IN THE SUPREME COURT OF THE STATE OF NEVADA

KIMBERLY TAYLOR,

Appellant,

v.

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

Respondents

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SUPREME COURT CASE NO. 83847

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

APPELLANT'S APPENDIX

VOLUME XI

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CERTIFICATE OF SERVICE

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

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

An Attorney or Employee of the firm:

/s/ Sarah Daniels
BREEDEN & ASSOCIATES PLLC

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

BEFORE THE HONORABLE MONICA TRUJILLO
DISTRICT COURT JUDGE
FRIDAY, OCTOBER 15, 2021

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 6

APPEARANCES:

For the Plaintiff: ADAM J. BREEDEN, ESQ.

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

RECORDED BY: DELORIS SCOTT, COURT RECORDER

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None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Friday, October 15, 2021

[Case called at 10:16 a.m.]

[Outside the presence of the jury]

THE COURT RECORDER: On the record, Your Honor?

THE COURT: Yes. All right. We're on the record in A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. And just a couple of matters before we begin. So we noticed that both sides filed proposed jury instructions. I'm going to ask that you please 1) speak with each other to see if you're going to agree on or what I need to rule on specifically. Please email my law clerk and JEA word versions of them so that when we have to change them after we finalize them. And I need a clean copy without citations too.

MS. HALL: And I can tell the Court, Your Honor, there are several in Plaintiff's that the Defense is going to agree to.

THE COURT: Okay.

MS. HALL: So hopefully we can hash that out and narrow down what's disputed.

THE COURT: All right. And so, do we want to anticipate doing jury instructions maybe Monday afternoon or Tuesday morning?

MR. BREEDEN: Yeah. I think that's probably reasonable. Monday afternoon. Yeah.

MR. MCBRIDE: Starting at 10:15 again, Your Honor, on Monday?

THE COURT: Yes. I think 10:30, because I have a calendar that morning, criminal.

MR. BREEDEN: Your Honor, you said Monday is 10:15?

THE COURT: Let me look. I think it's 10:30 actually. Yeah, 10:30 to 5:00 after my criminal calendar.

And anything else outside the presence?

MR. BREEDEN: No, Your Honor. Do you want Ms. Taylor to return to the witness stand here when the jury comes in?

THE COURT: Sure.

MR. MCBRIDE: Actually, one minor thing in terms of the lunch break. Any idea of as to when we might do that? We're just trying to figure out when to have our expert here.

THE COURT: I'm thinking we're going to take a -- well because we're starting late, probably 12:45 or 11:00. I'll take one bathroom break probably around 11:45 and then we'll go to probably 1:00 for lunch break.

MS. HALL: Perfect.

THE COURT: All right. So are we ready for the jury? I think we're waiting on one so it might be a minute.

[Pause]

THE COURT: Oh, before we move on. I know you're calling a witness out of order, so in criminal I only did it, but it was out of order in my own case-in-chief. So procedurally, how do you want me to say anything to the jury, if anything, since they're calling a witness out of order?

MR. BREEDEN: Yeah. You can just indicate, you know, ladies and gentlemen of the jury, for scheduling purposes, we're going to call one of the Defense witnesses out of order at this time.

THE COURT: Okay.

MR. BREEDEN: Something brief.

MS. HALL: That's perfect.

THE COURT: Okay. I just wanted to make sure.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 10:22 a.m.]

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

THE COURT: Thank you. You may be seated. Good morning and welcome back. And we're going to proceed with the Plaintiff's case. And, Ms. Taylor, you understand you're under oath, correct?

THE WITNESS: I do.

THE COURT: All right, thank you. Go ahead.

KIMBERLY TAYLOR, PLAINTIFF, PREVIOUSLY SWORN

DIRECT EXAMINATION CONTINUED

BY MR. BREEDEN:

Q Okay, Kim. I know we took a break in your testimony because we finished a little early there yesterday. I want to sort of summarize where we were first. So when we left off you were talking about this time period where you had gone home from Henderson Hospital, and you tried to contact Dr. Brill; do you recall that?

A I do.

Q Do you recall what time in the evening that was?

A The first time it was approximately -- well the first time I called -- I'm sorry, I only called -- I made an attempt to call him one time and that was before the first time we went to the ER. And I think it was approximately 11:45.

Q And what happened when you called?

A I didn't get through. My pain was so severe, you know. It was after hours. I got an answering service. I just, you know, I was on hold, and I just hung up. I was -- I remember being just scared, you know. I just hung. I hung up and I called 911.

Q Were you able to speak to a live person at the answering service?

A No.

Q Okay. And you never spoke to Dr. Brill?

A I did not, no.

Q And you said that you hung up. How long was it between when you hung up on the answering service and you called 911?

A Immediate. I didn't wait to delay. I mean, I think I called my parents first, and then Dr. Brill, and then 911 is my recollection.

Q Okay. What sort of symptoms were you having at that time that lead you to think hey, I need to call 911 here?

A I was having severe abdominal pain. I just knew something was wrong. You know, you know your body and, you know, you're being told that you're -- nothing happened. You know, basically my

surgery didn't happen, nothing happened. And I just knew something was wrong. I couldn't understand why or how I was in so much pain. Just something wasn't right. I was bent over. I was sweating. I remember sweating profusely.

Q Had you been vomiting or trying to vomit?

A I couldn't. I had nothing in my system, so I guess dry heaving.

Q And you say that, you know, you're severe pain. But, you know, describe to the jury a little more particular. Where is the pain? How did it feel? Did it come and go? Was it constant?

A You know, it was a progression. It would come and go. It was in my abdomen area on my stomach. It got to the point where, I mean, I was doubled over sweating profusely. At one point, and I believe it was the second time I called the ER, but at one point I had pain so bad that it radiated up to the corners of my shoulders. I don't know. It felt like, you know, am I having a heart attack? I was scared. I didn't understand what was happening and I just called 911.

Q Okay. So we're tied up the first time you called 911. What do you recall about meeting with the EMT's that responded and, you know, what you told them?

A I told them that I went in for surgery. That, you know, a surgery that I was told was too complicated and couldn't be completed. They hooked me up. I believe they did EKG, checked my vitals. I went on a gurney, and they transported me to the emergency room.

Q Okay. So what do you remember about who you saw and

what was done for you when you went to the emergency room? I guess first of all though, which emergency room were you taken to?

A I was taken to St. Rose Siena.

Q Do you know why you were taken to St. Rose as opposed to back to Henderson Hospital?

A I do not know for sure. I can only assume that, you know, St. Rose Siena is close to where I live, so I just assumed that's why I went there. I didn't ask to go there.

Q And so tell the jury, you know, what happened when you arrived at the emergency room? What was done for you?

A I went into the emergency room. They put me into the ER bay. A nurse came in. They did give me a small amount of pain medication in the ambulance. I do remember that, and they gave me some more additional pain medication when I was in the ER. I saw a nurse. I think they took my blood. They did a CT scan, and I met with the ER physician.

Q What was the ER physicians name at that time?

A Dr. Christensen.

Q Okay. What did Dr. Christensen tell you about your condition?

A Well after all of the -- everything I had done, the CT scan, the bloodwork, he came into the room and he said, you're free to go home young lady. He said he found nothing, and I just remember looking at him like, I guess I'm a big baby, you know. I had a lot of pain, and I couldn't wrap my head around -- it made me feel like I was crazy, you

know. And I went home.

Q What did Dr. Christensen tell you about the results of the CT scan?

A That he found nothing. I mean, he didn't find anything. That's all he told me.

Q Did he tell you he believed you had any perforations either to the uterus or the small intestine?

A No.

Q At that time, did you know you had perforations to the uterus or small intestine?

A No.

Q What time of day was it when you were released from the emergency room?

A That time it was around 3:00 a.m.

Q So you had been in Henderson hospital most of the day. You went home and then you had to go back to the emergency room where you were released at 3:00 a.m.?

A That is correct.

Q Okay. How did you get home from the emergency room?

A Well I didn't have transportation, so I went down with my phone, and I started -- I think I called one of my girlfriends Beth. It was 3:00 in the morning. She didn't answer. I called my mom first. They didn't answer. Then I called Beth. She didn't answer. And then I believe my third call was to Elizabeth. She answered and she came and picked me up.

Q Okay. And what's Elizabeth's last name?

A Laca.

Q And we heard from Elizabeth Laca earlier in this trial?

A Yes.

Q And so, what's your relationship with Elizabeth Laca?

A Coworker.

Q And so, is she someone that you know extremely well, and you socialize with outside of work or is she somebody you just kind of see at work?

A Mainly coworker. You know, we've worked together for many, many years. Probably fifteen plus years, so, you know, we know a lot about -- a lot about each other. I would consider her a friend.

Q Now, did Dr. Brill ever meet you at the emergency room at St. Rose the first time you went?

A No.

Q Describe to me what happened, where did you go, what did you do when you got home after leaving the emergency room at 3:00 a.m.?

A I got home. And again, I had the -- you know, I couldn't go up my steps. I couldn't walk upstairs. I don't -- you know, I have a two story; I don't have any bedrooms downstairs, so I got a makeshift bed on my sofa. And I just laid down. I just -- you know, I laid down and I tried to close my eyes and rest. I don't recall sleeping very well.

I think maybe if I did doze off, I was up. Maybe I dozed off and I was up, it was -- it was not comfortable.

Q Were you still in pain?

A Yes.

Q Were you still sweating?

A Sweating, very nauseous. You know, you feel -- still feeling like I had to throw up, but I didn't have anything in my stomach. I didn't -- there was nothing in me that -- it was, like, dry heaving.

Q Did you have anything to eat?

A I did not.

Q And so when it became morning or light out, what did you and Elizabeth do?

A Well, Elizabeth stayed with me. She wouldn't leave. She stayed with me, you know, from, you know, 3:00 a.m. till -- we were waiting for the pharmacy to open so that I could get -- Dr. Christensen had given me nausea -- a prescription for nausea medication that she was going to go drop off and fill for me and pick up -- and bring back to me. Which she did. She left and went to the pharmacy and then -- and then did come back.

So there was a period of time, I believe, I was home alone again for a short period of time. My parents were coming back over that morning.

Q Okay. Did there come a time when someone, again, called 911 to respond to your home?

A I believe it was my -- I believe it was my stepdad that called.

Q What time of day was that?

A I believe it was 11:45, 11:30, approximately.

Q In the morning?

A In the morning, uh-huh.

Q And so you had the procedure on April 26th, so by this time this is just before noon on the 27th?

A Correct.

Q This is more than 24 hours since your procedure?

A Correct.

Q Describe for the jury, sort of, the scene when the paramedics arrived the second time. Who was there and what do you recall?

A Again, I was in a lot of pain. I was in significant pain. I was -- it got worse. I think this was the time where I was doubled over, and I could feel, you know, sharp shooting pain in my shoulders that I felt like, you know, is this a heart attack coming on? It scared me. I didn't -- I remember when the EMT. got there the second time. There was a lot of them. There was EMT., there was the fire department. I just -- I was sitting on the couch. I was sweating profusely. My entire head was soaked.

I remember my mom sitting next to me and I pushed her away and I'm, like, mom, I don't want anybody touching me. Like, I was -- I remember they were asking me questions, but I couldn't -- I couldn't even concentrate to answer their questions because the pain was so intense, and I remember looking down. And then I remember looking up -- I don't know if it was the fire department guy or EMT. guy. And I looked up at him and I said, I see two of you. And that's when they said, okay, let's go. We're going to take you into the ER. And I went

back on the gurney. They did all the tests again. And I went back for a second time.

Q Okay. What hospital were you taken to that time?

A I was taken to St. Rose, yeah.

Q Did you see Dr. Christensen again when you arrived at St. Rose for the second time?

A I did not.

Q Okay. What doctor did you see in the emergency room?

A I saw Dr. Frankel.

Q And what do you recall about what tests were done and what Dr. Frankel said to you?

A He -- he came in. We don't -- basically, it was like we don't know what's wrong. We're going to find out and you're not going home. We're going -- we're going to figure this out. I know they did some more blood work. He went and looked at the scan that was previously done that Dr. Christensen did, and I remember him coming back in and he apologized on behalf of that doctor. I remember him saying that, you know, I'm sorry, Kim, but you have fluid air is the term he used. And you should not have been sent home. We're going to figure it out, and I stayed. I never -- I never left the hospital from that point on.

Q Did Dr. Brill meet you at the hospital this second time?

A No.

Q What options or treatment plans did Dr. Frankel discuss with you.

A He wanted to start me on IV antibiotics, and I know that they

were trying to get ahold of Dr. Brill. I know that Dr. Frankel came in and expressed that to me; I've left several messages, we're waiting for somebody to get back to us. He wasn't available. They had somebody from his practice -- a partner, I guess -- come in his place. They didn't want to start me on antibiotics. Dr. Frankel just basically overrode that decision and started me anyway, I know that. And then I believe it was by the time they finally had somebody come and see me from his practice -- I believe it was Dr. Schoenhaus.

Q Did Dr. Frankel tell you immediately that you had a uterus perforation?

A No.

Q Did he tell you immediately that you had a bowel perforation?

A No.

Q At some point, when you were there at St. Rose, were you transferred from the emergency room into the regular hospital?

A I went from the E.R. bay up to surgery.

Q Okay.

A I never went into a room. I stayed in the E.R. the whole time. I remember them -- you know, Dr. Frankel came in several times throughout, and I remember him, you know, giving me an option. You know, Kim, one, you're not going to go home, but you have two options, basically. We can keep you here for observation, and we can just monitor you and watch you, or we can take you up and do the exploratory surgery where we can, you know, just take the camera and

look around. We're waiting for one other call. And I don't -- he didn't tell me what -- who -- what phone call they were waiting for, but we're waiting for one other call and -- but it -- the decision was going to be left up to me. I was going to be able to decide what I wanted to do.

The next thing after that, I remember it was no longer an option. And I was -- you're going up for surgery and I was wheeled up. I remember getting up to the -- whatever surgical floor that was, and I remember seeing a woman standing at the end of the hallway, basically, just standing there. It was almost like she was waiting for me. I don't know. And then that's who came up and spoke to me about what was going to happen next.

Q Who was that woman?

A That ended up being Dr. Hamilton.

Q And Dr. Hamilton testified earlier via video conference in this trial, correct?

A Correct.

Q And so what did Dr. Hamilton tell you?

A She told me that -- she was very detailed. Very, very detailed with me. She said we're going to -- I'm going to go in with a camera first. I'm just going to kind of look around. She told me the -- she goes, you know, there's going to be two holes, probably, with the camera and then just kind of look around in your stomach. And then she said I'm -- if I don't like what I see, I'm going to end up having to, you know, open you up. She said I would have a vertical incision.

She told me that, you know, it -- if I -- when I wake up, don't

be surprised if I wake up with a colostomy bag. Don't be alarmed -- you know -- that that is a possibility that could happen.

Q Did you tell Dr. Hamilton that you had a perforation?

A I did not.

Q Did you know that at that time?

A I did not.

Q We -- we heard some testimony from Dr. Hamilton, and she said something to the effect of, well, I -- you know, I think Ms. Taylor might have told me she had a perforation. Did you agree or disagree with that?

A I disagree. I could only assume that she got that from Dr. Brill's partner --

MS. HALL: Your Honor -- excuse me.

THE WITNESS: -- that it was --

MR. MCBRIDE: Wait. Wait. Ma'am --

THE WITNESS: -- in the --

THE COURT: Ms. Taylor? Ms. Taylor? Ms. Taylor, stop.

MS. HALL: I'm going to object. It calls for speculation and lacks foundation.

THE COURT: Sustained.

MS. HALL: Thank you, Your Honor.

BY MR. BREEDEN:

Q Okay. Well -- so the surgery that was going to be done, you were going to be put under anesthesia again?

A Correct.

Q And give the jury an idea, as you recall, the time between, you know, you arrived in the emergency room and when they took you for surgery.

A I'm sorry, Adam. Can you repeat that?

Q Yeah, so do you recall, or can you tell the jury approximately how long was it between, you know, when you arrived in the emergency room and you saw Dr. Frankel, and then when you were taken into surgery with Dr. Hamilton.

A I mean, hours. I don't -- I don't recall the exact time that I was wheeled up for surgery. I know that I was in the E.R. bay for a good period of time.

Q So you're taken into surgery; tell me what you recall about when you woke up from surgery.

A When I woke up from surgery, I mean I -- I mean, I did -- okay. So I had to compare it to the first time that I woke up coming out of anesthesia, and I felt better. It was night and day. You know? When I woke up coming out of anesthesia from Dr. Brill's surgery, I didn't feel good. And when I woke up from anesthesia the second time, it was much different.

MR. BREEDEN: Can we just take a break?

MS. ALBERTSON: We need a --

MR. BREEDEN: Sorry.

THE COURT: You okay? Okay. All right. I've got to read the admonishment. I'm sorry. You're instructed not to talk to each other -- with each other or anyone else about any subject or issue

connected with this trial, you are not to read, watch, or listen to any report or commentary on the trial by any person connected with this case, by any media information, including newspapers, television, internet, or radio. You're not to conduct any research -- I'm so sorry. Research by using internet, reference material, test any theory of the case, recreate any aspect of the case, or in any other way investigate the case on your own. Please, don't talk with others, text others, tweet others, Google issues about any issue, party, or witness or attorney involved in this case. You're not to form and express any opinion on this matter until it's finally submitted to you.

Sorry, we'll take a break. Go ahead. I'm so sorry.

THE MARSHAL: All rise for the jury.

[Jury out at 10:45 a.m.]

[Outside the presence of the jury]

THE COURT: All right. We are outside the presence of the jury, and I guess we'll figure out what's going on before we are going to resume.

MR. MCBRIDE: Did you want to address the one objection --

THE COURT: I think it was on the record, so I think we're good unless you want to --

MS. HALL: Yeah, and I'm sorry for raising my voice. I don't project very well with this mask on. So you probably couldn't hear me, Ms. Taylor.

THE WITNESS: I didn't. I'm sorry.

MR. MCBRIDE: That's okay.

THE COURT RECORDER: Are we going off the record, Your Honor?

THE COURT: Yeah, you can go off the record.

[Recess from 10:46 a.m. to 11:11 a.m.]

[Outside the presence of the jury]

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

THE MARSHAL: All rise for the jury.

[Jury in at 10:55 a.m.]

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

THE COURT: Thank you. You may be seated. And we are going to resume with Ms. Taylor's testimony.

BY MR. BREEDEN:

Q Okay. Kim, before the break, we were talking about you had been taken in for a surgery at St. Rose with Dr. Hamilton. Do you recall that?

A I do.

Q Okay. What do you remember, you know, when you were out of surgery being told about what medical condition you had and what had to be done?

A The medical condition I had was unknown. It was not -- they didn't know. The way she broke it down to me was that we're going to go -- she was going to go in and look with cameras. And then --

Q You're talking about before the surgery?

A Correct.

Q Okay. So --

A I'm sorry.

Q So tell me about that, and then I'll tell -- ask you about afterward.

A Okay. So when I met with her, she was going to go in with cameras and look first. And mean she was -- I remember her being very detailed as to step by step. She told me that if she didn't like what she saw, that we would have to do an incision, is vertical incision, from my pubic bone area all the way up to my belly button, and that she would -- I mean she kind of joked around, I'll try to make -- you know, if that happens, your scar as minimal as I possibly can. And then she said, the worst -- the worst part -- the worst thing that -- you know, don't be surprised if you wake up with a colostomy bag. And that was, you know -- and then I just -- I was wheeled in for surgery with her.

Q Okay. Now, when you woke up after surgery, did you have a conversation with Dr. Hamilton about what she found and what she had to do?

A I did have a conversation with Hamilton, yes. She explained to me that I had a bowel perforation. She explained to me that I remember the terms or the words that she used, is that she had to repair the damaged part of the bowel, which means she had to remove a piece of the bowel and then sew the two ends, the healthy ends back together. I remember her saying, you know, after she did that, I had to clean, clean, clean, clean in all four quadrants of my stomach. And she

referenced that to -- that that was, I guess, the infection that was going throughout my body at the time.

Q You said stomach. Is maybe abdomen --

A Abdomen.

Q -- a better word?

A Yes.

Q Okay.

A All four quadrants of my abdomen.

Q And what's your understanding about whether you had an infection?

A I didn't at -- it didn't sink in at that moment with her the infection. It -- the fact that I had the infection, the -- that's called the peritonitis, that sunk in later during my stay and recovery at St. Rose. I then knew how serious it was, and I -- then it sunk in that I could have died. I know how serious that infection is. It sunk in after the fact, the severity of it.

Q After you had the repair surgery, were you released from the hospital that day?

A No.

Q How long did you have to stay in the hospital after your surgery?

A I was there for nine days.

Q So describe for the jury how you felt and the types of things that you had to do with the hospital during those nine days.

A The recovery was not fun. You know, I -- when I -- when I

went down to recovery, I had -- I still had a catheter I believe in during the surgery that they had to remove. I had -- I don't know what they're called, but they're things that you -- they put on your legs and they're compressions, and it's like air in it and it tightens and then it expands and then tightens. I guess just to get your blood circulating in your legs. I had that -- I had that on. I had to keep that on. You know, I was laying in bed. It was -- it was a long, painful, excruciating recovery for me.

Throughout the process of being able to leave, I -- they told me I had to be able to pass gas, that ultimately had to have a bowel movement. I still couldn't eat. I still didn't like, feel good. Ice chips is really the only thing that I could -- that I could -- that I was eating. I lost 20 pounds in nine days.

I remember -- you know, there were -- there were good days -- better days. I wouldn't say good days, but there were, you know, better days and then there were bad days. I wanted to get out of there obviously, and I -- what do I need to do to get out of here? Well, you got to get up and walk. And if you get up and walk, it's going to help you -- you know, you're -- help you pass gas.

I remember in one instance -- and -- it wasn't happening. That part wasn't happening. So they said, well, we can give you a suppository to help with that. And they -- and I agreed. And I said, okay. And it was the most excruciating, painful experience I went -- I mean I was sitting on the toilet with -- screaming in pain with the nurse putting pain medication in my arm. I don't wish that on anybody. It's -- it wasn't a fun experience. It was -- it was -- it was a slow process for healing.

You know, it was sporadic. You know, it was -- you know, think about -- I don't know how to explain it. Again, that -- that towel that, you know, you're trying to ring out with water and your insides being twisted and turned around and, you know, you have pain in your rectum area, and you just -- it's not fun. It's not fun.

Q Were you connected to I.V.s during your time in the hospital?

A The entire time.

Q Okay. And were you given pain medications while you were in the hospital?

A Yes.

Q Okay. Do you remember which kinds of medications?

A Dilaudid, probably -- Norco I think it's one of them. There -- it was a multiple of different pain meds throughout the entire stay.

Q Were you placed on a liquid diet?

A I was.

Q Were you able to eat any solid foods when you were in the hospital?

A No.

Q Did there come a time where it was recommended that you eat solid foods?

A At one of Dr. Brill's visits, came -- he came in just in routine, I guess, rounds that they do, he changed my diet. He put me on a full diet. Like a full -- I shouldn't say diet. But a full -- food. And I remember -- I don't believe it was Dr. Hamilton. I believe it is her partner, Knoblock, I think is how you pronounce her name, and they

were very upset. When they came back in, who put you on -- who put you -- who put you to take food? I said, well, Dr. Brill did. And they were very upset about it. They switched it -- I mean, I couldn't eat it. They were bringing the food in, but I just -- I couldn't eat. I couldn't -- it was -- just ice chips is the only thing that I had. And they reversed what he did and then put me back on the liquid diet.

Q And did you have to see an infectious diseases doctor while you were there?

A I did.

Q Okay. Do you remember that doctor's name?

A It was Dr. Lipman.

Q Okay. What do you remember about Dr. Lipman and what he did for you and what he told you?

A I remember Dr. Lipman in detail. And I'm -- and here's why. I -- he came in and saw me several different times. And I think the first time he came in and saw me was just more of an evaluation. He asked me in detail, you know, my history, am I -- am I a smoker, am I a nonsmoker, you know, just like routine questions. But, you know, in one of his visits -- and you have to understand, up until the point that I spoke with Dr. Lipman in one of his visits, I still -- I mean I know what happened to me was a perforation of my bowel, but I still was under the impression that nothing -- it was a -- basically I just -- I guess I just assumed it was an accident. And it wasn't until Dr. Lipman says to me -- you know, he mentioned the operative report and he mentioned Dr. Brill perforating my uterus. And I don't -- it raised at that point so many red flags, like,

wait a minute. Why didn't Dr. Brill tell me this? Why am I hearing this from an infectious disease doctor? Why am I now hearing this from -- you know, why didn't -- why didn't my own doctor tell me that he perforated my uterus? That never happened.

When Dr. Lipman came in and talked to me, and I guess you could say he kind of spilled the beans, I -- he's the one who told me, you had a perforation of your uterus in surgery with Dr. Brill. I still in my mind prior to that thought that this was just, you know, an accident. I didn't know that he knew he did it. I didn't know up until that point.

Q So when Dr. Lipman had that conversation with you after your bowel repair surgery, that was the first time you knew that Dr. Brill knew that he had actually caused the perforation during the surgery?

A That --

MS. HALL: Objection, Your Honor.

THE WITNESS: That is correct.

MS. HALL: Calls for speculation.

THE COURT: Hold on.

MS. HALL: I'd move to strike.

THE COURT: Counsel, approach.

[Sidebar at 11:07 a.m., ending at 11:08 a.m., not transcribed]

MR. BREEDEN: Thank you, Your Honor.

BY MR. BREEDEN:

Q Were you able to shower and bathe as normal when you were in the hospital?

A No.

Q What was that like?

A Humiliating. I -- they would not allow me to bathe alone by myself. When I got to the point where I wanted to get a shower, I had to have somebody stand and basically watch me shower, and -- it's embarrassing. I mean I -- it's embarrassing to me. I mean I don't --

Q Were you having bowel movements while you were in the hospital?

A No. I started -- I started at some point throughout, and I don't know when, but I had to pass gas first. And I kept saying to them, how am I going to do this if I'm not getting any food and there's nothing going in my system? And that's when they decided -- they go, we can, you know, give you assistance with that with the suppository. And that was a nightmare.

Q Did you have trouble dressing yourself?

A I never -- I never -- I mean I stayed in my gown. I stayed in my -- the gown that you wear, the -- you know, that they put you in. I never changed. I mean I couldn't shower by myself, you know. I had somebody that had to help me throughout the whole process. You know, I'm hooked up to the I.V. also, which is -- I mean it's a stand shower. It's not like a tub you would normally get in. You just walk in it, is what was in there.

Q I'd like to show you a document to ask if it refreshes your memory.

MR. BREEDEN: Kristy, can you give us -- I think it's Exhibit 1, the St. Rose Hospital records at 826?

MS. HALL: And refreshes her recollection as to?

MR. BREEDEN: As to difficulties dressing.

THE COURT: Ask the question first.

MR. BREEDEN: I did, and I don't -- I think she said she couldn't recall. She was in a gown.

THE COURT: She said she stayed in her gown?

MR. BREEDEN: Yes.

THE COURT: Counsel, approach.

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

BY MR. BREEDEN:

Q Do you remember how long it was after your bowel repair surgery that you were able to eat solid foods again?

A I -- even when I went home, I wasn't eating solid foods. I -- it was a lot of, you know, soup, broth. I know at least for a week at my mom's it was liquid, broth. It was some -- you know, I think I maybe did eat some egg whites. But not solid food. No. No.

Q How long after your bowel repair surgery was it before you began to have normal, solid bowel movements again?

A Oh man. It was -- again, it was a long -- it was a long recovery for me. It was -- I don't -- I mean, define normal bowel movements. It -- they were painful for me. I continued care with Dr. Raman. I know that I stayed with him for a good year and a half after surgery. I saw him every two months. I continued to have, like, spasms, like, sporadic painful spasms. He had sent me for a colonoscopy just to check everything to make sure everything was good. I know I did an

ultrasound with him at some point.

But the spasms continued on. It was a good -- I mean, it was a good year, year and a half before -- you know, and even now, today, sitting here today, there's once in a blue moon where I'll have a bowel movement that's extremely painful. Up until this surgery, I've never experienced that before. So I mean, there's nothing they can do. There's nothing -- you just deal with it, you know.

Q I'm going to take you back to your nine-day stay in the hospital at St. Rose. Do you recall Dr. Brill visiting you at any time during that stay?

A Yes.

Q How many times do you remember?

A I know he documented he saw me four times. I recall conversations with him twice. I specifically remember a conversation that he had. And I remember this because he came in, and it was probably the first time he saw me. And he came in and he sat down on the corner of my bed where my feet are. And I remember him looking down and just shaking his head saying, I didn't think I did anything. And I don't -- I mean, I don't -- again, up until that point, I still wasn't aware that he knew he did something in surgery.

He still -- that would've been an opportunity for him to come clean with me and to tell me in detail what happened. And he didn't. I didn't know what to say to him, you know. His conversation with me on that particular stay was more of on a go forward. What are we going to do or -- I remember him saying, you have to let your body heal, there's nothing

we can do until your body heals. And then -- and then, you know, we'll talk later about what the next steps are, whether that be continued medication, or a hysterectomy would be my next option. So his conversation with me was more of a proactive go forward conversation.

Q Not about what had happened during the surgery?

A He did not in any way, shape, or form break down to me in detail what happened in surgery at Henderson Hospital. That did not happen.

Q I'd like you to take a look --

MR. BREEDEN: Kristy, if you could put up Exhibit 1 at 103.

BY MR. BREEDEN:

Q Is your monitor on, Kim?

A There's nothing -- it's black. It's -- it looks on. But it does -- oh, there it goes.

Q Okay. We saw this document earlier in this case. And it indicates a conversation between Dr. Brill while your parents or family are present.

MR. BREEDEN: Kristy, can you -- thank you.

BY MR. BREEDEN:

Q Do you recall Dr. Brill ever meeting with your mother Barbara?

A He never met my mother.

Q Do you recall him ever meeting with your stepfather Clyde?

A He never met my stepfather.

Q Okay. Can you recall any conversation that is recorded in --

as recorded in Dr. Brill's record here where he had a conversation with you, and I think it says your parents?

A He -- no. He had a -- I spoke to him. But he's never met my parents. And I know -- I know that there was one instance where I know that he came in and saw -- and saw me, and I remember my parents came in right after him. And I go, oh, you just missed him, you just missed the doctor. And he -- they never had any encounter. They never met him. They never had a conversation with him. It didn't happen.

Q Now, you testified earlier that Dr. Brill told you on your Wednesday surgery that you'll be running a 5k by Sunday.

A He --

Q Where were you actually that Sunday?

A I was in the hospital.

Q Recovering from your surgery?

A Yes.

Q After nine days in the hospital, you were discharged?

A Yes.

Q Where did you go after you were discharged?

A Well, they wouldn't -- they would not discharge me home alone. I live -- you know, I share -- at the time, my son was -- I think he was 13 at the time this -- this happened. And I had shared custody with his dad. So he was -- he was -- Liam was with his dad. I had -- they would not discharge me to go home alone. So I had to be discharged to my parents' home. And I stayed with them for about a week.

Q And what did your parents help you do during that week?

A Well, because of the infection that I had, prior to being discharged, I had to have a pic line inserted in my arm. And what that is is just -- it's a line that goes into, like, your vein, and it goes up through your arm, through your shoulder. And it's a -- it's a wire that basically hangs down by your heart is the way it was explained to me. And then intravenously, I had to give myself a home IV of IV antibiotics for 30 days. You basically -- you know, you have an IV bag. They give you a pole for your home. And you -- well, I learned it's very difficult the situation that -- you know, you've got to let all the air out of the line. I didn't do that the first time. And then -- but I did. I had to do that for 30 days. Liam would help me sometimes hook the medicine up to the -- you know, to that port I guess is what it's called. And it was about for 30 days.

Q Did you have to see a doctor about that pic line?

A I saw -- I continued to see Dr. Lipman, who was the infectious disease doctor. I was unable to drive. I did not have permission to drive. So my stepdad would have to drive me to and from my appointments with -- my follow-up appointments with Dr. Hamilton. I had weekly visits with Dr. Lipman. I had visits with Dr. Raman, follow-up visits. All of which I was not able to take myself. My stepdad drove me to all of them.

Q How soon after you were released from the hospital did you return to work?

A I don't believe I went back for about eight to twelve weeks. Probably about eight to ten, I would say.

Q So when you were released, you originally went to your

mother's house for a week?

A Uh-huh.

Q Is that a yes?

A Yes. I'm sorry.

Q And then you went back to your house?

A Yes.

Q And so during this time, were your activities and what you could do restricted?

A Yes.

Q Okay. Could you drive?

A No. Not at first. Even when I went back to my house, I don't believe I drove -- I don't recall even driving during the time I had the pic line in my arm. I -- my stepdad did -- took me to and from my appointments. So I -- there's -- I just let my body heal, and let my body recover. I stayed home. I rested. I didn't, you know -- that -- at least for 30 days.

Q Were you left with any scars from the surgeries?

A Yes.

Q Tell the jury about where the scar is and how it appears.

A The scar that I have is approximately, I don't know, five inches, and it's from my pubic bone all the way up to my bellybutton. There's some raised portions. I have divots. So I guess where they came -- where they went in with the camera, there's almost, like, little pockets of divots. You know, there's a -- there's an area that might be flat, and then an area that's raised. It's a scar. It's a -- it's a visible scar.

You can see it. It's not naked to the eye by any means.

Q You mean it's not hidden?

A It's not hidden. I'm sorry.

Q And did you follow up with Dr. Hamilton after you were released from the hospital?

A I did.

Q Did you follow up with Dr. Raman after you were released from the hospital?

A I continued care with Dr. Raman for a substantial amount of time. Yes.

Q Now, we haven't spoken much about Dr. Raman. What kind of doctor is he, and what were you seeing him for?

A So he -- I met Dr. Raman, he was the hospitalist at the hospital. So he would routinely come -- he saw me every single day. And when they discharge you, they ask you, do you have a primary care physician that you can continue your care. I didn't. I chose -- because he was familiar with me and what I had been through, I chose to continue my follow-up care with him as my primary.

Q And you've spoken a little bit about this. But I want to make sure that it's clear for the jury. What symptoms or problems do you continue to have that you think are related to what you went through?

A Well, and -- symptoms or problems. I mean, my issues were never fixed. I went in for a surgery for my heavy bleeding and my menstrual cycles and a fibroid removal. I'm still in the same position I was when I went in for surgery. I have painful periods. I have long

periods. You know, I'm not normal, you know, three to four days. I'm more like seven to eight days.

Q What about pain from the -- leftover from the bowel resection surgery?

A I will have once in a blue moon now a painful bowel movement. It's a -- it's almost like a spasm it feels like in the rectum area, you know. Seeing Dr. Raman and the tests we've done, they don't -- they don't -- they didn't find anything. But it's pain that I feel. I've never had that before. And I'm just reminded once -- and I don't know if it's -- you know, I changed my diet. There's certain foods I can't eat that I ate before. I try to stay away from that just to prevent those painful instances, I guess. But every now and then in a blue moon, they'll -- I'll be -- I'll get a reminder. And it's painful.

Q After you were released from the hospital, did you ever go back to see Dr. Brill again?

A No.

Q We talked a little bit there a second ago about physically how you felt. Mentally, what has this done to you, emotionally?

A I mean, I've lost my faith in doctors. I'm scared. I don't -- I know that I need -- my next step is a hysterectomy. And I can't bring myself to go there because of fear that, you know, you think that you're under, you know, the best of hands and the best of care. And that's not what I got with Dr. Brill. I deserved to know what happened to me immediately after surgery. I should have been informed that I had a perforation. Had I been informed --

MS. HALL: Your Honor --

THE WITNESS: -- I could have gone back --

MS. HALL: -- may we approach?

THE WITNESS: -- to the hospital --

THE COURT: Hang on, Ms. Taylor.

[Sidebar at 11:26 a.m., ending at 11:26 a.m., not transcribed]

BY MR. BREEDEN:

Q I'm sorry, Kim. Go ahead and continue.

A I just -- I feel like what happened to me should not have happened. I don't -- I feel that I -- he should have told me. Good, bad, or indifferent, I should have been informed, Kim, we went in for surgery, you have a perforation. I don't know. Look for -- we're sending you home, but look for A, B, C, D. I left that hospital thinking from what he told me, that I was -- that it didn't happen. That nothing happened. That it was too complicated, we'll talk in your post-op.

I deserved to know of any complication. And I -- he didn't tell me. I would have been able to go back to the ER if need be and say, I -- he -- this is what happened, this -- I had a perforation. I could have told that to the ER doctor. I could have said that to him. And it -- and I didn't know. I couldn't tell him because he didn't tell me. That's not okay. That is not okay. And that's not the expectation I had going into surgery. If something goes wrong, my expectation is that the doctor's going to tell me anything that happened. And that's not what happened.

I have zero -- I have zero faith in -- I got the bad end of the stick all the way around. And I just -- I -- it's hard, you know, because I do believe

there's good doctors out there. But I got the short end of the stick all the way around. And it almost cost me my life.

Q It's been four years after this incident. Is it --

A Yes.

Q -- fair to say that emotionally, it still bothers you?

A 100 percent it does. I'm reminded of it every day when I see my scar, you know. It's a constant reminder.

Q Kim, would you like to take a break?

A I just need some tissues. I'm okay. I just -- I'm sorry. It just gets -- it just gets to me. Like, I don't understand.

Q Okay. Just take a moment. Are you okay?

A I'm okay.

Q Okay. As a result of all the medical treatment that you went through, did you receive medical bills for those services?

A I did.

Q Okay. What did you do with those bills?

A Well, I had -- I had insurance. I would -- I mean, I didn't -- I would receive them in the mail. I mean, I looked at them. I have insurance. I provided all my insurance information to all of the providers. They bill for the services that I had. And I paid whatever, you know, responsibility that I had.

Q Do you have to -- well, first of all, what's the name of your health insurance company?

A Aetna.

Q And do you have to pay for that health insurance?

A I do.

Q Okay. Is it through your work?

A Yes.

Q Okay. What is your portion of what you had to pay for the insurance back at that time in 2017?

A Back in 2017, oh my goodness. It's so much higher now. But I think back then I believe I had a 1,500-dollar deductible that had to be -- that had to be met. I had -- I believe it was either a 20 or 30 percent copay. I think it was 20 percent back at that time that I had to pay out of my pocket.

Q And the -- what about the -- you know, your health insurance is through your employer. So does your employer deduct money from your paycheck to help pay for that?

A Yes.

Q And what is that amount, and how frequent?

A Well, I'm paid biweekly, every two weeks. And they would take out 50 dollars a week -- I mean, biweekly. So 100 dollars a month was my insurance premium that I paid. My employer pays much more. But I -- that's my portion.

Q Do you know what your employer pays then, what share of that is?

A I believe they were somewhere around an additional -- I mean, and because of my position, being a VP, I know that my -- they're very good to me. They pay I want to say 600, 700 dollars. Maybe more. It may be more.

Q Is that per month or per year?
A Per month.
Q And your medical bills, your health insurance paid some of those?
A Correct.
Q But there were also uncovered portions of those bills?
A Correct.
Q And how much did you have to pay out of your own pocket towards those bills?
MS. HALL: Objection, Your Honor. Can we approach?
THE COURT: Yes.
[Sidebar at 11:32 a.m., ending at 11:34 a.m. not transcribed]
MR. BREEDEN: Just a moment, Your Honor. I'd like to look through my notes a little bit.
THE COURT: Okay.
MR. BREEDEN: I have no further questions, Your Honor.
THE COURT: Thank you. Before we start cross, I'm going to go ahead and take a bathroom break, and then -- so ladies and gentlemen, let's take a break. And you're instructed not to talk to each other or with anyone else about any subject or issue connected with this trial. You're not to watch or listen to any report or commentary on the trial by any person connected to the case, by any media, 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 dictionaries, using the internet, reference

materials, test any theory of the case, recreate any aspect of the case, or in any other way learn about or investigate the case on your own. 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, or attorney involved in this case. And finally, you're not form or express any opinion on any subject connected to this trial until the matter is finally submitted to you.

And we'll do a quick ten-minute break.

THE MARSHAL: All rise for the jury.

[Jury out at 11:35 a.m.]

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

[Outside the presence the jury]

THE COURT: Thank you. So we're outside the presence of the jury. Ms. Taylor, you're admonished not to speak with anybody about the testimony. You're still under oath. But if you need to take a bathroom break or anything, go ahead.

THE WITNESS: Okay. Thank you.

THE COURT: And you want to go ahead and put on the record?

MR. BREEDEN: Yeah. There are a few things to put on the record.

THE COURT: Okay.

MR. BREEDEN: I would like to make an offer of proof, Your Honor, because there was an objection to the last part of the testimony

that I was going to get into. The --

THE COURT: Wait, Mr. Breeden. Before you go there, can we just start in order from the -- there's, like, four objections I have.

MR. BREEDEN: Sure. Sure.

THE COURT: So there was an objection with regard to when Dr. Brill would have first known about the perforation because it was in the operative report. And Defense, you want to go with your objection on that?

MS. HALL: Yes. It was just that I thought it called for speculation because there had been no establishment that what she was testifying to was in her personal knowledge.

THE COURT: And anything further on that, Mr. Breeden?

MR. BREEDEN: No. I simply tried to rephrase it, you know, to her knowledge.

THE COURT: Okay. And I sustained the objection more so because of the way she was answering, not necessarily because of the question.

And the second objection was with regard to when you were going to refresh recollection, I believe the question was about her being able to dress herself in the hospital. She answered that she never did; she stayed in her gown the whole time. And the objection was?

MS. HALL: That there was nothing to refresh. She had testified to what she recalled. She never said I don't recall.

THE COURT: Any response, Mr. Breeden?

MR. BREEDEN: I have nothing further on that point, Your

Honor.

THE COURT: All right. And that was also sustained because she answered the question. She didn't establish that she did not have a recollection of what was happening.

And then the next objection was -- I cannot read my own notes on this next objection. Does anybody know what the third objection was?

MR. BREEDEN: I'm sorry, Your Honor. I do not. I do not have that recorded. I would guess it was probably a minor --

MS. HALL: I think that was the one where I objected that I thought she was offering expert opinion.

THE COURT: Oh, yeah. What she felt she should have known at the time. I overruled the objection. Any further argument on that?

MS. HALL: No, and I agree that once she continued, it didn't go where I anticipated it was going.

THE COURT: Okay. And then, I overruled it and said I think she was just trying to establish what she felt she should have known at the time of her surgery, and so it was okay.

All right. And then finally, the last objection was with regard to her testifying about how much she paid for her -- paid out herself with regard to the medical bills. The objection was, Ms. Hall?

MS. HALL: That we had had no establishment or foundation that it was -- the bills or the payments were reasonable, necessary, and customary. And that's an expert opinion. Expert testimony is needed for

that, and it can't be elicited from a lay witness.

THE COURT: And then, Mr. Breeden?

MR. BREEDEN: Yes, Your Honor. So as you know, we've had numerous discussions during this trial as to the bills, the amount of the bills, what information is admissible or inadmissible, and what sort of foundation needs to be laid for the usual, reasonable -- or I'm sorry, usual, customary, and reasonable nature of the bills. We discussed at a sidebar what I intended to have the client testify to and it was agreed that I would simply make a verbal offer of proof as to what her testimony would have been.

So had we been allowed to continue, Ms. Taylor would have testified that she paid from her own pocket over -- in small payments, monthly payments she arranged over a series of years, a total of $6,337.19. I do think that's very relevant because under the law, a bill presented and paid is presumed to be reasonable in amount. She would have testified that she received treatment from Dr. Lipman and that Dr. Lipman's office provided her with a bill in the amount of at least $16,785.12. She would have testified that the City of Henderson provided her with a bill for ambulance services in the amount of $2,330.56.

She would have testified that she received extensive treatment, including the failed procedures at Henderson Hospital and Henderson Hospital paid -- billed her the amount of $39,422. She would have testified she received treatment and a bill from Dr. Frankel, and that Dr. Frankel's charges were $1,233. She would have testified she received

laboratory treatment from Quest Diagnostics and that the bill she received from that company was $1,135.49. She would have testified she received radiology services from Radiology Associates of Nevada, and she received a bill from that company for $558.

She would have testified that she saw a Dr. Syed Rahman, and that she continued to see him both in and out of the hospital at St. Rose, and she was presented with a bill from him for $2,535. She would have testified that she received a treatment, including a nine-day hospitalization at St. Rose Dominican Hospital Siena campus, that she received a bill from St. Rose in the amount of $144,994.12. She would have testified that she received treatment from anesthesiologist Dr. Szu Yeh, and that she received a bill from Dr. Yeh in the amount of $1,162.

The witness would have continued that she has extensive history and knowledge of medical billing in the community, that she has been in the medical hospital and medical services billing for both doctors and other providers, such as hospitals, for 27 years, that she has lived and worked in Las Vegas for most of those years in that industry. She has seen thousands of bills and medical charges from hospitals and different medical providers, and that in her experience, the bills that were presented to her, the charges, were usual, customary, and reasonable.

THE COURT: On behalf of Defense?

MS. HALL: Very quickly, Your Honor. Bills received are not bills paid. So again, there's been no foundation of that. No expert has testified in this case, and Ms. Taylor -- to be very clear, Ms. Taylor was

not designated as an expert in this case. Had she been, I certainly would have taken her deposition in that capacity. But there's been no expert testimony as to the reasonableness, necessity, and whether the bills and amounts paid were customary. Further, there's been no expert testimony that any of that care was related to the alleged negligence.

THE COURT: All right. And I sustained it. Anything further before we take our three- to five-minute bathroom break?

MR. BREEDEN: Nothing further.

MR. MCBRIDE: Nothing further.

THE COURT: All right. Thank you.

[Recess taken from 11:43 a.m. to 11:51 a.m.]

[Outside the presence of the jury]

THE CLERK: Now back on the record.

THE COURT: Thank you. We're back on the record in case number A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. I just wanted to know for scheduling purposes if you think your cross is going to be longer than an hour, or?

MS. HALL: I hope not. And I -- that's my plan is to finish in an hour or less.

THE COURT: Well, I was going to say we can do 1:00, 1:15 because now that we took a little break --

MS. HALL: Oh, we can? Okay.

THE COURT: So I just -- I was just seeing if -- I didn't want to cut you off and you only have three questions left. So I guess before I

decide to take a lunch break, I'll ask you.

MS. HALL: Okay. Well, that would be great. And hopefully, I'll be efficient.

MR. BREEDEN: Let's cut her off at 15 minutes.

THE COURT: Are they ready?

THE MARSHAL: Yes, Your Honor.

THE COURT: All right. We're ready.

THE MARSHAL: All rise for the jury.

[Jury in at 11:52 a.m.]

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

THE COURT: Thank you. You may be seated. And Ms. Taylor, you understand you're still under oath?

THE WITNESS: I do.

THE COURT: Thank you. And cross-examination.

MS. HALL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. HALL:

Q Good almost afternoon, Ms. Taylor.

A Thank you.

Q I want to -- first and foremost, you and I first met in April of 2019, correct?

A That sounds right.

Q Do you remember me taking your deposition in this case?

A I do.

Q And do you remember me telling you at your deposition that

it was important for you to tell me all the information and give me your best testimony that day?

A I recall, I guess. Yes.

Q And in fact, when -- and I want to make sure that I understood what you testified here to today. With respect to the second phone call that you placed to 911 and the second time you were taken to St. Rose, is it your testimony that it was your stepdad who called 911 that second time?

A I believe it was, yes.

Q Okay. In fact, when I took your deposition, you told me that it was you who made both of those phone calls.

A Okay.

Q Do you remember that?

A I do not.

MS. HALL: Okay. Let me -- could I get the deposition, please, of Ms. Taylor?

BY MS. HALL:

Q I understand that your deposition was a while ago, so I'll show you that testimony.

A Okay.

MS. HALL: Thank you. May I approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q And Ms. Taylor, I'm going to first show you page 56, so --

THE WITNESS: Okay. I'm sorry, Judge, may I step down to

get my readers? My glasses?

THE COURT: Sure.

MS. HALL: Would you like me to grab those for you?

THE WITNESS: Yeah. They're in my purse on the --

MS. HALL: Do you know where they are, Ms. Johnson?

MS. JOHNSON: What is it? I'm sorry.

MS. HALL: Her glasses.

THE WITNESS: I need my glasses.

MS. ALBERTSON: Her readers.

MS. JOHNSON: Actually, I don't want to dig through her purse.

MS. HALL: Sure. May I approach, Your Honor?

THE COURT: Yes.

MS. HALL: And I am going to read it aloud, but --

THE WITNESS: Okay.

MS. HALL: -- I appreciate that you'd like to follow along.

THE WITNESS: Okay.

MS. HALL: So let me just get something to mark this for you. If you're ready, just let me know.

THE WITNESS: Okay.

BY MS. HALL:

Q So I'm going to start, Ms. Taylor, at page 56 of your deposition.

A Okay.

Q And I will represent to you that we had already discussed the

first phone call before this questioning.

A Okay.

Q And I'm at line 4 on page 56.

A Okay.

Q "Q From 4:00 a.m. or whatever time it was when you arrived home until 11:00 a.m., was anyone else with you?

"A Elizabeth.

"Q And who called 911 that morning?

"A I did."

A Okay.

Q Do you see that testimony?

A Yes.

Q "Q And what's the reason that you called 911?

"A Pain. Severe pain."

A Yes.

Q Does that refresh your recollection that it was you who called 911 the second time?

A I mean, if I said I did at that time. I know that they were all with me. So I -- one of us did, you know? I don't recall the second time, it was me. I remember being in so much pain that I remember sitting on the couch profusely in pain. So you know, I apologize if I told you it was me. I may have misspoken.

Q So my question, Ms. Taylor, was just me reading you that testimony and you following along, does that refresh your recollection that at the deposition that you gave in this case on April the 3rd, 2019,

you told me that it was you who placed that second phone call?

A If that's what I told you, that's what I told you.

Q Well, you read it with me, right?

A Correct.

Q And I want to show you -- this has been previously admitted as Exhibit 15. And when the EMTs came to your home that second time, you do remember having a conversation with the EMTs?

A Yes.

Q And if you look -- you can look on the screen or if you'd like the paper, I'm happy to get that out for you, so just let me know. Also, Ms. Taylor, I know earlier, when I, like, shouted out -- it's hard to hear me in this mask. If you have any difficulty hearing me, please let me know, okay?

A Okay.

Q Now, this is Exhibit 15, and I'm showing you -- is that page ten? I'm showing you COHA10. And if you see the box in the right-hand corner, it's got call received, dispatched, it tells the time that the EMTs were on their way to your home, tells the time that they were at your home, and that's where -- do you see on scene?

A Yes.

Q And what time is reflected for when they were on the scene?

A 11:58:07.

Q It also shows you how long they spent at your house. And how many minutes do they say they were on scene?

A Eleven minutes.

Q And if you go down the middle of this page, the patient information, I want to show you what they documented, the EMT documented. For patient information, is that -- it has your name, correct? See in the middle of that page, patient information, name, Kimberly Taylor?

A I do not. Treated. Okay.

Q Do you see that? That's you, right?

A Yes. It doesn't give my date of birth, but that's my name.

Q It does give your gender, female, correct?

A Correct.

Q It gives your age, 45. Is that accurate at the time?

A At the time, yes.

Q And you -- again, you do remember actually speaking with the EMTs once they were at your home that day. Is that a true statement?

A I mean, I remember looking up to the -- you're talking about the second time. I remember looking up to him. I couldn't answer any questions to him. It was mainly Elizabeth that was speaking. And I --

Q So Ms. Taylor, I don't mean to cut you off, but my question was simply do you remember speaking to the EMTs the second time that they were at your home that day?

A I -- no. It -- well, I was in a severe -- a severe amount of pain.

Q Okay. Let me show you COHA12, same exhibit. It's Exhibit 15. And when the EMTs come out, you're aware that they document information that they receive once they're there?

A Okay.
Q Are you aware of that?
A Well, I am now.
Q All right. Let me show you the narrative portion of this visit to your house. And you see where it says R95 was dispatched to a patient with abdominal pain. That's true, right? You had abdominal pain the second time that they came to your home?
A Yes.
Q And then it says, patient stated that yesterday morning at 800 she was scheduled to have a surgery on her uterus. That's true. That statement's true, correct?
A I was scheduled, yes.
Q And states them entering in, they found fibroids and were unable to perform the ablation on her uterus.
A Okay.
Q So when the EMTs came to your home the second time, you were aware that some portion of Dr. Brill's surgery had been performed?
A I was led to believe that the surgery did not happen. That it was too complicated and that he was not able to do it.
Q You don't remember telling the EMT at the second time that they were at your home, that it was the ablation portion of the --
A Surgery --
Q -- you got to let me finish. It was the ablation portion of the surgery that could not be completed.
A I had paperwork from what they gave me when I was

leaving. I remember giving them the paperwork. Here, this is what they -- what I went in for. I wanted them to see what I went in for. It's not what happened.

Q Okay. You would agree that this record says states, meaning patient states? It doesn't say --

A I can't answer to how they tran -- they tran -- they interpret my conversation with them. If that's what they documented, they documented.

Q Okay. Let's go on down to the same -- the narrative portion where it says, she was attempting to eat. And so we're in the same record. It's COHA12, Exhibit 15. And I want to show you a little more of this narrative that the ENT documented that morning.

MS. HALL: And sorry go up about three more lines.

BY MS. HALL:

Q Okay. And do you remember telling the EMT that day that you had been seen at Sienna ED, or emergency department and nothing was found?

A I do.

Q And did you also tell the EMT that you had been home and attempting to eat chicken broth, and took some pain medication, and that's when your stomach began hurting again?

A Attempted. Attempted. I couldn't eat.

Q Right. My question was attempted.

A Right.

Q So you did tell the EMT that?

A If it's in there, I guess I did.

Q Well, you do see it there? Do you?

A Yes.

Q And did you also tell the EMT --

MS. HALL: If you go down to the bottom of this record, Mr. McBride.

BY MS. HALL:

Q When you spoke to the EMTs the second time that they were at your home, did you tell them -- you see where it's documented, surgery for ablation on uterus stopped because they found fibroid removal and D&C. Shape, it says F, shape of uterus caused complications. Did you also tell the EMT's that when you spoke with them the second time?

A I did not. I cannot tell you how they interpreted my conversation and how they documented my conversation with them. I can't explain that. I was in pain.

Q And -- you also then have no explanation for where else they would have gotten this information?

A I gave them the discharge paperwork that I had received. And it was Elizabeth that was speaking with them. So, you know, they weren't even clear with what happened. None of us were clear with what happened.

Q And you would agree -- and I'm happy to let you read the rest of this record, that nowhere in this note is there any mention of Elizabeth or a friend. It only refers to patient.

A Okay.
Q Do you disagree with that?
A I -- that's what they say. I mean, I'm the patient.
Q And -- yes, that's absolutely correct. You're the patient, right?
A Correct.
Q And this conversation that you testified to earlier, the conversation that Dr. Brill had with you in the recovery area at Henderson Hospital.
A Correct.
Q You said that that conversation lasted one to two minutes.
A It was very short.
Q You said yesterday it lasted one to two minutes.
A Okay.
Q Do you remember that?
A Yes.
Q And you said Dr. Brill told you that it was too complicated -- it was simply too complicated, and he would speak to you at your post-op visit?
A That is correct.
Q And it's your testimony that took one to two minutes for Dr. Brill to say that?
A One to two minutes is short. It was a very, very short visit that he had with me.
Q So --

A He didn't stay in there long, no.

Q Yeah, it's just a -- it's just a yes or a no. Your testimony is that it took one to two minutes for Dr. Brill to say that brief statement, and then he left?

A Yes.

Q And in fact when you saw Dr. Brill in the recovery area, you would agree that you were not in excruciating pain at that time?

A I don't agree. I don't --

Q Do you remember being asked at your deposition about being -- whether you were in pain at the time that Dr. Brill saw you in recovery?

A I do not.

Q Okay.

MS. HALL: May I approach, Your Honor?

THE COURT: Yes.

MS. HALL: I'm going to show you that deposition testimony.

THE WITNESS: Okay.

MS. HALL: And so let me move this for you. We're going to be referring to page 44 of your deposition. Let me get you there.

BY MS. HALL:

Q Okay. Just letting you know, I'm going to start, Ms. Taylor, at page 44 of your deposition. And I am going to start with line -- actually let's start with line 17. Page 44, line 17. Do you have that in front of you?

A Yes.

Q And I asked you at your deposition,

"Q And what about Dr. Brill? Did you ever explain any of that to Dr. Brill when he saw you in the morning?"

And your answer was,

"A I never got an opportunity to."

And then I asked you,

"Q That pain that you described, do you know if that is what you were experiencing at the time when Dr. Brill came in to see you?"

And what was your answer?

A "No, I don't believe so. But let me -- you're referring to when I was seeing the -- right above that it's regarding the abdominal pain that I was experiencing when I attempted to go to the bathroom."

Q Okay, I'll let your --

A And --

Q -- Ms. Taylor, I'll let you -- if you think I'm not giving you all the information, your counsel can certainly clear that up. But let's go onto the next page of your deposition. And this is page 45 of your deposition at line 2. I asked you,

"Q And this that you have described for me, the pain where you felt like it might have been a rectal, and then you said it felt like was squeezing your insides."

"A Yeah.

"Q That was something that happened later while you were trying to go to the restroom?

And you said:

"A Correct. Right prior to my discharge."

You also told me that -- that was your testimony?

A Correct.

Q Okay. You also told me that you -- and I just read it to you at page 44, you never told Dr. Brill -- when he saw you in the recovery, you never spoke with him about any pain complaints, true?

A I saw Dr. Brill immediately after my surgery. You're referencing pain and when I was being discharged from the hospital. They're two different occasions.

Q I understand. So when you saw Dr. Brill, and it was shortly after your surgery, you did not speak to Dr. Brill about any pain complaints, true?

A I didn't get an opportunity to.

Q Were you -- okay.

A He came in just to brief -- give me an update on, you know, what happened, or what didn't happen.

Q Okay. And so --

A He didn't ask me.

Q That's not my question. My question is, when you spoke with Dr. Brill in recovery, you would agree that you did not discuss any pain complaints with Dr. Brill?

A No.

Q That is a true statement?

A Correct.

Q And in fact, during the seven and a half hours that you were

in recovery at Henderson Hospital, you would agree that you did not ask to see Dr. Brill?

A I did not.

Q And you never -- well, actually let's talk just a little bit about once you left Henderson Hospital. Once you were home after leaving Henderson Hospital, you said it was about 11:00 p.m., before you began getting that real bad abdominal pain?

A Approximately, yes.

Q And you did understand that --

A Well, what -- I'm sorry. You're talking about the first or second?

Q I'm talking about the first time that you called 911.

A Okay, correct.

Q It would have been about 11:00 you said --

A Yes.

Q -- when you got the pain?

A That is correct.

Q And that's what prompted you to call 911 the first time?

A Correct.

Q At that time, you knew that Dr. Brill's office was closed for the day, true?

A I mean he gave me a phone number to call. I was -- I just assumed that that's the number to get ahold of him.

Q Right. And my question is simply whether you knew at 11:00 at night or so that the Office of Women's Health Associates of

Southern Nevada was closed for the day?

A I wasn't aware, no.

Q You didn't know that?

A No, I -- that's the number he gave me and that's the number I called.

Q And you called -- you told us that that was his answering service, correct?

A I got a recording.

Q And well, you were -- were you on hold --

A I don't recall. You know, I was in so much pain, I was scared. I hung up. I didn't want to wait. I didn't want to -- I hung up, and I called 911.

Q And that's all I'm getting at. Is that when you called the answering service, you did not leave a message, true?

A No, I did not.

Q You did understand, though, that -- once you left Henderson Hospital, you did understand that you should call -- or you should return to the hospital or call 911 if you had pain that wasn't relieved by medication?

A And I did.

Q You understood that?

A Yes.

Q I want to show you -- well, first of all, when you left Henderson Hospital, did you receive discharge instructions?

A They gave me paperwork, yes.

MR. BREEDEN: Your Honor, I renew my objection.

THE COURT: Thank you. Overruled.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q And I'll show you those -- I guess before they come on the screen.

MS. HALL: May I approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q I want to show you, this has been admitted. It's Exhibit 5. And my question is just look at that and tell me if those are the discharge instructions or paperwork that you received at Henderson Hospital?

A Yes, this looks familiar.

Q And in fact, do you remember me asking you at your deposition about these discharge instructions?

A Yes.

Q I want to show you, this is Exhibit 5. And I want to show you HH13. When you got these discharge instructions, did the nurse go over them with you?

A I assume she did, or he did.

Q Okay. And you -- one of the instructions you were given, you were told to follow up with your doctor in one to two weeks as scheduled. And did you -- in fact, when you left Henderson Hospital that day, did you already have a post-op visit scheduled with Dr. Brill?

A I did.

Q You were also told to continue your home medications, true?
A True.
Q And that if you had any fever that was greater than 101, or pain that was unrelieved by medications, nausea, vomiting, that you should return to the hospital?
A True.
Q And you were also told -- I want to show you Exhibit 3 -- excuse me, Exhibit 5, HH15. Before -- now these discharge instructions, did you receive these after the surgery that you had with Dr. Brill?
A Like immediately after? I don't recall. I think they were given to me upon discharge.
Q And that was -- that was the way I asked my question. I'm sorry to be confusing. You did -- you got these discharge instructions sometime after the surgery with Dr. Brill?
A Correct.
Q Okay. Before you have the surgery with Dr. Brill, were you aware that one of the potential risk or complications of the surgery was infection?
A No.
MR. BREEDEN: Your Honor, I just want to renew my objection to this line of questioning.
THE COURT: Thank you.
MS. HALL: May I continue, Your Honor?
THE COURT: Yes.
BY MS. HALL:

Q Were you also aware -- before your surgery with Dr. Brill, were you also aware that bleeding was a potential risk and complication?

A Yes.

Q And I apologize because you told me you were not aware that infection was a --

A Infection wasn't brought up. I mean, when I met with Dr. Brill at my -- at his appointment I --

Q And we'll get there in just a moment. I don't mean to cut you off, but I want to focus for now only on what risks and complications you were aware of before your surgery.

A Okay.

Q So you were not, you said aware of infection as a possible risk and complication?

A I don't recall.

Q And that's a good point. Are you saying you weren't aware, or simply that you don't know one way or another?

A I don't recall infection being one, no.

Q And so are you saying no one advised you that infection was a potential risk, or it's simply that you don't recall one way or another?

A I know there's risks of surgery. I know there are.

Q And in fact --

A And you go in, you know that anything could happen. Absolutely. Everybody does. You know that there's a potential that something could happen, yes. I don't know where you're going with this.

Q Sure. You had surgery before April the 26th, 2017, correct?
A I did.
Q And you understood that every surgery carries the risk of -- a potential risk and complication of infection?
A Every surgery, no.
Q Okay.
A I mean I don't -- you know, you don't go under thinking that, no.
Q All right. Well, you did know, though, before Dr. Brill's surgery, that bleeding was a potential risk and complication?
A I knew -- yes, under what I was going in for, yes.
Q Did you also -- were you also aware that perforation of the uterus or the uterine wall, that that was also a potential risk and complication of that surgery?
A Yes.
Q And also a potential risk and complication prior to Dr. Brill's surgery that you were aware of, included damage to other organs?
A It's a risk, but a minimal risk is what I was told.
Q And in terms of the anesthesia that you received at Henderson Hospital; you don't have any complaints about anything to do with your anesthesia; is that true?
A Correct.
Q Now I want to talk to you about some of the visits that you had at Dr. Brill's office.
A Okay.

Q The -- I think when your attorney was questioning you yesterday, you testified that you agree that your first visit with Dr. Brill would have been sometime in November of 2015; is that correct?

A That sounds about right.

Q And the surgery that you had, that was on April the 26th, 2017; correct?

A That is correct.

Q You would agree that you do not have any complaints about any of the care that you had from Dr. Brill from that first visit until your April 26 surgery?

MR. BREEDEN: Object, Your Honor.

THE COURT: Counsel approach.

[Sidebar at 12:18 p.m., ending at 12:18 p.m., not transcribed]

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q I want to show you, let's --just to get it up, in March of 2017, do you remember having an endometrial biopsy at Dr. Brill's office?

A I do.

Q And what was your understanding of why you were having that endometrial biopsy?

A It was my understanding it was the cancer screening.

Q And you also understood that the endometrial biopsy, that that was a necessary step before you could have the D&C and ablation and the fibroid removal?

A That was my understanding.

Q In fact, you had spoken to Dr. Brill about that procedure, meaning the D&C, the uterine -- the fibroid removal, and the ablation, you had spoken to him about that procedure before you had the endometrial biopsy, true?

A I did.

Q And after you had that endometrial biopsy, did you also have a procedure at Dr. Brill's office on March the 9th, called a colposcopy?

A I did.

Q And was it your understanding that the colposcopy was to look at your cervix?

A I did.

Q And you knew that that was also a step that was needed before you could have the D&C, the ablation, and the removal of the fibroid?

A That's correct.

THE COURT: Excuse me.

MS. HALL: Bless you.

THE COURT: Sorry. Thank you.

BY MS. HALL:

Q I want to show you, this is a previously admitted Exhibit 3.

MR. BREEDEN: Page?

MS. HALL: And it's going to be page 7, 107. Oh, excuse me, 4010.

BY MS. HALL:

Q After, Ms. Taylor, after you had the colposcopy, did you also

have, do you remember having a pelvic ultrasound at an outside radiology place?

A I believe I did.

Q And then did you return to Dr. Brill's office?

A Immediately after? Is that what you're asking?

Q No, I'm sorry. The records reflect that you returned to Dr. Brill's office on April the 4th.

A Okay.

Q And you have any reason to disagree with that?

A No.

Q At that April 4th visit, did Dr. Brill discuss with you the results of the endometrial biopsy a colposcopy?

A Yes.

Q And did he also discuss with you the pelvic ultrasound that you had had?

A I believe so, yes.

Q And do you agree that he counseled you on your options, and talked to you about the recommended ablation procedure and D&C?

A Yes.

Q And did he also go over with you the pros and the cons and the risks and benefits of that surgery?

MR. BREEDEN: Objection, Your Honor.

THE COURT: Noted. Go ahead. Do you need to repeat it, Ms. Taylor?

THE WITNESS: Yes, please.

BY MS. HALL:

Q At that April 4th visit, did Dr. Brill also go over with you the pros, the cons, the potential risks and benefits of that surgery?

A If you're talking about my pre-op visit with him, I remember it being a very -- almost like a formality , just a brief visit, this is what you're going in for. It was a very simple procedure. He related to me it's very simple, you're going to be in and out, you know, it's a -- it almost sounded like it was routine.

Q So we're not there yet, we're not at your pre-op visit, we're just -- and we'll get there in just a moment.

A Okay.

Q Right now I'd like to focus you on the April 4th visit.

A Okay. I thought that's what we were speaking of, I'm sorry.

Q That's okay.

A So I don't recall, no, in detail, him going over anything like that with me.

Q You don't recall Dr. Brill discussing with you that the information that was available to the clinicians in terms of the success rate?

A He did not, no.

Q Let me -- I'm sorry. I wasn't finished.

A Oh, I'm sorry.

Q That's okay. It's hard to tell with these masks on. I understand. The April 4th visit that you had, do you recall Dr. Brill discussing with you that the information on the success rate and

potentially stopping this uterine bleeding that you were having was based on a normal uterus, and yours was not a normal uterus?

A I do not recall that conversation, no.

Q Okay. And are you-- you're not saying it didn't happen, you're just saying you don't recall?

A I don't recall a conversation like that happening, no.

Q Okay. Let me show you -- I will now show you the -- well, after this April 4th visit, did you make the decision to schedule the surgery?

A The timeline of when I did what, I don't recall. I mean, obviously, I did, I made that decision, and I know there was a pre-op appointment that I went in and met with him. I don't recall exactly the dates and a timeline of those events in my mind, no.

Q Sure. And that's fair enough. I'll show you that record. It's Exhibit 3.

MR. BREEDEN: Page?

MS. HALL: And it's pages -- let's start with BRILL5. If my -- if my iPad cooperates.

MR. BREEDEN: Okay.

BY MS. HALL:

Q Okay. Now at this visit that you had with Dr. Brill on April the 21st, his records reflect that this was your preop visit. You do recall having a preop visit with Dr. Brill?

A Yes.

Q And his notes also reflect that your surgery had already been

scheduled for April the 26th.

A Okay.

Q Does that in any way -- does that sound accurate to you?

A Yes.

Q Any reason to disagree with that?

A No.

Q Now at this visit that you had with Dr. Brill on April the 21st, I want to show you his plan. Can we go down to BRILL7, please? Now when you saw Dr. Brill from your preop visit, you would agree that he discussed with you the indications for the procedure?

A Discussed with me the indications; what do you mean?

Q The reason why --

A Oh, the reason I was going in? Yeah.

Q The reason why he recommended the surgery.

A Well, I went in with the understanding that the reason why I was going for surgery to eliminate the bleeding, the heavy bleeding, and to remove a fibroid.

Q Right. And that was discussed with you at this April 21st preop visit.

A Yeah.

Q True?

A Yeah.

Q And Dr. Brill also discussed with you your options of therapy and the potential risks and complications of that surgery, true?

MR. BREEDEN: Object, Your Honor.

THE COURT: Noted for the record. Overruled.

MS. HALL: Thank you, Your Honor.

THE WITNESS: Sure.

BY MS. HALL:

Q Well, you would agree that that was discussed?

A Yes.

Q And you were aware of all of that prior to making your decision to have the surgery on April the 26th?

A Yes.

Q And in terms of the surgery itself, Dr. Brill never made you any guarantees that if you had the ablation that it would, in fact, eliminate the heavy bleeding that you were experiencing?

A No. there were no guarantees. I knew that.

Q Were you also -- you were also aware prior to having the surgery that you might, if you experience a perforation, you might require a second surgery to appropriately treat it?

A Okay. Yes.

Q You were aware of that?

A Yes.

Q And you were aware of that prior to the surgery?

A Yes.

Q Now I want to ask you just a little bit about -- your testimony today was that you remember Dr. Brill seeing you on two occasions at St. Rose Hospital; is that correct?

A He documented he saw me four, but I recall, you know, I

recall specifically two conversations with him. I recall, you know, yes.

Q So -- and I'm not --

A I mean, it could have been together in one, but I recall two, two instances in my memory that, you know, come to light in my mind, yes.

Q Okay. So today you recall two occasions where Dr. Brill saw you?

A Correct.

Q Do you remember at your deposition you only remembered Dr. Brill seeing you on one occasion, at St. Rose?

A If that's what I said, yes.

Q Well, and I'm happy to show it to you if you don't recall.

A That's what I said and it's documented, yes.

Q Sure. Let me -- let me show you that deposition testimony.

MS. HALL: May I approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q I'm going to show you page 65 of your deposition.

A I'm not arguing with you. I'm saying yes.

Q Okay. If you -- I thought you said you didn't recall.

A Okay.

Q And I was just going to show it to you.

A Okay.

Q If you -- if you agree that that's what you said --

A I mean, it says what I said in my deposition. That's what I

said. I don't -- I don't -- in my mind, you know, I remember specifically in detail him sitting on the corner of my bed.

Q So all I was getting at is that at the time of your deposition, when your deposition was taken in 2019, you told me that you had only seen one entry in the St. Rose Hospital records from Dr. Brill; do you remember telling me that?

A I recall that, yes.

Q And now, today, have you now seen the four different entries that Dr. Brill made in your St. Rose Hospital chart?

A I have, yes.

Q Okay. I want to show you, and I'll show you those in just a moment, but you disagree that Dr. Brill saw you on four occasions at St. Rose?

A Do I disagree?

Q Right.

A I mean, he documented that he -- that he was there. I mean, I only recall conversations with him, that's my memory. I'm not disagreeing with you. If he says he was there, he was there. I don't -- in my mind, I can only -- I only remember what I remember.

Q Okay. Fair enough. And in a moment, I'll ask you some specific questions about those visits that Dr. Brill documents in the contemporaneous St. Rose records.

A Okay.

Q But before we get there, with respect to the first time that you called 911, you did know at that time that the portion of the surgery

for your uterine septum, that that portion of the surgery had been performed by Dr. Brill?

A I mean, I didn't -- the first time I called the ER? I was told is that -- the only thing I was told by Dr. Brill was the surgery was too complicated and that he would talk to me at my post-op.

Q Okay. Let me show you, the first time you called 911, it was you who called 911 that first time, right?

A Correct.

Q And you -- no one else was with you at the time that the EMT's arrived to your home?

A Correct.

Q That first time?

A Correct.

Q I want to show you, this is previously admitted Exhibit 15, and it's COH3.

MS. HALL: And I'm sorry, Robert, can -- or Mr. McBride, may I please go down to COHA5?

BY MS. HALL:

Q And I'm happy if you need me to, Ms. Taylor, I can show you the beginning of this note, but I'll represent to you this is the narrative portion of the EMT -- the EMT's record for the first time that they came to your home that evening, and the EMT documents that upon arrival, the patient is awake and alert and complaining of severe abdominal pain, post-vaginal fibroid removal and uterine septum and D&C.

A Okay.

Q Do you agree that you told the EMT's that you had had a fibroid removal, uterine septum, and D&C?

A I don't recall giving them a detailed explanation. I gave them my paperwork that I received from discharge. This is --

Q Meaning the discharge instructions?

A Correct.

Q Okay.

A That these are the three procedures I had. If they interpreted that to this, then that's what they did.

Q Sure. And you would agree, though, they don't say they got this information from any of the documentation, they say that this is something that the patient stated?

A Correct.

Q And you were the patient?

A Correct.

Q Now you disagree with --

MS. HALL: You may take that down, Mr. McBride. Thank you.

BY MS. HALL:

Q You disagree with Dr. Hamilton's testimony on Wednesday that it was -- that when she first saw you, prior to doing any surgery for you, that you told her you had had a uterine perforation? You disagree with that testimony?

A I do.

Q And what about Dr. Frankel, the emergency room physician

who you saw the second time in the St. Rose emergency department? Do you agree that Dr. Frankel discussed with you that you'd had a uterine perforation?

A When I spoke with Dr. Frankel, he, my conversation with him was that I -- we didn't -- he didn't know.

Q So --

A That's what he relayed to me.

Q So you do not believe Dr. Frankel relayed that you'd had a uterine perforation?

A He did not tell me I had a uterine perforation. No, he did not.

Q You did know that though, before you had the surgery with Dr. Hamilton?

A No.

Q Okay. You remember, you told us you do remember being seen by Dr. Schoenhaus?

A Correct.

Q And that was before the surgery that you had with Dr. Hamilton?

A Correct.

Q And you understood Dr. Schoenhaus was a partner of Dr. Brill's at Women's Health Associates?

A Correct.

Q I want to show you -- and do you remember any of your discussion with Dr. Schoenhaus?

A I don't recall. I don't, no.

Q Do you have any recollection of Dr. Schoenhaus explaining to you that she wanted to wait to start you on antibiotics after she had performed a physical examination of you?

A I read that in my medical record chart, yes.

Q Do you have any reason to disagree that that's accurate?

A Correct.

Q You --

A No, I don't.

Q You don't. Okay. Dr. Schoenhaus, when she saw you, the records reflect that it was about 6 p.m. on April the 27th; any reason to disagree that that's the time you were first seen by Dr. Schoenhaus?

A I don't recall. I don't --

Q Don't remember one way or the other?

A Huh-uh.

Q Dr. Schoenhaus, though, she did discuss with you that you'd had an incidental uterine perforation?

A Okay.

Q Do you remember that?

A I do not.

Q Do you -- do you dispute that Dr. Schoenhaus discussed that with you?

A I do not -- I do not recall her telling me I had a uterine perforation, no. I went up to surgery not knowing what was going to -- or what -- when I went up to see Dr. Hamilton, they were going up to explore, to see, to look. I did not have a confirmed perforation, no, I

don't -- I don't recall that.

Q And I'm just going to show you, this is previously admitted Exhibit 1, and it's page SRDH18 for the record.

A Okay.

Q And I'll represent to you, and I'm happy, if you look in the top, you can still kind of see it, but this is -- I will represent to you that this is Dr. Schoenhaus' history and physical that she took on April the 27th, 2017, around 6 p.m. in the evening.

A Okay.

Q And Dr. Schoenhaus documents that during the surgery, an incidental uterine perforation was noted, and the procedure was then aborted.

A Okay.

Q Did Dr. Schoenhaus discuss with you that there was a uterine perforation noted?

A No. I'm assuming she got that from Dr. Brill's operative report.

Q Well, I'm not -- I'm not asking you to assume. I'm only asking you if Dr. Schoenhaus discussed that with you?

A I -- no, I don't believe she did.

Q Did Dr. Schoenhaus, and at page 23, Elizabeth's -- I'm going to show you the last page of this initial history and physical, and it's, for the record, SRDH23, same exhibit. And in Dr. Schoenhaus' plan, she documents that, "While the patient did have a uterine perforation during surgery, and some free fluid and free air may be expected, I want to

observe the patient to make sure there is no other injury. Patient will be admitted, IV antibiotics started."

Did Dr. Schoenhaus explain to you that she wanted to observe you to see if there was any other injury?

A I don't recall that it's Dr. Schoenhaus that said that. I remember Dr. Frankel giving me the option that I was going to be -- it was -- it was up to me. I can either stay for observation or I can go up for exploratory surgery. I believe that was Dr. Frankel that went over that with me.

Q Dr. Frankel, the --

A Correct. The ER doctor.

Q And did Dr. Frankel explain to you why he wanted to observe you?

A I -- no, I don't recall that.

Q Now, the first time that Dr. Brill saw you at St. Rose Hospital, do you remember what day that was?

A I do not.

MS. HALL: All right. Let me show you that record. May I get Joint Exhibit 1? And SRDH208.

BY MS. HALL:

Q Now, in terms of the -- I understand you don't remember the day and this record reflects that the first time that Dr. Brill saw you at St. Rose was on April the 28th, 2017. Would that have been one day after, or a few hours, in fact. Does -- well, let me start -- sorry. Let me back up. The surgery that you had with Dr. Hamilton, she testified that it had

occurred late on the 27th of April. Is that your understanding as well?

A Yes.

Q And the note from Dr. Brill -- the first note from Dr. Brill in the St. Rose chart is dated April the 28th, 2017. You can see it on the screen?

A Yes.

Q And it's 8:05 in the morning, so that would have been about maybe nine or ten hours after the surgery you had with Dr. Hamilton, true?

A True.

Q And do you remember Dr. Brill discussing with you the perforation that had occurred during the hysteroscopy, when he saw you at St. Rose that first time?

A No.

Q I want to refer you to the bottom of this page where Dr. Brill documents, "while I reviewed with Kimberly the perforation that occurred during the hysteroscopy I performed two days ago." Do you disagree that he discussed that with you?

A He was -- he -- yes, I do. I disagree.

Q And he also documented, "At the time of the perforation, I did not suspect that the myomectomy device was actively cutting. I also did not see any bowel adjacent to the uterine perforation."

A He did not have a conversation with me.

Q You've got to let me --

A I'm sorry.

Q Sorry, you've got to let me ask the question. Did Dr. Brill discuss with you that he did not believe the myomectomy device was actively cutting, and did not see any bowel adjacent to the uterine perforation?

A No.

Q He also documented that you, Kimberly, reviewed with him the pain that you had that evening and the following day, and voiced to you that he was glad you called 911. Do you remember that discussion with Dr. Brill?

A I do not.

Q Do you remember Dr. Brill telling you that he learned that you were at St. Rose Hospital when he received a phone call from Dr. Schoenhaus?

A I do not recall that.

Q Do you remember Dr. Brill telling you that he wasn't able to come to the hospital, St. Rose, on the 27th because he was starting a laborious shift at another hospital?

A I do recall him saying that, yes.

Q You do recall?

A I do, yes.

Q And what about Dr. Ivie, did -- do you remember Dr. Brill explaining that Dr. Ivie was another partner of his at Women's Health Associates?

A I don't recall that, no.

Q Do you know -- do you have an understanding that Dr. Ivie

assisted Dr. Hamilton with your surgery?

A That's my understanding, yes.

Q Now, this -- the second occasion that you remember seeing Dr. Brill at St. Rose Hospital, do you know what day that was?

A I do not.

MS. HALL: Can you go back, please, to SRDH209? Sorry to jump around, Ms. Taylor. I want to -- before I move on from this April the 28th memo, I do want to show you SRDH209.

BY MS. HALL:

Q So we're talking still about the April the 28th visit that Dr. Brill had with you at St. Rose. And specifically, the top of the progress note. Do you recall telling Dr. Brill that your pain was better after Dr. Hamilton's surgery?

A I mean, if I said that, I guess, yes.

MS. HALL: Let's go to SRDH184, please.

BY MS. HALL:

Q And I'll represent to you that the medical records reflect that there is a second visit with Dr. Brill on April the 29th.

A Okay.

Q So I'd like to show you that. You do recall having at least two visits with Dr. Brill at St. Rose, you just don't know the dates?

A I don't know the dates. I don't -- no, I don't. I don't -- no, I don't recall.

Q And in terms of the second day, this would have been the second day after your surgery, would you agree that your nausea was

better except for with the pain medication?

A I mean, I was on nausea medication. I would assume it would be better, yes.

Q Were you also at that time, two days after the surgery, were you able to urinate by that point?

A I don't know. I don't recall. I don't -- I'm assuming I did. I had fluids going in me. So what goes in, goes out. I probably did.

Q The solid foods that you mentioned when your attorney was asking you questions, you would agree that you never consumed any solid foods while at St. Rose Hospital?

A I agree.

Q And again, you're not saying that this April 29th visit, so the second visit that is reflected, you are not saying it didn't happen, you just don't know the dates of them?

A I don't recall the dates.

Q Okay.

A I saw so many doctors, I can't even -- from his practice, from Hamilton's practice, from -- there were so many doctors in and out of my room.

Q Let me show you SRDH. For the record, we are still on Exhibit 1. I want to show you SRDH166. And Ms. Taylor, this is a progress note from -- let me get there first, sorry. There you go.

This is a progress note, I'll represent to you, from Dr. Brill in your St. Rose Hospital chart.

A Uh-huh.

Q And it's dated April the 30th, 2017. Do you have any reason to disagree that Dr. Brill saw you for a third occasion at St. Rose Hospital?

A I -- if that's what he documented. I don't recall, no.

Q But you don't disagree that it occurred?

A No.

Q By this visit, Dr. Brill's note reflects that you had not tolerated a liquid diet. And they were waiting for you to pass gas before advancing you to a clear liquid diet. Do you remember having any discussion with Dr. Brill about a clear liquid diet?

A I do not recall, no. I don't -- I know that that's who -- he is who changed my diet.

Q Okay. And for now, I understand the solid foods, and I think we have already discussed that. I am talking about the clear liquid diet.

A I -- yeah, I mean, if that's what he documented, I guess.

Q Okay. You do remember though -- I understand that you don't remember the day, but you remember Dr. Brill telling you that he was leaving town for a conference and that Dr. Garg would be covering for him?

A I recall him telling me that he was going out of town. I do not recall him telling me a specific doctor. There were several doctors throughout his practice that -- I saw Dr. Garg. I saw -- I saw a lot of people from his practice.

Q Okay.

A Not just Garg.

Q Sure. But you do though -- I understand you don't remember the name. You know he told you that there would be a doctor covering him for a few days?

A That he would be covering, yes.

Q Okay. And let me show you, the medical records from St. Rose reflect that there was a fourth visit that Dr. Brill had with you that occurred on May the 3rd, 2017.

A Okay.

MS. HALL: So let me show you that note. And that's going to be Exhibit 1, and just go to 103, SRDH103.

BY MS. HALL:

Q Now. The -- I believe your attorney showed you some of this note. And I want to have -- I have a few questions for you regarding this note.

A Okay.

Q The -- again, the medical records show that Dr. Brill saw you on May the 3rd, 2017.

A Okay.

Q Do you disagree that you were seen by Dr. Brill on that day?

A I don't know the dates that he saw me.

Q I understand. But do you have any reason to dispute that there was a fourth occasion that Dr. Brill saw you at St. Rose?

A I honestly don't recall seeing him that many times. But if he documented that he was there, it's possible.

Q So you are not suggesting to the jury that Dr. Brill

documented medical visits that did not occur?

A Well, he documented that he met with my parents, and he never met them.

Q Well, we'll get there in just a second. But I first want you -- my question was, you are not suggesting to the jury that Dr. Brill documented a medical visit at St. Rose that did not occur?

A I can't imagine that he would do something like that, no.

Q I want to show you, this is SRDH103. And when Dr. Brill saw you on that day, he documented, "I spoke to Kimberly and her parents at length again about the hysteroscopy last week and the nature of her uterus." You disagree that Dr. Brill spoke to you and your parents at length about --

A He didn't. I disagree.

Q Okay. He also documented that "During the resection portion, there was a perforation, and I could not proceed with the myomectomy and endometrial ablation." Do you disagree that Dr. Brill discussed that information with you the fourth time he saw you?

A I disagree.

Q And do you also disagree that you "voiced understanding and appeared to be in good spirits" after this discussion?

A I don't recall the conversation with him. I don't -- I don't recall that, no.

Q And I understand you don't remember the name Dr. Garg, but you do agree that Dr. Brill advised you that there would be an on-call physician covering for him while he was out of town for a few days?

A I recall that, yes.
Q Now, in terms of the conversation that you mentioned with Dr. Lipman, do you have any recollection of when that conversation occurred?
A I do not.
Q Do you believe it was the first time that Dr. Lipman saw you?
A I don't believe so.
Q I'll represent to you that the St. Rose records reflect Dr. Lipman's first visit with you was May the 3rd, 2017.
A Okay.
Q Do you believe that conversation occurred sometime after the first visit?
A I don't recall the time line of it, to be honest.
Q Fair enough. But you do agree that Dr. Lipman did not say anything to you that was negative of Dr. Brill?
A Negative, no.
Q He never said anything negative?
A No.
Q In fact, no medical provider at St. Rose said anything to you about --
MR. BREEDEN: Object, Your Honor.
THE COURT: Counsel, approach.
[Sidebar at 12:49 p.m., ending at 12:50 p.m., not transcribed]
BY MS. HALL:
Q In terms of the damages that you are claiming in this case,

you would agree that you aren't making a lost wages claim?

A I agree.

Q And in fact, you're not claiming that the surgical complication that you experienced has impacted your ability to earn income in the future?

A Correct.

Q And the colostomy bag that was mentioned, you never needed a colostomy bag, true?

A True.

Q Even though Dr. Hamilton did tell you that was a possibility before she did her surgery?

A Correct.

Q Thankfully, you didn't need that?

A Correct.

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

THE COURT: Uh-huh.

MS. HALL: I pass the witness, Your Honor. Thank you, Ms. Taylor.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. BREEDEN:

Q Kim, I have just a few follow-ups here for you. There were some discussions about who called 911. I just want to make sure what your testimony is. So what do you recall about who called 911 the first time you went to the hospital, and who called 911 the second time?

A I called 911 the first time. I was alone by myself. And the second time, it was my stepdad.

Q Okay. And did you actually see him calling 911?

A I was in a lot of pain. I -- no, I didn't. No.

Q Okay. Do you think that's particularly relevant to who caused your perforation and what happened to you afterward?

MS. HALL: Objection, Your Honor. This calls for a --

THE WITNESS: Absolutely not. Based on --

MS. HALL: -- legal conclusion.

THE COURT: Sustained.

MS. HALL: Thank you.

BY MR. BREEDEN:

Q You mentioned that when you met with Dr. Brill in the PACU immediately after your procedure, that he simply indicated he was going to see you at your postop appointment; do you recall that?

A I do.

Q Was your postop appointment scheduled for later that day?

A No, it was scheduled for two weeks out.

Q Okay. So Dr. Brill just said I'll see you two weeks later?

A Correct.

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

THE COURT: Any recross-exam?

MS. HALL: Nothing further, Your Honor.

THE COURT: Any questions from our jurors? I believe I don't see any questions. Thank you, Ms. Taylor. You may step down.

All right. Ladies and gentlemen, we'll go ahead and take our afternoon recess for lunch. And we're going to come back just a little bit later, just at 2:10. So I will see you at 2:10.

And during the break, you are instructed not to talk to each other or anyone else about any subject or issue connected with this trial. You are not to read, watch, or listen to any recorded commentary on the trial by any person by any medium of information, including without limitation, newspapers, internet, or radio.

You are not conduct any research on your own related to the case such as consulting dictionaries, using the internet or references here to test any theory of the case, research any aspect of the case, or in any other way learn about the case or investigate it on your own. You are not to talk to others, text others, tweet others, Google issues, or look at computer or book research with regard to any issue, party, or attorney involved in this case. And finally, you are not to form or express any opinion on any subject related to this trial until it is finally submitted to you.

I will see you back at 2:10. Thank you.

THE MARSHAL: All rise for the jury.

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

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

[Outside the presence of the jury]

THE COURT: Thank you. Let's put the few objections on the record. So there was continuing objections with regard to the discharge

instructions and the known risks of the surgery. And based on prior rulings, those were overruled.

MR. BREEDEN: Your Honor, can I comment on that very quickly?

THE COURT: Oh, go ahead.

MR. BREEDEN: I think this, you know, putting up HH15 or 13, I'm sorry, I can't read my notes here. And it talks about risks of bleeding and infection and an injury to other things, that's just a way to circumvent your prior ruling that for this particular procedure, the actual informed consent form my client signed cannot be shown to the jury.

So they were just showing you something that contains -- or they're showing the jury something else that contains very similar information. And I think that's improper. But there's a lot of issues in this case about risks and complication and how those can be introduced, and you've made rules.

THE COURT: Right. And I previously ruled that the discharge instructions were separate and different from the informed consent.

And then the next objection was with regard to prior case complaints. The objection was that it was not relevant. Anything further on that, Mr. Breeden?

MR. BREEDEN: Oh, yes. There was an objection because the question asked -- concerned, you know, prior to your hysteroscopy procedure, did you have any complaints about care that Dr. Brill gave to you. And I think my client had been a patient for about two years prior

to that point. And quite frankly, that's just irrelevant to any issue in this case as to the standard of care or what happened in the April 2017 procedure, and so I objected on that basis.

THE COURT: Any response?

MS. HALL: I wasn't trying to ask this lay witness about the standard of care. All I was attempting to establish -- and perhaps I worded the question poorly. I was attempting to establish that we're not talking about any of the care before this date. And that's all I was trying to get at, but I respect Your Honor's ruling that it was sustained.

THE COURT: And I sustained it as not relevant.

And then there was another objection to the numbers which you have already covered. And then finally, there was an objection during the cross about any other doctors commenting negatively on Dr. Brill. Anything further, Mr. Breeden?

MR. BREEDEN: And of course, the absence of criticism from other treating providers, who by the way, have not been disclosed as people who were going to comment on the standard of care in this case -- the absence of those criticisms is not evidence of what their opinion one way or another is. It's irrelevant, but it suggests because other providers did not go out of their way to criticize Dr. Brill, which often they don't, because they might work with Dr. Brill. They might see him regularly. And they're just focused on care going forward with this patient. That's their role with Ms. Taylor. That -- the lack of that is not probative of any issue in this case.

THE COURT: Okay. And then we had some discussion at the

bench, but Ms. Hall withdrew the question. So then we -- we're good. Anything else?

MR. BREEDEN: Nothing further from Plaintiff.

MS. HALL: Nothing further, Your Honor.

THE COURT: All right. I'll see you at 2:15.

MR. BREEDEN: 2:15. All right. That's going to be Dr. McCarus, correct?

MS. HALL: Yes.

[Recess from 12:58 p.m. to 2:15 p.m.]

[Outside the presence of the jury]

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

MR. BREEDEN: Nothing from Plaintiff, Your Honor.

MS. HALL: Nothing from the Defense.

THE COURT: And then we're going to be calling Mr. McCarus -- Dr. McCarus out of order, correct?

MS. HALL: Yes.

THE COURT: All right. Are you ready?

THE MARSHAL: Yes, Your Honor.

THE COURT: All right. We're ready.

THE MARSHAL: All rise for the jury.

[Jury in at 2:17 p.m.]

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

THE COURT: Thank you. You may be seated. Ladies and

gentlemen, due to scheduling issues, we are going to call a witness out of order. So this is still technically the Plaintiff's case, but because of a scheduling issue, we are going to call a Defense witness out of order, and then go back to the Plaintiff's case. So I just want you to make a note that this is a Defense witness.

So on behalf of Defense, go ahead.

MS. HALL: Thank you, Your Honor. We would call Steven McCarus, M.D., to the stand.

THE COURT: Thank you.

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

STEVEN MCCARUS, DEFENDANTS' WITNESS, SWORN

THE CLERK: Thank you. Please be seated.

DIRECT EXAMINATION

BY MS. HALL:

Q Good afternoon, Doctor.

THE CLERK: Sorry.

MS. HALL: Oh, I'm sorry.

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

THE WITNESS: My name is Steven, S-T-E-V-E-N, Douglas, McCarus, M-C-C-A-R-U-S.

MS. HALL: Thank you.

BY MS. HALL:

Q Good afternoon, Dr. McCarus.

A Good afternoon.

Q Can you tell the jury a little bit about what it is that you do as your profession?

A I'm an obstetrician gynecologist. I don't deliver babies anymore. I haven't done that in about 25 years. But I do a full gynecological practice. And my practice is focused on female surgery.

Q And can you explain -- I know you did touch on it. First when you began practicing, did you have an obstetrical practice?

A Yes. I practiced obstetrics, which is the delivery of the pregnant patient, her baby, for ten years in Baltimore, Maryland. And then after that, I ended up going to Chicago and started up a minimally invasive institute for GYN or gynecological surgery for three years. And then I relocated to Orlando, Florida, where I've been the last 22 years and have practiced gynecology only.

Q During those 22 years?

A Yes, ma'am.

Q Can you -- I want to back up just a moment and go over some of your background starting with can you tell the jury where you went to undergraduate?

A Yes. I'm -- I was born and raised in Charles Town, West Virginia. And after high school, I went to undergraduate college at West Virginia University in Morgantown, West Virginia, and got a Bachelor of Arts degree in biology. And then I went to Baltimore, Maryland, and did a residency program in obstetrics and gynecology. Prior to that, I went to medical school in Huntington, West Virginia at Marshall University School of Medicine. After my OB/GYN training in Baltimore, I stayed in

Baltimore, Maryland, and did OB/GYN for ten years. Then, went to Chicago.

Q Let me -- if I can interrupt. With respect to your medical school education, what year did you obtain your medical degree?

A My medical degree was in 1982.

Q And what institution? You said that was in Huntington, West Virginia. Was that Marshall University?

A Yes, ma'am.

Q And after you obtained your medical degree, you went on to Baltimore for a residency?

A Correct. At the Greater Baltimore Medical Center.

Q How long was that residency?

A That was from -- that was four years from 1982 to 1986.

Q And the residency that you did, was it in a particular specialty?

A Yes. In obstetrics and gynecology.

Q And Dr. McCarus, are you Board certified in any specialties?

A Yes, I am. In obstetrics and gynecology.

Q What Board are you Board certified through?

A We have our affiliate in obstetrics and gynecology. The American College of Obstetrics and Gynecology. The board is actually recognized through the American Board of Obstetrics and Gynecology. And I became board certified in 1989.

Q And for our jurors, can you just briefly explain what the Board certification process is and how you become board certified

through that institution?

A Okay. After college, if you go to medical school, then you -- after medical school, you do a residency program. So it's four years of college, four years of medical school, and then four years of your practice as an OB/GYN, your residency program. When you finish your residency program and you go into practice, you have to keep track of all your cases. And after you've been in practice for a couple years and you've got enough experience and you acquire what they call is a case list, then you're required to sit in front of the American College, the Board of OB/GYN. And you have to take an oral examination, which is really nerve racking and makes everybody nervous to do that because you have to sit in front of OB/GYNs and do an oral exam. And you also have to take a written exam. And if you pass your written exam and your oral exam, you're known as a fellow or a board certified OB/GYN.

Q And did you pass the oral and written component of that on your first attempt?

A Yes, ma'am.

Q And you said that you obtained that first in 1989; is that correct?

A Correct.

Q Since that time, have you needed to recertify in order to keep that Board certification?

A Yes. Every year you have to recertify. And I've maintained my certification all the -- all these years.

Q Now, you mentioned the American College of Obstetricians

and Gynecologists. Do you belong to that organization?

A Yes.

Q And are you what is called a fellow?

A Yes, I am.

Q Can -- are you familiar with the criteria in order to be eligible to become a fellow of ACOG?

A Well, to be eligible to become a fellow, you have to complete an OBGYN residency program. And then -- and then you have to compile a case list. And after you finish your OB/GYN education, you're eligible to be a fellow. And once you pass your oral and written exam, you become a fellow.

Q Okay. And in terms of becoming a fellow of the American College of Obstetricians and Gynecologists, or ACOG, you -- you're familiar with that term, right, ACOG?

A That's the term. Yes, ma'am.

Q And after -- are you eligible to apply to that -- to become a fellow in ACOG if you went to medical school at an osteopathic medicine school?

A Yes. You can. You can apply to be a fellow of the American College of OB/GYNs if you went to a Doctor of Osteopathic Medical school versus an MD medical school. You can be a fellow of that.

Q You would just need to complete those -- that -- satisfy that criteria that you mentioned?

A Correct.

Q In your -- tell the jury a little bit about -- and I don't want a list

of all the states that you are licensed in. But are you licensed in the State of Florida to practice medicine?

A Yes, I am.

Q In addition to Florida, are you licensed to practice in medicine in any other states?

A I have -- I have two other state licensures. I only practice medicine in the State of Florida. But I keep an active license in the State of Texas and in the State of Nevada.

Q And why is that, Dr. McCarus?

A Well, one time I had active licensures in about 11 states because throughout my career I decided I wanted to really specialize in surgery. And back in the early '90s, surgery was changing quite a bit. It was -- instead of doing open surgery where you always had to make a bikini cut or an up and down incision to do surgery, we were developing techniques where you could do laparoscopic or what we called minimally invasive surgery.

So I got involved with that in the early '90s and became involved with education. I was fortunate enough to work with my chairman, who is my mentor. And I learned how to do that surgery in the early '90s. And I got requested frequently to travel around the country and teach my colleagues how to do hysteroscopy and laparoscopic surgery.

So if you go out of state to practice surgery, you have to have a license in that state in order to be able to go into an operating room. Like I've operated in Las Vegas. But you just can't walk into a hospital and walk into an operating room even though you're a surgeon. You

have to be licensed in that state. So over time I had been requested to go around the United States to do surgery, so I had all those licensures. But in the past probably five, six, seven years, I've only maintained Nevada, Texas, and Florida.

Q And in terms of the training that you've done across the U.S., that training you said it also included training physicians on minimally invasive surgeries?

A Correct.

Q And that would include hysteroscopies?

A That's correct.

Q The techniques that you mentioned and the changes with surgery, have you yourself been responsible for developing any surgical technique?

A Yes, ma'am. I have. Yes.

Q And can you tell the jury just a little bit about that?

A With doing hysterectomies, there were a lot of different ways to do a hysterectomy. And there wasn't any standardization of how one may do that. So in 1996, I developed the McCarus hysterectomy technique that got published. It was a technique that was using an energy device that was not burning tissue when you did surgery. It was just more coagulating tissue. And I developed that technique and it got published. And I've used that technique over the years. And I actually still teach that technique today. So it was the McCarus hysterectomy technique.

Q And have you -- Dr. McCarus, have you had any involvement

in an organization called the American Institute of Minimally Invasive Surgery?

A Yes, ma'am.

Q What is that organization?

A Patients really don't know the expertise of their surgeon always. And a lot of times it's -- you want to know how good is my surgeon, or how many of these procedures that surgeon's done or hasn't done. So it was actually in 2008, here in Las Vegas, I collaborated with a colleague here and we developed an institute called the American Institute for Minimally Invasive Surgery. And it's still an active institute today where we would vet surgeons and look at data, and look at outcomes, and look at the skill of the surgeon. And I've been involved with that organization ever since its beginning. And it's still going on now. And it's -- we still have members and hospitals that we certify centers of excellence and surgeons of excellence.

Q And are you also one of the cofounders of that organization?

A Yes, ma'am.

Q The practice that you have in Florida --

A Uh-huh.

Q -- is that entirely devoted to gynecologic surgery?

A Yes, it is.

Q And can you tell the jury where it is that you practice or with what hospital system it is that you practice in Florida?

A Yeah. For -- when I left Chicago, I got recruited to go to Orlando and work at that time for Florida Hospital. And my wife's an

obstetrician and gynecologist and we operate together. She doesn't deliver babies. We both do surgery. And we were asked to start up a women's center at Advent Health or Florida Hospital Celebration. It's a hospital that's two miles from Walt Disney World. And they were looking to build a program. So we had moved from Chicago and went to Orlando and started up the women's center there. And I've maintained the designation of chief of the division of gynecological surgery. It's called Advent Health Hospital now and not Florida Hospital. But I'm the chief of surgery at Advent Health Celebration and Winter Park Hospital, and still do an active practice in women's health for surgery.

Q Could you briefly describe what your role as chief of surgery there, what that involves?

A Well, I've -- as chief of surgery, we have oversight of the department. And there's active OB/GYN physicians there. I'm not involved with the obstetrical side of -- the older side. But on the gynecological side. And then also, we started what's called a fellowship program. A fellowship program is where we have positions for OB/GYNs that have finished their training to want to do more education. And we've graduated ten fellows -- what we call fellows in that program.

As a matter of fact, one of the fellows that trained here in Las Vegas is now one of my partners. She does surgery and is within our department. We do typical meetings, and see patients, and do lecturing, and look at quality assurance things. And that's kind of the gist of what I do as the chief there.

Q When you say you see patients, you maintain a clinical

practice -- do you maintain a clinical practice where you provide patient care?

A Absolutely. I see -- my typical schedule is I operate every Monday and Tuesday. I see patients on Wednesday and Thursday. And then Friday is an administrative day, or a meeting day, or something like this kind of day.

Q And Dr. McCarus, I have a bottle of water for you.

MS. HALL: May I approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q Just in case you need it.

A Thank you. I appreciate that.

Q I understand you're parched.

A Yeah. Thank you.

Q And it's okay to -- we can take our masks down to have a sip, as long as we put it back up.

A Okay.

Q I want to talk to you just a little bit about your current practice. In terms of your surgical practice, do you perform hysteroscopies?

A Yes, I do.

Q Can you estimate for the jury how commonly you perform a hysteroscopy?

A Well, I do hysteroscopies every week. I think I did four this week. Hysteroscopy is a -- an operation that's very common. So I have

done that for years in my practice. And from just diagnostic hysteroscopy where you want to look in the uterus, or an operative hysteroscopy, where you have to do more surgical techniques like fibroids, or septum, or polyps. So I've done that my whole career regularly.

Q Well, and that's a good point. In terms of the -- what's your understanding of the planned procedure for the patient Ms. Taylor?

A The planned procedure for Ms. Taylor, I understood it to be a hysteroscopy with removal of a fibroid. And fibroids are muscle growths. The uterus is a very muscular organ. As you know, it holds a baby. It expands. So it's a lot of muscle wall in the uterus itself. And those muscles sometimes can enlarge and become a tumor, and it's called fibroids. And I think she had a fibroid that was diagnosed on an ultrasound. And she had heavy bleeding, which fibroids usually cause. That's the number one problem they cause is heavy bleeding.

So the plan was for her to have an operative hysteroscopy to look in the uterine cavity with a scope, with a camera attached to a scope, and try to resect out the fibroid. And I do that commonly in my practice. But also, not only do an operative hysteroscopy and try to remove the fibroids, she was going to have what's called an ablation. A uterine ablation is also done hysteroscopically [sic]. There's a lot of different ways to do it.

But basically, an ablation is where you want to take energy and whether it's heat from fluid, or radiofrequency, electricity from an electrode, and you want to get inside the uterus and coagulate or

cauterize the lining so the bleeding either goes away or is much less. And that's a commonly accepted procedure that's done all over the world, actually.

Q And the procedures that you just described, are those procedures that you regularly perform as part of your practice?

A Yes, ma'am.

Q There's also been mention -- is it your understanding that she was going to have something called a dilation and curettage?

A Yes.

Q Can you explain to the jury what a dilation and curettage is?

A Okay. So dilation. The cervix is the mouth of the uterus. And if you just look at your fist, everybody has a uterus with them all the time is how I show my patients, because the cervix is the very tip of your fingers, the uterus is your hand, and inside the cervix, you're in the uterine cavity. So to get into that cavity, you have to dilate the cervical canal.

And then you can get access into the cavity. And a curettage is a term that just means to scrape, or curette, the lining where you obtain tissue. And that's almost always done when you do a hysteroscopy. You always dilate and then do a curettage and then go from there, depending on what the case is.

Q So it's common to do the procedure in that manner?

A It's always done, basically.

Q Okay.

A You always have to dilate the cervix to get into the uterine

cavity.

Q Okay. And we'll go over some more specifics about that in a little bit.

A All right.

Q In terms of your work as a medical expert in legal matters, have you ever served as an expert in cases other than the one that you're here to testify about?

A Yes, ma'am.

Q And you understand, in this case, were you retained by the Defendants in this case?

A Correct.

Q And have you in your work as an expert -- first of all, how long have you been doing medical legal expert work?

A I've really -- I've really --

Q Where you come in and --

A I've really been doing it a long time, because as I was traveling around and helping my colleagues and involved with education, you meet a lot of people, and you get acquaintances, and you befriend your colleagues and those sorts of things. And then I was asked to start reviewing cases. That was probably in the early '90s. So I would get asked to review a case and see if there was any kind of issue with the medical record or the techniques. I've been doing it since early 1990s.

Q And Dr. McCarus, have you reviewed cases on behalf of the patient in these types of cases?

A Yes, ma'am.

Q And the review -- the cases that you do, do they always result in trial testimony where you have to come into a court?

A No, the -- I haven't been into court that many times. Probably a dozen times. But usually, the review of a medical record and the -- somebody's surgical experience, you review it, there may or may not be a deposition. Or you may just review it and that's all, or you may do a deposition, or you may go to trial. So I've done more depositions than going to trial.

Q And just generally speaking, have there been occasions where you've offered an opinion against an OB/GYN?

A Yes, ma'am.

Q And how often would you say it is that you're retained on behalf of the patient in medical legal cases?

A Currently, the majority of expert work that I do is to represent the patient. So I would say right now it's either 60, 70 percent working to help the patient and 30 to 40 percent helping or defending a physician.

Q What percentage of your practice would you say is devoted to expert work?

A Ten percent.

Q Just like Plaintiff's expert, Dr. Berke, are you -- first and foremost, in order for you to be here today to give testimony, are you having to miss time with patients in Florida?

A Yes.

Q And just like the expert who was retained by the Plaintiff, Dr. Berke, are you being compensated for your time away from your

patients today?

A Yes, ma'am.

Q Do you recall, Dr. McCarus, when it is that you were first retained in this case?

A I believe it was 2018, early that year. Maybe April of 2018.

Q And at that time, did you receive medical records from my office to review?

A Yes, ma'am.

Q And the medical records that you were provided, did that include medical records from Women's Health Associates of Southern Nevada?

A Yes, it did.

Q Did it also include medical records from Henderson Hospital for the April 16th surgery?

A It did.

Q What about when you were retained in this case, did you receive medical records from St. Rose Hospital to review?

A Yes.

Q And is it your understanding that Ms. Taylor had two visits to the emergency department at St. Rose?

A Yes.

Q And did you review both of those visits or admissions?

A I did.

Q Were you also provided some expert reports later in the case? Were you also provided some expert reports from Plaintiff's

expert, Dr. Berke?

A Yes, ma'am.

Q And what about the imaging? Did you review imaging from St. Rose Hospital?

A I didn't look at films, but I did review the reports.

Q So the reports from the radiologist?

A Yes.

Q And in addition to medical records, have you reviewed depositions that were taken in this case?

A I have.

Q Did you review the deposition of Ms. Taylor?

A I did.

Q And what about the deposition of the Defendant, Dr. Brill? Did you review Dr. Brill's deposition?

A I did.

Q And the anesthesiologist who participated in Ms. Taylor's April surgery with Dr. Brill, Dr. Yeh, did you review Dr. Yeh's deposition?

A I did.

Q And what about the deposition of Dr. Berke?

A I've read his.

Q Were you also provided records from the City of Henderson Fire Department?

A Yes.

Q Now, tell the jury a little bit, Dr. McCarus, about the device that was used in Dr. Brill's surgery, the resection device. What's the

name of that device?

A The Symphion hysteroscope.

Q Do you personally use the Symphion in your practice currently?

A I do not use that particular device.

Q Have you ever used the Symphion in a lab?

A Yes.

Q Can you tell the jury, are you familiar with the technology that is used in a Symphion?

A Well, I was actually involved with reviewing the system. We reviewed the Symphion. There's other systems like that. And so I did have exposure to that system. I used it in a lab. I evaluated it as a purchase item. We were trying to decide whether to use that in our hospital or not. But we ended up going with a different device that's very similar. So I did a comparison of that device with other devices.

Q And is that because you think the Symphion is not an appropriate device?

A No, I think it's a good device.

Q What are -- are there any benefits to the Symphion that -- well, let me back up just a moment.

A All right.

Q In terms of the technology that is used in a Symphion, is that considered to be unipolar or bipolar?

A It's a bipolar instrument.

Q Can you explain what that means --

A Yeah.

Q -- to be a bipolar instrument?

A Yeah. That -- when you talk about electricity, there was a big issue with hysteroscopy because what we were trying to do, instead of just looking in the uterus, which is a diagnostic procedure, you just want to look at something. You want to look and try to diagnose. If you look and diagnose and then want to treat, you go to operative hysteroscopy. And operative hysteroscopy utilizes what's called operative hysteroscopes. And when they first got developed, they used electricity. So you would plug it into a generator. The generator would be plugged into the wall. You hit a foot pedal, and an electrical current would go into the instrument where you could cut and cauterize whatever the disease is.

The problem with that was, and I'm sure you all are aware of this, when you have a current that goes into an area, that current not only goes in, but it has to exit. So it was always a complication consideration using electricity. That's called unipolar because it's a unidirectional current. The current would go into the scope, it would heat up the end of the scope. You could operate on tissue. But that current had to leave the patient, so you had to put a grounding plate on the patient's thigh.

As technology improved, like the Symphion system is a bipolar device. Bipolar means instead of that current just coming into the patient, doing what it needs to do, and exiting. The instrument was designed where the current would come into an area of the instrument and go to another are within the instrument and exit that way. So it

didn't have to travel through the patient's tissue, and that's a huge advantage, unipolar versus bipolar. And the Symphion system is a bipolar, what they call radiofrequency energy. That makes it much safer. And it's very common and considered a better device than a unipolar instrument.

Q So Symphion is a bipolar device?

A It is.

Q And you believe that bipolar device is generally safer than a unipolar device?

A I do believe that, yes.

Q Can you still -- can you get perforations with both of those systems, unipolar and bipolar?

A You can, yes.

Q In terms of the Symphion, when you've used it in the lab, like other resection devices, do you need a hysteroscope in order to access the uterus?

A You do.

Q Dr. McCarus, I actually have a hysteroscope and a Symphion, so what I'd like to do if it's okay with Your Honor is just have you come down and don't get very close to the jury, just stand right by your microphone.

A Okay.

Q And I'll get those demonstratives for you.

THE WITNESS: Okay with that?

THE COURT: Yeah.

MS. HALL: And I've been told that as long as you keep your voice up, this microphone will pick you up, so.

THE WITNESS: Okay.

MS. HALL: All right.

BY MS. HALL:

Q Now, if you could, without getting too close to the jury, can you -- first of all, what is the device that you're holding?

A This is called an operative hysteroscope. So it has an eyepiece with a lens that you can look through. So I can see you all looking through the scope. It has a post where you hook up a light. And it has an inflow channel and an outflow channel. So it's a very sophisticated hysteroscope. It has three channels. It also has lenses and rods to give you magnification. So when you put that through the cervix, you can see in that small, dark cavity because you have light, and you have eye -- you have vision. This is an operative hysteroscope.

Q And could I ask you, Dr. McCarus, in terms of -- so the black piece that we see, you said that's the lens?

A This -- yeah. That's the eye. It's called the eyepiece that you hook a camera to. So if I can put a camera on this eyepiece, I can look at the TV to operate. I can look down here to this and I can see you, so I could do it that way. But that's difficult. So you put a little small camera on the eyepiece, and it illuminates the image to a monitor in the operating room, and that's been done for a long time.

And then here is an open channel that you can take your hand piece that's going to do all the action. This is where the working hand

piece is. This is a Symphion resection tool. This whole thing together is called a resectoscope. So if we -- if we dictate, we're using a resectoscope, we mean all this together. This is a hysteroscope, but when you add this tool, we call it a resectoscope.

And the working element of the resectoscope goes down the operative channel. And see, now I have vision of the working part of that as I'm doing the cervix.

Q And may I interrupt right there? When you say the working part, can you explain what you mean by that?

A Yeah. The end of this Symphion system -- and I use a system very similar to this -- it has a blunt tip. So I could put my finger there. It's not cutting or hurting my skin at all. It's blunt. And you can push it against something, it's not going to hurt it. But this design is very neat, for lack of a better term. I think it's a cool design because it's a circular design, but there's a half-moon cut out of the tip of it. And within that part of the instrument, when you hit a foot pedal, that's what generates the energy, and it actually has a suction that pulls tissue into it to allow you to cut and remove the tissue.

The other point -- the other point that I think is important, though, if I dilate the cervix and push this into the cervix, I want to push this in without this exposed. So I get the scope in there first. And this is -- this is a blunt tip of the scope. So now, I'm in the --

Q Dr. McCarus, you can get just a little bit closer to the jury.

A I don't want to get judged.

Q Don't get too close.

A You guys will holler at me. Let's see. So now, see, you're going to dilate the cervix. And now, I have vision in the cavity. I can see the fibroid or see the polyp. And then I can hold this and advance the working instrument, and that only goes in so far. Now, I can rotate, rotate, rotate this 360. I can cut up, I can rotate, cut down. I can cut to the right or to the left because I'm looking on the monitor as I'm working. I do have to advance this, though, as I go further in. If I need to get high up in that uterus, I have to advance it. And this can perforate a uterus.

Q And when you say you need to advance it, are you referring to the entire resectoscope, the whole unit?

A This only goes in so far, okay?

Q Meaning the Symphion only goes in --

A Yeah. I can't push that Symphion any more into the scope. It's done. It's now a unit. So once I'm ready to work, if I'm cutting and I need to get more tissue, I advance this whole -- I what we call advance the camera.

Q And while you're advancing the camera, are you actively cutting?

A No.

Q And you explained --

A Not usually. Because what you want to do -- it depends. It depends on what you're working on. But if I'm wanting to cut tissue, I'm going to hit the foot pedal. I'm watching. The tissue goes away, then I may advance. I could come off the foot pedal and advance or I can advance gently with the foot pedal on. So it depends on what

you're -- what you're seeing. Every case is different. There's no two cases alike, so it just depends on what your objective is.

Q Okay. And in terms of the resection device and how you as the surgeon know whether it is actively cutting, how is that?

A You can see motion. You can see that. You can see that part moving and see the tissue sucking that up. So you know your start point and your end point.

Q And if you as the surgeon do not have your foot on the foot pedal, will the resection device cut?

A No. You'd have to hit the foot pedal.

Q And without getting too close to the jury, can you explain, in terms of the Symphion, this little channel or gap, for lack of a better word, is that the area where the energy is contained that is able to resect tissue?

A Yeah. So it's really a neat design because there's energy. This is hooked to a generator. This is plugged into a generator. So when you hit the foot pedal, that generator is producing voltage and ampage [sic] and wattage with this electrical cord, and that energy is coming to this instrument. That there is an active electrode, a positive electrode, on the end of this instrument, and a negative electrode, so it works like a bipolar.

Q Okay.

A So that energy is contained right there.

Q And may I ask you, Dr. McCarus, in terms of the entire unit, the -- you said this is referred to as the resectoscope.

A Resectoscope, the whole thing.

Q On the hysteroscope --

A Yeah.

Q -- there appear to be two small channels in addition to the channel that's large enough for the Symphion resection device. What is the purpose of these two small holes that are in the tip of the hysteroscope?

A Okay. That's a great question, because when you go -- when you dilate and get the scope into that small cavity, you have to distend the cavity. You have to blow it up. You have to get an operative field to be able to work. So what you do, with this system, there's a pump, like a water pump, and you hook the tubing to this channel. So the pump gets turned on, and it's measuring uterine pressures. It's measuring the pressure against that uterus on the -- on the prong. And the water is getting pumped down that channel into the cavity. When you hit the foot pedal, that activity of that -- the opening, it sucks fluid back out through this channel.

So there's an inflow channel pumping water in; there's an outflow channel pumping water out. And that's a safety feature because if you do perforate, that pump over their senses there's a problem, and it won't continue working.

Q And in terms of the channel that you said sucks the material and fluid out, where does that material go?

A It goes into a canister. So when you're -- when you're resecting tissue, that tissue also gets sucked out and gets collected in the

canister, and that goes to the pathologist.

Q So any tissue that is resected with the Symphion, it goes into the canister, you said that gets sent to a pathologist and presumably examined on the pathology report?

A Yes.

Q Thank you, Dr. McCarus. You can --

A I mean there may not be any tissue if you don't -- can't complete the surgery.

Q Okay. Now, Dr. McCarus, when you were retained in this case, were you asked to evaluate the care and treatment that Dr. Brill provided to Ms. Taylor?

A Yes, ma'am.

Q And based on your education, training, and background as a gynecologic surgeon, do you have an opinion as to whether the care that Dr. Brill provided met the standard of care?

A Yes.

Q Can you -- what is your opinion, Dr. McCarus?

A Well, after reviewing material, the operative report, the pathology reports, what subsequently happened to Mrs. Taylor, going back and reviewing again the preoperative evaluation of Mrs. Taylor, the indication for surgery for Mrs. Taylor, the surgical choice that was made for Mrs. Taylor, I felt like Dr. Brill did not breach the standard of care. I felt like he did everything that was expected of him as a physician taking care of her.

Q And, Dr. McCarus, how do you -- as a gynecologic surgeon,

how do you define standard of care?

A Standard of care to me means what a similar surgeon would be doing in a similar situation in the care of that patient. That if I was taking care of Mrs. Taylor, it would have been the same type of care. If somebody in Texas or D.C. or South Dakota was taking care of her, it would have been standardized. It's the standard of care.

Q And when you are evaluating care and treatment and whether a physician met the standard of care, is that evaluation based on the benefit of hindsight?

A No.

Q Can you explain --

A No.

Q -- what you mean by that?

A I -- when I review a case, I'm very open to what happened. I don't want to just look at the end result. I want to look at the beginning because the end is directly related to the beginning. So I try to look, and when I've defended patients in my career a lot. So I try to look at was there a breach in the standard of care along the journey of the patient that did damage to the patient. I know the outcome, but I don't let that bias me.

Q Okay.

A I try to figure was it done correctly or not.

Q Do you believe that Dr. Brill's choice of Symphion as the resection device was an appropriate choice?

A I do.

Q And in terms of the outcome, is it your understanding that there was a uterine perforation during Dr. Brill's surgery?

A Yes.

Q Is it your understanding that there was also a bowel perforation during Dr. Brill's surgery?

A Yes.

Q Do you believe that those perforations occurred at the same time or at different times?

A Same time.

Q And in just a moment, I'll show you some illustrations and I'll have you explain to the jury how you believe the injury occurred based on your review of all these materials. But let's talk generally about uterine and bowel perforation.

A Okay.

Q Is uterine and bowel -- let's start about uterine perforation. Is uterine perforation, is that a known risk and complication of the procedure that Ms. Taylor had?

MR. BREEDEN: Object.

THE COURT: Thank you. Go ahead.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q Do you need me to repeat it?

A Please.

Q Is uterine perforation, is that a known risk and complication of hysteroscopy and the related procedure?

A It's a known complication associated with hysteroscopy.

Q And is it one of the most common surgical complications that can occur with hysteroscopy?

A Yes.

MR. BREEDEN: This is a continuing objection, Your Honor.

THE COURT: So noted. Thank you. Go ahead.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q And I'm sorry, Dr. McCarus, I didn't hear your answer?

A It is, yes.

Q Okay. In terms of bowel perforation, is bowel perforation a known potential risk and complication of hysteroscopy?

A It is.

Q Is it -- is it as common as uterine perforation?

A No. It's not a common complication.

Q Would you agree that -- do you believe that bowel perforation is more rare than uterine perforation?

A Yes. Definitely.

Q And in terms of that phrase that I've used, known risk and complication, can you explain to the jury what a known risk and complication, generally what it is?

A Okay. So when you do surgery, if you -- there's times where you can do surgery and you do everything that's expected of you, and you do it correctly and you can get a complication. There's times where surgery is not done correctly or not done appropriately and you can get a

complication. So there's known risks of complications associated with surgery. The whole idea is could the risk -- could the complication be avoided if things were done properly or not. And that's kind of how I think about it.

Q So in terms of uterine and bowel perforation, can those occur in a circumstance where the surgeon did not do everything correctly?

A Yes, ma'am.

Q Can uterine and bowel perforation occur in a circumstance where a surgeon did everything correctly?

A Yes, it can.

Q And what about the patient's anatomy, does the patient's anatomy play any role in the risk -- or known risks and complications or the occurrence of known risks and complications?

A Well, usually when somebody needs surgery, there's an abnormal problem. I mean we don't operate on normal patients. They don't need surgery. But usually if there is a problem affecting the quality of the life of the patient, then she's willing to accept the risk that's associated to feel better. All right. So that's the whole concept around surgery. I mean we don't do surgery on normal patients. Then if the patient has abnormal anatomy, that increases the risk.

Q And, Dr. McCarus, you reviewed Ms. Taylor's deposition in this case?

A I did.

Q And you recall her testimony that she had been dealing with this heavy uterine bleeding for many years?

A Right. Yes.

Q And I think she also mentioned an example of -- or excuse me. She also mentioned that she had been dealing with this since about the time of the birth of her son. Do you remember reading that testimony?

A I remember in Dr. Brill's records she had been seen every year prior to the surgery. I believe she was even on birth control bills, but they were making her not feel good. So she had been dealing with heavy bleeding and was treated with medical therapy, which is what you should do before surgery. And that wasn't working. And she -- I believe I read in the record where she actually knew about ablation and asked if she could have an ablation.

Q And you -- do you believe that the surgery that Dr. Brill discussed and recommended to Ms. Taylor, do you believe that that was an appropriate recommendation?

A Yeah. Heavy bleeding, the first thing we try is medical therapy. Then we try, depending on the patient, ablation. If that doesn't work, you try hysterectomy. So there's a stepwise kind of algorithm of care that you're supposed to talk to the patient about. And I feel like that was done.

Q So in the event that Ms. Taylor had undergone the ablation portion of the procedure and it not eliminated her heavy bleeding, what would have been the next treatment recommendation?

A Yeah. Ablations with -- in general with a normal uterus, ablations only work 90 percent of the time. In abnormal uteruses with

different shapes -- although the ablation that Dr. Brill chose was going to be a hydrothermal ablation, which is the perfect choice for Mrs. Taylor because her uterus had an abnormal shape, the ablation success rate goes down when the uterus is shaped differently. So she would have ultimately more likely than not needed a hysterectomy.

Q And when you say the success rate or the -- yes, the success rate goes down, did Ms. Taylor's anatomy play any factor in the complications that she experienced from the April surgery?

A Well, she had -- on imaging she had uterine fibroid. That was described and dictated in the report. And she also had a heart-shaped uterus. So --

Q When you say heart-shaped, is that another way to describe bicornuate?

A Yes.

Q I want to show you -- did Ms. Taylor also have what's called a retroverted uterus?

A She did.

Q I'm going to actually have a diagram --

A Okay.

Q -- that I'm going to show you.

MS. HALL: If I may approach, Your Honor?

THE COURT: Yes.

BY MS. HALL:

Q So, Dr. McCarus, if you want to come down here and -- I wouldn't get any closer to the jury than, you know, maybe here.

A Okay.

Q And I do have a pointer, if you'd like it. But I have some questions for you. So if you want --

A Okay.

Q -- come down, I'll grab that.

MS. HALL: Thank you.

BY MS. HALL:

Q Now, first and foremost, the diagram that you're looking at, is this a diagram of a retroverted uterus?

A Yes.

Q And can you explain to the jury in terms of a retroverted uterus, how does that differ from a normal -- or what's another word for a normal uterus?

A I'm going to do it this way because I'm -- can I flip this?

Q Yeah. Absolutely.

A Because it makes -- it's easier for me to do it this way.

Q Oh, gotcha. Okay.

A I told you I was from West Virginia.

But this is the patient laying on the bed. Laying flat down. Here's her pubic bone. She's laying. Yeah, this photograph shows her laying down. Here's her bottom. Here's her tailbone. Here's her back. Here's her belly. And here's her the pubic bone. When something -- when a patient's laying flat, normally you'd have the uterus that's like this. It's straight. It's midline. Anteverted means it points up toward the bladder. So it goes up. You can feel it when you examine the patient.

So this is midline. This is anteverted, pushing toward the bladder. Here's the bladder. And retroverted means when you lay flat on the table, it points back toward the rectum and the back of the patient. And this is a common -- I mean it's not abnormal. I think it's 20 percent of patients we see have a retroverted uterus. It's not anything abnormal. But it tilts back. And retroverted uteruses typically can be associated with heavy bleeding with more pain, more menstrual cramps, and pain with intercourse.

Q And you mentioned that you think about -- it's about 20 percent of women who have retroverted uteruses?

A Yep. Uh-huh.

Q What about a bicornuate-shaped uterus?

A So this is showing on a bicornuate looks like. We'll flip it back. It's easier to see it that way. So -- and remember everybody's got a uterus. So a uterus is like a pear-shaped, or some people say like a light bulb. It looks like a light bulb. So it's kind of round or pear-shaped at the cervix. And this uterus -- bicornuate means there's an indentation on top of the uterus. It's like heart-shaped where it indents. And that -- that's not anything so weird. We see that. It's not real common, but it's a normal kind of structural change.

Q Let me -- since you don't have, I think, the capability with your hands to demonstrate the shape of a bicornuate --

A Okay.

Q -- let me give you this --

A Okay.

Q -- [indiscernible] --

A I'm going to do a magic trick. So --

Q So, first and foremost, let me ask you a question --

A Yeah.

Q -- Dr. McCarus. Can you demonstrate for the jury with this [indiscernible] what a bicornuate-shaped uterus looks like?

A Yeah. This is what -- how I show patients. This is the way that I do it because, I mean, pictures are better. So -- and that would be kind of a normal uterus where you have this cavity and it's kind of shaped like that. So that would be normal. But a bicornuate has this indentation. So it kind of folds in and has a groove at the top, and then it wiggles down into the cavity. It makes the cavity a little more smaller in the surface area.

Q Does that --

A Kind of [indiscernible].

Q As a surgeon, does that shaped uterus pose challenges to the surgeon?

A Well, it depends on the degree of how much that indents in. Because I've got to get in here and work in this space. So it may crowd things a little bit. You have to be watching and being careful how you work in that confined space. If you take that and then flip it back, if you flip it back, and I'm going through the cervix here, I'm going to dilate the cervix here and you're going to push that scope in here, it really does increase the chance of poking a hole right in there. Poking a hole right into the anterior wall of the uterus. And, of course, the bowel can be

sitting up there.

Q Thank you, Dr. McCarus.

A Yeah.

Q The perforation to the uterus that Ms. Taylor experienced, where was that perforation?

A On the -- it was on the anterior wall --

Q Is that what you would expect to see if a perforation occurred from the resectoscope in a patient with this type of a uterus?

A Well, the one thing about surgeon, we know anything's possible. I mean you can perforate the back; you can perforate the top. But with the uterus going back like that, more commonly you would poke a hole anteriorly.

Q And is that where Ms. Taylor's perforation was located?

A Yes.

Q And in terms of the perforations that occurred during the surgery, do you have an opinion if those opinions were caused by neglect of the surgeon?

A No, I don't think they were caused by neglect.

Q And the anatomy of the patient, do you believe that played any role in the perforations that occurred?

A There -- it increased the risk because of the positioning and the -- the shape of the uterus.

Q I'd like to show you -- in your review of this case, did you conduct a thorough review of Dr. Brill's operative report?

A Yes, ma'am.

Q I'd like to show you that if I --
A Okay.
Q -- could. And it's previously been admitted as Exhibit 5?
MS. HALL: Can you start with page 42? Oh, thank you.
BY MS. HALL:
Q Now, in terms of Dr. Brill's operative report, did he identify a --
A Sorry.
Q That's okay. And, actually, I need a drink of water myself. So I'll take an opportunity.
In the operative report, did Dr. Brill document a finding of a uterine perforation.
A He did. It's a little bit -- I think it's on the next page --
Q It's on that page.
A -- of the report.
Q Complication. Thank you.
A Oh, there it is.
Q So do you see there on your screen -- I'm showing you page 42 of Exhibit 5. In his operative report, did Dr. Brill document identifying a uterine perforation?
A Yes, he did.
Q Do you have an opinion as to when the uterine perforation occurred?
A And if you -- if you -- I do. In you go under findings, it actually says that it's perforated anteriorly.

Q Oh, okay.

MS. HALL: Can you please blow that up --

THE WITNESS: Under findings.

MS. HALL: -- Mr. McBride?

MR. MCBRIDE: Uh-huh.

MS. HALL: My eyesight's not good enough to read that -- that fine of a print.

BY MS. HALL:

Q So in Dr. Brill's operative findings, what did he document, Dr. McCarus?

A He documented that the cervix was tight. It was stenotic. Meaning just real close. He had to dilate that. And then there was a small canal going to the right side of the uterus and a small one going to the left side. And that would be typical with the septum there. And then there appears to be a large uterine septum. There's a perforation in the uterus noted anteriorly just after the beginning of the resection.

Q Okay. And let's take a look at the second page of Dr. Brill's operative report.

MS. HALL: And it's HH43 in exhibit 5 for the record.

BY MS. HALL:

Q Now, in terms of the surgical technique that Dr. Brill used during the surgery, did you find any deviations of the standard of care in the surgical technique of Dr. Brill?

A No, I did not. And this is one of the better operative reports that I've reviewed. It's very detailed. He describes exactly what he was

doing and thinking and how he did it.

MS. HALL: Can you blow up the bottom of this operator report? Thank you.

MR. MCBRIDE: Uh-huh. The very bottom?

MS. HALL: The -- no. The second paragraph.

MR. MCBRIDE: Yeah.

MS. HALL: Thanks.

BY MS. HALL:

Q Dr. McCarus, based on your review of this operative report as well as Dr. Brill's deposition in this case, do you have an opinion as to when during the hysteroscopy the uterine perforation was caused?

A According to the operative report, it says, "As I was able to slowly advance camera, during the process, there did appear to be a uterine perforation." So in reading the information, my opinion is as he was advancing the scope, that's when he noticed the perforation. And that's typically what I've experienced in my surgeries when I've had perforations.

Q Now -- and that's a good point. In your practice as a gynecologic surgeon for over 35 years, have you yourself experienced a uterine perforation during hysteroscopy?

A Yes, I have.

Q How many hysteroscopies would you estimate that you've performed over your career?

A Well, I do about ten hysteroscopies a month. And it's been that way for probably ten years. So thousands.

Q And in the uterine perforations that you, yourself have seen in your practice, do you believe that you ever deviated from the standard of care in any of those instances?

A No.

Q And is it true that -- can you as a surgeon, even if you use appropriate technique in terms of your surgical technique, can you still experience a uterine perforation with a patient?

A You can.

Q And the operative report that Dr. Brill dictated, does he -- does he describe causing the uterine perforation with the resectoscope or resection device activated?

A He doesn't describe that. No, he doesn't .

Q There was some suggestion in this case. I want you to assume that Dr. Berke testified that when Dr. Brill documents I was able to see what appeared to be a white uterine septum, that suggests that he wasn't certain he was at the septum. Do you agree or disagree with that statement?

A I mean, i disagree with it, because when you look in the uterus, depending on what you see, things can appear to be white, can appear to be a polyp, can appear to be a fibroid, can appear to be a lot of things. So we don't always pigeon-hole what we see as exact. That's a typical way a surgeon would describe what they saw. Appears to be a septum. Appears to be a polyp. I've removed polyps, and they were fibroids. So you're not sure until you actually remove it and get the tissue and get it diagnosed.

Q Does that indicate -- that language in Dr. Brill's operative report, does that indicate to you that he wasn't aware of the area where he was in the uterus?

A No. It suggests to me that he saw an abnormality in the uterus. It looked like a septum. It appeared to be a septum. And he was thinking through what am I going to do next steps. And that's exactly what you should do.

Q And I apologize, Dr. McCarus, I don't think I asked you this. But what is a septum?

A A septum is a thickening of the tissue. An exaggeration of collagen tissue that creates an abnormality within the uterus.

Q Let me show you. I have another illustration. You won't need to get down for this one.

A Okay.

Q Actually I misspoke, Dr. McCarus, you may want to.

A Okay.

Q I just want to know, in terms of this diagram that I'm showing you, does this diagram show a septum?

A It's a nice diagram. I think it shows the indentation of the top of the fundus. This should be pear shaped, going up, where you can see it has the hard indentation. And it also shows an exaggeration of a thickened tissue. And if you put your scope in here, that's what you're going to see. It's going to look whitish. The septum itself does not have a rich blood supply. It's just a thickened growth of tissue. The uterus is very vascular. It has a very rich blood supply. But the septum is

relatively avascular, that's why it appears to be white.

Q And when you say avascular, would you expect to see blood in the area if you resected this avascular tissue?

A No.

Q All right. You can take your seat again. Thank you, Dr. McCarus. In terms of the operative report, Dr. Brill documents that he -- there's no obvious fibroids seen at the right side because there was white tissue here, and I felt that there could be septum covering this area. And now based on that, Dr Brill -- is it your understanding that Dr. Brill then made the decision to switch over to the resectoscope?

A Yes, ma'am.

Q Did Dr. Brill, per his operative report, did he encounter any issues dilating the cervix for Ms. Taylor?

A No.

Q And once he switched over to the resectoscope, first and foremost, was it appropriate to do that?

A Yes, it was.

Q And the -- then was Dr. Brill able to place the Symphion into the hysteroscope that you showed us?

A Yes.

Q And once he did that, was he able to visualize the septum?

A Yes.

Q And in fact, in his operative report, he documents was able to visualize what appeared to be the septum. Does the fact that he used the language what appeared to be the septum, does that, as a surgeon,

indicate to you that Dr. Brill was not aware of where he was in the patient's uterus?

A Not at all. That's typically how you would dictate it.

Q Once Dr. Brill identified the septum, what did he do next, per his operative report?

A He then was starting to resect it. He thought well let me get rid of the septum, so I can see if she has a fibroid. So he used the yellow pedal. He began to cut what appeared the septum anteriorly.

Q And once Dr. Brill resected tissue, what's the next thing he did as described in his operative report?

A And -- I mean, and then it says as I was able to slowly, which is what you should do. You don't force the resectoscope with a strong thrust. You slowly advance the -- my impression of this when he says advance the camera, he's holding the resectoscope. He really means I'm advancing the resectoscope. But the camera's on your -- on the head of the resectoscope.

Q It's not inside the patient's body?

A Right. Right. But he means he's advancing his equipment to go ahead and try to work more. And as he slowly is advancing the camera, during the process, there did appear to be a uterine perforation.

Q Now in your opinion, was Dr. Brill activating the resection device at the time the uterine perforation occurred?

A No.

Q And what -- when do you believe the uterine perforation occurred?

A When you advance the camera, or advance the resectoscope, you're not -- you're not activating it. Right. So he's advancing it trying to get it in position to move that little aperture, that opening, to get it to abut up to the septum, then he hit the foot pedal. So he's advancing it, trying to get it in position. And then as he advances it, he notices a perforation. Which is -- which is really typically, in my experience how this happens. You never know -- you're not anticipating a perforation, right. I mean perforations are spontaneous. You're not trying to perforate a patient's uterus. You're trying to work in that space and in my experience. And I would say every perforation I ever had; it just happens. You don't anticipate it. You don't want it to happen. It just happens.

Q The bowel perforation that Ms. Taylor experienced, do you have an opinion as to whether that occurred at the same time as the uterine perforation?

A I think it did. I think they happened at the same time.

Q And in -- if the perforations occurred when Dr. Brill was advancing the camera, and not activating the resection device, should he have been able to visualize those perforations occurring?

A Of the bowel? Are you talking about the bowel?

Q Of the uterine and the bowel, yeah. The uterus and the bowel.

A When perforations happen you don't -- it's always after the fact. You don't push into the muscle and wait to see a perforation. You're working in this cavity, and you're trying to do the operative

procedure. So all of a sudden you see a hole. And it's spontaneous.

Q When there is a perforation of the uterus, is it possible for the surgeon to lose distention of the uterus?

A Oh, that always -- that always happens.

Q And I don't know if I've gone over that, but can you explain to the jury, when we say distention of the uterus, what are we referring to? What are you referring to?

A Well, remember we were talking about, you put the scope in. You have the water come in, the distended. That's distention. You have to create an operative field. So the water's coming in under that pump, it distends, or blows up the cavity. And then if you poke a hole, or if you get a perforation, then that water leaks out and you lose your distention, and it's harder to see.

Q I want you to assume that Dr. -- in terms of a perforation, in the occasion -- on the occasions where you've encountered a uterine perforation, do you typically suture a uterine perforation?

A No.

Q Is the uterus self-repairing?

A Yes.

Q And what does that mean?

A That means this is a muscle. So when you irritate the muscle, the reflexes contraction. So a blunt -- a blunt perforation, the tip is not sharp. It's a blunt pushed through. When you pull that back, that muscle contracts.

Q And is it your understanding, Dr. McCarus , that Dr. Brill did

not need to suture the -- did Dr. Brill need to suture the uterus and the uterine perforation that he noted in that April 26th surgery?

A He did not -- he did not need to suture the perforation.

Q And in fact, you've reviewed the operative report of Dr. Hamilton, the general surgeon who did the bowel resection the following day, correct?

A I did.

Q And in reviewing Dr. Hamilton's operative report, did she suture the uterine perforation?

A No.

Q Do you recall seeing in Dr. Hamilton's operative report that at the time she went in to explore the abdomen, there was already a clot formed at the uterine perforation?

A Correct.

Q Now I want to talk to you just a bit about -- now you weren't here for Dr. Berke's testimony, Plaintiff's expert?

A No.

Q I want you to assume that Dr. Brill -- excuse me, Dr. Berke, testified about the curette that Dr. Brill used. First and foremost, in Dr. Brill's operative report, explain to the jury what's documents regarding the curette that was applied.

A Well, he mentioned that there's no evidence of bowel or any other organ in the area of the uterine perforation, which is what you should do.

Q May I interrupt right there?

A Yeah.

Q What is the -- and that's my iPad, I apologize. It will come back in just a moment. But in terms of him documenting that there was no bowel in the area, what's the significance of that, Dr. McCarus?

A When you do get a uterine perforation, before the uterus contracts and closes, you can see the perforation. That's how you diagnose it. You can see there's a hole. And the scope is right there. So it's almost like you can look through that hole and see in the other side. And what we're trained to do is to do that. To look and see if there's any signs of any injury to any other organs.

And you also have the appearance and impression that it's a clean perforation. You didn't burn it; you didn't cut it. It's a blunt perforation. So if you look in there, and everything appears normal, that's what's documented here. And that's the standard of care. And that's what you're supposed to do.

Q And you've read Dr. Brill's deposition testimony where he described visualizing the uterine perforation and looking through and seeing no evidence of any other organs.

A Well, he actually did it twice. He did it at the time of the resectoscope when the perforation occurred. And then he took -- he stopped, which you're supposed to do. Took the resectoscope out. Then he put the smaller diagnostic hysteroscope in to double-check. And he could see it again. He looked twice. And then he pulled it out and said, okay, I'm comfortable. There isn't any major complication that I can detect, and then he stopped.

Q Given that information, Dr. McCarus, did the standard of care require Dr. Brill to do a diagnostic laparoscopy and run the patient's entire bowel?

A No. Not in this case, no.

Q And why is that?

A Because blunt injuries as Dr. Berke also said in his deposition, you don't have to do a laparoscopy or exploratory procedure if it's a blunt type of uterine perforation, and you've looked and done those things. You don't have to do any more surgery at that point.

Q Once the perforation of the uterus, though -- once that uterine perforation is identified, does the standard of care require the physician not to proceed with resection or further resection of the septum?

A It -- the standard of care does require you to not do any more operative surgery.

Q And that would include -- it requires -- does it also require the surgeon not to remove fibroid if that was the --

A Correct. You would not do that.

Q And in terms of --

A And you would --

Q I'm sorry, go ahead.

A And you wouldn't do an ablation. You wouldn't do any further operative procedures.

Q Dr. Berke, Plaintiff's expert, testified that the surgeon also should not use a curette. Do you agree or disagree with that opinion?

A I would disagree with him on that. I don't think he has enough experience, as a younger surgeon to understand you can do that. I've done that several times in my practice. If you're careful and you don't do an aggressive curettage. You want to just get enough tissue to make sure there's no cancer or hyperplasia or any other abnormalities in the patient's lining, you can do that. And I've done that myself.

Q So actually have -- I have a curette here. It's a little bit different size than the one that was used for Ms. Taylor, because Dr. Brill's operative report says a number 2 --

A Correct.

Q -- curette was used. But may I approach, Your Honor?

THE COURT: Uh-huh.

Q I just want to show you this and then I want you to explain the jury what a curette is and how you use it to do what's described in Dr. Brill's operative report.

A A curette is an instrument that allows us to -- I know it's kind of a terrible term, but it's scraping. Because if I scrape hard enough, you can hear it here. You actually can. So you can scrape tissue. It's got a little rounded edge. This one's a bigger one. But you can scrape and draw some tissue out of the uterus. It's a common procedure that OBGYN's do. And knowing that the uterus was perforated, according to the operative report, he went in carefully and went posteriorly, not anteriorly.

It wouldn't be appropriate. It would be a breach of the

standard of care to go in anteriorly and curette where you know there's a hole. So you can go in the cervix, go posteriorly and do a gentle curetting. I think that's appropriate. I disagree with Dr. Berke saying that that shouldn't have been done.

Q Well, and in fact, Dr. McCarus, in Dr. Brill's operative report, does he document that he did not palpate or was not working in the area of the uterine perforation?

A Yeah, and the pathology report for the tissue was normal, appropriate. There was no complication from doing the curetting.

Q You, as a gynecological surgeon, do you believe that it was appropriate to use a curette, even in the circumstance of an identified uterine perforation?

A Yes, I do.

Q Do you believe that the -- you mentioned that you don't believe that the curette or the curettage that was performed, had any involvement in the perforations; is that true?

A That's correct. I would agree with that.

Q The -- well, actually, let me take that back from you.

A Okay.

Q Now the bowel perforation that was experienced by Ms. Taylor, was that identified during Dr. Brill's surgery?

A No.

Q Was that below the standard of care?

A No. Matter of fact, most small bowel injuries are not diagnosed during the procedure.

Q And the specimen that you mentioned, the surgical specimen from Dr. Brill's surgery, I'd like to show you that.

A Okay.

Q Now this was previously admitted Exhibit 3, which is Dr. Brill's office chart. And you already told us, Dr. McCarus that when tissue is resected or there is a curettage, the entire specimen is sent to pathology; is that true?

A Yes, ma'am.

Q And in terms of -- I want to show you this. It's page 4 of Exhibit 3. This is the surgical pathology report from the specimen that was sent to pathology following Dr. Brill's surgery. First and foremost, do you see any evidence in this pathology report that there was bowel identified in the specimen?

A No. There's no bowel identified in this pathology report.

Q Generally what sort of language would you be looking for, or expect to see in a pathology report if bowel is included in the specimen?

A Well, you would see completely different description. You would see different cells. You would see histologically what the bowel looks like under the microscope. You would -- they would identify it as bowel.

Q And tissue -- the -- or the final diagnosis of the surgical pathologist, he notes that there was endometrium. Is that consistent with bowel?

A No.

Q He notes that there was endocervix and squamous mucosa

of the cervix. Is that consistent with bowel?

A It is not.

Q There was some testimony -- I want you to assume that Dr. Hamilton testified in this case that in her experience, there would not necessarily be any description of thermal injury in a surgical pathologist report. So with that in mind, have you, yourself, Dr. McCarus, have you had occasion during your career, to review surgical pathology reports?

A Yes, ma'am.

Q Have you also had occasion to review surgical pathology reports that describe a thermal injury to tissue?

A And you're talking about the bowel now, right? The bowel report.

Q Yeah.

A Not this report.

Q We'll get there in just a second and I'll show you the actual report.

A Okay.

Q But in terms of thermal injury and any information on a surgical pathology report, have you had occasion in your career to review surgical pathology reports, describing thermal injury?

A Yes.

Q Okay. And in a moment I'll show you that -- I'll show you that surgical pathology report.

A Okay.

MS. HALL: Your Honor, would now be a good time for an

afternoon break?

THE COURT: Sure. All right. We're going to take an afternoon bathroom break, or a ten minute break. 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 I'll see you in ten minutes.

THE MARSHAL: All rise for the jury.

[Jury out at 3:36 p.m.]

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

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. And Dr. McCarus you're admonished not to speak with anyone about your testimony. You're still under oath.

THE WITNESS: Okay.

THE COURT: Thank you. Any issues we need to talk about before the break?

MR. MCBRIDE: Do we have any objections? Yeah, I don't believe so.

MS. HALL: I don't think so.

MR. MCBRIDE: Yeah, I don't think so.

THE COURT: Okay, all right.

[Recess taken from 3:37 p.m. to 3:49 p.m.]

[Outside the presence of the Jury]

THE COURT: All right. We're back on the record in case number A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We're outside the presence of the jury. And are we ready to bring them back in?

MR. BREEDEN: I think so, Your Honor.

MS. HALL: Yes, Your Honor.

THE COURT: All right. Are you guys okay if -- I don't know how long cross is going to take, but I assume he can't stay over the weekend?

MS. HALL: He has a flight tomorrow.

THE COURT: So if we go a little bit past 5, are you guys fine with that?

MR. BREEDEN: Yeah. I think just from a scheduling perspective, this will be the last witness of the day.

THE COURT: Right.

MR. BREEDEN: And then on Monday, we'll come back, and Plaintiff's next witness will be Dr. Brill.

THE COURT: Okay. All right.

THE MARSHAL: All rise for the jury.

[Jury in at 3:51 p.m.]

THE MARSHAL: The jury is clear -- or I'm sorry. The jury is all present, Your Honor.

THE COURT: Thank you. You may be seated. All right. We'll continue with Dr. McCarus. And Dr. McCarus, you understand you're still under oath?

THE WITNESS: Yes, ma'am.

THE COURT: Thank you.

DIRECT EXAMINATION CONTINUED

BY MS. HALL:

Q Dr. Harris, I want to show you the pathology report from the surgical pathology for Dr. Hamilton's surgery. And it's Exhibit 1. And we'll start with 11/21. Dr. Hamilton testified on Wednesday in this trial. If she testified that the surgical pathologist measurement of a perforation is the most accurate measurement, is that a statement that you agree or disagree with?

A I would agree with that.

Q And can you explain to the jury why it is that the surgical pathologist's description is generally the most accurate of the size?

A Well, when you have the specimen, you have -- you send tissue to the pathologist. They actually measure. Part of their job is to

take measurements. They do it every day. They measure the length, the thickness, the diameter, the width of whatever tissue they're examining. And the same thing would go -- would be true if there is a hole in the bowel. They would measure that with specific tools.

MS. HALL: Now, if I could have that back up please, Mr. McBride?

BY MS. HALL:

Q The measurement that the surgical pathologist found in terms of the bowel perforation; what was that measurement?

A 1.6 by 1.2 centimeters.

Q The resectoscope, you said that's the entire unit -- the hysteroscope as well as the resection device in the channel?

A Correct.

Q The diameter or the tip of that resectoscope; is it 1.6 or 1.2 centimeters?

A No.

Q How is it possible to get a bowel perforation, which is 1.6 by 1.2, with the resectoscope and the blunt tip of that device?

A Well, that tissue contracts -- or it moves, it pulls in when you -- when you poke a hole in the bowel. The bowel, as you know, is a very contractile organ. It's peristalsis to move fluid and stool through it. So when you poke a hole in it and as it gets inflamed or as the injury starts to try to repair itself, it can -- it can open up. And it can be measured -- I mean, we don't -- we don't look at the size of an instrument to correlate exactly with a measurement on tissue. That's irrelevant to

anything that we do as surgeons.

Q And in terms of a patient's bowel -- and actually, let me show you on this diagram. Thank you. Oh, thanks. My brute strength. Thank you, Dr. McCarus. And I just -- really briefly. You don't need to leave the stand. Thank you, Dr. McCarus. I just wanted to ask you in terms of on this diagram, the pink and brown tissue up here, is that the patient's bowel depicted on this diagram?

A Yes.

Q In the abdomen, is the bowel in a straight line or does it loop back and forth over one another?

A It loops back and forth.

Q So simply because a 1.6 by 1.2 defect was found on the surgical pathology following Dr. Hamilton's surgery, does that mean that the defect was that size at the time that it occurred?

A No.

Q And I want to talk to you just a bit about the surgical pathologist's description of the specimen. First, does a surgical pathologist examining a specimen do both a gross and microscopic examination?

A They do.

Q And in terms of their analysis, does a surgical pathologist need to be told to look for any evidence of thermal injury to tissue?

A No, we don't request that when we send a specimen to the pathologist.

Q Earlier, I mentioned that Dr. Hamilton when she testified, she

said that in her experience, she doesn't see surgical pathologists describing thermal injury or mechanism of injury on pathology reports. Has your experience been different?

A It has been.

Q And can you explain to the jury in terms of in a circumstance where an injury occurred through thermal means, what sort of language would you be looking for in the gross or microscopic analysis of the surgical pathologist?

A So when there's a complication to the bowel and there's a second surgery to fix the bowel, we send that bowel to the pathologist. Usually, an astute pathologist would wonder, as we would, what was the mechanism of that bowel injury? Most commonly, bowel injuries are from thermal injuries. You know, heat. You're working and you're too close to the bowel, so there's a thermal injury. And that will show a totally different description than what we see on this gross description. So what I would -- what I've seen and would want a pathologist to tell me is if there is ischemia.

Because when you burn something, when you devascularize through heat part of the bowel, you cause ischemia. The blood -- the oxygen to that part of injury is gone, so you get ischemic changes that you can see under the microscope. Certain cells migrate into that area. The bowel tries to heal up on its own, but if it's a thermal injury, it's necrotic, it's dead, so it can't. So those are types of things that you would see on a pathology report if it was a thermal injury versus a blunt injury.

Q Might you also see thermal artifact described?

A Yes, you can.

Q Explain to the jury what thermal artifact is.

A There's some tissue change from just heat that shows up on staining because you got to cut this tissue and slice it, and then do stains. And an artifact means it's nonspecific. That they'll put it as a finding to let you know there have been changes that I really can't describe. And that's what an artifact would be.

Q The language of that surgical pathology report. Is there any description of ischemia?

A No.

Q Is there any description of ischemic necrosis or necrotic tissue from ischemia?

A No.

Q Is there any description of thermal artifact?

A No, ma'am.

Q The pathologist does note a transmural defect. Can you tell the jury what transmural means?

A Transmural means if you -- the small bowel is like a watering hose. There's a lot of it, and it's circular. So you have a circular organ. Transmural means the defect goes through the entire wall of that area. So it's all the way through. It's not a surface injury. It's a transmural, meaning it poked all the way through the wall.

Q And in your opinion, would that be consistent with an injury caused by the blunt tip of the resectoscope?

A It would, yes.

Q And the perforation that was identified during the surgery, the uterine perforation. Did the standard of care require Dr. Brill to discuss that complication with Ms. Taylor in the recovery area?

A No, not in recovery.

Q And why is that? Can you explain that to the jury?

A Yeah. In recovery, patients are waking up from anesthesia. And, of course, you know anesthesia, you're not thinking clearly. You're -- you've got IV drugs that put you to sleep. And when you wake up, you can talk. And, like, I'll take to a patient in the recovery room, and I'll tell a patient something.

And then I'll see her maybe the next day on the floor; she doesn't even remember talking to me. She'll answer; the patient will answer your question, but she doesn't remember that. So typically, I don't talk to patients in the recovery room because I know they're not going to remember.

So it's not required -- it's not a standard of care approach to always talk to a patient in the recovery room. Some doctors do, but you're not required to do it.

Q And what do you believe in terms of communication about the uterine perforation? What do you believe was required by the standard of care?

A The patient needs to be told there was a perforation. I mean --

Q And would it be appropriate to discuss the perforation with a

patient's family member who is present at the hospital?

A That would be appropriate. Yeah.

Q And you've read Dr. Brill's testimony and his testimony that it's his recollection he spoke with a Barbara regarding the uterine perforation and being unable to finish the remaining portion of the surgery?

A Yes.

Q Would that be appropriate to do?

A Yes, it would.

Q Would that meet the standard of care?

A It would.

Q You are, however, aware Dr. McCarus, that Ms. Taylor does recall speaking to Dr. Brill in the recovery area?

A Yes.

Q In terms of your experience, when a patient is coming out of anesthesia -- you touched on this a bit. But would it be common for them to have a vivid recollection of any conversations?

A Not usually, no.

Q Dr. McCarus, do you believe that an OB/GYN who's using a resectoscope for this type of a procedure needs to use their skill, training, and experience to avoid injury to the uterus to the extent possible?

A I do.

Q And do you believe that an OB/GYN using a resectoscope for this type of a procedure needs to use their skill, training, and experience

to avoid injury to the bowel to the extent possible?

A Yes, I do.

Q Do you believe that Dr. Brill did that here?

A Yes, I do.

Q And despite that, did this patient experience a known risk and complication?

A She did.

MR. BREEDEN: Objection.

THE COURT: Thank you. Overruled.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q Do you need me to repeat that, Dr. McCarus?

A No.

Q In terms of the injury that occurred with respect to Ms. Taylor's bowel and uterus, do you believe that was an injury that was avoidable?

A Yes.

Q And explain what you mean by that.

A Things can happen that -- or occur because of neglect, and things can happen because of patient's anatomy. I think if she would have had a normal uterus in the right position, it wouldn't have occurred. I think her anatomy with the shape of the uterus and the septum, and the fibroid increased her risk for the complication.

Q And have all of the opinions that you've stated here today been to a reasonable degree of medical probability?

A Yes, ma'am.

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

BY MS. HALL:

Q One thing I did want to ask you. Dr. McCarus, when you mentioned the discussion with the patient that's required by the standard of care, can you tell the jury is there a typical -- would it be typical to have a postoperative visit with a patient after a procedure like this one to two weeks after the procedure?

A Yes.

Q Is that a typical time period in which you would see a patient back for follow up?

A That's -- yes, one to two weeks postop is.

Q And would the standard of care require -- would the standard of care require the surgeon at that postop visit to discuss the perforation that was encountered during the surgery?

A Yes.

Q And is it your understanding that Dr. -- that Ms. Taylor did have a postop visit scheduled with Dr. Brill?

A Yes.

Q Now, in terms of your review in this case, were you asked to evaluate the care and treatment of any other providers involved in Ms. Taylor's care other than Dr. Brill?

A No.

Q Did you -- in reviewing the medical records, did you see any indication that once Ms. Taylor was in the recovery area for that seven

and a half hours, the nurse made any effort to contact Dr. Brill?

A No, I didn't see any indication of that.

Q Did you see any evidence that Nurse Hutchins made any effort to contact any OB/GYN?

A I didn't see any documentation that would support that.

Q And again, Dr. McCarus, have all the opinions that you've stated here today been to a reasonable degree of medical probability?

A Yes, they have.

Q Thank you very much.

MS. HALL: I'll pass the witness, Your Honor.

THE COURT: Thank you. Cross-examination?

MR. BREEDEN: We good?

MS. JOHNSON: Yes.

CROSS-EXAMINATION

BY MR. BREEDEN:

Q I'll go ahead and get started here while the tech is working. Doctor, good afternoon. First of all, this case concerns a Symphion resectoscope, correct?

A Yes.

Q And you've testified you do not use that in your own clinical practice or on your own patients, correct?

A Correct.

Q There are other similar devices that you use, right?

A Correct.

Q And hypothetically -- or I'll ask you to assume that Plaintiff's

expert, Dr. Berke, came in here yesterday and testified the same thing. That he uses a similar device but does not use the actual Symphion system. My question to you is do you think an expert has to personally be using these on their own patients in order to be able to testify as an expert on this case?

A No. I think the expert needs to have a fund of knowledge and understand the equipment and how it works and those sorts of things, but not actually have to use it on a patient.

Q Okay. So let's talk about this device a little bit. It has some safety features built right into the design, doesn't it?

A Yes.

Q And you talked about the blunt tip, right? In other words, I can touch it here and it's not going to hurt me; it's not sharp like a needle, correct?

A Correct.

Q That's a safety feature designed to reduce or eliminate the risk of perforations, isn't it?

A Correct.

Q And that's different from some older devices that have kind of like either prongs or loops or a rollerball on the end, correct?

A Correct.

Q Okay. This is an improved design of that, wouldn't you agree?

A Yes.

Q And the reason for the improvement is safety to prevent

perforations, correct?

A Correct.

Q Harder to cause a perforation with this instrument that with some of the older instruments, correct?

A Correct.

Q And then it also has what you would call a resecting window; do you see that?

A I can't see it, but I know what you're talking about.

Q You have some pretty good eyesight, sir. I'm going to give you credit that you saw it anyway, all right?

A Okay. Thank you.

Q That's also a safety device designed to reduce or eliminate the risk of perforations, isn't it?

A That's a safety device to be more accurate in resecting the tissue. The angle improves a safer resection. I'm not sure if the aperture was designed to prevent perforation.

Q Okay. Do you think --

A The blunt tip -- the bluntness of the instrument definitely is.

Q And of course, this instrument, I can touch it, and I can run my skin over it, and it's not cutting me right now because you have to activate it with energy by using the pedal in order to activate the cutting element and the electricity, correct?

A Correct.

Q And that's another safety feature designed to reduce or eliminate the risk of perforation, isn't it?

A I don't really know if that's to eliminate perforation. I think that's to get better access to a specific area of the tissue you're resecting. So it may improve the efficiency of the technique, which ultimately may decrease a perforation. But in my understanding of that device, the blunt tip is really -- the claim the company makes is really the blunt tip is what they say helps decrease perforation.

Q So Symphion itself has told you that that blunt tip is designed to reduce occurrences of perforation?

A That's correct.

Q All right. How many hysteroscopies have you performed in your career?

A You asked me that once before, and I didn't know then and I don't know now, but it's been thousands.

Q Okay. And that's what you testified before that you would estimate you've performed thousands.

A Correct.

Q Okay. So let me ask you. In all of those thousands of hysteroscopies that you yourself have personally performed on your patients, how many bowel perforations have you ever caused in your career?

A Thankfully, none.

Q Okay. And in fact, if we talk about all the OB/GYN experts that are going to testify during this trial. Dr. Brill's testimony is, other than Ms. Taylor's case, he has never caused a bowel perforation during hysteroscopy; do you recall that?

A I do.
Q That was in his deposition, right? You reviewed that?
A Yes, sir.
Q And Dr. Berke, who testified yesterday as Plaintiff's expert, has testified in the hundreds of hysteroscopies he has performed, he's never caused a bowel perforation; do you recall that?
A Well, I wasn't here yesterday. But in his deposition, I do remember him saying that.
Q Yeah. You've reviewed his deposition, so you know he's testified in that manner, correct?
A Correct.
Q Incidentally, were you provided with a transcript or a video of Dr. Berke's testimony?
A No. You mean of yesterday?
Q The testimony yesterday.
A Oh, no.
Q Okay. And so in fact, that's -- all the OB/GYNs testifying in this case have never -- other than this case, other than Ms. Taylor's case -- have never perforated the bowel before in hysteroscopy. And isn't that because it's incredible difficult to do if you're using the required skill, training, and experience to perform that procedure?
A It's a rare complication; I think we all agree on that. But you also have to factor in the distorted anatomy that we're working on increases the risk. I think -- I think we agree it's rare.
Q I'm going to ask you a question of law because it reflects on

your medical opinion. So that's why I'm doing that. Is it your understanding of the law that just because you call something a risk or a complication, the physician is not responsible for it?

MS. HALL: Objection, Your Honor. This -- we could approach, if you'd like?

[Sidebar at 4:12 p.m., ending at 4:14 p.m., not transcribed]

MR. BREEDEN: Thank you, Your Honor.

BY MR. BREEDEN:

Q I'm going to rephrase a little bit, Doctor. I just want to sort of recap your testimony from earlier. Your testimony is that your opinion is some perforations are a result of neglect by the physician and some are not; is that your testimony?

A Yes.

Q Okay. Now you've served as an expert witness in many lawsuits, haven't you?

A Yes.

Q And, in fact, you've given deposition testimony over 60 times; is that correct?

A Yes.

Q Do you've been disclosed as an expert in well over a hundred cases?

A I'm not sure what you mean. You mean disclosed as an expert? You mean have I been asked to look at over a hundred cases?

Q Yes.

A Yes.

Q Okay. And you say it's about ten percent of your income, this litigation work, as opposed to seeing patients?

A Yes.

Q Okay. And in all the time that you have testified, isn't it true that you have never testified that a uterine perforation during hysteroscopy is below the standard of care for a physician?

A Yes.

Q Okay. You have only testified that that does not violate the standard of care, right?

A Well, I've only had two cases where there's been a uterine perforation that I've been an expert witness on, so in those two cases, yes, I didn't find neglect, and Mrs. Taylor being one case, only had one other case, so in two cases, I didn't find neglect in those two cases.

Q So the particular issue in this case, you've only weighed in on that issue in this case and one other case?

A As far as a hysteroscopic perforation, correct.

Q Okay. Now you've testified in other gynecological surgery cases regarding hysterectomy and the standard of care, correct?

A Yes, sir.

Q And, in fact, in three different cases concerning hysterectomy, you've testified that bowel perforation is below the standard of care in those cases, didn't you?

A Yes, I did.

MS. HALL: Objection. Relevance, Your Honor.

THE COURT: Counsel approach.

[Sidebar at 4:12 p.m., ending at 4:14 p.m., not transcribed]

BY MR. BREEDEN:

Q You believe at least some bowel perforations during hysteroscopy can be negligence on the part of the physician; isn't that true?

A That, yes, sir.

Q Okay. Kimberly Taylor had a retroverted uterus, I think most of the witnesses have talked about this so far. Is it possible, in your opinion, to safely perform a fibroid resection procedure on such a patient?

A Yes.

Q And you can do that, in your opinion, without perforating the uterus or the small bowel?

A You can.

Q And, in fact, you've safely performed fibroid resection on your own patients, in your own practice, and not caused perforations; is that true?

A That's true.

Q I'm going to ask you the same question about a bicornuate uterus. Is it possible to safely perform fibroid resection on a patient with a bicornuate uterus?

A It is.

Q And you're able to safely do that without perforating the uterus or small bowel?

A You can.

Q And you've safely performed fibroid resection on such patients with a bicornuate uterus in your own practice without causing perforations?

A Yes.

Q Would you agree with me that if Dr. Brill felt for some reason, due to Kimberly's anatomy, he couldn't safely perform the procedure, he shouldn't have tried to perform it at all?

A I would agree with that.

Q Okay. The standard of care would require him if he truly felt that her anatomy was so unusual that he could not safely operate, he should not have operated at all, true?

A That's true.

Q All right. And you agree that Dr. Brill perforated Kimberly's uterus during the procedure?

A Yes.

Q And at what point in the procedure, and how do you believe he did that again?

A I believe it was a blunt perforation at the time of advancing the resectoscope into the uterus.

Q Okay. So your testimony is a little different from Plaintiff's expert, Dr. Berke, because you do not believe this injury occurred during the use of the yellow pedal, correct?

A Correct.

Q You instead think Dr. Brill just used so much force with the blunt tip that it went all the way through the uterus and into the small

bowel, correct?

A That's correct.

Q Are there, in your opinion, at least some such cases where you would say the physician was negligent in doing so?

A Well, I mean, that -- I need information about it. I mean, you just -- what happened, what was the uterus, were there fibroids, was there a septum, was there a polyp, was it a big uterus, was it a normal -- I mean, you've got to look at all the information to answer the question.

Q Well, let me ask you. I think you testified you have to be careful when you're using this device not to apply excessive force while you're inside the uterus, correct?

A Correct.

Q All right. And so do you think it's excessive force if you use this instrument so hard that you put a hole right through the uterus and into the small intestine; would that qualify as excessive to you?

A Well, you can get a perforation without excessive force. You can get a perforation with normal force.

Q Now let's assume for a moment that your theory is correct, and this perforation entry was caused with the blunt tip of the instrument, okay?

A Uh-huh.

Q During this procedure, if the doctor contacts the uterus with the blunt tip of the instrument, would you agree with me that the doctor should be able to feel that?

A Well, you can't feel with that instrument. You can't feel. You

can see, but you can't feel. When you touch the uterus in a water-filled cavity, you really don't feel how deep you're going into that structure. It's very soft, you know, it's not like you're hitting up against this wall, so you're advancing under vision more than feel, and that's why perforations catch you off-guard, because you don't -- if you felt, you wouldn't keep pushing, so you are visually trained to operate in a cavity, and before you know it, you've got a perforation. You didn't do it on purpose, you didn't push to make it happen, you can't feel with that.

Q All right. But there are parts of the procedure, for example, sounding the uterus, where that is done, and the procedure is --

A That's by feel.

Q That's by feel?

A That's by feel. When you're dilating the cervix with that cervical dilator, you can feel that because you're pushing up against the wall, but when you're in a fluid cavity, operating, you're not really feeling, oh, let's see, I'm getting close to a perforation, I better back off. You can't feel that.

Q So you're telling me you don't think a doctor would feel any resistance from the uterus as he pushed the blunt tip through it with a resectoscope?

A You don't push -- you don't push it through it. When you have a -- if you have a septum, you're up against it visually, you see what you're doing, you hit the foot pedal, and it starts working. You're not operating in the uterus muscle; you're operating in the diseased area.

Q Fair enough, but that's Dr. Berke's theory of this case, that he's using the yellow pedal and energizing it. I'm talking about your theory of the case where we're only talking about the blunt tip and the instrument isn't energized.

A Yeah, so --

Q Under that theory --

A Uh-huh.

Q -- you would feel some resistance from the uterus, wouldn't you?

A Well, you -- your -- you feel, but you don't know when that perforation is going to occur. Right? That's why you're always watching. Perforations occur and you visually diagnose it. You can't anticipate.

Q Would you agree with me that in no place on Dr. Brill's operative report does it indicate he felt any resistance from the resectoscope?

A I don't remember him ever mentioning anything about resistance.

Q And you believe that Dr. Brill perforated the small intestine at the exact same time that he perforated the uterus, correct?

A Correct.

Q You don't think those were two different occasions or with different instruments, you think it was both with the blunt tip of the instrument, correct?

A Correct.

Q Generally speaking, do you think a surgeon must use his or her skill, training, or experience to avoid uterine perforations to the extent possible?

A Yes, I do.

Q And you also agree that a surgeon must use his or her skill, training, and experience to avoid a bowel perforation to the extent possible, correct?

A Correct.

Q Now the part of Dr. Brill's procedure where he perforated the uterus and the small bowel, was that a blind portion of the procedure?

A Well, I don't know if you can -- you have to think about that because again, the perforation is spontaneous, so I'm work -- you can be working right in an area, all right, and all the sudden there's a perforation, so you see it. That's what he described in his operative report.

So it's not, you don't blindly do anything. You're operating, the anatomy's what it is, and you're working, and the next thing you know there's a perforation, so you don't really know that's going to happen.

Q Okay.

A That's why we know perforations are known to occur at the time of operative hysteroscopy.

Q So there are a lot of issues in your response, and I want to talk about them. First of all, you say that perforations are spontaneous, but you mean your observation of them during the procedure is spontaneous; is that how you're saying that?

A Yeah. Yes.
Q Okay.
A Yeah.
Q You don't mean you're just in there working and you --
A No.
Q -- never touch the uterus, and spontaneously, the perforation forms?
A No, that's correct.
Q Okay.
A I don't mean that. I mean when you diagnose an interoperative perforation, it's a spontaneous event.
Q Yes. One way or another, during Dr. Brill's procedure, this instrument or an instrument like it was physically pushed through the uterus and into the small bowel, correct?
A Yes.
Q All right. Do you agree that the standard of care for hysteroscopy requires the physician to be able to visually see where he or she is within the uterus at all times?
A Yes.
Q And that would mean if Dr. Brill had met the standard of care in this case, he should have actually seen the moment he perforated the uterus and the small bowel, would it?
A The uterus, he would see as it occurs. The small bowel, you may not see.
Q And that's not what he recorded in his operative report, is it?

He doesn't record that he actually saw himself cause the perforation, does he?

A I'm not sure what you mean. You can show me and maybe tell me what you're trying to explain because the operative report said that as he was doing the procedure he diagnosed the perforation.

Q Does it say that he actually saw himself cause the perforation?

A I don't think he would say that because he doesn't know the perforation's going to occur, so he wouldn't say, "I saw myself, I caused the perforation." You know, that isn't the way surgery works, so you would say, "As I'm doing the surgery, I noticed the perforation of the uterus, so I stopped." Surgery is a second-to-second dynamic art. You don't cause it. It -- as far as you meant to cause it, as you're doing the procedure, you do what you normally -- is right and correct, and it occurs.

Q Okay. But my question is, during Dr. Brill's procedure, he indicated he was using the yellow pedal to cut white tissue; you recall that?

A Yes.

Q And then shortly afterward, he --

A As he advanced the camera. He said, as I advanced the camera, I noticed the perforation.

Q Yes. Okay. Does he describe in his operative report that he actually saw the moment he perforated the uterus with the camera? He doesn't say that.

A Nobody says that. You don't say that as a surgeon. You don't say the moment I did this a perforation occurred. You don't -- that isn't how surgery works. You're operating and you're proceeding with a procedure, and you visually see an event, and that's what you dictate.

Q Okay. So would you agree with me --

A Right.

Q -- if Dr. Brill has proper visualization of his instruments during the procedure, he would have actually seen himself cause the perforations?

A Well, if he didn't have visualization, he would have stopped working. He's not going to be working if he can't see.

Q We would hope not, correct?

A Correct. I don't think he would.

Q That would below the standard of care --

A Yes.

Q -- if he was operating without clear visualization, correct?

A That's correct.

Q All right.

A Yes.

Q And the standard of care requires the physician to inspect a uterine perforation to determine if there is any damage to nearby structures, correct?

A Correct.

Q And nearby structures would include the bowel or the small intestine, correct?

A Correct.

Q How did Dr. Brill perform that investigation or inspection in this particular case?

A By visually looking through the hole.

Q With a camera?

A Uh-huh.

Q Inside the uterus?

A Correct.

Q Do you believe he did an adequate job of that inspection?

A Yes, I do.

Q If he did an adequate job of that inspection --

A Uh-huh.

Q -- how did he miss a large perforation in the small intestine?

A Well, because the intestine is a movable, dynamic organ. You could perf [phonetic] something, and it folds, and it falls, and it moves around, and you don't even see it. So you can have a perforation and not diagnose it interoperatively. Most small bowel perforations are diagnosed postoperatively like Mrs. Taylor's perforation was diagnosed the next day. That's the -- that's the more frequent type of diagnosis.

So we have a rule, the standard of care, which is what I try to think about when I'm looking at cases, that if you have a perforation hysteroscopically, you look through the perforation, as a matter of fact he did it twice, you look through the perforation, you look at the area, you've got a window, looking in there you don't see any bleeding, you don't see any succus material, any secretions, and perforation, you look

around. If everything looks normal to you, standard of care doesn't require you to do anything else.

Q So you said few things there, and we're going to go back and talk to them.

A Okay.

Q First of all --

A All right.

Q -- you said the intestine is really not in a fixed place, it kind of moves around.

A Correct.

Q Right?

A Correct.

Q So that makes it all the more unlikely that the blunt tip of this instrument would cause this injury, because the blunt tip might just push the intestine out of the way; would you agree with that?

A That could be, yes.

Q Okay. And you stated that if the site of the perforation is mobile, if the intestines move around, isn't that all the more reason to go in separately and laparoscopically into the abdomen to get a proper view of the intestine?

A The incidence of a small bowel perforation is extremely low. If you laparoscope every perforation that occurred during hysteroscopy, you would have so many more complications from the laparoscopy then from the perforation. So the standard of care says that you don't laparoscope a patient that has a uterine perforation unless you're using

active energy. unipolar cautery, and you're advancing into the field and perforate with an active current going. Then the standard of care says you have to do a laparoscopy. Laparoscopy is not a benign procedure.

Q So you would agree that if the perforations were caused with thermal injury, the standard of care would require laparoscopic evaluation of the bowel?

A Specifically unipolar thermal electricity.

Q Thank you. I'd like to show now Exhibit 1 at SRDH1 and 2. We've been talking about this. This is a surgical pathology report. This is from St. Rose Hospital after the bowel resection or bowel repair surgery, correct?

A Yes, sir.

Q Does this record anywhere indicate that the pathologist was asked to assess the sample of bowel that was removed for thermal injury?

A Well, it wouldn't. That's not something you would request.

Q Does it confirm or deny that thermal injury was on that sample?

A No.

Q Doesn't say one way or another, does it?

A No, you -- if you were worried about that, you would have had to request the pathologist to look at the slides again.

Q Yeah, and that wasn't done in this case, was it?

A I don't know. I'm not in -- I don't know if it was done or not. I didn't see it, but --

Q Okay.
A -- I don't know if you requested that or not. I'm not sure.
Q So also, when this pathology report is prepared, the sample had been removed from Kim's body after serious infection, correct?
A Yes.
Q And so hypothetically, maybe if there was thermal injury, might it be more difficult to see because of the infection of the tissue?
A Well, this sample was done in 24 hours from the event. All right. I mean, this was done the next day. That sample was given to the pathologist the next day, so if there was any thermal injury, regardless of any infection or anything, you would see it.
Q It may have been within 24 hours, but within that 24 hours, Ms. Taylor developed an incredibly serious life-threatening infection, didn't she?
A Well, I know, but that has nothing to do with the thermal injury of the bowel that you're looking under the microscope to diagnose.
Q Okay. But there's nothing in that report --
A I mean, she got sick because of the sepsis from the bowel perforation, but that doesn't reflect whether you would see thermal injury on a report.
Q The pathologist really doesn't comment whether or not he or she saw a thermal injury one way or another, do they?
A No.
Q Doesn't it just appear that the pathologist was just kind of

measuring the sample?

A No. The pathologist is reading microscopically and grossly a specimen. That's what they do routinely.

Q Just again to review, how large -- or what's the diameter of the tip of the resectoscope in terms of millimeters?

A 3.6 millimeters.

Q Okay. So if one of the attorneys had said during their questioning that the tip of the resectoscope was six millimeters or more in diameter, that would be inaccurate?

A The scope itself is 6.3. The resectoscope tip is 3.6.

Q Yeah. So to get that 6.3-millimeter part through the uterus or through a perforation, you'd have to first put the tip of the resectoscope through, and then you'd have to advance it so far that you actually put the tip of the hysteroscope, with the camera and everything, through the perforation, correct?

A If that was going to reach, sure. Yes, that's correct.

Q Okay. Do you think that would be an indication of carelessness on the surgeon's part if they went that far that they actually put the camera or the hysteroscope through the perforation?

A It would be unusual.

Q Would it be below the standard of care?

A I wouldn't think you would go that far in. If the bowel is -- if the bowel is sitting in the heart-shaped defect of the uterus and is adherent to her uterus, then that could occur without that distance that you're describing.

Q Okay. Now, the tip of this resectoscope, we just talked about it, is 3.6 centimeters.

A Millimeters.

Q Millimeters. I'm sorry, I misspoke. You're right, millimeters. When Dr. Hamilton gave her estimate of the size of the small bowel perforation, she said she felt it was three centimeters. Do you recall that?

A I do.

Q So according to her estimate, the size of the perforation was around eight times larger than the diameter of this tip. Would you agree with that? That's just math, right?

A Right.

Q And so the pathologist says the size of the perforation when the pathologist measured it was 1.6 centimeters, so that would be five times the diameter of this tip. Would you agree with that? That's just math, right?

A That's math, yes.

Q All right. Now, when the pathologist is doing their measurement on the sample, there's no blood supply to the sample, correct?

A Correct.

Q And the inflammation has subsided?

A Yes.

Q Okay. And the sample has been put in a clear liquid?

A Yes.

Q So it's not in a living, breathing, functioning body anymore, correct?

A Correct.

Q All right. Hypothetically, if Dr. Brill had caused a perforation through the uterus and into the lungs, would that be beneath the standard of care in your opinion?

A Yes.

Q Hypothetically, if Dr. Brill caused a perforation through the uterus and into the kidneys, would that be beneath the standard of care in your opinion?

A Yes.

Q Hypothetically, if Dr. Brill had caused a perforation that went through the uterus, into one side of the small bowel, and through the other side of the small bowel, would that be below the standard of care in your opinion?

A Yes.

Q And we talked about this, the standard of care requires Dr. Brill to inform the patient a perforation occurred. Would you agree with that?

A Yes, sir.

Q Okay. Now, you indicated that you wouldn't necessarily do that in the recovery room because sometimes, patients are groggy from anesthesia and they might forget that, correct?

A Yes, sir.

Q Okay. Would there be a harm in doing that anyway, though,

so the percentage of patients who weren't groggy and could understand could still be told they had a perforation at that time?

A It would be up to the surgeon if they want to do it or not.

Q Why not --

A It wouldn't be any harm. It wouldn't be any harm in doing it, but it's not the standard of care to have to do it.

Q That would be more careful than just advising a relative; would you agree?

A Yes.

Q Okay. You're aware that in this case, there is a dispute that the parents of Ms. Taylor deny that Dr. Brill told them of a perforation. Are you aware of that?

A No.

Q Okay. I want you to hypothetically assume that Dr. Brill did not tell Kim of the perforation and did not tell her parents of the perforation. Under that hypothetical, would you say that is beneath the standard of care?

A Yes.

Q Why is it important for the surgeon who has caused a perforation to advise the patient of the perforation?

A Well, I mean, the patient has a responsibility as well because the patient is going to think, well, I went in for a ablation. I went in for a resection. I didn't get really either one of those. What happened? So the surgeon has to tell the patient why they didn't complete the operation. That's why you have to tell the patient.

Q Okay. Have you ever experienced some sort of complication during a surgery and later that day, called the patient, maybe on her cell phone, to see how she was doing?

A Yes.

Q Okay. What do you think about those occasions that you can think of made it a good idea in your mind that that phone call occur?

A I would say that is something that the patient would appreciate, that if I called the patient and checked on her that evening, regardless of what it was, then the patient is going to appreciate the phone call.

Q Do you agree that one of the reasons the patient needs to know that they have sustained a perforation is so that if they experience symptoms, they can tell other medical care providers, I've had a perforation?

A Yes.

Q Now, we talked a little bit about your service as an expert and we know you've reviewed records and you've prepared reports. And you actually flew here from the state of Florida to testify here today, didn't you?

A I did.

Q Okay. And you have charged for those services, correct?

A Correct.

Q What do you charge hourly to do that work?

A $400 an hour.

Q Okay. And what do you charge for a day of trial testimony

and is that, like, an hourly fee or a flat fee?

A Well, the three days for this, yesterday, today, and tomorrow, because it's going to take all day to get home tomorrow, is $6,000 for those three days.

Q Okay. And so if we added up all the fees that you have charged Dr. Brill or whoever you're charging to be retained here, how much would that total in this case?

A I would say altogether probably about $9,000.

Q Okay. And you did prepare written reports earlier in this case, correct?

A Yes.

Q And it's your understanding that you are expected to put your anticipated opinions about this case into written reports; is that true?

A Yes.

Q All right. So do you have any opinion in this case that Kimberly Taylor caused or contributed to her own injuries?

A No.

Q Do you have any opinion that Ms. Taylor was malingering or exaggerating her symptoms after the perforations?

A No.

Q Do you have any opinion that for some reason, Ms. Taylor's medical treatment to repair her bowel after April 26th was not reasonable or necessary?

A No. It was --

Q In fact --

A It was necessary.

Q Yeah. You've reviewed all of her medical care, including her ambulance trips, her emergency room care, her bowel repair surgery, and her nine-day stay in St. Rose Hospital, and you've reviewed the after care, for example, with Dr. Lipman, the infectious diseases doctor. You've reviewed all of that care, correct?

A Yes, I did.

Q And you have no opinion in this case that for some reason, that care was not reasonable or necessary; do you agree?

A It was -- it was reasonable and necessary.

Q And you have no opinion that for some reason, that care was not caused by -- or the need for it was not caused by the perforations; do you agree?

A Yes.

Q Okay. And you are not giving any opinion in this case that for some reason, the amount of the charges on the bills to Ms. Taylor for medical care are not usual, customary, and reasonable; is that true?

A I haven't -- I haven't thought or looked at any charges. I have no opinion about any charges.

Q You are not commenting on the charges or disputing them; is that true?

A No, sir. That's correct.

Q Do you blame Nurse Hutchins or Henderson Hospital for any injury or damage to Ms. Taylor?

A No.
Q Do you blame Dr. Christianson or St. Rose Hospital for any injury or damages to Ms. Taylor?
A No, sir.
Q Okay. And do you agree that no provider other than Dr. Brill caused the perforations we're talking about?
A Yes.
Q Okay. You indicated earlier that you felt your role as an expert was to help or represent the people you were hired by. Do you recall that?
A Not really.
Q No? So what is your role --
A I'm here today --
Q -- as an expert? It should be to independently review the case and provide opinions whether they're good or bad for the person retaining you, correct?
A Yes.
Q Okay.
A I would agree with that.
Q All right. So you would agree with me that it's not appropriate to view your role as simply helping the side that hired you or representing them? Would you agree with that?
A Right. I would agree with that.
Q Okay. Now, you indicated earlier in your testimony that you were open to what happened during Dr. Brill's procedure. But the sole

piece of information we have in this case to rely on regarding what happened in that procedure is Dr. Brill's testimony and Dr. Brill's operative note, correct?

A Yes.

Q We have no actual video of the procedure, do we?

A No.

Q And we have no firsthand testimony from any other doctor as to how those perforations occurred, do we?

A No.

Q So if, for example, hypothetically, Dr. Brill did use the thermal cutting device here, and he saw himself go right through the uterus and into the small bowel, and hypothetically, if he wanted to write a report that was a little different from that or a little more flattering for him or a little more forgiving, he could have done such a thing, hypothetically, right?

A Anything is possible.

Q Okay. I love the old anything is possible answer. Goes around a lot in this business.

All right. We heard some testimony from you about the hydrothermal ablation procedure. But ultimately, would you agree with me that anything regarding the hydrothermal ablation is kind of moot in this case because that procedure never actually occurred?

A Correct.

Q Yeah. It was -- it did not occur because Dr. Brill noticed the perforations before he started to perform that, correct?

A Yes.
Q Okay. You indicated that you felt Dr. Brill's operative report here was very detailed.
A Yes.
Q Okay. Do you think maybe one of the reasons for that might be because Dr. Brill recognized that he had made some sort of error?
A No. I wouldn't think that. You might think that. I don't think that. I think he was describing what happened.
Q But you found it unusually detailed for this type of procedure, didn't you?
A No. I just thought it was a well-written operative report.
Q Did you know Dr. Brill or know of him prior to being retained in this case?
A I don't think so, no.
Q You indicated -- or -- well, we can agree that at least according to Dr. Brill's report, he was using the thermal energy cutting part of the resectoscope to cut away at the septum. Do you agree with that?
A Yes.
Q Okay. And you indicated that the septum does not have a good blood supply.
A Correct.
Q Okay. But in the pathologist's report for the samples that came from that procedure, the pathologist noted blood clots, didn't he?
A That's from the curettage.

Q Okay. So the pathology report, let's be clear, does that include cells from only the curettage, only the resectoscope thermal cutting, or is it a mixture of both?

A I'm not sure. I'm honestly not sure. I didn't see that document in any way. Or I know the curettage sample would definitely be submitted. I'm not sure about the other part.

Q Okay. So there wouldn't necessarily be bowel cells in that pathology report even if the thermal side of the resectoscope had touched the bowel?

A Well, if there was bowel in that specimen and it got submitted, you would see it. That's all I -- that's all I can tell you.

Q But you don't know if the material from the resectoscope was included in that specimen, correct?

A I don't -- that's correct. I don't know that.

Q Okay. You indicated that --

MR. BREEDEN: Strike that.

BY MR. BREEDEN:

Q We've talked about the uterus being self-repairing when it's been perforated. Do you recall that testimony?

A Yes, sir.

Q And so in most instances, if you leave the perforation alone, it will heal on its own, correct?

A Yes.

Q In some instances, is the perforation so bad that a repair does need to be made?

A Not usually.

Q Not usually. But are you familiar with that at all? Have you ever heard of a --

A Well I mean, if you have a substantial perforation that's large that would require repair, you would -- that would need a repair, yes. But usually, blunt perforations, I've never known one that needed anything. If it's bleeding, you might have to stop the bleeding of the perforated site. But usually, you don't have to do anything.

Q In the instances where the uterine perforation does need repaired, how is that performed?

A Laparoscopic or open.

Q Okay. So you could not --

THE CLERK: Doctor, I'm sorry, repeat that?

THE WITNESS: Laparoscopic or open.

THE CLERK: Okay.

BY MR. BREEDEN:

Q So you could not do that during the hysteroscopy. You would have to go back in through the abdomen, either with cameras, meaning -- or ports, meaning laparoscopically, or you would have to make an incision and actually open up the patient to do a uterine perforation repair, correct?

A Correct. If the perforation has some bleeding, this particular device, you can coagulate with. But if it's a lot of bleeding or a large perforation, you can go in laparoscopically and repair it, or open.

Q Okay. And Dr. Brill's operative report does not state he

attempted any repair of any perforation, true?

A True.

Q When you are using the hysteroscope, as you explained, there is a camera. And you as the physician are looking at, like, a monitor nearby to perform the procedure, correct?

A Correct.

Q And during the procedure, is there a method or a button that you can press to take photographs of the procedure?

A Well, yes. You can. You can capture an image, yes.

Q Okay. And did you see images that Dr. Brill took of this particular procedure?

A Yes.

Q And would you agree with me he took no photograph of the uterine perforation?

A Correct.

Q He took no photograph of what he claimed was his inspection of the bowel through the perforation, correct?

A Correct.

Q Would you agree with me that photographs of those, the perforation and the alleged inspection, that if those existed, they would be highly relevant to this case?

A Yes.

MS. HALL: Objection, Your Honor. This --

THE WITNESS: They could explain why he didn't --

MS. HALL: Wait.

MR. BREEDEN: Wait.

THE COURT: Hold on.

MS. HALL: One second, Dr. McCarus. Can we approach?

THE COURT: Yes.

[Sidebar at 4:53 PM, ending at 4:54 PM, not transcribed]

BY MR. BREEDEN:

Q Doctor, let me rephrase. Hypothetically, if there were photographs of the uterine perforation or the alleged inspection of the bowel, might those be relevant to your opinions?

A Yes.

Q Are you aware of any reason Dr. Brill did not take those photographs?

A Just with what he testified in his deposition, that it was more taking care of the issue and not worrying about capturing a picture.

Q Now, hypothetically, if we had a picture of the uterine perforation and it showed thermal injury or damage, that would cause you to change your opinions in this case, wouldn't it?

A Yes.

Q You indicated earlier that you felt if you were careful as a physician, you could do curettage in the uterus even after observing a perforation in the uterus. Do you recall that?

A Yes.

Q Okay. Would you describe a physician that has just caused a uterine perforation and a small bowel perforation during a hysteroscopy as a careful physician?

A Well, I think that's a unfair question because A, you didn't know there was a bowel perforation at the time, B, perforations can occur and we've all experienced that, and C, if you're careful, you can still do a curettage.

Q Earlier in your testimony, you did admit that the most common type of bowel injury during your work, gynecological surgery, is a thermal injury; is that correct?

A Yes.

MR. BREEDEN: One moment. Those are all my questions, Doctor, thank you.

THE WITNESS: Thank you.

THE COURT: Thank you. Redirect.

MS. HALL: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. HALL:

Q Dr. McCarus, in terms of the photographs that were taken during the surgery, you understand that Plaintiff's expert, Dr. Berke is not critical of the photographs and what is documented in terms of the photographs?

A Yes.

Q And you read Dr. Brill's testimony that when he noted the uterine perforation, do you recall reading that it was his concern -- patient safety was his primary concern?

A That's correct.

Q He wasn't concerned with documenting in anticipation of a

lawsuit. Do you remember that?

A That's correct.

Q And in fact, the reverse of that question, the question that Mr. Breeden just asked you. If Dr. Brill had been concerned with documenting for purposes of a lawsuit, and he had taken photos, and it had shown that it was a blunt injury, you would agree that we probably wouldn't even be in this courtroom today?

A I would agree with that.

Q The unipolar thermal device that you were asked about, you talked about that when a -- when a perforation occurs with a unipolar thermal -- electricity, that a laparoscopy should be performed?

A Correct.

Q Meaning run the bowel?

A Well, to look in. Look in and check the uterus and look at the bowel.

Q So to inspect the bowel with a laparoscope.

A Right.

Q The Symphion, is that a unipolar device?

A No.

Q And in fact it's a bipolar device, true?

A True.

Q And the medical bills, did you -- were you ever provided any of Ms. Taylor's medical bills to review as part of your expert retention and analysis in this case?

A No, ma'am.

Q The -- so is it -- do you have any knowledge of her medical bills, what charges were charged and whether those are reasonable?

A I do not.

Q The Plaintiff's expert, Dr. Berke, you are aware -- now you were not asked to review the medical treatment of Bruce Hutchins, the nurse in the PACU, correct?

A Correct.

Q You also weren't -- you weren't asked to evaluate the care and treatment provided by Henderson Hospital to Ms. Taylor. Is that a correct statement?

A That's correct.

Q Were you asked to evaluate Dr. Christensen's care? The emergency room physician at St. Rose Hospital?

A No.

Q Were you asked to evaluate whether the providers -- the nurses at St. Rose Hospital or Dr. Christensen complied with the standard of care in treating Ms. Taylor?

A No, ma'am.

Q But you are aware that Plaintiff's expert, Dr. Berke, he is critical of Bruce Hutchins, the PACU nurse?

MR. BREEDEN: I would object again, Your Honor. Just continuing objection.

THE COURT: Thank you. Go ahead.

BY MS. HALL:

Q Do you need me to restate that, Dr McCarus?

A Please.

Q You are aware that in this case, Dr. Berke, Plaintiff's expert, has offered an opinion that he believes Bruce Hutchins and Henderson Hospital fell below the standard of care?

A I read that in his report. He was critical then.

Q And you're also aware -- are you also aware that Dr. Berke has offered an opinion in this case that Dr. Christensen and St. Rose Hospital fell below the standard of care?

A Yes, ma'am.

Q Now you were asked some questions regarding perforation of the lungs and the kidneys. Is there -- did that happen here? Was there any perforation of Ms. Taylor's lungs?

A No.

Q Was there any perforation of her kidneys?

A No, ma'am.

Q You were also asked about the small bowel and if it would be below the standard of care to go through the small bowel and to go into another area of the small bowel. Did you see any evidence of that happening here?

A There was none.

Q I was a little confused by some of the questions, so I want to make sure I understood. With respect to the Symphion device and visualizing the perforation. When you showed us that hysteroscope and the scope with the Symphion inside. Does that device allow the surgeon to pull back the Symphion into the hysteroscope?

A It does. You can retract it.
Q And do you have an opinion as to the cause or the mechanism of how these perforations occurred during surgery?
A They're usually blunt perforations.
Q And do you believe that's how this occurred here?
A Yes.
Q Did the anatomy of the patient -- you were asked some questions about whether Ms. Taylor caused or contributed to her perforations. But did her anatomy contribute to her perforations, in your opinion?
A It increased the risk of perforation.
Q And in fact, that's what happened here, right?
A Right.
MS. HALL: Court's indulgence, Your Honor.
BY MS. HALL:
Q Did any of the questions that you were asked by Plaintiff's counsel change the opinions that you've offered in this case, since being retained in 2018?
A No, ma'am.
Q All right. And have all of the opinions that you've offered here today been stated to a reasonable degree of medical probability?
A They have.
MS. HALL: All right. Nothing further, Your Honor.
THE COURT: Recross?
MR. BREEDEN: Just very briefly.

RECROSS-EXAMINATION

BY MR. BREEDEN:

Q How long does it take to actually take one of those pictures?

A Just the amount of time it would take for somebody to hit the button.

Q It's not a minute long process; is it?

A No.

Q I just took a picture, right?

A Yes.

Q Okay, thank you. Counsel approach.

THE COURT: Any questions from our jurors? All right.

[Sidebar at 5:02 p.m., ending at 5:05 p.m., not transcribed]

THE COURT: All right. We have one question. This is if you know or not, whether or not the Symphion machine shows data or times every time the foot pedal is used, and how long it's used? And if not, why? If you know the answer.

THE WITNESS: I don't know the answer, but that's a great question. I know there's a generator that is probably a smart generator. I don't know if it collects that data or not. I don't know the answer to that.

THE COURT: Okay. Thank you. Any other questions. All right. Thank you, Doctor. Thank you, you can be excused.

THE WITNESS: Okay. Thank you.

THE COURT: All right. Ladies and gentlemen, I'm going to release you for the evening. And we will be back here at 10:30 on

Monday morning in this courtroom.

And 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. And finally, you're not to form or express any opinion on any subject connected to this trial until the case is finally submitted to you.

I'll see you at 10:30 on Monday. Thank you, so much.

THE MARSHAL: All rise for the jury.

[Jury out at 5:07 p.m.]

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

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. Let's put the objections for Dr. McCarus' testimony. There was a continuing objection for the known risks of the hysteroscopy, which obviously have already previously been discussed. There was an

objection to Mr. Breeden's question about negligence and Dr. McCarus' legal understanding with respect to the risks and complications. And it was objected to. Anything further with objections.

MS. HALL: No, Your Honor.

THE COURT: Okay, anything in response, Mr. Breeden?

MR. BREEDEN: Nothing further on those, Your Honor.

THE COURT: Okay. I sustained it, and you just rephrased and asked a similar question to what Ms. Hall asked on her direct.

Then there was an objection with regard to me questioning him about bowel perforations during hysterectomies. And the objection Ms. Hall.

MS. HALL: It's irrelevant. There's no relevance. It's not a hysterectomy that was performed here. It's an entirely different surgery. Much more complicated.

THE COURT: Any response Mr. Breeden?

MR. BREEDEN: So this is the Defense retained expert on standard of care. He has testified in similar gynecological surgeries that thermal injury to the bowel, which is the same injury that happened in this case, allegedly, is below the standard of care. I understand that this was a hysteroscopy and the other cases, and there were three of them where he had testified, were hysterectomies. Both are procedures to the uterus. They are obviously different procedures. However, I believe that's similar enough. I think I have broad rights to cross-examine experts. The difference between hysteroscopy and hysterectomy, that certainly would be appropriate for redirect by Ms. Hall, and I thought that

was a fair question and avenue of cross-examination I should be allowed to explore.

THE COURT: Okay. And I sustained the objection simply because it was a different surgery, and I thought it would be misleading and confusing to the jury, especially -- I mean medical terminology, hysterectomy, hysteroscopy, I just -- I think it would be confusing and therefore it wasn't relevant.

The next one was a discussion about the photos. I'm trying to read my notes here. The relevance of the photos during the procedure.

MR. BREEDEN: Well, I think we rephrased and there's not much more to discuss.

THE COURT: Yeah, it was sustained. You rephrased it, and then we moved. The next objection was the opinion regarding Bruce -- it was a continuing objection to basically the Parusi [phonetic] issues.

MR. BREEDEN: Parusi issues, yes.

THE COURT: And so that was overruled. And the last one, I don't remember the last one.

MR. BREEDEN: Well, the juror question I think is what we need to discuss. And Plaintiff's position was I thought it was a fair question, I'm sure I could have asked it on cross-examination. And ultimately I didn't think there was any prejudice or harm to asking it because my understanding is no such data on how long the yellow pedal is used or exactly one, is kept by this machine. And I think the witness testified how I expected him to testify. So I didn't see much harm in

allowing that question to be asked.

THE COURT: And Defense's objection was that it lacked foundation.

MS. HALL: Exactly, Your Honor.

THE COURT: Okay. And I went ahead and allowed the question, and he did answer that he didn't know. All right. Anything further outside the presence.

MR. BREEDEN: Yeah, just scheduling-wise, Your Honor.

THE COURT: Uh-huh.

MR. BREEDEN: Do we begin at 10:30 on Monday?

THE COURT: Yes.

MR. BREEDEN: Okay. So Plaintiff has Dr. Brill yet to call. And that will be Dr. Brill -- that will be Plaintiff's last witness. Plaintiff will rest.

THE COURT: Okay.

MR. BREEDEN: Now the Defense can correct me if I'm wrong, but I think after they're done with their examination of Dr. Brill, they will rest the Defense. We will have no rebuttal witnesses to call, either. So at that point I think we need to discuss, you know, when and how we're going to settle jury instructions and when everybody needs to be prepared for closing.

THE COURT: So we said jury instructions Monday afternoon. So as long as you guys send everything that I asked you to earlier to my law clerk and JEA, we can settle them Monday afternoon after you either agree upon and just tell me which ones I need to rule upon. And then I

don't mind, since we're going to argue Monday afternoon, letting them go a little early and starting closings Tuesday morning. If that's what you all want to do.

MR. BREEDEN: I think that's a very good idea. We pick up bright and early right on time, Tuesday morning. You read the instructions --

THE COURT: Bright and early at 10:30, yeah. After my calendar, but yes.

MS. HALL: Just for clarification in terms of the instructions, you would like counsel to confer this weekend, try to get an agreed upon set. And then for any agreed upon, any Plaintiff's offered, Defense offered.

THE COURT: Correct.

MS. HALL: The Clerk needs a copy with cites and in Word.

THE COURT: In Word.

MR. BREEDEN: What email should I use here, Your Honor?

THE CLERK: It's eett03lc@clarkcountycourts.us.

MR. BREEDEN: Anyone else that needs to be copied on that?

THE COURT: If you could copy my JEA, just in case. Terri Elliott.

MR. BREEDEN: Okay. We got -- we have Terri's.

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THE COURT: Yes. Anything else?

MR. BREEDEN: Nothing more for the record.

THE COURT: All right. We can go off the record. Thank you. Have a great weekend guys.

[Proceedings adjourned at 5:13 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.

Jessica B. Cahill

Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708