Affirmed and Majority and Dissenting Opinions filed May 28, 2020.

Fourteenth Court of Appeals

NO. 14-18-00457-CV

TEXAS CHILDREN'S HOSPITAL AND BAYLOR COLLEGE OF MEDICINE, Appellants

V.

SHERRY KNIGHTAND KENNY KNIGHT, INDIVIDUALLY AND AS NEXT FRIENDS OF K.K., Appellees

On Appeal from the 55th District Court
Harris County, Texas
Trial Court Cause No. 2017-16713

MAJORITY OPINION

In this interlocutory appeal, two health care providers, appellants Texas Children's Hospital and Baylor College of Medicine, challenge the trial court's denial of their motions to dismiss under the Texas Medical Liability Act (the "Act").[1] The health care providers contend that the trial court was required to dismiss the

[1] Tex. Civ. Prac. & Rem. Code §§ 74.001-.507; *see* Tex. Civ. Prac. & Rem. Code § 54.014(a)(9) (interlocutory appeals).

claims of appellees Sherry Knight and Kenny Knight, individually and as next friends of K.K. because the Knights' amended expert reports did not meet the requisite requirements under the Act. Because we conclude that the expert reports comply with the requirements of the Act, we affirm the trial court's order.

I. BACKGROUND[2]

This case involves a health care liability claim arising from a post-surgical circulatory complication called "Heparin-Induced Thrombocytopenia," or "HIT,"[3] following a thirteen-hour surgery on Sherry Knight that resulted in the amputation of her hands and feet.

On April 2, 2015, Sherry Knight ("Knight") underwent a heart surgery at Texas Children's Hospital ("TCH") in Houston. Dr. Jeffrey Heinle, a physician employed by Baylor College of Medicine ("BCM"), performed the surgery. In addition to Dr. Heinle and the TCH nurses, from April 2 to April 7 (the date Knight was transferred to St. Luke's Hospital), Knight was under the care of Dr. Ronald Easley, the BCM attending physician tasked with post-operative monitoring, and Dr. Peter Ermis, a BCM cardiologist who also treated Knight post-operatively. On April 4, Knight also was evaluated post-operatively by a critical care fellow, Dr. Brian Rissmiller.

During and after surgery, Dr. Heinle administered the anticoagulant drug heparin, to prevent blood clots. While not common, HIT is a well-known

[2] The expert report at issue in this interlocutory appeal provides the background facts. The medical records are not in the appellate record, and we rely upon the factual statements in the report for the limited purpose of this appeal. *See Bowie Mem'l Hosp. v. Wright*, 79 S.W.3d 48, 53 (Tex. 2002).

[3] The appellate record reflects that HIT is a "clotting disorder of the circulatory system that causes lack of circulation. . . ." "Heparin is routinely used during cardiac surgery." "When Heparin is continued post-operatively there is a danger of HIT."

complication of heparin therapy. When HIT occurs, instead of helping to prevent blood clots as intended, the drug has the opposite effect, inducing low blood platelets, called thromboyctopenia. HIT is diagnosed clinically, based upon physician and nursing assessment of a patient's condition; diagnosis does not require laboratory testing.

On April 4, two days following her surgery, Knight experienced a drop in blood platelets. Additionally, TCH nursing staff documented clinical signs of ischematic compromise (in layman's terms, insufficient blood flow), including coldness and discoloration in Knight's hands and feet. Nurses likewise documented that both Knight and her husband complained that Knight was experiencing pain in her hands and feet.

The next day, April 5, Knight experienced a dramatic drop in her platelet count. Neither Dr. Heinle nor Dr. Easely saw Knight. Her extremities were noted as "cool" in her chart. Knight's extremities were observed to appear "bluish."

On April 6, Knight's test result showed a further, dramatic drop in her platelet count to 39 (normal range: 150-450). Knight was observed and assessed at her bedside by a physician, Dr. Kritz, who ordered she be taken off heparin. A physical therapist noted, "RN and MD aware of [patient's] dusky blue distal UE [upper extremities] and LE [lower extremities] along with sensitivity to pain." Knight was transferred from the intensive care unit ("ICU") to the medical floor at TCH. Upon palpitation of extremities, nurses documented that Knight "screamed out stating that she was in pain." Dr. Sethness was notified of Knight's pain/comfort assessment and was called to Knight's bedside. Dr. Sethness ordered HIT testing.

On April 7, Knight's lab test result returned negative for HIT. In addition to the HIT test, other tests were run to determine potential causes of her circulatory compromise. Heparin was resumed on April 7. On April 7, five days after surgery,

Knight was transferred to St. Luke's Hospital. Heparin continued to be administered at St. Luke's, until Knight tested positive for HIT nearly a week after her transfer. Weeks after her transfer, Knight suffered from necrotic (dead) tissue in her hands and feet and underwent amputation of her hands and feet at St. Luke's Hospital.

In March 2017, Knight and her husband Kenny Knight filed health care liability claims against TCH and BCM, individually and as next friends of their child, K.K. ("the Knights"), for alleged negligence for Sherry Knight's post-heart surgery care at TCH.[4] The Knights timely served TCH and BCM with the report and curriculum vitae of Dr. Mark Murray, a board-certified hospitalist, and Registered Nurse Angela Jones. Both TCH and BCM objected to the reports, alleging the reports failed to meet the requirements of the Act on multiple grounds. The trial court sustained the objections and granted the Knights a 30-day extension of time to amend their reports.[5]

Knight timely filed supplemental expert reports. The hospitals filed separate objections, alleging the reports failed to satisfy the Act's requirements, and moved to dismiss the case because the Knights failed to serve a report satisfying the requirements of the Act within the statutory 120-day deadline.[6] On May 11, 2018, the trial court found both expert reports sufficient, overruled the objections, and denied the hospitals' related motions to dismiss. *See* Tex. Civ. Prac. & Rem. Code § 74.351.

[4] Plaintiffs have a Rule 11 Agreement with counsel for BCM in which BCM stipulates that all the physicians who treated Knight were BCM employees and in the course and scope of their employment in treating her. ***See*** Tex. R. Civ. P. 11.

[5] *See* Tex. Civ. Prac. & Rem. Code § 74.351(c).

[6] *See* Tex. Civ. Prac. & Rem. Code § 74.351(a), (b).

TCH and BCM timely filed interlocutory appeals of the trial court's order overruling their objections to the Knights' Chapter 74 expert reports and denying their motions to dismiss signed by the trial court on May 11, 2018.

II. ANALYSIS

A. Issues

In separate appellate briefs, TCH and BCM assert the trial court abused its discretion by finding the Knights' expert reports were sufficient under the Act and denying their motions to dismiss. Specifically, in its brief, BCM sets forth its sole issue, as follows:

> Did the district court abuse its discretion in finding that Dr. Murray's supplemental report satisfies the TMLA as to Baylor?
>
> A. The TMLA requires a report from an expert that fairly summarizes the standard of care, breach, and causation.
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> B. Knights' report fails to satisfy the TMLA.
>
> 1. The report does not establish that Dr. Murray is qualified in areas relevant to Appellees' claims.
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> 2. The report does not identify the applicable standards of care or how they were breached.
>
> 3. The report fails to explain the causal connection between the care provided and Appellees' injuries

TCH asserts in its brief the following issues:

> I. Whether the trial court abused its discretion by finding Appellees served sufficient Chapter 74 amended expert reports when:
>
> A. Dr. Murray's causation opinions fail to causally connect TCH's and TCH nurses' alleged breaches of their respective standards of care to Ms. Knight's injuries;
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> B. Both experts' proposed standard of care requires TCH nurses to make medical diagnoses and engage in the practice of medicine; and
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> C. Neither expert is qualified to render any opinions on

TCH's policies and procedures.

II. Whether the trial court abused its discretion by denying TCH's Motion to Dismiss when Appellees' failed to serve a sufficient expert report by a qualified expert showing their claims have merit, despite receiving the opportunity to amend each report.

In response, the Knights contend that their experts are qualified, and their reports are sufficient under the Act; hence, the trial court did not abuse it discretion in denying TCH's and BCM's motions to dismiss.

B. Standard of Review

We review a trial court's ruling on a motion to dismiss under Section 74.351 for an abuse of discretion. *Van Ness v. ETMC First Physicians*, 461 S.W.3d 140, 142 (Tex. 2015) (per curiam). A trial court abuses its discretion if it acts arbitrarily or unreasonably or without reference to guiding rules or principles. *Samlowski v. Wooten*, 332 S.W.3d 404, 410 (Tex. 2011). When reviewing matters committed to the trial court's discretion, a court of appeals may not substitute its own judgment for the trial court's judgment. *Bowie Mem'l Hosp. v. Wright*, 79 S.W.3d 48, 52 (Tex. 2002) (per curiam); *Sanjar v. Turner*, 252 S.W.3d 460, 463 (Tex. App.—Houston [14th Dist.] 2008, no pet.).

C. Applicable Law Under Section 74.351

Under the Act, a claimant must serve an expert report on each defendant or health care provider against whom a health care liability claim[7] is asserted not later

[7] The Act defines a "health care liability claim" as:

> a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.

Tex. Civ. Prac. & Rem. Code § 74.001(a)(13). There is no dispute that appellees' claim against TCH and BCM is a health care liability claim.

than the 120th day after the date each defendant's original answer is filed. Tex. Civ. Prac. & Rem. Code § 74.351(a). The purpose of the expert report requirement is to weed out frivolous malpractice claims in the early stages of litigation, not to dispose of potentially meritorious claims. *Abshire v. Christus Health Se. Tex.*, 563 S.W.3d 219, 223 (Tex. 2018); *see Am. Transitional Care Ctrs. of Tex. v. Palacios*, 46 S.W.3d 873, 877 (Tex. 2001); *see also Loaisiga v. Cerda*, 379 S.W.3d 248, 258 (Tex. 2012) ("[Expert report] requirements are meant to identify frivolous claims and reduce the expense and time to dispose of any that are filed."). In accordance with that purpose, the Act provides a mechanism for dismissal of the claimant's suit in the event of an untimely or deficient report. Tex. Civ. Prac. & Rem. Code § 74.351(b).

The statute defines an "expert report" as:

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

Tex. Civ. Prac. & Rem. Code § 74.351(r)(6). It is not necessary that the expert report marshal all the plaintiffs' proof, but it must set forth the experts' opinions on the three statutory elements: standard of care, breach, and causation. *Jelinek v. Casas*, 328 S.W.3d 526, 539 (Tex. 2010); *see also Columbia Valley Healthcare Sys., L.P. v. Zamarripa*, 526 S.W.3d 453, 460 (Tex. 2017). When the adequacy of the expert report is challenged, the issue for the trial court is whether the report represents an objective good-faith effort to comply with the statutory definition of an expert report in subsection (r)(6). Tex. Civ. Prac. & Rem. Code § 74.351(l), (r)(6); *see also Wright*, 79 S.W.3d at 52. The Texas Supreme Court has held that an expert report demonstrates a "good faith effort" when it: (1) informs the defendants of the specific conduct that the plaintiffs have called into question; and (2) provides a basis for the

trial court to conclude that the claims have merit. *Baty v. Futrell*, 543 S.W.3d 689, 693–94 (Tex. 2018). The law limits the trial court's inquiry to the four corners of the report. *Jelinek*, 328 S.W.3d at 539.

To meet these minimum standards, "'the expert must explain the basis of his statements to link his conclusions to the facts.'" *Wright*, 79 S.W.3d at 52 (quoting *Earle v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999)). The expert need not use "magical words" nor is the report held to the same standards as evidence offered on summary judgment or at trial. *Jelinek*, 328 S.W.3d at 540; *Kelly v. Rendon*, 255 S.W.3d 665, 672 (Tex. App.—Houston [14th Dist.] 2008, no pet.). Rather, a valid expert report must discuss the standard of care, breach, and causation with sufficient specificity to meet the Act's stated goals. *Baty*, 543 S.W.3d at 689. As this Court has previously recognized, the expert reports "are simply a preliminary method to show a plaintiff has a viable cause of action that is not frivolous or without expert support." *Kelly*, 255 S.W.3d at 678.

If the trial court concludes that the expert report does not constitute an objective good faith effort to comply with the statute, the court must, on the motion of the affected health care provider, dismiss the plaintiffs' claim with prejudice. Tex. Civ. Prac. & Rem. Code § 74.351(b), (l); *Miller v. JSC Lake Highlands Operations, LP*, 536 S.W.3d 510, 513 (Tex. 2017) (per curiam); *Wright*, 79 S.W.3d at 51–52; *Gannon v. Wyche*, 321 S.W.3d 881, 885 (Tex. App.—Houston [14th Dist.] 2010, pet. denied). If, on the other hand, the trial court concludes that the report represents an objective good faith effort to comply with the Act but is nevertheless deficient in some regard, the court may grant the plaintiffs one thirty-day extension to attempt to cure the deficiency. *See* Tex. Civ. Prac. & Rem. Code § 74.351(c); *Scoresby*, 346 S.W.3d at 556–57; *Gannon*, 321 S.W.3d at 885.

D. Adequacy of Expert Reports

1. Standard of Care

In its first issue, TCH contends that the trial court abused its discretion by denying its second motion to dismiss because Dr. Murray and Nurse Johnson are not qualified to render any opinions on TCH's policies and procedures. TCH further argues that both experts' proposed standard of care requires TCH nurses to make medical diagnoses and engage in the practice of medicine.[8]

BCM maintains in its sole issue that Dr. Murray's report fails to explain how Dr. Murray, a hospitalist, is qualified to opine on the standard of care for BCM physicians who practice multiple specialties.[9] BCM further argues that Dr. Murray's biography fails to establish that he has relevant training or experience in the care at issue, *i.e.*, the post-operative responsibility, if any, of non-hospitalist physicians regarding the diagnosis and treatment of HIT.

a. Qualifications

In order to provide an acceptable report, the expert must establish that he is qualified to do so. Tex. Civ. Prac. & Rem. Code § 74.351(r)(5)(B). The Act provides that an "expert" in a health-care liability claim is qualified to give opinion

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[8] As noted by the Texas Supreme Court in *Columbia Valley Healthcare Sys., L.P. v. Zamarripa*:

> Texas law prohibits nurses from practicing medicine. Tex. Occ. Code §§ 155.001-.003 (providing that no person may "practice medicine" without a medical license); *id*. § 151.002(a)(13) ("'[p]racticing medicine' means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder . . . or injury."); *id*. § 301.002(2), (4)–(5) (barring nurses from "acts of medical diagnosis or the prescription of therapeutic or corrective measures").

526 S.W.3d 453, 461 n.36 (Tex. 2017).

[9] The trial court did not consider Nurse Johnson's report to be a report (under the Act) against BCM, only as to TCH.

testimony regarding whether a health care provider departed from accepted standards of health care if he:

> (1) is practicing health care in a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care provider is an individual, at the time the testimony is given or was practicing that type of health care at the time the claim arose;
>
> (2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and
>
> (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

Tex. Civ. Prac. & Rem. Code § 74.402(b); *see also* Tex. Civ. Prac. & Rem. Code § 74.351(r)(5)(B) ("expert" means "with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402).

The person offering the expert opinion must do more than show that he is a physician, but he "need not be a specialist in the particular area of the profession for which testimony is offered." *Owens v. Handyside*, 478 S.W.3d 172, 185 (Tex. App.—Houston [1st Dist.] 2015, pet. denied). The critical inquiry is "whether the expert's expertise goes to the very matter on which he or she is to give an opinion." *Broders v. Heise*, 924 S.W.2d 148, 153 (Tex. 1996). A physician may also be qualified to provide an expert report, even when his specialty differs from that of the defendant, "if he has practical knowledge of what is usually and customarily done by other practitioners under circumstances similar to those confronting the malpractice defendant," or "if the subject matter is common to and equally recognized and developed in all fields of practice." *Keo v. Vu*, 76 S.W.3d 725, 732 (Tex. App.—Houston [1st Dist.] 2002, pet. denied).

In determining whether an expert witness is qualified based on training or experience, the court considers whether the witness:

> (1) is certified by a licensing agency of one or more states of the United States or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and
>
> (2) is actively practicing health care in rendering health care services relevant to the claim.

Tex. Civ. Prac. & Rem. Code § 74.402(c).

i. Dr. Murray

Here, Dr. Murray is board-certified in internal medicine and as a hospitalist. A hospitalist is a licensed physician who assesses and treats hospitalized patients including those who are pre-surgery, post-surgery, or hospitalized for acute or chronic conditions. Dr. Murray currently practices primarily as a hospitalist; his job is assessing patients from an internal medicine standpoint post-operatively. He has approximately twenty years' experience practicing internal medicine, and he has managed and supervised doctors in emergency centers. In his report, Dr. Murray explained that he works closely with post-operative staff in assessing complications in post-operative patients, which Dr. Murray asserts is the "very issue at the crux of this case."

Dr. Murray's report and *curriculum vitae* provide a basis to conclude that he meets Section 74.402 requirements because he is certified by a licensing agency and has substantial training and experience in the area of health care relevant to the claim at issue in this case; he is also actively practicing health care and rendering health care services relevant to the claims at issue in this case. *See* Tex. Civ. Prac. & Rem. Code § 74.402(c); *Mem'l Hermann Healthcare Sys. v. Burrell*, 230 S.W.3d 755, 762 (Tex. App.—Houston [14th Dist.] 2007, no pet.) (mem. op.).

ii. Nurse Johnson

Nurse Johnson is an experienced registered nurse. Her report provides her nursing experience and expertise, which includes extensive interaction and work with physicians in operative and post-operative situations. Nurse Johnson maintains that she has worked closely with physicians in assessing patients post-operatively for assessment of complications—the issue in this case. Nurse Johnson's report addresses post-surgical hospital procedures, stating that patients who are relatively immobilized are regularly prescribed compression hose, anticoagulant drugs, and regular ambulation to prevent deep vein thrombosis, a clotting disorder. Nurse Johnson further opines that as an endoscopy nurse, she has experience with cardiac patients in the ICU in "intermediate as well as acute conditions[.]"

Nurse Johnson's report and *curriculum vitae* are sufficient to conclude that she meets Section 74.402's requirements as related to TCH and its nurses. As set forth above, she is a registered nurse with extensive experience observing and documenting patient's conditions post-operatively and communicating her observations to physicians. Additionally, Nurse Johnson has experience working with immobilized patients to prevent deep vein thrombosis and is knowledgeable of clinical signs of ischemia and the importance of reporting such clinical findings of ischemic compromise as soon as possible to physicians to obtain a differential diagnosis. She is aware of the steps that should be taken by a nurse if physicians are not responding to or considering circulatory problems that have been reported. Nurse Johnson's report and *curriculum vitae* demonstrate she has training and experience relevant to the claim at issue in this case. *See* Tex. Civ. Prac. & Rem. Code § 74.402(b), (c); *see also Zamarripa*, 526 S.W.3d at 461 n.37 (Although nurse currently practiced in hemotology and oncology areas, "[t]he trial court was within its discretion to determine that Nurse Spears's training as a registered nurse and her

prior experience in the labor and delivery unit qualified her to opine on the standard of care.").

iii. The trial court did not abuse its discretion in concluding Dr. Murray is qualified to render an opinion regarding TCH's post-operative policies and procedures.

TCH maintains that Dr. Murray's *curriculum vitae* does not indicate he has any experience drafting hospital policies and procedures regarding the post-operative care rendered to patients in the ICU. TCH makes this same argument as to Nurse Johnson's qualifications—she has never served on a hospital committee or ever been involved in drafting any hospital policy or procedure. According to TCH, because both lack these qualifications, their expert opinions should have been disregarded.

Contrary to TCH's assertion, Dr. Murray's training and experience as a board-certified hospitalist bear directly on his opinions on standards for post-operative care in a hospital. In his report, Dr. Murray explained that as a board-certified hospitalist, he has diagnosed many patients with having clotting disorders or other ischemic compromises, and that he works closely with nursing staff and ICU and post-operative staff in assessing patients post-operatively for complications. Additionally, as a hospitalist, Dr. Murray stated in his report he "train[s] and educate[s] nursing staff about post-operative qualifications and how to report, document, and follow up with surgeons and hospitalists about such complications." Given his experience, Dr. Murray explained that he would expect to see policies and procedures for follow-up of patients in post-operative ICU situations, including the sharing of information through rounds. Dr. Murray is qualified to state the standard of care for the hospital because his report states he has experience and was involved with the type of claim at issue. *See Tenet Hosps. Ltd. v. Barnes*, No. 08–09–00093–

CV, 2010 WL 2929520, at *7–8 (Tex. App.—El Paso July 28, 2010, no pet.) (mem. op).

As such, the trial court did not abuse its discretion in concluding that Dr. Murray is qualified to render an opinion regarding the post-operative policies and procedures that are at issue in this case.

iv. The trial court did not abuse its discretion in concluding that Dr. Murray is qualified to render an opinion concerning the standard of care with respect to BCM physician's monitoring for post-operative complications.

BCM concedes that Dr. Murray is qualified to opine about hospitalists and internal medicine but argues that he is not qualified to testify concerning the post-operative responsibility, if any, of non-hospitalists physicians regarding diagnosis and treatment of HIT. Additionally, BCM argues there is nothing to indicate he gained the requisite experience or training to offer an opinion on the standard of care applicable to heart surgeons, cardiologists, and anesthesiologists. BCM's argument ignores the plain language of the statute, which focuses not on the defendant doctor's area of expertise, but on the condition involved in the claim. *See Blan v. Ali*, 7 S.W.3d 741, 746 (Tex. App.—Houston [14th Dist.] 1999, no pet.) ("there are certain standards of medical care that apply to multiple schools of practice and any medical doctor."). Regardless of each BCM physician's particular specialty, Dr. Murray is qualified to opine concerning the standard of care with respect to monitoring for post-operative complications because the standard of care with respect to post-operative follow up is the same regardless of what other specialized knowledge a physician may have:

> The standard of care applicable to surgeon Heinle, attending Easely and consultant Ermis for post-operative patients regardless of what the surgery is or was is to follow up on the patient's status and to check for

> post-operative complications. This is basic medicine whether the surgery is minor or major. As explained below in connections [sic] with my qualifications, this kind of follow-up is what I do as a hospitalist in conjunction with other physicians depending on the type of case, but regularly in post-operative situations.

As Dr. Murray explained in his report, unless a hospitalist is tasked with post-operative care and monitoring, it is routine and standard practice for the surgeon, attending physician, and consulting physicians to assess and follow the patient post operatively. His report states, "In current hospital practice, if there is no internal medicine physician following the patient post-surgery, it is the responsibility of the surgeon and the attending physician to follow the patient and seek appropriate consultations with specialists when complications occur." Dr. Murray specifically stated that in his practice as a hospitalist, he works closely with ICU and post-operative staff in assessing patients post-operatively for assessment of complications.

The trial court did not abuse its discretion in concluding that Dr. Murray is qualified to render an opinion concerning the standard of care with respect to BCM physician's monitoring for post-operative complications.

b. Applicable standards of care

To adequately identify the standard of care, an expert report must provide "specific information about what the defendant should have done differently." *Abshire*, 563 S.W.3d at 226; *Palacios*, 46 S.W.3d at 880. Again, the Act requires only a "fair summary" of the standard of care and how it was breached; that is, the expert report "must set out what care was expected, but not given." *Id*. (internal quotation omitted).

i. TCH

TCH argues that both experts proposed standard of care requires TCH nurses to make medical diagnoses and engage in the practice of medicine. Dr. Murray and Nurse Jones both opined that the applicable standard of care required the TCH nurses to go beyond making the minimal clinical notations that the TCH nurses made here. Instead of merely noting Knight's circulatory distress, the nurses should have promptly and directly informed the physicians as soon as the signs of circulatory distress appeared. According to Dr. Murray and Nurse Jones, when clinical symptoms of circulatory distress appeared on April 4, instead of merely making notations in the chart, the nurses should have directly communicated their observations to the physicians. Dr. Murray opines:

> In the case of HIT, the standard of care requires that once this condition is suspected clinically, by visual examination and patient complaints (as opposed to being confirmed by laboratory tests), waiting for confirming lab tests takes too long. Heparin must be stopped because the drug is among the most likely cause [of] the blood clotting problem. The standard of care for nursing staff in this situation, on finding reliable complaints confirmed by clinical notations of coolness and dusky extremities (feet and hands) post-surgery is to notify physicians of these findings. It is not enough to minimally document these findings in nursing notes—these findings are consistent with a dangerous and emergency condition that literally threatens life and limb.

Dr. Murray further opined that TCH "did not have a policy or procedure for post-operative assessment and did not have a hospitalist in charge of the patient, or if the hospital had a policy or procedure to assure post-operative assessments and appropriate intervention, that policy or procedure was not followed."

Nurse Jones echoed Dr. Murray's opinion, explaining that in this case, the applicable standard of care required the nurses to promptly report their clinical findings directly to the physicians instead of merely noting them in their charts:

> Under applicable standards of care, and those that apply to nursing staff or Texas Children's Hospital, nurses are expected to and are trained to assess patients for post-operative and post procedure complications and are required to make and document their findings, especially those that indicate serious complications or distress. More importantly, nurses in post-operative situations (including endoscopy) are required to notify physicians when they come across findings of this kind—compromised circulation in the patient's extremities so that physicians can make appropriate interventions and alterations in treatment such as stopping or substituting drugs, administering transfusions or taking the patient to surgery or other treatment, particularly when emergency or acute conditions are recognized.

Nurse Johnson adds that a nurse is not tasked with determining the cause of the bleeding, but she is required to inform the physician directly rather than simply making a note in a chart and walking away:

> So again, to clarify—this is not a case of failure of nursing staff to diagnose a complicated blood disorder. It is a case of failure of nursing staff (names and dates are in the chronology) [to show] that Dr . Heinle, Dr. Easely, and Dr. Ermis were not notified by nursing staff of early findings of coolness, pain, and dusky nailbeds and extremities. An analogy may be helpful. This is like a case where a patient comes into a medical office or an emergency room with uncontrolled bleeding; the nurse has to know this is a serious condition and may not know the cause but must report this timely to doctors so doctors can figure out what is going on with the patient.

Here, Dr. Murray and Nurse Johnson do not opine that the nurses should have *diagnosed* HIT. Rather, the expert reports state that the nurses were required to immediately and directly report the symptoms of ischemic compromise to the doctors so that the doctors had the necessary information to make an accurate diagnosis. This it is sufficient to satisfy the requirements of the Act at this stage of the litigation. *See Abshire*, 563 S.W.3d at 227.

ii. BCM

BCM contends that Dr. Murray does not differentiate between the BCM physicians' various specialties. As set forth above, BCM's contention misses the mark.

The Knights' health care liability claims involve the negligent conduct of three BCM physicians: Dr. Heinle, the surgeon who performed her cardiac revision surgery; Dr. Easley, the attending physician for post-operative monitoring and care, and Dr. Ermis, the cardiology physician who saw Knight post-operatively. Dr. Murray explained that the applicable standard of care required each physician to see and assess Knight post-operatively after her cardiac surgery, which included personally reviewing her condition and reading nursing notes that reflected the basic assessments the nurses had performed:

> All these doctors—Heinle, Easely and Ermis, under applicable standards of care that are not at all controversial and apply to all three, had the responsibility for following up on post-operative findings of circulatory distress reported by nursing staff in the ICU. Heinle should have been consulted because the problem could be related to a difficulty from the surgery. Easely was the admitting doctor and had a duty to follow the patient from an internal medicine standpoint (as I do as a hospitalist who is also Board-Certified in Internal Medicine); he should have examined the patient as explained below and above for her status or at least conferred with Dr. Ermis, the cardiologist, the physician who saw the patient and had a duty to examine the patient and to confer with nursing notes identifying the signs of circulatory compromise two days post-operatively.

Dr. Murray added that because each of the three physicians knew that Knight was being treated with heparin post-operatively, each physician had an independent duty to see and assess her after surgery:

> It is routine and standard practice and standard of care for the surgeon, Dr. Heinle, the attending Dr. Easely (usually an Internal Medicine

> physician) and consultants in cardiology, Dr. Ermis (a subspecialty of Internal Medicine) to see and assess the patient post-operatively after cardiac surgery, including review of the patient's condition considering nursing notes that reflect basic assessments done by nurses. Nurses are taught what are called ABC—Airway, Breathing, Circulation. These are basic nursing assessments and circulation is all about inspection of the patient's extremities to see if there are signs of ischemic compromise as happened in this case. But it is no excuse if the physician himself or herself does not assess the patient after reviewing the nurses' findings. In this case, the records show that the nurses' findings were not reported to the physicians, Dr. Heinle, Dr. Easely, or Dr. Ermis. But these physicians did not review or adequately assess the patient post-operatively—they know more than nurses do and only they can make diagnoses. Dr. Ermis, cardiology consultant, saw the patient and had the opportunity to review reports of ischemic compromise shortly after the surgery that occurred on April 2, 2015. All of these physicians, Dr. Heinle, Dr. Easley and Dr. Ermis, knew that the patient had been on Heparin continuously intra-operatively and post-operatively. Any trained Internal Medicine physician or Hospitalist would know that signs of ischemia (lack of blood flow to the body) following cardiac surgery could be the result of HIT and that Heparin administered postoperatively is causing the life-threatening condition.

Dr. Murray further explained that if Dr. Heinle, a busy surgeon, did not have the time or opportunity to examine Knight, Dr. Heinle should have followed up with the admitting physician, Dr. Easely, and the consultant, Dr. Ermis. Dr. Easely, as admitting physician, had a duty to follow the patient from an internal medicine standpoint; he too should have examined Knight or at the very least conferred with Dr. Ermis, the cardiologist who did examine the patient. Yet neither Drs. Heinle nor Easley saw Knight after her surgery or performed their own assessments. Of the three, only Dr. Ermis saw Knight, and he failed to examine Knight's extremities or confer with nursing staff or review their notes.

Moreover, Dr. Murray explained that Drs. Easely and Ermis had a duty to examine Knight's extremities during "rounds" and, upon observing her serious

symptoms of circulatory failure, to consult with Dr. Heinle or a hematologist regarding the discontinuation of heparin:

> [D]r. Easely or the cardiology consultant Dr. Ermis, under standards of care that apply to post-surgical patients, have a duty to examine the patient in "rounds" or in daily evaluations to assess the patient in four basic areas—the heart, the lungs, the abdomen and the extremities, regardless of whether a nurse or nurses have documented in the chart their assessments. Examination of the extremities is in part to ascertain the integrity of peripheral circulation. There is no documentation of this standard practice in the TCH chart. Had the physicians Easely or Ermis done these examinations post-surgery and coordinated their examinations with discussions with nursing staff, early on two days post-surgery, they would have to consider that a serious circulatory problem existed based on the dusky, cool, and discolored extremities and the complaints of the patient. These failures are a major failure to follow standards of care and caused delay in consideration of differential diagnosis and consideration of what was causing the problem, including consultation with the surgeon or a hematologist, if necessary to the consideration of continued use of Heparin.

Dr. Murray's report clearly informs BCM (1) of the standard of care that was expected from each physician and (2) that the standard of care was not followed.

2. Breach and Causal Connection

"[A]n expert must explain, based on facts set out in the report, how and why a health care provider's breach of the standard of care caused the injury." *Zamarripa*, 526 S.W.3d at 459–60 (citation and brackets omitted). "A bare expert opinion that the breach caused the injury will not suffice." *Id*. at 460 (citation omitted).

"Proximate cause has two components: (1) foreseeability and (2) cause-in-fact. For a negligent act or omission to have been a cause-in-fact of the harm, the act or omission must have been a substantial factor in bringing about the harm, and absent the act or omission—*i.e.*, but for the act or omission—the harm would not

have occurred." *Id*. (citation omitted). "This is the causal relationship between breach and injury that an expert report must explain to satisfy the Act." *Id*.

a. TCH

TCH contends that Knights' expert reports fail to provide a fair summary of the causal connection between TCH's and its nurses alleged failure to meet that standard and Knight's injuries. Additionally, TCH maintains Dr. Murray's proximate cause opinions are insufficient because he fails to adequately explain "how and why" TCH's and its nurses' alleged breach of the standard of care caused Knight's injury.

i. TCH Nurses

As to TCH nurses, Dr. Murray's causation opinion appears to be summarized as follows:

> The delay appears to be from 36-48 hours in recognizing the problem and then the patient was tested for HIT. The patient should have been taken off Heparin on April 4 when the symptoms of ischemia were noted by nursing staff (and when physicians should also have been notified and also examined the patient). This would have led to alternative measures [sic] should have been implemented that would have prevented this medical catastrophe.

Dr. Murray also opines:

> [T]here is little to no documentation of communications of [the findings of early ischemic compromise] by nursing staff to the attending physician or to the surgeon on April 4. This is a major failure on the part of nursing staff and as explained below, this is below the standards of care. Physicians who assess patients postoperatively . . . depend on communications by nursing staff about the patient's condition. As explained below, this is a system failure and the nursing staff and physicians failed to follow the standards of care causing this patient to continue to deteriorate and lose to amputation her hands and feet.

TCH argues that Dr. Murray's report fails to explain why administering heparin would have been stopped earlier if the nurses had verbally communicated additional information the physicians were already aware of and tested for. Additionally, TCH asserts that the report fails to provide an explanation why, based on additional reporting, the physicians would have retested for HIT or tested earlier. Finally, TCH alleges there is no explanation as to how the nurses "had either the right or the means to persuade" the physicians (either at TCH or St. Luke's) that heparin should be stopped or that Knight should be re-tested for HIT based on the assumption that the lab result produced a "false negative." Moreover, TCH argues that Dr. Murray does not explain the illusive "alternative measures" that would have altered the course of treatment and changed the outcome for Knight based on additional reporting by TCH's nurses. According to TCH, this incomplete causation opinion requires the Court to impermissibly fill "analytical gaps and missing links which render [Dr. Murray's] opinion conclusory." *Davis*, 542 S.W.3d at 25 (rejecting expert report for conclusory causation opinion regarding nurses alleged failure to diagnose and report without explaining how, but-for that act or omission, the patient's injuries would not have occurred).[10]

Next, TCH maintains that Dr. Murray's report fails to make any statement regarding foreseeability as to TCH's nurses. Rather, in recognizing the dangers of failing to investigate, it simply states:

> [T]he danger of progression of ischemic compromise and dangers to life and limb are foreseeable because these findings are consistent with a general circulatory failure such as heart failure or a clotting disorder.
>
> [T]he clinical signs of likely HIT as well as later drops in platelet count should have alerted the attending physicians as well as nursing

[10] To the extent these authorities require an expert to do anything more than link the breach of the standard of care to the injury, they are in conflict with *Abshire*, 563 S.W.3d at 226-27.

> personnel to the possible likelihood of a drug reaction causing these complaints and clinical findings.

According to TCH, the "possible likelihood of a drug reaction" and "progression of ischemic compromise" does not explain why any provider, let alone TCH nurses, would foresee HIT nearly a week after Knight left TCH, at a time when she was under the care of another hospital.

ii. TCH

TCH contends that "[f]or the same reasons Dr. Murray could not explain why additional reporting from TCH nurses would have changed the outcome, he cannot establish causation directly against TCH."

Dr. Murray makes the following statements regarding TCH's alleged breach (implementing certain post-operative policies and procedures) and how that breach caused Ms. Knight's injuries:

> Hospitals today have chest pain protocols, sepsis protocols, charting requirements, transfer criteria, and many other policies and procedures for monitoring patient care. As a hospitalist charged with following patients pre-operatively and post-operatively, I would expect to see some policies and procedures for follow-up of patients in postoperative ICU situations. If TCH . . . had such policies, they would include the standards I have outlined above and applicable standards of care require them. If they existed as required by standards of care, they were not followed and resulted in delayed consideration of this patient's status and caused her to deteriorate to the point that her ischemic compromise led to amputations of her hands and feet.
>
> [BCM and TCH] should have had policies and procedures requiring that the patient be regularly assessed for possible complications and consultation of appropriate physicians, including in this case hematology, i.e., blood and circulation experts that are of course readily available in a medical school and teaching hospital . . . . [TCH and BCM] did not have a policy or procedure for post-operative assessment and did not have a hospitalist in charge of the patient, or if the hospital

> . . . a policy or procedure to assure post-operative assessments and appropriate intervention, that policy or procedure was not followed.

In its appellant's brief, TCH argues that the only basis for this court to find causation in Dr. Murray's report, is for the court to assume that if the procedures advocated by Dr. Murray were in place—the nurses would have informed the physicians faster, the physicians would have ignored a negative HIT result and discontinued heparin, and heparin would have also been discontinued after Knight was transferred to St. Luke's—in effect requiring the court to fill in analytical gaps, which the court may not do. *See Abshire*, 563 S.W.3d at 226.

TCH further contends that any alleged breach by TCH is simply too attenuated from Knight's injuries to be a substantial factor, and further, that there is no explanation as to why Knight's injuries would not have occurred if TCH had implemented these alleged policies and procedures. TCH asserts because HIT was considered and ruled out after a negative lab result, no amount of additional reporting by the nurses would have altered the course of treatment for Knight.

Lastly, TCH argues that these proposed standards require nurses to practice medicine, to go beyond merely observing and assessing, and to second-guess the treatment decisions of the patient's physicians.

Dr. Murray opines:

> The clinical signs of likely HIT as well as later drops in platelet count should have alerted the attending physicians as well as nursing personnel to the possible likelihood of a drug reaction causing these complications and clinical findings.
>
> When nursing staff are aware of complications . . . and no physicians are responding or intervening, nursing staff are required to follow what is called a "chain of command"—notify their supervisors of the lack of attention to the patient's complications . . . .

b. BCM

BCM argues that Dr. Murray's report fails to inform BCM of the specific conduct criticized and fails to specify what care was expected but not given. Additionally, BCM maintains that Dr. Murray's expert report fails to explain the causal connection between the BCM physicians' purported breaches of the applicable standard of care and Knight's injuries. BCM further argues Dr. Murray's report does not connect discontinuance of the heparin between April 4–7 to avoidance of Knight's necrosis and eventual amputation at St. Luke's.

In response to both TCH and BCM challenges, the question before us is not whether Dr. Murray's and Nurse Johnson's statements about the standard of care and its breach are accurate. Rather, at this stage of the proceeding, we assume that the statements are accurate and ask whether the report is specific and sufficient to enable the trial court to determine whether the claims lack merit. Indeed, in *Abshire*, the Texas Supreme Court was careful to note that at this stage, the court's job is not to weigh the report's credibility; the court's disagreement with the expert's opinion does not render the report insufficient or conclusory:

> The ultimate evidentiary value of the opinions proffered by Dr. Rushing and Nurse Aguirre is a matter to be determined at summary judgment and beyond. In this regard, the court of appeals improperly examined the merits of the expert's claims when it identified what it deemed an "analytical gap." But at this stage we do not require a claimant to "present evidence in the report as if it were actually litigating the merits."

Abshire, 563 S.W.3d at 226 (citing *Palacios*, 46 S.W.3d at 879). Following *Abshire*, there can be no genuine dispute that Dr. Murray's causation opinions satisfy the Act. Dr. Murray explained that the TCH nursing staff's failure to notify the physicians of obvious signs of circulatory distress caused a delay in the BCM physicians' HIT diagnoses, which led to Knight's injury:

> Nurses' recognition of ischemic compromise (lack of blood flow or insufficient blood flow to the patient's hands and feet) were documented in the chart early on, as early as two days post- operatively but not communicated effectively to physicians who have the duty and responsibility to investigate the cause of this dangerous condition that literally threatens life and limb.

The expert reports are consistent with the statutory requirements, providing: (1) a fair summary of the applicable standards of care; (2) the manner in which TCH nurses and BCM physicians failed to meet those standards; and (3) the causal relationship between that failure and the amputation of Knight's hands and feet. *See* Tex. Civ. Prac. & Rem. Code 74.351(r)(6). Thus, the reports are sufficient to satisfy the requirements of Chapter 74 at this stage of the litigation. *See Abshire*, 563 S.W.3d at 227.

The trial court did not abuse its discretion by denying TCH and BCM's motions to dismiss. TCH's first issue is overruled. In light of this holding, it is not necessary to the disposition of the appeal to address TCH's remaining issue. *See* Tex. R. App. P. 47.1. BCM's sole issue on appeal is overruled.

III. CONCLUSION

Accordingly, we affirm the trial court's May 11, 2018 order.

/s/ Margaret 'Meg' Poissant
Margaret "Meg" Poissant
Justice

Panel consists of Chief Justice Frost and Justices Spain and Poissant. Majority Opinion delivered by Justice Poissant (Frost, C.J., dissenting).