



Establishing Causation Beyond Shortness of Breath



By Barbara K. Gotthelf

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The 1993 decision in *Giffear v. Johns-Manville Corp.*¹ changed “[t]he complexion of asbestos law”² in Pennsylvania. Before *Giffear*, plaintiffs with asymptomatic asbestos-related diagnoses could seek damages for fear and increased risk of asbestos-related cancers. *Giffear*, and its affirmation *sub nom* in *Simmons v. Pacor*³, established the rule that asymptomatic asbestos conditions are non-compensable, and that compensation for possible future diseases must await future manifestation.

The complexion of asbestos law may have changed again in August 2005, with the Pennsylvania Superior Court’s 4-4 *en banc* decision in *Summers v. Certaineed Corp.* and *Nybeck v. Union Carbide Corp.*⁴ (hereinafter “*Summers/Nybeck*”). *Summers/Nybeck* expressly recognized that where a plaintiff suffers from non-asbestos-related medical conditions and/or a significant smoking history that may account for his symptoms of shortness of breath, the court may rule, as a matter of law, that the plaintiff has failed to establish a causal connection between the plaintiff’s breathlessness and his asbestos exposure, and grant summary judgment. Just as *Giffear* restricted the number of active cases by requiring plaintiffs to establish a causal relationship between their alleged symptoms and their asbestos-related diagnosis, *Summers/Nybeck* may also reduce the number of active asbestos lawsuits by closing the courthouse doors to plaintiffs—even those with some degree of asbestosis—whose confounding medical conditions break the causal connection between their symptoms and their asbestos exposure.

The unusual nature of the 4-4 split in the *Summers/Nybeck en banc* panel has produced an even more unusual appellate scenario: Both plaintiffs *and* defendants have petitioned the Pennsylvania Supreme Court for allowance to appeal the Superior Court’s holding. Plaintiffs

argue that the affirming opinion should be reversed. The defendants, who support Judge Klein’s affirming opinion, are concerned about challenges to the precedential value of the decision because it does not represent a majority view. Both petitions for allowance of appeal are pending in the Pennsylvania Supreme Court.

An understanding of why *Summers/Nybeck* split the *en banc* panel, and an appreciation of the rationale supporting Judge Klein’s affirming opinion, begins with *Giffear*. The *Giffear* court’s conclusion that “asymptomatic . . . pleural thickening is a non-compensable injury and, therefore, does not give rise to a cause of action”⁵ has achieved mantra status in Pennsylvania asbestos jurisprudence. However, the reflexive application of this holding by some courts without regard to the facts of *Giffear* or the underlying basis for the holding in that case has led to confusion and inconsistency in the post-*Giffear* caselaw.

Significantly, the facts of *Giffear* demonstrate that the plaintiff was not “asymptomatic” as that term is commonly understood in a non-legal context. Plaintiff’s medical expert stated that Mr. Giffear had been experiencing shortness of breath and a cough for six to seven years before bringing suit.⁶ Moreover, Mr. Giffear demonstrated “an impressive degree of pleural disease for a man of such a young age [44 years].” However, the plaintiff’s expert also reported that Mr. Giffear’s lung function tests were essentially normal and, ultimately, the expert “could not attribute any physical symptoms to the pleural thickening.”⁷

It was the failure of the plaintiff’s medical expert to attribute Mr. Giffear’s symptoms to his asbestos-related diagnosis that persuaded the *Giffear* court to defer the plaintiff’s claims. Mr. Giffear may have been experiencing subjective symptoms of shortness of breath and

cough, but he was “asymptomatic” in a purely legal sense, meaning that his physical complaints had not been shown to be causally related to his asbestos exposure. Thus the *Giffear* court applied a traditional causation analysis to the facts of the case, and found the plaintiff’s evidence to be lacking.

In the decisions that followed *Giffear*, some courts remained committed to a causation analysis and resisted the application of a blanket rule that was derived from the language of the holding in *Giffear*, but divorced from the facts of that case. Other courts, however, took a more literal approach and read *Giffear* as a bright line rule that deferred claims based on pleural plaques, but allowed claimants with evidence of asbestosis to pursue their claims without fully addressing the causation question.

In 1996, shortly after *Giffear* was decided, the court continued to focus on causation in *Taylor v. Owens Corning*, which weighed the claims of multiple plaintiffs with pleural thickening and subjective complaints of shortness of breath. For at least one of these plaintiffs, the court noted that the plaintiff’s medical expert (who, interestingly, also served as Mr. Giffear’s medical expert) had failed to detect any “physical manifestations of asbestosis,”⁸ and was therefore unable to establish a link between the plaintiff’s symptoms and his radiographic changes. The *Taylor* court then added another important consideration to the causation analysis, which applied to all three plaintiffs in the case—the presence of confounding medical conditions unrelated to plaintiffs’ asbestos claims that could account for their symptoms. The plaintiffs in *Taylor* all had significant smoking histories, and one was overweight and had a heart condition. The court observed:

It is common knowledge that breathlessness is associated with any number of non-asbestos-related ailments including lung cancer, excessive cigarette smoking, heart disease, obesity, asthma, emphysema, and allergic reactions.⁹

Implicit in the court’s observation was the recognition that where so many conditions can cause shortness of breath, there may be no accu-

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rate way to establish a reliable causal connection between breathlessness and asbestos injury.

Relying on *Taylor*, the court in *Randt v. Abex Corp.*¹⁰ also concluded that the plaintiffs’ confounding medical conditions, which included obesity, diabetes, coronary artery disease and asthma, were critical to the causation analysis, even where plaintiffs’ experts testified that plaintiffs were suffering from asbestosis as well as pleural plaques, and at least one plaintiff had abnormal lung function tests. In *Ryan v. Asbestos Corp. Ltd.*, the court also applied a causation analysis, stating that, “Where the symptom of shortness of breath is causally related to a diagnosis of asbestos[is], a compensable injury does in fact exist.”¹¹ However, because the plaintiff’s medical expert in *Ryan* failed to assert that plaintiff suffered from shortness of breath due to an asbestos-related disease (just as was the case in *Giffear* and *Taylor*), summary judgment was affirmed in favor of the defendants. In a concurring opinion, Judge Klein foreshadowed his later opinion in *Summers/Nybeck* by addressing the plaintiff’s confounding medical conditions. Judge Klein noted that the plaintiff also was suffering from esophageal cancer and had a significant smoking history, both of which could have been the cause of plaintiff’s shortness of breath. Judge Klein wrote, “In any event, this is not a case where it is clear the parenchymal asbestosis is at a stage where it is symptomatic, certainly not in the face of shortness of breath from other causes.”¹²

While these courts kept focus on the fundamental question of whether plaintiffs’ medical evidence was sufficient to establish a causal connection between their symptoms and their asbestos-related diagnoses, other courts have strayed from this analysis and been willing to

infer causation based on a diagnosis of asbestosis, either standing alone or combined with testimony regarding the effect of plaintiffs’ symptoms on their day-to-day lives. In *McCauley v. Owens-Corning Fiberglas Corp.*¹³, the court found that the plaintiff had a cognizable cause of action where he established that he had been diagnosed with asbestosis and had abnormal pulmonary functions tests. The *McCauley* court noted that “shortness of breath . . . alone is not considered a compensable injury,” but found that “[the plaintiff’s] medical records . . . indicate that in addition to suffering shortness of breath he also suffered from asbestosis . . .”¹⁴ The *McCauley* court did not explain why the additional diagnosis of asbestosis transformed plaintiff’s shortness of breath into a compensable injury, but implicit in the holding is an assumption that Mr. McCauley’s diagnosis of asbestosis alone was sufficient evidence to support a causal connection between breathlessness and asbestosis exposure.

In *White v. Owens-Corning Fiberglas*,¹⁵ the court also found that the plaintiff had suffered a compensable injury when he was diagnosed with asbestosis, but then suggested an additional requirement for establishing a cognizable claim—that the plaintiff demonstrate his symptoms affected his daily activities. The *White* court held that the plaintiff established a compensable injury when he was diagnosed with asbestosis “and began to have difficulties walking more than half a block, climbing a flight of stairs, or washing dishes.”¹⁶ This additional evidentiary burden, dubbed the “impediment factor” by a later court,¹⁷ seems to confuse the distinct concepts of impairment and disability. Impairment refers to the loss of organ function; whereas disability refers to the loss of the ability to function as a person, at work or at

home. Moreover, the identification of “impediment factors” fails to advance the relevant legal analysis regarding causation. The *White* court’s finding that the plaintiff “[had] . . . difficulties walking more than half a block, climbing a flight of stairs, or washing dishes,” did nothing to establish or strengthen the causal connection between plaintiff’s breathlessness and his asbestosis. These difficulties, just like plaintiff’s shortness of breath, could easily have been caused by any number of medical conditions, such as heart disease, smoking-induced lung disease, obesity, advancing age, and deconditioning. In fact, plaintiff’s complaints amounted to little more than an elaboration on the underlying symptom of shortness of breath, a condition already deemed non-actionable absent other evidence of causation.

The Superior Court returned to a strong causation analysis in the 2003 decision *Quate v. American Standard Inc.*¹⁸ The plaintiff in *Quate* presented evidence that he was short of breath and that he had asbestosis. However, the *Quate* court declined to infer causation on this basis alone because Mr. Quate also suffered from a host of other medical conditions, “the symptoms of which are consistent with medical conditions arising from exposure to asbestos, . . .”¹⁹ Mr. Quate’s expert medical report stated that in addition to asbestosis, Mr. Quate, an ex-smoker, also was being treated for diabetes, hypertension and a prostate condition, had undergone heart surgery, and had a history of pneumonia and pleurisy. The Superior Court affirmed summary judgment in favor of the defendants, and agreed with the trial court’s conclusion that Mr. Quate’s multiple medical conditions “made it impossible to causally relate Quate’s shortness of breath to any particular medical condition that Quate has or to any physical restriction that he experiences.”²⁰

Thus, *Quate* stands for the proposition that where a plaintiff suffers from multiple health conditions that may cause or contribute to his breathlessness, and where plaintiff’s expert witness fails to rule out these other conditions as causing plaintiff’s impairment (and resulting disability), there is no legally sufficient causal connection between plaintiff’s shortness of breath and his asbestos-related X-ray changes,

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and summary judgment is appropriate. The *Quate* court expressly held:

Upon careful review, we hold that where a plaintiff suffers from a non-asbestos-related medical condition, the symptoms of which are consistent with medical conditions arising from exposure to asbestos, the existence of those non-asbestos-related medical conditions negate his ability to establish the necessary causal link between his symptoms and asbestos exposure. Under these circumstances, summary judgment is appropriate.²¹

Despite the clear holding in *Quate*, the court in *Cauthorn v. Owens-Corning Fiberglas Corp.*²² again lost sight of the causation analysis and retreated to unsupported inferences of causation as well as the analytically confused “impediment factor” requirement. Like Mr. Quate, the plaintiff in *Cauthorn* suffered from multiple non-asbestos medical conditions that could cause shortness of breath, and had an even more significant smoking history. The *Cauthorn* court conceded that, read “broadly and in the abstract,”²³ *Quate* would preclude Mr. Cauthorn from recovery. To avoid that result, the *Cauthorn* court offered an alternate reading of *Quate*, and suggested that *Quate* actually turned on consideration of the impediment factors; specifically, Mr. Quate’s failure to testify that his asbestos-related condition pre-

vented him from functioning normally or attending to his daily activities. According to *Cauthorn*, the actual holding of *Quate* is that “when a plaintiff suffers from breathlessness that does not affect his daily lifestyle, he cannot recover for his shortness of breath since the mere fact the plaintiff is short of breath could be due to all of his other non-asbestos-related medical conditions.”²⁴ The accuracy of this suggested holding is belied by its own logical disconnect. Testimony that shortness of breath affects one’s daily lifestyle would be irrelevant to the question of *which* of plaintiff’s multiple medical conditions was the cause of this alleged disability.

Having ostensibly extricated itself from the problem of Mr. Cauthorn’s confounding medical conditions, and having found that Mr. Cauthorn had, in fact, testified that his symptoms interfered with his lifestyle, the *Cauthorn* court was free to infer causation from the plaintiff’s expert medical report, which attributed an apparently unspecified percentage of plaintiff’s shortness of breath to his asbestos diagnosis.

Quate and *Cauthorn* brought to the forefront a fundamental disagreement in the Superior Court as to what constitutes a “symptomatic,” and therefore compensable, asbestos condition. Beginning with *Giffear* and continuing to *Quate*, a number of courts recognized the importance of the fundamental issue of causation, and held that unless a plaintiff could establish that his symptoms were causally related to his asbestos-related diagnosis (and not to another medical condition), he would be precluded from pursuing his claims. Other courts, including *White* and *Cauthorn*, strayed from a causation analysis and were willing to infer causation based on a medical diagnosis or “net” medical opinion, even in the face of confounding medical conditions that could break the causal connection.

The disagreement between *Quate* and *Cauthorn* came before the *en banc* Superior Court in *Summers/Nybeck*. Mr. Summers had radiographic evidence of pleural thickening; Mr. Nybeck had evidence of mild asbestosis. Both plaintiffs had changes in their pulmonary function tests. In addition, both plaintiffs had med-

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ical histories that included non-asbestos-related causes of shortness of breath. Mr. Summer's history included excessive cigarette smoking, asthma and obesity; Mr. Nybeck had obstructive lung disease and an 80-pack-year smoking history. Notwithstanding these other health conditions, both plaintiffs' expert medical reports stated that plaintiffs' asbestos exposures and asbestos-related diagnoses were "a substantial contributing factor" to their shortness of breath and abnormal pulmonary function tests.²⁵

Writing for the affirmance, Judge Klein refused to simply accept the conclusions of the plaintiffs' medical expert and infer causation. Judge Klein wrote, "Just because a hired expert makes a legal conclusion does not mean that a trial judge has to adopt it if it is not supported by the record and is devoid of common sense."²⁶ Applying his own knowledge of asbestos-related-injury, developed as the former supervising judge of the trial court's asbestos program, Judge Klein determined that plaintiffs' radiographic changes were relatively unremarkable, and the abnormalities noted on the pulmonary function tests were consistent with non-asbestos-related causes. Moreover, Judge Klein noted that where the record reveals multiple non-asbestos-related conditions that may account for a plaintiff's shortness of breath, expert testimony invoking the "magic words" of "substantial contributing factor" will not serve to reestablish the causal connection severed by confounding medical conditions.²⁷

Judge Klein's analysis is firmly based upon logic, law, and medicine. The affirming opinion in *Summers/Nybeck* properly introduces the requirement of sound, generally accepted methodology for expert witness opinion testimony on the issues of impairment and causation. Judge Klein's opinion thus reconnects the Pennsylvania law of evidence, which requires general acceptance of expert witnesses' methodologies, with summary judgment practice in the Pennsylvania asbestos docket.

The dissenting judges in *Summers/Nybeck*, like the court in *Cauthorn*, failed to recognize the

common thread of causation that connects much of the post-*Giffear* caselaw. Rather than viewing an evaluation of plaintiffs' confounding medical conditions as crucial to a causation analysis, the dissenters claimed that the affirming judges had created an additional test for compensability that went beyond a demonstration of a causal relationship between symptoms and diagnosis and the presence of impediment factors. According to the dissent, requiring the courts to consider the effect of confounding medical conditions on the compensability of asbestos claims "would represent an enormous re-working of the fundamental law at issue."²⁸ To the contrary, as demonstrated by *Giffear* and more than a decade of caselaw that followed, such a requirement is in keeping with traditional and firmly established rules regarding causation.

Having failed to properly consider the full record, including plaintiffs' extensive smoking and medical histories, the dissenting judges in *Summers/Nybeck*, like the court in *Cauthorn*, were free to accept, at least for purposes of denying summary judgment, the opinion of plaintiffs' expert that asbestos exposure caused the plaintiffs' symptoms. And, like the court in *Cauthorn*, the dissent also found the plaintiffs' impediment factors to be relevant, including Mr. Summers' testimony that he could no longer load or unload his truck, and Mr. Nybeck's testimony that he could only walk one block before becoming winded. The dissent fails to address the obvious problem of reliably relating those complaints to asbestos exposure in the light of each man's significant smoking history and non-asbestos-related medical conditions.

Principles of causation are as critical in the context of the asbestos litigation as they are in any other area of tort law. Where those principles are carefully applied, plaintiffs whose symptoms may be causally related to their asbestos exposure will be able to proceed with their claims, while plaintiffs who are "asymptomatic," i.e., plaintiffs who cannot demonstrate a causal link between their symptoms and their asbestos-related diagnoses, will see their cases dismissed or deferred. These fundamental principles of causation, which reach across the spectrum of cases from *Giffear* to Judge Klein's opinion in

Summers/Nybeck, must be followed in order to ensure that only plaintiffs with compensable claims are represented on the asbestos docket.

ENDNOTES

- ¹ *Giffear v. Johns-Manville Corp.*, 429 Pa. Super. 327, 632 A.2d 880 (1993).
- ² *Taylor v. Owens-Corning Fiberglas Corp.*, 446 Pa. Super. 174, 185, 666 A.2d 681, 686 (1995), *appeal denied*, 544 Pa. 661, 676 A.2d 1201, (1996).
- ³ *Simmons v. Pacor*, 543 Pa. 664, 674 A.2d 232 (1996).
- ⁴ ____ A.2d ____, 2005 WL 2495722 (Pa. Super., Oct. 11, 2005). (The opinion was first filed on August 25, 2005, but re-issued in October of 2005, because of confusion on the docket as to whether the initial opinion applied to both the *Summers* and the *Nybeck* cases. The even split in the court is treated as an affirmance of the lower court's decision.)
- ⁵ *Giffear*, 429 Pa. Super. at 341, 632 A.2d at 888.
- ⁶ The November 6, 1990, report of William Fineman, M.D., is part of the appellate record in *Giffear*.
- ⁷ *Giffear*, 429 Pa. Super. at 330, 632 A.2d at 882.
- ⁸ *Taylor*, 446 Pa. Super. at 181, 666 A.2d at 584.
- ⁹ *Taylor*, 446 Pa. Super. at 187, n.2, 666 A.2d at 688, n.2.
- ¹⁰ *Randt v. Abex Corp.*, 448 Pa. Super. 224, 671 A.2d 228 (1996).
- ¹¹ *Ryan v. Asbestos Corp. Ltd.*, 829 A.2d 686, 689 (Pa. Super. 2003).
- ¹² *Id.* at 690.
- ¹³ *McCauley v. Owens-Corning Fiberglas Corp.*, 715 A.2d 1125 (Pa. Super. 1998).
- ¹⁴ *Id.* at 1131.
- ¹⁵ *White v. Owens-Corning Fiberglas Corp.*, 447 Pa. Super. 5, 25, 668 A.2d 136, 146, *appeal denied*, 546 Pa. 648, 683 A.2d 885 (1996).
- ¹⁶ 447 Pa. Super. at 25, 668 A.2d at 146.
- ¹⁷ *Cauthorn v. Owens-Corning Fiberglas*, 840 A.2d 1028, 1038 (Pa. Super. 2004).
- ¹⁸ *Quate v. American Standard*, 818 A.2d 510 (Pa. Super. 2003), *appeal denied*, 557 Pa. 698, 845 A.2d 819 (2004).
- ¹⁹ *Id.* at 511.
- ²⁰ *Id.* at 513.
- ²¹ *Id.* at 511.
- ²² *Cauthorn v. Owens-Corning Fiberglas Corp.*, 840 A.2d 1028 (Pa. Super. 2004).
- ²³ *Id.* at 1037.
- ²⁴ *Id.* at 1038.
- ²⁵ *Summers/Nybeck*, 2005 WL 2495722 at *3, *4.
- ²⁶ *Id.* at *3.
- ²⁷ *Id.*
- ²⁸ *Id.* at *7.

