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 X

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CHRONOLOGICAL LIST

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

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

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

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

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

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

ALPHABETICAL LIST

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

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

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

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

CERTIFICATE OF SERVICE

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

RTRAN

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
THURSDAY, OCTOBER 14, 2021

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 5

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: MICHELLE RAMSEY, COURT RECORDER

INDEX

INDEX OF EXHIBITS

FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Thursday, October 14, 2021

[Case called at 8:35 a.m.]

[Outside the presence of the jury]

THE COURT: We're back on the record in A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We are outside the presence of the jury, and we are going to bring the jury in in a minute.

I'm just going to discuss my ruling on Brian Kleven. I heard arguments yesterday. We void dire'd three different witnesses, and the decision -- the decision as to Kleven was outstanding.

I reviewed a couple of cases, including the one, again, that counsel cited me to -- counsel for Plaintiff. *Curti v. Fanceschi*. I also looked at *Pizarro-Ortega v. Cervantes-Lopez*. And in looking at those, it was clear to me based on -- well, *Pizarro-Ortega* was whether or not a new trial was warranted based on exclusion of one of the nurse's testimony regarding billing, in a footnote the Supreme Court -- footnote 9, specifically -- the Supreme Court addresses that some of the testimony, specifically, the treating physician testified that he was familiar with billing practices for roughly twenty of the forty Las Vegas area pain management specialists and that he charges 16,000 per radio frequency procedure.

So that, to me, suggests what I was saying yesterday; that it has to be representative of the community, not one specific area. And yesterday Mr. Kleven testified that he was not familiar with the medical side, and he can't speak to the medical side or the reasonableness of the

cost of the treatment, just that he could say that that was what St. Rose charged similarly situated patients.

So to allow that testimony, which to me -- and I think it's pretty clear it's beyond a layperson. It is for an expert. But allowing such testimony for just -- to Dignity Health would be both misleading and confusing to the jury and would not assist them. So I am going to preclude his testimony.

MR. BREEDEN: Your Honor, just for the record, I did want to indicate to you -- last night I was looking for some additional sources, and I did notice that usual and customary has been defined by the Nevada Legislature in at least one statute. And this is N.R.S. 439B.670, Section 4. And that refers to prescription drug prices. And this is the only guidance we have from the legislature on this issue.

And it states, "Usual and customary price means that usual and customary charges that a pharmacy charges to the general public for a drug, as described in --" and then it gives CFR citation.

So I think it's very clear that the legislature equates the price that it's charged by a provider to the public at large as the usual and customary price. And, of course, that's what Mr. Kleven and the other witnesses are testifying to.

I think the counter argument had been nope, nope, these witnesses have to come in, and they have to testify that they're familiar with all the other providers in Las Vegas and the market in general. What I would say is, the price charged to the general public reflects market conditions. That is part of the analysis.

And I don't know if this will affect your ruling or not, but obviously, your ruling right now is an incredible boon to the Defense who had not even challenged the usual and customary nature of these charges when I asked their own retained expert and the Defendant -- weren't even challenged. And if you continue with your ruling, that will be approximately $200,000 less in damages that my client is entitled to present. This is not a small issue. We have presented evidence.

Now, if the Defense wants to cross-examine and try to weaken that evidence and make arguments to the jury in closing, that's fine, but we have sufficient evidence on this issue to present to the jury in my opinion.

THE COURT: Okay. And I disagree with some of your statements. As I said yesterday, it's the Plaintiff's burden to establish their case, to establish that there are reasonable costs.

I think voir dire made it clear yesterday that you have not done that. That's why I'm ruling this way. This is time set for trial. You announced already. You should have been prepared with your witnesses, and I don't see that they testified to reasonable and customary to introduce that in front of a jury.

MR. BREEDEN: Your Honor, then just for the record, I've issued a trial subpoena to the CFO of Henderson Hospital, who I would expect to testify very similarly to Mr. Kleven.

I see no reason to call the witness if you are not going to change your ruling, but I would make a proffer that that witness would come in and testify that the amount of the Henderson Hospital billing is

usual and customary and reasonable for this community, and that's 40-some-thousand dollars in charges.

THE COURT: I mean, how can you make a proffer if you haven't even spoken with him?

MR. BREEDEN: I would expect the testimony between the CFOs to be similar. Would you like to have a voir dire of that witness as well?

THE COURT: I mean, I think that's what you should do or request because I don't know how you make a proffer if you haven't interviewed a witness. A proffer is supposed to be based on what you know that -- that witness will testify to. You don't know what he's going to say.

MR. BREEDEN: I don't expect that witness to give testimony any different than Mr. Kleven did.

THE COURT: But an expectation and reality is different. So you decide what you want to do. It's not my case. I'm just making rulings based on what's presented before me.

MR. BREEDEN: Okay. We will try to subpoena the witness.

THE COURT: So please -- Ray, please call Mr. Kleven and tell him he doesn't need to appear today.

THE MARSHAL: Yes, Your Honor.

THE COURT: And that -- well, let's call the jury in first. Were there any other matters outside the presence? All right. And then you can call him. Thank you.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 8:43 a.m.]

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

THE COURT: Thank you. You may be seated. Good morning, and welcome back everyone. Sorry for the slight delay. We're going to continue with the Plaintiff's case.

Plaintiff, go ahead and call your next witness, please.

MS. ALBERTSON: Your Honor, our next witness is Dr. Nien Yeh, M.D.

THE COURT: Thank you.

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

SZU-NINE YEH, PLAINTIFF'S WITNESS, SWORN

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

THE WITNESS: My name is Szu-Nien Yeh. S-Z-U N-I-E-N Y-E-H.

DIRECT EXAMINATION

BY MS. ALBERTSON:

Q Dr. Yeh? Is that correct?

A Yes.

Q Okay. What's the name of your current practice?

A It's U-S-A-P. Which stands for United States Anesthesia Partners.

Q And was that your practice in April -- on April 26th, 2017?

A I believe so.
Q And are you an anesthesiologist? Is that correct?
A Yes.
Q How long have you been an anesthesiologist?
A I graduated in 1997.
Q Okay. I'm going to go through your educational background a little bit, but I might ask you a couple more follow up questions. I have a really sore throat this morning, so I have a cough drop in my mouth. So if at any time you don't understand me, please let me know. Okay?
A Yes.
Q So you graduated in 1997 from where?
A I did my anesthesia residency in the University of Arizona, Tucson.
Q Are you board certified?
A Yes, ma'am.
Q And you have -- have you taken any additional courses or studies since your residency?
A We only take, like, a continued medical education courses.
Q Are you up to date on those?
A Yes.
Q And is your license current?
A Yes.
Q How many states are you licensed in?
A Currently, just Nevada.
Q Okay. Have you been licensed in other states previously?

A Yes, I have been in Arizona where I did my residency. And I also did in California for a little while.

Q Did you render care to Kimberly Taylor as an anesthesiologist for a hysteroscopy she received at Henderson Hospital on April 26th, 2017?

A Yes.

Q Do you have knowledge of reasonable and customary billing rates for services provided by anesthesiologists in Clark County, Nevada in 2017?

A No. I do the coding for the diagnosis and the anesthesia provided, but the billing is provided by anesthesia services.

Q Do you know what appropriate billing amounts are?

A Not exactly.

Q Okay. Do you bill for the services you provide?

A I don't do the billing. Like I said, my department does. I only provide the diagnosis for the pre-op diagnosis and also the level of anesthesia I provide, and they do the coding and the billing.

Q Okay. Did you bill for the services you provided to Ms. Taylor on April 26th, 2017?

A Yes, I provided proper paperworks [sic] for my anesthesia department to do the proper billing.

Q Okay. Do you know how much your bill was?

A No, I don't.

MS. ALBERTSON: Your Honor, can I approach the witness to show them -- show him a copy of his bill to refresh his recollection?

THE COURT: Sure.

MS. HALL: And Your Honor, I would have an objection to this. I think it's beyond the scope of this witness and his treatment.

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

MS. ALBERTSON: I'm representing to you that I'm showing you the bill for your treatment. I'm sorry. I've got to get back to the microphone. The bill for your treatment of Ms. Taylor on April 26th, 2017. And I think it has an amount on there.

BY MS. ALBERTSON:

Q How much is the amount of that bill?

A I think the -- anesthesia services provided was billed at $1,162. And -- but there's a deduction in the contractual write --

Q Okay. I'm just asking you about the amount of the bill so far.

A Well --

Q So the full amount --

A -- at the end it says --

Q -- of the bill --

A -- zero. Amount zero, at the end.

Q Okay. But I'm asking the original bill. The $1,062 [sic] is the amount of the original -- is the original amount billed.

A Thank you. This is the -- according -- yes, this is the bill.

MS. ALBERTSON: Okay. Can I have that back for a second? Thanks.

BY MS. ALBERTSON:

Q Okay. So $1,162.00 is the amount originally billed for the

services rendered to Ms. Taylor on April 26th, 2017, correct?

A According to the paper, yes.

Q Okay. And was that amount usual, reasonable, and customary for such services in Clark County, Nevada in 2017?

A Again, I don't do the billing, but it doesn't seem to be unusual.

Q Okay. What do you mean by it doesn't seem to be unusual?

A It seems like in the reasonable range between what anesthesia was provided for the amount of care that was given within the -- my service.

Q Okay. How is this bill generated? Is it, like, an hourly? Is it flat rate? Is it -- it goes up by every fifteen minutes you work? Something like that?

A Again, yeah, usually we match the diagnosis with what -- the level of anesthesia provided, and there is a -- we go according to the Anesthesia Society recommendations and then we bill also by time, every fifteen minutes. And when you -- we generate some unit values, which is different for each insurance company or our contracts for -- you know -- for insurance. So the --

Q Okay.

A -- same procedure might not be exactly the same for everyone. It depends on the contracts.

Q And is this an unusual procedure to your knowledge?

A Which procedure?

Q I mean, is it -- well, you said you used the Anesthesia Society

guidelines, right? Is that what you said?

A Yes.

Q Okay. And you --

Do you also use AMA guidelines?

A The AMA is for coding for the diagnosis of the disease itself.

Q Okay.

A Not the billing for the anesthesia provider.

Q Okay. So you use the Anesthesia Society guidelines to come up with these amounts?

A Yeah.

Q Okay. Is that an excepted guideline in your field?

A It's used nationwide.

Q Nationwide. Okay. So would it be fair to say this is a usual, reasonable, and customary bill for such services rendered to Ms. Taylor in April of 2017?

A I believe so.

Q Okay. And again, just to clarify, $1,162. Okay. Was that full amount -- that full $1,162 all related to anesthesiology services you provided during the hysteroscopy performed on Ms. Taylor on April 26th, 2017?

A Yes.

Q What does your current practice entail?

A I'm a fully -- I'm active, fulltime staff. I work in many different hospitals providing anesthesia in different units. And I particularly specialize in obstetrics anesthesia, and I also do main OR anesthesia.

Q Okay. So you're -- is it fair to say you're providing anesthesia for people undergoing surgical procedures?

A Yes.

Q Do you provide anesthesia for any other reason?

A No, only for surgery.

Q And was your practice relatively the same in April of 2017 when you worked on the hysteroscopy that Ms. Taylor received?

A Yes.

Q And you said you work in various hospitals. Which hospitals?

A Pretty much every hospital in town with the exception of UMC, North Vista, and Centennial.

Q Those are the only ones you don't work in?

A Correct. I have privileges in every single hospital in town.

Q Okay. The -- I'll represent to you, and I think you'll recall as well, the surgery performed on Ms. Taylor was done in Henderson Hospital --

A Correct.

Q -- in April of 2017?

A Correct.

Q Did you have privileges at Henderson Hospital in April of 2017?

A Yes.

Q And have you ever previously given testimony in a court of law?

A No.

MS. ALBERTSON: Your Honor, pursuant to 16.1, I'm tendering Dr. Yeh as a qualified, non-retained treating physician to offer expert testimony in this matter pertaining to the procedures he performed on April 26th, 2017.

THE COURT: Counsel, approach.

[Sidebar at 8:53 a.m., ending at 8:54 a.m., not transcribed]

BY MS. ALBERTSON:

Q Okay. Other than the April 26th, 2017, hysteroscopy we're here to discuss today, have you provided anesthesia services for Dr. Brill on any other surgeries?

A Many, yes.

Q Okay. How many do you think?

A Probably over 100 to 200 in the course of years.

Q Per year or over many years?

A Over many years.

Q Okay. So it's not 100 to 200 per year, it's 100 to 200 total?

A It could be. It could be. I work in a very busy unit. Dr. Brill is a very busy surgeon. And we do a lot of procedures not just in the Main OR but as well as obstetrics. So over a year, probably over 100 a year.

Q So in 2017, you could have provided anesthesia services to Dr. Brill for over 100 surgeries?

A Yes.

Q Are you the only anesthesiologist providing services to Dr. Brill?

A No. My group has member -- several members, we are over 100 people.

Q Okay. So in addition to you, there are various other anesthesiologists that could also be providing services to Dr. Brill?

A Correct.

Q Now, I want to also be clear. You aren't here to give an opinion about malpractice today. You are just here to discuss your part in the hysteroscopy that was performed on Ms. Taylor on April 26th, 2017, and what you remember about that, correct?

A Yes.

Q How did you come to treat Ms. Taylor? How were you -- how was it that you became involved in that surgery?

A Dr. -- Ms. Taylor was scheduled through probably Dr. Brill's office to my office, and they just assigned me the case. So I have no prior -- I have not priorly [sic] met -- previously met Ms. Taylor.

Q Okay. And did you meet Ms. Taylor before the surgery?

A Yes, in the preop area.

Q Okay. You did talk to her?

A Yes.

Q Okay. Could you describe what you understand -- what you understood your role to be in the hysteroscopy that was attempted on Ms. Taylor on April 26th, 2017?

A I was there to provide anesthesia for the procedure described.

Q And could you describe to the extent of the anesthesia you

thought you had to provide? Was it -- was she supposed to be intubated or?

A The procedure is considered a minor procedure. Therefore, we provide general anesthesia. There's several levels of anesthesia. In that particular case, as an outpatient minor procedure we first start general anesthesia with a laryngeal mask airway which is a protection to the airway, but it is not a full intubation, we don't go to the vocal cords. It's just a more gentle level anesthesia which is proper for that procedure.

Q And are you in the OR, the operating room, the whole time the procedure is going on?

A Yes.

Q I know you've your records previously in this case. Did you records document anywhere that you were informed of any kind of complication with the procedure?

A I don't recall being informed of it, and therefore is not -- I do not chart anything.

Q If you were informed of a complication, do you believe you would have noted it somewhere?

A Not necessarily, because my anesthesia records pertains to anesthesia only. I only have to chart and document anesthetic complications, not surgical complications.

Q Okay. But like if a patient dies, that would be considered a complication. You would note that somewhere, correct? Even if there was no place?

A Yes, I can make an addendum to the -- to the anesthesia record, and I would provide further -- yeah, notes.

Q So you have the ability to make an addendum?

A I could.

Q To add complications, correct?

A Correct.

Q Okay. And if something like, if you have been informed that Ms. Taylor's bowel had been perforated, would you have probably added an addendum?

A No, not necessarily.

Q You wouldn't have added anything to your chart?

A It's not part of my anesthetic -- anesthesia record. It's not part of my job to document that. There's other peoples in the OR that would do that.

Q Is it Dr. Brill's job to do that as the doctor?

A It's probably the circulating nurse to make the notes to update the complications and change in procedures.

Q How would the circulating nurse even find out that that occurred?

A I would -- I would think by communication from -- directly from Dr. Brill.

Q Okay. The doctor would have to tell her or him, correct?

A Correct.

Q And your testimony today is you don't recall ever being told of any complication by Dr. Brill, correct?

A I just don't remember.

Q Okay. When did you first become aware that Ms. Taylor's uterus had been perforated during the hysteroscopy?

A Three years later, when I was contacted to provide witness testimony.

Q In this matter?

A Correct.

Q When did you first become aware that Ms. Taylor's bowel had been perforated and that was -- that resulted in an additional surgery that she had to receive, basically, within 48 hours of the April 26th, 2017, surgery?

A It was, again, when I receive the test -- I had -- I was summoned to do the testimony, three years later.

Q Okay. And when you say the testimony, you're talking about the deposition you gave previously in this matter?

A Yes, correct. I had no contact with her for the entire time.

Q Okay. But you had contact with Mr. Brill, correct?

A Just work related.

Q Okay. But the first time you recall finding out about the uterine perforation and the bowel perforation was three years later, when you were contacted to give testimony on this case. And I want to be clear, the testimony you had given previously in this case was not like this, correct? You were in the office, and you answered some questions while a court reporter wrote down your responses, right?

A Correct.

Q Now, you're part of a team when you perform anesthesia in a procedure like a hysteroscopy, correct?

A Of the surgical team, correct.

Q And you would agree that Dr. Brill was also part of that team, correct?

A Correct.

Q Do you think it's important for team members to work together and communicate?

A Yes.

Q Do you think it's important to share information with your team members in that kind of a setting?

A Yes.

Q And to be clear, in the operating room, in the OR, you are the anesthesiologist in your role in the hysteroscopy, right?

A Yes.

Q Do you take the lead in the surgery?

A No. I'm only responsible for the anesthetic portion of it.

Q Okay. So if there is a perforation to the uterus, and there is a need to explore that further, do you get to make that call or does someone else make that decision?

A That's not part of my scope of practice. I only pertain to anesthesia. The -- the surgical portion is the surgeon's call.

Q Okay. Thank you.

So fair to say you would not have had authority in that operating room, if you had been informed of a tear or perforation, to do any kind of

exploration on that yourself, correct?

A Correct.

Q And frankly, I'm not trying to negate your qualifications or experience, but your expertise is not even in that area, correct?

A Correct. My expertise is in anesthesia.

Q Now, you do give postop orders for medication that's to be administered in the PACU, the recovery unit that the patient goes into after a surgery, correct?

A Yes.

Q Okay. And did you do that in this instance?

A Yes.

Q And would you agree that to properly do that job, it would help to know if there was any complications with the surgery?

A Yes.

MS. ALBERTSON: Thank you. The Court's indulgence for just a moment. Thank you very much, Doctor.

THE COURT: Thank you. Cross-examination?

MS. HALL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. HALL:

Q Good morning, Dr. Yeh. I don't know if you can recognize me because most of my face is covered. And if you remember, when we took your deposition about a year ago, we did it by Zoom. So we were able to have our masks off because we weren't in the same room. Just in case you don't recognize me, my name is Heather Hall. I represent Dr.

Brill and Women's Health Associates in this case. And I have some questions for you, and I am going to jump around just a bit since I go second. I want to start with, first and foremost, Dr. Yeh, do you have a recollection of this patient?

A No.

Q Would you agree that your memory of the care that you provided, that occurred over four years ago, is entirely based on the records that you made at that time?

A Correct.

Q And in fact, when we took your deposition, and I think the date of your deposition was October the 28th, of 2020, does that sound right to you?

A I believe so.

Q When we took your deposition, do you recall being asked if you had any memory of any conversations with Dr. Brill about this patient?

A Yeah. We did not have any conversations regarding this patient.

MS. HALL: Well, and I understand your deposition was a while ago, so let me just show you your deposition testimony. Your Honor, at this time, I would move to publish the deposition of Dr. Yeh.

MS. ALBERTSON: Your Honor, can we approach for a second?

THE COURT: Sure.

[Sidebar at 9:06 a.m., ending at 9:08 a.m., not transcribed]

MS. HALL: Thank you. Your Honor, may I approach the witness?

THE COURT: Yes.

MS. HALL: Dr. Yeh, I am just going to show you, if you look here on this page, you see there is a page number up here and then the side is numbered. So we're going to start on page 20.

MS. ALBERTSON: What page are we starting on?

MS. HALL: Page 20. Actually, I'm sorry. May I approach again, Your Honor?

THE COURT: Yes.

MS. HALL: Beginning at page 32. It's this page.

THE WITNESS: Okay.

BY MS. HALL:

Q And Dr. Yeh, your memory of your deposition that occurred over a year ago, is that fresh in your mind?

A Yes.

Q And I understand that when we took your deposition in October of last year, you were asked, if you look at page 32 of your deposition, line 11.

A Okay.

Q And you were asked -- you were asked,

"Q Do you recall having any conversations, even at that time, with Dr. Brill regarding this procedure?"

And what was your answer?

A "No, I don't."

Q And is it your testimony, Dr. Yeh, that no conversations occurred or that you simply do not recall one way or another?

A I just don't recall.

Q Okay. You can set that to the side, Dr. Yeh.

Now, you were asked just a bit about your anesthesia record. And for those members of the jury who aren't familiar with anesthesiologists and information that they document, can you explain what you as an anesthesiologist are concerned with in terms of your documentation of care?

A At that particular hospital, we do electronic medical recording. So we have a template. It gives -- so allows and helps us keep track of all of the vital signs. It goes directly, it's fed from the machine, and it will put the patient's vital signs into the record. So that the important thing for me, obviously, is to have the proper diagnosis and justified to see that it was done, and also justify the level of anesthesia that the patient required. During the procedure, I make sure the patient is stable and comfortable and safe during the duration of the procedure to the level of anesthesia that's required for the particular procedure.

Q And Dr. Yeh, as the anesthesiologist, in your anesthesia record, are you concerned with documenting the application of the anesthetic agents that you use?

A Yes.

Q Are you also concerned with documenting any complications from application of that anesthetic agent or agents?

A Like I said before, in the template, it actually does not -- it doesn't have a place for me to document. It's not part of my duties to document the procedure's complications, like I said. There's another team, part of the team, the circulating nurse, that would probably document that part. I am entirely there -- entirely there for the anesthesia portion. So if there is a complication related to anesthesia or I have to change something in anesthetic approach due to potential complications or escalation of care, then I will make a notation to justify why I have to increase the level of anesthesia provided. Otherwise, yes.

Q But generally speaking, Dr. Yeh, if a patient experiences a surgical complication that has no impact on the anesthetic agents you used, would that typically be contained in your documentation?

A No.

MS. ALBERTSON: I am just going to object. It goes beyond the witness's scope and what he is supposed to be testifying to.

THE COURT: Overruled.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q In terms of the surgeon though, is it your expectation that the surgeon would document any surgical complication the patient experiences?

A Yes.

Q And I want to show you -- do you still have the -- and I'm sorry, Dr. Yeh, you -- I think you answered this when Ms. Albertson was asking questions of you. But just so everything is clear, you have never

practiced as a surgeon, correct?

A Correct.

Q You've never held surgical privileges at any hospital here in the community?

A Correct.

Q And you would defer to a surgeon as to the best way to respond or treat a surgical complication?

A Correct.

Q Do you still have the -- I think you maybe were shown the billing invoice --

A Yes.

Q -- for your office. Did you have that in the binder behind you?

MS. HALL: Is it okay if I approach, Your Honor?

THE COURT: Yes.

MS. HALL: It's going to be in binder -- if you look, Dr. Yeh, on those spines, there's a binder 4. To your right, sir. Right there, yeah. And if you look on the side, there are tabs. So I'd ask you to turn to tab 63. And just let me know, Dr. Yeh, when you get there.

MS. ALBERTSON: It's the Bates at the bottom of the page.

MS. HALL: It's joint proposed 63 that you went over with Dr. Yeh.

MS. ALBERTSON: That's the same page. Okay. I just wanted to make sure.

MS. HALL: There's two pages that I am going to refer to.

MS. ALBERTSON: Okay.

THE WITNESS: Yes, it's here.

BY MS. HALL:

Q Okay. And you've got that in front of you, Dr. Yeh?

A Yes, I do.

Q Now, you were asked about the charges for this bill, and you told us that the charges were 1,162, correct?

A Correct.

Q Does this invoice also reflect that --

MS. ALBERTSON: Your Honor, I am just going to object. Can we approach --

THE COURT: Counsel approach.

MS. ALBERTSON: -- really quickly?

THE COURT: Uh-huh.

[Sidebar at 9:15 a.m., ending at 9:17 a.m., not transcribed]

BY MS. HALL:

Q Okay, Dr. Yeh, you have proposed Exhibit 63 in front of you, correct? And this is the invoice for the anesthesia services that you provided for Ms. Taylor; is that correct?

A Correct.

Q And a moment ago when counsel was asking you questions, you were asked about the amount charged. And you testified that as reflected in this invoice, the amount charged was $1,162, correct?

A Correct.

Q And Dr. Yeh, you are familiar that when a patient has

insurance, that there are what's called write-offs or contractual write-offs?

A Correct.

Q And this invoice, does it reflect that Ms. Taylor had insurance?

A Invoices, yes.

MR. BREEDEN: Objection this is exactly what we didn't -- we just talked about this and there was not establishment for this.

THE COURT: Counsel approach.

[Sidebar at 9:18: a.m., ending at 9:21 a.m., not transcribed]

BY MS. HALL:

Q Okay. Dr. Yeh --

A Hi.

Q -- you still have that invoice in front of you?

A Yes, I do.

Q And what is the -- so the invoice, does it reflect that Ms. Taylor had insurance?

A Yes, she does.

Q And what is the insurance that is listed for Ms. Taylor?

A It's Aetna US Healthcare.

Q And does this invoice also reflect that there was an amount paid by Aetna US Healthcare Insurance?

A I believe so.

Q And if you can look across from -- you see the left hand column that says the date of the payment 7/20/2017?

A Yes.

Q And then you see the reference number from Aetna US Healthcare and what is the amount that was paid by Aetna?

A I believe -- is it the $655.70?

Q Sir, and if you want to follow that across from the date of 7/20 to the description, the amount listed is $655.70; true?

A Correct.

Q And there is also -- underneath that, there is a date for the contractual write-off. And can you explain to the jury what your understanding of the term contractual write-off is?

A This is the individual contracts we have with different insurance companies where we have a discounted rate.

Q And Dr. Yeh, for those of us who don't, you know, deal with those terms every day, does discounted rate, does that mean that the insurance company does not pay that amount?

A Correct.

Q Does that also mean that the patient does not pay that amount?

A Correct.

Q And what is the amount of the contractual write-off listed on this invoice?

A It's $506.30.

Q And does this invoice also reflect what was the responsibility of the patient, in terms of the amount of the bill?

A It does.

Q And what is that amount Dr. Yeh?

A It totals to the amount of $0 balance to the patient.

Q All right. Thank you, Dr. Yeh.

Now you have performed a hysteroscopy-- prior to April 26, 2017, had you performed hysteroscopies -- let me be a little clearer on my question. Had you acted as the anesthesiologist for a hysteroscopy procedure with Dr. Bill prior to April 26th, 2017?

A Absolutely I did.

Q Would you say that's a common procedure that you had done with Dr. Brill before that date?

A I agree.

Q In general, would you agree that a hysteroscopy can take anywhere from 15 minutes up to over an hour?

A Correct.

Q That would be a normal time you would expect?

A Correct.

Q And in general, how long would you expect a patient to be in the PACU, or recovery area after a procedure like this?

A Out-patient basis, we usually expect anything between 45 minutes to an hour.

Q Is it also common for a patient to experience nausea in the recovery area after having had anesthesia?

A Very common.

MS. HALL: Court's indulgence, Your Honor.

[Counsel confer]

MS. HALL: Sorry, Your Honor.

BY MS. HALL:

Q I want to show you Dr. Yeh, this is -- it's been previously admitted as Exhibit 5. Joint Exhibit 5, and this is page 42. There we go. And this is previously admitted Exhibit 5, and it's page 42 of that exhibit, and I'll represent to you if you want to look at the top of this page, Dr. Yeh, this is Dr. Brill's --

MR. BREEDEN: Objection. Can we approach?

THE COURT: Sure.

[Sidebar at 9:26 a.m., ending at 9:27 a.m., not transcribed]

MS. HALL: Thank you, Dr. Yeh. Those are all my questions. Pass the witness, Your Honor.

THE COURT: Thank you. Any redirect?

MS. ALBERTSON: Yeah, super quick.

REDIRECT EXAMINATION

BY MS. ALBERTSON:

Q You do not work for Aetna, correct, sir?

A No, I don't work for Aetna.

Q Okay. And do you know how Aetna establishes the rate they will or won't pay on a patient?

A No, I don't.

Q Okay. Do you know how Aetna establishes the rate a patient pays in any kind of contract?

A No, I don't.

Q Okay. So fair to say you don't know how these contractual

rates that you just discussed were established, or even what exactly my client was and was not required to pay, correct?

A I don't do the billing, so I don't -- I don't know.

Q So you would probably not be the best person to ask about these Aetna line items on this document, correct?

A Correct.

Q Somebody at Aetna would know much more than you, correct?

A Correct.

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

THE COURT: Any recross?

MS. HALL: Nothing further, Your Honor. Thank you.

THE COURT: Thank you. Any questions from our jurors. No questions. All right. Then, Dr. Yeh, thank you so much. You may be excused.

THE WITNESS: Thank you.

MR. BREEDEN: Your Honor, may we have a ten minute break and then we'll call the next witness.

THE COURT: Okay. All right. Ladies and gentlemen we're going to take a ten minute break.

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 read, write, or 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, 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 reference materials, test any theory of the case, repeat 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 learn about any other issue, party, witness, or attorney involved in this case. 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 ten minutes.

THE MARSHAL: All rise for the jury.

[Jury out at 9:30 a.m.]

THE MARSHAL: Jury's cleared the courtroom, Your Honor.

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. Any issues -- or do you want to put the objections on the record or take a break first and then come back?

MR. BREEDEN: Plaintiffs would like to put a couple of things on the record.

THE COURT: Okay, go ahead.

MR. BREEDEN: So regarding the objections, I think the primary disputed objections that occurred during sidebar were regarding collateral source issues. Improper introduction into evidence of collateral sources is, of course, per se reversible error. I thought that this was well discussed in some pretrial motions. First of all, we don't think

under the applicable statute, and the circumstances of this case, they can introduce evidence of the insurance payments at all. But it's very clear in my assessment, that they can't introduce evidence of write-offs. Write-offs are different from the insurance payments. That comes directly out of the *Khoury* case. And I consider that, per se reversible error.

THE COURT: Okay. And I previously ruled in the motion in limine that it's a medical malpractice exception, it's a benefit to the patient. And I ruled that it can come in, so your contemporaneous objection is noted. Anything further.

MS. ALBERTSON: I have a second point on that about the foundational problems with this witness offering this testimony. I'm sorry if it bothers you that I'm not pointing. I'm just doing it for my thoughts.

THE COURT: No, that's fine.

MS. ALBERTSON: This witness was clearly not -- not even qualified to offer the opinions about the write-offs. He clearly didn't have knowledge about how they were established or even who established them or what guideline. Very different offering an opinion about his own billing, where he said what that was based on.

However, as I discussed at the bench, I'm not even sure this witness was the best person to talk about his billing; however, because of the previous rulings in this case, I asked him about his billing, because I got the impression, Your Honor, that you wanted that coming from a provider. And he at least knew the guidelines that were used to come up with his billing amounts.

THE COURT: Okay. And then I the -- well, I'll let you talk, and then I'll go.

MS. HALL: Okay. Just really briefly, Your Honor. The Plaintiff opened the door on direct exam by asking Dr. Yeh about the billing invoice and the charges. And when he tried to continue commenting on the rest of the invoice, he was prevented from doing that which, you know, it's their direct exam, they can certainly do whatever they choose to do. But I think it's fair game for me on cross-exam, once they've opened the door on direct, to bring that out. For me to ask him questions, especially after having established the foundation that he is familiar with insurance, contractual write-offs, payments by the insurance company, the patient's responsibility .

So I think that the questions that I asked on cross were in direct response to what he answered on the direct exam of Plaintiff.

THE COURT: Ms. Albertson.

MS. ALBERTSON: Yeah. Okay. I agree that she has a right -- well, besides the collateral source issues, obviously, the right to ask those questions. However, this is not the right witness to ask those questions of. That's the problem right there. Okay. You need a witness that actually knows about this. He has no personal knowledge of this. He probably has never even seen this bill before, frankly, before it was put in front of him. But he has personal knowledge of his -- what he did -- what he did for Ms. Taylor in that surgery. And what that roughly would cost, based on how he knows that his services are billed. That's very different. He doesn't know about reductions. He doesn't know

what kind of reductions occur. He doesn't know who pays what in those reductions. If you look at those write-offs, that's a division between the patient and the insurance company, and how it's all going to break down. Those are negotiated amounts and there's all kinds of information that goes into them that he has no knowledge of it at all.

So I agree if Ms. Hall wants to ask questions about that, and you're ruling is that collateral source information comes in, obviously she would have a right to ask questions about it. She would need a witness there that actually knew about it. And that's the problem. Just because something can be asked about, just because you rule that it's okay for it to come in as evidence, doesn't mean that you can just randomly bring it in with the wrong witness.

It's the same problem that we were having a moment ago, which we're going to discuss next, where you can't just throw somebody else's record up and say isn't this what you said. Or look at this, doesn't this impeach you. You can't do that. Just because you said something is in, you can't just throw anything up there and hope that this witness can get it in. This is not the right witness for this information.

THE COURT: All right. And I think the real issue is you guys keep doing stuff and then you want them to be precluded from doing the same exact thing. Under just the basic evidence, rule of completeness, you brought that document up, and it's misleading to the jury to just give one portion of the document and talk about the amount, when the witness was clearly trying to answer on direct, and you cut him off when he was trying to continue with the rest of what you asked him to look at.

So under the rule of completeness and cross-examination, I think it was fair game. And that's why I sustained it.

MS. ALBERTSON: Okay. I cut him off because he was going beyond what my question was. My question was how much did you bill. Not how much did my client have to pay. Not what was the eventual write-off. It was how much was -- did you bill for your services?

THE COURT: I understand. He was still trying to answer the question the way that he understood the question to be, and you cut him off.

MS. ALBERTSON: Okay.

THE COURT: Anything further?

MS. HALL: No.

THE COURT: As to the next issue?

MS. ALBERTSON: You want to talk about the next objection I made?

THE COURT: Yes.

MS. ALBERTSON: I don't know exactly which one was next. But I did make an objection to the certain record being shown.

THE COURT: It was Exhibit 5.

MS. ALBERTSON: Okay. Exhibit 5. This is the third time this has happened in this case, where the Defense made efforts to impeach a witness on the stand, with someone else's statement. And interestingly enough, it's been their client's statement and their client's records. You cannot do that. I agree that some of this stuff can come in, but not with that witness. Okay. You can't impeach somebody with someone else's

statement.

THE COURT: Okay. And I sustained the objection. But again, Plaintiffs did this as well with the -- I can't remember the name. The wonder -- the other two nurses' documents with a different person. You did the same exact thing. And whether or not this happened two or three times, there was no objection. I don't recall it happening. But if there's not an objection, I can't make a ruling.

MS. ALBERTSON: Okay. I'm not sure exactly which -- what you're referring to, but I'll think about what you said, because I'm sorry, I don't know exactly what instance you're referring to.

THE COURT: When we had Nurse Hutchins up here.

MS. ALBERTSON: Okay.

THE COURT: And it was clear that the document was signed by two other nurses, that were not him, you questioned him on the entire document. So what I'm saying is you keep doing stuff, and then you want them to be precluded from doing the same thing.

MS. ALBERTSON: Well, okay, they have a right to object to anything we do that's improper.

THE COURT: Both of you guys do.

MS. ALBERTSON: And that's what my job is to do, is to object to what they're doing that's improper when they're doing it. You know, so I'll think about what you're saying. I don't remember the exact instance. But like I said I'll think about it. But it's not my job to make their objections. It's my job to make the objections on our side of this case. You know, and I understand if you're saying --

THE COURT: I agree.

MS. ALBERTSON: -- that like somebody else did this or that, but like that's just not how it works. The response is, well, then they need to object. You know, this happens all the time in trials. It's happened to me when I've been on both sides of it. And what judges have said in the past is, well, then you need to object. You know, and that's what it is. And frankly, Your Honor, it's theirs to bring that up, not yours to bring it up, if they think that's an issue that's happening in this case. Otherwise you run the risk of potentially advocating for them. And --

THE COURT: I don't think I'm advocating for anybody.

MS. ALBERTSON: Okay. Well, I mean, I have a duty to my client and that's what I'm trying to -- that's what I'm trying to do.

THE COURT: Understood. And I'm ruling on the objections. And like I said, I sustained the objection.

MS. ALBERTSON: Thank you, very much. I appreciate it.

THE COURT: Anything further on that point?

MS. ALBERTSON: No, you ruled for me, so thank you.

THE COURT: Is that -- is there another objection that needs to be put on the record?

MS. ALBERTSON: I don't remember if there was another one. Heather, do you think I've covered all of them?

MS. HALL: I think there were two regarding the collateral source issue, but I think that what you've argued has addressed both of those objections. And then the last objection is the one we just

discussed.

THE COURT: Okay. All right.

MS. HALL: I'm sorry but very quickly. I have pretrial conference in Department 31, at 10:15. Could I just find out who the next witness is, to decide if it's going to be me or Mr. McBride leaving the courtroom?

THE COURT: Okay.

MR. BREEDEN: I'm sorry, it's going to be -- I thought you knew, it's going to be Dr. Berke.

MS. HALL: Okay.

MR. BREEDEN: And then after Dr. Berke will be Ms. Taylor.

THE COURT: Okay.

MS. HALL: Okay. Thank you.

THE COURT: All right. So you have five minutes.

MR. MCBRIDE: Five minutes to use the restrooms?

THE COURT: Yes.

[Recess from 9:39 a.m. to 9:45 a.m.]

[Outside the presence of the jury]

THE COURT: We're back on the record in A-18773472-C, Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. Just logistically, how many more witnesses do we have before -- I'm trying to figure out when we're going to take lunch.

MR. BREEDEN: Yeah. So we have Plaintiff's retained expert, Dr. Berke. Boy, I don't know, I'm probably going to go two hours with him, and then there's going to be some cross. Then we'll start with the

Plaintiff, Ms. Taylor, after that.

THE COURT: So maybe we should do a lunch at 11:30, 11:45?

MR. BREEDEN: That might be a good idea.

THE COURT: Okay. Because we're going to need -- we have to end promptly at 3 today, so.

MR. BREEDEN: Oh, we do?

THE COURT: Yeah. That's --

MR. BREEDEN: Oh, I didn't realize that.

THE COURT: -- that was on the schedule. Yeah. I mentioned it yesterday. It's on the schedule from the email I sent two weeks ago.

MR. BREEDEN: You know, I do seem to remember that now.

THE COURT: So --

MR. BREEDEN: Well, we'll have to see where we are.

THE COURT: All righty. Anything else outside the presence?

MR. MCBRIDE: Not from the Defense, Your Honor.

THE COURT: Everyone's here, right?

MS. ALBERTSON: So sorry, you want to do an early lunch, you think?

THE COURT: Well, since we're ending at 3, I kind of wanted it to be like somewhere in between so we don't have to take --

MS. ALBERTSON: So they're not like going to lunch for -- and then coming back for ten minutes.

THE COURT: -- a break and then coming back for ten minutes. Yeah. So it might be during --

MS. ALBERTSON: So when exactly --

THE COURT: -- it might be during your direct. That's the only thing.

MR. BREEDEN: Yeah. And if that happens, it's just unavoidable and you know, we'll come back tomorrow morning and Ms. Taylor will finish her testimony.

THE COURT: Because I mean, like I said, I'd like to take a break about every 90 minutes. So depending on where we're back when we start back up.

MR. BREEDEN: Okay.

MS. ALBERTSON: Did we tell them 3:00 today?

THE COURT: Yeah. I told them that yesterday. And then tomorrow, I have 10 to 5. So again, we'll do a later lunch tomorrow. All right. Go ahead and bring them in. Thank you.

MR. MCBRIDE: And just for the record, Your Honor, we have our expert who is -- and it sounds like we're going to probably have to take him out of order tomorrow afternoon at some point, so. Dr. McCarus.

THE COURT: Okay. I think you have -- we had already -- there was --

MR. MCBRIDE: Yeah.

THE COURT: -- an email exchange about this.

MR. BREEDEN: Yeah. Is he going to be here first thing in the morning or is he going to be available all day?

MR. MCBRIDE: He could be available all day, I believe.

MR. BREEDEN: Oh okay. Good.

MR. MCBRIDE: Yeah.

MR. BREEDEN: So it sounds like we can finish up with Ms. Taylor, and then maybe go to Dr. McCarus.

MR. MCBRIDE: Well, yeah. That's -- that makes sense.

MR. BREEDEN: Yeah. Time permitting then, we would call Dr. Brill after that.

MR. MCBRIDE: Okay. Gotcha. Tentatively.

MR. BREEDEN: Life is tentative, is it not?

MR. MCBRIDE: It is. It is. All too true.

THE MARSHAL: All rise for the jury.

[Jury in at 9:48 a.m.]

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

THE COURT: Thank you. You may be seated. And we're going to proceed with the Plaintiff's case. Plaintiff, please call your next witness.

MR. BREEDEN: Your Honor Plaintiff calls Dr. David Berke.

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

DAVID BERKE, PLAINTIFF'S WITNESS, SWORN

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

THE WITNESS: First name David, D-A-V-I-D, last name Berke, B-E-R-K-E.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Doctor, before we begin, behind you there are some exhibit books. In Volume 4, there's an Exhibit 36 with some of your reports in it. Why don't you open it to that exhibit in case you need to refer during your testimony. So it's Exhibit 36. Doctor, what do you do for a living?

A I'm an obstetrician gynecologist.

Q Can you explain to the jury what an obstetrician gynecologist or OBGYN doctor does?

A So OB/GYNs take care of women's healthcare issues all through their spectrum of life from birth control early on to well woman exams for cervical cancer and breast cancer screening. We manage pregnancies, antepartum care before the baby is born, and care of the baby afterwards -- or the mother after the baby is delivered. And then all sorts of gynecologic issues that women may have, including birth control, permanent sterilization, any issues with heavy periods or bleeding or pelvic pain.

Q And so what's actually the difference between an obstetrician and a gynecologist?

A So an obstetrician only deals with pregnant women.

Q And so are most practitioners in this field are they both -- are they both obstetrician and gynecologist, or do they choose one or the other?

A Yeah. The majority of OB/GYN doctors do both -- a combination of both.

Q Where did you attend undergraduate school?

A Initially, I went to San Diego State University and got a bachelor's in psychology. And then went to George Washington and got a bachelor's of science where I did my physician assistant training.

Q And so what years were that?

A I went to -- I graduated San Diego State in 1992. And I graduated George Washington University in 1994.

Q Okay. And you mentioned physician assistant training that you had. Explain to the jury what sort of training and schooling you had for that.

A So that was a two-year program at that time after college that I did. I then became a PA afterwards.

Q Okay. How many years did you practice as a PA?

A Approximately eight to nine. Yeah.

Q Okay. What year or at what point in your life did you go back to medical school?

A In 2003.

Q And what medical school did you attend?

A Western University of Health Sciences.

Q How many years?

A Medical school is four years.

Q Okay. And what year did you graduate from medical school?

A 2007.

Q And what degree did you receive?

A Doctor of osteopathic medicine.

Q And explain for the jury what a residency is.

A So residency is an additional training after medical school where you pick a specialty and through many years and many hours and mentorship, you learn the ins and outs of that specialty and how to become competent to become a doctor in that specialty.

Q Now, by the way, when you worked as a physician assistant, what sort of medical practice or area of practice did you work in?

A So the first two years, I did orthopedic surgery. And then I changed jobs and did medical oncology.

Q Okay. And when you did your residency after medical school, what specialty did you go for?

A That was OB/GYN.

Q Okay. And after residency, what sort of training or education have you had?

A Well, after residency, you're still required to, you know, pass your boards. So you study for those. And then you're required to have continuing medical education every few years to renew your license, so.

Q And so you have to be licensed by a state to practice as a physician, correct?

A Yes.

Q What states are you licensed in?

A California.

Q Okay. When were you first licensed to practice medicine in the State of California?

A You actually can get your license to practice during residency. So the year after your internship. So that would've been, you

know, 2008 or '09.

Q Are you Board certified?

A Yes, I am.

Q And in what field?

A OB/GYN.

Q Explain -- well, first of all, what Board has certified you?

A The American College of Osteopathic OB/GYNs.

Q And explain to the jury what it means to be Board certified and what it takes to get certified by that Board.

A Yeah. So Board certification is mainly, you know, showing that your license is still valid, that you've done your continuing educational credits, and taking either an exam, which is a couple hundred question exam, or there's some alternative ways where you can do modules at home and take self-tests. Mine was the -- the test I took. And that's about every six years you have to renew that.

Q Do you have any hospital privileges to perform operations or procedures?

A I do.

Q Okay. At how many different hospitals?

A Three hospitals and one outpatient surgery center.

Q Are you a member of any professional organizations?

A Yeah. The Riverside Medical -- Riverside County Medical Association, the California Medical Association, American College of Osteopathic GYNs, and the American Osteopathic Association.

Q Have you ever served on any medical related peer review

committee?

A Yes.

Q Explain to the jury what a peer review committee is, and then explain your involvement.

A So I served on a peer review committee for one of the hospitals I practice at called Parkview Hospital. And peer review is kind of an internal process where the hospital takes complaints either made by either staff or patients and talks to the physician, gets a statement, and presents all this to the peer review board, who decides if any action has to be taken for the physician.

Q And does that include complaints of medical malpractice?

A Yes.

Q And have you ever held any positions with the Osteopathic Medical Board of California?

A Yes. So for the Osteopathic Medical Board of California, I'm an expert reviewer of cases that are brought to that board to evaluate physicians for disciplinary action based on again, patient complaints, or complications, or any hospital-based complaints.

Q And that includes for example, if somebody makes a complaint to the Board about an OB/GYN, their OB/GYN has committed very bad malpractice? That's the type of thing you review?

A Yes. In regards to the State, an actual medical license review.

Q And you then advise the actual licensing board of the State of California what your opinions are about the allegations?

A Yes. I review records from the doctor, the hospital, the patient's statements, the doctor's statements, and then make an opinion to the medical board if there should be any action taken.

Q Okay. And we've kind of mentioned, you know, that you're licensed in the State of California. California is obviously a pretty big state. What city do you live and practice in?

A I practice in Riverside, California, which is Southern California. And I live close by.

Q We've spoken a little bit about your educational experience. I want to talk about your work and employment experience as a physician. You mentioned you were a physician assistant for several years before you got your medical license. But where are you currently employed?

A Riverside Medical Clinic.

Q Okay. So in private practice then, tell me what that clinic does.

A Riverside Medical Clinic is a multispecialty about 150-provider group. It has multiple officers. I'm an OB/GYN, one of eight in that group.

Q And how many patients have you seen as an OB/GYN doctor over the years?

A I see between 25 and 30 patients a day, about four days a week. So thousands of patients.

Q Okay. And have you ever seen patients with complaints of heavy menstrual bleeding or menorrhagia?

A Yes.

Q Have you ever seen patients with fibroid tumors in their uterus?

A Yes.

Q How many hysteroscopies would you estimate you've performed in your medical career?

A At least, you know, 5 to 600.

Q And how many fibroid tumor resections would you estimate you've done in your career?

A During those hysteroscopies, that's often what you're doing them for. And probably one in every -- when we do have them, so probably 100.

Q Are you personal friends or a relative of the Plaintiff in this case, Kimberly Taylor?

A No.

Q Did you meet her or know of her prior to being hired to be involved in this case?

A No.

Q Did you personally know me or anybody at my law firm before this case?

A No.

Q Okay. Had we ever worked before on a case other than Ms. Taylor's case?

A No.

Q When were you hired in this matter to provide opinions?

A In I believe it was April of 2018, was when I first had contact.

Q And in order to provide opinions in this case, did you review various medical and other records concerning the case of Ms. Taylor?

A Yes.

Q Okay. Just generally speaking, what records did you review?

A So the records from Dr. Brill's outpatient practice, records from the Henderson Hospital Surgery Center, and records from the St. Rose ER visits and hospital stay.

Q And did you also review litigation documents like the deposition testimony of various witnesses?

A Yes.

Q Can you remember the names of depositions you've seen?

A The deposition of Dr. Brill and the deposition of Dr. Brill's expert witness.

Q Okay. I'd like you to explain some terms to the jury. What is a retroverted uterus?

A So a retroverted uterus is when the top of the uterus, which is also called the fundus, points backwards to, like, your backbone, rather than pointing forward to your bellybutton.

Q How common of a condition is that in the general population of women?

A It's about one in five.

Q Yeah, so would you call that quite common?

A It's not uncommon.

Q In your OB/GYN practice, have you seen many patients with a retroverted uterus?

A Yes.

Q Do you think it's possible to safely perform a hysteroscopy on a patient with a retroverted uterus?

A Yes.

Q Okay. Is having a retroverted uterus a contraindication to a hysteroscopy?

A No.

Q Same questions for a fibroid tumor resection.

A No. That's not a contraindication.

Q Okay. In other words, in case the jury doesn't catch what that means, it means that --

A That's not a reason to not do the procedure because the uterus is retroverted.

Q Thank you. And how about the term bicornuate uterus?

A So bicornuate uterus means that the kind of normal pear-shaped uterus is more the shape of like a -- like a valentine heart. So it has a middle section that can be kind of thick and can divide the two cavities up. So you can actually have two uterine cavities, or, you know -- or wombs, if you will.

Q Okay. And you know, that's a good point. The -- another name for a woman's uterus is the womb, right?

A Yes.

Q And then the womb is where if a woman is pregnant, the baby will develop?

A Yes.

Q How common is it in the general population of women to have a bicornuate uterus?

A That's much less common. Less than 1 percent. 0.4 percent is the number I got last time I looked it up.

Q Okay. So somewhere around 1 in 100?

A Or less.

Q Okay. And is it, in your opinion, still possible to safely perform a hysteroscopy on a woman with a bicornuate uterus?

A Yes.

Q And is it possible to safely perform a fibroid tumor resection on a woman with a bicornuate uterus?

A Yes.

Q Okay. What does the term menorrhagia mean?

A Menorrhagia means heavy menstrual bleeding or bleeding lasting longer than the expected number of days that you would have that.

Q Okay. And fibroid tumor in the uterus, explain to the jury what that is and what it -- what it looks like.

A A fibroid is a benign, which means not cancerous, muscle tumor in the muscle of the uterus. The uterus has one big muscle, and it grows these tumors, and they're called fibroids.

Q Okay. And is that common in women?

A It's -- yeah, it is common in women. About 40 percent of women have them. Many don't know they do. But they're very common.

Q Okay. And these fibroid tumors, is it typical for a woman just to have one or multiple tumors or there's no real association?

A They -- you can have -- you can have one or you can have many.

Q Okay. And how big, like in terms of a, you know, pea or a ping-pong ball or something like that, how big do these -- can these tumors get?

A So they vary. They can be the size of a pea and hardly noticeable, and they can be the -- you know, the size of a, you know, grapefruit or larger. Yeah.

Q So you've seen them the size of a grapefruit?

A Yes. And probably even larger.

Q All right. So I want to move now into your opinions regarding this particular case. So you reviewed Ms. Taylor's medical history and medical records prior to today in order to form your opinions, correct?

A Yes.

Q Okay. Can you give us an idea of Ms. Taylor's general medical history from an OB/GYN perspective prior to her April of 2017 procedure?

A So she had been, you know, complaining of heavy menstrual periods, the menorrhagia, which -- periods lasting longer than they should, heavier flow than expected, impacting her life, and I believe she had some, you know, pelvic discomfort and pelvic pain.

Q Okay. Is menorrhagia highly unusual?

A No.

Q Do many of your patients that see you have complaints of menorrhagia?

A Yes.

Q And so just talking about it in the time period of the -- the few months prior to this procedure, what sort of treatment was Ms. Taylor getting from an OB/GYN perspective?

A I believe she was on birth control pills, which we use for the hormones to kind of regulate the cycles, were -- were mentioned and tried and then the decision to proceed with the procedure that occurred.

Q Did she receive a biopsy?

A Yeah. I believe she had a biopsy in the office, yes.

Q Okay. Would --

A An endometrial biopsy to check the lining of the uterus to be sure that the cells in there were normal, so.

Q And were there any cancerous cells?

A There were not.

Q Okay. And I guess I would say malignant cancerous cells.

A Yeah.

Q And there --

A No. There was no evidence of any cancer in the inside.

Q Did she receive a procedure called a colposcopy?

A Yes. That was related to different -- to a different issue though. That's for the cervix though, so.

Q Okay. So explain to the jury what happens during a

colposcopy and why that was recommended for Ms. Taylor.

A So if you have an abnormal Pap smear, which is the cervical screening test, you oftentimes do a colposcopy, which is actually looking at the cervix with a microscope, to be sure that the Pap smear didn't miss any areas of inflammation that could be precancerous in the future. Biopsies are done often, and then based on what the result is, you can plan if you're going to do a procedure to the cervix to remove those cells or just monitor it more closely with more frequent Pap smears.

Q Okay. And what were the results of Ms. Taylor's colposcopy?

A I'd have to check the record again. I'm sorry. I don't recall.

Q Okay. Do you --

A I believe -- well, I'm -- I don't recall anything in the record saying that there was any cancerous cells in her cervix, so.

Q Okay. And that's what the procedure is to --

A Would have --

Q -- check for?

A Would have identified, yeah.

Q Okay. So prior to the hysteroscopy procedure, is it fair to say that Dr. Brill had done some other procedures and ruled out any malignant cancer?

A Definitely. Yes.

Q Okay. The procedure in this case then, we've been calling it a hysteroscopy generally, but what different procedures had been recommended for Ms. Taylor?

A The recommendation and the kind of pre-op diagnosis was

hysteroscopy, which is looking at the inside of the uterus with a camera, resection of a fibroid, which was identified on an ultrasound, and then a procedure called endometrial ablation.

Q Explain what endometrial ablation is.

A So the endometrium is the lining of the uterus. So the uterus muscle, and it's on the inside part where the womb is where the baby would have been, there's a lining called the endometrium. Those are the cells that fill up with blood every month and get bigger based on hormones, and then come out, if you're not pregnant, and cause the menstrual flow. Endometrial ablation is removing the endometrium.

Q Okay. And so how is it removed? How is it done?

A There's different ways to do that. It can be burned with electricity, burned with a hot -- heated water, it can be frozen, it can be -- as a way to do it with cold also. Those are the --

Q And so what's the goal or the desire, the end result for an endometrial ablation?

A The result -- the desired result is to decrease the menstrual flow. So a woman who has an endometrial ablation, we would like her to have fewer days of bleeding, less flow, and hopefully maybe never have a menstrual cycle again. But that's not as common.

Q Now, given your review of Ms. Taylor's records, do you think that those procedures that Dr. Brill recommended for her were appropriate given her symptoms?

A Yes.

Q And do you think there's anything about her anatomy or her

medical history that made those procedures somehow inherently unsafe?

A Hysteroscopy and the fibroid resection, no. The endometrial ablation is kind of a tough one. In a bicornuate uterus with a uterine architecture that's kind of different, those ablation procedures, or the one that was chosen, would be difficult to perform.

Q Okay. And we're flashing forward here in just a minute, but ultimately Dr. Brill did not even attempt endometrial ablation in the procedure, correct?

A That's correct.

Q Okay. In reviewing the records, was -- well, I guess I should lay more foundation. Did Ms. Taylor have a retroverted uterus?

A Yes. That was identified on ultrasound that she had a retroverted uterus.

Q Okay. And had she been diagnosed with a bicornuate uterus?

A Yes. The same way; with ultrasound.

Q And she had been diagnosed with menorrhagia?

A Yes. By her history and symptoms, yeah.

Q Okay. Were all of those conditions well-known to Dr. Brill prior to the procedure, the hysteroscopy?

A Yeah.

Q I'd like you to turn -- if you'd look in those books -- and again, I'm sorry, I don't know which volume it is. But I'd like you to look at Exhibit 5. It's book 3. So I think it would be the -- behind you there.

A Okay.

MR. BREEDEN: You can go ahead and put it up.

MS. JOHNSON: Number 43?

MR. BREEDEN: Yes.

THE WITNESS: Did you say Exhibit 5?

MR. BREEDEN: Yeah. Exhibit 5. And then you're going to look for what's called a Bates number in the lower right --

THE WITNESS: Okay.

MR. BREEDEN: -- and that's HH43. You also have a monitor there in front of you. Is that monitor on?

THE WITNESS: Yeah.

MR. BREEDEN: So you can follow along with the monitor or you can follow along --

THE WITNESS: Okay.

MR. BREEDEN: -- on the paper copy in front of you, whichever's more convenient for you.

THE WITNESS: Okay.

BY MR. BREEDEN:

Q Have you seen Exhibit 5, Bates HH43 before?

A I have.

Q This is part of the records you reviewed?

A Yes.

Q What is this record?

A This is the operative report by Dr. Brill for the procedure done, the hysteroscopy done, on April 26th.

Q Okay. And --

A That's --

Q -- looking at the page right before this one --

MR. BREEDEN: Kristy, if you could bring that up.

BY MR. MR. BREEDEN:

Q What was Dr. Brill's preoperative diagnosis?

A His preoperative diagnosis was menorrhagia, fibroid uterus, and bicornuate uterus.

Q And what was his indication for surgery on Ms. Taylor?

A His indication was she had menorrhagia. She had ultrasound findings of a bicornuate uterus with a fibroid in the right horn.

Q So Dr. Brill not only knew that she had a fibroid and a bicornuate uterus, but he knew it was somewhere on the right horn of the uterus?

A Yes.

Q Okay. And he knew all that before he began the procedure?

A Yes.

Q All right. Going to the next page now, we have sort of the -- the narrative of the operative report. I don't want you to just read that to the jury --

A Uh-huh.

Q -- but I want you to sort of go through it and explain to the jury what happened during the procedure and what Dr. Brill did.

A Okay. Do you want me to start at the beginning? So --

Q There -- there's a great place to start.

A Yeah. So the patient was taken to the operating room and properly identified. She was placed on the operating room table and given general anesthesia by LMA by the anesthesiologist. She was placed in a lithotomy position using candy cane stirrups. Her lower abdomen and vagina were prepped and draped in a normal sterile fashion. Her bladder was straight catheterized for a small amount of urine by the operative room nurse.

Q Now, I'm going to stop you for a moment. It says that the patient was given anesthesia. Was she put under complete anesthesia?

A Yeah, that's general anesthesia.

Q Yeah. Women are not awake, partially awake during this procedure, are they?

A No, not in this case.

Q Okay. And it says that she was placed in the lithotomy position. What does that mean?

A So the -- with the -- with the stirrups. The best way to describe that is basically on her back with her feet up in the air.

Q Okay. And she was also catheterized. Why is that done?

A I think you could say that that could be done to avoid an injury to the bladder, or it could be done so when she wakes up, she doesn't have to try and be taken to the bathroom when she's really sleepy. But that's definitely kind of not a required thing.

Q Do you always do that for your patients when you perform hysteroscopy?

A With hysteroscopies, typically I have the nurses just let them use the rest room before they go back to the operating room. It's not -- it's not a right or wrong thing to do. It's just a choice.

Q Go ahead and continue with the operative report and tell us how the operation proceeds next.

A Sure. An examination under anesthesia was done, which revealed a retroverted uterus approximately eight weeks' size.

Q Okay. Again, I'd like to stop you. What does that mean, eight weeks' size?

A So even though this is gynecology and not obstetrics and even though that Kimberly wasn't pregnant at the time, we in gynecology measure how big a uterus feels to us based on the pregnancy size of the uterus. So an eight-week uterus is a real small uterus, kind of corresponding to an eight-week pregnancy, very, very low. For instance, a 20-week uterus would be like at the belly button. Roughly around there. So that's kind of how we judge -- describe to other people how big a uterus is.

Q Okay. So for a nonpregnant patient undergoing a hysteroscopy, is there anything unusual about being an eight-week size?

A No.

Q Okay. Go ahead and continue.

A Okay. "A tying out procedure was performed" -- or -- "I then placed a speculum into the vagina and performed a paracervical block using a total of 10ccs of quarter-percent Marcaine with epinephrine, and I used a spinal needle to do that. I placed a single-tooth tenaculum on the

anterior lip of the cervix. I attempted to place a Uterine Sound, but the uterine" -- that's a typo -- "uterine os" it's supposed to say, not lost -- "was stenotic at the cervix."

Q Okay. So let me ask you, what's a Uterine Sound?

A A Uterine Sound is a metal rod that has a blunt end on it that we put through the cervix gently to touch the top of the uterus to measure how big the uterus is in centimeters.

Q Okay. And so that tells the doctor performing the hysteroscopy how much space he has to work with --

A Essentially.

Q -- with the uterus? Okay.

A The size of the uterine cavity, yeah.

Q And did anything go wrong or out of the ordinary when Dr. Brill attempted to perform the Uterine Sound?

A Well, he stated that he couldn't do it because of a stenotic cervix. And what that means -- stenosis means just a very -- it's like a narrowing and tightening. So he -- when you have a stenotic cervix, you can't actually put anything through that easily. You have to -- you have to really kind of try harder to get anything through that cervix, so.

Q Okay. So even though he had trouble with the Uterine Sound, which is designed to tell the OB/GYN how much space he has in a uterus --

A Uh-huh.

Q -- he proceeded with the procedure?

A He did proceed with the procedure, but because he used

some dilators to try to open up the cervical opening, the cervical os.

Q Okay. And what did he do next? You can start with; I placed the diagnostic hysteroscope.

A "I placed a diagnostic hysteroscope into the uterine cavity, being careful to follow the pathway of the dilation. Normal saline was used for distension medium."

Q Okay. I'd like to stop you there. So what -- what does that mean, this distension medium and insertion of saline? What's happening?

A Okay. So in its normal kind of situation, the uterus isn't open real wide where you can actually have any room to see or anything inside there. It's very much kind of collapsed on itself. So we put the hysteroscope in, one of the channels of the hysteroscope puts saline through the scope and into the uterus to open -- to open it up. So it creates space. You can see.

Q So it's sort of like if you had a deflated balloon and then you put saline or air in it, and it starts to blow up or --

A That's a perfect example.

Q Okay. So what did Dr. Brill do next?

A Okay. So he states, "I was able to see what appeared to be a white uterine septum and two small areas that appeared to be the uterine horns."

Q Now, let me stop you there. Did you find that unusual that he's saying -- he's not saying he found what they are; he's saying things appear to be. Did you find that unusual?

A It does -- well, it does introduce a little bit of uncertainty into it, yes.

Q Okay. And so what did he write next about whether he was able to immediately find the fibroid tumor?

A Well, he said there was -- there is no obvious fibroids seen at the right side because there was a -- there was white tissue here that he felt could be the septum covering the area.

Q And then he took pictures of that --

A Yeah.

Q -- right?

A Yeah, he took pictures.

Q Okay. So when Dr. Brill went to do the resection, the fibroid tumor resection, he could not locate the fibroid tumor originally; is that right?

A That -- that's correct.

Q Okay. And so he felt that it might be concealed by some white tissue that he saw, right?

MR. MCBRIDE: Objection. It's leading, Your Honor.

THE COURT: Sustained.

BY MR. BREEDEN:

Q So why did Dr. Brill say he was having difficulty finding the fibroid tumor?

A Because he appeared -- he believed that the septum was covering it up or some white tissue was covering it up, that he thought might have been the septum.

Q What did he decide to do next?

A Okay. At that point he switched over to the resectoscope and he put the -- he put this -- the resectoscope through the cervix and back into the uterine cavity.

Q Okay. And what did he do next?

A He looked again and said he was able to visualize what appeared to be the septum, and then using the yellow pedal of the resectoscope began to cut what appeared to be the septum anteriorly on the uterus.

Q Now, let me ask you, what's the significance of using the yellow pedal? What does that mean? Where is the yellow pedal positioned?

A So the hysteroscope is held in your hand and the -- and the -- and then the pedals are at your feet, and you can -- with this resectoscope, you can choose between two different pedals, a blue and a yellow, which controlled different functions on the resectoscope.

Q Do you recall what type of resectoscope Dr. Brill was using?

A It was a Symphion.

Q And so what happened immediately after Dr. Brill started using the yellow pedal?

A Almost immediately after, he mentioned that he used the yellow pedal, he stated that he saw was appeared to be a uterine perforation.

Q Okay. And did he describe where that perforation was?

A Not in this -- well, no. He did say he was cutting anteriorly,

and then noticed the -- noticed the perforation afterwards.

Q Okay. Do you know from later records where the perforation was?

A Yes, it was -- it was anterior on the uterus.

Q And is that in the area where Dr. Brill was intending to resect the white tissue?

A Yes.

Q Okay. So between the time that Dr. Brill activated the yellow pedal to begin resection, and the time that he observed the perforation, what was he doing inside the uterus?

A By the time he activated the pedal and noticed the perforation?

Q Yes, between.

A Well, he was cutting tissue and then saw the perforation.

Q It was immediately afterward?

A That's what it seems like in the note.

Q And so what did he do next after he observed a perforation in the uterus?

A Okay. Where is it? That he said he noted that the tip, that the -- that the uterine horns were narrow. He just made an observation there, and then he said he -- I immediately stopped the use of the resectoscope at the time of the perforation. I removed the hysteroscope and replaced it with a diagnostic hysteroscope, so --

Q I'm sorry. Let me interrupt you --

A Yup.

Q -- for just a second.

A Yup.

Q Why would you stop using the resection instrument once you identified a perforation?

A Because it's not safe to continue resecting when you have a hole in the uterus.

Q Okay. And so go ahead and continue; what did Dr. Brill do next?

A So he switched over to the diagnostic scope, so he took the resectoscope out, he again used saline for the distention medium, and then he noted there did appear to be an anterior perforation.

Q Okay.

A So at that point he confirmed that it was anterior.

Q Did he look for a bowel perforation or other evidence of injury to something other than the uterus?

A So in the next sentence, yes he said there was no evidence of bowel or other organs at the area of it. So he -- so no, it didn't appear that he looked at -- for injury, he just noticed that there wasn't any bowel near the area of perforation.

Q Does he state very clearly what he did to look for potential bowel injury?

A No. It just states that he -- let's see. He -- well, he used the scope to look is what it sounds like he did, but they didn't really state what -- how he did that.

Q Okay. Now is it your opinion that Ms. Taylor actually did

sustain a bowel injury or bowel perforation during this procedure?

MR. MCBRIDE: Objection, Your Honor. It's leading. He can ask what's -- or his opinion, but he's leading into the opinions.

THE COURT: Counsel approach.

MR. BREEDEN: Thank you.

[Sidebar at 10:22 a.m., ending at 10:24 a.m., not transcribed]

BY MR. BREEDEN:

Q So did -- during this procedure, did Dr. Brill identify any perforation to the bowel?

A No.

Q Okay. What did he do next?

A He decided not to use the resectoscope any longer, and then he decided to not do the endometrial ablation.

Q What -- I'm sorry. What is your opinion as to whether or not Ms. Taylor actually had a bowel perforation at that time?

A My opinion is that's when the bowel injury occurred.

Q Even though Dr. Brill did not find it?

A Correct.

Q And so what did Dr. Brill do next?

A Then he performed a sharp curettage after removing the hysteroscope.

Q Explain to the jury what a sharp curettage is.

A So a curette is kind of a -- like a loop of metal on a rod that is very, very, very sharp. It is -- it would cut you if you dragged it across your skin, and it's used to go inside the uterus and remove some of that

endometrial lining to send it to the lab to see if the cells are normal, you can use it to remove the thick tissue to try and help maybe make her period improve, it can -- it can be therapeutic, as well, or it can remove, you know, small polyps or a little growth or something that would be -- be in there.

Q Why would Dr. Brill do this for Ms. Taylor?

A So I believe he -- I'm not sure if it -- to get a sample of the uterine lining, to reevaluate it, to be sure there were normal cells still.

Q He had already done some other test to evaluate for malignant cancerous cells, correct?

A Yes.

Q Okay. It -- would this curettage be more definitive than his other test? Is there some reason why he would want to do this in addition to the other test?

A It can, it can be more definitive. You can potentially get more tissue.

Q And so after using the sharp curette to obtain tissue samples, what did Dr. Brill do?

A He then at that point stopped the procedure, did not do any more resecting, and did not do the ablation.

Q How long does a hysteroscopy typically take?

A So what I tell my patients, anywhere between five minutes and 30 minutes, just on -- depending on what has to be done, what we find, if we do have to resect a fibroid or a polyp or something, so --

Q Do you recall how long Ms. Taylor's hysteroscopy lasted?

A I'd have to double-check that. No, I don't recall.

Q Okay. If you could look at the previous page, that might say when the procedure began and stopped.

A Okay. Thank you.

Q Is it reflected on there?

A Let's see. I don't see it.

Q That's okay. I must have the wrong reference. I'd like you to look at HH 158 next.

A Okay. There is a timestamp of when -- well, yeah. I'm sorry, which number? 58?

Q I'm sorry. I don't want you to not answer. What's the timestamp?

A Well, I mean he -- it says perform and sign, and that was a two-hour thing, window there, but I don't know if that was done right away, and I think that there's probably notes somewhere in the chart that would definitely put the start time and the stop time more accurately than this.

Q What's the timestamp on the operative report that it was prepared by Dr. Brill?

A 10:08 a.m.

Q Okay. Is the operative report available to other medical care providers before it's officially closed and signed by Dr. Brill?

A That's a tough question to answer. Depending on if they used the same electronic health record, they may be able to see the draft of it before it's signed, but if they're in a system where they can't get

these records, then -- then no, you wouldn't have any record of it yet.

Q Okay. I'd like you to next look at HH158.

A 158?

Q 158. What's this document?

A This is the -- the pathology report from an endometrial curettage.

Q And are those from the -- where the cells from the curettage you're just describing were analyzed?

A Yes. Those would have went to the -- a lab and were analyzed by a pathologist.

Q Did they show anything unusual for those cells?

A No.

Q Does that report, in your mind, really have any significance in this case as to when or how the perforations of the uterus and the small bowel occurred?

A No.

Q Why is that?

A Why does the report not reflect the cause? Is that what --

Q Why do you think it's not particularly relevant to this case?

A Just because it just says normal benign endometrial tissue.

Q Okay. I mean, if there were perforations during the procedure, is it going to show up in that pathology report?

A I don't think so, no.

Q Doctor, in Defendant's opening statements, a remark was made that the uterine perforation was repaired. Did you see any

notation in Dr. Brill's report that he repaired the uterus perforation?

A No.

Q And so what sort of treatment is needed for uterine perforations, just in general?

A So in an uncomplicated uterine perforation, what the standard practice to do is to stop any resection procedures, if that was done, go ahead and tell the patient afterwards that there was a perforation, and she might expect a little more cramping than usual, maybe some -- a little more vaginal bleeding than usual, and that's it.

Q Okay. In your experience, do uterus perforations typically require a surgical repair?

A No.

Q Okay. Have you seen some that do?

A No, I've heard of them, other colleagues have done that, but it's very -- it's uncommon.

Q Okay. So I want to contrast that with a bowel perforation. In your experience, do most bowel perforations require surgical repair?

A Yes.

Q And so why is that? What's the difference? Why does the bowel need repair, but the uterus doesn't necessarily need repair?

A Well, like we said before, the uterus is a big muscle and if you have a simple, uncomplicated perforation, the muscle contracts, and a small amount of bleeding usually gets contained with that, and that's what causes those cramps; but when you perforate a bowel you leak fluid from inside the intestines into your body and that can cause a very

-- a lot of sickness, and even -- and even death if it's not identified and fixed.

Q Okay. And where was Kim taken after she was taken out of the operating room?

A She went to the post-anesthesia care unit called the PACU or what they call the recovery room back in the old days.

Q Okay. And so in your experience, for a normal hysteroscopy procedure, what's a typical amount of time to spend in a PACU?

A So most patients spend between, you know, 30 minutes and an hour max in the PACU. Once they're awake and aren't complaining of nausea from anesthesia and if their pain is controlled with pain medications which always usually is, their ride comes, and they get to leave.

Q Okay. How long was Kimberly Taylor in the PACU?

A Approximately seven hours.

Q Do you think that's unusually long?

A I think that's unusually long.

Q In your experience, what sort of pain levels or symptoms do women have after a hysteroscopy when they're in the PACU or recovery room?

A So the most common pain medication we give in PACU is a medication called Toradol which is just pretty much IV Ibuprofen, and when I send people home from these procedures, that's the only medication I give them, usually Motrin or Ibuprofen, and we don't use any narcotic pain medications like, you know, Vicodin, Norco; these are

the medications that are stronger.

Q So do you think that's out of the ordinary to have to administer medication such as Dilaudid or Fentanyl to a patient who's recovering from a hysteroscopy?

A Certainly.

Q What were Kim's pain complaints while she was in the PACU/

A She complained of, you know, ten out of ten pain, and had some associated nausea with that.

Q And again, in your experience, is it typical for patients when they have a hysteroscopy, and they go to the recovery room or the PACU to report ten out of ten pain?

A Not typically. Pain level can be very subjective, but ten out of ten pain is really severe, and that's a level that's higher than would be expected from a -- from a hysteroscopy.

Q Now up to this point in time when Kim has had the procedures and is in the PACU, did you see any indication in the records that anyone had advised her that she had a perforation during the surgery?

A No.

Q So I want to talk about after Kim was discharged from the hospital.

A Uh-huh.

Q There came a time when Kim called an ambulance and returned to the emergency room; do you recall reviewing those records?

A Yes.
Q Okay. Can you please turn to Exhibit 1 at 1211? So that's probably in another book there behind you.
A Going to be in there.
Q Think you can close that one up, we're -- I think we're done.
A You're done with this one? Okay. This is book one?
Q Yes.
A Okay. I have Exhibit 1 in front of me.
Q And we're looking at page 1211.
A Page 1211?
Q Yes. There's a Bates number in the bottom, not the page number, but the Bates number.
A Let's see here.
Q It will have a SRDH in front.
A SRDH, and you want 1211?
Q Correct.
A This book only goes to 730-something.
Q Oops, sorry. It will have to be the next volume.
A Getting a workout with these books. Almost there. Okay. I have SRDH1211 in front of me.
Q Great. So when Kim was taken by paramedics to the emergency room, what symptoms did she report?
A Abdominal pain, and nausea, vomiting, severe pain.
Q And what did she report to the paramedics?
A That she had -- that she just had a -- a fibroid removal and

removal of the uterine septum, and a D&C.

Q Okay. And how did she rate her pain?

A Let's see here. Severe abdominal pain, eight out of ten. So -- I'm sorry. I didn't lie. I misspoke. Patient states pain ten out of ten, throughout the abdominal pain, and then at -- in the ER it was eight, but yeah. So when she saw and talked with the paramedics she was complaining of ten out of ten pain.

Q Okay. And where did she describe the pain? Where was it on her body?

A She says diffuse, which is all over, throughout the abdomen and upper pelvis, and she said it was constant, so it wasn't going away.

Q Okay. And so I know this is kind of on the lower left of this report -- well, you know what I'll strike that. Once Kim arrived in the emergency room, what sort of treatment was administered to her?

A Lab work was drawn, IV fluids, and an IV was started and she was getting pain medication.

Q And do you recall the name of the doctor who saw her at that time?

A That was Dr. Christensen, the first ER.

Q Okay. Did she also have radiology?

A And then had -- yeah, she had imaging like a CAT scan, a CT scan.

Q And what did the CT scan show?

A The CT scan showed what they call pneumoperitoneum which is air in the abdominal peritoneal cavity, and fluid -- increased

fluid in the abdominal and pelvic cavity.

Q Okay. And so what do those findings on CT indicate to you?

A They indicate -- when you see pneumoperitoneum that is strongly suspicious for a perforation to an internal organ. And fluid -- the couple of things that fluid could be, but it could be blood. It could be fluid from hysteroscopy, but it definitely could be bowel contents.

Q And was Ms. Taylor given any further treatment on that trip to the emergency room or was she released?

A She was released.

Q Okay. Do you know where she went after she was released?

A She went back home.

Q Okay. Did there come a time where she returned to the emergency room?

A Yes, several hours later the next day she returned via ambulance to the emergency room because the pain and her nausea and vomiting continued.

Q What emergency room doctor did she see at that time?

A That was Dr. Frank that time.

Q What was Dr. Frank's assessment and diagnosis of her?

A Dr. Frank seemed concerned that there was a bowel perforation.

Q And did he attempt to consult any other physicians on that working diagnosis?

A Yes. So the -- as done in many medical groups, the person who is on call for the group fielded the phone call and received this

information and then was asked for -- at this -- it was a woman, so we asked for her opinion on what treatment steps were needed next.

Q Okay. And do you remember what her assessment was?

A That it was -- her assessment was that she was having pain but -- and that she had a uterine perforation but did not believe that there could have been a bowel perforation.

Q Okay. And do you have any reason, or do you know why that doctor would doubt there was a bowel perforation?

A Just because of how uncommon it is.

Q And so what happened next for Kimberly the second time she was taken to the hospital?

A She eventually had a consultation from a general surgeon who went over the labs and the CAT scan report.

Q Okay. And what was that --

A And examined her and determined that -- her findings.

Q Do you remember that surgeon's name?

A That's Dr. Hamilton.

Q Okay. And so I'd like you to please turn in Exhibit 1 -- it might be in the other book or the first book -- to page 39?

A Okay.

Q All right. What is this exhibit?

A This is Dr. Hamilton, the surgeon's full operative report of the operation on Kimberly Taylor.

Q What was Dr. Hamilton's preoperative diagnosis?

A Peritonitis. Concern for bowel perforation. And then a

recent uterine hysteroscopy for menorrhagia with a reported uterine perforation.

Q Okay. So the other day we actually heard testimony from Dr. Hamilton so I don't want to have you read her entire operative report again word for word, but can you explain to the jury very generally what type of operation was performed on Ms. Taylor and what Dr. Hamilton found?

A Okay. So initially, Dr. Hamilton made a small incision and inserted a laparoscope which is a camera to look inside the abdominal and the pelvic cavity. And then when she saw the extensive leakage of bowel contents and infection, converted to making a larger incision so she could see better and correct the perforation.

Q Okay. And did she find a uterine perforation?

A She noted that she saw an anterior uterine perforation.

Q And what was the size of it?

A She said the uterine perforation was about one centimeter.

Q Okay. And how does that compare to the size of the resectoscope?

A That's bigger than the resectoscope. The resectoscope is about three-and-a-half millimeters.

Q Okay. So the one-centimeter perforation then is -- you know, two-and-a-half, three times greater than the diameter of the resectoscope?

A About two-and-a-half times greater than the diameter of that scope, yeah.

Q All right. And did Dr. Hamilton find a bowel perforation?
A Yes. Dr. Hamilton saw a three-centimeter bowel perforation.
Q Okay. And where was this perforation in the body?
A She says it's -- it was a foot from the terminal ileum so that's -- yeah. In the middle of the --
Q Can you just explain that in lay person's terms, what that means?
A So we have our stomach, then we have our small intestine, which is you know, 20 feet of kind of tangled stuff, and then we have our big, large colon and this was in the small intestine up high.
Q And I'd like you to turn now in Exhibit 1 to page 1121 and 22. You know, Doctor, I'm sorry. Before you do that, I forgot to ask you --
A Yeah.
Q When Dr. Hamilton found the bowel perforation what did she do to fix or repair that?
A She had to resect a bowel on either side of the perforation and then reconnect it together again.
Q Okay. And how large of a portion of the small bowel did she have to remove?
A I would need to take a -- I think she said seven to nine centimeters is what she said, something like that.
Q And so can you please turn now to Exhibit 1, 1121?
A 1121?
Q Yes.
A Okay. 1121.

Q Okay. So what's this report?

A This is the pathology report for the removed bowel that had the perforation in it.

Q Now, the pathologist, is he actually there during the surgery?

A No. Not in this case, no.

Q Okay. How does he or she get the specimen then that's taken out of the patient.

A Okay. so immediately after it's taken out of the patient, it's put in a fixative, like formalin, which is liquid and then someone brings it down to the lab and it sits there likely until the next day when the pathologist will start examining it.

Q What did the pathologist in this case note in his report?

A He noted small bowel mucosa with marked acute serositis and a grossly identified transmural defect with marked acute serositis.

Q Oh gosh. Can --

A Yes.

Q -- can you translate that into normal English for people?

A So essentially, what that means is inflammation of the lining around the intestine and a transmural means like through the wall so a defect -- that's a fancy way of saying a perforation.

Q And so how big did the pathologist record the perforation?

A The pathologist said that there was a 1.6-by-1.2 centimeter transmural defect. So 1.6-by-1.2 centimeter perforation of the small intestine.

Q Okay. And again, I'll refer you to this report and it might

refresh your memory. How big was the actual portion of small bowel that was removed from Kimberly?

A Seven centimeters long.

Q And does the pathologist report tell you one way or another whether the perforation was caused by a thermal injury as opposed to just a puncture or a push type injury?

A The pathology report doesn't mention either way what was the cause of the perforation.

Q Is there any indication in the record that the pathologist was asked to comment on that issue?

A No.

Q All right. Doctor, what is your opinion as to when and how the uterus perforation was caused during Dr. Brill's surgery?

A So in my opinion, reading the operative report, it seems clear to me that the perforation occurred during resecting with the yellow pedal as that's the first time it's mentioned right after Dr. Brill pushed the yellow pedal, he noted a perforation.

Q And does that mean that the perforation was caused with thermal energy or heat?

A Yes.

Q And what is your opinion as to how and when the bowel perforation occurred?

A I believe the bowel perforation occurred at the same time as the heated resectoscope cut through the uterus and continued to cut in through the bowel.

Q Okay. Now, is it possible to have what's called a delayed thermal injury?

A It's possible.

Q Okay. And so what does delayed thermal injury mean?

A So that's where -- well, delayed thermal injury of the bowel would be where you burned the bowel but didn't cut through it. But that burn causes so much weakening of the wall that eventually it perforates on its own.

Q Okay. And in this particular case, do you think this is a delayed thermal injury or do you just think it was perforated with the resectoscope when the resectoscope first touched it?

A I think based on her symptoms and her initial CAT scan findings and everything, it happened right away with that resectoscope. I don't think it was a delayed injury. It was a cut into the bowel.

Q After her bowel resection surgery, how long did Kim have to stay in the hospital?

A She stayed for nine days.

Q What sort of treatment and therapies did she have to go through while she was in the hospital?

A She had to get pain medication, frequent lab work, IV fluids. She wasn't eating very well and intravenous antibiotics.

Q When Kim was released from the hospital, what sort of home care did she have to complete?

A So she had to have a special IV placed in her arm that goes all the way from the veins here all the way into your heart to administer

long-term antibiotics that she self-administered at home for four weeks.

Q Doctor, I want to ask you, you know, some of your opinions on standard of care now. Do you believe that Dr. Brill fell below the standard of care for a physician when he performed the original hysteroscopy and fibroid tumor resection?

A Yes.

Q Okay. In your opinion, what are all the ways Dr. Brill fell beneath the standard of care?

A So I think that not being sure where you're cutting in regards to anatomy of the uterus and cutting in an area that you can't visualize as well as you need to, using the resectoscope in a way that was unsafe that not only cut though the uterus but cut into bowel. I don't think it's standard practice to put a sharp curette into perforated uterus because I think that could open yourself up to injuring the bowel if the curette was put in there and went through that perforated hole, and it really is standard of care when you perforate the uterus using an energy device like the resectoscope which was used in this case not identifying -- or not evaluating the bowel more carefully to try and find an injury. And by that it's standard of care while using an energy device to do a laparoscopy which would be to look from inside to look at the bowel to be sure it was injured.

Q Okay. And do you have any opinions regarding alerting the patient of the injury?

A Certainly, giving the patient warning signs, you know, that they had a uterine perforation, and they might expect more pain and if

they do, to -- you know, to call and be seen sooner and to mention that. But that would be something I think the patient would need to know.

Q Okay. So we're going to go back and talk about these issues one by one. So the first opinion that you have was that Dr. Brill fell beneath the standard of care in his cutting in the uterus and in using the resectoscope; is that correct?

A Correct.

Q Okay. Is it your opinion that the procedure requires a doctor to be able to visualize where he's cutting when he's using the resectoscope?

A Yes, visualization is you know, a huge key to hysteroscopy. The fluid management systems, that saline distention that we talked about, that's all goes through a pump that helps provide pressure to open the uterus bigger so you can see better. It tries to use the suction to recirculate that fluid and get the blood out because you can see some bleeding. So visualization is very necessary and important in these procedures.

Q In your opinion, is it beneath the standard of care to use the cutting element of the resectoscope if you can't clearly visualize what you're cutting?

A I think so -- yes.

Q And in this case, regardless of how the uterine perforation was performed, Dr. Brill did not see himself actually perforate the uterus, did he?

A He didn't indicate that in the notes, so no.

Q He indicated that he was cutting and then saw the perforation later?

A Yes, that's what he said in the note.

Q Does the standard of care also require the doctor to avoid cutting or pushing so hard with the resectoscope that it causes a perforation --

MR. MCBRIDE: Objection, Your Honor. Again, it's leading.

THE COURT: Sustained.

BY MR. BREEDEN:

Q What does the standard of care require as to the use of force for these instruments in the uterus?

A I'm not certain there's a standard of care for that. But certainly, being careful and cautious during cutting procedures would be necessary to perform these safely.

Q You mentioned that you felt Dr. Brill fell beneath the standard of care in the use of the curette. What does the standard of care require of a physician performing a hysteroscopy once he or she observes a perforation?

A So again, if it's a simple, uncomplicated perforation using blunt instruments, I think the standard practice would be to stop any other procedure you're going to do so you don't inflict more injury. And then, informing the patient of the risks and the precautions.

Q And the use of the curette by Dr. Brill after he had already identified a perforation, is that below the standard of care in your opinion?

A I don't think that's standard practice to put a sharp instrument through a perforated uterus.

Q And when Dr. Brill used the curette after the perforation was identified, does he have visualization of that curette?

A No. No. So when you do the curettage, that is outside the body. You're -- you're putting it through the cervix and not seeing where you're -- what you're curetting. So a sharp -- a sharp instrument in the uterus where you wouldn't know where it would be.

Q When there's already an identified perforation.

A In this case, where there was already an identified perforation.

Q Okay. You mentioned that you felt Dr. Brill fell below the standard of care in assessing the patient for further injury beyond the uterus repair; is that true?

A I did say that.

Q Okay. What does the standard of care require in terms of looking for injury to the bowel or other adjacent organs after a uterine perforation is identified?

A So again, after a uterine perforation with a -- with a -- with a blunt instrument and no energy and no cutting, precautions and information for the patient. When you're using a heated energy device that can cause injury to the bowel, you need to determine if that happened or not. And that would be through the laparoscopy.

Q Okay. Does use of the thermal resectoscope device, does that present a greater risk to the patient of injury than another

instrument that doesn't have -- doesn't come with heat?

A Yes. Yes.

Q Okay. Explain for the jury what laparoscopic examination of the bowel would include.

A So laparoscopy would be making an incision around the belly button area and putting a camera through that area, using carbon dioxide gas to kind of blow up the area so you can see, and then looking at the intestines with your -- with your eyes.

Q Okay. And is that standard of care in your opinion?

A After a perforation with energy -- heat, yes.

Q Okay. And did you rely on any medical texts or treatises in order to form that opinion?

A Yes. A couple of the, you know, early books on hysteroscopy and some of the kind of standard textbooks for operations in gynecology state just that, that further evaluation of the bowel with laparoscopy is necessary with a perforation like Kimberly Taylor had.

Q So this isn't just something you've come up with today. This is something that's in medical texts on how to perform this procedure?

A Yeah.

Q And once there is a uterine perforation, what do you think the standard of care requires the doctor to do in terms of advising the patient of that?

A What -- I'm sorry. What's the standard of care in terms of advising her?

Q Yes. What should be done by the doctor to advise the

patient that a perforation has occurred?

A Well, you just tell her that the -- what happened and that they're going to, you know, that the procedure that was expected to be done wasn't done. And then, the kind of expected symptoms that she would have at home. And then the precautions of what would make her feel like there was something more serious going on and what to do about that.

Q Now, I'd like to talk a little bit about perforations during hysteroscopy. Sometimes, perforations of the uterus do happen during that procedure, don't they?

A Yes.

Q What is it about this particular case, Ms. Taylor's case, that makes you feel Dr. Brill fell below the standard of care, then?

A Because his uterine perforation wasn't confined to the uterus and went all the way through the uterus into another organ and injured it. And then, failure to kind of evaluate that situation and diagnose it earlier.

Q Have you ever caused a bowel perforation during hysteroscopy?

A No.

Q Okay. Is that considered a typical risk of that procedure?

A I think it's a very uncommon risk of that procedure.

Q Now, based on previous testimony in this case prior to trial, the Defense may suggest that this was not a thermal injury with the resectoscope while the resectoscope was activated, but instead, that the

tip of the resectoscope simply pushed through the uterus.

MR. MCBRIDE: Objection. Your Honor, again, misleading.

THE COURT: Sustained.

MR. BREEDEN: I'm just laying a foundation. I'll ask more generally, then.

BY MR. BREEDEN:

Q What are all the reasons why you think this injury happened during use of the thermal cutting device as opposed to the blunt tip of the instrument?

A Well first off, because that's when it was identified. In the operative report, it was stated that the yellow pedal was used, and then there appeared to be uterine perforation. While advancing the resectoscope, you're supposed to be able to see where you're going well and to approach the uterine wall and keep pushing seems unlikely. It seems more likely than not that the injury occurred during the resection with the -- using the yellow pedal.

Q And --

A And also -- sorry. But also, the size. The size of the uterine perforation would -- I would expect it to be smaller if it was done by that 3.5-millimeter scope -- resection device rather than the -- the result of -- of cutting, which would make a bigger defect.

Q When the doctor is using the resectoscope, if you touch the lining of the uterus, can a doctor feel that?

A Yes.

Q And can you describe to the jury, like, how easy or how

difficult is it to perforate the uterus in that manner? What does the doctor feel?

A So you would feel resistance, which is the -- you're hitting up against the uterine muscle. And you should notice that, that resistance.

Q Dr. Brill didn't list any such resistance in his operative report, did he?

A No.

Q Okay. Doctor, I just want to change topics here briefly. You traveled here from California to testify today, correct?

A Yes.

Q And you've previously reviewed many medical records and written reports regarding your opinions in this case, correct?

A I have.

Q Okay. And if you weren't here today and doing those sorts of things, you would be seeing patients of your own, right?

A Yes.

Q And so did you charge for the work that you've done?

A Yes.

Q Okay. And in total, you know, as of today, how much has been charged or how much is owed to you for the work that you've done?

A Not including today, but it's about, you know, $6,000 to date.

Q Okay. And as part of your preparation for this case, did you review the records of Henderson Hospital?

A Yes.

Q And do those include the operative report of Dr. Brill and the PACU records?

A Yeah.

Q Do those include the anesthesiology records of Dr. Yeh, who testified before you?

A Yes.

Q Okay. And do you find that the post-operative treatment that was administered at the hospital was reasonable and necessary?

A At the -- at the surgery center or at the hospital?

Q At Henderson Hospital, after the hysteroscopy in the PACU.

A I did question the PACU nurse's decisions to not inquire as to why the patient continued to have such bad pain for such a prolonged period of time after the procedure.

Q But the treatment that was administered, keeping her and administering medication, did you find that all to be reasonable and necessary?

A Well -- yes. Reasonable and necessary given what she had done.

Q Okay. And do you believe the reason the hysteroscopy was unsuccessful was due to the perforation caused by Dr. Brill?

MR. MCBRIDE: Again, it's leading, Your Honor.

THE COURT: Sustained.

BY MR. BREEDEN:

Q Why do you believe the hysteroscopy was unsuccessful?

A Because there was a complication created by Dr. Brill when

he perforated the uterus and the bowel.

Q Was there any reason other than the perforation that that procedure was unsuccessful?

A You couldn't continue the ablation with a perforation. But that would have been a simple complication, and this was different.

Q Do you believe the perforations caused the pain and suffering and other symptoms that Ms. Taylor reported at Henderson Hospital?

A Yes.

Q Did you also review the medical records of Dignity Health or St. Rose Dominican Siena Hospital?

A Yes.

Q And did those include the records of Dr. Frank?

A Yes.

Q Did those include the records of Dr. Hamilton?

A Yes.

Q Did they include the records of Dr. Raman?

A Yes.

Q Did those include the records of Dr. Lipman?

A Yes.

Q Do you recall what sort of treatment those providers administered? We'll start with Dr. Frank.

A What he -- he gave her pain medications and antibiotics.

Q But what type of doctor is he?

A Oh, emergency room physician. Sorry.

Q Okay. And then, Dr. Hamilton, what sort of doctor is she and what did she do?

A She's a general surgeon, and she performed the bowel resection.

Q And same question for Dr. Raman.

A Dr. Raman was the hospitalist who manages the daily, kind if inpatient care of -- of Ms. Taylor.

Q And same question for Dr. Lipman.

A Lipman was an infectious disease specialist who was consulted by the hospitalist to tailor the -- tailor the antibiotics to Ms. Taylor based on the type of infection she had.

Q Okay. And does the treatment at the hospital include radiology and labs?

A It did.

Q Okay. And so in your opinion, is all the treatment that Ms. Taylor received at St. Rose Hospital reasonable and necessary?

A Yes.

Q And was it caused by the perforations?

A Yes.

Q And in your opinion, are the symptoms that Ms. Taylor reported during her treatment at St. Rose Hospital, are those caused by the perforations?

A Yes, they were.

Q And you've testified that you're aware that Ms. Taylor had to be taken by ambulance to the hospital twice. Do you recall that?

A Yep. Yes, sir.
Q And in your opinion, is that ambulance treatment and transport to the hospital reasonable and necessary?
A Yes, it was.
Q And in your opinion, was that caused by the perforations that Dr. Brill did?
A Yes.
Q And are the symptoms, such as the pain and suffering and other things reported on those records, is that causally related by those perforations?
A Yes.
Q Okay. Doctor, have your opinions during your testimony here today been stated to a reasonable degree of medical probability?
A They have.
Q Okay. And do you believe the perforation injuries, you know, just as summary. Do you believe the perforation injuries we discussed were a result of Dr. Brill failing to meet the standard of care for the hysteroscopy procedure?
A Yeah.
Q Do you believe all the treatment Kimberly had afterward to address her injuries was related to the perforations?
A Yes.
Q Do you believe that care was reasonable and necessary?
A It was.
Q And do you believe that Kim's symptoms, such as her pain

and suffering and the other symptoms she reported during her stay, do you think those were caused by the perforations?

A Yes.

MR. BREEDEN: Just a moment, Your Honor.

THE COURT: Uh-huh.

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

THE COURT: Cross-examination.

MR. BREEDEN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. MCBRIDE:

Q Good morning, Dr. Berke. How are you?

A Good morning.

Q Good. Now, you and I have never met before, right?

A No.

Q All right. And Dr. Berke, you're here to testify against Dr. Brill, that his conduct fell below the standard of care; is that right?

A It is.

Q And it's also correct that you, yourself, have not used and do not use the Symphion device in your practice, true?

A True. I use a device called the MyoSure that I feel is safer. It does not have heat associated with it.

Q It's a yes or no question. And if you're -- if counsel wants to ask a follow-up question, it's a yes or no question.

A Sure.

Q You don't use the Symphion device, right?

A No.

Q And you don't have any experience using that Symphion device, true?

A No.

Q Okay. No, that's true?

A I do not have any experience using the Symphion device.

Q Okay. And in fact, when you talked about the size of the Symphion device, the measurement, you said the Symphion device is 3.6 millimeters, I think?

A Yeah.

Q Okay. The size of the resectoscope is a little bit larger. It's 6.3 millimeters, correct?

MR. BREEDEN: I object. It misstates the evidence.

THE COURT: Counsel, approach.

[Sidebar at 11:08 a.m., ending at 11:10 a.m., not transcribed]

BY MR. MCBRIDE:

Q Let me clarify, Doctor. The hysteroscope that the Symphion slips inside, the size of that is -- at the end is 6.3 millimeters, correct?

A I know there are different sizes, but that's a normal size, yes.

Q Okay.

A I would agree that that is the hysteroscope part.

Q Correct. Now, Doctor, let me go back and start with a little bit of your background. You're a doctor of osteopath medicine, correct?

A Correct.

Q All right. And did you apply to any medical schools other

than osteopathic schools?

A No.

Q Okay. And you were a fellow in the American College of Osteopathic OBGYNs, correct?

A Yes.

Q That's not the same organization that Dr. Brill belongs to, correct?

A No. It is not the same.

Q Okay. And you had testified in your deposition -- do you remember having your deposition taken in this case?

A Yes.

Q You testified that uterine perforations are a known risk and complication of a procedure like Dr. Brill performed, correct?

MR. BREEDEN: Object, Your Honor.

THE WITNESS: I testified that a --

THE COURT: Hold on one second. Counsel, approach.

[Sidebar at 11:11 a.m., ending at 11:11 a.m., not transcribed]

BY MR. MCBRIDE:

Q Doctor, do you recall having your deposition taken?

A Yes.

Q All right. Do you recall testifying that uterine perforation is a known risk and complication of the procedure performed by Dr. Brill?

A Yes.

Q Okay. You also testified that a bowel perforation is a known risk and complication of this procedure, true?

A Yes.
Q Okay. And you would agree with me that uterine perforations can and do occur in the absence of negligence?
A Simple ones, yes.
Q Well, Doctor, you would agree that they can occur in the absence of negligence, right?
A I would. Yes, I agree.
Q Okay. And in fact, you've had at least 10 to 20 patients with a uterine perforation, correct?
A Yes.
Q Ten to twenty patients in six hundred, by your estimate, procedures that Dr. Brill performed? Similar procedures?
A Yes.
Q So you're aware that's almost twice as many uterine perforations and half as many hysteroscopies as Dr. Brill?
A I am now.
Q You -- well, you read Dr. Brill's deposition, right?
A Yes.
Q You read Dr. McCarus' deposition, didn't you?
A Yes.
Q You're aware that Dr. McCarus, who has been practicing since the 1980s testified he has done thousands of hysteroscopies and has had a dozen or so uterine perforations?
A Yes, sir. I --
Q Okay.

A -- did.

Q Yet you testified in your deposition, you believe you met the standard of care in each of those instances, right?

A Yes.

Q And it's because you testified that you felt that it was because of the blunt end of the instrument caused the perforation, correct?

A I'm not sure what you mean.

Q Well, do you recall your deposition testimony?

A Yes. I don't -- what would you -- what do you mean about the blunt tip of the instrument? I'm sorry. If you could repeat the question, I would -- I would answer it again.

Q Sure. I'm happy to get your deposition testimony out and read it from your deposition if you want.

A So are you asking did I testify, or did I -- or at the deposition, did I state that the perforations that I caused were from the blunt tip of an instrument? Yes.

Q Okay.

A I did say that.

Q And you never did a laparoscopy with regard to any of those uterine perforations, true?

A I never needed to because I didn't suspect bowel injury.

Q Okay. And in your perforations, those occurred in the cervical dilatation of the procedure, right?

A Either the cervical dilatation or the uterine sounding.

Q Okay.
A The blind part of the procedure.
Q What you're measuring, as you -- as you talked about, the length of the uterus?
A Yeah, from the cervix to the top of the uterus.
Q All right. And you would also agree with me that the -- there are many known risks or complications of a procedure, such as a uterine perforation, or even a bowel perforation. They're not always identified at the time of the procedure, correct?
MR. BREEDEN: I object, Your Honor.
THE COURT: Counsel, approach.
MR. BREEDEN: It's the same issue as before, Your Honor, if you want to --
THE COURT: Okay. Go ahead. Overruled.
BY MR. MCBRIDE:
Q Do you want me to rephrase that?
A Please.
Q All right. You would agree that there are many of the known risks and complications of a procedure, such as a bowel perforation or a uterine perforation aren't always identified at the time they occur?
A Yes, I agree with that.
Q Okay. And just because a known risk occurs doesn't mean there was negligence, true?
A That's true.
Q You talked earlier about how the risk of a uterine perforation

can increase with a bicornate uterus; is that right?

A Yes, any anatomical variant could cause an increased risk during complication -- during procedure.

Q Right. And you -- and you, I think, testified here today that .4 percent of women have a bicornate uterus; is that right?

A Yeah, that was some information I just looked up, yes.

Q Okay. And in Ms. Taylor's case, she had both a bicornate uterus and a retroverted uterus?

A Yes.

Q Now, you testified that Dr. Brill's treatment plan, the treatment recommendations that the operation that he intended to proceed was appropriate, right?

A Yes. I only questioned the endometrial ablation part of it because I thought that was difficult to do the way he was going to try and do it, but that's -- never got done anyway, so it's a moot point.

Q It's a moot point, right?

A Yeah.

Q And you're not -- you're not telling the jury or anyone that this was -- that the procedure, the endometrial ablation procedure was performed?

A No, exactly, it was not performed.

Q All right. And Doctor, you, yourself, have been named as a defendant in a malpractice case on at least two occasions?

MR. BREEDEN: Object, Your Honor.

THE COURT: Counsel, approach.

[Sidebar at 11:17 a.m., ending at 11:18 a.m., not transcribed]

THE COURT: All right. Ladies and gentlemen, we're going to go ahead and take our afternoon break for lunch, and I'm going to have you back here at -- let's see, at 12 -- let's do 12:45.

And during the break, you are instructed not to talk to each other, 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 anything connected in this case by any medium of information, including, without limitation, newspapers, internet or radio.

You're not to conduct any research on your own related to this case, such as consulting dictionaries, using the internet, or reference materials, test any theory of the case including 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 any other kind of book or computer research with regard to any issue, party, 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. And I'll see you back at 12:45.

THE MARSHAL: All rise for the jury. Members, please close your notepads and leave them on the chairs.

[Jury out at 11:19 p.m.]

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

[Outside the presence of the jury]

THE COURT: Thank you. You may be seated. We're outside the --

MR. BREEDEN: Should the doctor be dismissed, Your Honor?

THE COURT: I'm about to admonish him and then I'll dismiss him. Thank you.

You can have a seat. We're outside the presence of the jury, and I just wanted to admonish you, your testimony is ongoing, so you're not to speak about the case to anyone --

THE WITNESS: Okay.

THE COURT: -- about your testimony.

THE WITNESS: Okay.

THE COURT: Okay. And then I'll see you at 12:45, after lunch.

THE WITNESS: Okay.

THE COURT: Thank you. You may be excused.

All right. So let's address the most recent objection. Counsel, on cross-examination, is attempting to get into Dr. Berke's medical malpractice claims, and Mr. Breeden, you objected. Do you want to go ahead?

MR. BREEDEN: Well, yeah, I don't think that's appropriate to ask about cases, allegations in other cases, which are essentially hearsay, case results. You know, are you fighting the case? Did you take a case to trial? Things like that are not relevant. I tried to think this through. I mean, look, if they're going to argue that they can impeach

him by saying, you know, has someone ever accused you of malpractice, then I ought to be able to go into that with Dr. Brill. Dr. Brill's got several proceedings against him in the past that we talked about during his deposition.

I don't -- I'm worried that there might be a way to do this that's permissible, but it certainly wouldn't be if they're going to say how many times have you been sued? You know, what are the results of all the lawsuits? How much money did you have to pay? Et cetera, et cetera.

And especially, given that if this proceeding is still ongoing, there hasn't been any finding or anything like that, and the allegations are denied, I certainly don't think that's relevant.

THE COURT: Okay. And your response?

MR. MCBRIDE: I'm going to let Ms. Hall address this, since she took Dr. Berke's deposition.

MS. HALL: So as we discussed at the bench, Your Honor, when I took Dr. Berke's deposition in July of this year, I very specifically asked him, as I do pretty much every retained expert in a medical malpractice case, I asked him at page 28 of his deposition, let's see, "Have you ever been" -- this is line 16 of page 28, "Have you ever been named as a defendant in a medical malpractice case? Answer: Yes."

I asked him, "On how many occasions?" He told me, "One." And I asked, "When was that? What year?" And he said, "It's an ongoing case." And he went onto give me some details regarding that case. And Mr. Breeden, during the deposition, asked that I not get into too many

specifics, given that it was ongoing, but there was some general discussion of that matter, and it continued onto page 29 of Dr. Berke's deposition.

The difference in the Defense's perspective, the difference between asking that of the Defendant is the purpose of that would be to bring in other bad acts -- alleged bad acts, to try and show action in conformity therewith, so that would be improper character evidence.

There was, and I've asked my office to email me a copy of it. I apologize I don't have it in front of me, but my recollection is that the stipulation on motions in limine, which was submitted in this case, included a stipulation among Plaintiff and Defense that there would be no reference to any prior litigation or claims involving the defendants in this case. That is a very different issue in my mind from questioning a retained expert on their litigation history because it goes to their credibility.

THE COURT: Okay.

MR. MCBRIDE: And Your Honor, I don't intend on going into any great detail about -- certainly not never to inquire into settlements. His position on those sorts of things, it's very cursory based on what the information he testified to in his deposition.

THE COURT: So your intent is just to ask have you -- do you have a medical malpractice -- what is your intent?

MR. MCBRIDE: Yeah, basically, that, and that it's -- that's it's currently ongoing, that it's a case involving, you know, just the information that he provided at his deposition.

THE COURT: Okay. Mr. Breeden.

MR. BREEDEN: Well, so it's not even the case where there's been some sort of finding of malpractice against him. It hasn't been adjudicated. And Judge, I promise you, I am constant as the Northern Star. When they approached me with the issues they have with Dr. Brill, I said, well, yeah, that's -- it's really not relevant that he's had other lawsuits or arbitrations where he's had to pay and been found that -- to have been negligent, and I'm taking the same position here, although it's even clearer, I think, with this witness since there's been no finding that he's ever committed malpractice before.

And I would also say, if it's just being offered to attack his credibility, it's not as if he stated in his deposition, no, I've never been sued by anybody, and then they found a lawsuit and that was untruthful. So they're not -- it's not to credibility of -- on that extent. He was truthful. And of course, the scope of discovery is broader than what's potentially admissible.

THE COURT: Okay. So I do have a concern that there's not been a finding. I think that that's different if there was a finding of actual malpractice. I think that would be a little misleading and confusing for the jury, so I'm going to sustain the objection.

MR. MCBRIDE: That's fine, Your Honor. Then we're at lunch until 12:45?

THE COURT: Yes.

MR. MCBRIDE: Thank you, Your Honor.

MR. BREEDEN: Thank you, Your Honor.

THE COURT: Anything -- oh, wait. Do we need to put the objections on the record?

MR. MCBRIDE: I think it was Mr. Breeden's continuing objection on the risk and complications.

MR. BREEDEN: Yes. Your Honor, this was well discussed in this trial. I've made several contemporous [sic] -- contemporaneous objections with the risks and complications. Otherwise, the only thing I can recall are some objections about maybe form or phrasing of the question that we tried to clean up.

THE COURT: Right. And there was one specifically to the size of -- well, there was argument as to whether the hysteroscope or the resectoscope, and we discussed at the bench, I think it was just confusion. We said he would rephrase and determine which instrument he was talking about.

Anything further on that, Mr. Breeden?

MR. BREEDEN: Yeah. The only -- where I had a problem with is that Mr. McBride represented that the resectoscope -- and the resectoscope and the endoscope with the camera and everything, those are different instruments. One fits inside the other. Okay. So the endoscope, you know, the whole shebang with the camera on it and everything is something like 6.3 millimeters. The tip of the resectoscope, which is what the Defense is claiming caused this injury, is only 3.5 or 3.6.

THE COURT: Okay.

MR. BREEDEN: And there hasn't been any testimony up to

that point about the size of the instruments, other than the tip of the resectoscope. So he came out of left field with that measurement, and that's not an accurate measurement. So if he wants to lay a foundation for what the size of those instruments are, that's fine, but he -- he stated a -- a fact that is untrue as to the size of the resectoscope.

THE COURT: Well, I mean, to be fair, it's cross-examination. Obviously, he's allowed to question like that. And if that was wrong, I think the witness could have answered. But then I asked him to rephrase anyways, and I think we established what we were -- instrument we were talking about. And obviously, you can clean that up on direct and break it down however you see fit to make sure that the sizes are being discussed are with the appropriate, either portion of the instrument or instrument.

Anything further?

MR. MCBRIDE: No. And Your Honor, I would simply offer that he actually testified there's different sizes, depending on those -- the systems that are used.

THE COURT: Right. And I believe he said the 6.6 was a normal size.

MR. MCBRIDE: Right.

THE COURT: Anything further?

MR. MCBRIDE: I don't think so.

THE COURT: All right. I'll see you back at 12:45.

MR. MCBRIDE: Thank you, Your Honor.

THE COURT: Thank you.

[Recess taken from 11:28 a.m. to 12:44 p.m.]

[Outside the presence of the jury]

THE COURT: All right. Let's get back on the record in case number A-18-772472-C, Taylor v. Brill. Counsel for both sides are present and we're outside the presence of the jury. And any matters before we call the jury back in?

MR. BREEDEN: Nothing from Plaintiff.

MR. MCBRIDE: And, Your Honor, nothing from the Defense. But just trying to get -- and again, I just wanted clarification in terms of the anticipated witnesses after Dr. Berke just so that we're on the same page.

MR. BREEDEN: We'll be calling Ms. Taylor after Dr. Berke.

MR. MCBRIDE: Okay, perfect.

MR. BREEDEN: And I think that will take us through the rest of the day.

MR. MCBRIDE: Perfect. Awesome. Thank you.

THE COURT: All right. Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 12:49 p.m.]

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

THE COURT: Thank you. You may be seated. We're going to continue with cross-examination of Dr. Berke.

THE MARSHAL: Sorry about that, Judge. My radio was going off. I didn't hear you.

THE COURT: Remember Dr. Berke, you understand you're

still under oath.

THE WITNESS: Yes.

THE COURT: Okay. Go ahead.

CROSS-EXAMINATION CONTINUED

BY MR. MCBRIDE:

Q Thank you, Your Honor. Good afternoon, Dr. Berke.

A Good afternoon.

Q Now I just had a couple of things to follow up on -- regarding your background. You indicated you were board certified, correct?

A Yes.

Q And obstetrician and gynecology.

A Right.

Q What group board certified you?

A It's the AOBOG, the American Osteopathic Board of OB/GYN,

Q Okay, not ACOG?

A ACOG is not a certifying board.

Q Right. And not the American Board of Obstetrics and Gynecology?

A No. They don't certify people who do osteopathic residencies.

Q Okay. And that's what you do?

A That's what I did.

Q All right. Okay, so Doctor, you've not authored any textbooks or medical articles specifically on minimally invasive procedures on patients, correct?

A I have not.
Q Okay. You also have not lectured or taught other surgeons or OB/GYN's across the country in minimally evasive techniques, correct?
A No, I have not.
Q You said that you have done work for the medical board, the Osteopathic medical board in California, correct?
A Yes.
Q But at the time of your deposition, the last time you did that was over a year ago, correct?
A Yes.
Q All right. You talked about, in your direct testimony, you talked about the medical treatment that was provided to Ms. Taylor. But you would agree with me that she will not require any future surgeries related to the injury to the bowel, correct?
A I can't say that with complete certainty, no.
Q Well, do you remember in your test -- in your deposition where you testified, she will not require future treatment for the injury to her body?
A Fair enough.
Q Okay.
A Can I add a comment or am I only allowed to do the yes or no?
Q Counsel can ask about that.
A I appreciate that.

Q And I'm just referencing your deposition testimony.

A In regard to that injury, no.

Q Okay. You testified also in your deposition that you participated in a conference call with Ms. Taylor early on in the case with her original attorney.

MR. BREEDEN: I object, Your Honor. May we approach?

THE COURT: Yes.

[Sidebar at 12:52 p.m., ending at 1:00 p.m., not transcribed]

BY MR. MCBRIDE:

Q All right. Dr. Berke.

A Yes.

Q So do you recall having a conversation where you participated in where Ms. Taylor was on the phone call around April 10 of 2018?

A I recall it happening. I don't recall the content.

Q Okay. Well in fact, you obtained information directly from Ms. Taylor at that point about what she claims had happened to her, correct?

A I honestly don't remember the content. I remember the conversation. I remember it was happening. My recollection is she was kind of in the background and I didn't really remember her speaking that much.

Q Okay. Did she speak at all?

A Did she speak at all?

Q Yeah.

A Yes, sir. Very briefly.

Q Okay. And she gave you information about what she felt had happened to her as well as any communications with Dr. Brill?

A I don't remember the content of the conversation. I don't recall her telling me how she felt or what she thought happened.

Q Okay. Now the opinions that you've rendered in your original declaration in this case as well as the subsequent reports that you've prepared in this case -- and there's a total of three reports, including your original declaration, correct?

A Yes.

Q You testified that you thought that Bruce Hutchins, the nurse in the PACU at Henderson Hospital and Henderson Hospital had fallen below the standard of care, correct?

MR. BREEDEN: I'll object, Your Honor. This has been discussed in motions previously. Renew the objection.

THE COURT: Okay. Same ruling. Thank you.

BY MR. MCBRIDE:

Q You can answer.

A I said that I thought that the PACU nurse, Bruce's handling of the patient was below the standard of care because he didn't notify Dr. Brill that this patient was requiring increased pain medication and hadn't left the PACU for seven hours, and that's Henderson Hospital. So yes, that's the same, one in the same.

Q Do you need your declaration to refresh your recollection of the specific allegations you made against doctor --

A Sure.

MR. MCBRIDE: Okay. Your Honor, can I approach?

THE COURT: Yes.

BY MR. MCBRIDE:

Q It's on page five of your report. And you can see it highlighted there. And could you read for me what your opinions were under this sworn declaration under penalty of perjury after your review of the medical records in this case, what your opinions were about Bruce Hutchins, R.N. and Henderson Hospital?

A It's exactly what I just said. That Bruce Hutchinson and Henderson Hospital failed to contact Dr. Brill and obtain an OB/GYN consult despite the excessive pain medication given to Ms. Taylor, which is the first thing I stated. Secondly, failure to contact Dr. Brill prior to releasing Ms. Taylor. Those kind of go together. They didn't ask him anything. And then releasing Ms. Taylor despite her ongoing abdominal pain.

Q Okay. And also, you go on to also criticize the care and treatment provided by Dr. Todd Christensen at St. Rose Hospital, right?

MR. BREEDEN: Same objection, Your Honor.

THE COURT: Thank you. Go ahead.

THE WITNESS: Yes.

BY MR. MCBRIDE:

Q Okay. Can you read what you wrote about those opinions that you formulated in your declaration sworn under penalty of perjury after reviewing all the medical records in the case?

A That I thought that Dr. Christensen failed to maintain consultation with an OBGYN, or a surgeon based upon the CT finding. And that he release Ms. Taylor despite the CT report even though she had ongoing severe pain. And he didn't rule out a more serious injury with a CT scan that was consistent with intestinal perforation or injury, which she had.

MR. MCBRIDE: Okay. And can I approach, Your Honor?

THE COURT: Yes.

BY MR. MCBRIDE:

Q And, Doctor, do you recall -- Dr. Berke, do you recall also testifying at your deposition that you still held those same opinions?

A Yes.

Q Okay. So with regard to the -- your deposition, you would agree that you can't quantify the standard of care by the size of a perforation? Do you remember testifying to that?

A I don't remember saying those words, but if you say I said it and if you want to show it to me, I will believe that is said that.

Q Well again, do you want me to show it to you?

A No. It's fine if you got it, so.

Q And your deposition was not taken that long ago, was it?

A No.

Q But you've reviewed it before today, correct?

A Yes.

Q All right. You've reviewed it at least more than once before today, correct?

A Probably, yes.

Q Okay. So you also testified that it's more how the perforation occurred, correct?

A I'd like to be allowed to expand on that if that's what I said.

Q And you'll get that opportunity with your counsel.

A Great. You know what I said. It's in black in white. If I said that, then I did, but I'd like to expound on that with my counsel.

Q Okay. But that's what you testified to in your deposition, true?

A Yes.

Q Okay. And, Doctor, you also agreed that if a perforation occurs with the blunt end of an instrument, the standard of care does not require a laparoscopy be performed, correct?

A Correct.

Q That -- in fact, that's what happened in your instances of the six to ten uterine perforations that you had, right?

A Correct.

Q Now you also don't know the size of the perforation that occurred at the time of Dr. Brill's surgery, true?

A We only have what Dr. Hamilton said she saw, and she said it was it was three centimeters.

Q Well we actually have the surgical pathology, which is actually more accurate representation of the size of that perforation, true?

MR. BREEDEN: Object.

THE WITNESS: I disagree that that's more accurate.

THE COURT: Hold on. What's the basis or do you want to approach?

MR. MCBRIDE: I'll withdraw it.

THE COURT: Thank you.

BY MR. MCBRIDE:

Q You disagree with the surgical pathologist who's examining the size of this perforation both grossly and microscopically and using measurements to determine the size of the perforation?

A I believe that the living tissue that Dr. Hamilton saw would represent more accurately what the size of the perforation was than a measurement done after it's been sitting all night in fluid and is now just this, you know lifeless tissue in a jar.

Q Okay. And Dr. Hamilton was here and testified yesterday. You're aware of that?

A I was aware that she testified.

Q Okay. And Dr. Hamilton, when I asked her the questions about how she measured the size of that perforation at the time of her operation, she just eyeballed it. Are you aware of that?

A Yes.

Q Okay. She didn't take out any measurement device or tools to measure the exact size of the perforation. You're aware of that?

A Yes.

Q Okay. Now, Doctor, you had talked about your opinions that you felt that Dr. Brill needed to do a further laparoscopy to determine the

extent of any injury to potential bowel or other organs, right?

A Yes, and there was an injury to the bowel.

Q Okay. And -- but again, in terms of the laparoscopic approach that you mentioned, you described it as making one incision to do a laparoscopic approach, true?

A Initially one. If you want me to give the technical details of laparoscopy, you can make one up to four inches depending on needing to access different parts of abdomen. But yeah, you start with one.

Q And in fact, if you're --

A Dr. Hamilton started with one.

Q Okay. And in fact, if you're going to manipulate the valve to run the valve to determine if there's any perforations, more than one or multiple perforations, you would need additional instruments and different holts, ports basically or incisions to manipulate the valve with those instruments, correct?

A Yes. Probably three total.

Q Now you don't want -- you would agree that you don't want to perform a procedure unless you have a clinical indication to do so, correct?

A I do agree.

Q Okay. And there are risks, potential risks and complications involved in performing laparoscopy, true?

A True.

Q In fact, bowel perforations is one of them, right?

A Yes.

Q In fact, it's one of the most common experienced complications or risks of a laparoscopic procedure, true?

A True.

Q I'm sorry?

A Yes, true.

Q I wanted to show you the operative note of Dr. Brill real quick that you talked about. Let me find it. Court's indulgence. Oh, here it is. It's page 42. In fact, I just had it in front of you. I think you closed the book. It's page 42 of Exhibit 5. It's also on the screen if you want to look at it that way. And this is the same operative report that you were referring to with Plaintiff's counsel, correct?

A Yes.

Q And you noted the date of the signed report by Dr. Brill, and it was signed at 10:08 the day of the surgery, 04/26/2017?

A Yes.

Q I want you also to -- did you have an understanding that the PACU nurse who testified here yesterday, that he had access or would have had access and testified he would have access to the operative report of Dr. Brill after, sometime after 10:08 a.m. in the morning?

A I think with an electronic medical record, yes. That would have been information you would have as soon as it's signed.

Q Right. And he also testified that he makes it regular practice to review the operative notes as soon as their available?

MR. BREEDEN: I'll object. Misstates testimony.

THE COURT: Counsel approach.

MR. MCBRIDE: Sure.

[Sidebar at 1:12 p.m., ending at 1:14 p.m., not transcribed]

BY MR. MCBRIDE:

Q I want you to assume a hypothetical. I want you to assume that hypothetically that Mr. Hutchins testified yesterday that if the operative report was in the records, that his customary practice would have been to review it, if available.

A Okay.

Q Okay. Given that information, you would agree with me that, assuming that hypothetical, that Mr. Hutchins would have seen that posterior complication perforation of the uterus?

A Yes.

Q So I want you to look at the report for the record. And let me see if I can zoom out.

Okay. And do you recall the series of questions that Mr. -- that counsel -- Plaintiff's counsel was asking you throughout your testimony, where he was asking you what did -- what happened next after you were reading the report?

A Uh-huh.

Q What -- is that a yes?

A Yes.

Q What Dr. Brill did next. Do you recall that?

A Yes.

Q Okay. And, in fact, when he talks about this portion, Dr. Brill, in his note, "I was able to place a Symphion hysteroscope into the cavity

and was able to visualize what appeared to be the septum." Did I read that accurately?

A Yes.

Q He says, "I used the yellow pedal and began to cut what appeared to be the septum anteriorly," correct?

A Yes.

Q And then when he asked -- when Ms. -- when Plaintiff's counsel asked you to read what did he do next, he left out, "As I was able to slowly advance the camera during this process." Do you recall that?

A Yes.

Q And in fact, the fact is that you read "did appear to be uterine perforation," correct?

A Yes.

Q So based on Dr. Brill's description of what he was doing immediately before discovering the perforation, he was slowly advancing the camera, correct?

A That's what his note says. That's correct.

Q Now are you aware -- you saw the surgical pathology that Plaintiff's counsel showed you a second ago. And using the Symphion device, are you aware that the Symphion device has a canister attached to it, of which also contains all of the collection of surgical specimen that are cut and taken during the procedure?

A Uh-huh.

Q Is that a yes?

A Yes. Yes. It -- there's a -- it's designed for that. Yes.

Q Okay. And you would agree that that surgical canister then gets transferred -- the entirety of that canister then gets transferred to surgical pathology for an evaluation examination, true?

A Yes.

Q Okay. So that would include any and all portion of the resectoscope, when the resectoscope was actually actively cutting any material, correct?

A Yes.

Q And in fact, this is the HH156. It mentions an aggregate mucoid material mixed with blood clot and red-tan tissue aggregated in 4.25 -- 4.2 times 2.5 times .5 cm. That's the entirety of the specimen that was collected from the Symphion, correct?

A Yes.

Q And in this report from the materials submitted at both the microscopic examination and gross examination, there's no evidence of any bowel material?

A True. True.

Q And, in fact, I think one of your criticisms is that Dr. Brill should not have used the curette following the discovery of the uterine perforation, true?

A That's true.

Q Okay. And I think -- just so it's clear, Doctor, you're not saying that Dr. Brill inserted the curette into the area of the uterine perforation.

A No. I'm saying there's a risk of doing that by using it.

Q But you're not saying that occurred in this instance?
A I'm saying I don't know if that occurred in that instance.
Q Okay. Well, in fact, if that occurred, the material that was taken from that -- and that's one of your theories in this case, that that potentially could have caused the injury to the bowel, true?
A That's one of the theories.
Q Right. One of the -- of several theories that you have, right?
A I don't -- I'm not sure I have several theories, but yeah.
Q Okay. One of at least two theories, right, as to how this could have occurred?
A The most -- that's the less likely theory.
Q Okay. But you indicate that, nevertheless, that's your criticism of him using the curettage?
A Is that he could have caused an injury by using it. Yes.
Q And you have no evidence that an injury to the bowel occurred, correct?
A I have a -- I do have evidence that injury to the bowel occurred.
Q From the curettage.
A Correct. I don't have evidence of which way it occurred.
Q Exactly. It --
A Although I do have more evidence than not, especially in this part of the note where he mentions that after he started cutting, he noted the perforation.
Q Doctor, he didn't insert the curette into the perforation.

A No. I meant this was a -- I was talking about the resectoscope.

Q Okay. Listen to my question if you can. He did not insert the curette inside the area of the uterine perforation, true?

A I don't know the answer to that.

Q Well, in fact, he took the curette and applied it in a totally different location from the area of the uterine perforation, true?

A That's what he intended to do.

Q Okay. That's what described in his report too, correct?

A Yes.

Q And that's what he testified to in his deposition, true?

A True, but no one could see this happening.

Q Okay. Doctor, if he had injured the bowel with the curette that you're claiming was negligently applied in this case following the discovery of the uterine perforation, you would expect to find bowel at the material that would have been sent to pathology on that.

A I think that's an interesting -- it's an interesting way to look at it, that you might. But I'm not sure the pathologist was looking for something like that, but I understand what you're saying.

Q And you would agree that that evidence would have been there potentially?

A No. I don't think it's a given that it would be there. I get your point, but you don't --

Q You have not --

A You don't always get back what you think you're going to get

back.

Q Okay. Doctor, you have never practiced as a surgical pathologist in your career, right?

A No. No, I have not.

Q Okay. You're not here to testify to the standard of care that -- of a surgical pathologist and what they saw and what they should have seen or didn't see, true?

A That's true.

Q In fact, your practice is limited to Riverside, California, correct?

A And the surrounding areas, yeah.

Q All right. So following up with that real quick, let me just read through my notes.

You recall repairing -- preparing your report dated August 16, 2021, where you stated it would be possible that the injury to the bowel could have occurred from the blunt end of the resectoscope?

A That is possible.

Q Okay. Now you also testified that -- well, you would agree that Dr. Brill appropriately counseled Ms. Taylor on the risks and complications of the procedure before she underwent the procedure, true?

MR. BREEDEN: Object, Your Honor.

THE COURT: Same ruling. Thank you.

BY MR. MCBRIDE:

Q You can answer.

A It's common practice, and I assume that he did. Yes.
Q Okay. Well, you saw it in his notes, correct?
A Yes. Yes.
Q And you also saw his -- read his deposition testimony where he --
A Yes.
Q -- testified to that, correct?
A Yes.
Q Under penalty of perjury, right?
A Right.
Q That's something you do on a regular basis, right?
A Yes.
Q Now were you told yesterday about the conversation that Dr. Hamilton had with Ms. Taylor before her surgery?
A No.
Q I want you to assume, hypothetically speaking, that Dr. Hamilton testified under sworn testimony that Ms. Taylor was the one who advised her that she had had a uterine perforation before the surgery that Dr. Hamilton performed, okay? If that's the case, you would agree with me that Ms. Taylor was informed of a uterine perforation at the time of her surgery with Dr. Brill, correct?
A I can't assume that. Potentially, Dr. Christiansen told her she had a uterine perforation. I don't know. I don't know who told her.
Q Okay.
A And I have no way of knowing that.

Q You didn't see, you didn't see any records in Dr. Christiansen's notes that he notified her that she had a uterine perforation, did you?

A No, I didn't see that.

Q Okay. So, again, I don't want you to assume certain things that aren't here. I want you to base your opinions on the records that you've reviewed.

A Okay.

Q Did you see anything in the records from Dr. Christiansen that he informed her that her uterus had been perforated?

A No, not by Dr. Christiansen nor Dr. Brill.

Q Well, you're aware that Ms. Taylor testified that she spoke to Dr. Brill in the recovery room? You read that?

A I have -- I don't recall reading, but I'd be happy to read it.

Q Wouldn't that be important to you if that's one of your criticisms that you have of Dr. Brill, is that he should have informed her of this? And wouldn't it have been important to you to look at her deposition to see what she testified today?

A Like I said, I can look at it right now and we can talk about it, but I don't recall that he did talk to her about that.

Q Okay.

A She has testified that he didn't talk --

Q I'm talking about Ms. Taylor at this point.

A Okay.

Q Okay. Dr. Brill testified he didn't recall. Do you recall that

testimony?

A Yes.

Q Okay. Do you recall what Ms. Taylor testified to about a discussion with Dr. Brill following the procedure?

A I'm sorry. I'm saying I don't recall.

Q Now you're aware that Dr. -- that Bruce Hutchins, at no time, based on his records and I'll represent to you his testimony yesterday -- that at no time did he ever call Dr. Brill with any concerns or complaints of severe pain or any issues with Ms. Taylor the entire time that she was in the PACU. You're aware of that?

A Yes.

Q And that's why you're critical of Mr. Hutchins, true?

A The care he provided, yes.

Q And you had -- I think had acknowledged that Mr. Hutchins fell below the standard of care because he should have contacted Dr. Brill before Ms. Taylor was ultimately discharged?

A Yeah. I think he have had a higher index of suspicion that there was a bowel injury, and he didn't.

Q And you --

A Or an injury and he didn't.

Q And you would also agree that Mr. Hutchins never contacted Dr. Yeh with any concerns of excessive pain?

A I didn't see anything there that he did that either.

Q Now a physician such as yourself has a duty to rely on the nurses in the PACU, as well as on the floor, or to advise them of any

changes in the patient's condition, true?

A True.

Q That -- I mean they're the eyes and ears of the doctor when you're not there, correct?

A Yes.

Q You have to have the ability to rely on them to -- in their background, training, and experience, to identify signs and symptoms of potential complications following surgery, correct?

A Correct.

Q And the criticisms of Dr. Christiansen that we talk about and St. Rose, you're aware that, again, you feel that Dr. Christiansen and St. Rose fell below the standard of care, correct?

A Yes.

Q And that you're aware that at no time did Dr. Christiansen ever attempt to call Dr. Brill? Are you aware of that?

A Yes.

Q And finally, doctor, you would agree that the entirety of your opinions here today are based on the benefit of hindsight, correct?

MR. BREEDEN: Object.

THE COURT: Overruled.

THE WITNESS: This happened in the past. Yes. So --

BY MR. MCBRIDE:

Q In fact, you knew going into the case what the allegations were and that the allegations were that Ms. Taylor had suffered a uterine perforation and a bowel perforation following the hysteroscopy by Dr.

Brill, correct?

A That was the complaint, yeah.

MR. MCBRIDE: That's all the questions I have.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. BREEDEN:

Q Doctor, you were asked some questions in your cross-examination about the Symphion device here or the resectoscope.

A Uh-huh.

Q Do you use a different model of resectoscope in your practice?

A Yeah. I use a different one. It's called a MyoSure, and it's different. It has a reciprocating blade but -- and does not use any energy, meaning it doesn't use any heat.

Q Are you familiar with the Symphion system and how it works?

A From what I've read about it in preparation for this trial.

Q Okay. Did you think that, for some reason, just because you don't use this particular model in your practice, did you feel that you weren't qualified to comment on the Symphion device?

A I feel like I'm qualified to comment on it.

Q Okay. Do you recall hearing that the Defense's retained expert also does not use the Symphion device? Do you recall reading that?

A I do recall. Yes.

Q Okay. You were asked some questions --

MR. MCBRIDE: Belated objection. It misstates the evidence in this case, but go ahead.

BY MR. MCBRIDE:

Q Okay. Doctor, you were asked some questions about measurements. And I think there was a little confusion that I want to clear up for the jury. So this instrument here is called the resectoscope, correct?

A Correct.

Q Now does it have a camera and a light on it?

A No.

Q Okay. There's another instrument that has a camera and a light on it, correct?

A Yeah. That's called a hysteroscope.

Q The hysteroscope. Is that also called an endoscope?

A Not -- that just means a scope that you're looking inside someone's body with. So the ones -- it could be called that too, but it's more accurately a hysteroscope.

Q Okay. So the resectoscope goes inside the hysteroscope?

A It goes through a -- yes. It goes through the sleeve of the hysteroscope.

Q And then the resectoscope peaks out the end of the hysteroscope. Is that --

A Yes.

Q Okay. So we need to talk about the different dimensions. If

we talk about the very tip of the resectoscope, how many millimeters is that?

A That's supposed to be at 3.5 millimeters.

Q Okay. And if you proceeded so far, like if you're causing a perforation, and you actually got the point where the resectoscope was in the hysteroscope, and you pushed the hysteroscope with the camera and everything through a perforation, so how many centimeters or millimeters would that be?

A Probably at least a centimeter.

Q Okay. Do you believe that just because something is a risk of a surgery, that if it happens, it is not negligent?

A I don't believe that. Yeah.

Q Okay. So to you, the mere fact that something is called a risk of a procedure does not bear on whether the doctor used a required skilled, training, and experience when performing the procedure?

A Yes, I agree with that.

Q Okay. You spoke earlier about simple perforations during this procedure. Describe again for the jury what a simple perforation would be?

A Well, I mean simple or uncomplicated would mean that the patient didn't suffer any long-lasting effects. So a simple perforation, you perforate the uterus. You tell the patient it happened. You explain to her the precautions, and she doesn't need to do anything else except for potentially come back and have a procedure repeated. Whereas a more complicated one would involve the involvement of other doctors,

cat scans and bowel resections and IV antibiotics. I think that's a way to kind of separate those two by the degrees of their severity.

Q Okay. What makes what occurred in this particular case a more complex perforation to you that is beneath the standard of care? Describe it for the jury.

A The severity of the injuries that Ms. Taylor experienced.

Q We talked a little bit about laparoscopic surgery to investigate around a uterine perforation. Do you recall that topic?

A Yes.

Q Okay. And so, if the -- well, let me ask you. Based on the operative report, did it appear that Dr. Brill knew exactly how he had perforated the uterus at the time?

A I don't -- he didn't state that he knew how he did it, but he stated when he noticed it.

Q Do you think it would have been reasonable for him at the time to be concerned that he did it with the thermal cutting part of the resectoscope?

A Absolutely.

Q And if you suspected that as a physician performing this, what again does the standard of care require?

A To evaluate the internal organs with laparoscopy.

Q Can you do that -- can you evaluate the adjacent organs from a camera still inside the uterus?

A Looking through the uterine perforation, no. I don't think you get a good enough picture of what you needed to see.

Q Okay. So you would have to perform another laparoscopic evaluation, so you could see on the outside of the uterus?

A To be thorough, yes.

Q You indicated that some perforations happened during a blind part of hysteroscopy. So explain to the jury what the blind parts of this procedure are.

A So I think we discussed before, when you dilate the cervix to get the sound and to measure how big it is, you are using instruments just from the outside. You're not looking at anything except for the patient. And then when you're using the uterine sound to see how big the cavity is, you're putting a piece of instrumentation through there without a camera. Those -- that means blind. But when you're doing it with a camera, you're actually watching yourself enter the cavity.

Q And in your opinion, did the perforation of Ms. Taylor, did that occur during a blind part of the procedure or a part of the procedure where the camera was in use?

A Again, all we have is -- all I have is -- to go off is the operative report, that it never mentioned the perforation until the resection device was used.

Q So do you think it's more likely than not that this perforation happened during a time when the camera was in use?

A I believe that is true.

Q Do you believe you have similar training and experience to Dr. Brill?

A I believe so.

Q The type of hysteroscopies you perform, are they different in any substantive way from what Dr. Brill does?

A No.

Q You were asked some questions earlier about future treatment of Ms. Taylor. And you had more to add, but the question had ended.

A Uh-huh.

Q And so, I wanted to ask you now. What more did you have to add about future treatment or symptoms that Ms. Taylor might experience?

A I don't think the bowel injury she sustained is going to cause her any more problems, because that piece of bowel with the hole in it is gone, because it was removed, and the other two pieces of bowel were connected together. But anytime you have a big surgery like that, where you have an incision, you're at risk for adhesions or scar tissue that could cause problems in the future, such as bowel obstruction. In fact, prior abdominal surgeries, the number one cause is a bowel obstruction. So things like that are things that she's at risk for in the future. And that's what I meant by that one. Yeah.

Q And do you believe Ms. Taylor may experience some abdominal discomfort with bowel movements in the future?

MR. MCBRIDE: Objection. This goes beyond the scope of his reports as well as his deposition.

MR. BREEDEN: I can show you the report where this is addressed and --

THE COURT: Absolutely. Approach.

[Sidebar at 1:36 p.m., ending at 1:38 p.m., not transcribed]

BY MR. BREEDEN:

Q Doctor, I'm going to rephrase my last question a little bit.

A Okay.

Q Do you think it's more likely than not, that in the future, Ms. Taylor will continue to experience mild abdominal discomfort, as a result of the perforations?

A I think that's not out of the question.

Q Well, do you think it's more likely than not?

A I do.

Q You were asked some questions on cross-examination about your criticisms of the care that Bruce Hutchins provided for Ms. Taylor. Do you recall that?

A I do.

Q Okay. Do you believe that Mr. Hutchins caused the perforations?

A No.

Q Do you believe that any delay in diagnosis that Mr. Hutchins caused was the reason why Ms. Taylor would need bowel resection surgery?

A No, I think with the uterine perforation that occurred, she would have needed discovery if it was discovered immediately or later, yes.

Q Okay. So hypothetically then I guess I would say --

MR. BREEDEN: Well, no, let me rephrase it.

BY MR. BREEDEN:

Q In your opinion then, what sort of damages did Mr. Hutchins' failure to find this out faster, cause Ms. Taylor?

A Only the pain that she experienced.

Q Only arguably some additional pain and suffering?

A Some additional pain that she would have.

Q Okay. Now I have a similar question for Dr. Christensen and St. Rose. Did Dr. Christensen cause either of the perforations in your opinion?

A No, he did not.

Q And did Dr. Christensen and St. Rose, did they cause the need for bowel -- for bowel resection surgery, or bowel repair surgery?

A No.

Q Okay. So at most, in your opinion, what are the additional damages that Ms. Taylor might have sustained because of Dr. Christensen or St. Rose?

A Just the delay in doing the surgery and the additional pain that she dealt with while she waited to go back to the E.R. the second time.

Q And do you remember, we talked about delay. How long did Ms. Taylor see Mr. Hutchins?

A She was there for several hours, seven hours or something like that.

Q And do you recall how many hours she saw Dr. Christensen

at St. Rose?

A She was in the E.R. I think four or five hours.

Q There was some testimony earlier about the difference between Dr. Hamilton's report of the perforation being three centimeters and a later pathologist report that measured it at I believe 1.6 centimeters. Again, for the jury's benefit, why do you believe that the surgeon at the time of surgery, that their measurement or estimate might be different from the pathologist?

A Because surgeons -- I've never seen a surgeon take a ruler out and measure anything that they're looking at to identify how big it is. They're pretty well trained at looking at something and saying how big they think it is . She was looking at living tissue from a fresh injury that had, you know, blood flow to it and everything like this. And I think the difference between what she saw and what the pathologist saw could be explained by it being put into a container with a fixative that sat overnight and, you know, was no longer alive.

Q And so when the pathologist sees it, there's no more blood flow in the sample, right?

A No, not at all.

Q And you say it's in a fixative. I mean explain to the jury what that means.

A Something to preserve, like formaldehyde or a formalin that they use now days. But yes, it's something to keep it fresh so it won't, you know, rot overnight. And then you can examine it more closely when you get to work.

Q So in your -- in your experience with tissue samples like that, will they shrink after they've been taken out of the body?

A It's a -- I imagine so.

MR. MCBRIDE: Well, I'm going to object. That lacks foundation. It's beyond the scope of this witness' expertise. He's not a pathologist.

THE COURT: Sustained.

MR. MCBRIDE: Can we also strike that answer?

THE COURT: Yes.

MR. MCBRIDE: Thank you.

BY DR. BREEDEN:

Q In your opinion, during Kim's hysteroscopy, was there a clinical indication for Dr. Brill that he should laparoscopically explore adjacent organs?

A Yes.

Q Adjacent to the uterus?

A Yes.

Q And what were the clinical indications for that?

A That he caused a uterine perforation while using an electricity device that causes heat and can damage other organs.

Q Do you have any reason to believe that Bruce Hutchins knew of any perforations to Ms. Taylor?

A I don't -- I don't have knowledge that he knew.

Q Do you have any reason to believe that Dr. Christensen, the first emergency room doctor, ever knew that there were perforations

caused during the procedure?

A I think only until after his CAT scan came back. After the CAT scan came back.

Q So you were asked some questions about a portion of Dr. Brill's testimony where he mentions that after using the yellow pedal, he was advancing the camera, and that's when he saw the perforation. Do you recall that?

A Yes.

Q Based on his report, do you think the perforation happened with the camera, or do you think it happened prior to him advancing the camera?

A I believe it happened prior to him advancing the camera.

Q With the resectoscope?

A With the resectoscope.

Q And do you believe that it is more likely that it happened while the thermal cutting part was activated, or just because the end of it was pushed through the uterus?

A The thermal part.

Q Which way do you think it would be easier to cause such a perforation?

A With the cutting device.

Q If you -- hypothetically, if you advance this into the uterus, to the point that the tip of the resectoscope touched the wall of the uterus, does the surgeon feel that?

A Yeah, I think we discussed earlier that the uterus is muscle.

So you can feel the resistance up against the wall when you're -- when you're touching it, yeah.

Q And does Dr. Brill's report anywhere indicate that he felt resistance from the tip like that?

A No.

Q And does it indicate anywhere that, for example, maybe he felt some resistance and then lack of resistance suddenly, as if he had just caused a perforation?

A No, he didn't mention that.

Q We talked about a pathologist report again when the cells form the curettage were analyzed. Do you recall that?

A Yes.

Q And there were no -- counsel stated that there was no stool in those samples.

MR. MCBRIDE: Objection. Misstates the -- misstates the question.

MR. BREEDEN: Let me see if I can rephrase.

BY MR. BREEDEN:

Q If we assume that Dr. Brill caused the perforations by cutting with the thermal element of the resectoscope, all the way through the uterus and into the small bowel, do you think you would absolutely see enteric contents in those samples?

A I don't think by not seeing them, that that proves he didn't do it that way. So I think that you could get a situation where you didn't see it.

Q Now, there was blood or blood clot in those samples, correct?

A Yes.

Q Okay. Did you see any indication in Dr. Brill's report that he encountered bleeding while he was resecting the white tissue?

A I did not see that in his report that he said that.

Q And in fact in the operative report, does he report bleeding at all?

A No.

Q Do you think it's more likely than not, that the blood in those samples came from the perforations?

A Yes. Either the perforation of the uterus or the bowel, yes.

Q There was some questions asked of you whether it was possible that Dr. Brill actually caused these perforations with the use of the curette after he stopped use of the resectoscope. Do you recall that?

A Yes.

Q Okay. Is it your testimony that there's another more likely scenario in your opinion?

A Yes.

Q Okay. And what is the scenario that is more likely than not in your opinion?

A It's more likely than not that he did -- the perforation happened earlier, because that's when he saw it, much earlier. So anyway, he noticed the perforation when he was using the yellow pedal, which is when the perforation occurred, which is when I believe the

injury occurred.

Q Okay.

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

THE COURT: Recross?

RECROSS-EXAMINATION

BY MR. MCBRIDE:

Q A few follow up questions for you, Doctor. Would you agree with me that the -- when you perform hysteroscopies and curettage and are using resection of -- a resection device during a hysteroscopy, that you are bound to encounter some minimal bleeding?

A Yes.

Q Yeah. It happens when you use a sharp curettage, correct?

A Yes.

Q All right. And I want to refer you back to the -- if we can switch it back to the pathology report that you talked about. You would agree with me it says consisted of an aggregate of mucoid material, mixed with blood clot. It doesn't say excessive amounts of blood. It says blood clot . And that could come from actually the use of the curettage that Dr. Brill described using after the resectoscope, true?

A True.

Q Okay. And I'm sorry, I don't think I asked the question -- I'm not -- I never asked you the question if you would expect to find enteric contents. My question that I asked you was whether you would expect to find bowel.

A Yes.

Q Do you remember that?

A Yeah.

Q And you indicated that it is possible if Dr. Brill had resected or used the resectoscope and had caused a perforation with the resectoscope.

A Uh-huh.

Q Is that right?

A I wasn't -- was that a question, sorry?

Q Yes, that was a question.

A Can you ask it again, please?

Q Yes. You acknowledged earlier that if Dr. Brill had used a resectoscope to cause that perforation, that it was possible that that would have been in the materials found in the pathology specimen.

A Yes, it's possible it would be. It's also possible it wouldn't be.

Q But you don't know, because you're not a surgical pathologist, and you have no experience in analyzing surgical pathology specimens following a hysteroscopy, true?

DR. BREEDEN: Object as asked and answered.

THE COURT: Overruled.

THE WITNESS: All we know is there was a perforation and --

BY MR. MCBRIDE:

Q Doctor, my question was -- it's a yes or no answer. You don't know one way or another because you're not a surgical pathologist,

true?

A Yes, that's true.

Q Okay. You'd be speculating.

A I agree.

Q All right. You don't want to do that, do you?

A I agree, I don't want to do that.

Q Okay. You were asked questions about Ms. Taylor's recovery. And in your report of February 10, 2021, you acknowledged and here today, you acknowledged that she complains of mild abdominal pain symptoms on occasion, correct?

A Correct.

Q And you think those are related to the bowel injury she may have suffered?

A I think more likely than not, they can be related to that.

Q And you also indicate that they would require no future treatment, true?

A In and of itself, from the actual injury point of view, no, but as I explained to the jury --

Q Doctor, let me show you your report.

MS. HALL: Can I approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q If you can read from right there, she complains.

A "She complains of mild abdominal pain symptoms on occasion which I do think are related to the perforation but will require

no future treatment."

Q That was your testimony in this report, correct? Correct?

A Her current symptoms may not need --

Q Doctor, the question was that was your --

A Yes. Yes. I just read that, yes.

Q -- your statement?

A Yes.

Q Okay. And you also say she appears to have made a nearly complete recovery from the perforation, true?

A I said that, too.

Q All right. You also were asked some questions about what injuries or what conduct by Dr. Christensen may have caused, or what injuries may have caused as a result of his breach of the standard of care. Do you recall that?

A Yes.

Q And in fact, you testified in your deposition that the violations of the standard of care of Dr. Christensen led to increased pain and suffering and a worsening of the patient's condition when the diagnosis was delayed. True?

A Yes.

Q In fact, Bruce Hutchins, if he had contacted Dr. Brill early on in the period of time she was in the PACU where complaints of pain, or abnormal pain, as you suggested, then at that point, there was a possibility that the surgeon or someone, would have been able to evaluate any complaints of her pain and could have found the bowel

perforation then, correct?

A That's speculative, also, but that's possible.

Q Well, that's what you expected of resections, and you anticipated it should have been done, correct?

A Correct.

Q And that would have meant that Ms. Taylor's use of long term or antibiotics for a long period of time also likely would have been lessened, true?

A That's a hard -- that's hard to answer. Because that's very speculative that if they would have done surgery sooner they would have prevented four weeks of antibiotics. I don't know the answer to that.

Q Oh, so you don't know the answer to that, but you acknowledge that the delay by Dr. Christensen led to a worsening of the patient's condition, true?

A Agreed. But also -- maybe not stated specifically there, but it could have been a life-threatening infection that she would have had to dealt with during that time, which would have been a risk that was unnecessary.

Q Now Doctor, I think you answered some questions. I want to give you a reverse of a question that Ms. -- that Plaintiff's counsel asked a second ago. If Dr. Brill did not expect a bowel perforation because he knew he was not operating the yellow pedal, there's no reason to perform a laparoscopy, true?

A So if he never touched -- if he never used the resectoscope or

used the yellow pedal, he wouldn't have to do a laparoscopy.

Q Okay, that's not my question. Listen very carefully. If at the time he was advancing the camera, and he knew that he was not using the resectoscope and then discovered the uterine perforation, you would agree with me, there's no reason to do the laparoscopy?

A Yes. In that case.

Q That's all the questions I have. Thank you.

MR. MCBRIDE: That's all the questions I have. Thank you.

THE COURT: Thank you. Do we have any questions from our jurors? All right, no questions. Thank you so much. You may be excused.

DR. BREEDEN: Can we just approach about scheduling?

THE COURT: Yes.

[Sidebar at 1:54 p.m., ending at 1:55 p.m., not transcribed]

THE COURT: All right. Ladies and gentlemen, as I advised you before, we're going to be ending at 3:00, but I don't know if we'll all make it until then. So we're just going to take a quick five minute bathroom break and then we'll come back and then we'll come back and then we'll end at 3:00 for the afternoon.

So 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 read, write, or 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, 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 reference materials, test any theory of the case, repeat 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 learn about any other issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected to this trial until the case is finally submitted to you.

So we'll take a quick five minute break.

THE MARSHAL: All rise for the jury.

[Jury out at 1:56 p.m.]

THE MARSHAL: Jury's cleared the courtroom, Your Honor.

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. Anything -- what are we putting on the record? Let's see.

MR. MCBRIDE: I forgot.

DR. BREEDEN: I have them, Your Honor. If you just want Plaintiff to speak these. During the cross-examination there were objections that -- questions about conversations between Ms. Taylor, my client's former attorney and the expert. And our position is, first of all, it's irrelevant, but second, they're attorney work product. They're not discoverable. They're essentially privileged, even though technically it's a work product exemption.

There were also numerous objections going to the risk and complications issue that permeates this trial. And there were also

numerous objections when testimony regarding the asserted negligence of non-parties, or parties that aren't here defending in the case was asked. And that has been addressed in a motion in limine, and I would call those peruse issues.

THE COURT: Okay. And just with regard to the conference call, there wasn't actually any information elicited. It was just -- I think the objection was anticipating that that was coming out. So that was the discussion on the bench. And then the questioning went on to not elicit anything about their conversation, but rather facts that he included in his report and his declaration.

And then anything else in response to those on behalf of the Defense?

MS. HALL: No, Your Honor.

THE COURT: All right. Quick bathroom break.

[Recess from 1:58 p.m. to 2:04 p.m.]

[Outside the presence of the jury]

THE COURT: Back on the record. A-18-773472-C, Taylor v. Brill. We're outside presence of the jury. Counsel for both parties are present. And are we ready to bring the jurors in?

MR. BREEDEN: Yes.

THE COURT: All right.

THE MARSHAL: All rise for the jury.

[Jury in at 2:05 p.m.]

THE MARSHAL: 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: Our next witness is the Plaintiff, Kimberly Taylor.

THE COURT: Thank you.

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

KIMBERLY TAYLOR, PLAINTIFF, SWORN

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

THE WITNESS: Kimberly Taylor. K-I-M-B-E-R-L-Y T-A-Y-L-O-R.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Good afternoon, Kim.

A Good afternoon.

Q I want to start with some questions about your background so that the jury gets to know you a little better. What's your date of birth?

A 10/25/71.

Q How old are you now?

A Forty-nine years old.

Q How old were you at the time of the hysteroscopy procedure involved in this case?

A Forty-five.

Q Where are you from originally? Where did you grow up?

A I grew up in a little town called Severn, Maryland.
Q How long in your life did you live in Maryland?
A All my life until I graduated high school.
Q Okay. What year did you graduate high school?
A 1990.
Q Do you come from a big family?
A I am a middle child. I have two sisters; one older, and one younger sister. My older sister, we're eleven month apart. And my younger sister is five years younger than me.
Q Now, you mentioned that you graduated from high school in 1990. What did you do after you graduated high school?
A Well, I got a job. I started a job working in Maryland right out of high school with a company called Central Healthcare [phonetic]. And it was a -- it was a billing receivables management company, and I started a job there doing physician billing.
Q Okay. And so did you enjoy that job?
A I did.
Q Okay. Did you know anybody in that industry before you got the job?
A No.
Q Okay. And when you say billing, what kind of billing are you talking about?
A It was -- the job I was doing at that time was physician billing.
Q And so just some more background information. Are you

currently married?

A No.

Q Do you have any children?

A I have one son, Liam [phonetic].

Q How old is Liam?

A Now, he's eighteen.

Q Do you have any other relatives that live in Las Vegas?

A My mom lives out here with my step-dad. Barbara Olsen and Clyde Olsen.

Q At what point in your life did you move to Las Vegas?

A I -- well, I didn't come directly to Las Vegas. So when I got that job in Maryland and I was doing physician billing, they took, at the time, some volunteers. They had a project at the University of Knoxville, and they had asked employees to, you know, volunteer who would like to go on this project. And I put my name in the hat, and I got selected. And I went to the University of Knoxville for about a year. I worked inside the business office there. From there, I did another small project in -- right outside of Nashville in Brentwood, Tennessee. And then -- I think that project was about six months. And then I had the opportunity within the company -- within the company I was working for at the time to either go to St. Pete, Florida or Las Vegas, and I chose Las Vegas. And that's where I'm at today.

Q And what year was that when you moved to Las Vegas?

A So I graduated in 1990. I did the year and a half project, and then -- till like sometime in '92, I guess.

Q Have you lived in Las Vegas, then, continuously since '92?
A Yes.
Q What side of town do you currently live on?
A Oh, I -- southeast.
Q Would you describe yourself as an active person?
A I am. Yes.
Q Give the jury of an idea of some activities or hobbies that you enjoy.
A Well, I -- for stress relief from my job, I -- you know, I run. And I try to get my workouts in about three days a week. You know, prior to that, in -- you know, high school I played softball. My dad, as a youth coach to my softball -- our softball leagues, me and my sisters. Up until high school I played, and then I did four years of volleyball in high school. But I'm an active person. I like to keep myself, you know, going.
Q After you graduated high school, did you continue your education in college?
A I did not.
Q What do you currently do for a living?
A I am a VP for a receivables management company here in Las Vegas called FIRM Revenue Cycle Management.
Q Okay. What's your job title or position there again?
A I'm a VP of eligibility services.
Q And VP means vice president?
A That is correct.
Q Okay. And how long have you worked for FIRM Revenue

Cycle Management?

A I've been with them nine years.

Q Since you went into the medical billing and receivables industry out of high school, is that what you've done for a living since?

A That is been my career for the last -- you know, since I've been out here. I, you know, started at an entry-level position. I liked it. I had some projects come up, and I just kind of worked my way up the ladder, so to speak. We -- I went through -- throughout my career, I went through different acquisitions, different company buyouts. So I've worked for very, very large corporations. And, you know, I just -- I just worked hard. I just worked my way up, and I'm in the position now just due to hard work.

Q Give the jury an idea about what you do from day to day at your job.

A So the department that I oversee, we call the eligibility services department. And so we contract with hospitals, and we take a portion of their receivables, and my department does all of the self-pay receivables. So if somebody that comes into the hospital with no health insurance at all, the hospitals will sign those accounts to my organization, and then we will conduct bedside interviews with the patients to determine whether or not they qualify for insurance. And it could be any insurance.

We can help them with, you know, marketplace applications with Affordable Care Act, Medicaid. If there's a county program, we would help facilitate that. If you have somebody that comes in the hospital that

is disabled or potentially disabled, we'll help them with their Social Security benefits, applying. We walk them through and advocate for them on behalf of the hospital to find a payer.

Q And does your company just work in Nevada?

A Our hub office is here in Las Vegas. It's where our corporate office is, but we're nationwide. So I have hospitals that I'm contracted with in California, in North Carolina, Mississippi. We're all over.

Q How many people do you supervise?

A Currently, I supervise -- there is seventeen employees. Fifteen, seventeen employees under me. In my -- in my history, in my career, I've supervised much more than that.

Q Okay. Do you actually work in the hospital?

A So if we -- yes and no. So if we get a new project that we sign on, my job, my responsibility is to meet with the CFOs, meet with the business office directors. We set up a protocol of, you know, where they would like us to fit in their flows and their processes of working with the patients.

Q Okay.

A So yes, when the setup project is. But I oversee the business from my Vegas office. We can VPN into the hospitals, hospital system as if we were sitting there in the hospital and, you know, review accounts and work business.

Q Do you participate in any charities associated with your work?

A I mean, I've done charities in my past. I've done -- did a

management leadership course through ChoiceCenter years, years ago that we did a charity for children that were born with cleft palates. So as a group, we had to come up with a charitable event that we wanted to contribute with. And as a group, we had to decide what we were going to contribute, and that was what we decided. We want to -- we wanted to raise money to give to children that were born with cleft palates to fix that for them.

Q Have you received any community recognition/awards for the work that you do?

A I received through the Chamber of Commerce a customer service excellence award. The hospital that I was working at at that time nominated me, and I got an award through the -- I had to go down to the Chamber of Commerce and accept my award. Yes.

Q Do you hold any professional licenses or certifications?

A Through my job, I have to -- one of them would be, example, I am a certified CEC counselor, which is -- what that means is it's a certified enrollment counselor. And it's through the State of California, and it allows me to be able to help people in the community apply for insurance through the marketplace. You have to -- you have to take a test, you have to do an annual exam, and you have to keep that going in order to keep your CEC license.

Q Kim, I want to talk now a little bit about your medical history. And I know sometimes, this can be embarrassing for people to tell strangers in a courtroom all this information, but I have to ask you for the case. Have you had trouble with your menstrual cycles over the

years?

A Yes.

Q Can you describe for the jury what your menstrual cycles are like and what the symptoms are?

A Well, they're long. Heavy bleeding. You know, normal periods would be, you know, three to four days. Mine would be, you know, seven to eight, sometimes longer. They're extremely painful, uncomfortable.

Q And how frequently do they come?

A I was getting -- I -- it seemed like I was menstruating constantly. I would get my cycle almost every two weeks. It wasn't a normal cycle. I never had a normal cycle. It was -- I just -- I was -- it felt like I was just -- it affected my day-to-day life. I was frustrated with it.

Q How would it affect your work or your social life?

A I -- just to give you an example; it's kind of embarrassing. But I'll just give you an example of how it -- I mean, I got to the point where I was trying to plan things or do things where I wasn't on my cycle. I remember going to a game, a Knights game, and on my period, and I ended up spending a full period of the game in the bathroom because of my heavy bleeding. I bled through the clothes that I was wearing. I was with my friends. It was embarrassing. So when I had situations like that, I would -- I'm like, okay, I'm not going to do it this time because this is -- you know, I have all these issues going on. It did affect me. It affected my day-to-day life.

Q How long have those symptoms been going on? Have you

had that your whole life or is that something that's come on later?

A So you know, prior to that, I -- it would -- when I was -- it would -- I was on birth control. So prior to my son being born, and he was born in 2003, you know, I would -- I would go through birth control. And then the older you get; different birth control methods were not working. I was finding myself crying all the time. I would -- I felt, you know, depressed. And it wasn't until a girlfriend -- I was talking to a girlfriend about how I was feeling, and she said, Kim, it's probably the side effects of the hormones with your birth control. And I didn't even think that.

So I took myself off of the birth control. My symptoms of the depression and the crying subsided. And then I just -- okay, so I just was, now what? Now, how am I going to fix the issues that I have?

Q So other than birth control or changing the type of birth control you were on, what else did you try to address your menstrual cycles?

A Well, meeting with Dr. Brill that I discussed if, you know, this would be another option that I could do would be the ablation and then with the removal of fibroid.

Q You mentioned your son. What year was he born?

A In 2003.

Q And was that a natural birth or a C-section?

A It was a natural birth.

Q Was Dr. Brill the doctor that delivered your son?

A No.

Q Were you a patient of Dr. Brill's at that time?
A No.
Q Have you ever been diagnosed with endometriosis?
A No.
Q Have you ever been diagnosed with cervical cancer?
A No.
Q Have you been diagnosed with any malignant cancer in your female reproductive organs?
A No.
Q Is it your understanding that you have what's a retroverted uterus?
A Yes.
Q Okay. And just in layperson's terms, can you explain, again, to the jury what that means?
A It's my understanding it's when the uterus tilts not forward but backwards.
Q When did you learn that?
A After the birth of my son. I did not know that I had any abnormalities of any shape or form until Liam was born.
Q Who told you that?
A The doctor who delivered Liam.
Q And were you ever told you were in some sort of danger because of your retroverted uterus?
A No.
Q Were you ever told that any of your symptoms, like for your

menstrual cycles, that that was related to having a retroverted uterus?

A No.

Q Were you ever told that you would need a treatment like a surgery to fix that?

A No.

Q Is it also your understanding you have what's called a bicornuate uterus?

A Yes.

Q And just, again, in layperson's terms can you describe what that means to the jury?

A So my understanding of a normal uterus is shaped like a T, and mine is shaped like a heart where I have two different chambers -- or horns is what they call it.

Q And when did you learn you had a bicornuate uterus?

A After my son was born.

Q And who told you that?

A The doctor who delivered.

Q Were you ever told you were in some sort of danger because of the bicornate uterus?

A No.

Q Have they ever told you your symptoms were because of that?

A No.

Q Were you ever told that you needed some sort of treatment or surgery for the bicornate uterus?

A No.
Q Is it also your understanding that you have, or have had in the past a fibroid tumor in your uterus?
A Yes.
Q Okay. What does that mean?
A It is a noncancerous tumor inside my uterus, the lining of it.
Q Do you know how many you have and what size they are?
A One that was, I believe they said it was maybe the size of a ping pong ball.
Q When did you learn -- first learn that you had a fibroid tumor?
A It would have been after Liam was born. Again, going through the issues that I was having, I had some CAT scans and some tests done back then as well.
Q And who first informed you that you had a fibroid tumor?
A I -- who -- it would have been -- I don't know specifically who, but it would have been the physician that I was under the care at that time, after Liam was born.
Q Okay. So all these conditions, a retroverted uterus, a bicornuate uterus, and fibroid tumor, you've known that you've had those conditions since your son was born?
A Correct.
Q Okay. And were you more or less just living with those up until 2017?
A Yes.

Q As an adult, have you regularly seen an OB/GYN?

A Yes.

Q And when did you first start seeing the Defendant in this case, Dr. Brill, as your OB/GYN?

A Well, so I was a patient of Women's Health Associates of Southern Nevada. He was not my original doctor. When I first started going to that facility -- or that clinic, I was, I believe his name was Dr. Skinner. He was my -- he was my doctor first. And then he left the practice, and then, I guess I was inherit -- there's multiple doctors within that practice, but I guess Dr. Brill inherited my -- because I'm a patient there, just inherited me, I guess.

Q So do you recall when you first started going to the clinic, and then when your care sort of transferred over to Dr. Brill?

A Oh, my goodness, I think I started seeing Dr. Brill in sometime of 2015. I don't know how long I had been with the clinic up until that point. Maybe a couple of years. I don't -- I don't recall how long I had been a patient of Women's Health Associates of Southern Nevada.

Q So the procedure in this case happened in April of 2017?

A Uh-huh.

Q So can you give the jury an idea about how many times you saw Dr. Brill, and for what conditions in the year leading up to that procedure?

A I would see him for my annuals, and then when I was getting frustrated about, you know, the issues I was having, you know, I wanted

to know what my options would be, and so we talked about, like, you know, doing the ablation for heavy bleeding, and then -- and then the removal of the fibroid would be a viable option for me. And so I had -- I had procedures -- there were steps that you had to take in order to get -- for that procedure to happen.

Q Tell the jury about that then.

A And so the biopsy of the endometrial lining was one, and then the biopsy of my cervix was the second. And so those were just -- and my understanding was they were just precautionary. Like, the -- we -- he had to do those to move -- to forward to this surgery. They were cancer screenings.

Q And so as best as you can recall, what are the names of different types of procedures that Dr. Brill wanted to move forward with?

A The D&C, which I believe was just routine. The ablation, and -- but the D&C is dilation and curettage and then the removal of the fibroid, so there was three -- technically three procedures that he was going to do.

Q And so what's your understanding of what happens during the ablation, and why did you want to undergo an ablation procedure?

A It was my understanding that the ablation -- and I have -- just to jump back, I have a girlfriend who had that procedure done, so I was able to speak with her, and I -- you know, I kind of knew what was -- what it consisted of, and it was the burning of the inside of the lining of the uterus. And that -- she had it done, and she just spoke wonders about it. And you know, and I wanted to know if that would have been an option

for me. Can I do this for my heavy bleeding? And that was my understanding.

Q And what's your understanding of what was going to happen with the fibroid tumor removal?

A That it would be cut. It -- the cut removed.

Q What was your understanding of how long the procedure was supposed to take?

A The procedure itself, approximately an hour.

Q Where was it going to be performed?

A At Henderson Hospital.

Q And did you expect to have to stay overnight in the hospital?

A No.

Q Well, what was your expectation then?

A He told me it was a very, very simple procedure.

Q I'm sorry, when you say "he," who are you referring to?

A I'm referring to Dr. Brill.

Q Okay. And so please continue.

A Okay. That I would be in surgery approximately an hour, and recovery would be anywhere from an hour to two hours and then I would be -- I would be able to go home.

Q And was Dr. Brill personally going to perform the procedure? Or was it going to be another OB/GYN or surgeon?

A It was Dr. Brill.

Q And what was your understanding about anesthesia during the procedure?

A That I would be going under full anesthesia.

Q And do you remember asking Dr. Brill about the recovery time after the procedure?

A I recall asking him, you know, how long the down time would be, and I don't -- I recall this because I was doing a 5k run that I was partnered -- partnering up. It was for Girls on a Run, and so I was partnering up with a -- acting as a mentor for a younger teenager, and I wanted to know am I going to be okay to do this run with this -- you know, with this -- this teenager, and -- because if I didn't, I needed somebody to fill my spot. And he said -- well, obviously, he said listen to your body, if you can't do it, but you'll be fine.

Q And so do you remember what day of the week you were scheduled to have the procedure?

A I had the procedure. I believe it was on a Wednesday.

Q And when was this 5k run that you were supposed to do?

A Sunday.

Q Okay. So you had asked Dr. Brill, prior to your hysteroscopy, whether you would still be able to do that on Sunday?

A I did.

Q Okay. And he told you you could?

A He did, yeah. He didn't see an issue with it.

Q And so let's go through what happens on the actual day of the hysteroscopy. How did you get to Henderson Hospital that morning?

A My step-dad picked me up and drove me there.

Q About what time a day did he pick you up?

A It was early in the morning. I had to be there early, maybe 5:30 in the morning, 6:00 in the morning, approximately.

Q And you say your step-dad. Can we put a name to him?

A Yes. Clyde Olsen.

Q And he testified earlier in this trial, right?

A He did.

Q And so did Clyde stay with you after driving you to the hospital?

A He did not.

Q Okay. Do you know why he didn't?

A He -- it was just -- they told him he didn't have to stay, that, you know, he could leave, and they would call me -- or call -- not me, call him when he -- when I was ready to be picked up.

Q What did you do, or where did you go when you got to the hospital?

A Well, you go to the outpatient registration surgery desk. You check in. They -- you know, they take all your information. They take you back and then they prep you in almost like a bay. It's not a room, but it's a bay, like with curtains.

Q Do you remember meeting with the anesthesiologist, Dr. Yeh, prior to the procedure?

A I do.

Q What do you remember him saying to you?

A I remember him being more formal questions, like you know, verifying my date of birth. Do you know what you're here for? You

know what, he did -- he introduced himself to me, you know, that he was the anesthesiologist, but it was more of a, you know, a formal verification of, you know, what I was there for, what I was going in for, and that he would see me inside the operating room.

Q Did you see Dr. Brill in the hospital before the procedure started?

A I did.

Q And what do you remember about your conversation with Dr. Brill at that time?

A It was very brief. Again, more, I guess, just the -- let me know that he was there, that -- you know, he may have mentioned he had another surgery ahead of mine, and that he would see me in the operating room.

Q Okay. So was it your understanding that Dr. Brill had other patients that day at the hospital to tend to?

A Yeah, one. One before me. I don't know if he had more after me, but I know that it -- I was -- I believe I was his second patient.

Q What was your expectation about when the surgery was going to start?

A Shortly. I mean, after he came in, I don't think I waited very long. You know, I went -- I went back fairly quickly.

Q About what time in the morning was that?

A About 8:00, 8:30, maybe possibly, 8:20.

Q Did -- do you remember how long you were at the hospital before you were taken into the operating room?

A You mean from the time I arrived when Clyde dropped me off?

Q Yeah.

A So he dropped me off 5:30, 6:00, and then I think I was taken back, approximately 8:00, 8:20.

Q Okay. Do you remember being taken into the operating room?

A On a gurney, yes.

Q Do you remember, did you feel nervous at that time?

A I -- actually, I was, and I remember -- I only remember this because the nurse, when I was waiting to be taken back, I don't know if she sensed how nervous I was, but she gave me, it was just -- almost like a Band-Aid. She put it on the inside of my wrist, and it more was like a lavender, kind of soothing thing that just would calm you. I was nervous.

Q What do you remember about the operating room itself?

A I mean, I don't -- I don't remember a lot. I remember being transferred over to the table, and then I remember Dr. Yeh, you know, asking me, like where I want to be on vacation, go to your happy place and we'll see you when you wake up. And then it was lights out after that.

Q So what is the next thing you remember?

A The next thing I remember is waking up in the recovery -- in the PACU unit.

Q Okay. So we've heard this term before, but PACU is basically

the recovery room?

A Correct.

Q Okay. And you know, where were you? Were you on a bed, or --

A I was on a bed, in like a bay. You know, it's like a -- like a -- like if you were to go in the ER, an ER bay, kind of. It's not a room, you know, because you're divided by curtains with other patients.

Q And who was there with you at first?

A I -- nobody. Well, the nurse. Nurse was with me. I mean, nurse -- I remember waking up to Nurse Hutchins.

Q Okay. Did you have another nurse that you worked with in the PACU? Or was it only Nurse Hutchins that you saw?

A It was only Nurse Hutchins.

Q Okay. When you woke up, do you remember what time of day that was?

A I do not.

Q Do you have any understanding of how long you were in surgery?

A I woke up in a lot of pain.

Q Okay. Tell me about then you wake up, and you're in a lot of pain. How would you describe the pain you were in when you woke up?

A Excruciating. Like if you were to take a wet towel and ring it in your stomach and your abdomen and it's just twisting and just jabs, it was -- I was in a lot of pain. I was -- it was excruciating.

Q Where was the pain on your body?

A My abdomen. My lower -- my lower part of my stomach.
Q And did you have any other symptoms?
A I was very nauseous. You know, I felt like I had to throw up, but I had nothing in me to throw up. Almost like dry heaving, I guess.
Q Were you able to stand and walk?
A No.
Q Okay. Did you try?
A No.
Q Well, if you didn't try, how do you know you weren't able to?
A I couldn't get up. I was in a lot of pain. I just laid there. I was hurting pretty bad. I didn't even -- I had no desire to get up.
Q And were your mom and step-father there at the time?
A When I first --
Q When you first woke up?
A No.
Q And do you remember seeing Dr. Brill in the PACU?
A I do.
Q What do you remember -- well, first of all, what's your understanding, or what's your recollection of how long it was after you woke up, before you saw Dr. Brill?
A He was there early. I remember seeing him then -- there early on. And he didn't come in the late afternoon, I know. It was -- it was early in the morning. You know, Nurse Hutchins was the first one I see, and then he came in right after.
Q And as best as you can recall, what did Dr. Brill say to you

about the procedure and what occurred?

A He didn't -- he didn't visit with me long. He came in and very briefly he said, Kim, the procedure was simply too complicated. We will talk at your -- at your post-op appointment in two weeks. And so -- and then he left. And so in my mind, I'm thinking, okay, because of all my abnormal -- abnormalities, that he couldn't do it, and that's all he said to me.

Q Now, if you put a stopwatch on it, how long was he there talking to you?

A A minute. Two minutes. It wasn't long at all. It was quick.

Q Do you remember anything you said back to him?

A I do not. I don't think I said anything. I think I said, okay, you know.

Q Now, some people, when they come out of anesthesia, they have a -- they feel groggy, or they have a poor memory. Do you recall that conversation vividly?

A I do.

Q And is it your understanding that Dr. Brill had to leave your side to tend to other patients?

A Yes.

Q Did you ever see Dr. Brill again that day after that one-minute conversation?

A No.

Q Did Dr. Brill ever tell you, during that conversation, that he had caused a perforation in your uterus?

A No.

Q Did Dr. Brill ever tell you during that conversation that he had caused a perforation in your small intestine?

A No.

Q Knowing what you know now, do you think Dr. Brill was upfront with you about what happened during the procedure?

A No.

Q How does that make you feel?

A Mad. I'm angry. I'm -- I don't understand it. I don't know. You think you're in the best of hands. And that -- I felt that knowing what I know now that I deserved an explanation of what happened to me. And then four years later is the first time I'm hearing that he attempted to repair. I've never heard that until this day in court. And it just angers me. And I just -- it's not okay. I deserve to know of any complication that happened to me immediately after surgery. And that's not what happened. And I feel cheated. And it almost cost me my life.

Q Around how long were you in the PACU in total that day?

A I was in there for seven and a half hours.

Q What was your understanding before the procedure about how long you would have to stay in the hospital afterward?

A He told me that I would only be in recovery for about an hour. The -- that was my understanding. And I ultimately ended up staying seven and a half.

Q Now, you mentioned that you saw Nurse Bruce Hutchins when you were in the PACU, and he was in charge of your care. Did

Nurse Hutchins ever tell you that you had sustained a perforation during the procedure?

A No.

Q To your knowledge, did Mr. Hutchins know that at the time?

A I don't know that he knew. I would think that he would have told me if he knew. I would think that again, that would be the practice of the healthcare provider to inform you. I was never informed. Nobody told me.

Q What sort of things do you remember in the seven, seven and a half hours that you were in the PACU, Nurse Hutchins doing for you?

A I mean, I was in a lot of pain. There was a lot of pain medication that he was giving me. I was nauseous. I know that there was nausea medicine that he was giving me. I just didn't feel right, you know. I just didn't -- I remember just not feeling good. Like, this -- I just felt bad.

Q What sorts of things would Mr. Hutchins or Nurse Hutchins ask you to do for him?

A Ask me to do?

Q Yes. Did he ask you to try to --

A I mean, he would ask me, you know -- he would ask me to rate my pain. I mean, is that what you're referencing? Like --

Q Yeah.

A Oh yeah. He would ask me like, you know, on a -- on a scale of one to ten, like what -- where are you. I mean, things like that. I

mean, that's the extent of what he asked me to do.

Q Would he ask you to try to stand and walk?

A No. I didn't have to do that until I had to urinate. They won't let you leave unless you urinate. So towards the end of the day when I had -- you know, they were discharging me, I had to go to the bathroom. That was the only time I got up.

Q What was that experience like? Was that easy to go to the bathroom?

A No. No.

Q Tell the jury what it was like.

A The nurse -- the nurse -- well, the nurse had to assist me, first of all. He walked me to the bathroom. You know, I remember -- I remember it specifically because when I went down to go sit on the toilet, I had this sharp shooting pain that almost, like, went directly up to my rectum. And it almost, like, pushed me back up. And when I asked Nurse Hutchinson [sic] is this normal, am I supposed to be feeling this -- it hurt. It was excruciating pain. It was -- it was like a -- like a knife or something stabbing you, like, going up inside. And his response was no, this is not normal. But what he said to me was it could be also considered what they call referred pain.

So when you have surgery in one area of your body, your mind or your brain might think that it's in another. So I just -- okay. I just accepted that. And I'm like, okay. Like, I didn't -- I didn't -- you know, that's what it -- I -- it hurt to go to the bathroom, to even sit down.

Q What kind of pain medications do you remember receiving?

A I remember receiving Dilaudid, Fentanyl, Norco, Percocet, several. Several. You know, then I think there was Tylenol. There was nausea medicine. There was -- I mean, all throughout, it was a lot.

Q How did those medications make you feel?

A Better. I mean, it seemed like they were just masking. You know, now that I look back on the whole scope of everything, the pain medication just masks the pain you're in at that time. So it helped, yeah. For sure.

Q Were you ever pain free in the PACU?

A I wouldn't -- I wouldn't say I was pain free. No. Absolutely not.

Q What time of day again, was it that they released you from the PACU?

A I believe it was 4:30, 5:30 p.m., approximately. Maybe 5:30.

Q Did Dr. Yeh come to check up on you in the PACU?

A I don't recall seeing him in the PACU.

Q At some point did your mother Barbara and your stepfather Clyde arrived?

A They did.

Q Okay. Were they present when Dr. Brill was there with you in the PACU?

A No. I wasn't -- I was by myself.

Q Did you ever see them talking to Dr. Brill?

A No. My parents didn't get there until, you know, after lunch. He came and saw me early morning. Like, right at -- you know, first.

Q How, if you know, did they know to come pick you up?

A I mean, I didn't -- how did -- I'm sorry, can you repeat that?

Q Yeah. If you know, how did your mother and Clyde know to come to the hospital when they did?

A They got -- they were supposed to get a call. But apparently, that's not what happened. Clyde had to call them and say, do you know is she ready. But they were originally supposed to get a call from the PACU to them that, you know, Kim's ready to be picked up. But that's not how that happened.

Q What was the process like around your discharge? Like, who did you speak to about should I be discharged, you know, and your health? Who made that decision?

A Well, I mean, I --

MS. HALL: Your Honor, I'm going to object. I think it calls for speculation as phrased.

MR. BREEDEN: I can try to --

THE COURT: Sustained.

MR. BREEDEN: -- rephrase.

THE COURT: Okay. Go ahead.

BY MR. BREEDEN:

Q Who made the decision to discharge you?

A I mean, I guess it's ultimately --

MS. HALL: Again, Your Honor --

THE WITNESS: -- the doctor's decision.

MS. HALL: Excuse me, Ms. Taylor. I'm sorry to interrupt.

THE COURT: Counsel, approach.

[Sidebar at 2:48 p.m., ending at 2:49 p.m., not transcribed]

BY MR. BREEDEN:

Q Kim, I don't want you to speculate. But do you know who -- do you know what medical care provider made the decision to discharge you?

A Henderson Hospital. The PACU nurse, I guess. He comes -- he -- I guess. I don't know. When you're ready.

Q What do you remember about your release from the hospital, your discharge?

A I remember I was still in pain. I remember I could not walk to the car. I was wheeled out. I remember I was leaving with a throw up -- they gave me a throw up bag. It was a blue -- it was a round circular with a bag, and it was blue, in case I had an accident in the car on the way home. And they gave me some prescriptions to get filled also.

Q Okay. Earlier, when we were reviewing pain assessment records with Nurse Hutchins, there was a record around the time of your discharge that says you were reporting two out of ten pain. Is that what you recall?

A I mean, my pain was significant. I mean, if I said that, it's because of the pain medication they were giving me. It drops your -- the amount of pain you're in down. So okay. That doesn't mean I was not in pain. I was still in pain. But it -- that's what pain medication does, masks -- you know, makes you feel a little bit better.

Q When you were discharged, did you think you were okay?

A I didn't feel good. No. I didn't feel good. I just wanted to go home and lay down. I just didn't feel good.

Q And so again, how did you get home?

A My stepdad.

Q What time did you get home?

A I think it was about 5:30.

Q And what happened to you when you got home? What did you do?

A I couldn't walk upstairs. I couldn't go upstairs. I have a two-story home, and I couldn't walk upstairs. So I made a makeshift bed on the couch, you know, blankets and pillows, and just kind of set myself up, you know, downstairs in my living room. And then I laid down.

Q Were you able to eat?

A No.

Q What symptoms were you having at that time?

A I was still nauseous. You know, dry heaving, I guess. I still had nothing in my system. So I mean, you feel like you've got to throw up. But there's -- you can't. There's nothing to come up. There's -- you know, you have nothing in your system. So very nauseous.

Q When did you next try to contact Dr. Brill?

A I want to say -- so I stayed -- I got home about, you know, 5:30. And I was -- my parents stayed until around 11. And I want to say it was after they left that that pain came back so severe that it scared me, and I made an attempt to call him. He had given me a phone number on paperwork. I couldn't get through. I just hung up, and I called 911. Just

the amount of pain I was in just -- it wasn't right. And it just -- I think it just scared me I think more than anything. Like, I didn't feel right.

Q So up until that point in time where you tried to call Dr. Brill, did Dr. Brill or someone from WHASN, Dr. Brill's clinic, try to contact you?

A I did not get one phone call, one follow-up from Dr. Brill, not from him, not from his office, not to check up on me. No phone calls at all. None.

Q And so you called 911 instead. What did you tell the 911 operator?

A I don't -- I don't recall the specific conversation I had. I just said, I need an ambulance. I didn't -- I didn't feel okay that I could even drive a car, first of all. I can't -- like, I knew something was wrong. I felt it in my -- you know, I didn't feel right. And I needed -- I needed a -- I needed somebody to come out and take me to the hospital. You know, I did try to call my parents. I didn't get through to them. And I -- that was my last option. I had to call -- I called 911. I didn't know what else to do.

Q Was there anyone else in the home with you at the time?

A No.

MR. BREEDEN: Your Honor, this is probably a good stopping point for today's testimony.

THE COURT: Okay. Ms. Taylor, stay there for one moment.

THE WITNESS: Okay.

THE COURT: Ladies and gentlemen, like I said, we're ending today at 3. Tomorrow, we're going to begin at 10:15. So I'll see you at

10:15 here.

And during the break, you're instructed not to talk with each other or anyone else about any subject or issue connected with this trial. You're 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.

You're not to conduct any research around or 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 on your own or investigate the facts. You're not to talk with others, text others, Tweet 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 connected with this trial until the matter is finally submitted to you. Thank you. And we'll see you at 10:15 tomorrow.

THE MARSHAL: All rise for the jury.

[Jury out at 2:55 p.m.]

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

[Outside the presence of the jury]

THE COURT: We're outside the presence of the jury. And there was an objection. Ms. Taylor, you can go ahead and go down there. But I'm going to remind you you're still under oath. So you're not

to talk about your testimony to anyone, okay?

THE WITNESS: Okay.

THE COURT: All right. Thank you. There was an objection during Ms. Taylor's testimony with regard to who discharged her from the hospital. And your objection, Ms. Hall?

MS. HALL: Just that I thought it called for speculation.

MR. BREEDEN: Yeah. I think it was really just kind of a form or phrasing objection. I don't think there was much more to say on it.

THE COURT: All right. And I had asked you to rephrase, which you attempted to do. But I think the response still was speculative. So it is what it is. But I did ask you to rephrase.

All right. Anything else before we leave?

MR. BREEDEN: Nothing further from Plaintiff.

MS. HALL: We had planned to call our expert tomorrow, Dr. McCarus. I have tried to get a hold of him. He is currently, I think, on his way here. And if he is available all day, my preference would be to go ahead and finish the examination of Ms. Taylor before putting him on. As soon as I hear, I'll notify counsel.

THE COURT: Okay.

MR. BREEDEN: Thank you for bringing that up. That was my expectation, as well, that you were going to need to proceed with Dr. McCarus immediately after Ms. Taylor.

MS. HALL: Yes. And I guess -- I'm sorry if that was confusing. But what I was trying to say is I had originally asked to call Dr. McCarus as the first witness on Friday.

THE COURT: Right.

MS. HALL: And I am checking with him. And as soon as I hear -- assuming he is available the entirety of tomorrow, my preference would be to finish the exam of Ms. Taylor, and then put Mr. -- excuse me -- Dr. McCarus on.

THE COURT: Okay. And Mr. Breeden, is Ms. Taylor your last witness, or we're still waiting to see what happens with --

MR. BREEDEN: I'll be calling Dr. Brill. And there may be other witnesses.

THE COURT: Okay. All right.

MR. BREEDEN: And I think that opposing counsel agreed that after I call Dr. Brill, they're going to defer any questions to Dr. Brill to their case-in-chief is my understanding.

MS. HALL: Well, that may be the case. I guess it's going to depend on when Dr. Brill is called. If he's the last witness of Plaintiff, I may not prefer my direct because that -- you know, if -- I don't know is the best answer.

THE COURT: Okay. That's great. I will see you all tomorrow at 10:15.

MR. BREEDEN: All right. Thank you, Your Honor.

THE COURT: Thank you.

MS. HALL: We're to be here, I'm sorry, when, Your Honor?

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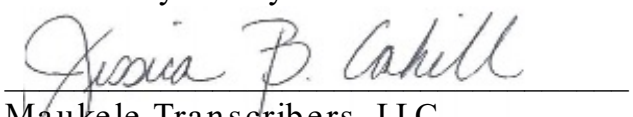
THE COURT: 10:15.

MS. HALL: Oh, thank you. I thought it was 8:30. 10:15.

THE COURT: Yes.

[Proceedings adjourned at 2:59 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.



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