TADC MEDICAL MALPRACTICE LAW NEWSLETTER

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I. TEXAS SUPREME COURT DECISIONS

A. INFORMED CONSENT

In *Schaub v. Sanchez*, 229 S.W.3d 322 (Tex. 2007), 50 Tex. Sup. Ct. J. 919, Janie Sanchez suffered from pain, numbness and tingling in her hand after undergoing wrist surgery performed by Dr. Kevin Crawford. Two stellate ganglion blocks, spinal injections that anesthetize nerves in the neck, had been ineffective in relieving the pain, and Sanchez informed Dr. Crawford she did not want any more block injections. During the course of a subsequent wrist manipulation procedure, Dr. Crawford and Dr. Lowry Schaub, the anesthesiologist assisting with the surgery, found signs of a flare-up of another of Sanchez's conditions, for which they believed another block would be beneficial. They performed the block, and as a result, Sanchez developed an infection and required spinal surgery.

Sanchez's malpractice-related claims were all dismissed by agreed order, leaving only her claim for lack of informed consent. The trial court found that the consent forms signed by Sanchez authorized the procedure and granted summary judgment in favor of the physicians. The Court of Appeals reversed, finding that a fact issue existed regarding whether the physicians acted outside of the accepted standard of medical care when performing the block.

The Supreme Court reversed and rendered that Sanchez take nothing. In a *per curiam* opinion, the Court found that summary judgment was proper because a claim for lack of informed consent is based on a physician's failure to disclose the risks of a particular procedure. Sanchez had admitted by affidavit that she had been informed of the danger of the block. The Court thus determined that Sanchez's claims sounded in battery or negligence, claims which she had voluntarily dismissed.

B. COMPARATIVE NEGLIGENCE

In *Jackson v. Axelrad*, 221 S.W.3d 650 (Tex. 2007), 50 Tex. Sup. Ct. J. 628, Dr. David Axelrad, a psychiatrist, suffered from intermittent abdominal cramps and diarrhea for several months. After an abrupt onset of acute pain, Dr. Axelrad sought treatment from Dr. Richard Jackson, an internist. Dr. Jackson prescribed a laxative and enema for fecal impaction. After returning home and performing the enema, Dr. Axelrad immediately felt severe abdominal pain with nausea, rigors and chills. Dr. Axelrad underwent surgery for what was thought to appendicitis, but which turned out to be diverticulitis and a perforated colon. Dr. Axelrad had to have a portion of his colon removed and a temporary colosty constructed. He later had to undergo further surgery and suffered from a severe drug reaction.

It was undisputed at trial that an enema is an inappropriate treatment for a patient suffering from diverticulitis due to the risk of perforated colon. What was disputed, as relevant to the case on appeal, was whether Dr. Axelrad informed Dr. Jackson of the specific location of his pain, given that the evidence showed that diverticulitis is commonly associated with pain in the lower left quadrant.

At trial, Dr. Axelrad and Dr. Jackson each claimed that the other was negligent. Specifically, Dr. Jackson asserted that Dr. Axelrad was negligent in failing to disclose the specific location of his abdominal pain. The jury found that Dr. Jackson was 49% at fault and that Dr. Axelrad was 51% at fault.

The Houston Court of Appeals reversed and remanded the case for a new trial, holding that Dr. Axelrad could not be comparatively negligent for failing to advise Dr. Jackson of the origin of his pain. 142 S.W.3d 418, 427 (Tex. App.—Houston [14th Dist.] 2004).

The Texas Supreme Court reversed and remanded. The Court noted that a patient's duty to cooperate with a treating physician requires ordinary care under all surrounding circumstances, and that contributory negligence is assessed under the same rules as those that govern a defendant's negligence. "As jurors analyzing the 'same or similar circumstances' must consider a physician's special knowledge when a doctor is the defendant, it is hard to see why they should not do so when a doctor is the plaintiff." Thus, the Court determined that a reasonable jury could have inferred that Dr. Axelrad, who presented himself to the jury as a person with

superior medical knowledge than that of a layperson, knew or should have known the significance of providing information regarding the origin of his abdominal pain to his treating physician.

C. SNAP-BACK

In *In re Christus Spohn Kleberg*, 222 S.W.3d 434 (Tex. 2007), 50 Tex. Sup. Ct. J. 682, the hospital received from a patient a notice of intent to file a health care liability claim. After receiving the notice, the hospital conducted an internal investigation in anticipation of litigation. The investigation generated a series of documents that were privileged as work product. The documents included summaries of interviews with employees and correspondence to and from the hospital's counsel. The documents were inadvertently produced to an expert witness retained by the hospital to testify as to standard-of-care issues. Counsel for the hospital discovered the inadvertent disclosure when the expert brought the documents with her to her deposition. The hospital filed an "Objection, Assertion of Privilege, and Motion to Return Privileged Documents" under the "snapback" provision of Rule 193.3(d). The witness claimed that she only glanced at the documents to identify what they were, and never actually read them. The trial court overruled the Hospital's claim of privilege on the basis that it was unclear that the witness did not see certain documents. The court of appeal denied mandamus relief.

The Texas Supreme Court held that the hospital was entitled to recover the documents under Rule 193.3(d) of the Texas Rules of Civil Procedure and maintain the privileged nature of the documents as long as the designated expert did not testify at trial. However, the Court held that to the extent that the hospital stood on its expert designation, Rule 192.3(e)(6) mandated that the documents were subject to discovery as documents provided to a testifying expert.

II. TEXAS APPELLATE COURT DECISIONS REGARDING CHAPTER 74 OF THE TEXAS CIVIL PRACTICE & REMEDIES CODE

A. DEFINITION OF "HEALTH CARE LIABILITY CLAIM"

In *Spiller v. Kothmann*, 2007 WL 2608562 (Tex.App.-San Antonio 2007, no pet. h.) (memorandum opinion), Hugh Bob Spiller suffered from a dangerous cardiac condition for which Rad Kothmann, M.D. recommended implantation of a pacemaker. Spiller refused the treatment. Dr. Kothmann contacted Spiller's wife, who agreed that she would try to persuade Spiller to consent to the procedure. Spiller's wife subsequently called Dr. Kothmann back to report that Spiller was behaving inappropriately and not following medical advice, and that she feared for her safety. Dr. Kothmann wrote a letter to a judge stating that he believed Spiller was making poor decisions due to complications of his medical condition, and requesting an emergency detention warrant. The judge issued the warrant, and Spiller was apprehended and taken in for examination by a social worker. The social worker released Spiller, who then filed suit against Dr. Kothmann alleging that Dr. Kothmann's actions caused him to suffer trauma and embarrassment. The trial court dismissed Spiller's claims after he failed to file a timely expert report. Spiller sought a new trial after the motion was granted, arguing that his claims were for invasion of privacy and were not "health care liability claims." The appellate court affirmed the trial court's order, finding that Dr. Kothman's decision to submit an application for emergency detention was based on his medical treatment of Spiller and his assessment of Spiller's mental and medical condition. As such, Dr. Kothman actions were an inseparable part of his rendition of health care services.

In *Clark v. TIRR Rehabilitation* Center, 227 S.W.3d 256 (Tex.App.-Houston [1st Dist.] March 15, 2007, no pet.), the family of Anita Clark filed suit against TIRR after Clark was left unattended on a balance board during physical therapy, fell, and sustained injuries that led to her death. The trial court dismissed the claims after Plaintiffs failed to timely file expert reports. The court of appeal affirmed the dismissal, holding that the claims brought by Plaintiffs were "health care liability claims" subject to the requirements of Chapter 74. The court found that patient supervision was an "integral part of the services rendered by TIRR" and that the staff was required to make professional judgments regarding the treatment and supervision patients required based on their condition. The court further noted that expert testimony would be required to prove any lapse in professional judgment on the aprt of the staff because "[p]roper supervision and protection of a patient in a weakened condition during physical therapy exercises is not within the common knowledge of the general public."

In *Sloan v. Farmer*, 217 S.W.3d 763 (Tex.App.-Dallas 2007, pet. filed), Stephen Farmer sought treatment from Dr. Matt Sloan for chronic pain. During the course of treatment, a letter from Dr. Sloan to Farmer terminating their patient-physician

relationship was inadvertently disclosed to Farmer's employer. That letter contained confidential medical information regarding the results of a positive random drug screen taken by Farmer, which positive drug screen was the basis for Dr. Sloan's termination of the relationship. Farmer and his wife brought suit against Dr. Sloan for slander and violations of physician-patient confidentiality, HIPAA, and the Texas Medical Records Privacy Act. After the Farmers failed to timely serve expert reports, Dr. Sloan moved to dismiss the action, and the trial court denied the motion. The court of appeal reversed, finding that a physician's duty of confidentiality to his patient is part of the "core function of providing health care services." The court determined that whether expert testimony would be necessary to support a verdict is not dispositive of whether a claim is a health care liability claim because the expert report requirement is a "threshold requirement for the continuation of a lawsuit, not a requirement for recovery."

In *Devereaux v. Harris County Hosp. Dist*., 2007 WL 852618 (Tex.App.-Houston [1st Dist.] 2007, no pet.) (memorandum opinion), Ora Devereaux filed negligence and breach of contract claims against Harris County Hospital District, alleging that she sustained injuries when, after a medical exam, the medical staff failed to properly assist her back into her wheelchair. The trial court dismissed the claims after Devereaux failed to file expert reports. The court of appeal affirmed the dismissal, holding that the actions taken by the medical staff in moving Devereaux were an inseparable part of the health care being rendered to her, and that the essence of her claim pertained to alleged lapses in professional judgment and treatment by health care providers. As such, the claims were "health care liability claims" and were subject to the requirements of Chapter 74.

Christus Health v. Beal, --- S.W.3d ----, 2007 WL 2132233 (Tex.App.-Houston [1st Dist.] 2007, no pet. h.) involved claims against a drug and alcohol rehabilitation center for injuries sustained by a patient whose bed collapsed while he slept. The court of appeal held that, although a drug and alcohol treatment center is a "health care provider" as that term is defined by section 74.001(12), the patient's claim was not a "health care liability claim" but was rather a premises liability claim. In so holding, the court determined that provision of a safe bed did not directly relate to the TIRR's treatment of the patient's drug addiction. Further, the court held that even though the patient believed that staff responded inappropriately to his injuries by making him get up out of the bed and not calling an ambulance, these additional claims still do not arise from the center's actual provision of drug and alcohol rehabilitation services.

B. DEADLINE FOR SERVING EXPERT REPORTS

1. EFFECT OF SCHEDULING ORDERS

McDaniel v. Spectrum Healthcare Resources, Inc., --- S.W.3d ----, 2007 WL 2377326 (Tex.App.-San Antonio 2007, no pet. h.) involved a unique set of facts encompassing federal and subsequent state litigation. Under the specific facts of the case, the San Antonio Court of Appeal held that an expert designation date provided for in a docket control order constituted an agreement by the parties to extend the deadline for filing Chapter 74 reports.

Janice McDaniel sustained a broken pelvis after falling off of a machine while doing physical therapy. She and her husband filed suit in federal court against the United States, and against Spectrum and Michael Sims, one of the physical therapists. The federal court signed an agreed scheduling order that provided an expert designation date. Before that expert designation date passed, but after 120 passed from the filing of the original petition, Spectrum and Sims moved to dismiss the plaintiffs' claims based on the plaintiffs' failure to timely serve a Chapter 74 report. The federal court denied the motion to dismiss, but granted a motion for summary judgment by the United States on other grounds. Dismissal of the United States as a party destroyed the basis for federal jurisdiction, and the federal court dismissed the plaintiffs' claims against Spectrum and Sims without prejudice. Plaintiffs subsequently re-filed in state court, and the parties entered into an Agreed Special Setting and Docket Control Order that provided a deadline for expert designation and submission of expert reports.

The plaintiffs filed their expert designation with reports in compliance with the docket control order. Thereafter, Spectrum and Sims moved to dismiss the case, alleging that Plaintiffs failed to timely serve Chapter 74 expert reports. The trial court granted the motion and dismissed Plaintiffs claim. The Court of Appeal reversed, using contract principles to determine that the docket control order constituted an agreement to extend the deadline by which Chapter 74 reports were due. The court concluded that the language in the docket control order providing that its deadlines prevailed over deadlines set by statute reflected an understanding by the parties that the expert designation therein would govern the deadline for Chapter 74 reports, particularly in light of an

express reference in the Order to Chapter 74 as it pertained to discovery.

The court further highlighted the uniqueness of the facts of the case by pointing out the circumstances of the initial federal litigation, including the length of time that the federal litigation had been pending. Further, the court noted that the parties had already been instructed by the federal court that the provisions of the federal scheduling order would govern expert reports unless the parties included a specific provision referencing Chapter 74 reports. The appellate court pointed out that the parties entered into the subsequent agreed scheduling order in state court with that admonition in mind, and failed to include a specific provision in the state agreed order referencing Chapter 74 reports.

In *Brock v. Sutker*, 215 S.W.3d 927 (Tex.App.-Dallas 2007, no pet.), the Dallas Court of Appeal determined that a scheduling did not extend the 120-day period for filing expert reports. The court found that the order did not mention section 74.351, and that nothing in the order suggested any agreement by the parties to extend the deadlines set by that statute.

The Dallas Court of Appeal reached the same conclusion in *King v. Cirillo*, --- S.W.3d ----, 2007 WL 2052138 (Tex.App.-Dallas 2007, no pet. h.), determining that the scheduling order at issue in that case referenced "testifying experts" and that an expert report under Chapter 74 does not have to be prepared by a testifying expert, or by a retained expert.

In *Lal v. Harris Methodist Fort Worth*, 230 S.W.3d 468 (Tex.App.-Fort Worth 2007, no pet. h.), the Fort Worth Court of Appeal found that a scheduling order did not constitute an agreement to extend the deadline for filing Chapter 74 reports. The court also found that no extension was permissible for a late expert report, even if it was the result of mistake and not conscious indifference.

2. NO TOLLING OF 120-DAY DEADLINE

In *Intracare Hosp. North v. Campbell*, 222 S.W.3d 790 (Tex.App.-Houston [1st Dist.] March 29, 2007, no pet.), Cindy Campbell filed a medical malpractice suit as next friend of her incompetent adult son. She was subsequently appointed guardian of her adult son, and filed an amended petition to reflect her proper capacity. Campbell filed an expert report within 120-days of the filing of the petition in which her capacity was cured, but more than 120 days after the filing of her original petition. The court of appeal held that the deadline to file an expert report was not tolled by Campbell's lack of capacity. In so finding, the court analogized cases holding that amended pleadings filed by a party who acquires capacity after the date of a claim's original filing "relate back" to the original filing for statute of limitation purposes.

In *Packard v. Miller*, 2007 WL 1662279 (Tex.App.-Amarillo 2007, pet. filed) (memorandum opinion), Maurice Miller filed a healthcare liability claim against Dr. Stanton Packard, but was unable to effectuate service of process until 130 days after the original petition was filed. An expert report was attached to the report when it was finally served. The court of appeal held that the Miller's claims must be dismissed for failure to comply with the120-day deadline of section 74.351. In so holding, the court rejected Miller's argument that Dr. Packerd, having "avoided process" should be equitably estopped from moving for such a dismissal, or that the court should adopt an "equitable extension," as neither such remedy was permissible under the explicit mandates of Chapter 74.

In *Smith v. Hamilton*, 2007 WL 1793754 (Tex.App.-Beaumont 2007, no pet.) (memorandum opinion), the Plaintiffs filed a medical malpractice suit against Dr. Michael Leigh Smith and other defendants. Plaintiffs filed an expert report and a supplemental expert report with the district clerk before the expiration of the 120-day deadline. Dr. Smith, however, did not file an answer until after the 120-day deadline had passed. On the day after Dr. Smith answered the lawsuit, Plaintiffs served upon Dr. Smith copies of the expert reports that they had previously filed with the district clerk. The Court of Appeal dismissed Plaintiffs' suit against Dr. Smith with prejudice, finding Plaintiffs' waiver and equitable estoppel arguments unpersuasive. The court held that Dr. Smith's failure to appear and to answer the lawsuit did not excuse Plaintiffs' obligation to serve timely expert reports upon him.

3. OTHER DEADLINE ISSUES

In *Daughtery v. Schiessler*, 229 S.W.3d 773 (Tex.App.-Eastland 2007, pet.), the court held that non-suiting a medical malpractice action and then re-filing it does not restart the 120-day deadline for expert reports.

In *University of Texas Health Science Center at San Antonio v. Ripley*, 230 S.W.3d 419 (Tex.App.-San Antonio 2007, no pet.), the court held that Plaintiff's service of an expert report upon

Defendants in a medical malpractice action filed in federal court but later dismissed met the service requirement of Chapter 74 in Plaintiff's subsequently filed state action.

In *Jain v. Stafford*, 2007 WL 1502084 (Tex.App.-Fort Worth 2007, pet. filed) (memorandum opinion), Dr. Sharad Jain treated Jack Stafford for metastatic melanoma using Interferon chemotherapy. After Stafford's death, Stafford's wife brought suit against Dr. Jain alleging negligence in his medical management of Stafford related to the Interferon chemotherapy. The court of appeal held that (1) a defendant's twenty-one day deadline to file objections to an expert's report is not triggered by a report that is not an "expert report" as to that Defendant; and (2) the three-day grace period provided in Rule 21a of the Texas Rules of Civil Procedure (the "mailbox rule") "applies to the statutory requirements contained in the Texas Civil Practice and Remedies Code for malpractice cases.

C. JURISDICTIONAL ISSUES

In *Padilla v. Loweree*, --- S.W.3d ----, 2007 WL 2456879 (Tex.App.-El Paso 2007, no pet. h.) the El Paso Court of Appeal held that it lacked jurisdiction to consider an order granting a thirty-day extension under 74.351(c) where the expert report was timely filed, but deemed "un-served" because it was found by the trial court to be deficient.

In *Hill Regional Hosp. v. Runnels*, 2007 WL 765291 (Tex.App.-Waco 2007, pet. filed) (memorandum opinion), the Waco Court of Appeal held that it lacked jurisdiction over a trial court's denial of a defendant's motion to dismiss based on an allegedly deficient expert report. The court acknowledged that its holding is in agreement with some other courts, including the Fort Worth Court of Appeal, and in conflict with the holding of some other courts, including Dallas and San Antonio Courts of Appeal.

In *Metwest, Inc. v. Rodriguez*, 2007 WL 1018640 (Tex.App.-Fort Worth 2007, pet. filed) (memorandum opinion), one of the cases referenced by *Hill*, the Fort Worth Court of Appeal also concluded that it lacked jurisdiction over a trial court's denial of a defendant's motion to dismiss based on a timely filed but allegedly deficient expert report. The Fort Worth Court elaborated that section 51.014(a)(10) only permits an interlocutory appeal of an order *granting* such a motion, and that section 51.014(a)(9) permits an appeal of a denial of a motion to dismiss, but only where no timely report was filed. The court acknowledged the conflict between appellate courts in this regard.

D. ADEQUACY OF EXPERT REPORTS

1. QUALIFICATIONS OF PROFFERED EXPERTS

In *Simonson v. Keppard*, 225 S.W.3d 868 (Tex.App.-Dallas 2007, no pet.), Carol Keppard presented to the emergency room with complaints of headache, nausea and vomiting. She was treated by Nurse Practitioner Donald Lehman, who diagnosed migraine, administered medication and released Keppard in slightly improved condition several hours later. Dr. Joan Wilkin signed off on Nurse Lehman's diagnosis. Dr. Robert Simonson was the admitting physician at the hospital. Keppard died the following day from a massive intracranial hemorrhage. Keppard's family sued Simpson, Wilkin and Lehman and provided an expert report. Objections to that report were sustained by the trial court, and Plaintiffs filed an amended report. The three defendants again filed objections and sought dismissal, which the trial court denied. The court of appeal reversed as to Nurse Lehman and affirmed as to Dr. Simonson and Dr. Wilkin.

With regard to Plaintiffs' claims against Nurse Lehmann, the court of appeal held that the Plaintiffs' expert report failed to establish that he had knowledge of the standard of care applicable to nurse practitioners. Indeed, the expert opined that the nurse practitioner "assumed the duties of a physician when he undertook to examine, diagnos[e] and treat Ms. Keppard." The court noted that the standards of care for an advanced nurse practitioner are set forth in the Texas Administrative Code, under which advanced nurse practitioners are accountable for advanced practice nursing care, but are not responsible for a doctor's care. An advanced nurse practitioner may only make a diagnosis within the confines of protocols or other written authorizations signed by a physician. The court found that the Plaintiffs' expert could not know the standard of care applicable to Nurse Lehman without first having an understanding of the specific protocols under which Nurse Lehmann was working at the time of the occurrence. Thus, the appellate court court found that the trial court erred in failing to dismiss Plaintiffs' claims against Nurse Lehmann.

As to Dr. Wilkin and Dr. Simonson, the court rejected the assertion that Plaintiffs' expert, as a neurosurgeon, was not qualified to testify as to the standard of care for emergency room physicians,

because the expert indicated in his report that he had worked in a hospital emergency department as a staff physician and served as a consulting physician seeing patients in the emergency room. The court also found that the Plaintiffs' expert sufficiently explained causation by stating that the failure of the defendants to perform certain testing "prevented the early diagnosis that in reasonable medical probability would have saved [Keppard's] life."

In *Thomas v. Alford*, 230 S.W.3d 853 (Tex.App.-Houston [14th Dist.] 2007, no pet. h.), Gene and Carolyn Thomas sued Gene Thomas' family physician and radiologist for failure to diagnose Thomas' cancer while it was still curable. The trial court dismissed Plaintiffs' claims, finding that the expert reports provided by Plaintiffs were inadequate. The court of appeal affirmed in part, and reversed and remanded in part.

The appellate court reversed the trial court's dismissal as to Dr. Alford, holding that Plaintiff's expert oncologist was qualified to render a report as to the standard of care for a family practitioner with regard to diagnosis and treatment of cancer. The court further found that the oncologist's expert report adequately addressed causation by stating that, had Thomas been properly evaluated by the family physician, Thomas's cancer would have been diagnosed while it was still treatable.

On the other hand, the appellate court affirmed the trial court's dismissal as to Thomas's radiologist, pointing out that the radiology expert attached to his report certain guidelines to which he claimed the treating radiologist failed to adhere, but the report itself failed to identify whether the guidelines were the standard of care for an ordinary radiologist or were a higher standard to which board certified radiologists should aspire. As such, the court held that the report did not adequately address the standard of care as to the treating radiologist, and dismissal was proper.

In *Konen v. Bass*, --- S.W.3d ----, 2007 WL 2325834 (Tex.App.-Dallas 2007, no pet. h.), Dr. Andrew Konen implanted a spinal column stimulator and battery into Greta Bass for pain management. Bass claimed that the placement of the stimulator and battery interfered with her daily activities, and that removal of the battery pack caused scar tissue and neurological symptoms. Bass filed suit against Konen, and served upon him a report by Dr. Schaeffer, who is board certified in internal medicine and neurology, and treats patients with spinal cord stimulators. The court affirmed the trial court's order denying Dr. Konen's motion to dismiss, finding that, because the sole issue was Konen's choice of location of the surgical insertion, Dr. Schaeffer was qualified by his own experience to observe and attest to the complications resulting from the placement of the device without ever having actually surgically implanted one himself.

In *Memorial Hermann Healthcare System v. Burrell*, 230 S.W.3d 755 (Tex.App.-Houston [14th Dist.] 2007, no pet.), the Houston Court of Appeal held that an expert was qualified to issue a report concerning decubitus ulcers based on the expert's statement in the report that he was familiar with the standard of care relating to prevention and treatment of decubitus ulcers, had experience in training nurses and other healthcare personnel proper prevention techniques relating to decubitus ulcers and has treated patients with decubitus ulcers. The court found that he provided fact-based explanations of the standard of care. The court also noted that lack of board certification does not disqualify a physician as an expert. In finding the expert qualified in this case, despite lack of board certification, the court considered the expert's 25-plus years experience practicing medicine, training he has received relevant to prevention and treatment of decubitus ulcers, his experience teaching relevant to infectious diseases, particularly decubitus ulcers and the fact that he was board eligible and had treated patients with decubitus ulcers. The court further found that the expert's education and training also qualified him to testify as to causation under Rule 702 of the Texas Rules of Evidence.

In *Wissa v. Voosen*, --- S.W.3d ----, 2007 WL 2780148 (Tex.App.-San Antonio 2007, no pet. h.), the San Antonio Court of Appeal held that an orthopedic surgeon was qualified for purposes of Chapter 74 report to opine as to the standard of care for an anesthesiologist. The court noted that the report did not criticize the anesthesiologist's administration of anesthesia. Instead, it was critical of the anesthesiologist's preoperative evaluation. The report noted that the standard for performing a competent History and Physical and Assessment and Plan contain the same elements for all specialties, and thus, as a surgeon, the expert was qualified to opine as to breaches of the standard of care for an anesthesiologist in that regard.

In *Wissa*, the anesthesiologist also argued that the trial court failed to properly analyze the scope of the legal duty he owed to the patient. However, the Court of Appeal rejected this argument, holding that a challenge to the scope of a physician's duty is not a

determination that is contemplated or required under Chapter 74.

2. REPORTS DEEMED SUFFICIENT

In *University Medical Center v. Ward*, 2007 WL 2403361 (Tex.App.-Amarillo 2007, no pet. h.) (memorandum opinion), Carita Ward presented to the hospital with labor pains. She was assessed as having a dilated cervix and attached to a fetal heart monitor. Ward was examined by the physician and told that her labor was not progressing and that she would be discharged. Ward requested that she be allowed to stay to see if her condition would change. Several hours later, the physician reexamined Ward, determined that there was still no change in her status, and discharged her home. Ward returned to the hospital a day after being discharged, again complaining of labor pains, but doctors were unable to detect a fetal heartbeat. Ward's fetus was delivered stillborn, and doctors concluded that the death was caused by a "true knot" in the umbilical cord. Ward filed suit against the physician that discharged Ward home as well as the hospital, and timely served expert reports by Dr. Donald Coney. The hospital challenged the adequacy of Dr. Coney's second supplemental report as to causation. Specifically, the report stated that Ward's fetal monitoring strip revealed non-reassuring patters that should have been recognized by the nurses as indicative of cord problems. Dr. Coney listed measures that could have been, but were not, taken to correct the cord problems, and criticized the nurses for allowing Ward to be discharged. Dr. Coney opined that, had the nurses recognized the symptoms associated with cord compression and taken the measures he described, the fetus would likely have been delivered "alive and intact." The hospital argued that the report did not explain how the measures proposed by Coney would have prevented the physician from discharging Ward or how such measures would have resulted in a successful delivery. The court of appeal determined that the expert report was sufficient, because an expert report need only provide a "fair summary" of the expert's opinions, and "need not present evidence as if the plaintiff was actually litigating the case on the merits."

In *Agana v. Terrell ex rel. Terrell*, 2007 WL 1793786 (Tex.App.-Beaumont 2007, no pet.) (memorandum opinion), the claimant's expert report was found to be adequate as to standard of care even though it did not articulate different standard of care for separate physicians. The court found that the expert's statement that the same standard of care applied to both physicians was sufficient, pointing out that it found no authority for the proposition that the same standard of care cannot apply to two physicians "when each is responsible for an overlapping aspect of patient's care." The court also found that the expert's statement that the patient would not have developed bedsores if she had been properly monitored was not conclusory, and was sufficient to establish causation.

In *Romero v. Lieberman*, --- S.W.3d ----, 2007 WL 2430019 (Tex.App.-Dallas 2007, no pet. h.), the Dallas Court of Appeal found an expert report adequate where it explicitly identified the treating doctors and stated how the conduct of each fell below the standard of care, and explained that the standard of care was the same for medical doctors of all specialties with regard to recognition and treatment of septicemia or septic shock. The court further held that the report was not conclusory because it provided a reasoned factual basis for the expert's opinion as to each of the statutory elements.

In *Chaupin v. Schroeder*, 2007 WL 2127713 (Tex.App.-Houston [14th Dist.] 2007, no pet. h.) (memorandum opinion), the Houston Court of Appeal determined that a pulmonologist was qualified to assess the conduct of a general surgeon regarding treatment of possible ileus with abdominal distension and pain. The court noted that the expert's criticism focused not on a surgical issue, but on the sufficiency of surgeon's assessment of the patient and the appropriateness of the tests ordered by the surgeon. The court found that the report was specific as to the care rendered to the patient, despite expert's reference to the standard of care for "any physician" with regard to use of blood gas monitoring. The court determined that the report sufficiently provided a causal link between surgeon's breaches of the standard of care and patient's death by stating that the surgeon's failure to properly monitor and evaluate the patient allowed his condition to deteriorate to the point that emergency intubation was necessary, and that the attempts to intubate led to the patient aspirating his vomitus, which led directly to the patient's death.

In *Harris County Hosp. Dist. v. Garrett*, --- S.W.3d ----, 2007 WL 1299872 (Tex.App.-Houston [1st Dist.] 2007, no pet.), Autrey Garrett had a biopsy performed on a breast lump in 2003, and the pathology findings established a diagnosis of breast cancer. She was not informed of the diagnosis, however, until eighteen months later. Garrett sued Harris County Hospital District, among others, for failing to timely disclose the biopsy results. In

support of her claims, Garrett served upon Defendants the expert report of Dr. Robert McWilliams, who claimed that the failure to disclose Garrett's biopsy results was a violation of the standard of care, and that the failure to disclose the results permitted Garrett's cancer to advance and metastasize, eliminating the availability of effective diagnostic measures and therapeutic options. The trial court denied a motion to dismiss by HCHD, and the court of appeal affirmed that order. In doing so, the court of appeal rejected HCHD's argument that Garrett did not provide a statutorily required curriculum vitae for Dr. Williams, noting Dr. Williams' report contained sufficient information by which to determine his qualifications. The court stated that there is no authority for the proposition that a curriculum vitae must be provided as a separate document where the information normally contained therein is found in the expert's report itself. The court found that Dr. Williams' report adequately set forth the standard of care, how HCHD breached that standard of care, and how the breach caused Garrett to sustain injuries.

3. REPORTS DEEMED INSUFFICIENT

In *Haddad v. Marroquin*, 2007 WL 2429183 (Tex.App.-Corpus Christi 2007, no pet. h.) (memorandum opinion), Cesar Marroquin underwent an appendectomy, after which a sponge was retained at the surgical site. Marroquin filed suit against the physician and the hospital, and timely served an expert report alleging, inter alia, that the sponge count was incorrectly performed by hospital staff and that the physician failed to control the material placed in Marroquin's abdominal cavity. Motions to dismiss filed by both Defendants were denied by the trial court. The court of appeal held that the report filed by Marroquin's expert did not represent a good-faith effort to comply with the statutory requirements of Chapter 74 because it did not set forth the appropriate standard of care relating to the use and count of sponges as to each defendant, or how such standard of care was breached. The court further held that the report did not adequately address the causal relationship between the physician's "inappropriate follow-up care" and the alleged injuries. Finally, the court held that, while *res ipsa loquiter* is an evidentiary rule permitted by section 74.201, it is not an exception to the expert report requirement of section 74.351. Although there may be no need for expert testimony at trial in a case involving *res ipsa loquiter*, an expert report is still required at the commencement of such litigation.

In *Baylor University Medical Center v. Biggs*, --- S.W.3d ----, 2007 WL 2421504 (Tex.App.-Dallas 2007, no pet. h.), Cheri Biggs died after receiving a transplant of a rabies-infected kidney. Her family filed suit against Dr. Chinnakotla, the harvesting surgeon, Dr. Sanchez, the transplanting surgeon, and Baylor University Medical Center, the facility at which the transplant occurred. Plaintiffs alleged that the Defendants failed to obtain informed consent because they failed to inform Biggs about the donor's medical condition at the time he presented to the hospital, and about the donor's high-risk social and medical history. Plaintiffs timely filed expert reports, and motions to dismiss by all three defendants were denied. The court of appeal held that the trial court abused its discretion in denying the defendants' motions to dismiss because the expert reports failed to properly identify the defendants and the specific duty owed by each. The court also held that the reports failed to address causation in that they did not identify whether a reasonable person would have been influenced by disclosure of the information allegedly withheld, and did not connect Biggs's death to the specific information which Biggs's family argued should have disclosed.

In *Ledesma v. Shashoua*, 2007 WL 2214650 (Tex.App.-Austin 2007, no pet. h.) (memorandum opinion), after allegedly sustaining injuries as a result of improper IV placement during surgery, Cecelia Ledesma filed suit against a number of health care providers, including the hospital, the surgeon, the anesthesiologist and Bruce Johns, the certified registered nurse anesthetist. After Ledesma served upon the defendants four expert reports, Johns sought and was granted dismissal on the grounds that the reports were inadequate as to him. The court of appeal upheld the dismissal, finding that two of the reports failed to identify Johns at all, and that the other two failed to identify the standard of care specifically applicable to Johns as opposed to that applicable to the rest of the "surgical team"

In *CHCA Mainland, L.P. v. Burkhalter*, 227 S.W.3d 221 (Tex.App.-Houston [1st Dist.] 2007, no pet.), the family of Glenda Burkhalter sued CHCA Mainland and Dr. Robin Lynn Armstrong, alleging wrongful death due to negligence in the treatment of Burkhalter's gallstone pancreatitis. The family timely served the expert report of Dr. John Fullerton on both Defendants. As to Mainland, the report stated in a single sentence that the hospital staff breached the standard in caring for Burkhalter. Mainland filed objections to the report and requested dismissal. The trial court overruled the objections, after which Mainland filed a Motion to Dismiss. The trial court denied Mainland's motion, and Mainland

filed its notice of appeal.

On appeal, the court held that the time period within which to file a notice of appeal began to run with the denial of Mainland's motion to dismiss, not the overruling of its objections. After finding that Mainland's appeal was timely, the court of appeal then reversed the trial court's order and rendered judgment dismissing the family's claims against Mainland, holding that Dr. Fullerton's report failed to identify how the hospital staff breached the standard of care, and failed to explain how the hospital staff caused Burkhalter's injuries or death. The court explained the standard used to judge the adequacy of an expert report, noting that "[w]hile a "fair summary" is something less than a full statement of the applicable standard of care and how it was breached, even a fair summary must set out what care was expected, but not given." The court went on to hold that when a claimant sues more than one defendant, "the expert report must set forth the standard of care for each defendant and explain the causal relationship between each defendant's individual acts and the injury."

In *Apodaca v. Russo*, 228 S.W.3d 252 (Tex.App.-Austin 2007, no pet.), Barbara Apodaca filed suit against Dr. Penni Russo alleging that Dr. Russo was negligent in failing implement anti-coagulation therapy and other precautions against pulmonary emboli when caring for Claudia McAulay, who died of a pulmonary embolism. The court of appeal affirmed the trial court's dismissal of Apodaca's claims against Dr. Russo, finding that the report filed by Apodaca did not mention Dr. Russo's name, and did not specify how Dr. Russo breached the standard of care or how such a breach caused McAulay's death. The court pointed out that, even though Plaintiff sued only Dr. Russo, the report itself implicated other doctors and health care providers and identified another doctor by name. The court further held that an expert report that fails to address a defendant physician constitutes "no report" as to that defendant, and the trial court is without discretion to grant an extension.

The court reached a similar conclusion in *Bogar v. Esparza*, --- S.W.3d ----, 2007 WL 1852904 (Tex.App.-Austin 2007, no pet. h.), finding that a report that failed to explicitly identify the defendant whose conduct was the subject of the expert's opinions regarding standard of care and causation was inadequate. The court further found that an extension would not be appropriate because this is a case where the report was so deficient as to constitute "no report", subjecting the plaintiff's claim to mandatory dismissal and precluding the discretionary extension allowed by 74.351(c).

In *Austin Heart, P.A. v. Webb*, 228 S.W.3d 276 (Tex.App.-Austin 2007, no pet.), Christian and Marilou Webb sued Austin Heart and Dr. David Kessler for failing to diagnose and treat medical conditions related to Mr. Webb's pacemaker. The Webbs timely filed an expert report by Dr. Alan Cororve. The trial court denied a motion to dismiss the claims based on alleged deficiencies in Dr. Cororve's report. The court of appeal reversed, noting that the report failed to identify either Dr. Kessler or Austin Heart as having breached the standard of care or causing injury to Mr. Webb. The Webbs argued that the fact that the background section focuses primarily on Dr. Kessler's actions makes clear that Dr. Cororve's opinions relate to Dr. Kessler. The Court of Appeal rejected that argument, holding that such an argument would impermissibly require to reader to "infer or make an educated guess" regarding who the expert is identifying as having breached the standard of care. The court went on, however, to decline the Defendants' request to find that the report was so deficient as to constitute "no report" as to Dr. Kessler, such that an extension to cure the deficient report would be prohibited. Instead, the Court remanded the case, pointing out that the report was served timely and made "more than a passing reference to Dr. Kessler." The court found that the report was only deficient because it did not expressly make the connection between the expert's conclusions and the conduct of Dr. Kessler referenced in the report. The expert could, then, cure the report without generating a "new, previously nonexistent report."

In *Maxwell v. Seifert*, --- S.W.3d ----, 2007 WL 2700959 (Tex.App.-Houston [14th Dist.] 2007, no pet. h.), Alista Maxwell sued Dr. Heidi Seifert for damages related to an epidural steroid injection. Dr. Seifert moved to dismiss Maxwell's claim after she failed to timely file expert reports. Maxwell argued that the medical records she produced in response to discovery requests were sufficient to constitute an expert report. The court of appeal disagreed, holding that Dr. Seifert could not be required to read bulk medical records to search for the information statutorily required to be in an expert report. The court also disagreed with Maxwell's argument that an expert report was not required because she alleged *res ipsa loquitor*, pointing out that they had previously rejected that contention in other medical malpractice cases. Finally, the court held that amending a petition to add new "claims" did not re-start the 120-day deadline to file an expert report.

In *Bidner v. Hill*, --- S.W.3d ----, 2007 WL 2130612 (Tex.App.-Dallas 2007, pet. filed), the Dallas Court of Appeal affirmed the trial court's denial of Dr. Bidner's motion to dismiss. The court found that the expert report filed on behalf of the Sherri Hill sufficiently addressed causation by stating that Dr. Bidner's failure to perform a reduction on Hill's wrist fracture allowed the fracture to heal out of proper alignment. The expert explained that as time went on, the angle at which the bone healed grew more distorted, and caused Hill to suffer pain and deformity. The court found this explanation to represent a good faith effort, to properly survive a motion to dismiss.

In *Grindstaff v. Michie*, --- S.W.3d ----, 2007 WL 2456853 (Tex.App.-El Paso 2007, no pet. h.), the El Paso Court of Appeal determined that an orthopedic surgeon was qualified to assess the standard of care as to a podiatrist based on the expert's familiarity with treatment of plantar fasciitis, the specific issue on which the expert was critical of the podiatrist. The court also held that the expert's report was adequate to establish causation where the report stated that the podiatrist improperly recommended a surgery and that, following the surgery, the patient's pain and condition worsened as a "direct result of the surgery that was neither warranted nor indicated." The court pointed out that "such is generally the case where the negligence claim arises from surgery gone awry."

4. PERMISSIBILITY OF EXTENSION TO CURE DEFICIENT REPORT

In *Danos v. Rittger*, --- S.W.3d ----, 2007 WL 625816 (Tex.App.-Houston [1st Dist.] 2007, pet. filed), the court found that an expert report written by Dr. Baker in Danos's suit against Dr. Rittger and other health care providers did not meet the requirements of Chapter 74 as to Dr. Rittger, and granted Danos thirty days to cure the deficiency. Danos subsequently filed a new report from Baker expert, and also filed a report by a new expert. The trial court subsequently dismissed Danos' claims against Rittger, determining that Baker's second report still did not adequately address causation, and ruling that Danos could not file a report from a new expert during the extension period. The court of appeal affirmed, noting that the provision of Chapter 74 which allows a claimant an extension to cure a deficient report speaks to the need to cure the deficiency in the report already provided. "There is no provision in the statute that allows a claimant to go beyond the 120-day deadline to cure a deficiency in a report by obtaining a new report from a different expert."

In finding that Dr. Baker's second report did not adequately address causation, the court noted the report did not differentiate the standard of care as to Rittger as opposed to the obstetrical consult, and complained of "collective failure[s]". As such, the report did not adequately address causation.

Cuellar v. Warm Springs Rehabilitation Foundation, 2007 WL 2428965 (Tex.App.-San Antonio 2007, no pet. h.) (memorandum opinion) involved two expert reports, one rendered by a nurse and the other by a physician licensed to practice in Mexico, but not licensed to practice in the United States. The court held that neither was qualified under Chapter 74 to issue a report addressing causation. The court further held that the trial court did not abuse its discretion in refusing to grant thirty-day extension. Given that neither expert was qualified to address causation, their respective reports could not be "cured" in that regard. The court held that the thirty-day extension allowed by Chapter 74 is only permitted to cure deficiencies in existing reports, and would not allow a plaintiff to file a new report to address causation.

De La Vergne v. Turner, 2007 WL 1608872 (Tex.App.-San Antonio 2007, no pet.) (memorandum opinion) also involved an expert report issued by a nurse. The court found that no extension was permissible because the nurse could not cure her lack of qualification to address causation.

In *Methodist Health Center v. Thomas*, 2007 WL 2367619 (Tex.App.-Houston [14th Dist.] 2007, no pet. h.) (memorandum opinion), the court found that a hospital administrator was not a medical doctor, and was, accordingly, not qualified to render a report as to causation. The court further found that no extension was warranted because the specific deficiency faced could not be cured absent a wholly new report by a new expert, which is not permitted under Chapter 74.

In *In re Padilla*, --- S.W.3d ----, 2007 WL 2456885 (Tex.App.-El Paso 2007, no pet. h.), the court found that where an expert report was timely served, but found deficient, the trial court did not abuse its discretion in granting a thirty-day extension. The court further held that the defendant had an adequate remedy at law because he could file a new motion to dismiss once the cured report is served.

4. USE OF PLAINTIFF'S EXPERT REPORT

In *Smith v. Financial Ins. Co. of America*, 229 S.W.3d 405 (Tex.App.-Eastland 2007, no pet.), Francisco Flores, Jr. filed suit against Dr. J. Scott Smith, alleging that Dr. Smith negligently performed his spinal surgery. Financial Insurance Company of America intervened in the suit, asserting that they had paid Mr. Flores worker's compensation benefits for injuries he sustained as a result of Dr. Smith's negligence, and as such, were subrogated to Mr. Flores's claims. The court held that the worker's compensation carrier could rely on the expert report filed by Mr. Flores because the carrier's claims were based on injuries sustained by Flores, rendering Flores and Financial collectively a single "claimant."

E. EX-PARTE COMMUNICATION WITH TREATING PHYSICIANS

In re Collins, 224 S.W.3d 798 (Tex.App.-Tyler 2007, pet. filed) concerned a defendant's right to communicate with a claimant's healthcare providers. Kelly Regian and James Regian filed a medical malpractice action against Dr. Lester Collins and provided the statutorily required authorization listing physicians and healthcare providers that had relevant information as well as physicians and health care providers who had only information that was privileged and not relevant. On motion by the Regians, the trial court entered an order prohibiting Dr. Collins from having ex parte communications with any of Ms. Regian's nonparty treating physicians. The appellate court found that section 74.052 "neither explicitly authorizes nor explicitly prohibits ex part communications," and determined that it was within the trial court's discretion to prohibit *ex parte* communications in this case to protect Ms. Regian's privileged information.