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

Electronically Filed
Mar 10 2022 11:53 a.m.
Elizabeth A. Brown
Clerk of Supreme Court

SUPREME COURT CASE NO. 83847

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

APPELLANT'S APPENDIX

VOLUME IX

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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 IX** via the method indicated below:

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

An Attorney or Employee of the firm:

/s/ Sarah Daniels
BREEDEN & ASSOCIATES PLLC

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DISTRICT COURT

CLARK COUNTY, NEVADA

KIMBERLY D. TAYLOR, Plaintiff, vs. KEITH BRILL, M.D., ET AL., Defendants.	CASE#: A-18-773472-C DEPT. III

BEFORE THE HONORABLE MONICA TRUJILLO
DISTRICT COURT JUDGE
WEDNESDAY, OCTOBER 13, 2021

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 4

APPEARANCES:

For the Plaintiff: ADAM J. BREEDEN, ESQ.
YIANNA ALBERTSON REIZAKIS, ESQ.

For the Defendants: ROBERT C. MCBRIDE, ESQ.
HEATHER S. HALL, ESQ.

RECORDED BY: JILL HAWKINS, COURT RECORDER

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Las Vegas, Nevada, Wednesday, October 13, 2021

[Case called at 10:30 a.m.]

[Outside the presence of the jury]

THE COURT: All right. We're on the record in case number A-18-773472-C, Kimberly Taylor v. Brill and Women's Health Associates of Southern Nevada - Martin PLLC. Counsel for both sides are present, and we are outside the presence of the jury. Are there any issues before we continue with Plaintiff's case?

MR. BREEDEN: Nothing at this time, Your Honor. We have all the jurors here now and we're ready?

THE COURT: Yes.

MR. BREEDEN: Oh, terrific. Our witness, who is appearing by BlueJeans, is ready as well.

THE COURT: Anything on behalf of Defendant?

MR. MCBRIDE: Nothing, Your Honor. We're discussing the possibility of maybe stipulating to admit Dr. Hamilton's office chart as an exhibit, which is Joint Exhibit 13, I believe.

[Counsel confer]

MS. HALL: So Your Honor, we do have one thing to put on the record before we bring the jury in.

THE COURT: Okay. Go ahead.

MS. HALL: We have stipulated to the admission of Joint Exhibit 13, which is Dr. Hamilton's office chart as well as Joint Exhibit 15, which is the City of Henderson ambulance records.

THE COURT: So Joint Exhibit 13 and 15 will be admitted by stipulation.

[Joint Exhibits 13 and 15 admitted into evidence]

THE COURT: And then I know we put stipulations on the record yesterday as to Joint Exhibit 1, Joint Exhibit 3 and Joint Exhibit 5, but I'm not sure we admitted them, so just for the record, they're going to be admitted by stipulation.

[Joint Exhibits 1, 3 and 5 admitted into evidence]

MS. HALL: And Your Honor, on that issue, it came to my attention that in the Henderson Hospital records, separate and apart from the discharge instructions, there were still included a few consent forms from the hospital. And I discussed that with Mr. Breeden and the agreement is my paralegal is going to do a revised joint exhibit list --

THE COURT: Okay.

MS. HALL: -- remove pages 62 through 66 from the Henderson Hospital exhibit and make that a separate joint exhibit, which will be clearly identified, should I, you know, try to introduce that in some fashion during the trial, but it will be --

THE COURT: So you don't want me to admit the previously -- you want to strike the Joint Exhibit 5 as it currently is?

MS. HALL: That is correct, because unfortunately, neither of us realized that it does contain four pages of consent forms from Henderson Hospital and I think subject to Your Honor's prior ruling, those should come out and be a separate exhibit, should I try to admit them at some other point.

MR. BREEDEN: And Judge, I don't know that you need to strike the exhibit. I just think we need to redact those pages out.

THE COURT: Okay. Well, the way she said it was they were going to redo a whole new one, so I just -- that's the only reason I said that.

MR. BREEDEN: Yeah, let's not --

MS. HALL: Either way is fine.

MR. BREEDEN: -- throw the baby out with the bath water.

MS. HALL: Sure.

MR. BREEDEN: We'll keep what we have and then Ms. Hall wants a new exhibit of those pages that are being redacted and that's fine. I don't know what she's going to do with them, but if wants to label them differently for probably purposes of the record.

THE COURT: Okay.

MS. HALL: Sure. I didn't mean to make that more confusing, but basically Exhibit 5 is fine as it is with the understanding that we'll be taking out pages 62 to 66.

THE COURT: Okay.

MS. HALL: And we'll put that at the end of the exhibit list.

THE COURT: Okay. Sounds good. And the BlueJeans is up and ready? Okay. Anything else?

MR. MCBRIDE: Nothing, Your Honor.

THE COURT: Okay. Go ahead and bring them in, Ray. Thank you.

THE CLERK: That was for Exhibit 5?

MS. HALL: Yes.

THE CLERK: What about Exhibit 3? Because yesterday you had said that you guys would be removing consent forms?

MS. HALL: That has already been removed, and it's accurately reflected. The Bate pages in that --

THE CLERK: Oh. So this is good?

MS. HALL: Yes. That is still correct.

THE MARSHAL: All rise for the jury.

[Jury in at 10:38 a.m.]

THE MARSHAL: The jury is all present, Your Honor.

THE COURT: Thank you. You may be seated. Parties stipulate to the presence of the jury?

MR. BREEDEN: Stipulated.

MR. MCBRIDE: Yes, Your Honor.

THE COURT: Thank you. Welcome back everyone and good morning. We are going proceed with the Plaintiff's case and on behalf of Plaintiff, do you have another witness?

MS. ALBERTSON: Yes, Your Honor. Plaintiff's call Elizabeth Hamilton, M.D.

MR. BREEDEN: Looks like she stepped away, Your Honor. If I could step into the hall.

THE COURT: Yeah.

[Pause]

MS. ALBERTSON: Dr. Hamilton?

DR. HAMILTON: Yes.

MS. ALBERTSON: Okay.

THE CLERK: Please raise your right hand.

ELIZABETH HAMILTON, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Elizabeth Hamilton, E-L-I-Z-A-B-E-T-H H-A-M-I-L-T-O-N.

DIRECT EXAMINATION

BY MS. ALBERTSON:

Q Okay. Dr. Hamilton, can you hear me okay?

A Yes, I can.

Q Okay. If at any point you cannot hear me, please let me know. We do all have to wear masks in here. I appreciate that you're not wearing a mask, because it'll make it easier for us to hear and understand you. And I just want to confirm you're in a place where it's okay for you not to wear one, correct?

A I'm in my tiny little office, so yes.

Q Okay. Thank you. Okay. Did you perform a surgery on Kimberly Taylor on April 27th, 2017 to repair a bowel perforation?

A Per the records, yes.

Q And is it your understanding that was a resection of the small bowel with -- and I'm going to do my best with this word, re-anastomosis. Is that correct?

A Yes, sir. May I just ask who's talking? I can't see who's talking to me.

Q Sure. My name is Anna Albertson. I'm co-counsel with

Adam Breeden.

A Oh, you're at the podium? Okay. At the podium. Okay.

Q Yeah. I have to stay here, because the microphone's right here.

A Okay.

Q And if I move away from it with the mask, you won't be able to --

A Okay.

Q -- hear me.

A Okay.

Q But -- sorry. I cannot see what you see, unfortunately, I don't think, unless --

A Okay.

MS. ALBERTSON: Is the small screen in the bottom what she's seeing?

THE CLERK: She should be able to see you.

MS. ALBERTSON: Okay.

BY MS. ALBERTSON:

Q Okay. I'm going to ask you some background questions now.

MS. ALBERTSON: And look, as far as the jurors go, I'm perfectly fine with you just facing her, if you want, because I'm just going to be asking questions, and she's going to be the one answering them. That might be easier than turning back and forth. And I'm sorry, but I do have to stay as close to this as I can, so it gets recorded.

BY MS. ALBERTSON:

Q Were you a physician, duly licensed to practice medicine in Nevada in April of 2017?

A Yes, ma'am.

Q Could you please describe your educational background for us?

A I'm a trained general surgeon, board certified. Do you want more background?

Q Yes, please. Yeah. If you can go through where you went to medical school, where you did any postgraduate --

A I went to --

Q -- course study work, internship, residency, things like that.

A Okay. I went to -- I'm from Nevada and I went to the University of Nevada School of Medicine for my medical school education from 1993 to 1997. I then moved to Dallas, Texas and did my internship and entire residency training at one institution, which was UT Southwestern/Parkland Hospital. And I did that from 1997 to 2004. I then was a -- I got boarded in 2005 and have just been a practicing general surgeon since.

Q Okay. Boarded in what specialty?

A General surgery.

Q And how long prior to April, 2017 did you practice?

A Well, I graduated from residency in 2004 and this case happened in 2017, so 13 years after residency.

Q Okay. And are you still currently board certified?

A Yes, ma'am.

Q Okay. And what does your current practice entail?

A I recently just switched positions, so I'm doing wound care and acute care emergency surgery, which is general surgery.

Q Okay. And you said you recently just switched positions. What did you do immediately previous to your current position?

A Acute care emergency surgery.

Q And was --

A And general surgery.

Q -- was that what you were doing in April of 2017?

A Yes, ma'am.

Q Okay. And can you describe what acute care emergency surgery encompasses?

A Yes. Acute care emergency surgery encompasses general surgical intervention on patients who present in a more urgent or emergent fashion, usually through an emergency room or through an inpatient like consultation while they're in the hospital, rather than electively making an appointment in a doctor's office, like for instance, for a hernia or something that is less pressing.

Q And have you ever previously given testimony in a courtroom?

A No.

Q Okay. So far you're doing really well with waiting for me to finish my question before you answer. I would just ask that we continue that way as much as possible and I would also ask that if at any point

you don't understand my question, ask for a clarification before you respond. Is that okay?

A Yes.

MS. ALBERTSON: Now, Your Honor, pursuant to 16.1, I'm tendering Ms. Hamilton as a qualified, non-retained treating physician to offer expert testimony pertaining to the procedures she performed on Kim in April of 2017.

MR. MCBRIDE: Well, to the extent -- I'm going to object to the -- her testimony is limited to those of a treating physician, not an expert witness. She has not authored any report. So as to opinions that she performed at the time of her kind of treatment.

THE COURT: Counsel approach.

MR. MCBRIDE: Sure.

[Sidebar at 10:46 a.m., ending at 10:48, not transcribed]

BY MS. ALBERTSON:

Q Okay. Now just to be clear, too, you aren't here to give an opinion about malpractice. You're just hear to discuss what you did, what you observed and any opinions you formed in the course and scope of your treatment of Ms. Taylor; is that clear?

A Yes, ma'am.

Q Okay. How did you come to treat -- and would you prefer I call -- look, we've been referring to our client as Kim, but would you prefer I call her Ms. Taylor, or Kim, or do you have a preference?

A Whichever makes her comfortable.

Q Okay. How did you come to treat or care for Kim in your

medical profession?

A On review of the notes on the hospital records, I was consulted to be available in the operating room or to help treat this patient who had presented to the hospital. And so I don't know if Dr. Ivie, the physician, the gynecologist who went to the operating room with me consulted me or -- it didn't seem like the emergency room had called me directly, but to answer your question, I'm not sure exactly who called me, but from review of my notes, I was asked to be available to help treat this patient, once she was already in the hospital.

Q What hospital was that?

A St. Rose Siena Hospital.

Q And what was your position at St. Rose Siena Hospital at that time?

A General surgery, general surgeon.

Q Now, I just want to be clear. You don't still work at St. Rose Sienna, right?

A Correct.

Q Okay. Because you don't currently live in Nevada. Is that correct?

A That's correct.

Q Okay. And that's part of what you're testifying the way you're testifying remotely, correct?

A That's correct.

Q Okay. But at the time, you did live in Nevada, and you were working as a general surgeon in St. Rose Siena?

A Yes, ma'am.

Q Okay. And it is your understanding that you were called for a surgical consult for Kim?

A Yes.

Q What were the symptoms or issues that were presenting that required your consultation?

A On review of my notes, it was that she'd had a recent surgical intervention and that she had re-presented to the hospital with severe abdominal pain.

Q Do you know what the -- and you can look at your notes -- what the recent surgical procedure was that you just referred to?

A Yes. I think she'd had a hysteroscopy and had some plan for addressing some fibroids, uterine fibroids and -- the day before.

Q Okay. So it was your understand --

A At a different hospital.

Q It was your understanding you were seeing her the day after the hysteroscopy?

A Yes, ma'am.

Q Okay. And I'm sorry. One more time. The symptoms that were -- that she was complaining about were what again?

A Severe abdominal pain.

Q Is it your understanding that that's a normal symptom following a hysteroscopy?

A It -- from the description, it sounded like it was much more significant than was expected after her procedure.

Q Okay. And did you do an exam of Kim?

A Yes.

Q What were your --

A My report --

Q -- findings? And you can refer to your notes, if need to.

A I think my consultation note had stated that I met with Ms. Taylor and her parents before the operation, that she had guarding and peritonitis on examination and that com -- this -- the complaint of severe abdominal pain, the examination of peritonitis and the CT scan finding that was available, maybe concerned that she had a complication.

Q What is peritonitis?

A Peritonitis is irritation of the lining of your abdominal cavity from a factor, whether it be infection or bleeding or something like that.

Q And how dangerous can that be?

A It can be dangerous. I mean, it could be life threatening. It's a symptom suggesting that there's a significant issue going on in the abdominal cavity.

Q And your notes indicate that you saw her for the first time, I think, on April 27th, which would have been the day after surgery for your initial exam?

A That's correct.

Q What would your initial exam have entailed?

A Speaking to the patient and trying to get as complete as history as possible about the series of events prior to this leading up to this presentation. And then a physical examination on just looking at

her in general. And then focusing on the -- mostly on the abdominal examination, then reviewing her laboratory and radiology studies and then trying to conduct with a plan of action to address her concern, her symptom complex.

Q How quickly after the exam did you devise a plan of action or is it immediate?

A Per my note, it suggested that I thought that this needed to be done and that there wasn't a clear question that it needed to be done. If you're asking how quickly we went to the operating room, I couldn't tell from the timing.

Q But you say per your note, there's something that needed to be done like urgently?

A Yes.

Q And the this you're talking about is the surgery that you were going to perform?

MR. MCBRIDE: Objection. Leading.

THE COURT: Overruled.

BY MS. ALBERTSON:

Q And what surgery were you going to perform or what surgery did you believe was needed after your exam?

A I'm trying to find my note, but I did just read it earlier. And what I felt that she had based on my examination of her on the 27th was peritonitis, which in the postoperative period I was concerned could represent a complication from surgery. I felt that she needed evaluation in the operating room rather than just continued observation with just

antibiotics. And that she would have -- that I was going to try to do a laparoscopy, which means looking in her peritoneal cavity with a camera. And if that didn't work, to open her up through a -- through a regular incision, open incision, and looking to make sure there wasn't a complication where something contributing to her symptoms.

Q Okay. Did you explain all that to her?

A Yes.

Q And did you eventually perform that procedure, that surgery you just talked about?

A Yes.

Q Okay. And did it end up being a closed procedure or a -- did you have to open her up?

A No. It looks like I started with a laparoscopy and converted to an open operation.

Q Okay. Let's take a look at your operative report. I believe the bate stamp at the bottom of the page is 00039. It's in the bottom right. And I'm sorry to the jurors, we can't have the doctor's face on the screen and have the page up, so we're going to do our best to make it as clear as possible what we're looking at and detail it.

Do you have your operative report open, Doctor?

A Yes.

Q Can you explain what this is exactly? I want you to give me like, you know, is this a record of the procedure you did that you take immediately after or how is this document made?

A Okay, wait. I'm trying to find it on my end. I got it, but I'm

looking at it. Are you showing it on the screen too? I don't see it on the screen.

Q Unfortunately, we can't show it on the screen too.

A Okay.

Q But it's the page that it says -- it's got a 00039 at the bottom right. So if we're on the same page, that should be the number on the bottom right of the page. And it starts with -- it says --

A I found it. I found it.

Q Okay.

A I found it.

Q Okay. So what is this document exactly?

A This is my operative report. And it indicates what I thought going into the operation, what I found in the operating room, and what I did in the operating room.

Q Okay. Let's break that down and talk about each one of those. The first thing I want to talk about is, I just want to be clear, this document lists you as the surgeon that performed the surgery, correct?

A Yes.

Q Was there any surgeon that assisted?

A It looked like Dr. Ivie.

Q Okay. What would have been your role? What would have been Dr. Ivy's role in the surgery to the best of your memory?

A Dr. Ivie must have been the gynecologist who was covering for that group, and I would have been the one who was, I guess, leading the operation.

Q Okay.
A The primary surgeon.
Q Thank you. Okay, let's go over your preoperative diagnosis. And can you first -- preoperative diagnosis, what does that mean?
A The diagnosis that I felt was true going into the operating room based on the information I had.
Q Okay. And what was your preoperative diagnosis? It looks like you had three different diagnoses, correct?
A Uh-huh. I had peritonitis.
Q Okay. And that again just to clarify is the -- it's an infection. Is that how you defined it for us?
A It's an irritation of the lining of the peritoneal cavity.
Q That can be deadly, correct?
A It is a pathologic finding, and it can be associated with deadly conditions.
Q Pre-operation, did you have any idea how that was caused or what caused that?
A The peritonitis?
Q Yeah. Yes.
A I think number two would suggest the answer to that question and that was concern for bowel perforation, which can lead to peritonitis.
Q Okay. So a bowel perforation could lead to peritonitis. And then what was your third preoperative diagnosis?
A A recent uterine hysteroscopy for menorrhagia with reported

uterine perforation.

Q Okay. So can you just kind of layman's term what that means?

A It means that -- my understanding was that she had a scope placed in her uterus and that there had been an identified perforation of the uterus during that procedure. And then my understanding was they had aborted a portion of the procedure that they planned to go ahead with. But the report was that she had a uterine manipulation somehow and a reported perforation.

Q Okay. So what was your understanding of how the uterine perforation was caused?

A I'm not a gynecologist, and I don't have any idea.

Q Okay.

A But somehow during that procedure.

Q During the hysteroscopy?

A Yes, ma'am.

Q Okay. And what about the bowel perforation. What was your understanding of how that was caused?

A I'm not sure that I can like -- are you asking me going into the operation or are you asking me what I found?

Q I'm going to ask you -- I'm asking you, going into the operation now, but I'm going to ask you as we get down this report when we get to -- after the operation I'm going to ask you a post-operation opinion as well.

A Are you asking me then why I thought the person had a

bowel perforation?

Q Well I would like the answer to that too. So if you want to answer that, that would be like -- but I think you described that a little bit because of the extreme abdominal pain, correct?

A Correct. I mean, I'm trying to follow you, but I think that the concern -- with my preoperative diagnosis I said, peritoneal, concern for bow perforation and recent uterine hysteroscopy for reported uterine perforation. The reason I would have written that third statement was that my concern was that the bowel perforation would have been caused by the number three.

Q By the hysteroscopy?

A By the reported uterine perforation. That's right.

Q Okay. Let's go a little bit into the procedure that you did, and then afterwards I want to discuss your postoperative diagnosis. So can you detail for the jury what -- well, let's start first with how quickly this procedure was done. Was this an urgent procedure that needed to be done like within 24 hours of the diagnosis?

A Yes, ma'am.

Q Okay. And was this done to your recollection and according to the records, within 24 hours of the diagnosis?

A Yes. I believe it was done the same evening.

Q Okay. Can you detail what you did in the operating room? And I think it is kind of detailed on the next pages, so feel free to read your notes. But I just kind of want you to go through with the jury step by step what happened.

A It sounds like I entered the abdomen. Again, the standard like way that I usually do by entering -- placing trocars into the abdomen and establishing pneumoperitoneum with carbon dioxide and then looking around inside the peritoneal cavity.

Q Okay. I'm going to stop you.

A Other than that my --

Q Sorry. I want to go bit by bit. So how did you look in the cavity? You entered -- you put cameras inside of Kim's body?

A I placed a Hassan trocar, it says, which is my usual way of entering an abdomen, the abdomen. And I would have created the space with carbon dioxide first and then put a camera in to look around.

Q Okay. And what did you find?

A It said significant adhesions of the small bowel to the anterior abdominal wall. And significant fibrinous exudate, evidence of succus spill [phonetic], and evidence of contamination in the abdomen, which was too significant proceed laparoscopically.

Q Okay.

A And there was contamination in four quadrants.

Q Okay. When you say too significant to proceed laparoscopically, what does that mean?

A It meant that working around the abdominal cavity, I didn't feel that I would be able to get a good view of everything that I needed to see, mainly bowel, and the uterus, and not just the small bowel, but the large intestine laparoscopically. And then I would need to have a larger incision. I would need to have my hands in the abdomen in order to

clean things up first and then be able to look around.

Q Okay. And you say that all four quadrants had, for lack of a better description, is it fecal matter floating around in there?

A I don't know if -- it didn't say fecal matter. It just said contamination or succus.

Q So contamination, okay. So what did you do next?

A It said, for this reason, I removed the scope, and I made a lower midline incision. And then on entering the abdomen, I evacuated that fluid and then I could just start evaluating once I cleaned it up enough to be able to see the structures definitively or un-definitively.

Q Okay. So at that point you cut him open for lack of a better description. What size cut do you make?

A It depends on what I think I need to do to see, but I said a lower midline incision on her, which would usually imply from about the bellybutton down.

Q Okay. And then so that basically you could see inside and clean out all that contamination?

A Yes.

Q Okay. And so, you did that and what happened next?

A Then I just started systematically looking at the bowel. So I was -- so it says right here -- let's see, I began by identifying the terminal ileum at the cecum. So I looked at -- I found the cecum, which is something you can usually find just because of where it is even when there's contamination. And I could see the appendix coming off the cecum where it always is. And then I started evaluating the bowel in a

sequential fashion from distally, which means at the cecum approximately towards the stomach.

Q Okay. When you say evaluating, are you essentially going through the small intestine to see if there's any kind of perforation?

A Yes. I'm just trying to look to the best of my ability, like every square inch of it to see if I -- if I can see a hole in it.

Q Okay. And did you see any kind of hole or perforation in it?

A Yes. Per my operative report, about one foot proximal to the terminal ileum, which is right where the cecum is and the appendix. There was a hole in the intestine.

Q Okay. And then what did you do next?

A I looked at the rest of the bowel, and I couldn't see anything as far as a clear hole. And I looked at the uterus and there was a perforation there and then it said -- and I looked at the rectum, which was in close proximity to that there too. And then it says I washed out and removed that portion of the bowel that was perforated.

Q Okay. What portion of the bowel was perforated? How big of a portion?

A Towards the end of the small intestine, about a foot approximal to the cecum was -- there was a small perforation, and I removed that section.

Q What size section did you have to remove?

A I think it was about --

Q And take your time because I think -- I do think it is in here.

A It said I found the size of the perforation was about three

centimeters. I thought it saw it, but I think it's on the top of my findings. But sorry, I'd have to look through this again. I saw it in the pathology report, but I'm sorry, I'm just not seeing it right here.

Q No. I think three centimeters -- I know there was like actual -- there's a little more measurements at a few different spots. But three centimeters sounds about right, and I think three centimeters is also what you noted in your findings. Do you want to flip to your findings and tell me if that's accurate?

A Here is my finding. I wasn't being able to see this. Yeah, I said -- sorry. Under specimen up on my findings I wasn't seeing this page. Removed a small bowel section of about five, six centimeters.

Q Okay. So about five to six centimeters is the section that you had to take out to repair the three-centimeter perforation?

A Yeah, to remove it.

Q Okay. And then once it's removed, what do you do next?

A Then you hook it back together. Well, you can do several things, but I hooked it back together in what we called stapled anastomosis, which is a reconnection of the intestine.

Q Does the intestine then fuse and then is it then able to repair?

A Yeah. Makes it heal together over time.

Q Okay. When you say over time, what kind of time are we talking about?

A To be thoroughly completely candid, I don't know exactly how many weeks it would be, but certainly within a month or two it would be healed.

Q Okay. So it takes multiple weeks for it to be fully healed?

A It takes weeks, yes.

Q And can there be lasting symptoms of pain or discomfort thereafter still?

A Sorry?

Q Are there lasting symptoms, pain, discomfort, anything like that that might prolong past that month or two healing period?

A From the healing of the intestine, I don't believe so. From healing from the surgery, very much so.

Q Okay. So there's multiple healings then. The intestine has to heal, but then your body has to heal from a surgical procedure like this as well, correct?

A The wound, yes. The open wound is usually what hurts.

Q Okay.

A And the perineal lining until contamination goes away.

Q Okay. How long would it take for the contamination to go away?

A Again, I think everybody might be a little bit differently, but we wash it out to get rid of the gross contamination with usually liters of fluid and I think I said we used at least three liters here to get rid of it. And then the body and antibiotics take care of the rest of it. And to answer your question, I'm not sure the exact amount of time. I think it might be different based on the level of contamination on everyone is different.

Q Okay.

A On how much of that -- uh-huh.

Q Okay. You said earlier those four quadrants were contaminated. How many quadrants are there?

A Four.

Q Okay. So all the quadrants were contaminated?

A Yes.

Q Okay. And so, you used three liters of fluid. Is that a lot of fluid to flush it out?

A Yeah, that's a lot of fluid. We usually just keep washing until it's clear, until you can't see -- until you feel like you've gotten all the gross contamination as possible out of the abdomen.

Q So is it fair to say there was a large amount of cleaning to do in this situation as well?

A Yes.

Q Okay. Now concerning the bowel perforation. Would the bowel perforation have been a normal complication or risk of a hysteroscopy?

MR. MCBRIDE: Objection. It's beyond the scope. She's a general surgeon. Not a gynecologist.

THE WITNESS: Yeah. I'm a general surgeon.

THE COURT: Sustained.

MR. MCBRIDE: Thank you.

BY MS. ALBERTSON:

Q And let's go back to the first page of your operative report. And before we look at your post-op diagnosis, which is what I want to

look at next, I want to look at the procedure performed. Can you read me the procedure performed; how you detailed it on your operative report?

A "Procedure performed: Diagnostic laparoscopy converted to exploratory laparotomy with small bowel resection and washout of the abdomen and pelvis."

Q Okay. And would you agree that's what you just described to us, correct?

A Yes, ma'am.

Q Okay. Do you believe this surgery, the procedure you performed, was reasonable and necessary in order to -- based on Kim's symptoms and complaints?

A Absolutely.

Q Do you think it was medically warranted?

A Absolutely.

Q Okay. Let's talk about your post-op diagnosis. What were your postoperative diagnoses in this matter?

A It said the same thing as the preoperative diagnosis. Peritonitis, concern for bowel perforation, and the same thing.

Q Okay. So fair to say --

A And the same --

Q Sorry for interrupting you. Go ahead.

A No. I think I could have put bowel perforation, not concern for it. But it says -- it says the same thing as the preoperative diagnosis. So I feel the findings are very detailed.

Q Okay. So essentially the only real difference between the pre-op and post-op, although they're the same on the sheet, is that instead of a concern for bowel perforation, you essentially confirmed a bowel perforation, correct?

A Absolutely.

Q Okay.

A And a uterine perforation.

Q Okay. Was the uterine perforation repaired?

A I don't -- I don't think so. I don't -- I have to look.

Q And I'm not asking about you. I'm asking when you first identified it, was the uterine perforation repaired? Because the next question I'm going to ask you is, did you repair it if you say it's repaired.

A I didn't see in my op report that I repaired the uterine perforation. It probably would have been Dr. Ivie if anyone did. But I don't see that I did.

Q Okay. And you don't see if you noted whether or not it was repaired, do you? And take your time.

[Witness reviews document]

THE WITNESS: I don't see -- I see that she -- no, I don't see that we did.

BY MS. ALBERTSON:

Q Okay. Is it something you would have repaired?

A In my experience, things that are self-limited that repair themselves, you know, you wouldn't necessarily repair it more.

Q Okay.

A It just depends on the specific situation, what you find, if there's still evidence of a, you know, wide open hole, if it's something that it's -- there's evidence of an injury. So just -- it's on a case-by-case basis. But do I usually repair uteruses? No.

Q Will a uterine perforation repair itself? Is that what you just said?

A Yeah. Do I -- is that what you're asking me?

Q Yes. Yeah. That's exactly what I'm asking, can it repair itself?

A Oh, I thought you said did I. Yes. Yes, they repair themselves.

Q So is it -- can you kind of describe that for me, how that occurs?

A Oh, I can't because you'd have to ask a gynecologist.

Q Okay. But it's your understanding as a general surgeon that a uterine perforation can repair itself?

A Yes.

Q Okay. What about a bowel perforation, can that repair itself?

A Bowel perforation. If they're tiny enough, then, yes, I think they can. For instance, ulcers, uh-huh.

Q Okay. In this case, we're dealing with a three centimeter bowel perforation. Is that --

A This is a different mechanism. This is a traumatic mechanism, and this is not the type that we would wait to see if it would heal itself. I'm not aware of these type of injuries healing themselves.

This is a completely different mechanism.

Q When you say traumatic mechanism, what are you referring to?

A A traumatic mechanism would be like caused, you know, from a surgery, not something like -- for instance, like a perforated peptic ulcer. So an injury caused by surgery, either manipulation with the hands, a thermal injury from cautery, or an instrument, or things like that. So in this situation, it is not -- I have -- I have not -- I'm not aware of a -- that it's appropriate to watch to see if these kind of things heal themselves.

Q So was it your opinion that the bowel perforation was caused by the hysteroscopy?

A Yes.

Q Okay. And that's why you're calling it a traumatic injury?

A Yes.

Q Because essentially that was the trauma?

A That's right.

Q Okay. It's different from -- I think you were just talking about like ulcers or something that might occur in someone's body -- I don't want to say naturally, but over time. Is that fair to say?

A Yeah. I guess iatrogenic. Meaning like caused or person caused versus -- or a mechanism that wasn't just something that, you know, just happened spontaneously in the person's body. Yes.

Q So you're saying this was person-caused, the bowel perforation, correct?

A From what it looked like.

Q Okay.

A Procedure-caused.

Q Procedure-caused. Thank you. And the procedure was the hysteroscopy?

A From the report.

Q Okay. And let's just -- I think we touched on most of your findings, but I just want to make sure we confirm them for the record. The findings you have listed on this operative report, those were post-surgical findings, correct?

A Yes.

Q So is it fair to say those are your opinions after opening up Kim, doing all the cleaning you were talking about, and doing the bowel repair? Correct?

A Resection and repair, yes.

Q Resection and repair. Thank you. Sorry. If I misstate anything, please just step in and correct.

Okay. So what were your -- there's five findings listed here. Can you go through each one of them? Can you start with the first one for me?

A Yes. "Perforated small bowel over the length of about three centimeters in this area for perforation is about one foot proximal to the terminal ileum. Fibrinous exudate and succus in the abdomen and pelvis. No clear injury noted to the colon. Normal appearing appendix. Perforation noted anterior to the" -- "anteriorly on the uterus with the

perforation being of about a centimeter in size with associated clot."

Q Okay. I think we understand number one, the perforated small bowel over a length of about three centimeters. We talked about that at length a few minutes ago, that there was a three centimeter perforation in Kim's bowel that was caused by the hysteroscopy.

Let's go over number 2 though.

MR. MCBRIDE: Objection. Your Honor, can we have less commentary and testifying by counsel and just ask questions of the witness, please?

THE COURT: Sustained. Ask the question.

MS. ALBERTSON: Okay.

BY MS. ALBERTSON:

Q Let's go over number 2. The fibrinous exudate. Can you read number 2 for me again and define what that means?

A They're going to succuate [phonetic] and succus in the abdomen and pelvis. The succus being the green contents of the bowel that we see in the -- in the abdominal cavity when bowel is perforated. And the fibrinous exudate is the yellowish-tan, stringy like thick material that's on there when the -- when the succus or the intestinal contents has been sitting there for a little -- for a little while.

Q Is this the contamination you were talking about?

A The succus and the -- the succus is the contamination -- all of it's the contamination because none of it's usually there.

Q Okay. So none of this should have been --

A I mean the pictures that I see in this record that -- I took

pictures.

Q And the pictures, I believe you have those as well. Unfortunately, it's going to be really hard to show the jury the pictures while you describe them. But I would like you to confirm the page that they're on. If you could skip ahead a couple of pages, I believe the pictures that you're talking about are on page 1119 and page 1120. You should have those pages, but they're probably pretty far ahead of where we are currently.

A Whoops. I just saw one.

Q Do you have them?

A Okay. I see them.

Q Okay. Are those the pictures you're referring to?

A Yes.

Q Okay. Which one of those pictures show the succus?

A I'm on SRDH-001119, and I -- there's four pictures on this chart. And I would say the two to the left. The one on the top left and bottom left.

Q And I know the juries can't -- the jurors can't see the pictures, but we'll probably be showing them later on. Where on these pictures is the succus? Which color basically is what I'm asking you.

A It's the fluid. The greenish-yellowish-tannish fluid. It's kind of hard to describe it, but --

Q So none of that is supposed to be there?

A Correct. And then the tannish, stringy, it looks like cobwebs, that's the exudate, the fibrinous exudate. That's easier to describe.

Q Okay. And that --
A The fluid that's in -- go ahead.
Q The cobweblike substance, that's visible on the other photographs as well; is that --
A Yes.
Q Those other photographs, do they also demonstrate the exudate?
A Yes.
Q Okay. So that was all you had to clean out? None of that should be there?
A None of that stuff in the -- none of that is usually there in a normal abdomen, no.
Q Okay.
A Especially the stuff down in the pelvis.
Q Okay. The next finding you had was, "No clear injury noted to the colon." Why would you note that?
A The significance is that when you've had pelvic surgery, gynecologic surgery, urologic surgery down there deep in the pelvis, one of the key structures that can get hurt is the rectum, the column or the rectum. And so you just make special -- you know, do as good a job as you can to make sure that you don't see an injury there.
Q Okay. And then the --
A Because it's in close -- it's in close proximity to the female organs, to the gynecologic organs.
Q Okay. And then the next finding, "Normal appearing

appendix." Would that be something similar because it's in close proximity of those organs?

A That's because I just was -- it can be in some people, but that's basically where the -- I started examining the abdomen.

Q At the appendix?

A And so --

Yeah. Like at the cecum and appendix. So I saw it, so I said that's -- it looked okay.

Q And then finally, number 5, "Perforation noted anteriorly on the uterus with the perforation being approximately one centimeter in size with associated clot." That's the uterus perforation that you talked about?

A Yeah. That's the basically presumed perforation that they had, I guess, self-reported that they knew had happened during the procedure.

Q And you say self-reported. Did you see documentation that that uterus perforation was previously reported?

A Yes. I -- actually the patient told me that -- that there had been a uterine perforation, and I felt like I'd seen some documentation or had a discussion with the -- with the person who was consulting me, because in my preoperative diagnosis it said uterine perforation.

Q Okay. Did you ever talk to Dr. Brill before you performed the surgery on Kim?

A No. I don't know if I've ever talked to Dr. Brill.

Q Okay. And that was going to be my -- did he ever contact

you or make any attempt to contact you before the surgery?

A Not that I can remember.

Q What about after the surgery?

A I -- it's been years, and I -- and I really don't remember. I saw documentation in the chart that he had spoken to his partners, so.

Q And do you know which partners?

A Schoenhaus, and I think -- I don't -- and Dr. Ivie.

Q Do you know when those conversations occurred?

A No. I just saw it in the medical record.

Q Okay. Okay. We also expect from this matter that we're going to hear some testimony about Dr. Brill changing Kim's diet after the surgery to a -- to one that allowed some solid foods.

MR. MCBRIDE: Your Honor, again, can we just have the question, please?

MS. ALBERTSON: I'm getting to the question.

THE COURT: Go ahead.

BY MS. ALBERTSON:

Q Did you put Kim on a liquid diet?

A Usually after this, and I didn't see my postoperative orders -- there are 1,200 pages of records, and I couldn't find like what specific postoperative order I wrote since they're electronic. But usually in this situation I would not give them a -- like a diet just to start with, because I would anticipate that the bowels would be slow to wake up.

Q So you would not give them solid food is what you're saying?

A Solid food immediately after the hospital, I usually do not.

Q Okay. How long are they on a liquid diet after this kind of operation?

A It is completely based on how the patient does clinically. There are multiple ways to proceed with advancing people's diet, and it also depends on like whether this is an emergent situation and what you found on the operation, or it's something elective and there's not contamination. But in this situation, my standard is usually to try to limit what they're eating until I know some bowel function has returned because I think it's really uncomfortable, you know, to vomit and things like that.

Q Okay. In this situation, according to your notes -- and feel free to take your time -- I want to ask you if you put Kim on a liquid diet and how long you had her on the liquid diet?

A I don't know if I'll ever be able to find that because I couldn't really specifically see that in the 1,200 pages of electronic records.

Q Okay.

A I didn't know where to find my postoperative orders, and I'm not sure if I wrote it or Dr. Ivie wrote the initial postoperative orders, because I think the patient remained on the gynecologic service.

Q What does that mean?

A There's -- I think the patient was admitted to the gynecology service, which means that send -- set of specialists or the patient's primary doctors. And then we were called in as consultants. There were many others consultants. I saw an infectious disease doctor, a

pulmonologist, et cetera. But I think that the patient remained on that -- with the gynecologists as her primary team. And so, again, I don't know if I wrote the postoperative orders or not, but often the primary team is the one that writes them.

Q Okay. So you're not even sure that you would have been the one who established her diet after the operation?

A We -- they usually defer to us on when to advance the diet. And usually we will have a conversation on a daily basis or write it in our note and say, okay, we think this would be appropriate. But, again, I can't see who wrote the postoperative orders. I can't -- I don't know where that is in this big thing.

Q Okay. Why do they defer to you on when to advance the diet?

A Because we're the most experienced with intestinal resections, and like knowing the course that people usually take after a situation like this.

Q Okay. So you would have been the best person to decide when to transfer from liquids onto solids in this situation?

A I would say that I would have been -- me or my partners would have been the most -- certainly probably the most experienced. I don't know the best, but most experienced.

Q Your partners are all general surgeons as well?

A Yes.

Q Okay. Because you said, I think, if I heard you correctly, that transferring on the solid diet too soon could cause what kind of

symptoms?

A Oh, sometimes their bowels just are very, very slow to wake up in these situations, and then eating could potentially make them nauseated and want to vomit.

Q Okay. That gets me to --

A Even more than they already want to.

Q Thanks. That gets me to my --

A Sorry.

Q -- next line of questioning, which is, to your knowledge, what's the recovery from a surgery like the one that Kim had? And let's talk like immediately. Like when she wakes up, what's her condition like?

A In my experience, people wake up and sometimes they feel a bit better because the contamination has been washed out, and I think psychologically they feel relieved that they know what's going on finally and that something's been done, that they're usually just -- shortly after that they become -- they have a significant amount of discomfort, depending on, you know, how successful the pain control is.

But the main thing that you know -- that I usually experience is that when there's been contamination, their bowels are very slow to recover, and that they have, and we call a prolonged ileus where their tummy is big and bloated and they feel nauseated, and they're not passing gas and they're not pooping, and it makes them very uncomfortable. And that is usually what slows the progression down the most in these situations. They also have wound complications -- they often have wound complications as well because of the contamination. But it's the ileus

usually that really slows the recovery.

Q The ileus that you're talking about, this bloating you just detailed -- excuse me --

A Uh-huh.

Q -- how long can that -- I'm going to use the word bloating instead of ileus just because it's an easier word for me because I can relate to that -- how long does that bloating and discomfort usually last?

MR. MCBRIDE: Objection.

BY MS. ALBERTSON:

Q How long does that bloating and discomfort usually last?

MR. MCBRIDE: Objection, Your Honor.

THE WITNESS: It can -- it can last --

MR. MCBRIDE: Wait. Specific to this patient as opposed to in general. We're talking about Ms. Taylor. So it's vague and ambiguous, overbroad.

THE COURT: I'm going to allow it. Go ahead. Overruled.

THE WITNESS: In this situation it is not unusual for them to have those ileus symptoms for a good week to two weeks.

MS. ALBERTSON: Okay.

THE WITNESS: Which I really hope --

BY MS. ALBERTSON:

Q And I think Kim was in the hospital for eight or nine days, so would it be fair to state she could have had those symptoms the whole time?

A Yes.

Q Okay. And I know that your records are hard to look through, but did you see anything in the records that reflected that she didn't have those symptoms for the full time she was in the hospital?

A It sounded like at least for the first week, perhaps at least until a couple of days before discharge, and potentially, even though a little bit at discharge, I couldn't tell there, but that she had symptoms of, you know, slow return of her bowel function.

Q Okay. Now in addition to that ileus, the, like bloating and discomfort, you said there was also, is it -- did you say wound pain? Did I hear that correctly?

A Incisional pain or pain in the wound, yeah, from being cut open. Uh-huh.

Q Okay. And what -- is that just -- is that pain while the body tries to repair that wound?

A Yes.

Q What does that involve? Is there itchiness, swelling?

A I think there's swelling, and there's just pain from the tissues having been cut open, and then the tissues are sewn back together, sewn and stapled back together, and I think they come together pretty quickly, but still, there's trauma to the -- to the skin and to the fat and to the layer between the muscles that's cut open to enter the bowel, and those all have to heal back, and those nerve endings have to heal.

Q How long does that wound pain usually last?

A I think it can last -- again, I think it's different on many people, and I think it's worse if you have infection than if it's kind of a

clean procedure to begin with, but it's not unusual for it to last weeks.

Q Okay. And that's even without infection, that lasting weeks?

A It can. I think everybody's a little different on their -- how they perceive that pain.

Q Okay. Why was Kim in the hospital for the eight or nine days following this procedure?

A I think it was a combination of reasons. Number one, she had to have -- she had the surgery, and she had to -- after the surgery she had to have pain control. She had to have resumed her bowel function so that she could sustain herself on taking in fluids and food, and she had to come -- get antibiotics, and, you know, be able to, like, come to meet the criteria so that it was thought she'd be safe to be outside the hospital setting.

Q Would you agree that that hospital stay was medically warranted and necessary?

A Definitely, in the -- in my opinion, I don't see --

Q And would you agree that it was --

A -- any other possibility.

Q Would you agree that it was reasonable?

A Yes.

Q Would you agree that it was all related to the surgery you performed?

A I know about the surgery I performed, but her pathology, her presenting bowel perforation.

Q So it was all related to the bowel perforation?

A Yes.

Q And was your understanding the bowel perforation related to the hysteroscopy, correct?

A That's my understanding, yes.

Q After Kim got out of the hospital, after those eight or nine days, what kind of recovery was she looking at thereafter? She get back to her daily activities with no problem or is there some downtime?

A I think many people are different, but usually people are somewhat weak and debilitated. Usually, they're encouraged to walk around and be active, but usually, in my opinion, it's weeks and it's not months until they regain their approximating the normal life, a normal level of activity, I should say.

Q So weeks if not months to get back to normal activity?

A In my experience in these situations, yes.

Q Okay. And did you have any reason to think that it wasn't going to take Kim weeks or months to get back to normal activity?

A No.

Q Okay. If Kim likes pretty intense workouts, some of these, like, Orange Theory and Boot Camps, would those workouts take a long time to get back to after a surgery like this?

A Very much so.

Q And would it be fair to say also that if you wanted to go back to working out, those kind of workouts, you'd have to go quite slowly?

A Yes.

Q Okay. Because you -- I think you said to --

A Well, you just have to listen to your body and go back when your body, you know, tells you it's ready.

Q Okay. And that could take up to months, you said, right?

A Absolutely.

Q Okay. What was Kim's alternative to the surgery you performed, and by that mean -- by that I mean your corrective surgery? Had you not performed it, what would have been the alternative?

A I think the alternative would have been observation with antibiotics alone or, I guess, observation without any antibiotics. I don't feel -- I feel either of them could have been life-threatening, however, and that would -- could lead to, you know, sepsis and death with an uncontrolled bowel perforation.

Q And fair to say that's your medical opinion?

A That's my medical opinion, yes, based on experience.

Q So I think you said a few times here, but I just want to confirm, you did believe the surgery to be urgent and medically necessary, and possibly even a life or death situation?

MR. MCBRIDE: It's been asked and answered, Your Honor.

THE COURT: Sustained.

BY MS. ALBERTSON:

Q Do your records note the level of pain Kim was in immediately before you performed your surgery?

A I thought my note somewhere said that she was in very, very significant pain.

Q Okay.

A Actually, somewhere in my note I had said where I talked to Kim and her parents before the operation and that she was in very significant discomfort.

Q Okay. And did you ever get the impression Kim was aware of the bowel perforation prior to your surgery?

A I thought so.

Q What did you say?

A I thought so, yes.

Q You thought she was aware that her bowel had been perforated?

A Oh, excuse me. I thought you said urine.

Q No, no.

A No. Bowel perforation? No. Uterine, yes.

Q Okay. Would you agree that but for the hysteroscopy, Kim would not have had a small bowel perforation?

A Do I believe if not for that she wouldn't?

Q Yes.

A Yes, I believe that.

Q And would you agree that but for the hysteroscopy, Kim would not have needed a small bowel resection and repair?

A I believe that if she hadn't had that procedure the day before, whatever that specific procedure entailed in detail, I don't think she would have had that bowel perforation.

MS. ALBERTSON: Okay. Thank you very much.

THE COURT: Cross-examination?

MR. MCBRIDE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. MCBRIDE:

Q Dr. Hamilton?

A Yeah.

Q Can you hear me okay?

A Yeah.

Q I'm at the podium now. Robert McBride, and I represent Dr. Brill in this matter. Now, Dr. Hamilton, you and I have never spoken before, have we?

A No, right.

Q And in fact, this, the records that you were provided, were those provided to you by Plaintiff's counsel?

A Yes.

Q All right. The -- were you provided with the entirety of the records from St. Rose?

A I don't know, but about 1,200 pages.

Q Okay. And were you provided with any records from your office visits with Ms. Taylor?

A I didn't see any -- in the surgery's notes.

Q Okay. Now we'll talk about that in a second, and I'll see if I could refresh your recollection, but outside the medical records, do you have an independent recollection of Ms. Taylor?

A Not really.

Q Okay. The --

A I remember the story. I remember the story, but not Ms. Taylor specifically.

Q Okay. The records that you were provided, were those the things that you were looking at on your phone just a minute ago?

A Yes.

Q All right. So you operated on her on the -- as you understood it, the day after the hysteroscopy that Dr. Brill had performed, correct?

A Yes, sir.

Q So roughly, within 24 hours of that surgery, correct?

A Roughly.

Q All right. The -- were you aware that Ms. Taylor had been seen in the emergency room at St. Rose Sienna before she was admitted to your service?

A Yeah, I'm not sure she was admitted to my service, but yes, from review of these notes it looked like she had come back either to St. Rose or a different hospital complaining of this pain and before this admission, before she was admitted.

Q And I'll represent to you that admission occurred at approximately 12:00 in the morning on the 26th which was the day of the surgery or into the 27th, and she was seen by Dr. Christensen in the ER; do you recall seeing those records?

A I don't think so.

Q All right. Do you know, from your understanding of her being seen by another physician, was she sent home?

A Yes. Somewhere in my note it said -- well, I was reading my note, and it looks like it's on page 000219.

Q Correct. Can we have that in front of you?

A Where I said -- I do, and it says, called by GYN, and call Dr. Ivie for assistance in a case. She's 45 year-old female whose had a hysteroscopy at Henderson Hospital yesterday morning. She was supposed to have removal of a fibroid and ablation for menorrhagia. It wasn't done, and there was concern for uterine perforation. She was sent out of the hospital last night about five --

Q Can you wait? Can you --

A -- after having severe --

Q Can you slow down just a little bit just for the court recorder?

A Sure. She said she was sent out of the hospital last night about 5 p.m. after having severe pain all day, but felt -- but she felt a little -- felt a bit better from 5 p.m. to 11 p.m. At 11 p.m. the pain returned, and it's been ten out of ten since. I mean, that's kind of what I had written there.

Q Okay. And then basically, do you -- are you aware a CT scan had been performed in the emergency room that evening?

A Yes, and I don't know if there were more than one, but I am aware of the one that said -- I had said she had associated nausea and vomiting and tenesmus, and she had sweating without fever, and she reported, like, her belly being hard and pressure, and that she came to the emergency for evaluation, and it says that CT showed free air and free fluid.

Q Okay. And then she was sent home and then returned to the ER later that day when you saw her, correct?

A I -- again, I don't know the sequence of events and when she was sent out because it's kind of a 24-hour period and there was a lot, you know, seems like there was a lot of coming and going, so I don't know the sequence of when she was sent out, if it was after this CT scan or not. I believe I -- I think I operated late in the evening, maybe at nine or ten at night, perhaps.

Q That's approximately --

A And I was trying to see the --

Q -- correct. I believe your note indicates your procedure was at 21:57 on the -- April 27.

A And I'm trying to see what time that CT scan was done, and I don't know, I can't say for sure, like, when -- okay. The CT scan looks like it was done at -- oh, my goodness. I can't tell from this CT, when it was done, the time, the timestamp on the CT scan.

Q I'll represent to you the records have been admitted into evidence, and it was done in the early morning hours of the 27th before she was ultimate --

A So the morning before I operated.

Q Correct.

A Of the same day. Okay.

Q Okay. And then she was discharged by Dr. Christensen, the emergency room physician.

A Okay. Okay. And then presented.

Q Correct. Does that refresh your recollection?

A It's consistent with the story that I knew. I just don't know the details of when she came and when she -- when she got sent out.

Q Okay. Now, Dr. Hamilton, have you as a general surgeon, have you had to repair traumatic bowel injuries before?

A Yes.

Q Have you had to repair traumatic bowel injuries that have occurred due to a specific operation or operative procedure?

A Yes. When you say repair, I would say it's often removal, so if you're using those synonymously, then yes, but yes, I have treated person and resected the bowel, the traumatic injury to the bowel multiple times.

Q Yeah. And again, that's a great point. In terms of your repair or the resection involves a resection of the damaged area of the bowel, and that's sent to pathology, correct?

A Yes, sir.

Q Okay. Now, you have your operative report in front of you?

A I did.

Q Okay. And you had previously testified that approximately five to six centimeters of the bowel was removed, correct?

A Yes.

Q And then the reanastomosis was of those two clean portions of the bowel that you reconnected, correct?

A Yes.

Q Okay. The -- when you talked about the -- well, let me ask

you this question. If the area inside her belly, abdomen, had been grossly contaminated, would you have been able to successfully perform a reanastomosis?

A If it hadn't been contaminated?

Q If it -- if it had been grossly contaminated?

A If it had been contaminated would I still have been able to put her back together?

Q Correct.

A Yes.

Q Okay. The --

A Well, because I did, I did do that.

Q Right. And that's what I was getting at. In terms of the area that you removed, and you identified, I think in your operative note, about one foot proximal to the terminal ileum, there was a clear enterotomy; what is an enterotomy? Can you explain?

A An opening, an opening in the small intestine.

Q Okay. It was identified it was about three centimeters in size with evidence of succus spill. Now when you're looking at that, that's from your operative note, correct?

A Yes.

Q All right. When you are looking at that three centimeter, which you estimate, are you just eyeballing that? You're not measuring it?

A Right.

Q Okay. Have you seen the pathology report that came from --

A Yes.
Q -- this surgery?
A Yes.
Q Okay. At the time you dictated your operative note, it's correct, you did not have the pathology findings, true?
A Right.
Q Okay. And, in fact, those pathology findings, have you seen the -- those findings before today?
A Yes.
Q And --
A Yes.
Q -- in fact, it says the center of the specimen displays a 1.6 by 1.2 centimeter transmural defect inked black. Is that the --
A Uh-huh.
Q -- the area of the perforation?
A Yes, there are multiple layers of the bowel, but it looks like there's a 1.6 centimeter full thickness defect.
Q Right. And so it's the 1.6 times the 1.2 centimeter transmural defect, right?
A Right.
Q Okay. And it's inked black, is that something that's done during your surgery where you note the area?
A I didn't do it no, that -- sometimes you do in some surgery, but I didn't do that.
Q Okay. And you would agree with me that there's no

evidence of any thermal injury or burn to the area of the bowel that was sent to pathology, correct?

A I didn't -- I didn't say that.

Q No, I mean you would --

A Sometimes you can --

Q You would agree that it's not referenced, there's no thermal injury to the bowel located in --

MS. ALBERTSON: Objection. Asked and answered.

MR. MCBRIDE: Can I -- what's the objection?

THE WITNESS: I think that's hard. I think that would -- sometimes --

THE COURT: Hold on.

THE WITNESS: -- you can tell grossly, and sometimes that would be something maybe you'd be able to see pathologically, but I just saw the hole in the bowel.

BY MR. MCBRIDE:

Q Okay. So am I correct, that you did not observe any thermal injury to the bowel, the --

A I didn't. I don't think I read -- wrote that in my operative report. Huh-uh.

Q And that's what I'm just trying to point out. It's not referenced in the pathology either, correct?

MS. ALBERTSON: Objection. This is the third time he's asked the same question.

THE COURT: It's because she's not understanding.

Overruled.

MR. MCBRIDE: Thank you, Your Honor.

THE WITNESS: I don't see that it's there.

MR. MCBRIDE: Okay.

THE WITNESS: That it says cautery injury or anything.

MR. MCBRIDE: Right.

THE WITNESS: Thermal injury.

BY MR. MCBRIDE:

Q Right. And that would be something that you would expect to see if there was a cautery injury, correct? A ref --

A You know, I -- of all the perforations that we remove, I don't know if they comment on that usually.

Q Okay.

A They just say that there's a hole.

Q Okay.

A And they -- you know, whether it's cancer, inflammation, but I don't know. They don't usually comment on the mechanism from what I can remember from pathology reports.

Q And you don't have any idea how exactly that perforation may have occurred, correct? Whether it was from --

A Just --

Q -- a blunt-force injury, you can't tell?

A Or cutting or cautery? No, I don't, I don't know, because I don't know, I don't know how they do the -- I don't know the details of the -- of the procedure he did, or they do --

Q Right, of the hysteroscopy?

A Yes.

Q Correct?

A Of that procedure that the person had, I don't know the details of what happened.

Q Okay. And, in fact, you don't do hysteroscopies as part of your practice, correct?

A That's correct.

Q And so in terms of the questions that were asked about but for this hysteroscopy, would this injury have occurred, you are not commenting on whether or not that surgery, the hysteroscopy was indicated in the first place?

A I am not commenting on the indications for the -- for the gynecologic procedure, just my own.

Q All right. Now, Doctor, the bowel, can -- is it true that the bowel moves around in the abdomen, it doesn't stay put in one spot, true?

A If the patient has adhesions, it stays in one spot more. But usually on those who have not had prior infections, bleeding, major operations, usually it's sliding around pretty freely.

Q All right. And I think you already testified, you saw succus in the area of the perforation, but you did not see any observable feces, correct?

A I saw succus around the majority -- or a lot. It's in all four quadrants of the peritoneal cavity. And with -- I saw liquid

contamination. I didn't see stool balls.

Q All right. Now --

A The small intestine is going to put out liquid and a colon is usually -- is going to put out liquid or stool.

Q Right. And do you have any understanding if there was any wound complications that Ms. Taylor suffered following your surgery?

A I think I closed her mainly, but left a couple of areas open of packing, which I think had to be -- she needed some continued care for that. But no, I don't know long term.

Q You're not aware of her developing any postoperative wound complications or infection, correct?

A No.

Q And in fact, on your operative note, it's on page 42 of that -- that exhibit that you have in front of you. You actually anticipated that she was going to have an ileus because of the nature of the surgery, you had prepared, correct?

A That's correct.

Q All right. Now do you recall seeing Ms. Taylor in follow-up in the hospital at least once?

A Again, I remember the story, but I don't remember seeing the specific patient.

Q I'll represent to you that I was able to locate one progress note from you on May 1, 2017, and it's at page 149 through 151 of those records.

A Okay.

Q Do you have that in front of you?

A Working on it. 149?

Q Through 151.

A I'm on -- wait, exhibit number or --

Q No, no, it's the St. Rose records, pages 149 --

A Okay, I'm on -- okay, I'm on 149 of 1119. I'm on that. I don't see my name there yet.

Q Oh, I think you're looking at page -- you're looking at -- you're not looking at the Bates stamp, but just below. Should be SRDH000149.

A Oh, that's what -- okay, I see my name on that one, yes.

Q Okay. And is this your note that you would have done, a progress note upon seeing Ms. Taylor in the hospital?

A Yes.

Q And under the subjective form section, you say, "Patient Complaint - patient feeling okay, passed a little gas yesterday. Ate a little clears and felt crampy." Clears meaning a clear liquid diet, correct?

A Yes.

Q Patient states it's getting better. And is that information that the patient is giving you? Is that what you write under the subjective portion?

A Yes.

Q Okay. And it -- under gastrointestinal, it says, "Soft abdomen, mildly distended? Hard to tell. Occasional bowel sounds." That would indicate to you that the bowels are starting to wake up, right?

A Usually.

Q Okay.
A Uh-huh.
Q "Wound is clean and the packing was replaced."
A Right.
Q Okay. Now I wanted to -- and then to the next page, which is page 150, under diagnosis, you say, "Patient doing well." It's at the bottom of the page. "After exploratory" or "ex-lap washout of abdomen and small bowel resection." "Afebrile" meaning no fever. Vital -- vss. What does that stand for?
A Stable -- vital signs stable.
Q Okay. "Looks well. Will just do sips of liquids until bowel functioning more significant." Did I read that correctly?
A Yep.
Q All right.
A Yes.
Q And then you said that you don't recall any specific conversations with Dr. Brill at any point in time regarding Ms. Taylor; is that correct?
A I don't remember.
Q But do you -- and you do recall Dr. Ivie, one of Dr. Brill's partners being in the surgery with you?
A I can't actually even say I remember Dr. Ivie being there. But my notes says she was.
Q All right. If she wasn't there, you wouldn't have put her in your operative note, right?

A That's correct.
Q All right.
A That's correct.
Q It's just that you don't have a recollection. This was four years ago. I understand. The -- with regard to your follow-up, did you see any other records of you seeing Ms. Taylor at St. Rose other than that May 1st note?
A No, but my partner saw her. I saw a note from Dr. Knoblock [phonetic]. I saw a note from Dr. Walton. And so my surgical partners would have rounded on her every day.
Q Right. So that happens on occasion where if you're involved in another surgery somewhere else, or off on a day, you'll have partners round on your patients in this hospital, correct?
A That's right.
Q All right. And then --
A Depending on the structure of your practice.
Q Right. And --
A Or spread out between different hospital.
Q Right. And so do you have recollection of seeing Ms. Taylor back in the office at a postoperative visit on May 26?
A I don't. Because I didn't get Southern Nevada Surgery records.
Q Okay. I'll represent that's been admitted into evidence as Exhibit 13. I know you don't have it in front of you, but your -- just for sake of reference, but that's Nevada Surgery Specialists; is that correct?

A Southern Nevada Surgery Specialists, yes.

Q Okay. And it's Exhibit 13. It's pages 10 through 13. Again I understand you don't have it in front of you, but I just wanted to, for the jury's reference. Do you recall anything about this visit, without seeing the record?

A No.

Q Do you recall if you ever saw her again for any reason related to this surgery you performed on her?

A I don't -- I don't remember.

Q And so therefore as you sit here, you're not aware of having to follow her for any complications or other issues for weeks or months after your surgery, correct?

A As I sit here, no. But if my Southern -- but if I have clinic notes from Southern Nevada Surgery that says I did, then me or one of my partners did. But do I remember that I don't.

Q Right. And I'll represent to you that's the only note of the visit -- of a visit that we have with Ms. Taylor at your surgical office. So if there's no other notes --

A What does it say?

Q I'm sorry, Doctor, if you could hold on one second. If there's no other notes by you or your other partners, is it fair to say that she did not return to your office for further care and treatment?

A Yes.

MR. MCBRIDE: And Doctor, that's all the questions I have for you. Thank you, very much.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. ALBERTSON:

Q I just have some -- a couple really quick ones. I want to just confirm, just to make sure it's clear. We didn't stop you from talking to Mr. McBride or his partner, Ms. Hall, correct?

MR. MCBRIDE: Objection, Your Honor. This is -- this is an improper question. It's irrelevant.

MS. ALBERTSON: He made it relevant --

MR. BREEDEN: Can we approach?

MS. ALBERTSON: -- when he asked

MR. MCBRIDE: Can we approach?

[Sidebar at 12:08 p.m., ending at 12:09 p.m., not transcribed]

BY MS. ALBERTSON:

Q Mr. McBride and -- nor Mr. McBride or Ms. Hall, counsel for Dr. Brill set your deposition in this matter, correct?

A Say that again, I couldn't hear you. I mean I couldn't understand what you said.

Q Sure. I wanted to confirm that Defense counsel didn't attempt to set your deposition in this matter to talk to you, correct?

A That's right.

Q Okay. And then I just want to talk about the pathology report that Mr. McBride just asked you some questions about. And I want to confirm, do the pathology reports usually comment on the mechanism of injury?

A I -- when I think about it, I don't think they usually say the mechanism of injury. They comment on the gross appearance of it, followed by the microscopic appearance of it. And I don't think that they usually talk about the mechanism of injury.

Q So for the pathology report not to indicate that there was a thermal injury or any kind of burn mark, would not be indicative of there not being one, just isn't something that would be normally documented in the pathology report, correct?

A I think you'd have to ask a pathologist exactly, but I don't think I usually read that. I don't usually read the mechanism. I think I just usually see the gross and the microscopic evaluation. Not really so much commenting on the mechanism.

Q Okay. The pathology doesn't really say one way or the other. In this case --

A No, it usually --

Q Sorry, go ahead.

A But I think -- I think it just -- I'm sorry to interrupt you. I'm sorry. I'm just thinking. The pathology report just say there's a hole in the bowel. Like this is about the measurements of it. Now they're looking at something that's been placed in formalin or just a bucket, and it's not in a patient anymore, and it's not connected to anything. And so they just look at it, ex vivo, where it's been sitting somewhere. And they comment on what they see grossly, first of all. Just by eyeball. And then they look at what's on their slides.

Q And in this case, did the pathology report say that this wasn't

a thermal injury?

A I didn't see that it say that it wasn't, but I don't think that -- I don't think they usually say.

Q So it really -- didn't say one way or the other, correct?

A Not that I see.

MS. ALBERTSON: Okay. Thank you, very much. Thank you, Doctor.

THE COURT: Recross?

MR. MCBRIDE: Thank you.

RECROSS-EXAMINATION

BY MR. MCBRIDE:

Q Dr. Hamilton, I'm back again. With regard to the surgical pathology report, you're not offering testimony regarding what a surgical pathologist typically puts into every examination or pathology report, true?

A True.

Q You're talking about your personal experience, correct?

A My experience of reading the pathology reports of the patients I operate on.

Q Right. And you understand that other physicians may have different experiences than you, correct?

A Yeah, I'm only commenting on my own experience.

Q Right. And with regards to whether or not there was a thermal injury versus a blunt force injury, you're not offering an opinion one way or another yourself, correct?

A I'm not offering an opinion. All I said was just that I found a hole in the bowel.

Q Right. Correct. Over a period of time --

MR. MCBRIDE: Well, strike it. That's all the questions I have. Thank you, very much.

THE COURT: Do we have any questions from our jurors? I don't see any questions. All right. Thank you, Dr. Hamilton. You may be excused.

Counsel approach, please.

[Sidebar at 12:13 p.m., ending at 12:14 p.m., not transcribed]

THE COURT: All right. Ladies and gentlemen we're going to take a quick ten minute break and then come back. And we have another witness. And we should -- we're not going to be long before lunch, so.

Before -- during your break I'll instruct you not to talk to each other or anyone else about any subject or issue connected to this trial. You're not to read, watch or listen to any recorded commentary on this trial by any media of information, including without limitation newspapers, television, internet, or radio.

You're not to conduct any research on your own, such as consulting dictionaries, using internet or reference material, test any theory of the case, recreate any aspect of the case, or in any other way investigate or learn about the case on your own. You're not to talk with others, Google issues, or conduct any other type of book or computer research with regard to any issue, party, witness or attorney involved in this case.

And finally, you're not to form or express any opinion on any subject related to this trial until it's finally submitted to you. I'll see you in ten minutes.

THE MARSHAL: All rise for the jury.

[Jury out at 12:15 p.m.]

THE MARSHAL: The jury is clear of the courtroom, Your Honor.

[Outside the presence of the jury]

THE COURT: All right. Thank you. We're outside the presence of the jury and just to put on the record a couple of the objections that we talked about at the bench that weren't recorded.

During Dr. Hamilton's direct testimony there was an indication by Plaintiff that basically made a commentary on whether or not -- I don't know, I guess it was a question of whether or not I was going to treat her as an expert. So there was an objection by the Defense. Go ahead and state your objection, Defense.

MS. HALL: Our objection was just that the question called for the Court to qualify her as an expert. She's here as a non-retained treating physician not as an expert. She's never authored a written report in this case.

THE COURT: And the response by Plaintiff.

MR. BREEDEN: Yeah, Your Honor, we discussed this witness was just disclosed as a non-retained expert. So she is an expert, she's just a non-retained expert. I think you allowed her to testify within those parameters.

THE COURT: Yeah. She was limited to anything related to treatment, diagnosis, anything in her medical records. So it was sustained.

And secondly, there was an objection with regard to the known complication of hysteroscopies.

MR. MCBRIDE: Correct.

THE COURT: And do you want any more on that?

MR. MCBRIDE: Yeah, and again she's not a gynecologist. She's already testified. It lacks foundation. She -- and it was outside the scope of her expert testimony. And she acknowledged that.

THE COURT: Anything on behalf of Plaintiff?

MR. BREEDEN: Yes, she could certainly testify as to her own experience. Whether she's seen that complication or that's typical from the type of procedure that Ms. Taylor had. And we thought those questions were appropriate.

THE COURT: Okay. And I sustained the objection. And I believe she did say well, I'm not a gynecologist, or something to that effect.

MR. BREEDEN: Correct.

THE COURT: So she ended up answering it anyway. As to the final objection that we discussed up here. There was an objection with regard to Plaintiff was asking the question as to whether -- or began to ask the question as to whether or not they prevented the doctor from speaking with the Defense. You guys approached. And go ahead with your objection, please.

MS. HALL: The objection was based on *Leavitt v. Saenz*, which is a Nevada Supreme Court case. It specifically clarifies that Defense counsel is not permitted to talk to a treating physician for any purpose outside of a deposition. So that was the objection. Because the question asked was whether Plaintiff's counsel had ever precluded her from talking with Defense counsel. And I think based on the conversation at the bench, the question was rephrased to an appropriate question, which was they never took your deposition.

THE COURT: Anything else on behalf of Plaintiff?

MR. BREEDEN: Nothing further from Plaintiff.

THE COURT: All right. And I think that's it, right?

MR. BREEDEN: I think so.

MR. MCBRIDE: Correct.

THE COURT: All right. See you back in ten minutes.

[Recess taken from 12:18 p.m. to 12:30 p.m.]

[Outside the presence of the jury]

THE COURT: All right. We are back on the record in A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. Any issues before we call the next witness?

MR. MCBRIDE: No. Plaintiff is ready to proceed, Your Honor.

THE COURT: Okay. Ray, go ahead and bring them in. Are they ready?

THE MARSHAL: Yes, ma'am. All rise for the jury.

[Jury in at 12:31 p.m.]

THE MARSHAL: The jury is all present, Your Honor.

THE COURT: Thank you. You may be seated. And Plaintiff, go ahead and call your next witness.

MR. BREEDEN: Okay. The Plaintiff calls their next witness, Elizabeth Laca.

THE MARSHAL: Please step up and watch your step. Please face the clerk to your left and please raise your right hand.

ELIZABETH LACA, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated.

THE COURT: Please state and spell your name for the record.

THE WITNESS: Elizabeth Laca, E-L-I-Z-A-B-E-T-H, Laca, L-A-C-A.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Okay. And Ms. Laca, I'll just ask you to kind of keep your voice up because we're all testifying through masks and everything, and I want to make sure all the jurors can hear you.

A Okay.

Q Okay? So how do you know the Plaintiff in this case, Kimberly Taylor?

A A coworker.

Q How long have you worked with her?

A Probably since 2003, 2004.

Q Okay. And do you know her well? Is she somebody you

socialize with a lot outside of work or do you know her mostly as a work acquaintance?

A Mostly as work. I have socialized with her, but mostly work.

Q Okay. And what do you do for a living?

A I work at Firm Revenue Cycle Management and I'm a eligibility worker.

Q Okay. And so what's your position vis-à-vis Kim at that company?

A I'm her eligibility manager.

Q Okay. And how long have you lived in Las Vegas?

A 1995.

Q And how frequently at work -- and we'll go back to the timeframe of 2017, 2016. How frequently would you interact with Kim at work?

A Well, we'd have to interact on a daily basis.

Q Okay. So she's someone you saw frequently at that time?

A Yes.

Q Okay. I'd like to take you to the time of the procedure involved in this trial, which is April of 2017. Do you recall learning that Kim was going to have some sort of medical procedure before it was done?

A Yes.

Q And how did you learn that?

A It was supposed to be just a in and out procedure.

Q What was your understanding of what was supposed to be

done?

A That, I don't remember, but I know it was just in and out.

Q Okay.

A Something that -- female problems.

Q And so did there come a time after the procedure where Kim contacted you?

A Yes.

Q Okay. So explain to me when she contacted you and why.

A She contacted me around 3:00 in the morning. I think it was the day of her procedure. I answered the phone. She was at the emergency room and asked me to pick her up.

Q Okay. So why would Kim call you at 3:00 in the morning?

A I have no idea.

Q Have you ever offered before that if Kim needs something, that you'd help her?

A Which, yeah, she knows that. Yes.

Q Okay. Had you ever picked her up or dropped her off at a hospital before?

A No.

Q Okay. Had you been at her house that day?

A No.

Q And so you received this call at 3:00 in the morning. As best as you can recall, what was said to you?

A She just asked me if I could pick her up. I said, where are you? She said, I'm at the hospital, St. Rose. And I just said, okay, I'll be

right there. And then I went and picked her up.

Q Had you been asleep?

A Yes, I was asleep.

Q Okay. How long did it take you to get to the hospital after she called you?

A I don't live very far from there. Maybe five minutes.

Q Did you -- do you have any idea of why she contacted you as opposed to other relatives or friends?

A No. Maybe -- I don't know. She probably tried calling other people, but I have no idea.

Q And what do you recall about when you arrived at the hospital? What did you do and where did you go to meet Kim?

A I went into the -- through the emergency room. I walked in, waited for her. We came out. I -- she had to wait so I could go get my car and bring it around so she could get into the car.

Q And so when you went to pick her up at the emergency room, what time of day was that?

A It was at 3:00 a.m.

Q Okay, well --

A Maybe 3:05.

Q So do you remember, is there a difference between when you were called and when you actually made it there? Do you remember when you actually arrived at the hospital?

A No. As soon as she called me at 3:00 a.m., she said she needed a ride, I got up, dressed, got in my car, went directly to the

hospital.

Q Okay.

A Went in, parked it. You know, parked my car in the emergency section and went in through there. And then picked her up.

Q And when you saw Kim at the emergency room, did she look well to you?

A No.

Q How did she appear?

A Like she was in pain. She -- her color wasn't good. She was bent over, you know, holding her tummy. And I said, are you okay? And she says, oh, I'm just in a lot of pain. And I said, you don't look good. And then I said, why -- you shouldn't -- you know, why are they discharging you? She said, everything is fine. They said everything is fine. And I said okay. They handed us some paperwork. Her -- I believe it was prescriptions. And then, came to the door. I had to go get my car, bring it around, picked her up. But she wasn't -- she wasn't good at all. She looked gray, no color in her face. Her lips were white.

Q How was she getting from place to place? Was she walking? Was she in a wheelchair?

A You know, I really don't remember. But if it -- we were getting discharged from the hospital, I'm assuming that they wheeled her out and while I went and got my car.

Q Okay. And so when you got your car and Kim got inside, where did you go next?

A To -- I took her home.

Q Okay. To your home or her home?

A Her home.

Q Okay. Did you help her get inside?

A Yes.

Q And what did you do for her once you got inside her house?

A She couldn't -- she couldn't walk upstairs to her bedroom. So I said, you know, let's, you know, go into the -- we went into her family room. There's a couch. She had some, like, throw covers. I said, lay -- you know, lay down. She lay down. I covered her. She was weak, nauseated. So once I got her settled on the couch, I went and got a bucket, put it, you know, on the -- on the floor just in case she got sick, and stayed there.

Q Did you see her trying to vomit or dry heave?

A Uh-huh. Yes.

Q How many times?

A I don't know. Through the whole time I was there, you know, she was bent over. Yeah, it was bad.

Q Did you stay at her house the rest of the morning?

A I did because she needed prescriptions and the pharmacy was not open.

Q Did you think she was also feeling so ill that it was a good idea that somebody stayed there with her?

A Yes. Absolutely.

Q Okay. And do you remember what kind of prescription she had, what they were for?

A One was pain meds and the other, I believe, was nausea. For nausea.

Q Okay. Why didn't you fill those immediately when you picked Kim up?

A The pharmacy was closed, so I stayed there until the pharmacy opened. As soon as it opened, I went, picked up her meds, and then brought them to her, gave them to her. And then I just stayed there for a little bit.

Q Now, overnight, between the time of, you know, when you got to her house and when you went to the pharmacy, did you observe Kim sleeping?

A She really didn't sleep. She really didn't sleep. She would try to doze off, and then she'd wake up, you know, like [groans], doing this, [groans], in pain. And I said I don't know -- I don't -- I don't understand. Why did they discharge you? You're not -- you're not well. You know, you're not well. I don't know. They said I was fine. You know, maybe the medicine will help. Okay.

Q Did you observe her try to go to the bathroom?

A No. She couldn't. She couldn't get up.

Q Did you observe her eat anything?

A No. She could not eat.

Q And so when you went to the pharmacy, did Kim go with you?

A No.

Q Okay. Did you leave her at her house, then?

A Yes.

Q Okay. And so what time do you think you returned to her house from the pharmacy?

A It was just -- the pharmacy was not too far away. Maybe 15 minutes, 10, 15 minutes, because I just went, picked it up, and came right back.

Q Okay. Do you remember maybe approximately what time that was once you got back from the pharmacy?

A Oh, I don't remember.

Q And so what did you do after you gave her the prescription medication?

A I stayed there a few minutes to see, you know, how she would react, if she needed anything.

Q And then, did you leave the house?

A I did.

Q Do you remember about what time that was?

A No. Maybe around 10:00, 11:00, maybe.

Q In the morning?

A Uh-huh.

Q Is that a yes? Just for the record.

A Yes. Yes.

Q Okay. If you say uh-huh or huh-uh, we have to ask if that's yes or no is why I say that.

A Yeah, okay. Yes, it was a longer time.

Q Okay. And so where did you go after you left Kim, then?

A I went home.

Q Okay. And did you see Kim later that day?

A Yes.

Q Okay. So when did you next see her?

A I saw her probably early evening. She called me. She wasn't -- still wasn't feeling well. She said -- I said, what's wrong? She goes, I don't know. Something is wrong. I don't feel good. I'm still in pain. I think I need to go back to the ER. I said, I'll be right there.

Q Okay. So how long did it take you to get from wherever you were then back to Kim's house?

A I don't live very far. Maybe five minutes, seven minutes, you know.

Q And when you arrived back at her house now, this second time -- or I guess the third time because you went to the pharmacy and back as well. When you arrived at that time, can you describe the scene for me? Who was there, what was Kim doing?

A When I arrived, I saw the paramedics there, and they were getting off of their -- the fire engines were there, the paramedics were there. They were getting off and walking in. So I got off my car and walked in. When I walked in through the door, they were standing in the family room where she was laying, where I had left her on the couch. She was laying there. I believe her mother was there and her stepfather was there. And there was, like, probably four or five ambulance people there. They were asking her questions which she couldn't answer because she was in so much pain. She couldn't answer. They were

asking her what medicine was taken, what happened.

But nobody -- like, her mom didn't know, the stepdad didn't know. So I told them, you know, I know what's going on. Here's some paperwork from the hospital. I had to take her to the -- and then I explained to them what happened. They asked me what medication she was on. I told them the names. You know, I gave them the discharge papers and said, that's what she was taking. At that time she was still, you know, on the couch bent over and moaning, you know, because she was in pain.

Q Was she able to walk?

A No.

Q How did they get her from where she was in the family room to the ambulance?

A They had to put her on a gurney. So the ambulance people had to help her get up, help her lay on the gurney, and then they took her in, into the gurney.

Q Okay. And at that time, did she look to you like she was in extreme pain?

A Absolutely.

Q Did she still look discolored?

A Yes.

Q Was she sweating at all?

A I don't remember.

Q She was having difficulty walking and moving?

A Walking, talking. She couldn't -- when they would ask her

something, she couldn't talk. She was just in a lot of pain. She was still -- there was no color to her, and that's why I kept saying something is wrong. You shouldn't look like that. They shouldn't have discharged you.

Q And so did you go with Kim to the hospital?

A I did. I followed the ambulance, just to make sure.

Q And what do you recall? Just tell us very generally about what you observed at the hospital and when you left?

A When I left the hospital?

Q Yes.

A Well, we got to the --

Q How long were you there and what did you see?

A When we got to the hospital, her mother and her step-father were there. We were waiting in the lobby. I don't -- I don't remember exactly, you know, what happened or what transpired there, but I do remember being in the -- you know, in the back where they had her lying down, and that was -- I don't know -- I don't know how long that was. For a few minutes, I guess, and then they kept her. So once they -- once I knew, they said, okay, we're keeping her. She's not going to leave or get discharged, then I left.

Q Okay. And I just want to ask you, the Defendant in the case is Dr. Keith Brill. He's seated here.

A Uh-huh.

Q Have you ever spoken to Dr. Brill?

A No.

Q Have you ever met him prior to today?

A No.

Q Okay.

MR. BREEDEN: Thank you very much. Those are all my questions.

THE COURT: Thank you. Cross-examination.

MS. HALL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. HALL:

Q Good afternoon, Ms. Laca.

A Good afternoon.

Q My name is Heather Hall, and myself and my partner, Mr. McBride, we represent the Defendants in this case, and I only have just a few questions for you.

A Okay.

Q Just a moment ago, you said that when you arrived to Kim Taylor's house the second time, that the EMTs were already there on the scene, correct?

A Yes.

Q And you thought that that was early evening on --

A I don't remember exactly what time it was. I don't know if it was early evening, or just, you know, a few hours after I had left.

Q Sure. And that's because this all occurred over four years ago, right?

A Right. Yes.

Q Let me see if I can show you some records from the EMTs.

A Uh-huh.

Q The records that we received from the Henderson Fire Department, the City of Henderson, they reflect that the EMTs arrived that morning at 11:58 a.m., so let me show you that and then I'll ask you a couple of questions.

MS. HALL: And for the record, Your Honor, this is Joint Exhibit 15, which has been previously admitted.

BY MS. HALL:

Q And I'd like to show you, it's COHA-10 of that exhibit. Let me see if I can focus this for us.

THE MARSHAL: If you waive your hand over it, it will clear up.

MS. HALL: No one wants to look at my ugly hands, but -- yeah, that's much better. Thank you so much.

BY MS. HALL:

Q So I just want to show it again, this is Exhibit 15, and it's COHA-10 of that exhibit. And if you can see on the screen there, Ms. Laca, in the right-hand corner here --

A Uh-huh.

Q -- it says the call -- the time that the call was received by the City of Henderson, and it shows 11:47. Now, you weren't present at the time that Ms. Taylor made the call the second time to 911, correct?

A No.

Q You were not present?

A No.

Q And if you see here where it says, "on scene at 11:58:07," do you have any reason to disagree that it was 11:58 in the morning on April 27th when the EMTs came to Ms. Taylor's house for the second time?

A You know, no, I don't remember that.

Q And do you know how long the EMTs had been on the scene at the point that you arrived at her home that morning?

A I don't. They -- to me, it looked like they had just gotten there because they -- when I walked in, they were asking the questions.

Q And as far as how long they had been there, you don't have any personal knowledge of how long they had been there prior to your arrival, true?

A No, or what time they got there, no.

Q And is it also fair to say that you were not -- you don't have any personal knowledge of any conversations the EMTs may have had with Ms. Taylor prior to you arriving?

MR. BREEDEN: I object. It's asked and answered.

THE COURT: I don't think she asked that. I'm going to overrule it. Go ahead.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q Do you need me to restate that?

A I'm sorry?

Q Do you need me to restate my question?

A Yes.

Q I know it gets a little confusing --

A Yes.

Q -- when there are objections. Is it fair to say that you do not have any personal knowledge of any conversations the EMTs may have had with Ms. Taylor that morning prior to your arriving?

A No, I don't. I think because we got there around the same time, because they were asking the questions, but nobody knew.

Q Okay. All right. Thank you.

MS. HALL: That's all I have, Your Honor.

THE COURT: Any redirect?

MR. BREEDEN: Nothing further from this witness, Your Honor.

THE COURT: All right. Thank you. Do we have any questions from our jurors? I don't see any questions.

All right. Thank you, Ms. Laca. You may be excused.

THE WITNESS: Thank you.

THE COURT: Counsel, approach.

[Sidebar at 12:51 p.m., ending at 12:53 p.m., not transcribed]

THE COURT: All right. Ladies and gentlemen, we're going to take our afternoon recess for lunch, and we'll be back here at 2:00.

And during the break, you're instructed not to talk to each other or anyone else about any subject or issue connected to this trial. You're not to read, watch, or listen to any report or commentary on the trial by any person connected to the case by any medium of information,

including, without limitation, newspapers, television, internet or radio.

You're not to conduct any research on your own related to this case, or consulting dictionaries, using the internet, or using reference materials, test any theory of the case, recreate any aspect of the case, or in any other way, investigate or learn about the case on your own.

You're not to talk with others, text others, Tweet others, Google issues or conduct any other kind of book or reference materials, research or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until the matter is finally submitted to you. I will see you at 2:00 after lunch.

THE MARSHAL: All rise for the jury.

[Jury out at 12:54 p.m.]

THE MARSHAL: The jury has cleared the courtroom, Your Honor.

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. No issues before lunch?

MR. BREEDEN: No, Your Honor.

MR. MCBRIDE: Correct.

THE COURT: Okay. I will see you guys at 2:00 then.

[Recess taken from 12:55 p.m. to 1:59 p.m.]

[Outside the presence of the jury]

THE COURT: All right. We are back on the record in

A18773472-C, Taylor v. Brill. And counsel for both sides are present. We are outside the presence of the jury. Any issues before we call the jury in?

MR. BREEDEN: Nothing from Plaintiff, Your Honor. I just want to note we're going to call very quickly a witness, Laurie Herda, who is a representative from the City of Henderson. I anticipate her testimony will be five or ten minutes. And then we're going to call Mr. -- Nurse Hutchins after that. Mr. Hutchins' testimony is anticipated to be longer.

THE COURT: Okay. Thank you so much. On behalf of the Defendant?

MR. MCBRIDE: Nothing, Your Honor.

[Pause]

THE MARSHAL: I've got them all back, Judge. They're lining up right now.

THE COURT: Okay. We're ready.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 2:03 p.m.]

THE MARSHAL: The jury's all present, Your Honor.

THE COURT: Thank you. You may be seated.

And Plaintiff, you can proceed with your next witness. You can proceed with your next witness.

MR. BREEDEN: Your Honor, Plaintiff calls Laurie Herda.

THE MARSHAL: Please step up. Please face the clerk to your

left. And please raise your right hand.

LAURIE HERDA, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state and spell your name for the record.

THE WITNESS: Laurie Herda, L-A-U-R-I-E H-E-R-D-A.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Good afternoon, Ms. Herda. Where are you employed?

A The City of Henderson.

Q And what's your position or job title there?

A Senior accountant.

Q Okay. And as part of your job duties, do you deal with billing records for Henderson Fire and Rescue?

A Yes, I do.

Q Okay. And so describe just to the jury very generally, what is Henderson Fire and Rescue?

A Basically, they provide emergency services throughout the City of Henderson, paramedic, ambulance transports, and then of course, firefighters.

Q And what aspects of billing do you handle?

A Ambulance transports.

Q Okay. Prior to coming to court this afternoon, did you familiarize yourself with the account of my client, Kimberly Taylor?

A Yes, I did.

Q Okay. There's some big books in white there behind you

where there are some exhibits. And I'd like to ask you to find the book that has Exhibit 59 in it for me. It should be number 4.

A Okay. I have it.

Q Okay. Can you tell me what Exhibit 59 is?

A It looks like a -- I see a custodian of records certification for two ambulance invoices.

Q And are those from the City of Henderson?

A Yes, they are.

Q Okay. And are these billing records that are kept in the ordinary course of the City's business?

A Yes, they are.

Q And to your knowledge, are those bills created at or near the time of treatment?

A Yes.

MR. BREEDEN: And Your Honor, I would move to admit Exhibit 59 into evidence.

THE COURT: Any objection?

MS. HALL: Yes, Your Honor. I would object as it lacks foundation.

THE COURT: Counsel, approach.

[Sidebar at 2:07 p.m., ending at 2:09 p.m., not transcribed]

BY MR. BREEDEN:

Q Ms. Herda, what time period does the billing that we're discussing cover?

A It looks to me 2017.

Q And are there -- how many different trips are in the billing records?

A Two.

Q Okay. And what is the date for the first trip?

A April 26th of 2017.

Q What was the date for the second trip?

A April 27th of 2017.

Q Okay. What is the amount of the billing for the first trip?

A The total, $1,196.41.

Q What is the amount of the billing for the second trip?

A $1,134.15.

Q Okay. How does the City come to the rates or the amount of charges that are charged for these trips?

A The rates are established by ordinance for the City of Henderson. And they are consistent throughout the county.

Q Okay. So was Kimberly Taylor charged anything more or anything less than what another person getting ambulance services on those dates would be charged?

A No.

Q And does the City of Henderson consider that billing to be usual, customary, and reasonable?

A Yes.

MR. BREEDEN: Now, Your Honor, at this time I would move to admit Exhibit 59.

MS. HALL: And same objection I placed earlier, Your Honor.

THE COURT: All right. Counsel, can you approach again? Sorry. Bring the exhibit.

[Sidebar at 2:11 p.m., ending at 2:12 p.m., not transcribed]

THE COURT: So that Exhibit 59 will be admitted.

[Plaintiff's Exhibit 59 admitted into evidence]

MR. BREEDEN: I have no further questions. Thank you, Ms. Herda.

THE WITNESS: Thank you.

THE COURT: Cross-examination?

MS. HALL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. HALL:

Q Good afternoon, Ms. Herda.

A Good afternoon.

Q My name's Heather Hall. I don't have very many questions for you. But in your role as a senior accountant with the City of Henderson, have you had any medical training?

A No, I have not.

Q You're not a physician?

A No.

Q You're not a nurse?

A No.

Q And in terms of whether the care -- medical care that the ENTs administered to the patient which corresponds with these bills that we discussed --

A Uh-huh.

Q -- you would not be able to comment on whether those were medically necessary or related to some other care, true?

A True.

MS. HALL: Okay. All right. Thank you. That's all I have, Your Honor.

THE COURT: Any redirect?

MR. BREEDEN: Nothing further from this witness.

THE COURT: Thank you. Do we have any questions from our jurors? All right. No questions. You may be excused. Thank you, Ms. Herda.

THE WITNESS: Thank you.

MR. BREEDEN: Your Honor, Plaintiff's next witness is Bruce Hutchins.

THE COURT: Thank you.

THE MARSHAL: Please step up. Please face the clerk to your left. And please raise your right hand.

BRUCE HUTCHINS, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state and spell your name for the record.

THE WITNESS: Bruce Hutchins, B-R-U-C-E H-U-T-C-H-I-N-S.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Mr. Hutchins, good afternoon.

A Good afternoon.

Q So during court, I know you're wearing a mask. And we have to make sure everything is clear for the record. So please just be sure to speak up so all the jurors can hear you today.

A Okay.

Q Can you do that for me?

A Sure.

Q All right. What do you do for a living, sir?

A I'm a nurse.

Q And explain to me the type of education you had to be a nurse.

A I went to College of Southern Nevada and took their associate's course for nursing.

Q What year did you graduate?

A In 2012.

Q Okay. So at the time of the events in this case, you had been a nurse for approximately five years?

A What year was the case?

Q 2017.

A Yes.

Q Okay.

A Well, no. I started nursing in 2013.

Q Okay.

A So it was about four years.

Q I assume you're a high school graduate?

A Yes.

Q And then after high school, that's when you went to College of Nursing?

A No.

Q Okay.

A Actually, before --

Q Explain that for me then.

A I went to a college in Arizona State. I went to a school for interior design, first.

Q Okay. And at what point in your life then did you go to nursing school?

A When the economy tanked in 2009, I was out of work for -- I was working for architects. And so I got a teaching license. I tried a drafting service. And then I began School of Nursing I think in 2010.

Q How many years was that program?

A Two.

Q And when you graduate form that program, what sort of degree do you have? In other words, CNA, RN.

A Associate's in RN.

Q Okay. So -- and RN stands for?

A Registered nurse.

Q All right. Did you have any special concentration? I know nursing is a broad field.

A My specialty at the time was PACU, post-anesthesia care unit.

Q Okay. So explain to the jury, you know, PACU stands for

post-anesthesia care unit. What does that mean in laymen's terms?

A That's means I recover patients after surgery.

Q Where do you work currently?

A I have two positions. One is at Southern Hills Hospital, and the other one is at Sunrise Hospital.

Q And do you work in the PACU at both of those hospitals?

A I've worked in the PACU in both, and I also worked in the OR at Southern Hills.

Q Did you ever work for Henderson Hospital?

A I did.

Q What period of time did you work for Henderson Hospital?

A It was, I think, 10 or 11 months. I believe I started, was it like December of 2016, or ended then. I forget what.

Q Until sometime --

A I forget the exact year.

Q -- in the summer of 2017?

A It was either -- I don't remember if I started in 2016 or if I ended in 2016, because I worked there and other hospitals here in town, and two travel assignments.

Q Okay. Explain to the jury, you know, basically what you're doing in your day-to-day duties as a PACU nurse.

A You are receiving patients from the OR. You are -- you want what I do?

Q Yes.

A Okay. You receive the patient. You hook them up to

monitors to watch them. You get reports from the OR nurse and from Anesthesia to -- as to what was done, the dressing, any complications that they had, medications that were received. And generally, you get a brief history of any other conditions the patient might have, any other health issues.

Q Now, in this case, Ms. Taylor had a procedure at Henderson Hospital on April 26th of 2017. Were you working at Henderson Hospital at that time?

A Yes, I was.

Q Do you recall being the PACU nurse for Ms. Taylor?

A I don't recall that, no.

Q Okay. You don't recall that specifically.

A No.

Q I'd like you to look behind you there, and there are some big white books there. And in Volume 1, I'd like you to open it up to Exhibit 5.

MS. JOHNSON: Volume 3.

MR. BREEDEN: Oh, I'm sorry. It sounds like it's in Volume 3. I apologize.

THE WITNESS: Exhibit 5?

MR. BREEDEN: Exhibit 5.

THE WITNESS: Okay. I've got it. The 5 tab? Okay.

BY MR. BREEDEN:

Q Can you briefly look through that exhibit and tell me what that is?

A Briefly look through it? Okay. I'm -- do you have better lighting in here?

THE COURT: I wish.

THE WITNESS: Because this writing is small, and my eyesight isn't that good.

MR. BREEDEN: I don't know if this would help.

THE WITNESS: Thank you. Okay. It's just Kimberly Taylor, hospital. Oh, that's her face sheet. This is the one. So what is it you want me to look for in here?

BY MR. BREEDEN:

Q Yeah, so just generally speaking, what are these records? What do they appear to be?

A They'd be the medical records.

Q Yeah. Of Kimberly Taylor?

A Yes.

Q From what facility?

A Henderson Hospital.

Q Okay. I'd like you to go to -- if you look in the bottom right, there's what we call Bates numbers. I'd like you to go Bates number HH38, 39, and 40. I'd like you to review those records and tell me if that refreshes your memory as to whether or not you were the PACU nurse for Ms. Taylor?

[Witness reviews document]

A I'm not seeing my name on any of these three pages.

Q Maybe if I could direct your attention to 123 and 169?

A Yep, I see my name in here.

Q Okay. So I take it from your responses so far -- and you can have a seat, sir, here temporarily. And we're going to put some records up in a minute, and they'll be on this screen and that little monitor --

A Okay.

Q -- in front of you. But I take it from your responses so far, you do not have an independent recollection of Ms. Taylor?

A No, just from reviewing.

Q Okay. And part of your job as a PACU nurse, is it to make medical records of your visit and treatment with patients?

A It's to document.

Q Okay. I'd like to call your attention back to HH38. What kind of procedure did Ms. Taylor have that day? Is your monitor on there, sir?

A No.

MR. BREEDEN: Maybe we can turn that on for him.

THE WITNESS: It says on here, she had a hysteroscopy with dilatation and curettage.

BY MR. BREEDEN:

Q Okay. And would you frequent -- frequently see hysteroscopy patients --

A Yes.

Q -- when you worked in the PACU?

A Yes.

Q Okay. Who was Ms. Taylor's surgeon that day?

A Dr. Keith Brill.

Q Okay. And when is it indicated that the surgery began? Look on your monitor.

A Procedure start is 8:43.

Q And when did the procedure end?

A At 9:10.

Q And those are a.m.?

A Correct.

Q Okay. So she was in surgery for approximately how many minutes?

A 27.

Q Do you have any recollection of Dr. Brill, the surgeon for Kimberly's case, telling you that she suffered a uterine perforation during her procedure?

A I do not recall.

Q Do you have any recollection of him telling you she sustained an intestinal perforation during the procedure?

A I do not recall.

Q Were you ever told that anything unusual happened during the procedure?

A I do not recall.

Q If you could look again on HH38, you indicated that part of your job as a PACU nurse is to document; is that correct?

A Correct.

Q What is documented on this page as to complications during the procedure? Direct your attention to sort of the lower right.

A The lower right.
Q It should be on your monitor, as well.
A It's kind of blocked by something. I'm sorry, there's something blocking most of this. Oh, there we go. On the bottom right? "Complications: None per surgeon."
Q Okay. And what does that mean to you?
A That there were no complications.
Q Would you be the person that made that entry?
A No.
Q Who would have made that entry?
A The surgeon.
Q So in this case, that would be Dr. Brill?
A Yes.
Q Would you have reviewed this in the PACU before you treated Ms. Taylor?
A No.
Q So what is the purpose then, of listing complications like that, if you as the PACU nurse are not going to review it?
A The notes are not always available when a patient comes out. I may not see the surgeon until -- I may not see the surgeon at all. I see the OR nurse, and I see the anesthesiologist, and I see the patient.
Q Would --
A Sometimes, they have somebody else bring the patient out. But I don't see the surgeon, generally, when the patient comes out.
Q Would you have had access to this note at the time you were

treating Ms. Taylor?

A Not necessarily.

Q Okay. Do you remember one way or another in this particular case?

A I don't.

Q Okay. What is -- in your experience, what is a typical time frame for a patient to be in the PACU who is recovering from hysteroscopy?

A Everybody's different. It varies. It's going to be a minimum of an hour, but there's no maximum. There's no maximum.

Q Okay. So what amount of time do you consider to be unusual for someone recovering from a hysteroscopy to be in the PACU?

A Unusual in what regard?

Q More than how many minutes or hours?

A That's hard to say because a patient may be in there extra time because they are unable to void. They may be there waiting for a ride to take them home. There could be any numbers of complications that keep them from going home. It could be nothing medical at all.

Q Do you recall how long Ms. Taylor was in the PACU?

A From review of the records, I think she came out at, like, 9 -- was it 9:24? Is that when she came out? When was it?

Q I'm asking you how long she was in the PACU after the procedure.

A From review of the records, I believe it was around seven hours.

Q Okay. Do you think that is an unusually long time to be in the PACU following a hysteroscopy?

A Once again, not necessarily.

Q Well, let me have you -- let me ask you this. During her stay in the PACU, did you monitor Kimberly's pain and other symptoms that she was having?

A Yes.

Q I'd like you to turn to HH168 through 174. Can you tell me what that section of the records is?

A A pain assessment.

Q Okay. And is this completed by you?

A Yes.

Q And is this completed at or near the time of the events that are recorded?

A I believe so.

Q Okay. I'd like to go through these records chronologically with you. So I'd like you to turn --

A Okay.

Q -- they are in reverse chronological order. So I need you to turn to the end of the last, which is 174.

A Okay.

Q What's the first entry you made?

A 9 -- 9:24.

Q Okay.

A Wait, 9 -- yeah, 9:24.

Q Do you believe that's the first time you made a pain assessment of Ms. Taylor following her procedure?

A Yes.

Q What did you record at that time?

A Pain scale of 10.

Q Okay. And what other symptoms?

A Abdominal lower and bilateral aching, crampy, sharp, status post-surgery, acute. So it was acute pain. It was a gradual onset. Nausea. That's it.

Q And now, are these symptoms that the patient is reporting to you or that you are observing yourself or a combination of those?

A Both.

Q Okay. So you don't simply take the patient's word for it, you use some of your judgment as well, in terms of what you have observed --

A Correct.

Q -- to complete this? Okay. And we spoke about timing early -- earlier, 9:24 in the morning, that's just a few minutes after she was released from the PACU, correct?

A From the OR.

Q Oh, from the OR. I'm sorry, I misspoke.

A Yes.

Q Now, I want you to turn very quickly. We're going to turn back to that page, but just very quickly, turn to page HH43. And can you tell me what this is?

A It says, "operative record".

Q Okay. And do you have to review operative records occasionally as part of your job?

A I do. I don't necessarily have to, but I do.

Q Do you recall reviewing this particular operative record for Ms. Taylor?

A No.

Q Okay. What time was that operative record created?

A 10:08, I believe.

Q And who prepared it?

A Dr. Brill.

Q Okay. So now, let's turn back to HH174. You indicated that your first assessment of Ms. Taylor was at 9:24 a.m., correct?

A Correct.

Q So it's fair to say that when you first assessed Ms. Taylor, you did not have access to an operative report that was created at 10:08?

A Correct.

Q All right. Now, I am going to go through each of your entries here. And maybe you could just quickly generally tell me about each of them?

A Okay.

Q Your next entry appears to be at 9:25 a.m. Can you tell me what you found?

A Pain is bilateral. Not an acceptable level of pain, which was still 10 out of 10. This an acute pain and gradual.

Q And how about your next entry, what time was that and what was --

A 9:30.

Q -- reported?

A Essentially, the same thing. Aching, cramping, sharp, acute.

Q At 9:30?

A Uh-huh.

Q So just five minutes later?

A Yes.

Q And if you could now turn to 173. What did you record at 9:35 in the morning?

A Abdominal lower bilateral aching, crampy, sharp. Still 10.

Q And what did you record at 9:40 in the morning?

A Still a 10.

Q What did you record at 9:41?

A Still a 10.

Q Along with aching, cramping, sharp pain?

A Correct.

Q Okay. And what did you record at 9:45 in the morning?

A The same. Aching, cramping, sharp, and 10.

Q Okay. And when was your next assessment?

A At 9:50.

Q What did you record at that time?

A A 10, using faces.

Q Okay. And faces is just a pain scale, and it shows --

A Based on their expression.

Q Yeah, based on an expression. And it shows people with a happy face and then people with a sad and painful face, and then you ask people where they are; is that right?

A Yeah.

Q Okay. And 10 out of 10, the worst possible pain, was being represented?

A Uh-huh.

Q And now, what did you record at 10 a.m.?

A Still a 10.

Q And your next assessment was at 10:06. What did you record at that time?

A 10.

Q Is that continued aching, cramping, sharp, 10 out of 10 pain, which is acute, with nausea?

A Yes.

Q Did you record the same thing at 10:13?

A I did.

Q Now, at 10:15, you recorded a 7 out of 10 pain, do you see that?

A Yes.

Q Okay. And then at 10:25, you recorded again, 10 out of 10, worst possible pain, acute. Do you see that?

A Yes.

Q Now, I want you to remember that time.

A 10:25.

Q 10:25 a.m.

A Okay.

Q Okay. We're going to talk about that time a little later. But looking at the rest of your pain assessment, do you see anymore 10 out of 10 pain after 10:25 a.m.?

A No.

Q Okay. So let's talk, you know, very quickly about the type of symptoms that you did record. And by the way, in these records, did you ever get to a point where Ms. Taylor was pain-free or 0 out of 0 to 10 was recorded -- 0 out of 10 pain was recorded?

A I don't believe so, no.

Q Okay. So if we continue past 10:25, we have a 10:30 entry of 5 out of 10 pain?

A Yes.

Q Continued aching, cramping, sharp pain, exacerbated by movement; do you agree with that?

A Yes.

Q We have similar findings of four at 10:45 a.m., correct?

A Correct.

Q At 11 a.m., we still have aching, cramping, sharp pain symptoms, correct?

A Yes.

Q 11:15 it's recorded as seven out of ten?

A Yes.

Q At 11:30, which is on the previous page, HH170, at 11:34, we have four-out-of-ten with aching, cramping, sharp pain, nausea. Do you see that?

A Yes.

Q And then as we go forward at noon, we have a 4 out of 10 pain reported; do you see that?

A Uh-huh. Yes.

Q And at 12:15, you recorded 4 out of 10 pain with aching, cramping, sharp pain increased with movement?

A Yes.

Q And we're going to continue. There's just a couple more pages here. 12:19, you recorded 4 out of 10 pain with aching, cramping, sharp pain?

A Yes.

Q 12:30, 4 out of 10?

A Yes.

Q 12:45, 4 out of 10?

A Yes.

Q 1300 which is 1 p.m., 4 out of 10 pain?

A Yes.

Q And she's still reporting aching, cramping, sharp abdominal pain --

A Uh-huh.

Q -- which is acute with symptoms of nausea at that time?

A Yes.

Q And that's at least four hours in the PACU roughly?
A Yes.
Q And then we see at 3:13, she's reporting 2 out of 2 pain?
A Yes.
Q 1400 hours, which is --
A Two o'clock --
Q -- 2 p.m., 2 out of 10 pain; do you see that?
A Yes.
Q And it continues onto the previous page, 168. At 1430, which is 2:30 p.m., she's still complaining of aching, cramping, sharp pain. Do you see that?
A Yes.
Q And then at 1600 which is 4 p.m., she's still complaining of aching, cramping, sharp pain status post-surgery 2 out of 10 with nausea. Do you see that?
A Yes.
Q And then the same entries or similar entries at 4:30 p.m.?
A Yes.
Q Okay. And is that your last entry for Ms. Taylor?
A On pain assessment, yes.
Q For pain assessment I meant, yes. And so is it your understanding that she was discharged shortly after 4:30 p.m.?
A I believe so.
Q Was there any other PACU nurse that was in charge of her care during her time there?

A I don't believe so.
Q Okay. What treatment did you administer to Ms. Taylor?
A Narcotics.
Q Okay. So pain medication, right?
A And anti-nausea.
Q Okay. So I'd like you to turn to page 123 through 128 of that same exhibit.
A Where do you want me to start, on 128 or 123?
Q Yeah, we're going to go through them in reverse chronological order.
A Okay.
Q So -- and actually, if you look at 127, the question I'm going to ask you is what is the first medication that's documented that you administered to Ms. Taylor?
A Dilaudid.
Q And what does the medication Dilaudid do?
A It's narcotic for pain.
Q What time did you administer that?
A 9:26.
Q Is that an over-the-counter medication?
A No.
Q It would be prescription only or --
A Yes --
Q -- for use in the hospital?
A Yes.

Q And --
A There is prescription for home as well.
Q Did you administer the drug ephedrine at 9:30?
A Yes.
Q And what is that drug for?
A Blood pressure.
Q Did you administer the drug acetaminophen at 9:36?
A Yes.
Q Directing your attention now to HH126, did you administer ephedrine again at 9:40 a.m.?
A Yes.
Q Why would you give two doses of ephedrine within ten minutes of each other?
A Because the narcotics would have an effect on her blood pressure.
Q Raising it or lowering it?
A Narcotics would lower your blood pressure.
Q Okay. So you were giving her that drug to help raise her blood pressure after the narcotics; is that correct?
A Yes.
Q At 9:41, did you administer the drug Dilaudid again?
A Yes.
Q At 9:45, did you administer ephedrine again?
A Yes. No. I did not -- the correction. 9:41 it was not -- Dilaudid was not given again. It was verified. And at 9:45 ephedrine

was verified not given.

Q It was verified that you had already given it?

A Yes. It's showing verified -- not given.

Q Okay. So the next drug you administered then was at 9:45 a.m.?

A Yes. You're asking what the drug was or did I give the drug?

Q I'm asking what the drug was and whether you administered it at that time?

A I administered fentanyl.

Q And what was the next drug that you administered and when?

A 9:58, Dilaudid.

Q And what was the next drug you administered?

A 10:10 fentanyl.

Q And is that the second dose of fentanyl that you had given Ms. Taylor?

A Yes, I believe so.

Q And so after the second time you administered fentanyl to Ms. Taylor --

A Uh-huh.

Q -- that same morning within an hour or so, is that when her pain symptoms appeared to go or decrease from ten out of ten?

A I'd have to review the -- that's at 10:10?

Q Yes.

A What page was the documentation on? What page was the

other documentation on?

Q We reviewed documentation earlier -- I can direct you towards it.

A Okay.

Q HH172.

A 172. At -- it was pain 10 out of 10 at 10:13.

Q And then afterward, it begins decreasing?

A Yeah, at 10:15 it was seven.

Q Shortly after you administered the second dose of fentanyl?

A Yes.

Q And do you think that is related?

A Yes.

Q So do you think the fentanyl at this point, is masking symptoms?

MR. MCBRIDE: Objection. That goes beyond this witness's area of expertise.

THE COURT: If he knows the answer, I'll allow -- if he has personal knowledge.

BY MR. BREEDEN:

Q Do you think the fentanyl is fixing something in Ms. Taylor or do you think it's simply decreasing her pain symptoms?

A I think it's decreasing her pain symptoms.

Q Now, I want to continue and we're back on HH124. What is the next drug that you administered to Ms. Taylor?

A After fentanyl?

Q After fentanyl.
A Percocet at 11:19.
Q You also did administer fentanyl again for a third time at 11:19 in the morning; didn't you?
A Yes.
Q And looking at HH123, what's the next drug you administered?
A Reglan at 11:59.
Q What does Reglan treat?
A Nausea.
Q And what's the next drug you administered?
A Phenergan at 1332.
Q And what does that drug treat?
A Nausea.
Q What's the next drug following that you administered?
A Morphine at 1343.
Q And are there any further records of medication administration for Ms. Taylor from you?
A I don't believe that one is for me, so I think that is the last of the medications that I gave her.
Q Okay. And we reviewed the last pain assessment that you did of Ms. Taylor earlier, and it indicated shortly before she was discharged she reported, or you recorded that she had 2 out of 10 pain. Do you recall that?
A Yes.

Q Is it fair to say that by that time she had been given multiple doses of pain medication such as Dilaudid, fentanyl and Percocet?

A Yes.

Q Did you have any further -- well, I'm sorry. Let me ask you this. At any time you were in the PACU, do you see in the records or your own personal recollection that you were advised there had been any complication with her procedure?

A I do not recall any complications.

Q And do you recall, or have you seen in any of the records that we went over that you were advised she sustained any sort of perforation during her procedure?

A I do not recall.

Q After Ms. Taylor was discharged from the hospital, did you have any further contact with her?

A After discharge, no.

Q Okay. You never spoke to her or met her afterward?

A No.

Q Okay. Thank you. Those are all the questions I have.

A Okay.

THE COURT: Cross-examination?

CROSS-EXAMINATION

BY MR. MCBRIDE:

Q Good afternoon, Mr. Hutchins.

A Hello.

Q How are you?

A Fine.

Q You're used to wearing a mask. Some of us aren't quite used to wearing it so you're doing great. I have a couple of questions for you. I want to ask you -- first off, you don't have any independent recollection of Ms. Taylor as you sit here today?

A No.

Q Okay. You've seen countless numbers of patients who have come through a PACU over the past four years, correct?

A About a thousand a year.

Q Al right. And prior to working at Henderson Hospital, in 2017 I think you indicated you worked in other PACUs here in Las Vegas before Henderson Hospital?

A Yes.

Q All right. So as a PACU nurse, did you -- would you say that you gained sufficient training and experience in both school and on the job in how to identify signs of a complication post-surgery?

A Yes.

Q All right. And have you over the years up until 2017 -- before 2017, had you ever encountered patients who had suffered a complication following surgery?

A I don't recall. Before then? I have no recall.

Q And at the time you were working in the PACU, you were the only nurse in the PACU at that day?

A No.

Q Okay. There's -- Ms. Taylor was just your patient?

A Correct.

Q One of the things I wanted to show you was what counsel had referred to -- and it's Exhibits 34 through 38. And I'll who it actually, on the screen. Now, the PACU documentation that you have -- and it indicates your name on it -- that is specifically referred to as the PACU -- or PACU nursing documents, right?

A These are not the same form that I document in, so these are -- if they have my name on them, that's my documentation. But is this referred to that? I don't know.

Q Right. And for the -- actually, that's a great point because you're entering all the information on electronic medical records, right?

A Yes.

Q And so the records you see in front of you here today that have been printed out, they don't look anything like what you're used to inputting information in, right?

A Not at all.

Q Is that correct?

A Correct.

Q All right. One thing, if you could wait until my question is completely out and then you can answer the question.

A Okay.

Q But I wanted to show you this. This is page 34, and I'm going to zoom out a little bit to give you a frame of reference. So this page 34 at the top here. See, it says HHNOR nursing document, right?

A Uh-huh.

Q Is that a yes?
A Yes.
Q And it says the person who is performing it is Kari Whaley [phonetic]; do you remember who Kari Whaley was?
A No.
Q All right. How about Gary Wernlund? Do you know Gary?
A The name sounds familiar, but I don't -- I can't picture him.
Q Okay. And I'll represent to you that the -- this operative record -- this is the nursing summary and nursing documentation of the actual individuals involved with the operation. That wasn't you, correct?
A I don't see my name on here.
Q Okay. And in fact, this talks about when the patient was set up in the room and what time anesthesia started and what time the patient exited the room, correct?
A Correct.
Q And you wouldn't have knowledge of that because you weren't in the operating room at the time?
A Correct.
Q All right. So the next page -- actually, let me go to page 38 that Plaintiff's counsel showed you just a second ago. And you had indicated -- and this is again, part of the operative record from the procedure that was done, and it says HHN surgical procedures, general case data. Based on your background, training, and experience, this would have been information that was prepared by the nurses in the operating room who attended to this patient, correct?

A Let me see who did do this.

Q I'll represent to you Gary Wernlund was --

MR. BREEDEN: Well, I'll object, Your Honor.

BY MR. MCBRIDE:

Q -- identified --

MR. BREEDEN: That lacks foundation.

BY MR. MCBRIDE:

Q -- it's right up there at the top.

THE COURT: This is -- counsel, approach.

[Sidebar begins at 2:51 p.m. and concludes at 2:52 p.m.]

BY MR. MCBRIDE:

Q All right. And just for clarification, I'll show you page 42 so it may make it clearer for you. So 42 is the operative record and you see up here where it says signed by Gary Wernlund and Kari Wheely -- Whaley?

A Yes, I see it.

Q Okay. Does that help refresh your recollection as to who would have prepared that document, those records that you saw earlier?

A Those two, obviously.

Q Okay. So when you originally had indicated that this section where it says complications none per surgeon, in fact, that's not prepared by Dr. Brill; you would agree with that?

A Can I see the entire document?

Q Sure.

A Is it there?

Q It's page 38, if you want to look at that.

MR. BREEDEN: I'll object again, for the record, Your Honor.

THE COURT: Thank you. Overruled.

THE WITNESS: Because I see up here on -- it says, "Prepped by Wernlund, Gary [phonetic]."

BY MR. MCBRIDE:

Q Correct.

A And then care --

Q And we just showed you the signatures. You signed this document?

A Electronic signature.

Q Right, but --

A Yes.

Q The ones I just showed you?

A Yeah. It says none per surgeon, but it's just listing who the surgeon is down here.

Q Right. But it lists the primary surgeon, but it doesn't say that --

A That he prepared it.

Q -- it is prepared -- wait. Hold on one second.

A Sorry.

Q It doesn't -- you would agree with me that that referenced the complications, number surgeon is not documented by Dr. Brill?

A Correct.

Q All right. That would have been either Gary Wernlund or Kari

Whaley, the ones who prepared this note, correct?

A Correct.

Q All right. Now, you said it's part of your regular practice -- you don't have to, but part of your regular practice to review the operative notes; is that correct?

A If they're available.

Q If they're available. And this one, you indicated that we had it -- that it was available by 10:08 a.m., right?

A Correct.

Q So at least within a half hour, 40 minutes of the patient coming to the PACU, the operative note would have been available in the electronic medical records, right?

A Correct.

Q And I want to show you this document. This is page 41. And it shows the report, departure from the OR, a report given by Dr. Yeh. Do you know, is that report given to you?

A Yes.

Q All right. And do you remember -- as you said here, do you remember anything about that report that was given by Dr. Yeh?

A No.

Q Okay. And then also a report given to Bruce Hutchins, that's you, transported by Gary Wernlund and Dr. Yeh, right?

A Yes.

Q Okay. And you indicated, I think earlier, is -- it's not unusual to not see a surgeon in the PACU immediately post-surgery, right?

A Correct.
Q Okay. And you don't recall, as you sit here, a -- if Dr. Brill came in at any point during -- in the PACU to see Ms. Taylor?
A I don't recall.
Q This is the operative note, at least the first page. This is page 42. And this is the one that you see that it was at 10:08. Do you see that?
A Yes.
Q All right. And then if you look at the bottom of this, it indicates, complications, perforations of uterus.
A I see that.
Q Okay. So that -- that would have been available to you at least by, let's say 10:15, 10:30 in the morning, correct?
A Correct.
Q Now, I wanted to show you -- now, is there a difference -- there's a -- is there a PACU-I and a PACU-II?
A Phase I and Phase II.
Q Phase I and Phase II. And what's the purpose of Phase I?
A More critical care.
Q And how long, typically, do patients stay in Phase I?
A It varies. There's no typical. Every patient is different.
Q Okay.
A But I don't --
Q Do they have to meet a certain criteria in order to get moved to PACU-II, or --

A Yes.

Q All right. What's the criteria you're familiar with?

A Maintain their airway. You want to know that they're alert and oriented. You want to know that they can -- well, if they're required to drink, their motor functions are good. So limitation and possibly mobile, if they're mobile, but maybe not.

Q And then they can graduate to the PACU-II?

A Correct.

Q All right. So these are all things that you're paying attention to very closely when you're monitoring your patients in the PACU, right?

A Yes.

Q And in order to make sure that they're going to be available for discharge, as long as they're continuing to improve, right?

A Correct.

Q So I wanted to show you, this is page 44. And I'll zoom in again. Not being too far away. Can you see that?

A It's a little fuzzy, but yeah, I can see it.

Q Okay. And this would indicate PACU-I care plan, right?

A Pre-care [indiscernible].

Q And do you see it up there?

A I see it says PACU care.

Q All right. So this is a document that you would have prepared, right? I'll show you down here your signature, it says finalized by Bruce Hutchins. Do you see your signature down there?

A I see a signature, yes.

Q Okay. All right.
A Okay.
Q So this would indicate that you -- noting that the patient's gastrointestinal status has maintained at, or improved from baseline levels and you noted, yes?
A Correct.
Q Patient demonstrates and/or reports adequate pain control. You wrote in, yes?
A Correct.
Q Also, patient's cardiovascular status is maintained at or improved from baseline levels, and you reported, yes, right?
A Yes.
Q So those are all signs that, in your opinion, that Ms. Taylor was getting better over the period of time she was in PACU-I?
A Yes.
Q Now, PACU-II documentation, or summary, that indicates that she was in PACU-II by about 1:00 in the afternoon; is that right?
A Yes.
Q Is that room -- is it -- is it right next door to PACU-I?
A It's in the same bed.
Q Okay. Oh, it's in the same bed?
A Yes, it's Phase I and Phase II is just the status of the patient.
Q Got you. So it's not like they move them to a different room?
A Some hospitals do.
Q Okay. But not Henderson Hospital?

A No.

Q Okay. And at this point, you noted under the PACU-II care plan, that the patient demonstrates and/or reports adequate pain control, right?

A Yes.

Q And the same thing goes for -- this is page 46, and it just continues on. Patient's gastrointestinal status is maintained or improved. Yes. And cardiovascular status is maintained or improved, correct?

A Yes.

Q And signed by you at 1711?

A Yes.

Q Okay. Now, counsel went through some of the -- your pain record -- your pain level chart that you noted on Ms. Taylor, but I don't want to spend a lot of time with that. We went through that, the fact that she had a pain level initially at a ten, as she reported, and then by the time she was ultimately discharged in the afternoon, it was at a pain level of two?

A Correct.

Q Okay. In your experience, in years of working in the PACU, are the levels of pain that Ms. Taylor experienced immediately post-surgery that she reported, ten out of a ten, and seven out of ten, is that unusual, or outside the areas of what you would expect for a patient recovering from a surgery?

A Not at all.

Q Okay. And in fact, the pain medications that were -- that Plaintiff's counsel went through that you administered, are those part of standard orders that are given by the physician and the anesthesiologist?

A Yes.

Q Okay. Do you recall at any point in time, based on your review of the medication administration record or the orders, it seemed any point in time where you had to call, either Dr. Yeh or Dr. Brill to notify them of the patient's pain levels?

A From my review, I think I did have to contact them for, not pain -- I don't know if it was pain levels, but I know -- I think it was for anesthesia -- or for nausea.

Q And that was Dr. Yeh. That Dr. Yeh, and I'll show you that in a second. Does that refresh your recollection?

A Yeah.

Q For the Reglan?

A Yes.

Q All right.

A Well, I know -- I don't know if it's for Reglan, but I know I called him.

Q And do you recall if you -- if you mentioned to him, any issues relating to the patient's pain levels?

A I don't recall.

Q Okay. All right. So what I wanted to show you real quick -- let's see if I can find it. So as part of your review of every patient in the PACU, are you taking their vital signs?

A Yes.

Q How often do you take the vital signs?

A Initially, it's -- depending on the hospital, and if it's a child, it's every five minutes, but initially, every 15 minutes, and then it goes to half hour, then to hour. Sometimes I just do it more often.

Q And why would you do it more often?

A Because I don't change the setting on the monitor to reflect half an hour or an hour. It's not required to do it more often.

Q You just try to be as -- I guess as efficient as you can when you're evaluating your patients?

A That, and if you give pain medications, then you need to reevaluate more -- the more -- like 15 minutes later, so --

Q Okay. So I wanted to show you 183. This is the assessments and treatments section where, again, all this information is entered in the electronic medical records as you're evaluating the patient after you're performing vital signs and so on, correct?

A Okay.

Q Is that correct?

A Yes.

Q All right. So one of the text results here, is that at 10:30, you do various assessments, including the HEENT defined assessment. What's that, for the jury's sake, an HEENT assessment?

A Ear, nose throat, all the full assessment.

Q Okay. Do you do a cardiovascular assessment, correct?

A Yes.

Q A respiratory define assessment?
A Yes.
Q And gastrointestinal define assessment, correct?
A Correct.
Q In addition to these others?
A Yes.
Q And including a neurological assessment, right?
A Yes.
Q So at 10:30, do you -- when you're doing these assessments, and in particular, gastrointestinal define assessment, are you using a stethoscope --
A Yes.
Q -- to check the bowel sounds?
A Yes.
Q Why are you doing that?
A To see if there's motility.
Q Motility. Can you explain that to the jury?
A If there's -- if the patient's got gas or bowels moving in there, you'll hear it. Narcotics will stop or slow that down.
Q Okay. But at this point, bowel sounds were normal in all quadrants, rights?
A Yes.
Q Nontender abdomen, soft and nondistended abdomen, correct?
A Yes.

Q What's the significance of that to you, monitoring a patient in the -- in the PACU post-surgery?

A That's there's no complications.

Q Okay. Now, next you do another one -- it's not highlighted here, but it's at 11:30, kind of a similar assessment, gastrointestinal define assessment; bowel sounds were normal. Same soft, nondistended abdomen, correct?

A Correct.

Q You do another one at 12:30. Bowel sounds normal, all quadrants. No diarrhea, no nausea, vomiting, nontender abdomen.

A Correct.

Q Soft, nondistended abdomen, right?

A Yes.

Q Is Ms. Taylor continuing to improve in your opinion?

A Yes.

Q And this is at 1330, or 1:30, same thing, bowel sounds normal, all quadrants, nontender abdomen?

A Yes.

Q She did report some nausea at this point, and that's when you called Dr. Yeh for the nausea medication?

A I don't know that.

Q Okay.

A I don't have that in front of me.

Q I'll --

A I don't recall, so I'd have to look at the record.

Q Okay. At some point, you do make -- have a recollection of calling a doctor for nausea medication?

A I don't have a recollection of it. I have -- I read something in the chart --

Q Okay.

A -- when in review.

Q Okay. Sounds good. We'll get to that. And then again at 1430, bowel sounds normal. Similar exam, right?

A Yes.

Q I'm almost done with this document, but I just want to make sure that we've covered them all. And again, at 1430, the assessment that you did -- well, we already covered that one. So at 1630, bowel sounds normal, all quadrants. No nausea, vomiting, nontender, soft, nondistended abdomen, correct?

A Yes.

Q So based on -- and I want you to assume that the report of the operative report that you just saw was in the EMRs at 10:08, or by 10:15 that morning, and it's your custom and practice to review those operative reports; you would have been aware of that post-operative perforation of the uterus listed on the operative report?

A Not necessarily aware. There's no alert, telling me the report is done.

Q Okay.

A They have up to, I believe 24 hours or the time of 24 hours to complete the report.

Q But if it was there -- if it was there in the chart, you would have had the ability to review it, correct?

A I would have had the ability.

Q Okay. All right. So the medication report, real quick, those standing orders that we just went through, and I'll just try to make it brief, but those orders that we talked about, that counsel went through at 9:30, 9:36 and so on, the order was by Dr. Yeh, correct?

A Yes.

Q All right. And without going through the rest of them, I'll show you there was one -- there's three orders, Dr. Brill at the top at 11:19 for Percocet, correct?

A Yes.

Q See at the very top? Here?

A I see that, yes.

Q Yeah. And so that's Dr. Brill's order, right?

A Yes.

Q And that's his standing order?

A He placed the order, yes.

Q Okay. In other words, it wasn't an order you specifically called him and needed him to place it at 11:19, correct?

A I don't recall.

Q Okay. I'll show you two other orders, 13:43 and 12:19, both by Dr. Bill. One was Percocet, and one was Morphine, right?

A Can you slide it down a little bit?

Q Sure.

A Yeah, 13:43, Morphine.
Q And then the Percocet as well from Dr. Brill?
A That's showing verified at that time.
Q Oh, for Dr. Brill, it's for the Percocet? Got you. Right here, you mean?
A Yes.
Q So the antinausea medication, Dr. Yeh that you called him for, was that the Phenergan or the Reglan?
A I don't recall.
Q Are both of them antinausea medications?
A Yes.
Q Okay. Have you ever had patients that you have seen in the OR who had suffered a post-operative complication of a bowel perforation?
A I don't recall.
Q Okay. But at any rate, you're trained in how to recognize the signs and symptoms of a bowel perforation, correct?
A Yes.
Q Okay. And at any point in time during your seven and a half hours of being with Ms. Taylor, did any of her signs and symptoms indicate to you that she had a bowel perforation?
A No.
Q Was there any reason, based on her signs and symptoms and her clinical status that we just went through, that you felt a need to call Dr. Brill for any concerns that she might have a bowel perforation?

A On a review of the records, no.

Q Okay. And I'll represent to you that the records of standing orders that Dr. Brill had issued were all at 10:09 a.m. Were you aware of that?

A No.

Q But that would be consistent with being a post-operative issued by a surgeon that you would typically follow a patient of theirs, right?

A Yes.

Q In your years of working in the PACU, have you ever had a patient report a zero out of zero pain?

A Yes.

Q Okay. How often does that happen?

A Not very often.

Q And so was there anything out of the ordinary with regard to Ms. Taylor's reports of pain?

A No.

Q Court's indulgence. Oh, when Ms. Taylor was discharged, did you also discharge her from the PACU and also from Henderson Hospital?

A I believe I -- I don't know if -- I don't remember if I wheeled her out to the car or if somebody else did.

Q Okay. That -- there was something --

A When she was discharged from -- when she's discharged from the PACU, she's discharged from the hospital, she's taken to the

car. Or to the entry where the car meets her.

Q Would you have also -- are you familiar with the discharge instructions that are given to patients following their discharge from the PACU?

A Yes.

Q Okay. Have you gone over those discharge instructions with patients in the past?

A Yes.

Q And I wanted to show you, this is 15 -- excuse me, 13 through 18.

MR. BREEDEN: Your Honor, I object. Renewed objection.

THE COURT: Thank you. Overruled.

BY MR. MCBRIDE:

Q 13 through 18, I just want to show these to you.

A Where do you want me to start?

Q 13 through 18, I can show it to you as well.

A Okay.

Q But if you want to look at them, it might be -- if it's easier for you up here. These are patient education notes. Are these, based on your background and training and experience, are these the discharge instructions or at least part of -- the first part, that are given to patients post-discharge from the PACU?

A Let me read it real quick.

Q I'm sorry?

A Let me read it.

Q Sure.

[Witness reviews document]

A This first section, yes.

Q Okay. And it says, "Return to the hospital for a fever greater than 101, pain unrelieved by medications, persistent" -- well, "persistent nausea or vomiting, and inability to void eight hours after discharge, or bleeding greater than one pad per hour or abnormal drainage."

A Yes.

Q Okay. There's also page -- there's the second page on 14, "When to call your doctor. Bleeding, severe abdominal pain, severe cramp -- cramps, fever above 101." At any point in time, in your review of the records from the PACU, did you see if Ms. Taylor's temperature ever exceeded 101?

A I don't recall.

Q Okay. Or chills or discharge? Correct? And then it talks about hysteroscopy.

A Chills? Hold on. Can you stop for a minute?

Q Sure.

A So chills. I don't know if I medicated her for shivering. I don't remember that. I would have to look at the medications. But not a discharge, though.

Q Okay. And that's a good point, because I think there's some patients who immediately come out of surgery, because of various reasons, the temperature in the room is typically a little bit colder in the operating room. Is it uncommon to find patients who will be in the

post-op recovery room and experience chills?

A Shivering is not uncommon. We medicate for it. But it is also a by-product of anesthesia.

Q Right. Okay. And at this point, you don't recall -- certainly at the time she was discharged, she wasn't experiencing any chills?

A No.

Q Okay. And then the patient education notes go on to another page. It talks about -- this is page 15. "Risks and possible complications of a hysteroscopy, including infection, bleeding, perforation, tearing of the uterine wall, damage to internal organs, scarring of the uterus, problems with anesthesia." Again, is this a typical patient education notice given to a patient following a hysteroscopy?

A Yes.

Q And again -- once again in highlighted section -- this is page 16 -- "Call your healthcare provider if you have heavy bleeding, a fever over 100.4, increasing abdominal pain or tenderness, foul-smelling discharge." Again, that's part of the same education notes you've seen in these discharge instructions?

A Yes.

Q Next one is simply just talking about going home, things to avoid, don't use heavy equipment, avoid alcohol, coping with pain, tips for taking pain medication, correct?

A Yes.

Q Next page, 18, talks about taking medications on a schedule, how you should not mix alcohol and pain medications. It talks about

managing nausea, correct, all consistent with the instructions you give the patient post-discharge?

A Yes.

Q And again, in blue, "Call your surgeon if you still have a pain an hour after taking medication. It may not be strong enough. Or if you feel too sleepy, dizzy, or groggy." And then this is the final page, page 19. "If you have side effects like nausea, vomiting, or skin changes."

And again, at the time you discharged Ms. Taylor from the PACU, was -- do you recall if there was ever any request by Ms. Taylor that she needed to be seen by a doctor for her complaints of pain?

A No. I don't recall.

Q Well, if she would have, would you have documented that?

A Yes.

MR. MCBRIDE: Okay. Court's indulgence. Thank you, Mr. Hutchins. That's all I have. Thank you.

THE WITNESS: Thank you.

THE COURT: Redirect?

MR. BREEDEN: A short redirect, Your Honor.

REDIRECT EXAMINATION

BY MR. BREEDEN:

Q Okay, Mr. Hutchins. Thank you so much. I know you've been up here for a little while. We'll try to get you out of here pretty quickly. I want to put back up a record that we've been discussing.

MR. BREEDEN: Do I need to hit switch, Kristy? I'm going to use this thing instead. Can you turn that on? I'm sorry, I had withdrawn

this.

THE COURT: Okay.

BY MR. BREEDEN:

Q There it goes. All right. So we've been talking quite a bit about this record where it says no complications. I'm sorry, it says, "Complications: none per surgeon." Somebody at the hospital wrote this, right?

A Correct.

Q Now, Gary Wernlund, if he wrote it, do you know what his involvement would be?

A He's probably the OR circulator.

Q So he would be somebody actually in the operating room --

A Yes.

Q -- with Ms. Taylor when this procedure is going forward?

A Yes.

Q Okay. Now, we talked a little bit about orders to administer pain medications. And those were referred to as standing orders. Do you recall that?

A Yes.

Q And so there's standing orders from Dr. Yeh, the anesthesiologist, and Dr. Brill. Do you recall that?

A Standing orders would be -- well, they place orders prior to the procedure, or they place them after the procedure. And those orders are just standing orders because I can use them at any time --

Q Yeah. You have discretion.

A Yes.

Q All right. So you didn't have to administer any pain medication if there were no complaints of pain, right?

A Correct.

Q Okay. But in your discretion, you administered very strong pain medications multiple times over a course of several hours, didn't you?

A To my experience, normal medications.

Q Normal medications? Multiple doses --

A Yes.

Q -- of fentanyl and Dilaudid?

A Yes.

Q Now, you indicated that during her stay in the PACU, Ms. Taylor continued to improve in terms of her pain symptoms.

A Yes.

Q But we already covered that she appears to have continued to improve in her pain complaints because you were giving her a lot of pain medications, right?

A To a point.

Q To a point. Okay. You were asked what the symptoms of a bowel perforation are. What are those to you?

A Bowel perforation could be lower back pain, if it -- if you have bleeding internally, your -- in your body cavity, your body doesn't like that; it hurts. So the pain would increase if there was -- in continued bleeding.

Q Would you agree with me that extreme pain, nausea, and difficulty moving are all symptoms of a bowel perforation?

A They're also symptoms of surgery.

Q Are they also symptoms of a bowel perforation?

A They can be both, yes.

Q Okay. Now, you indicated that you didn't think Ms. Taylor was having any pain that was out of the ordinary. She was complaining of 10 out of 10, excruciating pain, wasn't she?

A Pain is subjective, and you accept the pain the patient states at that level.

Q So did you doubt Ms. Taylor was actually in excruciating pain?

A No.

Q What would she have done to cause you to question what she was reporting to you?

A Well --

MR. MCBRIDE: Objection. He just said he wasn't questioning it. So --

THE COURT: Sustained. He said he wasn't --

MR. MCBRIDE: Thank you.

THE COURT: -- he didn't question it.

MR. MCBRIDE: It's argumentative. Sorry, Your Honor.

BY MR. BREEDEN:

Q Do you give everyone in the PACU fentanyl?

A If it's ordered, and it's necessary.

Q Okay. So the answer is do you give it to everyone?
A Not everyone, no.
Q Do you give everyone in the PACU Dilaudid?
A No.
Q Do you give everyone multiple doses of Percocet?
A Did I give multiple doses?
Q Do you give everyone in the PACU --
A No.
Q -- multiple doses of Percocet?
A No.
Q Okay. But you did all those things for Ms. Taylor, didn't you?
A I don't believe I gave her multiple doses of Percocet.
Q You gave her multiple doses of Dilaudid and fentanyl?
A Yes.
Q Is it your decision or do you have discretion regarding when the patient is discharged from the PACU?
A She has to meet PACU criteria. And sometimes the doctor will have specific requirements.
Q Okay. So let's talk about Ms. Taylor in particular. Are you the one that made the decision that said, hey, she's met the requirements and she can go home, or was it somebody else?
A It was my decision based on the requirements.
Q Okay. And at the time you made that decision, in the entire time you're treating her in the PACU, did you have any knowledge that she had either a perforation to the uterus or the small intestine?

A No.

MR. BREEDEN: Those are all the questions I have, thank you.

MR. MCBRIDE: No questions, Your Honor.

THE COURT: Thank you. Thank you. Any questions from our jurors?

All right. Thank you, Mr. Hutchins. You may be excused.

THE WITNESS: Thank you.

THE COURT: Counsel, approach.

[Sidebar at 3:26 PM, ending at 3:27 PM, not transcribed]

THE COURT: All right. Ladies and gentlemen, we're going to take an afternoon break. It's been about 90 minutes. And we're going to -- I'm going to give you a 30-minute break because we have a few legal issues we need to discuss. So we're going to try not to take up too much of your time.

During the break, you're instructed not to talk with each other or anyone else about any subject or issue connected to this trial. You're not to rewatch or listen to any report or commentary on the trial by any person connected with this case by any medium of information, including without limitation newspapers, television, internet, or radio.

You're not to conduct any research on your own related to this case, such as consulting a dictionary, using the internet, or other reference materials. You are not to test any theory of the case, recreate any aspects of the case or in any other way investigate the case on your own. You're not to talk to others, text others, tweet others, Google issues, or conduct any other kind of book or computer research with

regard to any issue, party, witness, or attorney involved in this case. And finally, you're not to form or express any opinion on any subject connected to this trial until the case is finally submitted to you.

I'll see you in 30 minutes at four o'clock.

[Jury out at 3:28 p.m.]

THE MARSHAL: The jury is clear of the courtroom, Your Honor.

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence -- thank you -- of the jury. And do you want to take a break first and come back?

MR. MCBRIDE: Sure.

THE COURT: So you want 5, 10 minutes?

MR. MCBRIDE: Sure.

THE COURT: All right.

[Recess from 3:29 p.m. to 3:35 p.m.]

[Outside the presence of the jury]

THE COURT: All right. Let's go back on the record in case number A18773472-C. Feel free to keep snacking and drinking. I know everybody needs something. We are on the record in Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. And let's put the objections on the record and then discuss the other issues.

During the testimony of Elizabeth Laca, correct, is that -- did I say that right, anybody?

MR. BREEDEN: She was this morning?

THE COURT: Did you hear he put that on the record?
MS. HALL: He sure did.
THE COURT: Okay. Sorry. I was just making sure.
MR. BREEDEN: I don't think there was much regardless, for her.
THE COURT: Okay. And are you sure? I know we discussed it at the bench. I don't recall talking about it outside, but if you guys say we did.
MR. MCBRIDE: I think we did before the break.
THE COURT: Okay.
MS. HALL: I think so.
THE COURT: All right.
MS. HALL: It feels like yesterday.
MR. BREEDEN: I don't recall any highly relevant objections during that testimony either way.
THE COURT: Well, it was the invoice argument.
MS. HALL: Oh, I'm sorry. I think that was Ms. Herda, the --
MR. BREEDEN: Yes.
MS. HALL: -- City of Henderson. Her name was Laurie Herda.
THE COURT: Oh, that's -- okay. Did we put that on the record?
MS. HALL: No.
THE COURT: That's the one I was -- okay. So that's the one that I'm referencing. Sorry. My apologies. So as to Ms. Herda, during

Plaintiff's questioning he was talking about two ambulance invoices with -- related to services that Henderson provided. There was a foundation objection. Anything further on behalf of Defendant?

MS. HALL: Very briefly, Your Honor. The *Banks v. Sunrise* case, 120 Nev. 822, it's a 2004 Nevada Supreme Court case, and it says that expert medical testimony is needed to establish that medical treatment and the costs associated are related to the Defendant's negligence. So it's my position that that is needed in order to have any of the medical billing for past medical treatment entered in this case. So that was the basis of my objection.

THE COURT: Okay. Any response by Plaintiff?

MR. BREEDEN: I have a very long response.

THE COURT: Go ahead.

MR. BREEDEN: Okay. So I need to frame this very clearly for the record. And this concerns both the objections made during Ms. Herda's testimony and some objections that I foresee from the next few witnesses, Your Honor.

THE COURT: Uh-huh.

MR. BREEDEN: Plaintiff will be attempting to introduce evidence of approximately $200,000 in related medical expenses. The Defense has not disclosed anybody who will testify that those are not usual, customary, and reasonable expenses. They have not disclosed anybody who will say that that care was not reasonable and necessary for Ms. Taylor. I have deposed both Dr. Brill and the Defense retained expert, Dr. McCarus. And neither one of them will be stating that they

find anything unreasonable about the medical expenses or any of the subsequent care not to be related.

However, the Defense is not stipulating. They want us to put on some evidence of usual, customary, and reasonable medical expenses and the relatedness of the care. Now, it sounds like we're going to get a parade of highly technical objections from the Defense as we try to put on this evidence. And I want to make procedural and substantive arguments to the Court. Okay.

Procedurally, Your Honor, if the Defense wanted to make these arguments. I think a good idea for them would've been to submit a motion in limine or a motion for summary judgment so these can be completely reviewed and thoroughly reviewed by the Court in advance. We are now at trial.

So I think the best care scenario here is you have to allow the evidence to proceed. If they feel they have a directed verdict -- or a directed verdict motion after presentation of Plaintiff's case, then I guess they can bring that. But there were quite a few problems with the Defense position. And again, I begin with a couple of procedural problems.

The Defense will have to concede that we have disclosed and a retained expert who will talk about the reasonableness and necessity of care, and the relation of that subsequent care to the perforation injuries, as well as the usual, customary, and reasonable nature of the expenses.

Now, if they are challenging the sufficiency of those

disclosures -- okay, in other words, they're saying, hey, they didn't do this, and technically, they should've done this, you know, they disclosed it in this way, but it should've been disclosed in another way, that is a discovery issue. That must be raised first before the Discovery Commissioner. And that allows a 2.34 conference, as well as typically, an opportunity to cure any technical defect by the allegedly offending party under Rule 37 before some sort of sanction, which would include excluded $200,000 in medical bills, is administered. And that comes directly from the Valley Health System v. 8th District Court case, 127 Nev. 167.

Over the last week is the first time I'm hearing any of these objections. And I'll tell you why I think that is in a minute. But it has been waived. It has also been waived under Rule 16.1A because I disclosed all of this information in our pre-trial disclosures when we explained what witnesses are going to appear and what they're going to testify to. And I cannot recall any written objections served within 14 days of that. Okay. The Defense has known this is coming.

Now, more substantively, the Defense is trying to pretend that we have no expert who will indicate that the care that Ms. Taylor received after the perforation is reasonable, necessary, or related to the perforations. And this is all true. First of all, again, both Dr. Brill and Dr. McCarus have not opposed this. They were asked at deposition. They have sworn deposition testimony. And I can certainly use what any other witness in this case has said. Ms. Hall reminding me of that on the perusing motion that was filed, when she wants to use my expert for a

point that she wants.

But in addition to that, if we look at Dr. Berke's report -- and I can provide you with a copy of all this. He plainly says, "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 resection surgery and related care, as well as her course of antibiotics post-op, are all related to the perforations caused by Dr. Brill. Now, I read further. "A summary of my opinions." It says, "David Brill 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."

Now, if the Defense was confused by that, we also made written disclosures, a disclosure statement, where we plainly state, reasonableness and necessity of care. The expert witness, which his Dr. Berke, who is expected to testify tomorrow, is expected to testify that the treatment of various providers stated in his report was reasonable and necessary following the perforation. It seems difficult to imagine that the Defense could not have comprehended that we are going to call Dr. Berke on this issue. And yet they want to make the argument, which has been waived under two different rules, that it has to be presented to the Discovery Commissioner first, and that they haven't objected in our pre-trial witness disclosures.

Now, let me go to the billing issue of usual, customary, and

reasonable charges because that's different form the medical causation and relatedness issues. Okay. The applicable law here is the *Curtis* case. This is really the only case that I'm aware of in Nevada -- of the Nevada Supreme Court that has commented on the level of evidence that you need to present to establish usual, customary, and reasonable charges. Okay.

In the *Curtis* case, they called a doctor, okay, who performed the treatment. And the doctor says, I don't know what's usual and customary, but I think my bill is reasonable. And the Defendant apparently challenged that, took it up on appeal. And the Nevada Supreme Court says you only need a minimal amount of evidence. I think it says substantial evidence. In order to support the reasonableness of charges, that's good enough.

Now, this issue, Judge, is not one that a -- for example, a retained expert witness needs to testify regarding. And in fact, my experience with treating providers is if you call them in, often the doctor will say, you know, I don't really deal with the billing myself, I leave that to my billing folks. Okay.

So in this particular case, we didn't have our retained expert comment on the usual, customary, and reasonable nature of charges. Instead, we have relied on the admissions from the Defendant and the Defense expert, that they are not challenging that. And we disclosed several witnesses, three of which are out in the hall right now waiting to testify. That those folks are going to come into court and say, this is our bill, this is what we charge, we charge from -- you know, we set the fee

schedule, we think our own bill is reasonable. Okay. This is very common, in my experience. This is not earth shattering or something new that I am trying.

However, it appears that about a week ago -- and by the way, so in advance of this trial, months ago, we reached out to these providers, and we said hey, we need a billing representative to testify to these issues, you know, tell us who that is, we'll disclose that apron. And we're going to call them as a witness in trial. Okay. So I had actual names for everybody. I was going to call for that, okay? One of the providers, which is the most reluctant, they did not originally object to any of the subpoenas, nor did Defense counsel. Okay. About a week ago, I get contact from somebody at St. Rose. And they're doing what I would describe as a shell game or a cat and mouse game. And they tell me, we don't want to bring anybody to testify that our own bills are reasonable. And I tell them look, I've given you a valid subpoena, you need to send somebody. Okay.

Now, three of the subpoenas that I did for today name actual people. The St. Rose one doesn't. And the only reason why is we originally -- it was either my staff or me that personally spoke to these folks. We had a name. We subpoenaed that person. They contacted us back and they said, no, no, no, want you to redo the subpoena, do it as building custodian of records and/or person most knowledgeable. So that' the way they did it.

So I find it frustrating that when I reserved that subpoena, St. Rose waiting two weeks until we're mid-trial, and then they file some

sort of attempted motion to quash the subpoena yesterday. Now, I would describe as what some of these providers are doing as trying to sabotage Ms. Taylor's case. Hear no evil, speak no evil, see no evil. If we don't show up and testify to the reasonableness of our own bills, maybe Ms. Taylor won't be able to prove the usual, reasonable, and customary nature of those bills. Now, I've served subpoenas. People have to appear. If they don't appear today to testify to that, I'll issue new subpoenas, or I'll ask you for a bench warrant for a representative from these companies.

I have never experienced in my entire career people that don't want to come to court and testify to the reasonableness of their own bills. Clearly, someone is qualified to do that over there. And I highly doubt they're going to come into court and say, yeah, we charge people like crazy, it's way overbilling, our billing is unreasonable. And even if they did that, Judge, I would have the right to say, well, what do you think a reasonable charge for this bill will be if it's not the face value of the bill. So this is that situation where we are.

THE COURT: Let me pause you for one second. What is the citation for the *Curtis* case?

MR BREEDEN: I'm sorry, Your Honor. I'd have to look it up on my phone. I think it's *Curtis v. Franceschi*.

THE COURT: Okay. I found it now. Go ahead.

MR. BREEDEN: Yeah. And you'll see, it's towards the end of that opinion. And it's one paragraph, I believe.

THE COURT: Okay. You can keep going.

MR. BREEDEN: And the truth is, Your Honor, I think even if I called these witnesses -- and this may be how this hashes out here in a few minutes. I may call on them and I may say, hey, is this your bill? Yup, that's a copy of our bill. You know, do you bill from a set schedule of fees or charges? Yes, that's what we do. Did you charge my client any more or any less than any other person who might have come into the hospital and received the same services on the same day? No, we didn't do that. Do you have any reason to think your bill is for some reason unreasonable in the amount? They'll probably say no. Do you have any reason to think your bill fits for some reason unreasonable in the amount? They'll probably say no. Do you have any reason to think it's not usual and customary for our community? I expect they'll say no.

If they say, I refuse to testify on that issue, then I think you're going to have to direct them to testify, or I'm going to ask them who at your company can testify to that issue? I'll issue a new trial subpoena, and we'll have the people here Monday. But I'm very frustrated with the fact that -- it appears some of the providers -- and I don't know if it's out of spite or because some of the Defense counsel don't like me. I don't know. But they're saying, we don't want to send a witness to help your client and testify truthfully. And that's why we subpoenaed these, folks, so that they can't make those arguments. And that's what I would say for the record.

THE COURT: All right. Hold on, Ms. Hall. Give me one second. All right. Go ahead, Ms. Hall.

MS. HALL: I don't really know where to start. So I will try

not to jump around too much. But I do want to start I guess with the idea that we have somehow waived our right to make contemporaneous objections when Plaintiff's counsel tris to admit medical bills. I don't believe that the defense is quired to in advance tell Plaintiff's counsel. If you try to admit this and you don't have the proper foundation, we will object. Not doing that doesn't waive our right to make contemporaneous objections as evidence is attempted to be admitting it at all.

Mr. Breeden just acknowledged to this Court that he did not have his expert, Dr. Beker, offer an opinion that the billing -- the medical bills are reasonable, necessary, and customary. I would tell this Court that in 15 years, I've had this come up, and I have had this come up with some very experienced plaintiff's counsel who do medical malpractice where they have failed to do that. Where they have failed to have their retained expert comment on the medical bills. And in every single one of those instances, those medical bills have not been admitted. If Mr. Breeden -- let me finish.

If Mr. Breeden has his expert come in here and offer a brand new opinion, which he has just acknowledge has never been offered, that the medical bills are reasonable, necessary, and customary, I absolutely have a right to object to that. But Mr. Breeden hasn't yet presented this for Dr. Berke. We are dealing with laypeople.

And with respect to counsel for St. Rose. Last Thursday, she sent an email to both Mr. Breeden and myself that said, "In communicating with Mr. Breeden, he indicated that the subpoena was

necessary because he wanted the witness from St. Rose to testify to reasonable, necessary, and customary regarding the Dignity Health billing".

And the attorney said that this is not appropriate testimony from a billing custodian. They are not medical people. That is not their job function. All they are is the custodian of the record, and they can say that the subject billing includes these dates of service, the total charges, and they're kept in the regular course. What they can't do without the necessary medical expertise, which is why most people have their retained expert do this, is say that the medical bills are related to the allege negligence. And so that is the basis for our objection.

I certainly -- I don't know. I have not spoken to any of these custodians of record, and I don't know what Mr. Breeden is going to attempt to do with these witnesses. But to the extent that all of them -- as in my experience, most billing custodians have zero medical training. They're not usually a nurse, they're not usually anything at all in terms of medical treatment. They are not qualified. And should they be attempting to elicit testimony from a lay witness for which they are not qualified, I absolutely have a right to object to that on behalf of the Defendants.

And with respect to my expert, Dr. McCarus, as well as Dr. Brill. Neither of those people in this matter have reviewed the medical billing for Ms. Taylor's care and treatment. So the suggestion that they haven't offered an opinion that the medical billing isn't reasonable or isn't necessary or isn't customary or isn't related to the alleged

negligence, that is not my burden. And in order for Plaintiff to get the medical bills admitted, again, that is the burden of the Plaintiff to present that evidence to this Court.

THE COURT: All right. Anything in response, Mr. Breeden?

MR. BREEDEN: A physician does not have to appear in order to testify that bills are usual, customary, and reasonable in amount. Okay, talking about the amount of the charges. And if you ask most physicians, they tell you, I don't do anything with billing. That's my billing department. You know, I've got a whole third-party company that I hired to do the billing. So I don't know anything about the bills. I don't know how much was even billed, let alone what is usually, reasonable, and customary in amount.

Okay. This is why it's routine to call these billing representatives to testify about that. I did not-- when I spoke to these folks and said, who from your organization is going to show up? I didn't say, hey, I just need somebody to say, yup, these are the bills, and walk off the stand. Okay. It is not only disclosed, but I've spoke to the folks and said, I need testimony regarding the usual, customary, and reasonable nature of expenses.

If you rule that a doctor has to come into court and testify on that, that would be the first ruling of that kind I have ever heard of. And I know that Ms. Hall has cited, you know, in her 15 years, these phantom cases, I have to tell you my experience is quite different, Your Honor. And I think this is very typical in a civil case. And again, the reason why you don't call the doctors -- we didn't ask Dr. Hamilton, okay?

Dr. Hamilton, I think her billing was four grand or something to that effect. And I know if I ask her that, she's just going to say, I don't know what was billed. You know, I leave that to the hospital, or I leave that to the -- you know, the clinic I used to work for. So we didn't even try to elicit that from her in this case.

And if you look at the *Curtis* case and cases from other jurisdictions, it is the faintest of evidence that is required to support this. I would even argue, Your Honor, that a bill that is unrebutted by the defense is, by itself, prima facie evidence of a usual, customary, and reasonable amount.

However, I'm going to ask the witnesses again, do you have any reason to think this is an unreasonable bill? Do you have any reason to think it's not usual and customary in our jurisdiction? And if they say no and no, then I guess that's some evidence, combined with the fact that the defense witnesses aren't going to oppose that, that the bill is usual, customary, and reasonable.

THE COURT: Okay. So couple of things since we're clearly all over the place. I do want to also note for the record, even though it's in the record, that on October 8th, counsel for St. Rose -- Dignity Health doing business as St. Rose Dominican Siena did file an objection to your subpoena indicating, I guess, outlines the same email that Ms. Hall just read into the record. To which I did not see your response. I am also reading the *Curtis v. Franceschi* case. And while it does say the award for medical services we believe is supported by substantial evidence, the next sentence says the attending physician testified as to what he

charged, and he believed that the charges were reasonable and that he had no usual and customary fee, and we think such testimony is sufficient.

And other cases that I've read also have typically physicians or some other expert. Now, I'm not saying it has to be a physician, but I don't see how just an average billing person can establish what's reasonable in the community rule -- reasonable, customary in the community. I mean, maybe if it was a top administrator who helped set the rates, that would be different.

Also, I do think it's the Plaintiff's burden to establish what's customary, usual, and reasonable in the community. I don't think that burden is on the Defendant.

MR. BREEDEN: That's who I've tried to subpoena, Judge, is somebody who can come in and talk about the usual, customary, and reasonable nature of these expenses. If the hospital doesn't want to provide it, that's not my issue. The hospital needs to comply with the subpoena.

THE COURT: Okay. So this is what we're going to do. The three witnesses are out there. I'm going to give you -- both sides a chance to voir dire them outside the presence of the jury just to make a complete record. And then I'll make a decision after that. So I'm going to bring the jury back in, go ahead and release them for the night. We'll come back tomorrow after we voir dire these three witnesses to see if you can lay a foundation for it. And if they have any basis of knowledge, obviously, I'm going to allow you to question them outside the presence

so we can see what they say they know or what they don' t know.

And tomorrow, we're set to start at 8:30. Any reason why we can't start at that time?

MR. BREEDEN: No, Your Honor. But I do have a doctor testifying tomorrow first, and it's kind of a firm time commitment for him.

THE COURT: At 8:30?

MR. BREEDEN: At 8:30.

THE COURT: Okay. Then we'll start 8:30.

So I'm going to bring the jury back in, release them until 8:30 tomorrow, and then we'll proceed one by one with the witnesses. Wait, we have one more -- well, we'll do that at the end.

Go ahead. Bring the jury back in.

MR. MCBRIDE: Your Honor, what are you going to do then so -- if you find that these witnesses have admissible information, you're going to have them come back another day? Okay.

THE COURT: Yeah. But we've got to establish that first. You guys aren't having any issues tomorrow outside the presence, right?

THE MARSHAL: All rise for the jury.

THE COURT: Okay.

MR. MCBRIDE: Your guess is as good as mine.

[Jury in at 4:04 p.m.]

THE MARSHAL: The jury is all present, Your Honor.

THE COURT: Thank you. You may be seated.

So our issues are taking a little bit longer than expected. And

rather than have you wait, I'm going to go ahead and release you for the evening. And tomorrow, we'll be back at 8:30, and we're going to go until 3:00 tomorrow. So I'm going to give you the admonishment again just because I have to. But, again, my apologies. We have to deal with some issues, and I just don't want you waiting around. So I'm going to go ahead and release you.

You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any report or commentary on the trial by any person connected with this case by any medium of information including without limitation newspapers, internet or radio, television.

You are not to conduct any research on your own related to this case, such as consulting dictionaries, using the internet or other reference materials, test any theory of the case, recreate any aspect of the case or in any other way learn about the case or investigate on your own. You are not to talk with others, text others, tweet others, google issues or conduct any kind of book or computer research with regard to any issue, party or witness involved in this case. And finally, you are not to form or express any opinion on any subject related to this trial until the case is submitted to you.

I'll see you at 8:30. Thank you so much.

THE MARSHAL: All rise for the jury. Go ahead and leave your notepads closed on your chair. Come on this way, please.

Jury is clear of the courtroom, Your Honor.

[Jury out at 4:06 p.m.]

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. And so who are we going to start with? Does it matter to you?

MR. BREEDEN: It'll be Christy Sandoval.

THE COURT: All right.

THE MARSHAL: Please step up. Please face the clerk to your left, and please raise your right hand.

CHRISTY SANDOVAL , PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state and spell your name for the record.

THE WITNESS: Christy Sandoval. C-H-R-I-S-T-Y, S-A-N-D-O-V-A-L.

VOIR DIRE

BY MR. BREEDEN:

Q Good afternoon, Ms. Sandoval.

A Hi.

Q Where are you employed?

A At -- with Brian Jonathan Lipman's office.

Q Okay.

A Infectious disease.

Q How long have you been employed at that office?

A At the office -- I've been back and forth. I was -- I've been employed with them about three years, but in the office the last six months. I used to work in and out of the office.

Q And what kind of physician is Dr. Lipman?

A Infectious disease.

Q And is he a solo practitioner or does he have a company where he practices with other doctors?

A He is the president of his practice, and he does have some nurse practitioners that work under him.

Q And what's your job position or title there?

A A little bit of everything. Personal assistant to his wife, administrator. I do the credentialing for the insurances. And I do some of the hospital billing, processing that to send that with the proper diagnosis codes to the billing department. And then I also do medical records requests for the office as well. Schedule.

Q Okay. So explain to me your involvement in the billing process.

A In the billing process. Basically, if an attorney asks for medical records in billing, I contact my billing department. They send me over the billing ledger, and then I submit that to the attorney's office.

Q Okay. Now, before you came to court here today, did you familiarize yourself with the billing account of my client, Kimberly Taylor?

A The only knowledge that I have on that because her chart is in archives is the billing ledger that I submitted to your office.

Q Okay. And what's the amount of that billing?

A I think it was around 20,000, I believe.

MR. BREEDEN: Your Honor, I'd like to show the witness something to refresh her recollection.

THE COURT: Okay.

[Witness reviews document]

BY MR. BREEDEN:

Q Handing you the document, does that refresh your recollection about the exact total of the billing for Ms. Taylor?

A Hold on. Yes. That's what I did submit to you.

Q And so what is the exact total to the penny?

A The exact total on the ledger is 20,800 -- and I think that's -- is that a 6.45?

Q Can you just state it again so it's clear for the record?

A $20,805 -- I can't -- because of the copy, I can't tell if it's 5 or 6 -- and 45 cents.

Q Okay. So within a dollar, you've told us what the amount of the bill is?

A Correct. Yes.

Q All right. How is the amount of Dr. Lipman's charges or billing determined?

A I mean, I'm not a billing manager, so I would say going by the insurance companies. As protocol for any medical office, you submit the billing to the insurance company, if it's through the insurance. If it's through a lien, then you submit it through the lien. If it's through a workman's comp, you submit it through the workman's comp.

Q Who is the billing manager of the office?

A Julie Urda. She owes the -- she' a CERD. She is the one who processes the billing for Dr. Lipman's office for hospital billing and in-

office billing.

Q Can you spell her last name?

A J-U-R-D-A. Pro -- I believe it's ProActive Medical Solutions Office.

Q Do you know where the office location is?

A The office location here is in Las Vegas. It's, I believe, on Durango. And she works from her home office in San Diego.

Q Do you know is the billing determined from a standard schedule of charges?

A Whatever is protocol for the insurance companies. So a standard protocol, I would say yeah.

Q Okay. So as far as you know, there is a standard schedule of fees -- charges?

A Whatever the -- when it comes to insurances, you basically -- it depends on if the patient has met their out-of-pocket deductible, their -- you have the deductible, you have their out of pocket, if there's a coinsurance. There's a lot of things that go into play for how the -- how the billing is processed.

Q Okay. And I don't mean in terms of deductibles and so forth. I mean the total amount of the charges. The 20,000 or so there; is that determined from a set schedule that Dr. Lipman or one of his billing people has?

A Well, you have billing codes that they would -- they would follow.

Q Okay.

A So whatever the billing code and the allowable amount to bill, then that's what the billing code is. It would go by the billing codes.

Q Okay. So the office uses standard codes, and based on those codes, it generates the amount of the bill?

A Correct.

Q Okay. How many bills from Dr. Lipman's office have you seen in your time there?

A We don't directly see the bills. The patients get a ledger from the -- mailed to them, so they usually call in to make a payment on those. If they -- when they call in and they ask me what their total balance is, I have to contact our billing department to get that total balance because I do not have access to the billing portion.

Q Do you have any reason to believe that Ms. Taylor was billed anything more or anything less than any other patient seen in Dr. Lipman's office for the same services would be charged?

A I have never came in contact with her. I don't -- I have never seen her medical records file completely. So I really can't comment on that as far as if she was -- how can I -- how can say it? If she was singled out, if that's what you are stating. I have no knowledge of that whatsoever.

Q Okay. So you have no reason to believe that occurred?

A Not -- no, not to my knowledge.

Q Do you have any reason to believe that the amount of the bill, the 20-some-thousand, that that is unreasonable for some reason?

A Because I have no seen her exact medical records chart or

know exactly what -- I don't know if she went into infusion. I don't know what exactly she did. I believe these bills come from 2017. And at that -- at that moment, I was not in the office to have personally engaged with her or know exactly what procedure she had done or checked her out to see what billing code that we billed for.

Q My question is do you have any reason to believe the amount of that billing is unreasonable for some reason?

A I don't know exactly the procedure she had, so I wouldn't be able to say. If she was -- if I knew she did exactly -- just all the confusion and that her insurance didn't cover a certain portion, then I would. I -- unfortunately, I can't give you a direct answer on that.

Q Okay. So excluding any issue of insurance rates or reimbursements, do you have any reason to think the amount of the bill is unreasonable?

A I don't know her medical record history. I've never seen those medical records, so I can't say that --

Q So you have no reason to believe the bill is unreasonable?

A With her medical -- without seeing her medical records or processing that, I can't say it's not an unreasonable amount.

Q Do you have any reason to believe that the bills, for some reason, are not usual and customary?

A Not usual and customary. Again, without knowing exactly what she was exactly seen for and seeing her and processing her billing myself, I can't say that they overcharged her or undercharged her.

Q Okay. If you are not the person associated with Dr. Lipman's

office that has the most knowledge about billing and how bills are calculated and what amounts are reasonable, usual, and customary, who would that be?

A To give you your exact answer for this would be Julie Urda.

MR. BREEDEN: Okay. Thank you. I have no further questions.

THE COURT: Thank you. On behalf of Defense?

MS. HALL: Thank you, Your Honor.

VOIR DIRE

BY MS. HALL:

Q Good evening, Ms. Sandoval.

A Hi.

Q My name is Heather Hall. I will try to be brief. I just have some -- a few questions for you. A minute ago, Counsel asked you if you could say whether -- if you had any reason to believe the billing provided to the patient was unreasonable. Is it true that you also -- you can't comment one way or another?

A Correct.

Q You can't say that it's unreasonable and you can't say that it's reasonable.

A Correct.

Q And that's because you personally -- do you have any involvement in setting the rates of charges to a patient at Dr. Lipman's office?

A Absolutely not.

Q Have you ever worked for any other infectious disease doctors here in Las Vegas?

A No.

Q Have you ever compared Dr. Lipman's billing on any patient, including Ms. Taylor, to charges from some other infectious disease doctor here in Las Vegas?

A No.

Q And in terms of the rate that is charged, are you able to say one way or another whether the rate Dr. Lipman's office charges is customary compared to other infectious disease doctors here in Las Vegas?

A No, because I've never worked for another infectious disease office.

Q And with respect to Ms. Taylor's medical records, you said you've never reviewed those?

A No.

MS. HALL: Thank you.

THE COURT: Any redirect?

MR. BREEDEN: Nothing further, Your Honor.

THE COURT: All right. Thank you. Could you wait outside in the hallway, please? Thank you so much. And who are you going to call next?

MR. BREEDEN: I call Tina Burch.

THE MARSHAL: Please step up. Please face the Court to your left and please raise your right hand.

TINA BURCH, PLAINTIFF'S WITNESS, SWORN

THE CLERK: Please be seated. Please state and spell your name for the record.

THE WITNESS: Tina Burch, T-I-N-A, B-U-R-C-H.

VOIR DIRE

BY MR. BREEDEN:

Q Good afternoon, Ms. Burch.

A Hi.

Q What do you do for a living?

A I am the customer service billing manager for UHS of Delaware.

Q Okay. Explain how UHS of Delaware is associated with Henderson Hospital.

A We contract with the facility. Henderson Hospital is one of our facilities.

Q And specifically, do you contract with them to handle medical billing?

A We do. I'm just the billing manager for the Henderson Hospital. So that's my part in UHS. And then, I'm not sure.

Q How long have you been the billing manager for Henderson Hospital?

A For six months.

Q Prior to that, what was your experience in medical billing?

A I've been doing it for about three years.

Q And has that entire time been in Las Vegas?

A For the three years, yes.
Q Okay. What other hospitals or companies have you worked for in the -- as a billing manager or a billing representative?
A Billing representative, just for UHS of Delaware.
Q Well, what other hospitals associated with UHS of Delaware, then?
A We have 12 facilities.
Q Do you have experience working with each of those 12 facilities?
A Correct.
Q And doing the billing for each?
A Correct.
Q And are those 12 facilities all in Clark County, Nevada?
A No.
Q How many of them are in Clark County?
A Seven. Well, we have one in northern Nevada. I don't know if that's considered Clark County.
Q Well, if it's in northern Nevada, it's probably Washoe County.
A Yeah. I --
Q You mean the Reno area?
A Yeah. I'm not familiar with the area. I've only been here for a short time.
Q Okay. So you have at least six hospitals in Clark County. What hospitals are those?
A We have Henderson, Spring Valley, Valley, Centennial,

Summerlin. I feel like I'm missing one. Desert Springs.

Q Prior to coming to court today, did you familiarize yourself with the billing account of my client, Kimberly Taylor?

A I have seen the bill.

Q Okay. Now, how is it that the amount of the charges for the hospital bills from Henderson Hospital are determined?

A It's not determined by myself. So I have no knowledge of that.

Q Okay.

A What those charges are determined by.

Q Does it come from a standard schedule of charges?

A I have no knowledge of that.

Q Does it come from coders that work in the billing department?

A I am not sure who comes up with the charges.

Q Okay. Who would know that at UHS or Henderson Hospital?

A You would have to check with the facility. We just get -- when we get the bill, the charges are already there. I don't come up with the charges or the amounts.

Q What department or what entity determines the amount of the charges?

A It would go back to that facility. I don't know the department who comes up with the charges. I would definitely try to check with that facility. We just do the bills. So when we get the bill, the charges are already there.

Q Who is the manager of the central business office at Henderson Hospital?

A We -- there's multiple managers for different departments. I'm not sure what you --

Q Can you provide me with their names and the department?

A I only know the CEO for Henderson, who is Sam Kaufman.

Q There are some white trial exhibits behind you. I'd like you to turn to Exhibit 57. Can you find that in there?

MR. BREEDEN: Which volume is that, Kristy?

MS. JOHNSON: Five. Four.

BY MR. BREEDEN:

Q It's in volume 4, the last book on the right if they're in order.

A And I'm sorry, you said 57?

Q 57, please. Okay. What is that exhibit?

A This is our itemized bill.

Q Okay. For which patient?

A It's showing here Kimberly Taylor.

Q What dates does the bill cover?

A I don't -- I'm only showing here the admission date from 4/26 of 2017.

MR. BREEDEN: Okay. And you know, Your Honor, since we're just doing voir dire, do you mind if I put that up?

THE COURT: Go ahead.

MR. BREEDEN: Okay. Just put it up, Kristy. Give me the next page, please.

BY MR. BREEDEN:

Q And what was the total amount of the bill for the service date of 4/26?

MR. BREEDEN: Leave it at 2, please, Kristy.

THE WITNESS: The total amount here is $40,465.

MR. BREEDEN: Kristy, 2, please?

MS. JOHNSON: Okay.

MR. BREEDEN: Okay, go to 3. I need the paper copy, please. Will you pull it? Just a moment, Your Honor.

BY MR. BREEDEN:

Q And what was the total amount of the bill again? I'll refer you to HH Bills 3.

A Yeah. So the total charge here is $40,465.

Q Okay. And there's a breakdown of the expenses as well. How much of that bill is for pharmacy services?

A According to the bill here, I'm showing the 2,201 as well as the $28.

Q And how much is for medical/surgical supply?

A $41.

Q How much is for laboratory services?

A $1,043.

Q How much is for anesthesia services?

A $7,171.

Q How much is for operating room charges?

A $16,020.

Q And how much is for recovery room charges?
A 13,961.
Q Recovery room, would that refer to the PACU?
A I'm sorry, I have no knowledge of that. I'm not a clinician.
Q Okay. Do you have any reason to believe that Ms. Taylor was charged anything more or anything less than any other patient presenting to the hospital receiving the same services?
A Yeah, I'm not sure.
Q Do you have any reason to believe that the amount of these charges is unreasonable for some reason?
A Not to my knowledge.
Q Do you have any reason to believe that the amount of those charges is for some reason not usual and customary?
A Not to my knowledge.
Q Okay. Who at Henderson Hospital would have more knowledge about this bill and how it's created than you?
A I would -- you would have to check with someone at the facility who actually comes up with the pricing. It wouldn't be me.
Q Who would that be or what department would they work in?
A Yeah, I'm not sure. I don't work at the facility. Again, we only -- once the bill drops, we -- the pricing is already there. I don't control the pricing.
Q Do you know what department it would be?
A I do not.
Q Okay. Are you aware that we sought the custodian of billing

records and person most knowledgeable as to billing today?

A I am not aware.

Q Okay. Would you agree with me that you're probably not the person with the most knowledge regarding this bill?

A I would agree.

MR. BREEDEN: I have no further questions, Your Honor.

THE COURT: Thank you. Cross?

VOIR DIRE

BY MS. HALL:

Q Hello.

A Hi.

Q You said you're the billing manager at Henderson Hospital?

A Yes, correct. I work for UHS.

Q And I'm sorry, that's right. You said UHS of Delaware.

A Correct.

Q And as billing manager, you said you are not a clinician. What did you mean by that?

A I don't know the medical specifics about the description on the bill.

Q And does that mean, Ms. Burch, that you are not -- based on your background and the expertise that you have in billing, you are not qualified to talk about whether the medical treatment and the costs associated with that are reasonable or unreasonable?

A Correct.

MS. HALL: All right. Thank you.

THE WITNESS: Thank you.

MR. BREEDEN: Nothing further from this particular witness.

THE COURT: Thank you. Can I just have you wait outside, please, for a couple minutes?

THE WITNESS: Sure.

THE COURT: Thank you so much, Ms. Burch.

THE WITNESS: You're welcome.

THE COURT: And lastly, we're calling? Mr. Breeden, who's the last one?

MR. BREEDEN: It's a representative from St. Rose Hospital.

THE COURT: Thank you.

THE MARSHAL: Please step up. Please face the Court to your left and please raise your right hand.

BRIAN KLEVEN, PLAINTIFF'S WITNESS, SWORN

THE WITNESS: I do.

THE CLERK: Please be seated.

THE WITNESS: Thank you.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Certainly. My name is Brian, B-R-I-A-N, last name Kleven, K-L-E-V-E-N.

VOIR DIRE

BY MR. BREEDEN:

Q Mr. Kleven, where are you employed?

A I'm employed at Dignity Health St. Rose.

Q Okay. And is that specifically the St. Rose Siena campus or

does that encompass other hospital campuses?

A I am the Nevada market chief financial officer, so I am the CFO for all of our entities in Nevada.

Q Okay. And so how many different entities in Nevada does the company have?

A There are three distinct hospitals. So that would be the Siena campus, San Martin campus, Rose de Lima campus. I'm also the CFO locally for the medical group. And then, there are four joint ventures that report up into me, but they are managed by separate entities.

Q Okay. And as CFO, how many employees work underneath you?

A Directly or across the whole hospital?

Q Well, we'll say directly.

A I do not know specifically. I'm going to guess around a hundred to 200 people.

Q Okay. And how long have you had the position of CFO?

A I've been a CFO for about 13 years in various capacities. I've been the Nevada market CFO for Dignity Health for about two years.

Q Okay. And so give us an idea of your background and history in the medical billing industry.

A So I mean, I've been a CFO since I was about 29. I was at a hospital in San Diego prior to moving to Las Vegas about six years ago. So I oversee all the financial operations of our entities and the previous ones that I've been a CFO for.

Q Okay. And as CFO, what are your duties and responsibilities when it comes to patient billing?

A I ensure that we follow laws and regulations, particularly for CMS, the Center for Medicare and Medicaid Services. But also our contracts with third-party payers, other health insurance companies. I also manage reporting earnings and other financial reports for Dignity Health -- for my entities and reporting up into the structure. I manage the finance departments at the hospital, oversee revenue cycle, treasury operations, and other financial aspects of the company.

Q Okay. And what department or departments are involved with patient billing, and if separate, the determination of the amount of charges that patients receive?

A There's no differentiation when we charge a patient. We charge all patients the same for the services that are performed across our hospitals. There is a charge master that for each service or procedure or item, it's a set, level charge that is uniformly applied to all patients.

Q And would that be the same for in April of 2017?

A It may, yes. It changes over time. Sometimes we do increases or decreases year to year. But at that point in time, same thing.

Q Okay. And so how does coding for billing charges and actually getting a bill out to a patient work? How does that happen?

A Complex question. Coding is a separate thing. So for the gross charge that is seen on a statement, that is entered by the staff in

the various departments that perform those services. So if you're in an operating room, the operating room is entering those charges. If you're in a cath lab, the cath lab would enter those charges. If you're in the emergency room, the emergency room would enter those charges. And then it goes into a scrubber to then be billed according to law. So there are some things that would be scrubbed out, say, like a band aid or something. But everyone is charged the same, equally, based on what is legally required.

Q And so the general flow is people who are administering treatment enter certain codes, and that generates a bill from a set or standard schedule of charges; is that how it works?

A No, they enter the set line. So if you're in an operating room and you're charged for a certain device, and then maybe operating room time, someone in that department will key the gross charge of that accordingly to our charge master, and then it eventually makes it way to a bill to be billed out accordingly to the payers. The insurance companies is the payers I'm referring to.

Q Okay. And not everyone has insurance, right?

A That's correct.

Q Okay. Is the gross charge to all patients the same, regardless of whether they do or do not have insurance?

A Yes.

Q So the insurance charge is a separately negotiated reimbursement rate with whatever the particular third-party payer is?

A Not an insurance charge. The rate we are paid would be

according to a contract.

Q Okay.

A The charge is the same.

Q Yes. I'm sorry, I used bad terminology.

A Yeah.

Q So in your industry, the charge means the gross charge to the patient, correct?

A Correct. Correct.

Q And then the reimbursement rate is sometimes different, depending upon whether, for example, it's private insurance or Medicare or Medicaid that might be paid?

A Yes.

Q Okay. I'd like you to -- oh, I'm sorry, did you familiarize yourself with the billing account of my client, Kimberly Taylor, from the 2017 timeframe prior to today?

A No, not particularly. I was called as the custodian of records, so I signed an affidavit that these are the charges for those accounts, but I didn't familiarize myself with it.

Q But you would agree with me that you have a lot of knowledge about how bills and the amounts of charges from St. Rose Hospital are generated?

A Yes.

Q In fact, you're the CFO. Would you be the top guy on that issue at the hospital?

A Yes. Here in Nevada, yes.

Q I'd like you to turn to Exhibit 53. And I think there's some binders there behind you. It's probably in volume 4.

THE COURT: He's going to put you to work for a little while.

MR. BREEDEN: Which one?

BY MR. BREEDEN:

Q Volume 4, Exhibit 53.

A Yeah. Okay.

Q I'd like to direct your attention -- so there are bates -- well, first of all, let's just talk about this exhibit, generally. What does this exhibit appear to be?

A It looks like a UB, a universal bill, a UB-04.

Q Okay. Go ahead and leaf through all of the pages and tell me, you know, are some bills -- would you describe them as different, or you describe the whole thing as a UB?

A Some are -- some appear itemized, so it's not all UB. Some also -- these look -- this one looks like, maybe a denial of some sort from an insurance company. So it's not all -- here's a letter from Aetna, so yeah, that's not the UB, but most of the form -- the other forms are universal bills, UB-04s.

Q Okay. And I'd like to direct your attention, and if you look at the bottom right, you'll see what's called Bate's numbers. There's one that's called SRDHB-2. Can you find that page?

A I found it.

Q What is that?

A That's an itemized bill.

Q And for what date of service or admission?
A Oh, I'll find it. 4/26/2017.
Q Okay. And does this appear to be for emergency room charges?
A Let me take a quick look. It looks like an emergency level is charged, yes. I see an AR level charge and then various other lab charges and CT imaging studies.
Q Is this itemized bill part of the hospital's ordinary business records kept by your company?
A Yes, it appears so, yes.
Q And --
A And I signed the affidavit of that, so yes.
Q And are these bills created at or near the time of treatment?
A Yes.
Q What is the total amount of billing for this date of service?
A For this one, the total is at the -- it's kind of at the bottom. You can kind of see it there. I want to make sure I'm reading it right. 17552.
Q Okay. And there's a breakdown as well, so I'm going to ask you, what portion of that bill is for cardio diagnostic services?
A I can't -- you would need a medical expert to answer that.
Q I'm sorry, if you look just above the grand total, you'll see summary of current charges.
A Yeah, it summarized them. So you asked cardio diagnostics?
Q Yes.

A 986.
Q And what portion of the bill is for CT scan?
A 9,599.
Q What portion of the bill is for clinic and laboratory services?
A 2,606.
Q What portion is for pharmacy services?
A 581.
Q And what portion is for the emergency department?
A 3,780.
Q Okay. Do you have any reason to believe that the charges on this bill for Ms. Taylor are any more or any less than what any other patient receiving those services on that day would have been charged?
A No.
Q Does the hospital consider these rates to be reasonable?
A Reasonable to what?
Q Reason --
A These -- these are the charges that we charge at that time.
Q Okay. And are those, in your opinion, reasonable charges?
A Relative to, like, market?
Q Yes.
A I can only speak for St. Rose and Dignity Health. I really can't establish that.
Q So speaking for St. Rose and Dignity Health, does the hospital consider its own charges here to be reasonable?
A These charges are exactly what we would charge anybody

else with a similar -- similar stay or similar line item charges, we charge equally across the board.

Q And do you also consider them to be usual and customary for Clark County, Nevada?

A I don't know if I -- as the custodian of records, I would only be saying that these are the charges that we charge patients at this point in time, equally. And at St. Rose, we would charge the same.

Q Okay. But you're the CFO for the entire hospital for billing and financial issues, correct?

A Yes.

Q Okay. So you do have some knowledge about how the hospital bills and what amounts, and what -- how the charges are determined, correct?

A Yes.

Q Okay. And I'll ask the same questions, but a little differently. Do you have any reason to believe that this particular bill, for some reason contains charges that are unreasonable in amount, or inconsistent with what you charge from your schedule?

A No.

Q Do you have any reason to believe that for some reason these charges are not usual and customary in the amount?

A Not for St. Rose Dignity Health, no.

Q Okay. I'd like you to turn a few pages for me. Please turn to SRDHB-22.

A Okay.

Q Can you explain to me what that page is?

A It looks like a bill generated for date of service 4/27 of 2017, but through a discharge of May 6, 2017.

Q Okay. And do these appear to be for hospital services? A stay in the hospital?

A Yes, it looks like a bill.

Q What's the total amount of that bill?

A One -- sorry, I want to make sure I'm on the bottom. 127,442.12.

Q Okay. And I'm not going to go through them individually, but does this bill also itemize what parts of that bill are associated with certain services? For example, private room, surgery services, ultrasound, et cetera?

A Yes, I see them listed, so like, yeah, surgery, yes.

Q Okay. And do you also consider the amount of the charges on this bill to be reasonable?

A For Dignity Health St. Rose, these are the charge rates at that point in time.

Q And do you also consider the charges on this to be usual and customary?

A For Dignity Health, yes. I can't answer relative to market.

Q Okay. Well, so if the judge, for example, required me to bring somebody in from Henderson Hospital to talk about the entire market and how charges from maybe one hospital to another in the entire market differ, who would that be at your hospital?

A I don't know if I can answer that. I don't know.

Q You don't know. You don't think there would be anybody at the hospital who could testify?

A There certainly could be. I mean, I'm called here as a custodian of record, but -- and I -- you know, the affidavit says everything that I would say here. I would say these are charges that were appropriate at the time for Dignity Health St. Rose, and we charge everybody the same, as you asked me.

Q Okay. And again, Dignity St. Rose has multiple hospitals in Clark County?

A Correct. We charge the same between our hospitals. I don't have a problem saying that.

Q And just -- I just want to ask similar questions in a slightly different wording. These charges here, the 127,442.12, on 22, do you have any reason to believe that those charges, the amount is unreasonable?

A No, not from my perspective.

Q Do you have any reason to believe those charges are for summaries and not usual and customary?

A No, these are the rates we charge at that point in time.

Q Okay. Thank you.

MR. BREEDEN: I have no further questions.

THE COURT: Cross.

VOIR DIRE

BY MS. HALL:

Q Good afternoon.

A Good afternoon.

Q Mr. Kleven, my name's Heather Hall. I just have a few questions for you. You said that you can only speak to St. Rose and the charges from St. Rose, is that because you are not familiar with the charges other hospital systems here in Las Vegas charge?

A That's correct, I do not know specific line item charges of other hospitals.

Q And do you, sir -- I know you mentioned that you're a CFO, but do you have any medical training? Like are you a nurse or a doctor? Do you have any training like that?

A No.

Q And is it true, Mr. Kleven, that you are not able to say, with regard to the specific care that Ms. Taylor received at St. Rose, you can identify the billing record, correct?

A Yes.

Q You can tell us what charges were charged to Ms. Taylor, correct?

A Yes.

Q That you cannot tell us whether the medical treatment and costs associated with that are reasonable or unreasonable?

MR. BREEDEN: Object as asked and answered.

THE COURT: It's cross. Go ahead.

BY MS. HALL:

Q Do you need me to repeat that for you?

A I'm sorry, I couldn't hear what she --

THE COURT: You can answer the question.

THE WITNESS: Oh, yes, I cannot speak to the medical side of it at all.

BY MS. HALL:

Q In fact --

A I have no training.

Q And in fact, Mr. Kleven, can you even tell us why Ms. Taylor was ever hospitalized at St. Rose Hospital?

A No, you would need a medical expert for that.

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

THE COURT: Thank you.

MR. BREEDEN: Nothing further from this witness, Your Honor.

THE COURT: All right. I'm going to ask that you wait outside for a few minutes. Sorry, I know it's almost 5:00.

THE WITNESS: No problem.

THE COURT: Thank you. I appreciate it.

THE WITNESS: Thank you.

MR. BREEDEN: Thank you, sir.

THE COURT: All right. On behalf of the Plaintiff.

MR. BREEDEN: Yes, Your Honor. I think the standard that the Defense is proposing here is that we have to call a witness who has conducted a gigantic survey of all providers in Clark County, Nevada, carefully compared them per itemized charge or CPT code, and can

testify that they've performed this extensive research and come in here and testify to that. That is not the legal standard. That is incredibly far from the laxed standard that the Curtis case set forth.

Now, I will say to you that the testimony of Mr. Kleven -- I mean, they literally brought in the CFO of the hospital, who has worked in billing. He testified these are standard charges that would be from any patient that went to these hospitals and receive the same treatment. He works, not just for one hospital, he works for multiple hospitals. He actually works for Dignity Health, which was an extremely large company.

If there's a suggestion from the Defense that I have to call somebody who's gone out and surveyed all the doctors and all the hospitals in the county, first of all, Judge, that information is not relative -- readily available to everyone. Some folks keep their billing amounts private, and that's confidential. That's proprietary, so that can't be done.

At least as to St. Rose, I don't know what more you would want me to do as Plaintiff's counsel then to literally call the CFO of a multi hospital group to testify about the usual customary and reasonable nature of the charges.

Now, the other two, I've subpoenaed somebody to come into court and testify about the billing. The people I was told could testify to that came in and they did not have a great deal of information. They had some information, and I think that's enough to put in front of the jury and have the jury decide. They were cross-examined. The jury can

determine if for some reason, combined with the fact that the Defense offers no rebuttal evidence, and that the Defense -- the Defendant and the Defense's retained expert aren't even going to dispute the usual customary and reasonable nature of the charges, that that is enough for the jury to decide. Okay. Especially since we have a bill, which on its face, is the same bill that anyone else would receive for the similar charges.

I will say that if you don't find that for Dr. Lipman and Henderson Hospital, I should have the right to issue a trial subpoena for the folks that those witnesses said would have more knowledge than them on this particular subject.

Okay. We've reached out to these witnesses and these medical offices. We asked them who should be called. We subpoenaed those folks. If you have a problem with the information that they have, you know, I interviewed them, and it seemed -- and particularly with Tina Burch, I mean, I spoke to Tina Burch personally on the phone and was told that she could testify that these bills were reasonable an amount.

And I don't know what's going on here. I don't accuse Mr. McBride or Ms. Hall of anything funny here, but I don't understand why these providers don't want to provide a witness to testify that their own bills are reasonable. I think that's very simple testimony, and I can issue a trial subpoena tomorrow for the CEO, Sam Kaufman, of the hospital. And there was another witness that I would subpoena, Julie Urda, and we can have them testifying on Monday, I guess. But I subpoenaed witnesses to testify as to certain knowledge. And what I was sent was

witnesses that didn't have that knowledge. And that's the argument that I would make.

THE COURT: On behalf of Defendant.

MS. HALL: Very briefly, Your Honor. The voir dire that we did of these three witnesses just further established that none of them are qualified to talk about whether the medical treatment and costs associated were reasonable, necessary, and customary. And under the Banks' [phonetic] decision, and my understanding of evidence and admissibility, I don't believe that I am required to bring in a witness to disprove admissibility of a medical bill. I think the foundation has to be laid first by the Plaintiff to have it admitted. And I don't think that any of these three witnesses have the necessary expertise to offer an opinion on reasonable, necessary, and customary for the bills. And without that, I don't think that the bills should be admitted.

THE COURT: Ms. Hall, what about, specifically to Mr. Kleven, I mean, arguably, he had more information. And granted, it's not on the medical basis and it's only for St. Rose, but anything in particular to him?

MS. HALL: Sure. He said I can only speak to St. Rose. I'm not familiar with the market. I'm not familiar with Las Vegas at large. All I can tell you is this is what we would charge at St. Rose. So again, although he has somewhat more -- you know, a little more information than Ms. Sandoval or Ms. Burch, he still doesn't have the necessary expertise to offer that foundational opinion to get those bills in. He even said, you know, he didn't know why she was hospitalized at St. Rose.

THE COURT: Anything in response, Mr. Breeden?

MR. BREEDEN: He's the CFO of three different hospitals in town, Your Honor. And I mean, where does this stop? I mean, who could possibly have more information than him about the reasonableness of that bill?

And what the Defense only wants here is an impossible standard. And I could tell you, I've never seen anything like this even argued in my 18, 19 years as an attorney in this jurisdiction. Very typical; you call a billing person. They say this is the amount of our bill. We think it's reasonable; that's enough to go to the jury. That was certainly enough to go to the jury in the *Curtis* case.

In the *Curtis* case --

THE COURT: But it was the doctor there though? That's the difference. I just read you from the opinion that you cited that it was a doctor.

MR. BREEDEN: Yes. A person with knowledge.

THE COURT: It's kind of going against your argument though. It wasn't a billing person; it was the doctor who was able to say that bill was reasonable and customary based on the medical treatment that he provided?

MR. BREEDEN: My position is that any person who has sufficient knowledge, it can be a billing representative, it can be a third-party -- you know, there's third party billing companies for these doctors and legal entities, hospitals. It could be the physician themselves. Any of those types of witnesses can come in and look at the bill and say yes, I think that's reasonable. And that was the exact type of testimony in

Curtis.

In *Curtis*, if you read the little blurb, they actually -- the doctor in that case didn't even say it's usual and customary. He testified, I don't really know what's usual and customary, but I think my bill's reasonable. And the Nevada Supreme Court said yeah, that's enough. You know, we don't need this multi-city survey of what every different doctor in every different hospital is charging. That would be virtually impossible to get anyway. Because again, some of those charges and schedules, that's proprietary information. So that's my position.

THE COURT: Right. But I think that even in -- and even in that case, he's saying that it's reasonable based on the treatment that he provided. So he has that personal knowledge. I'm not disagreeing that maybe potentially a billing person could, but I -- they all said here today, each of them, and obviously Mr. Kleven had a little more information, but to say that it was customary, usual and reasonable -- even to just reasonable as to the medical community, nobody said that today. I mean do you disagree.

MR. BREEDEN: I strongly disagree.

THE COURT: Who said that?

MR. BREEDEN: We just had a CFO that -- he's a CFO of three different major hospitals here in the county.

THE COURT: Who said he could not say it was customary in the community, only for St. Rose?

MR. BREEDEN: He's --

THE COURT: There's a difference.

MR. BREEDEN: He explained to you -- so now I have to ask him to go work for some other hospitals and come back and ask to compare with those charges?

THE COURT: That's not what I said.

MR. BREEDEN: What's the standard here, Judge? What would satisfy you?

THE COURT: Well, I just pointed you to the case that you sent me to read, and it seems like your physician should have testified to this.

MR. BREEDEN: So you think only a physician can testify to billing issue?

THE COURT: No, you just heard what I said. I said I don't disagree that a billing person could. I said that these people did not establish that they could.

MR. BREEDEN: So a billing person can only testify to this if they come in here, and they say I've done an extensive survey of all medical providers and hospitals in our community, and I have carefully compared the bills. And I can tell you that these bills are usual, customary and reasonable. Is that the standard you're setting forth?

THE COURT: No, you making an exaggeration doesn't change what I'm saying. They have to have a basis of personal knowledge. A basis to establish that it's reasonable based on the medical treatment that was given. And that is not what I heard today.

I didn't say they had to survey everything, because I'm sure some of these doctors didn't. But they also do know what they charge

for procedures.

MR. BREEDEN: I have nothing more to say on this issue. I think the law is extremely clear. I can't -- especially as to St. Rose Hospital, I can't imagine what more I could get a witness to testify to. And it just seems like you don't want anyone other than a physician to testify on this issue, and that is incorrect under the law.

THE COURT: I repeatedly said that's not the case.

Okay. As to -- I'm not going to allow the testimony of the first two. And I believe that is Christy Sandoval and Tina Burch, but I need to -- I want to look at a couple more cases as to Brian Kleven. And if I do allow Kleven, it will be limited to St. Rose and Dignity Health. So I'm going to call them all back in. I'm going to release those two. And then as to Brian Kleven -- Mr. Breeden, you said you had someone already coming at 8:30, right?

MR. BREEDEN: Correct.

THE COURT: So if I tell him we'll make a decision, and then did you have someone right after him as well? After the 8:30?

MR. BREEDEN: Yes.

THE COURT: Would you prefer that I tell Mr. Kleven I'm going to allow it after lunch, or does it matter? I don't want to mess up your case but if I allow it, obviously, I'm trying to --

MR. BREEDEN: Mr. Kleven's testimony will be what, 15 minutes? I don't think it will be long. We can probably squeeze him in right after the first witness who is a doctor.

THE COURT: Okay. And your first witness, how long do you

anticipate?

MR. MCBRIDE: That's Dr. Yeh, the anesthesiologist. I can't say for certain, Your Honor, but I don't think it will be a long witness. I would be surprised if he testified -- I mean, I can't control what cross is, but maybe 45 minutes.

THE COURT: So I would probably say 10:00 to be safe?

MR. BREEDEN: Well, I don't want a CFO of a hospital waiting around for two days, but I would like to have people back to back. And maybe if we could have him here around 9:15.

THE COURT: All right. Ray?

THE MARSHAL: Yes, ma'am.

THE COURT: Can you bring in Mr. Kleven, please?

THE MARSHAL: Yes, ma'am. Judge, I'm sorry, can you repeat the name?

THE COURT: Brian Kleven.

THE MARSHAL: I'm sorry.

THE COURT: Mr. Kleven so sorry to keep you, and to ask you -- you can just stand right there. I'm going to make a decision as to whether or not you're going to testify tomorrow. Can you leave your contact information with my marshal, and he will let you know. But as of now, I'm going to ask that you come back at 9:15 and testify. They indicated it's only going to be about 15 to 20 minutes. And if for some reason I make a decision that you won't, we will contact you and let you know that you don't need to appear.

MR. KLEVEN: Okay. What if I'm not available tomorrow at

9:15? I don't know. I'm going to check. How does that work?

THE COURT: I need you to be available.

MR. KLEVEN: You're like I'm the Judge. Okay. I can make it work.

THE COURT: All right. So I'll see tomorrow. And again if for any reason that changes, my marshal will contact you.

MR. KLEVEN: Thank you, Your Honor.

THE COURT: Thank you, so much, I appreciate it.

MR. KLEVEN: Thank you.

THE COURT: And then Ray the other two. Well, one at a time. Whoever is out there.

Hello. Thank you for your testimony, we appreciate it. And I just want to tell you, you're not going to be needed anymore, so we appreciate you coming.

MS. BURCH: Okay. thank you.

THE COURT: Thank you. Have a great day.

MS. BURCH: You, too.

THE COURT: Bye. And the other one you said went to go?

THE MARSHAL: She went to go pay for her parking. She'll be right back.

THE COURT: She's going to be mad. Sorry. And while they're out. Let's go ahead and put the other objections on the record. I think there were -- there's at least one more One second. We went over the invoices. Okay. During the cross-examination of Nurse Hutchins, Plaintiff objected to Defense counsel going into the name -- signed name

on the document. And anything further on your objection?

MR. BREEDEN: No. My -- I just thought that question needed to be rephrased.

THE COURT: Okay. And on behalf of Defense?

MR. MCBRIDE: Nothing, Your Honor.

THE COURT: All right. And I sustained the objection for two reasons. One that it's a stipulated joint exhibit that's already been admitted, so it's going back. And secondly, Plaintiff did also question -- appeared to say -- well, the answer he said that the doctor indicated that he wrote the note. And then it was obviously brought out on cross that it was signed by a different person, other than the doctor. I think two people, two nurses.

MR. BREEDEN: And you said you sustained that, but you overruled that.

THE COURT: I'm sorry, overruled. And then I think that -- that was it, right? That's my notes. Anyone have anything else?

MR. BREEDEN: Yes, Your Honor, just a couple of issues. Number one, I would be willing -- because I don't want a hospital CFO to have to come here twice. I would stipulate that if you rule that testimony is admissible and proper that perhaps we could play that to the jury. I think there's a CD recording of it. And I would agree to that to spare the witness from having to come in for another day.

And also, Your Honor, just for the record, if you are ruling that our billing representatives from Henderson Hospital and Dr. Brian Lipman, that you are excluding that evidence, I would seek the right to

issue a trial subpoena for Monday, to Sam Kaufman, the CEO of Henderson Hospital and Julie Urda, who is a billing representative from Dr. Brian Lipman's office. And so I would need to know if you would allow that, or if you would disallow that?

THE COURT: On behalf of Defense.

MS. HALL: With respect to Mr. Kleven, I want the opportunity to cross-examine him, should he be permitted to testify as to that issue, Your Honor.

THE COURT: Okay.

MS. HALL: For the other issue I don't really have a position. I mean I don't -- I think it would be, I guess a late trial subpoena. But the other side issue is that I suspect that they will be similar in their knowledge and ability to offer an opinion on that issue.

THE COURT: All right. I'll go ahead and allow it since the Defense isn't taking a position. But, you know, hopefully we don't run into the same issue because these witnesses told you that's who they needed, so I mean I guess we'll see. Anything else?

MR. BREEDEN: Nothing further from Plaintiff.

MS. HALL: Nothing from us, Judge.

THE COURT: Defendant? All right. So we'll be back at 8:30. There's not going to be any issues we need to talk about, or we don't know yet at this time?

MR. BREEDEN: I think we could go into Dr. Yeh's testimony pretty quickly.

THE COURT: Okay.

MR. BREEDEN: He will be here live.

THE COURT: All right. I will see you all tomorrow.

MR. MCBRIDE: All right, thank you, Judge.

MS. HALL: Thank you.

THE COURT: If you could just tell her that she's going to be released. We don't need any testimony and thank you.

THE MARSHAL: Sounds good, Your Honor.

THE COURT: All right. Thanks.

THE MARSHAL: Thank you.

[Proceedings adjourned at 5:07 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.

Jessica B. Cahill

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