ORAL ARGUMENT REQUESTED

No. 05-12-01394-CV
IN THE COURT OF APPEALS FOR THE
FIFTH DISTRICT OF TEXAS AT DALLAS

ENRIQUE N. PONTE, JR., M.D. ET AL.,
Appellants,

v.

MARCELA AND JOSE BUSTAMANTE, ET AL.,
Appellees.

From the 101st District Court of Dallas County, Texas
Hon. Martin Lowy, Presiding

APPELLEES' BRIEF IN RESPONSE TO APPELLANTS JORGE FABIO LLAMAS-SOFORO, M.D., AND JORGE FABIO LLAMAS-SOFORO, M.D., P.A. D/B/A EL PASO EYE CENTER

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STATEMENT ON ORAL ARGUMENT

Appellees respectfully request oral argument in this case and believe that it will help the Court in evaluating the case and resolving this appeal.

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

Rules

STATEMENT OF THE CASE

Marcela and Jose Bustamante, as next friends of Daniella Bustamante, a minor (the "Bustamantes") brought this medical malpractice action against (a) Appellants Enrique Ponte, Jr., M.D., and his employer Pediatrix Medical Services (b) Pediatrix Medical Group, Inc., and Pediatrix Medical Services, Inc., (c) Appellants Jorge Fabio Llamas-Soforo, M.D. ("Llamas") and Jorge Fabio Llamas-Soforo, M.D., P.A. d/b/a El Paso Eye Center, and (d) Hospital Corporation of America, CHC-El Paso Corp., Sun Towers/Vista Hills Holding Co., and El Paso Healthcare System, Ltd d/b/a Del Sol Medical Center (the "Hospital Defendants").[1] The Bustamantes alleged that the defendants' negligence and gross negligence caused complete blindness in Daniella's right eye and severe vision defects in her left eye.[2]

The Bustamantes settled their claims against the Hospital Defendants.[3] Their remaining claims were tried to a jury beginning October 24, 2011 in the 101st District Court, Dallas County, Texas, the Honorable Martin Lowy presiding.[4] Judge Lowy entered a directed verdict as to all direct liability claims against Pediatrix Medical Group, Inc. and Pediatrix Medical Services, Inc., leaving the

[1] 1 CR 19-35.

[2] 1 CR 25, 31-32, 307, 312-14, 492-500; 2 CR 459-65.

[3] 1 CR 319-20.

[4] 2 Supp. RR at 36.

Bustamantes' vicarious liability claims against Pediatrix Medical Services, Inc. based on the actions of their employee, Dr. Ponte.[5]

On November 8, 2011, the jury returned its 10-2 verdict in favor of the Bustamantes.[6] The jury apportioned responsibility at 45% to Ponte, 45% to Llamas, and 10% to the Hospital.[7] The jury awarded total damages of $2,124,000.[8] The Trial Court signed its Second Corrected Final Judgment (Nunc Pro Tunc) on October 9, 2012, and this appeal followed.[9]

[5] 4 CR 719; 11 Supp. RR 91-92.

[6] 4 CR 211-20.

[7] 4 CR 216.

[8] 4 CR 216-17.

[9] 4 CR 618-31.

ISSUES PRESENTED

1. Should Judgment be Affirmed Because the Jury's Verdict is Supported by Sufficient Evidence of Causation?

2. Should the Judgment be Affirmed Because The Jury's Award of Future Medical Expenses to Daniella is Supported by Sufficient Evidence?

3. Should the Judgment be Affirmed Because the Jury's Award of Future Attendant Care Expenses is Supported by Sufficient Evidence?

4. Should the Judgment be Affirmed Because the Trial Court Correctly Refused to Give a "Loss of Chance" Instruction?

5. Should the Judgment be Affirmed Because the Trial Court did not Abuse its Discretion by Denying Llamas' Motion for a Mistrial?

6. Should the Judgment be Affirmed Because There Was No Error Cumulative Error That Probably Resulted In An Improper Judgment

STATEMENT OF FACTS

Daniella was born to Marcela and Jose Bustamante on May 19, 2005.[10] Because she was premature and very small, Daniella was admitted directly to the neonatal intensive care unit (the "NICU") at Del Sol Medical Center in El Paso, Texas.[11] Appellant Enrique N. Ponte, Jr., M.D., the medical director of the NICU at Del Sol and an employee of Appellant Pediatrix Medical Services, was in charge of Daniella's care.[12] At birth, Daniella weighed less than 750 grams, and Ponte calculated Daniella's gestational age as 23 weeks.[13]

A baby born at 23 weeks and one day weighing less than 750 grams, like Daniella, had a more than 95 percent risk of developing Retinopathy of Prematurity ("ROP").[14] Thus, health care providers clearly know that ROP is likely to arise, and they are required by the standard of care to examine and monitor to identify it, to begin treatment before it becomes untreatable and to execute treatment in an appropriate manner.

Dale L. Phelps, a neonatologist, described ROP as uncontrolled blood vessel growth: "the blood vessels that nourish the retina, the part of the eye that sees,

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[10] 2 CR 5-6; PX 1.

[11] 4 Supp. RR at 17:2-21; PX 1, PX2.

[12] 4 Supp. RR at 156:20; 157:1.

[13] 4 Supp. RR at 166:23-25. Ponte testified that he believed Daniella was born the first day of the 23rd week of gestation. 4 Supp. RR at 180:9-25; 181:1-3.

[14] 6 Supp. RR 17:22-25; 18:1-6. At trial, Ponte himself testified that "100 percent of those babies born" at 23 weeks had ROP. 4 Supp. RR at 165:4-14.

grow out of control in the premature babies because they have been hurt. They are trying to make up for time, and they get out of control."[15] Instead of growing normally, flat against the back wall of the retina, they start to grow out into the eye's center cavity, which can lead to retinal detachment. As Dr. William Good, the Bustamantes' ophthalmological expert explained: "Eventually, these blood vessels will go away, but in the process they bring in cells that are precursors to the formation of scar tissue. And so the retina can detach, and it can detach partially or it can detach completely" leading to diminished vision or blindness.[16]

But, ROP can be successfully treated. Regarding the blood vessel growth characteristic, neonatologist Dr. Dale Phelps explained that "if you can just slow them down, get them to settle down for a while, then they will catch up, and the retina will stay where it belongs instead of becoming detached."[17] The disease generally progresses from no ROP to different levels of severity over the course of days or weeks.[18] While the excess blood vessel growth sometimes reverses on its own, for those babies whose eyes do not naturally return to normal vascularization, it is necessary to treat the eyes with laser photocoagulation, a therapy that is

[15] 6 Supp. RR at 14:11-18.

[16] 5 Supp. RR at 143:16-19.

[17] 6 Supp. RR at 14:11-25.

[18] 4 Supp. RR at 190:16-22; 5 Supp. RR 117:6-14.

effective in stopping the progression of ROP in most babies.[19] Because the risks of ROP developing are well known, screening regimens have been developed to diagnose ROP and treat it as soon as it reaches a treatable state.[20] The 2001 Guidelines developed jointly by the American Academy of Pediatrics, the American Association for Pediatric Ophthalmology and Strabismus, and the American Academy of Ophthalmology (the "2001 Guidelines"), recommended an initial ROP screening at four to six weeks after birth or 31 to 33 weeks gestational age.[21]

The 2001 Guidelines also recommend that in assessing the severity of ROP, ophthalmologists should use the International Classification for Retinopathy of Prematurity or "ICROP" nomenclature, which classifies the severity of the ROP based on the behavior of the blood vessels in three zones of the eye, hence references to ROP Zone I, II, or III as well as references to various stages of ROP ranging from 1 to 5.[22] The diagnosis also involves determining whether the baby is suffering from "plus" disease, which refers to a type of change in the structure of

[19] 5 Supp. RR at 103:3-10; 108:10-12. Before laser therapy became prevalent, the preferred method of treatment was cryotherapy, involving using a device to "freeze" portions of the retina. 8 Supp. RR at 143:9-14.

[20] 4 Supp. RR at 190:23-25; 181:1-2.

[21] PX 4.

[22] 5 Supp. RR at 127:9:14; PX 11. At trial, Dr. Darius Moshfegi explained the various stages of ROP: "there is stage 1 through 5 right now in the current classification. And if that disease becomes elevated, then we call that stage 2. If it is elevated as blood vessels are growing off of it, we call that stage 3. If there is retinal detachment, it is stage 4A, 4B, or 5." 4 Supp. RR at 12-17.

the blood vessels in the eyes' posterior wall.[23] An ophthalmologist performing a screening examination is ultimately looking for either (1) the blood vessels have reached Zone III and were complete (meaning the ROP had regressed) or (2), has the disease progressed such that it has reached a treatment "threshold."[24] The term "threshold" means that the baby has reached stage III ROP in a certain number of clock hours while also suffering from plus disease.[25]

For Daniella, due to her extreme prematurity and her very low birth weight, she was at extremely high risk of developing significant ROP, meaning "she was in a category of child who ***should have been followed closely***."[26] Ponte asked Llamas to do an examination earlier than the originally scheduled examination, so Llamas performed an examination on July 4, 2005.[27] In his examination notes, Llamas did not use the ICROP nomenclature. Instead, the notes of the exam indicate that Llamas found "fetal fundi" and incomplete vascularization, with Llamas recommending a follow-up examination in *four weeks*.[28] Under the

[23] 4 Supp. RR at 100:23-25; 101:1-12.

[24] 5 Supp. RR 187:16-19.

[25] 5 Supp. RR at 187:20-25; 188:1-3.

[26] 5 Supp. RR at 110:16-25; 111:1-2 (emphasis added).

[27] 5 Supp. RR at 113;15-25.

[28] 8 Supp. RR 196:13-19; PX 4. Llamas' note from the examination actually stated "complete vascularization," but Llamas testified this was a transcription error and that he had dictated "incomplete vascularization." 8 Supp. RR at 139:2-10. Dr. Ponte agreed it was physically impossible for Daniella to have "complete vascularization" on that date. 4 Supp. RR at 182:15-19.

Guidelines, a follow-up examination should have taken place within *one to two weeks*: "Those without ROP but with incomplete vascularization in zone I should be seen at one- to two-week intervals until retinal vascularization has reached zone III or until threshold conditions are reached."[29] Dr. Good explained that "Fetal fundi, according to Dr. Llamas, meant zone II immaturity. But I believe that Dr. Ponte's interpretation of that is that it was zone I immaturity. So if it was indeed zone I immaturity, then *every one- to two-week* examinations would be of benefit."[30]

Llamas did his follow-up exam as scheduled on August 1, 2005, and after discovering that Daniella had ROP in Zone I, he informed Ponte that Daniella would need laser surgery.[31] Llamas did not perform the laser surgery until August 4, 2005.[32] Photographs of the interior of Daniella's eyes were taken before and after the surgery using a device known as a RetCam, a camera designed to look inside the eyes of a very premature infant.[33] The RetCam images reveal numerous "skip areas" in the treatment administered by Llamas, that is, portions of the retina where the laser burns either did not take or were not administered.[34] Dr. Good

[29] 5 Supp. RR at 111:13-17; PX 30.

[30] 5 Supp. RR at 111:22-25; 112:1-3 (emphasis added).

[31] 4 Supp. RR at 167:18-25; 168:106.

[32] 4 Supp. RR at 170.

[33] 4 Supp. RR at 92:14-25; 93:125; 941:1-23.

[34] 5 Supp. RR at 141:19-25.

opined that Llamas' laser treatment of Daniella was beneath the applicable standard of care.[35]

Following the laser surgery, Daniella had a retinal detachment in her right eye and is now blind in her right eye with no vision.[36] While the retina in her left eye did not detach, Daniella suffered scarring from the ROP and her visual acuity in the left eye has been severely damaged.[37]

[35] 5 Supp. RR at 141:19-25; 142:1.

[36] 4 Supp. RR 134:1-2.

[37] 5 Supp. RR 135:25; 136:1-25; 137:1-25: 138:1-3.

SUMMARY OF ARGUMENT

The causation challenges made by Llamas in his brief were also made and rejected by Judge Lowy after careful consideration.[38] Causation was properly left to the jury, and the jury's finding of liability and award of damages should not be disturbed. There was ample evidence in the record supporting a finding that Llamas' negligence was a proximate cause of Daniella's injuries. The opinions of the Bustamantes' experts tied Llamas' actions to the injuries, and those opinions were supported by credible scientific evidence. Llamas did not offer statistical or epidemiologic evidence to support his claim that the experts' opinions were without foundation. Just as Judge Lowy did, this Court should rebuff the attempts of counsel to "interpret" data and engineer conclusions, which amounts to nothing more than impermissibly drawing inferences contrary to the jury verdict.

In particular, the Court should reject Llamas' efforts to characterize this as a loss-of-chance case. This case does not involve a preexisting, unknown illness, the character of which makes a claimant's chance of avoiding the ultimate harm improbable. Healthcare providers such as Llamas know well that ROP is likely to arise, and science and clinical experience both demonstrate that ROP is treatable and that proper treatment done at the proper time leads to the successful avoidance of unfavorable outcomes, such as the near blindness involved in this case, in the

[38] 1 CR 1049-84; 1 CR 1319-1352; 2 CR 5-94; 2 CR 113-149; 2 CR 150-200; 2 CR 354; 2 CR 380-454; 2 CR 486-967; 3 CR 208-219; 3 CR 404-478; 3 CR 824-856.

overwhelming majority of cases. Thus, Judge Lowy correctly rejected the lost chance instruction tendered by Llamas. Moreover, there is similarly sufficient evidence to tie each of Llamas' acts negligence to Daniella's injuries.

The amount of the jury's verdict should also not be disturbed. Under this Court's controlling precedents, the Bustamantes demonstrated physical conditions and limitations Daniella will have for life and that may well become worse, the forseeable needs for future medical treatment, and possible future treatments that might be available to her. The jury's judgment regarding the amount regarding her potential future medical needs during her lifetime is entitled to deference. The jury's award of damages for future attendant care is also supported by sufficient evidence.

With respect to the admission of evidence regarding other patients of Dr. Llamas, the Trial Court promptly promptly gave a curative, limiting instruction. Given the evidence supporting the verdict, Llamas cannot meet his burden of demonstrating that the error probably caused the rendition of an improper judgment, cumulatively or otherwise.

ARGUMENT

A. Standard of Review

1. Legal Sufficiency of the Evidence.

The court may sustain a legal sufficiency challenge only when (1) the record discloses a complete absence of evidence of a vital fact; (2) the court is barred by rules of law or of evidence from giving weight to the only evidence offered to prove a vital fact; (3) the evidence offered to prove a vital fact is no more than a mere scintilla; or (4) the evidence establishes conclusively the opposite of a vital fact. *Uniroyal Goodrich Tire Co. v. Martinez*, 977 S.W.2d 328, 334 (Tex. 1998). In determining legal sufficiency, the court must consider evidence favorable to the finding if a reasonable factfinder could do so and disregard evidence contrary to the finding unless a reasonable factfinder could not do so. *Central Ready Mix Concrete Co. v. Islas*, 228 S.W.3d 649, 651 (Tex. 2007).

2. Factual Sufficiency of the Evidence.

The court may set aside a finding for factual sufficiency only when, after considering and weighing all of the evidence in the record pertinent to that finding, the court determines that the credible evidence supporting the finding is so weak, or so contrary to the overwhelming weight of all the evidence, that the answer should be set aside and a new trial ordered. *Pool v. Ford Motor Co.,* 715 S.W.2d 629, 635 (Tex. 1986).

Point I The Judgment Must Be Affirmed Because the Jury's Verdict is Supported by Sufficient Evidence of Causation.

Texas law does not require either absolute certainty or mathematical precision for proof of causation. Llamas' demand for both in his brief is without support. This is not a loss of chance case, and the Court should reject Llamas' attempts to twist the case law and, through attorney argument, not trial evidence, extrapolate from and mischaracterize the relevant scientific evidence, all of which supports the conclusion that ROP is a treatable disease if the screening is done properly and the treatment is done properly. Instead, under the applicable standards, the jury's verdict is supported by ample evidence of causation.

A. The Applicable Causation Standard.

The Supreme Court has explained the distinction between the various burdens of proof used at trial and made it plain that neither a party nor an expert is required to proffer what the Supreme Court describes as "proof of an absolute certainty":

> [T]he law does not, and should not, require proof of an absolute certainty of causation or any other factual issue. It always settles for some lower threshold of certainty, whether beyond a reasonable doubt in criminal law, clear and convincing evidence in certain civil matters involving constitutional rights, or the more typical civil burden of reasonable probability.

Kramer v. Lewisville Mem'l Hosp., 858 S.W.2d 397, 405 (Tex. 1993). A plaintiff is required to show evidence of a "reasonable medical probability" or "reasonable

probability" that the plaintiff's injuries were proximately caused by the negligence of one or more defendants. *Park Place Hosp. v. Estate of Milo*, 909 S.W.2d 508, 511 (Tex.1995). The ultimate standard of proof on the causation issue is "whether, by a preponderance of the evidence, the negligent act or omission is shown to be a substantial factor in bringing about the [injury] and without which the harm would not have occurred." *Milo,* 909 S.W.2d at 511, *quoting Kramer,* 858 S.W.2d at 400. The causal connection between the defendant's negligence and the injuries must be established based on more than mere conjecture, speculation, or possibility. *Milo,* 909 S.W.2d at 511. A plaintiff, however, "is not required to establish causation in terms of medical certainty nor is he . . . required to exclude every other reasonable hypothesis." *Bradley v. Rogers,* 879 S.W.2d 947, 953–54 (Tex. App.—Houston [14th Dist.] 1994, writ denied).

In determining whether expert testimony on causal connection rests upon reasonable medical probability, a court must consider the substance and context of the testimony rather than semantics or use of a particular term or phrase. *Burroughs Wellcome Co. v. Crye,* 907 S.W.2d 497, 500 (Tex. 1995).

B. The Verdict is Supported by Admissible Evidence That Llamas' Negligence Was a Cause in Fact of Daniella's Injuries.

The evidence in the record is legally sufficient to support the jury's verdict with respect to causation. Dr. Good testified unequivocally that more likely than

not, Daniella's visual outcome would have been different had Llamas and the other Appellants not acted negligently:

> Q. Can you tell us more likely than not what her vision would be like had these defendants acted properly?
>
> A. More likely than not, she would have what I would call a sighted life. In other words, she would be able to use her vision to function in her environment.
>
> Q. Okay. And so what does that mean? Give us some -- what does that look like?
>
> A. It looks like a child who can read possibly with enlarged symbols but definitely can read. So it is a child who is a visual learner, who can learn about her environment by looking at it and observing it rather than having to use other senses to figure it out. It is a child who can ambulate. Now, she does have prostheses -- orthoses, but she needs assistance in ambulating. But if she had a sighted life, she would be able to get around and see her way around her environment. She would be able to do a lot of activities that require -- that are involved in self-care without requiring help because she could see; for example, where the toothbrush was and things like that.[39]

He also specifically testified about what Daniella's visual acuity would have been had she been appropriately treated, as well as explaining how this affected her life.[40]

This is far more than merely furnishing a condition that made the injury possible. Llamas contends that Dr. Good's testimony amounts to a claim that the negligence merely increased the chance of a poor outcome, thus furnishing a

[39] 5 Supp. RR at 167:19-25; 168:1-18.

[40] 5 Supp. RR at 179:24-25; 180:1-25; 181:1-25; 182:1-3.

condition that made the injuries Daniella was already prone to as a premature infant possible. (Llamas Brief at 17.) Make no mistake, this is a case where the physician's actions affirmatively made the situation and physical condition worse; it was not a situation where the physician failed to identify and learn of a pre-existing threat to survival. Dr. Good is clear that Llamas' delay in doing a follow-up examination prevented him from identifying ROP when it could have been treated with a better visual outcome. The delay in the actual laser treatment similarly increased the likelihood of a bad outcome, as did Llamas' failure to properly administer the laser treatment once he actually did it.

Llamas' uses semantics to attempt to undermine the causation evidence by focusing on Dr. Good's use of the terms "increment" and "incrementally" is without merit. (Llamas Brief at 16.) Llamas interprets Dr. Good's opinion, and his use of these terms, as indicating that Dr. Good "opined only that the alleged delays by Llamas increased the chance" of a poor outcome and did not support a finding of causation. (Llamas Brief at 17.) That is not what Dr. Good is saying, as is obvious from his actual testimony. Dr. Good states that "I think the standard of care was violated at several steps in the process of Daniella developing ROP and suffering loss of vision from it."[41] When he *looks at these steps* in the process "in an incremental fashion," Dr. Good is testifying about the sequence of events, that

[41] 5 Supp. RR at 140:23-25; 141:1.

is, the increments in the timeline – the four-week delay in doing a follow-up exam, followed by the three-day delay in performing the laser therapy, followed by Llamas' failure to perform the laser surgery properly – where, during each increment, the damage to Daniella's vision could have been avoided entirely or substantially, had Llamas (and/or Ponte) adhered to the applicable standard of care.

Dr. Good explained how Llamas violated the applicable standard of care in waiting four weeks to re-examine Daniella after his initial July 4th exam: "I think the standard of care was violated at several steps in the process of Daniella developing ROP and suffering loss of vision from it. The first is, Daniella should have been examined one week after she was first examined on July 4th, and instead she was examined at four weeks. I think . . . by any reasonable approach to the management of ROP, four weeks is taking a big chance on Daniella because of her high risk situation. She was very vulnerable to develop ROP, severe ROP, and also developing it earlier than say the average baby might develop it. So I think the delay in screening to four weeks violates the standard of care."[42]

Dr. Good then opines that, more likely than not, the negligence in this increment of the timeline was a proximate cause of Daniella's injuries:

> Q. All right. I would like to shift gears with you and talk about what the negligence, more likely than not, caused in Daniella Bustamante. Can you do that?

[42] 5 Supp. RR at 141:1-11.

A. Yes.

Q. What injury or change in Daniella resulted from the failures to examine appropriately, timely, and to treat properly and timely, more likely than not?

A. Well, if you look at the various places where negligence occurred, in an incremental fashion, each of those contributed to the poor visual outcome that Daniella experienced. The delay in screening examinations for four weeks to a probability prevented Dr. Llamas from identifying ROP when it could have been treated earlier. That would have improved the chance of a good visual outcome for her. The delay in laser treatment for three days also in my opinion incrementally increased the chances of a bad outcome for her.[43]

Dr. Good's opinion was also supported by the testimony of Dr. Dale L. Phelps, a neonatologist, who explained how and why the outcome would have been different had Llamas and Ponte adhered to the applicable guidelines for a follow-up examination schedule:

Q. . . . So what more likely than not would have resulted had Dr. Llamas and Dr. Ponte followed the follow-up examination schedule in the guidelines?

A. He would have seen the ROP as it started up or as it became established and before it became advanced. If it was looking very threatening, they might have moved their schedules -- exam schedules closer together to make sure they caught it quickly when it got to the point where it needed surgery.

Q. Okay.

A. That was -- that would be my expectation.

Q. Do you think more likely than not Daniella would have functional vision had they done it correctly?

[43] 5 Supp. RR at 166:6-25.

A. Yes.

***

Would Daniella Bustamante more likely than not in your opinion have functional vision had they done it correctly -- these doctors done this correctly?

A. Yes.[44]

Dr. Good also explains that once Llamas did reexamine Daniella and recognize the urgent need for prompt treatment, it was a violation of the standard of care to wait three days as he did before treating her, explaining that "every day that went by put the baby at further risk of suffering an adverse outcome:[45]

> Then . . . the delay in treatment of three days also violates the standard of care . . . [T]his baby had bilateral severe, . . . threshold retinopathy of prematurity--not prethreshold, not where it should have been treated but threshold ROP. And that every day that went by put the baby at further risk of suffering an adverse outcome.[46]

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[44] 6 Supp. RR at 32:22-25; 33:1-11, 25; 34: 1-4 (emphasis added). Dr. Phelps testified that this negligence also caused a delay in re-examination:

> Q. . . . [H]ow did that play into the failure to timely diagnose and treat Daniella . . . ?
>
> A. . . .[T]here was . . . some confusion about what her first exam looked like. And then there wasn't a red flag raised about why four weeks after this first exam, why wasn't it two weeks, which is -- or at the most three weeks, consistent with the guidelines.
>
> Q. Are the follow-up exams keyed off of the first exam?
>
> A. Yes, they are.

6 Supp. RR at 26:4-14.

[45] 5 Supp. RR at 141:17-18.

[46] 5 Supp. RR at 140:22-25; 141:1-18.

Dr. Good then explains:

> Thirdly, as I have looked at the pictures of the treatment administered by Dr. Llamas to Daniella, it looks to me like it was inadequate. There are skip lesions. There are areas where the retinal burns either didn't take or were not administered. And this also contributed to, in a proximate way, to her loss of vision in the right eye and some detrimental loss of vision in the left eye.[47]

Dr. Good's opinion regarding the laser surgery performed by Llamas is based on actual photographs of Daniella's eyes after the surgery, and Dr. Good explains in detail how Llamas failed to meet the applicable standard when he applied laser treatment in a non-confluent manner resulting in "skip areas" where there was no laser treatment at all:

> Q. But you have looked at the original images that the jury has seen, and will you describe what it is you are talking about on the images so that we will all be on the same page, so to speak?
>
> A. Yes. When a laser burn takes, it makes a white mark.

Examining the RetCam images of Daniella's eye on display for the jury, Dr. Good explains how the images should have looked had Llamas met the standard of care and specifically identifies the areas of Daniella's eyes where Llamas failed to meet the standard of care in applying laser treatment:

> A. So there are areas -- here is an area that got treatment. But the burns should be no more than one burn width apart. You can see there are areas even in here where the treatment has not been confluent enough. Then as you move out more peripherally, there are dark areas where there has been no treatment. I think this is the left eye of this child. Yeah, left eye.

[47] 5 Supp. RR at 141:19-25; 142:1.

. . . .

> Over here (indicating), the treatment is not very confluent. As you move up in this direction (indicating), it looks like there was scant treatment. When you look down in this region, although it is a little bit defocused, it still looks like there was -- this is a very large area where treatment was either very sparse or where there was no treatment at all. (Indicating) And when you look up in this area as well -- I don't know if I have already pointed this out -- this area also looks like it didn't get treated adequately. Now, this is -- this is not a picture of the entire fundus. This picture only goes out roughly halfway, so we don't really know whether treatment occurred out in areas here and around here. (Indicating) But at least in an area where you have good visibility usually, the treatment was not adequate.
>
> Q. Now, what is normal? What should it look like if it was done correctly in this photograph?
>
> A. It should look white. You should have white, fairly bright white burns scattered very close together all the way around adjacent to the neovascular ridge. It is a little hard to show where that is here, but I think it is around in this area. And so these burns look like they were light, the ones that did take. And, yeah, when you administer the burns, they simply look white.[48]

This evidence is more than sufficient under the applicable standards to support the jury's verdict.

Llamas asserts, without explanation, that other conditions from which Daniella suffered, such as "current disabilities," have some relevance, and Llamas also implies that Dr. Good's opinions are inadequate because he did not review her "school testing results." (Llamas Brief at 18.) Of course, nothing identified by Llamas has anything to do with the causation analysis, that is, whether Llamas'

[48] 5 Supp. RR at 144:13-25; 145:1-25; 146:1.

negligence was a proximate cause of Daniella's blindness in one eye and minimal vision in the other. Causation here is about Daniella's vision, not any other issues.

C. Loss-of-Chance Standards Inapplicable Because This Case Involves No Preexisting Illness That Made The Chance of Avoiding the Ultimate Harm Improbable Even Before The Negligence Occurred.

Llamas demands a certainty and mathematical precision that is simply not part of the causation analysis under applicable Texas law. Faced with this, Llamas repeatedly attempts to turn this case into something it is not by invoking the "loss of chance" concept. (Llamas Brief at 19-23.) This is not a "loss of chance" case, and the causation standard Llamas seeks to impose is inapplicable here. In claiming that the Bustamantes were required to show that ROP therapy has a 50% or greater probability of improved visual outcome, Llamas relies on the Texas Supreme Court's rejection of "loss of chance" as a theory of recovery in *Kramer v. Lewisville Memorial Hospital,* 858 S.W.2d 397, 400-403 (Tex. 1993), where the court framed the issue as "whether there is liability for negligent treatment that decreases a patient's chance of avoiding death or other medical conditions in cases *where the adverse result probably would have occurred anyway.*" *Kramer,* 858 S.W.2d at 398. Loss-of-chance cases, like *Kramer,* are ones where, even had the doctor acted timely and appropriately, the bad result ***was still likely***; i.e. without negligence the bad result was more likely than not. That is simply and unequivocally not the case here.

The Fort Worth Court of Appeals has characterized *Kramer* and the cases applying its rule as "lost chance of survival or cure arguments," explaining that (using the Supreme Court's own characterization of the factual scenarios) they are applicable only in a case where there are preexisting illnesses or injuries that made the claimant's *chance of avoiding the ultimate harm* improbable even before the negligent conduct occurred. *Marvelli v. Alston,* 100 S.W.3d 460, 481 (Tex. App. – Fort Worth 2003, pet denied) (expert testified that the risks of dislocation of artificial lens in eye surgery, where the dislocation caused ultimate loss of eye, ranged from high of two percent with the vertical insertion used by defendant to 'much less' with appropriate horizontal insertion). *Marvelli* looked at *relative risk*. In *Marvelli*, though the risk of harm, even without negligence, remained well below 50%, in the abstract, the defendant physician was held liable for the proximate result of the negligent placement of an artificial lens in that particular case. *In fact*, the eye doctor's negligence there led to the ultimate injury. It does in the extant case as well.

The *Marvelli* court rejected the defendants' attempts to apply *Kramer* and *Milo* by treating the case before it as a loss-of-chance scenario:

> This case is factually distinguishable from the line of cases involving lost chance of survival or cure arguments, in that no evidence was adduced at trial demonstrating that the preexisting illnesses or injuries [ROP in our case] made Alston's chance of avoiding the ultimate harm improbable *even before Dr. Marvelli's negligent conduct occurred.*

Marvelli, 100 S.W.3d at 481 (emphasis added).

In the context of this case, there is no evidence that Daniella's ROP made Daniella's chance of avoiding retinal detachment in the right eye and visual impairment in the left eye improbable even before Llamas' negligent conduct occurred. But there is testimony that, more likely than not, had she received competent care, she would have had a different result.

Llamas asserts, based on general data, that Daniella had a risk of bad outcomes in her eyes. He then selectively plucks data from the Cryo-ROP and ETROP studies to contend that there was a "greater than 50% likelihood of a poor structural outcome (e.g., detached retina) in babies with zone I disease" like Daniella. (Llamas Brief at 20.) The *Marvelli* court rejected similar efforts, noting that the portion of the expert's testimony emphasized by the defendant "was generalized and not related to [Plaintiff's] situation." *Marvelli,* 100 S.W.3d at 481. "Dr. Jaffe repeatedly testified that vertical placement and repeated failures to place the implant horizontally caused the dislocations, which necessitated the multiple incisions and loss of Alston's eye." *Id.* Here, both Dr. Good and Dr. Phelps emphasized that it is more likely than not that the negligent delays caused Daniella's harm, and there is ample expert testimony here about the causal link between Llamas' specific negligence and Daniella's specific harm.

Llamas' pseudo-scientific challenges are not based on actual testimony but are instead constructs created by lawyers trying to re-engineer and reinterpret the actual testimony after the fact. (Llamas Brief at 20, 21-22.) Llamas did not proffer any testimony from an epidemiologist, a statistician, or any other similar expert who would be qualified to opine regarding the meaning and significance of particular studies. The CRYO-ROP study dealt with a different type of treatment than provided to Daniella. CRYO-ROP involved the use of cryo therapy to treat the ROP, while Daniella was treated with laser. Dr. Good testified that laser therapy was effective in stopping the progression of ROP in most babies.[49] Further, CRYO-ROP was specifically designed to look at whether treatment with cryo-therapy was better than no treatment at all. In the CRYO-ROP study, one of a baby's eyes was treated with cryo-therapy and the other one was not treated at all.[50] The study was stopped before completion for ethical reasons because the data showed a statistically significant improvement for children between the treated eye and the untreated eye.[51] That is the only way the data from CRYO-ROP could be applied—whether treatment was better than no treatment. To do otherwise is to draw contrary inferences inconsistent with the applicable standard of review.

[49] 5 Supp. RR at 108:10-12.

[50] 5 Supp. RR at 238:1-9.

[51] 5 Supp. RR at 238:16-25; 239:1-7.

Llamas' brief to this Court attempts to spin the ETROP study to support Llamas' contention. Dr. Good did not say, as Llamas asserts, that there was a greater than 50% likelihood of a poor outcome in babies with zone I disease. (Llamas Brief at 20.) The portion of the testimony of Dr. Good cited by Llamas reveals no such testimony.[52] In any event, Llamas is trying to conduct an analysis of a subgroup of the children in the ETROP study (a subgroup chosen by Llamas) who had zone I disease, and extrapolate from data about that subgroup. This is both poor science and poor epidemiology. In support of this "50%" assertion, Llamas cites Dr. Quinn, Llamas' ophthalmology expert. Llamas does not cite Dr. Quinn's other testimony, however, where he admitted that the ETROP data ***cannot be used for this purpose*** and that any statistical conclusions based on such data would ***not have validity***:

> Q. And you would agree, wouldn't you, that a subgroup analysis is not something you ought to even be using ETROP for?
>
> A. I agree.
>
> Q. Because it's not –
>
> A. Well
>
> Q. – properly powered, right?
>
> A. Well, the study was not powered. The study was powered to answer that question of earlier treatment for high-risk eyes versus conventionally

[52] 5 Supp. RR at 220:1-25.

> managed, that's all. And we can't look at the individual lines and make statistical comments –
>
> Q. You've read --
>
> A. -- that have great validity.[53]

Contrary to Llamas' claim, there is no data to support counsel's assertion that statistically, Daniella had a less than 50% likelihood of a poor structural outcome like retina detachment. Indeed, Dr. Quinn wrote that ROP is a serious but largely preventable cause of blindness, admitting that it is "the most treatable cause of blindness in children."[54] ***And both Dr. Quinn and Dr. Good would agree that with proper screening and treatment, successful outcomes occur more than 75% of the time.***[55] The evidence simply does not support Llamas' attempts to equate this case to a loss-of-chance situation.

In addition, Dr. Good has the clinical expertise, science and reasoning to support his opinions that Daniella should have been treated at an earlier time, and successful laser therapy would have prevented the retinal detachment in her right eye and resulted in a more favorable visual outcome in her left eye. Obviously, there is no scientific evidence that exists, or would exist, evaluating the impact of withholding ROP treatment, as such a study would be unethical given what is

[53] Court's Exhibit 2 at 149:10-24.

[54] Court's Exhibit 2 at 235:18-25; 236:4-10.

[55] 5 Supp. RR at 150:3-8.

known about the beneficial results of treatment. Dr. Good has to reason based on experience to know that a different examination schedule and earlier treatment would make a difference.

D. There Is Sufficient Evidence That Treatable ROP Would Have Been Diagnosed Earlier With A Different Exam Schedule.

The evidence submitted is legally sufficient to show that treatable ROP would have been diagnosed earlier had Llamas not acted negligently. Llamas argues that because Dr. Good could not determine to a reasonable degree of certainty that Daniella's eyes reached threshold on any particular day, specifically July 18th (follow-up exam at two weeks) or July 25th (follow-up exam at three weeks), his opinion that earlier examinations would have made a difference is flawed. (Llamas Brief at 23-26.) In reality, Llamas is clearly confusing the issues. The question is not whether treatable ROP was present on July 18th or July 25th or any other specific date, to a reasonable medical probability or otherwise. *The question is whether the examination results from an exam on July 18th (at two weeks after the initial exam) would have altered the examination schedule and ultimately when the decision was made to do laser treatment.*

Dr. Good himself clearly explains what more frequent examinations, including an examination on July 18th, would have meant, and his opinion is not dependent on the presence of treatable threshold ROP on July 18th:

> Q. I'm going to put a check mark on this. Had ROP been evident on this day, July 18th, then what more likely than not would have been the monitoring or treatment schedule from that date forward if the standards of care were complied with?
>
> A. There are many possible answers to that question, and it would depend basically on what the ROP would look like on that date.
>
> . . . .
>
> So the advantage to Dr. Llamas having seen ROP on that date--and let's say it was mild, not in need of any treatment but still obviously in zone I--is that he could have come back the following week and learned a lot more detail about how this baby's eyes were behaving; meaning if there was a lot of rapid progression of the disease during that one-week time period and that zone I disease, that is an ominous finding. And I think it might have pushed him to want to treat this baby sooner than he did.
>
> Q. . . . Then if he had done the correct treatment -- examination schedule, when more likely than not would this kiddo have been lasered?
>
> A. It's hard to say. Certainly before August 4th, and certainly before August 1st. But I can't put an exact date on that.[56]

As Llamas acknowledges, pointing to Dr. Good's testimony, the undisputed evidence indicates that Daniella did not have any ROP when initially examined on July 4 by Llamas and that she had advanced ROP when Llamas next examined her on August 1st. (Llamas Brief at 23-24.) Dr. Good admitted that he could not make a determination with respect to any particular day as to when Daniella's eyes reached threshold ROP. But it does not follow that Dr. Good is therefore unable to

[56] 5 Supp. RR at 118:13-25; 119:1-12.

opine regarding whether a different examination schedule would have made a difference regarding when treatment should have taken place.

Dr. Good explained that the frequency of the examinations was itself to be affected by what each examination revealed, including other indications besides threshold. Using a calendar as a visual aid, Dr. Good explained to the jury how the examination schedule should have been done and why it would have made a difference. First, Dr. Good explained that "a baby born at 23 weeks and one day means that the gestational age is 23 weeks and one day basically. In other words, the baby was in gestation for that long a period of time."[57] Llamas did his first exam on July 4th, which would have been in week 30 of Daniella's gestational age.[58] The second examination took place on August 1st, in the 34th week of gestation, and the laser surgery took place on August 4th.[59] Dr. Good then explained how the examinations *should have* taken place:

> Q. So when . . . when on here should the exams have occurred, the weekly or every other week? What squares?
>
> A. Well, so the first examination, which was on July 4th –
>
> Q. I'm sorry.
>
> A. The first examination, which was on July 4th, was okay. I mean, it was maybe a little later than some people would have done it, but it is still in the

[57] 5 Supp. RR at 113:11-14.

[58] 5 Supp. RR at 113;15-25.

[59] 5 Supp. RR at 114:1-11.

range where you are very unlikely to see ROP. Or if you see ROP, it is going to be very mild.

But then after that first examination, I would argue that this baby should have been examined either on July 7th -- not July 7th, either on July 11th or July 18th, assuming that the doctor came back exactly on a weekly basis.

Q. Okay. I would like to put this yellow thing on the day you think the exam -- the next exam should have happened, more likely than not. So which square should I put this one on?

A. I would put it on July 11th.

Q. Which is right here? (Indicating)

A. Yes.

Q. All right. When should the next exam have happened?

A. The baby would have still had zone I immature vessels. We know that from the August 1st examination. So I think the next exam should have been a week after that.

Q. All right. And which square should I put this one on?

A. That should go on the 18th.[60]

Dr. Good then explained that what that exam (or the July 11th exam) revealed would dictate the actual remaining schedule:

Q. Right there. (Indicating) Okay. And then when should the next exam have occurred?

A. Well, that will depend. So it would depend upon whether there were any physical findings of ROP on that date.

. . . .

[60] 5 Supp. RR at 114:15-25; 115:1-21.

> But let's say -- well, there are many possible scenarios for that.
>
> . . . .
>
> But at a minimum, in one week. But if the baby had some of these pre-threshold physical findings, then the exam should have been probably in less than a week.
>
> Q. . . . So more likely than not, then what square should I put this one on?
>
> A. Well, I would go ahead and put it -- put it right below that.[61]

Dr. Good noted that the presence or absence of ROP at threshold on the 18th is simply not determinative, given that what was and was not observed at each examination dictated when further examinations were to take place.

Llamas also implies that Dr. Good cannot rely on conclusions drawn from experience based on Daniella's condition on July 4th, August 1, and August 4th, together with interpretations of the literature, suggesting that experts are prohibited from making reasonable inferences from the evidence. Case law holds the exact opposite. Indeed, unlike juries, experts not only may, but often must stack inferences. *See Welch v. McLean*, 191 S.W.3d 147, 160 n.7 (Tex. App. – Fort Worth 2005, no pet.); *Southern. Underwriters v. Hoopes*, 120 S.W.2d 924, 926 (Tex. App. – Galveston 1938, writ dismissed); *see also Insurance Co. of North America v. Myers*, 411 S.W.2d 710, 713 (Tex. 1966), and *Gideon v. Johns-*

[61] 5 Supp. RR at 115:22-25; 116:1-13.

Manville Sales Corp., 761 F.2d 1129, 1137 (5th Cir. 1985) (both cases hold that experts are permitted to make inferences from the evidence so long as the inference relies on "reasonable probabilities"). Good reaches a clinical judgment as he evaluates Daniella's complete medical record in context. Taken together, along with Good's nearly 20 years of experience in pediatric ophthalmology, Dr. Good's conclusions are more than sufficient to support the jury's verdict.

E. Dr. Good's Testimony Regarding the Benefit of Treating Within 48 Hours Establishes Causation.

Llamas is wrong in claiming that there is no reliable or scientific evidence supporting Dr. Good's opinion that Daniella should have been treated within 48 hours and that failure to do so was a proximate cause of her damages. (Llamas Brief at 26-28.) Dr. Good testified as follows:

> Then I think the delay in treatment of three days also violates the standard of care. I think this baby had bilateral severe, quote, unquote, threshold retinopathy of prematurity--not prethreshold, not where it should have been treated but threshold ROP. And that every day that went by put the baby at further risk of suffering an adverse outcome.[62]

Contrary to Llamas' contention, treating Daniella within 72 hours was not within the applicable standard of care. Llamas references the AAP/AAO 2001 Guidelines and notes that they were not officially changed until 2006 as support for his claim that treatment within 72 hours met the standard of care. (Llamas Brief at 5, 26-27.) When asked about the Guidelines at trial, Dr. Good was clear that while the

[62] 5 Supp. RR 141:12-18.

Guideline itself had not changed by 2005, when Daniella was treated, *the standard of care had changed* nonetheless:

> Q. "Treatment should generally be accomplished within 72 hours of determination of the presence of threshold ROP to minimize the risk of retinal detachment before treatment." Correct?
>
> A. That's in 2002, yes.
>
> Q. And that was still the guideline that was in place in 2005. True?
>
> A. It was the guideline, but it was not the standard of care.[63]

And contrary to Llamas' assertion that this opinion is conclusory, speculative, or unreliable, there is ample support for this standard of care, as Judge Lowy determined in rejecting Llamas' similar challenge at trial.[64] (Llamas Brief at 27-28.) Obviously, there is no scientific evidence that exists, or would exist, evaluating the impact of withholding ROP treatment for any period of time. Dr. Good had to use his experience to know that immediate treatment still mattered. Beyond that, however, Dr, Good's opinion is consistent with and supported by findings in the ETROP study, in which Dr. Good himself was involved. And ETROP was powered, as Dr. Quinn testified, "to answer the question of earlier treatment for high risk eyes versus conventionally managed"[65]:

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[63] 5 Supp. RR at 207:14-23.

[64] *See* Motion to Strike William Good, M.D.'s Opinions as Unreliable 1 CR 1050, 1065-71.

[65] Court's Exhibit 2 at 149:19-20.

Q. The ETROP results, did they -- did they advise that laser treatment should occur within 48 hours instead of 72 hours?

A. The -- that was the research protocol. So if you -- the eye that was assigned for early treatment -- You remember, I said if the baby had disease in both eyes, one would get the early treatment, and one would get the usual care. So the early treatment was, we are going to treat it now. We are not going to wait until it gets to threshold, and we are going to try and treat it within 48 hours.

. . . .

And that wasn't so much a practice recommendation for the future. That was research protocol.

Q. But in using the research protocol, the babies that were treated within 48 hours contributed to the favorable outcomes in the study?

A. Yes.[66]

Dr. Phelps elaborated further regarding the scientific support for the efficacy of earlier treatment:

Q. Now, the relative benefit in the ETROP results showed that half the kids had a benefit to early treatment.

A. Half the kids. I'm not –

Q. Well, I think the 7 percent or whatever it was out of the 14. Did I –

A. Right. So the -- in cryo, we went from about 52 percent bad outcomes down to about 26 percent with cryo.

Q. Um-hmm.

A. And then by the time we got to be doing the ETROP study, the kids treated with laser at conventional threshold times had good -- or their bad

[66] 5 Supp. RR at 83:10-25; 84:1-4.

> outcomes went down to, I think it was 14 percent, 16 percent, in there. And then if they were assigned to the early treatment group, the bad outcomes were down to 9 percent, less than 10 percent. So it's just -- you know, we just keep nibbling away at the bad outcomes and pushing them down.[67]

In addition, in this case, we have more than statistics and reasoned inferences from experience for proximate cause. There are actual photos of Daniella's eyes[68] that allowed Dr. Good to opine regarding whether earlier treatment would have resulted in a more favorable structural and visual outcome for Daniella.

F. There Is Sufficient Evidence That Llamas' Failure to Meet the Standard of Care by Providing More Confluent Laser Treatment Was a Proximate Cause of Daniella's Injuries.

Dr. Good explained that Llamas' actual treatment of Daniella violated the standard of care and was a proximate cause of her injuries:

> [A]s I have looked at the pictures of the treatment administered by Dr. Llamas to Daniella, it looks to me like it was inadequate. There are skip lesions. There are areas where the retinal burns either didn't take or were not administered. And this also contributed to, in a proximate way, to her loss of vision in the right eye and some detrimental loss of vision in the left eye.[69]

Llamas attempts to undermine Dr. Good's testimony as nitpicking, regarding millimeters and microns and the number of laser shots. (Llamas Brief at 28-29.) Llamas ignores the reality that Dr. Good's opinion regarding the laser surgery performed by Llamas is based on actual photographs of Daniella's eyes after the

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[67] 6 Supp. RR at 84:5-24.

[68] PX 12, 13, 14, 15, 16, & 19.

[69] 5 Supp. RR at 141:19-25; 142:1.

surgery. Llamas simply cannot deny that he failed to meet the applicable standard when he applied laser treatment in a non-confluent manner resulting in "skip areas" where there was no laser treatment at all:

> Q. But you have looked at the original images that the jury has seen, and will you describe what it is you are talking about on the images so that we will all be on the same page, so to speak?
>
> A. Yes. When a laser burn takes, it makes a white mark. And where there is no laser treatment or the laser burn does not take, there is no mark. And so there are -- the treatment pattern is not as confluent as it should have been, even where the laser burns have taken. But there are also areas called skip areas. These are areas where there is no treatment at all, and these contribute to an adverse outcome in a manageable ROP.
>
> Q. And how does that work? What's the physiology of that?
>
> A. We think the physiology is that the cells that exist outside of where the retina is vascularized, meaning the area where there are no blood vessels, we think that these cells after a while begin to send a signal. The signal is a protein, which is a growth factor. It is called vascular endothelial growth factor. And this signal incites the development of abnormal, more fragile blood vessels to grow. So literally what happens is, blood vessels begin to grow instead of normally along -- flat against the back wall of the retina, they start to grow out into the center cavity of the eye. Eventually, these blood vessels will go away, but in the process they bring in cells that are precursors to the formation of scar tissue. And so the retina can detach, and it can detach partially or it can detach completely.
>
> Q. And then so if you skip -- if you have skip areas, then does that keep the disease progressing instead of stopping?
>
> A. Well, it can, yes.[70]

[70] 5 Supp. RR at 142:11-25; 143:1-13.

Examining the RetCam images of Daniella's eye on display for the jury, Dr. Good explains how the images should have looked had Llamas met the standard of care specifically identifies the areas of Daniella's eyes where Llamas failed to meet the standard of are in applying laser treatment:

> So there are areas -- here is an area that got treatment. But the burns should be no more than one burn width apart. You can see there are areas even in here where the treatment has not been confluent enough. Then as you move out more peripherally, there are dark areas where there has been no treatment. I think this is the left eye of this child. Yeah, left eye.
>
> . . . .
>
> Over here (indicating), the treatment is not very confluent. As you move up in this direction (indicating), it looks like there was scant treatment. When you look down in this region, although it is a little bit defocused, it still looks like there was -- this is a very large area where treatment was either very sparse or where there was no treatment at all. (Indicating) And when you look up in this area as well -- I don't know if I have already pointed this out -- this area also looks like it didn't get treated adequately. Now, this is -- this is not a picture of the entire fundus. This picture only goes out roughly halfway, so we don't really know whether treatment occurred out in areas here and around here. (Indicating) But at least in an area where you have good visibility usually, the treatment was not adequate.
>
> Q. Now, what is normal? What should it look like if it was done correctly in this photograph?
>
> A. It should look white. You should have white, fairly bright white burns scattered very close together all the way around adjacent to the neovascular ridge. It is a little hard to show where that is here, but I think it is around in this area. And so these burns look like they were light, the ones that did take. And, yeah, when you administer the burns, they simply look white.[71]

[71] 5 Supp. RR at 144:13-25; 145:1-25; 146:1.

Dr. Good also made it clear that these skip areas – the failure to apply the laser to halt the dangers and unchecked growth of the blood vessels – were a proximate cause of the damage to Daniella's eyes:

> There are areas where the retinal burns either didn't take or were not administered. And this also contributed to, in a proximate way, to her loss of vision in the right eye and some detrimental loss of vision in the left eye.[72]

Far from being "conclusory, speculative, and unreliable" as Llamas claims (Llamas Brief at 29), Dr. Good goes into detail regarding both the science and the physiology behind his opinion that the skip areas contributed to an adverse outcome in what should have been treatable ROP:

> A. And where there is no laser treatment or the laser burn does not take, there is no mark. And so there are -- the treatment pattern is not as confluent as it should have been, even where the laser burns have taken. But there are also areas called skip areas. These are areas where there is no treatment at all, and these contribute to an adverse outcome in a manageable ROP.
>
> Q. Okay. And how does that work? What's the physiology of that?
>
> A. We think the physiology is that the cells that exist outside of where the retina is vascularized, meaning the area where there are no blood vessels, we think that these cells after a while begin to send a signal. The signal is a protein, which is a growth factor. It is called vascular endothelial growth factor. And this signal incites the development of abnormal, more fragile blood vessels to grow. So literally what happens is, blood vessels begin to grow instead of normally along -- flat against the back wall of the retina, they start to grow out into the center cavity of the eye. Eventually, these blood vessels will go away, but in the process they bring in cells that are precursors to the formation of scar tissue. And so the retina can detach, and it can detach partially or it can detach completely.

[72] 5 Supp. RR at 141:22-25; 142:1.

> Q. All right. And then so if you skip -- if you have skip areas, then does that keep the disease progressing instead of stopping?
>
> A. Well, it can, yes.[73]

This evidence is more than sufficient under the applicable standards to support the jury's verdict.

Llamas' cites his own expert Dr. Quinn, who disagreed with Dr. Good regarding whether laser treatment should be more confluent. (Llamas Brief at 29.) A conflict in evidence, however, is not grounds for reversal. The jury's role is to sort out such conflicts. Regarding Llamas' other contentions, Dr. Good did acknowledge that even with adequate laser treatment, retinal detachment can occur.

G. There is Sufficient Evidence That It Was Foreseeable That Daniella Would Develop Treatable Disease on or Before August 1.

The Judgment should be affirmed because there is sufficient evidence that it was foreseeable that Daniella would develop treatable disease on or before August 1. "Foreseeability, the other aspect of proximate cause, requires that a person of ordinary intelligence should have anticipated the danger created by a negligent act or omission. The danger of injury is foreseeable if its general character ... might reasonably have been anticipated." *Doe v. Boys Clubs of Greater Dallas, Inc.*, 907

[73] 5 Supp. RR at 142:11-25; 143:1-13.

S.W.2d 472, 478 (Tex. 1995) (citations omitted). It defies logic to assert, as Llamas does, that he could not have foreseen that Daniella could have developed ROP during the relevant time frame. It is undisputed that Ponte was concerned about Daniella's condition and asked Llamas to do an earlier exam on July 4th.[74] Llamas also acknowledged that the guidelines provided for follow-up exams based on the results of the first exam during the relevant time frame:

> Q. The 2001 guidelines say that "Those without ROP but with incomplete vascularization in zone I should be seen at one- to two-week intervals until retinal vascularization has reached zone III or until threshold conditions are reached." Did I read that correctly?
>
> A. I hear -- I don't know. Let me see.
>
> Q. Right here, paragraph B.
>
> A. (Reviewing the exhibit) Yeah, that is provided that the first examination is within the limits and, therefore, from there on.[75]

Llamas acknowledged that he was aware of opinions of his own expert, Dr. Quinn, that a 23-week baby, less than 750 grams, like Daniella, should be screened for the first time between four and seven weeks of age and then every other week until the risk of ROP is gone.[76] Contrary to the contention that it could only be foreseeable that treatment would be needed at a gestational age of 36 weeks, Ponte specifically

[74] 9 Supp. RR at 24:12-14: 25:1-8.

[75] 8 Supp. RR at 191:25; 192:1-10.

[76] 8 Supp. RR at 194:9-22.

admitted that treatment might be needed between the gestational ages of 29 and 36 weeks.[77]

H. The Evidence Is Factually Sufficient to Establish Causation as to Llamas.

The Court should also reject Llamas' alternate contention regarding the factual sufficiency of the evidence. When the entire record is considered, the evidence supporting the jury's verdict is neither so weak nor so contrary to the overwhelming weight of the evidence that the jury's answers must be set aside and a new trial ordered. *Pool v. Ford Motor Co.,* 715 S.W.2d 629, 635 (Tex. 1986). As discussed at length above, the jury's causation finding is supported by ample expert testimony as well as the facts and the relevant science. Llamas seeks to invoke other conditions suffered by Daniella as a basis for undermining the jury's verdict. (Llamas Brief at 32-33.) But there is no evidence whatsoever that Daniella's vision was impacted by anything other than the ROP from which she suffered and the Appellants' negligence in screening for and treating that ROP. Indeed, the issues Llamas identifies – "extremely low birth weight and gestational age, ICH, zone 1 disease, vitreous hemorrhage" – are precisely the kinds of conditions and risk factors that demanded hyper-vigilance and strict adherence to the applicable standards of care by Appellants from the day Daniella was born.

[77] 4 Supp RR at 166:4-15.

Point II The Judgment Should Be Affirmed Because The Jury's Award of Future Medical Expenses to Daniella is Supported by Sufficient Evidence.

The prior decisions of this Court and the Supreme Court require that great deference be given to a jury's award of damages for future medical expenses. The Bustamantes demonstrated unmistakable injuries that would require medical care in the future, specific medical care needed in the future, the need for future medical examinations to monitor and deal with changes in her condition in the future, and potential future treatments that might be developed and eventually be available to Daniella. It follows that the jury acted within the permissible discretion afforded to it under Texas law in determining the amount of damages to be awarded. Llamas' attack on the jury's award must be rejected because, as this Court has recognized, the cost of future medical care is inherently speculative and unpredictable. The jury's award is reasonable given that Daniella was a six-year-old child at the time of the trial, facing a long and difficult road as a near totally blind person, facing uncertainty as to the future progress and available treatments for her condition, with experts on both sides in agreement that her life expectancy would not be reduced by any of her conditions.

A. To Recover Future Medical Expenses, a Plaintiff Need Only Show There is a Reasonable Probability That Expenses Resulting From the Injury Will be Necessary in the Future.

Llamas is incorrect in claiming that no evidence supports the jury's award of damages for future medical care. (Llamas Brief at 33-39.) First, Texas does not require "reasonable medical probability" to support an award of future medical expenses. *Antonov v. Walters,* 168 S.W.3d 901, 908 (Tex. App. – Fort Worth 2005, pet. denied). "No precise evidence is required to support an award of future medical damage." *Id.*; *Pipgras v. Hart,* 832 S.W.2d 360, 366 (Tex. App. – Fort Worth 1992, writ denied). To recover for future medical expenses, a plaintiff must only show there is a reasonable probability that expenses resulting from the injury will be necessary in the future. *Ibrahim v. Young*, 253 S.W.3d 790, 808 (Tex. App. – Eastland 2008, pet. denied); *Whole Foods Market Southwest, L.P. v. Tijerina*, 979 S.W.2d 768, 781-82 (Tex. App. – Houston [14th Dist.] 1998, pet. denied); *City of San Antonio v. Vela*, 762 S.W.2d 314, 321 (Tex. App. – San Antonio 1988, writ denied); *Hughett v. Dwyre*, 624 S.W.2d 401, 405 (Tex. App. – Amarillo 1981, writ ref'd n.r.e.). The award of future medical expenses is within the discretion of the jury provided there is a reasonable probability that the expenses will be incurred. *Harvey v. Culpepper,* 801 S.W.2d 596, 599 (Tex. App. – Corpus Christi 1990, no writ); *Vela,* 762 S.W.2d at 321; *Armellini Exp. Lines v. Ansley,* 605 S.W.2d 297,

311 (Tex. App. – Corpus Christi 1980, writ ref'd n.r.e.). The jury may make an award for future medical expenses based on (a) the nature of the injuries, (b) the medical care rendered before trial, and (c) the person's condition at the time of trial. *Id; Anlonov*, 168 S.W.3d at 908; *see also Scott's Marina at Lake Grapevine Ltd. v. Brown*, 365 S.W.3d 146, 160 (Tex. App. – Amarillo 2012, pet. denied). The reasonable value of future medical care may also be established by evidence of the reasonable value of past medical treatment. *Thate v. Tex.* & *Pac. Ry. Co.,* 595 S.W.2d 591, 601 (Tex. Civ. App. – Dallas 1981, writ dism'd).

In the last decade, this Court has written at least twice on the subject, once in *Sanmina-SCI Corp. v. Ogburn*, 153 S.W.3d 639 (Tex. App. – Dallas 2004, pet. denied)., and again in 2009 in *Wal-Mart Stores Texas, LP v. Crosby*, 295 S.W.3d 346, 354 (Tex. App. – Dallas 2009, pet. denied). In both cases, this Court made it clear that the determination of what amount, if any, to award in future medical expenses rests within the jury's sound discretion. *Ogburn,* 153 S.W.3d at 643; *Crosby,* 295 S.W.3d at 354.

Llamas' argument, in essence, is that the jury's award is speculative. But given the unmistakable facts of her physical condition and the uncertainty of medical advances and the future costs of care, as this Court has held, the amount of damages is necessarily speculative:

> An award of future damages in a personal injury case is always speculative because issues such as life expectancy, medical advances,

> and the future costs of products and services are, by their very nature, uncertain.

Crosby, 295 S.W.3d at 354. Consistent with this observation, no precise evidence is required to support an award of future medical expenses. *Blakenship v. Mirick,* 984 S.W.2d 771, 778 (Tex. App. – Waco 1999, pet. denied). Thus, the Bustamantes need only establish that Daniella will likely require future medical expenses as well as the amount of those expenses where they are available. The evidence at trial more than meets this standard.

B. The Jury's Award of Future Medical Expenses Is Supported by Ample Evidence.

Llamas is incorrect in claiming there is no evidence to support the jury's award. In reviewing "no evidence" points, the Court considers only the evidence and inferences, when viewed in their most favorable light, that tend to support the jury's finding while disregarding all evidence and inferences to the contrary. *Sherman v. First Nat'l Bank,* 760 S.W.2d 240, 242 (Tex. 1988). If there is any evidence of probative force to support the finding, the point must be overruled and the finding upheld. *Sherman,* 760 S.W.2d at 242. The unchallenged testimony of Dr. Good, the Bustamantes' ophthalmology expert, more than meets the no evidence standard.

Dr. Good testified about Daniella's future ophthalmologic medical needs, including what he described as rehabilitation treatments for the right eye socket,

specifically, the need to construct and place porcelain shells due to the disfigurement of her eye:

> Q. Let's talk in some detail about what she is going to need, her life care needs throughout her life and focus just on the ophthalmological injury. What does her blindness mean in terms of her medical needs for the rest of her life?
>
> A. So again just -- for my clarification, just talking about the eyes?
>
> Q. Right.
>
> A. Not what the low vision does to her other possible needs in life?
>
> Q. Well, we will get to that part in just a minute.
>
> A. Okay. Focusing on the eyes, as I have already mentioned, she will need with certainty help with her right eye. The right eye is going to need -- the right eye socket and the phthisis of the right eye will need what I referred to as rehabilitation, so she will need *periodic examinations with an ocularist*. She will need to have a conformist fit. She will need a porcelain shell that's constructed to look like the other eye, to be placed between the eyelids for cosmetic purposes primarily. That's cosmetic but still, nevertheless, very important.[78]

Dr. Good also discussed the types of periodic exams Daniella would need:

> She needs *periodic examinations by an ophthalmologist*. And generally, when a child has had ROP and has had treatment for it, those examinations occur at an *every-six-month interval*. She already needs glasses, so she will need updates on her glasses. That depends upon the child, but I would say probably a couple of pair per year would make sense in terms of glasses. And she probably should have a retina doctor take a look at her periodically, you know, perhaps once a year or so, because *there are some aspects of peripheral retinal changes,* especially as children get older, that are -- that

[78] 5 Supp. RR. 171:6-25; 172:1-3.

require a retinal specialist to evaluate. And I think that's -- that's the sum of it.[79]

Thus, not only will Daniella need vigilant examinations, but she will also be subject to physical changes and developments as a result of her condition.

Most importantly, Dr. Good also testified about medical advances in the future that could be available to Daniella, the very types of "medical advances" this Court has recognized are a necessary component of a jury's award for future medical expenses:

> Q. . . . I want to visit with you briefly about some of the technologies that are being worked on today that are not quite ready for being put in patients. Can you tell us about what some of the technologies are that are promising and will be on the -- that are on the horizon?
>
> I would be happy to. The horizon is not nearby, but there are a number of technologies that are really coming along that are hopefully going to be remarkable advances for visually impaired, children and adults. One is a gene therapy. There is already a gene therapy that is available for retinopathy -- not retinopathy of prematurity but a certain retinal disease that occurs at birth. The gene therapy works remarkably effectively in dogs. I know that sounds like a -- it is a lot, but it also is now being tried in phase 1 trials in humans, and it seems to have an effect for human beings as well. And while gene therapy has had its ups and downs in terms of safety factors, it seems to be safe. So I think there will be a *molecular management* for Daniella that may come along sometime in the next hopefully 10 or 20 years or so.
>
> Secondly, there are *microchips* that can be placed in the eye that are photoresponsive. Initially, these were actually placed on the foreheads of patients, and that somehow allowed the patient to experience at least some sort of visual sensation. But now they can be placed in the eye, and they are being made with greater and greater sophistication. And for reasons that are

[79] 5 Supp. RR. 172:4-18 (emphasis added).

> not clear, these microchips do hook up to the optic nerve and allow patients, who have them implanted, to have better vision than they would have had without it. They still don't have very good vision, but they can see the direction of movement of things. They can see lights off and on. I believe they can see some color also.
>
> So, you know, with the technology going the way that it is, we can be hopeful that at some point on the horizon, there will be things like that that will be available for Daniella.[80]

Given this unchallenged expert testimony, Llamas also cannot succeed on his factual sufficiency challenge to the jury's award. A jury's finding can only be overturned on the basis of factual sufficiency if the credible evidence is so weak or so contrary to the overwhelming weight of all the evidence. *Pool v. Ford Motor Co.,* 715 S.W.2d 629, 635 (Tex.1986).

Llamas incorrectly asserts that future advancements in technology cannot be the basis for an award of future medical expenses. (Llamas Brief at 37-38.) But that is not the law. As this Court has recognized, a jury is allowed to consider medical advances in crafting an award, and due to the necessarily speculative nature of such advances, the Court must defer to the jury's determination. *Crosby*, 295 S.W.3d at 354. Such deference is particularly appropriate here given that Llamas did not proffer any evidence that would undermine Dr. Good's testimony regarding the medical advances that could help Daniella in the future.

[80] 5 Supp. RR at 178:6-25; 179:1-23.

With respect to the issue of life expectancy, Llamas is also incorrect in claiming that the record is devoid of any testimony regarding life expectancy or that any particular evidentiary showing regarding life expectancy was needed to support an award of future medical expenses. (Llamas Brief at 35.) At trial, Helen Woodard, the Bustamantes' life care planner,[81] testified that Daniella did not have any conditions or issues that would reduce her life expectancy, and Llamas offered no evidence to the contrary.[82] Also, Dr. Jerry Tomasovic, a pediatric neurologist who testified on behalf of Llamas, recanted on the stand his earlier opinion that Daniella only had a 40 to 50-year life expectancy, based on her improved mobility.[83]

The medical treatments described by Dr. Good, including the medical advances he anticipates, are not tied to any particular life expectancy. And as this Court has recognized, life expectancy is only one of the uncertain factors included in a jury's determination of future medical expenses. *Crosby,* 295 S.W.3d at 354. Given that there can be no certainty, the Bustamantes were not required to prove Daniella's exact life expectancy to a reasonable medical probability to recover future medical expenses. *See Columbia Med. Ctr. of Las Colinas v. Bush,* 122

[81] Ms. Woodard, a rehabilitation counselor and life care planner, was asked "to do a life care plan related to [Daniella's] blindness and to look at vocational issues related to [Daniella's] blindness." 7 Supp. RR at 7:23-25.

[82] 7 Supp. RR 40:13-25; 41:1-6.

[83] 11 Supp. RR at 63:6-24.

S.W.3d 835, 863 (Tex. App. – Fort Worth 2003, pet. denied) ("such a burden of proof is impossible because life expectancy, by its very nature, is uncertain.); *Pipgras,* 832 S.W.2d at 365 ("life expectancy, medical advances, and the future costs of products, services, and money are not matters of certainty"). In sum, the mathematical calculations based in part on an established life expectancy that Llamas repeatedly demands are neither required nor appropriate in connection with an award for future medical expenses.

Point III The Judgment Should Be Affirmed Because the Jury's Award of Future Attendant Care Expenses Is Supported by Sufficient Evidence.

The Court should also reject Llamas' challenge to the jury's award of future attendant care expenses. (Llamas Brief at 39-44.) Llamas is incorrect in asserting that there is no evidence that the need for attendant care can be traced to the damage to Daniella's vision. (Llamas Brief at 40-42.) First, contrary to Llamas' assertion, Dr. Good did not testify that Daniella needed attendant care only because of her developmental disabilities. (Llamas Brief at 40.) The exchange relied on by Llamas is as follows:

> Q. Candidly, Dr. Good, given those developmental challenges, this is probably not a child who could ever have been left alone safely. True?
>
> A. Well, I mean, so far that's true, yes.[84]

[84] 5 Supp. RR. at 225:12:15.

This answer came after two questions from defense counsel about whether Daniella had been toilet trained. Dr. Good's statement that "so far that's true" says nothing more than that as of the time of trial, the six-year-old Daniella had not yet been able to be left alone.[85] This is certainly not a blanket statement that the need for attendant care is solely a result of Daniella's developmental disabilities.

Instead, Dr. Good specifically testified that it was the damage to Daniella's vision, not just her developmental disabilities, that meant Daniella would need attendant care. Dr. Good discussed his experiences with other children who had functional vision and how Daniella would face different challenges due to her lack of functional vision:

> Q. Okay. Now, do you deal with CP kids who have functional vision, who have a sighted life as well?
>
> A. Yes.
>
> Q. And do those kids, are they -- do they require attendant care and things on a level like Daniella does?
>
> A. No.
>
> Q. What's the difference?
>
> A. Well, the difference is that a child who has cerebral palsy who is sighted can see what's going on in his or her environment. And most of the children I see with cerebral palsy have -- are either in a wheelchair, or they can ambulate with a lot of assistance. And so they can get around without having to have someone with them, helping direct them to where they are going. As they get older, they can do activities of daily living on their own

[85] 5 Supp. RR at 225:4-11.

> in many cases without assistance, again depending upon what limbs are affected by the cerebral palsy. But they can -- they can see what time it is. They can straighten out -- straighten up a house, do all kinds of things that just go into your daily life that you don't think about, but that are major obstacles to children who are significantly visually impaired.[86]

Dr. Good also explained how the damage to Daniella's vision created safety issues that would otherwise not be present, even with other developmental disabilities:

> Q. What about safety issues?
>
> A. There are safety issues for children who are profoundly visually impaired, yes.
>
> Q. Compared to someone who is mildly sighted?
>
> A. Yes, sure.
>
> Q. What are some of those? What does that look like?
>
> A. Well, very -- very much trouble ambulating or getting around. At our institute, we are trying to make things like talking signs and things that give feedback to visually impaired people so that they know that when they are crossing the street, there might be a car coming. That would be, I guess, maybe one easy example. They have to be very careful when they are moving around crossing streets and so on. Safety issues related to using the stove, to everything you can think of.[87]

Dr. Tomasovic may indeed have a different opinion. (Llamas Brief at 40-41.) But Dr. Good's testimony provides sufficient evidence of the causal link between the damage caused by the Defendants and the need for attendant care.[88] Ms.

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[86] 5 Supp. RR at 182:4-25; 183:1-3.

[87] 5 Supp. RR at 183:4-25.

[88] Ms. Woodard also testified about the type of assistance Daniella would need beyond what would have been needed for mild cerebral palsy as an adult:

Woodard's testimony regarding what the attendant care and other assistance would entail is unchallenged and, coupled with Dr. Good's causation testimony, provides ample evidentiary support for the jury's decision to award damages for attendant care.

Llamas again seeks to undermine the jury's award by asserting that it must be tied to definitive evidence of life expectancy. (Llamas Brief at 42-44.) This is simply incorrect. Life care planners often present ranges of possible future medical expenses, with juries themselves choosing a figure that is not identical to

---

> Q. Okay. What types of assistance will she need for care and transportation above what would have been needed for mild CP as an adult?
>
> A. Actually, I don't think if she just had mild CP, she would need much service at all. Probably in the range of a couple of hours a day, maybe three, if the CP and the developmental problems -- if they were mild, were all of the problems that she had. Now, I think she needs -- and are we talking about just age 18?
> Q. Yeah. 18 and over.
>
> A. I think that as an adult, once she transitions into adult life, she will need 8 to 10 hours a day related to her vision. The needs that will occur for her don't occur as -- in as narrow a time frame and can't be condensed as well as in other situations of disability. And her needs will occur constantly with the vision problems. I expect that she would have needed some additional assistance, as I said before, for the cerebral palsy and the developmental delays.
>
> Q. What is the cost that you have determined for the care and transportation assistance above and beyond what the CP would have required?
>
> A. $42,340 to $53,840.
>
> Q. Okay. And is that each year of life?
>
> A. Yes.

7 Supp. RR at 37:1-25; 38:1-2 (emphasis added).

any offered by a life care planner. *See Columbia Med. Ctr. of Las Colinas v. Bush,* 122 S.W.3d 835, 864 (Tex. App. – Fort Worth 2003, pet. denied) (evidence that future medical expenses would range between $7.2 million and $19.7 million depending on plaintiff's life span and the level of care provided; court affirms jury award of $10 million for future medical expenses). Ms. Woodard gave a range of annual attendant care and transportation expenses of $42,340 to $53,840. A life expectancy of 18 (higher range) to 25 (lower range) years (after age 18) would easily account for the total award of $988,000 for future attendant care. Viewing only the evidence and inferences tending to support the jury's award and disregarding all evidence and inferences to the contrary, the evidence is legally sufficient to support the jury's award here, given Ms. Woodard's testimony that Daniella's life expectancy would not be reduced by any conditions and Dr. Tomasovic's recanting of his earlier opinion regarding reduced life expectancy. [89] Further, given the uncontroverted yearly expenses identified by Ms. Woodward and the lack of evidence that Daniella's life expectancy was in any way limited by her conditions or otherwise,[90] the evidence supporting the jury's award is not so weak or contrary to the overwhelming weight of the evidence that the award should be set aside.

[89] 7 Supp. RR 40:13-25; 41:1-6; 11 Supp. RR at 63:6-24.

[90] 7 Supp. RR at 37:22-38:2.

Point IV The Judgment Should Be Affirmed Because the Trial Court Correctly Refused to Give a "Loss of Chance" Instruction.

This is not a loss-of-chance case, and the Trial Court was therefore correct in refusing to give a loss-of-chance instruction. A trial court has wide discretion in submitting instructions and jury questions. *Howell Crude Oil Co. v. Donna Ref. Partners, Ltd.,* 928 S.W.2d 100, 110 (Tex. App. – Houston [14th Dist.] 1996, writ denied). A trial court must submit only "such instructions and definitions as shall be proper to enable the jury to render a verdict." Tex. R. Civ. P. 277. A proper jury instruction is one that assists the jury and is legally correct. *Town of Flower Mound v. Teague,* 111 S.W.3d 742, 759 (Tex. App. – Fort Worth 2003, pet. denied).

Daniella's blindness is not like the cancer at issue in *Columbia Rio Grande Healthcare v. Hawley,* 284 S.W.3d 851 (Tex. 2008), where the evidence indicated that the plaintiff's chance of survival was at best, 50% or less. *Hawley,* 284 S.W.3d at 861. In *Hawley,* the Supreme Court held that the instruction was needed to ensure that plaintiff not recover damages based on evidence of less than a 50% chance of recovery, as required by *Kramer.* But ROP is a well known disease process with a proven, effective treatment that, in this case, was not applied in a timely manner and when finally applied, was not done properly. The doctors here were not like the healthcare providers in *Kramer* who knew nothing about the cancer involved there. Llamas knew of the risk of ROP, of the need to be vigilant

to watch for ROP with careful and timely examinations and to timely and effectively treat it. ROP is unlike late-stage cancer; it can be treated. In short, Llamas' attempt to equate this situation with a loss-of-chance case is based on a refusal to admit the obvious – that there is an approved treatment that has been shown to be effective in stopping development of ROP and preventing blindness in babies like Daniella.

Indeed, the Bustamantes' experts (and even defense expert Dr. Quinn) agree that with proper screening and treatment, successful outcomes occur more than 75% of the time. Asked to comment on Dr. Quinn's opinions, Dr. Good testified as follows:

> Q. Do you agree with Dr. Quinn that ROP laser therapy is effective in stopping the progression of ROP in most babies?
>
> A. Yes, I do.
>
> Q. With a 75 percent success rate, all comers?
>
> A. Or higher.[91]

Dr. Phelps also testified that treatment, both laser and cryo, was effective in stopping the advance of ROP:

> Q. And we have talked with the jury about Dr. Quinn, the defense expert's article that says -- a chapter that says, "Laser and cryo are both effective in preventing progression of the disease in most cases." Do you agree with that?

[91] 5 Supp. RR at 150:3-8.

A. Yes.[92]

Defense expert Dr. Quinn admitted that the ETROP study showed that 91 percent of high risk pre-threshold eyes did not develop an unfavorable structural outcome (including retinal detachment).[93]

The lost chance instruction requested was legally and factually inappropriate, unnecessary and not harmful. The jury was already instructed in Question 5 to not award damages for a condition existing before the occurrence in question except to the extent the condition was aggravated by injuries caused by the occurrence in question.[94] The Trial Court correctly rejected the instruction on lost chance requested.

Point V The Judgment Should Be Affirmed Because the Trial Court Did Not Abuse its Discretion by Denying Llamas' Motion for a Mistrial.

The Trial Court did not abuse its discretion when it denied Llamas' motions for a mistrial. (Llamas Brief at 51.) "Evidentiary rulings are committed to the trial court's sound discretion." *Owens-Corning Fiberglas Corp. v. Malone*, 972 S.W.2d 35, 43 (Tex. 1998). A trial court's evidentiary ruling must be upheld "if there is any legitimate basis for the ruling." *Id.* In addition, a judgment may only be reversed based on an erroneous evidentiary ruling if "the error probably caused the

[92] 6 Supp. RR at 84:25; 85:1-5.

[93] Court's Exhibit 2, Quinn Deposition at 140:18-20, 22-25; 141:1-6, 9.

[94] 4 CR 216.

rendition of an improper judgment." *Id.* A trial court's denial of a motion for a mistrial is reviewed under an abuse of discretion standard. *Deese v. Combined Specialty Ins. Co.,* 352 S.W.3d 864, 866 (Tex. App. – Dallas 2011, no pet.). The issue identified by Llamas arose out of questions during the cross examination of Llamas by the Bustamantes' counsel. Llamas gave an untruthful answer to a question "Daniella was not the first time that you had evaluated a very high risk ROP premie and decided not to come back for four weeks, is it?"[95] Llamas refused to admit the truth, that this was not the first time he had set a follow-up examination for four weeks. With Llamas thereby opening the door to such questioning, counsel proceeded to ask a short series of questions about cases where he had done precisely that.[96] After initially overruling Appellees' objections, the trial court reconsidered and promptly gave an explicit instruction to the jury to disregard all testimony about other babies Llamas may have treated.[97] Judge Lowy later gave an even more thorough limiting instruction:

> Ladies and gentlemen, in the course of this trial, you have heard a number of questions by Mr. Girards and some answers from witnesses concerning other patients of Dr. Llamas and of neonatal intensive care units managed by Pediatrix Medical Services, Inc., doing business as Pediatrix Medical Group of Texas.

[95] 8 Supp. RR at 198:3-7.

[96] 8 Supp. RR at 198:8-25; 199:1-22.

[97] 8 Supp. RR at 201:15-18.

> The Court has determined that this was not a proper subject of inquiry in this case, that such questions should not have been permitted, and that any evidence concerning other patients, including any facts or alleged facts you might have inferred from the questions, will all be stricken from the record.
>
> You are instructed to disregard anything you have heard during this trial pertaining to other patients. There will be no further discussion of other patients during the remainder of the trial.[98]

The Trial Court properly exercised its discretion by giving this strong curative, limiting instruction and refusing to grant a mistrial. Juries are presumed to follow the instructions given to them by the court. *See First Heights Bank, F.S.B. v. Gutierez,* 852 S.W.2d 596, 615 (Tex. App. – Corpus Christi 1993, writ denied) (on appeal, jury presumed to follow instruction to disregard Fifth Amendment plea as it related to any party except the one asserting the privilege); *see also Columbia Rio Grande Healthcare, L.P. v. Hawley,* 284 S.W.3d 851, 862 (Tex. 2009) ("the jury is presumed to have followed the court's instructions."). By its terms, the limiting instruction cured any potential effects of the questions and answers. There is no meaningful difference between the instruction requested by Llamas and that given by the Trial Court. Both make clear that the line of inquiry was not proper, should not have been permitted and that the testimony and anything connected with it had to be disregarded by the jury.

[98] 9 Supp. RR at 23:13-25; 24:1-3.

Llamas has failed to demonstrate that the jury's verdict was in any way affected by this issue, particularly in light of the curative instruction given. Llamas has failed to show any logical, or any other, connection between the testimony in question and the damage awards for future medical care and attendant care. The record contains ample evidence to otherwise support the jury's findings with respect to Llamas, and nothing indicates that the jurors agreed to a verdict contrary what they would have otherwise reached based on the limited amount of information regarding other cases.

Point VI. Should the Judgment Be Affirmed Because There Was No Cumulative Error That Probably Resulted In An Improper Judgment

Because there is no error, there is no cumulative error. *Town East Ford Sales, Inc. v. Gray*, 730 S.W.2d 796, 809-10 (Tex. App.–Dallas 1987, no pet.) Alternatively, in order to show cumulative error, Llamas is required to show that, based on the record as a whole, but for the alleged errors, the jury would have rendered a verdict favorable to him. *Id.* at 810. Here, Llamas asserts three alleged errors. Two of those alleged errors actually relate to the same ruling, the alleged erroneous admission of testimony regarding other babies treated by Llamas. This fails to satisfy the frequency and severity necessary to establish a basis for urging cumulative error. *Id.* at 810. Moreover, Llamas fails to show any correlation between the alleged errors and the conclusions reached by the jury. It must be

concluded that Judge Lowy, who presided over the entire trial and the admission of all of the evidence, was correct in concluding that the alleged errors would not have resulted in a favorable verdict for Llamas.

CONCLUSION AND PRAYER

Appellees ask the Court to affirm the judgment in its entirety and grant them such further relief to which they are justly entitled.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this Brief of Appellees was prepared using Microsoft Word 2010, which indicated that the total word count (exclusive of those items listed in Tex. R. App. P. 9.4(i)(1)) is 14,917 words.

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