

HOW TO BULLETPROOF YOUR EXPERT REPORT

Bill Liebbe
LAW OFFICE OF BILL LIEBBE, P.C.
223 South Bonner Avenue
Tyler, TX 75702
903.595.1240 Telephone
903.595.1325 Telecopier
bill@lobl.com

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I. INTRODUCTION

Practice Pointer: I have bolded phrases and statements in the paper that should, where appropriate to your case, be incorporated in the report.

The purpose of this paper is not to review all of the reported cases concerning the adequacy of expert reports in medical malpractice cases. There are simply too many of them and many of the opinions are contradictory. The purpose of this paper is to assist the practitioner in preparing a (hopefully) “bulletproof report” that will not be challenged by the defense.

The paper addresses the report requirements with regard to qualifications of the expert and the substantive requirements of the report regarding standard of care, breach and causal relationships. In addition, I have provided a sample letter requesting the expert to prepare the expert report and three examples of expert reports. Two were unchallenged and the third survived a motion to dismiss.

Practice Pointer: Send these reports to your expert to be used as a guide.

II. QUALIFICATIONS OF EXPERTS

Rule No. 1: The expert report should state that the expert is familiar with the standard of care and how the expert is familiar with the standard of care.

Rule No. 2: The expert report should show that the expert is qualified to opine regarding the causal relationship between the breach of the standard of care and the injury and harm claimed.

Practice Pointer: Limitations on recoverable damages may make the retention of multiple experts in different specialties impractical in many cases. For example, the type of expert who may be able to give opinions regarding standard of care issues may not be able to

render opinions on causation. More often than not, however, the medical expert who can give opinions on causation issues is also qualified to render opinions regarding the standard of care even though he is not practicing within the same specialty as the defendant. This portion of the paper will provide guidance on how a causation expert may also qualify as a standard of care expert.

A. WHO QUALIFIES AS AN EXPERT

Civil Practice and Remedies Code Section 74.351(r)(5)(a) defines an “expert” to mean “with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of care, an expert qualified to testify under the requirements of Section 74.401.”

Section 74.401(a) provides that “[i]n a suit involving a healthcare liability claim against a physician for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who:

- (1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;**
- (2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the *illness, injury, or condition involved in the claim*; and**
- (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.”**

The definition of and qualifications of an “expert” witness in a suit against a physician are identical in all respects to former Article 4590i, Section 14.01(a). The test to determine whether a

medical expert is qualified to render opinions is “rooted in the expert’s training, experience and knowledge of the standards applicable to the *illness, injury or condition involved in the claim.*”¹ An expert witness has never been disqualified solely on the basis that the expert does not have a practice identical to the defendant. Experts have been disqualified because they failed to *say* they were an expert who possessed knowledge of the subject.

While the proponent of expert testimony has the burden to show that the expert possesses special knowledge as to the very matter on which the expert proposes to give an opinion, what is required is simply that the offering party establish that the expert has “knowledge, skill, experience, training or education *regarding the specific issue before the Court* which would qualify the expert to give an opinion *on that particular subject.*”² In addition, when a party can

¹ *Blan v. Ali*, 7 S.W.3d 741, 746 (Tex. App.–Houston [14th Dist.] 1999, no pet.) (emphasis added) (referencing Tex.Rev.Civ.Stat.Ann.art.4590(i), Section 14.01(a)).

² *Broders v. Heise*, 924 S.W.2d 148 (Tex. 1995); *Ponder v. Texarkana Memorial Hosp.*, 840 S.W.2d 476, 477-78 (Tex. App.–Houston [14th Dist.] 1991, writ denied) (non-physician with a doctorate in neuroscience who conducts research on the causes of neurological injuries and

show that a **subject is substantially developed in more than one field**, testimony can come from a qualified expert in any of those fields.³

**B. TO BE QUALIFIED, THE EXPERT DOES NOT NEED TO BE A SPECIALIST OR BE OF
“THE SAME SCHOOL OF PRACTICE” AS THE DEFENDANT-PHYSICIAN**

teaches neurophysiology, neuroanatomy and neurochemistry to M.D.’s and Ph.D.’s may qualify as a medical expert on the cause of brain damage); *Bilderback v. Priestley*, 709 S.W.2d 736, 741 (Tex. App.–San Antonio 1986, writ ref’d, n.r.e.) (in a trial against a medical doctor who prescribed physical therapy, a non-physician professor of biophysics who taught physical therapy students to testify about “the mechanics, forces and effects of weights used in administering physical therapy”).

³ *Porter v. Puryear*, 153 Tex. 82, 262 S.W.2d 933, 936 (1953). See also *Hersch v. Hendley*, 626 S.W.2d 151, 154 - 55 (Tex. App.–Fort Worth, 1981, no writ) (Orthopedic surgeon could testify in suit against podiatrist on the standard of care for podiatric surgery since it “**was common throughout the medical profession.**”)

The physician serving as the expert witness need *not* be a specialist in the particular branch of the profession for which the testimony is offered.⁴ For example, an orthopedic surgeon can testify as to the standard of care for a radiologist because **the two professions work closely together, and their specialties are intertwined.**⁵ Likewise, a general surgeon is qualified to testify regarding the standard of care for post-operative procedures performed by a gynecologist because **post-operative procedures are common to both fields.**⁶ Because the determination of an expert's qualifications under both Rule 702 and section 14.01(a) is based on knowledge, training, or experience, it is incumbent upon the plaintiff in a medical malpractice case to present expert testimony of a medical doctor with knowledge of the specific issue which would qualify him or her to give an opinion on that subject.⁷

Additionally, the courts have held that a medical witness who is not of the same school or practice may be qualified to testify if **he or she has practical knowledge of what is usually and customarily done** by other practitioners under circumstances similar to those that confronted the defendant charged with malpractice.⁸ The Texas Supreme Court has made it clear that if **a subject of inquiry is substantially developed in more than one field**, a qualified expert in *any*

⁴See *Hernandez v. Altenberg*, 904 S.W.2d 734, 738 (Tex. App.–San Antonio 1995, writ denied); *Simpson v. Glenn*, 537 S.W.2d 114, 116 (Tex. Civ. App.–Amarillo 1976, writ ref'd n.r.e.).

⁵See *Silvas v. Ghiatas*, 954 S.W.2d 50, 54 (Tex. App.–San Antonio 1997, writ denied).

⁶See *Simpson*, 537 S.W.2d at 116–18.

⁷ See *Broders v. Heise*, 924 S.W.2d 148, 152 (Tex.1996).

⁸See *Marling v. Maillard*, 826 S.W.2d 735, 740 (Tex. App.–Houston [14th Dist.] 1992, no writ) (citing *Bilderback v. Priestley*, 709 S.W.2d 736, 740 (Tex. App.–San Antonio 1986, writ ref'd n.r.e.)

of those fields may testify.⁹ Likewise, the courts have held that if **the subject matter is common to and equally recognized and developed in all fields of practice**, any physician familiar with the subject may testify as to the standard of care.¹⁰

C. CASES OF IMPORTANCE

1. BRODERS V. HEISE

In *Broders v. Heise* the trial court's exclusion of the testimony of Fred Condo, M.D. an emergency room physician was upheld by the Texas Supreme Court because Dr. Condo, while knowing both that neurosurgeons should be called to treat head injuries and what treatments they could provide, *never testified that he knew, from either experience or study, the effectiveness of those treatments in general, let alone in that particular case.* "On this record, the Heise's simply did not establish that Dr. Condo's opinions on cause in fact would have risen above speculation to offer genuine assistance to the jury."¹¹ The Texas Supreme Court made it clear however that:

⁹ See *Broders*, 924 S.W.2d at 152.

¹⁰ See *Garza v. Keillor*, 623 S.W.2d 669, 671 (Tex. Civ. App.–Houston [14th Dist.] 1981, writ ref'd n.r.e.) (infection process); *Hersh*, 626 S.W.2d at 154 (taking a medical history, discharging a patient); *Sears v. Cooper*, 574 S.W.2d 612, 615 (Tex. Civ. App.–Houston [14th Dist.] 1978, writ ref'd n.r.e.) (use of a diuretic).

¹¹ *Broders v. Heise* at 153.

Our holding does not mean that only a neurosurgeon can testify about the cause in fact of death from an injury to the brain, or even that an emergency room physician could never so testify. **What is required is that the offering party establish that the expert has “knowledge, skill, experience, training or education” regarding the specific issue before the Court which would qualify the expert to give an opinion on that particular subject.**¹²

Since this Texas Supreme Court opinion in *Broders v. Heise*, Texas courts have held that an expert witness opinion regarding a specific medical condition is admissible if **he or she testifies affirmatively that he or she is qualified by knowledge, skill, experience, training or education to testify regarding those opinions.**

2. BLAN V. ALI

¹² *Id.* at 153.

In *Blan v. Ali*,¹³ a neurologist, Dr. Reisbord, was qualified to give an opinion regarding the standard of care applicable to a cardiologist and an emergency room physician. In that case, Blan was rushed to the emergency room after his family found him slumped over in the shower of his home. His wife immediately telephoned Dr. Ali, a cardiologist who had treated Blan in the past. After being admitted through the emergency room to the hospital, Blan suffered a stroke. He sued both the cardiologist and the emergency room physician, alleging that the failure to timely diagnose and treat his impending stroke caused him injury and harm. Summary judgment in favor of the cardiologist and the emergency room physician was granted by the trial court because the plaintiff's expert Dr. Reisbord was a neurologist and could not testify to the standard of care applicable to a cardiologist or emergency room physician.

The Court of Appeals correctly held that the trial court erred in granting summary judgment based on the challenge to the qualifications of Dr. Reisbord because Dr. Reisbord's affidavit listed **his experience and training as a neurologist and enunciated the standard of care for patients suffering a stroke** in accordance with the requirements of Section 14.01(a) and Rule 702. The Court of Appeals noted that Dr. Reisbord as a neurologist was qualified by training and experience to offer expert testimony regarding the *diagnosis, care and treatment of a neurological condition* such as stroke, and *since the condition involved in the Blan's claim was a CVA or stroke* found Dr. Reisbord qualified to testify regarding the standard of care applicable to a cardiologist and an emergency room physician regarding the diagnosis, care and treatment of a stroke. "The doctor's argument [that Dr. Reisbord was not qualified because he was neither a cardiologist nor an emergency room physician] ignores the plain language of the statute, which

¹³ 7 S.W.3d 741 (Tex. App.–Houston [14th Dist.] 1999, no pet.).

focuses not on the defendant doctor's area of expertise, but on the condition involved in the claim."¹⁴

3. MITCHELL V. BAYLOR

In *Mitchell v. Baylor University Medical Center*,¹⁵ Mitchell sued the hospital and a plastic surgeon alleging medical negligence in leaving a surgical sponge in her body during a mastectomy and breast reconstruction. Dr. Davidson, Mitchell's surgeon who later discovered the foreign body, testified that he removed a surgical sponge from Mitchell's breast. The defendant's expert Jeff Barnard, M.D., a forensic pathologist, testified that he had examined the material removed from Mrs. Mitchell and that the material was not a surgical sponge. The hospital and physician moved for summary judgment contending that the plaintiff's expert was not a pathologist and therefore not qualified to identify the mass he removed from Mitchell.

In reversing the granting of the summary judgment and remanding the case for trial, the Dallas Court of Appeals noted that Dr. Davidson, the surgeon, stated **his opinion was based on his "education, training and experience as a medical doctor and surgeon"** and that he was **"qualified by his training and experience as a surgeon to testify to surgical procedures and materials, including identifying a surgical sponge."** The Dallas Court of Appeals noted that to

be qualified as an expert, "the witness must be shown to possess special knowledge as to the very matter on which he gives his opinion."¹⁶ Based upon his testimony, the Court of Appeals concluded that Dr. Davidson was qualified to offer the opinion that the foreign body he removed was a surgical sponge.

¹⁴ *Id.* at 746.

¹⁵ 109 S.W.3d 838 (Tex. App.—Dallas 2003, no pet.).

¹⁶ *Mitchell* at 842. (citing *Gammill v. Jack Williams Chevrolet, Inc.*, 972 S.W.2d 713, 718 (Tex. 1998) and *Broders v. Heise*, 924 S.W.2d 148, 152-153 (Tex. 1996)).

4. CRESTHAVEN NURSING RESIDENCE V. FREEMAN

Cresthaven Nursing Residence v. Freeman,¹⁷ was a case where the daughters of a resident sued Cresthaven over the negligent care and treatment of their mother that resulted in her death. The jury awarded millions of dollars. In their eighth issue, Defendant complained that the Plaintiffs' expert, Dr. Brittain, who testified on standard of care, breach and proximate cause, was not qualified because he was merely a family practitioner and not qualified "to render an expert opinion on the issues in this case relating to urology, cardiology, and pathology."¹⁸ In rejecting their argument, the Amarillo Court of Appeals pointed out that

¹⁷ 134 S.W.3d 214 (Tex. App.—Amarillo 2003).

¹⁸ *Id.* at 232.

[T]he fact an expert is not a specialist in the particular branch of medicine for which the testimony is offered will not automatically disqualify him as an expert.” *Ali*, 7 S.W. 3d at 745. *The question to be resolved is the specific subject matter and the expert’s familiarity with it.* See *Heise*, 924 S.W. 2d at 153; *Ali*, 7 S.W. 3d at 745.¹⁹

¹⁹ *Id.* at 233.

The Amarillo Court of Appeals went on to note that the “focus of our determination is not on the doctor’s area of expertise, *but on the condition involved in the claim.*”²⁰ In dismissing the defense’s argument that Dr. Brittain could not testify since he was not a cardiologist, urologist or pathologist, the Amarillo Court informed that “**if the standards of care [the expert] discusses applied to any physician or healthcare provider who treats an elderly patient with long term catheter care and cardiology problems, then his lack of expertise in those special fields is irrelevant.**”²¹

5. COLUMBIA RIO GRANDE HEALTHCARE V. HAWLEY

*Columbia Rio Grande Healthcare v. Hawley*²² was a case where Mrs. Hawley was not told she had cancer until almost a full year after she was diagnosed by the pathologist at the hospital. After a judgment in favor of the plaintiffs, the defendants appealed and challenged the admissibility of Mrs. Holly’s treating oncologist, Dr. Escudier, asserting that “she was not qualified as an expert in the field of colon cancer treatment because she had no special training beyond medical oncology.” The Defendant also complained about the admissibility of the deposition testimony of Dr. Marek, a second board-certified oncologist who had treated Mrs. Hawley, along with Dr. Escudier. They challenged the testimony of the expert because “his opinion was based on speculation, had no factual or scientific support, was unreliable, and would not assist the jury, but would confuse them to cause them to speculate as to what his opinions

²⁰ *Id.*

²¹ *Id.* (emphasis added).

²² 188 S.W.3d 838 (Tex. App.–Corpus Christi 2006, pet. filed).

really meant.”²³

The Corpus Christi Court of Appeals rejected these arguments and commented:

We have reviewed the record, as well as the appellate briefs, and must
note
that one of the most confusing aspects of this case - aside from the highly
technical nature of much of the relevant testimony - is *the manner in
which*

²³ *Id.* at 856.

the hospital's brief represents the testimony given by Dr. Escudier
We have reviewed Dr. Marek's testimony and find these criticisms unfounded.²⁴

6. MCKOWEN V. RAGSTON

²⁴ *Id.* at 856.

In *McKowen v. Ragston*,²⁵ Dr. McKowen, a cardiothoracic surgeon, was sued when the plaintiff suffered injuries as a result of infectious complications associated with a permanent arteriovenous access graft. The Plaintiff's board certified internal medicine physician who practiced in the area of infectious disease stated in his report:

I have treated many patients with the type of infection suffered by Ms. Golden Ragston, specifically, infections of arteriovenous grafts. In addition, I have cared for many infections caused by Vancomycin Resistant Enterococci. As such, I am aware of the standards of care that exist related to these infections.

Noting that the plain language of Section 74.401 focuses on the condition involved in the claim and not the defendant doctor's area of practice, the plaintiff's expert was held to be qualified.

III. THE LAW CONCERNING ADEQUACY OF THE REPORTS

²⁵ 2007 WL 79330 (Tex. App.—Houston [1st Dist.] 2007, no pet. h.).

Under the Texas Civil Practice and Remedies Code §74.351(l) and §74.351(r)(6) the expert's reports must merely represent a good faith effort to provide a fair summary of the expert's opinions about the applicable standard of care, the manner in which the care failed to meet that standard, and the causal relationship between that failure and the claimed injury.²⁶ The reports need not marshal all the Plaintiffs' evidence, they simply must include the experts' opinions on each of the elements identified in the statute.²⁷

In setting out the experts' opinions on each of these elements, the reports must provide enough information to fulfill two purposes to constitute a good faith effort. First, the reports must inform the defendant of the specific conduct the plaintiffs have called into question. Second, and equally important, the reports must provide a basis for the trial court to conclude that the claims have merit.²⁸

To avoid dismissal, plaintiffs need not present evidence in the reports as if they were actually litigating the merits. The reports can be informal in that the information in the report does not have to meet the same requirements as the evidence offered in a summary-judgment proceeding or at trial.²⁹ In reviewing the expert reports, it is the substance of the opinions and not the technical words used that constitute compliance with the statute.³⁰ Magic words are not

²⁶ *Am. Transitional Care Centers of Texas v. Palacios*, 46 S.W.3d 873, 878 (Tex. 2001).

²⁷ *Id.* at 878.

²⁸ *Id.* at 878.

²⁹ *Id.* at 879.

³⁰ *Moore v. Sutherland*, 107 S.W.3d 786 (Tex. App.–Texarkana 2003, pet. denied).

always used, but magical words are not necessary.³¹ For example, to satisfy the “causal relationship” element the reports need not state the causal relationship in terms of “reasonable medical probability.” A statement that expresses the causal relationship in terms of “possibility” is sufficient to conclude that the claim has merit so long as the report explains how the breach caused the injury.³²

When the plaintiffs allege a breach with regard to the *method* of treatment, the reports cannot merely state the expert’s conclusions but rather must **explain the basis of the expert’s statements to link his or her conclusions to the facts.**³³ On the other hand, when the defendant is charged with a complete failure to diagnose and complete failure to treat it is sufficient that the expert’s report **express the “positive statement of fact” that earlier diagnosis and treatment would have prevented the injury or harm.**³⁴

Finally, plaintiffs may satisfy the requirements of an expert report by utilizing more than one expert report. Section 74.351(i) allows a plaintiff to utilize separate expert reports to satisfy the Acts’ requirements for advising a defendant of the standard of care, the manner in which the defendant failed to meet the standard of care and the causal relationship between that failure and the injury to the plaintiff.³⁵ It is an abuse of discretion for the trial court to review each expert

³¹ *Bowie Memorial Hospital v. Wright*, 79 S.W.3d 48, 53 (Tex. 2002).

³² *Id.*

³³ *Palacios* at 879; *Earl v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999).

³⁴ *See Moore v. Sutherland*, 107 S.W.3d 786, 791 (Tex. App.—Texarkana 2003, pet. denied).

³⁵ CPRC §74.351 (i) provides that “[N]otwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of *separate experts* regarding different physicians or healthcare providers *or regarding different issues* arising from the conduct of a physician or healthcare

report in isolation in determining whether plaintiffs have met the “good-faith requirement” required by the Act.

IV. SETTING FORTH THE STANDARD OF CARE AND BREACH

Rule No. 3: The expert report should specifically state the standard of care required of the named defendant under the circumstances.

Rule No. 4: The expert report should specifically state *how* the named defendant breached that standard of care.

To qualify as an adequate “expert report” the written report must provide a fair summary of the expert’s opinions regarding applicable standards of care and the manner in which the care failed to meet that standard.³⁶ After **reciting relevant facts from the medical record**, the expert report should clearly and concisely state the standard of care that was required of the specific defendant under those facts and circumstances and how specifically the defendant breached that standard of care. I personally do not believe it wise to place yourself in the position of having to argue that the report “need not marshal all of the plaintiffs evidence” or the standard of care can be inferred when simple statements in the report can avoid the argument entirely. A few recent cases will underscore the point.

The expert report in *In re Birdwell*³⁷ was extremely long and thorough *but it never made a direct statement as to the standard of care* applicable to the hospital, the hospital’s breach and

provider, such as issues of liability and causation. *Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or healthcare providers or with respect to both liability and causation issues for a physician or healthcare provider.*” (Emphasis added).

³⁶ Civil Practice and Remedies Code Section 74.351(r)(6).

³⁷ 122 S.W.3d 473 (Tex. App.—Texarkana 2003, pet. denied).

the specific injuries that the plaintiff suffered from the breach. The court held, however, that it is the substance of the opinion and not the technical words used that constitute compliance with the statute and the report was upheld because it gave “fair notice” to the hospital of the essential elements of the plaintiff’s case. Although the plaintiff prevailed, the challenge would likely have been avoided entirely if the expert had made a simple and direct statement regarding the applicable standard of care and how it was breached as to each defendant.

The plaintiff in *Birdwell* may have actually been lucky because the following year, the same Texarkana Court of Appeals issued a seemingly conflicting opinion in *Russ v. Titus Hospital District*.³⁸ There, the expert report specifically identified the standard of care as to each physician defendant and the breach of that standard but as to the nursing defendants, the report was deemed deficient. The report clearly set out in detail the omissions of the nurses which the plaintiff’s expert regarded as breaches of the standard of care but the Texarkana Court of Appeals held that this was not sufficient because **the expert had not set out the standard of care by stating *what* conduct was necessary or required**. The court stated that the report was fatally flawed because “the standard of care must be inferred.”

The need to specify the standard of care for each defendant and *how each* defendant breached the standard of care is underscored by *Gray v. CHCA Bayshore L.P.*³⁹ The plaintiff sued for injuries to her knee resulting from a malpositioning during surgery for sinus problems. The plaintiff’s expert specifically set out the standard of care with regard to both defendant physicians and Bay Shore Medical Center by stating that the standard of care for all three

³⁸ 128 S.W.3d 332 (Tex. App.–Texarkana 2004, pet. denied).

³⁹ 189 S.W.3d 855 (Tex. App.–Houston [1st Dist.] 2006, no pet h.).

defendants was “to monitor the positioning of the patient extremities to prevent injury during surgery and post-operatively.” The report specifically stated:

Based on these definitions and on a reasonable degree of medical probability, Dr. Ira H. Rap, M.D., Dr. Philip A. Matorin, M.D. and the Bayshore Medical Center Pre-Operative nursing staff failed to meet the standard of care when they neglected to detect a malpositioned left knee resulting in a dislocated left patella on December 5, 2001. The failure to monitor and detect the malpositioned left knee resulted in a dislocated left patella, severe pain and suffering, and subsequent medical treatment.

The Houston Court of Appeals held that while it is possible that an identical standard of care regarding limb monitoring during and after surgery attaches to an anesthesiologist, (Dr. Rap) and peri-operative nursing staff, (Bayshore) *such generic statements, without more, can reasonably be deemed conclusory.*

V. CAUSAL RELATIONSHIP

Rule No. 5: The expert report should explain *how* the breach caused the injury or harm complained of.

Rule No. 6: If the evidence suggests other possible causes of the plaintiff’s injury, the expert report should explain how those other causes were “ruled out.”

The adequacy of the expert report on causal relationship may turn on whether the breach of the standard of care is with regard to the *method* of treatment or whether the defendant is charged with a complete failure to diagnose and complete failure to treat. If the breach is with regard to the *method* of treatment, the reports cannot merely state the expert’s conclusions but rather must **explain the basis of the expert’s statements to link his or her conclusions to the**

facts.⁴⁰ When a defendant is charged with a complete failure to diagnose and complete failure to treat, it may be sufficient that the expert report **express the “positive statement of fact” that earlier diagnosis and treatment would have prevented the injury or harm.**⁴¹ The cases of *Bowie Memorial Hospital, Moore* and *Morrill* are instructive.

A. *Bowie Memorial Hospital v. Wright*, 79 S.W.3d 48 (Tex. 2002).

To demonstrate a “causal relationship” the report does not need to use the magic words “reasonable medical probability.” In fact, the “possibility” of a better outcome is adequate. In this case, Wright was injured in a car wreck and went to Bowie. Bowie’s physician assistant x-rayed Wright’s knee and foot and misread the x-ray leading to a much delayed diagnosis. Wright’s expert report stated that Bowie breached the standard of care by failing to have a system in place where the x-rays are read by a physician in a timely manner. On causal relationship, the report stated, “I do believe that it is reasonable to believe that if the x-rays would have been correctly read and the appropriate medical personnel acted upon those finding, then Wright would have had the possibility of a better outcome.” The trial court dismissed on a challenge to the adequacy of the report. On appeal, the case was reversed and remanded. The Texas Supreme Court affirmed the trial court dismissal because the report did not constitute a “good faith effort” to fairly summarize the causal relationship between Bowie’s alleged breach and Wright’s injury. To constitute “good faith effort” the report must provide enough information to fulfill two purposes: (1) It must inform the defendant of the specific conduct the plaintiff has called into question, and (2) it must provide a basis for the trial court to conclude

⁴⁰ *Palacios*, 46 S.W.3d at 879; *Earl v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999).

⁴¹ *Moore v. Sutherland*, 107 S.W.3d 786, 791 (Tex. App.–Texarkana 2003, pet. denied).

that the claims have merit.⁴²

While the report need not marshal all of the plaintiff's proof, it must include the expert's opinion on each of the three elements. A report cannot merely state the expert's conclusions about these elements.⁴³ "Rather, the expert must explain the basis of his statements to link his conclusions to the facts."⁴⁴

Here, the report simply opines that Wright might have had "the possibility of a better outcome" without explaining *how* Bowie's conduct (failing to correctly read or act upon the x-rays) caused injury to Wright. The court simply would not infer facts that were not contained in the report that would have explained the basis of his conclusion that she might have had the possibility of a better outcome. "We cannot infer from this statement, as the Wright's ask us to that Bowie's alleged breach precluded Wright from obtaining a quicker diagnosis and treatment for her foot. Rather, the report must include the required information within its four corners."

Practice Pointer: The report would have been adequate if it stated that earlier diagnosis and treatment would have prevented specific complications and explained why.

It is significant that the Supreme Court did not reverse the court of appeal's opinion that the statement that Wright would have had the "possibility" of a better outcome was adequate. "Although the causation statement recognized only the 'possibility'-rather than the 'reasonable medical probability' - that Barbara might have had a better outcome, the court of appeals concluded that the report's adequacy should not turn 'solely upon the claimant's failure to use

⁴² *Wright*, 79 S.W.3d at 52 (citing *Palacios*, 46 S.W.3d at 879).

⁴³ *Palacios* at 879.

⁴⁴ *Earle v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999).

magical words like ‘reasonable probability.’”⁴⁵ The Supreme Court stated: “We agree with the court of appeals conclusion that a report’s adequacy does not depend on whether the expert uses any particular ‘magic words.’ Nothing in the acts plain language, or in *Palacios* suggest that for these purposes, an expert must express causal relationship in terms of ‘reasonable medical probability.’”⁴⁶

B. *Moore v. Sutherland*, 107 S.W.3d 786 (Tex. App.–Texarkana 2003, pet. denied).

In demonstrating a causal relationship in a failure to diagnose and treat case, it is probably sufficient that the report makes a positive statement that there would have been a different outcome if the condition had been diagnosed and treated earlier. In this case, Moore was admitted to the hospital for a gastric ulcer and reflux on March 5, 1998, was discharged March 13th and died March 16th from bile peritonitis and small bowel volvulus due to a ruptured common bile duct. Dr. Miedena’s report stated that Dr. Sutherland should have had a high index of suspicion for a bile duct leak and that “most surgeons would have instituted a diagnostic evaluation to rule out bile peritonitis between 3/9/98 and 3/13/98. Dr. Sutherland’s failure to do so was below the standard of care. Had

the diagnosis of bile peritonitis been made before discharge from the hospital, treatment would have

prevented the patient’s death.”⁴⁷ The court found Miedena’s report adequate because “[a] statement that most surgeons would have instituted a diagnostic evaluation for bile peritonitis between march 9, 1998 and March 13, 1998, due to Moore’s developed abdominal pain and increased need for narcotics and that Sutherland’s failure to do so was below that standard of care is not a conclusionary statement.”⁴⁸

The “magic words” are not always used, but “magical words” are not necessary.⁴⁹

It is the substance of the opinions, not the technical words used, that constitutes compliance with

⁴⁵ *Wright*, 79 S.W.3d at 53. (citing 48 S.W.3d at 447).

⁴⁶ *Id.* at 53.

⁴⁷ 107 S.W.3d at 790.

⁴⁸ *Id.* at 791.

⁴⁹ *Id.* (citing *Wright* 79 S.W.3d at 53).

the statute.

The expert report need not present evidence as if it were litigating the merits of the case. It may be informal, and the information presented does not need to meet the same requirements as evidence offered in a summary judgment proceeding or in a trial.⁵⁰

This case is different from *Bowie Memorial Hospital v. Wright* because there the statement of causation did not summarize the causal relationship between the hospital's failure to meet the standard of care (correctly reading x-rays) and the patient's injury because "the report simply opines that Barbara may have had the possibility of a better outcome without explaining how Bowie's conduct caused injury to Barbara."

Miedena's report did not charge Sutherland with a negligent or substandard *method* of treatment. Rather, it charged that Sutherland's complete failure to diagnose and complete failure to treat the bile peritonitis was below the standard of care and that such failure caused Moore's death. "We believe this report gives Sutherland and the clinic fair notice of what Miedena considers the standard of care, how Sutherland breached that standard, and how that breach caused Moore's death."⁵¹

***C. Morrill v. Third Coast Emergency Physicians, P.A., 32 S.W.3d 324*
(Tex. App.—San Antonio 2000, pet. ref'd).**

In Morrill, the plaintiff's daughter went to the emergency room and was seen by Dr. Shaw who failed to diagnose bacterial meningitis.⁵² Dr. Gordon's expert report stated the standard of

⁵⁰ *Palacios* at 879.

⁵¹ *Moore*, 107 S.W.3d at 791.

⁵² *Morrill v. Third Coast Emergency Physicians, P.A.*, 32 S.W.3d 324 (Tex. App.— San Antonio 2000, pet. denied).

care was to order blood and spinal fluid cultures, begin antibiotic therapy and admit her to the hospital. Gordon stated that Shaw deviated from the standard of care by relying on CIE tests that have false negative potential and not sending specimens for gram stain and culture. Regarding the causal relationship, Dr. Gordon's report specifically stated that "I am convinced that the delay of care in Sandra Morrill caused by those actions or omission delayed her treatment resulted in injury to her."⁵³ The court found this simple statement to be adequate because it specifically stated causation.

D. *IN RE Barker* , 110 S.W.3d 486 (Tex. App.–Amarillo 2003, no pet.).

Although the detail of the expert report in a failure to diagnose and treat case does not require a specific discussion on causal relationship as is required in a case involving negligent method of treatment, it is certainly better practice to provide some detail for the Court as was done in *In re Barker*. This was a case of a failure to diagnose a subarachnoid hemorrhage and the defendant relied on *Bowie Memorial Hospital v. Wright* in challenging the report for failing to state how the causal connection was established. In affirming the trial court's decision not to dismiss the case, the Amarillo Court of Appeals stated:

⁵³ *Id.* at 326.

In contrast to the report in the *Bowie* case, Dr. Fleming explains in considerable detail the treatment that was needed if the bleeding had been timely diagnosed, and that **medical science “recognizes the relationship between the intra-cerebral blood delayed diagnosis, and the presence of vasospasm and the subsequent severity of global neurological injury and deficit.”** He goes on to conclude that **without the negligent failure to recognize the cranial bleeding, and the resulting delay in treatment, Calvin’s injuries would not be as severe as they were.** In this case, the trial court could reasonably have concluded that Dr. Fleming’s reports were sufficient to meet the statutory requirements and did not abuse its discretion in doing so.⁵⁴

E. *Ballan v. Gibson*, 151 S.W.3d 281 (Tex. App.–Dallas 2004, no pet.).

This case demonstrates the importance of **“ruling out” other potential causes in the expert report where there were pre-existing co-morbidities.** In *Ballan*, the expert report listed several pre-existing cardiac risk factors and then listed the defendant physician’s negligence in failing to appropriately deal with these risk factors. With regard to causation, the report simply stated that “based on reasonable medical probability” the defendant’s negligence was a proximate cause of the death of the patient. The report was held not to represent a good faith effort to comply with the statutory definition of an expert report. The court held:

⁵⁴ *In re Barker*, 110 S.W.3d 486, 491 (Tex. App.–Amarillo 2003, no pet.).

Kopita's report describes an individual in poor health, who died in an emergency room, with at least five different risk factors that could have contributed or caused his death. Some factors, such as tobacco abuse and body weight, were beyond the control of Gibson and may have played a significant role in the cause of death. Kopita does not state how Gibson's alleged failure to act regarding three of the risks caused Mr. Ballan's death, nor does he rule out the factors beyond Gibson's control as the cause of death. His statement regarding causation is conclusory and does not "provide a basis for the trial court to conclude that the claims have merit." ... [n]or does it state how any action on the part of Gibson caused Mr. Ballan's death.⁵⁵

VI. NAME THE DEFENDANT

Rule No. 7: The expert report should identify each individual defendant, the standard of care applicable to each individual defendant, how each individual defendant breached the standard of care and the causal relationship between each individual defendant's breach and the injury or harm claimed.

⁵⁵ *Ballan v. Gibson*, 151 S.W.3d 281, 284 (Tex. App.–Dallas 2004, no pet.) (citing *Palacios*, 46 S.W.3d at 879).

An adequate expert report must name the defendant.⁵⁶

In *Garcia v. Marichalar*,⁵⁷ several defendants were sued for damages arising from a retained sponge following exploratory surgery. The report failed to mention one of the physicians (Dr. Garcia) by name. The report therefore did not inform him of the specific conduct of Dr. Garcia that was being called into question and it did not represent a good faith effort to comply with the law. The plaintiff argued that Dr. Garcia was not specifically named because of conflicting medical records. This argument was rejected because the Court is limited to the “four corners” of the report in determining sufficiency. (Citing *Palacios*). **When suing multiple defendants** for the same identical breach of the standard of care, it is better practice for the report to **specifically state the specific standard of care and how that standard of care was breached as to each individual defendant** rather than making a global statement that “all of the defendants” breached the standard of care.

In *Taylor v. Christus Spohn Health System Corp.*,⁵⁸ the expert report read as follows:

⁵⁶ Civil Practice and Remedies Code Section 74.351(a); see *American Transitional Care v. Palacios*, 46 S.W.3d 873 (Tex. 2001).

⁵⁷ *Garcia v. Marichalar*, 198 S.W.3d 250 (Tex. App.–San Antonio 2006, no pet. h.).

⁵⁸ *Taylor v. Christus Spohn Health System Corp.*, 169 S.W.3d 241 (Tex. App.–Corpus Christi 2004, no pet.)

The cause of death in the case of Ronald Clayton Taylor was myocardial infarction due to coronary artery disease and his death, more likely than not, would have been avoided had the patient undergone diagnostic cardiac imaging and cardiac catheterization prior to his demise, as should have been done, but was not done. The failure to diagnose and treat this condition was negligence by Dr. Wright, Team Health Southwest, L.C., Coastal Cardiology, Charles Schecter, M.D., Raymond Graff, M.D. and Spohn Hospital Shortline Emergency Room, and that negligence was a proximate cause of the injury and death of Ronald Clayton Taylor.⁵⁹

This report was deemed conclusory because it failed to specify each defendant's individual negligent conduct. The court noted that the report failed to **set out the standard of care for each defendant, the manner in which such standard was breached, and further failed to state what each defendant should have done in order to meet the standard of care.**

⁵⁹ *Id.* at 244.

When suing a hospital for the negligence of its nurses, the report needs to identify the specific nurse or nurses whose conduct is called into question. It is not enough to simply state that the “hospital nurses” or the “nurses at the hospital” or “personnel at the hospital” breached the standard of care. This is especially true if each of the individual nurses are named as defendants.⁶⁰ If you are unable to determine the name of the specific nurse from the record, then the report should make every reasonable attempt to enable the defendant hospital to identify the specific nurse. For example, the report might state that “the nurse whose initials are A.W. who documented on the nursing narrative on January 15, 2007 at 8:30 A.M.”

Other examples of cases dismissed for failing to specifically name a defendant with regard to that individual defendant’s duty and breach of the standard of care are as follows:

Kuykendall v. Dragun, 2006 WL 728068 (Tex. App.–Eastland, pet. denied) (unpublished opinion).

Gereb v. Sedillo, 2006 WL 397909 (Tex. App.–San Antonio February 22, 2006, no pet. h.). The report globally opined that “the doctors, nurses and hospital were each subject to an independent responsibility to correct the improper location of the feeding tube and to prevent or limit damage to the patient” and “the individuals identified as parties in the lawsuit provided medical care that fell below the standard of care in the ongoing evaluation and management of Danielle,” failed to identify any specific defendant and therefore failed to discuss the standard of care, breach and causation applicable to each defendant.

Cavazos v. Cintron, 2006 WL 1766189 (Tex. App.–Corpus Christi 2006, no pet. h.) Although the expert report generally named each defendant, it failed to present the standard of

⁶⁰ See *Norris v. Tennant Houston Health System*, 2006 WL 1459958 (Tex. App.–Houston [14th Dist.] 2006, no pet. h.).

care relevant to each physician, nurse, midwife, nurses and other healthcare providers and failed to explain what each of these parties should have done and what each party failed to do.

VII. VICARIOUS LIABILITY CLAIMS

Rule No. 8: In vicarious liability claims, the report should name the individual employee but need not name the institution.

In *University of Texas Southwestern Medical Center v. Dale*⁶¹, UT Southwestern was sued on the basis that its residents had negligently treated a patient. The plaintiffs did not allege that UT Southwestern was directly negligent, but alleged that it was liable for the negligence of its residents. Plaintiffs served a report on UT Southwestern which named the residents, stated the standard of care and how each resident breached the standard of care and how the breach caused the injury. UT Southwestern complained that the report did not name “UT Southwestern” and therefore the case should be dismissed. The Dallas Court disagreed, holding that because the plaintiffs were not alleging that UT Southwestern was directly negligent, the report was not required to mention UT Southwestern by name. The Court noted in a footnote that “presumably, all that UT Southwestern asserts is that the expert should have included a statement that the residents were acting in the course and scope of their employment with UT Southwestern. However, we fail to see how a medical expert would be qualified to provide an opinion on this issue.”

VIII. TWO REPORTS MUST BE READ TOGETHER - C.P.R.C. §74.351(i)

***Chandler v. Singh*, 129 S.W.3d 184 (Tex. App.–Texarkana 2004, no pet.).**

The patient sued a physician and pharmacist alleging she was injured in a car accident

⁶¹ *University of Texas Southwestern Medical Center v. Dale*, 2006 WL 874085 (Tex. App.–Dallas 2006, no pet. h.).

caused by a seizure brought on by a prescription by her physician and provided by the pharmacist. The plaintiff gave two expert reports. One addressed the pharmacy's services, and the other addressed the physician's services and causation from the pharmacy's services. The reports read *together* constituted a good faith attempt to give a fair summary of the standard of care, the breach and the cause of the injuries suffered as a result of the breach concerning all of the defendants.

Martin v. Abilene Regional Medical Center, 2006 WL 241059
(Tex. App.-Eastland 2006, no pet. h.).

Since a nurse cannot opine on medical causation, two reports may be needed in a nursing malpractice case. In *Martin*, the plaintiff sued Abilene Regional Medical Center and a cardiologist, Dr. Gorman Thorp after he sustained a myocardial infarction subsequent to being discharged following a coronary stent placement with Plavix. The nursing expert report stated that the standard of care of the discharge nurse was to question Dr. Thorp about the absence of the order for Plavix and that the discharge nurse breached the standard of care by not bringing the absence of the order for Plavix to the attention of Dr. Thorp. The cardiology expert report did not address the negligence of the nurse but only addressed the negligence of Dr. Thorp in failing to prescribe Plavix. The cardiology expert report, however, detailed how in reasonable medical probability a prescription for Plavix at discharge would have prevented the subsequent heart attack. In rejecting the hospital's argument that since the nurse expert was not qualified to address the issue of medical causation and the doctor's report did not address negligence of the nurse, thus the case ought to be dismissed was rejected:

When the reports of Nurse Robinson and Dr. Thorp (sic) are read together, they allege that if Breisch informed Dr. Thorp of the lack of a prescription for Plavix at the time of Martin's discharge, Dr. Thorp *should* have prescribed Plavix when notified of the omitted prescription.

This allegation constitutes a good faith effort to provide a fair summary of a causal relationship between Abilene Regional's actions and the injury claimed by Martin.⁶²

⁶² *Martin v. Abilene Regional Medical Center*, 2006 WL 241059, at 5 (Tex. App.—Eastland 2006, no pet. h.).

The hospital argued further that even if both reports were considered together, they still do not state that Dr. Thorp *would* have prescribed Plavix had he been informed of the omitted prescription, but only that he should have. The court held that “should have” as opposed to “would have” constitutes a sufficient causal nexus to meet the “good faith requirements of an expert report.”⁶³

Practice Pointer: You can’t get a new expert to cure deficiencies after 120 days.

In *Danos v. Rittger, M.D.*,⁶⁴ the trial court granted a 30-day extension to cure after finding the expert report of Dr. Baker deficient. Plaintiff then served the expert report of Dr. Meyer for the first time during the trial court’s 30-day extension. The 1st District Court of Appeals held that the trial court did not err in finding that Danos could not file a report from a new expert during the 30-day extension.

IX. WILLFUL AND WANTON

In *Bosch v. Wilbarger General Hospital*,⁶⁵ the court held that the expert report in an “emergency care” malpractice case does not need to address whether the negligence of the defendant was “willful and wanton negligence.”

X. DEFENDANT WAIVES OBJECTIONS TO THE ADEQUACY OF THE REPORT BY ENGAGING IN DISCOVERY

Practice Pointer: If the defendant challenges the adequacy of the expert report and has engaged in discovery, include a waiver argument in your response.

⁶³ *Id.* (citing *Tovar v. Methodist Healthcare System of San Antonio, LTD*, 2005 WL 3079074 (Tex. App.–San Antonio 2005, no pet.)).

⁶⁴ *Danos v. Rittger*, No. 01-06-00350-CV (Tex. App.–Houston [1st Dist.] 2007, no pet. h.).

⁶⁵ No. 07-05-0068 CV, 2006 LEXIS 3269 (Tex. App.–Amarillo 2006, no pet. h.).

Civil Practice and Remedies Code Section 74.351(s) makes it clear that until a claimant has served the expert report and curriculum vitae as required by Subsection (a), “*all discovery in a healthcare liability claim is stayed* except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient’s healthcare.....”

This stay on all discovery, except for the acquisition by the claimant of information related to the patient’s healthcare, was obviously intended to serve the purpose of H.B. 4 to decrease the cost of litigation by imposing a stay on discovery until a sufficient report by a qualified expert has been served that informs the defendant of the specific conduct the plaintiff has called into question and provides a basis for the trial court to conclude the claims have merit.

When a claimant serves an expert report and curriculum vitae, the defendant can choose one of two options under the last sentence of Section 74.351(a):

1. The defendant can choose to serve objections to the sufficiency of the report and/or challenge the qualifications of the expert not later than the 21st day after the date the report and curriculum vitae were served; or
2. The defendant can choose not to file objections and thereby elect to waive all objections.

When a defendant files and serves objections to the sufficiency of the report, the defendant is taking the position that the claimant has not served an expert report and curriculum vitae as required by Subsection 74.351(a) and *Palacios*. If the defendant’s position is correct and the report “required by Section 74.351(a)” has not been served, then all discovery is stayed. It is unequivocally inconsistent to claim that the claimant has not complied with Section 74.351(a)

and ignore the stay on discovery until the claimant has complied with Section 74.351(a).

Waiver requires intent, either the “intentional relinquishment of a known right or intentional conduct inconsistent with claiming that right.”⁶⁶ Waiver may be established by conduct that is “unequivocally inconsistent with claiming a known right.”⁶⁷ In *Jernigan v. Langley*, the Texas Supreme Court explained that:

nothing
Waiver is largely a matter of intent, and for implied waiver to be found through a party’s actions, intent must be clearly demonstrated by the surrounding facts and circumstances. There could be no waiver of a right if the person sought to be charged with waiver says or does nothing inconsistent with an intent to rely upon such right. Waiver is ordinarily a question of fact, but when the surrounding facts and circumstances

⁶⁶ ” *Sun Exploration and Prod. Co. v. Benton*, 728 S.W.2d 35,37 (Tex. 1987) (citing *Mass. Bond and Ins. Co. v. Orkin Exterm. Co.*, 416 S.W.2d 396, 401 (Tex. 1967)).

⁶⁷ *Van Indep. Sch. Dist. v. McCarty*, 165 S.W.3d 351, 353 (Tex. 2005).

are undisputed, as in this case, the question becomes one of law.⁶⁸

The court in *Jernigan* determined that Dr. Jernigan's participation in the discovery proceedings was "not so inconsistent with an intent to assert the right to dismissal under Article 4590(i) as to amount to waiver of the right." The reasoning in *Jernigan* does not apply to cases filed under Chapter 74 because by adding Section 74.351(s) and adding the provision that "each defendant physician or healthcare provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived" in Section 74.351(a), the legislature clearly intended that there be only limited discovery by the claimant until an adequate expert report and curriculum vitae have been served.

⁶⁸ *Jernigan v. Langley*, 111 S.W.3d 153, 156-57 (Tex. 2003).

It is presumed that the legislature intended to make these changes to the existing law to serve the stated purposes of the legislation. The stated purpose of H.B. 4 was to “decrease the cost of those claims.” H.B.4 Section 10.10 (b)(2). When a statute is amended, the court should “endeavor to effect the change” intended in the existing law.⁶⁹ When an insurance defense lawyer engages in discovery by sending written discovery or taking depositions, the “cost of the claim” necessarily increases. These costs are unnecessary if the claimant’s report is inadequate and it was these costs the legislature sought to decrease in enacting H.B. 4.

In *Jernigan*, the defendant doctor participated in discovery but did not object to its adequacy until more than 600 days after receiving it. During that interval, one must presume that tens of thousands of dollars were paid by the malpractice insurance company to the doctor’s defense lawyers along with the expenses associated with defending the claim including the cost of expert witnesses. Clearly the legislature, being aware of *Jernigan*, sought to “decrease the cost of claims” by placing a stay on all discovery by the defendant until the expert report and curriculum vitae as required by Subsection(a) has been served. Since an “expert report” means a written report by an expert that provides a fair summary of the expert’s opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or healthcare provider failed to meet those standards, and the causal relationship between the failure and the injury, harm or damages claimed it is “unequivocally inconsistent” to claim on the one hand that a Section 74.351(a) report is inadequate and violate the stay on discovery under Section 74.351(s) on the other.

⁶⁹ *City of Houston v. Clear Creek Basin Auth.*, 589 S.W.2d 671, 681 (Tex. 1979).

In *Quint v. Alexander*,⁷⁰ the Austin Court of Appeals rejected a waiver by engaging in discovery argument based upon the Supreme Court’s decision in *Jernigan*. There was, however, no discussion in the opinion regarding the changes made in H.B.4.

XI. CONCLUSION

It is extremely unfortunate that some courts are requiring expert reports to meet standards well beyond the requirements of Chapter 74 and the Supreme Court’s opinion in *Palacios*. There will be many appellate opportunities for plaintiff’s lawyers to argue for a more reasoned and balanced approach to the adequacy of expert reports. You do not want to be one of those plaintiff’s lawyers. Until sanity and reason prevail on what is minimally required, you can “bulletproof” your report by including the following elements in the report:

- A. a list of all materials reviewed by the expert;
- B. a statement of the expert’s background, training, qualifications, experience and specific areas of practice stated in the report as well as incorporation of the curriculum vitae attached as part of the report for reference;
- C. a statement of how the expert’s experience, training and background qualifies the expert as being familiar with the standard of care;
- D. a statement that shows that the expert is qualified to opine regarding the causal relationship between the breaches of the standard of care and the injury or harm claimed;
- E. a review of the facts of the case;

⁷⁰ *Quint v. Alexander*, 2005 WL 2805576 (Tex. App.–Austin 2005, pet. denied).

- F. specific statements with regard to each individual defendant as to what the standard of care required under the circumstances;
- G. a specific statement as to how each individual named defendant breached the standard of care;
- H. a statement explaining how the breach caused the injury or harm complained of and “rules out” other possible causes of the injury where necessary; and
- I. a statement that the expert is familiar with the definition of “negligence”, “ordinary care” and “proximate cause” and that in the opinion of the expert based upon reasonable medical probability and based on the expert’s background, training, qualifications and experience that the named defendant was negligent and that negligence of the named defendant was a proximate cause of the specific harm or injury.

I realize that the “bulletproof” report is a “marshalling of the evidence” that goes far beyond the requirement of a “fair summary of the experts opinions” but until the courts uniformly stop giving only lip service to the statutory requirements, it is the safest practice.

(Date)

Dear Dr. :

Thank you for your review of the records concerning_____. Please prepare a report containing your opinions and send your report and CV to me by email and regular mail as soon as possible.

The report that I am requesting is not intended to be your “final” report, but rather a preliminary report that satisfies the statutory requirement that we provide a report demonstrating that we have a retained expert familiar with the standard of care who is willing to testify that Dr. _____ breached the standard of care and that his negligence was, in reasonable medical probability, a proximate cause of injury, harm or damage to _____.

The relevant Texas statute defines an “expert report” to mean:

... a written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.

To qualify as an expert witness, the relevant Texas statute states that the person offering the expert testimony or report :

- (1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;
- (2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the *illness, injury, or condition involved in the claim*; and
- (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.

To be qualified as an expert, the Texas Supreme Court has determined that the expert need not be of the same school or specialty so long as the expert has knowledge, training or experience of the standards applicable to the illness, injury or condition involved in the claim. The Texas courts have held that a medical witness who is not of the same school of practice may be qualified to testify if he or she has practical knowledge of what is usually and customarily done by other practitioners under circumstances similar to those that were involved in the claim. In addition, if the subject is substantially developed in more than one field, the report and testimony may come from an expert qualified in any of those fields.

The Texas Supreme Court has determined that in order to constitute a good faith effort to provide a fair summary of an expert's opinions, an expert report must inform the defendant of the conduct the plaintiff has called into question. This means that the report must:

- (1) discuss and set forth the expected standards of care;
- (2) discuss and set forth what expected standards of care were not given by the health care provider, and/or the manner in which the care rendered by the health care provider failed to meet the expected standards; and
- (3) discuss the manner in which the failure to give the expected care caused or substantially contributed to the injury, harm, or damages claimed.

In other words, if challenged, the report itself must demonstrate to the trial court that the claims have a reasonable basis. Mere conclusions about the standard of care, deviation from the standard of care, and proximate cause are insufficient. As such, you must be specific about each element. On the other hand, we are not required to marshal all of our proof or prove our case through your report; rather, we must fairly inform the defendant of the specific conduct we have called into question from your area of practice or specialty area.

With these instructions in mind, please prepare a report using your own words. In doing so, please include the following:

- (1) A short paragraph that briefly outlines your background, qualifications, and training; that states you are and were, at the time in question, a practicing physician; state or states of licensure; practice specialty or specialties and any applicable specialty certifications;
- (2) That you are familiar with the standard of care for any similar

health care provider in Texas or any other similar medical community under the same or similar circumstances; that states how you are qualified to address the standard of care in this case and to address the causal relationship between deviations from the standards of care and the injury, harm and damage;

- (3) That you are aware of the definitions of "negligence," "ordinary care," and "proximate cause," a copy of which is attached to this letter;
- (4) A list of the documents, records, materials and information that you have reviewed in formulating your opinions and a brief summary of the important facts;
- (5) A discussion/analysis of the case in the manner described above, naming the individual health care provider; setting forth the expected standards of care; setting forth what expected standards of care were not given by the health care provider and/or the manner in which the care rendered by the health care provider failed to meet the expected standards; and setting forth the manner in which the failure to give the expected care caused or substantially contributed to the injury, harm or damages claimed;
- (6) That you reserve the right to amend or supplement your opinions in the future, based on your receipt of additional information, additional records, or additional deposition testimony.

Thank you for your assistance. If you have any questions, or if you need any additional information, please do not hesitate to call me immediately.

Very truly yours,

Bill Liebe

BL/sc

(Date)

Bill Liebbe
223 South Bonner Avenue
Tyler, TX 75702

Re: (patient)

Dear Mr. Liebbe:

My name is _____, M.D. I am a physician licensed by the Texas State Board of Medical Examiners. I am Board Certified by the American Board of Internal Medicine with a specialty certification in cardiovascular diseases. My primary practice area is in cardiovascular diseases with a secondary practice in the area of internal medicine. At your request, I have reviewed the medical records of _____ as follows:

Review of Facts

_____ was a 44 year old woman who had a history of diabetes and hypertension. When she was admitted to _____ Hospital - _____ on August ____ by _____, M.D., an obstetrician/gynecologist for an elective hysterectomy. Her pre-operative labs showed a hemoglobin of 9.5 and hematocrit of 30.7. Her glucose was 390. Her blood pressure before surgery was 148 over 84 and her glucose the morning of surgery was 293. She was reported to have been out of her diabetic medication about a month and out of blood pressure medication for about two weeks.

According to the history and physical examination by Dr. _____, her chief complaint was "heavy vaginal bleeding, passing blood clots." She was noted to be anemic. Prior to surgery, Dr. _____ did not request a consultation with internal medicine or cardiology and she did not have an EKG, stress test or an echocardiogram prior to the procedure. Additionally, she did not receive transfusion of red blood cells prior to the procedure.

On August 25, 2004 at approximately 12:30 she was taken to surgery by Dr. _____ where he performed a hysterectomy. She was noted to have an estimated blood loss of 250 milliliters. Surgery ended at 14:30 and she was transferred to the post-anesthesia care unit where her oxygen saturations were noted to be 97 percent on 10 liters. After arriving to the floor at 15:36 she was noted to have an oxygen saturation of 89 to 90 percent on room air. A nasal canula was applied and her oxygen saturations increased to 97 percent. At 22:00 her glucose was 326 and 12 units of insulin was given. The following morning at 07:30 her blood sugar was 313 and 12 units of humulin M was given.

At 12:15 that afternoon her heart rate was 123 after returning to bed. It was noted that "patient remains pale. Complains of chest discomfort across chest and shoulder. She had been up to the bathroom." Dr. _____ was called and informed at 12:40 at which time he gave an order to infuse 2 units of packed red blood cells, obtain urine for a culture and sensitivity, Cipro 500 milligrams and an H&H after the second unit of blood was infused. At 13:30 Mrs. _____'s oxygen saturation were noted to be 83 percent on room air and 84 percent after being placed on 2 liters of oxygen. At 17:45 Dr. _____ ordered EKG, chest x-ray, electrolytes, blood gases, special lung CT scan and a consult with the hospitalist, Dr. _____. Dr. _____ dictated a consultation note at 19:37 in which he noted an ST elevation myocardial infarction that appeared to have started approximately 6 to 8 hours earlier and appeared to be moving to completion. The following morning she was transferred to _____ Medical Center under the care of Dr. _____.

Familiarity with the Standard of Care

As a cardiologist with a secondary practice in internal medicine I am often consulted by surgeons to evaluate, test and make treatment recommendations for pre-operative clearance in cases such as this. As such, I am familiar with the standard of care of a reasonable and prudent physician for pre-operative evaluating, testing and treating patients like _____ prior to total abdominal hysterectomy with bilateral salpingo-oophorectomy.

Standard of Care

Mrs. _____ was 44 years old with a history of diabetes and hypertension at the time of her admission to _____ on August _____. She was therefore at risk for having cardiovascular disease at the time of her admission. Individuals with underlying cardiovascular disease are at risk during the post-operative period for complications including myocardial infarction. Additionally, _____ was anemic with a hemoglobin of 9.5 and hematocrit of 30.7. Her glucose was elevated and it was reported that she had been out of her blood pressure medication for 2 weeks and her diabetes medication for a month. Pre-operatively therefore she was at a significant increased risk for

myocardial infarction during the post-operative period.

Having worked with obstetrician/gynecologists under these same or similar circumstances, I know that a reasonable and prudent gynecologist would have consulted either a doctor of internal medicine or a cardiologist for pre-operative evaluation, testing and treatments prior to taking a patient like _____ to the operating room for a total vaginal hysterectomy and bilateral salpingo-oophorectomy. The standard of care of a reasonable and prudent physician under the same or similar circumstances require the following:

1. Consultation with either a doctor of internal medicine or a cardiologist.
2. EKG stress testing and/or ecocardiogram to diagnose underlying cardiovascular disease.
3. Infusion of packed red blood cells to correct anemia and
4. Medications to stabilize her blood pressure and glucose prior to surgery.

Breach of Standard of Care

Doctor _____ breached the standard of care under these circumstances in the following manner:

1. Failure to consult with either a doctor of internal medicine or a cardiologist.
2. Failure to obtain an EKG stress test and possibly an echocardiogram.
3. Infusion of packed red blood cells to correct anemia.
4. Failing to provide medication to stabilize her blood pressure and correct her glucose levels.

Causal Relationship

If Dr. _____ had consulted with a doctor of internal medicine or cardiologist pre-operatively, then Mrs. _____ would have undergone an EKG stress test and possibly an echocardiogram prior to surgery. Since we now know at the time of cardiocatheterization at _____ Medical Center on August 28, 2004, she had 100 percent occlusion of the mid-left anterior descending artery, 100 percent occlusion of the proximal first diagonal and 100 percent occlusion of the distal first obtuse marginal, it is very likely that an EKG stress test prior to surgery August 25, 2004 would have revealed her underlying cardiovascular disease and would have been treated prior to her total abdominal

hysterectomy and her myocardial infarction would have been avoided.

Even in patients who do not have severe cardiovascular disease, anemia, stress from surgery, elevated glucose and hypertension are all factors that increase the risk for myocardial infarction following any surgical procedure. Dr. _____s failure to infuse packed red blood cells to correct anemia and to provide medication to stabilize her blood pressure and glucose levels prior to surgery were in all reasonable medical probably contributing factors that led to her myocardial infarction.

Conclusion

I am familiar with the terms “negligence”, “ordinary care”, and “proximate cause.” Based upon my review of these records and the foregoing analysis it is my opinion that Dr. _____ was negligent in his care and treatment of _____ and it my further opinion that his negligence as outlined above was a proximate cause of the myocardial infarction suffered by Phyllis Jackson on August 26, 2004.

I reserve the right to amend these opinions based upon receipt of any additional information or records.

Very truly yours,

____/____

Bill Liebbe
223 South Bonner Avenue
Tyler TX 75702

RE: Cindi Patient

Dear Mr. Liebbe,

This report is a supplement to my earlier report dated March 27, 2006 regarding the care provided to my patient Cindi Patient by Fred Defendant, M.D.

QUALIFICATIONS REGARDING THE STANDARD OF CARE IN THIS CASE

I am board certified in Family Medicine and have practiced Family Medicine in _____, Texas for the past eighteen years. The illness or medical condition involved in Cindi Patient=s claim against Fred Defendant, M.D. is gallstones and biliary pancreatitis. As a board certified Family Medicine physician, I have specific knowledge, training and experience in the diagnosis, care and treatment of the conditions involved in this claim. It is my understanding that Fred Defendant, M.D. is a cardiologist who was providing medical care to Cindi Patient after she had a laparoscopic gastric banding procedure by Dr. Richard _____ on August 1, 2003. Although I am not a cardiologist or a surgeon who performs laparoscopic gastric banding procedures, I am nonetheless familiar with the standard of care that applies to Fred Defendant, M.D. as it pertains to the diagnosis, care and treatment of gallstones and biliary pancreatitis because these conditions are common medical conditions which a Family Physician is expected to recognize and diagnose routinely, and the standard of care described in my report of March 27, 2006 and this supplemental report applies to any physician treating a patient suffering from gallstones. Furthermore, because of my background, training and qualifications as a Family Medicine practitioner, I have practical knowledge of what is usually and customarily done by other

practitioners under circumstances similar to those that confronted Fred Defendant, M.D. in March, April and June 2004 when Cindi Patient reported to Dr. Defendant after having laparoscopic gastric banding that she was having abdominal pain, increased vomiting and stabbing chest pain.

I am especially qualified as an expert on the standard of care in this particular case because, as Cindi Patient=s primary care physician, I was the admitting and attending physician of Cindi Patient when she was admitted to Henderson Memorial Hospital on July 4, 2004. At that time my admitting diagnosis was pancreatitis and my discharge diagnoses were (1) biliary pancreatitis and (2) status post stomach banding approximately 10-11 months ago.

QUALIFICATIONS REGARDING CAUSAL RELATIONSHIP

As a board certified Family Medicine physician, I have been trained to and I am qualified to diagnose, care for and make treatment recommendations for patients suffering from gastrointestinal diseases. These include ulcers, hernias, gallbladder diseases, pancreatitis, appendicitis, and diverticulitis as well as other gastrointestinal disorders. I also have been trained to assist at surgery, including gall bladder surgery, and to provide post operative care for surgical patients. In addition, I am familiar with the physiological processes of gall bladder disease and know that rapid weight loss often leads to the formation of gall stones and the recognized medical fact that untreated, gall bladder disease and gall stones may progress to biliary pancreatitis as occurred in the case of Cindi Patient. I am also familiar with the medical fact that if a patient with gall stones receives appropriate medical or surgical treatment for gall stones, they will not progress to biliary pancreatitis and the complications associated with that condition as occurred in the case of Cindi Patient.

STANDARD OF CARE, BREACH AND CAUSAL RELATIONSHIP

As stated in my report of March 27, 2006 it is my opinion that the standard of care under the circumstances presented to Fred Defendant, M.D. in providing care for Cindi Patient in March, April and June 2004 required Fred Defendant, M.D. to:

1. document Cindi Patient=s complaints of Asevere, stabbing chest pains that went through her back and her shoulder blade@ during the period of time from March 29 through June 11, 2004;
2. document temperature and vital signs and perform and document a physical examination;
3. obtain laboratory studies including CBC and liver function studies as well as amylase and lipase along with consideration of an ultrasound; and

4. as her symptoms progressed, refer her to a surgeon.

It is my further opinion that Fred Defendant, M.D. breached the standard of care by:

1. failing to document Cindi Patient=s complaints of Asevere, stabbing chest pains that went through her back and her shoulder blade@ during the period of time from March 29 through June 11, 2004;
2. failing to document temperature and vital signs and perform and document a physical examination;
3. failing to obtain laboratory studies including CBC and liver function studies as well as amylase and lipase along with consideration of an ultrasound; and
4. as her symptoms progressed, failing to refer her to a surgeon.

As a result of Fred Defendant, M.D.=s breach of the standard of care, Cindi Patient=s gall stones were not diagnosed and treated and she progressed to biliary pancreatitis. In reasonable medical probability, if Dr. Fred Defendant had not breached the applicable standard of care, Cindi Patient=s condition would not have progressed to biliary pancreatitis.

Again, I reserve the right to amend these opinions based on receipt of any further information or records which come to me.

Sincerely,

Charles M. Expert, M.D.

November 13, 2006

Bill Liebbe
223 South Bonner Avenue
Tyler, TX 75702

RE: Iris Patient

Dear Mr. Liebbe:

At your request, I have reviewed the medical records of Mrs. Iris Patient at the East Texas Medical Center during her admission of May 28, 2004. Based on my review of these records, it is my opinion that the standard of care was breached by Dr. Stefan Defendant, M.D., and that his breach of this standard of care was a proximate cause of the death of Mrs. Patient.

REVIEW OF FACTS:

Iris Patient, 58 years of age and in good health, presented to the Emergency Department at East Texas Medical Center - Tyler at 0450 on May 28, 2004. Her chief complaint was abdominal pain. The pain was described as "10 out of 10" and "crampy". She had abdominal tenderness and distention. The Emergency Room physician consulted with Dr. Stefan Defendant, M.D., a general surgeon, who agreed to accept the patient on his surgical service.

At 0615, abdominal x-rays were taken that were reported as showing mildly dilated loops of small bowel in the left side of the abdomen, suggestive of a mild

focal ileus. An inflammatory process could not be excluded. At 0830, the patient was transferred to room 3531A for observation under Dr. Defendant's care.

Dr. Defendant did not see the patient and evaluate her until 1320, some eight and a half hours after her arrival in the Emergency Department.

At 1535, the nurses noted a change in the patient's status. Mrs. Patient was diaphoretic, her respiratory rate was 148 per minute and she was extremely restless. Dr. Defendant was paged multiple times and he returned the page at 1610. He gave

a telephone order for two liter of saline, STAT troponin 1, oxygen, nitroglycerine and morphine. Ten minutes later, he called again, and directed the nursing staff to get a STAT lactic acid and call him with the results. At 1740, the nursing staff reported to Dr. Defendant that the patient's lactic acid was 54.3 (normal 4.5 to 19.8), her troponin was less than 0.3 (normal) and her heart rate was elevated at 126 per minute. Dr. Defendant ordered an increase in the patient's IV fluids, a repeat lactic acid in four hours, and antibiotics. He directed the nursing staff to call him if Mrs. Patient's condition failed to improve. At 1900, Mrs. Patient was taken for CT of the abdomen. On return from this procedure, she was found to be anxious, have a distended abdomen and extreme tenderness in the right lower quadrant, with rigidity. She was pale and diaphoretic, with a heart rate of 137 and a respiratory rate of 25-30. At 2000, she was noted to be pale and diaphoretic. At 2115, Dr. Defendant was notified of a lactic acid level of 47.4.

At 2300, the radiologist, Dr. Kent _____, discussed the CT findings with Dr. Defendant. Dr. _____, in his report, describes finding "a small amount of free air that suggests a possible duodenal ulceration with perforation." This finding, in this patient, strongly suggests perforation of an intra-abdominal viscus, a condition requiring immediate surgical intervention.

At 2350, Dr. Defendant wrote that he had reviewed the patient's CT scan and stated in his progress note that the CT of the abdomen suggested a perforated duodenal ulcer "with a retroperitoneal leak." He elected to treat the patient "conservatively."

At 0400 on May 29, 2004, Mrs. Patient's continued deterioration was noted. It was difficult to obtain a blood pressure, and heart rate was 127. The patient's skin was pale and clammy, she was diaphoretic and her respirations were rapid and shallow. The patient had a diminished urine output during the past eight hours. Her lips were cyanotic and her oxygen saturation was at 88%. At 0500, the patient was intubated and transferred to the intensive care unit. At 0645 on May 29, 2004, Dr.

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Defendant noted that the patient's respirations were rapid and shallow. She was hypotensive and tachycardic. Her oxygen saturation was low, despite supplemental oxygen. Dr. Defendant noted in his progress note that Mrs. Patient was now gravely ill and would not likely survive a surgical procedure. An arterial blood gas showed that she was in metabolic acidosis with a pH of 7.19, PCO₂ of 36.8, PO₂ of 84.8 and HCO₃ of 13.08.

At 1220, Duane _____, M.D., a surgeon, saw Mrs. Patient as a "second opinion." Dr. Andrews recommended immediate surgery, but by this time, Mrs. Patient had manifested a rapid downward spiral with respiratory and renal failure, as well as coagulopathy. Iris Patient was pronounced dead at 1335 on May 29, 2004.

FAMILIARITY WITH THE STANDARD OF CARE

I am a board-certified general surgeon, and I have been practicing continuously in _____, Texas, for nearly 30 years. A copy of my curriculum vitae is enclosed. I am familiar with the standard of care for a surgeon practicing in Texas and in any other state under these or similar circumstances.

QUALIFICATIONS REGARDING CAUSAL RELATIONSHIP

As a board-certified general surgeon, I have been trained to and am qualified to diagnose, care for and operate on patients who, like Iris Patient, have an acute abdomen secondary to a perforated viscus. Because of my background, training and experience, I know that timely surgical intervention for intra-abdominal perforation in a patient such as Iris Patient is usually life-saving. Surgical intervention must, however, be performed before the disease process progresses to the point where the patient is unstable and critically ill.

STANDARD OF CARE

The standard of care for any general surgeon such as Dr. Stefan Defendant, M.D., who accepts a patient like Iris Patient from the Emergency Room physician, is to examine the patient in a timely manner and order whatever diagnostic studies he feels are indicated based on this evaluation. Often, the evaluation of the patient by a skilled surgeon will determine the diagnosis. This timely evaluation of a patient is the standard of care because in patients presenting to the Emergency Room as

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Iris Patient did, there is a risk that the patient has an intra-abdominal catastrophe requiring immediate surgical intervention.

BREACH OF THE STANDARD OF CARE

Dr. Stefan Defendant breached the standard of care in this case by failing to examine the patient in a timely manner and failing to perform surgery expeditiously. As a result of these breaches of the standard of care by Dr. Stefan Defendant, he did not take Iris Patient to the operating room for surgical intervention and repair of her intra-abdominal perforation at a time when her life would have been saved.

CAUSAL RELATIONSHIPS

If Dr. Stefan Defendant had examined the patient within a couple of hours, he would likely have known before 10 a.m. on May 28, 2004, that Iris Patient had an intra-abdominal perforation requiring immediate surgical repair. It is reasonable to conclude under these circumstances that Iris Patient would have been operated on before 3 p.m., May 28, 2004. At that time, the patient had not deteriorated to severe hypovolemic shock and lactic acidosis. In most cases, patients like Iris Patient, who undergo surgical repair of an intra-abdominal perforation before deterioration into severe irreversible shock, survive and make a full recovery. By 3:30 p.m., however, on May 28, 2004, Iris Patient began a spiraling decline into hypovolemic shock and lactic acidosis and by 0400 on May 29, 2004, her condition had deteriorated to the point where survival was unlikely, even if surgical intervention were to be performed.

SUMMARY:

I have been made aware of the legal definitions of “negligence,” “ordinary care” and “proximate cause.” Based on my review of the medical records, my background, training and experience as a general surgeon, and my analysis of the care provided by Dr. Stefan Defendant, it is my opinion that Dr. Defendant breached the standard of care by failing to examine Iris Patient in a timely manner and in failing to take the patient to the operating room for surgical repair of her intra-abdominal perforation while she was still salvageable. These breaches of the standard of care constitute negligence and the negligence of Dr. Stefan Defendant, as outlined in this report was, in reasonable medical probability, a proximate cause

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of the death of Iris Patient.

I reserve the right to amend these opinions based on receipt of any further information or records.

Sincerely,

Robert M. Expert, M.D.