IN THE SUPREME COURT OF OHIO

LINDA ACKISON, Administratrix of the estate of Danny Ackison,	:	Case Nos. 2007-0219; 2007-0415
Appellee,	:	On appeal from the Lawrence County Court of Appeals, Fourth Appellate District
v.	:	
	:	Court of Appeals Case No. 05 CA 46
ANCHOR PACKING Co., et al.,	:	
Appellants.	:	

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Argument

Danny Ackison never had asbestosis and was not impaired by an asbestos-related nonmalignancy. The doctor that examined him in 2000 during a screening for asbestos disease did not diagnose asbestosis or impairment to his pulmonary function. Nevertheless, in 2001, Danny Ackison sued numerous manufacturers seeking compensation for a an alleged asbestos-related injury. This is exactly the type of case that forced the General Assembly to take action and enact H.B. 292.

In their opening brief, Appellants explained in great detail that H.B. 292 can be applied retroactively because it only changes the *manner* in which asbestos-related nonmalignancies are to be litigated. Ackison ignores this argument. Instead, Ackison focuses her argument on the assertion that H.B. 292 eliminates her allegedly valid cause of action, as it existed before H.B. 292 took effect. This overarching theme of Ackison's argument rests on two false premises 1) that Ackison had a vested right to every feature of the common law, and 2) that the Ohio Constitution prohibits the General Assembly from changing *how* asbestos cases are litigated.

Neither of these attacks satisfies the high threshold that justifies this Court expunging from the Revised Code the General Assembly's reform efforts. Legislation enjoys a strong presumption of constitutionality and this Court needs powerful proof of unconstitutionality before it wipes a law off the books. Against this high standard, Ackison's failure to prove the unconstitutionality of H.B. 292 is not surprising.

Without the reforms in H.B. 292, Ohio's courts will be saddled with the task of processing more than 40,000 asbestos cases without any guidance about which cases deserve attention first. The Ohio Constitution does not demand that result. Therefore,

this Court should reverse the judgment of the Fourth District and announce that Ohio's trial courts must apply the disputed parts of H.B. 292 to pending cases.

I. Ackison has not shown that she has a vested right to how asbestos litigation proceeded before H.B. 292 took effect.

Although Ackison argues that H.B. 292 violates her vested rights, she offers no explanation of what constitutes a vested right. Ackison seems to consider *any* change to the common law as constitutionally prohibited. But as Appellants explained at length in their merit brief, there is no vested right to the common law, particularly the common law of how a case is litigated. (App'lt Br. at 24-31).

Moreover, Ackison's claim that she has a vested right to *how* her case will be litigated merely because she filed a claim before H.B. 292 took effect clashes with this Court's most recent decisions about retroactivity. This Court recently assigned the "utmost significance" to a final judgment as a metric for vested rights. *Smith v. Smith*, 109 Ohio St.3d 285, 2006-Ohio-2419, 847 N.E.2d 414, at ¶11. Even more recently, this Court stated that "no one has a vested right in having the law remain the same over time", otherwise "the whole body of our law would be ossified forever." *City of E. Liverpool v. Columbiana Cty. Budget Comm.*, 114 Ohio St.3d 133, 2007-Ohio-3759, 870 N.E.2d 705, at ¶33 (internal citation and quotation marks omitted). Both *Smith* and *East Liverpool* recognize that this Court "distinguish[es] vested 'rights' from a mere 'privilege.'" Id. Ackison's claim that she has a vested right to how her case will be litigated flies directly in the face this Court's statements. She has no right to the ossification of the common law.

Moreover, Ackison's argument that the common law existing when she filed her claim only required that she demonstrate that "asbestos . . . caused an alteration of the lining of the lung" is simply wrong. (App'ee Br. at 14) (citing *In re Cuyahoga Cty. Asbestos Cases* (1998), 127 Ohio App.3d 358, 713 N.E.2d 20); see also App'ee Br. at 9 (citing *Verbryke v. Owens-Corning Fiberglass Corp.* (6th Dist. 1992), 84 Ohio App.3d 388, 616 N.E.2d 1162). This has never been the common law of Ohio. Further, Ackison is at a loss to explain why she has a vested right to this standard, a standard articulated by a single appellate district and repeated in dictum by one other. [1] Ackison would have this Court hold that the alteration-of-the-lining-of-the-lung language in two Ohio appellate opinions created a statewide common law standard and bars the General Assembly from making *any* changes to how asbestos cases are litigated. Only the General Assembly and this Court make the law for all Ohio. As the Twelfth District explained, "[i]t is difficult to maintain . . . that someone has a vested right to a standard that is not the law of the entire State, and is certainly not binding on other appellate districts." *Wilson v. AC&S, Inc.*, 169 Ohio App.3d 720, 2006-Ohio-6704, 864 N.E.2d 682, at ¶82 (internal punctuation omitted).

Despite 50 pages of briefing, Ackison nowhere explains the content of the vested right she claims prevents the General Assembly from changing the common law. Ohio law does not support her claim that she has a vested right in the way her case is litigated.

[1] Indeed, the *holding* of *Cuyahoga* has nothing to do with the common law. Although the *Cuyahoga* court noted the lining-of-the-lung standard from *Verbryke* in dictum, the court's *holding* involved the law of appealable orders. The court held that an order of creating an inactive docket for asbestos plaintiffs who had *yet to be injured* was not appealable. *In re Cuyahoga Cty. Asbestos Cases* (1998), 127 Ohio App.3d 358.

II. Ackison's claim that H.B. 292 eliminates her cause of action ignores the fact that her decedent did not have asbestosis or an impairment caused by a nonmalignancy.

Ackison repeatedly contends that H.B. 292 has eliminated her cause of action for asbestosis.[2] The problem is that her decedent did not have asbestosis or impairment of his pulmonary function. Therefore, it was not H.B. 292 that prevented her claim from proceeding, it was the fact that Mr. Ackison had not been injured.

Before H.B. 292, courts had no standards to separate meritorious asbestos claims from meritless ones. The result was a flood of cases that has crippled Ohio's courts. A gatekeeper was needed. H.B. 292 appointed trial judges as gatekeepers and directed them to examine hired-gun doctors and flimsy evidence of causation offered by many claimants. The mechanisms in H.B. 292 are designed to flesh out asbestos cases early so that courts can separate the meritorious from the meritless. This appeal is a good example.

H.B. 292 requires that a plaintiff alleging a non-malignant condition provide radiology results as well as pulmonary function test data to demonstrate actual impairment. Impairment simply cannot be determined from an x-ray alone.

In the trial court, Ackison submitted a single chest x-ray report (B-read) from Dr. Robert Altmeyer. The defendants moved to administratively dismiss Ackison's case based on two evidentiary failings: 1) Danny Ackison's chest x-ray report did not demonstrate asbestosis, and 2) she had not proffered any pulmonary function data. (T.D. 125). That B-read report found that Mr. Ackison had small irregular opacities on his

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[2] See, e.g., App'ee Br. at 8 ("the statute abrogates the valid common law claim", at 42 ("H.B. 292 functions to eliminate – permanently . . . lawsuits"), and at 48 (statute "abrogate[s] the valid . . . claims of the innocent").

chest x-ray that were graded at a profusion of 0/1 and pleural thickening.[3] (T.D. 125, Ex. 1). A B-reading of 0/1, which is lower than a 1/0, does not indicate even the early stage asbestosis. See *Asbestos, asbestosis, and cancer: the Helsinki criteria for diagnosis and attribution*, Scand J Work Environ Health 1997:23:311, 312 ("For . . . screening purposes, radiological findings of small opacities, grade 1/0, are usually regarded as an early stage of asbestos."). Indeed, even Dr. Altmeyer, the doctor who examined Mr. Ackison on behalf of Respiratory Testing Services, did not diagnose Mr. Ackison with asbestosis. Instead, he limited his diagnosis to "asbestos-related pleural thickening."[4]

Ackison argues that H.B. 292 deprives her of a vested right because, in 2000, her husband could not have known that he would need pulmonary function data to support his claim of non-malignant injury. (App'ee Br. at 13). That argument is a red herring. It is true that Ackison and her husband could not have known that he would need pulmonary function data to proceed under H.B. 292. However, in this case, Ackison had – but did not produce – pulmonary function data. That pulmonary function data is only in the record because defendants provided it to the trial court. (T.D. 125, Ex. 1).

A look at the reports that Ackison *chose not to submit* undermines the claim that her husband had an *impairment caused by asbestos*. The doctor's report states, "His only functional impairment is a mild reduction in his diffusing capacity, which is probably due to his prior long-term cigarette smoking." The report also indicates that pulmonary

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[3] Small irregular opacities on a chest x-ray can be consistent with asbestosis, as well as other lung conditions. The B-reading system, which was developed by the International Labor Organization, provides a standardized method of rating the severity of an occupational lung disease.

[4] The pleural thickening Dr. Altmeyer found does not meet the requirements of H.B. 292 either. See R.C. 2307.91(BB). Pleural thickening has numerous causes and is not usually linked to impairment.

function testing indicated "no obstruction or restriction" and that Mr. Ackison's total lung capacity was 116% of the predicted, normal capacity. (T.D. 125, Ex. 1). These conclusions undermine Ackison's claim that asbestos injured her husband. Notably, the company that performed the testing (Respiratory Testing Services ("RTS") is a screening firm known to be a captive to plaintiff's firms. If there was *any* indication that asbestos was the cause of Ackison's mild impairment, RTS or its doctor would have said so.[5]

Similarly questionable is Ackison's decision to ask an out-of-state, non-treating doctor to opine about the connection between Mr. Ackison's injuries and asbestos. Mr. Ackison's death does not prevent his treating doctors from offering opinions about his condition prior to his death. Nevertheless, Ackison instead chose to hire a doctor who never treated him and has made a career out of offering plaintiff's lawyers the opinions they want.

H.B. 292 does not prevent Ackison from pursuing her claim (App'ee Br. at 14). The fact that Ackison's own expert did not diagnose asbestosis or any impairment to pulmonary function prevents her claim. This is exactly the kind of gamesmanship the statute seeks to weed out. There are many legitimate claims of asbestos injury in Ohio. There are also thousands of dubious validity. H.B. 292 equips courts with the information and tools to separate one from the other. It does not operate to exterminate those claims.

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[5] As one federal judge observed about RTS "Perhaps most telling was when the Court asked [the RTS employee], 'What is your training on this, on [diagnosing] silicosis?', to which [the employee] replied: 'Whatever the criteria the law firm sets.'" *In re Silica Prods. Liab. Litig,* (S.D.Tex. 2005), 398 F.Supp.2d 563, 598.

III. Ackison's argument that H.B. 292 unconstitutionally bars her claim ignores a wealth of authority upholding laws that retroactively change rules regulating how litigation is conducted.

Ackison wants this Court to believe that H.B. 292 eliminates her cause of action. Ackison conflates laws that exterminate a claim with laws that make proving a claim more difficult. Ackison believes that *any* additional burden on her claim is prohibited by the Ohio Constitution. That is not the law. Only laws that exterminate a claim are unconstitutional.

Laws that make a claim more difficult to prove are permissibly retroactive. Appellants cited several examples in their opening brief. This Court's *Denicola v. Providence Hosp.* decision is a prime example, and it involved a requirement very similar to the "competent medical authority" element of H.B. 292. In *Denicola* the requirement that a medical expert devote less than 25% of her time to serving as a litigation consultant was applied retroactively. (1979) 57 Ohio St.2d 115, 116-17, 387 N.E.2d 231. That certainly made it more difficult for the plaintiff to prove her case. Yet this Court upheld the law, even though it disqualified the plaintiff's *only* medical expert. Other decisions from this Court are similar. See, e.g., *State ex rel. Slaughter v. Indus. Comm.* (1937), 132 Ohio St. 537, 9 N.E.2d 505 (new law narrowed scope of employee's right to appeal); *State ex rel. Holdridge v. Indus. Comm.* (1967), 11 Ohio St.2d 175, 228 N.E.2d 621 (deleted presumption made employer's case harder to prove); *State ex rel. Romans v. Elder Beerman Stores Corp.*, 100 Ohio St.3d 165, 2003-Ohio-5363, 797 N.E.2d 82 (new definition made employer's defense more difficult). In each case, the

retroactive rule affected only the "secondary" conduct of how litigants assemble and prove cases, not the "primary" conduct involved in the litigated, substantive law.[6]

Other jurisdictions also recognize that increased burdens on the chances of winning a lawsuit are not the same as retroactive changes that eliminate a cause of action. Three notable examples are, *Combs v. Comm'r of Social Security* (C.A.6, 2006), 459 F.3d 640, 647 (en banc) (upholding retroactive change in presumption even though it would be "outcome determinative for some claimants"), *Blatt v. Lynn* (Mich.App. 1999), No. 209686, 1999 WL 33441163, at *3 (retroactively applying law that defined previously undefined term; the amendment did not "create or abolish substantive rights" because – before the new law – plaintiff had only "a mere expectancy of surviving summary disposition,"), and *People v. Dolph-Hostetter* (Mich.App.1993), 664 N.W.2d 254, 256 (upholding admission of evidence under new law applied retroactively even though prosecution "would not be feasible" without the evidence), appeal denied, 674 N.E.2d 380.

Ackison's response to this authority is simply to list cases where courts have held that a retroactive law may not eliminate a cause of action. None of Ackison's cases *hold* that a rule that makes a case harder to win cannot be applied retroactively. This Court has struck laws that either eliminate a cause of action entirely or that undo this Court's own interpretation of the law, but this Court has *not* held that the increased burden of litigating a case is a constitutional violation. Courts from Ohio and around the country have upheld retroactive laws that do no more than change the manner of litigating.

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[6] See *Landgraf v. USI Film Prod.* (1994), 511 U.S. 244, 275, 114 S.Ct. 1483 (characterizing rules of procedure as regulations of secondary conduct that may be applied retroactively to conduct occurring before the rule's enactment)

Ackison ignores this body of authority. There is a constitutionally significant difference between retroactively eliminating a cause of action and retroactively adjusting the process of litigation to redress an "unfair and inefficient" judicial system. R.C. 2307.91, uncodified law at § 3(A)(2). There is no vested right against the latter.

Despite 50 pages of briefing, Ackison has not shown what constitutes a vested right. More fundamentally, she has not shown why *she* enjoys a vested right to every element of the common law as it existed when she filed her claim. Thus, she has failed to carry her burden of proof to show – clearly and convincingly – that H.B. 292 is unconstitutional.

IV. Ackison's attacks on three specific parts of H.B. 292 must fail because she misinterprets them and the relevant case law.

Ackison insists that three particular sections of H.B. 292 are unconstitutional when applied retroactively because they are substantive in nature. Her claim that these sections are substantive rests on her assertion that each infringes upon her vested right to the law that existed before H.B. 292 took effect. Ackison is wrong about the substantive effect of each requirement, either because the section is remedial or because the section does not change preexisting law.

A. H.B. 292's requirement that the diagnosis come from competent medical authority is constitutional because it affects only the manner of litigating asbestos cases.

Citing only the Fourth District decision in this appeal, Ackison contends that H.B. 292's requirement that the diagnosis come from competent medical authority is unconstitutional. H.B. 292 narrows who may offer opinions about a plaintiff's asbestos-related injury because the General Assembly was concerned that courts were being flooded with cases built upon dubious diagnoses from doctors for hire. Indeed, this case

is a perfect example. The medical evidence that Ackison produced (as well as some she did not) states on its face that it was prepared "at the request of Respiratory Testing Services, Inc." (T.D. 125, Ex. 1). In Judge Jack's memorable phrase, "in the business of mass screenings, a diagnosis, whether accurate or not, is money in the bank." *In re: Silica Prod. Liab. Litig.*, 398 F.Supp.2d 563 at 628. Ackison says that requiring her to bring forth the opinion of her husband's treating doctor is an unconstitutional invasion of her vested rights. Yet nowhere does she explain how courts before H.B. 292 dealt with the competent medical authority issues, nowhere does she cite precedent from this Court that allowed doctors to serve as competent medical authority regardless of their for-hire status, and nowhere does she explain why she enjoys a vested right to bar the General Assembly from addressing the problem of experts for hire.

The competent medical authority requirement does not eliminate her claim, it simply makes it more difficult to pursue. Therefore, it is permissibly retroactive.

B. The substantial contributing factor requirement is constitutional because it embraces, rather than rejects, this Court's holding in *Horton*.

Ackison also impugns the substantial contributing factor requirement in R.C. 2307.91(FF) and lodges two objections, 1) that it reverses a long line of Ohio precedent including *Horton v. Harwick Chem. Corp.* (1995), 73 Ohio St.3d 679, and 2) that in lung cancer cases, it contravenes accepted science. The second objection is easily addressed. Ackison admits that this case does not raise issues surrounding H.B. 292's requirements for lung cancer cases. (See App'ee Br. at 1 n.1 & 40 n.12 ("the only cause of action at issue is the claim for non-malignant asbestos[is]"). Accordingly, whether or not the substantial contributing factor requirement is in line with accepted science is inapposite.

Ackison's argument that the substantial contributing factor requirement contravenes Ohio precedent stems from her reading of that passage as requiring a plaintiff to prove that asbestos was the *most important* factor causing an injury. While the word "predominate" standing alone might suggest that the statute requires asbestos to be the most dominate cause, reading that language in context shows that the General Assembly did not intend "predominate" to have that narrow meaning.

The part of the statute that requires a plaintiff to show that asbestos was a substantial contributing factor is phrased in the singular. Ackison had to show that asbestos was "a substantial" factor. R.C. 2307.92(B). Thus, regardless of how substantial contributing factor is defined, the act recognizes that asbestos need be only one of – possibly several – substantial factors in the plaintiff's illness.

Moreover, the General Assembly knew it could not retroactively change the law as this Court interpreted it in *Horton*. In 2307.96(C), the General Assembly rejected part of this Court's *Horton* decision, but did so *prospectively* only, stating "[t]his section applies only to tort actions . . . that are brought on or after the effective date of this section"; see also, 2307.91, uncodified law at § 5 (noting that this, prospective, part of the law reverses part of *Horton*). This is what the Twelfth District concluded in *Wilson*, 169 Ohio App.3d 720 at ¶104, when it noted that the "predominant cause" element in R.C. 2307.91(FF) is consistent with the Restatement as adopted in *Horton*. The General Assembly's care in changing *Horton* prospectively only indicates that it did not intend for any of the retrospective elements of H.B. 292 to be in conflict with *Horton*.

Finally, if there is any remaining doubt about the meaning of the substantial contributing factor requirement, this Court should interpret the language to be consistent

with *Horton*. "Where reasonably possible, a statute should be given a construction which will avoid rather than a construction which will raise serious questions as to its constitutionality." *Co-operative Legislative Committee of Transp. Brotherhoods and Broth. of Maintenance of Way Emp. v. Public Utilities Commission* (1964), 177 Ohio St. 101, 103, 202 N.E.2d 699. Ackison's interpretation of the substantial contributing factor requirement is exactly the kind of construction that this Court should avoid.

C. The substantial occupational exposure requirement is not implicated in this appeal, and is constitutional nevertheless.

Ackison next takes aim at the substantial occupational exposure requirement. This part of the statute is only implicated in cases involving lung cancer and wrongful death. Ackison admits this appeal only involves the Fourth District's judgment relating to Ackison's non-malignant claim. (App'ee Br. at 1 n.1 & 40 n.12).[7] Thus, this Court should not address Ackison's challenges to this part of H.B. 292.

Even if the substantial occupational exposure requirement were before this Court, it passes constitutional muster. First, while H.B. 292 *permits* a plaintiff to establish a prima facie case by meeting minimum thresholds similar to the type that were rejected in *Horton* (time on the job and type of work), the law does not *require* those showings. R.C. 2307.91(GG); 2307.92(C)(1)(c). The act permits a plaintiff to establish a prima facie case of asbestos injury by showing *either* substantial occupational exposure *or* that the injured party's exposure is at least equal to "25 fiber per [cubic centimeter] years." R.C. 2307.92(C)(1)(c)(ii). The second avenue animates *Horton's* language [that] a

[7] See also id. at 24 (recognizing that the substantial occupational exposure requirement applies only to lung cancer and death cases).

plaintiff "has the burden of proving that exposure . . . was a substantial factor in causing the plaintiff's injury." 73 Ohio St.3d 679, paragraph 1 of the syllabus.

Second, the occupational exposure requirement of H.B. 292 concerns a different question than *Horton*. *Horton* evaluated whether a *particular defendant's* asbestos was a substantial contributing factor to a plaintiff's illness. *Horton* did not address the threshold requirement that a plaintiff demonstrate enough exposure to asbestos – regardless of its source – to show that asbestos, not some other cause, led to his illness.

This is exactly what the Twelfth District held in *Wilson*: "The General Assembl[y] knew how to [reverse *Horton*] and when it did so, it respected the boundaries of its power and did so prospectively. . . . [T]hese provisions . . . address the prima facie case (whether the claimant had sufficient collective exposure to asbestos generally to state a colorable claim of asbestos-related injury), and not the issue of proof regarding an individual product or defendant, which was the issue in *Horton*." *Wilson*, 169 Ohio App.3d 720, at ¶112 (internal quotation marks omitted). Ackison's arguments about the substantial occupational exposure element of H.B. 292 are irrelevant to this appeal. But even if they were relevant, those sections are constitutionally retroactive.

V. Ackison cites distinguishable authority from Pennsylvania and Georgia, but ignores on-point authority from Florida.

Ackison also points to cases from Pennsylvania and Georgia to suggest that this Court strike down H.B. 292. These cases are distinguishable. They focused on the prohibition against *eliminating* a cause of action or changing binding supreme court authority. H.B. 292, on the other hand, only changes the *manner* of litigating asbestos claims. Moreover, Ackison entirely ignores a Florida decision that held a statute almost identical to H.B. 292 constitutionally retroactive.

In *DaimlerChrysler Corp. v. Ferrante* (Ga. 2006), 637 S.E.2d 659, the Georgia Supreme Court struck down a statute that undid a definitive interpretation of the law in a prior Georgia Supreme Court decision. The challenged law changed the causation requirement from "contributing factor" to "substantial factor" despite a recent Georgia Supreme Court opinion *rejecting* the "substantial factor" test. Id. at 661 (citing *John Crane, Inc. v. Jones* (Ga. 2004), 604 S.E.2d 822, 825, 826). The Ohio General Assembly was careful to avoid the same problem. Those parts of H.B. 292 at issue in this appeal do not retrospectively reverse an Ohio Supreme Court opinion or standard.

Ackison also relies on a Pennsylvania case that struck a statute that *eliminated* liability for certain companies that inherited asbestos liability from corporations that manufactured asbestos products. In the court's words, "the Statute state[s] that a qualified corporation is not responsible for *any liability* that is related to any claim for relief related to asbestos." *Ieropoli v. AC&S Corp.* (Pa.2004), 842 A.2d 919, 929 (emphasis added). The statute in *Ieropoli* is wholly unlike H.B. 292. H.B. 292 does not insulate any defendant from liability, it merely sets standards for courts to distinguish legitimate from illegitimate claims of injury. These requirements do not shield corporations from "any liability"; the requirements merely tailor corporate responsibility to those injuries that were legitimately caused by their products.

Meanwhile, Ackison ignores entirely a recent Florida decision that reversed a trial court for refusing to apply an asbestos reform statute almost identical to H.B. 292. The Florida court explained that, "[p]rior to the enactment of the Act, the plaintiff had, at most, a 'mere expectation' that the common law would not be altered by legislation. . . . Thus, the plaintiff *did not have a vested right* in her common law asbestos claim."

DaimlerChrysler Corp. v. Hurst (Fla.App. 2007), 949 So.2d 279, 287 (emphasis added) (internal citation omitted), review denied, ___ So.2d ___, No. SC07-722 (July 6, 2007). In a passage that could describe this Court's holdings, the Florida court declared that, because "the Act merely affects the means and methods the plaintiff must follow when filing or maintaining an asbestos cause of action, the provision is procedural in nature, and may be applied retroactively." Id.

Measuring H.B. 292 against the requirement that a retroactive law may not *completely eliminate* a cause of action or *undo* a previous decision of this Court shows that H.B. 292 is compatible with the Retroactivity Clause. *Ferrante* and *Ieropoli* do not change this result.

VI. Ackison misreads the law regarding clarifying legislation.

Ackison makes three points to address Appellants' arguments that H.B. 292 is constitutional because it clarifies prior law, but each rests on mistaken assumptions. With H.B. 292, the General Assembly clarified terms that had no previously settled meaning in Ohio law.[8] Those clarifications are constitutional.

A. H.B. 292 clarified, but did not amend, R.C. 2305.10(B)(5) because the term "competent medical authority" had no settled meaning before H.B. 292.

Ackison contends – without any authority – that H.B. 292 cannot clarify R.C. 2305.10(B)(5) because it does not *amend* that section. This argument improperly conflates the concepts of clarifying and amendatory legislation. Clarifying legislation operates to state what an existing law meant. Amendatory legislation, on the other hand,

[8] This is distinct from *Hearing v. Wylie* where this Court struck down legislation that redefined a term that *this Court* had previously defined. (1962), 173 Ohio St. 221, 180 N.E.2d 921, overruled on other grounds, *Village v. Gen. Motors Corp.* (1984), 15 Ohio St.3d 129.

changes the meaning of the prior law. Clarifying legislation can be applied retroactively. (App'lt Br. at 20-22).

Ackison further asserts that H.B. 292 cannot clarify R.C. 2305.10(B)(5) because the definition of "competent medical authority" refers to diagnoses "for the purposes of" H.B. 292. This argument overlooks section 2307.92(A), where the General Assembly expressed its intent that the definitions in H.B. 292 apply to R.C. 2305.10(B)(5).[9] R.C. 2307.92(A). The General Assembly did not *amend* R.C. 2305.10(B)(5) because it intended only to clarify what that section has meant since 1980 – that an asbestos action does not accrue until "competent medical authority" diagnoses an asbestos-related injury.

B. Contrary to Ackison's argument, R.C. 2305.10(B)(5) requires diagnosis by a competent medical authority.

Next, Ackison argues that H.B. 292 could not clarify R.C. 2305.10(B)(5), because that section never required competent medical authority to diagnose the disease. Ackison focuses on the "or" in 2305.10(B)(5) to support her argument.[10] Ackison's focus is misplaced. R.C. 2305.10(B)(5), and the "competent medical authority" language, protect plaintiffs from an early running of the statute of limitations. The statute also protects defendants from plaintiffs who might argue that the cause of action had not accrued (and that the statute of limitations had not run) because no *competent medical authority* directly told her of the asbestos-injury connection. The "or" clause protects defendants

---

[9] Although R.C. 2307.92(A) only refers to the "bodily injury" and "substantial contributing factor" language, the latter incorporates the requirement of "competent medical authority." See R.C. 2307.91(FF)(2).

[10] R.C. 2305.10(B)(5) reads: "a cause of action for bodily injury caused by exposure to asbestos accrues upon the date on which the plaintiff is informed by competent medical authority that the plaintiff has an injury that is related to the exposure, or upon the date on which by the exercise of reasonable diligence the plaintiff should have known that the plaintiff has an injury that is related to the exposure, whichever date occurs first."

from these types of evasions if a plaintiff should have reasonably known of the link between asbestos and injury. This clause, though, does not *substitute* for the requirement that *competent medical authority* establish the asbestos-injury connection.

Indeed, a lay person could not tell whether asbestos or something else had caused her injury. See, e.g., *Yung v. Raymark Industries, Inc.* (C.A.6, 1986), 789 F.2d 397, 399 ("Ohio law states that the issue of causal connection between an injury and a specific subsequent physical disability involves a scientific inquiry that must be established by the opinion of medical witnesses competent to express such an opinion."). The "should have known" clause following the "or" permits courts to find that any reasonable plaintiff would have understood he or she had been diagnosed by "competent medical authority" with an asbestos-related injury. See, e.g, *Stroney v. Eagle-Picher Indus., Inc.* (Oct. 13, 1988), 8th Dist. No. 54955, 1988 WL 113008 (plaintiff claimed he was never "informed formally of his condition," but court affirmed summary judgment against plaintiff because "simply inquiring of the doctors" about why he was being treated would have apprised him of the diagnosis). The should-have-known clause merely reinforces the competent-medical-authority requirement.

C. Ackison claims that "competent medical authority" has a meaning outside of H.B. 292, but points to no authority to support that assertion.

Finally, Ackison cites the principle that courts will employ common usage to supply the meaning to a term not defined in legislation. (App'ee Br. at 38). She contends that "common usage" means she has a vested right to the application of whatever definition courts in the past have assigned to the term "competent medical authority". But Ackison points to no case that assigned meaning to that phrase before H.B. 292's

effective date. Instead, she points to generic cases about what makes an expert competent to testify. Oddly, her citation of cases about expert *testimony* is in tension with an earlier argument in her brief where she insists that H.B. 292 "in no way touches on the competency of *testifying* witnesses." (App'ee Br. at 35-36) (emphasis in original).

For Ackison to succeed in showing that the "competent medical authority" portion of H.B. 292 is unconstitutional, she must point to authority that vests her with a right against the General Assembly's prerogative to clarify it. She has not done so.

VII. Ackison's argument that H.B. 292 violates the Open Courts Clause of the Constitution must fail.

Perhaps concerned that her argument about constitutional retroactivity is wanting, Ackison has, for the first time in this litigation, challenged H.B. 292 as violative of the Open Courts Clause of the Constitution. Of course, "A party who fails to raise an argument in the court below waives his or her right to raise it here." *State ex rel. Zollner v. Indus. Comm.* (1993), 66 Ohio St.3d 276, 278, 611 N.E.2d 830.

Even if Ackison had not waived the argument before both the trial court and the Fourth District, her attack based on the Open Courts Clause should fail. Ackison's argument assumes two things that are not true 1) that she had a cause of action under prior law simply because she filed a claim in court, and 2) that H.B. 292 eliminates her claim. As was explained above, the x-ray reading, pulmonary function reports and medical report demonstrate that her husband did not have asbestosis and did not suffer any impairment caused by asbestos exposure. And, as explained above, H.B. 292 does not eliminate causes of action, it merely changes how those claims are litigated.

Ackison waived her open courts argument by not raising it until she reached this Court.[11] Moreover, the argument simply repackages what she argues elsewhere in her brief. This argument does not change the analysis – H.B. 292 is constitutional.

VIII. H.B. 292's requirements are severable.

Ackison contends that no part of H.B. 292 is severable, but offers no analysis as to why. She merely cites to the very brief discussion from the Georgia Supreme Court's *Ferrante* decision. She avoids the analysis offered in Appellants' opening brief, including citations to cases where this Court has severed individual clauses or words from statutes.

Ackison's reliance on *Ferrante* is misplaced. That decision found that the definition of causation was the "heart of the Act." 637 S.E.2d 659, 662. That is unlike H.B. 292, which contains at least four distinct components, each of which would help restore fairness and efficiency to asbestos litigation in this state. Specifically, H.B. 292 requires 1) that asbestos was a substantial contributing factor to a non-malignant injury, 2) that a competent medical authority take occupational, exposure, smoking, and medical histories of the plaintiff and opine about the "most probable cause" of any medical problems, 3) that the plaintiff demonstrate injury in accord with one of the listed criteria (including pulmonary function tests), and 4) that the doctor performing these tasks be competent within the meaning of the statute. R.C. 2307.92(B); R.C. 2307.91(Z)(2),(4).

Each of these requirements could stand alone if any other were found unconstitutional. For example, even without the "substantial contributing factor" requirement, the law could restrict diagnoses to those made by "competent medical

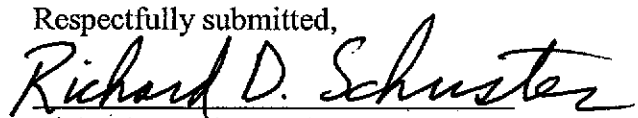
[11] Ackison also waived the undeveloped arguments based on the Fourteenth Amendment that she tucks into footnote 16 of her brief.

authority." Severability is only inappropriate if the offensive section is "so essentially connected with the remainder" of the law "that, if eliminated, the statute loses its intent." *State v. Hochhausler* (1996), 76 Ohio St.3d 455, 465, 668 N.E.2d 457. No part of H.B. 292 is "so essential[]" that the General Assembly would have intended that the whole reform effort rise or fall based on the constitutionality of any one part.

Conclusion

The General Assembly has the right to make policy decisions to alter the common law of the state. Moreover, the General Assembly may retroactively change the law unless to do so would reach back and extinguish a plaintiff's claims or undo this Court's prior decisions. H.B. 292 does neither of those things. Instead, H.B. 292 seeks to apply rationality to a complex and overburdening family of litigation. It does so by imposing prima-facie requirements that allow courts to sort meritorious from dubious claims. Ackison has not proven that Ohio's Constitution bars these measured reforms to a broken system.

Respectfully submitted,



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APPENDIX

EXHIBIT 1

Robert B. Altmeyer, M.D.
PULMONARY MEDICINE

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE IN PULMONARY DISEASES
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CERTIFIED B READER BY THE NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH
1131 NATIONAL ROAD
WHEELING, WV 26003
(304) 243-1446

ASBESTOS MEDICAL EVALUATION

ACKISON, DANNY I083 [redacted]

DATE OF CHEST X-RAY: 9/26/00

HISTORY:

This patient is a 62 year old, white male whom I examined in Ironton, Ohio on 9/26/00 at the request of Respiratory Testing Services, Inc.

OCCUPATIONAL HISTORY:

From 1964 until 2000 he worked for Dayton Malleable Corporation in Ironton, Ohio working in a foundry. He worked as a laborer, molder core setter, and worked on the electrical furnace. He indicated that he worked around furnaces and other machinery, which were insulated with asbestos. He overhauled electric furnaces, which contained asbestos. He worked alongside insulators, boilermakers, and pipe fitters. He has had a direct exposure to asbestos insulation, cloth, gloves, and fire brick.

SMOKING HISTORY:

From age 25 or 30 to age 50 he smoked 1 to 1 1/2 packs of cigarettes a day.

MEDICAL HISTORY:

In 1996 he was diagnosed as having diabetes mellitus. He takes an oral medication for diabetes. He has never been hospitalized. He has had no operations. He has no history of cancer, asbestosis, myocardial infarction, stroke, rheumatic fever, valvular heart disease, congestive heart failure, COPD, asthma, tuberculosis, pneumonia, chest surgery, chest trauma, or pleurisy. His current symptoms include some shortness of breath when walking or lying in bed at night, which has been present for eight to ten years. He has no chronic cough, wheezing, chest pain or hemoptysis.

PHYSICAL EXAMINATION:

Height:	73 inches
Weight:	237 pounds
Respiratory Rate:	14
Heart Rate:	88
Chest:	The chest was clear. There were no wheezes and no crackles. The forced expiratory time was normal.
Heart:	The heart is regular. There is a possible S4, but no S3 gallop.
Extremities:	There is some edema of the right leg. The nails are not cyanosed or clubbed.
Neck:	There is no supraclavicular adenopathy.

PULMONARY FUNCTION STUDIES:

A pulmonary function study obtained on 9/26/00 by Respiratory Testing Services, Inc. showed no obstruction or restriction, but there was a mild gas exchange impairment with a TLC at 116% of predicted.

CHEST X-RAY INTERPRETATION:

A chest x-ray taken on 9/26/00 showed 0/1, t/t in both mid and both lower lung zones, as well as category B/3/1 circumscribed pleural thickening along the right lateral chest wall, and category A/2/0 circumscribed pleural thickening along the left lateral chest wall. There is a calcified granuloma in the left lower lung zone.

IMPRESSION:

Based on the above data, it is my opinion with a reasonable degree of medical certainty, that this man has asbestos related pleural thickening. The basis of this diagnosis is the finding of fairly symmetrical bilateral pleural thickening in an

individual who has had a significant exposure to asbestos with an appropriate latency period and no other obvious cause for the pleural thickening. His only functional impairment is a mild reduction in his diffusing capacity, which is probably due to his prior long-term cigarette smoking.

He is at increased risk for the development of lung cancer, mesothelioma, and loss of lung function because of his asbestos exposure. For that reason, I advised him to have a yearly chest x-ray and examination by his personal physician. It is my opinion that his asbestos related pleural thickening was caused by the inhalation of asbestos fibers in the work place.

Sincerely,

Robert B. Altmeyer, M.D.

RBA/jrd

JAN. 11. 2001 12:03PM NMLKF ... 404 NO. 0090

Adkison, Donny L. — 12 26 00 (MO. DAY YR.) — 2017343257

1. Is Film Completely Negative? YES ☐ Proceed to Section 5 NO ☐ Complete Section 2A

2A. Any Parenchymal Abnormalities Consistent with Pneumoconiosis? YES ☐ Complete 2B and 2C NO ☐ Proceed to Section 3.

SMALL OPACITIES

a. SHAPE/SIZE — PRIMARY: p s q t r u; SECONDARY: p s q t r u

b. ZONES: R L

c. PROFUSION: 0/- 0/0 0/1 1/0 1/1 1/2 2/1 2/2 2/3 3/2 3/3 3/+

2C. LARGE OPACITIES — SIZE: 0 A B C — Proceed to Section 3

ANY PLEURAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS? YES ☐ Complete 3B, 3C and 3D NO ☐ Proceed to Section 4

PLEURAL THICKENING

a. Diaphragm (plaque): 0 R L

b. Costophrenic Angle: 0 R L

a. CIRCUMSCRIBED (plaque) — SITE: 0 R / 0 L; In Profile I. Width: 0 A B C; II. Extent: 0 1 2 3; Face On III. Extent: 0 1 2 3

3C. PLEURAL THICKENING ... Chest Wall — b. Diffuse — SITE: 0 R / 0 L; In Profile I. Width: 0 A B C; II. Extent: 0 1 2 3; Face On III. Extent: 0 1 2 3

PLEURAL CALCIFICATION

SITE: 0 R — EXTENT

a. Diaphragm: 0 1 2 3

b. Wall: 0 1 2 3

c. Other Sites: 0 1 2 3

SITE: 0 L — EXTENT

a. Diaphragm: 0 1 2 3

b. Wall: 0 1 2 3

c. Other Sites: 0 1 2 3

Proceed to Section 4

ANY OTHER ABNORMALITIES? YES ☐ Complete 4B and 4C NO ☐ Proceed to Section 5

OTHER SYMBOLS (OBLIGATORY)

0	ax	bu	ca	cn	co	cp	cv	di	ef	em	es	fr	hi	ho	id	ih	kl	pi	px	rp	tb

... ITEMS WHICH ... BE OF PRESENT ... ICAL SIGNIFICANCE ... THIS SECTION. (Specify or.) — Date Personal Physician notified? Mo. Day Yr.

OTHER COMMENTS: ELC Granuloma

... WORKER SEE PERSONAL PHYSICIAN BECAUSE OF COMMENTS IN SECTION 4C? Yes No — Proceed to Section 5

FACILITY PROVIDING ROENTGENOGRAPHIC EXAMINATION:

... Medical Provider Number (If applicable):

... film taken by a registered radiographer/radiographic technologist? ☐ Yes ☐ No — State

... Registration No.

Physician Interpreting Film (Print Name):

... your Board-certified Radiologist? ☐ Yes ☐ No. Board-eligible radiologist? ☐ Yes ☐ No. B-reader? ☐ Yes ☐ No.

... certify that this film has been interpreted in accordance with the instructions provided on Form CM-954a and/or 20 CFR 718, Subpart B, 718.102 and ... Appendix A.

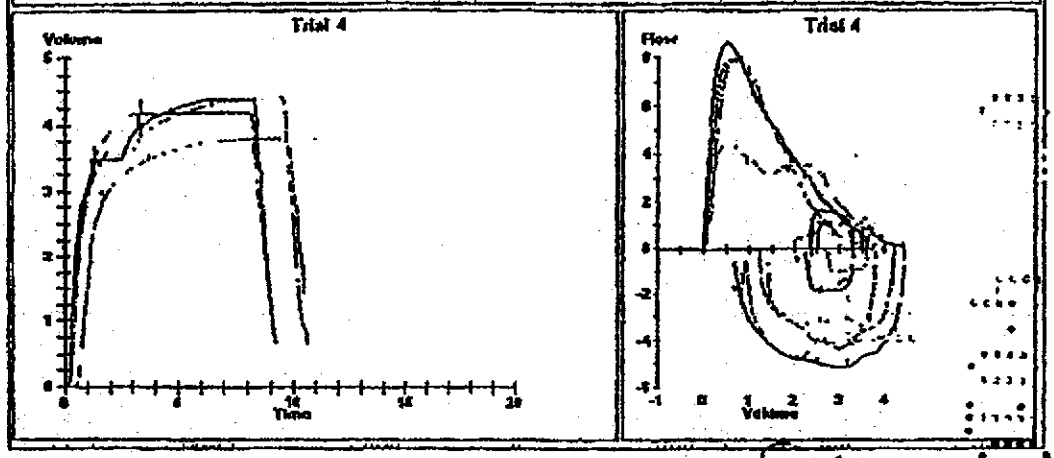
PHYSICIAN'S SIGNATURE: [signature] DATE OF READING: 9/18/00

RESPIRATORY TESTING [illegible]ES
MOBILE, ALABAMA

Date: 09/26/00 **Pre**

Flow Volume Loop — ACKISON, DANNY R. - ID-83 301-34-3257

	Rel	Best	% Ref	1	2	3	4
FVC	5.12	4.42	86	4.20	3.80	4.42	4.41
FEV1	3.56	3.46	97	3.46	2.79	3.25	3.29
FEV1/FVC	77	78		83	73	74	75
FEF25-75%	3.55	2.52	71	3.54	2.25	2.43	2.52
PEF		8.74		8.22	4.44	8.01	8.74



RESPIRATORY TESTING RVICES
MOBILE, ALABAMA

Date: 09/26/00 Pre

Flow Volume Loop — ACKISON, DANNY R. - 10-83 301-34-3257

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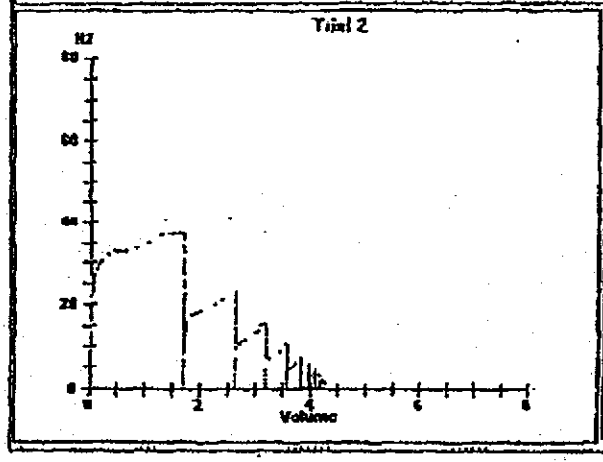
FVC	5.12	4.42	86	4.20	3.80	4.42	4.41
FEV1	3.96	3.45	87	3.46	2.79	3.26	3.25
FEV1/FVC	77	78		83	73	74	75
FEV3/FVC	92	89		100	92	86	89
FET100%		8.86		7.83	9.14	9.18	8.86
FEF25-75%	3.55	2.52	71	3.54	2.25	2.43	2.52
FEF25%		6.72		7.54	3.92	6.76	6.72
FEF50%		3.33		3.63	3.56	3.16	3.33
FEF75%		0.91		1.62	0.88	0.76	0.91
PEF		8.74		8.22	4.44	8.01	8.74
FVL ECode		000000		000	000	000	000
FIVC	5.12	3.76	73	2.99	2.42	3.86	3.76
PIF		5.24		4.48	3.60	4.73	5.24
FEF/FIF50		0.65		0.68	1.09	0.76	0.65

RESPIRATORY TESTING R. ES
MOBILE, ALABAMA

Date: 09/26/00 Pre

Lung Volumes — ACKISON, DANNY R. - IO-83 301-34-3257

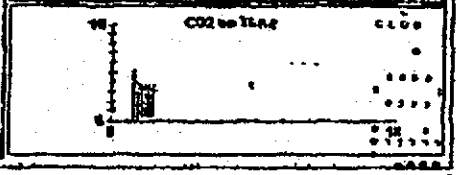
	Ref	Best	% Ref	1	2
TLC	7.57	8.82	116	8.49	8.82
VC	5.12	4.66	91	4.34	4.66
FRC N2	4.80	5.29	132	5.05	5.53
IC	3.36	3.37	100	3.44	3.38
RV	2.44	4.16	171	4.15	4.17



N2 1.1 %

FRC 4.30 L

Wash Time 0.7 Min



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RESPIRATORY TESTING RVICES
MOBILE, ALABAMA

Date: 09/26/00 Pre

Lung Volumes — ACKISON, DANNY R. - ID 83 301-34-3257

	Ref	Best	% Ref	1	2
TLC	7.57	8.82	116	8.49	8.82
VC	5.12	4.66	91	4.34	4.66
FRC NZ	4.00	5.29	132	5.65	5.53
IC	3.36	3.37	100	3.44	3.30
ERV	1.69	1.13	67	0.90	1.36
RV	2.44	4.16	171	4.15	4.17
RV/TLC	33	47		49	47
LCI		6.80		6.24	7.36
Wash Time		0.8		8.9	8.8
LVol ECode		000000		00	00
VE	9.0	22.8	254	19.3	26.3
Vt		0.65		0.60	0.70
f		35		32	38
LVol Time		09:26		09:26	09:30
LVol Date		09/26		09/26	09/26

RESPIRATORY TESTING REV. _S
MOBILE, ALABAMA

Date: 09/26/00 Pre

Single Breath DLCO — ACKISON, DANNY R. - ID-83 301-34-3257

	Ref	Best	% Ref	1	2	3	4
DLCO	37.0	25.9	70	26.6	[illegible]	25.2	26.6
DL Adj	37.0	25.9	70	26.6	[illegible]	25.2	26.6
IVC		4.26		4.07	[illegible]	4.24	4.27
VA		6.82		6.46	[illegible]	6.81	6.83
DL/VA Adj		3.80		3.97	[illegible]	3.70	3.80

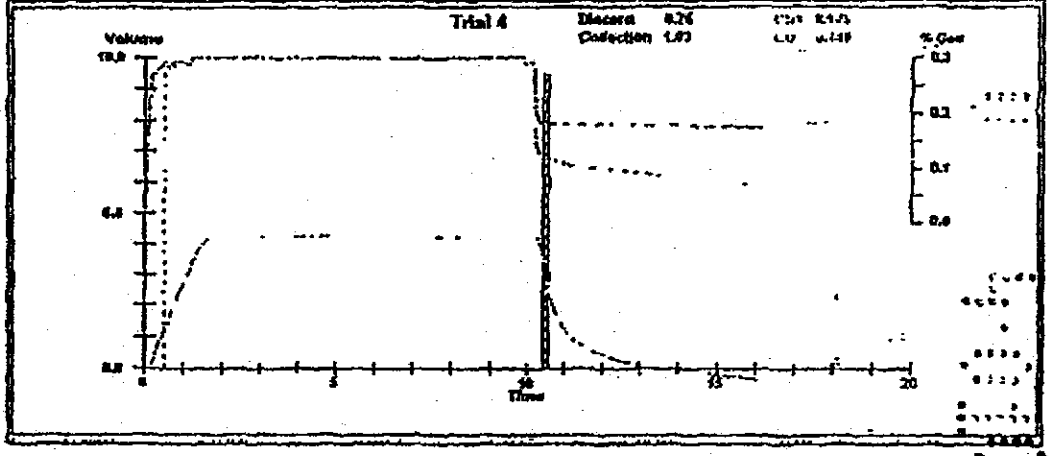

EXHIBIT 2

Consensus report

Scand J Work Environ Health 1997;23:311—6

Asbestos, asbestosis, and cancer: the Helsinki criteria for diagnosis and attribution

The International Expert Meeting on Asbestos, Asbestosis, and Cancer was convened in Helsinki on 20—22 January 1997 to discuss disorders of the lung and pleura in association with asbestos and to agree upon state-of-the-art criteria for their diagnosis and attribution with respect to asbestos. The group decided to name this document *The Helsinki Criteria*.

The requirement for diagnostic criteria was perceived in part because of new developments in diagnostic methods, with better identification of asbestos-related disorders. Such developments enhance awareness of health hazards imposed by asbestos, lead to practical prevention and appropriate compensation, and also provide an opportunity to carry out international comparisons. They also provide possible models for the risk assessment of other mineral dusts.

The meeting was attended by 19 participants from 8 countries not producing asbestos. The chairmen were Professor Douglas W Henderson (Flinders Medical Centre, Australia) and Professor Jorma Rantanen (Finnish Institute of Occupational Health, Finland). The group was a multidisciplinary gathering of pathologists, radiologists, occupational and pulmonary physicians, epidemiologists, toxicologists, industrial hygienists, and clinical and laboratory scientists specializing in tissue fiber analysis. Collectively, the group has published over 1000 articles on asbestos and associated disorders. This document is based on a more comprehensive report providing scientific evidence for the conclusions and recommendations (*People and Work Research Reports*, no 14, Finnish Institute of Occupational Health, Helsinki, 1997).

The meeting was scientifically supported by leading institutions in the field of asbestos research, and it was funded by the Ministry of Social Affairs and Health and the Finnish Work Environment Fund.

General considerations

Occupational exposures to asbestos dust have been widespread in all industrial countries and continue as a consequence of "in-place" materials. In detailed interviews about 20% to 40% of adult men report some past occupations and jobs that may have entailed asbestos exposure at work. In Western Europe, North America, Japan, and Australia the use of asbestos peaked in the 1970s, and currently about 10 000 mesotheliomas and 20 000 asbestos-induced lung cancers are estimated to occur annually in the population of approximately 800 million people.

In general, reliable work histories provide the most practical and useful measure of occupational asbestos exposure. Using structured questionnaires and checklists, trained interviewers can identify persons who have a work history compatible with significant asbestos exposure. Dust measurements can be used in the estimation of past fiber levels at typical workplaces and in the use of asbestos-containing materials. A cumulative fiber dose, as expressed in fiber-years per cubic centimeter, is an important parameter of asbestos exposure.

The clinical diagnosis of asbestos-related diseases is based on a detailed interview of the patient and occupational data on asbestos exposure and appropriate latency, signs and symptoms, radiological and lung physiology findings, and selected cytological, histological and other laboratory studies. Histopathological confirmation is required for suspected asbestos-related malignancies and for the resolution of differential diagnoses. A multidisciplinary approach is suggested for the evaluation of problem cases.

The chest radiograph is the basic tool for identifying asbestos-related diseases such as asbestosis, pleural abnormalities, lung cancer, and mesothelioma. The limitation of the chest radiograph in the detection of asbestosis and asbestos-associated pleural abnormalities is widely recognized. Computed tomography (CT) and high resolution computed tomography (HRCT) can facilitate the detection of asbestosis and asbestos-related pleural abnormalities, as well as asbestos-related malignancies; they are not recommended as a screening tool but may be invaluable for individual clinical evaluation and research purposes. Examples are the detection of pleural abnormalities in suspected cases of asbestosis and the detection of parenchymal disease obscured on the chest film and also use as an aid to differential diagnosis. As new imaging techniques such as digital radiography are evolving, standard images and interpretations must be developed. The place of other imaging techniques (ultrasound, magnetic resonance imaging, gallium scanning, ventilation-perfusion studies, positron-emission tomography) has yet to be established, and they are not currently recommended for the clinical diagnosis of asbestos-related disorders.

Analysis of lung tissue for asbestos fibers and asbestos bodies can provide data to supplement the occupa-

tional history. For clinical purposes, the following guidelines are recommended to identify persons with a high probability of exposure to asbestos dust at work: over 0.1 million amphibole fibers (>5 μm) per gram of dry lung tissue *or* over 1 million amphibole fibers (>1 μm) per gram of dry lung tissue as measured by electron microscopy in a qualified laboratory *or* over 1000 asbestos bodies per gram of dry tissue (100 asbestos bodies per gram of wet tissue) *or* over 1 asbestos body per milliliter of bronchoalveolar lavage fluid, as measured by light microscopy in a qualified laboratory.

Each laboratory should establish its own reference values. The median values for occupationally exposed populations should be substantially above the reference values. Efforts to standardize analytical methods for fiber burden analyses by different laboratories are recommended.

Asbestosis

Asbestosis is defined as diffuse interstitial fibrosis of the lung as a consequence of exposure to asbestos dust. Neither the clinical features nor the architectual tissue abnormalities sufficiently differ from those of other causes of interstitial fibrosis to allow confident diagnosis without a history of significant exposure to asbestos dust in the past or the detection of asbestos fibers or bodies in the lung tissue greatly in excess of that commonly seen in the general population. Symptoms of asbestosis include dyspnea and cough. Common findings are inspiratory basilar crackles and, less commonly, clubbing of the fingers. Functional disturbances can include gas exchange abnormalities, a restrictive pattern, and obstructive features due to small airway disease.

Asbestosis is generally associated with relatively high exposure levels with radiological signs of parenchymal fibrosis. However, it is possible that mild fibrosis may occur at lower exposure levels, and the radiological criteria need not always be fulfilled in cases of histologically detectable parenchymal fibrosis. The recognition of asbestosis by chest radiography is best guided by standardized methods such as the classification of the International Labour Organisation (ILO) and its modifications. Standard films must always be used. For research and screening purposes, radiological findings of small opacities, grade 1/0, are usually regarded as an early stage of asbestosis. Inspiratory basilar rales, restrictive impairment, small airway obstruction, and gas exchange disturbances in pulmonary function are considered valuable information for clinical diagnosis, for occupational health practice, and for attribution purposes. HRCT can confirm radiological findings of asbestosis and show early changes not seen on chest X rays, but should be performed only in selected cases.

Smoking effects should be considered in the evaluation of early asbestosis, lung function tests, and respiratory symptoms.

A histological diagnosis of asbestosis requires the identification of diffuse interstitial fibrosis in well inflated lung tissue remote from a lung cancer or other mass lesion, *plus* the presence of either 2 or more asbestos bodies in tissue with a section area of 1 cm^2 or a count of uncoated asbestos fibers that falls into the range recorded for asbestosis by the same laboratory.

In order to achieve reasonable comparability between different studies, a standardized system for the histological diagnosis and grading of asbestosis is required. The Roggli-Pratt modification of the CAP-NIOSH system is recommended as a reasonably simple and reproducible scheme for this purpose.

There is evidence that rare cases of asbestosis occur without significant numbers of asbestos bodies. These cases are recognizable — and distinguishable from idiopathic pulmonary fibrosis — only by analysis of the uncoated fiber burden. Rare cases of asbestosis in relation to the inhalation of pure chrysotile can occur, with a prolonged interval between the last exposure and the diagnosis and few or no detectable asbestos bodies and a low fiber burden. The existence of such cases is speculative and, if the diagnosis can be made, it must be done from other compelling clinical or radiological grounds combined with exposure data.

Fibro-inflammatory patterns other than conventional asbestosis have also been described for workers with occupational exposure to asbestos, including a pattern resembling desquamative interstitial pneumonia (DIP), the occurrence of granulomatous inflammation, a picture that resembles lymphocytic interstitial pneumonia, and organizing pneumonia with bronchiolitis obliterans. Although the DIP-like picture with asbestos bodies is probably asbestos-related, the other patterns have not yet been shown to be so related.

Pleural disorders

Asbestos-related pleural abnormalities are divided into pleural plaques, mainly involving the parietal pleura, sometimes with calcification, and diffuse pleural thickening, which is a collective name for pleural reactions involving mainly the visceral pleura. These include benign asbestos-related pleural effusion, blunted costophrenic angle, crow's feet or pleuroparenchymal fibrous strands, and rounded atelectasis. Avoidance of the term "pleural asbestosis" is recommended. Pleural plaques are usually asymptomatic, and without clinically important findings.

The specificity of pleural plaques according to the ILO 1980 Classification of Radiographs of Pneumoconioses is low unless the plaques are radiographically well

defined. The most common differential diagnosis is subpleural fat. Radiographic findings are reliable for the diagnosis of asbestos-related pleural plaques when they are characteristic (eg, bilateral circumscribed plaques, bilateral calcification, diaphragmatic plaques).

Pleural plaques represent circumscribed areas of fibrous thickening, typically of the parietal pleura, due to the deposition of paucicellular collagenous tissue with a laminar or basket-weave pattern; they may or may not calcify. In regions where plaques are not endemic, 80—90% of the plaques that are radiologically well defined are attributable to occupational asbestos exposure. The presence of pleural plaques may justify follow-up among occupationally exposed groups.

Diffuse pleural fibrosis designates noncircumscribed fibrous thickening of variable cellularity, which usually affects the parietal, but mainly the visceral, layers. In the setting of occupational asbestos exposure, such diffuse fibrosis is probably a result of benign asbestos pleuritis with effusion. It may or may not be associated with rounded atelectasis. Diffuse pleural thickening can be associated with mild, or rarely moderate or severe, restrictive pulmonary function defects.

Low exposures from work-related, household, and natural sources may induce pleural plaques. For diffuse pleural thickening, higher exposure levels may be required.

Mesothelioma

Malignant mesothelioma affecting any serosal membrane may be induced by asbestos inhalation. The histological, immunohistochemical and ultrastructural markers for the diagnosis of mesothelioma are well established. Expert opinion should be sought on atypical cases, or on those in which the diagnosis is uncertain because of discordant findings or in which the amount of material available is insufficient for definite diagnosis. Mesothelioma is frequently presented with pleural effusion, dyspnea, and chest pain.

With the exception of certain histological types of mesothelioma that are benign or of uncertain or borderline malignant potential (eg, multicystic mesothelioma, benign papillary mesothelioma), all types of malignant mesothelioma can be induced by asbestos, with the amphiboles showing greater carcinogenic potency than chrysotile.

A lung fiber count exceeding the background range for the laboratory in question *or* the presence of radiographic or pathological evidence of asbestos-related tissue injury (eg, asbestosis or pleural plaques) *or* histopathologic evidence of abnormal asbestos content (eg, asbestos bodies in histologic sections of lung) should be sufficient to relate a case of pleural mesothelioma to asbestos exposure on a probability basis. In the absence of such markers, a history of significant occupational, domestic, or environmental exposure to asbestos will suffice for attribution. There is evidence that peritoneal mesotheliomas are associated with higher levels of asbestos exposure than pleural mesotheliomas are. In some circumstances, exposures such as those occurring among household members may approach occupational levels.

The question is unresolved of whether or not a case of mesothelioma for which the lung fiber count falls within the range recorded for unexposed urban dwellers is related to asbestos. More information is needed regarding the interpretation of fiber burdens in the pleura or samples of tumor tissue before these measures can be used for the purposes of attribution.

The following points need to be considered in the assessment of occupational etiology:

- The great majority of mesotheliomas are due to asbestos exposure.
- Mesothelioma can occur in cases with low asbestos exposure. However, very low background environmental exposures carry only an extremely low risk.
- About 80% of mesothelioma patients have had some occupational exposure to asbestos, and therefore a careful occupational and environmental history should be taken.
- An occupational history of brief or low-level exposure should be considered sufficient for mesothelioma to be designated as occupationally related.
- A minimum of 10 years from the first exposure is required to attribute the mesothelioma to asbestos exposure, though in most cases the latency interval is longer (eg, on the order of 30 to 40 years).
- Smoking has no influence on the risk of mesothelioma.

Lung cancer

All 4 major histological types (squamous, adeno-, large-cell and small-cell carcinoma) can be related to asbestos. The histological type of a lung cancer and its anatomic location (central or peripheral, upper lobe versus lower lobe) are of no significant value in deciding whether or not an individual lung cancer is attributable to asbestos. Clinical signs and symptoms of asbestos-related cancer do not differ from those of lung cancer of other causes.

As examples, 1 year of heavy exposure (eg, manufacture of asbestos products, asbestos spraying, insulation work with asbestos materials, demolition of old buildings) or 5—10 years of moderate exposure (eg, construction, shipbuilding) may increase the lung cancer risk 2-fold or more. In some circumstances of extremely high asbestos exposure, a 2-fold risk of lung cancer can be achieved with exposure of less than 1 year.

The relative risk of lung cancer is estimated to increase 0.5—4% for each fiber per cubic centimeter per year (fiber-years) of cumulative exposure. With the use of the upper boundary of this range, a cumulative exposure of 25 fiber-years is estimated to increase the risk of lung cancer 2-fold. Clinical cases of asbestosis may occur at comparable cumulative exposures.

A 2-fold risk of lung cancer is related to retained fiber levels of 2 million amphibole fibers (>5 μm) per gram of dry lung tissue or 5 million amphibole fibers (>1 μm) per gram of dry lung tissue. This lung fiber concentration is approximately equal to 5000 to 15 000 asbestos bodies per gram of dry tissue, or 5 to 15 asbestos bodies per milliliter of bronchoalveolar lavage fluid. When asbestos body concentrations are less than 10 000 asbestos bodies per gram of dry tissue, electron microscopic fiber analyses are recommended.

Chrysotile fibers do not accumulate within lung tissue to the same extent as amphiboles because of faster clearance rates; therefore, occupational histories (fiber-years of exposure) are probably a better indicator of lung cancer risk from chrysotile than fiber burden analysis is.

A lung fiber burden within the range recorded for asbestosis in the same laboratory should be assigned a significance similar to that of asbestosis. For a patient with lung cancer and a fiber count that falls within the range recorded for unexposed urban dwellers, the relationship of the tumor to amphibole asbestos is doubtful at most.

Estimates of the relative risk for asbestos-associated lung cancer are based on different-sized populations. Because of the high incidence of lung cancer in the general population, it is not possible to prove in precise deterministic terms that asbestos is the causative factor for an *individual* patient, even when asbestosis is present. However, attribution of causation requires *reasonable* medical certainty on a probability basis that the agent (asbestos) has caused or contributed materially to the disease. The likelihood that asbestos exposure has made a substantial contribution increases when the exposure increases. Cumulative exposure, on a probability basis, should thus be considered the main criterion for the attribution of a substantial contribution by asbestos to lung cancer risk. For example, relative risk is roughly doubled for cohorts exposed to asbestos fibers at a cumulative exposure of 25 fiber-years or with an equivalent occupational history, at which level asbestosis may or may not be present or detectable. Heavy exposure, in the absence of radiologically diagnosed asbestosis, is sufficient to increase the risk of lung cancer. Cumulative exposures below 25 fiber-years are also associated with an increased risk of lung cancer, but to a less extent.

The presence of asbestosis is an indicator of high exposure. Asbestosis may also contribute some additional risk of lung cancer beyond that conferred by asbestos exposure alone. Asbestosis diagnosed clinically, radiologically (including HRCT), or histologically can be used to attribute a substantial causal or contributory role to asbestos for an associated lung cancer.

Pleural plaques are an indicator of exposure to asbestos fibers. Because pleural plaques may be associated with low levels of asbestos exposure, the attribution of lung cancer to asbestos exposure must be supported by an occupational history of substantial asbestos exposure or measures of asbestos fiber burden. Bilateral diffuse pleural thickening is often associated with moderate or heavy exposures, as seen in cases with asbestosis, and should be considered accordingly in terms of attribution.

A minimum lag-time of 10 years from the first asbestos exposure is required to attribute the lung cancer to asbestos.

Not all exposure criteria need to be fulfilled for the purposes of attribution. For example, the following can be considered: (i) significant occupational exposure history with low fiber burdens (eg, long exposure to chrysotile and long lag-time between the end of exposure and mineralogical analysis) and (ii) high fiber counts in lung or broncholavage fluid with an uncertain history or without long-term duration (short exposures can be very intense).

At very low levels of asbestos exposure, the risk of lung cancer appears to be undetectably low.

Although tobacco smoking affects the total lung cancer risk, this effect does not detract from the risk of lung cancer attributable to asbestos exposure. No attempt has been made in this report to apportion the relative contributions of asbestos exposure and tobacco smoking.

Prevention and screening

Screening of asbestos-exposed populations can be carried out for practical and scientific purposes. There are 4 goals of screening: (i) to identify high risk groups, (ii) to target preventive actions, (iii) to discover occupational diseases, and (iv) to develop improved tools for treatment, rehabilitation and prevention. Screening should aim to prevent asbestos-related diseases and therefore lead to gained healthy years of life among the screened or among those in similar risk situations. The benefits to the individual person should be viewed cautiously. The substantial morbidity and mortality related to asbestos exposure argue for continued efforts to increase the preventive power of screening.

Any screening for purely scientific purposes requires appropriate methods and criteria (eg, low cost and high predictive value). Before a screening program is initiated, the ethical, financial, and legislative aspects need to be considered. These aspects may include patient notification, data protection, allocation of costs, and follow-up of identified abnormalities. In addition, provision should

be made for epidemiologic analyses, quality control, primary and secondary prevention, and the assessment of program effectiveness.

As tools for screening, questionnaires and personal interviews should include items related to asbestos exposure, smoking, and other contributing factors. Questionnaires should preferably be validated for smoking habits and occupational histories. When possible, questionnaires should be applied nationally to permit epidemiologic analysis of the results.

Chest X-ray examinations can include frontal and lateral roentgenograms. Appropriate lung function tests can measure respiratory flow volumes and rates. In spirometry, attention should be given to careful calibration, acceptable performance efforts, and reproducibility.

The prevention strategies of asbestos-related diseases can be based on the identification of exposure sources and exposed people. There are 3 main targets for prevention: (i) an individual worker, (ii) a selected group of workers, and (iii) the work environment. At the level of the individual worker, the tools for prevention include health education and the introduction of safe work practices, the avoidance of tobacco smoking, and careful follow-up of health by surveillance. The group level methods are in part the same as at the individual level (ie, health information, education, and recommendations including the use of respiratory protective equipment).

The work environment is the most important target for preventive measures, starting from avoiding the use of asbestos, carefully controlling dust emissions using wet techniques, and controlling passive smoking at the workplace. Many countries have prohibited the use of asbestos, but there are still substantial amounts of asbestos in consumer products and in buildings that can expose workers in repair and removal work. Some countries have permitted asbestos work only under special authorization, training, and protective measures.

From the knowledge on potential exposures to asbestos, high-risk populations can be identified among persons exposed 10 or more years ago. The availability of registers — union, workers' compensation, and employment records — can be explored for this purpose.

Subjects can be assigned to subgroups for intervention or screening as defined by their risk (eg, the current risk of lung cancer and risk projected to given time windows in the future). Criteria for inclusion in each intervention or screening group should be established in the study protocol. Subsequently, the members of each subgroup can serve as separate targets for group-based and individual intervention programs.

Protocols for intervention should be designed in such a way that they serve each subject and subgroup optimally in terms of promoting individual health and the early detection of asbestos-related diseases. Data on these subgroups can also form a basis for more specific studies of disease outcome or various biomarkers. Identified abnormalities should be followed by the best clinical and occupational practices.

Research needs

There are several issues that still require clarification and further study. The following list of recommendations and future directions is not intended to be exhaustive.

- Improvement in the assessment and quantification of exposure to asbestos, to include specific worker groups, with collation of data and the development of an international standardized protocol for the assessment of exposure.
- Further analysis of job-exposure data and further studies on asbestos fiber burdens in tissue in relation to various asbestos-related disorders.
- Studies on chrysotile fiber burdens in lung tissue relative to the risk of lung cancer (also to include experimental investigations).
- Lung cancer relative to the lung tissue burdens of mineral fibers other than asbestos (eg, refractory ceramic fibers and zeolites).
- Improvement of the ILO system for the radiological diagnosis and categorization of pleural abnormalities.
- Development of a standardized system for the reporting of HRCT scans of asbestos-related disorders, analogous to the ILO system.
- Studies on the specificity of lesions of the pleura visualized by CT as markers of asbestos exposure and studies on the prognosis of diffuse pleural abnormalities.
- Improvement in ultrasound imaging of the pleura.
- Development of new digital imaging techniques for the investigation of asbestos-related diseases.
- Standardization of the approach to lung crepitations with the use of special auditory devices.
- Investigation of mesothelioma as a potential outcome of exposure to mineral fibers other than asbestos — such as refractory ceramic fibers — to include experimental studies and a series of mesothelioma patients without exposure to asbestos or erionite, supported by lung tissue fiber analysis.
- Multicenter studies on biomarkers for the detection of early asbestos diseases and the assessment of the response to new treatment modalities.
- Investigation of asbestos-associated tumors other than lung cancer and mesothelioma (eg, laryngeal carcinoma and renal carcinoma).
- Further studies on the effectiveness of screening programs.

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The reprint plus a copy of the conclusions and recommendations (People and Work Research Reports, no 14) can be obtained from the Finnish Institute of Occupational Health, Suvi Lehtinen, Topeliuksenkatu 41 a A, FIN-00250 Helsinki, Finland, for a price of FIM 80.00 + postage.

EXHIBIT 3

Not Reported in N.E.2d, 1988 WL 113008 (Ohio App. 8 Dist.)
(Cite as: Not Reported in N.E.2d)

Stroney v. Eagle-Picher Industries, Inc.

Ohio App.,1988.

Only the Westlaw citation is currently available.

CHECK OHIO SUPREME COURT RULES FOR REPORTING OF OPINIONS AND WEIGHT OF LEGAL AUTHORITY.

Court of Appeals of Ohio, Eighth District, Cuyahoga County.

James J. STRONEY, Plaintiff-Appellant,

v.

EAGLE-PICHER INDUSTRIES, INC., et al., Defendants-Appellee.

No. 54955.

Oct. 13, 1988.

Civil Appeal from Court of Common Pleas, Case No. 99,276.

Robert E. Sweeney, Linda L. Kesterson, Cleveland, for plaintiff-appellant.

Martin J. Murphy, Laura Kingsley Hong, Cleveland, for defendant-appellee.

JOURNAL ENTRY AND OPINION

PER CURIAM:

***1** This cause came on to be heard upon the accelerated calendar pursuant to App.R. 11.1 and Local Rule 25, the record from the Cuyahoga County Court of Common Pleas, the briefs and the oral arguments of counsel. Plaintiff-appellant James J. Stroney contends that the trial court erred in entering summary judgment against him by holding that the filing of this asbestos-related action on October 16, 1985, was barred by the two-year statute of limitations set forth in R.C. 2305.10. For the reasons that follow, we conclude that summary judgment was inapproriate because a genuine issue of material fact exists as to when Stroney's cause of action arose. Accordingly, we reverse.

To prevail on their motion for summary judgment, the defendants must establish that plaintiff's claim arose before October 16, 1983. The defendants did not present any evidence to suggest, and they do not argue on appeal, that plaintiff had been informed by competent medical authority that he had been injured by exposure to asbestos. See R.C. 2305.10. Thus, defendants must show that, by the exercise of reasonable diligence, plaintiff knew or should

have known prior to October 16, 1983, that he had been injured by the exposure to asbestos. R.C. 2305.10. The evidentiary materials presented to the trial court in this case demonstrate that genuine issues of fact precluded summary judgment.

Defendants' evidence showed that in January of 1983, Dr. Bal, a pulmonary specialist, wrote to plaintiff's treating physician, Dr. Bernat, and indicated that the changes in plaintiff's chest X-ray "would be compatible with asbestosis." One month later, in February of 1983, a Youngstown radiology comparison report of plaintiff's chest X-rays by Dr. Barrett noted "pleural calcifications which help establish the diagnosis of asbestosis." Nothing in the record indicates that these preliminary diagnoses were ever communicated to plaintiff Stroney.

Plaintiff's sworn testimony indicated that although he had experienced back pains as early as 1976 and some chest pains in 1983, Dr. Bal did not inform him that he had asbestosis until September 1985, one month before this action was commenced. Stroney stated that in spite of the tests that had been performed, "they couldn't figure out what the hell I had." Nothing in this record suggests that Stroney did not exercise reasonable diligence.

Construing this evidence most strongly in favor of the plaintiff, we conclude that the defendants did not sustain their burden of showing that no genuine issue of material fact exists. See

Harless v. Willis Day Warehousing Co. (1978), 54 Ohio St.2d 64, 66. Cf. *Yung v. Raymark Industries, Inc.* (C.A. 6, 1986), 789 F.2d 397 (jury question presented regarding timeliness of worker's discovery of asbestos-related injury). The credibility of plaintiff's testimony is a matter for the trier of fact and is not properly within the province of a hearing on defendants' motion for summary judgment. See *Duke v. Sanymetal Products Co.* (1972), 31 Ohio App.2d 78, 83. Accordingly, summary judgment was improper.

***2** The judgment is reversed and the cause is remanded for further proceedings.

PATTON and CORRIGAN, JJ., concur.

NAHRA, C.J., dissents (See attached opinion).

N.B. This entry is made pursuant to the third sentence of Rule 22(D), Ohio Rules of Appellate Procedure. This is an announcement of decision (see Rule 26). Ten (10) days from the date hereof this document will be stamped to indicate journalization, at which time it will become the judgment and order of the court and time period for review will begin to run.

NAHRA, Chief Justice, dissenting:

Claims for injuries resulting from exposure to asbestos must be brought within two years of " the date on which the plaintiff is informed by competent medical authority that he has been

injured by such exposure, or ... the date on which, by the exercise of reasonable diligence, he should have become aware that he had been injured by the exposure, whichever date occurs first." R.C. 2305.10; *O'Stricker v. Jim Walter Corp.* (1983), 4 Ohio St.3d 84, 447 N.E.2d 727. Appellant testified in his Sprint interview that Dr. Bal informed him in September, 1985, that he had asbestosis.

Appellees, however, in their motion for summary judgment contended that appellant knew or should have known of his asbestos-related disease sometime around January of 1983, about two years and nine months before appellant brought suit and about two years and eight months before appellant stated any doctor diagnosed his condition. Appellees attached a letter dated January 25, 1983, from Dr. Bal, a pulmonary specialist, to appellant's treating physician wherein Dr. Bal states: "On review of his old x-rays, similar changes were seen on films done in 1974, 1975, and 1980. These changes would be compatible with asbestosis." Appellees also attached a chest x-ray comparison report dated February 15, 1983, wherein Dr. Barrett, in comparing x-rays of appellant from January 17, 1983 and January 15, 1981, states: "Also noted are pleural calcifications which help establish the diagnosis of asbestosis." Appellant testified that his symptoms and medical testing began in about 1976.

Although appellant testified that he was not informed formally of his condition until September

1985, the evidence indicating that appellant should have been aware of his asbestos-related disease in early 1983 at the latest has not been contested. Appellant had been undergoing tests since 1976. The x-rays taken in January 1983 clearly establish the presence of asbestosis. Appellant argues he was not told of these results. However, given his long history of symptoms and treatment, appellant, through the exercise of reasonable diligence (e.g. simply inquiring of the doctors), should have been aware that he had asbestosis. Unlike the cases of *Yung v. Raymark Industries, Inc.* (6th Cir.1986), 789 F.2d 397, and *Myles v. Johns-Manville Sales Corp.* (1983), 9 Ohio App.3d 257, 459 N.E.2d 620, no genuine issue of material fact remains to be tried in this case regarding the discovery of appellant's condition and appellees were entitled to judgment as a matter of law. Reasonable minds could only reach a conclusion adverse to appellant after reviewing the evidence as to whether he should have known he had been injured by the exposure.

Ohio App.,1988.

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