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IN THE ASBESTOS CLAIMS COURT OF THE STATE OF MONTANA

IN RE ASBESTOS LITIGATION, *Consolidated Cases*	Cause No. AC 17-0694 THIS DOCUMENT RELATES TO: *MacDonald v. International Paper, et al.,* *Cascade County Cause No. DV-16-549* Judge John Parker

DEFENDANTS BNSF RAILWAY COMPANY AND JOHN SWING'S REPLY BRIEF IN SUPPORT OF MOTION SEEKING ACTIVE STATUS

MacDonald does not meet the requirements for being on the Deferred Docket. He does not have a nonmalignant asbestos related disease (ARD). He has not been diagnosed by a credible and competent medical provider. Plaintiff's *Response* admits his own doubt into the alleged diagnosis by arguing that BNSF failed to present evidence that Mr. MacDonald has been diagnosed with a nonmalignant ARD. It is not BNSF's burden of proving that. Mr. MacDonald must prove that he has a nonmalignant ARD to get on the Deferred Docket. The Court's Deferred Docket Order on p. 6 outlined the presentation of evidence from CARD regarding Mr. MacDonald. The Court did not rule that CARD or Dr. Black are qualified medical providers nor that the alleged diagnosis was based on competent and credible evidence. More importantly, on p. 17 of the Order the Court outlined criteria it would accept based on the American Thoracic Society (ATS) and all three

categories needed to be met. Mr. MacDonald has not presented a diagnosis that meets all three items and therefore, his diagnosis would be rejected. Until that occurs, his case should be active.

BNSF does not accept the proposition that it must admit or prove Plaintiff's case in order to exercise its constitutional due process rights. The Court's Order did not shift that burden. The burden to prove a diagnosis rests on the shoulders of the Plaintiff at the outset and once the pulmonary function test (PFT) falls below the standard set by the Court, Plaintiff's case is active.

The Court set a PFT criteria and Mr. MacDonald's pulmonary function testing met the criteria. Instead of accepting the criteria, Plaintiff responds by arguing disputed issues without any affidavit to support his claims. The Court's Order did not state that the PFT numbers are subject to qualifiers. For instance, Plaintiff is not invited to argue that perhaps Plaintiff had a cold that day, maybe his condition would improve 6 months later, Plaintiff lost weight and that helped his condition improve the following year or finally, Plaintiff went to a clinic that does better testing and just calibrated their testing system. The Court gave a number that would trigger activation. If the number was met, the case should be active.

BNSF did not just happen to pick one PFT that it "liked" as Plaintiff argues in his *Response*. Plaintiff's chart demonstrates there are multiple PFTs that fell below the standard set by the Court. Plaintiff instead is picking the sole number that he prefers for his argument. BNSF presented the PFT from 2016 because it corresponded with when Mr. MacDonald filed the lawsuit. This means that his case with this PFT would have never gone on the Deferred Docket in the first place, putting aside the fact that he does not have a nonmalignant ARD diagnosis.

Plaintiff presents no evidence to support his arguments that the 2016 PFT is not valid. He presents no evidence that any adverse factors existed or that the testing conducted did not meet ATS standards. He attempts to argue a distinction between actual and predicted; however, the

Court's Order sets the standard on predicted. Furthermore, Plaintiff does not submit any medical evidence in the form of an affidavit to support his claim. Instead he cites to an obscure article with no pin point citation for his claim. Dr. Anthony Dal Nogare explains in an affidavit why Plaintiff's argument about how increased age does not increase predicted FVC. Predicted FVC is adjusted taking age, sex and height into consideration. The value is then based on results obtained from normal and healthy individuals that share those same factors. The percentage result would not change due to age otherwise that would defeat the purpose of a standardized predicted value. Mr. MacDonald's predicted FVC increased not because his age increased but because his pulmonary function improved. *See* **Exhibit A**: Affidavit of Dr. Dal Nogare. Yet another undisputed factor showing that he does not have an asbestos related disease and his case does not meet the criteria for the Deferred Docket.[1]

The fact that Plaintiff is making these arguments shows why his claim should be active. The Court should reject Plaintiff's attempts at making the Deferred Docket a revolving door from active to deferred. A test that falls below the standard should activate a case even if a later test shows improvement because it demonstrates that the person does not have an asbestos related disease and the diagnosis is wrong.

The fact that Plaintiff is attempting to refute the same PFT testing that Dr. Black used to diagnose an ARD demonstrates how flawed CARD and Dr. Black's diagnosis is in the first place. CARD opines that his reduced PFT in 2013 and 2015 is due an ARD. Plaintiff now argues that those results are due to age and weight. That begs the question. If Plaintiff is no longer going to rely on CARD and Dr. Black and is now refuting their own findings and opinions, then what qualified medical provider is Plaintiff relying on for 1) arguing his case fits the criteria for the

[1] The rationale applies to Plaintiff's argument regarding his 12-pound weight loss. He presents no sworn affidavit to support his claim and the increased pulmonary functioning after losing weight would also be indicative of no ARD.

Deferred Docket and 2) refuting the validity of the PFTs cited to by BNSF. Since no affidavit was offered by Plaintiff, those two critical questions remain unanswered and Plaintiff's case should be active.

CARD should not be used for PFT to remain on the Deferred Docket. The Court need not address that issue substantively here, but BNSF submits that issue is one the Court should address globally with respect to management of the Deferred Docket.

Defendants have presented evidence both at the hearing and in *Wetsch vs. BNSF* that CARD was not following generally accepted guidelines for conducting PFTs. Defendants presented evidence at the July 23-24, 2018, hearing through the testimony of Dr. Weill that CARD's PFTs had documented issues with patient performance. Dr. Weill testified that he saw graphs that did not show smooth effort on the part of the patient. The graphs showed disruptions such as coughing, sneezing or patients simply stopping the effort. Dr. Weill testified that the concern is then how the improper test results are interpreted. Testimony from Dr. Haber in the *Wetsch vs. BNSF* case shows how CARD would interpret invalid PFT testing. The tests would not comply with ATS criteria; however, CARD would interpret it anyway. For instance, in *Wetsch*, CARD used two unreliable spirometry tests instead of obtaining three valid effort tests before reading the results. CARD then read the tests as restrictive despite failing to obtain three valid efforts under ATS guidelines. *See* **Exhibits B and C**.

CARD also withholds medical records and in the case of MacDonald, CARD withheld the same flow loop charts from the 2018 testing that would be needed to analyze valid effort. Mr. MacDonald brushed off this lack of disclosure on p. 9 of his *Response* by stating "[a]pparently, BNSF did not receive an update of Mr. MacDonald's medical records before filing its *Motion*." Yet somehow Plaintiff MacDonald was able to get the flow loop chart from CARD and never

produced them to BNSF. BNSF submitted a release and CARD withheld the documents. Undersigned Anthony Nicastro reviewed the packet of records disclosed by Plaintiff and CARD in preparation for this Motion. There is no explanation for why CARD only produced the clinic note, but withhold the flow loop charts for the same day. A review of the complete records show that past flow loop charts were also not produced by CARD. CARD is not capable of maintaining and producing a complete set of medical records. Management of the Deferred Docket requires competent PFT testing and competent production of medical records. CARD's conduct over the last 6 months clearly shows the CARD lacks both. Litigants such as Mr. MacDonald have obtained PFTs at clinics other than CARD and the Court is only requiring tests once a year. Again, the Court need not address that issue in this Motion; however, BNSF raises the issue now because Mr. MacDonald's *Response* suggests that BNSF was not being diligent in obtaining full records.

Mr. MacDonald has not met the Court's criteria for being on the Deferred Docket and even if he has, his PFT results fall below the Court's standard requiring activation of his case. Plaintiff failed to present any evidence to contradict his PFT results when his claim was filed and failed to present evidence to refute the fact that his 2018 PFT shows that he does not have an ARD.

BNSF respectfully requests that the Court enter an order stating that Mr. MacDonald's claim is active.

DATED this 23rd day of October, 2018.

Respectfully submitted,

KNIGHT NICASTRO, LLC

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CERTIFICATE OF SERVICE

I hereby certify that I have served true and accurate copies of the foregoing to the following counsel of record by the means indicated below on this 23rd day of October, 2018:

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IN THE ASBESTOS CLAIMS COURT OF THE STATE OF MONTANA

IN RE ASBESTOS LITIGATION, *Consolidated Cases*	Cause No. AC 17-0694 **AFFIDAVIT OF ANTHONY DAL NOGARE, MD** THIS DOCUMENT RELATES TO: *MacDonald v. International Paper, et al.,* *Cascade County Cause No. DV-16-549* Judge John Parker

STATE OF MONTANA)
:SS
COUNTY OF KALISPELL)

Anthony Dal Nogare, MD, being duly sworn upon oath states as follows:

1. My name is Anthony Dal Nogare.

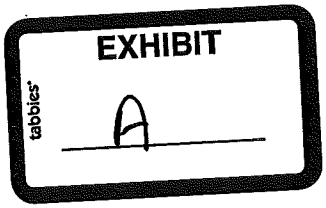
2. I am over the age of 18.

3. I am a board-certified pulmonologist practicing medicine at Kalispell Regional Healthcare.

4. I have experience treating patients who have asbestos related diseases.

5. I have experience with pulmonary function testing, including the interpretation of those tests.

6. I have been asked to evaluate and address a claim that a patient's increased age could explain an increased predicted FVC percentage over the course of a two-year period. This claim is not correct. Predicted FVC takes into account many different factors including age, sex and height. The predicted value is based on results obtained from normal and healthy individuals that share the same factors as the individual being tested. The predicted value is adjusted as the factors change, such as increased age. However, the percentage of predicted which is reported for the individual being tested does not change because a factor changes. That would defeat the purpose of having a standardized predicted value based on normal health individuals. Therefore,



as age changes the adjustments to the predicted value take into consideration those changes. This means that an increase or decrease in the predicted value for the individual being tested is not caused by an individual getting older. If a person's predicted FVC score increases over the course of two years, that suggests that the person's pulmonary function has increased. In other words, the person is now testing closer to the normal and healthly range than in previous years.

FURTHER AFFIANT SAYETH NOT.

Anthony Dal Nogare, MD

Subscribed to before me this 22 day of October, 2018.

Notary Public

DEBORAH G. DAVIS
NOTARY PUBLIC for the
State of Montana
Residing at Kalispell, Montana
My Commission Expires
December 05, 2020

Q. In evaluating the CARD's PFTs did you also find any issues with patient performance?

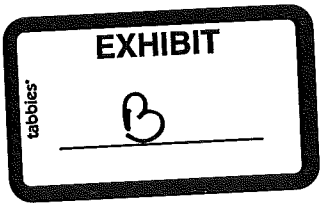
A. We did. And the way that that's measured is to look at actually the graphs themselves. And in a significant number of cases -- not all the graphs were available to us, but during that period where we studied this we looked at patient effort by examining the smoothness of the graph, in other words looking at the inspiratory effort and the exhalation effort we were able to determine whether or not the patient made a good effort or not and whether or not those inhalations and exhalations were interrupted by coughing, sneezing, stopping, whatever. But that's part of the reason the ATS requires the examination of those different PFT graphs, so you can determine whether or not the effort was okay.

Q. And the graphs were also referred to as flow value loops?

A. Right.

Q. And is one of the things that's required by ATS also for those results for those graphs to be re-produceable?

A. That's right, that's part of it. In other words you want to see them superimposed on one



another closely -- not exactly, but closely on one another so that you can have some confidence that the test was done properly.

Q. And to be able to do that how many times do you have to perform the test?

A. It varies from person to person. You want to get at least three re-produceable ones, but some patients, depending on their extent of lung disease require ten efforts to do that, at which point in my experience the patients are usually pretty tired and can't give much of an effort after that.

Q. And then in terms of patient effort were there any issues that you observed in reviewing all of those records from CARD of patient effort?

A. Yes, and there always are, the question is whether or not a practitioner chooses to interpret those. In other words if you see that there's a patient effort problem that's just what it is, and the only mistake you can make at that point is to try to read those PFTs and try to also attach clinical significance to them.

Q. -- and again, there was a lot of discussion today -- a lot of questioning about the lamellar -- am I saying it right?

A. Lamellar.

Brent Wetsch vs.
BNSF Railway Company

TRANSCRIPT OF JURY TRIAL

Vol. 5

June 8, 2018

4th JDC, Cause No. DV-16-1146

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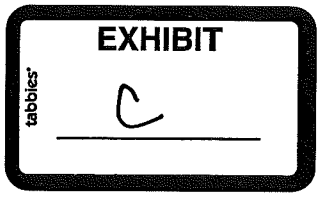

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your understanding as to what this evaluation consisted of and where you have concerns about it.
A. Okay. So Mr. Wetsch goes to the CARD clinic March 2015. Did a height and weight. They found a BMI, body mass index, of 38. 30 and above is obese. 40 and above is called morbid obesity. So he's getting up there.
His blood pressure was 142 over 90, so he's actually got high blood pressure. And he had actually had high blood pressure diagnosed as far back as at least 2010, was not taking any medication for it until 2011. And even after that his blood pressure repeatedly was too high when his doctors were measuring it. The lungs were clear when they listened to the chest.
Now, what they did, though, is that instead of even taking a chest x-ray or CAT scan from March of 2015, they instead looked at the CAT scan from April of 2014, which was right in the--just three months into his treatment of the COP. And according to Mr. Miller, Dr. Black said that this showed extensive bilateral pleural thickening and plaquing. But they never ordered any new x-rays and they never reviewed any of the other x-rays or CAT scans that had been taken

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before.
Q. Okay. So what's the problem with using the CT scan that was done right in the middle of the COP episode and recovery for this diagnosis?
A. When you are making a diagnosis for asbestos-related disease, or any disease for that matter, we have what's called a differential diagnosis. You are supposed to decide after looking at all of the information what the most likely cause or the most likely diagnosis is.
So I don't know how you exclude findings of another condition when the x-ray that you are taking still shows the effects, that he still had evidence of COP and he was not completely cleared up, although he was improving. So I don't see how you can say, "well, I've excluded other diseases," when it's right in the middle of this disease condition.
Q. Okay. All right. So in connection with this visit with Miles Miller with the CARD clinic in March 30, they performed a spirometry test on him or PFT?
A. Yes.
Q. Did you see any issues or problems with it?

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A. I did.
Q. Let's talk about that. You really probably ought to stay over there.
A. Okay. So a spirometry--I don't know if the jury has heard this. There are several different maneuvers in what's called a pulmonary function test or PFT. One of them is spirometry. That's the simplest one, most basic one, where it's just blow as hard and as fast as you can as if you are blowing out a candle, but you've got to keep blowing, blowing, blowing until you literally can't squeeze out any more air.
And there are criteria that you have to do to meet a reliability level, okay. You have to have what's called acceptability; so that the maneuver that the person does, it has to be acceptable. They have to have blown out long enough. They have to have blown out steady and hard and quick. They have to blow out for at least six seconds. They have to have no more air left in them. A very smooth exhalation. There are a lot of different factors that have to go into it, okay.
And if you don't get an acceptable maneuver, then you've got to do it again. And

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you've got to keep doing it until you get a minimum of three acceptable efforts. You don't stop at three if you don't have three acceptable efforts. You have to have three acceptable efforts.
Then when you get three acceptable efforts, you have to have two that are repeatable. So they have to be so close to each other that they are almost on top of each other. And if they are not repeatable, then you've got to do another acceptable that is repeatable.
And if you get to--we say typically if you go to eight efforts and the person still can't get it, then you say, okay, well, we've done our best, because he's going to get tired at that point.
The other pulmonary function testing is what's called lung volumes. We look at the size of the lungs. The spirometry is more for the flow, how quickly. We do that for COPD and asthma primarily.
The volume is to see if there is restriction of the lungs, if they are too small or if they are overly distended.
And then what's called diffusion

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capacity, which is how easily oxygen gets into the lungs, into the bloodstream.
And finally what's called the MVV, which is maximal voluntary ventilation, which is how fast you can breathe in and out like (indicating) really hard; and that is neuromuscular, to see if you've got a muscle problem around your chest.
So they did just a spirometry. And, number one--so these are their three efforts. This is the exhalation and this is the inhalation.
Inhalation, we're okay. But we have a real problem with the exhalation. On one of these efforts you see it kind of go down and up and down and up and down. It looks likes a squiggly line. It's not supposed to look at that. It's supposed to go up, straight down, very smooth. Not supposed to have any wiggle. So this is what's called variable effort. If you have any of it going--once it's going this direction, again it means he's taking--he's kind of (indicating) and it's stuttering and you are not getting a good result. So this is an unreliable result completely.
This one here has--again, it's up and down. So we only have really one effort that

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went--that looked actually pretty decent. So they didn't get three efforts that were acceptable. They got probably only one. And there's no repeatability, because you can't do repeatability if you don't those acceptable. So this is not a reliable test.
And then they went ahead and they interpreted it as being restrictive. So you can have what's called obstructive, which means the air does not flow very fast, like asthma or COPD; or if the lungs are very small, you get very high flows.
Now, typically, number one, to do--the definition of a restriction is based on lung volumes, the total lung capacity. You can only get a hint that there is a restriction if the FVC is abnormal. In this case it's not abnormal, so there was no restriction.
The other thing is, is that it not only has to be abnormal, but the FEV1 to FVC ratio has to be over 85 to 90 percent, and his was 79. So this would not even give you a suggestion of being restriction. It's certainly not a restrictive pattern. So they misinterpreted what was unreliable.

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Q. Okay. So in this next slide you've given us a way to kind of compare, I think, what showed up in Mr. Wetsch's flow loops there with what a restrictive disease would look like, correct?
A. Well, both a restriction and--this is from the American Thoracic Society. And as I say, they have published exactly how doctors are supposed to not only perform the test, but how they are supposed to handle their equipment, how they are supposed to QC it, and how you are supposed to get efforts to make sure that it's a reliable force. So this is one of their problem--it's called an unacceptable flow volume loop due to variable effort.
So we have this up-down, which is exactly what we had right here, this up-down. So this is an unacceptable according to ATS, and I agree.
This is where there was--so restriction actually doesn't stop you from breathing. These guys, they can--I mean, because it's almost like you are squeezing air out of a balloon. The air comes out really fast.
So although it's a low lung volume, this is the ATS example of restriction. They still have a beautiful straight, smooth and then a big

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deep inhalation. And that's the kind of pattern we want to see. We don't want to see this. And there should be three of them all on top of each other basically.
Q. Okay. So after he does this we get this diagnosis from Mr. Miller of an asbestos pleural disease, right?
A. That's correct.
Q. Okay. What else was going on that Mr. Miller might have caught had he been properly supervised by a pulmonologist?
A. Well, they did an analysis of Mr. Wetsch at nighttime. They put on what's called a pulse oximeter, which is a little clip that fits on the finger and it tells you your oxygen.
And at nighttime Mr. Wetsch's oxygen level was dropping down into dangerously low levels. 99 times out of 100 when you've got someone who is obese and is male and he snores--and he's reported as being a snorer. In fact, he was even reported to have had--noticed to have apneas by family members. Sleep apnea is the most likely cause.
And instead of even thinking that this could be sleep apnea, instead Mr. Miller

CERTIFICATE

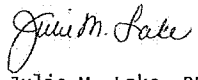
STATE OF MONTANA)
) ss.
COUNTY OF MISSOULA)

I, Julie M. Lake, RDR, CRR, CSR, Freelance Court Reporter for the State of Montana, residing in Missoula, Montana, do hereby certify:

That I was duly authorized to and did report the proceedings in the above-entitled cause;

I further certify that the foregoing pages of this transcript represent a true and accurate transcription of my stenotype notes.

IN WITNESS WHEREOF, I have hereunto set my hand on this the 2nd day of August, 2018.



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