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Abstract: The author administers six mass tort settlements with a medical component, including two with medical monitoring. This article reviews the status and history of medical monitoring, known claimant medical monitoring participation rates, the rationale for the remedy, arguments for and against its implementation, and its execution in practice. The author suggests a more holistic medical monitoring remedy, which includes not only testing/or disease but paying claimants for personal injury when they get sicker later, from a capped fund and under an agreed payment matrix, to provide closure to defendants and class members for claims resulting from toxic substances and product defects, which have long-term and often unknown effects on plaintiffs. It is suggested that this remedy is the logical long-term result of the evolution of medical monitoring, and will provide a much needed dynamic remedy for long-term maladies.

Introduction

The medical monitoring remedy is an evolving tort with differing levels of acceptance in the states, being law in 14 states and being rejected so far by 23 states. Eleven states have not addressed the issue and two states have divided decisions.

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In a nutshell, medical monitoring has been implemented where a population has been exposed to a toxin or defective product, but not all exposed persons manifest personal injury. States implementing medical monitoring require the defendant to provide testing of the population over time to see if the personal injury occurs, and states rejecting medical monitoring do so based on the argument that, without personal injury, there is no tort claim.

In this society, toxic substances are released and medical products are used without knowing fully their long-term effects. It is therefore suggested that, instead of applying the classic tort barrier to recovery based on lack of

personal injury, courts should embrace the need to have a current remedy for unknown long-term effects of exposure to toxic substances or dangerous products with both a testing and a payment component, in order to provide the plaintiff with a long-term remedy, allow the defendant closure on its legal exposure, and to circumvent the statute of limitations problem that will be encountered if such a holistic remedy is not implemented, if a plaintiff must first be injured to file a claim.

Currently, this suggested long-term remedy has not been implemented. It is suggested, however, that without developing medical monitoring to this logical policy conclusion, it will remain a hollow remedy: What good is it to know that you are injured if you are not compensated?

The Rationale and Beginnings of Medical Monitoring and a Geographic Survey

Looking at the map in Figure 1, the 14 states allowing medical monitoring do not follow a clear political pattern. We have California, thought to be a blue state. But Arizona and Utah honor the tort, as well as Missouri. Florida is thought to be politically divided, but it is in the medical monitoring bracket.

There are at least three useful 50-state surveys of medical monitoring. [1]

To show how medical monitoring keeps evolving, the BP oil spill disaster, much as the *Friends for All Children* case described below involving Vietnamese children, provided such a compelling set of facts that Judge Barbier allowed a medical benefits class

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Figure 1. Medical Monitoring Law Map

Legend

■ White = 14 states that allow medical monitoring without physical injury: Arizona, California, Colorado, Florida, Illinois, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, Utah, Vermont, and West Virginia.
■ Striped = 23 states that do not allow medical monitoring without physical injury: Alabama, Arkansas, Connecticut,

Georgia, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, and Wisconsin.
■ Dark gray = 2 states in which the laws are divided: Delaware and Indiana.
■ Light gray = 11 States in which the issue has not been addressed: Alaska, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Mexico, and South Dakota.

action settlement, applicable to claimants not only in Florida, where medical monitoring has been approved, but in Louisiana, Alabama, and Mississippi, where it is has not. [2]

So, the law may continue to evolve to meet society's needs in this field.

Simply put, states that allow medical monitoring do so when a group of claimants has been exposed to a known hazardous substance, such as lead, or a dangerous product, such as football

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helmet concussions, or air decompression in an airplane, through the conduct of the defendant, with the claimants therefore being at increased risk of contracting disease. Under this tort remedy, claimants are tested periodically, for an agreed or decided period, usually between 10 and 40 years, to see if they contract the disease linked to the toxic substance or dangerous product.

Thus, medical monitoring recognizes the long-term harmful nature of toxins and man-made products, thereby matching a remedy with the malady.

The tort is 30 years old. Medical monitoring, like many torts, got its start with a sympathetic set of facts, in *Friends for All Children Inc. v. Lockheed Aircraft Corp*. [3] In *Friends for All Children,* the court evoked public policy to create a remedy for 149 Vietnamese orphans who were injured in an aviation accident in Vietnam.

Most know the case: a plane loaded with Vietnamese orphans to be adopted in America crashed, resulting in cabin decompression and neurological

disorders, known as minimal brain dysfunction (MBD), in the children. Lockheed argued that tort law in the District of Columbia did not recognize a cause of action for diagnostic exams. The court ignored Lockheed's argument and established a half million dollar fund to conduct long-term brain exams of the children to determine if they were hurt.

The District of Columbia Circuit Court upheld the District Court's decision, with the following two quotations being frequently cited to justify the tort:

> Jones is knocked down by a motorbike when Smith is riding through a red light. Jones lands on his head with some force. Understandably shaken, Jones enters a hospital where doctors recommend that he undergo a battery of tests to determine whether he has suffered any internal head injuries. The tests prove negative, but Jones sues Smith solely for what turns out to be substantial costs of the diagnostic examinations. [4] It is difficult to dispute that an individual has an interest in avoiding expensive diagnostic examinations just as he or she has an interest in avoiding physical injury. When a defendant negligently invades this interest, the injury

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> to which is neither speculative nor resistant to proof, it is elementary that the defendant should make the plaintiff whole by paying for the examinations. [5]

The second most famous medical monitoring case is *Ayers v. Jackson Township,* [6] a classic community toxic tort medical monitoring case. Here, a township in New Jersey contaminated water with toxic pollutants reaching into an aquifer from the township landfill. In finding that the residents were entitled to the cost of medical surveillance based on enhanced risk of disease as a result of exposure to the toxic chemicals, the New Jersey Supreme Court held:

> That the cost of medical surveillance is a compensable item of damages where the proofs demonstrate, through reliable expert testimony predicated upon the significance and extent of exposure to chemicals, the toxicity of the chemicals, the seriousness of the diseases for which individuals are at risk, the relative increase in the chance of onset of disease in those

> exposed, and the value of early diagnosis, that such surveillance to monitor the effect of exposure to toxic chemicals is reasonable and necessary. The medical surveillance claim seeks reimbursement for the specific dollar costs of periodic examinations that are medically necessary notwithstanding the fact that the extent of plaintiffs' impaired health is unquantified. We find that the proofs in this case were sufficient to support the trial court's decision to submit the medical surveillance issue to the jury, and were sufficient to support the jury's verdict. [7]

In noting that medical monitoring usually does not adjudicate personal injury claims and allows the medical monitoring claimants to reserve them for the future, the New Jersey Court blessed the "discovery" rule for toxic tort-related statutes of limitation. [8] This construction of the relevant statute of limitations works hand-in-glove with medical monitoring, allowing a claimant who discovers that he or she is sicker later still to file a claim for personal injury in the courts.

The evolution of this tort is not different from the creation of negligence law during the industrial revolution in England. [9] Prior to

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the industrial revolution, English tort law was limited to intentional harm. However, as people began to live closer together, factories were created and modes of transportation became increasingly dangerous, and a duty of care in negligence was invented to adjust the law of torts to factual reality.

Arguably, the same is occurring or should occur with medical monitoring. We, as lawyers, devote much of our practice to latent injuries in our current society, from toxic chemicals, pharmaceutical drugs, and other human-created substances or products. Thus, tort law may need to accommodate these changes if it is to continue to maintain its role of adjudicating disputes resulting in injury or potential injury.

So, this article is a mere snapshot. Fifty years from now there may be ubiquitous medical monitoring with the holistic approach suggested in this article, or no medical monitoring at all.

An Ideal Case Study

The Fernald Uranium Plant Medical Monitoring Program in Ohio is a classic case with all of the ideal elements for a successful medical monitoring program, [10] except paying claimants if they get sick later.

In the case, 11,000 people were exposed to radiation in uranium dust from a plant that converted uranium ore to metal for use in nuclear plants and for nuclear weapons, but had no apparent physical injury.

There was a $78 million settlement fund for a medical monitoring program. Detailed testing was conducted and many people discovered that they had latent diseases in time to cure them. In addition, the population actually became healthier because people had medical checkups and took the doctors' advice. Turnout was the highest reported for any medical monitoring case.

Rationale for Medical Monitoring

The nearby residents' emotional distress was related primarily to the potential harmful health effects resulting from plant environmental releases. An annual medical monitoring program to identify disease if present or to reassure those claimants found to be healthy

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was one way to mitigate the emotional distress suffered by class members. The medical monitoring tests were available, whether harmful health effects occurred or not, thereby mitigating the distress related to uncertainty. It continues to be one of the largest and most extensive medical monitoring programs in the country.

The program focused on testing that had the most potential to improve subsequent health without regard to whether those conditions were potentially related to exposures to hazards from the plant. By contrast, most medical monitoring programs try to match the testing regimen with the expected etiology of the toxin or harmful nature of a product.

In legal terms, then, the benefit to the claimants was indirect. The rationale was that health screening and health promotion activities for common health conditions would balance or offset those exposure-related harms that could not be mitigated.

The medical monitoring program was administered by the University of Cincinnati. Surprisingly, 9,700, of the 11,000 eligible claimants, or 88%, participated. In my experience, a medical monitoring settlement is fortunate if half of the claimants participate, with a third sometimes being the case. See the Medical Monitoring Settlement Administration Tips section, below.

Health Benefits for the Participant Population

By the end of the seventh annual examination cycle, in November 2006, a total of 1,688 "major" adverse health findings for just a 11,000 people, or 15% of the population, had been made as a result of the medical monitoring examinations. The most common "major" finding was diabetes (486 cases). Others include 229 skin cancers, 145 breast cancers, 107 prostate cancers, 41 colon cancers, 38 lung cancers, and 37 urinary system cancers diagnosed as a result of examination findings. There were 8 cases of leukemia and 7 cases of lymphoma diagnosed as a result of the program.

Among those enrolled in the program as adults, life table analysis predicted 947 expected deaths (11%) by 2004, but, in fact, only 705 participants (8%) died.

In addition to improved mortality, there is evidence of reduction in cardiovascular risk factor levels, that may, with time, result in less heart and other cardiovascular diseases. In adult males who came

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to at least five of the first seven exams offered, mean total serum cholesterol levels decreased by about 30 mg/dL, across almost all age groups (age group assignment based on age at each exam). The same cholesterol finding was noted in women age 55 and older.

Possible Value of the Program as a Research Resource

The database and archived biospecimens represent a rich resource for future research of both health effects related to the environmental exposure and a wide range of nonexposure questions. For example, risk factor matrices have been developed from questionnaire information, such as a matrix of cumulative cigarette pack-years for all participants, for each calendar year. There are also matrices for family history for each type of cancer for each program participant.

Claimant Medical Monitoring Participation Rates in Two Cases

Because this remedy does not include medical care but only diagnosis, it is often difficult to convince claimants to participate. Below is a summary of medical monitoring participation rates in a Clarksburg, West Virginia, defunct zinc smelter settlement and a Mingo County, West Virginia, coal slurry water contamination settlement during the first round of testing, with each program scheduled to last 30 years, and with testing to be conducted every other year.

Settlement	Number of Eligible Claimants	Number Participating in the First Round of Testing	Participation Rate
Clarksburg (first round of testing in 2011)	4,148	2,040	49%
Mingo County (first round of test in 2014)	714	92	13%

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Subsequent rounds of testing for both programs have seen reduced participation rates, so that they are now between 5% and 10%. One reason is COVID-19, with the programs essentially not having a round during the pandemic. Rounds being carried out now will help us determine if the impact of the pandemic was temporary or is permanent.

Suggested methods to incent claimants to participate in medical monitoring ethically are outlined in the Medical Monitoring Outreach subsection.

Elements Necessary to Prove Medical Monitoring

The widely cited *Bowers* [11] test lists the following elements required to make a medical monitoring case:

> 1. the claimants have been significantly exposed, relative to the general population;
> 2. to a proven hazardous substance;
> 3. through the tortious (wrongful) conduct of the defendant (by the violation of environmental laws for example);
> 4. the exposure has proximately caused the claimants to suffer

> an increased risk of contracting a serious latent disease;
> 5. the increased risk makes it reasonably necessary for the claimant to undergo periodic diagnostic examinations different from what would have been prescribed in the absence of the exposure; and
> 6. monitoring procedures exist that make the early detection of the disease possible.

Currently I administer two medical monitoring settlements in West Virginia, and there are others. But, if you think that West Virginia is the golden arches of medical monitoring, look at *Dillon v. Goals Coal Company,* in the Raleigh County, West Virginia, Circuit Court Case Number OV-C-781, where a jury agreed with *Massey Energy* that a medical monitoring claim in connection with a coal silo near an elementary school emitting dust and possibly causing

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lung disease was not appropriate because of the lack of evidence of exposure and increased risk under the *Bowers* test.

Legal Background and Implementation

Legal Background

Medical monitoring typically does not include a personal injury claim, with this claim being preserved for the future. Also, punitive damages may not be available, as the defendant arguably acts somewhat responsibly in providing medical monitoring. [12]

The majority rule favors "the use of court-supervised funds to pay medical-surveillance claims as they accrue, rather than lumpsum verdicts." [13] Other courts have suggested that lump-sum damages may be an acceptable remedy in medical monitoring suits. [14] The damage award is usually placed in a court-administered fund, and plaintiffs only collect money for testing they actually undergo. The establishment of such court-supervised funds designated specifically for reimbursement of medical testing may lessen the attractiveness of these claims to plaintiffs as well as their counsel.

In my experience, medical monitoring turnout usually does not approach the 88% claimant participation rate as seen in *Fernald*. [15] One-third is more

like it, and you can expect a battle over whether a legal fee should be paid to plaintiffs' counsel for the claimants that do not show up. Contrast *Van Cylinder Gernert v. Boeing Co.* [16] with *Attorneys' Fees, Unclaimed Funds, and Class Actions: Aimlication of the Common Fund Doctrine.* [17]

Typical Implementation

The medical monitoring program is designed by experts. Typical procedures involve a blood test and a urinalysis, and a follow-up appointment to visit with a medical monitoring physician, to review the test results, and possibly to obtain recommendations for further care if any of the tests are positive.

Based on my experience in the Alabama PCB settlement and the *Perrine v. DuPont* settlement, I have found that medical provisioning for large groups of claimants is a lot cheaper if you follow a "retail" method, paying for units of medical service, or clicks, as

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opposed to a wholesale method, staffing a medical clinic, or bricks. Often, a third-party medical administrator is used, with experience in negotiating rates with medical providers.

Types of Medical Monitoring

Medical monitoring has been implemented in the following areas:

1. community toxic exposure from zinc, PCBs, fertilizer, creosote, dioxin, PFOA, or other defunct plants; [18]
2. lead paint-coated toys;
3. tobacco; [19]
4. medical device implants;
5. emissions from Chinese drywall;
6. radiation from cellular phones;
7. April 2010 BP oil spill disaster; [20]
8. September 11, 2001, New York City terrorists attacks;
9. mining;
10. animals—tainted pet food. [21]

However, medical monitoring has been largely unsuccessful with pharmaceuticals. Contrast fen-phen, where it was successful, [22] with Baycol, Rezulin, and Vioxx, where it was unsuccessful. [23]

Apparently, no medical monitoring is allowed under federal common law. The Supreme Court has spoken on this issue, and medical monitoring without personal injury does not appear to be a viable theory of liability in those areas (such as railroad law) governed by federal common law. [24]

Arguments For and Against Medical Monitoring

Below is an outline of arguments typically made for and against implementing this remedy.

For Medical Monitoring

1. Early detection is the key to the cure for many diseases, the old "ounce of prevention" argument. [25]

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2. A "pure" medical monitoring claim, that requests no personal injury, should enable the claimant to litigate a damages claim in the future despite typical claim-splitting (one bite at the apple) defenses.
3. Although there are costs associated with litigating a second, personal injury claim, they may be small in comparison to the societal and human costs avoided due to early detection of disease though medical monitoring.
4. Medical monitoring provides deterrence to defendants' bad conduct so that they do not avoid paying all the costs resulting from their negligence.
5. Savvy defendants may benefit because medical monitoring may provide enough notice to close out claims for punitive damages, and successful treatment in the early stages of disease may reduce overall damage claims.
6. Savvy defendants could couple a medical monitoring program with a personal injury payment grid to sew up the case. However, this has never been done.

Against Medical Monitoring

1. The two big defenses:

a. No physical injury. (See the next section: A Possible Cure for the Requirement for Physical Damage Prior to Having Medical Monitoring: Subcellular Damage Proof.)
b. Class certification should not be granted because individual proof would be required to determine and administer such claims. (See the subsequent section: The Increasingly High Bar: Denial of Class Certification.)

2. Legislatures, not courts, should resolve the type of "far-reaching and complex public policy issues" raised by plaintiffs' requests for medical monitoring.
3. Medical monitoring is an illegal expansion of tort law.
4. Requiring physical injury for medical monitoring reduces fraudulent claims and provides a clear line

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allowing fact-finders to distinguish between plaintiffs who have a claim and those who do not.
5. A medical monitoring claim runs afoul of the economic loss doctrine: the plaintiff is not hurt.
6. "Undesirable effects" could flow from a medical monitoring claim, such as it could "drain resources needed to compensate those with manifest physical injuries and a more immediate need for medical care," monitoring does not provide "an unmitigated benefit for all concerned," and could "wreak enormous harm" on the economy.
7. Medically necessary monitoring may be paid for by claimant insurance anyway. What about the Affordable Care Act?
8. The underlying conduct of the defendant was not tortious.
9. The plaintiff cannot establish that he or she is at a significant increased risk of injury.
10. The proposed monitoring is not capable of detecting the

> condition earlier than without monitoring.
> 11. The proposed monitoring is not reasonably necessary: Would a reasonable physician prescribe the proposed monitoring? [26]
> 12. The proposed monitoring is recommended/provided already even without the claimed increased risk of injury. [27]

A Possible Cure for the Requirement for Physical Damage Prior to Having Medical Monitoring: Subcellular Damage Proof

It is still the majority rule that medical monitoring without personal injury is not a good tort. Of course, medical monitoring with personal injury is an oxymoron, because the purpose of medical monitoring is to detect future injury.

A typical rationale is found in the Alabama Supreme Court case of *Hinton v. Monsanto Co.,* [28] in rejecting a medical monitoring claim brought by a claimant exposed to PCBs. The court reasoned:

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> To recognize medical monitoring as a distinct cause of action . . . would require this court to completely rewrite Alabama's tort-law system, a task akin to traveling in uncharted waters, without the benefit of a seasoned guide . . . we find it inappropriate . . . to stand Alabama tort law on its head in an attempt to alleviate [plaintiff's] concerns about what *might* occur in the future . . . *That law provides no redress for a plaintiff who has no present injury or illness.* [29]

See also the more recent Wisconsin case of *Alsten v. Wauleco,* [30] denying medical monitoring without personal injury based on this rationale: "We are persuaded by the United States Supreme Court's decision in *Metro-North Commuter Railroad Co. v. Buckley,* 521 U.S. 424 (1997), which held that an asymptomatic railroad worker who has been exposed to asbestos could not recover medical monitoring expenses under the Federal Employees' Liability Act, and by several other jurisdictions that have articulated compelling reasons not to recognize medical monitoring claims in the absence of actual injury."

Similar findings are made by the Supreme Courts of Kentucky, Louisiana, Michigan, Mississippi, Nevada, and Oregon.

If physical injury is required for medical monitoring, why not look for physical subcellular change that is a badge of future injury? In 2009, Massachusetts did just that in *Donovan v. Phillip Morris*. [31] A medical monitoring program for cigarette exposure was allowed to proceed despite the defendants' argument that there was no physical damage, based on the rationale that:

> [n]o particular level or quantification of increase in risk of harm is necessary, so long as it is substantial and so long as there has been a *corresponding subcellular change*. [32]

Better scientific proof may help clear the *physical injury* hurdle to medical monitoring. Advancements in diagnostic technologies may allow more plaintiffs to show present physical injury. Scientific advances are expanding diagnostic capabilities. These advances may have a positive effect on the utility of medical monitoring in litigation.

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The Increasingly High Bar: Denial of Class Certification

The United States Supreme Court case of *Dukes v. Wal-Mart Stores, Inc.* [33] may chill certification of medical monitoring claims in federal court.

For medical monitoring to be a practical remedy, it usually requires class certification, as the per-claimant recovery is relatively small. The threshold decision in bringing the tort claim is to decide whether to ask for a 23(b)(2) or a (b)(3) class. The expected favorite is Rule 23(b)(2) because no prior putative class member notice is required, saving expenses, and no opt-outs are allowed, providing class closure. However the *Perrine v. DuPont* case has a Rule 23(b)(3) medical monitoring class. Below is a medical monitoring Rule 23(b)(2) and (b)(3) class comparison:

> Rule 23(b)(2)
> ■ No prior notice and no opt-outs.
> ■ Applies when the party opposing class certification acted or refused to act on grounds that apply generally to the class so that injunctive or declaratory relief is appropriate respecting the

class as a whole.
■ Most courts have interpreted certification under this subsection as requiring "cohesion" among class members.
Rule 23(b)(3)
■ Predominance—common issues among class members predominate over individual ones.
■ Superiority—class treatment is superior to other methods of adjusting the issues.

The findings in *Dukes* may eclipse Rule 23(b)(2) medical monitoring classes. *Dukes* was a California case that involved a class of female Walmart employees alleging sexual discrimination against Walmart and seeking injunctive and declaratory relief, back pay, and punitive damages. The significance of *Dukes* is that it made clear that claims for monetary relief that are not incidental to the

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injunctive or declaratory relief sought cannot be certified under Rule 23(b)(2). [34] This clarification in *Dukes* that Rule 23(b)(2) classes must seek injunctive, rather than simply "equitable," relief reopens the debate about whether a court can ever certify medical monitoring claims to form a mandatory 23(b)(2) class. Is medical monitoring injunctive relief or damages? If it is merely damages, then the claim may not be classable under 23(b)(2) because of the underlying findings in *Dukes*.

The Class Action Fairness Act (CAFA) expanded the federal courts' diversity jurisdiction to cover, with limited exceptions, most class actions against nonresident defendants, worth more than $5 million, so any significant medical monitoring case will probably be in federal court. [35] Although several federal district courts have certified medical monitoring classes, federal appellate courts that have examined proposed medical monitoring class actions have often refused. [36] With the addition of Federal Rule of Civil Procedure 23(f) in 1998, the threat of appellate review became more potent. Federal Rule 23(f) authorizes parties to petition for immediate appellate review of a certification decision without leave of the district court.

These federal developments may impede class actions for medical monitoring for the time being.

If *Dukes* precludes any request for monetary relief by a Federal Rule 23(b)(2) class, then a court may need to determine whether the medical monitoring relief requested by the class is merely monetary. A defense attorney will argue that medical monitoring is a claim for monetary damages that has often been equitably administered by the courts. Again, is medical monitoring injunctive relief or damages?

As a Supreme Court case, *Dukes* has been cited frequently. Of the 3,837 times it was cited, 108 of them were in reference to the above holding regarding the certification of classes seeking monetary damages. Of those, two did so with respect to medical monitoring. [37] The first of those cases was the 2012 ruling from *Donovan v. Philip Morris, USA, Inc.* [38] There, the court determined that the *Dukes* holding did not prevent the class in the case from being certified under Rule 23(b)(2), as the class was seeking no damages beyond medical monitoring, there was no adequate

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monetary remedy, and the medical monitoring remedy was specific, requiring that funds be used only for the medical monitoring and noting that any funds not used for medical monitoring would be returned to the defendant. The court stood by its earlier decisions that the relief sought by the *Donovan* class was "wholly injunctive." [39]

The second case to cite *Dukes* is *Gates v. Rohm and Haas Co.* [40] There, the court noted *Dukes* and questioned whether the relief sought by the plaintiffs could be certified under 23(b)(2), as the types of medical screenings and costs required by the class would vary, so that they could not all be covered by a single injunction or declaratory judgment as required by Rule 23(b)(2). [41] However, as the plaintiffs' claims failed for other reasons, the court did not formally decide the issue.

The primary case discussing whether or not medical monitoring is injunctive or monetary relief appears to be *Day v. NLO, Inc.* [42] (overturned in part on other grounds). There, the court noted that there were many schemes by which medical monitoring could be structured, including ordering the defendant to pay the plaintiff directly, or ordering the defendant to pay the plaintiff's medical bills, neither of which would constitute injunctive relief as required by Rule 23(b)(2). [43] However, a court-established program, managed by a court-appointed, court-supervised trustee, under which the

plaintiff was monitored by particular physicians and the medical data was produced and utilized for group studies, and financed by the defendant, would constitute injunctive relief. [44]

Does a Medical Monitoring Claim Trigger Insurance Coverage (Or, Can the Defendant Have It Both Ways)?

Most courts have found that exposure to a harmful substance known to increase the risk of future illness is sufficient to trigger an insurer's duty to defend based on bodily injury. [45] At least one court has held that a medical monitoring claim also triggers general liability. [46]

More cleverly drafting a complaint may help trigger liability: medical monitoring putative class action complaints, by design, frequently exclude from class membership any person making

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claims for personal injuries because such claims necessarily entail individualized inquiry that is often fatal to class certification. Accordingly, the omission of allegations relating to physical injury in a medical monitoring class action suit may be grounds for denial of defense or indemnity to those claims. But, adding the claim may prevent two bites of the apple.

One might ask whether a defendant may have it both ways. The defendant may argue that physical injury is required to trigger medical monitoring but also tell its insurance carrier that there is physical injury to trigger coverage.

Medical Monitoring Settlement Administration Tips

Based on work on three medical monitoring or quasi-medical monitoring cases, I have the following settlement administrative suggestions.

Medical Monitoring Outreach and Compensation

To generate claimant interest in participating in medical monitoring, the following steps are recommended:

1. A local claims office staffed in part by locals, town meetings, and outreach using medical professionals.
2. Facilitate a claimant "buy-in" by having the claimants help

design the program, and by implementing the program by collaboration: claimants pick the doctors (their choices may be counterintuitive). In the *Perrine v. DuPont* case, the claimants wanted local doctors who already serve them. In the Mingo County case, the claimants did not trust local doctors. Without this collaborative step, we may never have detected this difference.

3. Make the program simple, easy to understand, and accessible:

a. Website to update claimants.

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b. Simple medical monitoring claimant questions and answers, and an understandable schedule of medical monitoring benefits. (See www.perrinedupont.com.)

c. In order to encourage doctors to participate, and not to shy away from a program that is related to "litigation," design a simple description of the plan and its implementation that is doctor friendly. (See www.perrinedupont.com.)

4. Claimants seldom do anything solely for their own benefit, so monetary benefits should be considered.

a. Cash incentive payments are successfully used to recruit claimants to sign up for medical monitoring. However, there are ethical problems in paying people to take medical tests, though compensation for travel and perhaps a meal ($100 to $200 per round of testing) is common.

b. One ethical incentive for medical monitoring is to combine it with medical care, such as in the 2003

Tolbert PCB Settlement in Anniston, Alabama (*Tolbert v. Monsanto Co.,* No. 2:01-CV-1407-UWC, N.D. Ala. 2001), where free primary care and prescription drugs are provided.
c. The medical monitoring long-term participation hurdle is difficult to clear. Initial enthusiasm at the onset is usually reduced in each succeeding round of testing. If monitoring were paired with monetary recovery, for claimants that get sicker with disease possibly linked to the toxigen, as suggested in this article, participation may remain more robust. We are trying a new approach in the Hoosick Falls, New York, Program. The Medical Monitoring Fund surplus at the end of testing will be shared ratably by the claimants to the extent they participated. (See Hoosick Falls PFOA Settlement Website, www.hoosickfallspfoa.com, Final Approval Order at pp. 20-21.)

5. Newsletters will generate interest in medical monitoring. Here are two examples:

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a. *The Medical Monitor* (*Perrine v. DuPont* Harrison County Cir. Ct., W.Va., case), found at www.perrinedupont.com. As noted in the newsletter, approximately half of the claimants who signed up for medical monitoring showed up to be tested. In this case, claimants were given the choice of merely receiving $400 and checking a no box for medical monitoring or receiving $400 and checking a yes box for medical monitoring. One-third chose the no box and the money. Of the remaining two-thirds who checked the yes box to participate in the program, only half went through with medical monitoring, so that approximately one-third of the

class benefited from the program.
b. *The Tolbert Newsletter* (Tolbert, Anniston, Alabama, PCB case), found at www.tolbertqsf.com.

6. Consider bringing testing to the claimants with a mobile clinic. A mobile clinic is being used in the Mingo County medical monitoring case, with costs that approximate those incurred with traditional standing clinics in the Anniston, Alabama, and Clarksburg, West Virginia, settlements. Where claimants are scattered or elderly, a mobile clinic is more convenient and may increase program participation.

Bridging the Disconnect Between Medical Monitoring to Determine a Claimant's Health and for Epidemiological Studies

As suggested in the *Fernald* case, one purpose of medical monitoring is to determine if there is linkage between the toxic substance or the dangerous product and disease. This usually requires an epidemiological study. However, most medical monitoring programs do not provide funding for epidemiological studies. Almost invariably, researchers want a grant before they do any work. The result may be that beautiful medical monitoring data may never be examined to determine possible linkage between the toxic substance and health.

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Often, the data collected in monitoring for human health is inadequate for epidemiological studies, because the experts that designed the medical monitoring program only focused on health and not scientific study. An epidemiologist should be involved in the case at the early stages to help design and fund the remedy, and the consequent medical monitoring test (and hopefully research) regimen.

Conclusion

Surprisingly, in all the reported litigation involving medical monitoring, no one representing either plaintiffs or defendants has suggested the commonsense holistic remedy of coupling testing with payment for injury if the testing is positive later. In my opinion, this approach would best serve the interests of both plaintiffs and defendants by providing a total plaintiff

remedy for exposure to toxic substances or dangerous products and defining the defendants' monetary exposure.

It is my hope that this is the future of medical monitoring.

Notes:

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[1.] D. Scott Aberson, *Note: A Fifty-State Survey of Medical Monitoring,* April 5, 2006, 1120 William Mitchell Law Review, Volume 32: 3, Page 1095; *Medical Monitoring and Toxic Tort Claims: Preparing for the Future and Post-Dukes Environment,* ALI CLE, December 8, 2011; and *Drug and Device Law: Medical Monitoring—Another Fifty State Survey 2010*.

[2.] *Deepwater Horizon* Medical Benefits Class Action Settlement Agreement, As Amended on May 1, 2012, and January 11, 2013, Order and Judgment Granting Final Approval thereof, *In Re Oil Spill, MDL 2179*.

[3.] 746 F.2d 816 (D.C. Cir. 1984).

[4.] *Ibid*. at 826.

[5.] *Ibid*.

[6.] 106 N.J. 557 (1987).

[7.] *Ibid*. at 22-23.

[8.] *Ibid*. at 12.

[9.] Percy H. Winfeld, *History of Negligence in the Law of Torts,* 42 Law Quarterly vol. 184 (1926).

[10.] Journal of Occupational and Environmental Medicine, 51(12): 1374-1383 (December 2009).

[11.] 522 S.E. 2d 434; 206 W.Va. 133 (W. Va. 1999).

[12.] 694 S.E. 2d fil 841 (W. Va. 2010).

[13.] Ayers, *supra*.

[14.] Bowers, *supra*.

[15.] Fernald, *supra*.

[16.] 590 F.2d 433, at 435 (2nd Cir. 1978), granted, 99 2158 (1979).

[17.] Anita R. Golbey, 48 Fordham Law Review Issue 3 Article 5.

[18.] Perrine, *supra*.

[19.] 914 N.E. 2d 891 (Ma. 2009).

[20.] *Ibid.*

[21.] No. 12-3299 (E.D.N.Y. 2012).

[22.] Re Diet Drugs, 2000 W.L. 1222042 (E.D. Pa. 2000).

[23.] Re Baycol, 218 F.R.D. 197 (D. Minn. 2003); Re Rezulin, 210 F.R.D. 61 (D. Minn. 2003); and Sinclair v. Merck, 195 N.J. 51 (2008).

[24.] Metro-North Commuter Railroad Co. v. Buckley, 521 U.S. 424, 441-44 (1997); see Norfolk & Western Railway. Co. v. Ayers, 538 U.S. 135, 156-57 (2003) (reaffirming Metro-North in dictum); June v. Union Carbide Corp., 577 F.3d 1234, 1249-51 (10th Cir. 2009) (no medical monitoring with respect to nuclear radiation under Price-Anderson Act); In re Hanford Nuclear Reservation Litigation, 534 F.3d 986, 1009-10 (9th Cir. 2008) (same); Syms v. Olin Corp., 408 F.3d 95, 105 (2d Cir. 2005) (no medical monitoring as "response costs" under CERCLA).

[25.] Siddhartha Mukherjee, *The Emperor of All Maladies* (Scribners, Nov. 2010).

[26.] In re Propulsid Prods. Liab. Litig., 208 F.D.R. 133 (E.D. La. 2002) (denying certification of medical monitoring class action in pharmaceutical case because "[n]either the FDA, nor any medical organization or institution, nor anyone else for that matter, except the plaintiffs has recommended or suggested that a program of medical monitoring or a group study of all former Propulsid users be undertaken").

[27.] *E.g.*, Sheridan v. NGK Metals Corp., 609 F.3d 239 (3d Cir. 2010) (affirming summary judgment for manufacturer of beryllium-based products because plaintiff failed to show that he was "sensitized" to beryllium).

[28.] 813 So. 2d 827 (AL 2001).

[29.] *Ibid.* at 830-32 (emphasis added).

[30.] 2011 W.L. 2314988 (Wisc. APP 2011).

[31.] 914 N.E. 2d 891, 901 (Mass. 2009).

[32.] *Ibid.* (emphasis added).

[33.] 131 S. Ct. 2541 (2011).

[34.] *Ibid.* at 2557.

[35.] 28 U.S.C. Section 1332(d).

[36.] *See* Barnes v. Am. Tobacco Co., 161 F.3d 127 (3d Cir. 1998), cert. denied, 526 U.S. 1114 (1999); Ball v. Union Carbide Corp., 385 F.3d 713, 728 (4th Cir. 2004); In re St Jude Med., Inc., 425 F.3d 1116, 1120 (8th Cir. 2005); In re St Jude Med., Inc., 522 F.3d 836, 840 (8th Cir. 2008), reh'g denied, 522 F.3d 836 (8th Cir. 2008); Zinser v. Accufix Research Inst., Inc., 253 F.3d 1180, 1196, amended, 273 F.3d 1266 (9th Cir. 2001); Boughton v. Cotter Corp., 65 F.3d 823 (10th Cir. 1995).

[37.] A third case, In re Ford Motor Co. E-350 Van Products Liability Litigation, appears in the references, but did not actually involve medical monitoring.

[38.] 2012 WL 957633.

39. *Ibid.* at 9.

40. 655 F.3d 255 (3rd Cir. 2011).

41. *Ibid.* at 263.

42. 144 F.R.D. 330 (S.D. Ohio 1992).

43. *Ibid.* at 335.

44. *Ibid.* at 336.

45. Motorola v. Assoc. Indem. Corp., 878 So.2d 824, 834 (La. Ct. App. 2004).

46. Baughman v. United States Liability Ins. Co., 662 F. Supp. 2d 386 (D.N.J. 2009).