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Citing a number of recent verdicts and settlements, attorney Anthony G. Hopp says we are seeing a resurgence of medical monitoring claims. In this article, Hopp lays out legal and policy arguments against medical monitoring, concluding that it awards damages to those who have suffered no harm, and does not improve the health of plaintiffs.

## **Bad Medicine: The Legal, Policy and Medical Arguments Against Medical Monitoring**

BY ANTHONY G. HOPP

In the eleven years since the United States Supreme Court rejected medical monitoring for Federal Employers Liability Act claims in *Metro North Commuter R.R. v. Buckley*,<sup>1</sup> most of the state and federal courts to have considered the issue have followed the Supreme Court's lead.<sup>2</sup> A recent spate of medical monitoring verdicts and settlements<sup>3</sup> in states where the cause of action is available, however, seems to have re-

<sup>1</sup> 521 U.S. 424, 117 S. Ct. 2113, 138 L. Ed. 560 (1997).

<sup>2</sup> A recent exception is *Meyer v. Fluor Corp.*, 220 S.W.2d 712 (Mo. 2007), which recognized medical monitoring as a cause of action in Missouri.

<sup>3</sup> See, e.g., *Jury Orders DuPont to Provide Medical Monitoring for Contamination from Smelter Waste*, Associated Press, October 10, 2007.

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vived interest in pursuing these claims. While there is arguably some surface appeal to providing medical testing to people who have been exposed to hazardous substances, medical monitoring—viewed as a medical issue, a policy issue or a legal issue—is a bad idea. It does not assist in the early detection of disease and may in fact have the opposite effect. It wastes judicial and societal resources, and it debases the court system by allowing uninjured plaintiffs to seek compensation for medical tests most do not need and will never undergo.

This article is intended to provide a resource for defendants facing medical monitoring claims. In addition to explaining some of the legal and policy arguments courts have used in rejecting medical monitoring, it will demonstrate that medical monitoring does not generally improve the health of plaintiffs, and may in fact be dangerous.

### **A. What is medical monitoring?**

Medical monitoring is health care for people who are not sick. It is the application of periodic diagnostic medical examinations and screening tests to diagnose illnesses or diseases before they would be diagnosed in

the ordinary course of medical care.<sup>4</sup> A typical medical monitoring plaintiff alleges that the defendant negligently, recklessly or intentionally exposed him or her to a hazardous substance and has increased the probability that the plaintiff will become ill in the future.<sup>5</sup>

In most states, the plaintiff must allege that his or her exposure was greater or more intense than the typical background exposures everyone else encounters, and that diagnostic tests are available which make possible early detection of an exposure-related disease.<sup>6</sup> Courts are divided on whether the exposure-related disease must be treatable or curable. Some courts have held that medical monitoring should be available even for incurable ailments because a plaintiff with knowledge of his or her inevitable demise can put his or her affairs in order or make peace with estranged loved ones.<sup>7</sup>

A medical monitoring claim is not the same thing as a claim for increased risk of a future injury. Nor is it the same thing as a claim for fear of future injury. Some states allow plaintiffs to recover damages based on the percentage chance that an exposure or other injury will result in illness or disease in the future.<sup>8</sup> Others allow plaintiffs to recover because the defendant's tortious conduct has created mental distress at the thought of future illness. While increased risk of future injury is a necessary element of a medical monitoring claim (and courts assume that anyone pursuing a medical monitoring claim has a fear of future injury), the focus of a medical monitoring claim is on preventative care. The medical monitoring plaintiff seeks to recover enough money to get routine checkups so that, if he or she ever gets sick as a result of exposure, a doctor will catch the disease early and be able to treat it successfully.

## B. The Scorecard: How do the states line up on medical monitoring?

### 1. Where is medical monitoring available?

Medical monitoring has been recognized as a cause of action or an element of damages in state or federal courts in Arizona, California, the District of Columbia, Florida, Minnesota, Missouri, New Jersey, New York, Ohio, Pennsylvania, Utah and West Virginia.<sup>9</sup>

<sup>4</sup> Christopher P. Guzelian, Bruce E. Hellner and Philip S. Guzelian, *A Quantitative Methodology for Determining the Need for Exposure Prompted Medical Monitoring*, 79 Indiana Law Journal, 57, 58 (2004).

<sup>5</sup> See, e.g., *Bower v. Westinghouse Electric Corp.*, 206 W. Va. 113, 522 S.E.2d 424 (W. Va. 1999).

<sup>6</sup> See, e.g., *Hansen v. Mountain Fuel Supply*, 858 P.2d 970 (Utah, 1993).

<sup>7</sup> *Bower*, *Id* at 434; see also *Bourgeois v. A.P. Green Industries Inc.*, 716 S.2d 355, 363 (La. 1998).

<sup>8</sup> See e.g., *Dillon v. Evanston Hospital*, 199 Ill. 2d 483, 771 N.E.2d 357 (2002).

<sup>9</sup> See, *Burns v. Jaquays Mining Corp.*, 752 P.2d 28 (Az. App. 1987); *Potter v. Firestone Tire and Rubber Co.*, 25 Cal. Rptr. 2d 550 (Cal. 1993); *Friends For All Children Inc. v. Lockheed Aircraft Corp.*, 746 F.2d 816 (D.C. Cir. 1984); *Petito v. A.H. Robbins Co.*, 750 So. 2d 103 (Fla. App. 1999); *Bryson v. Pillsbury Co.*, 573 N.W.2d 718 (Minn. App. 1998); *Meyer v. Fluor Corp.*, 220 S.W.3d 712 (Mo. 2007); *Ayers v. Township of Jackson*, 525 A.2d 282 (N.J. 1987); *Askey v. Occidental Chemical Corp.*, 477 N.Y.S.2d 242 (N.Y. App. Div. 1984); *Wilson v. Brush Wellman Inc.*, 817 N.E.2d 59 (Ohio 2004); *Redland Soccer Club v. Department of the Army*, 696 A.2d 137 (Pa. 1997); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970 (Utah 1993); *Bower v. Westinghouse Electric Co.*, 522 S.E.2d 424 (W. Va. 1999).

### 2. Where has medical monitoring been rejected?

State or federal courts in the following jurisdictions have rejected medical monitoring as a cause of action or a remedy: Alabama, Colorado, Delaware, Georgia, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Carolina, Oregon, Texas, Virginia and Washington.<sup>10</sup>

### 3. Who remains undecided?

A number of states have yet to decide the issue. They include Alaska, Connecticut, Hawaii, Idaho, Illinois, Iowa, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Wisconsin and Wyoming.

### C. Medical monitoring is bad medicine.

Decisions approving causes of action for medical monitoring almost never focus on the true nature of the remedy. A medical monitoring protocol is a series of medical tests. This definition may seem like a tautology, but it contains the essence of the problem with medical monitoring. Medical monitoring is court-ordered medical care. Unlike a typical monetary remedy, an award of medical monitoring costs means that an asymptomatic person is expected to go to a doctor for medical tests. The problem is that healthy people should not be undergoing unnecessary medical tests.

Even seemingly benign medical screening procedures like X-rays or CT scans carry some risks. A false positive test result often means unnecessary follow-up procedures, such as a biopsy or exploratory surgery. These more invasive procedures can result in negative consequences ranging from pain and discomfort to infection and even death. It is a statistical certainty that if enough people have enough medically unnecessary screening tests, one of them will die from complications due to unnecessary follow-up procedures. Subjecting healthy individuals to unnecessary risks is something the medical profession strongly disfavors.

Even worse than false positive test results is false negative results. These too are a statistical certainty. A person who undergoes a medical screening exam while asymptomatic may choose to ignore symptoms if they arise later. He or she is likely to rely on the negative test result to assume that the later-occurring symptom is of

<sup>10</sup> See, *Hinton v. Monsanto*, 813 So.2d 827 (Ala. 2110); *Cook v. Rockwell Intl. Corp.*, 755 F. Supp. 1468; *Mergenthaler v. Asbestos Corp.*, 480 A.2d 647 (Del. 1984); *Parker v. Bush Wellman, Inc.*, 377 F. Supp. 2d 1290 (N.D. Ga. 2005); *Allied-Signal v. Ott*, 785 N.E.2d 1068 (Ind. 2003); *Burton v. R.J. Reynolds Tobacco Co.*, 884 F. Supp. 1515 (D. Kan. 1995); *Wood v. Wyeth-Ayerst Labs*, 82 S.W.3d 849 (Ky. 2002); *LSA-CC Art. 2315 (Act 989, 1999)*; *Henry v. Dow Chemical Co.*, 473 Mich. 63, 701 N.W.2d 684 (Mi. 2005); *Paz v. Brush Engineered Materials Co.*, 949 So.2d 1 (Miss. 2007); *Trimble v. ASARCO Corp.*, 83 F. Supp. 2d 1034 (D. Neb. 1999); *Badillo v. American Brands Inc.*, 16 P.3d 435 (Nev. 2001); *Curl v. Am. Multimedia Inc.*, 2007 WL 4386334 (N.C. App. 2006); *Lowe v. Philip Morris U.S.A. Inc.*, 142 P.3d 1079 (Or. App. 2006); *Bund et al. v. Raytheon*, 414 F. Supp. 2d 659 (W.D. Tx. 2006); *Ball v. Joy Mfg. Co.*, 775 F. Supp. 1344 (S.D.W. Va. 1990); *Duncan v. Northwest Airlines*, 203 F.R.D. 601 (W.D. Wa. 2001).

no consequence. A false negative test result can provide a false sense of security, and delay necessary care.<sup>11</sup>

The United States Department of Health and Human Services (DHS) has devoted extensive study to when healthy people should undergo screening tests. The Public Health Service, a sub-agency within DHS, has convened the U.S. Preventative Services Task Force (the “Task Force”) for the purpose of vigorously evaluating clinical research on preventive measures, including screening tests. The Task Force’s job is to collect and systematically analyze all of the peer-reviewed, medical literature describing which screening tests are effective and which are not. This information is collected and published in several places, including *The Guide to Clinical Preventative Services*,<sup>12</sup> and the *Pocket Guide to Clinical Preventative Services*,<sup>13</sup> which is updated annually. The *Guide* represents the evidence-based “gold standard” recommendations from the Task Force.

Unlike paid experts in toxic exposure cases, the Task Force is independent, and its recommendations are not shaded by bias. The Task Force looks not only at the quality of evidence supporting a particular preventative service, but also at the magnitude of net benefit (benefits minus harms) in providing the service. Each recommendation is based on a rigorous review of the medical evidence supporting the proposed screening procedure. The Task Force either recommends a particular screening test, recommends against it, or states that the evidence is insufficient to recommend for or against.

Most exposure-based medical monitoring claims are based on the allegation that the defendant’s conduct increased the plaintiff’s risk of cancer. The Task Force has evaluated various cancer screening tests, and has made the following recommendations:

Cancer	Test	Recommendation
Bladder	Any available tests	Not recommended
Breast	Genetic testing	Not recommended
Breast	Mammography	Recommended for women over 40
Cervix	Pap smear	Recommended
Colorectal	FBOT	Recommended for men and women over 50
Oral	Visual screen	Neither for nor against
Ovarian	Serum CA-125 level or ultrasound	Not recommended
Pancreatic <sup>14</sup>	All available	Not recommended
Skin	Visual	Neither for nor against

<sup>11</sup> For a detailed explanation of the medical risks posed by unnecessary testing; see *Guzelian, et al.*, 79 Indiana Law Journal, pp. 66-73.

<sup>12</sup> U.S. Preventative Services Task Force, *Guide to Clinical Preventative Services*, 2nd and 3rd eds., McLean Virginia: International Medical Publishing, 2002.

<sup>13</sup> Available at: [www.ahrq.gov/clinic/pocketgd.htm](http://www.ahrq.gov/clinic/pocketgd.htm).

<sup>14</sup> The Task Force’s statement of its rationale for not recommending screening for pancreatic cancer describes the potential health risks of unnecessary screening: “There is a potential for significant harm due to the very low prevalence of pancreatic cancer, the limited accuracy of available screening tests, the invasive nature of diagnostic tests, and the poor outcomes of treatment.” [www.uhrq.gov/clinic/uspstf/uspspanc.htm](http://www.uhrq.gov/clinic/uspstf/uspspanc.htm).

Cancer	Test	Recommendation
Testicular	Self exam	Not recommended

Courts awarding medical monitoring costs seem to believe that all medical care is a good thing. It isn’t. Unnecessary medical tests can be risky, and even fatal. Nowhere in any of its publications does the Task Force generally recommend screening tests for people who have been exposed—even significantly exposed—to hazardous substances.

Further, the expert witnesses who promote medical monitoring in the courtroom rarely do so outside of it. The medical literature is devoid of peer-reviewed articles supporting exposure-prompted medical monitoring. The same witnesses who support medical monitoring in front of judges and juries never do so in front of their peers.

The medical profession does not support exposure-prompted medical monitoring. Lawyers and judges are not qualified to practice medicine. It is not appropriate—i.e., it’s bad medicine—for lawyers and judges to create medical screening protocols for healthy individuals when the current evidence-based medical science rejects such tests.

## D. Medical monitoring is bad social policy.

Social policy, rather than strict legal reasoning or medical necessity, is most often the focus of decisions on medical monitoring. Both the courts that accept medical monitoring and those that reject it do so on policy grounds. While there are some plausible policy arguments in favor of allowing plaintiffs to recover medical monitoring damages, the better arguments disfavor it.

### 1. Policy arguments in favor of medical monitoring.

The chief weapon in the policy arsenal of medical monitoring advocates is the notion that tortfeasors should pay for the damage they create, even if that damage has not yet manifested itself.<sup>15</sup> According to this line of reasoning, just as every person has a legally-protected interest in avoiding physical injury, so too does every person have a legally protected interest in avoiding expensive medical evaluations caused by the negligence of others. If an exposure causes the need for medical care, therefore, the person who caused the exposure should pay for the care. The problem with this justification is that it begs the question of when an injury requiring medical care occurs. If the plaintiff is healthy, then he or she has suffered no damage, and therefore has no claim, even if the defendant acted wrongfully and the plaintiff wants medical screening.

The second most popular justification for medical monitoring is that illnesses caused by toxic exposures are most often latent. Cancer can develop years or decades after the date of last exposure. By the time the victim’s disease manifests itself, his or her claims might be barred by the applicable statutes of limitation or repose, or the alleged tortfeasor may no longer be in business. Some recovery now is preferable to no recovery later.

A related argument is that it is not fair to force society to pay—through increased health care premiums

<sup>15</sup> See, e.g., *Paz v. Brush Wellman*, 949 So.2d 1, 7 (Miss. 2007); *Meyer v. Fluor Corp.*, 220 S.W.2d 712, 717 (Mo. 2007); *Hansen v. Mountain Fuel Supply*, 858 P.2d 970 (Utah, 1993).

and Medicaid reimbursements—for the negligent acts of industrial polluters. Rather, the persons who caused the need for health care should pay for it in some way. Additional arguments include avoiding unjustly burdening economically disadvantaged people with the expense of medical care due to another, likely richer, person's negligence and the public health interest in fostering access to early medical testing for people exposed to hazardous substances.

All of these justifications start to ring hollow, however, when one considers that medical monitoring is by its nature an overly-broad remedy. Many people exposed even to high doses of hazardous substances will never get sick. Those who do get sick will likely get sick for other reasons. As the years pass between the allegedly tortious exposure and the onset of illness, other risk factors become predominant, such as age, genetic predisposition and lifestyle. For most plaintiffs, therefore, an award of medical monitoring damages amounts to overcompensation. They are being paid to look for diseases that may never occur, or that may occur for other reasons. The arguable social value of transferring wealth from those who have it to those who do not simply does not trump the bedrock legal principle that courts will not award speculative damages. Only injured people should receive compensation. People who might be injured—but might not be—are not entitled to file tort claims.

## 2. Policy arguments opposing medical monitoring.

It is not surprising, therefore, that the social policy arguments advanced against medical monitoring are stronger than those in favor of it. High on this list is the floodgates argument. As one court put it:

The problem is that, as with the cases involving emotional distress and economic loss, the scope of liability resulting from a mere increase in risk that falls short of a probability is virtually limitless. As many courts and scholars addressing the subject have noted, each and every person in contemporary industrialized society faces significantly increased risks of future harm by merely getting up in the morning and breathing polluted air, drinking coffee, driving in a motor vehicle, eating certain prepared foods, taking over-the-counter and prescription medicines, and the like.<sup>16</sup>

If negligently exposing someone to a hazardous substance gives rise to a legal claim, then every person in the United States would daily have a long list of potential lawsuits to choose from. The fact that the courts in states where medical monitoring is available are not clogged with such lawsuits is proof that our society recognizes that these claims are not legitimate. So the floodgates argument has turned out to be a bit of a straw man. There are other, even stronger, policy reasons why medical monitoring is a bad idea.

As a nation, we struggle with the cost of medical care, the allocation of those costs, and how (or whether) to provide medical care to people who cannot afford it. Medical monitoring programs—to the extent that the people receiving the awards actually use them for their intended purpose—create a type of defendant-funded health maintenance organization. Our nation may some

day decide that the solution to the current problem of access to medical care is to force corporations to pay for medical monitoring. If we take this unlikely step, however, we should do so in the legislature, not the courts. It should not be up to a few lawyers and judges to decide who gets their medical care paid for and who does not.

Similar concerns exist with regard to the administration of medical monitoring programs, if they are administered at all. Most of the time, medical monitoring settlements or verdicts result in lump-sum awards. Plaintiffs are entitled to use the judgment or settlement for medical care or to blow it on a trip to Las Vegas. In other cases, the courts are asked to set up a fund to pay for tests as they occur. Administering a medical monitoring program is a complex undertaking akin to running a health insurance company. The administrator of such a fund would be charged with negotiating prices with medical providers and protecting the privacy of plan participants, among other things. Courts are not at all suited to this role, yet they seem to be the default choice for the task of administration.

Further, medical monitoring can be expensive. A yearly suite of medical screening tests can cost thousands of dollars. Multiply that cost by dozens or hundreds of plaintiffs and by decades of testing, and the total cost of providing medical monitoring to an exposed population could easily range in the tens of millions of dollars and possibly into the hundreds of millions. The recent West Virginia medical monitoring verdict against DuPont totaled \$130 million. Few corporate defendants can withstand these types of verdicts or settlements.

A very real possibility exists, therefore, that a medical monitoring judgment could bankrupt a defendant. In the event of a bankruptcy, the usual consequences would ensue. Employees would lose their jobs, retirees could lose their pensions, and shareholders and creditors would lose their investments, all for the sake of compensating people who are not injured in the traditional sense. More importantly, should a plaintiff with an actual, manifest disease come along later, there may be nothing left to compensate that person. Medical monitoring is bad social policy because it diverts resources from the places where they ought to be employed—building and running the company and paying good-faith claims—and devotes them to compensating people who might or might not be injured in the future.

## E. Medical monitoring is bad law.

The foundation of our tort system is the belief that people deserve compensation for actual, physical injuries that are negligently or intentionally inflicted. Awarding damages to a person who has suffered no harm and who has incurred no actual damages represents a sweeping change in our system of tort law.

For centuries, one of the fundamental principles of tort law has been that liability may not be imposed absent proof of physical injury or property damage. As Dean Prosser observed:

Since the action for negligence developed chiefly out of the old form of action on the case, it retained the rule of that action, that proof of damage was an essential part of the plaintiff's case. Nominal damages, to vindicate a technical right, cannot be recovered in a negligence action, where no actual loss has occurred. The threat of future harm, not yet realized, is

<sup>16</sup> *Lowe v. Philip Morris USA Inc.*, 142 P.2d 1079, 1082 (Or. App. 2006).

not enough. Negligent conduct in itself is not such an interference with the interests of the world at large that there is any right to complain of it, or to be free from it, except in the case of some individual whose interests have suffered.<sup>17</sup>

The Michigan Supreme Court's decision in *Henry v. Dow Chemical Co.* is instructive. In *Henry*, the plaintiffs alleged that Dow Chemical's plant in Midland, Michigan released dioxin, a potentially hazardous chemical,<sup>18</sup> into the Tittabawassee floodplain, where plaintiffs lived and worked. The Michigan Supreme Court noted that, in a typical "toxic tort" case, the plaintiff alleges that he or she has developed a disease caused by the defendant's negligent release of a hazardous substance into the environment. In *Henry*, however, the plaintiffs did not allege that the defendants' negligence caused the present manifestation of a disease or physical injury. Rather, they alleged that the defendants' negligence created the risk that plaintiffs may someday in the future develop a disease or a physical injury. Reversing the trial court, the Michigan Supreme Court held that the plaintiffs could not state a cause of action for negligence and could not recover medical monitoring damages because they did not allege any actual, physical injuries.

The *Henry* court reasoned that the requirement of a present physical injury serves a number of important purposes. First, it clearly defines who actually has a cause of action. Requiring a physical injury eliminates the need for the fact finder to speculate as to who has, and who does not have, a cognizable legal claim. Second, the requirement reduces the risk of fraud by setting a clear minimum threshold on who can proceed with a claim. The fact finder need not take the plaintiff's

word for whether he or she has been injured. Finally, and most significantly, the requirement avoids compromising judicial power. The Michigan Supreme Court held that the exercise of judicial power by the Court contemplates that there will be legally comprehensible standards that guide the judicial branch's resolution of matters brought before it. The present physical injury requirement establishes a clear standard by which judges can determine which plaintiffs state a valid claim, and which do not. The court reasoned:

In the absence of such a requirement, it will be inevitable that judges, as in the instant case, will be required to answer questions that are more appropriate for a legislative than a judicial body: How far from the Tittabawassee River must a plaintiff live in order to have a cognizable claim? What evidence of exposure to dioxin will be required to support such a claim? What level of medical research is sufficient to support a claim that exposure to dioxin in contrast to exposure to another chemical, will give rise to a cause of action?

The court concluded that the only present injury the plaintiffs in *Henry* were facing was the fear that their alleged dioxin exposure might make them sick in the future. The plaintiffs' fear, however reasonable, was not enough to state a claim for negligence.

Medical monitoring plaintiffs, by definition, do not have present, physical injuries. Some of them may contract exposure-related conditions in the future, but in all but a few exposure situations, most will not. Awarding personal injury damages to people who are not injured and are unlikely to become injured runs contrary to the very foundation of U.S. tort law.

## F. Conclusion.

Medical monitoring is a bad idea. Doctors, not lawyers and judges, should decide when medical screening procedures are appropriate. The social and economic costs of medical monitoring are potentially staggering, and the consequences of subjecting a person to medical monitoring are unpredictable and potentially dangerous. For all of these reasons, medical monitoring is bad medicine, bad policy and bad law.

<sup>17</sup> W. Page Keaton, *et al.*, *Prosser and Keaton on the Law of Torts*, 165 (5th Ed. 1984).

<sup>18</sup> Dioxin has been called the most hazardous chemical known to man. Linda S. Birnbaum and Suzanne E. Fenton, *Cancer and Developmental Exposure to Endocrine Disruptors*, 111(4) *Environmental Health Perspectives* at 391 (2003). Whether this is true or not remains the subject of intense debate. Cole, P., *et al.* *Dioxin and Cancer: A Critical Review*, *Regul. Toxicol. Pharmacol.* 38(3):378-388 (2003).