IN THE SUPREME COURT OF THE STATE OF NEVADA

KIMBERLY TAYLOR,

Appellant,

v.

KEITH BRILL, M.D. and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN, PLLC,

Respondents

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Elizabeth A. Brown
Clerk of Supreme Court

SUPREME COURT CASE NO. 83847

Dist. Court Case No. A-18-773472-C

APPELLANT'S APPENDIX

VOLUME I

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CHRONOLOGICAL LIST

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
VOLUME I			
Complaint	04/25/2018	I	APPX000001 – APPX000025
Answer to Complaint	09/26/2018	I	APPX000026 – APPX000043
Stipulation and Order to Dismiss Nurse Defendant Bruce Hutchins, RN without Prejudice	10/18/2018	I	APPX000044 – APPX000048
Notice of Entry of Order	10/24/2018	I	APPX000049 – APPX000056
Stipulation and Order to Dismiss Defendant Dignity Health D/B/A St. Rose Dominican Hospital – Siena Campus	03/09/2021	I	APPX000057 – APPX000061
Notice of Entry of Stipulation and Order to Dismiss Dignity Health D/B/A St. Rose Dominican Hospital Siena Campus	03/10/2021	I	APPX000062 – APPX000067
Stipulation and Order to Dismiss Defendant Valley Health System, LLC d/b/a Henderson Hospital with Prejudice and to Amend Caption	03/17/2021	I	APPX000068 – APPX000077
Notice of Entry of Stipulation and Order for Dismissal	03/19/2021	I	APPX000078 – APPX000090
Stipulation and Order for Defendant Christensen, M.D.'s Dismissal With Prejudice Only	04/21/2021	I	APPX000091 – APPX000097
Notice of Entry of Stipulation and Order for Defendant Christensen, M.D.'s Dismissal with Prejudice Only	04/22/2021	I	APPX000098 – APPX000106
Plaintiff's Motion in Limine #1: Motion to Permit Certain Closing Argument Techniques of Plaintiff's Counsel	08/18/2021	I	APPX000107 – APPX000115
Plaintiff's Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	08/18/2021	I	APPX000116 – APPX000189

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
VOLUME II			
Plaintiff's Motion in Limine #3: Motion to Exclude Evidence of Asserted Liability of Other Health Care Providers Under Piroozi	08/18/2021	II	APPX000190 – APPX000329
Plaintiff's Motion in Limine #4: Exclusion of Collateral Source Payments	08/18/2021	II	APPX000330 – APPX000349
Plaintiff's Proposed Jury Instructions	08/18/2021	II	APPX000350 – APPX000389
Plaintiff's Proposed Voir Dire	08/18/2021	II	APPX000390 – APPX000395
VOLUME III			
Defendant's Motion in Limine No. 3 to Exclude Defendants' Insurance Coverage	08/20/2021	III	APPX000396 – APPX000402
Defendant's Motion in Limine No. 1 to Include Others on the Verdict Form	08/20/2021	III	APPX000403 – APPX000467
Defendant's Motion in Limine No. 2 to Allow Defendants to Introduce Evidence of Collateral Sources Pursuant to NRS 42.021	08/20/2021	III	APPX000468 – APPX000613
Plaintiff's Opposition to Defendant's Motion in Limine #1: Inclusion of Others on Verdict Form	08/27/2021	III	APPX000614 – APPX000617
Plaintiff's Opposition to Defendant's Motion in Limine #2: Collateral Source Issues & NRS 42.021	08/27/2021	III	APPX000618 – APPX000621
VOLUME IV			
Plaintiff's Opposition to Defendant's Motion in Limine #3: Exclusion of Defendants' Insurance Coverage	08/27/2021	IV	APPX000622 – APPX000734
Defendants' Opposition to Plaintiff's Motion in Limine No. 1 to Permit Certain Closing Argument Techniques	09/01/2021	IV	APPX000735 – APPX000746
Defendants' Opposition to Plaintiff's Motion in Limine No. 2 to Exclude	09/01/2021	IV	APPX000747 – APPX000775

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Informed Consent Form and Terms or Argument Regarding Risk or Known Complication			
Defendants' Opposition to Plaintiff's Motion in Limine No. 3 to Exclude Evidence of Asserted Liability of Other Health Care Providers Under Piroozi	09/01/2021	IV	APPX000776 – APPX000803
Defendants' Opposition to Plaintiff's Motion in Limine No. 4 Exclusion of Collateral Source Payments	09/01/2021	IV	APPX000804 – APPX000827
Plaintiff's Reply in Support of Motion in Limine #1: Motion to Permit Certain Closing Argument Techniques of Plaintiff's Counsel	09/08/2021	IV	APPX000828 – APPX000833
Plaintiff's Reply in Support of Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	09/08/2021	IV	APPX000834 – APPX000838
Plaintiff's Reply in Support of Motion in Limine #3: Motion to Exclude Evidence of Asserted Liability of Other Health Care Providers Under Piroozi	09/08/2021	IV	APPX000839 – APPX000843
Plaintiff's Reply in Support of Motion in Limine #4: Exclusion of Collateral Source Payments	09/08/2021	IV	APPX000844 – APPX000847
Defendants' Reply to Motion in Limine No. 1 Include Others on the Verdict Form	09/09/2021	IV	APPX000848 – APPX000853
Defendants' Reply to Motion in Limine No. 2 to Allow Defendants to Introduce Evidence of Collateral Sources Pursuant to NRS 42.021	09/09/2021	IV	APPX000854 – APPX000858
VOLUME V			
Defendants' Reply to Motion in Limine No. 3 to Exclude Defendants' Insurance Coverage	09/13/2021	V	APPX000859 – APPX00956

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Transcript of Hearing - All Pending Motions in Limine	09/27/2021	V	APPX000957 – APPX000997
Transcript of Proceedings – Calendar Call	09/28/2021	V	APPX000998 – APPX001008
Motion to Reconsider or Clarify Order Regarding Plaintiff's Motion in Limine No. 2 to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication" on Order Shortening Time	10/04/2021	V	APPX001009 – APPX001061
Order on Defense Motions in Limine	10/06/2021	V	APPX001062 – APPX001068
Notice of Entry of Order on Defense Motions in Limine	10/06/2021	V	APPX001069 – APPX001078
Plaintiff Kimberly Taylor's Opposition to Defendants' Motion to Reconsider or Clarify Order Regarding Plaintiff's Motion in Limine to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	10/06/2021	V	APPX001079 – APPX001087
Plaintiff Kimberly Taylor's Trial Brief	10/06/2021	V	APPX001088 – APPX001097
Order Regarding Plaintiff's Motions in Limine	10/07/2021	V	APPX001098 – APPX001102
VOLUME VI			
Recorder's Transcript of Jury Trial – Day 1	10/07/2021	VI	APPX001103 – APPX001314
VOLUME VII			
Recorder's Transcript of Jury Trial – Day 2	10/08/2021	VII	APPX001315 – APPX001526
VOLUME VIII			
Plaintiff's First Amended Proposed Jury Instructions	10/09/2021	VIII	APPX001527 – APPX001573
Notice of Entry of Order Regarding Plaintiff's Motions in Limine	10/11/2021	VIII	APPX001574 – APPX001581

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Recorder's Transcript of Jury Trial – Day 3	10/12/2021	VIII	APPX001582 – APPX001707
VOLUME IX			
Recorder's Transcript of Jury Trial – Day 4	10/13/2021	IX	APPX001708 – APPX001905
VOLUME X			
Recorder's Transcript of Jury Trial – Day 5	10/14/2021	X	APPX001906 – APPX002091
VOLUME XI			
Recorder's Transcript of Jury Trial – Day 6	10/15/2021	XI	APPX002092 – APPX002292
VOLUME XII			
Recorder's Transcript of Jury Trial – Day 7	10/18/2021	XII	APPX002293 – APPX002491
VOLUME XIII			
Recorder's Transcript of Jury Trial – Day 8	10/19/2021	XIII	APPX002492 – APPX002602
Instructions to the Jury	10/19/2021	XIII	APPX002603 – APPX002641
Special Verdict Form	10/19/2021	XIII	APPX002678 – APPX002680
Plaintiff's Proposed Jury Instructions – Not Given at Trial	10/21/2021	XIII	APPX002642 – APPX002651
Plaintiff's Proposed Special Verdict Form Not Given at Trial	10/21/2021	XIII	APPX002652 – APPX002654
Transcript of Proceedings – Status Check	10/26/2021	XIII	APPX002655 – APPX002659
Judgment on Jury Verdict	11/19/2021	XIII	APPX002660 – APPX002665
Notice of Entry of Judgment on Jury Verdict	11/19/2021	XIII	APPX002666 – APPX002673
Notice of Appeal	11/22/2021	XIII	APPX002674 – APPX002675
Actual Symphion Resectoscope Photo 1		XIII	APPX002676
Actual Symphion Resectoscope Photo 2		XIII	APPX002677

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Educational Materials		XIII	APPX002681 – APPX002685
HH15		XIII	APPX002686
Pathology HH156-157		XIII	APPX002687— APPX002688
Pathology SRDH1-2		XIII	APPX002689 – APPX002690
Response to Jury Question No. 1		XIII	APPX002691

ALPHABETICAL LIST

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Defendants' Reply to Motion in Limine No. 3 to Exclude Defendants' Insurance Coverage	09/13/2021	V	APPX000859 – APPX00956
Defendants' Reply to Motion in Limine No. 1 Include Others on the Verdict Form	09/09/2021	IV	APPX000848 – APPX000853
Educational Materials		XIII	APPX002681 – APPX002685
HH15		XIII	APPX002686
Instructions to the Jury	10/19/2021	XIII	APPX002603 – APPX002641
Judgment on Jury Verdict	11/19/2021	XIII	APPX002660 – APPX002665
Motion to Reconsider or Clarify Order Regarding Plaintiff's Motion in Limine No. 2 to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication" on Order Shortening Time	10/04/2021	V	APPX001009 – APPX001061
Notice of Appeal	11/22/2021	XIII	APPX002674 – APPX002675
Notice of Entry of Judgment on Jury Verdict	11/19/2021	XIII	APPX002666 – APPX002673
Notice of Entry of Order	10/24/2018	I	APPX000049 – APPX000056
Notice of Entry of Order on Defense Motions in Limine	10/06/2021	V	APPX001069 – APPX001078
Notice of Entry of Order Regarding Plaintiff's Motions in Limine	10/11/2021	VIII	APPX001574 – APPX001581
Notice of Entry of Stipulation and Order for Defendant Christensen, M.D.'s Dismissal with Prejudice Only	04/22/2021	I	APPX000098 – APPX000106
Notice of Entry of Stipulation and Order for Dismissal	03/19/2021	I	APPX000078 – APPX000090
Notice of Entry of Stipulation and Order to Dismiss Dignity Health D/B/A St.	03/10/2021	I	APPX000062 – APPX000067

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Rose Dominican Hospital Siena Campus			
Order on Defense Motions in Limine	10/06/2021	V	APPX001062 – APPX001068
Order Regarding Plaintiff's Motions in Limine	10/07/2021	V	APPX001098 – APPX001102
Pathology HH156-157		XIII	APPX002687— APPX002688
Pathology SRDH1-2		XIII	APPX002689 – APPX002690
Plaintiff's First Amended Proposed Jury Instructions	10/09/2021	VIII	APPX001527 – APPX001573
Plaintiff Kimberly Taylor's Opposition to Defendants' Motion to Reconsider or Clarify Order Regarding Plaintiff's Motion in Limine to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	10/06/2021	V	APPX001079 – APPX001087
Plaintiff Kimberly Taylor's Trial Brief	10/06/2021	V	APPX001088 – APPX001097
Plaintiff's Motion in Limine #3: Motion to Exclude Evidence of Asserted Liability of Other Health Care Providers Under Piroozi	08/18/2021	II	APPX000190 – APPX000329
Plaintiff's Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	08/18/2021	I	APPX000116 – APPX000189
Plaintiff's Motion in Limine #4: Exclusion of Collateral Source Payments	08/18/2021	II	APPX000330 – APPX000349
Plaintiff's Motion in Limine #1: Motion to Permit Certain Closing Argument Techniques of Plaintiff's Counsel	08/18/2021	I	APPX000107 – APPX000115
Plaintiff's Opposition to Defendant's Motion in Limine #2: Collateral Source Issues & NRS 42.021	08/27/2021	III	APPX000618 – APPX000621

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Plaintiff's Opposition to Defendant's Motion in Limine #3: Exclusion of Defendants' Insurance Coverage	08/27/2021	IV	APPX000622 – APPX000734
Plaintiff's Opposition to Defendant's Motion in Limine #1: Inclusion of Others on Verdict Form	08/27/2021	III	APPX000614 – APPX000617
Plaintiff's Proposed Jury Instructions	08/18/2021	II	APPX000350 – APPX000389
Plaintiff's Proposed Jury Instructions – Not Given at Trial	10/21/2021	XIII	APPX002642 – APPX002651
Plaintiff's Proposed Special Verdict Form Not Given at Trial	10/21/2021	XIII	APPX002652 – APPX002654
Plaintiff's Proposed Voir Dire	08/18/2021	II	APPX000390 – APPX000395
Plaintiff's Reply in Support of Motion in Limine #3: Motion to Exclude Evidence of Asserted Liability of Other Health Care Providers Under Piroozi	09/08/2021	IV	APPX000839 – APPX000843
Plaintiff's Reply in Support of Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complication"	09/08/2021	IV	APPX000834 – APPX000838
Plaintiff's Reply in Support of Motion in Limine #4: Exclusion of Collateral Source Payments	09/08/2021	IV	APPX000844 – APPX000847
Plaintiff's Reply in Support of Motion in Limine #1: Motion to Permit Certain Closing Argument Techniques of Plaintiff's Counsel	09/08/2021	IV	APPX000828 – APPX000833
Recorder's Transcript of Jury Trial – Day 1	10/07/2021	VI	APPX001103 – APPX001314
Recorder's Transcript of Jury Trial – Day 2	10/08/2021	VII	APPX001315 – APPX001526
Recorder's Transcript of Jury Trial – Day 3	10/12/2021	VIII	APPX001582 – APPX001707
Recorder's Transcript of Jury Trial – Day 4	10/13/2021	IX	APPX001708 – APPX001905

DESCRIPTION OF DOCUMENT	DATE	VOL.	PAGE(S)
Recorder's Transcript of Jury Trial – Day 5	10/14/2021	X	APPX001906 – APPX002091
Recorder's Transcript of Jury Trial – Day 6	10/15/2021	XI	APPX002092 – APPX002292
Recorder's Transcript of Jury Trial – Day 7	10/18/2021	XII	APPX002293 – APPX002491
Recorder's Transcript of Jury Trial – Day 8	10/19/2021	XIII	APPX002492 – APPX002602
Response to Jury Question No. 1		XIII	APPX002691
Special Verdict Form	10/19/2021	XIII	APPX002678 – APPX002680
Stipulation and Order for Defendant Christensen, M.D.'s Dismissal With Prejudice Only	04/21/2021	I	APPX000091 – APPX000097
Stipulation and Order to Dismiss Defendant Dignity Health D/B/A St. Rose Dominican Hospital – Siena Campus	03/09/2021	I	APPX000057 – APPX000061
Stipulation and Order to Dismiss Defendant Valley Health System, LLC d/b/a Henderson Hospital with Prejudice and to Amend Caption	03/17/2021	I	APPX000068 – APPX000077
Stipulation and Order to Dismiss Nurse Defendant Bruce Hutchins, RN without Prejudice	10/18/2018	I	APPX000044 – APPX000048
Transcript of Hearing - All Pending Motions in Limine	09/27/2021	V	APPX000957 – APPX000997
Transcript of Proceedings – Calendar Call	09/28/2021	V	APPX000998 – APPX001008
Transcript of Proceedings – Status Check	10/26/2021	XIII	APPX002655 – APPX002659

CERTIFICATE OF SERVICE

Pursuant to Nev. R. App. 25, I hereby certify that on the 10th day of March, 2022, a copy of the foregoing **APPELLANT'S APPENDIX, VOLUME I** via the method indicated below:

X	Pursuant to NRAP 25(c), by electronically serving all counsel and e-mails registered to this matter on the Supreme Court Electronic Filing System.
	Pursuant to NRCP 5, by placing a copy in the US mail, postage pre-paid to the following counsel of record or parties in proper person:
	Via receipt of copy (proof of service to follow)

An Attorney or Employee of the firm:

/s/ Sarah Daniels
BREEDEN & ASSOCIATES PLLC

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DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive;

Defendants.

CASE NO.: A-18-773472-C

DEPT. NO.: Department 10

EXEMPT FROM ARBITRATION:

COMPLAINT FOR MEDICAL MALPRACTICE

COMPLAINT

COMES NOW Plaintiff, **KIMBERLY D. TAYLOR (Kimberly)**, an individual, by and through his counsel, JAMES S. KENT, ESQ., and for his causes of action against Defendants, and each of them, alleges and complains as follows:

/ / /

GENERAL ALLEGATIONS

1. That the Plaintiff, KIMBERLY D. TAYLOR (Kimberly), an individual, was at all times mentioned herein a resident of the State of Nevada.

2. Upon information and belief, Defendant, KEITH BRILL, MD, FACOG, FACS (Dr. Brill), an individual, was at all times mentioned herein a resident of Clark County, State of Nevada.

3. Upon information and belief, Defendant WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC, (WHASN) was a Nevada Professional Limited Liability Company and was licensed to do business in, and at all relevant times was doing business in, Clark County, Nevada.

4. Upon information and belief, Defendant, BRUCE HUTCHINS, RN (Hutchins),an individual, was at all times mentioned herein a resident of Clark County, State of Nevada.

5. Upon information and belief, Defendant HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES (HH), was a Foreign LLC and was licensed to do business in, and at all relevant times was doing business in, Clark County, Nevada.

6. Upon information and belief, Defendant, TODD W. CHRISTENSEN, MD, (Dr. Christensen), an individual, was at all times mentioned herein a resident of Clark County, State of Nevada.

7. Upon information and belief, Defendant DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL (St. Rose) was a Foreign Non-Profit Corporation and was licensed to do business in, and at all relevant times was doing business in, Clark County, Nevada.

8. That at all relevant times mentioned herein, Defendant Dr. Brill was a licensed physician pursuant to NRS §630.014, and was duly admitted and authorized to practice medicine in the State of Nevada.

9. That at all relevant times mentioned herein, Defendant Hutchins was a registered nurse licensed to practice as a nurse in the State of Nevada.

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10. That at all relevant times mentioned herein, Defendant Dr. Christensen was a licensed physician pursuant to NRS §630.014, and was duly admitted and authorized to practice medicine in the State of Nevada.

11. That at all relevant times mentioned herein, Defendant WHASN was the employer for some or all of the other Defendants herein, all of whom were acting within the scope of their employment with full authority.

12. That at all relevant times mentioned herein, Defendant HH was the employer for some or all of the other Defendants herein, all of whom were acting within the scope of their employment with full authority.

13. That at all relevant times mentioned herein, Defendant St. Rose Dominican was the employer for some or all of the other Defendants herein, all of whom were acting within the scope of their employment with full authority.

14. That at all relevant times mentioned herein, Roe Corporation I was the employer for some or all of the other Defendants herein, all of whom were acting within the scope of their employment with full authority.

15. That at all times relevant herein, Defendants designated as DOES I through XXX and ROE CORPORATIONS I through XXX, in their true capacities, whether individual, corporate, associate or otherwise of the Defendants named herein are unknown to Plaintiff who, therefore, sues said Defendants by said fictitious names; Plaintiff is informed and believes and thereon alleges that each of the Defendants designated as a DOES I through XXX and ROE CORPORATIONS I through XXX are responsible in some manner for the events and happenings referred to herein, and caused damages proximately to Plaintiff as herein alleged, and Plaintiff will ask leave of this court to amend this Complaint to insert the true names and capacities of DOES I through XXX and ROE CORPORATIONS I through XXX, when the same have been ascertained and to join such Defendants in this action.

16. That all events mentioned herein occurred in Clark County, Nevada.

17. On or about April 26, 2017 Plaintiff Kimberly Taylor appeared at Henderson Hospital to undergo a dilation and curettage with hysteroscopy with fibroid removal and hydrothermal ablation.

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18. That Dr. Brill was to perform, and did partially perform, the surgery referenced in Paragraph 17.

19. During the procedure, Dr. Brill perforated Kimberly's uterine wall and her small bowel.

20. Dr. Brill only confirmed the perforation with the hysteroscope and did not perform laparoscopy to evaluate for bowel or other injury to Kimberly.

21. Dr. Brill continued with the surgical procedure, but ultimately terminated it before completion.

22. Dr. Brill never informed Kimberly of the complication of perforating her uterine wall.

23. Dr. Brill did not inform the anesthesiologist of the complication of perforating Kimberly's uterine wall.

24. Dr. Brill informed the PACU that there were no complications as a result of the surgery.

25. After the surgery, Kimberly was transferred to the care of HH and Hutchins.

26. Kimberly was in the care of Hutchins and HH for approximately 7 hours, despite normal recovery for this procedure being 1-2 hours or less due to the failure to complete the surgical procedure.

27. While in post-operative care, Kimberly complained of severe abdominal pain and nausea.

28. Hutchins gave Kimberly significant amounts and types of medications to address her concerns.

29. Hutchins and HH never communicated with Dr. Brill, WHASN, or any other physician during the time Kimberly was in their care.

30. Hutchins and HH released Kimberly without contacting Dr. Brill despite her still having continuing abdominal pains and nausea.

31. On the evening of April 25/early morning of April 26, 2017, Kimberly was transported to the St. Rose emergency department via ambulance.

32. Dr. Christensen treated Kimberly at St. Rose for the visit referenced in Paragraph 32.

33. Kimberly appeared at St. Rose with complaints of extreme abdominal pain and diffuse torso pain.

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34. Dr. Christensen and St. Rose had a CT Abdomen and Pelvis performed, which noted postoperative pneumoperitoneum and small to moderate ascites.

35. Dr. Christensen was aware of the surgical procedure Kimberly underwent by Dr. Brill.

36. Dr. Christensen did not seek a consult with an OB/GYN and/or surgeon.

37. Dr. Christensen did not rule out a more serious injury despite the CT findings consistent with visceral perforation and injury.

38. Despite the forgoing, as well as Kimberly still having ongoing severe abdominal pain, she was treated for nausea and released after approximately three hours.

39. Later on April 27, 2017, Kimberly appeared yet again at St. Rose, where she was eventually admitted.

40. Kimberly underwent a surgical consult, which included examination and review of the previously taken CT scan.

41. Based upon the surgical consults examination findings, the clinical significant pain of Kimberly, and the CT findings (which findings were consistent with visceral perforation and injury), Kimberly underwent a diagnostic laparoscopy which was then converted to an exploratory laparotomy with a small bowel resection.

42. During the surgical procedure referenced in Paragraph 41, a 3 cm perforation of the small bowel was discovered and a resection was performed; Kimberly was also discovered to have suffered gross peritonitis in all 4 quadrants.

43. Kimberly thereafter suffered a prolonged, critical, post-operative course, and was discharged on May 5, 2017.

44. Kimberly continues to suffer ongoing repercussions from the aforementioned treatment and care.

45. Each of the Defendants were responsible for safely and properly following the standards of care for the medical treatment rendered to Kimberly for the periods referenced above.

46. As a result of the actions and inactions listed herein, Kimberly has incurred significant injury to her person and special damages by way of past and future lost personal services, past and future medical costs for treatment, and other losses that are ongoing and not fully calculated at this time.

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FIRST CLAIM FOR RELIEF
(Medical Malpractice/Professional Negligence of Defendant Dr. Brill (41A.100))

47. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

48. At all times pertinent hereto, Defendant Dr. Brill had a duty to adequately and properly provide competent and reasonably safe medical care within the accepted standard of care to Kimberly, as well as properly supervise, monitor, communicate with others, and otherwise ensure her health and safety while she was under his care and recovering from his treatment.

49. Dr. David Berke, DO, FACOOG, has opined in his report attached as Exhibit 1 that Defendant Dr. Brill's care and treatment of Kimberly, to a reasonable degree of medical probability and certainty, fell below the accepted standards of care as follows:

a. Not properly performing the surgical procedure, causing perforations of Kimberly's uterine wall and small bowel with use of a thermal instrument;

b. Continuing the surgery, including use of the curretage, after noting the perforation of the uterine wall;

c. Failing to properly evaluate and diagnose the extent of damage to Kimberly after the perforation of the uterine wall was noted;

d. Failing to inform and instruct PACU of the uterine perforation and to look for specific concerns which could evidence additional damage and require additional examination; and

e. Failing to inform Kimberly of the complications resulting from the surgical procedure.

50. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Brill, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to perforation of her uterus, perforation of her small bowel and burn injury to her small bowel, removal of a section of her small bowel, gross peritonitis, and a prolonged, critical, post-operative course, all within a reasonable degree of medical probability and certainty as per Dr. Berke, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

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51. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Brill, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

52. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Brill, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

53. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Brill, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

SECOND CLAIM FOR RELIEF
(Medical Malpractice/Professional Negligence of Defendant Hutchins (41A.100))

54. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

55. At all times pertinent hereto, Defendant Hutchinsl had a duty to adequately and properly provide competent and reasonably safe medical care with the accepted standard of care to Kimberly, as well as properly supervise, monitor, communicate with others, and otherwise ensure her health and safety while she was under his care and recovering from his treatment.

56. Dr. David Berke, DO, FACOOG, has opined in his report attached as Exhibit 1 that Defendant Hutchin's care and treatment of Kimberly, to a reasonable degree of medical probability and certainty, fell below the accepted standards of care as follows:

a. Failure to contact Dr. Brill or obtain a GYN consult despite the excessive pain medications being given to Ms. Taylor;

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b. Failure to contact Dr. Brill prior to releasing Ms. Taylor; and

c. Releasing Ms. Taylor despite her ongoing severe abdominal pain.

57. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Hutchins, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to gross peritonitis and a prolonged, critical, post-operative course, all within a reasonable degree of medical probability and certainty as per Dr. Berke, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

58. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Hutchins, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

59. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Hutchins, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

60. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Hutchins, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

THIRD CLAIM FOR RELIEF
(Medical Malpractice/Professional Negligence of Defendant Dr. Christensen (41A.100))

61. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

62. At all times pertinent hereto, Defendant Dr. Christensen had a duty to adequately and properly provide competent and reasonably safe medical care with the accepted standard of care to

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(702) 385-1100

Kimberly, as well as properly supervise, monitor, communicate with others, and otherwise ensure her health and safety while she was under his care and recovering from his treatment.

63. Dr. David Berke, DO, FACOOG, has opined in his report attached as Exhibit 1 that Defendant Dr. Christensen's care and treatment of Kimberly, to a reasonable degree of medical probability and certainty, fell below the accepted standards of care as follows:

a. Failure to obtain a consult with OB/GYN and/or surgeon based upon the CT report; and

b. Release of Ms. Taylor despite the CT report and ongoing severe abdominal pain without ruling out a more serious injury with CT findings consistent with visceral perforation and injury.

64. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Christensen, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to gross peritonitis and a prolonged, critical, post-operative course, all within a reasonable degree of medical probability and certainty as per Dr. Berke, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

65. As a direct and proximate result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Christensen, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

66. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Christensen, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

67. As a direct, proximate, and legal result of the medical malpractice, professional negligence and failures to meet the standard of care by Defendant Dr. Christensen, it has been necessary

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for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

FOURTH CLAIM FOR RELIEF
(Res Ipsa Loqitur - NRS 41A.100; Medical Malpractice/Professional Negligence of Defendant Dr. Brill)

68. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

69. At all times pertinent hereto, Defendant Dr. Brill was the physician performing Kimberly's dilation and curettage with hysteroscopy with fibroid removal and hydrothermal ablation.

70. During the course of his medical care, in particular his surgery, Defendant Dr. Brill unintentionally caused burn injuries by heat, radiation, or chemicals to Kimberly's uterus and bowel.

71. These injuries do not normally occur in the absence of negligence and a failure to meet the standard of care.

72. Kimberly could not and does not have comparative negligence as she was under general anesthesia, completely dependent, and under the total control of Dr. Brill during the entire period in which she sustained these injuries, which caused the intestinal contents to leak into the abdominal and pelvis cavities and directly result in infection and gross peritonitis.

73. Pursuant to Nevada Revised Statute 41A.100, Dr. Brill is therefore presumed professionally negligent (i.e. to have fallen below the standard of care).

74. As a direct and proximate result of Defendant Dr. Brill's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly suffered injuries and damages, all to Plaintiff Kimberly Taylor's detriment, in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

75. As a direct and proximate result of Defendant Dr. Brill's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

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76. As a direct and proximate result of Defendant Dr. Brill's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

77. As a direct and proximate result of Defendant Dr. Brill's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

FIFTH CLAIM FOR RELIEF
(Res Ipsa Loqitur - NRS 41A.100; Medical Malpractice/Professional Negligence of Defendant Henderson Hospital et al)

78. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

79. At all times pertinent hereto, Defendants Henderson Hospital et al were the owners, managers, distributors, retailers and/or otherwise providers of Henderson Hospital, its operating facility and surgical equipment, including but not limited to the facility used for and equipment used during Kimberly's surgery by Dr. Brill on April 26, 2017.

80. During the use of this equipment in Defendant Henderson Hospital's facility, Kimberly received multiple unintentional burn injuries caused by heat, radiation, or chemicals to Kimberly's uterus and bowel.

81. These injuries do not normally occur in the absence of negligence and a failure to meet the standard of care.

82. Kimberly could not and does not have comparative negligence as she was under general anesthesia, completely dependent, and under the defendants' control during the entire period in which she sustained these injuries, which caused the intestinal contents to leak into the abdominal and pelvis cavities and directly result in infection and gross peritonitis.

83. Pursuant to Nevada Revised Statute 41A.100, Dr. Brill is therefore presumed professionally negligent (i.e. to have fallen below the standard of care).

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84. As a direct and proximate result of Defendant Henderson Hospital et al's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly Taylor suffered injuries and damages, all to Plaintiff Kimberly Taylor's detriment, in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

85. As a direct and proximate result of Defendant Henderson Hospital et al's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

86. As a direct and proximate result of Defendant Henderson Hospital et al's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

87. As a direct and proximate result of Defendant Henderson Hospital et al's negligent acts and omissions, including, but not limited to, the above-stated res ipsa, presumption of professional negligence, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

SIXTH CLAIM FOR RELIEF
(Vicarious Liability of Defendant Women's Health Associates of Southern Nevada)

88. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

89. Defendant Dr. Brill was an agent and/or employee of Defendant WHASN, and was acting in the scope of his employment, under WHASN's control, and in furtherance of WHASN's interests at the time their actions caused Plaintiff's injuries.

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(702) 385-1100

90. Defendant WHASN is vicariously liable for damages resulting from their employees', agents', and/or independent contractors' negligent actions against Kimberly during the scope of their employment.

91. That Kimberly entrusted to Defendants Dr. Brill's and WHASN's care and treatment.

92. That as a direct and proximate result of the negligence and failures to meet the standard of care by Defendants Dr. Brill and WHASN, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to gross peritonitis and a prolonged, critical, post-operative course, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

93. That as a direct and proximate result of the negligence and failures to meet the standard of care by Defendants Dr. Brill and WHASN, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

94. That as a direct and proximate result of the negligence and failures to meet the standard of care by Defendants Dr. Brill and WHASN, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

95. As That as a direct and proximate result of the negligence and failures to meet the standard of care by Defendants Dr. Brill and WHASN, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

SIXTH CLAIM FOR RELIEF
(Vicarious Liability of Defendant Henderson Hospital et al)

96. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

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97. Defendant Hutchins was an agent and/or employee of Defendant Henderson Hospital and was acting in the scope of his employment, under HH's control, and in furtherance of HH's interests at the time their actions caused Plaintiff's injuries.

98. Defendant HH is vicariously liable for damages resulting from their employees', agents', and/or independent contractors' negligent actions against Kimberly during the scope of their employment.

99. That Kimberly entrusted to HH's care and treatment.

100. That HH selected the medical care providers who rendered care to Kimberly.

101. That Kimberly reasonably believed that the medical care providers selected by HH were the agents, employees, or servants of HH.

102. That as a direct and proximate result of the negligence and failures to meet the standard of care by Hutchins and/or other employees, agents, or servants of HH, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to gross peritonitis and a prolonged, critical, post-operative course, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

103. That as a direct and proximate result of the negligence and failures to meet the standard of care by Hutchins and/or other employees, agents, or servants of HH, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

104. That as a direct and proximate result of the negligence and failures to meet the standard of care by Hutchins and/or other employees, agents, or servants of HH, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

105. That as a direct and proximate result of the negligence and failures to meet the standard of care by Hutchins and/or other employees, agents, or servants of HH, it has been necessary for Plaintiff

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Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

EIGHTH CLAIM FOR RELIEF
(Vicarious Liability of Defendant St. Rose)

106. Plaintiff repeats and re-alleges each and every above paragraph as though fully set forth hereunder and incorporate the same by reference.

107. Defendant Dr. Christensen was an agent and/or employee and/or independent contractor of Defendant St. Rose and was acting in the scope of his employment and/or agency and/or contract, under St. Rose's control, and in furtherance of St. Rose's interests at the time their actions caused Plaintiff's injuries.

108. Defendant St. Rose is vicariously liable for damages resulting from their employees', agents', and/or independent contractors' negligent actions against Kimberly during the scope of their employment, agency, appointment, or other similar relationship.

109. That Kimberly entrusted to St. Rose's care and treatment.

110. That St. Rose selected the doctor, doctors, and/or medical care providers who rendered care to Kimberly.

111. That Kimberly reasonably believed that the doctor, doctors, and/or medical care providers selected by St. Rose were the agents, employees, or servants of St. Rose.

112. That as a direct and proximate result of the negligence and failures to meet the standard of care by Dr. Christensen and/or other employees, agents, or servants of St. Rose, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to gross peritonitis and a prolonged, critical, post-operative course, and all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

113. That as a direct and proximate result of the negligence and failures to meet the standard of care by Dr. Christensen and/or other employees, agents, or servants of St. Rose, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

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114. That as a direct and proximate result of the negligence and failures to meet the standard of care by Dr. Christensen and/or other employees, agents, or servants of St. Rose, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

115. That as a direct and proximate result of the negligence and failures to meet the standard of care by Hutchins and/or other employees, agents, or servants of St. Rose, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

NINTH CLAIM FOR RELIEF
(Negligent Hiring, Training, and Supervision of Defendants Women's Health Associates of Southern Nevada, Henderson Hospital et al, and St. Rose)

116. Plaintiff repeats and re-alleges each and every allegation and fact contained herein and incorporate the same by reference.

117. Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors, and representatives.

118. Defendants breached their duty by improperly hiring, improperly training, improperly supervising, and improperly retaining incompetent persons regarding their examination, diagnosis, and treatment of Kimberly during the times referenced herein.

119. Defendants breached the applicable standard of care directly resulting in Kimberly sustaining significant injuries including but not limited to perforation of her uterus, perforation of her small bowel and burn injury to her small bowel, removal of a section of her small bowel, gross peritonitis, and a prolonged, critical, post-operative course.

120. As a direct and proximate result of the Defendants' negligence, medical malpractice, and carelessness, Plaintiff Kimberly Taylor suffered injuries and damages, including but not limited to perforation of her uterus, perforation of her small bowel and thermal injury to her small bowel, removal of a section of her small bowel, gross peritonitis, and a prolonged, critical, post-operative course, all to Plaintiff's damages in an amount in excess of TEN THOUSAND DOLLARS ($10,000).

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121. As a direct and proximate result of the Defendants' negligence, medical malpractice, and carelessness, Plaintiff Kimberly Taylor has sustained physical and mental injuries, which have caused and will continue to cause physical and mental pain and suffering with loss of enjoyment of life. For these damages, Plaintiff is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

122. As a direct and proximate result of the Defendants' negligence, medical malpractice, and carelessness, Plaintiff Kimberly Taylor has incurred and will continue to incur medical expenses and other special damages for which Plaintiff Kimberly Taylor is entitled to be compensated in an amount to be determined at the time of trial in this matter and which is in excess of TEN THOUSAND DOLLARS ($10,000).

123. As a direct and proximate result of the Defendants' negligence, medical malpractice, and carelessness, it has been necessary for Plaintiff Kimberly Taylor to retain the law firm of James S. Kent, Ltd., to prosecute this action, and Plaintiff is entitled to recover reasonable attorney's fees and costs.

WHEREFORE, Plaintiff Kimberly Taylor, reserving the right to amend this Complaint at the time of trial to include all items of damages not yet ascertained, prays for judgment against the Defendants, and each of them, as follows:

1. FOR EACH AND EVERY CAUSE OF ACTION:

   a. For past and future general damages in a sum in excess of $10,000.00;

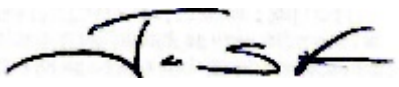
   b. For past and future special damages in a sum in excess of $10,000.00;

   c. For Plaintiff's Court costs and attorney's fees; and,

   d. For such other and further relief as to the Court may seem proper.

DATED this 25th day of April, 2018.

JAMES S. KENT, LTD.



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Attorney for Plaintiff

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EXHIBIT 1

DECLARATION OF DAVID BERKE, DO, FACOOG

STATE OF CALIFORNIA)
) ss:
COUNTY OF RIVERSIDE)

DAVID BERKE, having been duly sworn, deposes and says:

1. I am a board certified Obstetrician and Gynecologist. I am currently in full-time practice in Riverside, California. All of my licenses are on file with the appropriate authorities in California. My additional qualifications and training are further set forth in my Curriculum Vitae, which is attached hereto and incorporated herein by reference. Based upon my training, background, knowledge, and experience in gynecology and obstetrics, I am familiar with the applicable standards of care for the treatment of individuals demonstrating the symptoms and conditions presented by the Plaintiff in this action. Further, I am qualified on the basis of my training, background, knowledge and experience to offer expert medical care, the breaches thereof in this case, and any resulting injuries and damages arising therefrom. The opinions I give are within the reasonable medical probability and certainty.

2. I have reviewed the physician and hospital records pertaining to this matter:

a. Medical records from the office of Keith Brill, M.D./Women's Health Associates of Southern Nevada;

b. Medical records from Henderson Hospital; and

c. Medical records from Dignity Health D/b/a St. Rose Dominican Hospital.

3. My opinions below pertaining to the care of Kimberly D. Taylor are based upon my review of the aforementioned records, photographs, etc., from the referenced parties.

4. Ms. Taylor was a 45 year old woman who had been treated by Dr. Brill for several years prior to the incident in question. She had a history of menorrhagia, and had a bicornuate uterus with a fibroid. After counseling with Dr. Brill, she agreed to dilation and curettage with hysteroscopy with fibroid removal and hydrothermal ablation, all to be performed by Dr. Brill.

5. On April 26, 2017, Ms. Taylor appeared at Henderson Hospital for the referenced surgical procedure. During the procedure, Dr. Brill was using a symphion hysteroscope to begin resecting an apparent uterine septum when he noted a uterine perforation. Despite experiencing a

uterine perforation during the use of a device that cuts with energy, Dr. Brill only confirmed the perforation with the hysteroscope and did not perform laparoscopy to evaluate for bowel or other injury. He continued with the procedure, thereafter using a #2 sharp curette to remove a small amount of endometrial tissue, but thereafter terminated the procedure. Ms. Taylor was thereafter removed to recovery. There was no record of Ms. Taylor being informed of the perforation by Dr. Brill.

6. During a procedure such as the one performed herein, once the perforation of the uterine wall was noted, the proper standard of care is to identify and locate the extent of the injury, and cease all further invasive procedures which may cause injury to adjacent structures. Since a thermal instrument was being used at the time of the injury, a laparoscopy should have been performed immediately to determine if any further damage occurred, and/or obtain a surgical consult. The surgeon then has a duty to inform the patient about the condition and what occurred during surgery. The doctor is also obligated to inform current and subsequent providers of the concern to insure proper and appropriate treatment to the patient.

7. Ms. Taylor was thereafter in recovery at Henderson Hospital under the care of Bruce Hutchins, RN, where she remained for approximately 7 hours. It appears Ms. Taylor was discharged despite still complaining of severe abdominal pain. The PACU notes state that per surgeon, there were no complications. No complications were noted by the anesthesiologist. During her post operative stay, Ms. Taylor was medicated for ongoing pain and nausea. No communications to Dr. Brill were noted.

8. The normal recovery for the type of procedure performed in this instance would be an hour or two, and generally with minimal pain medications, and the PACU nurse should know this. If a patient is in recovery for 7 hours, and having been given significant pain medications to alleviate the pain being expressed, the proper standard of care is for the PACU nurse to contact the surgeon and inform the surgeon of the patient's condition so the surgeon may determine if alternative or additional treatment should be provided.

9. Approximately 7.5 hours after being released from Henderson Hospital, Ms. Taylor appeared via ambulance at St. Rose Dominican ER where she was received by Dr. Todd Christensen.

Her complaints at that time were extreme abdominal pain and diffuse torso pain. A CT Abdomen and Pelvis was performed, noting postoperative pneumoperitoneum and small to moderate ascites. Despite these findings, she was treated for nausea and released after approximately three hours without further workup or consultation regarding a possible bowel injury.

10. When the CT Abdomen and Pelvis showed "postoperative pneumoperitoneum and small to moderate ascites" following the procedure noted herein, the proper standard of care would be to seek a surgical consult to rule out any possible bowel or other injury.

11. Ms. Taylor subsequently appeared at St. Rose ER approximately 6 hours later, again via ambulance, complaining of worsening abdominal pain. A call was placed to Dr. Brill, who was unavailable. Samantha Schoenhause, DO, OB-GYN, covering for Dr. Brill, admitted Ms. Taylor, but despite her condition, there was still no indication any person associated with the matter had any knowledge that Ms. Taylor's uterine wall had been perforated during the surgery the day before. Elizabeth Hamilton, M.D., was eventually consulted and was eventually informed by report that a uterine perforation had occurred during the prior surgery. Based upon her examination findings, clinical significant pain, and the CT findings (which suggested evidence of perforation), Dr. Hamilton felt it was highly likely Ms. Taylor had a bowel perforation. Dr. Hamilton performed a diagnostic laparoscopy which was then converted to an exploratory laparotomy with a small bowel resection. A 3 cm perforation of the small bowel was discovered and a resection was performed. Ms. Taylor also suffered gross peritonitis in all 4 quadrants. She was eventually discharged nine days later.

12. It is my professional opinion, to a reasonable degree of medical certainty, that the care and treatment provided by Dr. Brill, Bruce Hutchins RN, Henderson Hospital, Dr. Christensen, and St. Rose was grossly deficient, negligent, and below the standard of care, including but not limited to the following:

a. Dr. Brill

i. Not properly performing surgical procedure causing perforations of Ms. Taylor's uterine wall and small bowel with use of a thermal instrument;.

ii. Continuing the surgery, including use of the curretage, after noting the perforation of the uterine wall;

iii. Failing to properly evaluate and diagnose the extent of damage to Ms. Taylor after the perforation of the uterine wall was noted;

iv. Failing to inform and instruct PACU of the uterine perforation and to look for specific concerns which could evidence additional damage and require additional examination;

v. Failing to inform Ms. Taylor of the complications resulting from the surgical procedure;

b. Bruce Hutchins, RN, and Henderson Hospital

i. Failure to contact Dr. Brill or obtain a GYN consult despite the excessive pain medications being given to Ms. Taylor;

ii. Failure to contact Dr. Brill prior to releasing Ms. Taylor;

iii. Releasing Ms. Taylor despite her ongoing severe abdominal pain;

c. Dr. Christensen and St. Rose (first visit to ER)

i. Failure to obtain a consult with OB/GYN and/or surgeon based upon the CT report;

ii. Release of Ms. Taylor despite the CT report and ongoing severe abdominal pain without ruling out a more serious injury with CT findings consistent with visceral perforation and injury..

13. The actions of Keith Brill, MD, FACOG, FACS; Women's Health Associates of Southern Nevada - Martin, PLLC; Bruce Hutchins, RN; Henderson Hospital and/or Valley Health System, LLC and/or Henderson Hospital; Todd W. Christensen, MD; and Dignity Health d/b/a St. Rose Dominican Hospital, and their employees, agents and/or contractors, fell below the standard of care and were the direct cause of the injuries sustained by Ms. Taylor, including but not limited

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to uterine perforation, bowel perforation, bowel resection, gross peritonitis in all 4 quadrants, and a prolonged, critical, post-operative course.

14. I reserve the rights to amend my findings upon the presentation of additional facts and/or records related to this matter.

DAVID BERKE, DO, FACOOG

SUBSCRIBED AND SWORN to before me
this 25 day of April, 2018.

NOTARY PUBLIC

J. BERGSTROM
Commission No. 2067304
NOTARY PUBLIC-CALIFORNIA
RIVERSIDE COUNTY
My Comm. Expires JUNE 4, 2018

242 EAGLE GROVE AVE • CLAREMONT,CA 91711
PHONE (909) 910-8364 • E-MAIL DAVID.BERKE108@GMAIL.COM

DAVID BERKE, DO, FACOOG

EDUCATION

Western University of Health Sciences 6/2003 - 5/2007 Pomona, CA
Doctor of Osteopathic Medicine

The George Washington University 8/1992 -8/1994 Washington, DC
Bachelor of Science –Physician Assistant

San Diego State University 8/1987- 6/1992 San Diego, CA
Bachelor of Arts – With Distinction in Psychology

PROFESSIONAL EXPERIENCE

Riverside Medical Clinic 6/2013 –present Riverside, CA
Obstetrician and Gynecologist

- Full spectrum OB/GYN care, with emphasis on minimally invasive Gynecologic procedures, in large multi-specialty Medical Group
- Assistant Clinical Professor, Department of Obstetrics and Gynecology, University of California, Riverside, School of Medicine
- Medical Director of Ambulatory Surgery Center
- Member of Medical Practice and Peer Review Committees

Magnolia Women's Center 7/2011 – 6/2013 Riverside, CA
Obstetrician and Gynecologist

Arrowhead Regional Medical Center 7/2008 – 6/2011 Colton, CA
Resident in Obstetrics and Gynecology

- Training at both San Bernardino and Riverside's County Hospitals
- Chief Resident 2010-2011

Arrowhead Regional Medical Center 6/2007 – 6/2008 Colton, CA
Internship – Specialty Track for Obstetrics and Gynecology

City of Hope National Medical Center 12/1996 –6/2003 Duarte, CA
Physician Assistant

- Department of Medical Oncology and Therapeutics Research

Behrooz Tohidi, MD 8/1994 – 12/1996 Oceanside, CA
Physician Assistant

- Orthopedic Surgery

RESEARCH

Tyrosine Kinase Receptor Inhibition and ET-743 for the Ewing Family of Tumors, presented at Western Student Medical Research Forum 2005

Incidence of Umbilical pH < 7.0 in Elective Cesarean Section at Term, presented at Society for Gynecologic Investigation 2007

CURRENT LICENSURE/CERTIFICATION

Board Certified in Obstetrics and Gynecology

Licensed to practice Medicine in the State of California

PROFESSIONAL MEMBERSHIPS

Fellow, American College of Osteopathic Obstetricians and Gynecologists

American Osteopathic Association

California Medical Association

Riverside County Medical Society

ANS

ROBERT C. McBRIDE, ESQ.
Nevada Bar No. 7082
HEATHER S. HALL, ESQ.
Nevada Bar No. 10608
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Attorneys for Defendants,
Keith Brill, M.D., FACOG, FACS and
Women's Health Associates of Southern Nevada –
MARTIN, PLLC

DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEMS, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH; d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive;

Defendants.

CASE NO.: A-18-773472-C
DEPT: X

DEFENDANTS KEITH BRILL, M.D., FACOG, FACS AND WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC'S ANSWER TO PLAINTIFF'S COMPLAINT

COME NOW, Defendants, KEITH BRILL, MD, FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, by and through their counsel of record, ROBERT C. McBRIDE, ESQ. and HEATHER S. HALL, ESQ. of the law firm of CARROLL, KELLY, TROTTER, FRANZEN, McBRIDE & PEABODY, and hereby answer Plaintiff's Complaint as follows:

GENERAL ALLEGATIONS

1. Answering Paragraph 1, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

2. Answering Paragraph 2, these answering Defendants admit each and every allegation contained therein.

3. Answering Paragraph 3, these answering Defendants these answering Defendants admit each and every allegation contained therein.

4. Answering Paragraph 4, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

5. Answering Paragraph 5, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

6. Answering Paragraph 6, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

7. Answering Paragraph 7, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

8. Answering Paragraph 8, these answering Defendants admit each and every allegation contained therein.

9. Answering Paragraph 9, these answering Defendants are without sufficient

knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

10. Answering Paragraph 10, these answering Defendants admit each and every allegation contained therein.

11. Answering Paragraph 11, these answering Defendants deny each and every allegation contained therein.

12. Answering Paragraph 12, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

13. Answering Paragraph 13, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

14. Answering Paragraph 14, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

15. Answering Paragraph 15, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

16. Answering Paragraph 16, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

17. Answering Paragraph 17, these answering Defendants admit each and every allegation contained therein.

18. Answering Paragraph 18, these answering Defendants admit each and every allegation contained therein.

19. Answering Paragraph 19, these answering Defendants deny each and every allegation contained therein.

20. Answering Paragraph 20, these answering Defendants admit that there was no evidence of injury to the bowel and the standard of care did not require a laparoscopy to be performed. As to the remainder, denied.

21. Answering Paragraph 21, these answering Defendants deny each and every allegation contained therein.

22. Answering Paragraph 22, these answering Defendants deny each and every allegation contained therein.

23. Answering Paragraph 23, these answering Defendants deny each and every allegation contained therein.

24. Answering Paragraph 24, these answering Defendants deny each and every allegation contained therein.

25. Answering Paragraph 25, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

26. Answering Paragraph 26, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

27. Answering Paragraph 27, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

28. Answering Paragraph 28, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

29. Answering Paragraph 29, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.30. Answering Paragraph 30, these answering Defendants

31. Answering Paragraph 31, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

32. Answering Paragraph 32, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

33. Answering Paragraph 33, these answering Defendants are without sufficient

knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

34. Answering Paragraph 34, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

35. Answering Paragraph 35, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

36. Answering Paragraph 36, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

37. Answering Paragraph 37, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

38. Answering Paragraph 38, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

39. Answering Paragraph 39, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

40. Answering Paragraph 40, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

41. Answering Paragraph 41, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

42. Answering Paragraph 42, these answering Defendants deny each and every allegation contained therein insofar as it pertains to these answering Defendants.

43. Answering Paragraph 43, these answering Defendants deny each and every allegation contained therein insofar as it pertains to these answering Defendants.

44. Answering Paragraph 44, these answering Defendants deny each and every allegation contained therein insofar as it pertains to these answering Defendants.

45. Answering Paragraph 45, these answering Defendants deny each and every allegation contained therein insofar as it pertains to these answering Defendants.

46. Answering Paragraph 46, these answering Defendants deny each and every allegation contained therein insofar as it pertains to these answering Defendants.

FIRST CLAIM FOR RELIEF

(Medical Malpractice/Professional Negligence of Defendant Dr. Brill (41A.100))

47. Answering Paragraph 47, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 46, inclusive, and incorporate the same by reference as though set forth fully herein.

48. Answering Paragraph 48, these answering Defendants aver that duty is a question of law to which no response is required. To the extent a response is required, these answering Defendants deny each and every allegation contained therein.

49. Answering Paragraph 49(a) through (e), these answering Defendants deny each and every allegation contained in this paragraph and deny each and every allegation contained in Dr. Berke's declaration.

50. Answering Paragraph 50, these answering Defendants deny each and every allegation contained therein.

51. Answering Paragraph 51, these answering Defendants deny each and every allegation contained therein.

52. Answering Paragraph 52, these answering Defendants deny each and every allegation contained therein.

53. Answering Paragraph 53, these answering Defendants deny each and every allegation contained therein.

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SECOND CLAIM FOR RELIEF

(Medical Malpractice/Professional Negligence of Defendant Hutchins (41.A100))

54. Answering Paragraph 54, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 53, inclusive, and incorporate the same by reference as though set forth fully herein.

55. Answering Paragraph 55, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

56. Answering Paragraph 56(a) through (c), these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

57. Answering Paragraph 57, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

58. Answering Paragraph 58, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

59. Answering Paragraph 59, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

60. Answering Paragraph 60, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

THIRD CLAIM FOR RELIEF

(Medical Malpractice/Professional Negligence of Defendant Dr. Christensen (41A.100))

61. Answering Paragraph 61, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 60, inclusive, and incorporate the same by reference as though set forth fully herein.

62. Answering Paragraph 62, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

63. Answering Paragraph 63(a) and (b), these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

64. Answering Paragraph 64, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

65. Answering Paragraph 65, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

66. Answering Paragraph 66, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

67. Answering Paragraph 67, these answering Defendants are without sufficient knowledge to form a belief as to the truth of the allegations contained in said paragraph and therefore deny the same.

FOURTH CLAIM FOR RELIEF

(Res Ipsa Loqitur – NRS 41A.100; Medical Malpractice/Professional Negligence of Defendant Dr. Brill))

68. Answering Paragraph 68, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 67, inclusive, and incorporate the same by reference as though set forth fully herein.

69. Answering Paragraph 69, these answering Defendants aver that Plaintiff's res ipsa loquitur claim against these answering Defendants was dismissed by Court Order.

70. Answering Paragraph 70, these answering Defendants deny each and every allegation contained therein.

71. Answering Paragraph 71, these answering Defendants deny each and every allegation contained therein.

72. Answering Paragraph 72, these answering Defendants deny each and every allegation contained therein.

73. Answering Paragraph 73, these answering Defendants deny each and every allegation contained therein.

74. Answering Paragraph 74, these answering Defendants deny each and every allegation contained therein.

75. Answering Paragraph 75, these answering Defendants deny each and every allegation contained therein.

76. Answering Paragraph 76, these answering Defendants deny each and every allegation contained therein.

77. Answering Paragraph 77, these answering Defendants deny each and every allegation contained therein.

FIFTH CLAIM FOR RELIEF

(Res Ipsa Loqitur – NRS 41A.100; Medical Malpractice/Professional Negligence of Defendant Henderson Hospital et al)

78. Answering Paragraph 78, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 77, inclusive, and incorporate the same by reference as though set forth fully herein.

79. Answering Paragraph 79, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

80. Answering Paragraph 80, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

81. Answering Paragraph 81, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

82. Answering Paragraph 82, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

83. Answering Paragraph 83, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

84. Answering Paragraph 84, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

85. Answering Paragraph 85, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

86. Answering Paragraph 86, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

87. Answering Paragraph 87, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

SIXTH CLAIM FOR RELIEF

(Vicarious Liability of Defendant Women's Health Associates of Southern Nevada)

88. Answering Paragraph 88, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 87, inclusive, and incorporate the same by reference as though set forth fully herein.

89. Answering Paragraph 89, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

90. Answering Paragraph 90, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

91. Answering Paragraph 91, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

92. Answering Paragraph 92, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

93. Answering Paragraph 93, these answering Defendants deny each and every

allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

94. Answering Paragraph 94, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

95. Answering Paragraph 95, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

SIXTH CLAIM FOR RELIEF

(Vicarious Liability of Defendant Henderson Hospital et al)

96. Answering Paragraph 96, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 95, inclusive, and incorporate the same by reference as though set forth fully herein.

97. Answering Paragraph 97, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

98. Answering Paragraph 98, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

99. Answering Paragraph 99, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

100. Answering Paragraph 100, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

101. Answering Paragraph 101, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

102. Answering Paragraph 102, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

103. Answering Paragraph 103, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

104. Answering Paragraph 104, these answering Defendants deny each and every

allegation contained therein insofar as it pertains to them.

105. Answering Paragraph 105, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

EIGHTH CLAIM FOR RELIEF

(Vicarious Liability of Defendant St. Rose)

106. Answering Paragraph 106, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 105, inclusive, and incorporate the same by reference as though set forth fully herein.

107. Answering Paragraph 107, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

108. Answering Paragraph 108, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

109. Answering Paragraph 109, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

110. Answering Paragraph 110, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

111. Answering Paragraph 111, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

112. Answering Paragraph 112, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

113. Answering Paragraph 113, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

114. Answering Paragraph 114, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

115. Answering Paragraph 115, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them.

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NINTH CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision of Defendants Women's Health Associates of Southern Nevada, Henderson Hospital et al, and St. Rose)

116. Answering Paragraph 116, these answering Defendants repeat and restate each and every response to Paragraphs 1 through 116, inclusive, and incorporate the same by reference as though set forth fully herein.

117. Answering Paragraph 117, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

118. Answering Paragraph 118, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

119. Answering Paragraph 119, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

120. Answering Paragraph 120, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

121. Answering Paragraph 121, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

122. Answering Paragraph 122, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

123. Answering Paragraph 123, these answering Defendants deny each and every allegation contained therein insofar as it pertains to them. These answering Defendants specifically deny committing negligence.

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AFFIRMATIVE DEFENSES

1. The Complaint fails to state a claim against these answering Defendants upon which relief can be granted.

2. Defendants allege that in all medical attention and care rendered to Plaintiff, these answering Defendants possessed and exercised that degree of skill and learning ordinarily possessed and exercised by members of the medical profession in good standing practicing in similar localities and that at all times these answering Defendants used reasonable care and diligence in the exercise of his skill and application of learning, and at all times acted in accordance with his best medical judgment.

3. Defendants allege that any injuries or damages alleged sustained or suffered by the Plaintiffs at the times and places referred to in Plaintiff's Complaint were caused in whole or in part or were contributed to by the negligence or fault or want of care of the Plaintiff, and the negligence, fault or want of care on the part of the Plaintiff was greater than that, if any, of these answering Defendants.

4. That in all medical attention rendered by these answering Defendants to the Plaintiff, these Defendants possessed and exercised the degree of skill and learning ordinarily possessed and exercised by members of their profession in good standing, practicing in similar localities, and that at all times, these answering Defendants used reasonable care and diligence in the exercise of their skills and the application of their learning, and at all times acted according to their best judgment; that the medical treatment administered by these answering Defendants was the usual and customary treatment for the physical condition and symptoms exhibited by the Plaintiff, and that at no time were these answering Defendants guilty of negligence or improper treatment; that, on the contrary, these answering Defendants performed each and every act of such treatment in a proper and efficient manner and in a manner approved and followed by the medical profession generally and under the circumstances and conditions as they existed when such medical attention was rendered.

5. Defendants allege that they made, consistent with good medical practice, a full and complete disclosure to the Plaintiff of all material facts known to them or reasonably

believed by them to be true concerning the Plaintiff's physical condition and the appropriate alternative procedures available for treatment of such condition. Further, each and every service rendered to the Plaintiff by these answering Defendants was expressly and impliedly consented to and authorized by the Plaintiff on the basis of said full and complete disclosure.

6. Defendants allege that they are entitled to a conclusive presumption of informed consent pursuant to NRS §41A.110.

7. Defendants allege that the Complaint is barred by the applicable statute of limitations.

8. Defendants allege that Plaintiff assumed the risks of the procedures, if any, performed.

9. Plaintiff's damages, if any, were caused by and due to an unavoidable condition or occurrence.

10. Plaintiff has failed to mitigate her damages.

11. Defendants allege that the injuries and damages, if any, alleged by the Plaintiff were caused in whole or in part by the actions or inactions of third parties over whom these answering Defendants had no liability, responsibility or control.

12. Defendants allege that the injuries and damages, if any, complained of by the Plaintiff were unforeseeable.

13. Defendants allege that the injuries and damages, if any, complained of by the Plaintiff were caused by forces of nature over which these answering Defendants had no responsibility, liability or control.

14. Defendants allege that the injuries and damages, if any, complained of by the Plaintiff were not proximately caused by any acts and/or omissions on the part of these answering Defendants.

15. Plaintiff's Complaint violates the Statute of Frauds.

16. Defendants allege that pursuant to Nevada law, they would not be jointly liable, and that if liability is imposed, such liability would be several for that portion of the Plaintiff's damages, if any, that represents the percentage attributed to these answering Defendants.

17. Defendants allege that the injuries and damages, if any, suffered by the Plaintiff were caused by new, independent, intervening and superseding causes and not by these answering Defendants' alleged negligence or other actionable conduct, the existence of which is specifically denied.

18. Defendants allege that Plaintiff's damages, if any, are subject to the limitations and protections as set forth in Chapter 41A of the Nevada Revised Statutes including, without limitation, several liability and limits on non-economic damages.

19. Defendants allege that it has been necessary to employ the services of an attorney to defend this action and a reasonable sum should be allowed these Defendants for attorney's fees, together with the costs expended in this action.

20. Defendants allege that they are not guilty of fraud, oppression or malice, express or implied, in connection with the care rendered to Plaintiff at any of the times or places alleged in the Complaint.

21. Defendants allege that at all relevant times they were acting in good faith and not with recklessness, oppression, fraud or malice.

22. Defendants allege that they never engaged in conduct which constitutes battery, abuse, neglect or exploitation of Plaintiff.

23. Defendants allege that the injuries and damages, if any, suffered by Plaintiff can and do occur in the absence of negligence.

24. Plaintiff has failed to allege any facts sufficient to satisfy Plaintiff's burden of proof by clear and convincing evidence that these answering Defendants engaged in any conduct that would support an award of punitive damages.

25. No award of punitive damages can be awarded against these answering Defendants under the facts and circumstances alleged in Plaintiff's Complaint.

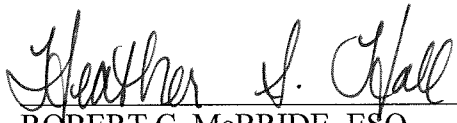
26. To the extent Plaintiff has been reimbursed from any source for any special damages claimed to have been sustained as a result of the incidents alleged in Plaintiff's Complaint, Defendants may elect to offer those amounts into evidence and, if Defendants so elects, Plaintiff's special damages shall be reduced by those amounts pursuant to NRS §42.021.

27. Pursuant to NRCP 11 all possible affirmative defenses may not have been alleged since sufficient facts were not available and, therefore, these Defendants reserve the right to amend this Answer to allege additional affirmative defenses if subsequent investigation warrants. Additionally, one or more of these Affirmative Defenses may have been pled for the purposes of non-waiver.

WHEREFORE, these answering Defendants pray that Plaintiff take nothing by way of her Complaint, that the Complaint be dismissed with prejudice and that the Court award fees and expenses as deemed appropriate.

DATED this 25th day of September 2018.

CARROLL, KELLY, TROTTER,
FRANZEN, McBRIDE & PEABODY



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Las Vegas, Nevada 89113
Attorneys For Defendants,
Keith Brill, M.D., FACOG, FACS and Women's Health Associates of Southern Nevada – Martin, PLLC

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 26th day of September 2018, I served a true and correct copy of the foregoing **DEFENDANTS KEITH BRILL, M.D., FACOG, FACS AND WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC'S ANSWER TO PLAINTIFF'S COMPLAINT** addressed to the following counsel of record at the following address(es):

☒ **VIA ELECTRONIC SERVICE**: By mandatory electronic service (e-service), proof of e-service attached to any copy filed with the Court; or

☐ **VIA U.S. MAIL:** By placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, addressed as indicated on the service list below in the United States mail at Las Vegas, Nevada

☐ **VIA FACSIMILE:** By causing a true copy thereof to be telecopied to the number indicated on the service list below.

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Attorneys for Defendant Todd Christensen, M.D.

An Employee of *CARROLL, KELLY, TROTTER, FRANZEN, McBRIDE & PEABODY*

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efile@hpslaw.com
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, Plaintiff, vs. KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; Defendants.	CASE NO. A-18-773472-C DEPT NO. X **STIPULATION AND ORDER TO DISMISS NURSE DEFENDANT BRUCE HUTCHINS, RN WITHOUT PREJUDICE**

COMES NOW, Plaintiff, KIMBERLY D. TAYLOR, by and through her counsel of record JAMES KENT, ESQ., Defendant, HENDERSON HOSPITAL, by and through its counsel

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1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

of record, BRITTANY A. LEWIS, ESQ., Defendants, KEITH BRILL, MD, FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA, by and through their counsel of record, HEATHER S. HALL, ESQ., Defendant, TODD W. CHRISTENSEN, MD, by and through his counsel of record, KIM I. MANDELBAUM, ESQ., and Defendant, ST. ROSE DOMINICAN HOSPITAL, by and through its counsel of record, KEITH WEAVER, ESQ., hereby stipulate and agree as follows:

1. BRUCE HUTCHINS, RN at all times relevant to the instant litigation was an employee/agent of HENDERSON HOSPITAL and was acting in the course and scope of his employment at all times during the care and treatment of KIMBERLY TAYLOR as it relates to the allegations found in Plaintiff's complaint; and
2. Nothing in this stipulation will limit the evidence admitted at trial of acts and/or omissions of BRUCE HUTCHINS, RN, or discovery related to the same;
3. That Defendant BRUCE HUTCHINS, RN may be dismissed, without prejudice, from the instant litigation in case A-18-773472-C, with each party to bear their own attorneys' fees and costs; and
4. This matter is to proceed against the remaining Defendants.

IT IS SO STIPULATED.

DATED this 3rd day of ~~September~~ October, 2018.

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
Las Vegas, Nevada 89144
Attorneys for Defendant Henderson Hospital

DATED this 28th day of September, 2018.

JAMES S. KENT, ESQ.
Nevada Bar No. 5034
9480 S. Eastern Ave., Suite 228
Las Vegas, NV 89123
Attorneys for Plaintiffs

DATED this 5th day of ~~September,~~ October 2018.

ROBERT MCBRIDE, ESQ.
Nevada Bar No. 7082
HEATHER HALL, ESQ.
Nevada Bar No. 10608
CARROLL, KELLY, TROTTER, FRANZEN, MCBRIDE & PEABODY
8329 W. Sunset Road, Suite 260
Las Vegas, NV 89113
Attorneys for Defendants Keith Brill, MD, FACOG, FACS & Women's Health Associates of Southern Nevada – MARTIN, PLLC

DATED this 5th day of ~~September~~ October, 2018.

KEITH A. WEAVER, ESQ.
Nevada Bar No.
DANIELLE WOODRUM, ESQ.
Nevada Bar No.
BIANCA V. GONZALEZ, ESQ.
Nevada Bar No.
LEWIS, BRISBOIS, BISGAARD & SMITH
6385 S. Rainbow Blvd., Suite 600
Las Vegas, NV 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

ORDER

BASED UPON THE FOREGOING STIPULATION OF COUNSEL, THIS COURT HEREBY FINDS THAT: BRUCE HUTCHINS, RN at all times relevant to the instant litigation were employees/agents of HENDERSON HOSPITAL and were acting in their course and scope of their employment at all times during the care and treatment of KIMBERLY TAYLOR as it relates to the allegations found in Plaintiff's complaint.

AS A RESULT OF THIS FINDING AND BASED UPON THE STIPULATION OF COUNSEL THE COURT ORDERS AS FOLLOWS:

1. **IT IS HEREBY ORDERED THAT,** Nothing in this stipulation will limit the evidence admitted at trial of acts and/or omissions of BRUCE HUTCHINS, RN, or discovery related to the same;

///

///

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

2. **IT IS FURTHER ORDERED,** That Defendant BRUCE HUTCHINS, RN be dismissed, without prejudice, from the instant litigation in case A-18-773472-C, with each party to bear their own attorneys' fees and costs; and

3. **IT IS FURTHER ORDERED,** This matter is to proceed against the remaining Defendants.

DATED this 10 day of October, 2018.

DISTRICT COURT JUDGE

Respectfully Submitted by:

HALL PRANGLE & SCHOONVELD, LLC

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
CANDACE C. HERLING, ESQ.
Nevada Bar No. 13503
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
Las Vegas, Nevada 89144
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

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NEO
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
BRITTANY A. LEWIS, ESQ.
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efile@hpslaw.com
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, Plaintiff, vs. KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; Defendants.	CASE NO. A-18-773472-C DEPT NO. X **NOTICE OF ENTRY OF ORDER**

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HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

PLEASE TAKE NOTICE that a Stipulation and Order to Dismiss Nurse Defendant Bruce Hutchins, RN, without Prejudice in the above entitled Court on the 18th day of October, 2018, a copy of which is attached hereto.

DATED this 24th day of October, 2018.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/: Brittany A. Lewis, Esq.*
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
Las Vegas, Nevada 89144
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

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TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 24th day of October, 2018, I served a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER** as follows:

XX the E-Service Master List for the above referenced matter in the Eighth Judicial District Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules;

_____ U.S. Mail, first class postage pre-paid to the following parties at their last known address;

_____ Receipt of Copy at their last known address:

James S. Kent, Esq.
9480 S. Eastern Ave., Suite 228
Las Vegas, NV 89123
jamie@jamiekent.org
Attorneys for Plaintiffs

Robert McBride, Esq.
Heather Hall, Esq.
Carroll, Kelly, Trotter, Franzen,
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8329 W. Sunset Road, Suite 260
Las Vegas, NV 89113
rcmcbride@cktfmlaw.com
hshall@cktfmlaw.com
Attorneys for Defendant
Keith Brill, MD, FACOG, FACS and Women's Health Associates of Southern Nevada

Keith Weaver, Esq.
Lewis Brisbois Bisgaard & Smith
6385 S. Rainbow Blvd., Suite 600
Las Vegas, NV 89118
keith.weaver@lewisbrisbois.com
Attorneys for Dignity Health d/b/a St. Rose Dominican Hospital

Kim Irene Mandelbaum, Esq.
Sherman B. Mayor, Esq.
Mandelbaum, Ellerton & Associates
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filing@meklaw.net
Attorneys for Todd W. Christensen, M.D.

/s/: Audrey Ann Brown
An employee of HALL PRANGLE & SCHOONVELD, LLC

4849-3784-3048, v. 1

SAO
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
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Phone: 702-889-6400
Facsimile: 702-384-6025
efile@hpslaw.com
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, Plaintiff, vs. KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; Defendants.	CASE NO. A-18-773472-C DEPT NO. X **STIPULATION AND ORDER TO DISMISS NURSE DEFENDANT BRUCE HUTCHINS, RN WITHOUT PREJUDICE**

COMES NOW, Plaintiff, KIMBERLY D. TAYLOR, by and through her counsel of record JAMES KENT, ESQ., Defendant, HENDERSON HOSPITAL, by and through its counsel

HALL PRANGLE & SCHOONVELD, LLC
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HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

of record, BRITTANY A. LEWIS, ESQ., Defendants, KEITH BRILL, MD, FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA, by and through their counsel of record, HEATHER S. HALL, ESQ., Defendant, TODD W. CHRISTENSEN, MD, by and through his counsel of record, KIM I. MANDELBAUM, ESQ., and Defendant, ST. ROSE DOMINICAN HOSPITAL, by and through its counsel of record, KEITH WEAVER, ESQ., hereby stipulate and agree as follows:

1. BRUCE HUTCHINS, RN at all times relevant to the instant litigation was an employee/agent of HENDERSON HOSPITAL and was acting in the course and scope of his employment at all times during the care and treatment of KIMBERLY TAYLOR as it relates to the allegations found in Plaintiff's complaint; and
2. Nothing in this stipulation will limit the evidence admitted at trial of acts and/or omissions of BRUCE HUTCHINS, RN, or discovery related to the same;
3. That Defendant BRUCE HUTCHINS, RN may be dismissed, without prejudice, from the instant litigation in case A-18-773472-C, with each party to bear their own attorneys' fees and costs; and
4. This matter is to proceed against the remaining Defendants.

IT IS SO STIPULATED.

DATED this 3rd day of ~~September~~ October, 2018.

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
Las Vegas, Nevada 89144
Attorneys for Defendant Henderson Hospital

DATED this 28th day of September, 2018.

JAMES S. KENT, ESQ.
Nevada Bar No. 5034
9480 S. Eastern Ave., Suite 228
Las Vegas, NV 89123
Attorneys for Plaintiffs

DATED this 5th day of ~~September,~~ October 2018.

ROBERT MCBRIDE, ESQ.
Nevada Bar No. 7082
HEATHER HALL, ESQ.
Nevada Bar No. 10608
CARROLL, KELLY, TROTTER, FRANZEN, MCBRIDE & PEABODY
8329 W. Sunset Road, Suite 260
Las Vegas, NV 89113
Attorneys for Defendants Keith Brill, MD, FACOG, FACS & Women's Health Associates of Southern Nevada – MARTIN, PLLC

DATED this 5th day of ~~September~~ October, 2018.

KEITH A. WEAVER, ESQ.
Nevada Bar No.
DANIELLE WOODRUM, ESQ.
Nevada Bar No.
BIANCA V. GONZALEZ, ESQ.
Nevada Bar No.
LEWIS, BRISBOIS, BISGAARD & SMITH
6385 S. Rainbow Blvd., Suite 600
Las Vegas, NV 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

ORDER

BASED UPON THE FOREGOING STIPULATION OF COUNSEL, THIS COURT HEREBY FINDS THAT: BRUCE HUTCHINS, RN at all times relevant to the instant litigation were employees/agents of HENDERSON HOSPITAL and were acting in their course and scope of their employment at all times during the care and treatment of KIMBERLY TAYLOR as it relates to the allegations found in Plaintiff's complaint.

AS A RESULT OF THIS FINDING AND BASED UPON THE STIPULATION OF COUNSEL THE COURT ORDERS AS FOLLOWS:

1. **IT IS HEREBY ORDERED THAT,** Nothing in this stipulation will limit the evidence admitted at trial of acts and/or omissions of BRUCE HUTCHINS, RN, or discovery related to the same;

///

///

2. **IT IS FURTHER ORDERED,** That Defendant BRUCE HUTCHINS, RN be dismissed, without prejudice, from the instant litigation in case A-18-773472-C, with each party to bear their own attorneys' fees and costs; and

3. **IT IS FURTHER ORDERED,** This matter is to proceed against the remaining Defendants.

DATED this 10 day of October, 2018.

DISTRICT COURT JUDGE

Respectfully Submitted by:

HALL PRANGLE & SCHOONVELD, LLC

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
CANDACE C. HERLING, ESQ.
Nevada Bar No. 13503
BRITTANY A. LEWIS, ESQ.
Nevada Bar no. 14565
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Ste. 200
Las Vegas, Nevada 89144
Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE, STE. 200
LAS VEGAS, NEVADA 89144
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ELECTRONICALLY SERVED
3/9/2021 4:00 PM

Electronically Filed
03/09/2021 3:59 PM
CLERK OF THE COURT

KEITH A. WEAVER
Nevada Bar No. 10271
E-Mail: Keith.Weaver@lewisbrisbois.com
DANIELLE WOODRUM
Nevada Bar No. 12902
E-Mail: Danielle.Woodrum@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, ,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG,FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; ,

Defendants.

CASE NO. A-18-773472-C
Dept. No.: III

STIPULATION AND ORDER TO DISMISS DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL - SIENA CAMPUS

Plaintiff KIMBERLY D. TAYLOR, by and through her undersigned counsel of record, the law firm BREEDEN & ASSOCIATES, PLLC and Defendant Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus, by and through its undersigned

counsel of record, the law firm LEWIS BRISBOIS BISGAARD & SMITH LLP, hereby stipulate and agree as follows:

FIRST, all claims against Defendant Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus be dismissed with prejudice.

SECOND, each party shall bear their own attorneys' fees and costs incurred in this action.

THIRD, that this stipulation does not dismiss all claims as to all parties, only those as to Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus . Therefore, no other hearing dates, discovery deadlines or the trial date should be vacated at this time and this case should remain open.

IT IS SO STIPULATED.

Dated: February 19, 2021
LEWIS BRISBOIS BISGAARD & SMITH LLP

/s/ Danielle Woodrum

Keith A. Weaver
Nevada Bar No. 10271
Danielle Woodrum
Nevada Bar No. 12902
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

Dated: February 17th, 2021
BREEDEN & ASSOCIATES, PLLC

Adam J. Breeden, Esq.
Nevada Bar No. 8768
376 E. Warm Springs Road, Suite 120
Las Vegas, NV 89119
Attorneys for Plaintiff

Taylor v. Dignity Health, et al.
Case No.: A-18-773472-C
Dept. No.: III

ORDER

Based upon the foregoing stipulation, IT IS HEREBY ORDERED in the above-entitled action, that DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL-SIENA CAMPUS be DISMISSED WITH PREJUDICE and each party shall bear their own attorneys' fees and costs in this matter.

Dated this 9th day of March, 2021

Dated this the ____ day of _____, 2021.

DISTRICT COURT JUDGE

009 326 3DEA D366
Monica Trujillo
District Court Judge

mg

Respectfully submitted by:
LEWIS BRISBOIS BISGAARD & SMITH LLP

/s/ Danielle Woodrum

KEITH A. WEAVER
Nevada Bar No. 10271
DANIELLE WOODRUM
Nevada Bar No. 12902
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

LEWIS BRISBOIS

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Kimberly Taylor, Plaintiff(s)	CASE NO: A-18-773472-C
vs.	DEPT. NO. Department 3
Keith Brill, M.D., Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Stipulation and Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 3/9/2021

Adam Breeden	adam@breedenandassociates.com
E-File Admin	efile@hpslaw.com
Kellie Piet	kpiet@mcbridehall.com
Heather Hall	hshall@mcbridehall.com
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Robert McBride	rcmcbride@mcbridehall.com
Kristine Herpin	kherpin@mcbridehall.com
John Cotton	jhcotton@jhcottonlaw.com
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Keith Weaver	keith.weaver@lewisbrisbois.com
Danielle Woodrum	Danielle.Woodrum@lewisbrisbois.com
Maceo Butler	Maceo.Butler@lewisbrisbois.com
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James Kent	jamie@jamiekent.org
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KEITH A. WEAVER
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DANIELLE WOODRUM
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LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, ,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG,FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive,

Defendants.

CASE NO. A-18-773472-C
Dept. No.: III

NOTICE OF ENTRY OF STIPULATION AND ORDER TO DISMISS DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL - SIENA CAMPUS

/ / /

/ / /

/ / /

PLEASE TAKE NOTICE that the Stipulation and Order to Dismiss Defendant Dignity Health D/B/A St. Rose Dominican Hospital – Siena Campus was entered on March 10, 2021, a true and correct copy of which is attached hereto.

DATED this 10th day of March, 2021

LEWIS BRISBOIS BISGAARD & SMITH LLP

By */s/ Danielle Woodrum*

KEITH A. WEAVER
Nevada Bar No. 10271
DANIELLE WOODRUM
Nevada Bar No. 12902
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

ELECTRONICALLY SERVED
3/9/2021 4:00 PM

Electronically Filed
03/09/2021 3:59 PM
CLERK OF THE COURT

KEITH A. WEAVER
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FAX: 702.893.3789
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, ,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG,FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; ,

Defendants.

CASE NO. A-18-773472-C
Dept. No.: III

STIPULATION AND ORDER TO DISMISS DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL - SIENA CAMPUS

Plaintiff KIMBERLY D. TAYLOR, by and through her undersigned counsel of record, the law firm BREEDEN & ASSOCIATES, PLLC and Defendant Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus, by and through its undersigned

counsel of record, the law firm LEWIS BRISBOIS BISGAARD & SMITH LLP, hereby stipulate and agree as follows:

FIRST, all claims against Defendant Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus be dismissed with prejudice.

SECOND, each party shall bear their own attorneys' fees and costs incurred in this action.

THIRD, that this stipulation does not dismiss all claims as to all parties, only those as to Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus . Therefore, no other hearing dates, discovery deadlines or the trial date should be vacated at this time and this case should remain open.

IT IS SO STIPULATED.

Dated: February 19, 2021
LEWIS BRISBOIS BISGAARD & SMITH LLP

/s/ Danielle Woodrum

Keith A. Weaver
Nevada Bar No. 10271
Danielle Woodrum
Nevada Bar No. 12902
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

Dated: February 17th, 2021
BREEDEN & ASSOCIATES, PLLC

Adam J. Breeden, Esq.
Nevada Bar No. 8768
376 E. Warm Springs Road, Suite 120
Las Vegas, NV 89119
Attorneys for Plaintiff

Taylor v. Dignity Health, et al.
Case No.: A-18-773472-C
Dept. No.: III

ORDER

Based upon the foregoing stipulation, IT IS HEREBY ORDERED in the above-entitled action, that DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL-SIENA CAMPUS be DISMISSED WITH PREJUDICE and each party shall bear their own attorneys' fees and costs in this matter.

Dated this the ____ day of _____, 2021.

Dated this 9th day of March, 2021

DISTRICT COURT JUDGE

009 326 3DEA D366
Monica Trujillo
District Court Judge

mg

Respectfully submitted by:
LEWIS BRISBOIS BISGAARD & SMITH LLP

/s/ Danielle Woodrum

KEITH A. WEAVER
Nevada Bar No. 10271
DANIELLE WOODRUM
Nevada Bar No. 12902
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant Dignity Health d/b/a St. Rose Dominican Hospital

LEWIS BRISBOIS

CERTIFICATE OF SERVICE

I hereby certify that on this 10th day of March, 2021, a true and correct copy of **NOTICE OF ENTRY OF STIPULATION AND ORDER TO DISMISS DEFENDANT DIGNITY HEALTH D/B/A ST. ROSE DOMINICAN HOSPITAL - SIENA CAMPUS** was served by electronically filing with the Clerk of the Court using the Odyssey E-File & Serve system and serving all parties with an email-address on record, who have agreed to receive electronic service in this action.

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Attorneys for Defendants Keith Brill, M.D., FACOG, FACS and Women's Health Associates of Southern Nevada - MARTIN, PLLC

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Telephone: (702) 832-5909
Facsimile: (702) 832-5910
Attorneys for Defendant Todd W. Christensen, M.D.

By */s/ Christopher Ouellette*
An Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

ELECTRONICALLY SERVED
3/17/2021 1:35 PM

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03/17/2021 1:34 PM
CLERK OF THE COURT

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Adam@Breedenandassociates.com
Attorneys for Plaintiff

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY TAYLOR, an individual,

Plaintiff,

v.

KEITH BRILL, M.D., FACOG, FACS, an individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive,

Defendants.

CASE NO.: A-18-773472-C

DEPT NO.: III

STIPULATION AND ORDER TO DISMISS DEFENDANT VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL WITH PREJUDICE AND TO AMEND CAPTION

The Parties, Plaintiff, KIMBERLY TAYLOR, by and through her counsel Adam J. Breeden, Esq. of BREEDEN & ASSOCIATES, PLLC and Defendant, VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, improperly identified collectively in Plaintiff's Complaint as "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED

Case Number: A-18-773472-C

HEALTH SERVICES, a Foreign LLC" (hereinafter "VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL"), by and through their counsel Ian M. Houston, Esq. of HALL PRANGLE & SCHOONVELD, LLC, KEITH BRILL, M.D. and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA- MARTIN, PLLC by and through their counsel Heather Hall, Esq. of McBRIDE HALL, and TODD W. CHRISTENSEN, M.D. by and though his counsel Adam A. Schneider, Esq. of John H. Cotton & Associates, Ltd., hereby enter into the following stipulation:

IT IS STIPULATED AND AGREED that Defendant, VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, be dismissed from the above-referenced matter with prejudice, each party to bear its own attorney's fees and costs associated with the action and its own attorney's fees and costs associated with the dismissal of VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL.

IT IS FURTHER STIPULATED AND AGREED that, although this dismissal does resolve and dismiss all of Plaintiff's claims as against VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL under any theory of liability, this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and TODD W. CHRISTENSEN, M.D., and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER STIPULATED AND AGREED that the caption in this Action shall be amended to remove "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" and to remove previously dismissed party "BRUCE HUTCHINS, RN, an Individual".

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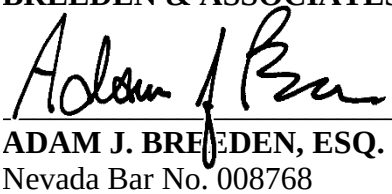
IT IS FURTHER STIPULATED AND AGREED that Co-defendants, KEITH BRILL, M.D., FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1) only.

IT IS SO AGREED.

DATED this 17th day of March, 2021.

BREEDEN & ASSOCIATES, PLLC



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adam@Breedenandassociates.com
Attorneys for Plaintiff

DATED this 17th day of March, 2021.

HALL PRANGLE & SCHOONVELD

/s/ Ian M. Houston, Esq.

IAN M. HOUSTON, ESQ.
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1140 N. Town Center Drive, Suite 350
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ihouston@hpslaw.com
Attorneys for Defendant Valley Health System, LLC d/b/a Henderson Hospital

DATED this 17th day of March, 2021.

McBRIDE HALL

Heather S. Hall, Esq.

HEATHER S. HALL, ESQ.
Nevada Bar No. 010608
8329 W. Sunset Rd., Suite 260
Las Vegas, Nevada 89113
Attorneys for Defendants
Keith Brill, M.D. and
Women's Health Assoc. of S. Nev. – Martin, PLLC

DATED this 17th day of March, 2021.

JOHN H. COTTON & ASSOCIATES, LTD.

/s/ Adam A. Schneider, Esq.

JOHN H. COTTON, ESQ.
Nevada Bar No. 5268
ADAM A. SCHNEIDER, ESQ.
Nevada Bar No. 10216
7900 W. Sahara Ave., Suite 200
Las Vegas, Nevada 89117
Attorneys for Defendant
Todd W. Christensen, M.D.

ORDER

Upon stipulation of the parties, by and through their respective counsel of record, and good cause appearing therefore;

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that pursuant to the stipulation of the parties and for good cause shown Defendant VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, improperly identified collectively in Plaintiff's Complaint as "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" (hereinafter "VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL"), is dismissed from the above-entitled action with prejudice, with each party to bear its own attorney's fees and costs.

IT IS FURTHER ORDERED, that although this dismissal does resolve and dismiss all of Plaintiff's claims as against VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL under any theory of liability, this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and TODD W. CHRISTENSEN, M.D. and therefore all remaining deadlines and the trial date shall remain on calendar and this matter shall not be dismissed in its entirety.

IT IS FURTHER ORDERED that the caption in this Action is amended to remove "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" and to remove previously dismissed party "BRUCE HUTCHINS, RN, an Individual".

/ / /

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IT IS FURTHER ORDERED that Co-defendants, KEITH BRILL, M.D., FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1) only.

IT IS SO ORDERED.

Dated this 17th day of March, 2021

068 258 9337 11B2
Monica Trujillo
District Court Judge

Respectfully submitted by:

BREEDEN & ASSOCIATES, PLLC

ADAM J. BREEDEN, ESQ.
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Attorneys for Plaintiff

Kristy Johnson

From: Heather S. Hall <hshall@mcbridehall.com> on behalf of Heather S. Hall
Sent: Wednesday, March 17, 2021 10:48 AM
To: Adam Breeden; Kristy Johnson; Adam Schneider; Ian M. Houston
Cc: Candace P. Cullina; Robert McBride; Kristine Herpin
Subject: FW: Taylor v. Brill, M.D., et. al.
Attachments: 2021.03.17 REVISED SAO for Dismissal with Prejudice - Henderson Hospital.pdf

You may use my e-signature.

Heather

From: Adam Breeden <adam@breedenandassociates.com>
Sent: Wednesday, March 17, 2021 9:38 AM
To: Ian M. Houston <ihouston@hpslaw.com>; Heather S. Hall <hshall@mcbridehall.com>; Adam Schneider <aschneider@jhcottonlaw.com>
Cc: Kristy Johnson <kristy@breedenandassociates.com>
Subject: Taylor v. Brill, M.D., et. al.

Counsel,

Our office recently settled all claims with Valley Health/Henderson Hospital and so it is necessary to dismiss that entity from the case. I have attached a stipulation and order to dismiss that legal entity only.

Please kindly review the attached proposed stipulation. We are asking counsel for Dr. Brill and Dr. Christensen to sign off, although this stipulation does not affect those Defendants.

If you approve, please "reply all" so we can submit to the Court with your e-signature.

Adam J. Breeden
Trial Attorney, Breeden & Associates, PLLC
(702) 819-7770 | adam@breedenandassociates.com
www.breedenandassociates.com
376 E. Warm Springs Rd., Suite 120 Las Vegas, NV 89119-4262

Kristy Johnson

From: Ian M. Houston <ihouston@hpslaw.com> on behalf of Ian M. Houston
Sent: Wednesday, March 17, 2021 10:44 AM
To: Adam Schneider; Adam Breeden; Heather S. Hall
Cc: Kristy Johnson; Nicole M. Etienne
Subject: RE: Taylor v. Brill, M.D., et. al.
Attachments: 2021.03.17 REVISED SAO for Dismissal with Prejudice - Henderson Hospital.pdf

Good Morning,

I approve the use of my electronic signature for use on this document only.

Thank you,

Ian

HALL PRANGLE+ SCHOONVELD LLC
WHERE TRIAL LAWYERS ARE THE NORM

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Ian Houston
Associate
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Legal Assistant: Nicole Etienne
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From: Adam Schneider <aschneider@jhcottonlaw.com>
Sent: Wednesday, March 17, 2021 9:56 AM
To: Adam Breeden <adam@breedenandassociates.com>; Ian M. Houston <ihouston@hpslaw.com>; Heather S. Hall <hshall@mcbridehall.com>
Cc: Kristy Johnson <kristy@breedenandassociates.com>
Subject: RE: Taylor v. Brill, M.D., et. al.

I approve the use of my e-signature.

Adam Schneider, Esq.
JOHN H. COTTON & ASSOCIATES, LTD.

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From: Adam Breeden
Sent: Wednesday, March 17, 2021 9:37 AM
To: Ian M. Houston; Heather S. Hall; Adam Schneider
Cc: Kristy Johnson
Subject: Taylor v. Brill, M.D., et. al.

Counsel,

Our office recently settled all claims with Valley Health/Henderson Hospital and so it is necessary to dismiss that entity from the case. I have attached a stipulation and order to dismiss that legal entity only.

Please kindly review the attached proposed stipulation. We are asking counsel for Dr. Brill and Dr. Christensen to sign off, although this stipulation does not affect those Defendants.

If you approve, please "reply all" so we can submit to the Court with your e-signature.

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CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Kimberly Taylor, Plaintiff(s)	CASE NO: A-18-773472-C
vs.	DEPT. NO. Department 3
Keith Brill, M.D., Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Stipulation and Order for Dismissal With Prejudice was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 3/17/2021

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DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual,

Plaintiff,

vs.

KEITH BRILL, MD, FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an Individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, MD, an Individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive;

Defendants.

CASE NO. A-18-773472-C
DEPT NO. 3

NOTICE OF ENTRY OF STIPULATION AND ORDER

PLEASE TAKE NOTICE that a Stipulation and Order to Dismiss Defendant Valley Health System, LLC dba Henderson Hospital with Prejudice and to Amend Caption was entered on the 17th day of March, 2021. A copy of which is attached hereto.

DATED this 19th day of March, 2021.

HALL PRANGLE & SCHOONVELD, LLC

By: /s/ Ian Houston

KENNETH M. WEBSTER, ESQ.
NV Bar No. 7205
IAN M. HOUSTON, ESQ.
NV Bar No. 11815
KEVIN J. PETERSON, ESQ.
NV Bar No. 14598
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Attorneys for Defendants Henderson Hospital and Bruce Hutchins, RN

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 19th day of March 2021, I served a true and correct copy of the foregoing **NOTICE OF ENTRY OF STIPULATION AND ORDER** as follows:

XX the E-Service Master List for the above referenced matter in the Eighth Judicial District Court e-filing System in accordance with the electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules;

_____ U.S. Mail, first class postage pre-paid to the following parties at their last known address;

_____ Receipt of Copy at their last known address:

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adam@breedenandassociates.com
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Heather Hall, Esq.
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Attorneys for Defendant
Keith Brill, MD, FACOG, FACS and Women's Health Associates of Southern Nevada

Keith Weaver, Esq.
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Attorneys for Dignity Health d/b/a St. Rose Dominican Hospital

John H. Cotton, Esq.
Adam A. Schneider, Esq.
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aschneider@jhcottonlaw.com
Attorneys for Todd W. Christensen, M.D.

/s/ Nicole Etienne
An employee of HALL PRANGLE & SCHOONVELD, LLC

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CLERK OF THE COURT

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Adam@Breedenandassociates.com
Attorneys for Plaintiff

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY TAYLOR, an individual,

Plaintiff,

v.

KEITH BRILL, M.D., FACOG, FACS, an individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive,

Defendants.

CASE NO.: A-18-773472-C

DEPT NO.: III

STIPULATION AND ORDER TO DISMISS DEFENDANT VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL WITH PREJUDICE AND TO AMEND CAPTION

The Parties, Plaintiff, KIMBERLY TAYLOR, by and through her counsel Adam J. Breeden, Esq. of BREEDEN & ASSOCIATES, PLLC and Defendant, VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, improperly identified collectively in Plaintiff's Complaint as "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED

Case Number: A-18-773472-C

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IT IS STIPULATED AND AGREED that Defendant, VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, be dismissed from the above-referenced matter with prejudice, each party to bear its own attorney's fees and costs associated with the action and its own attorney's fees and costs associated with the dismissal of VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL.

IT IS FURTHER STIPULATED AND AGREED that, although this dismissal does resolve and dismiss all of Plaintiff's claims as against VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL under any theory of liability, this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and TODD W. CHRISTENSEN, M.D., and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER STIPULATED AND AGREED that the caption in this Action shall be amended to remove "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" and to remove previously dismissed party "BRUCE HUTCHINS, RN, an Individual".

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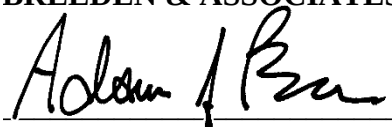
IT IS SO AGREED.

DATED this 17th day of March, 2021.

BREEDEN & ASSOCIATES, PLLC



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Phone: (702) 819-7770
Fax: (702) 819-7771
adam@Breedenandassociates.com
Attorneys for Plaintiff

DATED this 17th day of March, 2021.

HALL PRANGLE & SCHOONVELD

/s/ Ian M. Houston, Esq.

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Fax: (702) 384-6025
ihouston@hpslaw.com
Attorneys for Defendant Valley Health System, LLC d/b/a Henderson Hospital

DATED this 17th day of March, 2021.

McBRIDE HALL

Heather S. Hall, Esq.

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8329 W. Sunset Rd., Suite 260
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Attorneys for Defendants
Keith Brill, M.D. and
Women's Health Assoc. of S. Nev. – Martin, PLLC

DATED this 17th day of March, 2021.

JOHN H. COTTON & ASSOCIATES, LTD.

/s/ Adam A. Schneider, Esq.

JOHN H. COTTON, ESQ.
Nevada Bar No. 5268
ADAM A. SCHNEIDER, ESQ.
Nevada Bar No. 10216
7900 W. Sahara Ave., Suite 200
Las Vegas, Nevada 89117
Attorneys for Defendant
Todd W. Christensen, M.D.

ORDER

Upon stipulation of the parties, by and through their respective counsel of record, and good cause appearing therefore;

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that pursuant to the stipulation of the parties and for good cause shown Defendant VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL, improperly identified collectively in Plaintiff's Complaint as "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" (hereinafter "VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL"), is dismissed from the above-entitled action with prejudice, with each party to bear its own attorney's fees and costs.

IT IS FURTHER ORDERED, that although this dismissal does resolve and dismiss all of Plaintiff's claims as against VALLEY HEALTH SYSTEM, LLC d/b/a HENDERSON HOSPITAL under any theory of liability, this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and TODD W. CHRISTENSEN, M.D. and therefore all remaining deadlines and the trial date shall remain on calendar and this matter shall not be dismissed in its entirety.

IT IS FURTHER ORDERED that the caption in this Action is amended to remove "HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEM, LLC, a Foreign LLC dba HENDERSON HOSPITAL, and/or HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC" and to remove previously dismissed party "BRUCE HUTCHINS, RN, an Individual".

/ / /

/ / /

/ / /

IT IS FURTHER ORDERED that Co-defendants, KEITH BRILL, M.D., FACOG, FACS and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1) only.

IT IS SO ORDERED.

Dated this 17th day of March, 2021

068 258 9337 11B2
Monica Trujillo
District Court Judge

Respectfully submitted by:

BREEDEN & ASSOCIATES, PLLC

ADAM J. BREEDEN, ESQ.
Nevada Bar No. 008768
376 E. Warm Springs Road, Suite 120
Las Vegas, Nevada 89119
Phone: (702) 819-7770
Fax: (702) 819-7771
Attorneys for Plaintiff

Kristy Johnson

From: Heather S. Hall <hshall@mcbridehall.com> on behalf of Heather S. Hall
Sent: Wednesday, March 17, 2021 10:48 AM
To: Adam Breeden; Kristy Johnson; Adam Schneider; Ian M. Houston
Cc: Candace P. Cullina; Robert McBride; Kristine Herpin
Subject: FW: Taylor v. Brill, M.D., et. al.
Attachments: 2021.03.17 REVISED SAO for Dismissal with Prejudice - Henderson Hospital.pdf

You may use my e-signature.

Heather

From: Adam Breeden <adam@breedenandassociates.com>
Sent: Wednesday, March 17, 2021 9:38 AM
To: Ian M. Houston <ihouston@hpslaw.com>; Heather S. Hall <hshall@mcbridehall.com>; Adam Schneider <aschneider@jhcottonlaw.com>
Cc: Kristy Johnson <kristy@breedenandassociates.com>
Subject: Taylor v. Brill, M.D., et. al.

Counsel,

Our office recently settled all claims with Valley Health/Henderson Hospital and so it is necessary to dismiss that entity from the case. I have attached a stipulation and order to dismiss that legal entity only.

Please kindly review the attached proposed stipulation. We are asking counsel for Dr. Brill and Dr. Christensen to sign off, although this stipulation does not affect those Defendants.

If you approve, please "reply all" so we can submit to the Court with your e-signature.

Adam J. Breeden
Trial Attorney, Breeden & Associates, PLLC
(702) 819-7770 | adam@breedenandassociates.com
www.breedenandassociates.com
376 E. Warm Springs Rd., Suite 120 Las Vegas, NV 89119-4262

Kristy Johnson

From: Ian M. Houston <ihouston@hpslaw.com> on behalf of Ian M. Houston
Sent: Wednesday, March 17, 2021 10:44 AM
To: Adam Schneider; Adam Breeden; Heather S. Hall
Cc: Kristy Johnson; Nicole M. Etienne
Subject: RE: Taylor v. Brill, M.D., et. al.
Attachments: 2021.03.17 REVISED SAO for Dismissal with Prejudice - Henderson Hospital.pdf

Good Morning,

I approve the use of my electronic signature for use on this document only.

Thank you,

Ian

HALL PRANGLE+ SCHOONVELD LLC
WHERE TRIAL LAWYERS ARE THE NORM

1140 North Town Center Dr.
Suite 350
Las Vegas, NV 89144
F: 702.384.6025

Ian Houston
Associate
O: 702.212.1462
Email: ihouston@hpslaw.com

Legal Assistant: Nicole Etienne
O: 702.212.1446
Email: netienne@hpslaw.com

From: Adam Schneider <aschneider@jhcottonlaw.com>
Sent: Wednesday, March 17, 2021 9:56 AM
To: Adam Breeden <adam@breedenandassociates.com>; Ian M. Houston <ihouston@hpslaw.com>; Heather S. Hall <hshall@mcbridehall.com>
Cc: Kristy Johnson <kristy@breedenandassociates.com>
Subject: RE: Taylor v. Brill, M.D., et. al.

I approve the use of my e-signature.

Adam Schneider, Esq.
JOHN H. COTTON & ASSOCIATES, LTD.

7900 W. Sahara Ave., Ste. 200
Las Vegas, NV 89117
T: (702) 832-5909
F: (702) 832-5910
aschneider@jhcottonlaw.com

From: Adam Breeden
Sent: Wednesday, March 17, 2021 9:37 AM
To: Ian M. Houston; Heather S. Hall; Adam Schneider
Cc: Kristy Johnson
Subject: Taylor v. Brill, M.D., et. al.

Counsel,

Our office recently settled all claims with Valley Health/Henderson Hospital and so it is necessary to dismiss that entity from the case. I have attached a stipulation and order to dismiss that legal entity only.

Please kindly review the attached proposed stipulation. We are asking counsel for Dr. Brill and Dr. Christensen to sign off, although this stipulation does not affect those Defendants.

If you approve, please "reply all" so we can submit to the Court with your e-signature.

Adam J. Breeden
Trial Attorney, Breeden & Associates, PLLC
(702) 819-7770 | adam@breedenandassociates.com
www.breedenandassociates.com
376 E. Warm Springs Rd., Suite 120 Las Vegas, NV 89119-4262

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Kimberly Taylor, Plaintiff(s)	CASE NO: A-18-773472-C
vs.	DEPT. NO. Department 3
Keith Brill, M.D., Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Stipulation and Order for Dismissal With Prejudice was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 3/17/2021

Adam Breeden	adam@breedenandassociates.com
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Heather Hall	hshall@mcbridehall.com
Jody Foote	jfoote@jhcottonlaw.com
Jessica Pincombe	jpincombe@jhcottonlaw.com
Robert McBride	rcmcbride@mcbridehall.com
Kristine Herpin	kherpin@mcbridehall.com
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Maceo Butler	Maceo.Butler@lewisbrisbois.com
Michelle Newquist	mnewquist@mcbridehall.com
Kristy Johnson	kristy@breedenandassociates.com
James Kent	jamie@jamiekent.org
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Tiffane Safar	tsafar@mcbridehall.com
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Penny Williams	pwilliams@mcbridehall.com
Timothy Evans	tevans@mcbridehall.com
Xiao Jin	xiaowen.jin@lewisbrisbois.com
Hugo Hernandez-Diaz	hugo.hernandez-diaz@lewisbrisbois.com
Christopher Ouellette	Chris.Ouellette@lewisbrisbois.com

SAO
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Nevada Bar Number 5268
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ADAM A. SCHNEIDER, ESQ.
Nevada Bar Number 10216
ASchneider@jhcottonlaw.com
JOHN H. COTTON & ASSOCIATES, LTD.
7900 West Sahara Avenue, Suite 200
Las Vegas, Nevada 89117
Telephone: (702) 832-5909
Facsimile: (702) 832-5910
Attorneys for Defendant, Todd W. Christensen, M.D.

DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, Plaintiff, vs. KEITH BRILL, M.D., FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; Defendants.	CASE NO.: **A-18-773472-C** DEPT. NO: **III** **STIPULATION AND ORDER FOR DEFENDANT CHRISTENSEN, M.D.'S DISMISSAL WITH PREJUDICE ONLY**

John H. Cotton & Associates, Ltd.
7900 West Sahara, Suite 200
Las Vegas, Nevada 89117

The Parties, Plaintiff, KIMBERLY TAYLOR, by and through her counsel Adam J. Breeden, Esq. of BREEDEN & ASSOCIATES, PLLC and Defendant TODD W. CHRISTENSEN, M.D. by and through his counsel the law firm of JOHN H. COTTON & ASSOCIATES, LTD., and KEITH BRILL, M.D. and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA- MARTIN, PLLC by and through their counsel Heather Hall, Esq. of McBRIDE HALL hereby enter into the following stipulation:

IT IS STIPULATED AND AGREED that Defendant TODD W. CHRISTENSEN, M.D. be dismissed from the above-referenced matter with prejudice, each party to bear their own

attorneys' fees and costs associated with the action and its own attorney's fees and costs associated with the dismissal of TODD W. CHRISTENSEN, M.D.

IT IS FURTHER STIPULATED AND AGREED that, although this dismissal does resolve and dismiss all of Plaintiff's claims as against TODD W. CHRISTENSEN, M.D., this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER STIPULATED AND AGREED that the caption in this Action shall be amended to remove "TODD W. CHRISTENSEN, M.D."

IT IS FURTHER STIPULATED AND AGREED that Co-defendants KEITH BRILL, M.D., FACOG, FACS, and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1).

IT IS SO AGREED.

//

//

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas. NV 89117

Case name: Taylor v. Brill, et. al.
Case no.: A-18-773472-C
Dept no.: III

DATED this 19th day of April 2021.

JOHN H. COTTON & ASSOCIATES

/s/ Adam Schneider

ADAM A. SCHNEIDER, ESQ.
7900 W. Sahara Ave., Ste. 200
Las Vegas, NV 89117
Attorneys for Defendant
Todd Christensen, M.D.

DATED this 19th day of April 2021.

McBRIDE HALL

/s/ Heather Hall

HEATHER HALL, ESQ.
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Defendants
Keith Brill, M.D., FACOG, FACS, and
Women's Health Associates of Southern
Nevada- Martin PLLC

DATED this 19th day of April 2021.

ADAM BREEDEN & ASSOCIATES

/s/ Adam Breeden

ADAM BREEDEN, ESQ.
376 E. Warm Springs Rd., Ste. 120
Las Vegas, Nevada 89119
Attorneys for Plaintiff

ORDER

Upon stipulation of the parties, by and through their respective counsel of record, and good cause appearing therefore:

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that pursuant to the stipulation of the parties and for good cause shown Defendant TODD W. CHRISTENSEN, M.D. is dismissed from the above-entitled action with prejudice, with each party to bear their own attorneys' fees and costs.

IT IS FURTHER ORDERED that although this dismissal does resolve and dismiss all of Plaintiff's claims as against TODD W. CHRISTENSEN, M.D., this dismissal does not resolve

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas, NV 89117

all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER ORDERED that the caption in this Action shall be amended to remove "TODD W. CHRISTENSEN, M.D."

IT IS FURTHER ORDERED that Co-defendants KEITH BRILL, M.D., FACOG, FACS, and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1).

IT IS SO ORDERED.

Dated this 21st day of April, 2021

ADA B05 445F 8E17
Monica Trujillo
District Court Judge

Submitted by:

JOHN H. COTTON & ASSOCIATES

/s/ Adam Schneider

ADAM A. SCHNEIDER, ESQ.
7900 W. Sahara Ave., Ste. 200
Las Vegas, NV 89117
Attorneys for Defendant
Todd Christensen, M.D.

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas, NV 89117

From: Adam Breeden
Sent: Monday, April 19, 2021 2:03 PM
To: Heather S. Hall
Cc: Adam Schneider; Jody Foote; Candace P. Cullina; Kristy Johnson
Subject: Re: A-18-773472-C / SAO / Taylor v. Christensen- proposed SAO

Adam,

I also have no objection to the language in the stipulation, go ahead and submit it.

The linked image cannot be displayed

Adam J. Breeden
Trial Attorney, Breeden & Associates, PLLC
(702) 819-7770 | adam@breedenandassociates.com
www.breedenandassociates.com
376 E. Warm Springs Rd., Suite 120 Las Vegas, NV 89119-4262

On Mon, Apr 19, 2021 at 10:06 AM Heather S. Hall <hshall@mcbridehall.com> wrote:

> Adam,
>
> No changes from me. You may use my e-signature. My bar number is 10608 if you need it.
>
> Thanks,
>
> Heather
>
> **From:** Adam Schneider <aschneider@jhcottonlaw.com>
> **Sent:** Monday, April 19, 2021 9:30 AM
> **To:** Adam Breeden <adam@breedenandassociates.com>; Heather S. Hall <hshall@mcbridehall.com>

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Kimberly Taylor, Plaintiff(s)	CASE NO: A-18-773472-C
vs.	DEPT. NO. Department 3
Keith Brill, M.D., Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Stipulation and Order for Dismissal With Prejudice was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 4/21/2021

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Heather Hall	hshall@mcbridehall.com
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Penny Williams	pwilliams@mcbridehall.com
Timothy Evans	tevans@mcbridehall.com

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7900 West Sahara Avenue, Suite 200
Las Vegas, Nevada 89117
Telephone: (702) 832-5909
Facsimile: (702) 832-5910
Attorneys for Defendant, Todd W. Christensen, M.D.

DISTRICT COURT
* * *
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual,

Plaintiff,

vs.

KEITH BRILL, M.D., FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive;

Defendants.

CASE NO.: **A-18-773472-C**
DEPT. NO: **3**

NOTICE OF ENTRY OF STIPULATION AND ORDER FOR DEFENDANT CHRISTENSEN, M.D.'S DISMISSAL WITH PREJUDICE ONLY

PLEASE TAKE NOTICE that an Order was entered on the 21st day of April 2021 in the above-captioned matter, a copy of which is attached hereto.

Dated this 22nd day of April 2021.

JOHN H. COTTON & ASSOCIATES, LTD.
7900 West Sahara Avenue, Suite 200
Las Vegas, Nevada 89117

/s/ Adam Schneider
JOHN H. COTTON, ESQ.
ADAM A. SCHNEIDER, ESQ.

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas, NV 89117

CERTIFICATE OF ELECTRONIC SERVICE

I hereby certify that on the 22nd day of April 2021 I served a true and correct copy of the foregoing ***NOTICE OF ENTRY OF STIPULATION AND ORDER FOR DEFENDANT CHRISTENSEN, M.D.'S DISMISSAL WITH PREJUDICE ONLY*** was submitted electronically for filing and/or service with the Eighth Judicial District Court, made in accordance with the E-Service List, to the following individuals:

Adam J. Breeden, Esq.
BREEDEN & ASSOCIATES, PLLC
376 E. Warm Springs Rd., Ste. 120
Las Vegas, NV 89119
Attorneys for Plaintiff

Robert C. McBride, Esq.
Heather S. Hall, Esq.
MCBRIDE HALL
8329 West Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Defendants, Keith Brill M.D. and Women's Health Associates of So. NV

/s/ Jody Foote
An Employee of John H. Cotton & Associates

ELECTRONICALLY SERVED
4/21/2021 4:42 PM

Electronically Filed
04/21/2021 4:41 PM
CLERK OF THE COURT

SAO
JOHN H. COTTON, ESQ.
Nevada Bar Number 5268
JHCotton@jhcottonlaw.com
ADAM A. SCHNEIDER, ESQ.
Nevada Bar Number 10216
ASchneider@jhcottonlaw.com
JOHN H. COTTON & ASSOCIATES, LTD.
7900 West Sahara Avenue, Suite 200
Las Vegas, Nevada 89117
Telephone: (702) 832-5909
Facsimile: (702) 832-5910
Attorneys for Defendant, Todd W. Christensen, M.D.

DISTRICT COURT
CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, an Individual, Plaintiff, vs. KEITH BRILL, M.D., FACOG, FACS, an Individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive; Defendants.	CASE NO.: **A-18-773472-C** DEPT. NO: **III** **STIPULATION AND ORDER FOR DEFENDANT CHRISTENSEN, M.D.'S DISMISSAL WITH PREJUDICE ONLY**

John H. Cotton & Associates, Ltd.
7900 West Sahara, Suite 200
Las Vegas, Nevada 89117

The Parties, Plaintiff, KIMBERLY TAYLOR, by and through her counsel Adam J. Breeden, Esq. of BREEDEN & ASSOCIATES, PLLC and Defendant TODD W. CHRISTENSEN, M.D. by and through his counsel the law firm of JOHN H. COTTON & ASSOCIATES, LTD., and KEITH BRILL, M.D. and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA- MARTIN, PLLC by and through their counsel Heather Hall, Esq. of McBRIDE HALL hereby enter into the following stipulation:

IT IS STIPULATED AND AGREED that Defendant TODD W. CHRISTENSEN, M.D. be dismissed from the above-referenced matter with prejudice, each party to bear their own

attorneys' fees and costs associated with the action and its own attorney's fees and costs associated with the dismissal of TODD W. CHRISTENSEN, M.D.

IT IS FURTHER STIPULATED AND AGREED that, although this dismissal does resolve and dismiss all of Plaintiff's claims as against TODD W. CHRISTENSEN, M.D., this dismissal does not resolve all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER STIPULATED AND AGREED that the caption in this Action shall be amended to remove "TODD W. CHRISTENSEN, M.D."

IT IS FURTHER STIPULATED AND AGREED that Co-defendants KEITH BRILL, M.D., FACOG, FACS, and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1).

IT IS SO AGREED.

//

//

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas. NV 89117

Case name: Taylor v. Brill, et. al.
Case no.: A-18-773472-C
Dept no.: III

DATED this 19th day of April 2021.

JOHN H. COTTON & ASSOCIATES

/s/ Adam Schneider

ADAM A. SCHNEIDER, ESQ.
7900 W. Sahara Ave., Ste. 200
Las Vegas, NV 89117
Attorneys for Defendant
Todd Christensen, M.D.

DATED this 19th day of April 2021.

McBRIDE HALL

/s/ Heather Hall

HEATHER HALL, ESQ.
8329 W. Sunset Road, Suite 260
Las Vegas, Nevada 89113
Attorneys for Defendants
Keith Brill, M.D., FACOG, FACS, and
Women's Health Associates of Southern
Nevada- Martin PLLC

DATED this 19th day of April 2021.

ADAM BREEDEN & ASSOCIATES

/s/ Adam Breeden

ADAM BREEDEN, ESQ.
376 E. Warm Springs Rd., Ste. 120
Las Vegas, Nevada 89119
Attorneys for Plaintiff

ORDER

Upon stipulation of the parties, by and through their respective counsel of record, and good cause appearing therefore:

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that pursuant to the stipulation of the parties and for good cause shown Defendant TODD W. CHRISTENSEN, M.D. is dismissed from the above-entitled action with prejudice, with each party to bear their own attorneys' fees and costs.

IT IS FURTHER ORDERED that although this dismissal does resolve and dismiss all of Plaintiff's claims as against TODD W. CHRISTENSEN, M.D., this dismissal does not resolve

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas, NV 89117

all claims as to all parties and therefore this Action shall remain pending as to Defendants KEITH BRILL, M.D., FACOG, FACS; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA - MARTIN, PLLC; and no current trial or discovery dates shall be vacated at this time by the Court.

IT IS FURTHER ORDERED that the caption in this Action shall be amended to remove "TODD W. CHRISTENSEN, M.D."

IT IS FURTHER ORDERED that Co-defendants KEITH BRILL, M.D., FACOG, FACS, and WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC reserve all rights and are signing this Stipulation and Order for the parties to comply with NRCP 41(a)(1).

IT IS SO ORDERED.

Dated this 21st day of April, 2021

ADA B05 445F 8E17
Monica Trujillo
District Court Judge

Submitted by:

JOHN H. COTTON & ASSOCIATES

/s/ Adam Schneider

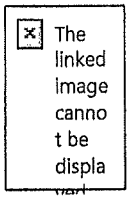
ADAM A. SCHNEIDER, ESQ.
7900 W. Sahara Ave., Ste. 200
Las Vegas, NV 89117
Attorneys for Defendant
Todd Christensen, M.D.

John H. Cotton & Associates
7900 W. Sahara, Suite 200
Las Vegas, NV 89117

From: Adam Breeden
Sent: Monday, April 19, 2021 2:03 PM
To: Heather S. Hall
Cc: Adam Schneider; Jody Foote; Candace P. Cullina; Kristy Johnson
Subject: Re: A-18-773472-C / SAO / Taylor v. Christensen- proposed SAO

Adam,

I also have no objection to the language in the stipulation, go ahead and submit it.



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Trial Attorney, Breeden & Associates, PLLC
(702) 819-7770 | adam@breedenandassociates.com
www.breedenandassociates.com
376 E. Warm Springs Rd., Suite 120 Las Vegas, NV 89119-4262

On Mon, Apr 19, 2021 at 10:06 AM Heather S. Hall <hshall@mcbridehall.com> wrote:

> Adam,
>
> No changes from me. You may use my e-signature. My bar number is 10608 if you need it.
>
> Thanks,
>
> Heather

From: Adam Schneider <aschneider@jhcottonlaw.com>
Sent: Monday, April 19, 2021 9:30 AM
To: Adam Breeden <adam@breedenandassociates.com>; Heather S. Hall <hshall@mcbridehall.com>

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Kimberly Taylor, Plaintiff(s)	CASE NO: A-18-773472-C
vs.	DEPT. NO. Department 3
Keith Brill, M.D., Defendant(s)	

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Stipulation and Order for Dismissal With Prejudice was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 4/21/2021

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Adam@Breedenandassociates.com
Attorneys for Plaintiff

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY TAYLOR, an individual,

Plaintiff,

v.

KEITH BRILL, M.D., FACOG, FACS, an individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEMS, LLC, a Foreign LLC d/b/a HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive,

Defendants.

CASE NO.: A-18-773472-C

DEPT NO.: III

PLAINTIFF'S MOTION IN LIMINE # 1: MOTION TO PERMIT CERTAIN CLOSING ARGUMENT TECHNIQUES OF PLAINTIFF'S COUNSEL

HEARING REQUESTED: YES

Plaintiff, KIMBERLY TAYLOR, by and through her attorney of record, ADAM J. BREEDEN, ESQ. of BREEDEN & ASSOCIATES, PLLC, and hereby submits his Motion in Limine #1: Motion to Permit Certain Closing Argument Techniques.

/ / /

/ / /

/ / /

This Motion is made and based on the following Points and Authorities, the pleadings and papers on file herein, the Declaration of Adam J. Breeden, Esq., and any oral argument allowed by the Court at the time of hearing on this matter.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC

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Adam@Breedenandassociates.com
Attorneys for Plaintiff

DECLARATION OF ADAM J. BREEDEN, ESQ. PER EDCR 2.47

STATE OF NEVADA)
) ss:
COUNTY OF CLARK:)

I, ADAM J. BREEDEN, ESQ., being first duly sworn, deposes, and says:

1. I am Adam J. Breeden, Esq. and am counsel for Plaintiff, Kimberly Taylor, in the instant litigation and make this affidavit pursuant to EDCR 2.47.

2. I am a licensed attorney in the state of Nevada. I am the managing partner of Breeden & Associates, PLLC. I know the following facts to be true of my own knowledge and, if called to testify, I could competently do so.

3. On August 5, 2021, counsel for the parties conducted a meet-and-confer conference telephonically regarding anticipated Motions in Limine. Letters were exchanged prior to that regarding the anticipated motions. The conference lasted approximately 30 minutes. Many issues were discussed, and probably half were able to be resolved by stipulation. The issue raised in this motion, however, is one that counsel was unable to resolve, thus requiring court intervention.

/ / /

/ / /

/ / /

4. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 18th day of August, 2021.

ADAM J. BRIEDEN, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff Taylor's Motion in Limine #1 seeks an advance ruling to allow certain closing argument techniques by Plaintiff's counsel to the jury including (1) "send a message" argument, (2) rule breaking and safety arguments with reference to news media, (3) the "want ad" argument as to damages, and (4) per diem damages arguments. Said arguments often create distracting objections at trial and these techniques have been approved in Nevada, although some judges are not aware of the finer points of law.

II. OMNIBUS STATEMENT OF FACTS FOR ALL MOTIONS IN LIMINE

This is a medical malpractice action by Plaintiff Kimberly Taylor against her OB/GYN Defendant Keith Brill. On April 26, 2017, Dr. Brill performed an intended dilation and curettage with hysteroscopy combined with fibroid tumor removal and hydrothermal ablation procedure on Ms. Taylor. In layman's terms, this meant that a small scope and cutting device called a resectoscope would be inserted through the vagina into the uterus and a fibroid tumor previously identified via ultrasound in the uterus would be removed. This procedure was done with the use of a Symphion system resectoscope and ablation device. This is a small, tube-like device of 2-3 mm in diameter that is inserted into the uterus. The tip has an ablation device which cuts with radiofrequency or heat from electricity. The patient is under complete anesthesia for the procedure.

It is undisputed that during the procedure Dr. Brill caused the resectoscope to **perforate through the wall of the uterus where the instrument then also perforated the small intestine**, **causing free leakage of stool and body waste into the abdomen of Mrs. Taylor**. It is also undisputed that Dr. Brill saw the uterine perforation intraoperatively but *failed* to recognize that he

had also injured the small bowel. The parties disagree as to what Dr. Brill told Ms. Taylor about the perforation and exactly how and when the perforations occurred and whether the perforations were beneath the standard of care. The resectoscope procedure was terminated but Ms. Taylor had unknown intestinal leakage into her abdomen. After two visits to the emergency room post-operatively, another physician finally diagnosed the injury to the small intestine. A second surgery had to occur wherein a portion of Ms. Taylor's small intestine had to be removed and she had to be hospitalized for over a week. She presents a claim for approximately $225,620.07 in medical special damages and the cap amount of $350,000 for pain and suffering.

The parties do not appear to dispute damages and injury but instead dispute whether Dr. Brill's treatment fell below the standard of care for the procedure. Dr. Brill appears to want to argue that merely because uterine and similar injury is a "risk" of the procedure to which Ms. Taylor consented that he can never be held liable, which is an incorrect statement of the law.

III. LEGAL STANDARD FOR A MOTION IN LIMINE

Motions in limine are designed to seek the Court's ruling on the admissibility of arguments and assertions of evidence in advance of trial. They are a common vehicle through which litigants bring requests to exclude potentially prejudicial evidence from a jury trial. *Kelly v. New West Fed. Sav.*, 56 Cal. Rptr.2d 803, 808 (1996) ("Motions in limine are a commonly used tool of trial advocacy and management…when evidentiary issues are anticipated by the parties.").

The Nevada Supreme Court has approved the use of motions in limine in a number of cases by recognizing the legitimacy of such pre-trial motion practice and the courts' authority to rule on these motions. *Bull v. McCuskey*, 96 Nev. 706, 615 P.2d 957 (1980) (holding a motion in limine should have been granted); *State ex. rel. Dept. of Highways v. Nevada Aggregates & Asphalt Co.*, 92 Nev. 370, 551 P.2d 1095 (1976) (district court properly exercised discretion in granting a motion in limine to exclude certain evidence). Additionally, Nev. R. Civ. P. 16(c)(3) provides the Nevada courts' authority to rule on motions in limine by allowing for "advance rulings...on the admissibility of evidence." *See* EDCR 2.47 (addressing timing of filing motions in limine)

Motions in limine "permit more careful consideration of the evidentiary issues that would take place in the heat of battle during trial" thus promoting judicial economy by minimizing "side-

bar conferences and disruptions during trial" and by resolving "potentially critical issues at the outset, they enhance the efficiency of trials and promote settlements." *Kelly,* 56 Cal.Rptr.2d at 808.

One significance of a motion in limine is also preserving issues for appeal. The Nevada Supreme Court has concluded that by making a matter the subject of a motion in limine, that issue is preserved for appeal even if no further objections are made during the course of the trial. *Richmond v. State*, 118 Nev. 924, 932, 59 P.3d 1249 (2002) (where an objection to evidence was thoroughly briefed in a prior motion in limine, the "motion in limine is sufficient to preserve an issue for appeal").

Essentially, motions in limine can be utilized to narrow the issues in a case to make for a quicker trial, to assist with possible settlement, and to make the case easier for the jury to understand.

IV. LAW AND ARGUMENT

This Motion is brought due to various closing argument techniques that Plaintiff's counsel may intend to use at trial. Part of the purpose of a motion in limine is to avoid constant and disruptive objections from opposing counsel and to educate the Court, which might hurriedly make an incorrect ruling in a trial setting where full briefing is impossible. Plaintiff's counsel seeks an advance ruling allowing the following plaintiff closing argument techniques:

A. The "Send a Message" Argument

Many defense counsel incorrectly believe (or incorrectly argue) that the phrase "send a message" is per se improper closing argument. This is untrue.

The Nevada Supreme Court has repeatedly allowed the phrase "send a message" if used to direct the juror's message *to the Defendant* as opposed to others in the community. For example, the argument "[i]f you want to send a message to the homeowners that their houses are safe, tell them, 'I sat for 12 weeks; I listened to everything; your house is safe'" in a construction defect case was proper. *Gunderson v. D.R. Horton, Inc.*, 319 P.3d 606, 611 (Nev. 2014). This is because the argument is for the jury to send a message to *that particular defendant* rather than the community in general.

Similarly, an argument in a personal injury case was expressly approved by the Nevada Supreme Court recently wherein the Court held that "to the extent that counsel's comments could

be construed as asking the jurors to 'send a message,' counsel asked the jury to do so based on the evidence. In *Gunderson*, 130 Nev. at 77-78, 319 P.3d at 613-14, although this court did not expressly approve of 'send a message' arguments, we concluded that such arguments are not prohibited so long as the attorney is not asking the jury to ignore the evidence." *Pizarro-Ortega v. Cervantes-Lopez*, 396 P.3d 783, 790 (Nev. 2017).

"Send a message" arguments only run astray when counsel asks the jury to "send a message" to persons or entities not a party to the case as part of some greater statement rather than as a result of the evidence in the case. *Lioce v. Cohen*, 124 Nev. 1 (2008) (defense counsel's arguments to request a defense verdict to show other claimants that similar "frivolous" cases would be unsuccessful were improper).

In this case, Plaintiff's counsel intends to make argument that the jury with its verdict should "send a message" to Defendants that safety is important, that he must answer for the injury he caused to his patient, and that he cannot be careless toward his patient, etc. Such arguments are expressly permitted by case law and should be allowed.

B. Rule Breaking and Mentioning News Media

In *Pizarro-Ortega v. Cervantes-Lopez*, 396 P.3d 783, 790 (Nev. 2017), the Nevada Supreme Court expressly considered closing argument that a verdict that is too low shows that people can break safety rules and that verdicts might be reported by news media and encourage a defendant to break rules or cut corners if there are little consequences. In particular, the following arguments were allowed in closing argument by plaintiff's counsel:

> You [the jury] have important power and important duty and a service that you provided here for us today. And you have two options. *If your verdict is too low, then that tells people they can get away with breaking the rules…Your verdict might even hit the paper*. Verdicts hit the paper. The reason they do that is because people read verdicts. And verdicts shape how people follow the rules. I submit to you the evidence in this case. *If you return a verdict that is too low, people don't follow the rules*.

These statements/techniques were expressly found permissible by the Nevada Supreme Court. It is not impermissible to talk about general rules of safety for the community. It is not impermissible to speak about possible reaction to a verdict. It is not impermissible to argue that the defendant won't change their behavior with a smaller verdict. It is not impermissible to refer to the

jury as the conscious of the community. None of these arguments asks the jury to decide the case on some basis other than the evidence. The arguments are all defendant-focused and approved by the Nevada Supreme Court.

C. <u>The "Want Ad" Closing Technique</u>

The "Want Ad" closing technique shows the jury a hypothetical want ad like would be placed in a newspaper showing all the pain and suffering caused to the Plaintiff and asks the jury how much money it would have taken the Plaintiff to want to respond to such an ad. The Want Ad in this case might be phrased as follows and shown to the jury:

> **WANTED**
>
> Woman in early 40s is sought for unique position. Applicant should be willing to have a medical device inserted through her vagina and uterus, into the small intestine, putting a hole in the uterus and intestine. Fecal material and other waste will empty into the Applicant's abdomen from the hole, causing extreme pain, suffering and infection. This position involves risk of loss of life and at a minimum removal of a large part of the small intestine to repair the damage after a long hospital stay. Apply in person with Dr. Keith Brill. Compensation is $_____.

Display of the Want Ad is then followed by the question to the jury "How much money do you think it would have taken for my client to respond to that ad???"[1]

The "Want Ad" technique has been considered and accepted by other courts. *Streeter v. Sears, Roebuck & Co.*, 533 So. 2d 54, 64 (La. Ct. App. 1988) (no error in plaintiff's "want ad" argument); *Gardner Oil, Inc. v. Chavez*, No. 12-10-00274-CV, 2012 Tex. App. LEXIS 3655, at *28 (App. May 9, 2012) (want ad argument held not error); *Catlett v. Ill. C. G. R. Co.*, No. 55668, 1989 Mo. App. LEXIS 1795, at *17 (Ct. App. Dec. 12, 1989) ("job offer" or want ad argument was not impermissible). In Nevada, the argument was approved by Judge Hardy in the *Thompson v. Playland International, Inc.*, Case No. A-14-697688-C matter. Plaintiff's counsel only requests to proceed with what other similar trial counsel have been allowed to argue in their cases. The Want

[1] The technique is plainly erroneous if the jurors are asked "how much would *you* want to respond to that ad?" Such a question would plainly be a golden rule argument and, thus, Plaintiff's counsel will assure the question asks how much *the Plaintiff* i.e., Mrs. Taylor, would have needed to respond.

Ad argument should be allowed.

D. Per Diem Damages Arguments

Some states have a per se bar on "per diem" damages arguments. Nevada does not. Nevada allows such arguments. *Johnson v. Brown*, 75 Nev. 437, 447, 345 P.2d 754, 759 (1959) ("What is it worth to have a cast around your body? What is it worth to be in a prison for 67 days? Would ten cents a minute be unfair? That would be $6 an hour. Consider it yourselves. I will give that ten cents a minute, $6 an hour. You can make up your minds whether you feel that is unfair or not. That would be $144 a day, or counsel can correct me if I am wrong, $ 9,648 for 67 days."); *Barnard v. Las Vegas Metro. Police Dep't*, No. 2:03-cv-01524-RCJ-LRL, 2011 U.S. Dist. LEXIS 62306, at *14-15 (D. Nev. June 7, 2011) (discussing such arguments in Nevada as permissible). Per diem arguments can be made off of said figures under Nevada law. The jury is not bound by a per diem argument, but the arguments can be made.

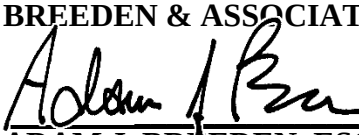
V. CLOSING

For the reasons stated above, the Court should issue an advance ruling that Plaintiff's counsel in closing may:

- Use appropriate "send a message" arguments directed at the Defendants;
- Refer to rule breaking and possible news media coverage of their verdict;
- Use the "want ad" closing technique; and
- Use per diem arguments.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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Adam@Breedenandassociates.com
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on the 18th day of August, 2021, I served a copy of the foregoing legal document **PLAINTIFF'S MOTION IN LIMINE # 1: MOTION TO PERMIT CERTAIN CLOSING ARGUMENT TECHNIQUES OF PLAINTIFF'S COUNSEL** via the method indicated below:

X	Pursuant to NRCP 5 and NEFCR 9, by electronically serving all counsel and e-mails registered to this matter on the Court's official service, Wiznet system.
	Pursuant to NRCP 5, by email using a Dropbox link and/or by placing a copy in the US mail, postage pre-paid to the following counsel of record or parties in proper person: Heather S. Hall, Esq. McBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, Nevada 89113 *Attorneys for Defendants Keith Brill, M.D. and Women's Health Associates* Adam A. Schneider, Esq. JOHN H. COTTON & ASSOCIATES, LTD. 7900 W. Sahara Avenue, Suite 200 Las Vegas, Nevada 89117 *Attorneys for Todd W. Christensen, M.D.* Danielle Woodrum, Esq. LEWIS BRISBOIS BISGAARD & SMITH 6385 S. Rainbow Boulevard, Suite 600 Las Vegas, Nevada 89118 *Attorneys for Dignity Health dba St. Rose Dominican Hospital* Ian M. Houston, Esq. HALL PRANGLE & SCHOONVELD, LLC 1140 N. Town Center Drive, Suite 350 Las Vegas, Nevada 89144 *Attorneys for Henderson Hospital & Bruce Hutchins, RN*
	Via receipt of copy (proof of service to follow)

An Attorney or Employee of the following firm:

/s/ Kristy Johnson
BREEDEN & ASSOCIATES, PLLC

MLIM
ADAM J. BREEDEN, ESQ.
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Adam@Breedenandassociates.com
Attorneys for Plaintiff

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY TAYLOR, an individual,

Plaintiff,

v.

KEITH BRILL, M.D., FACOG, FACS, an individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA – MARTIN, PLLC, a Nevada Professional Limited Liability Company; BRUCE HUTCHINS, RN, an individual; HENDERSON HOSPITAL and/or VALLEY HEALTH SYSTEMS, LLC, a Foreign LLC d/b/a HENDERSON HOSPITAL, a subsidiary of UNITED HEALTH SERVICES, a Foreign LLC; TODD W. CHRISTENSEN, M.D., an individual; DIGNITY HEALTH d/b/a ST. ROSE DOMINICAN HOSPITAL; DOES I through XXX, inclusive; and ROE CORPORATIONS I through XXX, inclusive,

Defendants.

CASE NO.: A-18-773472-C

DEPT NO.: III

PLAINTIFF'S MOTION IN LIMINE # 2: MOTION TO EXCLUDE INFORMED CONSENT FORM AND TERMS OR ARGUMENT REGARDING "RISK" OR "KNOWN COMPLICATION"

HEARING REQUESTED: YES

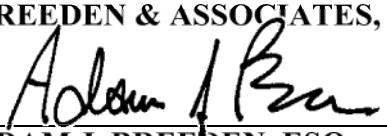
Plaintiff, KIMBERLY TAYLOR, by and through her attorney of record, ADAM J. BREEDEN, ESQ. of BREEDEN & ASSOCIATES, PLLC, and hereby submits his Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complications."

This Motion is made and based on the following Points and Authorities, the pleadings and papers on file herein, the Declaration of Adam J. Breeden, Esq., and any oral argument allowed by

the Court at the time of hearing on this matter.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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Adam@Breedenandassociates.com
Attorneys for Plaintiff

DECLARATION OF ADAM J. BREEDEN, ESQ. PER EDCR 2.47

STATE OF NEVADA)
) ss:
COUNTY OF CLARK:)

I, ADAM J. BREEDEN, ESQ., being first duly sworn, deposes, and says:

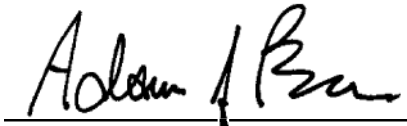
1. I am Adam J. Breeden, Esq. and am counsel for Plaintiff, Kimberly Taylor, in the instant litigation and make this affidavit pursuant to EDCR 2.47.

2. I am a licensed attorney in the state of Nevada. I am the managing partner of Breeden & Associates, PLLC. I know the following facts to be true of my own knowledge and, if called to testify, I could competently do so.

3. On August 5, 2021, counsel for the parties conducted a meet-and-confer conference telephonically regarding anticipated Motions in Limine. Letters were exchanged prior to that regarding the anticipated motions. The conference lasted approximately 30 minutes. Many issues were discussed, and probably half were able to be resolved by stipulation. The issue raised in this motion, however, is one that counsel was unable to resolve, thus requiring court intervention.

4. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 18th day of August, 2021.



ADAM J. BREEDEN, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff Taylor's second motion in limine is Motion in Limine #2: Motion to Exclude Informed Consent Form and Terms or Argument Regarding "Risk" or "Known Complications." As many courts have already found, introduction of an informed consent form or use of these terms is misleading to a jury and irrelevant to the issue of standard of care because (1) a patient may not consent to negligence and (2) the mere fact that an injury is a "risk" or "known complication" of a procedure is irrelevant to the actual contested issue as to whether the doctor exercised reasonable care during the procedure to avoid the injury.

II. OMNIBUS STATEMENT OF FACTS FOR ALL MOTIONS IN LIMINE

This is a medical malpractice action by Plaintiff Kimberly Taylor against her OB/GYN Defendant Keith Brill. On April 26, 2017, Dr. Brill performed an intended dilation and curettage with hysteroscopy combined with fibroid tumor removal and hydrothermal ablation procedure on Ms. Taylor. In layman's terms, this meant that a small scope and cutting device called a resectoscope would be inserted through the vagina into the uterus and a fibroid tumor previously identified via ultrasound in the uterus would be removed. This procedure was done with the use of a Symphion system resectoscope and ablation device. This is a small, tube-like device of 2-3 mm in diameter that is inserted into the uterus. The tip has an ablation device which cuts with radiofrequency or heat from electricity. The patient is under complete anesthesia for the procedure.

It is undisputed that during the procedure Dr. Brill caused the resectoscope to **perforate through the wall of the uterus where the instrument then also perforated the small intestine**, **causing free leakage of stool and body waste into the abdomen of Mrs. Taylor**. It is also undisputed that Dr. Brill saw the uterine perforation intraoperatively but *failed* to recognize that he had also injured the small bowel. The parties disagree as to what Dr. Brill told Ms. Taylor about the perforation and exactly how and when the perforations occurred and whether the perforations were beneath the standard of care. The resectoscope procedure was terminated but Ms. Taylor had unknown intestinal leakage into her abdomen. After two visits to the emergency room post-operatively, another physician finally diagnosed the injury to the small intestine. A second surgery

had to occur wherein a portion of Ms. Taylor's small intestine had to be removed and she had to be hospitalized for over a week. She presents a claim for approximately $225,620.07 in medical special damages and the cap amount of $350,000 for pain and suffering.

The parties do not appear to dispute damages and injury but instead dispute whether Dr. Brill's treatment fell below the standard of care for the procedure. Dr. Brill appears to want to argue that merely because uterine and similar injury is a "risk" of the procedure to which Ms. Taylor consented that he can never be held liable, which is an incorrect statement of the law.

III. LEGAL STANDARD FOR A MOTION IN LIMINE

Motions in limine are designed to seek the Court's ruling on the admissibility of arguments and assertions of evidence in advance of trial. They are a common vehicle through which litigants bring requests to exclude potentially prejudicial evidence from a jury trial. *Kelly v. New West Fed. Sav.*, 56 Cal. Rptr.2d 803, 808 (1996) ("Motions in limine are a commonly used tool of trial advocacy and management…when evidentiary issues are anticipated by the parties.").

The Nevada Supreme Court has approved the use of motions in limine in a number of cases by recognizing the legitimacy of such pre-trial motion practice and the courts' authority to rule on these motions. *Bull v. McCuskey*, 96 Nev. 706, 615 P.2d 957 (1980) (holding a motion in limine should have been granted); *State ex. rel. Dept. of Highways v. Nevada Aggregates & Asphalt Co.*, 92 Nev. 370, 551 P.2d 1095 (1976) (district court properly exercised discretion in granting a motion in limine to exclude certain evidence). Additionally, Nev. R. Civ. P. 16(c)(3) provides the Nevada courts' authority to rule on motions in limine by allowing for "advance rulings...on the admissibility of evidence." *See* EDCR 2.47 (addressing timing of filing motions in limine)

Motions in limine "permit more careful consideration of the evidentiary issues that would take place in the heat of battle during trial" thus promoting judicial economy by minimizing "side-bar conferences and disruptions during trial" and by resolving "potentially critical issues at the outset, they enhance the efficiency of trials and promote settlements." *Kelly*, 56 Cal.Rptr.2d at 808.

One significance of a motion in limine is also preserving issues for appeal. The Nevada Supreme Court has concluded that by making a matter the subject of a motion in limine, that issue is preserved for appeal even if no further objections are made during the course of the trial.

Richmond v. State, 118 Nev. 924, 932, 59 P.3d 1249 (2002) (where an objection to evidence was thoroughly briefed in a prior motion in limine, the "motion in limine is sufficient to preserve an issue for appeal").

Essentially, motions in limine can be utilized to narrow the issues in a case to make for a quicker trial, to assist with possible settlement, and to make the case easier for the jury to understand.

IV. LAW AND ARGUMENT

This case is a medical malpractice action involving hysteroscopy, which involves insertion of medical devices including a hysteroscope and resectoscope into the uterus. It is undisputed that Plaintiff Taylor, prior to her procedure, signed various informed consent form that disclosed the following:

> Perforation of the Uterus: The most serious complication of the procedure is the creation of a perforation, or hole, in the wall of the uterus. Perforation of the uterus may lead to injury of other structures and organs within the abdomen (blood vessels, nerves, intestines, and bladder) bleeding or infection.[1]

During the procedure, Dr. Brill caused the resectoscope to perforate both the uterus and the small intestine, severely injuring Ms. Taylor.

One possible theory of medical malpractice is a lack of informed consent, in other words that the physician failed to advise or disclose all potential risks to the patient so the patient can make an informed decision as to whether they wish to undergo the procedure. *Smith v. Cotter*, 107 Nev. 267, 272, 810 P.2d 1204, 1207 (1991) (explaining lack of informed consent standards in Nevada). **However, in this case at no time in this litigation has Ms. Taylor alleged *lack* of informed consent**. No lack of informed consent cause of action or argument will be presented at trial. Neither the text of the complaint itself nor the attached supporting medical expert affidavit even uses the word "consent" or alleged lack of informed consent. **This case is not a lack of informed consent case by the patient.** Instead, Taylor and her expert allege that the perforations caused by Dr. Brill were caused because he fell beneath the standard of care by cutting when he could not adequately

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[1] *See* Informed Consent form BRILL00072-00087 attached hereto as **Exhibit "1."**

view and identify what he was cutting and thus the injuries were avoidable.

Dr. Brill's main defense, as he repeatedly made clear in his deposition, is that because he warned Ms. Taylor and uterine and (less commonly) intestinal perforation is a "risk" or "known complication" for the procedure, he is immune from liability and cannot be found to have acted negligently. Dr. Brill repeatedly made statements during deposition such as "we discussed risks and benefits,"[2] "[t]his surgery has this risk,"[3] "every surgery I perform has risks and benefits, and there's a known risks of complications. Its unfortunate it happened here,"[4] "unfortunately there was a complication that's a known risk of the surgery,"[5] "[a]ny surgery has…a risk can occur, even in the best of hands,"[6] "this is a complication that was unfortunate but a known risk of the surgery that happens,"[7] "the risk of complication can happen at any surgery,"[8] "a perforation did occur. Again, it's a known risk and complication that happened…,"[9] "we live in a world where there are risks and benefits."[10] In response to nearly every other question, Dr. Brill doubled down on his assessment that the perforations were just a risk or complication of surgery and, therefore, he was not responsible for them.

Not to be outdone by Dr. Brill, Dr. Brill's retained medical expert also repeatedly stresses the idea that perforations are merely a known risk or complication of the procedure as if that exonerates Dr. Brill from negligence. He plainly bases his opinion that no negligence occurred on the assertion that "[d]uring the procedure, Ms. Taylor experienced a known risk and complication-uterine perforation. This known risk and complication occurs even without a breach of the standard

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[2] Brill Depo. at pg. 31, **Exhibit "2."**

[3] Brill Depo. at pg. 71, **Exhibit "2."**

[4] Brill Depo. at pg. 73, **Exhibit "2."**

[5] Brill Depo. at pg. 74, **Exhibit "2."**.

[6] Brill Depo. at pg. 74, **Exhibit "2."**

[7] Brill Depo. at pg. 96, **Exhibit "2."**

[8] Brill Depo. at pg. 100, **Exhibit "2."**

[9] Brill Depo. at pg. 116, **Exhibit "2."**

[10] Brill Depo. at pg. 123, **Exhibit "2."**

of care."[11]

The problem with the intended defense of this case is that it is clearly an incorrect statement of the law to say that a patient cannot sue a physician if the physician discloses a particular injury as a risk or complication of the procedure. However, many jurors, doctors and defense attorneys seem to have trouble understanding this.

The issue of fact the jury must decide in this case is whether Dr. Brill used the expected "reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care" when he performed the surgery. NRS § 41A.015. It is *irrelevant* whether an injury has been deemed a risk or complication because risks and complications are quite often avoidable if the physician simply uses reasonable care.

The distinction between an unavoidable risk and falling below the standard of care can be difficult to grasp at first for the un-initiated juror. As an example, prior to almost every surgery a patient administered anesthesia will be warned there is a risk of death and will sign a consent form saying that they know all anesthesia has risks, including death, yet they consent to the procedure. However, imagine then that the anesthesiologist then accidentally misreads the dosage label and administers *5 mg* of an anesthesia drug instead of *.5 mg*, thus overdosing the patient by giving 10 times the amount of acceptable anesthesia and causing death. Would we permit the anesthesiologist to evade liability merely by arguing that death is a known risk of anesthesia? Certainly not, because the actual issue for the jury to resolve is whether the doctor met the standard of care and properly performed the procedure, not whether a result is a known risk or complication.

Patients are often asked to sign all-encompassing consent forms prior to undergoing a procedure. Doctors often try to roll unlikely and worst-case scenarios into informed consent forms, *but this does not absolve a doctor from liability*. If the law allowed doctors to deem anything a risk or complication to escape liability, the public would quickly have a system where doctors never had to answer for any malpractice because the medical industry would simply deem *everything* a risk or

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[11] Report of Defense expert Dr. McCarus at pg. 4, ¶7, **Exhibit "3."**

complication. Therefore, as a matter of public policy there is no assumption or risk or known complication defense in a medical malpractice case.

Courts all over the nation have recognized that in a medical malpractice case where lack of informed consent is not alleged, evidence of informed consent of the patient or argument of known risks and complications is **irrelevant** and **must be excluded at trial**. The Missouri Supreme Court recently addressed this issue in *Wilson v. Patel*, 517 S.W.3d 520 (Mo. 2017). In that case, the patient sustained an esophageal tear during an endoscopy, an alleged risk or complication of the procedure. *Id*. at 521-522. The doctor sought to defend the case by referring to the patient's consent form that disclosed such a risk and by arguing the tear was a "known complication." *Id*. at 522, 523. Further, the doctor's counsel argued that the patient "was aware" of a risk of a tear as a "known complication" and yet "agreed" to the procedure as a defense. *Id*. at 523, 525. All of this was held to be improper. The Missouri Supreme Court reviewed numerous other court decisions around the country and correctly determined that evidence of informed consent should have been withdrawn from the trial. The court found that **"evidence of alleged informed consent is irrelevant and can only mislead the jury in a medical malpractice case based on negligent performance of care and treatment."** *Id*. at 526. This is because the real task of the jury is to determine whether the physician used reasonable care, skill and training when conducting the procedure. Therefore, the Missouri Supreme Court reversed and remanded the case because the admitted evidence and argument as to informed consent and a known complication "could only confuse the jury in its determination of the facts" as to the real issue which is standard of care. *Id*. at 521.

The Missouri Supreme Court relied on another leading case on this issue from the Virginia Supreme Court, *Wright v. Kaye*, 267 Va. 510, 593 S.E.2d 307 (2004). In that case, a doctor was sued after he performed a urachal cystoscopy and, in the process, injured the adjacent bladder with staples, an alleged risk or complication of the procedure. The patient moved to exclude informed consent and risk evidence from the malpractice trial. The trial court declined to do this and the Virginia Supreme Court reversed. It correctly found that where the patient does not plead lack of informed consent, evidence of the informed consent discussions or consent form "is neither relevant nor material to the issue of the standard of care" and "pre-operative discussion of risk is not

probative upon the issue of causation: whether [the doctor] negligently performed the procedure." *Id*. at 528-529. The court made clear that it is not a "defense" that something is or is not a risk of surgery and evidence or argument to that effect merely serves to confuse the jury:

> awareness of the general risks of surgery is not a defense available to Dr. Kaye against the claim of a deviation from the standard of care. While Wright or any other patient may consent to risks, she does not consent to negligence. Knowledge by the trier of fact of informed consent to risk, where lack of conformed consent is not an issue, does not help the plaintiff prove negligence. Nor does it help the defendant show he was not negligent. In such a case, the admission of evidence concerning a plaintiff's consent could only serve to confuse the jury because the jury could conclude, contrary to the law and the evidence, that consent to the surgery was tantamount to consent to the injury which resulted from that surgery. In effect, the jury could conclude that consent amounted to a waiver, which is plainly wrong. *Id*.

This legal principal, i.e. that a doctor may not argue informed consent or known risk or complication, has been repeatedly recognized in many states: *Waller v. Aggarwal*, 116 Ohio App. 3d 355, 357-358, 688 N.E.2d 274, 275 (Ohio App. 1996) (trial court erred by allowing evidence of informed consent when malpractice action was based on negligence); *Warren v. Imperia*, 252 Ore. App. 272, 287 P.3d 1128, 1132 (Ore. Ct. App. 2012) ("Evidence of plaintiff's awareness of [information about the nature of the procedure, its inherent risks, or available alternatives] would neither have assisted plaintiff in proving negligence nor have assisted defendant in showing that he was not negligent."); *Brady v. Urbas*, 631 Pa. 329, 340-41, 111 A.3d 1155, 1162 (2015) ("there is no assumption-of-the-risk defense available to a defendant physician which would vitiate his duty to provide treatment according to the ordinary standard of care. The patient's actual, affirmative consent, therefore, is irrelevant to the question of negligence."); *Hayes v. Camel*, 283 Conn. 475, 486, 927 A.2d 880, 889 (2007) ("evidence of informed consent, such as consent forms, is both irrelevant and unduly prejudicial in medical malpractice cases without claims of lack of informed consent"); *Ehrlich v. Sorokin*, 451 N.J. Super. 119, 131, 165 A.3d 812, 819 (Super. Ct. App. Div. 2017) ("Plaintiff's acknowledgment of the risk for perforation had no bearing on this determination [of negligence]…although negligent treatment and informed consent fall under the umbrella of medical negligence, our law clearly distinguishes the two claims…"); *Knight v. Jewett*, 3 Cal. 4th 296, 11 Cal. Rptr. 2d 2, 834 P.2d 696, 705-06 (Cal. 1992) (stating that a patient "by voluntarily

encountering" a risk of injury does not "'impliedly consent' to negligently inflicted injury or 'impliedly agree' to excuse the surgeon from a normal duty of care"); *Schwartz v. Johnson*, 206 Md. App. 458, 483, 49 A.3d 359, 373 (2012) (explaining why jurors should not hear evidence of informed consent and risk of surgery in a negligence case not premised on lack of informed consent).

These cases unanimously discuss and agree that in a medical malpractice case not premised on lack of informed consent, evidence of informed consent, consent forms and discussion of risks and complications of the procedure are: (1) irrelevant to the ultimate issue of whether the physician exercised reasonable care, (2) not probative of an assumption of risk defense, which the law does not recognize for medical malpractice actions and (3) such evidence is highly prejudicial and creates juror confusion.

In this case, we have a classic abuse of informed consent and discussion of risks or complications in progress by the defense. The **entire defense** in this case seems centered on the fact that Ms. Taylor was advised perforation was a risk of the procedure and not the actual relevant legal issue of whether Dr. Brill used "reasonable care, skill and knowledge" to avoid injury to the patient. NRS § 41A.015 (definition of negligence). As such, evidence of the informed consent form or evidence or argument that perforations are known risks of complications of hysteroscopy should be excluded. Such evidence and argument is both irrelevant and thus subject to exclusion under NRS § 48.025 (only relevant evidence is admissible) and more prejudicial than probative warranting exclusion under NRS § 48.035 (exclusion of evidence more prejudicial than probative).

V. CLOSING

For the reasons stated above, the Court should issue an advance ruling that:

Excludes all evidence or argument that Ms. Taylor executed an informed consent form;

Excludes all evidence that Dr. Brill verbally discussed risks and complications of the procedure with her;

Excludes all reference to the perforations in this case being known risks or complications; and

- Use of a jury instruction advising the jury that it is irrelevant whether perforations in general are a known risk or complication.

DATED this 18th day of August, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that on the 18th day of August, 2021, I served a copy of the foregoing legal document **PLAINTIFF'S MOTION IN LIMINE # 2: MOTION TO EXCLUDE INFORMED CONSENT FORM AND TERMS OR ARGUMENT REGARDING "RISK" OR "KNOWN COMPLICATION"** via the method indicated below:

X	Pursuant to NRCP 5 and NEFCR 9, by electronically serving all counsel and e-mails registered to this matter on the Court's official service, Wiznet system.
	Pursuant to NRCP 5, by email using a Dropbox link and/or by placing a copy in the US mail, postage pre-paid to the following counsel of record or parties in proper person: Heather S. Hall, Esq. McBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, Nevada 89113 *Attorneys for Defendants Keith Brill, M.D. and Women's Health Associates* Adam A. Schneider, Esq. JOHN H. COTTON & ASSOCIATES, LTD. 7900 W. Sahara Avenue, Suite 200 Las Vegas, Nevada 89117 *Attorneys for Todd W. Christensen, M.D.* Danielle Woodrum, Esq. LEWIS BRISBOIS BISGAARD & SMITH 6385 S. Rainbow Boulevard, Suite 600 Las Vegas, Nevada 89118 *Attorneys for Dignity Health dba St. Rose Dominican Hospital* Ian M. Houston, Esq. HALL PRANGLE & SCHOONVELD, LLC 1140 N. Town Center Drive, Suite 350 Las Vegas, Nevada 89144 *Attorneys for Henderson Hospital & Bruce Hutchins, RN*
	Via receipt of copy (proof of service to follow)

An Attorney or Employee of the following firm:

/s/ Kristy Johnson
BREEDEN & ASSOCIATES, PLLC

EXHIBIT “1”

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Women's Health Associates of Southern Nevada

SOUTH VALLEY EAST
SOUTH VALLEY WEST

PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. ***If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."***

ENDOMETRIAL ABLATION

Definition
Endometrial = pertaining to the tissue layer that forms the inner lining (endometrium) of the uterine (womb) wall
Ablation = Removal of a body part or the destruction of its function, as by a surgery, disease, or noxious substance.
Hystero = of or denoting the womb (uterus)
Scopy = examination with an instrument for improved viewing, often with magnification and directed lighting

Heavy or irregular vaginal bleeding is a common problem for women in their reproductive years. The menstrual cycle is designed to prepare a healthy endometrial lining for a fertilized egg to grow in. Once a month, if a woman does not become pregnant, the "old" lining is shed through the cervical canal with the menstrual period and replaced with "new" lining in preparation for pregnancy. This cycle is repeated throughout a woman's lifetime until her ovaries no longer make enough of the hormones needed to continue a regular, monthly cycle. Alterations in this cycle and irregularities of the lining of the uterus (such as polyps or fibroids) can lead to episodes of vaginal bleeding that are unpredictable, heavy, or cause significant discomfort.

Irregular uterine bleeding during your reproductive years is rarely due to uterine cancer. Uterine cancer is more common in older women than in younger women, and in women with continuous high levels of estrogen. It is, however, important that the cause of bleeding be investigated and treated. Cancers of the uterus, when discovered early in their development, can be cured.

There are several tests your doctor may perform to investigate the cause of your abnormal uterine bleeding prior to initiating treatment or continuing unsuccessful treatments. Many times it is necessary to sample the endometrium (with an endometrial biopsy or D&C) to look for concerning overgrowth (hyperplasia) and malignancies (cancer) of the lining. Visualization of

Patient Initials: KS

the contour and any irregularities of the uterine lining can be accomplished with ultrasound, x-rays or direct visualization using a hysteroscope.

After successfully excluding irregularities of the uterine lining and shape of the cavity, your doctor will begin medical treatment. Medical treatment of heavy uterine bleeding commonly involves the combinations of hormone therapy (estrogen and/or progesterone), anti-inflammatory medications, and occasionally steroids and medications to cause a "medical menopause". This approach is usually very effective, but when medical treatment fails, the next step typically involves surgery.

Surgical treatment of heavy or excessive uterine bleeding includes dilation and curettage, endometrial ablation and hysterectomy. Dilation and curettage can be a useful procedure to treat sudden heavy bleeding that has resulted in severe anemia; however, for most women it offers no long-term improvement. Approximately 600,000 hysterectomies are performed each year in the United States. Almost half of these are done for abnormal bleeding. For women who wish to preserve their uterus, who wish to avoid major surgery, or are at increased surgical risk (from other conditions), but who are finished with childbearing, treatment may be performed by endometrial ablation.

Endometrial ablation, the destruction of the lining of the uterus, is an alternative to hysterectomy for many women with heavy uterine bleeding who do not respond to medical management. This is a procedure that has traditionally been performed in the outpatient (same-day) surgery center but now can also be performed in your doctor's office with devices designed for that purpose. Most women have a rapid recovery with little discomfort and are able to return to normal activity by the following day. Women who wish to preserve fertility or who have significant menstrual pain are not candidates for endometrial ablation and should consider alterative treatments.

The vast majority of women are pleased with the results of their procedure, though only some will have a complete absence of uterine bleeding after ablation. The success of endometrial ablation varies depending on the method of ablation, the presence of irregularities of the uterine contour, and the goals of the treatment.

Patient Initials: KB

Preparation

In-office procedure: Preparation for an in-office ablation will depend on the method of pain control used by your doctor. The procedure can be comfortably performed with administration of oral or intravenous medications, usually along with injection of local anesthetic. Intravenous medications are given to produce a "conscious sedation" and often require an empty stomach. Your doctor will give you instructions based on the planned procedure and anesthetic choice.

Outpatient hospital procedure: As with all procedures in which general anesthesia is administered, you will be asked not to eat or drink anything after a certain time, typically midnight, on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken; you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. *Please refer to the attached list and tell us if you took any of these within the past 10 days.* If your new medication is not on the list, alert us immediately so that we may ensure optimal

procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure

Endometrial ablation is an outpatient procedure that takes between 30 minutes and one hour to complete, though some in-office procedures are quite brief. If you are to receive any medication for pain control and sedation, it will be given before the procedure begins.

You will be lying on your back with your knees bent and heels in stirrups as you would for a pelvic examination. A brief examination to find out the location of your cervical opening and the size and shape of your uterus will be done.

Following this, a speculum will be placed in the vagina to hold it open and an antimicrobial soap will be used to clean the vagina and cervix. Again, depending on the method of anesthesia, an injection of numbing medicine into the cervix might be given at this point. The cervix is lightly grasped with an instrument to hold it still, while the opening is gradually dilated with surgical instruments until the hysteroscope or ablation probe can be inserted without force.

The cavity of the uterus is much like a balloon: when empty it is flat but when inflated, space is created inside the balloon where there was none. Performing hysteroscopy involves "inflating" the cavity of the uterus with a liquid or gas so that each surface can be seen. Miniaturized instruments can then be placed along with the hysteroscope to correct many of the abnormalities of the shape of the cavity. When your doctor performs a hysteroscopic ablation (using a resectoscope), the lining is either cut out using miniaturized cutting instruments designed for ablation or destroyed using electrical energy. A resectoscope can also be used to remove polyps of the lining or fibroids on the surface before or as part of ablation.

Destruction of the lining can be accomplished by a variety of methods: heating, freezing, and electrical energy. The method used will vary depending on your circumstances, anatomy, and what is available for your doctor's use.

Patient Initials: _____

Post Procedure

Recovery from endometrial ablation is rapid, and most women will go home within one or two hours of the procedure. Though you may have some discomfort and cramping following the procedure, it is not necessary for you to plan time off from work or your normal activities beyond the day of surgery. It is normal to have some bleeding and discharge following endometrial ablation. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching, and tampon use until told you may resume by your doctor.

Medications, such as ibuprofen or naproxen, are usually all that is needed for the cramping you might have after your surgery. Ask your doctor what is recommended or if a prescription for pain medicine will be given. An antibiotic prescription may also be given and should be taken until completion. If any side effects occur, contact our office immediately.

Expectations of Outcome

Endometrial ablation is an alternative to hysterectomy for women with abnormal uterine bleeding. The vast majority of women are pleased with the results of their procedure, though only some will have a complete absence of uterine bleeding after ablation. The success of endometrial ablation varies depending on the method of ablation, the presence of irregularities of the uterine contour, and the goals of the treatment. Following endometrial ablation:

- 90% of women will be pleased with the results
- Between 25% and 60% of women will have complete absence of uterine bleeding
- 40% of women will have decreased uterine bleeding
- One in four women will have hysterectomy within four years of treatment

Possible Complications of the Procedure

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- Perforation of the Uterus: The most serious complication of the procedure is the creation of a perforation, or hole, in the wall of the uterus. This occurs when the dilator, hysteroscope, or ablation probe is pushed too far or with too much force. Perforation of the uterus may lead to injury of other structures and organs within the abdomen (blood vessels, nerves, intestines, and bladder), bleeding, or infection. Perforation is not common, however, may require another operation to be treated appropriately
- Bleeding/Discharge: Most women will have watery or bloody discharge for several weeks following ablation. If you develop a foul smelling or greenish vaginal discharge, please contact your doctor.
- Infection: Endometrial ablation involves placing instruments through the vagina and cervix into the uterus. Because of this, it is possible to introduce a microorganism (such as bacteria or yeast) from the vagina into the uterine or abdominal cavity. Many microorganisms are normally present in the vagina and cause no infection or other symptoms. However, when these same microorganisms are present within the pelvis or cavity of the uterus or abdomen, a more serious infection can be the result. Signs of infection that you should be watchful of are: foul-smelling vaginal discharge, tenderness or pain in the vagina and pelvis for more than two days, fevers, shaking chills, nausea, vomiting, weakness, and feeling ill
- Hematometrium: Blood may collect within the uterine cavity if scarring from the procedure prevents its exit. This may lead to cyclic abdominal pain.
- Injury to Abdominal Organs: Risk of injury to abdominal organs is reduced through careful surgical technique and safety systems built into the ablation devices. In spite of this, there is a small risk of internal injury with endometrial ablation.
- Pregnancy: Although the chances of pregnancy are reduced following endometrial ablation, it is still possible to become pregnant. Pregnancy following endometrial ablation is very dangerous to both you and the fetus. You should not have an endometrial ablation

if you plan to become pregnant in the future and should use some form of birth control after endometrial ablation.

- Detection of Malignancy: Another rare, but important, risk of any endometrial ablation procedure is that it may decrease your doctor's ability to make an early diagnosis of cancer of the endometrium. The reason for this is that one of the warning signs of endometrial cancer is bleeding, and endometrial ablation procedures decrease or eliminate bleeding.
- Treatment failure: While endometrial ablation has been shown to be very effective, it will not always "cure" uterine bleeding. One out of 10 women who have endometrial ablation will be dissatisfied with her results. Only half of women will be completely without uterine bleeding. One out of four women will have a hysterectomy in the following four years.
- Fluid Imbalance: In addition to water, fluids used to "inflate" the cavity of the uterus for hysteroscopy contain dissolved sugars, starches, and salts. These substances give the fluids certain desirable properties for visualization of the uterine cavity. When too much fluid flows from the uterus and enters the abdominal cavity or blood stream, an "imbalance" in the water content of the blood may result. Careful choice of fluid and monitoring of fluid delivery make this an uncommon complication
- Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE): In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. ***If you notice these signs, you should go directly to an emergency room and also call our office.*** Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems
- Lower Extremity Weakness/Numbness: This, too, is a rare event that may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected
- Chronic Pain: As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some feeling of numbness may persist. If persistent, further evaluation may be necessary

Physician	Date	Witness	Date
Patient	4-21-17 Date	Kimberly Taylor (208186) print patient name	

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PROCEDURE EDUCATION LITERATURE

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MYOMECTOMY

Definition
Leio = denoting smooth
Myoma = benign tumor of musole
Ectomy = denoting surgical removal of a segment or all of a part or an organ

A leiomyoma is a benign (non-cancerous) tumor made up of smooth muscle and connective tissue and can arise in any part of the body containing smooth muscle. There are numerous terms used to refer to leiomyomas, such as myomas, fibromas and, most frequently *fibroids*, or *fibroid tumors*. The discussion here pertains to leiomyomas of the uterus, the most common tumors of the uterus and female pelvis.

Almost half of all women will have uterine myomas of some size, though most women will not have any symptoms from them. The symptoms of uterine leiomyomas are abnormal uterine bleeding, pelvic and vaginal pressure, pain, abdominal distortion, spontaneous miscarriage and infertility. Risk factors for symptoms are size, location, number, and rapid growth.

Risk factors for the development of fibroids appear to be:
- African American ethnicity (two to three times as frequent as white women)
- Obesity
- First period when younger than age 12

Uterine myomas can be divided into those occurring beneath the lining of the uterus (submucous), within the muscle of the uterus (intramural), and those on the "outside" surface of the uterus (subserous).

Patient Initials: _____

A myomectomy refers to the surgical removal of one or more uterine leiomyoma(s). Myomectomy is intended to remove fibroids from the uterus that are responsible for symptoms such as those listed earlier. This operation can be performed using three different methods:

- Hysteroscopy: operating within the uterine cavity with telescopic vision and small instruments to remove submucous fibroids (see *D&C/Hysteroscopy*)
- Laparoscopy: operating through the abdomen with telescopic vision and small instruments to remove or ablate (destroy) fibroids on the abdominal surface and within the uterine muscle
- Laparotomy: traditional "open" abdominal surgery to remove larger fibroids or many small fibroids.

Leiomyomas do not require treatment. Only when symptoms from fibroids appear will a recommendation for treatment be made. Treatment of fibroids can include observation, myomectomy, hysterectomy, and in recent decades, procedures to destroy (ablate) the tumors or to deprive them of their blood supply to cause them to die (uterine artery embolization). Medications to shrink fibroid tumors can be given for a short period and sometimes are use prior to myomectomy.

The approach to management of your leiomyomas will depend on your symptoms, the size, location and number of fibroids, treatment goals and the preference of you and your doctor. The pros and cons of each will be discussed with you in your consultation.

Preparation

As with all procedures in which general anesthesia is administered, you will be asked not to eat or drink anything after a certain time, usually midnight, on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken, you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. The procedure will not be performed if you are currently taking, or have recently taken any medication that may interfere with your ability to clot your blood ("blood thinners, aspirin, anti-inflammatory medicines, etc…"). The most common of these medications are aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter). ***Please refer to the attached list and tell us if you took any of these within the past 10 days.*** If your new medication is not on the list, alert us immediately so that we may ensure optimal procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure

For hysteroscopic and laparoscopic surgery you will be lying on your back with your knees and hips bent and heels in stirrups much like you would for a pelvic examination; for abdominal surgery you will be lying on your back with your legs extended. The procedure can take from between 30 minutes and 3 hours depending on the size, number and location of fibroids as well as the type of surgery. General anesthesia is administered, and you will "go to sleep" for the duration of the surgery.

Patient Initials: _____

Hysteroscopy: The procedure begins by gently cleaning the vagina and then placing a speculum in the vagina to hold it open. The cervix is grasped with an instrument to hold it still, while the opening is gradually dilated with surgical instruments until the hysteroscope ("telescope" for the uterine cavity) or resectoscope (hysteroscope for operating) can be inserted without force.

The cavity of the uterus is much like a balloon: when empty it is flat but when inflated space is created inside the balloon where there was none. Performing hysteroscopy involves "inflating" the cavity of the uterus with a liquid or gas (flowing in and out through the "telescope") so that each surface can be seen. Miniaturized instruments can then be placed along with the telescope to remove or destroy the fibroid(s).

Laparoscopy: After cleaning the abdomen, a small incision is made at the belly button and the laparoscope ("telescope" to see in the abdomen) is inserted. Other small incisions are made to allow small surgical instruments to be inserted. Using techniques similar to traditional "open" surgery, the fibroids are removed or destroyed.

Laparotomy: After cleaning the abdomen, an incision large enough to see and reach into the pelvis is made. Large and multiple fibroids can then be removed. Laparotomy permits the easiest access to the uterus, but also requires the longest hospitalization and recovery.

Post Procedure
You will be in the recovery room for a short time before being sent home, in the case of hysteroscopy and sometimes laparoscopy, or to your hospital bed as with laparotomy. Most patients usually will stay one or two nights in the hospital following laparotomy. There may be some discomfort around the incision sites, within the vagina, and on the lower abdomen depending on the procedure you had performed. There will be a small dressing over the abdominal incision site (if one was made), which is to remain until your follow up visit unless otherwise instructed.

There may be small blood staining on the wound dressing. If the dressing becomes soaked, or you see active blood oozing, please contact us immediately. You may shower one day after surgery, but no bathing or swimming (unless otherwise instructed). It is normal to have some bloody discharge from the vagina for a day or two. If you have significant bleeding, you should call our office. We ask that you refrain from any strenuous activity or heavy lifting until your follow up office visit. Every patient has some degree of swelling and bruising, and it is not possible to predict in whom this might be minimal or significant.

Hysteroscopy: Though you may have some discomfort and cramping following the procedure, it is usually not necessary for you to plan time off from work or your normal activities beyond the day of surgery. It is normal to have some bleeding and discharge following hysteroscopy/myomectomy. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching and tampon use until told you may resume by your doctor

Patient Initials: KC

Laparoscopy: You may have some discomfort and cramping following the procedure, including gas pain and shoulder pain. This discomfort is often due to the gas used to inflate the abdomen for surgery and typically resolves after the first post-operative day. It is not necessary for you to plan an extended time off from work or your normal activities; most women are able to resume activity, other than strenuous activity and lifting, within two to three days. It is normal to have some bleeding and discharge following hysteroscopy/myomectomy. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching and tampon use until told you may resume by your doctor

Laparotomy: We strongly encourage you to take at least two to three weeks off from work and perhaps more if your occupation requires strenuous activity or heavy lifting. In the first 48 hours, it is to your advantage to minimize activity and to often rest in a lying down position. Periodic walking is encouraged. Some patients have almost no discomfort while others are somewhat uncomfortable for a few days to weeks. Severe pain is unlikely but possible. We may provide you with a prescription for pain medication to alleviate most of the discomfort. Take this medication as prescribed and as needed. An antibiotic prescription may also be given and should be taken until completion. If any side effects occur, contact our office immediately.

**You must refrain from any strenuous activity or heavy lifting until we tell you otherwise. Sexual activity of any sort is absolutely prohibited (usually four to six weeks) until we tell you that you may resume.*

Expectations of Outcome

The goals of myomectomy are the relief of symptoms while keeping the uterus. Many women will notice a reduction in symptoms, while others will not. The success of myomectomy for long-standing infertility depends largely on the age of the patient, the size/number of fibroids, and other factors affecting fertility.

Myomectomy is complicated by bleeding that requires hysterectomy in 10% of cases. Within 20 years of myomectomy, 25% of women will have hysterectomy for recurrent leiomyomas.

Possible Complications of the Procedure

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- Urinary Tract Infection or Sepsis: Although we may give you antibiotics prior to and after the operation, it is possible for you to get an infection. The most common type is a simple bladder infection (after the catheter is removed) that presents with symptoms of burning urination, urinary frequency and a strong urge to urinate. This will usually resolve with a few days of antibiotics. If the infection enters the bloodstream, you might feel very ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness or dizziness, nausea, and

Patient Initials: KT

vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients on long-term steroids, or in patients with disorders of the immune system.

- Wound Infection: The incision sites can become infected. While it typically resolves with antibiotics and local wound care, occasionally, part or all of the incision may open and require revision.
If you have symptoms suggesting any of the above after your discharge from the hospital, you must contact us immediately or go to the nearest emergency room.

- Scar Tissue Formation: Scar tissue can form within the abdomen (adhesions) or within the cavity of the uterus that can lead to infertility.
- Need for Cesarean Section/Risk of Uterine Rupture: If the incision to remove the fibroid(s) goes from the cavity of the uterus to the abdominal side of the uterus, your doctor might recommend cesarean section without labor for delivery of all future pregnancies.
- Treatment Failure: Many women will see improvement in their symptoms after myomectomy, although these same symptoms can recur at some point in the weeks, months and years after surgery. Twenty-five percent of women will have a hysterectomy for recurrent fibroids.
- Blood Loss/Transfusion: The uterus is quite vascular. Usually blood loss in this procedure is minimal to moderate. In some cases blood loss can be significant enough to necessitate hysterectomy to control bleeding or transfusion to replace blood lost to hemorrhage.
- Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE): In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. ***If you notice these signs, you should go directly to an emergency room and also call our office.*** Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.
- Fluid Imbalance: (applies only with Hysteroscopic myomectomy) In addition to water, fluids used to "inflate" the cavity of the uterus for hysteroscopy contain dissolved sugars, starches and salts. These substances give the fluids certain desirable properties for visualization of the uterine cavity. When too much fluid flows from the uterus and enters the abdominal cavity or blood stream, a serious "imbalance" in the water content of the blood may result. Careful choice of fluid and monitoring of fluid delivery make this an uncommon complication.
- Bleeding/Hematoma: When a small blood vessel continues to ooze or bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time, and surgical drainage is rarely necessary.

Patient Initials: _____

- Lower Extremity Weakness/Numbness: This, too, is a rare event which may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected.
- Chronic Pain: As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some feeling of numbness may persist. If persistent, further evaluation may be necessary.

Physician	Date	Witness	Date
Patient	4-21-17 Date	Kimberly Taylor (208186)	

COPY

WHASN
Women's Health Associates of Southern Nevada

SOUTH VALLEY EAST
SOUTH VALLEY WEST

PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."*

DILATION AND CURETTAGE/HYSTEROSCOPY

Definition
Dilation = the act of stretching the cervical (the neck of the womb) opening to the cavity of the uterus (womb)
Curettage = scraping the lining of the uterus (endometrium) for removal of (normal and/or abnormal) tissue, often for diagnostic evaluation
Hystero = of or denoting the womb (uterus)
Scopy = examination with an instrument for improved viewing, often with magnification and directed lighting

Dilation and curettage (D&C) is an outpatient procedure during which your doctor will enlarge the opening to the uterus (womb) so that a surgical instrument, called a curette, can be inserted to scrape out the lining of the uterus. Hysteroscopy is the direct visualization of the uterine cavity with lighting and magnification through a long, pencil-sized "telescope" inserted in the cavity of the uterus. D&C, with or without a hysteroscopy, can be performed for a variety of symptoms, such as abnormal uterine bleeding, postmenopausal bleeding, and irregularity in ultrasound or x-ray of the uterus. Often this is done to aid in the diagnosis of infertility or when cancer of the uterine lining is suspected.

The menstrual cycle is designed to prepare a healthy endometrial lining for a fertilized egg to grow in. Once a month, if a woman does not become pregnant, the "old" lining is shed through the cervical canal with the menstrual period and replaced with "new" lining in preparation for pregnancy. This cycle is repeated throughout a woman's lifetime until her ovaries no longer make enough of the hormones needed to continue a regular, monthly cycle. Alterations in this cycle and irregularities of the lining of the uterus can lead to episodes of vaginal bleeding that are unpredictable, heavy, or cause significant discomfort.

Patient Initials: _____

For women in their teens, 20s, and 30s, irregular bleeding is most often the result of either pregnancy or an egg not being released during their menstrual cycles (anovulation). As women enter their 40s and 50s, ovulation becomes less regular and may lead to abnormal patterns of uterine bleeding. Another cause of bleeding in women in their 40s and 50s is thickening of the uterine lining. In the woman who has stopped menstruating, or reached menopause, a common cause for uterine bleeding is hormone therapy.

Irregular uterine bleeding and bleeding during menopause are often signs of uterine cancer. Because uterine cancer is more common in older women than in younger women, it is important that the cause of bleeding is investigated and treated. Cancers of the uterus, when discovered early in their development, can be cured.

Abnormalities in the shape of the uterine cavity can lead to a variety of symptoms including abnormal bleeding, repetitive pregnancy loss, inability to conceive, and others. Abnormal separations (septations), fibroid tumors (benign tumors), endometrial polyps, and scarring are only some of the causes of abnormalities in the shape of the uterine cavity.

There are a variety of procedures to collect endometrial tissue from the lining of the uterus. Some are designed to be performed in your doctor's office (endometrial biopsy) with very little advance preparation or discomfort. Dilation and curettage (D&C) is a procedure that removes a larger sample of the uterine lining and is typically performed in an outpatient hospital setting or surgery center. Dilation and curettage, when combined with hysteroscopy, allows your doctor to see most abnormalities present, and many times, an opportunity to correct them. The type of procedure recommended will depend on your symptoms, age, results of other testing, and the preference of your doctor. The pros and cons of each will have already been discussed with you in your consultation.

Preparation

No special preparation is necessary for most patients. However, for some it is necessary to begin the process of opening the cervix the day before the procedure. There are different methods of preparing the cervix, including the placement of dried sponge-like material in the opening and placement of medicines in the vagina near the cervix. This preparation will be started in the office if you doctor feels it is necessary to include it in your care. Your doctor will tell you which medicines you may take for discomfort.

If you have been having heavy bleeding, your doctor might ask for a blood test to check for anemia (low blood count). A pregnancy test is usually performed for women who might be pregnant.

The D&C can be performed with anesthesia (pain management and sedation) given locally (injected around the cervix), regionally (delivered around the nerve supply to the pelvis), or generally (medicine given in the veins to control pain and make you sleep). Your gynecologist and anesthesiologist will make a recommendation for anesthesia based on your condition, the goals of the D&C/hysteroscopy, and if any other procedures will be performed at the same time.

Patient Initials: KT

As with most procedures in which regional or general anesthesia is administered, you will be instructed not to eat or drink anything after a certain time, usually midnight, on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken, you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. The procedure might not be performed if you are currently taking, or have recently taken any medication that may interfere with your ability to clot your blood ("blood thinners, aspirin, anti-inflammatory medicines, etc..."). The most common of these medications are aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter). *Please refer to the attached list and tell us if you took any of these within the past 10 days.* If your new medication is not on the list, alert us immediately so that we may ensure optimal procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

Procedure

You will be lying on your back with your legs elevated in stirrups, much like you would for a pelvic examination. The procedure usually takes between 30 minutes and one hour depending on the type of anesthesia used and if other procedures are to be performed at the same time.

The procedure begins by gently cleaning the vagina and placing a speculum in the vagina to hold it open. The cervix is grasped with an instrument to hold it still, while the opening is gradually dilated with surgical instruments until the hysteroscope or curette can be inserted without force.

The cavity of the uterus is much like a balloon: when empty it is flat but when inflated, space is created inside the balloon where there was none. Performing hysteroscopy involves "inflating" the cavity of the uterus with a liquid or gas (flowing in and out through the "telescope") so that each surface can be seen. Miniaturized instruments can then be placed along with the telescope to correct many of the abnormalities of the shape of the cavity.

After hysteroscopy is completed, the lining is scraped out through the opening and collected for microscopic examination in the laboratory by a pathologist. Hysteroscopy may or may not be repeated following curetting the lining of the cavity.

Post Procedure

You will be in the recovery room for a short time before being sent home from the outpatient surgery center. Though you may have some discomfort and cramping following the procedure, it is not necessary for you to plan time off from work or your normal activities beyond the day of surgery. It is normal to have some bleeding and discharge following D&C/hysteroscopy. It is suggested that you use menstrual pads to maintain hygiene and protect your clothing. You are instructed to refrain from vaginal intercourse, douching, and tampon use until told you may resume by your doctor.

Medications, such as ibuprofen or naproxen, are usually all that is needed for the cramping you might have after your surgery. Ask your doctor what is recommended or if a prescription for pain

Patient Initials: KS

medicine will be given. An antibiotic prescription may also be given and should be taken until completion. If any side effects occur, contact our office immediately.

Expectations of Outcome

Your doctor will explain what information was found following your surgery. The results of the microscopic examination of the specimens collected will take up to a week to become available from the laboratory. Once this information is available, your doctor will make recommendations for further treatment based on the specific results of your testing.

Many women who have experienced heavy or irregular uterine bleeding will return to a regular menstrual cycle following D&C. Maintenance of regular cycles may be assisted with hormone or birth control pills.

If your surgery was part of an investigation into infertility, your doctor will explain what was found and accomplished by the surgery and will help you understand the impact of these findings on your future fertility.

Possible Complications of the Procedure

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- Perforation of the Uterus: The most serious complication of the procedure is the creation of a perforation, or hole, in the wall of the uterus. Perforation of the uterus may lead to injury of other structures and organs within the abdomen (blood vessels, nerves, intestines, and bladder), bleeding, or infection. Perforation is not common, however, may require another operation to be treated appropriately.
- Infection: D&C/hysteroscopy involves placing an instrument through the vagina and cervix into the uterus. Because of this, it is possible to introduce a microorganism (such as bacteria or yeast) from the vagina into the uterine cavity. Many microorganisms are normally present in the vagina and cause no infection or other symptoms. However, when these same microorganisms are present within the cavity of the uterus, a more serious infection can be the result. Signs of infection that you should be watchful of are: foul-smelling vaginal discharge, tenderness, or pain in the vagina and pelvis for more than two days, bleeding lasting more than two days, fevers, shaking chills, nausea, vomiting, weakness, and feeling ill.

  If you have symptoms suggesting any of the above after your discharge from the hospital, you must contact us immediately or go to the nearest emergency room.

- Bleeding: Most women will have a small amount of bleeding following this procedure. If your bleeding is heavier than your normal period, or lasts longer than two days, please call your doctor.

Patient Initials: KK

- Fluid Imbalance: In addition to water, fluids used to "inflate" the cavity of the uterus for hysteroscopy contain dissolved sugars, starches, and salts. These substances give the fluids certain desirable properties for visualization of the uterine cavity. When too much fluid flows from the uterus and enters the abdominal cavity or blood stream, an "imbalance" in the water content of the blood may result. Careful choice of fluid and monitoring of fluid delivery make this an uncommon complication.
- Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE): In any operation (especially longer operations), you can develop a clot in a vein of your leg (DVT). Typically, this two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. *If you notice these signs, you should go directly to an emergency room and also call our office.* Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.
- Lower Extremity Weakness/Numbness: This, too, is a rare event that may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected.

Physician — Date 4/21/17 — Witness — Date

Patient — Date 4-21-17 — Kimberly Taylor (208186) print patient name

The information contained in this Medical Informed Consent form ("Consent Form") is intended solely to inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional. While Oakstone endeavors to ensure the reliability of information contained in its Consent Forms, such information is subject to change as new health information becomes available. Oakstone cannot and does not guaranty the accuracy or completeness of the information contained in this Consent Form, and assumes no liability for its content or for any errors or omissions. Laws vary from state to state regarding the information that must be given to a patient for informed consent. Please be sure to check the laws regarding legal informed consent as they apply in the your state. Please call your physician or other healthcare provider if you have any questions.

EXHIBIT “2”

Taylor v. Brill, M.D., FACOG, FACS, et al.

Videotaped Deposition of Keith Brill, M.D.

April 16, 2021

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1

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

KIMBERLY TAYLOR, an individual, Plaintiff, vs. KEITH BRILL, M.D., FACOG, FACS, an individual; WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN, PLLC, a Nevada Professional Limited Liability) Company, et al., Defendants.

CASE NO.: A773472

VIDEOTAPED DEPOSITION OF KEITH BRILL, M.D.
Taken on Friday, April 16, 2021
At 1:05 p.m.
At 376 East Warm Springs Road, Suite 120
Las Vegas, Nevada

Reported By: Lori M. Unruh, R.D.R., C.C.R. #389

2

APPEARANCES:
For the Plaintiff: ADAM J. BREEDEN
ATTORNEY AT LAW
BREEDEN & ASSOCIATES, PLLC
376 East Warm Springs Road,
Suite 120
Las Vegas, Nevada 89119

For the Defendants Keith Brill, M.D., et al.: HEATHER S. HALL
ATTORNEY AT LAW
McBRIDE HALL
8329 West Sunset Road,
Suite 260
Las Vegas, Nevada 89113

The Videographer: Andrew Jones,
Certified Legal Videography

Also Present: Kimberly Taylor
(via videoconference) Leslie Smith

I N D E X

3

MR. JONES: Good afternoon.
This begins the video recorded deposition of Keith Brill, M.D.
Today's date is April 16th, 2021. The time is 1:05 p.m.
We are at 376 East Warm Springs Road in Las Vegas, Nevada 89119, for the matter entitled Kimberly Taylor versus Keith Brill, M.D., et al., Case No. A-18-773472-C, being heard in the Eighth Judicial District Court, Clark County, Nevada.
I am the videographer, Andrew Jones. The court reporter is Lori Unruh with Western Reporting Services.
Will counsel please identify yourselves and affiliations, and then the reporter will administer the oath.
MR. BREEDEN: This is Attorney Adam Breeden, Bar No. 8768, representing the Plaintiff Kimberly Taylor.
MS. HALL: Heather Hall for Defendants WHASN and Dr. Brill.
And I also have Leslie Smith with me from ProAssurance; she's on video.
MR. BREEDEN: I guess we should state for the record that my client, Kimberly Taylor, is also observing this via Zoom.
THE WITNESS: I'm Keith Brill, M.D. I am the

4

defendant.
MR. BREEDEN: Okay. We'll go ahead and swear you in now.
* * * * *
Whereupon --
KEITH BRILL, M.D., having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:
* * * * *
EXAMINATION
BY MR. BREEDEN:
Q Okay. Good afternoon, Dr. Brill.
Please state your full name for the record, and go ahead and spell your first and last name as well.
A Sure. Good afternoon.
For the record, my name is Keith, K-e-i-t-h, Brill, B-like-bravo-r-i-l-l.
Q Okay. Dr. Brill, my name is Adam Breeden. We met very briefly before the deposition. I'm the attorney for a woman named Kimberly Taylor, who has filed a lawsuit against you after a procedure that occurred on April 26th of 2017.
Do you understand the reason why you are here this afternoon is to give your formal deposition testimony in that case?

5

A I do understand that I'm here for my deposition, yes.
Q I'm going to explain a few things about the deposition process for you on the record before we begin.
Understand that the oath that was just administered to you by the court reporter is the same oath that you would take in a court of law, as if you were in front of a judge and a jury today, and it obligates you to tell the truth under penalty of perjury.
Do you understand that?
A I do understand what you just said, yes.
Q Your deposition today is being videotaped, and your testimony may be either played or read to the jury later in this case.
Do you understand that?
A I do understand that, yes.
Q The court reporter to my left, your right, is taking down everything that is said during today's deposition, all the questions and answers and objections that are made. And after today's deposition, she'll put everything in a booklet or transcript form that can be read.
After the deposition, you can review the transcript and make changes to your testimony, if you wish. I would just caution you that if you make a

6

substantive change, I would have the right to comment on the fact that you said one thing here today and then later on you changed it in a substantive or meaningful way, as opposed to if you just corrected a typographical error or a minor grammatical error that was made.
Do you understand that?
A I do understand, yes.
Q It is important for us to get a good record today. Please ask me to repeat or rephrase a question if you do not understand, and I'll be happy to do that.
There are several other things I would ask you to do.
During today's deposition, you need to always give an audible or out loud answer, such as a yes or a no. Please do not shake your head up and down or side to side or say huh-uh or uh-huh if you give a response because those responses do not show up well, if at all, on the transcript when we go back later to look at it.
Can you do that for me?
A I will do answering by words, yes.
Q Okay. Also, you've done an excellent job so far; but during today's deposition, as a general rule, try not to speak at the same time anyone else is speaking, and wait for me to completely finish my question before you begin your response.

7

There are several reasons I ask you to do that, but perhaps the most important one is that it is difficult for the court reporter to take down what two people are saying at the same time. So we need to be a little formal today and not speak over one another. I will give you the same courtesy as well.
Do you understand that?
A I do understand that, yes.
Q During today's deposition, one of the attorneys may object to a question. I want to explain to you how objections work during a deposition because they work differently than what you might have seen on TV or in a courtroom.
Obviously we do not have a judge present here today to immediately rule on objections. So during the deposition process, generally what occurs is if I ask the question, there is an objection stated for the record; but after the objection is stated, unless your attorney clearly instructs you not to respond, we'll all look to you to give your response, and then later a judge can go back and look on the transcript and decide whether the objection should be overruled or sustained or whether your response can be used as evidence.
Do you understand how objections are going to work today?

8

A I do understand, yes.
Q Okay. Having explained those to you, do you have any questions for me about how today's deposition is going to proceed?
A I have no questions at this time.
Q Have you consumed any alcoholic beverages in the last 24 hours?
A I have not consumed any alcohol, no.
Q Have you taken any kind of other drug, including prescription medications, in the last 48 hours?
A I do take blood pressure medication every day.
Q Okay. And is that something that you've been on for an extended period of time?
A Yes. I've been on it for several years, yes.
Q Do you feel that that medication will affect your memory or your ability to testify here today?
A I have no reason to think that these medications will affect that, no.
Q Okay. Do you have any other sort of medical condition, an extreme example would be dementia or early onset Alzheimer's, that may affect your memory or your ability to testify here today?
A No, I don't have any condition like that.
Q What if anything have you done to prepare for today's deposition?

9

A So prior to today, I met with my counsel. I reviewed my medical records from this case.
Q Okay. And so when did you last review the medical records?
A I last reviewed the medical records within the last 24 hours.
Q And without revealing what was said during the meeting, when did you meet with your counsel?
A I last met with my counsel approximately two weeks ago.
Q And was anyone present at that meeting other than you and your counsel?
A Physically only my counsel was present. I believe Leslie from ProAssurance was present by Zoom or some videoconference as well.
Q Okay. And other than your own medical records or the records from Women's Health Associates of -- of Southern Nevada, did you review any other medical records, for example the records from Henderson Hospital or St. Rose Hospital?
A I believe I did see some of the records from Henderson Hospital, mainly being my operative report. And I did see some of the records, but not all, from the St. Rose Hospital after my surgery.
Q Okay. We'll just say in the last 90 days, have

10

you spoken with any other witness in this case, including some of the other healthcare professionals that were previously named as a defendant?
A I have not spoken with any other witness or person named in this case, no.
Q Have you reviewed the expert report of your own designated expert?
A I have not.
Q Have you reviewed the expert report of plaintiff's designated expert, Dr. Berke?
A I have not.
MR. BREEDEN: And just for the court reporter, Berke is spelled B-e-r-k-e.
Q So since you have not reviewed the expert report of Dr. Berke, you do not intend to testify regarding that report or comment on it in any way today, do you?
A Well, I haven't read the actual report. My counsel has discussed the key findings or -- or statements from that; but I haven't read the physical report.
So I don't know if I can answer your question the way you're asking it to me.
Q Okay. So you have an idea as to what the report says from your counsel, but you haven't actually read it; is that your testimony?
A That is correct, yes.

11

Q And have you reviewed any other depositions taken in this case?
A I have not reviewed or seen any of the depositions, no.
Q Okay. As I told you before we got started, I -- I don't think today's deposition will be terribly long, approximately maybe two hours. We'll try to take a break after an hour or so. If for some reason you need to stop during the deposition to take a break, just ask me to do so, and we can take a short break.
I'd just ask if there's a question pending, that you respond to the question before we go off the record.
And I should also advise you that pursuant to a Nevada Supreme Court case called Coyote Springs, if you have a conversation with your counsel during a break in your testimony, your conversations with counsel may not be protected by attorney/client privilege.
So I want you to be aware of that, okay?
A Okay.
Q Also, during today's deposition, the phrase reasonable degree of medical probability may be used.
Are you familiar with that legal standard for medical testimony?
A I understand the words you said. I don't know if -- what you mean by familiar with that standard.

12

Q Okay. So for some testimony in a medical case, it must be stated to a reasonable degree of medical probability. That means it is more likely than not or more than 50 percent likely. And we distinguish that from things which are merely possible or less than probable or less than 50 percent likely.
Do you understand the difference between those two standards?
A So if I'm understanding you, when you -- you say reasonable probability, we're assuming at least a 50 percent chance of happening, as opposed to possible, which would be less than 50 percent is -- I believe.
Q I think that's a good summary of those standards.
A Okay. Good.
Q So during today's deposition, if you testify to something that you believe is -- is merely possible but something that you would not say is more likely than not, I'd like you to indicate that for me, okay?
A I will try my best as I answer your questions, yes.
Q Okay. You are a OB-GYN physician; is that correct?
A Yes, that's correct.
Q Explain what a OB-GYN physician is and -- and what that type of specialty does.

13

A So an obstetrician and gynecologist is what OB-GYN stands for. It's a women's health specialist who -- the obstetrics side usually revolves around pregnancy-related care, and the gynecology side relates around nonpregnancy women's healthcare, usually related to women's reproductive organs and -- and the breasts, not typically other issues that may -- you know, that may affect a woman. It's usually more with gynecological organs.

Q And you have both specialties?

A Yes. I practice OB-GYN, yes.

Q Yeah. And -- and I know obviously they're both related to women's health, and we commonly see a doctor say they're an OB-GYN.

Are there some doctors out there that are only obstetricians but not gynecologists or vice versa?

A So yes, that's true for both. There are obstetricians only, and there are also gynecologists only who only practice gynecology.

Q Okay. But you have both designations.

A Correct. I do both -- I practice both of those, OB-GYN.

Q And so what percentage of your practice is devoted towards the practice of being an obstetrician versus the practice of being a gynecologist?

14

A Sitting here today, I can't be exactly sure, but I'd -- I'd say it's likely 50-50 in what I do.

Q Okay. What states have you ever been licensed to practice medicine in?

A So I've been licensed here in Nevada and then in Pennsylvania.

Q Okay. And give me an idea when -- when were you licensed in Pennsylvania?

A So during my residency program, which was 1995 to 1999, I initially had a residency or training license. And I would say about -- I -- I think in my third out of the fourth year, I -- I did get a full license for Pennsylvania as well.

Q Is your Pennsylvania license currently active?

A It is not currently active for Pennsylvania, no.

Q And did you allow it to go inactive, or is there some other reason why it's not active?

A Once I practiced in private practice in Nevada, I was never going to practice in Pennsylvania, so it just lapsed and became inactive. There's no other reason why.

Q And so what year did it become inactive?

A I want to say it would be 2003, when I started my private practice here in Nevada. It may have expired shortly after that, but around that time.

Q And in what year did you first become licensed in

15

Nevada?

A So I first became licensed to practice in Nevada in 2003.

Q Okay. And your Nevada medical license has been active continuously since 2003?

A Yes, it has.

Q It's active today?

A It's active today, yes.

Q Are you board certified in the fields of OB-GYN?

A Yes, I'm board certified in OB-GYN.

Q When did you first become a board certified OB-GYN?

A I first became board certified in 2001, when I was first eligible to become board certified.

Q And I know that there are many different medical boards.

Which particular one has certified you?

A So I'm certified with the American Board of Obstetrics and Gynecology.

Q And has that been renewed over the years?

A Yes. So I've maintained my certification every year since then, and I'm currently board certified today.

Q Okay. So most boards -- some used to be lifetime board appointments, then they went to maybe recertifying or renewing every five years or every 10 years.

16

What is it about the -- the board that you're certified? What's their policy?

A So our board makes us recertify every year and have to take a test or answer questions based on our -- on keeping current in our field. So I've been recertifying every year since 2003 -- or 2001. I'm sorry.

Q Have you ever been board certified in any other field?

A No, I've not been certified in any other fields.

Q Okay. Briefly summarize to me your undergraduate and medical school education.

A So I attended the University of Miami bachelor's of science slash medical degree six-year program. So I attended University of Miami undergraduate for two years and then went right into medical school at University of Miami School of Medicine, graduating in 1995.

Q And is that the University of Miami, Florida? I know there's one in Ohio as well.

A Yes. It's Miami, Florida, yes.

Q Okay. And just can you -- since graduating from medical school then, can you summarize your training and work experience.

A So I performed my OB-GYN residency at Thomas Jefferson University Hospital, which is in Philadelphia, Pennsylvania. It's part of Jefferson Medical College.

17

That was from 1995 to 1999, my final year being the chief resident of that program.

From 1999 to 2003, I was an active duty Air Force physician and officer here at Nellis Air Force Base. So I practiced as an OB-GYN and -- and as a military officer until 2003.

And then I separated from the military and joined a private practice here in Las Vegas from 2003 on. I stayed with that practice until 2014.

And then I changed to my current practice, which is another private practice in Nevada; it's from 2015 to present.

Q And -- and I'm sorry, did you say that the last change was in 2014 or 2015?

A I -- well, I finished calendar year 2014 with the previous practice and started in the calendar year 2015.

Q Okay. And so that private practice that you began working for in 2015, was that Women's Health Associates of Southern Nevada?

A That was not that practice, no.

Q Okay. So when did you begin working for Women's Health Associates of Southern Nevada?

A So I began practicing with Women's Health Associates of Southern Nevada in 2015.

Q Okay. So maybe I -- you misunderstood my

18

question or I misunderstood your answer.

But have you worked for Women's Health Associates of Southern Nevada continuously since 2015?

A Yes. That's where my practice has been, yes.

Q And what was the name of the private practice you worked for just prior to that?

A So -- I'll answer it the best I can.

So it was called WellHealth Quality Care, which was a company that took over the practice that we originally were named when I started, which was called Women's Specialty Care.

Q Okay. And I'm -- I'm just trying to figure out -- because I've reviewed discovery in this case.

It appears to me from contracts and paperwork that I've seen between you and Women's Health Associates of Southern Nevada that you are considered an employee doctor of that company; is that correct?

MS. HALL: Form.

THE WITNESS: I am a employed physician with Women's Health Associates; and then my particular office or care center, which is one component of that company, is -- is the Essential Care Center, and I'm a partner of that -- of that organization.

So it's a partner of my practice, which is part of a larger organization, which I'm an employed physician

19

of.

Q (BY MR. BREEDEN) Okay. So is that a different legal entity than -- than Women's Health Associates of Southern Nevada?

A No. The care center is -- it's -- it's -- we -- all of the different care centers or offices have different names. Each one has its own agreements. And so I'm a partner of that, but it's -- it's a component of Women's Health Associates of Southern Nevada.

Q Okay. So you have some ownership interest in that particular part of the company.

A Correct.

Q But as far as you know, there's only one legal entity, and that is Women's Health Associates of Southern Nevada.

A Correct.

And I believe, as a partner of my Essential Care Center, it's considered to be a partner of Women's Health Associates.

So in answering your question, I'm -- I'm employed by them, but I'm also a partner, so I don't -- I practice the same way, however.

Q Okay. So let me ask you this because it's -- it's important for the entities that are named in this lawsuit.

20

A Okay.

Q When you performed the procedure on Kimberly Taylor on April 26 of 2017, were you acting on behalf of or as an employee of the Women's Health Associates of Southern Nevada?

A I believe I was a partner physician at that time of 2017. So my employer is the -- is the entity, but I'm one of the partners, and there's several partners of the -- of the company.

Q Okay. But you were acting on behalf of or in conjunction with that company.

A Right. I was working under the -- the name of Women's Health Associates of Southern Nevada, yes.

Q There's -- there's no other medical practice since 2015 that you've been affiliated with, is there?

A No, I've not, that's correct.

Q Okay. Just briefly, how many times have you ever been deposed?

A I would say I believe I was deposed four times in my career.

Q Okay. Tell me about the first of those times. What do you recall?

A The first -- I have very little recollection. It was back in my residency from a private practice physician who had a complication during her surgery. I was the

21

resident physician assisting the surgery. And soon after my deposition, I was dropped or un- -- unnamed from that case. That was the first one. And it probably was around 1998 or 19- -- or -- 1997 or 1998.

Q Okay. So in approximately the late 1990s, you were sued for medical malpractice in the state of Pennsylvania, and you were deposed in that action.

A I believe it was actually in New Jersey because it was a -- it was a hospital that we went to in New Jersey.

Q Okay. Do you remember what county in New Jersey?

A I do not recall, no.

Q Do you remember if it was in New Jersey state court or federal court?

A I know it wasn't federal court, so I would assume -- I believe state court or the local court.

Q And did the allegations of that case concern a perforation of the uterus or other organs of that patient?

A I do not recall what the exact injury was, but it was due to an injury from the surgery. This was a long time ago.

Q Tell me about the second time you're thinking of.

A The second time I'm thinking is when I was a practicing physician, not a defendant, for a procedure that invol- -- involved the use of vaginal mesh. So it

22

was a lawsuit on -- where my -- the patient I practiced -- I -- I performed the surgery on, I was part of this lawsuit, and I was just named as a treating physician, not as a defendant or named in the lawsuit.

Q In other words, you were just an expert or a witness that testified. You were not a party to that case.

A Correct.

Q Was that here in Clark County, Nevada?

A That was in Clark County, Nevada, yes.

Q Do you remember what year that was?

A I do not recall it. Probably at least -- at least five to 10 -- had to be more cause it was my previous practice, so at least -- probably more like 10 years ago.

Q And your testimony is that that case did not concern a perforation of any body part. It was a vaginal mesh case only.

A That's correct, yes.

Q All right. Tell me about the third occasion you're thinking of.

A The third occasion was also a mesh-related case, very similar. I was the treating physician and -- or, you know, expert physician, and there was no perforation. It was just the same -- similar kind of a situation, similar

23

patient.

Q Was that in Clark County, Nevada?

A That was Clark County, Nevada.

Q And approximately what year was that?

A That probably was about seven to eight years ago, I would say.

Q And tell me about the fourth occasion you're thinking of.

A The last one was for a case that was -- when I was with my former company, so it had to be at least five years ago, where I was the treating -- I was the treating physician, but I was named in the lawsuit.

Q Was that here in Las Vegas, Nevada?

A Yes, that was Las Vegas, Nevada.

Q Were -- do you recall the name of the plaintiff that filed that lawsuit?

A I do not recall today, no.

Q And that lawsuit did involve a perforation?

A So that lawsuit was in a laparoscopic surgery that did involve perforation of the intestine, yes.

Q So was that lawsuit -- did it go to trial, or did it resolve prior to trial?

A So based on my malpractice carrier at the time, it went to binding arbitration, and it did go to arbitration.

24

Q Okay. Was the arbitration confidential?

A I don't know.

Would you know that, Heather?

MS. HALL: I be- -- are you -- you mean the results of the arbitration?

MR. BREEDEN: Yes.

MS. HALL: I believe that it was. I was no longer with that law office at the time that it actually got arbitrated, but I believe that it was.

THE WITNESS: Okay. I don't know.

Q (BY MR. BREEDEN) What year did that go to arbitration?

A I would say it was definitely prior to when I joined my current practice, so I want to say maybe 2012, around that time frame.

Q And so because I do not know the particular allegations of that, but do you admit that for that prior patient that you did perforate that patient's intestines?

MS. HALL: Form.

And, for the record, Mr. Breeden, this is in his answer to interrogatory number four where he talks about this case and it being a thermal injury to the ureter.

THE WITNESS: It was a ureter injury?

So I haven't recall -- so I haven't even looked at those records in a long time, but -- so it wasn't a

25

bowel injury. I take that back then. It was a ureter injury.
What was your question then? I'm sorry.
Q (BY MR. BREEDEN) Yeah. The question was did -- did you cause that injury, or did -- was your defense that some other doctor had caused it?
MS. HALL: Form, foundation.
THE WITNESS: So I defended my care at the time of the surgery. I believe that I performed my surgery within the standard of care at the time. I truly thought that I did not cause medical malpractice, if that's what you're asking, but a complication did occur from the surgery at a time after the surgery.
Q (BY MR. BREEDEN) Was there a finding against you in that arbitration?
A So the arbitration was my -- I don't know the exact wording of it; but it was against me, yes.
Q Okay. And so other than those four occasions that you can think of where you were deposed, and today, are there any other times you can recall where you were deposed?
A No, there's no other times I can recall.
Q Okay. Now are there any times that you can recall that you testified in a courtroom or in an arbitration proceeding under oath that we have not already

26

spoken about?
A No. I've never done any other testimony like that, no.
Q Have you ever been named as a party in any other case, but you did not testify?
A I was named in a case within the last five years, but the case never went forward, and I never was asked to testify or have a deposition.
Q Was that filed here in Clark County, Nevada?
A Yes, that was.
Q Is the case filed by Kimberly Taylor the only case where your current counsel Heather Hall or her law office has represented you in a le- -- in a medical malpractice case?
A So her current company, I would say the answer is yes. I know she was employed with the -- with the company when I was involved with my previous case, but she wasn't my representing counselor.
Q Okay. So the -- Ms. Hall or a law firm Ms. Hall worked for has represented you in at least one other medical malpractice matter.
A Correct.
Q Have you ever had any professional license or accreditation suspended or revoked?
A No. I've never had any of that happen to me, no.

27

Q Have you ever tested for a medical license or applied for an accreditation and it's been denied?
A No. I've had no -- no testimony or accreditation denied.
Q Has a court ever excluded you in whole or in part as a expert from testifying to a certain opinion?
A No. I've never been excluded from testifying as an expert.
Q This case concerns a procedure that I would describe as a dilation and curettage with hysteroscopy and fibroid tumor removal.
How many of those procedures have you performed in your career?
A So, first, I believe there was initially more to the procedure that was planned. It wasn't just that.
But I -- I performed over a thousand hysteroscopies. I would say with removal of a fibroid or other lesion, I would say in the hundreds, if not more.
Q Okay. And have the number of those procedures you've performed -- have they changed over time during your career? In other words, maybe you didn't perform that procedure at all early in your career, but you've performed a lot of them in the last three years, or has it more or less been the same amount of those procedures over the years?

28

A I would say my volume has never changed. It's been around the same steady amounts -- stable amount throughout my career.
Q Do -- do you consider those procedures to be generally safe to women?
MS. HALL: Form.
THE WITNESS: So I think that all surgical procedures have risks and benefits, and safety is my number one priority when performing a surgery. I perform surgical -- surgery in a safe fashion, if that's what you're asking. But I -- I believe every surgery has -- even -- even -- even in the best of hands has the risk of complication.
Q (BY MR. BREEDEN) Well, but my question is do you tell your patients that those are generally safe procedures? Would you describe them as risky procedures?
A So I don't say any of those to my patients. I discuss risks and benefits and alternatives. That's how I've always been trained. And to say, you know, there's options of performing the surgery, options of not performing the surgery, and what the risks and benefits of each of those would be.
But to say generally safe or generally unsafe, that's not something that I would ever counsel a patient.
Q You don't consider that -- the procedures you

29

perform to be generally safe?
MS. HALL: Form, misstates testimony.
THE WITNESS: I think that surgeries are considered in terms of risks and benefits. I think that's the way --
(Reporter interrupted for repeat of answer.)
THE REPORTER: I think that surgeries are?
THE WITNESS: Are considered in -- in -- in terms of risks and benefits. It's not in absolutes, all or none, safe or not safe, or generally safe. I don't know how to define generally safe.
Q (BY MR. BREEDEN) Okay. Well, to the best of your recollection, what did you tell my client, Kimberly Taylor, specifically regarding the safety of these procedures, risks and benefits?
A So sitting here today -- I mean this conversation happened four years ago. I would ask to see my records if you're going to ask me a question about specific conversations with Ms. Taylor.
Q So you have no independent recollection of your conversation with her apart from what would be in medical records.
A So, yeah, sitting here today four years after these -- this conversation -- or conversations occurred during several visits, I have no specific recollection of

30

what was said --
Q Okay.
A -- at that time.
Q Can you testify at all that you even remember discussing risks and benefits with Ms. Taylor, or do you simply have Ms. Taylor or other patients sign a form?
MS. HALL: Form --
THE WITNESS: So --
MS. HALL: -- lacks foundation.
Go ahead, Doctor.
THE WITNESS: I always in our -- in discussion with a patient discuss risks -- risks and benefits. I have my patient review a comprehensive form that they have the ability to ask questions about.
And I know that did occur in this case. But when you're asking me specifics of a independent recollection today of a conversation four years ago, I can't answer that question properly.
Q (BY MR. BREEDEN) Okay. So you cannot testify here today specifically what was said to Ms. Taylor. You can only refer to the medical records.
A Well, I don't think that's what I said.
I said that I do recall having a conversation about risks and benefits about her procedure.
The -- to look -- I would need help looking at my

31

records to help me with my recollection of -- of what was said during that conversation.
Q So your testimony, to be clear, is you can recall there was a conversation; but without looking at medical records, you can't specifically recall what was said.
A So what I'm saying is we discussed risks and benefits and alternatives of the procedure and of not performing the procedure, and my patient was given the opportunity to ask questions and review the consent forms with me. I know that all occurred.
But if you're asking me specifically what did I say when I walked into the room from the time I walked in till I walked out, I can't answer that four years later today.
Q Based on medical literature that you've seen in your industry, what is the percentage of incidence of a uterine perforation during hysteroscopy?
MS. HALL: Form, foundation.
THE WITNESS: I usually anticipate a complication of approximately one percent of a uterine perforation during a hysteroscopy procedure.
Q (BY MR. BREEDEN) In your experience as a physician performing a hysteroscopy, dilation and curettage, how many times would you estimate you've perforated the uterus?

32

A So I -- I can't sit here and give an exact number. I know that -- I mean I said I performed over a thousand of these procedures. I would likely say somewhere in the -- in the -- in the range of -- of five to 10, I would say, in my -- in my career of -- of -- of just -- of a uterine perforation at the time of hysteroscopy.
Q Other than Ms. Taylor's case, have you ever perforated the intestine during those procedures in another patient?
A No. I've --
MS. HALL: Form -- excuse me -- form, foundation.
THE WITNESS: So first of all, you're asking me if I -- are you asking if I perforated the bowel during this case? That is how you started your question?
Q (BY MR. BREEDEN) No.
I'm saying excluding anything that may or may not have occurred in this case, have any of your other patients experienced a perforated bowel from those procedures that you performed?
A No. I've never had a bowel perforation from a hysteroscopy during my career.
Q Okay. Do you admit in this litigation that as a result of the procedures you formed on -- you performed on April 26 of 2017, Ms. Taylor did sustain a bowel

33

perforation?
A Can you ask the question again?
Q Sure.
A Yeah.
Q So there's -- I see a lot of crazy things in this world, so I never assume what the doctor's going to testify to or not testify to.
It appears pretty clear to me that during the procedure you performed on April 26, 2017, Ms. Taylor's bowel was perforated or injured -- her intestines, I should say.
Now, do you agree with that statement, or do you not think you injured the intestines during the procedure?
MS. HALL: Form, foundation.
THE WITNESS: So I did not see a bowel perforation occur during my surgery. I know that's in the records that I reviewed. I do know a bowel perforation was diagnosed the following evening.
But you're asking me did I actually perforate the bowel at the time of my surgery. I can't tell you when the bowel perforation occurred. It could have happened after the surgery. I don't know when it exactly occurred.
Q (BY MR. BREEDEN) Okay. Do you have any opinion that the bowel perforation occurred at some time other than your April 26, 2017, procedure?

34

A So, yeah, based on my operative report and -- and recollection of that, I did not see any bowel injury at the time of the surgery. I felt the surgery was performed properly, and I -- with my medical judgments, I did not see or feel there was a bowel perforation at the time of the surgery.
So like I said earlier, I cannot tell you sitting here today when exactly the bowel injury occurred after the surgery.
Q Okay. Based on what you know today, given the history of this patient and this lawsuit, do you believe that the bowel injury did occur during the time of your surgery?
MS. HALL: And I'm going to instruct him not to answer with any conversations that he has discussed with counsel.
And I'd also offer we're going to offer a stipulation, he's not going to be giving a causation opinion at the time of trial.
So that's on the table if plaintiff wants it.
Q (BY MR. BREEDEN) So essentially what your attorney is saying is you can say I take no position as to when the bowel injury occurred; and if that's the position you want to take during this deposition, that's up to you. I would submit to you that a jury may later look at that

35

type of response as evasive.
Given the totality of the evidence in this case, it appears pretty clear that you did injure the bowel during the procedure, doesn't it?
MS. HALL: Can I have that question read back, please.
THE REPORTER: "So essentially what your attorney is saying is you can say I take no position as to when the bowel injury occurred; and if that's the position you want to take during this deposition, that's up to you. I would submit to you that a jury may later look at that type of response as evasive.
"Given the totality of the evidence in this case, it appears pretty clear that you did injure the bowel during the procedure, doesn't it?"
MS. HALL: You can answer.
THE WITNESS: So as I said, I did not see a bowel perforation happen at the time of the surgery. Bowel perforations or injuries can happen after the surgery. There are other causalities that could cause them, including thermal injury, including possibility of the

36

bowel getting stuck into the perforation after.
But if you're asking me specifically did I see the perforation happen at the time of the surgery, my answer is still no.
Q (BY MR. BREEDEN) Okay. So you have no opinion one way or another as to when the bowel was perforated or how it happened; is that your testimony?
MS. HALL: Form.
THE WITNESS: Based on the surgery -- re- -- re- -- recalling the -- the surgery from my operative report, I did not see a bowel injury occur at the time of the surgery.
If I had thought there was going to be a -- was possibly a bowel injury, I would have proceeded to the next step, which would likely be a laparoscopy or some other surgery or consultation to see if there would be a bowel injury.
But I cannot tell you exactly when the bowel injury occurred.
Q (BY MR. BREEDEN) That would be the standard of care, to do a laparoscopy to assure that no other organs were injured if you suspect that, isn't it?
MS. HALL: Form, foundation.
THE WITNESS: So if I'm understanding your question, you're asking it would be standard of care if I

37

suspected a bowel injury?
So I did not suspect a bowel injury. I did not -- I had clear visualization of the uterine perforation. I was able to see there was no injury to the bowel at the time of the hysteroscopy.
If I did see clear signs of bowel injury, which I have been trained to look for and I've seen before, I would have proceeded to the next step.
But at this time, I certainly -- in my medical judgment, there was no reason to proceed with a surgery that could have also risks to a -- to a patient that I did not think was necessary at the time.
Q (BY MR. BREEDEN) Well, you're telling me that you've seen bowel injury before from this type of procedure, but I thought you just testified a few minutes ago that you had never had any other patient that sustained a bowel injury from this type of procedure.
So how have you seen it before?
A So I've been per- -- performing surgery for 20-plus years.
What you asked me was did it happen during a hysteroscopy, and my answer to this -- this day is still clearly no.
I have seen bowel injuries as complications of abdominal surgery. I've seen them since probably day --

38

day one or two of my residency training. These things happen. They're known complications of -- of any surgery where you're operating adjacent to organs that are nearby.
So I've seen bowel -- bowel injuries and know what to look for but never had one during a hysteroscopy.
Q And that's because it's very difficult to injure the bowel during a hysteroscopy, isn't it?
MS. HALL: Form, incomplete hypothetical.
THE WITNESS: I don't know what you mean by very difficult.
Q (BY MR. BREEDEN) Well, it hasn't happened in your entire career, so it can't be easy to injure the bowel during a hysteroscopy.
A So bowel injuries are rare, I -- I do agree with that, from a hysteroscopy.
Q Let's talk a little bit about the history of your treatment of Kimberly Taylor.
There's medical records that have been produced in this litigation. It appears that she was a -- originally a patient of Women's Health Associates of Southern Nevada dating back to at least 2014. I think there's a reference to a Dr. Skinner at that time.
Have you ever worked with Dr. Skinner?
A I know of Dr. Skinner. Dr. Skinner was not part of the practice at Women's Health Associates when I

39

joined.
Q Yeah. So it appears that in 2015, after you joined the practice, that's when you took over Ms. Taylor's care.
Does that sound accurate to you?
MS. HALL: Are you asking from his memory, or would you like him to look at the medical record?
MR. BREEDEN: I'm asking from his memory.
THE WITNESS: I cannot sit here and tell you exactly when I took over. It sounds -- sounds about right. And I don't know -- I saw her as a patient at that time, and Dr. Skinner was no longer part of our practice.
Q (BY MR. BREEDEN) Okay. Would you agree that Ms. Taylor had been a patient of yours for at least a couple of years before the procedure in April of 2017?
A I honestly cannot answer without looking at my records to see the exact dates. I don't recall the exact dates.
Q Okay. And if Ms. Taylor was -- was here in front of us or you walked by her on the street, do -- do you recall her specifically? Would you recognize her?
A Having not seen her for at least four years, I cannot -- I cannot say if I would -- would recognize her without having seen her.
Q Okay. And you indicated that just within the

40

last week, you've reviewed your medical records for Ms. Taylor, correct?
A Yes. I've reviewed records within the last week, yes.
Q Okay. So leading up to this procedure in April of 2017, what were her medical problems that she was seeing you for?
A Honestly, I reviewed my records. I didn't memorize them.
So physicians rely on their medical records to answer questions like this. I would -- and that's how we perform our care. I would ask to see my records without, you know, trying to hypothesize about what she was coming to me for.
Q Okay. Do you recall having performed ultrasound and MRI on Ms. Taylor shortly before the April 2017 procedure?
MS. HALL: Form, foundation --
THE WITNESS: I would --
(Reporter interrupted; multiple speakers.)
MS. HALL: Form, foundation, calls for speculation.
And before you answer, for the -- the good of our court reporter, I'd just ask you to try and slow down a little bit in your talking.

41

THE WITNESS: Okay.
MR. BREEDEN: Okay. Can I ask a question here be- -- before the -- the doctor proceeds.
Are the people joining by Zoom -- is the audio good? Do you need me to try to turn it up somehow?
THE WITNESS: They're on mute.
MS. SMITH: It's fine. I can hear you.
MR. BREEDEN: It's fine? Thank you.
MS. TAYLOR: It's -- I'm good, Adam. Thank you.
MR. BREEDEN: Okay. Thank you.
Q Okay. So let me repeat the question.
Do you recall Ms. Taylor undergoing ultrasound and MRI shortly before her procedure in April of 2017?
A So I'm going to keep answering the same question -- the same answer.
I would like to see my records to have an exact idea when, cause I don't know what you mean by shortly.
I do recall seeing an ultrasound report. I don't have the exact specifics of what it says. I do not specifically recall an MRI.
Q Okay. Do you remember performing a colposcopy shortly before -- we'll just say in the six months before the procedure?
A So from reviewing my records, I do recall that a colposcopy was performed; but the details I don't have

42

memorized today.
MR. BREEDEN: Okay. Let's do this, if it's okay, Heather.
Let's briefly go off the record. I'll print off a copy of his records, and he can review them to refresh his memory.
Is that fair?
MS. HALL: Sure. I don't have an objection to that.
MR. BREEDEN: Okay. We'll go off the record so I can print a copy of the medical records for the doctor.
MR. JONES: We are off the record; 1:50 p.m.
(Recess.)
MR. JONES: We are back on the record at 2:03 p.m.
MR. BREEDEN: Okay. Dr. Brill, we went off the record briefly while I printed some of your medical records.
So just to -- for the record, I've placed what's been Bates labeled as BRILL 1 through 78 in front of you.
We'll have that marked as Exhibit 1 to this deposition.
(Plaintiff's Exhibit 1 was marked for identification by the reporter.)
Q (BY MR. BREEDEN) So I asked you before if you

43

could recall having done an ultrasound of -- of Ms. Taylor, and I refresh your memory by referring you to Bates label BRILL 62.
A Okay. I have -- I have that.
Q Okay. So does that refresh your memory as to when an ultrasound was performed and what the findings were?
A Yes. I can see the dates and the findings here.
Q Okay. So when was the ultrasound performed?
A This was performed on March 31st, 2017.
Q Okay. So shortly before the procedure involved in this case in late April, right?
A Yes. Prior to the surgery, yes.
Q And I asked you if you recalled a colposcopy.
I'd refer you to Bates number 50.
A So yes, I have that page.
Q Okay. So was the colposcopy performed; and if so, when?
A Yes. This is my record from a colposcopy procedure on March 9th, 2017.
Q And did you have a MRI of the abdomen and uterus area of Ms. Taylor as well? Refer you to Bates label 55.
A So I have page 55.
Q And so was -- was an MRI done on Ms. Taylor as well?

44

A So this MRI was not ordered by me. It's from September 7th of 2005, so much -- much earlier.
Q Oh, much earlier.
So you didn't order that particular MRI.
A Correct.
Q Okay. Based on the ultrasound and your knowledge of Ms. Taylor as a patient, did she have a retroverted uterus?
A I'll just look at the record here.
So I know you're asking -- your question asks based on the ultrasound. I don't see the words retroflexed or verted.
I -- I believe from other reports in my records that it was noted during my exam and ultimately during the surgery, but it doesn't say it in this ultrasound.
Oh, no, I take it -- wait. I'm sorry.
Looking through it -- it's -- it's hard to read; but at the end of the first paragraph, it says the uterus is retroverted, yes.
Q And I'm sorry, I didn't mean you to limit your response to solely what was in the ultrasound. I was simply using that to refresh your memory as to whether you had knowledge of a retroverted uterus in Ms. Taylor.
And so your response is yes, you -- you did know that prior to the procedure.

45

A Yes, I did know that.
Q And just in layperson's terms, what is a retroverted uterus?
A A retroverted uterus is when the uterus body is tilting downwards towards the patient's back, as opposed to being anteverted, where it's tilted up more towards the abdomen.
So in this case, it's tilted more down -- downward.
Q Okay. Is that unusual anatomy in a woman in your experience?
A It's -- it's not unusual. I would say it's -- we see this less often than an anteverted or -- uterus, but I -- we do see it often.
Q Okay. And so if you had to estimate the percentage of women with a retroverted uterus, what would your estimate be?
MS. HALL: Form, foundation.
THE WITNESS: That's a -- that's a difficult thing to answer here today.
I'd probably say between 10 and 20 percent of patients.
Q (BY MR. BREEDEN) Yeah. So I looked it up prior to today's deposition, and the medical literature says approximately 25 percent of women --

46

A Okay.
Q -- or one in four.
So the point of that is to say while this is not the normal anatomy of a woman, it's not highly abnormal either, is it?
MS. HALL: Form.
THE WITNESS: No. I would -- I would not say it's abnormal to have a retroverted uterus.
Q (BY MR. BREEDEN) And you've performed these procedures, dilation and curettage, hysteroscopy, fibroid tumor removal -- you've performed all those on women with retroverted uteruses previously, right?
A Yes, that's correct, so on -- on patients with all directions of their uterus, yes.
Q Okay. And that was well known to you before you did the procedure on April 26th. It wasn't something that surprised you in the middle of the procedure, was it?
A Yes. I was aware of it prior to the surgery.
Q Okay. Now Ms. Taylor also had a bi- -- I hope I pronounce this right -- bicornuate uterus.
Just in layperson's terms, what does that mean?
A So a bicornuate uterus is when we -- in the lay- -- layperson's terms would say it's a heart-shaped uterus, so -- as com- -- as compared to a -- a uterus that doesn't have that, which would have more of a -- a -- a

47

pear configuration at the top. It's more smooth and rounded.
Bicornuate would have an indentation at the top, so you'd have a right and a left side once you look inside or when it's seen on ultrasound or imaging studies.
Q Have you ever encountered that in a patient before?
A Yes. I've seen bicornuate uterus many times in my career.
Q Okay. And what -- what percentage of women do you think have that?
A I'll say --
MS. HALL: Form, foundation -- sorry, Doctor -- form, foundation.
Go ahead.
THE WITNESS: I would -- I would have to -- based on my -- I would say it's less than 25 percent. I'd -- I'd probably say that's probably like 10 percent chance of that. But I'm -- I'm just trying to --
Q (BY MR. BREEDEN) Okay.
A And the reason -- and the reason why I say that is because I would say the majority of patients that I see, we don't perform imaging that would document that.
So I don't know -- you'd -- you'd only be able to diagnose that or give a percentage based on if you took

48

every patient and found out. But most of the time we only find out when we're doing an imaging study, and which is not the majority of our patients who don't need -- have an issue to be worked up.
Q Yeah, because neither of these conditions, a retroverted uterus or a bicornuate uterus -- these are not highly dangerous urgent medical conditions for most women, correct?
MS. HALL: Form.
THE WITNESS: I would say having a retroverted uterus or a bicornuate uterus by itself is not what you -- like -- you said an urgent medical condition?
Q (BY MR. BREEDEN) Yes.
A I -- I would not say that.
Q Many women walk around with them in the general population and don't even know that they have that anatomy, correct?
A I would imagine that to be true, yes.
Q They -- they tend to maybe not know that unless they have a problem, for example during a pregnancy, correct?
MS. HALL: Form, incomplete hypothetical.
THE WITNESS: I can't tell you when a patient would find out she has a bicornuate uterus or a retroverted uterus.

Q (BY MR. BREEDEN) Okay. Most would need to have some sort of imaging study to even find that out, wouldn't they?
A I would say for a bicornuate uterus, yes.
For a retroverted uterus, no. We -- we usually can diag- -- diagnose that by a pelvic exam.
Q And you also knew prior to the procedure on April 26th that Ms. Taylor had a bicornuate uterus, correct?
A Yes. I was aware of that, yes.
Q Okay. So, again, that was not a condition that surprised you mid-procedure. You knew that was her anatomy beforehand.
A Yes. I was not surprised by the bicornuate uterus.
MR. BREEDEN: Okay. And so I'm going to hand you now what we'll have marked as Exhibit 2, and basically this is just your operative report. It's Bates labeled BRILL 89 and 90.
I got a copy for you as well.
MS. HALL: Thank you.
(Plaintiff's Exhibit 2 was marked for identification by the reporter.)
Q (BY MR. BREEDEN) And so we're going to talk quite a bit about this operative report and -- and walk

through it a little bit.
You're welcome to refer to it as I ask you questions.
A Thank you.
Q So what sort of symptoms or problems was Ms. Taylor having that led you to perform the procedure on April 26th?
A So I -- I summarized her indication for surgery as being a 45-year-old woman with a history of menorrhagia at the time of the surgery as an indication for surgery.
Q Okay. And just in laymen's terms, what is menorrhagia?
A So menorrhagia is the -- the term for heavy menstrual flow that's -- a patient is symptomatic or bothered by.
Q Okay. And what other findings had appeared on ultrasound?
A So just looking at my report, I documented at least here ultrasound showed a bicornuate uterus with fibroid in the right horn.
And I think that's what you asked, what else it showed.
Q Okay. And so what procedures did you intend to perform?
A So the intended procedure was a dilation and

curettage of the uterus with hysteroscopy with fibroid removal and hydrothermal endometrial ablation.
Q Okay. So let's sort of walk through each of those in laymen's terms.
What does the dilation in that procedure mean or refer to --
A Dilation refers --
Q -- in that phrasing?
(Reporter interrupted; multiple speakers.)
Q (BY MR. BREEDEN) What does that term dilation mean or refer to?
And I'm sorry, that was my problem, I did a rambling question.
A Dilation refers to the dilation of the cervix and able -- to be able to enter the uterine cavity for visualization and to perform the rest of the procedure.
Q And then curettage, what does that refer to?
A Curettage is the procedure where I use a curet to sample the lining of the uterus during the surgery.
Q And then hysteroscopy, what does that refer to?
A Hysteroscopy is the placement of a -- of a endos- -- endoscope or camera that's intended to go inside the uterus. Hyster is -- it means uterus. So it's placing a camera inside the uterus for visualization.
Q Okay. And this is, for lack of a better

description, a -- a long thin tube that has a camera on the end of it and some other instruments that are inserted into the uterus, correct?
A So there's different kinds of hysteroscopes.
But a hysteroscope is a -- a telescope kind of device with a camera lens on one end, and then we visualize the -- the -- the part that gets attached to the video screen is on my end. It also has other channels on it for in- -- input of fluid and the output of fluid. And then depending on what kind of hysteroscopy, there's usually a channel for procedures to be performed through the -- through an operative channel or port on the hysteroscope.
Q Fibroid tumor removal, explain what a fibroid tumor is in this context.
A So a fibroid tumor is a smooth muscle tumor that is seen very often in women.
And in this context of Ms. Taylor's case, because her fibroid was noted to be in the right uterine horn, I believe, based on what I'm reading here, if I was able to visualize the fibroid hysteroscopically, my intention was to remove as much of the fibroid as possible at the time of the surgery.
Q Okay. And it indicates you intended to perform hydrothermal endometrial ablation.

53

What does that mean in layperson's terms?
A So endometrial ablation is where we try to destroy the endometrial tissue, and there's different ways to do it.
The purpose is to try to reduce menstrual flow, so someone has -- will hopefully go from a symptomatic heavy cycle of -- or menstrual flow to a much lighter menstrual flow that she can tolerate.
And hydrothermal is the particular technique that I was intending to use, where heated water is placed throughout the uterine cavity over a specific amount of time to perform the ablation and complete the procedure.
Q Okay. Now looking at this operative report, before we go any further, it says -- you know, right under the little square that says operative report, it's on the left, it says service date and time, 3-20-2013.
What's the significance of that?
A I have no idea. I would say that's an error.
Q That appears to be some sort of error in the report.
A Correct.
Q Okay.
A I know that next to that is the proper day and time, at least when the -- when the note was started --
Q Okay.

54

A -- or the procedure was started.
I don't -- I don't -- I didn't notice that, and I don't know why it would say that.
Q So that's just a typo in there referring to a 3-20-2013 date.
The -- the procedure actually began on 4-26-2017 at 8:06 Pacific time?
A I know that -- I think this implies that the note was opened at 8:06. I don't -- I don't -- honestly don't recall the time the surgery actually started though.
Q Okay. So if -- if you look further down on that, it says perform information, and then to the side it says Brill MD, Keith, and then it says 4-26-17, 8:08 Pacific time.
So what -- what does that mean, perform opera- -- information?
A Again, I -- I'm -- I'm not certain what that means.
I believe this is just when the notes are -- is opened up in the charts. I -- this has nothing to do as far as I know about the start and stop time of the actual surgery.
Q Okay. And then -- so similar question, below that it says sign information, and then to the side of that it says 10:08.

55

Do you know what that indicates?
A So to me, looking at this, that's when I completed the notes and electronically signed it that I was comfortable with what the notes said.
Q Okay. Looking further down, it indicates, under operation, dilation and curettage with hysteroscopy. So that's -- that was mentioned under your indication for surgery as well. And then it says, quote, partial resection of uterine septum, end quote.
Did you perf- -- intend to partially resect the uterine septum prior to beginning the procedure?
A So a bicornuate uterus, like we mentioned earlier, is part of a continuum of different kind of diagnoses, where I mentioned the heart shape. The heart shape can be a very narrow or shallow or it can be deeper. So a septum in this case, which did not go all the way down to the -- to her cervix, is part of the bicornuate -- bicornuate uterus.
So to visualize and to perform the resection of the fibroid, that was performed to be able to visualize better.
Q Okay. Did you know that you were going to perform a resection of the septum before you began the procedure?
A My intended surgery was removal of the fibroid.

56

And based on my recollection of the anatomy, the fibroid appeared to be behind that septum going towards the right side of the uterus.
So part of a procedure to remove a fibroid hysteros- -- hysteroscopically -- with a hysteroscope, you have to be able to get to where the -- where the fibroid is.
Q Okay. So my question maybe is a little finer, and -- and perhaps you're not understanding it.
But did you believe that you were going to have to perform a partial resection of the septum before you began the operation, or is that a decision you made mid-procedure based on what you saw once you got the scope in there?
A Let me just look at my chart real quick, if that's okay.
So from what I wrote, I said there was no obvious fibroid seen because there was white tissue here, and I felt that there could be the septum covering the area, so I made the decision to switch over to the resectoscope and was set to visualize what appeared to be the septum.
So to -- the intended procedure was to successfully remove a fibroid. At the time of the surgery, I saw the septum on top of this area and made the decision to make my approach to the fibroid by entering

57

this area where the septum was.
Q Okay. Did you tell Ms. Taylor in advance of the surgery that it may be needed that you would resect the septum?
MS. HALL: Form.
THE WITNESS: So sitting here today, I don't recall the -- the exact details of what every detail of the surgery procedure would be. My surgery counseling always says that there are -- could possibly be other procedures that need to be done, as indicated.
And for me to remove the fibroid that was behind the septum, that was what needed to be done, but...
Q (BY MR. BREEDEN) So you've given a nice answer.
But the bottom line of your answer is that your response is you can't recall specifically discussing that with Ms. Taylor, can you?
MS. HALL: Form, misstates his testimony, and it's argumentative.
You can answer, Dr. Brill, again.
THE WITNESS: So not having seen a septum, I couldn't have that conversation with her.
Similarly, if I would have seen a uterine polyp or another lesion that I felt would have been indicated to remove, which happens frequently during surgery, I can't say that I have a conversation with the patient until it's

58

seen during surgery. And if I feel it's my -- it's -- the most prudent decision is to proceed to perform that while we're doing the surgery, that's what I usually would do.
MR. BREEDEN: Okay. The -- the next part of this under operation says using a Symphion resectoscope.
I'd like to provide you with another few pages of documents that begin with TAYLOR1769, and we'll have this marked as the next exhibit. I think that's Exhibit 3.
MS. HALL: Are you finished with Exhibit 2?
MR. BREEDEN: No.
MS. HALL: No. Okay.
MR. BREEDEN: We'll be going back to this.
MS. HALL: I just want to get this out of your way --
THE WITNESS: Okay.
MS. HALL: -- so that we don't get these mixed up.
So it's 2.
(Plaintiff's Exhibit 3 was marked for identification by the reporter.)
Q (BY MR. BREEDEN) Take a look at Exhibit 2 [sic]. I will represent to you that these are pages from a Symphion manual.
Looking at the system as it appears here on the exhibit, is that the system that you used with Ms. Taylor?

59

A Yes. I believe it is the system I used at the time of the surgery, yes.
Q Okay. And if you actually look at the second page of the exhibit, which is 1770, we see figure six, the resecting device; do you see that?
A I do see figure six, yes.
Q And, again, so that -- that sort of looks like a long needle, and then it's got some instruments on the end for doing the procedure; is that fair?
A This is not a needle. It is an operative device that goes through the operative port of the hysteroscope.
You can't see it in the picture, but the -- at the number one area, that's the area where the instrument is used to resect tissue.
Q Yeah. And I didn't mean to imply that it is a needle. It -- it clearly is not. It's just rather long and thin, and it -- and it is inserted through the hysteroscope, correct?
A Yes, that is correct.
Q All right. And also if you could look at TAYLOR1776, that should be the next page of that exhibit, do you see figure 38 on that page?
A I do see figure 38, yes.
Q That's essentially a figure showing how the tip of the resectoscope works; would you agree?

60

A Yes. I see a picture of a lesion on the left side, and it looks like the resection portion of the -- of the device is directly next to it.
Q How long have you been using the Symphion system to perform these procedures?
A I don't remember exactly when I started, but it's been for at least -- at least several years even prior to Ms. Taylor's case, but I don't recall the exact start time.
Q Do you recall when the Symphion system hit the market?
A I don't recall specifically, no.
Q At the time you performed Ms. Taylor's procedure, how many times do you -- have you used the Symphion instruments in other patients?
A Sitting here today, I don't have an exact recollection cause I perform so many resectoscopes and I use different devices.
But I -- I would -- I would say 20, 30, or more, but I'm -- I'm -- I'm guessing, but it -- I mean I used it often. There's multiple different options for using a resectoscope, and this is one of them that I use.
Q Okay. So you indicated you had performed hundreds, if not more than a thousand, of these procedures; but you're saying at the time of this

61

procedure, you had only used this particular device perhaps 20 or 30 times.
A Well, if I recall your question, you asked in my career, and I believe this only was introduced on the market, like I said, in the -- in the -- the near past.
So -- I mean I've -- I've used it many times. But, you know, I'm -- I'm going back to 1999 time frame. It's -- it's -- there's a lot of hysteroscopies I performed. But resectoscopes of this device I would say is probably somewhere in that area of the number I mentioned.
Q Who trained you to use the Symphion products?
A Symphion, I believe I was trained at a course for this and -- as well as by representatives from the company cause it -- it came out after our residency training, so I didn't learn it from my residency training back in the '90s.
Q And do you recall when you received that training?
A I don't. I -- I -- I don't believe we started using this -- the instrument was released on the market -- I don't remember when it was introduced in the Nevada market, but it was -- it was before I performed my first procedure, which, you know, had to be, you know, at least five to six years ago, I would say.

62

Q So five to six years ago from today, so --
A Correct.
Q -- 2015? 2016?
A Correct.
Q And this procedure was in April of 2017, so --
A Correct. I don't know the exact -- I don't know the exact day when I first started my training and started using this.
Q Do you recall the names of specific doctors or Symphion representatives who trained you?
A I do not recall that, no.
Q What was the training like?
A So it was a -- courses for operative hysteroscopy, where usually there are vis- -- video demonstrations followed by model demonstrations.
I know I've done resectoscope courses where there are also cadaver labs. I don't specifically recall if we used a cadaver lab though for Symphion, so I don't want to testify. I don't -- I don't recall today.
Q Do you have any written materials from that training?
A I don't know if I do, more than the instructions for use manual, which I believe I have.
Q How's the Symphion resectoscope differ from a traditional resecting device?

63

MS. HALL: Form, calls for an expert opinion.
THE WITNESS: So when I make a decision on what kind of resectoscope I want to use to resect tissue -- what I think is unique about the Symphion is its safety features, the fact that it uses bipolar energy, and that is meant to minimize the risk, although the risk is never zero, of injury from the thermal energy that's -- that's used. I also like that you can directly see where the actual cutting -- or -- or not cutting, that's the wrong word -- but where the resection occurs. It's in your field, and it's not direct -- it's not the tip of the device.
So, again, what -- what was the exact -- did I answer the question? Or what was the question you asked?
Q (BY MR. BREEDEN) Well, you -- well, you did, but -- you know, a traditional resecting device sort of looks like a little wire loop on the tip of the device, right?
A So previous to -- to these -- this kind of proc- -- device, there were mono- -- monopolar, which is a different kind of energy, devices, with loops -- with a loop. That procedure is a -- is -- is an older technology. It -- it ha- -- it uses, like I mentioned, monopolar energy, which I do feel has higher risks. Also, you have to use certain kinds of distension fluid inside

64

the uterus to avoid the energy from the loop spreading to other -- to -- to other areas.
So in my 21-plus-year career, I've seen improvements in technology, which were meant for safety, and that's one of the reasons why I chose the Symphion for many of my patients.
Q At any point in time, did you begin exclusively using the Symphion?
A Exclusively, you're meaning not using any other device for resection?
Q Correct.
A So there are other devices that I still have used, depending on the patient, that are -- that are still in -- on the market and available at our hospitals here today.
Q Did -- did you ever begin predominantly using the Symphion system; and if so, what -- when did that occur?
A I wouldn't say I predominantly. It's -- it's part of my -- my training armamentarium.
I would say there's -- there's two to three devices that I -- I still use routinely, this being one of them.
Q Okay. And why did you select the Symphion devices specifically for Ms. Taylor?
A So I feel the safety of this device, especially,

65

like I mentioned, using bipolar energy -- bipolar energy means there's less chance of spread. And also, it doesn't use a sharp instrument for the cutting. There's no actual cutting device there. It uses this energy to try to pull the tissue inside.

I also chose this because it help- -- it can help reduce bleeding and because I knew we were attempting a fibroid removal. Fibroids can have bleeding. So knowing we had the option -- it has a coagulation option in case there's bleeding, that could help.

I also like that this device has a very specific safety system for the fluid intake and -- and output, because this kind of procedure, if you do enter any blood vessels, you can have fluid with -- not very visible to you quickly under pressure going into pa- -- a patient's blood vessels. So this system is a closed system, so it measures very accurately, from my experience, how much fluid goes in and goes out.

So for a variety of reasons, I thought this was the -- the best for the safety interests of this surgery.

Q So safety was your primary consideration.

A Safety, to be able to complete this procedure, yes.

Q Uh-huh. And the -- the Symphion system is built around trying to be as safe as it can in terms of

66

preventing cuts and perforations to the patient, right?

A I -- I didn't design the Symphion. I don't know what their intention was.

I think their intention was to improve the availability of choices that we had on the market when performing this kind of surgery.

Q If we look at figure 38 on TAYLOR1776, it has a very blunt, dull tip to try to avoid perforations, doesn't it?

MS. HALL: Form, foundation.

THE WITNESS: I mean I'm -- I'm looking at the same picture you're looking at. I -- I can't tell you -- I think it is -- I think it is curved at the end, so it's not pointing. You mentioned dull. I -- I mean I'm looking at what you're looking at.

But I believe it was designed to try to reduce uterine perforation, if possible, but not to get rid of the risk completely.

Q (BY MR. BREEDEN) It -- it lacks a mechanical blade, in other words, like a little razor tool or something in there, right?

A That's my understanding, yes, that compared to some of the other devices that have a cutting tool that goes back and forth, this one does not do that, so it uses the energy to try to bring the tissue inside to -- to

67

remove it in small pieces.

Q That's right. It -- it cuts with heat that's generated from radiofrequency, correct?

A Yes. My understanding is is radiofrequency energy is used.

Q And so if I took one of these resecting devices, the tip of it, and I sort of rubbed it on my skin, it doesn't have anything like a razor, and it's not constantly hot that I would burn myself, and it's designed for that purpose, right? It's designed only to cut when the device is engaged, correct?

MS. HALL: Form, incomplete hypothetical.

THE WITNESS: So you need to -- to be able to resect tissue, you have to actually push the pedal for the resectoscope, and that's what generates the energy to -- to cause the -- the cutting effect, even though it's not a cutting blade, like you mentioned.

That doesn't mean there's not going to be energy transmitted. And it doesn't mean that if you touched it immediately after, it might not be wa- -- it might be warm. But if you just take the device out of the box and touch your skin, there's no sharp edges, at the end of it, at least, and there's -- it doesn't feel warm --

Q (BY MR. BREEDEN) It's --

A -- to my understanding.

68

Q It's designed to cut only when the physician is operating one of the pedals, right?

A Yes. To get tissue inside the resectoscope portion -- the resection portion, you have to plus -- press the pedal for it to activate.

Q And if you look at figure 38, the design is interesting to me because it -- it kind of looks like a ballpoint pen that a little bite is taken out of. So that when you're using it, the -- the cutting element or the resecting element is sort of protected, so it makes it more difficult for that element to accidentally touch tissue you're not trying to resect, doesn't it?

MS. HALL: Form.

THE WITNESS: Yes. So -- I mean looking at the device -- and, again, why I think this is a -- a -- a -- a device that I use for these kinds of procedures, it's meant to have the tissue enter the resectoscope at the upper side of it, not at the distal edge of it, so you can have adequate -- adequate visualization of the tissue that's going into the device during the resection.

Q (BY MR. BREEDEN) And -- but look like in -- in figure 38, even if the resecting device is touching tissue on the right side, the -- the device is shielding that tissue from the resecting element there that get- -- that gets hot so that it won't cut it.

69

Do you agree with that?
MS. HALL: Incomplete hypothetical.
THE WITNESS: So I don't know the temperature of that area. I -- I don't think I've ever -- you know, this isn't a hysteroscope in any uterus when we're -- when I'm activating the -- the -- the energy, so I can't tell you it's not warm.
But the energy transmits between like one pole and the other pole. That's the bipolar. So it should stay in between that area. I mean I can't tell you how much might be spread, so it might be warm. But it's meant to contain the energy within the two poles of the upper and the lower end of that opening for the resection.
Q (BY MR. BREEDEN) Well, you're the physician performing this operation.
Are you telling me you don't know how this device is to be applied against tissue to cut it?
MS. HALL: Form, misstates his prior testimony.
Q (BY MR. BREEDEN) It's designed to cut the tissue that's only in that little window, right?
A So I -- I never stated what was part of your first question.
I do understand how this -- how this works. And yes, it's meant to have the opening window go next to the tissue and to remove that area that's in that resection

70

portion of the resectoscope.
Q And it's designed so that if the tissue is not in the opening window, it's not going to cut it, right?
MS. HALL: Form.
THE WITNESS: If the tissue is not directly adjacent to that, it should not cut that tissue, that's correct.
Q (BY MR. BREEDEN) In your opinion, is this a safer method of performing this procedure as opposed to a resectoscope with a mechanical blade, in other words, something you could accidentally press up against tissue and it might cut it?
MS. HALL: Foundation, incomplete hypothetical.
THE WITNESS: I don't know what you -- honestly what you mean by safer.
I think this is a safe device, and when properly done, which I -- you know, when I perform these procedures, it's meant to re- -- to pr- -- to remove tissue in -- with the device getting the energy just in the area where you can see it.
Q (BY MR. BREEDEN) When the procedure is properly performed, like you just said, it's designed to make it very difficult to perforate or cut where you're not supposed to, right?
MS. HALL: Foundation.

71

THE WITNESS: I don't think anyone ever expects there to be a perforation during any surgery.
This surgery, as I mentioned, has this risk. So this device can help reduce that risk. And, again, that's one of the reasons why I chose it, especially knowing her anatomy, which I was aware of.
But, you know, again, I can't tell you why -- if it was designed specifically to reduce the risk of uterine perforation. I think that's what you asked.
Q (BY MR. BREEDEN) Well, do you agree as a surgeon that one of your primary concerns during this procedure should be to avoid causing a perforation?
A I think safety is the most -- the most important part of any surgery I perform. And even though a perforation can have -- happen in -- in the best of hands of any surgeon, it's a known complication, and it -- it -- it did occur in Ms. Taylor's case.
But it's -- it's always a concern. I'm always concerned about this --
Q Okay.
A -- if that's the question.
Q Okay. Now, can a perforation occur also because the physician is careless or negligent?
MS. HALL: Form, incomplete hypothetical.
THE WITNESS: First of all, in this case I'm

72

adamantly saying I was not negligent. I -- I know you're asking me a hypothetical question.
I performed the surgery properly and was able to identify and recognize the perforation.
But if you're asking about some other surgeon who doesn't know what they're doing and is performing the procedure without proper training and does- -- and not following the proper training that they were trained to do the surgery, I mean that's a theoretical question, but that's not what happened here.
Q (BY MR. BREEDEN) So there are at least some cases where you could concede the perforation could be caused by the negligence or the carelessness of the physician.
MS. HALL: Incomplete hypothetical, calls for speculation.
THE WITNESS: I only perform surgeries with -- with me being the primary surgeon. So you're asking a theoretical risk that -- I mean there could be any physician who's not properly trained and decides to use a device. That's not me. That was not this case.
You're asking, again, a hypothetical question that -- you know, I was trained to perform this procedure, and I performed to the best of my ability at the time of the surgery the way I've always been trained.

73

Q (BY MR. BREEDEN) Well, that's exactly what this case is about, right? Whether this perforation and the injury to Ms. Taylor was avoidable or whether it was because -- whether it was caused because you were careless in the manner that you used the instrument and did the cutting.

Would you agree with that?

MS. HALL: May I have that question read back.

THE REPORTER: "Well, that's exactly what this case is about, right? Whether this perforation and the injury to Ms. Taylor was avoidable or whether it was because -- whether it was caused because you were careless in the manner that you used the instrument and did the cutting.

"Would you agree with that?"

MS. HALL: I'm going to object to the extent that it calls for attorney/client communication.

But outside of our discussions, you can answer the question, Dr. Brill.

THE WITNESS: So every surgery that I perform has risks and benefits, and there's known risks of complications. It's unfortunate that it happened here.

74

But I do not agree with you at all that that means the surgery is done carelessly, or recklessly, I think that's the word you used.

I performed the surgery properly the way I performed the surgery, and unfortunately there was a complication that's a known risk to the surgery.

Q (BY MR. BREEDEN) Well, let's -- well, let's talk about this.

And even if something is a known risk, that doesn't mean it's unavoidable, does it?

MS. HALL: Form, incomplete hypothetical.

THE WITNESS: Any surgery has -- can -- a risk can occur, even in the best of hands. And no one intends for a complication to happen. It's -- like I mentioned, safety is always my number one priority when performing a surgery, or choosing to stop a surgery, when we chose to stop in this -- in Ms. Taylor's case, but a complication can -- even in the best of hands might not be avoidable.

Q (BY MR. BREEDEN) Okay. Did you use the best of hands in this particular procedure?

A Yes. I performed the surgery the best of my ability, the way I was trained, and I believe I performed the surgery medically to the best of my judgment and to my skill.

Q A procedure where an instrument or cutting went

75

all the way through the uterus and caused a three-centimeter perforation to the small bowel you think was done at -- to the best of your ability?

MS. HALL: Form, foundation.

THE WITNESS: So at the time of the surgery, there was no evidence of any bowel injury.

I believe you're referring to the operative report of the general surgeon from the next day, where a three-centimeter opening to the bowel was seen. I still here to this day cannot tell you when that bowel injury occurred.

Bowel injuries can change. The bowel is an active organ, as you know. It continues to dige- -- digest food.

And, again, I did not see a bowel injury at the time of the surgery. And that does not mean that a bowel injury couldn't get bigger with time.

So you're asking me was it a -- something that should have been avoidable. There was no evidence of bowel injury at the time of the surgery.

Q (BY MR. BREEDEN) How -- how many cases in your medical career of spontaneous bowel perforation have you ever seen?

A I don't understand your question.

Q Well, you -- you seem, again, to -- to try to be

76

saying you don't think the surgery caused the bowel surgery -- perforation.

Well, it most certainly did, didn't it?

MS. HALL: Form, misstates his prior testimony.

THE WITNESS: So I don't -- don't believe I ever said that.

I said I don't know when the bowel injury occurred. It was not visible at the time of the surgery. That's what I had said.

Q (BY MR. BREEDEN) Okay. Well, we're -- we're going -- we're going to talk about that in -- in just a second.

Let's go through your operative report a little more here, and you can look at the second page of it.

THE WITNESS: You have it here?

MS. HALL: Yeah. One second.

Q (BY MR. BREEDEN) BRILL 90, and we're going to start with the area that says technique; do you see that?

A I do see that.

Q Okay. So I'm going to read from the report, and so I'll indicate "quote" and "end quote," and then I'll -- I'll ask you questions, okay?

Quote, the patient was taken to the operating room and properly identified. She was placed on the operating room table and given general anesthesia and LMA

77

by the anesthesiologist, end quote.
So this procedure is done under complete anesthesia to the patient, correct?
A Yes. The patient's under general anesthesia. And LMA is the method that the anesthesiologist gets the anesthesia into the patient's lungs.
Q Okay. So it's not twilight anesthesia. The patient isn't partially conscious. The patient can't tell you oh, I feel pain or discomfort or anything like that.
They are completely out, correct?
A Yes. They are under general anesthesia, which means they are asleep during the surgery.
Q Okay. To continue, quote, she was then placed in a lithotomy position using candycane stirrups. Her lower abdomen and vagina were prepped and draped in the normal sterile fashion. Her bladder was straight catheterized for a small amount of urine by the operating room nurse, end quote.
So the -- the lithotomy position, is -- is that sort of the classic position we see when for example a woman is giving birth?
A Yes, that's correct. That's when a patient is pretty -- I mean in lay terms -- laymen's language is placed into stirrups. Lithotomy position is when the -- the legs are elevated so I have -- can have adequate

78

visualization and approach to the pelvis.
Q To continue, quote, an examination under anesthesia was done which revealed a retroverted uterus approximately eight week size, end quote.
We've already discussed this, and that was nothing unexpected by you from what you knew prior to the procedure, correct?
A Yes, that is correct. I was aware of it. I was just documenting it during my exam here during anesthesia.
Q And it's certainly possible to safely perform this procedure on a woman with a retroverted uterus without causing a perforation to any organs, correct?
MS. HALL: Incomplete hypothetical.
THE WITNESS: Yes. A retroverted uterus is not a contraindication to perform hysteroscopy.
Q (BY MR. BREEDEN) The note continues, quote, a timeout procedure has been performed, end quote.
Tell -- tell me what a timeout procedure is and why it was done at that point in the procedure.
A Yes. So prior to any surgery that is performed, the timeout procedure is where everyone stops what they're doing and we identify the patients and identify the procedure, make sure that everyone is aware of what we're doing.
It was a safety measure that was taken -- that

79

was made -- made by most hospitals years ago when there were reports of people operating on the wrong limb or it's -- you know, operating on the wrong side of a body.
So even though this was not on a particular side, every surgery we perform, there's a timeout to make sure we're doing the -- or in the right place, have the right patient, doing the right procedure.
Q So that had nothing to do with Ms. Taylor's case specifically or Ms. Taylor's anatomy.
A That's correct. We -- we do a timeout procedure on every -- on every -- on every surgery.
Q Now the -- the next couple of sentences describe the dilation and insertion of certain instruments. I'm -- I'm going to skip those.
I'm going to go down a couple lines and begin, quote, I placed a diagnostic hysteroscope into the uterine cavity being careful to follow the pathway of the dilation. Normal saline was used for distension medium, end quote.
Did you have any trouble with distension of the uterus?
A Looking at this operative report, and to the best of my recollection, there was no -- I have no mention of that in my report, so I do not believe there was any issue with getting saline to distend the uterus.

80

Q And distension just means you are sort of filling up the uterus with saline, sort of blowing it up like a balloon; is that fair?
A It's similar to that. The -- the uterus is not made of rubber, of course, or latex, of course.
But in -- you know, whatever you look at, you know, pictures like you showed earlier or you look at cartoons of the uterus, it makes it look like there's a -- a large cavity of empty space just sitting there, and that's not the case.
The -- the anterior and the posterior of the wall -- walls of the uterus usually are against each other. So to be able to visualize, you need to place something inside. So we use saline to expand the walls. It's not blowing it up like a balloon, but just to expand the walls so we can get ade- -- adequate visualization of the interior of the uterus.
Q Now if there'd been a perforation at that time, you likely would have encountered some problems with distension, right? Because there would be an outlet for the saline.
A Correct.
So also, when I place the uterine sound inside, which is the blunt instrument that's used to measure the depth of the uterus, that's also a way that we can try to

81

dis- -- detect that there could be a uterine perforation.
So I had no evidence of a uterine perforation at that time when we first placed the saline for distension medium.
Q Okay. Your note continues, quote, I was able to see what appear to be a white uterine septum and two small areas that appear to be the uterine horns, end quote.
Why do you use the term what appears to be? Were you confident that you were looking at a septum?
A Yes. So I -- this goes into semantics, I would imagine.
But I already mentioned a bicornuate uterus can be in a continuum with a septum. It's a terminol- -- again, it's a term that I use in this case where the lower end of the bicornuate uterus is dis- -- is going farther down into the uterus.
So I don't have a better term to use of that lower aspect of a bicornuate uterus than a septum. That's a piece of tissue that's going down and -- again, in that heart-shaped. There's no like other name for it that I'm -- that I'm aware of. We don't call it the upper end of the bicornuate uterus. We -- based on what I saw, I was calling what appeared to be a septum.
MR. BREEDEN: We've been going for close to two hours. We did take a little break while I printed off

82

some materials.
Does anyone need to take a break?
THE WITNESS: I'm okay.
MR. BREEDEN: Okay. I'm -- I'm going to proceed then, and maybe we'll take a break in another half hour.
THE WITNESS: Take a sip of water.
MS. HALL: Sure. Take a drink of water.
And while you're taking a drink of water, I just want to remind you to slow down how fast you're speaking so our court reporter can make sure to take it down.
THE WITNESS: I apologize.
Q (BY MR. BREEDEN) The note continues, quote, there is no obvious fibroid seen at the right side because there was white tissue here and I felt that there could be the septum covering this area. Pictures were taken, end quote.
When you were performing this procedure, you couldn't find the fibroid tumor you intended to resect, could you?
MS. HALL: Form, misstates the evidence.
THE WITNESS: So when I'm visualizing the uterine cavity here, I'm looking for where the fibroid tumor -- tumor would be located before it could be removed.
And based on the anatomy and what was described in the ultrasound, it was in the right side or right horn

83

of this bicornuate uterus. So it was directly behind where this septum was located based on my understanding of the -- of the anatomy at that time.
Q (BY MR. BREEDEN) But you couldn't immediately find it visually, could you?
A According to my op report, I said there was no obvious fibroids seen at the right side. Then I give my explanation with the white tissue here.
Q So your plan that you formed at that time then was to begin resecting the septum, cutting the septum, to try to find the fibroid, right?
A Yes. I made the decision to change to the resectoscope and to remove the septum, which, again, is located in the inside of the uterus in this heart shape.
And then if you think of the heart shape, if I'm looking at her, this is the right, this is the left -- so I know the camera's probably reversed -- but the fibroid, according to the ultrasound, should be right behind that in the right side.
So I made the decision to -- on the inside of the uterus, where the camera's here, to start to sha- -- try to resect this to get to the -- where the fibroid should be based on her anatomy.
Q Okay. Now the septum is -- is part of the wall of the uterus, right?

84

A So the septum is part of the inside of the uterus. So if you're -- you know, trying to describe it as best I can, the outside of the uterus has, you know, a skin, so to speak, which -- or it's called a serosa. I'm looking at the inside cavity, so I'm looking at the indentation tissue here on the inside. It's -- it's -- usually I'm looking on the inside of the uterus. I'm not looking at the outside wall of the uterus. I'm looking at the inside.
Q Well, how can you be sure where the septum is in relation to the outside wall of the uterus? Could be very close or there could be quite a bit of room, right?
A So based on my medical judgment, my experience, based on what I saw, the septum appeared to be over the right horn of the uterus, which, again, is inside the uterine cavity.
So based on what I saw at the time, based on my medical judgment and decision-making, it felt like it was right adjacent to the right horn and was able to be resected, as opposed to the upper area, where it might be, you know, right adja- -- adjacent to a wall.
A septum -- I was at the lower end of the -- of the septum. By definition, there's going to be a part that's all the way at the top, but that's not where I was doing my resection. It was at the lower part down here.

85

Q So you never found the fibroid, did you?
A So because the surgery had to be stopped, I never identify a fibroid based on stopping the procedure.
Q Your solution, when you couldn't find the fibroid, was to start cutting parts inside the uterus to try to find it, right?
MS. HALL: Form, foundation.
THE WITNESS: So I've already mentioned what I -- what I performed, the idea that the septum was covering this right horn where the fibroid was located. So it's not a part. It's the exact part that I was able to visualize.
And I've removed septum before. This is not the first time. It's something that is typically done when this is seen. If you see a septum that's covering an area and it's a safe place inside the uterus, again, based on my medical judgment, the -- the next step would be to try to remove that.
Q (BY MR. BREEDEN) Other than searching for the fibroid tumor, was there any medical reason to start cutting the septum?
A The intention of the surgery was to remove the fibroid successfully and then to complete the endometrial ablation.
So there was no other reason for me to be inside

86

the uterus to look at the sep- -- to look for a septum, if that's what you're asking.
Q Okay. Because sometimes the -- the -- a procedure is performed on the septum for pregnancy reasons or fertility reasons, correct?
A Yes. So if someone has a known bicornuate uterus and they have either difficulty becoming pregnant or they have miscarriages, and that's identified as part of the workup for possibly being a cause, that's one of the reasons why I -- it's performed and why I've done this in the past as well.
Q And that's not the reason you were performing this procedure, right? You were doing it solely to look for the fibroid.
A Yes. The -- the initi- -- the intention of the surgery was to treat Ms. Taylor's menorrhagia, which we described. And part of the treatment was to remove the fibroid because it was inside the uterus and likely one of the causes of her bleeding.
Q Now the note continues, quote, I made the decision to switch over to the resectoscope and was set up. I had to dilate again to follow the proper pathway. I was able to place the Symphion hysteroscope into the cavity was able to visualize what appeared to be the septum, end quote.

87

Again, you use this qualifier, what appeared to be the septum.
Are you certain you were looking at the septum?
A I mean looking at my op report, I used the words what appeared to be.
Based on my medical judgment and what I saw, yes, I believed this was the septum.
Q Okay. Then why did you say what appeared to be the septum then? Was there doubt in your mind?
A I think that to get a final answer about exactly what a tissue is, you take a biopsy. And so it -- based on my visualization, this appeared to be the septum. And that's what I'm doing, I'm looking at this.
Ultimately, if tissue is removed, it would be told to me is this part of the uterine septum or this is possibly the fibroid that was beneath it.
Q Your note continues, quote, I used the yellow pedal and began to cut what appeared to be the septum anteriorly, end quote.
Now the yellow pedal refers to the pedal on the Symphion system that begins resection or cutting with heat, correct?
A Yes. That's what the yellow pedal -- pedal -- pedal is meant to do.
Q And we've discussed this before, that that

88

resection tip, it's not always sharp, and it's not always hot. The pedal has to be engaged to activate the heat cutting, correct?
A Yes. It has to be activated to generate the energy.
Q Okay. So this is the first time in the procedure you begin to cut any tissue, correct?
A Yes. This is where the resection began of the -- of the septum area.
Q And you were doing this on the anterior part of the uterus at the septum, correct?
A Correct.
So if I'm looking inside the uterus and there's a distension medium -- the septum, again, is a heart shape, so I'm looking more anteriorly, where the septum -- the bottom edge of the septum appeared to be, as opposed to going to the back wall of the uterus. It looked like it was more towards the anterior wall.
Q Okay. The note continues, quote, as I was able to slowly advance camera during this process there did appear to be a uterine perforation, end quote.
How large did the perforation appear to you to be?
A At that time it did -- it did appear to approximately be I would say about one centimeter,

89

although during a surgery everything is being expanded on a -- on a -- on a camera, on a screen. So it's not like it's direct visualization. It's being -- it's like having a TV expanded for you. So you're not looking at a -- I'm not looking at -- I'm looking at a TV on -- you know, right next to me. It's going to look much larger on the screen.

But just based on my experience doing this, I would say approximately one centimeter, so the size like the width of a -- of a -- of a finger, I would say.

Q And so why did you not list in your report how many millimeters or centimeters the perforation appeared to be?

A I would say that that's not something that I was prepared to do, meaning I didn't measure the perforation. I think it was important that I noted the perforation to -- because it had effects on the rest of the surgery.

Q Okay. The perforation occurred because of one of your instruments, didn't it?

A The perforation occurred during the process of advancing the camera during the surgery.

Q So do you think it was the camera device or the resecting device that caused the perforation?

A So it's all one resectoscope. So the camera -- when I say that I'm holding the part where that video

90

camera is attached, so that's what I'm touching on the outside of Ms. Taylor, and I'm advancing it, so that it's likely that tip area that we've seen in these pictures, that was what perforated as I advanced the camera slowly.

Q And what was the appearance of the perforation? Was it bleeding?

A So looking at my operative report, I have no mention of bleeding at the time, so I do not believe there was bleeding at the time.

Q You have no mention in the entire operative report of any trouble visualizing anything, do you?

A I'd have to review my whole report before I answer that question.

Q Go ahead.

A I was able to visualize the perforation, and I was comfortable with my visualization that there was no bowel injury at that time that was noted.

Q Okay. Well, we'll -- we'll talk about that in -- in a little bit again.

So the perforation did not appear to be bleeding to you even though it was a centimeter large?

MS. HALL: Form.

THE WITNESS: Yes.

And this is my experience with perforations that occur usually in the anterior wall, or even the fundus,

91

the top of the uterus, because the -- the major blood supply to the uterus is on the sides, much below of where I was operating.

So in my experience, perforations very often do not have active bleeding.

Q (BY MR. BREEDEN) Okay. As best as you can describe to another OB-GYN who performs these procedures, where in the uterus did this perforation occur? Where did you observe it?

A So as I was entering the area where the septum was covering the right uterine horn -- again, so I see this uterus that's not pear-shaped like this -- it's like this -- and I was cutting the septum, I would say it was at the anterior wall of the uterus, right at the lower edge of where the septum was. So right over -- right here, looking at it three-dimensionally.

Q In the area where you were resecting.

A Correct.

Q And did it appear to you to be a -- a clean perforation? Did it appear to be torn or jagged? What was the appearance?

A Sitting here today, I can't recall the exact appearances of it. But I do note there was a perforation and no evidence of bowel injury.

Q How long were you using the yellow pedal before

92

you observed this perforation?

A I don't have an exact recollection of that. I know I -- I mentioned that I'm advancing the camera to -- to use the energy to cut the septum; and immediately when I saw the perforation, I stopped that. But I can't tell you the exact amount of time sitting here today.

Q Your note continues, quote, again it was noted that the uterine horns were very narrow. I immediately stopped the use of the resectoscope device at the time of the perforation, end quote.

Why did you immediately stop the use of the resectoscope device?

A So at the time of a -- of a uterine perforation, whenever it's diagnosed, the -- the immediate appropriate step is to stop performing a procedure that's occurred at the time of the perforation, so --

Q That's -- that's the standard of care, correct, to immediately stop the entire procedure?

MS. HALL: Form.

THE WITNESS: The entire procedure was not what I said.

To stop the use of the resectoscope and to do my best at that time to visualize if there could be possible injury, which is always my concern.

Q (BY MR. BREEDEN) Well, what -- what does the

93

standard of care require you to do then in terms of continuing or discontinuing the procedure when you observe a port perforation in the uterus?
A I don't understand what you mean by port -- port perforation. Can you --
Q Okay.
A -- clarify that?
Q You are performing this procedure. You observe at some point a perforation in the uterus.
What does the standard of care require you to do in terms of continuing or discontinuing the procedure? In other words, are -- are you supposed to immediately stop? Are you supposed to continue? What's the standard of care?
A So I think the standard of care, first of all, will depend on the situation. I don't think there's one exact situation for every surgery.
Because I was confident that there was no evidence of bowel injury, the resectoscope portion was -- was discontinued. I did not -- I made a conscious decision not to proceed with the hydrothermal ablation.
But I -- but I don't think I would say it's standard of care to stop the surgery immediately at that time.
Q The note continues, quote, I removed the

94

hysteroscope and replaced it with the diagnostic hysteroscope. Again saline was used for distension medium and there did appear to be an anterior perforation, end quote.
So you went in for an -- an additional look at the perforation, right?
A Yes.
So the resectoscope is a larger device than -- in terms of its width compared to a diagnostic hysteroscope.
So with my immediate detection of the uterine perforation with the resectoscope camera, I did not visualize any bowel injury or have any indication there could be a bowel injury based on my experience.
So the diagnostic hysteroscope, which is a smaller device, I felt would be a safer way to get another look at this area, also be sure there might be -- not be bleeding that's happened subsequently. And that was my decision, to place the smaller diagnostic hysteroscope that I used initially to be able to visualize better.
Q Well, how many millimeters in size or circumference is the resectoscope you were using versus the diagnostic hysteroscope?
A So I -- I -- I believe the -- the Symphion is approximately six and a half millimeters, and the diagnostic usually is more in the -- in the -- in the

95

nature of four millimeters, so it's -- it's a smaller device. It only has the camera. It doesn't have those operative channels, and it doesn't have the channels to detect the input and output, which I like the Symphion for. Those take space. The input and output mechanisms are -- are outside of the actual area there.
Q Now it indicates you used more saline for distension medium, but you were able to properly visualize the perforation.
A Yes. Saline was used to distend the uterus again so I could visualize that area.
Q Okay. Now, your note continues, quote, there was no evidence of bowel or other organs at the area of the uterine perforation, end quote.
So your sole method of looking for injury to the bowel or other organs is the camera on the diagnostic hysteroscope, correct?
A No, that's not true.
I was able to directly visualize the perforation at the time with the resectoscope and did not see bowel injury at that time. And then I also did not see bowel injury or -- or bladder injury, I mean any -- any organ possibly injured at -- with the second scope as well.
Q Okay. So the resectoscope and the hysteroscope are inside the uterus, right?

96

A Yes, but not at the same time. That's -- that's where we were doing the surgery, yes.
Q Yes.
But you did not advance either tool through the perforation, did you?
A No. And neither would I or should I. That's not considered the standard of care, cause that by itself can cause more injury, and I would not want to do that.
Q Right. It would be very -- very dangerous to put an instrument all the way through the uterus into another organ, for example the intestine, right?
A Can you ask that again, please.
Q Yeah.
So the point is it would be very dangerous for you to put an instrument through the perforation all the way into another organ, for example the intestines.
A Of course. If you're asking if it's dangerous to purposely put an instrument into a -- an organ, yeah.
But that's -- that's not -- this is a complication that was unfortunate but a known risk of the surgery that happens.
Q You seem very proud of saying that you have checked for bowel perforation or damage to other organs and you didn't see any.
How could you possibly see those organs from a

97

camera inside the uterus?
MS. HALL: May I have that question read back.
THE REPORTER: "You seem very proud of saying that you have checked for bowel perforation or damage to other organs and you didn't see any.
"How could you possibly see those organs from a camera inside the uterus?"
MS. HALL: Form, foundation, argumentative. Go ahead.
THE WITNESS: So I'm -- I never used the word pro- -- proud.
I was confident in my medical decision at the time of this -- of the perforation that there was no bowel injury. So confident based on my surgical training and skill is what I'm talking about.
Do I ever want there to be a bowel injury, but I would -- I would state to you I do not believe it's the standard of care that whenever there's a perforation and there's no evidence of bowel injury that you must then proceed to another way to find a bowel injury that you don't think existed because you have no reason to believe so.
Q (BY MR. BREEDEN) How could you possibly have

98

visualized the bowel to rule in or rule out injury to the bowel with a camera inside the uterus? The camera can't see through the uterus, can it?
MS. HALL: Form.
THE WITNESS: So yes, it -- it can, from where it's looking.
So the uterus is here. Let's say there's a perforation here. We -- I can see that. So I can see behind that and see if there might be yellow adipose tissue which is associated next to the bowel. If I could see bowel, I can see bladder.
So we're not going inside. But a camera is seeing the hole. The hole didn't instantly close at the time of the perforation. So if there's bowel there, or bowel fluid or contents, I would see that.
And I am confident that I did not see it at the time of the surgery. If I did see it, the next step would be to look inside the abdomen, but I did not see it.
Q (BY MR. BREEDEN) Well, those internal organs are soft and move around, right?
A You're describing the bowel as soft and moving around? I don't know -- I don't know if I understand.
Q Particularly the intestines, particularly if something's hit it hard enough to perforate it, wouldn't you agree with that? If you hit an organ hard enough to

99

perforate it, you've hit it hard enough to move it, right?
MS. HALL: Form, foundation, incomplete hypothetical.
THE WITNESS: So at the time of the surgery, there was no evidence of any bowel injury, so I can't, again, tell you when the bowel injury occurred. I don't know if there was a bowel against this area cause I didn't see it at the time of the perforation. If I did see bowel there -- I mean I'm watching in realtime. It's not like I was advancing the camera. I mean I mentioned how careful I was doing the surgery, and that was my job to be careful.
And not seeing a bowel injury, but noticing a perforation, the standard of care in my opinion is not to proceed automatically to a surgery that has risks as well. Doing a laparoscopy is not a -- a surgery that doesn't -- doesn't have its own risks. That -- that also can cause injury. And based on my medical judgment, there was no indication to go to another surgery at that point.
Q (BY MR. BREEDEN) So you think you were careful in a surgery where the uterus had a one-centimeter perforation and the intestines behind the uterus had a three-centimeter perforation. You'd describe that as you being careful.
MS. HALL: Lacks foundation.

100

Q (BY MR. BREEDEN) That's what you think of your work in this case?
A I think I performed the surgery appropriately.
And I mentioned with -- the care that I took during this, trying to advance this very slowly. I make very I think detailed notes of her anatomy. I -- you know, I can't control her anatomy. Every uterus is different.
And the risk of complication can happen at any surgery. It happened here. And, again, that's unfortunate. But it's -- it's not something that was intended to happen. And yes, I believe I performed the surgery appropriately and adequately and within the -- the standard of care as -- as it's defined.
Q Now in some cases, after observation of a uterine perforation, laparoscopic surgery is done to inspect the bowel and nearby organs to see if they've been damaged, correct?
MS. HALL: Incomplete -- excuse me -- incomplete hypothetical.
THE WITNESS: So in a different surgery, if there would have been evidence of bowel or other organs possibly injured at the time of the perforation, the next indicated surgery, which I would have performed should I felt that was the case in Ms. Taylor's case, but, again, I didn't,

101

based on what I saw, would be to perform some kind of abdominal surgery, and typically I would perform a laparoscopy the way you asked.

Q (BY MR. BREEDEN) Would you do that, or would you bring in a general surgeon to conduct that?

A So typically I would start this kind of a procedure. I didn't do that here because I didn't feel it was indicated. And if it was not clear, based on what I'm seeing, that there was bowel injury, and I couldn't be confident, my next step would be to intraoperative -- call for an intraoperative consultation with a general surgeon.

But I believe that I would be able to start the -- the laparoscopy and to attempt to visualize the bowel. If there was any difficulty or any uncertainty at all, my next step would of course be to call a general surgeon or other surgeon that's capable of identifying the entire bowel.

Q And you did not consult with a general surgeon at all, did you?

A Again, I did not feel an indication for that based on what I saw, so the answer is no.

Q And you did not begin laparoscopic surgery to inspect for another perforation, correct? You didn't even start that procedure.

A Correct. It was not in my medical judgment at

102

the time necessary to go to the next surgery, which, again, could have its own risks.

Q You didn't perform any type of radiology or ultrasound or anything like that to look for damage to other organs, did you?

A So I'm not sure what you're -- radiology is a field. And no, I did not perform an ultrasound.

And I would say that -- that if I did suspect an injury, which, again, I did not at this -- in this case, the next step would not be a radiology procedure. It would be exploratory surgery.

Q Okay. So you -- you keep saying I -- I didn't -- I'm sorry if I get the phraseology wrong -- I did not expect another perforation; is that what you said?

A No. I didn't -- I didn't have indication that there was a bowel injury based on my direct visualization of the perforation at the time.

Q Yes.

So looking from the inside of the uterus through the perforation, you could not see an injury to any tissue on the other side.

A At the time of the perforation, there was no bowel or evidence of any other organ at the area of the perforation in realtime as it happens.

MR. BREEDEN: We have an issue with the recording

103

time, so we're going to take a break and go off the record.

Seems like a good time to maybe take a 10-minute break anyway.

THE WITNESS: Okay.

MR. JONES: We are off the record; 3:14 p.m.

(Recess.)

MR. JONES: We are back on the record at 3:23 p.m.

Q (BY MR. BREEDEN) Okay. Doctor, so before we went off the record, you know, what I was -- what I was asking you about is this -- this concept where you think from a camera inside the uterus you can properly inspect the bowel and other organs to see if they've been damaged as a result of a perforation.

You think that's perfectly acceptable?

A I do. I do. I believe that's the standard of care when a bowel injury is not suspected at the time of a perforation, and that's what -- what happened here.

Q Well, this was a one-centimeter perforation during use of a -- a cutting tool, right?

A So the -- the descrip- -- description was one-centimeter, again, in -- in the operative report from the surgeon.

So yes, using a -- a tool where there was a blunt

104

end, as we des- -- described, and where the energy field that we're using was visualized inside the uterus, yes.

Q And so you don't think that's suspicious of injury to other structures on the other side of the uterine wall?

A At the time of the perforation, there was no indication, no evidence, of bowel injury that I saw.

Q Well, that's because you didn't do the laparoscopic examination.

A I would say that's not the indicated procedure when you do not suspect this with uterine perforation. Uterine perforation does happen, we -- we said one percent of the time. And it is not the standard of care to perform an exploratory surgery unless you have concern that there's a bowel injury, and I did not have that concern based on my medical judgment and doing the surgery at the time.

Q Okay. And the only thing that you're saying did not give you that concern was from a camera inside the uterus, you believe you were adequately able to survey the bowel and intestines and determine there was no perforation there.

MS. HALL: Form, misstates testimony.

THE WITNESS: So if you're asking if I could perform a hysteroscopy to adequately see the entire

105

intestines, that is not what I said.
I said at the time of the perforation, I did not see any area of the bowel that was adjacent or, like I said, any other organ, such as the bladder, which is in the an- -- on the anterior wall of the uterus as well, at the time of the perforation.
Q (BY MR. BREEDEN) Well, there has to be some organ very close to that perforation, doesn't there? I mean the organs are all pressed up against each other, right?
A That's a -- that's -- that's not how I understand the anatomy of the bowel.
If you look at a -- at a typical picture, there's loops of bowel throughout the abdomen, but that doesn't mean they're necessarily next to the uterus at the time of the -- at the time of the surgery.
Q Well, I guess in Ms. Taylor's case it was, right?
MS. HALL: Form, argumentative.
THE WITNESS: Not knowing when the bowel injury actually occurred, it doesn't -- there was no evidence of bowel right next to her uterus at the time of the perforation.
Q (BY MR. BREEDEN) Your report continues, quote, because of the perforation I did not proceed with any further use of the resectoscope and I did not utilize

106

endometrial ablation device as well, end quote.
So basically you stopped cutting, and you did not perform the endometrial ablation that you had intended as well, correct?
A Yes, that is correct.
Q Your report continues, quote, I had performed sharp curettage after removing the hysteroscope, end quote.
Why did you feel that was safe to do, given that there was a noted perforation?
A So knowing the anatomy of Ms. Taylor, knowing where the posterior wall of the uterus was, as in a retroverted uterus, and because performing a curettage was part of the surgery that we had discussed performing, where I can get at least some sampling of the tissue, I felt performing a curettage, which I perform at every hysteroscopy, so over a thousand times, I could comfortably place the curet and have it angled so it's only touching the posterior wall of the uterus, and that's what I document in my op report.
Q Well, you apparently thought you were safely using the resectoscope and caused a perforation.
Why would you think using the curet is any safer?
A So I disagree with that question.
I do not -- I did perform the surgery safely.

107

You said I did not. And I did perform the surgery safely.
And, again, I did not see the perforation, and I still cannot tell you today what the timing of the perforation was.
So being a trained surgeon, using my medical judgment, I felt comfortable that I could use the curet and guide the curet in a posterior retroverted fashion to get some sampling of the posterior wall for a tissue diagnosis.
Q Now your report continues that you use a number two sharp curet and you took endometrial tissue for evaluation.
Why -- why did you do that, given that you'd already done a coloscopy within 60 days of this procedure?
MS. HALL: Form.
THE WITNESS: So I believe you mean colposcopy?
Q (BY MR. BREEDEN) Colposcopy. I'm sorry.
A That's okay.
Q Did I -- did I say colonoscopy?
A It's all right. You said coloscopy, which I --
Q Coloscopy.
A Somewhere in the middle.
(Reporter interrupted; multiple speakers.)
Q (BY MR. BREEDEN) I misspoke. I mean -- meant colposcopy.

108

A So yes, a colposcopy is a completely separate procedure, which was indicated due to her abnormal Pap and HPV results from the chart. It is only taking a biopsy of the outer portion of the cervix. It's not performing a biopsy of the inside of the uterus.
MR. BREEDEN: I'd like to show you some pictures that we'll have labeled the next exhibit, which I believe is Exhibit 4.
(Plaintiff's Exhibit 4 was marked for identification by the reporter.)
Q (BY MR. BREEDEN) Are these pictures that you took intraoperatively?
A Yes. I believe these are pictures that were taken with the hysteroscope, yes.
Q Okay. These pictures are numbered one through six.
Can you go through each of these pictures and explain to me what is visualized in them. Just begin with number one.
A So I -- you know, during the -- the course of the surgery, I -- I can't recall exactly when the pictures were -- were taken, but it was, you know, using a video camera in realtime to push a button to take a picture.
So number one looks like me just entering the uterine cavity from the cervix, and I see some -- I would

109

say like fluffy white tissue on the -- on the right side. Otherwise, the -- the more shadowy area up at the top looks like the area where the beginning of the bicornuate aspect of the uterus is.

Q I'm sorry. I don't mean to interrupt you, but a couple of quick questions.

Are these pictures in chronological order with what you took them during the surgery?

A I -- honestly, I believe so. That's what usually happens when they go -- they're taken -- taken in order. I have seen surgeries where sometimes they tell me that a picture didn't -- didn't save, so we take a picture of something we saw earlier. But I -- I don't recall that in this procedure here.

Q And then a second question.

You said for image one that there appeared to be some white tissue on the right as you entered the uterus. The picture shows white tissue on the left, it appears.

Is this a inverted image, left to right?

A Yes. So I'm talking about the -- the patient's anatomical right.

So we're look- -- we're -- our -- our angle is we're in the cervix. I'm -- you know, I'm between Ms. Taylor. She's in the lithotomy position, so her right leg is here, her left leg is here.

110

So when we're looking here, the right side to me is what we see as the left side. It's just the anatomical right is what I'm referring to.

Q So continue with image two.

A So this looks like I'm advancing the camera, and I have adequate visualization towards the fundus of the uterus.

And, you know, it's -- it's really difficult to interpret these pictures. But seeing picture three, it looks like I continue to advance and see the area of the septum, or what -- cause it looks like on the right side -- again, the -- no, I take -- I'm sorry.

On the right side of the picture, which is her left side, I'm starting to see the horn area there, and I know it's -- this is a two-dimensional picture of a three-dimensional vis- -- visual, but the inside part in the middle, almost looks like a triangle, is the lower part of that septum.

Picture four, honestly, it's difficult to tell. I see white tissue in front of the screen. I really don't know what I'm seeing behind it.

Picture five, again, I also see mainly white tissue. And I -- I don't want to speculate, cause I don't have, you know, memory of exactly when the picture was taken, and it's difficult just in the context because

111

we're -- we're zoomed up more towards the top of the uterus to see where we're at.

Picture six as well, it looks like I probably was pulling back from where I was and just taking another general picture of the top of the uterus.

Q Did you take any pictures of the perforation?

A No, I did not. It's not easy to take a picture immediately when you -- when you stop a procedure.

Also, these pictures were all taken with the diagnostic hysteroscope. And I would have to look at the device on the Symphion camera to see even -- sometimes there's a button for a picture there. Sometimes you have to ask the operating room staff. And I honestly don't recall where the picture is, cause this is -- this is being taken with the diagnostic hysteroscope.

Q Well, so are you saying there are pictures additional to these six that were taken intraoperatively?

A No. I'm saying there are no further pictures.

Q So you did not photograph the perforation, correct?

A Correct. There's no pictures of that -- of that time of the surgery.

Q And so we also do not have a picture of what you claim was sufficient visualization of the bowel through the uterus to enable you to rule out bowel injury,

112

correct?

A Yes. There's no further pictures.

Q That would be nice to have for this case, wouldn't it?

A As I said earlier, at the immediate time of a perforation, my concern is not the documentation or the -- the picture. My concern is safety. And immediately stopping a resectoscope and removing the resectoscope is my priority once I was able to see it, not to start taking pictures of that area.

But like I said, in realtime, which is the majority of this surgery, not these six snapshots from the diagnostic hysteroscope, there was no evidence. But I can't produce a picture that wasn't taken.

Q Well, doesn't the Symphion hysteroscope have a camera?

A As I said earlier, it does have a camera. I don't recall whether it's right on the -- the device itself or if it's something that the OR staff has to take a picture of, cause that sometimes has to happen.

Q For a procedure like you performed on Ms. Taylor, if everything goes normally, how long would you expect that procedure to last?

A So every patient's unique. This is -- as you see, there are multiple parts of the surgery. It can take

113

30 minutes to an hour and a half.
I mean as a -- as a -- as a guide, I mean if we're trying to do a resect- -- a resection, that can take time, and then performing the hydrothermal ablation takes -- takes time. There's no rush for the surgery.
It's different than doing a diagnostic hysteroscope where you look inside, get adequate visualization, perform a curettage. That can take 20 minutes.
It all would depend on how readily available the fibroid was removed and then moving on to the ablation.
Q I assume, like many doctors, you have clinical days and surgery days?
A Yes. I have days where I operate, days where I am in my office.
Q What block of time did you set aside or reserve for Ms. Taylor's procedure?
A I don't have that recollection. I know that I had three hysteroscopies that day, and I believe she was the second. And it was -- I don't -- I don't know the exact times. I believe they were blocked one hour apart. But that's more for scheduling. And the surgery takes as long as it takes. There's no -- it's not like a TV show where we have to be done at a certain time. So we -- we -- we do what we need to do based on -- on the surgery.

114

Q When and how do you prepare your operative reports? We'll -- we'll use Ms. Taylor's case specifically.
A So prior to the surgery, I typically will write the indication for surgery, and that's when I first open the notes, as well as the preoperative diagnosis.
Immediately after the surgery, once it's completed, I then go to the surgery dictation area and dictate the notes immediately so it's freshest in my -- in my memory.
Q And so for Ms. Taylor's particular case, it indicates on the second page electrically -- electronically signed by Dr. Brill on 4-26-17, 10:08 a.m.; is that correct?
A Yes. That's -- that's when I completed those notes.
Q Okay. So how long after the procedure was completed would you have finished that note?
A It would have been immediately once I left -- once I left the room.
I don't recall the actual stop time, but I know it was relatively soon after. There was -- that's -- that's the first thing that I do after -- after a surgery.
Q Okay. The uterine perforation, is it your opinion that that was caused while you were using the

115

resectoscope?
A Yes. I visualized the uterine perforation as I advanced the camera with the end of it having the resectoscope -- the -- the resection part of the scope. I'm sorry.
Q Now I think there's a -- there's a couple rules when you do this type of surgery, and the first rule is if you're going to cut, you must know what you are cutting.
Do you agree with that?
MS. HALL: Form, foundation.
THE WITNESS: I don't understand your question, must know what you're cutting.
Can you rephrase that?
Q (BY MR. BREEDEN) Well, if you're going to use the resectoscope, you need to know what you're using it on, right?
A So in -- in this case, I used the resectoscope on the white tissue that appeared to be the septum, based on my operative report.
Q Okay. That's -- that's not what I'm asking.
My -- my question is do you agree with -- as a general statement, if you're going to use that cutting tool on the resectoscope, you need to be sure of what you're cutting?
A So I think that's a broad generalization of

116

performing a resectoscope.
Yes, I would feel comfortable knowing where we were in the uterus before I would activate a resectoscope.
Q Okay. And as sort of a corollary to that rule then, you have to have clear visualization of what you're cutting, otherwise you shouldn't be cutting at all.
You agree with that?
MS. HALL: Form.
THE WITNESS: I would want to have clear visualization of directly in front of my camera where I'm cutting before I cut, yes.
Q (BY MR. BREEDEN) Okay. Now somehow, despite those rules, you still managed to perforate the uterus, right?
A A perforation did occur. Again, it's a known risk and complication that happened and was identified immediately when it happened.
Q Okay. And it appears as -- at least that some of the doctors think you also perforated the intestines.
Do you think you perforated the intestine?
A I believe the intestine was perforated based on what we saw in the operative report, but I still cannot tell you the exact timing of it, and it could have occurred after my surgery, but -- as a result of the surgery, but after the surgery.

117

Q Okay. So you do concede that the perforation occurred as a result of the surgery.
A The perforation of the bowel?
Q Yes.
A Yes. I -- I mean I -- I don't think that Ms. Taylor was doing anything else between the time of the surgery and recovering and going home and coming back.
So I have no other reason to think that there was not a perforation noted after my surgery.
Q Now per the later report of Dr. Hamilton, who performed the bowel resection surgery and the laparoscopy examination, she found that the perforation of the uterus was approximately one centimeter, and that matches your memory of what you directly visualized during the procedure, correct?
A Yes. Approximately -- you know, I think we mentioned the -- the width of the resectoscope is 6.5 millimeters. So, you know, having performed surgeries, I don't -- I -- I -- I don't see that evidence in that op report -- again, it's not in front of me -- that she took a ruler. I think based on doing a laparoscopy, she was estimating that, but I can't -- you know, we're talking a few millimeters.
So what I saw was, you know, between six and a half millimeters and a centimeter, I would say, and I'm

118

sure she was visualizing the same thing from the opposite side.
Q And when she examined the bowel, she refers in her operative report to enterotomy of the bowel, three centimeters long.
Was does the term enterotomy mean?
A So enter is -- means bowel, and otomy means opening. So there was an opening of the bowel that was -- that was three centimeters long from her.
Q Well, it's more specific than that, isn't it? It indicates a surgical cutting of the bowel, doesn't it?
A I don't know what she was thinking, honestly. And -- and when she -- I mean no one -- when you perform a procedure that opens something up, that's the -- like laparotomy, so I think she's using the term that she saw an opening, and -- but I -- I don't know what you mean by -- it wasn't like a surgery that was performed the day before that was an enterotomy, if that's what you're asking me.
Q So how big is the Symphion hysteroscope?
A So approximately six and a half millimeters, and I know it's in that -- that document somewhere. I think about six and a half millimeters.
Q And how large is the Symphion resecting device?
A The actual device itself?

119

Q Yes.
A I don't recall that. I mean it's -- it's likely between a half a centimeter and a centimeter, but I'm -- I'm sure it's in those -- in the image -- images. I don't recall the actual --
Q So you can look at the --
A -- size.
Q -- at the Symphion exhibit, and you can refer to TAYLOR1789, and the Symphion folks were nice enough to put the measurements right on there.
So the hysteroscope measures 6.3 millimeters, the resection device measures 3.6 millimeters; you see that?
A I do see that, yes.
Q You don't have any reason to disagree with the Symphion people about the measurements of their own instruments, do you?
A I have no reason to disagree with -- with this document, no.
Q Okay. So a three-centimeter perforation or cut in the bowel would be somewhere around eight times the size of the resectoscope school -- tool, correct?
A I'm sure, if we do the math, that's probably -- probably right. I mean it's larger --
Q Well --
A -- yes.

120

Q -- what's the size of a typical perforation of the uterus --
MS. HALL: Form, foundation --
Q (BY MR. BREEDEN) -- when it occurs.
A So I --
MS. HALL: Excuse me.
Calls for speculation.
Go ahead, Doctor.
THE WITNESS: I have to remember.
MS. HALL: Yeah. So just try to pause --
THE WITNESS: So I would say --
(Reporter interrupted; multiple speakers.)
MS. HALL: Just try and pause a second, and we all need to try not to talk over one another.
THE WITNESS: So I don't think there's such a thing as a typical perforation. Perforations can occur at many different times during a surgery. They can occur during a dilation. They can occur during a -- a curettage procedure. They can perform at the time of a resectoscope.
And so I think a perforation would likely be similar to the size of the device that's being used when the perforation occurs.
Q (BY MR. BREEDEN) Yeah. So the resectoscope in this case is only 3.6 millimeters, but the size of the

121

perforation was almost three times that, a one-centimeter perforation in the uterus, right?
A So looking back at 1789, you're talking about the actual size of the resection portion of the scope. The perforation likely occurred from the tip of the resectoscope, the blunt end that we described. I don't see a description of the width of that. I see a description of the resectoscope, which is more in a -- you know, more of a latitude horizontal direction.
The perforation, when occur- -- when occurs, was with the tip as well, so I don't know what the width of that is. It's -- it's somewhere in the middle there, I would imagine.
Q What did you tell Ms. Taylor about what occurred during the procedure when she came out of anesthesia?
A So it's not my custom and practice to talk to a patient directly after anesthesia recovery because she will not re- -- remember that -- that conversation.
So it is my custom to go speak to the family member or significant other of the -- of -- of our -- of our -- of the patient, and that's what -- what occurred here.
But typically it's not done to the patient directly because I don't expect her to remember what we say, just like we don't have patients drive themselves

122

home after a surgery, it wouldn't be safe. I usually talk to a family member or whoever the person's significant other is and explain the surgery and what happens and then have a further conversation in the future.
Q Who was that in Ms. Taylor's case that you spoke with?
A I believe it -- her name was Barbara. I can't remember if there were two people that I spoke with, but I -- I -- I mean I can't remember the specifics of the conversation, but I know the conversation did occur.
Q Well, did you tell them that there was a perforation?
A I believe I did, based on my knowledge. I mean I don't have a specific recollection. But in order for me to explain why we didn't proc- -- continue with the fibroid removal and the ablation, I would tell them there was a perforation because there was a perforation.
Q Do you think this procedure was a success?
A I think that the surgery was not able to com- -- be completed based on the known risk that occurred, unfortunately; and ultimately, there was a complication, and that's -- that's unfortunate.
But I don't think we define surgeries as successes or wins and losses. I think you do the best job you can at the time of the surgery based on your ability

123

and the risks -- the risks and benefits of the procedure.
Q Well, the surgery certainly didn't achieve the goals that were intended by the surgery, right?
A The goal being to treat the -- Ms. Taylor's menorrhagia, that was not done, at least the way I intended.
Now, like I mentioned earlier, sometimes a curettage can help improve bleeding. But in terms of what I was intending to do in terms of removing her fibroid, in terms of using the ablation, that was not able to be performed because of the perforation.
Q Well -- yeah. You actually -- you weren't able to remove the fibroid, you weren't able to use the hydrothermal ablation, and she actually left the procedure worse off than when she started because she had perforations to structures as a result of the surgery, right?
MS. HALL: Form.
THE WITNESS: So she had a -- a known complication to the surgery.
If every surgery in the best of hands had a hundred percent chance of no complication, that would be a great world to live in. But we live in a world where there are risks and benefits. And, you know, based on her anatomy, based on, you know, her retroverted uterus, she

124

had a complication that was, you know, unfortunately a known complication, and it occurred.
Q (BY MR. BREEDEN) Well -- well, you're not blaming Ms. Taylor for this result, are you?
A Of course not, no.
Q Okay.
A I mean I -- I can't control her anatomy, and neither -- neither can she. But her anatomy is, you know, a part of the -- the procedure, but it's not someone's fault.
Q Did you tell people in the PACU that there had been a perforation?
A So it's my experience that after a surgery, I go, as I mentioned, to the operative -- to the operative dictation area while the patient is being brought to the recovery area by the anesthesiologist and by the PACU nurses. And it is in my experience a nurse-to-nurse communication about what happened during the surgery, and then the handoff from the operating room circulating nurse to the PACU nurse. And that's what happened in this situation.
Q Okay. So I'm sorry, I -- I can't quite follow your -- your response.
So did you, the surgeon, tell anybody that there had been a perforation or complication to anyone at the

125

PACU?
A So like I said, I -- the OR nurse -- operating room nurse was aware of this.
My immediate place to go is to the dictation area so I can document what happened cause I want to be able to be as fresh as I can to document the surgery. But it is my expectation, in every surgery I perform, whether there is a complication or not a complication, that that handoff occurs between nurses, not between the doctor and the nurse.
Q Who was the OR nurse then that would have reported this to the PACU?
A Sitting here today, I don't recall her name. I'd have to see the record and see, cause I operate and there's -- it's not like I use one operating room nurse, so I don't know the answer today.
Q Would it be in the operative report? You have that in front of you.
A No, because she's the -- or he or she, I should say, is not a -- performing the surgery. There are -- there are surgical technicians that -- or usually one, that scrubs in. They're not usually named in my report cause they're not performing a procedure. And then there's also the operating room nurse. There might be several nurses.

126

Q Would you agree that it's important for staff in the PACU, the PACU nurse specifically, to know that there was a complication, a perforation?
A I do expect that the PACU nurse was made aware of that because that's what usually happens. It's, one, documented in my operative report, which is -- was as you see in the computer immediately after the surgery, possibly even before she entered the PACU, and also the handoff, like I said, occurs between operating room nurse to PACU nurse. So I expect they did know about this.
Q Did you tell anyone in the PACU that there had been no complications?
A No. I don't -- didn't have any conversation directly with the PACU nurse, so I did not say that.
MR. BREEDEN: Let's see. I think this will be Exhibit 5. It's Bates number TAYLOR150.
(Plaintiff's Exhibit 5 was marked for identification by the reporter.)
Q (BY MR. BREEDEN) These are some records from the PACU, correct?
A So this is operative record, so it looks like it is -- at least I -- I -- I recognize the name at the top, Gary Wernlund, who is a -- a circulating nurse that I work with.
So I can't say this is a PACU. This came from

127

the computerized electronic record from the surgery.
Q So do you see here where it says complications, none per surgeon?
You would be the surgeon, right?
A Where are you looking here specifically?
Q I've got it highlighted on this one.
A Oh, here.
I do see that. This wasn't entered by me, but I do see that.
Q Okay. Are you saying that that record is inaccurate, that you told someone there had been a complication?
MS. HALL: Form.
THE WITNESS: I mean I -- I didn't write this document. But my operating room team was all well aware, as we are completely aware of everything that happens during the surgery, that there was a perforation.
Now I don't know if my telling the staff there was a perforation means they think that's a complication. They know there's a perforation. And in my operative report, which is in the chart, I put that as a complication.
But when a perforation occurs, it's -- it's my understanding that -- that hopefully the OR staff, who is familiar with these cases, knows that's a complication of

128

a procedure, and that's why we stopped the procedure.
Q (BY MR. BREEDEN) Okay. So this record indicates that somebody asked you if there were any complications; and per you, the surgeon, it was indicated there were none.
That's untrue, isn't it?
MS. HALL: Form, misstates the document.
THE WITNESS: So I've never visualized this document before. I have no idea if this is just a line that they click in the chart, because I know electronic health records very often have lines that you click, and they're already prepopulated with words. So "none per surgeon" was, you know, nothing that I have any control over.
But I feel confident the -- that the operating room personnel, including the nurse, was aware of the complication of the perforation.
Q (BY MR. BREEDEN) So there wouldn't be any incentive for any of these nurses to write something incorrect on this record, would there?
MS. HALL: Calls for speculation.
THE WITNESS: I honestly, like I said, have no idea when this was even done, the timing of it. I don't know what was in the nurse's mind when -- when he typed this.

129

But I don't think anyone would purposely document something improperly.
Q (BY MR. BREEDEN) Did you follow up with Ms. Taylor when she was in the PACU?
A So I had another surgery after. And in my experience, this kind of surgery usually are -- the patient will recover within one to two hours and then is discharged.
Now I was never notified that the patient was here -- was there longer than expected. And so it would not be my experience after a surgery like this to talk to a patient with the thought process that she likely has been discharged. I already spoke to the family, and that's who I typically talk to after a surgery like this.
Q Well, as you sit here today, you know that Ms. Taylor actually spent something like seven hours in the PACU when one to two hours is normal, right?
A I have learned that subsequently, but I was never notified that the patient was in the PACU for that long.
Q She -- she was immediately complaining of severe pain and -- and symptoms consistent with a bowel injury, right?
MS. HALL: Form, foundation.
Q (BY MR. BREEDEN) In the PACU.
A I cannot tell you what happened in the PACU. I

130

wasn't there.
Q Well, do you know from a later review of records? I mean this is your patient.
A I'd have to -- to look at the hospital records. I mean my concern is my patient.
And having looked at this, but not having the records in front of me, my understanding is she was at the -- in the PACU significantly longer than I would expect.
And I expect the PACU nurse who's trained to be able to recognize a complication or I should say how a patient's recovering that it might be out of the ordinary, then to notify the surgeon.
It's clear to me that never happened cause I was never notified.
Q Okay. Well, listen, you performed this procedure. You're -- you're the one in charge of the patient's care. You know that a -- a fairly sizable uterine perforation occurred, if not other injury.
You didn't feel the need to -- to reach out and follow up with Ms. Taylor at all following this procedure?
MS. HALL: Form.
THE WITNESS: I think that's an unfair statement.
I did speak to the patient's family and spoke to them clearly about what happened. And that's what I

131

expect to happen. And then there will be subsequent discussions after that.
If I would have been told the patient was there much longer than I expected, I think we'd be having a different conversation at this time. But unfortunately, and I can't tell you why, I was never contacted by the PACU nurse the patient was there the majority of that day without ever notifying me.
Q (BY MR. BREEDEN) Well, when was the next time that you learned of -- of something that was out of the ordinary with Ms. Taylor's health then?
MS. HALL: And I just want to caution you, he's asking you outside of your communications with your attorney.
THE WITNESS: So my recollection is the following day when I was called -- and I have to look at my records -- by one of my on-call physicians that the patient was presenting to an emergency room, I believe for the second time, and a consultation was occurring. I was not notified about anything prior to that.
Q (BY MR. BREEDEN) Okay. So what did you do when you learned that?
A So when I learned about it, I was -- you know, the way my practice works is we have an on-call physician who covers 24/7. And I -- I believe I -- from looking at

132

my documents, I was actually working that following evening as what's called an in-house laborist, l-a-b-o-r-i-s-t, at a different hospital, which means I have to be in-house.
So I have confidence with my partners that they'll be able to, you know, participate in the patient's care of mine. And I was notified that the patient was taken to the operating room.
And I'd have to look at the timing, but I know the following morning, when I was done with my shift at the other hospital and did my sign-outs, I came and spoke to Ms. Taylor immediately.
Q But you weren't able to do the -- the initial surgery.
A No. I had my on-call physician, who, as part of my practice, normal experience, as -- as assisting the general surgeon, who is, you know, the appropriate surgeon when there's concern for a possible bowel injury, which it sounds like there was from the emergency room evaluation.
Q Are you aware of other attempts to contact you by telephone by Ms. Taylor that were unsuccessful?
MS. HALL: Form, foundation.
THE WITNESS: I'm not aware of any other attempts, no.
Q (BY MR. BREEDEN) After the original procedure on

133

April the 26th, and you did identify a uterine perforation at that time, did you prescribe any antibiotics at all?
A No, I did not prescribe antibiotics.
Q Why not? Just as a prophylaxis-type measure.
A Not suspecting, again, any bowel injury, not suspecting any cause for infection, a perforation that isn't immediately identified, to me, is not an indication to empirically, meaning give antibiotics without an indication. I don't think there's a reason to give antibiotics after a uterine perforation just because it occurs.
Q Would you agree with me that Ms. Taylor -- you know, she did have a three-centimeter bowel perforation, and that's a -- a serious emergent medical condition.
A So my recollection of the general surgeon's op- -- operative report was he saw a three-centimeter opening.
Again, not knowing when the actual op- -- perforation of the bowel -- or injury to the bowel occurred, I should say, I don't know the -- the size and -- and the -- the natural progress, whether it -- like I mentioned earlier, whether it enlarged or not, cause I didn't see it happen at the time of the surgery.
Q Well, the condition that she was in at the time of the surgery --

134

A Which surgery?
Q The -- I'm sorry -- the second surgery, when the bowel perforation or hole in the bowel was identified, that's a serious medical condition, right?
A Yes. And I -- I am -- I am grateful that she ultimately was wise to call 911 and get back to the hospital, because she was in pain, and, you know, having a bowel injury identified within 24 hours I think is -- is something that I'm -- I'm glad that it happened -- that it was identified that soon. I don't -- I'm not glad, of course, that this happened at all, but the fact that it was identified. It's -- it's a complication that occurred, yes.
Q And it is a very serious complication; and if left untreated, it most likely would have resulted in her death, right?
A I -- I -- I don't have a cause to say because I've never seen in my experience someone have a perforation that was never identified and treated that ultimately led -- or -- or not treated and ultimately led to death.
But it's a serious complication that was fortunately identified and she was brought to the surgery and had the proper care.
Q Well, had she not received the proper care, the

135

progression more likely than not would have been that she would have free spillage of stool into the abdomen, she would have developed sepsis, and if further untreated, she would have died of that sepsis, right?
MS. HALL: Incomplete hypothetical, calls for speculation.
THE WITNESS: I think you're going down a pathway of -- that you're describing that could occur. I mean I can't predict the future.
Typically a bowel injury does present with symptoms. And if a patient doesn't present to an operating -- I'm sorry -- to an emergency room or to a -- to a -- to a doctor, I can't tell you what's going to be the progression. But I know a bowel injury needs to be identified and treated.
Q (BY MR. BREEDEN) Yeah. What I'm getting at is this is very serious. This is not something that you just walk off. It's not something that the bowel spontaneously heals itself. It's a serious medical condition that needs urgent attention; would you agree?
A Once there's suspicion of a bowel injury, based on the patient's presentation, it should be managed urgently, yes.
Q So let's again re- -- review some things that didn't occur from the -- the medical records.

136

There's no indication in the medical records that you consulted with a general surgeon at all for inspection of the abdominal cavity after the original procedure, correct?
A Yes. At the time of my original surgery, I did not suspect or have any reason to suspect a bowel injury cause I was able to see the bowel and did not see an injury. So I would not go to the next step, which would be to perform a laparoscopy and possibly a general surgery consultation.
Q Yeah. So you didn't do that yourself, nor did you consult with another physician about the wisdom of doing that, right?
A Can you rephrase? I don't know what you mean by wisdom.
Q Yes.
You neither did a laparoscopic surgery yourself to inspect for further injury, nor did you consult with another surgeon to see if they felt that would be a good idea, correct?
A Correct. When I performed the surgery, I did not suspect a bowel injury based on my visualization of the perforation and therefore would not need a consultation at that time.
Q There's no indication in the written medical

137

records that you told Ms. Taylor that she suffered a perforation of any kind, uterine or otherwise. You never told her that.

Your testimony here today is you told a relative of hers that; is that your testimony?

A So based on the chronology you presented, immediately after the surgery, after I did my operative report, I spoke to the family members.

But I did also say in another question was that immediately after the surgery, when I was relieved of my shift as a laborist, I did talk to her about the surgery and discussed the perforation, and I know that's documented in my -- in my chart as well.

Q So there will be documentation -- oh, you're -- you're talking about after the bowel -- bowel perforation was identified.

A Yes. So I -- cause you said --

Q By Dr. Hamilton.

I'm sorry to speak over you.

A Yes. Your question was there's nothing in the record, and my -- my answer was that I spoke to the family, which is my practice and my normal experience, and then I spoke to Ms. Taylor the morning after her surgery once I was relieved of my duty as the laborist.

Q Okay. But there's certainly nothing -- that

138

conversation did not occur directly between you and Ms. Taylor on the day of the original procedure, April 26th, right?

A That's correct, nor would it be my experience from doing this for 20-plus years to do that.

Q In fact, the only record that does exist about any such conversation is here on TAYLOR150, which indicates that complications, none per surgeon.

So the only record that we have indicates that you did not tell anyone there was a complication.

MS. HALL: Form, lacks foundation.

THE WITNESS: So I disagree with that.

My operative report clearly says per- -- a complication, perforation of uterus, which was available to everyone, and my operating room team was aware of the perforation.

So I know you're referring to this note that I can't -- was out of my control. But my operating room team was -- was aware, and they also have full -- the -- the way hospital records work nowadays, and including back then, was I did what's called Dragon dictation, which means this -- the dictation was immediately in the chart. It wasn't like the old ways where you call a phone number and then 24 hours later a dictation service does this. We -- we have technology where my dictation was in that

139

chart at 10:08 a.m.

So it's in the record there's a perforation, and it's from the surgeon.

Q (BY MR. BREEDEN) Who did you send that record to?

A I don't understand your question.

Q Did you share your operative record with anybody on April 26th?

A So we don't share -- if you mean like I don't take a report and hand it to somebody. The PACU nurse has the patient next to them and has a computer, the same exact computer system that I'm using, and every document is there, including the operative reports, including all the orders that I gave and -- and -- right after I did the surgery, the vital signs.

There -- I mean I don't know -- like I don't know the timing of this -- notes that you presented from the -- the operating room nurse, but my records were there, and that's how we share. That's -- I mean the whole purpose of the electronic health record is that we all communicate. And fortunately, the hospital has the ability for this operative report to not have to sit in some dictation queue for 12 hours. It's -- it's in the report immediately.

Q So after the bowel perforation was identified,

140

Ms. Taylor required an additional hospital stay and additional surgery to fix the intestine. Her medical billing that has been claimed in this case is a little over $225,000.

Have you reviewed any of the medical billing?

A I have not personally reviewed the medical billing, no.

Q Okay. Are you going to give any testimony here today or do you intend to at trial that any of those medical bills are not usual, customary, and reasonable for the procedures that Ms. Taylor needed?

A So I haven't reviewed those charges and -- you're talk- -- you're talking about the totality of her care?

Q Yes.

A Okay.

So there are charges -- you know, in terms of how I understand how my practice works, there are charges, and then there's what's paid typically by a third party.

And I believe Ms. Taylor had insurance. So I would imagine that the charges of some amount have been based on -- on contracts and based on how hospital -- how hospitals have contracts with the payer, in her case which was Aetna. And this is, you know, a little bit out of my field, it's more of the billing, that a charge would be such amount, but the amount paid is based on a reduced

amount.
So I don't know the exact number, but I believe that -- like a reduced amount is paid by a third party.
And let's say that Ms. Taylor did not have insurance. There's usually a cash discount that's applied.
So, you know, I think the -- the care -- the economic part of this is based on ultimately what the cost was that was actually paid to the hospital and the -- and the -- and the -- and the different doctors that were involved and all the tests that needed to be done after the surgery, including my surgery.
Q Okay. So there's an as-billed amount, and there's an as-paid amount.
Are you going to testify that the as-billed amount was not usual, reasonable, and customary for the services that were provided?
MS. HALL: Beyond the scope.
THE WITNESS: Again, having not reviewed that, I have no reason to think that unusual charges that were not in the usual, customary charges were -- were placed in her -- in her bill.
Q (BY MR. BREEDEN) Okay. And as part of this litigation and your -- your personal knowledge of what happened after the -- the April 26th surgery, you know,

Ms. Taylor incurred a hospitalization I think of another nine days and some other procedures, a couple of emergency room visits, are -- do you intend to testify here today or at trial that any of that aftercare was somehow not reasonable or necessary for her medical condition?
MS. HALL: Foundation, scope.
THE WITNESS: So I wasn't involved in that -- in that medical care. I wasn't involved with the emergency room initial evaluation or the second evaluation.
But I would -- I would expect, if I did review those, that the charges from the facility and from the -- from the doctors or other staff involved would be the usual and customary.
Q (BY MR. BREEDEN) Okay. So there's nothing in your mind that you have seen that you're going to testify no, she did not need that care or that was not related to the perforation she sustained.
A So --
MS. HALL: Form, foundation.
THE WITNESS: I think the complication that did occur was appropriately treated ultimately by the surgery approximately, you know, 24 hours later, and there is going to be the usual and customary charges associated with that surgery and the evaluation through -- from the emergency room and then the subsequent nine-day

hospitalization.
MR. BREEDEN: Those are all the questions that I have.
Counsel, do you have any questions?
MS. HALL: No.
But we do want to review and sign.
MR. BREEDEN: Okay. So the doctor will exercise his right to review the transcript.
I will take a copy, since I'm the deposing attorney.
Usually they like to ask the doctor's counsel whether they want a copy.
Do you want a copy, Heather?
MS. HALL: I'd like an etrans only.
Thank you.
MR. BREEDEN: Okay. That concludes the deposition.
We'll go off the record at this time.
MR. JONES: We are off the record; 4:09 p.m.
(The taking of the deposition was adjourned at 4:09 p.m.)
* * * * *

CERTIFICATE OF DEPONENT

I, KEITH BRILL, M.D., deponent herein, do hereby certify and declare the within and foregoing transcription to be my deposition in said action, subject to any corrections I have heretofore submitted; and that I have read, corrected, and do hereby affix my signature to said deposition.

_____
KEITH BRILL, M.D., Deponent

Subscribed and sworn to before me this
_____ day of _____, _____.

STATE OF NEVADA)
ss:
COUNTY OF CLARK)

_____
Notary Public

CERTIFICATE OF REPORTER

STATE OF NEVADA)
ss:
COUNTY OF CLARK)

I, Lori M. Unruh, a Certified Court Reporter licensed by the State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, KEITH BRILL, M.D., commencing on Friday, April 16, 2021, at 1:05 p.m. That prior to being examined the witness was by me duly sworn to testify to the truth. That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of said shorthand notes.

I further certify (1) that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action, and (2) that transcript review by the witness pursuant to NRCP 30(e) or FRCP 30(e), as applicable, was requested.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this _____ day of _____, 2021.

_____
Lori M. Unruh, RDR, CCR No. 389

EXHIBIT “3”

STEVEN McCARUS, MD, FACOG
McCarus Surgical Specialists for Women
Advent Health Gynecology
100 N Edinburgh Dr #102, Winter Park, FL 32792

February 16, 2021

Heather Hall
McBride Hall
8329 West Sunset Road,
Suite 260
Las Vegas, Nevada 89113

Re: *Taylor v. Brill, MD*

Dear Ms. Hall:

Thank you for asking me to provide my opinions in this case regarding the care and treatment Keith Brill, MD provided to Kim Taylor. I have reviewed all of the materials your office has provided me. Based upon my review of those materials, as well as my education, training and extensive practice as a Board Certified OB/GYN surgeon and a Fellow of the American College of Obstetricians and Gynecologists, it is my opinion to a reasonable degree of medical probability that Dr. Brill fully complied with the standard of care in the care and treatment he provided.

Background & Qualifications

I graduated cum laude from West Virginia University in 1977. I obtained my medical degree from Marshall University School of Medicine in 1982. I then completed a residency in obstetrics-gynecology at Greater Baltimore Medical Center. I was Chief Resident from 1985 – 1986. I was certified by the American Board of Obstetrics and Gynecology in 1989 and have continuously recertified. I am a Fellow of the American College of Obstetricians and Gynecologists I am currently licensed to practice medicine in Florida, Nevada and Texas. I am Chief of Gynecological Surgery at AdventHealth Celebration and Winter Park and the Founder/Director of McCarus Surgical Specialists for Women. In addition to my practice, I currently serve as an Assistant Professor in the Department of OB/GYN at University of Central Florida.

A complete copy of my C.V. is provided with this report. I am familiar with the issues in this case and am qualified to offer expert opinions regarding Dr. Brill's care and treatment of Kim Taylor.

Records Reviewed

To date, I have reviewed the following documents:

1. Complaint with attached expert affidavits
2. Medical records from Women's Health Associates (BRILL 0001-118)
3. Henderson Hospital Operative Report of 4/26/17 (2 pages)
4. Henderson Hospital medical records (HH 0001-200)
5. St. Rose Dominican Hospital – Siena 4/27/17 First ER (SR 1- 0001-24)
6. St. Rose Dominican Hospital – Siena 4/27/17 Admit (SR 2- 0001-85)
7. Deposition transcript of Plaintiff Kim Taylor
8. Plaintiff's Responses to Discovery

I have requested all pertinent documents in this case, including deposition transcripts. It is my understanding, as of the date of this report, only Ms. Taylor's deposition is available for my review. I will review any additional document as they are made available to me.

Summary of Care

Ms. Taylor was a 45 year-old woman who treated with Dr. Brill for several years prior to the incident in question. She had a history of menorrhagia and had a bicornuate uterus with a fibroid. After consulting with Dr. Brill, she agreed to dilation and curettage (D&C) with hysteroscopy with fibroid removal and hydrothermal ablation, all to be performed by Dr. Brill. Dr. Brill's April 21, 2017 pre op note states "Discussed procedure, options, risks and complications as well as benefits" and he documents similar information on the day of surgery.

On April 26, 2017, Ms. Taylor presented to Henderson Hospital for the referenced surgical procedure. During the resection portion of procedure Dr. Brill noticed a uterine perforation while advancing the camera. Upon identifying the perforation, Dr. Brill stopped the procedure to investigate the extent of the damage by direct visualization with a diagnostic hysteroscope. He documents finding an anterior perforation, but seeing no evidence of bowel injury or injury to other organs. Because he saw no other injury to the bowel or other organs, Dr. Brill determined that it was not necessary to perform a diagnostic laparoscopy. Due to the perforation, Dr. Brill did not proceed with the resectoscope and did not utilize the endometrial ablation device. He performed the curettage, removing a small amount of endometrial tissue, and stopped the procedure. Ms. Taylor was taken to recovery in stable condition.

While in recovery at Henderson Hospital, Ms. Taylor was under the care of Bruce Hutchins, RN, where she remained for approximately 7 hours. During her postoperative stay, she was medicated for ongoing abdominal pain and nausea and thereafter

discharged.

Approximately 7.5 hours after being discharged from Henderson Hospital (on 4/27/17 around 12:30 a.m.), Ms. Taylor was transported by ambulance to St. Rose Dominican – Siena Hospital where she was treated by Dr. Todd Christiansen. Ms. Taylor continued to complain of extreme abdominal pain and diffuse torso pain. A CT scan of her abdomen and pelvis were performed which showed postoperative pneumoperitoneum and small to moderate ascites. Ms. Taylor was then treated for her nausea and was discharged after approximately 3 hours. She was instructed to return if her condition worsened and to follow-up with the surgeon, Dr. Brill.

Approximately 6 hours after being discharged from St. Rose Hospital, Ms. Taylor returned to St. Rose Hospital via ambulance complaining of worsening abdominal pain. She arrived at approximately 1:30 p.m. with complaints of diffused sharp and burning abdominal pain in all quadrants, radiating to her shoulders and groin. Dr. Brill was called at 2 p.m. and Samantha Schoenhaus, D.O., the OB/GYN who was covering for Dr. Brill, returned the call. Once labs were available, Dr. Schoenhaus did not want to start antibiotics at that time. Dr. Schoenhaus personally evaluated Ms. Taylor in the emergency department and she was admitted to WHASN's service. IV antibiotics were started and the patient was kept NPO.

Dr. Schoenhaus's Initial H&P documents that there was an incidental uterine perforation during Dr. Brill's procedure and the procedure was aborted. CT results demonstrated intraperitoneal fluid and air which was reported by the radiologist as post op surgical changes. Dr. Schoenhaus indicated that, if her condition worsened, she may need additional surgery or evaluation by a general surgeon.

Later that day, Ms. Taylor was seen and evaluated by general surgeon Elizabeth Hamilton, M.D. Dr. Hamilton performed an examination and reviewed the CT findings which showed free air and free fluid that Dr. Hamilton thought could likely be the result of a perforated viscus or the result of the gynecologic procedure itself. On exam, she had rigid abdomen with peritoneal signs throughout.

Dr. Hamilton consented the patient for a diagnostic laparoscopy with possible exploratory and she was taken to the operating room. Dr. Hamilton performed the surgery with Jocelyn Ivie, M.D. assisting. The diagnostic laparoscopy was converted to an exploratory laparotomy. Intraoperatively, she found a 3 cm perforation of the small bowel about 1 foot proximal to the terminal ileum. Dr. Hamilton successfully performed a small bowel resection and anastomosis. The surgery was completed with no complications.

Following surgery, Dr. Brill documents that he saw the patient on 4/28/17 and reviewed with her the perforation that had occurred during the hysteroscopy he performed. Per his documentation, at the time of the perforation, he did not suspect that

the myomectomy device was actively cutting. He also did not see any bowel adjacent to the uterine perforation. Because Dr. Brill was beginning an in-house OB laborist shift at another hospital when he was notified of her presentation to the emergency department, Dr. Ivie (on-call physician for the group) assisted with Dr. Hamilton's surgery.

She continued to be followed by surgery and WHASN. She was seen by Dr. Brill again on post-op day 2, 4/29/17, and reported she was getting better and ambulating. Dr. Brill saw her post-op day 3 and she was having difficulty with passing flatus and advancing her diet. On 5/3/17, she was seen by Dr. Brill. His documentation states that he discussed with the patient that if her vaginal bleeding did not improve, he would recommend either medical treatment or hysterectomy once she was healed from the bowel surgery.

That same day, infectious disease was consulted due to lack of appetite and concerns her condition was not improving. A repeat CT demonstrated a resolved ileus. She was cleared for discharge by OB, surgery, and ID on 5/6/17 and discharged home on 5/6/17, 9 days after admission.

Expert Opinions

Based upon my review of the materials, to a reasonable degree of medical probability, Dr. Brill and Women's Health Associates of Southern Nevada fully complied with the standard of care in the care and treatment provided to patient Kim Taylor.

Plaintiff's expert, Dr. Berke, states that Dr. Brill fell below the standard of care by causing the perforations of Ms. Taylor's uterine wall and small bowel with use of a thermal instrument, continuing the surgical procedure despite noting the perforation injury, failing to properly evaluate and diagnose the extent of the damage to Ms. Taylor following discovery of the perforation to her uterine wall and failing to inform and instruct PACU of the uterine perforation and to advise them to look for specific concerns which could evidence additional damage and require further examination. I disagree with Dr. Berke's criticisms and will address each of them.

The surgery Dr. Brill performed on April 26, 2017 was indicated and appropriate surgical technique was utilized. It is appropriate to treat a patient of Ms. Taylor's age with abnormal uterine bleeding via hysteroscopic approach and the instrumentation Dr. Brill used was appropriate.

During the procedure, Ms. Taylor experienced a known risk and complication – uterine perforation. This known risk and complication occurs even without a breach of the standard of care. The patient's complication was not caused by any deviation in the standard of care on the part of Dr. Brill. The fact that Ms. Taylor has a retroverted uterus likely contributed to her complication. In the Op Note, her uterine horns were noted to be very narrow which increases the potential for perforation. It was not a deviation of the

standard of care.

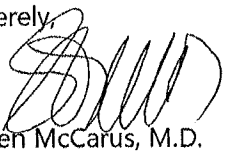
Not only is this a known risk, but the patient had an abnormal uterus. The uterus was retroverted, meaning the uterus tilts back, instead of up to the bladder floor. A retroverted uterus that is bicornuate in shape and abnormal with the submucous fibroid and/or septum is associated with an increased incidence of uterine perforation, in particular the anterior wall, which in fact is exactly where the perforation occurred. These factors were well known by the patient and Dr. Brill as noted at the April 4, 2017 visit, prior to the April 26, 2017 surgery. A detailed consent form was signed by Ms. Taylor.

I disagree with Dr. Berke that he continued the procedure. Dr. Brill immediately noticed a perforation of the uterus anteriorly, following the resection. Dr. Brill did the appropriate thing upon recognition of the uterine perforation. He stopped the procedure. I also disagree that Dr. Brill needed to perform a laparoscopy to inspect the bowel. The standard of care does not always require a laparoscopy to be performed. That is only necessary if Dr. Brill saw some evidence of possible bowel injury or had some reason to suspect that was a possibility. His Op Note states: "No evidence of bowel or other organs in area of uterine perforation". If Dr. Brill directly visualized the area and saw no evidence of injury to the bowel or other organs, scoping the patient was not required by the standard of care. This is a known risk and complication that can and does occur in the absence of negligence. Dr. Brill recognized it immediately and met the standard of care. He noted the complication of the uterine perforation in his operative report under the heading complication.

I am unable to render an opinion on Dr. Brill's communications with the PACU nurses, as I have not received a deposition of Dr. Brill or the PACU nurses. I can state that, generally, PACU nurses are trained to look for signs and symptoms of surgical complications and to relay those to the physician if there is any change in the patient's condition. I see no evidence that any nurse failed to do so here because of an alleged lack of communication of the intraoperative complication to the PACU. Assessment of pain and treatment would be expected due to the nature of the procedure. Vital signs remained normal as did the examination throughout the recovery period and prior to discharge. The patient was given postoperative material including uterine perforation as a complication.

All of my opinions expressed in this report are held to a reasonable degree of medical probability. Please continue to provide me with materials as they become available and I will notify you if my opinions change in any regard.

Sincerely,



Steven McCarus, M.D.