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6th Circuit Paging Ph.D. Jones?: Reliable Physician Causation Testimony Requires More Than Clinical Experience

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In *Thomas, Melau, and Anderson v. Novartis Pharms. Corp.*, the Sixth Circuit Court of Appeals recently affirmed a trio of cases prohibiting the testimony of treating physicians as specific causation experts. Though the appellate court's opinion was not recommended for full-text publication, it nonetheless offers a salient reminder of a *Daubert* rule well-enunciated in the Sixth Circuit: A physician's presumed expertise is in the diagnosis and treatment of disease, not necessarily in the scientifically reliable determination of its underlying cause.

Thomas involved three plaintiffs who filed separate lawsuits, but whose claims were heard by the Middle District of Tennessee pursuant to consolidated MDL proceedings. They alleged they developed biophosphonate-induced osteonecrosis of the jaw after taking Zometa and Aredia, drugs manufactured by Novartis for the prevention of bone maladies, typically in cancer patients. The plaintiffs retained general causation experts, but relied for proof of specific causation upon their non-retained treating physicians. Each plaintiff's treating physician was excluded, but it is the exclusion rationale in *Thomas* that is of interest here.

The court began its analysis by noting that Thomas' physician, Dr. Johnson, "appears to have used some form of a differential diagnosis, or differential etiology, which we have previously recognized is a proper basis for determining the cause of a medical condition when done properly." *Id*. at 5. The propriety of such a method, however, depends upon the underlying expertise of the practitioner. The court acknowledged that Dr. Johnson was "unquestionably an experienced oral surgeon with many years of practice and training. He treated other patients with osteonecrosis of the jaw, and has read literature and attended conferences on osteonecrosis of the jaw." *Id*. at 6. However, "[b]ecause Thomas relied on Dr. Johnson to give an expert opinion on the cause of his osteonecrosis of the jaw, it is not enough to show that Dr. Johnson can recognize and treat osteonecrosis of the jaw." *Id*.

Thomas argued that expertise in causation was inherent in Dr. Johnson's unquestioned ability to diagnose and treat osteonecrosis because "a treating physician needs to be able to distinguish the cause of the disease. The treatment usually used for osteonecrosis of the jaw would actually worsen conditions in those suffering from biophosphonate-induced osteonecrosis of the jaw. Because the cause of the osteonecrosis is central to determining the best course of treatment, and Dr. Johnson can treat osteonecrosis of the jaw, Thomas argues that Dr. Johnson, therefore, must be able to determine the cause of the condition." *Id*. at 7. The court demurred. "While this inferential chain shows the importance of correctly determining the cause of the osteonecrosis, it does nothing to establish that Dr. Johnson can in fact, reliably determine the cause of a patient's osteonecrosis of the jaw." *Id*.

Thomas' refusal to impute causation expertise to every clinical physician is rooted in an observation made by the Eastern District of Tennessee over 10 years ago: "[T]here is a fundamental distinction between [a physician's] ability to render a medical diagnosis based on clinical experience and her ability to render an opinion on causation of [the plaintiff's] injuries. *Wynacht v. Beckman Instruments, Inc.*, 113 F. Supp. 2d 1205, 1209 (E.D. Tenn. 2000). The Sixth Circuit acknowledged and elaborated upon this distinction between diagnosis and etiology in *Tamraz*: "To use an analogy, chronic shortness of breath may be caused by diseases ranging from emphysema to lung fibrosis to bronchitis to heart disease – which would be the diagnosis. Heart disease, to pick one of these diagnoses, may be caused by diet, smoking, genetics or some combination of the three – which would be the etiology." *Tamraz v. Lincoln Elec. Co.*, 620 F.3d 665, 673 (6th Cir. 2010). The *Tamraz* court went on to observe that the nature of a clinician's daily practice renders the etiologic component, which is critical in the courtroom, diminished past the point of scientific reliability in the doctor's office or hospital:

When physicians think about etiology in a clinical setting . . . moreover, they may think about it in a different way from the way judges and juries think about it in a courtroom. Getting the diagnosis right matters greatly to a treating physician, as a bungled diagnosis can lead to unnecessary procedures at best and death at worse. But with etiology, the same physician may often follow a precautionary principle: If a particular factor might cause a disease, and the factor is readily avoidable, why not advise the patient to avoid it? . . . This low threshold for making a decision serves well in the clinic but not in the courtroom, where a decision requires not just an educated hunch but at least a preponderance of the evidence.

Id. (emphasis in original) (citations omitted).

Thomas never cited *Tamraz*, but *Tamraz*'s conclusion clearly underpins *Thomas*' result: "The ability to diagnose medical conditions is not remotely the same as the ability to deduce in a scientifically reliable manner, the causes of those medical conditions. Doctors thus may testify to both, but the reliability of one does not guarantee the reliability of the other." *Id*. at 673-74 (citation omitted) (overturning district court's admission of expert as an abuse of discretion).