AFFIRM; and Opinion Filed November 27, 2018.

In The
Court of Appeals
Fifth District of Texas at Dallas

No. 05-17-01358-CV

COLUMBIA MEDICAL CENTER OF ARLINGTON SUBSIDIARY L.P. D/B/A MEDICAL CENTER ARLINGTON AND COLUMBIA NORTH TEXAS SUBSIDIARY GP, LLC, Appellants
V.
CEDRIC SHELBY AND MELANIE SHELBY, Appellees

On Appeal from the 101st Judicial District Court
Dallas County, Texas
Trial Court Cause No. DC-17-05925

MEMORANDUM OPINION

Before Justices Bridges, Francis, and Lang-Miers
Opinion by Justice Lang-Miers

In this interlocutory appeal, we consider whether expert reports filed by appellees Cedric and Melanie Shelby to support a health care liability claim against appellants Columbia Medical Center of Arlington Subsidiary L.P. d/b/a Medical Center Arlington and Columbia North Texas Subsidiary GP, LLC (together, "MCA")[1] meet the requirements of section 74.351 of the civil practice and remedies code. TEX. CIV. PRAC. & REM. CODE ANN. § 74.351 (West 2017). We conclude that they do, and we affirm the trial court's order overruling MCA's objections to the reports and denying MCA's motion to dismiss.

[1] Appellees' operative petition alleges that appellant Columbia North Texas Subsidiary GP, LLC is the sole partner of appellant Columbia Medical Center of Arlington Subsidiary, L.P. d/b/a Medical Center of Arlington, a limited partnership organized and operating under Texas law. Because appellants are represented by the same counsel and filed a joint brief, we refer to them together in this opinion as "MCA."

BACKGROUND

This is a medical malpractice case arising from appellants' treatment of Cedric Shelby following an injury to Shelby's right calf while playing baseball. Shelby, 39 years old, was admitted to MCA on July 11, 2016 for treatment of the injury. Shelby's condition deteriorated over the next two weeks, and on July 29, 2016, his leg was amputated.

Shelby and his wife Melanie brought suit against MCA and others on May 18, 2017, and on the same date, served the expert report of D. Preston Flanigan, M.D. MCA moved to dismiss the Shelbys' claims, arguing that the report did not meet the requirements of section 74.351 of the civil practice and remedies code. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.351 (requirement of expert report for health care liability claim). Over the next several months, the Shelbys filed additional expert reports by Benny Gavi, M.D., M.T.S. and Thomas DeCoster, M.D., amended reports by Drs. Flanigan and Gavi, and an amended petition. MCA responded by filing motions to dismiss that addressed each report and amendment. The trial court held two hearings on MCA's motions. After the second hearing, the trial court denied MCA's motions in an order dated November 17, 2017, and MCA filed this appeal. This appeal concerns only the experts' opinions regarding claimed negligence of the nurses at MCA.

In one issue with five subparts, MCA contends the trial court erred by overruling its objections to the Shelbys' Chapter 74 expert reports and denying its motion to dismiss. MCA alleges:

> (1) the experts do not explain how and why the nurses' alleged failure to timely report Shelby's decreased sensation or pulse on July 12, 2016, proximately caused Shelby's injuries;
>
> (2) the experts do not sufficiently explain how and why the nurses' failure to report Shelby's July 13, 2016 signs or symptoms proximately caused Shelby's injuries;
>
> (3) the experts do not sufficiently explain how and why the nurses' alleged failure to report Shelby's July 14, 2016 changes in pulse or rising creatinine kinase ("CK") levels proximately caused Shelby's injuries;

(4) the experts do not sufficiently explain how and why the nurses' alleged failure to invoke the chain of command at various stages of Shelby's treatment proximately caused Shelby's injuries; and

(5) the deficiencies in the experts' reports are not curable.

STANDARD OF REVIEW

We review a trial court's ruling on a motion to dismiss a health care liability claim under section 74.351 for an abuse of discretion. *Baty v. Futrell*, 543 S.W.3d 689, 693 n.4 (Tex. 2018); *Children's Med. Ctr. of Dallas v. Durham*, 402 S.W.3d 391, 395 (Tex. App.—Dallas 2013, no pet.). Under this standard, we must determine whether the trial court acted arbitrarily and without reference to any guiding rules or principles. *Nexion Health at Duncanville, Inc. v. Ross*, 374 S.W.3d 619, 622 (Tex. App.—Dallas 2012, pet. denied). A trial court does not abuse its discretion merely because it decides a discretionary matter differently than an appellate court would under similar circumstances. *Nexion Health at Terrell Manor v. Taylor*, 294 S.W.3d 787, 791 (Tex. App.—Dallas 2009, no pet.). But a trial court has no discretion in determining what the law is or in applying the law to the facts. *Ross*, 374 S.W.3d at 622.

DISCUSSION

An expert report under section 74.351 must represent a good-faith effort to provide a fair summary of the expert's opinions. *See Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 878–79 (Tex. 2001). The report need not marshal all the plaintiff's proof, but must include the expert's opinion on each of the elements identified in the statute. *Id.* To constitute a good-faith effort, the report must (1) inform the defendant of the specific conduct the plaintiff has called into question, and (2) provide a basis for the trial court to conclude the claims have merit. *Id.* at 879. In addition, "the expert report must make a good-faith effort to explain, factually, how proximate cause is going to be proven," although the report need not use the words "proximate cause," "foreseeability," or "cause in fact." *Columbia Valley Healthcare Sys., L.P. v. Zamarripa*,

526 S.W.3d 453, 460 (Tex. 2017). "'[T]he expert must explain the basis of his statements to link his conclusions to the facts.'" *Id.* (quoting *Earle v. Ratliff*, 998 S.W.2d 882, 890 (Tex. 1999)).

The three expert reports include detailed explanations of how Shelby's initial injury progressed from pain and swelling to "compartment syndrome" to tissue necrosis. As Dr. Flanigan explained, in compartment syndrome of the calf, "pressure builds up within the compartments of the calf and eventually inhibits circulation to the compartment contents such that they can suffer ischemic damage, dysfunction, and eventually necrosis." The experts explained that because Shelby's compartment syndrome was not timely diagnosed and treated, the tissue in his leg died and amputation became necessary.

All three experts explained that "time is of the essence" in diagnosing and treating compartment syndrome. As Dr. DeCoster stated, "[c]ompartment syndrome is not typically present at the time of injury but develops over hours to days. It is crucially important to be recognized as it develops and to be treated swiftly once identified from signs and symptoms." All three experts opined that because the pressure in Shelby's leg was not timely decreased and relieved, there was a significant and prolonged decrease or elimination of blood flow to the muscles that caused tissue death and the need for amputation. As Dr. Flanigan explained, "[t]he ischemic tissue injury, the muscle necrosis and the amputation were caused by the failure to timely diagnose and treat the compartment syndrome. In reasonable medical probability, Mr. Shelby's compartment syndrome could have been successfully treated with appropriate care from his health care providers." Flanigan also described and explained the care and treatment that in his opinion, Shelby should have received.

All three experts assigned some of the responsibility for the delay to the nurses at MCA. Specifically, the experts cited:

- The failure of Sarah Sowah, R.N. ("Nurse Sowah")[2] to report Shelby's decreased sensation and decreasing pulse, a "very significant change in condition," to Bruce I. Prager, M.D. (an orthopedic surgeon) or Guy Robert Bibeau, M.D. (a hospitalist)[3] on July 12, 2016;

- Nurse Sowah's failure to notify any doctor of "critical facts" she noted on July 13 at 1:41 a.m., that "there was 3+ pitting edema" of Shelby's leg "with pain of 8/10";

- Nurse Sowah's failure on July 14 to notify her Charge Nurse or the supervising physician that a physician's assistant had delayed four hours in responding and failed to provide any new orders after Nurse Sowah called about a level of CK the experts described as "alarming" because it indicated that tissue was dying;

- Nurse Sowah's failure on July 14 to notify Ashfaq H. Siddiqui, M.D. (a vascular surgeon) sooner of "significant changes" in Shelby's condition including "the faint/absent posterior tibial pulse, the loss of Doppler pulse in the dorsalis pedis, and the rising CK level"; and

- The failure of Nurse Sowah and other nurses to initiate the chain of command when Drs. Bibeau, Prager, and Siddiqui failed to provide timely treatment.

MCA complains that the Shelbys' experts do not sufficiently link any of these alleged failures to Shelby's ultimate injuries. The Shelbys respond that MCA "seek[s] to use the alleged negligence of subsequent actors—here, the doctors who the Shelbys also allege acted negligently—to claim that the nurses' negligence could not have been a but-for cause of Mr. Shelby's injuries, giving rise to so-called 'analytical gaps' in the causation opinions."

Each of the Shelbys' experts addressed the nurses' conduct. Flanigan's report states:

> Nurses at Medical Center of Arlington
>
> Nurse Sowa[h] was below the standard of care at 11:27 a.m. on July 12 for not reporting decreased sensation and decreasing pulse to Dr. Prager or Dr. Bibeau. This was a very significant change in condition and the standard of care required that it be reported.
>
> Nurse Sowa[h] was below the standard of care early in the morning of July 14 to not notify Dr. Siddiqui sooner about the faint/absent posterior tibial pulse, the loss of Doppler pulse in the dorsalis pedis, and the rising CK level. These were

[2] In its brief, MCA explains that "Nurse Sowah is sometimes mistakenly referred to as 'Sowall' in the petitions and expert reports."

[3] Drs. Prager and Bibeau are defendants in the trial court, as are their employers, Orthopedic Center of Arlington, PLLC (Prager) and Questcare Hospitalists, PLLC (Bibeau). Dr. Ashfaq H. Siddiqui, discussed below, is also a defendant in the trial court.

significant changes indicating worsening compartment syndrome and the standard of care required that these be reported to Dr. Siddiqui.

Then, once it became apparent that Dr. Siddiqui was not treating Mr. Shelby as having compartment syndrome or rhabdomyolysis, the nurses at Medical Center of Arlington should have initiated the chain of command in order to protect the patient's safety. The nurses at Medical Center of Arlington have their own independent duties to the patient. If they note signs and symptoms which are very concerning, and it either takes too long for a physician to see the patient (lack of timely responsiveness) or if the physician is not timely providing appropriate intervention, then it is the duty of the nurses to initiate the chain of command and serve as advocates for that patient and document same.

Late on July 12/early on July 13, after Dr. Sigler noted that there was no flow in the right popliteal artery, and no flow more distal in the anterior tibial artery, Nurse Sowa[h] noted (at 1:41 am) that there was 3+ pitting edema of Mr. Shelby's left leg with pain of 8/10. There is no documentation to suggest that she notified anyone of these critical facts at this time, which was a violation of the accepted standard of care. Had she notified a physician and he or she failed to come in a timely fashion (an hour or two) to evaluate the deteriorating patient, Mr. Shelby, then Nurse Sowa[h] should have initiated the chain of command by notifying her Charge Nurse. If Nurse Sowa[h] or the Charge Nurse could not get the on-call physician to come and evaluate the patient in a timely fashion, the Nurse Sowa[h] or her Charge Nurse should have gone further up the chain of command and asked the Section Chief or another physician to come evaluate Mr. Shelby.

On July 14, at 12:15am, Nurse Sowa[h] noted that the CK level was elevated and left a message for the physician assistant; then at 3:34am, the CK had risen to 9999. At 4:03am, she left a message for the physician assistant but received no call until 4:16am. No new orders were given at that time, in spite of the alarming CK level (which the nurse was concerned enough about to notify the physician assistant). At 5:45am, Nurse Sowa[h] noted the posterior tibial pulse was now absent.

When the physician assistant failed to call back after the 12:15am call, and then again after the 4:03am call, Nurse Sowa[h] needed to notify her Charge Nurse and either Nurse S[owah] or the Charge Nurse needed to notify the Supervising Physician of the PA, in order to meet the standard of care. They failed to do so, and as such, violated the accepted standard of care. Then, when the physician assistant did call back, but provided no new orders, the Nurses at Medical Center of Arlington failed to meet the standard of care by failing to notify the PA's Supervising Physician and the treating physician on call of the lack of orders in response to the clearly alarming CK level. This failure was a violation of the accepted standard of care.

If Nurse Sowa[h] or the Charge Nurse could not get the on-call physician to come and evaluate the patient in a timely fashion, then Nurse Sowa[h] or her Charge Nurse should have gone further up the chain of command and asked the Section Chief or another physician to come evaluate Mr. Shelby.

Flanigan then discusses causation at length. He includes an explanation of how the nurses' violations of the standard of care caused Shelby's injuries:

> Had Nurse Sowa[h] reported the decreased sensation and diminishing pulse on July 12 at 11:27 AM and this resulted in Dr. Prager performing a four compartment fasciotomy, as it should have, then there would have been no residual neuromuscular damage and no amputation of the right lower extremity. Had Nurse Sowa[h] notified Dr. Siddiqui earlier on July 14 about the adverse change in the pulses and the rising CK levels, and Dr. Siddiqui would have been within the standard of care, then there would have been less ischemic neuromuscular damage from the new hematoma but there likely would have been some residual neuromuscular deficit but no limb loss.

Similarly, Gavi explains that the standard of care required MCA nurses to timely notify the appropriate physician of changes in Shelby's condition. The standard of care also required MCA nurses to "initiate the chain of command"—to "ask the Section Chief or another physician to come evaluate Mr. Shelby"—and serve as advocates for Shelby's care if the physician did not respond. In his report, Gavi cites to Nurse Sowah's July 12 failure to report Shelby's decreasing sensation and pulse to any physician, and her July 13 failure to notify a physician "that there was 3+ pitting edema of Shelby's left leg with pain of 8/10." Gavi adds that if Nurse Sowah or the Charge Nurse "could not get the on-call physician to come and evaluate the patient in a timely fashion," they "should have gone further up the chain of command and asked the Section Chief or another physician to come evaluate Mr. Shelby." And Gavi details Shelby's rising CK levels on July 14 and Nurse Sowah's failure to initiate the chain of command when the physician's assistant failed to respond to her calls.

Gavi explains the effect of these failures:

> Then, had the nurses (including Nurse Sowa[h]) timely notified a physician of the decreased sensation and decreased pulse on July 12, or of the faint/absent posterior tibilar pulse and lack of Doppler pulse, along with elevated CK levels, then a surgeon would have been able to have faster and timely surgical intervention to relieve the pressure in the compartment of Mr. Shelby's right leg. If the nurses attempted to notify the physician of this critical information, or if the physician had the information at a later time and then failed to act appropriately, then the nurses needed to get a different physician to evaluate the patient. As described herein, time

> is of the essence when presented with a patient suffering from compartment surgeon [sic]. The nurses' failure to have a physician timely evaluate the patient (as described herein), and their failure to have a different physician evaluate the patient through the chain of command, proximately caused a delay which prevented timely surgical intervention to relieve the pressure in the compartment of Mr. Shelby's right leg.

DeCoster explains that the standard of care required the nurses at MCA to "timely notify Dr. Prager, or the appropriate physician, of significant changes in Mr. Shelby's condition." If the physician "did not provide an appropriate response," then the standard of care "required the nurses to initiate the chain of command and serve as advocates for the patient's care." DeCoster states that Nurse Sowah "fell below the standard of care" when she "failed to report decreasing sensation and pulse to Dr. Prager, or any other physician" on July 12, 2016. DeCoster adds that Nurse Sowah "failed to recognize the deteriorating signs and symptoms for Mr. Shelby on July 14 and fail[ed] to report the feint/absent posterior tibilal pulse, the lack of a Doppler pule [sic], and a rising CK level to Dr. Prager or any other physician." And DeCoster opines that the MCA nurses fell below the standard of care when they "failed to initiate the chain of command and serve as advocates" for Shelby "when Dr. Prager prescribed anticoagulants to Mr. Shelby, a patient with a known risk of compartment syndrome." DeCoster also explains how both the nurses' and the doctors' failures to meet the accepted standards of care caused Shelby's eventual amputation, as we discuss below.

In *Acedo v. Springs*, we concluded that an expert's report opining that nurses were negligent by failing to initiate the chain of command to obtain additional assistance for a patient was sufficient to meet Chapter 74's requirements. No. 05-12-00454-CV, 2013 WL 3477348, at *4–5 (Tex. App.—Dallas July 9, 2013, pet. denied) (mem. op.). In that case, Springs allegedly suffered injury and died while receiving medical treatment and surgical care at a hospital. *Id.* at *1. An anesthesiologist began a minor surgical procedure without the surgeon and other personnel present, and when Springs began having difficulty breathing, the anesthesiologist could not establish an airway for almost half an hour. *See Hollingsworth v. Springs*, 353 S.W.3d 506, 511–

12 (Tex. App.—Dallas 2011, no pet.) (previous appeal in same case); *see also Godat v. Springs*, No. 05-08-00791-CV, 2009 WL 2385569, at *1 (Tex. App.—Dallas Aug. 5, 2009, no pet.) (mem. op.) (claims against surgeon from same incident). Springs suffered a cardiopulmonary arrest and brain damage, and later died. *Hollingsworth*, 353 S.W.3d at 512. In a previous appeal, we concluded the expert's causation opinions regarding the plaintiff's chain of command claims were conclusory because the expert "did not opine that the nurses' failures to solicit assistance when problems arose in the operating room were the proximate cause of Springs's injuries; he did not address what would have been the better outcome if help had been called; and he did not explain what actions would have resulted from a call for help (or initiating the chain of command) that would have resulted in awakening Springs." *Acedo*, 2013 WL 3477348, at *4 (citing *Hollingsworth*, 353 S.W.3d at 523).

The expert supplemented his report to address these issues, and we concluded the supplemental report was sufficient. *See id.* at *4–5. The expert explained that with a call for help and initiating the chain of command, "additional personnel, including the surgeon and others, would have been available to provide input and assistance." *Id.* at *4. The expert stated that, with this additional input and assistance, the anesthesiologist likely would not have administered a neuromuscular blocking agent that caused paralysis, and Springs would not have suffered hypoxic brain injury. *Id.* And even if the blocking agent had been administered, additional specialized personnel and equipment could have assisted in establishing an airway more quickly, so that the injury to Springs's brain would not have been as severe. *Id.* at *5. We concluded that the expert's reports sufficiently informed the nurses of the specific conduct that the expert called into question and provided a basis for the trial court to conclude that the plaintiff's claims against the nurses had merit. *Id.*

Here, MCA argues that according to the Shelbys' pleadings, when the doctors did respond, the surgery they performed was inadequate. MCA reasons that even if the nurses had acted sooner, the doctors' subsequent negligence was the sole proximate cause of Shelby's injuries. But there may be more than one proximate cause of an injury. *Bustamante v. Ponte*, 529 S.W.3d 447, 457 (Tex. 2017). "[A] defendant's act or omission need not be the sole cause of an injury, as long as it is a substantial factor in bringing about the injury." *Id.* Flanigan, Gavi, and DeCoster all explain that the delay in recognizing and treating Shelby's compartment syndrome was a proximate cause of the loss of his leg. Each expert opines that the nurses contributed to this delay by failing to report specific symptoms to Shelby's doctors and, when they did report symptoms, failing to initiate the chain of command to obtain a timely response. As DeCoster explained:

> After a timely fasciotomy, the patient can expect the best chance at recovery from compartment syndrome. Not recognizing the signs and symptoms, not performing adequate checks to reveal the signs and symptoms, and not reporting the signs and symptoms to the appropriate medical personnel will all increase the time between onset of compartment syndrome and a fasciotomy operation to reduce compartment pressure. As explained, with increased time comes increased tissue death and damage to the patient's limb until the only surgical management possible is amputation.

He concluded,

> Had the pressure within the compartments of Mr. Shelby's right leg been timely decreased and relieved, then, in reasonable medical probability, there would not have been a significant and prolonged decrease or elimination of blood flow to the muscles. Therefore, in reasonable medical probability, there would have been no need for an amputation of Mr. Shelby's right leg, because the tissue necrosis would not have progressed to that point.

In *Acedo* and its related cases, the plaintiffs met Chapter 74's requirements to support claims against a number of different defendants, including Springs's surgeon, three anesthesia technicians, and two nurses. *See Godat*, 2009 WL 2385569, at *5; *Acedo*, 2013 WL 3477348, at *4–6. This was so even though the plaintiffs also alleged that the anesthesiologist was negligent, and the sufficiency of the experts' opinions regarding the anesthesiologist's negligence was not at

issue. *See Acedo*, 2013 WL 3477348, at *1; *Godat*, 2009 WL 2385569, at *1; *Hollingsworth*, 353 S.W.3d at 524.

In three cases cited by MCA, expert reports were insufficient to satisfy Chapter 74's requirements regarding the plaintiffs' chain of command and causation complaints. *See Zamarripa*, 526 S.W.3d at 460–61; *Humble Surgical Hosp., LLC v. Davis*¸ 542 S.W.3d 12 (Tex. App.—Houston [14th Dist.] 2017, pet. pending); *HealthSouth Rehab. Hosp. of Beaumont, LLC v. Abshire*, No. 09-16-00107-CV, 2017 WL 1181380 (Tex. App.—Beaumont Mar. 30, 2017) (mem. op.), *rev'd*, No. 17-0386, 2018 WL 6005220, at *7 (Tex. Nov. 16, 2018) (per curiam). In *Zamarripa*, a pregnant woman suffering from placenta accreta died after being transported from one hospital to another. 526 S.W.3d at 456–57. The plaintiff's expert opined that the hospital, through its nurses, breached the applicable standard of care by not stopping the transfer. *Id.* at 460–61. The court held the expert's report failed to show "how proximate cause is going to be proven," because the expert did not explain how the nurses could have stopped the transfer, or if they had the authority to do so. *Id.* The hospital had not ordered the transfer, and the court questioned "even whether [the hospital] had any say in the matter." *Id.*

In *Davis*, the plaintiff was discharged from the hospital after surgery to correct foot deformities. 542 S.W.3d at 15–16. She later developed gangrene and her leg was amputated. *Id.* at 16. In her subsequent suit against the hospital, Davis alleged that a nurse was negligent by failing to intervene and invoke the chain of command to delay Davis's discharge from the hospital. *Id.* at 23–24. The court concluded the report had analytical gaps:

> Although Dauphinee [the physician expert] explains how following the articulated standards of care would have resulted in Davis receiving additional care and ultimately saved her leg, Dauphinee does not explain why this would have happened. Instead, Dauphinee's explanation requires us to make various assumptions. We must assume that the nursing diagnoses or request for intervention/modification communicated to a physician or the chain of command would have caused Gordon or another physician to delay Davis's discharge. Dauphinee does not explain why this would happen. We must assume that during

> any such delay, Davis would have exhibited signs and symptoms yielding a medical diagnosis of vascular compromise, not the risk of vascular compromise, which as Dauphinee points out "should have been a concern from the beginning." Dauphinee does not state that the signs and symptoms Davis exhibited prior to discharge or during the delayed discharge period would have led a physician to diagnose her with vascular compromise at the time of her discharge or shortly thereafter. Moreover, Dauphinee's opinion is inconsistent in that, on one hand, he states that following the standard of care would have led to a discharge delay providing doctors more time to arrive at a diagnosis and provide treatment, and on the other hand he concludes that Davis's leg likely would have been saved "[h]ad this condition been discovered *and treated* at the time of her discharge *at 10:53am on December 15th, 2013*" (emphasis added).

Id. at 25–26. Consequently, the *Davis* court concluded that the trial court should have granted the hospital's motion to dismiss. *Id.* at 26.

In *Abshire*, the plaintiff visited the defendant hospital's emergency room five times in a two-week period for chest pain, shortness of breath, and back pain. 2018 WL 6005220, at *1. Abshire was transferred between the hospital and a rehabilitation clinic before her physicians discovered that she had suffered a spinal compression fracture. *Id.* at *1–2. She underwent emergency surgery for the fracture, but the injury "ultimately rendered Abshire a paraplegic and incontinent." *Id.* at *2. In her lawsuit against the hospital, Abshire alleged that nurses failed to document her longstanding diagnosis of osteogenesis imperfecta ("OI") that predisposed her to fractures. *Id.* at *2–3.

The court of appeals concluded there was an analytical gap in the expert's opinion that the nurses' failure to chart Abshire's history of OI caused Abshire's injury, because the expert did not "explain how the nurses' alleged failure to document OI was a substantial factor in causing or exacerbating Abshire's injuries, or that had such been known then the physicians would have changed the course of treatment, or that it would have changed the outcome." *Abshire*, 2017 WL 1181380, at *18 (court of appeals opinion). Consequently, the court concluded that the report was deficient. *Id.* In its briefing in this case, MCA relied on the court of appeals' opinion in support of its argument that there are analytical gaps in Shelby's experts' opinions. But after the parties had

completed their briefing and submission of this case, the supreme court reversed the court of appeals' judgment in *Abshire*. *See Abshire*, 2018 WL 6005220, at *1. The supreme court concluded that the expert "explained how the nurses' breach—failing to consistently document Abshire's OI, particularly in light of her continued complaints of back pain—caused a delay in diagnosis and proper treatment and why that delay caused the issues that led to Abshire's paraplegia." *Id.* at *5. The court explained, "the report draws a line directly from the nurses' failure to properly document Abshire's OI and back pain, to a delay in diagnosis and proper treatment (imaging of her back and spinal fusion), to the ultimate injury (paraplegia)." *Id.* The court concluded, "[t]hus, the report adequately explained the links in the causal chain." *Id.* Accordingly, the supreme court reversed the court of appeals' judgment and remanded the case to the trial court for further proceedings. *Id.* at *7.

The Shelbys contend that their experts' reports do not have the deficiencies identified by the courts in *Zamarripa* and *Davis*. They argue that Flanigan explains "both the 'how' and 'why' supporting his opinion, in particular, how and why there would have been a better result if the nurses had fulfilled their obligation under the standard of care to make certain that Mr. Shelby was evaluated and treated by a physician adhering to the standard of care." We agree and conclude that the Shelbys' reports do not have the gaps identified in MCA's cases. For example, in *Zamarripa*, the expert did not explain how the nurses could have stopped the transfer, or if they had authority to do so. *See Zamarripa*, 526 S.W.3d at 461. In *Davis*, the expert failed to explain why and how a physician would have heeded a nurse's request to delay Davis's discharge and in so doing, diagnosed and treated vascular compromise, when the expert did not opine that Davis would have had signs and symptoms of vascular compromise at the time of her discharge or during any period of delay. *See Davis*, 542 S.W.3d at 25–26.

Here, the experts answered these questions. All three experts opined that the standard of care required the nurses to report significant changes in a patient's condition to a physician who is most qualified to manage that change in condition. Specifically, the experts explained that the nurses at MCA were required to timely report changes in Shelby's condition to Bibeau, Prager, or Siddiqui, and if those physicians failed to provide an appropriate response, then the nurses were required to initiate the chain of command. All three experts opined that there were significant changes in Shelby's condition that the nurses failed to report or delayed reporting to a physician, and all three experts further opined that the nurses failed to initiate the chain of command when physicians failed to provide an appropriate response to their reports. The experts gave specific examples, such as the nurses' failure to report a physician's assistant's four-hour delay in responding and subsequent inaction to the assistant's supervising physician, when Shelby's CK had risen to an "alarming" level. All three experts opined that these failures caused delays in Shelby's treatment. All three experts detailed the consequences of delay in treating compartment syndrome in general and in Shelby's case in particular. And they explained how specific, timely treatments would have changed Shelby's result to "a totally functional right lower extremity with the only residual abnormality being surgical scars." Instead, Shelby "was allowed to progress to irreversible tissue injury, necrosis, and eventual[ ] . . . amputation." Unlike the reports in *Zamarripa* and *Davis*, Flanigan's, Gavi's, and DeCoster's reports state sufficient facts linking the nurses' failure to meet the standard of care to the harm claimed. And like the reports in *Abshire*, the experts' reports "draw a line directly" from the alleged failure to meet the standard of care "to a delay in diagnosis and proper treatment" to "the ultimate injury." *Abshire*, 2018 WL 6005220, at *5.

MCA also argues that Shelby's experts require the nurses to diagnose medical conditions and engage in the practice of medicine, contrary to state law. We disagree. The experts'

conclusions that the nurses did not meet accepted standards of care were based on the nurses' failure to notify doctors of symptoms they observed, and, when the doctors did not timely respond, to initiate the chain of command to obtain a response. Neither of these standards required the nurses to diagnose Shelby's condition or to practice medicine.

We conclude that the trial court did not abuse its discretion in denying MCA's motion to dismiss. *See Palacios*, 46 S.W.3d at 875. We decide MCA's issue against it.

CONCLUSION

We affirm the trial court's order denying MCA's motion to dismiss.

/Elizabeth Lang-Miers/
ELIZABETH LANG-MIERS
JUSTICE

171358F.P05

Court of Appeals
Fifth District of Texas at Dallas

JUDGMENT

COLUMBIA MEDICAL CENTER OF ARLINGTON SUBSIDIARY L.P. D/B/A MEDICAL CENTER ARLINGTON AND COLUMBIA NORTH TEXAS SUBSIDIARY GP, LLC, Appellants

No. 05-17-01358-CV V.

CEDRIC SHELBY AND MELANIE SHELBY, Appellees

On Appeal from the 101st Judicial District Court, Dallas County, Texas
Trial Court Cause No. DC-17-05925.
Opinion delivered by Justice Lang-Miers; Justices Bridges and Francis, participating.

In accordance with this Court's opinion of this date, the trial court's order denying the motions to dismiss of appellants Columbia Medical Center of Arlington Subsidiary L.P. d/b/a Medical Center Arlington and Columbia North Texas Subsidiary GP, LLC, and overruling their objections to the Chapter 74 expert reports submitted by appellees Cedric Shelby and Melanie Shelby is **AFFIRMED**.

It is **ORDERED** that appellees Cedric Shelby and Melanie Shelby recover their costs of this appeal from appellants Columbia Medical Center of Arlington Subsidiary L.P. d/b/a Medical Center Arlington and Columbia North Texas Subsidiary GP, LLC.

Judgment entered this 27th day of November, 2018.