



CONTROLLING RISING DEFENDANT EXPENDITURES IN ASBESTOS CLAIMS, LITIGATION, AND BANKRUPTCIES

Review of the A.M. Best and RAND Institute for Civil Justice Asbestos Reports and Their Implications for Medical Information Management

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Introduction

The summer of 2001 witnessed the publication of two reports that may have major implications for the management of present and future asbestos claims and litigation. The first of these, A.M. Best's "Asbestos Claims Surge Set to Dampen Earnings for Commercial Insurers,"¹ released on May 7, 2001, speaks to the maturation of asbestos-related diseases, such as mesothelioma; continued problems with asbestos liabilities and corporate bankruptcies; a rise in the number of peripheral defendants in asbestos litigation; and an anticipated tidal surge of asbestos claims.

Subsequently, on August 15, 2001, the RAND Institute for Civil Justice published "Asbestos Litigation in the U.S.: A New Look at an Old Issue,"² which constitutes another examination of the asbestos liabilities quandary. The RAND Institute report highlights the issue that an accurate figure for the number of asbestos-related claims/lawsuits is unknown and that experts differ in their perceptions of the future trend of asbestos litigation.

In general, both reports are noteworthy for the degree of consensus within their independent analyses. Each documents that asbestos claims are on the rise, and numbers are projected to worsen in coming years. This proliferation is predicted to overwhelm existing legal resolution mechanisms and further compromise the financial viability of a great number of American companies. As the A.M. Best report concludes, "the worst is yet to come."

Claims Growth Forecast

A.M. Best cites an alarming increase in the number of new asbestos claims filed against both traditional and nontraditional defendants. This flood of cases is attributed to the growing number of bankruptcy filings by asbestos producers, targeting of more "peripheral" defendants, fears of insurance policy reclassifications, and maturation of costly lawsuits involving mesothelioma, a disease which may have a fifteen-to-forty-year latency period from the time of asbestos fiber exposure to disease manifestation.³

According to RAND Institute estimates, some 27 million individuals in the United States were occupationally exposed to asbestos during the period 1940 to 1979.⁴ No centralized mechanism is presently in place to tabulate total asbestos claims filed; however, the RAND Institute did analyze available claims data associated with asbestos litigation involving five major asbestos defendants. Allowing for overlap of claims filed against multiple defendants, the RAND Institute arrived at a conservative estimate indicating that over 500,000 asbestos claims have been filed to date.⁵

IN THIS ISSUE

- ❖ National Management of Medical Information in Asbestos Litigation
- ❖ Report: Chemical Restraints in Nursing Homes
- ❖ Report: AHIMA Definition of the Legal Medical Record
- ❖ Noteworthy Upcoming Conferences
- ❖ Book Review: A New Perspective on "Junk Science"

Mesothelioma claims typically constitute the most serious and costly asbestos-related disease cases. The RAND Institute assessment determined that the numbers of these claims exhibited a downward trend in the early 1990's, but by mid-decade, numbers began to climb once again. Some of RAND's sources opined that this was the most important recent change in asbestos litigation.⁶

Management of these hundreds of thousands of asbestos cases will prove progressively more challenging; as a consequence, legislators, judges, defendant corporations, insurers, attorneys, and claimants will increasingly come to demand innovative solutions to the handling of the asbestos litigation crisis. One facet of asbestos claims management remains problematic and that is the acquisition, organization, storage, and review of millions of pages of plaintiff medical and non-medical records required to appropriately evaluate injury allegations. The following discussion proposes a centralized, national strategy to streamline asbestos case management so as to offer a deeper analysis of medical claims while simultaneously controlling costs for this activity.

Rise in Case Management Costs

The history of fluctuating case transaction expenditures in asbestos litigation is recounted in the RAND Institute report. According to this analysis, in the 1980's, claimants received 37% of each dollar awarded because of the contentious nature of asbestos litigation at that time. Plaintiff attorneys aggressively litigated these cases in response to stiff resistance from the defense. Insurers and defendants quarreled over policy coverage issues. Defendant companies pursued separate legal strategies, resulting in redundant case management expenditures.

In subsequent years, more cooperative types of legal arrangements evolved, such as the 1986 initiative of the Asbestos Claims Facility (that gave way to the Center for Claims Resolution in 1988), which are believed to have lowered case transaction costs. During the 1990's, defendant corporations pursued more collaborative strategies and accordingly reduced overlapping case management expenditures. Furthermore, the RAND Institute report notes that in this decade, insurance coverage issues were less contentious when viewed from a global perspective, and the numbers of costly courtroom battles were reduced as more settlements were negotiated.

The RAND Institute report predicts that recent events in asbestos litigation may again prompt an increase in transactional expenditures. In some cases, plaintiff law firms are

pursuing more aggressive asbestos litigation strategies. Experts anticipate increasing insurance coverage controversies. The Center for Claims Resolution, characterized by the RAND Institute as "the leading example of asbestos defendant cooperation," discontinued active claims and litigation management in 2001. The RAND Institute's analysis suggests that these trends may be at the forefront of a relatively lengthy period of higher asbestos litigation and claims management costs.⁷

Deficiencies in the Current System

The RAND Institute's report details a number of shortcomings in the nationwide management of current asbestos litigation and claims:

1. No national registry of asbestos claims or lawsuits presently exists. The true magnitude of the asbestos claims and litigation crisis cannot be accurately estimated, but it is known that, to date, there have been over 500,000 claimants.
2. Most asbestos lawsuits now involve multiple defendants, *each keeping their own records*. Typical claimants may simultaneously file cases against several dozen corporations; accordingly, the magnitude of asbestos litigation is amplified beyond the situation seen with more traditional tort litigation in which the number of defendants is more limited.
3. Claimants receive money from multiple sources over long periods of time, both from defendants presently in the tort system and various bankruptcy trusts established to manage asbestos liabilities of former defendant companies.
4. Some resources for data on asbestos claimants are not publicly available.⁸

The RAND Institute report notes that all parties involved in the asbestos liabilities crisis are directly impacted by these deficiencies in the current system. The groups include:

- Claimants and their families.
- Defense and plaintiff attorneys/law firms.
- Defendant corporations and shareholders.
- Insurers of defendant corporations.
- Financial institutions bearing the costs of covering asbestos liabilities.
- Civil justice system.⁹

From the perspective of corporate legal departments, insurance claims managers, bankruptcy trust administrators, and outside counsel, effective medical case management of claims and litigation is pivotal in the efficient defense and resolution of asbestos-related disease cases. This paper proposes how a National Asbestos Medical Data Repository (NAMDR) can be created and operationalized for the centralized management of all medical documentation relating to the defense of asbestos claims and litigation.



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Goals of the NAMDR

Goals promoting the establishment of the NAMDR make the concept equally attractive to all parties engaged in asbestos case defense:

1. The NAMDR will facilitate *timely access* to objective analyses of relevant medical information on each asbestos claimant.
 2. NAMDR's medical case management will permit *early analysis and differentiation* of those claimants presenting with viable asbestos-related disorders from those with no disability. For example, protocols can be developed to categorize claimants' medical status according to the variations found among approved bankruptcy trust criteria.
 3. The NAMDR will bring *consistency* to the evaluation of asbestos claims through the implementation of a common review process and collection of standard data sets.
 4. The NAMDR will foster *improved communication* among common defendants in these cases because all participating parties will be reading from universal, shared medical review work products available through the NAMDR in both hardcopy and electronic formats. This concept for asbestos claims resolution is even more applicable in lawsuits involving bankrupt defendants.
 5. The NAMDR will conduct ongoing *research* on the presenting medical and demographic characteristics of the aggregate claimant population whose records undergo review, and will prepare regular reports summarizing these findings. The NAMDR will regularly disseminate these reports to the participating defense parties and will also publish these reports in relevant medical and legal journals.
 6. NAMDR's dual incorporation of economies of scale and centralization of record acquisition and review tasks will ultimately result in a *reduction of discovery and case resolution expenditures* for all defendant parties.
- The hallmark of the NAMDR will be its neutrality. The NAMDR will not attempt to negotiate claims, settlements, or otherwise seek to resolve asbestos disputes among participating parties. The principal objective of the NAMDR will be the generation of an unbiased medical case review.
 - The NAMDR will not attempt to assign liability or allocate injury awards for any of the cases it reviews. The onus of responsibility for these activities will remain with the courts and mediators. Asbestos case reviews prepared by the NAMDR will be restricted to a summarization of the factual evidence relating to the presence and degree of medical injuries in a given claim.
 - The NAMDR will not manage payments associated with the resolution of asbestos claims. This activity will continue to reside with existing mechanisms for payment disbursement. Functional separation of medical record evaluation and compensation management activities will help ensure that the NAMDR's medical reviews retain their objectivity.
 - The NAMDR will not process the reviews as traditional "claims"; instead, reviews will be conducted by health care professionals possessing clinical experience with pulmonary and other medical records germane to asbestos-related disease cases. These medical professionals will be trained to review asbestos records factually, without rendering any opinion as to the appropriateness or inappropriateness of an asbestos-related disease diagnosis assigned to a given plaintiff.

Beyond Pleural Registries

The mission of the NAMDR also should not be confused with that of court-mandated "pleural registries." These entities have been primarily designed to manage the overloaded dockets of asbestos litigation courtrooms by shifting claims filed by asymptomatic, non-impaired asbestos plaintiffs to an inactive status until such time as actual asbestos-related disease manifests. For such cases, statutes of limitations are to be tolled until the claimant develops a compensatory asbestos illness.

Pleural registries are presently a jurisdictionally driven concept, rather than a more encompassing national solution. Furthermore, pleural registries have met with varying degrees of acceptance by some parties in asbestos litigation who may perceive this concept as favoring one party at the expense of the other.

Centralized Management

The most important element of an NAMDR will be the creation of a central repository for relevant medical data on asbestos plaintiffs who have filed claims involving participating defendants. The "one stop shopping" nature of the NAMDR will provide each defendant and its agents with a single source for medical record acquisition, review, and

A criticism targeting mass processing of asbestos claims as cited in the RAND Institute analysis is the loss of "individualized" consideration for each particular case.¹⁰ The NAMDR will overcome this through an impartial review of select, relevant medical documentation for each claim conducted by a medical professional experienced in the critical elements of pulmonary and asbestos medicine. In this manner, the objective of global medical case management of asbestos claims will be achieved.

What the NAMDR is Not

The concept of the NAMDR should not be confused with other national experiences in the centralized management of asbestos claims and litigation, as it will differ from these programs in several important respects:

reporting. As a result, the NAMDR will offer the following case management benefits:

1. **Coordination:** The concept of the NAMDR is very compelling for asbestos litigation involving multiple defendants. As the number of “peripheral” asbestos defendants continues to swell, there will be an increasingly heightened need for some form of centralized management of medical documents. The NAMDR will coordinate the one-time acquisition and review of medical records relevant to each claim. Defense counsel and bankruptcy trust administrators will then obtain copies of these medical records, and their respective objective reviews, from the central NAMDR facility on an “as needed” basis.
2. **Communication:** Once the NAMDR acquires medical records for a given asbestos claim, original hard-copy will be warehoused at the central NAMDR location. These records will also be maintained in a master NAMDR database so that defense litigators and bankruptcy trust administrators will have the option to request either photocopies or electronic images of a given set of documents.

A similar option will exist to obtain NAMDR’s medical reviews prepared from these records. The NAMDR will offer participating parties the flexibility to consider case documents and reviews via access to a secure Extranet site hosted and maintained by the repository.

For the individual attorney, centralization of medical information management within the NAMDR provides a single source for answers regarding findings contained in the case review. Because records associated with each claim will be reviewed by only one designated medical professional, attorney questions will be researched and addressed quickly by the individual who actually reviewed the medical documentation.

3. **Cost Sharing:** The NAMDR will offer participants significant cost savings resulting from economies of scale associated with a common protocol for the acquisition and review of voluminous quantities of medical and non-medical records. Further economies will be realized as additional participants sign on to the NAMDR. This assertion is validated by the A.M. Best special asbestos report that notes “legal defense costs have been steep for the industry, particularly given the *piece-meal handling of the same suits by multiple insurers* (emphasis added).”¹¹

The argument for a centralized approach to medical information management in asbestos litigation is most compelling from the perspective of cost sharing. Case preparation expenditures will be minimized as the NAMDR acquires and stores one single copy of pertinent medical and non-medical records for each claimant in a central repository. When a defense attorney needs full text versions of these records, the

NAMDR will be positioned to quickly deliver the indicated files. Acquisition expenses and charges for photocopies/electronic files of the medical records for a given action will be shared among all parties requesting copies.

4. **Consistency:** Once the NAMDR acquires a collection of records for a given plaintiff, documents will be organized according to mutually agreed upon protocols. Attorneys will always receive these documents in a consistent format with elimination of the need to adapt to differing organizational schemes.

The NAMDR will develop templates for common work products resulting in a standardized layout for each medical review. This practice will result in significant time saving for attorneys and their staff as the need to adapt to different formats and changing styles of medical reviews will be eliminated. Development of these templates will be based upon input from end-users.

5. **Quality Assurance:** An internal program of peer review will ensure that case reviews developed by NAMDR’s medical professionals are factual, accurate, and consistent in format.

Medical Record Acquisition

Review of medical records will be restricted to those materials essential to completing an objective case evaluation. Accordingly, medical record acquisition and related costs will be limited to those directly required to accurately review the claim. In general, these documents will include, but may not be limited to:

- Copy of the claim or lawsuit filed, including the medical allegations.
- Pulmonary function test (PFT) reports.
- Radiologist interpretations of chest and related pulmonary radiographs. These will include all B-reader evaluations.
- Chest CT and associated imagery studies.
- Independent medical examination (IME) evaluations.
- Asbestos and other occupational/non-occupational histories.
- Relevant surgical and related pathology reports.

The NAMDR will coordinate the nationwide acquisition of these medical records and become the central repository for their storage. The efficient capture and delivery of data will be dependent on application of state-of-the-art technologies. Because of the large volume of documents involved, the NAMDR will employ imaging technology to scan and electronically index these materials. The use of optical imaging/storage will facilitate multiple user access to a single medical document, thereby significantly reducing photocopying and storage expenses. The NAMDR will also

maintain a restricted entry Extranet site for online access to imaged medical records for law firms desiring this option.

Radiograph Repository

Another service provided by the NAMDR will be the acquisition, cataloging, and storage of plaintiff chest radiographs and CT scans. The NAMDR repository will obtain copies of these films from hospitals, clinics, physician offices, etc., on an "as-needed" basis; log the films into the NAMDR central database; and house the films in secure, fire-resistant storage. When these films are needed by defense attorneys or B-readers, the NAMDR will provide options for either on- or off-site review.

The Review Process

The primary defense attorney work product available from the NAMDR will be the Medical Record Abstract. This document will consist of a brief summarization of relevant factual information from IME, radiology, PFT, surgical, pathology, and other reports. This information will be limited to the most pertinent demographic and clinical information. In addition, a numeric Case Severity Rating will indicate the most severe, documented asbestos-related disease diagnosis or finding.

Validation of PFT Reports

Administration and interpretation of PFT tests for asbestos claimants have proven contentious based on allegations of fraudulent application. In claims involving controversial PFT records, the NAMDR will analyze the reports against standards promulgated by professional associations, such as the American Thoracic Society (ATS) and American Association for Respiratory Care (AARC). Both organizations have published widely accepted guidelines for PFTs. The NAMDR will review disputed PFT studies to determine if the conduct and reporting of these tests achieved professional benchmarks. The NAMDR will develop a reporting system, the PFT Validation Study, derived from the ATS and AARC protocols.

Medical and Scientific Literature

The foundations upon which asbestos claims and defenses are based have evolved significantly in the past decade. During the early 1980's medical and scientific research, or lack thereof, often played a pivotal role in the litigation process. Although asbestos litigation has matured, defense attorneys continue to need access to medical/scientific literature on certain issues, such as the significance of pleural plaques as markers for future development of more severe asbestos-related conditions. Currently, each law firm conducts its own review of the literature to address these concerns.

The NAMDR concept proposes that its central facility will also become a focal resource for asbestos reference materials via a Centralized Asbestos Medicine Reference Center. This national repository will allow for easy access to medical and scientific articles, texts, reports, etc. Medical information specialists at the NAMDR will be able to assist in research, retrieval, and dissemination of asbestos reference documents in a highly cost efficient manner.

Other Asbestos Information

The NAMDR will also offer an asbestos news service accessible by all its users. This free defense resource will consist of a regular, web-based update containing summaries of the latest medical and scientific literature relevant to asbestos litigation. Whenever feasible, this news service will incorporate hyperlinks to full text versions or abstracts of a given report/article.

Although some web sites currently publish calendars containing medical legal conference postings, no comprehensive listing exists at this time. To promote networking and professional development among asbestos attorneys representing the defense, the NAMDR web site will also host a complete calendar of upcoming medical legal conferences sponsored by various associations, publishers, and law firms. Particular emphasis will be placed on targeting seminars devoted to such subjects as asbestos, silica, and related toxic torts.

Summary

The conclusion of the RAND Institute's report identifies a number of policy implications associated with the

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Speaker: Jean C. Bourgeois, LMI COO

asbestos liability crisis that support the concept of a National Asbestos Medical Data Repository as put forth in this paper:

1. The matter of resolving asbestos claims fairly and efficiently remains a significant policy issue.
2. In the aggregate, not even 50% of potential asbestos claims have yet been filed in the United States.
3. Given the numbers of asbestos company bankruptcies filed within recent years, a window of opportunity may now be open to rethink national strategy for management of asbestos claims and litigation.¹²

Although a national policy to address the asbestos dilemma presently languishes, the NAMDR concept anticipates that eventually a unified social policy will be enacted for the management of claims and litigation. Objective, knowledgeable, and centralized medical case management will be the cornerstone of an equitable claims resolution process. Accordingly, the NAMDR proposal offers an effective solution to achieve these ends in the asbestos litigation crisis.

The authors wish to express their appreciation to John G. Gaul, Esq. for his review of this article.

¹ G Altonji, K Horvath, E Simpson. *Special Report: Asbestos Claims Surge Set to Dampen Earnings for Commercial Insurers*. Oldwick, NJ: A.M. Best; May 7, 2001. Online: www.ambest.com.

² D Hensler, S Carroll, M White, J Gross. *Asbestos Litigation in the U.S.: A New Look at an Old Issue*. RAND Institute for Civil Justice. Santa Monica: August 2001. Online: www.rand.org.

³ A.M. Best. 3, 5.

⁴ RAND. 21.

⁵ RAND. 2-3.

⁶ RAND. 7.

⁷ RAND. 37-9.

⁸ RAND. 3, 15.

⁹ RAND. 14.

¹⁰ RAND. 49.

¹¹ AM Best. 4.

¹² RAND. 50.

OIG REPORT: PSYCHOTROPIC DRUGS AS CHEMICAL RESTRAINTS IN NURSING HOMES*

Psychotropic medications include the anti-psychotic, anti-anxiety, and hypnotic drug categories. Nursing home administration of these agents has increased since 1995. Because of widespread concern that facilities possibly utilize psychotropics to control resident behavior, the United States Senate Special Committee on Aging requested that the Office of Inspector General (OIG) investigate to what extent these potential “chemical restraints” may have become a component of nursing home care.

According to the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203), and specifically its Nursing Home Reform Act, chemical restraints are appropriate only when used to protect the safety of the nursing home resident and/or other residents. These medications should not be dispensed as a means of resident discipline or for nursing care convenience. OBRA 1990 imposes Drug Regimen Reviews and regulates the use of certain drugs in nursing home populations.

The OIG research methodology incorporated medical record reviews on 485 nursing home residents receiving psychotropic agents, analysis of data from the National Ombudsman Reporting System (NORS) and Online Survey Certification and Reporting System (OSCAR), evaluation of 135 nursing home Drug Regimen Reviews, actual visits to 10 facilities, and interviews with 20 state surveyors and ombudsmen. For study purposes, inappropriate prescriptive practices were predicated on regulation [42 C.F.R. §483.25(1)] of the Center for Medicare & Medicaid Services (1989, revised 1991) that stipulates nursing home residents’ drug regimens must exclude unnecessary medications. Excessive dosing or duration of administration, lack of adequate medical monitoring or clear indications for prescription, continued use despite adverse effects, and failure to delineate target behavioral

symptoms constitute misuse of psychotropics among nursing home residents.

The final 18-page OIG analysis discovered generally favorable prescriptive practices within the nursing home industry and revealed psychotropic medications were appropriately dispensed in 85% of the study population. Only eight percent (8%) of the nursing home residents evaluated received psychotropic drugs improperly. In the remaining 7% of cases, there was inadequate medical record documentation to make an accurate determination.

A 31-page supplement to the main report described practice characteristics in the use of psychotropics across a sample of 10 nursing homes from Ohio, California, Florida, Idaho, Maryland, Massachusetts, Missouri, New York, Texas, and Wisconsin. The institutions varied by size, incidence of psychotropic drug use, and locale (urban versus rural). Ninety percent (90%) were for-profit entities. The supplementary investigation, intended to complement findings of the main report, described the subjects’ self-reported approaches for behavioral management of residents requiring psychotropic medications.

This report was prepared by the Office of Evaluation and Inspections (OEI), a branch of the OIG. By P. L. 95-452, the mission of the OIG is to protect the integrity of the Department of Health and Human Services programs, as well as the health and welfare of beneficiaries served by this agency.

Reviewed by: Elizabeth B. Juliano & James R. Fell

*Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections. *Psychotropic Drug Use in Nursing Homes*. November 2001. Copies of this report can be obtained by calling the OEI in New York at 212.264.2000 or from the OEI web site at <http://www.hhs.gov/oig/oei>.

AHIMA PRACTICE BRIEF: DEFINITION OF THE HEALTH RECORD FOR LEGAL PURPOSES*

Methods for documentation of confidential patient healthcare information are evolving from traditional hardcopy medical records to systems that are increasingly computer- and network-based. While this development offers many advantages for coordination of patient care and reimbursement for services rendered, it also presents security and privacy challenges. Large quantities of privileged information are now shared via virtual formats that are potentially subject to unauthorized access. Accordingly, contents of these electronic medical records and their integrity are of growing concern to regulatory agencies and healthcare consumers alike.

Laws and regulations defining the makeup of the patient medical record can differ from state to state. Medical record content can also vary by clinical facility. However, a new practice brief published October 2001 in the *Journal of the American Health Information Management Association* (AHIMA) seeks to establish an authoritative and legal standard for information that should be universally included in the healthcare record. With the introduction of the virtual medical record and Health Insurance Portability and Accountability Act (HIPAA) privacy guidelines, this issue has assumed special importance.

The AHIMA defines the Legal Health Record (LHR) as "the documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by a healthcare provider organization." A list of documents routinely found in the LHR is outlined in this practice brief. Defense attorneys and paralegals will find this inventory to be a valuable resource when attempting to identify relevant plaintiff medical records during the discovery phase of litigation.

It is important to understand the information a patient's medical record will not typically include. The AHIMA indicates that the LHR should exclude those documents that are not official business records of a healthcare provider, as is the case with **personal health records** (PHRs), which are materials controlled, managed, and populated by the patient. An exception is the documentation released by the patient to the healthcare provider for purposes of care planning and delivery. Records of serum glucose self-monitoring are one example.

An adjunct component of the organization's legal business record is **patient-identifiable source data**. This information is typically stored separately from the LHR and may include items such as physician dictation audiotapes, digital patient photographs, diagnostic films, fetal monitoring strips, videotapes of examinations and procedures, recordings of telemedicine consultations, and similar items. The AHIMA notes that in the absence of reports containing summaries or interpretations of patient-identifiable source data, the source data itself should then be considered a part of the LHR and be retrievable upon request.

Administrative data, such as birth and death certificates, incident and accident reports, clinical practice guidelines, patient information reviewed for quality assurance analysis, requests for release of information, and similar materials, are also not regularly maintained in the patient's LHR. Other information not considered part of the LHR is **derived data**, which is material extracted from patient medical records for preparation of various institutional statistical, accreditation, public health, research, and other reports. As with administrative data, derived data records will not normally be provided in response to an attorney's subpoena requesting the patient's "medical record."

Once an attorney or paralegal acquires a full appreciation of the documents characteristically found in the patient's Legal Health Record, he or she can more effectively retrieve this information from healthcare providers and enhance planned defense strategy. To learn more about the LHR and other patient data sources, consult the complete AHIMA practice brief available online from the organization's web site at <http://www.ahima.org/journal/pb/01.10.2.html>.

Reviewed by: Elizabeth B. Juliano & James R. Fell

*American Health Information Management Association. Practice Brief: Definition of the Health Record for Legal Purposes. *Journal of AHIMA*, 2001;72(9):88A-H.

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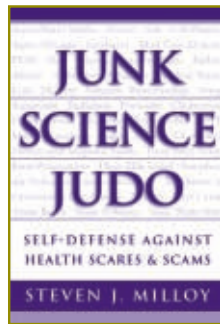
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BOOK REVIEW

MILLOY, STEVEN J. *Junk Science Judo: Self Defense Against Health Scares and Scams.*
WASHINGTON, DC: CATO INSTITUTE, 2001. HARDCOVER, 216 PAGES, \$18.95.

The challenge posed by the use of “junk science” in product liability and toxic exposure litigation is all too familiar to attorneys tasked with the defense of lawsuits arising from statistical manipulation of medical and scientific research. Steven Milloy’s latest book, *Junk Science Judo: Self Defense Against Health Scares and Scams*, educates both lawyers and a vulnerable public on how societal emotions and decisions are influenced via this misapplication of research reports by plaintiff attorneys, competitor corporations, activist groups, politicians, and the media, all seeking to advance various special-interest agendas.



Written in style and language easily comprehended by a reader lacking a medical or scientific background, *Junk Science Judo* is organized into twelve “lessons” designed to coach one in how to separate “good” from junk science. Milloy describes proper application of the scientific method and distinguishes between different types of research studies as to the value and limits of information each will reveal. Once these lessons are mastered, the reader will earn Milloy’s “black belt” for debunking junk science.

Milloy frequently cites cases of interest to attorneys who defend class actions involving alleged toxic exposures. For example, the author depicts the Dow Corning silicone breast implant mass tort as a case where litigation preceded science. Although in the early 1990’s the scientific community was still undecided regarding the safety of these medical devices, juries were swayed by plaintiff experts and their novel, but unsupported, theories of silicone-associated disease. Subsequently, medical report after medical report vindicated Dow Corning.

All studies revealed no causal connection between silicone implants and various systemic disorders claimed by many of the plaintiffs; nonetheless, irreparable damage had been inflicted upon the company that ultimately buckled under the “evidence” of junk science. In Milloy’s analysis, debates about the dangers of exposure to Bendectin, fenphen, cell phones, power lines, and vinyl IV bags are further instances in which “junksters” have hyped and overly sensationalized risks posed by useful products.

Plaintiff attorneys and their experts are not the only parties who profit from the utilization of junk science, according to Milloy. He notes that an entire industry of environmental remediation has developed and prospered because of social panic induced by junk science’s nurturing a culture of fear surrounding asbestos, lead paint, radon (and now we can add toxic mold) exposure.

Milloy states that sometimes even respected medical and scientific journals publish junk science in the name of “sound” science. He contends that competition for subscribers and advertising dollars, plus occasional outside pressure from groups such as plaintiff attorneys, may influence the research that these journals will elect to publish. Furthermore, editors’ publication biases favor research that identifies a positive risk-exposure association versus research that yields less exciting negative findings. Milloy terms this partiality “fear over facts.” For corporations and defense attorneys, the impact of these junk science articles is evidenced in the volume of lawsuits initiated on the heels of each new frightening medical report.

There are several rules to remember when one critiques a new medical or

scientific study involving exposure to a particular chemical compound, medical device, or other agent. For instance, toxicology studies are typically carried out on animal subjects, although findings in laboratory animals may or may not be applicable to humans. In the case of epidemiology studies, researchers work with statistics, but statistics alone cannot prove the presence or absence of risk.

When a study claims an association between a given agent and a particular medical disorder, the strength of this “correlation” must be statistically significant. Milloy indicates that good research will indicate the strength of this observed relationship utilizing either *p*-value and/or confidence interval testing. He explains how to interpret both assessments in a manner that the non-statistician can easily understand.

For further examinations of the junk science controversy, Milloy’s two earlier books (*Science Without Sense*, 1995, and *Silencing Science*, 1999) address the issue of the application of faulty research in social policy, government regulation, and litigation. Readers may also wish to consult Milloy’s web site, Junkscience.com, which updates visitors on a daily basis regarding the latest misuse and misinterpretation of medical and scientific research.

Milloy’s eclectic background enables him to provide a refreshing and authoritative perspective on the issue of junk science. He holds a B.A. in natural sciences and a Master of Health Sciences in biostatistics from the Johns Hopkins University, as well as a *Juris Doctorate* from the University of Baltimore and a Master of Laws degree from Georgetown University Law Center. Milloy has testified before Congress on risk assessment and Superfund matters.

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