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Medical Monitoring: The Right Way and the Wrong Way

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INTRODUCTION****

Most scientists and doctors believe that medical monitoring is only appropriate when it has the potential to prevent or cure disease. At all times, cost-benefit and risk-utility analyses must precede any implementation of a medical monitoring plan. These principles are recognized by the courts that prohibit claims of medical monitoring in the absence of present physical injury. Yet, some courts have ignored the scientific and medical literature's guidance on sound medical monitoring. Such courts have allowed medical monitoring claims to proceed without evaluating the effectiveness, cost, and risks of medical monitoring in a given case. In doing so, these courts have brought about drastic changes to the common law. As this Article will show,

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these major changes are much better left to state legislatures. The legislature is better equipped to make any far-reaching changes in the law because of its information-gathering ability, prospective treatment of new laws, and broad perspective. We have suggested this in the past.¹ Now time has shown—and key state supreme courts have realized—this practical truth.

This Article discusses the accepted scientific and medical approach to medical monitoring and explains the considerations involved. Next, the Article outlines how courts have approached these issues. Then, it details the reasons the courts are ill-equipped to implement medical monitoring causes of action. Finally, the Article explains why the legislature is the institution that should decide whether to implement medical monitoring as a valid claim.

I. MEDICAL MONITORING: THE PREVAILING SCIENTIFIC AND MEDICAL PERSPECTIVE

Medical monitoring lawsuits “reach out across a long-standing divide between personal injury litigation and public health.”² The scientific and medical community views medical issues much differently than the legal community.³ Scientists and medical professionals, the true experts in the field, view medical monitoring as one component of medical care and disease prevention—a diagnostic tool tailored to detect the potential development of specific diseases.⁴ In the courts, claims for medical monitoring are intended to finance examinations for currently asymptomatic plaintiffs who have had an exposure with the goal of detecting and treating the onset of disease.⁵ Generally, for a medical monitoring claim in the courts, plaintiffs do not need to prove they are presently injured.⁶

In contrast, the majority of doctors and scientists believe medical monitoring programs, which generally pose some degree of risk to the pa-

1. See Victor E. Schwartz et al., *Medical Monitoring—Should Tort Law Say Yes?*, 34 WAKE FOREST L. REV. 1057 (1999).

2. David M. Studdert et al., *Medical Monitoring for Pharmaceutical Injuries: Tort Law for the Public’s Health?*, JAMA, Feb. 19, 2003, at 889, 890.

3. Cf. Carl F. Cranor & David A. Eastmond, *Scientific Ignorance and Reliable Patterns of Evidence in Toxic Tort Causation: Is there a Need for Liability Reform?*, LAW & CONTEMP. PROBS., Autumn 2001, at 5, 7 (vast differences between scientific and legal thought on the issue of causation create “an uncomfortable interface between science and the law”).

4. See generally Laura Welch & Pekka Roto, *Medical Surveillance Programs for Construction Workers*, 10 OCCUPATIONAL MED.: STATE OF THE ART REVIEWS 421, 422 (Knut Ringen et al. eds., 1995).

5. See Arvin Maskin et al., *Medical Monitoring: A Viable Remedy for Deserving Plaintiffs or Tort Law’s Most Expensive Consolation Prize?*, 27 WM. MITCHELL L. REV. 521, 522 (2000).

6. *Id.*

tient, must have the potential to be effective.⁷ They believe medical monitoring is only appropriate when it could lead to the cure or prevention of disease.⁸ To the mainstream medical community, “[d]ocumented effectiveness is—or generally should be—the most basic requirement for providing a health care service. It is a particularly important prerequisite for preventive services, where the clinician has a compelling responsibility to ‘do no harm’ to healthy patients.”⁹

Most doctors and scientists value medical monitoring in specific situations. They do not believe that medical monitoring is a preventive “cure all” that can detect all types of diseases in all situations. The majority of medical professionals disagree with the courts that believe a claim for medical monitoring is valid for any type of disease. One medical scholar notes:

The enthusiasm generated over the past several years for medical monitoring, or as it is often called, medical surveillance, has been extensive. The excessive claims made in its name in regard to the prevention of disease have little or no relation to reality or objectivity, and it would seem the time has come to recall A.J. Balfour’s apt comment, “It is unfortunate, considering that enthusiasm moves the word, that so few enthusiasts can be trusted to speak the truth.”¹⁰

As we will show, application of the truth will prevent the creation of false hopes and potential risk to patients.

A. A Look at Medical Monitoring from the Mainstream Scientific and Medical Perspective: Its Definition and Requirements

To many medical professionals and scientists, “[m]edical monitoring of a patient is a form of surveillance based on repetitive use of the same test or test group to detect a specified change in the patient indicating a change in his prognosis or need for treatment or a change in his treatment.”¹¹ Scientists and

7. See Myrton F. Beeler & Robert Sappenfield, *Medical Monitoring: What Is it, How Can it Be Improved?*, 87 AM. J. CLINICAL PATHOLOGY 285, 286 (Myrton F. Beeler et al., eds. 1987).

8. See *id.*

9. U.S. PREVENTIVE SERVICES TASK FORCE, U.S. DEP’T OF HEALTH & HUMAN SERVS., GUIDE TO CLINICAL PREVENTIVE SERVICES xxxv (2d ed. 1996), available at <http://odphp.osophs.dhhs.gov/pubs/guidecps/PDF/Frontmtr.PDF> [hereinafter TASK FORCE].

10. W.K.C. Morgan, *Medical Monitoring with Particular Attention to Screening for Lung Cancer*, in OCCUPATIONAL LUNG DISEASE 157, 157 (J. Bernard L. Gee et al. eds., 1984).

11. Beeler & Sappenfield, *supra* note 7, at 285. It is important to distinguish the medical monitoring claims discussed in this paper with medical monitoring, also

medical professionals sometimes interchangeably refer to the terms “medical monitoring,” “medical surveillance,” “medical screening,” and “medical supervision.”¹²

Some doctors believe that, at times, medical monitoring has been misused.¹³ They suggest that medical monitoring “could probably be improved merely by applying common sense and current concepts of medical decision analysis.”¹⁴ The leading medical and scientific communities believe that common-sense concepts should govern medical monitoring:

Monitoring is indicated, generally, when the patient is at sufficiently increased risk for [the disease being monitored] that one believes the potential benefits will outweigh the costs and potential risk of monitoring. That implies that the benefits of detecting the feared event before it has developed to the point of being obvious clinically must be sufficient to justify monitoring. For this to be true, obviously, the event itself must be serious enough, if untreated, to justify the treatment; and early treatment must be beneficial.¹⁵

We can break down this common-sense concept of appropriate medical monitoring into four basic parts: Medical monitoring may be appropriate for diseases when (1) detection is possible before the disease would typically manifest itself through the patient’s symptoms; (2) early detection can lead to early treatment or cure of the disease; (3) the potential benefits of medical monitoring outweigh its cost; and (4) the potential benefits of medical monitoring outweigh its risks.¹⁶

called “medical surveillance,” in the industrial hygiene context. Industrial hygiene “[m]edical surveillance programs are designed to systematically collect and analyze health information on workers exposed to hazardous materials. . . . The end results of this surveillance are used to take both preventive and ongoing action in the workplace.” Gary R. Krieger et al., *Medical Surveillance and Medical Screening for Toxic Exposure*, in *CLINICAL ENVIRONMENTAL HEALTH AND TOXIC EXPOSURES* 107, 108 (John B. Sullivan, Jr. & Gary R. Krieger eds., 2d ed. 2001).

12. Michael Gochfeld, *Medical Surveillance and Screening in the Workplace: Complementary Preventive Strategies*, 59 ENVTL. RES. 67, 68 (1992).

13. See Beeler & Sappenfield, *supra* note 7, at 285 (“Improvement of monitoring protocols for following specific medical problems might help lessen misuse of medical monitoring tests.”).

14. *Id.*

15. *Id.* at 286.

16. *See id.*

1. Detection Must Be Possible Through Medical Monitoring Before the Disease Would Generally Manifest Itself Through Patient Symptoms

The prevailing view of the medical and scientific community is that medical monitoring is only appropriate when it might detect disease earlier than the patient would learn of the disease as a result of experiencing symptoms. Health scientists note, “[i]f the health condition is not detected before a worker would seek help anyway (e.g., when the worker becomes symptomatic), then medical surveillance has no additional preventive benefit.”¹⁷

Following this principle, many scientists and medical professionals advise against medical monitoring for categories of diseases where symptoms generally develop in patients at or before the time medical monitoring can detect the diseases, such as some forms of cancer or nephrotoxicity resulting from lead exposure.¹⁸ In these categories, medical monitoring becomes “questionable and costly,” not to mention redundant, because it alerts professionals to a problem no sooner than they would be alerted otherwise by a patient experiencing symptoms of the disease.¹⁹

2. Early Detection of the Disease Through Medical Monitoring Must Be Beneficial, Leading to Possible Treatment of the Disease

The mainstream scientific and medical community does not believe that medical monitoring is always beneficial. As one medical professional has said,

17. NICHOLAS A. ASHFORD ET AL., *MONITORING THE WORKER FOR EXPOSURE AND DISEASE: SCIENTIFIC, LEGAL, AND ETHICAL CONSIDERATIONS IN THE USE OF BIOMARKERS* 32 (1990). See also Morgan, *supra* note 10, at 158 (citing the criteria formulated by the World Health Organization, including “[t]here should be a recognizable latent or early symptomatic stage” and “[t]here should be a suitable screening test or examination for detecting the disease at the latent or early symptomatic stage, and this test should be acceptable to the population,” and noting these criteria are “as apropos now as when they were first published”).

18. See ASHFORD ET AL., *supra* note 17, at 32 (noting that “serum blood tests will detect an elevated serum blood urea nitrogen (BUN) level in workers who have nephrotoxicity as a result of lead exposure only after 66% of kidney function is lost or when symptoms of renal failure are present”); James E. Cone & Jon Rosenberg, *Medical Surveillance and Biomonitoring for Occupational Cancer Endpoints*, 5 *OCCUPATIONAL MED.: STATE OF THE ART REVIEWS* 563, 563 (1990) (noting that “most tests for early signs of cancer do not provide significantly earlier diagnosis than that based on the appearance of symptoms and thus merely lengthen the time between diagnosis and death, without affecting outcome significantly”).

19. See Krieger et al., *supra* note 11, at 108 (“Applying medical tests of little or no proven value to asymptomatic populations with low prevalence of disease is questionable and costly.”).

the assumption that early diagnosis is always beneficial is fallacious. . . . If it is not possible either to cure or substantially improve the prognosis of the condition, or failing that to delay morbidity and mortality in those affected, then early detection is futile.²⁰

Because of this, many scientists and medical professionals have determined that untreatable and incurable diseases are not appropriate for medical monitoring.²¹ Examples of such diseases include mesothelioma, multiple sclerosis, and amyotrophic lateral sclerosis.²²

The reason for this requirement is that early detection of an unalterable or incurable disease may cause patients great distress. In these cases, “no benefit from earlier diagnosis accrues and considerable psychological damage may result from an earlier knowledge that the subject has developed an incurable disease.”²³ Since early detection can lead to great patient turmoil but cannot lead to cure or treatment of the disease, the scientific and medical community has deemed medical monitoring inappropriate in these situations.

20. Morgan, *supra* note 10, at 157-58 (noting that the goal of medical monitoring “is to detect disease at an early or asymptomatic stage where cure or appreciable relief of symptoms is possible” and citing medical monitoring criteria formulated by the World Health Organization— “[t]here should be an acceptable form of treatment for patients with recognizable disease” and “[t]reatment at the presymptomatic, borderline stage of a disease should favorably influence its course and prognosis”—and noting these criteria are “as apropos now as when they were first published”). See generally Beeler & Sappenfield, *supra* note 7, at 285 (monitoring for the particular disease must be “more effective early than later”); Brian Boehlecke, *Medical Monitoring of Lung Disease in the Workplace*, in OCCUPATIONAL LUNG DISEASE 225, 225, 233 (J. Bernard L. Gee ed., 1984) (stating that medical monitoring may be used “to detect individual workers with potentially reversible adverse health effects of exposure” and stating “[s]ince the purpose of medical monitoring for case finding is to detect abnormalities at a stage in which intervention will improve the prognosis, a suitable means of intervention must be available if screening is to be worthwhile”); Cone & Rosenberg, *supra* note 18, at 570 (criticizing OSHA’s carcinogen medical surveillance program for a “[l]ack of evidence for efficacy of the recommended test methods to determine carcinogenic effects early enough to change the outcome”); Welch & Roto, *supra* note 4, at 422 (“The outcome the program is designed to detect should be alterable; something can be done if an abnormality is found. . . . Further diagnosis and treatment also should be available and acceptable.”).

21. See Morgan, *supra* note 10, at 157.

22. See *id.*

23. *Id.* Considering mesothelioma, “a condition for which neither cure nor treatment is available,” one doctor notes, “at the present time such detection would be inappropriate and could only lead to unnecessary anxiety.” *Id.*

3. The Potential Benefits of Medical Monitoring Must Outweigh the Cost

The cost of a medical monitoring program should always be taken into consideration in a decision to implement that program. Many doctors and scientists caution, “[i]t is important that courts resist efforts to extend injury surveillance to circumstances in which it does not serve health promotion goals in a cost-effective manner.”²⁴ Instead, the cost of determining whether a person has the health condition at issue, “(which would include the cost of diagnosis and treatment)[,] needs to be economically balanced in relation to possible expenditure on medical care as a whole.”²⁵ This cost analysis “should have an increasing role in individual and public policy decisions about providing preventive services.”²⁶ “Properly used, cost-effectiveness analysis incorporates and complements evidence of effectiveness to inform recommendations on clinical preventive and other health care services.”²⁷

Health professionals should always consider the attendant cost when they evaluate tests proposed to monitor patients, thereby “screen[ing] out new procedures or technologies that are poor uses of medical resources.”²⁸ In fact, “it is both reasonable and necessary for clinicians to consider cost-effectiveness in many cases, weighing whether the marginal benefit to an individual patient of a test, procedure, or treatment as compared to an alternative justifies its additional cost to the patient or to society as a whole.”²⁹ Following this principle, the prevailing viewpoint among doctors warns that “[a]pplying medical tests of little or no proven value to asymptomatic populations with low prevalence of disease is questionable and costly.”³⁰

24. Studdert et al., *supra* note 2, at 893-94.

25. Morgan, *supra* note 10, at 158 (quoting WHO criteria). An important element of the cost-benefit calculus is not only the cost of the monitoring, but also the cost of treating any disease detected by the medical monitoring. *See id.* at 163 (stating, with regard to Mayo Clinic occupational lung cancer study, “it is apparent that early detection cannot be equated with cure and the cost of curing one cancer detected from the screening program will be appreciably greater and indeed enormous”).

26. TASK FORCE, *supra* note 9, at xxxv. The U.S. Preventive Services Task Force, convened by the Public Health Service to “rigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests,” *U.S. Preventive Services Task Force*, available at <http://www.ahrq.gov/clinic/cps3dix.htm> (last visited May 19, 2005), includes an entire section on “Cost-Effectiveness and Clinical Preventive Services” in its *Guide to Clinical Preventive Services*. *See* TASK FORCE, *supra* note 9.

27. TASK FORCE, *supra* note 9, at xxxv.

28. *Id.* at xxxvii.

29. *Id.* *See also* Beeler & Sappenfield, *supra* note 7, at 285 (noting that for a medical monitoring program, there must “be available an inexpensive, low risk, sensitive test for the screening process”).

30. Krieger et al., *supra* note 11, at 108.

4. The Potential Benefits of Medical Monitoring Must Outweigh the Risks

Doctors and scientists caution that the risks of medical monitoring should not exceed the potential benefits. Because of the risks of medical monitoring, doctors have noted that a patient's decision to participate in medical monitoring "must be fully informed and voluntary and should be preceded by a sufficient understanding of both the benefits and liabilities. Some thoughtful observers believe that participants in medical surveillance should sign informed consent forms."³¹

Scientists recognize that medical monitoring is always risky to some extent because all screening programs may have adverse effects.³² For example, colonic perforation is a risk of sigmoidoscopy, one particularly invasive form of medical monitoring; impotence is a risk of the follow-up tests, biopsies, and treatments that can follow prostate cancer screenings; and radiation exposure always occurs in mammograms, a particularly troublesome risk for women under the age of forty.³³ Similarly, doctors believe that cancer screenings often involve risks to the patient. In fact, one doctor serving as a plaintiff's expert witness in a medical monitoring case "acknowledge[d] the considerable limitations of the currently known examinations and tests for the early detection of cancer, as well as the fact that some, such as lung cancer screening, create risks that outweigh the potential benefits."³⁴

Doctors note that the risks of medical monitoring include the risk of false test results.³⁵ False negative test results are troublesome, as they can

31. *Id.* at 116.

32. See Boehlecke, *supra* note 20, at 236-37 ("One must also consider that like all screening programs, those for cancer may have adverse effects.").

33. George W.C. McCarter, *Medical Sue-Veillance: A History and Critique of the Medical Monitoring Remedy in Toxic Tort Litigation*, 45 RUTGERS L. REV. 227, 276-77 & n.239 (1993) (citing U.S. PREVENTIVE SERVS. TASK FORCE, U.S. PUBLIC HEALTH SERV., GUIDE TO CLINICAL PREVENTIVE SERVICES 49-50 (1989) (discussing risks of sigmoidoscopy); Jane E. Brody, *Nationwide Tests Set for Prostate Cancer, but Doubts Surface*, N.Y. TIMES, Sept. 20, 1992, Section 1, at 1 (risks of prostate cancer screenings); R.W. & Paula Dranov, *Mammograms: When and Where?*, AM. HEALTH, Sept. 1992, at 54 (discussing risks of mammograms)).

34. *Redland Soccer Club, Inc. v. Dep't of the Army*, 55 F.3d 827, 848 (3d Cir. 1995).

35. False positives and negatives occur with a frequency that "depends on where the 'normal' limits of the test are set. A test that measures biological distribution of variables is normal when the result falls within a predetermined range of values." ASHFORD ET AL., *supra* note 17, at 32. See Beeler & Sappenfield, *supra* note 7, at 287 (noting the "risks and costs of not adjusting treatment when change is truly indicated, and of adjusting treatment inappropriately when change is not truly indicated"); McCarter, *supra* note 33, at 277 (discussing the problem of false positives, which "are likely to foster a 'cry wolf' attitude in all [medical monitoring] participants," and false

provide “false reassurance” and can take away incentives to change patient habits that may worsen the progression of a disease.³⁶ Equally troublesome are the effects of false positive test results. False positives can devastate patients and their families.³⁷ They can lead to costly follow-up medical procedures which can cause further health complications and even death.³⁸ As one doctor notes, “[e]ven with all currently available diagnostic techniques, some patients will be subjected to major surgical procedures for benign conditions.”³⁹ For example, a recent study of individuals who received spiral computed tomography lung cancer screenings found that 98 percent of positive results were false positives, and 25 percent of those tested were false negatives.⁴⁰ Those with false positive results “underwent thoracotomies only to learn they had benign disease.”⁴¹

The above risks must all be taken into account when determining whether medical monitoring is appropriate in a given case.⁴²

B. Medical Monitoring Programs Must Be Tailored to Specific Diseases and Individuals: One Size Does Not Fit All

According to prevailing medical thought, medical monitoring tests must be tailored to specific diseases and to specific individuals. Doctors cannot simply slather a patient with “a batch of so-called routine tests,” a practice one scholar calls “biochemical bingo.”⁴³

Rather, medical monitoring “necessitates the selection of appropriate tests . . . that will establish or point to the presence of the condition being

negatives, which “may even delay seeking treatment when warning symptoms appear”).

36. See Krieger et al., *supra* note 11, at 108.

37. See *id.* (“An unfortunate reality of most screening programs is that the false-positives greatly outnumber the true positives. False-negatives are also a significant issue in that they provide false reassurance . . .”).

38. Boehlecke, *supra* note 20, at 230.

39. *Id.* at 237. The author concludes this problem arises in the industrial hygiene context, where “the cost and morbidity associated with further evaluation of workers with positive results who do not have the condition may outweigh the benefits to those true cases identified.” *Id.* at 230.

40. See Daniel DeNoon, *Docs Nix Lung Scan*, WEBMD MED. NEWS, Feb. 22, 2002, available at http://my.webmd.com/content/Article/24/1822_50264.htm.

41. Laurel J. Harbour & Angela Splittgerber, *Making the Case Against Medical Monitoring: Has the Shine Faded on This Trend?*, 70 DEF. COUNS. J. 315, 320-21 (2003).

42. See Morgan, *supra* note 10, at 158 (recognizing these risks, the World Health Organization’s list of criteria for medical monitoring includes the criterion “[t]hat the benefits accruing to the true positive should outweigh the harm done as a result of false-positive diagnosis”).

43. *Id.*

sought.”⁴⁴ Choosing the appropriate criteria to govern medical monitoring requires “knowledge of the pathophysiologic effects [of a given disease] so that any recommended tests will result in its detection.”⁴⁵ The goals of any particular medical monitoring program will “depend upon the state of knowledge about the causes of the condition of interest and the extent to which effective preventive measures are known.”⁴⁶

Medical monitoring programs must also be tailored to the personal habits of the individuals being screened.⁴⁷ Additionally, an important element of a medical monitoring program to medical professionals is providing health promotion education, with the goal of changing the patient’s behavior patterns that increase the risk of disease.⁴⁸ In sum, the scientific and medical community believes medical monitoring programs are specific regimens that must reflect patient histories and expected disease.

44. *Id.* In fact, medical professionals believe that:

Each test [included in a medical monitoring program] should be considered in terms of the following criteria: 1. Acceptance by subjects: safety, comfort; 2. Simplicity: equipment and procedure; 3. Objectivity: not influenced by subject cooperation or observer bias; 4. Precision (reproducibility): measurement error; equipment and observer true biologic variability; 5. Accuracy: relation of quantity measured to what one wishes to know; 6. Validity: sensitivity, specificity, and predictive value.

Id. at 159. See also Welch & Roto, *supra* note 4, at 425 (“To design an effective substance-specific or disease-specific monitoring program for construction workers, we need to know the nature and extent of hazardous exposures, which workers have these exposures, what diseases the exposures cause, and which workers are at risk from exposure or from personal factors We need then to know the utility of the tests and their predictive value.”). Cf. Cone & Rosenberg, *supra* note 18, at 564-70 (detailing the specific designs of OSHA programs monitoring for cancer caused by specific carcinogens); Welch & Roto, *supra* note 4, at 428-31 (detailing the specific health conditions a medical monitoring program for construction workers must be geared to detect).

45. Morgan, *supra* note 10, at 158-59.

46. RAYMOND S. GREENBERG ET AL., *MEDICAL EPIDEMIOLOGY* 43 (2d ed. 1996). See generally Cone & Rosenberg, *supra* note 18, at 578 (“Problems that have been identified with monitoring employees for chemical carcinogens include . . . the marketing of technologies, particularly for biological markers of exposure, that are not yet proven to be related to actual risk.”); Welch & Roto, *supra* note 4, at 428-31 (describing specific medical monitoring programs for health conditions experienced by construction workers).

47. See Welch & Roto, *supra* note 4, at 425.

48. See *id.* at 431 (noting information may be provided about nutrition, alcohol consumption, and physical health promotion, for example). See also Gochfeld, *supra* note 12, at 76.

*C. Medical Monitoring Programs
Must Evolve with Progressing Scientific Knowledge*

Just as the criteria for an effective medical monitoring program will differ for each disease, the individual program criteria for detecting a particular disease may vary over time. The criteria will “depend upon the state of knowledge about the causes of the condition of interest and the extent to which effective preventive measures are known.”⁴⁹ According to medical experts, “rapid advances in science and technology often cause rapid obsolescence of accepted diagnostic and monitoring strategies.”⁵⁰ New, more effective tests for various diseases are likely to be discovered and current tests are likely to become outmoded. Over time, science may find that an exposure previously thought to cause harm, in fact, does not. The need for medical monitoring, therefore, would cease. Because of this, the purposes, goals, and criteria of medical monitoring will evolve over time alongside the scientific community’s steadily advancing understanding of science. No one set of court-established criteria can remain viable for long.

II. MEDICAL MONITORING AS PLAYED OUT IN THE COURTS

Over the past two decades a few courts have permitted medical monitoring.⁵¹ The first court to allow medical monitoring was the United States Court of Appeals for the District of Columbia Circuit in *Friends for All Children, Inc. v. Lockheed Aircraft Corp. (FFAC)*.⁵² In *FFAC*, the defendant’s airplane was used in a rescue mission to evacuate Vietnamese children from Saigon at the end of the Vietnam War.⁵³ Tragically, the plane crashed mid-flight due to the decompression of the interior compartments.⁵⁴ *FFAC*, the legal guardian for the surviving children, sought compensation from Lockheed for diagnostic examinations to determine if the decompression or the crash itself caused residual brain dysfunction syndrome in the children.⁵⁵

Predicting the approach of courts in the District of Columbia, the D.C. Circuit held that a medical monitoring remedy should be recognized.⁵⁶ In its reasoning, the court concluded medical monitoring would not be necessary “but for the fact that these children endured explosive decompression and

49. GREENBERG ET AL., *supra* note 46, at 43.

50. Beeler & Sappenfield, *supra* note 7, at 287.

51. See McCarter, *supra* note 33, at 231-42 (giving a detailed history of medical monitoring jurisprudence).

52. 746 F.2d 816 (D.C. Cir. 1984).

53. *Id.* at 819.

54. *Id.*

55. *Id.*

56. *Id.* at 824-25.

hypoxia aboard [the] plane.”⁵⁷ The court further held that the need for medical monitoring constituted an “injury” within the definition of the Restatement (Second) of Torts,⁵⁸ because “an individual has an interest in avoiding expensive diagnostic examinations just as he or she has an interest in avoiding physical injury.”⁵⁹

In this case, the court carefully limited medical monitoring. It allowed only comprehensive diagnostic testing, rather than continued lifetime medical monitoring.⁶⁰ Also, the award in this case arose out of a traumatic physical impact, a very different situation from a toxic tort action where the direct causal effects of an alleged wrongdoing may be harder to identify. The court made clear it intended to restrict medical monitoring to cases where the plaintiff’s injury is not speculative.⁶¹ The court also sought to prevent plaintiffs from recovering excessive damages, expressing its concern with the hardship its holding would impose upon the defendant.⁶² These legitimate concerns led the court to impose three fundamental requirements. First, to ensure payments to plaintiffs actually went toward monitoring, a fund was created to disperse money only to plaintiffs who submitted a voucher detailing their anticipated expenses.⁶³ Second, to ensure the tests given to plaintiffs were necessary, a panel of psychologists, psychiatrists, and neurologists were to provide input on tests a particular child should undergo.⁶⁴ Third, the court designated that any funds remaining in the interest-bearing medical monitoring fund after the completion of the plaintiffs’ exams were to be returned to the defendant.⁶⁵

The court also took steps to prevent redundant testing. The court required a doctor’s review of what tests a child had already undergone before allowing more tests, in an attempt to eliminate unnecessary duplication.⁶⁶ Importantly, the court ensured its decision avoided double recovery by some plaintiffs through collateral sources: it limited medical monitoring relief to the children adopted in countries that did not have public health systems that would pay for the children’s medical examinations.⁶⁷

In sum, there were many key reasons that supported the medical monitoring ruling in *FFAC*, but other courts in other jurisdictions have knocked these legs down. As we will show, some other courts have allowed medical monitoring in cases where there was no physical injury. Although the *FFAC*

57. *Id.* at 825.

58. The Restatement defines “injury” as “the invasion of any legally protected interest of another.” *RESTATEMENT (SECOND) OF TORTS* § 7(1) (1965).

59. *FFAC*, 746 F.2d at 826.

60. *Id.* at 823.

61. *Id.* at 826 (The injury must be “neither speculative nor resistant to proof.”).

62. *Id.* at 823.

63. *Id.* at 823, 831.

64. *Id.*

65. *Id.* at 823 n.10.

66. *Id.* at 835 n.34.

67. *Id.* at 822 n.7 (allowing recovery only for the French plaintiffs).

court noted it intended to limit medical monitoring awards to cases where the injury is not speculative, some courts have not applied that limitation. For example, medical monitoring has been allowed in some speculative chemical exposure cases.⁶⁸ Additionally, very few other courts mandated a court-supervised fund to counter concerns about lump-sum awards and to make sure that recoveries were actually spent on monitoring.⁶⁹

Today, eleven states plus the District of Columbia allow medical monitoring in the absence of present physical injury.⁷⁰ As we will show, however, these early decisions on medical monitoring do not reflect the current trend. In fact, the clear trend in the courts has been away from allowing medical monitoring when people have no current injury.⁷¹ These cases reflect a judi-

68. *Ayers v. Township of Jackson*, 525 A.2d 287 (N.J. 1987), was one of the first toxic exposure cases to recognize medical monitoring. *Ayers* was brought by 339 plaintiffs from Jackson, New Jersey, after toxic pollutants from the town's landfill leaked into the town aquifer and contaminated the plaintiffs' drinking water. *Id.* at 291. The New Jersey Supreme Court affirmed a lump-sum award of over \$8.2 million to cover the cost of plaintiffs' future medical check-ups. *Id.* The court later retreated from its holding. See *Theer v. Philip Carey Co.*, 628 A.2d 724, 733 (N.J. 1993) ("medical surveillance damages are not available for plaintiffs who have not experienced direct and hence discrete exposure to a toxic substance and who have not suffered an injury or condition [as a result]"). See also, e.g., *In re Paoli R.R. Yard PCB Litig.*, 916 F.2d 829, 850-51 (3d Cir. 1990) (In a case where plaintiffs feared exposure to PCBs, the court held that plaintiffs who can demonstrate that medical monitoring is "reasonably anticipated" can demonstrate an economic injury.); *Cook v. Rockwell Int'l Corp.*, 755 F. Supp. 1468, 1474 (D. Colo. 1991) (allowed medical monitoring under CERCLA for hazardous waste exposure where plaintiffs could prove that monitoring was necessary to test the environmental effects of a release or threatened release of hazardous waste); *Potter v. Firestone Tire & Rubber Co.*, 863 P.2d 795, 823 (Cal. 1993) (allowed medical monitoring for toxic waste contamination of plaintiffs' drinking water); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970 (Utah 1993) (allowed medical monitoring for asbestos exposure).

69. See *In re Paoli*, 916 F.2d 829; *Cook*, 755 F. Supp. 1468; *Potter*, 863 P.2d at 825 n.28 (discussed but did not mandate court-supervised fund); *Hansen*, 858 P.2d at 982 (discussed but did not mandate court-supervised fund). But see *Redland Soccer Club, Inc. v. Dep't of the Army*, 696 A.2d 137, 142 n.6 (Pa. 1997).

70. These jurisdictions include: Arizona (*Burns v. Jaquays Mining Corp.*, 752 P.2d 28 (Ariz. Ct. App. 1987)); California (*Potter*, 863 P.2d 795); Colorado (*Cook*, 778 F. Supp. 512); District of Columbia (*Friends for All Children v. Lockheed Aircraft Corp.*, 746 F.2d 816 (D.C. Cir. 1984)); Florida (*Petito v. A.H. Robins Co.*, 750 So. 2d 103 (Fla. Dist. Ct. App. 1999)); Illinois (*Lewis v. Lead Indus. Ass'n, Inc.*, 793 N.E.2d 869 (Ill. App. Ct. 2003)); Montana (*Lamping v. Am. Home Prods. Inc.*, No. DV-97-85786/93 (Mont. Dist. Ct. Feb. 2, 2000)); New Jersey (*Ayers*, 525 A.2d 287); Ohio (*Day v. NLO*, 851 F. Supp. 869 (S.D. Ohio 1994)); Pennsylvania (*Redland Soccer Club*, 696 A.2d 137); Utah (*Hanson*, 858 P.2d 970); and West Virginia (*Bower v. Westinghouse Elec. Corp.*, 522 S.E.2d 424 (W. Va. 1999)).

71. Jurisdictions that do not allow medical monitoring claims absent present physical injury include: Alabama (*Hinton v. Monsanto Co.*, 813 So. 2d 827 (Ala.

cial understanding that is in harmony with that of the mainstream scientific and medical community: medical monitoring is only appropriate where it can be expected to be effective and where its benefits outweigh its costs.⁷² A basic objective “predictor” for this result is some contemporary injury or harm. In contrast, other courts have ignored this medical and scientific guidance and have instead implemented full-scale medical monitoring awards where the plaintiffs have no present physical injury.⁷³

*A. A Number of Courts, Including the United States Supreme Court,
Have Wisely Rejected Medical Monitoring
Absent Present Physical Injury*

The Supreme Court of the United States refused to recognize medical monitoring as a cause of action under the pro-plaintiff Federal Employers’ Liability Act (“FELA”)⁷⁴ in the landmark case *Metro-North Commuter Railroad Co. v. Buckley*.⁷⁵ Over the past few years, the supreme courts of Nevada, Alabama, and Kentucky all have similarly rejected medical monitoring claims.⁷⁶ In doing so, these courts have reaffirmed the fundamental tort law principle that damages are not recoverable absent a present physical injury.⁷⁷

2001)); Connecticut (*Goodall v. United Illuminating*, No. X04CV 950115437S, 1998 WL 914274 (Conn. Super. Ct. Dec. 15, 1998)); Indiana (*Baker v. Westinghouse Elec. Corp.*, 70 F.3d 951 (7th Cir. 1995)); Kentucky (*Wood v. Wyeth-Ayerst Labs.*, 82 S.W.3d 849 (Ky. 2002)); Louisiana (LA. CIV. CODE ANN. art. 2315 (West 1997 & Supp. 2005)); Michigan (*Myerhoff v. Turner Constr. Co.*, 575 N.W.2d 550 (Mich. 1998)); Missouri (*Elam v. Alcolac, Inc.*, 765 S.W.2d 42 (Mo. Ct. App. 1988)); Nebraska (*Trimble v. Asarco, Inc.*, 232 F.3d 946 (8th Cir. 2000)); Nevada (*Badillo v. Am. Brands, Inc.*, 16 P.3d 435 (Nev. 2001)); New York (*Abusio v. Consol. Edison Co. of N.Y., Inc.*, 656 N.Y.S.2d 371 (N.Y. App. Div. 1997)); North Carolina (*Carroll v. Litton Sys., Inc.*, No. B-C-88-253, 1990 WL 312969 (W.D.N.C. Oct. 29, 1990) (mem.)); Oregon (*Mead v. Aventis Pasteur, Inc.*, No. 0107-07137 (Or. Cir. Ct. Oct. 8, 2003)); South Carolina (*Rosmer v. Pfizer, Inc.*, No. CIV.A. 9-99-2280-18RB, 2001 WL 34010613 (D. S.C. Mar. 30, 2001) (mem.)); Virginia (*Ball v. Joy Tech. Inc.*, 958 F.2d 36 (4th Cir. 1991)); and Washington (*Garcia v. Aventis Pasteur Inc.*, No. 01-2-27335-3-SEA (Wash. Super. Ct. Apr. 7, 2003)).

72. See *Beeler & Sappenfield*, *supra* note 7, at 286.

73. See *supra* note 70 and accompanying text.

74. 45 U.S.C. §§ 51-60 (2000). FELA defines rights and duties in personal injury cases brought by railroad workers against their employer railroads. FELA is the tort equivalent of workers’ compensation in the railroad field.

75. 521 U.S. 424 (1997).

76. See *Badillo v. Am. Brands, Inc.*, 16 P.3d 435 (Nev. 2001); *Hinton v. Monsanto Co.*, 813 So. 2d 827 (Ala. 2001); *Wood v. Wyeth-Ayerst Labs.*, 82 S.W.3d 849 (Ky. 2002).

77. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* 165 (5th ed. 1984) (“Actual loss or damage resulting to the interests of another [is a neces-

1. The United States Supreme Court Has Reviewed and Rejected Medical Monitoring

In *Metro-North Commuter Railroad Co. v. Buckley*,⁷⁸ the United States Supreme Court ruled 7-2 against allowing a medical monitoring claim brought under FELA by a pipefitter against his railroad employer for occupational exposure to asbestos.⁷⁹

The case involved sympathetic plaintiffs who had literally been covered with asbestos while working for the railroad. Still, the Court did not allow a medical monitoring claim.⁸⁰ Instead, the Court closely considered the serious policy concerns accompanying the adoption of a medical monitoring cause of action. These concerns are similar to those recognized by the scientific and medical community. They include the difficulty of identifying which medical monitoring costs exceed the costs of preventative medicine ordinarily recommended for everyone, which particular tests or treatments are appropriate in a given case, and which adjustments need to be made based upon an individual plaintiff's unique medical needs.⁸¹

The United States Supreme Court appreciated that medical monitoring absent actual physical injury could permit literally "tens of millions of individuals" to "justify some form of substance-exposure-related medical monitoring."⁸² Defendants, in turn, would be exposed to potentially unlimited liability, and a "'flood' of less important cases" would drain the pool of resources available for meritorious claims by plaintiffs with serious, present injury.⁸³ Further, the Court rejected the argument that medical monitoring awards are not costly.⁸⁴ The Court also feared that allowing medical monitoring claims could create double recoveries because alternative, collateral sources of payment, such as health insurance, are often available to those seeking money for medical monitoring.⁸⁵

Importantly, the Court distinguished medical monitoring for toxic torts from claims arising from traumatic events where subsequent injuries can be

sary element of a negligence cause of action]. . . . The threat of future harm, not yet realized, is not enough.").

78. 521 U.S. 424 (1997).

79. *Id.* Over the years, FELA has been subject to construction that is very favorable to plaintiffs. *See, e.g.,* *Beeber v. Norfolk S. Corp.*, 754 F. Supp. 1364, 1372 (N.D. Ind. 1990) ("If the defendant's negligence, however slight, plays any part in producing plaintiff's injury, the defendant is liable."); *Pry v. Alton & S. Ry. Co.*, 598 N.E.2d 484, 499 (Ill. App. Ct. 1992) (stating that, under FELA, "[o]nly slight negligence of the defendant needs to be proved.").

80. *Metro-North*, 521 U.S. at 444, 447.

81. *See id.* at 441-42.

82. *Id.* at 442.

83. *Id.*

84. *Id.*

85. *Id.* at 442-43.

fairly traceable. The Court explicitly stated that *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*⁸⁶ (FFAC) was neither applicable nor persuasive in a case alleging harm “through negligent exposure to a toxic substance,” noting that FFAC involved the “special recovery-permitting circumstance[]” of “the presence of a traumatic physical impact.”⁸⁷

2. The Supreme Court of Nevada Has Refused to Recognize Medical Monitoring

Recently several state supreme courts have followed the United States Supreme Court’s guidance. *Badillo v. American Brands, Inc.*,⁸⁸ before the Nevada Supreme Court, involved a collection of smokers and casino workers who brought class actions seeking the establishment of a court-supervised medical monitoring program to aid the early diagnosis and treatment of alleged tobacco-related illnesses.⁸⁹ The Nevada Supreme Court, responding to a certified question from the United States District Court for the District of Nevada, held that “Nevada common law does not recognize a cause of action for medical monitoring.”⁹⁰ The court recognized that “[m]edical monitoring is a novel, non-traditional tort and remedy.”⁹¹ The court also noted that changing fundamental tort law rules raises important public policy choices that should be left to legislatures. The court stated: “Altering common law rights, creating new causes of action, and providing new remedies for wrongs is generally a legislative, not a judicial, function.”⁹²

3. The Supreme Court of Alabama Has Rejected Medical Monitoring Claims in the Absence of a “Manifest, Present Injury”

The Alabama case, *Hinton v. Monsanto Co.*,⁹³ involved a claim by a citizen who alleged that he had been exposed to polychlorinated biphenyls (“PCBs”) that were reportedly released into the environment by the defendant.⁹⁴ As in Nevada, the Alabama Supreme Court refused to recognize a medical monitoring cause of action in the absence of a “manifest, present injury.”⁹⁵ The court stated that “[t]o recognize medical monitoring as a distinct cause of action . . . would require this Court to completely rewrite Ala-

86. 446 F.2d 816 (D.C. Cir. 1984).

87. *Metro-North*, 521 U.S. at 440.

88. 16 P.3d 435 (Nev. 2001).

89. *Id.* at 438.

90. *Id.* at 441.

91. *Id.* at 438.

92. *Id.* at 440.

93. 813 So. 2d 827 (Ala. 2001).

94. *Id.* at 828.

95. *Id.* at 829.

bama's tort-law system, a task akin to traveling in uncharted waters, without the benefit of a seasoned guide"—a voyage upon which the court was "unprepared to embark."⁹⁶

The court also detailed a number of public policy concerns, such as a potential avalanche of claims and the unlimited liability exposure for defendants.⁹⁷ It also realized that "a 'flood' of less important cases" would drain the pool of resources available for meritorious claims by plaintiffs with serious, present injuries and would adversely affect the allocation of scarce medical resources.⁹⁸ The court concluded: "we find it inappropriate . . . to stand Alabama tort law on its head in an attempt to alleviate [plaintiffs'] concerns about what *might* occur in the future. We believe that Alabama law . . . provides no redress for a plaintiff who has no present injury or illness."⁹⁹

4. The Supreme Court of Kentucky's Recent Ruling Signals a Clear Trend by Courts Away from Medical Monitoring

Most recently, the highest court in Kentucky joined those in Nevada and Alabama in rejecting medical monitoring claims. In *Wood v. Wyeth-Ayerst Laboratories*,¹⁰⁰ the plaintiff, on behalf of herself and as representative for a class of patients, sought the creation of a court-supervised medical monitoring fund to detect the possible onset of primary pulmonary hypertension from ingesting the "Fen-Phen" diet drug combination.¹⁰¹

The Kentucky Supreme Court, citing cases dating as far back as 1925, recognized that "[t]his Court has consistently held that a cause of action in tort requires a present physical injury to the plaintiff."¹⁰² The court noted that the same basic requirement governed recent toxic tort cases, where it had decided that "'until such time as the plaintiff can prove some harmful result from the exposure . . . his cause of action has yet to accrue."¹⁰³ The court then concluded that "all of these cases lead to the conclusion that a plaintiff must have sustained some physical injury before a cause of action can accrue. To find otherwise would force us to stretch the limits of logic and ignore a long line of legal precedent."¹⁰⁴

96. *Id.* at 830.

97. *Id.* at 830-31.

98. *Id.* at 831 (quoting *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 442 (1997)).

99. *Id.* at 831-32.

100. 82 S.W.3d 849 (Ky. 2002).

101. *Id.* at 851.

102. *Id.* at 852.

103. *Id.* at 853 (quoting *Capital Holding Corp. v. Bailey*, 873 S.W.2d 187, 195 (Ky. 1994)) (alteration in original).

104. *Id.* at 853-54. A recent Sixth Circuit decision applying Kentucky law reinforced the public policy reasons against allowing claims absent present physical injury. In *Rainer v. Union Carbide Corp.*, No. 03-6032, 2005 WL 525235 (6th Cir.

B. The Unsound Alternative: The West Virginia "Anyone Can Sue" Approach to Medical Monitoring

West Virginia provides a practical example of the adverse impacts of allowing medical monitoring claims when the plaintiffs have not been injured. In 1999, in *Bower v. Westinghouse Electric Corp.*,¹⁰⁵ the Supreme Court of Appeals of West Virginia established an independent cause of action allowing an individual to recover future medical monitoring costs absent physical injury.¹⁰⁶ In that case, the plaintiffs, who had no symptoms of any disease, alleged that they were exposed to toxic substances as a result of the defendants' maintenance of a pile of broken glass debris from the manufacture of light bulbs.¹⁰⁷

The court's holding in *Bower* stands in stark contrast to the medical and scientific perspective that medical monitoring programs should only be implemented for patients who have potentially treatable or curable disease. Instead, the court held that a suit can be filed *even* if the amount of exposure to a toxic substance does not correlate with a level sufficient to cause injury¹⁰⁸ or if there is no effective treatment available for the disease.¹⁰⁹ The court also rejected the argument that any funds awarded should be awarded in a court-

Mar. 8, 2005), the court determined that like medical monitoring claims, claims of subcellular damage to DNA and chromosomes without any salient clinical symptoms cannot be sustained as a matter of public policy. The court reasoned that

"Given that negligently distributed or discharged toxins can be perceived to lie around every corner in the modern industrialized world, and their effects on risk levels are at best speculative, the potential tort claims involved are inherently limitless and endless." Accepting the plaintiffs' claim would therefore throw open the possibility of litigation by any person experiencing even the most benign subcellular damage. Based upon the average American's exposure to chemically processed foods, toxic fumes, genetically modified fruits and vegetables, mercury-laden fish, and hormonally treated chicken and beef, this might encompass a very large percentage of the total population. Nowhere in their arguments do the plaintiffs address these "floodgate" concerns.

Id. at *12 (quoting *Wood*, 82 S.W.3d at 857-58) (citation omitted).

105. 522 S.E.2d 424 (W. Va. 1999). In February 2003, the West Virginia Supreme Court of Appeals applied *Bower* to reverse a circuit court order denying class certification to five thousand users of an allegedly defective prescription drug, Rezulin, who sought to recover costs of medical monitoring. *See In re W. Va. Rezulin Litig.*, 585 S.E.2d 52 (W. Va. 2003).

106. *Bower*, 522 S.E.2d at 432-33.

107. *Id.* at 426-27.

108. *Id.* at 433 (noting that "[i]mportantly, 'no particular level of quantification is necessary'") (quoting *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970, 979 (Utah 1993)).

109. *Id.* at 434.

administered fund and instead awarded funds to plaintiffs in a lump sum.¹¹⁰ Rather than being guided by principles of effective treatment or cure of disease, the court's ruling unabashedly allows for medical monitoring based on "the subjective desires of a plaintiff for information concerning the state of his or her health."¹¹¹

The court's criteria for medical monitoring do not require a cost-benefit analysis, in stark contrast to scientific recommendations. It requires, instead, "that the plaintiff ha[ve] a significantly increased risk of contracting a particular disease relative to what would be the case in the absence of exposure."¹¹² The court's medical monitoring criteria state that this significantly "increased risk" must make it "reasonably necessary" to undergo medical monitoring that could allow early detection of the disease.¹¹³ The court noted that "factors such as financial cost and the frequency of testing need not necessarily be given significant weight."¹¹⁴

Medical monitoring is a primary reason the rulings of courts in West Virginia are considered unfair and imbalanced.¹¹⁵ Respected torts scholars James A. Henderson, Jr. and Aaron D. Twerski, Reporters for the American Law Institute's *Restatement of Torts, Third: Products Liability*, criticize *Bower's* "superlative"-riddled criteria.¹¹⁶ They note that *Bower's* criteria "will not prevent most well-prepared cases from reaching triers of fact. There is no escaping the conclusion that defendants in these medical monitoring cases face potentially crushing liabilities."¹¹⁷ Despite this criticism, the West Virginia Supreme Court of Appeals has rejected attempts to institute stricter, more scientifically and medically sound criteria for the loose criteria enshrined in *Bower*.¹¹⁸

110. *Id.*

111. *Id.* at 433.

112. *Id.*

113. *Id.* at 432.

114. *Id.* at 433.

115. See Robert D. Mauk, *McGraw Ruling Harms State's Reputation in Law, Medical Monitoring*, CHARLESTON GAZETTE, Mar. 1, 2003, at 5A ("[T]he *Bower* medical-monitoring ruling has cast a shadow over our state's reputation in the legal field. It affects West Virginia jobs, taxes, health care and the public credibility of our courts."); see also Editorial, *Legislators Need to Restrict the Legal Industry on this One*, CHARLESTON DAILY MAIL, Feb. 19, 2003, at 4A ("People should be compensated for injuries caused by the negligence of others. But lawyers should not profit from imaginary harm.").

116. See James A. Henderson, Jr. & Aaron D. Twerski, *Asbestos Litigation Gone Mad: Exposure-based Recovery for Increased Risk, Mental Distress, and Medical Monitoring*, 53 S.C. L. REV. 815, 845 (2002).

117. *Id.* (footnote omitted).

118. See *In re W. Va. Rezulin Litig.*, 585 S.E.2d 52, 73 (W. Va. 2003). In this case, the West Virginia Supreme Court of Appeals reversed a lower court's denial of the class certification of five thousand plaintiffs with medical monitoring claims in the diet drugs litigation. *Id.* at 76. The West Virginia Supreme Court rejected the

As a result of *Bower*, uninjured plaintiffs in West Virginia can sue under a distinct medical monitoring cause of action even when the level of exposure is not sufficient to cause disease. Furthermore, they do not have to spend any of their award on medical monitoring. In a dissenting opinion in the case, Justice Maynard asserted, "the practical effect of [the *Bower*] decision is to make almost every West Virginian a potential plaintiff in a medical monitoring cause of action."¹¹⁹ This appears to be what has occurred.

It used to be that only sick smokers sued cigarette makers. But shortly after the *Bower* decision, plaintiffs' lawyers filed a class-action suit seeking medical monitoring damages against the major cigarette manufacturers on behalf of approximately 250,000 West Virginia smokers who had not been diagnosed with any smoking-related illnesses.¹²⁰ In November 2001, the jury found that medical monitoring was unnecessary, that cigarettes are not a defective product, and that cigarette makers "were not negligent in designing, making or selling them."¹²¹ Nevertheless, the process of trying such a case is an extraordinary waste of judicial resources.

lower court's approach of using more stringent medical monitoring criteria than set forth in *Bower* to determine that the claims of the class action did not predominate. *Id.* The lower court used the following scientifically-based criteria for medical monitoring: that (1) the disease in question progresses asymptotically following toxic exposure; (2) a diagnostic test with high sensitivity exists; (3) the exposed population has a relatively high prevalence of disease; (4) the diagnostic test therefore has a high predictive value; (5) the test is relatively low-cost; (6) medical monitoring could be integrated into standard clinical follow-up of those with disease; (7) monitoring could lead to early preventive care; and (8) monitoring allows for the appropriate timing of definitive treatment. *In re W. Va. Rezulin Litig.*, No. CIV. A. 00-C-1180-H, 2001 WL 1818442, at *11 (W. Va. Cir. Ct. Dec. 13, 2001), *rev'd*, 585 S.E.2d 52 (W. Va. 2003). The West Virginia Supreme Court of Appeals enforced the *Bower* criteria and ruled that since the plaintiffs' claims all met the *Bower* criteria, commonality prevailed. *In re W. Va. Rezulin Litig.*, 585 S.E.2d at 73.

119. *Bower v. Westinghouse Elec. Corp.*, 522 S.E.2d 424, 435 (W. Va. 1999) (Maynard, J., dissenting).

120. *See In re Tobacco Litig. (Medical Monitoring Cases)*, Civ. Action No. 00-C-6000 (W. Va. Cir. Ct. 2001) (also known as "the Blankenship case").

121. *See Vicki Smith, Jury Rejects Smokers' Suit Seeking Free Medical Tests; Case 1st of Kind in U.S.*, CHARLOTTE OBSERVER, Nov. 15, 2001, at 12A. The West Virginia Supreme Court of Appeals is currently considering the plaintiffs' appeal of the verdict and request for another trial. *See Chris Wetterich, Smokers Want Another Trial; Evidence Unheard, Lawyers Argue, in Medical Monitoring Lawsuit*, CHARLESTON GAZETTE, Nov. 6, 2003, at 1C.

*C. Courts Have Not Implemented Medical Monitoring Programs
that Meet the Goals and Purpose of Medical Monitoring,
as Seen by the Scientific and Medical Community*

Courts tread on quicksand when they liberally allow medical monitoring claims. Since exposure to potentially harmful products is so widespread, “the universe of potential medical monitoring plaintiffs seems vastly over-inclusive.”¹²² Windfall recoveries do not only affront the purpose of medical monitoring, they also “pose[] the real risk that little or no resources will be available to compensate those who are truly injured.”¹²³ In *Metro-North*, the United States Supreme Court stated it was “troubled” by the effects of medical monitoring claims “upon interests of other potential plaintiffs who are not before the court and who depend on a tort system that can distinguish between reliable and serious claims on the one hand, and unreliable and relatively trivial claims on the other.”¹²⁴

Where a plaintiff alleges only exposure to a harmful substance—particularly when the amount of exposure does not amount to a level sufficient to cause disease—and presents no present physical injury to bolster the claim, medical monitoring does not serve its purpose of being a cost-effective tool to help cure or prevent the onset of disease. As such, medical monitoring of a patient who presents no present physical injury strays far from the guidance of the scientific and medical community.

1. Lump Sum Medical Monitoring Awards
Do Not Comport with Scientific and Medical Principles
of Effective Medical Monitoring for Disease

The greatest example of divergence of medical and legal thought in the context of medical monitoring is the practice of awarding lump-sum medical monitoring awards. Lump sum awards are starkly at odds with the traditional scientific goal of medical monitoring and surveillance: detecting the onset of disease.¹²⁵ Medical experts point out the difference between the scientific

122. Maskin et al., *supra* note 5, at 529.

123. *Id.*; see also Harbour & Splittgerber, *supra* note 41, at 320 (“Awards to asymptomatic plaintiffs who are the first to rush into court could consume all available funds from defendants, leaving those plaintiffs who later have physical injuries with nothing to recover.”); HUGH R. WHITING, *REMEDY WITHOUT RISK: AN OVERVIEW OF MEDICAL MONITORING* 29 (Wash. Legal Found., Contemporary Legal Notes Series No. 42, Aug. 2002).

124. *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 443-44 (1997).

125. The traditional goal of medical surveillance is to “monitor the spread of infectious diseases through a population.” GREENBERG ET AL., *supra* note 46, at 43. In fact, even the word “surveillance literally means ‘to watch over.’” *Id.* Yet, the courts giving medical monitoring lump sum awards by no means “watch over” the plaintiffs and the plaintiffs’ potential disease.

approach and the approach of the courts that have awarded lump-sum medical monitoring damages:

[C]ourts generally take little interest in the details of how compensation is used to obtain medical care. Monetary damages in personal injury cases often include allowance for the plaintiff's future health care costs, but how that money is spent is the plaintiff's concern, not the court's. In contrast, public health is centrally concerned with prevention of disease and injury, addresses itself to the health of populations rather than specific individuals, and takes great interest in the interventions used to achieve these goals.¹²⁶

There is no assurance that healthy plaintiffs will spend lump sum awards on medical monitoring. If they do not, these awards are no more than a windfall recovery.¹²⁷ Often, this is exactly what happens.

For example, the 1987 New Jersey Supreme Court case, *Ayers v. Township of Jackson*,¹²⁸ illustrates the fact that lump-sum awards for medical monitoring often may not lead to any medical monitoring whatsoever. In *Ayers*, 339 plaintiffs, all without present physical injury, were awarded over \$8 million as a lump sum for medical monitoring.¹²⁹ Law review article commentator George W.C. McCarter conducted an informal survey of the

126. Studdert et al., *supra* note 2, at 890. See generally McCarter, *supra* note 33, at 253-54 (noting that courts can award medical monitoring based upon either public health measure goals or the legal goals of deterrence or punishment).

127. See, e.g., *Lilley v. Bd. of Supervisors of La. State Univ.*, 735 So. 2d 696 (La. Ct. App. 1999). One year after the Louisiana Supreme Court recognized medical monitoring as a cause of action in *Bourgeois v. A.P. Green Industries, Inc.* (*Bourgeois I*), 716 So. 2d 355 (La. 1998), *superseded by statute as stated in Edwards v. State*, 804 So. 2d 886 (La. App. Ct. 2001), a trial court awarded a lump sum of \$12,000 per plaintiff for medical monitoring, *Lilley*, 735 So. 2d at 699, despite the fact the *Bourgeois I* court expressly declined to extend its holding to claims for lump sum damages, *Bourgeois I*, 716 So. 2d at 357 n.3. Fortunately, the award was overturned on appeal. *Lilley*, 735 So. 2d at 706. The Louisiana Legislature recognized this problem and in 1999—only one year after *Bourgeois I*—amended the Louisiana Civil Code article 2315 (the portion of the Code specifying what damages may be awarded in a civil case) to eliminate medical monitoring as a compensable item of damage in the absence of a manifest physical or mental injury or disease. *Bourgeois v. A.P. Green Indus., Inc.*, 783 So. 2d 1251, 1255 (La. 2003) (*Bourgeois II*); *Bonnette v. Conoco, Inc.*, 837 So. 2d 1219, 1230 n.6 (La. 2003). The Louisiana Supreme Court recognized the amendment as forbidding medical monitoring claims. *Id.* The court, however, has interpreted the amendment as prospective only and has allowed medical monitoring claims to proceed when the claims accrued prior to the enactment of the amendment on July 9, 1999. *Bourgeois II*, 783 So. 2d at 1261 (allowing a medical monitoring claim to proceed when the claim accrued prior to the date of the 1999 amendment).

128. 525 A.2d 287 (N.J. 1987).

129. *Id.* at 291.

plaintiffs after the lawsuit.¹³⁰ The survey, however, garnered only three responses.¹³¹ The three responses may be telling: one plaintiff noted that he used his medical monitoring damages to buy a home and that after receiving his award, he had not seen his doctor any more than in prior years.¹³² The two other respondents, who could not even remember if the damages they received were for medical monitoring, reported they did not see their doctors more frequently as a result of the award.¹³³

The American Law Institute ("ALI") has suggested that the plaintiffs in *Ayers* did not appear to use their medical monitoring funds for health care. In their study, *Enterprise Responsibility for Personal Injury*, the ALI Reporters stated: "We do not favor awarding damages under the label of 'medical monitoring' and having the money paid directly to plaintiffs to be spent on additional medical attention only if they are so inclined,"¹³⁴ for "[t]his was reportedly the eventual outcome of the litigation in *Ayers v. Township of Jackson*."¹³⁵

The testimony of some plaintiffs who have sought medical monitoring damages is an indicator of the level of their willingness to use any funds for monitoring. In *Ironbound Health Rights Advisory Commission v. Diamond Shamrock Chemical Co.*,¹³⁶ "motion practice left medical monitoring as the only damage claim remaining" for most of the ninety-seven plaintiffs in a dioxin exposure suit.¹³⁷ Testimony of the plaintiffs suggested an unwillingness and lack of desire to be tested. In one plaintiff's deposition, the defense attorney asked the plaintiff if he had ever been or ever wanted to be tested to discover if he had any toxic substance in his body.¹³⁸ The plaintiff seeking medical monitoring replied, "I don't know. I don't know if I want to know."¹³⁹

At trial in the case, the plaintiffs were cross-examined about whether they had ever expressed their concerns about their exposures to their doctors in the time leading up to trial.¹⁴⁰ Time and time again, plaintiffs responded

130. See McCarter, *supra* note 33, at 257 n.158.

131. *Id.*

132. *Id.*

133. *Id.*

134. 2 A.L.I., REPORTER'S STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 379 (1991) [hereinafter ENTERPRISE RESPONSIBILITY]. Ultimately, however, the ALI Reporters endorsed limited medical monitoring as a viable cause of action. *Id.* at 381-82. Initially, the ALI Study would require medical monitoring to be established by court-appointed experts or science panels. See *id.* at 379-80.

135. *Id.* at 379 n.59.

136. 578 A.2d 1248 (N.J. Super. Ct. App. Div. 1990).

137. See McCarter, *supra* note 33, at 270 n.212. The "case was settled during trial on terms favorable to the [defendant]." *Id.* at 271 n.212.

138. *Ironbound Health Rights Advisory Comm'n*, 578 A.2d at 1249.

139. *Id.*

140. McCarter, *supra* note 33, at 270 n.212.

that they had not mentioned any such concerns, though they knew of the exposures at the time of their appointments.¹⁴¹ For instance, one plaintiff's testimony revealed his seeming lack of concern:

Q: Did you discuss with the doctor your concerns about dioxin exposure?

A: I had no reason to. I was there to get my bus license.¹⁴²

Another plaintiff similarly did not mention his exposure to his doctor:

Q: Is that, in fact, true, that you did see a doctor for a physical exam within the year preceding [your deposition in this case]?

A: Yes I guess, I've seen a doctor on occasion.

Q: Okay. Well, now, when you saw that doctor, you didn't mention to him your concerns about exposure to dioxin, did you?

A: No, it was—didn't come to my mind.¹⁴³

Other plaintiffs gave similar testimony.¹⁴⁴ The fact that these plaintiffs did not alert their doctors to their exposures during routine visits may suggest the plaintiffs will not be quick to do so if they succeed in their medical monitoring claims.

A similar example of plaintiffs showing unwillingness to engage in medical monitoring occurred in *Hansen v. Mountain Fuel Supply Co.*¹⁴⁵ In *Hansen*, workers sought medical monitoring because of asbestos exposure.¹⁴⁶ Nearly seven years after learning of their exposure, the plaintiffs participated in only preliminary examinations revealing no asbestos-related illness.¹⁴⁷ Other than the preliminary tests, the plaintiffs underwent no further testing.¹⁴⁸ One commentator remarked of the plaintiffs' inaction: "The fact that none had undergone testing over a period of almost seven years casts grave suspicion over their assertions that they would use any medical monitoring sums awarded for their stated purpose."¹⁴⁹

141. *See id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. 858 P.2d 970 (Utah 1993).

146. *Id.* at 972-73.

147. *Id.*

148. *See id.*

149. Maskin et al., *supra* note 5, at 541-42.

A final illustration of the use to which plaintiffs put their medical monitoring funds, when given the choice of how to use the money, shows once again that the goals of medical monitoring will not be achieved if plaintiffs are awarded a lump sum. In *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*,¹⁵⁰ a partial settlement occurred early on in the case, in which the defendant provided \$5,000 to each of the Vietnamese infants' guardians *ad litem*.¹⁵¹ The funds could be used either for the babies' medical treatment or for their litigation expenses.¹⁵² "All of the money was used for litigation expenses"¹⁵³

These examples show that medical monitoring awards may not result in the plaintiff actually being monitored. As one group of commentators noted:

The incentive for healthy plaintiffs to carefully hoard their award, and faithfully spend it on periodic medical examinations to detect an illness they will in all likelihood never contract, seems negligible. The far more enticing alternative, in most cases, will be to put the money towards a new home, car or vacation. Visiting a physician is not something many people wish they could afford to do more often.¹⁵⁴

Lump-sum awards do not appear to further the goals of medical monitoring programs.

2. Courts Awarding Medical Monitoring in the Absence of Physical Injury Have Ignored the Mainstream Medical and Scientific Community's Requirement that Medical Monitoring Only Be Awarded if Its Benefits Outweigh Its Cost

Courts awarding medical monitoring in the absence of physical injury, particularly in the form of lump sum damages, have awarded a negligible health benefit at a great cost. The cost of such awards is high. For example, in *Ayers v. Township of Jackson*,¹⁵⁵ the plaintiffs were awarded \$8 million for medical monitoring.¹⁵⁶ This cost per plaintiff obviously compounds in the

150. 746 F.2d 816 (D.C. Cir. 1984).

151. *Id.* at 820.

152. *Id.*

153. See Bill Charles Wells, *The Grin Without the Cat: Claims for Damages from Toxic Exposure Without Present Injury*, 18 WM. & MARY J. ENVTL. L. 285, 307 n.150 (1994).

154. Maskin et al., *supra* note 5, at 540-43 (footnote omitted) (noting, "the potential for abuse" is apparent).

155. 525 A.2d 287 (N.J. 1987).

156. *Id.* at 291.

context of aggregated litigation.¹⁵⁷ Costs also include the real risk that resources may run dry for injured claimants because of the potential for so many individuals to become claimants.¹⁵⁸ This cost is astronomical compared to the dubious health benefits to patients, particularly to claimants who receive lump sums or who already receive monitoring funds through insurance coverage.¹⁵⁹

III. COURTS ARE NOT EQUIPPED TO ADDRESS THE MANY UNCERTAINTIES AND DIFFICULTIES OF IMPLEMENTING MEDICAL MONITORING CAUSES OF ACTION

Medical monitoring, absent present physical injury, presents an about-face to two hundred years of American tort law. It also raises complicated questions begging for in-depth scientific input. As commentators have noted:

Clearly, deterrence of polluters and amelioration of disease should be encouraged by our legal system. However, encouraging litigation is not necessarily the best way to achieve these laudable goals. When judges feel forced to make decisions that eliminate a basic requirement of tort causes of action, namely, the presence of injury, in order to compensate plaintiffs, it is time to reevaluate the direction our political and legal institutions are taking.¹⁶⁰

Courts are institutions suited to adjudicate rights of the individual parties. They are not, however, able to provide in-depth study and a comprehensive solution to a public policy matter affecting many interested parties. Medical monitoring, if instituted as a cause of action at all, should be instituted by state legislatures, not the courts.

157. See Studdert et al., *supra* note 2, at 890 (Studdert's article notes "the shift to contemplate future harms would be little more than an intriguing doctrinal development were it not for the context in which claims of medical monitoring generally arise—aggregated litigation. Over the past 20 years, private referral arrangements, class action lawsuits, and court-overseen consolidation have changed the face of personal injury litigation, allowing attorneys to pursue lawsuits on behalf of hundreds, thousands, even tens of thousands of similarly situated plaintiffs for damages and attorney compensation on a scale previously unknown.") (endnotes omitted); Henderson & Twerski, *supra* note 116, at 848 ("[mass tort and toxic tort] medical monitoring claims may turn out to be uniquely suited to class action treatment").

158. See *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 442 (1997); *Hinton v. Monsanto Co.*, 813 So. 2d 827, 830-31 (Ala. 2001).

159. See generally *McCarter*, *supra* note 33, at 257 n.158.

160. Susan L. Martin & Jonathan D. Martin, *Tort Actions for Medical Monitoring: Warranted or Wasteful?*, 20 COLUM. J. ENVTL. L. 121, 121 (1995).

A. Allowing Medical Monitoring Claims in Cases in Which There Is No Present Injury Constitutes a Sweeping Change to Two Hundred Years of Tort Law that Warrants Legislative Consideration

For much of this nation's history, courts developed tort law in a slow, incremental fashion. In recent years, however, some courts have abandoned this incremental approach. This has resulted in potentially large adverse consequences to the nation's civil justice system and to those who must abide by its rules.

For over two hundred years, a fundamental principle of tort law has been that a person must be injured to hold another person liable. The reason for this basic rule is simple: in order to determine whether money should be transferred from a defendant to a plaintiff, a jury needs some objective manifestation that an individual has been harmed. Medical monitoring claims, however, "reject[] the prerequisite of palpable harm," eschewing "several time-honored tenets of personal injury litigation."¹⁶¹ As Professors Henderson and Twerski note:

any attempt to embrace [medical monitoring] within the mainstream of traditional tort law is manifestly unwise. In truth, [medical monitoring claims] constitute radical departures from long-standing norms of tort law, advanced in recent years to bludgeon a disfavored group of defendants. But the wrongdoing of a defendant, or defendants, does not justify creating legal doctrine that is substantively unfair, especially when doing so strikes mercilessly at another group of plaintiffs who, when the funds to pay damages run dry, will be denied recovery for real, rather than anticipated, ills.¹⁶²

Allowing an award where a plaintiff currently suffers no harm and has no symptoms of harm is an abrupt change from a fundamental principle of tort law. Such a sweeping change warrants legislative consideration.

Asbestos provides an example of the grave harm that can result from a drastic change to long-established legal principles. Early in the asbestos liti-

161. Studdert et al., *supra* note 2, at 890, 894. See also Martin & Martin, *supra* note 160, at 125. The minority view of West Virginia, that increased risk of future injury from exposure to a toxin is akin to a physical injury from a car accident, is unfounded. See Henderson & Twerski, *supra* note 116, at 841. As Professors Henderson and Twerski wrote, "[f]rom the beginnings of our negligence jurisprudence, 'injury' has been synonymous with 'harm' and connotes physical impairment or dysfunction, or mental upset, pain and suffering resulting from such harm." *Id.* at 841-42. It has been the "linchpin in determining the duties of care owed by defendants." *Id.* at 842. Allowing a claim without injury should be "neither 'only remedial' nor 'business as usual.'" *Id.*

162. Henderson & Twerski, *supra* note 116, at 818.

gation, courts empathetic to the claims of asbestos plaintiffs deviated from accepted legal principles to permit recoveries that traditionally would have been barred.¹⁶³ While the courts in such cases undoubtedly had good intentions, the litigation turned into a judicial “disaster of major proportions.”¹⁶⁴ Unimpaired plaintiffs flooded the tort system, causing about seventy employers so far to file for bankruptcy protection, and putting disproportionate financial pressure on newer “peripheral defendants.”¹⁶⁵ Filings by the unimpaired have depleted funds needed to compensate the truly sick, now and in the future.¹⁶⁶ The problem of separating out and quickly assisting the seriously injured plaintiffs was so great that the judiciary sought congressional intervention to address this crisis, explaining that the “courts [were] ill-equipped to meet [the crisis] effectively.”¹⁶⁷ The legacy of the asbestos lesson continues and should be instructive in the medical monitoring context.

B. Courts Are Not Equipped to Answer the Many Questions Involved in Allowing Medical Monitoring Claims

Implementing a medical monitoring program involves complex medical understanding. As doctors note, “[f]inal scientific selection of [medical monitoring] test strategies . . . could only be made based on results of observa-

163. See Victor E. Schwartz & Leah Lorber, *A Letter to the Nation's Trial Judges: How the Focus on Efficiency Is Hurting You and Innocent Victims in Asbestos Liability Cases*, 24 AM. J. TRIAL ADVOC. 247 (2000).

164. JUDICIAL CONFERENCE AD HOC COMMITTEE ON ASBESTOS LITIGATION, REPORT OF THE AD HOC COMMITTEE 2 (1991).

165. See, e.g., STEPHEN J. CARROLL ET AL., ASBESTOS LITIGATION COSTS AND COMPENSATION: AN INTERIM REPORT 20 (RAND Inst. for Civil Justice, 2002); Mark A. Behrens & Rochelle M. Tedesco, *Two Forks in the Road of Asbestos Litigation*, 18 MEALEY'S LITIG. REP.: ASBESTOS 1, 1-3 (Mar. 7, 2003); Christopher F. Edley, Jr. & Paul C. Weiler, *Asbestos: A Multi-Billion-Dollar Crisis*, 30 HARV. J. ON LEGIS. 383, 392 (1993); Henderson & Twerski, *supra* note 116, at 845 (“If the past decade of asbestos litigation has taught us anything, it is that the appetites of the plaintiff's bar know no limits in the ongoing search for secondary and even tertiary generations of defendants against whom to bring massive collective actions on new and expanding legal theories.”).

166. See, e.g., *In re Asbestos Prods. Liab. Litig.*, No. MDL 875, 2002 U.S. Dist. LEXIS 16590, at *2-3 (E.D. Pa. Jan. 16, 2002) (“filing of mass screening cases is tantamount to a race to the courthouse and has the effect of depleting funds, some already stretched to the limit, which would otherwise be available for compensation to deserving plaintiffs”); Mark A. Behrens, *Some Proposals for Courts Interested in Helping Sick Claimants and Solving Serious Problems in Asbestos Litigation*, 54 BAYLOR L. REV. 331 (2002).

167. JUDICIAL CONFERENCE AD HOC COMMITTEE ON ASBESTOS LITIGATION, *supra* note 164, at 2.

tional or experimental, clinical, outcome-based research aimed at evaluating medical and economic risks, costs and benefits.”¹⁶⁸

The courts are not fit to answer all the questions arising with the implementation of a medical monitoring system. The *Journal of the American Medical Association* notes, “[t]he accurate sorting of strong and weak cases for medical monitoring requires careful examination of relevant medical and epidemiological evidence. Previous experience in toxic tort cases creates some reason to doubt courts’ competence in this area.”¹⁶⁹ One legal commentator aptly concluded, “courtrooms are the last place where medicine should be practiced, where prescriptions should be written and tests ordered.”¹⁷⁰

1. Courts Cannot Effectively Answer the Question: “For Which Diseases Should Medical Monitoring Be Available?”

When courts make bright-line rules allowing medical monitoring for all types of diseases, they disregard the critical medical understanding that medical monitoring is only appropriate for curable or treatable disease. These decisions display a critical misunderstanding of the purpose of medical monitoring and illustrate that courts do not have access to all the information they need to make wise decisions about appropriate medical monitoring.

Courts allowing medical monitoring claims must make scientific decisions about which treatment is proper for specific plaintiffs. In some cases, plaintiffs’ lawyers deluge the court with a battery of diagnostic tests they would like to see the court allow for their clients.¹⁷¹ Critics have suggested that “[t]he all-too-transparent method behind this madness [is] to inflate as much as possible the cost of yearly monitoring per plaintiff so as to maximize plaintiffs’ damage award and their attorneys’ contingent fees.”¹⁷² Courts must then decipher which of these suggested tests to channel the plaintiff toward by “scrutiniz[ing] the clinical efficacy of the [suggested diagnostic tests] and, in some cases, even the treatments planned to follow identification of dis-

168. Beeler & Sappenfield, *supra* note 7, at 287.

169. Studdert et al., *supra* note 2, at 892 (citing articles regarding the clash between science and the law in breast implant cases and toxic tort causation).

170. THOMAS M. GOUTMAN, *MEDICAL MONITORING: HOW BAD SCIENCE MAKES BAD LAW* 16 (2001).

171. The plaintiffs in *In re Paoli R.R. Yard PCB Litig.*, 113 F.3d 444 (3d Cir. 1997), requested the following diagnostic tests for their feared PCB exposure: “amniocentesis, developmental and achievement testing, electrocardiography, pulmonary function tests, mammography, sigmoidoscopy, urine cytology, sputum cytology, ‘basic immunotoxicology panel,’ ‘chromosomal analysis,’ complete ‘optomologic evaluation,’ complete ‘cardiovascular evaluation,’ complete ‘neurological evaluation,’ complete ‘gastrointestinal evaluation,’ PCB ‘detoxification,’ urinalysis, PSA, CBC, urine porphyrin, and male fertility evaluation.” GOUTMAN, *supra* note 170, at 14-15.

172. GOUTMAN, *supra* note 170, at 15.

ease.”¹⁷³ Adding complexity, this determination will change over time with emerging cures and treatments for current diseases and with the introduction of new types of diseases.¹⁷⁴

The courts are not equipped to make these kinds of decisions, which require the reasonable input of physicians, epidemiologists, and other experts.¹⁷⁵ State legislatures are better-suited to undertake this analysis than the courts. Legislatures have the capacity to examine, and then reexamine, the medical literature and call, then recall, medical and scientific witnesses. Unlike the courts, legislatures can consider the interests of all affected by any pending legislation.

2. Courts Cannot Effectively Answer the Question: “What Criteria Should Be Used to Determine Whether Medical Monitoring Is Appropriate in a Given Case?”

Recognition of a medical monitoring claim may require courts to detail the criteria for when recovery is allowed, since open-ended recovery could deluge the courts with claims. Such criteria will be impossible to put into a judicial opinion and challenging to even put into legislation.

Unless clear criteria for medical monitoring claims are established, a flood of new lawsuits is likely to come.¹⁷⁶ Medical monitoring claims could have potentially gigantic proportions because “[t]he specter of a massive, never-ending que [sic] of claimants is very real.”¹⁷⁷ As the United States Supreme Court has recognized, “tens of millions of individuals may have suffered exposure to substances that might justify some form of substance-exposure-related medical monitoring.”¹⁷⁸ People are “exposed to potential health hazards each day through the air they breathe, water they drink, food and drugs they ingest, and on the land on which they live.”¹⁷⁹ Because so many individuals may qualify as potential medical monitoring claimants, contingency fee attorneys will be able to recruit people off the street to serve as plaintiffs. No longer would plaintiffs’ attorneys have to wait for injury to file suit. The familiar advertisement, “Have you been injured?” could become, “Don’t wait until you’re hurt, call now!”¹⁸⁰

173. Studdert et al., *supra* note 2, at 890.

174. *See generally* Beeler & Sappenfield, *supra* note 7, at 287.

175. *See generally* Harbour & Splittgerber, *supra* note 41, at 320.

176. *See* Henderson & Twerski, *supra* note 116, at 845 (“[C]ourts will face, in the long run, an overwhelming flood of litigation in this area.”).

177. *Id.* at 850.

178. *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 442 (1997).

179. Terry Christovich Gay & Paige Freeman Rosato, *Combatting Fear of Future Injury in Medical Monitoring Claims*, 61 DEF. COUNS. J. 554, 562 (1994).

180. Victor Schwartz, *Some Lawyers Ask, Why Wait for Injury? Sue Now!*, USA TODAY, July 15, 1999, at A17.

As a result, courts are likely to become clogged with speculative medical monitoring claims. Access to justice for those with present, serious physical injuries may be delayed or denied.¹⁸¹ As one court that rejected medical monitoring stated:

There is little doubt that millions of people have suffered exposure to hazardous substances. Obviously, allowing individuals who have not suffered any demonstrable injury from such exposure to recover the costs of future medical monitoring in a civil action could potentially devastate the court system as well as defendants. . . . [T]here must be a realization that such defendants' pockets or bank accounts do not contain infinite resources. Allowing today's generation of exposed but uninjured plaintiffs to recover may lead to tomorrow's generation of exposed and injured plaintiff's [sic] being remediless.¹⁸²

The enormity of the potential claims requires a thorough study of who should be eligible for medical monitoring.

Even if one believes that courts can effectively compose a list of criteria to stem the avalanche of medical monitoring cases and govern the monitoring of the spectrum of diseases,¹⁸³ there are broad public policy issues and complexities involved that a court cannot adequately resolve. For instance, a clear and sound "trigger" must be set to identify the circumstances under which a

181. The Alabama Supreme Court realized that "a 'flood' of less important cases" would drain the pool of resources available for meritorious claims by plaintiffs with serious, present injury and would adversely affect the allocation of scarce medical resources. *Hinton v. Monsanto Co.*, 813 So. 2d 827, 831 (Ala. 2001).

182. *Ball v. Joy Mfg. Co.*, 755 F. Supp. 1344, 1372 (S.D. W. Va. 1990) (applying Virginia law), *aff'd sub nom. Ball v. Joy Techs. Inc.*, 958 F.2d 36 (4th Cir. 1991).

183. We believe the best court-established criteria were set forth in the diet drug litigation for use in evaluating the fairness of a class action settlement that established a complicated compensation and medical screening program. See *In re Diet Drugs Prods. Liab. Litig.*, No. 99-20593, 2000 US Dist. LEXIS 12275 (E.D. Pa. Aug. 28, 2000). There, the judge found the medical monitoring scheme was fair because it met each of the following criteria, namely whether (1) the disease in question progresses asymptotically following toxic exposure; (2) a diagnostic test with high sensitivity exists; (3) the exposed population has a relatively high prevalence of disease; (4) the diagnostic test therefore has a high predictive value; (5) the test is relatively low-cost; (6) medical monitoring could be integrated into standard clinical follow-up of those with disease; (7) monitoring could lead to early preventive care; and (8) monitoring allows for the appropriate timing of definitive treatment. *Id.* at *166-67. The *Journal of the American Medical Association* found these stringent criteria to be "consonant with sound epidemiological principles and the best available scientific knowledge of the disease at issue. They also resonate with health policy recommendations for the adoption of cost-effective disease prevention strategies." Studdert et al., *supra* note 2, at 893.

claimant is eligible for a medical monitoring award for different types of disease. Setting a “trigger” to allow the monitoring of specific diseases for individuals with different exposures and at-risk characteristics will require access to information from numerous sources only partially available to courts. Even to a legislature, equipped with the resources to initiate broad information gathering, the task of establishing a trigger for the monitoring of all types of diseases will be daunting. Still, a legislature is better suited for this mission than the courts.

Courts that have permitted recovery for medical monitoring have recognized the problem of potentially open-ended recovery and have established certain criteria in an attempt to confine claims.¹⁸⁴ Yet, they have not demonstrated an ability to articulate consistent eligibility requirements for medical monitoring.¹⁸⁵ As a result, medical monitoring “triggers” established by courts will invariably lead to inconsistent decisions among jurisdictions, causing disparate treatment of similarly situated plaintiffs and costly litigation as parties attempt to clarify their rights and duties.¹⁸⁶ Further, these triggers will

184. See, e.g., *Potter v. Firestone Tire & Rubber Co.*, 863 P.2d 795, 824-25 (Cal. 1993) (listing five factors to determine the reasonableness and necessity of medical monitoring); *Bourgeois v. A.P. Green Indus.*, 716 So. 2d 355, 360-61 (La. 1998) (establishing seven criteria necessary for recovery of medical monitoring damages), *superseded by statute as stated in* *Edwards v. State*, 804 So. 2d 886 (La. App. Ct. 2001); *Redland Soccer Club v. Dep’t of the Army of the United States*, 696 A.2d 137, 145-46 (Pa. 1997) (setting forth seven factors a plaintiff must establish in order to prevail on a claim for medical monitoring). When courts set forth generalized factors, they often do not specify whether each element must be separately established, or whether all factors should be weighed together. See *McCarter*, *supra* note 33, at 265.

185. For example, courts usually require a showing of “increased risk” for disease. See, e.g., *Cook v. Rockwell Int’l Corp.*, 755 F. Supp. 1468, 1477 (D. Colo. 1991); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970, 979 (Utah 1993). One court required the plaintiffs to show it was “reasonably certain” they would develop the need for medical monitoring. *Potter*, 863 P.2d at 823. Under any of these court-established standards, “[i]t is . . . difficult to quantify the amount of increased risk imposed on an individual who does not yet have a disease.” Allan Kanner, *Medical Monitoring: State and Federal Perspectives*, in *LITIGATION* 549, 560 (PLI Litig. & Admin. Practice Course, Handbook Series No. 363, 1988). Further, it is “difficult to conceptualize what that risk is worth in money damages,” *id.*, especially where plaintiffs are being compensated ““for injuries which have not yet occurred and which . . . probably never will.”” *Carey C. Jordan*, Comment, *Medical Monitoring in Toxic Tort Cases: Another Windfall for Texas Plaintiffs?*, 33 HOUS. L. REV. 473, 487 (1996) (quoting *Potter v. Firestone Tire & Rubber Co.*, 274 Cal. Rptr. 885, 896 (Cal. Ct. App. 1991), *rev’d*, 863 P.2d 795 (Cal. 1993)) (alteration in original).

186. A lack of consistency and specificity in judicially-created eligibility standards has proved disastrous in asbestos litigation. Trials essentially have become “games of chance” because of the lack of clearly delineated standards for recovery. Even when similarly situated plaintiffs have tried their cases in the same jurisdiction, awards have been inconsistent. Cf. Lester Brickman, *The Asbestos Litigation Crisis: Is There a Need for an Administrative Alternative?*, 13 CARDOZO L. REV. 1819, 1852-

inevitably change over time as scientific and medical knowledge expands.¹⁸⁷ Legislatures are better equipped than courts to consider the scientific and medical information necessary to set a “trigger” and to change these “triggers” as scientific knowledge progresses.

3. Courts Cannot Effectively Answer the Question: “How Should a Medical Monitoring Program Be Administered?”

Allowing medical monitoring claims involves innumerable questions of how a given medical monitoring program will be administered. Developing such a program would be virtually impossible for courts, and daunting even to legislatures armed with the benefit of committee hearings and the ability to call numerous experts to testify.

Devising a sound medical monitoring plan would require, at a minimum, specifying the nature and amount of benefits available, the source of funding and funding allotments, the procedures for determining eligibility for monitoring, the payment mechanism for the provider and the percentage of provider reimbursement, when eligible parties may join the program, the length of time the program should last, the frequency of any periodic monitoring and the circumstances in which the frequency can be changed to allow special monitoring, the content of the monitoring exams, whether the facility testing will be formal or informal, and whether the service provider is to be designated by the court or chosen by the claimant.¹⁸⁸

Additionally, as a medical monitoring program matures, its scope and administrative operation will inevitably require adjustments, particularly if the program’s designers erroneously estimate funding needs or the number of eligible participants. Administration requires much more flexibility and guidance than a court can give. Administrative intricacies compound in the instance of medical monitoring class actions, where courts would have to manage each class member’s monitoring program, a task that would place “additional strains on courts that should be hesitant to undertake such a costly and time-consuming responsibility.”¹⁸⁹

Establishing a soundly administered program is far beyond the capacity of the courts. Instead, it is best left to the legislature.

59 (1992) (discussing the different treatment accorded pleural plaque claims in different jurisdictions).

187. See generally GREENBERG ET AL., *supra* note 46, at 43; Beeler & Sappenfield, *supra* note 7, at 287.

188. See Beeler & Sappenfield, *supra* note 7, at 286-87; Krieger et al., *supra* note 11, at 113-15; Jesse R. Lee, *Medical Monitoring Damages: Issues Concerning the Administration of Medical Monitoring Programs*, 20 AM. J.L. & MED. 251, 267-72 (1994); Studdert et al., *supra* note 2, at 892.

189. Harbour & Splittgerber, *supra* note 41, at 320.

IV. IF THERE IS A NEED FOR NEW MEDICAL MONITORING RIGHTS, IT SHOULD BE A LEGISLATIVE MATTER

When courts have allowed recovery for medical monitoring, they have often produced results allowing for unlimited recoveries, resulting in an avalanche of claims.¹⁹⁰ Legislatures are in a better position to address the many complexities of medical monitoring and to stymie snowballing claims.

A. The Legislature Is the Proper Forum to Conduct Hearings and Bring in Experts to Address the Many Questions Involved in Allowing Medical Monitoring Claims

The questions medical monitoring raises are difficult and complex. A medical monitoring scheme requires delineating the types of diseases that may be monitored, the tests used in monitoring, and the continuing administration of each patient's monitoring program. These issues are extremely broad and are not totally within judicial control.

Courts are well-suited to adjudicate individual disputes concerning discrete issues and parties. Lawyers in the courtroom advocate the interests of their clients and present experts of the same mind. A court, when faced with implementing a medical monitoring scheme, is guided only by the "battle of the experts" the plaintiff and defendant provide.¹⁹¹ The particularized focus of the judiciary deprives the court of comprehensive access to information essential to the formation of complex tort policy rules.

On the other hand, legislatures are well-equipped to reach fully informed decisions about the need for widespread changes in the law. They have more complete access to information, including the ability to call witnesses and receive comments from persons representing a multiplicity of perspectives.¹⁹² As a result, they can engage in the effectiveness and cost-

190. This was the case after West Virginia allowed medical monitoring in *Bower v. Westinghouse Electric Corp.*, 522 S.E.2d 424, 432-33 (W. Va. 1999). Shortly after *Bower*, plaintiffs' lawyers filed a class-action suit against the major cigarette manufacturers on behalf of approximately 250,000 West Virginia smokers who had not been diagnosed with any smoking-related illnesses, seeking medical monitoring damages. See *In re Tobacco Litig. (Medical Monitoring Cases)*, No. 00-C-6000 (W. Va. Cir. Ct. 2001).

191. Patricia E. Lin, Note, *Opening the Gates to Scientific Evidence in Toxic Exposure Cases: Medical Monitoring and Daubert*, 17 REV. LITIG. 551, 568 (1998).

192. If the issue came before a legislature, all interested parties would have the opportunity to provide input on the issue. For instance, insurance companies could come forward to testify about the impact on the insurance industry of medical monitoring claims against their policyholders. See Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942, 972-73 (1988); Katherine B. Posner & Robert S. Bennett, *Liability and Insurance Coverage for Medical*

benefit analyses required by scientists and doctors for the implementation of any medical monitoring program much better than courts can. With their superior access to information, legislatures are in the best position to consider whether a medical monitoring remedy is needed and if so, how to resolve its many complexities.

B. The Legislature Will Prospectively Address the Issue of Medical Monitoring, Providing Fair Warning to Potential Defendants

Medical monitoring is a topic well-suited for the legislature because it is an inherently prospective concept and it involves a change to long-standing principles of tort law. Medical monitoring is a distinctly prospective claim aimed at preventing future disease. It does not involve compensation for current harm, but “introduces prospective action.”¹⁹³ In the courts, “[t]ort law’s retrospective focus means that it has rarely been able to serve prevention goals.”¹⁹⁴ Medical monitoring, with its inherent prospective purpose of prevention, is better suited to legislative remedy.

Allowing medical monitoring claims also involves a change to fundamental principles of tort law. The courts’ retroactive focus, although possibly appropriate when implementing minor adjustments to common law principles, is not appropriate when the “adjustments” precipitate a broad, fundamental change in an available tort remedy. If the tort system adopts the novel remedy of medical monitoring, thereby denoting a sweeping change to the rights and responsibilities of the public, the change should be done prospectively to provide “fair notice” to those potentially affected. This is particularly true since medical monitoring poses the potential for enormous expense to defendants.¹⁹⁵ This great expense harms not only defendants, but also future

Monitoring Awards: Will Policyholders Get Relief?, 7 ENVTL. CLAIMS J. 19, 25 (1995).

193. Studdert et al., *supra* note 2, at 890.

194. *Id.*

195. Commentators have noted that if courts drop the injury element from medical monitoring cases, defendants will become liable for potentially astronomical costs, because “we may all have reasonable grounds to allege that some negligent business exposed us to hazardous substances.” Martin & Martin, *supra* note 160, at 130-31 (noting the amount of unwarranted expense is compounded when this cause of action is available to many people whose exposure to naturally occurring substances or whose own conduct may put them at greater risk of disease than their limited exposure to a possible carcinogen attributable to a municipality or business with deep pockets); Maskin et al., *supra* note 5, at 529 (“Most people are thus legitimate potential medical monitoring plaintiffs, a clear indication that the boundaries of this potential tort remedy must be narrowly drawn to prevent it spiraling out of control.”). An example of the “enormity of the universe of potential medical monitoring plaintiffs” is the amount of hazardous chemicals and waste with which the public comes into contact. *Id.* at 528. The Environmental Protection Agency has reported that “billions of pounds of hazardous chemicals are released into the air each year.” *Id.* It “further

claimants. Professors Henderson and Twerski have warned that “as the massive number of uninjured claimants presenting anticipatory claims devours the defendants’ resources, those defendants are forced into bankruptcy leaving nothing for those whose ills, when they eventually manifest themselves, are not the least bit speculative.”¹⁹⁶ Thus, this potential for enormous expense “begs for a legislative solution rather than a judicial one.”¹⁹⁷

C. The Legislature Is the Proper Forum to Address the Very Need for Medical Monitoring, Given the Collateral Source Rule

If a party’s costs for medical monitoring are already covered by an employer or health care insurer and there is no proof of injury, a basic public policy question arises as to whether the “collateral source rule” should apply. Under this rule, a claimant’s insurance benefits, workers’ compensation benefits, and government benefits are not deducted when calculating the amount of the claimant’s damages owed by the tortfeasor, since the tortfeasor did not pay for those benefits.¹⁹⁸ When the “collateral source rule” applies, the plaintiff gets funds from the insurance company as well as damages from the defendants, allowing essentially a double-recovery.

Those who advocate medical monitoring as a cause of action “have cited the unfairness of requiring plaintiffs to bear the costs of medical diagnostic examinations which, but for the defendant’s actions, they would not be compelled to undergo. This rationale obviously assumes that plaintiffs do indeed incur the expenses associated with medical monitoring”¹⁹⁹ But, “medical

reports that nearly 20 percent of the U.S. population (approximately 40 million people) live within four miles of a hazardous waste site on the National Priority List.” *Id.*; Paul J. Komyatte, *Medical Monitoring Damages: An Evolution of Environmental Tort Law*, 23 COLO. LAW. 1533, 1533 (1994) (citing U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HAZARDOUS SUBSTANCES & PUBLIC HEALTH (Agency for Toxic Substances and Disease Registry, Atlanta, Ga.), May/June 1992, at 1).

196. Henderson & Twerski, *supra* note 116, at 850.

197. Martin & Martin, *supra* note 160, at 131. Also, in *Ball v. Joy Technologies, Inc.*, 958 F.2d 36 (4th Cir. 1991), the Fourth Circuit recognized the economic hardship that eliminating the physical injury requirement in medical monitoring cases would impose upon defendants and emphasized the appropriateness of legislative consideration.

198. See John G. Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CAL. L. REV. 1478, 1478 (1966). A plaintiff, however, does not necessarily receive double recovery when the collateral source rule is applied. Health insurance contracts, for example, may provide that the insurer is to be subrogated to the insured’s tort claim. See VICTOR E. SCHWARTZ ET AL., PROSSER, WADE AND SCHWARTZ’S TORTS 542 (10th ed. 2000).

199. Maskin et al., *supra* note 5, at 526 (footnote omitted).

monitoring may be an entirely redundant remedy for those who already have health insurance.”²⁰⁰

For those who do not have health insurance, coverage for such monitoring is a social problem that legislatures are best-equipped to address. The United States Supreme Court suggested this approach in *Metro-North Commuter Railroad Co. v. Buckley*, when it said: “where state and federal regulations already provide the relief that a [medical monitoring] plaintiff seeks, creating a full-blown tort remedy could entail systemic costs without corresponding benefits” because recovery would be allowed “irrespective of the presence of a ‘collateral source’ of payment.”²⁰¹

V. CONCLUSION

Medical monitoring, to the majority of scientists and doctors, is a specific tool useful in diagnosing disease at a point when diagnosis potentially can lead to effective treatment or cure the disease. Medical monitoring is only appropriate where its benefits outweigh both its risks and its cost. Such programs should be tailored to specific diseases and individuals, and should be flexible enough to adapt to advances in scientific understanding about the treatment and diagnosis of disease.

The passage of time since a few courts adopted medical monitoring has shown that it is the wrong remedy in the wrong forum. Courts should follow the recent lead of the United States Supreme Court and the state supreme courts of Nevada, Alabama, and Kentucky and reject the medical monitoring claims of plaintiffs who do not have present physical injury. This approach is cognizant of the scientific and medical goals of a medical monitoring program. Courts are not the place to introduce a drastic change to tort law by allowing a claim absent present physical injury. Courts cannot answer the many questions posed by implementing medical monitoring as a new cause of action. A medical monitoring cause of action, if implemented at all, should be implemented by the legislature.

200. *Id.* at 528. In fact, approximately 80 percent of all standard medical testing is paid for by third party insurance. See ENTERPRISE RESPONSIBILITY, *supra* note 134, at 379.

201. *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 443 (1997).

