The Viability of Medical Monitoring Class Actions

Medical monitoring first emerged as a novel theory of recovery almost 30 years ago in the groundbreaking case Friends for All Children, Inc. v. Lockheed Aircraft Corp., 746 F.2d 816 (D.C. Cir. 1984). Since that time, more than half of the jurisdictions in the nation have permitted medical monitoring awards either as an independent claim or as a theory of recovery. While most early medical monitoring cases were limited to cases involving exposure to toxic chemicals or environmental spills, for nearly twenty years the plaintiffs’ bar has slowly been attempting to expand the reach of medical monitoring into the pharmaceutical and medical device arena. Using the rationale adopted in these early toxic tort cases, plaintiffs with unidentifiable injuries have sought to circumvent the limitations of conventional tort law by bringing broad medical monitoring claims. With increasing frequency, however, courts have rejected these claims. The most striking example of this trend is from New Jersey, where the state’s supreme court recently rejected an ambitious, national medical monitoring program for 20 million former Vioxx users.

For any litigator with an active pharmaceutical or medical device practice, New Jersey is an all too familiar jurisdiction. New Jersey has a rich industrial past and a progressive judiciary. The Garden State also has some of the most expansive, intricate tort law and class action jurisprudence in the nation. As a result, it has developed a reputation among plaintiffs’ lawyers, sometimes unfounded, as fertile ground for new and novel claims. Notably, slightly more than 20 years ago, no court had recognized a medical monitoring claim involving exposure to a toxic chemical. Medical monitoring claims, which seek to recover the quantifiable costs of periodic medical examinations to detect a disease before a plaintiff has manifested any symptoms, simply did not exist. The common law provided no redress for an individual claiming an alleged exposure without an existing injury or illness.

In 1987, however, the New Jersey Supreme Court became the first court in the nation to move beyond Friends for All Children to recognize medical monitoring as a form

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of recovery in a toxic tort suit. While the court in Ayers v. Jackson Twp., 525 A.2d 287, 311 (N.J. 1987), fell short of recognizing medical monitoring as a separate cause of action, the court’s ruling was the first to draw broad attention to medical monitoring claims. In the wake of Ayers, plaintiffs across the country asserted medical monitoring claims with increasing frequency. It was during the 1990s that medical monitoring claims began to surface in pharmaceutical and medical device cases. Even the Supreme Court’s decision in Metro-North Commuter R.R. Co. v. Buckley, 521 U.S. 424 (1997), in which the Court soundly rejected a medical monitoring claim under the Federal Employers Liability Act, did not dissuade the plaintiffs’ bar. What was once a novel claim appeared to move into the mainstream when medical monitoring class actions were allowed for users of Fen-Phen in states across the union. See, e.g., In re Diet Drugs Prods. Liab. Litig., No. 1203, 99-20593, 2000 WL 1222042 at *3 (E.D. Pa. Aug. 28, 2000). By the start of this decade, medical monitoring seemed to take root as a potentially devastating cause of action for defendants, as medical monitoring programs are often expensive and, by their very nature, expansive.

While medical monitoring claims continue to be a ubiquitous element of nearly every pharmaceutical and medical device mass tort, the long-term viability of these claims today is unquestionably in doubt, especially in cases with no existing injury. Over the past five years, numerous courts have soundly refused to certify medical monitoring classes for a host of pharmaceutical products and medical devices, from Baycol to Rezulin. See, e.g., In re Baycol Prods. Litig., 218 F.R.D. 197 (D. Minn. 2003); In re Rezulin Prods. Liab. Litig., 210 F.R.D. 61 (S.D.N.Y. 2002). Finally, in June 2008, the New Jersey Supreme Court, which first seeded this novel cause of action, resoundingly rejected an ambitious medical monitoring program for former Vioxx users. The New Jersey Supreme Court’s 5–1 decision in Sinclair v. Merck & Co., Inc., 195 N.J. 51 (N.J. 2008), marks a significant turning point in the viability of medical monitoring claims in pharmaceutical and medical device class actions. While courts across the country have almost universally rejected class actions for medical monitoring in cases involving pharmaceutical and medical devices in recent years, the Sinclair decision is significant because it was issued by the very same court that authored Ayers and first spurred the plaintiffs’ bar to pursue these claims.

Today, the vast majority of jurisdictions have rejected medical monitoring as a cause of action in cases involving pharmaceutical products or medical devices. This article will examine the history of medical monitoring claims and their declining viability in pharmaceutical product and medical device actions. Additionally, this article will provide some practical suggestions on how best to defend against these claims, highlighting important issues to be aware of when facing a medical monitoring claim. Decisions such as Sinclair have put pharmaceutical and medical device companies on solid ground to defeat these actions, regardless of the jurisdiction. Early, quick action to either dismiss these claims outright or defeat class certification can often ensure that these claims do not take root or spiral out of control.

**What Is Medical Monitoring?**

Medical monitoring, also known as claims for medical surveillance or medical screening, is at its foundation a judicial mechanism for addressing alleged harm proactively. The basic goal of a medical monitoring claim is to recover the costs of medical testing for health problems allegedly caused by exposure to a hazardous substance. While these claims are often filed in conjunction with claims involving existing injuries, most medical monitoring class actions are pursued on behalf of plaintiffs without existing injuries. These “no injury” plaintiffs only assert some basis to believe that some future disease or problem may develop requiring further medical evaluations beyond normal physicals.

**Origins and Basis of Medical Monitoring Claims**

The first case in which a broad medical monitoring monitoring award was authorized for a class of plaintiffs was the landmark case Friends for All Children, Inc. v. Lockheed Aircraft Corp., 746 F.2d 816 (D.C. Cir. 1984). The case centered on the decompression and subsequent crash of an aircraft evacuating Vietnamese children from Saigon at the end of the Vietnam War. The plaintiffs, the evacuation organizer and children, sued Lockheed, the aircraft manufacturer, for the cost of medical monitoring associated with an increased risk of brain damage caused by the decompression or subsequent crash.

The court concluded that “even in the absence of physical injury [a plaintiff] ought to be able to recover the cost for the various diagnostic examinations proximately caused by [a defendant’s] negligent action.” Friends for All Children, 746 F.2d at 825. This conclusion was based on a now well-cited hypothetical posed by the court:

Jones is knocked down by a motorbike that Smith is riding through a red light. Jones lands on his head with some force. Understandably shaken, Jones enters a hospital where doctors recommend that he undergo a battery of tests to determine whether he has suffered any internal head injuries. The tests prove negative, but Jones sues Smith solely for what turns out to be the substantial cost of the diagnostic examinations.

Id. at 825.

The court reasoned that, like Jones, the children on board the flight were exposed to a quantifiable risk—brain damage—and thus were entitled to medical monitoring. The D.C. Circuit Court, however, failed to address the issue that the plaintiffs did suffer some injury, no matter how slight, from the aircraft crash. Likewise, Jones, in the above hypothetical, was subject to physical injury. Hence, Friends for All Children left the question of liability, in the absence of physical injury or a traumatic event, open for the next major medical monitoring case.

The New Jersey Supreme Court answered the question of liability, applying medical monitoring to a group of victims who were exposed to toxic chemicals but lacked any demonstrable injury. See Ayers v. Township of Jackson, 106 N.J. 557, 606, 525 A.2d 287 (N.J. 1987). Relying on the rationales of public-health reform and the deterrence of pollutants, the court in Ayers established a precedent for awarding medical monitoring compensation for victims of toxic exposure. In Ayers, plaintiffs sought damages under the New Jersey Tort Claim Act related to their alleged exposure to chemicals through their municipal water supply. Id. at 565. While the court denied the plain-
through reliable expert testimony predicated upon the significance and extent of exposure to chemicals, the toxicity of the chemicals, the seriousness of the diseases for which individuals are at risk, the relative increase in the chance onset of disease in those exposed, and the value of early diagnosis, that such surveillance to monitor the effect of exposure to toxic chemicals is reasonable and necessary.

*Id.* at 606.

In the wake of *Ayers*, various state and federal courts showed more willingness to allow medical monitoring claims in cases involving not only environmental torts and toxic exposure, but also asbestos and pharmaceutical products. These decisions almost universally relied on the rationale and factors outlined in *Ayers*. See, e.g., *Petito v. A.H. Robins Co.*, 750 So. 2d 103, 108 (Fla. Dist. Ct. App. 1999) (relaying on *Ayers* in recognizing medical monitoring as valid cause of action in context of class action brought by Fen-Phen user); *Potter v. Firestone Tire & Rubber Co.*, 863 P.2d 795, 824–25 (Cal. 1993); *Hansen v. Mountain Fuel Supply Co.*, 858 P. 2d 970, 978 (Utah 1993); *W. Va. Rezulin Litig.*, 585 S.E.2d 52 (W.Va. 2003) (certifying medical monitoring class for Rezulin users).

Today, depending on the jurisdiction, relief for medical monitoring can be sought as a cause of action or a form of damages, or even form the basis for a class of injunctive relief. For example, in Florida and Pennsylvania, medical monitoring claims are recognized as independent causes of action. See, e.g., *Petito*, 750 So. 2d at 103 (recognizing an independent cause of action for medical monitoring in absence of a present, physical injury); *Redland Soccer Club, Inc. v. Department of the Army and Dept. of Defense of the U.S.*, 548 Pa. 178, 696 A.2d 137 (Pa. 1997) (same). While in West Virginia and California, medical monitoring is merely an element of damages, analogous to a traditional claim for future medical expenses. See, e.g., *Bower v. Westinghouse Elec. Corp.*, 206 W. Va. 133, 139, 522 S.E.2d 424 (W. Va. 1999); *Potter*, 863 P.2d at 795. Regardless of the jurisdiction, courts that recognize medical monitoring claims generally require plaintiffs to establish the following elements: (1) exposure; (2) to a hazardous substance; (3) caused by the conduct of a defendant; (4) which results in an increased risk that the plaintiffs will contract a serious, latent disease; and (5) a viable medical monitoring program exits to detect the alleged disease or future harm. See, e.g., *In re Paoli R.R. Yard PCB Litig.*, 916 F.2d 829, 852 (3d Cir. 1990); *Hansen v. Mountain Fuel Supply Co.*, 858 P.2d 970, 979 (Cal. 1993).

Typically, the only damages available to plaintiffs in a medical monitoring class action is the value of the medical services and medical testing required to detect the latent disease at issue in the case. A damages award can take the form of a lump-sum payment to individual plaintiffs, a court-created and administered trust fund, or an order that a defendant provide the necessary medical monitoring in the future. Most courts favor a court-administered fund, rather than direct, lump-sum payments, to ensure that plaintiffs will actually spend the money on the required medical monitoring programs. See, e.g., *Redland*, 696 A.2d at 142 n. 6 (encouraging the use of medical monitoring funds).

**Current Standing of Medical Monitoring Claims**

While the rationale espoused in *Ayers*, *Paoli* and their progeny provide a basic framework for medical monitoring awards, both federal and state courts have recently hesitated in toxic tort cases to support pharmaceutical medical monitoring classes. Indeed, the current trend, especially in federal courts, has been overwhelmingly away from certifying medical monitoring classes in pharmaceutical and medical device class actions when the proposed class has no substantiated injuries.

The growing reluctance to certify medical monitoring class actions, especially in the federal courts, originated with the Supreme Court’s decision in Metro-North Commuter R.R. Co. *v. Buckley*, 521 U.S. 424, 440 (1997). In *Buckley*, the Court declined to recognize a medical monitoring claim because a “separate tort cause of action” for medical monitoring was not available to the plaintiff under the Federal Employers’ Liability Act (FELA). In failing to “endorse a full-blown, traditional tort law cause of action for lump-sum damages” compensating medical surveillance, the court relied on “the uncertainty among medical professionals” regarding the level of necessary surveillance and the difficulty in identifying the necessary costs for medical monitoring. See *id.* at 441. Likewise, the Court was also wary of the flood of litigation that would likely ensue if the Court diluted the fundamental tort law principle that a plaintiff must have an actual injury to obtain recovery. *Id.*

Despite the Supreme Court’s strong language, plaintiffs have continued to file pharmaceutical-based medical monitoring class actions. In response, the vast majority of federal and state cases that have followed *Buckley* have also recognized that traditional tort doctrines, developed around causation, simply cannot recognize or remedy a nonexistent wrong that has not manifested in some tangible form. See, e.g., *Wood v. Wyeth-Ayerst Laboratories*, 82 S.W.3d 849 (Ky. 2002). Indeed, in the past two years, a flood of state supreme court decisions have rejected medical monitoring claims, including decisions in Alabama, New Jersey, Mississippi, Oklahoma, and Oregon. See *Houston County Health Care Authority v. Williams*, 961 So. 2d 795, 811 (Ala. 2007); *Sinclair v. Merck & Co., Inc.*, 195 N.J. 51 (N.J. 2008); *Paz v. Brush Engineered Materials, Inc.*, 949 So. 2d 1 (Miss. 2007); *Cole v. ASARCO, Inc.*, No. 03-CV-327-GKF-PJC, 2009 WL 920581, at *4–5 (N.D. Okla. April 2, 2009); *Low v. Philip Morris USA Inc.*, 183 P.3d 181, 186–87 (Or. 2008).

In Barnes, former smokers had filed an action against cigarette manufacturers seeking certification of a medical monitoring class. See Barnes, 161 F.3d at 130–31. The Third Circuit affirmed the district court’s decertification of a medical monitoring class, stating that too many individual issues, including addiction, causation, and affirmative defenses, precluded class action certification for medical monitoring. Id. The Third Circuit emphasized that these issues must be determined on an individual basis, noting that “the requirement that each class member demonstrates the need for medical monitoring precludes certification.” Id. at 146.

Notwithstanding the strong language against medical monitoring class actions from both the Third Circuit and Supreme Court, the court in In re Diet Drugs distinguished Barnes, noting that tobacco litigation involved far more individual issues than the Fen-Phen case. The district court wrote that no individual issues divided the diet-drug class, which was marked by “a great deal of cohesion,” due to members’ exposure to one substance and risk of basically one type of injury. Id. at *46.

Today, however, the Fen-Phen decision stands alone. District courts considering Prempiro, Rezulin, Seroquel, Baycol, and Aredia/Zometa MDLs have all declined class certification for medical monitoring claims. These courts, as discussed more fully below, have all found that because of the nature of prescription drugs, the individual issues of each plaintiff are far too numerous to allow a broad class action for medical monitoring. See In re Prempiro Prods. Liab. Litig., 230 F.R.D. 555 (E.D. Ark. 2005); In re Rezulin Prods. Liab. Litig., 210 F.R.D. 61 (S.D.N.Y. 2002); Zehel-Miller v. AstraZeneca Pharmaceuticals, L.P., 223 F.R.D. 659 (M.D. Fla. 2004); In re Baycol, 218 F.R.D. 197 (D. Minn. 2003); and In re Aredia & Zometa Prods. Liab. Litig., No. 3:06-MD-1760, 2007 WL 3012972 (M.D. Tenn. October 10, 2007).

The most striking example of the trend against certifying medical monitoring classes, however, came from a state supreme court in the Vioxx litigation. In a widely anticipated decision, the New Jersey Supreme Court declined to recognize a putative class of all Vioxx users in the United States who had not filed personal injury claims. Sinclair v. Merck & Co., Inc., 195 N.J. 51 (N.J. 2008). In rejecting these plaintiffs’ ambitious attempt to force the pharmaceutical defendant to fund a massive, nationwide medical monitoring program for 20 million former Vioxx users, the court noted that the plaintiffs had failed to plead the manifest-injury element of the underlying product liability action. The court interpreted the statutory definition “personal physical illness, injury or death” in the New Jersey’s Products Liability Act, N.J.S.A. 2A:58C-1 et seq. to require a “physical injury.” Id. at 65. In reaching this decision, the court recognized that the present claim was significantly different from Ayers and its progeny, and Ayers should only be applied in rare circumstances. Id. at 56. The court also expressly rejected the plaintiffs’ effort to expand the definition of harm to include medical monitoring, noting that this was something “best directed to the Legislature.” Id. at 65.

In light of the New Jersey Supreme Court’s recognition in Sinclair that Ayers did not apply to pharmaceutical actions, various state court pharmaceutical class action decisions that relied in some part on Ayers now invite questions. Indeed, the court in Sinclair expressly noted that medical monitoring was not a cause of action but rather a special remedy that required establishing a separate tort. As other recent decisions rejecting medical monitoring in Oregon, Kentucky, Oklahoma, and Mississippi, the Sinclair decision may help close the door on the popularity of these types of suits.

Even if the door is never closed fully, however, these recent cases provide a specific framework for defending against medical monitoring pharmaceutical class action claims.

**Defeating Class Actions for Medical Monitoring**

As outlined above, medical monitoring class action law is still quite dynamic. Thus, from the very beginning, it is important that defendants determine if the law on medical monitoring in their particular jurisdiction is well established. The first questions to ask are whether a jurisdiction recognizes medical monitoring, and if so, whether it requires a medical monitoring claimant to demonstrate an existing physical injury. If the state requires an existing physical injury, a defendant can argue from the outset that any claim not based on an existing injury must be immediately dismissed. State courts are beginning to realize that the viability of medical monitoring claims depends on the type of product and exposure. As Sinclair outlined, prescription-drug plaintiffs are quite different from the mass-accident environment exposure plaintiffs in Ayers. Prescription drug and medical device plaintiffs are most often willing consumers who received specific warnings about the product and its side effects. Likewise, these plaintiffs often have complex, varied medical histories coupled with quite different dosage prescriptions, which make class action certification difficult. See, e.g., In re Fosamax Prods. Liab. Litig., 2008 WL 58890 (S.D.N.Y. Jan. 3, 2008).

Defendants should also review a state’s statutes or products liability act, as many require that plaintiffs suffer from a recognizable injury to state a valid claim. New Jersey and Louisiana are but two examples. These statutes may, on their face, expressly bar plaintiffs’ medical monitoring claims. Additionally, these types of state statutory schemes raise another important argument: because medical monitoring falls outside of the common law, adopting medical mon-
itoring claims belongs to the legislature’s realm. *In re Propulsid Prods. Liab. Litig.*, 208 F.R.D. 133 (E.D. La. 2002) (recognizing that creating new causes of action is better left to the legislative, not the judicial branch). This public policy-related argument has proven successful in a number of jurisdictions. See, e.g., *Henry v. The Dow Chemical Co.*, 701 N.W.2d 684 (Mich. 2005).

### Various state court pharmacological class action decisions that relied in some part on *Ayers*

Now invite questions.

While attacking the absence of existing physical injuries is an increasingly successful tool in defeating pharmaceutical class actions, a number of jurisdictions still permit plaintiffs to establish a prima facie case without demonstrating an existing physical injury. In these jurisdictions, defendants can still aggressively attack each of the five factors plaintiffs must prove to establish a medical monitoring class. Early in a case a defendant can initiate a “science first” motion, which attacks plaintiffs’ ability to establish general causation—that is, that the plaintiffs were exposed to a proven hazardous substance—or, a traditional summary judgment motion. See, e.g., *In re Human Tissue Prods. Liab. Litig.*, 582 F. Supp.2d 644 (D.N.J. 2008).

Notably, the district court in the *Propulsid* litigation stated that it was not inclined to fill the scientific void regarding the feasibility of plaintiffs’ proposed medical monitoring program. *In re Propulsid*, 208 F.R.D. at 147; see also *In re Baycol*, 218 F.R.D. at 212 (finding that the absence of recommendations from the medical community regarding the need for a medical monitoring program was fatal to plaintiffs’ claims). Thus, defendants should always consider attacking plaintiffs’ ability to establish that use of the product in question increased the risk of contacting a serious latent disease or that a form of medical monitoring exists that makes early detection of the disease possible. See, e.g., *In re Meridia Prods. Liab. Litig.*, 328 F. Supp. 2d 791 (N.D. Ohio 2004) (dismissing medical monitoring claim due to plaintiffs’ insufficient evidence that the drug increased plaintiffs’ risk of contracting a disease).

Finally, defendants should consider removing these cases to a federal court. As noted above, the federal courts have almost universally rejected these claims. Importantly, federal courts and the federal rules for class certification are typically more stringent than similar state rules.


As background, plaintiffs seeking class certification must generally meet the requirements of Federal Rule of Civil Procedure Rule 23, or the corresponding local class action rule or statute. *Fed. R. Civ. P. 23(a)* sets forth the four familiar prerequisites to all class actions:

- the class is so numerous that joinder of all members is impracticable;
- there are questions of law or fact common to the class;
- the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
- the representative parties will fairly and adequately protect the interests of the class.

In a typical pharmaceutical or medical device case, there is generally no shortage of potential claimants who are likely to share common interests. Indeed, most courts find that plaintiffs have little problem meeting the first two requirements of *Fed. R. Civ. P. 23(a)*. However, it is the size and scale of the class that presents the biggest hurdle in class certification. Thus, the first and most important element to emphasize in a defense is that medical monitoring is not well designed for class treatment because of the breadth of the typical class. Medical monitoring classes often attempt to include every individual who allegedly ingested a drug or received a medical device, regardless of age, medical condition, or dosage history. These broad national classes can, therefore, include thousands, if not millions of users, as in the case of Vioxx.

Recently, Judge Keenan soundly rejected this type of broad class in the Fosamax litigation. *In re Fosamax Prods. Liab. Litig.*, 2008 WL 58890 (S.D.N.Y. Jan. 3, 2008) (finding that “almost every element of a medical monitoring claim will require highly individualized proof of each class member’s medical condition and the circumstances of their use of [the drug]”). In a well-reasoned opinion, Judge Keenan noted that individual claims and individual medical issues predominated, and the class “did not set any dosage limitations on class membership,” or “attempt to screen individuals with unique risk factors for ONJ [osteonecrosis of the jaw],” and it “fail[ed] to specify the duration of the proposed dental monitoring program.” Without this information, the court noted that it could not “conduct the numerosity, commonality, typicality[,] and adequacy analyses that must precede certification.”

In short, the consensus is that mass torts are typically ill-suited to class treatment. As the U.S. Supreme Court noted in *Ortiz v. Fibreboard Corp.*, “mass accident resulting in injuries to numerous persons is ordinarily not appropriate for a class action because of the likelihood that significant questions, not only of damages, but of liability and defenses of liability would be present, affecting the individuals in different ways.” 527 U.S. 815, 855 n. 20 (1999).

Likewise, in *In re Aredia & Zometa*, the district court also noted that despite meeting the numerosity requirements, plaintiffs did not satisfy the typicality standard because the class members’ claims involved so many distinct factual and legal questions to render class certification inappropriate. *In re Aredia & Zometa*, No. 3:06-MD-1760, 2007 WL 3012972 at *3. Furthermore, the court noted that these individual differ-
ences also defeated the argument that the class representative would fairly and adequately represent the interests of the class, because there would be conflicts of interest between the class representative and members of the proposed class. *Id.* at *4–5. The court in *In re Aredia & Zometa* also touched on another common theme in federal cases rejecting class certification: state laws governing product liability and medical monitoring vary greatly. *Id.; see also In re Paxil Litigation*, 212 F.R.D. at 551 (noting the risk of jury confusion, when taken together with risk of improperly grouping different states’ laws, outweighs any possible advantages to be gained from certification).

Even if a plaintiff can establish the criteria of Fed. R. Civ. P. 23(a), the party must still satisfy one of the following requirements of Fed. R. Civ. P. 23(b):

- There is a risk of incompatible standards of conduct for the party opposing certification if the actions are prosecuted separately;
- The defendant has acted or refused to act on grounds generally applicable to the class as a whole, and, therefore, injunctive or declaratory relief would benefit the class as a whole; or
- Common questions predominate, and the class action is the superior method of adjudication.

Fed. R. Civ. P. 23(b)(3), as noted by the District of Minnesota in the *Baycol* litigation, provides another common bar to medical monitoring class actions because individualized issues are almost always inextricably intertwined with the common issues identified by plaintiffs in satisfying Rule 23(a). *In re Baycol*, 218 F.R.D. at 208. Indeed, most courts have found that common issues do not predominate, rendering certification under Fed. R. Civ. P. 23(b)(3) inappropriate. As the court in *In re Baycol* noted:

Plaintiffs’ claims of failure to warn turn on what Defendants knew at the time was prescribed. As the class members were prescribed at different times, the issue of Defendants’ knowledge will differ from case to case. The same is true for the claims based on negligence. For example, negligence claims depend on individual facts—whether there is a breach of duty or the foreseeability of harm will depend on what Defendants knew or should have known at the time the prescription was written and whether Defendants acted reasonably based on the knowledge it had at that time. With respect to the claims of design defect, liability cannot be established without consideration of individualized issues such as dosage. *Id.*

As previously mentioned, plaintiffs in prescription drug cases invariably used a drug or device at different times, took different dosages or used different device models. Similarly, plaintiffs’ medical histories will be quite complex and unique, making class certification nearly impossible. As the Supreme Court noted, plaintiffs in medical monitoring actions often share “little in common, either with each other or with the presently injured class members and... will also incur different medical expenses because their monitoring and treatment depends on singular circumstances and individual medical histories.” *Achem Products, Inc. v. Windsor*, 521 U.S. 591, 624 (1997).

Most recently, the Third Circuit, in *In re Hydrogen Peroxide Antitrust Litig.* , 552 F.3d 305 (3d Cir. 2009), further clarified the standard that district courts in that circuit must apply before permitting a class action to proceed. In this case, the Third Circuit specified that class actions should no longer be granted when plaintiffs’ claims are only supported by conjecture. The Third Circuit vacated the district court’s certification of a nationwide class of plaintiffs who alleged that manufacturers of hydrogen peroxide and other products had engaged in a conspiracy. The district court had certified the class even though the plaintiffs had failed to demonstrate predominance with any certainty. The Third Circuit reversed, noting that “[a] party’s assurance to the court that it intends or plans to meet the requirements is insufficient.” *Id.* In light of the heightened standard outlined in *Hydrogen*, the issue of class certification must be considered as an effective means to dispose of a medical monitoring claim at the earliest stages of the lawsuit.

Finally, in an effort to avoid the demands of Fed. R. Civ. P. 23(b)(3), plaintiffs have sought certification of medical monitoring classes under Fed. R. Civ. P. 23(b)(2), which authorizes class actions seeking primarily injunctive relief. While plaintiffs argue that medical monitoring claims are at their core a request for injunctive relief, courts have almost universally seen these plans as a means of avoiding the predominance or superiority requirements of Fed. R. Civ. P. 23(a). See, e.g., *Zinser v. Accufix Research Ins.*, 253 F.3d 1180 (9th Cir. 2001); *In re Propulsid*, 208 F.R.D. 133 (E.D. La. 2002); *Mehl v. Canadian Pacific Railway Ltd.*, No. A4-02-009, 2005 WL 1027158, *5 (D.N.D. May 4, 2005).

**Conclusion**

In the wake of *Sinclair*, the long-term viability of medical monitoring claims for pharmaceutical products and medical devices is certainly in question. While the prospect of facing medical monitoring claims was once foreboding, early and decisive motion practice can ensure the early dismissal of these claims. *Sinclair* provides great ammunition for defendants facing medical monitoring claims. While the New Jersey Supreme Court spurred the early development of these claims with *Sinclair*, this court might also help to close the door on the widespread use of medical monitoring class actions in cases involving pharmaceutical products and medical devices.

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