NOT DESIGNATED FOR PUBLICATION

STATE OF LOUISIANA

COURT OF APPEAL

FIRST CIRCUIT

2013 CA 1974

BESSIE DAY BROWN AND CLARENCE BROWN

VERSUS

DR. KARIPPELIL MATHEW AND HIS INSURER, XYZ INSURANCE COMPANY, ST. ELIZABETH HOSPITAL, ITS HEIRS, SUCCESSORS, AGENTS, EMPLOYEES AND ASSIGNS AND ITS INSURER, ABC INSURANCE COMPANY

RHP by JMG

JMG

EGD by JMG

On Appeal from the 23rd Judicial District Court
Parish of Ascension, Louisiana
Docket No. 95,866, Division "C"
Honorable Guy Holdridge, Judge Presiding

Geri Broussard Baloney **Abril Baloney Sutherland** **Broussard Baloney Law Firm, APC** **New Orleans, LA**	**Attorneys for** **Plaintiffs-Appellants** **Bessie Day Brown and** **Clarence Brown**
W. Luther Wilson **Taylor, Porter, Brooks** **and Phillips, L.L.P.** **Baton Rouge, LA**	**Attorney for** **Defendant-Appellee** **Dr. Karippelil Mathew**

BEFORE: PARRO, GUIDRY, AND DRAKE, JJ.

Judgment rendered DEC 3 0 2014

PARRO, J.

In this medical malpractice case, Bessie Day Brown and her husband, Clarence Brown, appeal a judgment rendered in accordance with a jury verdict in favor of Dr. Karippelil Mathew, dismissing their claims for damages arising out of Dr. Mathew's surgical treatment of Ms. Brown. They also appeal a judgment denying their motion for a judgment notwithstanding the verdict. Dr. Mathew answered the appeal, seeking assessment of the cost of his expert witness. For the following reasons, we affirm the trial judgment and the judgment denying the JNOV.

FACTUAL AND PROCEDURAL BACKGROUND

On October 8, 2007, Ms. Brown visited Dr. Anu P. Vellanki at St. James Primary Care, complaining of indigestion, constipation, and left-sided abdominal pain. An ultrasound revealed a two-centimeter gallstone, and she eventually was referred to Dr. Mathew for surgery at St. Elizabeth Hospital.[1] On October 24, he performed a laparoscopic cholecystectomy, which is the removal of the gallbladder using a laparoscopic technique, rather than an open surgery. During the procedure, a clip used to close off a blood vessel apparently slipped, causing "brisk" bleeding into the site from the cystic artery. Dr. Mathew was able to stop the bleeding by inserting clips on the artery and concluded the procedure without further complications. Ms. Brown was given pain and nausea medication to take and was discharged from St. Elizabeth Hospital that evening.

She returned the following day due to severe abdominal pain, difficulty breathing, fever, itching, and nausea. Dr. Mathew admitted her to the hospital overnight, performed an EKG, abdominal and chest x-rays, and blood tests. These showed no abnormality, and she was discharged on October 26 with medications for itching, pain, and nausea. However, these post-operative problems continued, and over the course of several weeks, she also became extremely jaundiced. Therefore, on November 10, she went to St. James Hospital for evaluation, where blood tests revealed that her bilirubin levels were significantly elevated.[2] Based on these symptoms

[1] Ms. Brown testified that on the advice of a co-worker, she first went to Dr. Turner, who reviewed the test results from Dr. Vellanki and referred her to Dr. Mathew.

[2] Dr. John Bolton testified that bilirubin is a measurement of the level of bile in the blood stream.

and test results, she was immediately transferred back to St. Elizabeth Hospital for care not offered at St. James Hospital. Additional tests performed at St. Elizabeth Hospital confirmed the elevated levels of bilirubin and the possibility of a restriction or obstruction in the bile duct. Over the course of several days, efforts were made to clear the bile duct obstruction. When these were unsuccessful, on November 14, Ms. Brown was transferred to Ochsner Clinic Foundation (Ochsner) in New Orleans, where more specialized and advanced treatment was available.

An endoscopic procedure was performed at Ochsner the following day. During this procedure under general anesthesia, a lighted scope was inserted through her mouth and advanced to where her gallbladder had been removed, where radioactive contrast material was injected in order to film the area. This procedure showed that the middle third of the main bile duct contained stenosis, or narrowing. Also, the lower third of the main bile duct contained one small stone, which was removed. Attempts to pass a wire across the stenosis in the mid-bile duct were unsuccessful. During the next several days, additional attempts were made to place a tube to bypass the stricture in the bile duct; these efforts also failed due to inflammation of the duct. Therefore, a temporary drainage system was inserted, allowing fluid to drain through a catheter into an external drainage bag. After installation of the drainage system, Ms. Brown's symptoms dramatically improved. However, the procedure had to be repeated on November 19, because the drainage catheter had dislodged internally. During this hospitalization at Ochsner, she was also treated for pain, anemia, and a staph infection. Ms. Brown was discharged on November 21, when these conditions were under control; she had daily visits from home health services until she could be seen the following week by Dr. John Bolton regarding surgery to repair the bile duct obstruction.

Ms. Brown was re-admitted to Ochsner on November 30, 2007. Dr. Bolton performed an open surgical procedure that initially required over an hour and a half simply to separate adhesions in her abdomen resulting from earlier surgeries,[3] including the laparoscopic procedure. Once he reached the site of the cholecystectomy, he noted that there was "intense subacute inflammatory reaction in the porta hepatis. Multiple

[3] Ms. Brown had previously undergone a hysterectomy and two surgeries to remove ovarian cysts.

surgical clips are found and removed, a total of 15 in all ... ."[4] He discovered that Ms. Brown had "variant hepatic ductal anatomy," that is, the anatomy of her bile ducts differed from that of most persons, making the corrective surgery more difficult. He found "a good deal of necrosis at the terminus of these ducts," which had to be debrided before the bile ducts could be re-attached. After repairing the obstructed bile ducts by inserting stents, Dr. Bolton replaced the temporary drainage system with a more permanent system and concluded the operation.

The external drainage system was removed on January 18, 2008, and at a follow-up visit six weeks later, Dr. Bolton's note indicates, "Ms. Brown is doing very well from the standpoint of her biliary stricture repair." However, she was experiencing lower back pain unrelated to her surgical procedures. Dr. Bolton's note concludes that she would be discharged with full work duties as tolerated, following the workup for her back pain. He advised her to obtain liver function tests every three months for the next three years, and to return for office visits every six months.

Ms. Brown submitted claims against Dr. Mathew and St. Elizabeth Hospital to a Medical Review Panel, which found that Dr. Mathew "failed to meet the applicable standard of care as charged in the complaint." The reason given for this was that the panel could find no evidence that Ms. Brown was appropriately informed of the risks of and alternatives to the procedure. The panel indicated that it would not speculate as to whether she would have gone forward with the procedure, had she been fully informed of the material risks of this procedure, especially the risk of common bile duct injury. The panel further noted that a common bile duct stricture is a well established risk associated with laparoscopic cholecystectomy and that her post-operative care was appropriate. It found no breach of the standard of care by St. Elizabeth Hospital or its employees.

Following receipt of the opinion of the Medical Review Panel, the Browns filed suit on April 1, 2010, against St. Elizabeth Hospital and its insurer and Dr. Mathew and his insurer. In September 2010, both Dr. Mathew and St. Elizabeth Hospital filed motions for summary judgment. A hearing on the hospital's motion was held, after

[4] The porta hepatis is a deep fissure in the inferior surface of the liver through which all the neurovascular structures and hepatic ducts enter or leave the liver.

which the court granted the motion and dismissed the Browns' claims against St. Elizabeth Hospital. This judgment was not appealed. Dr. Mathew then supplemented his motion for summary judgment, which was denied after a hearing. The case went to a two-day jury trial in July 2012. The jury found no breach in the standard of care by Dr. Mathew. A judgment in accordance with the jury's verdict, dismissing the Browns' suit, was signed on October 23, 2012. The Browns filed motions for judgment notwithstanding the verdict (JNOV) or alternatively, for a new trial. The motions were denied in a judgment signed February 21, 2013. This appeal of both judgments followed.

The Browns assign as error: (1) the jury's finding that Dr. Mathew did not deviate from the standard of care in performing the laparoscopic cholecystectomy on her; (2) the jury's failure to find that a reasonable person in her position would not have chosen to have the surgery had she been informed of the risks; (3) the jury's failure to award damages to the Browns; (4) the court's denial of their motions for JNOV or alternatively, for a new trial; and (5) the court's omission of applicable law and essential legal principles when it set forth the issues to be decided by the jury.

STANDARD OF REVIEW

A court of appeal may not overturn a judgment of a trial court absent an error of law or a factual finding that is manifestly erroneous or clearly wrong. Morris v. Safeway Ins. Co. of Louisiana, 03-1361 (La. App. 1st Cir. 9/17/04), 897 So.2d 616, 617, writ denied, 04-2572 (La. 12/17/04), 888 So.2d 872. In order to affirm the factual findings of the trier of fact, the supreme court posited a two-part test for the appellate review of facts: (1) the appellate court must find from the record that there is a reasonable factual basis for the finding of the trier of fact; and (2) the appellate court must further determine that the record establishes that the finding is not clearly wrong (manifestly erroneous). Mart v. Hill, 505 So.2d 1120, 1127 (La. 1987). Thus, if there is no reasonable factual basis in the record for the trier of fact's finding, no additional inquiry is necessary to conclude there was manifest error. However, if a reasonable factual basis exists, an appellate court may set aside a factual finding only if, after reviewing the record in its entirety, it determines the factual finding was clearly wrong. See

Stobart v. State, through Dep't of Transp. and Dev., 617 So.2d 880, 882-83 (La. 1993); Moss v. State, 07-1686 (La. App. 1st Cir. 8/8/08), 993 So.2d 687, 693, writ denied, 08-2166 (La. 11/14/08), 996 So.2d 1092.

Due to the jury's opportunity to evaluate live witnesses or to evaluate a mixture of deposition and live testimony, great deference is accorded to the jury's factual findings. See Sistler v. Liberty Mut. Ins. Co., 558 So.2d 1106, 1111 (La. 1990). Where there is a conflict in testimony, reasonable evaluations of credibility and reasonable inferences of fact should not be disturbed upon review, even though the appellate court may feel that its own evaluations and inferences are as reasonable. Rosell v. ESCO, 549 So.2d 840, 844 (La. 1989). Where there are two permissible views of the evidence, the fact finder's choice between them cannot be manifestly erroneous or clearly wrong. Id.

Further, a jury may accept or reject in whole or in part the opinion expressed by an expert; such testimony is to be weighed the same as any other evidence. Matherne v. Barnum, 11-0827 (La. App. 1st Cir. 3/19/12), 94 So.3d 782, 790, writ denied, 12-0865 (La. 6/1/12), 90 So.3d 442. The weight to be given to the testimony of experts is largely dependent upon their qualifications and the facts upon which their opinions are based. Ponthier v. Vulcan Foundry, Inc., 95-1343 (La. App. 1st Cir. 2/23/96), 668 So.2d 1315, 1317. In evaluating the testimony of medical experts, the jury must consider the opportunities each physician had for observation and examination of the patient and the expert's familiarity with the patient and his or her history. Woods v. Petroleum Helicopters, Inc., 415 So.2d 978, 982 (La. App. 1st Cir. 1982). Therefore, a treating physician's opinion is generally given more weight than that of a non-treating physician. Ponthier, 668 So.2d at 1317.

ANALYSIS

Jury Instructions

We will first address Ms. Brown's contention that the court legally erred by omitting applicable law and essential legal principles when it set forth the issues to be decided by the jury. The record shows that in the weeks before the trial, each party submitted a list of jury instructions for the court's consideration. These lists were

discussed with the court at a pre-trial status conference. After closing arguments, the court gave the jury charge and excused the jury to begin deliberations. Dr. Mathew's attorney had several objections to the instructions given to the jury, because the court had not included some of the instructions on his list. The court denied his request to have the jury instructed on those items. Ms. Brown's attorney had no objections to the jury charge as given by the court.

Louisiana Code of Civil Procedure article 1793 outlines the procedure by which objections to the proposed jury instructions are to be made, as follows:

> A. At the close of the evidence, or at such earlier time as the court reasonably directs, a party may file written requests that the court instruct the jury on the law as set forth in the requests.
>
> B. The court shall inform the parties of its proposed action on the written requests and shall also inform the parties of the instructions it intends to give to the jury at the close of the evidence within a reasonable time prior to their arguments to the jury.
>
> C. A party may not assign as error the giving or the failure to give an instruction unless he objects thereto either before the jury retires to consider its verdict or immediately after the jury retires, stating specifically the matter to which he objects and the grounds of his objection. If he objects prior to the time the jury retires, he shall be given an opportunity to make the objection out of the hearing of the jury.

This article creates a mandatory rule for preserving an objection to a trial court's ruling regarding requested jury instructions. Martin v. Francis, 600 So.2d 1382, 1387 (La. App. 1st Cir.), writ denied, 606 So.2d 541 (La. 1992). To preserve the right to appeal a trial court's refusal to give a requested instruction or its giving of an erroneous instruction, a party must not only make a timely objection, but must state the grounds of his objection. Id. at 1387; Cole v. Celotex Corp., 588 So.2d 376, 380 (La. App. 3rd Cir. 1991), aff'd, 599 So.2d 1058 (La. 1992).

In this case, Ms. Brown's attorney did not object to the jury instructions when given the opportunity to do so after the jury retired to deliberate. Therefore, any objection that might have been made was not preserved to be considered by this court on appeal.

Informed Consent

Ms. Brown also assigns as error the jury's failure to find that a reasonable person in her position would not have chosen to have the surgery, had she been informed of

the risks. The jury verdict form contained two questions regarding informed consent. The first asked, "Was the plaintiff properly informed of the risks and alternatives to the laparoscopic procedure?" The jury answered, "No." The second was, "Would a reasonable person, in the plaintiff's position, have withheld consent to the laparoscopic procedure, chosen another procedure, or forgone any surgery at all, if she had been properly informed of the risks and alternatives?" The jury again answered, "No."

This case falls among the most common "lack of informed consent" cases, which arise not from the failure to notify the patient of the type of procedure to be performed, but rather the failure to inform the patient of the material risks that may occur during the procedure. See Lugenbuhl v. Dowling, 96-1575 (La. 10/10/97), 701 So.2d 447, 450. In a suit against a physician involving a medical malpractice claim based on the failure of the physician to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician, "the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent." See LSA-R.S. 40:1299.39.5(D). Louisiana jurisprudence requires that a plaintiff in an action based on a failure to obtain informed consent prove the following four elements in order to prevail: (1) a material risk existed that was unknown to the patient; (2) the physician failed to disclose the risk; (3) the disclosure of the risk would have led a reasonable patient in the patient's position to reject the medical procedure or choose another course of treatment; and (4) the patient suffered injury. See Snider v. Louisiana Medical Mut. Ins. Co., 13-0579 (La. 12/10/13), 130 So.3d 922, 929-30; Brandt v. Engle, 00-3416 (La. 6/29/01), 791 So.2d 614, 619 n.1.

To recover damages, the plaintiff, after establishing a failure to inform the patient of a procedure or the attendant material risks, must also prove causation between the doctor's failure and the claimed damages. Otherwise, the doctor's conduct, however wrongful, has no legal consequence. In material risk cases, the plaintiff must prove both that the breach of duty was a cause in fact of the damage and "that a reasonable patient in the plaintiff's position would not have consented to the treatment or procedure" because of the disclosed information. Richard v. Colomb, 04-

1145 (La. App. 1st Cir. 6/29/05), 916 So.2d 1122, 1128, writ denied, 05-1939 (La. 2/3/06), 922 So.2d 1182.

The question of whether informed consent was or was not given is a question of fact to be resolved by the fact finder, and the manifest error standard of review applies to such a finding of fact on appellate review. Snider, 130 So.3d at 938.

The patient consent form for Ms. Brown's surgery at St. Elizabeth Hospital describes the nature of the treatment as "Laparoscopic/Open Cholecystectomy," the purpose of which was "Removal of gallbladder through laparoscopic/surgical opening of abdomen and removal of gallbladder." Subparagraph (a) of the consent form where the material risks of that procedure were to be described is blank, and there is no attachment on which those risks were detailed. However, subparagraph (b) of the material risks section states, "Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, paralysis, the loss of or loss of function of body organs, the loss of or loss of function of any arm or leg, infection, bleeding, and pain." Dr. Mathew signed the form, indicating that he had explained the information in the form and answered all questions from the patient or the patient's representative concerning the procedure. Ms. Brown also signed the form, acknowledging that she had conferred with Dr. Mathew and was given the chance to ask questions, and authorized the surgical procedure described in the consent form.

Ms. Brown testified at trial that the form was not completed when she signed it. She also said she did not know her gallbladder was going to be removed, but thought only the gallstone was going to be removed by "laser surgery." She believed her gallbladder was healthy; the gallstone was the only problem. She said she would not have had her gallbladder removed if she had been told of the risks. However, she admitted that she had been experiencing pain for over two months when she first saw Dr. Vellanki, and the pain had been getting worse with the passage of time. After the referral to Dr. Mathew, she met with him and he explained what she called "laser surgery" that he planned to use to correct her problem. He told her it would involve putting three small incisions in her abdomen through which the work would be done.

He also explained that the gallstone would get worse, as would the pain, and it could cause an infection that would make her very ill if the procedure were not done. Mr. Brown was with her at Dr. Mathew's office when this discussion took place; he confirmed the accuracy of her statement that there was no mention of the particular risks that might be encountered with the "laser surgery."

Dr. Mathew testified that he had no specific recollection of his conversations with Ms. Brown before the surgery, but stated that he has a routine procedure of discussing the surgery with each patient before obtaining the patient's signature on the consent form. During that discussion, he tells them that he recommends gallbladder surgery using the laparoscope, which is less painful, has less hospitalization, less recovery time, less scarring, less bleeding, less complications, and less chance of infection than an open surgery. If the surgery cannot be completed using the laparoscope, he might have to do an open procedure, which would involve making a longer incision below the right rib cage, cutting the muscle, opening the abdomen, and removing the gallbladder. He further explains that in both procedures, there are chances of "violent injury, injury to other organs, bleeding, infection, bile duct stricture, retained stones in the common bile duct, [and] need for further surgery or endoscope procedures." Dr. Mathew stated that he would never tell a patient that he would remove the gallstone without taking the gallbladder out, because it is unheard of to remove the stone and leave the diseased gallbladder in place.

Dr. Christopher Rupp, a board-certified general surgeon with a fellowship in liver, pancreatic, bile duct, and gallbladder surgery, testified as an expert on behalf of Ms. Brown. He stated that the failure to inform Ms. Brown of the potential risks associated with the surgery was a breach of the standard of care. He stated that the patient has the right to choose not to have the surgery, even if that choice is contrary to the doctor's recommendation. However, he admitted that in his own practice, after discussing all the potential risks with his patients, none of them decided to select the open surgery over the laparoscopic technique.[5]

---

[5] There was one exception—a mentally ill patient whose caretaker elected for her to have the gallbladder removed through open surgery.

Faced with this conflicting evidence, the jury concluded that Dr. Mathew did not properly inform Ms. Brown of the risks and alternatives to the laparoscopic procedure. Therefore, Ms. Brown established the first two elements needed to prove her claim of lack of informed consent. However, the jury apparently did not believe that she would not have consented to the laparoscopic procedure, would have chosen an alternative procedure, or would have foregone any kind of surgery if she had been fully informed of the risks associated with the surgery. The evidence supporting this conclusion includes the fact that Ms. Brown had been experiencing increasing levels of abdominal pain and other digestive problems in the months preceding her initial doctor's visit. The ultrasound conducted by Dr. Vellanki revealed the presence of a large gallstone. Ms. Brown acknowledged that Dr. Mathew told her that the gallstone, if not removed, would continue to cause increasing pain and possible complications, such as infection, which could make her very ill. In her deposition, Ms. Brown was asked, "[I]f the choice is having the surgery or perhaps having the gallbladder get infected and getting septic, which could threaten your life, would you have said, oh, I'll take a risk of my life being [threatened] and I'll live with this pain, or would you have said, let's go forward with the surgery?" She responded, "I would have the surgery." The Medical Review Panel opinion stated that "[a] common bile duct stricture is a well established risk associated with laparoscopic cholecystectomy." Given this information, the jury had evidentiary support for its conclusion that no reasonable person would reject going forward with some form of surgery to correct this problem, even with the risk of a bile duct stricture. Also, Ms. Brown's stated belief that the gallstone would be removed without removing the gallbladder was not reasonable, and the jury may not have believed her on this point, because she had stated in her deposition that she knew she had to have her gallbladder removed, "[b]ecause it was paining me so bad. It was hurting so bad."

Regarding the alternative of open surgery, all of the physicians who testified agreed that the laparoscopic procedure is safer for the patient and is preferred to open surgery for removal of the gallbladder. Ms. Brown said Dr. Mathew told her that he would do the surgery by putting just a few very small holes in her abdomen and that open surgery would require a "big cut." When asked on cross-examination if Dr.

Mathew had explained to her that he preferred to do the surgery with the small holes, because it was safer than open surgery, she replied, "Something like that." Therefore, the jury had evidence supporting its conclusion that a reasonable patient in Ms. Brown's position would not reject the laparoscopic procedure and instead choose the open surgery or no surgery at all.

Based on our review of the evidence, we conclude that Ms. Brown did not carry her burden of proving that the disclosure of the risk would have led a reasonable patient in her position to reject the laparoscopic procedure, choose another course of treatment, or forego treatment entirely. She did not establish that the lack of information about the risk of injury to the common bile duct caused her any damage, as any reasonable person would have gone forward with the laparoscopic procedure, rather than facing increasing pain and the possibility of life-threatening infection. Therefore, our review of the record as a whole reveals that the jury's conclusion on this element of the informed consent claim is not manifestly erroneous.

Medical Malpractice

Ms. Brown also assigns as error the jury's conclusion that Dr. Mathew did not deviate from the standard of care in performing the laparoscopic cholecystectomy on her. To establish a medical malpractice claim against a physician, a plaintiff must establish by a preponderance of the evidence the applicable standard of care, a breach of that standard of care, and a causal connection between the breach and the plaintiff's resulting injuries. See LSA-R.S. 9:2794(A). Resolution of each of these inquiries are determinations of fact which should not be reversed on appeal absent manifest error. Martin v. East Jefferson Gen. Hosp., 582 So.2d 1272, 1276 (La. 1991); Aymami v. St. Tammany Parish Hosp. Service Dist. No. 1, 13-1034 (La. App. 1st Cir. 5/7/14), 145 So.3d 439, 446. Expert testimony is generally required to establish the applicable standard of care and whether or not that standard was breached. See Samaha v. Rau, 07-1726 (La. 2/26/08), 977 So.2d 880, 884. Where the fact finder's determination is based on its decision to credit the testimony of one of two or more witnesses, that finding can virtually never be manifestly erroneous. This rule applies equally to the evaluation of expert testimony, including the evaluation and resolution of conflicts in

expert testimony. Where expert witnesses present differing testimony, it is the responsibility of the trier of fact to determine which evidence is the most credible. Aymami, 145 So.3d at 447.

Dr. Bolton was called by Ms. Brown as a fact witness, as well as an expert witness. He described Ms. Brown's variant anatomy by analogizing it to a tree, stating, "if you think of a tree trunk, the trunk being the common bile duct, the main bile channel, normally that would be two major branches of it and in her case there [were] three major branches of it." He said approximately 15% of the population has this variant anatomy. Dr. Bolton stated that there was no way Dr. Mathew could have known of this variant anatomy when he went in to perform the laparoscopic procedure. He also said that it is not common to have excessive bleeding within the operative site, but "certainly it's not unheard of by any means. It can happen." To get control of such bleeding may require more clips than are generally used in this procedure, because "the surgical field is obscured by the bleeding." However, the use of more clips does create a higher risk of problems with the bile duct. Dr. Bolton said that although conversion to an open surgery is always an option during a laparoscopic procedure, it is not a safer alternative, and most surgeons would first try to expose the bleeding site and control it, as was done by Dr. Mathew. He said the necrotic tissue that he found at the ends of the bile ducts was a pretty standard finding of a bile duct repair. When questioned during his deposition about whether there was anything improper in the way Dr. Mathew did the laparoscopic procedure, he responded:

> I can't really say or comment on that. I mean, obviously Ms. Brown had a problem and we knew that. I'm back to fix it and there was an injury pattern to her common duct, but I don't think you equate that necessarily with improper or proper. If it's a problem, then you fix it. It's not the outcome that you expect or want after the surgery, but as I mentioned earlier[,] cases where there's severe inflammatory disease or [variant] anatomy or bleeding during surgery[,] this can happen and it can happen to the best surgeon on the best day of his life.

Dr. Rupp testified as an expert on behalf of Ms. Brown. He had reviewed the Medical Review Panel documents, as well as Ms. Brown's medical records from St. Elizabeth Hospital and Ochsner. He stated that the ultrasound performed by Dr. Vellanky revealed a two-centimeter gallstone, but laboratory analysis and a CT scan showed that her gallbladder, pancreas, and liver were within normal limits; her

gallbladder showed no cholecystitis, or inflammation, at that time. Based on these findings, he said he would not have removed the gallbladder, because, although the gallstone was large, it was not causing a problem with her gallbladder. Reviewing Dr. Mathew's deposition, in which he described the laparoscopic procedure he used, Dr. Rupp stated that this technique would be described as an "infundibular technique for a cholecystectomy or [a variant] technique that we do to remove the gallbladder." He further stated that this technique has been recognized in several publications as associated with a higher risk of injuring the main bile duct or if there is a variant anatomy present, injuring that. He said this technique has largely been abandoned and is currently not the acceptable technique for removal of the gallbladder. He said the current practice is known as "critical view of safety," because if there is inflammation in the area or a variant anatomy, it may be hard to identify the critical structures. Dr. Rupp opined that the technique Dr. Mathew used contributed to Ms. Brown's injury, as did the bleeding problem he encountered. Dr. Rupp described the "critical view of safety" process as:

> identifying all of the structures, the cystic artery, dissecting all of that soft tissue or extra tissue that holds the gallbladder to the liver; if you don't remove it, you will not see this [variant] anatomy. The critical view of safety, the [tenets] of that are to remove all of that tissue and make sure you only have two structures present, a cystic duct and cystic artery connecting the gallbladder to ... the area where the bile duct is and only at that point a transecting of those structures.

He agreed with Dr. Bolton that the use of 15 clips would be associated with increased rates of injury. Dr. Rupp concluded that, based on the operative report, Dr. Mathew's deposition, and Dr. Mathew's failure to obtain the critical view of safety, he did not believe the anatomy was correctly identified, which was a breach of the standard of care and the cause of Ms. Brown's injuries. He also said that Dr. Mathew's failure to convert to an open procedure when problems were encountered was another breach of the standard of care. In summary, Dr. Rupp found three instances in which Dr. Mathew breached the standard of care: using the infundibular technique instead of using the critical view of safety; excessive use of clips; and failure to convert to an open procedure. On cross-examination, Dr. Rupp admitted that Ms. Brown's initial problems of pain, nausea, and vomiting would get worse with time, as the gallbladder would not

heal with a large gallstone in it. Ultimately, there could be sepsis, but this rarely occurs, because laparoscopic cholecystectomies are done and the gallbladder is removed before the condition gets to that point. He also acknowledged that the risks of either an open procedure or a laparoscopic procedure are infection, unwanted bleeding, and potential damage to adjacent organs, all of which can happen without any fault on the part of the doctor. In fact, he confirmed that these problems can happen to a good doctor on the best day, without fault.

Dr. Mathew, who is a fellow in the American College of Surgeons, testified in his own defense. The laparoscope is a camera with a lighted end, which transmits the image of the surgical site to two televisions in the operating room. The procedure is always done by the surgeon, with the help of an assistant. Dr. Mathew stated that when he performed the laparoscopic cholecystectomy on Ms. Brown, he did not know that she had a variant anatomy, and it was not in the area where he was dissecting and doing the surgery; the additional segment of the bile duct was inside the liver. He agreed during his deposition that after reviewing Dr. Bolton's findings, it appeared that Ms. Brown may have had an unanticipated variant right hepatic artery, which was clipped wholly or partially, compounded by pancreatitis and cholangitis. Dr. Mathew described his recollection of her procedure as follows:

> I have a recollection of Ms. Brown's procedure because of the bleeding. This is not something which happens often during gallbladder surgery. ... [S]tarting with the surgery, she was found to have so much scar tissues from all of the previous surgeries she had and all of the recurrent bouts of inflammation in the gallbladder producing thick vascular additions of [omentum] going to the gallbladder.
>
> I had to use several clips to divide the [adhesions] and then I found the anatomy of the gallbladder well. I dissected it out clearly, the outline. And then I started dissecting out the main cystic duct and the cystic artery. I looked at the structures and the anatomy around, and then I proceeded with applying clips, two clips proximally and one clip distally on the cystic duct as well as cystic artery. And then using endo strips, I divided them.
>
> After that, I lifted up the gallbladder and the gallbladder was slowly dissected off from the liver bed. That procedure went on without any problem.
>
> ***
>
> Okay. While I was dissecting the gallbladder from ... under the gallbladder bed, I was almost half way through and then I saw this brisk bleeding. That's the memory I have. It was a certain burst of blood coming out from the area where I had put the clip on the cystic artery and this is where the surgeon has to make an immediate decision. ... The first

> thing, you know, to do is to identify where the blood is coming from. It is not like [blindly] firing boom, boom, boom, putting clips. I did not do that. This is a very careful identification of the bleeder.
>
> ***
>
> So the bleeder, I identified the bleeder, the careful placement [of] a clip from the side transgentially and one from this end and if the bleeding doesn't stop, I would have to put one more underneath.

He said he had no problem visualizing what he wanted to see during the surgery until the bleeding occurred, when he had to take immediate steps to control it. Dr. Mathew explained that with blood spurting from the artery, even a drop of blood falling on the camera light could totally obscure his vision. After controlling the bleeding and suctioning out the fluid, he was able to remove the gallbladder and complete the surgery. Dr. Mathew agreed that a probable cause of the bleeding was that a clip on the cystic artery had slipped. He explained that a stricture of the common bile duct could be caused by many reasons, including irritation from the gallstone; inflammation; any injury to the bile duct, such as a clip across the duct resulting in an obstruction; a malignancy in the bile duct; repeated attempts to insert a scope and visualize the bile duct; and ascending inflammation or infection going up the bile duct. An ultrasound conducted two weeks after her surgery showed there was no violation or obstruction of the bile duct at that time. With reference to Dr. Rupp's "critical view of safety" technique, Dr. Mathew said that essentially what Dr. Rupp does is, "go in, dissect some of the fat tissue from around the gallbladder and find the cystic duct and cystic artery, visualize the whole area. ... That's exactly what I do, what every surgeon does." He stated that the way he performed the procedure was the same as other doctors do, and that he believed he satisfied the standard of care in his treatment of Ms. Brown.

Dr. George Golightly, a member of the Medical Review Panel, was called as an expert witness for the defense. He stated that the panel concluded that a common bile duct injury is a known and established complication of a laparoscopic cholecystectomy and that the identification and care, including the transfer to Dr. Bolton at Ochsner in New Orleans, was appropriate and timely. In sum, the panel had a unanimous finding that Dr. Mathew was not guilty of medical malpractice, but only failure to inform Ms. Brown of the risks of the laparoscopic procedure. Upon further questioning, he

reiterated that his opinion was that there was no deviation from the standard of care that would be construed as malpractice.

As with the informed consent issue, the jury in this case was presented with several conflicting opinions concerning the standard of care and whether or not Dr. Mathew breached that standard of care. Given the statements from both Dr. Bolton and Dr. Rupp that the risks inherent in the laparoscopic procedure could happen without any fault on the part of the doctor and, in fact, could happen "to the best doctor on his best day," the jury was reasonable in finding that Dr. Mathew did not breach the standard of care. Our review of the record does not persuade us that this conclusion was manifestly erroneous.

Judgment Notwithstanding the Verdict

Ms. Brown also contends that the court erred in failing to grant her a JNOV. A JNOV is a procedural device authorized by LSA-C.C.P. art. 1811, by which the trial court may modify the jury's findings to correct an erroneous jury verdict. Article 1811 states, in pertinent part:

> A. (1) Not later than seven days, exclusive of legal holidays, after the clerk has mailed or the sheriff has served the notice of judgment under Article 1913, a party may move for a judgment notwithstanding the verdict.
>
> (2) A motion for a new trial may be joined with this motion, or a new trial may be prayed for in the alternative.
>
> B. If a verdict was returned the court may allow the judgment to stand or may reopen the judgment and either order a new trial or render a judgment notwithstanding the verdict.

Article 1811 does not set out the criteria to be used when deciding a motion for JNOV. However, the Louisiana Supreme Court has established the standard to be used in determining whether a JNOV is legally called for, stating:

> JNOV is warranted when the facts and inferences point so strongly and overwhelmingly in favor of one party that the trial court believes that reasonable persons could not arrive at a contrary verdict. The motion should be granted only when the evidence points so strongly in favor of the moving party that reasonable persons could not reach different conclusions, not merely when there is a preponderance of evidence for the mover. The motion should be denied if there is evidence opposed to the motion which is of such quality and weight that reasonable and fair-minded persons in the exercise of impartial judgment might reach different conclusions. In making this determination, the trial court should not evaluate the credibility of the witnesses, and all reasonable inferences or factual questions should be resolved in favor of the non-moving party.

> This rigorous standard is based upon the principle that "[w]hen there is a jury, the jury is the trier of fact." (Citations omitted.)

Joseph v. Broussard Rice Mill, Inc., 00-0628 (La. 10/30/00), 772 So.2d 94, 99.

In a case such as this, the trial court must first determine whether the facts and inferences point so strongly and overwhelmingly in favor of the plaintiffs that reasonable jurors could not arrive at a contrary verdict. Stated simply, if reasonable persons could have arrived at the same verdict, given the evidence presented to the jury, then a JNOV is improper. Cavalier v. State, Dep't of Transp. & Dev., 08-0561 (La. App. 1st Cir. 9/12/08), 994 So.2d 635, 644.

An appellate court reviewing a trial court's grant of a JNOV employs the same criteria used by the trial court in deciding whether to grant the motion. See Smith v. State, Dep't of Transp. & Dev., 04-1317 (La. 3/11/05), 899 So.2d 516, 525. In other words, the appellate court must determine whether the facts and inferences adduced at trial point so overwhelmingly in favor of the moving party that reasonable persons could not arrive at a contrary finding of fact. Id. If the answer is in the affirmative, then the appellate court must affirm the grant of the JNOV. Id. However, if the appellate court determines that reasonable minds could differ on that finding, then the trial court erred in granting the JNOV, and the jury verdict should be reinstated. Id.; Wood v. Humphries, 11-2161 (La. App. 1st Cir. 10/9/12), 103 So.3d 1105, 1109-10, writ denied, 12-2712 (La. 2/22/13), 108 So.3d 769.

After reviewing the record in this case, we cannot find that the evidence points so strongly in favor of Ms. Brown that reasonable persons could not reach a different conclusion on the issues presented at trial. The testimony presented by Dr. Bolton, Dr. Rupp, and Dr. Mathew was reasonable, and each supported his opinions with facts concerning Ms. Brown's treatment. Obviously, reasonable minds could differ on whether Dr. Mathew breached the standard of care in his treatment of her. Accordingly, the jury verdict must be upheld.

Assessment of Costs

Louisiana Code of Civil Procedure article 1920 states that unless the judgment provides otherwise, costs shall be paid by the party cast, and may be taxed by a rule to show cause. Except as otherwise provided by law, the court may render judgment for

costs, or any part thereof, against any party, as it may consider equitable. Additionally, LSA-C.C.P. art. 2164 states that appellate courts shall render any judgment which is just, legal, and proper upon the record on appeal, and may tax the costs of the lower or appellate court, or any part thereof, against any party to the suit, as may be considered equitable.

In his answer to the appeal, Dr. Mathew challenges the failure of the trial court to tax the losing party, Ms. Brown, with the cost of his expert witness, Dr. Golightly. Following the trial, the defense filed a rule to tax the cost of its only expert witness, $5062.50, as a court cost in the proceeding. The court denied the motion, citing a Fifth Circuit decision, Carcamo v. Raw Bar, Inc., 12-0294 (La. App. 5th Cir. 11/27/12), 105 So.3d 936. In that case, although there was no finding that the defendants had taken actions during the litigation to deliberately increase costs, the district court declined to tax the costs against the plaintiff, who had lost the case, despite incurring $65,000 in damages. The court stated:

> I don't, I didn't feel like it was a frivolous case. I think the case may have had merit. The jurors decided in favor of the Defendants. You guys won at trial. Now, you're trying to come back and get cost from the Plaintiffs. I think it's a bit much so I'm going to deny your Rule to Show Cause for costs of these proceedings.

Id. at 938. In affirming the district court's decision, the Fifth Circuit explained:

> While it is the general rule that the party cast in judgment should be taxed with costs, the trial court may assess costs in any equitable manner and against any party in any proportion it deems equitable, even against the party prevailing on the merits. *Saunders v. Hollis,* 44,490 (La.App. 2 Cir. 8/19/09), 17 So.3d 482, 485-86, *writ denied,* 09-2221 (La.12/18/09), 23 So.3d 945. The trial court has great discretion in awarding costs and a trial court's assessment of costs can be reversed only upon a showing of abuse of discretion. *Hacienda Construction, Inc. v. Newman,* 44 So.3d at 337.
>
> The trial judge declined to assess costs against plaintiffs in this case. In doing so, the trial judge explained her reasons which we set forth above. While we recognize that generally the prevailing party is not assessed costs unless he incurred additional costs pointlessly or engaged in other conduct which justified an assessment of costs against him, the trial judge has great discretion in this regard. Although we do not find, from our review of the designated record before us, that defendants incurred additional costs pointlessly or engaged in other conduct justifying the assessment of costs against them, the trial judge can assess costs on her discretionary authority alone. *See Lee v. Constar, Inc.,* 05-633 (La.App. 5 Cir. 2/14/06), 921 So.2d 1240, 1254, *writ denied,* 06-880 (La.6/2/06), 929 So.2d 1263. After review, we do not find the trial judge abused her discretion in refusing to assess costs against plaintiffs in this case.

Id. at 939-40.

In the matter before us, the district court explained the decision as follows:

> THE COURT: Because Ms. Brown had to endure $150,000 more of medical expenses because of the action of the defendant.
>
> MR. WILSON: But we have a judgment in favor of the defendant.
>
> THE COURT: Well, what everybody agrees is that it was the action of the defendant that made her incur these costs. It wasn't negligence and it wasn't medical malpractice, but it was his actions.

In Sallinger v. Robichaux, 98-2160 (La. App. 1st Cir. 6/23/00), 762 So.2d 761, 764-65, vacated in part on other grounds and remanded, 00-2269 (La. 1/5/01), 775 So.2d 437, this court stated that this court's test for an abuse of discretion has been premised on whether there is support in the record that the party against whom the costs have been disproportionately ascribed caused costs to be pointlessly incurred or engaged in other conduct that would justify a realignment of court costs. Absent such a finding, an assessment of costs against a party who has not been cast in judgment is an abuse of the court's discretion. However, in a more recent case, although there was a zero verdict and no indication that either party had incurred costs needlessly, the court ordered each party to bear its own costs. See Townes v. Liberty Mut. Ins. Co., 09-2110 (La. App. 1st Cir. 5/7/10), 41 So.3d 520, 531-32. Also, in Anglin v. Anglin, 09-0844 (La. App. 1st Cir. 12/16/09), 30 So.3d 746, 753-54, this court recognized that a trial court may assess costs against a party who prevails to some extent on the merits, citing Adams v. Rhodia, Inc., 07-0897 (La. App. 1st Cir. 2/13/09), 5 So.3d 288, 289. Although the trial court could have required both sides to bear some portion of the court costs in the case, this court found no abuse of discretion in assessing all costs against the party whose actions made it necessary for the appellants to bring the lawsuit and incur the costs of litigating. Anglin, 30 So.3d at 754.

In light of these more recent cases from this court, we find no abuse of discretion in the district court's refusal to assess the costs of Dr. Mathew's expert against Ms. Brown.

CONCLUSION

Based on the above analysis, the October 23, 2012 judgment rendered in accord with the jury verdict is affirmed, as is the February 21, 2013 judgment denying the plaintiff's motions for a judgment notwithstanding the verdict or new trial. The court's denial of the defendant's motion to assess its expert witness costs to the plaintiff is also affirmed. Each party is to bear its own costs of this appeal.

AFFIRMED.