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IN THE ASBESTOS CLAIMS COURT OF THE STATE OF MONTANA

IN RE ASBESTOS LITIGATION,	)	**Cause No. AC 17-0694**
Consolidated Cases	)	*MacDonald v. BNSF Railway Company et al.*, Cascade County Cause No. DV-16-549
	)	**Also Applicable to All Cases**

DEFENDANTS' COLLECTIVE RESPONSE TO PLAINTIFF'S MOTION FOR DEFERRED DOCKET

BNSF Railway Company, International Paper Company, the State of Montana, and Maryland Casualty Company, Stimson Lumber Company, and Zurn Industries Inc. (collectively "Defendants"), by and through counsel, file this Response to Plaintiff's Motion for a Deferred Docket.

INTRODUCTION

Plaintiff's request, at its core, proposes that this Court take not only his case, but the cases of an unspecified number of claimants with "latent disease," and place them on a deferred docket, indefinitely, until their counsel unilaterally deems their disease "sufficiently disabling" to return to an active docket. Plaintiff's counsel makes no attempt to provide the parties or the Court notice as to which particular claims should be deferred, the claimants' current diagnoses, or the basis for deferring. This is in spite of the fact that all of the Plaintiffs with claims pending before this Court have specifically plead that they presently suffer from asbestos-related diseases ("ARDs"), and at the time of filing their claims, had already accrued damages. Despite already making these claims, Plaintiff's request now suggests that instead of litigating the claims they have filed, he and all similarly situated Plaintiffs be allowed to stay their cases because not enough of an injury has already accrued. Alternatively, Plaintiffs seek an order dismissing the claims of all "unimpaired"

Plaintiffs without prejudice so as to toll the statute of limitations. This would give Plaintiffs' counsel unfettered, unilateral discretion to re-file any claims at any time in the future.

Defendants oppose the creation of a deferred docket for several reasons. First, creation of a deferred docket would be in direct conflict with the mandate that created this Court—to resolve all of the currently pending cases. Second, it would not promote settlement as the Defendants will spend an undefined period of time with the threat of more, expensive litigation looming over them — in some cases this includes claims that are currently 50, 60, and even 70 years old. Third, it would defeat the primary reasons a corporate defendant has for settlement—closure, capping exposure, and not having open claims against them on their books. Fourth, a deferred docket would undermine the prompt resolution of pending cases, as it would enable issues regarding the validity of the CARD Clinic's ("CARD") diagnoses to further evade a factfinder's review. Fifth, it would also enable Plaintiffs to circumvent Montana's statute of limitations,[1] and it would flout the *Manual for Complex Litigation's* (4th Ed.) ("MCL's") policy that any case proceeding to trial should serve as a sample reflective of greater classes of cases so as to narrow the issues. Finally, each of the Plaintiffs, at the time of filing their claims, have alleged present injury and present damages, and defendants will be prejudiced if unable to litigate the issues presented by their claims in a timely manner. The deferral of claims by potentially more than 1,000 Plaintiffs would merely create the illusion of clearing the docket. This would achieve neither justice nor due process for Defendants or the affected Plaintiffs.

[1] Defendants in no way concede that the cases currently before this Court comport with Montana's statute of limitations. Defendants emphatically state that they do not waive or withdraw any defense that the claims before this Court are barred by the statute of limitations.

Plaintiff's request for a deferred docket is another attempt to litigate the sickest Plaintiffs' claims first—an approach that has already been rejected by the Court. For these reasons, and those fully set forth below, the Court should deny the Plaintiff's Motion for a Deferred Docket.

RELEVANT FACTS

A. Facts Specific to Jason MacDonald

Plaintiffs rely on the claims of Jason MacDonald as the impetus for the creation of a deferred docket.[2] Mr. MacDonald, like the other, unnamed claimants Plaintiff's counsel wishes to defer indefinitely, in his June 17, 2016 Complaint alleged that he had accrued both an injury and damages—there was no mention that his case was not yet ripe or that at the time of filing his Complaint he did not yet suffer any impairment. He also failed to allege he had not suffered any impairment when he sought leave to amend his Complaint nearly two years later, on April 27, 2018.[3] To the contrary, Mr. MacDonald, like every other "unimpaired" Plaintiff, repeatedly alleges that he is presently sick and presently injured. Plaintiff's Complaint alleges, in relevant part:

> 87. As a direct, proximate and legal result of the State of Montana's negligence and unlawful conduct, and that of its agencies and agents as described above: *Plaintiff suffers* from asbestos diseases and asbestos related bodily injuries and *has incurred* the damages alleged herein.

(Exhibit A: Complaint, ¶87) (emphasis added). Plaintiff reiterates that allegation in paragraph 92 of the Complaint:

> 92. As a direct, proximate and legal result of the Defendant's violation of the enumerated rights of Plaintiff under the Montana Constitution: Plaintiff has been exposed to asbestos, *suffers from* asbestos diseases and asbestos related bodily injuries, and *has incurred the damages* alleged herein.

[2] Plaintiff's motion comes only after the Court set the MacDonald matter for trial as part of its five lead test cases following a hearing at which all parties had the opportunity to be heard.
[3] The motion for leave to amend the complaint has not yet been granted.

(*Id.* at ¶92) (emphasis added); (*see also Id.* at ¶¶ 100, 106, 114, 120, 133, 146, 158, 167 and 174). In short, Mr. MacDonald's Complaint makes no mention that he is asymptomatic or has yet to suffer any negative effects from his alleged disease. Instead, he alleges that he "*has suffered* and will suffer," among other things, lost enjoyment of life, lost earnings, physical and emotional pain, medical expenses, lost insurability. (*Id*. at ¶ 179).

Now, Mr. MacDonald submits an unnotarized declaration[4] that acknowledges he has a pulmonary impairment, but nonetheless states he would "prefer not to adjudicate this proceeding…until [my] asbestos related disease manifests into serious impairment."[5] This declaration confirms that Mr. MacDonald has a present, diagnosed pulmonary impairment. The declaration is also inconsistent with the records from Mr. MacDonald's visit to CARD in 2013, which demonstrate that Mr. MacDonald, a physical education teacher, traveled from Anchorage, Alaska to CARD in Libby, Montana because he was suffering severe deconditioning to such a degree that he could no longer swim because it was "too extreme." His initial screening records from CARD on July 8, 2013 provides as follows:

> PULM: The patient has a dry cough a few days per month, not chronic throughout the day. He does feel short of breath with activity such as running with his kids, he is a PE teacher. He also now reports that swimming is "too extreme" for him. He relates this to deconditioning.

(Exhibit B). It was these pulmonary symptoms that CARD relied upon when it diagnosed Mr. MacDonald with "Asbestos Related Pleural Disease."

[4] Mr. MacDonald was the only plaintiff to submit a declaration; none of the unnamed Plaintiffs whom counsel wishes to defer have made such a declaration.

[5] Although Mr. MacDonald attests that he has normal-to-mild ARD, the Defendants are not aware of him seeing any doctor since CARD diagnosed him with "Asbestos Related Pleural Disease" on July 17, 2013. (Exhibit B).

B. Facts as to Other Unnamed Plaintiffs

All of the Plaintiffs with claims pending in this Court similarly alleged in their pleadings that they have been diagnosed with an ARD, they have suffered injury, and they have sustained damages. Indeed, Plaintiff's counsel acknowledged as much at a January 31, 2018 conference:

> THE COURT: Now, Mr. Kovacich or Mr. Garvey or Mr. Sullivan, what percent of – I believe you said it's about 2500 Libby claimants are in front of the Court. What percent have exposure, but have yet to be diagnosed with an asbestos related disease?
>
> Mr. MCGARVEY: *They've all been diagnosed*.
>
> THE COURT: They've all been diagnosed. I was under the understanding that there were some claimants who had filed claims in order to preserve the statute of limitations, but had not actually yet received an asbestos related diagnosis.
>
> MR. McGARVEY: The two are tied together. The triggering date for the statute of limitations is the diagnosis, so upon diagnosis, the statute of limitations is running.

(Exhibit C, p. 26) (emphasis added). Plaintiff's counsel was unequivocal. Every plaintiff with a pending claim has received a diagnosis. Plaintiff's counsel further stated:

> [E]ither they're going to advance to disease that warrants the attention of this Court and litigation, or they are not. *If they don't, they're going to be dismissed*.

(Exhibit C, pg. 35) (emphasis added).

ARGUMENT

I. A Deferred Docket Defeats the Purpose and Mandate of the Asbestos Claims Court

The creation of a deferred docket defeats the mandate of this Court. On November 28, 2017, the Montana Supreme Court, by unanimous vote, issued its Order Establishing the Asbestos Claims Court and Consolidating Cases ("Order"). In that order, the Supreme Court stated that it

was particularly concerned with the timely resolution of these claims. The Supreme Court explained:

> In particular, the Court has considered the need of all parties to have asbestos-related claims *timely resolved*, the extraordinary complexity and cost of these cases, and the enormous detrimental impact on the resources of Montana district courts if required to litigate these cases on an individual basis.

(Exhibit D, ¶1) (emphasis added).

This Court acknowledged those interests at the January 31, 2018 preliminary conference:

> THE COURT: I'm certain that many of the Defendants would agree that if they could find full resolution with all the claimants, *instead of sitting on those cases for five or ten years, that's to everyone's benefit,* and it would be my expectation that that's what would occur.

(Exhibit C, p. 37).

A. A deferred docket allows vital issues to escape resolution.

This Court has already explained that allowing Plaintiffs to prioritize claims by severity of injury does not provide "any meaningful way to address the legal issues that cut across everyone." (Exhibit C, p. 22). The Court noted that causation, the statute of limitations, and exposure times were examples of such issues that cut across everyone. (Exhibit C, p.22-23).

Mr. MacDonald's case is a "test case" within the meaning of the MCL, which provides, "[T]est cases should produce a sufficient number of *representative* verdicts and settlements to enable the parties and the court to determine the nature and strength of the claims, whether they can be fairly developed and litigated on a group basis, and what the range of values may have if resolution is attempted on a group basis." MCL 22.315 (emphasis added). The more representative the test case, the more reliable the information about similar cases will be. MCL 22.315.

By Defendants' calculations, Mr. MacDonald's and the other unnamed Plaintiff's claims constitute approximately 60% of the cases pending in this Court.[6] Those 60% raise issues unique to that class of Plaintiffs: timeframe of exposures, alleged latency period, date of diagnoses, date they should have known they had a claim, outlook for their diagnoses, and the credibility and validity of their diagnoses. Here, Plaintiffs essentially argue that this Court should not litigate any case where the credibility of the diagnosis is in question. Plaintiffs also appear to be stalling the dismissal of these cases to avoid addressing latency period issues. Delaying litigation of important, ripe issues because a plaintiff would rather wait for his or her disease to become more severe undermines this Court's purposes of achieving timely resolution of claims.

B. Deferring thousands of 30-70 year-old claims is contrary to the purpose of the statute of limitations.

To indefinitely delay diagnosed, ripe cases or dismiss them without prejudice denies Defendants the protection provided by the statute of limitations. The Montana Supreme Court of Montana has stated:

> The primary purpose of statutes of limitations is the suppression of stale claims which, with the attendant passage of time, *inhibits a party's ability to mount an effective defense*. Thus, "statutes of limitations are regarded as statutes of repose governing the period within which actions must be brought and are designed to compel the exercise of a right of action within a reasonable time, *while the evidence remains fresh in the memory of the witnesses*." *Statutes of limitations also serve to suppress the bringing of fraudulent claims*.
>
> The policy underlying the bar imposed by statutes of limitations is, at its roots, one of *basic fairness*. Our system of jurisprudence is designed to achieve substantial justice through application of the law after the parties have had an opportunity to fully present both sides of a controversy. *The failure to bring an action within a reasonable time is clearly not conducive to a full presentation of*

[6] As of the January 31, 2018 preliminary conference, BNSF was aware of 608 individual Plaintiffs whose exposures began more than 30 years before their diagnoses. Of those 608, BNSF believes 372 showed normal-to-mild impairment. That number represents 61% of the class against BNSF.

> *the evidence nor a search for the truth*. Consequently, the law will not reward the plaintiff who sleeps on his or her rights to the detriment of a defendant. Rather, failure to bring an action within the statute of limitations constitutes a bar to the claim.

E.W. v. D.C.H., 231 Mont. 481, 484 (1988) (quoting *Monroe v. Harper*, 164 Mont. 23, 26, 518 P.2d 788, 790 (1974)) (emphasis added),[7] overruled on other grounds *Blackburn v. Blue Mountain Women's Clinic,* 286 Mont. 60, 74, 951 P.2d 1, 9 (1997)

Contrary to Plaintiff's counsel's representations to the Court in January 2018, Montana's statute of limitations period does not begin at the discovery of the injury; it begins at the point the claimant discovered *or should have discovered* the injury. *See Kaeding v. W.R. Grace & Co*., 1998 MT 160, 289 Mont. 343, 961 P.2d 1256 (holding that references to asbestosis in the plaintiff's medical records, his knowledge of the potential danger of asbestosis, and the doctor's conclusions meant plaintiff *should have* discovered he suffered from asbestosis at least four years before filing suit, and therefore, the three-year statute of limitations barred the plaintiff's claim). A plaintiff's lack of knowledge of a claim or cause of action or its accrual does not postpone the beginning of the limitations period. Mont. Code Ann. § 27-2-102(2); *Gomez v. State*, 1999 MT 67, 293 Mont. 531, 975 P.2d 1258.

Jason MacDonald's alleged exposure began 41 years ago, in 1977. That is 11 years longer than the longest latency period described by Dr. Alan Whitehouse, Plaintiff's own expert and CARD's physician.[8] He previously testified in another case:

> Q: So the [asbestos-related] disease doesn't appear immediately upon inhaling the fibers?
>
> A: *No. 20 to 30 years later.*

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[7] While Plaintiff's counsel relies on *Burnett v. New York Cent. R. Co*., 380 U.S. 424, 428, *accord, E.W. v. D.C.H.* (1988), 231 Mont. 481, 484, 754 P.2d 817, 818-819 in support of his argument for a deferred docket, neither case proposes or adopts a deferred docket for those who have been actually diagnosed and who have plead present injury, illness and damages.

[8] This fact is indicative of the larger issue of the reliability of CARD's medical diagnoses. *See supra* Part II.B.

(*Daley v. BNSF, et al*., Cause No,. DV095-882; Montana Eleventh District, Trial testimony on 7/13/2017; pg. 120) (emphasis added). In fact, of the 2, 117 plaintiffs included on Plaintiff's Master Claims List (filed April 15, 2018), 1,224 (54%) are listed as having an asbestos disease diagnosis, and Plaintiff's counsel identifies the 1,224 as currently having normal-to-mild ARD. For 1,083 of those 1,224 (95%), their exposure began over 30 years ago.

Plaintiffs want to defer many claims that, according to their own alleged exposures periods, are now 40-70 years old. Yet, 6 out of every 10 cases that appear to fall within Plaintiff's definition of "unimpaired" present ripe issues directly pertaining to latency period, validity of diagnosis, and, ultimately, timeliness under the statute of limitations.

C. Plaintiffs have sustained an injury that is ripe for trial, despite Plaintiff's counsel's assertion that they are "unimpaired."

Deferred dockets traditionally involve instances where plaintiffs have not plead a compensable injury and have no diagnosis. Here, by contrast, all Plaintiffs have an asbestosis diagnosis and claim they have sustained damages because of that present illness. Indeed, this Court noted at the January 2018 initial conference:

> THE COURT: I agree with you to the extent *a deferred docket is designed for people who have not been diagnosed*, and I thought that was the situation. I thought there was a certain percent of claimants that have been consolidated into the Court who actually did not have the diagnosis.

(Exhibit C, pg. 32) (emphasis added).

The parties agree that Plaintiffs have a present medical diagnosis by a licensed facility, albeit an unsigned one from a pediatrician. However, the parties disagree sharply on whether a plaintiff's counsel can stall a case indefinitely because of their layman, subjective belief that a plaintiff's symptoms aren't yet severe enough. Asbestos litigation is no different than most other

personal injury cases: the plaintiff must establish that (1) he or she has in fact sustained the injury alleged and (2) the defendant's conduct caused the injury. A plaintiff will not meet this burden without demonstrating an injury-in-fact. *Brown v. North Am. Mfg. Co.*, 176 Mont. 98, 576 P.2d 711 (1978).

Knowledge of the future severity of a disease does not impact whether a plaintiff can demonstrate injury-in-fact. Plaintiffs assert that their conditions may worsen over time, and therefore this Court should defer their cases until they do worsen. Yet, future damages adequately account for this phenomenon; damages not yet incurred are compensable if a plaintiff proves them through testimony of a physician based upon a reasonable degree of medical certainty. *Frisnegger v. Gibson*, 183 Mont. 57, 598 P.2d 574, 583 (1979). Indeed, Mr. MacDonald expressly pleads future damages in his complaint. (*See, e.g.,* Exhibit A, ¶ 179, p. 30-31, items 1, 3-4). Nevertheless, Plaintiff's argument implies that normal-to-mild ARD isn't an actual injury, and therefore the symptoms must worsen before it can become compensable.

Defendants submit, and Plaintiffs appear to agree,[9] that the American Thoracic Society's ("ATS") Diagnosis and Initial Management of Nonmalignant Diseases Related Asbestos (2003) ("ATS Criteria") is an authoritative source of diagnostic criteria for ARDs. It provides:

> It is understood that *disease may be present* at a subclinical level and may not be sufficiently advanced to be apparent on histology, imaging, or functional studies.

ATS Criteria, p. 1 (emphasis added).

It also provides:

> *Demonstration of functional impairment is not required for the diagnosis* of non-malignant asbestos-related disease, but where present should be documented as part of the complete evaluation.

[9] Plaintiffs annexed this ATS Criteria as an exhibit to their motion.

Id. (emphasis added).

Under the ATS Criteria, it is clear Plaintiffs have an injury within the meaning of the applicable standards and law.

Moreover, Plaintiff's own doctors contradict the notion that some of these Plaintiffs haven't had the opportunity for their disease to progress; CARD's Dr. Whitehouse, whom some of the Plaintiffs have retained, has testified that the latency period for asbestosis is 20 to 30 years. (*See supra* p. 9).

D. Deferring thousands of claims does not promote settlement.

Allowing thousands of claims to loom over Defendants for an indeterminate period of time will not encourage resolution of either deferred or active cases. A defendant's primary motivations for settlement are: (1) closure, (2) controlling and ensuring predictability in financial exposure, and (3) avoiding open, adverse claims on the books. As the Court recognized at the January 31, 2018 conference:

> THE COURT: I'm certain that many of the Defendants would agree that if they could find full resolution with all the claimants, instead of sitting on those cases for five or ten years, that's to everyone's benefit, and it would be my expectation that that's what would occur.

(Exhibit C, pg. 37, lines 4-10).

Contrary to Plaintiff's assertions,[10] if this Court grants Plaintiffs a deferred docket, Defendants will lose all sense of predictability and closure, as they will remain in constant fear of

[10] It should be noted that Plaintiff's counsel, in support of the notion that a deferred docket will promote settlement, argued, "the parties to the Asbestos litigation arising from Libby vermiculite have successfully resolved thousands of claims using . . . projections [of disease progression]." That representation is incorrect. It is true that some defendants settled with some plaintiffs; however, those settlements involved no admission of fault or liability, and were based on internal decisions by both defendants and plaintiffs which may or may not be related to "progression projections."

the next case, who will bring it, whether the evidence to defend has been preserved, and when or if the stream of asbestos litigation out of Libby will ever end.

In fact, where other defendants *have* settled in Asbestos cases thus far, it has brought little-to-no closure; once a case settles, Plaintiffs' firms are free – indeed, incentivized – to solicit more clients, obtain dubious diagnoses from the same clinic, and then file new actions. In fact, Plaintiff's counsel here is commencing another round of actions separate and apart from the thousands already pending in this Court. There is no end in sight, and a deferred docket only cements that notion. With an inactive docket in which any person to set foot in Libby[11] can bring a claim and then ask the court to indeterminately warehouse it, Defendants have no incentive to settle.

II. Deferring the 60% of Claims of Normal and Mild ARD Cases Indefinitely Deprives the Defendants of a Full and Fair Opportunity to Litigate (1) the Issue of Causation, and (2) the Validity of CARD Clinic Diagnoses

As the Court is aware from the collective Position Statement of Libby Asbestos Defendants, Defendants share concern over two central issues: causation and the credibility of CARD diagnoses.

A. Causation

In Montana, a defendant cannot be liable if the injurious event would have occurred regardless of defendant's conduct. *Busta v. Columbus Hosp. Corp.*, 276 Mont. 342, 371, 916 P.2d 122, 139 (1996). None of the Defendants here mined, processed, packaged, or sold vermiculite ore. If this Court allows Plaintiffs to indefinitely defer litigation, evidence bearing on the issue of causation will become less reliable over time.

[11] With each new claim, the credibility of each CARD diagnosis becomes more suspect. For example, some Plaintiffs with claims pending in this Court claim exposure after working one summer job in Libby 40-50 years ago.

B. Validity of the CARD Center Diagnoses

With respect to the CARD diagnoses, Defendants contend that the diagnoses have not been conducted in a manner consistent with necessary medical standards, and thus lack reliability and accountability. (Exhibit B, p. 34). Allowing Plaintiffs to defer litigation may enable them to avoid litigating the validity of the CARD diagnoses altogether as over time witnesses' memory become less reliable and evidence may be lost; Plaintiff's request allows them to avoid having to address the validity of CARD's diagnoses and practices. This would deny Defendants the opportunity to timely litigate one of the most important issues before this Court: whether the CARD diagnoses have been conducted in a manner consistent with necessary medical standards, and thus fail due to lack of reliability and accountability.

While the Montana Supreme Court has yet to address mass diagnoses and attendant misdiagnoses, other courts and authorities have done so. . *See, e.g. In re Silica Products Liability Litigation*, 398 F.Supp.2d 563 (S.D. Tex. 2005); Am. Bar Ass'n Comm'n on Asbestos Litig., ABA Report to the House of Delegates, Recommendation and Resolution, at 8 (2003). For example, in a 2004 Johns Hopkins study, a panel of B readers (physicians certified to read chest x-rays) re-examined 492 x-rays obtained from plaintiff's lawyers. The original readers, hired by screening companies, claimed to find evidence of possible asbestos-related lung damage in 95.9% of the x-rays. In stark contrast, the independent B readers, who were unaware of the original findings, found evidence of possible asbestos-related injury in just 4.5% of the x-rays. Joseph N. Gitlin, et al., *Comparison of "B" Readers Interpretations of Chest Radiographs for Asbestos Related Changes,* 11 Acad. Radiology 843 (2004).

Defendants are concerned about the mass screenings performed by CARD. In most instances, there is no actual reading or signature by the clinic's doctor – a pediatrician; the records

simply state, "Per Dr. Black."[12] In many instances, the findings of certified radiologists and film readers wholly contradict the findings of CARD's pediatrician. In other instances, CARD relies on diagnoses of "Libby Disease," a form of asbestosis CARD allegedly discovered that only CARD can see or diagnose.

Plaintiff's counsel argues that it would be "wasteful" for Defendants to question the initial CARD diagnoses, because even if Defendants successfully prove that an individual received an erroneous diagnosis of ARD, the individual can nevertheless refile if they are subsequently diagnosed. This argument erroneously assumes that if a plaintiff fails to meet his or her burden of proof as to a disease, that plaintiff is entitled to a second bite at the apple after shopping for a new doctor.[13] There is good reason why Plaintiff's counsel wants to avoid trying normal-to-mild ARD cases on the merits; there is a reasonable likelihood they will not be able to show damages, or at best only nominal damages or possibly even meet their burden of proof in other ways.[14] This is because, in a substantial number of cases, the diagnosis is dubious at best.

In July, Defendants will present evidence to this Court that will show nearly all of the cases Plaintiff's counsel seeks to defer involve a CARD diagnosis that is unconfirmed or refuted by the radiologists and pulmonologists who took and interpreted the Plaintiffs' x-rays and CT scans in the first place. The July 26, 2018 hearing will establish several facts about CARD, including the following:

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[12] In most instances, there is no indication any of these Plaintiffs ever actually saw a licensed physician at CARD.

[13] Plaintiffs again disregard the statute of limitations. Plaintiff's counsel argues that presently diagnosed, presently injured clients should be able to wait and refile at a later time regardless of the statute of limitations because they aren't yet sick enough to justify litigation. That is not a valid, recognized, or codified exception to the applicable statute. *See supra* Part I.C.

[14] Plaintiffs assert that Defendants wish to drag the Court into lengthy, collateral litigation over the probative value of CARD's initial diagnoses. This is a mis-statement of the Defendants' intent. As set forth below, whether a plaintiff's alleged disease exists and whether the diagnosis is credible and reliable are central issues to the defense in claims by more than 2,000 Plaintiffs.

1. *CARD did not employ any certified B readers, radiologists or pulmonologists.*

   The Centers for Disease Control and Prevention's ("CDC") National Institute for Occupational Safety and Health ("NIOSH") designates the qualifications B readers must meet in order to be certified in classifying pneumoconiosis[15] films using the International Labor Office's ("ILO's") Classification System. To be a certified B reader, the physician must pass a proficiency examination. The few courts that use a deferred docket around the country require this certification. Yet, no one at CARD had this qualification. In fact, many, if not virtually every, CARD diagnosis(es) from the past 14 years was made by a pediatrician. Asbestosis is a pulmonary disease diagnosed through radiological studies. None of CARD's findings were made by a pulmonologist or radiologist.

2. *CARD did not perform any x-rays or CT scans itself.*

   CARD did not have its own equipment. Instead, it referred patients to local hospitals in Libby where certified radiologists and pulmonologists with extensive experience and training with asbestos diseases read the films and issued signed reports. CARD's uncertified pediatrician would then often find evidence of asbestos disease in direct contravention of the certified radiologists and pulmonologists. In many instances, the pediatrician neither wrote a report nor signed off on the records; a nurse simply noted that the diagnosis was "per Dr. Black."

3. *CARD makes intentionally vague diagnoses.*

   For a facility that claims to be highly reputable, its pediatrician's diagnoses are alarming, vague, incomplete, and show either a startling lack of knowledge of asbestos disease or misrepresentation. CARD doctors made no effort to quantify their findings; did not differentiate circumscribed pleural plaques from diffuse pleural thickening; did not comment on en face plaques, calcification and diaphragmatic plaques; did not differentiate between unilateral and bilateral pleural disease; and used vague descriptions of parenchymal disease, including not separating X-rays with or without profusion supportive of asbestosis. CARD also omits that not every parenchymal disease or pleural change is causally related to tremolite or other asbestos fiber. An asbestosis diagnosis for individuals with pleural thickening but without interstitial fibrosis is generally considered fundamentally flawed.

4. *CARD ignored the possibility of alternative causes altogether.*

   Pleural disease and interstitial fibrosis are not associated exclusively with asbestos. There are numerous other probable causes of pleural abnormalities that are generally accepted in the medical community including trauma, tuberculosis, rheumatoid arthritis, emphysema, post-surgical, hemothorax, and obesity with

[15] Pneumoconiosis refers to a disease of the lungs due to inhalation of dust.

subpleural fat. CARD's pediatrician and nurses did not investigate, explore, or even mention any of these alternative causes. Many other conditions may clinically and radiographically mimic asbestos-related diseases; aside from the above, certain autoimmune diseases, fibrogenic dusts other than asbestos, various infections and inflammatory diseases, pulmonary edema, infiltrative disorders like amyloidosis, certain medications, post-operative complications, diseases of unknown etiology such as sacroidoises, adult respiratory distress syndrome, and idiopathic pulmonary fibrosis can also cause interstitial fibrosis or abnormalities. CARD also failed to consider or address any of these alternative causes.

5. *CARD's gathering of operative facts was grossly incomplete.*

It is possible CARD failed to address alternative causes because it failed to collect the basic information necessary for an accurate and scientifically reliable assessment. CARD failed to obtain (1) patients' complete chronological histories, particularly with regard to the other conditions known to cause the same pleural abnormalities as asbestosis; (2) basic information about patients' exposure histories at work including dates of employment, job title, job location, and duties; (3) patients' medical and surgical history, social history, family history; and (4) data pertinent to the ATS Criteria for diagnosing lung disease related to asbestos, including any change in ventilatory function, impaired gas exchange, or inflammation such as bronchoalveolar lavage.[16] In many cases, CARD failed to even have a doctor speak to or examine the patient.

6. *CARD's pulmonary functions tests ("PFTs") are unreliable.*

PFTs involve a series of maneuvers aimed at providing the physician with information regarding air flow, lung volumes, and the ability of oxygen to transverse through the airways to the bloodstream. Among other functions, PFTs detect signs of pulmonary disease, measure the effect of disease on pulmonary function, and assess prognosis and treatment response. The American Medical Association (AMA) promulgates the applicable criteria for evaluating respiratory impairment in its Guides to the Evaluation of Permanent Impairment. The ATC has additional guidelines for assessing pulmonary function. The evidence thus far shows that, in its PFTs, CARD failed to follow ATS and AMA guidelines by (1) not using appropriate measurements (resulting in patient's grades appearing worse than they should); (2) changing machines between tests that measure differently; and (3) using different technicians and uncalibrated equipment (while the ATS stated spirometers must be calibrated at least daily and the results logged, CARD

[16] All parties before this Court agree that the American Thoracic Society (ATS) is the preeminent authority in the relevant field of medicine, and its diagnostic criteria provide definitive guidelines for diagnosis of asbestos-related disease and impairment. Plaintiffs confirmed their agreement in this Court. ACC Hearing Transcript, Jan. 31, 2018, at 68:18-22 ("[W]ith more advanced disease, you have plaintiffs that have a demonstrable disease according to the American Thoracic Society criteria, that I think everyone in this room could basically concur with."). Defendants agree that the ATS is the authority in this field, and that diagnoses should align with the ATS Criteria in order to be used in this litigation.

kept no calibration logs at all. If calibration is off, then the volumes measured will be unreliable.) Moreover, and disturbingly, in many instances, CARD's PFTs include handwritten changes to predicted values. Predicted values are the *published* "normal" values based upon the patient's age, gender, height and race. There are also handwritten alterations to patients' "actual" values. Such alterations are undated and unsigned.

7. *There is concern that CARD evaluated x-rays and CT scans that were not of the patients they purported to be of.*

> Non-party W.R. Grace retained Dr. Steven E. Haber, a certified B reader radiologist and occupational pulmonologist, to evaluate CARD's findings as part of the criminal trial of W.R. Grace in the U.S. District Court for the District of Montana, Missoula Division (CR-05-07-M-DWN). In his report (Exhibit D), Dr. Haber explained that he traveled to Libby and reviewed the original films. Notably, he observed several instances where (1) an x-ray with no evidence of a previous heart surgery was attached to the file of a patient who reported having had heart surgery, and (2) a female's x-ray was attached to a male's file (and vice versa).

This Court has already recognized the importance of the issue of CARD's reliability. The Court specifically addressed the issue at an April 16, 2018 conference:

> I want to get to this issue of whether the diagnostic criteria used by the CARD Clinic is in compliance with medical standards. That would be one issue. *Because if it's not in compliance with medical standards then those people who have been diagnosed with asbestosis solely at the CARD Clinic may not have claims*, or need to get a renewed medical diagnosis that's in compliance.

(Exhibit E, p. 35) (emphasis added).

In sum, for the reasons discussed above, Defendants submit that the Court should deny Plaintiff's motion for a deferred docket. In the alternative, if the Court does not outright deny that motion at this time, the Court should defer ruling on the motion until it sets or adopts objective criteria for determining whether Plaintiffs have claims or impairment

Plaintiff's counsel made clear:

> [E]ither [Plaintiffs are] going to advance to disease that warrants the attention of this Court and litigation, or they are not. If they don't, they're going to be dismissed.

(Exhibit C, pg. 35. Lines 17-20).

Deferred dockets need to comport with due process. At its core, due process guarantees the "opportunity to be heard at a meaningful time and in a meaningful manner." *Mathews v. Eldridge,* 424 U.S. 319, 333 (1976) (internal quotes omitted). As Justice Frankfurter observed, "Due process is not a mechanical instrument. It is not a yardstick. It is a process. It is a delicate process of adjustment inescapably involving the exercise of judgment by those whom the Constitution entrusted with the unfolding of the process." *Anti-Fascist Committee v. McGrath*, 341 U.S.123, 95 L.Ed. 817, 849 (1951). "Notice sufficient to comport with due process is that which is reasonably calculated to inform parties of proceedings which may directly affect their legally protected interests." *Pickens v. Shelton-Thompson*, 2000 MT 131, ¶15, 300 Mont. 16, 21, 3 P.3d 603, 607. Indefinite delay of 30-70 year-old claims, under the guise that the Plaintiffs aren't sick enough yet, deprives Defendants of the opportunity to be heard at meaningful time and in a meaningful manner.

With respect to Plaintiff's own due process claim, not one of the authorities relied on by Plaintiff's counsel stands for the proposition that a Plaintiff is entitled to have his or her case sit in abeyance, waiting for the severity of that Plaintiff's damages to worsen. Asking Plaintiffs to litigate their present claims regarding a present diagnosis of a present illness after alleging present damages does not violate Plaintiff's right to due process. However, allowing Plaintiff's counsel unfettered discretion to decide which claims should be litigated and when *does* undermine fundamental notions of due process *as to Defendants*.

Plaintiff's counsel offers no criteria for determining whether a case involves an illness that "warrants the attention of this Court." Setting specific medical criteria for impairment would provide clarity to all parties and ensure objectivity when determining whether a claim should be litigated or deferred. A lack of established criteria permits Plaintiffs to unilaterally decide which

cases ought to be deferred, and which cases ought to be activated. This will indefinitely extend the amount of time a case could be on file with no recourse for Defendants. This is inconsistent with fundamental notions of due process.

Mr. MacDonald's claim is a fitting illustration of why objective criteria beyond a CARD diagnosis is necessary. According to Dr. Stephen Becker, the licensed radiologist then-affiliated with St. John's Lutheran Hospital, Mr. MacDonald's July 8, 2013 x-ray showed "no evidence of asbestos exposure." Similarly, his CT scan from the same facility showed "no evidence of previous asbestos exposure." Yet, CARD's uncertified pediatrician found asbestos-related pleural disease.

As discussed in Defendants' collective Position Statement in January 2018, several states have established medical criteria that must be met before a Plaintiff may pursue his or her asbestos-related disease claims. In fact, every jurisdiction that has employed a deferred docket for asbestos-related disease claims has created clear parameters to remove a plaintiff from the docket. For example, in New York, in order to move to the active docket, the plaintiff must meet specific medical criteria. For non-malignancies, they must show (1) scarring of their lung tissue or pleural thickening to a certain defined level as manifest on chest x-rays; (2) impaired pulmonary lung function; and (3) that the lung scarring is "a substantial contributing factor to their pulmonary function change." For malignancies, a board-certified internist, pulmonary specialist, oncologist, or pathologist must provide a diagnosis of a primary cancer that states, to a reasonable degree of medical certainty, that the cancer in question is caused by asbestos exposure. Texas requires that in order to move off the deferred docket, there must be a qualified physician's report that:

- Verifies the patient has been physically examined;
- Provides details of the patient's occupational, exposure, medical, and smoking history;

- Verifies that a certified B reader has read a chest x-ray of the patient, the results of which meet specific grading criteria under the ILO's standards, specifically that one of the following was found (for actions filed after May 1, 2005):
    - Bilateral small irregular opacities (s, t, or u) with a profusion grading of 1/1 or higher
    - Bilateral diffuse pleural thickening graded b2 or higher including blunting of the costophrenic angle, or
    - Pathological asbestosis graded 1(B) or higher under the criteria published in "Asbestos-Associated Diseases," 106 Archives of Pathology and Laboratory Medicine 11, Appendix 3 (October 8, 1982).
- Verifies that the patient's PFTs meet specific criteria, specifically:
    - Forced vital capacity ("FVC") below the lower limit of normal or below 80% of predicted; and FEV1/FVC ratio at or above the lower limit of normal, or at or above 65%; or
    - Total lung capacity ("TLC"), by plethysmography or timed gas dilution, below the lower limit of normal or below 80% of predicted
- Verifies the physician's conclusion that the patient's impairment was not more probably the result of causes other than exposure to asbestos, based on the occupational, exposure, medical, and smoking history.

TEX. CIV. PRAC. & REM. CODE ANN. § 90.003(a) (2015).[17]

Similar standards would be necessary in this Court to maintain fairness and ensure due process. Should this Court grant Plaintiff's request for a deferred docket, Defendants renew their request that the Court adopt Texas's criteria, which has the benefit of specificity. Under these criteria, individuals initially placed on the deferred docket would need to produce a qualifying medical report demonstrating impairment under the criteria in order to move to the active docket.

Moreover, upon a Plaintiff's filing of a medical report for the purpose of moving to the active docket, Defendants should be afforded the opportunity to challenge the activation. While it is impossible to foresee all possible circumstances, such challenges will likely revolve around the reliability of the medical report, the practices of the diagnosing physician, or whether applicable standards were met. Objections may be unnecessary in most instances, but the procedural opportunity is necessary, especially given the well-documented history of abuse and fraud in

[17] Notably, the Texas standards for pulmonary function mirror the medical criteria for claims against the W.R. Grace Asbestos PI Trust (Grace Trust).

asbestos litigation. This would ensure fairness to Defendants in a process that is otherwise controlled by Plaintiffs and prevent unnecessary clogging of the active docket with dubious claims.

Finally, if the Court allows the creation of a deferred docket or dismisses these cases without prejudice, then Defendants respectfully request that the Court require each Plaintiff seeking deferral to submit a declaration or affidavit attesting that (1) he or she currently has no impairments; (2) counsel has advised him or her that a deferred docket would result in his or her claim being abandoned indefinitely; (3) it is possible his or her claims may never be activated; (4) he or she understands that his or her claims will be subject to specific criteria to be reactivated; and (5) he or she consents.

IV. Statements in Plaintiff's Motion That Must Be Addressed

Finally, Plaintiff's Brief in Support of the Motion for Deferred Docket contains statements that warrant this Court's attention.

First, Plaintiff's counsel used the term "Unimpaired Plaintiffs," and notes that the term refers to the "fact that these Plaintiffs have little or no current impairment of their pulmonary function." Defendants note that there is no legal authority for this definition. Plaintiff's counsel uses it solely to imply that the relevant Plaintiffs lack a basis for moving his or her case forward due to a lack of present impairment, not that the Plaintiffs have not been injured or damaged.

Second, in footnote 2, Plaintiffs refer to an unnamed study, citing it only as "Miller (2017)." Plaintiffs assert this study stands for the proposition that there is absolutely no indication of a pattern of over-diagnosis at the "highly reputable" CARD Clinic. In this footnote, Plaintiffs refer to the "exceptionally high (88%) rate of diagnosis confirmation." This study, annexed hereto as Exhibit C, makes no such reference. The study, which was co-authored by CARD's pediatrician, Dr. Black, finds abnormalities in 88% of *W.R. Grace miners*. There is no discussion at all

regarding a review of CARD diagnoses for confirmation. The study is not what Plaintiff's counsel represents it to be, and Plaintiff's counsel failed to disclose the fact that CARD's pediatrician is one of the study's primary authors. Moreover, the majority of the cases and claims before this Court do not involve *W.R. Grace miners;* they involve community member claims.

Third, on pages 4-6 of their brief, Plaintiff's counsel refers to a tolling agreement, attaching an example agreement as an exhibit. The exhibit references BNSF as a party to the agreement. BNSF has never entered into such an agreement. While BNSF entered into an informal agreement years before this Asbestos Court was created, that agreement solely regarded service of the Complaints and BNSF's obligation to answer. At no point has BNSF entered into the agreement attached to Plaintiff's brief, nor would it based upon the reasoning set forth herein.

CONCLUSION

A deferred docket will not lead to resolution of claims. While its existence may produce an illusion that the Court's docket is clearing, it would only serve to create a new class of Plaintiffs to whom the statute of limitations, rules of procedure, rules of evidence, due process, and the stated purposes of this Court do not apply. Plaintiffs' counsel would be free to solicit and initiate new cases, and Defendants would be powerless to investigate. The cases and the core issues they present will remain unresolved until they fall back into the Court's lap at an undetermined date. When Plaintiff's counsel activates the cases, there is likely to be fewer living witnesses, fewer preserved facts, and no discovery accomplished. Such a procedure runs afoul of the U.S. Constitution, the Montana Constitution, and fundamental notions of due process.

As such, Defendants respectfully request that this Court deny Plaintiff's request for a deferred docket. To grant the request would allow Mr. MacDonald's claim – and countless others involving claims of normal-to-mild ARD – to sit dormant for an indeterminate amount of time. In

the alternative, if the Court deems an inactive docket appropriate, then Defendants respectfully defer ruling until the Court adopts clear and objective criteria for a person being placed on the deferred document and how a claim could be re-activated including, most importantly, that a certified B reader examines the patient's films.

Dated: May 14, 2018

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Electronically signed by Tara Thal on behalf of Chad M. Knight
Dated: 05-14-2018