Filed 1/19/17 Ramirez v. Long Beach Memorial Medical Center CA2/8

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

HERMINIA RAMIREZ et al., Plaintiffs and Appellants, v. LONG BEACH MEMORIAL MEDICAL CENTER, Defendant and Respondent.	B265548 (Los Angeles County Super. Ct. No. NC051507)

APPEAL from a judgment of the Superior Court of Los Angeles County. Ross M. Klein, Judge. Affirmed.

Law Offices of Philip P. DeLuca and Philip P. DeLuca for Plaintiffs and Appellants.

Dummit Buchholz & Trapp, Craig S. Dummit, Harmon B. Levine and Michael H. Wellen for Defendant and Respondent.

This is an appeal from the grant of summary judgment in favor of Long Beach Memorial Medical Center (LBMMC or hospital) in a wrongful death action alleging the hospital's negligence caused the death of plaintiffs' decedent, Julio Cesar Ramirez. Before the hospital obtained summary judgment, judgments had been entered in favor of the emergency room physician and the nurse who treated and cared for Mr. Ramirez, and plaintiffs dismissed with prejudice their claims against a second treating physician. Plaintiffs do not contend the third physician who performed surgery on Mr. Ramirez was negligent.

Plaintiffs contend the hospital's delay in obtaining the services of an on-call vascular surgeon caused Mr. Ramirez's death. We conclude there is no admissible evidence that any member of the hospital's non-medical staff caused Mr. Ramirez's death by failing to perform in accordance with the prevailing standard of care. We also conclude that plaintiffs were not entitled to a continuance of the hearing on the motion for summary judgment to conduct further discovery, and affirm the judgment.

GOVERNING LEGAL PRINCIPLES

Before turning to the evidence in support of and in opposition to the summary judgment motion, we first discuss the applicable legal principles which determine our disposition of this appeal.

Summary judgment motions must be based on admissible evidence (Code Civ. Proc., § 437c, subd. (d)), and must demonstrate the absence of a triable issue of material fact. (*Id.*, subd. (c).)

In professional malpractice cases, expert opinion testimony is required to prove or disprove that the defendant performed in

accordance with the prevailing standard of care (*Miller v. Los Angeles County Flood Control Dist.* (1973) 8 Cal.3d 689, 702), except in cases where negligence is obvious to a layman. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001 [discussing doctrine of res ipsa loquitur].) This is not a case where negligence is obvious, but a case in which expert opinion is required, as demonstrated by the parties' submission of expert declarations in support of and in opposition to the motion.

As we stated in *Bozzi v. Nordstrom, Inc.* (2010) 186 Cal.App.4th 755, "[w]hen the moving party produces a competent expert declaration showing there is no triable issue of fact on an essential element of the opposing party's claims, the opposing party's burden is to produce a competent expert declaration to the contrary. (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493 [plaintiff's experts in medical malpractice case did not create material dispute by stating it was ' "more probabl[e] than not" ' that plaintiff's injury resulted from trauma during surgery without explanation or facts other than assumed facts for which no evidence was presented]; *Golden Eagle Refinery Co v. Associated Internat. Ins. Co.* (2001) 85 Cal.App.4th 1300, 1315 disapproved on other grounds in *State of California v. Allstate Ins. Co.* (2009) 45 Cal.4th 1008, 1036 [expert declaration stating toxic spill was 'sudden and accidental' was inadmissible to prove that fact because it was devoid of any basis, explanation, or reasoning]; *Ochoa v. Pacific Gas & Electric Co.* (1998) 61 Cal.App.4th 1480, 1485, 1487 [declaration of treating doctor, who 'felt' exposure to methane gas leak ' "probably aggravated [the plaintiff's] respiratory problems" ' because he did ' "not know of any more medically probable cause," ' was equivocal, speculative,

and lacked sufficient foundation to create triable issue of fact].)" (*Bozzi v. Nordstrom, Inc.*, at pp. 761-762.)

Expert witnesses must state the factual bases for their opinions. (*Griffith v. County of Los Angeles* (1968) 267 Cal.App.2d 837, 847 [expert opinions, though uncontradicted, are worth no more than the reasons and factual data upon which they are based].) " 'An expert's opinion is no better than the reasons given for it. " 'If his opinion is not based upon facts otherwise proved . . . it cannot rise to the dignity of substantial evidence.' " ' " (*Ibid*.)

FACTS AND DISCUSSION OF AUTHORITIES

1. The Hospital's Evidence in Support of the Summary Judgment Motion

The declarations of Tammi McConnel, RN, and David V. Cossman, MD, in support of the hospital's summary judgment motion establish the following material facts:

Shortly after 11:00 p.m. on July 28, 2007, Mr. Ramirez and another victim were shot with AK-47's at a party following Mr. Ramirez's recent release from prison. Mr. Ramirez was shot in the leg, and the other victim was shot in the abdomen. Paramedics transported them by ambulance to the LBMMC emergency room. The other victim arrived first, at 11:27 p.m. Mr. Ramirez arrived at 11:42 or 11:45 p.m. Upon arrival, Mr. Ramirez was examined by the trauma surgeon, Dr. Frederick Stafford, and the emergency room physician, Dr. Atul Gupta. Dr. Stafford told Dr. Gupta to order a CT angiogram of the abdomen, pelvis and leg for Mr. Ramirez. At 11:50 p.m., he left the emergency department to perform surgery on the other trauma patient, leaving Mr. Ramirez in the care of Dr. Gupta and nurse Lynn Witte.

Mr. Ramirez was taken for a CT scan at midnight and returned to the emergency room at 12:30 a.m. Dr. Gupta called Dr. Stafford in the operating room at about 1:00 a.m. to report the results of the CT scan. Dr. Stafford told Dr. Gupta to contact the on-call vascular surgeon. Shortly thereafter, Dr. Gupta asked the unit secretary in the emergency room to contact the call service to page the on-call vascular surgeon.

The unit secretary called the call service at 1:05 a.m. The call service paged two on-call surgeons, Dr. Maginot and Dr. Baumgartner, within minutes of receiving the call from the unit secretary. Yet at 1:26 a.m., neither on-call surgeon had called into the hospital. Throughout this time, Dr. Gupta repeatedly personally approached and called the unit secretary by a desktop voicebox to inquire about the status of the on-call vascular surgeon, and relayed these efforts to nurse Witte.

At 1:31 a.m., the unit secretary called the hospital operator on the PBX line and requested that the on-call vascular surgeon be contacted at home, and she notified Dr. Gupta she had done so. The on-call surgeon, Dr. Baumgartner, contacted Dr. Gupta at about 1:40 a.m. to say he was en route to the hospital but stuck in traffic. The unit secretary was notified that Dr. Baumgartner had spoken to Dr. Gupta at 1:47 a.m., and Dr. Gupta notified nurse Witte that Dr. Baumgartner would be coming to operate on Mr. Ramirez.

While waiting for Dr. Baumgartner to arrive, nurse Witte repeatedly reported to Dr. Gupta that Mr. Ramirez was bleeding, his blood pressure began to drop, and his thigh began to swell. Mr. Ramirez received eight units of blood between 1:15 a.m. and 2:40 a.m. His vitals were taken continuously and documented 16 times between 11:50 p.m. and 2:40 a.m.

Mr. Ramirez suffered cardiac arrest at 2:15 a.m. He was resuscitated in the emergency room, intubated and taken to the operating room for surgery. Shortly thereafter, Dr. Baumgartner arrived in the emergency department. Dr. Stafford arrived before Dr. Baumgartner, having gone to the emergency department immediately after the other trauma victim had died. Over four hours into surgery, after a successful arterial reconstruction, Mr. Ramirez had a second cardiac arrest during wound closure. He was pronounced dead at 7:01 a.m.

Dr. Cossman testified that the second, and fatal, cardiac arrest was caused by a well recognized complication of the successful vascular surgery that Dr. Baumgartner performed. After a successful revascularization, lactic acid in the restored blood flow exerts a "powerful negative systemic effect" which may lead to cardiac arrest. Dr. Baumgartner could not have prevented the second cardiac arrest even if he had commenced surgery before 2:30 a.m. That is because Mr. Ramirez had suffered hypovolemic (hemorrhagic) shock from the massive blood loss that led to the first cardiac arrest. Although he received massive blood and fluid resuscitation in the emergency department, and he was able to undergo a four-hour surgery to reconstruct the femoral artery, the shock that caused the first cardiac arrest rendered Mr. Ramirez intolerant to the inevitable additional systemic insult he experienced when the highly acidic blood supply returned to his leg.

Dr. Cossman testified that by the time Dr. Baumgartner became involved in this case, it is more likely than not that Mr. Ramirez's chance of survival was no longer medically probable due to the first cardiac arrest he experienced from excessive blood loss and hypovolemic shock. If Mr. Ramirez had

been taken to the operating room at any time between 30 and 60 minutes before his first cardiac arrest (i.e., any time between 1:15 a.m. and 1:45 a.m.), more likely than not he would have survived.

Dr. Cossman testified that Dr. Baumgartner complied with the applicable standard of care. Plaintiffs offered no evidence that Dr. Baumgartner was negligent in opposition to the hospital's summary judgment motion. Thus, there is no material dispute that Dr. Baumgartner was not negligent.

2. The Inferences We Draw From Dr. Cossman's Opinions Regarding the Cause of Mr. Ramirez's Death

Dr. Cossman's testimony indicates that, if there was negligence that caused Mr. Ramirez's death, the negligent acts or omissions happened before 1:45 a.m., the latest time by which Dr. Cossman opined that surgery might have saved Mr. Ramirez's life. The record demonstrates the only people who were involved in the care and treatment of Mr. Ramirez between the time he arrived at the hospital (11:45 p.m.) and 1:45 a.m. (when surgery might have saved his life) were Dr. Gupta, Dr. Stafford, nurse Witte, the unit secretary, and the on-call service staff.

Judgment has been entered in favor of Dr. Gupta, nurse Witte, and the on-call service following their motions for summary judgment. Plaintiffs dismissed their claims against Dr. Stafford with prejudice following a good faith settlement. Both summary judgment and a dismissal with prejudice following a settlement are final judgments on the merits for purposes of collateral estoppel. (See *Boeken v. Philip Morris USA, Inc.* (2010) 48 Cal.4th 788, 793 [dismissal with prejudice]; *White Motor Corp.*

v. Teresinski (1989) 214 Cal.App.3d 754, 762-763 [summary judgment].) Accordingly, the hospital cannot be vicariously liable for any negligence on the part of Dr. Gupta, Dr. Stafford, nurse Witte, or the on-call service. (*Staples v. Hoefke* (1987) 189 Cal.App.3d 1397, 1415 [applying doctrine of collateral estoppel and finding "if the defendant's responsibility is necessarily dependent upon the culpability of another who was the immediate actor, and who, in an action against him by the same plaintiff for the same act, has been adjudged not culpable, the defendant may have the benefit of that judgment as an estoppel"]; see also *Campbell v. Security Pac. Nat. Bank* (1976) 62 Cal.App.3d 379, 386.)[1]

That leaves only the unit secretary as a possible source for the hospital's liability. In its moving papers, the hospital offered the expert opinion of nurse McConnel, who testified the unit secretary and other hospital staff were not negligent. Nurse McConnel offered extensive expert testimony explaining that nurse Witte complied with the standard of care. This testimony, even though disputed by plaintiffs' experts, cannot create a material dispute to defeat summary judgment in favor of the hospital, since judgment has been entered in favor of nurse Witte. Therefore, we summarize the testimony only briefly.

---

[1] Plaintiffs' opposition to the defendants' motion for summary judgment, and plaintiffs' appellate brief, contend that defendant hospital is barred from raising the issues of res judicata or collateral estoppel in its motion for summary judgment because they were not raised as an affirmative defense in its answer. Plaintiffs are mistaken. It is well settled that collateral estoppel need not be specially alleged as a defense. (*Dakins v. Board of Pension Commissioners* (1982) 134 Cal.App.3d 374, 387.)

Expert nurse McConnel stated she understood that plaintiffs contended the LBMMC's nursing staff were negligent in failing to go " 'up the hospital chain of command by calling in the house R.N. supervisor to take command of calling physicians on a more frequent basis than was done by the unit secretaries or contacting other qualified physicians in a more timely manner.' " She was also told plaintiffs contend LBMMC personnel were negligent in that an error in the on-call list resulted in a delay in calling Dr. Baumgartner.

In the opinion of expert nurse McConnel, nurses and hospital staff are responsible for monitoring the patient's condition, reporting pertinent findings to the physicians, and properly implementing physician orders. The unit secretary is responsible to contact the call service for the on-call physician's group when told to do so by the physician.

Physicians—not nurses or staff—are responsible for ordering diagnostic tests, medications and treatment, and for making decisions about procedures and surgery. The nurses at all times timely and properly monitored Mr. Ramirez, continually relayed pertinent changes in Mr. Ramirez's condition to the emergency room physician, and promptly administered blood, potassium and pain medication as ordered by the physician. Dr. Gupta was the physician who was responsible to see that the on-call physician was contacted several times, even at his home. Once Dr. Gupta notified nurse Witte at 1:47 a.m. that Dr. Baumgartner was en route to the hospital, it was entirely unnecessary for a nursing supervisor to contact another vascular surgeon.

Expert nurse McConnel testified that the nurses, agents and non-physician employees of the hospital met the standard of

care in the community with regard to the care and treatment of Mr. Ramirez.

3. Plaintiffs' Opposing Expert Declarations Do Not Create a Material Dispute.

The opinions of plaintiffs' medical expert, Dr. Melvin Shiffman, and nurse expert, nurse Divina Pulmano, are virtually identical regarding the performance of Dr. Stafford and Dr. Gupta and the inconsistencies in their testimony. These opinions are immaterial since judgments have been entered in favor of Dr. Stafford and Dr. Gupta, and the hospital cannot be vicariously liable for any negligence attributed to them as a matter of law. The opinions of Dr. Shiffman and nurse Pulmano as to whether Drs. Stafford and Gupta responded in a timely manner to the information that Mr. Ramirez might have a vascular injury, and whether Dr. Gupta acted promptly once Dr. Stafford determined that he needed vascular surgery, are similarly immaterial because judgments have been entered in their favor. For the same reason, the opinion of plaintiffs' medical expert, Dr. Corre, that Dr. Gupta was negligent is irrelevant and immaterial, and we do not discuss it further.

The bulk of nurse Pulmano's declaration concerns the standard of care required of nurses and the basis for her opinion that nurse Witte was negligent by failing "to go up the hospital chain of command to seek a surgeon for this patient immediately to attempt to control his bleeding." Nurse Pulmano's opinions regarding the care provided by nurse Witte are also immaterial because judgment has been entered in favor of nurse Witte.

We turn to the opinions of Dr. Shiffman and nurse Pulmano regarding the on-call list which mistakenly showed Dr. Maginot was the on-call vascular surgeon on the night of

Mr. Ramirez's shooting, and their opinions that a 30-minute delay caused Mr. Ramirez's death. They both testified that Dr. Gupta told the unit secretary to call for a vascular surgeon, and the call was made at 12:45 a.m., not at 1:00 or 1:05 a.m. They both opined the contract between LBMMC and the on-call service required that a physician present to the hospital within 30 minutes of receiving an emergency request. When the on-call service called Dr. Maginot at 1:05 a.m., he told the service he was not the on-call doctor, and to call Dr. Baumgartner.

Nurse Pulmano opined there was an "inexcusable error on the call list which listed Dr. Maginot as the surgeon on call." She opined LBMMC is solely responsible for preparing the on-call list, and this "error caused a lapse of thirty (30) minutes, the time in which a surgeon should have already arrived to the Emergency Department according to the contract and the need of the patient, who bled profusely in the Emergency Department."

Dr. Shiffman also opined the hospital was solely responsible for the mistake on the on-call list, and the mistake caused a lapse of 30 minutes, the time in which a surgeon should have already arrived and commenced surgery. Dr. Shiffman continued, "It is my opinion to a reasonable degree of medical certainty that in this case, the specific act of generating an incorrect on-call list was a substantial factor in causing the untimely death of Julio Cesar Ramirez."

The hospital objected to the opinions of nurse Pulmano and Dr. Shiffman as lacking foundation and misstating the evidence, among other grounds. The trial court did not rule on the objections to the Pulmano declaration, but ruled that Dr. Shiffman's declaration was "vague, conclusory, and lacking foundation" and declined to consider it. (It appears the trial court

implicitly sustained the objection that the Pulmano and Shiffman opinions misstated the evidence, as the trial court concluded the call logs clearly indicated the on-call service paged Dr. Maginot at 1:05 a.m., he immediately responded and told the service to call Dr. Baumgartner, and the service paged Dr. Baumgartner at 1:06 a.m.) We agree both declarations misstated the evidence by describing a 30-minute delay for which there is no corroborating evidence, but we find that point is of no significance.

Nurse Pulmano opined "this specific act of generating an incorrect on-call list was a substantial factor in causing the untimely death of [Mr. Ramirez]." The hospital objected to this opinion as lacking foundation and an improper opinion from a nursing expert. We agree that nurse Pulmano is not competent to offer an expert opinion on the cause of Mr. Ramirez's death. (*Reid v. Google, Inc.* (2010) 50 Cal.4th 512, 535 [appellate court may review de novo evidentiary objections on which the trial court did not rule]; see also Evid. Code, § 801, subd. (b).)

However, Dr. Shiffman *is* competent to offer an opinion on the cause of Mr. Ramirez's death. The trial court sustained the hospital's objections that Dr. Shiffman's declaration was vague, conclusory and lacked foundation. We do not find the trial court abused its discretion in sustaining the objections; at least, not with respect to most of Dr. Shiffman's declaration. (*Reid v. Google*, *supra*, 50 Cal.4th at p. 535 [evidentiary rulings may be reviewed for abuse of discretion].) In part of Dr. Shiffman's declaration, he offered admissible expert opinion as to the cause of Mr. Ramirez's death, but we conclude nothing in Dr. Shiffman's declaration or in the declaration of nurse Pulmano created a material dispute that the hospital was negligent, for three reasons we explain below.

First, there is no evidence in the record from which it may be inferred that the unit secretary—*the only agent or representative of the hospital involved in the care of Mr. Ramirez for whom judgment has not been entered*—was responsible to prepare the on-call list. The hospital offered the declaration of expert nurse McConnel that the unit secretary is responsible only to contact the service for the on-call physician's group when told to do so by the physician. Nurse Pulmano did not dispute that. Indeed, nurse Pulmano agreed with nurse McConnel as to the standard of care required of the unit secretary, opining that, "A unit secretary does not have the skill, knowledge or duty that is required of a registered nurse. They function under the direction of the physician and the registered nurse and are not autonomist [*sic*] in their role in the emergency room." Whether the unit secretary called the service at 12:45 a.m. or 1:05 a.m. is immaterial, because there is no dispute that she called the service immediately upon receiving doctor's orders to do so.

Dr. Shiffman said nothing about the standard of care required of the unit secretary and offered no opinion regarding the performance of the unit secretary in this case. Thus, there is no material dispute that the unit secretary complied with the standard of care.

Second, there is no foundation for Dr. Shiffman's general opinions regarding the preparation and maintenance of the on-call list. Dr. Shiffman is not an expert in the operation of hospital emergency rooms in this or any other community. The hospital objected his opinions lacked foundation because he has no emergency room experience, and the trial court did not abuse its discretion in sustaining those objections. Dr. Shiffman stated he has been *an on-call surgeon* to the emergency rooms of various

hospitals, and thereby "became familiar with various hospital procedures *as pertaining to the handling of patients* in need of emergency medical attention after being seen in the Emergency Departments." (Italics added.) Dr. Shiffman's experience reporting as an on-call surgeon to various emergency rooms and his familiarity with the handling of patients in the emergency room does not establish he is competent to opine on the internal emergency room procedures regarding preparation and maintenance of a list of on-call physicians.

Even if we were to find Dr. Shiffman was competent to offer an opinion concerning the preparation of an emergency room list of on-call physicians, Dr. Shiffman offered an inadequate factual basis for his opinion in this case that the hospital was negligent regarding the list. He based his opinion on the contract between the hospital and the on-call service, which he interpreted as placing responsibility for maintenance of the call list "squarely" on the hospital. We are not persuaded that contract interpretation falls within the purview of medical expertise. Dr. Shiffman offers no other factual basis for his opinion. He does not state which individual or group employed by the hospital is responsible to prepare the call list. He offers no information about medical community standards for the preparation and maintenance of an emergency room call list. He does not state what is the standard and acceptable period of time within which the medical community requires that an on-call surgeon present at the emergency room after the emergency room physician tells the unit secretary to place an urgent call. Therefore, Dr. Shiffman's opinion that the hospital was negligent regarding the call list is inadmissible because it lacks a factual basis.

(*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1117.)

Third, to the extent Dr. Shiffman offered an admissible expert opinion as to the cause of Mr. Ramirez's death, his opinion did not dispute the opinion of Dr. Cossman. Dr. Shiffman opined that Mr. Ramirez's "cause of death to a reasonable degree of medical certainty was cardiac arrest due to hemorrhagic shock, largely due to the significant delay in his receipt of adequate medical treatment and surgical intervention." Dr. Shiffman opined that "surgical intervention should have occurred well *before* 2:17 a.m. on July 29, 2007, so as to stabilize Mr. Ramirez's condition, if nothing else. This failure to commence surgery was an unnecessary delay that was tantamount to negligence."

Significantly here, the hospital did not seek summary judgment on the basis that the delay in performing vascular surgery on Mr. Ramirez was not the cause of his death. There is no dispute that if the vascular surgery had begun before Mr. Ramirez suffered his first cardiac arrest, it is more likely than not that he would have survived. As described above, Dr. Cossman opined that if Mr. Ramirez had been taken to the operating room at any time between 30 and 60 minutes before his first cardiac arrest (i.e., any time between 1:15 a.m. and 1:45 a.m.), it is more likely than not he would have survived. This is entirely consistent with Dr. Shiffman's opinion that Mr. Ramirez probably would have survived if surgery had commenced before 2:17 a.m. It is also consistent with nurse Pulmano's opinion that a vascular surgeon should have presented at the hospital not later than 1:15 a.m.

That a delay in beginning surgery caused Mr. Ramirez's death does not prove the hospital was negligent. Plaintiffs

contend in their reply brief it is common knowledge that a person admitted to an emergency room expects to receive medical care, and that a patient who does not receive timely care and treatment will bleed to death from a gunshot wound. While that argument has emotional appeal, it is far too sweeping and general a statement to create a dispute as to medical negligence. It is common knowledge that emergency rooms in Los Angeles County are routinely crowded and under-staffed, patients experience delays in receiving treatment, and some patients die, but those facts alone are insufficient to create a material dispute whether in each case the hospital was negligent. (See *Baumgardner v. Yusuf* (2006) 144 Cal.App.4th 1381, 1389 [describing doctrine of res ipsa loquitur].)

To demonstrate a triable issue of fact that the delay here was due to the hospital's negligence, plaintiffs had to produce admissible expert evidence with specific facts that explain how the delay deviated from the standard of care in emergency room hospitals. It is established as a matter of law that the physicians and nurse who cared for and treated Mr. Ramirez, and the on-call service, met the standard of care. The hospital is entitled to summary judgment because plaintiffs did not present admissible evidence to dispute the hospital's expert testimony that the agents and representatives of the hospital (other than the physicians and nurse for whom judgment had previously been entered) complied with the standard of care in the community with regard to the care and treatment of Mr. Ramirez.

4. The Court Did Not Abuse Its Discretion by Denying Plaintiffs' Continuance Request

A. Factual background

In their opposition to the motion for summary judgment, plaintiffs argued they were entitled to a continuance due to outstanding discovery issues between the parties. Plaintiffs wanted to depose Mark Wade, the charge nurse who was on duty on the night Mr. Ramirez was admitted to the hospital, and Patti Burkhard, the house supervisor on duty that night. The hospital did not timely provide contact information for Mr. Wade, who no longer worked for the hospital, and objected to the deposition of Ms. Burkhard.

The opposition, and supporting declaration of counsel, argued that Ms. Burkhard's testimony was essential to oppose the motion for summary judgment, as she was likely familiar with the training of nurses and the protocols for "going up the chain of command once an emergency room nurse acknowledged that her patient is dying because he is not receiving . . . timely surgical intervention." Plaintiffs also hoped to discover information about the hospital's policies and procedures for when an on-call surgeon "does not return a STAT call." Plaintiffs argued that they intended to file a motion to compel Ms. Burkhard's deposition.

Defendants' reply argued that the outstanding discovery was irrelevant, because judgment had already been entered in nurse Witte's favor.

Defendants' motion for summary judgment first came on for hearing on February 10, 2015. The court acknowledged that it had appointed a discovery referee to resolve outstanding discovery disputes between the parties, and concluded that

plaintiffs were entitled to a ruling on any outstanding discovery requests "prior to a potentially dispositive ruling" on defendants' summary judgment motion. The court continued the hearing on the motion, and ordered that the parties could provide supplemental briefs "limited solely to the effects of the pending discovery on this motion . . . ." The hearing on the motion for summary judgment was continued to May 7, 2015.

The discovery referee recommended that the issue of Ms. Burkhard's deposition first be ruled upon by the trial court. Therefore, plaintiffs filed their motion to compel the deposition of Ms. Burkhard on April 2, 2015, which was calendared for hearing on April 28, 2015.

On April 10, 2015, plaintiffs moved to continue the hearing on the motion for summary judgment, reasoning that motions to compel further responses to special interrogatories and requests for production were pending before the discovery referee, calendared for hearing on April 20, 2015. Moreover, the motion to compel the deposition of Ms. Burkhard was calendared for hearing in the trial court on April 28, 2015. Plaintiffs were also attempting to locate Mr. Wade so that his deposition could be taken. The trial court denied the request.

Plaintiffs filed their supplemental opposition to the motion for summary judgment on April 20, 2015, which was substantially the same as the first opposition insofar as the deposition of Ms. Burkhard. Also, plaintiffs' process server had discovered that the address for Mr. Wade was no longer valid and plaintiffs were attempting to locate him to subpoena his deposition.

Defendants' supplemental reply again asserted that the outstanding discovery related to nurse Witte, and was therefore irrelevant to any issue raised by defendants' motion.

The trial court denied plaintiffs' request for a further continuance, finding that "[a]ll of the discovery at issue relates to claims against Nurse Witte, who has already received a judgment on the merits in this case." The court found the policies and procedures related to the chain of command at the hospital concerned the culpability of nurse Witte, who had already been deemed to not have acted negligently. "All of this is irrelevant and is not reasonably calculated to lead to the discovery of admissible evidence. None of the discovery relates to the issues related to Defendant's Motion for Summary Judgment. The fact that there is a discovery dispute concerning this discovery has no bearing on this Motion for Summary Judgment."

B. Analysis

Code of Civil Procedure section 437c, subdivision (h) provides that "[i]f it appears from the affidavits submitted in opposition to a motion for summary judgment . . . that facts essential to justify opposition may exist but cannot, for reasons stated, be presented, the court shall deny the motion, order a continuance to permit affidavits to be obtained or discovery to be had, or make any other order as may be just."

We apply an abuse of discretion standard of review to the trial court's decision not to continue a summary judgment motion for the purpose of allowing further discovery. (*Knapp v. Doherty* (2004) 123 Cal.App.4th 76, 100.)

We find no abuse of discretion here. The court's initial grant of a continuance did not require the court to grant further continuances once the court had determined the evidence

plaintiffs sought was not "essential" to any disputed issue. Whatever the hospital's policy and procedure may have been is irrelevant, absent an expert declaration explaining what policy and procedure in these areas is standard in the community and how deviation from the standard is negligent. Further, it does not explain how these depositions might have defeated summary judgment in the face of judgments in favor of the doctors, nurse, and on-call service. It does not explain how the depositions might lead to the discovery of evidence that the unit secretary or another non-nursing staff member failed to comply with the standard of care. Plaintiffs had no right to obtain rulings on discovery disputes to pursue discovery on issues that were immaterial to the determinative issue of causation. (See *Combs v. Skyriver Communications, Inc.* (2008) 159 Cal.App.4th 1242, 1270-1271 [no error in denying continuance where counsel's supporting declaration did not explain why the outstanding discovery was essential to opposing motion; even if the court had erred in denying continuance, any such error would be harmless in light of conclusion there was no triable issue of material fact as to the issue to be adjudicated].)

DISPOSITION

The summary judgment entered in favor of the hospital is affirmed. Respondent is awarded costs on appeal.

GRIMES, J.

WE CONCUR:

BIGELOW, P. J. FLIER, J.