

Commentary

Asbestos Litigation: Momentum Builds For State-Based Medical Criteria Solutions To Address Filings By The Non-Sick

By
Mark A. Behrens
and
Phil Goldberg

[Editor's Note: Mark A. Behrens is a partner in the law firm of Shook, Hardy & Bacon L.L.P. in Washington, D.C. He received his B.A. in Economics from the University of Wisconsin-Madison in 1987 and his J.D. from Vanderbilt University in 1990, where he served as Associate Articles Editor of the Vanderbilt Law Review. Phil Goldberg is an associate in the Public Policy Group in the Washington, D.C. office of Shook, Hardy & Bacon L.L.P. Mr. Goldberg received his B.A. from Tufts University and his J.D. from The George Washington University School of Law, where he was a member of the Order of the Coif. Copyright 2005 by the authors. Replies to this commentary are welcome.]

The United States Supreme Court has said that this country is in the midst of an “asbestos-litigation crisis”¹ as a result of the “elephantine mass” of claims that have been filed.² Former Attorney General Griffin Bell has said that the crisis has worsened “at a much more rapid pace than even the most pessimistic projections.”³ Spreading like a renewed wild fire, the number of asbestos cases pending nationwide doubled from 100,000 to more than 200,000 during the 1990s.⁴ At least 300,000 asbestos claims are now pending.⁵ More than 100,000 new claims were filed in 2003 — “the most in a single year.”⁶ The RAND Institute for Civil Justice predicts that at least one million more claims may be filed.⁷

Meanwhile, calls for solutions have continued to grow. In addition to renewed efforts to pass federal reform,⁸

state courts and legislatures are aggressively acting to address the litigation within their own jurisdictions and borders. This article discusses why filings by “unimpaired claimants” are at the core of the current asbestos litigation crisis, the impact those filings are having on the truly sick, and the ramifications for defendant companies and the economy as a whole. The article then highlights medical criteria-based reforms that state courts and legislatures have adopted to give priority to the truly sick, while preserving the right of currently unimpaired claimants to pursue legal actions if, and when, they develop asbestos-related impairments. The appendix to this article summarizes the various medical criteria that have been adopted to date.

I. The Current Asbestos Litigation ‘Crisis’

A. Mass Filings By The Non-Sick

Threaten Payments To The Truly Sick

In the past, most asbestos claims were filed by “workers suffering from grave and crippling maladies,” such as debilitating breathing impairment, lung cancer or mesothelioma.⁹ Today, however, the vast majority of new asbestos claimants are “people who have been exposed to asbestos, and who (usually) have some marker of exposure such as changes in the pleural membrane covering the lungs, but who are not impaired by an asbestos-related disease and likely never will be.”¹⁰ Recent estimates indicate that up to ninety percent of new asbestos claims filed nationally are brought by plaintiffs with little or no impairment.¹¹

Mass screenings conducted by plaintiffs' lawyers and their agents have "driven the flow of new asbestos claims by healthy plaintiffs."¹² Such screenings are frequently conducted in areas with high concentrations of workers who may have worked in jobs where they were exposed to asbestos.¹³ Plaintiffs are recruited through exaggerated ads, such as "Find out if YOU have MILLION DOLLAR LUNGS!"¹⁴ Attorney General Bell has said: "These screenings often do not comply with federal or state health and safety law. There often is no medical purpose for these screenings and claimants receive no medical follow-up."¹⁵ Some attorneys reportedly pass an x-ray around to numerous radiologists until they find one who is willing to say that the x-ray shows markers of an asbestos-related disease, a practice strongly suggesting unreliable scientific evidence.¹⁶

Recently, the American Bar Association ("ABA") Commission on Asbestos Litigation studied this problem.¹⁷ The ABA Board of Governors authorized the formation of the Commission to craft a legal standard for asbestos-related impairment. With the assistance of the American Medical Association, the Commission consulted some of the Nation's most prominent physicians in the field of occupational medicine and pulmonary disease. The doctors interviewed "represented a cross-section of experts in this area — some had testified for plaintiffs in asbestos litigation, some had testified for defendants, some for both and some for neither."¹⁸ These physicians confirmed published reports that only a small percentage of current asbestos claims involve functional impairment:

Asbestos-related cancer and impairing asbestosis continue to occur, but they represent a small fraction of annual new filings. According to the recent RAND report, somewhere between two-thirds and 90% of new claims are now brought by individuals who have radiographically detectable changes in their lungs that are "consistent with" asbestos-related disease (and with dozens of other causes), but have no demonstrated functional impairment from those changes. In sum, it appears that a large and growing proportion of the claims entering the system in recent years were submitted by individuals who have not incurred an injury that affects

their ability to perform activities of daily life.¹⁹

The ABA Commission also confirmed that a large percentage of asbestos cases arise from the activities of for-profit litigation screening companies whose sole purpose is to identify large numbers of people who have minimal x-ray changes that are "consistent with" prior asbestos exposure, thus providing the pretext for a lawsuit. The Commission reported:

For-profit litigation "screening" companies have developed that actively solicit asymptomatic workers who may have been occupationally exposed to asbestos to have "free" testing done — usually only chest X-rays. Promotional ads declare that "You May Have Million \$ Lungs" and urge the workers to be screened even if they have no breathing problems because "you may be sick with no feeling of illness." The X-rays are usually taken in "x-ray mobiles" that are driven to union halls or hotel parking lots. There is evidence that many litigation-screening companies commonly administer the x-rays in violation of state and federal safety regulations. In order to get an x-ray taken, workers are ordinarily required to sign a retainer agreement authorizing a lawsuit if the results are "positive."

The x-rays are generally read by doctors who are not on site and who may not even be licensed to practice medicine in the state where the x-rays are taken or have malpractice insurance for these activities. According to these doctors, no doctor/patient relationship is formed with the screened workers and no medical diagnoses are provided. Rather, the doctor purports only to be acting as a litigation consultant and only to be looking for x-ray evidence that is "consistent with" asbestos-related disease. Some x-ray readers spend only minutes to make these findings, but are paid hundreds of thousands of dollars — in some

cases, millions — in the aggregate by the litigation screening companies due to the volume of films read.²⁰

Given the way in which mass litigation screenings are conducted, it is hardly surprising that the medical “findings” they generate are notoriously unreliable. The ABA Commission reported that the rate of “positive” findings (*i.e.*, findings consistent with prior asbestos exposure) generated by litigation screening companies is “startlingly high,” often exceeding fifty percent and sometimes reaching ninety percent.²¹ The result is an “epidemic of asbestosis observed . . . in numbers which are inconceivable and among industries where the disease has never been previously recognized by medical investigation.”²²

The problem presented by mass filings by unimpaired claimants is self-evident: they create judicial backlogs and exhaust scarce resources that should go to “the sick and the dying, their widows and survivors.”²³ Sick plaintiffs and asymptomatic claimants are forced to compete against each other for scarce resources.²⁴ Senior U.S. District Judge Charles Weiner, who presides over the federal asbestos docket (MDL 875), has explained this problem: “Only a very small percentage of the cases filed have serious asbestos-related afflictions,” but they “are prone to be lost in the shuffle with pleural and other non-malignant cases.”²⁵

Consider, for example, the litigation involving Johns-Manville, which filed for bankruptcy in 1982. It took six years for the company’s bankruptcy plan to be confirmed. Payments to Manville Trust claimants were halted in 1990, and did not resume until 1995. According to the Manville trustees, a “disproportionate amount of Trust settlement dollars have gone to the least injured claimants — many with no discernible asbestos-related physical impairment whatsoever.”²⁶ The Trust is now paying out just *five cents on the dollar* to asbestos claimants.²⁷ The trusts created through the Celotex and Eagle-Picher bankruptcies have similarly reduced payments to claimants.²⁸

The same injustice can be seen on an individual level. For example, the widow of a Washington State man who died from mesothelioma has been told that she should expect to receive only fifteen percent of the \$1 million she might have received if her husband had

filed suit before the companies he sued went bankrupt.²⁹ The widow of an Ohio mechanic will recover at most \$150,000 of the \$4.4 million award that she received for her husband’s death.³⁰

Not surprisingly, lawyers who represent cancer victims have been highly critical of mass screenings and the filings they generate. Here is what some of these lawyers have said:

- Matthew Bergman of Seattle: “Victims of mesothelioma, the most deadly form of asbestos-related illness, suffer the most from the current system . . . the genuinely sick and dying are often deprived of adequate compensation as more and more funds are diverted into settlements of the non-impaired claims.”³¹
- Peter Kraus of Dallas: Plaintiffs’ lawyers who file suits on behalf of the non-sick are “sucking the money away from the truly impaired.”³²
- Mark Iola of the same Dallas firm has said that unimpaired asbestos claimants are “stealing money from the very sick.”³³
- Steve Kazan of Oakland, California has testified that recoveries by the unimpaired may result in his clients being left uncompensated.³⁴
- Randy Bono, a prominent Madison County, Illinois attorney: “I welcome change. Getting people who aren’t sick out of the system, that’s a good idea.”³⁵
- Terrence Lavin, an Illinois State Bar President and Chicago plaintiffs’ lawyer: “Members of the asbestos bar have made a mockery of our civil justice system and have inflicted financial ruin on corporate America by representing people with nothing more than an arguable finding on an x-ray.”³⁶

B. The Heavy Toll Of Asbestos-Related Bankruptcies

Asbestos litigation has forced more than seventy companies into bankruptcy.³⁷ The “process is accelerating,”³⁸ due to the “piling on” nature of asbestos liabilities.³⁹ These bankruptcies represent more than the demise of a business. They also have a real impact on the job prospects of employees,

the retirement savings of ordinary citizens, and the economy as a whole.

For instance, Nobel Prize-winning economist Joseph Stiglitz of Columbia University and two colleagues found that bankruptcies resulting from asbestos litigation put up to 60,000 people out of work between 1997 and 2000.⁴⁰ Those workers and their families lost \$175 million to \$200 million in wages.⁴¹ Employee retirement assets declined roughly twenty-five percent.⁴² National Economic Research Associates found that workers, communities, and taxpayers will bear as much as \$2 billion in additional costs, due to indirect and induced impacts of company closings related to asbestos.⁴³ For instance, for every ten jobs lost directly, the community may lose eight additional jobs.⁴⁴ The shutting of plants and job cuts decrease per capita income, leading to declining real estate values, and lower federal, state and local tax receipts.⁴⁵ Additional costs brought upon workers and communities include up to \$76 million in worker retraining, \$30 million in increased health-care costs and \$80 million in payment of unemployment benefits.⁴⁶

Asbestos litigation also has brought about a staggering loss to the U.S. economy. RAND recently estimated that \$70 billion had been spent in the litigation through the end of 2002.⁴⁷ The remaining future cost of the litigation is an estimated \$130 billion.⁴⁸ To put these vast sums in perspective, Attorney General Bell has pointed out that asbestos litigation costs will exceed the cost of "all Superfund sites combined, Hurricane Andrew, or the September 11th terrorist attacks."⁴⁹

C. The Effect On Peripheral Defendants

As more companies have been forced into bankruptcy, "the net has spread from the asbestos makers to companies far removed from the scene of any putative wrongdoing."⁵⁰ Plaintiffs' attorney Richard Scruggs has remarked that the litigation has turned into the "endless search for a solvent bystander."⁵¹

There are now more than 8,500 asbestos defendants,⁵² up from only 300 in 1982.⁵³ Many of these defendants are household names; many others are small businesses facing potentially devastating liability.⁵⁴ Asbestos litigation now touches firms "in industries engaged in almost every form of economic activity

that takes place in the American economy."⁵⁵ Attorney General Bell predicts that half of the companies in the Dow Jones Index may soon be affected.⁵⁶ According to Senior U.S. District Court Judge Jack Weinstein, "[i]f the acceleration and expansion of asbestos lawsuits continues unaddressed, it is not impossible that every company with even a remote connection to asbestos may be driven into bankruptcy."⁵⁷

II. State-Based Initiatives To Prioritize Asbestos Claims

State courts and legislatures have overlapping authority to prioritize asbestos cases. Recently, more are exercising that authority to re-evaluate the way their jurisdictions handle asbestos claims to account for the massive increase in unimpaired claimant filings. Courts and legislatures have found that requiring a minimum level of impairment, such as evidenced by pulmonary function tests, is an effective way to address filings by the unimpaired and the potential for fraud.

A. Inactive Dockets

A growing number of courts have chosen to implement an unimpaired asbestos docket (also called an inactive docket, pleural registry or deferred docket) to give trial priority to the truly sick and preserve compensation for those that may become sick in the future, rather than have those resources depleted by earlier-filing unimpaired claimants.⁵⁸ Claims placed on an unimpaired docket are exempt from discovery and do not age.⁵⁹ Claimants are moved to the active docket when they present credible medical evidence of impairment.⁶⁰ These plans offer several important public-policy benefits:⁶¹

- ***The truly sick:*** The sick are able to move "to the front of the line" and not be forced to wait until earlier-filed claims by unimpaired individuals are resolved. Removing these delays can be especially important if the individual has a fatal disease. In addition, resources needed to compensate the truly sick, now and in the future, can be preserved by eliminating the pressure on companies to settle unimpaired claims and reducing transaction costs spent litigating those claims.⁶²
- ***The unimpaired are protected:*** Unimpaired individuals are protected from having their

claims deemed time-barred should an asbestos-related disease later develop. This would address a primary engine driving the filing of many claims by unimpaired claimants.⁶³

- **Defendants:** Defendants are able to conserve scarce financial resources that are needed to compensate sick claimants. Unimpaired dockets also can reduce the specter of more employers being driven into bankruptcy and help slow the spread of asbestos litigation to peripheral defendants.⁶⁴
- **The judicial system:** Unimpaired dockets relieve the pressure on courts to decide “claims that are premature (because there is not yet any impairment) or actually meritless (because there never will be).”⁶⁵ Other parties in the civil justice system can have their cases heard more quickly.

In the late 1980s and early 1990s, three major jurisdictions adopted unimpaired docket plans — Massachusetts, Chicago and Baltimore.⁶⁶ Judges from all three courts have stated that they believe the plans are working well for all parties. For example, Judge Hiller Zobel, who implemented the inactive docket in Massachusetts, commented that the inactive docket has been “really a very good system that has worked out. . . .”⁶⁷ Baltimore County Circuit Court Judge Richard Rombro has written that “the docket is working and . . . a substantial number of cases have been moved to the active docket while those without any impairment remain on the unimpaired docket.”⁶⁸

Since 2002, unimpaired dockets have been implemented in St. Clair, Illinois (February 2005); Portsmouth, Virginia (August 2004); Madison County, Illinois (January 2004); Syracuse, New York (January 2003); New York City (December 2002); and Seattle, Washington (December 2002).⁶⁹ Madison County, Illinois, asbestos plaintiffs’ lawyer John Simmons has said that Madison County’s unimpaired docket has been “a win-win. . . . If they (plaintiffs without symptoms) never get sick, they never get paid, and that’s the best scenario. And it preserves the dollars that are going to be spent on settlements for those who are truly deserving.”⁷⁰ As of this writing, the Michigan Supreme Court is considering a petition filed by nearly seventy companies and numerous *amici* who have asked the court to adopt a statewide unimpaired asbestos docket.⁷¹

B. Court-Based Administrative Dismissals

Other courts have entered case management orders requiring potential plaintiffs to meet certain objective medical criteria in order to proceed with a claim. For example in September 2004, the Court of Common Pleas of Cuyahoga County (Cleveland), Ohio, entered an order to “administratively dismiss the cases of those plaintiffs who have been diagnosed with pleural plaques or with a condition ‘consistent with asbestosis’ and who have not failed a pulmonary function test.”⁷² The order also states that “[c]ases that are administratively dismissed will be restored to the regular trial docket when the plaintiff develops evidence of impairment or when all plaintiffs’ cases are resolved.”⁷³

Likewise, in 2002, the judge appointed by the South Carolina Supreme Court to coordinate and control all asbestos-related cases filed in the South Carolina Circuit Courts issued a case management order governing all asbestos-related cases filed by the Wallace & Graham law firm based in Salisbury, North Carolina.⁷⁴ The order dismissed without prejudice all Wallace & Graham asbestos-related claims except those filed by persons who suffer from malignant diseases, have functionally impairing asbestosis, or have died as a result of an asbestos-related disease.⁷⁵

C. State Asbestos Medical Criteria Legislation

The latest trend is for state legislatures to require asbestos claimants to demonstrate physical impairment in order to bring or maintain a claim. In 2004, Ohio became the first state to enact such legislation.⁷⁶ Ohio also passed silica medical criteria legislation to help ensure that silica filings would not be exacerbated by plaintiffs’ lawyers who might be discouraged from bringing weak or meritless asbestos suits as a result of the asbestos medical criteria law.⁷⁷ In 2005, Georgia became the second state to enact asbestos and silica medical criteria legislation.⁷⁸ Other states are considering similar legislation, including Florida and Texas.⁷⁹ The number of states considering medical criteria legislation jumped in 2005; that trend will no doubt continue as more states follow the lead of Ohio and Georgia.

III. Conclusion

State courts and legislatures increasingly are taking steps to prioritize asbestos claims by promoting the claims of

the truly sick and suspending or dismissing claims filed by the unimpaired until such time that they may become sick. Attached are charts that detail the specific medical criteria that have been adopted for asbestos claims (Appendix A) and silica claims (Appendix B). Absent a uniform federal solution to the litigation, momentum will continue to build for state-based medical criteria solutions that focus resources on the actually injured.

Endnotes

1. Amchem Prods., Inc. v. Windsor, 521 U.S. 591, 597 (1997).
2. Ortiz v. Fibreboard Corp., 527 U.S. 815, 821 (1999).
3. Hon. Griffin B. Bell, *Asbestos Litigation and Judicial Leadership: The Courts' Duty to Help Solve the Asbestos Litigation Crisis*, BRIEFLY, Vol. 6, No. 6, June 2002, at 2 (Nat'l Legal Center for the Pub. Interest monograph), available at <<http://www.nlcpi.org>> (last visited April 4, 2005) [hereinafter Bell, *Courts' Duty*].
4. See *The Fairness in Asbestos Compensation Act of 1999: Hearing on H.R. 1283 Before the House Comm. on the Judiciary*, 106th Cong. 4 (July 1, 1999) (statement of Christopher Edley, Jr., Professor, Harvard Law School) [hereinafter Edley Testimony].
5. See S. Rep. 108-118, 22 (2003). More than 600,000 people filed asbestos personal injury claims through the end of 2000. See Stephen Carroll et al., *Asbestos Litigation Costs and Compensation (Draft)* vi (RAND Inst. for Civil Justice, Feb. 2004) [hereinafter RAND Rep.].
6. Editorial, *The Asbestos Blob, Cont.*, WALL ST. J., Apr. 6, 2004, at A16.
7. RAND Rep., *supra* note 5, at 77.
8. See Jan Amundson, *How a Congressional Answer to Asbestos Litigation Would Help Litigants, Courts, and the American Economy*, 44 S. TEX. L. REV. 925 (2003); Victor E. Schwartz et al., *Congress Should Act to Resolve the National Asbestos Crisis: The Basis in Law and Public Policy For Meaningful Progress*, 44 S. TEX. L. REV. 839 (2003).
9. Roger Parloff, *The \$200 Billion Miscarriage of Justice; Asbestos Lawyers Are Pitting Plaintiffs Who Aren't Sick Against Companies that Never Made the Stuff and Extracting Billions for Themselves*, FORTUNE, Mar. 4, 2002, at 158.
10. Edley Testimony, *supra* note 4, at 5; see also *In re Haw. Fed. Asbestos Cases*, 734 F. Supp. 1563, 1567 (D. Haw. 1990) ("In virtually all pleural plaque and pleural thickening cases, plaintiffs continue to lead active, normal lives, with no pain or suffering, no loss of the use of an organ or disfigurement due to scarring."); Alex Berenson, *A Surge in Asbestos Suits, Many by Healthy Plaintiffs*, N.Y. TIMES, Apr. 10, 2002, at A15, available at 2002 WLNR 4092639.
11. See RAND Rep., *supra* note 5, at 11; Jennifer Biggs et al., *Overview of Asbestos Issues and Trends 3* (Dec. 2001), available at <<http://www.actuary.org/mono.htm>> (last visited Apr. 4, 2005); see also Roger Parloff, *Asbestos*, FORTUNE, Sept. 6, 2004, at 186 ("According to estimates accepted by the most experienced federal judges in this area, two-thirds to 90% of the nonmalignants are 'unimpaired' — that is, they have slight or no physical symptoms.").
12. Griffin B. Bell, *Asbestos & The Sleeping Constitution*, 31 PEPP. L. REV. 1, 5 (2003) [hereinafter Bell, *Asbestos*]; see also Lester Brickman, *On The Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality?*, 31 PEPP. L. REV. 33 (2003).
13. See *Eagle-Picher Indus., Inc. v. Am. Employers' Ins. Co.*, 718 F. Supp. 1053, 1057 (D. Mass. 1989) ("[M]any of these cases result from mass X-ray screenings at occupational locations conducted by unions and/or plaintiffs' attorneys, and many claimants are functionally asymptomatic when suit is filed."); *In re Joint E. & S. Dists. Asbestos Litig.*, 237 F. Supp. 2d 297, 309 (E.D.N.Y. & S.D.N.Y. 2002) ("Claimants today are diagnosed largely through plaintiff-lawyer arranged mass screening programs targeting possibly asbestos-exposed workers and attraction of potential claimants through the mass media.").
14. Pamela Sherrid, *Looking for Some Million Dollar Lungs*, U.S. NEWS & WORLD REP., Dec. 17, 2001, at 36.
15. Bell, *Asbestos*, *supra* note 12, at 5.
16. See David Egilman, *Asbestos Screenings*, 42 AM. J. OF INDUS. MED. 163 (2002). See also Stephen Hudak

- & John F. Hagan, *Asbestos Litigation Overwhelms Courts*, CLEVELAND PLAIN DEALER, Nov. 5, 2002, at 1 (reporting that a plaintiffs' expert medical witness remarked, "I was amazed to discover that, in some of the screenings, the worker's x-ray had been 'shopped around' to as many as six radiologists until a slightly positive reading was reported by the last one.").
17. See Am. Bar Ass'n Comm'n on Asbestos Litig., *Report to the House of Delegates*, at 8 (2003), available at <http://www.abanet.org/leadership/full_report.pdf> (last visited Apr. 4, 2005) [hereinafter ABA Comm'n Rep.]. As a result of its findings, the ABA Commission proposed the enactment of federal medical criteria standards for nonmalignant claims. The ABA's House of Delegates adopted the Commission's proposal in February 2003. See *Asbestos Litigation: Hearing Before the Sen. Comm. on the Judiciary*, 107th Cong., Appen. A (Mar. 5, 2003) (statement of Hon. Dennis Archer, President-elect, American Bar Ass'n), available at 2003 WL 785387.
 18. ABA Comm'n Rep, *supra* note 17, at 11.
 19. *Id.* at 7.
 20. *Id.* at 8.
 21. *Id.* As one physician has explained, "the chest x-rays are not read blindly, but always with the knowledge of some asbestos exposure and that the lawyer wants to file litigation on the worker's behalf." David E. Bernstein, *Keeping Junk Science Out of Asbestos Litigation*, 31 PEPP. L. REV. 11, 13 (2003) (quoting Lawrence Martin, M.D.) [hereinafter Bernstein]. In 2004, researchers at Johns Hopkins University reevaluated 551 x-rays and 492 matching interpretive reports used as a basis for an asbestos claim. The x-ray readers who had been retained by plaintiffs' lawyers found that 95.9% of the films revealed abnormalities. When six independent radiologists reinterpreted the x-rays, they found abnormalities in only 4.5% of the cases. See Joseph N. Gitlin et al., *Comparison of "B" Readers' Interpretations of Chest Radiographs for Asbestos Related Changes*, 11 ACAD. RADIOLOGY 843 (2004). In a study of 439 chest films from tire workers that had filed legal claims, an independent panel of three board-certified radiologists found that less than 4% had conditions consistent with an asbestos exposure. See Bernstein, *supra*, at 13.
 22. Andrew J. Ghio, M.D., Editorial, *Asbestosis: Over Diagnosed?*, THE NEWS & OBSERVER (Charlotte, North Carolina), Apr. 12, 2004, at A11; David M. Setter et al., *Why We Have to Defend Against Screened Cases: Now Is the Time for a Change*, 2:4 MEALEY'S LITIG. REP.: SILICA 11 (2003).
 23. *In re Collins*, 233 F.3d 809, 812 (3d Cir. 2000), cert. denied sub nom. *Collins v. Mac-Millan Bloedel, Inc.*, 532 U.S. 1066 (2001) (internal citation omitted); see also *Larson v. Johns-Manville Sales Corp.*, 399 N.W.2d 1, 23 (Mich. 1986) ("We believe that discouraging suits for relatively minor consequences of asbestos exposure will lead to a fairer allocation of resources to those victims who develop cancers."); Steven Hantler, *Judges Must Play Key Role in Stemming Tide of Asbestos Litigation*, 25:14 ANDREWS ASBESTOS LITIG. RPTR. 12 (May 22, 2003) (assistant general counsel for DaimlerChrysler Corp. stating, "The tragedy is that as plaintiffs' lawyers enroll the healthy into their lawsuits in order to line their own pockets, less money is available for those who are actually sick and dying.").
 24. See *In re Joint E. & S. Dists. Asbestos Litig.*, 129 B.R. 710, 751 (E.D.N.Y. & S.D.N.Y. 1991) ("Overhanging this massive failure of the present system is the reality that there is not enough money available from traditional defendants to pay for current and future claims. Even the most conservative estimates of future claims, if realistically estimated on the books of many present defendants, would lead to a declaration of insolvency — as in the case of some dozen manufacturers already in bankruptcy."), vacated, 982 F.2d 721 (2d Cir. 1992).
 25. *In re Asbestos Prods. Liab. Litig.* (No. VI), 1996 WL 539589, *1 (E.D. Pa. Sept. 12, 1996).
 26. Quenna Sook Kim, *Asbestos Trust Says Assets Are Reduced As the Medically Unimpaired File Claims*, WALL ST. J., Dec. 14, 2001, at B6.
 27. See *id.*
 28. See Mark Goodman et al., Editorial, *Plaintiffs' Bar Now Opposes Unimpaired Asbestos Suits*, NAT'L L.J., Apr. 1, 2002, at B14.
 29. See Albert B. Crenshaw, *For Asbestos Victims, Compensation Remains Elusive*, WASH. POST., Sept. 25, 2002, at E1.
 30. See Stephen Hudak & John F. Hagan, *Asbestos Litigation Overwhelms Courts*, CLEVELAND PLAIN DEALER,

- Nov. 5, 2002, at A1, *available at* 2002 WLNR 269888.
31. Matthew Bergman & Jackson Schmidt, Editorial, *Change Rules on Asbestos Lawsuits*, SEATTLE POST-INTELLIGENCER, May 30, 2002, at B7, *available at* 2002 WLNR 2149929.
 32. Susan Warren, *Competing Claims: As Asbestos Mess Spreads, Sickest See Payouts Shrink*, WALL ST. J., Apr. 25, 2002, at A1.
 33. Thomas Korosec, *Enough to Make You Sick*, DALLAS OBSERVER, Sept. 26, 2002, *available at* <www.dallasobserver.com/issues/2002-09-26/feature.html/1/index.html> (Last visited Apr. 4, 2005).
 34. *See Asbestos Litigation: Hearing Before the Sen. Comm. on the Judiciary*, 107th Cong. (Mar. 5, 2003) (statement of Steven Kazan, partner, Kazan, McClain, Edises, Abrams, Fernandez, Lyons & Farrise), *available at* 2003 WL 785389.
 35. Paul Hampel & Philip Dine, *Asbestos Litigation Deal Could Force Law Offices to Find New Specialties; Bill Would Substitute Trust Fund for Lawsuits*, ST. LOUIS POST-DISPATCH, July 23, 2003, at A1.
 36. Editorial, *ABA Backs Asbestos Reform*, WASH. TIMES, Feb. 16, 2003, at B2.
 37. *See* Mark A. Behrens & Rochelle M. Tedesco, *Two Forks in the Road of Asbestos Litigation*, 18:3 MEALEY'S LITIG. REP.: ASBESTOS 1 (Mar. 7, 2003).
 38. *Collins*, 233 F.3d at 812.
 39. *See* Mark D. Plevin & Paul W. Kalish, *What's Behind the Recent Wave of Asbestos Bankruptcies?*, 16:6 MEALEY'S LITIG. REP.: ASBESTOS 20 (Apr. 20, 2001); *see also In re Combustion Eng'g, Inc.*, 391 F.3d 190, 201 (3d Cir. 2005) ("For some time now, mounting asbestos liabilities have pushed otherwise viable companies into bankruptcy."); *Ieropoli v. AC&S Corp.*, 842 A.2d 919, 932 (Pa. 2004) (noting concern about "the heavy toll that asbestos litigation is visiting upon certain Commonwealth corporations."); Christopher Edley, Jr. & Paul C. Weiler, *Asbestos: A Multi-Billion-Dollar Crisis*, 30 HARV. J. ON LEGIS. 383, 392 (1993) (explaining that each time a defendant declares bankruptcy, "mounting and cumulative" financial pressure is placed on the "remaining defendants, whose resources are limited.>").
 40. *See* Joseph E. Stiglitz et al., *The Impact of Asbestos Li-*
 - abilities on Workers in Bankrupt Firms 12 J. BANKR. L. & PRAC. 51 (2003).
 41. *See id.* at 76.
 42. *See id.* at 83.
 43. *See Solving the Asbestos Litigation Crisis: Hearing on S. 1125, the Fairness in Asbestos Injury Act of 2003, Before the Sen. Comm. on the Judiciary*, 107th Cong. (June 4, 2003) (statement of Fredrick C. Dunbar, Ph.D., Senior Vice President, Nat'l Econ. Research Assocs.), *available at* 2003 WL 21291239.
 44. *See id.* 8.
 45. *See id.*
 46. *See id.*
 47. *See* S. Rep. 108-118, at 59 (2003) (citing RAND's Stephen Carroll).
 48. *See Solving the Asbestos Litigation Crisis: Hearing on S. 1125, the Fairness in Asbestos Injury Act of 2003, Before the Sen. Comm. on the Judiciary*, 107th Cong., at 1 (June 4, 2003) (statement of Jennifer L. Biggs, Consulting Actuary, Tillinghast-Towers Perrin).
 49. Bell, *Courts' Duty*, *supra* note 3, at 4.
 50. Editorial, *Lawyers Torch the Economy*, WALL ST. J., Apr. 6, 2001, at A14; *see also* Editorial, *The Job-Eating Asbestos Blob*, WALL ST. J., Jan. 23, 2002, at A22.
 51. 'Medical Monitoring and Asbestos Litigation' — *A Discussion with Richard Scruggs and Victor Schwartz*, 17:3 MEALEY'S LITIG. REP.: ASBESTOS 5 (Mar. 1, 2002); *see also In re Joint E. & S. Dists. Asbestos Litig.*, 129 B.R. at 747-48 (stating that "[a] newer generation of peripheral defendants are becoming ensnarled in the litigation."); Richard B. Schmitt, *Burning Issue: How Plaintiffs' Lawyers Have Turned Asbestos Into a Court Perennial*, WALL ST. J., Mar. 5, 2001, at A1; Susan Warren, *Plaintiffs Target Companies Whose Premises Contained Any Form of Deadly Material*, WALL ST. J., Jan. 27, 2003, at B1.
 52. *See* Deborah R. Hensler, *California Asbestos Litigation — The Big Picture*, COLUMNS — RAISING THE BAR IN ASBESTOS LITIG., Aug. 2004, at 5,
 53. *See* RAND Rep., *supra* note 5, at 6.

54. See Susan Warren, *Asbestos Suits Target Makers of Wine, Cars, Soups, Soaps*, WALL ST. J., Apr. 12, 2000, at B1.
55. RAND Rep., *supra* note 5, at 42.
56. See Bell, *Courts' Duty*, *supra* note 3, at 24.
57. Remarks of the Hon. Jack Weinstein, at a symposium held at the Bar Association of the City of New York, *Asbestos: What Went Wrong?*, Oct. 21, 2002, at 12.
58. See Susan Warren, *Swamped Courts Practice Plaintiff Triage*, WALL ST. J., Jan. 27, 2003, at B1.
59. For background on the use of medical criteria to prioritize asbestos claims, see Dr. John E. Parker, *Understanding Asbestos-Related Medical Criteria*, 18:10 MEALEY'S LITIG. REP.: ASBESTOS 45 (June 18, 2003).
60. See Victor E. Schwartz et al., *Addressing the "Elephantine Mass" of Asbestos Cases: Consolidation Versus Inactive Dockets (Pleural Registries) and Case Management Plans that Defer Claims Filed By the Non-Sick*, 31 PEPP. L. REV. 271(2004); Mark A. Behrens & Monica G. Parham, *Stewardship for the Sick: Preserving Assets for Asbestos Victims Through Inactive Docket Programs*, 33 TEX. TECH. L. REV. 1 (2001).
61. See *In re* USG Corp., 290 B.R. 223, 227 n.3 (Bankr. Del. Feb. 2003) (stating that "[t]he practical benefits of dealing with the sickest claimants first have been apparent to the courts for many years and have led to the adoption of deferred claims registries in many jurisdictions."); *Sopha v. Owens-Corning Fiberglass Corp.*, 601 N.W.2d 627, 641 (Wis. 1999) (indicating that a pleural registry "may be [a] good solution to an admittedly difficult situation for both claimants and alleged tortfeasors"); *In re* Report of the Advisory Group, 1993 WL 30497, at *51 (D. Me. Feb. 1, 1993) (stating that "[b]y using the suspense docket, plaintiffs need not engage in the expense of trial for what are still minimal damages, but are protected in their right to recover if their symptoms later worsen. For defendants, the procedure is costless and carries the possibility that plaintiffs will live out their lives without significant injury from asbestos.>").
62. See Paul F. Rothstein, *What Courts Can Do in the Face of the Never-Ending Asbestos Crisis*, 71 MISS. L.J. 1 (2001).
63. See *In re* Asbestos Cases, 586 N.E.2d 521, 523 (Ill. App. Ct. 1991) (a primary reason that so many unimpaired individuals are filing claims is the "fear that their claims might be barred by the statute of limitations if they wait until such time, if ever, that their asbestos-related condition progresses to disability."); *The Fairness in Asbestos Compensation Act of 1999: Hearing on H.R. 1283 Before the House Comm. on the Judiciary*, 1999 Leg., 106th Cong. 4 (July 1, 1999) (statement of Dr. Louis Sullivan, former Secretary of the U.S. Department of Health and Human Services) (there are "mass filings of cases on behalf of large groups of people who are not sick and may never become sick but who are compelled to file for remedial compensation simply because of state statutes of limitation."), available at 1999 WL 458248.
64. See Mark A. Behrens, *Some Proposals for Courts Interested in Helping Sick Claimants and Solving Serious Problems in Asbestos Litigation*, 54 BAYLOR L. REV. 331, 346 (2002).
65. Peter H. Schuck, *The Worst Should Go First: Deferral Registries in Asbestos Litigation*, 15 HARV. J.L. & PUB. POL'Y 541, 555 (1992).
66. See Mass. State Ct. Asbestos Pers. Injury Litig., Order (Middlesex Super. Ct., Mass. Sept. 1986); *In re* Asbestos Cases (Cook County Cir. Ct., Ill. Mar. 26, 1991) (Order to Establish Registry for Certain Asbestos Matters); *In re* Asbestos Pers. Injury and Wrongful Death Asbestos Cases, 1992 WL 12019620 (Baltimore City Cir. Ct., Md. Dec. 9, 1992) (Order Establishing an Inactive Docket for Asbestos Personal Injury Cases).
67. *Unimpaired Asbestos Dockets: Are They Easing the Flow of Litigation?*, COLUMNS — RAISING THE BAR IN ASBESTOS LITIG., Feb. 2002, at 2.
68. *In re* Pers. Injury and Wrongful Death Asbestos Cases, No. 24-X-92-344501, at 5 (Baltimore City Cir. Ct., Md. Aug. 15, 2002) (Memorandum Opinion and Order Denying Modification to Unimpaired Docket Medical Removal Criteria).
69. See *In re* All Asbestos Litig. Filed in St. Clair County (St. Clair County Cir. Ct., Ill., Feb. 25, 2005) (Order Establishing Asbestos Deferred Registry); *In re* All Asbestos Cases (Portsmouth Cir. Ct., Va. Aug. 4, 2004) (Order Establishing an Inactive Docket for Cases Filed by the Law Offices of Peter T. Nicholl Involving Asbestos-Related Claims); *In re* All Asbestos Litig.

- Filed in Madison County (Madison County Cir. Ct., Ill. Jan. 23, 2004) (Order Establishing Asbestos Deferred Registry); *In re* Fifth Jud. Dist. Asbestos Litig. (N.Y. Sup. Ct. Jan. 31, 2003) (Amendment to Case Management Order; *In re* New York City Asbestos Litig., 2002 WL 32151568 (N.Y.C. Sup. Ct., N.Y. Dec. 19, 2002) (Order Amending Prior Case Management Orders); Letter from Judge Sharon S. Armstrong, King County, Wash., to Counsel of Record, Moving and Responding Parties 1 (Dec. 3, 2002).
70. Paul Hampel, *Lack of Trust Poisons Efforts to Reform Asbestos Litigation*, ST. LOUIS POST-DISPATCH, Sept. 22, 2004, at A1, available at 2004 WLNR 1310972.
71. See *In re* Pet. For An Admin. Order, No. 124213, 2003 WL 22341301 (Mich. Sept. 11, 2003). The court held an administrative hearing on the Petition in January 2004.
72. *In re* Cuyahoga County Asbestos Cases, Special Docket No. 73958 (Ct. Com. Pl. Cuyahoga County, Ohio Sept. 16, 2004); see also *In re* Cuyahoga County Asbestos Cases, Special Docket No. 73958 (Ct. Com. Pl. Cuyahoga County, Ohio Nov. 18, 2004) (amending September 2004 order to clarify that "screening reports alone" and a statement that a condition is "consistent with asbestosis" are not sufficient for reinstatement).
73. *Id.*
74. See *In re* Wallace & Graham Asbestos-Related Cases (Cir. Ct. Greenville County, S.C. Nov. 26, 2002).
75. See *id.* at 4.
76. See OHIO REV. CODE § 2307.91 *et seq.* (Anderson 2005); see also Kurtis A. Tunnell et al., Commentary, *New Ohio Asbestos Reform Law Protects Victims and State Economy*, 26:22 ANDREWS ASBESTOS LITIG. 10 (Aug. 26, 2004).
77. See OHIO REV. CODE § 2307.84 *et seq.* (Anderson 2005). Recently, there has been a marked increase in silica litigation. See Mark A. Behrens et al., *Silica: An Overview of Exposure and Litigation in the United States*, 20:2 MEALEY'S LITIG. REP.: ASBESTOS 33 (Feb. 21, 2005). Some plaintiffs' lawyers appear to have modified their "asbestos litigation kits" to bring silica claims. See Susan Warren, *Silicosis Suits Rise Like Dust/ Lawyers in Asbestos Cases Target Many of the Same Companies*, WALL ST. J., Sept. 4, 2003, at B5. Many claims are asbestos "re-treads" — brought by claimants that have already obtained recoveries for asbestos exposure. See David Hechler, *Silica Plaintiffs Suffer Setbacks: Broad Effects Seen in Fraud Allegations*, NAT'L L.J., Feb. 28, 2005, at 18 ("One of the most explosive revelations that has emerged from the [federal silica multi-district litigation in Corpus Christi, Texas] is that at least half of the approximately 10,000 plaintiffs in the silica MDL had previously filed asbestos claims."); *Asbestos: The Mixed Dust and FELA Issues: Hearing Before the Senate Committee on the Judiciary*, 109th Cong., at 9 (Feb. 2, 2005) (statement of Lester Brickman, Professor, Benjamin N. Cardozo School of Law of Yeshiva University), available at 2005 WL 265224; Jonathan D. Glater, *Companies Get Weapon In Injury Suits; Many Silica-Damage Plaintiffs Also Filed Claims Over Asbestos*, N.Y. Times, Feb. 2, 2005, at C1.
78. See GA. H.B. 416, 2005-2006 Legis. Sess. (2005).
79. See S.B. 1133, 2005 Leg., Reg. Sess. (Ark. 2005) (asbestos and silica claims); H.B. 1019, S.B. 2563, 2005 Leg., Reg. Sess. (Fla. 2005) (asbestos and silica claims); H.B. 741, 2005 Leg., Reg. Sess. (Mo. 2005) (asbestos claims); H.B. 1561, S.B. 1790, 2005 Leg., Reg. Sess. (Tenn. 2005) (asbestos and silica claims); H.B. 8, S.B. 15, 2005 Leg., Reg. Sess. (Tex. 2005) (asbestos and silica claims); H.B. 3036, 2005 Leg., Reg. Sess. (W. Va. 2005) (asbestos and silica claims). ■

APPENDIX A

<p><u>Syracuse Inactive Docket</u> (Jan. 2003)</p>	<p><u>New York City Inactive Docket</u> (Dec. 2002) (2002 WL 32151568)</p>	<p><u>Portland, OR</u> <u>CMO</u> (Draft. 2002)</p>	<p><u>South Carolina</u> <u>CMO</u> (2002)</p>	<p><u>Baltimore, MD</u> <u>Inactive Docket</u> (Dec. 1992; amended Mar. 1993, Aug. 1993, and Apr. 1995) (1992 WL 12019620)</p>	<p><u>Chicago, IL</u> <u>Inactive Docket</u> (Mar. 1991)</p>	<p><u>Boston, MA</u> <u>Inactive Docket</u> (Sept. 1986; amended Sept. 1994)</p>
<p><u>Asbestos/ Nonmalignant I</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/0; and pulmonary function testing that, in the opinion of a board-certified pulmonary specialist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 65% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>Asbestos/ Nonmalignant I</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/0; and pulmonary function testing that, in the opinion of a board-certified pulmonary specialist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>Asbestos/ Nonmalignant I</u> Chest x-rays which, in the opinion of a certified B-reader, show small irregular opacities of ILO grade 1/0, and pulmonary function testing that, in the opinion of a pulmonologist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 75% (actual value), or (2) TLC $<$ 80%.</p>	<p><u>Asbestos/ Nonmalignant I</u> The plaintiff has been diagnosed with asbestosis, his or her chest x-rays have been given an ILO grade of at least 1/1 by a currently certified B-reader, and he or she has been given an impairment rating of Class 4 under AMA Guidelines.</p>	<p><u>Asbestos/ Nonmalignant I</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/0; and pulmonary function testing that, in the opinion of a board-certified pulmonary specialist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>Asbestos/ Nonmalignant I</u> A chest x-ray with an ILO rating of 1/0 or greater, as read by a certified B-reader, and a pulmonary function test performed under the supervision of and interpreted by a board-certified pulmonologist which demonstrates either: (1) Diffusing capacity for oxygen $<$ 70% of normal with FEV-1/FVC \geq 75% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>Asbestos/ Nonmalignant I</u> An ILO B reading of 1/0 or above; and a pulmonary function test which demonstrates: FVC $<$ 80% of predicted with FEV-1/FVC $>$ 75% (actual value) and DLCO $<$ 75%.</p>
<p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/1 or greater, and pulmonary function testing that, in the opinion of a board-certified pulmonologist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC $>$ 65% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/1 or greater, and pulmonary function testing that, in the opinion of a board-certified pulmonologist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 70% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a certified B-reader, show small irregular opacities of ILO grade 1/1 or greater, and pulmonary function testing that, in the opinion of a pulmonologist or internist, shows either of the following: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 70% (actual value), or (2) TLC $<$ 80% of predicted.</p>	<p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/1 or greater, and pulmonary function testing that, in the opinion of a board-certified pulmonologist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 65% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/1 or greater, and pulmonary function testing that, in the opinion of a board-certified pulmonologist or internist, shows either: (1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted.</p>	<p><u>OR</u> <u>Nonmalignant II</u> A chest x-ray with an ILO rating of 1/1 or greater, as read by a certified B-reader, and a pulmonary function test performed under the supervision of and interpreted by a board-certified pulmonologist which demonstrates a diffusing capacity less than 80%.</p>	<p><u>OR</u> <u>Nonmalignant II</u> An ILO B reading of 1/1 or above and a pulmonary function test which demonstrates FVC $<$ 80% of predicted with FEV-1/FVC $>$ 70% (actual value).</p>
<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-rays which, in the opinion of a currently certified</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-rays which, in the opinion of a currently certified</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-rays which, in the opinion of a certified B-reader, to</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-rays which, in the opinion of a certified B-reader,</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-rays demonstrating</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-ray demonstrating</p>	<p><u>OR</u> <u>Bilateral Pleural Thickening</u> Chest x-ray demonstrating</p>

<p><u>Syracuse Inactive Docket</u> (Jan. 2003)</p>	<p>B- reader, to a reasonable degree of medical certainty, demonstrate bilateral asbestos-related pleural thickening which has an ILO grade B2 or greater and with pulmonary testing that, in the opinion of a board-certified pulmonary specialist or internist, to a reasonable degree of medical certainty shows either:</p>	<p><u>New York City Inactive Docket</u> (Dec. 2002) (2002 WL 32151568)</p>	<p>B- reader, to a reasonable degree of medical probability, show asbestos-related bilateral diffuse pleural thickening graded C2 or greater on the ILO scale and which includes the blunting of at least one costophrenic angle and pulmonary function testing that, in the opinion of a pulmonologist or internist, shows either of the following:</p>	<p><u>Portland, OR CMO</u> (Draft 2002)</p>	<p><u>South Carolina CMO</u> (2002)</p>	<p><u>Baltimore, MD Inactive Docket</u> (Dec. 1992; amended Mar. 1993, Aug. 1993, and Apr. 1995) (1992 WL 12019620)</p>	<p><u>Chicago, IL Inactive Docket</u> (Mar. 1991)</p>	<p><u>Boston, MA Inactive Docket</u> (Sept. 1986; amended Sept. 1994)</p>
<p>(1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted,</p>	<p>(1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted,</p>	<p>(1) FVC \leq 75% of predicted with FEV-1/ FVC \geq 70% (actual value), or (2) TLC $<$ 75% of predicted with FEV/FVC $>$ 70% (actual value).</p>	<p>(1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted,</p>	<p>(1) FVC \leq 80% of predicted with FEV-1/ FVC \geq 68% (actual value), or (2) TLC \leq 80% of predicted,</p>	<p>(1) FVC \leq 75% of predicted with FEV-1/FVC $>$ 70% (actual value), or (2) TLC $<$ 75% of predicted and with FEV-1/FVC $>$ 70% (actual value).</p>	<p>asbestos-related bilateral pleural encasement and graded C2 or greater on the ILO scale including blunting of at least one costophrenic angle with:</p>	<p>and with a statement by a board-certified pulmonary specialist or internist that, based upon a complete review of the claimant's entire medical record, to a reasonable degree of medical certainty, the asbestos-related changes are a substantial contributing factor to the pulmonary function changes.</p>	<p>OR</p> <p><u>Nonmalignant Changes By Pathology</u> In the case of a claim brought on behalf of a decedent, if representative lung tissue of the decedent is available, a report by a board-certified pathologist, stating that, to a reasonable</p>
<p>and with a statement by a board-certified pulmonary specialist or internist that, based upon a complete review of the claimant's entire medical record, to a reasonable degree of medical certainty, the asbestos-related changes are a substantial contributing factor to the pulmonary function changes.</p>	<p>and with a statement by a board-certified pulmonary specialist or internist that, based upon a complete review of the claimant's entire medical record, to a reasonable degree of medical certainty, the asbestos-related changes are a substantial contributing factor to the pulmonary function changes.</p>	<p>OR</p> <p><u>Nonmalignant Changes By Pathology</u> Representative lung tissue is available for which a report by a pathologist shows that to a reasonable degree of medical certainty more than one representative of lung tissue that</p>	<p>OR</p> <p><u>Nonmalignant Changes By Pathology</u> If a claim does not otherwise meet clinical criteria for activation, and if representative tissue is available, a report by a board-certified pathologist, stating that, to a reasonable</p>	<p>OR</p> <p><u>Nonmalignant Changes By Pathology</u> Upon exceptional circumstances and for good cause shown and upon notice to all parties, a party may by petition to the Court demonstrate actual impairment</p>	<p>OR</p>	<p>and with a statement by a board-certified pulmonary specialist or internist that, based upon a complete review of the claimant's entire medical record, to a reasonable degree of medical certainty, the asbestos-related changes are a substantial contributing factor to the pulmonary function changes.</p>	<p>OR</p> <p><u>Nonmalignant Changes By Pathology</u> Upon exceptional circumstances and for good cause shown and upon notice to all parties, a party may by petition to the Court demonstrate actual impairment</p>	

<p><u>Syracuse Inactive Docket</u> (Jan. 2003)</p>	<p>degree of medical probability, more than one representative section of lung tissue that was unaffected by any other process (e.g., cancer or emphysema) demonstrates a pattern of peribronchiolar or parenchymal scarring in the presence of a characteristic asbestos bodies, and that there is no other more likely explanation for the presence of fibrosis.</p>	<p>OR Cancer A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer in question is caused by asbestos exposure.</p>		
<p><u>New York City Inactive Docket</u> (Dec. 2002) (2002 WL 32151568)</p>	<p>degree of medical probability, more than one representative section of lung tissue that was unaffected by any other process (e.g., cancer or emphysema) demonstrates a pattern of peribronchiolar or parenchymal scarring in the presence of a characteristic asbestos bodies, and that there is no other more likely explanation for the presence of fibrosis.</p>	<p>OR Cancer A diagnosis of cancer caused by asbestos exposure, made to a reasonable degree of medical certainty by a pulmonologist, internist, oncologist, or pathologist.</p>		
<p><u>Portland, OR CMO</u> (Draft 2002)</p>	<p>is otherwise uninvolved with any other process (e.g. cancer or emphysema) demonstrates a pattern of peribronchiolar or parenchymal scarring in the presence of asbestos bodies, and for which there is no more likely explanation for the presence of fibrosis.</p>	<p>OR Cancer The plaintiff has been diagnosed with a malignancy attributed, at least in part, to the plaintiff's alleged exposure to asbestos.</p>		
<p><u>South Carolina CMO</u> (2002)</p>	<p>degree of medical probability, more than one representative section of lung tissue that is otherwise uninvolved with any other process (e.g., cancer or emphysema) demonstrate a pattern of peribronchiolar or parenchymal scarring in the presence of characteristic asbestos bodies, and that there is no other more likely explanation for the presence of the fibrosis.</p>	<p>OR Cancer A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist, or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer is caused by asbestos exposure.</p>		
<p><u>Baltimore, MD Inactive Docket</u> (Dec. 1992; amended Mar. 1993, Aug. 1993, and Apr. 1995) (1992 WL 12019620)</p>	<p>equal to or greater than that set forth in (1) and (2) above. Examples of the type of such evidence contemplated hereunder would include: (1) evidence of asbestosis determined pathologically, or (2) evidence that impairment due to interstitial fibrosis or pleural encasement is so severe that pulmonary function testing cannot be completed.</p>	<p>OR Cancer A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist, or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer is caused by asbestos exposure.</p>		
<p><u>Chicago, IL Inactive Docket</u> (Mar. 1991)</p>	<p>equal to or greater than that set forth in (1) and (2) above. Examples of the type of such evidence contemplated hereunder would include: (1) evidence of asbestosis determined pathologically, or (2) evidence that impairment due to interstitial fibrosis or pleural encasement is so severe that pulmonary function testing cannot be completed.</p>	<p>OR Cancer A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist, or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer is caused by asbestos exposure.</p>		
<p><u>Boston, MA Inactive Docket</u> (Sept. 1986; amended Sept. 1994)</p>	<p>equal to or greater than that set forth in (1) and (2) above. Examples of the type of such evidence contemplated hereunder would include: (1) evidence of asbestosis determined pathologically, or (2) evidence that impairment due to interstitial fibrosis or pleural encasement is so severe that pulmonary function testing cannot be completed.</p>	<p>OR Cancer A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist, or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer is caused by asbestos exposure.</p>		<p>OR Claimant Deceased If the claimant is deceased, as an alternative to the above proof of asbestosis, an appropriate diagnosis of pathological asbestosis greater than Grade 1B as defined in the <i>Archive of Pathology and Laboratory Medicine</i>, Asbestos-Associated Diseases, Vol. 106, No. 11, App. 3 (Oct. 8, 1982).</p>

<p>St. Clair County, IL <u>Inactive Docket</u> (Feb. 2005)</p> <p>Satisfaction of the ABA Standard for Non-Malignant Asbestos-Related Disease Claims (2003) as evidenced by a detailed narrative Medical Report and Diagnosis signed by the diagnosing doctor, verifying all of the following:</p>	<p>Portsmouth, VA <u>Inactive Docket</u> (Aug. 2004)</p> <p>Asbestosis/Nonmalignant I Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/0; and pulmonary function testing that, in the opinion of a board-certified pulmonary specialist or internist, shows either:</p> <p>(1) FVC < 80% of predicted with FEV-1/FVC > 60% (actual value), or (2) TLC < 80% of predicted.</p>	<p>Ohio Am. Sub. H.B. 292, 125th Gen. Assem., Reg. Sess. (June 2004) (codified at Ohio Rev. Code § 2307.91 et seq. (Andersen 2005))</p> <p>Nonmalignant Conditions No person shall bring or maintain an asbestos tort action based on a nonmalignant condition in the absence of a prima-facie showing that the exposed person has a physical impairment as a result of a medical condition, and that person's exposure to asbestos was a substantial contributing factor to the medical condition. That prima-facie showing shall include the following:</p> <p>(1) Evidence verifying that a competent medical authority has taken a detailed occupational and exposure history of the exposed person from the exposed person or, if that person is deceased, from the person who is most knowledgeable about the exposures that form the basis of the asbestos claim for a nonmalignant condition, including all of the following: (a) All of the exposed person's principal places of employment and exposures to airborne contaminants; (b) Whether each principal place of employment involved exposures to airborne contaminants, including, but not limited to, asbestos fibers or other disease causing dusts, that can cause pulmonary impairment and, if that type of exposure is involved, the general nature, duration, and general level of the exposure; and (2) Evidence verifying that a competent medical authority has taken a detailed medical and smoking history, including a thorough review of the person's past and present medical problems and the most probable causes of those medical problems.</p>	<p>King County (Seattle), WA CMO (Feb. 2004)</p> <p>A plaintiff alleging non-malignant asbestos-related disease shall file the following report in order to be considered for immediate inclusion in a trial group or to receive a trial date:</p>	<p>Madison County, IL <u>Inactive Docket</u> (Jan. 2004)</p> <p>Satisfaction of the ABA Standard for Non-Malignant Asbestos-Related Disease Claims (2003) as evidenced by a detailed narrative Medical Report and Diagnosis signed by the diagnosing doctor, verifying all of the following:</p>	<p>ABA Standard For Non-Malignant Asbestos-Related Disease Claims (Feb. 2003)</p> <p>The filing of any civil action alleging asbestos-related non-malignant disease must be accompanied by a narrative Medical Report and Diagnosis signed by the diagnosing doctor verifying that:</p>
<p>History. That the doctor or a medical professional employed by and under the direct supervision and control of the diagnosing doctor has taken: (1) a detailed occupational and exposure history from the person ("claimant") whose alleged injury forms the basis for the action or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the principal employments and exposures of the claimant involving exposures to airborne contaminants. It should indicate whether each employment involved exposure to airborne contaminants (including, but not limited to, asbestos fibers, and other disease causing dusts) that can cause pulmonary impairment and the nature, duration, and level of any such exposure; and (2) a detailed medical and smoking history that includes a thorough review of the claimant's past and present medical problems, and their most probable cause.</p>	<p>History. That the doctor or a medical professional employed by and under the direct supervision and control of the diagnosing doctor has taken: (1) a detailed occupational and exposure history from the person ("claimant") whose alleged injury forms the basis for the action or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the principal employments and exposures of the claimant involving exposures to airborne contaminants. It should indicate whether each employment involved exposure to airborne contaminants (including, but not limited to, asbestos fibers, and other disease causing dusts) that can cause pulmonary impairment and the nature, duration, and level of any such exposure; and (2) a detailed medical and smoking history that includes a thorough review of the claimant's past and present medical problems, and their most probable cause.</p>	<p>History. The plaintiff has a reliable history of exposure to asbestos fibers. The occupational history and tobacco use history shall be detailed as recommended in Section 5.3 of Chapter 5, The Respiratory System, The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, or most current edition.</p>	<p>History. That the doctor or a medical professional employed by and under the direct supervision and control of the diagnosing doctor has taken: (1) a detailed occupational and exposure history from the person ("claimant") whose alleged injury forms the basis for the action or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the principal employments and exposures of the claimant involving exposures to airborne contaminants. It should indicate whether each employment involved exposure to airborne contaminants (including, but not limited to, asbestos fibers, and other disease causing dusts) that can cause pulmonary impairment and the nature, duration, and level of any such exposure; and (2) a detailed medical and smoking history that includes a thorough review of the claimant's past and present medical problems, and their most probable cause.</p>	<p>History. The doctor or a medical professional employed by and under the direct supervision and control of the diagnosing doctor has taken: (1) A detailed occupational and exposure history from the person whose alleged injury forms the basis for the action or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the principal employments and exposures of the claimant involving exposures to airborne contaminants. It should indicate whether each employment involved exposure to airborne contaminants (including, but not limited to, asbestos fibers, and other disease causing dusts) that can cause pulmonary impairment and the nature, duration, and level of any such exposure; and (2) A detailed medical and smoking history that includes a thorough review of the claimant's past and present medical problems, and their most probable cause.</p>	

<p><u>St. Clair County, IL</u> <u>Inactive Docket</u> <u>(Feb. 2005)</u></p> <p><u>Latency</u> At least 15 years have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p>	<p><u>Portsmouth, VA</u> <u>Inactive Docket</u> <u>(Aug. 2004)</u></p> <p><u>OR</u> <u>Nonmalignant II</u> Chest x-rays which, in the opinion of a currently certified B-reader, show small irregular opacities of ILO grade 1/1 or greater; and pulmonary function testing that, in the opinion of a board-certified pulmonary specialist or internist, shows either: (1) FVC < 80% of predicted with FEV-1/FVC > than 65% (actual value), or (2) TLC < 80% of predicted.</p>	<p><u>Ohio Am. Sub. H.B. 292,</u> <u>125th Gen. Assem., Reg. Sess.</u> <u>(June 2004) (codified at Ohio Rev. Code</u> <u>§ 2307.91 et seq. (Andersen 2005)</u></p> <p><u>(Impairment)</u> A diagnosis by a competent medical authority, based on a medical examination and pulmonary function testing of the exposed person, that all of the following apply to the exposed person: (1) The exposed person has a permanent respiratory impairment rating of at least class 2 as defined by and evaluated pursuant to the AMA guides to the evaluation of permanent impairment; and (2) Either of the following: (a) The exposed person has asbestosis or diffuse pleural thickening, based at a minimum on radiological or pathological evidence of asbestosis or radiological evidence of diffuse pleural thickening. The asbestosis or diffuse pleural thickening, rather than solely chronic obstructive pulmonary disease, is a substantial contributing factor to the exposed person's physical impairment, based at a minimum on a determination that the exposed person has any of the following: (i) FVC below the predicted lower limit of normal and a ratio of FEV-1/FVC that is greater than or equal to the predicted lower limit of normal; (ii) TLC, by plethysmography or timed gas dilution, below the predicted lower limit of normal; (iii) A chest x-ray showing small, irregular opacities (s, t) graded by a certified B-reader at least 2/1 on the ILO scale; or (b) If the exposed person has a chest x-ray showing small, irregular opacities (s, t) graded by a certified B-reader as only a 1/0 on the ILO scale, then in order to</p>	<p><u>King County (Seattle), WA</u> <u>CMO</u> <u>(Feb. 2004)</u></p> <p><u>Latency</u> There is an appropriate time interval between the exposure and the detection of disease, given the type of asbestos fiber and the magnitude and duration of exposure. (For asbestos-related non-malignant disease, the usual latency period is more than 15 years. However, benign asbestos-related pleural effusion may occur less than 10 years following initial exposure).</p>	<p><u>Madison County, IL</u> <u>Inactive Docket</u> <u>(Jan. 2004)</u></p> <p><u>Latency</u> At least 15 years have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p>	<p><u>ABA Standard For Non-Malignant</u> <u>Asbestos-Related Disease Claims</u> <u>(Feb. 2003)</u></p> <p><u>Latency</u> At least 15 years have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p>
--	---	---	--	--	--

<p><u>St. Clair County, IL</u> <u>Inactive Docket</u> <u>(Feb. 2005)</u></p>	<p><u>Portsmouth, VA</u> <u>Inactive Docket</u> <u>(Aug. 2004)</u></p>	<p><u>Ohio Am. Sub. H.B. 292,</u> <u>125th Gen. Assem., Reg. Sess.</u> <u>(June 2004) (codified at Ohio Rev. Code</u> <u>§ 2307.91 et seq. (Andersen 2005)</u></p>	<p><u>King County (Seattle), WA</u> <u>CMO</u> <u>(Feb. 2004)</u></p>	<p><u>Madison County, IL</u> <u>Inactive Docket</u> <u>(Jan. 2004)</u></p>	<p><u>ABA Standard For Non-Malignant</u> <u>Asbestos-Related Disease Claims</u> <u>(Feb. 2003)</u></p>
<p>That the claimant has: (1) A quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiological findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded b2 or higher or bilateral diffuse pleural thickening graded b2 or higher including blunting of the costophrenic angle; or (2) Pathological asbestosis graded 1(B) or higher under the criteria published in the <i>Asbestos-Associated Diseases</i>, Special Issue of the Archives of Pathological and Laboratory Medicine, Vol. 106, Number 11, App. 3 (October 8, 1982).</p>	<p>OR Bilateral Pleural Thickening Chest x-rays which, in the opinion of a currently certified B-reader, to a reasonable degree of medical certainty, demonstrate bilateral asbestos-related pleural thickening which has an ILO grade B2 or greater and with pulmonary testing that, in the opinion of a board-certified pulmonary specialist or internist, to a reasonable degree of medical certainty shows either: (1) FVC < 80% of predicted with FEV-1/FVC > 68% (actual value), or (2) TLC < 80% of predicted, and with a statement by a board-certified pulmonary specialist or internist that, based upon a complete review of the claimant's entire medical record, to a reasonable degree of medical certainty, the asbestos-</p>	<p>establish that the exposed person has asbestosis, rather than solely chronic obstructive pulmonary disease, that is a substantial contributing factor to the exposed person's physical impairment the plaintiff must establish that the exposed person has both of the following: (1) FVC below the predicted lower limit of normal and a ratio of FEV1 to FVC that is equal to or > the predicted lower limit of normal; (II) TLC, by plethysmography or timed gas dilution, below the predicted lower limit of normal. No person shall bring or maintain a tort action alleging an asbestos claim based upon lung cancer of an exposed person who is a smoker, in the absence of a prima-facie showing that the exposed person has a physical impairment as a result of a medical condition, and that the person's exposure to asbestos is a substantial contributing factor to the medical condition. That prima-facie showing shall include all of the following minimum requirements: (1) A diagnosis by a competent medical authority that the exposed person has primary lung cancer and that exposure to asbestos is a substantial contributing factor to that cancer; (2) Evidence that is sufficient to demonstrate that at least 10 years have elapsed from the date of the exposed person's first exposure to asbestos until the date of diagnosis of the exposed person's primary lung cancer. The 10-year latency period described in this division is a rebuttable presumption, and</p>	<p>Radiographic Imaging Chest x-rays shall be quality 1 or quality 2 if a film is not available, per the 1980 Guidelines for the Use of ILO Classification of Radiographs of Pneumoconiosis. The reading shall be performed by a NIOSH certified B-reader. (1) With regard to pulmonary asbestosis, there is evidence of type "s," "t," or "u" small irregular opacifications of a profusion of 1/0 or greater. (2) With regard to pleural plaques, there is evidence of calcification within the plaques, or in the case of non-calcified plaques, there is a chest CT scan confirming the presence of true fibrous pleural plaquing (as opposed to extra-pleural fat shadowing), and there is no alternative explanation for the plaques, such as old chest trauma, tuberculosis, emphysema, or other prior medical condition not related to asbestos exposure.</p>	<p>That the claimant has: (1) A quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiological findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 1/0 or higher or bilateral diffuse pleural thickening graded b2 or higher including blunting of the costophrenic angle; or (2) Pathological asbestosis graded 1(B) or higher under the criteria published in the <i>Asbestos-Associated Diseases</i>, Special Issue of the Archives of Pathological and Laboratory Medicine, Vol. 106, Number 11, App. 3 (October 8, 1982).</p>	<p>Radiographic Imaging (1) The claimant has a quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiologic findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 2/1 or higher including blunting of the costophrenic angle; or (2) Pathological asbestosis graded 1(B) or higher under the criteria published in the <i>Asbestos-Associated Diseases</i>, Special Issue of the Archives of Pathological and Laboratory Medicine, Vol. 106, No. 11, App. 3 (October 8, 1982).</p>

<p><u>St. Clair County, IL</u> <u>Inactive Docket</u> <u>(Feb. 2005)</u></p>	<p><u>Portsmouth, VA</u> <u>Inactive Docket</u> <u>(Aug. 2004)</u></p> <p>related changes are a substantial contributing factor to the pulmonary function changes.</p>	<p><u>Ohio Am. Sub. H.B. 292,</u> <u>125th Gen. Assem., Reg. Sess.</u> <u>(June 2004) (codified at Ohio Rev. Code</u> <u>§ 2307.91 et seq. (Andersen 2005)</u></p> <p>the plaintiff has the burden of proof to rebut the presumption; and (3) Either of the following: (i) Evidence of the exposed person's substantial occupational exposure to asbestos asbestos (i.e., the exposed person was employed for at least 5 years in an occupation in which, for a substantial portion of a normal work year, the person was exposed to asbestos fibers or worked in close proximity to persons handling asbestos or working in a manner that exposed them to asbestos fibers); or (ii) Evidence of the exposed person's exposure to asbestos at least equal to 25 fiber per cc years as determined to a reasonable degree of scientific probability by a scientifically valid retrospective exposure reconstruction conducted by a certified industrial hygienist or certified safety professional based upon all reasonably available quantitative air monitoring data and all other reasonably available information about the exposed person's occupational history and history of exposure to asbestos.</p> <p>If a plaintiff alleges an asbestos claim based upon lung cancer of an exposed person who is a smoker, alleges that the plaintiff's exposure to asbestos was the result of living with another person who, if the tort action had been filed by the other person, would have met the exposure requirements specified in this section, and alleges that the plaintiff lived with the other person during which time the exposed person was employed for at least 5 years in an occupation in which, for a substantial portion of a normal work</p>	<p><u>King County (Seattle), WA</u> <u>CMO</u> <u>(Feb. 2004)</u></p> <p>(3) With regard to pleural thickening, either unilateral or bilateral, there is evidence of thickening graded a2 or higher, with or without extension into the costophrenic angle, and the thickening is confirmed by CT scan. (4) With regard to pleural effusion, there is evidence of effusion, either unilateral or bilateral, confirmed by either lateral decubitus films or chest CT scan.</p>	<p><u>Madison County, IL</u> <u>Inactive Docket</u> <u>(Jan. 2004)</u></p>	<p><u>ABA Standard For Non-Malignant</u> <u>Asbestos-Related Disease Claims</u> <u>(Feb. 2003)</u></p>
--	--	---	---	--	--

<p>St. Clair County, IL <u>Inactive Docket</u> (Feb. 2005)</p>	<p>Portsmouth, VA <u>Inactive Docket</u> (Aug. 2004)</p>	<p>Ohio Am. Sub. H.B. 292, 125th Gen. Assem., Reg. Sess. (June 2004) (codified at Ohio Rev. Code § 2307.91 et seq. (Andersen 2005))</p> <p>year, the person was exposed to asbestos fibers or worked in close proximity to persons handling asbestos or working in a manner that exposed them to asbestos fibers, the plaintiff is considered as having satisfied the requirements above pertaining to evidence of exposure.</p>	<p>King County (Seattle), WA CMO (Feb. 2004)</p>	<p>Madison County, IL <u>Inactive Docket</u> (Jan. 2004)</p>	<p>ABA Standard For Non-Malignant Asbestos-Related Disease Claims (Feb. 2003)</p>
<p>Impairment That the claimant has asbestos-related pulmonary impairment as demonstrated by pulmonary function testing, performed using equipment, methods of calibration and technique that meet the criteria incorporated in the AMA Guides to the Evaluation of Permanent Impairment (5th ed.) and reported as set forth in 20 CFR 404, Subpt. P, App 1, Part (A) §3.00 (E) and (F), and the interpretative standards set forth in the Official ATS Statement entitled "Lung Function Testing: Selection of Reference Values and Interpretive Strategies" as published in Am. Rev. Resp. Dis. 1991:144:1202-1218 that shows: (1) FVC below the lower limit of normal and FEV1/FVC ratio (using actual values) at or above the lower limit of normal; or (2) TLC, by plethysmography or timed gas dilution, below the lower limit of normal. (3) Where the pulmonary function test results do not meet the requirements set forth [above], a claimant may submit an additional report, by a board certified pulmonologist, internist or occupational physician that states that:</p>	<p>Wrongful Death No person shall bring or maintain an asbestos wrongful death claim in the absence of a prima-facie showing that the death of the exposed person was the result of a physical impairment, that the death and physical impairment were a result of a medical condition, and that the deceased person's exposure to asbestos was a substantial contributing factor to the medical condition. That prima-facie showing shall include all of the following minimum requirements: (1) A diagnosis by a competent medical authority that exposure to asbestos was a substantial contributing factor to the death of the exposed person; (2) Evidence that is sufficient to demonstrate that at least 10 years have elapsed from the date of the deceased exposed person's first exposure to asbestos until the date of diagnosis or death of the deceased exposed person. The 10-year latency period described in this division is a rebuttable presumption, and the plaintiff has the burden of proof to rebut the presumption; and (3) Either of the following: (i) Evidence of the deceased exposed person's substantial occupational exposure to asbestos (i.e., the exposed person was employed for at least 5 years in an occupation in which, for a substantial portion of a normal work year,</p>	<p>Impairment (1) Overall Respiratory Impairment shall be Class 2, 3 or 4 according to the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 5. (2) If the overall permanent respiratory impairment is Class 2, 3 or 4, then the examiner shall indicate whether the impairment is due wholly, partly, or not at all to an asbestos-related condition. If a coexisting or preexisting condition is present, that condition shall be specified in the report. The examiner shall indicate what portion of the overall condition is due to asbestos-related disease vs. any coexisting condition. (3)(a) If only asbestos-related disease is present, in addition to chest X-ray, documentation shall include pre- and post-bronchodilator spirometry conforming to the 1994 ATS Statement of Standardized Spirometry. If objective impairment is manifested only by a reduced lung diffusing capacity (DLCOsb), additional confirmatory evidence, in the form of a high resolution CT scan (HRCT) shall be provided, and a cardiopulmonary exercise test shall be performed if the single breath diffusing capacity is below 60% of</p>	<p>Impairment That the claimant has asbestos-related pulmonary impairment as demonstrated by pulmonary function testing, performed using equipment, methods of calibration and technique that meet the criteria incorporated in the AMA Guides to the Evaluation of Permanent Impairment (5th ed.) and reported as set forth in 20 CFR 404, Subpt. P, App 1, Part (A) §3.00 (E) and (F), and the interpretative standards set forth in the Official ATS Statement entitled "Lung Function Testing: Selection of Reference Values and Interpretive Strategies" as published in Am. Rev. Resp. Dis. 1991:144:1202-1218 that shows: (1) FVC below the lower limit of normal and FEV1/FVC ratio (using actual values) at or above the lower limit of normal; or (2) TLC, by plethysmography or timed gas dilution, below the lower limit of normal. (3) Where the pulmonary function test results do not meet the requirements set forth [above], a claimant may submit an additional report, by a board certified pulmonologist, internist or occupational physician that states that:</p>	<p>Impairment The claimant has asbestos-related pulmonary impairment as demonstrated by Pulmonary Function Testing, performed using equipment, methods of calibration and technique that meet the criteria incorporated in the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.) and reported as set forth in 20 CFR 404, Subpt. P, App 1, Part (A) §3.00 (E) and (F), and the interpretative standards set forth in the Official Statement of the American Thoracic Society entitled "Lung Function Testing: Selection of Reference Values And Interpretive Strategies," as published in Am. Rev. Resp. Dis. 1991:144:1202-1218 that shows: (1) FVC below the lower limit of normal and FEV1/FVC ratio (using actual values) at or above the lower limit of normal; or (2) TLC, by plethysmography or timed gas dilution, below the lower limit of normal. Where the Pulmonary Function Test results do not meet the requirements above, a claimant may submit an additional report, by a board certified pulmonologist, internist or occupational physician that states:</p>	<p>Impairment The claimant has asbestos-related pulmonary impairment as demonstrated by Pulmonary Function Testing, performed using equipment, methods of calibration and technique that meet the criteria incorporated in the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.) and reported as set forth in 20 CFR 404, Subpt. P, App 1, Part (A) §3.00 (E) and (F), and the interpretative standards set forth in the Official Statement of the American Thoracic Society entitled "Lung Function Testing: Selection of Reference Values And Interpretive Strategies," as published in Am. Rev. Resp. Dis. 1991:144:1202-1218 that shows: (1) FVC below the lower limit of normal and FEV1/FVC ratio (using actual values) at or above the lower limit of normal; or (2) TLC, by plethysmography or timed gas dilution, below the lower limit of normal. Where the Pulmonary Function Test results do not meet the requirements above, a claimant may submit an additional report, by a board certified pulmonologist, internist or occupational physician that states:</p>

<p>St. Clair County, IL <u>Inactive Docket</u> (Feb. 2005)</p>	<p>Portsmouth, VA <u>Inactive Docket</u> (Aug. 2004)</p>	<p>Ohio Am. Sub. H.B. 292, 125th Gen. Assem., Reg. Sess. (June 2004) (codified at Ohio Rev. Code § 2307.91 et seq. (Andersen 2005)</p>	<p>King County (Seattle), WA CMO (Feb. 2004)</p>	<p>Madison County, IL <u>Inactive Docket</u> (Jan. 2004)</p>	<p>ABA Standard For Non-Malignant Asbestos-Related Disease Claims (Feb. 2003)</p>
<p>(a) The doctor has a doctor/patient relationship with the claimant; and (b) The claimant has: a quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiological findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 2/1 or higher; and (c) The claimant has restrictive impairment from asbestosis and set forth in detail the specific pulmonary function test findings that the doctor relies upon to establish that the claimant has restrictive impairment; and (d) The physician shall submit the reports and readouts from all pulmonary function, lung Vol., diffusing capacity or other testing relied upon for the report's conclusions. Such tests must comply with the equipment, quality and reporting standards set forth herein.</p>		<p>the person was exposed to asbestos fibers or worked in close proximity to persons handling asbestos or working in a manner that exposed them to asbestos fibers); or (ii) Evidence of the deceased exposed person's exposure to asbestos at least equal to 25 fiber per cc years as determined to a reasonable degree of scientific probability by a scientifically valid retrospective exposure reconstruction conducted by a certified industrial hygienist or certified safety professional based upon all reasonably available quantitative air monitoring data and all other reasonably available information about the deceased exposed person's occupational history and history of exposure to asbestos.</p>	<p>predicted. (3)(b) If a coexisting or preexisting condition is present HRCT scan and lung Vol. measurements shall be provided. The presence of obstructive patterns of pulmonary function shall be interpreted as evidence of a condition other than asbestos-related disease, unless a pattern of "small airways dysfunction" is seen in a patient without a history of tobacco use or asthma. (4) All lung function and other tests that support the impairment rating shall be included in the report.</p>	<p>(a) The doctor has a doctor/patient relationship with the claimant; and (b) The claimant has: a quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiological findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 2/1 or higher; and (c) The claimant has restrictive impairment from asbestosis and set forth in detail the specific pulmonary function test findings that the doctor relies upon to establish that the claimant has restrictive impairment; and (d) The physician shall submit the reports and readouts from all pulmonary function, lung Vol., diffusing capacity or other testing relied upon for the report's conclusions. Such tests must comply with the equipment, quality and reporting standards set forth herein.</p>	<p>(1) That the doctor has a doctor/patient relationship with the claimant; and (2) That the claimant has: a quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards (in a death case where no pathology is available, the necessary radiological findings may be made with a quality 2 film if a quality 1 film is not available), and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 2/1 or higher; and (3) That the claimant has restrictive impairment from asbestosis and set forth in detail the specific pulmonary function test findings that the doctor relies upon to establish that the claimant has restrictive impairment; and (4) That the physician shall submit the reports and readouts from all pulmonary function, lung Vol., diffusing capacity or other testing relied upon for the report's conclusions. Such tests must comply with the equipment, quality and reporting standards set forth herein.</p>
		<p>Mesothelioma No prima-facie showing is required for a mesothelioma claim.</p>	<p>Causation (1) The treating pulmonologist or occupational medicine specialist shall state, to a reasonable degree of medical probability, that the patient's asbestos exposure was a substantial factor in causing the patient's asbestos-related disease. A statement that radiographic findings</p>		<p>Causation Verifies that the doctor has concluded that the claimant's medical findings and impairment were not more probably the result of other causes revealed by claimant's employment and medical history.</p>

<p><u>St. Clair County, IL</u> <u>Inactive Docket</u> <u>(Feb. 2005)</u></p>	<p><u>Portsmouth, VA</u> <u>Inactive Docket</u> <u>(Aug. 2004)</u></p>	<p><u>Ohio Am. Sub. H.B. 292,</u> <u>125th Gen. Assem., Reg. Sess.</u> <u>(June 2004) (codified at Ohio Rev. Code</u> <u>§ 2307.91 et seq. (Andersen 2005))</u></p>	<p><u>King County (Seattle), WA</u> <u>CMO</u> <u>(Feb. 2004)</u></p>	<p><u>Madison County, IL</u> <u>Inactive Docket</u> <u>(Jan. 2004)</u></p>	<p><u>ABA Standard For Non-Malignant</u> <u>Asbestos-Related Disease Claims</u> <u>(Feb. 2003)</u></p>
<p>An asbestos-related malignancy.</p>	<p>other process (e.g., cancer or emphysema) demonstrate a pattern of peribronchiolar or parenchymal scarring in the presence of characteristic asbestos bodies, and that there is no other more likely explanation for the presence of the fibrosis.</p>	<p>may be confirmed by surgical pathology (biopsy or lung resection) report or necropsy (autopsy) report by a board certified pathologist, or by an operative report of an operating surgeon.</p>	<p>may be confirmed by surgical pathology (biopsy or lung resection) report or necropsy (autopsy) report by a board certified pathologist, or by an operative report of an operating surgeon.</p>	<p>may be confirmed by surgical pathology (biopsy or lung resection) report or necropsy (autopsy) report by a board certified pathologist, or by an operative report of an operating surgeon.</p>	<p>may be confirmed by surgical pathology (biopsy or lung resection) report or necropsy (autopsy) report by a board certified pathologist, or by an operative report of an operating surgeon.</p>
<p>OR Cancer</p> <p>An asbestos-related malignancy.</p>	<p>OR Cancer</p> <p>A diagnosis of cancer, which is demonstrated by a medical report of a board-certified internist, pulmonary specialist, oncologist or pathologist showing the diagnosis as a primary cancer, which states to a reasonable degree of medical certainty that the cancer in question is caused by asbestos exposure.</p>	<p>OR Cancer</p> <p>An asbestos-related malignancy.</p>	<p>OR Cancer</p> <p>An asbestos-related malignancy.</p>	<p>OR Cancer</p> <p>An asbestos-related malignancy.</p>	<p>OR Cancer</p> <p>An asbestos-related malignancy.</p>
<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>	<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>	<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>	<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>	<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>	<p>OTHER</p> <p>History</p> <p>Must provide detailed occupational and exposure history by diagnosing doctor. Plaintiff also must provide a detailed medical and smoking history, including a thorough review of past and present medical problems and their most probable causes.</p> <p>Latency</p> <p>At least 15 years must have elapsed between the claimant's first exposure to asbestos and the time of diagnosis.</p> <p>Radiographic Imaging</p>

<p><u>St. Clair County, IL</u> <u>Inactive Docket</u> <u>(Feb. 2005)</u></p>	<p><u>Portsmouth, VA</u> <u>Inactive Docket</u> <u>(Aug. 2004)</u></p>	<p><u>Ohio Am. Sub. H.B. 292,</u> <u>125th Gen. Assem., Reg. Sess.</u> <u>(June 2004) (codified at Ohio Rev. Code</u> <u>§ 2307.91 et seq. (Andersen 2005)</u></p>	<p><u>King County (Seattle), WA</u> <u>CMO</u> <u>(Feb. 2004)</u></p>	<p><u>Madison County, IL</u> <u>Inactive Docket</u> <u>(Jan. 2004)</u></p>	<p><u>ABA Standard For Non-Malignant</u> <u>Asbestos-Related Disease Claims</u> <u>(Feb. 2003)</u></p>
<p>Chest X-rays shall be quality 1 film per the "1980 or 2000" Guidelines for the Use of ILO Classification of Radiographs of Pneumococcosis.</p>					

<p><u>Ga. Sen. Comm. Sub. to H.B. 416, 2005-2006 Legis. Sess. (2005)</u></p>	<p><u>Nonmalignant Conditions</u> No person shall bring or maintain an asbestos tort action based on a nonmalignant condition in the absence of a prima-facie showing that the exposed person has a physical impairment as a result of a medical condition for which exposure to asbestos was a substantial contributing factor. To make out a prima-facie claim, a board certified internist, pulmonologist, or pathologist must sign a detailed narrative medical report and diagnosis stating that the exposed person suffers from a nonmalignant disease related to asbestos. In addition, the report shall:</p>	<p><u>(History)</u> Verify that the doctor signing the narrative medical report and diagnosis or a medical professional employed by and under the direct supervision of that doctor has taken (1) a detailed occupational and exposure history from the exposed person or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the exposed person's principal employments and his or her exposures to airborne contaminants that can cause pulmonary impairment, including, but not limited to, asbestos, silica, and other disease-causing dusts, and the nature, duration, and level of any such exposure; and (2) a detailed medical and smoking history that includes a thorough</p>
--	--	--

<p><u>Ga. Sen. Comm. Sub. to H.B. 416, 2005-2006 Legis. Sess. (2005)</u></p>	<p>review of the exposed person's past and present medical problems, and their most probable cause.</p>
<p><u>(Latency)</u> Set out the details of the occupational, medical, and smoking histories and verify that at least 15 years have elapsed between the person's first exposure to asbestos and the time of diagnosis.</p>	<p><u>(Radiographic Imaging)</u> Verify that the exposed person has: (1) an ILO quality 1 chest x-ray taken in accordance with all applicable state and federal regulatory standards, and that the x-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral small irregular opacities (s, t, or u) graded 1/1 or higher or bilateral graded 1/1 or higher or bilateral diffuse pleural thickening graded b2 or higher including blunting of the costophrenic angle; provided, however, that in a death case where no pathology is available, the necessary radiologic findings may be made with a quality 2 film if a quality 1 film is not available; or (2) pathological asbestosis graded 1(B) or higher under the criteria published in the Asbestos-Associated Diseases, Special Issue of the <i>Archives of Pathological and Laboratory Medicine</i>, Vol. 106, Number 11, App. 3, as amended from time to time.</p>

<p><u>Ga. Sen. Comm. Sub. to H.B. 416, 2005-2006 Legis. Sess. (2005)</u></p>	<p>(Impairment) Verify that the exposed person has pulmonary impairment related to asbestos as demonstrated by pulmonary function testing, performed using equipment, methods of calibration and techniques that meet the criteria incorporated in the AMA Guides to the Evaluation of Permanent Impairment (5th ed.), and reported as set forth in 20 CFR 404, Subpt. P, App 1, Part (A) §3.00 (E) and (F), as amended from time to time by the AMA, and the interpretative standards of the American Thoracic Society, "Lung Function Testing: Selection of Reference Values and Interpretive Strategies," 144 Am. Rev. Resp. Dis. 1202-1218 (1991), as amended from time to time by the American Thoracic Society, that shows: (1) FVC below the lower limit of normal and FEV1/FVC ratio (using actual values) at or above the lower limit of normal; and (2) TLC, by plethysmography or timed gas dilution, below the lower limit of normal.</p>	<p>(Causation) Verify that the doctor signing the detailed narrative report and diagnosis has concluded that exposure to asbestos was a substantial contributing factor to the exposed person's medical condition and physical impairment and that they were not more probably the result of other causes revealed by the exposed person's employment and medical histories.</p>
--	---	---

Ga. Sen. Comm. Sub. to H.B. 416,
2005-2006 Legis. Sess.
(2005)

Lung Cancer

No person shall bring or maintain an asbestos tort action based on a malignant condition in the absence of a prima-facie showing that a board certified pathologist has made a diagnosis of pleural or peritoneal mesothelioma, or a diagnosis of cancer demonstrated by a medical report showing the diagnosis as a primary cancer, and the pathologist has signed a report certifying to a reasonable degree of medical certainty that exposure to asbestos was a substantial contributing factor to the diagnosed cancer and that it was not more probably the result of causes other than the asbestos exposure revealed by the exposed person's employment and medical histories.

APPENDIX B

<p><u>Ca. H.B. 416, 2005-2006</u> <u>Legis. Sess. (2005)</u></p>	<p><u>Ohio Am. Sub. H.B. 342</u> <u>125th Gen. Assem., Reg. Sess. (2004)</u> <u>(codified at Ohio Rev. Code. § 2307.84 et seq.</u> <u>(Anderson 2005))</u></p>
<p>Nonmalignant Conditions No person shall bring or maintain a silica tort action based on a nonmalignant condition in the absence of a prima-facie showing that the exposed person has a physical impairment as a result of a medical condition for which exposure to silica was a substantial contributing factor. To make out a prima-facie claim, a board certified internist, pulmonologist, or pathologist must sign a detailed narrative medical report and diagnosis stating that the exposed person suffers from a nonmalignant disease related to silicosis. In addition, the report shall:</p>	<p>Nonmalignant Conditions No person shall bring or maintain a tort action alleging a silicosis claim based on a nonmalignant condition in the absence of a prima-facie showing that the exposed person has a physical impairment that is a result of a medical condition for which the person's exposure to silica is a substantial contributing factor. "Substantial contributing factor" means (1) exposure to silica or mixed dust is the predominate cause of the physical impairment alleged in the silicosis claim or mixed dust disease claim, whichever is applicable; and (2) a competent medical authority has determined with a reasonable degree of medical certainty that without the silica or mixed dust exposures the physical impairment of the exposed person would not have occurred. The prima-facie showing shall include the following:</p>
<p>(History) Verify that the doctor signing the narrative medical report and diagnosis or a medical professional employed by and under the direct supervision of that doctor has taken (1) a detailed occupational and exposure history from the exposed person or, if that person is deceased, from the person most knowledgeable about the exposures that form the basis for the action. The history shall include all of the exposed person's principal employments and his or her exposures to airborne contaminants that can cause pulmonary impairment, including, but not limited to, asbestos, silica, and other disease-causing dusts, and the nature, duration, and level of any such exposure; and (2) a detailed medical and smoking history that includes a thorough review of the exposed person's past and present medical problems and their most probable cause.</p>	<p>(History) (1) Evidence verifying that a competent medical authority has taken a detailed occupational and exposure history of the exposed person from the exposed person or, if that person is deceased, from the person who is most knowledgeable about the exposures that form the basis of the silicosis claim for a nonmalignant condition, including all of the following: (a) all of the exposed person's principal places of employment and exposures to airborne contaminants; and (b) whether each principal place of employment involved exposures to airborne contaminants, including, but not limited to, silica or other disease causing dusts, that can cause pulmonary impairment and, if that type of exposure is involved, the general nature, duration, and general level of exposure. (2) Evidence verifying that a competent medical authority has taken a detailed medical and smoking history of the exposed person, including a thorough review of the exposed person's past and present medical problems and the most probable causes of those medical problems.</p>

<p><u>Ga. H.B. #16, 2005-2006</u> <u>Legis. Sess. (2005)</u></p> <p>(Latency)</p> <p>Set out the details of the occupational, medical, and smoking histories and verifies a sufficient latency period for the applicable stage of silicosis.</p>	<p><u>Ohio Am. Sub. H.B. 342</u> <u>125th Gen. Assem., Reg. Sess. (2004)</u> <u>(codified at Ohio Rev. Code § 2307.84 et seq. (Anderson 2005))</u></p> <p>(Impairment)</p> <p>A diagnosis by a competent medical authority, based on a medical examination and pulmonary function testing of the exposed person, that both of the following apply to the exposed person:</p> <p>(a) the exposed person has a permanent respiratory impairment rating of at least class 2, as defined by and evaluated pursuant to the AMA guides to the evaluation of permanent impairment; and</p> <p>(b) the exposed person has silicosis based at a minimum on radiological or pathological evidence of silicosis.</p>
<p>(Radiographic Imaging)</p> <p>Verify that the exposed person has:</p> <p>(1) An ILO quality 1 chest X-ray taken in accordance with all applicable state and federal regulatory standards, and that the X-ray has been read by a certified B-reader according to the ILO system of classification as showing bilateral nodular opacities (p, q, or r) occurring primarily in the upper lung fields, graded 1/1 or higher; provided, however, that in a death case where no pathology is available, the necessary radiologic findings may be made with a quality 2 film if a quality 1 film is not available; or</p> <p>(2) Pathological demonstration of classic silicotic nodules exceeding 1 centimeter in diameter as set forth in <i>Archives of Pathological & Laboratory Medicine</i>, July, 1988, as amended from time to time.</p>	<p>"Pathological evidence of silicosis" means a statement by a board-certified pathologist that more than one representative section of lung tissue uninvolved with any other disease process demonstrates a pattern of round silica nodules and birefringent crystals or other demonstration of crystal structures consistent with silica (well-organized concentric whorls of collagen surrounded by inflammatory cells) in the lung parenchyma and that there is no other more likely explanation for the presence of the fibrosis.</p> <p>"Radiological evidence of silicosis" means a chest x-ray showing bilateral small rounded opacities (p, q, or r) in the upper lung fields graded by a certified B-reader as at least 1/1 on the ILO scale.</p>

<p><u>Ga. H.B. 416, 2005-2006</u> <u>Legis. Sess. (2005)</u></p>	<p><u>Ohio Am. Sub. H.B. 342</u> <u>125th Gen. Assem., Reg. Sess. (2004)</u> <u>(codified at Ohio Rev. Code, § 2307.84 et seq.</u> <u>(Anderson 2005))</u></p>
<p>(Impairment) Verifies that the exposed person has at least Class 2 or higher impairment due to silicosis, as set forth in the American Medical Association's <i>Guides to the Evaluation of Permanent Impairment</i>, fifth edition, as amended from time to time.</p>	<p>Lung Cancer No person shall bring or maintain a tort action alleging that silica caused that person to contract lung cancer if the exposed person is or was also a smoker in the absence of a prima-facie showing that the exposed person has a physical impairment that is a result of a medical condition for which the person's exposure to silica is a substantial contributing factor. That prima-facie showing shall include the following: (1) A diagnosis by a competent medical authority that the exposed person has primary lung cancer and that exposure to silica is a substantial contributing factor to that cancer; (2) Evidence that is sufficient to demonstrate that at least 10 years have elapsed from the date of the exposed person's first exposure to silica until the date of diagnosis of the exposed person's primary lung cancer. The 10-year latency period is a rebuttable presumption and the plaintiff has the burden of proof to rebut the presumption.</p>
<p>(Causation) Verifies that the doctor signing the detailed narrative medical report and diagnosis has concluded that the exposure to silica is a substantial contributing factor to the exposed person's medical condition and physical impairment and that they were not more probably the result of other causes revealed by the exposed person's employment and medical history.</p>	<p>(3) Both the following: (a) Radiological or pathological evidence of silicosis; and (b) evidence of the exposed person's substantial occupational exposure to silica. "Pathological evidence of silicosis" means a statement by a board-certified pathologist that more than one representative section of lung tissue uninvolved with any other disease process demonstrates a pattern of round silica nodules and birefringent crystals or other demonstration of crystal structures consistent with silica (well-organized concentric whorls of collagen surrounded by inflammatory cells) in the lung parenchyma and that there is no other more likely explanation for the presence of the fibrosis. "Radiological evidence of silicosis" means a chest X-ray showing bilateral small rounded opacities (p, q, or r) in the upper lung fields graded by a certified B-reader as at least 1/1 on the ILO scale.</p>

<p><u>Ca. H.B. 416, 2005-2006</u> <u>Legis. Sess. (2005)</u></p>	<p><u>Ohio Am. Sub. H.B. 342,</u> <u>125th Gen. Assem., Reg. Sess. (2004)</u> <u>(codified at Ohio Rev. Code § 2307.84 et seq.</u> <u>(Anderson 2005))</u></p>
<p>Lung Cancer</p> <p>No person shall bring or maintain a tort action for a silica related lung cancer without a written diagnosis demonstrated by:</p> <p>(1) A medical report showing the diagnosis as a diagnosis of a primary lung cancer, and</p> <p>(2) A signed report certified by a board certified internist, pulmonologist, or pathologist stating to a reasonable degree of medical probability that exposure to silica was the cause of the diagnosed lung cancer with underlying silicosis demonstrated by bilateral nodular opacities (p, q, or r) occurring primarily in the upper lung fields, graded 1/1 or higher and not more probably the result of causes other than the silica exposure revealed by the exposed persons employment and medical histories</p>	<p>"Substantial occupational exposure to silica" means employment for a cumulative period of at least 5 years in an industry and an occupation in which, for a substantial portion of a normal work year for that occupation, the exposed person handled silica; fabricated silica-containing products so that the person was exposed to silica in the fabrication process; altered, repaired, or otherwise worked with a silica-containing product in a manner that exposed the person on a regular basis to silica; or worked in close proximity to other workers engaged in any of these activities in a manner that exposed the person on a regular basis to silica.</p> <p>"Substantial contributing factor" means (1) exposure to silica or mixed dust is the preponderant cause of the physical impairment alleged in the silicosis claim or mixed dust disease claim, whichever is applicable; and (2) a competent medical authority has determined with a reasonable degree of medical certainty that without the silica or mixed dust exposures the physical impairment of the exposed person would not have occurred.</p>