Filed 4/1/14 Faraj v. Ritter CA2/1

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

EDMOND FARAJ, Plaintiff and Respondent, v. MANFRED P. RITTER et al., Defendants and Appellants.	B245891 (Los Angeles County Super. Ct. No. EC054278)

APPEAL from an order of the Superior Court of Los Angeles County, David S. Milton, Judge. Affirmed.

Cole Pedroza, Kenneth R. Pedroza, Matthew S. Levinson, Tammy C. Weaver; Reback, McAndrews, Kjar, Warford, Stockalper & Moore, and Patrick Stockalper for Defendants and Appellants.

Blumberg Law Corporation, John P. Blumberg and Ave Buchwald for Plaintiff and Respondent.

_____

Appellant Manfred P. Ritter, M.D. (Dr. Ritter) removed respondent Edmond Faraj's (Faraj) gallbladder and in the process cut the common bile duct. Faraj brought an action against Dr. Ritter and the Foothill Surgical Specialists Medical Group (hereafter collectively appellants), Sam H. Carvajal, M.D. (Dr. Carvajal) and Verdugo Hills Hospital, contending that cutting the common bile duct fell below the standard of care.[1] The jury returned a verdict for the defendants. The trial court granted Faraj's motion for a new trial because the court found that the verdict was against the weight of the evidence. Appellants contend, in essence, that the trial court should have weighed the evidence and made credibility determinations more favorable to them. We accord the requisite level of deference to the trial court's finding that the verdict was against the weight of the evidence and affirm.

FACTS

1. Background

The removal of a gallbladder is called a cholecystectomy. A cholecystectomy may be performed laparoscopically or it may be "open." The procedure used by Dr. Ritter was a laparoscopic cholecystectomy. This procedure requires four very small incisions and the insertion into one of those incisions of a laparoscope which is a camera that allows the surgeon to see the area of the procedure. An open cholecystectomy requires one large incision.

Dr. Ritter diagnosed Faraj with severe cholecystitis on August 8, 2009. A large gallstone was lodged in the neck of Faraj's gallbladder. It is undisputed that this required a cholecystectomy. Dr. Ritter performed this surgery on August 8, 2009.

The stem of the gallbladder is called the cystic duct. The cystic duct must be cut in order to remove the gallbladder. The cystic artery, which supplies the gallbladder with blood, also must be cut in order to remove the gallbladder.

---

[1] Dr. Carvajal and Verdugo Hills Hospital were dismissed prior to trial.

The common bile duct goes from the intestine to where the cystic duct joins the gallbladder. It does *not* enter the bottom of the gallbladder and is *not* to be cut during a colecystectomy.

An "intraoperative cholangiography" or a cholangiogram is a procedure that helps the surgeon differentiate between the common bile duct and the cystic duct, which may be mistaken for one another on solely visual inspection. Contrast is injected into the structure thought to be the cystic duct and one follows the contrast by means of X-ray. The contrast "lights up the whole biliary tree."[2] The procedure requires the surgeon to make a hole in the structure in order insert the contrast by means of a catheter.

2. Dr. Ritter's professional background

Dr. Ritter attended medical school in Munich, Germany, completed a surgical residency at the University of Southern California, and two fellowships in colorectal and thoracic/esophageal surgery. He is board certified by the American Board of General Surgery and a fellow of the American College of Surgeons. He estimated that he has performed approximately 660-670 laparoscopic and 30 open cholecystectomies.

3. The procedure

After making the standard incisions, Dr. Ritter found Faraj's gallbladder to be acutely inflamed. Dr. Ritter tried to "retract," i.e., move or shift the gallbladder in order to open up the area where the cystic duct joins the common bile duct. Opening up this area makes it a safer operation. Dr. Ritter tried to move the gallbladder up but this movement was limited in scope by Faraj's liver. He then was able to move the gallbladder sideways or laterally. This movement is important since it facilitates viewing the area where the cystic duct, the common bile duct and the cystic artery all are located. This movement was successfully accomplished.

Dr. Ritter next dissected tissue, meaning that he separated tissue with a blunt instrument in order to be able to identify the cystic duct and cystic artery. His operative report states that he identified a tubular structure that "'was clearly leading towards the

---

[2] "Biliary tree" is a reference to structures that carry bile.

gallbladder.'" Dr. Ritter was convinced that this was the cystic duct "because it was going into the bottom of portion of the gallbladder." He cut this structure. Next, he identified and cut the cystic artery.

Once the cystic duct and cystic artery have been cut, the gallbladder is removed from where it is attached to the liver. In attempting to do so, Dr. Ritter encountered a second tubular structure that looked to him like a bile duct. Dr. Ritter became suspicious that the first tubular structure that he had encountered and cut could have been the common bile duct. There is only one tubular structure that goes into the gallbladder—the cystic duct. This second structure was going into the gallbladder.

Dr. Ritter decided to perform a cholangiography. This procedure showed that there was a "bile duct injury." In other words, with his first cut, Dr. Ritter had severed the common bile duct, thinking it was the cystic duct.

Dr. Ritter decided to call in Dr. Carvajal who is an expert in bile duct reconstruction. Dr. Carvajal took over as the primary surgeon with Dr. Ritter assisting. The procedure was converted into an open cholecystectomy. Dr. Carvajal performed a hepatojejunostomy to repair the bile duct by sewing the bile duct directly to the intestine.

In addition to recounting the procedure, Dr. Ritter offered a number of opinions. We summarize these in section 5.

4. Faraj's injuries

As a result of the severance of his common bile duct, Faraj visited the emergency room two or three times and was admitted to the hospital four or five times. Faraj had stricturing or narrowing of the common bile duct and cholangitis or an infection of the biliary tree. He was prescribed pain medication.

Dr. Ritter referred Faraj to Dr. Robert Selby. Dr. Selby performed a second surgery on Faraj in December of 2009 to take down the prior repair operation due to scarring, a known complication. The scarring/stricturing recurred and Dr. Selby performed a third surgery to address it. In between the surgeries, Dr. Selby also did serial dilations of the common bile duct, which is designed to deal with scarring.

5. The experts

Stanley R. Klein, M.D., F.A.C.S. for Faraj[3]

(i) The standard of care

According to Dr. Klein, when performing a cholecystectomy, nothing should be clipped or cut until everything is accurately identified. In order to do this, a surgeon must achieve the "'critical view of safety.'" The critical view of safety requires that the surgeon tease apart the structures so that he is able to see the cystic duct and cystic artery simultaneously and can see the liver behind them.

Achieving the critical view of safety may be difficult because of anatomic variation. Additionally, recurrent inflammation will cause scarring that may pull together the gallbladder with the surrounding organs, including the common bile duct. If the critical view of safety cannot be obtained, Dr. Klein provided a step-by-step checklist to follow.

The surgeon can invite a more sophisticated colleague to join the surgery. If he is comfortable proceeding alone, he can perform a cholangiogram. Dr. Klein testified that the holes made for a cholangiogram are of no consequence. If the hole is made in the cystic duct, the cystic duct will be cut anyway. If the hole is made in the common bile duct, it can be repaired with one little stitch.[4]

---

[3] Dr. Klein is a graduate of the School of Medicine of the University of California at San Diego. He completed a residency in surgery and held fellowships in critical care and vascular surgery. He is board-certified in general surgery, critical care surgery and vascular surgery. He is a Professor of Medicine at UCLA. and is on the staff at Harbor-UCLA Medical Center. He teaches surgery to medical students, including specifically gallbladder surgery. He has published widely.

[4] There was a conflict in the evidence on the effects of a cholangiogram. According to Dr. Ritter, Faraj's common bile duct was unusually small, i.e., 3.2 millimeters, and the catheter used to inject the contrast had a diameter of 2.2 millimeters. Dr. Ritter disagreed with Dr. Klein's opinion that a small stitch would close the hole made for the catheter. This conflict in the evidence is of no moment at this stage of the proceedings. (See fn. 8.)

Dr. Klein "completely" disagreed with the defense expert, Dr. Kenneth Deck, who opined that performing a cholangiogram would injure plaintiff and require surgical repair. According to Dr. Klein, medical literature states that a cholangiogram should be used liberally if the critical view of safety cannot be achieved. Doing a cholangiogram is a negligible trauma. The benefit of the cholangiogram is that it provides the surgeon a roadmap so that the surgeon knows where he is going.

If the surgeon is still unable to achieve the critical view of safety, the surgeon could add an extra port to look through to help retraction in order to obtain a better view.

Finally, the surgeon can convert the surgery to an open procedure so that the surgeon can touch and feel with his fingers. The incision in an open procedure is a lot harder to heal but the gallbladder will come out safely. Dr. Klein stated without reservations that changing the procedure to an open cholecystectomy would have prevented the harm that befell Faraj.

Dr. Klein opined that these steps, starting with the critical view of safety, the cholangiogram, and conversion to an open procedure, constitute the standard of care for surgeons doing gallbladder surgery. The sequence is taught to surgery residents and is emphasized in postgraduate courses.

(ii) Dr. Ritter's performance analyzed

Dr. Klein relied on the report of the operation prepared by Dr. Ritter.

Dr. Ritter got hold of the gallbladder and tried to pull it so he could look for the structures. Dr. Ritter noted that retraction was only possible to a limited extent, meaning that the liver was not moving much and he was having trouble seeing the critical view of safety. Dr. Ritter then saw a structure that he identified in his judgment at that time to be "clearly heading towards the gallbladder." He cut it. Dr. Klein noted that at no point in time prior to cutting the structure did Dr. Ritter ever mention that he had achieved the critical view of safety. This fell below the standard of care.[5]

---

[5] Dr. Klein summed it up as follows: "And the very fact that Dr. Ritter was saying he was unable to retract it means it won't spread apart. The structures are stuck

Next, Dr. Ritter found a very short cystic artery and cut it. He then encountered a second tubular structure that also looked like a bile duct and then suspected that the first structure he cut might have been the common bile duct.

Dr. Ritter now decided to do a cholangiogram. This reversed the proper sequence in that he should have performed the cholangiogram before he started cutting. He now found that the common bile duct had been cut. In cutting the common bile duct instead of the cystic duct, Dr. Klein opined that Dr. Ritter violated the safety rules of the standard of care.

Dr. Ritter called in Dr. Carvajal to assist in the repair of the injury by hepatojejunostomy. Dr. Ritter could have called Dr. Carvajal before cutting if he could not "understand the anatomy." Again, Dr. Klein opined that Dr. Ritter did things out of order in that Dr. Ritter should have taken safety steps to identify what he was cutting before he cut it.

(iii) *Cutting the common bile duct is negligence*

When asked whether cutting the common bile duct occurs only when the surgeon is negligent, Dr. Klein answered: "Absolutely. It should not happen." Dr. Klein opined that Faraj's injury was a completely preventable problem.

Having repaired 50 of these problems personally, Dr. Klein stated that problems invariably come from not following the rules and not achieving the critical view of safety, not doing a cholangiography, and not calling for help. The consequences of cutting the common bile duct are very serious. Many problems can arise; Dr. Klein described the situation as precarious and life threatening. The repair can fail and a leak can start, leading to infection. The repair can scar and stricture, and the patient can require a series of procedures and perhaps more operations to fix it. Such adverse consequences did in fact befall Faraj.

---

together. So in the setting of being stuck together, unable to open them up, without seeing the critical view, the structure, this tubular structure, which you don't know what it is, is clipped and cut."

(iv) Dr. Klein and the defense expert

Dr. Klein also testified that the American College of Surgeons provides guidelines outlining what individuals are appropriate expert witnesses. One guideline is board certification at the time the expert is reviewing a case. Dr. Klein testified that Dr. Deck admitted in deposition that he was not board certified at the time he reviewed Faraj's case. Dr. Klein also disagreed with Dr. Deck's opinions that injury to the common bile duct is a recognized risk and that this can occur in the best of hands and under the best of circumstances.

Kenneth B. Deck, M.D., for the defense[6]

Dr. Deck was board certified in general surgery in 1983 and recertified in 1994. He had the option to recertify in 2004 but did not do so because he chose to switch the focus of his practice more toward breast cancer and breast surgery. He was told that a breast certification examination was due to be given shortly and decided to wait for that. A couple of years after 2004, the breast examination still was not available. Thus, he was not board certified at the time of his record review and testimony.

Dr. Deck has performed between 4,200 and 4,300 laparoscopic cholecystectomies in his career. He has told every patient that he has operated on that a common bile duct injury is possible. Dr. Deck opined that common bile duct injury is a recognized complication that occurs in the best of hands. He explained that removal of the gallbladder requires the surgeon to divide the cystic duct and the cystic artery, which both go to the gallbladder. There are times when the cystic duct and the common bile duct look identical. One can inadvertently injure the common bile duct.

Dr. Deck's opinion was that Dr. Ritter met the standard of care. In his opinion, bile duct injuries can occur in the absence of negligence. They also can result from negligence. Dr. Deck opined that Dr. Ritter encountered a "perfect storm" when he operated on Faraj, inasmuch as there was an acute gallbladder that was very distended, a

---

[6] Dr. Deck attended medical school at Ohio State University, graduating in 1973. He completed a four-year residency in surgery at the University of Southern California and had a fellowship in vascular surgery. He is in private practice.

stone that was impacted down at the bottom of the gallbladder, and an extremely short cystic duct, which defendant believed was headed directly into the gallbladder. Dr. Deck testified that a surgeon always looks for a tubular structure that goes directly into the gallbladder because that is the cystic duct.

Faraj's common bile duct was small. The cystic duct is classically two to four millimeters in size. The common bile duct here appeared to go directly to the gallbladder. Dr. Deck characterized the misidentification of the common bile duct as the cystic duct as a "visual misperception."

According to Dr. Deck, a cholangiogram of the common bile duct, which was three millimeters, by a catheter two to three millimeters in size would have required the kind of repair of the common bile duct that was in fact done in this case by Dr. Carvajal. Dr. Deck disagreed with Dr. Klein that one stitch would have been enough to close up the common bile duct after a cholangiogram. Dr. Deck also disagreed with Dr. Klein's view that the procedure should have been converted into an open procedure as Dr. Deck opined the risks of a laparoscopic procedure are less than those of an open procedure.

However, Dr. Deck was impeached with a declaration in another matter that he had signed previously and that stated as follows: "It is my further professional opinion that even though transecting the common bile duct is reported in the medical literature as a complication, this alone does not mean that when a transection of the common bile duct occurs, it is not the result of the surgeon's or other healthcare provider's negligence.

"It is my further professional opinion that *a transection of the common bile duct during a laparoscopic cholecystectomy procedure does not occur in the absence of negligence as such in the case of Darcy Arnold, because in performing the procedure, the surgeon must always identify the structure's anatomy before cutting*.

"Based on my professional opinion and review of the medical records, depositions, and declarations of the respondent's expert, to a reasonable degree of medical probability, Dr. Coleman and Kaiser failed to properly make such identification before cutting. (Italics added.)

Dr. Deck explained that the facts of the previous case were different. The previous matter did not involve acute cholecystitis. The surgeon there put a number of clips on a number of different structures without attempting to identify a structure going into the gallbladder. Dr. Deck opined that Dr. Ritter did attempt to identify the plaintiff's structures and anatomy before cutting.

Robert Selby, M.D., for the defense

Dr. Selby, a board certified surgeon, was Faraj's treating physician following the cholecystectomy performed by Dr. Ritter. Dr. Selby has performed cholecystectomies and has treated 300 to 400 common bile duct injuries in his career. Of the common bile duct injuries that he has treated, 98 percent of them were due to cholecystectomies. Dr. Selby performed several surgeries on Faraj to repair scarring and stricturing.

Dr. Selby opined that common bile duct injuries occur during gallbladder removal through three mechanisms. First, if there is an injury that causes bleeding, the bleeding may obscure the field and accidental injury to the duct may occur in an attempt to obtain control of the bleeding. Second, the field may be so inflamed that it is not possible to determine the tissue planes, and in an attempt to try to define those, the injury occurs. Lastly, the injury can be caused by a lack of technical skill. In Dr. Selby's opinion, common bile duct injuries can occur even with highly experienced surgeons.

Dr. Selby opined that the most common cause of common bile duct injuries is that inflammation has made it difficult to define the structures. This was the cause of Faraj's injury.

When asked whether he ever formed the opinion that Dr. Ritter was careless or inexpert, Dr. Selby answered no. Dr. Selby disagreed with Dr. Klein's view that common bile duct injury in a cholecystectomy only occurs as a result of negligence.

When asked whether defendant had met the standard of care, Dr. Selby answered that it was his impression that plaintiff had an inflammatory change in the gallbladder that was the reason for the bile duct injury. He testified that he could not comment on the degree of skill that Dr. Ritter used on August 8, 2009 in performing the laparoscopic cholecystectomy on Faraj.

Dr. Selby was familiar with the critical view of safety. He recognized that the critical view of safety involves identifying simultaneously arteries and ducts. However, Dr. Selby testified that one cannot always simultaneously view the cystic duct and cystic artery. This is because inflammation distorts the anatomy and makes it difficult to achieve a critical view of safety.

Dr. Selby did not agree that achieving a critical view of safety and following those rules would always prevent common bile duct injury. There are many different aberrations of the biliary tree and some of them involve what is called "sectoral ducts," meaning segments of the liver that enter in odd locations, which are most difficult to pinpoint. In those particular circumstances, one can see the cystic duct, the cystic artery and the upward part of the common bile duct, clip the duct, and still have an injury.

Dr. Selby agreed that plaintiff's common bile duct was small. He stated that he would not put a two millimeter catheter into a 3.2 millimeter duct because of the likelihood of getting a narrowing of the common duct. Dr. Selby stated that he would not put any size catheter into a 3.2 millimeter duct.

Dr. Selby also opined that he probably would not repair a hole in the common bile duct with one stitch. The hole would already be nearly the diameter of the duct and a one-stitch repair would not be orthodox surgical therapy.

Finally, Dr. Selby opined that a reasonably careful surgeon who sees what he believes is the cystic duct heading directly into the bottom of the gallbladder and feels that he can clearly visualize the anatomy does not need to do anything further.

Dr. Ritter

Dr. Ritter testified that he complied with the standard of care. He explained that he misidentified the common bile duct as the cystic duct because the common bile duct was very small and the cystic duct was unusually thin.

According to Dr. Ritter, common bile duct injuries are a recognized complication of gallbladder surgeries and can happen even in the best of hands. In his opinion, the standard of care is met when the surgeon identifies a tubular structure that enters the bottom of the gallbladder.

The Order Granting a New Trial

The court's order was almost seven pages long and very detailed. It set forth Dr. Klein's testimony in considerable detail that need not be repeated here. The court followed its account of Dr. Klein's testimony by writing: "The operative report shows that [Dr. Ritter] did not have the 'critical view of safety' when he clipped and cut. . . . This violates the first ten[e]t of gallbladder surgery that you don't cut anything until it is identified. . . . The safety checklist was not followed. Dr. Carvajal could have been called in before the transection. Cutting the common bile duct should not happen, it was a completely preventable problem."

The court found Dr. Ritter's testimony to be unpersuasive in several respects. First, Dr. Ritter testified at one point that "he certainly saw [the structure he cut] go into the gallbladder."[7] Later, he was forced to admit that he could not actually have seen it go into the gallbladder because the structure he cut—the common bile duct—does not go into the gallbladder. The trial court remarked that Dr. Ritter's testimony "could not be true" and questioned Dr. Ritter's credibility on another point as well. The court remarked that Dr. Ritter "should have taken much greater care by attempting to achieve the 'critical view of safety' or following the safety checklist . . . ."

Next, the court noted that Dr. Ritter admitted that the critical view of safety requires the surgeon to see simultaneously the cystic duct and cystic artery enter the gallbladder. Dr. Klein testified that if Dr. Ritter had complied with this standard, the injury would not have happened. The admission on the part of Dr. Ritter that the critical view of safety was not achieved further weakened his defense.

The court also noted that the gallbladder was inflamed, the common bile duct was unusually thin, and the cystic duct was unusually short, all of which were circumstances that should have led Dr. Ritter to perform a cholangiogram or to change the procedure to

---

[7] The operative report states that the first tubular structure that he saw was "clearly heading towards the gallbladder." Also, Dr. Ritter testified that during the surgery, he saw a tubular structure that "was going into the bottom portion of the gallbladder. . . ." This was what he cut.

an open surgery before he cut the tubular structure that turned out to be the common bile duct.

The court rejected Dr. Ritter's testimony that he complied with the standard of care as not persuasive because, if he had achieved the critical view of safety, the injury would not have happened.

As to the testimony of Dr. Selby, the court only stated, "Dr. Robert Selby had no opinion whether the defendant's conduct fell below the standard of care."

The court did not find Dr. Deck's testimony to be persuasive because he had taken a position inconsistent with his trial testimony when previously he had testified, "'It is my further professional opinion that a trans[e]ction of a common bile duct . . . does not occur in the absence of negligence . . . because . . . the surgeon must always identify the patient's structures and anatomy before cutting. . . .'"

The new trial order concluded: "Because the defendant admittedly failed to follow an 'important' safety protocol, which, if followed, would have prevented the injury, the court believes his conduct fell below the standard of care. For all of the reasons expressed heretofore, the court finds the jury's verdict was against the weight of the evidence and should not stand."

DISCUSSION

When the trial court grants a motion for a new trial because the evidence is insufficient to justify the verdict, the order granting the new trial must comply with two requirements: (1) it must "briefly recite the respects in which [the court] finds the evidence to be legally inadequate" (*Mercer v. Perez* (1968) 68 Cal.2d 104, 116); and (2) it "must briefly identify the portion of the record which convinces the judge 'that the court or jury clearly should have reached a different verdict or decision.'" (*Ibid.*)

The provision in section 657 requiring the trial court to give its reasons for granting the new trial motion does not require the trial court "'to cite page and line of the record, or discuss the testimony of particular witnesses'" or discuss "'the weight to be given, and the inferences to be drawn from each item of evidence . . . .'" (*Scala v. Jerry Witt & Sons, Inc.* (1970) 3 Cal.3d 359, 370.) The statement of reasons only needs to be

"specific enough to facilitate appellate review and avoid any need for the appellate court to rely on inferences or speculation." (*Oakland Raiders v. National Football League* (2007) 41 Cal.4th 624, 634.)

"[O]n appeal from an order granting a new trial upon the ground of the insufficiency of the evidence . . . [the] order shall be reversed as to such ground only if there is no substantial basis in the record for any of such reasons." (Code Civ. Proc., § 657.) The order granting a motion for a new trial on the ground of the insufficiency of the evidence "must be sustained on appeal unless the opposing party demonstrates that no reasonable finder of fact could have found for the movant on that theory." (*Jones v. Citrus Motors Ontario, Inc.* (1973) 8 Cal.3d 706, 710.)

"It is well settled that the granting of a motion for a new trial rests so completely within the discretion of the trial court that its action will not be disturbed unless a manifest and unmistakable abuse of discretion clearly appears. [Citations] On appeal all presumptions are in favor of the order granting a new trial [citations], and the order will be affirmed if it may be sustained on any ground [citations]." (*Brandelius v. City & County of S. F.* (1957) 47 Cal.2d 729, 733.)

The reason for this deferential standard of review is that the trial court, in ruling on the motion for new trial, sits as an independent trier of fact. (*Neal v. Farmers Ins. Exchange* (1978) 21 Cal.3d 910, 933.) "Therefore, the trial court's factual determinations, reflected in its decision to grant the new trial, are entitled to the same deference that an appellate court would ordinarily accord a jury's factual determinations." (*Lane v. Hughes Aircraft Co.* (2000) 22 Cal.4th 405, 412.)

The new trial order before us complies with the requirements applicable to new trial orders. First, the order recites the respects in which the trial court found the evidence in favor of the verdict to be legally inadequate. Second, the order identifies the portions of the record which convinced the trial judge that the jury should have reached a different verdict. (*Mercer v. Perez, supra,* 68 Cal.2d at p. 116.) Both prongs are supported amply by the evidence here.

As to the first prong, Dr. Ritter was caught in the pincers of a defense case that was inherently contradictory. He had to insist that he actually saw the first tubular structure enter the gallbladder in order to justify cutting it, but he also had to admit in the same breath that he could not possibly have seen it enter the bottom of the gallbladder, because the common bile duct, which he cut, does not enter the bottom of the gallbladder. This contradiction in his testimony as to the key factual issue could be viewed as fatal to the defense, even without Dr. Klein's testimony.

Once Dr. Klein's testimony is taken into account, it is evident that a reasonable finder of fact could have found for Faraj based on the facts and Dr. Klein's testimony. First, Dr. Klein's opinion rested on a principle that is eminently logical—that a surgeon should not sever a structure that he or she has not identified. As Dr. Klein explained, it follows logically that, if it is not possible to identify the cystic duct and cystic artery, recourse should be to the cholangiography in order to identify these organs.[8] If the answer still eludes the surgeon, he should call in more sophisticated help, add another port through which his view may be improved, or convert the procedure to an open cholecystectomy. In other words, one should not sever a structure before it is identified.

For appellants to prevail on their appeal, they would have to persuade us that no reasonable trier of fact could have agreed with Dr. Klein. Appellants'efforts have fallen short of that mark here. Therefore, the new trial order must be affirmed. (*Jones v. Citrus Motors Ontario, Inc., supra,* 8 Cal.3d 706, 710.) We can find no "manifest and unmistakable" abuse of discretion (*Brandelius v. City &County of S. F., supra*, 47 Cal.2d at p. 733) that would authorize reversal.

Appellants' arguments are focused on the trial court's order. They contend based on three short passages that the trial court failed to consider all the evidence and relied on

---

[8] The debate about the safety of a cholangiogram was of marginal relevance at trial and is of no account in this forum because we are limited to determining whether there is evidence that supports the ruling. Conflicts in the evidence are of no moment. In any event, it is not persuasive to claim that a procedure that is designed as a safety measure poses such a risk that it should not be employed.

inaccurate statements of fact. When scrutinized, these are really arguments that the trial court should have weighed the evidence and made credibility determinations in a manner more favorable to Dr. Ritter. In other words, the judge should have put greater stock in what Dr. Selby and Dr. Deck said and disbelieved Dr. Klein's testimony when it contradicted theirs.

This argument misses the mark. First, it does not address the proper standard for review of a new trial order in that it does not demonstrate "manifest and unmistakable" abuse of discretion or that "no reasonable finder of fact could have found for" Faraj based on the facts and the testimony of Dr. Klein. (*Jones v. Citrus Motors Ontario, Inc.*, *supra*, 8 Cal.3d at p. 710.) It simply argues that the court gave too much weight to Dr. Klein's testimony and not enough to Dr. Selby's or Dr. Deck's. Essentially, this is what appellants argue when they contend the trial court failed to consider all the evidence.

The second flaw in appellants' argument is that, on appeal of a new trial order, "all presumptions are in favor of the order granting a new trial [citations] and the order will be affirmed if it may be sustained on any ground. [Citations.]" (*Brandelius v. City &County of S. F.*, *supra*, 47 Cal.2d 7at p. 733.) Again, appellants have failed to show that Dr. Klein's testimony and the facts could not support a verdict for Faraj.

Third, appellants' arguments set a standard of perfection for new trial orders that is wholly inconsistent with the rules applicable to such orders. The rules do not require that the trial court "'discuss the testimony of particular witnesses,'" or "'the weight to be given, and the inferences drawn from each item of evidence . . . .'" (*Scala v. Jerry Witt & Sons, Inc.*, *supra*, 3 Cal.3d at p. 370.) The trial court's lengthy and detailed order was more than sufficient to fulfill its role of being "specific enough to facilitate appellate review and avoid any need for the appellate court to rely on inference or speculation." (*Oakland Raiders v. National Football League*, *supra*, 41 Cal.4th at p. 634.)

We turn now to appellants' specific arguments about the trial court's alleged failure to consider all the evidence and reliance on inaccurate statements of fact. Appellants contend that the trial court failed to consider all of the evidence, notably that it disregarded the testimony of Dr. Selby. It is true that the only reference in the new trial

order to Dr. Selby is this: "Dr. Robert Selby had no opinion whether the defendant's conduct fell below the standard of care."

Appellants point to a number of statements by Dr. Selby that were favorable to their side. Thus, they cite his testimony that the standard of care does not require a simultaneous view of the cystic duct and cystic artery; that bile duct injury can occur in the absence of negligence; that Dr. Selby did not think that Dr. Ritter acted carelessly or without skill; and that Dr. Selby implied that the cause of Faraj's injury was the inflammation of the gallbladder and not Dr. Ritter's negligence. That the trial court did not discuss Dr. Selby's testimony in the new trial order does not mean that the court failed to *consider* his testimony. It is likely that the trial court considered Dr. Selby's testimony but concluded it added nothing of significance because it simply echoed Dr. Deck's and Dr. Ritter's views.

The appellants also claim the trial court erred in stating in its order that Dr. Selby expressed "no opinion whether the defendant's conduct fell below the standard of care." The trial court's characterization is accurate whereas the appellants' is not. When asked directly whether Dr. Ritter had complied with the standard of care, Dr. Selby replied evasively that based on his conversation with Dr. Ritter, ". . . it was my impression that he had an inflammatory change in the gallbladder that was the reason for the bile duct injury." Later, Dr. Selby was asked, "You can't comment on the degree of skill that Dr. Ritter used . . . when he did the laparoscopic cholecystectomy on Mr. Faraj, can you?" Dr. Selby's answer was "no."

The next alleged factual flaw in the new trial order is that the order states that the liver was bulky "with limited retraction." Appellants point out that the testimony was that retraction was limited in an upward direction, but not in a lateral direction. Appellants' claim that this showed that the trial court misunderstood the facts is erroneous. It was accurate for the trial judge to state that retraction was limited since there was no movement in an upward direction. A reading of the trial court's lengthy and detailed order discussing the facts of this case demonstrates that the trial court had an excellent grasp of the facts.

Finally, appellants claim that the trial court erred in stating in the new trial order that Dr. Ritter admitted that viewing the vessels in question simultaneously was important. The trial court had an adequate basis for this statement. Dr. Ritter was asked on cross-examination whether he had testified in his deposition that it was "important to identify the cystic artery and cystic duct at the same time to prevent biliary ductal injury, you said, 'yes'?" His answer was: "Important, yes." Moreover, Dr. Ritter testified that, in his opinion, the standard of care is met when the surgeon identifies a tubular structure that enters the bottom of the gallbladder. As we have noted previously, Dr. Ritter could not have met the very standard of care he described because he could not have identified the structure he cut as one entering the bottom of the gallbladder.

Appellants have failed to demonstrate error by the trial court. The order granting the motion for a new trial meets the prescribed standards.

In light of our disposition of this appeal, it is not necessary to address the balance of appellants' contentions.

DISPOSITION

The order is affirmed. The respondent is to recover his costs on appeal.

NOT TO BE PUBLISHED

MILLER, J.*

We concur:

ROTHSCHILD, Acting P. J.

CHANEY, J.

---

* Judge of the Los Angeles Superior Court assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.