



MEDICAL INFORMATION MANAGEMENT IN MOLD LITIGATION

Part II: Researching Medical and Scientific Literature

by: Elizabeth B. Juliano and James R. Fell

Introduction

Mold litigation is a relatively new, but rapidly expanding, field for attorneys defending insurance carriers, construction companies, lenders, auto manufacturers, landlords, and other targets of these liability actions. Development of defense strategy in these lawsuits is complicated by the fact that as a whole, the alleged causal relationships associated with mold-related medical disorders remain controversial among medical and scientific experts.

Part I of this series provided an overview of the diverse medical conditions now claimed in mold liability actions and how the defense attorney might apply findings from medical record review to differentiate valid from invalid injury allegations. Refuting contentions linking mold exposure and physical/psychological disorders requires a solid understanding of the relevant medical and scientific research, as well as professionally-accepted medical standards for diagnosis and treatment of these conditions. In Part II, the authors further discuss

how medical information management (MIM) principles might be applied to mold litigation, describing how defense counsel and medical legal specialists might locate, retrieve, and critically evaluate mold-science literature and associated medical practice guidelines.

Defense Cost Sharing Opportunity

Plaintiff attorneys are becoming increasingly creative in their identification of potential defendants for an indoor mold-exposure case. Anyone, from the physician who allegedly misdiagnosed and inappropriately treated a mold disorder, to the realtor who unknowingly managed the sale of a mold-contaminated structure, might be named as defendants in a mold action. Accordingly, any number of co-defendants might be targeted in this scenario. In the past, each defendant has typically relied on his/her own insurer and its outside counsel to muster a winning defense strategy.*

Mold Science:

The Fungus Among Us

To fully dissect medical claims in mold lawsuits, attorneys need to conduct a certain amount of literature review. Although there has been a host of mold medicine articles published in professional journals, lay magazines, and throughout the Internet, not all this material represents "good science."

How can an attorney separate "sound medicine" from "junk science" when defending a mold lawsuit? Numerous professionally-respected resources for toxic mold information are readily available to the attorney or medical legal researcher, if one knows where and how to access these. The following paragraphs will critique a number of

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resources and propose strategies to effectively locate, access, and critique this published material.

Selectively Rely on Internet Resources

General browsing of the Internet will reveal a large number of sites that offer a good deal of so-called “information” pertaining to mold-related disorders. Some of these resources go by a variety of identifiers purporting that their particular site is a “mold resource center,” “mold information clearinghouse,” and so on. These labels should not mislead the investigator.

Unfortunately, many of the mold site addresses returned on general Internet browsing fail to provide accurate, objective research upon which the attorney might build a credible defense. This is especially true for plaintiff law firm sites that are marketing-driven, consumer-oriented, and perhaps biased in terms of content published. Other mold information sites might originate from, and be maintained by, mold “victims” or plaintiff-oriented organizations. Information presented on these sites might reflect the orientation and perspectives of the site sponsor.

As a consequence, attorneys should carefully research and evaluate all web pages to establish their actual originators before accepting a site’s information at face value. In some cases, making this determination can be difficult for even the most seasoned Internet researcher, as this data might not be readily apparent. However, legitimate sources for objective mold information will clearly identify site sponsors on their Internet pages.

There are numerous excellent Internet resources for medical mold information, and this section will consider a few of the best. One of the takeoff points for Internet research on the health effects of mold exposure is the U.S. Environmental Protection Agency’s (EPA) web site. The EPA’s “Mold Resources” page at <http://www.epa.gov/iaq/pubs/moldresources.html> contains links to a large number of mold references that are topically categorized, i.e., “Asthma and Mold,” “Health and Mold,” “Homes and Mold,” etc. The EPA’s “Mold Remediation in Schools and Commercial Buildings,” at <http://www.epa.gov/iaq/molds/index.html> not only discusses actions to investigate, evaluate, and remediate moisture and mold problems in buildings, but also contains information pertaining to mold biology and the health effects of mold, written in nontechnical language.



Elizabeth B. Juliano is the founder and President of Litigation Management, Inc. The author can be contacted via e-mail at ContactLMI@litigation-mgmt.com or by telephone to 1-800-778-5424.

The Consumer Product Safety Commission, American Lung Association, EPA, and American Medical Association co-sponsor “Indoor Air Pollution: An Introduction for Health Professionals,” <http://www.cpsc.gov/CPSCPUB/PUBS/455.html>. This document is less specific for mold information, but contains a valuable diagnostic quick reference chart comparing medical signs and symptoms for various indoor pollutants and irritants. This chart might prove helpful to attorneys seeking to introduce issues of alternative causation into the defense strategy.

Another highly credible source for online mold research is the web site of the Centers for Disease Control and Prevention (CDC), which contains a number of publications on environmental mold and mold-related conditions. In addition, this site offers links to other resources, such as a series of research articles on infant pulmonary hemorrhage and hemosiderosis published over several years in the CDC’s newsletter, *Morbidity and Mortality Weekly Report*. A good location at which one can begin this review is <http://www.cdc.gov/nceh/airpollution/mold/>.

In September 2001, the National Association of Mutual Insurance Companies (NAMIC) launched [MoldUpdate.com](http://www.moldupdate.com) (www.moldupdate.com), a resource that contains a wealth of information on mold litigation that will be of interest to defense and insurance counsel. Visitors can access links to various mold science publications and mold litigation news articles. A conference and events schedule lists a number of upcoming seminars pertinent to the defense of mold lawsuits. Experts in mold testing, abatement, restoration, and other services can be located in the site’s service directory. An option is also available to register to receive a free email newsletter.

Review Published Medical Research

Many attorneys and medical legal specialists will initiate their review of the mold literature with a PubMed (<http://www.ncbi.nlm.nih.gov/PubMed>) or similar database search. While it is beyond the scope of this article to provide step-by-step instruction in the use of this service, researchers will generally need to employ a variety of search terms to fully capture all relevant citations, depending on a case’s medical allegations.

A single search employing only one keyword is seldom sufficient when researching medical mold issues. At the time this article was composed, sample PubMed searches using “toxic mold,” “sick building syndrome,” “stachybotrys,” and “hemosiderosis” returned respectively, 62, 351, 199, and 1766 citations. Citation lists returned by these searches should be cross-referenced to ensure that all relevant publications are captured. Once knowledge requirements become clearer in ongoing medical information management of the mold case, the investigator should employ combinations of selected keywords to provide finer research concentration.

As citations are reviewed and the researcher identifies useful articles, PubMed hyperlink connections, labeled “related articles,” permit one to progressively expand the scope of the search, if required. In this manner, the investigator will increasingly capture more and more relevant information as the pattern of research is gradually refined.

Research reports and their findings should be thoughtfully analyzed before accepting the conclusions of any study at face value. An excellent primer for learning to distinguish good research is *Junk Science Judo: Self Defense Against Health Scares and Scams*, authored by attorney and biostatistician, Steven Milloy. (See a review of this text published in *The M.I.M. Reporter*, Volume V, Number 1.) This book outlines how to critically review scientific research and identify those studies that have been conducted according to accepted scientific method principles. Milloy also describes how to interpret research statistics and how different validity measures and tools can be applied to evaluate the strength of these findings. Further information regarding *Junk Science Judo* can be obtained via the Cato Institute web site, <http://www.cato.org/special/junkscience>, or Milloy’s “junk science” web site, www.junkscience.com.

Investigate Mold Experts

PubMed can also be searched by name. This feature can prove helpful to the defense attorney who seeks to understand the medical and scientific foundations upon which plaintiff counsel is developing its mold-exposure case. Once the plaintiff’s mold experts are identified, the defense attorney can search PubMed to locate citations for medical articles these “authorities” may have published. Review of these publications can suggest a line of questioning for effective deposition of the mold expert, and potential strategies to impeach testimony. Cross referencing a mold expert’s deposition statements against this expert’s previously published articles and research may reveal inconsistencies which defense counsel might later highlight in the courtroom.

Conversely, defense counsel can employ a PubMed search to identify its own medical experts for the mold case. Credible mold experts will be well-published in a variety of peer-reviewed journals. To determine if a given journal is a *bona fide* peer-reviewed publication, the attorney should investigate protocols for manuscript submission and evaluation, as published within the given journal. Other actions to identify a mold expert include an assessment of how frequently an author’s work has been cited by other researchers, and if his/her published papers have been presented at professional conferences. This latter information will sometimes be noted within an article’s footnotes.

Locate Medical Standards

At the present time, there is no universally accepted professional criterion that establishes guidance for the diagnosis and

treatment of a stand-alone mold disorder, as such. However, for many of the associated medical conditions alleged to be related to mold exposure there is published guidance available from a variety of sources. The following sections will suggest a few locations from which these standards might be acquired.

Aspergillosis includes a number of disorders caused by the *Aspergillus* species of mold. To assist physicians in the recognition and medical management of aspergillosis conditions, the Infectious Diseases Society of America (IDSA) established its practice guidelines for cases involving *Aspergillus* infection. These are available in the IDSA journal,¹ or online at <http://www.journals.uchicago.edu/CID/journal/issues/v30n4/991226/991226.text.html>. The IDSA standards are accompanied by 202 medical and scientific references that offer excellent background reading on this topic.

In some cases, clinical standards for one medical condition will have elements of transferability for the evaluation of the appropriateness of a specific mold-associated diagnosis. For example, the mold plaintiff may claim that his/her asthma began or worsened because of mold exposure. There are over fifty (50) evidence-based sets of medical practice standards published in various forms relating to asthma or conditions involving some type of asthmatic component. The National Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health released one of the most detailed protocols for this in 1997. The NHLBI’s “Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma” at <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf> contains approximately 150 pages of comprehensive guidance for diagnosis and management of the pediatric and adult asthmatic. One part of this publication is devoted to the appropriate application of pulmonary function testing in evaluation of asthma cases.

Some highly-regarded teaching hospitals also publish practice standards. The University of Michigan Health System’s clinical care guidelines for asthma depict an algorithm, adapted from the National Heart, Lung and Blood Institute, for the identification and management of four levels of asthma severity. Indoor fungi are identified within a list of asthma “triggers.” The fourteen-page pdf file can be downloaded from <http://cme.med.umich.edu/pdf/guideline/asthma.pdf>.

Standards of diagnosis and treatment are also published for much less serious medical diagnoses and symptoms that may arise in the mold lawsuit. For example, one disorder sometimes claimed in mold exposure cases is sinusitis. There are at least six (6) different sets of professional practice guidelines published regarding this condition. One such resource from the American Academy of Pediatrics³ consists of eleven (11) pages of instruction for the management of pediatric sinusitis, which the attorney may find informative when defending lawsuits involving childhood mold exposures. This document is an expert

consensus opinion resulting from a comprehensive analysis of the medical literature on the subject. The panel's recommendations are available at <http://www.aap.org/policy/0106.html>.

The American Academy of Allergy, Asthma and Immunology; the American College of Allergy, Asthma and Immunology; and the Joint Council of Allergy, Asthma and Immunology co-developed an extensive set of practice parameters for sinusitis case management in both children and adults.³ A clinical algorithm <http://www.harcourthealth.com/scripts/om.dll/serve?action=searchDB&searchDBfor=iss&id=jai981026b&target> directs the healthcare provider from initial evaluation of the sinusitis complaint through successful treatment. Page S120 of the guide presents information on fungal sinusitis.

Use Research to Question Diagnostic Studies

Attorneys developing medical defense strategy in mold litigation should recognize that a mold-exposure diagnosis predicated on findings from a given laboratory or clinical test should not always be accepted without challenge. Results obtained from diagnostic medical studies are only as valid as the skills, experience, and integrity of the testing technician and evaluator.

Health care facilities, professional associations, and other recognized authorities frequently promulgate guidelines that precisely dictate standards for administration and interpretation of a great number of medical tests. Failure to adhere to these protocols can call into question the validity of a study's findings. While the defense attorney might wish to challenge diagnostic evidence submitted by plaintiff counsel and counsel's experts, to effectively do so one must first determine the most widely accepted professional standards applicable to the given study.

There are a number of ways that attorneys can successfully incorporate knowledge of medical standards into their repertoire of defense tactics. A review of the professional guidelines for the administration of single-breath carbon monoxide diffusing capacity testing (DLCO) provides one good example of how an understanding of these protocols might be successfully applied to a mold case. DLCO may be used to evaluate medical conditions such as asthma, pulmonary hemorrhage, and certain infections that may arise in the mold lawsuit. In 1999, the American Association for Respiratory Care (AARC) published meticulous standards that define appropriate applications and methodologies for DLCO administration.⁴ This guidance is available online at

http://www.rcjournal.com/online_resources/cpgs/sbcmde99cpg.html.

To illustrate how defense counsel can apply standards of care to discredit certain diagnoses derived from medical testing, consider AARC guidance identifying factors that can impact DLCO test findings. Variables such as the patient's body position during testing, altitude at which the study was administered, patient smoking patterns, bronchodilator use, and even the occurrence of menstruation can all impact the results obtained from DLCO. Test interpretations should take these factors into account before a final diagnosis or assessment is rendered.

The AARC also lists standards to which the DLCO technician must adhere for validation of testing technique, equipment function, and test quality assessment and monitoring. AARC DLCO protocols list measures for regular equipment calibration, leak testing, and quality assurance (QA). Ongoing adherence to these standards should be documented by the DLCO technician in a QA logbook. This log will usually be stored in the DLCO lab area. The attorney and reviewing medical legal specialist should seek access to this logbook to discover potential departures from QA standards during the time a given diagnostic test was administered.

When the medical legal specialist is called upon to critically appraise the accuracy of a particular diagnostic study, the evaluation process begins with careful analysis of the records of this test as contained in the plaintiff's health care record. This documentation will be all that the health care provider will typically release when receiving a request for a plaintiff's "medical record." However, other documentation can be equally important, but may be more difficult to acquire for review. In the case of DLCO testing, to fully evaluate the integrity of a given study, the attorney must also request that the health care facility provide non-medical record documentation, such as *biomedical maintenance records*, which might identify ongoing problems with equipment operation that can in turn cast doubt on the validity of a given study's findings. These records are typically housed in the biomedical engineering department of the hospital/clinic.

Owner manuals for given biomedical instrumentation can also be helpful when questioning the validity of findings for a particular diagnostic study. Generally, the attorney will not be able to acquire and remove these from the healthcare facility, but may be able to review them on-site. Alternatively, the attorney may successfully locate these manuals directly via the manufacturer's Internet site through a link to the customer support department. If this

information is not available online, the attorney will need to directly call or write the manufacturer's customer service department at a point of contact published on the corporate web site. Many manufacturers will charge a fee for a copy of their owner manuals.

Conclusion

Attorneys defending the mold case must familiarize themselves with the etiology, presenting symptoms and complaints, evaluation, diagnosis, and treatment of medical conditions allegedly associated with mold exposure. Review of published medical and scientific materials is a first step in formulating a winning defense strategy in these lawsuits. The challenge to corporate, insurance, and defense counsel lies in differentiating "sound science" from "poor science" in mold litigation.

* As illustrated in Part I of this series, duplication of time and fiscal resources can be minimized in the mold case if defendants join a cost sharing initiative for the acquisition, review, and analysis of claimant medical records. The potential for cost sharing in the mold case also applies in situations where

background medical and scientific literature research is required for defense preparations. Multi-party defendants can contract for this service on a one-time basis with a MIM provider and equally distribute research work products and expenditures.

¹ Infectious Diseases Society of America. Practice guidelines for diseases caused by *Aspergillus*. *Clinical Infectious Diseases*. 2000;30(4):696-709.

² American Academy of Pediatrics. Clinical practice guideline: Management of sinusitis. *Pediatrics*. 2001;108(3):798-808.

³ Spector SL, *et al*. Parameters for the diagnosis and management of sinusitis. *Journal of Allergy and Clinical Immunology*. 1998;102(6):S107-S144.

⁴ American Association for Respiratory Care. AARC clinical practice guideline: Single-breath carbon monoxide diffusing capacity, 1999 update. *Respiratory Care*. 1999;44(5):539-46.

HHS Publishes Final Modifications to Privacy Rule

The US Department of Health and Human Services (HHS) Office of Civil Rights (OCR) posted a draft of the final changes to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations on Friday, August 9. The official copy of the new privacy rule was published in the *Federal Register* on August 14, 2002. The new rule will take effect on April 14, 2003 for most covered entities.

This rule provides comprehensive federal regulation that gives patients protection over the privacy of their medical records. HHS Secretary Tommy G. Thompson noted, "This regulation gives patients the power to protect their privacy and still get efficient health care."

Final modifications were made in the areas of Marketing,

Consent and Notice, Uses and Disclosures Regarding FDA-Regulated Products and Activities, Incidental Use and Disclosure, Authorization, Minimum Necessary, Parents and Minors, Business Associates, Research, Limited Data Set, and other provisions relating to Hybrid Entities, Health Care Operations: Changes in Legal Ownership, Group Health Plan Disclosures or Enrollment and Disenrollment Information, Accounting Disclosures, Disclosure for Treatment, Payment or Health Care Operations of Another Entity, and Protected Health Information: Exclusion for Employment Records.

The final changes may be viewed at <http://www.hhs.gov/ocr/hipaa/finalreg.html>. The link to the *Federal Register* is also available from this site.

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Immunization Safety Review: Multiple Immunizations and Immune Dysfunction Institute of Medicine¹ - February 2002

Reviewed by Elizabeth B. Juliano and Janice Dana

Of concern to many parents is the safety of the immunizations that their children are receiving. A commonly held fear among the public is that although these immunizations are effective in protecting children from such childhood diseases as mumps, measles and pertussis, they may be associated with the onset of chronic diseases including allergies, diabetes, and autoimmune disorders. In order to address these fears, the Immunization Safety Review Committee was established by the Institute of Medicine. The Immunization Safety Review Committee is comprised of distinguished scholars, scientists, epidemiologists and physicians who review current publications, studies, and workshop findings on various vaccine safety topics.

For the purposes of this study, the Committee examined the validity of the hypothesis that multiple immunizations increase the risk for immune dysfunction. They focused specifically on whether multiple immunizations posed a risk for asthma and Type 1 diabetes. The Committee performed its research with thoroughness and scientific rigor. The Committee also researched the scientific evidence in terms of its social impact on the public at large, employing the following criteria:

- The scientific assessment has two components: an examination of the epidemiological and clinical evidence regarding a possible causal relationship between the immunization and the adverse event, and an examination of experimental evidence for any biological mechanisms relevant to the hypothesis.
- The significance assessment addresses such considerations as the burden of the health risks associated with the vaccine-preventable disease compared with the risks associated with the adverse event in question, as well as the level of public concern about the safety issue.

The effectiveness of immunizations in-and-of-themselves was not questioned by the Committee, rather it focused on how multiple immunizations affected the developing immune system. Just how the human organism develops its immunity is a complex and highly sophisticated question, which is only now beginning to be understood. The incidence of Type 1 diabetes and allergies having sky-rocketed over the last 20 years, and the number of vaccinations children receive has also increased substantially over the same period. The

committee found that multiple immunizations do not lead to a higher risk of infection or Type 1 diabetes. But on the question of whether or not they posed a risk for increasing allergies, the Committee's finding was indeterminate.

The Committee studied the mechanisms by which vaccinations introduce antigens into the body. What it found was that despite the increased number of vaccinations given today, the number of antigens they actually introduced into the human body has significantly dropped. For example, the Committee's findings reiterate the established fact that the whole-cell pertussis vaccine given before 1991 which contained about 3,000 antigenic components was replaced by an acellular vaccine containing only 2-5 antigens. The acellular vaccine marked a great immunological advance, and after discontinuing the smallpox vaccine in 1971, the U.S. further decreased the total amount of antigens in the human body by approximately 200. The conclusion is that antigen overload from today's vaccines could not, therefore, account for childhood immune disorders.

Another possibility that has been raised as contributing to the increased incidents of autoimmune disorders, allergies, and Type 1 diabetes is known as the "hygiene hypothesis," which presumes that the changes in immune function result from the relatively aseptic conditions in today's society. This hypothesis poses the question that changes in our immunological development has resulted in changes in the human body's Th1/Th2 responses, consequently causing an increase in autoimmune diseases and allergies. This is one area, the Committee has concluded, that requires more research.

Ultimately, the Committee recommended, "limited but continued public health attention to this issue in terms of exploiting current research efforts." The report is extensive and provides a large list of references for further review.

Copies of this report may be obtained from the National Academy Press, 2101 Constitution Avenue, N.W., Box 285, Washington, DC 20055 or visit www.nap.edu. For more information on the Institute of Medicine visit www.iom.edu. For more information on this specific project visit www.iom.edu/imsafety.

¹ *Immunization Safety Review: Multiple Immunizations and Immune Dysfunction*, Institute of Medicine (2002). Kathleen Stratton, Christopher B. Wilson and Marie C. McCormick, *Editors*, Immunization Safety Review Committee, Board on Health Promotion and Disease Prevention.

BOOK REVIEW

The Age of Expert Testimony: Science in the Courtroom, Report of a Workshop

Review by Elizabeth B. Juliano and Sara S. Pakrashi, JD

A central part of civil litigation is the role of expert testimony. Within this arena, tension exists between the legal and scientific community regarding the process which qualifies an expert. It is this tension that the Science, Technology, and Law Panel of the National Research Council explores in the book, *The Age of Expert Testimony: Science in the Courtroom, Report of a Workshop*. The book is a summary of various panel discussions at a workshop held on September 7, 2000 and reviewed in 2002. The purpose of the workshop was not to offer conclusions, but to fairly evaluate all viewpoints, both legal and scientific.

Addressing many current issues on the subject, *The Age of Expert Testimony* offers all sides of the argument. Given a historical progression of issues, the reader easily grasps the intricacies of the subject. For example, the authors point out that the interest in the debate over expert testimony has increased due to a recent series of Supreme Court cases. These cases, referred to as "The Supreme Court Trilogy"¹ not only alter the way in which expert testimony is evaluated, but change the role of the judge to a "gatekeeper of information." These cases were incorporated in to Federal Rule of Evidence 702. Now, scientific, technical, and "other specialized knowledge"² is evaluated upon the same principles.

It is this greater role of the judge as gatekeeper that acts as the starting point for the debate. The authors assert that the degree of scrutiny given to expert testimony and evidence is by no means standardized within the legal forum. Frequently, the amount of scrutiny changes depending upon the court, the stakes and the function of the evidence. Due to the growth of toxic tort litigation and its far-reaching implications for both the plaintiffs and defendants, there has been a need to develop standards for admitting scientific evidence. As the authors observed, the ability to draw such well-defined lines remains elusive.

To illustrate this point, the participants discussed the basis of certain expert testimony. While there seemed to be

a consensus that "junk science" should be thrown out, there appeared to be no consensus as to the definition of "junk science." One workshop participant claimed that "junk science" was a term used to describe evidence intended to favor plaintiffs in toxic tort cases. Another participant applied the term to studies conducted by scientists employed by corporations on whose behalf the scientist later testified at trial. By having all sides present at the workshop, it was easy to demonstrate the difficulty in standardizing "acceptable" science.

Other issues explored by the workshop involved the tension between legal and scientific viewpoints. The participants acknowledged the inequity of requiring expert witnesses to uphold higher standards of accuracy in the courtroom than in the world of science. Also cited was the issue of the absence of data. A case can be won or lost due to the lack of data, but that does not necessarily refute causation. It was observed that a variety of situations could result in a lack of data. A study may not have been feasible due to the lack of technology or funding. Alternatively, it may have been feasible, but not undertaken. Discussion of this issue provided an appreciation of the difficulties in acquiring reliable evidence.

This is one of the many reasons why scientists may be reluctant to testify. The legal system is an adversarial one. Some of the scientific participants voiced concerns about being embarrassed publicly, or misunderstood. As some of the scientific participants observed, it is very possible for two scientists to disagree on a subject in good faith, without implying that a theory is either weak or strong. No hypothesis can be labeled "permanently true" because the available data are constantly changing. Therefore, in the legal forum, it is unrealistic to expect a scientist to give an absolute answer. The authors discussed options for providing the courts a better understanding of the information being presented, as well as its limitations.

Litigation Management, Inc. is pleased to be a Sponsor at the American Bar Association Pharmaceutical Program on November 7, 2002 in New Jersey.

Perhaps one of the largest topics addressed was causation. The discussion of relative risk within the book brings forth an issue that is paramount in toxic tort cases. Because there are no uniform standards, some courts adopt their own. Some of these courts require a relative risk higher than 2.0 in order to establish causality.³ However, scientists are concerned about such distinct parameters. Among the list of reasons is the observation that there is no basis to use the 2.0 standard as opposed to any other standard. Such a standard would permit entering evidence showing a 2.0 risk, but evidence with a 1.9 standard would be excluded. Therefore, if an agent or condition is associated with a risk level of less than 2.0, the court will not determine it to be likely causation for a plaintiff's injury, even if there is some evidence that the agent or condition is associated with a higher risk.⁴ This problem demonstrates the gap between legal and scientific disciplines which can only be closed through improved communication.

Through its diverse participants, this workshop successfully portrayed the issues faced by the legal community while assessing expert testimony. This report is a valuable guide to important issues in evaluating the admission or exclusion of scientific evidence. It is available at www.nap.edu.

¹ See, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786 (1993), *General Electric Co. v. Joiner*, 118 S.Ct. 512 (1997), *Kumho Tire Co. LTD. v. Carmichael*, 119 S.Ct. 1167 (1999).

² Fed. R. of Ev. 702.

³ "By definition, an agent that creates a health risk of 2.0 is said to double the risk. Similarly, an agent that creates a health risk of 1.2 is said to increase a risk by 20 percent, and so on." Science, Technology, and Law Panel, National Research Council, *The Age of Expert Testimony: Science in the Courtroom, Report of a Workshop 20* (2002).

⁴ Science, Technology, and Law Panel, National Research Council, *The Age of Expert Testimony: Science in the Courtroom, Report of a Workshop 20* (2002).

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