**In The**

***Court of Appeals***

***Ninth District of Texas at Beaumont***

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**NO. 09-10-00363-CV**

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**SILSBEE OAKS HEALTH CARE, L.L.P., Appellant**

**V.**

**MARY LOUISE CHUMLEY, AS REPRESENTATIVE OF THE ESTATE OF ROY CHUMLEY, Appellee**

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**On Appeal from the 88th District Court**
**Hardin County, Texas**
**Trial Cause No. 49041**

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## MEMORANDUM OPINION

Mary Louise Chumley, representative of the estate of Roy Chumley, filed a health care liability claim against appellant Silsbee Oaks Health Care, L.L.P. Appellant filed a motion to dismiss challenging the plaintiff's expert reports. The trial court denied appellant's motion. This appeal followed. Finding no abuse of discretion by the trial court, we affirm the trial court's order.

## BACKGROUND

Roy Chumley was a patient at the nursing home. He suffered a black eye. X-rays taken at the hospital showed two rib fractures.

His wife, Mary Chumley, filed a medical malpractice suit alleging that a nurse at Silsbee Oaks struck Roy Chumley in the chest with her fist. The petition asserted that Silsbee Oaks was vicariously liable under the doctrine of *respondeat superior* for the actions of its employees. The petition also asserted that Silsbee Oaks was directly liable for, among other things, the failure to "require training and instruction for the nursing staff to keep the staff from assaulting patients" and for the failure to "provide a safe environment and [to] protect[] Mr. Chumley from abuse[.]"

Plaintiff submitted the expert report of Dr. Lige Rushing. In his report, Rushing states he reviewed the records from Silsbee Oaks, Christus St. Elizabeth Hospital, and Village Creek/Lumberton Rehab Facility. Rushing explains that Roy Chumley had a history of COPD, anxiety disorder, osteoarthritis, dementia, type 2 diabetes, asbestosis, partial epilepsy, and coronary artery disease. The report states that the hospital's "emergency department records document[ed] an alleged assault as the reason for this visit." Rushing further states as follows:

> The record reflects that [Chumley] had been struck in the right anterior chest with a fist, and that this had occurred in the nursing home on 07/22/06. Mr. Chumley complained of pain in the right anterior chest. He also stated that he had been struck with a fist according to the medical records.

> Additionally, he had a black eye (left). The record reflects that the family was told that this came about as a result of a fall. An x-ray at the hospital showed two fractures involving the lateral aspect of the right 7th and 8th rib. These fractures appeared to be likely acute or subacute. After he was evaluated and stabilized in the hospital, he was transferred back to the Silsbee Oaks Facility on 07/27/06.

Dr. Rushing's report describes his qualifications in detail and sets out the standard of care, breach of the standard of care, and the causation.

The trial court concluded that the report was a good-faith effort to comply with statutory requirements, but found unspecified deficiencies in the report. The order permitted the plaintiff to cure any deficiencies. Chumley filed another expert report -- that of Melody Antoon, a registered nurse. In setting out the facts and the standard of care, Antoon's report substantively mirrors Rushing's report.

## APPLICABLE LAW

Within 120 days of filing suit, a plaintiff in a health care liability suit must serve an expert report for each physician or health care provider against whom the claim is asserted. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(a) (West Supp. 2010). The expert report must identify the "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 Ann. § 74.351(r)(6) (West Supp. 2010). An expert means "a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence[.]" Tex. Civ. Prac. & Rem. Code Ann. § 74.351(r)(5)(c)

(West Supp. 2010). An expert must have knowledge, skill, experience, training, or education "regarding the specific issue before the court which would qualify the expert to give an opinion on that particular subject." *Broders v. Heise*, 924 S.W.2d 148, 153 (Tex. 1996) (citing Tex. R. Evid. 702); *see also* Tex. Civ. Prac. & Rem. Code Ann. § 74.402(b), (c) (West 2005).

In determining whether the witness is qualified as an expert under section 74.351, a court generally only considers the expert's report and curriculum vitae. *See Bowie Mem'l Hosp. v. Wright,* 79 S.W.3d 48, 52-53 (Tex. 2002) (limiting review of an expert report to information contained within its four corners); *Am. Transitional Care Ctrs. of Tex. v. Palacios*, 46 S.W.3d 873, 878 (Tex. 2001) (holding that the issue of compliance of an expert report under article 4590i is determined on the basis of information contained within the four corners of the report). The reviewing court cannot fill in gaps in an expert report by drawing inferences or guessing as to what the expert likely meant or intended. *See In re McAllen Med. Ctr., Inc.*, 275 S.W.3d 458, 463 (Tex. 2008); *Austin Heart, P.A. v. Webb*, 228 S.W.3d 276, 279 (Tex. App—Austin 2007, no pet.).

The report has two purposes: (1) to inform the defendant of the specific conduct the plaintiff has called into question; and (2) to provide a basis for the trial court to conclude the claims have merit. *Palacios*, 46 S.W.3d at 879. The report need not marshal all of the plaintiff's proof, but it must include the expert's opinion on each of the elements identified in the statute. *Id.* at 878. In considering a motion to dismiss, the issue

is whether the report represents a good-faith effort to comply with the statutory definition of an expert report. *See Bowie Mem'l Hosp.*, 79 S.W.3d at 52. Section 74.351(i) allows a claimant to satisfy the expert report requirement of section 74.351 by serving reports of separate experts. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(i) (West Supp. 2010); s*ee Packard v. Guerra*, 252 S.W.3d 511, 527 (Tex. App.—Houston [14th Dist.] 2008, pet. denied).

We review the trial court's denial of a motion to dismiss under an abuse of discretion standard. *See Palacios*, 46 S.W.3d at 877 (discussing predecessor statute to section 74.351(c)); s*ee also Mem'l Hermann Healthcare Sys. v. Burrell*, 230 S.W.3d 755, 757 (Tex. App.—Houston [14th Dist.] 2007, no pet.).

## CORRECTION OF DEFICIENCIES

In issue one, appellant argues the trial court abused its discretion by denying appellant's motion to dismiss the suit, because Chumley did not amend Dr. Rushing's expert report. In a motion filed with the court, appellant objected that Rushing was not qualified to offer an expert opinion on the standard of care, breach, or causation elements required by the statute, and further objected that the report was conclusory and based on speculation. We do not have a record of a hearing on appellant's objections.

We have reviewed the reporter's record of the hearing on the motion to dismiss. From the attorney's discussion at that hearing, it appears that plaintiff's attorney previously had agreed, without argument before the court, that supplementation would be

appropriate. The trial court had signed an order presented by the parties granting a 30-day extension to cure any deficiencies. The trial court's order did not specify any deficiencies. Plaintiff submitted an additional report from Melody Antoon, R.N.

Appellant correctly states that a nurse cannot, as a matter of law, establish the causation prong required by section 74.351(r)(6). *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(r)(5)(C) (West Supp. 2010), § 74.403(a) (West 2005); *Benish v. Grottie*, 281 S.W.3d 184, 205 (Tex. App.—Fort Worth 2009, pet. denied). A nurse may, however, give an opinion on the standard of care for nurses and a breach of the standard. *See Christus Spohn Health System Corp. v. Sanchez*, 299 S.W.3d 868, 877-78 (Tex. App.—Corpus Christi 2009, pet. denied); *Benish*, 281 S.W.3d. at 205-06. The court could consider the reports together as adequate. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(i); *Sanchez*, 299 S.W.3d at 877-78 (Nurse's report on standard of care for nurses and physician's report on causation were considered together.). The trial court here did not abuse its discretion in considering the two reports together. Because we find in this opinion that the reports are sufficient, we overrule issue one.

QUALIFICATIONS OF THE EXPERTS

Appellant argues the trial court abused its discretion in denying appellant's motion to dismiss because the experts were not qualified to render opinions on the standard of care. To be qualified, an expert must satisfy the requirements in section 74.402 of the Civil Practices and Remedies Code. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.402

(West 2005). Section 74.402(b)(2) requires an expert to have "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 to be "qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care." *Id.*; *Doctors Hosp. v. Hernandez*, No. 01-10-00270-CV, 2010 WL 4121678, at **5-6 (Tex. App.—Houston [1st Dist.] Oct. 21, 2010, no pet. h.). Section 74.402(c) provides that the court determines whether a witness is qualified on the basis of training and experience by considering whether at the time the claim arose or at the time the testimony was given, 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).

Appellant challenges Rushing's qualifications to render the expert report on the following grounds: (1) general experience in a specialized field is insufficient to qualify a witness as an expert; (2) the report does not contain any information showing he is an expert on nursing home facilities; (3) just because a physician is qualified to medically treat a patient for a certain condition does not mean the physician is qualified to give an

opinion on the standards of care at a health care facility; (4) experience, training, and skill in more than one facility is necessary.[1]

Rushing meets the requirements of the statute. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.402(b). He is licensed to practice medicine in Texas and is board certified in internal medicine, geriatrics, and rheumatology. At the time of the report, he was "actively engaged in the practice" of these three specialties and was on the attending staff at Presbyterian Hospital in Dallas. Dr. Rushing's report states he has "diagnose[d] and treat[ed] patients with conditions substantially similar or identical with Mr. Chumley's in both the hospital setting and the nursing home setting." He has "served as a primary care physician for more than 10,000 patients in hospitals and nursing homes over the course of [his] career[,]" and he has "cared for and treated numerous patients in nursing homes who were confused, who experienced anxiety, who had diabetes, arthritis, dementia, and coronary artery disease." Dr. Rushing states he has "worked closely with and written orders for and supervised the execution of these orders for the care and treatment of [his] patients. [H]e ha[s] supervised the nurses (registered nurses, licensed vocational nurses, and CNAs), who have been assigned to provide nursing care for [his] patients."

The trial court did not abuse its discretion in finding Rushing qualified to testify about the standard of care applicable to a patient like Chumley in a nursing home facility. *See IHS Acquisition No. 140, Inc. v. Travis*, No. 13-07-481-CV, 2008 WL 1822780, at

[1]Appellant also contends that Rushing's curriculum vitae is deficient because it contains no dates of his educational degrees, certifications, or practice areas. Whether to require that under the circumstances was in the discretion of the trial court.

**5-6 (Tex. App.—Corpus Christi 2008, pet. denied) (mem. op.) (Doctor, who was board certified in geriatrics, "knowledgeable about the types of people who reside in nursing homes, their afflictions, and most importantly, the relevant treatment and standard of care for such patients[,]" was qualified to opine about the standard of care applicable to a nursing home.).

Under issue two, appellant also contends that nurse Melody Antoon is not qualified to give an opinion on the standard of care. Chumley argues that appellant waived this issue. Although appellant filed objections to Antoon's report, the record does not reveal that appellant obtained a ruling on its objections to the report. Further, appellant did not challenge Antoon's report in the motion to dismiss. Appellant did not preserve this challenge for review. *See* Tex. R. App. P. 33.1(a). Issue two is overruled.

STANDARD OF CARE

In issue three, appellant contends that Dr. Rushing's report fails to establish the standard of care, and that the report is speculative and conclusory and constitutes conjecture. Appellant essentially argues that the statements of the standard of care lack specificity, fail to provide any factual basis, and erroneously conclude that negligence occurred because injury occurred. Rushing's report states in part as follows:

> The standards of care for a long-term care facility such as Silsbee Oaks Health Care and its staff requires that they provide that levels of care and treatment that a reasonable, prudent and similar facility would provide under the same or similar circumstances.

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being as defined by and in accordance with the comprehensive assessment and plan of care.

Appellant contends Rushing's general statements on the standard of care are "mere recitations and characterizations of statutes and regulations, which is prohibited." Appellant appears to argue that because plaintiff may have used a nursing home licensure statute and a Medicare regulation as part of the statement of the standard of care, the plaintiff is seeking to base the standard of care on negligence per se or *res ipsa loquitor*. Rushing does not rely solely on these preliminary statements. His statement in his report continues as follows:

> The standard of care also requires that the nursing home provide the necessary care and treatment and supervision to prevent accidents.
>
> The standard of care also requires that the nursing home provide a safe environment and that patients are protected from abuse of all kinds including but not limited to physical abuse, sexual abuse, and emotional abuse. The standard of care also requires that the nursing staff make periodic rounds and/or observations at 10 to 15 minute intervals to make sure that there are no arguments, fights, or confrontations between patients. The standard of care also requires training and instruction for the nursing staff to keep the staff from assaulting patients. The standards of care also requires relocation of patients such that those who do not "get along with each other" are separated and put in different areas of the facility.
>
> The standard of care also requires the isolation of the patients who exhibit "violent" behavior and pose a threat to other patients. If patients who exhibit violent behavior cannot be isolated to protect other patients then these patients should be discharged/dismissed to the family's care or to a facility capable of providing the needed care.

Dr. Rushing's report explains standards of care for Silsbee Oaks and its nursing staff: the nursing home must provide a safe environment, protect patients from abuse and prevent accidents, have its nursing staff make rounds or observations at 10 to 15 minute intervals, provide training and instruction for the nursing staff to prevent assaults, and relocate patients who do not get along with each other. Nurse Antoon's report similarly states the applicable standards of care for Silsbee Oaks and its nursing staff.

As the Supreme Court has noted, nursing homes, as health care providers, have a duty to protect their residents and patients from harming themselves and each other. *Diversicare Gen. Partner, Inc. v. Rubio*, 185 S.W.3d 842, 850 (Tex. 2005). In their reports, Rushing and Antoon indicate that the records of the nursing home do not reflect that the nurses conducted periodic rounds or observations of the patients, and the records do not indicate that nurses and staff received training to prevent assaultive conduct against patients.

Relying on *Gonzales v. Graves*, No. 07-03-0268-CV, 2004 WL 510898, at *4 (Tex. App.—Amarillo 2004, no pet.) (mem. op.), appellant argues that the inability to find something in a medical record does not equate to a breach of the standard of care. In *San Jacinto Methodist Hospital v. Bennett,* the expert witness stated that a sacral decubitus on a patient was noted in the hospital discharge summary, but no skin care documentation was included in the medical record. 256 S.W.3d 806, 809-10 (Tex. App.—Houston [14th Dist.] 2008, no pet.). From the lack of documentation in the record,

the expert concluded proper skin care was not done. *Id*. The expert stated that the general standard of care for decubitus ulcers included, among other things, "follow up with skin care nursing and protocol interventions when decubitus ulcers are detected." *Id*. The Fourteenth Court concluded that the report was a good-faith effort to provide a fair summary of the expert's opinion that, had the proper measures been taken by the nursing staff (including proper skin care), the plaintiff would not have sustained the injury. *Id*. at 813-818. If the expert report correctly states that the standard of care requires the performance of an act, and if the report indicates the medical records do not reflect that the act was performed, the trial court may conclude that the expert was correct in stating that a breach of the standard of care occurred. Silsbee Oaks argues that simply because Roy Chumley sustained an injury does not mean that negligence occurred. While that is true, the purpose of the report is to give a fair summary of the standard of care, breach, and causation. Reading the reports together in their entirety, the trial court could reasonably conclude they provide a fair summary of the standard of care and the manner in which the health care provider failed to meet that standard. We overrule issue three.

### CAUSATION

In issues four and five, appellant argues Chumley failed to establish the proximate cause required by the statute and the nexus between the breach of the standard of care and causation. Dr. Rushing's report states as follows:

> The breach of the standards of care by the nursing home and its staff as outlined here resulted in Mr. Ch[u]mley's being subjected to an assault,

> which in turn resulted in the physical injuries including the black eye and the fractured ribs described in this report and the medical records.
>
> The broken ribs, in this instance, resulted in soft tissue damage and bleeding in to the tissue, which in turn irritates the sensory nerves resulting in pain. Broken ribs are substantially painful in most cases. As to the black eye, it too is bleeding into the periorbital tissue [ ] and such bleeding irritates the sensory nerves resulting in pain.
>
> It is my opinion that the failures outlined in this report by Silsbee Oaks Health Care and its nursing staff proximately caused Mr. Chumley's injuries.

Essentially, the report states that the failure to properly monitor the patients, to make periodic rounds, and to train and instruct the nursing staff on assault prevention caused Chumley's injuries. The emergency room records reviewed by Rushing explain that Chumley stated he had been struck in the chest at the nursing home. Dr. Rushing's report addresses the possibility of a fall or an assault by an employee or another patient. Whether the broken ribs are the result of a fall or an assault, the report explains why the experts believe that Chumley's injuries arose from and were caused by the breach of the standard of care by Silsbee Oaks and its employees. At the medical report stage, given the incomplete status of discovery, the plaintiff is not required to prove its claim. *See Apodaca v. Russo*, 228 S.W.3d 252, 255 (Tex. App.—Austin 2007, no pet.). Although the expert report is not required to prove the defendant's liability, it must provide notice of what conduct forms the basis for the plaintiff's complaints. *Id.* Dr. Rushing relied on the history contained in the medical records he reviewed. One purpose of the expert report is to show that a plaintiff has a viable cause of action that is not frivolous or without expert

support. Rushing's report sufficiently informs Silsbee Oaks of conduct by Silsbee Oaks that the plaintiff believes caused injury to Chumley. The trial court did not abuse its discretion in denying appellant's motion to dismiss. We overrule issues four and five.

We affirm the order denying appellant's motion to dismiss.

AFFIRMED.

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DAVID GAULTNEY
Justice

Submitted on October 20, 2010
Opinion Delivered December 30, 2010

Before McKeithen, C.J., Gaultney and Kreger, JJ.