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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SUPREME COURT CASE NO. 83847

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

APPELLANT'S APPENDIX

VOLUME II

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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 II** 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

MLIM
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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 # 3: MOTION TO EXCLUDE EVIDENCE OF ASSERTED LIABILITY OF OTHER HEALTH CARE PROVIDERS UNDER *PIROOZI*

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 #3: Motion to Exclude Asserted Liability of Other Health Care Providers Under *Piroozi*.

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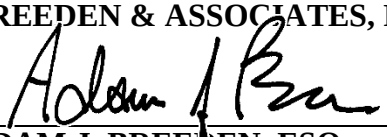
This Motion is made and based on the following Points and Authorities, the pleadings and papers on file herein, the Declaration of Adam J. Breeden, Esq., and any oral argument allowed by the Court at the time of hearing on this matter.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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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.

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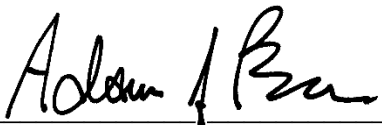
4. I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

DATED this 18th day of August, 2021.



ADAM J. BREEDEN, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff Taylor's Motion in Limine #3: Motion to Exclude Asserted Liability of Other Health Care Providers Under *Piroozi* seeks the Court's guidance as to how non-party doctors will be treated on the jury verdict form in this case. Each case must be assessed under its own unique set of facts and under the facts of this case, Plaintiff does not believe that the Nevada Supreme Court's decision in *Piroozi v. Eighth Judicial Dist. Court*, 131 Nev. 1004, 363 P.3d 1168 (2015) applies or that, if it does apply, that it applies only to a very limited type of damages. Therefore, Plaintiff moves to prevent health care providers other than Defendant Dr. Brill and his clinic from being on the jury verdict form for apportionment of fault.

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

A. The Facts of This Case are Unique

This case is a medical malpractice action involving hysteroscopy, which involves insertion of medical devices (a hysteroscope and a resectoscope) into the uterus. It is undisputed that during the procedure on April 26, 2017, Defendant Dr. Brill while working for the Women's Health Associates clinic perforated Plaintiff Taylor's uterus and small intestine during surgery. The small intestine injury was not immediately recognized. As a result, Ms. Taylor was in great pain following the procedure and it took two trips to the emergency room before she was admitted to the hospital and another doctor diagnosed the small intestine perforation and operated to repair it.

In the original complaint, Ms. Taylor asserted (1) a cause of action against Dr. Brill for negligence in causing the original perforations and failing to identify the small intestine perforation, as well as (2) causes of action against Defendants nurse Hutchins, Christensen, St. Rose Hospital and Henderson Hospital for a delay in diagnosing and treating the small bowel perforation.[1] The

[1] *See* Plaintiff's Complaint attached hereto as **Exbibit "1."**

supporting medical expert affidavit attached to the Complaint by Plaintiff's retained expert Dr. Berke made a case against all of those Defendants *but for different types of damages*.[2] It should be stressed that at no time did Plaintiff or her expert argue that any physician other than Dr. Brill was responsible for the initial perforations.

Prior to the formal production of initial expert reports on February 16, 2021, Taylor sought to focus her case and Dr. Brill and resolved her causes of action against Defendant's nurse Hutchins, St. Rose Hospital and Henderson Hospital. Therefore, when initial expert disclosures were made, Plaintiff's formal initial expert witness report mentioned *only* causes of action against Dr. Brill and Dr. Christensen (the first for causing the initial perforations, the second for failing to timely diagnose and treat them).[3]

Plaintiff's expert report against Dr. Christensen clearly delineated different damages caused by the doctors and stated only that "Dr. Christensen's breaches of the standard of care led to additional pain and suffering for Ms. Taylor during her delay in diagnosis." The "delay in diagnosis" was only a period of around six (6) hours between Taylor's first ER visit where she was seen by Dr. Christensen and her second ER visit where she was seen by another doctor and correctly diagnosed. Plaintiff's expert Dr. Berke made clear in his report that it was solely Dr. Brill that was responsible for "failure of the original procedure, Ms. Taylor's subsequent pain and discomfort, her two emergency room visits, her hospitalization with the resection surgery and related care as well as her course of antibiotics post-op."

Neither Plaintiff's expert, Defendant Dr. Brill, nor Defense expert Dr. McCarus prepared a formal expert report as to any asserted liability of nurse Hutchins, St. Rose Hospital and Henderson Hospital. Therefore, there is no admissible written medical expert report as required by NRCP 16.1 as to the asserted liability of those Defendants for any medical causation or damages.

Shortly after the initial expert witness written report deadline, the case against Dr. Christensen was resolved and dismissed and thus the only Defendants remaining for trial are

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[2] *See* Affidavit of David Berke, M.D. attached hereto as **Exhibit "2."**

[3] *See* Expert report of David Berke, M.D. attached hereto as **Exhibit "3."**

Dr. Brill and his clinic.

At deposition, Dr. Brill did not fault any other physician for the injuries to Ms. Taylor.[4] Similarly, at the deposition of Dr. Brill's retained expert, Dr. McCarus, Dr. McCarus did not give any opinions that any other physician is responsible for any injury to Ms. Taylor.[5] Therefore, the only evidence in this case against any health care provider other than Dr. Brill is from Plaintiff's expert, Dr. Berke.

It is anticipated that the Defense will argue to allow the jury to apportion fault for this incident to the non-party health care providers who have now resolved the claims against them by adding them to the jury verdict form under *Piroozi v. Eighth Judicial Dist. Court*, 131 Nev. 1004, 363 P.3d 1168 (2015). Plaintiff disagrees that the facts of this particular case allow such an apportionment.

B. *Piroozi* and its Holding as to Apportionment of Liability to Non-Parties

In a typical injury case, a jury may not apportion fault to a non-party or settled defendant who is not defending at trial. This results in an unusual circumstance where a defendant may use a so-called "empty chair" defense and argue that the defendant is not at fault at all but rather some missing third party is wholly responsible for the injury to the plaintiff. However, the defendant cannot ask for some apportionment of fault with non-party or settled parties not defending at trial (for example, a 50-50% of liability). *See* NRS § 41.1411 and *Banks ex rel. Banks v. Sunrise Hospital*, 120 Nev. 822, 102 P.3d 52 (2004) (explaining the state of the law prior to KODIN). This rule actually encourages settlement by having the non-settling defendant risk bearing all the liability at trial as the so-called last man standing before the jury.

Within a year after *Banks* was decided, the KODIN ballot initiative was passed into law and abolished joint liability for providers of health care in a professional negligence action.

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[4] *See* Dr. Brill's deposition generally, attached hereto as **Exhibit "4."**

[5] *See* Dr. McCarus' deposition transcript at 38 attached hereto as **Exhibit "5."** Q: Do you intend to give any opinion that any healthcare provider other than Dr. Brill breached the standard of care, in other words, that Dr. Christensen, Henderson Hospital, Nurse Hutchins, or St. Rose Hospital somehow breached the standard of care? A: I am not.

NRS § 41A.045. The Nevada Supreme Court, however, did not address jury apportionment of fault to settled or non-party health care providers in a medical malpractice action until a decade later in *Piroozi v. Eighth Judicial Dist. Court*, 131 Nev. 1004, 363 P.3d 1168 (2015). Unfortunately, the *Piroozi* opinion does not provide many details regarding the background facts of the case. The opinion states only that the plaintiff "filed a complaint against several health-care providers, alleging that the providers' professional negligence caused [the plaintiff] to suffer permanent brain damage." However, for further background, *Piroozi* involved a child born severely premature at 28 weeks and weighing only 2 lb. 3oz. The child fell under the care of two neonatal physicians at the Sunrise Hospital NICU. After 80 days the neonatal specialists discharged the seemingly healthy child with instructions for follow up blood screening tests, including a blood differential, CBC blood and reticulocyte blood test in one month to be performed by the child's pediatrician. The pediatrician, however, saw no need for the tests and cancelled them. Only months later the child went into anemic shock and sustained significant brain injury. She was eventually diagnosed with a rare disorder, Diamond Blackfan Anemia, which the blood tests may have shown had they been conducted.[6]

The child's parents sued the neonatal doctors and the pediatrician. The pediatrician (who seemingly had the greatest proportion of liability) settled prior to trial, leaving only the neonatal doctors. Under existing law of NRS § 41.1411 and *Banks ex rel. Banks v. Sunrise Hospital*, 120 Nev. 822, 102 P.3d 52 (2004), the neonatal doctors would have been barred from asking the jury to apportion fault to the settled pediatrician at trial, who seemingly would have borne the highest percentage of fault for cancelling the ordered tests. However, bad facts make for bad law and in a difficult-to-follow 4-3 decision over a strong dissent, a bare majority of the Nevada Supreme Court granted writ relief to the neonatal physicians. The thinnest majority possible held that NRS § 41A.045 (several liability in a medical malpractice action) conflicts with NRS § 41.1411 and, therefore, NRS § 41A.045 trumped the other statute and required the names of other potentially responsible health care providers to be placed on the jury verdict form so the jury could apportion

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[6] These facts are taken from the actual Petition for Writ of Mandamus in the *Piroozi* case, attached hereto as **Exhibit "6."**

fault to them. This leads to a ludicrous result wherein a plaintiff often must prove a negative (that other physicians were *not* responsible for the injuries) and other inherent unfairnesses as the defendant blames parties not even before the court and against whom the court can enter no binding findings.

The only other meaningful time the Nevada Supreme Court has discussed *Piroozi* was in an unreported decision, *Bhatia v. Eighth Judicial Dist. Court of Nev.*, 134 Nev. 915, 417 P.3d 352 (2018) (unreported). In *Bhatia*, a 36-year-old Type 1 diabetic man was admitted to St. Rose Hospital for various symptoms. He was eventually transferred to ICU and then a whole different hospital, but his neurological status declined to the point where he became a quadriplegic. The man then sued numerous doctors and alleged his condition could have been properly diagnosed and treated and he should not have been rendered a quadriplegic. Some physicians settled prior to trial while others proceeded to trial. *Bhatia* decided two minor issues not addressed in *Piroozi*. The first is that *Piroozi* does not apply only to *settled* prior defendants, but rather extended to any "identified persons" allegedly sharing fault (they need not have actually been sued or previously settled). Second, a defendant seeking to assign fault to non-parties at trial need not produce *their own* medical expert on standard of care but rather can rely on witnesses and experts of other parties, including the plaintiff's own expert witness. Thus, in *Bhatia*, the Supreme Court reversed and allowed the defendant doctors to add non-parties to the jury verdict form for apportionment.

C. *Piroozi* should not Apply under the Facts of Ms. Taylor's Case

The District Court must now deal with how to apply *Piroozi* to the unique facts of this case. Both *Piroozi* and *Bhatia* involved cases where multiple physicians had a chance to timely diagnose and treat the Plaintiff's condition but failed to do so, leading to a serious result. In both cases the theory of liability was that *all* party and non-party/settling doctors failed to timely diagnose and treat a serious condition, leading to *one identifiable injury* (brain damage in *Piroozi*, quadriplegia in *Bhatia*) that was the *same for all defendants*. Thus, at least *Piroozi* is logical in the sense that the jury can assess the liability for all physician for the *exact same injury and damages*, so it makes sense in such a case to allow a total apportionment of liability for the *same* injuries and damages among the various defendant physicians. The remaining doctor(s) under Piroozi then pay only their

percentage of fault. For example, if all doctors are responsible for $1,000,000 in damages then a doctor responsible for 30% of the fault pays for only $300,000 (30%) of the damages.

Ms. Taylor's case, however, is not factually similar to *Piroozi* and *Bhatia*. In her case she has sued *only* Dr. Brill for causing her uterus and small intestine perforations, the need for future emergency room visits, the need for a bowel resection surgery and the associated hospitalization. At no time have either Ms. Taylor or her expert, or any other expert, argue that any provider of health care other than Dr. Brill caused or contributed to the perforations.

Instead, at best Plaintiff's expert Dr. Berke argues only that Ms. Taylor's pain and suffering was extended by around six (6) hours between ER visits due to the failure to the dismissed defendants, nurse Hutchins, Dr. Christensen, St. Rose Hospital and Henderson Hospital to timely diagnose and treat her perforations. As is made clear by Plaintiff's expert Dr. Berke (the only medical expert in the entire case who has made opinions on the subject) in his report[7] and at his deposition, the only damages attributable to the non-party defendants is a small amount of additional pain and suffering due to the approximately six (6) hour delay in diagnosis. At deposition Dr. Berke's testimony about non-party liability was as follows:

> Q: You were asked some questions during your earlier testimony about prior defendants in this case, Nurse Hutchins, Henderson Hospital, Dr. Christensen and St. Rose. I want to go through those one by one so that your testimony is clear. First of all, for the initial injury to the uterus and the bowel, is Dr. Brill the only doctor that you believe caused the initial injuries?
>
> A. Yes.
>
> Q. So you do not think Nurse Hutchins caused the initial injuries, do you?
>
> A. I don't think that.
>
> Q. Do you believe Henderson Hospital caused or contributed to the initial injuries?
>
> A. No.
>
> Q. Do you believe Dr. Christensen caused or contributed to the initial injuries?

[7] Dr. Berke's expert report attached hereto as **Exhibit "3."** He states only that "Dr. Christensen's breaches of the standard of care led to additional pain and suffering for Ms. Taylor during her delay in diagnosis."

A. No.

Q. Do you believe that St. Rose Hospital caused or contributed to the initial injuries?

A. No.

Q. So Dr. Brill is, in your opinion, 100 percent responsible for the initial perforations to the bowel and uterus; is that your testimony?

A. That's correct.

***

Q: So during Dr. Brill's procedure, there is an injury or perforation to the uterus and the bowel of Ms. Taylor. At that point will Ms. Taylor require a bowel resection procedure regardless of when this is diagnosed, or in your opinion, was it the delay in diagnosis that caused the need for the resection surgery? [Objection stated]

A. The delay did not cause -- the initial injury was caused at the time of the original surgery by Dr. Brill that required the treatment that she got. She would have needed bowel resection, bowel surgery based on the bowel perforation that was caused at the time of the perforation that he caused.

Q. Okay. So hypothetically, let's say there was not any delay in diagnosis of the bowel perforation, would Ms. Taylor have still needed a bowel resection or bowel repair surgery even if, for example, that injury was noted within an hour of the original procedure?

A. Yes. Definitely.[8]

At no time has Dr. Berke, for example, stated that but for the delay in diagnosis Ms. Taylor would not have needed a bowel resection surgery. Indeed, at his deposition he was clear to testify to the opposite, i.e., that Ms. Taylor would have needed the bowel resection surgery *regardless* of whether Dr. Christensen or any other provider delayed diagnosing her.[9] The bowel resection surgery was necessary as soon as Dr. Brill perforated the bowel and it not related at all to the non-settling parties. The court has to keep in mind that the report and deposition testimony of Dr. Berke is the *only* evidence in this case of any kind as to liability of non-party health care providers and even Dr. Berke's testimony is very, very limited in terms of what damages were caused. He has *never* stated that all the health care providers caused the same damages.

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[8] Dr. Berke's deposition transcript at 40-41, 43-44 attached hereto as **Exhibit "7."**

[9] Dr. Berke's deposition transcript at 40-41, 43-44 attached hereto as **Exhibit "7."**

Applying *Piroozi* to this case then would not make sense for two reasons. First, Dr. Brill should not get a reduction for an apportionment of fault as if the non-settling doctors were responsible for the *same injury and damages*. No medical expert has alleged this. At best, the non-party medical providers are responsible for a small increase in pain and suffering over a short period of time. For example, let's say that Taylor proceeded to trial and found Dr. Brill 75% responsible and Dr. Christensen 25% responsible. *The problem is that these doctors were not sued for the same injury or damages to the patient.* Dr. Christensen was sued only for a small increase in pain and suffering for perhaps a six (6) hour period. The rest of the damages are completely attributable only to Dr. Brill. Therefore, it would be grossly unfair to Taylor to give Dr. Brill a reduction of liability for 25% of the whole resection surgery hospital bill of $144,994.12 when no medical expert has blamed Dr. Christensen's delay in diagnosis for that surgery bill (the expert testimony is that those damages would have occurred regardless). Stated differently, giving Dr. Brill a global reduction in damages when the jury did not find Dr. Christensen liable for all of those damages would be a reduction of damages windfall for Dr. Brill.

Second, Dr. Brill is legally responsible for all subsequent malpractice and all pain and suffering after the initial perforations because he caused those perforations. The law clearly states that "it is well-settled law that the original tortfeasor is liable for the malpractice of the [later] attending physicians." *Hansen v. Collett*, 79 Nev. 159, 165, 380 P.2d 301, 304 (1963); *see also* Restatement (Second) of Torts § 457 (Am. Law Inst. 1965). In other words, the damages caused by the original tortfeasor (Dr. Brill) include any damages a subsequent health care provider (such as Dr. Christensen) may cause. There is no court decision stating that KODIN changed this principal of law, that the damages recoverable against a doctor include subsequent malpractice. This is a rule of proximate causation, not a rule of joint liability. Therefore, *Piroozi*'s attempt to carve out Dr. Brill's damages from damages caused by other health care providers fails—those subsequent damages are attributable to Dr. Brill, and he is liable for them.

Lastly, even if the District Court felt *Piroozi* is applicable to this trial to some degree, a special verdict form should be given, and the jury should apportion the fault of the non-party health care providers only as to the alleged increase in or prolonged pain and suffering caused by the delay

in diagnosis. In other words, the worst-case scenario even if *Piroozi* were applied to would be to apportion the fault of non-parties but *only* as to the increase in pain and suffering for that delay period and *not* the entire damages.

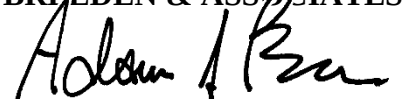
V. CLOSING

In closing, Plaintiff Taylor seeks a pre-trial ruling from this Court that *Piroozi* does not apply to this action at all or, if it does, that the jury is to separately award damages for the delay in diagnosis period (which is quite short) and then apportion fault for that delay only by way of a special verdict.

Piroozi continues to be a case that may sound logical but is very difficult to practically apply. Indeed, *Piroozi* can only be neatly applied to cases where several doctors each fail to properly diagnose and treat a patient, thus the damages each caused are the same. This case presents a scenario where the health care providers were sued for *different* measures of damages and, therefore, the remaining non-settling Defendant, Dr. Brill, should get an apportionment as to certain damages only but not a reduction on the entire verdict.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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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 # 3: MOTION TO EXCLUDE EVIDENCE OF ASSERTED LIABILITY OF OTHER HEALTH CARE PROVIDERS UNDER PIROOZI** 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”

Electronically Filed
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Steven D. Grierson
CLERK OF THE COURT

COMP
JAMES S. KENT, ESQ.
Nevada Bar No. 5034
9480 S. Eastern Ave.
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Las Vegas, Nevada 89123
(702) 385-1100
Attorney for Plaintiff

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:

/ / /

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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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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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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;

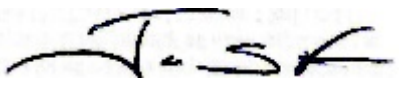
   b. For past and future special damages in a sum in excess of $10,000.00;

   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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Nevada Bar No. 5034
9480 S. Eastern Ave., Suite 228
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(702) 385-1100
Attorney for Plaintiff

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EXHIBIT “2”

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

EXHIBIT “3”

Riverside Medical Clinic
6405 Day Street - Riverside, CA 92507 - (951) 607-5500 - Fax (951) 697-5475

INTRODUCTION

I have been retained to review the care administered to Kimberly Taylor during and following her dilation and curettage with hysteroscopy and fibroid removal procedure performed on April 26, 2017. I have been asked by counsel for Ms. Taylor to provide opinions as to the standard of care and medical causation which may be used in litigation. This report is intended to state my opinions in this matter to a reasonable degree of medical probability.

QUALIFICATIONS

I am a board-certified Obstetrician and Gynecologist, having received my Doctor of Osteopathic Medicine (D.O.) degree from Western University of Health Sciences in 2007. I am licensed to practice medicine in the state of California and am a Fellow of the American College of Osteopathic Obstetricians and Gynecologists, and a member of the American Osteopathic Association, California Medical Association and the Riverside County Medical Society. I am currently in full-time clinical practice as an OB/GYN in Riverside, California at the Riverside Medical Clinic having practiced in various medical centers and women's clinics during my career. I have performed hundreds of dilation and curettage, hysteroscopy and fibroid tumor removal procedures during my career. 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 opinions regarding the medical standard of care, the breaches thereof in this case, and any resulting injuries and damages arising therefrom.

DOCUMENTS REVIEWED

To form my opinions I have primarily reviewed the following: (1) Medical records from Keith Brill, M.D./Women's Health Associates of Southern Nevada, (2) Medical records from

Henderson Hospital, (3) Medical records from Dignity Health/St. Rose Dominican Hospital, (4) deposition of Kimberly Taylor, Plaintiff. A complete chart of what has been provided to me is attached as *Exhibit 1* to this Report.

OPINIONS

At the time of the incident in this case, Ms. Taylor was a 45 year old woman (DOB 10/25/1971) who had been treated by Dr. Brill for several years prior to the incident in question. She had a history of menorrhagia,[1] and had a bicornuate uterus with a fibroid tumor. 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 at Henderson Hospital.

On April 26, 2017, Ms. Taylor appeared at Henderson Hospital for the referenced surgical procedure.[2] During the procedure,[3] Dr. Brill was using a symphion hysteroscope to begin resecting an apparent uterine septum when he noted a uterine perforation. I note that Dr. Brill's operative report is full of qualifiers such as he saw "what *appear[ed]* to be a white uterine septum…" and he was able to later visualize "what *appeared* to be the septum" when cutting. This indicates to me that Dr. Brill was uncertain as to where he was in the uterus, yet he proceeded regardless. He noticed the perforation immediately after use of the "yellow pedal" which operates the hydrothermal ablation instrument and the perforation occurred at that time in my opinion. 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 or other providers being informed of the perforation by Dr. Brill and she denied being told of the perforation during her deposition. Moreover, Dr. Brill failed at that time to recognize that he had actually perforated the small bowel as well during surgery.

Ms. Taylor was thereafter in post op recovery at Henderson Hospital under the care of Bruce Hutchins, RN, where she remained for approximately 7 hours, despite that normal recovery prior to discharge would be 1-2 hours for this procedure. It appears Ms. Taylor was discharged despite still complaining of severe abdominal pain. The PACU notes state that per surgeon, there were no complications[4] which would be incorrect since the operative note states the procedure was aborted due to perforation. No complications were noted by the

[1] Menorrhagia is the medical term for menstrual periods with abnormally heavy or prolonged bleeding.

[2] A retroverted uterus means the uterus is tipped backwards so that it aims towards the rectum instead of forward towards the belly button. This was well known to Dr. Brill prior to the surgery and is a condition present in 20-30% of women. I do not believe the retroverted uterus complicated the April 26th procedures or significantly contributed to the perforations.

[3] The procedure operative note is at TAYLOR 0154-0155.

[4] The record states "Complication(s) None per Surgeon" TAYLOR 00150. Thus we know this information came directly from Dr. Brill but is inaccurate, the complication of the perforation actually caused the termination of the procedure.

anesthesiologist. During her postoperative stay, Ms. Taylor was medicated for ongoing pain and nausea then released.

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. Her deposition further states her "pain started getting extremely, extremely severe" she started "sweating profusely" and "vomiting" or "dry heaving."[5] A CT Abdomen and Pelvis was performed, noting postoperative pneumoperitoneum and small to moderate ascites.[6] Despite these findings, she was treated for nausea and released after approximately three hours without further workup, differential diagnosis or consultation regarding a possible bowel injury. 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.

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, clinically significant pain, and the CT findings (which suggested 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[7] in all four abdominal quadrants. The resected portion of her small bowel measured 7.0 x 2.6 x 1.2 cm with exposed mucosa being focally tan-brown and edematous with a "moderate" amount of yellow-green exudate also present, which is indicative of infection.[8] She was hospitalized and underwent diagnostic laparoscopy, exploratory laparotomy, resection of ileum, reanastomosis and washout of pelvic contamination. She was eventually discharged nine days later but underwent outpatient administration of antibiotics even after discharge.

My opinion is that Dr. Brill breached the standard of care in a number of respects. These include: (1) failing to use proper care and caution in use of the hydrothermal ablation instrument, (2) failing to properly identify the body part upon which he was operating, to the extent that he actually perforated completely through the uterus and into the small bowel, (3) failing to immediately terminate the procedure after identifying a uterine perforation and instead continuing surgery, including use of the curettage, (4) failing to properly evaluate and diagnose

[5] Deposition of Ms. Taylor at pg. 46.
[6] CT Report at Taylor 00323.
[7] Peritonitis is the inflammation of the peritoneum, the membrane that lines the inner abdominal wall and covers the organs within your abdomen, in Ms. Taylor's case due to bacterial infection from the bowel perforation.
[8] Surgical pathology report at TAYLOR 00336.

the extent of damage to Ms. Taylor after uterine perforation was noted, including failing to explore the patient laparoscopically after identifying the perforation to assure no other internal damage was caused,[9] and (5) failing to advise both the patient and other medical providers such as the PACU that a uterine perforation had occurred.

I would comment that a simple perforation of the uterus is a known complication of the procedures performed by Dr. Brill and, in some cases, can occur without negligence on the part of the physician. However, the perforation injury in this case is so severe that it exceeds a mere complication of a properly performed procedure and instead crosses a line into carelessness and a breach of the standard of care in my opinion. The size of the uterine perforation was large (1 cm) and the size of the bowel perforation was even larger (3 cm). This was not a small pinhole type perforation. Dr. Brill simply did not use proper caution and technique when using the hydrothermal ablation instrument and he failed to assure that he was operating on the intended body part. The perforation and the extent of it was avoidable in this case in my opinion.

In terms of medical causation, the failure of the original procedure, Ms. Taylor's subsequent pain and discomfort, her two emergency room visits, her hospitalization with the resection surgery and related care as well as her course of antibiotics post-op are all related to the perforations caused by Dr. Brill.

I also believe that Dr. Christensen's care fell below the standard of care. I am familiar with the standard of care for patients presenting to the Emergency Room following uterine surgery both from my specific practice and my general education as a physician. In my practice, I do on occasion interact with Emergency Room physicians for my patients. Ms. Taylor presented to the ER and Dr. Christensen shortly following a dilation and curettage procedure. She presented with extreme abdominal pain and diffuse torso pain and nausea. A CT Abdomen and Pelvis was performed, noting postoperative pneumoperitoneum and small to moderate ascites. All of this is suspicious for perforation, especially since dilation and curettage does not require an open entry into the abdomen that might otherwise cause these findings unlike, for example, an appendicitis. Dr. Christensen breached the standard of care by (1) failing to consult with Dr. Brill or any other OB/GYN or surgeon based on the CT report, (2) failing to conduct a proper differential diagnosis to rule in/out perforation and instead simply releasing Ms. Taylor, and (3) failing to properly diagnose and treat the perforation. I do believe Dr. Christensen's breaches of the standard of care led to additional pain and suffering for Ms. Taylor during her delay in diagnosis.

---

[9] The standard of care per medical literature requires further exploration to determine the extent of the perforation and possible damage to adjacent structures when the perforation occurs while cutting with heat. ***"Uterine perforation" in TeLinde's Operative Gynecology (page 366-367, 10th edition, 2008) that clearly states when resecting a uterine septum often it is done with simultaneous laparoscopy to prevent perforation. As well it states that laparotomy or laparoscopy should be done if a perforation is experienced while using an energy device. Another book "Diagnostic and operative hysteroscopy" (written by one of the current leading experts in minimally invasive GYN surgery) states simultaneous laparoscopy should be done with septum resection and that if perforation occurs with electrosurgical devices structures anatomically close to the uterus should be explored to rule out an associated injury.***

Regarding Ms. Taylor's prognosis, she appears to have made a nearly complete recovery from the perforation. She complains of mild abdominal pain symptoms on occasion which I do think are related to the perforations but will require no future treatment.

STATEMENT OF COMPENSATION

My fee for expert review and reports is $350.00/hour with a $2,000 non-refundable engagement fee/retainer. To date, I have charged $2,465.00 for my work on this matter, which has been paid.

CONCLUSION

My opinions set forth herein are stated to a reasonable degree of medical probability based on the information and documents I have reviewed to date. A summary of my opinions is that Dr. Brill fell beneath the standard of care during the procedures performed, resulting in perforation of the uterus and small bowel, causing the patient extreme pain and discomfort and resulting in nine days of hospitalization, bowel resection and other post-operative medical care that should not have been necessary. Similarly, Dr. Christensen's failure to properly diagnose and treat Ms. Taylor led to increased pain and suffering and a worsening of her condition while proper diagnosis was delayed.

I reserve the right to amend my findings upon the presentation of additional fact and/or records related to this matter.

2/10/2021

David Berke, D.O., FACOOG Date

Exhibit 1

DOCUMENTS/MATERIALS REVIEWED

Record/Document	**Bates Range**
Women's Health Associates of Southern Nevada (WHASN) (Contained in Initial Production)	TAYLOR000001 – TAYLOR000113
Henderson Hospital Medical Records (Contained in Initial Production)	TAYLOR000114 – TAYLOR000311
Dignity Health d/b/a St. Rose Dominican Hospital Medical Records (Contained in Initial Production)	TAYLOR000312 – TAYLOR001661
Henderson Hospital Billing Records (Contained in 1st Supplemental Production)	TAYLOR001662 – TAYLOR001664
Dignity Health d/b/a St. Rose Dominican Hospital Billing Records (Contained in 1st Supplemental Production)	TAYLOR001665 – TAYLOR001666
Dignity Health d/b/a St. Rose Dominican Hospital Additional Billing Records (Contained in 1st Supplemental Production)	TAYLOR001667 – TAYLOR001668
Henderson Hospital Additional Billing Records (Contained in 1st Supplemental Production)	TAYLOR001669 – TAYLOR001681
Associated Pathologists Chartered Billing Records (Contained in 1st Supplemental Production)	TAYLOR001682
Radiology Associates of Nevada Billing Records (Contained in 1st Supplemental Production)	TAYLOR001683
Quest Diagnostics Billing Records (Contained in 1st Supplemental Production)	TAYLOR001684 – TAYLOR001685
Valley Anesthesiology Consultations Billing Records (Contained in 1st Supplemental Production)	TAYLOR001686
City of Henderson Ambulance Billing Records (Contained in 1st Supplemental Production)	TAYLOR001687
Women's Health Associates of Southern Nevada Billing Records (Contained in 1st Supplemental Production)	TAYLOR001688
Brian J. Lipman, M.D. Billing Records (Contained in 1st Supplemental Production)	TAYLOR001689
Sahara West Urgent Care Billing Records (Contained in 1st Supplemental Production)	TAYLOR001690 – TAYLOR001691
Henderson Hospital Billing Records (Contained in 1st Supplemental Production)	TAYLOR001662 – TAYLOR001664
Dignity Health d/b/a St. Rose Dominican Hospital Billing Records (Contained in 1st Supplemental Production)	TAYLOR001665 – TAYLOR001666
Dignity Health d/b/a St. Rose Dominican Hospital Additional Billing Records (Contained in 1st Supplemental Production)	TAYLOR001667 – TAYLOR001668

Henderson Hospital Additional Billing Records (Contained in 1st Supplemental Production)	TAYLOR001669 – TAYLOR001681
Associated Pathologists Chartered Billing Records (Contained in 1st Supplemental Production)	TAYLOR001682
Radiology Associates of Nevada Billing Records (Contained in 1st Supplemental Production)	TAYLOR001683
Quest Diagnostics Billing Records (Contained in 1st Supplemental Production)	TAYLOR001684 – TAYLOR001685
Valley Anesthesiology Consultations Billing Records (Contained in 1st Supplemental Production)	TAYLOR001686
City of Henderson Ambulance Billing Records (Contained in 1st Supplemental Production)	TAYLOR001687
Women's Health Associates of Southern Nevada Billing Records (Contained in 1st Supplemental Production)	TAYLOR001688
Brian J. Lipman, M.D. Billing Records (Contained in 1st Supplemental Production)	TAYLOR001689
Sahara West Urgent Care Billing Records (Contained in 1st Supplemental Production)	TAYLOR001690 – TAYLOR001691
Excel Spreadsheet with breakdown of medical billing charges, insurance payments, and Plaintiff responsibility (Contained in 2nd Supplemental Production)	TAYLOR001741 – TAYLOR001749
Summary of Care Discharge documents from Henderson Hospital (Contained in 2nd Supplemental Production)	TAYLOR001750 – TAYLOR001755
Surgical Pictures from Dr. Brill	BRILL000119
Deposition of Kimberly Taylor	N/A
Kimberly Taylor's Response to Defendant Keith Brill, M.D.'s First Set of Interrogatories	N/A
Kimberly Taylor's Response to Defendant Todd W. Christensen, M.D.'s First Set of Interrogatories	N/A
Kimberly Taylor's Response to Defendant Todd W. Christensen, M.D.'s First Set of Special Interrogatories	N/A
Kimberly Taylor's Response to Defendant Henderson Hospital's First Set of Interrogatories	N/A
Kimberly Taylor's Response to Defendant Dignity Health d/b/a St. Rose Hospital's First Set of Interrogatories	N/A

EXHIBIT “4”

Taylor v. Brill, M.D., FACOG, FACS, et al.

Videotaped Deposition of Keith Brill, M.D.

April 16, 2021

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

KIMBERLY TAYLOR, an individual,
Plaintiff,
vs.) CASE NO.: A773472
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.

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

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

EXHIBITS MARKED FOR IDENTIFICATION

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

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?

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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

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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.

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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?

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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?

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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

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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.

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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.

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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.

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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?

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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

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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.

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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.

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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

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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

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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.

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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

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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

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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

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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.

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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

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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

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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.

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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?

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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

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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

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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

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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?

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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

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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?

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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

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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

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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

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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 --

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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

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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

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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.

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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

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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

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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?

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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.

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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 --

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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

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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

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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.

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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.

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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.

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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.

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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

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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

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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?

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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?

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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

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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.

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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?

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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

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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,

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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

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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

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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.

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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.

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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

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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.

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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

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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.

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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.

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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?

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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.

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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

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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.

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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

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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,

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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

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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,

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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

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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

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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

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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

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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?

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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

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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

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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

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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.

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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,

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

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

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

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

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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

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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.

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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.

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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

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.

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

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,

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

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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.

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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

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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

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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.

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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

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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?

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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.

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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

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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

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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

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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

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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

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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.

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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

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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

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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.

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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

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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

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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

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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

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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 --

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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

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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.

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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

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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

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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

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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,

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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 “5”

Taylor v. Brill, M.D., FACOG, FACS, et al.

Videoconferenced Deposition of Steven D. McCarus, M.D.

August 6, 2021

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

KIMBERLY TAYLOR, an individual,
Plaintiff,
vs. CASE NO.: A773472
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.

VIDEOCONFERENCED DEPOSITION OF STEVEN D. McCARUS, M.D.
Taken on Friday, August 6, 2021
At 11:03 a.m. Pacific Standard Time
All Attendees Appearing Via Videoconference

Reported By: Lori M. Unruh, R.D.R., C.C.R. #389

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APPEARANCES:
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(via videoconference) 8329 West Sunset Road,
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Las Vegas, Nevada 89113
Also Present: Kimberly Taylor
(via videoconference)

I N D E X

EXHIBITS MARKED FOR IDENTIFICATION
(No exhibits marked)

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(NRCP 30(b)(4) or FRCP 30(b)(5), as applicable, was waived by the parties.)
Whereupon --
STEVEN D. McCARUS, M.D., having been first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified via videoconference as follows:
* * * * *
EXAMINATION
BY MR. BREEDEN:
Q Good morning, Dr. McCarus.
Can you please state and spell your full name for the court reporter.
A Steven, with a "v," Douglas McCarus, M-c-C-a-r-u-s.
Q All right. Dr. McCarus, my name is Adam Breeden. I'm the attorney for a woman named Kimberly Taylor, and she's filed a lawsuit against a Dr. Keith Brill and his clinic, the Women's Health Associates, arising out of a procedure that was performed on April 6th of 2017.
Do you understand you're here today to give your formal deposition testimony in that case?
A Yes, sir.
Q Now you're a retained expert in that case, meaning you were never the treating physician of

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Ms. Taylor; is that true?
A That's true.
Q Is it true that you've never met or spoken to Ms. Taylor?
A That's true.
Q And you were not present when that procedure occurred in April of 2017, correct?
A That's correct.
Q How many times have you been deposed?
A I'm guessing around 60 times.
Q How many times have you appeared as an expert witness in a court proceeding or trial?
A I'm guessing again. I don't know the exact number. I'm going to say 12 times.
Q Do you have a clinical practice in addition to your practice as an expert witness?
A Yes, I do.
Q Okay. What percentage of your work as an expert witness is for the plaintiff or the injured patient versus the defendant doctor?
A It's probably 70 percent for the plaintiff and 30 percent for the defense.
Q And what percentage of your income would you estimate comes from litigation expert work versus your other practice?

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A Well, I have a full clinical practice, which is my full-time job.
I would say medical expert work that I get asked to do is probably about less than 10 percent of my income.
Q Have you ever had any professional license or accreditation suspended or revoked?
A No, sir.
Q Have you ever tested for a medical license or accreditation and been denied?
A No.
Q Has the court ever excluded you as an expert, either in whole or in part, as to a certain opinion?
A One time I was asked to give expert opinion in the state of North Carolina. It was a -- it was a GYN or gynecological oncology case. And I didn't honestly know it at the time, but I did eventually find out that I was excluded as an expert because I was not a GYN oncologist.
Q And what were the allegations made in that case?
A It was a sarcoma of the uterus that -- the best that I can remember, I think it was a case where the cancer may have spread due to the technique that was used.
Q This case concerns a hysteroscopy.
How many of those procedures have you performed in your career, would you estimate?
A I -- I've done -- I don't know the exact number.

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I'm guessing in the thousands.
Q Okay. I'm just trying to figure out, let's say over the last five years, has the number of hysteroscopies you've performed been consistent in your career, or have they increased or decreased or stayed the same over the last five years?
A I have a GYN surgery only practice. I do not do obstetrics. My practice is solely related to surgery. So I approximately do 10 hysteroscopies a month, and it's been consistent over the past five years.
Q Okay. I'd like to talk to you about the device that was used in this particular case, the Symphion resectoscope.
Are you familiar with that resectoscope?
A I'm familiar with it, yes, sir.
Q Have you ever used it in your clinical practice?
A It -- I'm involved with education. I've never used it on a patient. But I've seen it and tried it at conferences and that sort of thing. We use a similar type of the resectoscope/hysteroscope, but it's not this particular one.
Q What particular kind do you use?
A I use what's called the Omni scope, which is an operative hysteroscope that gives you resection capabilities.

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Q How's that differ from the Symphion resectoscope?
A It's very similar. It has a fluid management system. It has multi-channel. It has a resectoscope, for the lack of better term, handpiece that would go down the operative channel of the Omni scope for resection of polyps or fibroids or septums.
Q So to be clear, you've never personally used a Symphion resectoscope?
A No, I have not.
MS. HALL: That misstates his testimony.
Q (BY MR. BREEDEN) I believe your answer was that is correct; is that correct, Doctor?
A I've never used it on a patient. I've only tested it and learned how to use it in the laboratory setting.
Q Okay. And so when you do that, do you work on a dummy or a model?
A You have a model -- simulation type of model and tissue that you resect.
Q Okay. Do you believe that you're still qualified as an expert to testify about the Symphion system?
A Yes, sir.
Q So you don't think it's necessary to personally use a Symphion resectoscope in order to testify as to the standard of care in this case?

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A I do not. I'm very well educated about this piece of equipment, how it works, the advantages of the system. I have seen it in labs and have used it. I feel comfortable that I could give appropriate testimony on the equipment and how it should or shouldn't be used.
Q Do you think the Symphion resectoscope device is the safest resectoscope that Dr. Brill could have selected for this procedure?
A It definitely has advantages over traditional past hysteroscopes. This is a bipolar radiofrequency type of resection tool, which is much safer than unipolar electrosurgery instrumentation.
So yes, I think this is a much -- appropriate choice to use to do the procedure he was trying to do.
Q Yeah. So the Symphion device has a blunt tip as exposed -- as opposed to an exposed prongs or blade, correct?
A Correct. It has a blunt ti- -- the resectoscope part of the instrumentation is blunt.
Q And that's --
A The hysteroscope itself is not blunt, but straight.
Q And that blunt tip is designed to help avoid perforations or injury to the uterus during the procedure, correct?

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A Correct.
Q The Symphion device has a heating or cutting element that has to be activated with a pedal to cut, doesn't it?
A Correct.
Q In other words, if I took that device, even if it was plugged in, as long as I'm not activating the pedal or using the pedal, I can touch it to my skin or some other place on the body, and it's not going to burn me or cut me, correct?
A That's correct.
Q And that's also a safety feature designed to reduce injury or perforation to the uterus, wouldn't you agree?
A Well, it's -- it's not -- that's not -- in particular is not a safety feature to prevent injury to another adjacent organ.
It's a type of approach that allows one to get more coagulation and better resection of the tissue that you're trying to remove.
Q Well, that's certainly a lot safer than inserting a mechanical blade or some sort of heat cutting device that's always hot into the uterus, isn't it?
A Well, there's no such thing as that.
It's definitely safer than taking a resectoscope

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loop, which has been kind of the gold standard for years to use, like a cheese cutter type of open ex- -- open exposed loop. So this would be much safer than that, if that's what you were referring to.
Q Well, it is.
And the purpose of that change from a loop or an exposed roller ball to the type of cutting mechanism that the Symphion device has is to try to reduce incidents of injury and perforation to the uterus, correct?
A Not really, no.
It's -- it's -- it's a -- unipolar electrosurgery is more unpredictable than a bipolar radiofrequency type of electrosurgery, but you can get perforations with either one of those systems.
It's -- it's -- it's beneficial to have a blunt tip than an exposed electrode. But as far as what you're trying to accomplish, you know, they both work very well.
Q Well, they both work very well. But all other things being considered, it's safer to have a cutting device that's enclosed and not constantly activated than one that is not, isn't it?
A Neither one of these are constantly activated. You have to hit a foot pedal to activate the energy to do the operation.
Q Well, the loop device traditionally has an

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exposed loop with two prongs on the end of it, correct?
A Well, it's a loop, yeah. It's like a cheese cutter loop, that's correct. And it's unipolar electricity. And that was what we used for years in gynecology for resection. So this is a better, safer type of electrosurgical unit.
(Technical interruption.)
Q (BY MR. BREEDEN) The Symphion device also has a cutting element that's partially enclosed, correct?
A It's inside an aperture, so there's an opening on the end of the handpiece where the energy is activated and the cutting mechanism occurs.
Q And it has a camera attached to it so the surgeon can see what he or she is cutting, correct?
A Well, it's independent. It's not attached to it. But it -- there is a lens and a camera so you can see what you're doing, yes, sir.
Q And if you look through the Symphion manual, it actually says the Symphion device is, quote, created from the ground up to pave the way for greater safety, end quote.
Do you disagree with that?
A Well, I don't think there's ever been a head-to-head study between the Symphion and other resectoscopes. I think that's a claim the company may put

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in a marketing brochure or on their website.
I don't necessarily disagree or agree. I just don't know of any data that would support that statement.
Q Okay. So you take no opinion on that statement then.
A Correct.
Q Now I want to ask you something here.
Is it your understanding of the law that if something during a procedure is deemed to be a known risk or complication of the procedure, that the physician is never responsible for that risk or complication if it occurs? Is that what you believe the law to be?
MS. HALL: And I'm going to object. He's here as a medical doctor, not to offer opinions on the law in the state of Nevada. So I think it calls for a legal conclusion and it's beyond the scope of this witness.
Q (BY MR. BREEDEN) You can answer, Doctor.
A I don't believe that. I believe that complications can occur with neglect of the surgeon or without neglect of the surgeon.
Q Okay. So with Ms. Taylor's particular case, she had what's called a bicornuate uterus, correct?
A Correct.
Q That condition was well known to Dr. Brill prior to the surgery, correct?

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A Correct.
Q In your opinion, is it possible to safely perform a hysteroscopy and fibroid tumor removal on a patient who has a bicornuate uterus?
A Yes, sir.
Q You've certainly done that in your clinical practice without causing a perforation to the uterus or bowel, haven't you?
A I have.
Q Okay. Ms. Taylor also had what's called a retroverted uterus.
That condition was well known to Dr. Brill prior to surgery, wasn't it?
A It was.
Q Is it possible to safely perform a hysteroscopy and fibroid tumor removal on a woman with a retroverted uterus without causing injury to the uterus or the bowel?
A Yes, it is.
Q And you certainly have done those procedures on women in your clinical practice without injuring the uterus or bowel, correct?
A I have.
Q Okay. During the procedure that Ms. Taylor had, the use of the resectoscope was not blind, was it?
A No.

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Q There are certain parts of the procedure that are done blind, in other words, without the use of the camera or visualization by the surgeon, correct?
A Correct.
Q Would it be more proper to say "doctor" or "physician" rather than "surgeon," or is "surgeon" acceptable to you?
A Oh, you can call me whatever you want to. It doesn't matter to me.
Q What parts of this procedure are blind then?
A The part that is blind is when you're inserting the equipment into the cervix, until you get able to distend the cavity so you have an operative field to be able to see.
Q In your opinion, is it more likely that injuries or perforations during the procedure occur during the blind portions of the procedure?
A No, I don't -- I don't share that opinion.
All the perforations that I've ever had -- I've never had a perforation with going through the cervix. They've all occurred once I was in the uterine cavity.
So I don't know the data on that. But in my experience as a surgeon, I've never known to have a perforation when dilating the cervix.
Q What are the other blind portions of the

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procedure?
A Usually the only blind portion is dilatation of the cervix.
Q All the other portions of the procedure should be done under visualization?
A That's the idea, yes.
Q Okay. When during the procedure on Ms. Taylor do you believe the injury to the uterus occurred?
A Well, my belief after reviewing the record is that it occurred when Dr. Brill was advancing the camera in the process of taking the septum down.
Q Okay. Do you believe it occurred during the use of the resectoscope then?
A The resectoscope was in place. It was in the operative channel of the hysteroscope. But I don't believe there was active energy deployed when this perforation occurred. I think it was when -- I believe it was when he was advancing the equipment into the uterus to get to the septum.
Q Okay. So in your opinion, the injury to the uterus was not caused when the yellow pedal was activated?
A No, I don't believe so.
Q Okay. So it is your opinion that this injury to the uterus was not caused by the cutting element of the resectoscope then.

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A No. I don't believe that.
Q Okay. You believe it was caused by a mechanical push of an instrument through the uterine wall?
A Yes.
Q Okay. And do you believe then that was caused by the resectoscope or the camera?
A Well, they're all in one. The -- you know, the camera is just the end of the scope, and the resectoscope goes beyond the lens of the camera so you can see it.
Q Yeah. So in terms of centimeters or millimeters, how far apart is the end of the resectoscope from the camera?
A I'm not sure of that exact number, how far. But I know it extends beyond the end of the scope.
Q Okay. Are they close? Do you think it's a matter of millimeters or centimeters?
A I would think it was a -- it would be a couple centimeters.
Q Okay. And, again, do you think it was the tip of the resectoscope or the camera that caused the injury to the uterus?
A I believe it was the tip of the resectoscope, as he was advancing the camera, went through the uterus.
Q When do you believe the injury to the small bowel occurred?

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A At that time, when he perforated the uterus.
Q So you believe it was one act that the tip of the resectoscope went through the uterine wall and into the small bowel.
A Correct.
Q And you do not believe the yellow pedal was engaged at that time; is that correct?
A That's correct.
Q If it was the tip of the resectoscope causing the perforation, shouldn't Dr. Brill have been able to see all of this on the camera?
A No, because you lose your distension. The -- the equipment has a fluid management system that monitors intrauterine pressure as you distend the cavity; and once you poke a hole into the musculature of the uterus, you lose your ability to see.
Q Okay. There were no problems with dilation or distension prior to the injury to the uterus, correct?
A According to the records, I would say that's correct.
Q Okay. So correct me if I'm wrong, but if the injury occurred as you say it occurred, Dr. Brill would have been looking at the tip of the resectoscope the entire time while the injury occurred; is that accurate?
A Yes. But you can't see that when it occurs --

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Q Why can't you?
A -- cause you lose your -- well, you ever -- if you fill up a balloon with water and you poke a hole in that balloon, what happens? You lose the distension of the balloon, and you lose your ability to see.
And that's what always happens when you have a perforation. So once the perforation occurs, you lose that vision until you're able to distend the cavity and see the perforation, cause once the perforation occurs, you get contraction of the muscle that allows that to fill up and see the perforation.
Q Based on your review, do you have an opinion as to whether or not the camera was ever advanced past the uterine wall?
A I -- I don't -- I don't know. According to my review, I can't determine if it did or didn't.
Q So you have no opinion on that particular subject.
A Yeah. That the camera went past the uterine wall --
Q Yes.
A -- that was the question?
No. I know the camera was able to visualize the perforation. That -- that we know.
But as far as how far or how deep into the

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perforation to visualize, I don't ever remember reading any testimony that that question was ever asked.
Q So is it your opinion then that the most likely scenario is the tip of the resectoscope went through the uterine wall, into the small bowel, but the camera portion of the instrument did not go past the uterine wall?
MS. HALL: Calls for speculation.
THE WITNESS: Again, I don't -- there's nothing in the records that would answer that question.
So my answer would have to be I don't have an answer. I mean I -- I don't know.
Q (BY MR. BREEDEN) Okay. Just generally speaking, Doctor, do you believe an OB-GYN using a resectoscope for a procedure such as this needs to use his or her skill, training, and experience to avoid injury to the uterus to the extent that is possible?
A Yes, I would agree with that statement.
Q Again, generally speaking, do you believe an OB-GYN using a resectoscope for a procedure such as Ms. Taylor's must use his or her skill, training, and experience to avoid injury to the small bowel to the extent that is possible?
A Yes, I would agree with that.
Q Do you believe the standard of care for this procedure requires the physician to be able to visually

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see where he is within the uterus at all times?
A Yes.
Q Okay. And do you believe he's required to visually identify what he or she is cutting before activating the cutting element?
A Yes.
Q Would you agree with me that if a physician is unable to clearly identify where he or she is within the uterus, they should not be activating the cutting element with the yellow pedal?
A Yes.
Q Okay. But you don't think this injury was caused during use of the yellow pedal, do you?
A No, I don't.
Q During a hysteroscopy, when fibroid tumor removal -- scratch that.
Do you believe the standard of care requires a doctor to stop during the procedure after an injury to the uterus is identified?
A Stop what? Stop what they're resecting? Or stop the whole operation? Can you be a little more specific on the question?
Q Yes.
To stop the entire procedure and remove all instruments.

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A Well, I think they have -- if they do that, they're not able to assess the degree of the injury. So I believe that they can continue in a cautious and acceptable manner to do whatever it is they feel they have to complete at that time.
Q And so when you say what you feel they have to complete, do you mean what is necessary to inspect for the damage? Or do you mean to continue with the intended procedure?
A No. The -- the standard of care requires once a perforation is recognized, that you need to complete any operative hysteroscopic techniques. So you would not continue to do the resection of the septum or the fibroid or the ablation.
Q Okay. Would you continue to do curettage?
A You can do that if you do it in a careful, safe manner. You can -- you can do that. I've done that. I've perforated uteruses, and I've been careful to get at least a tissue sample to rule out any cancer or any hypoplasia or any other pathology that you'd be concerned about.
Q You don't think the standard of care requires you to stop curettage, not do curettage after injury's identified?
A No. I think that, as described in the operative

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report, in a retroverted uterus, knowing there's an anterior perforation, that Dr. Brill was not practicing out of the standard of care to do a soft posterior wall curettage. I think that is okay to do.
Q So you did say that the standard of care requires the physician to inspect the injury or perforation, correct?
A Correct.
Q So what does that standard of care require the physician to do?
A To look at the perforation, to look into the opening to see if there's any signs of any other complications that may occur.
If you're using unipolar electrosurgery and you get a perforation as you're advancing the electrode with energy on, then the standard of care would require you to do a laparoscopy to look and make sure there's no thermal injury to the bowel or other organs.
Q Okay. What leads you to believe or conclude that this injury occurred with the tip of the resectoscope as opposed to with the cutting element?
A Well, if you're cutting, you're resecting tissue, right? So if you perforate the uterus as you're activating the cut mode of the resectoscope and you perforate the bowel, you're going to have bowel tissue in

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your sample, which it's a -- it -- it works by cutting and sucking. So when you resect, you're actually pulling tissue into the operative channel of the instrument. So obviously that wasn't done because there was a specimen sent.
And the other thing you would notice would be on the pathology report of that tissue that you burned and resected more of a thermal injury, not a blunt injury.
So there's really no evidence to suggest that this was a thermal injury.
Q So when it was eventually identified, the injury to the small bowel was 3 centimeters long, correct?
MS. HALL: Form --
THE WITNESS: No, that's incorrect.
MS. HALL: Sorry, Doctor.
It misstates the evidence.
Go ahead, Doctor.
THE WITNESS: That's -- that's incorrect.
It was a 1.6 centimeter injury to the small bowel.
Q (BY MR. BREEDEN) And so where do you get that measurement from?
A From the pathology report.
Q Okay. Have you seen the doctor's report that indicates 3 centimeters?

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A Yes, I did. She -- she -- had she measured that injury -- she just -- I think that was a visual -- visual guess on Dr. Hamilton's part.
Certainly the pathology report is a measurement that's much more specific, reliable, than one's visual guessing of the size of an opening.
Q Let me ask you, in millimeters, how big is the blunt end of the resectoscope?
A 3.6.
Q Millimeters.
A Yes.
Q So what, approximately five or six times less than the injury to the small bowel, correct?
A Yeah. But you have a small bowel that's been leaking, that's inflamed, that's been under pressure, that stretches, that moves, so that -- you can't compare -- those aren't apples to apples in comparison.
Q Okay. So you don't think -- the measurement post-op of the injury you don't think is reflective of the size of the original injury?
A No.
Q So Dr. Brill completely failed to identify a bowel injury intraoperatively, correct?
A Yes, sir.
Q He indicated that he looked with the camera from

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inside the uterus to the bowel to see if there were any injury. Do you recall reading that in his deposition?
A Yes, I did.
Q Okay. Do you believe that's possible, to adequately observe the bowel from a camera inside the uterus?
A Well, I've done that on cases where I've perforated.
And, again, blunt perforations, which that's what this was, a blunt perforation, that's the standard of care, to look at the perforation, see if there's any type of injury in the area of the perforation; and if there's not, then that's satisfied by the standard of what you should do in a perforation with a hysteroscope.
Q So, again, my question is do you think Dr. Brill was able to adequately assess the small bowel for injury from a camera inside the uterus?
A Well, no. You can't do that. But there was no need to adequately look at the bowel. You look at the area of perforation and see if there's any bowel in that area, and that's what's required of the surgeon at the time of a uterine perforation.
Q Well, we know in fact that there was a bowel perforation during the procedure that Dr. Brill failed to find, correct?

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A Well, we also know that a bowel perforation is a known complication of a procedure like this. So it was eventually diagnosed and treated.
Q Yes. All the more reason why it should be adequately looked for after a perforation of the uterus.
So let's go back to my question. We know that there actually was a bowel perforation during the procedure that Dr. Brill failed to identify, correct?
A You always don't identify complications when they occur. That's known in what we do as surgeons. Complications occur, and you -- as a matter of fact, the majority of small bowel perforations are diagnosed postoperatively, not intraoperatively.
Q Why wouldn't Dr. Brill explore the bowel laparoscopically to make sure he had not injured it?
A Because it -- he felt like he ade- -- in his operative report, he says there's no evidence of bowel or other organs in the area of the uterine perforation, and that's what's required of him when this occurs.
So he did what he felt was acceptable. He looked for a bowel injury, looking through the hole in the uterine wall. It was the anterior part of the uterus. He didn't see any signs of a bowel perforation. That doesn't mean there isn't one there. But he looked and didn't see one, and that was acceptable. That's how we operate.

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There's risks associated with surgery. You always don't diagnose bowel injuries or any other type of injury at the time of the procedure.
Q How many times have you perforated a patient's uterus in your practice?
A Probably a dozen times.
Q How many times have you perforated a patient's bowel performing this type of procedure?
A None that I know of.
Q Very rare, wouldn't you agree?
A This is a very rare complication. We all know that. It's a very rare complication. Unfortunately, it occurred, and nobody intended to perforate Mrs. Taylor's bowel.
Q Do you believe the standard of care required Dr. Brill to advise the PACU nurse that there was injury to the uterus during the procedure?
A No.
Q Do you believe the standard of care required Dr. Brill to advise Ms. Taylor that there was injury to the uterus during the procedure?
A Yes.
Q Okay. And so what would the standard of care require him to do to advise her of that?
A Well, you would have -- A, you would have to

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document it in the operative report; and B, you would have to tell the patient during the procedure there was a perforation of the uterus.
Q When should that be done?
A Whenever it's appropriate, when the patient and you are having the conversation. I wouldn't do it in the recovery room, cause usually when I talk to patients in the recovery room, which I never do anymore, they don't remember what you tell them. So I would have told her either at the post-op visit, or if I talked to her before that visit, I would tell her.
Q Okay. So how in your opinion then would a patient the day of the procedure ever find out there had been an injury to the uterus?
A Well, I would -- usually I'd call a family member to tell them how the procedure went or go out and talk to a family member, and that's who I would tell, you know, immediately there was a perforation in the uterus, and that's why I didn't complete what we were hoping to complete. That would be acceptable to do that.
Q And if that didn't occur in this case, would you say that's below the standard of care?
A I would say a conscien- -- I would say the standard of care -- I'm really not sure what the standard of care is on what you tell a family member, because I've

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had patients tell me, you know, don't tell my family anything.

But I would think a reasonable approach would be to tell the family if you felt that was acceptable to the patient.

Q Okay. What if there were -- just hypothetically, what if there were no family member? I mean this patient didn't have any family member, they're in the recovery room, how would you make sure they were advised so they know over the next 24, 48 hours that there was a perforation of their uterus?

A Well, I would probably -- and you said a hypothetical. Let's say if the patient went home, then I would probably call the patient that night and check on them, when she's more alert and can understand what you're saying and tell her what happened.

Q And can we agree that Dr. Brill did not do that in this case?

A I don't believe so. I think he said in his deposition he told a family member or friend by the name of Barbara that there was a perforation.

Q Have you ever seen a uterus injury caused during hysterectomy and fibroid tumor removal that you felt was beneath the standard of care?

MS. HALL: Object to the form, lacks foundation.

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THE WITNESS: I think he said hysterectomy, but he didn't mean that, right?

Q (BY MR. BREEDEN) Oh, you're right. I'm sorry. I meant hysteroscopy.

A Have I ever seen -- I'm -- I'm sorry. Maybe I'll ask you to repeat the question.

Q Yeah. To repeat the question -- you're right. I apologize. I used the wrong terminology.

Have you ever seen a case where a doctor performed a hysteroscopy and fibroid tumor removal where there was a perforation through the uterus that you felt was beneath the standard of care?

A I've never reviewed a case -- this is a rare complication. It's not very common. So I -- I can't think of a case that I've actually reviewed or saw at a conference or something like that where I felt gosh, that doctor really messed up. I just haven't -- don't recall of anything like that.

Q So every time you've seen that injury occur, it has in your opinion just been an unpreventable risk to the patient?

MS. HALL: Form, misstates --

THE WITNESS: Well --

MS. HALL: -- the testimony.

Sorry, Doctor.

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THE WITNESS: No. I mean I -- I don't have any reference point to answer the question. So I've just never seen something where a doctor negligently, you know, got a bowel perforation doing a hysteroscopy. I just haven't seen anything to give you an answer.

Q (BY MR. BREEDEN) Okay. So I'm sorry, I don't know if I misspoke or if you misinterpreted my question.

I'm going to separate it out into uterine injury and bowel injury.

A Okay.

Q So the first question is have you ever seen a case where the doctor injured the uterus during a procedure -- a hysteroscopy and you said that is beneath the standard of care, what was done there was below the standard of care, that could have been prevented?

A I've never had an opportunity to answer that question. I've never seen it. I've never been asked to review a case like that.

Q Okay. So all the cases you've been asked to review that refer to uterus injury during hysteroscopy, your opinions have been that there was no violation of the standard of care.

MS. HALL: Foundation.

THE WITNESS: Yeah. And this is, again, not a common occurrence. So I'm not saying that I've reviewed a

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hundred cases like this --

Q (BY MR. BREEDEN) Now --

A -- but I do recall --

Q I didn't mean to cut you off, Doctor. I thought you were done with your response.

A No. I'm done. It's okay.

Q So the follow-up question is a similar one.

But I guess maybe the answer is you've never even seen this before, but have you ever seen a bowel injury caused during hysterectomy that you felt was beneath the standard of care for the physician?

MS. HALL: You mean hysteroscopy?

MR. BREEDEN: Hysteroscopy. I'm sorry.

Let's create a clean record.

MS. HALL: I don't want to interrupt you, but I want it to be right.

MR. BREEDEN: Yes. Okay. So let me restate the question.

Q Have you ever seen a bowel injury caused during hysteroscopy that you felt was beneath the standard of care by the physician?

A No.

Q Okay. Have you ever seen a -- another bowel injury during hysteroscopy as happened in Ms. Taylor's case in any other case?

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A The only other case -- I've never seen a hysteroscopy like Mrs. Taylor's case.
I have seen a bowel injury and have heard of bowel injuries from ablation.
Q So you've been retained by claimants or injured patients in other matters, correct?
A Correct.
Q You've testified in other matters that when the physician caused a bowel injury during a gynecological procedure, that that was beneath the standard of care, haven't you?
A Yes, I have.
Q Okay. Approximately how many times have you testified to that in other cases?
A I'm not sure.
Q Well, let's talk about a few of them.
A Okay.
Q I was looking at your testimony list, and there's a case called Craigo versus McLean.
What do you recall about that case?
A You'll have to refresh my memory on that.
Q Well, that -- that --
(Reporter interrupted; multiple speakers.)
Q (BY MR. BREEDEN) That appears to be a case out of the state of Michigan where you testified that a rectal

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perforation during a hysterectomy was beneath the standard of care by the gynecologist.
Do you recall that?
A I'm sorry, I don't. I mean I'm not saying I didn't do it. I just don't recall the details of it.
Q Do you recall the case of Lewis versus Pickle out of Arlington, Texas, where again you testified that a rectal perforation during hysterectomy was beneath the standard of care?
A Again, I'm sure I did that. I think that was -- I think that one was a hysterectomy, if I remember correctly, yes. I remember a little bit of that case at this point.
Q And there's another matter, the Thompson case, from Florence, Alabama, about perforation, again it appears during a hysterectomy, where you testified that was beneath the standard of care, didn't you?
A Yes.
Q Okay. What about those bowel perforations was beneath the standard of care? And how is that different from this case where you're testifying that the bowel perforation is within the standard of care?
A Well, I mean there's so much more information. Those I believe were laparoscopic procedures with different disease, different approaches. I mean I

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don't -- I can't remember specifics of each one of those cases.
But I look at each individual case and -- and give my thoughts and through my education and training if there was a breach in the standard of care or not.
Q In those cases, just like Ms. Taylor's case, wouldn't there have been some sort of consent form that says we're performing this hysteroscopy, one of the risks is perforation of adjacent structures or the bowel?
MS. HALL: Form, foundation.
THE WITNESS: Yes, sir.
Q (BY MR. BREEDEN) But, again, in those cases, you testified against the physician, whereas in this case you're testifying in favor of the physician.
A Well, I think that probably by definition is what an expert does. You review the records and see what happened, and you look at all the circumstances, and you see if there was a breach in the standard of care or not, and --
Q Hypothetically --
A -- I believe --
Q I apologize again. I thought you were done with your answer.
Do you have anything more?
A That's okay.

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Q Hypothetically, if Dr. Brill perforated the uterus and perforated the small bowel and went all the way and perforated the lungs of Ms. Taylor, would you think that's below the standard of care?
A Yes.
MS. HALL: Incomplete hypothetical.
Q (BY MR. BREEDEN) So is the difference to you the severity in the perforation?
A No. It's the -- well, it -- I'm not sure what you mean by that.
But obviously, if you have a -- you're doing a hysteroscopy and you perforate somebody's lungs, which is virtually impossible, that would be complete neglect.
Q Let me give another example then.
How about perforated through the uterus, through the small bowel, into the kidney?
A That would be I believe -- I would say that would be -- this is all hypothetical, obviously. But yes, I would feel that that would be a breach of the standard of care.
Q I want to talk quickly about opinions that based on your report you don't appear to have.
Do you have any opinion that Ms. Taylor caused or contributed to her injuries?
A No. I mean my opinion -- I'm sorry.

My opinion is that she did not.
Q Do you have any opinion that Ms. Taylor is somehow malingering or exaggerated her symptoms after her injury?
A No, sir, I don't believe she has.
Q Do you have any opinion that Ms. Taylor's treatment to repair her bowel after the April 26th procedure was for some reason not reasonable?
MS. HALL: Form.
THE WITNESS: My opinion is that she did not do something that was unreasonable.
Q (BY MR. BREEDEN) Okay. So I'm talking about the medical treatment after the perforations, after the original procedure.
You've reviewed all those records, haven't you?
A Yes, sir.
Q Those include emergency room records, correct?
A Correct.
Q They include ambulance records, correct?
A Correct.
Q They include hospital records, correct?
A Correct.
Q And do they include some outpatient treatment as well?
A I believe so, when she -- after the surgery to

repair the bowel, yes, sir.
Q Yes.
And so you're not going to give any opinion that for some reason that treatment was unreasonable, given what had happened to her, are you?
A No.
Q Okay. Have you reviewed the medical billing in this case?
A No, sir.
Q Okay. Do you intend to give any sort of opinion that the medical billing for some reason is excessive or not usual and customary?
A I am not.
Q Do you intend to give any opinion that any healthcare provider other than Dr. Brill breached the standard of care, in other words, that Dr. Christensen, Henderson Hospital, Nurse Hutchins, or St. Rose Hospital somehow breached the standard of care?
A I am not.
Q Have your opinions today been to a reasonable degree of medical probability in your field?
A Yes, sir.
MR. BREEDEN: Those are all the questions that I have.
THE WITNESS: Okay.

MR. BREEDEN: Do you have anything, Heather?
MS. HALL: No.
We'll review and sign.
MR. BREEDEN: Okay.
Before we go off the record, I do want to indicate -- I'm sorry. I think there was a typo in my notes.
I may have referred to the date of surgery as April 6th instead of 26th. And if I did that, I just wanted to be on the record that obviously that was mistaken if I said that.
So we'll go off the record at this time.
MS. HALL: Before we do that, Dr. McCarus, did you receive payment for today?
MR. BREEDEN: Oh --
THE WITNESS: No, I did not.
MS. HALL: Okay. We'll talk about that then off the record.
MR. BREEDEN: Yes.
THE WITNESS: Okay. No problem.
MR. BREEDEN: We're off the record now.
(The taking of the deposition was adjourned at 11:52 a.m.)
* * * * *

CERTIFICATE OF DEPONENT

I, STEVEN D. McCARUS, 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.

_____
STEVEN D. McCARUS, 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, STEVEN D. McCARUS, M.D., commencing on Friday, August 6, 2021, at 11:03 a.m. Pacific Standard Time. 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) was not 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 “6”

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BEFORE THE SUPREME COURT OF THE STATE OF NEVADA

ALI PIROOZI, M.D., Petitioner, v. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK; AND THE HONORABLE JAMES BIXLER, DISTRICT COURT JUDGE, Respondent. TIFFANI D. HURST and BRIAN ABBINGTON, jointly and on behalf of their minor child, MAYROSE LILI-ABBINGTON HURST; MARTIN BLAHNIK, M.D., Real Parties in Interest.	Supreme Court Case No.: _____ EJDC Case No.: A-10-616728-C **EMERGENCY PETITION FOR WRIT OF MANDAMUS** **RESPONSE REQUESTED PRIOR TO TRIAL COMMENCING ON FEBRUARY 18, 2014**

Petitioner, Ali Piroozi, M.D., by and through counsel of record Cotton, Driggs, Walch, Holley, Woloson & Thompson hereby brings this Petition on an emergency basis due to the fact that trial is set to begin in this matter on February

18, 2014 and end February 28, 2014. The issue in this Petition is limited in scope to the questions of: (1) Whether or not settling former defendants in a medical malpractice case who was alleged to be negligent can be placed on the jury verdict form so that a jury can properly allocate fault to the settling defendants per NRS 41A.045; and (2) whether or not remaining defendants in a medical malpractice case can do more than simply argue no negligence or 100% negligence of settling defendants. Respondent in this case improperly Ordered that, pursuant to NRS 41.141 and Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004), the remaining Defendants could not: (1) Allocate fault to settling defendants; nor (2) place the settling defendants on the verdict form. Respondent further held that, the remaining Defendants could only argue to a jury that they were not at fault and/or that the settling defendants were 100% at fault.

DATED this 4th day of February, 2014.

COTTON DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

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VERIFICATION

Under penalty of perjury, the undersigned declares that he is the attorney for Petitioner named in the foregoing Petition and knows the contents thereof; that the pleading is true of his own knowledge, except as to those matters stated on information and belief, and that as such matters he believes to be true. This verification is made by the undersigned attorney pursuant to NRS 15.010, on the ground that the matters stated, and relied upon, in the foregoing Petition are all contained in the prior pleadings and other records of the District Court, true and correct copies of which have been attached hereto.

Executed this 4th day of February 2014.

Christopher G. Rigler, Esq.

SUBSCRIBED AND SWORN to before me

this 4th day of February, 2014

NOTARY PUBLIC in and
for said County and State

NOTARY PUBLIC
J. LINCOLN-BRYSON
STATE OF NEVADA - COUNTY OF CLARK
APPOINTMENT EXP. AUGUST 21, 2014
No. 02-77157-1

PETITION FOR WRIT OF MANDAMUS

I. INTRODUCTION

Below is a general background of the case. The Statement of Facts provides citations to specific relevant facts this Court needs to evaluate the instant Petition.

This is a medical malpractice cases involving treatment of an extremely premature child (born at 28.2 weeks gestation weighing 2 pounds, 13 ounces), MayRose Lili Abbington-Hurst (hereinafter "MayRose"), who was ultimately diagnosed with an extremely rare condition called Diamond Blackfan Anemia. The child was under the care of two neonatologists, the remaining Defendants Ali Piroozi, M.D. (hereinafter "Petitioner Piroozi") and Martin Blahnik, M.D. (hereinafter "Defendant Blahnik"), at Sunrise Hospital and Medical Center (hereinafter "Sunrise") from May 14, 2008 (date of birth) until August 2, 2008 being treated for various medical conditions. At discharge, Petitioner Piroozi ordered, among other things, follow-up CBC, Dif and Retic testing within one month and sent the child for a pediatrician follow-up. Thereafter, the parents of MayRose passed along the discharge instructions to former Defendant Ralph Conti, M.D. (hereinafter "Conti") during the first appointment with him at former Defendant Foothills Pediatrics (hereinafter "Foothills") just three days after the discharge from Sunrise. MayRose would attend six total visits with either Conti or other physicians at Foothills. The orders provided at discharge from Petitioner Piroozi were never carried out but, during the last visit at Foothills on October 24,

2008, a non-defendant Kathleen Weber, D.O., ordered blood testing to rule out a viral infection. The tests ordered by Dr. Weber were carried out on October 28, 2008 but, unfortunately, the very next day, MayRose went into anemic shock and was taken to Summerlin Hospital. Notably, the anemic shock incident took place nearly three months after Petitioner Piroozi discharged the child from Sunrise (discharge took place on August 2, 2008). It was later determined that the child suffered a significant brain injury after the anemic shock incident. It wasn't until April 7, 2009 that the child was diagnosed with Diamond Blackfan Anemia.

Prior to his passing, Conti testified in a deposition that he did not perform the follow-up testing ordered by Petitioner Piroozi because he did not feel as though such was necessary after examination of the child during the follow-up appointments. As he was not sure whether or not he read the discharge summary that was given to him by MayRose's mother, Conti testified that: "...If I had read it, and I'm looking at this kid, and I'm looking at this, I'm looking at MayRose, and I think she absolutely didn't need this, I probably wouldn't do it..." Prior to his passing, both Conti and Foothills settled for a substantial amount.[1]

During expert testimony in the case, Plaintiff's experts testified that: (1) Neonatal physicians have a right to rely upon pediatricians to follow discharge

[1] The amount of settlement is not disclosed herein as the Motion to Compromise Minor's Claim in connection with the settlement was filed under seal. Upon Order from this Court, the documentation regarding said Motion which references the settlement amount can be filed under seal for the Court's review.

instructions; (2) neonatal physicians cannot be held responsible for actions of a follow-up physician if orders are communicated to that follow-up physician and not carried out; and (3) if Conti had followed the discharge instructions, it could have prevented the profound anemia that allegedly ultimately led to the brain injury.

The expert testimony discussed above prompted a Motion for Summary Judgment on the issue of causation which was filed by Sunrise[2] and Joined by Petitioner Piroozi and Defendant Blahnik. Respondent denied the Motion for Summary Judgment finding that there was a question of fact as to causation. Although an improper ruling, that ruling is not challenged at this time but will be challenged on direct appeal should an adverse verdict be rendered. However, that Motion for Summary Judgment is important as it provides the factual predicates in this case and also contains important information relevant to the issues presented in this Petition.

After the Motion for Summary Judgment was decided, Respondent also heard and decided various Motions in Limine filed by Plaintiff. Specific to this Petition is Motion in Limine No. 2 entitled: "Exclude Dr. Conti's Settlement from Trial". Through that Motion in Limine, Plaintiff sought to: (1) Prohibit mention of the Conti and Foothills settlement to the jury during trial; (2) prohibit apportionment or comparison of fault (with offset after trial and removal of Conti

[2] Sunrise is no longer a Defendant in this case as they also settled.

and Foothills from the verdict form); and (3) allow for introduction of all alleged reasonable charged medical expenses. Regarding this particular Motion in Limine, Respondent found:

> Plaintiffs' Motion in Limine No. 2 regarding Dr. Conti's settlement is **GRANTED**. Specifically, (1) The fact that a settlement has occurred and the amount of the settlement paid by Dr. Conti and Foothills Pediatrics will not be discussed at trial; **(2) Defendants are not permitted to allocate fault to Dr. Conti and/or Foothills Pediatrics, compare their fault to Dr. Conti's and/or Foothills Pediatrics' fault or place Dr. Conti and/or Foothills Pediatrics on the jury verdict form pursuant to NRS 41.141 and Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004); (3) Defendants may argue to the jury that they are not at fault for MayRose's injuries and/or that Dr. Conti and/or Foothills Pediatrics is 100% at fault for her injuries;** and (4) Plaintiffs are permitted to introduce the full measure of their damages and the Defendants will receive an offset if any verdict is rendered in the amount of any previous settlement amounts pursuant to NRS 41.141.

(Emphasis added).[3]

As will be discussed in the argument section, the findings that are highlighted are in direct opposition of Nevada law and are challenged through this Petition.

II. STATEMENT OF FACTS

Below is a comprehensive statement of facts that are relevant to the instant Petition.

[3] Of note, in the same Order granting Motion in Limine No. 2, Respondent also denied the above referenced Motion for Summary Judgment filed by Sunrise and Joined by Petition Piroozi and Defendant Blahnik.

1. Complaint

The Complaint in this matter was filed on was filed on May 14, 2010. (APP 1-86). Within the Complaint are allegations that Petitioner Piroozi, Defendant Blahnik and Conti were negligent in their care of MayRose. (APP 9-11). There are also allegations of vicarious liability against Foothills and Sunrise. (APP 11-13). Attached to the Complaint are various affidavits including an affidavit from Alan H. Rosenthal, M.D. who details the alleged negligence of Conti and, by way of vicarious liability, Foothills. (APP 16-19). Dr. Rosenthal was eventually disclosed as an expert against Conti and, by way of vicarious liability, Foothills.

2. General Statement of Facts

MayRose was born May 14, 2008 when Ms. Hurst was 28 6/7 weeks pregnant and weighed 2 pounds 13 ounces. (APP 107-111) (discharge summary). Mayrose was treated by various physicians for a plethora of serious medical conditions and had multiple surgical procedures performed. (APP 107-111). MayRose was in the Neonatal Intensive Care Unit (hereinafter "NICU") at Sunrise for a period of 80 days from May 14, 2008 until August 2, 2008. (APP 107-111). In the discharge summary, Petitioner Piroozi noted, among other things:

> The family was instructed to call Dr. Conti for an appointment in 3 days...Follow-up tests: 1) Sweat test; 2) Head U/S; 3) **CBC, Dif, Retic 1 month after discharge**...CC's to Ralph M. Conti, M.D....

(APP 111) (emphasis added).

On August 5, 2008, MayRose, Ms. Hurst and Mr. Abbington attended a follow-up with Conti. (APP 113) (Foothills records). Ms. Hurst testified during her deposition:

> "Well Brian and I took [MayRose] and I handed [Conti] the paperwork...I told him about our entire traumatizing experience from day one with the thick nuchal fold all the way to discharge..."

(APP 236) (Hurst Depo at110:10-16).

During the appointment, Conti noted that the child was a "well child." (APP 113). Conti did not order the follow-up blood testing. (APP 113). Regarding this, Conti provided the following testimony during his deposition:

> Q: Okay, so to be clear, in this case, is it your testimony that even if you had read this discharge order on the first day that MayRose came to you, on August 5, 2008, based on your assessment of her as time goes on that she was not anemic, you would have chosen not to do this test, the CBC with differential?
>
> ...
>
> A: I don't recall whether I read the discharge summary or not. If I had read it, and I'm looking at the kid, and I'm looking at this, I'm looking at MayRose, and I think she absolutely didn't need this, I probably wouldn't do it...

(APP 169) (Conti Depo at 122:16-123:7).

> Q: Okay. In any event, whether you read it or whether you didn't, you did not comply with the NICU doctors' request that you draw a CBC and diff with retic count 30 days after discharge, Correct?
>
> ...
>
> A: I did not order a CBC with retic count at the time. We order what the child needs and nothing more.

Q: And it was you opinion based on your examination of MayRose, that she did not require a follow-up CBC with differential and retic count. Correct?
A: Yes.

(APP 171) (Conti Depo at 130:19-131:9).

Subsequent to the initial appointment, Conti and/or other physicians at Foothills examined MayRose five other times over a nearly three month period (from September 9, 2008 through October 24, 2008) but did not follow the discharge instructions from Petitioner Piroozi. (APP 115-120) (Foothills records). It is undisputed that on October 29, 2008 (nearly three months after discharge from Sunrise), MayRose went into anemic shock. Plaintiff alleges that this anemic shock caused significant brain injury. (APP 7-8). It is undisputed that MayRose was eventually diagnosed with Diamond Blackfan Anemia.

3. Plaintiff's Experts Deposition Testimony

Plaintiff disclosed two experts regarding the standard of care required by Petitioner Piroozi and Defendant Blahnik and causation. Those experts are Marcus C. Hermansen, M.D. and John Strouse, M.D., Ph.D. (APP 129-136) (expert reports). Both were deposed in connection with the lawsuit. (APP 174-194) (Strouse Deposition Transcript); (APP 196-213) (Hermansen Deposition Transcript).

During Dr. Strouse's deposition, the following colloquy took place:

Q: But you agree if the pediatrician in this case had ordered the recommended tests for Mayrose within one month of her discharge

that that likely would have shown some anemia?
A: I think it would have almost certainly shown significant anemia.
Q: And would you agree with me if that pediatrician had ordered those tests and looked at the results that the episode of profound anemia here could have been prevented?
A: I do.

....

Q: Okay. Would you expect – at least, based on the recommendations here – would you expect a competent pediatrician to actually order and assess the complete blood count and retics recommended by Doctor Piroozi within one month post-discharge?
A: Yes.

...

Q: The practical matter is, if once the child's in the pediatrician's hands, whether he had diagnosed it in two weeks or thirty days, still would have had the same outcome here if he doesn't do the test, correct?
A: That is true.

(APP 186-187) (Strouse Depo at 50:5-15; 50:21-51:6; 55:12-17).

During Dr. Hermanson's deposition, the following colloquy took place:

...But basically the answer is, if I've come up with a good plan [discharge plan] and get that plan into the pediatrician's functions, to get the pediatrician aware of the plan, agreeing to the plan and taking it over, I think the neonatologist is off the case at that point.
Q: Okay. And once you've done that and gotten the plan into the hands of the pediatrician, if subsequently the pediatrician decides to ignore portions of your plan but doesn't tell you, do you think you're responsible for the conduct?
A: Not if I've given him a good plan and communicated it. If I've done those then – and – no, I don't feel responsible if they go on their own route.

(APP 203-204) (Hermansen Depo at 32:14-33:3).

4. Stipulations By Plaintiff Regarding Evidence At Trial

Via stipulation, the parties agreed as follows regarding evidence that can or cannot be presented at trial:

> ...It is uncontested and agreed by all parties that Plaintiff's Diamond Blackfan Anemia not being diagnosed in the NICU by Defendants Martin Blahnik, M.D., and Ali Piroozi, M.D., was not below the standard of care. All parties agree that it will not be argued before the jury that Plaintiff's Diamond Blackfan Anemia should have been diagnosed in the NICU by Defendants Martin Blahnik, M.D. and Ali Piroozi, M.D.; however, Plaintiff specifically reserves the right to argue, among other things, that the standard of care did require Defendants Martin Blahnik and Ali Piroozi to recognize (1) that MayRose Hurst's anemia was not 'due to prematurity'; (2) that there was an undiagnosed pathological cause for the anemia; and (3) that further investigation into the cause of MayRose's anemia was warranted by said Defendants; and...
>
> It is uncontested and agreed by all parties and their respective experts that MayRose Hurst did not require further hospitalization at the time of her discharge from the NICU. However, [Plaintiff] reserve[s] the right to argue that MayRose Hurst's hematocrit and hemoglobin were not stable at the time of discharge and were in fact on a downward decline which indicated MayRose's need for both (1) investigation into the cause of her ongoing anemia on either an inpatient or outpatient basis; as well as (2) instructions to MayRose's parents and pediatrician that she had ongoing anemia that would need to be closely followed to determine if she would continue to require transfusions on a weekly and/or bi-weekly basis as she had done from the date of her birth. All parties agree that Defendants Martin Blahnik, M.D., and Ali Piroozi, M.D., did not fall below the standard of care by discharging Plaintiff from the NICU on August 2, 2008; however, [Plaintiff] reserve[s] the right to argue that the method and manner of MayRose's discharge, including the discharge plan, instructions, orders, as well as the information given to the parents and/or pediatrician at the time of discharge was below the standard of care...

(APP 383-384) (Stipulation and Order).

5. Motion For Summary Judgment Regarding Causation

Based on the information available to the parties after all depositions were taken and after Conti and Foothills were dismissed via settlement, on October 1, 2013, Sunrise moved for summary judgment regarding causation. (APP 87-213) (Motion); (APP 220-281) (Reply). Petitioner Piroozi and Defendant Blahnik filed Joinders to that Motion. (APP 214-216; APP 217-219).[4] Respondent denied the Motion for Summary Judgment finding that there was a question of fact regarding causation. (APP 374).

6. Motion In Limine Regarding Conti/Foothills Settlement

On November 8, 2013, Plaintiff filed a Motion in Limine to exclude the Conti and Foothills settlement from trial (entitled "Motion in Limine No. 2: Exclude Dr. Conti's Settlement from Trial"). (APP 282-291). Specifically, the Motion sought to: (1) Prohibit mention of the Conti and Foothills Settlement to the jury during trial; (2) prohibit apportionment or comparison of fault (with offset after trial and removal of Conti and Foothills from the verdict form); and (3) allow for introduction of all alleged reasonable charged medical expenses. (APP 282-291). On December 9, 2013, Petitioner Piroozi filed an Opposition to the Motion in Limine. (APP 292-297). On December 9, 2013, Defendant Blahnik filed an

[4] As the ruling on the Motion for Summary Judgment is not specifically challenged in this Petition, all of the pleadings regarding this Motion are not attached. Specifically, Plaintiff's Opposition is not attached as it is rather lengthy. Should the Court wish to review the Opposition, it can be provided upon Order from this Court.

Opposition to the Motion in Limine. (APP 298-304). On December 9, 2013, Sunrise filed an Opposition to the Motion in Limine. (APP 305-314). On December 30, 2013, Plaintiff filed a Reply to the Oppositions. (APP 315-324). During the subsequent hearing on all Motions in Limine, Respondent requested additional briefing regarding Motion in Limine No. 2. (APP 325-326) (Court Minutes). On January 15, 2014, Sunrise filed Supplemental Briefing. (APP 351-359). On January 17, 2014 Petitioner Piroozi filed Supplemental Briefing. (APP 327-334). On January 17, 2014, Defendant Blahnik filed Supplemental Briefing. (APP 335-350). On January 17, 2014, Plaintiff filed Supplemental Briefing. (APP 360-370). After hearing on the issue, Respondent found as follows:

> Plaintiffs' Motion in Limine No. 2 regarding Dr. Conti's settlement is **GRANTED**. Specifically, (1) The fact that a settlement has occurred and the amount of the settlement paid by Dr. Conti and Foothills Pediatrics will not be discussed at trial; **(2) Defendants are not permitted to allocate fault to Dr. Conti and/or Foothills Pediatrics, compare their fault to Dr. Conti's and/or Foothills Pediatrics' fault or place Dr. Conti and/or Foothills Pediatrics on the jury verdict form pursuant to NRS 41.141 and Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004); (3) Defendants may argue to the jury that they are not at fault for MayRose's injuries and/or that Dr. Conti and/or Foothills Pediatrics is 100% at fault for her injuries;** and (4) Plaintiffs are permitted to introduce the full measure of their damages and the Defendants will receive an offset if any verdict is rendered in the amount of any previous settlement amounts pursuant to NRS 41.141.

(APP 374-375) (Emphasis added).

Petitioner challenges the findings in bold as discussed below.

III. ISSUES PRESENTED

Whether Respondent manifestly abused its discretion by: (1) Prohibiting the remaining Defendants from allocating fault to Conti and/or Footills and placing Conti and Foothills on the verdict form; and (2) only allowing remaining defendants to argue that they are not at fault and/or Conti and/or Foothills are 100% at fault.

IV. STATEMENT OF REASONS WHY THIS COURT SHOULD ISSUE A WRIT OF MANDAMUS

A. Writ Of Mandamus Standard/Request For Relief

A writ of mandamus is an extraordinary remedy by this Court available (1) "to compel the performance of an act which the law requires as a duty resulting from an office, trust or station"; (2) "to control a manifest abuse of or arbitrary or capricious exercise of discretion"; or (3) "to clarify an important issue of law." Bennett v. Eighth Judicial Dist. Court, 121 Nev.Adv.Rep. 78, ___, 121 P.3d 605, 608 (2005) (internal quotation marks and citations omitted); NRAP 21. The decision whether to issue a writ lies within this Court's discretion, where the Court "considers the interests of judicial economy and sound judicial administration." Id. (citing State v. Eighth Judicial Dist. Ct. (Riker), 121 Nev. ___, 112 P.3d 1070, 1074 (2005)). "[A] writ will not be issued by this court 'where the petitioner has a plain, speedy, and adequate remedy in the ordinary course of law.'" Id. (quoting Riker, 121 Nev. at ___, 112 P.3d at 1074)).

In the instant case, Respondent committed manifest abuse of discretion because there was evidence specially submitted by Plaintiff in discovery that Conti and Foothills are responsible for the injuries to Plaintiff and, to prohibit arguing allocation of fault and placing both former defendants on the verdict form will subject the remaining Defendants to joint and several liability. Such an error of law calls for this Court to issue a Writ of Mandamus to prevent Petitioner from incurring exorbitant and unwarranted legal fees[5] to continue through a two week trial that will most certainly have to be redone due to obvious error by Respondent. There is no adequate and speedy remedy available to Petitioner to address this problem as Petitioner should not have to adjudicate a trial that will be unfair which, due to clear error, could subject Petitioner to a rather sizable verdict that will take some time for appellate review.[6]

B. Respondent Manifestly Abused Its Discretion When It Essentially Reinstituted Joint And Several Liability In A Medical Malpractice Case

Nevada Revised Statute 41A.045, in clear and unambiguous terms, abrogates joint and several liability for medical malpractice defendants as the statute provides:

> In an action for injury or death against a provider of health care based upon professional negligence, **each defendant is liable to the plaintiff for economic damages and noneconomic damages**

[5] Along with Drs. Strouse and Hermansen, it is expected that Plaintiff will call a total of 8 retained experts while the remaining Defendants will likely call at least 4 retained experts.

[6] Plaintiff is seeking in excess $10,000,000.00 in damages in this case.

> **severally only, and not jointly, for that portion of the judgment which represents the percentage of negligence attributable to the defendant.**
>
> This section is intended to **abrogate joint and several liability** of a provider of health care in an action for injury or death against the provider of health care based upon professional negligence.

(emphasis added).

By its terms, NRS 41A.045 is not limited to certain types of medical malpractice cases and must be construed as applying to all medical malpractice cases. In a medical malpractice case, a defendant can only be held liable for his/her/its ***percentage*** of negligence. A defendant in a medical malpractice case cannot be liable for his/her/its "percentage of negligence" if all reasonable parties who could be responsible for the negligence are not included in the jury's analysis. In this statute, the word "percentage" must have meaning.[7] To remove potentially responsible parties from the verdict form would essentially subject medical malpractice defendants to the concept of "joint and several" liability, which was specifically abrogated by its terms through NRS 41A.045. The Nevada Legislature left it to the Courts to protect the clear and unambiguous intention of ensuring that no defendant in a medical malpractice case is held liable for more than his/her/its percentage of negligence/fault for an alleged injury by a plaintiff. Accordingly, this Court must correct Respondent's decision that essentially allows a jury to find

[7] This Court has held that a statute, "must be construed as a whole and not be read in a way that would render words or phrases superfluous or make a provision nugatory. . . . Further, every word, phrase, and provision of a statute is presumed to have meaning." Butler v. State, 120 Nev. 879, 892-893, 102 P.3d 71, 81 (2004) (internal citations omitted).

the remaining Defendants subject to liability beyond those Defendants' percentage of fault.

To make its finding, Respondent relied upon NRS 41.141 and Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004). As is discussed below, such is not in alignment with current Nevada law.

Nevada Revised Statute 41.141 provides as follows:

> **When comparative negligence not bar to recovery; jury instructions; liability of multiple defendants.**
>
> 1. In any action to recover damages for death or injury to persons or for injury to property in which comparative negligence is asserted as a defense, **the comparative negligence of the plaintiff or the plaintiff's decedent** does not bar a recovery if that negligence was not greater than the negligence or gross negligence of the parties to the action against whom recovery is sought.
>
> 2. In those cases, the judge shall instruct the jury that:
>
> (a) The plaintiff may not recover if the plaintiff's comparative negligence or that of the plaintiff's decedent is greater than the negligence of the defendant or the combined negligence of multiple defendants.
>
> (b) If the jury determines the plaintiff is entitled to recover, it shall return:
>
> (1) By general verdict the total amount of damages the plaintiff would be entitled to recover without regard to the **plaintiff's comparative negligence**; and
>
> (2) A special verdict indicating the percentage of negligence attributable to each party remaining in the action.
>
> 3. If a defendant in such an action settles with the plaintiff before the entry of judgment, the comparative negligence of that defendant and the amount of the settlement must not thereafter be admitted into evidence nor considered by the jury. The judge shall deduct the amount of the settlement from the net sum otherwise recoverable by the plaintiff pursuant to the general and special verdicts.
>
> 4. **Where recovery is allowed against more than one defendant in such an action, except as otherwise provided in**

subsection 5, each defendant is severally liable to the plaintiff only for that portion of the judgment which represents the percentage of negligence attributable to that defendant.

5. This section does not affect the joint and several liability, if any, of the defendants in an action based upon:

(a) Strict liability;

(b) An intentional tort;

(c) The emission, disposal or spillage of a toxic or hazardous substance;

(d) The concerted acts of the defendants; or

(e) An injury to any person or property resulting from a product which is manufactured, distributed, sold or used in this State.

6. As used in this section:

(a) "Concerted acts of the defendants" does not include negligent acts committed by providers of health care while working together to provide treatment to a patient.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(Emphasis added).

Respondent went astray by interpreting this statute because **comparative negligence of the Plaintiff** is not the issue here. The issue is comparative negligence of the current remaining non-settling Defendants and the former settling Defendants and, as such, NRS 41.141 has no application and this Court must correct such an error.

Respondent also relied upon this Court's ruling in Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.3d 52 (2004). In Banks, this Court held, in pertinent part:

> Nothing in NRS 41.141 prohibits a party from attempting to establish that either no negligence occurred or that the entire responsibility for a plaintiff's injury rests with non-parties, including those who have separately settled their liabilities with the plaintiff.

Banks, 120 Nev. at 845, 102 P.3d at 67.

Respondent erred herein by applying Banks to this issue because, once again, we are not dealing with an instance wherein comparative negligence of Defendants (current and former) and Plaintiff is at issue, we are dealing with solely apportionment of all former and current Defendants' allocation of fault. In addition, Banks was issued after a trial that occurred in 1999, prior to the enactment of NRS 41A.045 which did not come into effect until 2004. Id. at 829-830, 102 P.3d at 57-58. As such, this Court must evaluate the current state of the law on the issue of allocating percentage of negligence of all Defendants.

Finally, it is worth noting that, although this Court does not have a case directly on point, other states have allowed the placement of all possible current and former Defendants on a verdict form and argument for a jury to compare the negligence of all possible parties. See e.g. Le'Gall v. Lewis County, 129 Idaho 182, 185, 923 P.2d 427, 430 (1996) (citing Hickman v. Fraternal Order of Eagles, 114 Idaho 545, 547, 758 P.2d 704, 706 (Idaho 1988)) (holding in a non-medical malpractices case "...the jury should consider the negligence of all actors involved in the event giving rise to the negligence, even if the actors are not parties to the particular action or they cannot be liable to the plaintiff by operation or law or settlement...if the jury could conclude, based on the evidence, that an actor negligently contributed to the plaintiff's injury, then the actor must be included on

the special verdict form").

Respondent clearly has abrogated several liability in this case by removing Conti and Foothills from the jury verdict form and by limiting the arguments of the current Defendants at trial. Plaintiff herself has contended through her pleadings and expert testimony that Conti and Foothills (by way of vicarious liability) were negligent and caused damages. (APP 10-13; APP 16-19) (Complaint with Rosenthal affidavit); (APP 186-187) (Strouse Depo at 50:5-15; 50:21-51:6; 55:12-17); (APP 203-204) (Hermansen Depo at 32:14-33:3). As such, this Court must issue a Writ of Mandamus to Respondent and Order that Respondent allow placement of Conti and Foothills on the verdict form (or allow for special interrogatories) and permit argument regarding apportionment of fault to those former Defendants. As asserted at the outset, Petitioner requests that this Court issue the requested Writ of Mandamus prior to the trial which commences on February 18, 2014. Should this Court need additional time to evaluate this issue, Petition requests that this Court issue a stay on the current case in District Court until such time that the issue is decided.

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V. CONCLUSION

For the foregoing reasons, Petitioner respectfully requests that this Court grant this Petition for Writ of Mandamus. Specifically, the Court should Order Respondent to: (1) Place Conti and Foothills on the verdict form so that the jury can allocate appropriate fault to them; and (2) allow for the remaining Defendants to argue that the jury should allocate fault to Conti and Foothills and that the remaining Defendants are not limited to only arguing that no negligence occurred or that Conti and Foothills are 100% negligent.

Finally, should this Court need additional time to review this issue, Petitioner request that, if such is necessary, this Court issue an Order staying the case until resolution of this Petition.

Dated this 4th day of February, 2014.

COTTON DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

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CERTIFICATE OF COMPLIANCE

1. I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because:

[x] It has been prepared in proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

2. I further certify that this brief complies with the page-or type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is:

[X] Proportionally spaced, has a typeface font of 14 points or more, and contains 6,203 words.

3. Finally, I hereby certify that I have read this appellate brief, and to the best of my knowledge, information, and belief, it is not friviolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the

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requirements of this Nevada Rules of Appellate Procedure.

DATED this 17th day of February, 2014.

COTTON DRIGGS, WALCH, HOLLEY, WOLOSON & THOMPSON

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CERTIFICATE OF MAILING

I HEREBY CERTIFY that, on the 4 day of February, 2014 and pursuant to NRCP 5(b), I deposited for mailing in the U.S. Mail a true and correct copy of the foregoing **EMERGENCY PETITION FOR WRIT OF MANDAMUS**, postage prepaid and addressed to:

The Honorable Judge James Bixler
The Eighth Judicial District Court
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89101
Respondent

Catherine Cortez Masto
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EXHIBIT “7”

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; et al., Defendants.	No. A-18-773472-C

DEPOSITION OF DAVID BERKE, D.O., a witness herein, noticed by MCBRIDE HALL, taken at 6809 Indiana Avenue, Suite 100, Riverside, California at 12:55 p.m., Monday, July 19, 2021, before Deborah Deveny, CSR 7990, RPR, RMR.

Job No.: 775800

APPEARANCES OF COUNSEL:

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BY ADAM J. BREEDEN
376 East Warm Springs Road, Suite 120
Las Vegas, Nevada 89119

For Defendants:
McBRIDE HALL
BY HEATHER S. HALL
8329 West Sunset Road, Suite 260
Las Vegas, Nevada 89113

Also Present: Michael Kelly, Video Tech

INDEX

WITNESS: DAVID BERKE, D.O.

EXHIBITS

DEFENSE	DESCRIPTION	IDENTIFIED	MARKED
EXHIBIT A	Notice of Deposition	15	15
EXHIBIT B	Invoices	15	15

DAVID BERKE, D.O.,
a witness herein, having been sworn, testifies as follows:

-EXAMINATION-

BY MS. HALL:

Q. Could you state and spell your full name for the record?

A. Sure. David Berke, D-a-v-i-d, B-e-r-k-e.

Q. And Doctor, you are a D.O., correct?

A. Yes.

Q. And have you ever given a deposition?

A. Yes. Sorry. Yes.

Q. One thing, and we will get into just a moment your deposition experience, but it's very important that you and I do not talk over one another during today's deposition. And that's just so that our court reporter takes us both down accurately. You said you have given a deposition before today. On how many occasions?

A. One.

Q. When was that?

A. In residency. 2000 -- roughly 2010, I would say.

Q. Given that it has been a while since you gave a deposition, I would like to go over some of the ground rules

for today's deposition. One of those is that the oath that you took, obviously we are sitting here in a conference room, but it's the same oath that you take in a court of law. Carries with it the same penalty of perjury.

A. Okay.

Q. And another thing as I mentioned at the outset is just to please try and allow me to finish my question before you start answering so we get a clear record. You will get the opportunity, if you so choose at the end of today's proceeding, we can chat with Mr. Breeden if you need to, but you will get the opportunity to review today's deposition transcript and make any changes you wish to make. But I would caution you that if you make any what I would consider substantive changes, those can be commented upon at trial and can negatively affect your credibility. Do you understand what a substantive change would be?

A. Yes.

Q. Do you have any questions at all before we get started?

A. No.

Q. Have you ever been an expert in a case with similar allegations to the one that you're here to discuss?

A. No.

Q. Can you tell me a little bit about your current medical practice? Do you have any partners at your current

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medical practice?
A. Yes. I'm in a multispecialty medical group with 8 other OB/GYNs.
Q. And am I correct that in addition to the OB/GYNs, that multispecialty group includes other medical specialties?
A. Yes.
Q. Total how many physicians are part of that practice group?
A. 100.
Q. And what sort of specialties other than OB/GYN are included?
A. Adult medicine, internal medicine, dermatology, surgery, urology, endocrinology.
Q. Any maternal/fetal medicine or anything like that?
A. No.
Q. As part of your practice, do you do both obstetrical and gynecologic care?
A. Yes.
Q. Can you break down for me what percentage of your practice is obstetrical as compared to gynecologic?
A. 60 percent obstetrics and 40 percent gynecologic.
Q. And I think I saw probably on your C.V. you graduated from osteopathic medical school in 2007?
A. Uh-huh. Yes.
Q. How long have you been in private practice?

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A. 10 years.
Q. And during that 10 years, how many hysteroscopies have you performed?
A. 500. It's an estimate, between 5- and 600.
Q. 5- and 600 would be your best estimate?
A. Yes.
Q. What about during your medical training, did you perform any hysteroscopies during your medical training?
A. Yes. But much fewer than that.
Q. Can you estimate for me how many during training?
A. 50.
Q. Have you ever, to your knowledge, have you ever had a patient experience a uterine perforation from hysteroscopy?
A. Yes.
Q. On how many occasions are you aware of that happening?
A. 10 to 20.
Q. And do you agree that uterine perforation is a known risk and complication of hysteroscopy?
A. A simple uterine perforation without major complication is an accepted or known risk of the procedure.
Q. What about bowel perforation, have you ever had a patient experience a bowel perforation following hysteroscopy?
A. No, I have not.
Q. And did you review Dr. Brill's deposition in this

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case?
A. I did.
Q. Is it your understanding per his testimony that Ms. Taylor is the first bowel perforation he's ever had a patient experience with hysteroscopy?
A. I don't recall that in his deposition.
Q. You don't recall reading that?
A. No, I don't recall that point.
Q. Do you agree that bowel perforation is a known risk and complication of hysteroscopy?
A. Yes.
Q. It is however more rare than uterine perforation, correct?
A. Yes.
Q. Where are you currently -- where do you currently hold a medical license?
A. State of California.
Q. Any other states?
A. No.
Q. Do you hold surgical privileges anywhere?
A. I do. At our surgery center that is part of the group I work with and at two hospitals in Riverside.
Q. And what are those?
A. Riverside Community Hospital and Parkview Community Hospital and the surgery center is Riverside Medical Clinic

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Ambulatory Surgery Center.
Q. I want to show you the notice in a moment, we will go over the deposition notice for today. But you did tell me off the record that you do not have any documents with you today, correct?
A. Correct.
Q. So just want to show you the curriculum vitae that I received for you in this case. And I just want to know if there's been any changes, if anything needs to be updated. If I can find it. One second.
MR. BREEDEN: I'd help you out but I don't have a printed copy.
MS. HALL: I definitely have it. It's just a matter -- we can go off the record.
(A brief recess was taken.)
BY MS. HALL:
Q. We can go back on. So this is the C.V. which I received for you and I will give you a second to look it over. But my question is just whether anything has changed since that?
A. No. This is -- yes, this is up to date.
Q. The board certification that you have, in what specialty is that?
A. Obstetrics and gynecology.
Q. When did you obtain that?

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A. I initially -- I just got recertified two years ago so --
Q. And obviously --
A. When I first passed the boards after residency.
Q. So you're not grandfathered in, you must recertify?
A. Yes.
Q. And is that every 10 years?
A. 6.
Q. Every 6. I also saw on your C.V. that you're a fellow of the American College of Obstetrics and Gynecology.
A. Yes.
Q. When did you first become a fellow of ACOG?
A. Five years ago.
Q. Is that still current?
A. Yes.
Q. Have you ever been a fellow of the American College of Surgeons?
A. No.
Q. How long have you been doing medical/legal expert work?
A. Two years.
Q. How long -- in those two years, how many cases would you say that you had reviewed? And I mean just reviewed, not necessarily gone on to give a deposition.
A. And you mean not from the state of California for

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like this type of -- because I'm also an expert for the Medical Board of California and I review cases for them so I can include cases for them.
Q. Let's start without that because am I correct that the work you do for the Medical Board of California, that is to assist the board in deciding whether to take action against a physician?
A. Yes.
Q. Okay. So we will talk about that in just a moment. But in terms of medical/legal work.
A. This is the first one.
Q. This is the first one. Since you were retained in this case, have you reviewed any additional medical/legal cases?
A. Nothing formally.
Q. What do you mean by that?
A. Adam asked me an opinion on another case recently. It was informal on the phone.
Q. Given that this is the only litigation matter or medical/legal matter, am I correct that you've never reviewed a medical/legal case on behalf of a defendant?
A. Correct.
Q. Have you ever in your capacity and your work with the California Medical Board, have you ever given any testimony in any administrative matters?

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A. Testimony like verbally or written opinion, which do you mean?
Q. I mean verbally.
A. No.
Q. And it sounds like you have given some written opinions for the board?
A. Yes.
Q. The fee schedule that I received for you says that you charge $350 per hour for review of materials; is that correct?
A. Yes.
Q. And 450 an hour for deposition and trial testimony?
A. Yes.
Q. Assuming that you were to travel to Las Vegas for the trial in this case, what would you anticipate charging per hour for your travel to Las Vegas?
A. The 350 per hour I would anticipate charging.
Q. And do you require any half-day trial payment or full-day trial payments or would it just be an hourly charge?
A. Hourly would be fine.
Q. I read I think in one of your reports, did you charge a retainer in this case?
A. With the first attorney that contacted me about the case I did.
Q. And that would be Jamie Kent?

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A. Yes.
Q. And what was the amount of the retainer that you charged?
A. $2,000.
Q. And did you bill against that retainer for the work that you did from that point forward?
A. Another $450, I believe, yes.
Q. In addition to the 2,000?
A. In addition.
Q. Got it. Can you estimate for me how much total you have been paid for your work in this case?
A. With Mr. Kent and Mr. Breeden?
Q. Yes, total.
A. It's exactly $5,000.
Q. And I believe it was in your February 10, 2021 report, and I'm happy to show that to you where you said that as of that report you had been paid $2,465.
A. Or maybe it was 465, not 450.
Q. That 2,465, did that include the time that you had spent for both your original affidavit as well as your February 10, 2021 report?
A. Yes.
Q. And then since that time you've been paid some additional money bringing it to a total of 5,000?
A. Yes.

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Q. Do you anticipate submitting any bills for any prep time that you may have incurred to prepare for today's deposition?
A. No.
Q. Did you meet with counsel to prepare?
A. On the telephone.
Q. And without disclosing the contents of that discussion, how long was that discussion?
A. 45 minutes.
Q. And when did that occur?
A. Last Friday. Friday, my days --
Q. I think with COVID they all blend together so -- do you know how the first attorney in this case, Jamie Kent, do you know how Jamie found you?
A. Yes. I was referred to Jamie from another expert who knows of me.
Q. And who was that?
A. Paul Sinkhorn.
Q. Do you do any advertising as an expert?
A. I have my information like uploaded to an expert -- online expert firm, and I've been contacted by them but never taken a case, on only one or two occasions.
Q. Do you know the name of it?
A. It was Thomson Reuters but I am not sure if it changed names because I got an e-mail formerly Thomson Reuters

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but I can't recall the name.
Q. Do you know if your name is still listed on that database?
A. I assume so, yes.
Q. Do you pay any fee for that service?
A. No.
Q. In terms of the work that you have done, have you actually prepared billing invoices to submit to the attorney?
A. Yes.
Q. And do you still have those in your possession at your office or on your computer?
A. Yes.
Q. I ask because I want to show you, this has been marked as Exhibit A. And if you turn to the second page there are some requests to produce. And I don't need to go through all of those with you, Doctor. But what I would ask is that if you have any billing invoices related to your work in this case, that would include if you submitted one for your retainer, anything that you did in this case, I just ask that you get copies of those billing invoices, and if you provide those to our court reporter, we can mark those as Exhibit B to today's deposition.
A. Okay.
(Whereupon the documents referred to are marked by the reporter as EXHIBIT A and EXHIBIT B for identification.)

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Q. Have you made any handwritten notes or any memoranda related to your review of materials in this case?
A. No.
Q. Have you ever spoken with Kim Taylor?
A. No. She was on a conference phone call when I believe I spoke with Jamie Kent but I never -- no conversations.
Q. And do you know about when that conference occurred?
A. No.
Q. Would that have been prior to -- I will represent to you that the original affidavit from you in this case is dated April the 25th, 2018. Do you believe that that conference occurred prior to your authoring that original affidavit?
A. Yes.
Q. And do you remember any contents of that discussion?
MR. BREEDEN: I am going to object. I think that would all be exempt from discovery under the new rules. So I would instruct the witness not to respond to that question.
Q. I am not sure I agree with you but your objection is noted and he's instructed you not to answer so I will move on. The defense expert in this case, do you know a medical doctor named Steven McCarus?

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A. No.
Q. Have you ever heard of him?
A. Only in reading his defense expert testimony, whatever you -- yes, his information.
Q. Prior to your work in this case?
A. No, no, no.
Q. Sorry. You've got to let me finish. I know it's hard. Prior to your work in this case, were you familiar with Steven McCarus?
A. No.
Q. When is the last time that you performed a hysteroscopy?
A. A week ago.
Q. In an average month, how many hysteroscopies would you say you perform?
A. Upwards of 10.
Q. I received three reports for you in this case. And I'm happy, since you don't have them with you, I'm happy to show them to you. I got the original affidavit, which was attached to the complaint in this case, and dated April the 25th, 2018. That's the first report I received. And then I received a report that was signed by you February the 10th, 2021.
A. Okay.
Q. And then I received a report that was dated -- from

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you, that was dated May 17th, 2021.
A. Uh-huh.
Q. Have you authored any additional reports other than these three?
A. No.
Q. Have you ever been asked to do so?
A. No.
Q. So again, I do have a copy of your original deposition of affidavit so I will give that to you. If you go to Paragraph 12 of this report, first, I guess Paragraph 2, you list out the documents that you reviewed prior to authoring this affidavit. You did have Dr. Brill, Women's Health Associates of Southern Nevada's medical chart for the patient before you wrote this affidavit, correct?
A. Yes.
Q. You also had reviewed the medical records from Henderson Hospital?
A. Yes.
Q. And the medical records from Dignity Health or St. Rose Hospital.
A. Yes.
Q. Did you feel that you had all of the materials you needed to issue opinions at that time?
A. Yes.
Q. I want to direct your attention to Paragraph 12 of

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this document, and specifically 12-A, you list out -- first in the introductory paragraph for Paragraph 12, you talk about that the care and treatment provided by Dr. Brill, Bruce Hutchins, R.N., Henderson Hospital, Dr. Christensen and St. Rose was grossly deficient, negligent and below the standard of care. And then you go on to give specifics as to your opinions as to how the standard of care was violated by different providers, correct?
A. Correct.
Q. And first you list out Dr. Brill's violation of the standard of care that you found in reviewing those medical records, right?
A. Yes.
Q. And then you list 12-B, you have Bruce Hutchins, R.N. and Henderson Hospital. And at the time you wrote this report you felt that Bruce Hutchins and Henderson Hospital had violated the standard of care by not contacting Dr. Brill or some other OB/GYN regarding the excessive pain medication that had been given to Ms. Taylor, correct?
A. Correct.
Q. You also felt that Bruce Hutchins and Henderson Hospital had violated the standard of care by failing to contact Dr. Brill prior to releasing Ms. Taylor, correct?
A. Correct.
Q. And lastly, you noted that it was a violation of

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the standard of care by Bruce Hutchins and Henderson Hospital to release Ms. Taylor despite her ongoing severe abdominal pain, correct?
A. Correct.
Q. Do you still hold those opinions today?
A. Yes.
Q. If I could direct your attention to 12-C, you list violations of the standard of care that you found for Dr. Christensen and St. Rose regarding that E.R. visit. First, Doctor, you understand that Dr. Brill was uninvolved in that E.R. visit?
A. Yes.
Q. And in fact, nothing in the documentation from that E.R. visit indicates that Dr. Brill was ever contacted; is that your understanding?
A. Yes.
Q. And for Dr. Christensen and St. Rose, you found that there was a violation of the standard of care for failing to obtain a consult with an OB/GYN and/or surgeon based upon the CT report?
A. In relation to the recent surgery she had, yes.
Q. And then you go on to explain what it was about the CT report and the severe abdominal pain that she was continuing to experience. And I will go into it in a moment when we get to your February report. But those opinions, do

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you still hold those opinions today?
A. Yes.
Q. And in fact, in your February report you do list violation of the standard of care by Dr. Christensen, correct?
A. Yes.
Q. And the findings on the CT scan that you feel were suspicious for injury, what were those?
A. The free pelvic fluid and the free air.
Q. And free pelvic fluid --
A. Just pelvic fluid, but increase in the pelvic fluid and the free air.
Q. For those of us who are not medical doctors, the free fluid or the pelvic air, I think one of the words that is used in the CT report or at least Dr. Christensen's documentation is pneumoperitoneum. What does that mean?
A. That means air within the peritoneal cavity.
Q. So they're interchangeable?
A. Yes.
Q. And in your opinion, those violations of the standard of care by Dr. Christensen, Bruce Hutchins, St. Rose, Henderson Hospital, did those all contribute to what you view as the delay in treating this patient's complication?
A. Yes.
Q. I will take that back from you, Doctor. Thank you. So I only have one copy of your February report so if we do

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need to take a break and get an extra, I can certainly do that. May be able to kind of share.

MR. BREEDEN: I think I have a copy.

Q. Oh, good. Thank you.

MR. BREEDEN: February 10, 2021?

Q. Yes, exactly. So I don't -- obviously I am somewhat functionally literate so I've read your report and I don't have a ton of questions for you, but there are some specific things I wanted to ask you about in particular, Doctor. And you were also kind enough or the counsel who retained you was kind enough to give me a list of documents that had been reviewed so let me show you that. So in the initial expert disclosure, which was produced in this case that had your February report, I received Exhibit 1, which says documents, materials reviewed and it's Taylor 1761 and 1762. So I would like to give you a copy so if you could take a look at that list and just mark for me -- actually let's do it on my list so I don't ruin Adam's copy. If you could take a moment and look at this list and identify what documents you had at the time that you authored the original affidavit, I think that would be a short list. So if you could just put a mark or check aside of the ones that you believe you had at the time that you wrote your original affidavit.

A. Okay. It's a little tough because it was a while back, right?

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Q. Well, if that's too difficult, let me ask you this. We already went through that original affidavit and the fact that you had both charts from Henderson and St. Rose Hospital.

A. Yes.

Q. And as well as Dr. Brill's WHASN medical chart. Did you have any other documents to review at the time that you wrote that original affidavit?

A. No.

Q. So other than those materials, everything else on this list would be new information or materials that were provided to you prior to authoring the February report?

A. Yes.

Q. Okay. Very good. I noticed on here that you had some responses to written discovery from plaintiff. Have you ever reviewed any responses to written discovery on behalf of Dr. Brill, in other words, Dr. Brill's responses to written discovery?

A. No.

Q. You did, between that February report and your third report which we will discuss, you did review the deposition of Dr. Brill?

A. Yes.

Q. Have you reviewed any other depositions other than Dr. Brill and Ms. Taylor's which I saw on your list?

A. No.

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Q. Those would be the extent?

A. Yes.

Q. On Page 2 of your report, the February report, you get into your opinions in this case. And then at the bottom of Page 3, you list out your opinions as to how you believe Dr. Brill breached the standard of care. The first opinion that you list is that he failed to use proper care and caution in using the hydrothermal ablation instrument. During what portion of Ms. Taylor's procedure do you believe that Dr. Brill was using the hydrothermal ablation instrument?

A. I think it might be more correct in getting more familiar with that device that it would be that that sentence should say failing to properly use care and caution of the resection instrument that he was using.

Q. Do you now know from reviewing Dr. Brill's deposition that he did not get to the ablation portion of this procedure?

A. Yes.

Q. Do you have any reason to disagree with that?

A. No.

Q. So to be more accurate, that first criticism should say resection or resectoscope?

A. Yes.

Q. The third criticism that you list is that he failed to immediately terminate the procedure after identifying a

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uterine perforation, and instead continued the surgery, including the curettage. Knowing that Dr. Brill did not complete the ablation portion, are you still critical of his use of the curettage?

A. Yes.

Q. And can you explain why?

A. Placing a sharp curette into the uterus that was perforated could increase the chance that the curette would go through that perforation and cause an injury to another organ.

Q. Anything else?

A. Because it's a blind technique and you wouldn't know where the curette was going.

Q. I think you told me that you believe that you've had a patient experience a uterine perforation 10 or 20 times during the hysteroscopies that you have performed during your career. In each of those occasions, did you discuss the complication with the patient directly in recovery?

A. Yes.

Q. And what about the family members for the patient, in each of those occasions, do you recall if you discussed the complication with the patient's family member?

A. Yes, I did.

Q. In this report you go on to talk about the size of first the uterine perforation and then the bowel perforation. In your mind is there a size of uterine perforation which

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would be within the standard of care?
A. No.
Q. So --
A. I don't think you can quantify standard of care necessarily by the size of the uterine perforation. It's more though on how the perforation occurred.
Q. And do you intend to offer an opinion in this case as to the mechanism of Ms. Taylor's uterine perforation?
A. I plan to deliver opinion on the most probable mechanism of injury.
Q. And what is that?
A. Using the resection device.
Q. And are you able to state that to a reasonable degree of medical probability?
A. I am.
Q. And what about the bowel injury, are you intending to offer an opinion as to the mechanism of injury for the bowel perforation?
A. Yes.
Q. And are you able to state that to a reasonable degree of medical probability?
A. Yes.
Q. What is your opinion?
A. That it was done with the resection device that perforated the uterus.

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Q. And do you intend to offer an opinion that both perforations occurred at the same time?
A. Yes.
Q. And what is that opinion based on, Doctor?
A. Reasonable medical certainty that as he perforated the uterus, he kept on going and perforated the bowel.
Q. If a bowel perforation occurs at the time of surgery, what sort of signs would you expect to see as a surgeon?
A. Potentially no signs at the time of surgery.
Q. In the 10 or 20 times that you have had a uterine perforation occur, did you perform a -- did you run the bowel for each of those patients?
A. No. Because I never perforated the uterus with an energy device or a sharp instrument.
Q. And how did the perforation occur on those occasions?
A. Typically with cervical dilation, which is a blunt instrument with a low probability of causing that injury to adjacent organs.
Q. So am I correct then that if uterine perforation occurs with a blunt instrument, you do not believe the standard of care requires that the surgeon run the bowel to inspect for potential bowel injury?
A. Correct. With a stable patient post-op not

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exhibiting signs of a complication.
Q. Right. And I apologize if my question wasn't clear. I want to focus on intraoperatively. So intraoperatively if a uterine perforation occurs with a blunt instrument, you would agree that the standard of care does not require the surgeon to run the patient's bowel for --
A. Yes.
Q. The occasions where you've had a patient experience this complication, meaning uterine perforation, do you believe that you met the standard of care in those instances?
A. Yes.
Q. Is there ever an occasion when a patient had a uterine perforation that you feel you did not meet the standard of care?
A. No.
Q. Have you ever been named as a defendant in a medical malpractice case?
A. Yes.
Q. And on how many occasions?
A. One.
Q. And when was that, what year?
A. It's ongoing. Well, yes, it's an obstetric case.
Q. Given that it's an ongoing litigation, I don't want to get into too deeply of a discussion, but can you briefly tell me what the nature of the allegation is in the case?

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MR. BREEDEN: Yeah. I would like to add I don't think Ms. Hall is going to try to get into too many details in that other case, but I take it you're probably represented by an attorney in that matter?
A. Yes.
MR. BREEDEN: So maybe if you could just limit your answer to things which may be publicly alleged in the complaint. Certainly wouldn't want you to give any details of conversations you have had with your other attorney for that matter.
Q. Exactly. I just want to know what the nature of the allegations raised is.
A. The allegation is allegedly with other physicians in the group the way we managed labor. So allegedly not managing labor correctly.
Q. Is that a birth injury case?
A. No.
Q. And what jurisdiction has that case been filed in?
A. Riverside County.
Q. Who is the name of the attorney who represents you?
A. I don't remember. I just get through e-mail notification and one phone call.
Q. Do you know the name of the plaintiff in the case that's been filed?
A. I do.

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Q. What is the name of the plaintiff?
A. Is that something we can talk about?
MR. BREEDEN: Yeah. It's public information.
A. Her lame is Llado, L-l-a-d-o, Melissa Llado. The court date has been vacated so I don't know if that means that it's over. But it appears that maybe it's over if that's what that means.
Q. You certainly have not authorized any payment of indemnity money on your behalf in that case?
A. No, I haven't been deposed on that either.
Q. That was going to be my next question. So you haven't been deposed in that case. Have you been named in any other litigation matters as a defendant in a medical malpractice?
A. Yes. One other one in the previous -- sorry. I had a job before the current job. The previous job I was named in the complaint was a birth injury but I was only named. My involvement was admitting the patient for induction on the phone because I was on call. I got the phone call that she was there and I had a summary judgment on that one.
Q. Did you give a deposition in that case?
A. No. I met with the attorney but did not give a deposition.
Q. Are those the only two matters where you've been named as a defendant?

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A. Yes.
Q. Do you still do medical work for the California Medical Board?
A. I am available to. I haven't been asked for over a year.
Q. Before that year, how long had you done that?
A. About two years prior.
Q. And are you compensated for that work that you do for the Medical Board?
A. Yeah. $150 per hour.
Q. In this report that we've been going over on Page 4 of the report, it's got a little -- actually does yours have a number, the one that says 1759?
A. Yes.
Q. You refer to some medical literature.
A. Uh-huh.
Q. What medical literature, if any, did you review as part of your work in this case?
A. Well, this one, Te Linde's Operative Gynecology.
Q. Is this a textbook?
A. Yes.
Q. Any other textbooks or medical literature you referenced or referred to as part of your work in this case?
A. I utilized -- I don't know the name of it but it was a hysteroscopy textbook that was just about hysteroscopy.

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It was old. It was from the '90s but I had it so I just looked at that.
Q. And you said you don't recall the name of that?
A. No.
Q. Anything else that you might have reviewed?
A. No. Actually I think I referenced it here. Diagnostic Hysteroscopy.
Q. I'm sorry. I didn't see that. So that would have been the text that you think you looked at regarding hysteroscopy?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. So other than those two things, did you review any medical literature, textbooks, anything at all like that?
A. I believe I did a PubMed search and just saw if there was any recent articles or if they had percentages. But it was nothing scanned, didn't take notes or didn't use it for more information than that.
Q. Nothing that you shared with plaintiff's counsel or former plaintiff's counsel?
A. Correct.
Q. On the next page of this report, you discussed that you believe that Ms. Taylor will require no future treatment. Since preparing this report, have you received any materials

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to alter that opinion that she will require no future treatment?
A. No.
Q. And this is where, if you see on this page, you note your statement of compensation, and you state that to date you've charged $2,465.
A. Uh-huh.
Q. And that would include the $2,000 retainer that you received from Mr. Kent.
A. Correct.
Q. Do you know if that retainer -- do you know how much time was spent on this February report?
A. I would have to go back and look at the numbers but maybe 6 hours.
Q. Do you think that would be reflected on those invoices?
A. Yes. It would be. Can I go back to the note for no future treatment necessary? Is that okay to go back?
Q. Sure.
A. I think that was in regards to the perforation and the bowel injury, you know, that she would not need any future treatment. That's what we are saying, if that sentence -- or is that how you asked the question?
Q. Well, this is your report. So in your report you note that she will require no future treatment.

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A. I agree that she will not need any future treatment most likely for the problems she had with the bowel injury. But she may still require treatment for the heavy vaginal bleeding that she was having that led to the procedure.
Q. And you're not offering an opinion in this case that her heavy vaginal bleeding was in any way caused by Dr. Brill's surgery, right?
A. Correct.
Q. In fact, that preexisted the April --
A. I just want to make sure I'm clear about the no further treatment implied.
Q. I understood. And that's a good distinction. But with respect to Dr. Brill's surgery he performed on April 26th, it's your opinion that Ms. Taylor requires no future treatment related to the complications she experienced?
A. Correct.
Q. The name of the device that Dr. Brill used during that April 26th procedure, do you know what that was?
A. The Symphion resectoscope.
Q. Do you use the Symphion in your practice?
A. I do not.
Q. Have you ever?
A. No.
Q. The cervical dilation that you referred to having caused uterine perforations in the instances where you've seen

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that, can you explain to me how that the cervical dilation can cause a uterine perforation?
A. When you need to dilate the cervix, you have to push the metal dilator through the cervical opening, I'm using the word blindly, which means of course, you can't see the other side. So you're pushing it into an empty closed-ended pouch. And typically when the cervix is stenotic or very, very narrow, you have to use -- you have to push pretty hard to get it through there. And sometimes that force could go through the cervix and into the uterine cavity and puncture the uterus and cause a perforation.
Q. Does the risk of that occurring increase with a bicornuate uterus?
A. I think the risk, yes. I think the risk increases with any type of anatomic anomaly.
Q. Do you believe Ms. Brill, excuse me, Ms. Taylor, Ms. Taylor's unusual anatomy played any factor in the complications that she experienced?
A. Dr. Brill described it as a retroverted uterus too and that is known to be a factor for perforation.
Q. And have you ever reviewed the ultrasounds and other imaging from prior to this April surgery confirming that was, in fact, her anatomy?
A. Yes. Although one of the reports did say it wasn't bicornuate. It was subseptate, which is a little bit

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different than bicornuate. That was clear on one of the MRI reports. That was the impression from radiology.
Q. Okay. So are you intending to offer an opinion that Ms. Taylor had normal anatomy with respect to her uterus?
A. No.
Q. In your opinion, did Dr. Brill do anything which you believe met the standard of care in relation to his treatment of this patient?
MR. BREEDEN: Just object as overly broad and vague. You can respond.
A. I can respond?
MR. BREEDEN: Yes. You can respond.
A. Can you repeat the question? Sorry.
Q. I guess to lay some foundation, Dr. Berke, you've reviewed the medical chart from Dr. Brill's office, correct?
A. Yes.
Q. And you did so with the intent of reviewing the medical care he provided to Kimberly Taylor?
A. Yes.
Q. In your opinion, did Dr. Brill do anything in relation to his treatment of Kim Taylor which you believe met the standard of care?
A. Yes.
Q. And what is that?
A. That he ordered imaging, he had done a prior

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endometrial biopsy. There was evidence in the chart. That was appropriate. His treatment plan was appropriate,
Q. When you say his treatment plan meaning --
A. His decision to address her abnormal uterine bleeding with hysteroscopy, resection of polyp fibroid if it was there or not, and ablation is appropriate management for women with abnormal uterine bleeding.
Q. Anything else that you believe he did which met the standard of care?
A. No, nothing else I can comment on.
Q. Are you able to say for Ms. Taylor what was the size of the uterine perforation at the time that it occurred?
A. Am I allowed? Sorry. One more time.
Q. I misspoke. The bowel perforation, are you able to to state what was the size of the bowel perforation at the time that it occurred?
A. It was -- yes, because the pathology report recorded it and measured it.
Q. And pathology report from?
A. From the surgical resection.
Q. And would that have been Dr. Hamilton's surgery?
A. Yes.
Q. So based on the pathology from Dr. Hamilton's resection surgery or bowel repair?
A. Or her operative -- I interrupted you. Or her

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operative report, which I didn't review again, but it is likely in the op report she mentioned the size of the perforation.

Q. Right. And that would have been the size of the perforation at the time Dr. Hamilton performed her surgery, correct?

A. Right.

Q. Do you intend to offer an opinion in this case as to what the size of the bowel perforation was at the time that it occurred during Dr. Brill's surgery?

MR. BREEDEN: I will object as asked and answered. You can answer.

A. No. Because we don't know because he didn't laparoscope her to look for it.

Q. And that was my question. You would agree that we do not know what the size of the bowel perforation was at the time that it occurred, correct?

A. We have no way of knowing.

Q. That's correct?

A. I agree.

Q. But we do know when Dr. Hamilton did her surgery what the size of the perforation was at that time?

A. Yes.

MS. HALL: Doctor, I am going to take a peek at my notes and we are going to take a 5 or 10 minute break. We may

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be close to being finished.

THE WITNESS: Okay.

MR. BREEDEN: We are off the record.

(A brief recess was taken.)

BY MS. HALL:

Q. I just have a couple more questions. That May 17 report that you wrote, was the purpose of that report to comment on your review of Dr. Brill's deposition as well as the report of Dr. McCarus that you received?

A. Yes.

Q. And I think you may have answered this at the outset, but I don't recall. Since preparing this May report, have you been asked to author any additional reports for this case?

A. I have not been asked.

MS. HALL: All right. That's all I have, Dr. Berke. Thank you.

BY MR. BREEDEN:

Q. Doctor, my name is Adam Breeden. And of course, we have spoken before. I represent Ms. Taylor. You were asked some questions at the beginning of your deposition as to whether a simple uterine perforation is a known risk or complication of a hysteroscopy. Would you describe the type of injury that Ms. Taylor sustained as a simple perforation?

A. No.

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Q. And the type of injury that Ms. Taylor sustained to the uterus and bowel, that was preventable in your opinion for Ms. Taylor's particular case; is that true?

A. Yes. I think it was an avoidable complication.

Q. Avoidable is a better term for it. Thank you. You were asked some questions during your earlier testimony about prior defendants in this case, Nurse Hutchins, Henderson Hospital, Dr. Christensen and St. Rose. I want to go through those one by one so that your testimony is clear. First of all, for the initial injury to the uterus and the bowel, is Dr. Brill the only doctor that you believe caused the initial injuries?

A. Yes.

Q. So you do not think Nurse Hutchins caused the initial injuries, do you?

A. I don't think that.

Q. Do you believe Henderson Hospital caused or contributed to the initial injuries?

A. No.

Q. Do you believe Dr. Christensen caused or contributed to the initial injuries?

A. No.

Q. Do you believe that St. Rose Hospital caused or contributed to the initial injuries?

A. No.

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Q. So Dr. Brill is, in your opinion, 100 percent responsible for the initial perforations to the bowel and uterus; is that your testimony?

A. That's correct.

Q. Earlier in your testimony, Ms. Hall referred to quote, abnormal anatomy, end quote, of Ms. Taylor. You mentioned a retroverted uterus. Have you ever seen a retroverted uterus before?

A. Yes.

Q. Is it possible to safely perform hysteroscopy on a woman who has a retroverted uterus?

A. Yes, it is.

Q. Do you have any idea what percentage of the general population of women have a retroverted uterus?

A. 10 to 15 percent.

Q. And then I have the similar questions about a bicornuate uterus. Have you seen a bicornuate uterus before in your practice?

A. Yes.

Q. Is it possible to safely perform hysteroscopy on patients with a bicornuate uterus?

A. Yes.

Q. And do you have any idea the number or the percentage of women in the general population that have a bicornuate uterus?

A. That would be much less than the other. I would imagine 1 to 2 percent, uncommon.

Q. In this particular case, was Dr. Brill aware of those conditions of Ms. Taylor before he began the hysteroscopy?

A. Yes.

MR. BREEDEN: Those are all the questions that I have.

BY MS. HALL:

Q. Just a few follow-up, Dr. Berke. The opinions that Mr. Breeden just covered with you regarding let's start with Bruce Hutchins and Henderson Hospital. Overall, one of the opinions that you've offered in this case is that there was a delay in identifying and treating Ms. Taylor's bowel perforation, correct?

A. Correct.

Q. And the standard of care violations that you identify in this affidavit for Bruce Hutchins and Henderson Hospital, the standard of care violation by those two individuals or entities, you do believe those actions did contribute to a delay in diagnosing and treating her bowel perforation?

A. I do.

Q. And same questions with respect to Dr. Christensen and St. Rose Hospital, and the decision not to admit

Ms. Taylor when she presented to the E.R., do you believe those violations of the standard of care which you identified did contribute to a delay in diagnosing and treating her bowel perforation?

A. I do.

Q. In fact, and I'm happy to show it to you, but in that February report that you authored in this case, you noted that the violation of standard of care by Dr. Christensen led to increased pain and suffering and a worsening of the patient's condition when diagnosis was delayed. Is that still your opinion today?

A. Yes.

MS. HALL: Okay. That's all I have, Dr. Berke.

BY MR. BREEDEN:

Q. Just a quick follow-up to that. So during Dr. Brill's procedure, there is an injury or perforation to the uterus and the bowel of Ms. Taylor. At that point will Ms. Taylor require a bowel resection procedure regardless of when this is diagnosed, or in your opinion, was it the delay in diagnosis that caused the need for the resection surgery?

MS. HALL: Form, foundation. It's beyond the scope and it asks for a new opinion which has never been disclosed before.

Q. You can answer.

A. The delay did not cause -- the initial injury was

caused at the time of the original surgery by Dr. Brill that required the treatment that she got. She would have needed bowel resection, bowel surgery based on the bowel perforation that was caused at the time of the perforation that he caused.

Q. Okay. So hypothetically, let's say there was not any delay in diagnosis of the bowel perforation, would Ms. Taylor have still needed a bowel resection or bowel repair surgery even if, for example, that injury was noted within an hour of the original procedure?

A. Yes. Definitely.

MR. BREEDEN: Okay. Those are all the questions that I have.

MS. HALL: Nothing further for you, Doctor. But if you would just let us know, more accurately, the court reporter, whether you would like to review today's deposition transcript for purposes of changes or accuracy.

MR. BREEDEN: I will indicate that the expert will exercise his right to review and the court reporter can reach out to my office to arrange for that when the transcript is prepared.

MS. HALL: Sure. That's fine with me. So what that means is counsel, Mr. Breeden will be provided the original transcript with an original errata sheet and that will be provided to you by his office for purposes of you reviewing it. Again, I just remind you as I said at the

beginning that if you are to make any changes like changing a yes answer today to a no answer when you review it, that's the kind of change that I would comment upon at the time of trial and it could negatively impact your credibility with a jury.

THE WITNESS: I understand.

MS. HALL: Any questions about that?

THE WITNESS: No.

MS. HALL: All right. Thank you very much.

MR. BREEDEN: And before we go off the record, I note sometimes the reporter likes to put it on the record whether counsel will take a transcript so my office will take a transcript.

(Proceeding concluded at 2:01 p.m.)

***

STATE OF CALIFORNIA) ss

I, Deborah Deveny, CSR 7990, RPR, RMR, do hereby declare:

That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn pursuant to Section 2093(b) and 2094 of the Code of Civil Procedure;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to text under my direction.

I further declare that I have no interest in the event of the action.

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

WITNESS my hand this 26th day of July, 2021.

Deborah Deveny

Deborah Deveny, CSR 7990, RPR, RMR

ERRATA SHEET

I declare under penalty of perjury that I have read the foregoing _____ pages of my testimony, taken on _____ (date) at _____(city), _____(state), and that the same is a true record of the testimony given by me at the time and place herein above set forth, with the following exceptions:

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Date: _____ _____

Signature of Witness

_____

Name Typed or Printed

HEALTH INFORMATION PRIVACY & SECURITY: CAUTIONARY NOTICE

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MLIM
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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 #4: EXCLUSION OF COLLATERAL SOURCE PAYMENTS

HEARING REQUESTED: YES

Plaintiff, KIMBERLY TAYLOR, by and through her attorney of record, ADAM J. BREEDEN, ESQ. of BREEDEN & ASSOCIATES, PLLC, and hereby submits her Motion in Limine #4: Exclusion of Collateral Source Payments.

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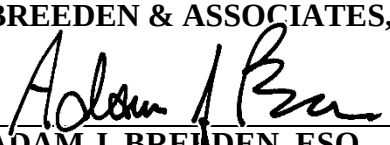
This Motion is made and based on the following Points and Authorities, the pleadings and papers on file herein, the Declaration of Adam J. Breeden, Esq., and any oral argument allowed by the Court at the time of hearing on this matter.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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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.

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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 Motion in Limine #4 seeks an advance ruling to exclude collateral source payments of Plaintiff's health care insurer for her medical bills. Under the facts of this case, the Defendant has failed to provide any qualified testimony that the collateral source payments are the usual, customary and reasonable value of those services and thus NRS § 42.021(1) does not apply in this action. As a secondary argument, Plaintiff argues that NRS § 42.021(1), which allows introduction of collateral source payments into evidence in some medical malpractice actions, is unconstitutional. The constitutional issue has been previously raised to the Nevada Supreme Court but remains undecided.

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

A. An Explanation of the State of the Law as to the Collateral Source Rule in a Medical Malpractice Action

In this case, following the alleged malpractice Taylor incurred approximately $225,620.07 in medical expenses. Due to privately negotiated discounts, Taylor's private health care insurance paid these bills or reimbursed the medical care providers $67,320.87. Mrs. Taylor had out of pocket expenses of $20,065.52.

A personal injury claimant is entitled to recover the reasonable value of medical services that is usual and customary for the community. *Curti v. Franceschi*, 60 Nev. 422, 428, 111 P.2d 53, 56 (1941). This is often called the usual, customary and reasonable or "UCR" amount. In a typical personal injury action, evidence of payments made by health insurers on behalf of the plaintiff are considered *inadmissible* collateral source payments. In *Proctor v. Castelletti*, the Nevada Supreme Court adopted a "per se rule barring the admission of a collateral source of payment for an injury into evidence for any purpose." *Proctor v. Castelletti*, 112 Nev. 88, 90, 911 P.2d 853, 854 (1996) ("Collateral source evidence…greatly increases the likelihood that a jury will reduce a plaintiffs award of damages because it knows the plaintiff is already receiving compensation."). The strong

policy reasons behind the collateral source rule for health insurance payments include that it is unfair for a defendant to benefit from the plaintiff's act of obtaining health care insurance, that there is a risk that a jury will award substantially less if they hear about health insurance payments, that the injured person has paid the insurer for such coverage, and that it might discourage people from buying or using health insurance. Additionally, the amount of the insurance payments are irrelevant to the jury's true task which is to determine the usual, customary and reasonable value of the medical services. Indeed, the Nevada Supreme Court expressly held in *Khoury v. Seastrand*, 377 P.3d 81, 93 (Nev. 2016) that "[e]vidence of payments showing medical provider discounts, or write-downs, to third-party insurance providers" is irrelevant to a jury's determination of the reasonable value of the medical services and will "likely lead to jury confusion." In other words, the Nevada Supreme Court has already held that evidence of insurance company discounts and payments is not probative of the usual, customary and reasonable value of medical services.

Nevada's medical malpractice laws were greatly changed by a 2004 ballot initiative referred to as KODIN ("Keep Our Doctors in Nevada"). *Thomas v. Hardwick,* 126 Nev. 142, 146 n.2, 231 P.3d 1111, 1114 (2010) ("'Keep Our Doctors in Nevada' or 'KODIN' refers to a ballot initiative…that voters passed in 2004 to limit medical malpractice claims. The initiative's changes to Nevada's medical malpractice law are codified in NRS Chapter 41A."). KODIN was the brainchild of doctors and their insurers and sought to handicap victims of medical malpractice in the court system and curb medical malpractice cases. Among other oppressive provisions, KODIN sought to cap pain and suffering damages, cap plaintiff attorney fees (so attorneys could not financially afford to bring cases and to prevent victims from finding attorneys), and eliminate joint and several liability.

One of KODIN's provisions was apparently designed to supersede *Proctor v. Castelletti* and the collateral source rule in a medical malpractice action. Later codified as NRS § 42.021, Section 9 the KODIN ballot initiative allowed a defendant to introduce evidence of payments to the malpractice victim from "any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical,

hospital, dental or other health care services." NRS § 42.021(1)[1] As a sort of trade-off for allowing evidence of these payments, NRS § 42.021(2) then bars subrogation or repayment of payments by the payor of the benefits.

Unfortunately for victims of medical malpractice, the Nevada Supreme Court has generally upheld the provisions of KODIN to legal challenges. *See Tam v. Eighth Judicial Dist. Court*, 131 Nev. 792, 358 P.3d 234 (2015) (generally upholding damage caps and other legal provisions enacted in KODIN against equal protection, trial by jury and other Constitutional challenges). However, the Nevada Supreme Court has *never* ruled on the Constitutionality of NRS § 42.021 or the extent to which NRS § 42.021 applies where the Defendant lacks admissible expert testimony that the insurance reimbursement rate for the charges is the usual, customary and reasonable value of those medical services. Therefore, Plaintiff Taylor raises these two issues now and seeks to exclude admission of collateral source payments in this case.

B. <u>The Evidence of Collateral Source Payments under NRS § 42.021 is Irrelevant and Should be Excluded in this Particular Action</u>

The jury must determine the usual, customary and reasonable value of medical expenses incurred by the Plaintiff. This is to be established by expert testimony, typically either a doctor or billing representative. *Curti v. Franceschi*, 60 Nev. 422, 428, 111 P.2d 53, 56 (1941). However, the Nevada Supreme Court has already ruled that evidence of health insurer payments is irrelevant to the usual, customary and reasonable value of the medical services. *Khoury v. Seastrand*, 132 Nev. 520, 538, 377 P.3d 81, 93 (2016) ("Evidence of payments showing medical provider discounts, or write-downs, to third-party insurance providers 'is irrelevant to a jury's determination of the

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[1] Curiously, NRS § 42.021(1) does not tell the jury what to do with the collateral source information. However, the Nevada Supreme Court has ruled that evidence of discount payments of a health insurer or plan are irrelevant to the issue of the reasonable value of medical services. *Khoury v. Seastrand*, 132 Nev. 520, 538, 377 P.3d 81, 93 (2016) ("Evidence of payments showing medical provider discounts, or write-downs, to third-party insurance providers 'is irrelevant to a jury's determination of the reasonable value of the medical services and will likely lead to jury confusion.'") *citing Tri-Cty. Equip. & Leasing v. Klinke*, 128 Nev. 352, 360, 286 P.3d 593, 598 (2012).

reasonable value of the medical services and will likely lead to jury confusion.'") *citing Tri-Cty. Equip. & Leasing v. Klinke*, 128 Nev. 352, 360, 286 P.3d 593, 598 (2012).

In this case, the Defense has provided **no expert testimony that the usual, customary and reasonable value of medical services is the insurance reimbursement rate**. In order to make an argument that the insurance reimbursement rate is the usual, customary and reasonable value, the Defense would have to disclose some expert witness who could testify to that issue. However, the defense has not disclosed any such expert in this action.

NRS § 42.021(1) states that a defendant in a medical malpractice action "*may* introduce evidence of any amount payable as a benefit to the plaintiff." Curiously, NRS § 42.021(1) does not tell the jury what to do with the collateral source information. The statute does not say that the plaintiff may recover *only* the amounts actually paid by the collateral source. In fact, any argument that the plaintiff may *only* recover the amounts a collateral source paid for the medical care under a contract of insurance was rejected by the Nevada Supreme Court in *Capanna v. Orth*, 134 Nev. 888, 432 P.3d 726 (2018), wherein the Court found no error when a jury heard the amounts charged by the providers and the amounts paid by the collateral source and awarded the plaintiff the full amount of the medical bills.

Although NRS § 42.021(1) states that a defendant in a medical malpractice action "*may*" introduce evidence of collateral source language, all evidence to be admissible must be relevant, NRS § 48.025, and all evidence must be more probative than prejudicial and not tend to confuse or mislead the jury, NRS § 48.035. NRS § 42.021(1) certainly does not take from the courts the ability to determine relevant and admissible evidence generally. Given that the amount the collateral source paid is legally irrelevant under *Khoury* and the fact that the defense has no expert who will testify that the usual, customary and reasonable value of the medical services is the insurance payments, there is no permissible evidentiary reason to allow evidence of the payments in this case as there is no expert testimony to support that the reimbursement rate is the usual, reasonable and customary value of the services. The sinister insinuation in this case then is that the Defense wants to introduce the collateral source evidence merely to make a nullification appeal to a jury to disregard the law and award an insufficient amount for the medical expenses. Nullification arguments, or arguments

that the jury should not follow the law, are of course not permitted. *Lioce v. Cohen*, 124 Nev. 1, 21, 174 P.3d 970, 983 (2008) (reversal of verdicts due to nullification arguments to jurors). It would be, for example, impermissible nullification for the defense to argue the jury should award only the reimbursement rate amounts because they have no expert testimony that amount is the usual, customary and reasonable value.

Therefore, introduction of the insurance payments should not be made in this particular case. The District Court retains control over determining what evidence is relevant versus misleading and confusing to the jury. Without the testimony of a qualified witness to say the collateral source payments represent the usual, customary and reasonable value of the medical services, introduction of collateral source payments under NRS § 42.021(1) should not be allowed.

V. THE DISTRICT COURT SHOULD FIND NRS § 42.021 UNCONSTITUTIONAL

In the case of *Capanna v. Orth*, 134 Nev. 888, 432 P.3d 726 (2018), the Nevada Supreme Court was asked to determine whether NRS § 42.021 violated the equal protection clauses of the United States and Nevada Constitutions. In that case, a medical malpractice action, the plaintiff had introduced evidence of his medical bills and the defendant doctor introduced evidence of insurance payment of those bills. The jury then awarded the full amount of the bills instead of the insurance reimbursement amounts. Although the plaintiff had asked for NRS § 42.021 to be declared unconstitutional, because the full amount of the bills was admitted despite introduction of collateral source payments, the Nevada Supreme Court declined to rule on the issue because the plaintiff in that case was not aggrieved and any ruling would simply be an advisory opinion. Plaintiff Taylor raises that Constitutional argument now.

A. NRS § 42.021 is Unconstitutional Because the Statute Violates the Equal Protection Clause of the United States and Nevada Constitutions

The Fourteenth Amendment of the United States Constitution provides that no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws." U.S. Const. Amend. 14, § 1 (2016). Nevada's counterpart to the Fourteenth Amendment's Equal Protection Clause is found in Article 4, Section 21, of the Nevada Constitution. *Laakonen v. Eighth Judicial Dist. Court*, 91 Nev. 506, 508, 538 P.2d

574, 575 (1975).

NRS § 42.021(1) is unconstitutional because it deprives victims of medical malpractice equal protection of the law. The equal protection clauses of both the United States and Nevada Constitutions are implicated when a "...statute effectuates dissimilar treatment of similarly situated persons." *Rico v. Rodriguez*, 121 Nev. 695, 703, 120 P.3d 812, 817 (2005). NRS § 42.021 discriminates against different classifications of injured tort victims based on who caused the injury and medical malpractice tort victims who maintain health insurance and those who do not.

NRS § 42.021(1) also has the potential to operate as an indirect cap on economic damages. Allowing a jury to consider otherwise irrelevant evidence to reduce damage awards for past medical expenses actually rewards negligent health care and encourages jury nullification.

B. NRS § 42.021(1) Treats Injured Plaintiffs Differently Based on The Person Or Entity Who Caused The Injury

Claimants in all other tort actions except professional negligence/medical malpractice may recover the full amount of reasonable medical expenses incurred without reductions based on third-party payments, write-downs, or discounts. Plaintiffs in medical negligence actions do not receive the benefit of the collateral source rule because NRS § 42.021 allows defendants to introduce irrelevant evidence to determine the reasonable value of medical services.

C. NRS § 42.021(1) Treats Injured Plaintiffs Differently Based on Whether They Treated With Or Without Health Insurance

NRS § 42.021 discriminates against those victims of medical malpractice who received their treatment through health insurance. An uninsured victim of medical negligence who treated on a lien basis can introduce evidence of the usual and customary charges incurred for the medical treatment without evidence of write-downs or third-party payments. *Khoury*, 377 P.3d at 93. Thus, the uninsured victim will not face the potential prejudice of the jury considering evidence that such treatment was paid by health insurance. *Id*. However, injured victims of medical negligence who had health insurance pay for their treatment are subject to the consequences of NRS § 42.021. This means injured plaintiffs who are insured face the likelihood that their recovery will be reduced simply because they have health insurance. This not only denies them equal protection under the

law but discourages people from obtaining or using their health insurance following a medical malpractice injury.

D. NRS § 42.021(1) Treats Medical Providers Liable for Professional Negligence Differently from Other Tortfeasors

NRS § 42.021(1) also treats negligent medical providers differently than other tortfeasors. Negligent medical providers receive the benefit of potentially lower jury verdicts. Thus, NRS § 42.021 operates as a potential indirect cap on economic damages along with the statutory cap on non-economic damages pursuant to NRS § 41A.035. In all other personal injury cases, the tortfeasor must pay the full amount of reasonable medical damages that he caused. NRS § 42.021 confers a benefit on negligent medical providers not available to other tortfeasors. The inherent unfairness of this result is more apparent because negligent medical providers already receive other protections not afforded to other negligent defendants.

In another medical malpractice case, Judge Weise of the Eighth Judicial District Court provided a hypothetical illustrating the unfair burden NRS § 42.021 imposes on insured victims of medical malpractice.

Besides the $350,000 cap, another protection afforded to medical malpractice defendants is they are only severally liable for damages that result from their negligence. See NRS § 41A.015. Meanwhile, defendants in other tort actions are jointly and severally liable. *Id*. Not only does NRS § 41A.015 protect a negligent physician from joint liability, it also imposes a risk of nonpayment to the injured party if one of the defendants cannot pay his percentage share of damages.

This Court previously invalidated a statute on equal protection grounds because it treated one class of defendants differently than another. *State Farm Fire & Casualty Co. v. All Elec.*, 99 Nev. 222, 660 P.2d 995 (1983) (overruled on other grounds). In *State Farm*, the Nevada Supreme Court concluded a statute that abolished a party's claim for injury after 6 years caused by a design deficiency only against entities that designed, planned, supervised, or observed a construction project, not owners or occupiers, violated equal protection. *Id*. at 229, 1000. The Nevada Supreme Court reasoned that the statute improperly granted one class of defendant's immunity from suit without a reasonable basis. *Id*. at 226, 998. The same is true for NRS § 42.021(1) because it grants

a benefit to one group of tortfeasors (medical doctors), but not to other tortfeasors, on an arbitrary basis.

E. NRS § 42.021(2) Negatively Impacts a Plaintiff's Health Insurer in Professional Negligence Lawsuits

NRS § 42.021(2) undermines health insurance companies and third-party payers in medical malpractice suits because it strips the insurer or payer's right of subrogation. Subrogation arises in the insurance context when an insurer reimburses its insured for injuries the insured received at the hands of a tortfeasor. *Harvey's Wagon Wheel v. MacSween*, 96 Nev. 215, 218, 606 P.2d 1095, 1097 (1980). In personal injury cases, generally, an insurer has the right to subrogation for amounts paid on behalf of its insured. NRS § 42.021(2) precludes a source of collateral benefits from seeking subrogation.

NRS § 42.021(2) is particularly offensive to health insurers because they lose their subrogation rights for payments made. This leads to unfair results for health insurers as well.

Hypothetically, assume patient A is injured due to medical malpractice and incurs $5,000 in medical expenses. Plaintiff's health insurer reimburses A for these medical expenses. A then sues B, the medical provider tortfeasor, for the $5,000 in medical expenses plus $10,000 for pain and suffering. When the jury awards A the full $15,000 from B, A is not required to repay A's health insurer the $5,000 of medical expenses pursuant to NRS § 42.021(2).

F. NRS § 42.021 Arbitrarily Discriminates Against Professional Negligence Plaintiffs and Insurers Based on Pre-Existing Contractual Write-Down Agreements

The Nevada Supreme Court has expressly held that "...evidence of payments showing medical provider discounts or write-downs is 'irrelevant to a jury's determination of the reasonable value of medical services and will likely lead to jury confusion.'" *Khoury*, 377 P.3d at 93. This evidence is irrelevant because "...[w]rite-downs reflect a multitude of factors mostly relating to the relationship between the third party and the medical provider and not actually relating to the reasonable value of medical services." *Id*.

An insurer's buying power enables it to negotiate discounted terms with medical providers and the insured receives the benefit of reduced fees. A medical provider can provide the same service

to two different patients yet accept completely different reimbursement amounts. The amount of payment received by the provider, therefore, is not based on the reasonable value of the service provided, but on a separately negotiated contract.

Not only does NRS § 42.021 negatively affect a plaintiff's ability to recover the reasonable value of damages, it does so arbitrarily and in contravention of this Court's holding in *Khoury*, 377 P.3d at 93. Under NRS § 42.021, a reasonable jury could potentially decrease the plaintiff's award based on the random and arbitrary amount paid by the insurer rather than the reasonable value of the medical service.

VI. STANDARDS OF REVIEW FOR DECLARING A STATUTE UNCONSTITUTIONAL ON EQUAL PROTECTION GROUNDS

Equal protection allows different classifications of treatment only if the classifications are reasonable. *Flamingo Paradise Gaming, LLC v. Chanos*, 125 Nev. 502, 520, 217 P.3d 546, 558-59 (2009). "The standard for testing the validity of legislation under the equal protection clause of the state constitution is the same as the federal standard." *In re Candelaria*, 126 Nev. 408, 416, 245 P.3d 518, 523 (2010).

The United States Supreme Court recognizes three standards of review in determining a statute's constitutionality on equal protection grounds. The most critical level of scrutiny is "strict scrutiny" and requires the classification be necessary to achieve a compelling state interest. *Shapiro v. Thompson*, 394 U.S. 618, 634, 89 S. Ct. 1322, 1331 (1969) (overruled on other grounds).

The next standard of review is intermediate scrutiny and requires the classification be substantially related to an important government purpose. *Craig v. Boren*, 429 U.S. 190, 197, 97 S. Ct. 451, 457 (1976).

The lowest standard of review is the "rational basis" test. Under the rational basis test, the challenging party must prove the classification is not rationally related to the government's legitimate interest. *McGowan v. Maryland*, 366 U.S. 420, 425, 81 S. Ct. 1101, 1105 (1961). Under rational basis, equal protection is satisfied if: "(1) there is a plausible policy reason for the classification," (2) the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental decisionmaker, and (3) the relationship of the

classification to its goal is not so attenuated as to render the distinction arbitrary or irrational." *Tutor-Saliba Corp. v. City of Hailey*, 452 F.3d 1055, 1062 (9th Cir. 2006)

Taylor requests this Court apply a heightened rational basis standard to assess NRS § 42.021 under the equal protection clause. Taylor believes the Nevada Supreme Court adopted a heightened rational basis test in *Laakonen*, 91 Nev. at 509, 538 P.2d at 575. While not a suspect class, medical malpractice tort plaintiffs are a particularly vulnerable group. By the time a jury is deciding to award damages, it has determined the medical provider was negligent and injured the plaintiff. Like other tort victims, medical malpractice plaintiffs depend on the courts to deliver justice and provide a fair and adequate remedy to make them whole. The interest of bodily health, safety and integrity is of vital importance to the citizens of Nevada, which justifies the application of a heightened level of scrutiny.

VII. NRS § 42.021 DOES NOT BEAR A SUBSTANTIAL AND RATIONAL RELATION TO A LEGITIMATE STATE INTEREST.

In *Laakonen*, this Court enumerated a heightened standard of review under the rational basis test. 91 Nev. at 509, 538 P.2d at 575 (1975). To pass constitutional muster under this heightened test, NRS § 42.021 must bear a "...substantial and rational relation" to a legitimate state interest. *Id*. A classification must also be reasonable, not arbitrary. Id. at 505, 575.

The United States Supreme Court also adopted a heightened rational basis test. *Coburn v. Agustin*, 627 F.Supp. 983, 990 (D. Kan. 1985) (*citing City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 105 S. Ct. 3249 (1985)). Under the *Cleburne* formulation, "the question is whether the legislative classification is in fact related to the object of the statute." *Cleburne*, 473 U.S. at 449-50, 105 S. Ct. at 3259-60.

"A legislature does not act 'rationally' when it acts in logical furtherance of lesser goals at the gross expenses of more vital goals." *Bell v. Hongisto*, 501 F.2d 346, 355 n.12 (9th Cir. 1974). "A court must examine the nature of the class burdened, the importance of the rights affected, and the extent to which they are impaired, and must balance these considerations against the significance of the government interest." *Coburn*, 627 F.Supp. at 991. "In circumstances where a right is particularly important or a class is particularly in need of protection, heightened scrutiny under the

rational basis test appears to be required." *Id*. Moreover, the history of KODIN clearly indicates that it was ballot-imposed by doctors and malpractice insurers and considered by the legislature at all. Its purpose was to increase insurance company profits and prevent large awards against bad doctors, neither of which is a worthy goal.

This Court should apply heightened rational basis scrutiny to assess the constitutionality of NRS § 42.021 because of the disparate impact it has on one class of innocent victims. In *Coburn*, a similar statute that abrogated the collateral source rule in medical malpractice actions was analyzed under a heightened rational basis standard. *Coburn*, 627 F. Supp. at 985-86. The *Coburn* court considered that the collateral source statute conferred benefits on negligent medical providers unavailable to other tortfeasors. *Id*. at 993. *Coburn* also noted that the statute distinguished between tort plaintiffs injured by medical malpractice and all other tort victims by restricting amounts medical malpractice victims could recover as damages. *Id*. The collateral source statute also distinguished between medical malpractice plaintiffs based on the types of reimbursement they received. *Id*.

The *Coburn* court applied a heightened form of rational basis scrutiny because it is significantly important to protect "...intimate personal liberties and rights regarding bodily integrity." *Id*. at 993-94. The *Coburn* court further noted that medical malpractice victims, by and large, lack control over the cause of their injuries and the political power to protect their interests. *Id*. at 994.

Notwithstanding the legislature's purpose, to assure the availability of malpractice insurance and quality health care providers for Kansas, the *Coburn* court determined that providing litigation benefits to negligent medical providers does very little to protect public health. *Id*. at 995. Legislation like NRS § 42.021 overlooks the cause of the alleged medical malpractice crisis in the first place, careless medical care, which is a serious health crisis by itself. "It is a major contradiction to legislate for quality health care on the one hand, while on the other hand, in the same statute, to reward negligent health care providers." *Farley v. Engelken*, 241 Kan. 663, 676-77, 740 P.2d 1058, 1067 (Kan. 1987).

The *Coburn* court balanced societal interests against class interests served by the collateral

source statute. *Coburn v. Agustin*, 627 F. Supp. 983, 996 (D. Kan. 1985). The court ultimately held that "the legislative means of affording health care providers a method of reducing their liability for damages is not sufficiently related to the legislative goal of better health care." *Id*. at 497.

Coburn's reasoning is persuasive because it equally applies to NRS § 42.021. This Court's determination that the classification must have a "fair and substantial" relation to the legislation necessarily encompasses the view of the *Cleburne* and *Coburn* courts that rational basis scrutiny "...requires a balancing of state interests and personal rights." *Laakonen*, 91 Nev. at 509, 538 P.2d at 575, *Cleburne*, 105 S. Ct. at 3260; *Coburn*, 627 F.Supp. at 991.

NRS § 42.021 was passed for the same purported reasons as the statute in *Coburn*, to "stabilize medical malpractice premiums and help your doctors stay in Nevada." See Nevada Ballot Questions 2004, Question No, 3, Argument in Support of Question No. 3, at 16. The introduction of collateral source payments received by medical malpractice victims was intended to eliminate or reduce medical malpractice lawsuits, which would reduce medical insurance premiums and improve the availability and quality of health care in Nevada. *Id*. However, studies have shown that the number of claims filed, and number of claims paid do not affect a medical provider's malpractice insurance premiums and that several other factors have a greater impact. See Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 Emory L.J. 1263, 1273 (2004). Thus, the admission of collateral source benefits in medical malpractice cases does nothing to reduce doctors' liability insurance premiums, one of NRS § 42.021's purported goals. Indeed, the state of California's experience under its similar MICRA statute passed in 1975 is that MICRA did nothing to stop high insurance rates on physicians. Instead, it was only legislation capping the cost and profits of such policies passed over a decade later that accomplished that goal.

The drafters of KODIN never considered the adverse consequences of passing NRS § 42.021 because its entire focus was to "keep" doctors in Nevada, regardless of quality. NRS § 42.021 severely restricted the ability of one distinct group of injured parties to obtain full recovery from the wrongdoer. The law, which must provide equal protection, should have no interest in providing economic relief to one distinct profession.

More importantly, the state has neither a compelling nor legitimate interest in providing

economic relief to one segment of society by depriving those who have been wronged of access to, and remedy by, the judicial system. If such a hypothesis were once approved, any profession, business or industry experiencing difficulty could be made the beneficiary of special legislation designed to ameliorate its economic adversity. Under such a system, our constitutional guarantees would be gradually eroded, until this state became no more than a playground for the privileged and influential. *Kenyon v. Hammer*, 142 Ariz. 69, 84, 688 P.2d 961, 976 (1984).

Medical malpractice victims' right to bodily safety and corresponding right to relief from violations of bodily integrity deserve the utmost protection especially because they typically lack the political clout necessary to protect their interests. *Farley*, 241 Kan. at 672, 740 P.2d at 1064. In *Farley*, the Kansas Supreme Court resolved the issue of whether Kansas's statute abrogating the collateral source rule in medical malpractice actions was constitutional. *Id*. at 678, 1068. The Farley court concluded that the statute was **unconstitutional** because it violated equal protection based on conclusions similar to those in *Coburn*. *Id*.

Like *Farley* and *Coburn,* other jurisdictions recognize the unconstitutionally prejudicial effect of a statute abrogating the collateral source rule in medical malpractice actions. *Arneson v. Olson*, 270 N.W.2d 125, (N.D. 1978); *Carson v. Maurer*, 424 A.2d 825, 836 (N.H. 1980) (overruled on other grounds); *Graley v. Satayatham*, 343 N.E.2d 832, 837-38 (Ohio C.P. 1976); and *Boucher v. Sayeed*, 459 A.2d 87, 90 n.11 (R.I. 1983).

NRS § 42.021 only protects the privileged medical providers to the severe detriment of the victims of their malpractice. Like the Kansas Legislature, the drafter of KODIN "...overlooked, or more likely, ignored the fundamental cause of the so-called crisis: it is the unmistakable result not of excessive verdicts, but of excessive malpractice by health care providers." *Farley*, 241 Kan. at 678, 740 P.2d at 1068. The different classifications of medical malpractice victims and medical provider tortfeasors that result from NRS § 42.021 are not fairly and substantially related to maintaining a high quality of health care for Nevadans. Therefore, NRS § 42.021 is unconstitutional.

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VIII. NRS § 42.021 IS UNCONSTITUIONALLY VAGUE BECAUSE IT DOES NOT PROVIDE SPECIFIC STANDARDS REGARDING THE ADMISSION OF COLLATERAL SOURCE EVIDENCE

The application of NRS § 42.021 creates arbitrary and capricious awards that are not based on the reasonable amount of a plaintiff's medical expenses. By failing to provide a jury with specific standards, a jury will enforce NRS § 42.021 in a discriminatory manner.

In *Silvar v. Eighth Judicial Dist. Court*, 122 Nev. 289, 293, 129 P.3d 682, 685 (2006), this Court clarified the standard for vagueness:

> A statute is unconstitutionally vague and subject to facial attack if it (1) fails to provide notice sufficient to enable persons of ordinary intelligence to understand what conduct is prohibited and (2) lacks specific standards, thereby encouraging, authorizing, or even failing to prevent arbitrary and discriminatory enforcement.

As currently constituted, NRS § 42.021 leaves open many questions regarding how a judge and jury must apply its terms. NRS § 42.021 allows a defendant to introduce collateral source evidence, if he so desires. It does not say anything about how such evidence shall be introduced at trial or when such evidence can be introduced.

The statute is also silent concerning what the jury is supposed to do with the collateral source evidence. There are no standards for the jury to consider about the amount it can deduct from past medical expenses in its award for damages. Clearly, a jury is not permitted to consider evidence of medical provider discounts or write-downs to third-party insurers because they are irrelevant. *Khoury*, 377 P.3d at 93.

The same is true as to what a jury can add to its award. NRS § 42.021 allows a plaintiff to introduce "any amount that the plaintiff has paid or contributed to secure the plaintiff's right to any insurance benefits." Yet, the statute offers no standard for how to calculate "any amount." The statute provides no instruction regarding the relevant timeframe a plaintiff is allowed to introduce payments in relation to when the benefits were provided, or the claims were paid. Without specific parameters outlining which premium payments a jury may consider, it is impossible to enforce the law. Instead, any reduction of collateral source payments or addition of plaintiff's premiums will be arbitrary. As such, NRS § 42.021 is void for vagueness because it encourages arbitrary enforcement

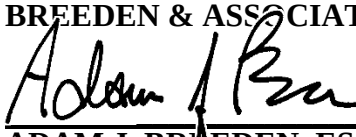
and does nothing to prevent it.

IX. CLOSING

In closing, Plaintiff Taylor seeks a pre-trial ruling barring evidence of collateral source payments in this case. She does so because (1) the defense lacks and amissible expert witness testimony that the collateral source payments represent the usual, customary and reasonable value of the medical services and (2) because NRS § 42.021 denies equal protection under the law and is otherwise unconstitutional.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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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 #4: EXCLUSION OF COLLATERAL SOURCE PAYMENTS** 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: Robert C. McBride, Esq. 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* John H. Cotton, Esq. 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.* Keith A. Weaver, Esq. 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

JI

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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; Defendants.	CASE NO.: A-18-773472-C DEPT NO.: III **PLAINTIFF'S PROPOSED JURY INSTRUCTIONS**

PLAINTIFF'S PROPOSED JURY INSTRUCTIONS

Plaintiff Kimberly Taylor hereby submits the following proposed jury instructions. This submission may be added to or amended as needed and as ordered by the Court.

DATED this 18th day of August, 2021.

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DUTY OF JUDGE AND JURY

LADIES AND GENTLEMEN OF THE JURY:

It is my duty as Judge to instruct you in the law that applies to this case. It is your duty as jurors to follow these instructions and to apply the rules of law to the facts as you find them from the evidence.

You must not be concerned with the wisdom of any rule of law stated in these instructions. Regardless of any opinion you may have as to what the law ought to be, it would be a violation of your oath to base a verdict upon any other view of the law than that given in the instructions of the court.

NEV. J.I. 1.0

General Pattern Instruction Pre-2011

DISCUSSION OF TRIAL AND MEDIA COVERAGE

Again, let me remind you that until this case is submitted to you:

1. Do not talk to each other or anyone else about it or about anyone who has anything to do with it until the end of the case when you go to the jury room to decide on your verdict.

2. "Anyone else" includes members of your family and your friends. You may tell them that you are a juror in a civil case, but don't tell them anything else about it until after you have been discharged as jurors by myself.

3. Do not let anyone talk to you about the case or about anyone who has anything to do with it. If someone should try to talk to you, please report it to me immediately by contacting the bailiff/marshal.

4. Do not read any news stories or articles or listen to any radio or television reports about the case or about anyone who has anything to do with it.

5. Do not post anything on social media or the internet such as facts of the case or that you are serving as a juror in this case. This includes Facebook, Twitter, Instagram, chat rooms and other sites.

We must ask you to do this to assure that the parties receive a fair trial, and an impartial jury.

This instruction is similar to the requirement in criminal cases. *See NRS 175.401.* Some minor adjustments have been made as to Social Media.

GENERAL INSTRUCTION 1GI.9 (2011)

USE OF INSTRUCTIONS

If, in these instructions, any rule, direction or idea is repeated or stated in different ways, no emphasis thereon is intended by me, and none may be inferred by you. For that reason, you are not to single out any certain sentence or any individual point or instruction and ignore the others, but you are to consider all the instructions as a whole and regard each in the light of all the others.

The order in which the instructions are given has no significance as to their relative importance.

NEV. J.I. 1.01

General Pattern Instruction Pre-2011

PURPOSE OF THE TRIAL

The purpose of the trial is to ascertain the truth.

NRS 50.115(1)(a).

GENERAL INSTRUCTION 1GI.1 (2011)

EVIDENCE, STATEMENTS OF LAWYERS AND RULINGS

Your purpose as jurors is to find and determine the facts. Under our system of civil procedure, you are the sole judge of the facts. You determine the facts from the testimony you hear and the other evidence, including exhibits introduced in court. It is up to you to determine the inferences which you feel may be properly drawn from the evidence. It is especially important that you perform your duty of determining the facts diligently and conscientiously, for ordinarily, there is no means of correcting an erroneous determination of facts by the jury.

The parties may sometimes present objections to some of the testimony or other evidence. It is the duty of a lawyer to object to evidence which he or she believes may not properly be offered and you should not be prejudiced in any way against the lawyer who makes objections on behalf of the party he or she represents. At times I may sustain objections or direct that you disregard certain testimony or exhibits. You must not consider any evidence to which an objection has been sustained or which I have instructed you to disregard.

Anything you may have seen or heard outside the courtroom is not evidence and must also be disregarded.

If counsel for the parties have stipulated to any fact, you will regard that fact as being conclusively proved as to the party or parties making the stipulation.

You must not speculate to be true any insinuations suggested by a question asked the witness. A question is not evidence and may be considered only as it supplies meaning to the answer.

You must not be influenced in any degree by any personal feeling of sympathy for or prejudice against the plaintiff or defendant. Both sides are entitled to the same fair and impartial consideration.

GENERAL INSTRUCTION 1GI.5 (2011)

CLAIMS MADE AND ISSUES TO BE PROVED

The credibility or "believability" of a witness should be determined by his or her manner upon the stand, his or her relationship to the parties, his or her fears, motives, interests or feelings, his or her opportunity to have observed the matter to which he or she testified, the reasonableness of his or her statements and the strength or weakness of his or her recollections.

Many of the doctors and experts presented to you have been paid or compensated for their appearance. You can give this fact as much or as little weight as you see fit when you assess the credibility of the witnesses.

U.S. v. Lizarraga-Cedano, 191 Fed.Appx. 586 (9th Cir. 2006)*; Young Ah Chor v. Dulles,* 270 F.2d 338 (9th Cir. 1959).

GENERAL INSTRUCTION 1GI.6 (2011)

DEPOSITION EVIDENCE

During trial, if certain testimony has been read into evidence from a deposition or the deposition testimony has been recorded by video and played for you. A deposition is testimony taken under oath before the trial and preserved in writing or on video. You are to consider that testimony the same as if it had been given in court by a live witness. You must not make any speculation as to why the witness did not personally appear in court. There are many reasons such as cost and convenience for out of state witnesses that the witness was not here live. You must not give the testimony less weight simply because the testimony was presented to you by means other than by a live witness. All parties or their attorneys were given the opportunity to attend the deposition and cross-examine the witness.

NEV. J.I. 2.03

General Pattern Instruction Pre-2011

**EVIDENCE TO BE CONSIDERED GENERALLY;
DIRECT AND CIRCUMSTANTIAL EVIDENCE**

The evidence which you are to consider in this case consists of the testimony of the witnesses, the exhibits and any facts admitted or agreed to by counsel.

There are two types of evidence: direct and circumstantial. Direct evidence is direct proof of a fact, such as testimony by a witness about what the witness personally saw or heard or did. Circumstantial evidence is the proof of one or more facts from which you could find another fact. The law makes no distinction between the weight to be given either direct or circumstantial evidence. Therefore, all of the evidence in the case, including the circumstantial evidence, should be considered by you in arriving at your verdict.

Statements, arguments and opinions of counsel are not evidence in the case. However, if the attorneys stipulate to the existence of a fact, you must accept the stipulation of evidence and regard that fact as proved.

You must not speculate to be true any insinuations suggested by a question asked a witness. A question is not evidence and may be considered only as it supplies meaning to the answer.

You must also disregard any evidence to which an objection was sustained by the court and any evidence ordered stricken by the court. Anything you may have seen or heard outside the courtroom is not evidence and must also be disregarded.

See, MANUAL OF MODEL CIVIL JURY INSTRUCTIONS FOR THE NINTH CIRCUIT (April 2007), Instruction 1.6: "What is Evidence*"; see* also, *Deveroux v. State, 96 Nev.* 388, 610 P.2d 722 (1980)*; Crawford v. State*, 92 Nev. 456, 552 P.2d 1378 (1976) (circumstantial evidence alone may sustain a conviction).

EVIDENCE INSTRUCTION 2EV.3 (2011)

CHARTS AND SUMMARIES

Certain charts and summaries have been received into evidence to illustrate facts brought out in the testimony of some witnesses. Charts and summaries are only as good as the underlying evidence that supports them. You should therefore give them only such weight as you think the underlying evidence deserves.

See, Federal Rules of Evidence, Rule 1006, 28 U.S.C.A.: "Summaries"*; see* also, *United States v. Nguyen,* 267 Fed.Appx. 699 (9th Cir. 2008) (the court noted that the District Court properly instructed the jury that the charts and summaries were only as good as the underlying evidence on which they were based); *United States v. Poschwatta*, 829 F.2d 1477 (9th Cir. 1987) (holding that admission of a chart summarizing income figures already admitted into evidence, while perhaps not the best practice, was not an abuse of discretion); *United States v. Gardner,* 611 F.2d 770 (9th Cir. 1980) (holding that admission of a chart summarizing the defendant's financial status was well within the discretion of the trial court pursuant to Fed.R.Evid. 611(a))*; United States v. Krasn,* 614 F.2d 1229 (9th Cir. 1980) *(*holding that charts should not have been admitted, but that it was harmless error as the defendant had an opportunity to challenge the facts and data upon which the charts were based and the court gave a limiting instruction); *United States v. Gardner,* 611 F.2d 770 at *776 (noting the defendant's opportunity to cross-examine the government witness who prepared the chart and finding no reversible error in admission of chart).

EVIDENCE INSTRUCTION 2EV.14 (2011)

ATTORNEY'S RIGHT TO INTERVIEW WITNESS

An attorney has a right to interview a witness for the purpose of learning what testimony the witness will give. The fact that the witness has talked to an attorney and told that attorney what he or she would testify to does not, by itself, reflect adversely on the truth of the testimony of the witness.

Cacoperdo v. Demosthenes, 37 F.3d 504 (9th Cir.1994) ("[B]oth sides have the right to interview witnesses before trial."); *United States v. Rich,* 580 F.2d 929 (9th Cir. 1978) ("Abuses can easily result when officials elect to inform potential witnesses of their right not to speak with defense counsel."); *United States v. Black,* 767 F.2d 1334 (9th Cir. 1985) ("Absent a fairly compelling justification, the government may not interfere with defense access to witnesses.") cert. denied, 474 U.S. 1022, 106 S.Ct. 574, 88 L.Ed.2d 557 (1985).

EVIDENCE INSTRUCTION 2EV.15 (2011)

CREDIBILITY OF WITNESS; WITNESS THAT HAS TESTIFIED FALSELY

The credibility or "believability" of a witness should be determined by his or her manner upon the stand, his or her relationship to the parties, his or her fears, motives, interests or feelings, his or her opportunity to have observed the matter to which he or she testified, the reasonableness of his or her statements and the strength or weakness of his or her recollections.

If you believe that a witness has lied about any material fact in the case, you may disregard the entire testimony of that witness or any portion of this testimony which is not proved by other evidence.

NEV. J.I. 2.07

BAJI 2.22

General Pattern Instruction Pre-2011

DISCREPANCIES IN A WITNESS'S TESTIMONY

Discrepancies in a witness's testimony or between his testimony and that of others, if there were any discrepancies, do not necessarily mean that the witness should be discredited. Failure of recollection is a common experience, and innocent misrecollection is not uncommon. It is a fact, also, that two persons witnessing an incident or transaction often will see or hear it differently.

Whether a discrepancy pertains to a fact of importance or only to a trivial detail should be considered in weighing its significance.

NEV. J.I. 2.08

BAJI 2.21

General Pattern Instruction Pre-2011

JURORS NOT TO CONDUCT INDEPENDENT INVESTIGATION

You must decide all questions of fact in this case from the evidence received in this trial and not from any other source. You must not make any independent investigation of the facts or the law or consider or discuss facts as to which there is no evidence. This means, for example, that you must not on your own visit the scene, conduct experiments or consult reference works for additional information.

Rowbottom v. State, 105 Nev. 472, 779 P.2d 934 (1989) (juror misconduct, in which juror conducted independent investigation of crime, which was a prejudicial error which entitled defendant to new trial even though juror did not share her findings with other jurors until penalty phase of trial); *Meyer v. State*, 119 Nev. 554, 80 P.3d 447 (2003) (jurors are prohibited from conducting an independent investigation and informing other jurors of the results of that investigation).

EVIDENCE INSTRUCTION 2EV.16 (2011)

EXPERT WITNESS: GENERAL

A witness who has special knowledge, skill, experience, training or education in a particular science, profession or occupation is an expert witness. An expert witness may give his or her opinion as to any matter in which he or she is skilled.

You should consider such expert opinion and weigh the reasons, if any, given for it. You are not bound, however, by such an opinion. Give it the weight to which you deem it entitled, whether that be great or slight, and you may reject it, if, in your judgment, the reasons given for it are unsound.

Many of the doctors and experts presented to you have been paid or compensated for their appearance. You can give this fact as much or as little weight as you see fit when you assess the credibility of the witness.

EXPERTS INSTRUCTION 3EX.1 (2011)- MODIFIED

EXPERT WITNESS: HYPOTHETICAL QUESTION

A hypothetical question has been asked of an expert witness. In a hypothetical question, the expert witness is told to assume the truth of certain facts, and the expert witness is asked to give an opinion based upon those assumed facts. You must decide if all of the facts assumed in the hypothetical question have been established by the evidence. You can determine the effect of that admission upon the value of the opinion.

Wrenn v. State, 89 Nev. 71, 506 P.2d 418 (1973) (rejecting expert opinion testimony because assumed facts were not established).

EXPERTS INSTRUCTION 3EX.4 (2011)

NUMBER OF WITNESSES

The preponderance, or weight of evidence, is not necessarily with the greater number of witnesses.

The testimony of one witness worthy of belief is sufficient for the proof of any fact and would justify a verdict in accordance with such testimony, even if a number of witnesses have testified to the contrary. If, from the whole case, considering the credibility of witnesses, and after weighing the various factors of evidence, you believe that there is a balance of probability pointing to the accuracy and honesty of the one witness, you should accept his or her testimony.

Baker v. Morton, 79 U.S. 150 (1870)

NEGLIGENCE INSTRUCTION 4NG.3 (2011)

INTRODUCTORY INSTRUCTION; SINGLE LEGAL BASIS

The plaintiff seeks to establish a claim of professional negligence. This is also sometimes called "medical malpractice." I will now instruct you on the law relating to this claim.

RESTATEMENT (SECOND) OF TORTS §§ 281, 284

NEGLIGENCE INSTRUCTION 4NG.9 (2011)- MODIFIED

DEFINITIONS: MEDICAL MALPRACTICE, PROFESSIONAL NEGLIGENCE, AND PROVIDER OF HEALTH CARE

"Professional negligence" means the failure of a provider of health care, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care.

"Provider of health care" includes a physician.

NRS 41A.009; NRS 41A.015; NRS 41A.017; NRS 630.091; NRS 633.014; NRS 7.095; *Perez v. Las Vegas Medical Ctr.*, 107 Nev. 1, 805 P.2d 589 (1991); *Orcutt v. Miller*, 95 Nev. 408, 595 P.2d 1191 (1979).

MEDICAL MALPRACTICE INSTRUCTION 9MM.1- HEAVILY MODIFIED DUE TO CHANGES IN THE STATUTORY DEFINITIONS ENACTED FOLLOWING 2011

PLAINTIFF'S BURDEN OF PROOF

The plaintiff has the burden to prove by a preponderance of the evidence:

1. The accepted standard of medical care or practice;
2. That a doctor's conduct departed from the standard;,
3. That the doctor's conduct was the proximate (legal) cause of injury and/or death; and
4. The plaintiff's damages.

Prabhu v. Levine, 112 Nev. 1538, 930 P.2d 103 (1996); *Perez v. Las Vegas Medical Ctr.*, 107 Nev. 1, 4, 805 P.2d 589, 590-91 (1991); *Orcutt v. Miller*, 95 Nev. 408, 411, 595 P.2d 1191, 1193 (1979); NRS 41.

MEDICAL MALPRACTICE INSTRUCTION 9MM.2- MODIFIED, PARTS REGARDING CONTRIBUTORY NEGLIGENCE ARE REMOVED

DUTY OF PHYSICIAN AND SURGEON; HOLDING OUT AS SPECIALIST

It is the duty of a physician or surgeon who holds himself out as a specialist in a particular field of medical, surgical, or other healing science to have the knowledge and skill ordinarily possessed, and to use the care and skill ordinarily used, by reasonably well-qualified specialists practicing in the same field.

A failure to perform such duty is negligence.

Stevens v. Duxbury, 97 Nev. 517, 519, 634 P.2d 1212 (1981); *Orcutt v. Miller*, 95 Nev. 408, 595 P.2d 1191 (1979).

MEDICAL MALPRACTICE INSTRUCTION 9MM.5:

DUTY OF PHYSICIAN AND SURGEON: BOARD-CERTIFIED SPECIALIST

It is the duty of a physician or surgeon who is a board-certified specialist to have the knowledge and skill ordinarily possessed, and to use the care and skill ordinarily used, by reasonably well-qualified specialists practicing in the same field.

A failure to perform such duty is negligence.

Stevens v. Duxbury, 97 Nev. 517, 519, 634 P.2d 1212 (1981); *Orcutt v.Miller*, 95 Nev. 408, 595 P.2d 1191 (1979).

MEDICAL MALPRACTICE INSTRUCTION 9MM.6

STANDARD OF SKILL AND CARE: NATIONAL

The standard of skill and care required of a physician or surgeon should be determined by reference to the practice within his field of practice nationally, rather than by the practice among a more geographically circumscribed subset of his colleagues.

Stevens v. Duxbury, 97 Nev. 517, 519, 634 P.2d 1212, 1213-14 (1981); *Orcutt v. Miller*, 95 Nev. 408, 413, 595 P.2d 1191, 1194 (1979); *Mishler v. State of Nev. Bd of Medical Examiners*, 109 Nev. 287, 849 P.2d 291 (1993).

MEDICAL MALPRACTICE INSTRUCTION 9MM.7

"RISK" OR "COMPLICATION" OF PROCEDURE

The mere fact that a provider of health care considers an injury to a patient to be a "risk" or a known "complication" of a procedure does not mean that the defendant is not liable or did not breach the standard of care. The mere fact that a patient was advised of a potential "risk" or "complication" also does not mean that the defendant is not liable or did not breach the standard of care.

Instead, a physician must use reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care to avoid known "risks" or "complications" to the extent possible and this is the issue you must resolve in this case.

NON-STANDARD INSTRUCTION

NEGLIGENCE: ADDITIONAL LIABILITY

A physician liable for negligent medical treatment or negligent failure to render medical treatment is likewise liable for injury or death resulting from any additional medical treatment to which the patient is exposed as a proximate (legal) result of the original physician's negligence irrespective of whether such subsequent treatment is rendered in a proper or in a negligent manner.

RESTATEMENT OF TORTS § 457 (modified); *Lindquist v. Dengel*, 92 Wash.2d 257, 595 P.2d 934 (1979).

MEDICAL MALPRACTICE INSTRUCTION 9MM.8

NEGLIGENCE: PROXIMATE CAUSE: DEFINITION

When I use the expression "proximate cause," I mean a cause which, in foreseeable and continuous sequence, unbroken by any efficient intervening cause, produces the injury complained of and without which the result would not have occurred. It need not be the only cause, nor the last or nearest cause. It is sufficient if it concurs with some other cause acting at the same time, which in combination with it, causes the injury.

Goodrich & Pennington Mortgage Fund, Inc. v. J.R. Woolard Inc., 120 Nev. 777, 784, 101 P.3d 792, 797 (2004) *citing Taylor v. Silva*, 96 Nev. 738, 741, 615 P.2d 970, 971 (1980) *(quoting Mahan v. Hafen,* 76 Nev. 220, 225, 351 P.2d 617, 620 (1960)); *Dow Chemical Co. v. Mahlum,* 114 Nev. 1468, 1481, 970 P.2d 98, 107 (1998); RESTATEMENT (SECOND) OF TORTS § 431.

NEGLIGENCE INSTRUCTION 4NG.13 (2011)

MEASURE OF DAMAGES

In determining the amount of losses, if any, suffered by the plaintiff as a proximate result of the accident in question, you will take into consideration the nature, extent and duration of the injuries you believe from the evidence plaintiff has sustained, and you will decide upon a sum of money sufficient to reasonably and fairly compensate the Plaintiff for the following items:

1. The reasonable medical expenses Plaintiff has necessarily incurred as a result of the accident and the medical expenses which you believe he is reasonably certain to incur in the future as a result of the accident, discounted to present value;

[Non applicable parts omitted]

2. The physical and mental pain, suffering, anguish and disability endured by the plaintiff from the date of the accident to the present; and

3. The physical and mental pain, suffering, anguish and disability which you believe plaintiff is reasonably certain to experience in the future.

Arnold v. Mt. Wheeler Power Co., 101 Nev. 612, 707 P.2d 1137 (1985); *Shere v. Davis*, 95 Nev. 491, 596 P.2d 499 (1979); *Sierra Pac. Power Co. v. Anderson*, 77 Nev. 68, 358 P.2d 892 (1961);

PERSONAL INJURY DAMAGES INSTRUCTION 5PID.1 (2011)- MODIFIED TO REMOVE NON-APPLICABLE DAMAGES INSTRUCTIONS

REASONABLE VALUE OF MEDICAL EXPENSES- UNREBUTTED BY DEFENDANT

The Plaintiff is entitled to recover the usual, customary and reasonable value of medical expenses that you find to be causally related to the accident.

The Plaintiff has produced evidence that the medical expenses are reasonable, usual and customary in amount for our community. The Defendant has failed to present any counter-evidence to assert that the claimed medical expenses are unreasonable or not usual and customary.

There mere fact that a health insurer actually paid the medical expenses for a lesser amount is not evidence of the usual, customary and reasonable value of the services provided.

Therefore, I instruct you that if you find the medical treatment claimed by the Plaintiff to be reasonable, necessary and causally related to the accident, you are to award 100% of the claimed medical expenses. The amount of the medical expenses has not been challenged by the defense.

Curti v. Franceschi, 60 Nev. 422, 428 (1941) (physician's testimony is substantial evidence of reasonable value of medical services); *Khoury v. Seastrand*, 377 P.3d 81, 93 (Nev. 2016). "Evidence of payments showing medical provider discounts, or write-downs, to third-party insurance providers 'is irrelevant to a jury's determination of the reasonable value of the medical services and will likely lead to jury confusion.'" Citing *Tri-Cty. Equip. & Leasing v. Klinke*, 128 Nev. 352, 360, 286 P.3d 593, 598 (2012) (Gibbons, J., concurring).

Non-standard instruction.

PAIN AND SUFFERING: NO DEFINITE STANDARD

No definite standard or method of calculation is prescribed by law by which to fix reasonable compensation for pain and suffering. Nor is the opinion of any witness required as to the amount of such reasonable compensation. In making an award for pain and suffering, you shall exercise your authority with calm and reasonable judgment and the damages you fix shall be just and reasonable in light of the evidence.

Canterino v. The Mirage Casino-Hotel, 117 Nev. 19, 16 P.3d 415 (2001); *Stackiewicz v. Nissan Motor Corp. in U.S.A.*, 100 Nev. 443, 686 P.2d 925 (1984).

PERSONAL INJURY DAMAGES INSTRUCTION 5PID.2 (2011)

DAMAGES: UNCERTAINTY AS TO AMOUNT

A party seeking damages has the burden of proving both that they did, in fact, suffer injury and the amount of damages resulting from that injury. The amount of damages need not be proved with mathematical exactitude, but the party seeking damages must provide an evidentiary basis for determining a reasonably accurate amount of damages. There is no requirement that absolute certainty be achieved; once evidence establishes that the party seeking damages did, in fact, suffer injury, some uncertainty as to the amount of damages is permissible. However, even if it is provided by an expert, testimony that constitutes speculation not supported by evidence is not sufficient to provide the required evidentiary basis for determining a reasonably accurate award of damage.

Gramanz v. T-Shirts and Souvenirs, Inc., 111 Nev. 478, 484-85, 894 P.2d 342, 346-47 (1955); *Mort Wallin of Lake Tahoe, Inc. v. Commercial Cabinet Co. Inc.*, 105 Nev. 855, 857, 784 P.2d 954, 955 (1989); see also *Perry v. Jordan*, 111 Nev. 943, 948, 900 P.2d 335, 338 (1995).

CONTRACTS INSTRUCTION 13CN.48

OPINIONS REGARDING OTHER AWARDS AND CASES MUST BE SET ASIDE

Some jurors have had experiences with other cases or read about jury awards in other cases and considered the award too high or too low. As a juror, you must disregard any opinion you have of other cases when determining your award. In other words, if you feel the plaintiff is entitled to a certain dollar amount, you should not *reduce* that amount or award less because you believe from other cases that juries award too much money. Similarly, if you feel the plaintiff is entitled to a certain dollar amount, you should not *increase* that amount or award because you believe from other cases that juries do not award enough money. Please consider only the case and facts before you and not the impact your award may or may not have on other cases in our community.

Additionally, the Defendants may have to pay claims from multiple parties arising from the same accident. You should determine what the plaintiff in this matter should be awarded and not concern yourself with the total amount of claims the Defendants may have to pay to other persons.

Non-standard instruction.

INSURANCE:
COLLATERAL SOURCES

You are not to discuss or even consider whether or not the defendant was carrying insurance that would reimburse him for whatever sum of money it may be called upon to pay to the plaintiff.

Whether or not the defendant was insured is immaterial and should make no difference in any verdict you may render in this case.

NEV. J.I. 1.07

General Pattern Instruction Pre-2011 (Modified)

CLOSING INSTRUCTION

Whether any of these elements of damage have been proven by the evidence is for you to determine. Neither sympathy nor speculation is a proper basis for determining damages. However, absolute certainty as to the damages is not required. It is only required that plaintiff prove each item of damage by a preponderance of the evidence.

Quintero v. McDonald, 116 Nev. 1181, 14 P.3d 522 (2000).

PERSONAL INJURY DAMAGES INSTRUCTION 5PID.9 (2011)

ALL INSTRUCTIONS NOT NECESSARILY APPLICABLE

The court has given you instructions embodying various rules of law to help guide you to a just and lawful verdict. Whether some of these instructions will apply will depend upon what you find to be the facts. The fact that I have instructed you on various subjects in this case must not be taken as indicating an opinion of the court as to what you should find to be the facts or as to which party is entitled to your verdict.

NEV. J.I. 11.00

BAJI 15.22

General Pattern Instruction Pre-2011

DUTY OF JUROR TO CONSULT

It is your duty as jurors to consult with one another and to deliberate with a view toward reaching an agreement, if you can do so without violence to your individual judgment. Each of you must decide the case for yourself but should do so only after a consideration of the case with your fellow jurors, and you should not hesitate to change an opinion when convinced that it is erroneous. However, you should not be influenced to vote in any way on any questions submitted to you by the single fact that a majority of the jurors, or any of them, favor such a decision. In other words, you should not surrender your honest convictions concerning the effect or weight of evidence for the mere purpose of returning a verdict or solely because of the opinion of the other jurors. Whatever your verdict is, it must be the product of a careful and impartial consideration of all the evidence in the case under the rules of law as given you by the court.

NEV. J.I. 11.01

General Pattern Instruction Pre-2011

READING BACK TESTIMONY

If, during your deliberation, you should desire to be further informed on any point of law or hear again portions of the testimony, you must reduce your request to writing signed by the foreman. The officer will then return you to court where the information sought will be given to you in the presence of the parties or their attorneys.

Read backs of testimony are time consuming and are not encouraged unless you deem it a necessity. Should you require a read back, you must carefully describe the testimony to be read back so that the court reporter can arrange her notes. Remember, the court is not at liberty to supplement the evidence.

NEV. J.I. 11.02

General Pattern Instruction Pre-2011

GENERAL VERDICT WITH SPECIAL FINDINGS

After the closing arguments, when you retire to consider your verdict, you must select one of your number to act as foreperson, who will preside over your deliberation and will be your spokesperson here in court.

During your deliberation, you will have all the exhibits which were admitted into evidence, these written instructions and forms of verdict which have been prepared for your convenience.

In civil actions, three-fourths of the total number of jurors may find and return a verdict. This is a civil action. Your verdict does not have to be unanimous. If your verdict is in favor of the plaintiff, you are directed to make special findings of fact consisting of written answers to the questions in a form that will be given to you.

You shall answer the questions in accordance with the directions in the form and all of the instructions of the court. As soon as six or more of you have agreed upon every answer in the special findings, you must have the verdict and special findings signed and dated by your foreperson, and then return with them to this room. Even if one juror disagrees as to an answer that six or more jurors agree upon, that juror should still participate in answering subsequent questions on the verdict form.

NEV. J.I. 11.06

General Pattern Instruction Pre-2011

EXPLANATION OF VERDICT READING

After you decide on your verdict, you will be called back one last time for the reading of your verdict in open court.

Following the reading of your verdict, you will be discharged as jurors and allowed to leave. On occasion, attorneys will try to interview or contact jurors to discuss the case and your verdict. Sometimes attorneys do this out of curiosity or to learn more about how juries arrive at a verdict. Sometimes attorneys do this to try to obtain information with which they can challenge your verdict or move for a new trial. The decision as to whether you wish to speak to the attorneys or anyone from their office after your verdict is entirely yours. You are under no obligation to do so.

NON-PATTERN INSTRUCTION

ARGUMENTS OF COUNSEL

Now you will listen to the arguments of counsel who will endeavor to aid you to reach a proper verdict by refreshing in your minds the evidence and by showing the application thereof to the law; but, whatever counsel may say, you will bear in mind that it is your duty to be governed in your deliberation by the evidence, as you understand it and remember it to be, and by the law as given you in these instructions, and return a verdict which, according to your reason and candid judgment, is just and proper.

NEV. J.I. 11.03

General Pattern Instruction Pre-2011

VER

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; Defendants.	CASE NO.: A-18-773472-C DEPT NO.: III **VERDICT FOR PLAINTIFF**

We, the jury in the above-entitled action, find in favor of Plaintiff Kimberly Taylor and against Defendants Keith Brill, M.D. and Women's Health Associates of Southern Nevada-Martin, PLLC, and award the following damages:

Past Medical Expenses .....$_____

Past Pain & Suffering, Mental Anguish and
Loss of Enjoyment of Life.....$_____

Future Pain & Suffering, Mental Anguish and
Loss of Enjoyment of Life.....$_____

TOTAL .....$_____

_____
JURY FOREPERSON

_____
DATE

VOIR
ADAM J. BREEDEN, ESQ.
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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; Defendants.	CASE NO.: A-18-773472-C DEPT NO.: III **PLAINTIFF'S PROPOSED VOIR DIRE**

Plaintiff Kimberly Taylor hereby submits the following proposed voir dire. This submission may be added to or amended as needed and as ordered by the Court.

In this matter, a jury questionnaire has not been used. Therefore, Plaintiff's counsel anticipates any or all of the following background/general questions:

1) Is there anyone who would get offended if I used the pronouns him or her or used the words Mr. or Ms. to refer to them? Is it okay if I call you by your last name?
2) Is there anyone who knew any court staff, other jurors, either of the parties or any of law offices working on this case before you walked in here?
3) Is there anyone who has been convicted of a felony and has <u>not</u> had their civil rights restored?
4) Is there anyone who does <u>not</u> currently reside in Clark County, Nevada?
5) What is your age?

6) What race do you most identify with?

7) How long have you lived in Clark County?

8) Where did you live before Clark County?

9) Are you registered to vote? If so, with what party?

10) What is your educational history?

11) What is your current occupation? Have you ever been a supervisor?

12) Are you married? If so, what does your spouse do?

13) Do you have any children? If so, what are their ages?

14) Do you come from a large family?

15) Have *you* ever worked or received training in, or do you have any *close friends or relatives* who have worked in or received training in, the *medical* field?

16) Have *you* ever worked or received training in, or do you have any *close friends or relatives* who have worked in or received training in, the *legal* field?

17) Have *you* ever worked or received training in, or do you have any *close friends or relatives* who have worked in or received training in, the *insurance* field?

18) Have *you* ever worked or received training in, or do you have any *close friends or relatives* who have worked in or received training in, the *law enforcement* field?

19) What Social Media, Radio or Television programs do you get your news from?

20) If I caught you watching Television, what shows are you most likely to be watching?

21) Who is a public figure like a former president, an athlete, a performer or musician that you admire, and why do you admire him or her?

22) Have you ever served on a jury before and, if so, tell me about that experience? Civil or Criminal? What was the case about?

23) Have you ever been a victim of any serious theft, robbery, fraud, or scam?

24) Do you regularly worry about your own safety or your family's personal safety?

25) When you hear that someone has been hurt, killed, or has become seriously ill, how often do you think it might have happened because of bad things the person may have done earlier in life? As in, some people call that karma or what a person deserves.

26) Some people believe that when someone is killed or hurt, it is usually due to fate, or destiny, God's will, or just plain bad luck – so it is wrong to sue anyone, because what was going to happen was destined to happen anyway. What do you think for that?

27) Do you believe that most personal injury lawsuits are frivolous?

28) Do you agree that some defendants refuse to pay legitimate claims?

29) Do you agree that some defendants dispute legitimate claims because they have more resources to drag out litigation and make the claim more costly for the other person?

30) Do you agree that some defendants refuse to pay legitimate claims in order to keep their insurance rates lower?

In addition, Plaintiff discloses the following questions which are less demographic:

a) Name something you are passionate about for me (don't say God or Family).

b) When you were a little kid, did you ever cut in line? What did you think of other kids who would cut in line? Why did you think that?

c) Have you ever seen an OB/GYN? How frequently?

d) Do you know anyone that has suffered an injury from a doctor?

e) Does anyone here feel like doctors never make mistakes?

f) Does anyone on the jury remember a ballot initiate in 2004 called KODIN? Did you have strong feelings about KODIN?

g) Does anyone feel like they were ever injured and couldn't do something but other people did not believe them?

h) Have you ever been betrayed? What do you need first to be betrayed?

i) I'm an injury lawyer. What bad things have you heard about injury lawyers? What good things do you think injury lawyers do?

j) Who has helped someone they didn't know in the last three years? What did you do?

k) Do you believe in awarding damages for pain and suffering, would you put a cap on it, what cap?

l) Presentation of the following scenario: Twelve-year-old Chris/Christina is playing baseball in the neighborhood with friends and breaks a window. All the other kids take off after they see the ball break the window and Chris is left alone. What would you do when you were Chris' age? If you were Chris' parent, what would you tell Chris to do?

m) Presentation of the following scenario: While you were waiting to come into the courtroom, another juror said to you "wow, I really have a bad headache today, I just can't stand it and might not be able to go forward today." What conclusion would you

draw from that statement and would you believe that person? Would you take the person at face value? Now, add the fact that you learn that juror is actually going to be a plaintiff in another case the next week where he or she alleges they have headaches because of a car accident. Does that change your assessment? How? Why?

n) Presentation of the following scenario: Karen is driving on Charleston Blvd. in normal traffic when she has to come for a stop at a traffic light. Bob is driving behind her, fails to stop in time and severely damages Karen's car. When Bob gets out of his car, he says "I've not going to pay for this. You should know when you drive around that it's a risk that other cars will rear end you. Its just part of driving and you know that." Who do you think is at fault? What do you think of Bob's argument?

o) Presentation of the following scenario: Imagine a man boarded a passenger bus and headed on a trip out of town. While the bus was travelling on the highway, the bus lost control and flipped over several times, caught on fire, and the man and several other passengers were killed. Afterward, the man's family learned that the man had survived the initial accident but died a slow, painful death in the fire. Investigations showed that a mechanic for the bus company improperly worked on the steering of the bus before the trip, which caused the bus to veer out of control.

The family of the man knew several attorneys that urged them to sue and the bus company contacted the man's family with a generous offer. But the man's family believed that it was fate or God's will that the man be taken early and believed that suing over such a tragedy would not be right. They refused to sue and declined money from the bus company and received nothing. What do you think of the family's decision?

p) In this case, Plaintiff may seek hundreds of thousands of dollars in damages. Is there an amount of money so large that you do not think you would be able to award it?

q) As a juror, you are acting as the conscience of our community. Are you uncomfortable judging others?

r) Imagine that you are on a jury that is considering awarding a very large amount of money to an injured person. You know that it is likely that local news stations and the Las Vegas Review Journal are likely to print the amount of the award and details, and that some friends and family members might learn you were on the jury. Given that information, how would that effect the decision you made? Would it affect your decision at all?

s) This case is a patient against her doctor. Does anyone feel like, at this stage, they are a little more inclined to rule in favor of the patient? How about the doctor?

t) If you were in my client's position, is there any reason you would not want yourself on this jury?

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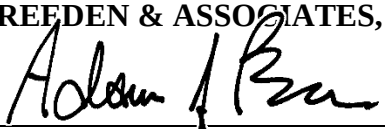
THIS LIST IS NOT INTENDED TO BE ALL-ENCOMPASSING, RATHER ONLY A FAIR DISCLOSURE OF *LIKELY* QUESTIONS. NOT ALL QUESTIONS WILL BE ASKED OF EVERY JUROR FOR PURPOSES OF TIME. PLAINTIFF RESERVES THE RIGHT TO ASK ADDITIONAL QUESTIONS OF JURORS AS PERMITTED.

DATED this 18th day of August, 2021.

BREEDEN & ASSOCIATES, PLLC



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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 PROPOSED VOIR DIRE** 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