IN THE SUPREME COURT OF TEXAS

NAVARRO HOSPITAL, L.P. D/B/A NAVARRO REGIONAL HOSPITAL

Petitioner

V.

CHARLES WASHINGTON AND GWENDOLYN WASHINGTON, EACH INDIVIDUALLY AND AS NEXT FRIENDS OF CHARLES DONELL WASHINGTON

Respondents

On Petition for Review from the Tenth Court of Appeals at Waco, Texas

PETITION FOR REVIEW

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The following is a list of the names and addresses of all parties to the trial court's judgment and their counsel made pursuant to Texas Rule of Civil Procedure 53.2(a).

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TEXAS CASES

Texas Supreme Court

Texas Court of Appeals

TEXAS STATUTES

RULES

STATEMENT OF THE CASE

NATURE OF THE CASE:

This Petition for Review originates from an interlocutory appeal brought pursuant to Texas Civil Practice and Remedies Code §51.014(a)(9), in which the Tenth Court of Appeals issued an Order affirming the judgment of the trial court which denied Petitioner's motion to dismiss filed pursuant to Texas Civil Practice and Remedies Code § 74.351(b). The underlying lawsuit in which the Motion to Dismiss was sought is a healthcare liability claim governed by Texas Civil Practice and Remedies Code Chapter 74, also referred to as the Medical Liability Act.

TRIAL COURT:

The designation of the trial court is the 13th Judicial District court of Navarro County, Texas, the Honorable James E. Lagomarsino presiding, Cause No. D12-21439 CV. The trial court denied Petitioner's Motion to Dismiss made pursuant to Texas Civil Practice and Remedies Code § 74.351(b), and an interlocutory appeal was subsequently taken pursuant to Texas Civil Practice and Remedies Code §51.014(a)(9).

COURT OF APPEALS:

The parties in the Court of Appeals were Petitioner Navarro Hospital, L.P. d/b/a Navarro Regional Hospital and the incorrectly named and/or improperly joined defendants CHS/Community Health Systems, Inc. individually and d/b/a Navarro

Regional Hospital, Triad-Navarro Regional Hospital Subsidiary LLC, Navarro Regional LLC and Quorum Health Resources, LLC and Respondents Charles Washington and Gwendolyn Washington, each individually and as next friends of Charles Donell Washington. The Court of Appeals was the 10th District of Texas, Waco. Justices Gray, Davis and Scoggins participated in the panel decision of the Court of Appeals, and Justice Scoggins was the author of the opinion. The citation for the Court of Appeals' Opinion is *Navarro Hosp., L.P. v. Washington*, 10-13-00248-CV, 2014 WL 1882763 (Tex. App.—Waco May 8, 2014, no. pet. h.). The Court of Appeals affirmed the denial of Petitioner's Motion to Dismiss. No motions for rehearing were filed by the Petitioner.

CITATIONS TO THE RECORD

Citations to the Clerk's Record are to "CR___".

Citations to the Reporter's Record for the January 18, 2013 hearing on Defendants' Motion to Dismiss are to "RR__".

STATEMENT OF JURISDICTION

This court has jurisdiction over this appeal pursuant to Tex. Civ. Prac. & Rem. Code §51.014(a)(9), which allows an interlocutory appeal from an order denying a motion to dismiss under Tex. Civ. Prac. & Rem. Code §74.351(b). Tex. Civ. Prac. & Rem. Code §51.014(a)(9); *Lewis v. Funderburk*, 235 S. W.3d 204 (Tex. 2008).

This Court has jurisdiction over this case pursuant to TEX. GOV'T CODE ANN. § 22.001(a)(2), (3), and (6) because this case involves questions of law arising from a case, which has been brought to the court of appeals from an appealable judgment of the trial court, and in which: (a) the court of appeals holds differently from a prior decision of another court of appeals on a question of law material to the decision of the case; (b) involves the construction or validity of a statute necessary to the determination of the case, and (c) is a case in which it appears an error of law has been committed by the court of appeals, and that error is of such importance to the jurisprudence of the state that, in the opinion of the supreme court, it requires correction. *See* TEX. GOV'T CODE ANN. § 22.001(a).

ISSUES PRESENTED

The Texas Civil Practice & Remedies Code, Chapter 74, governs medical malpractice cases in Texas. It requires that expert reports be filed that address the standard of care, breach of the standard of care and proximate causal connection between the alleged breach and the alleged injuries and sets forth requirements for the reports and the qualifications of witnesses who pen them.

Issue No. 1: Whether the Court of Appeals erred in concluding that the reports of Respondents' expert witnesses sufficiently established the standard of care and alleged departures of the standard of care as to Petitioner as required by Texas Civil Practice & Remedies Code Chapter 74.

Issue No. 2: Whether the Court of Appeals erred in concluding that the reports of Respondents' expert witnesses were collectively sufficient to satisfy the causal relationship requirement of Texas Civil Practice & Remedies Code §74.351(R)(6)

STATEMENT OF FACTS

The underlying lawsuit arises out of medical care provided to Charles Donell Washington by Navarro Hospital, L.P. d/b/a Navarro Regional Hospital and the incorrectly named and/or improperly joined defendants CHS/Community Health Systems, Inc. individually and d/b/a Navarro Regional Hospital, Triad-Navarro Regional Hospital Subsidiary LLC, Navarro Regional LLC and Quorum Health Resources, LLC ("Petitioner"). (CR 1-12).

Respondents filed suit for medical negligence against Petitioner on July 13, 2012. (CR 4). Petitioner was served with the Petition on July 18, 2012. The Respondents brought negligence and gross negligence claims against Petitioner "directly, and by and through their employees or agents" as well as Douglas B. Hibbs, M.D. and James Goodman, M.D. (CR 8). The case is currently pending in the 13th Judicial District Court, Navarro County, Texas, Cause Number D12-21439CV, before the Hon. James E. Lagomarsino.

On August 15, 2012, Respondents filed an expert report (and accompanying curriculum vitae) by Edward Panacek, M.D. (CR 43, Appendix F). On September 6, 2012 Petitioner timely filed objections to the sufficiency of Dr. Panacek's report. (CR 31). On November 8, 2012, Respondents filed the supplemental expert report of Arthur S. Shorr, MBA, FACHE (and accompanying

curriculum vitae). (CR 102, Appendix G). On November 29, 2012, Petitioner timely filed objections to the sufficiency of Arthur Shorr's report. (CR 120). The trial court considered Petitioner's Chapter 74 Objections to Respondents' expert reports and Petitioner's Motion to Dismiss on January 18, 2013. On June 20, 2013, the trial court overruled Petitioner's Objections to the Respondents' Expert Reports (Appendix Tab A) and denied their Motion to Dismiss. (Appendix Tab B). Petitioner timely perfected an accelerated appeal challenging the trial court's denial of the Motion to Dismiss, pursuant to Texas Civil Practices and Remedies Code § 51.014(a)(9). (CR 281-87).

The 10th Court of Appeals issued its opinion on May 8, 2014, affirming the trial court's order denying Petitioner's motion to dismiss. (Appendix D, E)

SUMMARY OF ARGUMENT

Review should be granted because the Court of Appeals erred in concluding that the reports of Respondents' expert witnesses were collectively sufficient to satisfy the requirements of Texas Civil Practice & Remedies Code §74.351. Such a determination is at odds with prior interpretation of the statutory requirements of 74.351 of the Texas Civil Practice and Remedies Code.

Additionally, review should be granted because the expert reports of Dr. Panacek and Mr. Shorr do not establish their qualifications to offer opinions regarding the standard of care for Petitioner regarding hospital administration,

staffing, development of policies or protocols and/or education/training. Dr. Panacek and Mr. Shorr's purported standard of care and breach opinions as to Petitioner are generic, boilerplate, and are based entirely on assumptions, speculation and conjecture, and thus are insufficient and do not meet the requirements of an expert report pursuant to Texas Civil Practice & Remedies Code §74.351(r)(6).

Alternatively, the Appellate Court erred in concluding the reports of Respondents' expert witnesses were collectively sufficient to satisfy the causal relationship requirement of Texas Civil Practice & Remedies Code §74.351(r)(6). The report of Mr. Shorr does not address the required element of causal relationship at all. Moreover, both Mr. Shorr and Dr. Panacek are unqualified to opine as to causal relationship in this case. Additionally, Dr. Panacek's opinions regarding causal relationship are merely conclusory, failing to link his conclusions to the facts of the case and are therefore incapable of demonstrating to the Trial Court that Respondents' claims against Petitioner have merit.

As to the above issues, review should be granted because the Court of Appeals has interpreted the requirements of Texas Civil Practice & Remedies Code §74.351 inconsistently with prior opinions of this court and that of other Courts of Appeals and due to the importance of the issues presented. Tex. R. App. 56(a)(2), (5).

ARGUMENTS AND AUTHORITIES

ISSUE ONE: **Review should be granted because the Court of Appeals erred in concluding that Respondents' expert reports sufficiently established the standard of care and alleged departures of the standard of care as to Petitioner.**

The definition of an "expert report" under § 74.351(r)(6) requires, as to ***each defendant***, a fair summary of the expert's opinions about the applicable standard of care, the manner in which the care failed to meet that standard, and the causal relationship between that failure and the claimed injury. *Am. Transitional Care Centers of Texas, Inc. v. Palacios*, 46 S.W.3d 873, 878 (Tex. 2001)(emphasis added). Here, Respondents' expert reports address only a theory of liability as to the defendant physicians but fail to support either a vicarious or direct liability claim against the Petitioner.

Respondents' expert reports do not constitute a good-faith effort to inform the Court and Petitioner of the applicable standard of care and alleged violations of the standard of care and causal relationship specifically as to Petitioner. Thus, the Court of Appeals erred in affirming the Trial Court's denial of Petitioner's Motion to Dismiss Respondents' claims. The Texas Supreme Court has stated that "***[i]dentifying the standard of care is critical***: whether a defendant breached his or her duty to a patient cannot be determined absent **specific information about what the defendant should have done differently**." *Palacios* 46 S.W.3d at 880.

(emphasis added). "'It is not sufficient for an expert to simply state that he or she knows the standard of care and concludes it was [or was not] met.'" *Id* .(*quoting Chopra v. Hawryluk*, 892 S.W.2d 229, 233 (Tex. App.—El Paso 1995, writ denied).

Both of Respondents' expert reports have utterly failed to properly address the standard of care applicable to Petitioner, alleged violations of the standard of care by Petitioner separately and apart from any other Defendant, and the causal relationship between the alleged violations of the standard of care committed and/or omitted by Petitioner and the injuries or harm being complained of. Moreover, the expert reports fail to establish the experts' qualifications and experience which they claim allows them to address these issues.

A. Dr. Panacek's report fails to adequately set forth the applicable standard of care; Nor is he qualified to do so.

Dr. Panacek's report does not constitute a good-faith effort to inform the Court and Petitioner of the applicable standard of care being alleged. Dr. Panacek's recitation of the standard of care applicable to Petitioner consists of three sentences of meaningless, boilerplate and generic language and thus has utterly failed to identify specifically what the standard of care is, or that he is familiar with the specific standard of care or that he is qualified to offer opinions regarding the specific standard of care for the Petitioner in this case. Dr. Panacek opines that the

standard of care requires that the hospital have "specialized intubation equipment immediately available" and that the hospital "have and/or enforce adequate protocols, or policies and procedures to assure that medical personnel and staff are aware of and trained to utilize this specialized intubation equipment." (CR 48; Appendix F, p. 4). "While a 'fair summary' is something less than a full statement of the applicable standard of care and how it was breached, even a fair summary must set out what care was expected, but not given." *Palacios* 46 S.W.3d at 880. The use of such generic terms without specification or further explanation renders them meaningless, and Dr. Panacek fails to make any specific connection to these generic "standards" and the facts or his opinions in this particular case.

B. Dr. Panacek's opinions regarding Petitioner's alleged failure to meet the standard of care are inadequate and based entirely on speculation/conjecture.

Dr. Panacek provides **no** basis for his opinion that Petitioner breached the standard of care other than his mere assumption based on his review of the medical records, diagnostic studies, laboratory results and documents contained within the Navarro Regional Hospital chart. (CR 45; Appendix F, p. 1). He opines that the hospital failed to have specialized intubation equipment immediately available for use, however he gives no reasonable basis for this assumption. (CR49; Appendix F, p. 5). Therefore, he admits he has not reviewed other documents nor does he have knowledge of any facts to support his claim. Moreover, he claims Petitioner

either failed to have or failed to enforce protocols, policies and procedures to assure that medical personnel and staff were aware of and trained to utilize specialized intubation equipment—proving he has no idea if Petitioner in fact *had* the policies, procedures or protocols in place. (CR 49; Appendix F, p. 5). He gives no basis for his opinion that Petitioner either failed to have or failed to enforce these protocols, policies and procedures. He makes no mention of reviewing any hospital policies, procedures, protocols or equipment checklists which would show the absence of the specific items he mentions.

Additionally, his assumption that Petitioner breached the standard of care is based entirely on the defendant ***doctors'*** alleged acts or omissions in this case. Dr. Panacek failed to review any documents pertaining to policies, procedures, protocols or equipment available in the ICU or ER units, but yet assumes, given the doctors' alleged struggles to intubate Mr. Washington, that such polices and equipment must not have been in place. He fails to cite anywhere in the medical records or chart that indicate such equipment or policies were not present. His opinions in this regard are thus based on nothing more than his advocate assumptions and are not derived from his review of any actual documents supporting same.

Furthermore, Dr. Panacek's report states that defendants allegedly breached the standard of care, but he does not delineate specifically how <u>each</u> individually

acted negligently. An expert report may not assert that multiple defendants are all negligent for failing to meet the standard of care without providing an explanation of how each defendant specifically breached the standard and how that breach caused or contributed to the cause or injury. *Taylor v. Christus Spohn Health Sys.*, 169 S.W.3d 241, 244 (Tex.App.—Corpus Christi 2004, no pet.).

Finally, the Trial Court did not limit its inquiry to the four corners of Dr. Panacek's report. *See Palacios,* 46 S.W.3d at 878. As stated by the Supreme Court, the "only information relevant to the inquiry is within the four corners" of the report. *Id.* In response to Petitioner's motion and objections, Respondents filed their Response and Motion for Extension of Time. (CR 164). In their response, Respondents inserted diagrams and descriptions of medical devices in support of their claims of the sufficiency of their expert's report. (CR 166-168). At the hearing on Petitioner's motion, Respondents offered argument referencing same. (RR 16:212). Respondents improperly injected matters outside the four-corners of the expert report.

C. Mr. Shorr's report fails to specify the applicable standard of care and alleged breaches of the standard of care.

Mr. Shorr's statements regarding the alleged applicable standards of care and the alleged breaches of same are vague, conclusory, based entirely on assumption and thus wholly insufficient to inform the court and Petitioner of the

manner in which the care rendered by Petitioner failed to meet the standard of care.

Mr. Shorr identifies a laundry list of items from various sources which Mr. Shorr claims are standards of care applicable to the Petitioner. The "standards" identified are boilerplate, generic language that fail to identify specifically what the standard of care is. Mr. Shorr states broadly that Petitioner owed a duty "to ensure the availability of supplies and equipment needed to intubate and resuscitate," "to ensure that Navarro Regional Hospital's nursing and physician staff members were able to recognize and respond to changes in Mr. Washington's condition in a timely manner," and "to ensure that its contracted physicians were competent to perform an intubation in a timely manner." (CR 49; Appendix G, pp. 3-6). The use of such generic terms without specification or further explanation renders them meaningless, and Mr. Shorr fails to make any specific connection to these generic "standards" and the facts or his opinions in this particular case.

Mr. Shorr's report offers **no** basis for his opinion that Petitioner breached any of the aforementioned standards of care other than his mere assumption based on his review of the "*circumstances* regarding the hospitalization of Charles "Donnell" Washington," Plaintiff's Petition, Hospital's response to Request for Production, Hospital's Answer's to Interrogatories, Dr. James Goodman's Answers to Interrogatories, and the report of Respondents' expert Dr. Edward Panacek. (CR 45; Appendix G, p. 1). He opines that the hospital failed to meet the standards of

care; however, he gives no reasonable basis for these assumptions. (CR 45; Appendix G, p. 6). As such, Mr. Shorr *de facto* admits he has not reviewed other documents nor has knowledge of any facts to support his claim. Based on his report, Mr. Shorr did not review any documents which would indicate that supplies and equipment needed to intubate and resuscitate were *not* available to the doctors/staff at issue and/or that said doctors were not competent to perform an intubation in a timely manner. Mr. Shorr offers this opinion despite not being qualified to assess or opine on the defendant physicians' competency. He does not identify any specific piece of equipment which he claims was absent and needed. He makes no mention of reviewing any hospital policies, procedures, protocols, medical records, or equipment checklists which would show the absence of intubation equipment. Nowhere does he opine as to the specific protocols or training of health care providers he claims should have been provided. Nowhere does he set forth specific training or supervision that he claims should have been provided, but was not. Moreover, Mr. Shorr offers nothing in support of his conclusory statement that the hospital nursing and physician staff members failed to recognize and respond to changes in Mr. Washington's condition in a timely manner. His opinions in this regard are thus based on nothing more than his vague, unqualified advocate assumptions and are not derived from his review of any actual documents supporting same.

Furthermore, Mr. Shorr's assumption that Petitioner breached the standard of care is based entirely on Dr. Edward Panacek's unsupported assertions about the doctor defendants' alleged acts or omissions in this case. Mr. Shorr failed to review any documents pertaining to policies, procedures, protocols or equipment available in the ICU or ER units, but yet assumes, given the doctors' alleged struggles to intubate Mr. Washington, that such polices and equipment must not have been in place. He fails to cite any documents that indicate such equipment was not present. Mr. Shorr failed to review the medical records, but yet still assumes that Petitioner's nursing and physician staff members were not able to recognize and respond to changes in Mr. Washington's condition and that contracted physicians were not competent to perform intubations in a timely manner. His opinions in this regard (in addition to departing from "administrative standards") are based on his unqualified personal assumptions, are conclusory and nothing more than unsubstantiated advocacy and therefore fail the *Palacios* test. Therefore the Court of Appeals erred in determining that Mr. Shorr's report adequately states the manner in which Petitioner allegedly breached the applicable standard of care.

Dismissal is required when a court would be required to infer what the standard of care is from the general statements of an expert witness. *Norris v. Tenet Houston Health System*, 2006 WL 1459958 at p. 7 (Tex. App. –Houston

[14th Dist.] 2006, no pet.) (mem. op.); *Russ v. Titus Hosp. Dist.,* 128 S.W.3d 333, 343 (Tex. App—Texarkana 2004, pet. denied) (dismissal of nurses proper when report set forth omissions of, but not standards of care for, the nurses). The Trial Court was and this Court would be required to infer what the specific standard of care is for Petitioner from the general reports of Dr. Panacek and Mr. Shorr.

D. Dr. Panacek and Mr. Shorr are unqualified to opine regarding the standard of care applicable to Petitioner or their alleged breach thereof.

Dr. Panacek opines regarding equipment which the hospital should make available in ICU and ER units as well as "protocols, policies and procedures to assure that medical personnel and staff are aware of and trained to utilize" said equipment. (CR 49; Appendix F, p. 4). But Dr. Panacek fails to indicate his qualifications to even opine as the standards of care applicable to Petitioner. He fails to indicate how his qualifications, experience, skill or education as a physician qualify him to testify regarding hospital administration, staffing, development of policies or protocols and/or education/training.

Additionally, Mr. Shorr is unqualified to opine on the standard of care that a hospital provides for patients in need of airway management and/or intubation or to discuss breaches in that standard of care in emergent, difficult airway scenarios like the one in Mr. Washington's case. *See* TEX. CIV. PRAC. & REM. CODE §§ 74.351(r)(5), 74.402(b), 74.403. There is nothing in Mr. Shorr's report to indicate

he has knowledge of accepted standards of care for health care providers in the "diagnosis, care or treatment" for airway management or intubation of a patient such as Mr. Washington, i.e. the *diagnosis, care, or treatment of the illness, injury, or condition* involved in this claim. There is nothing in Mr. Shorr's report to show that he is qualified on the basis of training or experience to render an opinion on the medically necessary supplies and equipment that he alleges are needed/required for proper, timely airway management or more specifically because of the allegations in this case, intubation of patients such as Mr. Washington; whether nursing and physician staff members are able to recognize and respond to specific changes in patient condition in a timely manner; or to evaluate the competency of physicians or nursing staff who participated in caring for Mr. Washington. (CR 102). Mr. Shorr's report does not indicate he has any experience supervising health care providers, supervising care givers, or any basis to opine as to training and/or competency of health care providers. Mr. Shorr's opinions go beyond mere hospital administration and offer criticism of medical care under the guise that it is "administrative standards." Opinions on "diagnosis, care or treatment of the condition at issue," which is a black letter requirement of Texas Civil Practice & Remedies Code §74.402, are clearly beyond his alleged area of expertise as outlined in his report. This renders him unqualified to serve as an "expert witness in a suit against a health care provider" and thus further renders his report

insufficient to meet the requirements of CPRC §74.351 as a matter of law. His opinions on these issues are simple advocacy, and barred as unqualified, unsubstantiated assumptions.

Given the above, the Appellate Court erred in affirming the Trial Court's denial of Petitioner's Motion to Dismiss. Accordingly, review should be granted.

ISSUE TWO: The Appellate Court Erred in Concluding the Reports of Respondents' Expert Witnesses Were Collectively Sufficient to Satisfy the Causal Relationship Requirement of Texas Civil Practice & Remedies Code §74.351(r)(6).

Respondents, through their expert witnesses, failed to establish a causal relationship between any alleged breach of the standard of care by Petitioner and the injuries and damages alleged in this case.

An "expert report" within the statute means:

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

Tex. Civ. Prac. & Rem. Code §74.351(r) (Vernon 2010) (emphasis added).

Respondents' expert reports do not, individually or collectively, establish any causal relationship between any alleged violations of the standards of care by Petitioner and the injuries and damages claimed in this case. At best, the reports offer only conclusory and global assertions about causal relationship without

attributing them to any specific alleged breaches from the standards of care.

A. Dr. Panacek's report fails to meet the causation requirement of CPRC §74.351(r)(6) nor is he qualified to opine regarding same.

Dr. Panacek, while arguably incapable of meeting the causal relationship requirement because he is not licensed to practice medicine in Texas, lacks proper qualifications to opine as to Petitioner as he has indicated no experience, training or education regarding hospital administration, staffing or training. A physician is qualified to submit an expert report on causation when he would otherwise be qualified to address causation under TRE 702. *Collini v. Pustejovsky*, 280 S.W.3d 456, 465 (Tex.App.—Fort Worth 2009, pet. denied). According to TRE 702, an expert must have knowledge, skill, experience, training, or education regarding the specific issue before the court that would qualify the expert to give an opinion on that particular subject. Here, Dr. Panacek provides no indication he satisfies the Rule 702 requirements as to the Petitioner's alleged deviation from the standard of care with regard to the standard equipment available in ICU and/or ER units or hospital policies, procedures or protocols.

Moreover, Dr. Panacek attempts, with the use of conclusory language on page 6 of his report, to opine that the "negligent acts" of Petitioner "were each a proximate cause of Mr. Washington's profound brain damage and related sequelae." (CR 50; Appendix F, p. 6). Dr. Panacek gives an explanation of how

lack of oxygen can result in brain injury, but fails to indicate how the alleged "negligent acts" of Petitioner caused Mr. Washington's alleged brain injury other than merely stating the Defendants were "negligent in their care and treatment of Donell Washington." (CR 50; Appendix F, p. 6). Dr. Panacek's conclusory insights are insufficient as they fail to link his conclusions to the facts of the case as to Petitioner. "It is not enough for a report to contain conclusory insights about the plaintiff's claims. Rather, the expert must explain the bases of the statements and link his or her conclusions to the facts." *Russ*, 128 S.W.3d at 340. The use of such conclusory language without specification or further explanation renders them meaningless.

The Appellate Court therefore erred in concluding that Dr. Panacek's report, taken collectively with Mr. Shorr's, satisfied the causal relationship element mandated by CPRC §74.351(r)(6), and therefore review must be granted.

B. Mr. Shorr's report fails to address the causation requirement of CPRC §74.351(r)(6), nor is he qualified to opine regarding same.

Mr. Shorr's report is insufficient as a matter of law because it **completely fails to address the causal relationship** between the alleged failures to meet the standards of care and the injury, harm, or damages claimed. Petitioner objects to the conclusory language regarding causation, *i.e.*, that all of Petitioner's alleged breaches of the standards of care caused a lack of oxygen for an extended period of

time, which caused brain damage. (CR 110; Appendix G, p. 6.) As discussed below, Mr. Shorr is not a physician and thus cannot opine on the causal relationship under 74.351(r)(5). Assuming *arguendo*, that Mr. Shorr could offer such opinions, Mr. Shorr offers no explanation for how Petitioner's alleged breach of the standard of care "resulted in a lack of oxygen" to the patient or how this supposed lack of oxygenation was of a type or severity to cause "brain damage" in Donnell Washington. The report does not address how the unavailability of unspecified equipment caused this lack of oxygen or how the equipment that was available would have been insufficient to meet the standard of care. Similarly, the report does not address how any alleged inability to recognize and respond to changes in Mr. Washington's condition resulted in a lack of oxygen. Mr. Shorr's report is wholly deficient in providing a summary of the causal relationship between the failure to meet the standard of care and the injuries claimed.

Moreover, Mr. Shorr is patently unqualified to offer any opinion on the causal relationship and is explicitly prevented from doing so under Texas state law.[1] Chapter 74 specifically requires that a person "giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability

[1] Petitioner maintains that Mr. Shorr's report is inadequate as to causal relationship on basis of content, as well as his lack of qualifications.

claim [be a] physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence." TEX. CIV. PRAC. & REM. CODE §§ 74.351(r)(5), 74.403. As such, Mr. Shorr, who is not a physician, can offer no statements attempting to attribute alleged breaches in the standard of care to injuries suffered by Donnell Washington.

Lastly, and based on the same reasoning as above, Mr. Shorr is unqualified to opine or make assumptions as to the physician defendants' competency, which seemingly comprise the sole, unsubstantiated basis of some or all of the opinions set forth in his report. *See* TEX. CIV. PRAC. & REM. CODE §§ 74.351(r)(5), 74.401. Chapter 74 specifies that only a physician can qualify as an expert on how a "physician departed from accepted standards of medical care." TEX. CIV. PRAC. & REM. CODE § 74.401.

The Court of Appeals erred to the extent it determined, based on his curriculum vitae and report, that Mr. Shorr is qualified to opine on causal relationship in this case. The Court should not consider any statements an expert, such as Dr. Panacek or Mr. Shorr, is not qualified to make. *Ehrlich v. Miles*, 144 S.W.3d. 620, 626 (Tex. App.—Fort Worth 2004, pet. denied)(after excluding opinions the expert was not qualified to make, all that was left was an opinion that the Defendant's negligence caused the patient's pain and suffering, which is not sufficient and dismissal was required).

The Court of Appeals therefore erred in concluding that Dr. Panacek's report, taken collectively with Mr. Shorr's, satisfied the causal relationship element mandated by Texas Civil Practice & Remedies Code §74.351(r)(6), and in affirming the denial of Petitioner's Motion to Dismiss. Accordingly, Petitioner respectfully requests the Court grant review of the Appellate Court decision.

CONCLUSION AND PRAYER

The Court of Appeals erred in concluding that Respondents' expert reports sufficiently identify the applicable standard of care, the alleged breach of the standard of care and causal relationship between the alleged breach and the resulting injuries as to Petitioner. Thus, Respondents' expert reports, even taken collectively, do not represent an objective good faith effort of an expert report required by Texas Civil Practice & Remedies Code §74.351.

Alternatively, the Court of Appeals erred by concluding the reports of Respondents' expert witnesses were collectively sufficient to satisfy the causal relationship requirement of Texas Civil Practice & Remedies Code §74.351(r)(6). Neither Dr. Panacek nor Mr. Shorr is qualified to opine as to causal relationship in this case. Additionally, Dr. Panacek's causal relationship opinions are merely conclusory without specific connection between the generic standards of care offered and the alleged breach and injuries or harm alleged, and therefore are incapable of demonstrating to the Court that Respondents' claims have merit.

Petitioner respectfully prays that this Court grant review and subsequently reverse the judgment of the Court of Appeals as to these two issues and render judgment in Petitioner's favor.

Respectfully submitted,

/s/ Jeffrey F. Wood

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CERTIFICATE OF SERVICE

I certify that I served a true and correct copy of the foregoing instrument on Respondent's Counsel by certified mail delivered on the 23rd day of June, 2014 as follows:

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JEFFREY F. WOOD

CERTIFICATE OF COMPLIANCE

I certify that the foregoing Petition for Review has a total word count of 4,484 words excluding the caption, identity of parties and counsel, table of contents, table of authorities, statement of the case, statement of jurisdiction, issues presented, certificate of service, certificate of compliance and appendix, in compliance with Texas Rule of Appellate Procedure 9.4(i)(2)(D).

/s/ Jeffrey Wood

JEFFREY F. WOOD

IN THE SUPREME COURT OF TEXAS

NAVARRO HOSPITAL, L.P. D/B/A NAVARRO REGIONAL HOSPITAL

Petitioner

V.

CHARLES WASHINGTON AND GWENDOLYN WASHINGTON, EACH INDIVIDUALLY AND AS NEXT FRIENDS OF CHARLES DONELL WASHINGTON

Respondents

On Petition for Review from the Tenth Court of Appeals at Waco, Texas

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APPENDIX

APPENDIX – TABLE OF CONTENTS

CAUSE NO. D12-21439-CV

CHARLES WASHINGTON and GWENDOLYN WASHINGTON, Each Individually and as Next Friend of CHARLES DONNELL WASHINGTON	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	NAVARRO COUNTY, TEXAS
CHS/ COMMUNITY HEALTH SYSTEMS, INC. individually and d/b/a NAVARRO REGIONAL HOSPITAL, TRIAD-NAVARRO REGIONAL HOSPITAL SUBSIDIARY LLC, NAVARRO REGIONAL LLC, NAVARRO HOSPITAL LP d/b/a NAVARRO REGIONAL HOSPITAL, NAVARRO REGIONAL HOSPITAL by its common name, QUORUM HEALTH RESOURCES, LLC, DOUGLAS B. HIBBS, M.D., and JAMES GOODMAN M.D.,	§	
Defendants.	§	13TH JUDICIAL DISTRICT

ORDER DEEMING PLAINTIFFS' CHAPTER 74 EXPERT REPORTS ADEQUATE

The Court finds that Plaintiffs' Chapter 74 Expert Reports of Edward Panacek, M.D. and Arthur Shorr are adequate pursuant to TCPRC §74.351.

ENTERED this 20th day of June, 2013.

PRESIDING JUDGE

CAUSE NO. D12-21439-CV

CHARLES WASHINGTON and GWENDOLYN WASHINGTON, Each Individually and as Next Friend of CHARLES DONNELL WASHINGTON	§	IN THE DISTRICT COURT OF
Plaintiffs,	§	
v.	§	NAVARRO COUNTY, TEXAS
CHS/ COMMUNITY HEALTH SYSTEMS, INC. individually and d/b/a NAVARRO REGIONAL HOSPITAL, TRIAD-NAVARRO REGIONAL HOSPITAL SUBSIDIARY LLC, NAVARRO REGIONAL LLC, NAVARRO HOSPITAL LP d/b/a NAVARRO REGIONAL HOSPITAL, NAVARRO REGIONAL HOSPITAL by its common name, QUORUM HEALTH RESOURCES, LLC, DOUGLAS B. HIBBS, M.D., and JAMES GOODMAN M.D.,	§	
Defendants.	§	13TH JUDICIAL DISTRICT

ORDER DENYING DEFENDANTS' MOTION TO DISMISS

CAME ON TO BE HEARD on January 18, 2013, Defendants Navarro Hospital, L.P. d/b/a Navarro Regional Hospital, CHS/Community Health Systems, Inc. individually and d/b/a Navarro Regional Hospital, Triad-Navarro Regional Hospital Subsidiary LLC, Navarro Regional LLC and Quorum Health Resources, LLC's Motion to Dismiss. After considering the Motion, the law, hearing argument of counsel and being otherwise fully advised, the Court DENIES Defendants' Motion to Dismiss.

ENTERED this 20th day of June, 2013.

PRESIDING JUDGE

Vernon's Texas Statutes and Codes Annotated
Civil Practice and Remedies Code (Refs & Annos)
Title 4. Liability in Tort
Chapter 74. Medical Liability (Refs & Annos)
Subchapter H. Procedural Provisions (Refs & Annos)

V.T.C.A., Civil Practice & Remedies Code § 74.351

§ 74.351. Expert Report

Effective: September 1, 2013
Currentness

(a) In a health care liability claim, a claimant shall, not later than the 120th day after the date each defendant's original answer is filed, serve on that party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the later of the 21st day after the date the report is served or the 21st day after the date the defendant's answer is filed, failing which all objections are waived.

(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a), the court, on the motion of the affected physician or health care provider, shall, subject to Subsection (c), enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider; and

(2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.

(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant one 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the 120-day deadline has passed, then the 30-day extension shall run from the date the plaintiff first received the notice.

(d) to (h) [Subsections (d)-(h) reserved]

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving of an expert report regarding any issue other than an issue relating to liability or causation.

(k) Subject to Subsection (t), an expert report served under this section:

(1) is not admissible in evidence by any party;

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party during the course of the action for any purpose.

(*l*) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective good faith effort to comply with the definition of an expert report in Subsection (r)(6).

(m) to (q) [Subsections (m)-(q) reserved]

(r) In this section:

(1) "Affected parties" means the claimant and the physician or health care provider who are directly affected by an act or agreement required or permitted by this section and does not include other parties to an action who are not directly affected by that particular act or agreement.

(2) "Claim" means a health care liability claim.

(3) [reserved]

(4) "Defendant" means a physician or health care provider against whom a health care liability claim is asserted. The term includes a third-party defendant, cross-defendant, or counterdefendant.

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 74.401;

(B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.

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

(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient's health care through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a), the restrictions imposed by Subsection (k) on use of the expert report by any party are waived.

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two depositions before the expert report is served as required by Subsection (a).

Credits

Added by Acts 2003, 78th Leg., ch. 204, § 10.01, eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 635, § 1, eff. Sept. 1, 2005; Acts 2013, 83rd Leg., ch. 870 (H.B. 658), § 2, eff. Sept. 1, 2013.

Notes of Decisions (1866)

V. T. C. A., Civil Practice & Remedies Code § 74.351, TX CIV PRAC & REM § 74.351

Current through the end of the 2013 Third Called Session of the 83rd Legislature

End of Document

IN THE
TENTH COURT OF APPEALS

No. 10-13-00248-CV

NAVARRO HOSPITAL, L.P. D/B/A
NAVARRO REGIONAL HOSPITAL,
Appellant

v.

CHARLES WASHINGTON AND GWENDOLYN
WASHINGTON, EACH INDIVIDUALLY AND AS
NEXT FRIENDS OF CHARLES DONELL WASHINGTON,
Appellees

From the 13th District Court
Navarro County, Texas
Trial Court No. D12-21439 CV

MEMORANDUM OPINION

In this appeal, appellant, Navarro Hospital, L.P. d/b/a Navarro Regional Hospital, complains about the trial court's denial of its motion to dismiss a health-care liability claim brought by appellees, Charles Washington and Gwendolyn Washington, each individually and as next friends of Charles Donell Washington ("Donell"). In two issues, appellant challenges appellees' expert reports as not constituting a good faith

effort. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(r)(6) (West Supp. 2013). We affirm.

I. BACKGROUND

In their original petition, appellees asserted health-care liability claims against appellant and two doctors, Douglas B. Hibbs, M.D. and James Goodman, M.D., among others.[1] In particular, appellees alleged that Donell was an accomplished musician "who had a full and active life" when he was admitted to Navarro Regional Hospital on July 13, 2010. At the time, Donell complained of difficulty breathing, dizziness, nausea, vomiting, and pain in his throat and right ear. Appellees noted that Donell appeared depressed and had difficulty with verbal expression when he was admitted to the hospital. Nevertheless, Donell was stable at that time. Dr. Hibbs was the attending physician, and he ordered that Donell be given IV fluids, insulin, and medications to address his agitation and restlessness.

Donell was taken to the ICU, and he remained there the following day. Doctors noted that Donell became increasingly agitated and unresponsive to verbal stimuli. They also observed increases in Donell's blood pressure and heart rate.

At approximately 2:25 a.m. on July 15, 2010, Donell's heart rate and oxygen saturation dropped suddenly, and he was placed on 100% oxygen via mask. Five

[1] Drs. Hibbs and Goodman are not parties to this appeal.

minutes later, Donell's heart rate decreased to 39, and a Code Blue was called. Doctors commenced chest compressions, and an ambubag was used to ventilate Donell.

Drs. Hibbs and Goodman tried multiple times to intubate Donell, but they were unsuccessful in their attempts. According to appellees, no one tried to use the "'difficult airway' equipment that is standard and sometimes necessary to achieve intubation of a patient such as Donell." Appellees further asserted that this "equipment was unavailable or was otherwise not brought to the room. The responsibility for having such equipment and assuring hospital staff bring it to the room rests with the corporate defendants."

Approximately forty-five minutes after the Code Blue was called, a Dr. Stevener arrived and successfully intubated Donell. However, by the time that he was intubated, Donell suffered extensive and permanent brain damage.[2] Appellees argued that Donell's brain damage was caused by "the needless delay in getting Donell ventilated."

Based on these facts, appellees asserted negligence and gross-negligence causes of action against Drs. Hibbs and Goodman and appellant, among others. With respect to appellant, appellees contended that appellant "failed to have the difficult airway equipment readily available, and failed to have and/or enforce adequate policies related to such equipment. These failures resulted in Donell needlessly suffering severe, permanent brain damage." Appellant responded by filing an original answer denying

[2] At the hearing on appellant's motion to dismiss, counsel for appellees stated that Donell is now deceased.

each of the allegations contained in appellees' original petition and asserting special exceptions and numerous affirmative defenses.

Appellees subsequently filed expert reports from Edward Panacek, M.D. and Arthur S. Shorr, MBA, FACHE. Appellant filed objections to both expert reports and a motion to dismiss appellees' claims. Thereafter, the trial court conducted a hearing on appellant's motion to dismiss and ultimately denied the motion. The trial court also signed an order deeming appellees' expert reports adequate. This interlocutory appeal followed. *See id.* § 51.014(a)(9) (West Supp. 2013) (permitting the appeal of an interlocutory order from a district court that "denies all or part of the relief sought by a motion under Section 74.351(b)").

II. STANDARD OF REVIEW & APPLICABLE LAW

We review a trial court's denial of a motion to dismiss under section 74.351 for an abuse of discretion. *Bowie Mem'l Hosp. v. Wright*, 79 S.W.3d 48, 52 (Tex. 2002); *Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 875 (Tex. 2001). A trial court abuses its discretion if it acts in an arbitrary or unreasonable manner or without reference to any guiding rules or principles. *Walker v. Gutierrez*, 111 S.W.3d 56, 62 (Tex. 2003); *Downer v. Aquamarine Operators, Inc.*, 701 S.W.2d 238, 241-42 (Tex. 1985).

Section 74.351 of the Texas Civil Practice and Remedies Code provides that within 120 days of filing a health-care liability claim, a claimant must serve a curriculum vita and one or more expert reports regarding every defendant against

whom a health-care claim is asserted. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(a); *see also Hillcrest Baptist Med. Ctr. v. Payne*, No. 10-11-00191-CV, 2011 Tex. App. LEXIS 9182, at *6 (Tex. App.—Waco Nov. 16, 2011, pet. denied) (mem. op.). The expert report must contain,

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

TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(r)(6); *see Palacios*, 46 S.W.3d at 877. If a plaintiff timely files an expert report and the defendant moves to dismiss because of the report's inadequacy, the trial court must grant the motion "only if it appears to the court, after hearing, that the report does not represent a good faith effort to comply with the definition of an expert report in [section 74.351(r)(6)]." *Wright*, 79 S.W.3d at 51-52; *see Palacios*, 46 S.W.3d at 878.

To constitute a "good faith effort," the report must provide enough information to fulfill two purposes: (1) it must inform the defendant of the specific conduct the plaintiff has called into question; and (2) it must provide a basis for the trial court to conclude that the claims have merit. *Wright*, 79 S.W.3d at 52-53 (noting that "magical words" are not necessary to provide a fair summary of the standard of care, breach of that standard, and causation); *see Palacios*, 46 S.W.3d at 879 ("A report that merely states the expert's conclusions about the standard of care, breach, and causation does not

fulfill these two purposes. Nor can a report meet these purposes and thus constitute a good-faith effort if it omits any of the statutory requirements."). The trial court should look no further than the report itself, because all the information relevant to the inquiry should be contained within the document's four corners. *Wright*, 79 S.W.3d at 52 (citing *Palacios*, 46 S.W.3d at 878).

An expert report, however, does not need to marshal all of the plaintiff's proof; it may be informal, and the information presented need not meet the requirements of evidence offered in summary-judgment proceedings or in trial. *See Spitzer v. Berry*, 247 S.W.3d 747, 750 (Tex. App.—Tyler 2008, pet. denied); *see also Bakhtari v. Estate of Dumas*, 317 S.W.3d 486, 496 (Tex. App.—Dallas 2010, no pet.). Moreover, "[e]xpert reports can be considered together in determining whether the plaintiff in a health[-]care liability action has provided adequate expert opinion regarding the standard of care, breach, and causation." *Salais v. Tex. Dep't of Aging & Disability Servs.*, 323 S.W.3d 527, 534 (Tex. App.—Waco 2010, pet. denied); *see Walgreen Co. v. Hieger*, 243 S.W.3d 183, 186 n.2 (Tex. App.—Houston [14th Dist.] 2007, pet. denied); *see also* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(i).

III. APPELLEES' EXPERT REPORTS

In its first issue, appellant contends that the trial court erred in denying its motion to dismiss because appellees' expert reports failed to establish the standard of care and alleged departures from the standard of care. More specifically, appellant

argues that: (1) Dr. Panacek and Shorr are not qualified to render opinions as to the standards of care and the alleged departures from the standards of care; (2) Dr. Panacek's report fails to adequately set forth the applicable standard of care; (3) Dr. Panacek's opinions about the breach of the standard of care are inadequate and based on speculation and conjecture; and (4) Shorr's report fails to specify the applicable standard of care and breach. In its second issue, appellant asserts that Dr. Panacek and Shorr are unqualified to opine as to causation and that their reports do not adequately explain the causation element.

a. The Qualifications of Experts in Health-Care Liability Claims

Section 74.351(r)(5) of the Texas Civil Practice and Remedies Code provides that an "expert" in a health-care liability claim is:

> (B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;
>
> (C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence . . . .

TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(r)(5)(B)-(C). Section 74.402 states the following, in pertinent part:

> (b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of

whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care provider is an individual, at the time, the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

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

(2) is actively practicing health care in rendering health care services relevant to the claim.

Id. § 74.402(b)-(c) (West 2011). Moreover, section 74.402(a) describes the following as "practicing health care":

(1) training health care providers in the same field as the defendant health care provider at an accredited education institutional; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

Id. § 74.402(a).

In light of the foregoing statutes, the Texas Supreme Court has stated that a professional need not be employed in the particular field about which he is testifying so long as he can demonstrate that he has knowledge, skill, experience, training, or education regarding the specific issue before the court that would qualify him to give an opinion on that subject. *Broders v. Heise*, 924 S.W.2d 148, 153-54 (Tex. 1996); *see* TEX. CIV. PRAC. & REM. CODE ANN. § 74.402 (West 2011) (listing the requirements for an expert to be considered qualified in a suit against a health-care provider); *see also* TEX. R. EVID. 702 (allowing experts to testify based on their "knowledge, skill, experience, training, or education"). "[W]hen a party can show that a subject is substantially developed in more than one field, testimony can come from a qualified expert in any of those fields." *Broders*, 924 S.W.2d at 154.

Qualifications of an expert must appear in the expert reports and curriculum vitae and cannot be inferred. *See Salais*, 323 S.W.3d at 536; *see also Estorque v. Schafer*, 302 S.W.3d 19, 26 (Tex. App.—Fort Worth 2009, no pet.) (citing *Olveda v. Sepulveda*, 141 S.W.3d 679, 683 (Tex. App.—San Antonio 2004, pet. denied)). Analysis of the expert's qualifications under section 74.351 is limited to the four corners of the expert reports and the expert's curriculum vitae. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(a); *In re McAllen Med. Ctr., Inc.*, 275 S.W.3d 458, 463 (Tex. 2008) (considering an expert's curriculum vita and report in determining whether the expert was qualified to opine

about plaintiff's negligent-credentialing cause of action); *Polone v. Shearer*, 287 S.W.3d 229, 238 (Tex. App.—Fort Worth 2009, no pet.); *see also Lewis v. Funderburk*, No. 10-05-00197-CV, 2008 Tex. App. LEXIS 9761, at *6 (Tex. App.—Waco Dec. 31, 2008, pet. denied) (mem. op.).

Merely being a physician is insufficient to qualify as a medical expert. *See Broders*, 924 S.W.2d at 152; *see also Hagedorn v. Tisdale*, 73 S.W.3d 341, 350 (Tex. App.—Amarillo 2002, no pet.) ("Every licensed doctor is not automatically qualified to testify as an expert on every medical question."). But we defer to the trial court on close calls concerning an expert's qualifications. *See Larson v. Downing*, 197 S.W.3d 303, 304-05 (Tex. 2006); *see also Broders*, 924 S.W.2d at 151 ("The qualification of a witness as an expert is within the trial court's discretion. We do not disturb the trial court's discretion absent clear abuse.").

1. Dr. Panacek's Qualifications

On appeal, appellant complains that Dr. Panacek is not qualified to render an opinion in this case because he failed to explain his qualifications for rendering an opinion about the equipment which a hospital should make available in ICU and ER units, as well as "protocols, policies and procedures to assure that medical personnel and staff are aware of and trained to utilize" such equipment. As noted above, this case involved a patient that required advanced airway management and equipment in

response to a Code Blue. In the qualifications section of his expert report, Dr. Panacek stated the following:

> I am a physician licensed to practice medicine by the state of California. I received the MD degree at the University of South Alabama College of Medicine in Mobile AL in 1981. I am a Diplomate of the American Board of Internal Medicine, the National Board of Medical Examiners, the American Board of Emergency Medicine and am a Diplomate in Critical Care Medicine. I am an instructor in Advanced Cardiac Life Support, and Advanced Trauma Life Support. I am a past Program Director of the Emergency Medicine Residency program at the University of California Davis Medical Center in Sacramento CA. I am a Professor of Emergency Medicine at that same facility. My CV is attached to this report and is incorporated by reference. I have extensive experience in establishing and maintaining airways in patients, responding to Code Blues, and using standards of care related to airway management during Code Blue situations in the hospital setting, and these standards of care are common to internal medicine, emergency medicine, and critical care medicine. I am familiar with the medical treatment of a patient similar to Charles "Donell" Washington in 2010 and am qualified by training and experience to render opinions regarding the appropriateness of his medical treatment.

The language above demonstrates that Dr. Panacek is a practicing doctor with a medical license from California and describes his expertise in critical-care and emergency medicine, especially with regard to airway management and responding to Code Blue situations—the type of expertise involved in the claims asserted in this case. Additionally, Dr. Panacek opines that he is familiar with the medical treatment of a patient similarly situated as Donell in this case. As such, Dr. Panacek asserts that he is qualified to render his opinion in his expert report based on experience, as well as knowledge, skill, and education. Other language in his expert report, including his

description of the standards of care involved in this case, indicates that he is familiar with the actions and equipment necessary for the advanced airway management involved here. Therefore, based on the language contained in Dr. Panacek's expert report, we cannot say that the trial court clearly abused its discretion by implicitly concluding that Dr. Panacek is qualified to give an opinion on the subject matter involved in this case. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.402; *see also Broders*, 924 S.W.2d at 153.

2. Shorr's Qualifications

Appellant also contends that Shorr is unqualified to opine on the standard of care and causation in this case. In his report, Shorr states that he is Board Certified in Hospital and Healthcare Administration and is a Fellow of the American College of Healthcare Executives. He further states that he has worked as a healthcare administrator for forty years, of which includes a sixteen-year stint in senior executive management of acute-care hospitals. Additionally, Shorr recounts numerous executive and academic positions he has held in the healthcare industry. Shorr also notes that he has published numerous articles in peer-reviewed professional healthcare-administration journals and that he has authored a textbook on administrative issues in the healthcare industry. Furthermore, Shorr's report reflects that he has been a provider of consulting services to physicians and hospitals, "first as Arthur S. Shorr & Associates,

Inc.: Consultants to Healthcare Providers, and currently as Shorr Healthcare Consulting."

Based on Shorr's extensive experience in healthcare administration, and given that Shorr is Board Certified in Hospital and Healthcare Administration and provides consulting services to hospitals regarding administration services, we conclude that Shorr is qualified to opine as an expert as to the standards of care and the corresponding departures from the standards of care involving appellant's alleged failure to have difficult airway equipment available and appropriate policies in place to ensure that such equipment is available to treating physicians and that hospital personnel are trained how to use such equipment. *See id.* § 74.402(a)-(c); *see also* TEX R. EVID. 702; *Broders*, 924 S.W.2d at 153-54. However, we do agree with appellant that Shorr, a non-physician, is not qualified to opine as to causation in this matter. *See id.* § 74.403(a) (West 2011) (stating that only a physician is qualified to render causation opinions in health-care liability claims); *see also Petty v. Churner*, 310 S.W.3d 131, 134 (Tex. App.—Dallas 2010, no pet.); *Hieger*, 243 S.W.3d at 186 n.2. We will now address the adequacy of the expert reports.

b. Adequacy of the Expert Reports

With regard to the standard of care applicable to appellant, Dr. Panacek stated the following:

> Airway management is one of the most critically important skills for an emergency or critical care practitioner to master because failure to secure

> an adequate airway can quickly lead to death or disability. Endotracheal intubation using rapid sequence intubation (RSI) is the cornerstone of emergency airway management.
>
> . . . .
>
> The relevant standards of care for hospitals treating Donell Washington during the admission of July 13, 2010 are such that the hospital must have specialized intubation equipment immediately available in all ICU and ER units, as well as available to each code blue. Such equipment includes endotracheal tubes of various sizes, a laryngoscope with blades of various sizes, Laryngeal Mask Airways, and naso- and oro-pharyngeal airways. Difficult airway equipment must be quickly available as well. Further, minimal standards of care require that the hospital have and/or enforce adequate protocols, or policies and procedures to assure that medical personnel and staff are aware of and trained to utilize this specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time.

Thereafter, Dr. Panacek described how appellant departed from the applicable standard of care and caused Donell's injuries. Specifically, Dr. Panacek noted that appellant's actions,

> fell below applicable standards of care by failing to have specialized intubation equipment immediately available for use on Donell Washington. Further, they fell below applicable standards of care by failing to have, or failing to enforce, protocols, polices, and procedures to assure that medical personnel and staff were aware and trained to utilize specialized intubation equipment during code situations. Had such equipment been available it more likely than not would have been used on Donell Washington at the beginning of his Code Blue.

And as a result of appellant's alleged departures from the applicable standards of care, Dr. Panacek stated the following, among other things:

> Had applicable standards of care been used on Donnell Washington, the hospital would have had the equipment identified above in a crash cart on

the unit where Donell Washington was located. When the Code Blue was called the crash cart would have been rolled into the room very quickly by the nurses as the Code Team was arriving. Drs. Goodman and Hibbs would have taken steps to assure that an adequate airway was established and maintained during the Code Blue. These physicians would have intubated Donell Washington as soon as possible after they arrived at Washington's bedside by taking a laryngoscope from the crash cart, putting the appropriate blade on it, and then putting the blade into the patient's mouth and into his larynx, visualizing his vocal cords and inserting the plastic endotracheal tube into the patient's throat. . . . At that point, these physicians should have gone to an LMA or naso- or oro-pharyngeal mask. An LMA is simply a tube with an inflatable mask on one end that is inserted into the patient's throat to achieve a seal over the tracheal opening so that oxygen can be forced into the patient's lungs. Almost certainly, these physicians would have been able to adequately ventilate this patient at that point. If for some reason, they could not accomplish this, then the physicians should have used a scalpel and made an incision in the anterior surface of Washington's neck, identified and cut through the cricothyroid membrane and intubated the patient through this opening. At this point, Washington would have been ventilated adequately until a definitive airway could be established. Brain damage due to lack of oxygen would more likely than not have been avoided.

In order to comply with applicable standards of care, CMS/Community Health Systems d/b/a Navarro Regional Hospital and the operator of that hospital, which I understand to be Quorum Health Resources, would have had specialized intubation equipment, to specifically include the intubation equipment listed above, immediately available in the ICU unit where Mr. Washington was being maintained at the time the Code Blue was called. Moreover, Navarro Regional Hospital should have had and/or enforced protocols or policies and procedures assuring that the medical personnel and staff (including Drs. Goodman and Hibbs) were aware of and trained to utilize this specialized intubation equipment during a Code Blue. Had this occurred, then all of the equipment listed above would have been physically present in Donell Washington's room and available for use by Drs. Goodman and Hibbs. Unfortunately, the hospital failed to take these actions, thereby proximately causing Mr. Washington's injury.

> It is my opinion beyond a reasonable medical probability, based on my training and education and experience, that the negligent acts of Dr. Goodman, Dr. Hibbs, and Navarro Regional Hospital . . . outlined above were each a proximate cause of Mr. Washington's profound brain damage and related sequelae. It is well accepted in the medical community at large that the brain requires a constant flow of oxygen to function normally. When the flow of oxygen is cut-off—and in a patient who is unconscious and not breathing—the blood oxygen levels drop. At a certain point, the low oxygen state causes the cells of the body to go into anaerobic respiration, rather than aerobic respiration based on the oxygen supply. This produces lactic acid as a by-product of anaerobic respiration. The lactic acid builds up and brain cells begin to die. A hypoxic-anoxic injury occurs when the flow of blood is disrupted, essentially starving the brain and preventing it from performing vital biomechanical processes. With complete cessation of oxygenation, the cells of the brain begin to die in approximately 4 to 6 minutes. Brain-cell death is not reversible. When oxygen deprivation is severe enough, a profound hypoxic-anoxic brain injury results via this mechanism of injury. This is what happened to Donell Washington as a result of his being without an adequate airway for approximately 46 minutes during the Code Blue. Subsequent workup confirmed this diagnosis of hypoxic-anoxic encephalopathy. Specifically, an MRI on July 16, 2010 showed extensive cortical and deep gray abnormalities, and overall configuration and findings suspicious for hypoxic ischemic injury or global anoxic event. On July 28, 2010, CT of Mr. Washington's head showed abnormalities involving bilateral lentiform and caudate nuclei consistent with anoxic brain injury, with subacute petechial hemorrhage. EEG findings were deemed to show a pattern that was "consistent with our diagnosis of hypoxic encephalopathy." The brain damage is permanent and quite severe.

Shorr, on the other hand, mentioned that appellant is directly responsible for providing safe and effective healthcare services and are liable for the negligence of Drs. Goodman and Hibbs. Shorr stated that the relevant standards of care for hospitals are to ensure that its staff are competent and adequately trained to appropriately manage Donell's airway during a Code situation and that it should have and/or enforce

protocols, policies, or procedures to assure that medical personnel and staff "are aware of and trained to utilize this specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time." In support of his opinion on the standard of care, Shorr cites to numerous regulations and accreditation standards for hospitals, including those pertaining to hospital accountability for patient care, hospital requirements to have supplies and equipment needed for patient care readily available, duties of hospital staff to recognize and respond to changes in a patient's condition, and duties of the hospital to ensure that all staff are competent to carry out patient treatment.

After reviewing the four corners of the proffered expert reports, we conclude that the reports inform appellant of the specific conduct that appellees have called into question—appellant's failure to: (1) have specialized intubation equipment readily available at the time the Code Blue was called; and (2) have or enforce protocols, policies, or procedures for ensuring that personnel are aware of and trained to utilize such equipment—and provide the trial court with a basis to conclude that the claims have merit. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351(r)(6); *Wright*, 79 S.W.3d at 52-53; *Palacios*, 46 S.W.3d at 879; *see also Salais*, 323 S.W.3d at 534; *Hieger*, 243 S.W.3d at 186 n.2. And to the extent that appellant complains that certain aspects of the expert reports are deficient, we emphasize that the reports need not marshal all of appellees'

proof or meet the same requirements as evidence offered in summary-judgment proceedings or in trial. *See Bakhtari*, 317 S.W.3d at 496; *see also Spitzer*, 247 S.W.3d at 750.

Based on the foregoing, we cannot say that the trial court acted in an arbitrary or unreasonable manner or without reference to guiding rules and principles when it denied appellant's motion to dismiss. *See Walker*, 111 S.W.3d at 62; *see also Downer*, 701 S.W.2d at 241-42. Accordingly, we cannot conclude that the trial court abused its discretion in denying appellant's motion to dismiss. *See Wright*, 79 S.W.3d at 52; *see also Palacios*, 46 S.W.3d at 875. We overrule both of appellant's issues on appeal.

IV. CONCLUSION

Having overruled both of appellant's issues on appeal, we affirm the judgment of the trial court.

AL SCOGGINS
Justice

Before Chief Justice Gray,
Justice Davis, and
Justice Scoggins
Affirmed
Opinion delivered and filed May 8, 2014
[CV06]

TENTH COURT OF APPEALS

McLennan County Courthouse
501 Washington Avenue, Rm 415
Waco, Texas 76701-1373
Phone: (254) 757-5200 Fax: (254) 757-2822

May 8, 2014

In accordance with the enclosed Memorandum Opinion, below is the judgment in the numbered cause set out herein to be entered in the Minutes of this Court as of the 8th day of May, 2014.

10-13-00248-CV NAVARRO HOSPITAL, L.P. D/B/A NAVARRO REGIONAL HOSPITAL v. CHARLES WASHINGTON AND GWENDOLYN WASHINGTON, EACH INDIVIDUALLY AND AS NEXT FRIENDS OF CHARLES DONELL WASHINGTON - ON APPEAL FROM THE 13TH DISTRICT COURT OF NAVARRO COUNTY - TRIAL COURT NO. D12-21439 CV - AFFIRMED - Memorandum Opinion by Justice Scoggins:

"This cause came on to be heard on the transcript of the record, and the same being considered, because it is the opinion of this Court that there was no error in the judgment of the court below; it is therefore ordered, adjudged and decreed that the judgment of the court below be, and hereby is, affirmed. It is further ordered that appellant pay all costs in this behalf expended, and that this decision be certified below for observance."

EXPERT OPINION OF EDWARD PANACEK, M.D.

This report is written at the request of James E. Girards and is written in order to comply with *Texas Civil Practices & Remedies Code* § 74.351. I have been informed that subsection (k) of the statute provides that an expert opinion prepared under this law is not admissible in evidence by any party; shall not be used in a deposition, trial, or other proceeding; and shall not be referred to by any Defendant during the course of any proceeding in this case. All opinions expressed herein are based upon reasonable medical probability.

I have reviewed the medical care given to Charles "Donell" Washington in July 2010 at Navarro Regional Hospital in Corsicana, TX by the hospital staff and the physicians there, including James Goodman, MD, Larry Stevener, MD, and Douglas Hibbs, MD. I have reviewed the medical records, diagnostic studies, laboratory results, and all related documentation contained within the Navarro Regional Hospital chart.

QUALIFICATIONS

I am a physician licensed to practice medicine by the state of California. I received the MD degree at the University of South Alabama College of Medicine in Mobile AL in 1981. I am a Diplomate of the American Board of Internal Medicine, the National Board of Medical Examiners, the American Board of Emergency Medicine and am a Diplomate in Critical Care Medicine. I am an instructor in Advanced Cardiac Life Support, and Advanced Trauma Life Support. I am a past Program Director of the Emergency Medicine Residency program at the University of California Davis Medical Center in Sacramento CA. I am a Professor of Emergency Medicine at that same facility. My CV is attached to this report and is incorporated by reference. I have extensive experience in establishing and maintaining airways in patients, responding to Code Blues, and using LMA (laryngeal mask airway) devices, and performing cricothyrotomy. I am familiar with the standards of care related to airway management during Code Blue situations in the hospital setting, and these standards of care are common to internal medicine, emergency medicine, and critical care medicine. I am familiar with the medical treatment of a patient similar to Charles "Donell" Washington in 2010 and am qualified by training and experience to render opinions regarding the appropriateness of his medical treatment.

All opinions expressed in this report are based on reasonable medical probability.

I understand that in Texas, "negligence", when used with respect to a physician, means the failure to use ordinary care; that is, doing that which a physician of ordinary prudence would not have done under the same or similar circumstances, or failing to do that which a physician of ordinary prudence would have done under the same or similar circumstances.

I understand that in Texas, "negligence", when used with respect to a hospital, means the failure to use ordinary care; that is, doing that which a hospital of ordinary prudence would not have done under the same or similar circumstances, or failing to do that which a hospital of ordinary prudence would have done under the same or similar circumstances.

I understand that in Texas as to a physician, "ordinary care" means that degree of care which would be used by a physician of ordinary prudence under the same or similar circumstances.

I understand that in Texas as to a hospital, "ordinary care" means that degree of care which would be used by a hospital of ordinary prudence under the same or similar circumstances.

I understand that in Texas, "proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a physician using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. I understand that there may be more than one proximate cause of an event.

PATIENT HISTORY

In July 2010, Charles "Donell" Washington was a 34-year old male, with a history of bipolar disease and schizophrenia. His medication history included Cogentin, Trazodone & Zyprexa.

On July 13, 2010, he was taken to the Emergency Department at Navarro Regional Hospital by his parents. His vital signs were: T 97.3, P 123, R 22, BP 116/59, O2 97%. He was unable to rate his pain. Donell complained of difficulty breathing since yesterday, fever of 100.1 per his mother. The patient was feeling dizzy with nausea and vomiting x 1 day and pain in throat and right ear. The patient's behavior is inappropriate and he appeared depressed. The patient appeared to be mentally challenged and was not speaking. His pupillary response was brisk. The patient was having difficulty with verbal expression. No deficits noted bilaterally to upper extremities. Weakness noted bilaterally to lower extremities. Donell's best verbal response was incomprehensible words, best motor response was withdrawal from pain. His heart rate was 125, with sinus tachycardia, his skin was clammy, his capillary refill was less than 2 seconds. Edema was not present. His laboratory results were normal except for CL 93 (L) , HC02 <5 (LC), Glu 941, BUN 58 (H), Creat 3.8 (H), TP 9.7 (H), AST 11 (L), ALP 215 (H), Acetone positive , WBC 18.4 (H). Later, additional labs showed glucose of 942, hemo 18.1, and he was given 25 units of Insulin. An IV was started.

Donell's blood gasses at 11:55 were as follows: PH 7.08 (CL), PC02 11.0, P02 114.0, HC03 3.3 (L), BE – 24.2 (L). At 1300, his vital signs were: T 97.3, P 128, R 38 unlabored, BP 146/71, O2 Sat 97%, he was unable to rate his pain. At 1339, he was moved to the ICU.

By 1715, Donell's blood sugar was down to 462. At 17:30, he was noted to be agitated, and was still not responding to commands trying to get out of bed, Dr. Hibbs was notified and new orders were received for Ativan 1 mg which was given. At 2030, Donell was restless in bed and thrashing about. Dr. Hibbs was called and an order was given for Ativan 1 mg. At 20:40, Donell was placed in restraints. At 2100, Dr. Hibbs was in the room to place a catheter line. At 2315, Donell was given more Ativan for agitation.

At 0200 on the 14th, Donell was given Ativan 1 mg for restlessness, and agitation. At 0400 his glucometer check was 336. At 0445, Donell was noted to be restless, agitated, would not follow commands, would not look at the nurse. He was given Ativan 1 mg.

At 1800, Donell was given a Catapres TTS patch as ordered. He continued to be extremely agitated. At 1830, he was given Hydralazine for his blood pressure. At 2340, Donell's blood pressure was noted at 176/99, and he was given Hydralazine 10mg IV as ordered.

At 0110 on the 15th, Donell was given Ativan 1 mg. At 0150 his heart rate was noted at 142 with sinus tachycardia. His blood pressure was 189/85. Dr. Hibbs was called. At 0200, Donell was given Lopressor 5 mg for heart rate of 142 as ordered.

At 0225, Donell's heart rate was 73, with shallow respirations. His oxygen saturation was 69%, which was checked with a portable unit at 60%. Donell was placed on 100% oxygen via mask.

At 0230, Donell's heart rate was 39, and a Code Blue was called, with no pulse palpable. Chest compressions were started and an ambubag was used in attempt to ventilate the patient.

At 0241, Dr. Goodman arrived to assist the Code Blue effort. At 0245, Dr. Goodman attempted to intubate Donell but was unable to accomplish this. At 0249, another attempt was made to intubate Donell, again unsuccessfully. At 0251, a third attempt to intubate was made and again it was unsuccessful. At 0253, another attempt was made to intubate Donell but this was also unsuccessful. At 0255, a call was placed to Dr. Stevener to intubate Donell. At 0305, Dr. Hibbs attempted to intubate Donell but this was unsuccessful.

At 0316, Dr. Stevener obtained a special scope and was able to successfully intubate Donell.

Donell was later diagnosed with brain damage due to lack of oxygen. In reasonable medical probability, this resulted from the extended delay in getting Donell ventilated and oxygenated.

STANDARDS OF CARE

Airway management is one of the most critically important skills for an emergency or critical care practitioner to master because failure to secure an adequate airway can quickly lead to death or disability. Endotracheal intubation using rapid sequence intubation (RSI) is the cornerstone of emergency airway management. The relevant standards of care for physicians treating a patient such as Donell Washington during the admission of July 13, 2010 are such that when a Code Blue is called on the patient it is imperative to ventilate the patient as quickly as possible in order to prevent brain and organ damage. This most often is by the use of endotracheal intubation. When attempts at endotracheal intubation are repeatedly frustrated, it is required that the physician immediately use another method such as a Laryngeal Mask Airway, a naso- or oro-pharyngeal airway, other specialized airway equipment or cricothyrotomy in order to achieve ventilation before the patient suffers damage to the brain or vital organs. The standard of care for Drs. Hibbs and Goodman required that they achieve ventilation of a patient such as Donell Washington by first attempting endotracheal intubation, and if that is not successful, to place a

Laryngeal Mask Airway or a naso- or oro-pharyngeal airway to ventilate the patient. Failing that, the standard of care requires that the approach to airway management get much more aggressive, using more specialized personnel or a cricothyrotomy be accomplished to assure the patient is adequately oxygenated before brain injury occurs. A cricothyrotomy is a technique in which the physician uses a scalpel to make an incision through the anterior surface of the neck and through the cricothyroid membrane into the trachea in order to establish an airway for the patient until a definitive airway can be established.

The relevant standards of care for hospitals treating Donell Washington during the admission of July 13, 2010 are such that the hospital must have specialized intubation equipment immediately available in all ICU and ER units, as well as available to each code blue. Such equipment includes endotracheal tubes of various sizes, a laryngoscope with blades of various sizes, Laryngeal Mask Airways, and naso- and oro-pharyngeal airways. Difficult airway equipment must be quickly available as well. Further, the minimal standards of care require that the hospital have and/or enforce adequate protocols, or policies and procedures to assure that medical personnel and staff are aware of and trained to utilize this specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time.

VIOLATIONS OF THE STANDARDS OF CARE

My review of the medical records related to Donell Washington's July 2010 admission leads me to conclude that, based on reasonable medical probability, James Goodman MD fell below the applicable standards of care in his treatment of Mr. Washington by failing to adequately manage his airway during his code situation in order to achieve successful ventilation of this patient via endotracheal intubation, Laryngeal Mask Airway, naso- or oro-pharyngeal airway, other specialized equipment, or cricothyrotomy. Dr. Goodman attempted endotracheal intubation on Donnell Washington four times but was unable to accomplish this. Dr. Goodman failed to utilize any of the other techniques to achieve ventilation of this patient. Under the definitions listed above, I must conclude that Dr. Goodman wasted precious time repeated the same failed technique and was negligent in his care and treatment of Donell Washington during his July 2010 admission for these reasons. Had Dr. Goodman acted within applicable standards of care he would most likely have been able to achieve a successful endotracheal intubation or he would have been able to successfully apply the LMA or naso- or oro-pharyngeal airways. In the event of his inability to achieve ventilation using one of these techniques he certainly should have been able to perform a cricithyrotomy and achieved adequate ventilation in that manner.

My review of the medical records related to Donell Washington's July 2010 admission leads me to conclude that, based on reasonable medical probability, Douglas Hibbs, MD fell below the applicable standards of care in his treatment of Mr. Washington by failing to adequately manage his airway during his code situation in order to achieve successful ventilation of this patient via endotracheal intubation, Laryngeal Mask Airway, naso- or oro-pharyngeal airway, or cricothyrotomy. Dr. Hibbs attempted endotracheal intubation on Donnell Washington using the same failed technique and was unable to accomplish this. Dr. Hibbs failed to utilize any of the other techniques to achieve ventilation of this patient. Under the definitions listed above, I must conclude that Dr. Hibbs was negligent in his care and treatment of Donell Washington during his July 2010 admission for these reasons. Had Dr. Hibbs acted within applicable standards of care he would

most likely have been able to achieve a successful endotracheal intubation or he would have been able to successfully apply the LMA or naso- or oro-pharyngeal airways. In the event of his inability to achieve ventilation using one of these techniques he certainly could have performed a cricithyrotomy and achieved adequate ventilation in that manner.

Both Drs. Goodman and Hibbs, if unfamiliar with advanced airway equipment and techniques should have immediately called for help from anesthesia.

My review of the records related to Donell Washington's July 2010 admission leads me to conclude that, based on reasonable medical probability, CMS/Community Health Systems d/b/a Navarro Regional Hospital and the operator of that hospital, which I understand to be Quorum Health Resources, fell below applicable standards of care by failing to have specialized intubation equipment immediately available for use on Donell Washington. Further, they fell below applicable standards of care by either failing to have, or failing to enforce, protocols, policies and procedures to assure that medical personnel and staff were aware of and trained to utilize specialized intubation equipment during code situations. Had such equipment been available it more likely than not would have been used on Donell Washington at the beginning of his Code Blue. Under the definitions listed above, I must conclude that Navarro Regional Hospital was negligent in its care and treatment of Donell Washington during his July 2010 admission for these reasons.

APPROPRIATE PATIENT CARE

Had applicable standards of care been used on Donell Washington, the hospital would have had the equipment identified above in a crash cart on the unit where Donell Washington was located. When the Code Blue was called the crash cart would have been rolled into the room very quickly by the nurses as the Code Team was arriving. Drs. Goodman and Hibbs would have taken steps to assure that an adequate airway was established and maintained during the Code Blue. These physicians would have intubated Donell Washington as soon as possible after they arrived at Washington's bedside by taking a laryngoscope from the crash cart, putting the appropriate blade on it, and then putting the blade into the patient's mouth and into his larynx, visualizing his vocal cords and inserting the plastic endotracheal tube into the patient's throat. Frequently, inability to intubate an unconscious patient who does not have a documented difficult airway is due to lack of skill. Whether this is the case here or otherwise, these physicians should have recognized that they were not being successful in getting the patient intubated timely. At that point, these physicians should have gone to an LMA or a naso- or oro-pharyngeal mask. An LMA is simply a tube with an inflatable mask on one end that is inserted into the patient's throat to achieve a seal over the tracheal opening so that oxygen can be forced into the patient's lungs. Almost certainly, these physicians would have been able to adequately ventilate this patient at that point. If for some reason, they could not accomplish this, then the physicians should have used a scalpel and made an incision in the anterior surface of Washington's neck, identified and cut through the cricothyroid membrane and intubated the patient through this opening. At this point, Washington would have been ventilated adequately until a definitive airway could be established. Brain damage due to lack of oxygen would more likely than not have been avoided.

In order to comply with applicable standards of care, CMS/Community Health Systems d/b/a Navarro Regional Hospital and the operator of that hospital, which I understand to be Quorum Health Resources, would have had specialized intubation equipment, to specifically include the intubation equipment listed above, immediately available in the ICU unit where Mr. Washington was being maintained at the time the Code Blue was called. Moreover, Navarro Regional Hospital should have had and/or enforced protocols or policies and procedures assuring that the medical personnel and staff (including Drs. Goodman and Hibbs) were aware of and trained to utilize this specialized intubation equipment during a Code Blue. Had this occurred, then all of the equipment listed above would have been physically present in Donell Washington's room and available for use by Drs. Goodman and Hibbs. Unfortunately, the hospital failed to take these actions, thereby proximately causing Mr. Washington injury.

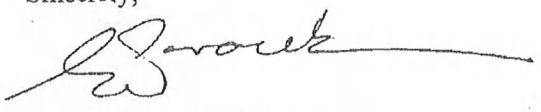
CAUSATION & DAMAGES

It is my opinion beyond a reasonable medical probability, based on my training and education and experience, that the negligent acts of Dr. Goodman, Dr. Hibbs, and Navarro Regional Hospital [CMS/Community Health Systems d/b/a Navarro Regional Hospital and the operator of that hospital, which I understand to be Quorum Health Resources] outlined above were each a proximate cause of Mr. Washington's profound brain damage and related sequelae. It is well accepted in the medical community at large that the brain requires a constant flow of oxygen to function normally. When the flow of oxygen is cut-off - as in a patient who is unconscious and not breathing - the blood oxygen levels drop. At a certain point, the low oxygen state causes the cells of the body to go into anaerobic respiration, rather than aerobic respiration based on the oxygen supply. This produces lactic acid as a by-product of anaerobic respiration. The lactic acid builds up and brain cells begin to die. A hypoxic-anoxic injury occurs when the flow of blood is disrupted, essentially starving the brain and preventing it from performing vital biomechanical processes. With complete cessation of oxygenation, the cells of the brain begin to die in approximately 4 to 6 minutes. Brain-cell death is not reversible. When oxygen deprivation is severe enough, a profound hypoxic-anoxic brain injury results via this mechanism of injury. This is what happened to Donell Washington as a result of his being without an adequate airway for approximately 46 minutes during the Code Blue. Subsequent workup confirmed this diagnosis of hypoxic-anoxic encephalopathy. Specifically, an MRI on July 16, 2010 showed extensive cortical and deep gray abnormalities, and overall configuration and findings suspicious for hypoxic ischemic injury or global anoxic event. On July 28, 2010, CT of Mr. Washington's head showed abnormalities involving bilateral lentiform and caudate nuclei consistent with anoxic brain injury, with subacute petechial hemorrhage. EEG findings were deemed to show a pattern that was "consistent with our diagnosis of hypoxic encephalopathy." The brain damage is permanent and quite severe.

In sum, it is my opinion beyond a reasonable medical probability, based on my training and education and experience, that Dr. Goodman, Dr. Hibbs, and Navarro Regional Hospital [CMS/Community Health Systems d/b/a Navarro Regional Hospital and the operator of that hospital, which I understand to be Quorum Health Resources] were negligent in their care and treatment of Donell Washington. Further, it is my opinion that each of these acts and omissions of negligence was a proximate cause of his brain damage injury and its sequelae.

I reserve the right to amend this report as more information becomes available.

Sincerely,



Edward Panacek, M.D., MPH

EXPERT OPINION OF ARTHUR S. SHORR, MBA, FACHE

This report is written at the request of James E. Girards and is written in order to comply with Texas Civil Practices & Remedies Code §74.351. I have been informed that subsection (k) of the statute provides that an expert opinion prepared under this law is not admissible in evidence by any party; shall not be used in a deposition, trial, or other proceeding; and shall not be referred to by any Defendant during the course of any proceeding in this case. All opinions expressed herein are based upon reasonable administrative probability.

I have reviewed the circumstances regarding the hospitalization of Charles "Donell" Washington in July 2010 at Navarro Regional Hospital in Corsicana, TX. I have reviewed the Plaintiff's Petition, Hospital's Response to Request for Production, Hospital's Answer's to Interrogatories, Dr. James Goodman's Answers to Interrogatories, and the Expert Opinion of Edward Panacek, M.D.

QUALIFICATIONS

I am Board Certified in Hospital and Healthcare Administration, and a Fellow of the American College of Healthcare Executives. My 40-year career in Health Care Administration includes senior executive management of acute care hospitals for 16 years. Specifically, this includes the following positions: Chief Operating Officer/Senior Vice President for Administration at Cedars-Sinai Medical Center in Los Angeles; Administrator, Chief Operating Officer, and Acting President/Chief Executive Officer of Mount Sinai Medical Center in Milwaukee, Wisconsin; and Assistant Director for Patient Care Services of Hutzel Hospital, The Detroit Medical Center in Detroit, Michigan. Since July 1983 to the present my professional career has been as a provider of consulting services to hospitals and physicians, first as Arthur S. Shorr & Associates, Inc.: Consultants to Healthcare Providers, and currently as Shorr Healthcare Consulting. I am Executive in Residence and Assistant Professorial Lecturer of Health Services Management & Leadership at The George Washington University School of Public Health & Health Services. I have served as a member of the Board of Trustees of numerous accredited hospitals and healthcare institutions, and currently am a member of the Governing Body of an accredited acute care hospital in California, for which I accept legal and fiduciary responsibility for hospital activities. My curriculum vitae is attached to this report and is incorporated by reference.

I have authored numerous articles in nationally recognized peer-reviewed professional health care administration journals including but not limited to: "Trustee: Journal of the American Hospital Association," and "Healthcare Executive: The Magazine for Healthcare Leaders," Journal of the American College of Healthcare Executives, each of which are germane and relevant to matters in this case. I am the author of a textbook entitled: "Hospital Negligence: Legal and Administrative Issues." Based on my background, training, and experience I am an

expert in the administrative community standards of care applicable to all hospitals in the United States, including Navarro Regional Hospital in Corsicana, Texas.

All opinions expressed in this report are based on reasonable administrative probability.

I understand that in Texas, "negligence," when used with respect to a hospital, means the failure to use ordinary care; that is, doing that which a hospital of ordinary prudence would not have done under the same or similar circumstances, or failing to do that which a hospital of ordinary prudence would have done under the same or similar circumstances.

I understand that in Texas as to a hospital, "ordinary care" means that degree of care which would be used by a hospital of ordinary prudence under the same or similar circumstances.

I understand that in Texas, "proximate cause" means that the cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a physician or hospital using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. I understand that there may be more than one proximate cause of an event.

HOSPITALIZATION OF CHARLES "DONELL" WASHINGTON

Mr. Washington was admitted to Navarro Regional Hospital on July 13, 2010. It is my understanding that over a period of approximately 13 hours his condition progressively deteriorated until he became non-responsive. A Code Blue was called at 2:30 a.m. on July 14. An Emergency Room physician, James Goodman, MD, arrived to assist with resuscitating Mr. Washington. Dr. Goodman made four unsuccessful attempts to intubate Mr. Washington. Mr. Washington was finally intubated at 3:16 a.m. by another physician, 46 minutes after the Code Blue was called. It is my understanding that Mr. Washington survived, but has been diagnosed with brain damage due to lack of oxygen, which resulted from the extended delay in getting him ventilated and oxygenated.

ADMINISTRATIVE STANDARDS OF CARE FOR HOSPITALS

The standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) are the nationally accepted minimum standards of care governing the administrative behavior of Hospitals, and their employees and agents, and are applicable to CMS/Community Health Systems d/b/a Navarro Regional Hospital, and Quorum Health Resources. The Center for Medicare Services (CMS), the federal oversight agency that monitors and oversees all hospitals in the United States that accept federal funds, recognizes the Joint Commission standards as the minimum national standards by which all hospitals must

comply. Hospitals that achieve Joint Commission accreditation are deemed to meet the minimum standards for participation in the Medicare and Medicaid programs.[1] In addition, the State of Texas recognizes Joint Commission standards as applicable to hospitals in Texas. Additional standards, above these minimums, may be established by state and local authorities, clinical specialty organizations, and through the bylaws and policies of individual hospitals.

Under the relevant standards of care, CHS/COMMUNITY HEALTH SYSTEMS, INC. individually and d/b/a NAVARRO REGIONAL HOSPITAL, TRIAD-NAVARRO REGIONAL HOSPITAL SUBSIDIARY LLC, NAVARRO REGIONAL LLC, NAVARRO HOSPITAL LP d/b/a NAVARRO REGIONAL HOSPITAL, NAVARRO REGIONAL HOSPITAL by its common name, QUORUM HEALTH RESOURCES, INC. (the "Hospital Entities") are directly responsible for providing safe and effective healthcare services. The Hospital Entities are directly liable for the negligence of Drs. Goodman and Hibbs. The relevant standards of care for the Hospital Entities are such that the Hospital Entities had a duty to ensure that its staff was competent and adequately trained to adequately manage Donell Washington's airway during a Code situation. Further, the relevant standards of care required that the Hospital Entities have and/or enforce adequate protocols, or policies and procedures to assure that medical personnel and staff are aware of and trained to utilize this specialized intubation equipment during code situations so that no patient goes without oxygen for an inordinate amount of time.

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[1] Title 42 Code of Federal Regulations, Chapter IV, Part 488, Subpart A, Section 488.5 Effect of JCAHO or AOA Accreditation of Hospitals:

(a) Deemed to meet. Institutions accredited as hospitals by the JCAHO or AOA are deemed to meet all of the Medicare conditions of participation for hospitals, except

(1) The requirement for utilization review as specified in section 1861(e)(6) of the Act and in Sec. 482.30 of this chapter;

(2) The additional special staffing and medical records requirements that are considered necessary for the provision of active treatment in psychiatric hospitals (section 1861(f) of the Act) and implementing regulations; and

(3) Any requirements under section 1861(e) of the Act and implementing regulations that CMS, after consulting with JCAHO or AOA, identifies as being higher or more precise than the requirements for accreditation (section 1865(a)(4) of the Act).

(b) Deemed status for providers and suppliers that participate in the Medicaid program. Eligibility for Medicaid participation can be established through Medicare deemed status for providers and suppliers that are not required under Medicaid regulations to comply with any requirements other than Medicare participation requirements for that provider or supplier type.

Title 42 Code of Federal Regulations, Chapter IV, Part 488, Subpart A, Section 488.10 State survey agency review: Statutory provisions. ....(d) Section 1865(a) of the Act also provides that if CMS finds that accreditation of a hospital... by any national accreditation organization provides reasonable assurance that any or all Medicare conditions are met, CMS may treat the provider or supplier as meeting the conditions.

The Administrative Standards of Care for Hospitals demonstrate that accountability for hospitals that are elements of a healthcare system is the responsibility of the corporate governing body.

The Joint Commission 2010 Hospital Accreditation Standards

LD.01.03.01 The governing body is ultimately responsible for the safety and quality of care, treatment, and services.

Rationale: The governing body's ultimate responsible for safety and quality derives from its legal responsibility and operational authority for hospital performance. In this context, the governing body provides for internal structures and resources, including staff, that support safety and quality.

Elements of performance:

1. The governing body defines in writing its responsibilities.
2. The governing body provides for organization management and planning.
3. The governing body approves the hospital's written scope of services.
4. The governing body selects the chief executive responsible for managing the hospital.

Medicare Conditions of Participation

42CFR Ch IV §482.12 Conditions of participation: Governing body.

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

The Administrative Standards of Care for Hospitals require that supplies and equipment needed for patient care, including intubation, be readily available when needed.

The Joint Commission 2010 Hospital Accreditation Standards

PC.02.01.11 Resuscitation services are available throughout the hospital.

Elements of performance:

1. Resuscitation services are provided to the patient according to the hospital's policies, procedures, or protocols.
2. Resuscitation equipment is available for use based on the needs of the population served.
3. Resuscitation equipment is located strategically throughout the hospital.
4. An evidenced-based training program is used to train staff to recognize the need for and use of resuscitation equipment and techniques.

LD.04.01.11 The hospital makes space and equipment available as needed for the provision of care, treatment, and services.

Rationale: The resources allocated to services provided by the organization have a direct effect on patient outcomes. Leaders should place highest priority on high risk or problem prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the hospital.

Elements of performance:

5. The leaders provide for equipment, supplies, and other resources.

LD.01.03.01 The governing body is ultimately responsible for the safety and quality of care, treatment, and services.

Rationale: The governing body's ultimate responsible for safety and quality derives from its legal responsibility and operational authority for hospital performance. In this context, the governing body provides for internal structures and resources, including staff, that support safety and quality.

Elements of performance:

5. The governing body provides for the resources needed to maintain safe, quality care, treatment, and services.

LD.01.04.01 A chief executive manages the hospital.
Elements of performance:
The chief executive provides for the following:
3. Physical and financial assets.

The Administrative Standards of Care for Hospitals require that staff recognize and respond to changes in a patient's condition.

The Joint Commission 2010 Hospital Accreditation Standards

PC.02.01.19 The hospital recognizes and responds to changes in a patient's condition.

Rationale: A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient's condition by a specially trained individual(s) may reduce cardiopulmonary arrests and patient mortality.

Elements of performance:

1. The hospital has a process for recognizing and responding as soon as a patient's condition appears to be worsening.
2. The hospital develops written criteria describing early warning signs of a change or deterioration in a patient's condition and when to seek further assistance.
3. Based on the hospital's early warning criteria, staff seek additional assistance when they have concerns about a patient's condition.
4. The hospital informs the patient and family how to seek assistance when they have concerns about a patient's condition.

The Administrative Standards of Care for Hospitals require that all individuals providing care in the hospital are competent to carry out their responsibilities.

The Joint Commission 2010 Hospital Accreditation Standards

LD.03.06.01 Those who work in the hospital are focused on improving safety and quality.

Rationale: The safety and quality of care, treatment, and services are highly dependent on the people in an organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a successful hospital, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the hospital, including staff and licensed independent practitioners.

Elements of performance:

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services.
4. Those who work in the hospital are competent to complete their assigned responsibilities.

LD.04.03.09 Care, treatment, and services provided through contractual agreements are provided safely and effectively.

Elements of performance:

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
5. Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.
6. Leaders monitor contracted services by evaluating those services in relation to the hospital's expectations.

The Administrative Standards of Care for hospitals require that hospitals are responsible for care provided through contractual agreements.

Medicare Conditions of Participation

42CFR Ch. IV §482.12: Condition of participation: governing body. The hospital must have an effective governing body legally responsible for the conduct of the hospital

(e) Standard: Contracted Services. The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor for services (including one for shared services and joint venture) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for contracted services.

U.S. Federal Register

51 Fed Reg 116 (1986), 22015: The 1983 NPRM (Notice of Proposed Rule Making) was intended to clarify that the hospital has ultimate responsibility for services, whether they are provided directly, such as by its own employees, by leasing, or through arrangement, such as formal contracts, joint ventures, informal agreements, or shared services. Because many contracted services are integral to direct patient care and are important aspects of health and safety, a hospital cannot abdicate its responsibility simply by providing that service through a contract with an outside resource. For purposes of assuring adequate care, the nature of the arrangement between hospital and the "contractor" is irrelevant. The NPRM, therefore, proposed to specify that the governing body must be responsible for these services and that the services must be provided in a safe and effective manner...

Texas Administrative Code

Section 133.41(f) (7) Contracted Services. The governing body shall be responsible for services furnished in the hospital whether or not they are furnished directly or under contracts. The governing body shall ensure that a contractor of services (including one for shared services and joint ventures) furnishes services in a safe and effective manner that permits the hospital to comply with all applicable rules and standards for contracted services.

VIOLATIONS OF THE ADMINISTRATIVE STANDARDS OF CARE

My review of the circumstances regarding the hospitalization of Mr. Washington in July 2010 leads me to conclude, based on reasonable administrative probability that the above-described Hospital Entities fell below the administrative standards of care in the following ways:

I The hospital entities failed to ensure the availability of supplies and equipment needed to intubate and resuscitate Mr. Washington in a timely manner. This failure contributed to the delay in intubating Mr. Washington, resulting in lack of oxygen for an extended period of time. Lack of oxygen for an extended period of time is known to be a cause of brain damage.

II The hospital entities failed to ensure that Navarro Regional Hospital's nursing and physician staff members were able to recognize and respond to changes in Mr. Washington's condition in a timely manner, resulting in lack of oxygen for an extended period of time. Lack of oxygen for an extended period of time is known to be a cause of brain damage.

III The hospital entities failed to ensure that its contracted physicians were competent to perform an intubation in a timely manner, resulting in lack of oxygen for an extended period of time. Lack of oxygen for an extended period of time is known to be a cause of brain damage.

In summary, it is my opinion beyond a reasonable administrative probability, based on my training, education, and experience, that the hospital entities were negligent in their operation and supervision of the hospital, and that each act of negligence contributed to the delay in intubating Mr. Washington and thereby were each proximate causes of his injuries. In addition, it is my opinion that the hospital entities are responsible for the negligence of their contracted physicians, if such negligence is determined.

I reserve the right to amend this report as more information becomes available.

Sincerely,

Arthur S. Shorr, FACHE 11/8/2012