Affirmed and Opinion filed October 25, 2001.

In The

Fourteenth Court of Appeals

NO. 14-99-01401-CV

KENT B. MONTET, Individually, and on Behalf of the Estate of ANITA D. MONTET, Deceased, and as Guardian of RACHEL MARIE CUPPLES, a Minor, JUDY A. MARTIN, and BILLY BROWN, Appellants

V.

NARCOTICS WITHDRAWAL CENTERS, INC. and LAURIE SCHNEIDER, M.D., Appellees

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On Appeal from the 11th District Court
Harris County, Texas
Trial Court Cause No. 96-62549

O P I N I O N

Appellants, Kent B. Montet, Individually, and on Behalf of the Estate of Anita D. Montet, Deceased, and as Guardian of Rachel Marie Cupples, a Minor, Judy A. Martin, and Billy Brown, appeal from the trial court's take-nothing judgment on their wrongful death and medical malpractice claims against appellees, Narcotics Withdrawal Centers, Inc. and Laurie Schneider, M.D. We affirm.

I. Background

On December 12, 1994, Anita Montet went to the Narcotics Withdrawal Center ("NWC") for treatment for her addiction to Vicodin, which is a prescription pain medication and opiate, and cocaine. NWC is a methadone clinic specializing in the treatment of opiate abusers. Anita saw Dr. Laurie Schneider, NWC's medical director. Anita complained of anxiety, muscle cramps, nausea, headache, backache, and insomnia. Dr. Schneider also observed low blood pressure, perspiration, and pupillary dilation. Anita told Dr. Schneider she had been taking 15 tablets of Vicodin a day for seven years and had started using cocaine about four months earlier. Based on Anita's symptoms and reported history of opiate use, Dr. Schneider determined that Anita was opiate dependent and admitted her to NWC's methadone treatment program.[1]

Dr. Schneider initially prescribed 15 milligrams of methadone to Anita. Anita returned to NWC a few hours later, still in opiate withdrawal, i.e., she was still experiencing opiate "cravings," and received another 10 milligrams of methadone. On December 13, Anita returned to NWC complaining of insomnia and muscle cramps. She did not see Dr. Schneider, but, instead, saw a nurse for follow-up assessment. The nurse noted pupillary dilation. The nurse called Dr. Schneider with her assessment of Anita. Based on the nurse's report, Dr. Schneider increased the dosage and prescribed 35 milligrams of methadone to Anita. On December 14, Anita returned to NWC, still complaining of insomnia. Anita did not see Dr. Schneider, but saw the nurse, who called Dr. Schneider. Dr. Schneider, again, increased the dosage and prescribed 40 milligrams of methadone to Anita. That evening, Anita passed out for 10 to 15 seconds, while sitting upright in a chair having a conversation with friends. On December 15, Anita was still complaining of insomnia and muscle aches.

[1] A urine sample was taken from Anita, but NWC did not receive the results of the urinalysis until December 15, 1994. The results of the urinalysis showed that Anita was positive for cocaine, but negative for opiates even though she had reported to Dr. Schneider that she had been taking 15 tablets of Vicodin a day for several years.

Anita saw the nurse, who called Dr. Schneider with her assessment of Anita. Increasing the dosage, Dr. Schneider, prescribed 50 milligrams of methadone to Anita.[2]

On the morning of December 16, Anita returned to NWC. Anita told the nurse she had slept well and was feeling better. Because Anita was not reporting any withdrawal symptoms, the nurse did not write anything on Anita's chart or call Dr. Schneider. Anita received 50 milligrams of methadone, i.e., the same amount she had received the day before. When she returned home from NWC, Anita started feeling drowsy and was slurring her words. Anita laid down in her bedroom. She got up around 1:00 p.m., but went back to bed. Anita's husband, Kent, found her dead in her bed that evening. The autopsy report stated that Anita had a blood level of 1700 ng/ml methadone and had died of methadone toxicity.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

At trial, appellants claimed Anita was not opiate dependent when she came to NWC, but, instead, was addicted only to cocaine. According to appellants, because Anita was not opiate dependent, she was not opiate tolerant and, therefore, the administering of methadone was fatal to her. Appellants also asserted that Dr. Schneider and NWC did not properly monitor Anita while administering methadone to her. Appellants brought this lawsuit against NWC and Dr. Schneider for wrongful death and medical malpractice.

After a bench trial, the trial court made the following findings of fact, in relevant part:

> 9. The standard of care opined by Defendants' expert J. Thomas Payte, M.D., applies to this case. The higher standard of care opined by Plaintiffs' expert, George Glass, M.D., does not apply to this case, but in the opinion of this Court, should apply to society.

[2] Also that day, Anita called NWC to ask if she could take an over-the-counter cough suppressant. Anita was told she could. According to appellants' brief, methadone is an antitussive drug, which is a respiratory suppressant, and the over-the-counter medication Anita was taking was also a respiratory suppressant.

> 10. Defendants, LAURIE SCHNEIDER, M.D. AND NARCOTICS WITHDRAWAL CENTERS, INC., breached the applicable standard of care, but such breach was not a proximate cause of Anita D. Montet's death and the Plaintiffs' damages.
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> 11. Defendants, LAURIE SCHNEIDER, M.D. AND NARCOTICS WITHDRAWAL CENTERS, INC., breached the inapplicable standard of care opined by Plaintiffs' expert, George Glass, M.D., and such breach was a proximate cause of Anita D. Montet's death and the Plaintiffs' damages.

The trial court made the following conclusions of law:

> 14. As the breach of the standard of care applicable to this case did not proximately cause the death of Anita D. Montet and Plaintiffs' damages, judgment [is] rendered in favor of the Defendants herein.
>
> 15. This Court has no legal authority to raise the applicable standard of care.

At trial, both sides presented evidence, through expert testimony, on the standard of care for health care providers in methadone treatment programs. The trial court found NWC and Dr. Schneider established the applicable standard of care for methadone treatment programs. The trial court determined NWC and Dr. Schneider had breached that standard of care, but that their breach was not a proximate cause of Anita's death.[3] Accordingly, the trial court entered a take-nothing judgment in favor of NWC and Dr. Schneider.

The trial court made alternative findings with regard to the standard of care proffered by appellants, which it determined was not applicable to methadone treatment programs.

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[3] In announcing its findings, the trial court stated:

> What is the standard of care? Dr. Glass asked me to impose the standard of care that I admit is not prevalent, but which he says should be the standard of care. I agree. I wish it were in my power to dictate what the standard of care is because if I could I would raise it considerably over what the testimony in this case establishes. . . . The standard of care the people of Houston should be entitled to is not being met from the testimony by the defendant in this case or, for that matter, most of the methadone clinics according to the testimony, all the methadone treatment centers in Houston.

In accordance with that alternative finding, the trial court determined that the "inapplicable" standard of care was breached and such breach was a proximate cause of Anita's death. The trial court further found with regard to its alterative findings that if it had committed an error of law or fact, appellants were entitled to damages in the following amounts: (1) $75,000.00 for Kent B. Montet, Individually and on Behalf of the Estate of Anita D. Montet; (2) $500,000.00 for Rachel Marie Cupples; (3) $50,000.00 for Judy A. Martin; and (4) $1.00 for Billy Brown.

III. Issues on Appeal

On appeal, appellants contend: (1) the trial court incorrectly ruled that methadone clinics and physicians in methadone clinics have a lower duty to their patients than do other physicians and health care providers in the community; (2) the evidence established as a matter of law that Dr. Schneider and NWC breached their respective duties to provide reasonably prudent care to Anita, thereby proximately causing her death; (3) the trial court's findings that NWC and Dr. Schneider's treatment of Anita was reasonable is so against the great weight and preponderance of the evidence as to be manifestly unjust; (4) the trial court's finding that NWC and Dr. Schneider's breach of the lower standard of care did not proximately cause Anita's death is so against he great weight and preponderance of the evidence as to be manifestly unjust; and (5) the trial court erred in allowing NWC to rely on the testimony of Dr. Schneider's expert, Dr. J. Thomas Payte, when the clinic had not designated him as its own expert.

IV. Standard of Review

We review the trial court's findings of fact for legal and factual sufficiency of the evidence by the same standards applied in reviewing the evidence supporting a jury's finding. *Catalina v. Blasdel*, 881 S.W.2d 295, 297 (Tex. 1994); *Skrepnek v. Shearson Lehman Bros., Inc.*, 889 S.W.2d 578, 579 (Tex. App.—Houston [14th Dist.] 1994, no writ). Because appellants challenge findings on issues on which they had the burden of proof, they

must demonstrate that the evidence conclusively established, as a matter of law, all vital facts in support of the issue. *Dow Chem. Co. v. Francis*, 46 S.W.3d 237, 241 (Tex. 2001). In reviewing a matter of law challenge, we must first examine the record for evidence supporting the trial court's finding, while ignoring all evidence to the contrary. *Sterner v. Marathon Oil Co.*, 767 S.W.2d 686, 690 (Tex. 1989). If there is no evidence to support the fact finder's answer, we then examine the entire record to determine if the contrary proposition is established as a matter of law. *Id.* We may sustain the matter of law challenge only if the contrary proposition is conclusively established. *Dow Chem. Co.*, 46 S.W.3d at 241.

Because appellants challenge the factual sufficiency of an adverse finding on which they had the burden of proof, they must demonstrate on appeal that the adverse finding is against the great weight and preponderance of the evidence. *Id.* at 242. In reviewing a complaint that the trial court's finding is against the great weight and preponderance of the evidence, we must examine the entire record to determine if there is some evidence to support the finding. *Oadra v. Stegall*, 871 S.W.2d 882, 892 (Tex. App.—Houston [14th Dist.] 1994, no writ). Only if the finding is so contrary to the overwhelming weight and preponderance of the evidence as to be clearly wrong and manifestly unjust, must we sustain the challenge. *Id.* Because the appellate court is not the fact finder, it may not substitute its own judgment for that of the trier of fact, even if a different answer could be reached on the evidence. *Knox v. Taylor*, 992 S.W.2d 40, 50 (Tex. App.—Houston [14th Dist.] 1999, no pet.); *Peter v. Ogden Ground Servs., Inc.*, 915 S.W.2d 648, 649 (Tex. App.—Houston [14th Dist.] 1996, no writ). The amount of evidence necessary to affirm a judgment is far less than necessary to reverse a judgment. *Bracewell v. Bracewell*, 20 S.W.3d 14, 23 (Tex. App.—Houston [14th Dist.] 2000, no pet.); *Knox*, 992 S.W.2d at 50.

Legal conclusions are subject to de novo review. *MCI Telecomm. Corp. v. Texas Util. Elec. Co.*, 995 S.W.2d 647, 651 (Tex. 1999). The standard of review for conclusions of law is whether they are correct. *Dickerson v. DeBarbieris*, 964 S.W.2d 680, 683 (Tex.

App.—Houston [14th Dist.] 1998, no pet.). Conclusions of law will be upheld on appeal if the judgment can be sustained on any legal theory supported by the evidence. *Amerada Hess Corp. v. Wood Group Prod. Tech.*, 30 S.W.3d 5, 11 (Tex. App.—Houston [14th Dist.] 2000, pet. denied). We do not reverse incorrect conclusions of law if the controlling findings of fact will support a correct legal theory. *Id.*

III. STANDARD OF CARE

In their first two issues, appellants claim the trial court did not apply the correct standard of care owed by NWC and Dr. Schneider in the administering of methadone to Anita. To prevail on a claim for medical malpractice, the plaintiff must establish, through expert testimony, the following elements: (1) a duty requiring the defendant to conform to a certain standard of care; (2) the applicable standard of care and its breach; (3) resulting injury; and (4) a reasonably close causal connection between the alleged breach of the standard of care and the alleged injury. *Preble v. Young*, 999 S.W.2d 153, 155 (Tex. App.—Houston [14th Dist.] 1999, no pet.). The threshold issue in a cause of action for medical malpractice is the standard of care. *Hall v. Tomball Nursing Ctr., Inc.*, 926 S.W.2d 617, 620 (Tex. App.—Houston [14th Dist.] 1996, no writ). The standard of care must be established so that the fact finder can determine whether the defendant deviated from it. *McIntyre v. Smith*, 24 S.W.3d 911, 914 (Tex. App.—Texarkana 2000, pet. denied); *Chopra v. Hawryluk*, 892 S.W.2d 229, 233 (Tex. App.—El Paso 1995, writ denied). The standard of care in Texas mandates that a "physician has duty to act as would a physician of reasonable and ordinary prudence under the same or similar circumstances." *Chamber v. Conaway*, 883 S.W.2d 156, 158 (Tex. 1993); *see also Mills v. Angel*, 995 S.W.2d 262, 268 (Tex. App.—Texarkana 1999, no pet.) (stating hospital has a duty of care to do what a hospital would have done under same or similar circumstances). The standard of care must be established through expert testimony unless the mode or form of treatment is a matter of common knowledge or is within the experience of a layman. *Hood v. Phillips*, 554 SW.2d 160, 165-66 (Tex. 1977).

The crux of this appeal focuses on what appellants contend is a "two-tiered" standard of care set forth by the trial court. In other words, appellants assert the trial court concluded that methadone clinics and physicians treating patients at methadone clinics are to be held to a "lower" duty than are hospitals and physicians treating patients in hospitals or private practice, i.e., the care that a reasonably prudent physician or clinic would have provided. Therefore, according to appellants, a hospital or a physician at a hospital or in private practice treating Anita for her drug abuse would have been obligated to provide better care to Anita than what she received from NWC and Dr. Schneider.

Appellants' complaints regarding the treatment Anita received from NWC and Dr. Schneider are primarily based on their assertions that: (1) Anita was not opiate dependent, but, instead, was addicted to cocaine and, therefore, NWC and Dr. Schneider should not have administered methadone to Anita for her cocaine addiction; (2) NWC and Dr. Schneider should not have administered methadone to Anita prior to the urinalysis being made available; and (3) Dr. Schneider should have seen Anita personally after the initial interview, rather than having a nurse doing follow-up assessments.

To be admitted to a methadone treatment program, federal regulations require that the patient: (1) have been physically dependent on opiates for at least one year prior to admission to a treatment program, and (2) have a current physiological dependence of opiates. *See* 21 C.F.R. § 291.505 (2001). Current physiological dependence is demonstrated by subjective symptoms, including headaches, backaches, nausea, and insomnia, which are reported by the patient, and objective signs, including dilated pupils, perspiration, and low blood pressure, which are observed by the physician.

Dr. Thomas Payte, appellees' expert, testified that it is within the standard of care to admit a patient, who satisfies the criteria set forth in the federal regulations, to a methadone treatment program if the admitting physician is of the opinion that such treatment is appropriate. Dr. Payte further stated that it is within the standard of care for the physician to consider the patient's subjective complaints and the patient's reported history of current

and past narcotic use. Dr. Payte opined that Anita's subjective symptoms of anxiety, headache, backache, insomnia, and nausea, her statement that she had been taking 15 tablets of Vicodin a day for several years, and objective signs of dilated pupils, perspiration, and low blood pressure are consistent with withdrawal from opiates sufficient to meet the criteria for admission to the methadone treatment program.

With regard to treating a patient who is both opiate dependent and addicted to cocaine, Dr. Payte opined it is within the standard of care to first stabilize the patient with methadone. Dr. Payte testified that once the patient is stabilized, a significant amount of the cocaine use will diminish, and if the cocaine addiction continues, then a cocaine specific intervention will be considered. With regard to administering the initial dose of methadone, Dr. Payte testified the standard of care requires that a urine sample be taken prior to administering the initial dose, but that it is within the standard of care for a reasonable and prudent physician to admit a patient to a methadone treatment program and administer methadone prior to the results of the urinalysis being made available. Finally, Dr. Payte testified it is within the standard of care for a nurse to be responsible for the assessment of patients on their return to the clinic.

Appellants presented evidence on the standard of care through its expert, Dr. George Glass. After reviewing the record, we find the testimony of Dr. Glass is not sufficient to establish the standard of care for treatment of opiate dependent patients with methadone. Unlike Dr. Payte's testimony, Dr. Glass did not testify as to what the standard of care actually is, but, instead, as to what he believes the standard of care should be. For example, Dr. Glass testified:

> Q. Dr. Glass, before the break we were talking about whether it would be necessary if you were exercising that degree of skill and care of a reasonably prudent methadone physician in this community to examine the patient yourself as a physician daily during the induction period. Would you please answer that for us?
>
> A. I think so. I would. I have.

*   *   *

> Q. All the opinions you have expressed today is [sic] your opinion about what the standard of care should be. It is not based on your personal knowledge of what actually is being done by the prudent and reasonable physicians in Harris County?
>
> A. It is not what is being done in the methadone clinics today.
>
> Q. Your opinion is not what is being done; right?
>
> A. That people may be put on methadone before their urine comes back.
>
> Q. And people may be assessed by nurses on their follow-up visits; right?
>
> A. That's true.
>
> Q. That's what is being done; isn't it?
>
> A. Yes.

*   *   *

> Q. Is the gold standard for treating patients in your practice the standard of care for psychiatric treatment of opiate dependent patients higher than the minimum federal standards? In other words, would you do more than simply prescribe methadone and have an LVN [licensed vocational nurse] check your patient daily?
>
> A. Yes, I would.

What a testifying expert personally would or would not have done or what he would like to have seen done under the same or similar circumstances is not sufficient to establish the requisite standard of care. *Jaime v. St. Joseph Hosp. Found.*, 853 S.W.2d 604, 614-15 (Tex. App.—Houston [1st Dist.] 1993, no writ); *Hernandez v. Nueces County Med. Soc. Cmty. Blood Bank*, 779 S.W.2d 867, 870 (Tex. App.—Corpus Christi 1989, no writ); *Hersh v. Hendley*, 626 S.W.2d 151, 159 (Tex. App.—Fort Worth 1981, no writ); *Bearce v. Bowers*, 587 S.W.2d 217, 219 (Tex. Civ. App.—Fort Worth 1979, no writ); *see also Hutchins v. Blood Servs. of Mont.*, 161 Mont. 359, 506 P.2d 449, 452 (1973) (stating expert's "preference does not establish standard of care"); *Hines v. St. Joseph's Hosp.*, 86

N.M. 763, 527 P.2d 1075, 1078, *cert. denied*, 87 N.M. 111, 529 P.2d 1232 (1974) (finding that expert's opinion that standards should be changed was not sufficient to raise issues of material fact on claim of negligence).

Moreover Dr. Glass's opinions are not based on his personal knowledge of what actually is being done by prudent and reasonable health care providers with regard to methadone treatment:

> Q. You have absolutely no idea what is being done in Harris County or any of the surrounding counties in regards to the operation of methadone maintenance programs, do you?
>
> A. Only by reviewing the standards and talking to other doctors.
>
> Q. So the only way you know is by reading what Dr. Payte tells us?
>
> A. And the federal standards and going to continuing education meetings where I learn about what is happening with methadone.
>
> Q. You have no personal knowledge.
>
> A. That is correct.
>
> * * *
>
> Q. . . . [Y]ou don't have personal knowledge of whether or not anything Dr. Schneider did deviated from what reasonable and prudent docs in methadone treatment programs we [sic] are doing in 1994; do you?
>
> A. No.

Finally, Dr. Glass appeared to agree with certain aspects of Dr. Payte's testimony on the applicable standard of care for treatment of opiate dependency with methadone. For example, with regard to whether a physician should personally monitor a patient rather than having a nurse conduct follow-up assessments, Dr. Glass testified the standard of care provides for a nurse to reassess the patient on follow-up visits and does not include the physician seeing the patient on a daily basis:

> Q. And you read Dr. Payte's opinion that it is well within the standard of care to have the nurse reassess the patient on the follow-up?
>
> A. I read that.
>
> Q. That is the standard of care, that is the guideline; isn't it?
>
> A. That is correct.
>
> * * *
>
> Q. You know from Dr. Payte's deposition that the standard of care is not for the physician to see the patient every day and follow up; you understand that?
>
> A. Yes.
>
> * * *
>
> Q. . . . You understand according to Dr. Payte and the state guidelines that the standard of care does not require that the physician see the patient on day two, day three, day four, day five or any of those days that the dose is being increased?
>
> A. Yes.
>
> Q. You just disagree with that?
>
> A. I think there are circumstances that the doctor needs to be called or followed up with; that's true.
>
> * * *
>
> Q. . . . Is it your opinion that [Dr. Payte] would violate the standard of care if he let his nurses do it?
>
> A. He did not violated the minimal standards.
>
> Q. Would it be your opinion that a doctor violated the standard of care if they let a nurse see this patients [sic] on day two, three, four and five, and didn't see the patient personally?
>
> A. Not necessarily.

With respect to whether methadone should be administered prior to the results of the urinalysis being available, Dr. Glass testified the standard of care "most likely" being exercised in Harris County is to begin administering methadone prior to those results being available:

> Q. There was some discussion about the urinalysis that was done in this case. There is no requirement that the urine screen had come back prior to the administration of methadone; correct.
>
> A. That is correct.
>
> Q. In fact, the standard of care in Harris County and the surrounding communities is to begin methadone treatment before the urine screen comes back?
>
> A. That may be what people do at times, yes.
>
> Q. That is the standard of care that is being exercised in this county; isn't it?
>
> A. In general it most likely is.

Appellants claim the trial court erroneously equated the standard of care with NWC's typical practice. Appellants argue custom and industry practice can fall below the level of care required of a reasonably prudent health care provider in the same or similar circumstances. *See Jaime*, 853 S.W.2d at 613 (stating that "[w]hen an entire industry has been negligent, courts have compelled an entire industry to upgrade its standard of care"). Appellants assert the trial court was incorrect in its conclusion that it has "no legal authority to raise the applicable standard of care" and, therefore, ask this court to adopt a "higher" standard of care than that adopted by the trial court. From our review of the trial court's oral rendition and its findings of fact and conclusions of law, we do not find the trial court articulated distinct standards of care for methadone treatment clinics and other health care providers in the area of methadone treatment. Moreover, assuming arguendo, there are two distinct standards of care, one based on the custom and practice of methadone clinics and physicians at methadone clinics and the other based on what hospitals and physicians at hospitals and in private practice do, appellants presented no evidence with respect to the standard of care provided by hospitals and physicians at hospitals and in private practice.

Appellants contend the practice of methadone clinics, even if operating within the parameters of federal guidelines, is not sufficient to satisfy the standard of care. While evidence of government regulations and organizational bylaws is admissible to define the

standard of care, generally such evidence does not conclusively establish that a health care provider satisfied its duty of care to its patients and does not necessarily preclude a finding of negligence. *Hernandez*, 779 S.W.2d at 871. Instead, such evidence is a "factor to consider when determining good, prudent medical care." *Id.*

In *Hernandez*, the plaintiff contracted hepatitis from a blood transfusion, and sued the blood bank alleging it was negligent in failing to conduct two surrogate screening tests on the donor blood she received after surgery. *Id.* at 868. It was undisputed that at the time the plaintiff received the transfusion, neither the Food and Drug Administration nor the American Association of Blood Banks ("AABB") recommended or required the use of those particular tests. *Id.* It was established, however, that a few months after the plaintiff received the transfusion, the AABB recommended and eventually required that all blood banks test every unit of donor blood for that type of hepatitis by use of surrogate testing. *Id.* The court observed there was evidence that other blood banks were already using the tests prior to the AABA mandate. *Id.* at 872. Indeed, "there was evidence the Blood Bank may have *unduly lagged* in the adoption of new screening procedures . . ." *Id.* at 871 (emphasis added). The court held, under the facts of that case, mere compliance with federal and accreditation standards did not conclusively insulate the blood bank from liability. *Id.* at 872. Instead, a fact issue existed concerning the reasonableness of the blood bank's failure to use the surrogate testing. *Id.*

The distinguishing factor in *Hernandez* was there was evidence that other blood banks were using the tests at issue to screen donor blood for hepatitis. As previously noted, appellants introduced no evidence on the standard of care for other health care providers in the treatment of opiate dependent patients with methadone. We find appellants have failed to establish the standard of care with regard to the treatment of opiate dependent patients. The trial court correctly determined the applicable standard of care. Appellants' first and second issues are overruled.

IV. PROXIMATE CAUSE

In their eighth and ninth issues, appellants claim the trial court's finding that NWC and Dr. Schneider's breach of the applicable standard of care did not proximately cause Anita's death was so against the great weight and preponderance of the evidence as to be manifestly unjust. To establish proximate cause, the plaintiff must prove: (1) foreseeability, i.e., that the defendant should have anticipated the danger that resulted from his or her negligence; and (2) cause-in-fact, i.e., that the defendant's negligence was a substantial factor in bringing about the injury and without which no harm would have occurred. *Sloan v. Molandes*, 32 S.W.3d 745, 749 (Tex. App.—Beaumont 2000, no pet.); *Campos v. Ysleta Gen. Hosp., Inc.*, 836 S.W.2d 791, 794 (Tex. App.—El Paso 1992, writ denied). With regard to cause-in-fact, the plaintiff must establish a causal connection based upon reasonable and medical probability, not mere conjecture, speculation, or possibility. *Steinkamp v. Caremark*, 3 S.W.3d 191, 199 (Tex. App.—El Paso 1999, pet. denied); *Arlington Mem. Hosp. Found., Inc. v. Baird*, 991 S.W.2d 918, 922 (Tex. App.—Fort Worth 1999, pet. denied).

The rule of "reasonable medical probability" relates to the showing that must be made to support an ultimate finding of fact and not to the standard by which the medical expert must testify. *Bradley v. Rogers*, 879 S.W.2d 947, 954 (Tex. App.—Houston [14th Dist] 1994, writ denied) (citing *Lenger v. Physicians Gen. Hosp., Inc.*, 455 S.W.2d 703, 706 (Tex. 1970)). That is, reasonable probability is determined by consideration of the substance of the testimony of the expert witness and does not turn on semantics or the use of any term or phrase by the witness. *Arlington Mem. Hosp. Found., Inc.*, 991 S.W.2d at 922 (citing *Burroughs Wellcome Co. v. Crye*, 907 S.W.2d 497, 500 (Tex. 1995)); *Bradley*, 879 S.W.2d at 954. It is not necessary for the plaintiff to establish causation in terms of medical certainty or to exclude every other reasonable hypothesis. *Krishnan v. Ramirez*, 42 S.W.3d 205, 212 (Tex. App.—Corpus Christi 2001, pet. filed) (quoting *Bradley*, 879 S.W.2d at 954) (citing *King v. Flamm*, 442 S.W.2d 679, 682 (Tex. 1969)). Although an expert may testify as to

possible causes of the condition to assist the trier of fact in evaluating other evidence of causation, "a possible cause becomes probable only 'when in the absence of other reasonable causal explanations it becomes more likely than not that the injury was a result of its actions.'" *Blankenship v. Mirick*, 984 S.W.2d 771, 775 (Tex. App.—Waco 1999, pet. filed) (quoting *Parker v. Employers Mut. Liab. Ins. Co.*, 440 S.W.2d 43, 47 (Tex. 1969)).

The trial court found NWC and Dr. Schneider had breached the applicable standard of care, but such breach was not the proximate cause of Anitas' death. The autopsy report showed that at the time of her death, Anita had a blood level of 1700 ng/ml methadone. Dr. Payte testified that for Anita to have had that blood level of methadone, she would have had to ingest at least 320 milligrams of methadone during the 24 hour period prior to her death. Dr. Glass also testified to this fact. Dr. Payte further stated that based on the actual dosage given to Anita in the 24 hour period prior to her death–50 milligrams–her anticipated blood level would be 250ng/ml to 350 ng/ml. The evidence showed that over a period of five days, Anita received only 200 milligrams of methadone from NWC. Appellants did not introduce any evidence showing that Anita had received in excess of 320 milligrams of methadone from NWC in the 24 hour period prior to her death or even that she had received more than 200 milligrams from NWC over a five-day period. Indeed, Dr. Glass stated that Anita had not received from NWC the amount of methadone required for her to have a 1700 ng/ml blood level of methadone.

Appellants rely on two forensic articles on studies concerning the variability of methadone concentrations in blood drawn postmortem.[4] Those articles concern the results of studies showing (1) some variation in methadone concentration levels in blood drawn postmortem depending upon the location of the body or "site" from which the blood was drawn, and (2) higher methadone concentration levels in blood drawn postmortem than in

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[4] *See* Barry Levine, Ph.D., Ann Dixon, M.D. & John E. Smialek, M.D., *Site Dependence of Postmortem Blood Methadone Concentrations*, 16 AM. J. FORENSIC MED. & PATHOLOGY 97 (1995); Richard W. Prouty, B.S., DABFT & William H. Anderson, Ph.D., *The Forensic Science Implications of Site and Temporal Influences on Postmortem Blood-Drug Concentrations*, 35 J. FORENSIC SCI. 243 (1990).

blood drawn prior to death. On the other hand, Dr. Payte testified that the articles show "fairly modest differences, but the differences go in both directions. It is very hard to predict or interpret. A heart level might be higher; it might be lower." Dr. Payte further stated there was not anything in those articles that would cause him to change his opinion regarding the cause of Anita's death. We do not find the evidence supporting the trial court's finding that NWC and Dr. Schneider's breach of the applicable standard of care did not proximately cause Anita's death is so against the great weight and preponderance of the evidence as to be manifestly unjust. Appellants' eighth and ninth issues are overruled.

V. Designation of Expert Witness

In their fifth issue, appellants claim the trial court abused its discretion in allowing NWC to rely on expert testimony from Dr. Schnieder's expert when it had not designated him as its own expert. At trial, appellants' trial counsel objected to NWC's reliance on Dr. Payte's testimony on the basis that NWC had not designated Dr. Payte as its own expert. NWC's trial counsel responded to appellants' objection: "Your Honor, we haven't designated [Dr. Payte] as an expert but he can give his opinion and the trier of fact is free to use it as they could use the testimony from any other witness." The trial court overruled appellants's objection stating that NWC could not call Dr. Payte as a witness, but could ask Dr. Payte questions.

NWC's trial counsel was mistaken when he stated to the trial court that NWC had not designated Dr. Payte as its own expert. NWC's answers to appellants' first set of interrogatories, which were provided to appellants on February 26, 1999, show that in response to appellants' request for the names of experts whom NWC expected to call as expert witnesses at trial, NWC listed: "J. Thomas Payte, M.D.—See Expert's Report and Written Articles." The record reflects that NWC timely designated Dr. Payte as its own

expert.[5] Appellants did not otherwise object to NWC's designation of Dr. Payte as an expert. In light of the fact that NWC had, in fact, designated Dr. Payte as its own expert, the trial court did not abuse its discretion in allowing NWC to rely on Dr. Payte's testimony. Appellants' fifth issue is overruled.

VI. CONCLUSION

We find appellants failed to establish the standard of care through expert testimony and the trial court correctly determined the applicable standard of care. We further find that even if NWC and Schneider had breached the applicable standard of care, the evidence supporting the trial court's finding that their breach was not the proximate cause of Anita's death is not so against the great weight and preponderance of the evidence as to be manifestly unjust. Because appellants cannot establish all the elements of a claim of negligence, we need not address their third, fourth, sixth, and seventh issues concerning NWC and Dr. Schneider's breach of the standard of care. Accordingly, we affirm the judgment of the trial court.

/s/ J. Harvey Hudson
Justice

Judgment rendered and Opinion filed October 25, 2001.

Panel consists of Justices Anderson, Hudson, and Seymore.

Do Not Publish — TEX. R. APP. P. 47.3(b).

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[5] *See* TEX. R. CIV. P. 195.2 (providing for designation of experts by later of 30 days after request is served, or (a) with regard to all experts testifying for party seeking affirmative relief, 90 days before end of discovery period; (b) with regard to all other experts, 60 days before end of discovery period). According to NWC, appellants did not depose Dr. Payte until May 14, 1999, which was more than 60 days after the date NWC had designated him. On March 1, 1999, NWC further filed with the trial court its certificate of filing discovery responses, and on March 9, 1999, its response to appellant's request for disclosure, indicating that all information regarding testifying experts had been previously provided in its answers to appellants' interrogatories.