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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA  
THIRD APPELLATE DISTRICT

(Sutter)

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JAVIER BEDOLLA-REYES,

Plaintiff and Appellant,

v.

GARRY T. VALLIER,

Defendant and Respondent.

C067211

(Super. Ct. No. CVCS081264)

Plaintiff Javier Bedolla-Reyes appeals from a judgment entered in favor of defendant Garry T. Vallier, M.D., in a medical malpractice action. Bedolla-Reyes asserts that the trial court prejudicially erred by declining his request to instruct the jury with Judicial Council of California Civil Jury Instruction (CACI) No. 405 on comparative fault. We disagree and affirm the judgment.

As we explain, the trial court appropriately declined to give the requested instruction because Dr. Vallier did not claim any negligence on the part of Bedolla-Reyes contributed to his harm. We also conclude that any error was harmless because the jury found in favor of Dr. Vallier on the basis of causation. Thus, we can reverse only if there

is a reasonable probability that, had the jury been instructed that it could reduce Bedolla-Reyes's damages by the percentage of fault attributable to him, this would have changed its finding as to whether Dr. Vallier's negligence was a substantial factor in causing the harm in the first place. The jury was properly instructed on causation. We must presume it followed these instructions and find no reasonable probability of a different result absent the asserted error.

### BACKGROUND

On May 27, 2007, Bedolla-Reyes lived and worked at Micheli Farms in Live Oak, a small agricultural community north of Yuba City. He was allowed to keep his two horses on the property. While loading one of the horses onto a trailer, Bedolla-Reyes stepped into a hole and broke his lower leg. Both the tibia and fibula were fractured. Two friends took him to Rideout Memorial Hospital in Marysville, where he was seen by Dr. Vallier, a board certified orthopedic surgeon. Bedolla-Reyes had diabetes, a condition that often leads to problems with wound healing following surgery.

#### *Treatment by Dr. Vallier*

Dr. Vallier performed surgery on Bedolla-Reyes shortly after his admission to the hospital. As Dr. Vallier explained the procedure, the tibia fracture required the placement of an "intramedullary nail" into the center of the bone with "upper and lower interlocking screws." The fibula fracture did not require surgical repair. Surgery on the tibia took 52 minutes. Dr. Vallier used a tourniquet during the surgery to keep the "incision area free of blood which would obscure [his] view" of the procedure. Prior to inserting the intramedullary nail into the center of the tibia, Dr. Vallier used a "reamer" to clear a path for the nail. The nail used was 12 millimeters in diameter. Dr. Vallier then placed two interlocking screws at the top and bottom of the tibia to support the nail. These screws went through one side of the bone, the nail, and the other side of the bone. Dr. Vallier

noted that the upper screw “had really good bicortical purchase,” meaning that it was firmly planted in both sides of the bone, while the lower screw had “moderate purchase.” Dr. Vallier was “satisfied with all aspects of [the] surgery.”

The following day, Bedolla-Reyes was discharged from the hospital with a splint on the back of the calf. He was instructed to stay off his feet as much as possible, to use crutches for walking, and to place no more weight on the injured leg than touching the toe to the ground. As Bedolla-Reyes did not speak English, someone at the hospital gave him the instructions in Spanish.

On June 4, 2007, Bedolla-Reyes returned for a postoperative appointment. He was driven to this appointment by Aaron Bermudez, an acquaintance who also acted as interpreter during the visit. Dr. Vallier noted that the leg was “not very swollen” and the wound appeared to be “healing well.” Dr. Vallier believed that Bedolla-Reyes was following his postoperative instructions and decided to remove the splint and allow him to “progress with the weigh-bearing process.” Dr. Vallier noted in Bedolla-Reyes’s treatment plan: “He may begin advancing his weight-bearing as tolerated, and when he gets comfortable enough he can switch to a single crutch, then a cane. I expect that [he] probably will not get to that point before the next visit which will be four weeks from now at which point we will obtain an x-ray, AP and lateral of the right tibia.” According to Dr. Vallier, he instructed Bedolla-Reyes during the appointment that “these fractures take months to heal,” the first step in the weight-bearing process was “toe-touch weight-bearing,” and subsequent steps would be dictated by his body’s feedback, “specifically pain, if it hurts, back off.” Dr. Vallier testified that he expected Bedolla-Reyes would still be using two crutches the next time he came in for an appointment, but that he would be comfortably putting some weight on his injured leg by then.

According to Bedolla-Reyes and Bermudez, Dr. Vallier gave very different instructions. Bedolla-Reyes testified that Dr. Vallier told him to “just start walking” and to “leave the crutches and go swimming.” Bermudez testified that Dr. Vallier told Bedolla-Reyes: “[Y]ou don’t need the crutches anymore, you supposed to, you know, I expected you would be walking by now, and [Bedolla-Reyes], you know, [Bedolla-Reyes] told me to tell him like, you know, his feet still hurt, and the doctor said you don’t need the crutches no more, you know, you need to start, you know, exercise your feet to put some weight, to put some weight on your feet, and even the doctor he mentioned, hey, you ready, you know, you’re okay, you want to go swimming, you can go swimming, you got swimming pool in your house, he said no, you know, I expected you to be already, you know, walking already.” According to Bedolla-Reyes, he “started laughing” because he thought it was a joke. Dr. Vallier responded: “I’m serious, leave the crutches and start walking.”

Bedolla-Reyes’s testimony conflicted regarding whether he followed Dr. Vallier’s purported advice to start walking on his injured leg. On direct examination, he testified that he used the crutches when he left the appointment because he was “scared” and “just didn’t feel secure for [his] foot yet.” Bermudez then took him to a store, where he used a shopping cart for support. Bedolla-Reyes then testified that he no longer used the crutches when he got home, but was “cautious” about putting weight on his injured leg. During the next few days, most of his time was spent resting his leg. But he did walk a short distance on occasion, “from [his] room to the car [to] go eat and come back home.” One night, his foot began to hurt. When he got out of bed the following morning, he saw that “it was crooked.” On cross-examination, Bedolla-Reyes changed his testimony concerning whether he used the crutches, stating that he “was holding onto one because [he] didn’t feel too secure.” He then said that he “had to use them, and even both of

them.” Bedolla-Reyes also testified that he “was really careful” not to put any weight on his injured leg when he went out to get food because he “didn’t feel secure.”

On June 12, 2007, the day Bedolla-Reyes noticed that his foot was crooked, he called Dr. Vallier’s office and was told to come in immediately. Dr. Vallier did not see Bedolla-Reyes that day, but his assistant took x-rays of the leg after Bedolla-Reyes reported increased pain and a “crunching in his ankle” over “the last three or four days.” The x-rays revealed that the intramedullary nail was “still centered nicely within the bone,” but the lower part of the tibia had “moved upwards a bit which then allowed the tip of the [nail] to poke through . . . the lower end of the tibia” and into the ankle joint. There was also a new fracture of the fibula. Dr. Vallier scheduled surgery for the following week. His plan was to attempt to repair the existing fixation, but he realized that he might need to replace the nail with a plate, which had to be ordered. The hospital also required prior authorization from Medi-Cal before Bedolla-Reyes could be admitted for surgery. The preoperative report written by Dr. Vallier noted the cause of the fixation failure as “walking on it against directions.”

On June 18, 2007, Dr. Vallier replaced the intramedullary nail and interlocking screws with a plate and screws. He also used a plate and screws to fix the fibula fracture. This surgery took 137 minutes. Dr. Vallier used a tourniquet during the surgery because this procedure usually involved “much more blood loss than the previous surgery.” Indeed, according to Dr. Vallier, he had problems controlling the bleeding despite use of the tourniquet. Because of this, the tourniquet had to be removed and reapplied during the procedure. Bedolla-Reyes also became hypotensive during the surgery, which Dr. Vallier attributed to blood loss. He was given two units of blood during the surgery and an additional two units during recovery.

Bedolla-Reyes remained in the hospital for four or five days. Following his discharge, he returned for a postoperative appointment on June 25, 2007. At that point, the wounds were clean and dry, except the longer incision Dr. Vallier made to insert the plating was still moist in the center. He did not remove the nylon sutures because this incision “had been closed under some tension” due to the fact that there was not much tissue between the skin and plate used to cover the tibia fracture. On July 5, 2007, Bedolla-Reyes returned to have the sutures removed. When Dr. Vallier did so, “the wound opened up at the center,” revealing the plate underneath. Bedolla-Reyes was again admitted to the hospital and evaluated by wound care nurses. Because the “skin edges were still pink” and did not appear to be dead, Dr. Vallier and the nurses decided that putting on a wound vacuum (wound vac) would be appropriate. He was also given intravenous antibiotics. After the second change of the wound vac, the nurses contacted Dr. Vallier and informed him that the wound edges were “turning black,” indicating that the tissue was dead. Either that day or the following day, on July 11, 2007, Dr. Vallier took Bedolla-Reyes back to surgery and removed the dead tissue. Bedolla-Reyes remained at the hospital receiving wound care until July 20, 2007.

At the time Bedolla-Reyes was discharged, Dr. Vallier noted that he would require a “muscle flap for coverage” of the wound, a procedure that involves taking vascular tissue from another area of the body, using this tissue to cover the wound, and then performing a skin graft over the tissue. Dr. Vallier was not capable of performing such a surgery and began making arrangements for Bedolla-Reyes to see a plastic surgeon at a University of California at Davis facility (UC Davis). A tentative appointment was scheduled for August 4, 2007. Bedolla-Reyes was not evaluated by the plastic surgeon at UC Davis until November 13, 2007. Apparently, UC Davis was not able to admit Bedolla-Reyes until his Medi-Cal application was approved, which was delayed because

of a problem verifying his immigration status. In the meantime, home health nurses visited Bedolla-Reyes at his home three days a week to care for his wound. Bedolla-Reyes also continued to be seen by Dr. Vallier. According to Dr. Vallier, getting Bedolla-Reyes into UC Davis was not an emergency because the “fracture was stable” and the wound “had the wound vac on there which is state of the art for this kind of wound short of surgery.” Dr. Vallier also testified that he expanded his effort to find a qualified microvascular surgeon to perform the needed surgery, but ran into similar problems getting him admitted elsewhere.

#### *Treatment at UC Davis Medical Center*

As mentioned, Bedolla-Reyes was evaluated by the plastic surgeon at UC Davis on November 13, 2007. On November 20, 2007, he was admitted to the hospital and seen by an orthopedic surgeon, Phillip Wolinsky, M.D. At this point, Bedolla-Reyes had an infection in the bone. The following day, Dr. Wolinsky performed an “irrigation debridement,” in which he removed dead skin, soft tissue, and six to eight centimeters of bone. He also removed the hardware installed by Dr. Vallier, cleaned out the center of Bedolla-Reyes’s tibia, and then “put in some bone cement” with “high local concentrations of antibiotics.” The same procedure was performed again on November 24, 2007. On November 28, 2007, Dr. Wolinsky replaced the plate on the tibia. Two days later, the plastic surgeons covered the wound with muscle from Bedolla-Reyes’s abdominal wall and performed a skin graft over the top of the muscle. Bedolla-Reyes was discharged on December 18, 2007.

On May 30, 2008, Dr. Wolinsky performed a bone graft surgery. While this procedure could have been done two to three months following the muscle flap transfer, it too was delayed because of “insurance issues.” On December 3, 2009, Bedolla-Reyes had a spontaneous recurrence of the bone infection. Because the fracture had completely

healed by then, Dr. Wolinsky removed the hardware for a final time and treated the infection. Bedolla-Reyes will always be at risk for recurrence of this infection.

### *The Lawsuit*

On May 23, 2008, Bedolla-Reyes sued Dr. Vallier for medical malpractice. The case went to trial in November 2010. The trial involved a battle of experts, Hugh Selznick, M.D., on behalf of Bedolla-Reyes and Thomas Sampson, M.D., on behalf of Dr. Vallier.

Dr. Selznick testified that Dr. Vallier's treatment of Bedolla-Reyes fell below the standard of care in nine respects, each of which added up to "the perfect storm." The first two alleged breaches occurred during the initial surgery. First, Dr. Selznick testified that Dr. Vallier's use of a tourniquet in performing this surgery fell below the standard of care, "especially in a diabetic with calcified [blood] vessels," because "[w]hen one puts a nail down you have to . . . machine out the inside of the tibia with reamers to accept a nail of a certain diameter. In this particular case the nail was a 12-millimeter nail. That means Dr. Vallier reamed up to 13 millimeters to put that nail down. That's okay, but reaming is known to cause heat just like a drill bit going through a 2 by 4 it gets hot. With [the use of a] tourniquet there's no blood going into the leg. Without blood there's tremendous heat generated and bone can die. It's a known entity to have thermal necrosis after reaming, and the literature bears that out." Second, according to Dr. Selznick, Dr. Vallier breached the standard of care by using a screw on the lower end of the tibia that was "not long enough, small criticism, but it did not have purchase of both cortices."

The third alleged breach occurred following the surgery while Bedolla-Reyes was in the recovery room. Dr. Vallier ordered a set of x-rays to be taken, but either neglected to review the films or failed to appreciate two new fractures, specifically, "an obvious injury to the distal fibula, to the lateral malleolus," and "an injury to the posterior

malleolus, the plethron of the distal tibia.” According to Dr. Selznick, these injuries amounted to “a new fracture of the ankle” that “may have been there and not on the original injury films, but it’s definitely there in [the] recovery room after the nailing procedure.” Fourth, Dr. Selznick opined that Dr. Vallier should have ordered a new set of x-rays during the first postoperative appointment, but failed to do so. According to Dr. Selznick, had Dr. Vallier ordered a new set of x-rays, he similarly would have seen the new fractures.

The fifth alleged breach involved Dr. Vallier’s instructions to Bedolla-Reyes during this postoperative appointment. Dr. Selznick testified that had Dr. Vallier appreciated the new fractures noted above, he “would have made [Bedolla-Reyes] protected weight-bearing. He would not have said, and I quote, ‘Patient may begin advancing his weight-bearing as tolerated.’” Dr. Selznick explained the importance of recognizing the new fractures, particularly the posterior malleolar fracture, in the following terms: “The best way to make an analogy, if you have a rotten floorboard and you step down on it your foot could break through because it lacks structural integrity. There had to be a structural issue, there was a fracture there, that’s the rotten floorboard, and the rod went through, and this is definitely the original posterior malleolar fracture that we saw on that postoperative film in the recovery room. That’s where the rod fell through. These nails, these rods, . . . something has to mess up the integrity of the end of your tibia for that rod to go through.” Dr. Selznick further testified that had the fracture of the posterior malleolus not been there, “normal walking or weight-bearing is not enough force to put the rod through the tibia.”

The sixth alleged breach involved the fact that Dr. Vallier waited almost a week before performing surgery to address the fixation failure. According to Dr. Selznick, this fell below the standard of care because the longer the delay in fixing the problem, the

more likely the “bone spike under the skin” would lead to skin problems, which occurred. Seventh, Dr. Selznick testified that using a tourniquet during the second operation also breached the standard of care. While this procedure did not involve reaming the bone, the standard of care required that a tourniquet be used for no more than 120 minutes. The operation lasted 137 minutes, during which a tourniquet was used. As Dr. Selznick explained: “If I’m not done with an operation and I hit 120 minutes of tourniquet time, you release the tourniquet, you let the leg get blood supply, you wait a few minutes, and then you reinflate the tourniquet and proceed with the surgery. That’s the standard of care.”

Eighth, Dr. Selznick testified that when Bedolla-Reyes returned on July 5, 2007, “with a wound problem and with necrosis,” Dr. Vallier should not have waited six days to “irrigate and debride the wound.” Dr. Selznick described this delay as “inappropriate wound management.” Finally, Dr. Selznick faulted Dr. Vallier for the delay in getting Bedolla-Reyes admitted to UC Davis, which “play[ed] a distinct role in prolonging [his] convalescence and treatment.” Dr. Selznick opined: “The most important thing is there’s obviously social economic obstacles, that’s why he didn’t get him in August 4th as Dr. Vallier dictated in his discharge summary, but you’ve got to see this patient weekly almost, you’ve got an open wound, exposed plate and try your best to do whatever you can to try to get ultimate treatment and then document things.”

As mentioned, Dr. Sampson testified on behalf of Dr. Vallier and disputed each of the alleged breaches chronicled by Dr. Selznick. First, he disagreed that using a tourniquet during the initial surgery violated the standard of care. Nor did he believe that the amount of heat generated by the reamer would be sufficient to cause thermal necrosis. On this point, Dr. Wolinsky, who performed the subsequent orthopedic surgeries at UC Davis, testified that he did not diagnose Bedolla-Reyes as having any signs of thermal

necrosis. Second, Dr. Sampson testified that the screw placed in the lower portion of the tibia was long enough to achieve bicortical purchase and that Dr. Vallier's placement of that screw did not fall below the standard of care. On this point, Dr. Vallier also testified that the film Dr. Selznick used to show the jury the screw was too short was an image taken during surgery with intraoperative fluoroscopy. According to Dr. Vallier, as confirmed by subsequent intraoperative films, he realized this screw was too short during the operation and replaced it with a longer screw that engaged both cortices.

Third, Dr. Sampson agreed with Dr. Selznick that the postoperative films showed a "distal fibula fracture," but disagreed that they showed a "posterior malleolar fracture." Dr. Sampson testified that the distal fibula fracture was "not significant at all," and would not have altered Dr. Vallier's treatment of Bedolla-Reyes. Nor did Dr. Sampson believe that this fracture contributed to the fixation failure. Instead, according to Dr. Sampson, the fixation failed because "the bone probably failed where the screws were, no longer held. The fracture became unstable. It's a spiral fracture. It's not two ends of the bone, and with that the whole thing just collapsed, and the rod has a sharp tip, it's not really sharp, but it's pointed, and that rod, after the collapse the rod just penetrated right through the top of the tibia. A strong bone it [*sic*] probably wouldn't penetrate through the top of the bone, but I think [Bedolla-Reyes's] bone is not that strong, especially in that area." With respect to what caused the bone to fail at the screw points, Dr. Sampson testified that "you don't know exactly how these things happen," but "[i]t could be from muscle pull, it could be from torquing, it could be from weight-bearing." Dr. Sampson further opined: "It's just part of complications, and you take a patient the way you get them, and, you know, when [Bedolla-Reyes] had his surgery, you can't do a bone density study, even if you did, you'd probably do the same surgery. You just try to fix the fracture and

hope for the best, and most of the time things work out. These are complications that occur, but not that often.”

Fourth, Dr. Sampson testified that the standard of care did not require Dr. Vallier to order additional x-rays during the first postoperative appointment. According to Dr. Sampson, even if Dr. Vallier knew about the distal fibula fracture, the x-rays are required only “if you suspect something’s going on differently than your plan” and the distal fibula fracture would not have altered the plan. Fifth, Dr. Sampson testified that Dr. Vallier did not breach the standard of care by instructing Bedolla-Reyes to begin “advancing his weight-bearing as tolerated.” Dr. Sampson did not believe the distal fibula fracture seen in the postoperative films should have altered these instructions. However, as mentioned, he did not believe the films showed a posterior malleolar fracture.

Sixth, Dr. Sampson testified that Dr. Vallier was not negligent in waiting six days before repairing the fixation failure. Nor did he see the “tenting of the skin” that Dr. Selznick claimed contributed to Bedolla-Reyes’s subsequent skin problems. Seventh, Dr. Sampson testified that, while orthopedic surgeons are taught to keep a tourniquet on for no longer than two hours, “there’s no hard and fast rule, [and] at two hours you could be in a critical part of the surgery and let the tourniquet down and all the bleeding starts. You have to finish the case and be reasonable about it. That’s part of making judgments as a surgeon, so having the tourniquet on for [17] minutes longer, it’s not a big deal.” Moreover, Dr. Vallier did remove the tourniquet during the surgery and replace it because the original tourniquet was not controlling the bleeding. Even with the replacement tourniquet, the “wound still oozed the entire time through the case, so there was still bleeding, even with the tourniquet on, it’s bleeding.” Based on that,

Dr. Sampson concluded that the use of the tourniquet did not compromise blood supply to the legs or cause any of Bedolla-Reyes's subsequent problems.

Eighth, Dr. Sampson testified that Bedolla-Reyes likely developed an open wound at the incision site because of poor circulation and high blood sugar, explaining: "If you have any kind of bacteria around which we all do, we all have bacteria on our skin, all of us in this room, you can't survive without bacteria, but what happens when you have blood sugar that's a little high and you have poor blood supply you don't have the same defense mechanism, so probably all that is why he developed the problem." Dr. Sampson also opined that it was within the standard of care to wait six days before performing the irrigation and debridement of the wound. On this point, contrary to Dr. Selznick's testimony, Dr. Vallier testified that the wound was not necrotic when Bedolla-Reyes was admitted on July 5, 2007. Instead, the wound edges did not begin "turning black" until either the day before or the day of the debridement surgery. Finally, Dr. Sampson did not fault Dr. Vallier for the delay in getting Bedolla-Reyes admitted at UC Davis. Nor did he perceive any deficient care while Bedolla-Reyes waited to be admitted.

The jury found Dr. Vallier to have been negligent in his treatment of Bedolla-Reyes, although the special verdict form used did not specify which of the alleged breaches of the standard of care the jury found to have occurred. Nevertheless, the jury found for Dr. Vallier on the basis of causation. Judgment was entered in favor of Dr. Vallier. Bedolla-Reyes moved for a new trial, which was denied. This appeal followed.

## DISCUSSION

### I

#### *Failure to Instruct on Comparative Fault*

Bedolla-Reyes asserts the trial court erred in denying his request to instruct the jury with CACI No. 405 on comparative fault.<sup>1</sup> We disagree.

#### A.

#### *Comparative Fault Principles*

“Contributory negligence is conduct on the part of the plaintiff which falls below the standard to which he should conform for his own protection, and which is a legally contributing cause cooperating with the negligence of the defendant in bringing about the plaintiff’s harm.” (*Li v. Yellow Cab Co.* (1975) 13 Cal.3d 804, 809 (*Li*), quoting Rest.2d Torts, § 463.) In *Li*, our Supreme Court abandoned the rule that a plaintiff’s contributory negligence “[b]ars recovery from a defendant whose negligent conduct would otherwise make him liable to the plaintiff for the harm sustained by him” in favor of “a rule which assesses liability in proportion to fault.” (*Li, supra*, 13 Cal.3d at pp. 809-810, italics omitted.) Thus, while a plaintiff’s contributory negligence no longer completely bars recovery, it is still a defense that “reduce[s] the total amount of the plaintiff’s damages by the proportion or percentage of negligence attributable to the plaintiff.” (*Drust v. Drust*

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<sup>1</sup> CACI No. 405 would have informed the jury: “[Dr. Vallier] claims that [Bedolla-Reyes]’s own negligence contributed to [his] harm. To succeed on this claim, [Dr. Vallier] must prove both of the following: [¶] 1. That [Bedolla-Reyes] was negligent; and [¶] 2. That [Bedolla-Reyes]’s negligence was a substantial factor in causing [his] harm. [¶] If [Dr. Vallier] proves the above, [Bedolla-Reyes]’s damages are reduced by your determination of the percentage of [Bedolla-Reyes]’s responsibility. I will calculate the actual reduction.” (CACI No. 405.)

(1980) 113 Cal.App.3d 1, 6, fn. 1.) The burden of proving that the plaintiff's negligent conduct contributed to his harm rests squarely upon the defendant. (*Id.* at p. 6.)

**B.**

***Additional Background***

Dr. Vallier's answer to Bedolla-Reyes's complaint asserted comparative fault as a defense. Prior to trial, Dr. Vallier submitted CACI No. 405 as a proposed jury instruction. Dr. Vallier's attorney argued during his opening statement that the fixation failure occurred because Bedolla-Reyes "either ignored or misunderstood the directions given to him" and "went full weight-bearing on [his injured leg], not even weight-bearing as tolerated, simply full weight-bearing on it, and what happened is the hardware failed, predictably the hardware failed." Defense counsel also argued that Bedolla-Reyes's wound had difficulty healing "at least in part" because of "unmanaged diabetes." At trial, while there was evidence that the fixation failed because Bedolla-Reyes walked on his injured leg, and that diabetes contributed to the poor healing of his wound, there was no expert testimony that either walking on the leg or failing to keep his blood sugar below a certain level fell below the standard to which he should have conformed for his own protection.

Prior to closing arguments, defense counsel withdrew his request to have the jury instructed with CACI No. 405. Bedolla-Reyes's attorney argued that the instruction should be given, "unless [defense counsel] would like to stipulate that he's withdrawing that affirmative defense and any claim that [Bedolla-Reyes] was comparatively at fault," because "[t]here was substantial evidence put on during the trial that [Bedolla-Reyes] was comparatively at fault by walking on his leg against direction." Defense counsel responded: "Your Honor, I don't have to withdraw anything. This isn't an instruction that's appropriate for the plaintiff to request. It's a defense instruction, and it places

squarely the burden of proof on the defendant to prove it, and I don't want that instruction, and I don't request that instruction. It's improper for the plaintiff then to request an instruction to the jury that inappropriately shifts the burden of proof to me. [¶] . . . [¶] And let me just say, also, that I don't have to argue he's comparatively negligent. I can argue that he misunderstood the instructions that were given to him. I haven't made an issue that he was negligent in this case. I never asked if he breached a standard of . . . care of a reasonable person." The trial court declined to include the requested instruction.

Thereafter, during closing argument, defense counsel did not argue that Bedolla-Reyes was negligent. Instead, with respect to the initial surgery and postoperative instructions, defense counsel argued: (1) Dr. Vallier's use of a tourniquet during the initial surgery did not fall below the standard of care and there was no evidence the intramedullary reaming caused thermal necrosis; (2) Dr. Vallier was not negligent in using a screw that was too short to have adequate bicortical purchase, as Dr. Selznick claimed, because the intraoperative films showed that Dr. Vallier replaced this screw with a longer screw during the surgery; (3) Dr. Vallier's failure to recognize the new distal fibula fracture that appeared on the postoperative films did not cause any harm to Bedolla-Reyes because Dr. Selznick agreed this fracture would not have changed Dr. Vallier's treatment plan; (4) Dr. Selznick's testimony that the postoperative films showed a posterior malleolar fracture should be discredited because both Dr. Sampson and Dr. Vallier testified that there was no such fracture and the radiologist who reviewed the films at the hospital noted the distal fibula fracture but did not note a posterior malleolar fracture; and (5) Dr. Vallier did not tell Bedolla-Reyes to "go walking, go ahead, put all your weight on it," but instead told him to "stay off of it as much as you can, but put a little bit of weight on it, if it hurts, back off, we'll get an x-ray in a month and see where you're at, I think you'll be on two crutches in a month. This is the

conversation Dr. Vallier had. Now, if it was misinterpreted or misunderstood by [Bedolla-Reyes] that doesn't come back on Dr. Vallier. Dr. Vallier's duty is to instruct the patient properly, and he did instruct him properly. That is what his duty is. I can't account for what [Bermudez] translated to [Bedolla-Reyes], but folks, it doesn't make sense that a doctor who eight days earlier came in on a Sunday and put this patient's leg back together using all of his skill and expertise eight days later would give an instruction that he knows is going to cause everything to fall apart."

With respect to what caused the fixation failure, defense counsel argued: "I think Dr. Sampson said, you know, it's kind of part of a perfect storm, he had a weak bone to begin with, probably why he fractured it the way he did in a couple of places, the hardware may have been [along] a weak area, and as it fails, the rest of it fails, and if the patient puts weight on it that's likely to accelerate that process, and if he walks on it, certainly. Dr. Vallier's first impression was trauma, went off a step too hard, one of those things, but it failed. Medicine isn't perfect. Not every fracture that's fixed remains fixed. Fixation failures happen, and that's what Dr. Sampson was trying to tell you that, you know, obviously, we hope for 100 percent, but that's not the way it happens in the medical world, *and it doesn't mean that there's negligence on the part of anybody*. It's just there can be multiple, multiple factors, and he thinks there were multiple factors in this case that caused the fixation to fail, but he's fairly confident, you know, he's absolutely certain that the cause of the failure wasn't some missed malleolar fracture." (Italics added.)

Turning to the remaining allegations of negligence, defense counsel argued: (6) Dr. Vallier was not negligent in waiting six days to repair the fixation failure because the hospital required Bedolla-Reyes's Medi-Cal application to be approved before he could be admitted for surgery, the plate Dr. Vallier anticipated would be required to

replace the intramedullary nail had to be ordered, and there was no “tenting of the skin” to indicate that surgery should be performed sooner to prevent damage to the skin; (7) the standard of care required Dr. Vallier to use a tourniquet during the second surgery, the tourniquet was not used for 137 continuous minutes because it had to be removed and replaced during the surgery due to Bedolla-Reyes’s loss of blood; (8) Dr. Vallier was not negligent in waiting six days to debride the wound that opened up following the second surgery because there was no dead tissue to remove upon Bedolla-Reyes’s readmission to the hospital and Dr. Vallier performed the debridement as soon as the wound showed signs of necrosis; and (9) Dr. Vallier made “extraordinary efforts” to get Bedolla-Reyes admitted to UC Davis, but was unable to do so until about four months later because of problems with Bedolla-Reyes’s insurance coverage.

Finally, with respect to what caused Bedolla-Reyes’s incision to come apart and fail to heal properly, defense counsel argued: “[Y]ou have an incision over a very poorly vascularized area, *and no one blames [Bedolla-Reyes] for having diabetes*, but it is significant in your consideration overall in this case because it affects his healing, and it was uncontrolled, and you’ll see from the records his blood sugars are over 300, and Dr. Sampson told you that does create a problem, *but no one’s blaming [Bedolla-Reyes] that he’s a diabetic. No one’s blaming him that he’s got this condition*, but we can’t ignore that it played some background and a significant background in his subsequent healing.” (Italics added.)

### C.

#### *Analysis*

Bedolla-Reyes argues that he was entitled to an instruction on comparative fault because “[n]one of the instructions given informed the jury that fault could be apportioned between [Bedolla-Reyes] and [Dr. Vallier], hence, the finding of negligence,

but no causation.” We disagree for two reasons. First, we disagree with Bedolla-Reyes’s underlying assumption that the failure to instruct on comparative fault necessarily caused the jury to find negligence but no causation. Indeed, as we explain in the portion of this opinion addressing prejudice, we find no reasonable probability that it had such an effect.

Second, while “[a] party is entitled upon request to correct, nonargumentative instructions on every theory of the case *advanced by him* which is supported by substantial evidence” (*Soule v. General Motors Corp.* (1994) 8 Cal.4th 548, 572, italics added), comparative fault was not a theory advanced by Bedolla-Reyes. It is a defense. As mentioned, Dr. Vallier raised this defense in his answer to the complaint. However, he did not advance it at trial and adduced no expert testimony that Bedolla-Reyes’s conduct, either walking on the injured leg or failing to keep his blood sugar below a certain level, fell below the standard to which he should have conformed for his own protection. (See *Barton v. Owen* (1977) 71 Cal.App.3d 484, 506 [“where contributory negligence arises in a medical malpractice context there is need for the defendant to have offered expert testimony on the issue”].)

Nor did Dr. Vallier’s attorney argue in his closing argument that Bedolla-Reyes was negligent for walking on his injured leg or failing to control his diabetes. Instead, defense counsel argued Dr. Vallier did not tell Bedolla-Reyes to abandon his crutches and walk on the injured leg. Accordingly, if Bedolla-Reyes did so, regardless of whether he was negligent in so doing or reasonably misunderstood the instructions due to poor translation, the fixation failure was not caused by Dr. Vallier’s instructions. Defense counsel also argued that other factors could have led to the fixation failure, e.g., weakness in Bedolla-Reyes’s bones or accidental trauma caused by any number of things not attributable to negligence on the part of either Bedolla-Reyes or Dr. Vallier. And while

defense counsel argued that diabetes contributed to the poor healing of the wound, he did not argue that Bedolla-Reyes was at fault for failing to control his blood sugar levels.

Bedolla-Reyes's reliance on *Logacz v. Limansky* (1999) 71 Cal.App.4th 1149 and *Granius v. Pacific Gas & Elec. Co.* (1962) 201 Cal.App.2d 126 (*Granius*) is misplaced. In *Logacz*, a medical malpractice case in which, like here, "one of the critical issues to be resolved by the jury was causation" and the jury found negligence on the part of the defendant doctor but no causation, the Court of Appeal held that the trial court prejudicially erred in refusing the plaintiffs' request to instruct the jury on concurrent causation, i.e., that multiple causes of harm do not preclude recovery by the plaintiffs as long as the defendant's negligence is a substantial factor in causing the harm. (*Logacz, supra*, 71 Cal.App.4th at p. 1157-1159.) Here, as we explain more fully below, the jury was properly instructed on concurrent causation and nothing in *Logacz* suggests that such an instruction must be accompanied by a comparative fault instruction.

Nor does *Granius, supra*, 201 Cal.App.2d 126 provide assistance to Bedolla-Reyes. There, the plaintiffs sued a gas company for damages arising from a house fire allegedly caused by negligence on the part of the defendant. During jury selection, the trial court described the concept of contributory negligence to the prospective jurors. During trial, the defendant withdrew the issue of contributory negligence and offered no instruction on the concept. Following a defense verdict, the trial court granted the plaintiffs a new trial because "the jury may have been misled' by the absence of an instruction removing the issue from jury consideration." (*Granius, supra*, 201 Cal.App.2d at p. 128.) The Court of Appeal affirmed, explaining: "If this appeal were from the judgment, we should be strongly disinclined to import error by regarding the preliminary statement as a part of the instructions, particularly in view of the fact that two and one-half days of trial intervened between the questioned statement and the

submission of the case to the jury upon the more formal instructions. However, we cannot hold that, as a matter of law, the trial court was without power to view its statement concerning contributory negligence as a part of the instructions, and to determine that it confused and misled the jury.” (*Id.* at p. 129.)

Bedolla-Reyes argues that here, like *Granius*, *supra*, 201 Cal.App.2d 126, “the defense of comparative fault was plead [*sic*] by [Dr. Vallier] as an affirmative defense” and “no instruction was offered to the jury regarding the issue.” He misreads *Granius*. The problem in *Granius* was not *the failure to instruct the jury on contributory negligence*, but rather the fact that the trial court described the concept of contributory negligence to prospective jurors before trial and then *failed to inform the jury that the issue had been withdrawn by the defendant*. Here, the trial court did not describe comparative fault to the jurors and therefore there was no need to inform the jury that the issue had been withdrawn. Perhaps anticipating this conclusion, Bedolla-Reyes further argues that “unlike *Granius*, [Dr. Vallier] never withdrew the issue of comparative fault.” While true, as we have explained, because Dr. Vallier did not advance comparative fault as a defense at trial, there was no need to instruct on the concept.

We conclude the trial court properly declined to instruct the jury on comparative fault because Dr. Vallier did not claim any negligence on the part of Bedolla-Reyes contributed to his harm.

## II

### *Harmless Error*

Even if we were to find that the trial court erred in declining to instruct on comparative fault, the error would be harmless.

“A judgment may not be reversed on appeal, even for error involving ‘misdirection of the jury,’ unless ‘after an examination of the entire cause, including the

evidence,’ it appears the error caused a ‘miscarriage of justice.’ (Cal. Const., art. VI, § 13.) When the error is one of state law only, it generally does not warrant reversal unless there is a reasonable probability that in the absence of the error, a result more favorable to the appealing party would have been reached.” (*Soule v. General Motors Corp.*, *supra*, 8 Cal.4th at p. 574, citing *People v. Watson* (1956) 46 Cal.2d 818, 835.) “Thus, when the jury receives an improper instruction in a civil case, prejudice will generally be found only “[w]here it seems probable that the jury’s verdict may have been based on the erroneous instruction . . . .” [Citation.] That assessment, in turn, requires evaluation of several factors, including the evidence, counsel’s arguments, the effect of other instructions, and any indication by the jury itself that it was misled. [Citation.]” (*Soule v. General Motors Corp.*, *supra*, 8 Cal.4th at p. 574.)

Bedolla-Reyes asserts the trial court erred in failing to instruct on comparative fault. As mentioned, the jury found in favor of Dr. Vallier on the basis of causation. Thus, we may reverse the judgment only if, after considering the aforesaid factors, we find there to be a reasonable probability that had the jury been instructed on comparative fault, it would have found Dr. Vallier’s negligence was a substantial factor causing harm to Bedolla-Reyes in the first place. We find no such probability.

Beginning with the effect of other instructions, we note that the jury was properly instructed on causation with CACI Nos. 430 and 431. As delivered by the trial court, these instructions provided: “A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm. It must be more than a remote or trivial factor. It does not have to be the only cause of the harm. . . . A person’s negligence may combine with another factor to cause harm. If you find that [Dr. Vallier]’s negligence was a substantial factor in causing [Bedolla-Reyes] harm, then [Dr. Vallier] is responsible for the harm. [Dr. Vallier] cannot avoid responsibility just

because some other person, condition or event was also a substantial factor in causing [Bedolla-Reyes] harm.”

“Jurors are presumed to have understood instructions and to have correctly applied them to the facts as they find them.” (*Linden Partners v. Wilshire Linden Associates* (1998) 62 Cal.App.4th 508, 523.) Thus, we must presume the jury found Dr. Vallier’s negligence did not contribute to Bedolla-Reyes’s harm in more than a remote or trivial way. We must also presume that even if the jury believed that a person, i.e., Bedolla-Reyes, or a condition, i.e., diabetes, was a substantial factor in causing Bedolla-Reyes harm, the jury understood and followed the instruction that this would not insulate Dr. Vallier from liability as long as he was also a substantial factor in causing the harm.

Turning to the evidence and argument of counsel, we do not believe these factors support the conclusion that the jury’s verdict was based on the trial court’s failure to provide an instruction on comparative fault. While the special verdict form does not reveal which particular act or acts of negligence the jury found to be true, there are a number of scenarios, fully supported by the evidence and urged by defense counsel in his closing argument, in which the jury could reasonably have found negligence but no causation. For instance, the jury could have found Dr. Vallier was negligent in failing to appreciate the distal fibula fracture on the postoperative films, but that this fracture would not have altered his treatment of Bedolla-Reyes. The jury could also have found that Dr. Vallier was negligent in using a tourniquet during the initial surgery, but that this did not cause any harm because, as Dr. Wolinsky testified, there were no signs of thermal necrosis. Similarly, the jury could have found that Dr. Vallier was negligent in using a tourniquet for 137 minutes during the second surgery, but that this did not cause any harm because, as both Dr. Sampson and Dr. Vallier testified, Bedolla-Reyes continued to bleed throughout that operation.

Moreover, even if we were to conclude that the evidence and argument of counsel supported a finding that Bedolla-Reyes's negligence contributed to his harm, the comparative fault instruction would simply have informed the jury that his damages would be reduced by the percentage of fault attributable to him. (CACI No. 405.) The jury would not have reached the question of apportioning damages unless it first found that Dr. Vallier's negligence was a substantial factor causing the harm. We cannot presume, as Bedolla-Reyes suggests, that the jury disregarded proper causation instructions because it was uncomfortable holding Dr. Vallier responsible for all of Bedolla-Reyes's damages. Finally, the jury did not indicate that it was misled by the instructions.

Any error in declining to instruct the jury on comparative fault was harmless.

#### DISPOSITION

The judgment is affirmed. Garry T. Vallier shall recover his costs on appeal. (Cal. Rules of Court, rule 8.278(a)(1).)

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HOCH, J.

We concur:

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RAYE, P. J.

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MAURO, J.