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OF WEST VIRGINIA

Benjamin, J., dissenting:

I respectfully disagree with my colleagues that the circuit court should have admitted into evidence the testimonies of Dr. Peter Gregor and Ewen Todd, Ph.D, putative expert witnesses engaged by the appellants. I dissent specifically with respect to the majority's adoption of syllabus points 4 and 5. I believe the majority's adoption of syllabus point 4 will serve to have a lasting negative impact on litigation in the State of West Virginia and our legal community, ultimately making summary judgment nothing more than an unattainable fiction. Additionally, the majority, for reasons I cannot discern, has taken this opportunity to adopt a rule of law (which has absolutely no application to the case before us<sup>1</sup>) that will deprive our trial courts of their discretion to act on motions by requiring a hearing prior to making a ruling on expert admissibility. Also troubling is the majority's reliance for these changes on a minority view of law that has only been adopted by the First and Third

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<sup>1</sup> In the case *sub judice*, the appellee filed a motion for summary judgment *at the close of discovery, upon a fully developed record*. A hearing was conducted, and *the parties had adequate opportunity to be heard at the pretrial level*, before the circuit court made its decision to grant summary judgment for the appellees. Indeed, the majority arrives at its conclusion to reverse the circuit court's ruling, not by using the principles of law enunciated in syllabus point 4, but for entirely different reasons.

Circuits.<sup>2</sup>

I am most concerned that the majority believes that “the summary judgment process does not conform well to the discipline and analysis that *Daubert v. Merrell Dow*

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<sup>2</sup> In relying on *Cortes-Irizarry v. Corporacion Insular De Seguros*, 111 F.3d 184 (1997), the majority fails to mention that there, the plaintiff argued that *Daubert* was strictly a time-of-trial phenomenon. The Court, in reasoning that the plaintiff’s position was wrong, stated that

The *Daubert* regime can play a role during the summary judgment phase of civil litigation. ***If proffered expert testimony fails to cross Daubert’s threshold for admissibility***, a district court may exclude that evidence from consideration when passing upon a motion for summary judgment.

111 F.3d at 188 (emphasis added).

The court also acknowledged that

Though such an opportunity is most easily afforded at trial or in a trial-like setting, ***courts have displayed considerable ingenuity in devising ways in which an adequate record can be developed so as to permit Daubert rulings to be made in conjunction with motions for summary judgment***. See, e.g., *Brown v. SEPTA (In re Paoli R.R. Yard PCB Litig.)*, 35 F.3d 717, 736, 739 (3d Cir. 1994)(discussing use of in limine hearings), cert. denied, 513 U.S. 1190, 115 S.Ct. 1253, 131 L.Ed.2d 134 (1995); *Claar*, 29 F.3d at 502 (discussing district court’s technique of ordering experts to submit serial affidavits explaining the reasoning and methodology underlying their conclusions.) We do not disparage such practices; we merely warn that the game sometimes will not be worth the candle.

*Id.* at fn. 3 (emphasis added).

*Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786 (1993) and *Wilt v. Buracker*, 191 W. Va. 39, 443 S.E.2d 196 (1993) impose.” I do not believe that either holding was ever intended to be rarely used at the summary judgment stage.

With respect to the specific testimony at issue, the focus of my disagreement is not upon the qualifications of Dr. Gregor and Dr. Todd as experts in their specific fields but upon the unreliability of both of their testimonies. The offered testimony of Dr. Gregor should, in my opinion, be excluded because it is unreliable both in Dr. Gregor’s diagnosis of Mr. San Francisco’s symptoms as a foodborne illness, specifically an *E. Coli* 0157: H 7 bacteria-induced infection, and in his determination that the external cause of the illness was a Wendy’s hamburger that Mr. San Francisco had partially eaten within an hour or two prior to the onset of his symptoms. (According to Dr. Todd, Mr. San Francisco became ill too quickly for a typical *E. Coli* infection to have occurred in that *E. Coli* requires incubation of three to seven days from ingestion for the pathogen to attach to the intestine walls and produce verotoxin, the direct cause of an illness attributable to *E. Coli*.) The offered testimony of Dr. Todd should, in my opinion, be excluded because it is also unreliable, in this case, by reason of Dr. Todd’s theorizing<sup>3</sup> that the reason Mr. San Francisco’s symptoms occurred within a couple of hours after he had partially eaten the hamburger, instead of the usual incubation period of three to seven days from ingestion, was because verotoxin had

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<sup>3</sup>In their Brief, the San Franciscos label Dr. Todd’s testimony as his ““verotoxin theory.”

already formed on the hamburger (“pre-formed verotoxin”) before it was eaten due to the “possibility” that the beef had been “abused,” of which he had no direct evidence.<sup>4</sup>

## I.

### *Daubert, Kumho Tire and Wilt*

In *Daubert*, the U.S. Supreme Court held that the traditional “general acceptance” test enunciated in *Frye v. United States*, 54 App. D.C. 46, 47, 293 F. 1013, 1014 (1923), which required that a scientific technique be generally accepted as reliable in the scientific community in order to be admissible, was superseded by the adoption of the federal rules of evidence. 509 U.S. 579, 113 S.Ct. 2786. The Court, in stating that the rules provide the standard for admitting expert testimony, analyzed Rule 702 and found that nothing in the rule stated that “general acceptance” was a prerequisite to admissibility. Subsequently, in *Wilt*, 191 W. Va. 39, 443 S.E.2d 196, this Court concluded that *Daubert*’s analysis of Federal Rule 702 should be followed in analyzing the admissibility of expert testimony under Rule 702 of the West Virginia Rules of Evidence. Neither decision explicitly, or implicitly, cautions against utilizing summary judgment in the expert admissibility context. To the contrary, the *Daubert* Court specifically cautioned that

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<sup>4</sup>Dr. Todd’s theory concerning pre-formed verotoxin is based on a single 15-year-old study where *E. Coli* was added to ground beef and held for four days at a temperature of 98.6°F.

the Rules themselves place no limits on the admissibility of purportedly scientific evidence. Nor is the trial judge disabled from screening such evidence. To the contrary, under the Rules the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.

*Daubert*, 509 U.S. at 588, 113 S.Ct. at 2795.

It is well recognized that because “[t]he law must seek decisions that fall within the boundaries of scientifically sound knowledge,” Honorable Stephen Bryer, *Introduction to Reference Manual on Scientific Evidence* 4 (2d ed. 2000), *Daubert* imposed a gatekeeping function for trial courts to ensure that ***only relevant and reliable scientific evidence reaches the jury***. (emphasis added). “Rule of Evidence 702 imposes a special obligation upon a trial judge to ‘ensure that any and all scientific testimony. . . ***is not only relevant, but reliable***.’” *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 147, 119 S.Ct. 1167, 1177 (1999)(quoting *Daubert*, 509 U.S. at 589) (emphasis added). The very purpose of *Daubert*, “is to make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom ***the same level of intellectual rigor that characterizes the practice of an expert in the relevant field***.” *Kumho*, 526 U.S. at 152 (emphasis added). The trial judge must have ***considerable leeway*** in deciding in a particular case how to go about determining whether particular expert testimony is reliable. *Id.*, 526 U.S. at 151 (emphasis added).

It is crucial that the factor of reliability continue to be determined by the circuit court, in its gatekeeper capacity; not the jury, under the rubric of weight. Because reliability is properly an issue of admissibility, *not weight*, this is not an issue within the province of the jury to conclude. I fear that holdings such as the majority's opinion herein will give the illusion that reliability is, in essence, virtually an issue of weight. We must be reminded that,

In analyzing the admissibility of expert testimony under Rule 702 of the West Virginia Rules of Evidence, the *trial court's initial inquiry* must consider whether the testimony is based on an assertion or inference derived from the scientific methodology. Moreover, the testimony must be relevant to a fact in issue. Further assessment should then be made in regard to the expert testimony's reliability by considering its underlying scientific methodology and reasoning. This includes an assessment of (a) whether the scientific theory and its conclusion can be and have been tested; (b) whether the scientific theory has been subjected to peer review and publication; (c) whether the scientific theory's actual or potential rate of error is known; and (d) whether the scientific theory is generally accepted within the scientific community.

Syl. Pt. 2, *Wilt v. Buracker*, 191 W. Va. 39, 443 S.E.2d 196 (emphasis added). Undoubtedly, “when an expert opinion is based on data, a methodology, or studies that are simply inadequate to support the conclusions reached, *Daubert* and Rule 702 ***mandate the exclusion of that unreliable opinion testimony.***” *Amorgianos v. Nat’l R.R. Passenger Corp.*, 303 F.3d 256, 266 (2d Cir. 2002) (emphasis added).

## II.

## **The Testimony of Dr. Peter Gregor**

In the case before us, the majority holds that Dr. Gregor was both qualified to render an expert opinion regarding causation and that his opinion was reliable because it was formed through a scientific method called “differential diagnosis.” The majority, in adopting Syllabus Point 5, concludes that a medical opinion based upon a properly performed differential diagnosis is sufficiently valid to satisfy the reliability prong of Rule 702. I do not agree with the majority’s holding, particularly because the majority confuses the terms, “differential diagnosis” and “differential etiology.” I believe Dr. Gregor simply was not qualified to render an expert opinion on the *cause* of the gastroenteritis from which Mr. San Francisco was suffering, and any opinions in this regard were unequivocally unreliable.

While Dr. Gregor, a cardiologist, may have been qualified to testify as to the *indications, diagnosis, and treatment* of food poisoning since he evaluated Mr. San Francisco in the emergency room, I believe that he required more specialized knowledge and information in order to testify regarding the issue of external causation. Dr. Gregor admitted that, as a cardiologist, he was not an expert on etiology in foodborne illness. Despite this, the majority relies upon *Westberry v. Gislaved Gummi AB*, 178 F.3d 257, 262 (4<sup>th</sup> Cir. 1999), a case recognizing that a differential diagnosis, or differential etiology, is a standard scientific technique of identifying the cause of the medical problem by eliminating the likely causes until the most probable one is isolated sufficient to meet the requirement of Rule 702.

I agree with the contention set forth by the appellees, that the terms differential diagnosis and differential etiology are two separate concepts - a differential diagnosis being a medical process and differential etiology being a legal concept.

### **A. Differential Diagnosis**

The majority defines the term “differential diagnosis” as a methodology employed by medical practitioners to determine by a process of elimination both the disease or condition from which a patient is suffering and the internal or external cause of the disease or condition. The majority, like many courts, have used the term in a way that differs from its dictionary definition and from its usage in the medical community.<sup>5</sup>

As recognized by the Eleventh Circuit Court of Appeals in *McClain v. Metabolife Intern., Inc.*, 401 F.3d 1233, 1252 (11<sup>th</sup> Cir. 2005):

Differential diagnosis involves “the determination of which one of two or more diseases or conditions a patient is suffering from, by systematically comparing and contrasting their clinical findings.” *DORLAND’S ILLUSTRATED MEDICAL DICTIONARY* 240, (Douglas Anderson *et al.* ed., 29<sup>th</sup> ed. 2000)). This leads to the diagnosis of the patient’s condition, not necessarily the cause of that condition. The more precise but

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<sup>5</sup>See Federal Judicial Center, Reference Manual on Scientific Evidence 443 (2d ed. 2000).



rarely used term [for determining the cause of a condition] is differential etiology, which is “a term used on occasion by expert witnesses or courts to describe the investigation and reasoning that leads to the determination of external causation, sometimes more specifically described by the witness or court as a process of identifying external causes by a process of elimination.” See Mary Sue Henifin *et al.*, *Reference Guide on Medical Testimony*, in *REFERENCE MANUAL ON SCIENTIFIC EVIDENCE* 439, 481 (Fed. Jud. Ctr. 2d ed. 2000)).

“At one level, the confusion is terminology in only semantic . . . [h]owever, at another level the confusion can mislead.” 2 Faigman, *Modern Scientific Evidence* at §20-1.1 at 541. The danger is that, in conflating these two concepts, a physician could, as here, be permitted to testify beyond his or her areas of expertise.<sup>6</sup>

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<sup>6</sup>Courts often confuse differential diagnosis, a technique accepted in the medical field and used by doctors every day, with differential etiology, which is a very different process. “Differential diagnosis refers to the clinical process by which doctors determine the internal disease that is causing a patient’s suffering; differential etiology is used for determining the external causes of the problem. In a differential diagnosis, a doctor isolates a disease that is causing the patient’s symptoms, whereas differential etiology isolates an external factor that has caused the internal disease.” Ian S. Spechler, “Physicians at the Gates of *Daubert*: A Look at the Admissibility of Differential Diagnosis Testimony to Show External Causation in Toxic Tort Litigation,” 26 Rev. Litig. 739, 743 (Summer 2007) (internal footnote omitted). See also Edward J. Imwinkelried, “The Admissibility and Legal Sufficiency of Testimony about Differential Diagnosis (Etiology): Of Under- and Over-Estimations,” 56 Baylor L. Rev. 391,402-03 (Spring 2004) (“If the key question is the cause of the illness rather than the nature of the illness, the physician uses a related, but distinct technique, that is, differential etiology. It is true that the expressions ‘differential diagnosis’ and ‘differential etiology’ are sometimes utilized interchangeably as if they are synonymous. However, strictly speaking, differential diagnosis uses process-of-elimination reasoning to identify the patients’s illness while differential etiology adopts the same mode of reasoning to determine the cause of the illness.”)(internal footnotes omitted); Faigman, “Symposium: The Role of the Judge in the Twenty-First Century[,] Judges as ‘Amateur Scientists’,” 86 B.U.L. Rev. 1207, 1221 (December 2006) (“Properly understood, differential diagnosis refers to the identification of the illness or behavioral condition that a person is experiencing. Differential etiology refers

While the two methodologies may employ a similar process, that of deduction or elimination, the differences are more than nomenclature, they are substantive for “[v]ery different skill sets are usually involved in these two determinations,”<sup>7</sup> that of diagnosing a patient’s condition and that of identifying the external cause of the condition. As one author has explained:

The distinction between differential diagnosis and differential etiology may seem subtle, but it is actually quite profound. Although doctors receive substantial training on formulating a differential diagnosis, they receive very little training, if any, on how to conduct a differential etiology. Furthermore, doctors rarely perform differential etiology when treating patients. . . . If an elderly patient were to tell a doctor that she had shortness of breath, the doctor may use a differential diagnosis to eliminate heart disease, anemia, lung fibrosis, and emphysema as possible causes. [The doctor] may then conclude that the most likely cause of the shortness of breath is chronic bronchitis, an internal disease. The physician would rarely analyze external factors such as workplace conditions in practice, but patients often call in doctors to do so in litigation. Thus, if a court were to mistake a differential etiology analysis for a differential diagnosis analysis, the court could errantly overemphasize the physicians’s qualification to give competent and relevant testimony . . . In contrast to a differential diagnosis, evaluating

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to the cause or causes of that condition.”)(internal footnotes omitted); Note, Wendy Michelle Ertmer, “Just What the Doctor Ordered: The Admissibility of Differential Diagnosis in Pharmaceutical Product Litigation,” 56 Vand. L. Rev. 1227,1228, n. 5 (May 2003) (“‘Differential diagnosis,’ as I use the term in this Note, is more properly referred to as ‘differential etiology.’ The term ‘differential diagnosis’ actually refers to the process by which physicians diagnose a patients’s condition, rather than the cause of that condition. See, e.g., Faigman et al., *Modern Scientific Evidence: The Law and Science of Expert Testimony* § 20-1.1 (2d ed. 2002). ‘Differential etiology.’ on the other hand, refers to the process of causal assessment.”) *See also* 27 Minn. Prac., Products Liability Law § 16.20.

<sup>7</sup>Faigman, *supra*, note 6, at 1222.

external causation is a process in which most physicians are “inexperienced and uncomfortable.”

Spechler, *supra*, note 6, at 743-746.<sup>8</sup>

Differential diagnosis involves a rigorous exercise in ruling out possible diagnoses and ruling in the most likely diagnosis. Differential etiology involves ruling out other possible external causes for the diagnosed condition and ruling in the mostly likely external cause. As one commentator has observed,

suppose that the expert purported to rest the opinion solely or primarily on the timing—the fact that the plaintiff contacted the illness shortly after exposure to the alleged causal factor.<sup>[9]</sup> There is a grave doubt whether such an opinion would even be admissible. The opponent would have two cogent arguments. Under amended Federal Rule 702(3), the opponent would urge that the expert has not followed accepted methodology in conducting the analysis. The opponent would have an even

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<sup>8</sup>See also Imwinkelried, *supra*, note 7, at 405 (“the two techniques [that of differential diagnosis and differential etiology] are distinguishable. As we have seen, the techniques address fundamentally different questions: the nature of the illness as opposed to the cause of the illness. Moreover, physicians receive more formal training in differential diagnosis than in differential etiology. Lastly, practicing physicians have more experience working with the differential diagnosis technique, since in many cases the cause of the illness is irrelevant to the patient’s treatment. In short, an expert physician’s opinion about the nature of an illness, based on a differential diagnosis, might well be more reliable than the same physician’s opinion about causation, arrived at by differential etiology”) (internal footnotes omitted); Faigman, *supra*, note 7, at page 1222 (“Differential etiology, however, is anything but a straightforward affair, and most areas of science give it little or no attention.”).

<sup>9</sup>It appears that Dr. Gregor in this case primarily, if not solely, identified the Wendy hamburger as the external cause of Mr. San Francisco’s symptoms because of the temporal relationship between the eating of the hamburger and the onset of the symptoms.

stronger argument that the opinion is inadmissible because it is not “based upon sufficient facts or data.” Inferring causation from the timing is an example of the classical logical fallacy, post hoc, *ergo propter hoc* – it is illogical to infer that event A caused condition B because A preceded B. Even if the judge generously admitted a differential etiology opinion with such a skimpy basis, that opinion certainly would not be adequate to support a finding of specific causation.

Imwinkelried, *supra*, note 6, at 416-17 (internal footnotes omitted).<sup>10</sup>

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<sup>10</sup> Imwinkelried goes on in the succeeding pages of his Baylor Law Review article to describe the process and misconceptions of the differential etiology methodology. One such misconception “relates to the precise ultimate inference which the physician is endeavoring to draw.” *Id.* at 418. He thus elaborates:

The practicing physician employing differential etiology is not attempting to decide whether it is more likely than not that a particular factor caused the plaintiff’s illness. The physician faces a treatment exigency: the condition of the physician’s patient may be deteriorating rapidly, and the physician must make a treatment intervention. The physician will not wait until he or she is satisfied that it more likely than not that a particular factor is the cause of the patient’s illness. . . .The physician seeks to isolate the best causal hypothesis. In etiological analysis, the physician could conceivably select a potential cause with a fifteen percent probability if the probabilities for all the other possible causes were lower than fifteen percent. In other words, a differential etiology analysis does not necessarily yield an opinion that is more likely than not that the selected factor caused the illness.

*Id.* (internal footnotes omitted). In the case at hand, it appears that Dr. Gregor’s diagnosis of Mr. San Francisco’s symptoms was largely based upon what he believed to be a cause, the temporal relationship between the eating of the hamburger and the onset of the symptoms.

## **B. The Unreliability of Dr. Gregor's Causation Testimony**

In the case at hand, a reliable and properly conducted differential diagnosis of Mr. San Francisco's symptoms required Dr. Gregor to rule in or out pre-existing gastrointestinal problems, alcohol use, peptic ulcer disease, diverticulitis, and foodborne illness. A reliable and properly conducted differential etiology to determine an external cause of the diagnosed condition (foodborne illness) required Dr. Gregor to rule in or rule out a ham, home-cooked chicken strips, homemade beef stew, pork chops, potato salads, a Wendy's hamburger, and other items that Mr. San Francisco had eaten within the week preceding the onset of his symptoms as the cause of his symptoms. The appellees in their brief represent that Dr. Gregor in his deposition acknowledged that he was not aware of Mr. San Francisco's having eaten these foods, except for the Wendy's hamburger. How is it possible for a physician to rule out other possible foods as the cause of Mr. San Francisco's symptoms if he was unaware of what other foods had been eaten by Mr. San Francisco within the typical incubation period for *E. Coli* to develop into a verotoxin? Moreover, how could Dr. Gregor reliably conclude that the Wendy's hamburger was the cause of his diagnosis of Mr. San Francisco's symptoms if he did not consider that no other patrons of that same Wendy's restaurant had reported any illness from eating a Wendy's hamburger on the day that Mr. San Francisco developed his symptoms, including Mr. San Francisco's wife who ate a portion of her own allegedly underdone hamburger?

The appellants represent that Dr. Gregor's testimony as to the diagnosis and causation of Mr. San Francisco's illness has a sufficient factual background based on Dr. Gregor's "observations and treatment" of the patient and that his testimony will assist the trier of fact. "Observations and treatment" as the basis for making a diagnosis and identifying a cause of a diagnosed condition fall far short of demonstrating that Dr. Gregor made a properly conducted and reliable differential diagnosis of Mr. San Francisco's symptoms and made a properly conducted and reliable differential etiology of the cause of Mr. San Francisco's symptoms.

The appellants further contend: that Dr. Gregor noted that Mr. San Francisco vomited 1.8 liters while in the emergency room, which he considered very substantial; that after considering the patient's history, Dr. Gregor was able to rule out other causes for the illness by performing a differential diagnosis which included his findings of no pre-existing gastrointestinal problems, no alcohol use, no peptic ulcer disease and no history of diverticulitis; that after a thorough clinical examination, Dr. Gregor was able to reach a diagnosis and opinion as to causation, based on his examination of the patient and his symptoms, the patient's medical history, his recent travel history and his food intake history<sup>11</sup>; and that each of the items was specifically considered. In so doing Dr. Gregor

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<sup>11</sup>Just what that "food intake history" may have been is not disclosed by appellants. As noted earlier, the appellee contends that Dr. Gregor was not aware of a great number of foods that Mr. San Francisco had eaten within the week before the onset of his symptoms, (continued...)

testified, “[i]f you ask me, do I think a hamburger at a restaurant with diarrhea, vomiting and fluid loss shortly thereafter was the cause of the hospitalization, I would say yes . . . It was the hamburger.”

The appellants’ arguments are for the most part conclusory and do not show the procedures followed by Dr. Gregor in making a differential diagnosis of Mr. San Francisco’s condition or in making a differential etiology of the cause of the condition. They only represent that Dr. Gregor reached a diagnosis and opinion as to causation, based on his examination of the patient and his symptoms, the patient’s medical history, his recent travel history and his food intake history. An “examination” of the patient’s “symptoms” and various histories does not amount to the formation of a reliable opinion as to diagnosis or the cause of the diagnosis based upon a properly conducted differential diagnosis and differential etiology. Moreover, Dr. Gregor in his testimony acknowledged that his identification of the cause of Mr. San Francisco’s symptoms as being the Wendy’s hamburger was because of the temporal relationship between the eating of the hamburger by Mr. San Francisco and his onset of the symptoms. As Imwinkelried noted in his Baylor Law Review article “[i]nferring causation from the timing is an example of the classical logical fallacy, *post hoc, ergo propter hoc*—it is illogical to infer that event A caused condition B simply because A preceded B.” Imwinkelried, *supra* note 6, at 417

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<sup>11</sup>(...continued)  
and which possibly could have caused a foodborne illness.

The majority opinion concludes that “a differential diagnosis is a tested methodology, has been subject to peer review/publication, does not frequently lead to incorrect results, and is generally accepted in the medical community.” Majority slip opin., pp. 21-22, *quoting Turner v. Iowa Fire Equip. Co.*, 229 F.3d 1202, 1208 (8<sup>th</sup> Cir. 2000). The majority further concludes “that a medical opinion based upon a properly conducted differential diagnosis is sufficiently valid to satisfy the reliability prong of the Rule 702 inquiry under *Dauber/Wilt*.” Majority slip opin., p. 25. The majority opinion notably does not disclose why it believes that Dr. Gregor properly conducted a differential diagnosis in both diagnosing Mr. San Francisco’s condition and determining the cause of his condition.

For all of the above reasons, I would exclude the testimony of Dr. Gregor on the basis that it is unreliable. Because it is evident that a differential diagnosis is not relevant to the issue of causation, summary judgment was appropriate in this case.<sup>12</sup>

### **III.**

#### **The Testimony of Ewen Todd, Ph.D.**

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<sup>12</sup>This is not to say that I believe a differential diagnosis may *never* provide a sufficient basis for an opinion as to general causation. Indeed, other courts have recognized that while a differential diagnosis usually does not support an opinion as to general causation, there may be instances where, because of the rigor of the differential diagnosis performed, the expert’s training and experience, the type of illness or injury at issue, or some other case-specific circumstance, a differential diagnosis is sufficient to support an expert’s opinion in support of both general and specific causation. *See McCulloch v. H.B. Fuller Co.*, 61 F.3d 1038, 1043-44 (2d Cir. 1995).



The majority admitted the testimony of Dr. Todd because they believe that Dr. Todd's opinion "explained precisely how the conclusions were reached, and pointed to an objective source to show that his conclusions were based on a scientific source to show his conclusions were based on a scientific method used by at least a minority of scientists in the field." Majority Slip Opin., p. 29. My disagreement with the majority is based upon my opinion that Dr. Todd's testimony is unreliable and for that reason should be excluded. The appellants aptly described Dr. Todd's testimony as being his "verotoxin theory." Dr. Todd's testimony is unreliable for a very simple reason: he theorized that the hamburger which Mr. San Francisco had partially eaten was contaminated with E.Coli; theorized that verotoxin from the E. Coli had already formed on the hamburger before it was consumed; and theorized that the pre-formed verotoxin accounted for the rapid onset of Mr. Francisco's symptoms after he had eaten the hamburger. Dr. Todd conceded, however, that verotoxin is not pre-formed in the absence of "abusive" manufacturing, and that he had no evidence that the Wendy's hamburger had been subjected to such conditions. He stated, "We don't have any—any evidence directly that the beef was abused, but it's still a *possibility* that that occurred."<sup>13</sup> (Emphasis added).

Dr. Todd had no evidence that the hamburger eaten by Mr. Francisco was

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<sup>13</sup>Thus, his opinion was based on the *assumption of a fact without any evidentiary support*, making it unreliable.

contaminated with *E. Coli* and that verotoxin had pre-formed thereon before it was eaten. He had only his theories and possibilities. It is rather obvious that Dr. Todd developed his theory to meet the exigencies of this litigation; *i.e.*, to explain the short temporal relationship between the eating of the hamburger and the start of the symptoms, and to thereby hopefully avoid the classic illogic of inferring that the hamburger caused Mr. San Francisco's symptoms simply because the eating of the hamburger preceded the symptoms: *post hoc, ergo propter hoc*. Dr. Todd's testimony is theory unsupported by facts. It is unreliable and summary judgment was appropriate.

#### IV.

##### **Principles and Methodologies: A Matter of Admissibility or A Matter of Weight**

While the Supreme Court said in *Daubert*, that the “focus, of course, must be solely on principles and methodology, not on the conclusions that they generate[,]” 509 U.S. at 595, it subsequently explained that this language did not create a strict dichotomy between methods and conclusions because “conclusions and methodology” are not entirely distinct from one another.” *General Elec. Co. v. Joiner*, 522 U.S. 136, 146, 118 S.Ct. 512, 139 L.Ed.2d 508 (1997). “[N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert. *A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.*” *Id.* (emphasis added). “In other words, trial

courts may focus on the conclusions of the experts in determining whether the data actually supports the conclusion.” Dick Thornsburch, *Junk-Science-the Lawyer’s Ethical Responsibilities*, 25 Fordham Urb. L.J. 449, 459 (1998).

“Since *Daubert* . . . parties relying on expert evidence have had notice of the *exacting standards of reliability* such evidence must meet.” *Weisgram v. Marley Co.*, 528 U.S. 440, 455, 120 S.Ct. 1011, 145 L.Ed.2d 958 (2000) (emphasis added). “The law of evidence has long been viewed as the product of the jury system, i.e., the need to shelter untrained citizens from the temptation to accept uncritically that which may be unreliable and of doubtful credibility.” 1 Franklin D. Cleckley, *Handbook on Evidence for West Virginia Lawyers*, 1-9 (2d ed. 2000). Thus, “expert witnesses merit special attention because their testimony can be powerful and simultaneously very ‘misleading because of the difficulty in evaluating it.’” Douglas R. Richmond, *Regulating Expert Testimony*, 62 Mo. L. Rev. 485, 487 (1997)(citations omitted). In short, maintaining standards on the admissibility of expert testimony “is particularly important considering the aura of authority experts often exude, which can lead juries to give more weight to their testimony.” *Elsayed Muktar v. California State Univ.*, 299 F.3d 1053, 1063-64 (9<sup>th</sup> Cir. 2002).

When this Court adopted the *Daubert* standard in *Wilt*, Justice Neeley, in his concurrence, foresaw the problems accompanying increasingly loose expert standards:

Today, virtually any doctor armed with a medical degree is qualified to testify. Sometimes he will be expected to assert that his opinion has a “reasonable basis,” that it does not originate in chicken entrails or phases of the moon, but this is not much of a standard. He need not be a recognized authority or specialist. He need not reconcile his opinions with public-health statistics of epidemiology. He need not establish that his diagnostic methods or logical leaps enjoy “general acceptance” among other doctors. Quite the contrary: he may insist that he alone among doctors understands the importance or origins of certain symptoms. He may claim, in short, to be a new Galileo, a lonely, misunderstood genius who can see wonders that others neither discern or understand. The standards are almost equally loose for other, nonmedical experts.

*Wilt*, 191 W. Va. at 58-56, 443 S.E.2d at 212-13 (quoting Peter Huber, *Galileo's Revenge: Junk Science in the Courtroom*, 16 (1991)).

The recent decisions of this Court regarding the admissibility of expert opinions now beg the question once again - how far will the boundaries of expert admissibility continue to be stretched? *See Walker v. Sharma*, \_\_W.Va.\_\_, \_\_S.E.2d.\_\_ (No. 33284 Nov. 21, 2007)(Benjamin, J., dissenting)(finding that once a trial court has found an expert qualified to testify, a determination of weight to be afforded to the expert’s testimony rests within the province of the fact finder). My fear is that the majority, in going too far astray from our prior precedent and the intent of our rules of evidence, is headed down a path where virtually every aspect of expert testimony, including the factor of reliability, is evaluated simply as a matter of weight, and not admissibility. However, my hope is that our

circuit courts (much like the circuit court at issue here) will properly balance the liberal thrust of our rules of evidence with the need to preserve their role as gatekeepers and apply the new rules of law enunciated by the majority in a careful, commonsensical manner, continuing to utilize necessary legal tools such as summary judgment as the circumstances warrant.

For all of these reasons, I dissent.