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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

GABRIEL AGUAYO, Plaintiff and Appellant, v. ST. FRANCIS MEDICAL CENTER, Defendant and Respondent.	B232877 (Los Angeles County Super. Ct. No. TC023880)

APPEAL from a judgment of the Superior Court of Los Angeles County, William P. Barry, Judge. Reversed.

Law Offices of Michael A. Lotta, Inc. and Michael A. Lotta for Plaintiff and Appellant.

Ryan, Datomi & Mosely, Richard J. Ryan, Jeffrey T. Whitney and Dawn Cushman for Defendant and Respondent.

Plaintiff and appellant Gabriel Aguayo was a patient for over two months at St. Francis Medical Center after he was shot multiple times in an attempted

robbery. Appellant filed suit against the hospital, alleging medical malpractice because he developed skin breakdown, or bedsores, during his ten-week hospitalization. He now appeals from a judgment entered after the trial court granted the motion for summary judgment brought by respondent St. Francis Medical Center. We conclude that the trial court abused its discretion in excluding the expert declaration submitted by appellant in opposing the summary judgment motion, and that the declaration is sufficient to raise a triable issue of material fact. We therefore reverse.

Evidence in Support of Summary Judgment[1]

Respondent submitted the declaration of Robert T. Wang, M.D., Ph.D., a board-certified internist with added qualifications in geriatrics, who had reviewed appellant's medical records and the complaint.

On October 8, 2008, appellant, who was 61 years old at the time, was taken by ambulance to St. Francis Medical Center after sustaining gunshot wounds to his abdomen, chest, left forearm, and right leg. Appellant underwent an emergency exploratory laparotomy, a procedure that involves "incising the abdominal wall to gain access to the abdominal cavity." The surgery was necessary because appellant had suffered a life-threatening injury to his bowel, in which his bowel

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[1] Appellant failed to include any citations to the record in his recitation of the facts. "'It is the duty of a party to support the arguments in its briefs by appropriate reference to the record, which includes providing exact page citations. [Citations.] Briefs which do not meet this requirement may be stricken. [Citation.] As practical matter, the appellate court is unable to adequately evaluate *which facts* the parties believe support their position when nothing more than a block page reference is offered in the briefs . . . . The problem is especially acute when, as here, the appeal is taken from a summary judgment.' [Citation.]" (*Spangle v. Farmers Ins. Exchange* (2008) 166 Cal.App.4th 560, 564, fn. 3.) Instead of striking the brief, however, we have chosen to disregard the noncompliance. (Cal. Rules of Court, rule 8.204(e)(2)(C).)

contents were leaking into his abdominal cavity. The surgeon decided to leave the surgical wound open to facilitate the drainage of blood and abscess material in subsequent procedures.

Appellant was transferred to the intensive care unit because his condition was critical. He was placed on a ventilator and was given a special rotating bed to help his respiration and to shift his weight, and Prevalon boots to help prevent skin breakdown.

Over the ensuing weeks, appellant underwent additional laparotomies for various reasons, including drainage of abdominal abscess, removal of necrotic tissue, and evacuation of a hematoma. He also required surgical removal of his gall bladder, spleen, a portion of his pancreas, and additional segments of his bowel. Appellant underwent at least 17 abdominal surgeries during his 10-week stay at the hospital. He also required surgery for his leg wound, a bronchoscopy to clear secretions from his lungs, and numerous blood transfusions. He required hemodialysis for acute kidney failure and continued administration of broad-spectrum antibiotics throughout his hospitalization.

On October 28, 2008, appellant developed a skin tear, or stage 2 ulcer, in his sacral area. The attending surgeon "initiated skin integrity orders and requested a wound care consultation."

On November 24, 2008, appellant underwent endoscopic replacement of a nasoduodenal tube for nutritional support. However, because his bowel did not regain normal function during his hospitalization, he never received any substantial nutrition through the feeding tube.

In late November through early December 2008, the nursing staff charted the development of additional skin breakdown, including on his left ear and the

back of his head. His skin breakdown treatment included regular cleansing with normal saline and application of lotions, gels, and/or foam.

On December 2, 2008, appellant "underwent debridement and excision (surgical removal of dead and infected tissue) of his sacral ulcer, along with skin flap closure of both his abdominal incisional wound and sacral ulcer, which had progressed to a stage 4 wound."

When appellant was transferred to Kaiser Hospital Los Angeles on December 17, 2008, for further care, the attending physicians concluded that his sacral ulcer was healing. During his hospitalization from December 17, 2008 to January 22, 2009, his sacral and head ulcers received continued treatment.

Dr. Wang opined that St. Francis Medical Center personnel "did not engage in any substandard act or omission that, to a reasonable degree of medical probability, caused or contributed to any medical complications that [appellant] may have experienced, including the development of and worsening of skin breakdown." He explained that appellant's physicians evaluated him on a daily basis and that the physicians, not hospital personnel, were responsible for appellant's treatment.[2] Hospital personnel treated appellant in accordance with the orders issued by his treating physicians.

Dr. Wang stated that appellant's skin breakdown was inevitable, given his compromised medical condition, and was not caused by any breach of the standard of care by hospital personnel. As a result of his critical condition, appellant developed anasarca, or massive generalized edema, in which the patient's skin becomes soggy, fragile, and prone to tearing, and Dr. Wang stated that it was the anasarca, not substandard conduct, which led to the skin breakdown. Dr. Wang

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[2] Appellant did not dispute that the physicians who practice at St. Francis Medical Center are independent contractors, not employees or agents of the hospital.

further stated that appellant's impaired circulatory status and respiratory status impeded his skin's ability to maintain integrity and to heal.

Dr. Wang also explained that appellant's medical condition prevented him from being repositioned regularly during his hospitalization. After his October 8, 2008 surgery, his abdominal cavity was left open, and repositioning would have increased the risk of his abdominal contents "spilling out" through the incision site. Appellant therefore was placed in a rotating bed, which repositioned him as much as was tolerable given his medical condition.

Evidence in Opposition to Summary Judgment

In opposition to the summary judgment motion, appellant filed the declaration of Judith Hannah, R.N., C.C.N., who had reviewed appellant's medical records and Dr. Wang's declaration. Hannah stated that she had been a licensed registered nurse since 1979 and was a staff nurse through 1985. Since that time her responsibilities had included "developing and implementing Quality Management Programs and Risk Identification and Management." She stated that her education, training, and experience made her familiar with the standards of care required of nurses and other health care practitioners in documenting, recognizing, and treating skin breakdown or pressure ulcers. She described the four stages of bedsores and stated that bedsores develop quickly and progress rapidly. She stated that the "cornerstones of a care plan to address the risk of developing bedsores include position changes along with supportive devices; daily skin inspections; adequate, prompt and persistent recognition of skin breakdown and pressure ulcers, with supportive care; and a maximally nutritious diet." Hannah opined that the failure to recognize, document, and care for appellant's skin breakdown caused his bedsores to develop and/or worsen.

According to Hannah, appellant suffered from multiple areas of skin breakdown that were unrecognized, not properly documented, and not promptly cared for, causing them to develop and worsen. She stated that, on October 13, 2008, appellant developed a stage 2 pressure ulcer on his right dorsum, but the nurses and staff failed to recognize or document stage 1 of the ulcer. She further stated that there was no nurses' note on a second ulcer that developed on appellant's foot on October 22, 2008, although there was a picture of it.

Hannah stated that, between October 13 and 28, 2008, the nurses' notes do not mention skin breakdown or bedsores. On October 28, 2008, there was a picture of the stage 2 ulcer on appellant's coccyx, but no notes about it. She pointed out that, although the attending surgeon initiated a skin integrity order and requested a wound care consultation on October 28, there was no record that the consultation ever took place.

On November 1, 2008, there were pictures of ulcers on the left thigh, right ankle, coccyx, and right ankle. On November 5, 2008, a Wound and Impaired Skin Assessment indicated a stage 3 ulcer in the sacral area that was not documented when it was in stage 1 or stage 2.

Hannah further stated that, between October 28 and November 30, 2008, the nurses' notes failed to mention skin breakdown or bed sores, even though there were pictures of various ulcers taken on November 26, 2008: a left ear wound, not staged or sized; a stage 2 ulcer on the left elbow; a sacral bedsore; a right foot wound; and a left foot wound. She pointed out that there was no documentation in the notes of any of those bedsores prior to the date the pictures were taken, indicating a lack of attention to and lack of care for potential and existing areas of skin breakdown and pressure ulcers. Because there was no documentation in the

notes of the ulcers on the left ear, left elbow, and left foot prior to November 26, 2008, it was not clear when those areas began to break down.

Contrary to Dr. Wang's statement that the attending physicians concluded that appellant's sacral ulcer was healing when he was transferred to Kaiser Hospital Los Angeles, Hannah noted that the transfer summary did not mention the sacral pressure ulcer or the head pressure ulcer.

Hannah stated that appellant developed approximately eight areas of skin breakdown or ulcers that could have been prevented or reduced with adequate, prompt, and persistent recognition and care. She stated that, because appellant was at high risk for bedsores and developed his first one within five days of his admission to the hospital, the standard of care required a wound care nurse to provide better instruction to hospital staff to provide adequate wound care, but the nurses' notes often did not mention the bedsores. Hannah opined that the failure to provide adequate, prompt, and persistent recognition, documentation, monitoring, and care for appellant's bedsores led to ulcers in eight areas of appellant's body that were allowed to worsen.

Proceedings in Trial Court

On December 28, 2009, appellant filed a complaint against St. Francis Medical Center, alleging medical negligence for the development of his skin breakdown. Respondent filed a motion for summary judgment.

At the hearing on the summary judgment motion, the trial court addressed the admissibility of Hannah's declaration. Appellant's counsel argued that the fact that the physician did not mention the numerous bedsores in the transfer summary supported his argument that nurses, not physicians, care for and focus on bedsores.

The trial court concluded that a nurse was not qualified to contradict the opinion of a doctor that the progression of an infection was inevitable. The court thus sustained respondent's objections to Hannah's declaration on foundation and relevancy grounds, found that appellant failed to raise a triable issue of material fact, and granted respondent's summary judgment motion. Judgment was entered in favor of respondent and against appellant. Appellant filed a timely notice of appeal.

DISCUSSION

"Summary judgment is properly granted where there are no triable issues of fact and the moving party is entitled to judgment as a matter of law. [Citation.]" (*Nielsen v. Beck* (2007) 157 Cal.App.4th 1041, 1048.) The moving party "bears an initial burden of production to make a prima facie showing of the nonexistence of any triable issue of material fact; if he carries his burden of production, he causes a shift, and the opposing party is then subjected to a burden of production of his own to make a prima facie showing of the existence of a triable issue of material fact." (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.)

"'"[T]he trial court in ruling on a motion for summary judgment is merely to determine whether such issues of fact exist, and not to decide the merits of the issues themselves." [Citation.] The trial judge determines whether triable issues of fact exist by reviewing the affidavits and evidence before him or her and the reasonable inferences which may be drawn from those facts.' [Citation.] However, a material issue of fact may not be resolved based on inferences if contradicted by other inferences or evidence. [Citation.]" (*Truong v. Glasser* (2009) 181 Cal.App.4th 102, 109.)

"We review a grant of summary judgment de novo and decide independently whether the facts not subject to triable dispute warrant judgment for the moving party as a matter of law. [Citation.]" (*Callahan v. Gibson, Dunn & Crutcher LLP* (2011) 194 Cal.App.4th 557, 566.) "When deciding whether to grant summary judgment, the court must consider all of the evidence set forth in the papers (except evidence to which the court has sustained an objection), as well as all reasonable inferences that may be drawn from that evidence, in the light most favorable to the party opposing summary judgment. [Citations.]" (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal.App.4th 463, 467 (*Avivi*).) "We must resolve any doubts as to the propriety of granting the motion in favor of . . . the party opposing the motion. [Citation.]" (*Zavala v. Arce* (1997) 58 Cal.App.4th 915, 935.)

Although an order granting summary judgment is reviewed de novo, "any determination underlying the order granting summary judgment is reviewed under the standard appropriate to that determination. [Citation.] A court's decision to exclude expert testimony is reviewed for abuse of discretion. [Citation.]" (*Avivi*, *supra*, 159 Cal.App.4th at p. 467.)

Sufficiency of the Record

Respondent contends that the judgment should be affirmed because appellant failed to provide a sufficient record for meaningful review. Appellant failed to provide the complaint and answer in the record, and respondent states that there are numerous other exhibits that appellant failed to include. "Error must be affirmatively shown. [Citation.] The party appealing has the burden of overcoming the presumption of correctness. For this purpose, it must provide an adequate appellate record demonstrating the alleged error. Failure to provide an adequate record on an issue requires that the issue be resolved against the

appellant. [Citation.]" (*Defend Bayview Hunters Point Com. v. City and County of San Francisco* (2008) 167 Cal.App.4th 846, 859-860.)

Although appellant may have failed to include numerous documents in the record, the determination underlying the order granting summary judgment was the trial court's exclusion of Hannah's declaration, which was based on its determination that Hannah was not qualified to refute Dr. Wang's declaration. Both declarations are in the record. Moreover, the question is whether the nursing staff was negligent in its care for appellant's bedsores, and, as discussed below, Hannah's declaration indicates that she was competent to testify about that issue. We therefore decline to affirm based solely on the evidence the court ruled was admissible.

Admissibility of Hannah's Declaration

The trial court excluded Hannah's declaration on the basis that, as a nurse, she was not qualified to contradict a physician's opinion regarding the progression of an infection. The court relied in particular on a picture from November 22, stating that the ulcer was untreatable, and stated that a nurse was not qualified to comment on whether the progression of the infection was preventable or not.

"In order to testify as an expert in a medical malpractice case, a person must have enough knowledge, learning and skill with the relevant subject to speak with authority, and he or she must be familiar with the standard of care to which the defendant was held. [Citations.] . . . If the expert has disclosed sufficient knowledge of the subject to entitle his or her opinion to go to the jury, the court abuses its discretion by excluding his or her testimony. [Citation.]" (*Avivi*, *supra*, 159 Cal.App.4th at pp. 467-468.)

"The determinative issue in each case must be whether the witness has sufficient skill or experience in the field so that his testimony would be likely to assist the jury in the search for the truth, and no hard and fast rule can be laid down which would be applicable in every circumstance. . . . [¶] The unmistakable general trend in recent years has been toward liberalizing the rules relating to the testimonial qualifications of medical experts." (*Brown v. Colm* (1974) 11 Cal.3d 639, 645.) "Where a witness has disclosed sufficient knowledge, the question of the degree of knowledge goes more to the weight of the evidence than its admissibility. [Citation.]" (*Mann v. Cracchiolo* (1985) 38 Cal.3d 18, 38.)

"It is true that whether or not an individual is qualified to testify as an expert is a question for the trial court which will very rarely be set aside. [Citations.] However, it cannot be said as a matter of law that an individual is not qualified to give a medical opinion just because that person is not a licensed physician. [Citation.] Because of the dramatic growth of diverse interdisciplinary studies in recent times, often individuals of different nonphysician professions are called upon to give medical opinions or at least opinions involving some medical expertise. [Citations.]" (*People v. Villarreal* (1985) 173 Cal.App.3d 1136, 1142; see also *Chavez v. Glock, Inc.* (2012) 207 Cal.App.4th 1283, 1318-1319 ["'[W]ork in a particular field is not an absolute prerequisite to qualification as an expert in that field.' [Citation.] For example, '[q]ualifications other than a license to practice medicine may serve to qualify a witness to give a medical opinion.'"]; *People v. Rance* (1980) 106 Cal.App.3d 245, 255 [trial court did not abuse its discretion in admitting expert testimony of a registered nurse, even though she was not a medical doctor].)

It is apparent from appellant's arguments in the trial court and on appeal, as well as from Dr. Wang's and Hannah's declarations, that appellant's claim is based

on the allegation that the hospital staff, not the physicians, breached the standard of care of hospital personnel in treating and helping to prevent appellant's skin breakdown. Hannah, a registered nurse, stated that her education, training, and experience made her familiar with the standards of care required of hospital personnel in documenting, recognizing, and treating skin breakdown or pressure ulcers. She described the different stages of bedsores and the need for daily skin inspections and prompt recognition of their development in caring for them. She also noted that the nurses' notes did not document several of the ulcers before they reached stage 2 or became unstageable. Although the trial court concluded that Hannah was not qualified to comment on the progression of an infection, her declaration indicates that she did have knowledge about the standard of care required of nurses and other hospital personnel to try to prevent bedsores from progressing through the four stages that some of appellant's bedsores apparently did. Hannah's declaration thus disclosed that she possessed sufficient knowledge regarding bedsores such that her testimony would be likely to assist a jury, even though she was not a medical doctor.

"The exclusion of the sole expert relied upon by a party because of an erroneous view of his or her qualifications in a case where expert testimony is essential is an abuse of discretion, requiring reversal. [Citation.]" (*Avivi*, *supra*, 159 Cal.App.4th at p. 472.) Expert testimony is essential to a medical malpractice case. (*Hanson v. Grode* (1999) 76 Cal.App.4th 601, 606-607.) The exclusion of Hannah's testimony on the basis of her perceived lack of qualifications accordingly was an abuse of discretion.

Causation

The trial court further reasoned that Hannah's declaration did not provide "a factual foundation identifying why a particular breach led to a particular negative outcome for [appellant]." In other words, the trial court found that appellant failed to establish causation.

"'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.' [Citation.]" (*Chakalis v. Elevator Solutions, Inc.* (2012) 205 Cal.App.4th 1557, 1571.)

"In a medical malpractice action, a plaintiff must prove the defendant's negligence was a cause-in-fact of injury. [Citation.] 'The law is well settled that in a personal injury action causation must be proven within a reasonable medical probability based [on] competent expert testimony. Mere possibility alone is insufficient to establish a prima facie case. [Citations.] That there is a distinction between a reasonable medical "probability" and a medical "possibility" needs little discussion. There can be many possible "causes," indeed, an infinite number of circumstances [that] can produce an injury or disease. A possible cause only becomes "probable" when, in the absence of other reasonable causal explanations, *it becomes more likely than not that the injury was a result of its action.* This is the outer limit of inference upon which an issue may be submitted to the jury. [Citation.]' [Citations.]" (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1118.)

We are to view Hannah's declaration in the light most favorable to appellant and draw all reasonable inferences from the declaration in his favor. (*Avivi, supra,*

159 Cal.App.4th at p. 467.) The declaration states that, in light of appellant's high risk for skin breakdown, the medical staff's failure to promptly recognize and document, and to persistently care for the ulcers caused them to develop and worsen. For example, Hannah states that, as a result of the multiple bedsores "that went unrecognized, were not properly documented and/or were not adequately, persistently or promptly cared for[, . . .] skin breakdown and/or bedsores were allowed to develop and/or worsened." She points out a two-week period and an almost month-long period in which the nurses' notes fail to mention appellant's skin breakdown, and she states that there is no record of a wound care consultation after a physician requested one on October 28, 2008. In addition, Hannah cites several specific ulcers that were not documented before they reached stage 2, stage 3, or became unstageable. It is reasonable to infer from Hannah's declaration that, if appellant's ulcers had been recognized and treated at an earlier stage, they would not have reached the more serious stages they did. Hannah's declaration thus raises a triable issue of material fact as to whether appellant's serious ulcers were caused by the hospital staff's negligence.

DISPOSITION

The judgment of the superior court granting summary judgment in favor of respondent is reversed. Appellant shall recover costs on appeal.

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WILLHITE, J.

We concur:

EPSTEIN, P. J.

MANELLA, J.