Filed 9/24/04 Nichols v. Good Samaritan Hospital CA2/3

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

JAMAR NICHOLS, JR., etc., et al., Plaintiffs and Appellants, v. GOOD SAMARITAN HOSPITAL, Defendant and Appellant.	B168140 (Los Angeles County Super. Ct. No. BC243634)

APPEAL from a judgment of the Superior Court of Los Angeles County, David L. Minning, Judge. Reversed and remanded for further proceedings.

Law Offices of Bruce G. Fagel and Associates, Bruce G. Fagel and James E. Wright for Plaintiffs and Appellants.

Horvitz & Levy, David M. Axelrad, H. Thomas Watson; Fonda & Fraser, Michael A. O'Flaherty and Kristen J. Heim for Defendant and Respondent.

INTRODUCTION

In this medical malpractice action, plaintiffs and appellants Jamar Nichols, Jr., a minor, and Maria Butler, his mother, appeal a judgment based upon a directed verdict in favor of defendant and respondent Good Samaritan Hospital. After the jury hung on the question of whether the nurses employed by defendant were negligent in their care and treatment of plaintiffs during the birth of Jamar, Jr., the trial court granted defendant's motion for a directed verdict.

After examining the expert testimony presented by plaintiffs, and with regard to the proper standard of review applicable to directed verdicts, we conclude that plaintiffs presented sufficient expert evidence on the issue of causation for the case to go to a jury. We reverse and remand for further proceedings.

FACTUAL BACKGROUND

A. *Plaintiffs' Experts*

Plaintiffs presented two experts. Laurence Shields, M.D., a perinatologist, was an associate professor at the University of Washington, and also a board certified obstetrician and gynecologist. He had a specialty in maternal fetal medicine, which focused primarily on complicated obstetrical patients.

Laura Mahlmeister, R.N., Ph.D, practiced as a labor and delivery nurse for 31 years. She obtained a Master of Science Degree in Nursing, with a focus on high risk obstetric patients. Nurse Mahlmeister obtained a Doctorate in Nursing after a four-year program from the University of California San Francisco School of Nursing. She also taught in a variety of nursing schools and started her own continuing education company in obstetrics. Nurse Mahlmeister testified that she was not offering any expert testimony on the issue of causation. She was not licensed to deliver babies in California.

B. *The Birth of Jamar, Jr.*

On February 19, 2000, at 3:30 p.m., Maria Butler was admitted to Good Samaritan Hospital for labor and delivery. Bulter received fetal monitoring from the time she was admitted until the morning of February 21, when Jamar, Jr. was born. Defendant,

Dr. Mory Nouriani, was the attending physician responsible for the labor. Dr. Harris was the resident physician. At the time Bulter arrived at the hospital, the fetal heart rate was normal.

At approximately 8:00 p.m. on February 20, the fetal heart rate dropped for seven minutes before recovering. This was called Bradycardia.[1] According to Dr. Shields, this was a significant event because babies generally did not have seven minutes drops in their heart rates. The baby recovered. The standard of care did not require a caesarian section at that time.

At approximately 11:00 p.m. on February 20, the fetal heart rate again dropped, this time for six minutes. Dr. Shields testified that the attending physicians breached the standard of care by failing to deliver the baby via caesarean section at that time, and that the breech was a substantial factor in the baby's injuries.[2] Dr. Shields testified that had the baby been born then, he would not have sustained any injuries.

By midnight, the fetal heart rate indicated the baby had recovered and returned to normal. By 12:20 a.m., Butler had developed a fever of 100.7. She was given antibiotics. Dr. Shields testified this was appropriate, based upon the diagnosis of an infection in the bag of waters. Nurse Mahlmeister testified that at this point she would have considered Butler to be a "high risk" patient.[3]

---

[1] Bradycardia is sometimes defined as the fetal heart rate dropping below 110 beats per minute for 10 or 15 minutes.

[2] Dr. Shields testified: "I think you have to separate substantial factor and the factor. There isn't going to be the factor. There is going to be an accumulation of the clinical situation that develops in this case that leads to the severe and neurological injury in this case. You are not going to be able to say, well, is it this one factor? That is not going to happen."

[3] Nurse Mahlmeister testified that the qualifications of the nurse on duty and in charge at 12:20 a.m., were below the standard of care for the hospital. Nurse Mahlmeister also testified it was below the standard of care for the hospital to fail to reassign a more experienced nurse to care for Butler at this time.

Around 1:00 a.m., Dr. Nouriani went into another surgery. The incision time was 1:45 a.m. Dr. Shields testified that the standard of care required the nurses to call in the back-up physician.[4] Counsel for plaintiff then asked Dr. Shields: "Doctor, was the failure to call in Dr. Incerpi as the backup obstetrician the direct cause of injury to this baby?" Dr. Shields responded: "No."

Nurse Mahlmesiter agreed that the failure to call a back-up physician was below the standard of care for the nurses. Nurse Mahlmeister testified it was below the standard of care for the nurses to fail to call the back-up physician at midnight, and after the 4:00 a.m., 4:15 a.m., and 5:00 a.m. reports to the attending physicians, who remained in the operating room with the other patient, regardless of the reports.[5]

The assigned back-up physician, Dr. Incerpi, was readily available on the evening in question.

---

[4] Counsel for plaintiff asked: "What should have been done at that point, between 1:00 and 1:45 or so, *in order to comply with the standard of care*?" (Italics added.)

Dr. Shields answered: "So now at this point the patient has continued to progress in her labor. She is now eight centimeters dilated, 10 being complete, and the only physicians available to take care of her, are going to another operating room on another floor. [¶] The situation . . . was set up so . . . there [was] a back-up physician to be called if they need[ed] him. That physician was never called by the doctors, *nor the nurses*, even though they had a patient that was now becoming more ill by temperature elevations as well as getting close to potential vaginal delivery and there would be nobody there to take care of her." (Italics added.)

[5] Nurse Mahlmeister testified: "Since she was a high risk patient they had to ascertain who the back-up physician was who [could care] for her and respond to an emergency and to make sure that physician was immediately available." Nurse Mahlmeister testified that there was no indication that the attending nurses contacted Dr. Incerpi at any time after midnight of the evening in question. As to the nurses' failure to call the back-up physician after the 4:00 a.m., 4:15 a.m., and 5:00 a.m. reports to Dr. Nouriana and Harris, Nurse Mahlmeister explained: "Because at that point in time there were signs that the maternal condition was deteriorating and that the baby was not tolerating the pushing efforts and the doctors were in the operating room and were not immediately available. Another physician needed to be there to examine Ms. Butler and her baby as quickly as possible."

Dr. Shields testified that between 1:00 a.m. and 5:00 a.m., the condition of the baby continued to deteriorate. At 3:45 a.m., the nurses had Butler push without any physicians present. This pushing led to an eight-minute fetal heart rate deceleration. Dr. Shields testified it was below the standard of care for the nurses to have the patient push with no doctors present.[6]

Dr. Shields noted that the medical records indicated that when the nurses started pushing, the diameter of Butler's cervix was nine centimeters. He explained that this was below the standard of care because Butler had not completely dilated to 10 centimeters and this was her first baby.

Dr. Shields testified that the fetus had recovered, "[b]ut at this point, again, Dr. Incerpi should have been called in. . . . The likelihood this . . . baby [was] going to need emergency delivery now has gone much, much higher."

Nurse Mahlmeister testified that from a nursing perspective, the heart rate decelerations at this time following the two pushes were "significant drops," which should have been recorded and communicated to the physicians. Nurse Mahlmesiter testified that the nurse in charge did not maintain adequate communications with Dr. Nouriani after the pushing event because there was no indication in the medical reports to the physicians at 4:00 a.m., 4:10 a.m., or 4:50 a.m., that the nurses had attempted to have the patient push and that there were decelerations in the heart rate. Nurse Mahlmeister also testified that the nurses failed to note the pushing incidents in their notes and chart. Nurse Mahlmeister testified this was below the standard of care.

During this time period, Butler continued to receive a drug called Pitocin. Dr. Shields testified that the nurses' failure to turn off the Pitocin in response to the eight-minute heart rate deceleration accompanied by hypoxic deceleration in the second push

---

[6] Dr. Shields explained: "We got a baby that may be [in] need [of an] emergency delivery at this point. [¶] . . . If this continued on, the nurses are going to do a C-section? I don't think so. Unbelievable."

was below the standard of care. Likewise, Nurse Mahlmeister testified the nurses' failure to off the Pitocin at 3:45 a.m. was below the standard of care.

As to causation, Dr. Shields testified, the continued use of Pitocin was not "a direct cause of injury" to the baby. Dr. Shields, however, expounded upon that answer. Plaintiffs' counsel asked: "The same concept at around 3:45, if the baby was not injured at that point either neurologically, can you tell us from your perspective how the nurses' actions at around 3:45 were significant contributing factors as it relates to the ultimate injury [to] this baby?" [7] Dr. Shields answered: "The way I reviewed the medical records and the way I outlined the five things that . . . were significant factors in this case . . . should have alerted the healthcare providers that an alternative method of therapy was indicated at that point. [¶] The nurses pushing with this patient at 3:45 in the morning obtaining a severe bradycardic episode, then simply to leave her contracting for the rest of the time to do what, I'm not sure, was wrong. It didn't cause the direct injury to the baby, but even the Pitocin on, No. 1, allowed her to continue to contract, which we already – we will see develops into a response that the baby doesn't tolerate. [¶] And . . . beginning at about 6:00 in the morning begins progressive deterioration and at the same time getting this response with no physicians available[,] required them . . . to call the back up doctor in. They had nobody to take care of this woman who was not having a normal labor . . . ." [8]

The doctors returned from surgery at 5:15 a.m. They had Butler push, and she suffered another bradycardic episode with the fetal heart rate decelerating for a period of 16 minutes before returning to normal. The Pitocin should have been turned off. According to Dr. Shields, the physicians should have, and could have successfully

---

[7] The trial court overruled defense counsel's objection to this question.

[8] The trial court overruled defense counsel's objection to this part of Dr. Shield's answer.

delivered the baby at this point by caesarian section. Every clinical parameter showed the baby would not come out vaginally.

Instead, around 5:30 a.m., the physicians attempted to administer an amnioinfusion to facilitate the birth. Dr. Shields testified that he found the amnioinfusion so "highly irregular . . . Dr. Incerpi should have been called by the nurses because of this response by Dr. Nouriani."

Nevertheless, the baby's heart rate returned to normal. Dr. Shields testified there was still time for a caesarian section. Dr. Shields testified that had the baby been delivered by no later than 6:00 a.m., it would have been neurologically normal. According to Dr. Shields, "at 6:00 [a.m.,] this baby was normal and then [began] to have aggressive, . . . abnormal response to the intrauterine environment and labor."

At 6:00 a.m., the fetal monitor began showing a dip in the baby's heart rate after every contraction, called late decelerations, as well as some degree of hypoxia. By 6:20 a.m., the fetal monitor showed a drastic change. At this point, there should have been an emergency caesarean section. Had the baby been born by caesarean section prior to 6:30 a.m., more likely than not, it would not have sustained a significant neurological injury. Dr. Shields testified that the failure of the doctor to order a caesarean section at this time was below the standard of care.

Nurse Mahlmeister testified that by 6:15, because of the late decelerations, a nurse, practicing within the standard of care, would have done all she could to facilitate the delivery of the baby, including turning off the Pitocin. Nurse Mahlmeister testified there was no indication that the Pitocin was turned off before 7:00 a.m, but acknowledged that it could have been turned off at 6:36 a.m., when Butler was moved to the operating room.

Nurse Mahlmeister testified the nurses' failure to turn off the Pitocin was contrary to defendant hospital's written policy, and that a nurse could disagree with a physician about the continued use of Pitocin. Nurse Mahlmeister testified that nurses have separate

and independent duties regarding the use of Pitocin while in the operating room, even if the doctor told them to do something differently.

Nurse Mahlmeister specifically testified that the standard of care required the nurses turn off the Pitocin by 6:04 a.m. Nurse Mahlmeister testified that the nurses should have put in their notes that the continued use of Pitocin was per doctors' orders, because it was contraindicated by hospital policy. Nurse Mahlmeister concluded this failure to document was below the standard of care. She also testified that a reasonable nurse would have known that even the small dose of Pitocin that Butler was receiving could have a significant impact upon a person.

On cross-examination, Nurse Mahlmeister explained the nurses were concerned about the fetal monitor strip and called the doctors by 6:05 a.m. Dr. Harris was present by 6:15. a.m. Dr. Nouriana was present by 6:30. a.m.

At 6:36 a.m., Butler was moved to the operating room. Dr. Nouriani attempted to facilitate the delivery with the use of a vacuum. He used the vacuum three times during an 11-minute period from 7:05 to 7:16 a.m. The vacuum popped off on each occasion.

Dr. Shields testified that it was his understanding that there was no monitor screen of, and no paper printing out, the fetal heart rate during delivery. Dr. Shields noted that the equipment had the capability to print a tracing during the delivery. Dr. Shields testified that had Dr. Nouriani had a printout, this should have made a difference in the decision to use the vacuum.[9] There is no evidence in the record as to why the printer was not engaged.

---

[9] Plaintiffs introduced Dr. Nouriani's deposition testimony that he would not have used the vacuum had he seen a printout of the fetal heart rate.

On this point, Nurse Mahlmeister testified that had the printer been operating on the fetal heart monitor in the operating room, a reasonably trained, prudent nurse would have recognized the pattern between 6:53 a.m. and 7:00 a.m. was "not good."

Jamar, Jr. was born at 7:44 a.m., by which time he had suffered severe neurological injury. The major contributing causes were hypoxia with increasing acidosis. The majority of injury to the baby occurred from 7:10 a.m. to 7:44 a.m.

In his redirect examination, referring to an exhibit, plaintiffs' counsel asked: "Are these the five items, 1, 2, 3, 4, 5,[**10**] that you went over at your deposition and indicated, starting at 11:00 p.m., or 2311 hours, the first item and going down then to the time in the operating room as the fifth item, were these the five items that you felt were significant deviations from the standard of care for the doctors or the nurses or [a] combination thereof and that these items were, from your perspective[,] significant factors in terms of leading to the ultimate injury in this patient?"

After the trial court overruled defendant's objection and before Dr. Shields answered the above-question, plaintiff's counsel clarified: "So with regard to these five factors, then, even though the injury to the baby, that is the neurologic injury, did not occur until after 6:00 and the acidosis severity indicated on the monitor strip, primarily in the operating room, was it nonetheless your understanding that the way things happened in obstetrics is that when there are events that precede the actual injury, that those events may still be significant factors in leading to the ultimate injury?"

Dr. Shields answered: "Yes. When I did my original report and put together these five things, I tried to clarify that issue this morning and I hope it was clear. Is that these were time points in the course of this patient's labor where I felt that the clinical picture, in total, not just the fetal monitor, but the labor progress, the status of the woman's temperature, the status of the degree for which the baby [was] progressing through the

---

10 It is a reasonable inference from the record, that the five items about which Dr. Shields was testifying included (1) the failure to deliver the baby by caesarian section at 11:00 p.m. on February 20, (2) the nurses' attempts to have the patient push without physicians present, (3) the continued use of Pitocin, (4) the nurses' failure to call for a back-up physician, and (5) the physicians' failure to perform a caesarian section before 6:00 a.m. on the morning of February 21.

birth canal, her cervical dilatation; these were unique opportunities where those things were significantly enough out of the ordinary that they warranted delivery at those various time points."

PROCEDURAL BACKGROUND

Plaintiffs sued defendant hospital and a number of physicians for negligence in relation to the birth of Jamar, Jr. Pursuant to various motions, the trial court dismissed all of the physicians, except Dr. Nouriani.

After a more than five-week trial and three weeks of deliberations, the jury found Dr. Nouriani was negligent in the care and treatment of plaintiffs and awarded damages. Pursuant to a special verdict form, however, the jury hung on the question of defendant hospital's negligence: "Were the nurses at defendant . . . negligent in the medical care and treatment of the plaintiffs?" The jury never reached the issue of causation.[11]

Pursuant to Code of Civil Procedure section 630, subdivision (f),[12] defendant filed a motion for a directed verdict. Defendant asserted that plaintiffs failed to establish causation to a reasonable medical probability because plaintiffs failed to show that the minor plaintiff's injuries were more likely than not the result of negligence by the hospital's nurses.

In its order granting defendant's motion, the trial court ruled: "Plaintiffs did not prove, to a reasonable degree of medical probability, by expert witness testimony, that the injury to the minor plaintiff was more likely than not caused by the purported negligence of hospital nurses."

---

[11] The second question pertaining to the hospital asked: "Was such negligence on the part of the nurses at defendant . . . a cause of injury to the plaintiffs?"

[12] Section 630, subdivision (f), provides in pertinent part: "When the jury for any reason has been discharged without having rendered a verdict, the court on its own motion or upon motion of a party, notice of which was given within 10 days after discharge of the jury, may order judgment to be entered in favor of a party whenever a motion for directed verdict for that party should have been granted had a previous motion been made."

The trial court entered judgment for defendant. Plaintiffs filed a timely notice of appeal.

CONTENTIONS

This appeal involves one issue – whether plaintiffs presented sufficient expert testimony on the issue of causation for the case to be tried by a jury.[13]

STANDARD OF REVIEW

In *Fountain Valley Chateau Blanc Homeowner's Assn. v. Department of Veterans Affairs* (1998) 67 Cal.App.4th 743, the Court of Appeal explained: "[I]f a defendant believes that the plaintiff has not presented substantial evidence to establish a cause of action, the defendant may move for a nonsuit if the case has not yet been submitted to the jury, a directed verdict if the case is about to be submitted, or a judgment notwithstanding the verdict (jnov) following an unfavorable jury verdict. [¶] While made at different times, the three motions are analytically the same and governed by the same rules. [Citation.] The function of these motions is to prevent the moving defendant from the necessity of undergoing any further exposure to legal liability when there is insufficient evidence for an adverse verdict. [Citation] Put another way, the purpose of motions for nonsuit, directed verdicts and jnovs is to allow a party to prevail as a matter of law where the relevant evidence is already in. [¶] And naturally, given the constitutional right to jury

---

[13] Each party raises a number of other non-dispositive issues we resolve here. (1) The trial court was statutorily empowered to enter a directed verdict, following the failure of the jury to reach a verdict (Code Civ. Proc., § 630, subd. (f)). (2) There is no evidence the trial court employed an incorrect evidentiary standard. Both parties correctly briefed the standard to the trial court that it was required to view the evidence in the light most favorable to plaintiffs and resolve all ambiguities and conflicts in plaintiffs' favor. (3) We reject the argument that because plaintiffs did not provide a complete trial transcript, plaintiffs waived the substantial evidence argument. Defendant makes no attempt to show how other portions of the trial transcript are relevant to the issue presented in this appeal and the only issue presented to the trial court – whether plaintiffs' expert testimony sufficiently established causation for the case to be heard by a jury.

trial and a policy of judicial economy against willy-nilly disregarding juries' hard work (even, in the case of a motion for nonsuit, the work of the jury in listening to the case up to that point), the basic rules regarding these motions are predictably strict. Conflicts in the evidence are resolved against the moving defendant and in favor of the plaintiff; all reasonable inferences to be drawn from the evidence are drawn against the moving defendant and in favor of the plaintiff. [Citations.]" (*Id*. at p. 750, italics omitted.)

Stated another way, " '[a] motion for a directed verdict "is in the nature of a demurrer to the evidence, and is governed by practically the same rules, and concedes as true the evidence on behalf of the adverse party, with all fair and reasonable inferences to be deduced therefrom." ' " (*Brassinga v. City of Mountain View* (1998) 66 Cal.App.4th 195, 210.)

DISCUSSION

Plaintiffs assert that the record contains sufficient evidence on the issue of causation that the trial court's directed verdict improperly derived plaintiffs of their right to a jury trial. Defendants respond that the evidence was insufficient to show that the alleged conduct of the nurses legally or proximately caused the injuries.

As an essential element of their case, tort plaintiffs are required to prove a proximate casual connection between the alleged medical negligent conduct and the subsequent injury for which damages are sought. In *Espinosa v. Little Co. of Mary Hospital* (1995) 31 Cal.App.4th 1304, a medical malpractice birth case, the Court of Appeal addressed the issue of what constituted a "substantial factor" causing the baby's injuries, after the trial court granted a nonsuit following the testimony of the plaintiff's expert causation witness. The court reversed the nonsuit and concluded that there were "three separate, [but] interacting" (*id*. at p. 1316), causes of the plaintiff's injuries. For two of the causes, the court concluded that the plaintiff had presented sufficient causation evidence for the case to be heard by a jury.

The *Espinoza* court explained: " 'The law is well settled that in a personal injury action causation must be proven within a reasonable medical probability based upon

competent expert testimony.' " (*Espinosa v. Little Co. of Mary Hospital, supra,* 31 Cal.App.4th at pp. 1315-1316.) The court clarified that an event may be considered a medical probability if "it [was] more likely than not that the injury was a result of its action." (*Id*. at p. 1316.) The court explained: " ' "It is enough that [a plaintiff] introduces evidence from which reasonable men may conclude that it is more probable that the event was caused by the defendant than that it was not. . . . If, as a matter of ordinary experience, a particular act or omission might be expected to produce a particular result, and if that result has in fact followed, the conclusion may be justified that the causal relation exists. . . ." [Citation.] [¶] . . . Conduct can be considered a substantial factor in bringing about harm if it "has created a force or series of forces which are in continuous and active operation up to the time of the harm" ' " (*Id*. at p. 1314.)

The *Espinoza* court also explained: "In a medical malpractice action the element of causation is satisfied when a plaintiff produces sufficient evidence 'to allow the jury to infer that in the absence of the defendant's negligence, there was a *reasonable medical probability* the plaintiff would have obtained a better result.' " (*Espinosa v. Little Co. of Mary Hospital*, *supra*, 31 Cal.App.4th at pp. 1314-1315, italics in original; see also *Saelzler v. Advanced Group 400* (2001) 25 Cal.4th 763, 775; *Western Digital Corp. v. Superior Court* (1998) 60 Cal.App.4th 1471, 1487; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 216.)

Recently, in *Viner v. Sweet* (2003) 30 Cal.4th 1232, a legal transaction malpractice case, the defendant appealed on the ground that the trial court did not require the plaintiffs to prove that they would have obtained a better deal but for the alleged negligence. The California Supreme Court reversed the trial court. The court explained how the substantial evidence test "subsume[d] the traditional 'but for' test of causation." (*Id*. at p. 1240.) The court re-affirmed that the law of negligence required a plaintiff to establish causation by "showing either (1) *but for* the negligence, the harm would not

have occurred, or (2) the negligence was a concurrent independent cause of the harm." (*Id*. at p. 1241, italics in original.)

Finally, the testimony of a single credible witness may constitute substantial evidence. (*Oregel v. American Isuzu Motors, Inc*. (2001) 90 Cal.App.4th 1094, 1101; *Las Palmas Associates v. Las Palmas Center Associates* (1991) 235 Cal.App.3d 1220, 1239.) "So long as the witness' testimony is 'substantial,' [defendant] is not aided by the fact that several other witnesses testified to the contrary." (Eisenberg et al., Cal. Practice Guide: Civil Appeals and Writs (The Rutter Guide 2003) [¶] 8:52, pp. 8-20 to 8-21 (rev. #1, 2003).)

Defendant claims that plaintiffs did not present sufficient expert testimony on the issue of causation to connect the failure to call for backup to plaintiff's injuries.[14] Defendant notes that Dr. Shields testified that the failure to call a back-up physician was not a "direct" cause of plaintiffs' injuries. Defendant also asserts that plaintiff cannot show that it was more likely than not that the injuries resulted from the nurses' failure to call for backup, because by 6:00 a.m., the baby still would have been neurologically normal if delivered by caesarean section. The decision whether to deliver by caesarian was exclusively for Dr. Nouriani.

Defendant also claims that it would have been improper speculation as to how a back-up physician would have reacted had the nurses called one.

We reject these arguments. There is sufficient expert testimony in the record upon which a reasonable jury could conclude that *but for* the failure of the nurses to call a back-up physician, plaintiffs would not have sustained their injuries. (*Viner v. Sweet*, *supra*, 30 Cal.4th at p. 1240.) Additionally, plaintiffs presented sufficient expert testimony to allow the jury to conclude that absent the negligence, there was a *reasonable medical probability* the plaintiff would have obtained a better result or, that it was more

---

[14] We address this issue, despite the fact that defendant did not raise it before the trial court, and thus, may have waived it on appeal.

likely than not that the injury was a result of this breach of the standard of care. (*Espinosa v. Little Co. of Mary Hospital*, *supra*, 31 Cal.App.4th 1304.)

Plaintiffs presented substantial expert testimony that the nurses' conduct fell below the standard of care from 1:00 a.m. to 5:30 a.m., by their failure to call for a back-up physician. Plaintiffs' experts testified that the nurses should have called for a back-up physician at 1:00 a.m., when Dr. Nouriani went into another surgery. Likewise, it was below the standard of care for the nurses to fail to call the back-up physician after the 4:00 a.m., 4:15 a.m., and 5:00 a.m. reports to the attending physicians who remained in the operating room despite the reports. Finally, Dr. Shields testified that he found the 5:30 a.m. amnioinfusion so "highly irregular" that the nurses should have called for a back-up physician.

While Dr. Shields's testified that the failure to call for a back-up physician was not a "direct" cause of the injuries in this case, he also testified that this failure was a "significant factor" in leading to the ultimate injury. This testimony was sufficient pursuant to *Espinosa v. Little Co. of Mary Hospital*, *supra*, 31 Cal.App.4th at pages 1317-1318, where the court explained: "Clearly, where a defendant's negligence is a concurring cause of an injury, the law regards it as a legal cause of the injury, regardless of the extent to which it contributes to the injury." (Italics omitted.)

Based upon Dr. Shields's testimony in its entirety, it is reasonable to conclude that he was testifying that the independent acts of omission by the nurses in failing to call for a back-up physician could have caused the injuries. He consistently acknowledged that a caesarean section by 6:00 a.m. would have prevented the injuries. He also testified that the nurses' failure to call a back-up physician was a significant factor which led to the baby's injuries. It is a reasonable inference based upon Dr. Shields's testimony that he was assuming that a back-up physician would have acted within the standard of care and performed a caesarean section prior to 6:00 a.m. on the morning in question. (*Oregel v. American Isuzu Motors, Inc*., *supra*, 90 Cal.App.4th at p. 1101 ["Inferences may

constitute substantial evidence as long as they are the product of logic and reason rather than speculation or conjecture."])

Defendant responds, however, that it would have been pure speculation by the jury as to how a back-up physician would have reacted to Butler's situation. For purposes of defendant's motion for directed verdict, we disagree. Dr. Shields testified that it was below the standard of care for the physician not to conduct a caesarean section at 11:00 p.m., the night before. Dr. Shields also testified that a caesarean section should have been performed a number of other times that evening, and each failure was a violation of the standard of care.

The conclusion is inescapable, based on Dr. Shields's unequivocal testimony, that all through the evening in question it was a violation of the standard of care not to perform a caesarian section. Essentially, by asserting that the conduct of the back-up physician would have been speculative, defendant is suggesting that plaintiffs, the jury, the court and the public, cannot infer that, on this record, the hospital's back-up physician would have acted within the standard of care, and ordered a caesarean section. In other words, defendant is suggesting that it was equally probable that its back-up physician would not have acted within the standard of care. We reject this suggestion.

On this record, given Dr. Shields's testimony, the trier of fact could reasonably conclude that a back-up physician would have acted in accordance with the standard of care, performed the caesarean section, and prevented the injuries. (Cf. *Dillenbeck v. City of Los Angeles* (1968) 69 Cal.2d 472, 483, fn. 10 ["[T]he 'expert' cases flow from the proposition that each person in society is expected to exercise that degree of care which can reasonably be anticipated from him in light of his peculiar attributes, including knowledge, perception, and memory. . . . The public generally may expect that defendants, including experts, will conduct themselves reasonably in light of their peculiar attributes and capabilities."])

Thus, plaintiffs presented sufficient expert testimony to allow the jury to infer that, in the absence of the defendant's negligence, there was a *reasonable medical probability*

the plaintiff would not have been injured. (*Espinosa v. Little Co. of Mary Hospital*, *supra*, 31 Cal.App.4th 1304.) Based upon the foregoing, we conclude that the trial court erred by granting defendant's motion for a directed verdict.

DISPOSITION

The judgment based upon the directed verdict in favor of defendant hospital is reversed. We remand this case to the trial court for further proceedings. Plaintiffs are awarded costs on appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

KITCHING, J.

We concur:

KLEIN, P.J.

CROSKEY, J.