A TALE OF TWO CASES: *Crump* and *Casas*, and Their Lessons About the Pitfalls in Proving Medical Causation

Prologue: The Best of Times, the Worst of Times, Don't Trifle With the System

> It was the best of times, it was the worst of times, . . .we had everything before us, we had nothing before us, we were all going direct to heaven, we were all going direct the other way . . . .

A Tale of Two Cities, by Charles Dickens

> It's kind of like that book
> they had us read one time in school.
>
> It started out sayin', "It was
> the best time I ever had, and it
> was the worst time I ever had."
>
> I believe it was by Dick somebody.
> I'll be dogged.

Claude Montgomery, from the movie *Daddy and Them*, written and directed by Billy Bob Thornton.

> Any society that will put [former Hell's Angel Sonny] Barger in jail and make Al Davis [the owner of the Oakland Raiders] a respectable millionaire at the same time is not a society to be trifled with.

"Fear and Loathing at the Super Bowl" from p. 58 of *The Great Shark Hunt*, by Hunter S. Thompson.

A. Two Supreme Court Cases Involving the Admissibility of the Testimony of Medical Experts on Causation–*Transcon Ins. Co. v. Crump* and *Jelinek v. Casas*.

In 2010, the Supreme Court heard arguments less than a month apart in two cases involving the admissibility of expert testimony of medical doctors concerning medical causation; it issued opinions in those cases barely three months apart. The two cases were *Transcon. Ins. Co. v. Crump,* 330 S.W.3d 211 (Tex. 2010) (argued January 20, 2010, opinion delivered August 27, 2010) and *Jelinek v. Casas*, 328 S.W.3d 526 (Tex. 2010) (argued February 18, 2010, opinion delivered December 3, 2010).

1. *Crump*: The first case was the best time ever for a treating doctor. . . .

Crump, the earlier case, involved a workers' compensation claim. In *Crump*, the treating physician had used a particular diagnostic tool, "differential diagnosis," both to treat the patient, and eventually to opine "that Crump's [on the job] wound became infected, that the infection weakened his organs, and that the natural progression of these events caused his death." *Id.*, at 218. The

Supreme Court noted that differential diagnosis is a "is a routine diagnostic method used in internal medicine whereby a treating physician formulates a hypothesis as to likely causes of a patient's presented symptoms and eliminates unlikely causes by a deductive process of elimination." *Id.*, at 216. The Supreme Court recounted the treating doctor's many accomplishments and accolades, and recognized him as a physician whose "educational and clinical qualifications to treat post-transplantation, immunosuppressed patients, such as Crump, are not in dispute." *Id.*, at 218. The Court extensively analyzed how a treating physician's use of differential diagnosis can, and in that case did, sufficiently eliminate other potential causes of the worker's death, and provided sufficient evidence of medical causation to support the jury's verdict under both *E.I. du Pont de Nemours & Co. v. Robinson,* 923 S.W.2d 549 (Tex. 1995) and *Gammill v. Jack Williams Chevrolet, Inc.,* 972 S.W.2d 713 (Tex. 1998). *Id.*, at 217-20. The Court still reversed and remanded the judgment in favor of the plaintiffs–it held that the trial court's omission of the but-for component in the jury charge constituted reversible error, and that the trial court erred in not submitting the issue of the plaintiff's reasonable and necessary attorney's fees to the jury. *Id.*, at 232. But the doctor's differential diagnosis withstood both a *Robinson* and *Gammill* analysis.

2. *Casas*: The second case was the worst time for a testifying doctor. . . .

The opinion the Court issued three months later in *Casas* involved a medical malpractice claim. In it, Mrs. Casas, who had an abdominal infection of some type, had been admitted to the Hospital, and had been prescribed two antibiotics. *Casas*, 328 S.W.3d at 530. For some reason, post-surgery, those two antibiotics were allowed to lapse, which the Hospital admitted should not have happened. *Id.* The plaintiffs claimed their now deceased mother's hospital stay would not have been as long, and she would not have experienced as much pain, if the prescriptions had not lapsed. *Id.* At one point, Mrs. Casas' condition–whatever caused the infection–deteriorated to the point that "a foul smell" emanated from her. *Id.*, at 531. It was so intense that her son said that "as soon as they opened the door [to his Mother's room] the whiff of this putrid smell just engulfed me," and the Hospital brought fans into the room to dissipate the odor. *Id.*, at 531, 530. The family sued the Hospital and an infectious disease doctor who treated their mother.

The decedent's family and the hospital/healthcare providers offered competing explanations, in a very fact-intensive and lengthy hospital setting, as to what caused Mrs. Casas' bowel infection, and whether the lapsed antibiotics would have treated the same. *Casas*, 328 S.W.3d at 530, *et seq.* The plaintiffs' expert opined that Mrs. Casas' infection was caused by an anaerobic bacteria which the two lapsed antibiotics would have treated; the healthcare providers' experts said those lapsed antibiotics would not have treated the infection, which they opined was either a staph or a fungal infection. *Id.* The plaintiffs' expert did concede that the infections which were suggested by the healthcare providers' experts could have caused some, or all, of her symptoms. *Id. Casas* held that the opinion of the medical doctor retained by the plaintiffs as an expert witness failed to provide sufficient evidence of causation. *Id.*, at 536-37, 538. The Court reached that holding because the plaintiffs' expert failed to show why his proposed cause of the patient's problems was more likely than other causes offered by the defendants. The Court said that the opinion of the plaintiffs' expert "raises no more than a possibility of causation, which is insufficient" to support the jury's verdict favorable to the plaintiffs. *Casas*, at 537.

Casas did not mention *Robinson* nor *Gammill*, and did not allude to the extensive discussion

about differential diagnosis in *Crump*, even though *Casas*, like *Crump*, involved competing causation theories. Other than the fact that it did not have to invoke *Robinson* and *Gammill* to exclude the testimony of the plaintiffs' expert in *Casas*, it's curious why the Court did not at least mention *Robinson* or *Gammill*. For example, in *Crump* the Court said:

> "[T]he relevance and reliability requirements of *Rule 702* [apply] to *all* expert evidence offered under that rule . . .The mere fact that differential diagnosis was used does not exempt the foundation of a treating physician's expert opinion from scrutiny--it is to be evaluated for reliability as carefully as *any other* expert's testimony."

Crump, at 217-18. Some courts of appeals have subjected expert testimony in medical malpractice cases to a *Robinson/Gammill* analysis, and it would seem that *Crump* would have provided a good opportunity to either endorse, or decry, that practice. *See, e.g., Wilson v. Shanti*, 333 S.W.3d 909, 914-16 (Tex. App.–Houston , pet. den.), *Fennern v. Whitehead*, 2010 Tex. App. LEXIS 4587, *4-14 (Tex. App.– Austin June 18, 2010, no pet.); *Taber v. Nguyen Roush*, 316 S.W.3d 139, 147-160 (Tex. App.– Houston [14th Dist.] 2010, no pet.).

3. *Crump* and *Casas* involved the same doctor–and their respective outcomes emphasize that this is not a system for you to trifle with.

In rejecting the opinion of the plaintiffs' expert, *Casas* also did not mention one curious little factoid: the expert whose opinion it accepted in *Crump* was apparently the same expert whose opinion it rejected in *Casas*. You'd a thunk this might have borne mentioning, if for no other reason than trivia.

But what really gets your attention about *Casas* is the tag line. The Supreme Court expressly empathized with the "unfortunate" facts in *Casas*, the "Casas family's predicament and frustration," and "the difficulty of proving that the lapsed prescriptions caused a painful infection." *Casas*, 328 S.W.3d at 532, 538. That empathy did not deter the Court from remanding the case to the trial court for an "award of . . . [the infectious disease doctor's] attorney's fees" against the plaintiffs under former article 4590i §13.01. The Court ordered that remand because it agreed that the expert report of the plaintiffs' expert was deficient in that it "failed to provide more than conclusory statements of causation." *Casas*, 328 S.W.3d at 541, 538-9. Chief Justice Jefferson, Justice Green, and Justice Lehrmann dissented from this last ruling.

B. So what do we learn from *Crump* and *Casas*?

Maybe nothing, except that recreational research reveals some curious but basically meaningless coincidences, of interest to no one except some dull, post-middle age appellate type.

Or perhaps the causation testimony of a treating physician in a worker's compensation case, or a personal injury case, is subject to *Robinson* and *Gammill* analyses, and the causation testimony of a retained medical expert in a medical malpractice case is not. But that disjunction does not seem to make sense–especially since any number of courts of appeals have held that medical testimony in malpractice cases is subject to that analysis.

But we do know that the number and type of cases falling with the ambits of Chapter 74 keeps growing, thus increasing the importance of knowing whether *Robinson* and *Gammill* apply in medical malpractice cases. As two Supreme Court Justices have said in a dissenting opinion, the Court has "implicitly" held that "that all injuries in a health care setting, regardless of any relationship to medical care, must be filed as health care liability claims." *Omaha Healthcare Ctr., LLC v. Johnson*, 2011 Tex. LEXIS 506, *11; 54 Tex. Sup. J. 1314 (July 1, 2011)(Lehrmann, J., dissenting, joined by Medina, J.). And in civil case filings in at least one court of appeals, it seems that only parental right termination cases outnumber healthcare liability cases in which an expert's opinion is challenged. http://www.stevehayeslaw.com/IssuesPresented.pdf, approx. pp. 48-53, 71-78.

So, in what seems an ever growing field, to avoid becoming that unenviable test case with a bad result, perhaps we ought to take all the warnings we can from *Casas* and *Crump*:

1) Don't assume the well-earned, stellar reputation of your testifying expert will carry the day on its own. It won't.
2) Assume your expert physician's opinion will have to withstand both a *Robinson* and *Gammill* analysis, and make sure your expert understands and meets that challenge.
   A) For those of you who represent plaintiffs, good luck on getting a treating physician to prepare for a *Robinson*/*Gammill* challenge. In my saltier days, it nearly took an act of Congress to get a treating physician to meet with me for ten minutes prior to his or her deposition. And for those of you on the defense side of the docket–the first two lawyers I heard complain about the Supreme Court's decision in *Robinson* were two defense lawyers sitting behind me on a flight from Love Field to Houston. They were wondering how much trouble it was going to be to get their experts qualified. You might give some thought to that, too. What's good for the goose is good for the gander.
3) If you offer a medical expert to opine about medical causation, and other explanations are offered as potential causes for the patient's injury or damages, always remember:
   A) Have your expert specifically and fully rebut each other potential cause, and explain why each such other potential cause is not correct, and why his or her opinion as to causation is superior to the other expert's opinion;
   B) If there are factors which reduce the likelihood of alternative causes offered by the other side's expert, have your expert point out all those factors. Do not leave it up to the courts to do so, nor assume that they will.
4) If you cross-examine a medical expert on whom the other side places it hopes of success:
   A) Get the other side's expert to concede that the causes preferred by your client share symptoms with the cause offered by the expert;
   B) Get the expert to concede there is no objective evidence of the cause he opines about.
5) Make sure your expert's report satisfies the requirements of Chapter 74.

Let me know if you see anything else. Always happy to learn from others, and to give them credit

for it.