (1999) (concluding that patients on the diet drugs for periods exceeding six months experienced significantly higher risk for developing valvular heart disease); Julius M. Gardin et al., Valvular Abnormalities and Cardiovascular Status Following Exposure to Dexfenfluramine or Phentermine/Fenfluramine, 283 J. AM. MED. ASS’N 1703 (2000) (finding that patients who took the diet drug for 30 days continuously were two to three times more likely to have mild or greater aortic insufficiency than the control group and that patients who took the drugs for period exceeding three months experienced higher rates of aortic regurgitation); and James G. Jollis et al., Fenfluramine and Phentermine and Cardiovascular Findings: Effects of Treatment Duration on Prevalence of Valve Abnormalities, 101 CIRCULATION 2071 (2000) (finding that, relative to a control group, patients taking the diet drugs for 90-360 days experienced an insignificant increase in risk for mild or greater aortic regurgitation but those who took drugs for a longer period of time (180-360 days) were significantly more likely to demonstrate mild or greater aortic regurgitation).

116 See PTO 1415, supra note 105, at *14-15; “The Prevalence of Significant Valvular Regurgitation and Pulmonary Hypertension in 753 Patients Who Took Fenfluramine and Phentermine in a Community Setting,” reported in Studies On Valve Disease, Pulmonary Hypertension In Anorectic Drug Users Presented At ACC Seminar, 2 Mealey’s Litigation Report: Fen-Phen/Redux 5 (March 1999) (concluding that, while the prevalence of significant valvular regurgitation (referring primarily to moderate regurgitation) and PPH in individuals who had previously taken fen-phen is higher than reported for the general population, severe valvular regurgitation and severe pulmonary hypertension are both rare in fen-phen users, and that aortic insufficiency is the most common abnormality observed as a result of the drug use); “Valvular Abnormalities and Cardiovascular Status Following Exposure to Dexfenfluramine or Phentermine/Fenfluramine,” reported in Study Links Diet Drugs To Aortic, But Not Mitral, Valve Damage, Serious Events, 3 Mealey’s Litigation Report: Fen-Phen/Redux 6 (April 2000) (concluding that Redux and fen-phen are associated with an increase in aortic regurgitation, but not with an increased prevalence of mitral valve regurgitation “or with serious cardiac events.” This study was supported by a grant from Wyeth; two of the authors reported that they were consultants to Wyeth in 1997
for less than three months do not have a significantly increased risk of significant valvular regurgitation. \textsuperscript{117} Finally, studies of the effects of fen-phen use, including a follow-up of the Mayo Clinic study, indicate that at least some fen-phen users with valvular regurgitation not only do not get progressively worse after cessation of use of the drugs but their condition actually improves to the point where their echocardiograms are normal. \textsuperscript{118}

during the planning phase of the study); Andrew J. Burger, MD, \textit{Low Prevalence of Valvular Heart Disease in 226 Phentermine-Fenfluramine Protocol Subjects Prospectively Followed for up to 30 Months}, 34(4) J. AMER. COLL. OF CARDIOLOGY 1153 (1999), \textit{available at http://content.onlinejacc.org/cgi/reprint/34/4/1153} (last accessed 08/06/07) [hereafter, Burger Study]; \textit{Study Links Diet Drugs to Aortic, But Not Mitral, Valve Damage}, 3 Mealey’s Litigation Report: FenRedux 6 (April 2000) (finding that “[f]en-phen therapy is associated with a low prevalence of significant valvular regurgitation. Valvular regurgitation in our subjects may reflect age-related degenerative changes.” It concluded that “[t]hese findings question the contribution of fen-phen . . . as an independent risk factor for valvular regurgitation.”)

Some researchers have found that there is no significant relationship between Redux use and valvular heart disease. \textit{See, e.g.}, Neil J. Weissman et al., \textit{An Assessment of Heart-valve Abnormalities in Obese Patients Taking Dexfenfluramine, Sustained-release Dexfenfluramine, or Placebo}, 339 NEW ENG. J. MED. 725 (1998) (finding that the risk of mitral regurgitation was small, relative to the placebo group). \textsuperscript{117} \textit{See PTO 1415 supra note 105, at *14.}

\textit{Three 1999 studies found that heart valve damage resulting from the use of the diet drug combination did not worsen after stoppage of the drugs; to the contrary, the heart valve injury regressed. See 3 New Medical Studies Indicate Valve Damage May Regress Or Not Worsen}, 3 Mealey’s Litigation Report: Fen-PhenRedux 2 (December 1999). In a follow-up to their 1997 study regarding the potential health risks resulting from the use of the fen-phen diet drug combination, researchers at the Mayo Clinic (including Dr. Heidi M. Connolly, the lead author of the 1997 study) conducted a study of 5 obese patients who had ingested fen-phen for a period ranging from 8 to 73 weeks, all of whom had developed mild aortic heart valve regurgitation (one of the patients had also developed pulmonary hypertension). The researchers found that six months after the patients had stopped ingesting the drugs, each of their echocardiograms had improved and none met the standard for drug-related valvular disease. The pulmonary artery pressure in the patient who had been diagnosed with pulmonary hypertension decreased to levels that were close to normal. The researchers concluded that (1) valvular heart disease did not appear to progress after stoppage of the use of fen-phen, and (2) the patients’ echocardiograms appeared to improve over time. The Mayo researchers also reasoned that “if the improvement of mild valvular disease noted in this study is indicative of the course of valvular disease in other patients who took fenfluramine and phentermine, the burden of disease may be less than expected from the number of people who were prescribed these drugs.” \textit{See Echocardiographic Improvement Over Time After Cessation of Use of Fenfluramine and Phentermine}, Donald D. Hensrud, M.D., et al., Mayo Clinic Proceedings, December 1999, Vol. 74, No. 12, Pages 1191-1197). (The Mayo study was supported in part by a grant from Gates Pharmaceuticals).

Other studies have also found evidence of regression after discontinuation of patients’ use of the diet drugs. A 1999 study concluded that regurgitation related to dexfenfluramine may regress after stoppage of use of the diet drugs. Indeed, the researchers pointed out that “[t]he decline in the frequency of regurgitation over time after drug discontinuation may indicate the potential for regression of valvulopathy associated with dexfenfluramine.” The researchers noted that although the presence of
B. The Onset of Litigation

While a few lawsuits had been filed prior to 1997, Wyeth’s withdrawal of the drugs precipitated an onslaught of claim filings. In December 1997, federal court fen-phen cases were consolidated into an MDL proceeding in the Eastern District of Pennsylvania. In the period September 1997 to November 1999, 18,000 lawsuits were filed against Wyeth.

What gave the fen-phen litigation longer “legs” was the fact that millions of people have some degree of valve regurgitation. The Mayo Clinic, for example, states that “as many as

abnormal regurgitation linked to the use of dexfenfluramine is estimated to be 5.5 percent, factors other than dexfenfluramine are independently linked with significant valve regurgitation in obese patients. See Bruce K. Shively, M.D., et al., Prevalence and Determinants of Valvulopathy in Patients Treated With Dexfenfluramine, 100 CIRCULATION 2161 (1999). (This study was supported by a grant from Interneuron Pharmaceuticals Inc., which licensed dexfenfluramine.)

Another study concluded that the small increase in minor degrees of mitral and aortic regurgitation in patients who had ingested dexfenfluramine for a period of two to three months had disappeared three to five months after the patients had discontinued use of the drugs. The researchers pointed out that the data suggests that the degree of regurgitation observed in patients who used Dexfen (dexfenfluramine) for a relatively short duration does not progress over time. The researchers suggested that progression of either mitral or aortic regurgitation is unlikely with respect to patients who had ingested dexfenfluramine for three months or less, noting that after such patients had discontinued treatment for three to five months, there was no difference in prevalence of either aortic regurgitation or mitral regurgitation of any severity between treated and control patients. See Neil J. Weissman, M.D., et al., Prevalence of Valvular-Regurgitation Associated With Dexfenfluramine Three to Five Months After Discontinuation of Treatment, 34 J. OF THE AMER. COLLEGE OF CARDIOLOGY 2088 (1999). The study was sponsored by the Wyeth-Ayerst Research Division of Wyeth Laboratories.

Id. As of 1999, more than 1,000 cases were transferred as part of MDL 1203. In re: Diet Drugs Prods. Liab. Litig., 1999 WL 782560, at 2 (E.D. Pa. Sept. 27, 1999).

Id. The Fen-Phen Follies: Mistaken Assumptions, Greedy Lawyers and Suggestions of Fraud Have Made Fen-phen a Disaster of a Mass Tort, 27 THE AMERICAN LAWYER, 92, 94 (2005) [hereafter, Frankel, Fen-Phen Follies].

See Evanston Northwestern Healthcare, Mitral Valve Regurgitation, March 10, 2004, noting that “[m]itral valve regurgitation is the most common type of heart valve insufficiency. It affects about 4 million people in the United States and 250,000 people develop significant mitral valve regurgitation each year.”
one in five people over age 55 have some degree of mitral valve regurgitation.” 124 Furthermore, the majority of healthy people have an even more minimal level of mitral regurgitation called “trace” regurgitation. 125 In addition, a much smaller but still substantial number of persons have aortic regurgitation. 126 Indeed, valvular “regurgitation occurs to varying degrees in the majority of entirely healthy individuals.” 127 Though valvular regurgitation is widespread, especially mild and trace mitral valve regurgitation, unless the regurgitation is substantial, it poses no health risk. The FDA has determined that the only levels of valvular regurgitation that do pose a health risk are moderate or greater mitral valve or mild or greater aortic valve regurgitation. These levels of regurgitation have become known as FDA Positive. 128

1. Medical Monitoring Class Actions

regurgitation (i.e. trace [or] mild mitral regurgitation or trace aortic regurgitation) are relatively common in the general population and are not generally considered abnormal.” Order No. 1415, supra note 111, at 25.

124 See www.mayoclinic.org/mitral-valve, supra note 108.

125 See Joint Proposed Findings of Fact, citing Tr. I at 44:4-8 (Dent), supra note 108, at 10.

Approximately 90% of the general population has at least trace regurgitation. See Joint Proposed Findings of Fact, supra note 108, citing J.P. Singh, et al., Prevalence of Clinical Determinants of Mitral, Tricuspid and Aortic Regurgitation (The Framingham Heart Study), 83 JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY 897, W-89 at Tables Ila, llb (1999); Frederick Helmcke, et al., Color Doppler Assessment of Mitral Regurgitation with Orthogonal Planes, 75 CIRCULATION 175, Tr. II at 291:24-292:23. There is little or no clinical difference between having no, trace or mild mitral regurgitation. See Joint Proposed Findings of Fact, citing Tr. I at 44:9-14, Tr. II at 14:3-8 (Dent), supra note 108, at 10.

126 Approximately 5 out of every 10,000 people have aortic insufficiency. It is most common in men between the ages of 30 and 60. See Medline Plus, A Service of the National Library of Medicine and the National Institutes of Health, available at http://www.nlm.nih.gov/medlineplus/ency/article/000179.htm (last accessed 10/07/07).

127 PTO 1415, supra note 105, at *9.

128 The term “FDA Positive” refers to individuals who are diagnosed with moderate or greater mitral valve regurgitation or mild or greater aortic valve regurgitation. The FDA has observed that “minimal degrees of regurgitation (i.e., trace [or] mild mitral regurgitation or trace aortic regurgitation) are relatively common in the general population and are not generally considered abnormal. Thus, only mild or greater aortic regurgitation and moderate or greater mitral regurgitation are referred to as ‘FDA Positive regurgitation.’” See In re Diet Drug (Phentermine, Fenfluramine, Dexfenfluramine) Products Liability Litigation, Brown v. AHP Corp., et. al, 226 F.R.D. 498, 501 (E.D. Pa. 2005) (citations to PTO 1415 omitted) [hereafter, In re Diet Drugs 2005]. Furthermore, “[a]ll of the experts who testified at the Settlement Agreement Fairness Hearing agreed that the FDA case definition, or “FDA Positive,” is the appropriate way to define medically relevant valvular regurgitation and that the lesser degrees of regurgitation have no medical significance.” Id. at 143.
In addition to the individual lawsuits that were filed based on a claim of injury from use of the diet drugs, Wyeth was also faced with more than a hundred filings seeking class action certification including a substantial number that sought medical monitoring relief. In these cases, plaintiffs would not need to prove that they had been injured by use of the diet drugs but only that they had been exposed to an unreasonable risk justifying the relief of annual medical testing to determine whether they had contracted the illness in question.

The threat level posed by these class action filings was elevated when several national and statewide medical monitoring classes were certified or conditionally certified and were proceeding to trial. If these suits succeeded and the relief granted was that Wyeth would have

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129 Plaintiffs in tort actions for “medical monitoring,” which is also sometimes called “medical surveillance,” seek “post-exposure, pre-symptom recovery for the expense of periodic medical examinations to detect the onset of physical harm.” See Victor E. Schwartz, Mark A. Behrens, Emma K. Burton, Jennifer L. Groninger, Medical Monitoring – Should Tort Law Say Yes? 34 Wake Forest L. Rev. 1057, 1058 (1999). A medical monetary claimant need not show any present physical injury nor even a substantial likelihood that he will sustain such an injury in the future as a consequence of the inhalation, ingestion or exposure to an alleged harmful substance. In theory, hundreds of millions of consumers could therefore be aggregated into class actions claiming billions of dollars in reimbursement for medical testing with commensurable contingency fees paid to the lawyers. While some courts have permitted recovery for medical monitoring, others have rejected such claims. See id. (discussing the leading cases in which courts have permitted recovery for medical monitoring, and the cases in which courts have rejected such claims). See also Medical Monitoring And Asbestos Litigation - A Discussion With Richard Scruggs And Victor Schwartz, 17 Mealey’s Litigation Report: Asbestos 3 (2002) (discussing the controversial nature of medical monitoring, and recounting its origins as a response to some of the challenges that plaintiffs face in meeting all of the requirements for class certification under Rule 23 of the Federal Rules of Civil Procedure.); See also Note, Viivi Vanderslice, Viability of a Nationwide Fen-Phen/Redux Class Action Lawsuit in Light of Amchem v. Windsor, 35 Cal. W. L. Rev. 199, 218-19 (1999) (discussing the advantages to plaintiffs’ lawyers of medical monitoring classes over class actions that seek damages, including the ability to avoid many causation and damages issues unique to individual plaintiffs).

130 See PTO 1415, supra note 105, at *3-4. These medical monitoring classes included: United States District Court for the Eastern District of Pennsylvania, Jeffers v. American Home Products Corp., C.A. No. 98-CV-20626 (E.D. Pa.) (In re Diet Drug Products Liability Litigation, MDL 1203) (nationwide medical monitoring class); West Virginia (Burch et al. v. AHP, Civil Action No. 97-C-204(1-11)) (statewide personal injury and medical monitoring class); Illinois (Rhyne v. AHP, 98 CH 4099) (statewide refund and monitoring reimbursement class); New Jersey (Vadino et al. v. AHP, Docket No. MID-L-425-98) (statewide Unfair and Deceptive Acts and Practices and medical monitoring class); New York (New York Diet Drug Litigation, Index No. 700000/98) (statewide medical monitoring class); Pennsylvania (Pennsylvania Diet Drug Litigation, Master Docket No. 9709-3162 C.C.P. Phila.) (statewide medical monitoring class); Texas (Earthman v. AHP, No. 97-10-03970 CV, Dist. Ct.)
to pay for three years of annual echocardiograms read by a cardiologist at a cost of about $1000 for each check-up, then assuming that the class size approximated 6,000,000 fen-phen users, Wyeth was facing a potential cost of up to $18 billion.

C. The Settlement Agreement

In April 1999, Wyeth began negotiating for a global resolution of the litigation. During the course of the negotiations, Wyeth was faced with: a jury verdict in Texas that proved damaging to its position;\(^\text{131}\) multiple medical monitoring class actions that were proceeding


At the trial, Ms. Lovett’s attorneys argued that Wyeth had attempted to minimize the possible risks of the diet drug by trying to limit the warnings on side effects. Robert Langreth, American Home Ins. Ordered to Pay $23.6 million in Diet-Drug Suit, WALL ST. J., August 9, 1999 at A4. The jury award was regarded by Ms. Lovett, whose symptoms were limited to shortness of breath and fatigue, and her counsel as indicating “anger at the company, not sympathy” for Ms. Lovett. Id. This view is accentuated by the fact that Ms. Lovett’s own cardiologist had testified that her heart problems preceded her use of fen-phen. See Jim Yardley, $23 Million Awarded in Suit Against Maker of Diet Drug, N.Y. TIMES, August 7, 1999, at A7. After the Lovett verdict, “[s]everal Wall Street analysts expressed surprise at the verdict and predicted it would encourage more lawsuits against the company, particularly since [Wyeth] appeared to have solid evidence that Ms. Lovett’s heart condition existed before her use of the diet drugs.” Id.

In addition to the Lovett case, two plaintiffs received a $29.2 million verdict in 2000, which was then settled for an undisclosed amount. The jury verdict came down after the settlement was entered into by the parties, but prior to the court’s approval. Baston v. American Home Products Corp., et al., No. 99-0306, Wirt v. American Home Products Corp., No. 99-0037, Ore. Cir., Coos Co. See Oregon Case Settled for Undisclosed Amount, 3 Mealey’s Litigation Report: Fen-Phen/Redux 10 (August 2000).
through discovery and one such action in New Jersey that had commenced trial; individual cases that were poised for remand for trial in the MDL 1203 proceedings,\(^{132}\) and thousands of personal injury suits that were underway.\(^{133}\) Faced with this litigation environment,\(^{134}\) on October 7, 1999, Wyeth agreed to enter into a Rule 23 (b)(3) settlement ("Settlement") of a national class action with all of the medical monitoring class actions subsumed into the Settlement.\(^{135}\) Under its terms, a trust ("Trust") was created consisting of two separate funds, which together were capped at $3.75 billion.\(^{136}\) Fund A consisted of $1 billion to pay smaller cash benefits or provide medical services including medical monitoring for fen-phen users who had either not suffered valve damage or had less than FDA Positive regurgitation. Fund B totaled $2.55 billion and was the

\(^{132}\) PTO 1415, supra note 105, at *4, *45.

\(^{133}\) Id. at *45. The number of lawsuits filed during the period of negotiation that lasted from April to October 1999 when a settlement was agreed to, grew from a total of 3,100 to a number estimated to exceed 10,000. Jim Yardley, $22 Million Awarded in Suit Against Maker of Diet Drug, supra note 131.

\(^{134}\) Professor Richard A. Nagareda concluded that the principle threat to Wyeth was the possibility of multiple punitive damages awards. NAGAREDA, MASS TORTS, supra note 1, at 137 (2007). However there is little evidence to support the contention that the threat of multiple punitive damage awards loomed larger to Wyeth than the one posed by medical monitoring class actions.

Other consideration may have also played a role in Wyeth’s decision to enter into the Settlement Agreement. Prior to the Settlement Agreement, a news article reported that Wyeth “may also be interested in reaching a settlement because its strategic position has eroded in recent weeks. For one thing, the Federal Bureau of Investigation has begun, in a preliminary way, to look into Redux’s 1996 approval by the Food and Drug Administration; any new revelations could hurt [Wyeth’s] defenses in civil trials.” Laura Johannes and Robert Langreth, Fen-Phen Defense: Marketer of Redux, Mulling Settlement, Sees Plaintiffs’ Hand-Those Suing American Home Assail Way It Monitored Diet Drugs’ Side Effects – The ‘Flood of Red Folders’, WALL STREET JOURNAL (Eastern edition) September 28, 1999, at A1.


\(^{136}\) See $3.75 Billion Global Settlement Approved in Diet Drug MDL, 16 ANDREWS PHARMACEUTICAL LITIG. REP. 3 (Nov. 2000). In 2004, by the terms of the Seventh Amendment to the Settlement Agreement, $1.275 billion was added to the Trust. See MDL Court Denies Motion To Find Settlement Void Because Of Changes In Terms, 9 Mealey’s Litigation Report: Fen-Phen/Redux 6 (April 2006).
compensatory trust for claimants who qualified for one of the four payment matrixes.\textsuperscript{137} Any money not paid out by the Trust to satisfy claims would benefit Wyeth.

To obtain the Settlement, Wyeth made significant concessions including that claimants would not need to establish causation,\textsuperscript{138} that Wyeth waived any statute of limitations defense,\textsuperscript{139}

\textsuperscript{137} See In re Diet Drugs Prods. Liab. Litig., Nos. 1203, 99-20593 (E.D. Pa. Nov. 18, 1999) (nationwide class action settlement agreement with Wyeth) (as amended), available at http://www.settlementdietdrugs.com (last accessed 07/16/07) (follow “Settlement Documents” hyperlink) [hereafter, Settlement Agreement]. Fund A, capped at one billion dollars, provided limited benefits to those class members who ingested Pondimin and/or Redux for 60 days or less and who did not meet the FDA Positive standard. It also provided three primary benefits to those class members who ingested Pondimin and/or Redux for 61 or more days and did not meet the FDA Positive levels of valvular regurgitation: (1) echocardiogram screening; (2) an option between receiving valve-related medical services up to $10,000 in value or $6000 in cash; and (3) reimbursement for the cost of diet drug prescriptions ($30 per month of use for Pondimin, $60 per month of use for Redux), subject to a maximum of $500 per class member. A maximum of $25 million of the money placed into Fund A could be used to finance education and medical research pertaining to heart disease. See Settlement Agreement at §IV.A.

Fund B, capped at $2.55 billion, provided compensatory benefits to those diagnosed as FDA Positive, or with mild mitral regurgitation as of the end of the screening period in the event that within 14 years from final approval of the settlement (but not later than December 31, 2015), those class members developed serious heart valve disease. Four payment matrices (A-1, A-2, B-1, and B-2) were established under Fund B. In addition, Fund B also established five levels of injury, Levels 1-5 (5 being the most severe), in each matrix. Matrix A-1 was designed for those who used fen-phen for 61 or more days and in the case of the most severe level of injury, depending on age, would pay upwards of $1.485 million. Matrix B-1, which provided 20\% of the compensation amount stated in Matrix A-1, was established for individuals who had taken the drug for less than two months, had mild mitral valve regurgitation regardless of duration of diet drug use, or had alternative medical explanations (such as a pre-existing injury to the heart valve at issue, which had required surgery) for their injuries. Matrix A-2 and B-2 applied to derivative claimants. See Settlement Agreement at §IV.B.2.c. See also PTO 1415, supra note 105, at 50.

In order to receive matrix compensation benefits, a “Green Form” had to be submitted. The Green Form contained the result of the echocardiogram, medical history and physical exam information of the individual, a copy of the video or disk of the echocardiogram, a declaration under penalty of perjury from the individual that to the best of his knowledge, such condition was not present prior to usage of the diet drug(s), and declarations by a cardiologist stating that the individual qualifies for a particular matrix payment. In addition to the Green Form, documentary proof has to be submitted of the period of time during which the individual used the diet drug(s). See Settlement Agreement, id. at VI.C.2.

\textsuperscript{138} See Alison Frankel, Still Ticking, THE AMERICAN LAWYER, March 2005 at 92 (“Wyeth gave diet drug users a very good reason to stay in the class: It conceded the fight over causation. Claimants who stayed in the class wouldn’t have to prove, as they would in court, that Pondimin or Redux had caused their heart valve damage, only that they had heart valve damage and had taken the drugs.”) [hereafter, Frankel, Still Ticking].

\textsuperscript{139} Since Wyeth had withdrawn the drugs in 1997, and many statutes of limitations on tort claims require suit within one to two years, this defense that Wyeth waived could have proved formidable in the state tort systems. See PTO 1415, supra note 105, at *18.
and that those who did not exercise their initial Federal Rule 23 opt out right could opt out at a later time and pursue a remedy in the tort system; however, if they exercised this later or “downstream” opt out right, they could not bring claims for punitive damages, consumer fraud damages or medical monitoring.\textsuperscript{140} In exchange, Wyeth obtained terms that it believed would confine both its liability and the time frame in which the extent of its liability would be established.\textsuperscript{141} In particular, it believed that it had substantially contained the problem it faced in

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\textsuperscript{140} Class members who did not exercise an initial opt out right could later choose to file a claim in the tort system. As set forth below, under the terms of the Settlement, class members had the right to exercise an intermediate opt out or a back-end opt out, collectively referred to as “downstream opt outs.” See PTO 1415, \textit{supra} note 105, at *21.

Class members had the right to opt out of the settlement within a prescribed time frame and pursue a claim for compensatory damages in the tort system without meeting the bar of the statute of limitations or a defense of splitting of causes of action and without relying on any prior verdicts or judgment against Wyeth under the doctrines of collateral estoppel, res judicata, or other doctrine of issue or claim preclusion. This “intermediate opt-out” right was in addition to the initial opt-out right of all class members.” See PTO 1415, \textit{supra} note 105, at *2.

If class members with FDA Positive levels of regurgitation progress to serious levels of VHD by the year 2015, they have the right to receive compensation pursuant to the terms of the settlement matrices or to exercise a “back-end opt-out” and pursue their claim for compensatory damages (but not punitive damages) in the tort system without any time bar or other defense arising from a statute of limitations, a statute of repose or the like. \textit{Id.}

The Settlement Agreement explicitly excluded those individuals with a more serious condition, primary pulmonary hypertension (“PPH”), allowing them to sue Wyeth in the state tort system. The settlement did not include any recovery for plaintiffs alleging a variety of conditions, including neurotoxicity and elevated pulmonary hypertension because the District Court found that the evidence did not support a connection between the use of diet drugs and these conditions. See Clark v. Wyeth, 431 F. 3d 141, 145 (3d Cir. 2005).

The Settlement also included a “financial insecurity opt out right,” whereby if a condition of “financial insecurity” arose with respect to Wyeth’s obligations under the Settlement, all diet drug users who had been previously diagnosed as either FDA Positive or having mild mitral regurgitation and who had registered for settlement benefits by the deadline could opt out of the Settlement Agreement. Additionally, there was also a Sixth Amendment Opt out right created, which was available to those class members who otherwise qualified for the back-end opt out right, who claimed matrix benefits on or before May 3, 2003, and who qualified for Matrix Compensation Benefits but had not received such benefits or payment of any settlement funds from Wyeth. \textit{See In re Diet Drug (Phentermine, Fenfluramine, Dexfenfluramine) Products Liability Litigation, Brown v. AHP Corp., et. al, 226 F.R.D. 498, 503 (E.D. Pa. 2005).}

\textsuperscript{141} See NAGAREDA, MASS TORTS, \textit{supra} note 1, at 141 (discussing Wyeth’s strategy with respect to confining “within a modest time period the uncertainty surrounding its ultimate liability for such relief.”). Containing the litigation took on added importance because Wyeth was attempting to merge with Warner-Lambert, which owned the rights to Lipitor. This $70 billion merger failed; Pfizer won the race to merge. Jeffery H. Dyer et al., \textit{When to Ally and When to Acquire}, HARV. BUS. REV. at 108, 113-14 (July-Aug. 2004).
the tort system where large numbers of litigants who had pre-existing mild mitral value
regurgitation attributed that condition to short term fen-phen use, by requiring that in order to
receive matrix level compensation from the Trust, claimants had to present documentary proof of
the duration of use of the drugs, a diagnosis based on an echocardiogram reading of FDA
Positive, and a cardiologist’s signature on the “Green Form” attesting to a compensatory medical
condition.\textsuperscript{142} In addition, Wyeth undoubtedly expected that the results of ongoing clinical
studies including ones that would vindicate Wyeth’s position that even if fen-phen users had an
increased risk of valvular regurgitation,\textsuperscript{143} any such injury regressed after cessation of the
drug,\textsuperscript{144} would be reflected in reductions in claiming activity against the Trust and in the number
of downstream opt out cases brought in the tort system.\textsuperscript{145}

D. The Post-Settlement Claiming Process

Three claiming streams flowed from the Settlement. First, a substantial number of class
members exercised their Rule 23 right to opt out of the Settlement (“initial opt outs”) and pursue
their claims in the tort system. Second, another substantial number of class members who chose

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\textsuperscript{142} In re Diet Drugs (Phentermine, Fenfluramine, Dexfenfluramine) Products Liability
[hereafter, In re Diet Drugs 2005]. Wyeth no doubt expected that these terms would limit those with pre-
existing, mild mitral valve regurgitation to the matrix B-1 level.

\textsuperscript{143} See supra notes 111, 116.

\textsuperscript{144} See supra note 118.

\textsuperscript{145} An issue in the fen-phen litigation and Settlement was whether fen-phen use resulted in
latent injury which would manifest at some future time. A finding by the court that there is no latent
injury resulting from the ingestion of the client drugs was a crucial element of the Settlement approval.
See Judge Bechtle Finds Compensation Reasonable, Approves AHP Settlement, 3 Mealey’s Litigation
Report: Fen-Phen/Redux 11 (September 2000). This finding of no latency helped avoid the “futures”
problem which led to the rejection of the class action settlement in Amchem v. Windsor, 521 U.S. 591
(1997). While studies have indicated that any valve injury resulting from fen-phen use improves over
time to the point where echocardiograms become normal, see supra note 118, there are medical experts
who have testified that there is a latency period and the issue of latency continues to be disputed. See
Declaration of Dr. Colin Bloor. Ex. B.Certain Class Members Reply Memorandum of Law in Support of
Their Motion Under Rule 60(b) For Relief From Judgment, November 4, 2005, available at
http://www.fen-phen-eresource.com/60.pdf (last accessed 08/06/07); see also Class Members Argue
not to exercise an initial opt out and had the required documentary evidence sought compensation from the Trust. Third, a substantial number of these class members subsequently exercised a downstream opt out right that allowed them to seek compensation in the tort system albeit with the limitations set forth in the Settlement.\footnote{See supra note 140.}

1. Initial opt outs

Upon approval of the Settlement, 50,000 plaintiffs exercised their opt out right under Fed. R. Civil Pro. 23(b) (3), and proceeded in the tort system.\footnote{Wyeth said it had resolved “all but a small percentage” of those 50,000 claims. \textit{Up to 90,000 Opt Out of AHP Settlement; 61,000 File Claims}, 6 Mealey’s Litigation Report: Fen-Phen/Redux 8 (June 2003) [hereafter, Mealey’s Opt Out].} As part of their calculus, it is likely that these class members (or at least their lawyers) variously concluded that meeting the FDA Positive standard, as required by the Settlement, would be problematic whereas, in the tort system, they could take their chances because no minimal levels of injury would be required of a plaintiff to prevail, or because of the severity of the injury, they could get more compensation in the tort system than under the Settlement matrix.\footnote{While most studies indicated that use of fen-phen for less than three months did not result in significant valvular injury, \textit{see supra} note 117, juries in the tort system were free to ignore such data and instead based their decisions on Wyeth’s alleged failure to have notified the FDA and doctors of knowledge of the effects of use of the drugs and on sympathy for the plaintiff.} Notably many of the opt out cases had been filed in jurisdictions which have a reputation as being favorable to plaintiffs’ interests.\footnote{Many of the opt out plaintiffs had chosen to sue Wyeth in Mississippi, Texas, and West Virginia. \textit{See www.captran.com, supra} note 131. In Jefferson County, Mississippi where over 500 out-of-state fen-phen cases had been filed, the total number of all liability claims pending in the Circuit Court outnumbered the number of residents in the county. \textit{See David J. Morrow, American Home to Settle Some 1,400 Fen-Phen Suits: Deal May Imperil Warner-Lambert Merger}, N.Y. TIMES, December 23, 1999, at C2.} Wyeth settled virtually all of these claims on terms which were likely highly favorable to the plaintiffs.\footnote{Class counsel noted that Wyeth was “settling everything in sight for huge amounts of money,” and also observed that “It was a feeding frenzy like I’ve never seen.” It was reported that}
2. **Trust Claims**

Those class members who did not initially opt out of the Settlement or exercise a downstream opt out right to sue in the tort system could claim non-matrix benefits under Fund A or matrix level benefits from Fund B. The number of class members filing Trust claims, however, far exceeded the number that had been projected.

The uncontroverted medical evidence introduced in the Settlement hearings as well as the provisions of the Settlement led to “conservative assumptions likely to overstate the demands ‘on the Trust,’” that there would be a maximum of 8,345 serious injury claims and a little over three times that number of lesser injury claims -- a total of 36,000 claims, at a cost to Wyeth of $2-$4 billion. Moreover the projected ratio of diet drug-induced aortic regurgitation to diet drug-induced mitral regurgitation was five to one. Those projections were based on a “medical model” wherein class members would go to their own doctors and receive a diagnosis in the course of their medical care. Instead of 36,000 claims, however, the Trust received over 87,000 matrix level claims with the vast majority claiming moderate mitral valve regurgitation.

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“Wyeth hardly paused to consider the strength of individual cases, settling enormous inventories of cases in mass agreements with plaintiffs firms.” Frankel, *Still Ticking*, *supra* note 138, at 96. The Napoli firm (discussed *infra* at notes 170 et seq.) settled at least 5,600 of the initial opt-out cases. *Id.*


In *re Diet Drug 2005, supra* note 142, at 505.

*Id.* at 506.

As of August 12, 2002, the Trust had received a total of 42,244 Green Forms, representing approximately 35,000 claimants (since some file duplicate forms) and was receiving claims at a rate of about 1000 per week. *Order No. 2662, supra* note 151, at 8. By April 4, 2004, approximately 85,000 claims were received, “a little less than half of which were sufficiently complete to state on their face a claim for matrix benefits.” *In re Diet Drugs 2005, supra* note 142, at 507-08. As of January 5, 2005, in excess of “120,900 Green Forms were filed with the Trust, which represented more than 87,700 potential claims after duplicates were tagged.” *Id.* “In sum, these numbers manifest an enormous increase over what was anticipated at the Fairness Hearing in 2000.” *Id.* at 508. In particular, Wyeth received many more Level II benefits claims than expected. One journalist noted that “Wyeth had
Wyeth’s reliance on the requirement of documentary proof of the duration of use of the diet drugs as well as its reliance on the on the FDA Positive requirement and on cardiologists’ integrity in filling out the Green Forms, turned out to be profoundly misplaced. In an unknown but perhaps significant number of cases, plaintiffs submitted false medical and pharmacy records which had undoubtedly resulted in substantial settlement payments from Wyeth; a few plaintiffs and attorneys were later convicted of perpetrating these crimes. More to its dismay, however, Wyeth learned that the FDA Positive standard could easily be subverted by cardiologists, who with the help of sonographers maladministering echocardiograms, would read both trace and mild mitral regurgitation as moderate regurgitation because of the financial incentives for such misreadings.

Indeed, the Settlement, coupled with the effects of a few large verdicts in initial expected relatively few people to show these ominous indicators [which were required in order to satisfy Level II], yet tens of thousands submitted echocardiograms and green forms claiming them.” Frankel, Still Ticking, supra note 130, at 4; See also supra note 142).

155 See Jimmie E. Gates, Vicksburg Attorney Indicted in Scam, CLARION-LEDGER, May 27, 2006. In Barnett v. Wyeth, the plaintiff alleged that she was suffering from heart valve damage as a result of having taken Redux from February 1989 – June 1989. The court found, however, that the complaint was false in three distinct respects. Firstly, Redux was not available in the United States until June 1996; secondly, the name of the doctor that she claimed had prescribed the drugs to her was a fabrication; thirdly, the address where she claimed to have bought the drugs is the location of a bar, not a pharmacy. Barnett v. Wyeth, (In re Diet Drugs (Phentermine/Fenfluramine/Dexfenfluramine) Prods. Liab. Litig.), 381 F. Supp. 2d 421 (D. Pa. 2005). In United States v. Arledge, a Mississippi plaintiff attorney was convicted in the U.S. District Court for the Southern District of Mississippi for his role in the submission of fraudulent claims by patients in the fen-phen settlement. United States v. Arledge, No. 5:06-cr-18 [DCB] [JCS], S.D. Miss.,Western Div.). See Mississippi Attorney Guilty in Scheme to Create Fraudulent Records, 10 Mealey’s Litigation Report: Fen-Phen/Redux 6 (April 2007).

156 An editorial written following the Burger Study, see supra note 116, by a doctor affiliated with the University of California at San Francisco, Adult Echocardiography Laboratory who had been a consultant for Wyeth and who had been asked to provide expert testimony on both sides of the issue, questioned the contribution of fen-phen as an independent risk factor for valvular regurgitation, and rejected the conclusion that fen-phen use caused valvular heart disease. The writer stated that the FDA’s definition of “moderate mitral regurgitation” has no clearly defined medical or clinical meaning, and thus trace or mild mitral valve regurgitation can easily be manipulated by those lawyers and doctors with financial incentives to do so. Nelson B. Schiller, M.D., Editorial, 34 JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY, 1159 (October 1999); see also Low Prevalence of Valve Disease Found in New Fen-Phen Study, 2 Mealey’s Litigation Report: Fen-Phen/Redux 12 (October 1999). See also infra note 174.
opt out cases brought in the tort system\textsuperscript{157} and Wyeth’s perceived generosity in settling thousands of the initial opt out tort claims, proved to be the equivalent of the ranch house cook banging on the metal triangle at dinner time. That call was met by several law firms who responded to the establishment of the Trust and the downstream opt out right by instituting screenings to generate claimants by the tens of thousands.\textsuperscript{158} These law firms replaced the medical model with the screening model used to generate claims in asbestos litigation. To implement the model, they hired sonographers -- the medical technicians who administer echocardiograms -- and a comparative handful of cardiologists who were ready and eager to, in the words of U.S. District Court Judge Janis Jack, “manufacture diagnoses for money.”

3. Downstream Opt Outs

Litigation screenings also played a significant role in driving up the number of downstream opt outs. As noted, under the terms of the Settlement, class members who did not initially opt out of the Settlement could opt out later, at the back-end of the Settlement, and file a claim in the tort system subject to restrictions set forth in the Settlement including meeting the FDA Positive requirement and foregoing punitive damages.\textsuperscript{159} This right allowed class members to first determine what amount the Trust would offer in settlement and, if that was regarded as

\textsuperscript{157} Several substantial verdicts that were rendered in Mississippi drove up settlement costs significantly and also led to an increased number of opt outs. \textit{Gold Rush}, supra note 106, at 90. In 2000, in a case filed in state court which was decided after the settlement was entered into but before the settlement gained judicial approval, an Oregon jury awarded a total of $29.2 million to two plaintiffs who alleged mild aortic heart valve damage as a result of fen-phen ingestion. Baston v. American Home Products Corp., et al., No. 99-0306, Wirt v. American Home Products Corp., No. 99-0307, Ore. Cir., Coos Co. \textit{See Oregon Case Settled for Undisclosed Amount}, 3 Mealey’s Litigation Report: FenPhenRedux 10 (August 2000).

\textsuperscript{158} \textit{See infra} notes 166 et seq. for a description of these litigation screenings.

\textsuperscript{159} \textit{See supra} note 140.
insufficient, to then opt out and seek relief in the tort system, albeit with the limitations noted.\textsuperscript{160}

This strategic error created a situation in which Wyeth was essentially bargaining with itself to satisfy the claims of class members.\textsuperscript{161} Approximately 90,000 claimants exercised this downstream opt out right under the Settlement.\textsuperscript{162} Wyeth would later pay an additional $1.275 billion to the Trust in exchange for a limitation on downstream opt out rights.\textsuperscript{163} Wyeth has vigorously contested downstream opt out cases, in particular, those generated by litigation

\textsuperscript{160} See In re Diet Drugs 2005, supra note 142, at 515 (“Some claimants have completed a Green Form and submitted it to the Trust seeking matrix benefits. However, these claimants have also filed with the Trust their intention to exercise their intermediate opt out right in the event that the Trust auditors found them FDA Positive only but not entitled to matrix benefits.”)

\textsuperscript{161} See NAGAREDA, MASS TORTS, supra note 1, at 139. Nagareda observes that the “class settlement grid served as the analogue to the $50 exercise price of the put option for General Motors stock. Like the holders of put options in financial markets, moreover, fen-phen users were not obligated by the class settlement to exercise their put options. Rather, the put option enabled them, over time, to compare the compensation available under the class settlement and that available in tort litigation.” \textit{Id}. The put option in the fen-phen settlement “placed Wyeth in the position of being compelled to purchase the tort claims of fen-phen users in the event that they exercised their put options (by seeking compensation under the settlement grid) \textit{and} if they did not (by suing in the tort system instead, if only for compensatory damages.” \textit{Id}. at 144 (citations omitted). Furthermore, as a result of the fact that “atypically high-value claims stand to lose the most from a settlement grid that constrains the variance of payments . . . [.] high-value claimants will tend to depart, leaving mid- to low-value claims in the class.” \textit{Id}. at 145.

\textsuperscript{162} See 369 F.3d 293, at 312-15. By the May 3, 2003 deadline for downstream opt outs, individuals had filed 90,000 opt out notices and at least 61,000 claims for injury compensation under the Settlement; 70,000 of these downstream opt outs were intermediate opt outs (claiming mild or greater aortic regurgitation and/or moderate or greater mitral regurgitation), while 20,000 were back-end opt outs, who asserted more serious injury. See \textit{Mealey’s Opt Out}, supra note 147. As of September 2006, there were an estimated 60,000 downstream opt outs. See, NAGAREDA, MASS TORTS, supra note 1, at 147.

\textsuperscript{163} Faced with the prospect of claimants seeking to take two bites out of the apple, the Seventh Amendment to the Settlement Agreement sought to ameliorate some of the problems associated with claimants attempting to play their hand in a calculated manner. The Seventh Amendment dealt with the issue of “covering opt outs,” whereby some claimants completed a Green Form and submitted it to the Trust seeking matrix benefits. These claimants also, however, filed with the Trust their intention to exercise their intermediate opt out rights in the event that the Trust auditors found that they met the FDA Positive criteria only but were not entitled to matrix benefits. “Because the covering opt outs’ primary purpose was to be paid matrix benefits, the Seventh Amendment treats them as Category One claimants who are required to opt out of the Seventh Amendment if they want to preserve their downstream or other opt out rights. Thus, the Seventh Amendment effectively eliminates claimants’ opt outs’ ability to take a second bite at the apple. In an effort to end the type of litigation that ensued from the close to 60,000 downstream opt outs in the existing Settlement Agreement, those who participate in the Seventh Amendment no longer have any right to exercise an intermediate, back-end, Sixth Amendment, or financial insecurity opt out and thus will forgo the right to sue Wyeth in the tort system.” In re Diet Drug (Phentermine, Fenfluramine, Dexfenfluramine) Products Liability Litigation, Brown v. AHP Corp., et. al, 226 F.R.D. 498, 501 (E.D. Pa. 2005). See Seventh Amendment § XI.A.
screenings, with some considerable success. Many plaintiffs have received little or no compensation and a significant number have discontinued their claims without any payment from Wyeth. Part of this success is due to the bifurcation of a number of downstream opting out case trials. In a bifurcated trial, the jury first decides the issue of damages: whether there is an injury and how much compensation is to be awarded. If the jury finds injury and damages, then in the second phase of the trial, it determines whether Wyeth is liable for that injury. This typically works to Wyeth’s benefit since the issues of injury and damages are decided without the plaintiff being able to introduce damaging documentary evidence of Wyeth’s alleged bad conduct, namely, its alleged failures to have disclosed the harmful effects of ingestion of the diet drugs.

E. Litigation Screenings

Just as with the silicone breast implant litigation settlement, the fen-phen Settlement created an entirely new set of financial incentives for lawyers to manufacture claims on a massive scale. To do so, several law firms and echocardiogram companies created specifically

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164 See infra note 183.
165 Id. In re Diet Drugs 2005, supra note 142, at 522 (“claimants who have had the burden of establishing liability and damages in the tort system face substantial risk.”) See also, Frankel, Still Ticking, supra note 138, at 7 (“Without the threat of punitive damages – and furious to see in court some of the same lawyers, doctors, and echo mills that, in its view, had corrupted the class action – Wyeth has taken a much harder line in these cases than it did in the quickly settled first round of opt-out suits.”) Wyeth’s first win in a downstream opt out case came in a 2003 case where Wyeth argued that the plaintiff’s injury was the result of a pre-existing condition. The trial resulted in a unanimous jury verdict for the defendant. Eichmiller v. American Home Products Corporation, et. al., No. 2002CV52077, Ga. Super., Fulton Co., reported in Wyeth Wins Trial of Back-End Opt out On Unanimous Verdict, 7 Mealey’s Litigation Report: Fen-Phen/Redux 2 (December 2003). In a 2004 case, a downstream opt out plaintiff alleged that she was suffering from moderate aortic regurgitation as a result of having ingested the diet drug Pondimin. The jury found that the plaintiff did in fact suffer an injury to her aortic valve, but that Pondimin was not the cause of the injury. Furthermore, three of the plaintiff’s echocardiograms revealed that she only had trace aortic regurgitation. Istnick v. American Home Products, Ct. of Common Please, Pa., Philadelphia County, No. 00268. Sept. 10, 2004. See Jury Awards $48,000 to 1 Intermediate Opt out, Finds for Wyeth in 2nd Case, Mealey’s Litigation Report: Fen-Phen/Redux (July 2004). For more details regarding the downstream opt-out litigation – including judicial and expert commentary on echocardiogram quality, see infra notes 171, 174, and 183.
for the purpose of conducting litigation screenings spent millions of dollars\(^\text{166}\) to set up makeshift “echo mills” in law offices and hotel rooms where sonographers administered echocardiograms to the thousands who responded to advertisements to attend the screenings if they had used fen-phen.\(^\text{167}\) The entrepreneurial sonography firms were paid tens of millions of dollars for their efforts\(^\text{168}\) which included substantial bonuses if the litigant received any settlement proceeds from the Trust.\(^\text{169}\)

In July 2001, the Napoli, Kaiser, Bern & Associates LLP law firm and Hariton D’Angelo LLP, a law firm formed in June 2001 mostly for the purpose of bringing fen-phen claims, formed an association (“Napoli/Hariton”) to generate clients who would submit claims to the Settlement

\(^{166}\) A lead counsel for Wyeth in the fen-phen litigation estimated that lawyers spent $100 million dollars for fen-phen screenings. See Zimroth, Task Force Minutes supra note 28, at 162. See also Peter Grossi and Sarah Duncan, Litigation-Driven ‘Medical’ Screenings: Diagnoses for Dollars, 33 PROD. SAFETY & LIAB. REP. 1027, 1028 (2005) [hereafter, Grossi & Duncan, Screenings] (citation omitted) (stating that one survey by plaintiffs’ lead counsel in the fen-phen class action estimated that in just three years, plaintiffs’ firms spent $51 million on television commercials soliciting potential claimants.).

\(^{167}\) Gold Rush, supra note 106, at 88. “At least one law firm, New York’s Hariton & D’ Angelo, was founded in July 2001 solely to find and prosecute fen-phen claims. It employed a medical staff of more than 60 nurses and sonographers, who used the firm’s own echocardiogram equipment to test diet drug users.” Frankel, Fen-Phen Follies, supra note 120, at 96.

\(^{168}\) One such firm, EchoMotion Diagnostics Network, Inc., which was set up solely for fen-phen litigation, performed about 70,000 screenings in a little over a year and cleared $10 million in profit on a gross of $15 million. See Gold Rush, supra note 106, at 91. See also Grossi & Duncan, Screenings, supra note 166, at 1028 (citation omitted) (stating that EchoMotion recruited its technicians from a list of the founder’s friends; these technicians then screened up to 30 patients a day in hotel rooms or lawyer’s offices). Another echo mill, Diagnostic Management Service, wrote to attorneys in 1999 that his group had already performed over 2000 echocardiograms in the Southeast, and that “approximately 90% of the reads are positive for abnormal heart value functioning. . . .” Quoted in Wyeth’s Amended Opposition To Certain Class Members’ Expedited Motion For An OrderSuspending the Claims Integrity Program And The Medical Practices Questionnaires Deadlines, Oct. 30 2003 at 25, In re Diet Drugs Prods. Liab. Litig., MDL No. 1203, E.D. Pa. [hereafter, Wyeth’s Amended Opposition]. Southern Imaging, another sonography firm, indicated that it had billed at least $2,483,475 to two law firms for echocardiogram testing. See Memorandum In Support of Motion To Intervene (Brown et al. v. Wyeth et al.) Feb. 17, 2006, In re Diet Drugs Prods. Liab. Litig., Civil Action #: 99-20593, U.S.D.C. E.D. Pa. [hereafter, Memorandum/Simien & Simien]; Memorandum in Support of Motion To Intervene, Feb. 17, 2006 (Williams et al. v. Wyeth et al.), case no. 2:05-cv-20494-HB [hereafter, Memorandum/Tyner].

\(^{169}\) See Memorandum/Simien & Simien, id. (indicating that Southern Imaging was paid $425.00 for administering an echocardiogram and an additional payment of $1275 “as a deferred amount of compensation. . . . if parties . . . received any settlement proceeds from Fen-Phen litigation.”); Memorandum/Tyner, Id. (also so indicating).
Trust. The firm hired sonographers and employed 80 cardiologists from around the country to provide and read echocardiograms.\textsuperscript{170} The sonographers hired by Napoli/Hariton, as well as by other attorneys, according to a medical expert, frequently maladministered the echocardiograms.\textsuperscript{171} In addition, a unique feature of the agreements entered into by

\textsuperscript{170} As described in one of Wyeth’s pleadings:

As a result of advertising efforts and other means, the Napoli/Hariton firms were successful in gathering an inventory of thousands of diet drug clients. To process the clients, Napoli/Hariton set up an echocardiogram “assembly line.” They purchased 3 or 4 echocardiogram machines, which were used by 8 sonographers hired directly by Napoli/Hariton and paid on per diem basis. These sonographers traveled to various locations to conduct echocardiograms and then sent the echocardiogram tapes to cardiologists around the country to read. . . .

In addition to its own hired sonographers conducting echocardiograms, Napoli/Hariton also employed about 80 doctors from around the country, including Drs. [Linda] Crouse and [Richard] Mueller, to both acquire and read echocardiograms. But Napoli/Hariton’s paid sonographers were closely involved in this process too. . . . [A] sonographer employed by Napoli/Hariton traveled to the doctors’ offices ostensibly to “train” the doctors’ sonographers on how to measure valvular regurgitation.

One such Napoli/Hariton sonographer, whose principal responsibility was to travel around the country conducting such “teaching” sessions testified that she would “explain and show [the doctors’ sonographers] exactly how to do” the planimetry to measure mitral regurgitation. Similarly, Dr. Crouse testified that before she began performing echocardiograms for Napoli/Hariton, a sonographer from the Hariton firm met with Dr. Crouse’s lead sonographer to “make sure we understood how to make the measurements.”

To complete the claimants’ medical histories, nurses employed by Napoli/Hariton met with the clients and filled out a worksheet. . . . Two of [the nurses who took these histories] them testified that they did not fill out or ask about the portions of the worksheet concerning valvular regurgitation diagnosed prior to diet drug use and carcinoid tumors B factors which could have resulted in an 80% decrease in the individuals’ Matrix compensation. . . . One of these nurses even testified that the Hariton firm’s Medical Coordinator, Barbara Krohmer, actually instructed her not to complete certain of these items on the form. . . .

Based on these ersatz “medical histories,” Napoli/Hariton would then frequently fill out the entire Green Forms, except for the date and the doctor’s signature. . . .


\textsuperscript{171} See infra note 180 and text at notes 186-192. In a letter opinion issued on May 9, 2005, New Jersey Superior Court Judge Charles J. Walsh ruled that the echocardiograms and/or echo
Napoli/Hariton with the cardiologists they hired to read the echocardiograms was a “hold harmless” clause which purported to “relieve the doctors reading the echocardiograms from any medical and legal responsibility for erroneous readings.” This clause appears to have been a virtual invitation to the cardiologists to disregard medical protocols.

This invitation appears to have been readily accepted by two of these cardiologists hired by Napoli/Hariton, Drs. Linda Crouse and Richard Mueller. Between them, they read thousands of echocardiograms and were paid millions of dollars for finding that the substantial majority of screened litigants were eligible for compensation from the Trust. They were the subject of extensive proceedings during the course of administration of the Trust which revealed, inter alia, that they had relied on medical histories provided by the law firms and signed “pre-checked” Green Forms filed out by the law firms that hired them. Because of these mass production interpretations of 41 of 47 plaintiffs who had opted out of the settlement were inadequate and returned them to the settlement class. In re: Diet Drug Litigation, Master Docket No. BER-L-13379-04MT, 2005 WL 1253991 (N.J. Super. L.) (May 9, 2005). Judge Walsh concluded that the echocardiograms of these plaintiffs “have not been performed and/or interpreted in a medically reasonable manner.” Id. at *2. In many instances, Judge Walsh noted, “the techniques used in performing the echocardiograms fell so far below appropriate practice so as to make the data reported in the echocardiograms virtually worthless in either diagnosis or treatment.” Id. at *11.

See Wyeth’s Memorandum In Support Of Its Motion To Deny Claims, supra note 170, at 9.

. . . Despite the fact that they signed under penalty of perjury thousands of Green Forms requiring information from the patient’s medical history, in the vast majority of cases, Drs. Crouse and Mueller played no role in the taking of these histories. Instead, they let the law firms decide how to compile and report the medical histories.

. . . Based on these ersatz “medical histories,” Napoli/Hariton would then frequently fill out the entire Green Forms, except for the date and the doctor’s signature, for Drs. Course and Mueller. Dr. Crouse admitted to signing these “pre-checked” Green Forms. Dr. Crouse thus never reviewed medical records or took patient histories before signing thousands of Green forms under penalty of perjury. Incredibly, Dr. Crouse testified at the hearing that “it is the law firm’s duty to take a history.”

Dr. Mueller also acknowledged signing forms that appeared to have been filled out by computer. In reviewing this practice, the Court specifically noted that it is “concerned about the Hariton firm’s involvement in supplying Dr. Mueller
techniques, Drs. Crouse and Muller were found to have provided thousands of medically unreasonable readings. \(^{174}\)

with information required in the Green Form” given that the form “explicitly states that Part II is to be 'completed by a Board-Certified Cardiologist.'”

After reviewing the evidence and briefing submitted in connection with the Napoli/Hariton hearing, the Court . . . [issued] findings with respect to the “recurring flaws” in Drs. Crouse and Mueller’s readings [that] illustrate how the mass claim operation . . . generated inflated, medically unreasonable readings - - readings that were designed to earn the firms million of dollars in contingency fees . . . .

Based on the findings -- and the facts described above concerning the dubious “mass production” operation that Napoli/Hariton had engineered -- the Court ordered not only that the Trust could audit all of the claims submitted by Drs. Crouse and Mueller, but also all of the claims submitted by Napoli/Hariton.

\(^{174}\) \textit{Id.} at 6-10 (citations to Movants’ Joint Proposed Findings of Fact and Conclusions of Law, Sept. 23, 2002 and PTO 2640 omitted).

\(^{174}\) \textit{Id.} at 9-16. In 1998, Dr. Crouse participated in a clinical study which examined the link between the fen-phen and valvular abnormalities. The study was “blinded” and Dr. Crouse was unaware, at the time that she read the echocardiograms, whether or not each patient had taken the diet drugs. She performed 600 echocardiograms over a six month period as part of the study and found that approximately 5% of the diet drug patients had moderate or greater mitral regurgitation. Her findings were similar to the overall conclusions of the study. Order No. 2640, supra note 108, at 22. Nonetheless, Dr. Crouse found at least moderate damage in 60-70% of the thousands of claims she reviewed for litigation purposes. \textit{Id.} at 21. This percentage is remarkably similar to the percentage of positive findings of fibrosis in asbestos litigation. \textit{See supra} note 55.

In a challenge to the attestations of moderate or more severe mitral regurgitation by Drs. Crouse and Mueller, Dr. John Dent, an expert in echocardiography, testified that he disagreed with 53 out of 55 echocardiograms interpreted by Dr. Crouse and 25 of 28 echocardiograms interpreted by Dr. Mueller as to whether there was any reasonable medical basis to support the benefits sought. Joint Proposed Findings of Fact, \textit{supra} note 108, at 14. According to Dr. Dent, Dr. Crouse’s sonographer – and ultimately Dr. Crouse herself – misinterpreted backflow as moderate mitral regurgitation in 46 of the 55 claimants he reviewed. \textit{Id.}, citing Tr. I at 108:1-6. For a discussion of backflow and how it can be misread as regurgitation, \textit{see supra} note 108. Dr. Dent further testified that none of the claimants exhibited significant levels of mitral valve regurgitation -- findings which the court accepted. Order No. 2640 \textit{supra} note 111, at 13-16. In New Jersey, a state court judge presiding over downstream opt out cases appointed independent experts to review the claims. \textit{See Wyeth’s Memorandum In Support Of Its Motion, supra} note 170, at 2. These experts found that the medical evidence was “fake.” \textit{Id. See also} Sharon P. Duffy, \textit{Fen-Phen: Are Claims Exaggerated? The Legal Intelligencer}, Sept. 26, 2002.

Dr. Crouse earned $725,000 for reviewing 725 electrocardiograms for Napoli/Hariton and $2.5 million in a one year period for reviewing 10,000 echocardiograms for a consortium of lawyers -- this, in addition to her seeing 80 patients a week and participating in other activities. 236 F. Supp. 2d. at 456, \textit{see also id.} Thus, she was paid approximately $3.25 million for fen-phen work. Doctor Richard Mueller was paid $1500 for filling out each Green Form which he acknowledged took him only about five minutes. \textit{See Grossi & Duncan, supra} note 166, at 1030; \textit{see also} Frankel, \textit{Fen-Phen Follies, supra} note 120, at 92. He was thus paid an estimated $18,000 per hour to fill out the forms, in contrast to the estimated $1500 per hour he received to review echocardiograms. \textit{Id.} citing to a deposition transcript. Thus he had a significant financial incentive to find a compensable condition.
F. Litigation Screenings: A Comparison of Fen-phen and Asbestos Screenings

There are many parallels between the litigation screenings in the fen-phen litigation and the asbestos and silica screenings -- which were undoubtedly a model for the fen-phen screenings. In asbestos and silica litigation, doctors certified as B Readers were paid hundreds of thousands of dollars a year for reading chest X-rays; in the fen-phen litigation, cardiologists were paid millions of dollars for reading echocardiograms. In both litigations, the payments were in exchange for diagnosing very high percentages of disease. Moreover, just as in asbestos and silica litigation, some of the cardiologists who accounted for the largest number of diagnoses never met the individuals they diagnosed and did not even review the medical records of the claimants.\(^\text{175}\) Also, as in asbestos litigation, some cardiologists were paid more if they found that those screened had suffered heart valve damage. This was done by paying the doctors substantial sums to fill out a “Green Form,” required to accompany a claim for payment under the terms of the National Class Action Settlement.\(^\text{176}\) Of course, a Green Form was only filled out if the cardiologist certified that the claimant had the requisite heart valve damage. This same “bonus” payment for finding disease also prevailed in asbestos litigation.

\(^{176}\) See supra note 174.
As in asbestos and silica screenings, legal staff rather than doctors recorded critical medical histories and instructed technicians.\textsuperscript{177} And just as in asbestos and silica screenings, doctors diagnosed the requisite disease that would yield compensation without regard to possible other causes of the condition that was being relied on for the diagnosis.\textsuperscript{178}

Just as in asbestos litigation with respect to the maladministration of PFTs by technicians employed by screening companies,\textsuperscript{179} the fen-phen sonographers had ample ways of distorting the results of the echocardiograms in order to produce the desired findings\textsuperscript{180} that would generate substantial bonuses for successful claims.\textsuperscript{181}

Unlike asbestos litigation, however, the specious claim generation by the “echo mills” has not been an unmitigated success. First, Wyeth has vigorously defended the downstream opt

\begin{footnotesize}
\textsuperscript{177} See supra notes 170 and 173; see also Gold Rush, supra note 106, at 88.
\textsuperscript{178} Thus, one part of the trust’s claim form required the doctor to certify that the claimant did not have a history of diseases or drug use known to cause the valvular heart diseases. Grossi & Duncan, Screenings, supra note 166, at 1040. This requirement was routinely ignored by the cardiologists who supplied the bulk of the diagnoses. \textit{Id.} One cardiologist “contended that precisely because he had never met with the claimants, reviewed their medical records, nor taken any medical history, he could check, ‘NO’ for all of those alternative causes -- since, given that ignorance, ‘to the best of [his] knowledge,’ the answer was ‘NO.’” \textit{Id.} (citing to a deposition transcript) (emphasis in original).
\textsuperscript{179} See Brickman, Asbestos Litigation, supra note 23, at 111-128.
\textsuperscript{180} For example, “by adjusting even slightly the settings on the [echocardiogram] machine, a cardiologist or sonographer can influence and even distort the quality of the image that he or she sees. Over-manipulated settings can produce false images, including artifacts and phantom jets.” Order No. 2640, supra note 108, at 6. In addition, a technician may artificially inflate the degree of regurgitation shown on the tape by improperly setting the machine. \textit{Id.} Additionally, screening companies employed other methods in attempts to artificially increase patients’ echocardiogram readings. A plaintiff who had opted out of the Wyeth Settlement testified, for example, that she and a group of 15 or 20 diet drug claimants were screened by a company called “Cardiovascular Sonographers” at a Ramada Inn in Mississippi. The plaintiff testified that she was told to drink a large amount of water because “whatever the problem is would show up better if you had a lot of water.” This instruction to the potential litigants to “drink a lot of water” was an apparent effort to artificially increase blood pressures and thereby inflate any regurgitation that might show up on echocardiograms. Van Norman Tr. At 123-26, 213-14 (Exh. 11 hereto) Wyeth’s Memorandum in Support of Its Extended Motion For Entry of a Court-Approved Procedure to Preserve Settlement Funding and to Address the Pervasive Abuse of the Matrix Claims Process, January 27, 2004 at 6, \textit{In re:} Diet Drugs Products Liability Litigation, MDL Docket No. 1203, U.S.D.C. E.D. Pa. It is similar to the practice of smoking a cigarette immediately before being administered a battery of pulmonary function tests in asbestos litigation screenings in order to inflate any findings of lung impairment.
\textsuperscript{181} See supra note 169.
\end{footnotesize}
out cases and has succeeded in gaining the dismissal of large numbers of Napoli/Hariton generated claims. Second, because of the volume of suspect Trust claims, the audit procedure was changed and instead of auditing 15% of the claims, the Trust was ordered to audit every claim for matrix level benefits from Fund B that had not yet been paid. These audits resulted in the rejection of many of the claims generated by the screenings. In addition, the Trust hired Dr. Joseph Kisslo, a prominent Duke cardiologist who had been a leading expert on the design

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182 See supra note 165.
183 See Wyeth’s Memorandum in Support of Its Motion to Deny Claims, supra note 170, at 14-17. In downstream opt out cases brought in New Jersey before Judge Charles J. Walsh, court-appointed experts strongly disagreed with the exaggerated readings submitted by Napoli/Hariton. In 10 cases filed by Napoli/Hariton in which the plaintiffs alleged severe aortic or mitral regurgitation, for example, court-appointed experts found that the plaintiffs in five of the cases had, at most, trivial or trace regurgitation; three others had only mild regurgitation, to the extent to which these echocardiograms were readable at all, and one echocardiogram was not susceptible to any medical assessment at all as a result of poor frame image quality. The court-appointed experts were disturbed by the medical diagnoses reached by the plaintiffs’ qualifying echocardiogram readers. In Henrie v. Wyeth, for example, a court-appointed expert described the assessment of mild aortic regurgitation that had been made by the plaintiff’s echocardiogram reader, Dr. Mueller, as “all together ridiculous.” The expert referred to the quality of the relied upon echocardiogram as “absolutely dreadful,” and likened the echocardiogram to “modern art,” explaining that “no reasonable person would have attempted to even measure it. “In another case, Harris v. Wyeth, another court-appointed medical expert explained that the finding of moderate aortic regurgitation rendered by Napoli/Hariton’s qualifying echocardiogram reader, Dr. Mark D. Gelernt, “didn’t meet, under any anatomy of the imagination[,] [FD]A criteria for a significant leak of either valve.” Tr. Of Sept. 7, 2004, at 9-10, 28-30. In LaRocca v. Wyeth, a court appointed expert explained that it was unreasonable for Dr. Mueller even to have attempted to measure the poor quality image which he had used to diagnose mild aortic regurgitation in the plaintiff, nothing that any other trained physician would not have even tried to make a measurement of the frame from the echocardiogram. Tr. Of Aug. 27, 2004, at 17. Wyeth’s Memorandum in Support of Its Motion to Deny Claims, supra note 170, at 14-17. See New Jersey Judge Dismisses 6 of 7 Opt out Cases On Medical Eligibility, 7 Mealey’s Litigation Report: Fen-Phen/Redux 12 (October 2004). See Harris v. Wyeth Inc., No. BER-L-6818-03-MT; Henrie v. Wyeth Inc., No. BER-L-8202-03-MT; LaRocca v. Wyeth Inc., No. BER-L-8260-03-MT.

Also, on June 2, 2005, Judge Walsh had dismissed 47 out of 55 opt outs based on poor echocardiogram quality and/or exaggerated readings. Judge Walsh stated that “The initial reports of physicians with respect to virtually all these challenged echocardiograms have significantly overstated the pathology observed and/or claimed that the echocardiograms were of good diagnostic quality when they clearly were not.” New Jersey Judge Dismisses 47 Of 55 Opt outs On Echocardiogram Quality, 8 Mealey’s Litigation Report: Fen-Phen/Redux 9 (July 2005).

184 Pretrial Order No. 2662, supra note 151. Prior thereto, the Settlement Agreement provided for an audit procedure but limited the number of audits to 15% of claims filed. See Settlement Agreement §§ VI.E.1 and VI.F.2.
and utilization of the echocardiogram machine, to conduct reviews of the echocardiograms.\textsuperscript{185} Dr. Kisslo assembled a panel of seven cardiologists assisted by nine cardiac sonographers to review 968 sets of echocardiograms \textit{that had passed the audit procedure} but had not yet been paid prior to the stay ordered by the court in May 2004 when it became apparent that thousands of bogus claims had been filed and were being paid.\textsuperscript{186}

The results are essentially a replay of the PFT tests in asbestos litigation which have mostly been administered to produce false findings of impairment.\textsuperscript{187} The Kisslo panel found that in 70\% of the claims that had successfully passed the audit, the echocardiograms were manipulated to produce incorrect results and evidenced “material misrepresentations of the level of regurgitation.”\textsuperscript{188} Dr. Kisslo concluded that it was reasonable to infer that there had been “intentional misrepresentation” based upon findings of alterations of medical records, errors and techniques that consistently inflated the size and duration of regurgitation\textsuperscript{189} in order to make “non-payable claims appear to be payable.”\textsuperscript{190} Among his findings was that 87 echocardiogram studies contained “extrinsic inserts [rogue frames inserted into the printouts] that are not contemporaneous with the time of the rest of the echocardiogram study,” which were “deliberate misrepresentations of the actual medical condition of the claimants . . . .”\textsuperscript{191} In plain words, Dr. Kisslo found that a significant number of the echocardiograms had been fraudulently administered or altered after the fact in order to show evidence of injury that was not there. He stated that:

\begin{quote}
\textsuperscript{186} \textit{Id.}
\textsuperscript{187} \textit{See supra} note 87.
\textsuperscript{188} Kisslo Report, \textit{supra} note 185, at 21; \textit{see also} at 5.
\textsuperscript{189} \textit{Id.} at 21-22.
\textsuperscript{190} \textit{Id.} at 23.
\textsuperscript{191} \textit{Id.} at 28-29.
\end{quote}
my review has confirmed that... echocardiogram companies that performed large numbers of diet drug echocardiograms devised and used distinct methods ("recipes") to misuse echo machines and to misrepresent ("cook") the degree of regurgitation represented on their echocardiograms. These providers manipulated echo machine settings repeatedly in such a way as to create images that... exaggerated the appearance of blood flow patterns.192

G. The Cost of the Fen-phen Litigation

Wyeth has thus far set aside approximately $22 billion to pay damages to approximately 600,000 people.193 It is not yet determinable whether this sum overstates Wyeth’s ultimate liability or whether additional amounts will have to be added to the reserve. A substantial portion of the money paid by Wyeth to claimants in the fen-phen litigation has gone to settle the 50,000 initial opt out claims brought in the tort system.194 As previously noted, many of the initial opt out cases were filed in jurisdictions that were quite favorable to the interests of plaintiffs and their lawyers. The terms of the Settlement reflect Wyeth’s great vulnerability in these opt out cases even where the plaintiff’s regurgitation almost certainly pre-existed the ingestion of the diet drugs and where the drugs were taken for less than the minimum threshold duration reported in clinical studies.

Wyeth has also settled an additional 50,000 downstream opt out cases brought in the tort system which were mostly generated by litigation screenings. Wyeth has vigorously defended these cases,195 and the settlements here have been far less generous than the initial opt out cases. Indeed, many of these cases have been settled for “nuisance value” nominal amounts as part of

192 Id. at 41.
193 Gold Rush, supra note 106, at 86. The authors provide an estimate that about $6 billion, which was 70% of the money that was thus far paid, went to patients who “aren’t sick or don’t deserve it.” The authors of the Gold Rush article added that “it may add up to one of the biggest tort scams ever…” Id.
194 See supra notes 147, 150.
195 See supra notes 164-165.
inventory settlements with individual law firms in which Wyeth agreed to pay a set sum and the
law firm allocated specific amounts to each of its clients included in the settlement as it saw
fit.\footnote{196} I estimate that the settlement value of that portion of the 50,000 downstream opt out cases
which were generated by screenings and based on the type of diagnoses described in this article
is in the range of one billion dollars. Illegitimate screening-generated Trust claims probably
account for an additional few hundred million dollars. Even though the court instituted a 100
percent audit in response to the screenings, many specious claims had already been approved for
payment\footnote{197} and according to Dr. Kisslo, a significant number of the claims that passed the audit
in response to the screenings, had echocardiograms that were manipulated to produce incorrect
results.\footnote{198}

\textit{In toto}, litigation screening claims supported by improperly administered
echocardiograms and the assembly line diagnoses by a comparative handful of cardiologists have
probably accounted for somewhere in the vicinity of one to one and a half billion dollars in

\footnote{196} These are aggregate settlements and under ethical rules, clients must give their informed
consent to their assigned settlement amounts. This disclosure must include the fact that a single sum of
money has been provided by the defendant, that the lawyer has allocated specific amounts to each client
and that each client’s allocation depends upon what the lawyer has allocated to the other clients
participating in the aggregate settlement. \textsc{ABA Model Rules of Professional Conduct}, Rule 1.8(g).
Failure to obtain informed consent may result in fee forfeiture. \textit{See} Burrow \textit{v.} Arce, 997 S.W.2d 229 (TX
1999). In a proceeding currently before New York Supreme Court Justice Charles Ramos, the issue of
whether the law firm of Napoli Kaiser & Bern (“Napoli Firm”) entered into an aggregate settlement with
Wyeth of 5,000 claims for a reported $1 billion and whether it conformed to New York Disciplinary Rule
5-106, 22 NYCRR §1200.25 with regard to notifying its clients that there was an aggregate settlement
and getting their informed consent, is being determined. \textit{See} In re New York Diet Drug Litigation
(Appel-Hole \textit{v.} Wyeth), 15 Misc. 3d 1114 (A) (N.Y. Sup. 2007). Also under review is an allegation by
the law firm of Parker and Waichman LLP, that when the Napoli Firm allocated the settlement proceeds
among its 5,000 clients, it allocated disproportionately larger amounts to its own clients and lesser
amounts to the clients referred to the firm by Parker and Waichman, so that the Napoli Firm could capture
contingency fees at the expense of Parker and Waichman. \textit{See} Parker \& Waichman \textit{v.} Napoli, et al., 29
A.D.3d 396 (N.Y. 2006), \textit{recalling and vacating} 24 A.D.3d 165 (2005). \textit{See also}, Anthony DePalma,

Prior to instituting the 100% audit imposed in mid-2002, however “85 percent of [Trust] claims were being paid without any real check on their legitimacy…” \textit{In re Diet Drugs Prods. Liab.

\textit{See supra} notes 188-192.
payments. This amount, however, is only a fraction of what law firms which sponsored the screenings undoubtedly anticipated. While the litigation screenings in the fen-phen litigation did not achieve nearly the financial success as those in the asbestos and silicone breast implant screenings, they certainly matched those screenings in terms of the brazenness of the scheme to generate tens and perhaps hundreds of thousands of manufactured claims.

VI. Silicone Breast Implant Litigation

According to the scientific literature, women with silicone breast implants have no greater incidence of autoimmune connective-tissue diseases including rheumatoid arthritis, lupus, and scleroderma than do women without breast implants. Despite the absence of

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199 Autoimmunity is the mechanism by which the body turns its immune system defenses against foreign bodies against the cells and molecules of the body itself; connective tissue disease refers to any disease in which connective tissues are the primary location of disease, such as in arthritis. MARCIA ANGELL, SCIENCE ON TRIAL: THE CLASH OF MEDICAL EVIDENCE AND THE LAW IN THE BREAST IMPLANT CASE 107 (W.W. NORTON & COMPANY, 1997) [hereafter ANGELL, SCIENCE ON TRIAL]. Autoimmunity is the cause of some connective tissue diseases and is suspected in others. Id.


202 Scleroderma is a disease that can cause thickening, hardening or tightening of the skin, blood vessels and internal organs. Approximately 240,000 women have this disease. Arthritis Foundation, Disease Center. Scleroderma, available at http://www.arthritis.org/conditions/DiseaseCenter/scleroderma.asp (last accessed September 29, 2006); Scleroderma Research Foundation, http://www.srfcure.org/srf/home.htm (last accessed September 29, 2006).

203 INFORMATION FOR WOMEN ABOUT THE SAFETY OF SILICONE BREAST IMPLANTS 6-7 (Martha Grigg, Stuart Bondurant, Virginia L. Ernster, & Roger Herdman eds., National Academies Press 2000) [hereafter, SAFETY OF SILICONE BREAST IMPLANTS].
evidence of causation, breast implant litigation attained mass tort status on the basis of hundreds of thousands of claims of connective tissue and rheumatoid diseases alleged to have been caused by silicone breast implants. Here, too, the litigants were recruited by screenings organized by lawyers and their claims were supported by specious diagnoses and theories of causation in search of a fee that were inconsistent with the medical and scientific evidence.

The first silicone breast implants were manufactured and sold by Dow Corning in 1962. At the time, implants, which are considered medical devices, were not subject to regulation by the Food and Drug Administration (“FDA”) or other government agency. Nor did Dow or any of its competitors perform studies on women who had received the implants to determine whether they were safe, despite knowing that an undetermined percentage of implants ruptured and that minute amounts of silicone could leak through the permeable membrane. Instead, the manufacturers relied on plastic surgeons to inform patients of the possible dangers, a task that often went unperformed. In 1976, Congress passed the Medical Devices Amendment to the Food, Drug and Cosmetic Act, placing breast implants and other medical devices under the regulatory jurisdiction of the FDA. Under the amendment, the FDA could, at its discretion, require that the manufacturers of new devices submit animal and human studies of safety and

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204 ANGELL, SCIENCE ON TRIAL, supra note 199, at 39. Silicone was apparently first used to enlarge breasts in Japan after World War II. Japanese prostitutes had liquid silicone injected directly into their breasts in order to increase their appeal to American-occupation forces. This practice, however, led to often painful and disfiguring complications. Id. at 35-38.


206 Id.

207 Id. (citing a memo from Dow Corning’s public relations team that noted that doctors “haven’t wanted to bother the pretty little heads of their patients with all this information” despite the fact that Dow had provided it to them).

208 Id. at 463; see also, ANGELL, SCIENCE ON TRIAL, supra note 199, at 51.
effectiveness before getting approval to market the device.\footnote{209} Breast implants were initially exempt from this requirement because they had been on the market for almost fifteen years. By 1982, however, the FDA, concerned about the scar tissue that formed around the implants, the potential toxic effects of silicone leaks, and the impact of silicone in the implant shells themselves, for the first time proposed that manufacturers submit studies to verify the safety of the devices.\footnote{210} It would be another six years before the regulation was finalized.\footnote{211}

Nineteen-eighty-two also saw the filing of the first lawsuit that alleged that silicone that had leaked from breast implants had caused a woman’s serious health problems. With little more than the speculation of her doctors that silicone might have caused her chronic fatigue and joint pain, Maria Stern sued Dow Corning and ultimately won a verdict of $1.4 million dollars.\footnote{212} Because there was no valid scientific evidence supporting a link between silicone breast implants and Stern’s health problems,\footnote{213} Stern’s lawyers used internal Dow Corning documents to argue that the company had irresponsibly marketed a product without knowing whether it was safe.\footnote{214} The strategy worked. A trickle of suits followed Stern’s victory, but it would be several more years before a combination of political pressure, media sensationalism, and regulatory action would produce an atmosphere conducive to the creation of a mass tort.

\footnote{209} Id.
\footnote{210} Id.; see also, Bernstein, supra note 205, at 463, 465.
\footnote{211} ANGELL, SCIENCE ON TRIAL, supra note 199, at 51-53. Manufacturers were given two and a half years to provide the data. Id. at 52.
\footnote{212} Id., supra note 205, at 463-64. The jury awarded Stern $200,000 in compensatory damages and $1.2 million in punitive damages. Id. at 464. Other sources say the award was close to $2 million. ANGELL, SCIENCE ON TRIAL, supra note 199, at 52.
\footnote{213} A few anecdotal reports noted the presence of connective tissue disease in women who had had silicone injected directly into their breasts. Id. at 51-52. Another article found connective tissue disease in three Australian women with silicone-filled implants. Id. at 52. But none of these anecdotal reports provided proof of a causal connection between the implants and disease.
\footnote{214} Bernstein, supra note 205, at 463-64 & n.22.
The political pressure was provided by Public Citizen, a Naderite consumer advocacy group that released a study done by Dow Corning scientists in which silicone gel implanted under the skin of rats caused cancer in 20-25% of the animals.\textsuperscript{215} This study, however, did not indicate that humans would have a similar outcome. To the contrary -- the same response does not occur in humans.\textsuperscript{216} Congressional hearings that followed relied solely on expert witnesses hired by plaintiffs’ lawyers for its scientific evidence.\textsuperscript{217} The litigation was really fueled, however, in 1990 when a television program, \textit{Face to Face with Connie Chung}, set off a national panic. Calling silicone gel “an ooze of slimy gelatin that could be poisoning women,”\textsuperscript{218} Chung, with the active assistance of plaintiffs’ lawyers, showcased the stories of five women who believed that they had serious illnesses that were related to their breast implants.\textsuperscript{219} The sensationalistic nature of the program was capped when one woman revealed her chest, disfigured by the removal of her implants, to the audience.\textsuperscript{220}

The public alarm raised by the show spurred an increase in the number of breast implant lawsuits filed.\textsuperscript{221} Public Citizen put together a “Silicone Clearinghouse” of thirty-nine law firms

\begin{footnotes}
\item[215] Id. at 465.
\item[216] The problem with the study was that the type of cancer found in the rats, fibrosarcoma, occurs in rodents in response to any large smooth object placed under the skin. Id. at 465-66. This same response does not appear to occur in humans. Id. at 466. Bernstein argues that Public Citizen ignored this fact in its determination to use the breast implant issue to push its agenda to reverse the anti-regulatory policies of the Reagan Administration. Id. at 466-67.
\item[217] Id. at 468.
\item[218] Id. at 467 (quoting Chung as cited in Michael Fumento, \textit{A Confederacy of Boobs}, 27 \textit{REASON}, Oct. 1995, at 37-38).
\item[219] Marcia Angell, M.D., \textit{Evaluating the Health Risks of Breast Implants: The Interplay of Medical Science, the Law, and Public Opinion}, 334 \textit{NEW ENG. J. MED.} 1513, 1514 (1996) [hereafter, Angell, \textit{Evaluating the Health Risks of Breast Implants}]. Chung cited two doctors to support a link between implants and auto immune disease but failed to indicate that they had never published studies in a major medical journal and that both were paid medical experts for plaintiffs’ lawyers in pending breast implant litigations. See, Kathy McNamara-Meis, “It Seemed We Had It All Wrong,” \textit{Forbes MediaCritic}, Winter 1996, at 40, 43 [hereafter, McNamara-Meis, \textit{Had It All Wrong}].
\item[220] Bernstein, supra note 205, at 467-68.
\item[221] Id. at 471.
\end{footnotes}
to provide representation for potential plaintiffs.\textsuperscript{222} And, as some of the lawsuits filed earlier began to come to trial, plaintiffs won several multi-million dollar verdicts, providing new financial incentives for plaintiffs and lawyers alike.\textsuperscript{223} The most important of these cases involved Mariann Hopkins,\textsuperscript{224} a California woman diagnosed with mixed connective tissue disorder, an autoimmune disorder with clinical features of systemic lupus, rheumatoid arthritis, polymyositis, and scleroderma.\textsuperscript{225} The diagnosis came just three years after one of her silicone breast implants had ruptured.\textsuperscript{226} The jury awarded Hopkins $7.34 million despite the fact that her own rheumatologist testified that he believed her symptoms began \textit{before} she received her first set of implants.\textsuperscript{227} Once again, the “bad documents” that had been used in the Stern case seven years earlier seemed to play an important role in the jury’s decision.\textsuperscript{228} Despite these successes, the number of litigants still remained relatively small, with just 137 lawsuits filed as of early December 1991.\textsuperscript{229}

Against this backdrop of multi-million dollar verdicts, political pressure, and media outrage,\textsuperscript{230} and despite the lack of any new scientific evidence of the health impacts of silicone

\begin{itemize}
\item \textsuperscript{222} Id. The president of Public Citizen later acknowledged his intention to create a deluge of lawsuits against the manufacturers as a means to further his agenda. \textit{Id.}
\item \textsuperscript{223} A woman in Alabama was awarded $5.35 million in damages (later reduced to $2.25 million before being vacated and remanded for a new trial) while a New York plaintiff received a $4.45 million verdict (later reduced to $1.5 million dollars). \textit{Id.} In his opinion, the judge in the Alabama case wrote that the scientific basis for the testimony of the plaintiff’s expert was “not generally accepted.” Toole v. McClintock, 778 F. Supp. 1543, 1549 (M.D. Ala. 1991), \textit{vacated} 999 F.2d 1430 (11th Cir. 1993).
\item \textsuperscript{224} Hopkins v. Dow Corning Corp., 33 F.3d 1116 (1994).
\item \textsuperscript{225} \textit{ANGELL, SCIENCE ON TRIAL, supra} note 199, at 118-19.
\item \textsuperscript{226} \textit{Id.} at 119.
\item \textsuperscript{227} \textit{Id.} at 122.
\item \textsuperscript{228} Bernstein, \textit{supra} note 205, at 473.
\item \textsuperscript{229} \textit{Id.} at 472.
\item \textsuperscript{230} Following Chung’s program, other media outlets picked up the story including ABC’s \textit{PrimeTime Live}, which used the story to attack deregulation, and \textit{The Jenny Jones Show}, where the host told the story of her own personal experience with breast implants. \textit{Id.} at 474; \textit{ANGELL, SCIENCE ON TRIAL, supra} note 199, at 45-46. In addition, Dow Corning was forced to release to the public the internal memos that had played a key role in several of the verdicts against it and acknowledge that it had
\end{itemize}
breast implants, in early 1992, an FDA advisory panel recommended for the first time that silicone breast implants be banned in almost all situations.\textsuperscript{231} The only exception was for women who required reconstructive surgery following a mastectomy. The exception appeared peculiar given the reasons for barring the implants because these women, generally recovering cancer patients, were already facing severe health problems and a safe alternative, saline implants, was available.\textsuperscript{232} On April 16, 1992, FDA commissioner David Kessler followed the panel’s recommendation and implemented the ban.\textsuperscript{233}

In the two years following the FDA ban, more than 16,000 lawsuits brought by more than a thousand lawyers were filed in state and federal courts.\textsuperscript{234} The combination of aggressive advertising and computer networking that allowed lawyers to read about and copy the complaints filed in cases from across the country helped spur the increase.\textsuperscript{235} The number of lawyers connected to Public Citizen’s clearinghouse also rose to 179 by the end of 1992, while the Breast Implant Committee of the Association of Trial Lawyers of America increased 800% from 20 to 160 in the six months prior to the FDA ban.\textsuperscript{236}

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\item known for two decades that some silicone gel would leak through the implant’s membrane. Bernstein, \textit{supra} note 205, at 474-75.
\item \textit{Id.} at 475.
\item \textit{Id.} Bernstein believes the decision was a political one given that breast cancer survivors were “well-organized politically, were represented on the FDA panel, and would have fought bitterly . . . if the ban had been applied to women who had undergone mastectomies. Other potential implant recipients were diffuse and unorganized.” \textit{Id.} at 476.
\item Angell, \textit{Evaluating the Health Risks of Breast Implants, supra} note 219, at 1514. Access to silicone implants was limited to women requiring reconstruction due to mastectomy, and then only under carefully controlled clinical protocols. \textit{See} Council on Scientific Affairs, American Medical Association, \textit{Silicone Gel Breast Implants}, 270 JAMA 2602 (1993).
\item ANGELL, \textit{SCIENCE ON TRIAL, supra} note 199, at 69. The number of suits against Dow Corning, for example, rose from 200 at the end of 1991 to approximately 10,000 at the end of 1992. \textit{Id.} Other sources put the second number closer to 3,500 lawsuits. Tim Smart, \textit{Breast Implants}, BUS. Wk., June 10, 1998 at 94.
\item ANGELL, \textit{SCIENCE ON TRIAL, supra} note 199, at 70. This copying was evident in the appearance of identical typographical errors in many of the complaints. \textit{Id.}
\item \textit{Id.}
\end{itemize}
At the same time as the FDA implemented its ban, the first studies investigating the link between breast implants and cancer were published. None found any connection. As a result, plaintiffs’ attorneys quickly shifted their focus from the claims alleging that breast implants caused the plaintiff’s cancer to those claiming that the ruptures of or leaks in the silicone gel implants caused a systemic immune system disease, such as rheumatoid arthritis, lupus, or scleroderma. This switch was facilitated by the fact that the epidemiological studies that would prove or disprove a link between breast implants and these diseases were still several years from being published.

Still, the success of this strategy turned on the “scientific legitimacy of the silicone-related diagnosis.” To convince juries that the implants were really the cause of the diseases required scientific and medical expert witnesses who would testify that (1) the plaintiffs had serious diseases and (2) that the silicone implants caused the diseases. The financial incentives to provide this testimony were substantial and a small group of doctors and scientists emerged to fill the need for such testimony. Three in particular, Marc Lappé, Dr. Nir Kossovsky, and Dr. Frank Vasey, played key roles in the breast implant litigation, testifying at trials, appearing before Congress, and providing new medical “theories” upon which plaintiffs’ cases often

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238 Additional studies in subsequent years found similar results. See Bernstein, *supra* note 205, at 476 n.94.

239 *Id.* at 476. Silicone implants do occasionally cause complications that require surgery and removal. These are implant rupture, capsular contracture, and pain. *SAFETY OF SILICONE BREAST IMPLANTS, supra* note 203, at 2.


242 See *supra* note 217 and accompanying text.
rested. Dr. Kossovsky was referred to by John O’Quinn, the leading lawyer in this mass tort, as “senior world authority on the biological properties of silicone.” Only one of the three, Vasey, was an expert in rheumatology, the branch of medicine dealing with connective tissue disease, and none were epidemiologists, schooled in the study of the connections between disease and possible risk factors. All three, however, were eager proponents of the idea that the silicone gel in breast implants can cause autoimmune diseases and each advanced his own theory in support. Indeed, the key to the plaintiffs’ lawyers’ success were the testimony of

243 ANGELL, SCIENCE ON TRIAL, supra note 199, at 120.
244 Taubes, Silicone in the System, supra note 241, at 66-67.
245 ANGELL, SCIENCE ON TRIAL, supra note 199, at 120-22.
246 Lappé, whose background is in experimental pathology, had postulated a new autoimmune disease, silicone-reactive disorder, in which “silicone triggers an intense overstimulation of the immune system, perhaps in response to the silica component of the silicone envelope.” Id. at 108. While he has published his theory in a journal called Medical Hypotheses, he has not provided persuasive evidence to support it. Id.; M. Lappé, Silicone-Reactive Disorder: A New Autoimmune Disease Caused by Immunostimulation and Superantigens, 41 MEDICAL HYPOTHESES 348 (1993). Moreover, the epidemiological evidence demonstrates the theory is invalid.

Kossovsky, also a pathologist who did not have board certification in either rheumatology or immunology -- disciplines that were central to the issues of causation -- advanced a theory that the silicone that leaks from implants combines with native molecules to form a new complex that the body no longer recognizes. (A native compound is one that occurs naturally within the cell or its extracellular environment. Edward D. Harris, PhD., Biochemical Facts Behind the Definition and Properties of Metabolites, Texas A & M University, available at www.fda.gov/ohrms/dockets/ac/03/briefing/3942b1_08_Harris%20Paper.pdf (last accessed October 10, 2006).) As a result, he postulated that the body attacks these new particles in an autoimmune response and this reaction spreads to other parts of the body. ANGELL, SCIENCE ON TRIAL, supra note 199, at 107. Kossovsky had shown that such a response occurs in guinea pigs where the immune system reacts to the presence of silicone-serum complexes, but not to silicone itself, but this result does not prove a similar response in women with implants, nor that the result is an autoimmune disease. Id. He dismissed the epidemiological studies showing that there was no increased risk of autoimmune or connective diseases as irrelevant, because the silicone implants were causing a new, as of yet unrecognized by medical science, disease which he called “silicone syndrome.” MICHAEL E. GORMAN, TRANSFORMING NATURE 226 (Kluwer Academic Pub. 1998). This assertion about a new disease is not supported by scientific evidence. SAFETY OF SILICONE BREAST IMPLANTS, supra note 203, at 6. He also marketed a diagnostic test, Detecsil, mainly to trial lawyers that purported to “diagnose” this disease. Taubes, Silicone in the System, supra note 241, at 74, 75. However, this test could not actually diagnose any disease and Kossovsky admitted in a court deposition that his test could not actually determine if someone was sick. Id. at 74. The Autoimmune Disease Center at Scripps Research Institute in LA Jolla, California sent him “blind” samples of blood for testing. Kossovsky’s test failed to distinguish women with autoimmune diseases and implants from women with autoimmune disease and no implants. Id. at 70. When asked to provide the raw data from which he is making his conclusions, he offered that it must have been destroyed by an
these expert witnesses on causation and diagnoses by a cadre of doctors that had focused their practices on developing evidence for use in the litigation so that they could collect substantial fees. These doctors and scientists who advanced their fanciful theories of causation, however, had no support in the scientific literature. Indeed, by 1994, published epidemiological studies showed no association between silicone implants and the claimed diseases. Two years later, U.S. District Court Judge Robert E. Jones, who was overseeing breast implant cases, appointed an independent panel of experts to assess the scientific validity of the testimony of the plaintiff’s earthquake, and that coffee spilled on everything, and he threw out anything that “looked disgusting or not particularly important.” Id. at 74. Moreover, the FDA warned that “until Detecsil had proven diagnostic ability…[its promotion]…was misleading . . . .” Id at 74. See also Bernstein, supra note 205, at 481. Nevertheless, Kossovsky has been one of the most popular and effective plaintiffs’ witnesses, testifying in the Hopkins and Johnson cases, among many others. ANGELL, SCIENCE ON TRIAL, supra note 199, at 151. Having heard Kossovsky speak at a program for trial lawyers, I can personally attest to his effective manner. Even though I have an undergraduate degree in science, I was hard put to find a defect in the step-by-step argument that Kossovsky reprised “showing” that the silicone that leaked from implants created new particles that the body did not recognize and so generated an autoimmune response. Kossovsky’s causation theory was bogus but his presentation was convincing.

Vasey’s belief in the connection between silicone breast implants and connective tissue disease comes from a clinical rather than a theoretical perspective. The chief of the Division of Rheumatology at the University of South Florida College of Medicine, Vasey reported a group of patients in his practice whose connective tissue disease or symptoms were alleviated by the removal of their breast implants. Id. at 121-22; see also FRANK B. VASEY & JOSH FELDSTEIN, THE SILICONE BREAST IMPLANT CONTROVERSY: WHAT WOMEN NEED TO KNOW (1993). Clinical impressions, however, can be misleading:

In medical practice, it is not unusual for a specialist who attracts patients with a certain type of problem to gain erroneous impressions about its frequency or its association with other conditions. Without controls and appropriate population sampling techniques, it is easy to draw conclusions that will not stand up to later, more careful epidemiological analysis. Even a large clinical experience, while possibly suggestive, cannot substitute for a cohort or case-control study in getting at whether implants cause disease. The history of medicine is replete with examples of mistaken clinical impressions based on uncontrolled and often undocumented personal experience.

ANGELL, SCIENCE ON TRIAL, supra note 199, at 122.

247 See infra notes 269-279 and accompanying text.
249 ANGELL, SCIENCE ON TRIAL, supra note 199, at 101. In 1994, the Mayo Clinic and other medical schools and clinics conducted several epidemiological studies, which unanimously found that there was no association between the breast implants and a higher risk of developing any of the claimed diseases. Id. at 101-102. These studies were further followed up by studies from the Harvard Medical School, which concluded that “we did not find an association between silicone breast implants and connective-tissue diseases…” Jorge Sánchez-Guerrero, M.D. et al., Silicone Breast Implants and the Risk of Connective-Tissue Diseases and Symptoms, 332 NEW ENG. J. MED. 1666 (1995).
experts under the Daubert standards, and based on this assessment, he ruled that plaintiffs’
experts would not be permitted to testify. In that expert testimony on general causation,
the plaintiffs had no case.

In June 1992, before the epidemiological studies disproving the connection between
silicone breast implants and connective tissue diseases were finished, the federal Judicial Panel
on Multidistrict Litigation certified a multi-district class action lawsuit against the major implant
manufacturers. By December 1992, plaintiffs had filed 3,558 suits against Dow Corning, the
manufacturer with the largest market share. That same month, the O’Quinn, Laminack &
Pirtle firm won the biggest verdict yet, $25 million, including $20 million in punitive damages,
for a plaintiff whose implants had ruptured and who claimed that the silicone that leaked out
caused an auto immune disorder. What made the case unique was that the plaintiff, Pamela
Johnson, had never been diagnosed with a recognized immune system or connective tissue
disease. Instead, she suffered from what her lawyer described as a silicone-induced
“autoimmune disorder, in which she feels like she has a bad case of the flu all the time.” Her
symptoms were all vague and nonspecific, such as sinusitis, respiratory ailments, sore throats,
colds, and bladder infections. Her lawyers, however, succeeded by keeping the focus on the
concern that her condition could worsen and the idea that their client was a proxy for the

251 Smart, supra note 234, at 94. Other sources put the number higher. See supra note 234.
252 Bernstein, supra note 205, at 479.
253 ANGELL, SCIENCE ON TRIAL, supra note 199, at 134.
254 Id.
255 Id.
256 During closing arguments, Johnson’s lawyer told the jury
[My client] has seen the women with this disease that has progressed to the point that
ey can’t walk or they can only walk with a can. Must she not think, Dear God, is this
going to happen to me. She’s heard of the lymphomas and cancers and all the real
serious diseases of that nature that are found among the hundreds of thousands of women
with this condition.
thousands of other women who might get sick due to their implants. The O’Quinn firm and others responded opportunistically to this victory by filing hundreds of new lawsuits, engaging public relations agencies, and traveling around the country with medical experts to stage events to explain the dangers of implants, create public awareness of the “new threat,” offer legal advice and refer women to doctors and laboratories that they had selected that would diagnose silicone related diseases. By December 1993, the number of lawsuits filed against Dow Corning alone had grown to 12,359.

In the spring of 1994, the implant manufacturers, Dow Corning, Bristol-Myers Squibb, Baxter International, and Minnesota Mining & Manufacturing Co. (“3M”), agreed in a class action settlement to pay $4.75 billion to women with silicone implants, of which about $1 billion would go to the attorneys. However, the settlement soon collapsed under the weight of a

Bernstein, supra note 205, at 478 (quoting attorney John O’Quinn). Note the reference to cancer fears despite the fact that two scientific studies released just eight months earlier had found no connection between silicone breast implants and cancer.

ANGELL, SCIENCE ON TRIAL, supra note 199, at 135. Johnson’s case was also weak for other reasons. She was a smoker and at least some of her symptoms could have been related to that fact. Id. at 136. In addition, her doctor had ruptured the implant during a procedure intended to break up scar tissue. Id. at 135. To counter this fact, O’Quinn argued that the issue wasn’t whether the implants were defective, but whether the manufacturer could prove that they were safe. Id. at 136. This shift in the normal burden of proof was so effective that O’Quinn’s tactics were the subject of a teaching videotape entitled Look Over Here: Johnson v. Bristol-Myers Squibb Company: How Houston Plaintiff’s Lawyer John O’Quinn Won the Largest Breast Implant Verdict to Date by Keeping a Jury on the Strongest Elements of His Case. Id. at 136-37. For more in-depth discussion of the strategy and tactics used by the plaintiff’s lawyers in this case, see id. at 134-40; Bernstein, supra note 205, at 477-79.

O’Quinn alone had approximately 700 cases pending by the end of 1992; by mid-1995, that number was over 2,000. ANGELL, SCIENCE ON TRIAL, supra note 199, at 140. His success in court combined with his large pool of litigants gave him considerable leverage in settlement talks. By mid-1995, his firm had apparently settled close to 200 cases for over $1 million each and another 300 for less than that. Id. at 141. O’Quinn’s success earned him the sobriquet the “king of torts” from Forbes magazine in July 1995. Id. at 140. See also C. Palmeri, A Texas Gunslinger, FORBES, July 3, 1995, at 42.


Bernstein, supra note 205, at 479.

Angell, Evaluating the Health Risks of Breast Implants, supra note 219, at 1515. The settlement applied to all women with silicone breast implants who already had or within the next thirty years developed one of ten listed connective tissue diseases or the symptoms thereof, so long as the symptoms began or worsened after the implants were inserted, though proof of causation was not required. ANGELL, SCIENCE ON TRIAL, supra note 199, at 80-81. Compensation was determined according to the
much larger than expected pool of claimants and the decision of litigants with the strongest cases to opt out of the settlement.\textsuperscript{262} The implosion was the result of a lack of sufficient specificity in the medical requirements listed for eligibility for compensation\textsuperscript{263} and the absence of any requirement that the illness alleged was caused by implants.\textsuperscript{264} As the settlement was structured, a woman could qualify for lucrative compensation even without any objective signs of illness. For example, joint and muscle aches, disturbed sleep, fatigue, and burning pain in the chest—all symptoms that cannot be objectively verified by a doctor—would be enough to entitle the claimant to up to $700,000.\textsuperscript{265} All she would need was substantiating medical records or a doctor’s diagnosis.\textsuperscript{266} And, of course, plaintiffs’ lawyers would supply the doctors who would consistently provide the “right” diagnosis. These defects were quickly exploited by lawyers. Using “800” telephone numbers and other mass advertising techniques, they instituted screenings and recruited more than 440,000 claimants\textsuperscript{267}—far beyond what was anticipated when the settlement was entered into. According to one estimate, the defendant manufacturers would have had to contribute an additional $24 billion to the settlement fund to pay these claims.\textsuperscript{268}

In some cases, lawyers flew doctors all over the country to see potential claimants and sometimes lawyers’ offices doubled as examining rooms for cursory examinations on an

\begin{footnotes}
\item[262] Bernstein, \textit{supra} note 205, at 479.
\item[263] ANGELL, \textit{Science on Trial}, \textit{supra} note 199, at 70.
\item[264] Gina Kolata & Berry Meier, \textit{Doctors, Lawyers and Silicone: A Special Report; Implant Lawsuits Create A Medical Rush to Cash In}, N.Y. \textit{Times}, Sept. 18, 1995, at A1 [hereafter, Kolata & Meier, \textit{Doctors, Lawyers and Silicone}]. (There was no process created in the settlement for verifying that the illness that was alleged was caused by the implants; plaintiffs’ attorneys referred clients to clinicians whose practice was based on such patients, and whose fees were paid by attorneys.)
\item[265] ANGELL, \textit{Science on Trial}, \textit{supra} note 199, at 81.
\item[266] \textit{Id}.
\item[267] In re Dow Corning Corp., 86 F. 3d 482, 485, 486 n. 2 (6th Cir. 1996).
\item[268] In re Dow Corning Corp., 211 B.R. 545, 552 (BANKR. E.D. Mich. 1997).
\end{footnotes}
assembly line basis which were mostly paid for by the lawyers. In this manner, thousands of women were diagnosed by a few dozen doctors for whom “implant work is a lucrative specialty.”

For example, Dr. Robert I. Lewy, an internist and hematologist in Houston, saw 4,700 women with implants within two years. He said that lawyers had referred over 90% of them and that he had found 93% of them sick. Dr. Lewy said his income rose from about $300,000 in 1993, to $2 million in 1994 when he focused on breast implant diagnosing.

Another doctor, Dr. Bernard Patten, a Houston neurologist, performed nerve biopsies on women with implants, claiming that 80% of them had nerve damage. He would prescribe expensive

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269 Kolata & Meier, Doctors, Lawyers and Silicone, supra note 264. Many of the women complained that their examinations were “assembly line,” with dozens of women in the waiting room. One woman commented “It was kind of like cattle…it took a few minutes. He told me to stick out my tongue, he looked in my ears, thumped on my chest, boom boom. That was the test, period.” Another woman was told by such a doctor that she had a degenerative nerve disorder linked to the implants, but she went to see two neuropathologists, and they both said her nerve was normal. Id.

270 Id.

271 These cases became such a large part of his practice that Dr. Lewy even set up a foundation, Breast Implant Research, Inc. ANGELL, SCIENCE ON TRIAL, supra note 199, at 147. He would perform a large array of tests, including expensive bone scans and MRIs to reach his diagnoses — despite the fact that there is no specific test or series of tests for finding silicone-related diseases — and recommended that at least some of them be repeated every three months. Id. at 148. According to his foundation’s brochure, Dr. Lewy seems to believe that women with breast implants will almost inevitably develop an autoimmune disorder and that their children are at risk as well (under the class-action settlement, children of women with breast implants can also be entitled to compensation). Id. at 147. Dr. Lewy is quite open about the ultimate purpose of his diagnoses. In his brochure, he points out that “Documentation of the complaint by medical personnel is important, but diagnosis of a condition related to them (such as chronic fatigue, myalgia, fibromyalgia, scleroderma, nerve abnormalities) is of great value to your claim.” Id. at 149 (emphasis from the original brochure).

A Houston television station reported the story of a nurse who allegedly saw Dr. Lewy after being referred by a lawyer she consulted about any compensation she might be entitled to under the class action settlement. Id. Although she did not see Lewy himself, she underwent an extensive series of tests, including an MRI which she was instructed to have at a particular facility, not at the hospital where she worked. Id. Alarmed by the diagnosis of lupus she was eventually given, she sought a second opinion from her own doctor who could find no evidence of disease. Id. The doctor believed her diagnosis to be based on borderline results from one test (which were not uncommon even in healthy people) and the MRI that was reported as “abnormal.” Id.

272 Kolata & Meier, Doctors, Lawyers and Silicone, supra note 264.

273 Id.

274 ANGELL, SCIENCE ON TRIAL, supra note 199, at 150. Patten was featured on a CNN investigative report about the breast implant controversy, Fire and Fury, Part 4: The Merchants of Fear. Id.
and risky treatments including intravenous gamma globulin, corticosteroids, and antimetabolites that cost about $10,000 per month.\textsuperscript{275} According to reports, Patten earned more than $300,000 a year from his breast implant practice.\textsuperscript{276} Some of the doctors involved in the screening set up assembly-line practices, charging $6,000 per examination including tests,\textsuperscript{277} and diagnosing more than 90\% of the women with “symptoms that would make them eligible for compensation. . .”\textsuperscript{278} One doctor reported earning approximately a million dollars for doing consultations and dealing with forms.\textsuperscript{279}

The women who opted out of a revised class action settlement\textsuperscript{280} found that juries remained generous. In March 1994, two of O’Quinn’s clients won $19.2 million in actual damages and $10 million in punitive damages despite complaining of only vague symptoms\textsuperscript{281} and despite the fact that their implants remained intact. O’Quinn convinced the jury that the minute amount of silicone that leaked through the implant’s membrane was enough to cause immune system problems.\textsuperscript{282}

However, the science continued to favor the plaintiffs. In June of 1994, the first study investigating the relationship between silicone breast implants and connective tissue diseases

\textsuperscript{275} One former patient reported being hospitalized on three separate occasions at a cost of $30,000 each time though her condition never changed. \textit{Id.} at 151. Patten warned her that without the treatments, “you’ll be very surprised how quickly you will go downhill, and you could potentially die.” \textit{Id.}

\textsuperscript{276} \textit{Id.} (citing the CNN report).

\textsuperscript{277} Kolata & Meier, \textit{Doctors, Lawyers and Silicone}, supra note 264. \textit{See also supra} note 271.

\textsuperscript{278} McNamara-Meis, \textit{Had It All Wrong}, supra note 219, at 44.

\textsuperscript{279} ANGELL, \textit{SCIENCE ON TRIAL}, supra note 199, at 151 (citing an article in the Medical-Legal Aspects of Breasts Implants newsletter).

\textsuperscript{280} Following agreement on a new class action settlement involving just Bristol-Myers Squibb, Baxter International, and 3M (Dow Corning chose to declare bankruptcy instead of taking part in the settlement, \textit{see} discussion infra note 289 and accompanying text), 92\% of eligible women chose to participate. Bernstein, \textit{supra} note 205, at 479. None of the O’Quinn firm plaintiffs opted in. \textit{Id.}

\textsuperscript{281} The plaintiffs complained of fatigue, malaise, and muscle pain. \textit{Id.}

\textsuperscript{282} \textit{Id.} at 480.
was published in the New England Journal of Medicine. It found no association. A second study a year later reached similar results. Based on these two studies, the American College of Rheumatology and the FDA both concluded that silicone breast implants did not significantly increase the risk of connective tissue disorders. Since that time, peer-reviewed scientific journals have published over a dozen additional studies that failed to find a connection.

Although one study did find a 24% increase in connective tissue disorders in women with breast implants, these results were based on self-reports and not medical records, so its reliability is questionable in light of the extensive publicity the issue received.

After the original class action settlement imploded under the weight of the 440,000 claims mostly generated by lawyer-sponsored screenings, Dow Corning made the strategic decision to walk away from the settlement and instead file for bankruptcy. While the other three manufacturers, Bristol-Myers Squibb, Baxter, and 3M made a business judgment to continue and pay their share of a revised settlement, Dow determined that it would fare better in the bankruptcy arena where it believed it could get a quick up-or-down ruling on general causation based on the epidemiological data that had emerged indicating that there was no causal relationship between autoimmune disease and silicone breast implants. The bankruptcy court,

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283 Sherine E. Gabriel et al., Risk of Connective-Tissue Diseases and Other Disorders After Breast Implantation, 330 NEW ENG. J. MED. 1697 (1994). See also ANGELL, SCIENCE ON TRIAL, supra note 199, at 100-01.
284 Marcia Angell, the editor of the journal, wrote an accompanying editorial that noted that while the study could not “conclusively rule out some association of breast implants with the disorders studied . . . . any possible risk from breast implants in this population could not be large.” Bernstein, supra note 205, at 480 (quoting Marcia Angell, Do Breast Implants Cause Systemic Disease? Science in the Courtroom, 330 NEW ENG. J. MED. 1748, 1748 (1994)).
286 Bernstein, supra note 205, at 482.
287 Id. at 483.
288 Id. at 482. See also ANGELL, SCIENCE ON TRIAL, supra note 199, at 102.
289 See NAGAREDA, MASS TORTS, supra note 1, at 35-36.
however, declined to place the initial focus of the proceeding on the valuation of pending tort claims, and rejected Dow Corning’s motion for appointment of a panel of experts under Rule 706 of the Federal Rules of Evidence to consider the issue of general causation, leaving the issue to be litigated later in the proceeding.

Five years of intense litigation ensued before Dow Corning was able to obtain approval to proceed to the full-blown claims-allowance process that it was seeking to include a trial on general causation. By then, however, Dow Corning suffered a case of “cold feet” and while its motion for summary judgment, based on the absence of causation and the exclusion it sought of the claimants’ experts in a Daubert proceeding, was pending, it negotiated a plan in which it agreed to set aside $3.2 billion to pay claims that the epidemiological evidence demonstrated had not been caused by the implants.

In total, approximately $4 to $5 billion has been paid by the manufacturers for connective tissue and auto immune disease claims mostly generated by litigation screenings netting lawyers $1 to $2 billion despite the fact that “there is no evidence that silicone breast implants contribute to an increase in autoimmune (connective tissue) diseases…and [there is] no link between implants and connective disease or rheumatic conditions.”

VII. Welding Fume Litigation

Litigation screenings have also been used to generate thousands of claims of injury allegedly caused by exposure to gasses emitted in the welding process. Since at least 1931,

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293 SAFETY OF SILICONE BREAST IMPLANTS, supra note 203, at 6-7.
welders have sought compensation for injuries caused by exposure to welding fumes, but starting in the early 1990s, welding fume litigation has increasingly centered on claims that exposure to manganese in welding fumes causes neurological disorders. Even these claims were sporadic, however, until the January 2001 publication of a study that suggested the possibility of a link between welding and Parkinson’s disease spurred an onslaught of litigation in state and federal courts across the country. Shortly thereafter, several groups of plaintiffs’ lawyers began using litigation screenings to generate large numbers of claimants.

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295 See, e.g., Kallenbach v. Lincoln Elec., No. 91-C-1012-S (W.D. Wis. 1992); Siddens v. Lincoln Elec., No. 90-2273 (C.D. Ill. 1994); Canfield v. Lincoln Elec., No. 92-C-0517 (E.D. Wis. 1995); Jones v. Lincoln Elec. (N.D. Ind. 1995). Now, the overwhelming majority of welding rod cases state this claim. This article will focus exclusively on welding rod litigation based on alleged neurological injury.


297 Most welding fume claims were originally brought in state courts, especially in Mississippi and West Virginia, whose generous joinder rules allowed hundreds of specious claims to be joined with a single compelling one, see discussion infra notes 344-346 and accompanying text, as well as in Texas, Illinois, Louisiana, and Pennsylvania, among others. After a number of cases were filed in federal district courts or removed there by defendants, those claims were consolidated into an MDL and transferred to the Northern District of Ohio for consideration. See infra note 371. Two states, California and Ohio, have also created coordinated proceedings to handle the welding fume cases in their jurisdictions. The California Coordinated Welding Products Cases litigation involved approximately a hundred cases at its peak, while as a many as a hundred remain in the Ohio proceedings. Welding Products Cases, JCCP004368 (Calif. Super., Alameda Co. 2004); Welding Rod Civil Actions Products Liability Litigation, No. 531703 (Ohio Comm. Pls., Cuyahoga Co.).

298 This article discusses the screenings conducted by four groups of lawyers involved in the federal multi-district welding fume litigation. Three of these groups—one from Mississippi that includes Richard Scruggs and Don Barrett, one from Texas that includes the Provost Umphrey Law Firm, and one from Louisiana—employed Dr. Paul Nausieda and a small group of additional neurologists to conduct
As a consequence, within a few years of the study, the number of cases had burgeoned from dozens to thousands, with close to 10,000 new lawsuits against welding rod manufacturers and distributors filed in 2003 alone.\textsuperscript{299} One of the lawyers leading the charge was Richard “Dickie” Scruggs, the lawyer who pioneered asbestos litigation screenings and the state tobacco litigations.\textsuperscript{300} Determined to create a new mass tort, Scruggs and another Mississippi tort lawyer, Don Barrett, were the first to begin screening welders during this period.\textsuperscript{301} Several groups of plaintiff lawyers have now generated thousands of welding fume claims through litigation screenings.\textsuperscript{302} Although some of the screening procedures have been ostensibly designed to

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\textsuperscript{299} According to defense attorney John Beisner, 9,510 cases were filed in 2003, more than in any other year. Margaret Cronin Fisk, \textit{Lincoln No-Accord Stance Avoids Tobacco-Sized Awards (Update 2)}, BLOOMBERG.COM, April 22, 2008, available at http://www.bloomberg.com/apps/news?pid=20601103&sid=aUj.XZ.h5H9Q&refer=us# (last visited June 4, 2008).

\textsuperscript{300} See Terry Carter, \textit{Long Live The King of Torts?}, ABAJ 44, 46 (April 2008), available at http://abajournal.com/magazine/long_live_the_king_of_torts/ (last visited June 28, 2008); Boyer, supra note 25, at 46-48. See also discussion infra note 391. Scruggs began paying for screenings for prospective clients in asbestos cases to gain a competitive edge. Boyer, supra note 25, at 46. Indeed, Scruggs earned his reputation as the “King of Torts” not in the courtroom, where he reportedly lost the only case he tried to verdict, but through his prowess in recruiting clients and then using the resulting mass of claims to force defendant corporations into massive settlements. Carter, supra, at 46. He used his attorneys’ fees from asbestos litigation to capitalize the launch of the concerted litigation by states against the big tobacco companies. \textit{Id.}


\textsuperscript{302} As of February 2006, lawyers involved in the MDL litigation had screened over 57,823 welders “with exposure and reported symptoms,” including the 33,239 by the Barrett Law Offices, 16,169 screened by a group of Texas lawyers, 4,142 screened by Ranier, Gayle & Elliot, a Louisiana law firm, and 4,573 screened by Motley Rice, a South Carolina-based law firm. Hearing Tr., supra note 301, at 243; Plaintiffs’ Memorandum in Opposition to Defendants’ Motion for Fees, Sanctions and Remedial Relief at 10, \textit{In re Welding Fume Products Liability Litigation, No. 1:03-CV-17000, MDL No. 1535 (N.D. Ohio January 17, 2006)} [hereafter Plaintiffs’ Memorandum 1/17/06]. Of those screened, 2,408 had received a diagnosis of parkinsonism related to manganese exposure, while an additional 3,552 had not completed the second stage of the two-stage screening process as of early 2006. Hearing Tr., supra note 301, at 244;
avoid the worst abuses of the litigation screenings considered in this article, the results of the
Scruggs-Barrett screenings which I focus on in this article, indicate that large numbers of
diagnoses are being generated that appear to be more the product of financial incentives than
good faith medical practices. 303

A. The Welding Process

Welding is a process used to join two pieces of metal by melting the edges together, often
with the use of welding rods made of manganese, iron, chromium, nickel, zinc, aluminum,
copper and other materials that are used to strengthen the joint. 304 When the pieces cool, a solid
joint is formed. During the heating process, fumes are emitted which are primarily made up of
materials from the welding rod, including manganese, which is essential to create hardness in the
joint. 305 The amount of manganese and other particulates present in the fumes depends on the
welding process employed, 306 the composition of the welding rod, 307 and the conditions present

Plaintiffs’ Memorandum 1/17/06, supra, at 10. See also discussion, infra notes 430 and 435, for more
detail regarding the screening results.
303 See discussion infra notes 455-458.
University Press (on file with author).
305 James M. Antonini et al., Fate of Manganese Associated with the Inhalation of Welding
Fumes: Potential Neurological Effects, 27 Neurotoxicology 304, 305 (2006) [hereafter Antonini,
Manganese] (“Manganese is an essential ingredient in the welding of steel because it increases hardness
and strength, prevents steel from cracking during manufacture, improves metallurgical properties, and
acts as a deoxidizing agent to remove iron oxide from the weld pool to form a stable weld.”).
306 The American Welding Society has identified over eighty different types of welding and
allied processes including shielded manual metal arc welding, gas metal arc welding, flux-cored arc
welding, gas tungsten arc welding, submerged arc welding, and plasma arc welding. Antonini, Health
Effects, supra note 294, at 63.
307 See Antonini, Manganese, supra note 305, at 305 (“Most of the materials in the welding
fume come from the electrode, which is consumed during the welding process.”). Depending on the
metals being joined and the welding process being used, the welding rod may contain a combination of
the following elements: chromium, nickel, iron, manganese, silica, fluorides, zinc, aluminum, copper, or
cadmium. See Antonini, Health Effects, supra note 294, at 67-69. During the welding process, the metals
vaporize into very small particulates that become suspended in the air, creating the welding fume. Id. at
67. The amount of manganese in welding rods varies from 1 to 20% of the metals present depending on
the welding process used and the joint hardness required. Antonini, Manganese, supra note 305, at 305
at the worksite. Thus, both the content of and degree of exposure to welding fumes varies widely from workplace to workplace and welder to welder.

B. Manganese, Welding, and Health

The presence of manganese in welding fumes has spurred the current litigation against manufacturers and suppliers of welding rods, companies that use welding in their operations, and associated trade organizations and businesses. Manganese, although an essential and common element, has long been known to cause neurological consequences among miners and smelters ("[M]ost welders are exposed to mixed metal fumes that contain a small percentage of manganese (<5% per total metal present). However, some welders are exposed to aerosols generated from hard-facing electrodes that contain a higher percentage of manganese (10-20%)."). See Id. ("[Welders] work in a variety of locations, ranging from well-ventilated outdoor and indoor settings to poorly-ventilated confined spaces (e.g., hull of a ship, building crawl space).") See also American Welding Society, Careers in Welding http://www.aws.org/wa/education/career.html (last visited August 18, 2007) (listing careers in welding including shipbuilding, automobile manufacturing and repair, aerospace applications, underwater welding; metal sculpting; bridge construction and repair; pipe-joining in pipelines, power plants, and refineries; construction welding on oil platforms at sea or on skyscrapers on land; and manufacturing of small electronic devices, medical components, and nanotechnology).

"Several hundred studies have evaluated the health effects associated with welding fume inhalation. However, these effects are oftentimes difficult to assess because of differences in worker populations, industrial settings, work area ventilation, welding processes and materials used, and other occupational exposures besides welding fumes." Antonini, Manganese, supra note 305, at 308 (noting that differences in welding process and rod composition can impact the body’s ability to transport, process, or absorb manganese inhaled in welding fumes).

Defendants include current and former manufacturers and sellers of welding products, such as Lincoln Electric Company, Hobart Brothers, The ESAB Group Inc., BOC Group and Deloro Stellite Company; manufacturers of welding machines, such as Miller Electric Manufacturing Company; trade organizations such as the American Welding Society, the National Electrical Manufacturer’s Association, and Ferroalloys Association; and premises/contractor defendants such as Kinder Morgan Energy Partners, LP, Proctor & Gamble Paper Products Company, Chevron USA Inc., Union Oil Company, and C&H Sugar Company. Ralph A. Zappala, Scientific Aspects of Welding Rod Cases at 4, available at http://www.lbbslaw.com/publications.aspx?t=6 (last visited April 2, 2008); Jean Hellwege, Welding Rod Litigation Heats up: Workers Claim Toxic Fumes Cause Illness, TRIAL, July 1, 2004, available at http://goliath.ecnext.com/coms2/gi_0199-573630/Welding-rod-litigation-heats-up.html (last visited July 3, 2008).

Manganese is the twelfth most common element and the fourth most commonly used metal. C. W. Olanow, Manganese-Induced Parkinsonism and Parkinson’s Disease, 1012 ANNALS N.Y. ACAD. OF SCI. 209, 209 (2004). It is abundant in the environment and is an essential dietary component, because it plays a critical antioxidant role in neurons and other cells. Foods such as nuts, grains, tea, and legumes provide an average daily intake of about 5 mg/kg. Joseph Jankovic, Searching for a
exposed to toxic levels of the metal.\textsuperscript{312} The resulting condition, known as manganism, is a form of parkinsonism, the term used for any condition that causes movement abnormalities such as those seen in Parkinson’s disease.\textsuperscript{313} Manganism is distinguishable from Parkinson’s disease by

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Parkinson’s disease, the most common form of parkinsonism, affects 1-2% of the adult population. Olanow, \textit{supra} note 311, at 210. It is distinguished by four primary symptoms: rest tremor (trembling in the hands, arms, legs, jaw, and face); rigidity (stiffness of the limbs and trunk); bradykinesia (slowness of movement); and postural instability (impairment of balance and coordination). Chadwick W. Christine & Michael J. Aminoff, \textit{Clinical Differentiation of Parkinsonian Syndromes: Prognostic and Therapeutic Relevance}, 117 AM. J. MED. 412, 413 (2004); National Institute of Neurological Disorders and Strokes (NINDS), National Institutes of Health, NINDS Parkinson’s Disease Information Page, (June 24, 2008), \url{http://www.ninds.nih.gov/disorders/parkinsons_disease/parkinsons_disease.htm} (last visited July 3, 2008). While symptoms are subtle at first and appear gradually, as they become more pronounced, they can impair a patient’s ability to walk, talk, and complete simple tasks. \textit{Id.} Parkinson’s disease, which usually affects people over the age of fifty, is both chronic and progressive. \textit{Id.} Patients may become severely disabled or experience only minor symptoms. \textit{Id.} Parkinson’s disease can be difficult to diagnose accurately. \textit{Id.} To date, there is no definitive blood or laboratory test for the disease (or parkinsonism in general), so doctors use a patient’s medical history and a neurological exam to make their diagnosis. \textit{Id.} In addition, brain scans and laboratory tests can rule out other diseases. \textit{Id.} In the early stages of disease, however, it may be difficult to determine whether a patient has Parkinson’s disease or another parkinsonism disorder. Swanson, \textit{supra}. The misdiagnosis rate may be as high as 25%. Olanow, \textit{supra} note 311, at 210 (citing A. J. Hughes et al., \textit{Accuracy of Clinical Diagnosis of Idiopathic Parkinson’s Disease: A Clinico-Pathologic Study of 100 Cases}, 55 J. NEUROL. NEUROSURG. PSYCHIATRY 181 (1992)). As the disease progresses, additional signs and symptoms can help differentiate the diagnoses. \textit{Id.} While there is no cure for Parkinson’s disease, medications such as levodopa can provide relief from some symptoms. NINDS, \textit{supra}.

Manganism is a form of parkinsonism caused by exposure to manganese. It is also sometimes referred to as manganese-induced parkinsonism. It can be distinguished from Parkinson’s disease and other parkinsonisms by its bilateral onset, symmetric impairment, absence of rest tremor, gait and balance problems (including a distinctive “cock walk”), dysarthria (slow or slurred speech), and poor or non-response to levodopa. Jankovic, \textit{supra} note 311, at 2023; D.B. Calne et al., \textit{Manganism and Idiopathic Parkinsonism: Similarities and Differences}, 44 NEUROLOGY 1583, 1583-84 (1994). In addition, brain scans show that different areas of the brain are implicated in manganism and Parkinson’s disease. Olanow, \textit{supra} note 311, at 210-216 (noting that degeneration of dopamine neurons in the substantial nigra pars compacta (SNC) is a hallmark of Parkinson’s disease while the primary sites of damage following manganese neurotoxicity are the globus pallidus (GP) and the substantia nigra pars reticularis.
its bilateral onset of symptoms, distinctive gait, absence of rest tremor, lack of response to the drug levodopa, and implication of different areas of the brain.\footnote{314}

Despite the widespread use of manganese in industrial processes,\footnote{315} manganism is relatively rare.\footnote{316} Researchers disagree whether there is even a connection between the disease and manganese in welding fumes.\footnote{317} According to James Antonini, a research toxicologist at (SNr)). As a result, PET scans and MRIs may be able to differentiate between the two disorders. See, e.g., Yangho Kim et al., \textit{Positron Emission Tomography (PET) in Differentiating Manganism from Idiopathic Parkinsonism}, 44 \textit{J. OCCUPATIONAL HEALTH} 91 (1999) (suggesting that PET scans can differentiate between manganism and idiopathic Parkinson’s disease with incidental exposure to manganese).\footnote{314} Jankovic, \textit{supra} note 311, at 203 (citing seventeen typical features of manganese-induced parkinsonism); Olanow, \textit{supra} note 311, at 210 (outlining the clinical features of manganism).

Of the eight million tons of manganese mined annually, more than 90\% is used in the manufacture of steel (where it acts as a hardening agent). Olanow, \textit{supra} note 311, at 209. Manganese is also used in batteries, water purification, bactericidal and fungicidal agents, and MMH, an antiknock agent added to gasoline. \textit{Id.}\footnote{315} Jankovic, \textit{supra} note 311, at 2021. See also Olanow, \textit{supra} note 311, at 210 & nn.2-21 (noting the case reports and studies of manganese toxicity from 1837 to 1989). Historically, manganism primarily occurred in workers involved in the mining, grinding, or smelting of manganese ore or in the manufacture of dry batteries. \textit{Id.} It was almost never seen in welders. \textit{Id.} There were no cases of manganese-induced parkinsonism in welders reported in the scientific literature during and after World War II, despite a 2000\% upsurge in welding during the war. See, e.g., WALDEMAR C. DREESSEN ET AL., U.S. PUBLIC HEALTH SERVICE, \textit{HEALTH OF ARC WELDERS IN STEEL SHIP CONSTRUCTION}, PUBLIC HEALTH BULLETIN NO. 298 (1947); JUDY WALRATH ET AL., NATIONAL INSTITUTE OF HEALTH, MORTALITY PATTERNS AMONG U.S. VETERANS BY OCCUPATION AND SMOKING STATUS, NIH PUBLICATION NO. 85-2756 (1985); Caroline M. Tanner, \textit{Occupation and Risk of Parkinson's Disease (PD): A Preliminary Investigation of Standard Occupational Codes (SOC) in Twins Discordant for Disease}, 60 Neurology A415 (2003) (Suppl. 1). Researchers have postulated several reasons for this difference in toxicity including the lower exposure levels involved, the body’s better ability to expel the small particulates present in welding fumes than the larger particles present in ore dust, and the presence of iron, which inhibits the transport of manganese across the blood-brain barrier, in welding fumes, Antonini, \textit{Manganese}, \textit{supra} note 305, at 306-307; Jankovic, \textit{supra} note 311, at 2022.\footnote{316}

\textit{Id.}\footnote{317} The debate has become more complicated as the two sides in the welding fume litigation have become major funders of much of the research that is currently being published on the issue. Plaintiffs’ attorneys have funded studies supporting the connection between welding fumes and parkinsonisms, \textit{see, e.g.}, Brad A. Racette et al., \textit{Prevalence of Parkinsonism and Relationship to Exposure in a Large Sample of Alabama Welders}, 64 \textit{NEUROLOGY} 230 (2005) [hereafter Racette, \textit{Prevalence of Parkinsonism}] (comparing rates of neurological disease found in welders identified through litigation screenings to a general population sample from another county); and Leonard Post, \textit{Suits Sparked by Arc Welding}, NAT’L LAW J., Dec. 9, 2003, \textit{available at} \url{http://www.law.com/jsp/article.jsp?id=1069801713142} (last visited June 4, 2008) (discussing a study of 20,000 welders by Dr. Paul Nausieda, a neurologist who has performed a major proportion of the welding fume litigation screenings that were funded by a group of plaintiffs’ attorneys, but which has never been published). The welding rod industry has funded a number of the studies that have found no connection
between welding fumes and parkinsonisms, see, e.g., Jon P. Fryzek et al., *A Cohort Study of Parkinson’s Disease and Other Neurodegenerative Disorders in Danish Welders*, 47 J. OCCUPATIONAL & ENVIRONMENTAL MED. 466 (2005) (using hospital records to compare the rate of Parkinson’s disease between welders and the general population); and C.M. Fored et al., *Parkinson’s Disease and Other Basal Ganglia or Movement Disorders in a Large Nationwide Cohort of Swedish Welders*, 63 OCCUPATIONAL & ENVIRONMENTAL MED. 135 (2006) (comparing the rates of hospitalization and death of a cohort of 50,000 Swedish welders to a control group of 500,000 Swedish non-welders; funding was provided by the International Epidemiology Institute which, in turn received funding from current and former manufacturers of welding rods). Still other studies have been published by doctors and researchers with known ties and financial connections to one side of the litigation or the other, although the authors either received support for that specific study from more neutral sources or did not reveal the source of funding at all. See, e.g., William C. Koller et al, *Effect of Levodopa Treatment for Parkinsonism in Welders: A Double-Blind Study*, 62 NEUROLOGY 730 (2004) (Koller helped design one of the litigation screening processes and was one of the screening neurologists for plaintiffs’ attorneys) and Olanow, *supra* note 311 (Olanow is an expert witness for the defense; two consulting firms linked to him reportedly received almost $2.9 million in fees from welding rod manufacturers).

In December of 2007, after years of legal battles over money paid to researchers by both sides, Judge Kathleen O’Malley, who is presiding over the Welding Fume MDL, ordered each side to submit a full accounting of payments made to scientists studying the effects of welding fumes. Jim Morris, *Toxic Smoke and Mirrors*, MOTHER JONES, July/August 2008 at 28, available at http://www.motherjones.com/commentary/columns/2008/07/witness-smoke-and-mirrors.html. Specifically, Judge O’Malley wanted to see a list of payments made to the authors of scientific articles relied on by expert witnesses during their testimony. While the disparity between the numbers submitted by the two sides is large—$12.5 million paid out by welding fume companies versus just over $522,000 by plaintiffs, id.—a closer look at the reports put together by each side reveals a more complex story. See also List of Authors Payments Submitted by Defendants, *In re* Welding Fume Products Liability Litigation, No. 1:03-CV-17000, MDL No. 1535 (N.D. Ohio Feb. 19, 2008), available at http://projects.publicintegrity.org/Manganese/ManganesePayOutList.pdf (last visited July 9, 2008) [hereafter Defendants’ Payments]; Author Payments (Plaintiffs), *In re* Welding Fume, No. 1:03-CV-17000 (Feb. 5, 2008) (on file with author); Supplemental Author Payments (Plaintiffs), *In re* Welding Fume, No. 1:03-CV-17000 (Feb. 7, 2008) (on file with author); Second Supplemental Author Payments (Plaintiffs), *In re* Welding Fume, No. 1:03-CV-17000 (Feb. 21, 2008) (on file with author) [hereafter the three separate lists of plaintiffs’ author payments will be referenced collectively as Plaintiffs’ Payments].

To begin with, defendants made payments to twenty-five organizations, including many universities, and thirty-three researchers, Morris, *supra*, at 28, while plaintiffs payments went to just two organizations and twelve researchers. See Defendants’ Payments, *supra*; Plaintiffs Payments, *supra*. This disparity reflects, at least in part, the fact that the majority of research to date has failed to find a connection between exposure to welding fumes and parkinsonism. Indeed, over 80% of the payments made by plaintiffs went to just two men: Dr. William Koller, who helped design the screening process described in this article and who performed some of the early screenings, and Dr. Brad Racette, author of the 2001 article that suggested the possibility of a link between welding and Parkinson’s disease. Plaintiffs Payments, *supra*. Plaintiffs provided over $230,000 to help fund Racette’s 2005 study of a group of Alabama welders identified through litigation screenings that found a higher prevalence of Parkinson’s disease among welders than non-welders. *Id.*; Racette, *Prevalence of Parkinsonism*, *supra*, at 230. Their accounting also did not include the more than $2 million that has been paid to Dr. Paul Nausieda, the neurologist that has performed the vast majority of the screenings, because his work has not been accepted for publication. See discussion infra notes 458, 464. Meanwhile, of the $12.5 million paid out by defendants, approximately $7 million has gone to testifying experts and close to $1.5 million for payments made to sources covered by the work product privilege, primarily non-testifying experts. See Defendants’ Payments, *supra*. Another $4 million has been used to fund research, including over $3.3
the National Institute for Occupational Safety and Health (NIOSH) who studies the effects of welding fumes, “There is a question whether manganese is even available enough in welding fumes to cause an effect.”

In 2006, he noted that a “causal association between neurological effects and the presence of manganese in welding fume has yet to be established.”

His colleague, Robert Park, a NIOSH epidemiologist, however believes there is ample evidence that welding fumes cause neurological effects. Citing several Korean studies from the 1990s that showed a greater incidence of tremors and speech and gait impairment in welders than non-

million for a prospective study by The Parkinson’s Institute that has not been completed yet. Id. at 20-21. An additional $645,000 was paid to the International Epidemiology Institute to help fund two Scandinavian studies that did not find a link between welding and Parkinson’s disease. Id. at 9; Fryzek, supra; Fored, supra.

A final note. As recently as 2005, plaintiffs’ lawyers were castigating the welding rod industry for not having funded epidemiological studies to determine whether welding fumes cause neurological problems. See Trial Transcripts: Presler v. Lincoln Electric, LITIGATION WATCH: WELDING FUMES, March 2005, at 9-10, available at www.harrismartin.com/pdfs/WeldingFumes0503Issue.pdf (plaintiff’s opening statement by attorney Mikal Watts). Plaintiffs’ lawyers now contend that studies funded by the welding rod industry should be rejected because their validity is compromised by the source of the funding. See, e.g., Scruggs Law Firm Announces Favorable Verdict in Welding Fume Case, REUTERS, Dec. 5 2007, available at http://www.reuters.com/article/pressRelease/idUS238289+05-Dec-2007+PRN20071205 (“This jury heard for the first time that the industry even went so far as to pay for bogus scientific studies and biased medical articles written by industry-paid hired guns to attempt to dispute the scientifically proven link between welding fume exposure and neurological injury.”).

318 M.R. Kropko, Suit Claims Welding Fumes Caused Tremors, THE ASSOCIATED PRESS, Monday, June 12, 2006, available at: http://www.washingtonpost.com/wp-dyn/content/article/2006/06/12/AR2006061200774.html (quoting NIOSH researcher James M. Antonini). Antonini and others believe the body’s ability to either rid itself of or neutralize the manganese from inhaled welding fumes limits its toxic potential, especially as compared to the larger, more easily ingested particles found in the manganese dust from mining that is known to cause neurological problems. Antonini, Manganese, supra note 305, at 306-307; Jankovic, supra note 311, at 2022, 2024-25.

319 James M. Antonini et al., Development of an Animal Model to Study the Potential Neurotoxic Effects Associated with Welding Fume Inhalation, 27 NEUROTOXICOLOGY 745, 750 (2006). In a more recent review of the scientific literature co-written with industry consultants (per Morris, supra note 317, at 82), Antonini and his co-authors conclude that available data does not support the conclusion that the manganese in welding fumes causes neurological disorders in welders, but suggests areas for further research on the topic. Annette B. Santamaria et al., State-of-the-Science Review: Does Manganese Exposure During Welding Pose a Neurological Risk?, 10 J. TOXICOLOGY & ENVIRONMENTAL HEALTH, PART B 417 (2007).

welders,” he said, “I’d be amazed if there was something else going on instead of manganese.” NIOSH’s own website links manganese exposure from welding fumes to “changes in mood and short-term memory, altered reaction time, and reduced hand-eye coordination,” but reaches no conclusion on the clinical significance of these findings. The vast majority of scientific studies, however, including six recent large scale epidemiological studies, among others, have failed to find a link between welding or exposure to welding

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322 Morris, *supra* note 317, at 82.
324 See, e.g., Fryzek, *supra* note 317 (finding no significant difference in the rates of hospitalization for Parkinson’s disease between welders and the general population in Denmark over a twenty-five year period); Fored, *supra* note 317 (finding no support for a relation between welding and Parkinson’s disease or any other neurodegenerative disorder in a study of almost 50,000 Swedish welders); Jankovic, *supra* note 311 (finding no convincing evidence in the scientific literature that welding is a risk factor for Parkinson’s disease or other parkinsonisms); Jungsun Park et al., *Occupations and Parkinson’s Disease: A Multi-Center Case-Control Study in South Korea*, 26 NEUROTOXICOLOGY 99 (2005) (finding that occupations with potential manganese exposure such as welder, smelter, welding rod manufacturer, miner, and worker in the iron and steel industries “showed consistently negative association with Parkinson’s disease after adjusting for confounders such as age, sex, smoking, and education level.”); Joseph K.C. Tsui et al., *Occupational Risk Factors in Parkinson's Disease*, 90 CANADIAN J. OF PUBLIC HEALTH 334 (1999) (finding that welding was not one of the occupations associated with an increased risk of Parkinson’s disease in the general population of Vancouver, British Columbia); Gary M. Marsh & Mary Jean Gula, *Employment as a Welder and Parkinson Disease Among Heavy Equipment Manufacturing Workers*, J. OF OCCUP & ENVTL. MED. 1031 (2006) (finding no elevated risk of developing Parkinson’s disease, parkinsonism, or related disorders among welders employed by Caterpillar as compared to employees of the company who were not exposed to welding fumes); R. Frigerio et al., *Education and Occupations Preceding Parkinson Disease: A Population-Based Case-Control Study*, 65 NEUROLOGY 1575 (2005) (finding an inverse association between being a metal worker (a group that includes welders) and a risk of developing Parkinson’s disease in a study of all Parkinson’s disease cases among the residents of Olmstead County, Minnesota); Jungsun Park et al., *A Retrospective Cohort Study of Parkinson's Disease in Korean Shipbuilders*, 27 NEUROTOXICOLOGY 445 (2006) (finding no increased risk of Parkinson’s disease among Korean shipyard workers as compared to a control group who were not exposed to manganese); Finlay D. Dick et al., *Environmental Risk Factors for Parkinson’s Disease and Parkinsonism: The Geoparkinson Study*, OCCUP. ENVTL. MED. (May 30, 2007).
fumes and neurological disorders such as manganism, Parkinson’s disease, or other, similar movement disorders.\textsuperscript{325}

Nonetheless, in a 2001 article, Dr. Brad Racette, a neurology researcher at Washington University, postulated just such a causal link between welding and Parkinson’s disease.\textsuperscript{326} Finding an earlier age of onset of Parkinson’s disease among the fifteen welders in a study of 953 parkinsonian patients at a movement disorder clinic, he hypothesized that exposure to manganese in welding fumes might have accelerated the onset of the disease.\textsuperscript{327} Other researchers have criticized Racette’s speculation.\textsuperscript{328} They point out, among other flaws in the study, that the majority of the welders examined had a family history of Parkinson’s disease, a fact that has a high correlation with early onset of the disease.\textsuperscript{329} Indeed, Racette and his co-

\textsuperscript{325} From a scientific standpoint, it is rarely possible to prove that a particular substance causes a specific disease; it is merely possible to show that it is a risk factor that is associated with the disease. ANGELL, SCIENCE ON TRIAL, supra note 199, at 98. This distinction is important because it limits not only what scientific evidence can prove, but also how it can prove it. Specifically, when it comes to disease causation, it is not enough to show that people with exposure to a particular substance have a specific disease; to prove an association between the two, researchers must find a significantly greater percentage of the disease in people with the exposure than in people without it. Id. at 100. Anything less can be simply coincidence. Thus the only scientifically accepted way to prove that a substance such as manganese in welding fumes is a risk factor for a specific disease such as parkinsonism is an epidemiological study that compares the rate of disease between large, demographically matched populations of people who were exposed to the substance and people who were not. Id. at 98-100.

\textsuperscript{326} Racette, Welding-Related Parkinsonism, supra note 296.

\textsuperscript{327} Id. at 12.

\textsuperscript{328} See, e.g., Jankovic, supra note 311, at 2025 (criticizing the methodology of the study, including the lack of random selection of study participants, the lack of information about the employment of the welders and how they came to be referred to the clinic where the study occurred, and the possible bias created by studying a pool of specialty clinic patients who are generally atypical of the general population); Antonini, Health Effects, supra note 294, at 84 (noting that Racette’s findings did not prove that manganese caused the early onset of Parkinson’s disease).

\textsuperscript{329} Jankovic, supra note 311, at 2025 (noting that more than half—eight out of fifteen—of the welders had a family history of the disease as compared to 15% of the general population). See also Caroline M. Tanner et al., Parkinson Disease in Twins: An Etiologic Study, 281 J. AMER. MED. ASS’N 341, 345 (1999) (finding 100% concordance between monozygotic twins with early onset Parkinson’s disease, suggesting a genetic component); BA Rybicki et al., A Family History of Parkinson’s Disease and Its Effect on Other PD Risk Factors, 18 NEUROEPIDEMIOLOGY 270 (1999) (finding a greater correlation between Parkinson’s disease and a family history thereof in people under 70 years old than in those over 70).
authors acknowledged that the results did not prove that manganese is the cause and that exposure to other substances could be responsible for Parkinson’s disease in welders.\textsuperscript{330}

C. The Creation of a Mass Tort

Despite the so far tenuous evidence linking welding fumes to neurological disorders, Racette’s study appears to have been an impetus for Dickie Scruggs, Don Barrett, and other plaintiffs’ lawyers to attempt to create another mass tort patterned after the asbestos screening model that Scruggs had pioneered in the early 1980s. The requisite ingredients for entrepreneurial lawyers to create a mass tort appear to have been in place. First, the mass. With an estimated 376,630 active welders in the United States\textsuperscript{331} and hundreds of thousands of former welders and others who have worked around welders, the pool of potential litigants is well over 700,000 and could be as high as two million people.\textsuperscript{332} Plaintiffs’ attorneys and industry analysts estimated that as many as 35,000–70,000 claims could be filed against welding rod

\textsuperscript{330} Racette, \textit{Welding-Related Parkinsonism}, supra note 296, at 12. He concluded that “further studies are necessary to clarify this important issue.” \textit{Id}. Racette reiterated this point while testifying in the \textit{Elam} case in Illinois in 2003: “This research doesn't prove that welding causes Parkinson's disease, but it's suspicious that the majority of these patients had a much younger age of onset.” Brian Brueggemann, \textit{Welders Seem Unworried About Parkinson's After Jury Awards $1 Million to Ailing Man}, \textit{BELLEVILLE NEWS-DEMOCRAT (IL)}, November 3, 2003, available at \url{http://www.weldinginfonetwork.com/media/11_03_03_bnd.html} [hereafter Brueggemann, \textit{Welders Seem Unworried}].


\textsuperscript{332} HSBC Bank estimated in 2003 that there are approximately 700,000 current and former welders in the United States. BOC GROUP: LITIGATION A REAL RISK, HSBC BANK, January 20, 2003 at 1, 4; see also Richard W. Fields, Esq et al, \textit{How Should Your Company Respond to Welding Rod Claims?}, WELDING & GASES TODAY ONLINE, Summer 2004, available at \url{http://www.datakey.org/gawdajournal/3q04/claims_a.php3} (last visited June 4, 2008). This number does not include people who have worked around welding and who thus may have been exposed to fumes although they themselves did not weld. \textit{Id}. One estimates puts the number of exposed non-workers as high as 1.2 million. Post, supra note 317 (quoting plaintiffs’ attorney Allen Vaughan). Elam, the first successful welding fume plaintiff, is an example of the latter group. \textit{See} discussion \textit{infra} notes 397-402.
manufacturers. Second, general causation. The Racette study, however tenuous on this issue, would be sufficient if the asbestos model prevailed, that is, the use of mass filings in selected jurisdictions to compel settlements. Third, the mass injury to sustain the mass filing. The fact that there was no evidence of any mass injury would be overcome by use of litigation doctors motivated by financial incentives who would screen potential litigants and find sufficient numbers of the requisite neurological disorders that meet the requirement of specific causation. These findings would be facilitated by the fact that there are no medical tests that would definitively establish the presence or absence of the neurological disorder being claimed. This strategy would come to be implemented by use of Dr. Paul Nausieda, a board-certified neurologist, to be the “lead litigation doctor.” Dr. Nausieda would diagnose the vast majority of welders screened in a process sponsored by Scruggs and Barrett and attorneys from Texas and Louisiana. The head of a Parkinson’s clinic in Wisconsin, Dr. Nausieda never connected welding and parkinsonism until a patient told him about an ad soliciting plaintiffs for

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333 In 2003, the investment bank HSBC, put the potential damages as high as $70 billion in 70,000 suits. BOC Group, supra note 332, at 4; Fisk, supra note 299. In addition, those who worked around welding fumes could be potential plaintiffs, like Elam, greatly expanding the pool of litigants.

334 Autopsy is generally considered the only definitive means to confirm a diagnosis of Parkinson’s disease. Mark Guttman et al., Current Concepts in the Diagnosis and Management of Parkinson’s Disease, 168 CAN. MED. ASS’N J. 293, 294 (2003), available at http://www.cmaj.ca/cgi/content/full/168/3/293 (last visited July 3, 2008); Jankovic, supra note 311, at 2021 (noting that recent genetic discoveries have begun to challenge that view). Some researchers have argued that PET scans or MRIs may be able to distinguish between different parkinsonisms, specifically Parkinson’s disease and manganism. Id. at 2023; Olanow, supra note 311, at 211-16.

335 Of the approximately 700 cases in the MDL for which plaintiffs submitted Notices of Diagnosis, see infra notes 375-377, as of October 2007, 90% had positive screening diagnoses made by one of three doctors hired by plaintiffs’ counsel: Dr. Paul Nausieda, Dr. Juan Sanchez-Ramos, or Dr. Katherine Widnell, an associate of Dr. Nausieda; Dr. Nausieda alone was responsible for 70% of those 700 positive diagnoses. Defendants’ Motion For Entry of Supplemental Case Administration Order, at 3, In re: Welding Fume Prods. Liab. Litig., MDL 1535, (N.D. Ohio Oct. 3, 2007) [hereafter Defendant’s Motion of 10/3/07]. Plaintiffs’ court filings, which separated out the numbers for the screenings by the attorneys who sponsored them, see supra note 302, put the total percentage of welders screened by Dr. Nausieda (and given positive diagnoses) even higher. Of the 3,649 welders seen by neurologists at screenings funded by Scruggs and Barrett and lawyers in Texas and Louisiana, Dr. Nausieda diagnosed 3,093, or 84.8%. Plaintiffs’ Memorandum 1/17/06, supra note 302, at 7. He found 1,889 of the 3,093, or 61.1%, positive for manganese-induced parkinsonism. Id.
As for the welders identified through screenings as having related neurological disorders, the vast majority had never seen a doctor about their disorder either prior to or even after being diagnosed with the disorder by Dr. Nausieda or another screening doctor.  

These then are the ingredients for a mass tort. To recruit the mass, thousands of plaintiffs would be screened using the tactics that proved highly effective in asbestos litigation. These included advertisements holding out the promise of lucrative paydays to prospective litigants and websites designed to look like neutral medical or scientific resources but which are actually intended to generate litigants for screenings. In addition, pre-screening questionnaires or fact sheets were provided that offered a laundry list of the exact symptoms lawyers were seeking such as lack of facial expression, slow or slurred speech, trembling fingers, nervousness, hoarse voice, difficulty writing, difficulty swallowing or eating, muscle stiffness, tremors or shaking.

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336 In 1993, a patient of Dr. Nausieda sent him an advertisement for a Chicago law firm soliciting welders with Parkinson’s disease and asked, “What is this about?” Hearing Tr., supra note 301, at 400. Unable to answer his patient’s question, Dr. Nausieda contacted the law firm for more information. Id. at 400-01; see also Testimony of Paul Nausieda at 40-41, Elam v. A.O. Smith, No. 01-L-1213 (Cir. Ct., Madison County, Ill. June 12, 2003) [hereafter Nausieda Testimony 6/12/03]. Until that moment, Dr. Nausieda had not associated welding and Parkinson’s disease. Hearing Tr., supra note 301, at 401. Interestingly, Nausieda himself welded occasionally as a hobby. Nausieda Testimony 6/12/03, supra at 41-42. The law firm that ran the ad was Vaughan Cascino Law Offices, a small firm that specializes in toxic tort and accident cases. Robert McCoy and others in the firm were among the first to file welding fume claims. See Hearing Tr., supra note 301, at 401. See also Post, supra note 317; Vaughan Cascino Law Offices, Ltd. Home Page, available at http://www.vclo.com/ (last visited July 3, 2008).

337 Nausieda Testimony 6/12/03, supra note 336, at 40.

338 The New York Daily News, for example, ran an ad promising that “[i]f you, or a family member have been exposed to welding fumes you may be entitled to compensation.” Dan Sheridan, Riding Out the Tidal Wave of Litigation: Industry Responds to Plaintiffs’ Strategy, CYROGAS INT’L, August/September 2005 at 30.

339 See, e.g., Manganism.org, http://www.manganism.org/manganism.html (last visited July 9, 2007) (presenting itself as an online medical resource for information about the development of manganism—complete with a caduceus, the snake entwined symbol for medicine in America, and a friendly operator standing by to help); Manganism, HealthDangers.org, http://www.healthydangers.com/toxic-substances/welding-fumes/index.htm, (last visited April 4, 2008) (providing information to “educate the general public about current health issues which may affect their lives,” then forwarding inquiries to sponsoring law firms to evaluate the merits of a site visitor’s claim); LevodopaScreening.com, http://www.levodopascreening.com/ (last visited April 4, 2008) (providing information about non-responsiveness to the Parkinson’s drug Levodopa as a lure for potential welding fume litigants).
shuffling or difficulty walking, urinary problems, impotence and poor balance, among others. These lists provide a blueprint for individuals who are so inclined to fabricate or exaggerate their symptoms in order to manufacture a claim. The outreach effort was successful. According to fact sheets submitted by the plaintiffs in the MDL, 54% heard about the screenings through ads on television or in a newspaper, 15% were contacted directly by an attorney, 16% heard about the screenings from their union, and 15% from friends. As a result, plaintiffs’ attorneys were able to quickly screen thousands of welders to create a large pool of litigants.

To avoid having to litigate individual cases once the necessary mass of claims was manufactured, they would be filed mostly in Mississippi and West Virginia which had joinder rules tailor made for mass tort generation. In both jurisdictions, provided there was one or more properly venued plaintiffs, a nearly unlimited number of other plaintiffs from any jurisdiction could be joined to that litigation provided there was some tenuous connection. Mississippi and West Virginia effectively invited plaintiffs’ lawyers from across the country to bring their mass tort cases to their states even though the cases had no connection to the jurisdictions. As

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341 At least two litigants have been caught exaggerating their symptoms to make a claim. See, e.g., discussion of the Morgan case, infra note 484.

342 Hearing Tr., supra note 301, at 16.

343 Sheridan, Riding Out the Tidal Wave, supra note 338, at 28-30. See also screening numbers, supra note 302.

344 Rule 20(a) of the Mississippi Rules of Civil Procedure provides that “All persons may join in one action as plaintiff if they assert any right to relief jointly, severally, or in the alternative in respect of or arising out of the same transaction, occurrence, or series of transactions or occurrences, and if any question of law or fact common to all of these persons will arise in the action. . . .” Mississippi does not permit class actions. Rule 20(a) as applied filled this gap.
the dissent in *Shewbrooks v. A.C. & S., Inc.*, the Mississippi case that opened the door to these out-of-state cases, warned:

> It is not just that we have obligated our courts to decide this particular controversy in spite of the fact that no sane person could imagine that it has any relation to our state. One such incident could be borne, albeit with some grumbling. The greater evil is that the present litigants are but the scouts for the plague of locusts that will inevitably descend upon us in response to today's engraved invitation. We have doomed Mississippi to become a dumping ground for the nation's homeless tort litigation.

The strategy that had generated billions of dollars in payments for specious claims brought in Mississippi and West Virginia required that the one or more properly venued plaintiffs have a credible case and serious injury. Joining numerous other plaintiffs would allow them to tar each of the defendants with voluminous acts of alleged wrongdoing without any examination of the medical condition of the individual plaintiffs. Even a jury determined to keep separate mental notes on each plaintiff’s claim would simply be overwhelmed and would be inclined to find that the totality of alleged wrongdoing was to be credited to each of the plaintiffs and be inculpatory of each of the defendants. Moreover, the serious harm suffered by the properly venued plaintiff would be ascribed to all of the others no matter how tenuous their claim of injury.

Scruggs and Barrett’s intentions appear clear. Few, if any, of the tens of thousands of cases to be generated by the screenings would be litigated. Defendants, when faced with the

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345 529 So. 2d 557 (Miss. 1988).
346 *Id.* at 574 (Anderson, J. dissenting). The dissent noted that the plaintiffs in the case were from Delaware, that it was not clear that they had ever even been to Mississippi before, that none of the numerous defendant corporations had their principal place of business in Mississippi, and that the injuries that were the basis of the suit occurred on the other side of the country. *Id.* “In short, we have a controversy that has about as much to do with Mississippi as does a feud between two nomadic tribes in the Gobi Desert.” *Id.*
The prospect of trying cases in Mississippi and West Virginia under their aggregated procedures would elect to settle the claims *en masse* as they had done in asbestos litigation.

To jump start the screenings, lawyers took a page out of the silicosis litigation play book. In the silica litigation, lawyers had paged though their Rolodexes of asbestosis claimants and retreaded many of them as silica claims. Indeed 60-70% of the silica plaintiffs in the MDL had previously filed asbestosis claims. Judge Jack called the process of retreading asbestosis claims part of a “scheme” by “lawyers, doctors and screening companies [who] were all willing participants,” to “manufacture. . . [diagnoses] for money.” Despite Judge Jack’s characterization of these retreaded asbestosis claims as essentially fraudulent, plaintiffs’ lawyers in the welding fume litigation nonetheless sought to retread some of these same asbestosis and asbestosis/silicosis claims into welding fume claims. Welding fume lawyers apparently culled their asbestos and silica files, looking for former clients who were welders, then sent them letters outlining “information that may be important to you.” As a result, according to the fact sheets filed by plaintiffs in the welding fume MDL, 28% of welding fume litigants had previously filed asbestos claims and 8% had filed silica claims. The vast majority of those who filed silica claims had also filed asbestos claims as well.

The first in the wave of cases that was intended to lead to the creation of a mass tort was the Charles Ruth case. Ruth had a compelling case. He was not a product of the screening

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348 MDL 1553, 398 F. Supp. at 635. *See also supra* notes 97-103.

349 Hearing Tr., *supra* note 301, at 14.


351 Hearing Tr., *supra* note 301, at 14.

352 The Vernon Stanley Morris case, involving 22 plaintiffs, was filed in Copiah County, Mississippi a month before the Ruth case, but was not served until 2002.
process that Scruggs and Barrett had instituted; he was clearly ill and had a diagnosis of manganism from his treating neurologist. In fact, he was the subject of a case report published in the scientific literature. He was thus an ideal plaintiff to use to spearhead the creation of a mass tort. Ruth filed his original complaint on August 27, 2001 in Hinds County, Mississippi, but shortly thereafter, it was amended twice—first on November 11, 2001 then again on November 30, 2001—to add a total of thirty-four additional plaintiffs. Dozens of multi-plaintiff cases soon followed, both in Mississippi and West Virginia state courts. One case filed in West Virginia involved 2400 plaintiffs.

The Scruggs/Barrett game plan fell victim to a political change and a counter strategy. First, Mississippi underwent a sea change in the legislative, executive and judicial arenas. In

353 Ruth, who had begun welding at the Ingalls Shipyard in Pascagoula, Mississippi in 1997, was diagnosed with manganese-induced parkinsonism just three years later. Morris, supra note 317, at 83; Richard P. Schweitzer, Esq., Settlement Not the End for Welding Fume Litigation: Legal Battle to Continue in 2006, WELDING & GASES TODAY ONLINE, Winter 2006, available at http://www.datakey.org/gawdajournal/1q06/settlement.php3 (last visited June 27, 2008). His symptoms, including facial “masking” and impaired motor skills, were obvious and would be quite visible to a jury. Id. A journalist who visited the former welder in 2008 described his condition at that time:

[H]is face looked blank, his voice was a dull monotone, and his right hand shook ceaselessly. Since his diagnosis, Ruth’s marriage had failed and he’d lost his job, not to mention hunting, fishing, and the church softball league. He can’t drive anymore—at one point he was detained by an officer convinced by Ruth’s erratic driving that he’d pulled over a drunk. He’s had recurring depression and suicidal thoughts, but hasn’t acted on them because of his girls, ages 10 and 16, and his 8-year-old boy. “I can’t wrestle with my son because I’m scared I might fall on him and hurt him,” Ruth laments. “When I eat, food goes all over me.”

Morris, supra note 317, at 83.

354 Ruth was diagnosed by doctors at the Baylor Medical Center in Houston, Texas. M.R. Kropko, Worker Settles Lawsuit Over Exposure to Welding Fumes, ASSOC. PRESS STATE & LOCAL WIRE, September 5, 2005, available at www.weldinglitigation.com/newsroom/associatepress-090605.htm (last visited June 4, 2008) [hereafter Kropko, Worker Settles]. See also Hearing Tr., supra note 301, at 98. See discussion infra note 414.

355 Ahmed H. Sadek et al., Parkinsonism Due to Manganism in a Welder, 22 INT’L J. TOXICOLOGY 393 (2003). See also Rosemarie M. Bowler et al., Parkinsonism Due to Manganism in a Welder: Neurological and Neuropsychological Sequelae, 27 NEUROTOXICOLOGY 327 (2006). Dr. William Koller, who helped design the screening process described in this article and who performed some of the initial litigation screenings, was a co-author of the Bowler case report. Id. at 327.

2002, Mississippi enacted tort reform legislation, effective January 1, 2003 that did away with mass joinder “Mississippi style” and required that “in any civil action where more than one (1) plaintiff is joined, each plaintiff shall independently establish proper venue; it is not sufficient that venue is proper for any other plaintiff joined in the civil action.”\footnote{Miss Code Ann. §11-11-3(2).} To beat the deadline, plaintiffs filed over fifty welding fume cases with multiple plaintiffs in Mississippi state courts. The Dantzler case, for example, was filed on December 31, 2002; it had 1,199 plaintiffs and an unknown number of spouses, with over half of the plaintiffs residing in Georgia.\footnote{Dantzler v. Sanderson Farms, Inc., No. CI02-0458 (Cir. Ct., Forrest County, Miss. 2002).} Ultimately, plaintiffs’ lawyers filed eighty-four multi-plaintiff lawsuits in Mississippi with more than 4,000 named plaintiffs.\footnote{Hearing Tr., \textit{supra} note 301, at 22.}

The legislative reform still left tens of thousands of multi-plaintiff asbestos, silica and welding fume tort cases pending in Mississippi. However, the Mississippi Supreme Court, sporting a new look thanks to election campaigns that had unseated pro-plaintiff lawyer judges,\footnote{After Mississippi’s liberal joinder rules opened the door to a flood of lawsuits, plaintiffs’ lawyers used their settlement money to help promote the election of pro-plaintiff judges. Boyer, \textit{supra} note 25, at 47. The result, as Scruggs himself candidly acknowledged during a panel discussion in 2002, was a playing field strongly tilted against corporate defendants: The trial lawyers have established relationships with the judges that are elected; they’re State Court judges; they’re populists. They’ve got large populations of voters who are in on the deal, they’re getting their piece in many cases. And so, it’s a political force in their jurisdiction, and it’s almost impossible to get a fair trial if you’re a defendant in some of these places. . . . The cases are not won in the courtroom. They’re won on the back roads long before the case goes to trial. Any lawyer fresh out of law school can walk in there and win the case, so it doesn’t matter what the evidence or the law is. \textit{Id.} (quoting comments made by Scruggs at a 2002 panel discussion hosted by Prudential Financial). Eventually, the U.S. Chamber of Commerce and corporate interests instituted a campaign to raise money to support the election of pro-business judges and politicians committed to tort reform. \textit{Id.} 866 So. 2d 1092 (Miss. 2004).} put the kibosh to these “beat-the-clock” claims in \textit{Janssen Pharmaceutica, Inc., v. Armond},\footnote{866 So. 2d 1092 (Miss. 2004).} a pre-tort reform multi-plaintiff case. Plaintiffs, fifty-six users of the prescription drug, Propulsid, filed suit against the manufacturer and forty-two physicians who allegedly
prescribed the drug, alleging a full panoply of torts.\textsuperscript{362} Of the fifty-six plaintiffs, only one resided in Jones County where the action was filed.\textsuperscript{363} The court found that joinder in this case unfairly prejudiced the defendants in that the fifty-six plaintiffs had different medical histories, alleged different injuries at different times, ingested different amounts of Propulsid over different periods of time, received different advice from forty two different doctors, who, in turn, gave different information about the risks associated with the medicine via six different warning labels utilized during the time of the lawsuit.\textsuperscript{364} Put plainly, with this decision, the court announced that it had begun to close the forum-shopping tort window,\textsuperscript{365} throwing Scruggs and Barrett’s strategy into disarray.\textsuperscript{366}

The Mississippi Supreme Court administered the \textit{coup de grâce} in \textit{Harold’s Auto Parts, Inc. v. Flower Mangialardi}.\textsuperscript{367} In their decision, the court admonished plaintiff lawyers for not providing specific facts about each claim in a multi-plaintiff lawsuit. The lawyers, who represented 264 residents of Bolivar County in their suit against 137 asbestos manufacturers, had not indicated in the complaint which residents were exposed to which products manufactured by which manufacturer in which workplace at what particular time.\textsuperscript{368} The court viewed the

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\item[(362)] \textit{Id.} at 1093. Plaintiffs’ stated claims based on strict liability, negligence, breach of warranty, negligent misrepresentation, fraud and deceit/civil conspiracy, agent misrepresentation, products liability, and medical malpractice/negligence. \textit{Id.}
\item[(363)] \textit{Id.} at 1094 & n.2.
\item[(364)] \textit{Id.} at 1095, 1096.
\item[(365)] \textit{Janssen} made clear that allegations of an industry-wide conspiracy, by itself, was not sufficient grounds to justify joinder of cases. \textit{Id.} at 1098. Subsequent cases limited the grounds for joinder further. \textit{See, e.g.}, Amchem Prod., Inc. v. Rogers, 912 So. 2d 853, 858 (Miss. 2005) (use of or exposure to the same product alone is not enough to provide a basis for Rule 20(a) joinder); Crossfield Prod. Corp. v. Irby, 910 So. 2d 498, 501 (Miss. 2005) (common worksite or employer alone is not enough to establish a basis for joinder under Rule 20(a)); \textit{and Miss. Life Ins. Co. v. Baker}, 905 So. 2d 1179, 1184-85 (Miss. 2005) (mass fraud and misrepresentation alone not enough to establish grounds for joinder under Rule 20(a)).
\item[(366)] Barrett acknowledged as much when he stated that the \textit{Janssen} case “thr[ew] a monkey wrench in our trial strategy.” Hearing Tr., \textit{supra} note 301, at 112.
\item[(367)] 889 S. 2d 493 (2004).
\item[(368)] \textit{Id.} at 494.
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lawyers’ practice, common in mass tort cases, of filing dozens if not hundreds of cases before knowing whether there was a viable claim or against whom the claim should be made “a perversion of the justice system.” In fact, the lawyers were simply following the established model: screen, sue and settle, without even having to show any inculpatory evidence in most cases.

D. The Welding Fume MDL

In addition to falling victim to tort reform, the scheme launched by Scruggs and Barrett also fell victim to a counter strategy: defendants’ removal of many of the state court cases to federal court. Thus, for example, the Ruth case was removed to federal court on April 24, 2002. In June 2003, as the number of cases either brought in or removed to federal district courts grew, the Judicial Panel on Multidistrict Litigation transferred all pending cases to the courtroom of Judge Kathleen O’Malley in the Northern District of Ohio for consolidated pretrial proceedings. As discussed infra, plaintiffs later selected Ruth as the first case to be tried in the MDL proceeding that was created.

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369 Id. at 495. Furthermore, the court wrote, “[a]bsent exigent circumstances, plaintiffs’ counsel should not file a complaint until sufficient information is obtained, and plaintiffs’ counsel believes in good faith that each plaintiff has an appropriate cause of action to assert against a defendant in the jurisdiction where the complaint is to be filed. To do otherwise is an abuse of the system, and is sanctionable.” Id. at 494.

370 In an interview, Steve Harburg of O’Melveny & Meyers and liaison counsel for the MDL defendants explained that plaintiffs prefer to bring suit in state courts where they think they have the best chance to win a large verdict, while defense lawyers prefer the federal court system and the chance to litigate issues in consolidated, multi-district litigations. Sheridan, supra note 338, at 31 (“[W]e have a belief that the Federal Court system provides a much more fair battleground in which to have these issues litigated. . . . With an MDL, you don’t have to be putting out fires in lots of different courts. You have one judge who devoted themselves [sic] to the issues involved in the case and controls the discovery process.”).

371 In re Welding Fume Products Liability Litigation, No. 1:03 CV 17000, MDL No. 1535 (N.D. Ohio, 2003).

372 See infra note 414.
To date, more than 10,000 plaintiffs have been a part of the welding fume MDL, though in many cases their claims were eventually remanded back to state courts.\footnote{As of April 2006, the court had remanded the claims of approximately 4,500 individuals back to state courts. Order at 6, \textit{In re} Welding Fume Products Liability Litigation, No. 1:03 CV 17000, MDL No. 1535, Slip Copy, 2006 WL 1173960 (N.D. Ohio April 5, 2006) [hereafter “April 2006 Order.”].} By early 2006, there were 5,500 active cases filed in the MDL, with another 8,600 potential plaintiffs who had taken advantage of a tolling agreement filed with the court.\footnote{An agreement in the MDL allowed for the statute of limitations to be tolled at the plaintiffs request in order to limit cases to those that were already cognizable. MDL Tolling Agreement, \textit{In re} Welding Fume Products Liability Litigation, No. 1:03 CV 17000, MDL No. 1535 (N.D. Ohio). As of mid-2008, the number of tolled cases had reached 11,000. Morris, \textit{supra} note 317, at 83. Including the cases remanded back to state courts, the MDL had dealt at least tangentially with almost 19,000 plaintiffs and potential plaintiffs as of early 2006. April 2006 Order, \textit{supra} note 373, at 6.} Since that time, a substantial number of the cases that were in the MDL have been dismissed by plaintiffs or by the court largely as a result of the court’s case management order requiring plaintiffs to provide a Notice of Diagnosis.\footnote{On March 31, 2006, Judge O’Malley entered a Case Administration Order requiring, among other things, that each plaintiff in the MDL submit a Notice of Diagnosis by December 31, 2006. Case Administrative Order at ¶ I.B, \textit{In re} Welding Fumes, No. 1:03 CV 17000 (N.D. Ohio March 31 2006); see also Defendant’s Motion of 10/3/07, \textit{supra} note 335, at 3; Ralph A. Davies, \textit{A Balanced Perspective: The Welding Fume Litigation, FOR THE DEFENSE}, August 2007, available at \url{www.dmcpc.com/documents/DRIArticleD0285577.PDF}.} The Notice required the plaintiff or a physician to certify that a licensed medical doctor had examined and diagnosed the plaintiff with a manganese-induced neurological disorder.\footnote{\textit{Id.}} The form also asked whether “the medical conclusion by the above-named doctor [was] made at a screening?”\footnote{\textit{Id.}; Defendant’s Motion of 10/3/07, \textit{supra} note 335, at 3. See, \textit{e.g.}, Notice of Diagnosis, Steelman v. Lincoln Electric Co., No. 1:06-CV-17206, MDL No. 1535 (N.D. Ohio Dec. 21, 2006) (answering in the affirmative) (on file with author).} Between June and November 2005, approximately 25 percent of the pending claims were dismissed by the court for failure to comply with this order.\footnote{Transcript of Proceedings of Nov. 8, 2005 at 67, \textit{In re: Welding Fumes Prods. Liab. Litig.} (Morgan v. Lincoln Electric et al.), MDL No. 1535.} A substantial number of the fact sheets for claims pending at the time failed to identify any disease...
suffered as a result of exposure to welding fumes or failed to allege a diagnosis of any neurological condition.  

In addition, the court ordered medical records discovery for one hundred cases chosen by the court. Plaintiffs’ counsel were to review the cases with their clients and determine whether they would proceed to trial or dismiss them without prejudice. The court would then choose fifteen of these cases for full discovery. Of the first one hundred cases the court selected, plaintiffs dismissed fifty-nine before records could be collected. When the court named replacements for these cases, plaintiffs immediately dismissed nineteen of the newly-chosen claims. Indeed, as of July 2008, plaintiffs have dismissed approximately 140 of the 179 cases the court has selected for medical records discovery. All told, plaintiffs have dismissed more than 4,000 cases since January 2006. Including 200 cases dismissed in March of 2008, there has now been a 80% reduction in cases in the federal MDL and a more than 66% drop in pending cases.

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379 Id. at 68-69.
380 Second Case Administrative Order, In re Welding Fumes Products Liability Litigation, No. 03 CV 17000, MDL No. 1535 at 2 (N.D. Ohio, Jan. 7, 2008) [hereafter, Second Case Administrative Order]. Plaintiffs’ lawyers moved to make ten of the first seventeen cases they dismissed part of the tolling agreement, see supra note 374, but the court ordered them to “fish or cut bait” and make a final determination about whether they were prepared to take the cases to trial. Second Case Administrative Order, supra, at 10.
381 Id. at 2.
382 Id.
383 Id.
384 Id.
385 According to the Welding Rod Litigation Network, a group of current and former manufacturers and distributors of welding consumables. Id. at 1. See also WELDING ROD LITIGATION INFORMATION NETWORK, WELDING FUME LITIGATION STATUS REPORT: JULY 2008 at 2, available at http://www.weldinginfonetwork.com/litigation/Welding%20Fume%20Litigation%20Update%20July%202008.pdf [hereafter JULY 2008 STATUS REPORT].
Estimates place the number of cases still pending in state and federal courts as of mid-2008 at 2800.\textsuperscript{387} As of October 2007, approximately 700 plaintiffs in the MDL who had not dismissed their cases had submitted Notices of Diagnosis.\textsuperscript{388} Of these, 70\% were diagnosed at screenings run by Dr. Nausieda and an additional 20\% were diagnosed by two other doctors, Dr. Juan Sanchez-Ramos and an associate of Dr. Nausieda’s, Dr. Katherine Widnell.\textsuperscript{389} Thus, the vast majority of the claims remaining in the MDL as of October 2007 were the product of the screenings sponsored by Scruggs, Barrett, and the lawyers from Texas and Louisiana—and most of them were the product of screenings conducted by, Dr. Nausieda.

1. Plaintiffs’ Co-Lead Counsel

On September 17, 2003, Judge O’Malley appointed Scruggs and Barrett, the two Mississippi lawyers that had led the charge to create a new mass tort, as co-lead counsel.\textsuperscript{390} Both Scruggs and Barrett had previous appearances before Judge O’Malley in mass tort litigations.\textsuperscript{391}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{387} Morris, \textit{supra} note 317, at 83
\item \textsuperscript{388} Defendant’s Motion of 10/3/07, \textit{supra} note 335, at 3.
\item \textsuperscript{389} \textit{Id.}
\item \textsuperscript{390} \textit{See} Case Management Order at 4, \textit{In re Welding Rod Prods. Liab. Litig.}, Case No. 13-CV-1700, MDL No. 1535 (N.D. Ohio Sept. 17, 2003).
\item \textsuperscript{391} Richard “Dickie” Scruggs is best known for his role in initiating the states’ attorneys-general litigations against the tobacco companies which culminated in a $248 billion dollar settlement that enriched the lawyers retained on a contingency fee basis by over $15 billion payable over twenty-five years. Carter, \textit{supra} note 300, at 44. Scruggs’ share of the fee is reported to be about $1 billion. \textit{Id.}; Beck, \textit{Trophy Fees}, \textit{supra} note 301. Scruggs began his mass tort career in asbestos litigation and appears to have been the first lawyer to use litigation screenings to generate claims on a mass basis. It has been reported that in “the early 1980s, while others were taking only those [asbestos] clients who had exhibited symptoms, Scruggs was the first lawyer to pay for X-rays and asbestosis screening for potential clients.” Carter, \textit{supra} note 300, at 46. For discussion of asbestos screenings, \textit{see} section III, \textit{supra}. To bring his clients cases to trial faster, he convinced a judge to institute a two-tiered trial process that determined general liability in one hearing for all plaintiffs, then determined individual awards in separate mini-
\end{itemize}
\end{footnotesize}
Scruggs, however, resigned as co-lead counsel on March 31, 2008, after having pled guilty to hearings. Boyer, supra note 25, at 46-47. The fear that a single bad verdict in the initial hearing would expose defendants to huge financial risks encouraged early settlement of cases. Id. at 47.

Scruggs appeared before Judge O’Malley in another proceeding in 2002. On that occasion, Scruggs and Joseph Langston, another Mississippi attorney, teamed to represent Sulzer AG, a Swiss Company which was the target of a class action involving defective hip and knee replacements. Langston and Scruggs were retained by Sulzer to use their ties to plaintiffs’ lawyers to obtain a resolution of the litigation. One of the principal negotiators on the plaintiffs’ side was Don Barrett, who had previously worked with Scruggs on the tobacco litigation, among others. Affidavit of John W. (Don) Barrett at *6, September 9, 2004, available at http://www.barrettlawoffice.com/pdfs/AFFIDAVIT_091304.pdf (last visited April 28, 2008) [hereafter Barrett Affidavit]. Scruggs, Barrett, and their negotiating partners eventually reached a $1.045 billion settlement on behalf of the parties. Id. This new role created by Scruggs and Langston has become known as “resolution counsel.” According to Langston, “the concept of resolution counsel is unique in that traditional plaintiff firms like ours are hired by corporate defendants to work with the plaintiffs’ bar to resolve mass tort litigation.” Quoted in Special Advertising Section, MID-SOUTH SUPER LAWYERS’ MAGAZINE (Nov. 2006). The resolution of the Sulzer litigation was approved by Judge O’Malley in In re: Inter-Op Hip Prosthetics Prod. Liab. Lit., 2002 U.S. Dist. LEXIS 21696 (N.D. OH 2002), after the initial settlement amount had been substantially increased. Scruggs is reported to have earned $25 million in fees for his representation of Sulzer, including a $20 million “success fee.” Susan Beck, The Legend of Richard Scruggs: More Myth Than Fact?, AM. LAWYER, Mar. 7, 2008, available at http://www.law.com/jsp/article.jsp?id=1204804005480 (last visited April 28, 2008).

Scruggs has recently pled guilty to charges that he and others conspired to bribe a Mississippi state court judge who was presiding over a fee dispute between plaintiff lawyer John Griffin Jones and Scruggs and several other attorneys. Jones claimed that Scruggs and the others refused to pay him his share of the $26.5 million in attorney fees awarded in Katrina-spawned litigation brought on behalf of Mississippi home owners against State Farm Insurance Company. Carter, supra note 300, at 48. See also Jonathan D. Glaten, Guilty Plea by Lawyer to Bribery, N.Y. TIMES, March 15, 2008 at C1; Boyer, supra note 25, at 55-57. For a brief period, Scruggs was represented by Langston in this bribery case. See Jimmie E. Gates, Scruggs Faces up to 5 years in Prison, CLARION LEDGER at 1A (March 15, 2008). Scruggs received the maximum sentence of five years in prison and a $250,000 fine (along with the costs of incarceration) from a federal judge who deemed Scruggs’ actions “reprehensible.” Abha Bhattarai, Class-Action Lawyer Given 5 Years in a Bribery Case, N.Y. Times, June 28, 2008 at C3.

Co-lead counsel Don Barrett, a fellow member of the “Ole Miss plaintiffs’ bar,” had joined Scruggs in many lawsuits, including the tobacco litigation, a subprime lender case, the post Katrina claims against insurance companies, and the Sulzer hip replacement MDL. See Beck, Trophy Fees, supra note 301; Suzanne Sataline, Dickie Scruggs Takes on the Welding Industry, LEGAL AFFAIRS, May/June 2005, available at http://www.legalaffairs.org/issues/May-June-2005/scene_sataline_mayjun05.msp (April 29, 2008); Barrett Affidavit, supra. Scruggs, himself, bragged that Barrett “made a lot of money off me in the tobacco litigation.” Sataline, supra.

In yet another case, both Scruggs and Barrett, along with their law firms, were disqualified from representing the plaintiffs in another lawsuit against State Farm Insurance Company after it was discovered that Scruggs had made inappropriate payments to two witnesses who worked for the insurer. Memorandum Opinion on Motion to Disqualify Members of the Katrina Litigation Group and Associated Counsel, McIntosh v. State Farm, NO.1:06CV1080 LTS-RHW (S.D.MI April 4, 2008), available at http://fortunelegalpad.files.wordpress.com/2008/04/mcintosh-disqualification-order-4-4-08.pdf. Barrett, along with the other plaintiffs’ lawyers involved in the case were barred from any further involvement in the case because they “were aware or should have been aware that the payments were being made and did nothing to prevent their continued payment.” Id. at 3.
bribery charges in an unrelated case. Allegations of misconduct by Scruggs’ have also impacted state welding fume litigation. In January 2008, Judge Bobby Delaughter recused himself from at least ten welding fumes cases brought by Scruggs and his law firm in Mississippi state court after another attorney pled guilty to conspiring with Scruggs to illegally influence the judge in a dispute over asbestos litigation fees.

E. Welding Fume Litigation

The welding rod industry has prevailed against twenty of the twenty-three plaintiffs whose cases have gone to verdict and seen thousands of other suits dismissed in both state and federal courts, including six due to the plaintiffs’ misrepresentations. Prior to publication of the Racette study that claimed to identify a possible link between welding fumes and the early onset of Parkinson’s disease, eight cases went to trial alleging that welding fumes caused the plaintiff’s manganism. In each case, the defense countered that the plaintiff suffered from idiopathic

392 See Letter from Richard Scruggs to Judge Kathleen M. O’Malley, March 31, 2008 (on file with author).
393 Langston, the attorney who pled guilty, had originally represented Scruggs in this dispute over attorney fees. The suit alleged that the Scruggs firm had cheated another lawyer of asbestos litigation fees due him. Boyer, supra note 25, at 50-51; Carter, supra note 300, at 49. According to exhibits filed by federal prosecutors in the Katrina bribery case, Joey Langston paid $900,000 to the former Hinds County, Mississippi District Attorney—a close friend of Judge Bobby Delaughter who was presiding over that litigation—for his help in getting the judge to rule favorably for Scruggs in the fee dispute litigation. Id. at 49. It is also alleged that Scruggs used his connection to former Senate Majority Leader Trent Lott, Scruggs’ brother-in-law, “to dangle[] the possibility of a federal judgeship” in front of DeLaughter. Id.; Boyer, supra note 25, at 50-51. “The judge—disregarding a special master’s recommendation that Scruggs owed the plaintiffs roughly fifteen millions dollars—essentially ruled for Scruggs, saying that he owed the plaintiff nothing further.” Id. at 50. Langston pled guilty to corruption charges in January 2008 for his admitted attempt to influence the judge. Id. See also, Gates, supra note 391. As of June 2008, no charges have been filed against Scruggs or Delaughter in this matter. Michael Kunzelman, Miss. Judge Recused Amid Federal Probe, ASSOC. PRESS, January 18, 2008, available at http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2008/01/15/national/a123413S61.DTL&hw=henry&sc=245&sn=009; Judge Removes Himself From Cases Amid Federal Probe, HERALD TRIB., January 19, 2008, available at http://instituteforlegalfreedom.com/media/displayarticle.cfm?artid=ILL1290155856.
394 Kallenbach v. Lincoln Elec., No. 91-C-1012-S (W.D. Wis. 1992); Siddens v. Lincoln Elec., No. 90-2273 (C.D. Ill. 1994); Canfield v. Lincoln Elec., No. 92-C-0517 (E.D. Wis. 1995); Jones v. Lincoln Elec. (N.D. Ind. 1995); Caldwell v. Lincoln Elec., No. 231-1991 (Clarion County Pa. 1997);
Parkinson’s disease, not manganism. All eight resulted in defense verdicts. Following the publication of Racette’s study postulating a link between welding and Parkinson’s disease, however, plaintiffs won their first verdict in *Elam v. Airco,* a 2003 case brought in Madison County, Illinois. Elam’s case differed from the previous eight cases in two significant ways. First, unlike previous plaintiffs, Elam, who had been diagnosed in 1995 by a neurologist he consulted, cited Racette’s study and argued that even if he suffered from Parkinson’s disease and not manganism, his exposure to welding fumes contributed significantly to his disease. Second, because he had worked around welding but rarely welded personally, he claimed that the manufacturers’ warnings about the dangers of welding fumes were not adequate because they were aimed at welders and not those who worked around them. Despite doubts, the jury

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395 In each of the eight cases, defense counsel employed the same two-part strategy. D. Patterson Gloor, *The Real Story Behind Welding Rod Litigation: Why Elam is an Aberration, LITIGATION WATCH: WELDING RODS 1* (June 2004), available at http://www.weldinginfocenter.org/litigation/harris_martin.pdf. First, the defense maintained that the plaintiffs had not developed manganism, but rather idiopathic Parkinson’s disease. *Id.* They effectively differentiated the two disorders for the jury by highlighting their clinical, pharmacological, pathological, and neuroimaging differences. *Id.* They then argued that because no scientific evidence existed that linked welding fumes to Parkinson’s disease (a fact conceded by plaintiffs’ experts), welding could not be shown to have caused the plaintiff’s illness. *Id.*

396 In all eight cases, the jury verdicts in favor of the defense were unanimous. *Id.*


398 Madison County has been renowned as a magnet for plaintiffs’ lawyers. See, e.g., Rep. Norwood Releases Letter to Attorney General Ashcroft Concerning Civil Justice Abuse in Madison County, Illinois, U.S. FED. NEWS, Sept. 13, 2004 (highlighting some of the most egregious verdicts and alleging a wide range of First Amendment and due process violations in the courts of Madison County).


400 Elam acknowledged that he might suffer from Parkinson’s disease, not manganism. Gloor, *supra* note 395, at 4. Based on the Racette study, he argued that exposure to welding fumes contributed significantly to his disease. *Id.*

401 The Elam case, like many welding fume claims, is based in large part on the industry’s “failure to warn” of the dangers involved in exposure to welding fumes. *Elam,* 841 N.E.2d at 1041. In this case, manufacturers had placed warnings on the welding rod cartons. *Id.* at 1043. The plaintiff’s
awarded him $1 million dollars, though this was less than half of the $2,300,000 he had sought.402

Plaintiffs’ lawyers were encouraged by this result, believing it heralded the creation of a new mass tort, the next “asbestos” so some believed.403 Indeed, Elam appears to have accelerated filings that were mostly already in the pipeline. During the peak period of the welding fume litigation, 2003-2006, thousands of cases pended in state courts across the country expert testified that this placement was not an effective communication of the warning because “it was directed only toward welders, and not toward welders’ assistants or other bystanders who are within the plume of the welding fumes.” Id. (emphasis added). In other cases, the adequacy of the warning alone was enough to support a defense verdict. See, e.g., Judgment and Verdict Form, Solis v. Lincoln Elec. Co., No. 1:04-CV-17363 (N.D. Ohio June 27, 2006) (jury determination that manufacturer’s warnings were adequate ended the case in the defendants favor); Verdict Form, Ronnie LaBauve, Andre v. A.O. Smith Corp., No. 03-11573 (La. Dist., Orleans Parish March 7, 2008) (juror determination that not only were warnings adequate, but that plaintiff failed to prove an injury caused by exposure to manganese in welding fumes) (on file with the author).

402 A first trial resulted in a hung jury, but the second jury awarded Elam $1,000,000 in damages. Gloor, supra note 395, at 4. Even in the second trial, however, the jury was split. Five of the panel’s members initially favored a defense verdict, but eventually agreed to a compromise that awarded the plaintiff less than half the $2,300,000 judgment he sought. Brian Brueggemann, Disease Makes Him a Recluse Man Says, BELLEVILLE NEWS-DEMOCRAT (IL), October 30, 2003, available at http://weldinglitigation.com/newsroom/bellevillenews-103003.htm. After the trial, one juror admitted that she wasn’t completely convinced of the link between welding and Parkinson’s disease, finding it merely “suspicious.” Brueggemann, Welders Seem Unworried, supra note 330.

403 Some commentators speculated that “welding fumes [would] be the next asbestos—producing soaring rewards for victims, bankrupting big companies and tying up the court system with thousands of trials.” Laborers’ Health and Safety Fund of North America, Welding Fume Dangers Get Fresh Scrutiny (July 2004, Vol. 1, Number 2), available at http://www.lhsfna.org/index.cfm?objectID=5CE2DA3D-D56F-E6FA-9C537BAF0D35BC04 (last accessed July 5, 2007). Plaintiffs’ lawyers pushed the story in the press, emphasizing both the scope of the litigation (“If every welder in the country gets tested, that is going to translate into 35,000 cases. The industry is in serious trouble.”) and the potential costs to the industry (“We have gotten involved because billions are at stake,” and “I think we’re talking aggregate damages way in excess of a billion dollars.”). Hearing Tr., supra note 301, at 27 (quoting various plaintiffs’ lawyers from Trial Magazine, American Lawyer, and Forbes Magazine, respectively). Plaintiff lawyers were highly optimistic as to their prospects. One Cleveland-based plaintiff attorney explained, ”There's a large population that's been exposed, and I think we're talking aggregate damages way in excess of a billion dollars.” Mary Ellen Egan, Torch Song, FORBES, February 2, 2004, at 44. Even though lawyers conceded there would probably be fewer claimants than in the asbestos litigation, they anticipated much larger monetary awards: “With asbestosis you have shortened breath, but a person with manganism can’t talk, they shake, they can hardly walk, their personality changes.” Hellwege, supra note 310.
in addition to the 5,500 cases consolidated into the MDL.\footnote{404} But despite this flood of filings, only ten post-Elam cases involving fourteen plaintiffs have gone to trial since 2004.\footnote{405} The first seven cases, which involved eight plaintiffs including the first three bellwether plaintiffs whose cases were tried in the MDL, resulted in verdicts for the defense.\footnote{406} Two more recent cases, like the *Ruth* case, involved plaintiffs who did not attend a screening. These cases, *Tamraz v. Lincoln Electric*\footnote{407} and *Jowers v. Arcos Industries*,\footnote{408} both decided in early 2008, resulted in multi-million dollar verdicts for the plaintiffs.\footnote{409} Both are subject to appeal. Finally, the day after the

\footnote{404}For example, an estimated 2,400 plaintiffs were involved in a putative class action in West Virginia. *Severed Plaintiffs, supra* note 356, at 17. Seventy-two plaintiffs had joined coordinated proceedings in California as of January 2006, with additional plaintiffs added later. *California Coordinated Trial Scheduled For June 2007; 10 Representatives To Be Named, 2-12 MEALEY'S LITIG REPORT WELDING RODS 10* (2006). See also *supra* note 373-374 for a discussion of the number of cases involved in the MDL.


\footnote{406}Two of the cases, *Boren, id.*, and *Haskell, id.*, were tried in Madison County, Illinois, the same plaintiff-friendly venue that produced the *Elam* verdict. The Texas and Arkansas courts where *Presler, id.*, *Godwin, id.*, and *Calloway, id.*, were tried also have reputations as plaintiff-friendly jurisdictions according to a website maintained by defense counsel. *FEBRUARY 2007 STATUS REPORT, supra* note 385, at 5.

\footnote{407}No. 1:04-CV-18948-KMO (N.D. Ohio 2007).

\footnote{408}No. 1:08-CV-36-KMO-JMR [MDL No. 1535, N.D. Ohio] (S.D. Miss. 2008).

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Jowers decision, a jury in a four-plaintiff trial in Louisiana delivered a defense verdict after just one hour of deliberation. The four plaintiffs had been diagnosed with manganism caused by chronic exposure to welding fumes by Dr. Nausieda in the course of a screening even though three of the four plaintiffs had been diagnosed previously with Parkinson’s disease, not manganism, by their treating neurologists. During the trial, Dr. Nausieda acknowledged that he had not published or presented to the medical community the criteria he used for diagnosing manganism.

In all three cases in which plaintiffs prevailed out of the twenty-three that went to trial, the initial diagnosis was made by treating doctors, not by a litigation screening doctor. The pattern among cases dismissed or settled before trial is similar. The Ruth case, which plaintiffs selected as the first of the MDL bellwether trials and which involved a diagnosis made by a treating neurologist, settled on the eve of trial. At least six other cases were dismissed by

Ruth v. A.O. Smith, No. 04-CV-18912 (N.D. Ohio). The case, the first MDL case scheduled to go to trial, reportedly settled for $1.5 million on the eve of its September 2005 trial date. Robert R. Lawrence, Hot Liability: Recent Pro-Plaintiff Developments in Welding Fume Litigation Have Put Welding Companies and Insurers on the Alert, BEST’S REVIEW 2006 WLN 6872401 (April 1, 2006). At the time, defense attorneys disputed that Ruth’s disorder was the result of his exposure to manganese in welding fumes, Kropko, Worker Settles, supra note 354 (quoting John Beisner of O’Melveny & Meyers who serves as the lead defense counsel in the welding fume MDL), but in late 2007, during the Tamraz trial, they appeared to concede that Ruth did indeed suffer from manganism, Morris, supra note 317, at 83, although their intent appears to have merely been to differentiate Ruth from later cases.
either the court\textsuperscript{415} or the plaintiffs after significant discovery, five due to fraud or misrepresentations by the plaintiffs.\textsuperscript{416} Four of these cases arose out of the screening process.\textsuperscript{417} In the other two, Dr. Nausieda consulted on the cases and confirmed the diagnosis.\textsuperscript{418} Plaintiffs have also dismissed the first ten cases they had chosen to try in consolidated proceedings in the state courts of California.\textsuperscript{419} Still, at least four more cases are on the docket for 2008, including the next case in the MDL and what would be the first case to go to trial in the coordinated proceeding in California state court.\textsuperscript{420}

\textbf{F. Welding Fume Litigation Screenings}

Lawyer-sponsored screenings have generated the large majority of the thousands of manganese exposure cases brought against welding rod manufacturers.\textsuperscript{421} The Scruggs-Barrett

\textsuperscript{415} The case, Boyd v. Lincoln Elec. Co., No. 04-545413 (Cuyahoga County Court of Common Pleas, Ohio), had been scheduled to begin trial on September 17, 2007. AUGUST 2007 STATUS REPORT, supra note 385, at 3. On July 10, in granting the defendants’ motion for summary judgment, the presiding judge cited the plaintiff’s sworn admission that he had never read the warnings on the welding rod labels as dooming his failure to warn and fraudulent concealment claims, while a lack of evidence undermined his negligent undertaking claim. \textit{Id.} Plaintiff appealed the decision, \textit{Id.}, but no ruling has been made as of the date of this writing.

\textsuperscript{416} See discussion infra note 471.


\textsuperscript{418} Dr. Nausieda consulted in the cases of Dewey Morgan and Darwin Peabody. For discussion of the two cases see infra notes 484-485.

\textsuperscript{419} The plaintiffs in the tenth case asked the court to dismiss the case with prejudice just ten days before their trial was scheduled to begin. \textit{California Test Trial Plaintiffs Dismiss Claims In Exchange For Avoiding Fight Over Fees,} 4-11 MEALEY’S LITIG. REPORT WELDING RODS 4 (2008). In exchange, the defense agreed not to attempt to recover the costs they incurred preparing their defense. \textit{Id.}

\textsuperscript{420} The sixth MDL case is set for November 3, 2008, with a plaintiff from Alabama. Second Case Administrative Order, supra note 380, at 1. Five cases in California are spread throughout the year from March through November. Case Management Order No. 9, Welding Products Cases, JCCP No. 4368 at 3 (Alameda County Sup. Ct., Aug. 24, 2007).

\textsuperscript{421} For example, as of January 2006, the lead lawyers in the MDL litigation reported screening a total of 57,823 welders. Hearing Tr., supra note 301, at 243. Of that number, 33,239 were screened by the Barrett Law Office alone. \textit{Id.} at 383. Another 16,169 were screened by a group of Texas lawyers led by the Provost Umphrey Law Firm, 4,142 were screened by Ranier, Gayle & Elliot (“RGE”), a Louisiana law firm, and 4,573 were screened by the South Carolina-based Motley Rice law firm.
screenings, as well as the other lawyer-sponsored screenings that used Dr. Nausieda as the primary diagnostic neurologist, have ostensibly attempted to avoid the kinds of abuses that characterized previous screenings documented in this article, including those sponsored by Scruggs in asbestos litigation,422 and those condemned by Judge Jack. First, the lawyers did not hire any screening companies.423 Instead, they directly hired physicians and had them trained to examine potential litigants at all levels of the process.424 In addition, the lawyers paid the physicians doing the screenings by the hour or by the day; there was no added bonus for a positive diagnosis.425 Nevertheless, careful analysis of the screening process shows that it, too, is influenced by similar financial incentives and questionable scientific underpinnings that have led to mass production of specious claims in the other four litigations discussed.

The Nausieda-conducted welding fume litigation screenings, designed by a board-certified internist,426 involve a two tier process.427 In the first tier, medical residents evaluated...
the subjects using a protocol derived from a standard neurological exam. They took medical and work histories of each welder and examined them for twenty pre-selected physical manifestations of neurological disorder. Only 12-15% of those screened by first tier examiners continued on to the second tier of the process. Doctors were paid the same hourly rate regardless of their determinations.

At the second level, Dr. Nausieda and a handful of other neurologists examined each welder in person and assessed his or her symptoms in an examination that, according to defense attorneys, lasted on average five to nine minutes per person. Again, the doctors were paid a flat rate. Dr. Nausieda received $10,000 per day plus $2,000 in expenses, while his associate, Dr. Widnell received $8,000 per day. While many welders were sent home—often with diagnoses of neurological disorders not linked to welding fume exposure—60% of those who

1,650, 534 were passed through to the second tier, and 194 were given a diagnosis of manganism. An additional seventy-three were diagnosed with Parkinson’s Disease unrelated to manganese exposure. The doctors were residents in areas such as ophthalmology and internal medicine who would have a familiarity with and training in neurological examinations. The other law firms found similar rates: 2,418, or 15%, of the 16,169 welders screened by the Texas law firms continued through to the second tier, while 12.8% (529 of 4142) of the group screened by RG and 11.7% (534 of 4,573) of the Motley Rice screenees were referred for further screening. Of the 57,823 total reported screened by the MDL lawyers as of January 2006, 7,735, or 13.5%, were passed through to the second tier. See also supra note 427 for a discussion of the slightly different screening process employed by the Motley Rice law firm.

The rate was $65 per hour. Dr. Nausieda pushed back against the idea that the time he spent with each person was inadequate: “An obvious case is an obvious case. You just need to do the remainder of the exam quickly to confirm it. Other cases took much longer periods of time.” Nevertheless, he acknowledged that the numbers appeared accurate given the number of people seen and the number of hours worked on any given screening day.

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were selected as positive in the first tier screening were diagnosed as having welding-related neurological injury, most commonly, manganism.435

Judge O’Malley ruled that this screening process was “robust.”436 She specifically cited Judge Jack’s ruling in the silica MDL and rejected the argument that the same abuses were occurring here.437 Still, recognizing the inherent risks of such a process, Judge O’Malley imposed the requirement that every plaintiff file a “Notice of Diagnosis” describing the diagnosis they have received and from whom they received it.438 With regard to screenings, Judge O’Malley stated that, “There is no question but that a medical screening is not fully diagnostic or that a plaintiff will need more than the opinion professed by a screening neurologist to prevail at trial.”439 Nonetheless, Judge O’Malley issued a key ruling upholding the validity of the Nausieda screenings, stating that “the two-tiered screening process used by plaintiffs, culminating in a medical opinion by Dr. Nausieda, provides a sufficient and adequate basis upon which a plaintiff may file a claim for neurological injury caused by welding fumes”440 and prosecute that case.441

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435 April 2006 Order, supra note 373, at 8. As of January 2006, 3,649 of the welders screened by the Mississippi, Texas, and Louisiana law firms, see supra note 421, went on to the second tier neurologist. Plaintiffs’ Memorandum 1/17/06, supra note 302, at 7. Of that group, 2,222 had been diagnosed with a manganese-induced parkinsonism. Id.
436 April 2006 Order, supra note 373, at 7.
437 Judge O’Malley cited the fact that doctors in the silica proceeding testified that they had not seen the patients they diagnosed, were not familiar with the criteria for diagnosing silicosis, and did not believe they were diagnosing patients. Id. at 7. Other abuses she wrote about included the diagnosis of the same clients with both asbestosis and silicosis, a medical impossibility, the payment of doctors for positive diagnoses only, the finding of silicosis at a thousand times the expected rate, and the fact that at least some lawyers were aware of and participated in these abuses. Id. Not finding such blatant abuses here, Judge O’Malley dismissed the argument that there were meaningful similarities between the two screening processes. Id.
438 Case Administration Order, In re Welding Fume Products Liability Litigation, No. 1:03-CV-17000, MDL 1535 at 6 (N.D. Ohio, March 31, 2006) [hereafter Case Administration Order 3/31/06].
439 April 2006 Order, supra note 373, at 9.
440 Id.
441 Case Administration Order 3/31/06, supra note 438, at 6. Judge O’Malley wrote that “[g]enerally, the Court is satisfied so long as a plaintiff’s Notice of Diagnosis documents a medical
In approving the screening process, Judge O’Malley observed in referring to the screenings conducted by Dr. Nausieda that while “a medical screening is not fully diagnostic,” the medical community has long used screening processes to detect in large populations medical conditions that do not have an objective diagnostic signature, and which rely largely on self-reporting. She went on to state that “the United States Senate has recognized that the use of medical screenings by plaintiffs’ counsel has helped many asbestos victims learn they have a disease, when otherwise they might not have known they have a condition.”

Judge O’Malley’s statements about medical screenings indicate a lack of recognition of the essential differences between medical screenings and litigation screenings: litigation screenings have no intended health benefits. Their only purpose is to generate claims for litigation. As for her contention that the U.S. Senate has recognized that asbestos screenings have conferred a health benefit, that is simply a mischaracterization of the Senate Report on S. 852, The Fairness in Asbestos Injury Resolution Act of 2005 with respect to litigation screenings.

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442 See supra note 439.
443 April 2006 Order, supra note 373, at 9.
444 See id. at 9 n.14.
445 See Brickman, Asbestos Litigation, supra note 23, at 63-64. Medical screenings involve “the application of a test to detect a potential disease or condition in a person who has no known signs or symptoms of that disease or condition,” for the purpose of detecting disease “early in its natural history when treatment might be more effective, less expensive, or both.” David M. Eddy, How to Think About Screening, in COMMON SCREENING TESTS 1, 1 (David M. Eddy ed., 1991). By comparison, litigation screenings are massive recruitment programs of target populations who may have been exposed to a particular toxic agent in order to secure a massive pool of potential plaintiffs. They are not intended to detect disease for purposes of treatment. Indeed, litigation screenings have no intended health benefits. One of the largest asbestos screening enterprises, Most Health Services, which has screened over 400,000 potential litigants, acknowledged that it provided no health services. Instead, “the sole purpose. . . of [t]he screening process [conducted by Most]. . . is collecting evidence for future asbestos litigation.” Brief of Appellants at 19, In Re: Asbestos Prods. Liability Litig., Nos. 98-1166 and 98-1165 (3d Cir. 2000), quoted in Mem. In Support Of Motion For Case Management Order Concerning Mass Litigation Screenings at 5-10, In re: Asbestos Prods. Liability Litig. (No. VI), Civ. Action Nos. MDL 875, 2 MDL 875 (E.D. Pa. 2001) (describing in detail, including references to depositions and exhibits, the operation of Most Health Services, Inc., a screening company).
Indeed, the Senate Bill sought to establish medical criteria for diagnosis of asbestos related diseases as a replacement for the diagnoses produced by the litigation doctors which the bill sought to entirely supplant. Judge O’Malley’s misunderstanding of the fundamental difference between a medical screening and a litigation screening and of the import of the Senate Report may have led her to minimize the effects of the financial incentives which are the sole motivation for the screenings and which are inherent in the screening process that she termed "robust" — the same financial incentives which were the basis for the other four litigation screenings discussed in this article.

1. The Insufficiency of the Screenings

A more in-depth analysis of the procedures employed in the screenings by the MDL lawyers reveals their lack of medical purpose. To begin with, the screenings are held in hotels, union halls, and convention centers, not medical facilities. Furthermore, the first tier examination, which rejected 85% of those screened, is not as objective as claimed; attorneys appear to have sought plaintiffs who could be expected to generate a sympathetic reaction from juries. To that end, the protocol employed by the medical residents, who generally were not trained in neurology, focused on "signs," or visible physical manifestations of disease that could be observed by a jury, rather than "symptoms," a patient's subjective self-report of disease indicia such as headaches, insomnia, and irritability, to make determinations. The exam's designer argued that this emphasis made the results more objective—because they were based on a

446 S. 852, 109th Cong. §225 (2005), S. Rep No 109-97 (June 30, 2005). Judge O’Malley cites to page 83 of the Senate Report for the proposition that the Senate also noted that there can be “problems associated with mass screenings.” April 2006 Order, supra note 373, at 9, note 14.
447 Hearing Tr., supra note 301, at 17.
448 Id. at 242.
449 Id. at 352.
screener's observations—rather than based primarily on a patient's self-reported symptoms. But these “signs” could easily be faked. Indeed, in the last two years, two cases that were close to trial were ultimately dismissed with prejudice when videotapes showed that the plaintiffs had been faking or exaggerating their symptoms and another four were dismissed based on fabrications in their claims. Moreover, early during the screenings, the second tier screening neurologists mainly Dr. Nausieda and to a lesser extent, Dr. Juan Sanchez-Ramos and Dr. Katherine Widnell, concerned about the low yield from the first tier screenings, instructed the first tier medical residents to pass through more subjects. Dr. Nausieda testified that he told the residents, “Just have them walk, have them move their hands look at their face, listen to their speech, and if it strikes you as abnormal, move them through to us. We’ll take care of them.”

Even one physical sign of a neurological disorder was enough to pass a subject through to the second tier.

The problems at the second tier are even more profound. Although there is no “bounty” for positive diagnoses as there has been in the other litigation screenings considered, the neurologists still have a financial incentive to provide a substantial proportion of litigable diagnoses. Since they have a financial interest in continuing to be hired—at the rate of $10,000 per day plus $2000 for expenses—they have a financial incentive to find a compensable

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450 Id. at 356. Dr. Cunningham, the protocol’s designer, testified that he chose to focus on the physical manifestations of neurological disorders, the “signs,” because the brief nature of the screening made it difficult for the residents doing the first tier screenings to determine the significance of self-reported “symptoms” that could not be seen first-hand by the doctor. Id. In other words, it would be harder for the subjects to lie about or fake a neurological disorder. Id. at 357. Nevertheless, five cases in the discovery phase have already been dismissed due to plaintiffs who lied about or faked their illness. See discussion, infra note 471.

451 See discussion, infra note 471.

452 Hearing Tr., supra note 301, at 366.

453 Id. at 18 (quoting Nausieda deposition testimony from another case).

454 Id. at 380.
In addition, by finding a compensable disease, they create the opportunity to be designated a testifying expert and obtain substantial additional fees. The effect of these financial incentives is borne out by the percentages of positive diagnoses. Dr. Nausieda diagnosed 85% of the welders screened in the second tier by Scruggs, Barrett, and the lawyers from Texas and Louisiana and found that approximately 60 percent had manganism. Drs. Sanchez-Ramos and Widnell had similar diagnosis rates. For his efforts as both a screening doctor and a testifying expert, Dr. Nausieda has earned more than $2 million in fees as of April 2008.

In addition, Dr. Nausieda and the handful of other neurologists involved in the screenings are selected and paid by plaintiffs’ attorneys. Not surprisingly, the lawyers have selected doctors who contend that exposure to manganese in welding fumes can lead to parkinsonism and other neurological disorders. The large majority of doctors and researchers who have

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455 Id. at 62, 387, 417.
456 Dr. Nausieda saw 3,093 (or 84.7%) of the 3,649 welders who went to tier two screenings sponsored by the Barrett-Scruggs, RGE, and Texas groups of lawyers. Plaintiffs’ Memorandum 1/17/06, supra note 302, at 7. Of the 3,093, Dr. Nausieda diagnosed 1,889 (or 61.1%) with manganese-induced parkinsonism. Id. This number represents 85% of the 2,222 total welders who received positive diagnoses in these screenings. Id.
457 Doctors other than Dr. Nausieda saw 556 of the 3,649 welders screened at the second level. Id. They gave positive diagnoses to 333, or 59.9%, of them. Id.
459 Hearing Tr., supra note 301, at 385-87. The Barrett Law Offices, which oversaw the screening of more than 33,000 welders, hired just four neurologists. Id. at 385. Drs. William Koller and Juan Sanchez Ramos each only saw a small number of subjects. Id. Drs. Nausieda and Katherine Widnell, his then colleague at a regional Parkinson’s disease clinic in Wisconsin, did the vast majority of the second tier examinations for the law firm, with Dr. Nausieda alone seeing over 70% of the total. Id.
460 In addition to Dr. Nausieda and his colleagues who performed the screenings for the lead MDL lawyers, Dr. Koller, who helped design the screening protocol, wrote several papers about welding and parkinsonism. See, e.g., Koller, supra note 317; Bowler, supra note 355 (discussing Charles Ruth, the welder who settled his MDL case before it went to trial). Dr. Brad Racette, who authored the paper that first posited a link between welding and Parkinson’s disease, used claimants seen at litigation screenings in Arkansas, as the basis for a second paper. See Racette, Prevalence of Parkinsonism, supra note 317.
investigated the issue reject this view.\textsuperscript{461} Indeed, the few neurologists who have performed the vast majority of the screenings have also written many of the papers and produced most of the data that have linked welding to Parkinson’s disease and other disorders,\textsuperscript{462} giving them a further, career-based incentive to find significant numbers of welding-related parkinsonian disorders. To complete the feedback loop, Dr. Racette has used claimants identified in screenings as the basis for a scientific paper purporting to show a link between welding and neurological disorders.\textsuperscript{463} Dr. Nausieda’s study of 20,000 welders in four Gulf Coast states, which was funded by plaintiffs’ lawyers, has not been accepted for publication.\textsuperscript{464} Plaintiffs’ lawyers have nonetheless used Dr. Nausieda’s study, as well as Dr. Racette’s, to argue that the science supports their welding fume claims.\textsuperscript{465}

\textsuperscript{461} See discussion supra note 324-325. Many of the neurologists who have concluded that there is no link between welding fumes and parkinsonism, such as Dr. C.W. Olanow, Dr. David Garabrant, Dr. Karl Kieburtz, and Dr. Anthony Lang, have testified on behalf of the defense in hearings and trials in state and federal court.

\textsuperscript{462} In addition to the papers authored or co-authored, for example, by Dr. Koller, see supra notes 317, 355, Dr. Nausieda attempted to publish a study based on data collected from 20,000 welders involved in litigation screenings on the Gulf Coast. Transcript of Deposition of Dr. Paul Nausieda at 45-49, In re Welding Fume Products Liability Litigation, No. 1:03 CV 17000, MDL No. 1535 (N.D. Ohio Oct. 10, 2007) [hereafter Nausieda Deposition 10/10/07].

\textsuperscript{463} See Racette, Prevalence of Parkinsonism, supra note 317.

\textsuperscript{464} Post, supra note 317 (describing Dr. Nausieda’s study of 20,000 welders he saw during litigation screenings in four Southern states); Nausieda Deposition 10/10/07, supra note 462, at 45-48 (describing the unsuccessful attempts by Dr. Nausieda and his sometime co-author, Dr. Juan Sanchez-Ramos, another litigation screening neurologist, to get a paper based on the results of the screenings published in a peer-reviewed scientific journal). In 2004, Robert McCoy, who was among the first lawyers to pursue welding fume litigation, commented on the importance of having new research by Drs. Nausieda and Racette published in the scientific literature: “The sooner the better. We’ve got the law. Now we have to get the medicine.” Hellwege, supra note 310. However, peer-reviewed scientific journals have repeatedly rejected the papers submitted by Dr. Nausieda on the topic, Nausieda Deposition 10/10/07, supra note 462, at 45-48, while the specific research by Racette that McCoy referenced—research intended to undermine defense experts claims that MRIs, PET scans, and other imaging tests can distinguish manganism from Parkinson’s disease—has apparently generated only a single, inconclusive article. B.A. Racette et al., \textit{[18F]}FDOPA PET and Clinical Features in Parkinsonism Due to Manganism, \textit{20 Movement Disorders} 492 (2005) (describing the PET scans of a single parkinsonism patient with elevated levels of blood manganese).

\textsuperscript{465} See, e.g., Elam v. Lincoln Electric Co., 841 N.E.2d 1037, 1049-50 (Ill. App. Ct. 2005) (ruling that testimony about Dr. Nausieda’s Gulf Coast study was admissible).
Given these incentives, it is not surprising that the screening doctors appear to have expanded their criteria for diagnosing disease beyond what the science can support. Dr. Nausieda, for example, diagnosed several former welders and others who worked around welders as having developed manganism or welding-induced Parkinson’s disease eighteen to twenty-one years after their last exposure to welding fumes. On several occasions, however, he admitted under oath that he is not aware of a single peer-reviewed article in the scientific literature that supports the finding of such a long latency period. Moreover, when asked during a deposition, “If I were to show you a thousand 70-year-old men and all of them had classic Parkinson’s disease with no atypical features and all 1000 were welders, would you tell me that all 1000 had Parkinson’s disease caused by welding?” Dr. Nausieda replied, “[M]ore likely than not, yes.” Finally, despite having spent years diagnosing welders and others with manganism, he admitted that he did not know what movement disorders specialists and neurologists considered to be the generally accepted criteria for diagnosing manganism.

A medical expert retained by the Motley Rice firm which was competing with Scruggs and Barrett for domination of welding fume litigation, acknowledged that the Nausieda screenings were medically deficient. In an E-mail to another medical expert retained by that firm, he stated:

Defense lawyers highlighted three examples during their opening statements in a hearing to determine whether to levy sanctions in two cases involving fraud and misrepresentation on the part of the plaintiffs. Hearing Tr., supra note 301, at 67-68. In one case, a ninety-one year old man presented with a slight tremor, some slowing of movement, and a bad balance problem that first manifested eighteen years after he quit welding. Id. at 67. Two non-welders who worked in the vicinity of welding attended screenings where they demonstrated mild symptoms approximately twenty years after their final exposure. In one case, Dr. Nausieda diagnosed the person with manganism, in the other Parkinson’s disease caused by welding. Id. at 458. Dr. Nausieda shrugs off such criticism reasoning that “[I]t is up to the literature to explain what we’re seeing. It’s not up to me to make my findings fit the literature.” Id. at 67 (quoting prior testimony from Dr. Nausieda).

Id. at 65 (quoting previous deposition testimony given by Dr. Nausieda).

Id. at 448 (testimony of Dr. Nausieda).
Some of the more aggressive attorneys, such as the ones involved in the tobacco settlements [referring to Scruggs and Barrett] have begun screening widely and loosely in order to get a large number of clients in case there is a lump-sum settlement such as occurred with asbestos, even though the clients may be minimally involved.\footnote{470}

Furthermore, the “robust” screening process employed in the MDL has not prevented significant abuses by potential plaintiffs themselves. Of the first seven MDL cases chosen by plaintiffs to go to trial, three were later voluntarily dismissed after defendants proved that the welders involved either lied about, faked, or exaggerated their symptoms.\footnote{471} The subjective, vague, self-reported nature of many of the symptoms, combined with the easy checklist provided on attorney websites and questionnaires, are a virtual manual for plaintiffs to identify the “signs” and “symptoms” that they need to exhibit that would lead to compensation.\footnote{472}

Even though the screening process, unlike other screenings discussed in this article, has weeded out the vast majority of potential claimants, this has not prevented plaintiffs’ attorneys from trying to overwhelm defendants with large numbers of cases, thus forcing them into settlements that would inevitably reward many, at best, marginal plaintiffs—along with their attorneys. Indeed, lawyers have filed hundreds if not thousands of welding cases in the

\footnote{470} Quoted in Hearing Tr., \textit{supra} note 301, at 25.

\footnote{471} In one case, the plaintiff was videotaped riding a tractor, gardening, carrying groceries, and walking without assistance, all activities he had claimed he was incapable of performing. April 2006 Order, \textit{supra} note 373, at 2. In two others, the plaintiffs lied about prior drug use that could have caused their neurological symptoms. \textit{Id.} at 1; Memorandum and Order at 2, Peabody v. Lincoln Electric Co., No. 1:05-CV-17678 (N.D. Ohio July 31, 2006) [hereafter Peabody Order]. Only one of the three plaintiffs, Scott Landry who lied about past drug abuse, came through the screening process, Second Case Administrative Order, \textit{supra} note 380, at 6, but Dr. Nausieda also examined Dewey Morgan, the plaintiff caught exaggerating his symptoms on multiple occasions. Hearing Tr., \textit{supra} note 301, at 432.

\footnote{472} The listing of “symptoms” replicates the process used by the law firm of Baron & Budd in preparing asbestos claimants to testify at deposition. The firm prepared a memo containing a list of “symptoms” clients could choose including shortness of breath; trouble sleeping; hiring help with household chores and repairs; cutting back on sports, activities, and hobbies; short-temper with grandchildren; less enjoyable sex life; depression; and fear of cancer. See Brickman, \textit{Asbestos Litigation}, \textit{supra} note 23, at 278-81 for a longer list of “symptoms.” For examples of attorney websites with lists of symptoms, see \textit{supra} note 340.
expectation they would never come to trial, but rather be included in large-scale inventory settlements without ever having to be litigated on their own merits.\textsuperscript{473}

In still other thousands of cases, attorneys didn’t even wait for the screening to generate a claim, but rather filed suit even before the welders had been diagnosed with a neurological disorder.\textsuperscript{474} Indeed, as many as 45\% of litigants in the MDL filed cases before they had even been to a screening or completed the screening process.\textsuperscript{475} As with the other litigation screenings in the asbestos, silica, fen-phen, and silicon breast implant cases, the overwhelming majority of MDL plaintiffs (70\%) diagnosed with a manganese-induced neurological disorder had not seen a doctor about their symptoms either before or after their screening diagnosis.\textsuperscript{476} Indeed, Dr. Nausieda, who diagnosed the vast majority of the welders involved in the MDL screening, included a letter for the welder to take to his own doctor stating, \textit{inter alia}, that the person had been seen at a “union-backed” or “union-supported” screening.\textsuperscript{477} This peculiar “medical”

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\textsuperscript{473} Plaintiffs’ co-lead counsel Don Barrett explained this tactic to the court in a February 2006 hearing in the Welding Fume MDL: “Some lawyers go get clients and sit on them in a case, a mass tort . . . and they know they are not going to have to try their cases. . . . [They wait until other cases have been tried and] a trend is established . . . then, bingo, there they are, and they say, ‘Pay me, too.’” Hearing Tr., supra note 301, at 122. Barrett admitted he does not expect or have the time to try all 1345 cases he has filed. \textit{Id.} at 123. “[I]t has been my experience and the experience of other lawyers . . . that are involved in mass torts that after a certain amount of time, there is a resolution of the cases either by some class remedy or . . . a grid formula . . . .” \textit{Id.}

\textsuperscript{474} Based on the fact sheets submitted by plaintiffs in the MDL as part of the discovery process, defense attorneys estimated that 45\% of plaintiffs had never received a diagnosis from either a doctor or through a screening process. \textit{Id.} at 30-31. The plaintiff’s attorneys argued that many of the filings were made to meet state statutory limitations on filing claims based on the date of last exposure rather than diagnosis of the disease. \textit{Id.} at 111. By filing the claims, they preserved their client’s ability to sue when a diagnosis was received. \textit{Id.} However, an earlier agreement in the MDL allowed for the statute of limitations in such cases to be tolled at the plaintiffs request in order to limit cases to those that were already cognizable. \textit{See} discussion supra note 374. Most of the 3,100 cases dismissed in the MDL in 2006 and 2007 were dismissed for this lack of diagnoses. \textit{August 2007 Status Report}, supra note 385, at 2.

\textsuperscript{475} Hearing Tr., supra note 301, at 31, 35.

\textsuperscript{476} \textit{Id.} at 40.

\textsuperscript{477} Nausieda Deposition 10/10/07, supra note 462, at 164.
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communication appears to be a signal to the litigant’s family or treating physician to appropriately discount the diagnosis.

Most importantly, plaintiffs’ counsels have essentially voted “no confidence” in the screenings that they have sponsored. In August 2004, Judge O’Malley established a process for selecting candidates for bellwether trials, with a focus on “providing opportunities for educating the Court and the parties regarding the science and other issues that are likely to recur in litigating individual cases.” 478 Ultimately, plaintiffs were solely responsible for choosing the second and fourth bellwether trial cases, while they had to select the plaintiff for the third trial from a list of 7-10 representative candidates submitted by defendants. 479 The intent of the parties was to try three bellwether cases involving plaintiffs with obvious movement disorders and a fourth with only subclinical neuropsychiatric symptoms. 480

Given the opportunity to choose their strongest cases to establish precedents that would shape all subsequent litigation and the damages awarded, plaintiffs’ lawyers ignored the vast majority of claimants, more than 90%, diagnosed at screenings 481 and chose plaintiffs with diagnoses from treating doctors instead. 482 For example, neither of the plaintiffs’ initial choices for the second and fourth MDL trials—Dewey Morgan and Darwin Peabody—were originally

479 Fourth Case Management Order ¶¶ I.1-3, In re Welding Fume Products, No. 1:03 CV 17000 (Mar. 24, 2005); see also Solis v. Lincoln Elec. Co., Case No. 05-17363, 2006 U.S. Dist. LEXIS 3869, at *7-8 (N.D. Ohio, Feb. 1, 2006). As noted, the first bellwether plaintiff was Charles Ruth, who settled his case before trial. See supra note 414.
480 Peabody Order, supra note 471, at 2.
481 Defendants’ Motion of 10/3/07, supra note 335, at 3. As of October 2007, 70% of the plaintiffs who remained in the MDL and who had submitted Notices of Diagnosis required by the court, see discussion supra notes 375-377, had been diagnosed by Dr. Nausieda and another 20% by Drs. Sanchez-Ramos and Widnell. Defendants’ Motion of 10/3/07, supra note 335, at 3. It is unclear how many of the remaining 10% had been diagnosed in the screenings involving Dr. Swash.
482 Id. at 3-5.
identified at a screening. But Plaintiffs ultimately had to dismiss both claims before trial after Morgan was videotaped engaged in activities he claimed he could no longer do and Peabody lied about past drug use. Likewise, for the fifth MDL trial, plaintiffs’ counsel again steered clear of any of the screening-diagnosed claimants in the MDL pool. They selected Robert

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483 Id. at 4. Peabody received his diagnosis from Dr. Kenneth Katz of the University of Pittsburgh Medical Center. Id. Katz later recanted his diagnosis under oath. Transcript of the Deposition of Dr. Kenneth D. Katz at 25, Peabody, No. 1:05-CV-17678 (March 7, 2006). Although Morgan had a diagnosis from a treating doctor, he was also examined by Dr. Nausieda who gave him a diagnosis of manganism. Hearing Tr., supra note 301, at 535; Defendants’ Motion of 10/3/07, supra note 335, at 4. The first bellwether plaintiff, Charles Ruth, whose case settled, had also been diagnosed by his own doctors, not at a litigation screening. See supra note 354.

484 Morgan was videotaped riding a tractor, gardening, carrying groceries, and walking without assistance, all activities he had claimed he was incapable of performing. April 2006 Order, supra note 373, at 2; Memorandum in Support of Defendants’ Motion for Fees, Sanctions and Remedial Relief at 1, 18-19, In re Welding Fume Products, No. 1:03 CV 17000 (Dec. 6, 2005), available at http://www.weldinginfonetwork.com/litigation/index.html [hereafter Defendants’ Motion 12/6/05]. In addition, Morgan’s doctors had previously diagnosed him with essential tremor (a hereditary condition unrelated to manganese exposure), a disabling back injury, and depression. Id. at 12-13. Many of the symptoms he later claimed to be the result of his exposure to welding fumes—severe hand tremors, anxiety, depression, and sleep problems—are also attributable to these pre-existing conditions. See, e.g., Mayo Clinic Staff, Essential Tremor, MayoClinic.com, August 18, 2006, available at http://www.mayoclinic.com/health/essential-tremor/DS00367 (last visited July 6, 2008) (noting that hand tremors are the most common symptom of essential tremor). Morgan filed suit on March 23, 2004, then soon thereafter, was examined by Dr. Nausieda who diagnosed him with manganism. Defendants’ Motion 12/6/05, supra, at 14. Before Morgan’s deceptions were exposed, Dr. Nausieda testified at deposition that Morgan’s tremors were increasingly debilitating and that he had great difficulty getting out of his chair. Id. at 15 (citing testimony Dr. Nausieda gave at his October 28, 2005 deposition). The previous month, however, two leading neurologists hired as defense experts, Drs. C. Warren Olanow and Anthony Lang, had examined Morgan and concluded that his symptoms were psychogenic, not based on a physical cause. Id. at 16. They noted that his tremor was variable and diminished when he was distracted and that other symptoms worsened after he was questioned about them. Id.

485 Peabody did not report his past illicit drug use to the doctors who examined him in preparation for his lawsuit. Defendants’ Motion for Order to Reopen Discovery at 6, Peabody, No. 1:05-CV-17678. However, medical records discovered by the defense showed that Peabody had undergone treatment at a substance abuse clinic following “a long history of alcohol and drug problems.” Id. at 4. While there, Peabody had complained of memory problems, irritability, and depression, as well as changes in sleep patterns, violent behavior, social interactions, and suicidal thoughts—symptoms that are the same as or similar to the ones he attributed to welding fume exposure—more than a year before he had started welding. Id. at 5-6. See also FEBRUARY 2007 STATUS REPORT, supra note 385, at 3; Industry Defendants Accuse Welding Bellwether Plaintiff Of Concealing Health Evidence, 3-4 MEALEY’S LITIG REPORT WELDING RODS 6 (2006).

486 Defendants’ Motion of 10/3/07, supra note335, at 5.
Jowers and Jeff Tamraz, both of whom prevailed at trial.\footnote{487} Once again, however, neither of these plaintiffs was diagnosed at a screening.

Even in the single instance when plaintiffs’ lawyers selected a small group of screening-diagnosed claimants for a proposed consolidated trial in the MDL,\footnote{488} they chose welders diagnosed in the smaller screenings conducted by Dr. Michael Swash on behalf of the Motley Rice law firm, not litigants identified in the much larger screenings involving Dr. Nausieda.\footnote{489} Ultimately, because the plaintiffs were bringing suit under the laws of more than one state, Judge O’Malley chose to consolidate only two of the cases,\footnote{490} holding the other three over until a later date. Defendants prevailed in the consolidated proceedings,\footnote{491} and the remaining three plaintiffs moved to dismiss their claims in April of 2008.\footnote{492}

Indeed, the only case to go to trial with a plaintiff originally diagnosed at a Nausieda, Sanchez-Ramos, or Widnell screening, was the case chosen from the list of seven candidates proposed by defendants. Because the defendants’ list was made up entirely of screening-generated cases, plaintiffs’ counsel had no option except to choose a screening case for that trial.\footnote{493} Plaintiffs’ first selection, Scott Landry, was diagnosed by Dr. Nausieda at a litigation

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\footnote{487}{See supra notes 407-409.}
\footnote{488}{Plaintiffs’ counsel originally proposed seven litigants for the consolidated trial, but eventually cut the list down to five. Memorandum and Order at 2, In re Welding Fume Products Liability Litigation, No. 1:03-CV-17000 (N.D. Ohio Oct. 5, 2006). The cases became known as the “Duke Power Cases” because all five plaintiffs had worked for the Duke Power Company in the Carolinas. Id.}
\footnote{489}{Defendants’ Motion of 10/3/07, supra note 335, at 5.}
\footnote{491}{The jury found for the manufacturers because Duke Power was a sophisticated user who had the duty to warn its employees of any dangers inherent in the use of welding rods. MDL 1535 Jury Returns Verdict For Manufacturer Defendants: Sophisticated User Defense Wins, 3-9 MEALEY’S LITIG. REPORT WELDING RODS 1 (2006). The jury did find that the defendants’ negligence was a proximate cause of Goforth’s “injury,” but not Quinn’s. Id.}
\footnote{492}{See Remaining Duke Power Plaintiffs Seek Dismissal Of Claims Against Welding Manufacturer Defendants, 5-1 MEALEY’S LITIG. REPORT WELDING RODS 2 (2008).}
\footnote{493}{Defendants’ Motion of 10/3/07, supra note 335, at 4.}
screening.  However, plaintiffs declined to go forward with his case after discovery revealed his extensive history of drug use and a dishonorable discharge from the military. Plaintiffs then chose Ernesto Solis from the candidates remaining on the defendants’ list. The jury unanimously rejected his claims. Of the five other screening-generated cases submitted by the defense, plaintiffs have voluntarily dismissed four. And as of July 2008, Solis remains the only person initially diagnosed at a screening conducted by Dr. Nausieda, Dr. Sanchez-Ramos or Dr. Widnell whose case has been tried in the MDL.

Plaintiffs’ counsel’s extreme reluctance to proceed to trial in cases where Dr. Nausieda and a few other litigation doctors have provided diagnoses thus appears well founded.

The Scruggs/Barrett screenings appear to have attempted to avoid the worst abuses of previous litigation screenings. Nonetheless, many of the same fundamental flaws that have been identified in other litigation screenings as perverting both science and the civil justice system appear to be present in welding fume screenings as well.

VIII. The Failures of the Civil and Criminal Justice Systems To Deter or Sanction Litigation Screening Fraud

Approximately 1,500,000 potential litigants have participated in litigation screenings undertaken in the five mass tort litigations considered in this article. A comparative handful of litigation doctors used in each of these five litigations found that a total of approximately 1,000,000 of those screened had the requisite condition conferring a right of compensation,

494 Defendants’ Motion 12/6/05, supra note 484, at 20. See also April 2006 Order, supra note 373, at 5 (noting that the only diagnosis of Landry on the record is Dr. Nausieda’s diagnosis of manganese-induced parkinsonism).
495 Defendants’ Motion of 10/3/07, supra note 335, at 4.
496 Id. at 4-5.
497 Id. at 4-5.
whether asbestosis, silicosis, an autoimmune disease, moderate mitral or aortic valve regurgitation, or a neurological disorder. On the basis of the evidence I have examined, I estimate that approximately 900,000 of these claims were based on diagnoses that were “manufactured for money.” I further estimate that the settlement value of these “manufactured for money” claims is in the range of $35-$40 billion dollars and that the resulting contingency fees are in the range of $13-$14 billion. Finally, I estimate that the litigation doctors who produced the medical reports for the screened litigants and the screening companies that they worked for have been paid well in excess of $250 million.

Despite the considerable evidence reviewed in this article that much of the medical evidence produced in the course of litigation screenings is at least specious, if not simply manufactured for money, both the civil and criminal justice systems have not only largely failed to deter this conduct but have, in fact, facilitated it.

Judge Jack’s one-of-a-kind decision aside, there is no effective mechanism in the civil justice system for reliably detecting and deterring the kind of specious claim generation that is endemic in most litigation screenings. An even more compelling indictment of the civil justice system are the significant impediments posed by that system to even exposing the specious claim generation methods that are used in litigation screenings. Furthermore, bankruptcy courts adjudicating asbestos related bankruptcies have effectively legitimized the use of litigation screenings to generate huge numbers of specious if not fraudulent claims. This is done by

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498 See Brickman, Disparities, supra note 12, at n.4, for commentary on Judge Jack’s unprecedented use of a Daubert hearing to find that the litigation doctors’ diagnoses to prove specific causation were unreliable.

499 Cf. John L. Watts, To Tell The Truth: A Qui Tam Action for Perjury in a Civil Proceeding is Necessary to Protect the Integrity of the Civil Justice System, 79 TEMPLE L. REV. 773 at 778 (2006) (discussing what the author calls an “epidemic of perjury” in high stakes civil litigation and the “shortcomings of the legal system’s traditional tools employed to combat perjury” including the lawyer disciplinary process and criminal prosecution.)
adopting procedures for estimating current and future nonmalignant claim liability advanced by professional experts retained by the tort claimants which ignore the issue of liability in the quest to maximize the liability of the debtor and its insurers. In addition, the criminal justice system has failed to sanction either the screening companies or the doctors who manufacture diagnoses for money on a mass scale let alone the lawyers who hire them for precisely this reason. Finally, lawyer disciplinary systems also appear disinterested in prosecuting ethical violations endemic to litigation screenings let alone litigation screening fraud. As a consequence, these actors are

500 A reference by U.S. District Court Judge Harvey Bartle III to New York disciplinary authorities of his findings that a law firm in the fen-phen litigation had a “highly questionable practice” that created a financial incentive for one of the cardiologists it hired who read thousands of echocardiograms to find compensable injury, see supra notes 170-174, resulted in a finding “that there was no breach of the [New York] Code of Professional Responsibility” and the dismissal of the complaint. See Trusts Amend Suit Against New York Doctor, Adding RICO Claims, 7 Mealey’s Litigation Report: Fen-Phen/Redux 10 (Aug. 2004).

The Mississippi Supreme Court upheld a trial court’s refusal to sanction the law firm of Campbell-Cherry-Harrison-David and Dave, P.C. (CCHDD) for bringing over 4,200 lawsuits against 131 unrelated defendants for alleged injuries caused by exposure to silica. See Choctow, Inc. et al. v. Campbell-Cherry-Harrison-David and Dave, No. 2006-CA-01621-SCT (Miss. Sup. Ct. Oct. 4, 2007). These lawsuits, brought in Mississippi state court, were removed to U.S. District Court and became part of MDL 1553. It was these and other suits in the MDL that Judge Jack proclaimed were generated by a scheme hatched by doctors, lawyers and screening companies to manufacture diagnoses for money. After Judge Jack determined that she lacked subject matter jurisdiction and the cases were then remanded to Mississippi state court, the defendants moved for sanctions alleging that CCHDD had filed frivolous suits because the firm did not have valid diagnoses to sustain their claims of silica-related disease. After reviewing the standard for a finding a matter “frivolous,” the Mississippi Supreme Court found that the cases were not frivolous because the plaintiffs had some hope of success when the claims were filed. Id.

Looking at the screening process that CCHDD used to generate silica litigants and noting that the firm had no direct contact with Dr. Ray Harron (who diagnosed 99% of those whose files he reviewed as having asbestosis and whose testimony raised “red flags of fraud” for Judge Jack) because the N&M screening company was a barrier between the firm and Dr. Harron, the Court sustained the lower court’s conclusion that the lawsuits were not brought without substantial justification and therefore were not “frivolous.” The Court also sustained the ruling denying defendants additional discovery that they sought to buttress their allegations.

The Mississippi Supreme Court’s determination that the cases were not frivolous since the plaintiffs had some hope of success when the claims were filed, is empirically supportable. The more than 4,200 silica claims in the MDL brought by CCHDD, though specious and very likely fraudulent, may well have been successful but for the highly improbable intervention of U.S. District Court Judge Janis Jack. See Brickman, Asbestos/Silica Litigation, supra note 42, at 311-312 and Brickman, Disparities, supra note 12, at 516-517 n.4 for a discussion of the improbability of Judge Jack’s decision.

Specious asbestos claims have proved immensely profitable. Hundreds of thousands of such claims have generated billions of dollars in settlements. In the silica MDL, one of the plaintiff’s lawyers
essentially immune from prosecution for fraud under the civil and criminal justice systems.\footnote{501}

These systemic failures of both the civil and criminal justice systems require a variety of corrective mechanisms.

A. The Civil Justice System Failure: A Statement of the Problem

1. The “Expert” Status of Testifying Doctors

Since doctors are licensed professionals, when testifying on specific causation and rendering diagnoses in their specialty, they are, by definition, medical experts and therefore qualified to wear the mantle of “expert” when they testify.\footnote{502} In theory, a doctor’s expert status may be challenged on the grounds of lack of reliability by a motion \textit{in limine} in a \textit{Daubert}\footnote{503} proceeding. In mass tort litigations, however, even though a comparative handful of litigation made a demand for a one billion dollar settlement, pointing out that this represented a substantial discount from the actual settlement value of the cases in the tort system. \textit{See} Letter from Quinn, Laminack & Pirtle to defense counsel, April 16, 2004 (on file with the author). Thus, there was more than a mere hope of success that the specious and likely fraudulent claims would be successful. And as the court essentially declared, however likely the cases are to be specious if not fraudulent, the likelihood of success meant that they were not frivolous by Mississippi standards.

A second sanctions motion also met the same fate from this court. Though U.S. District Court Judge Janis Jack sanctioned the law firm of O’Quinn, Laminack & Pirtle for filing an original jurisdiction case in the silica MDL that Judge Jack concluded was groundless, the Mississippi Supreme Court agreed that Judge Jack’s finding was not binding on the state court and refused to sanction the firm for this conduct. Clark Sales & Rental, Inc., et al. v. Braxton; consolidated with Clark Sales & Rental Inc., et al. v. McDuff, No. 2006-CA-01577-SCT (Miss. Sup. Ct.). \textit{See} Court News, HarrisMartin-Silica, April 3, 2008.

These holdings by the Mississippi Supreme Court are consistent with previous decisions of that court essentially excluding asbestos litigation from the purview of the court’s ethical rules regulating lawyers. \textit{See} Brickman, \textit{Asbestos Litigation, supra} note 23, at 72 n.109. \textit{See} Lester Brickman, \textit{DOJ’s Free Pass For Tort Fraud}, \textit{WALL ST. J.} at A11 (Dec. 26, 2007).\footnote{501}

\footnote{502} A degree and license in medicine clearly meets the standard of the Federal Rules of Evidence, which requires an expert to be qualified by “knowledge, skill, experience, training, or education.” \textit{FED. R. EVID.} 702. The standard is liberally applied. \textit{See In re Paoli R.R. Yard PCB Litig. (“Paoli II”), 35 F.3d 717 (3rd Cir. 2003) (finding abuse of discretion for precluding a trained internist, now primarily occupied as a litigation consultant who is well versed in medical literature , despite her lack of board certification in internal medicine or toxicology”). \textit{See generally} 4 \textit{WEINSTEIN’S FEDERAL EVIDENCE} § 702.04 (2007). \textit{See} Brickman, \textit{Disparities, supra} note 12, at n.3.\footnote{503}
doctors\textsuperscript{504} account for hundreds or thousands of medical reports generated during the course of litigation screenings, defendants lack an effective means of challenging those doctors’ reliability. This is so because courts do not allow discovery of the data that would enable the most effective challenges to be made. One such set of data that likely would be discovered -- if discovery were allowed -- is that a litigation doctor who had provided medical reports for hundreds or thousands of screened litigants, frequently failed to comply with established medical protocols for diagnosing the condition in question such as performing a thorough physical examination, taking a detailed occupational and exposure history (rather than relying on a history taken by a nonmedically trained person who is directly or indirectly employed by the lawyer sponsoring the screening), and undertaking a differential diagnosis to eliminate other possible causes of the diagnosed disease.\textsuperscript{505} Another potentially effective basis for challenge would be to show that the percentage of all of those that the litigation doctor diagnosed with the signature disease is far higher than what clinical studies or other medical literature would indicate, or that, according to other evidence introduced (such as a review by neutral medical experts of a randomized sample of those diagnoses), the doctor’s diagnoses have a very high error rate. To raise a challenge based on these arguments, defendants need to have access to the medical records of the hundreds or thousands of other similar claimants diagnosed by that litigation doctor but who are not litigants in that case. But this access is precisely what defendants are denied. To be sure, during the trial, defendants can put on their own medical experts to testify that the litigant does not have the disease alleged or that exposure to the defendant’s product was not a substantial factor in

\textsuperscript{504} See supra note 16.

\textsuperscript{505} For an example of such a challenge which sought to exclude the expert testimony of Dr. Jay T. Segarra, one of the most prolific of the asbestos litigation doctors, on the grounds that Dr. Segarra’s medical reports and diagnoses do not follow standard diagnostic protocols for diagnosing occupational diseases, see Certain Defendants’ Combined Motion And Brief To Exclude Expert Testimony By Dr. Jay T. Segarra And To Dismiss The Claims of Plaintiffs Relying On Same (Sept. 7, 2007), In re: Asbestos Products Liability Litigation (No. VI), MDL 875 (E.D. Pa.).
causing the disease -- a traditional “battle of the experts.” But the effectiveness of this “retail”
case-by-case response pales by comparison with the effect of the “wholesale” production of
thousands of medical reports by a handful of doctors to support claims generated by litigation
screenings. The strategy of massing large numbers of claims generated by screenings has been
effective in compelling defendants to enter into large scale settlements of specious if not
fraudulent claims. Because litigation screenings have proven to be immensely profitable and
the most effective means of mounting a Daubert challenge to litigation doctors are essentially
precluded as are the use of litigation doctors’ records to challenge claims generated by
screenings, the practice of using a comparative handful of doctors to generate literally thousands
and tens of thousands of medical reports has become standard in certain mass tort litigations such
as those discussed in this article.

2. Litigation Doctors’ Immunity from Challenge to their Expert Status

Litigation doctors who are properly credentialed are usually effectively immune from
challenge to their status as a testifying expert on specific causation in asbestos litigation. This
is so because the scope of discovery in a deposition is usually limited to the medical report in the
single case before the court; if a number of cases have been joined, then discovery and cross
examination are limited to those cases where the doctor has provided medical reports which are
the basis for their diagnoses. Thus litigation doctors are not subject to challenge as to their

506 As noted by Judge Jack in the silica MDL proceeding, the use of litigation screenings as
an entrepreneurial means of claim generation is a strategy that seeks
to inflate the number of Plaintiffs and claims in order to overwhelm the Defendants and
the judicial system. This is apparently done in hopes of extracting mass nuisance-value
settlements because the Defendants and the judicial system are financially incapable of
examining the merits of each individual claim in the usual manner.
507 A testifying expert is “[a]n expert who is identified by a party as a potential witness at
trial” whereas a non-testifying or consulting expert is one “who, though retained by a party, is not
expected to be called as a witness at trial.” BLACK’S LAW DICTIONARY 619 (8th ed. 2004).
reliability even if there is a considerable body of evidence that could be discovered -- if
discovery were allowed -- indicating that these doctors manufactured thousands of similar
diagnoses for money rather than engaging in good faith medical practice. In particular, the
inability to discover these records effectively prevents defendants from determining the doctors’
total number of positive and negative medical reports which in turn prevents calculation of
each doctors’ percentages of positive diagnoses. This percentage is a critical factor if the
reliability of a litigation doctor’s diagnoses is to be placed in issue. While litigation doctors
largely refuse to answer questions with respect to their percentages of positive diagnoses --
claiming that they simply don’t know the percentage, on the few occasions when they have
responded to such questions in depositions, they have mostly maintained that their positive X-ray
readings are in the 10%-30% range. However, in fact, their actual percentages of positive X-
ray readings are far higher -- at least in the 50%-90% range. In addition, litigation doctors
diagnose 80%-90% or more of those with a positive X-ray reading as having asbestosis.
These high percentages of positive findings exceed the results of clinical studies of
occupationally exposed workers by a margin of more than ten to one and are thus strong
evidence that the X-ray readings and diagnoses are “manufactured for money.” Even plaintiffs’
lawyers acknowledge that the validity of a litigation doctors’ findings may be dependent on the

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508 By positive medical report, I mean in the context of asbestos litigation that the litigation
doctor has either read an X-ray as indicating fibrosis using the ILO scale, see supra note 49, or has made
a diagnosis of asbestosis or both. By negative medical report, I mean that the X-ray was either not read as
indicating fibrosis or the litigant was not diagnosed with a disease caused by exposure to asbestos. See
Brickman, Silica/Asbestos Litigation, supra note 42, at 302 for a discussion of the “smoking gun”
significance of being able to determine the percentage of those screened that the litigation doctor found
positive for disease.

509 See Brickman, Disparities, supra note 12, at 529.

510 Id. at 529.

511 Id. at 529, 531.

512 Id. at 589.
number of negative reports issued by that doctor. The refusal of litigation doctors as well as the lawyers who hire them to provide the information that would allow calculation of their percentage of positive X-ray readings or diagnoses is intended to and does serve to insulate these doctors from a challenge to their reliability.

3. The Changing Role of Discovery In Asbestos Litigation

Judge Jack’s finding of pervasive litigation screening fraud in the silica MDL, even though largely advisory in nature because Judge Jack determined that she lacked subject matter jurisdiction, has changed the legal landscape with regard to discovery in asbestos litigation. Whereas prior to Judge Jack’s decision, there were few attempts to seek to compel production of a substantial portion of the medical reports of the litigation doctors and near uniform rejection of whatever attempts were made, defendants in asbestos and silica litigations, emboldened by

513 See Letter from Weitz & Luxenberg to Judge Helen Freedman, New York Supreme Court, re FIFO Trial Plan, Sept. 25, 2007 at 4 (defending the integrity of the medical reports of several litigation doctors including Dr. Richard Levine, stating that “[t]he validity of Dr. Levine’s positive findings is supported by the fact that he also provided large numbers of negative reports for participants in screenings in which Weitz & Luxenberg was involved. . . .”) Dr. Levine is an asbestos litigation doctor who has provided thousands of medical reports. See CRMC Response, supra note 18, at Exh. B (indicating that Dr. Levine was the sixth most prolific litigation doctor in authoring B-reads submitted to the Manville Trust), Exh. C (indicating that Dr. Levine was the fourth most prolific doctor in authoring diagnoses submitted in support of claims to the Manville Trust), and Exh. D (indicating that Dr. Levine was the sixth most prolific doctor in authoring medical reports submitted to the Manville Trust). It is notable that despite the fact that thousands of Dr. Levine’s X-ray readings were relied upon by plaintiffs’ lawyers as the equivalent of a diagnosis and million of dollars have been paid to claimants on the basis of Dr. Levine’s medical reports, Dr. Levine has repudiated any use of his X-ray readings as diagnoses, stating that his X-ray readings were not diagnoses and that he never rendered a single diagnosis of asbestosis. See Transcript of Trial at 61-65 (Jan. 23, 2008), In re W.R. Grace & Co., et al., 305 B.R. 175 (Bankr., D. Del. 2004) (No. 01-1139).

514 See Response and Brief In Support of Response of Jay Segarra, M.D. To Defendant’s Combined Motion And Brief To Compel Response To Subpoena To Jay Segarra, M.D. And Combined Motion And Brief In Support of Motion of Jay Segarra, M.D., To Quash Or, In the Alternative, Modify Subpoena to Jay Segarra, M.D., Sept. 13, 2006, In re: Asbestos Product Liability Litigation (No. VI) MDL No. 875, U.S.D.C. E.D. Pa. [hereafter, Segarra Response] (“The one thing that the defendants do not have are copies of Dr. Segarra’s negative reports. . . .”). Id. at 4 (emphasis in original)).

515 See infra note 527.

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Judge Jack’s order, are aggressively seeking broad ranging discovery of the medical evidence produced for the plaintiff and of the plaintiffs’ medical experts. In response, judges whose consciousness of possible litigation screening fraud has been raised by Judge Jack’s opinion, are beginning to permit defendants in asbestos litigation to conduct broader discovery of the B
Readers and diagnosing doctors who were used in the screenings that generated the cases before the court. An indication of the near sea change wrought by Judge Jack can be seen in the evolution of the positions taken by U.S. District Court Judge James T. Giles, who succeeded the late Judge Charles Weiner in presiding over the asbestos MDL. In January 2007, Judge Giles responded to defendants who were seeking wide ranging discovery of the litigation doctors’ records, that his “Court is... not an investigating Grand Jury. That information which is likely to be useful in a trial is the kind of information that will be the subject of discovery. . . . I do not presume that there is fraud in mass tort litigation.” After being exposed to the products of the discovery that he allowed in the proceeding -- which decisions about the scope of discovery were likely influenced by Judge Jack’s findings -- Judge Giles, four months later, found that the

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517 See e.g., Statement of Marcy Croft of the defense firm of Forman, Perry, Watkins, Krutz & Tardy, LLP, Transcript of Proceedings of Jan. 31, 2007 at 5-7, MDL 875 (“[As part of] our continuing investigation into fraudulently diagnosed asbestos plaintiffs pending before this Court in MDL 875... we have issue[d] over 40 subpoenas to screening doctors and screening companies. . . . We have had to file six motions to compel. Four... have been resolved. . . . We asked. . . every screening doctor and screening company. . . . [for] the records that related to their business of screening and diagnosing plaintiffs in anticipation of asbestos litigation. So [far],. . . every. . . doctor and screening company that we [subpoenaed except Dr. Segarra and the OMR screening company] has produced these documents.”)

518 See Brickman, Silica/Asbestos Litigation, supra note 42, at 311-314 for a discussion of the effect of Judge Jack’s ruling on mass tort litigation. See also Judge Giles’ ruling in a motion to quash discovery at infra note 564.


medical reports generated by asbestos litigation screenings “lack reliability and accountability” and are “inherently suspicious as to their reliability.”

Because there are tens of thousands of cases in MDL 875, Judge Giles’ orders allowing discovery of the medical records produced by litigation doctors and screening companies have generated a considerable volume of data which is being processed by defendants. Nonetheless, for the reasons set forth below, defendants remain stymied when attempting to elicit or use this data in individual litigations.

4. Issues Arising From the Demand for Discovery in Asbestos Litigation

Typically, when a nonmalignant asbestos claim is filed in a court, a defendant who does not agree to settle the claim will, in preparation for trial, seek to depose the doctor who is going to testify that the litigant has an asbestos related disease caused by exposure to the defendant’s products. If the testifying expert is a litigation doctor, defendants will likely subpoena that doctor requiring, *inter alia*, that he bring to the deposition copies of all relevant materials including records of all reports that doctor prepared not just in that case or cases but for all other asbestos litigants generated by screenings. At the deposition, defendant’s counsel will ask the

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523 Initially, in 1991, when the Judicial Panel on Multidistrict Litigation centralized all pending actions involving allegations of personal injury or wrongful death caused by asbestos in a single forum under 28 U.S.C. §1407, the number of plaintiffs was 26,639. See MDL 875, supra note 519, at 415. However, by 2007, the number of claims pending in MDL 875 had grown to approximately 99,000 plaintiffs. See Transcript of Motions Hearings, MDL 875, 771 F. Supp. 415 (E.D. Pa Jan. 31, 2007).
524 See supra note 517.
525 See, e.g., Subpoena served on N&M, Inc., Sept. 28, 2004, In re Silica Products Liab. Litig., No. MDL 1553, 398 F. Supp. 2d 563, (seeking all records of testing and screening of approximately 9,474 plaintiffs listed in Exhibit C of the subpoena, including pulmonary function tests, X-ray readings, physical exams, electronic files, medical histories, notes, diagnostic reports, invoices, and documents reflecting payments for services rendered in connection with any of Plaintiffs); Subpoena served on Healthscreen, Nov. 2, 2005, In re Asbestos Products Liability Litigation (No. VI), MDL 875, 771 F. Supp. 415; Subpoena served on Dr. Alvin Schonfeld, M.D., Dec. 11, 2005, In re Asbestos Products Liability Litigation (No. VI), MDL 875, 771 F. Supp. 415. See also supra note 516 for orders denying motions to compel production of medical records subpoenaed by defendants. See also supra note 527 for
The doctor will typically provide a copy of his CV, information about prior deposition testimony, copies of some billing records and copies of the plaintiff’s medical reports prepared by that doctor. The litigation doctor will not, however, bring or provide copies of X-ray readings or diagnoses in his possession that he prepared for the hundreds or thousands of other screened litigants for whom he prepared medical reports.

Defendants may also seek discovery of a litigation doctor who has not been designated as a testifying expert in the case before the court but who provided an X-ray reading or a diagnosis of the litigant in that case and who thus claims the mantle of consulting expert. That medical report has likely been used to obtain compensation from various asbestos bankruptcy trusts and perhaps from other defendants but is not being relied on by the plaintiff in the matter before the court. Once again, defendants’ ability to attempt to show that the litigation screening that generated the claimant who is now before the court was part of a scheme to manufacture diagnoses for money depends on obtaining discovery of, and testimony from, that litigation doctor with regard to the totality of X-ray readings and diagnoses he provided in the course of multiple litigation screenings.

Courts limit the production of testifying expert’s medical records to those prepared for parties in that litigation and sustain objections to producing the totality of a litigation doctor’s

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orders denying motions to compel production of medical records subpoenaed by defendants. In some jurisdictions, case management orders stipulate specific information that each side must provide to the other. None of these orders require that the defendant be provided with the plaintiff’s doctors’ records of X-ray readings and diagnoses rendered for other plaintiffs generated by litigation screenings.

A consulting expert is not expected to be called as a witness at trial. See supra note 507 for definitions of testifying and consulting experts. See infra section VIII.A.5 for an explanation of why the nontestifying litigation doctor is not a consulting expert for purposes of insulating him from discovery.
medical reports, irrespective of whether he is a testifying or consulting expert.\textsuperscript{527} Production of a litigation doctor’s medical reports if he is only a consulting expert is even more limited.\textsuperscript{528} Objections raised by the litigation doctors and plaintiffs’ counsels to discovery include: (1) the records sought are medical records and therefore protected from disclosure by the Health Insurance Portability and Accountability Act (“HIPAA”);\textsuperscript{529} (2) the records sought are not

\textsuperscript{527} See, e.g., Special Master’s Report and Recommendation, May 27, 2003, Curtis Johnson, et al., v. American Optical Corp. et al., Cir. Ct. Copiah Cty., Miss., no. 2002-0030. (Defendants sought the medical reports produced for the N&M screening company by litigation doctors. In response to a Defendants’ Motion to Compel and N&M, Inc.’s Opposition to Motion to Compel and Motions to Quash and for Protective Order, the Special Master recommended that N&M be required to submit to a deposition and respond to questions about its “normal testing or screening procedures, the specific testing or screening procedures used with the named plaintiffs in this matter and any and all test results and documentation related to these tests...” \textit{id} at ¶ 2; but “[t]o the extent that Defendants seek personal information regarding clients or patients of N&M, Inc., \textit{who are not parties to this litigation},... this information is protected and not subject to discovery.” \textit{Id.} at ¶ 4 (emphasis supplied))’; Order Adopting the Special Master’s Recommendation in Civil Action no. 2002-0027, June 6, 2003, Underwood et al., v. American Optical Corp., et al., Cir. Ct., Copiah Cty., Miss., no. 2002-0027; Order, Jan. 10, 2005, In re Silica Products Liab. Litig., MDL 1553, 398 F. Supp. 2d at __. U.S.D.C. S.D. Miss. (modifying subpoena for N&M’s records in MDL 1553, in response to N&M’s motion for a protective order, to provide that “all identifying information regarding individuals who are not plaintiffs in MDL 1553, shall be redacted by N&M prior to production of the documents). See also Order Denying Motion by Defendants to Compel Discovery, Dec. 17, 2002, Morton County Asbestos Docket Sets E and G, Dist. Ct., Morton Cty., N.D. (Defendants had argued that the plaintiffs provided no meaningful information in their responses to the screening discovery, did not produce any documents and did not respond to the question of whether they attended any asbestos screenings and, if so, seeking copies of all records produced by those screenings or medical records resulting from the screenings. \textit{See} Defendants’ Memorandum of Law In Support of Their Motion To Compel, Nov. 12, 2002, Motion County Asbestos Dockets E and G, Dist. Ct., Motion Cty., N.D. The court held that while “defendants are entitled to all available medical records concerning each of the individual plaintiffs, together with all medical services, medical history, and current diagnosis. ... [it denied] the defendants motion to compel discovery so as to cause the plaintiffs to identify each individual plaintiff and each individual screening to which a plaintiff may have been subjected [as well as the location and service provider or entity responsible for such screening.”]).

\textsuperscript{528} \textit{See infra} notes 556-602 and accompanying text for discussion of the consulting expert privilege.

\textsuperscript{529} See, e.g., Response & Brief in Support of Response of Jay Segarra, M.D., to Defendants’ Combined Motion & Brief to Compel Response to Subpoena to Jay Segarra, M.D. and Combined Motion and Brief in Support of Motion of Jay Segarra, M.D., to Quash or, in the Alternative, Modify Subpoena to Jay Segarra, M.D., Sept. 13, 2006, \textit{In re:} Asbestos Products Liability Litigation (No. VI), MDL 875, U.S.D.C., E.D. PA in which Dr. Jay Segarra argued that “If (he was) ‘practicing medicine’...then HIPPA...appl[ies], and [he] is not at liberty to produce any documents other than those pertaining to named plaintiffs in [the] lawsuit, as they are the only ones who have waived their medical privilege as to the issues raised in [the] proceeding.”
relevant to the litigation; (3) producing the records would amount to an “undue burden”; (4) the medical reports are “work product” and therefore not subject to discovery; (5) if the litigation doctor has not been designated as a testifying expert, the records are not subject to discovery because of the “consulting expert” privilege; and (6) the medical expert was only informally consulted in preparation for trial but was never specially employed as a consultant.

Courts have emphatically rejected the HIPAA argument which, in any event, is largely pretextual.

The relevance argument is that the subpoena for a litigation doctor’s medical reports prepared for litigants in other proceedings is overly broad in that the documents being sought are not relevant to that court proceeding. While some courts have denied enforcement of

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See e.g., Order, Feb. 2, 2007, MDL 875 (“The Court has previously considered the applicability of the Health Insurance Portability and Accountability Act [hereafter, “HIPAA”] to the documents, materials, and items subpoenaed by Certain Defendants from various screening companies and screening doctors. The Court found that these subpoenaed entities were engaged in the business of screening individuals for pneumoconiosis for litigation rather than medical purposes. Given the nature of the litigation screening industry and the nature of the records utilized and generated in same, the Court previously found that the documents, materials, and items sought by Certain Defendants did not fall within the scope of HIPAA. Similarly, the Court finds that [certain doctors and a screening company] . . . were also engaged in the business of evaluating individuals for pneumoconiosis for litigation rather than medical purposes and that the documents, materials, and items sought by the subpoenas at issue do not fall within the scope of HIPAA.”)

All of the litigation doctors, including those who cite HIPAA as the basis for not producing these records, consistently maintain that the services they are rendering are not “medical” and that no doctor-patient relationship exists between them and the litigants for whom they have provided supporting evidence. See e.g., Letter from Leo J. Castiglioni, M.D., to N&M, Inc. (May 29, 1998) (stating a diagnosis “consistent with asbestosis” and further stating “I am not practicing medicine on the above named individual (George Maye) and I am not functioning as his or her doctor. He or she and I do not have a patient-doctor relationship and there is no confidentiality relative to this relationship”) (on file with author); See medical file compiled by Dr. Ray Harron for an asbestos litigant, including a statement signed on May 25, 2001 by an MDL 875 plaintiff, acknowledging that no doctor/patient relationship has been created (“I understand and acknowledge that Ray A. Harron M.D. is not my doctor and he and I have no doctor/patient relationship…[he] is functioning as an expert medical witness…and…not practicing medicine on me.”) (on file with author).

See, e.g., Objections to Subpoena For Documents And Things, Dec. 27, 2005, In re: Asbestos Products Liability Litigation (No. VI), MDL 875, U.S.D.C., N.D. Ohio, East. Div. in which Dr. Alvin Schonfeld objected to the subpoena for his litigation screening records because “the subpoena seeks
subpoenas to obtain the medical records of asbestos litigation doctors prepared for persons who are not parties to the litigation on this basis, these decisions are not in accord with the Federal Rules of Civil Procedure or state adaptations of those Rules. The Federal Rules allow for discovery by a party of “any matter . . . that is relevant to the claim or defense of any party.” The matter itself need not be admissible at trial as long as its discovery is “reasonably calculated to lead to the discovery of admissible evidence.” Furthermore, a court may for good cause expand discovery beyond material related to claims or defenses to encompass the “relevant subject matter of the action,” if there is “any possibility” of it leading to a relevant subject matter. Thus, a federal court has held that discovery of a doctor’s examination records of records belonging to Dr. Schonfeld’s patients other than the parties to the above-referenced action on the grounds that production of such non-party records is not relevant nor reasonably calculated to lead to the discovery of admissible evidence in this action. . . .”

See supra note 527.

Id. Unless otherwise limited by court order, the scope of discovery is as follows: Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense — including the existence, description, nature, custody, condition, and location of any documents or other tangible things and the identity and location of persons who know of any discoverable matter. For good cause, the court may order discovery of any matter relevant to the subject matter involved in the action. Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence. All discovery is subject to the limitations imposed by Rule 26(b)(2)(C).

FED. R. CIV. P. 26(b)(1).

Id.

Id. The limitation of party discoverable material to that which is relevant to a “claim or defense” is a result of the 2000 amendments to the Federal Rules. See 6 MOORE’S FEDERAL PRACTICE § 26.43 (3rd ed. 2007) (citing advisory committee’s notes). This limitation was written to give courts more control over the discovery process. Discovery of any matter “relevant to the subject matter of the action,” the former standard, is still allowed on a showing of good cause. Thus, even if the requested records are not deemed to be relevant to a claim or defense, it is still possible to show good cause and have discovery expanded to matters “relevant to the subject matter involved in the action.” FED. R. CIV. P. 26(b)(1). See Martinez v. Schock Transfer & Warehouse Co., 789 F.2d 848, 850 (10th Cir. 1986) (“Control of discovery is entrusted to the sound discretion of the trial courts.”) (citing Smith v. Ford Motor Co., 626 F.2d 784, 794 (10th Cir. 1980), cert. denied, 450 U.S. 918, 101 S. Ct. 1363, 67 L. Ed. 2d 344 (1981)).

EEOC v. Electro-Term, 167 F.R.D. 344, 346 (D. Mass. 1996) (“[R]elevancy must be broadly construed at the discovery stage such that information is discoverable if there is any possibility it might be relevant to the subject matter of the action.”) (emphasis added). See also Oppenheimer Fund v. Sanders 437 U.S. 340, 351 (1976) (“[R]elevant to the subject matter involved in the pending action’ has
patients other than those involved in the matter before the court is proper if it is necessary to establish a claim of bad faith and because it might lead to relevant evidence.\footnote{539}{

There are at least four circumstances where the relevance of the medical records prepared by the litigation doctors in support of thousands and tens of thousands of claims generated by screenings is apparent. First, if a litigation doctor is to testify as an expert witness on specific causation, producing these medical records would allow defendants to determine that doctor’s percentage of positive reports, which could then be the basis for mounting a \textit{Daubert} challenge on the grounds of lack of reliability. Second, even if a \textit{Daubert} challenge is not mounted, the totality of the medical records can be used to attack the validity of a diagnosis on the basis of the doctor’s methodologies and failure to follow medical protocols. A perfect illustration of the relevance of the totality of a litigation doctor’s medical reports is provided by a current proceeding in a Wayne County, Michigan Circuit Court. Approximately 90\% of about 1800 X-ray readings by Dr. R. Michael Kelly, a testifying expert in 70 to 83 asbestos cases in a single trial group in that court, are refuted by hospital radiologists who initially read the identical X-rays in the ordinary course of administering the X-rays.\footnote{540}{Thus, according to neutral X-ray readers, Dr. Kelly finds radiographic evidence of interstitial fibrosis ten times more frequently than is present.}

\textit{Small v. Provident Life & Acc. Ins. Co.}, 1999 WL 1128945 (E.D. Pa. 1999). In \textit{Small}, the court denied a party’s request to quash a subpoena for broad discovery of a doctor over challenges to relevance. In order to establish a claim of bad faith, records of the doctor’s examination of other patients were necessary to show a biased pattern towards insurance companies. \textit{See Caban v. 600 E. 12st Street Co.}, 200 F.R.D. 176 (E.D.N.Y. 2001) (compelling in camera review of the academic records of non-party siblings of infant plaintiff in a toxic tort case on the grounds that “[w]hatever their admissibility at trial . . . the possibility remains that the [requested discovery] might lead to evidence related to plaintiff’s cause of action”).\footnote{540}{\textit{See infra} notes 584-596.}
A third circumstance in which relevance is apparent is when the litigation doctor does not testify but the testifying doctor relied on the litigation doctor’s X-ray reading as a basis for his diagnosis. Here, the defendants would be able to challenge the validity of the diagnosis if they had access to all of the litigation doctors’ X-ray readings for similarly screened litigants. These X-ray readings are often highly subjective and the evidence I have compiled indicates that the percentage of X-rays read as positive for fibrosis by litigation doctors is largely a function of financial incentives.\textsuperscript{541} Having access to the totality of that litigation doctor’s X-ray readings could enable the defendant to show, for example, that his percentage of positive X-ray readings far exceeds any medically plausible percentage as indicated by clinical studies. Fourth, even if the testifying doctor did not rely on any of the medical records produced by the litigation doctor who had read the litigant’s X-ray at a screening, obtaining the full panoply of that litigation doctor’s screening records could enable defendants to make a credible if not compelling case that the claim before the court is, to use the words of Judge Janis Jack, one of thousands generated by “lawyers, doctors and screening companies who were all willing participants” in a scheme to “manufacture. . . [diagnoses] for money.”\textsuperscript{542}

The gist of the “undue burden” argument is that because of the broad scope of the requests, production of the documents would subject the plaintiffs to an undue burden or hardship.\textsuperscript{543} This argument is unsustainable since the Federal Rules provide that a party seeking discovery of the other party’s experts must pay that expert for his time and expense in complying

\textsuperscript{541} See Brickman, \textit{Disparities, supra} note 12, at 524-30.
\textsuperscript{542} 398 F. Supp. 2d at 635.
\textsuperscript{543} See, e.g., Response & Brief in Support of Response of Jay Segarra, M.D., to Defendants’ Combined Motion & Brief to Compel Response to Subpoena to Jay Segarra, M.D. and Combined Motion and Brief in Support of Motion of Jay Segarra, M.D., to Quash or, in the Alternative, Modify Subpoena to Jay Segarra, M.D., at 6, Sept. 13, 2006, \textit{In re: Asbestos Products Liability Litigation} (No. VI), MDL 875, U.S.D.C., E.D. PA. (“Compliance with the terms of the subpoena would also be unduly burdensome and Dr. Segarra anticipates it would take at least two (2) months to comply with the requests in the subpoena.”).
with the request. That payment largely alleviates the burden. Furthermore, the court has discretion to protect against unduly burdensome requests by issuing a protective order.

The “work product” privilege argument is based on Federal Rule 26 (b)(3) which limits discovery of documents in the possession of agents of the other party to where there is a “substantial need” of the materials and the party seeking discovery will face undue hardship to obtain equivalent documents elsewhere. This work product privilege, which applies to documents and other tangible things prepared in anticipation of litigation or for trial, “shelters the mental processes of the attorney, providing a privileged area within which he can analyze and prepare his client’s case.” The argument is that the medical reports of a litigation doctor which were prepared for litigants who are not plaintiffs in that individual litigation are work product prepared at the request of counsel and are therefore protected from discovery in that case. Accordingly, these reports are afforded “near absolute protection from discovery” and requires a showing of “rare and exceptional circumstances” to overcome.

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544 FED. R. CIV. PROC. 26(b)(4)(C) (requiring that the party seeking discovery “pay the expert a reasonable fee for time spent in responding to discovery.”). In rejecting a claim of undue burden in the Silica MDL, Judge Jack relied on this exact argument and noted that “any burden imposed on the doctors should be mitigated by the requirement of Federal Rule of Civil Procedure 26(b) (4) (C).” MDL 1553, 398 F. Supp. 2d 563, Order No. 17 (Dec. 2, 2004).

545 FED. R. CIV. PROC. 26 (c)(1) (“The court may, for good cause, issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense.”).

546 Subject to the provisions of subdivision (b)(4) of this rule, a party may obtain discovery of documents and tangible things otherwise discoverable under subdivision (b)(1) of this rule and prepared in anticipation of litigation or for trial by or for another party or by or for that other party’s representative (including the other party’s attorney, consultant, surety, indemnitor, insurer or agent) only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the party’s case and that the party is unable without undue hardship to obtain the substantial equivalent of the materials by other means.


548 For example, in the silica MDL, N&M, a screening company that had generated most of the claims in the MDL, argued inter alia, with regard to producing records of all medical testing
The medical reports prepared by litigation doctors, however, do not reflect or reveal a
counsel’s mental processes and are arguably therefore not work product. Even if the reports are
deemed work product, defendants have a “substantial need” for the reports and “are unable
without undue hardship to obtain the substantial equivalent. . . by other means.” This
argument is further developed in the paragraphs that follow.

The “consulting expert” privilege claim, a kissing cousin of the work product argument,
is based upon Federal Civil Procedure Rule 26(b)(4)(B) which requires a showing of
“exceptional circumstances” for a party to obtain discovery of a consulting expert, that is, an
expert retained by another party in anticipation of litigation but who is not expected to be called
to testify. Litigation doctors who have provided medical reports for plaintiffs in that case but
who are not going to be called to testify argue that they are merely consulting experts and that

performed by N&M for plaintiffs in the MDL, that plaintiffs’ counsel had instructed N&M not to produce
the records because they were protected by the work product doctrine, since the work N&M did was at
the request of counsel in preparation for litigation. See Motion For Protective Order, Oct. 8, 2004, In re
Silica Products Liab. Litig., No. MDL 1553, 398 F. Supp. 2d at ¶10 (U.S.D.C. S.D. Miss.)

Add discussion of each argument: HIPPA; something else, Work Product -- consulting expert.
Judge Jack denied re consulting expert. Also B&B refuted in brief -- use brief.

549 In re Cendant Corp., 343 F.3d at 663, citing In re Ford Motor Co., 110 F.3d 954, 962 n.7
(2d Cir. 1997).

550 In re Cendant, 343 F. 3d at 663.
552 A party may, through interrogatories or by deposition, discover facts known or
opinions held by an expert who has been retained or specially employed by
another party in anticipation of litigation or preparation for trial and who is not
expected to be called as a witness at trial only as provided in Rule 35 (b) or upon
a showing of exceptional circumstances under which it is impracticable for the
party seeking discovery to obtain facts or opinions on the same subject by other
means.

F.R.C.P. 26(b)(4)(B).

553 The principal reason why litigation doctors, in recent times, are rarely used as testifying
experts is precisely because of the concern that that may open the door to discovery of that doctor’s X-ray
readings done in the course of screenings and diagnoses of other screened litigants. See, e.g., Special
Master’s Report No. 13 at ¶6, Fairley v. Pulmosan Safety Equipment Co., et al., Civil Action No. CI-
2004-001-SI, Circuit Ct., Jackson Cty., Miss. (Dec. 21, 2006). Because many of the litigation doctors’
thousands of X-ray readings have gained a reputation for being suspect at best, plaintiffs’ lawyers seeking
to maintain the financial viability of these claims, hire another doctor, as yet untainted, to re-read the X-
no “exceptional circumstances” exist because the defendants seeking discovery can have their own experts analyze a plaintiff’s medical record or injuries and thereby at least adequately defend each individual claim.\footnote{554} \textit{A fortiori}, they argue that the medical reports they prepared for litigants in other proceedings are not discoverable.

The “consulting expert” privilege argument has been held to effectively insulate a litigation doctor’s medical reports of litigants that are not named in that proceeding from discovery.\footnote{555} The “consulting expert” privilege is less effective, however, in insulating medical reports of litigants when they are part of an aggregated proceeding such as an MDL from discovery. This is so because, depending upon the luck of the draw, the cases in the MDL may include several hundred and even several thousand plaintiffs for whom medical reports were provided by one of the litigation doctors. U.S. District Court Judge Janis Jack rejected the “consulting expert” privilege argument in MDL 1553 with respect to these medical reports but on limited grounds. She held that even though plaintiffs’ lawyers identified those doctors as non-testifying experts, since the plaintiffs had listed the litigation doctors’ reports in response to her order that each plaintiff produce a diagnosis of a silica-related disease, that was the equivalent of testimony and thus the litigation doctors were not limited to being consulting experts with regard to claims in that MDL.\footnote{556}

\footnote{554} As argued by Dr. Segarra in moving to quash a subpoena for his medical records in screened cases: “There is nothing in the Federal Rules of Civil Procedure or any other authority that would permit . . . [defendants] access to such information, and to order Dr. Segarra to produce this information would be to ignore the clear language of the Federal Rules of Civil Procedure.” Segarra Response, supra note 514, at 9.


\footnote{556} See MDL 1553, 398 F. Supp. 2d 563, Order No. 17 (Dec. 2, 2004) (noting that ten motions to quash subpoenas for the records of litigation doctors who provided medical reports for the approximately 10,000 plaintiffs in the MDL had been filed, and rejecting the arguments advanced that the
By analogy, this argument can be extended to apply to individually litigated cases where the litigation doctor is again not designated as a testifying expert but where his reports were the basis for filing claims for that litigant with asbestos bankruptcy trusts. Indeed, it is a virtual certainty that most litigation doctors’ medical reports were the basis for the several million claims filed with asbestos bankruptcy trusts. According to Judge Jack, that is the substantial equivalent of testimony. Thus those non-testifying litigation doctors should be subject to discovery in a case filed in the tort system where the plaintiff had previously submitted claims to a bankruptcy trust supported by that litigation doctor’s medical reports.

Alternatively, the fact that a doctor who is not named as a testifying expert, has read a litigant’s X-ray or rendered a diagnosis of asbestosis, and this was the basis for filing claims for that litigant with asbestos bankruptcy trusts, is an “exceptional circumstance” under Rule 26(b)(4)(B), thus allowing for his discovery by defendants. This issue was posed squarely in the asbestos MDL. Defendants had noticed the deposition of Dr. James C. Krainson, a litigation doctor who issued a diagnosis for one of the litigants in the MDL but who was not designated as

subpoenas subject the doctors to an undue burden, violate HIPAA and are inappropriate requests to “consulting-only experts.” With respect to the latter, Judge Jack stated:

Finally, Plaintiffs’ argument that the subpoenas are inappropriate requests to “consulting-only experts” is grounded on Federal Rule of Civil Procedure 26(b) (4) (B)’s admonition that discovery may not proceed against non-testifying experts “retained . . . by another party” without a showing of “exceptional circumstances under which it is impracticable for the party seeking discovery to obtain facts or opinions on the same subject by other means.” However, plaintiffs have failed to establish the prerequisites for the application of this rule.”

More importantly, plaintiffs cannot have it both ways: they cannot present these [litigation] doctors as the sole physicians diagnosing the injuries that form the bases of these suits while simultaneously claiming that they are merely non-testifying experts. In other words, so long as Plaintiffs are proffering the doctors and their diagnoses to fulfill this Court’s requirement under Order No. 6 that Plaintiffs produce diagnoses of silica-related disease, Plaintiffs cannot claim the doctors are non-testifying.

*Id.* at 2-3.
a testifying expert.\textsuperscript{557} The importance of the deposition of Dr. Krainson, whom defense counsel charged “was involved in a significant amount of fraudulent screening,”\textsuperscript{558} is manifested by the fact that the plaintiffs offered to dismiss those defendants seeking to depose Dr. Krainson, “with prejudice” rather than go forward with the deposition.\textsuperscript{559} Plaintiff moved to quash the deposition of Dr. Krainson on the basis that he was a non-testifying expert and there had been no showing of exceptional circumstances as mandated by Rule 26(b)(4)(B).\textsuperscript{560} Defense counsel responded that Dr. Krainson’s reports were the basis for filing a claim with the Manville Trust\textsuperscript{561} and that documentary evidence produced by Dr. Krainson in response to a subpoena “show[ed] that he had fraudulent and suspect activity throughout the United States in several cases including. . . [plaintiff’s] that are before this Court.”\textsuperscript{562} Judge James T. Giles, presiding over the asbestos MDL, found “that there are exceptional circumstances,” including the fact that the plaintiff had relied on Dr. Krainson’s diagnosis in making a claim against the Manville Trust.\textsuperscript{563} Judge Giles added: “[T]his court has jurisdiction to make sure that all claims that are filed against defendant’s asbestos claims are legitimate.”\textsuperscript{564}

The next step in this progression is to seek discovery of a non-testifying litigation doctors’ medical reports prepared for screened litigants not before the court where that doctor read the X-ray or rendered a diagnosis of the litigant before the court but is not designated as a testifying expert. Rule 26(b)(4)(B)’s policy basis for precluding unreasonable access to an

\textsuperscript{557} See Transcript of Telephone Conference Before The Honorable James T. Giles, U.S. District Court, April 1, 2008 at 7, In re: Asbestos Products Liability Litigation (No. VI), MDL 875 (E.D. Pa.) (hereafter TR. of 4/1/08).
\textsuperscript{558} Id.
\textsuperscript{559} Id. at 6.
\textsuperscript{560} Id. at 5, 9.
\textsuperscript{561} Id. at 10.
\textsuperscript{562} Id. at 11.
\textsuperscript{563} Id. at 17.
\textsuperscript{564} Id.
opposing party’s trial preparation does not support precluding access to a litigation doctor’s reports for other screened litigants where that expert has unique knowledge that the defendant is unable to otherwise acquire: the litigation doctors’ percentages of positive X-ray readings and diagnoses. A case in point is Dr. Jay T. Segarra, one of the most prolific of the X-ray readers and diagnosing doctors in asbestos litigation. Dr. Segarra’s response (by counsel) to a demand for the totality of his screening reports effectively demonstrates both the unique knowledge that he has that the defendants are unable to otherwise acquire and why that qualifies as an exceptional circumstance under Rule 26: “The one thing the Defendants do not have [and cannot have] are copies of Dr. Segarra’s negative reports.” Access to these reports would permit calculation of Dr. Segarra’s or other litigation doctors’ percentages of positive diagnoses. This information could be the basis for: (1) a motion in limine to exclude that doctor as a testifying expert witness because his diagnoses are unreliable; (2) impeaching that doctor’s testimony by showing that his percentage of positive diagnoses varies substantially from that indicated by clinical studies of that occupational group and, if applicable, the considerable variance between the percentage of positive diagnoses that the doctor has previously claimed and the much higher

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565 See Charles Alan Wright & Arthur R. Miller, et al., Federal Practice and Procedure § 2032 (2007). A party expecting to call an expert witness to testify is subject to various disclosure and discovery rules by the Federal Rules of Civil Procedure. See Fed. R. Civ. P. 26(a)(2); see also supra notes 533-542 and accompanying text (discussing the role of determinations of relevance in limiting the discovery of expert witnesses to the single case before the court). In contrast, a non-testifying or consulting expert is an expert that is retained in anticipation of litigation by a party for consultation but is not expected to testify at trial. Fed. R. Civ. P. 24 (b)(4). These experts are excepted from the discovery requirements in order to prevent parties from unfairly availing themselves of their opponents’ trial preparation. See, e.g., Hartford Fire Ins. Co. v. Pure Air on the Lake, Ltd., 154 F.R.D. 202, 210 (N.D. Ind. 1993) (holding that allowing discovery of a non-testifying expert report “is contrary to the intent of the Rule which is to prevent ‘one party from having a free ride at the expense of the other party.’”) (quoting In re Shell Oil Refinery, 132 F.R.D. 437, 443 (E.D. La. 1990)).

566 See Brickman, Disparities, supra note 12, at 526-529 note 35 for a description of Dr. Segarra’s role in litigation screenings.

percentage that access to his records could show; \(^{568}\) (3) impeaching the plaintiff’s testifying medical expert if he is not one of the litigation doctors but has based his diagnosis on that litigation doctor’s B reading; \(^{569}\) and (4) making a credible if not compelling case that the claim before the court was one generated by lawyers, doctors, and screening companies as part of a scheme to “manufacture. . . [diagnoses] for money.” \(^{570}\) Dr. Segarra’s candid proclamation attests to the importance of this information and therefore why it should be held to qualify as an “exceptional circumstance” exception to Rule 26(b)(4)B’s limitation on discovery. \(^{571}\)

The importance of this information is further made manifest by the results of the discovery allowed by Judge Jack in MDL 1553. Without this discovery, Judge Jack could not have found that certain litigation doctors’ diagnoses of thousands of plaintiffs in the MDL were unreliable because they were “manufactured for money.”

A sixth argument that can be advanced by plaintiffs’ counsel in support of their opposition to discovery of the litigation doctors’ records is that the doctor was informally consulted in preparation for a trial but was never retained or specially employed and will not be a trial witness. Therefore under Fed. Rule 26(b)(4), neither the names of such persons nor their information is subject to discovery. \(^{572}\)

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\(^{568}\) See Brickman, Disparities, supra note 12, at 526-529, n. 35 listing multiple reasons to question Dr. Segarra’s probity.

\(^{569}\) Cf. id. at 587 n. 257.

\(^{570}\) 398 F. Supp. 2d at 635.

\(^{571}\) See Braun v. Lorillard Inc., 84 F.3d 230, 236 (7th Cir. 1996) (allowing discovery of plaintiff’s non-testifying experts’ negative test results in a products liability suit for asbestos in cigarette filters because it would be impossible to find whether there were fibers in the samples tested by plaintiff’s testifying expert otherwise).

\(^{572}\) See CHARLES ALAN WRIGHT & ARTHUR R. MILLER, ET AL., FEDERAL PRACTICE AND PROCEDURE § 2033 (2007); Proctor & Gamble Co. v. Haugen, 184 F.R.D. 410 (D.C. Utah, 1999); Ager v. Jane C. Stormont Hospital & Training School for Nurses, 622 F.2d 496, 502 (10th Cir. 1980) (“If the expert is considered to have been only informally consulted in anticipation of litigation, discovery is barred.”).
This argument, however, has no applicability to litigation doctors’ records. This is so because either the law firm sponsoring the screenings or the screening company hired by the lawyer has retained the litigation doctor to read X-rays, supervise the administration of pulmonary function tests, and conduct physical examinations of potential litigants, albeit very brief ones. For these services, litigation doctors have been paid well in excess of $100 million. Accordingly, these doctors were retained and specially employed and therefore are not immune from identification or discovery on the basis of Fed. Rule 26(b)(4).

5. Litigation Doctors As Percipient Witnesses

Another counter to the argument that a nontestifying litigation doctor is a consulting expert and therefore protected by the work product privilege, is that the litigation doctor is, instead, a “percipient witness.” A doctor who has read an X-ray or examined an alleged injured party who is a litigant is a “percipient witness” because he has observed facts; that is, he is “[a] witness who has perceive[ed] the things about which he or she testifies.”

A typical example of a doctor who is a percipient (fact) witness is a treating doctor. These services were not rendered for the purposes of litigation and thus do not fall under Fed. Rule 26(b)(4) which “places limits on discovery of those insights only where they are developed for litigation. . . .” The treating doctor, therefore, is subject to wide ranging examination with regard to his services and his observations. Even if the litigation is a malpractice action

\[575\] WRIGHT & MILLER, supra note 565, at § 2033, p. 457.
\[576\] See Baker v. Taco Bell Corp., 163 F.R.D. 348, 349 (D. Colo. 1995) (“[The treating physicians] are witnesses testifying to the facts of their examination, diagnosis and treatment of a patient. It does not mean that the treating physicians do not have an opinion as to the cause of an injury based upon their examination of the patient or to the degree of injury in the future. These opinions are a
against a hospital and its professional agents, those agents of the named defendant who formulated professional opinions and made professional judgments in providing care to the plaintiff are subject to discovery as fact witnesses.577

Unlike treating doctors, litigation doctors are not hired to perform medical services. Rather, they are hired by lawyers or their agents to participate in screenings of potential litigants and produce reports to support litigation claims. Judge Giles in the asbestos MDL concluded that the screening work done for plaintiffs by Dr. James C. Krainson, a nontestifying litigation doctor, was not the practice of medicine. This is consistent with the position that all litigation doctors maintain that no doctor/patient relationship is created when they read an X-ray or render a diagnosis. They further stoutly maintain that they are providing litigation services, not medical services. Therefore, Judge Giles concluded that the doctor was not a medical expert for purposes of the litigation before the court and therefore could be required to provide testimony.578

Judge Giles ruling cuts right to the chase. A nontestifying litigation doctor has observed facts which are relevant to the case before the court. An examination of the role of litigation doctors in screenings further demonstrates why they are percipient witnesses, not consulting experts. Litigation screenings are conducted solely for the purpose of generating medical and occupational exposure information and documentation which are provided to diagnosing physicians (who may also be litigation doctors). At screenings, litigants disclose their medical histories which may be recorded by screening company personnel or by an on-site litigation

578 See TR of 4/1/08, supra note 557, at 13, 17-18. (In denying motion to quash the deposition of a litigation doctor, the Court found that “if what [the doctor] did was screening, he’s not really a medical expert... a plaintiff relied upon by him for making a claim... [the doctor] appears not to have been engaged in anything other than a screening as a non-medical person since he apparently was not holding himself out as a licensed practitioner.”)
doctor and later provided to a diagnosing physician. The screening companies administer chest
X-rays and on many occasions, perform pulmonary function tests (“PFTs”). The X-ray films,
PFTs, and physical examinations provide one-time snapshots of litigants’ then-existing medical
conditions. The screening companies may have an on-site litigation doctor interpret chest X-rays
and PFTs, conduct physical examinations, evaluate the exposure and medical histories and make
diagnoses. Alternatively, the screener may mail the chest X-rays, the collected medical and
exposure history information, the PFT reports, and physical examination reports to the litigation
doctor to review and render diagnoses. Some screening companies use a combination of these
two procedures by taking X-rays and having doctors conduct PFTs and physical examinations
on-site, but then forward their impressions and results to a diagnosing doctor for the actual
diagnosis. These on-site doctors are percipient witnesses in these circumstances.

The information, documentation, medical interpretations, reports and diagnoses generated
by screenings are often the sole basis for claims against a host of potential defendants and
asbestos bankruptcy trusts. These medical records are relevant to a variety of issues in these
lawsuits, including: (1) the accuracy of the diagnoses made; (2) the qualifications of the
screening personnel and doctors; (3) the reliability of the litigation doctors’ methodology and the
opinions they produce; (4) the reliability of the equipment and methodologies of screening
companies; (5) the thoroughness and quality of the screening process; (6) the measurement of the
extent of the alleged disease; (7) the progression of the alleged disease; (8) the accuracy of
litigants’ alleged impairment and related issues about prognoses based on pulmonary function
testing; and (9) the accuracy of alleged damages and disability.

A chest X-ray is, literally, a snapshot of an individual’s lungs at the time the X-ray is
taken. This creates a record of a one-time event showing the then-existing radiological status of
pulmonary health of the individual. Such records can never be duplicated. Moreover, even if subsequent X-rays are administered, prior X-rays are relevant to show the progression, or lack of progression, of any alleged disease over time. Because chest X-rays are generally required to make a diagnosis of asbestosis, a progressive lung disease, X-rays taken by screening companies are necessarily relied upon by doctors making the diagnoses. The relevance of chest X-rays is thus patent. Defendants are entitled to the X-rays and records relating to the interpretation of those X-rays, as well as the identity of the screening entities administering the X-rays and the identity of the doctors interpreting the X-rays in order to assess (1) the quality of the X-rays; (2) the reliability of the X-ray equipment and the procedures employed in shooting the X-rays; (3) the accuracy of the X-ray interpretations; (4) the qualifications of the technicians shooting the X-rays and the doctors interpreting the X-rays; and (5) the reliability of the methodology of the screening process, X-ray interpretations and the reasonableness of the diagnoses.

Similarly, a PFT measuring lung function provides a snapshot of a plaintiffs’ lung function and any impairment at a given time. As with X-rays, PFTs cannot be later duplicated to show the medical condition of the litigants at the moment of the previous administration. Plaintiffs submit PFTs to support their allegations of impairment and as a measurement of the degree of injury suffered and therefore the amount of compensation sought. Similarly, PFT results and records, as well as the identity of the screening entity, the methods employed during testing, the PFT records, including all values and graphs, and the doctors’ interpretations of the PFT results are relevant to litigants’ claims and may provide information that leads to reasonable alternative explanations of litigants’ medical conditions.

While it is clear that attorneys hire these screening companies and litigation doctors (or other physicians interpreting screening-generated materials) to make diagnoses of asbestosis as
the basis for asserting claims in the tort system, that fact alone is not determinative of whether the records generated pursuant to that arrangement are protected as attorney work product. The purpose of the attorney work product privilege is to “shelter the mental processes, conclusions, and legal theories of the attorney, providing a privileged area within which the lawyer can analyze and prepare his or her case.”579 The protection afforded by attorney work product, however, “does not extend to facts of the case the attorney may acquire.”580

The medical facts recorded in the documents generated by screenings do not contain mental processes, conclusions, or legal theories of the attorneys. This is so because the litigation doctors were not hired for consultation purposes; they were hired to provide diagnoses. The screening generated documents simply are medical records that record the physical conditions and/or statements of litigants about their medical condition and exposure and which include X-rays, PFTs, X-ray readings and diagnoses. The consulting-only expert and attorney work product claim therefore does not shelter the litigation doctors or the requested information from discovery.581

As noted, this argument was successfully advanced before U.S. District Court Judge James T. Giles in the asbestos MDL in response to the motion to quash the deposition of Dr. James C. Krainson.582 Dr. Krainson had issued medical reports for the litigant but was not designated as a testifying witness. Counsel for the defendant successfully argued that the deposition should be allowed to go forward because Dr. Krainson is “a fact witness in this case.

580 Id. (citing, supra, at note 2).
581 See Teran v. Longoria, 703 S.W.2d 300, 300 (Tex.App.CCorpus Christi 1985 orig. proceeding) (“If a medical expert is hired for a purpose other than as a trial consultant, such as for examination and treatment, or for consultation in connection with improving the health of the person, his or her identity and records are not protected from discovery.”)
582 See supra note 578.
He was there when... [plaintiff’s] claim was created. He was there when [plaintiffs] went through these screenings, he was there to see the procedure... He knows how... [plaintiff’s] claim was created from beginning to end. There’s nobody else who can testify to that, he’s the only one.”  

The final step in the discovery process is to allow a defendant to discover a nontestifying litigation doctor’s medical reports in cases not before the court. The fact that the litigation doctor diagnosed a substantial percentage of screened litigants with asbestosis, for example, can be relevant to the veracity of the records he caused to be created with regard to the individual litigant or litigants before the court. The relevance -- indeed the immense importance -- of such discovery is fully revealed in litigation ongoing in Wayne County, Michigan. Dr. R. Michael Kelly is a testifying expert who rendered diagnoses in 70 of the 83 asbestos cases that made up the May 2008 trial group. The defendant moved to compel Dr. Kelly to respond to questions about diagnoses of asbestosis that he rendered for over 4000 other litigants that he screened who were not part of the 83 cases that were in the trial group. Prior to March 2006, Dr. Kelly obtained X-rays for asbestos screenings from Sparrow Hospital in Lansing, Michigan where he was employed. Each set of chest X-rays that Dr. Kelly ordered were read by a hospital radiologist and these reports were provided to Dr. Kelly with the X-ray. The defendant reviewed 1,795 cases where there was both an X-ray interpretation of the same film by Dr. Kelly.

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583 TR. of 4/1/08, supra note 557, at 12.
585 See Brief In Support of Motion To Compel The Completion of Dr. R. Michael Kelly’s Deposition And for Court’s Ruling On Objections Made At Deposition, at 9, April 30, 2008, Garza et al. v. Sure Seal Prods. Co.
586 Id. at 9.
587 Id.
and one of the 50 different hospital radiologists who read the 1,795 films. This review indicated that in 89% of the cases where Dr. Kelly found evidence of asbestos-related disease, the hospital radiologists made no such findings.

A side-by-side comparison of one set of X-ray reports indicates the following: Dr. Kelly: “the chest X-ray is reviewed from films taken on 05/03/05. There are bilateral increased interstitial markings. The ILO reading is 1/1 with s and t-sized irregular opacities in both lower lung fields. There is pleural plaquing bilaterally, grade B3.” The hospital radiologist report for the same X-ray states: “The lungs are clear. . . . No pleural abnormality is demonstrated."

Only in 5% of the cases where Dr. Kelly found asbestos-related disease on an X-ray (interstitial fibrosis and/or pleural plaques or thickening) did any of the 50 hospital radiologists who had interpreted the same X-ray films, find evidence of interstitial fibrosis. Of the 70 of 83 cases in the trial group where he is serving as plaintiffs’ expert, there are 58 cases where Dr. Kelly and a hospital radiologist each reviewed the same X-ray. In 53 of these 58 cases, the hospital radiologist found no evidence of the asbestos-related disease that Dr. Kelly found. Dr. Kelly testified that the differences resulted because he uses the NIOSH B Reader format whereas the hospital radiologists do not. Dr. Kelly, however, is not a NIOSH certified B Reader, having failed the exam the only time he sat for it following a two-day class that he attended in 1989. Moreover, the ILO system that Dr. Kelly is referring to is a method of

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588 Id. at 10-11.
589 Id. at 11.
590 See Report of Dr. Kelly to the Goldberg, Persky & White law firm, July 18, 2005, on file with the author.
591 See Hospital radiologist report of 05/03/05 on file with the author.
592 Brief, supra note 585, at 11.
593 Id. at 9.
594 See supra notes 48-49.
595 Brief, supra note 585, at 10.
596 Id.
classifying lung opacities. Whether or not the ILO classification system is used should have no bearing on whether or not a radiologist finds interstitial fibrosis.

It should also be pointed out that a hospital radiologist’s finding of radiographic evidence of interstitial fibrosis is not a diagnosis of asbestosis. There are more than a hundred different causes of interstitial fibrosis besides asbestos exposure, including aging, smoking, obesity and the use of certain medications. Clinical studies indicate that approximately 25% of those occupationally exposed to asbestos who have interstitial fibrosis may properly be diagnosed with asbestosis.

Dr. Kelly has refused to answer questions about any of his diagnoses beyond the 70 in the trial group. When the defendant sought to compel a response, Judge Robert J. Columbo ruled that Dr. Kelly cannot be questioned about any cases beyond the 70 where he was serving as plaintiffs’ expert.

While Dr. Kelly was a testifying expert, the same facts and conclusions to be drawn from those facts would be present if Dr. Kelly was not designated as the plaintiffs’ testifying expert but had provided medical reports for any of the litigants.

Judge Columbo’s rulings may be incompatible with the goal of preserving the integrity of the civil justice system. One effect of courts’ refusals to allow discovery of a litigation doctor’s records of screened litigants who are not parties in that proceeding may be to envelope a scheme to generate specious claims in procedural protections. If that were the case here, then the effect of Judge Columbo’s ruling may be to keep from public disclosure the very evidence that Judge

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597 See Brickman, Disparities, supra note 12, at 64-65.
598 Id.
599 Motion, supra note 585, at 5.
Jack compelled to be produced -- evidence that was the basis for her conclusion that the civil justice system had been corrupted.

B. The Role of Bankruptcy Courts in Legitimizing Litigation Screenings

One consequence of the failure of the civil justice system to permit mass tort defendants to expose the specious claim generation if not outright fraud that permeates litigation screenings is the ineluctable bankruptcy of most of the companies named as defendants by the lawyers representing the hundreds of thousands of claimants generated by the screenings. However unintentional, bankruptcy courts have effectively legitimated the use of litigation screenings in a variety of ways. For example, these courts have inhibited debtors’ and commercial creditors’ ability to contest the basis for the mass tort litigation by precluding or inhibiting a trial on general causation. A second form of legitimation is these courts’ refusals to permit or order a formal review of a sample of the medical records of pending claimants that would be needed to show that the medical reports were unreliable and had been manufactured for money.

In the silicone breast implant litigation, as discussed in section VI of this article, after a $4.2 billion class action settlement was reached, lawyers instituted litigation screenings that ballooned the number of claimants by over 400,000, to a total of 440,000. With the settlement about to implode, Dow Corning filed for bankruptcy apparently with the hope that the bankruptcy proceeding would enable it to get a quick-up-or-down ruling on the issue of general causation based on epidemiological data that had been developed indicating that silicone breast

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602 In re Dow Corning Corp., 86 F. 3d 482, 485, 486 n. 2 (6th Cir. 1996).
implants did not cause auto immune disease.\textsuperscript{603} The bankruptcy court, however, declined to permit a general causation trial at the outset. Had it done so, and had it approved appointment of an independent panel of experts under Rule 706 of the Federal Rules of Evidence to advise the court on the scientific validity of the plaintiffs’ experts’ theories on general causation – as did U.S. District Court Judge Robert E. Jones\textsuperscript{604} — and on that basis, excluded plaintiffs’ experts in a \textit{Daubert} proceeding because the theories they advanced lacked scientific credibility, then Dow Corning would have prevailed. Instead, the outcome enriched the plaintiffs’ lawyers who undertook the screenings by hundreds of millions of dollars in addition to the hundreds of millions of dollars they received from the other settling defendants.

Undoubtedly the highest rewards approved or facilitated by bankruptcy courts for specious claims generated by litigation screenings have occurred in asbestos related bankruptcy proceedings. Indeed, litigation screenings have played a prominent role in most of the eighty bankruptcy filings of companies that had been involved in asbestos litigation.\textsuperscript{605} At the time of each bankruptcy, large numbers of asbestos injury claims are pending, mostly generated by screenings. Frequently, plaintiffs’ lawyers enter into settlements of these pending cases either immediately before the bankruptcy filing or shortly thereafter, which provide for preferential treatment of their pending cases. In an indication that some bankruptcy judges are departing from the “business as usual” approach to asbestos bankruptcies, Bankruptcy Judge Kathryn C.

\begin{footnotes}
\item[603] See NAGAREDA, MASS TORTS, \textit{supra} note 1, at 35-36.
\end{footnotes}
Ferguson recently refused to confirm a plan of reorganization in the Congoleum bankruptcy because it violated the bedrock principle of equality of distribution.\footnote{Opinion Resolving Motions And Cross Motions For Summary Judgment On Confirmation Of Joint Plan Of Reorganization Dated As Of February 5, 2008, June 5, 2008, In re Congoleum Corp., et al., No. 03-51524 (Bankr. D. N.J.).}

In an asbestos bankruptcy, the assets from which pending and future claims will be paid are transferred to a trust set up under §524(g) of the bankruptcy code.\footnote{See Brickman, *Ethical Issues In Asbestos Litigation*, supra note 47, at 862.} The amount set by the bankruptcy court that will need to be transferred to the trust is determined in the course of an estimation proceeding\footnote{"If contingent claims are to be treated and discharged in bankruptcy, somehow their value must be estimated and they must be included in and provided for in the bankruptcy plan." See DAVID G. EPSTEIN, ET AL., *Bankruptcy §11-5* (West Publishing 1993). Section 502(c) of the Bankruptcy Code allows the Court to “estimate[ ] for purpose of allowance... any contingent or unliquidated claim, the fixing or liquidation of which, as the case may be, would unduly delay the administration of the case.” Congoleum Holdings, Inc. (In re G-I Holdings, Inc.), 295 B.R. 211, 218 (D.N.J. 2003) (quoting 11 U.S.C.A. § 502(c)).} largely on the basis of testimony by a small coterie of professional experts who regularly appear in asbestos bankruptcies and provide “cookie cutter” reports and testimony on behalf of the asbestos tort claimants and the future claimants. These professional experts’ expertise is in asbestos settlement behavior. They use pre-bankruptcy settlements as dispositive evidence of the debtor’s liability for pending and future claims. Notably missing from their expertise and testimony is how exposure to asbestos causes disease, the level of exposure needed to cause disease, and the density and duration of exposure experienced by pending claimants and others who used the debtor’s products. Most bankruptcy courts have approved this method by which the liability of the debtor for pending and future claims is simply assumed based on historical settlement practices, sometimes with some adjustments, rather than...
requiring that the estimation be based on the intrinsic nature of the debtor’s products, the levels of exposure of users of the product and other criteria related to disease causation.609

This method allows the professional experts and the court to dispense with the issue of causation including whether a pending claimant was actually exposed to the debtor’s products, whether these products contained a respirable form of asbestos, whether the exposure was of sufficient density and duration to have caused the diagnosed disease, whether the claimant had an asbestos related disease diagnosed by a doctor using reliable methods, and whether the occupational and medical history relied on by the diagnosing doctors was taken by that doctor or even by a medically trained person who was not in the direct or indirect employ of the lawyers. Instead this estimation procedure simply assumes for purposes of valuing pending and future claims, that if a pre-bankruptcy claim had been settled, then that indicates that there was causation irrespective of whether the elements of causation, as listed above, were present and irrespective of whether a substantial portion of settled claims were specious if not fraudulent and relied on medical reports of some litigation doctors who, along with some screening company principals, have subsequently refused to testify about how diagnoses were produced, citing their Fifth Amendment rights against self-incrimination.610

This estimation method is inconsistent with section 502 of the Bankruptcy Code which provides that state law governs the substance and validity of claims,611 but that claims that are


610 See Brickman, Disparities, supra note 12, at 586, n. 256.

611 See 11 USC §101(5) (A) (2005)). “The claims being valued arise under state law, hence state law determines their validity and value. The basic federal rule in bankruptcy is that state law governs the substance of claims, Congress having generally left the determination of property rights in the assets of a bankrupt's estate to state law. The same principle applies to estimation proceedings under § 502(c) [of the Bankruptcy Code],” See Owens Corning, 322 B.R. at 721-2. “If claims are substantively valid under state law they may not be effectively denied by indefinite postponement without violating the rule
“unenforceable against the debtor and property of the debtor under . . . applicable law” must be disallowed. Bankruptcy courts have effectively held that if fraudulent claims were settled, even en masse, then pending and future fraudulent claims are in accord with state law. No state statute or decisional law, however, provides that a tort claim is valid in the absence of proof of the elements of causation as listed above. By validating the use of retained experts’ reliance on past settlements rather than any assessment of disease and causation to establish both liability and the value of claims, bankruptcy courts have effectively endorsed the litigation screenings that generated the large majority of the pending claims despite the considerable evidence reviewed here that the large majority of these claims are meritless and the product of a scheme to manufacture them for money.

To estimate future claims, these professional experts project the number of future mesothelioma claims, based largely on epidemiological data, then determine from historical evidence the propensity of those stricken with that disease to sue the debtor. These

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See e.g. Owens Corning v. Credit Suisse First Boston, 322 B.R. 719, 722, 724 (D. Del. 2005) (having established that the validity of the projections provided is to be determined in accordance with state law and “on the basis of what would have been a fair resolution of the claims [in the state tort law system] in the absence of bankruptcy.” Judge Fullam refused to discount the estimation provided by the tort claimants’ lawyers’ experts despite the fact “that, in the past, non-meritorious claims may have been generated as a result of intensive “marketing” efforts by law firms….“); In re: USG Corp., 290 B.R. 223, 225 (D. Del. 2003) (stating that the court lacks discretion “as to the application of federal or state substantive law to the merits of the claims themselves” and therefore in accordance with “an unbroken line of authority…state law claims remain governed by state law, even after the debtor invokes federal bankruptcy protection.”)

“Several epidemiological studies aimed at projecting total [incidence of mesothelioma] in the United States were conducted in the late 1970s and 1980s. Each of these studies predicted the number of [mesothelioma] cases or deaths expected to occur in the future among persons occupationally exposed to asbestos over the previous several decades. Litigators still use the study by Nicholson et al. (1982) [Nicholson, Perkel & Selikoff, Occupational Exposure to Asbestos: Population at Risk and Projected Mortality – 1980-2030, AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 3:259-311 (1982)] as the
estimations tend to conflate other cancer claims, including lung cancer, with the projection of mesothelioma claims. This same process, however, cannot be used to project nonmalignant claims, mostly asbestosis, because there is no epidemiological basis for doing so. To overcome this hurdle, the professional experts invariably base their projections of the future number of asbestosis claims on the past ratios of asbestosis claims to mesothelioma claims filed against the debtor or on ratios of nonmalignant to malignant claims, adjusted for a variety of projected conditions -- not on the disease criteria discussed above. Here, too, these experts assume that the pre-bankruptcy settlements entered into by the debtor of nonmalignant claims are proof that the elements of causation listed above were met even though there is considerable evidence that these claims were not settled on the basis of their merits but rather were the product of mass filings. Nonetheless, based on historical settlement patterns, these experts calculate a ratio, referred to as the “nonmalignant multiplier,” which is the ratio of nonmalignant to malignant claims that they project would be the case if the debtor had remained in the tort system.

Separating out the mesothelioma claims from the lung cancer and “other cancer” claims in these calculations and also separating out asbestosis claims from other nonmalignant claims, mostly pleural plaque claims, yields a ratio/projection, by these experts, of approximately 10 times as many asbestosis claims as mesothelioma claims.\(^{615}\) This method of claim projection is used to

\(^{615}\) See e.g. Expert Report of Mark A. Peterson, J.D., PH.D., at 37 (Nov. 29, 2004), In Re: Federal Mogul Global, Inc., et al., 330 B.R. 133, 293 B.R. 124 (D. Del. 2005). (In his expert report, Dr. Peterson explained that he generated the nonmalignant multiplier by calculating the ratio of nonmalignant claim filings to cancer claim filings during a given year. The results of this calculation provided him with a ratio of 10.19 nonmalignancy claims filed for every cancer claim. He then estimated the number of nonmalignancy claims that will be filed in a future year by multiplying the already established projection of future cancer claims for that year by the nonmalignant multiplier; Supplemental Expert Report of Dr. Robin A. Cantor at 26 (April 26, 2005), In Re: Federal Mogul Global, Inc., et al., 330 B.R. 133, 293 B.R. 124 (D. Del. 2005) (reporting that the weighted average of nonmalignant to malignant claims in the 1998-2001 period was 12.9:1); Report on Opinions and Support for Opinions of Mark A. Peterson, Re: Asbestos Liabilities of Babcock and Wilcox on June 30, 1998 and March 31, 1999 at 20 (indicating that
generate the highest possible numbers of asbestosis claims and therefore the highest possible transfers of assets into the ensuing asbestos bankruptcy trusts for distribution to pending and future claimants and their lawyers.

The work of these professional experts, who rely on settlement practices to project disease, is belied by recently compiled data on the incidence of asbestosis. To counter the professional experts’ reliance on a so-called nonmalignant multiplier as a substitute for an epidemiological basis for projecting asbestosis, the debtor in the W.R. Grace Company bankruptcy, retained an expert, Dr. Howard Ory, to conduct an epidemiological study of the incidence of asbestosis.616 Using the General Practice Research Database (GPRD),617 which is

the nonmalignant to malignant multiplier for Babcock v. Wilcox for the 1992-1994 period was 12.376 and for 1995-1997 it was 14.245; Mark A. Peterson, Findings Re: Liability of H.K. Porter for Future Asbestos Personal Injury Claims at 4 (Jan. 6, 1994) (stating “that across time and for every asbestos defendant the number of nonmalignancy claims is a fairly stable multiplier of the number of cancer claims: approximately 7 nonmalignancy claims for every cancer claim.” See also Email from CRMC, Manville Personal Injury Settlement Trust: Breakdown of Claim Filings for Selected Diseases (Primary Disease Only), Dec. 12, 2007 (on file with author) [hereafter, Manville Trust Claim Filings] (according to data provided by the CRMC, the total number of nonmalignant claims filed with the Manville Trust during the 1988-2002 period was 480,140 compared to 93,977 malignant claims, a ratio of approximately 5:1. During that period, 380,515 asbestosis claims were filed with the Manville Trust, compared to 23,812 mesothelioma claims, a ratio of approximately 16:1); CARROLL ET AL., ASBESTOS LITIGATION, supra note 605, at 71 (Table 4.1). RAND reports that for the period 1988 – 2002, there were a total of 567,507 nonmalignant claim filings and 67,828 malignant claim filings (of which 21,323 were for mesothelioma), a ratio of approximately 8.4:1 of nonmalignant to nonmalignant claims. RAND does not break out the number of asbestosis claims from the nonmalignant total. However, Manville Trust data indicates that approximately 80% of nonmalignant claims that were filed with the Trust were for asbestosis. See infra note 622. Applying that percentage to the RAND data indicates that of the 567,507 nonmalignant claim filings filed in the 1988-2002 period, approximately 454,000 were for asbestosis. Thus, the ratio of asbestosis to mesothelioma in the 1988-2002 period, on the basis of RAND data, was 21.3:1. While there is considerable variability in the ratios used for projection purposes in various expert reports of nonmalignant to malignant claims and asbestosis to mesothelioma claims, a 10:1 ratio of asbestosis to mesothelioma claims appears to be as close to a consensus ratio used in plaintiffs’ experts projections as can be obtained.


617 The database which, began in 1989, encompasses 3,000,000 people who are enrolled with selected general practitioners. For the period examined, 1989 through mid-2005, there were thus 30,000,000 person-years of epidemiologic observation. Id. at 11. The U.S. Food and Drug Administration has noted that “GPRD is the largest pharmacoepidemiologic database in the world with
collected from information in the United Kingdom and includes data on the diagnosis of disease. Dr. Ory concluded that the actual diagnosis-based asbestosis to mesothelioma ratio is 0.95; that is, in the period 1989 and 2005, for every 100 men diagnosed with mesothelioma, there were 95 men diagnosed with asbestosis. Based upon several U.S. databases, Dr. Ory determined that there were approximately 28,961 cases of men diagnosed with mesothelioma that occurred in the U.S. in the period 1989 through 2001. In that 1989-2001 period, RAND reports that there were approximately 493,000 claims filed for nonmalignant asbestos related conditions. Using W.R. Grace data to calculate the breakdown of nonmalignant claims into asbestosis and pleural plaques, Dr. Ory estimated that approximately 81% of these claims, 399,000, alleged asbestosis. On the basis of Dr. Ory’s epidemiological study, this result is 14 times greater than the number of medically plausible cases of asbestosis. Dr. Ory cites to additional evidence in support of his epidemiologically based ratio calculation including the scientific implausibility of the substantial rise in the number of asbestosis claims filed against defendants and asbestos bankruptcy trusts in the 1989-2001 period at a time when the overall incidence rates of mesothelioma had peaked and began to fall within that period.

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618 Id. at 15. Dr. Ory also concludes that the mesothelioma rate in England is twice the rate of that in the United States. Ory Report, supra note 616, at 35. Therefore, his calculated 0.95:1 ratio of asbestosis to mesothelioma overstates the number of medically plausible claims of asbestosis in the United States.

619 Id. at 17-20.

620 Id. at 21, citing to STEPHEN J. CARROLL et al., ASBESTOS LITIGATION 71 (Table 4.1) (RAND Institute for Civil Justice 2005)

621 This is virtually identical to the Manville Trust data. See supra note 307.

622 Ory Report, supra note 616, at 21, 23. Using Manville Trust data yields similar percentages in the 1988 – September 30, 2007 period; of the total 589,867 nonmalignant claims filed during that time, 472,870 or 80.17% claimed asbestosis. See Manville Trust Claim Filings, supra note 615.

623 See CARROLL et al., ASBESTOS LITIGATION, supra note 605, at 71 (Table 4.1) (showing a rise in the number of nonmalignant claims filed in the period between 1989 – 2001. According to the data provided by RAND, the number of nonmalignant filings in 1989 were 45,151 and by 2001, the number
Based on the 0:95:1 disease ratio, Dr. Ory concluded that there were 27,970 men in the United States who could plausibly have developed asbestosis during the years 1989-2001. As noted, however, there were approximately 399,000 asbestosis claims in that period. Assuming that each claim generated approximately $50,000 in settlements, then over $18.5 billion has been paid out for 70,000 specious asbestosis claims in the period 1989-2001. This estimate does not include the asbestosis claims filed in 2002-2005 nor the billions of dollars transferred to asbestos bankruptcy trusts as a consequence of estimation proceedings which based the projection of future asbestosis claims on a 10:1 ratio to future mesothelioma claims. The 2002-2005 data adds approximately $2.7 billion to this computation, for a total of $21.2 billion as the value of specious asbestosis claims. Taking into account the approximately $30 billion that had grown significantly to 89,308.) See also Manville Trust Claim Filings, supra note 615 (providing data that from 1988–2003, the number of nonmalignant claims filed rose from approximately 28,239 to 78,376.)

624 See MESOTHELIOMA SEER INCIDENCE, 1975-2003, FIGURE XVII-1. Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov) SEER*Stat Database: Incidence - SEER 9 Regs Limited-Use, Nov 2006 Sub (1973-2004), National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2007, based on the November 2006 submission, showing a decline in the mesothelioma incidence rate. Based on “SEER (Surveillance Epidemiology & End Results Database of the National Cancer Institute] data of the annual percentage change of mesothelioma incidence rates [Dr. Ory concludes that there is a striking] improbability that the number of cases of asbestosis would rise as…the incidence rate of mesothelioma has been steadily declining since 1989.” Ory further suggests that “[g]iven the declining consumption of, and exposure to, asbestos since 1950…the rate of decline of asbestosis incidence rate should be steeper than that for mesothelioma [because] a greater level of exposure [to asbestos] is required for a person to develop asbestosis than for a person to develop mesothelioma.” Ory Report, supra note 616, at 27-31.

625 Id. at 40.

626 In the period 1990 - 2000, an unimpaired nonmalignant asbestos claim was worth $60,000-$100,000. See Thomas Korosec, Enough To Make You Sick, DALLAS OBSERVER (Sept. 26, 2002) at 3.

627 Using Manville Trust data as a proxy for the total number of asbestosis claims filings in order to update RAND data, there were approximately 147,243 non-malignant claims filed in the 2002-2005 period. See Manville Trust Claim Filings, supra note 615. Applying Dr. Ory’s 81% estimation to this total indicates that approximately 119,266 of the 147,243 nonmalignant claims filed during the 2002-2005 period alleged asbestosis. During that same period, the CRMC reports approximately 12,294 claims of mesothelioma were filed with the Manville Trust. Id. Accordingly, applying Dr. Ory’s 0:95:1 ratio, the number of medically plausible asbestosis claims filed in the 2002-2005 period was 11,679. Thus, the excess, medically implausible, number of asbestosis claims filed in that period was approximately
has been sequestered in asbestos bankruptcy trusts for payment of claims, the total payout for specious asbestosis claims may exceed $25 billion.

Lung cancer projections are also subject to substantial overstatement in the estimation process. The large majority of lung cancers in the United States are attributable to smoking. Substantial occupational exposure of smokers to asbestos significantly increases the risk of lung cancer. However, for the increased risk of lung cancer to be multiplicative, the density and duration of a smoker’s asbestos exposure must have been sufficient to have caused underlying asbestosis. When asbestos defendants prevail in lung cancer litigation brought by or on behalf

107,587. For the 2002-2005 period, I am using an estimated value for asbestosis claims of $10,000-$50,000 with a $25,000 average.

See Brickman, Ethical Issues in Asbestos Litigation, supra note 47, at 868 n.141.


See Heather H. Nelson & Karl T. Kelsey, The Molecular Epidemiology of Asbestos and Tobacco in Lung Cancer, 21 ONCOGENE 7284 at 7284 (2002) citing to Selikoff I, Hammond EC and Churg J., Asbestos Exposure, Smoking and Neoplasia, 204 J. AM. MED. ASSOC. 106 (1968) (“Asbestos exposure alone is associated with an approximate fivefold increase in lung cancer risk, smoking alone with about a 10-fold risk and in workers with both exposures risk has been estimated at about 50-fold above that for the unexposed.”). The studies concluding that smokers with asbestos exposure face a multiplicative risk of lung cancer rely on the epidemiological studies conducted by Dr. Irving Selikoff or on reports that rely on these early studies. However, these early Selikoff studies were based on much higher asbestos exposure levels than occur today and in the recent past. See Brickman, Disparities, supra note 12, at 533-538. The Selikoff studies have also been criticized because they did not adequately account or control for disease risk factors, including smoking. See Testimony of Dr. James D. Crapo, Professor of Medicine, National Jewish Center and University of Colorado Health Sciences Center, Before the Senate Committee on the Judiciary Concerning S. 1125, the Fairness in Asbestos Injury Resolution Act of 2003, June 19, 2003, at 44 [hereafter, Crapo Testimony]. Moreover lung cancer risk attributable to asbestos cannot be accurately established because of the lack of adequate exposure data and problems of confounding and therefore current estimates may be biased upward. See Robert W. Morgan, M.D., Attitudes About Asbestos and Lung Cancer, 22 AM. J. INDUS. MEDICINE 437 (1992). In addition, the evidence that asbestos exposure alone can cause lung cancer is weak. Id. See William Weiss, Asbestosis: A Marker for the Increased Risk of Lung Cancer Among Workers Exposed to Asbestos, 115 CHEST 536 (1999) and sources cited therein. See also, Norfolk & W. Ry. Co. v. Ayers, 123 S. Ct. 1210, 1222 ( 2003) quoting from A. Churg & F. Green, PATHOLOGY OF OCCUPATIONAL LUNG DISEASE 343 (2d ed. 1998) (“studies provide strong support for the notion that asbestosis is crucial to the development of asbestos-associated lung cancers.”)); Crapo Testimony, id. at 6.
of a smoker, it is usually because the plaintiff is unable to prove that there was sufficient exposure to defendant’s product to have constituted that exposure as a substantial factor, in addition to smoking, in causing the lung cancer.

A study of male lung cancer deaths in England in the period 1980-2000 (excluding 1981) concluded that 2-3% were attributable to asbestos exposure. The study also found that the ratio of asbestos-related lung cancer to mesothelioma deaths during the time period was between two-thirds and one. Applying a one-to-one ratio of lung cancer claims to mesothelioma claims to Manville Trust data indicates that approximately 25% of the 47,582 lung cancer claims filed with the Manville Trust in the period 1988-July 30, 2006, that is, 12,300 lung cancer claims, are not properly attributable to asbestos exposure. Accordingly, lung cancer claim projections based on previous filings are likely to overestimate the actual number of lung cancers where asbestos exposure is a substantial causal or contributing factor by a similar margin.

But see Victor L. Roggli, Samuel P. Hammer Philip C. Pratt et al., Does Asbestos or Asbestosis Cause Carcinoma of the Lung?, 26 AM. J. IND. MED. 835 (1994). See Andrew J. Darnton et al., Estimating The Number of Asbestos-Related Lung Cancer Deaths in Great Britain from 1980 to 2000, 50 Ann. Occup. Hygiene 29, 34 (2006). The study acknowledged that other studies of Western European populations had found somewhat higher percentages, in the 5.7% to 14% range. Id. at 34. While mesotheliomas are virtually always fatal, lung cancer mortality is more mixed. For purposes of this comparison, however, that variance will be ignored.

The number of mesothelioma claims filed with the Manville Trust in the period 1988 – June 30, 2006 was 35,293, while the number of lung cancer claims filed was 47,582. See Claims Resolution Management Corporation, Manville Total Claim Filings by Year (2006) (on file with author). Thus, approximately 12,300 lung cancer claims were “excess” on the basis of the Darnton Study. It is not clear whether there are significant variations between occupational exposures in England and the United States which could account for some of the “excess” lung cancer claims. See American Lung Association: Lung Cancer Fact Sheet (October 2007) available at http://www.lungusa.org/site/apps/nl/content3.asp?c=dvLUK9O0E&b=2060245&content_id=%7BBD3F3387-3AA3-4660-9EF7-3F5BD8B6D251%7D&notoc=1 (last accessed on 11.29.07) (“The number of deaths due to lung cancer has increased approximately 4 percent between 1999 and 2004 from 152,156 to 158,009.”)
C. The Civil Justice System Failure: Proposed Remedies

The failures of the civil justice system to cope with specious if not fraudulent claim generation by litigation screenings requires a multiplicity of approaches, some fairly simple but involving resolute actions by courts and others more complex.

Perhaps the simplest resolution is for trial (and appellate) courts to allow defendants to discover all of the medical reports prepared by a litigation doctor for other screened claimants if that doctor prepared a medical report for a litigant before the court irrespective of whether that the litigation doctor is an testifying or consulting expert. As argued above, not allowing this discovery violates Rule 26(b)(1) of the Federal Rules of Civil Procedure and state equivalents of that Rule.

A second resolution is for bankruptcy courts to require that for pending and future claims to be valid, all of the essential elements of causation required to maintain a cause of action under state law have to be met. As part of the process, bankruptcy courts should allow debtors or commercial creditors to subject a stratified random sample of pending claims to medical review by unaligned medical experts in order to test the reliability of the medical reports prepared to support these claims. The outcomes of these inquiries should than be incorporated into the process of claim estimation to replace the use of experts’ reliance on historic settlement values and ratios which serves to promote the generation of specious if not fraudulent claims.

To this point resolution of some of the failures of the civil justice system are attainable by corrective actions of judges. However, an additional response prompted by defendants’ use of an MDL strategy and Judge Jack’s historic expose’ of litigation screening fraud by allowing

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635 Cf. In re A.H. Robins Co., 880 F. 2d 694, 699 (4th Cir. 1989) (data collected from a random sample of pending Dalkon Shield claims ordered by the court enabled experts to weed out claims where there was no valid medical proof of the use of the product.).
discovery of all of the medical reports of litigants in MDL 1553, is a necessary adjunct of civil justice reform.

1. The MDL Strategy For Overcoming the Barriers to Discovery

Defendants in MDL 1553 finessed the barrier to discovery of the totality of litigation doctors’ reports by adopting a strategy to create an MDL proceeding with a sufficient number of claims so that some of the doctors who had rendered thousands of the diagnoses for claims in the MDL could be cross examined about all of those medical reports. To get to the critical mass, defendants removed thousands of claims, filed mostly in state courts in Mississippi, to federal courts where they were then aggregated into an MDL proceeding. All plaintiffs raised jurisdictional objections, asserting that the cases had been improperly removed. Upon initial review, Judge Jack expressed the concern that she lacked subject matter jurisdiction because the removals from state court were improper.\(^{636}\) Though plaintiffs’ counsels had been opposed to the MDL, once it was convened, they saw a benefit to be obtained and requested the court to defer ruling on the pending remand motions so that they could take advantage of the MDL proceeding by conducting discovery of the defendants.

This proved to be a strategic blunder. Per their request, Judge Jack deferred ruling on jurisdiction.\(^{637}\) But Judge Jack also allowed defendants to take some initial discovery of plaintiffs relating to the claims and jurisdiction. That discovery quickly led to the unraveling of the scheme to “manufacture diagnoses for money.”

The success of the defendants’ MDL strategy rested on Judge Jack’s willingness to allow discovery before making the jurisdictional determination that the court lacked subject matter jurisdiction.

\(^{636}\) MDL 1553, 398 F. Supp. 2d at 637.
\(^{637}\) Id. at 666.
jurisdiction for most of the claimants. Most federal judges, however, instead of permitting, let alone personally directing discovery, would likely have dismissed most of the claims on jurisdictional grounds at the outset. However improbable, Judge Jack did not do so. She went ahead even though she knew that the court lacked jurisdiction and that her opinion was mostly advisory in nature. Indeed, in remanding the cases back to state court, she stated:

In spite of this, the Court has included its findings concerning all of the testimony it received, in hopes that the state courts that ultimately must shepherd these cases to their conclusion will not have to re-hear Daubert-type challenges to these doctors and their diagnoses.638

But for the confluence of the factors that led to MDL 1553, including the improper removals, and Judge Jack’s willingness to continue with discovery despite being aware of the lack of subject matter jurisdiction, MDL 1553 would not have occurred and the fact that thousands of diagnoses had been “manufactured for money” would never have come to light in any authoritative manner. Nor would Judge Jack’s extensive and detailed findings on the use of an “assembly line” method of generating claims in which, she observed, lawyers were making medical judgments and doctors were making legal judgments.639

MDL 1553 thus not only provides the most important insight in the judicial literature into the mass production of specious medical evidence in litigation screenings, it also points towards a legislative strategy that would provide defendants with the means of dealing with the illegitimate aspects of litigation screenings in the absence of an MDL.

I propose that in a mass tort litigation where litigation screenings are used and large numbers of cases are filed in various state courts, defendants should be empowered to remove

638 See supra note 19, at 637.
639 Id. at 635. Judge Jack stated: “In the majority of cases, these diagnoses are more the creation of lawyers than of doctors. . . . [At the same time,] the challenged doctors seemed to be under the impression they were practicing law rather than medicine.”
those cases which meet minimal diversity standards under the Constitution to federal courts, where they would then be aggregated into an MDL proceeding for pre-trial purposes. In such a proceeding, litigation doctors and other medical personnel who have provided large numbers of medical reports in support of the claims may have their reliability tested in a Daubert challenge. In such a proceeding, defendants would be allowed to subpoena and examine, subject to confidentiality protections, all of the records of that doctor or medical technician that were produced to support identical or similar claims of injury for those litigants who were recruited to attend litigation screenings.

Under this proposed legislation, where at least 1000 plaintiffs have brought tort actions in one or more state courts, and each alleges the identical or similar injuries caused by one or more defendants, and there is commonality of law and fact, and the claims have been generated by a litigation screening, then any defendant may remove all such claims that meet the minimum diversity standard to a federal court designated by the Judicial Panel on Multi-district Litigation under 28 U.S.C. § 1407 (a) irrespective of the jurisdictional amount. Findings of the federal court designated by the Panel with regard to the admissibility of evidence of causation and the

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640 Article III of the Constitution provides that “[t]he judicial Power shall extend . . . to Controversies . . . between Citizens of different States.” U.S. CONST. art. III, sec. 2. Although Justice Marshall announced a rule of “complete diversity” in the early case of Strawbridge v. Curtiss, requiring that all parties in a multi-party suit must be diverse from all opposing parties, the requirement has been held to be merely statutory. Strawbridge v. Curtiss, 7 U.S. (3 Cranch) 267 (1806); see also State Farm Fire & Casualty v. Tashire, 386 U.S. 523 (1967) (reading Strawbridge as limited to interpretation of the First Judiciary Act as opposed to a statement of the Constitutional limitations on diversity jurisdiction). Thus, under the Constitution, Congress could grant jurisdiction to courts over cases in which the parties are minimally diverse (that is, at least one of the parties on one side is a citizen of a different state than the opposing parties) as opposed to completely diverse. See generally 13B CHARLES ALAN WRIGHT, ARTHUR R. MILLER ET AL., FEDERAL PRACTICE AND PROCEDURE § 3605 (2007) (discussing minimal diversity and Congress’s ability to “authorize[] something less than complete diversity”). The Class Action Fairness Act of 2005 (CAFA) relies on the Constitutional standard of minimal diversity to support its provision granting federal district courts original jurisdiction in class actions and mass actions in which the amount in controversy exceeds $5,000,000 and “any member of the class of plaintiffs is a citizen of a State that is different from any defendant.” 28 U.S.C. 1332 (d)(2) (2006). See also the discussion of CAFA, infra notes 642-646 and accompanying text.

641 See text at supra notes 16-17.
reliability of medical and scientific experts used to establish both general and specific causation shall be binding on all state and federal courts to which the cases are transferred after the completion of the MDL proceeding.

For purposes of determining whether the requisite number of cases have been filed in state courts to permit removal to federal court under this provision, cases that have been joined together or consolidated for trial shall be counted according to the number of individual plaintiffs that have been joined together or consolidated for trial.

The proposal bears some resemblance to the “mass action” provision found in Section 4 of the Class Action Fairness Act of 2005 (CAFA). This section expands the class action treatment of 28 U.S.C. 1332 to permit removal of actions by a large number of plaintiffs (over 100) which though not certified as a class action, may be “class actions in disguise.”


Various incarnations of CAFA had been introduced numerous times in the House and Senate, as early as the 105th Congress. Class Action Fairness Act of 1998, S. 2083, 105th Cong. (1998). Treatment of mass actions, however, did not enter the bill until it was reintroduced in the 107th Congress, which allowed “a civil action that is not otherwise a class action” to be “deemed a class action.” Class Action Fairness Act of 2001, S. 1712, 107th Cong. § 4 (2001) (addressing mass actions in the contexts of named plaintiffs who are not an attorneys general purporting to act for the general public and general claims for monetary relief by 100 or more persons, proposed to be tried jointly because of common questions of law or fact). The term “mass action” was first introduced in the Class Action Fairness Act of 2003, which excepted “private attorney general” claims by plaintiffs claiming to represent the general public under a state statute authorizing such actions from mass action treatment. Class Action Fairness Act of 2003, S. 1751, 108th Cong. § 4 (2003) (defining civil actions involving the claims of 100 or more plaintiffs for monetary relief “proposed to be tried jointly in any respect on the ground that the claims involve common questions of law or fact” to be “mass actions” deemed to be class actions).

Under the statute, a “mass action” is defined as: any civil action (except a civil action within the scope of section 1711(2)) in which monetary relief claims of 100 or more persons are proposed to be tried jointly on the ground that the plaintiffs’ claims involve common questions of law or fact,
Specifically, it allows the removal to federal court of a requisite number of individual actions which are to be adjudicated in one combined trial in a state court. This would have particular application to the mass consolidations that are authorized by statute and which have taken place in Mississippi and West Virginia.645

This proposal would allow mass tort defendants who are being sued by claimants generated by litigation screenings to use discovery to determine whether the medical reports generated by the screenings were “manufactured for money.”646

D. The Criminal Justice System Failure: A Statement Of The Problem

Undoubtedly the greatest threat to the continuation of “entrepreneurial” litigation screenings has been the ongoing investigations of silica and asbestos litigation by the U.S. except that jurisdiction shall exist only over those plaintiffs whose claims in a mass action satisfy the jurisdictional amount requirements under [28 U.S.C. § 1332(a)].


645 MISS. CIV. P. 20 (West 2005); W. VA. CIV. P. 20 (LexisNexis 2005).

646 Though based in some measure on CAFA, the proposal set forth in this article differs in material ways from the “mass action” provision in CAFA. CAFA has carved out four exceptions to the mass action treatment: (1) actions in which all the claims arise from an accident within a state and the alleged injuries were caused in the state or contiguous states; (2) the claims are joined by the defendant; (3) the claims are asserted on behalf of the general public pursuant to a state statute authorizing such “private attorney general” actions; and (4) claims that have been consolidated solely for pretrial proceedings. 28 U.S.C. § 1332(d)(11)(A). The first and third exceptions specifically seek to keep cases involving uniquely state issues out of the federal courts. See S. Rep. No. 108-123, at 40 (2003) (suggesting that removing sudden major accident cases may in fact lessen the efficiencies generally sought by the statute). Of the four exceptions, the one most at odds with the proposed legislative strategy is the second which precludes the defendant from joining state court claims in order to remove them to federal court for treatment as a class action. It provides that “the term ‘mass action’ shall not include any civil action in which . . . the claims are joined upon the motion of a defendant.” 28 U.S.C. § 1332(d)(11)(B)(i)(II). See also, S. Rep. No. 108-123, at 40 (2003) (“[T]his provision will prevent defendants from moving to federal courts claims that do not otherwise qualify for federal jurisdiction something the original . . . mass actions provision was never intended to do.”). The resistance to expansion of the mass action removal is further affirmed by an ultimately rejected amendment that would have also exempted claims “joined by the court sua sponte” and those joined solely for pretrial proceedings. S. Amdt. 3 to Class Action Fairness Act of 2005, S. 5, 109th Cong. § 4 (2004); 5 151 Cong. Rec. S1076 at 1082 (statement of Sen. Lott) (2005) (expressing his disapproval of an amendment which would “open the door for lawyers to make an end run around what we are trying to do with class actions in this bill”).

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Attorney for the Southern District of New York, and of the fen-phen litigation by the U.S. Attorney in Philadelphia. Neither investigation has resulted in indictments and given the length of time that has elapsed since these investigations were begun and other considerations, it appears increasingly unlikely that indictments will be forthcoming.

These failures to indict the doctors or lawyers involved in the schemes to manufacture diagnoses for money highlights a critical defect in the criminal justice system. The inescapable conclusion from the evidence is: litigation screening fraud works.

Settlements and judgments resulting from the evidence and testimony in the five mass tort litigations discussed in this article amount to many billions of dollars. Medical and scientific experts in these litigations have been paid at least one hundred million dollars in fees for their diagnoses and testimony. Virtually none have been sanctioned for their conduct. Indeed, as one journalist noted, “[m]isconduct has not been punished, but rewarded.” The failure of the civil justice system to provide a mechanism for testing the reliability of hundreds of thousands of screening-generated medical reports is matched by the inability of the criminal justice system to sanction the medical and scientific experts who provide evidence that is at least not a product of good faith medical or scientific practice and, at worst, shows compelling evidence of fraud.

It would appear that a principal reason why prosecutors are reticent to prosecute the litigation doctors, even though they were in Judge Jack’s words, part of a scheme to manufacture diagnoses for money and to prosecute, as well, scientific experts is that the proof of fraud can be adduced only by (1) a videotape, phone recording, or other direct evidence of a transaction in

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647 See Brickman, Silica/Asbestos Litigation, supra note 42, at 313-314.
648 Gold Rush, supra note 106, at 92.
649 See supra note 501.
650 See infra note 657.
651 Alison Frankel, Still Ticking, Mistaken Assumptions, Greedy Lawyers, and Suggestions of Fraud Have Made Fen-Phen a Disaster of a Mass Tort, 27 AMERICAN LAWYER 92 (March 2005).
which the doctor or other expert acknowledges that he or she is committing fraud, (2) testimony
to that effect by another participant in the transaction, or (3) testimony of other experts. The first
two types of evidence appear unobtainable. The third type, reliance on testimony of other
experts, is problematic from the perspective of prosecutors.

An opt illustration is provided by asbestos screenings. In any given case or few hundred
cases involving the X-ray detection of mild asbestosis, medical experts can and do differ in their
interpretations of the X-rays. The phenomenon is known as “inter-reader variability.” In the
aggregate, however, when a litigation doctor has read tens of thousands of X-rays, the possibility
that huge and consistent discrepancies between the interpretations of neutral X-ray readers not
concerned about a future flow of revenue and the X-ray readers regularly selected by plaintiffs’
lawyers who realize tens of millions of dollars in repeat business from finding evidence of
asbestosis can be explained as “inter-reader variability” recedes to near zero.

 Nonetheless, prosecutors are apparently concerned that “reasonable doubt” is virtually
inherent in a process which relies on a “battle of the experts” for evidence of fraud. Moreover,
The use of litigations screenings

absolute witness immunity for experts testifying in litigations and similar prohibitions in many states protect the expert against sanctions for anything short of perjury. The effect of prosecutors’ failure to indict litigation doctors who have manufactured thousands of diagnosis for money has been to confer on these doctors (and the lawyers who hire them) a special dispensation to commit fraud. Doctors and scientists are obviously well aware of their effective immunity from prosecution and act accordingly. That immunity extends to medical licensing boards and professional associations. What doctors testify to in their role as expert witnesses is, for the most part, invisible to the expert’s professional community. Even when their testimony is flagged by other doctors or otherwise becomes known, licensing boards, for the most part, do not consider the acts of doctors who provide specious X-ray readings and diagnoses, even by the thousands, to be within their purview.  

percentage of slides that resulted in surgery. Those results were then compared to Dr. Rosin’s results to show that Dr. Rosin had performed unnecessary surgery.  


See e.g., report that two asbestos litigation doctors would only “face public reprimands but keep their licenses after the Mississippi Board of Medical Licensure determined they violated the physician’s code of conduct by signing or stamping their signatures on documents involving 700 silicosis claims when they had not actually made diagnoses.” Two Doctors Found Guilty for False Diagnosis Will Keep Licenses, THE CLARION [MISSISSIPPI] LEDGER, Sept. 21, 2007. “In courts around the nation, countless asbestosis and silicosis suits remain open on the strength of diagnoses from a dozen doctors [Judge] Jack exposed. All have escaped accountability except” Dr. Harron, who entered into an agreement with the Texas Board of Medical Licensure in which he agreed to cease practicing medicine until the expiration of his license and further agreed not to seek renewal of his license. See Judge Jack’s Fury Over Asbestos Fraud Ignored by State Courts, THE RECORD., Oct. 4, 2007. Dr. Harron accounted for over 80,000 medical reports filed with the Manville Trust and is the most prolific of the asbestos litigation doctors. See CRMC Response, supra note 18, at Exh. F. A few recent cases indicate that some voluntary professional organization have attempted to sanction experts who provide specious testimony by suspending or expelling them from the organization. See, e.g., Budwin v. American Psychological Ass’n, 29 Cal. Rptr. 453 (Ct. App. 1994) (the American Psychological Association); Austin v. American Ass’n of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001). Reportedly the American Association of Neurological Surgeons has disciplined ten of its members over the past fifteen years, see Jennifer A. turner, Going After the ‘Hired Guns’: Is Improper Expert Witness Testimony Unprofessional Conduct or the Negligent Practice of Medicine?, 33 PEPP. L. REV. 278, 282 (2006). In a small number of recent cases, professional licensing boards have sanctioned experts who provided misleading testimony. See Deatherage v. Examining Board of Psychology, 948 P.2d 828 (Wash. 1997); cf. Huhta v. State Board of Medicine, 706 A. 2d. 1275 (Pa. Commw. Ct. 1998) (physician disciplined for the disclosure of confidential patient records.).
It would therefore appear that state and federal legislation is needed to empower prosecutors to pierce doctor’s and scientific experts’ effective immunity from criminal prosecution. Drafting such legislation to distinguish between legitimately disputed diagnoses or theories of causation and manufacturing medical or scientific evidence for money however will be a daunting task and not one that I am attempting in this article.

IX. Conclusion

The evidence considered in this article leads to the ineluctable conclusion that mass tort litigation screenings almost invariably involve the mass production of medical reports which are manufactured for money and are not the product of good faith medical practice. These practices flourish because (1) they are very lucrative; (2) courts insulate the litigation doctors and their records from the extensive discovery that Judge Jack allowed; and (3) bankruptcy courts allow the testimony of professional experts to substitute for proof of causation in estimation proceedings. Litigation screenings have also flourished because of the failures of the civil and criminal justice systems to allow detection of fraudulent claim generation, let alone to sanction this conduct. Instead these institutions have effectively granted litigation doctors immunity from prosecution no matter how blatant their practices. Unless judges and legislatures change practices, rulings and statutes, the wholesale manufacture of claims in litigation screenings will continue to flourish.
Mold Litigation

Mold litigation is an example of entrepreneurial general causation theories being advanced to generate substantial fees for the experts. The litigation has proceeded because a small number of experts, paid millions of dollars in fees for advancing theories rejected by medical science, regularly testify that mold causes “a terrifying array of diseases from lung cancer, to cirrhosis of the liver.”

Mold is a fungus which is alleged to cause a wide variety of disease and disabilities. After a groundbreaking $32 million verdict in Texas, followed by a number of successful lawsuits, “mold is gold” became a byword of lawyers who anticipated a big pay day: tens of

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One doctor, Gary Ordog, M.D., who had testified in hundreds of lawsuits alleging injury from mold and mycotoxins, received his medical training in emergency medicine. His fees were $10,000 a day for testimony and travel time. Daniel Fisher, Dr. Mold: Why Sketchy Science Doesn’t Stop Medical “Experts,” FORBES, April 11, 2005 at 100 [hereafter, Fisher, Dr. Mold]. Dr. Ordog, one of the very few doctors disciplined for improper diagnostic practices in mass tort litigation, was disciplined for his practices in diagnosing and treating mold patients and other alleged toxic tort patients. The Medical Board of California suspended his medical license and prohibited him from engaging in “medical-legal or forensic practices.” The Board found by clear and convincing evidence that he had made some diagnoses that were “not sufficiently supported by the evidence,” and that his care and treatment of patients fell short of the standard of practice because of his “unbridled zeal to accomplish a legal result rather than a medical result.” In the Matter of the Second Amended Accusation Against Gary Ordog, M.D., Medical Board of California Case No. 05-2001-124743 (May 2006). Another rare subject of disciplinary action is Dr. William Campbell. The staff of the State Medical Board of Texas have brought a disciplinary action against Dr. Andrew William Campbell, which is currently awaiting a final decision. In the Matter of the Complaint Against Andrew William Campbell, M.D., Texas Medical Board, SOAH Docket No. 503-04-5717 (Feb. 2006). The Administrative Law Judges at The State Office of Administrative Hearings have filed a Proposal for Decision dated October 10, 2006, in which they find that Dr. Campbell has violated provisions of law by, among others, “failing to practice medicine in an acceptable manner consistent with public health and welfare”, and committing “unprofessional or dishonorable conduct likely to deceive, defraud, or injure the public.” These conclusions were based on many findings of fact, including that Dr. Campbell’s diagnosis of “mold exposure condition” is not supported by scientific evidence. Texas State Board of Medical Examiners v. Andrew William Campbell, M.D., SOAH Docket No.503-04-5717, (October 10, 2006).

Fisher, Dr. Mold, id.


See, e.g., Anonymous v. Anonymous (Los Angeles Co., Simi Co., Cal. 1999), as reported
thousands of lawsuits generating hundreds of millions of dollars in contingency fees. While the lawsuits have been highly profitable – the Insurance Information Institute estimates that $3 billion in mold claims were paid out in 2002\textsuperscript{661} -- mold litigation has never fulfilled its early promise of being “the next asbestos.”

Mold litigation requires scientific and medical testimony that mold causes a variety of illnesses including the ones alleged in the litigation. The scientific evidence, however, does not support the conclusion that mold causes significant injury to humans.\textsuperscript{662} According to the evidence-based statement of the American College of Occupational and Environmental Medicine (ACOEM),\textsuperscript{663} mold is a fungus which is ubiquitous in the environment. Everyone is exposed to molds and other fungi both indoor and outdoors. The only exception is where there is very stringent air filtration, and isolation and environmental sanitation measures are observed, as in organ transplant isolation units. Molds and other fungi generally are not pathogenic to healthy


\textsuperscript{661}Fisher, \textit{Dr. Mold}, supra note 657.

\textsuperscript{662}In 2003, the Center for Disease Control and Prevention of the United States Department of Health and Human Services, requested the Institute of Medicine (IOM) to convene a committee of experts and conduct a “comprehensive review of scientific literature regarding the relationship between damp or moldy indoor environments and the manifestation of adverse health effects, particularly respiratory and allergic symptoms.” IOM found that there is no “sufficient evidence of a casual relationship” between the presence of mold or other agents in damp indoor environments and such health outcomes as asthma development, skin symptoms, gastrointestinal tract problems, fatigue, cancer, mucous membrane irritation syndrome, chronic obstructive pulmonary disease, rheumatologic and other immune diseases and inhalation fevers. \textbf{DAMP INDOOR SPACES AND HEALTH, EXECUTIVE SUMMARY 10} (Committee on Damp Indoor Spaces and Health, Board on Health Promotion and Disease Prevention, Institute of Medicine, The National Academies Press 2004). \textit{See also}, text at \textit{supra} note 97.


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humans but may adversely affect human health through three processes: 1) allergy, 2) infection, and 3) toxicity.\(^{664}\)

A. Allergy

Most allergic reactions are to molds found outdoors. Typically, these symptoms are referred to as “hay fever.” While medical literature associates a variety of respiratory illnesses such as asthma and cough to living in damp buildings, mold spores are not responsible for these inflammatory responses to a damp environment.\(^{665}\) These responses are usually caused by dust mite infection and bacterial growth which occurs in damp environments. In those who do develop an allergic reaction to mold, the reactions are mostly limited to rhinitis (“runny nose”) or asthma.\(^{666}\) Other claims about allergic reactions to mold are discussed by ACOEM:

> Although it is not relevant to indoor mold exposure... there is a belief among some health practitioners and members of the public regarding a vague relationship between mold colonization, molds in foods, and a “generalized mold hypersensitivity state.” The condition was originally proposed as the “Chronic Candida Syndrome” or “Candida Hypersensitivity Syndrome,” but now has been generalized to other fungi. Adherents may claim that individuals are “colonized” with the mold(s) to which they are sensitized and that they react to these endogenous molds as well as to exposures in foods and other materials that contain mold products... The claim of mold colonization is generally not supported with any evidence, e.g., cultures or biopsies, to demonstrate the actual presence of fungi in or on the subject. Instead, proponents often claim colonization or infection based on the presence of a wide variety of nonspecific symptoms and antibodies detected in serologic tests that represent no more than past exposure to normal environmental fungi. The existence of this disorder is not supported by reliable scientific data.\(^{667}\)

\(^{664}\) Id.

\(^{665}\) Id. at 2.

\(^{666}\) Another condition alleged to be caused by mold is hypersensitivity pneumonitis (HS) -- an intense local immune reaction. However, most cases of HP result from occupational exposures and a HP is not induced by normal or even modestly elevated levels of mold spores.” Id. at 3.

\(^{667}\) Id. at 4. (Endnotes omitted).
B. Infection

Serious fungal infections occur primarily among those with severely compromised immune systems such as those with leukemia, cancer patients receiving chemotherapy and those with organ transplants who are on immunosuppressive drugs. In contrast to serious internal infections, superficial fungal infections on the skin or mucosal surfaces are extremely common.\(^{668}\) Accordingly, “[o]nly individuals with the most severe forms of immunocompromise need to be concerned about the potential for opportunistic fungal infections.”\(^{669}\)

C. Toxicity

Some molds that propagate indoors may, under some conditions, produce mycotoxins. Some mycotoxins such as penicillin or cyclosporine are of clinical value whereas others can be toxic. Current scientific evidence, however, does not support the proposition that inhaled mycotoxins produced by molds adversely affect human health.\(^{670}\)

While most poisonings from molds involve eating moldy foods,\(^{671}\) “[t]he present alarm over human exposure to molds in the indoor environment derives from a belief that inhalation exposures to mycotoxins cause numerous and varied, but generally nonspecific, symptoms.” One of the claims made is that mold in buildings can cause disease. However, according to ACOEM:

“Sick building syndrome,” or “non-specific building-related illness,” represents a poorly defined set of symptoms (often sensory) that are attributed to occupancy in a building. Investigation generally finds no specific cause for the complaints, but they may be attributed to fungal

\(^{668}\) Id. at 4.
\(^{669}\) Id. at 5.
\(^{670}\) Id. at 2.
\(^{671}\) Id. at 5.
growth if it is found. The potential role of building-associated exposure to molds and associated mycotoxins has been investigated. . . Often referred to in the lay press by the evocative, but meaningless terms, “toxic mold” or “fatal fungus,” [one type of mold]. . . elicits great concern when found in homes, schools, or offices, although it is by no means the only mold found indoors that is capable of producing mycotoxins. Recent critical reviews of the literature concluded that indoor airborne levels of microorganisms are only weakly correlated with human disease or building-related symptoms and that a casual relationship has not been established between these complaints and indoor exposures to [mold].

Mold spores are present in all indoor environments and cannot be eliminated from them. Normal building materials and furnishing provide ample nutrition for many species of molds, but they can grow and amplify indoors only when there is an adequate supply of moisture. Where mold grows indoors there is an inappropriate source of water that must be corrected before remediation of the mold colonization can succeed. Mold growth in the home, school, or office environment should not be tolerated because mold physically destroys the building materials on which it grows, mold growth is unsightly and may produce offensive odors, and mold is likely to sensitize and produce allergic responses in allergic individuals. Except for persons with severely impaired immune systems, indoor mold is not a source of fungal infections. Current scientific evidence does not support the proposition that human health has been adversely affected by inhaled mycotoxins in home, school, or office environments.

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672 Id. at 6 (endnotes omitted).
673 Id. at 8 (emphasis added).