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IN THE ASBESTOS CLAIMS COURT FOR THE STATE OF MONTANA

IN RE ASBESTOS LITIGATION, *Consolidated Cases*	Cause No. AC 17-0694 PLAINTIFFS' RESPONSE TO BNSF'S RENEWED MOTION FOR SHOW-CAUSE ORDER RELATED TO A CARD DIAGNOSIS OF ARD *Applicable to 103 Personal Representative Claims on the Deferred Docket*

INTRODUCTION

BNSF filed its *Renewed Motion for Show-Cause Order Related to a CARD Diagnosis of ARD* ("BNSF's Motion") seeking to dismiss 103 personal representative claims on the Deferred Docket alleging the sole basis for those claims is a CARD diagnosis, which BNSF contends is unreliable. Specifically, BNSF alleges it seeks a show cause hearing:

> [R]equiring any of these 103 deceased claimants who do not carry a mesothelioma diagnosis to tender a diagnosis by a board-certified pulmonologist not affiliated with the CARD Clinic or Mount Sinai within six months or have their claim dismissed.

BNSF's Motion, p. 24. No other Defendant has joined in *BNSF's Motion*. BNSF admits not all those

103 claimants have claims against BNSF (only 24 do).[1]

BNSF asserts that,

> "[L]itigating cases based solely on a CARD diagnosis flies in the face of judicial economy and wastes all parties' time and resources."

BNSF's Motion, p. 3. MHSL Plaintiffs couldn't agree more. MHSL Plaintiffs fully ascribe to and embrace the Court's lead case paradigm and would prefer to expend valuable judicial resources and time on those cases. That is why counsel have affirmatively stated we would not be calling Dr. Black to testify in our lead cases going to trial, since in those lead cases, the initial diagnosis has been superseded by later diagnostic testing and treatment of a progressed asbestos disease.[2]

The CARD diagnoses are not the issue, as BNSF contends. Rather, the issue is the statute of limitations and litigation attendant thereto for a progressive latent disease. Addressing the heart of the real issue, MHSL Plaintiffs are separately filing a *Motion for Claim Registry for Plaintiffs Willing to Forego Claims for Present Damages* ("Motion for Registry") which proposes a reasonable solution.

Regarding the 103 personal representative claims for which BNSF seeks a show cause order, BNSF filed a separate *Motion to Dismiss 103 Personal Representative Claims on the Deferred Docket* alleging that because those same claimants were diagnosed by the CARD Clinic and the claimants did not disclose an "expert report" or "verification" when they died, those cases should be summarily dismissed. MHSL Plaintiffs incorporate their response thereto herein. The filing of that

[1] BNSF does not have standing to seek dismissal of claimants' claims who do not have claims against BNSF. *Heffernan v. Missoula City Council*, 2011 MT 91, ¶ 29, 360 Mont. 207, 255 P.3d 80 ("A court lacks power to resolve a case brought by a party without standing—i.e., a personal stake in the outcome—because such a party presents no actual case or controversy.").

[2] Such later developed medical evidence includes CT scans showing advanced disease, pulmonary function testing done years after the initial diagnosis, and expert opinions (e.g. Yale School of Medicine occupational medicine Dr. Carrie Redlich's expert reports in *Barnes et al. v. BNSF* and *Hutt v. Maryland Casualty Co.).*

separate motion, along with the current motion regarding the same 103 claimants, shows that *BNSF's Motion* is really seeking a show cause hearing for a blanket determination regarding the CARD Clinic diagnoses, despite the fact this Court has already conducted a two-day hearing regarding the CARD Clinic diagnostic criteria after which the Court refused to indulge BNSF's requests. *BNSF's Motion* encourages this Court to reconsider that prior abstention and impose relief that is not supported or proper.

The examples of CARD Clinic diagnoses BNSF relies upon highlight the fact that analysis of such diagnoses must be done on a case-by-case basis, making the blanket relief BNSF requests improper. Even if the Court were to entertain BNSF's request, that relief is not proper as it would require making findings regarding the non-party CARD Clinic in litigation in which it is not a party, without regard to the CARD Clinic's own due process rights.

MHSL Plaintiffs respectfully request the Court decline to engage in BNSF's second attempt to obtain rulings against non-parties who are not otherwise before the Court, deny *BNSF's Motion*, and grant MHSL Plaintiffs *Motion for Registry*.

ARGUMENT

I. MHSL Plaintiffs' proposed Registry provides a solution to the statute of limitations issues and needless litigation attendant thereto.

The duplicity of BNSF's position becomes apparent by following its line of argumentation. On the one hand, BNSF states "a CARD diagnosis is baseless," BNSF's Motion, p. 2, and "a CARD diagnosis of asbestos related disease (ARD) has no legitimacy—and must not be considered as a legitimate basis for a claim before this Court," BNSF's Motion, p. 3. On the other hand, BNSF takes the position that "Plaintiffs have correctly stated that a positive screening from CARD triggers the statute of limitations." BNSF Motion, p. 9. BNSF's attempt to have it both ways highlights the real issue in these cases: the statute of limitations construed in *Kaeding* as applied to a progressive latent

disease diagnosis. The statute begins to run with indication of findings "consistent with" asbestos disease. *See Kaeding v. W.R. Grace & Co.-Conn.*, 1998 MT 160, ¶ 25, 289 Mont. 343, 961 P.2d 1256. However, mechanical application of such a rule ignores the import of the "damage rule" that provides that a cause of action does not accrue with respect to a particular injury until that "damage" has occurred or it is known it will occur. *See Uhler v. Doak* (1994), 268 Mont. 191, 197, 885 P.2d 1297. *Uhler* has also been cited with approval by the Montana Supreme Court in the context of Montana's "continuing tort" jurisprudence. *See Christian, et al v. Atlantic Richfield Co*., 2015 MT 255, ¶ 13, 380 Mont. 495, 358 P.3d 131. As the *Christian* Court explained:

> A continuing tort is one that is "not capable of being captured by a definition of time and place of injury because it is an active, progressive and continuing occurrence. It is taking place at all times." *Floyd v. City of Butte,* 147 Mont. 305, 312, 412 P.2d 823, 826 (1966). The continuing tort exception may be applied to injuries that are ongoing or in some way recurring.

Christian, ¶ 17 (citations omitted; emphasis added). Like the toxins deposited from the air into plaintiffs' soil in *Christian,* here the asbestos toxins from BNSF's properties were deposited from the air into plaintiffs' bodies. Both are a type of injury that is "progressive and continuing." The injuries are "ongoing." Judicial recognition of the dilemma faced by plaintiffs who have alleged such injury underlies the Montana Supreme Court's adoption of the "continuing tort" exception to the application of the statute of limitations.

Here, the parties agree no expert can opine to a reasonable degree of medical probability whether a given claimant will progress, and thus, the future damages attendant thereto remain speculative. As a result, if a given claimant's case is forced into active litigation without knowing that critical information, the claimant must proceed at significant expense with litigating their minimal current damages or withdraw the case, and face the defense BNSF will certainly assert that such dismissal bars any future case for far more significant damages that have not yet occurred.

This statute of limitations issue is not solvable by this Court making a finding that the CARD Clinic diagnoses are, or are not, legitimate as claims must still be filed pursuant to *Kaeding*. Rather, the statute of limitations issue can be resolved through the reasonable solution MHSL Plaintiffs propose: a Registry for Plaintiffs willing to forego current damages as outlined in MHSL Plaintiffs' *Motion for Registry*. Otherwise, the parties will continue to engage in needless litigation that is consuming judicial resources, such as the instant motion.

A further example of such needless litigation is *MacDonald v. BNSF*, which BNSF activated over Plaintiff's objection using an outdated PFT that showed Jason MacDonald had mild disease. It is undisputed Jason's most recent PFT confirms he has normal lung function. Jason had significant exposures to asbestos by growing up in Libby, including playing baseball adjacent to BNSF's downtown Libby railyard since a very early age, eventually becoming a high school star player. Jason was screened at the CARD Clinic and currently, the only doctor supporting his diagnosis of non-malignant ARD is Dr. Black.

Jason would gladly forego his present damages of lost insurability and fear of cancer if he could be placed on a registry that would allow him to pursue future damages in the unfortunate circumstance that his disease progressed (just like his grandparents' disease did and so many others he knows) such that it became worth his time and money to pursue a case. Instead, the status quo for Jason's normal disease case is that: BNSF activated his case; BNSF served 51 interrogatories and 60 requests for production; BNSF conducted Jason's deposition; after the stay (per the issues appealed in *Barnes*) was lifted, BNSF requested a scheduling conference from Judge Parker; and despite not having any scheduling conference or resulting scheduling order BNSF is requesting four more depositions (his parents, Dr. Black, and medical provider in Alaska) in the month of May, stating:

> A scheduling order is not necessary for us to conduct discovery. This case has been pending for a very long time and there is no reason why we cannot be proactive in preparing this case and reporting our efforts

to the Court when a scheduling conference occurs.

Exhibit A (emails between counsel re: May depositions). In addition, BNSF is now also requesting a Rule 35, M.R.Civ.P., exam in Montana of Jason who is a schoolteacher in Alaska. **Exhibit B** (letter from BNSF counsel).

Jason does not want to litigate his current minimal damages and incur the costs related thereto, which would be done with the attendant risk that he may not be able to prove his disease, diagnosed via CARD's screening protocols, to a reasonable degree of medical probability. Both BNSF and MacDonald want the case dismissed. However, contrary to BNSF's stated position about litigating CARD diagnoses, BNSF seeks to actively and prematurely litigate this normal case into a dismissal with prejudice. Conversely, MacDonald very simply wishes to preserve his right to a remedy against a Defendant which is strictly liable for causing asbestos exposures in Libby. The other party to Jason's case, International Paper is in agreement that there is no need for this case to be litigated at this time. Thus, IP came forth with a common-sense solution: dismissal without prejudice and a tolling agreement to which Jason is agreeable. However, regarding BNSF, absent a Registry, Jason's current only option to avoid expensive litigation of nominal current damages is to dismiss his case with prejudice, and should he progress later face the defense BNSF will certainly assert that such dismissal bars any future case for damages that have not yet occurred.

The foregoing needless litigation, and the litigation attendant to the blanket relief sought in *BNSF's Motion*, can be avoided through the implementation of the Registry.

II. Even if the Court were to consider the blanket relief BNSF requests, that relief is not supported as CARD diagnoses are proven, or disproven, over time.

As this Court has previously recognized:

> Well, part of the problem here is this intersection between the medical screening that's being done in Libby for purposes of the mission of the CARD Clinic versus medical diagnosis, versus admissibility for legal purposes.

Asbestos Claims Court Hearing (7/24/2018), 491:6-12.

The CARD Clinic's grant from the Agency for Toxic Substances and Disease Registry ("ATSDR") under the Affordable Care Act ("ACA") is for the purpose of early detection of asbestos-related disease in Lincoln County. In 2010, the ACA was signed into law, and a number of Libby-centric provisions were enacted, including a program entitled "The Program For Early Detection of Certain Medical Conditions Related to Environmental Health Hazards." 42 U.S.C. § 1397(h). This program created grants "for the purpose of screening at-risk individuals for environmental health conditions." *Id.* Under the aegis of the ATSDR, the CARD Clinic has received these grants to undertake a comprehensive health screening of approximately 6,000 Lincoln County residents with exposure to asbestos to determine the presence of asbestos-related disease. The grant serves to provide early detection and diagnosis of the disease, then provide interventions. Asbestos Claims Court Hearing (7/24/2018), 188:13-189:6 (Dr. Brad Black).

Exposure to asbestos, and in particular sufficient exposure resulting in an early-stage diagnosis of non-malignant asbestos-related disease,[3] increases the risk of the development of an asbestos-related malignancy. 42 U.S.C. § 1397(a)(1). The CARD Clinic and Mount Sinai collaborate in a lung cancer screening program, where CT scans are taken in Libby and read by a group of board-certified thoracic radiologists at Mount Sinai. Patients of CARD who have been diagnosed with asbestos-related disease and are asymptomatic for lung cancer are followed for early signs of cancer. The purpose of this program is to catch lung cancer in a high-risk population at an early and treatable stage. Asbestos Claims Court Hearing (7/24/2018), 33:5-25 (Dr. Albert Miller). The first step in

[3] Diagnosis at the CARD Clinic is made in accordance with ATS (2004). Dr. Albert Miller, a member of the Scientific Assembly on Environmental and Occupational Health of the American Thoracic Society, which developed ATS 2004, testified that during his time observing the CARD Clinic, diagnoses were made in accordance with the ATS Criteria. Asbestos Claims Court Hearing (7/24/2018), 64:7-65:19.

overreading the CARD Clinic CTs is for the thoracic radiologists to confirm or deny the existence of a non-malignant ARD, which is a prerequisite to be included in the lung cancer program. Notably, Dr. Yankelevitz testified in the over 1,500 CT images he has reviewed for that purpose, he has seen non-malignant ARD "on virtually all of them [CTs]." Asbestos Claims Court Hearing (7/24/2018), 323:13-324:12.[4]

During this Court's hearing in July 2018, Dr. Black provided a case study of a former W.R. Grace mine worker that was diagnosed with asbestos-related disease in 2011. This worker had very significant exposures and accompanying symptoms of dyspnea on exertion and significant chest pain. On CT, Dr. Black observed early lamellar pleural thickening, "which typifies the subtle pleural fibrosis observed in Libby amphibole exposure, that is thin, noncalcified and easily escapes recognition." *See* Brad Black, Ronald F. Dodson, James R. Bruce, Lee W. Poye, Claudia Henschke & Gregory Loewen, A clinical assessment and lung tissue burden from an individual who worked as a Libby vermiculite miner, Inhalation Toxicology, DOI: 10.1 080/08958378.2017.1372536 (2017). However, other radiologists are not as adept at early detection of the disease in CTs. Dr. Stephen Becker read the same CTs as negative for non-malignant disease in 2011 and again in 2013.

Because the worker was diagnosed with asbestos-related disease he qualified for the lung cancer screening program, and the screening found early-stage adenocarcinoma. During the removal of cancer, the surgeon noticed the pleural surfaces revealed a parietal pleural layer of fibrotic tissue. A biopsy was taken. The histology of pleural tissue confirmed the presence of pleural fibrosis (pleural scarring) and ferruginous bodies with Libby Amphibole Asbestos cores. Notably, the

[4] Likewise, Dr. Albert Miller testified that in the 256 overreads of CTs for purposes of a study published in 2018, the thoracic radiologists there found evidence of non-malignant ARD in 88% of the CTs. Asbestos Claims Court Hearing (7/24/2018), 69:15-18 referencing Albert Miller, MD, et al., Libby Amphibole Disease: Pulmonary Function and CT Abnormalities in Vermiculite Miners, 60 JOEM 2 (February 2018) (describing the unique appearance of Libby's pleural disease and demonstrating lamellar pleural thickening alone contributes to impairment of pulmonary function).

mineralogical analysis revealed the individual's lung tissue contained 5,377,090 Libby Amphibole fibers per gram demonstrating that an individual can be severely impacted by Libby asbestos disease while only exhibiting "lamellar" pleural thickening on CT. *Id.*; *see also* Asbestos Claims Court Hearing (7/24/2018), 225:1-232:5 (Dr. Brad Black).

BNSF ignores that testimony and articles published on pleural disease in Libby that include lamellar pleural thickening[5] and instead relies upon its former W.R. Grace, now BNSF expert, Dr. Stephen Haber and others, to contend that all pleural thickening Dr. Black sees is just pleural fat. However, BNSF's own expert Dr. Godwin testified at the July 24-25, 2018 hearing before this Court that although one could call it pleural thickening, one could call it pleural fat:

> So it's -- he said it was hard to distinguish pleural thickening from fat, and his vote in those cases is that he's going to call that pleural thickening, but you could just as well call that fat. So in these ambiguous cases where there's a very thin stripe why isn't it fat, especially in an obese population there's often fat in that location.

Asbestos Claims Court Hearing (7/24/2018), p. 456, lns. 4-11.

[5] Lamellar pleural thickening is not meant to connote a distinct asbestos related disease. Instead it is utilized as a descriptive medical term to describe the distinct pattern of pleural fibrosis observed among the Libby cohort. Several peer reviewed studies published in scientific and medical journals have adopted this terminology in describing this pattern of pleural thickening. *See, e.g.* Miller, et al., Libby Amphibole Disease: Pulmonary Function and CT Abnormalities in Vermiculite Miners, 60 JOEM 2 (February 2018) (discussed above); Szeinuk, et al., Pulmonary Abnormalities As a Result of Exposure to Libby Amphibole During Childhood and Adolescence—The Pre-Adult Latency Study (PALS), Am J Ind Med. 2017, 60: 20-34 (describing lamellar pleural thickening, finding associated impairment of pulmonary function above typical observations of circumscribed pleural thickening (pleural plaques), and noting it can be distinguished from subpleural fat on CT and due to progression and calcification often observed on follow-up scans); Loewen, et al., Lung Cancer Screening in Patients with Libby Amphibole Disease, Am J Ind Med. 2019; 1-6 (finding that "Patients with LA disease present with a predominance of diffuse parietal pleural fibrosis which has been characterized as 'lamellar' and which may progress to frank respiratory failure" and given its association with an increased risk of lung cancer should be considered an important factor in determining eligibility for lung cancer screening programs); Brad Black, Ronald F. Dodson, James R. Bruce, Lee W. Poye, Claudia Henschke & Gregory Loewen, A clinical assessment and lung tissue burden from an individual who worked as a Libby vermiculite miner, Inhalation Toxicology, DOI: 10.1 080/08958378.2017.1372536 (2017) (discussed above wherein 5,377,090 Libby Amphibole fibers per gram were found demonstrating that an individual can be severely impacted by Libby asbestos disease while only exhibiting "lamellar" pleural thickening on CT).

The salient point here is that a blanket determination by this Court on what is a genuinely debatable issue[6] is not appropriate. Ultimately the disease is proven, or disproven, over time—and this reality underlies Plaintiffs' Registry motion.

III. The examples of CARD diagnoses BNSF relies upon highlight that analysis of such diagnoses must be done on a case-by-case basis, making the blanket relief it requests wholly unsupported.

To support its request for a show cause hearing for a blanket determination regarding the CARD Clinic diagnoses, BNSF references the cases of *Watson v. BNSF* (8th Judicial Dist., Cause No. ADV-10-0740), *Kampf v. BNSF* (8th Judicial Dist., Cause No. CDV-16-0424), and *Holly Warboys v. Liberty Northwest Ins. Corp.*, 2020 MTWCC 5 (WCC No. 2017-4127, March 10, 2020). However, those cases confirm the fact each diagnosis is inherently case-specific.

In *Watson*, BNSF activated that FELA case over Kelly Watson's objection. Kelly's case was previously ready for trial in 2017, with experts disclosed and deposed and discovery complete. Kelly wanted his case to go to trial in 2017. Kelly had significant exposures to asbestos while working for BNSF, including at its railyard in Libby now adjudicated as "abnormally dangerous." BNSF alleges all CT reads except Dr. Black's CT read were negative. However, in doing so, BNSF ignores the following three doctors (not affiliated with the CARD Clinic) that have identified radiographic findings indicative of asbestos related disease:

1. Dr. Anders Engdahl, Kalispell Regional Medical Center: 3/21/2012 X-Ray "mildly increased interstitial lung markings and mild blunting of the costophrenic angles" and "minor scarring." **Exhibit C**, p. 1.
2. Nicholas Satovick, Kalispell Regional Medical Center: 5/2/2016 CT Scan "There is apical

[6] BNSF's reference to *Daubert* (BNSF's Motion, pp.9-14) is not applicable here. The Montana Supreme Court has instructed, "medical diagnosis is not 'novel scientific evidence' and therefore the *Daubert* standard does not apply." *State v. Price*, 2007 MT 269, ¶ 24, 339 Mont. 399, 171 P.3d 293. Because Dr. Black is a treating, diagnosing physician, *Daubert* does not apply. Moreover, Plaintiffs do not intend to call Dr. Black as a witness at trial.

pleural thickening and/or scarring greatest on the left." **Exhibit C**, p. 2.

3. Dr. James Schumacher, Kalispell Regional Medical Center:
    a. 5/2/2016 CT Scan "New mild reticular interstitial lung disease in the periphery of the upper lobes compatible with mild interstitial lung disease." **Exhibit C**, pp. 3-4.
    b. 10/18/2019 CT Scan "There is mild apical scarring…there is minimal reticular interstitial lung abnormality … mild interstitial lung disease which appears similar to 2017." **Exhibit C**, p. 5.

Critically, and perhaps most telling, BNSF ignores the findings of its own Rule 35, M.R.Civ.P., expert Dr. Brendan Billew, who identified radiographic findings indicative of asbestos related disease:

4. Dr. Brendan Bellew, Billings Clinic: CT Scans of 10/22/2007, 9/2/2008, 2/2/2010, and 5/22/2016 were all read as showing pleural thickening throughout left and right lungs measuring between 7 mm and 3 mm in thickness. **Exhibit C**, pp. 8-9.

Unfortunately, there was a three-year delay in *Watson* while summary judgment on BNSF's statute of limitations defense was appealed, and then further stayed on remand pursuant to the creation of this Court. During that time Kelly was diagnosed with Stage IV prostate cancer. Once activated over Kelly's objection, no further discovery occurred. Kelly sought to settle his case with BNSF and in doing so affirmatively told BNSF he wanted to focus his limited time and energy on his aggressive prostate cancer treatments and his family, as opposed to litigating his non-malignant ARD case against BNSF. On the day BNSF responded that it was a "zero offer" case, despite BNSF's prior offers made in 2017, Kelly voluntarily dismissed his case with prejudice. Nevertheless, BNSF is seeking sanctions for that dismissal alleging it was vexatious litigation. Attached hereto as **Exhibit D** is Watson's Response to BNSF's Motion for Sanctions.

As for *Kampf*, there too a case-specific analysis is needed. BNSF activated Jim Kampf's

FELA case over Jim's objection forcing Jim to incur costs and litigate a case he did not know whether he could prove medically. Jim worked for BNSF for many years, including in BNSF's "abnormally dangerous" Libby railyard, thereby incurring significant exposures, and he suffers from undisputed pulmonary impairment. Nevertheless, after limited discovery and an inability to find a causation expert for his undisputed pulmonary impairment, Jim dismissed his case with prejudice and is now barred from any recovery of his nonmalignant ARD, regardless of its future severity. Jim sought that dismissal the day after he received a verbal report while being evaluated at the Mayo Clinic. Plaintiff sought to extend the expert disclosure deadline to allow time for the Mayo Clinic findings to be incorporated into all expert disclosures, but BNSF objected. In response to Kampf's motion to dismiss with prejudice, BNSF sought attorney fees and costs alleging it was vexatious litigation not to dismiss his case on the date he informed BNSF he would not be calling Dr. Black to testify. Attached hereto as **Exhibit E** is Kampf's Response to BNSF's Motion for Sanctions.

Finally, regarding *Warboys*, MHSL Plaintiffs will defer to Warboys' counsel Kovacich Snipes as to the case-specific inquiry needed there. In sum, a blanket determination by this Court as BNSF requests is not proper as each diagnosis, regardless of the diagnosing physician, is inherently fact specific.

IV. Dr. Black and the CARD Clinic are not before this Court. Rulings against them in their absence are not appropriate.

In response to BNSF's first attempt to obtain a blanket determination from this Court regarding CARD Clinic diagnoses, the CARD Clinic filed *Non-Parties' CARD Clinic's and CARD Foundation's Second Response to Defendants' Motion for Reconsideration Seeking to "Unquash" Amended Subpoenas and Re-Open Depositions* ("Second Response"). *See* **Exhibit F**. There, non-party CARD Clinic had been drawn into discovery requests and depositions. In Defendants' *Reply to the Clinic's and Foundation's Response to Defendants Motion for Reconsideration*, Defendants true

motive was unmasked:

> If their funding comes from Federal or State grants or funds only because CARD is diagnosing ARD, but the information requested would refute those diagnoses, then the grants and funds would go away and CARD and CARD Foundation's survival would be threatened, if not done in-with entirely.

Defendants' Reply, pp. 3-4. As stated in CARD's *Second Response*, given the potential significance of any order in this proceeding addressing the Clinic or the Foundation's credibility and reliability, at the very least, due process requires that the CARD Clinic and CARD Foundation be allowed to respond to a direct motion that provides notice of the factual and legal bases of any challenge to the CARD Clinic or CARD Foundation's credibility and reliability. *See In re Best*, 2010 MT 59, ¶26, 355 Mont. 365, 229 P.3d 1201.

To support their due process concerns and request to respond to direct allegations, the CARD Clinic noted the misleading presentation of evidence by BNSF in cross examination of Dr. Black at the July 24-25, 2018 hearing. **Exhibit F**, pp. 3-5. In cross examining Dr. Black regarding David Selke, BNSF presented evidence of a negative B-read, a negative CT read by Dr. Black, and a negative CT read by Dr. Becker and accused Dr. Black of falsifying Mr. Selke's application for Medicare benefits. However, Defense counsel withheld from the Court documents in Mr. Selke's medical file that confirmed Mr. Selke, in fact, <u>had a separate positive B-read</u> which entitled him to Medicare benefits and was the factual basis for Dr. Black's support of Mr. Selke's application. **Exhibit F**, p. 4 (Exhibit 7). Likewise, BNSF showed Dr. Black the outside radiologic read of a CT that noted Diane Allen had right rib fractures but then accused Dr. Black of failing to rule out that trauma. However, BNSF withheld from the Court documents in Ms. Allen's medical file that confirmed Dr. Black did just that:

> Per Dr. Black, lamellar noncalcified pleural thickening on the <u>left</u> posterior chest 29/63. Multiple <u>right</u> posterior rib fractures.

Exhibit F, p. 5 (Exhibit 9).

This Court did not indulge in BNSF's previous request to make any determination about the CARD Clinic diagnoses and should not do so here either. At a minimum, fair notice to the CARD Clinic and an opportunity to response would be required should it do so now. *See In re Best*, ¶26.

CONCLUSION

For the foregoing reasons, MHSL Plaintiffs respectfully request the Court deny BNSF's *Renewed Motion for Show-Cause Order Related to a CARD Diagnosis of ARD*.

Respectfully submitted this 15th day of May, 2020.

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CERTIFICATE OF SERVICE

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Dated: 05-15-2020