REVERSE and REMAND and Opinion Filed July 8, 2020

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-19-01129-CV

WILLIAM NIX, INDIVIDUALLY AND AS REPRESENTATIVE OF THE ESTATE OF LINDA NOELLE NIX, DECEASED, Appellant
V.
CHARLES S. CHANG, M.D., INDIVIDUALLY AND D/B/A CHANG NEUROSURGERY & SPINE CARE, Appellee

On Appeal from the 416th Judicial District Court
Collin County, Texas
Trial Court Cause No. 416-05813-2018

MEMORANDUM OPINION

Before Justices Bridges, Pedersen, III, and Evans
Opinion by Justice Evans

Appellant William Nix ("Nix"), individually and as representative of the Estate of Linda Noelle Nix ("Linda"), deceased, appeals the trial court's dismissal of a health care liability claim filed under the Texas Medical Liability Act. In five issues, Nix asserts the trial court abused its discretion by granting the dismissal motion filed by appellee Charles S. Chang, M.D., individually and doing business as Chang Neurosurgery & Spine Care (collectively, "Chang"), because: (1) C. Warren Adams, M.D. is qualified to offer expert opinions on standard of care;

(2) Adams' supplemental report sufficiently identifies the standard of care and breaches thereof; (3) Adams is qualified to offer expert opinions regarding causation; (4) Adams' opinions on causation were not conclusory; and (5) the trial court "judged the credibility of the report based on the court's assessment that Chang's counsel did not 'agree' with the statements in the report." We reverse and remand for further proceedings consistent with this opinion.

BACKGROUND

Linda was a 30-year old female with multiple comorbidities for her age including a history of hyperthyroidism, hypertension, neuroblastoma, mild renal insufficiency, history of congenital bicuspid aortic valve and clinical congestive heart failure symptoms. Linda's cardiologist referred her to a cardiovascular surgeon and a surgical evaluation was performed on April 14, 2016. A second follow-up with the cardiovascular surgeon was performed on June 24, 2016, and the surgeon recommended a combination of aortic valve replacement with ascending aortic aneurysm repair.

On August 15, 2016, Linda was admitted to Baylor Scott & White The Heart Hospital – Plano ("Baylor Heart") for surgery to replace an aortic valve with a metallic valve and the ascending aorta was replaced with a graft. Notes in her medical chart indicate on August 18, 2016, at approximately 10:00 a.m., the physical therapist could not complete his therapy because Linda could not keep her eyes open or stand without losing her balance. At 11:00 a.m., a nurse noted that Linda was

unsteady and that her left pupil was greater than the right. The nurse informed the doctor on duty and the doctor ordered a CT scan. The CT scan revealed a left subdural-arachnoid bleed. The anticoagulant medication prescribed for the metallic valve was discontinued and a neurosurgical consultation was obtained from Chang.

Linda was transferred from Baylor Heart to Baylor Regional Medical Center at Plano ("Baylor Plano"). Chang recommended "emergent 'burr-hole' placement for drainage of this acute subdural hematoma." On August 18, 2016, Chang performed the procedure and Linda remained at Baylor Plano under Chang's care. On August 19, 2016, Chang spoke with Linda's cardiovascular surgeon about the timing of commencing anticoagulation medication because of Linda's metallic valve. Chang indicates in his notes "no contraindication to anticoagulation" and started Heparin per protocol with transition to oral Coumadin on August 25, 2016.

On August 28, 2016, the physical therapist documented Linda's complaint of chest pain and shortness of breath. On August 30, 2016, Chang's progress notes indicated that Linda was stable with normal vital signs and would be discharged imminently. On August 30 and 31, 2016, Linda complained of shortness of breath and chest pains. A nurse noted tightness in the chest and notified a doctor and was told to give Linda morphine. On the afternoon of August 31, 2016, the physical therapist documented that Linda was unable to complete treatment due to shortness of breath and tachycardia, and one-sided weakness was observed. At approximately

3:31 p.m. on August 31, 2016, Linda suffered a cardiac arrest and was pronounced deceased at 4:20 p.m.

Nix filed a lawsuit against Chang which asserted health care liability claims regarding his treatment and care of Linda. On March 29, 2019, Nix served the expert report of Adams ("initial report"). In response, Chang filed objections to the initial report and moved to dismiss the case. On May 15, 2019, the trial court sustained Chang's objections and granted Nix thirty days to cure the deficiencies in the initial report. On June 13, 2019, Nix served Adams' supplemental expert report dated May 22, 2019 ("supplemental report"). On July 3, 2019, Chang filed objections to the supplemental report and moved to dismiss the case. On August 19, 2019, the trial court sustained Chang's objections and dismissed Nix's claims with prejudice ("August 19 order"). Nix then timely filed this appeal.

ANALYSIS

A. Standard of Review

We review the trial court's ruling on an expert report's sufficiency for abuse of discretion. *Van Ness v. ETMC First Physicians*, 461 S.W.3d 140, 142 (Tex. 2015). In analyzing a report's sufficiency under this standard, we consider only the information contained within the four corners of the report. *See Abshire v. Christus Health Southeast Texas*, 563 S.W.3d 219, 223 (Tex. 2018). Appellate courts defer to the trial court's factual determinations if they are supported by the evidence but review its legal determinations de novo. *See Van Ness*, 461 S.W.3d at 142. A trial

court abuses its discretion if it acts arbitrarily, unreasonably, or without reference to any guiding rules or principles. *Id.*

B. Expert Qualification

In his first and third issues, Nix argues that Adams is qualified to offer expert opinions. In a suit involving a health care liability claim against a physician for injury to or death of a patient, "a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who: "(1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose; (2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care." TEX. CIV. PRAC. & REM. § 74.401(a). "In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness (1) is board certified or has other substantial training or experience in an area of medical practice relevant to the claim and (2) is actively practicing medicine in rendering medical care services relevant to the claim." *Id.* at §74.401(c).

i) Standard of care and breaches of standard of care

It is important to explain the scope of Adams's opinions in order to properly analyze his qualifications to express them. As we noted above, Adams is a board-

certified cardio-thoracic surgeon while Chang is a neurosurgeon. Here is what we discern to be the core of Adams's opinions pertaining to the standard of care when a patient's changed condition requires neurosurgeons to interface with cardio-thoracic surgeons:

> If the patient begins to experience complications, such as Ms. Nix's tachycardia, one-sided weakness, chest pain and shortness of breath, *that are outside the neurosurgeon's expertise*, it is the standard of care and the neurosurgeon's responsibility and duty to convey those changes in condition and/or complications to the appropriate healthcare provider, in this case, Ms. Nix's cardiovascular surgeon and/or arrange a timely transfer or consultation. Further, if the neurosurgeon has taken on the patient's cardiac care, such as Dr. Chang did in this case as he was Ms. Nix's attending physician at Baylor Plano, if he is not going to call in a cardiovascular surgeon to address the complications, it is the standard of care for him to address the complications himself.

(emphasis added). Thus, the essence of Adams's opinion is that regardless of Chang's expertise as a neurosurgeon, once he took over Linda's care and cardio-thoracic issues arose Chang either had to obtain the involvement of Linda's cardio-thoracic surgeon or treat those cardiac issues himself. To be sure, Adams has far more detailed opinions in his report filling out this thematic opinion. But this core opinion is indicative of the scope of Adams's opinions.

We do not concern ourselves with the force of logic of Adams's core opinion at this point. He must state in his report in sufficient detail how he is qualified to render his opinion about the standard of care pertaining to a neurosurgeon in this interface context. So, we examine Adams's report for qualifications with this scope of opinion in mind.

In Chang's motion to dismiss, he argued that Adams, a cardiovascular and thoracic surgeon, could not opine on the standard of care or the breaches of the standard of care because the case required a neurosurgeon's expertise. Chang argued "Adams does not make any assertions of expertise pertaining to a neurosurgeon's duties when providing post-neurosurgical care and monitoring of a patient such as Ms. Nix." Chang noted that "the expert report does not demonstrate how Dr. Adams' knowledge, skill, training, or education qualifies him to render an opinion about the particular breaches of the standard of care applicable to a neurosurgeon."[1] To support these assertions, Chang relies on *Jepson v. Wyrick*, No. 02-18-00148-CV, 2019 WL 2042303 (Tex. App.—Fort Worth May 9, 2019, no pet.) (mem. op.) (expert radiologist failed to explain basis for his familiarity regarding standard of care for a nurse practitioner to communicate diagnostic impressions and findings to patient), *Mangin v. Wendt*, 480 S.W.3d 701 (Tex. App.—Houston [1st Dist.] 2015, no pet.) (expert anesthesiologist failed to provide a sufficient explanation how his qualifications would allow him to opine that a cardiologist breached the standard of care by manner in which he managed complications of the stent insertion or by

[1] Nix asserts that this first issue need not be addressed based on the trial court's oral pronouncements that it would "overrule the objection as to qualifications." The trial court, however, granted Chang's objections without limitation. Accordingly, the trial court granted Chang's objection regarding Adams' qualification to opine on the standard of care, because a trial court's final written order prevails over its oral pronouncements. *See Kaur-Gardner v. Keane Landscaping, Inc.*, No. 05-17-00230-CV, 2018 WL 2191925, at *4 (Tex. App.—Dallas May 14, 2018, no pet.) (mem. op.) ("the trial court's written conclusion that [the parties] had an express contract controls over the trial court's oral statements that a contract did not exist."); *Sherman v. Triton Energy Corp*., 124 S.W.3d 272, 279 (Tex. App.—Dallas 2003, pet. denied) ("the written final judgment prevails over the prior oral pronouncement"). Thus, we determine this issue on the merits.

alleged delay in seeking assistance from other specialists), and *Methodist Hospitals of Dallas v. Winn*, 496 S.W.3d 148 (Tex. App.—Dallas 2016, no pet.) (expert was a former emergency room physician who was not "actively practicing health care in rendering health care services relevant to Winn's claims").

In these cases on which Chang relies, the expert's qualifications were challenged because the expert was opining about areas (1) outside of his or her expertise; (2) not sufficiently explained in their report; or (3) in which expert was not actively practicing. In this case, however, Adams is a practicing board-certified cardiovascular and thoracic surgeon and he opined about the specific issue at hand: the standard of care owed to a patient in a post-surgical cardiac setting with management of ongoing cardiac issues. Linda was a cardiac patient who underwent cardiac surgery and required a neurosurgical procedure following her cardiac surgery. While Linda was recovering from cardiac surgery, she exhibited symptoms of ongoing cardiac issues. Adams pointed out, Linda's symptoms were "tachycardia, one-sided weakness, chest pain and shortness of breath, *that are outside the neurosurgeon's expertise*" but for which Chang was responsible because "the neurosurgeon has taken on the patient's cardiac care, such as Dr. Chang did in this case as he was Ms. Nix's attending physician at Baylor Plano." (emphasis added). Adams noted that he was familiar with "the postoperative care of patients undergoing similar cardiovascular surgical procedures as performed on Mrs. Nix" and that as a result of his training, his personal clinical and teaching experience and

his position as an attending physician that he was "familiar with and knowledgeable about the applicable standards of care which govern all aspects of the delivery of healthcare in a post-surgical critical care or intensive care setting, including the care provided by non-cardiac consulting specialists such as neurosurgeons." He further addressed Chang's concerns regarding his qualifications in his supplemental report as follows:

> I routinely interact and consult with with [sic] neurosurgeons when they have evaluated or treated patients in a post-surgical critical care setting, so I understand what the limitations and standard of care is for neurosurgeons in the same or similar circumstances. As a cardiothoracic surgeon, I directly diagnose and treat cardiac medical conditions, and, when confronted with certain issues, I myself obtain consultations, diagnoses or confirmation of my own diagnoses from other physicians having particular specializations, including neurosurgery. In such cases, while I may not be a neurosurgeon nor a specialist in that area of medicine, I am knowledgeable about the same, and I will actively collaborate with the neurosurgeon or specialist in the development and implementation of diagnostic and treatment strategies. I also routinely participate and communicate with neurosurgeon specialists in ensuring there is a coordinated plan of care for post-surgical patients such as Ms. Nix. Thus, through my training, experience and knowledge I am fully aware of and knowledgeable about the standard of care applicable to Dr. Chang, a neurosurgeon called in to consult on a postsurgical neurological complication that Ms. Nix experienced that involves management of ongoing cardiovascular issues.
>
> Further, as a cardiac surgeon, I am familiar with the generally available diagnostic and treatment modalities for a patient, such as Ms. Nix, experiencing symptoms of shortness of breath, tachycardia, chest pain and one-sided weakness in a post-operative setting. I am familiar with the consequences of not diagnosing or treating these symptoms. Indeed, I provide the delivery of such treatment and management the coordination of care to address these symptoms in post-surgical patients such as Ms. Nix.

> *Thus, this report is meant to evaluate the management of cardiac issues by a consulting neurosurgeon, Dr. Chang*.

(emphasis added).

As stated above, an expert meets the requirements of section 74.401 if he or she (1) is actively practicing medicine; (2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and (3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care. *See* TEX. CIV. PRAC. & REM. §74.401(a). Adams' supplemental report complies with these requirements.

First, as stated in his supplemental report, Adams is an actively practicing board-certified cardiovascular and thoracic surgeon.

Second, as far as Adams' knowledge of accepted standards of medical care, his supplemental report specifically stated that he (1) is familiar with indications for surgery, the postoperative approach, and the postoperative care of patients undergoing similar cardiovascular surgical procedures as performed on Linda; (2) is familiar with and knowledgeable about the "applicable standards of care which govern all aspects of the delivery of healthcare in a post-surgical critical care or intensive care setting, including the care provided by non-cardiac consulting specialists such as neurosurgeons"; (3) has familiarity with obtaining consultations, diagnoses or confirmation of his diagnoses from other physicians having particular

specializations, including neurosurgery; and (4) has experience in collaborating with neurosurgeons and has participated and communicated with neurosurgeon specialists in ensuring there is a "coordinated plan of care for post-surgical patients."

Finally, Adams is qualified to offer his opinion on the "management of cardiac issues by a consulting neurosurgeon," as he is a practicing cardiovascular and thoracic surgeon with over thirty-six years of experience. In addition, Adams opines on standards of care that are common to multiple fields of medicine, including communication among physicians, changes in medical status or condition, and the need for consultations from specialists.

Adams is qualified because these general standards of care are not specific to one medical field but involve standards of care common to all physicians in this post-operative setting. *See Broders v. Heise*, 924 S.W.2d 148, 154 (Tex. 1996) ("And when a party can show that a subject is substantially developed in more than one field, testimony can come from a qualified expert in any of those fields."); *Blan v. Ali*, 7 S.W.3d 741, 746 (Tex. App.—Houston [14th Dist.] 1999, no pet.) ("Despite the fact that we live in a world of niche medical practices and multilayer specializations, there are certain standards of medical care that apply to multiple schools of practice and any medical doctor. To categorically disqualify a physician from testifying as to the standard of care solely because he is from a different school of practice than the doctors charged with malpractice ignores the criteria set out in section 14.01(a) of the Medical Liability Act and Rule 702."). Accordingly, the trial

court abused its discretion to the extent it sustained Chang's objections based upon the alleged lack of qualification in Adams' supplemental report regarding standard of care or the breaches of the standard of care. We sustain Nix's argument.

ii) Causation

In his brief, Nix notes that it is "unclear whether Dr. Chang ultimately challenged Dr. Adams' qualifications to opine on causation. The heading of the causation discussion in Dr. Chang's Motion to Dismiss the Supplemental Report asserts that Dr. Adams is not qualified to opine on causation, but the substance of the section does not address this argument."[2] Chang addressed Adams' qualifications to serve as an expert in section II of Chang's motion to dismiss in a section titled "Dr. Adams is Still Not Qualified to Serve as an Expert as to Dr. Chang Under Chapter 74." In section II, however, Chang does not address Adams' qualifications regarding his ability to opine on causation. Instead, Chang's argument is limited to Adams' ability to opine on the standard of care. Accordingly, as Chang did not object to Adams' ability to opine on causation in his motion to dismiss, we

[2] The referenced heading reads as follows: "Dr. Adams' Report is Conclusory and Silent as to any Knowledge Equipping Him to Comment on any *Causal Connection* Between any Conduct on the Part of Dr. Chang and the Death of Ms. Nix."

need not address this issue and to the extent it served as a basis for the trial court's ruling that was an abuse of discretion.

C. Expert Report Requirements

A health care liability claimant must timely provide each defendant health care provider with an expert report. *See* TEX. CIV. PRAC. & REM. CODE § 74.351(a). An expert report means a "written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed." *See* TEX. CIV. PRAC. & REM. CODE § 74.351(r)(6). To constitute a good-faith effort to comply with the statutory requirements, the report must provide enough information to fulfill two purposes: (1) inform the defendant of the specific conduct the plaintiff has called into question; and (2) provide a basis for the trial court to conclude that the claims have merit. *See Baty v. Futrell*, 543 S.W.3d 689, 693–94 (Tex. 2018). A report that merely states the expert's conclusions as to the standard of care, breach, and causation does not fulfill these purposes. *See Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios,* 46 S.W.3d 873, 879 (Tex. 2001). The expert must explain the basis of his statements and must link his conclusions to the facts. *See Bowie Mem'l Hosp. v. Wright,* 79 S.W.3d 48, 52 (Tex. 2002).

In his second and fourth issues, Nix asserts that the trial court abused its discretion when it granted Chang's motion to dismiss because Adams' supplemental report adequately stated the standards of care, breaches of such standards, and the resulting injuries.

i) Standard of care

In his motion to dismiss, Chang argues that Adams failed to describe the standards of care by failing to provide "any specifics as to what a neurosurgeon like Dr. Chang *should have done* or what is required by the applicable standard of care." Chang further argues that Adams' opinions were conclusory because this "purported expert never clarifies what 'issue' Dr. Chang was required to monitor, what 'communications' needed to take place and between whom, and what 'changes' in the patient's conditions Dr. Chang was aware of that were required to be reported to the cardiovascular surgeon."

We disagree. Adams' supplemental report addressed the standards of care as follows:

> The specific standard of care applicable to a consulting specialist neurosurgeon in the post-surgical critical care setting, requires that he be able to recognize material changes in a patient's medical status or condition, that he understand the need to promptly report and document the same, and that all he understand the need to secure a prompt assessment of any such changes in medical status or condition, by appropriate medical personnel.
>
> Further, the standard of care for a neurosurgeon consulting after a heart surgery, such as a neurosurgeon like Dr. Chang, is to manage whatever issue he is called in to consult upon, in this case Ms. Nix's acute

> subdural hematoma, but continue to communicate and involve the cardiovascular surgeon in the patient's care and let the cardiovascular surgeon take a leading role in managing the cardiac care. *If the patient begins to experience complications, such as Ms. Nix's tachycardia, one-sided weakness, chest pain and shortness of breath, that are outside the neurosurgeon's expertise, it is the standard of care and the neurosurgeons responsibility and duty to convey those changes in condition and/or complications to the appropriate healthcare provider, in this case, Ms. Nix's cardiovascular surgeon and/or arrange a timely transfer or consultation. Further, if the neurosurgeon has taken on the patient's cardiac care, such as Dr. Chang did in this case as he was Ms. Nix's attending physician at Baylor Plano, if he is not going to call in a cardiovascular surgeon to address the complications, it is the standard of care for him to address the complications himself.*
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> It is the standard of care for a consulting neurosurgeon who has had the patient transferred from a specialty heart hospital to a different hospital to manage an acute subdural hematoma to transfer the patient back to the specialty heart hospital once the patient is neurologically stable or otherwise ensure that cardiovascular issues are being managed appropriately by the consulting neurosurgeon or specialists in the field.
>
> Further, the standard of care for a consulting neurosurgeon who has taken over management of a patient's care is to not discharge a patient without verifying all symptoms are managed (which here involved cardiac symptoms such as tachycardia, one-sided weakness, chest pain and shortness of breath) or otherwise under control and again, if the symptoms are not under control/managed the standard of care requires a consulting neurosurgeon to consult with the appropriate medical professional (here a cardiovascular surgeon) to manage the conditions.

(emphasis added).[3] Here, Adams identifies the following standards of care for a consulting neurosurgeon with a cardiac patient in a post-surgical critical care setting: (1) continuing to communicate and involve the cardiovascular surgeon in the patient's care; (2) recognizing and conveying any changes or complications in the

[3] We quoted the portion in italics above in our analysis of Adams's qualifications.

patient to the cardiovascular surgeon or arranging a transfer or consultation; (3) addressing the complications himself if he does not consult the cardiovascular surgeon; (4) transferring the patient back to the specialty heart hospital once the patient is neurologically stable; and (5) when preparing the patient for discharge, verifying all medical conditions including cardiac symptoms are managed and under control before authorizing discharge.

The standard of care for a physician is what an ordinarily prudent physician would do under the same or similar circumstances. *Russ v. Titus Hosp. Dist.*, 128 S.W.3d 332, 340 (Tex. App.—Texarkana 2004, pet. denied). To adequately identify the standard of care, an expert report must set forth specific information about what the defendant should have done differently. *Abshire*, 563 S.W.3d at 226. Here, Adams did identify the 'issue' Chang was required to monitor, what 'communications' needed to take place and between whom, and what 'changes' in the patient's conditions Chang was aware of that were required to be reported to the cardiovascular surgeon.

The "issue" Chang was required to monitor was outlined by Adams in his supplemental report: Chang's standard of care required him to recognize material changes in Linda's medical status or condition, understand the prompt need to report and document the same, and obtain a prompt assessment of any such changes by appropriate medical personnel. Adams emphasized Chang's "communications"

needed to involve the cardiovascular surgeon because Linda was recovering from heart surgery.

The "changes" in Linda's condition about which Adams opined regard a recovering cardiac patient who begins to experience complications—such as tachycardia, one-sided weakness, shortness of breath or chest pain—then Chang's standard of care would include familiarizing himself with her medical conditions,[4] then conveying those changes to her cardiovascular surgeon and/or arranging a timely transfer or consultation. The standard of care identified by Adams also states that, to the extent Chang failed to call in a cardiovascular surgeon, then he would need to address the cardiac complications himself as her attending physician. In addition, Adams opined that Chang's standard of care required him to transfer Linda back to the specialty heart hospital once she was neurologically stable or otherwise ensure that Linda's cardiovascular issues were being appropriately managed.

Finally, Chang's final progress notes on August 30, 2016 state that Linda will "be discharged imminently." Adams opines that Chang's standard of care required that he not discharge a patient without verifying that all symptoms were managed such as her tachycardia, one-sided weakness, chest pain and shortness of breath

[4] As we discuss later in the text, Chang complains Adams does not clearly state in either report Chang had this duty in his role as Linda's attending physician. Chang also complains Linda was never discharged so discharge authorization is irrelevant to this case. We disagree. Adams's supplemental report states, although not as clearly as it could, that when Chang took over the role of Linda's attending physician he had a duty to be familiar with her changing medical conditions as reflected in her chart. The relevance of Chang's authorization for discharge is that it is in that context Adams's report states clearly Chang had a duty to know Linda's condition and it is undisputed Chang authorized Linda's discharge.

along with the appropriate consultation with a cardiovascular surgeon. Accordingly, Adams' supplemental report provided sufficient information as to the standard of care owed by Chang. We conclude that the trial court abused its discretion to the extent that it sustained Chang's objections based upon this argument.

ii) Breach

In the motion to dismiss, Chang alleged that Adams' opinions as to the alleged breach of the standard of care were conclusory because Adams failed to state "*how* Dr. Chang's specific action or inaction could have *caused* the patient's injury and/or death. Taken as a whole, the report does not provide this Defendant with the specific conduct called into question or what he should have done differently." Adams' supplemental report addressed the breaches of the standards of care as follows:

> It is my professional medical opinion that the postoperative care provided by neurosurgeon Dr. Chang deviated and departed from the accepted standard of care one would expect for a consulting neurosurgeon managing a patient with this complex postoperative course, as specifically set forth below.
>
> Specifically, Dr. Chang breached the standard of care by assuming the role of a cardiovascular surgeon; although one "telephone" conversation occurred between Mrs. Nix's cardiovascular surgeon and Dr. Chang with regard to anticoagulation, Dr. Chang breached the standard of care by failing to communicate and involve Ms. Nix's cardiovascular surgeon in her care and by failing to let her cardiovascular surgeon taking a leading role in the management of the care. Instead. Dr. Chang took on the leading role. In doing so, Dr. Chang breached the standard of care.
>
> In addition, Dr. Chang breached the standard of care by failing to recognize the cardiovascular complications, *i.e.* the tachycardia, one-sided weakness, shortness of breath and chest pain that Mrs. Nix

> clinically exhibited. Instead of recognizing these complications for what they were, Dr. Chang's progress notes reflect that Ms. Nix was doing, well and in fact, even in the face of tachycardia, shortness of breath, and chest pain he was ready to discharge Mrs. Nix to a rehabilitation facility. Dr. Chang further breached the standard of care by failing to recognize these cardiac symptoms and by failing to act on them by conveying those changes in condition to Ms. Nix's cardiovascular surgeon or other cardiovascular doctor who was equipped and qualified to handle and evaluate such complications or otherwise obtain medicine or intervention identified below. These failures constitute breaches of the standards of care.
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> Dr. Chang breached the standard of care by failing to transfer Ms. Nix back to Baylor Heart after she was neurologically stable. Instead, Dr. Chang took over all aspects of her care and Ms. Nix stayed at Baylor Plano even after she was neurologically stable. Dr. Chang's failure to transfer Ms. Nix back to Baylor Heart after she was neurologically stable was a breach of the standard of care.
>
> As reflected in Dr. Chang's progress notes, Dr. Chang stated that Ms. Nix was ready for discharge "imminently". Dr. Chang's decision that Ms. Nix was ready for discharge in the face of unexplained tachycardia, shortness of breath, one-sided weakness and chest pain is a breach of the standard of care. Dr. Chang's decision to discharge Ms. Nix in the face of cardiac symptoms that were not controlled or managed was a breach of the standard of care.

In this portion of his report, Adams identifies numerous breaches of the standard of care by Chang, including: (1) assuming the role of a cardiovascular surgeon by failing to communicate with and involve Linda's cardiovascular surgeon in her care; (2) failing to recognize the signs of cardiovascular complications and failing to act on them by conveying the changes to Linda's cardiovascular doctor; (3) failing to transfer Linda back to Baylor Heart after she was neurologically stable so that her cardiac symptoms could be addressed; and (4) concluding that Linda was ready for

discharge "imminently" despite the fact that she was having uncontrolled and unmanaged cardiac symptoms.

In his brief, Chang further argues that there is nothing in Adams' supplemental report to indicate that Chang knew or should have known about Linda's cardiac complications. Further, Chang argues that he could not have breached the standard of care if Linda never displayed cardiovascular complications during his evaluation. We disagree. In this case, Adams' stated in his supplemental report that "it was clearly noted in the physical therapist's notes on August 28, 2016" that Linda experienced "chest pain and shortness of breath, particularly after ambulation." Adams' supplemental report also states:

> According to the medical records Mrs. Nix continued to have complaints of shortness of breath and chest pain on August 30 and August 31. A nurse noted tightness in the chest and notified a doctor (although the records do not state which doctor was notified) and was told to give Mrs. Nix morphine. There was concern as Mrs. Nix had excessive one-sided weakness during a physical therapy treatment of a possible TIA. On the morning of August 31, a patient care technician performed an EKG at 9:21 a.m. On the afternoon of August 31, 2016, Mrs. Nix complained of shortness of breath and chest pain to the nurse on duty and the physical therapy note at 2:45 p.m. indicates Mrs. Nix is unable to complete the treatment due to shortness of breath and tachycardia, again right sided weakness is observed.

Adams states the standard of care of Chang "requires that he be able to recognize material changes in a patient's medical status or condition" and that he convey those changes in condition to Linda's cardiovascular surgeon and/or arrange a timely transfer or consultation. Even if Chang did not observe the cardiac complications

during his evaluation of Linda, Linda's medical records contained references to these complications. Adams opines that since Chang took on "the leading role" in Linda's care, he had a duty to address these complications himself as her attending physician.[5] Further, Adams opined that Chang had a duty not to discharge Linda without "verifying all symptoms [were] managed (which here involved tachycardia, one-sided weakness, chest pain and shortness of breath) or otherwise under control . . . ." The supplemental report states that it was a breach of the standard of care to consider discharging Linda "imminently" in the face of these complications.

In accordance with our review, we note that the medical liability statute requires the expert report provide the manner in which the care rendered by the physician or health care provider failed to meet the standards. *See* TEX. CIV. PRAC. & REM. CODE § 74.351(r)(6). It is not necessary that the expert report marshal all of plaintiff's proof. *Peabody v. Manchac*, 567 S.W.3d 814, 821 (Tex. App.—Houston [14th Dist.] 2018, no pet.). Here, Adams specifically opined that Chang breached the standard of care by failing to (1) communicate and involve Linda's cardiovascular surgeon in her care; (2) recognize cardiovascular complications and act on them; (3) transfer Linda back to Baylor Heart if she was neurologically stable; and (4) concluding that Linda was ready for discharge "imminently" despite the fact

[5] Adams's supplemental report specifically states "if the neurosurgeon has taken on the patient's cardiac care, such as Dr. Chang did in this case as he was Ms. Nix's attending physician at Baylor Plano, if he is not going to call in a cardiovascular surgeon to address the complications, it is the standard of care for him to address the complications himself."

that she was having uncontrolled and unmanaged cardiac symptoms. Thus, we conclude Adams' supplemental report provided adequate detail on how the care rendered by Chang failed to meet the required standards of care as described above. Accordingly, the trial court abused its discretion to the extent that it sustained Chang's objections based upon this argument.

ii) Causation

In his motion to dismiss, Chang argued that Adams did not "explain how 'but for' Dr. Chang's action or inaction, Mrs. Nix would not have ultimately died, nor does he state how the patient's death was foreseeable at the time." Adams' supplemental report addressed the injuries sustained and causal link between the breaches of standards of care and injury as follows:

> Because Dr. Chang breached the standard of care by: (l) taking over all aspects of Ms. Nix's care and failing to communicate with Ms. Nix's cardiovascular surgeon; (2) failing to recognize the cardiac complications that Ms. Nix was experiencing and act on them himself or by consulting with Ms. Nix's cardiovascular surgeon or other cardiovascular surgeon; (3) failing to transfer Ms. Nix back to Baylor Heart once she was neurologically stable; and (4) proceeding to discharge Ms. Nix at a time when she was experiencing cardiac symptoms that were not managed or under control. Ms. Nix's cardiac status was not managed properly. Indeed, under Dr. Chang's care Ms. Nix's cardiac status continued to deteriorate and went unaddressed, and ultimately this failure to manage the condition lead to Ms. Nix's demise and death.
>
> The cardiac arrest that caused Ms. Nix's death was both foreseeable and preventable to the extent that Dr. Chang had not breached the standard of care and instead had communicated properly with Ms. Nix's cardiovascular surgeon, had timely intervened and arranged a consultation with a cardiovascular surgeon and/or transferred Mrs. Nix

back to Baylor Heart Hospital. Specifically, had Dr. Chang timely intervened, this intervention would have led to several changes in the care for Mrs. Nix which would have more likely than not, to a reasonable degree of medical probability, prevented her undue suffering and discomfort, her cardiac episode and subsequent death.

Specifically, after examination by a cardiovascular surgeon (which would have occurred but for Dr. Chang's breaches) or after Dr. Chang addressed the issues himself (which would have occurred but for Dr. Chang's breaches), Mrs. Nix should have been provided with medication changes, including starting low dose inotropic therapy (Dobutamine), diuretic therapy, and high flow oxygen. These changes in medication would have ensured that Mrs. Nix remained stable from a cardiac standpoint. Mrs. Nix should have had increased monitoring (i.e. transfer back to the Cardiac Surgical Intensive Care Unit) to help prevent other cardiac episodes and/or treat them in a timely manner and Mrs. Nix would have had more surgery if medically indicated and necessary. Such surgical procedures might include the following: placement of a Swan-Ganz percutaneous cardiac monitor, pericardiocentsis, subxphoid pericardial window to release cardiac fluid accumulation in the pericardial space. This increased monitoring, medication changes and/or surgical options, in my opinion, more likely than not, to a reasonable degree of medical probability would have treated Mrs. Nix's condition sufficiently and precluded her cardiac arrest and subsequent death. In other words, Mrs. Nix would have received this intervention but for Dr. Chang's breaches of the standard of care which precluded it, as discussed above.

In summary, although Mrs. Nix had a postoperative neurological event, which can and does occur in postoperative cardiovascular surgical patients, she was transferred in the immediate postoperative period to another service, in this case, neurosurgery. However, once the neurosurgical issues were addressed, the [sic] Ms. Nix was not transferred back to the admitting, attending physician. Instead, Dr. Chang continued to keep Mrs. Nix under his care and failed [sic] appropriately communicate with her cardiovascular surgeon, failed to appropriately follow her condition and consult with a cardiovascular surgeon and/or transfer her back to the Baylor Heart Hospital once she was stable from a neurotological standpoint. Instead, Dr. Chang proceeded to discharge Mrs. Nix while she was suffering from cardiac symptoms and complications.

Essentially, Adams concludes that Chang's breaches caused Linda's death due to his failure to manage her cardiac care as her status continued to deteriorate and her symptoms went unaddressed. Adams specifically notes that had Chang properly communicated with Linda's cardiovascular surgeon or addressed her symptoms himself, her cardiac episode and subsequent death would have "more likely than not" been prevented because Linda would have been provided with medication changes and increased monitoring, as well as any necessary surgical procedures.

In response to the amended report, Chang relies on *Greenville SNF, LLC v. Webster*, No. 05-18-00038-CV, 2018 WL 6716621 (Tex. App.—Dallas Dec. 21, 2018, no pet.) (mem. op) in support of his assertion that Adams' causation explanation remains deficient. In *Webster*, Frances Robinson was a resident at a rehabilitation center and was discovered by an employee in a non-responsive state with a significantly diminished oxygen saturation level. *Id.* at *1. The employee waited forty-five minutes before contacting 911 to transfer Robinson to a hospital. *Id.* At the hospital, Robinson was found to have sustained irreversible brain damage and later died. *Id.* In that case, this Court determined that "[w]ith respect to causation, [the expert] merely opined in a conclusory manner that, based on reasonable medical probability, as a result of Greenville's forty-five minute delay in calling 911 after discovering Robinson unresponsive and with an oxygen saturation level of seventy-two percent, Robinson more likely than not developed multiple brain infarcts which proximately caused her death." *Id.* at *5. In short, this

Court held that the expert report "failed to explain how and why Greenville's forty-five minute delay in calling for 911 medical response was the proximate cause of Robinson's death." *Id.*

In this case, however, Adams' report does provide a causal link between Chang's failure to communicate and involve Linda's cardiovascular surgeon in her care and/or recognize cardiovascular complications and act on them and Linda's subsequent death by cardiac arrest. Here, Adams specifically notes that if Linda had seen a cardiologist (or if Chang had addressed the issues himself), Linda would have been given medication changes, diuretic therapy, and high flow oxygen which would have "ensured that [Linda] remained stable from a cardiac standpoint." Further, Linda would have received increased monitoring and transfer back to the Cardiac Surgical Intensive Care Unit to help prevent other cardiac episodes or received timely surgical procedures, including a Swan-Ganz percutaneous cardiac monitor, pericardiocentsis, or a subxiphoid pericardial window to release cardiac fluid accumulation in the pericardial space. In addition, Adams specifically opined that the increased monitoring, medication changes and/or surgical options would have "treated [Linda's] condition sufficiently and precluded her cardiac arrest and subsequent death." As Adams was able to identify a causal link between Chang's breaches and the injury, we do not find the *Webster* opinion persuasive in this case.

The closest case on point is *Abshire v. Christus Health Southeast Texas*, 563 S.W.3d 219 (Tex. 2018) in which the court found that the expert report satisfied the

element of causation. In that case, Abshire visited the emergency room at Christus Hospital five times in a two-week period for chest pain, shortness of breath, and back pain. *Id.* at 221–22. During the first and fourth visit, Abshire's medical history failed to note she suffered from osteogenesis imperfect (OI), also known as brittle bone disease. *Id.* at 221. During Abshire's second and third visit, the OI history was noted. *Id.* After the fifth visit, Abshire was transferred to a rehabilitation hospital but was ultimately sent back to Christus two days later. *Id.* at 222. Christus then transferred her to another hospital, Baptist Beaumont. *Id.* Baptist ordered an MRI which revealed that she suffered from a compression of her T-5 vertebrae and this injury rendered Absire a paraplegic. *Id.*

In her lawsuit against Christus, Abshire alleged that the nurses failed to recognize and document her OI, which predisposed her to fractures, and failed to recognize the symptoms of spinal compression fracture resulting in a delay in treatment. *Id.* In the section titled "Causal Relationships," Dr. Rushing opined as follows:

> The harm/injury that resulted from the substandard care provided by [Christus] was the exacerbation of an undiagnosed vertebral fracture that lead [sic] to a spinal cord injury resulting in paraplegia and bowel and bladder incontinence.
>
> Failure of the nursing staff to document a complete and accurate assessment resulted in a delay in proper medical care (ie. [sic] the ordering of imaging studies and protection of the spine.).... [H]ad the symptomology that Ms. Abshire was experiencing been appropriately linked to the [OI] diagnosis then she could have been admitted to the hospital on absolute bed rest, imaging studies such as a CT or MRI of

> her back ordered, then treatment started to preserved [sic] the integrity of the spine....
>
> The hospital staff clearly ignored signs and symptoms of spinal injury and kept investigating the same areas over and over with no relief to the patient.... This failure on the part of the hospital staff allowed the spinal injury to progress to the point of paraplegia.
>
> Failure to consider the patient's prior relevant medical history was mostly [sic] likely a cause of the hospital staff's focus on the potential cardiac element of Ms. Abshire's pain.... Had they had a complete medical history they would have known to examine other areas and that this patient had a high probability of a compression fracture. The lack of proper documentation in the patient's medical record lead [sic] to a delay in treatment of Ms. Abshire's compression fracture which in medical probability lead [sic] to paralysis.

Id. at 224–25. The supreme court concluded that "Dr. Rushing's explanation provides a straightforward link between the nurses' alleged breach of the standard of care and Abshire's spinal injury. That is, the report draws a line directly from the nurses' failure to properly document Abshire's OI and back pain, to a delay in diagnosis and proper treatment (imaging of her back and spinal fusion), to the ultimate injury (paraplegia)." *Id.* at 225.

The expert report in this case contains a causal link similar to the one presented by Dr. Rushing in the *Abshire* case. As stated above, Adams specifically opined that the increased monitoring, medication changes and/or surgical options would have "treated [Linda's] condition sufficiently and precluded her cardiac arrest and subsequent death." As in *Abshire*, Adams's supplemental report draws a line directly from Chang's failure to communicate and involve Linda's cardiovascular surgeon in her care and/or recognize cardiovascular complications and adequately

treat them himself, to a delay in treatment (i.e., increased monitoring and transfer back to the Cardiac Surgical Intensive Care Unit to help prevent other cardiac episodes or surgical procedures, including a Swan-Ganz percutaneous cardiac monitor, pericardiocentsis, or a subxiphoid pericardial window to release cardiac fluid accumulation in the pericardial space), to the ultimate injury (Linda's death). Accordingly, the trial court abused its discretion to the extent that it sustained Chang's objection based upon his causation argument and we sustain Nix's fourth issue.

D. Oral Pronouncements

In his fifth issue, Nix argues that the trial court abused its discretion in dismissing the case when it examined the merits of the supplemental report and "judged the credibility of the report based on the court's assessment that Dr. Chang's counsel did not 'agree' with the statements in the report." Nix then cites to excerpts from the hearing to support his allegation that the trial court relied "on counsel for Dr. Chang's assertions of the way things occurred instead of the four corners of the expert report."

In this case, the trial court signed a written order sustaining Dr. Chang's written objections to the supplemental expert report and dismissed the case. It is those objections, not the oral pronouncements made by the trial court, which are the focus of this appeal. As stated above, a final written judgment prevails over prior

oral pronouncements. *See Kaur-Gardner*, 2018 WL 2191925, at *4; *Sherman*, 124 S.W.3d at 279. Accordingly, we overrule appellant's fifth issue.

CONCLUSION

On the record of this case, we reverse the trial court's order granting the motion to dismiss and remand for further proceedings.

/David Evans/
DAVID EVANS
JUSTICE

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Court of Appeals
Fifth District of Texas at Dallas

JUDGMENT

WILLIAM NIX, INDIVIDUALLY AND AS REPRESENTATIVE OF THE ESTATE OF LINDA NOELLE NIX, DECEASED, Appellant

No. 05-19-01129-CV V.

CHARLES S. CHANG, M.D., INDIVIDUALLY AND D/B/A CHANG NEUROSURGERY & SPINE CARE, Appellee

On Appeal from the 416th Judicial District Court, Collin County, Texas
Trial Court Cause No. 416-05813-2018.
Opinion delivered by Justice Evans.
Justices Bridges and Pedersen, III participating.

In accordance with this Court's opinion of this date, the judgment of the trial court is **REVERSED** and this cause is **REMANDED** to the trial court for further proceedings consistent with this opinion.

It is **ORDERED** that appellant WILLIAM NIX, INDIVIDUALLY AND AS REPRESENTATIVE OF THE ESTATE OF LINDA NOELLE NIX, DECEASED recover his costs of this appeal from appellee CHARLES S. CHANG, M.D., INDIVIDUALLY AND D/B/A CHANG NEUROSURGERY & SPINE CARE.

Judgment entered July 8, 2020.