COURT OF APPEALS
SECOND DISTRICT OF TEXAS
FORT WORTH

NO. 02-16-00433-CV

COLUMBIA NORTH HILLS HOSPITAL SUBSIDIARY, L.P. D/B/A NORTH HILLS HOSPITAL	APPELLANT
V.	
MARCELO GONZALES, INDIVIDUALLY AND O/B/O THE ESTATE OF REBECCA GONZALES, DECEASED; JEREMIAH GONZALES; MARCELO GONZALES JR.; ROSE ANN GONZALES; MELISSA GONZALES; MICHELLE GONZALES; DAVE GONZALES; DAVID GONZALES; AND MARK GONZALES	APPELLEES

FROM THE 342ND DISTRICT COURT OF TARRANT COUNTY
TRIAL COURT NO. 342-279557-15

MEMORANDUM OPINION[1]

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[1]*See* Tex. R. App. P. 47.4.

In this appeal, we are asked to decide whether a medical expert's report was sufficient to establish causation such that it met the statutory requirements to avoid dismissal of the claims addressed in the report. Because we conclude that the trial court did not abuse its discretion by finding that the report was an objective, good-faith effort to explain the causal relationship between the breach and the injury, thereby establishing a chain of events leading to the patient's injuries, we affirm the trial court's order.

I. BACKGROUND

A. FACTS LEADING TO LITIGATION

On December 16, 2013, Rebecca Gonzales was admitted to appellant Columbia North Hills Hospital Subsidiary, L.P. d/b/a North Hills Hospital (Hospital) for acute respiratory failure and pneumonia. Rebecca was diabetic; therefore, her treating physician ordered that she be given fifty units of Detemir insulin at bedtime, thirty units of Glargine insulin once a day, and Lispro insulin on a sliding scale before meals. The amount of Lispro ordered was based on Rebecca's blood-glucose level (BGL):

> 150-199 4 UNITS
> 200-249 8 UNITS
> 250-299 12 UNITS
> 300-349 16 UNITS
> >= 350 20 UNITS, REPEAT BS IN 2 HOURS
> IF STILL > 350, NOTIFY PHYSICIAN
>
> . . . .
>
> LOWER SS [i.e., sliding scale] ONE LEVEL WHEN 2 BS IN 12 HOURS ARE < 100 OR IF . . . ANY INSTANCE OF BS < 70 . . . .

On December 17, 2013, at 8:00 a.m., Rebecca's BGL was 115 and she was not given any insulin. At 9:00 a.m., she had a BGL of 116 and was given her once-daily dose of thirty units of Glargine. At 11:30 a.m., her BGL was 173 and she was administered four units of Lispro. At 4:30 p.m., Rebecca's BGL was forty-nine, and she was given no insulin at that time. At 9:00 p.m., her BGL was 356, and she was given twenty units of Lispro and her bedtime dose of fifty units of Detemir. The next day at 5:15 a.m., Rebecca was found unresponsive with a BGL of thirty-seven.[2]

An emergency computerized-tomography scan of Rebecca's head ordered by a neurologist revealed "[n]o evidence of acute hemorrhage or acute infarction," and an electroencephalogram (EEG) showed "[r]ecordings grossly abnormal with a very slow background along with a low amplitude" that was "consistent with a moderately severe diffuse cerebellar dysfunction." Rebecca was diagnosed with "[a]cute encephalopathy, most probably related to her hypoglycemic episode and this may have resulted in a significant global brain injury." After Rebecca remained unresponsive, she was discharged to Plaza Medical Center and later transferred to Pleasant Medical Center where she died on January 24, 2014.

[2]A later medical note stated that her BGL "[a]pparently" was fourteen when she was discovered.

B. PETITION, EXPERT REPORT, AND EXTENSION

On July 2, 2015, Rebecca's estate, her husband, and her eight children (Appellants) filed suit against Hospital, alleging negligence under a vicarious-liability theory—"Hospital is vicariously liable for the acts of negligence of their servants, borrowed servants, employees[,] and agents." Specifically, Appellants asserted that Hospital's nursing staff was negligent in two ways: (1) "failing to follow the physician's order and reduce the dosage from 20 units of [Lispro] insulin to 16 units of [Lispro] insulin at 21:03 on December 17, 2013," and (2) "failing to contact a physician to report hypoglycemic event at 16:40 on December 17, 2013."

Appellants attached to their petition the curriculum vitae and expert report of Dr. Chad S. Miller, who opined that the nursing staff's failure to report Rebecca's BGL of forty-nine to the treating physician and failure thereafter to reduce her 9:00 p.m. Lispro dose to sixteen units "fell below the standard of care and contributed to a hypoglycemic event, which ultimately resulted in a comatose state and death." *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(a) (West 2017). Hospital objected to Miller's report and moved to dismiss Appellants' claims on the basis that Miller's report was conclusory and failed to establish a causal link between the alleged misconduct and Rebecca's injuries. *See id.* § 74.351(a)–(b), (*l*), (r)(6). Appellants responded, asserting that Miller's report was sufficient to meet the statutory standard for such a report but alternatively requesting a thirty-day extension to cure any deficiencies found by the trial court.

The trial court found that the report was inadequate "with regard to causation" but granted Appellants an extension "to rectify any deficiencies." *See id.* § 74.351(c).

C. AMENDED EXPERT REPORT AND DENIAL OF MOTION TO DISMISS

Appellants served an amended report that expanded on Miller's causation opinion:

> As a direct result of the excessive and combined doses of insulin at bedtime on December 17, 2013[,] the patient suffered a hypoglycemic injury with severe neurologic sequela. By combining the two insulin medications, and giving an excessive dose of the short-acting Lispro insulin, the patient's blood sugar dropped to an excessively low level. The records do not indicate that there was any intervention in terms of additional blood glucose testing nor food after 2100 until the time of the patient being found unresponsive. I concur with the treating physicians that [Rebecca] sustained a prolonged hypoglycemic coma/event. That led to her unresponsive condition and neurologic insult. The patient never recovered from the neurologic insult and was never responsive again. After attempted treatment in subsequent facilities [Rebecca] was referred to hospice at which point she died as a result of the complications from neurologic injury and hypoglycemic event that occurred on December 18, 2013.
>
> If the nurses had met the standard of care and contacted a physician who employed ordinary care, or if the nurses had followed physician's orders and provided the lower dose of short-acting Lispro insulin in reasonable medical probability, meaning more likely than not, the patient would not have had a catastrophic hypoglycemic event which was first identified at 5:45 AM on December 18, 2013. At that time the patient's blood glucose was only 37. It is well understood and recognized in medicine that prolonged episodes of hypoglycemia can inflict severe and irreversible neurological damage on a patient like [Rebecca]. By reducing the blood sugar to as low as 37[,] the brain was not provided the level of glucose it needs to function properly and was permanently damaged.
>
> The human brain is dependent on serum glucose in order to function. Episodes of low blood glucose result in loss of consciousness. Prolonged episodes can cause neurological

> damage and even brain death. In this instance, [Rebecca] was obviously subjected to an extended period of low blood glucose. As a result, her brain did not have sufficient glucose in order to function properly and suffered severe neurologic insult. As a result of the neurologic insult[,] the patient never regained consciousness and died on January 24, 2014. But for the hypoglycemic event, the patient would not have sustained the global brain damage as indicated on the EEG and therefore would not have died as a result of this global neurologic deficit/damage.

Miller also explained that Lispro is a "short-acting" insulin that produces "wide swings in [BGLs]" and that "[t]he excessive doses of insulin at 2100 (the 20 units of Lispro and the 50 units of Detemir) caused [Rebecca's BGL] to drop to 37 which caused the hypoglycemic coma," from which she never recovered. Thus, Miller opined that the nursing staff breached the standard of care in two ways: (1) administering twenty units of Lispro in violation of the sliding-scale order along with fifty units of Detemir and (2) failing to notify the treating physician that Rebecca had a BGL of forty-nine at 4:45 p.m. Miller attached portions of Rebecca's medical records to his report in support of his factual averments upon which his causation opinion was based.

Hospital filed a second motion to dismiss—again asserting that Miller failed to sufficiently establish causation—and argued that he provided no link between the administration of twenty units of Lispro (as opposed to sixteen) and her hypoglycemic coma, between her hypoglycemic coma on December 18 and her death thirty-seven days later, or between the nursing staff's failure to contact the treating physician at 4:45 p.m. and Rebecca's death weeks later. Appellants responded that Miller's report provided "adequate medical detail as to how the

chain of events occurred" and provided a basis for the trial court to conclude that the claims had merit. The trial court overruled Hospital's objections and denied its second motion to dismiss.

Hospital now argues in this accelerated appeal that the trial court abused its discretion by denying its second motion to dismiss because Miller failed to sufficiently address causation. Under this general argument, Hospital raises three "sub-issues," which hew to those raised in its second motion to dismiss: (1) Miller failed to explain how or why the administration of four additional units of Lispro led to Rebecca's hypoglycemic episode, injuries, or death; (2) Miller failed to explain the causal relationship between the nursing staff's alleged failure to notify the treating physician of her BGL of forty-nine and Rebecca's hypoglycemic episode, injuries, or death; and (3) Miller failed to explain a causal relationship between Hospital's alleged breaches and her death thirty-seven days later.

II. LAW GOVERNING MEDICAL-EXPERT REPORTS AND STANDARD OF REVIEW

In the healthcare-liability context, the legislature has erected a pretrial hurdle over which such claims must jump—the expert-report requirement—in order to ensure only claims that have "potential merit" proceed. *Samlowski v. Wooten*, 332 S.W.3d 404, 410–11 (Tex. 2011); *see also id.* at 416 (Wainwright, J., dissenting & concurring). Within 120 days of filing suit, a claimant must serve each healthcare-provider defendant with an expert report, accompanied by the

expert's curriculum vitae. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(a). Such a report must provide "a fair summary of the expert's opinions . . . regarding applicable standards of care, the manner in which the care rendered by the . . . health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed." *Id.* § 74.351(r)(6). A compliant report need not marshal the necessary proof and no particular words are required to address these elements, but bare conclusions or inferences will not satisfy the report requirement. *Scoresby v. Santillan*, 346 S.W.3d 546, 556 (Tex. 2011); *Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 878–79 (Tex. 2001). In deciding whether this standard has been met, the trial court is to examine only the four corners of the expert's report and may not draw inferences or otherwise supply links in the causal chain. *See Bowie Mem'l Hosp. v. Wright*, 79 S.W.3d 48, 52 (Tex. 2002); *Palacios*, 46 S.W.3d at 878. But the expert may make inferences based on medical history. *See Granbury Minor Emergency Clinic v. Thiel*, 296 S.W.3d 261, 265 (Tex. App.—Fort Worth 2009, no pet.).

A trial court may grant a motion to dismiss only if it appears to the court that the report is not an objective, good-faith effort to comply with the statutory requirements for such a report. Tex. Civ. Prac. & Rem. Code Ann. § 74.351(*l*). An objective good-faith effort is one that (1) informs the defendant of the specific conduct the plaintiff called into question and (2) provides a basis for the trial court to conclude that the claims have potential merit. *Scoresby*, 346 S.W.3d at 556;

Samlowski, 332 S.W.3d at 410. "A report meets the minimum qualifications for an expert report under the statute 'if it contains the opinion of an individual with expertise that the claim has merit, and if the defendant's conduct is implicated.'" *Loaisiga v. Cerda*, 379 S.W.3d 248, 260 (Tex. 2012) (quoting *Scoresby*, 346 S.W.3d at 557). In short, "the purpose of an expert report is to give the trial court sufficient information within the four corners of the report to determine if the plaintiff's claim has [potential] merit." *Id.* at 261; *Samlowski*, 332 S.W.3d at 410. However, the expert must explain the bases of his statements and link his conclusions to the facts. *See Wright*, 79 S.W.3d at 52 (quoting *Earle v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999)). If the expert does so on at least one liability theory, the entire case may proceed. *See Certified EMS, Inc. v. Potts*, 392 S.W.3d 625, 630–32 (Tex. 2013); *SCC Partners, Inc. v. Ince*, 496 S.W.3d 111, 114–15 (Tex. App.—Fort Worth 2016, pet. dism'd by agr.).

We review the trial court's ruling on a motion to dismiss under section 74.351 for an abuse of discretion. *See Van Ness v. ETMC First Physicians*, 461 S.W.3d 140, 142 (Tex. 2015); *Palacios*, 46 S.W.3d at 877–78. Under this standard, we defer to the trial court's factual determinations if supported by the evidence but review its legal determinations de novo. *See Van Ness*, 461 S.W.3d at 142. An abuse occurs if the trial court rules without reference to guiding rules or principles or renders a decision lacking support in the facts or circumstances of the case. *See Samlowski*, 332 S.W.3d at 410. But an abuse does not occur if a trial court decides the matter differently than an appellate

court would under similar circumstances. *See Baylor Univ. Med. Ctr. v. Rosa*, 240 S.W.3d 565, 569–70 (Tex. App.—Dallas 2007, pet. denied).

III. CAUSATION

Hospital argues that Miller's opinions are conclusory and speculative, requiring any reader to fill in the gaps between the facts and his ultimate conclusion: "Th[is] [c]ourt would have to make multiple inferences and fill in many gaps in Dr. Miller's report and how he gets from point A (alleged excessive dose of insulin [and failure to contact the treating physician earlier]) to point B (hypoglycemic coma) to point C (injuries and/or death) to understand his causation opinion." In short, Hospital asserts that Miller failed to establish a causal relationship, or unbroken chain of events, from any act or omission by the nursing staff to Rebecca's hypoglycemic episode and later death.

To be considered a good-faith effort to comply with the expert-report requirement, Miller's report not only had to address the standard of care and the manner in which the standard of care was breached, which Hospital does not contest, but the report also had to explain the causal relationship between the breach and the injury, harm, or damages claimed, which Hospital does contest. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(r)(6); *Wright*, 79 S.W.3d at 52; *Palacios*, 46 S.W.3d at 875. A causal relationship is shown by proof that the alleged negligent act or omission constituted a substantial factor in bringing about the harm and that the harm would not have occurred absent that act or omission. *See Cornejo v. Hilgers*, 446 S.W.3d 113, 123 (Tex. App.—Houston

[1st Dist.] 2014, pet. denied). An expert may not simply say that one event "in medical probability" caused another; he "must go further and explain, to a reasonable degree, how and why the breach caused the injury based on the facts presented." *Jelinek v. Casas*, 328 S.W.3d 526, 539–40 (Tex. 2010). The report should "provide an articulable, complete, and plausible path toward a cause of action against" the healthcare provider. *Mendez-Martinez v. Carmona*, 510 S.W.3d 600, 610 (Tex. App.—El Paso 2016, no pet.).

Clearly, an expert report that speaks only of possibilities will not meet the statutory standard for causation. *Wright*, 79 S.W.3d at 53; *Hutchinson v. Montemayor*, 144 S.W.3d 614, 617 (Tex. App.—San Antonio 2004, no pet.). And a causation opinion that contains an obvious gap in the chain of causation also will not qualify as a good-faith expert report. *Wright*, 79 S.W.3d at 53; *Tenet Hosps., Ltd. v. Love*, 347 S.W.3d 743, 755 (Tex. App.—El Paso 2011, no pet.); *Estorque v. Schafer*, 302 S.W.3d 19, 28 (Tex. App.—Fort Worth 2009, no pet.). But a statement on causation will be sufficient if the expert establishes a logical, complete chain that begins with a negligent act and ends in injury to the plaintiff. *See Mendez-Martinez*, 510 S.W.3d at 607; *McKellar v. Cervantes*, 367 S.W.3d 478, 485 (Tex. App.—Texarkana 2012, no pet.).

In sum, "[a] bare expert opinion that the breach caused the injury will not suffice." *Van Ness*, 461 S.W.3d at 142. The expert must provide some basis that the healthcare provider's act or omission proximately caused the injury,

explain the bases of his statements, and plausibly link his conclusions to the facts. *See Wright*, 79 S.W.3d at 52; *Cornejo*, 446 S.W.3d at 123.

A. Causal Chain From Excessive Dose to Injury

Hospital argues that Miller failed to provide any medical detail to support a causal relationship between the administration of twenty units of Lispro, a short-acting form of insulin, and Rebecca's coma eight hours later. Hospital's argument focuses on the fact that Miller failed to differentiate between the metabolic effects of sixteen units of Lispro versus twenty units of Lispro when combined with fifty units of Detemir. It also contends that Miller's report is insufficient on causation because it lacks medical detail explaining the interplay between glucose and insulin, such as what insulin medicines accomplish, how those medicines affect BGLs, what BGL is needed for adequate brain function, and what BGL over what period of time will cause an adverse event.

Miller's report stated that short-acting Lispro causes "wide swings" in BGLs and "must be closely monitored and adjusted," especially after a recent hypoglycemic episode. The nursing staff, however, did not follow the sliding-scale order and administered "an excessive dose of the short-acting Lispro insulin." Based on his review of Rebecca's medical records, Miller opined that this excessive dose of Lispro combined with the fifty units of Detemir caused Rebecca's BGL to drop "to an excessively low level" and led to a prolonged hypoglycemic coma, her neurologic injury, and her eventual death of complications from this neurologic injury. Miller explained that Rebecca's BGL of

thirty-seven when she was discovered eight hours after the excessive dose of Lispro combined with the dose of Detemir and the fact that her medical records showed no subsequent "intervention" such as more frequent BGL testing or food "indicate[] insufficient levels of glucose in the bloodstream to support adequate neurologic/brain function," which permanently damaged her brain. Finally, Miller explained the effect of low BGL in the body and how Rebecca's hypoglycemic event caused her injuries and death:

> The human brain is dependent on serum glucose in order to function. Episodes of low blood glucose result in loss of consciousness. Prolonged episodes can cause neurological damage and even brain death. In this instance, [Rebecca] was obviously subjected to an extended period of low blood glucose. As a result, her brain did not have sufficient glucose in order to function properly and suffered severe neurologic insult. As a result of the neurologic insult [Rebecca] never regained consciousness and died on January 24, 2014. But for the hypoglycemic event, [Rebecca] would not have sustained the global brain damage as indicated on the EEG and therefore would not have died as a result of this global neurologic deficit/damage.

He further stated that if the nurses had followed the sliding-scale order and given the lower dose of Lispro, "in reasonable medical probability, meaning more likely than not, [Rebecca] would not have had a catastrophic hypoglycemic event which was first identified at 5:45 AM on December 18, 2013."

This report, when read in its entirety and in context, is not so conclusory regarding causation such that we may conclude that the trial court abused its discretion. *See Bakhtari v. Estate of Dumas*, 317 S.W.3d 486, 496 (Tex. App.—Dallas 2010, no pet.) ("We determine whether [the expert's] causation opinion is

sufficient by considering it in the context of his entire report."). Miller clearly stated what the nursing staff should have done to properly manage Rebecca's diabetes. He contended that if she had received proper care according to the doctor's dosage order, she in reasonable medical probability would not have suffered the hypoglycemic event. Miller did not merely state conclusions, but adequately explained the factual and medical bases for his causation opinion and described a causal chain plausibly linking the breach—the insulin overdose—Rebecca's low BGL eight hours later in the absence of further intervention, and her brain death. *See Presbyterian Cmty. Hosp. of Denton v. Smith*, 314 S.W.3d 508, 518–19 (Tex. App.—Fort Worth 2010, no pet.); *Tovar v. Methodist Healthcare Sys. of San Antonio, Ltd.*, 185 S.W.3d 65, 69–70 (Tex. App.—San Antonio 2005, pet. denied); *see also Mendez-Martinez*, 510 S.W.3d at 609–10; *Covenant Health Sys. v. McMillan*, 446 S.W.3d 861, 868 (Tex. App.—Amarillo 2014, no pet.); *Nexion Health at Terrell Manor v. Taylor*, 294 S.W.3d 787, 795–96 (Tex. App.—Dallas 2009, no pet.); *Sanjar v. Turner*, 252 S.W.3d 460, 467–68 (Tex. App.—Houston [14th Dist.] 2008, no pet.). Miller met "the fair summary standard on causation by logically linking the alleged breach and the alleged harm step-by-step with enough medical detail to allow the trial court to decide that [Appellants] could state a claim under Texas law." *Mendez-Martinez*, 510 S.W.3d at 610; *see also McKellar*, 367 S.W.3d at 486. Although Miller had to explain how and why an alleged breach caused an alleged injury, he was not required to "describe all biological processes involved in the onset of the injury"

or to rule out all other possible causes of her injury. *Valley Reg'l Med. Ctr. v. Gonzalez*, No. 13-12-00572-CV, 2013 WL 2298470, at *6 (Tex. App.—Corpus Christi May 23, 2013, no pet.) (mem. op.); *see Baylor Med. Ctr. at Waxahachie, Baylor Health Care Sys. v. Wallace*, 278 S.W.3d 552, 562 (Tex. App.—Dallas 2009, no pet.).

Hospital relies on two cases from this court in arguing that Miller's report was insufficiently specific regarding causation because he did not explain how or why the excessive dose caused Rebecca's injuries: *Estorque v. Schafer*, 302 S.W.3d 19 (Tex. App.—Fort Worth 2009, no pet.) and *Collini v. Pustejovsky*, 280 S.W.3d 456 (Tex. App.—Fort Worth 2009, no pet.). But these cases are distinguishable. In *Estorque*, the plaintiffs' expert opined that the defendant doctors' failure to consult with a urologist or gynecologist caused delayed diagnosis and treatment of the patient's conditions. 302 S.W.3d at 28. We concluded that the expert failed to provide a "chain of causation" because he did not state that the patient's injuries would not have occurred if the defendants had consulted with a urologist or gynecologist sooner. *Id.* at 29. Thus, the expert's "limited description of causation" did not sufficiently explain how the complained-of conduct caused the patient's injuries such that the trial court could conclude that the plaintiffs' claims had merit. *Id.* Here, Miller's causation opinion is not so limited and explains how the excessive dose of insulin with no further intervention led to Rebecca's abnormally low BGL eight hours later, which did not support brain function and caused "severe and irreversible neurological damage." That is

all section 74.351 mandates. *See Tenet Hosps., Ltd. v. Garcia*, 462 S.W.3d 299, 310–12 (Tex. App.—El Paso 2015, no pet.). Similarly, we found an expert report insufficient in *Collini* because the expert provided no medical detail of how a prolonged and continued dose of a medication, which had been prescribed by the defendant doctor, led to the patient's condition. 280 S.W.3d at 467–68. In short, the report in *Collini* skipped from the use of the prescribed drug to the physical harm to the patient with no explanation of how such a drug, if used for a prolonged time, would cause the patient's symptoms. *Id.* at 467; *see also Vestal v. Wright*, No. 2-08-237-CV, 2009 WL 2751020, at *8 (Tex. App.—Fort Worth Aug. 31, 2009, pet. denied) (mem. op.) (finding causation opinion insufficient where expert failed to link departure from standard of care by nurses to doctor's failure to recognize mistake, leading to injuries). But Miller supplied those links. He stated what the excessive dose of Lispro combined with the Detemir does and how the absence of any further intervention resulted in Rebecca's low BGL, which caused neurologic damage based on the brain's need for sufficient glucose to function.

Requiring more specificity than supplied by Miller here, as urged by Hospital, would impermissibly engraft onto an expert report filed under section 74.351 a marshaling-of-proof dictate. *See Sanjar*, 252 S.W.3d at 467–68; *see also* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(s) (allowing only limited discovery before expert report is filed). This goes beyond the purpose of such a report, which is merely to notify Hospital of the specific conduct called into

question and to provide a basis for the trial court to assay the claims' potential merit. *See Wright*, 79 S.W.3d at 52. Miller's report did both and, therefore, met the fair-summary standard on causation. *See Smith*, 314 S.W.3d at 518–19; *see also Nexion Health at Garland, Inc. v. Townsend*, No. 05-15-00153-CV, 2015 WL 3646773, at *7–8 (Tex. App.—Dallas June 12, 2015, pet. denied) (mem. op.); *McMillan*, 446 S.W.3d at 868; *Gonzalez*, 2013 WL 2298470, at *6–7. Indeed, the Hospital's causation argument "sounds to us like an invitation to resolve an ultimate cause-in-fact question on the merits, not like an attack on whether [Miller's] summary on causation is a fair one." *Mendez-Martinez*, 510 S.W.3d at 610. We decline to do so, recognizing that the expert-report requirement is a pretrial hurdle, not an impassable evidentiary moat. *See Palacios*, 46 S.W.3d at 880 (recognizing a fair summary is something less than a complete statement of the applicable standard of care and how it was breached).

While we might have decided the sufficiency of Miller's report differently than did the trial court, that is not our standard of review. We must show great deference to the trial court's determination that the expert report in question was a good-faith effort to comply with section 74.351. *See McMillan*, 446 S.W.3d at 868–69. The trial court's conclusion was not so arbitrary or unreasonable based on the content of Miller's report that we may conclude the trial court abused its discretion. *See IHS Acquisition No. 140, Inc. v. Travis*, No. 13-07-481-CV, 2008 WL 1822780, at *8 (Tex. App.—Corpus Christi Apr. 24, 2008, pet. denied) (mem.

op.). *See generally Samlowski*, 332 S.W.3d at 411 ("A reasonable error in judgment, however, is not an abuse of discretion.").

Hospital asserts that comments made by the trial court on the record show that there were missing links in Miller's chain of causation that the trial court supplied sua sponte; thus, the trial court abused its discretion. Indeed, at the hearing on Hospital's second motion to dismiss, the trial court appeared to go outside Miller's report and supply these links based on a general knowledge of diabetes as a disease:

> [The effect of the eight-hour gap] doesn't need to exist in this particular report because if she's not getting anything to eat and there's nothing in the medical records - - because he's indicating there wasn't any change in her . . . dietary stuff, and it's, what, 9:00 o'clock at night, okay? This is an overnight drop in her [BGL] and nobody is paying attention to it. And, in fact, the last thing they did is pop her with a bunch of medication to drop it, okay?
>
> . . . .
>
> Basically what you're asking me to do is say because he hasn't given me a seminar on basic diabetes that this doesn't have sufficient information for me to be able to conclude that there is some evidence of negligence here and some evidence of causation, okay?
>
> . . . .
>
> . . . So exactly what [am] I supposed to do with the fact that somehow the 37 just appeared, that there's something in her makeup as a diabetic that she can maintain a 300 for eight hours without any input whatsoever, after getting medication that's designed to knock it down?
>
> . . . .

> . . . Here, we know that unless there's input of eating at any point in time, if you give someone blood medication - - the medication that's given, even when the medication quits working, okay? Let's say it quit working at midnight, so it got her blood sugar down till midnight, okay? It quit working, [it is] no longer efficacious, the blood sugar will keep it going down for the next five hours.
>
> [Counsel for Hospital]: Okay. Your Honor, that right there, what you said, that's exactly our objection, because what . . . Your Honor just said, that we know that unless you quit eating, the blood sugar will keep going down. That is not in this report . . . .
>
> . . . .
>
> THE COURT: Diabetes is a well-known illness, and he's got enough in here to describe what the impact is with regard to the need for that medication to reduce the blood sugar, okay? And if you reduce it . . . too low, then you have brain damage . . . .

These comments could be construed as impermissible inferences based on the trial court's prior medical knowledge that were entirely divorced from the four corners of Miller's report. But Miller's report was sufficient on its own to support the trial court's denial, and the trial court did not impermissibly propose unique causation theories that were not discussed in Miller's report. *See Travis*, 2008 WL 1822780, at *9. Therefore, these comments did not improperly insert links in the chain of causation not supplied by Miller's report such that the trial court's conclusion that the report was a fair summary cannot be deferred to. Although the trial court ultimately did not supply causation theories or links not sufficiently addressed in the report, its remarks on the record did supply Hospital with a strong appellate argument that otherwise would not have arisen.

B. REMAINING LIABILITY THEORIES

Hospital also asserts that Miller's report failed to explain why or how the nursing staff's failure to contact the treating physician when Rebecca's BGL fell below seventy at 4:45 p.m. was a substantial factor in Rebecca's injuries and ultimate death. It also argues that Rebecca's wrongful-death claim cannot survive the motion to dismiss because there was no link between any breach of the standard of care and Rebecca's death thirty-seven days later. As we have discussed, Miller's report established a sufficient causal relationship as to a single theory of negligence; therefore, the report was sufficient as to all claims and theories raised by Appellants. *See Potts*, 392 S.W.3d at 630; *McMillan*, 446 S.W.3d at 868.

IV. CONCLUSION

We conclude that Miller's medical expert report informed Hospital of the specific conduct claimed to be negligent and provided a reasonable basis for the trial court to conclude at least one claim had merit. Therefore, the trial court did not abuse its discretion by concluding that Miller's report was a good-faith effort to comply with the report requirement and by denying Hospital's motion to dismiss. *See* Tex. Civ. Prac. & Rem. Code Ann. § 74.351(*l*); *McMillan*, 446 S.W.3d at 868–69. We overrule Hospital's issue and affirm the trial court's order. *See* Tex. R. App. P. 43.2(a).

/s/ Lee Gabriel

LEE GABRIEL
JUSTICE

PANEL: LIVINGSTON, C.J.; GABRIEL and KERR, JJ.

DELIVERED: June 1, 2017