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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FIVE

HEBREW RICHARDSON et al.,

Plaintiffs and Appellants,

v.

CONTRA COSTA COUNTY,

Defendant and Respondent.

A131855

(Contra Costa County
Super. Ct. No. MSC09-01856)

Hebrew and Joan Richardson (Plaintiffs) sued Contra Costa Regional Medical Center and Contra Costa Health Services¹ (Hospital) for the wrongful death of Tahali Richardson (Richardson), Hebrew's mother and Joan's daughter. Hospital successfully moved for summary judgment on the basis that Plaintiffs failed to present expert testimony necessary to prove a breach of the medical standard of care. We affirm.

I. BACKGROUND

We summarize the evidence submitted in support of, and in opposition to, Hospital's summary judgment motion.

On November 17, 2008, at 4:35 p.m., Richardson arrived at the Hospital's emergency room with complaints of chest pain. Richardson had a history of lupus, coronary artery disease, seizures, pulmonary embolism, and multiple abscesses. She had a previously inserted intravenous line (a peripherally inserted central catheter or PICC line) in her arm that administered antibiotics for an abscess on the arm. Richardson

¹ The County of Contra Costa responded to the complaint, stating that it was "sued herein as" the named entities.

reported that she suffered chest pain and shortness of breath in the mid-afternoon, which she twice treated with nitroglycerin with limited success. Richardson called an ambulance because she was concerned that she was having a heart attack.

Dr. Melissa Hubiak evaluated Richardson at the hospital, ordered an EKG and laboratory tests, and successfully treated Richardson's chest pain with the application of nitroglycerin paste to the chest wall. Richardson received ampicillin, which was part of her normal medication regimen, and morphine for pain apparently associated with the abscess. Richardson reported the morphine was not effective, and she requested and received 8 milligrams of Dilaudid (hydromorphone), her normal pain medication, to be taken orally.² About 10 minutes after receiving the oral medication (around 9:30 p.m.), a nurse observed blue particles in Richardson's PICC line. When questioned, Richardson claimed she took Dilaudid pills (which are blue) by mouth and particles of the medicine came out the PICC line. Hubiak told Richardson it was impossible for particles of oral medication to be expelled through a vein into a PICC line, and she warned Richardson that any manipulation or interference with the line was dangerous. In Richardson's medical chart, Hubiak wrote that she was concerned Richardson was crushing the pills and adding them to her PICC line. Hubiak told Richardson not to put the medication in the PICC line, and Richardson acknowledged what the doctor had told her. Hubiak assessed Richardson as well-educated, well-mannered and cooperative, and she had the impression that Richardson would comply with her advice.

At about 11:40 p.m., Richardson was admitted to the intermediate care unit and seen by Dr. Arwen Mohr. Richardson told Mohr that the morphine was not effective and asked to be provided with intravenously administered Dilaudid. Mohr wrote in his notes that Richardson was taking Dilaudid and methadone at home and she could be discharged on the same medication regimen. When Richardson was discharged the next day, Mohr

² Hubiak's declaration implies that Richardson was requesting stronger pain medication to be administered intravenously. She wrote, "I did not believe that the patient needed the IV medications which she was requesting. Rather, I ordered oral Dilaudid for her."

prescribed her five Dilaudid tablets to carry her over until she could see her primary care physician the following day. She was given discharge teaching (“including medication”) in the morning,³ and at 2:00 p.m. Richardson signed discharge instructions that stated she should take 8 milligrams of Dilaudid by mouth “Q4 HOURS PRN” and noted, “10 a.m. last dose.”

At about 3:15 p.m., Richardson was found by nurses slumped over in a locked bathroom with a syringe of blue liquid that she was self-injecting into her PICC line. The nurses called for help and moved Richardson to a bed. She was breathing when first discovered, but once Richardson was placed on the bed she stopped breathing and had no pulse. The nurses called a “Code Blue.” After 50 minutes of chest compressions and intubation, Richardson was pronounced dead. A “Death Summary” written by two treating physicians stated that Richardson presumably had added crushed Dilaudid pills to her PICC line, and that during the Code Blue procedure she was given four doses of Narcan (naloxone), a medication that counteracts the effects of an opiate overdose. However, a “Code Blue Record” indicates that Richardson received “0.4” of Narcan at 3:32 p.m. and “0.4” at 3:46 p.m. In their Death Summary, the treating physicians wrote, “It is unclear what was the cause of the death It was clear that [it] was not an opiate overdose because in that case she should have responded to the Narcan and to intubation. It is thought that maybe there was an air embolus when the patient injected into her PICC.”

Dr. Arnold R. Josselson, a forensic pathologist, performed an autopsy and found the cause of death to be acute hydromorphone intoxication or Dilaudid overdose. He found 95 nanograms per milliliter of free hydromorphone in Richardson’s blood, which was consistent with an overdose. Also, Richardson’s lungs were congested, which is a common finding in opiate overdoses. The remainder of the autopsy was also consistent

³ Although the statement of undisputed material facts states that discharge teaching was provided at 7:15 p.m. and Plaintiffs did not dispute this statement, the cited medical record shows a time of “07-15,” i.e., 7:15 a.m., and the parties agree that Richardson died at 3:15 p.m.

with an overdose and did not disclose pulmonary emboli or other causes of death. Cardiac arrhythmia was a possible cause of death. When asked about the opinion in the Death Summary that an opiate overdose could be ruled out because Richardson did not respond to Narcan, Josselson disagreed and testified, “I’ve seen many cases of opiate overdoses where [N]arcan was administered but was unsuccessful.”

Dr. Dean J. Nickles, a physician with 32 years of experience and a former clinical instructor of medicine at Stanford University School of Medicine, opined that the care and treatment Richardson received in the Hospital met the applicable standard of care and no negligent act or omission by Hospital personnel caused her death. Regarding the decision to allow Richardson access to Dilaudid despite the evidence she had previously crumbled the pills and added them to her PICC line, Nickles wrote: “Based on Dr. Hubiak’s Declaration, the patient seemed to understand what she was told and there was no reason to believe the patient would not obey the instruction she was given. Further, the standard of care was met when any subsequent care providers assumed that once the patient was warned, the patient would heed the medical advice she was given. The standard of care did not require nor is it appropriate for medical personnel to confiscate a patient’s personal possessions when a patient is voluntarily admitted to the hospital as occurred in this case.” Nickles also averred that “[a]ll aspects of the in-hospital care rendered to the patient related to the reason for her admission complied with the standard of care.”

Regarding the attempts to resuscitate Richardson after she was found slumped over in the bathroom, Nickles wrote: “[O]n the belief that the patient experienced a self-induced Dilaudid overdose, the Code Blue team administered Narcan. Usually, the combination of the Narcan and the intubation should have served to revive the patient which did not occur. [¶] Based on the deposition of Dr. Josselson and the attached autopsy report, the amount of Dilaudid in the patient’s system was sufficiently large that the amount of Narcan administered during the code[,] which is usually enough to resuscitate an overdose patient[,] was not adequate. Understandably, the Code Blue team did not know the amount of Dilaudid the patient injected and therefore did not recognize

the need to administer more Narcan. Rather, the Code Blue team had a series of possible causes of the arrest to consider in the treatment plan. As an example, the patient had an underlying heart disease condition. Like most opioids, Dilaudid is a cardiac depressant which precipitates hypotension which, in this instance, could have led to a cardiac arrhythmia not detectable on a subsequent autopsy. Another possibility was an air embolism which entered the patient's circulatory system when she injected herself. ¶ In my opinion, the management of the code in all respects complied with the standard of care and no negligent act or omission on the part of the Code Blue team caused or contributed to the cause of decedent's demise. ¶ . . . ¶ In my opinion, . . . Richardson died of a self-administered opiate overdose"

Plaintiffs submitted the declaration of James Shalaby, Pharm.D., a licensed pharmacologist, on the standard of care and cause of death. On the decision to allow Richardson access to Dilaudid despite her earlier misuse of the medicine, he wrote, "[T]he average person similarly situated, whether a treating physician or otherwise, would never allow the patient to have in her possession Dilaudid pills after such an event, while the patient is still in the hospital and still has a PICC in her arm, and would assure that the patient received instructions at a time when the patient was not intoxicated by opiates. . . . It is my opinion that it was negligent on the part of the treating physician to assume the patient understood the doctor's instructions, or even a sufficient degree of competence in that state to be left alone with Dilaudid in her possession and the PICC line in her arm"

Regarding the effort to resuscitate Richardson, Shalaby cited two internet sources on the dosage and administration of Narcan⁴ and wrote, "Both resources present that Narcan should be administered every 2 to 3 minutes . . . , or every 30-60 seconds These doses are consistent with the well-established standard of care and appropriate dispensing of Narcan in the medical profession worldwide. . . . ¶ . . . The administration

⁴ Plaintiffs requested judicial notice of the internet materials. The court denied Plaintiffs' request for judicial notice and sustained three of the Hospital's evidentiary objections to Shalaby's declaration.

of Narcan to the decedent as disclosed by the defendants was clearly inadequate and quite below the standard of care. . . . [T]he administration of Narcan to the patient was totally ineffective to reverse the Dilaudid Intoxication noted by the coroner as the cause of death.”

In his deposition, Shalaby testified that he had training in medical pain management including dosing of opiates and had prescribed medications in a hospital setting under the supervision of a physician, but he had never worked in an emergency room and had never participated in resuscitating a patient or administered Narcan. As to providing Richardson with Dilaudid, he suggested that Hubiak or the nurse should have put a note on the front of the file to alert subsequent care providers that Richardson was a risk for drug abuse. Regarding the resuscitation effort, he testified: “[T]he code started at 3:20. Narcan was given, you know, 12 minutes after that at [3:32].⁵ . . . [¶] But what was unusual beyond that is that she only got one other dose of Narcan. Unless it wasn’t documented in here, she only got two doses of Narcan, .4 milligrams each. The second dose was at 3:46. Narcan is supposed to be repeated every two to four minutes. And . . . you can get up pretty high, up to 10 milligrams of Narcan. She got only .8 milligrams. [¶] That wouldn’t have been enough [¶] Also, the amount of time between Narcan doses was very long. . . . [¶] . . . [¶] [E]ven if you didn’t know how much opiate you knew that she was on opiates. [¶] You typically in a situation of trying to reverse opiate intoxication will give a series of Narcan two to four minutes apart. There are doses of .4 milligrams. And you can get up to ten milligrams.”

However, when asked if he was opining that the doctors committed malpractice by virtue of the amount of Narcan administered, Shalaby testified, “I’m not saying that they committed medical malpractice” and that “it’s hard to tell if the Narcan would have . . . saved her[,]” since “she had a lot of other problems.”

⁵ The transcript states “3:52,” but this is clearly a misstatement or typographical error. Twelve minutes after 3:20 is 3:32, and the Code Blue Record shows Narcan was first administered at 3:32.

The court granted summary judgment for the Hospital. The court ruled that expert medical testimony was necessary to prove a breach of the standard of care in a medical malpractice case and that Plaintiffs failed to present such testimony. “Plaintiffs’ expert, James Shalaby, is a pharmacologist and can attest to the appropriate dosage of Narcan, but he cannot attest to compliance with the standard of medical care where the cause of the cardiac arrest was not certain.” The court further ruled “there is no evidence that defendant’s care and treatment of the decedent was the cause of or contributed to the cause of her death. Plaintiffs’ only expert testified that he does not know whether additional doses of Narcan would have revived the patient.” The court further ruled that Joan Richardson lacked standing to bring the action on her own behalf under Code of Civil Procedure section 377.60.⁶

II. DISCUSSION

Summary judgment is appropriate “if all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” (§ 437c, subd. (c).) “The party moving for summary judgment bears the burden of persuasion that there is no triable issue of material fact and that he is entitled to judgment as a matter of law.” (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850, fn. omitted (*Aguilar*)). “There is a triable issue of material fact if, and only if, the evidence would allow a reasonable trier of fact to find the underlying fact in favor of the party opposing the motion in accordance with the applicable standard of proof.” (*Ibid.*)

When the plaintiff bears the burden of proving facts by a preponderance of the evidence and the defendant moves for summary judgment, the defendant “must present evidence that would require a reasonable trier of fact *not* to find any underlying material fact more likely than not” (*Aguilar, supra*, 25 Cal.4th at p. 851.) That is, the defendant must present facts that negate an essential element of the plaintiff’s cause of

⁶ Unless otherwise noted, all further statutory references are to the Code of Civil Procedure.

action or establish a complete defense to the claim. (§ 437c, subd. (p)(2); *Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 304 (*Johnson*)). Only if the defendant meets this burden does the burden shift to the plaintiff to demonstrate the existence of triable material facts. (*Johnson*, at p. 305.)

Summary judgment is a drastic remedy and any doubts about the propriety of summary judgment must be resolved in favor of the party opposing the motion. (*Johnson, supra*, 143 Cal.App.4th at p. 304.) In ruling on the motion, the court must draw all reasonable inferences from the evidence in the light most favorable to the opposing party. (*Aguilar, supra*, 25 Cal.4th at p. 843.) An order granting summary judgment is reviewed de novo. (*Id.* at p. 860.)

“The elements of a cause of action for medical malpractice are: (1) a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise; (2) a breach of the duty; (3) a proximate causal connection between the negligent conduct and the injury; and (4) resulting loss or damage. (*Hanson v. Grode* (1999) 76 Cal.App.4th 601, 606.)” (*Johnson, supra*, 143 Cal.App.4th at p. 305, parallel citation omitted.) In a medical malpractice case, expert testimony is required to prove or disprove performance within the standard of care unless the defendant’s negligence is obvious to a lay person. (*Ibid.*) To shift the burden to the plaintiff in a summary judgment motion, a medical malpractice defendant must “present evidence that would preclude a reasonable trier of fact from finding it was more likely than not that their treatment fell below the standard of care.” (*Ibid.*)

A. *Richardson’s Access to Dilaudid*

Plaintiffs argue expert opinion evidence was not required on the issue of whether the Hospital was negligent in allowing Richardson to access Dilaudid, after discovering her earlier attempt at intravenous self-administration. Plaintiffs contend that “[t]his is a

question of what the average person, doctor or not, would have done under the circumstances.”⁷ We disagree.

“ ‘ “The standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts . . . , unless the conduct required by the particular circumstances is within the common knowledge of the layman.” [Citations.]’ [Citations.] The ‘common knowledge’ exception is principally limited to situations in which the plaintiff can invoke the doctrine of *res ipsa loquitur*, i.e., when a layperson ‘is able to say as a matter of common knowledge and observation that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised.’ [Citation.] The classic example, of course, is the X-ray revealing a scalpel left in the patient’s body following surgery. [Citation.]” (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001, fn. omitted [remanding to trial court to determine whether hospital personnel’s failure to put up side rails on a gurney to prevent sleeping patient’s fall was matter within common knowledge of lay people or required expert evidence]; see also *Massey v. Mercy Medical Center Redding* (2009) 180 Cal.App.4th 690, 695–696 [expert evidence not required where it was alleged that patient was a fall risk, nurse left him unattended, and patient fell].) In *Mann v. Cracchiolo* (1985) 38 Cal.3d 18, 36–37, the Supreme Court cited other examples of medical malpractice that need not be proven by expert evidence: a radiologist’s failure to note a fracture in a radiology report; a patient’s fall during a common x-ray procedure, and an unexplained failure to conduct tests that were recommended by a radiologist.

Prescribing pain medication to patients is an activity peculiarly within the experience and expertise of physicians. Only licensed medical professionals may issue prescriptions. (Health & Saf. Code, § 11150.) Plaintiffs suggest it would be obvious to a layperson that Richardson should not have been trusted with narcotics after

⁷ We observe that, were Plaintiffs correct, Shalaby’s opinions offered on this issue would be irrelevant. (Evid. Code, § 801, subd. (a) [expert testimony must be “related to a subject that is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact”].)

demonstrating that she might use it in an improper and medically risky manner and after demonstrating questionable judgment by attempting to cover up her misuse with a patently false explanation. However, the decision whether to prescribe narcotic pain medication to a patient, and in what amounts requires the exercise of professional judgment by a physician. As Shalaby acknowledged, his own ability to prescribe medication was limited to a hospital setting under the supervision of a physician.

Plaintiffs further suggest that Hubiak should have assessed Richardson as mentally impaired and “likely already not of sound mind due to being under the influence of opiates,” but again, psychiatric evaluation is itself a matter of professional judgment and peculiarly within the experience and expertise of medical professionals. Hubiak averred that she determined, based on Richardson’s demeanor before and after the incident, that she was capable of understanding the doctor’s warnings of the dangers of misuse of Dilaudid and was willing to comply with her instructions. The incident was charted and Richardson remained under Hospital supervision for at least another 16 hours before she was prescribed additional Dilaudid and discharged. There is no indication in the medical records before us that in that period of time she showed other psychological disturbance. While it is possible to hypothesize a case where a patient’s behavior is so bizarre and the response so inexplicable that a lay person could find negligence without expert assistance, this is not such a case.

“[W]here the conduct required of a medical professional is not within the common knowledge of laymen, a plaintiff must present expert witness testimony to prove a breach of the standard of care. [Citations.]” (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493, 509 (*Bushling*)). Plaintiffs failed to do so.

B. *Administration of Narcan*

Plaintiffs contend that the Hospital was negligent in failing to administer sufficient Narcan to Richardson during the Code Blue procedure. They argue that Nickles’s declaration did not satisfy the Hospital’s burden as the moving party on summary judgment. Alternatively, if Nickles’s declaration did meet that burden, Plaintiffs argue

that Shalaby's declaration was sufficient to raise a triable issue of fact precluding summary judgment.

Plaintiffs are correct that the moving party (here, the Hospital) has the burden to establish the absence of triable issues of fact and its entitlement to judgment as a matter of law. (*Aguilar, supra*, 25 Cal.4th at p. 850.) Only if the moving party meets this burden does the burden shift to the party opposing summary judgment to demonstrate the existence of triable material facts. (*Johnson, supra*, 143 Cal.App.4th at pp. 304–305.) In our de novo review of the evidence, we must strictly construe the affidavits of the moving party and liberally construe those of the opponent, and doubts as to the propriety of summary judgment should be resolved against granting the motion. (*Miller v. Silver* (1986) 181 Cal.App.3d 652, 661.) Two elements of the cause of action are in dispute: breach of the standard of care and causation.

1. *Adequacy of Nickles's Declaration*

Plaintiffs insist that Nickles's declaration is too conclusory to satisfy the Hospital's initial burden. Nickles opined that "the amount of Dilaudid in the patient's system was sufficiently large that the amount of Narcan administered during the code[,] which is usually enough to resuscitate an overdose patient[,] was not adequate. Understandably, the Code Blue team did not know the amount of Dilaudid the patient injected and therefore did not recognize the need to administer more Narcan." Plaintiffs argue the declaration is insufficient because Nickles did not affirmatively describe the standard of care in administering Narcan to a patient suspected of having overdosed on opiates, i.e., the amount and timing of Narcan doses that should be administered. Plaintiffs rely on *Kelly v. Trunk* (1998) 66 Cal.App.4th 519 (*Kelly*), which holds that "an opinion unsupported by reasons or explanations does not establish the absence of a material fact issue for trial, as required for summary judgment." (*Id.* at p. 524.) In *Kelly*, however, the medical expert simply summarized the treatment the plaintiff had received and stated in conclusory fashion, "[the defendant] acted appropriately and within the standard of care under the circumstances presented." (*Id.* at p. 522; see also *Johnson, supra*, 143 Cal.App.4th at p. 306 [defense declaration too conclusory to satisfy defense

burden].) Here, on the other hand, Nickles identified the probable cause of Richardson's death (opiate overdose), described the appropriate treatment (administration of Narcan in the amount administered to Richardson), and explained why that treatment did not prevent death in this case (the standard treatment was insufficient given the amount of opiates Richardson had injected, which was unknown to Hospital personnel). The declaration was sufficient to shift the burden to Plaintiffs to demonstrate the existence of triable material facts. (*Johnson, supra*, 143 Cal.App.4th at p. 305.)

Plaintiffs also argue that Nickles's declaration is insufficient because it was based on incorrect data. Plaintiffs are correct that there is a conflict in the record about the dosage of Narcan that was actually administered to Richardson. The treating physicians' Death Summary states four doses of an unidentified quantity were administered. The Code Blue form only indicates that two doses of 0.4 milligrams were administered.⁸ Nickles opined that "the amount of Narcan administered during the code" was an amount that is usually sufficient to revive an overdose patient, but did not specifically identify that amount. Plaintiffs assert that because Nickles's declaration might have been based on information that four doses (presumably of 0.4 mgs. each) were administered and there is a triable issue of fact about whether two or four doses were administered, his declaration does not conclusively establish that the Hospital met the standard of care in administering Narcan to Richardson (i.e., the Hospital may have administered just two doses.) Plaintiffs ignore, however, the fact that Nickles averred that he had reviewed the medical records, which would include the Code Blue form. Whatever amount was administered, he opined that the amount "was not adequate" to resuscitate. He further explained that "[u]nderstandably, the Code Blue team did not know the amount of Dilaudid the patient injected and therefore did not recognize the need to administer more Narcan," and that the team "had a series of possible causes of the arrest to consider in the treatment plan." He concluded that "the management of the code in all respects complied

⁸ Shalaby testified that he could not tell from the documentation "because codes are a stressful situation" whether it was "lack of documentation and they might have given more Narcan or they simply only gave two doses of Narcan and quit."

with the standard of care and no negligent act or omission on the part of the Code Blue team caused or contributed to the cause of decedent's demise."

2. *Shalaby's Testimony*

Plaintiffs argue Shalaby's declaration nevertheless raised triable issues of fact that precluded summary judgment. We disagree.

The trial court found that Shalaby, a licensed pharmacologist, was qualified to attest to "the appropriate dosage of Narcan," but not to attest to "compliance with the standard of medical care where the cause of the cardiac arrest was not certain." In his declaration and deposition testimony, Shalaby stated that in response to a suspected opiate overdose Narcan should be administered, apparently in about 0.4 milligram doses, at intervals of 30 seconds to four minutes up to a maximum dosage of 10 milligrams.⁹ He claimed in his declaration that "these doses are consistent with the well-established standard of care and appropriate dispensing of Narcan in the medical profession worldwide. . . ." The difficulty with that last conclusion, of course, is that Shalaby is not qualified to testify as to the medical standard of care for physicians and for the Hospital, and he specifically declined to opine in his sworn deposition testimony that the doctors committed malpractice by virtue of the amount of Narcan administered.

Even if we were to conclude that Shalaby's testimony was sufficient to raise a factual dispute about whether the Hospital met the standard of care in its administration of Narcan to Richardson, there is another, and equally fatal, defect in Plaintiff's evidence. Nothing in Shalaby's declaration or in his deposition testimony meets Plaintiffs' burden of establishing a causal connection between the amount of Narcan administered and Richardson's demise. Plaintiffs "must show that [a defendant's] breach of the standard of care was the cause, within a reasonable medical probability, of his injury. [Citation.]" (*Bushling, supra*, 117 Cal.App.4th at p. 509.) Shalaby did not claim that administration of Narcan in the manner he contends was appropriate would have prevented Richardson's

⁹ We assume, without deciding, for purposes of this discussion that Shalaby could properly rely on the unauthenticated internet sources as a basis for this opinion.

death from opiate overdose given the amount of Dilaudid that was in her system. The forensic pathologist, Josselson, testified, “I’ve seen many cases of opiate overdoses where [N]arcan was administered but was unsuccessful.” At deposition, Shalaby agreed that “[i]t’s hard to tell what killed her.” Thus, even if Shalaby’s declaration created a factual dispute about the sufficiency of the Narcan administered, it failed to create a factual dispute about causation.

Plaintiffs also argue that summary judgment should have been denied because the Hospital did not rule out the possibility that Plaintiffs could prove their cause of action through the testimony of the treating physicians. Citing *Kahn v. East Side Union High School Dist.* (2003) 31 Cal.4th 990, 1003 (*Kahn*), Plaintiffs argue that to prevail on summary judgment the Hospital must “demonstrate that the plaintiff does not possess and cannot reasonably obtain, needed evidence.”

The *Kahn* language relied upon by Plaintiffs comes from a passage in *Aguilar* in which the Court explains that under California law a defendant seeking summary judgment must present evidence (either negating an element of the plaintiff’s cause of action or demonstrating that the plaintiff cannot present evidence establishing the cause of action) and cannot simply rely on argument to prevail on their motion. (See *Aguilar, supra*, 25 Cal.4th at p. 854.) Here, the Hospital did not rely simply on argument but presented affirmative evidence negating Plaintiffs’ cause of action. Nickles’s declaration was evidence that the Hospital acted within the standard of care and that its conduct did not cause Richardson’s death. *Aguilar* does not require that the Hospital also present evidence that all other potential witnesses would likewise testify that it was neither negligent nor the cause of Richardson’s death. Instead, the burden shifted to Plaintiffs to raise a triable issue of fact regarding the Hospital’s evidence that Plaintiffs were unable to prevail. Plaintiffs failed to satisfy that burden.

Because Plaintiffs produce no evidence that the Hospital’s alleged failure to comply with the standard of care in administering Narcan to Richardson during the Code Blue procedure was a substantial factor in causing Richardson’s death, the trial court properly granted summary judgment to the Hospital on this cause of action.

C. *Continuance to Obtain Expert Witness Opinion*

At the hearing on the summary judgment motion, Plaintiffs asked for a continuance to obtain another expert. The trial court properly denied the request.

“If it appears from the affidavits submitted in opposition to a motion for summary judgment or summary adjudication or both that facts essential to justify opposition may exist but cannot, for reasons stated, then be presented, the court shall deny the motion, or order a continuance to permit affidavits to be obtained or discovery to be had or may make any other order as may be just. The application to continue the motion to obtain necessary discovery may also be made by ex parte motion at any time on or before the date the opposition response to the motion is due.” (§ 437c, subd. (h).) Plaintiffs did not make a timely application for a continuance under this statute. Continuance of a summary judgment hearing is not mandatory when no affidavit is submitted or when the submitted affidavit fails to make the necessary showing. “ ‘Thus, in the absence of an affidavit that requires a continuance under section 437c, subdivision (h), we review the trial court’s denial of appellant’s request for a continuance for abuse of discretion.’ [Citation.]” (*Park v. First American Title Co.* (2011) 201 Cal.App.4th 1418, 1427.) We find no abuse of discretion.

Plaintiffs were not entitled to a continuance under the statutory standard even if timely application had been made. Discovery was already closed. Plaintiffs explained they did not obtain adequate expert opinion evidence to oppose summary judgment because, first, they believed they did not need such evidence to defeat the Hospital’s motion, and second, they did not have sufficient funds to retain an expert or depose the Hospital’s witnesses. Neither reason suffices. Misapprehension of the law is no excuse for failing to meet statutory requirements, and plaintiffs wishing to pursue litigation must either find the means to produce evidence proving their claims or abandon their causes of action. (See *Willard v. Hagemeister* (1981) 121 Cal.App.3d 406, 413–414 [faulting plaintiff for failing to gather the required information during the discovery period].)

At the hearing on the summary judgment motion, Plaintiffs also cited section 473 in support of their request for a continuance and asserted excusable neglect. Section 473,

subdivision (b) provides, “The court may, upon any terms as may be just, relieve a party or his or her legal representative from a judgment, dismissal, order, or other proceeding taken against him or her through his or her mistake, inadvertence, surprise, or excusable neglect.” This statute is inapposite as the court had not yet entered a judgment or order from which relief could be granted. Rather, section 437c, subdivision (h), the statute specifically addressing requests for continuances to obtain additional evidence to oppose a summary judgment motion, controlled and for the reasons already stated Plaintiffs fail to demonstrate their entitlement to a continuance under that statute.¹⁰

III. DISPOSITION

The judgment is affirmed.

Bruiniers, J.

We concur:

Jones, P. J.

Simons, J.

¹⁰ Because we conclude summary judgment was properly granted on Plaintiffs’ malpractice cause of action, we need not consider whether the court properly granted summary judgment of Joan Richardson’s claims on the ground she was not a dependent adult entitled to bring a wrongful death action based on the demise of her daughter.