WHAT EXPERTS MAY RELY UPON

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I. IN GENERAL: ANYTHING

When reviewing the adequacy of a report, the only information relevant to the inquiry is the information containing within the four corners of the document. *Transitional Care Ctrs. of Tex., Inc. v. Palacios,* 46 S.W.3d 873, 878 (Tex. 2001). 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*. *Id* at 879. The reports need not marshal all of the plaintiff's evidence, they simply must include the expert's opinions on each of the elements identified in the statute. *Id* at 878.

Notwithstanding these clear directives from the Texas Supreme Court, there have been numerous evidentiary type challenges directed to the underlying basis of the opinions contained in expert reports. Some of these challenges attempt to attack the methodology and reliability of the expert opinions contained in the Chapter 74 report. The initial inquiry to a challenge regarding the adequacy of a report should therefore be whether the challenge is an evidentiary challenge. If the challenge is evidentiary, the challenge should be summarily dismissed.

The reason evidentiary challenges to Chapter 74 expert reports have been rejected is due to the limited discovery available prior to service of the expert reports. (Civ. Prac. & Rem. Code Section 74.351(s) limiting discovery to the acquisition by the claimant of information related to the patient's health care.) Medical records alone may not provide sufficient information for the preparation of an adequate expert report. Without the ability to utilize information "outside" of the medical record, claimants would be prohibited in some cases from the preparation of an expert report that informs the defendant of the specific conduct the plaintiffs have called into question and provide a basis for the trial court to conclude that the claims have merit.

A challenge to the adequacy of an expert report shall be granted only if it appears to the court that the report does not represent an objective good faith effort to comply with the definition of an expert report. Civ. Prac. and Rem. Code Section 74.351(l). If the records are inadequate such that a claimant cannot prepare an expert report, then the court can take into account the state of the records "in determining whether a report represents a good faith effort to comply with the statute." *In re Jack Jorden* 249 S.W.3d 416, 423 (Tex. 2008).

When *Palacios* and *Jorden* are read together, it is apparent that in preparing the Chapter 74 report, the expert can rely on any information revealed to the expert even if the source of that information would be objectionable "in a summary judgment proceeding or at trial." *Palacios* at at 879. Challenges to expert reports based upon "objections" that the report relies upon hearsay, incompetent evidence or assumption of facts not in evidence should therefore be rejected, especially if the expert states in the report that the records are inadequate to provide a fair summary of the expert's opinions regarding applicable standards of care, the manner in which the care rendered by the physician or healthcare provider failed to meet the standards, and the causal relationship between the failure and the injury, harm or damages claimed without relying upon information outside of the record.

Many practitioners and courts, having failed to recognize this interpretation of *Palacios* and *Jorden*, have advanced evidentiary challenges to expert reports. Some of these cases are discussed below.

II. ASSUMPTIONS VS. INFERENCES

In *Cooper v. Arizpe,* 2008 WL 940490 (Tex. App.-San Antonio 2008, pet. denied), Linda Arizpe was admitted through the emergency department where she had received multiple sedative medications. After she was transferred to the floor, the sedatives caused respiratory depression and respiratory arrest resulting in hypoxic brain injury. The plaintiffs' expert report criticized hospitalists Wilcox and Cooper for failing to place Arizpe on continuous

monitoring or transferring her to the ICU. The expert report stated that if she had been continuously monitored or placed in the ICU, progressive respiratory depression resulting from the sedatives received in the emergency department would likely have been detected and treated before Linda Arizpe arrested and suffered any brain injury.

The San Antonio Court of Appeals rejected the arguments of Cooper and Wilcox that the report was inadequate as to causal relationship, but upheld the challenge that the report was speculative because the report "assumes that the ED chart and Dr. Skeet's notes concerning the events in the ED were included in the floor chart and available for Cooper and Wilcox to review." The report stated that the ED chart and Dr. Skeet's notes "should have been" with the floor chart and that the applicable standard of care required Cooper and Wilcox to review these records that "supposedly were in the chart on the floor."

Since the expert report relied on the assumption that the ED chart and Dr. Skeet's notes were with the floor chart, the San Antonio Court of Appeals held that the expert's opinions were "speculative and conclusory." Note that the court specifically said that there was no evidence in the expert report itself demonstrating that the chart and notes were available to review. Therefore, the trial court abused its discretion in denying the motion to dismiss.

COMMENT:

At the expert report stage, it is difficult to understand how the plaintiffs could have proven that the chart was on the floor and therefore available to the defendants for review. In *Cooper*, the plaintiffs argued their expert was merely reciting evidence discovered in a deposition of one of the floor nurses, "that Dr. Skeet's notes should have been on the floor chart." The Court of Appeals did not take this argument into consideration since their analysis was restricted to the "four corners" of the report. (There is no explanation as to how, when or why this nurse's deposition had been taken). Perhaps there would have been a different result if the expert report had never stated that the chart and notes "should have been" with the floor chart and simply restricted the criticism to the failure to review the charts" without expressing an assumption they were available. Alternatively, the report may have been held adequate if the report had "reasonably inferred" that the charts were available rather than "assuming" that they were available.

Compare *Cooper v. Arizpe* to *Reardon v. Nelson* 2010 WL 917573 (Tex. App.—Houston [14th Dist.] March 16, 2010, no pet. h.). Defendant physician, Reardon, appealed the trial court's denying his motion to dismiss Nelson's suit based on Nelson's expert report by Dr. Seaworth. Dr. Reardon performed a double bypass on Nelson's coronary arteries, but Dr. Reardon failed to recognize that Nelson had a ramus artery. Dr. Reardon bypassed the ramus instead of the circumflex artery.

Seaworth's report claimed that Dr. Reardon failed to review video images and preoperative procedure worksheets, resulting in his failure to bypass the correct artery. The trial court found the report sufficient because it specifically identified what Dr. Reardon should have done differently. *Id*. at 2.

The 14th Court of Appeals distinguishes these facts from *Cooper* because

> …there is substantiation in Dr. Seaworth's report for his conclusion that video images and procedure worksheets were not reviewed by Dr. Reardon. Apparently, the trial court concluded that Dr. Seaworth's opinion was not speculation but reasonably derived from averments in Nelson's medical

records. Dr. Seaworth noted that a cardiac-catherization worksheet generated before surgery showed the ramus branch. Moreover, pre-operative video images revealed the presence of a ramus artery. Dr. Seaworth explained that a notation of a ramus artery should appear in two places: the pre-operative notes and the operative or surgical notes. Dr. Seaworth concluded the pre-operative notes reflected Dr. Reardon was not aware of ther ramus artery, resulting in the conclusion that he did not review the cardiac-catheterization worksheet before commencing surgery. *Id*. at 5.

These were sufficient facts to link Dr. Seaworth's causation opinions to those facts. *Id*.

In *Marvin v. Fithian* 2008 WL2579824 (Tex. App.—Houston [14th Dist.] July 1, 2008, no pet.) (mem. op.) Vicky Fithian developed multiple complications following a gastric banding procedure by Dr. Marvin. Her expert report stated that Dr. Marvin breached the standard of care by failing to timely conduct a physical examination after Fithian presented with evidence of a post-operative infection. Dr. Marvin appealed the denial of his motion to dismiss based in part on the assertion that the expert engaged in an "impermissible inference that the pin hole in Fithian's stomach existed on February 3." The Fourteenth Court of Appeals disagreed, noting that the expert *inferred* the existence of the pin hole *based on the fact* that she exhibited signs of infection only three days after undergoing gastric band surgery and the source of major infection was ultimately determined to stem from that surgery. The Court acknowledged that the expert's conclusion may have been based on an inference gleaned from medical records, and while acknowledging that trial courts are prohibited from drawing inferences from outside the four corners of an expert report, "Section 74.351 ***does not prohibit experts from making inferences based on medical history.***"

In *Benish v. Grottie* 281 S.W.3d 184 (Tex. App.-Fort Worth 2009 pet. denied) Dr. Dingler complained that the expert report "needed to provide some factual information that Dr. Dingler did not train, supervise or monitor Nurse Benish. Dr. Dingler argued that merely expressing an *ipse dixit* opinion that because Nurse Benish allegedly breached the standard of care, she must not have been trained or supervised properly" did not represent a good faith effort to provide a fair summary of standard of care violations. The expert report stated that based upon the "numerous deficiencies in Nurse Practitioner Benish's history and physical examination of Amarissa, it is clear that Dr. Dingler did not ensure that this nurse practitioner knew how to take an adequate history and physical examination." Noting that for purposes of a statutory expert report, statements concerning the standard of care and breach need only identify what care was expected and was not given with such specificity that inference need not be indulged to discern them, the Fort Worth Court of Appeals held that the report met this requirement.

The Court of Appeals in *Benish* noted that when reviewing the adequacy of a report, the only information relevant to the inquiry is the information contained within the four corners of the document. This requirement precludes a court from filling gaps in a report by drawing inferences or guessing as to what the expert likely meant or intended, but it does not prohibit experts from making inferences based on medical history. *Id.* (citing *Marvin v. Fithian*, supra and Tex. R. Evid. 703 (providing that an expert may draw inferences from the facts or data in a particular case); Tex. R. Evid. 705 (providing that expert may testify in terms of opinions and inferences)).

III. DEFENDANT'S USE OF RECORDS TO CHALLENGE THE FACTUAL BASIS OF THE REPORT

In *Baptist Hospitals of Southeast Texas v. Carter* 2008 WL2917109 (Tex. App.-Beaumont 2008, no pet. h.) Carter sued Dr. Schrapps, who performed two surgeries at Baptist. Carter underwent two additional surgeries at St. Luke's after his discharge. Carter later amended his pleadings to name Baptist Hospitals, complaining that Baptist had failed to ensure that Dr. Schrapps had filed operative reports timely. The contention was that the failure to have an operative report from previous surgeries at Baptist hindered the surgeons at St. Luke's from being able to properly address Carter's surgical complications. Baptist objected to the sufficiency of Dr. Macho's report, asserting that it was conclusory regarding how Baptist's acts or omissions had caused the delays in Carter's treatment. At the hearing on Baptist's objections to the report, Baptist introduced copies of the operative reports on Carter's two surgeries at Baptist to show that Dr. Macho's expert report was inadequate because it was "built on a foundation of assumptions and speculation" since the second operative report provided the information that Dr. Macho said was not available to the surgeons at St. Luke's.

The Court of Appeals concluded that Dr. Macho did not provide sufficient facts to sufficiently explain how Baptist's alleged omissions caused delays in Carter's treatment. "Instead, Dr. Macho's amended report bases its causation analysis on several assumptions about Carter's treatment at Baptist and at St. Luke's that are *inconsistent with the medical records placed in evidence at the hearing.*"

This memorandum opinion in *Carter* that apparently permits an attack on the adequacy of the expert report with records outside of the four corners of the report, was rejected in *Collini v. Pustejovsky*, 280 S.W.3d 456 (Tex. App.-Fort Worth 2009, no pet. h.). Dr. Collini incorporated his complete medical file on Pustejovsky, spanning more than 700 pages, in an attempt to discredit the factual information and resulting conclusions contained in Pustejovsky's expert report. In reciting the rule that when reviewing the adequacy of a report, the only information relevant to the inquiry is the information contained within the four corners of the document, the court discussed *Carter* in a footnote as follows:

> "We recognize that the Beaumont Court of Appeals has held that medical records submitted by defendant in an objection to an expert report may be considered by the trial court in determining the adequacy of the report. see *Baptist Hospitals of S.E. Tex. v. Carter*. Dr. Collini relies on *Carter* to urge us to review the medical records submitted in her reply at trial, which she claims demonstrate inconsistencies with the factual statements contained in Dr. Haberer's report. In essence, Dr. Collini asserts that we should consider information outside of the expert report on her behalf while we are prohibited from doing so on behalf of Pustejovsky. We disagree with the reasoning expressed by our sister court in *Carter,* and we rely on the language contained in *Palacios* and *Bowie Memorial Hospital* to constrain our review of the report's adequacy at this preliminary stage in the proceedings to the specific information and allegations contained within it. see *Bowie Memorial Hospital*, 79 S.W.3d at 53 (limiting review of an expert report to information contained within its four corners); *Palacios* 46 S.W.3d at 878 (stating that a

> court "should look no further than the report); see also *Maris v. Hendricks*, 262 S.W.3d 379, 386 (Tex. App.-Fort Worth 2008, pet. denied) (prohibiting a physician from using deposition testimony to attack the adequacy of an expert report served upon him)."

The Waco Court of Appeals in *Hamilton v. Durgin* 2008 WL4816624 (Tex. App.-Waco November 5, 2008, no pet.) also declined to consider hospital records which the defendant argued would demonstrate that the expert report contained an inaccurate factual basis by noting that "the defendants essentially argue the merits of Durgin's claim, relying on documents and information outside of the reports." *Id.* (*see also Kingswood Specialty Hospital, Ltd. V. Barley*, 2010 WL 4262049, No. 14-10-00241-CV (Tex. App.—Houston [14th Dist.] October 28, 2010, no pet. h.).

The Beaumont Court of Appeals has, since it issued its opinion in *Carter*, clarified that a challenge to the sufficiency of an expert report is limited to the four corners of the expert report. *Christus Health Southeast Texas v. Broussard* 306 S.W.3d 934, 939 (Tex. App.—Beaumont 2010, no pet. h.). In *Broussard*, the court held that, despite inconsistencies between assertions made in a plaintiff's expert report and those made in a defendant's motion to dismiss, a trial court may not look beyond the four corners of the expert report to determine whether the facts asserted in the report are false. *Id*. *Broussard* clearly expressed that extraneous information, which was not relied upon by an expert in making his determinations and which does not appear in the report, may not be reviewed in determining the sufficiency of an expert report. *Id*.

IV. OPINIONS OF OTHERS

In *Kelly v. Renden* 255 S.W.3d 665 (Tex. App.—Houston [14th Dist.] 2008, no pet.) the expert reports of the medical doctors incorporated by reference the report of the plaintiff's nurse expert. Each physician then relied on the nurse expert report in rendering their own opinions regarding the standard of care and medical causation. In concluding that the trial court had not abused its discretion in considering the nurse's report in its determination of the hospital defendant's motion to dismiss since it had become part of the reports of the physician experts, the court noted that there was "nothing in the healthcare liability statute prohibiting an otherwise qualified physician from relying on another opinion in the formation of the physician's own opinion." *Id* at 676.

In *Packard v. Guerra*, 252 S.W.3d 511, (Tex. App.—Houston [14th Dist.] 2008, no pet.) a non-physician corporate lawyer prepared an extensive report that connected the dots between the entities and individuals responsible for training programs and management of emergency rooms so that the plaintiff's physician experts could prepare a sufficient expert report. The Houston 14th Court of Appeals held that the physician experts *could* rely on the expert opinion of the attorney in the formation of their own opinions regarding the standard of care and causation.

V. THE EXPERT MAY RELY ON INADMISSIBLE HEARSAY AND PRIVILEGED COMMUNICATIONS

Texas Rule of Evidence 703 provides that "the facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by, reviewed by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence."

In analyzing this rule of evidence, the Texas Supreme Court in *In re Christus Spohn*

Hosp. Kleberg 222 S.W.3d 434 (Tex. 2007) explains that "experts are generally unfettered by firsthand-knowledge requirements that constrain the ordinary witness. While lay witnesses may only testify regarding matters in which they have personal knowledge, expert witnesses may testify about facts or data not personally perceived, but 'reviewed by, or made known' to them." Tex. R. Evid. 703. If the facts or data are of a type upon which experts in the field reasonable rely in forming opinions on the subject, the facts or data need not even be admissible in evidence. Thus, in many instances, *experts may rely upon inadmissible hearsay, privileged communication and other information that the ordinary witness may not*. Moreover, an expert may state an opinion on mixed questions of law and fact, such as whether certain conduct was negligent or proximately caused injury, that would be off limits to the ordinary witness. Tex. R. Evid. 704; *Birchfield v. Texarkana Mem'l. Hosp.*, 747 S.W.2d 361, 365 (Tex. 1987)."

VI. INFORMATION SUPPLIED BY PATIENT OR FAMILY MEMBERS

In *Hiner v. Gaspard*, 2007 WL 2493471 (Tex. App.-Beaumont September 6, 2007, pet. denied) the Beaumont Court of Appeals affirmed the trial court's denial of the defendant's motion challenging the Gaspard's expert report. The experts stated in their reports that they had reviewed numerous medical records as well as the affidavit of Linda Gaspard, the patient's wife. In the affidavit, Linda stated that a nurse told her that she "stuck [Gaspard] with the same needle three times." Linda also stated in her affidavit that Gaspard had develop fever and chills, and his arm was turning red." The affidavit continued with additional statements by Linda Gaspard regarding her husband's physical complaints and appearance.

The defendants objected to Linda Gaspard's affidavit as being "incompetent, containing hearsay and based on conclusions, speculation and assumed facts." In overruling these objections, the court of appeals noted that the defendants had cited no authority holding that an expert preparing a report is required by Chapter 74 to not review documents that would not be admissible into evidence at trial. The court specifically noted that expert reports served "under this Section" are not admissible into evidence and may not be used in a "deposition, trial or other proceeding." Since Chapter 74 prohibits the introduction of expert reports into evidence, the legislature likely did not intend that expert reports and the evidence reviewed by experts in preparing reports must comply with the rules of evidence. Furthermore, the court noted that assuming *arguendo* that the Rules of Evidence apply to expert reports, Rule 703 allows an expert to base opinions or inferences on matters perceived by, reviewed by or made known to the expert and if of a type reasonably relied upon by experts in a particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible into evidence. Moreover, the court of appeals placed the burden on defendant of demonstrating that the affidavit of Linda Gaspard "did not supply the type of facts or data reasonably relied upon by medical experts in preparing the reports required by Chapter 74", noting that "appellants have cited no authority supporting that proposition."

In *Comstock v. Clark* 2007 WL3101992 (Tex. App.-Beaumont 2007, pet. denied) Dr. Clark complained that Dr. Orr's causation testimony was "based upon speculation, and [that] he did not link his conclusions to the facts of this case. Specifically, Dr. Clark argued that "without reviewing the medical records of Megan's post-operative hospital admission, Dr. Orr had no competent medical evidence of any injury and thus, could not link Megan's injuries to the healthcare providers' breach of the applicable standards of care. Dr. Orr's report stated that he reviewed Megan's clinical records from the procedure at issue *and that he spoke with Megan's mother regarding the events surrounding the procedure and her present*

condition.

It is noteworthy that in *Comstock*, Dr, Orr based his opinion that Megan Comstock had sustained a hypoxic brain injury secondary to respiratory depression based solely upon a conversation he had with Megan's mother. Although Dr. Orr had not reviewed *any* medical records demonstrating hypoxic brain injury, the Beaumont Court of Appeals found that Dr. Orr's expert report provided a fair summary to reflect the bases of his opinions, citing *Palacios* 46 S.W.3d at 875. The court noted that it did not imply or suggest that an expert report's sufficiency for purposes of Chapter 74 immunizes the report from a challenge that it is not sufficiently reliable *to be admitted before the trier of fact*. The court noted that this type of challenge generally carries with it a more developed record than was before it in this preliminary proceeding.

In *Gannon v. Wyche*, 321 S.W.3d 881 (Tex. App.—Houston [14th Dist.] 2010, pet. filed) the court held that the plaintiff's expert may rely upon an unsworn written statement by the infant patient's mother in writing the Chapter 74 report. Kyla Wyche was born prematurely and had numerous IVs placed at various parts at various times. Drs. Gannon and Anselmo noted that one IV had been infiltrated and the area was puffy, red, edematous and firm, and the IV was discontinued. Later, Dr. Anselmo noted a green pustule on Kyla's left foot. She discussed it with Dr. Gannon but neither documented an assessment of the left foot. The Wyches contend that the swelling and redness continued in Kyla's left foot. Kyla was eventually diagnosed with Staphylococcus aureus, cellulites, osteomyelitis, and left hip septic arthritis.

Appellants objected to Appellees' expert report by Dr. Rotbart, in part, because it was based on Traci Wyche's unsworn, undated statement that contained a day-by-day description of Kyla's condition and symptoms. *Id.* at 885.

The court noted that Dr. Rotbart's report stated that the medical records had no documented assessments of Kyla's left leg and foot between May 12 and May 14, 2006, and therefore he could not determine from the record whether or not the conditions persisted, progressed or resolved; however Traci Wyche's statement indicated the condition persisted and possibly worsened. *Id* at 886.

Appellants argue that Dr. Rotbart may not rely on Traci Wyche's statement, and one Appellant further argued that the statement could have been made by anyone and Traci Wyche could have been a janitor at the hospital. *Id*. at 888.

The court concluded that Traci Wyche's statement was like unsworn communication with the patient's mother in *Comstock*, and both *Hiner* and *Comstock* courts recognized that a Chapter 74 report is a preliminary proceeding in which the rules of evidence may not apply to either the expert reports or the evidence the experts reviewed in preparing the reports. *Id*. at 891-92.

Since the medical records were silent for a period of time regarding Kyla's left foot and leg, Dr. Rothbart relied upon Traci Wyche's statement regarding Kyla's progression of symptoms to fill in the gaps; Dr. Rothbart also specifically addressed how the statement and the medical records corroborate each other. *Id*. 891-92. Therefore, Dr. Rotbart's opinion was reliable. *Id*. at 892.

VII. CONCLUSION

It is instructive to note that the Texas Supreme Court denied petition for review in *Hiner* and *Comstock* on March 28, 2008, the same day the Texas Supreme Court decided *In re Jorden*.

If the Supreme Court is not satisfied that the opinion of the court of appeals has correctly declared the law in all respects, but determines that the petition presents no error that requires reversal or that is of such importance to the jurisprudence of the state as to require correction, the Court will deny the petition with the notation "Denied." Tex. R. App. Proc. 56.1(b)(1).

In re Jorden holds that if the records are inadequate to prepare an expert report that represents an objective good faith effort to comply with the definition of an expert report, the court "can take into account the state of the records in deciding whether a report represents a good faith effort to comply with the statute." By denying the petition for review in *Hiner* and *Comstock* on the same day, it is clear that in preparing the report, the expert may rely and utilize information, including statements of patients and family members, not contained in the medical record.