Semiannual Guide to Expert Witnesses

# Los Angeles Lawyer

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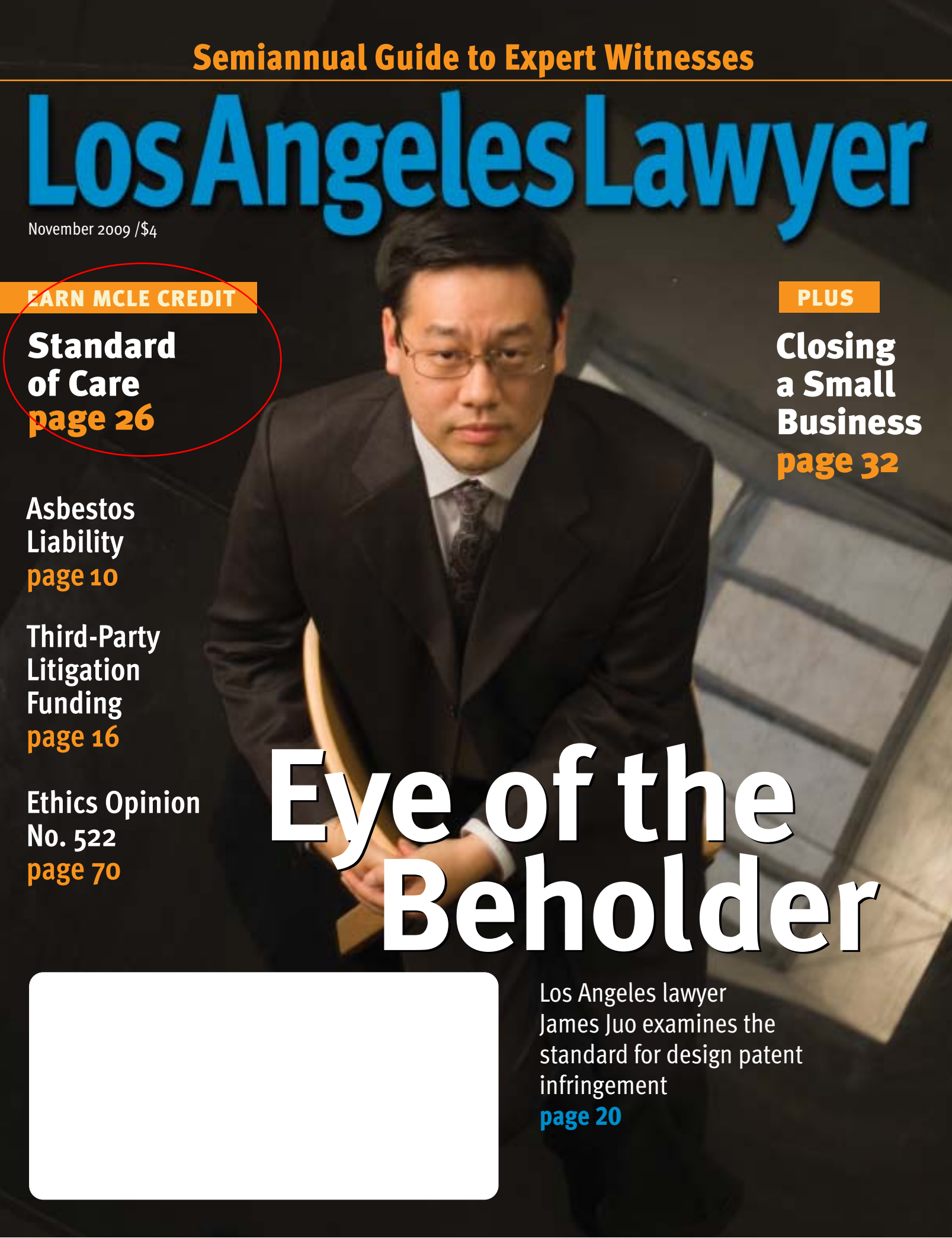

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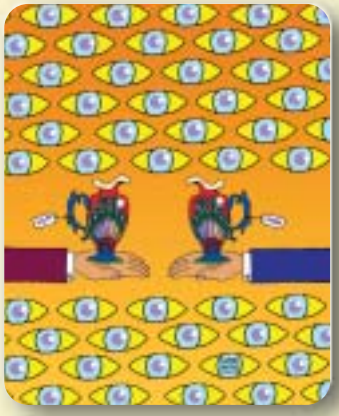

## FEATURES




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## DEPARTMENTS



11.09

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by Howard A. Kapp

# Operating Room

## In lawsuits involving medical negligence, the standard of care should be based on objective, verifiable facts

The differing approaches of many practicing attorneys regarding the application of the standard of care in medical malpractice[1] actions in California resemble Sir Winston Churchill's description of Russia—"a riddle, wrapped in a mystery, inside an enigma." Some trial lawyers present the standard of care as an abstract concept or as a matter of scientific principle. Others argue to the trier of fact that the standard is set by what "should have been done" in a given factual setting. Some lawyers suggest that the standard of care is a matter of policy. This definitional battle can, and frequently does, direct the outcome of malpractice litigation.

In actuality, however, California jury instructions and case law are clear: The standard of care, as applied to the conduct of a professional accused of negligence, should be based on objective, verifiable facts. Although medical malpractice is a subset of negligence, major substantive differences distinguish the two. For example, medical malpractice actions involve the need for expert testimony, the application of MICRA (the Medical Injury Compensation Reform Act), and the existence of special rules that apply in certain contexts.[2]

The "reasonable person" standard of negligence is not changed by classifying a case as a malpractice action; rather, the means of proof is altered. The defendant's conduct is still measured against the conduct of reasonable people in the same or similar circumstances. In this sense, the standard is akin to the Basic Speed Law, which mandates that drivers maintain a safe speed, depending on the circumstances presented by a given situation, and not drive "at a speed which endangers the safety of persons or property."[3] In malpractice litigation, the standard of care likewise governs what a prudent professional would do under actual circumstances.

Thus, the standard of care should not be viewed as an abstract or mysterious concept. Instead, it should be an objectively verifiable fact of "what like people do" in any given situation. Moreover, the case law and author-

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ities are in agreement on this point.[4] Indeed, the prevailing approved jury instruction on standard of care in California states:

> A [specified type of medical practitioner] is negligent if [the defendant] fails to use the level of skill, knowledge, and care in diagnosis and treatment that *other reasonably careful* [specified type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care."[5]

Case law further amplifies that "[t]o be sure, 'professional prudence is defined by actual or accepted practice within a profession, rather than theories about what 'should' have been done."[6]

Because the standard of care—or its synonym, standard of practice—is not a matter of opinion but rather the objectively verifiable fact of what is actually done by practitioners, malpractice litigation should not implicate issues of what practitioners should do as a matter of "better public policy" or, on the other hand, what practitioners "can get away with" as an absolute "scientific" or "medical" minimum. The former is sometimes the plaintiff's argument, and the latter, the defendant's. Nor, to be sure, is it a minimum standard akin to a posted speed limit. Just as the Basic Speed Law may require a driver to maintain a speed well below the posted speed limit, so too the standard of care, when properly understood and applied, may require a professional to perform above and beyond the requirements of a bare scientific necessity.

Irrespective of the desires of well-meaning consumer advocates, malpractice is not a a vehicle to improve quality by retrospective fiat but instead is a legal theory designed to compensate for past negligence. While malpractice actions may lead to improvements in the quality of professional conduct, this is a desirable but incidental outcome of a compensation-for-negligence system.

A professional whose conduct has been called into question is judged against the backdrop of the real-life experience that forms the environment in which the professional practices his or her profession, rather than abstract notions or scientific principles. Since that environment is, by definition, unknown to the lay public, expert testimony is required to inform triers of fact what competent members of the relevant professional community do in their practices. The standard jury instructions—CACI 501 (second paragraph) and BAJI 6.30—make this explicit. Evidence of the defendant practitioner's "state of mind"—whether good or bad—may be interesting to jurors and lawyers, but it has no role to play in classic malpractice litigation except as it may pertain to ancillary causes of action, such as intentional torts. Indeed, "it is no defense to a charge of negligence that [the defendant] did the best he could."[7]

## Expert Testimony

The role of the standard-of-care expert thus is usually twofold: teach the jury the specific community standard governing the case (that is, the standard of care; in the automobile analogy, the jury would be told the speed limit) and then explain how the defendant's conduct did, or did not, depart from (or "fall below") that standard of care. Expert testimony is generally required precisely because this information is outside an ordinary person's knowledge. The uncommon exception to this rule is malpractice within common knowledge,[8] such as a failure to remove a sponge during surgery.[9] Still, in those cases, it may be good practice to have an expert testify to the obvious, since other issues—such as causation or assigning blame among defendants—may be intertwined with assertions of negligence.

CACI 506, which replaced BAJI 6.00.1 as the authoritative definition of standard of care, provides that "a [type of professional] is negligent if [he or she] fails to exercise the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [type of professionals] would possess and use in similar circumstances." This jury instruction is phrased in neutral, present-tense terms and does not invite the jury to make policy decisions or judge the wisdom of the present system; instead, it strictly instructs the jury to find, as a matter of fact, what "reasonably careful" practitioners do.

The standard of care (or practice) is thus a term of art that defines a threshold below which the defendant professional is deemed to be negligent.[10] Unless the expert affirmatively demonstrates an understanding that the term is a "community standard," the expert is likely to provide legally meaningless or misleading opinions that can only confuse the jury and the issues. This type of testimony would be a realization of the adage "garbage in, garbage out."

In fact, the term "standard of care" is so misunderstood and so loosely applied, it would be better and more precisely identified to the jury as the "custom of the community" or "community standard." When an expert is questioned about standard of care, the expert must first demonstrate an understanding of the concept and then be able to explain it in a manner consistent with the jury instructions. Any other testimony or opinions—whether they explicate good faith, motives, or policy concerns—should be precluded as irrelevant and affirmatively misleading.

It is not surprising that the defense and plaintiff bars often misapply the standard of practice. Naturally, their misapplications differ according to their opposing objectives. Using the testimony of their expert witnesses, defense attorneys sometimes argue that the standard of care should be judged by a minimum threshold, which in practice would equate to what a practitioner "can get away with." This approach is designed to lower the standard of care and bring the questioned conduct of the practitioner within the community standard. However, this approach is simply not consistent with the established objective legal standard.

For example, a defense expert may be critical of a plaintiff expert's higher standard of practice as constituting "defensive medicine"—practicing medicine in fear of being sued for malpractice. In fact, however, the relevant community is aware of the potential of being sued. Thus, this argument, while it has a certain political and logical appeal, is wrongheaded. A relevant professional community's concerns about claims reduction is as much a part of the community standard as the existence of insurance coverage, or the practitioner's pride in being a good doctor. What doctor, for example, would simply announce, without protest, to a patient that his or her insurer had denied coverage for a possibly important test because of concerns that the test was statistically not cost-effective?

The defense expert may choose to engage in a subjective, misleading, and irrelevant discussion of "what you can get away with" instead of "this is what practitioners really do." This type of testimony is commonly offered in a conclusory fashion, without any discussion of why "what you can get away with" is purported to be the standard of care. By testifying in this fashion, the defense expert erroneously assumes the standard encompasses the lowest common denominator and ignores real-life considerations. Indeed, it is not uncommon for these defense experts to testify that they "would never personally practice [in the same way as the defendant]"—as if the defendant doctor were permitted to act at a lower standard.

This testimony also may be characterized by speculative, indeed dismissive, assumptions that the standard of care provided in other settings—whether in minority communities, public or charity hospitals, a teaching or nonteaching facility, or HMOs—is lower than the expert's own practice community. Such assumptions are and should be exposed as legally erroneous and repugnant to core American values. It would undoubtedly shock providers in those other settings to know that their colleagues assume that they provide an inferior level of care. Obviously, no provider, insurer, or HMO holds itself out as being permitted to provide

negligent care because it is cheaper, or because the doctor's practice setting is different than others. Less expensive care does not justify negligence or inferior care.

In contrast, plaintiffs' counsel may argue what the standard of care "should be"—an idealized, perfect-world level of care, retrospectively discovered by the plaintiffs' bar. In this erroneous approach, plaintiffs' counsel serves as some sort of modern white knight, bent on using the legal system to fix the medical system. But what really matters is what was being done by competent and similarly situated practitioners at the relevant time. This general rule has been definitively set forth in a series of cases involving blood banks, in which the plaintiffs unsuccessfully argued the community standard itself was, in retrospect, inadequate, allowing infectious diseases to spread to innocent victims.[11] This is the difference between litigation-for-compensation (permitted) and using litigation to alter community standards (not permitted).

Consider, for example, a scenario that reflects the divergent positions of the defense and plaintiffs' bar. An HMO patient dies while waiting two weeks for a critical but expensive test that, in retrospect, would have diagnosed a life-threatening cardiac condition. The defense asserts the standard of care did not require that the test be done on an urgent basis. The plaintiff's cardiology expert independently surveys his professional colleagues and asks, "Assuming that you had a patient with this presentation, how long *could* you wait to get this test done?" The answers range from one to two weeks. Plaintiff's counsel subsequently restates the question as, "Assuming that you had a patient with this presentation, how long would a competent cardiologist in this community wait to do the test?" The doctors uniformly reply that the test should have been done no later than the next day.

The cardiologist's phrasing ("could") involves a scientific, risk-benefit analysis that is not based in actual practice. Essentially, his question seeks to ascertain when the risk of sudden but avoidable cardiac death became so statistically significant that it would rise to a high level of concern to the answering cardiologist. The expert's question has no necessary relationship with the real world and is an attempt to practice medicine in a vacuum. In fact, the answer called for by the expert's question is totally subjective, relating solely to the answerer's—and not necessarily a patient's or the community's—level of risk tolerance.

The attorney's question ("would"), however, is framed in real-life experience and the objective context of a community standard. The lawyer's question subsumes nonmedical but important considerations that are the daily components of the practice of medicine (and, by analogy, other professions as well). In the medical context, these would include, for example, 1) the lack of benefit in delay, 2) the patient's convenience, 3) the interim management of the patient's potentially fatal stress, 4) the availability of the testing equipment in the community, 5) insurance coverage, 6) a doctor's internalized desire to advocate for his or her patients, 7) the decision to maintain a reputation among colleagues as a "good doctor," 8) a doctor's aim to promote his or her practice by demonstrating a caring approach for the patient's needs, 9) the aspiration to be a good doctor, 10) the doctor's and/or the patient's risk-benefit analysis, based on their respective tolerance of risk, and 11) concern that delay would lead to a statistically certain but totally avoidable risk of disability or even death and, in that unhappy event, a medical malpractice claim.

This approach is how doctors are taught to practice medicine. No professional is taught to practice by the "what you can get away with" test. They are taught to practice with a sense of pride in an environment in which their patients have a right to demand more. Indeed, the standard of practice may involve factors not related to "science" or "necessity" or other factors that lawyers, jurors, and judges may assume are important.

Thus, the assumption that the standard of practice is directly tied to the avoidance of a bad outcome is wrong. Professionals commonly act out of concern for patients or clients, for professional and personal pride, and even for competitive reasons—not solely out of bare necessity. These factors can establish the standard of care, even if the connection between competition-driven behavior and the injury in question seems tenuous.

Consider an example from the legal malpractice arena. A lawyer accepts a case and properly calendars it for filing. On the very last day, as is the lawyer's established practice—a practice that has worked well for decades—the lawyer hands the package of filing materials to a courthouse messenger. Unfortunately, on the way to the courthouse, the messenger is involved in a no-fault accident and is unable to complete the task. Since the standard is negligence, and not a guarantee of success, is the lawyer guilty of malpractice? The answer reflects attitudes toward the practice of law. Although a lawyer can usually "get away with" waiting to the last minute to complete a task, is that the appropriate conduct of a competent lawyer in the community?

The motivation of competent lawyers is not merely the timely filing of lawsuits; the motivation may well be to avoid sleepless nights, to bring positive results to partners, or to achieve good client relations. The stress-reducing motivation may not appear, at first blush, to be relevant to the standard of care, but it is useful to explain to the jury why one expert's opinion is more credible than that of his or her opponent. Motivation is not itself decisive, but it may be offered to substantiate the credibility of the conflicting testimony. In evaluating conflicting expert testimonies, the jury is entitled to consider facts that demonstrate that the opposing expert's opinions are based on an unrealistic—and thus false—view of how similarly situated people actually operate in a complex environment. The professional community's concerns over practice management, malpractice avoidance, stress reduction, and the like all factor into the community standard.

It is thus critical to frame standard-of-care questions to any expert, or prospective expert, in community terms. Similarly, the expert must understand this context in order to respond appropriately to cross-examination. Unless someone has formally surveyed the relevant group of doctors and obtained their honest answers to the precise questions at issue, or the specialty has published specific practice guidelines, testimony regarding the

In evaluating conflicting expert testimonies, the jury is entitled to consider facts that demonstrate that the opposing expert's opinions are based on an unrealistic—and thus false—view of how similarly situated people actually operate in a complex environment.

# MCLE Test No. 186

**The Los Angeles County Bar Association certifies that this activity has been approved for Minimum Continuing Legal Education credit by the State Bar of California in the amount of 1 hour.**

**1.** The standard of care in medical malpractice litigation is determined by subjective criteria.
True.
False.

**2.** The "reasonable person" standard is irrelevant in determining the standard of care.
True.
False.

**3.** The standard of care is defined in CACI 506.
True.
False.

**4.** The standard of care is strictly a matter of weighing the conflicting experts' opinions as to what they think is done by competent practitioners.
True.
False.

**5.** The standard of care is used to determine the "better" public policy and thus improve public safety.
True.
False.

**6.** Expert opinion is required to inform the jury on the standard of care solely because it is not a matter of common knowledge.
True.
False.

**7.** Evidence that the defendant did the best he or she could do is a defense to malpractice.
True.
False.

**8.** The meaning of the term "standard of care" is defined by the community of practitioners at issue.
True.
False.

**9.** The standard of care is measured by what a practitioner can usually get away with.
True.
False.

**10.** Juries should be instructed that a plaintiff may not use the existence of the practice of "defensive medicine" to prove malpractice.
True.
False.

**11.** Settings such as charity hospitals and HMOs can be held to a lower standard of care because they are frequently underfunded or known to be more cost-effective.
True.
False.

**12.** Courts have permitted parties to use malpractice litigation to establish a new and better standard of care.
True.
False.

**13.** The determination of the standard of care in medical malpractice cases includes nonmedical considerations such as insurance coverage and doctors' concerns about their own standing in the community.
True.
False.

**14.** The jury is entitled to consider experts' testimony regarding external factors that affect how those in the applicable community of practitioners actually function.
True.
False.

**15.** Geography is usually a highly relevant factor in the determination of the standard of care.
True.
False.

**16.** The community is measured solely by the defendant's own area of recognized expertise, as determined by factors such as board certification.
True.
False.

**17.** Only one standard of care is applicable to a defendant in a malpractice case.
True.
False.

**18.** Cosmetic surgery is an AMA-recognized area of medical specialty.
True.
False.

**19.** If a defendant negligently fails to refer the plaintiff to a specialist, the defendant is held to the standard of care for that specialty.
True.
False.

**20.** In presenting their medical malpractice cases, plaintiffs should ignore the external factors that affect the actual community standard.
True.
False.

## MCLE Answer Sheet #186

**OPERATING ROOM**

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| | | |
|---|---|---|
| 1. | ☐ True | ☐ False |
| 2. | ☐ True | ☐ False |
| 3. | ☐ True | ☐ False |
| 4. | ☐ True | ☐ False |
| 5. | ☐ True | ☐ False |
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| 8. | ☐ True | ☐ False |
| 9. | ☐ True | ☐ False |
| 10. | ☐ True | ☐ False |
| 11. | ☐ True | ☐ False |
| 12. | ☐ True | ☐ False |
| 13. | ☐ True | ☐ False |
| 14. | ☐ True | ☐ False |
| 15. | ☐ True | ☐ False |
| 16. | ☐ True | ☐ False |
| 17. | ☐ True | ☐ False |
| 18. | ☐ True | ☐ False |
| 19. | ☐ True | ☐ False |
| 20. | ☐ True | ☐ False |

standard of care is, and always will be, subject to conscious, or unconscious, manipulation, usually to suit the needs of the hiring lawyer who has arrived with check in hand. Indeed, testimony as to the fact of a community standard, even in the most obvious case, is subject to deliberate perjury.

Every medical malpractice lawyer has stories of bizarre standard-of-practice testimony from the other side's expert. Board-certified specialists have testified successfully to the absence of a standard of practice for something as common as an uncomplicated broken leg. This is an unavoidable consequence of allowing—indeed requiring—expert witnesses to testify as to what other competent practitioners in the community do in the privacy of their own offices in response to very specific fact patterns.[12] Nonetheless, the courts invariably permit such testimony on the assumption that such knowledge is gleaned, apparently by some sort of professional osmosis, by practice within the relevant community.[13] This is a convenient fiction: the issues in malpractice cases are usually very fact-specific and rarely appear in some universally accepted practice guide.

## Defining the Community

Defining the relevant professional community is an essential task. It is well established that the initial focus in a malpractice action is on the challenged conduct and the defendant's representations, not the defendant's specialty. The community is no longer generally related to geography.[14]

In some cases the medical procedure at issue can be performed by multiple medical specialists. For example, many physicians are commonly involved in primary care or general care, including internists, family practitioners, gynecologists, pediatricians, and others. Virtually all of these specialists will provide ongoing nonspecialty care to their regular patients. Thus, even though their specialties may be different, the assumption by doctors of a specific medical responsibility is what counts. Ultimately, and subject to CACI 506 (the multiple acceptable modalities rule), only one standard of practice is applicable. Thus, for example, a family practitioner—whose specialty necessarily overlaps with a number of other specialties—may be qualified to testify regarding the actions of a host of other specialists. In cases involving a procedure performed by radically different professionals, the same concept may still apply. Foot surgery, for example, is commonly performed by podiatrists but is also done by orthopedists—some of whom may be well trained for the procedure (such as foot-and-ankle specialists), and some not (general orthopedists).

Moreover, more than one standard of care may be applicable to the same defendant in a single case. Practitioners trying these cases must be particularly precise in their presentations to the trier of fact. The textbook example involves the claim of a negligent failure to refer a patient to a specialist, as defined by CACI 508. The plaintiff must offer expert testimony that the standard of care required the nonspecialist to refer the patient to a specific type of specialist and that the standard of care for that type of specialist would have required specific conduct.

Geography can sometimes be a factor in the standard of care. Historically, especially in medical malpractice cases, an assumption existed that "the community" corresponded to a particular geographical area. This view is largely archaic.[15] CACI 501, which expresses the standard of care in terms of "same or similar circumstances," does not mention location.[16] Moreover, "[g]eographical location may be a factor considered in making that determination, but, by itself, does not provide a practical basis for measuring similar circumstances."[17] In fact, one court accepted, in opposition to a motion for summary judgment, the opinions of an Israeli orthopedist regarding the relevant standard of care in the United States.[18]

Still, locality may be important in the relatively rare circumstance of a true emergency—for example, in a rural setting where there is simply no time to transport the patient to a better equipped facility.[19] In fact, in that example the "community" is not a geographical construct but rather a community of like practitioners—people who do what the defendant does. This definition of "community" involves several factors, such as licensure; the availability of local emergency services; the defendant's representations, express or implicit,[20] of qualifications (for example, the concept of "holding out");[21] specialization; and the duty to refer.

A common contemporary example of a doctor "holding out" his or her qualifications is that of the now ubiquitous "cosmetic surgeon." Organized medicine has no such specialty. An established specialty of plastic surgery, requiring many years of formal training, exists, but "cosmetic surgery" may be little more than an advertising device to entice patients confused by the difference between cosmetic surgery and plastic surgery. Some cosmetic surgeons—who may have little or no specialty training—may even claim board certification, although the boards to which they refer are not affiliated with the American Medical Association[22] and may be the medical equivalent of diploma mills. Still, if a patient is willing to undergo a procedure by one of these physicians, the patient is entitled to assume that the surgeon has appropriate credentials and can sue for fraud if something goes wrong due to lack of training or experience.

In fact, the duty to refer essentially changes "the community" from one for nonspecialists to one for the appropriate specialist.[23] Assuming the presence of expert opinion that the defendant should have referred the patient or client to a specialist, the jury—if it finds that the failure to refer constitutes negligence—is required to hold the defendant to the standard of care of the specialist.[24]

Finally, it is important to recognize that a defendant cannot lower his or her own standard of practice. This is sometimes argued by lawyers representing federal institutions (for example, the Veterans Administration), county (or charity) hospitals or providers, and some HMOs. Essentially, the argument is that the defendant can define his or her own (lower) standard of care without reference to the legally required community standard. This is allegedly justified by the defendant's internal efforts to economize or, in the case of publicly supported facilities, lack of public funding. Of course, if a defendant facility is able to define its own standard of care, that defendant, almost by definition, must prevail in all cases. This argument has no support in law, common sense, or public perceptions. It is unimaginable that any facility would advertise its services as inferior or that its own staff would admit to a lesser standard.

Attorneys trying a malpractice action must be able to convey to their experts, the court, and ultimately, the trier of fact that the standard of care is the functional equivalent of the community standard—that is, what is actually done in the relevant professional community, considering all of the relevant factors, even those that do not directly implicate the scientific basis for the profession. The focus should be exclusively on objective compliance with relevant community standards. Any expert testimony or argument that ignores factors or issues involving what is actually done in the community should be viewed with deep distrust. ■

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[1] The rules that are applicable in defining "standard of care" in medical malpractice cases are the same for any form of professional negligence. Similarly, the same legal standard applies to specialists, with the conduct of specialists determined by the relevant community of specialists. *See*, *e.g.*, Flowers v. Torrance Mem'l Hosp. Med. Ctr., 8 Cal. 4th 992, 997-98 (1994).

[2] *Id.*

[3] VEH. CODE §22350.

[4] *See* CACI 501 (new version of BAJI 6.00.1) and cases cited therein.

[5] *Id.* (emphasis added).

[6] Hanson v. Grode, 76 Cal. App. 4th 601, 607 (1999).

[7] Rainer v. Buena Cmty. Mem'l Hosp., 18 Cal. App. 3d 240, 260 n.22 (1971) (instruction approved).

[8] The general rule is stated in Evidence Code §801(b). *See also* Flowers v. Torrance Mem'l Hosp. Med. Ctr., 8 Cal. 4th 992, 1001 (1994); Curtis v. Santa Clara Valley Med. Ctr., 110 Cal. App. 4th 796 (2003). For

the common knowledge exception, *see* Gannon v. Elliot, 19 Cal. App. 4th 1, 6 (1993).

[9] Ales v. Ryan, 8 Cal. 2d 82, 93 (1936).

[10] The terminology is somewhat confusing: a practitioner who is negligent is said to be "acting below the standard of care," as if it were a demarcation line. A practitioner who is not negligent is said to be "acting within the standard of care."

[11] N.N.V. v. American Ass'n of Blood Banks, 75 Cal. App. 4th 1358 (1999) ("Allowing an expert to second-guess the profession results in the standard of care being established by the lay opinion of the jury; i.e., the jury substitutes its opinion of what the standard of care should have been for what the standard of care was as established by the medical profession. Existing law holds the applicable standard of care should not be '"evaluated by the ad hoc judgments of a lay judge or lay jurors aided by hindsight."'"); Spann v. Irwin Mem'l, 34 Cal. App. 4th 644 (1995); Osborn v. Irwin Mem'l Blood Bank, 5 Cal. App. 4th 234 (1992).

[12] Some experts attempt to overcome their lack of knowledge of the actual practices of other practitioners by informal surveys of their colleagues. Experts who at least attempt to objectify the process by formally surveying the relevant community are perhaps so honest that they essentially disqualify themselves as standard-of-care experts (*see* Korshak v. Atlas Hotels, Inc., 2 Cal. App. 4th 1516, 1525 (1992))—leaving much of the field to rogues and professional experts. This is why most experienced experts claim to rely upon the usual boilerplate and frequently cynical mantra of "training, background, and experience."

[13] This assumption is commonly false since most practitioners, especially doctors, tend to practice mostly in the privacy of their offices.

[14] *See*, *e.g.*, Avivi v. Centro Medico Urgente Med. Ctr., 159 Cal. App. 4th 463 (2008). The court of appeal held that the trial court had erred in rejecting expert testimony on the standard of practice from an Israeli orthopedist. *See also* text, *infra*.

[15] Rainer v. Buena Cmty. Mem'l Hosp., 18 Cal. App. 3d 240, 259 (1971).

[16] Avivi, 159 Cal. App. 4th at 470.

[17] *Id*.

[18] *Id*.

[19] The concept of facilities specifically includes higher-end diagnostic or treatment equipment—but not staff. It is almost impossible to imagine any emergency case in which a rural physician could not call an appropriate specialist for an emergency consultation.

[20] The defendant, by accepting the assignment, presumably has at least implicitly represented himself or herself as qualified for the task. A defendant who falsely represents his or her qualifications may be guilty of fraud in inducing the patient or client to use the defendant's services.

[21] For example, several types of physicians—including generalists, specialists (orthopedists), and subspecialists (foot-and-ankle orthopedists)—and podiatrists may treat foot conditions. In a case against a podiatrist, it may be necessary to determine whether the relevant community is podiatrists or "foot doctors." While, presumably, the standard of care for podiatrists in some contexts may be lower than, for example, foot-and-ankle orthopedists, it is doubtful that any podiatrist would admit to having a lower standard of practice than a foot-oriented physician.

[22] *See* http://abms.org/About_ABMS/member_boards.aspx.

[23] The belief that a generalist who negligently fails to refer is automatically at fault is thus in error. A negligent failure to refer merely shifts the community and, by definition, is only the first part of a two-step proof of standard of care.

[24] *See* CACI 508 (medical); CACI 604 and CAL. RULES OF PROF'L CONDUCT R. 3-110(C) (legal).