Preservation of Pathology Evidence

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I. Introduction

The range of medical evidence potentially at issue in a case alleging asbestos-related disease is great. Potential source material is found in clinical examination and reports of such examination, radiography in its many evolving forms, tissue and fluid specimens, and other areas. Today’s discussion could also include access to testimonial evidence available from medical staff. Limitations of time and interest will prevent exploration of all of these many avenues. Instead, we will focus in a summary fashion on specimen pathology: why it is at all important to a truth finding mission; how one obtains access to the pathology; obstacles to such access; and, use and application of the results of specimen analysis.

II. Why Analyze Pathology

A pathology expert’s decision tree analysis of disease conditions encountered in asbestos litigation begins with proper identification of the disease process and its point of origin. The nature of the diseases at issue includes non-malignant and malignant processes. Because non-malignant processes tend to be diagnosed without available tissue or fluid samples and because true non-malignant disease impairment cases have become quite rare, our attention is directed to malignant processes. Narrowing further the discussion, we will focus upon the diagnosis of mesothelioma and will not focus upon disease claims brought into question as admittedly primary malignancies other than mesothelioma.

A. Why the Correct Diagnosis Counts

While a diversity of expert testimony exists on the subject, primary Diffuse Malignant Mesothelioma (DMM) is the only form of mesothelioma that is generally accepted in the medical and scientific community as strongly associated with exposure to asbestos as a potential agent of etiology. The challenge therefore, is to obtain a firm and reliable diagnosis indicating whether the disease entity at issue is DMM as opposed to one of the other entities potentially misdiagnosed as DMM. Determination of this distinction has been the subject of a recent consensus statement of the International Mesothelioma Interest Group ("Guidelines"). The authors of this consensus statement include 16 prominent scientists and pathologists, several of

whom appear with frequency as consulting or testifying experts in cases involving possible mesothelioma disease claims.

Awareness of the risk of misdiagnosis and the extent of confusion in the diagnosis of DMM is critical to the court’s understanding that this is not a mere red herring. Today’s discussion will identify these issues without engaging the very active debate as to etiology of these other disease entities. It is self-evident that one can find an “expert” who will attempt to persuade that everything from appendicitis to ingrown toenails is related to asbestos exposure. Most scientists, including the members of this consensus group, agree that there are many other entities that have an appearance that is often confused with DMM and are often misdiagnosed as DMMs, for example:

1. Non-primary, metastatic tumors appearing in the mesothelium, i.e., secondary tumors of the mesothelium including but not limited to:
   - Malignant pleural effusion from a pulmonary carcinoma—sometimes called pseudomesotheliomatous adenocarcinoma;
   - Pleural involvement of carcinoma of the breast;
   - Epithelial carcinomas of the ovary, pancreas, GI cancers, and kidney;
   - Metastatic renal cell carcinoma;
   - Malignant lymphoma; and,
   - Others.

2. Tumors and conditions misdiagnosed as DMM:
   - Localized malignant mesothelioma;
   - Reactive processes in the serosal membranes;
   - Serous neoplasm of the peritoneum;
   - Primary serous papillary carcinoma of the peritoneum;
   - Benign multicystic mesothelioma;
   - Adenomatoid tumor;
   - Intra-abdominal desmoplastic round cell tumor;
   - Solitary fibrous tumor;
   - Localized fibrous tumor;
   - Fibrous mesothelioma;
   - Reactive mesothelial hyperplasia; and,
   - Fibrous pleurisy.

3. Mesothelial tumors of unknown etiology, e.g.:
   - Well-differentiated papillary mesothelioma;
   - MM of the tunica vaginalis testis; and,
   - Pericardial mesothelioma.

Asbestos litigation has had the misfortune of developing “experts” and “pseudo-experts” who ignore recognized diagnostic testing protocols in order to label non-asbestos related disease in the pleura and peritoneum as DMM. In addition, some of these “experts” receive dozens or hundreds of cases through asbestos litigation referral sources and use these litigation-collected
“disease cohorts” to declare the existence of an association with asbestos exposure, totally ignoring the gross impact of selection bias.

Our purpose is to identify the existence of misdiagnosed cases and not to further debate whether the true diagnosis might also be related to asbestos in a given case. For example, an erroneous mesothelioma diagnosis of what is in fact a primary adenocarcinoma of the lung in a person with proven asbestosis has a good probability of being a lung cancer caused by asbestos. By way of contrast, an erroneous DMM diagnosis of what is actually a metastatic ovarian cancer in a person with very little opportunity for asbestos exposure is almost certainly not caused by asbestos.

**B. How a Sure Diagnosis Can Be Established through Specimens**

As is made clear by the Guidelines, the pathologist should not base the diagnosis of malignant mesothelioma on a history of asbestos exposure; and, such a history should not be taken into consideration in the diagnosis. Instead the diagnosis should be made in reliance on an adequate biopsy along with appropriate radiology, clinical, and surgical findings. The sex of the patient is important in a differential diagnosis.

A very well developed protocol is available utilizing examination of cytologic features and immunohistochemistry. Even with the use of this protocol, it is not unusual for the most experienced panels of experts to differ in as high as 30% of cases. In a 1991 report, in 200 referred cases, only 70.5% of the cases had a three-fourths majority agreement of the U.S. and Canadian Mesothelioma Reference Panel. See Guidelines at 1330. Roughly 60 of the 200 cases failed to achieve three-fourths majority agreement among the most prominent experts in the world in the identification of DMM.

A critical threshold as to the correct diagnosis of the precise disease at issue must be established before any issue of causality and, thus, potential liability may be addressed. Far too often, legal counsel accepts the “testimony” of a death certificate or of initial impressions reflected in medical records. Without the preservation of pathology for analysis, this threshold cannot be crossed.

**C. How a Diagnosis Is Related To Cause**

The literature is replete with detailed statistical analysis indicating the incidence of cancers in the general population. The vast majority of cancers are attributable to known or unknown causes other than asbestos exposure. If a cancer appearing in the pleura or the peritoneum has a primary source outside of the mesothelial cells--especially in the absence of clear asbestos markers in the lung and the pleura--there is little to no persuasive evidence that the cancer is caused by asbestos exposure.

A well-developed presentation of epidemiology as to the primary cancer provides a very stout defense on the issue of causation; this is true even in jurisdictions with causation charges similar to the infamous Rutherford charge in California. At the heart of the issue is the two-part question of whether: (1) the plaintiff’s disease is result of asbestos exposure; and (2) if so, that
this particular defendant caused or contributed to the occurrence of the disease (or in California, contributed to the risk). If the disease is not a primary malignant mesothelioma, the plaintiff’s burden is far greater.

III. How Pathology Assists in the Cause Analysis of True DMM Cases

For the last 15 or so years, the defense has had an uphill battle in persuading juries that the mesothelioma in a given case is not attributable to asbestos exposure. The defense bar has allowed the opposing party to own this issue. Even in those cases in which some defendants raise the “Chrysotile defense,” the normal pattern has been to blame “other exposures” rather than to argue that the disease is one of the many mesothelioma cases that have no identified cause. That is to say, the cancer in the case at bar is in company with a very substantial number of cancers of uncertain cause that occur each year in the human population. While this concession might be understandable in higher dose plaintiffs, we are now facing a large population of persons appearing before the courts with a firm diagnosis of DMM and no evidence of asbestos exposure beyond that of most of the general population.

Recent studies demonstrate that the cases entering the litigation arena today are of highly questionable etiology. The most recent analysis indicates that as few as 58% of mesotheliomas occurring in 2008 can be demonstrated to be the product of asbestos exposure. The fact is that the time has come to require proof of causation, not conclusory “expert” testimony of a prepackaged causation opinion with every malignant mesothelioma diagnosis.

The typical plaintiff expert testimony goes like this, "It is a cancer of the mesothelial cells. Asbestos is the one proven carcinogen of mesothelial cells (untrue, by the way). There is a history of asbestos exposure. Therefore one can conclude, within a reasonable degree of medical and scientific certainty, that asbestos exposure caused the cancer."

The scientific literature on the lack of valid attribution of asbestos as the cause of mesotheliomas in women and in many, if not most, peritoneal mesotheliomas is emerging with substantial, persuasive strength. Well-placed scientists are calling for legitimate medicolegal criteria for distinguishing these cases of unknown cause from those warranting treatment as the product of occupational and paraoccupational exposures.

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4 See Alberto M. Marchevsky, MD & Mark R. Wick, MD, Current Controversies Regarding the Role of Asbestos Exposure in the Causation of Malignant Mesothelioma: The Need for an Evidence-Based Approach To Develop Medicolegal Guidelines, 7 Annals of Diagnostic Pathology 5, Oct. 2003, at 321.
Despite the very great job of advocacy being done by the plaintiffs’ bar and by their supporting experts, the causation evidence in many cases is very weak. In order to demonstrate this weakness, defendants need access to tissue analysis in the truly low or questionable dose cases. That is to say, the search for truth in the cases demands that cases involving asbestos exposures at or approaching background be subject to analysis that would permit a comparison of the dose to the general population.

IV. How One Gets from Here To Tissue Analysis

A substantial part of the problem is that most suits served do not include a tissue sample. One can hardly fault the plaintiffs’ bar for electing not to be so accommodating. Despite all of our sober nods to the proper placement of the burden of proof, the fact is that the law as applied in most state courts, in effect, shifts the burden to the defendants to prove that the mesothelioma is not caused by asbestos exposure. Some would argue that states with the California approach to proof of causation lowers the bar so low that only the careless plaintiff or the exceptional jury would ever find that a mesothelioma was not caused by asbestos exposure. The not so simple fact is that a well-prepared defense can persuade a jury that the case at bar is among the growing number of mesotheliomas that are not attributable to asbestos exposure.

The gold standard in determining the dose of asbestos experienced by the plaintiff is tissue analysis, preferably a tissue fiber burden study through tissue digestion. In order to perform any form of tissue analysis, it is obvious that tissue is needed. The remainder of this discussion will address how one might accomplish this acquisition of tissue. While it is a worthy topic, this discussion will not attempt to cover how the results of the tissue study may be compared to norms (i.e., asbestos fiber burden in the general population of persons without occupational or paraoccupational exposure to asbestos) in order to determine whether the individual plaintiff may be properly compared with a given exposure cohort in order to determine the likelihood of the case at bar’s causal association with asbestos exposure.

V. Avenues for Obtaining Pathology

Since we have assumed that most plaintiff firms do not deliver pathology along with the complaint, how does one acquire the pathology materials or assure that the materials are preserved? The three primary approaches are: (1) through cooperation of counsel; (2) through court case management intervention; or, (3) through court-supported subpoena or order of the medical services custodian compelling production or preservation. These approaches will be treated individually and as they intersect.

A. Acquiring Pathology by Consent

It would be a wonderful world in which to practice law if opposing attorneys were willing to fulfill their responsibility to represent their clients, while at the same time practicing in a collegial environment where the elements of proof to which the opposition has a right in the pursuit of the truth would be provided upon request. I have had the pleasure of practicing in several jurisdictions where this air of collegiality is something that the bar considers a valued
tradition. In fact many, if not most, jurisdictions do require that the plaintiff provide the
defendant with a medical authorization granting unfettered access to medical records and
collected pathological material specimens. Unfortunately, the practice of law has evolved in
many venues where courtesy is very nearly equated with malpractice.

For those of you who are not fortunate enough to work well in discovering your cases, on both
sides—I recognize that this is a two-sided sword, I am attaching an example of a request for
delivery of and/or access to pathology materials. [See Attachment] This is either the product of
the idyllic practice environment or of the lawyers being forced into cooperative collegiality by
judges who have tired of playing babysitter to contentious lawyers. In either case, someone
should be saluted.

B. Acquiring Pathology through Judicial Case Management
Direction

In the absence of the cooperative exchange model, intervention of the court is a logical stopping
point for assuring that access to pathology material is obtained. The two methods of obtaining
court assistance in this process are: (1) petition in each appropriate case; and, (2) development
of a case management order governing the process. My experience has been that most courts
prefer the second option because this avoids constant consumption of court resources in dealing
with what should be routine processes. Examples of case management orders, jurisdictional
general orders, and individual case orders are attached. [See Attachments]

While most courts are very accommodating in facilitating access to pathology materials for
analysis, the question that always faces the defense lawyer in seeking access to pathology is,
“Why would any court be less than willing to provide access to the materials needed for a full
evaluation of the case?” The answer and the solution to solving this problem lie in a look at the
history of the litigation.

The 1980’s and 1990’s witnessed a volume of asbestos cases moving through the system such as
the history of courts has never before experienced. The volume of the cases forced a “one size
fits all” approach to defending the cases. We are not now in such an era nor do we advocate a
“one size fits all” approach.

In order to gain the confidence of the courts in seeking assistance in structuring individual case
orders and case management orders that provide full access to existing pathology materials,
defendants must educate the court as to the elements of proof that will only be available through
access to pathology. A hearing for the purpose of educating the court on the disease process(es)
alleged to be at issue in the cases and the use that will be made of the pathology material in
questioning the diagnosis and the implications of the evidence on proof of etiology will go far in
preparing the court to hear the cases with an open mind. Simply put, unless defense counsel
provide the background for understanding, a judge who is facing the 10th or 100th or 1000th
mesothelioma case from the local docket cannot be expected to appreciate the significance of a
defense based upon incorrect diagnosis or absence of proof of general causality.
The proper presentation of how pathology materials will be used would include testimony from three specialty fields (hopefully through less than three experts):

1. General Pathology: explaining the difficulties involved in a correct diagnosis and the tools available to avoid meaningful misdiagnosis;
2. Clinical Pathology: discussing the process of harvesting and analyzing the pathology specimens; and,
3. Epidemiology or Occupational Medicine: describing for the court the application of the results of the analysis of the pathology to the question of causality.

Where the court must be drawn into the discovery process, I recommend that defense counsel engage in the exercise of common sense and discretion in choosing cases in which analysis of the specimens will be meaningful rather than rote. I believe that you are doing your client and the court a great service by selectively challenging individual case diagnoses. Despite this recommendation, I do recognize that some clients view verification of every mesothelioma diagnosis as critical to its case management.

Absent a client directed full court press on the analysis of pathology, here are my recommendations: if there is existing analysis (e.g., immunohistochemical staining), initial consideration should be given to the contribution this provides in weighing the likelihood of the accuracy of the diagnosis. Contrary to the objective analysis advocated by Guidelines (i.e., no consideration of work history in the diagnostic process), the attorney plotting a case strategy should give serious consideration to the external facts that would assist in drawing conclusions about the probability of the correctness of the diagnosis and regarding pathological evidence supporting causality. That is to say, if your plaintiff is a school teacher with no evidence of occupational or paraoccupational exposure traditionally associated with mesothelioma or with asbestos-related disease, a full work up is needed. On the other hand, if your plaintiff is a career insulator and the diagnosis is from a qualified pathologist, your investment in the analysis may not be warranted absent evidence of another tumor that may have metastasized (e.g. a history of metastatic prostate cancer). While that is not to say that the given insulator’s mesothelioma is absolutely not one of the roughly 1000 background (i.e., unknown cause) mesotheliomas occurring each year, it is to say that your likelihood of establishing this is exceedingly poor. It is possible that a work up of the insulator’s pathology might permit the conclusion that the tumor is a secondary/non-primary tumor found in the mesothelium. Absent other indicia of unreliability in the diagnosis, I would tend to move to another case with higher likelihood for fruitful analysis.

I advocate picking your cases and spending your goodwill and your client’s money on the cases in which there is a greater probability of reward.

VI. Sources of Pathology Specimens

Pathology material becomes available in what I have separated into three general categories: (1) select pathology--specimens harvested from existing tissue for the purpose of the analysis; (2) casual pathology--specimens that exist as a result of other procedures, exams, or testing; and, (3) prescriptive pathology--specimens harvested from additional procedures for the purpose of the analysis. The first two categories tend to involve relatively low controversy in the collection process (cf., the issues discussed below related to the objections of Baylor medical). The target
tissue, fluid, or slides already have been removed and need simply to be applied to the analysis. The third category involves compelling the surrender of specimens from a living patient or by way of autopsy, which is discussed in more detail later in this presentation.

Defendants should engage expert assistance in any hearings process involving a challenge to the surrender of the tissue. The primary issues involve limitations on destructive testing, timing of access to testing, and chain of custody issues. Mere argument will not provide the court with adequate information as to the resolution of these issues. Only expert pathology testimony will permit the court to understand how equal access can be provided to all interested parties.

In cases in which there is little tissue available or if time for analysis is limited, it may be necessary to have a court appointed expert to harvest the tissue and supervise or conduct agreed procedures. The scarcity of qualified experts to perform the full spectrum of analysis that is required in this unusual subject area may well compel a search for agreed experts who have either no history of litigation involvement—and I wish the litigants luck on that front—or experts who have a history of having done work for either side in asbestos cases. I know of less than five such asbestos litigation experienced experts who would likely achieve this level of acceptance; this signals a real need for expansion of expert resources. These facts indicate the need for early attention to the selection of such experts.

A. Invasive Examination: Providing the Court with a Reason To Order Access To Specimens

Preparation of the case for persuading a court to order minimally invasive examination of a living plaintiff involves the assistance of a credible expert. The testimony, live, by deposition, or by affidavit, must focus upon (1) the necessity, (2) the proposed procedure, (3) the minimally invasive nature and lack of added risk to the plaintiff, and (4) the expectation of invasive procedures during the course of ordinary treatment, if indeed expected. The expert should be prepared to utilize and to highlight less invasive options where available and applicable. In support of the expert, defense counsel must be prepared to utilize applicable law and practice as suggested in the analogy to the public order and criminal law context cases. Some case management orders anticipate such invasive procedures where necessary to the case.

B. Preparing for the Post-Mortem Access Issue

Whether the living invasive examination argument is successful or not, proper exposure of the court to the issue can assist in mounting a future assault on the less controversial invasive examination subject area: compelled autopsy. One should not be mislead by the use of the term “less controversial.” Simply put, the range of responses observed across the country are from routine court acceptance of the necessity and appropriateness of this practice in the preservation of evidence to moral outrage that such a ghoulish practice would find its way into a “civil” court. See for example, attached CMO's anticipating autopsy and contrast same with attached order

5 See e.g., Kris M. McLaughlin, Keith M. Kerr, & Graeme P. Currie, Letter to the Editor, *Closed Pleural Biopsy to Diagnose Mesothelioma: Dead or alive?* 65 Lung Cancer, Sept. 2009, at 388.

The cases involving an effort to have the court compel harvesting of pathology specimens have received a good deal of attention in recent months.6 The primary subject area is related to compelling post-mortem examination. Few topics seem to present as much in the way of trigger points as the compelling of post-mortem examination. In the identified cases, these seem to be primary decision-affecting issues:

1. Was the issue addressed by statute, case management order, left to the discretion of the court?
2. What was the decision?
3. Was there an order in place prior to death?
4. When was the issue raised relative to the death?

In reviewing the several post-mortem examination hearings that have occurred recently, there are several issues that seem to drive the decision:

- Local practice;
- Personal, religious or ethical objection by the plaintiff;
- Perceived justification for/efficacy of the proposed procedure; and,
- Timing of the request.

The issue of compelling invasive examination, upon post-mortem examination, is an issue that the plaintiff’s side of the bar has owned. The irony of this fact is the virtually universal acceptance of invasive examination and testing in criminal law context and in “public order” cause of death examinations. If the courts and the public acquiesce in compelled invasive examination in these contexts, logic would dictate that low risk invasive examination and, certainly, post-mortem examination should be a matter of right to a party that is being sued in cases alleging damages of many millions of dollars. In the criminal law and public order context, the examinee criminal defendant is at most charged, but presumed innocent, and the uncharged decedent is involuntarily subjected to examination, as in the case of the victim of an automobile-related death. In the context of a civil lawsuit, the plaintiff has elected to forego elements of privacy for the purpose of vindicating an alleged civil wrong.

C. Case Management Orders (CMOs) for Post-Mortem Examination

The goal of defense counsel should be to have the post-mortem examination practice ruling ingrained into local practice through standing case management orders well in advance of the emotional setting of an emergency hearing as the bereaved mourners wait at the graveside.

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6 Examples of cases in which compelling autopsy has been a litigated issue are included in the attachments to this paper. The issue has been addressed in at least Utah, Florida, Illinois, Pennsylvania, and Nevada. [See Attachments]
Success has been accomplished in a number of jurisdictions and these should be used as persuasive exemplars for the court in its consideration of the issue. The presence of such an order permits the court’s decision on the issue without the heart rending spectacle experienced in the St. John matter. Furthermore, the presence of a post-mortem examination provision in the case management order makes it possible for plaintiffs’ counsel to cooperate in facilitating discovery without the perception of failing to advocate fully the plaintiff's position.

Once a case management order on post-mortem examination is in place, it is prudent of defense counsel to confirm with counsel for plaintiff the defendant’s desire for post-mortem examination; this should occur at the earliest point in anticipation of the potential need for raising the issue in application upon the death of the plaintiff. At the time of its answer, the defendant is well advised to correspond with counsel for plaintiff requesting medical records, preservation of pathology, and, in the event of death, an autopsy. Naturally, this will not replace formal discovery requests absent custom and practice in the local court, but the presence of the request, followed by any appropriate update request in the event of impending death, will do much to gain the support of the court in any subsequent proceeding.

D. Procedure for Assuring Compliance in Providing Post-Mortem Examination

If an autopsy occurs, defendants must have provided prior notification to Plaintiff and, if at all possible, court direction that defendants must be notified in advance and have an opportunity to participate through an expert in the process. From this point, details of how the selection of tissue is made and related matters do not usually require court involvement. Every case should have this protection in place. No case involving the elderly or potentially mortal disease should fail to address access to and opportunity for selection of study specimens in the event an autopsy is performed.

Expert testimony is necessary in describing for the court and the parties how post-mortem examination can be done on an adequate, but limited, basis through focused selection of target tissue. A full autopsy with all of the negative connotations is not necessarily required. In most instances, specimens of the tumor and small blocks of lung tissue will provide all that is required for diagnostic testing and fiber burden analysis.

VII. Use of CMOs To Avoid Dispute

It is obvious that jurisdictions with detailed case management orders tend to anticipate the need to provide access to pathology as well as other medical evidence issues. Predictability of outcomes, alone, would warrant addressing the issue through case management orders. Judicial economy seems to make the case management order approach a favored tool by the parties and the courts. Excerpts from examples of jurisdictions that function well through the use of case management orders accompany this report. [See Attachments]

The risk of a “one size fits all” approach must be considered in the treatment of cases under the case management order. The current litigation environment is quite different from what has been experienced during the previous, high-volume asbestos litigation world. We are all experiencing
a litigation that is quickly maturing to one that is driven by and primarily focused upon the
alleged mesothelioma cases. Now more than ever counsel must be attentive to selection and
processing of cases that present very real issues of proper diagnosis and of causality. For this
reason, it might be appropriate to identify disputed cases involving substantial challenge as to
diagnosis and as to objective evidence of non-elevated dose, which cases can serve as pilot cases
for making the procedure palatable to the parties and the court in the future. Failure to properly
select the cases presenting these issues can cost the defendants credibility and future success in
cases more suited for such a challenge. On the other hand, proper selection and handling renders
it routine.

VIII. Preserving the Defendant’s Right To Access

When the court makes invasive examination available, whether through specific case order,
through case management order, or on the basis of statute, defendants must be prepared to act
without delay in making use of the latitude provided. It is too late to begin the search for a
supporting expert once the issue arises in a case. An expert of choice for the selection of the
specimen and for processing the specimen once obtained, must be identified in advance of the
occurrence of the opportunity. Time is of the essence. Counsel must appreciate the timeline
involved in the process and not expect to obtain a report overnight. Likewise, the court must be
made aware of the time required to prepare a proper analysis of the specimen and to obtain
results of the various tests. The process of conducting the tests required is well described in
PATHOLOGY OF ASBESTOS-ASSOCIATED DISEASES (Victor L. Roggli et al. eds., 2nd ed. 2004).

What is the appropriate remedy in the event a request for post-mortem examination is refused or
an order of court granting post-mortem examination is violated? It is likely that a more severe
sanction would and likely should be imposed for violation of a court order. At least one court
entered the sanction of dismissal of the case; see Kirkham v. Garlock et al., attached. [See
Attachment] A more practical question is: what relief is appropriate when a request is refused,
but no order has issued?

Most evidence codes and case law provide for an adverse inference instruction when a party has
evidence under its control but it fails to provide that evidence for the consideration of the jury.
Likewise, spoliation of evidence subjects a party to sanctions ranging from a jury charge of
adverse inference to dismissal or directed judgment. Under these circumstances, the individual
orders of the courts or the case management orders should set a standard of at a minimum,
advising the plaintiff that a request for an adverse inference instruction will be given in the event
a plaintiff elects not to accede to a request for an autopsy. How defendants elect to make use of
such a charge is another matter entirely.

The defendant who receives an adverse inference instruction concerning the failure to grant
access to tissue blocks post-mortem should be prepared for a jury presentation (1) to identify the
nature of the request, (2) to demonstrate that the purpose of the request was made known to the
party (e.g., examination of lung tissue blocks are requested in order to permit analysis of the
quantity of asbestos fiber in the lungs of the plaintiff which will allow the expert to determine
whether asbestos fiber quantities in the allegedly exposed lung is higher than normal in the
general population of persons not exposed in an occupational setting or a paraoccupational
setting), (3) demonstrate how the expert would use this information to determine the comparable exposure cohort in the epidemiological literature, and (4) show how the results of the examination would provide an objective basis for forming an opinion as to whether the disease at issue was among those that were caused by exposure to asbestos. A similar presentation would be applicable if the absence of pathology materials prevented a proper analysis of the diagnosis.

The potential benefits of making use of such an instruction must be weighed against the direct or indirect effort of the plaintiff’s lawyer to portray this search for truth revealed in objective analysis of tissue as nothing more than ghoulish oppression of the already suffering family. It is recommended that the defense lawyer attempting this distinction be particularly aware of the risk that a ham-handed failure would entail.

**IX. Custodian Originating Obstacles To Access**

The custodian of the pathology specimens can present an interesting challenge for the acquisition of pathology materials for analysis. The complications in obtaining release run deep and assistance of the court is needed and likely necessary.

Counsel should initiate the process as soon as the treating facilities are identified. Whether the facilities are willing or recalcitrant, it is advisable to make use of a court-enforced subpoena in the process of requesting the pathology materials as well as the medical records. Depending upon local custom and experience with the custodian facilities, I recommend using the subpoena even where medical authorizations are provided. Normally, more timely response is forthcoming with the force of a subpoena behind the request. Furthermore, the subpoena frees the custodian from some of the burden of decisions leading to compliance.

A recent dispute has arisen in Texas that is reflective of disputes that have played out on a lower profile basis around the country. In the Texas MDL, the Baylor College of Medicine filed a motion for protective order in an effort to avoid the production of tissue blocks in an asbestos litigation case. The college of medicine argued that there was an ongoing need for the blocks in possible future treatment and that new imaging (virtual slide technology) made it possible to create duplicate originals of slides so as to permit access to the slides and, at the same time, to protect the integrity of the original specimen. Ultimately, the testimony offered by the expert witness appearing to defend the Baylor College of Medicine’s refusal to comply with the Texas MDL’s order to produce tissue blocks was to the effect that the most appropriate protocol would be an initial analysis of virtual slides with a subsequent request for access to a given block in the event additional staining or destructive testing were needed. According to the Baylor expert, the virtual slides could be placed online so that all experts could have simultaneous access; this, of course, would not obviate the necessity of access to tissue blocks for fiber burden studies conducted through a tissue digestion process.

Even though the virtual slide technology presents intriguing promise for a portion of the analysis, there are evidentiary questions presented that the new technology brings into the equation. As yet, the question of how one would lay a foundation for the use of the virtual slides remains unresolved. Chain of custody issues likewise raise new issues for the litigants. Regardless, this does provide an option for early access to very important pathology material. It does not appear
that this technology would replace destructive testing in those low dose cases that form the primary target of this discussion. That is, if the case is such a clear case of exposure that conclusions could be drawn from asbestos bodies appearing in the virtual slides, it is unlikely that a tissue digestion would be necessary. It does appear possible that the virtual slides could be used to investigate but not foreclose the possibility of misdiagnosis of DMM.

As interesting as the virtual slide technology might be, the real object lesson of the Baylor College of Medicine motion for protective order is that the custodian of the pathology materials and medical records can present as much of an obstacle to full discovery as any other non-party participant in asbestos case discovery. Ultimately, a party is dependant upon the good offices of the court to provide relief when such a stonewall is encountered. In this case, the party seeking relief must be fully prepared to educate and to persuade the court as to the necessity of the relief to a finding of truth on the issue of disease identity and causation.

X. Conclusion

The current era of asbestos litigation presents a great challenge to proper planning and execution of any defense related to diagnosis and etiology in mesothelioma cases. Cases of questionable diagnosis and etiology are becoming more common with each passing year. The defense lawyer who is prepared to identify and address these issues provides the client with a viable defense on medical issues. The growing emergence of a greater community of low dose cases makes this preparation necessary and appropriate.

Preservation of and access to pathology materials are critical in cases in which there is any substantial question of diagnosis or etiology. Failure of defendants to challenge the correctness of the diagnosis of DMM and to question etiology, especially in low dose cases, amounts to a concession that will facilitate the continuation of asbestos litigation for decades yet to come. Even after mesothelioma returns to a level of background cases fully unrelated to asbestos exposure in around 2025, disease incidence will remain as high as 1000 cases per year—the non-asbestos caused background incidence rate—into the unlimited future. This future incidence is likely, even though there have been few asbestos exposures above urban background levels in the United States in 20 to 30 years.

The litigation capture rate of diagnosed mesothelioma cases, both valid and spurious, is approaching 80% (my own estimate based upon approximate claims filed, divided by approximate incidence). The actual rate may be higher. Our plaintiffs’ bar colleagues have made clear their response to the occurrence of mesothelioma among those with no indication of what lawyers for both plaintiffs and defendants have considered meaningful occupational or paraoccupational asbestos exposures. They will contend as follows:

- every fiber is contributory;
- any exposure is excessive exposure;
- any exposure indicates defendant negligence; and,
- every disease entity labeled “mesothelioma” is a viable indemnity case.
With very few shining exceptions around the country, these contentions have the real effect of shifting the burden to the defendant to rebut each of these contentions. Access to and proper analysis of pathology materials are necessary tools in permitting defendants to narrow the core liability disputes to those cases in which there are (1) true DMM cases (2) involving persons with a history of asbestos exposure at a level demonstrated by reliable epidemiology to have been caused by asbestos exposure.

It seems simple enough to say that the litigation must return to a world where the plaintiff has the true burden of proof for (1) disease, (2) general causation, (3) specific causation, and (4) negligence or strict liability. However, the defendant's failure to engage a defense on the first three of these elements converts the litigation into an unending line of future indemnity for cases that are unrelated to asbestos exposure. Best estimates are that this cohort of cases will continue into eternity at a rate of at least 1000 per year.