Filed 8/14/13 Doyle v. Shapiro CA2/4

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

JONATHAN DOYLE, Plaintiff and Appellant, v. MICHAEL SHAPIRO, Defendant and Respondent.	B238593 (Los Angeles County Super. Ct. No. PC044073)

APPEAL from a judgment of the Superior Court of Los Angeles County, Melvin D. Sandvig, Judge. Affirmed.

Law Offices of Michael J. Rand and Michael J. Rand for Plaintiff and Appellant.

Carroll, Kelly, Trotter, Franzen & McKenna, John C. Kelly, David P. Pruett, and Gabriel M. Irwin for Defendant and Respondent.

INTRODUCTION

In this action for medical negligence, plaintiff Jonathan Doyle appeals from a judgment entered in favor of defendant Michael Shapiro, M.D., entered after a jury found in Dr. Shapiro's favor. Doyle contends he should have been granted a new trial based on surprise testimony by Dr. Shapiro that prejudiced Doyle's ability to have a fair trial and also raises various contentions of evidentiary and instructional error. Because we conclude that none of these contentions has merit, we affirm the judgment.

FACTUAL AND PROCEDURAL BACKGROUND

I. The Accident and Surgery

On June 3, 2007, Doyle was riding his motorcycle with his wife as a passenger when another vehicle cut him off at an intersection, causing an accident in which Doyle was severely injured. As relevant to this case, both of his hips were broken. He was taken to Northridge Hospital, where Dr. Hrair Darakjian performed surgery to repair breaks of his left wrist and right arm. Dr. Darakjian explained that Northridge Hospital is a level two trauma facility, while other facilities such as UCLA and Cedars-Sinai are tertiary level one trauma facilities that provide a "higher level of care" and would have specialists that deal with complex pelvic fractures, for example. After reviewing the imaging studies of Doyle's injuries, Dr. Darakjian informed the head of the trauma team assigned to Doyle's care, Dr. Samuel, that he could not perform the pelvic surgery Doyle required, so Dr. Samuel would either have to find a surgeon at Northridge Hospital who had privileges to perform acetabular (hip socket) surgery or transfer him to another facility with such a specialist.

The day following the accident, defendant Dr. Michael Shapiro, an orthopedist, performed open reduction surgery at Northridge Hospital on Doyle's left hip using a procedure that required the placement of three screws secured in bone. He also performed a closed reduction procedure on the right hip, pulling the femur bone down

because the femoral head had been pushed into the pelvis and the sciatic nerve was at risk of being damaged further as a result. Three days later, on June 7, 2007, Dr. Shapiro performed open reduction surgery on Doyle's right hip. Dr. Shapiro also performed a total knee replacement on Doyle's right leg on June 22, 2007.

After treatment in the hospital for his numerous injuries, Doyle was transferred to a rehabilitation facility and eventually, on July 6, 2007, home with full-time nursing care. He periodically received physical therapy. It was not until mid-August 2007 that he was able to begin putting weight on his legs.

II. Postoperative Visits to Dr. Shapiro

Doyle was taken by ambulance to Dr. Shapiro's office on July 11, 2007. He was transported on a gurney as he was unable to sit upright, even in a wheelchair. He had x-rays taken and after Dr. Shapiro reviewed the x-rays he told Doyle his right hip was "shot" and he would need a total right hip replacement. Doyle's femur bone had broken. Doyle commented that in the x-ray of his left hip the three screws Dr. Shapiro had inserted seemed to point in different directions and were too close to the joint. Dr. Shapiro told him not to worry, that the left hip was "healing fine." Dr. Shapiro did not indicate there was any problem with the left hip or say Doyle would need additional surgery on that hip. Doyle returned home in the ambulance and continued to be confined to a hospital bed at home. Dr. Shapiro's notes for that visit erroneously indicated that Doyle was able to walk with a boot.

Doyle's second visit to Dr. Shapiro's office took place on July 27, 2007. He again was transported by ambulance on a gurney and had x-rays taken at the office. His discussion with Dr. Shapiro focused on his right hip. The doctor again said Doyle would need surgery to perform a total hip replacement on the right side. Dr. Shapiro showed no concern about his left hip.

Doyle's final office visit with Dr. Shapiro occurred on August 10, 2007. They did not discuss Doyle's left hip and Doyle believed his left hip was in good condition. Doyle understood that his right hip joint was broken beyond repair and needed to be replaced.

They scheduled the surgery for August 15, 2007. Later on August 10, Dr. Shapiro's office contacted Doyle's wife and told her they wanted him to sign a lien for the surgery. As a result, Doyle contacted the personal injury attorney who was representing him regarding the motorcycle accident. After speaking with his attorney, Doyle contacted Dr. Robert Klapper at Cedars-Sinai Hospital to obtain a second opinion. Doyle informed Dr. Shapiro's office he was obtaining a second opinion and told them to place the surgery on hold.

III. The Subsequent Opinions

When Doyle visited Dr. Klapper on August 23, 2007, he was able to sit in a wheelchair. After examining Doyle's x-rays, Dr. Klapper said his right hip was "toast." He said Doyle still had a fracture in the acetabulum (pelvic portion of the hip joint) in the right hip and needed reconstructive surgery. Dr. Shapiro had never told Doyle any of that information. For the first time, Doyle became concerned with Dr. Shapiro's level of care in performing the two hip surgeries.

Dr. Klapper referred Doyle to Dr. Brian Solberg, an acetabular fracture specialist at Cedars-Sinai Medical Center, and Doyle saw Dr. Solberg the same day. Dr. Solberg took additional x-rays and after reviewing them recommended acetabular reconstruction of the right hip. He further opined that the three screws on the left side had been placed within the hip joint and said they should not have been. The following day, August 24, 2007, Doyle canceled the surgery with Dr. Shapiro.

Doyle was then referred by his family physician to Dr. Eric Johnson, an acetabular fracture specialist at UCLA. He was seen by Dr. Johnson on September 4, 2007. Dr. Johnson took x-rays and performed a CT scan, and also reviewed Dr. Shapiro's x-rays. He agreed with Drs. Klapper and Solberg, saying the three screws in the left hip were "intra-articular," or impinging into the joint, and needed to be removed immediately. He said the screws could tear up the femoral head, flatten it, and cause cartilage damage.

IV. The Subsequent Surgeries

Dr. Johnson performed surgery on September 27, 2007. He removed the three screws from Doyle's left hip, and performed a reconstruction of the right acetabulum and a total hip replacement on the right side.

Four months later, Doyle was continuing to experience pain in his left hip. Dr. Johnson determined that a total hip replacement on the left side was required. Dr. Johnson performed that surgery on January 31, 2008.

V. Postoperative Recovery

Beginning in April 2008, Doyle became increasingly able to bear weight on his legs. He began to walk with the support of canes in July 2008. He was able to resume working on a limited basis in May or June 2008. Doyle continues to suffer from persistent pain and weakness in his right leg and groin area.

VI. The Present Action for Medical Negligence

Doyle filed a complaint for medical negligence against Dr. Shapiro on November 17, 2008. Dr. Shapiro answered, generally denying all of the allegations.

A. The Motions in Limine

Trial began on October 11, 2011. On that date, the court heard the motions in limine filed by the parties. Doyle moved to exclude Dr. Shapiro's expert, Dr. Kevin Ehrhart, from testifying to the standard of care as to the surgery performed on Doyle's right hip. Doyle asserted Dr. Ehrhart was not qualified to testify because he had not trained for, studied, researched, or performed such a complex acetabular fracture repair procedure. Dr. Shapiro opposed the motion, attaching portions of Dr. Ehrhart's deposition and his curriculum vitae. The court denied the motion in limine.

Doyle also moved for an order excluding statements by Dr. Ehrhart that he had operated on well known, popular people such as President Ronald Reagan and Governor Arnold Schwarzenegger. Doyle asserted such testimony was grandstanding, and was

irrelevant and unduly prejudicial. Dr. Shapiro asserted such references were relevant and would add substantial weight to Dr. Ehrhart's testimony. The court denied the motion to exclude that testimony.

B. Plaintiff's Witnesses

1. Treating/Consulting Doctors

Dr. Darakjian, who performed surgery on Doyle's arm and wrist, testified he had been an orthopedic surgeon since 1989 and as of the time of Doyle's accident Dr. Darakjian had had privileges at Northridge Hospital for 12 years. He was not aware that Dr. Shapiro held himself out to be a pelvic fracture repair specialist.

Dr. Brian Solberg testified he was an orthopedic surgeon with a specialty in orthopedic traumatology and considerable experience in performing pelvic reconstruction and acetabular repair. As of 2007, he had performed surgery on pelvic and acetabular fractures about 400 times. Dr. Solberg reviewed the x-rays he had taken of Doyle's hips on August 23, 2007, and opined that after Dr. Shapiro's surgery the right acetabular fracture was "malreduced." Solberg explained that "reduction" refers to the process of putting fractured bones back into their correct position. He said the ischial segment was significantly malrotated and the femoral head seemed to be causing nerve dysfunction. He thought that the femoral head had been "subluxed," i.e., that it was not completely dislocated out of the joint but was also not perfectly located in the joint. That would cause destruction of the cartilage to the femoral head. He said the right joint could not be reconstructed and recommended pelvic reconstruction and a total hip replacement. Solberg acknowledged that given the severity of Doyle's injury, even if the right hip had been repaired "perfectly," there was still a significant likelihood that he would at some point need a total hip replacement.

Regarding the left hip, Dr. Solberg said the left acetabulum appeared to have been repaired with three cannulated (hollow-centered) screws, at least one of which appeared to have been placed in the joint and to have scythed the joint, i.e., it had passed through

the joint and "tak[en] a little bite out of it." If the screw was in fact located within the joint, it would have been because it was placed there during the surgery.

Dr. Solberg expressed surprise that the complex surgery involved here had been attempted at Northridge Hospital. He did not know of any surgeon at Northridge, including Dr. Shapiro, who was qualified to repair these kinds of complex fractures.

2. Plaintiff's Expert Witness

Dr. Eric Johnson testified he held a board certification in orthopedic surgery and was an acetabular and pelvic reconstruction expert. He had been chief of the orthopedic trauma center at UCLA Medical Center since 1982. UCLA is a level one trauma center, meaning it handles the most complex orthopedic cases. He performed surgery on both of Doyle's hips. Although he normally did not testify as an expert witness, he agreed to testify in this case because he thought Doyle's left hip could have been saved and his right hip could have been reconstructed.

Dr. Johnson testified that it could not be determined whether the screws in Doyle's left hip were properly placed using the imaging methods Dr. Shapiro had used. He opined that a reasonable surgeon exercising reasonable care must use "Judet views," a particular type of fluoroscopic image machine that creates rotated views, to determine where the screws were placed. He did not think direct observation of the joint or listening for scraping sounds would be sufficiently determinative of the screw's placement outside of the joint. He said screws can loosen and back out but they do not migrate or move from one position to another. He said, "[in] no CT scan that I have seen is there any evidence that the screw has moved from one position to another. I would see that as a defect in the bone. So in my opinion they did not migrate."

Dr. Johnson stated that the x-rays and CT scans he took on September 4 of Doyle's hips showed that all three screws inserted by Dr. Shapiro were inserted in the left hip joint, between the femoral head and the acetabulum. The placement of the screw head against the femoral head had already begun to cause erosion of cartilage in the joint so removal of the screws was necessary. When Dr. Johnson performed the surgery, joint

fluid came out of the center of the screws, confirming that the screws were indeed seated in the joint.

Dr. Johnson stated that the extent of the defect in Doyle's ischium on the right side meant that Doyle needed to have a total hip replacement. Dr. Johnson removed all of the surgical implants Dr. Shapiro had inserted because they had seated in a bad position. He cut the fracture site in the ischium to correct its position, used the femoral head to reshape the damaged socket, and put in a new metal plate. Dr. Johnson opined that Dr. Shapiro fell below the standard of care by doing a limited internal fixation of the posterior portion of the pelvis, leaving the ischium in the position it was in and expecting that would result in the growth of bone stock, and anticipating he would go back in the future and do a total hip replacement. That is not a recognized practice in orthopedic surgery. Because this was not an emergency operation, Dr. Johnson opined that the standard of care required that Doyle be transferred to a level one trauma center. The technique used by Dr. Shapiro showed a lack of competence. The procedure was a complete failure, either because Dr. Shapiro lacked technical knowledge or lacked the surgical skill to perform the operation. Dr. Johnson opined he should not have even attempted the surgical repair on the right hip. Dr. Johnson had seen about two such fractures each year during his 27 years of practice; he considered it a very unusual and severe fracture.

Dr. Johnson said that Dr. Ehrhart, Dr. Shapiro's expert witness, was not a specialist in acetabular repair. Dr. Ehrhart did not have the skill to perform an acetabular repair as was involved in this case.

C. The Defense Witnesses

1. Dr. Ehrhart

Dr. Kevin Ehrhart stated he had been board certified in orthopedic surgery since 1986. He had been affiliated with St. John's Health Center for 33 years. His practice involved general orthopedics. About one-fourth of his practice involved replacement of hips and knees, and some shoulders. His practice did not involve the repair of complex acetabular fractures. The last time he had any training in that sort of pelvic internal

fixation was during his residency 32 years before. He had not done any research into the medical literature on the issues involved in this case before testifying, but he reviewed the pertinent literature on a monthly basis. He acknowledged that he did not have the experience or technical capability to perform the surgery required to repair Doyle's right hip and that it would be below the standard of care for him to attempt to perform such a complex pelvic repair using internal fixation.

Dr. Ehrhart was not acquainted with Dr. Shapiro personally or by reputation. Based upon a reading of Dr. Shapiro's deposition testimony, Dr. Ehrhart opined that Dr. Shapiro had the background and experience to perform this sort of pelvic acetabular repair because Dr. Shapiro had repaired between 6 and 12 complicated acetabular fractures during his career. He considered six or seven such repairs over the course of a 30-year career to be "a lot."

Dr. Ehrhart stated that the surgery Dr. Shapiro performed on Doyle's right hip did not leave the pelvis in a stable and fixated condition. Nonetheless, Dr. Shapiro complied with the standard of care in the community and did not cause injury to Doyle. Dr. Shapiro's attempt to temporize the right hip and stabilize it before doing a total hip replacement was within the standard of care. The chance of getting the right hip back together in one surgery and having a functional hip that caused no pain was extremely low. Doyle was going to need a total hip replacement no matter what.

Dr. Ehrhart opined that the precautions Dr. Shapiro took to avoid placing the screws in the joint in Doyle's left hip were also within the standard of care. He believed the screws had been properly placed but the bone collapsed, causing the screws to protrude into the joint.

Dr. Ehrhart acknowledged that orthopedic specialists such as Dr. Johnson might have been able to repair the right hip without the need to perform a total hip replacement. However, most well-trained doctors who perform such surgery on pelvic fractures would not be able to do so. The relevant standard of care was not what Dr. Johnson or Dr. Matta, the two greatest doctors in the country, were capable of doing. Dr. Ehrhart opined that the average orthopedist who does pelvic fractures and acetabular fractures

would think what Dr. Shapiro did was very appropriate. Furthermore, Dr. Ehrhart agreed with Dr. Shapiro's assessment that it posed a serious risk to Doyle to consider transferring him to another facility. He had suffered considerable blood loss and was "hemolyzing," meaning the trauma caused by his multiple injuries induced his body to start "chewing up its own red blood cells." A reasonably prudent surgeon would elect not to transfer such a patient to a different hospital.

2. Dr. Shapiro

Dr. Shapiro testified that he had been a practicing physician since 1980. His website stated he performed orthopedic surgery with multiple subspecialties, including traumatology, which includes acetabular repair. He had performed over 100 pelvic fracture surgeries, half of which involved acetabular fractures. He was board certified by the American Board of Orthopaedic Surgery in 1995, and recertified in 2009. He did not take part in a fellowship program in acetabular and pelvic reconstruction. However, he has performed acetabular repairs on complicated fractures and pelvic surgery on many occasions.

Before operating on Doyle's right hip, Dr. Shapiro explained to Doyle that it was going to be a staged procedure because the repair could not be accomplished at one time. He said the injury to Doyle's right hip was so severe that it was a "relative certainty" that he would likely need a total hip replacement "in anybody's hands." He therefore stabilized the patient by pulling the right hip down in order to reestablish leg length and reestablish the length of the sciatic nerve, considering these goals more important than the outside chance that somebody with remarkable skills might be able to spare him a total hip replacement.

On the left hip, Dr. Shapiro used guide pins to ensure proper placement of the cannulated screws, checking the placement by looking directly in the joint, moving the joint through a range of motion and listening for sounds, and also by using a C-arm fluoroscopy machine with 45-degree views in different planes. He said screws could loosen or move as a result of normal patient movement, and there was no guarantee a

fracture would heal. If it did not heal the position of the hardware could be subject to alteration.

As to the right hip, Dr. Shapiro said he wanted to stabilize the hip in a relatively normal position and allow more bone stock to grow, in order to be able to later accomplish a successful total hip replacement by placing the hardware in the new bone stock. The articular cartilage in the acetabulum was completely fragmented and destroyed and had no possibility of being able to heal in an anatomic fashion. It was fragmented and there were gaps or areas of missing cartilage, such that there was not a continuous surface for the ball of the hip joint to slide easily. The posterior wall was badly comminuted, or broken into pieces. He said, "You can't put screws in air. You can't put screws in powder. Nonetheless, it was mandatory to attempt to perform internal fixation so as to maintain congruity of the hip and stability." He planned to later use Doyle's femoral head as a bone graft to "make a perfect seat in the bone for placement of an acetabular cup just as if it were a primary total hip with a socket that had never been broken." Dr. Shapiro stated that even if the right hip had been reconstructed, Doyle would probably still have needed a total hip replacement at some point. He explained the conditions that indicated in his opinion that reconstruction of the right hip could not have been reasonably expected to succeed.

In addition, all four of Doyle's limbs were injured and required surgical repair, and he required further surgery on his right knee. This tended to argue against attempting reconstruction of the right hip because it would have extended the time for him to remain nonweight-bearing on the right side.

Dr. Shapiro said it would have been risky to transfer Doyle to another facility because he had multiple injuries and life-threatening conditions. His spleen was lacerated and had to be watched for bleeding along with his pelvic fractures, and he also had polytraumatized lungs and head trauma. He had suffered considerable blood loss. Both arms were fractured and his right knee was destroyed.

Dr. Shapiro opined that the care he provided to Doyle met the community standard of care.

D. The Verdict, the Posttrial Motion, and the Appeal

The jury was instructed by the court and the following day returned a special verdict in favor of Dr. Shapiro by a vote of ten to two. Judgment was entered on October 21, 2011. Doyle then filed a notice of and motion for new trial. Doyle argued a new trial was warranted based on the irregularity and surprise resulting from Dr. Shapiro's revelation that his notes from July 11, 2007, did not pertain to Doyle, and that Dr. Ehrhart was not entitled to express an opinion about the standard of care pertaining to complex pelvic surgery for which he was not trained, could not perform, and had not studied. The trial court denied the motion for new trial.

This timely appeal followed.

DISCUSSION

I. Dr. Shapiro's Medical Records and the Motion for New Trial

At his deposition, Dr. Shapiro produced records purporting to contain his "Patient Progress Notes" regarding Doyle's office visits. One of the records contained a notation that at the office visit of July 11, 2007, Doyle was "'able to walk in [a] boot.'" At his deposition, Dr. Shapiro read this entry into the record. When asked about that entry at trial on redirect examination, Dr. Shapiro testified for the first time that the notes he produced relating to that date applied not to Doyle, but to some other patient whom Dr. Shapiro saw on the same day. According to Dr. Shapiro, the records he produced had inadvertently been put in Doyle's file.

Following the verdict, Doyle moved for a new trial under Code of Civil Procedure section 657, subdivision 3, on the ground, inter alia, that the "surprise" occasioned by Dr. Shapiro's testimony resulted in prejudice justifying a new trial. The trial court denied the motion. On appeal, Doyle contends that the trial court erred. We disagree.

"It is well settled that a party's right to a new trial upon the ground of surprise is waived if the alleged surprise is not called to the court's attention by a motion for a

continuance or other relief. [Citations.] The rule finds its justification upon essentially practical and equitable considerations: it would be intolerable, in such cases, to permit parties to proceed without objection or application for relief, speculate as to the rulings of the court, and then after an unfavorable decision, predicate a claim of surprise upon a ground [that] could have been obviated in the first instance had timely objection been made. Moreover, the failure to object tends strongly to indicate that the party has not, in fact, been misled." (*Noble v. Tweedy* (1949) 90 Cal.App.2d 738, 742-743, citing *Kauffman v. De Mutiis* (1948) 31 Cal.2d 429, 432 ["where a situation arises [that] might constitute legal surprise, counsel cannot speculate on a favorable verdict. He must act at the earliest possible moment for the 'right to a new trial on the ground of surprise is waived if, when the surprise is discovered, it is not made known to the court, and no motion is made for a mistrial or continuance of the cause'"].)

Here, Doyle failed to seek any relief from the alleged surprise during trial. Therefore, he forfeited his right to seek a new trial on that ground.

Doyle relies on a purported exception to the rule of forfeiture, citing *Delmas v. Martin* (1870) 39 Cal. 555, 558. There, the defendant in a property title dispute was surprised by the last piece of evidence offered in the trial: a previously unknown deed conveying title to the plaintiff. The Supreme Court found no forfeiture because, *inter alia*, defense counsel did not have sufficient opportunity before the conclusion of evidence to decide "deliberately and discreetly[] what course it was proper to pursue in respect to the last item of proof which was offered in the cause." (*Ibid.*)

Delmas provides no relief to Doyle. In *Ferrer v. Home Mutual Ins. Co.* (1874) 47 Cal. 416, 430, the Supreme Court described *Delmas* as "peculiar," and declined "to extend the relaxation [of the general rule of forfeiture] beyond [its] facts." (See *Kauffman, supra,* 31 Cal.2d at p. 433 [*Ferrer* "expressly limited [*Delmas*] to its facts"].) Whatever the continuing viability of *Delmas*, it does not apply here, where Doyle's

counsel had ample opportunity during trial to seek relief from any alleged prejudice caused by Dr. Shapiro's testimony concerning his notes of Doyle's office visits.[1]

In any event, the trial court did not abuse its discretion in denying the motion for a new trial. "[A] trial judge is accorded a wide discretion in ruling on a motion for new trial and . . . the exercise of this discretion is given great deference on appeal. [Citations.]" (*City of Los Angeles v. Decker* (1977) 18 Cal.3d 860, 871-872.) "[I]t is our duty to review all rulings and proceedings involving the merits or affecting the judgment as substantially affecting the rights of a party [citation], including an order denying a new trial. In our review of such order *denying* a new trial, as distinguished from an order *granting* a new trial, we must fulfill our obligation of reviewing the entire record, including the evidence, so as to make an independent determination as to whether the error was prejudicial. [Citations.]" (*Ibid*.)

To be entitled to a new trial on the ground of surprise, the moving party must show, among other things, "'some condition or a situation in which a party to an action is unexpectedly placed to his detriment'" that causes a material adverse effect on the party's case. (*Hata v. Los Angeles County Harbor/UCLA Medical Center* (1995) 31 Cal.App.4th 1791, 1806.) In the present case, Doyle cannot show that any surprise from Dr. Shapiro's testimony materially prejudiced the presentation of his case.

Doyle testified that he was transported to and from Dr. Shapiro's office on the date in question by an ambulance and remained on a gurney. He was not capable of walking. Thus, although his counsel might have expected Dr. Shapiro to testify consistently with the note indicating Doyle could walk, he could not have been surprised to Doyle's detriment in the presentation of his case when Dr. Shapiro in essence conceded that Doyle could not walk.

Doyle contends that the prejudice to him lay in a shift in Dr. Shapiro's defense theory after Doyle's expert, Dr. Johnson, had already testified. According to Doyle, he believed that the defense at trial would be that the migration of the screws in his hip was

---

[1] Doyle also cites *Whitfield v. Debrincat* (1937) 18 Cal.App.2d 730. Because it relies on *Delmas* and related decisions, we find it inapplicable.

caused not by Dr. Shapiro's negligence, but by Doyle's walking. Dr. Johnson testified, in part, that the screws did not migrate after their initial placement. Their initial placement in the hip joint was negligent. Then, after admitting that his notation that Doyle was walking was in error, Dr. Shapiro purportedly changed his defense theory to contend that the screws moved not because Doyle was walking, but because the bone to which he attached the screws was too severely damaged in the accident to hold the screws. According to Doyle, "the thrust of the defense shifted from Doyle's post-surgery activities, to the severity of the accident."

There was no shift in the defense theory. In his opening statement to the jury, Dr. Shapiro's counsel repeatedly stressed that Doyle's injuries were caused by the severity of the injuries that resulted from the motorcycle accident. Counsel noted that after Doyle's surgery at Northridge "[h]e was transferred from bed to chair or bed to ambulance," and because his right side was immovable, all of the force of moving him was on the left side. Counsel said, "*I think maybe counsel misunderstands what the defense is with respect to the screws.* They don't screw themselves into a hard bone. But when you have force on a screw that's trying to hold a small piece of bone and it moves, the head of the screw is going to go out; the tip of the screw is going to go towards the joint. And Dr. Ehrhart will tell you this happens all the time in repairs of fractures. It happens all the time. It's a medically known complication." (Italics added.)

Thus, Doyle's counsel might have been disappointed upon discovering he could not capitalize on *Doyle's* theory of the case: that Dr. Shapiro would contend that Doyle walked prematurely and caused the screws in his left hip to move, and Doyle would prove that he did not walk and destroy Dr. Shapiro's defense. But the record demonstrates that Dr. Shapiro's theory all along was that the bone holding the screws was too weak or unsound and that this caused the screws to later protrude into the joint.

Thus, this purported shift in the defense theory had no impact on Doyle's case. Dr. Johnson's testimony that the screws in the hip did not move from initial placement rebutted the defense theory, whether the movement was caused by walking or weakness of the bone. Moreover, Doyle was able to fully cross-examine Dr. Shapiro regarding the

purported change in defense theory and his failure to produce accurate records. The trial court did not abuse its discretion in denying the motion for a new trial.

II. Evidentiary Errors

Doyle contends that the trial court erred in certain evidentiary rulings. None of his contentions has merit.

Doyle sought to admit evidence that Dr. Shapiro attempted to have Doyle sign an arbitration agreement on his first office visit on July 11, 2007, after the surgeries. According to Doyle, the evidence was relevant to show Dr. Shapiro's consciousness of guilt. We disagree. That Dr. Shapiro sought to have Doyle sign an arbitration agreement does not reasonably suggest that he believed he had botched the surgeries, especially considering, as Doyle concedes, that the record does not show that the attempt was made after Doyle questioned Dr. Shapiro about the competence of the surgeries.

During cross-examination of Dr. Shapiro, Doyle's counsel asked whether the misfiling of patient records in Dr. Shapiro's office had occurred before in cases other than those involved in litigation. The court sustained an objection that the question was argumentative and lacked foundation, and Doyle now assigns the ruling as error. We need not discuss the propriety of the ruling, because there was no possibility of any prejudice. Doyle's counsel cross-examined Dr. Shapiro at length regarding the misfiled record, and this cross-examination was more than adequate to attack his credibility.

Doyle contends the trial court erred in disallowing evidence that prior to the scheduled fourth surgery (which did not occur), Dr. Shapiro's office called and asked Doyle to sign a lien. According to Doyle, "[s]tanding alone, the fact that Dr. Shapiro's office attempted to have Doyle execute a lien may have appeared to have little probative value. Taken together with the arbitration agreement, however, it would tend to show a pattern of conduct [to undertake] surgical procedures beyond his expertise for . . . financial gain." Suffice it to say, that such theory is so thin and the evidence so tangential that the trial court did not abuse its discretion in excluding the evidence.

III. Defense Expert Testimony

Doyle moved in limine before trial: (1) to exclude the testimony of Dr. Shapiro's expert witness, Dr. Ehrhart, on the ground that he was not qualified to offer an expert opinion on the standard of care for surgery on Doyle's right hip, and (2) to exclude any reference in Dr. Ehrhart's testimony that he had operated on former President Ronald Reagan and former Governor Arnold Schwarzenegger. The trial court denied the motions.

Doyle contends that the court erred in these rulings. We disagree. As to the first motion—seeking to exclude any opinion testimony by Dr. Ehrhart regarding surgery on Doyle's right hip—Doyle argued in his motion in limine (without citation to authority and referring to no evidence) that Dr. Ehrhart lacked the required qualifications because he "has not trained, studied, researched or even performed one of the surgeries at issue in this case: . . . a right, T-Shaped, associated acetabular fracutures [*sic*] which is asserted to have been negligently carried out by defendant Shapiro."

In opposition, Dr. Shapiro noted the deficiencies in the motion (no reference to authority or evidence), and also argued that Dr. Ehrhart was an orthopedic surgeon qualified to opine on the relevant standard of care regarding the surgery at issue. In his deposition (the relevant portion of which was attached to the opposition), he testified that 65 to 75 percent of his practice involved total joint replacements and the balance of his practice involved sports medicine relating to knees and shoulders. Moreover, his curriculum vitae, which was submitted with the opposition, showed that he performed a surgical internship at UCLA School of Medicine from 1974 to 1975, was a resident in orthopedic surgery there (with rotations through other hospitals) from 1975 through 1979, and owned his own orthopedic practice since 1979. In addition, he was board-certified by the National Board of Medical Examiners and the American Board of Orthopedic Surgeons and Director of Orthopedic Surgeons at Saint John's Health Center from 2002 to 2006.

This showing was sufficient to defeat Doyle's motion in limine. "'The unmistakable general trend in recent years has been toward liberalizing the rules relating

to the testimonial qualifications of medical experts. Thus, whereas a number of earlier cases held that a physician of necessity must possess the skill ordinarily practiced only in the *same* locality [citation], only six years later this requirement was relaxed so that a physician was deemed qualified as an expert if he could testify to the practice in a *similar* community. [Citation.] Some early cases were unbending in requiring expertise as to the precise injury involved in the litigation, as, e.g., not permitting an autopsy surgeon to testify on urology [citation]. Other authorities, however, have permitted variations, as, e.g., a pathologist was qualified to testify as to causes of aseptic necrosis [citation]; an expert in otolaryngology to testify regarding plastic surgery [citation]; a homeopathic physician and surgeon to testify on the degree of care required of a physician educated in the allopathic school of medicine [citation]; a pathologist and professor of pathology to testify on the subject of gynecology [citation]. [¶] There are sound and persuasive reasons supporting this trend toward permitting admissibility more readily, rather than rigidly compelling rejection of expert testimony. It is obvious that an overly strict standard of qualification would make it difficult and in some instances virtually impossible to secure a qualified expert witness.' [Citation.] [¶] [T]he 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.' [Citation.] 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, 37-38 (*Mann*).)

Dr. Ehrhart's qualifications as an orthopedic surgeon, especially in light of Doyle's failure to refer to any authority or evidence demonstrating to the contrary, constituted sufficient experience and knowledge of joint replacements that his opinion would "assist the jury in the search for the truth." (*Mann, supra,* 38 Cal.3d at p. 38.) The extent of his experience and knowledge of the particular type of joint surgery performed by Dr. Shapiro went to the weight of his testimony, not its admissibility.

Indeed, Doyle all but concedes that under the current state of the law Dr. Ehrhart's testimony was admissible. He argues that the "relaxed notion of who can qualify as a medical expert . . . was, perhaps, appropriate in the past," but now, in an era of "not only specialties, but subspecialities and divisions of those subspecialties . . . such testimony should draw stricter scrutiny." We, of course, are bound by the settled law established by our Supreme Court. (*Auto Equity Sales, Inc. v. Superior Court* (1962) 57 Cal.2d 450, 455.) Only by deviating from that law could we conclude that Dr. Ehrhart's testimony was inadmissible. The trial court did not abuse its discretion in denying Doyle's motion in limine.

We note, further, that Dr. Ehrhart's trial testimony only confirmed the correctness of the trial court's in limine motion. Doyle contends, in substance, that because Dr. Ehrhart testified that he himself would not personally have performed surgery on Doyle, he was necessarily unqualified to offer an opinion on the standard of care. Given the more relaxed standard for qualifying experts, the argument lacks merit. Moreover, Dr. Ehrhart's testimony revealed, among other qualifications, that about a quarter of his general orthopedic practice involved replacement of hips, knees, and shoulders. He had performed four total hip replacement surgeries, and in the previous 12 to 14 years performed between six to nine total joint replacement surgeries on a weekly basis. He had experience with treatment of the type of fracture suffered by Doyle, and based on his 30 years of experience as an orthopedist he had sufficient judgment and experience to determine whether Dr. Shapiro complied with the applicable standard of care. We have little difficulty concluding that his qualifications were adequate to offer an opinion that would be helpful to the jury.

As for Doyle's second motion in limine—challenging Dr. Ehrhart's testimony that he performed hip surgery on former President Reagan and former Governor Schwarzenegger—we conclude that even if the evidence ought not to have been admitted, there was no prejudice. The evidence did little to enhance Dr. Ehrhart's standing as an expert on the issues involved in the case. Doyle's counsel cross-examined Dr. Ehrhart vigorously concerning his relevant qualifications and offered his own detailed

expert evidence on the alleged malpractice. The notion that the jury's knowledge that Dr. Ehrhart had performed hip surgery on former President Reagan and former Governor Schwarzenegger was the difference in the jury's assessment of all the evidence in reaching a verdict in Dr. Shapiro's favor strains credulity. We conclude that even if the trial court erred in allowing Dr. Ehrhart to give this testimony, it is not reasonably probable a different result would have been reached in the absence of the error. (*People v. Watson* (1956) 46 Cal.2d 818, 836.)

IV. Instruction on Duty of Care

A medical specialist must possess and use the learning, care, and skill normally possessed and exercised by practitioners of that specialty under the same or similar circumstances. (*Quintal v. Laurel Grove Hospital* (1964) 62 Cal.2d 154, 159.) Here, the trial court instructed the jury pursuant to CACI No. 502, the pattern instruction for the standard of care for, *inter alia*, surgeons who specialize in a particular practice area.[2] In the instruction, the court described the particular practice area as "orthopedic surgeon."

Doyle contends that orthopedic surgery was Dr. Shapiro's "general area" of practice and that Dr. Shapiro held himself out as an expert in complex pelvic fractures. Therefore, according to Doyle, the relevant specialty was "acetabular fracture specialist," and the trial court erred by instructing that Dr. Shapiro was to be held only to the standard of care of an "orthopedic surgeon."

There was no error. First, Doyle fails to offer any authority to show that "acetabular fracture specialist" is a recognized special practice area. Dr. Shapiro notes in his respondent's brief that while the American Board of Orthopaedic Surgery recognizes

---

[2] The instruction as given stated: "An *orthopedic surgeon* is negligent if he fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful *orthopedic surgeons* would use in similar circumstances. This level of skill, knowledge, and care is sometimes referred to as 'the standard of care.' [¶] You must determine the level of skill, knowledge, and care that other reasonably careful *surgeons* would use in similar circumstances based only on the testimony of the expert witnesses including Michael Shapiro, M.D., who have testified in this case." (Italics added.)

the specialty certificate of orthopedic surgery and certificates of two subspecialties not here relevant, it does not recognize a certificate for the so-called specialty of "acetabular fracture specialist." That Dr. Shapiro held himself out on his website as being an orthopedic surgeon specializing in, inter alia, traumatology including acetabular fracture repair, does not mean that the relevant medical specialty for the standard of care was "acetabular fracture specialist."

Second, "[t]he difference between the duty owed by a specialist and that owed by a general practitioner lies not in the degree of care required but in the amount of skill required." (*Valentine v. Kaiser Foundation Hospitals* (1961) 194 Cal.App.2d 282, 294, disapproved on another ground as stated in *Siverson v. Weber* (1962) 57 Cal.2d 834, 839.) The specialist must exercise the skill and knowledge required of the specialty. (*Neel v. Magana, Olney, Levy, Cathcart & Gelfund* (1971) 6 Cal.3d 176, 188.) This question is resolved based on expert testimony. Here, the expert testimony raised two related issues, each of which was covered by the instruction given.

The first was whether Dr. Shapiro possessed the requisite level of skill and knowledge to perform the surgery on Doyle's hips (Dr. Shapiro testified he did), or whether instead he should have referred Doyle to a level one trauma center (as opined by Doyle's surgery and medical expert, Dr. Johnson). Under the instruction given, had the jury credited Dr. Johnson's opinion, Dr. Shapiro obviously would have breached the duty of care of an orthopedic surgeon by performing the surgery himself and not referring Doyle to an orthopedist with greater skill in complex hip fractures.

The second issue was whether, having performed the surgery himself, Dr. Shapiro exercised the degree of skill, knowledge, and care that other reasonably careful orthopedic surgeons would use in similar circumstances. Dr. Shapiro and Dr. Eckhart testified that he did. Dr. Johnson and Dr. Solberg testified he did not. Again, under the instruction given, the jury could correctly decide this question based only on the testimony of the expert witnesses.

Doyle also contends that the instruction was confusing, because in the final paragraph, the instruction directed the jury to "determine the level of skill, knowledge,

and care that other reasonably careful *surgeons* would use in similar circumstances" based on the expert testimony. (Italics added.) Because this final paragraph referred to "surgeons" rather than "orthopedic surgeons," Doyle contends that the standard of care was even further diluted.

However, instructions must be read as a whole. Read in its entirety, the instruction, clearly referring to Dr. Shapiro, first told the jury that "[a]n *orthopedic surgeon* is negligent if he fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful *orthopedic surgeons* would use in similar circumstances. This level of skill, knowledge, and care is sometimes referred to as 'the standard of care.'" (Italics added.)

Second, in the paragraph cited by Doyle, the instruction, referring to the standard of care of an "orthopedic surgeon," stated: "You must determine the level of skill, knowledge, and care that other reasonably careful *surgeons* would use in similar circumstances based only on the testimony of the expert witnesses including Michael Shapiro, M.D., who have testified in this case." No reasonable juror would have construed this isolated reference to "surgeons" to mean that Dr. Shapiro need only have used the skill and knowledge of a general surgeon, especially in light of the expert testimony, which referred to orthopedic surgery, and the arguments, which did the same.

For these reasons, Doyle's contention that the instruction on duty of care deprived him of the opportunity of fully presenting his malpractice claims to the jury is not persuasive.

DISPOSITION

The judgment is affirmed. Costs on appeal are awarded to respondent Dr. Shapiro.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

SUZUKAWA, J.

We concur:

WILLHITE, Acting P. J.

MANELLA, J.