

Nos. 34334 and 34335

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

LENORA PERRINE, et al.

Plaintiffs Below/Appellees,

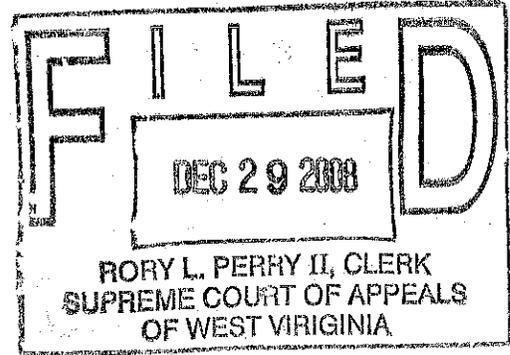
v.

E. I. DU PONT DE NEMOURS AND COMPANY, et al.,

Defendants Below,

E. I. DU PONT DE NEMOURS AND COMPANY,

Appellant.



**APPELLEES' RESPONSE TO
WEST VIRGINIA STATE MEDICAL ASSOCIATION'S AMICUS BRIEF**

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INTRODUCTION

The West Virginia State Medical Association (“WVSMA”) has filed an amicus brief in this action in support of E. I. DuPont De Nemours and Company. The amicus brief provides little new information, adopting the same positions that DuPont adopted at trial and on appeal.¹ The WVSMA seeks to have the option of low-dose single-breath-hold CT chest scans removed from the Medical Monitoring Program approved by the Circuit Court. Relying on outdated and inapplicable information, the WVSMA insists the efficacy of low-dose CT scans is doubtful and that radiation poses great risk to the participating class members. Plaintiffs, however, presented substantial evidence that low-dose CT chest scans are effective in detecting early stage lung cancers and that the benefits of such detection outweigh the risks. Furthermore, the Circuit Court included an extra layer of protection for all participants by requiring patient/physician interaction, informed consent, and a mandatory periodic review of all procedures to account for advancements in science and technology.

Although the WVSMA takes aim at the inclusion of the optional low-dose CT scans within the Medical Monitoring Program, the WVSMA’s ultimate target is *Bower v.*

Westinghouse Electric Corp., 206 W. Va. 133, 522 S.E.2d 424 (1999). The WVSMA asks

¹ Attaching a number of articles that were not discussed at trial or post-trial and, therefore, are untested by any cross-examination, the WVSMA has cited selective studies in an effort to deny participants access to the CT scan. These articles (identified by WVSMA as Exhibits D, E, F, and G) should be stricken from the appellate record. “[T]he brief of an amicus curiae, or attachments thereto, cannot be used as a vehicle to present additional evidence or new evidence to the appellate court.” 4 Am. Jur. 2d Amicus Curiae § 8; see also *State of Louisiana v. Quantex Microsystems, Inc.*, 809 So. 2d 246, 249 (La. App. 1 Cir. 2001)(“The affidavits were not presented to the trial court in this matter. Thus, we are precluded from considering them.”); *Wiggins Brothers, Inc. v. Department of Energy*, 667 F.2d 77, 83 (Temp. Emerg. Court of Appeals for N.D. Tex. 1981)(“And in the absence of exceptional circumstances, amicus curiae is not entitled to introduce additional evidence” (parenthetical omitted)).

the Court to impose a separate requirement that plaintiffs seeking medical monitoring must first establish that their proposed medical monitoring program does not unnecessarily endanger the participants well-being. Because the Court has already imposed the requirement that diagnostic testing be reasonably necessary, a separate requirement is unnecessary and redundant.

ARGUMENT

I. The Circuit Court's decision to include *access* to low-dose single-breath-hold Computed Tomography (CT) chest scans for lung cancer screening is supported by the evidence.

Blithely dismissing the training, experience and expertise of an environmental health physician on the faculty of West Virginia University, the WVSMA mistakenly declares that over 8,000 asymptomatic West Virginians will be subjected to "extensive, long-term radiation" from "ineffective" CT scans. The reality, however, is that low-dose single-breath-hold CT chest scans are an effective tool for early detection of lung cancer and that medical monitoring participants should be given *access* to the CT scan for such screening after informed consent. Although DuPont and WVSMA contend the potential radiation from the low-dose CT scans will cause more harm than good, neither DuPont nor the WVSMA has produced any studies measuring radiation dosage from low-dose single-breath-hold chest CTs. Instead, DuPont and WVSMA have relied on conclusions drawn from outdated atomic radiation studies in Japan. Furthermore, the Circuit Court did not *mandate, subject, or otherwise require* any citizen to undergo a CT scan. Rather, the Circuit Court included the CT scan as an option if a patient elects to undergo the monitoring after consulting with his or her physician and providing informed consent. Finally, as a means of minimizing any risks associated with the low-dose CT chest scan, the Court mandated a

periodic review of all screening procedures in the monitoring program (every 5 years or every 2 cycles) that would allow for administrators to adjust the program to account for any new developments in science and technology.²

A. Dr. Werntz is a well-qualified physician and environmental medicine specialist.

Plaintiffs relied on Dr. Carl Werntz to develop a medical monitoring program appropriate for the class, a population exposed for decades to arsenic, cadmium, and lead. (Binder 46, 10/02/07 Tr. 4017-4018). Dr. Werntz is a licensed practicing physician on the faculty of West Virginia University (“WVU”). (Binder 46, 10/02/07 Tr. 4013-4014). Board-certified in internal medicine as well as occupational and environmental medicine,³ he serves in the Department of Community Medicine at WVU, where he teaches Public Health and Environmental Health. (Binder 46, 10/02/07 Tr. 4015-4018). In addition to teaching public health doctoral courses, Dr. Werntz also teaches “a course in medical toxicology, which is primarily aimed at residents in occupational medicine” (Binder 46, 10/02/07 Tr. 4016) and includes medical “monitoring both for the environmental exposures as well as workplace exposures” (Binder 46, 10/02/07 Tr. 4017). As part of his work with WVU, Dr. Werntz travels to various industrial sites in West Virginia and southeastern Pennsylvania to perform on-site physical examination of employees in compliance with

² Dr. Werntz encouraged the Court to include a re-evaluation provision, during which time should conclusive evidence of increased risk of CT scanning emerge, different testing could be substituted. (Binder 53, 01/15/08 Tr. at 32-33).

³ As Dr. Werntz explained it, “Occupational medicine is a field of medicine that focuses primarily on the interface between work or workplace exposures or environmental exposures and human health, in both directions, both looking at the effects of the workplace on health, such as exposure in the workplace, [and] also looking at the effects of health, maybe a medical condition, something you have, on their ability to work... Medical monitoring is a very common part of occupational medicine, as many people who have different workplace exposures to different chemicals are required sometimes by law and sometimes by plan—program design, to have monitoring to check their exposures, much like the workers that DuPont talked about with their lead exposure... That—yes, that’s something I do on a regular basis.” (Binder 46, 10/02/07 Tr. 4014-4016).

various state and federal regulations. (Binder 46, 10/02/07 Tr. 4021-4022). *Unlike any other testifying expert at trial, Dr. Wertz considered his services to be an extension of his regular work at WVU and, as such, he received no additional compensation for testimony.*⁴

In addition to serving on WVU's faculty, Dr. Wertz also works with the NIOSH Coal Workers Health Program. The NIOSH program is a medical program monitoring for Black Lung. Every two years, coal-miners undergo x-rays to look for evidence of Black Lung. Dr. Wertz serves as a physician liaison, explaining test results to the miners and recommending additional testing or treatment when necessary. (Binder 46, 10/02/07 Tr. 4020-4021). In short, Dr. Wertz is a board-certified, qualified physician, well-versed and experienced in environmental and public health, occupational medicine, and medical monitoring of exposed populations.⁵

B. The Medical Monitoring Program does not require CT Scans.

Recognizing that lung cancer is common to all three constituents of concern—arsenic, cadmium, and lead—Dr. Wertz recommended *access* to screening for lung cancer in his medical monitoring program. Specifically, he included a “low-dose single-breath-hold CT scan,” which takes “10 second or 15 seconds and they scan the entire lung from top to bottom with a preloaded dose of radiation.” (Binder 46, 10/02/07 Tr. 4110). Dr. Wertz, a qualified physician, recommended that the participants of the medical monitoring program, who are (1) over the age of 35 and (2) not pregnant, “have *access* to CT for lung cancer screening” every two years. (Binder 46, 10/02/07 Tr. 4119)(Binder 53,

⁴ “This—this work is part of my work at the University. I receive my regular salary. I receive no additional money of any sort...the only difference this makes is that I'll be paid for driving to Clarksburg and back, but that's the only actual money that I'll ever see, what it costs to drive here.” (Binder 46, 10/02/07 Tr. 4019-4020).

⁵ Dr. Wertz also volunteers as a field team leader for the Mountaineer Area Rescue Group, a wilderness search and rescue team based in north central West Virginia, and as the camp physician for Boy Scout Camp Mountaineer. (Binder 46, 10/02/07 Tr. 4023-4024).

01/15/08 Tr. 32). Dr. Werntz reiterated that whether participants undergo a CT scan is their choice and only occurs after informed consent. (Binder 53, 01/15/08 Tr. 11)(Binder 46, 10/02/07 Tr. 4119 (“The – both – participation in any part of the program is voluntary. There’s – nothing is required. And a class member could decide to have parts of the testing and not other parts. That’s perfectly acceptable. The big deal here is not that—it’s not that testing is required; it’s access to testing. And it’s access because of increased risk, because of the exposure to arsenic, cadmium, and lead.”)). The Circuit Court ordered the CT scans, along with other tests included in the medical monitoring plan, be reevaluated on a regular basis for efficacy and safety.

C. Dr. Werntz performed a risk-benefit analysis and concluded that the benefits of access to the low-dose single-breath-hold chest CT scan outweigh the risks associated with it.

Although *Bower* does not require an existing treatment protocol for a diagnosed disease, Dr. Werntz’s criteria for screening within the medical monitoring program nevertheless included whether early detection would change the outcome of a particular illness. (Binder 46, 10/02/07 Tr. 4104-4105). After reviewing the literature, Dr. Werntz concluded that low-dose single-breath-hold chest CT scans are effective in diagnosing lung cancer during its early stages. (Binder 46, 10/02/07 Tr. 4115-4118 (“Right now, there’s nothing as effective as detecting lung cancer as the CT scan.”)). Earlier diagnosis allows for consideration for a treatment plan and possible extension of life and long-term survival. (Binder 46, 10/02/07 Tr. 4117). Some studies have found long term survival is increased with a CT screening program. (Binder 46, 10/02/07 Tr. 4116). At a minimum, early detection allows the patient to explore treatment options and prepare business and family matters. Dr. Werntz confirmed that the CT scan as a diagnostic tool for lung cancer is “very

promising” and that “it is being used in a number of centers around the country currently to screen for lung cancer.” (Binder 53, 01/15/08 Tr. 41).

DuPont and, now, the WVSMA have cited the United States Preventative Services Task Force Guidelines (“USPSTF”) as conclusive evidence that no one has established any benefit from using CT scans to screen for lung cancer. First, it is important to note that generally, the United States Preventive Service Task Force measures benefit primarily by a decreased mortality rate. Second, USPSTF makes screening recommendations for the general population, as opposed to an exposed population at greater risk of contracting disease. Third, the USPSTF has found “fair evidence” that screening with low-dose CT, chest x-ray and/or sputum cytology can detect lung cancer at an earlier stage and that the sensitivity of low-dose computerized tomography for detecting lung cancer is 4 times greater than the chest x-ray.⁶ Fourth, and perhaps most importantly, the USPSTF has not recommended *against* screening for lung cancer. Specifically, the agency concluded “that the evidence is insufficient to recommend for or against screening asymptomatic persons for lung cancer.”⁷

Contrary to DuPont’s and the WVSMA’s contentions, Dr. Wertz considered both the benefits and the risks associated with CT scans. With regard to benefits, he testified:

So, that’s number one, is it effective in diagnosing lung cancer? I think the answer is yes. And even the articles that aren’t very much in favor of using it widely agree[d] that it’s good for early detection, so –which has two benefits. One, it gives people the opportunity to get treated earlier, and the second thing is, even if it doesn’t change the outcome, it gives people more advanced notice so if they need to arrange their affairs, they’ve got time to deal with that. The second question is, does it change long-term survival, and on that question, there are, I would say, two-thirds

⁶ DuPont Trial Exhibit 2286, “Lung Cancer Screening: Recommendation Statement,” attached to Amicus Brief as Exhibit B.

⁷ DuPont Trial Exhibit 2286, “Lung Cancer Screening: Recommendation Statement,” attached to Amicus Brief as Exhibit B.

of the studies—at least half the studies say it does, the other half say it doesn't. But there's—because this is—this is pretty new technology, being able to follow people for five or ten or fifteen or twenty years and see how they do is very difficult, because they only developed it [low-dose single-breath-hold CT chest scan] ten years ago or fifteen years ago.

(Binder 46, 10/02/07 Tr. 4117). Dr. Wertz also specifically testified that he considered the radiation risk for exposure to the CT scan although he did not quantify it. (Binder 46, 10/02/07 Tr. 4170). Ultimately, after weighing the efficacy of the low-dose single-breath-hold CT chest scan in early detection of lung cancer against radiation risks, Dr. Wertz concluded that the benefits to the patient exceeded the risk to the patient. (Binder 46, 10/02/07 Tr. at 4170).

D. The preponderance of the evidence at trial supports inclusion of a low-dose single-breath-hold CT chest scan as an option for the medical monitoring class.

Unquestionably, DuPont presented more “expert” witnesses than Plaintiffs during the second phase of the trial, but in this case more is not better. Cross-examination of the witnesses revealed that their opinions were based on outdated data and technology. DuPont's witnesses failed to produce one single study that accurately identified radiation dosimetry from low-dose single-breath-hold CT chest scans. Even the study that DuPont belatedly introduced through its accountant during post-trial hearings relied on dosimetry calculations from full-body CT scans rather than the limited chest scan. Despite these obvious limitations to DuPont's evidence, the WVSMA is asking this honorable Court to accept DuPont's expert witnesses' testimony entirely as fact and find that it outweighs Dr. Wertz's conclusions concerning the efficacy of low-dose CT chest scans. A review of DuPont's actual evidence, however, reveals that it is flawed and insufficient to overcome Dr. Wertz's very credible testimony.

- New England Journal of Medicine*: DuPont produced and the WVSMA cites to an article⁸ published after trial which they contend demonstrates CT scans will cause unacceptable risk to the medical monitoring participants. There are a number of salient facts, however, that undermine DuPont's use of this article. For example, the article discusses risks from head and abdomen CT scans—not the low dose single breath hold chest CT scan recommended by Dr. Wertz. (Binder 53, 01/15/08 Tr. 31, 39-40). Chest CT scans use a far lower dose of radiation than either the head or the abdomen CTs. (Binder 53, 01/15/08 Tr. 31, 39-40).

Moreover, the radiation data in the article is taken from Japanese atomic bomb survivors and not from CT scan patients. (Binder 53, 01/15/08 Tr. 31, 39-40).

Doctor Arnold Van Moore, Jr., chair of the American College of Radiology Board of Chancellors, has stated that "Relying on Japanese atomic bomb survivors to gauge CT risk is like comparing apples and oranges." (Binder 53, 01/15/08 Tr. at 38-39).
- Dr. Valberg*: The WVSMA bases the entire premise of its risk argument on Dr. Valberg's quantification of the radiation risk. Dr. Valberg, however, relied on old studies and old technology to form his conclusions. Specifically, he relied on the Japanese atomic bomb studies of radiation and data for whole body CT scanning, rather than low-dose single-breath-hold chest CTs. During cross-examination he

⁸ Notably, DuPont entered this article into evidence post-trial through its only witness at the post-trial hearing addressing the scope, duration and funding of the medical monitoring program. That witness was a CPA from Seattle about who the Circuit Court remarked: "Of the plethora of witnesses that testified at the scores of hearings and trial in this matter, the Court finds Mr. Menenberg to be the least credible of all. It is clear that if one has the money, Mr. Menenberg will provide an opinion whether it is within his field of expertise or not and whether there is any factual or professional basis for the opinion or not. In the sixteen years as a sitting trial judge, Mr. Meneberg is the biggest 'hack' to have testified before this Court." (Binder 54, 2/25/08 Order at 8, n. 9).

was forced to acknowledge that “CT scans used a low dose of radiation, less than one average background radiation a person receives in the United States, and similar to that of a mammogram.” (Binder 46, 10/04/07 Tr. 4615). He also admitted that he was unfamiliar with the academic articles criticizing the use of atomic bomb data as having significant errors. (Binder 46, 10/04/07 Tr. 4610-4611).

- *Dr. Nelson:* The WVMSA cites Dr. Nelson’s testimony as evidence of the risks associated with low-dose CT scans. Although Dr. Nelson made a few inflammatory, if not histrionic, remarks about the purported use of CT scans, cross-examination revealed that he knew very little about survival rates, early detection rates, radiation dosimetry or even design and administration of a medical monitoring program. (Binder 46, 10/03/07 Tr. 4457-4463, 4479-4480).⁹ A friend and personal physician of one of DuPont’s counsel (Binder 46, 10/03/07 Tr. 4383-4384), Dr. Nelson acknowledged that he is not a public health expert (Binder 46, 10/03/07 Tr. 4393) and that he would defer to occupational medicine specialists concerning exposure to a substance and resulting need for screening (Binder 46, 10/03/07 Tr. 4436; 4451-4452). Further examination revealed that his research about the efficacy and risks of CT scans consisted of another DuPont expert’s references that had been provided to Dr. Nelson on compact disc by DuPont’s counsel. (Binder 46, 10/03/07 Tr. 4439-4440).¹⁰

⁹ Dr. Nelson testified that “You know, physicists deal with those numbers, the milliamperes and all that. No, I can’t have a rational discussion about the exact level of radiation; I just know it’s – I know it’s ionizing radiation and its dangerous. I know it’s a lot less than it used to be, but I know it’s still radiation.” (Binder 46, 10/03/07 Tr. 4479-4480).

¹⁰ Dr. Nelson’s credibility had already been called into question before the Circuit Court during the class certification hearing, when Dr. Nelson was forced to admit that he did not know arsenic was a carcinogen, that he had never reviewed the United States Task Force Preventative Services Task Force Handbook, and that DuPont’s counsel had drafted his first expert report. (Binder 15,

E. The Circuit Court mandated regular review of the medical monitoring plan, including access to low-dose CT chest scans.

As a means of minimizing risks, the Circuit Court also included within the medical monitoring plan a requirement that the plan be reviewed at regular intervals every five years. (Binder 54, 2/25/08 Order at 15). Dr. Wertz specifically recommended this review: "What I proposed is that periodically, the program would be reevaluated as far as what tests are being performed. I don't expect that the diseases will change significantly but that the—as technology changes in medicine, that it would be appropriate to re-evaluate and make sure we're using the best tests available at the time to detect the diseases in question." (Binder 53, 01/15/08 Tr. 11).

Dr. Wertz indicated to the Court that the CT scan is one of the tests that should be reevaluated on a regular basis. (Binder 53, 01/15/08 Tr. 40-41). Noting that over time the efficiency of CT scanning has increased and radiation dosage has decreased, Dr. Wertz observed that every few years a new CT technology is developed that requires "lower and lower and lower doses to achieve the same picture quality." (Binder 53, 01/15/08 Tr. 41). Recognizing the continual advancement in all testing technology, including CT scans, Dr. Wertz encouraged the Court to include a re-evaluation provision, during which time should conclusive evidence of increased risk of CT scanning emerge, different testing could be substituted. (Binder 53, 01/15/08 Tr. at 32-33). Indeed, Dr. Wertz pointed out that the National Lung Screenings Trial results are expected in 2010, and he could revisit the issue at that time. (Binder 46, 10/02/07 Tr. 4164-4165).

With its mandatory order of a regular review, the Court has adhered to Dr. Wertz's recommendations and complied with the *Bower* requirement that tests be ones "that a

Class Certification Tr. at 753, 756) (See also, Binder 9, *Plaintiffs' Motion to Strike Expert Report and to Limit Testimony of Kelly Nelson, M.D.*, p. 4035-4194).

qualified physician would prescribe.” *Bower v. Westinghouse Electric Corp.*, 206 W. Va. 133, 142, 522 S.E.2d 242, 433 (1999). As Dr. Werntz noted, we “don’t have the luxury of waiting. If it’s not granted—access to this potentially life-saving technology is not granted now, it can’t be added later.” (Binder 46, 10/02/07 Tr. at 4164-4165).

In short, the Circuit Court authorized access to low dose single breath hold chest CT scans for the medical monitoring class (over the age of 35 and not pregnant) after full informed consent and physician/patient interactions. That access will be reevaluated on a regular basis. The Circuit does not *require* participants to undergo CT scans and participants are not even eligible until after they reach the age of 35. Since Harrison County has reported record numbers of serious medical conditions which are caused by arsenic, cadmium and lead exposure, and Plaintiffs have demonstrated with independent evidence, as well as through Dr. Rodricks’s testimony,¹¹ that class members’ homes and soil are contaminated by these products from the smelter, they are in a high risk group within West Virginia and should be allowed access to medical testing.

II. *Bower* already requires plaintiffs to demonstrate proposed medical testing does not unnecessarily endanger participants’ existing health.

The fifth element of *Bower* already imposes a reasonableness requirement that effectively ensures that any proposed medical monitoring program does not unnecessarily endanger the participants’ health. Specifically, *Bower* requires that “[d]iagnostic testing must be ‘reasonably necessary’ in the sense that it must be something that a qualified physician would prescribe based upon the demonstrated exposure to a particular toxic agent.” 206 W. Va. at 142, 522 S.E.2d at 433. *Bower* also requires the proposed test be “medically advisable.” Implicit in the “reasonableness” requirement is the understanding

¹¹ See Binder 15, Class Certification Hearing Tr. 567-572 (DuPont’s expert, Dr. Rodricks, outlining the increasing rates of some cancers in Harrison County).

that no "qualified physician" will prescribe a test that is not medically advisable or, in other words, unnecessarily endangers the patient. Accordingly, an additional, separate requirement would be redundant and is unnecessary.

The WVSMA is aware that a qualified physician will not prescribe a testing protocol that will unnecessarily endanger a patient's health. What the WVSMA really wants is a new rule that "a plaintiff's subjective desire for information" is never sufficient to overcome any risk associated with the procedure. Such a blanket prohibition is paternalism in its worst form, stealing from the patient any autonomy over his or her own health. Worse yet, elimination of the "subjective desire" as a cognizable benefit will, in turn, require the plaintiff to show some other benefit—i.e., a proven treatment protocol and, ultimately, a decreased mortality rate. The *Bower* Court specifically and emphatically rejected that particular litmus test. Observing that medical science is not static, the *Bower* Court rejected the notion that a plaintiff should be required to show that a treatment currently exists for the disease at issue. 206 W. Va. at 142-143, 522 S.E.2d at 433-434. Instead, the Court embraced the idea that medical science and technology is rapidly changing, with new treatments being developed every day as well as the idea that knowledge of health—whether good or terminal—brings some benefit.¹² The design of Plaintiffs' medical monitoring program embodies this philosophy.

¹² Dr. Nelson, one of DuPont's expert witnesses, acknowledged there have been times in his practice as a primary care physician that he has administered a diagnostic test when the benefit was simply to put the patient's mind at rest:

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15 Q. But you performed it on the patient who
16 requested it because she in fact wanted it to
17 allay her concerns that she felt it might help her
18 better detect ovarian cancer?

19 A. Correct. And at some level -- this is --
20 you know, you would rather help a patient and have

Regardless, however, of whether this Court repudiates the elements first set out in *Bower* that recognized the inherent value in "subjective desire" for knowledge about one's health, Plaintiffs adduced sufficient evidence of "benefit" to overcome DuPont's and the WVSMA's dire claims of risk. Dr. Wertz performed a risk/benefit analysis based on whether early detection could change the outcome of the lung cancer. In the instant action, Dr. Wertz identified *two* benefits to the low-dose CT chest scans: (1) early diagnosis allows for earlier treatment and better survival and (2) alternatively, early diagnosis allows a patient to prepare for death in the event his or her lung cancer is not amenable to treatment. Based on his research, including statistics indicating an 80% survival rate for lung cancer diagnosed in Stage 1 and his knowledge of the risks associated with low-dose CT scans, Dr. Wertz made the informed, qualified determination that the class members should be provided with *access* to low-dose single-breath-hold CT chest scans with a review of the

21 faith that they're going to get the full story and
22 full information than to just say, "No, not going
23 to do it" and them go to another practitioner who
24 might not explain to them as fully as I want to

4475

1 explain to them "This is not a good test."

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16 Q. Dr. Nelson, you saw some benefit to
17 that patient in allowing her to have the test
18 because she felt that it would help her feel
19 better about exploring potential medical
20 diagnosis, correct?

21 A. That's part of it. I also felt that
22 there was benefit if she was going to get it done
23 by somebody I was going to make darn sure she
24 heard both sides of that coin.

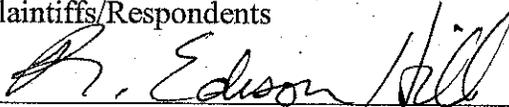
(Binder 46, 10/03/07 Tr. 4474-4475).

procedure, including new information, studies and technology, every five years or two cycles.

CONCLUSION

After hearing Plaintiffs' evidence, as well as DuPont's evidence—questionable in both substance and credibility—the Circuit Court rightly concluded that the preponderance of the evidence weighed in favor of providing access to low-dose CT chest scans with scheduled reviews of the issue. Accordingly, Plaintiffs urge the Court to deny the WVSMA's request for relief that lung cancer screening by low-dose single-breath-hold CT scans be stricken from the medical monitoring plan.

Respectfully submitted,
Plaintiffs/Respondents



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E. I. DU PONT DE NEMOURS AND COMPANY, Appellant.

CERTIFICATE OF SERVICE

I, R. Edison Hill, counsel for Plaintiffs, hereby certify that I have served a true and exact copy of "APPELLEES' RESPONSE TO WEST VIRGINIA MEDICAL ASSOCIATION'S AMICUS BRIEF" upon the following counsel via US Mail this 29th day of December 2008:

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