Will Blood Testing Revive Medical Monitoring Claims?

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In July, a New York state trial court in Burdick v. Tonoga certified what appears to be the first medical monitoring class defined by the level of a particular chemical measured in class members' blood serum. Given the ubiquity of many chemicals in the environment and the abundant data collected by government agencies about blood serum chemical levels, the success of the Burdick plaintiffs' certification strategy may revive plaintiffs' interest in medical monitoring class actions. While fundamental obstacles remain to certifying medical monitoring classes, plaintiffs' reliance on blood serum chemical levels to define a proposed class may require defendants to refine their strategies for challenging class certification.

What Is Medical Monitoring?

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Medical monitoring is either a cause of action or a claim for relief asserted by a plaintiff who alleges exposure to toxic substances and who contends that the exposure has increased his or her risk of future illness. Medical monitoring plaintiffs seek to recover the cost of regular medical testing to determine whether the alleged exposure has resulted in a treatable medical condition.

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Medical monitoring has always been controversial and in recent years has fallen out of favor, particularly in federal courts. Some courts have rejected the notion that someone who does not have (and might never develop) a clinical illness could nonetheless collect damages based on the notion that he or she needs prepaid medical care.[1] Because exposure to toxic substances is an everyday occurrence in modern life, some courts and commentators have rejected medical monitoring based on "floodgates" concerns.[2] While some state and federal trial courts have certified medical monitoring classes, every federal appellate court that has examined a proposed medical monitoring class has refused certification.[3] Particularly in the aftermath of the U.S. Supreme Court's decision in Wal-Mart Stores v. Dukes,[4] heightened commonality requirements have raised increased obstacles to certifying medical monitoring claims. As one commentator noted: "While Dukes has not killed medical monitoring class actions entirely, as a practical matter, it has left them on life support."[5]

Burdick v. Tonoga bucks the recent trend in medical monitoring case law. The question is whether Burdick is an outlier, or whether it has the potential to revive medical monitoring class actions.

The Burdick Certification Ruling

Burdick involves residents of Petersburgh, New York. Like their neighbors in the town of Hoosick Falls,[6] the Petersburgh residents allege that the defendant's use of perfluorooctanoic acid, or PFOA, in its manufacturing process has resulted in contamination of the town's drinking water with PFOA. The plaintiffs allege that PFOA, once ingested, binds to proteins in blood serum and bioaccumulates in the body. Four hundred and seventy seven residents of Petersburgh participated in a state-run blood testing program. More than 400 had PFOA levels in their blood in excess of the U.S. general population geometric mean of 1.86 parts per billion. The plaintiffs' expert testified that, while it is unclear whether exposures at or below background are associated with a health risk, elevated levels above background significantly increase the risks of a range of dissimilar illnesses, including thyroid disease, ulcerative colitis and kidney cancer. The Burdick court, citing recent New York case law,[7] held that the plaintiffs had stated a cognizable claim for medical monitoring because they had a present injury (an accumulation of PFOA in their bodies) and also had a "rational basis" for their "fear of contracting the disease."[8]

The Burdick court looked to case law interpreting Federal Rule 23 on the issues of commonality, superiority and typicality. The defendant argued that individual issues predominated over common ones because each individual plaintiff had a unique level of risk based on, among other things, his or her level of exposure and background risk of contracting each of the unrelated diseases identified by the plaintiffs' expert. Analysis of increased disease risk also depended on factors such as age, gender, body weight, smoking status, obesity and alcohol consumption. The defendant's expert opined that it is not scientifically possible to assess increased disease risk on a group basis where individual factors varied so widely among the putative class members. These are well-founded, and almost always successful, defenses to class certification for medical monitoring. The Burdick court, however, was not persuaded.

In certifying the class, the Burdick court relied heavily upon: (1) the defendant's admission that its activities were the only source of the PFOA in the town's drinking water; and (2) the definition of the medical monitoring class to include only those people whose blood serum levels had been tested above the "recognized average background level." The court held that several questions were common to all class members including: whether the defendant was negligent in releasing the PFOA; whether PFOA is hazardous to human health; and whether a screening test is available for the diseases linked to PFOA exposure. The court acknowledged the defendant's arguments that causation issues differed among the class members, but held that such differences did not overcome the facts that all the plaintiffs' medical monitoring claims arose out of the same course of conduct by a single defendant and were based on the same legal theory.

Will Reliance on Blood Serum Testing Revive Medical Monitoring Classes?

The plaintiffs' use of blood tests of some class members as evidence that the proposed class has been exposed to a chemical is not new. The Burdick ruling, however, is different — it appears to be the first medical monitoring decision to define a medical monitoring class based exclusively on biomonitoring results. Past attempts to certify classes based on lead blood lead levels in children, for example, were denied.[9]

Burdick is unusual in several respects. PFOA has been extensively studied in recent years, including in studies specifically tied to blood serum levels. While there is intense debate over the science, the plaintiffs' experts in Burdick were able to point to at least some evidence of increased risk of disease at blood PFOA levels above the median. Moreover, in Burdick, a state government agency collected the blood data that provided the basis for the plaintiffs' certification bid, so the plaintiffs did not need to incur the substantial expense of collecting such data themselves. Finally, the Burdick decision arguably is based on a misreading of New York state law, and may not survive an appeal.[10] For these reasons, Burdick presented unusually favorable circumstances for the plaintiffs to seek certification.

Despite these unusual facts, Burdick creates cause for concern for several reasons.

First, government agencies, most notably the Centers for Disease Control, compile biomonitoring data about the levels of dozens of chemicals detected in the general population, including the geometric median level, through the National Health and Nutrition Examination Survey, or NHANES.[11] Not surprisingly, the NHANES data demonstrate that many chemicals are present in the blood serum of the general population. From this perspective, the Burdick court's holding that an "injury" for the purpose of medical monitoring could be "the accumulation of a toxic substance within [the plaintiff's] body," even without clinical symptoms, is troubling.[12]

Second, future plaintiffs may rely on Burdick to argue anyone whose blood serum level of a particular chemical exceeds the median — by definition half of the population — has been injured and is at an increased risk of developing a latent disease that requires medical monitoring. The Burdick court's logic is faulty, however, for several reasons. First, blood serum measures the level of a chemical that enters the body from all sources; it does not establish that the chemical came from a particular source. Individual blood serum levels also measure the presence of a chemical at a moment in time; they do not necessarily establish a long-term exposure. Further, as a matter of pharmacokinetics, blood serum levels will vary among members of the population who often metabolize chemicals differently based on many of the same variables that defendants typically cite as variables that impact risk: age, race, gender, obesity, other health problems and lifestyle factors such as smoking and alcohol use. And, the presence of a chemical in someone's blood above the population median does not "by definition" cause increased risk; plaintiffs should still be required to prove general and specific causation. For many chemicals, the available toxicological and epidemiological literature does not identify the blood serum level of a chemical necessary to cause a disease.

In summary, blood serum data may provide plaintiffs with a new angle they can rely upon to pursue medical monitoring class actions, but it should not alter the consensus against certifying medical monitoring class actions.[13] The same defense arguments about individualized issues related to exposure, causation and risk will continue to apply. They will just need to be reframed to ensure that courts understand the limited value of blood serum evidence and its inability to overcome the individualized issues that typically defeat certification of medical monitoring claims.

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[1] E.g., Ball v. Joy Techs. Inc., 958 F.2d 36 (4th Cir. 1991); Houston Cty. Health Care Auth. v. Williams, 961 So. 2d 795, 811 (Ala. 2007); Wood v. Wyeth-Ayerst Labs, 82 S.W.3d 849, 859 (Ky. 2002); La. Civ. Code Ann. art. 2315 (1998); Henry v. Dow Chem.l Co., 701 N.W.2d 684, 686 (Mich. 2005); Paz v. Brush Engineered Materials Inc., 949 So.2d 1, 3–6, 9 (Miss. 2007); Badillo v. American Brands Inc., 16 P.3d 435, 438–39 (Nev. 2001); Lowe v. Philip Morris USA Inc., 183 P.3d 181, 186–87 (Or. 2008).

[2] See, e.g., Schwartz, Medical monitoring: Should tort law say yes?, 34 Wake Forest L.R. 1057, 1079-1080 (1999) ("Once a showing of present physical injury is eliminated, as is the case in awards for medical monitoring, attorneys representing plaintiffs could virtually begin recruiting people off the street to serve as medical monitoring claimants.").

[3] In re Hanford Nuclear Reservation Litig., 534 F.3d 986, 1009–10 (9th Cir. 2008); Barnes v. Am. Tobacco Co., 161 F.3d 127 (3d Cir. 1998), cert. denied, 526 U.S. 1114 (1999); Ball v. Union Carbide Corp., 385 F.3d 713, 728 (4th Cir. 2004); In re St Jude Med. Inc., 422 F.3d 1116, 1120 (8th Cir. 2005); In re St Jude Med. Inc., 522 F.3d 836, 840 (8th Cir. 2008), reh'g denied, 522 F.3d 836 (8th Cir. 2008); Zinser v. Accufix Research Inst. Inc., 253 F.3d 1180, 1196, amended, 273 F.3d 1266 (9th Cir. 2001); Boughton v. Cotter Corp., 65 F.3d 823 (10th Cir. 1995).

[4] 564 U.S. 338 (2011).

[5] Jennifer Quinn-Barabanov, Has Dukes Killed Medical Monitoring?, For The Defense (DRI), November 2011, at 51.

[6] PFOA contamination in Hoosick Falls has also been the subject of medical monitoring litigation (Baker v. St.-Gobain Performance Plastics Corp., 232 F. Supp. 3d 233, 236 (N.D.N.Y. Feb. 6, 2017)), although no class has yet been certified in Hoosick Falls.

[7] Id. at 250–53.

[8] Burdick v. Tonoga, Inc. No. 253835, 2018 N.Y. Misc. LEXIS 2812, *32 (N.Y. Sup. Ct. July 3, 2018).

[9] See Paige v. Phila. Hous. Auth., No. 99-0497, 2003 U.S. Dist. LEXIS 15563, *2 (E.D. Penn. Aug. 18, 2003); Parkhurst v. D.C. Water & Sewer Auth., No. 2009 CA 000971 B, 2013 D.C. Super. LEXIS 4, *12 (D.C. Super. Ct. April 8, 2013).

[10] Baker, the case on which Burdick relies, arguably misinterpreted the New York Court of Appeals decision in Caronia v. Phillip Morris Inc., 22 NY 3d 439, 452 (2013). Caronia rejected medical monitoring as a cause of action for people who did not already have physical symptoms. Baker is currently on appeal to the Second Circuit.

[11] https://www.cdc.gov/exposurereport/

[12] Many courts have rejected Burdick's approach and have held that medical monitoring is only available if the plaintiff can prove a present, physical injury. See, e.g., Metro-North Commuter R.R. Co. v. Buckley, 521 U.S. 424, 441–44 (1997); Ball v. Joy Techs. Inc., 958 F.2d 36 (4th Cir. 1991); In re Prempro, 230 F.R.D. 555, 569 (E.D. Ark. 2005); Cole v. ASARCO Inc., 256 F.R.D. 690, 695 (N.D. Okla. 2009); Houston City Health Care Auth. v. Williams, 961 So. 2d 795, 811 (Ala. 2007); Wood v. Wyeth-Ayerst Labs, 82 S.W. 3d 849, 859 (Ky. 2002); Henry v. Dow Chem. Co., 701 N.W.2d 684, 686 (Mich. 2005); Paz v. Brush Engineered Materials Inc., 949 So. 2d 1, 3 (Miss. 2007); Curl v. Am. Multimedia Inc., 654 S.E.2d 79, 81 (N.C. Ct. App. 2007); Lowe v. Philip Morris USA Inc., 183 P. 3d 181, 183 (Or. 2008).

[13] See Barnes, 163. F.3d at 141.