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 XII

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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 XII** via the method indicated below:

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

An Attorney or Employee of the firm:

/s/ Sarah Daniels
BREEDEN & ASSOCIATES PLLC

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

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

BEFORE THE HONORABLE MONICA TRUJILLO
DISTRICT COURT JUDGE
MONDAY, OCTOBER 18, 2021

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 7

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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FOR THE PLAINTIFF	MARKED	RECEIVED
None		

FOR THE DEFENDANT	MARKED	RECEIVED
None		

Las Vegas, Nevada, Monday, October 18, 2021

[Case called at 10:46 a.m.]

[Outside the presence of the jury]

THE COURT: We are 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. Any issues before we bring the jurors in?

MS. HALL: There's a couple for the Defense.

MR. BREEDEN: I don't think anything from Plaintiff.

THE COURT: All right. Go ahead.

MS. HALL: Very quickly. The deposition of Dr. Brill was videotaped. I don't know if Mr. Breeden intends to use any of that videotaped deposition. But to the extent that he does and any of it was subject to an objection made by me at the deposition, I wanted to ask Your Honor, in my past experience, we've gotten a ruling on the objection before the testimony is shown if there was an objection made at the deposition. So I don't know how Your Honor wants to handle it, but that would be my preference that if there is in fact going to be a clip shown that was subject to an objection, that I be given a ruling on the objection.

THE COURT: Okay. So procedurally, since we're here now, and he's testifying next, how are we going to do that?

MR. BREEDEN: Your Honor, if that occurs, and I want to play a deposition clip, I will approach, we'll do the whole rigmarole where

you unseal the deposition transcript. And I'll show you the portion that I would like to play. And then you can rule at that time. I think that's how we should handle that.

THE COURT: Okay. Do you think that --

MS. HALL: And that makes sense to me. And I did notify counsel this weekend that I would be making that request.

THE COURT: Okay.

MS. HALL: And the last issue, Your Honor -- and I don't know when -- you know, if we'll get to my direct exam of Dr. Brill before lunch. But assuming we do, I wanted to bring this up to the Court before that examination. I understand Your Honor's ruling that I am not permitted to discuss the signature of the Plaintiff on any consent forms. The documents that were stricken from Dr. Brill's office record is -- they're educational materials. So I wanted to ask Your Honor if in my questioning of Dr. Brill, if I ask him after his discussion with the patient, "were written educational materials provided", is that a violation of the Court's order? I don't believe that it is.

I have no intention of trying to show him those forms or calling them consent forms. And in fact, Dr. Brill doesn't call those consent forms either. He calls those educational materials. They're not the actual consent form. The consent form is what is signed at the hospital at Henderson Hospital. I have no intention of going over the fact that the patient signed those documents. That those, you know, are -- I'll never refer to them as a consent form. But I do think I should be permitted to ask him whether written educational materials were also

provided.

THE COURT: And what is included in the educational materials?

MS. HALL: Education about the specific procedures to be performed.

THE COURT: And this would have been pre?

MS. HALL: Exactly. It was given to the patient at the April 21st visit, about five, six days before the surgery.

THE COURT: Mr. Breeden?

MR. BREEDEN: It's no different from the consent form, Your Honor. It's the same thing. They're just trying to circumvent your prior ruling.

THE COURT: Well, I mean --

MR. BREEDEN: What other purpose would they be wanting to use those forms for?

THE COURT: Isn't it consistent with the discharge instructions, which I've already allowed?

MR. BREEDEN: Well --

THE COURT: If we're not going into the content. We're just saying it's -- something was provided, which --

MR. BREEDEN: And I objected at the time you allowed those discharge instructions in. Certainly, something given to my client after the procedure can't be relevant to the standard of care or what her knowledge was of risks or complications prior to the procedure. So I objected at that time. And I am consistent. I continue to object.

Educational materials is just another way of framing informed consent forms. It's just another way of describing it.

THE COURT: Okay. Ms. Hall?

MS. HALL: I don't believe that the word "educational materials" has the same connotation as informed consent or consent forms. I would never refer to it as that. I envision it coming up in the context of the discussion that was had with the patient at her two April visits. And then in addition to the discussion, were any written explanation or educational materials about the procedure provided.

THE COURT: Okay.

MS. HALL: And that is the extent of it.

MR. BREEDEN: And Your Honor, if I can. I don't want to debate this point for the next hour. But just so you know, during his deposition testimony, I asked Dr. Brill, you know, what did you discuss with this patient before the procedure? And he says, "I have no independent recollection of what I discussed with her." Okay. So that's sort of what the problem is on the Defense side is they want to come in and they want to say, oh yeah, we told her all about infection and risk of perforation and risk of injury to adjacent organs, et cetera, et cetera. And Dr. Brill's already testified he has no independent recollection of that.

THE COURT: I mean, but don't the medical records support that it was given and/or there were discussions had?

MR. BREEDEN: And I've objected to that.

THE COURT: Okay. I'm going to allow it.

MS. HALL: And -- thank you, Your Honor. I'll shut up now.

THE COURT: Anything else?

MR. BREEDEN: Yeah. I'm sorry, Your Honor. Very quickly. You know, there's been a lot of discussion about the medical billing. And you have excluded some of that. And I just wanted to note if it wasn't already apparent for the record, that we would make an offer of proof of Exhibit 53, which is the St. Rose Dominican Hospital billing records, and an offer of proof for Exhibit 57, which are the Henderson Hospital billing records. We would move to admit those. And I assume you will deny that consistent with your previous rulings.

Additionally, Your Honor, I would move to admit into evidence one of the exemplar Symphion Resectoscopes. They've been discussed by multiple witnesses that this is the type of resectoscope used on the Plaintiff. I'd like to have it actually marked as an exhibit so the jury can have it back in the deliberation room. You know, they can touch it, and they can feel it, and they can see what it's like. It is kind of a small instrument. So it may help them to be able to see it up close. Because of COVID reasons, we didn't pass it around to the jury. Normally, we would do that.

And my understanding is that typically, just for housekeeping purposes, the clerk hates when we give physical evidence, as if it's to be stored as an exhibit. So what we did is we had Exhibit 44 and 45 as photographs. And I would request that those be admitted, along with the actual exemplar resectoscope so the jury can see it.

THE COURT: And 44 and 45 are just photos of it?

MR. BREEDEN: Correct.

THE COURT: Ms. Hall?

MR. BREEDEN: It's my understanding that's how the Court usually wants the physical evidence treated. They just want a photograph so that it doesn't have to go to some evidence storage room, and they have to store this darn thing for the next seven years.

THE COURT: Ms. Hall?

MS. HALL: No objection to those demonstratives of the photos, 44 and 45. I just don't want to admit the actual demonstrative, meaning the Symphion --

THE COURT: Right.

MS. HALL: -- or the hysteroscope, unless somebody wants to bail me out of jail when Henderson Hospital comes after me for the cost of that hysteroscope.

THE COURT: All right. So then since there's no objection, we'll allow the photos 44 and 45. And then Mr. Breeden, other than having them marked as what you would have wanted to admit 53 and 57, any additional discussion or offer on those two, or are they going to speak for themselves?

[Plaintiff's Exhibit 44, 45 admitted into evidence]

MR. BREEDEN: Well, I think they speak for themselves. The face value of the bill is evidence of the usual, customary, and reasonable amount of the bill.

THE COURT: Okay. Anything else?

MR. BREEDEN: Your Honor, what's your ruling on the exemplar resectoscope actually going back to the jury?

THE COURT: That?

MR. BREEDEN: Yes.

THE COURT: No. That's not going to go back. Just the photos.

MR. BREEDEN: Okay. May --

THE COURT: And everybody --

MR. BREEDEN: -- may I ask for why? Why is that the Court's ruling?

THE COURT: I just don't -- I don't think we should have anything going back there to the jury like that right now, especially with the whole COVID issue.

MR. BREEDEN: Is it a COVID concern?

THE COURT: Yeah. I just don't think anything besides -- actually, I don't even know if we've sent paperwork back there. We have?

THE CLERK: Yeah. The exhibit folder.

THE COURT: No, I know. But the -- like in the -- we haven't sent any, like -- hasn't it mostly been on the laptop?

THE CLERK: Yes. But we --

THE COURT: But we sent a couple other papers?

THE CLERK: -- but we do, like, if they admit a gun or something without the bullets as an exhibit.

THE COURT: Well, yeah. You know, I'll -- let me at least ask someone and see if it's going to be okay. But right now, I'm going to reserve ruling on that. We'll make a decision before we send the

evidence back.

MR. BREEDEN: Okay. And I just want to make sure. Your concern is not that a proper foundation hasn't been laid, et cetera? Your concern is simply because of COVID?

THE COURT: Yeah. And them passing it around and things like that. And I don't -- so let me just confirm. And then I'll reserve ruling on that.

MR. BREEDEN: Thank you, Your Honor. Nothing further.

THE COURT: And Ray, everyone's here?

THE MARSHAL: Yes, Your Honor.

THE COURT: All right. You can go ahead and bring them in.

THE MARSHAL: All rise for the jury.

[Jury in at 10:57 a.m.]

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

THE COURT: Thank you. You may be seated. Good morning and welcome back. I hope everyone had a great weekend. And we are going to proceed with Plaintiff's case.

Mr. Breeden, go ahead with your next witness.

MR. BREEDEN: Plaintiff's next witness is the Defendant, Dr. Keith Brill.

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

KEITH BRILL, M.D., PLAINTIFF, SWORN

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

THE WITNESS: Keith, K-E-I-T-H, Brill, B-R-I-L-L.

DIRECT EXAMINATION

BY MR. BREEDEN:

Q Okay. Doctor, we're here to discuss a hysteroscopy and fibroid tumor resection, a surgery that you performed on Kimberly Taylor on April 26th of 2017. You understand that's why you're here, correct?

A I do, sir. Yes.

Q And you've sat through this whole trial so far, and you've heard some of the different witnesses and some of the different doctor experts that have testified, correct?

A I have.

Q So you're familiar with their testimony?

A I am.

Q Okay. You admit you perforated Kimberly's uterus during that procedure, correct?

A Yes.

Q You admit the size of the perforation was about a centimeter, correct?

A Based on my estimation at the time, yes.

Q And that's even though the tip of the resectoscope is about 3.6 millimeters; isn't that correct?

A I disagree with that.

Q You disagree that this is 3.6 millimeters in diameter?

A I do because you're referring to that as the resectoscope.

And that's not the resectoscope. So your question is that that device is 3.6 millimeters. The resectoscope is not.

Q The device that I have in my hand?

A Correct.

Q And this is the tip that would have been extending out during the procedure. The tip of this instrument is 3.6 millimeters; is that accurate?

A Yes. The resection device for the Symphion has a width of 3.6 millimeters.

Q Okay. And so the perforation that you caused in the uterus was roughly three times the size of the tip of that instrument, correct?

A Yes.

Q You admit you perforated Kimberly's small intestine during that procedure, correct?

A Yes, I do.

Q And your own expert, Dr. McCarus, has stated the intestinal perforation occurred at the same time as the uterine perforation, correct?

A That's what I heard him say. Yes.

Q You admit you caused those perforations with this instrument that I called the resectoscope, correct?

A I admit that it occurred with the combination of the resectoscope, which is the camera, with the reception device inside the operative channel of the resectoscope at the same time.

Q So you are calling this the resection device as opposed to the resection -- the resectoscope. Is that the difference in how we're naming

this instrument?

A Yes. So the hysteroscope that allows for a resection device in its totality is called the resection device -- or I'm sorry, the -- it's so confusing. I'm sorry. It's called the resectoscope device. That device individually separate what you're holding is the resection device by Symphion.

Q Okay. I'll try to refer to it as the resection device then. But you heard all the testimony earlier in this case. Nobody else really made any naming difference between this being the resecting device or the resectoscope, did they?

MS. HALL: Objection. Misstates the evidence.

THE COURT: Sustained.

MS. HALL: Thank you.

THE WITNESS: believe hearing Dr. McCarus on Friday --

THE COURT: Dr. Brill --

MS. HALL: You have to wait until he asks you a question.

BY MR. BREEDEN:

Q Now, you admit you failed to find the small bowel perforation during the procedure, correct?

A That's correct.

Q Now, let's talk about what happened during the actual procedure. You admit that upon entering the uterus, you could not find the fibroid tumor that you were there to resect, correct?

A That is correct.

Q And your solution was to cut at white tissue in an attempt to

find it?

A I believe according to my operative report, I cut a tissue that I believed to be the uterine septum.

Q Okay. And you believed it to be the uterine septum. Do you believe it to be anything different at this time?

A No. I believe it appeared to be the uterine septum at the time. And I still believe that, yes.

Q You admit you did not see the perforations as they happened, correct?

A I do not agree with that.

Q Why do you not agree with that?

A Well, I agreed -- I'll agree to that I saw the uterine perforation as it occurred with the camera in real time.

Q Why did you not take a picture of that?

A There's many reasons. To be able to take a picture of a uterine perforation as it occurs spontaneously in real time would need me to be able to predict the future, which I cannot do. You'd have to literally almost like bursting your phone, have to push pictures continuously during a surgery in anticipation of an event you don't expect to happen. So if that's the question, how can I take a picture at the moment of a perforation, I would say that just not -- cannot happen during surgery.

Q Does your operative report indicate that you actually saw yourself cause the perforation during the procedure?

A I'd ask to see my operative report to see the actual wording.

But I do believe I said that I saw what appeared to be a uterine perforation.

Q And you saw that sometime after it had actually occurred?

A Right.

Q Or you saw it in real time as you were doing the operation?

A I saw it in real time as I was doing the procedure. Yes.

Q You admit that in your report you notice the perforation shortly after using the yellow pedal on the resecting device, correct?

A Again, I don't have my operative report in front of me. But having seen it several times on the screen, and having reviewed it, I believe I said as I advanced the camera, during that process of advancing the camera, I saw the uterine perforation.

Q And that was shortly after finishing or shortly after you indicated you had used the yellow device for the system, correct?

A Correct. It was after that. Yes.

Q And the yellow device is what activates the thermal cutting part of this instrument, correct?

A Yes. That's correct. That's right.

Q And you admit that this perforation that you observed was in the anterior area of the uterus?

A Yes. It was on the interior wall of the uterus near the septum.

Q And that's the same area that you had been using the yellow pedal in the uterus, correct?

A Well, I was using the resection device against the area of the

septum. The pedal is on the floor. I use my foot to push the pedal to activate the device right at the bottom of the septum.

Q But the area of the uterus where you perforated, that was the anterior area of the uterus, and that's the area of where you had been using the resecting device, correct?

A Yes.

Q You admit that if you're going to use the resecting tool, you need to be sure of what you're cutting before you activate it; is that correct?

A That is correct.

Q And you agree that you need to have good visualization before activating the resecting tool, correct?

A That's correct.

Q Standard of care requires that?

A Yes.

Q You admit that the area where the -- I'm sorry, strike that. You admit you do not recall personally telling Kim in the PACU that you perforated her uterus, correct?

A I do not agree with that.

Q Okay. So did you or did you not tell Kim in the PACU that you had perforated her uterus?

A So from what I've seen, the conversation did occur. But I don't recall what was said specifically during that conversation.

Q Okay. So your testimony is you recall there is a conversation, but you cannot specifically recall telling her a perforation

occurred; is that your testimony?

A Correct. Sitting here four years plus today, I can't tell you the exact nature of that conversation. Yes.

Q So you are not saying one way or another whether you told Kim in the PACU that her uterus was perforated? You have no recollection? That's what your testimony is?

A I would say it's certainly possible. It would have been my custom and practice. I likely would have said it. But I can't tell you specifically what I said today.

Q All right. Well, at the time of your deposition, you said you had no recollection of that, right?

A I said yes, at that time, having not reviewed any of the previous depositions, that I had no recollection of that conversation occurring. Yes.

Q Okay. You admit you didn't personally tell the PACU nurse who testified earlier, Nurse Hutchins, about the perforations, correct?

A When you say personally, as a direct conversation, I agree. Through my operative report, which was available immediately after the surgery, that's how the communication occurs.

Q Okay. Well, you don't deliver that operative report to Mr. Hutchins, do you?

A No. The electronic record is completely computerized and every PACU nurse has a station right next to them the entire time that they're there with the entire record there.

Q So what your testimony is, you didn't bother to advise Nurse

Hutchins, but Nurse Hutchins had access to your report; that's what you're saying?

A Yes, and that is the custom of surgery for operative reports to be in the chart at the time of -- for the PACU nurse to see them.

Q But you don't think it's important for the PACU nurse to know that there's been a perforation?

A I do. And the PACU nurse did know from my operative report.

Q And so do you believe that the standard of care would require you to advise people in the PACU that this complication has occurred?

A I would agree that would -- should occur and it did occur based on my operative report being in the record at the time.

Q Now, we reviewed some records earlier, and one of the PACU notes under complications, someone wrote, "None per surgeon." Do you recall seeing that?

A I do recall seeing that from the -- I never saw it at the time of the actual admission in the hospital, but I've seen it subsequently.

Q Okay. Do you recall speaking to anyone at the PACU or anyone in the OR and telling them that there were no complications during the procedure?

A No. That conversation never occurred.

Q Okay. So what you're saying is that record is incorrect?

A I'm not saying that. I don't know how or why that particular operating room nurse filled out that form. It likely was a drop-down

menu. But there was no specific question by that nurse, whose name is Gary, Dr. Brill, did you perform a complication at work, and then the surgeon said no. That never occurred.

Q Well, you don't recall that conversation, but somehow, that's what wound up in the medical records, correct?

A That is correct.

Q And you admit that you left Kim in the PACU to tend to other patients, correct?

A After I left Kim, I had one other surgery at Henderson Hospital, yes.

Q And so how much longer were you at Henderson Hospital that day?

A Sitting here today, I don't recall. I'd say roughly an hour to two hours.

Q Okay. So that would have meant that you left the hospital by approximately what time?

A I would say somewhere between 12:00 and 12:30 p.m., that day.

Q Okay. So Kim's procedure was done at 9:00, correct? Approximately?

A I'd have to see the actual time, but somewhere in that -- in that -- it was 9-something based on the records I've seen here, yes.

Q Okay. And you just testified that your other procedure would end in an hour to an hour and a half. So that would put it at about 10:30 at the latest you left the hospital, correct?

A No, that would not be correct. I know I signed my operative report at 10:08, and that means they haven't even started the next case. So the next case likely would -- you know, it takes time to turn over the room. So you're asking me estimations of time. I don't have a specific log of the timing. I'm trying to do my best to answer your question.

Q Were you there at 4:30 p.m., when Kim was discharged?

A No, I was not present then.

Q Did you have any part in the decision to discharge her?

A Not particularly at the time. There is a discharge order in the standing order based on PACU criteria that is based -- is what the PACU nurse decides when the patient should go home. But not the specific time of when the -- when the PACU patient goes home.

Q But that standing order, that was created before the procedure, correct?

A No. It was -- it was entered and signed, I believe, right when I did my operative report. I think it was at 10:09. When I do it -- so when I say standing order, I mean it was an order that was placed as my post-operative order after the surgery.

Q Okay. But you were not actually in the PACU directing Nurse Hutchins to give pain medication, correct?

A That is correct.

Q All right. You admit you ordered no CT to determine if there was air or free fluid in Kim's abdomen, correct?

A That's correct.

Q And you admit you did not try to contact Kim later that day to

see how she was doing, correct?

A Are you referring to after the conversation that happened in the PACU?

Q After the conversation that happened in the PACU, you never spoke to Kim later that day or attempted to contact her, correct?

A That is correct.

Q You admit you selected the Symphion resectoscope or the resecting device for this procedure primarily because of its safety, correct?

A For multiple safety features of the system, yes.

Q Yes. And this has multiple safety features designed to avoid the very types of perforations that occurred in this case, correct?

A I think it is multiple safety features for multiple purposes, not just to try to reduce the risk of perforation.

Q But one of those safety purposes is to reduce or eliminate occurrences of perforations exactly like the type that happened to Ms. Taylor, correct?

A I would agree that it's meant to minimize the risk. I don't think you could ever eliminate a risk from a surgery.

Q Well, I understand because sometimes, you can burn or just push right through the uterus, right?

A Someone could. I don't know who you're referring to. I mean, anything is possible, yes.

Q You admit that you have a duty to avoid excessive cutting or force within the uterus while you're using this tool, correct?

A Can you restate the question? Sorry.

Q Yeah. You admit that you have a duty, or the standard of care requires you to avoid excessive cutting or force when using this instrument within the uterus, correct?

A Well, I would -- I would question what excessive force means because I don't -- I'm not sure that I know what that means. But it's my job to perform the surgery properly and appropriately and within the standard of care, yes.

Q Okay. And you admit that safety is the most important part of any procedure you perform, correct?

A I do agree, yes.

Q And you admit that you have to use your skill, training, and experience to avoid perforations during hysteroscopy to the extent that you are able to, correct?

A I do agree, yes.

Q And you admit you failed to take any pictures of the perforation or your alleged inspection of adjacent structures, for example, the bowel, during the procedure, correct?

A I agree with that. I wouldn't say it's a failure. I would -- but I would agree the pictures were not taken.

Q Okay. I'd like you to look at Exhibit 5, HH48.

MR. BREEDEN: Can you put that up, Kristy? It will be up on the monitors if you just want to look at that. Can you blow that up a little bit, Kristy?

BY MR. BREEDEN:

Q These are the pictures you took during the hysteroscopy, correct?

A These are from the diagnostic hysteroscopy before the use of the -- of the Symphion, yes.

Q Okay. And you would admit none of these photographs show the perforation, correct?

A That is correct.

Q And none of these photographs show any sort of inspection of a small bowel or adjacent tissues, correct?

A Correct.

Q You just simply never took those photographs, correct?

A Those photos were not taken after the perforation, no.

Q Right. So you admit you performed your entire inspection for damage to the bowel or adjacent structures with the camera still inside the uterus, correct?

A With the resectoscope, initially, at the time of the perforation. And then with a second attempt to look for any possible complication at the perforation site with the diagnostic hysteroscope --

Q Okay.

A -- inside the uterus.

Q And all of that was done inside the uterus, trying to look through the perforation to the other side, correct?

A It was looking at the perforation to see what evidence there may be of any other possible injury, yes.

Q And you agree that the standard of care requires you to

check for injury to adjacent organs, doesn't it?

A The standard of care, with a blunt injury, is to look for signs of possible damage to any organ near an injury, yes.

Q How could you be sure that this was blunt injury at that time? How could you be sure it wasn't thermal injury?

A So being the surgeon at the time, knowing that I advanced the camera with my foot off that yellow pedal we had referred to, knowing there was no cutting occurring at the time, there was no reason for bipolar energy to be used at the time of the perforation, which luckily, I saw in real time.

Q Would you agree that the standard of care, if you suspected thermal injury, would be to do a separate laparoscopic examination on the outside of the uterus?

A Yes, I would.

Q Now, you knew Kim had a retroverted uterus prior to the procedure, correct?

A Yes, I did.

Q You knew Kim had a bicornuate uterus prior to the procedure, correct?

A Yes. By the ultrasound results, yes, I did.

Q Those conditions were not a surprise to you during the procedure, correct?

A Correct.

Q They were not unexpected by you, correct?

A Correct.

Q And you felt that despite that knowledge of Kim's anatomy that you could still safely perform hysteroscopy, correct?

A Yes.

Q Are you trying to blame what happened to Kim, those perforations, on her own anatomy?

A No. I'd never blame anything on Kim's anatomy, but those become increased risk factors for a perforation at the time of a surgery like this.

Q You agree that in at least some instances, uterine perforation during the procedure is a result of conduct below the standard of care by the surgeon, correct?

A Yes, that can occur.

Q And you agree that in at least some instances, bowel perforation during the procedure can be caused by something the doctor has done that is below the standard of care, correct?

A Yes.

Q Okay. And in fact, you've performed many hysteroscopies in your career and Ms. Taylor's case is the only one where a bowel perforation has occurred; is that correct?

A That is true.

Q Would you describe Kim's surgery as a success?

A Like I mentioned in my deposition, I don't think we define surgeries as successes or wins or losses, but the surgery could not be completed, so the desired result that was supposed to happen could not occur, so that could be not -- I would say that's not a successful surgery

because we could not continue the surgery.

Q Do you think you made errors during that procedure?

A I did not make errors during the surgery.

Q So if you had to do it over again, you would do everything exactly the same?

A Absolutely.

Q Did you ever tell Kim you were sorry about what happened?

A I don't recall specifically saying I was sorry for the surgery. But I believe I was apologetic that this happened.

Q What is an iatrogenic injury? What does the term "iatrogenic" mean?

A Iatrogenic would mean something that's caused by medical care or by -- whether it's a medication error, you know, something medically, or whether it's an error performed during surgery.

Q Okay. And the uterus and bowel injury in this case, those were iatrogenic injuries, weren't they?

A They were injuries that occurred during the surgery, yes. So they were caused by the surgery, yes.

Q We've heard some testimony in this case about what's been called risks of hysteroscopy. Do you have any independent recollection of what you told Kim about the risks of this procedure before she underwent it?

A So -- remember -- recalling the specific conversation that happened four and a half years ago? If that's what you mean by specific recollection, I cannot say verbatim.

Q Okay. Thank you, Doctor. Do you think it's easy for a surgeon to perforate the small bowel during hysteroscopy?

A I do not think I would use the term easy. I think it's unfortunate and it can happen, but it's not easy for that to occur. Again, I don't know how you define the word easy in a surgery.

Q In fact, out of the three OBGYNs, including you, that have testified in this case -- so that includes Ms. Taylor's expert, which is Dr. Berke, and your own expert, Dr. McCarus, this is the only instance of bowel perforation that any of those OBGYNs have ever seen, correct?

A From what I've heard, yes, me included. Yeah.

Q In opening statements, your attorney described Kim as "doing pretty well" after she was discharged home from Henderson Hospital. You've heard the testimony in this case. Do you think Kim was "doing pretty well" at that time?

MS. HALL: Objection, Your Honor.

THE COURT: Counsel, approach.

[Sidebar at 11:18 a.m., ending at 11:19 a.m., not transcribed]

BY MR. BREEDEN:

Q Doctor, the question -- I'll restate it. Do you believe that Kim was doing pretty well after she was released from Henderson Hospital?

A I can only tell you based on what I've read in reports and what I've heard Ms. Taylor say, that she was in pain. But according to the nurse, Hutchins, she met criteria for discharge based on his judgment.

Q But in fact, Kim has testified that she was in extreme pain,

that she was nauseous, that she was profusely sweating, that she was complaining out of 10 out of 10 pain, so much so that they had to administer multiple doses of a very powerful pain medication. You recall all that testimony, correct?

A I think you're referring to what occurred during her recovery room stay, not after she left the hospital; is that correct?

Q Correct.

A Correct. Yes, I do recall that. Yes.

Q Okay. Do you have any opinion that Kim caused or contributed to her own injury?

A I do not think she caused her injury, no.

Q You would agree with me that the bowel perforation that Ms. Taylor sustained is a serious injury, correct?

A It's a serious, unfortunate complication of the surgery. Yes.

Q It needs to be urgently addressed, correct?

A Once it's diagnosed, yes, it should be addressed urgently if not immediately.

Q If unaddressed, that injury can be fatal, correct?

A If a bowel injury is not diagnosed properly, it can be fatal if untreated, yes.

Q Okay. With a bowel perforation of that kind, you would agree with me that the type of material that comes out into the abdomen is bodily fluids, digestive juices, and the stool or feces at some point in the digestive system, correct?

A Yes. I mean, I believe the stool and feces specifically come

from the large intestine, which is farther down. But it's still a liquid state in the small intestine because the digestion is still occurring. But that fluid is digestive fluid, which will eventually become stool once it enters the large intestine, yes.

Q Okay. And in this particular case, Kim got a serious infection as a result of that material that was flowing out into her abdomen, correct?

A Correct. She was diagnosed with peritonitis. Yes.

Q Do you have any opinion that Kim was malingering or exaggerating her symptoms afterward?

A I would never expect a patient to malinger or exaggerate their symptoms, no.

Q Do you have any opinion that Kim's treatment after being released from the PACU -- in other words, her emergency room visits, her ambulance calls, the bowel resection surgery, her stay -- her nine-day stay in St. Rose Hospital, the home care she received with the administration of antibiotics at home -- do you have any opinion that for some reason, that care was not reasonable and necessary?

MS. HALL: Objection. Lacks foundation.

THE COURT: Counsel approach.

[Sidebar at 11:22 a.m., ending at 11:25 a.m., not transcribed].

BY MR. BREEDEN:

Q Doctor, I'm going to break my question down a little bit so it's not so compound and rambling. And I'm sorry. That's what attorneys do is they ramble, right? So --

A That's your words, not mine.

Q Let's back this up a little bit, all right? So you sat through this trial, and you heard testimony that Kim had to be treated for extreme pain and other symptoms in the PACU at Henderson Hospital, correct?

A Yes. She was treated for her pain. The pain medication at the PACU, yes.

Q Okay. Is there any reason you think that treatment was not reasonable and necessary or related to the perforation she sustained?

A Those are terms you -- I know you've used throughout the week. Those are -- I mean, I think she received appropriate medical care based on what I've seen from the records, yes.

Q Okay. I'm going to ask you the same question, then, about her first ambulance trip to the emergency room. Is there any reason why you think that first ambulance call and the trip to the emergency room was for some reason not reasonable, necessary, and related to the perforation she sustained?

A I have no reason to believe that.

Q Okay. Next question is about her first visit to the emergency room at St. Rose Hospital. Do you have any reason to believe that for some reason, that first emergency room visit was not reasonable, necessary, and related to the perforation she sustained?

A I believe it was reasonable and necessary. I wish I would have been contacted when she was there, but I was not.

Q Okay. Well, Ms. Taylor tried to contact you later the day of the procedure and couldn't get through to you. Do you recall that

testimony?

A What I recall is that she tried to call my answering service and while she was waiting, she hung up.

Q Okay. And even though you knew that you had caused a perforation, neither you yourself nor anyone from your office called Kim later that evening to see how she was doing; is that correct?

A That's correct, and I think you've asked me that. So I got the same answer, yes.

Q So back on the medical care. So now we're at the second time the ambulance is called and transports Kim to the hospital. Do you have any reason to think that that trip was not reasonable, necessary, and related to the injuries that Kim sustained?

A I have no reason to think that.

Q And her nine-day stay in St. Rose Hospital and her bowel repair or bowel resection surgery, do you have any reason to believe that that treatment is not reasonable, necessary, and related to the perforation she sustained?

A I have no reason to. I think it was appropriate, yes.

Q Okay. And you heard Dr. Hamilton testify earlier in this case and you have no reason to doubt that her care is reasonable, necessary, and related to the perforations, correct?

A That's correct.

Q Okay. And now, we'll talk about the -- Ms. Taylor testified that afterward, she was released, and she had to have a PICC line in her arm and she had to self-administer herself antibiotics for -- I think it was

either four or five weeks. Do you have any reason to believe that that care is not reasonable, necessary, or caused by the perforations that occurred in this case?

A No. I would -- I would defer that decision to the infectious disease specialist, that if in their judgment they feel -- they felt she needed four weeks of home antibiotics, I think that's appropriate.

Q Okay. Do you blame Nurse Hutchins or Henderson Hospital for any injury or damage that Ms. Taylor sustained?

A You said injury or damage?

Q Yes.

A So -- no. The -- Nurse Hutchins did not cause the perforation at the time of the surgery, no.

Q Okay. And do you blame Ms. -- Doctor Christensen or St. Rose Hospital for any injury or damage to Kim?

A Specifically, damage, no. Concern that there was a possible delay because she was sent home, yes.

Q Okay. Do you think that caused, for some reason, additional medical treatment to be necessary? Or do you think even if there hadn't been a delay, she more likely than not would have still needed that bowel repair surgery?

A I do agree with that. It was -- it was inevitable that the bowel perforation presented itself with symptoms to require more diagnosis and then surgery, ultimately.

Q Okay. So to be clear, once that bowel perforation is sustained, she's going to need that repair surgery, correct?

A Correct.

Q So as far as you are concerned, you do not think the delay by Nurse Hutchins or Dr. Christensen, or any other medical care provider caused the need for that surgery with the delay. Is that your testimony?

A I think that the surgery needs to be performed once a diagnosis is established. So you know, a delay did occur because of what happened with the first hospital -- ER visit. But the surgery was going to happen once it was discovered there was a bowel perforation. Or the -- sorry, the symptoms suggesting a bowel perforation. I'm sorry.

Q Now, I'd like you to look at Exhibit 1, SRDH 208.

MR. BREEDEN: Can you put that up on the monitor, Kristy? And can you maybe blow up the narrative part at the bottom for us?

BY MR. BREEDEN:

Q This is a progress note that you offered at St. Rose Hospital, correct?

A Yes, that's correct.

Q And this was authored two days after the bowel perforation occurred, correct?

A Correct. It was the morning after the surgery for the bowel injury occurred -- when the bowel repair occurred.

Q So at the time this note was dictated, you now have knowledge that there was a uterine perforation and a bowel perforation during the original hysteroscopy, correct?

A Correct, except I didn't dictate this. I typed this directly into the computer. But everything you said is true, yes.

Q I'm sorry. Then I won't use the term dictated. You personally typed all of this out.

A Correct.

Q All right. And again, this was entered not at Henderson Hospital just after the hysteroscopy, but two days later at St. Rose Hospital, correct?

A Correct.

Q Okay. Now, you write in this --

MR. BREEDEN: And Kristy, if you could highlight this for us.

BY MR. BREEDEN:

Q "At the time of the perforation, I did not suspect that the myomectomy device was actively cutting." First of all, what's the myomectomy device?

A So that refers to the Symphion device, the resection device.

Q This device right here in my hand that we've been discussing, right?

A That's correct.

Q Okay. So aren't you writing this to indicate that even though you didn't think it at the time, you now suspect this device actually was cutting with thermal energy during the injury?

A Are you asking me did I type exactly the opposite of what I thought -- should have typed? Is that what you're asking me?

Q I'm asking you if you wrote, "I did not suspect that the myomectomy device was actively cutting." Why did you preface that with the line, "at the time of the perforation"?

A So I am trying to explain to Ms. Taylor, my patient, what I believe occurred and I'm saying that I did not believe the myomectomy was cutting when the perforation occurred.

Q But if I made a mistake and I came up to somebody and I said to them later, you know, at the time, I didn't think I had made a mistake, that implies that in the present, I do think I made a mistake. Wouldn't you agree with that?

A I disagree with that.

Q Isn't that what you're indicating in this record, that now, with some retrospection, you believe that this device was actively cutting with thermal injury during the perforations?

A If I believed I used the thermal device during the perforation, I would have told my patient that. So I don't agree with what you just said.

Q How did you cause the bowel injury, then?

A The bowel injury was not recognized at the time of the surgery. I think we've established that. So I believe it occurred bluntly with the advancing of the camera, which is part of the resectoscope device. At the same time.

Q Okay. So just to be clear, then, explain to the jury again how and when do you think the bowel perforation occurred during the procedure?

A So I believe -- and again, I don't have the operative report here, but I think we've seen them enough -- that as I was advancing the camera -- and what that means -- I know we have it over there -- but I'm

holding the camera with one hand. I take the Symphion device back into the operative channel of the camera as I advance it, trying to go to the next part of the septum I was trying to cut. That when the perforation occurred. There was no cutting and it's not indicated in my op report, which I wish I had. I don't have it. But that's my understanding from reviewing this, from what happened in real time.

Q Do you remember me asking you that question at your deposition?

A I remember being asked similar questions. I don't remember the exact questions, but yes.

Q When I asked you "how did this bowel perforation occur" during your deposition, do you recall what you told me?

A I'd have to see my deposition, but I believe that I did not see bowel perforation at the time of the uterine perforation.

MR. BREEDEN: Okay. Your Honor, I would like to -- if we could approach?

THE COURT: Uh-huh.

[Sidebar at 11:35 AM, ending at 11:38 a.m., not transcribed]

MR. BREEDEN: If I can approach, Your Honor?

THE COURT: Yes.

BY MR. BREEDEN:

Q Dr. Brill, I am handing you a copy of your deposition. Earlier in this case, you gave deposition testimony about what your recollection and opinions in this matter were, didn't you?

A I did, yes.

Q And you understood that you were under oath under penalty of perjury at that time?

A Yes.

Q And so that deposition represents your sworn testimony that you gave earlier in this action?

A Yes.

Q And if you look at the first page, what is the date that deposition testimony was taken?

A Taken on Friday, April 16th, 2021.

Q Okay. I'd like you to turn to page 34.

A Okay.

Q I'd like you to look at lines 7 through 9 and read for the jury to me what your answer was when I asked you during that deposition how and when the bowel injury was caused.

A So you're saying read only from line 7?

Q Line 7 to 9, please. Your response.

A "So like I said earlier, I could not tell you sitting here today when exactly the bowel injury occurred after the surgery."

Q And the testimony you just gave earlier was that now, you have same opinion of Dr. McCarus that this was caused at the time of the uterine perforation and with the blunt tip, correct?

A Knowing what we know now, I know that a bowel perforation occurred. What I was trying to answer at the time -- my understanding of your questions was did I see a bowel injury at the time of the surgery and my answer then and today was no.

Q You're changing your testimony here today to match Mr. McCarus' testimony, aren't you?

A I disagree.

Q You told me, and you just read from it at the time of your deposition, you said you can't tell when exactly the bowel injury occurred after the surgery, right?

A So this is part of several questions, like I said, I believe, saying, did you see a bowel injury and multiple times, I said I did not see a bowel injury, so not seeing it, I can't tell you when it exactly happens, but it does seem clear that it happened with the perforation of the uterus.

Q Okay. So you didn't see it happen with the blunt tip, either, did you?

A I didn't see a bowel perforation at the time, no.

Q Now, I also asked you how you thought it was possible that you missed the bowel perforation during your inspection. Do you recall me asking you those questions?

A I'd have to see them specifically, but I mean, we had a lot of questions about this line of what happened.

Q Do you recall telling me that one reason you thought you may have missed the bowel perforation was because it was potentially a delayed thermal injury?

A I said that, because yes, that could be a -- that could be a cause of bowel injury. There already was previous use of the cutting device that use of thermal energy near the wall of the uterus and knowing that a septum area is a thinned area, there could be thermal

energy that cause delayed injury to the bowel. That's a known thing that can happen, so that's my answer to that, yes.

Q So let's review this for the jury, so that the jury is very clear on this point. You're saying here today that you think you caused that injury with the blunt tip of the resecting device, correct?

A Correct. Well, what I said is the uterine perforation occurred with the blunt tip, yes.

Q Okay. And if it had been caused with the blunt tip, that's a type of perforation or injury that would have been immediately apparent, correct?

A I disagree with that.

Q Well, it would have been immediately caused -- the -- in other words, it's not a delayed reaction, right? You run the tip of that instrument through the small bowel. All of a sudden, there's a perforation in the small bowel, right?

A That's one theory. Also, the device could crush the organ. The small bowel is very thin. I know we see it on these cartoons here, these pictures, but it's very thin walled. If you do an open surgery, you can literally see contents of a bowel through its wall. So my device could have crushed against the wall and then cause an injury. It doesn't mean necessarily what you've been saying, that it went right through the wall. It's possible, but I didn't see it, so I can't tell. So when you ask me what could have happened, those are theories, because I didn't visually see the bowel perforation.

Q Well, that's not what Dr. McCarus, your own expert testified

to earlier in this case, is it? He testified that it was immediately caused with the blunt tip of the instrument, didn't he?

A I believe he said that. I don't know if he went through the bowel or if you asked him specifically about a crush injury or other -- these are theories, because no -- it was not able to be seen at the time.

Q That's right. And one reason why it might not be able to be seen is because it's a delayed thermal injury, correct?

A That's a possible cause of a bowel injury, yes, in general.

Q So if it's a delayed thermal injury, that would mean that you were activating the thermal cutting device on this instrument when it touched the bowel, wouldn't it?

A I disagree.

Q Hypothetically speaking, if it's a delayed thermal injury, the only thermal instrument you were using is this instrument right here, right? The resecting device?

A That is right.

Q Okay. So there's no other thermal instrument that was inside Ms. Taylor prior to that perforation, right?

A True.

Q Okay. Now, I want the jury to understand very clearly what you mean by delayed thermal injury, all right? If I had a hot curling iron here and I touched it to my hand, my hand might not immediately look injured, but over an amount of time, it would get red and swollen and bubble and it might even break the skin. That's what a delayed thermal injury is, correct?

A Correct. It's an effect from heat that's nearby that can delay -- in a delayed fashion cause a damage to an organ instead of immediately. That's what I said could be the case here, because I didn't see it happen at the time.

Q Okay. So at the time of your deposition, you were saying one possible reason I didn't see this bowel perforation at the time is because it was a delayed thermal injury. That was what your testimony was just a few months ago, correct?

A Correct. Based on what you had asked me at that time, yes.

Q Doctor, I'm going to ask you a hypothetical, okay? Hypothetically, if, in fact, you cut through and caused a perforation of the uterus and the small bowel with the thermal cutting tip of the resecting device, would you agree that that is below the standard of care?

A I would not agree with that.

Q So you think the standard of care would allow you to burn with thermal injury right through Ms. Taylor's uterus and small bowel? You think that would be within the standard of care?

A I think that an injury can happen, even if the surgery is done correctly and even through in this situation, the cutting device was not used, if a cutting device is used in a hypothetical situation against a very thinned out area of the uterus and the bowel, which is behind the uterus and not visible at the time gets perforated, that can happen. That's why we counsel patients on risks and complications that can occur.

MR. BREEDEN: I'm going to object, Your Honor. Move to strike.

THE COURT: Overruled.

MS. HALL: He's answering the question.

THE COURT: Overruled. Go ahead, Dr. Brill.

MS. HALL: Thank you, Your Honor.

THE WITNESS: So that's why we counsel patients on risks. Now, can it be done negligently? That can be done. But you asked does it mean it's negligence. My answer to this day is no. It doesn't mean it's negligent just because it happened. And this is, again, hypothetical.

BY MR. BREEDEN:

Q So hypothetically then, out of the universe of times where there's a perforation through the uterus and into the small bowel caused by the thermal cutting instrument, do you think most of those are due to the physician being below the standard of care?

A I have no way of answering that. I mean, I have never seen another case, but I know that complications can occur with any device that we use inside a patient's body. We take this very, you know, seriously, what we do as surgeons. And a thermal injury can occur. That doesn't mean it was done negligently.

Q But you agree with me that the standard of care requires the physician to avoid causing perforations with the thermal cutting device to the extent possible? Do you agree with that?

A Yes, 100 percent.

Q Okay. Thank you. Those are all my questions.

THE COURT: Cross-examination.

MS. HALL: Thank you, Your Honor. Dr. Brill, I'll let you take

a drink of water.

MR. BREEDEN: I object, Your Honor.

CROSS-EXAMINATION

BY MS. HALL:

Q Dr. Brill, was this a delayed thermal injury?

A No.

Q And in fact, you were here when Plaintiff's expert, Dr. Berke, testified. Is it your understanding that Dr. Berke's opinion is that the perforation to the uterus and bowel occurred with activation of the cutting device?

A You're asking if Dr. Burke feels that way?

Q Right. When you were here and you heard Dr. Burke testify, did you hear Dr. Burke testify that the -- it's his opinion that the cutting device is what caused the uterine and bowel perforation?

A I did hear that, yes.

Q And you've never heard -- have you ever heard Dr. Burke offer an opinion in this trial that this was a delayed thermal injury?

A I do not recall that, no.

Q When you were deposed in this case, had you reviewed the surgical pathology from the St. Rose Hospital surgery that Dr. Hamilton performed?

A I have, yes.

Q And -- but at the time of your deposition, had you reviewed that?

A That I don't know, no.

Q You have reviewed it now, though.

A Yes. Yes.

Q The deposition testimony that you were shown by Mr. Breeden, do you still have your deposition in front of you?

A Yes, ma'am.

Q I'd like to refer you to page 36 of your deposition. Now, your deposition lasted how many hours, would you say, that your deposition lasted?

A I think with the breaks, a little over three hours, I want to say.

Q And you recall -- do you recall at your deposition being asked multiple times whether you saw a bowel perforation occur during your surgery?

A I do recall that, yes.

Q I want to refer you to page 30 -- it's page 36, line 5 of your deposition. And Mr. Breeden asked you, "So you have no opinion one way or another as to when the bowel was perforated or how it happened. Is that your testimony?" And I'd like you, Dr. Brill, to read your answer, which starts on line 9 and go down to 17.

A Okay.

Q When Mr. Breeden asked you that question whether you had an opinion one way or another as to when the bowel was perforated or how it happened, is that your testimony, what was your answer?

A I had said, "Based on the surgery, recalling the surgery from my operative report, I did not see a bowel injury occur at the time of the surgery. If I had thought there was going to be or was a -- possibly a

bowel injury, I would have proceeded to the next step, which would likely be a laparoscopy or some other surgery on consultation to see if there would be a bowel injury."

Q Now, Dr. Brill, if at the time of --

MR. BREEDEN: I'm sorry. Your Honor, can I have him read the next two lines as well?

MS. HALL: Sure.

MR. BREEDEN: 18 and 19?

BY MS. HALL:

Q Go ahead and read --

MS. HALL: You -- actually, Your Honor, I think that Mr. Breeden, if he wants to show the rest of the deposition, he certainly can do that.

THE COURT: I'll allow it on redirect.

BY MS. HALL:

Q And Dr. Brill, did you see a bowel perforation occur that you were able to visualize during Ms. Taylor's surgery?

A I did not.

Q Had you seen that, what would you have done?

A If I was concerned or saw evidence of a bowel injury, the next step would be to immediately ask for the laparoscopy tray to be brought to the operating room and to likely start the laparoscopy, but then ask if there are any general surgeons available for an interoperative consultation, but I wouldn't want to delay that. I'd want to start the surgery, because I'm trained to perform laparoscopy.

Q And did you have any reason to suspect that her bowel had been injured in any manner during her surgery?

A I had no reason to believe that, no.

Q And we'll get to your operative report, but in terms of what you had reviewed at the time that you were deposed, had you reviewed the deposition of Ms. Taylor taken in this case?

A I had not.

Q Had you reviewed the entirety of the St. Rose Hospital chart?

A I'd seen parts of it. I don't know if I saw the entire chart, but I definitely saw parts of it.

Q And with respect to the Henderson Hospital Chart, had you seen that entirety?

A I had access, I know, to the medical records. I don't know if I had some of the specific nursing notes about the pain levels from the PACU, but the care that I did, the orders that -- if that's what you're referring to, that's what I did see.

Q You had reviewed -- had you reviewed the notes that you authored?

A Yes, I did.

Q Had you reviewed the notes of other providers authored by people not yourself?

A And which hospitalization are you referring?

Q At Henderson Hospital.

A So which -- I don't know which providers you'd be referring to?

Q Let me ask you this. In terms of the nursing notes at Henderson Hospital, did you review the nursing notes prior to giving a deposition in this case?

A I did not.

Q Have you now reviewed those?

A I have seen when I was present here in the courtroom, yes.

Q Now, a moment ago, you explained, but I want to give you an opportunity to explain a little further. Do you believe that the uterine and bowel perforation occurred at the same time during your surgery?

A From what I can see, yes. That was the immediate cause of the bowel injury was the uterine perforation, yes.

Q And when you say from what you can see, explain what you mean.

A Meaning that it wasn't evident at the time of the surgery, but having, you know, the benefit of hindsight, knowing what unfortunately happened here, there's no other explanation as to why a bowel would be injured after this kind of a surgery, if there was -- you know, having a uterine perforation at the time.

[Counsel confer]

BY MS. HALL:

Q While Mr. McBride is loading this, I want to ask you. You were asked about these photographs. This is Exhibit 5, page 48 of that exhibit. Now, you were asked about these photos. And in a moment, we'll go over the language that you documented in your operative report at the time of your surgery or shortly after. But these six photos that are

depicted on this screen, when were these photographs taken?

A So these are all taken with the diagnostic hysteroscope prior to my decision to convert to the resection -- resectoscope with the Symphion.

Q So in your practice when you are performing a procedure like this, do you take before and after photographs?

A I do, especially with the idea that we are going to be performing a fibroid resection and then the endometrial ablation, which I know we've spoken about. I think it's usually pretty effective to show a patient, if you are able to complete a surgery, the before and the after, because the pictures look very different. That's typically why I perform the diagnostic hysteroscope before, take pictures. I think should the surgery be completed with an endometrial ablation, I like to show the patient when she comes back to the office, hey, this is what happened with the surgery. This is the change, and this is why hopefully you'll get the benefit of the surgery to reduce your menstrual flow.

Q Are all of these photographs before photographs?

A Correct. These are all the diagnostic hysteroscopic pictures before -- when you say before, before the use of the resectoscope, yes.

Q And why -- are there any after photographs in your records?

A There are not.

Q Can you explain to the jury why that is?

A I don't think they would have been helpful to my clinical care of Ms. Taylor. The -- there was no way to take an instantaneous picture of a perforation, like I mentioned earlier, in real time. And from that

point forward, knowing there's a hole in the patient's uterus and that fluid, like we mentioned earlier, with a pump, is being pushed into the uterus to get the operative field, you only have a limited amount of time to see. So my job was to diagnose and to care for my patient, make sure that I didn't see injury. My thoughts at the time are not taking pictures. They're on the safety of the patient and trying to complete the surgery with the fluid inside, so -- quickly, so we can get the fluid out.

Q Well, you mentioned that it's your custom and practice that your after photographs will be taken when?

A Typically at the conclusion of the surgery to show the before and the after. So if I would have seen a fibroid, I'd like to take a before and after of that. If I would have seen -- if I would have performed the ablation, like I was mentioning, the color change, usually the entire uterine lining becomes gray-whitish from that burning effect of the ablation, which, you know, didn't occur here, because we had to stop the surgery.

Q And it didn't occur, but you mean -- were you ever able to remove Ms. Taylor's fibroid?

A I was not.

Q Were you ever able to perform an endometrial ablation for the patient?

A I was not.

Q And why is that, Dr. Brill?

A Because of the recognition of perforation. It would be contradicted to perform any kind of further resection of tissue. It would

be contraindicated, meaning it's not appropriate to perform any heated fluid in the uterus knowing there's a hole. If I would have done that, that would be negligence and I did not do that.

Q Well, let me ask you this, Dr. Brill. You've told the jury that you believe the uterine and bowel perforation occurred during your surgery; is that correct?

A Correct.

Q How then -- do you believe that you met the standard of care in performing Ms. Taylor's surgery?

A Absolutely I did.

Q How is it that she had a uterine and bowel perforation and yet you still believe that you met the standard of care?

A Because I performed the surgery carefully and properly. I, in my op report, show the care that used to try to follow the pathway of her uterus. And despite all that, doing everything with the -- with my training, a perforation occurred at her uterus.

Q Dr. Brill, you were present when your expert, Dr. McCarus testified?

A I was.

Q And Dr. McCarus -- did you hear Dr. McCarus testify that a known risk and complication means that it can happen even when the surgeon does everything right?

A I did hear that, yes.

Q Do you agree with that?

A I do agree.

Q What does the term, known risk and complication mean to you?

MR. BREEDEN: Object, Your Honor.

THE COURT: Overruled.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q Do you need me to repeat it, Dr. Brill?

A Yes, please. Overruled and sustained confuses me, so go ahead.

Q That's okay. And actually, you talk pretty fast, and it's difficult sometimes for our reporter to get that down, so just try to, if you can, just slow down a little bit.

A Yes, ma'am.

Q Now, the term, known risk and complication, what does that mean to you as a physician?

A That means that every surgery where we enter a patient's body from head to toe, there are known risks and complications when you're operating on an organ that has organs nearby, and it would not be proper for a doctor or a surgeon to not counsel a patient about these risks before the patient makes the decision to proceed.

Q If a patient experiences a known risk and complication, does that lead to the conclusion you violated the standard of care?

MR. BREEDEN: Just a continuing objection on that question, legal --

THE COURT: Counsel approach.

[Sidebar at 11:58 a.m., ending at 11:59 a.m., not transcribed]

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q If a patient experiences a known risk and complication, does that mean you deviated from the standard of care?

A It does not.

Q Can you explain that to the jury?

A So that means that, you know, if a surgery occurs, you want the best outcome you can possibly have. But you're entering a person's body and you're trained to perform the surgery properly. And even doing the surgery properly, taking every precaution, a complication can occur, and they do occur. They've happened in other surgeries. I've taken care of patients throughout my career. There are complications that occur. They've happened in my practice with other patients, other doctors that I've taken care of. These things happen. There's a low risk, but they're known risks.

Q Was this the first occasion where you had a patient experience a bowel perforation from hysteroscopy?

A Yes, it was.

Q What about since? Since Ms. Taylor's case, have you encountered any bowel perforations during hysteroscopy?

A I have not.

Q And the -- is bowel perforation less common than uterine perforation from hysteroscopy?

A Yes, it is.

Q Is bowel perforation also a known risk and complication of the procedure?

A Yes and injury to organs nearby. In this case the uterus has the bladder nearby and the intestines. The small intestine and large intestine, the colon. So these are all organs that are in the area of the surgery and that's how I counsel my patients.

Q Have you ever had a bowel injury occur during hysteroscopy from activation of the resection device?

A No, I do not.

Q Did you do that here?

A I did not.

Q And why -- how do you know that, Dr. Brill?

A I know that based on my contemporaneous operative report that what happened at the time of the surgery that I dictated -- after I had performed the initial cutting of the septum, I then advanced the camera. Meaning the resection -- resectoscope and noticed the perforation during the advancing of the camera. Not during activation of the device.

Q Now Dr. Brill, you keep referring to advancing of the camera. And since I am not a physician, I'd like you to explain to the jury. If I could have you --

MS. HALL: Is it okay, Your Honor, if I have him come down from the stand just to use this?

THE COURT: Yes.

BY MS. HALL:

Q So I have here the hysteroscopy as well as the resection

device. So first and foremost, I want you to explain to the jury how the resection device goes into the operative channel of the hysteroscope.

A Okay. So just to show you it's held this way, but this is what we --I'm sorry.

Q Excuse me. Let me get the microphone a little closer to you.

A Should I get closer.

Q And because of your low voice, I would just suggest that you stand close to this so that the reporter can pick you up.

A So as we heard earlier, this is the resectoscope, which is they hysteroscope used for resection. This is the operative channel here. So this is meant for the Symphion. There are -- you know, that's why it has the word Symphion. If there are other kind of resectoscopes. This would go inside here. And what's happening when we say camera -- this is the lens.

Now, you know, when laparoscopy and hysteroscopies were first started, we didn't have video technology. So literally, you'd have to put your eye here. I can remember performing laparoscopies where you were looking like this. When we say camera, there is a video camera that fits around this lens here and then will project that image onto your screen.

Q And let me interrupt. Is a hysteroscopy, in your experience, is that videotaped so that it can be reviewed later after the fact?

A No. It do not routinely videotape surgeries unless it's either for educational purposes of teaching. And to do that -- plus it's not routinely done. We have to get patient permission for that. We don't

routinely do that during any of our surgeries.

Q And in terms of the camera, can you explain -- you mentioned that that's on the lens of the hysteroscope. Is the lens ever inside of the patient's body?

A It is not. This is all on the outside of the client.

Q And does that mean also -- with respect to the camera itself, is the camera ever inside of the patient's body?

A It is not. It is in my hand. So pretend there was a round camera device. I'd be holding it with my left hand here because I'm a righty. So I'd be a -- you know, when I use the actual Symphion device, I would be advancing it with here but I'm holding the camera here. And what I mean by advancing a camera is if a septum is here, I'm advancing my camera to that septum.

And once we get to that area, I think we've seen pictures that there's a little divot on the side here, so the cutting -- what I like about this device, it's not on the edge. It's on the side. So to do that, I have to advance my camera to the septum. Once I see it, then you advance the device to that area. Once I'm comfortable up against the tissue, then you hit the yellow paddle wing cut.

So advancing the camera, which is -- what I mean by that is I'm taking my hand and pushing on the camera, which means the entire resectoscope device is being advanced.

Q And entire resectoscope device, what do you mean when you use that phrase?

A So that's the entirety of what I'm holding. So that's the

resectoscope and the resection device together.

Q Now -- and again in a moment, I'm going to show your operative report, but when you, as the surgeon, when you advance the camera, can you explain to the jury what, if anything, you're doing with the Symphion portion of the resectoscope?

A Yeah. So I think we mentioned some of the pictures. There's two lenses here, so the camera here is magnifying what happens here. So, you know, there's optics and physics. That's way beyond my scope. But there's a light here and there's a lens here. So when you advance this, you don't see on the screen the resection device until you push it forward so it's visible. So --

Q And let me stop you right there. When you said you don't see on the screen the resection device until you push it forward, are you referring to pushing it forward from the hysteroscope?

A Correct. So I am advancing the camera. To get the proper view, I would pull this back just to the edge here then advance the camera. See the next area of tissue that I want to cut, then advance -- keep my hands still here then advance here. When I mention in the op report, I know we haven't reviewed it in much detail yet today, surprised, I know we will, is that --

Q I'm getting there.

A -- during the advancing of the camera, before any further resection can occur is when I documented the perforation, and that's why there was no further use of the thermal cutting instruments.

Q When you do hysteroscopy, Dr. Brill, do you ever activate the

resection device as you're advancing the camera?

A No. I would not do that in this case. You know, I remember we saw a video in the opening day of the removal of a polyp, I think, or a fibroid, which is very different than this kind of a surgery. In that surgery you're using this device and you could be moving it left and right to kind of go in a circular fashion because you're removing a legion. But to physically advance a camera, I would not do that, you know, to the next area of a septa, which we saw is a different kind of anatomy and a round legion that we seen in the video area, I would not advance that with the resection device in my way to do that. I want to be able to see before I advance this to be able to get to the cutting area.

Q Thank you, Dr. Brill. I'll take that, and you can go head and get back on the stand.

Now there's been some suggestion that -- well, let me ask you, Dr. Brill. Did you intend -- did you try to deceive Ms. Taylor about the fact that a uterine perforation had occurred during your surgery?

A No. I would never do that.

Q Have you ever done that in your years as a practicing surgeon here in Las Vegas?

A I would never deceive the patient nor would I or should I.

Q The conversation that Mr. Breeden asked you about, was there ever a conversation between you and Gary Wernlund, the operative nurse for Ms. Taylor that day?

A Yeah. I mean, we interact throughout the surgery. He's the circulating nurse. So there are conversations that occur. Especially

when we switch from the diagnostic to the resectoscope, he's the one who has to start plugging in the fluid intake and the fluid output in all the machines, so those conversations do occur. I'm the one asking for that to occur.

Q The operating nurse, the operative room nurse, would he have been present during your operation?

A Yes.

Q And when a perforation is noted during surgery, what do you do in terms of advising the staff members present in the operating room?

A So immediately at the time of perforation, it's announced there's a perforation and the surgery is stopped. And then my job then is to quickly act for the safety of the patient to try to visualize it and then decide what the next steps will be.

Q Are you telling the jury that Gary was attempting to deceive Ms. Taylor?

A I don't think Gary was trying to.

Q You mentioned a dropdown menu when you were asked about Gary's note. What is -- can you explain to the jury what a dropdown menu is in the electronic medical record?

A So there are many forms that are in the chart that are filled out with data collection purposes and that particular note, which I don't fill out, that has nothing to do with me, my understanding is that that is the first line. It says non, per surgeon. But there was no -- Gary doesn't say, Dr. Brill, I'm filling out this form now. Can you answer this

question? Was there a complication? And then I would say no, there was not. And he would say none per surgeon. That never occurred. I didn't know of the -- of that entry until it was presented to me for the first time at my deposition.

Q And in terms of electronic medical record, have you heard the term auto populated?

A I have heard of that, yes.

Q What does that mean to you?

A So my understanding is that auto populated means that notes will often have a standard of faults, which would likely be no to most questions or, you know, did the surgery end? It would say yes. I mean, things like that. That's my understanding of auto population default on the notes.

Q And the operative report that you dictated for Ms. Taylor's surgery, when did you dictate that operative report?

A So what was mentioned earlier is my practice is to open the notes and to dictate the preoperative diagnosis and the plan procedure beforehand. And that's just for efficiency because --

Q Let me get your operative report, Dr. Brill. It's Exhibit 5 and I'd like to start with page 42 please. I have the first page of your operative report on the screen. And when you mentioned that there was a portion of your operative report you dictate before the procedure begins, can you tell us what portion of this operative report you would dictate before beginning the surgery?

A Yes. So the only -- it would be the first two lines, which are

the indication for surgery, meaning why are we here? What are we doing or planning to do? And then the preoperative diagnosis. Otherwise, everything else is done subsequent to the surgery.

Q In terms of the indication for surgery, what was the planned surgery that you intended to perform that day?

A So what is documented here and also in my chart was she was counseled and agreed to dilation and curettage with hysteroscopy with fibroid removal and hydrothermal endometrial ablation.

Q And is there any mention in your indication for surgery of a uterine septum for Ms. Taylor?

A No. There's no mention of a uterine septum preoperatively.

Q What about in terms of the remainder of this page, the post-operative diagnosis, the operation section? Are those two sections completed before or after the surgery?

A Everything from that point forward is all done by me after the surgery.

Q In your operation section, you -- what is that meant to document?

A So that is the procedure that was actually performed as opposed to what was planned ahead of time.

Q And did you perform dilation and curettage with hysteroscopy for Ms. Taylor?

A I did.

Q Did you also perform a partial resection of a uterine septum for Ms. Taylor?

A I did.

Q And what did you use in order to partially resection the uterine septum?

A So I utilized the Symphion resectoscope. The one that I was holding. Well not that specific one, but that device.

Q And I want to take you down to the bottom of this note. Let's start with your findings. Did you document in your findings the uterine perforation that you noted?

A I did.

Q And can you explain to the jury what the purpose of your finding section is in your operative report?

A So the purpose is to pretty much tell the narrative of the surgery. So this is a summation of what occurred and what the findings were. So I said there was a perforation of the uterus noted anteriorly just after the beginning of the resection.

Q When you document that the perforation was noted anteriorly just after beginning the resection, is that meant to convey that you were activating the yellow pedal when the uterine perforation occurred?

A No, it's not. Because I didn't say during the resection. I said after the resection.

Q And what about complications? Is there a section in your operative report where you document the complication that you noted during surgery?

A There is and it says perforation of uterus.

Q And in a little while we'll go over the more detailed narrative portion of your operative report. But before we do that, Dr. Brill, I'd like to talk to you a little bit about your background and give the jury some information about your education and training as a physician. Start with -- can you tell the jury where were you born and raised?

A So I was born in Brooklyn, New York. I was raised on Long Island until I left for college.

Q Are you married?

A I am married.

Q And your wife, is she here today?

A She's here. She's in the back with a blue mask, yes.

Q Do you have any children?

A I have three children, yes.

Q And --

A And I have a grandchild too.

Q Don't look old enough to have a grandchild.

A No.

Q You're three children, what are there -- briefly, what are their names and ages?

A So I have a stepdaughter, her name is Courtney [phonetic]. She's 24. I have a son, Toby [phonetic]. He's 18. And I have a son Sydney [phonetic], and he's 16.

Q And where did you go to college?

A So I went to college and medical school at the University of Miami in Miami, Florida.

Q Can you tell us a little bit about that program, and I'll ask you a few questions, but I also want to know how long did it take you to get your undergraduate degree, and then how long did it take you to get your medical degree at that institution?

A So I applied out of high school for what's called the combined bachelor's medical degree program. It's called the Honor's Program in Medicine. So I was accepted to medical school right at -- in high school.

Q I'm sorry to interrupt, but did you -- when did you make the decision to go to medical school?

A In high school while I was taking biology class is when I knew that's what I wanted to do.

Q And so, the six-year program that you were accepted into, at what point during your education did you apply for that program?

A So it was during my senior year when you would normally apply for colleges, they have a program that -- that takes a -- you know, a small amount of people who are guaranteed acceptance into the medical school as long as you complete your bachelor's degree in two years, which is what I did. So I know your -- you asked -- so I was an undergraduate for two years at the University of Miami and then completed the full medical school, which, you know, they don't shortcut medical school. Medical school is four years.

Q And your undergraduate degree, you were -- were you able to complete that in two years?

A Yes, technically. I -- the way it works is they use your first year of medical school classes to count towards your bachelor's degree. But I was technically attending medical school. But they don't award you the bachelor's of science until after your first year of medical school. So I received that in 1992.

Q And what was your bachelor's of science in?

A It was in biology.

Q And then did you go on to medical school at the same institution?

A Correct. The University of Miami School of Medicine, yes.

Q What year did you obtain your medical degree?

A I received it in 1995.

Q Without, you know, going into a lot of detail, for those of us who don't know a lot about medical school, can you briefly describe what sort of education you receive in medical school?

A You receive a lot of information in a -- in a short amount of time. Your first two years of medical school are what -- are what are called the basic science years. So you are basically in classrooms for the most of your time learning -- usually in your first year of medical school, it's all about normal subjects. So normal -- you start with gross anatomy, which we've all heard about from TV shows. You learn about physiology, biochemistry, microbiology, medications, like pharmaceuticals. Slowly -- and they started doing this while I was a med student -- they start introducing clinical skills. So you start to interview your first patients and start to use your stethoscope and all the general

things you picture a doctor using with their light pen.

The second year of medical school is usually based on diseases and trying to learn it. You know, what's -- you know, you just learn medicine to learn about the normal; you have to learn about the abnormal next. So most of second year of medical school is learning about, you know, organ by organ, system by system learning about the different fields. And at least in a basic science way, you learn about pathology, about, you know, what they look at under a microscope.

And ultimately it's progressing up to your third and fourth year as a medical school, which we call the clinical years, which you are, you know, the medical student on the wards doing rounds and you sometimes go to doctors' offices. But you're doing all different fields and learning, you know, a lot of different fields in medicine.

Q Now, once you got your medical degree in 1995, what's the next thing you did in terms of your education so?

A So when you are finishing medical school, you have many choices. And you can decide to become a general medical doctor and, you know, maybe do one year at internship and then practice -- and then put a shingle up and practice. Or you can specialize. So I chose to specialize in a obstetrics and gynecology. I applied for -- you know, you apply for residency programs, and then there's a match process that matches you up to a program based on how you rank the programs and how they rank, and an envelope will tell you your fate in March of your senior year of medical school.

Q So did you go on -- did you go on to do a residency?

A I did.

Q In what specialty?

A In OB/GYN, which is obstetrics and gynecology.

Q Where did you do that residency?

A So that was at Thomas Jefferson University Hospital, which is in Philadelphia, Pennsylvania.

Q And how long is the residency that you did?

A It was four years including the first year, which is the internship year.

Q So of the four-year program, you mentioned that the first year is the residency. In terms of the last year of -- excuse me -- the internship. In terms of the last year of your residency, explain to the jury if you held any positions during your last year of your residency.

A I did. So when you're a senior resident, which is the fourth-year resident, I was elected to be what's called the chief resident. So that means you're pretty much -- now, your -- once -- when you're a fourth-year resident, you're one step away from now practicing on your own without another doctor behind your back looking over your shoulder.

So the chief resident is the one who pretty much is in charge of the entire program. I didn't know that until after I got it. But you're in charge of doing all the schedules, you know, you're in charge of making sure that the correct mentorship occurs between the junior residents. So besides all the typical training you have to do as a fourth-year resident, you know, because you're -- they have to make sure you know how to do

your surgeries and that you can be trusted when you -- when you walk out the door, I was also -- had administrative functions as the chief resident as well.

Q And when in your medical training did you first perform a hysteroscopy?

A Personally you're talking about opposed to like watching one in medical school or --

Q Sure. Let's start with watching. When in your medical training is the first time you observed a hysteroscopy being performed?

A So the first time would be during my third and fourth year at medical school, I performed obstetrics and gynecology clerkships. So the first times would be then. But I wouldn't be performing the surgery. I mean you're lucky if you get to hold the instruments. My first time actually performing would be probably during my first month of my internship. There are senior residents next to you, but like I mentioned, they're there to help guide you and get me to their level. That's what happens in a residency program.

Q During your four-year residency, did you perform hysteroscopies?

A All the time, yes.

Q During your four year residency, were you trained on identifying injury to the uterus during hysteroscopy?

A I was, yes.

Q And during your four-year residency, were you trained on identifying injury to other organs during hysteroscopy?

A Yes, I was.

Q Does that include the bowel?

A It does.

Q And can you explain in terms of what you as the surgeon are looking for in a surgery? What sort of signs or symptoms -- what sort of signs would you expect to see if an injury to the bowel had occurred during hysteroscopy?

A So if a bowel injury occurs during any surgery that you're able to recognize, you would -- there's -- you know, the bowel looks very different than the inside of a uterus. Typically if you see bowel, there's adipose tissue. There's like yellow tissue connected to the large intestine. The small bowel has loops with blood vessels that look very different. So if you see evidence of the -- of the organ of the bowel nearby, you would see that. You -- if you see an actual perforation, you should see fluid or bowel contents come out. Again, it depends on what part of the bowel we're talking about. But that's what you would typically see.

Q What about the small bowel, what sort of signs would you expect to see if there had been injury to the small bowel during surgery that you're able to identify?

A So if you're able to identify a true perforation, you should see fluid, which is a distinctive color. It's usually a yellow-greenish color. The green comes from the bile that gets secreted from the liver into the upper part of the small intestine, which is called the duodenum, and then that combines with food. So the fluid looks very different. It sometimes

gets toward the -- towards the colon, and it's going to start turning more greenish-brown. But most of the small intestine I would say there's a yellowish-greenish fluid that you would expect to see. You might actually see food too, if you see this also.

Q Those signs that you've described, Dr. Brill, is that something that you learned in your medical training?

A Yes.

Q And tell the jury what it is that you did in terms of your medical education. What is the next thing that did after you completed your residency? And first -- I'm sorry. Let me back up. What year did you complete your residency?

A I completed my residency in 1999.

Q After you completed that residency, what's the next thing you did in terms of medical education?

A In terms of my medical education or -- wait. I don't understand the question.

Q Let me -- let me rephrase it. After you completed your residency, what's the next thing you did in terms of your practice?

A So I had a U.S. Air Force scholarship for medical school, which I applied to once I knew I'd gotten into medical school. So I was in the reserves during medical school. Meaning that during the summers, you had to go either to trade -- we'd go to officer training. And during the summers in the third and fourth year, you went to Air Force military hospitals to do some clerkships. And part of that scholarship is you now owe time as an officer in the military to serve as a physician. So I was

assigned to Nellis Air Force Base here and served at Mike O'Callaghan Federal Hospital.

Q And what years were you serving as an officer at Nellis Air Force Base?

A I was here in 1999 to 2003 as --

THE COURT: And, Counsel, before you proceed -- sorry to interrupt, Dr. Brill. We are approaching 90 minutes, so I'm going to go ahead and take a bathroom break for the jury.

MS. HALL: Absolutely.

THE COURT: And during this break, you're admonished to not talk with each other or anyone else about any subject or any issue connected with the trial. You're not to read, watch, or listen to any report or commentary on the trial by any person connected with this case by any medium of information, including, without limitation, newspapers, television, the Internet, or radio.

You're not to conduct any research on your own related to the case such as consulting dictionaries, using the Internet, or other reference materials, test any theory of the case, recreate any aspect of the case, or any in any other way learn 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 to form or express any opinion on any subject connected with this trial until it's finally submitted to you.

We're going to take a 15-minute bathroom break.

THE MARSHAL: All rise for the jury.

[Jury out at 12:25 p.m.]

THE MARSHAL: The jury's clear 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. Brill, you're instructed not to speak with anyone about your testimony. You're still under oath.

And you want to put the objections on the record before we take our break?

MS. HALL: Sure. So the first objection I have is --

THE COURT: So the first objection I have is -- you can step down, Dr. Brill. Go ahead and have a seat out there.

MS. HALL: You can stretch your legs.

THE COURT: Let's see. There was an objection by Defense during direct examination about commentary that was made by counsel during opening statement. The objection was that the comments are not evidence. I sustained it, and we -- and counsel rephrased it. Anything further on that objection?

MR. BREEDEN: Nothing further from Plaintiffs.

MS. HALL: Nothing further from Defense.

THE COURT: Okay. And then there was a question asked about a lot of things, including medical bills, but I guess the reference was whether or not everything was reasonable, and treatment was reasonable, and billing was reasonable. Is that an accurate

characterization?

MR. BREEDEN: We rephrased and broke it down --

THE COURT: Right.

MR. BREEDEN: -- on the reasonableness and causation of the treatment.

THE COURT: Correct.

MR. BREEDEN: As to the billing issues, you did not allow me to ask those questions before the jury. I indicated that I would make an offer of proof. And if it's acceptable to you, what I would do is just file -- it's a couple of pages from his deposition about his testimony on that issue. But to summarize it, I think at that fair summary of his testimony would be that he would say he didn't specifically review all the billing, but he has no reason to believe that it's not usual, customary, and reasonable.

THE COURT: Okay. And I'm fine with you submitting those as an offer of proof as exhibits. And then response by Defense?

MS. HALL: Just that, you know, as we discussed at the bench, he's never reviewed the medical billing. I think that exceeds his scope of treatment to try and elicit that expert opinion without any foundation that he's ever reviewed medical billing.

THE COURT: Okay. And as the billing, I did sustain it. And then as to -- I think I also mentioned I believed it was burden-shifting. And I think it's the Plaintiffs' obligation to establish that any billing was reasonable and -- with regard to medical treatment. And I think by asking a Defendant does he object to it; you're shifting the burden to the

Defense to establish that it wasn't reasonable.

And then, finally, we have the continuing objections to the risks and complications which Mr. Breeden had a continuing objection to and politely asked if he could just have that continuing objection instead of interrupting, which the Court allowed. So for the record, it's a continuing objection as to risks and complications. Anything further?

MR. BREEDEN: I think -- no, nothing further at this time.

THE COURT: Okay. I'll see you in ten minutes.

And just as to -- we have -- this is going to be finish, you're going to rest?

MR. BREEDEN: Yes.

THE COURT: And then --

MR. BREEDEN: Are you going to re-call him, Heather --

THE COURT: That's what my --

MR. BREEDEN: -- or are you going to --

THE COURT: That's what --

MS. HALL: No. I'm doing my direct exam now.

THE COURT: Okay.

MR. BREEDEN: That's what I thought we were seeing.

MS. HALL: I guess I could have explained that. But I am doing my direct exam now.

THE COURT: So then we anticipate maybe like another 30, 40 minutes before lunch or -- I guess the question is, because we're going to have to do jury instructions, argument. I did receive it. I haven't had a chance to review it. I was going to look over it during

lunch. So I'm wondering are we -- Defense is going to rest after this?

MS. HALL: Yes.

THE COURT: And then we can just let them go and come back tomorrow. I mean we'll stay to do instructions.

MR. BREEDEN: That's how I foresaw things proceeding today.

THE COURT: Okay. So then instead of taking a lunch, I'll just release them for the day whenever we're done.

MR. MCBRIDE: So what time for lunch were you thinking? About another 30 minutes when they get back and then --

THE COURT: Yeah.

MR. MCBRIDE: -- take a break?

THE COURT: As soon as we finish this and then you guys will rest, and then we'll go to lunch, but I'll let them go for the day and come back tomorrow.

MR. BREEDEN: Just assuming --

MR. MCBRIDE: Well --

MR. BREEDEN: -- Ms. Hall doesn't think she's got another two hours of questions. I mean, if she does --

MR. MCBRIDE: Well --

MR. BREEDEN: -- then we ought to break for lunch and --

MS. HALL: I don't think I have two hours --

THE COURT: Well, yeah

MS. HALL: -- but I do think I probably have another 45 minutes or an hour.

THE COURT: I'm fine with that. I just -- that's why I wanted them to take a break. But, either way, I wasn't going to take a lunch until like 1:30 anyways, so.

MS. HALL: Challenge accepted.

MR. BREEDEN: To be honest -- to be honest with you, my preference would be to take a lunch break at this time and then come back in the afternoon, so nobody feels rushed or hungry or anything. But it's up to you.

THE COURT: Well --

MR. MCBRIDE: I think -- I agree.

THE COURT: -- I think they would prefer to go home than take a lunch and come back for 30 to 40 minutes and then go home.

MR. BREEDEN: All right. Let's --

THE COURT: That's the --

MR. BREEDEN: Let's do it.

THE COURT: That's all. I -- and I'm not rushing. I mean we got here -- they got here at 10:30. I don't think they should be hungry until about 2 maybe.

MS. HALL: Yeah.

MR. BREEDEN: Judge, I'm known for three-hour lunches. I'm ready for it.

THE COURT: All right.

MS. HALL: I'll speed it up.

THE COURT: So ten minutes for us, and I'll see you back in a few.

MR. BREEDEN: Thank you.

MS. HALL: Thank you.

[Recess taken from 12:30 p.m. to 12:40 p.m.]

[Outside the presence of the jury]

THE CLERK: Back on the record, Your Honor.

THE COURT: Thank you.

All right. We're back on the record in A-18-773472-C, Taylor v. Brill. Counsel for both sides are present. We are outside the presence of the jury, and we are going to proceed with Dr. Brill's testimony. Do you want to get back on the stand?

[Pause]

THE COURT: All right. Bring them in. Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 12:43 p.m.]

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

THE COURT: Thank you. You may be seated.

And ladies and gentlemen, we're going to proceed with the testimony of Dr. Brill. And just to give you a heads up, we will be releasing you early today because we have legal issues to discuss. So don't start stressing out about -- we might go a little passed when I normally would let you go to lunch, but I'm going to let you just go home for the afternoon and come back tomorrow at 10:30. So I just wanted to give you a heads up. Go ahead, Ms. Hall.

MS. HALL: Thank you, Your Honor.

BY MS. HALL:

Q Now, before we took a break, we were discussing the year you left the air force. And what year was that, Dr. Brill?

A 2003.

Q And once you left, were you -- your discharge; was that honorable?

A Yes, honorable discharge, yes.

Q And once you left the air force, did you then enter private practice?

A I did. Here in Las Vegas, yes.

Q Are you board certified?

A I am board certified, yes.

Q In what specialty?

A In obstetrics and gynecology.

Q And when did you obtain that board certification?

A The first time I took the exam and passed it was -- when I was first eligible -- was 2001.

Q Did you pass that exam on the first attempt?

A Yes.

Q And did that include oral and written portions?

A Correct. The written is done right after you finish your residency. And the oral you take a couple of years after you collect your cases.

Q And after obtaining that board certification, have you recertified?

A Yes, every year since 2001.

Q And --

A And currently I'm board certified.

Q Briefly, in terms of maintaining that board certification; what does that require you to do?

A So every year you're required to read articles that are picked by the board that they feel are relevant to, like, things that will possibly change how we practice medicine. And then they changed the rules after this, but six years after I initially became board certified, I did have to take another written examination. And, of course, the year after I finished that they decided they were going to drop that and just allow us to do more articles. It used to be just one set of articles, now it's three sets of articles throughout the year so they can keep updating them. And you have to answer them to -- and get a certain grade to be able to stay board certified.

Q Has there ever been a period of time where your board certification has lapsed for any reason?

A No, it has not.

Q Are you a member of the American College of Obstetricians and Gynecologists?

A I am, yes.

Q And what is that called when you're a member of that organization?

A Once you're board certified, you're a fellow. If you choose to apply, you're a fellow of the American College of Obstetrics and Gynecologists.

Q And that organization, is it referred to often as ACOG?

A It is, yes.

Q Does ACOG have both a national and local level?

A It does. We have sections, including, like, Nevada section. And then we have districts, which includes -- like, for us, we're in District 8, which is most of the southwest except California. And then there's an ACOG national office in Washington that deals with government and congress.

Q I just want to remind you Dr. Brill to try and keep your voice up as best you can and --

A I'm trying.

Q -- and talk as slowly as you can. With respect to ACOG, is -- have you held any national leadership positions?

A I have. I was on the national committee for government relations for two years and then I served on the national committee for patient safety and quality of care for four years, I believe.

Q What does that committee do?

A So that committee, the Patient Safety and Quality Care, would meet several times a year and review documents and try to establish baselines for how you establish quality in our field in terms of, you know, what's -- what should the C-section rate be and how should we improve that? You know? What is -- how should surgeries be done properly? It looks just generally at patient safety, but it's looking at a -- the entire specialty, not like a case-by-case basis.

Q And the four years that you were on the committee, what

four years were those?

A I don't remember. I don't -- I want to say the early to mid-2000s, but I'd have to look at my resume. I don't remember exactly.

Q And what about the local chapter of ACOG? Have you held any leadership positions in your career on the local chapter of ACOG?

A I did.

Q And can you tell the jury briefly what you'd done locally with the Nevada section of ACOG?

A Well, I could even go before that. When I was in the military, the military has what's called the Armed Forces District, which does everything that ACOG does except it doesn't -- you're not allowed to lobby congress, for example, for women's health issues, but I served as the Air Force section chair when I was in the Air Force. And then the Air Force's section is part of the district, which is called the Armed Forces District. So it was Army, Navy, Air Force, Marines. And I was the chairman of that entire district for the Armed Forces District.

When I then was separate -- when I separated from the military, I then didn't want to -- you know, I was actively involved at that level, so for the Nevada section -- that's what we're -- they're called sections. I became an officer. I first was the secretary treasurer, and then I moved up to the vice chair and then chairman of the Nevada section of ACOG.

Q And how many years were you chair of the Nevada section?

A It's a three-year term. So it's three years as chair, also three years as vice chair.

Q During those three years, what sort of duties did you have as chair of the American College of Obstetricians and Gynecologists?

A So we would have meetings throughout the year for OBGYNs. They usually bring in speakers and discuss either updates that ACOG recommend we discuss in terms of -- you know, new procedures, new committee opinions. You know? ACOG comes out with documents about -- you know, about medicine. So we'd have speakers about that. We also would work on a local level for women's health issues, as we have to go to the legislature to discuss, you know, things to help protect our patients and help improve patient care.

Q In terms of lobbying to Nevada's government, have you had occasion to do that?

A I have, yes.

Q And can you tell the jury what the Nevada maternal mortality review is?

A So as we're trying to improve obstetrical care in the country -- you may have heard -- I mean, in the news -- and -- you know -- we've had worsening maternal mortality. Meaning mothers who just gave birth or in childbirth who died. And most states in our country have had what are called maternal mortality review committees.

Nevada was a notable exception. And so it took several years for us to work on this because things don't move very quickly with -- without our government here and with trying to get bills passed, but not this most recent legislative session, but the last one, we finally were able to get a maternal mortality review committee, and that was pretty much

what I was champion -- championing for -- as far as from the ACOG standpoint, but also from Nevada State Medical Association, which helped us with that effort.

Q And what is the purpose of that committee?

A So it -- the purpose is if -- you know -- if God forbid or unfortunately there's, like, a maternal death, it will review the entirety of care to try to look at the system to see -- you know -- what could have caused this? Is there something that could be done to improve it or was it something that was out of our control, but it wants to try to find a cause. And -- you know -- interestingly, we're finding it had a lot to do with mental health and issues that are not necessarily related to obstetrical care. That's kind of what we found so far.

I know that wasn't your question, but in terms of what we do for a living, it's trying to see -- you know -- can we find a way in a way that's not punishing to a doctor or to a nurse or to a hospital what could have been done better or was there -- was there a miss that -- something that was missed. So it tries to review that so that improved care can happen.

Q Have you held any leadership positions in local hospitals here in Las Vegas?

A I have.

Q And starting with -- first that you held in your practice; tell us a little bit about that.

A So with my practice, I was -- initially became the chairman of OBGYN at Spring Valley Hospital in the southwest. And I was chairman there for ten years.

And as part of being a chairman, it's not just an administrative role. You're actually reviewing charts and proving credentials for physicians, looking at charts that are red-flagged to see if -- you know, for -- if something is a -- is a complication or something needs to be reviewed. So it's basically peer review.

So my first leadership, at least in the civilian world -- I should say that when I was at the Air Force base for my last two years, I was the chairman of OBGYN. They call it the Chairman of Women's Health at Nellis for my last two years. And also while I was at Nellis I was the chair of what they call the Patient Ethics Committee. So there's, like, a hospital ethics committee and I was the chairman of that during my final year at Nellis.

Q Since you've been in civilian life, since leaving the military, have you had any involvement in leadership roles in Henderson Hospital?

A Yes. So after I finished my term -- or my ten years as Spring Valley's OBGYN chair, I believe it was in the next year or two that Henderson Hospital first opened. So I was elected to be the initial chief of staff, which is the chief of the entire medical staff, not just the chief of the OB/GYN Department. And I've held that position currently until now, including now.

Q The Clark County Medical Society; have you held any positions with that organization?

A Yes, so the Clark County Medical Society is a physician and physician assistant-based organization that tries to advocate for patients

-- for healthcare in Nevada. I had multiple positions with them, including --

Q What's the most recent position?

A The most recent was the chairman. I was the president of Clark County Medical Society several years ago.

Q And the Nevada State Medical Association; what is that and have you held any leadership positions with that organization?

A So Nevada State Medical Association is the physician organization -- like, it also has physician assistants and medical students for the entire state, and it's made up of county organizations. So Clark County is part of that. Washoe County is part of it. Carson, Douglas is part of that. So most recently, I was the president of the Nevada State Medical Association. I just finished that term in -- I want to say it was August or September. I just finished.

Q Of this year?

A Of this year.

Q The resection device that was used for Ms. Taylor's surgery; what is the name of that resection device?

A It's the Symphion resection device.

Q What type of energy is used by the Symphion?

A So I know we're heard some of -- about it today -- this last week. It's a bipolar energy that uses radio frequency ablation to take the energy from one pole to the other, so the energy stays within that small divot in the instrument we were shown. It's different than the monopolar, or unipolar, I think, is how it was referred to last week.

Q And I know you use the term monopolar. Is monopolar the same as unipolar?

A It is, yes.

Q Have you ever published any articles on bipolar devices?

A I have.

Q And can you tell us a little bit about any articles that you've published on that subject?

A Yeah, so just as I was finishing my residency, I was involved with a research publication that was -- had to deal with bipolar energy for the use of a LEEP. procedure. LEEP procedures are loop -- I don't want to get too medical, but -- Loop Electrosurgical Excision Procedure. So it's a procedure that's performed on a woman's cervix when there's abnormal cells. And traditionally, it's done with a monopolar energy. The idea -- the paper was to see if a bipolar energy could be done safely.

Q And the research that you did for that article; did that require you to look at surgical pathology for both monopolar and bipolar devices?

A It did.

Q And what did you find?

A So the purpose of the study was to see if this would be a safer mechanism than monopolar. Also, when you perform any kind of a surgery with energy -- electro surgery -- and you cauterize -- you cut with an -- this loop that has electricity. As it cuts, it's going to cause what's called thermal artifacts. So -- on purpose. When you perform, for example, a LEEP procedure, which is something gynecologists do all the

time, you get a specimen that has around the edges -- burned edges -- you know -- sort of, in layman's terms -- what we call thermal artifact. The whole purpose of the study was, one, to prove it was safe and make sure that there weren't any higher injuries or, if anything, less injuries to a patient than a monopolar current.

And it was also to see if by using bipolar -- because it actually used two different loops. I know it's technical, but a loop -- a LEEP procedure uses one -- with monopolar uses one loop to go across. The bipolar used two. So the energy to go from one to the other. So by having these two there, would it -- would it cause thermal artifact enough to still allow us to be able to interpret the specimen. So that was the idea. So by having -- using a safer current, which is bipolar, because, like, I think it was mentioned by Dr. McCarus, it doesn't have to enter and exit the body somewhere else. It all stays within those loops.

Can it do that and still allow for the proper excision and the proper pathological diagnosis under a microscope despite using two different loops, which can cause thermal energy artifact?

Q Does the fact that the Symphion uses bipolar energy and bipolar is safer; does that mean that a uterine perforation can't occur?

A No, it doesn't mean that.

Q Does that mean that a bowel perforation cannot occur?

A It does not mean that either, no.

Q And were you -- did you hear Dr. McCarus' testimony that if you had caused the perforation by the bipolar device, that there'd be evidence of thermal energy?

A Evidence where? I'm sorry.

Q Did you hear Dr. McCarus' testimony about the pathology for Ms. Taylor's surgery and if there had been injury from the resection device itself, there would be evidence of thermal injury on the pathology?

A I did hear that for -- on the bowel. Yes, I did hear that.

Q Do you agree with that?

A I do agree with that.

Q And why?

A Because the way bipolar energy cuts, as I think we discussed earlier -- it's not a -- it's not a scalpel, it's not a sharp edge. It's literally energy that's causing the suctioning of the tissue into the -- into that little divot and causing cutting.

So if -- the actual bipolar energy with the mechanism of injury here; if that's what caused cutting, I would expect that cutting to then have evidence of it on the bowel specimen. And that was not present in the bowel specimen that I reviewed. At least on the report I reviewed by [indiscernible].

Q And your -- meaning -- do you mean the surgical pathology report from St. Rose hospital?

A Correct.

Q And the Symphion; is that the only resection device that you use in your practice?

A It is not.

Q What other resection devices do you use?

A So the two that I also use, one is called MyoSure. And the other one I believe is called TruClear.

Q And why did you choose Symphion for Ms. Taylor?

A So as I said, there's multiple reasons why I chose Symphion. One, I -- it was mentioned that the reasons why it was made, I think, was to improve safety. So in this particular procedure where we had the intention of removing a fibroid -- and she had a pretty sizeable fibroid. I believe it was 3.8 or 3.9 centimeters. Fibroids have a blood supply to them. That's what -- how they survive. And I mean, there's a blood supply there that shouldn't be there. It would normally be going to the regular uterine wall, but if you have this ball of muscle, which is a fibroid, I think I was -- I was explaining to you guys, there's blood supply to make that stay alive.

So when I'm trying to resect a fibroid, I have to be prepared for bleeding at any time. So this device allows me to see if there's bleeding and it uses this -- it uses -- the energy that's used has the ability to coagulate, which the MyoSure does not. The MyoSure and TruClear just use sharp edges. So that's one reason because I -- as we talked about earlier, I need to be able to see. If all of a sudden your uterine cavity is filling up with blood, you've got to try to stop that bleeding or you've got to stop your surgery for that reason too.

One of the other reasons is we -- you know -- we talk about the size of the -- of the resectoscope -- the Symphion -- and it has what's called -- a pretty advanced fluid management system. And what that means is I -- it was explained that you have to be able to create pressure on the fluid

to be able to see where you're operating. Like I mentioned earlier, in the real world the uterine walls are up against each other. I think Dr. Berke said this too; you have to expand that.

The MyoSure doesn't do this. The TruClear doesn't do this. In the actual system of the Symphion itself, it has an inflow and an outflow that will monitor the pressure of the fluid. It's all connected with the Symphion device.

Q And let me interrupt just a moment.

A Sorry.

Q The video that was played in opening statement, it showed a tube -- showed two tubes going into the hysteroscope in addition to the resection device. Those two tubes, what are those for?

A So one is the inflow of fluid that goes inside, and that fluid then goes through -- I believe it showed at the end of the camera, there's two holes there. One is where the fluid will come out of. The other one is the outflow. So the outflow is taking the fluid that was inside the uterus and it's continuously circulating it and it's monitoring the pressure. And why that's important is if you're cutting a fibroid, you can open up a blood vessel. And if a blood vessel is open and you're putting pressure of fluid, high volume fluid, it can very quickly go into that blood vessel and cause what's called fluid overload. And that can be very dangerous.

That can cause people to have pulmonary edema, where they have fluid in their lungs. They can have a lot of fluid all of a sudden in their body. So the Symphion is designed in the system itself to have this

mechanism that if it sees fluid is overloading, meaning all this fluid is going in, but none of it's coming out, it sees a fluid imbalance and it will immediately notify us and stop the fluid.

Q Were there any issued with fluid overload during Ms. Taylor's surgery?

A There were not.

Q And were there any issues with the pressure monitoring system of the Symphion?

A There were not.

Q The Symphion device, does it or any of its components record real time data of when it's activated using the yellow pedal?

A I had to check this, but the answer is no.

Q And the resection -- the resection device -- so the Symphion itself -- and I won't have you get down off the stand, but the resection portion of the Symphion. Is that this little window we see here where there's a space?

A Correct. On the side of it, where the divot is, yes.

Q When tissue is resected using the Symphion, where does the tissue go?

A So it gets suctioned in and then the cutting then occurs by the thermal bipolar energy. It goes inside the operative port and then connected to the back of the Symphion, I think there's -- are -- you know, we don't have the full operating room setup, but there is another tube that then goes into a collection device, so it gets -- tissue gets siphoned into a container and then the fluid goes into the actual unit itself and

then the fluid is trying to -- if it recirculates the same fluids, it tries to get rid of blood. And -- but the tissue itself that's solid goes into that siphoning cannister, which ultimately gets sent to pathology.

Q And did that occur here?

A That did occur here, yes.

Q If you had resected the bowel using the resection device, the Symphion, what would you be looking for in terms of the pathology for that specimen?

A Let me just make sure I understand. So if I resected the bowel?

Q Yes. If --

A Okay.

Q -- you had injured the bowel using the Symphion, would that tissue have been sucked into the Symphion device and deposited into the canister?

A Yes. I mean, if the device was actively cutting, meaning using that thermal energy, I would expect that energy to pull the bowel wall. And it could be quick and instantaneous, but I would expect it to pull it into that area and it would get siphoned into the container that has whatever specimen was removed by the cutting instrument.

Q Now, in your experience, if there is bowel present in a tissue specimen, what sort of language would you be looking for in the pathology report?

A So, pathology reports should pretty much say what they see on a gross level as well as a microscopic level and then after they make

their comments, there's a specific diagnosis. So very often, I submit -- for example, we do a hysterectomy with removal of fallopian tubes. It'll say uterus -- this is the diagnosis, cervix. This is the diagnosis. If I -- if there was bowel, I would expect it to say endometrium or you know, removal, this diagnosis, bowel wall present or bowel -- bowel mucosa. Whatever term they would use as the pathologist present, and this is what we see. And that was not present in our pathology reports.

Q Did you see anything at all to indicate to you there was bowel in that specimen?

A I did not.

Q Before you did the surgery for Ms. Taylor, did you speak with her about the surgery at your office?

A I did on multiple occasions, yes.

Q I'd like to show you -- this is Exhibit 3 and I'm going to show you page 23.

MS. HALL: Actually, 26, Mr. McBride.

BY MS. HALL:

Q Now, your office chart from -- your office chart -- Ms. Taylor came to your office for a visit on February the 14th, 2017. What's your understanding of the purpose of that visit?

A My understanding is this was initially set up as an annual well woman's examination.

Q Okay. And at this annual visit, if we look down at your assessment portion, what was discussed at that annual visit with the patient?

A So you know, other than the annual exam, we very often ask is there anything -- you're not just here to have a -- your pelvic and breast exam and PAP smear and go. Is anything else going on? And Ms. Taylor was on a birth control pill, which is called Seasonique, and my notes say she was getting very emotional Seasonique, crying when she normally wouldn't and not just during the last week. And what I'm referring to is the last week of the birth control pills, where you typically has a lower dose that then causes a period. She stopped it in April. She says she has a bicornuate uterus. She is interested in endometrial ablation. Counseling done. Check US, which is ultrasound and then EMBX, which is shorthand for endometrial biopsy first.

Q Dr. Brill, did you know at this visit that Ms. Taylor had a uterine fibroid?

A I did not know that, no.

Q Is that something that you learned after this visit?

A Correct. That was the purpose of the ultrasound was to look for physical causes of heavy bleeding. And that's where we -- the ultrasound that was done showed a fibroid, yes.

Q I'd like to show you -- so you mentioned that you wanted to get an endometrial biopsy. Why did you want to get an endometrial biopsy?

A So we had discussed the idea of performing an endometrial ablation, which is a procedure I think we've heard about, to try to reduce menstrual flow without going to the -- like the most definitive step, which is a much more involved surgery, which would by a hysterectomy. The

standard of care to perform an endometrial ablation is to have a sample of the endometrial lining to make sure the cells are benign and not precancerous, or God forbid, cancerous. It would be -- you would never proceed to an endometrial ablation if you had precancerous or cancerous cells, because you're then burning cells that would -- that should be removed.

So you always want to go through in a stepwise fashion for evaluation. So even though we discussed it, I didn't -- at that point, I did not say that Ms. Taylor was a candidate. We had to go through the steps to see if she would be a candidate for an endometrial ablation.

Q And let me ask you, Dr. Brill. Do you remember the conversation that you had with Ms. Taylor on February the 14th, 2017?

A The specific conversation I cannot recall today, no.

Q Do you have a custom and practice of what you would discuss with a patient who is interested in endometrial ablation?

A I do.

Q What would that be?

MR. BREEDEN: I would object.

THE COURT: Counsel approach.

[Sidebar at 1:07 p.m., ending at 1:08 p.m., not transcribed]

BY MS. HALL:

Q What is -- Dr. Brill, what is your custom and practice of what you would discuss with a patient who's considering endometrial ablation?

A So it would start with very similar to what I already had

mentioned that you don't just have one. There are steps we need to take to see if you're a candidate for one. And then even if someone is a candidate, we need to talk about all the options that are available in terms of not just endometrial ablation, but, you know, why are we choosing a medical -- a surgical option as opposed to a medical option. And I always want a patient to know, if you're going to choose a surgical option, you should know about the choice of hysterectomy, because an endometrial ablation is not 100 percent perfect in reducing menstrual flow.

It has a high success rate, but it's not guaranteed. And if a patient would voice to me, I want you to guarantee to me, doctor, I'll never have a period ever again -- and there are women who will say that to me -- the only way to say it counsel then properly received then a hysterectomy is the only option for that.

Q Now let's go to -- you mentioned that there are steps that you take before endometrial ablation. Is one of those steps an endometrial biopsy?

A It is, yes.

Q I'd like to show you -- it's Exhibit 3, page 22. Now, Dr. Brill, is this the note for the endometrial biopsy performed for Ms. Taylor?

A Yes. From my office, yes.

Q When was this procedure performed?

A March 6th of 2017.

Q Who performed it?

A It was done by me.

Q And can you briefly explain why is endometrial biopsy, why is that a step you want to take before you proceed with an endometrial ablation?

A Similar to what I said earlier. You don't want to perform a procedure where you're actually burning tissue that's going to stay alive in a patient's body and not be removed, if there's a chance of a cancer or a precancerous change. And as women get older, pretty much it's a standard of care in the OB/GYN world, if a woman is over the age of 35 and has abnormal bleeding that we can't otherwise explain, meaning she doesn't -- didn't like miss a birth control pill, if we have no explanation, we want to usually proceed with an endometrial biopsy. It's typically done as a screening test for uterine cancer.

You've all probably heard of PAP smears, which is routinely done for screening for cervical cancer. There is no routine screening for endometrial cancer, be it would involve an invasive procedure, which is an endometrial biopsy. And I say that, even though we know that in terms of the incidence of cancers in women, the most common female gynecological cancer is uterine cancer. It's not cervical cancer, even though women always go in there once a year for their PAP smears.

So it's -- if a woman has a possible symptom of endometrial cancer, which if you look at the symptoms includes abnormal bleeding, we need to make sure we're not missing that, so it's one of the initial steps I would evaluate, not just because a woman wants an endometrial ablation. I gotta make sure there's nothing abnormal going on before we can get to that point.

Q And in your -- in the plan portion of this note, you have some instructions, and you document that the patient will be contacted with the biopsy report and further treatment recommendations. Did you make further treatment recommendations to the patient based on this endometrial biopsy?

A I did, once we had her postop -- her post-procedure visits. She ended up having two procedures, which I think was heard earlier. So at the same visit, we discussed the two results of her procedures and then discussed the next steps, based on those.

Q Okay. I want to show you -- I believe it's 8 -- page 8 of Exhibit 3. I'm going to so you -- this is --

MS. HALL: 18 please.

MR. MCBRIDE: 18?

MS. HALL: Yeah.

BY MS. HALL:

Q I'm going to show you -- it's Exhibit 3, page 18 of your chart. And first, Dr. Brill, what is this note for? What is the procedure that was performed that day?

A So this is March 9th, 2017. It's a separate procedure known as a colposcopy.

Q What is a colposcopy?

A So colposcopy is a procedure where we use a scope or a camera to look at a woman's cervix, because of having some kind of abnormal PAP smear results. And the idea is by looking at the cervix, we can try to see where the abnormal cells that showed up on the PAP

smear are and if we see those, then we take a biopsy of those.

Q Do -- when you are working a patient up for a potential endometrial ablation, do you always recommend a colposcopy?

A I do not.

Q And why was it recommended for Ms. Taylor?

A So a colposcopy is looking for cervical changes in the cervix. Even though it's the neck or the opening of the uterus, it's not considered the same organ. So the part of an abnormal bleeding workup includes doing the PAP smear and her PAP smear result ended up being abnormal and that was the indication for the colposcopy. If her PAP smear results would have been completely normal, we would not -- it's not standard of care to do a colposcopy to make sure someone's a candidate for an endometrial ablation.

Q I want to show you the next office visit in your records after this procedure and that is Exhibit 3, and we'll start with page 9 of that exhibit. Now, after the colposcopy that you performed on March the 9th, is it your understanding that the patient then had a pelvic ultrasound?

A I know it was done. I honestly -- I have to look at the dates. I know it was done somewhere between my visits and these procedures and everything was reviewed at this April visit, but I'd have to look at the dates.

Q Okay. Let's take a look at the next visit that you had with Ms. Taylor? And this is -- what's the date of this visit?

A This is April 4th of 2017.

Q And by this visit, had Ms. Taylor completed an ultrasound of

the pelvis and abdomen?

A She had, yes.

Q And did you go over the results of that ultrasound with the patient?

A I did.

Q What were the results?

A So I wrote here the ultrasound US shows a bicornuate uterus, the right side of the bicornuate uterus measuring 8.7 by 7.8 by 5.8 centimeters with ES, and that is shorthand for endometrial stripe or endometrial thickness. That's the lining of her endometrium measuring --

Q Meaning -- sorry to interrupt, but does that mean how thick her endometrium was?

A Correct. On the right side, because it actually measured the two different horns of her uterus, because there was a cavity going to the right and a cavity going to the left. So this was actually a pretty detailed ultrasound showing both of those there. So it was 9 millimeters. And then in the right horn, which is that upper part of the uterus in the heart shaped area, there was a 3.9 centimeter submucosal fibroid, which is a specific type of fibroid.

Q Well, let's talk about that in just a moment. Is -- what types of fibroids exist?

A So fibroids, I think what we've heard, are very common in women. Some are symptomatic. Some are not. There are three kinds. The one -- and they're all related to the anatomy of the uterus. So a

fibroid is a smooth muscle growth of the -- a tumor of the muscle of the uterus. And we had heard -- you know, there's a thick muscle in most of the wall of the uterus, because that's what usually contracts when a woman's having -- in labor. So we don't know why it happens, but some of these muscles can grow into balls of -- muscle cells can grow into balls.

So there's three kinds. One is called -- it's technical. I apologize. But one's called subserosal and that means it's on the outer surface of the uterus, more protruding into someone's abdomen. So I can tell you, we do C-sections on patients and very often, we palpate the uterus when we're delivering a baby and we feel a fibroid, which is on the outside surface of the uterus. The second one is that's called intramural and that's the medical term for within the wall. So if you picture those -- the uterus that we saw looks like a pear. Inside the muscle itself, that wall, there's a ball of muscle, so it's within the wall of the uterus.

Q Now, the third type, what's that?

A And the third type is called submucosal, which is what we're seeing here and what that indicates is that the fibroid is protruding into the lining of the uterus, which is the endometrial mucosa. So the ultrasound -- a radiologist will read this report and not only see a fibroid, but they see it indenting into the uterine cavity as opposed to seeing that normal T or triangle shape we've seen on pictures. There's a fibroid inside the uterine cavity.

Q When you have a submucosal fibroid like Ms. Taylor's, why not just proceed with endometrial ablation prior to removing -- I mean

without removing the fibroid?

A So a fibroid that's submucosal is likely one of the causes of the bleeding, because it's protruding on that endometrial lining, so when we try to counsel a patient about the success rates of an endometrial ablation, meaning you know, what's the changes you're going to walk out of this and get what you like? Meaning you're going to have less menstrual flow and it won't bother you again, you know, hopefully and at least for most of you, you're -- most of the time. All the data on that is based on a normal shaped uterus. When these companies submit their data to get FDA approval, it was all based on that initially.

Now there's then reports of it being done with a fibroid present, so my goal is to try to -- in offering a surgery is to try to get my patient back to as normal as possible. And there are techniques to remove the submucosal portion of the fibroid that's protruding into her endometrial lining. And the benefit of that is by removing that first, then you can proceed with the remainder of the ablation, which means that heat will get up against the endometrium without that fibroid there.

So the chance of needing a subsequent surgery is diminished, because we can do this all at the same time and hopefully get the best outcome in terms of reducing menstrual flow.

Q And when you say heat next to the endometrium, are you referring to the hydrothermal ablation?

A Correct. That's the ablation that I chose because of her anatomy, having this fibroid there. There are other ways to do it, which I did not think would be appropriate for her.

Q Did the ultrasound that you went over with Ms. Taylor, did it describe that she had a bicornuate uterus?

A It did.

Q Did it describe the presence of a uterine septum?

A It did not.

Q Do all bicornuate uteruses have a uterine septum?

A They do not.

Q I want to show you this diagram.

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

THE COURT: You may.

BY MS. HALL:

Q So Dr. Brill, if you could just step down these stairs, and I'll have you explain a few things on these diagrams.

THE COURT: Make sure you're by the mic, Dr. Brill.

BY MS. HALL:

Q Actually, yes. Let's have you stand -- since you're a lot more softspoken than I am. So first and foremost, Dr. Brill -- and if you need to look at the diagrams and then step back to the microphone, that's perfectly fine. But the diagram on the left, what does this show?

A So this shows that -- an example of a bicornuate uterus. And what that implies, if you look at the -- when we talk about this heart shape, it's that top part. So the serosa is this outer portion here. So instead of it being -- I know this is not labeled a normal uterus, but this top of part is actually normal. Instead of being rounded, you've heard the pear shape. That's very common terminology by gynecologists. It

actually has an indentation.

Q So I just want to make sure --

A And that's where we talk about -- oh.

Q -- that everyone can see, so I'll hold this for you.

A The heart -- sorry. I know we're talking over each other. Sorry. But that's the heart shape that's described on a bicornuate uterus.

Q So the heart shape, meaning up here on the outside of the uterus?

A Correct.

Q Now, the diagram to the right, can you tell the jury what this is showing?

A So this is showing -- it's labeled septate uterus. I mean, the medical term is subseptate uterus. What a septum is, if you notice the uterus still has its normal pear shape at the top, but there is an indentation here and it's a white tissue, because it's different tissue here. A full septate uterus, which this doesn't show, would have this septum go all the way down here. And there's actually -- there's a whole continuum of what's called congenital uterine anomalies or how women can be born. There's one -- the most distinguished one is called a didelphis uterus, where this goes all the way down to the point to where there's two uteruses.

And I've had patients with this with two cervixes, two completely separate uteruses, based -- and the septum goes all the way down to here. Then there's a full septum, which can go all the way down to the bottom of the uterus here. And this is the cervix. And then a subseptate

uterus is what we see here, where you see this indentation going down and then in terms of like what are called the horns, you can have that on a bicornuate uterus or a subseptate uterus, but you have this one cavity here --

Q The one --

A -- one cavity here.

Q -- cavity here, what is that?

A So this -- I mean, so remember, we're looking at the back wall of a patient's uterus. You know, as if we removed the front. So we're looking here. This is the patient's left side, which is always confusing. That's the patient's right side here. So this is the left horn. That is the right horn.

Q Thank you, Dr. Brill. You can join -- you can get back up on the stand. Now, in terms of the ultrasound that you had Available to you at this April 4th visit, did it describe seeing a uterine septum in any way or indicate any language that would suggest to you that there was the presence of a septum?

A It did not.

Q I want to show you page 10 of Exhibit 3. And this is just a continuation of that visit. Now, at the April 4th visit, did you go over the results of the endometrial biopsy and colposcopy you had performed?

A I did.

Q And were those -- did those results show the presence of any malignancy?

A No, they both showed benign cells.

Q Now, in the assessment portion of your note, you document that she was counseled on options and would like to have hysteroscopic fibroid resection as well as HTA ablation and D and C. Dr. Brill, do you remember the conversation that you had with Ms. Taylor at this April 4th, 2017 visit?

A I have a vague memory, but the specific conversation word for word, I cannot tell you today.

Q Do you have a custom and practice of what you would discuss with a patient who's considering that procedure?

MR. BREEDEN: Object.

THE COURT: I'm sorry. Can you repeat the question?

MS. HALL: Sure. I just asked if he has a custom and practice for what he would discuss with a patient considering that procedure.

THE COURT: Overruled.

THE WITNESS: I do.

BY MS. HALL:

Q And what is that, Dr. Brill?

A So I would break things up and you know, endometrial ablation is -- has a discussion and the resection of a fibroid has a discussion. Not every patient asks to have both, or you know, has an indication for both. There's different reasons why we do these procedures. But typically I would talk about the pros and the cons, meaning what are we trying to gain from this and what are the cons if we don't do the procedures.

And then I talk -- when it says here R-slash-B-slash-A, you know,

me, being a doctor, I use shorthand. And I'm typing usually things very fast. That stands for risks, benefits and alternatives discussed as well as the option of not having surgery. So it'd be my practice to review what we're talking about, why would we do it, as opposed to not doing it, what are the benefits we're trying to achieve, what are the complications that could occur? Because we're choosing to perform surgery under my hands. I don't want a patient to not know that there are risks to surgery. There are.

Q As part of your custom and practice, what risks, and potential complications would you discuss with a patient?

A So as part of my practice, it depends on the surgery and the part of the body.

Q For this --

A For this --

Q -- for this surgery that you were discussing.

A So performing a hysteroscopy with these procedures, there's risks of infection, because we're entering someone's body. There's risk of bleeding, again, because we're inside somebody's body. And any procedure where we're removing something or performing a curettage can cause bleeding. And then I always discuss the risk of injuring organs that are nearby and that would be tailored to what surgery we're doing.

So near the uterus, like I mentioned earlier -- I can't remember who -- which one of you guys asked me, but there's -- you know, the pelvis has the bladder in front of the uterus. It has the colon and the rectum behind it, and it has the small intestine surrounding it. There's

also the urinary track which is the ureter. These are all organs that are nearby. I very often will say the risk of injury to urinary tract and not go through every specific, but a patient needs to know there's a risk of injury organs that are nearby.

Q Do you believe that you discussed those pros and cons, risks, benefits and alternatives with Ms. Taylor at this visit?

A I do.

Q And when you document that, you discuss the most recent data on hypo-menoria [sic]. Is that how you say that?

A Hypomenorrhea.

Q Menorrhea. What is menorrhea?

A Menorrhea.

Q Hypo -- what is hypomenorrhea?

A So Hypomenorrhea means decreased blood flow. And what it -- it's the medical term for blood flow that's not bothersome, meaning a patient's not going to present to me and say, hey, this is bothersome to me. What can I do? So the ultimate goal of the endometrial ablation is to do a conservative treatment, meaning -- by surgery, meaning not a hysterectomy and try to achieve hypomenorrhea. And the rates that are known that are in all of our textbooks or you know, if you read articles on this, are based on a normal triangle-shaped uterus, not one that has a bicornuate shape or has a fibroid inside.

Q Do you believe that you discussed that with Ms. Taylor at this visit?

A I did.

MS. HALL: Your Honor, may we approach?

THE COURT: Yes.

[Sidebar at 1:26 p.m., ending at 1:27 p.m., not transcribed]

BY MS. HALL:

Q Now, Dr. Brill at this visit, you document surgical complex decision making visit. What does that mean?

A So that's -- you know, to me this is the most important visit, because this is when a discussion occurs about you know, should we have surgery and if so, what is -- what are the risks and benefits. So it's a complex decision making visit. This is where the majority of the discussion will occur about are we going to make this -- are you going to -- as my patient, going to make this choice. And, you know, that's -- if a patient's going to make that choice, she has to know what she's signing up for.

Q Now, after this visit, your records indicate that you saw Ms. Taylor back on April the 21st, so I'd like to show you that note, and we'll start with page 5 of Exhibit 3. With -- in your practice, is the surgical complex decision making visit, is that generally a more lengthy visit than your preoperative visit?

A It generally is, yes.

Q Now, I've got on the screen for you, this is page 5 of Exhibit 3. Why did you see Ms. Taylor on April the 21st, 2017?

A So this is what we call a preoperative visit, which is a visit to discuss the surgery that we are going to proceed with after the decision making from the last visit. It's also to discuss how to prepare for the

surgery, you know, when to stop eating night before, what time to come to the hospital, basic stuff like you can't drive yourself home from the hospital. We also give paperwork to take to the hospital to register and usually get some preoperative labs, if they're needed.

Q And I want to direct you down to page 7 of Exhibit 3 and this is a continuation of your April 21st office note. And in your assessment, you indicate that the patient had a fibroid and menorrhagia. What is menorrhagia, Dr. Brill?

A Menorrhagia refers to -- rhagia means heavy, so it's heavy menstrual flow, so it's heavy bleeding from menstrual flow, menstrual tract.

Q By this visit, had Ms. Taylor scheduled her surgery?

A Yes. It was already scheduled.

Q And the plan portion of your note, what do you indicate in terms of any discussion with the patient?

A So it says admit for surgery, because this is what becomes the preoperative history and physical, so this is in the Henderson Hospital record for me. But I discussed with the patient the indications for the procedure included in the discussion where the options of therapy, which means the surgery, the risks and complications as well as the benefits. Ample time was given to answer all the questions. And then I described the procedures that were planned.

Q Do you recall specifically your conversation with Ms. Taylor at this April 21st visit?

A The same answer. Specifically, no. About what happened

during that visit, I can't say the specific words.

Q And earlier, when we went over the April 4th visit, you told us about your custom and practice. Would you have -- as part of your custom and practice, would you have discussed the risks and complications that you first discussed at the April 4th visit?

A Yes. So you know, we have patient education literature that is given to a patient, and we use very detailed program that describes every procedure. So the dilation and curettage with the hysteroscopy is one. The resection of the fibroid is another and the hydrothermal ablation. So it says in -- pretty much in laymen's terms -- you know, because I know I'm a doctor, so I speak like a doctor, but I try my best to explain to a patient, so she understands what -- the surgery she already has signed up for. So we review those forms. That can be a very quick discussion, based on the patient. It can -- sometimes people can go with it line by line. I've seen, you know, the whole myriad of what can happen.

And then typically copies are given to the patient as well, so they have those. And then ultimately, those orders that are signed by me and are given to the patient in a packet, which she takes to the hospital sometime between that visit and the actual surgery date to register at the hospital, get labs done. They do like the preadmission, so everything's ready. When she shows up that morning, she had her band ready for her arm, all the data of her background and contact information, all of that is in there.

Q Well, and that brings up a good point. In terms of in addition

to any discussion that you had with Ms. Taylor at this visit, was she also provided written education materials about the procedures?

A She was. That's what I was mentioning earlier, yes.

Q That would have been written materials that the patient was given to take home?

A Correct.

Q And then you mentioned that ample time was given to answer all questions. Why is it important to you as a surgeon to give a patient an opportunity to ask questions?

A Well, this is the patient's surgery. I perform surgery, you know, every week. But a patient has to feel comfortable. And even if a patient signed up a week ago and doesn't exactly understand what she signed up for or doesn't understand all the risks and benefits, I mean, I want to make sure our patient knows what she's doing, meaning signing up for a surgery that's going to be performed by me. So I -- you know, I want to make sure the patient has the chance to ask me those questions.

Q Now, after Ms. Taylor left your office that day, did you then perform surgery for her on April the 26th?

A I did, yes.

Q Do you remember speaking to Ms. Taylor at Henderson Hospital before your surgery?

A I do, yes.

Q And do you remember the conversation that you had with her before the surgery?

A Same answer. I don't have the specific recollection of what

was said, but I have a general conversation with my patient before, yes.

Q The -- let's go to your operative report. And that's Exhibit 5 page 42. Now, you told us earlier, Dr. Brill, that the indication for surgery and the preoperative diagnosis, those portions -- are those completed before surgery?

A They are, yes.

Q And the operation portion of this note, do you indicate that you removed a fibroid for the patient?

A I do not.

Q Do you indicate that you resected a uterine septum?

A I believe it was on the last page, but it says partial resection --

Q I'm sorry.

A -- of uterine septum.

[Counsel confer]

BY MS. HALL:

Q Sorry about that, Dr. Brill.

A It's okay. I believe it says partial resection of uterine septum.

Q And we'll go to that. In the operation portion, do you note that you partially resected a uterine septum?

A Yes.

Q When is the first time that you learned Ms. Taylor had a uterine septum?

A It was during the procedure intraoperatively when I placed the diagnostic hysteroscopy inside.

Q And when you encounter a complication during surgery, do

you believe it's important to note that in your operative report?

A I do.

Q Did you do that here?

A I did.

Q I want to go to page 43 of Exhibit 5. Now, if you can, for those who haven't seen an operative report before this trial, can you just generally explain what is the purpose of documenting the technique portion of the operative record?

A So from day one of our training, we're trained to dictate basically everything that happens in a surgery, you know, not second by second, but pretty much what happens from the beginning to getting the patient onto the operating room table to the end, when you take her off the table. So it's documenting the technique of the surgery that occurs. Here it's called technique. I know when I -- other systems, if I dictate into a phone, I say procedure in detail, but here, they have it prepopulated to say technique and then you dictate your note there.

Q This operative record that we're looking at, did you dictate this?

A I did.

Q And the record indicates that Ms. Taylor was placed on the operating room table and given general anesthesia and LMA. What does LMA mean?

A So LMA is a way to control a patient's airway, because she's put under anesthesia, so she -- we have to breathe for -- well, the anesthesiologist has to control her breathing. So instead of intubating a

patient, which means you put an intubation tube all the way into her lungs, you put this mask. It's a laryngeal mask that goes inside her upper -- or her throat to control her airway and try to prevent her from throwing up or aspirating. But ultimately what it's doing is controlling her airway, so the respiratory with the anesthesiologist can breathe for her.

Q Well and who decides how to deliver anesthesia or control the patient's airway?

A It's the anesthesiologist, typically based on what kind of surgery is being done.

Q And this also indicates that the patient was prepped and draped in the normal sterile fashion. What does that mean?

A So I mentioned the risk of infection, so you know, we don't want an infection to occur, so this is why, you know, doctors wear sterile gloves, and, you know, we scrub our hands, and we prep -- what prepping machines and is place surgical antiseptic prepping on a patient. So you know, depending on the situation, you might use iodine, or you might use chlorhexidine, but it's an antiseptic solution that's surgical grade that's placed on the patient before we touch her surgically.

And then after that's placed, then we drape her. So if you've ever seen on TV an operating room, there's usually blue or green drapes. Those are all part of the sterile field. So if my circulating nurse is handing us -- or walking around the table, they know not to touch anything that's draped, because it can -- so we can keep our sterile field to try to reduce the chance of infection. And you also dictated that her

bladders was straight catheterized for a small amount of urine by the operating room nurse. Why was that done?

A So to me that's very important, too, for a hysteroscopy because, you know, even if a patient urinates on her -- or voids, you know, on her own just prior to being walked back to the operating room, the bladder is right in front of the uterus, so if a patient has a full bladder when I perform a hysteroscopy knowing that there's a risk of injuring the organs that are nearby, which are not just the bowel. It's the bladder. I don't want there to be a full bladder. I want the bladder to be as empty as possible, so there's less chance of a full bladder pushing onto the uterus and then if there's a perforation with a larger bladder there, there's a higher likelihood the perforation could go into her bladder, which is a whole separate complication. So this is -- it sounds like a small thing, but it's an important step.

Q And next you say that an examination under anesthesia was done, which revealed a retroverted uterus approximately eight weeks size. What do you mean by that?

A So when the patient's under anesthesia, she's not awake, so it's normally done by gynecologists to perform an examination under anesthesia, because this way I could carefully palpate the uterus without the patient awake. When you perform an exam on a patient who is awake, she's -- she might feel pain, if I really push hard. You know, a pelvic exam, I don't want to get too graphic, but two of my fingers are in the vagina, pushing on the cervix, so I can feel the cervix. My other hand is on the abdomen trying to feel the uterus between.

So I -- besides what an ultrasound shows, I'm the one operating. I need to know the direction of the uterus, the shape, so I can do as careful of an exam as I've done. Even though I've done an examination on her -- on any patient in the office, when they're awake, you can do a more involved exam without the concern of a patient, you know, being in pain, because she's under anesthesia already. So before I do any entering of the patient's body surgically, I want to do that examination under anesthesia.

Q And then you say a timeout procedure was performed. What is a timeout procedure?

A You know, a timeout is done on every surgery. This is a -- I mentioned my patient safety committee background. This is one of the things that came out of patient safety committees, because we've heard of you know, wrong limb surgery or you know, wrong knee or someone had the wrong kidney taken out or wrong organ taken out. So instead of just doing a time out procedure on someone who has a unilateral, like if someone was going to have a right-side ovary removed or a left -- as opposed to a left, every surgery now has a time out as a patient safety measure. So it wasn't just done here.

The idea, we are identifying that this is the right patient, that they didn't mess up and, you know, the patient is now asleep. Do we have the wrong patient here? Is -- what's -- we all -- we discuss the surgery that's planned, and the anesthesiologist announces what anesthesia they're using. They announce the fire risk, safety score. There's all these things that are announced so we all feel comfortable we're doing

the right procedure on the right patient in the right place.

Q And can you just walk us through from your operative report, after that time out procedure, what steps you then took?

A Yeah. So -- I'm sorry I'm looking this way, but I placed a speculum into the vagina, and a speculum is what's usually used during pap smears so I can visualize the cervix. And then I performed a paracervical block. And what that is is placing numbing medicine around the cervix, the idea being that even though the patient is under anesthesia, she could feel pain after surgery, as we -- as we all know.

So the idea of doing a paracervical block before I do any entering of her cervix, before I do any dilating, by putting a nerve block with local anesthesia, which is what that next part is, the Marcaine. It puts a field of local anesthesia around the nerves of the cervix so when she does wake up, she's less likely to feel pain from the cervix, at least, from dilating. So that's a standard procedure I perform before dilating a cervix.

And it explains I used a total of 10 ccs -- or milliliters -- of a quarter percent Marcaine, which is a long-acting anesthetic, with epinephrine. Epinephrine is something that is -- that tries to constrict blood vessels, so it tries to also just keep the anesthetic there and not -- and less chance of spreading throughout her blood -- her body. And I used a spinal needle. What that means, that's just a very small-sized needle. If you've had your blood drawn, they usually use a certain size bore of a needle. Spinal needles are about as small as they get. They're used for spinal anesthesia and people who have, like, C-sections. But they're very small.

So just, I'm trying to focus that local anesthetic just around the cervix where the nerves are.

Q After you were able to apply the local anesthetic, you document that you attempted to place a uterine sound, but the internal loss was stenotic at the cervix. And then you used Hank dilators. What are Hank dilators?

A So Hank dilators, when we talk about dilation and curettage, there are actually devices that are set. There's different kinds of dilators. The reason why it shows Hank dilators, and again, this is -- I think this is important, is traditional -- when a -- when a uterus is either mid-position or anteverted, or when it faces up, we will very often use what are called Hegar dilators. Again, a medical term. But they pretty much look like a cigar. That's how we were always trained, Hegar, it looks like a cigar. So they -- they're -- they have blunt edges, but they're basically straight with a very small curvature to them. But they're basically straight like a cigar.

Hank dilators are different. The ends of them curve up and curve down. So knowing she had a retroverted uterus, which we had discussed, that's pointing backward, the dilation is one of the portions of the procedure which is done blindly. I think we heard Dr. Berke say that. You don't put a camera in when you dilate. You're first trying to get inside the uterus to begin with so you can go to the next step.

So on purpose, I dilate with a Hank dilator, aiming towards the retroverted lesion because if I don't do that, I could perforate the cervix and the anterior uterus right there and then. So I --

Q If you did that --

A Yes.

Q -- if you perforated the cervix during dilation, what would you expect to see?

A I would feel that as you are placing this instrument, which is a blunt tip, it normally will only go a certain amount through her cervix. You can feel where the cervix ends and where the uterine cavity begins. So as it goes inside, if it just keeps going and keeps going and keeps going, you know there's no way that it's being stopped by the uterine wall, it means it's perforated and gone through. So I'm feeling for that because you have to. You can't visualize it.

Q And did that happen here?

A It did not occur here.

Q Would you have been able to distend the uterus if a perforation had occurred at that point?

A I would not. Not with a hole in the cervix or uterus.

Q Were you able to distend the cervix and uterus?

A Yeah, with the distention medium we discussed, the fluid that was used. Yes.

Q Now, after you were able to do that, you say that you placed a diagnostic hysteroscope, being careful to follow the pathway of the dilation. Why did you exercise care in following the pathway of dilation?

A So I mention that because the diagnostic hysteroscope is rigid. It's, you know, similar -- when we saw the Symphion, which just is not diagnostic, but it's a metal, straight tube. It doesn't have a curvature

on it like those Hank dilators do. So knowing that her anatomy goes downward, you know, part -- I know you didn't ask me this, but there's a reason why there's a single tenaculum on the anterior lip of the cervix. So the cervix, and you picture this as, like, her -- it's like -- I'm looking at her -- like this end of my fist here. This is her cervix. If -- the cervix can move. So if I'm trying to put a dilator or a camera inside, the cervix can keep moving. And you don't really want to have a moving target. I want that uterus as still as possible to reduce any risks.

So after the nerve block, you put the tenaculum on. I'm holding that on her cervix. And that's -- so this way, when the dilator goes in, and then ultimately, your question, when the diagnostic hysteroscope goes in, I can hold the uterus and cervix -- well, the cervix, in place, and then aim my camera in that retroverted fashion. Because if I don't do that, there's a very increased likelihood I'm going right through that anterior wall of the uterus because her uterus was just -- shaped the way it is. It's shaped downward as opposed to upward, which are the majority of uteruses.

Q And once you were able to get the diagnostic hysteroscope in place, what's -- what did you see and what did you do?

A So once it was in place, you know, while I'm doing it, fluid is going. We -- I placed the fluid on very -- like, kind of slowly to help kind of slowly open the cervix. And then once it's inside, past the opening of the cervix, you're then in what's called the uterine cavity or the endometrial cavity. And that's when I start to see if I get visualization. Sometimes it's blurry the second you open -- you get inside. So you

wait for the auto-focus feature to happen.

And then, that diagnostic hysteroscope is also placing fluid inside and fluid out, so you're making sure you can see properly. And you literally are watching the uterus expand. And then you document -- I document what I see, which is what happened -- is next in my op report.

Q And you document that you saw what appeared to be white uterine septum and two small areas that appear to be the uterine horns. Dr. Brill, does that language indicate to you that you did not know what you were looking at inside of the uterus?

A Not at all.

Q And you say that, "There is no obvious fibroid seen at the right side because there was white tissue here." The white tissue, is that a reference to the septum?

A I say what appeared to be the septum because there was no mention of a septum before, so I'm seeing white tissue in a triangle area, very, you know, similar. It's not exactly like the cartoon that was here before. But it appears to me to be that. No one can prove that to you unless you biopsy it so you know for sure. If it would have been a more simple bicornuate uterus, where you just saw an indentation, I would have likely dictated what appears to be the bicornuate uterus. But I'm saying that I see this white tissue, which is a much more broad triangle than just a little indentation of a heart for a bicornuate uterus.

Q And then you go on to say that you felt that there could be septum covering the area; pictures were taken. Are those the six pictures that we saw earlier?

A They are, yes.

Q Were all six of those photos taken with the diagnostic hysteroscope?

A They were, yes.

Q And I think you told us this earlier, but was it your intent that those six photographs would be before photographs?

A Correct. Yes.

Q And then you say, "I made the decision to switch over to the resectoscope and was set up. I had to dilate again to follow the proper pathway." If the uterus had been perforated during your switch over to the resectoscope, would there have been distension of the uterus?

A There likely would not have been. And the reason why I mention this is because the hysteroscope -- I'm now switching to the resectoscope; it's a larger width. We -- you know, the diagnostic scopes are usually about four millimeters, that are smaller on purpose. We're now switching to the 6.3-millimeter Symphion resectoscope. So I had to again dilate to make sure that the camera would be able to -- this larger camera would now be able to fit down that backwards-facing pathway.

Q Meaning the patient's right horn?

A No, I'm still -- I'm talking about going -- I dilated her cervix again after the -- because the camera, once it's inside -- the diagnostic scope -- it's keeping the cervix open. Then I remove it. Then I dilate it again to make sure that a six-millimeter hysteroscope would properly fit before I put the scope inside. So that's why I document that.

Q And did you have any difficulty doing that?

A I did not.

Q Once you had the resectoscope device in place, you document that you, "were able to visualize what appeared to be the septum. I used the yellow pedal and began to cut what appeared to be the septum anteriorly." Is that an indication that you did not know what tissue you were cutting when you activated the resection device?

A No. I would say it indicates that I saw the white tissue that appears to be the septum and put my device up to it and that's when I began the cutting.

Q So after you resected -- partially resected the septum, what did you do next?

A So I used the yellow pedal and began to cut. Then, as I was able to slowly advance the camera during this process, which means advancing the camera, there did appear to be a uterine perforation.

Q Dr. Brill, did you cause the uterine perforation from activation of the Symphion?

A I did not.

Q And explain to the jury how you know that.

A I know that because I would not -- I did not advance the camera while actively pushing on a yellow pedal to go to the next area of tissue. It's no -- we explained that triangle here. I'm -- I cut one area of the tissue. Then, you have to go to the next area of the tissue. So to advance the camera, I would take the resectoscope device, pull it back so I can see where I'm advancing the camera. Otherwise, you see this big, black-appearing or grey-appearing device in your way. And then, you

advance to that next area of the septum. It was during that process -- not during any cutting. There was no cutting because I didn't have that device pushed up against to the septum yet. That's when the perforation was noted, in that instance.

Q And once you noted the uterine perforation, what did you do next?

A So I stopped the resectoscope part of the procedure, which means the entire idea of going to the next step or trying to identify a fibroid and continuing to try to remove the septum, was stopped.

Q Did you inspect the area to look for any injury to organs other than the uterus?

A Yeah. So you know, in real time, you're advancing the camera, then all of a sudden, you see an opening, so you see what you see. And you see the hole in the uterus. And if there is bowel right there, you're going to see it. If there's not bowel right there, you're not going to see it, at least in that -- in that instance. Once I did the procedure, I looked the best I could. But remember that now, there's a hole in the uterus with fluid. The system is going to shut down within seconds. So you do the best look you can while you can before you have to then, you know, make your -- a decision for what your next steps will be.

Q And you documented there was no evidence of bowel or other organs at the area of the uterine perforation. How were you able to determine that?

A That was based on my direct visualization of that perforation

as it occurred. And then in the -- immediately after it occurred with the resectoscope still in, before I go to next portion where I -- where I try to look for a second time with the diagnostic hysteroscope.

Q So did you first visualize the area with the resectoscope?

A I did, yes.

Q And did you see any indication that there was injury to other organs?

A No. There was no evidence of urine -- or bladder in the area. There was no evidence of bowel contents, or fluid, or the yellow adipose tissue you would expect. I saw none of that.

Q Once you switched to the -- back to the diagnostic hysteroscope, what did you do?

A So the purpose of that was to get a look again because that diagnostic hysteroscope does not have that safety feature of turning off the fluid immediately based on the pressure difference. So you can put a diagnostic hysteroscope in very carefully, put a small amount of fluid in, and look. And that is the purpose of the -- it's a smaller camera. It's not as large. But you can get a picture of that area as best you can to try to reassure yourself that you still do not see any evidence of bowel injury.

Q Dr. Brill, once you noted the uterine perforation, did you proceed with any further resection?

A I did not.

Q Did you proceed with removing Ms. Taylor's fibroid?

A I did not.

Q Did you proceed with performing an ablation for the patient?

A I did not, so.

Q And an ablation, we've heard some testimony in this case, is that essentially heat energy used to burn the inside of the uterus?

A Correct. And the technique I was planning here was that hydrothermal, which means hot water. And there are -- like I mentioned earlier, there are multiple reasons -- multiple different options. This one, I think, is the perfect option for this scenario because that fluid circulates over about a ten-minute period into literally every nook and cranny of the inside of the uterus. And it circulates it and heats it. It's almost at a boiling point. It's at, like, I believe 90 degrees Celsius. And the idea is it's going to try to burn every area if you know, if we would have gotten to that.

There are other devices that try to put this mesh-looking device that will try to mold to the walls of the uterus -- there's one called NovaSure; there's some others that are out there -- that tries to transmit heat that way. That would not have been appropriate in my opinion as a surgeon because she had the bicornuate uterus and this would not have gotten that heat right against the wall. The hydrothermal was the right choice, in my opinion, because it can, like I said, get around every nook and cranny and keep circulating.

Q Well, and in fact, did you ever -- you did not -- did you ever get to the hydrothermal ablation portion?

A I could not, no.

Q And is that because of the perforation you noted?

A Correct. I would not want to put 90-degree Celsius water or

hotter into a uterus with a perforation. That would -- that would definitely be below the standard of care.

MS. HALL: May I approach, Your Honor?

THE COURT: Yes.

BY MS HALL:

Q I'm giving you a curette. And I understand in your document -- documentation, you said that you used a Number 2 curette. What I handed you, what size is that curette?

A This is a Number 4, which means it's larger.

Q Okay. Can you describe for the jury the -- how you used the curette for Ms. Taylor and why?

A So the old-fashioned D&C, dilation and curettage, this is the curette. This is what's used for a curettage. So the idea of this curette is it has a blunt area, and it looks like a spoon at the top. But I think like Dr. McCarus showed you, it has only a sharp edge on the front side of it, here. This part is not. It's completely blunt. It doesn't cut. It doesn't do anything.

So the idea of doing the curette is you can tilt it -- you can help -- this is a moldable device. You can -- you can do it this way. So you would mold it in the way you want it to go. So when I perform this, the idea is that you can angle it downward through the cervix and palpate the back wall of her uterus. I knew where that perforation was. It was here. This area here is completely blunt. There's no sharp edges to it. There's no scalpel. There's nothing sharp. So the idea is if I'm going to try to get some benefit of the surgery, which I was hopeful for

because I don't want my patient to have to leave the operating room and not, you know, have some -- maybe some help in her menstrual flow.

The idea -- you know, before endometrial ablations occurred, D&C was it. Like, you would have a D&C. If that didn't work, you would have a hysterectomy. And that's why, 50 years ago, a lot more women were having hysterectomies than they are today. So the idea was I still can palpate the bottom wall of the uterus, get some sampling of tissue, more so than we got in the office. But also, by removing that tissue, there is a chance it might improve her menstrual flow.

Q The uterine perforation that you noted, where was that?

A It was on the anterior wall.

Q Meaning the upper wall?

A At the top, going close -- like, closer to her belly button as opposed to the back.

Q The curette that you used, you said you used that on the posterior wall?

A Correct.

Q The -- is that anywhere near where Ms. Taylor's uterine perforation was?

A It was nowhere near, no.

Q Do you believe that the use of the curette caused her uterine perforation?

A I do not.

Q Did you have any reason to suspect during your surgery that Ms. Taylor had an injury to her bowel?

A I did not.

Q If you did suspect there might be an injury to the bowel, what would you have done?

A If I suspected bowel injury or any organ injury, the next step is to explore that further. And traditionally, we are trained to perform a laparoscopy. And if that's not the proper surgery, to perform a laparotomy, which would be like a C-section incision or an up-and-down incision to get inside the abdomen.

Q Now Dr. Brill, I want to direct you down to the bottom of where your signature is in this operative report. At the bottom of your dictation, it says, "Electronically signed by Brill, Keith, M.D. on April 26, 2017, at 10:08 Pacific." What does that indicate?

A The way our dictation system works, it's -- it uses what's called a Dragon dictation, which is different than when I first started my training, you would get onto a phone and you dial a number and you go, this is Dr. Brill dictating this surgery. And then, you get an operative report number. And what we would do is we would then write up what's called a brief operative report in the charts. And then, that dictation would get transcribed by a reporter. And then it gets sent back to me to sign and then it gets put into the charts.

So this system we use does not do that. This will -- I'm literally dictating into a Dragon phone. It's like a recorder. And I'm dictating and it records what I'm saying immediately. And if there is a typo -- if I recognize it; sometimes I don't and if I speak quickly, I know -- it'll all appear there. I will then review this, make sure that I'm comfortable with

what it says, and then sign it. And then from that moment forward, it is in the charts for anyone to see.

Q So this operative report would have been available in the electronic medical record at 10:08?

A Correct.

Q Same day of the surgery?

A Correct.

Q The uterine perforation that you noted, do you believe that was because you fell below the standard of care?

A I do not.

Q And explain why.

A Because I did everything I could -- and given the anatomy of this patient -- to dilate the proper way, to perform the surgery the proper way. And even doing all of that, a perforation occurred.

Q Dr. Brill, did you know that the bowel had been injured during your surgery?

A I did not know.

Q Do you know now that a bowel injury occurred?

A I do know, yes.

Q And do you believe -- the fact that Ms. Taylor had a bowel injury, do you believe that you fell below the standard of care?

A I do not.

Q Why not?

A Because surgeries have risks, they have benefits. And doing everything right, using all your medical experience, all your judgment,

doing the technique the proper way, you still could have an injury occur. You're going to have a complication occur. It's a -- it can happen to any surgeon. And do I want it to happen in any of my patients? Of course not. I'm -- you know, it's really unfortunate. No one wanted any of this to happen and go down this course we're going down here. But it can happen and by any surgeon doing the surgery properly.

Q And I want to talk to you just a bit about after the surgery. After you documented in your operative report the uterine perforation that occurred -- the complication that occurred, do you have a custom and practice of who, if anyone, you would advise of a complication during surgery?

A So the entire operating room team would immediately be -- be aware of what happened because we are not proceeding with our intended surgery. So everyone knows we are now stopping the resectoscope and that a uterine perforation occurred.

Q When a complication such as a uterine perforation occurs, is that called out to the operating room?

A Yes. I mean I can't specifically recall, "Look, there was a complication." I mean I don't know if that was said, but we said, "There's a uterine perforation," and the machine shuts down, we stop it, and we go to the next step. But it's announced. Everyone is aware what's going on.

Q And as part of your custom and practice, do you advise the patient or any family members when a complication occurs?

A Yes. So after every surgery, I would talk to whatever family

member was available, whether by phone or in person.

Q Do you remember -- do you actually remember a conversation with Ms. Taylor in recovery after the surgery?

A I know that she referred to it. I didn't have a specific recollection until I'd heard about it. But I believe it occurred, but I don't have a specific recollection of it occurring.

Q And you were present when Ms. -- did you hear Ms. Taylor's testimony that you did speak with her in recovery?

A I did, yes.

Q After the surgery?

A Yes.

Q Do you have any reason to deny that -- or dispute that you did speak with her in recovery after surgery?

A No, I have no reason to.

Q She testified -- or did you hear her testify that you told her it was complicated, and you weren't able to do any of the surgery?

A I did hear her say that.

Q Did you ever tell Ms. Taylor that?

A I would never say that because it's an untrue statement.

Q And when you say it's an untrue statement, what are you referring to?

A Meaning I did perform the surgery, but I had to stop the surgery at a certain time. It wasn't like no surgery was done. And it's not my medical terminology to ever use -- to say something was complicated because I wouldn't want to use that term. I wouldn't even

know what it means. But I would use the term complication, because a complication did occur. But nowhere would I say something was, quote, unquote, "complicated." I have no doubt that she believes she heard that. But I would also never say something untruthful such as, "I didn't perform the surgery," because that would mean that the patient went to the operating room and got taken right out. And that's not what happens.

Q In your deposition that was taken in April of this year, did you recall speaking to a family member of Ms. Taylor's?

A From reviewing everything, I had a vague recollection of talking to Barbara, who was her mother.

Q Did you remember -- at your deposition, did you remember the specifics of any discussion with Ms. Taylor's family members?

A I did not, no.

Q Did you ever attempt to mislead Ms. Taylor or her family as to the uterine perforation that you encountered?

A I never did.

MS. HALL: Your Honor, I have -- just for scheduling purposes, I have about ten more minutes. Would you like me to just continue?

THE COURT: Yes.

MS. HALL: Thank you.

BY MS. HALL:

Q The uterine perforation that you noted, did you at some point -- let's go actually to the St. Rose Hospital records. And this is

Exhibit 1. And I'm going to show you very quickly SRDH-208. Now, when Ms. Taylor went to St. Rose the first time, when she was seen in the emergency department by Dr. Christensen, were you ever contacted?

A I was not and nor was by answering service or physicians on call, no.

Q And when Ms. Taylor went to the emergency room the second time, I want to show you -- it's your understanding -- the second time that Ms. Taylor went to St. Rose, is it your understanding that she was admitted at that time?

A Yes. After the evaluation, including a consultation with the on-call doctor in my practice at the time.

Q And I want to show you very quickly, Dr. Brill -- this is SRDH-208, page -- of Exhibit 1. And I want to take you down to the subjective portion of your progress note. The first question is what is the date that -- of this progress note?

A I can't see it right now. There it is. April 28th, 2017 at 7:55 a.m.

Q And do you have an understanding of when Ms. Taylor had her surgery with Dr. Hamilton?

A Yes. My understanding was it was the evening before.

Q And so did you, in fact, see Ms. Taylor on April the 28th, 2017 around 7:55 in the morning?

A Yes. This is the first opportunity I had based on me working the previous night as an in-house laborist as a different hospital. So I was notified of the surgery, but I couldn't physically leave my previous --

my -- where I was doing an in-hospital shift at a different hospital. So as soon as I was able to get to that facility, I did.

Q Really quickly, what's a -- when you say you were doing an in-house [sic] shift, what is that?

A So the -- all the labor floors that I deliver babies at -- because that the OB part of my job -- have laborists. And there are times when doctors in the community perform laborist shifts back then. It was more frequently. Now these programs have been around a longer. We tend to have more full-time laborists. But that means I was the -- it's kind of like being the emergency doctor for the labor floor. So if someone come into triage, they don't just have a nurse see her and then they call their doctor at home, they have -- a doctor sees every patient. Where they're on standby for deliveries, if a doctor's on the way, we help on C sections.

So I happened to have a shift that previous night that goes from 6:30 p.m. to 6:30 a.m. And you can't physically leave. You're contracted. You know, it's not like you're on call for a hospital and if no one's in labor, you leave. You have to stay there because you never know what's walking through the door.

So I was not able to leave. I was, you know, contacted by my on-call physicians during the day and nights, and was aware that this was all occurring. But because it was at a different St. Rose Hospital, it was at San Martin Campus, the sign-out happened between 6:30 and 7; once that's done, then I had headed over to St. Rose - Siena.

Q And then we get to when you were able to come to the patient's bedside?

A Correct.

Q Tell us what you documented when you saw her on April the 28th in terms of your subjective.

A So subjective, there's some general statements. "Incisional pain, well controlled." And those are kind of like drop-down menus. But then I type in, "Well, I reviewed with Kimberly the perforation that occurred during the hysteroscopy I performed two days ago. At the time of the perforation, I did not suspect that the myomectomy device was actively cutting. I also" --

Q And let me stop you right there.

A Yes.

Q Mr. Breeden earlier asked you about this documentation. Were you indicating that you now suspected the myomectomy device was actively cutting at the time of the perforation?

A Not at all.

Q And then you say, "I also did not see any bowel adjacent to the uterine perforation." Did you believe at the time of your surgery there was no bowel adjacent to the uterine perforation?

A I do.

Q And was that based on your direct visualization of the perforation?

A Yes.

Q Had your mind changed in any way by the time of this progress note?

A It did not.

Q You say that, "Kimberly reviewed with me the nature of her pain that night and the following day. I voiced to her that I was glad she called 911 and came to the hospital." Is that a discussion that you had with Ms. Taylor?

A It is.

Q And you say, "I was notified by Dr. Schoenhaus yesterday afternoon about events after the surgery." Dr. Schoenhaus, is she one of your partners at WHASN?

A She is. You know, the way -- I don't know if it's the reference, but the way practice works is we -- at the time, we had six physicians, now we have seven. But one doctor is always out of the office and out of the operating room as our rounding on-call doctor because babies can come at any time, people can come into in the emergency room any time. I would say to you most practices don't do that. We do. And we think it's the safest way to practice OB/GYN. So this doctor is only focusing on what's happening at the hospital while the rest of us are either in surgeries or in the office.

So at the time, Dr. Schoenhaus was our on-call doctor. So if an emergency room is going to contact my practice, they call the on-call doctor, who was Dr. Schoenhaus, who is my partner I work with every day.

Q And I believe we've seen Dr. Schoenhaus' note. But did Dr. Schoenhaus see Ms. Taylor on April the 27th?

A I believe she did, yes.

Q And if you had not had a laborist shift that required you to be

at St. Rose, San Martin, would you personally have gone in to Siena to see Ms. Taylor on the 27th?

A Absolutely.

Q You also document that -- about your OB laborist shift and that Dr. Ivie, who was the nighttime on call for the group, Dr. Ivie, is she another physician with WHASN?

A She's one of my partners. Yes.

Q And she -- did she assist Dr. Hamilton with her surgery?

A She did.

Q After Dr. Ivie assisted Dr. Hamilton, did she notify you of the small bowel perforation?

A She did.

Q I want to direct you to page 217. It's the same visit. And in your progress note, Dr. Brill, do you document discussing the hysteroscopy procedure and uterine perforation with Ms. Taylor?

A I did.

Q What do you document?

A So under the procedures part, even though it wasn't technically this hospitalization -- that was just the part I typed this in -- I wrote, "POD number one" -- which is postoperative day number one -- "after a laparoscopy converted" -- "converted to a laparotomy" -- which is the open incision we heard about with the vertical scar -- "for a small bowel resection and reanastomosis" -- which is the reattachment -- "due to bowel injury, likely related to the previous hysteroscopic procedure where a uterine perforation was noted. Patient is doing well at this time.

We discussed the surgery two days ago, and the surgery last night, and the expected recovery course. I'll try to" -- "we'll have her try to sit up as much as possible and ambulates and void" -- which means pee or try to pee -- "while advanced diet is clear based on general surgery's recommendation, I appreciate their input."

Q At the time that you saw her on the 28th, were you discussing her care with general surgery?

A I don't have a -- recall this specifically. Because I was rounding in the morning, I don't think the general surgeon was there at the time. So we very often communicate by notes like this. But --

Q And did you document that you would discuss the diet with general surgery?

A Well, I would say it would be -- it would be advance at that time based on the general surgeries -- surgeon's recommendations on day one.

Q Okay. I want to show you your progress note from April the 29th very quickly.

MS. HALL: And it's SRDH-184 of Exhibit 1.

BY MS. HALL:

Q First, Dr. Brill, if you write a progress note, if you dictate a progress note or type in a progress note for a patient, does that mean that you physically saw that patient?

A It does.

Q I want to show you very quickly -- this is a progress note from April the 29th, 2017. Did you see Ms. Taylor on that date?

A I did.

Q And how was she doing, according to your documentation?

A So under subjective, which is me asking the patient questions, "Patient states she's getting better. She's ambulating. She's tolerating sips of water and ice. Only has nausea with pain medication. No shortness of breath or leg pain. Has minimal vaginal bleeding. Able to void without difficulty. Not passing flatus" -- or passing gas from below -- "and patient's pain is better."

Q And I want to show you a progress note from April the 30th. I'm sorry. Bear with me.

MS. HALL: It's SRDH166, Mr. McBride.

BY MS. HALL:

Q Did you see -- did you see Ms. Taylor on April 30th, 2017?

A Yes. This note is timed 5:47 a.m. on April 30th at least when I -- when I open the notes.

Q I want to show you page 170 of this progress note. Now, you document -- on page 170, you document that the patient was -- this was postoperative day three when you saw her on April the 30th, 2017, correct?

A Correct.

Q And how was she doing at that time, per your documentation?

A So I say, "Post-update number three. She has bowel sounds." Which means her bowels are starting to make noise and wake up. She did not tolerate liquid diet yesterday, so we are waiting passage

of flatus before advancing back to clears. I encouraged her to be upright in bed and/or chair when she is awake." And that's because I want her to have less chance of her lungs collapsing. You want somebody to be upright as much as they can after surgery. "She is ambulating and able to void. Having potassium replaced and receiving parenteral" -- which means I.V., not oral -- "analgesics," which is pain medication. "Patient counseled regarding bowel function and need for bowels to function after the reanastomosis before advancing diets. All questions answered."

Q Okay. Thank you, Dr. Brill. I'll represent to you that the St. Rose chart reflects that Ms. Taylor was seen following this April 30th visit, that Ms. Taylor was seen by physicians named Dr. Herpolsheimer and Dr. Garg. Are those physicians with Women's Health Associates of Southern Nevada?

A Yes. They are partners in my practice, both of them.

Q On any date where you were unavailable to come to St. Rose and see Ms. Taylor, is it your understanding that some physician from your practice did see her?

A That's my understanding, yes.

Q I want to show you the next note in the chart for you. And that's SRDH-100.

Now, did you see -- what's the next date that you saw Ms. Taylor when she was hospitalized at St. Rose?

A So this is May 3rd, 2017.

MS. HALL: And I want to go to 103, please.

BY MS. HALL:

Q I want to show you page 103 of this exhibit. And when you saw Ms. Taylor on May the 3rd, did you document that you had a discussion with her and her parents?

A I did.

Q What did you -- what discussion did you document?

A So I wrote here, "I spoke to Kimberly and her parents at length again about the hysteroscopy last week and the nature of her uterus. The CT read the shape is bicornuates. And during the hysteroscopy, there was a large septum noted, which made seeing the right horn where the fibroid was located difficult. During the resection procedure, there was a perforation, and I could not proceed with the myomectomy and endometrial ablation. I did not see bowel appear in wall at the time of the perforation.

Based on the findings in the OR the next day, there was an injury to the bowel. That was repaired. I told Kimberly that if her vaginal bleeding does not improve, I would recommend either medical treatment or a hysterectomy. But she needs to heal and recover from this bowel surgery first. She voiced understanding and she appears to be in good spirits. I did let her know that Dr. Garg and my group's on-call physicians all cover for each other for in-patients, and I will be out of town for a meeting from Friday to Sunday of this week. Plan for now is to continue ambulation. Awaits improving bowel function with goal of eating regular diet. She has little appetite at this time."

Q Dr. Brill, did you discuss with Kimberly and her parents all of

the information that is documented in this note?

A I did.

Q Would you have documented you had a discussion if know discussion occurred?

A I would never do that, no.

Q Were you ever trying to hide the fact that the bowel perforation was a result of a complication from your surgery?

A I was never trying to hide that, no.

Q And the risk and complication that Ms. Taylor experienced, was that a uterine perforation?

A During my surgery, all that I recognized at the time was a uterine perforation. But ultimately it was diagnosed that she had a bowel perforation as well.

Q And based on what you know now, do you believe that bowel perforation was a complication from the surgery that you performed?

A I do.

Q Do you believe that you met the standard of care?

A I do.

Q How is it that the patient had this complication and yet you still believe that you met the standard of care?

A Because I -- like I said earlier, I performed the surgery to the best of my ability using my training, doing everything that is supposed to be done during a surgery to carefully try to avoid a risk of injury. But you cannot avoid 100 percent complications or injury. No one would

ever do surgery if we were held to that kind of a standard.

Q Did you make a mistake when you did her surgery?

A No, I did not perform -- make a mistake.

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

[Counsel confer]

BY MS. HALL:

Q Dr. Brill, have -- has your testimony here today and the opinions that you've stated, have those all been to a reasonable degree of medical probability?

A They have.

Q Thank you.

MS. HALL: Pass the witness, Your Honor.

THE COURT: Redirect.

MR. BREEDEN: We're just going to reconnect the technical issue here. I'll just go ahead and start, Kristy --

MS. JOHNSON: Sure.

MR. BREEDEN: -- while you're -- while you're getting that up.

REDIRECT EXAMINATION

BY MR. BREEDEN:

Q Doctor, just a few points of clarification. And I know you've been testifying for several hours. We've gone over a lot of subjects. When you recognized that you made the perforation to the uterus, you were required by the standard of care to inspect that to see if adjacent organs are damaged, correct?

A You're required to investigate the perforation to the best of

your ability, yes.

Q Okay. And we know that you didn't actually see the damage to the small bowel, but you're required to inspect for that damage under the standard of care, correct?

A We know subsequently that there was an injury to the small bowel, but it was not visually seen at the time of the surgery, if that's what you're asking.

Q Yes. So when you inspected for damage to adjacent organs, you did that from a camera inside the uterus, correct?

A Correct. And that's the standard of care. Yes.

Q Did you ever advance the camera through the perforation, through the uterus?

A No. That's not something that we were ever trained to do or would we ever -- would we ever do that. No.

Q Okay. Would that be below the standard of care?

A Yes.

Q Okay. You dictated your operative note, and it says it's electronically signed at 10:08 a.m. Do you recall that?

A I do, yes.

Q Is that -- was that dictation or -- I'll call it electronic signing at 10:08. Was that before or after you had seen your next patient of the day?

A It would be before.

Q Okay. Your visit with Ms. Taylor in the PACU, would that be before or after 10:08, when you electronically signed that?

A It would be after.

Q Okay. How soon after you finished the report at 10:08 a.m. did you then meet with Ms. Taylor in the PACU?

A I honestly have no recollection, so I don't -- I don't know. My best -- I know it's speculation, so there might be objections. But it would be a bit likely as I was coming out of the next surgery. The next hysteroscopy would be coming to the -- to the area because you pass the recovery room as you go to the dictation area. And if she was there and awake, it's probably why I stopped there then.

Q Okay. When was your next -- was it a hysteroscopy you were to perform afterward, another hysteroscopy?

A Correct. It was -- it was a diagnostic hysteroscopy, which was following Ms. Taylor's case.

Q Okay. And so when was that procedure completed?

A I don't know. I know it was -- it was a relatively short procedure, but I don't have the timing of that. I don't know.

Q Yeah. And so the problem is if you testify here today, for example, that that procedure was complete at 11 a.m., we know you couldn't have possibly spoken to Kimberly's parents because they didn't arrive until after noon, right?

A That's not true.

Q You're not fixing the time because the time will ruin your narrative that you had spoken to Kimberly's parents and advised them of the uterine perforation, isn't that true, sir?

MS. HALL: Objection, Your Honor.

THE COURT: Counsel, approach.

[Sidebar at 2:21 p.m., ending at 2:22 p.m., not transcribed]

BY MR. BREEDEN:

Q Doctor, did you -- yourself, that is. You did not attempt any repair of the uterus perforation, did you?

A I did not, no.

Q And you yourself did not attempt any repair of the bowel perforation, correct?

A Correct. I did not see a bowel perforation.

Q Yeah, you didn't even -- you didn't know it existed.

A Couldn't repair something I didn't know existed. Yeah.

Q Okay. You indicate in your testimony that during the procedure, you called out in the operating room that there had been a perforation; do you recall that?

A I do.

Q Okay. Dr. Yeh, the anesthesiologist, was there, correct?

A Correct.

Q And there's nothing in his records that indicate any sort of perforation, correct?

A And I believe he said there's no place for him to document that. That's my place to do that.

Q He said he can also do an addendum if something like that happens; do you recall that?

A Yes.

Q There was no such addendum, was there?

A No because usually, he documents anesthesia complications. I document surgery complications.

Q He had no recollection -- personal recollection of any problem with this procedure as well, correct?

A If that's what he said, I agree with that. Yes.

Q And we saw records that the operating nurse appears to have created, Gary Wernlund. Do you recall that?

A Yes.

Q Do you know Gary personally?

A I know him from working with him, but not on a personal basis.

Q Okay. He doesn't work for WASN, does it?

A No, he works for Henderson Hospital. He's still there. He still works in the rooms I work in.

Q He's there during your actual operation, correct?

A Correct.

Q And he recorded in his records complications, none per surgeon, correct?

A Correct.

Q And per surgeon means you, Dr. Brill; doesn't it?

A I understand, yes.

Q Do you recall testifying earlier that you were unaware that Ms. Taylor had a septum prior to the procedure?

A Correct.

Q It was your testimony just a few minutes that that was

completely unknown to you prior to the procedure?

A The presence of that septum, until I saw it in the operating room, was not -- was not known to me. Yes.

Q You would agree with me that the standard of care requires you to familiarize yourself with the patient and her anatomy before you operate, correct?

A I would say yes. But you can't physically document every part of the anatomy until you do surgery. You need to use your eyes. And you can rely on imaging studies and pelvic exams, but, you know. If you've seen ultrasounds, they're black and white and gray and they take pictures of the walls of the uterus. But until you put a camera inside, you don't know what you're going to see until you see it.

Q I'd like to show you Exhibit 3 at Brill 130. It's part of your records; isn't it, Doctor? Explain to the jury what this is.

A So this is a Desert radiologist MRI report from 2005 when the patient was not a patient of mine. It says the physician was Kenneth Jones, who was a physician but not in my practice.

Q These are part of your records, aren't they?

A I don't know where this comes from. This is Desert Radiology.

Q Well, why don't you look in your books there behind you then at Exhibit 3? Pull that out and tell me what Exhibit 3 is.

A Which book would it be?

Q Volume 2. And I'll sort of cut to the chase here. Exhibit 3 are your records from Women's Health Associates of Southern Nevada that

you produced in this litigation. Just confirm that for us when you find the exhibit.

A Is this tab 3 you're talking about?

Q Tab 3.

A Yes, I see hospital records and imaging studies, yes. Including Women's Health Associates.

Q Okay. So those are your records, correct?

A Correct.

Q Do you recall Ms. Taylor providing you and WASN a copy of her records from before she became a patient?

A I do recall one of my notes saying that the patient brought a copy of an MRI from 2005.

Q Yeah. Does this appear to be that 2005 MRI?

A It does, yes.

Q Okay. So even though you just testified a few minutes ago that you had no idea there was a septum. That that was something unknown and was something a surprise to you. What does this MRI indicate?

A So that says, "The uterus demonstrates a subseptate uterine configuration. [Indiscernible] septation demonstrated, which contains the myometrium. The bicornuate distance is approximately 4.2 centimeters, and the angle is approximately 15 degrees between the two horns".

Q It clearly documents a septum, doesn't it?

A This does, yes.

Q Yes. Now, look at the next page with me.

MR. BREEDEN: In case the jury actually wants to actually see the word "septum" in the record. Kristy, if you could blow that up under "impression"?

BY MR. BREEDEN:

Q Tell the jury what that record shows.

A So this is the impression, I'm assuming from the same report. "Subseptate uterine configuration is demonstrated with the myometrium extending deep into the septum".

Q So in fact, your own records from Ms. Taylor refute your testimony here within the last half hour that you had no idea there was a septum.

A So I know I reviewed the ultrasound with her. I don't document that I reviewed this MRI with her, and I don't document that I discussed the septum with her. No.

Q You don't think it's important to familiarize yourself with the patient's anatomy before you operate?

A I do think it is.

MR. BREEDEN: Thank you.

MS. HALL: Thank you, Your Honor.

RECROSS EXAMINATION

BY MS. HALL:

Q This 2005 MRI. Was Ms. Taylor a patient of yours in 2005?

A She was not, no.

Q The note where you document that she brought it in, do you

document that you reviewed the actual MRI films or the MRI report?

A To the best of my recollection, no.

Q If in the ultrasound that was performed close in time to your surgery, that ultrasound had shown a septum, is it your expectation that the provider interpreting the ultrasound would dictate that there was a septum?

A I would expect that, and they typically would.

Q And was there anything in that ultrasound from March of 2017 to indicate the presence of a septum?

A There was not.

Q The uterus -- and the uterine perforation that you noted during your surgery. Did you suture the uterine perforation?

A I did not.

Q Why not?

A That is not the standard of care typically when a blunt perforation happens in the uterine muscle wall either the anterior wall towards the fundus since it's nowhere near where the blood supply is. And the uterus muscle typically will close around itself and contract, so it is within the standard of care, unless there's an active bleeding lesion, that you let this repair on its own.

Q When you say that the uterine will close around itself -- the uterine wall will close around itself, is the uterus self-repairing?

A It is.

Q And by the point of Dr. Hamilton's surgery, did she note that there was the presence of a clot at the uterine perforation?

A I believe she did, yes.

Q What does that indicate?

A That's mean -- that means that there's no active bleeding there. That blood has already coagulated, which we call a blood clot, in that area. Typically, when there's healing starting to occur, blood can coalesce in that area. When the next step, healing, occurs as the tissue tries to come together, very often we'll see a clot, which is the first step. The platelets to try to get the uterine muscles to come together.

Q Does a clot indicate that the perforation is healing?

A To me, it means the start of the process and that there's no active bleeding.

MS. HALL: Thank you, Dr. Brill.

THE COURT: Any questions from our jurors? All right, no questions. Dr. Brill, thank you for your testimony. You may have a seat back at table.

And ladies and gentlemen, as indicated, we're going to go ahead and release you for the afternoon so we can discuss some legal issues. We'll be coming back tomorrow at 10:30 here in this courtroom. And we're going to proceed with jury instructions and closing arguments.

On behalf of Defendant before I release them, Ms. Hall or Mr. McBride, do you intend to call any -- well, I guess Mr. Breeden first.

MR. BREEDEN: Plaintiff would rest.

PLAINTIFF RESTS

THE COURT: All right. And on behalf of Defense?

MS. HALL: Your Honor, at this time, the Defense would rest.

DEFENDANT RESTS

THE COURT: Okay. So then we're going to proceed in the morning with jury instructions and closing arguments at 10:30.

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

You are not to conduct any research on your own, test any theory of the case, consult dictionaries, use internet or reference materials, recreate any aspect in theory of the case or in any other way investigate or learn about the case on your own. You're not to talk with others, text others, Tweet others, Google issues or conduct any book or computer 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 connected to this trial until the case is finally submitted to you.

I'll see you tomorrow at 10:30. Thank you.

THE MARSHAL: All rise for the jury.

[Jury out at 2:32 p.m.]

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

[Outside the presence of the jury]

THE COURT: Thank you. We're outside the presence of the jury. I'm going to go ahead and put the objections on the record.

There was -- the first objection, I believe, was during the cross-examination of Dr. Brill. There was an objection as to a question that called for custom and practice.

Mr. Breeden, anything further on that?

MR. BREEDEN: Well, yes. I think essentially, it just calls for speculation because the witness indicated he did not have a personal recollection. And I think that the information that was solicited would be more prejudicial than probative regardless.

THE COURT: And on behalf of Defense?

MS. HALL: Briefly. Custom and practice is permissible. A doctor is permitted to testify as to their documentation of custom and practice without having a specific recollection.

THE COURT: And I sustain the objection under NRS 48.059. They're allowed to testify to custom or routine or practice, either a person or organization. Yes?

MR. BREEDEN: Judge, I'm sorry. I just wanted to add. Of course, I think that line of questioning also pertained to the risks and complications, and I've made many objections on previous occasions on that basis as well.

THE COURT: Okay. But as to the habit and routine and practice, I think it was an appropriate question. I also think it was consistent with the medical records, which indicated his shorthand and what his general practice is, and the discussions that he had associated with risks and complications. Which, again, you have a standing objection to.

There was another objection. I think --

MS. ALBERTSON: Your Honor, I'm sorry. Did you say -- you said you sustained the objection, but I thought you --

THE COURT: I meant overrule.

MS. ALBERTSON: -- overruled.

THE COURT: My apologies.

MS. ALBERTSON: Thank you for clarifying it.

THE COURT: I'm getting hungry and tired. Sorry.

MS. ALBERTSON: You overruled that objection, right? That's how I'm noting it?

THE COURT: Yes.

MS. ALBERTSON: Thank you.

THE COURT: And then I think there were two others with the same objection, specifically with regard to the practice of the DNC and ablation procedure. Same objection. Anything further, Mr. Breeden?

MR. BREEDEN: Same arguments.

THE COURT: On behalf of Defense?

MS. HALL: Same arguments, Your Honor.

THE COURT: Okay. That was also overruled.

And I think it was -- just to be clear. The medical records that were shown on the screen, I think it was also supported by the medical records, his shorthand, and what he typically would describe as risks/benefits associated with a surgery.

Then there was an objection to really just approach with regard to the informed consent. Ms. Hall was lodging her objection

about not being able -- allowed to get into informed consent. And Mr. Breeden was continuing his objection with regard to the educational materials. So basically, I said my ruling stands. No informed consent, but the educational materials were allowed in. Anything further on behalf of either side?

MR. BREEDEN: On behalf of Plaintiff, I think that's a fair summary. I think Ms. Hall was essentially making an offer of proof at that time. At that point in the testimony, she would have asked about the informed consent form had she been allowed.

MS. HALL: Exactly, Your Honor. I just wanted to renew my request to be permitted to show the Defendant the educational materials and forms that were signed, and make sure that I had done that for the record.

THE COURT: Okay. And then I said that ruling stands on both of those.

And then finally, there was an objection to a question with regard to -- I think the question was basically about Dr. Brill's narrative and with regard to talking to Ms. Taylor and her parents. And the objection on behalf of Defense was?

MS. HALL: That it was argumentative. Is this the one about the timing of his next surgery and --

THE COURT: Yes.

MS. HALL: -- that it was argumentative. And also, I thought that it suggested that we should -- the Defense should somehow be punished for a lack of evidence, meaning not knowing the time of that

second surgery, which was a completely different patient. And so that was the basis.

THE COURT: And then on behalf of Plaintiff?

MR. BREEDEN: I can't access that patient's records to cross-examine. There are clear records in the Defendant's possession that would show when that surgery ended. I thought it was very fair cross-examination, but you sustained the objection.

THE COURT: And I was more concerned with the argumentative nature of the question. I mean, obviously, you can elicit facts and then argue, but you were basically arguing in your question and telling the jury that he's going against his own narrative, which I don't think is appropriate. So I did sustain the objection.

And then as far our break, I'm going to give -- we've been going since 8:30, so I'm going to give myself just a little bit extra time. I'm going to ask that you and staff come back at 3:45. And if you guys look over all the exhibits so we're ready to go tomorrow? Make sure everything that's going back to the jury is appropriate, agreed upon, redacted. And then I'll come in at 4 and we'll do jury instructions, arguments. And if there's any issues with the exhibits, we'll cover that.

MS. HALL: Perfect.

MR. MCBRIDE: Sounds good.

THE COURT: Anything else?

MR. BREEDEN: Nothing further from Plaintiff at this time.

THE COURT: All right, guys.

MS. HALL: Nothing.

MR. MCBRIDE: Nothing, Your Honor.

THE COURT: Thank you.

[Recess from 2:37 p.m. to 3:56 p.m.]

THE COURT RECORDER: Back on the record.

THE COURT: Thank you. All right. Back on the record in A-18773472-C, Taylor v. Brill. Counsel on both sides are present. We're outside the presence of the jury and we're going to go over instructions. You guys already resolved all the exhibit issues, correct?

MR. BREEDEN: Correct.

MS. HALL: Yes.

THE COURT: All righty. So I know you just submitted an additional agree-upon instruction, and after we go through everything I'm going to ask that you kind of figure out where every -- what --- in what order you want everything to go and then we'll put them all on the record.

MR. BREEDEN: Uh-huh.

THE COURT: So have your agreed-upon, and let's go through Plaintiff's proposed, and starting with the risk or complication of procedure. I said I was going to give you an instruction, you guys couldn't agree upon a language, on behalf of Defense?

MS. HALL: Sorry. One second, Your Honor.

MR. BREEDEN: And you don't mind if we remain seated; do you, Your Honor?

THE COURT: Huh-uh.

MS. HALL: Sorry, Adam. Let me just get here a sec. Sorry.

And I'm sorry, what was your question, Your Honor?

THE COURT: I had already said I wasn't going to give an instruction like this, you could -- and then I had said if you guys could agree on the language; you couldn't agree on the language?

MS. HALL: No. I think the one that I would suggest would be consistent with what is the instruction from *Busick v. Trainor*, which is -- which -- I guess, let me back up. I don't believe there's been any evidence in this case of consent. There's been no discussion of consent, the consent forms haven't been discussed, and when we just -- when we pretrial, we're having the conversation about giving that instruction, *Busick vs. Trainor*, there was consent, and that was discussed in the trial, and in order to prevent any confusion to the jury, the trial judge in that case gave the instruction that says simply because a patient consents does not mean they consent to a negligently performed surgery.

So if any instruction is given on that issue, I think it should be consistent with what was given in that case, but I don't believe there's been any evidence in this case of consent or consent forms.

THE COURT: Right. And I think he tailored it for, specifically for a risk of complication, but I understand what you're saying, but I had already previously ruled that obviously since I was allowing evidence of risk or complications that I would give them an instruction, so unless you want to talk about the language a little bit, I'm inclined to give it.

MS. HALL: Sure. Let me get it. Okay. Sorry. Bear with me, Your Honor. Here it is. So in terms of what Plaintiff's offered, if in the first paragraph, if that first sentence read: the mere fact that a provider

of healthcare considers an injury to be a -- to a patient to be a risk or a non-complication, I don't think it should say injury. I think it should say: the mere fact that a provider of healthcare -- let me see. I think it should say: the mere fact that a patient experiences a known risk or complication of a procedure does not mean the Defendant did not breach the standard of care.

THE COURT: Mr. Breeden?

MR. BREEDEN: Judge, all I would have to say about this instruction is that I think every paragraph is accurate, I tried to write it in laymen's plain English, and I don't think any changing to the -- change to the wording is warranted.

THE COURT: Okay. Anything else, Ms. Hall, with regard to the other ones?

MS. HALL: Line 7 should, in my opinion, come out, where it says: a patient cannot consent to negligence of a physician, and that's just because as I said, there's been no evidence of consent.

MR. BREEDEN: Your Honor, an alternate way of phrasing that would be that assumption of risk is not a defense in this case, and of course, this comes from the *Busick v. Trainor* matter. Again, though, I think that this is phrased in sort of plain English for the jurors, and I think it's an accurate statement of the law, and I would remark, by the way, Your Honor, that I think this instruction is probably the most important instruction that the parties were unable to agree on, and so I think that this is very important information for the jury, both of these points of law, that there's, you know, there's no consent or assumption of risk

defense in this case.

THE COURT: All right. So since there was no evidence of consent I'm going to take that portion out, but how did you want me to phrase it with regard to assumption of the risk?

MR. BREEDEN: Well, an alternate way of stating that would be that there is no assumption of risk defense in this case.

MR. MCBRIDE: I think he said, stated assumption of the risk is not a defense.

MR. BREEDEN: That's more artfully stated.

MR. MCBRIDE: It's what you said originally.

THE COURT: All right. So negligence of the physician, continue with this.

MR. BREEDEN: Assumption of risk is not a defense to negligence of the physician.

THE COURT: Okay.

MR. BREEDEN: I think that would be accurate.

THE COURT: All right. So with that change I'm going to give the rest as is, and I'll make that change since we have the Word version.

MR. BREEDEN: Your Honor, we propose that that be given after agreed instruction 24, on the standard of skill and care.

THE COURT: I'm going to go ahead and put it in right now.

MS. HALL: Well, we -- I thought we were going to figure out the order at the end because --

THE COURT: Of the what?

MR. MCBRIDE: The order.

MS. HALL: Order of the instructions.

THE COURT: Yeah, we are. I -- but he -- I --

MR. BREEDEN: Well, you --

THE COURT: -- I thought you just -- he just said you all agreed.

MR. BREEDEN: Oh, no, no, no, I didn't mean that.

THE COURT: Oh, okay, then we'll -- yeah. No. Wait 'till the end then --

MR. BREEDEN: Going to save for the order at the end?

THE COURT: -- and then I'll see if you guys agree once I decide on which ones I'm giving, and then you can place them in order, and then I'll put them on the record. All right. As to the second one, the negligence, additional liability, Mr. Breeden?

MR. BREEDEN: Your Honor, this is a pattern instruction, so it's obviously a correct statement of the law. I think that -- yes, and the issue here is perhaps a fine one, but this addresses any possible argument or confusion by the jury that the Defendant's malpractice has to be the sole cause of any injury or damage. It doesn't have to be the sole cause, it can be a cause, and then under particular medical malpractice law, we know that then if there is more than one cause or actor who has caused that harm, then it gets proportioned, but Dr. Brill is still a proportion responsible for that. He does not have to be the sole cause of the injury, and that's why I felt this instruction was particularly warranted for this case.

THE COURT: All right. And Ms. Hall or Mr. McBride?

MS. HALL: So this one was briefed in the pretrial motions, and this goes back to the *Piroozi* issue, and the 9 and in 8 pattern instruction, that only applies, Your Honor, as an example, in a circumstance where if a doctor -- and let's use this case as the example.

If there was an allegation that Dr. Hamilton negligently performed the bowel resection, that is a surgery that was necessitated by the alleged negligence. That is when this type of an instruction would come into play. What they're attempting to do with this instruction is not that at all. They're trying to say that Dr. Brill is responsible for the alleged negligence of the PACU nurse who was acting independently of Dr. Brill, and whose care and treatment was not necessitated because of any alleged negligence, but more importantly is the issue which is discussed in the Lindquist case that this instruction is based on, that if the provider is acting independently of the alleged negligent original provider, they are not responsible. That is, you know, joint and several liability has specifically been abrogated in medical malpractice cases.

Here, not only the admission, this first visit to the ER was to an entirely different hospital, it was an emergency room physician who saw the patient, acting independently of Dr. Brill, never contacted an OBGYN, including Dr. Brill, and the same issue for St. Rose Hospital. This isn't a situation where anyone is accusing the surgeon who had to do the repair because of the alleged negligence of committing malpractice. That is when this instruction would apply.

MR. BREEDEN: Your Honor, just very quickly, I think the distinction here is Dr. Brill is still liable, he is simply severally liable, and,

you know, that's why I want this in here, so the jury doesn't think that he has to be solely or a hundred percent responsible for some measure of damages. The jury can proportion that, and that's, of course, comes from *Piroozi*, but that's what this instruction, I believe, is trying to advise the jury.

THE COURT: Okay. I do think it's covered by the *Piroozi* issue which you have proposed two alternates to. I think adding this one would be confusing. I also think proximate cause is sufficient and covered by the other instructions which we'll get to shortly. As to this one, I'm not going to give this one. Next one, the proximate cause, and both of you guys submitted it, so I'm going to address them at the same time. Mr. Breeden, on behalf of your proximate cause definition?

MR. BREEDEN: Well, and I think what happened here is there was a competing version --

THE COURT: Uh-huh.

MR. BREEDEN: -- from the Defense. Do you mind if I pull that up so I can --

THE COURT: It's page 3.

MR. BREEDEN: -- explain to you what the different is?

THE COURT: Page 3.

MS. HALL: I thought we agreed with this one. I mean, I don't -- it's about legal --

THE COURT RECORDER: I'm sorry, I can't hear you.

MS. HALL: I'm so sorry. I was just trying to chat with the attorney about something I thought we agreed to.

MR. BREEDEN: Yeah, I -- this one, we may have been able to agree upon, Judge. This -- oh, no, no, no. Yeah. So if you look at -- the two competing versions here are Defendant's proposed on page 11, and I'm sorry, they don't -- they didn't number theirs, but the reason why I wanted this, this is a pattern instruction here on proximate cause, and the difference between Plaintiff's proposed and Defendant's proposed is Plaintiff's proposed has this pattern language in it, quote, "It need not be the only cause, nor the last or nearest cause. It is sufficient if it concurs with some other cause acting at the same time, which in combination with it, causes the injury," end quote.

And that's what we're talking about here when we talk about hey, you know, some of these damages might be jointly caused by, for example Dr. Christianson and Dr. Brill, and I think that's important to know, and this sort of gets back to that last instruct, as well, that we're trying to make the jury understand, you do not have to find the damages were 100 percent caused by Dr. Brill. They could be jointly caused with other tortfeasors, if that's what the jury finds.

THE COURT: Okay. Ms. Hall?

MS. HALL: So the portion that is the issue is that this is a -- is this the negligence instruction?

THE COURT: Yes.

MR. BREEDEN: It is.

THE COURT: The proximate cause definition.

MS. HALL: And I'm sorry, what page is this of -- on this set?

THE COURT: Apparently, I have different numbers from you

all, so I'm not --

MS. HALL: Yeah, I'm sorry.

THE COURT: -- I'm not going to say anything more, but --

MR. BREEDEN: This is Plaintiff 's --

THE COURT: -- it's titled "negligence proximate cause definition."

MS. HALL: Found it. I'm so sorry about that. So this is a general negligence instruction that Plaintiff has offered. This is not a general negligence case. My issue is that this instruction is instructing the jury that Dr. Brill is jointly liable, and 41(a) abrogates joint and several liability in med-mal cases, so it would not be appropriate to give that portion of the general negligence instruction when this is not a general negligence case.

THE COURT: Anything else, Mr. Breeden?

MR. BREEDEN: Nothing further on this point, but clearly, we need to give a proximate cause instruction to the jury.

THE COURT: Yeah, and I --

MS. HALL: And I did offer 4.04.

THE COURT: Right, and I think -- well, I'm looking. It seems like that's the most recent pattern jury instruction with regard to proximate cause, so I'm inclined to give the Defendant's cause one. All right. On the next one, reasonable value of medical expenses, Mr. Breeden?

MR. BREEDEN: Again, the citations are given to the Curtis and the Quarry cases. This is accurate. Obviously, this instruction would

have had more relevance to this case had the hospital bills been admitted. However, we did, if you recall, there was quite a bit of testimony on this issue with Dr. Yeh's invoice, and then the jury did get to hear that my client has health insurance, and so they might speculate regarding the ambulance bill, as well, which is going to be presented. Again, I think everything on this instruction is accurate and it is pertinent to Plaintiff's case, so I would ask for this instruction to be given.

THE COURT: Okay. And before your argument, I think that I've already ruled that it's a medical malpractice exception under 42.021, so I'm fine with the first paragraph if you want to have that, but I don't think we should be discussing the insurance, I really don't since I already ruled on that previously.

MS. HALL: And I would agree to the first sentence, the mere -- the Plaintiff is entitled to recover the usual, customary, and reasonable value of medical expenses that you find to be causally related to the accident. I agree, that would be appropriate. It's the remainder, and I think it's directly contradicted by 42.021, which Your Honor, has already ruled is applicable here since this is a med mal case. It comments contrary to what the law is in a medical malpractice case, the remainder of the -- of the proposed instruction.

THE COURT: So Mr. Breeden, do you want the first paragraph or no?

MR. BREEDEN: Well, I would definitely want anything I can get from this instruction. You know, certainly, let -- you know, let me address this, and you know, I respect Ms. Hall, but Ms. Hall's

interpretation of that statute is incorrect. That statute says that evidence of payments is admissible. It does not tell the jury what to do with those, that evidence, and the payments, and it certainly doesn't comment on it, what is usual, customary, and reasonable, and if we look at the *Orth v Capanna* case, that is a case where this information came in of the insurance payments, and the jury still awarded the full amount, the charged amount, not the insurance reimbursed amount, okay, and the Nevada Supreme Court found no fault in that.

So I want to be clear, the state of the law is not that the reimbursement amount limits what my client can recover, but certainly by introducing evidence of that amount, that is what -- that is the impression that the Defense wants to give to the jury, and that is incorrect under that statute, respectfully.

THE COURT: Anything else, Ms. Hall?

MS. HALL: Just that the only bill that's at issue, that's been admitted in the case is the Henderson --

THE COURT: Ambulance?

MS. HALL: -- yes, and I don't recall there being any discussion of write-downs with respect to the Henderson -- City of Henderson Ambulance.

THE COURT: Is that your recollection, Mr. Breeden?

MR. BREEDEN: There was testimony as to Dr. Yeh's bill, as well, and the amounts and the reasonableness. I don't have to actually introduce the bill, I mean, the testimony is sufficient.

THE COURT: Right. But I mean, I think she just means there

was not -- there was not cross with regard to the ambulance, as to the bill.

MR. BREEDEN: As to the ambulance bill, I agree.

THE COURT: Okay. Let me -- I'm going to reread that statute and just to -- and then I'll read, reread *Orth and Capanna*, and then I'll decide that, and we're going to come a little bit early tomorrow, so if we have to insert one I'll reserve ruling on that. All right. As to damages, uncertainty as to amount?

MR. BREEDEN: Well, Your Honor, I think this is an accurate statement of the law that, you know, the jury does not have to be 100 percent convinced of all damages, and the language here is the not be proved with the mathematical exactitude, you know, there just has to be an evidentiary basis, not -- I think this is an accurate instruction for an injury case.

THE COURT: Ms. Hall?

MS. HALL: I just don't think this applies here, and there is a pattern instruction, and I'm blanking on the number, but it says -- I thought it was already in here, a measure of damages, but --

THE COURT: I think there is one about damages in here, I just -- I can't --

MR. BREEDEN: Agreed instruction 25 is a measure of damages.

MS. HALL: So I guess, first, I don't think this contracts instruction applies here, and I think it's already covered to the -- in an appropriate way in an agreed-upon instruction. There wasn't, for

instance, an economist or specialist to interpret a contract in this case.

THE COURT: If you're worried about the mathematical exactitude, is that the sentence that you most -- that you're most concerned with, Mr. Breeden?

MR. BREEDEN: I would say yes.

THE COURT: All right. So I'm inclined to -- the one that's already agreed upon, 25, add that sentence to the bottom of that, so under 30 of the amount of damages need not be proved. Okay. And we'll make that change, with mathematical exactitude, and the continuation of that sentence.

MR. BREEDEN: Thank you, Your Honor.

THE COURT: Okay. And then number proposed 6, opinions regarding other awards in cases must be set aside, Mr. Breeden.

MR. BREEDEN: Yeah. Your Honor, this is a non-standard instruction. And all that I would offer anecdotally is, of course, you know, my biggest concern as counsel for Plaintiff is that we will have a juror, and either they have some opinion that, you know, awards are outrageously high in this jurisdiction, so they should keep things low, or on the alternate side of it, maybe some juror thinks that they had an experience and awards are too low and they need to award higher.

This simply reminds the jury, look, you're supposed to base your award decision in this case based on the evidence you've heard in this case, not your opinion as to whether or not there's problems in this jurisdiction of awards being too high or too low. And I think it's a fair instruction.

THE COURT: Ms. Hall?

MS. HALL: I think it's very confusing. And there's been no evidence presented in this case of awards in other cases. So I don't think it's applicable in any way as to the evidence that came in during this trial.

MR. BREEDEN: You know, we had the McDonald's coffee case come up in voir dire, right? And I -- every juror in the country probably knows of that case, right? And that, that's why this is in here. You know, anecdotally, when you talk to these jurors after cases, you know, they'll tell you, oh, yeah, my cousin, you know, he went in for a case and he didn't get anything. You know, so I was thinking of that. And that's what this instruction is designed to address.

THE COURT: Okay. I think it's sufficiently covered by other instructions, especially because we repeatedly harp on that you must base your verdict solely on evidence in this case. So I don't think it's necessary. It's covered by other instructions.

As to the insurance collateral sources, you're not to discuss or even consider whether or not Defendant was carrying insurance. Mr. Breeden?

MR. BREEDEN: Well, this is a pattern instruction. It's been around for decades. My experience is that this instruction is given in every personal injury action, including medical malpractice actions. And we discussed this at length in a motion in limine several weeks ago. And frankly, this issue was definitively decided by the Nevada Supreme Court in *Orth v. Capanna* where this instruction was given in another medical

malpractice case just like I've requested. And then, plaintiff's counsel just made a very quick comment that, you know, look, if jurors are back there and they're worried about, you know, where the money is coming from, just please remind that juror that, you know, you're not supposed to consider insurance or the source of the money in coming to your ruling.

In this particular case, if you remember when we were doing jury selection, Juror No. 2 actually started it, and he kind of said, you know, I have a tough time making these big financial decisions. You know, a big decision that might adversely affect the parties. And then a couple of other jurors indicated they had the same concerns. And those are the exact type of jurors that might get back there, you know, maybe they would speculate this case is going to trial because Dr. Brill doesn't have insurance. I don't know. All possibilities.

But certainly, this is a pattern instruction. There's not a single deviation from the pattern instruction in here. And we already have a Nevada Supreme Court case that's about four years old that explicitly says, look, given this instruction in a med mal case, and allowing plaintiff's attorney to comment on it, isn't here. So I think that this should be given.

THE COURT: Okay. Well, I think that I addressed this already in the motion in limine arguments. And I think since there's been no evidence of Defendant's insurance, that precluded it and they said it wasn't relevant that given the instruction would be confusing to the jury. So I'm not going to give this one.

As to non-parties on verdict form, *Piroozi*, alternate 1, I did look at your alternates. And I know that Defense has one on my page seven. I'm inclined to give Plaintiff's Alternate 2 and then if you guys can agree -- if not, we'll see. But the last paragraph of Defendant's proposed page seven, which is basically the fault must equal to 100 percent at the end of your, Mr. Breeden, your alternate two, *Piroozi*.

MR. BREEDEN: I'm just looking for the Defense one.

THE COURT: I don't know what page it's on. Sorry.

MS. HALL: Hold on, and I'll find it.

MR. BREEDEN: It's okay. I think it's on page 16 of what I have.

THE COURT: "If you find more than one person at fault," is how it starts.

MR. BREEDEN: "The fault of one person may be greater or lesser than that of another," is that -- oh, I see. Yes. Yes.

THE COURT: The hundred percent portion. Yes.

MR. BREEDEN: Yeah. And so you're talking about on that instruction, you will just give lines 7 through 9, the last paragraph of that?

THE COURT: Correct, added onto your alternate 2.

MR. BREEDEN: I think that would be reasonable.

THE COURT: Ms. Hall?

MS. HALL: I'm sorry, Your Honor. I'm trying to find mine yet.

MR. BREEDEN: Heather, would you like to take a look at this

one?

MS. HALL: Okay. Thank you.

MR. BREEDEN: I'd need it back, but --

MS. HALL: Yeah. So it would be -- that's fine. That's fine, Your Honor.

THE COURT: All right.

MR. BREEDEN: Well Your Honor, I guess I should say by agreeing to that instruction, I am not waiving other objections that I have made that this is not an appropriate case to apply *Piroozi*.

THE COURT: Understood. All right. And finally, the explanation of verdict reading. Generally, this is something that I say orally. Any particular reason why you want it in an instruction?

MR. BREEDEN: Well Your Honor, I have not had every judge explain this and it's a non-pattern instruction. Obviously, if you didn't give this, then I wouldn't think it would be any kind of error. But I do know that sometimes, jurors are a little confused and they think maybe they're not supposed to speak to the attorneys afterward. And you know, we always like to get feedback from jurors about what they believed and why they believed certain things with liability and damages. And it would be nice to have something formal like this read to the jury. I'm not going to lose sleep over it if you don't read this because it sounds like you say that you normally --

THE COURT: I do.

MR. BREEDEN: -- say something like this anyway. But right here it is in black and white, and you know, if you'd care to read this,

then more power to you.

THE COURT: All right. I'm not going to give it because I definitely talk to them about it after they give their verdict. And then I go have a conversation with them, and then I allow parties to do the same if they want to.

All right. As to Defendant's proposed -- the first one is -- I don't know what page it is -- but with regard to the expert, it seems like it's the alternate expert jury instruction that begins, "Within this case, you've heard medical experts' express opinions." Ms. Hall?

MR. MCBRIDE: Actually, I'll address that, Your Honor. And again, Your Honor, this is, I think, a standard jury instruction that we provide and proffer in virtually every medical malpractice case. And it's 6.19, so I think it's just simply important to point this out relative to the weighing the credibility of the experts and the opinion which they want to give the appropriate weight to it. So I think it's a standard instruction and we would submit it should be given.

THE COURT: Mr. Breeden?

MR. BREEDEN: Yeah. Your Honor, were you referring to the instruction that begins, "A witness who has special knowledge, skill, experience"?

THE COURT: No, that was the agreed upon. This is their proposed. It starts with, "In this case, you have heard medical experts' express opinions."

MR. BREEDEN: Yes. I simply felt that this instruction was duplicative and repetitive of other instructions. Particularly proposed

instruction 7 and 12 of Plaintiff's proposed. And I'm sorry, I don't -- I didn't write the note down to the agreed one. But there are several instructions here that address medical experts, and I just didn't think that this was necessary in this case.

THE COURT: All right. I think it's sufficiently covered by the other expert and this needs to be the ultimate, so I'm not going to give this one. As to the next one, NRS 41A.100, provide one method of proving, on behalf of Defendant?

MR. MCBRIDE: I'm sorry, Your Honor. Let me get to that. The one that says NRS 41A.100?

THE COURT: Yes.

MR. BREEDEN: I had this on page 12.

MR. MCBRIDE: Yeah. That's what I have as well. Again, Your Honor, I think this is consistent with the new pattern -- or I mean the new jury instructions. I think to the extent that we've -- the issue of risks and benefits have been discussed. And also, your prior ruling about the consent, as well, and that instruction given by the Defense. I think this is something that needs to be added to make that make sense, basically, to the jurors.

THE COURT: Mr. Breeden?

MR. BREEDEN: This instruction is not applicable to this case because my client has not alleged a lack of informed consent. Therefore, this instruction is highly misleading and will suggest to the jury that if they find that my client has consented to the procedure, then they should not make an award to my client.

And I believe this is tied in -- and I'm sorry if I have this statutory citation wrong -- but I believe this is tied in or in the same statute that talks about res ipsa loquitur. And you can't even use that statute as a plaintiff if you retained an expert. And so it's just wholly not applicable. Not only is this not applicable because it's not a lack of informed consent case, but it is confusing to the jury for that reason. You know, the jury is going to wonder, well, why are we hearing these -- this instruction on, you know, when informed consent is established? Consent must be a defense in this case. And that's why I object to this.

THE COURT: All right. In light of the fact that I haven't allowed information about informed consent come in, I'm not going to give this instruction. I think it would be confusing to the jury. As to the mere fact that a complication occurred to the patient involved in this action is not sufficient of itself to predicate liability. On behalf of Defense?

MR. MCBRIDE: Yeah. I think this is an accurate statement of the law under the *Gunlock* [phonetic] case, Your Honor. I think it's, again, another standard instruction that we've given in the past. And it's been testified to by their own expert as well as other -- Dr. Brill as well as Dr. McCarus, too.

THE COURT: Mr. Breeden?

MR. BREEDEN: Yeah. Your Honor, I don't think Gunlock is actually the case most directly on point here. There are two other cases from the Nevada Supreme Court. They are *D & D Tire v.*, I believe it's

pronounced [oo-lay] or *Ouellette*, as well as *Cook v. Sunrise Hospital*. And in both of those cases, what happened was the defendant in a -- in *Cook v. Sunrise Hospital*, it was a medical malpractice action. And in both of those cases, the district court refused to give a mere happening instruction. And the defendants appealed and said, you know, this is error. We should have been entitled to this instruction.

And in both of those Nevada Supreme Court cases, Nevada Supreme Court says no, it is not error to refuse to give this instruction. So this has been litigated recently by the Nevada Supreme Court. And you know, *Cook v. Sunrise Hospital* is a 2008 case. And again, the facts of that are essentially identical to this case in terms of how the Defense wants to use this mere happening instruction. And not only the district court but the Nevada Supreme Court rejected this instruction in that case. And I would ask you to do what the judges in that matter did and not provide this.

I think it is confusing as well because it suggests that, you know, that there hasn't been competent evidence presented in this case. And I just oppose this instruction.

THE COURT: All right. I'm going to reserve ruling because I want to read those cases that you just provided --

MR. BREEDEN: Would you like --

MS. HALL: And Your Honor --

MR. BREEDEN: Would you like the actual cite, Your Honor?

THE COURT: I already have it.

MR. BREEDEN: Okay.

MS. HALL: And I would just point out, in your review, when you have an opportunity to review that, in the instruction that was given and disapproved in *Cook* varies pretty significantly from what we proposed.

THE COURT: Okay. All right. And the next on, a medical provider in treating a patient is not an insurer of favorable results. On behalf of the Defendant?

MR. MCBRIDE: Yes, Your Honor. This is a jury instruction that's already been offered, again on the basis of a hindsight instruction. It's something that Plaintiff's counsel -- excuse me -- that Plaintiff's counsel actually has even questioned Dr. McCarus as well as I've questioned Dr. Berke on this issue. And the fact that just to point out that they're not -- a medical provider is not an insurer of favorable results. And this also, "and the concept of negligence does not include hindsight." And I think it's supported by the *McNabb v. Landis* case.

MR. BREEDEN: And Your Honor, from Plaintiff, the citation that's given for this proposition, by the way, *McNabb v. Landis,* that's a Georgia Court of Appeals case from 1996. I appreciate that perhaps some judge in the state of Georgia gave a highly defense-oriented, defense-friendly instruction. It should not be given in this case. I think the particular risk here is that it suggests to the jury, you know, when it says, "A medical provider is not an insurer of favorable results," we have not alleged that any specific guarantees were given in this case. This instruction suggests that if a specific guarantee wasn't given, then that liability should not be found in this case.

And to my knowledge, this instruction has not been used in other district court cases or the Nevada Supreme Court. Sounds like Mr. McBride and Ms. Hall are trying to get this in their cases because this is one of the most defense-oriented instructions I have ever seen. And I would very vigorously oppose this instruction.

MR. MCBRIDE: And Your Honor, if I can offer, the last -- to clarify Counsel's concern, it was offered and accepted in the last jury trial that I had last week in this very same courthouse. So I think it is a jury instruction that has been given routinely in cases where the issue of hindsight is become a factor or an issue in the expert's opinions. So I think it's appropriate jury instruction.

THE COURT: Okay. I mean, other than the hindsight, the first paragraph seems to be sufficiently covered by the physician's negligence agreed upon instruction as well as the standard of care instruction, the duty owed to the patient.

MR. MCBRIDE: Again, the term hindsight, I think, Your Honor, is more of a layperson, you know, colloquialism, basically, that jurors are familiar with. And I think it's merely restating the paragraph in a way that they can understand it.

MR. BREEDEN: One of the other problems I would have, particularly with hindsight, Your Honor, is the retained experts can only review what happened in this case with the benefit of hindsight to try to figure out, you know, what was done and where the standard of care was either met or breached. The word hindsight may have even come up in Dr. Berke's testimony. And you know, I would hate for them to

play that and then all of a sudden, then they flash at this instruction and say, negligent doesn't include hindsight. Dr. Berke can only rely on what's happened before him. He's a retained expert.

MR. MCBRIDE: Well again, as Dr. McCarus has pointed out, he enters into the situation -- everyone, including, actually, the jury, based on the evidence that's been presented, has seen how hindsight may enter into a situation because that's why we're here in court. But the concept of negligence is -- does not include hindsight, I think it's an important distinction to make. And I think that that's why, you know, there is a point in, you know, explaining this concept to the jury. And it's appropriate when the evidence raises any issue as to whether the claim is premised on later acquired knowledge.

THE COURT: All right. Simply because I think it's sufficiently covered by the instructions; I'm not going to give it. I think both parties brought up hindsight and I think you can sufficiently argue it in closings based on the evidence as presented. So I'm not going to give that one.

As to "if you find more than one person at fault for Plaintiff's injury"?

MR. BREEDEN: We covered this one already, Your Honor.

THE COURT: Yeah. Yeah. That was the -- combined with their number 9.

All right. On to the --

MS. HALL: That's it. Verdict.

THE COURT: The verdict form. So then those are the three that I -- the three that you need to agree upon, or decide if you can, to

insert with the other instructions are the risks for complication, the proximate cause one, and the *Piroozi*. And then I reserved ruling on 2. And I'll give you my ruling tomorrow and we'll make that adjustment. But I'll ask you if you have an order preference.

And then on to the verdict forms. Okay. So there was -- and correct me if I'm wrong -- there was no indication of future pain and suffering or future treatments, correct?

MR. BREEDEN: There were no future medical expenses and I think we agreed to remove that. But there was future discomfort with bowel movements and from the surgery itself. There was testimony from both Dr. Berke and Ms. Taylor to that effect.

THE COURT: Okay. All right. So as to -- I mean, I'm going to tell you what my inclination is and then obviously, I'll let you make a record. In looking at both, I understand the Defense breaking everything up. I just think it's a little bit overwhelming for the jury to break it up like that. However, for Plaintiff's proposed question 5, if I am inclined to give Plaintiff's version, I think that we should break up the Hutchins and Henderson Hospital and Christensen and St. Rose. Is there a reason why you didn't, Mr. Breeden?

MR. BREEDEN: Yes.

THE COURT: On page two.

MR. BREEDEN: Because the liability of those providers is derivative or vicarious. In other words, the only theory of liability against Henderson Hospital was that they are the employer of Bruce Hutchins.

THE COURT: Thank you for that definition of vicarious liability.

MR. BREEDEN: I'm sorry?

THE COURT: Thank you for that definition of vicarious liability. I did -- I am aware of that. But I just, you know, I also think it's confusing to the jurors to put together. So I just wanted to hear your basis. So that's --

MR. BREEDEN: So the problem is that, you know, maybe the jury goes down and they're just filling in 10. Okay. 10 percent here, 10 percent there, 10 percent here. So then they would have assigned, you know, an additional 10 percent of liability to Henderson Hospital, when their liability is just derivative of Nurse Hutchins. And then the same issue with St. Rose. And by the way, the issue with St. Rose was even perhaps a little more tenuous because I think the only theory against St. Rose was a parent agency or agency by estoppel or ostensible agency, whatever term you want to use, because Dr. Christensen was not even a direct employee of St. Rose Hospital.

THE COURT: All right.

MR. BREEDEN: So --

THE COURT: And then as to your question 3. Are you inclined to separate the past pain and suffering, emotional distress from the future into a third part? Anything on that?

MR. BREEDEN: I would just prefer that those be one entry. There's no reason to divide it between past and future.

THE COURT: On behalf of Defendant?

MS. HALL: I know that originally, the verdict form that we had submitted did not break it down. And I know it's a lot on a verdict form. But I'm worried that if we don't have a question that asks them did there breach of -- was there a breach of the standard of care by this other party or individual? Did that breach cause injury? I'm afraid that invites error that we don't have that broken down. And a determination by the jury that the breach of the standard of care, if any, from that other individual caused injury or damage to the Plaintiff.

MR. MCBRIDE: If I may, Your Honor? It's also important, relative to the *Piroozi* case, to make sure that we're consistent with that. Because one of the issues in the *Piroozi* case is that if there was another care provider, that misconduct caused the alleged negligence as support by medical expert testimony. You still have to find the elements of that claim of the breach, the duty, and so on.

So I think Ms. Hall is correct. The concern is that invites error because it doesn't break that up. We have that testimony from the Plaintiff's expert from Dr. Berke. And that's where I think -- if we need to, we're going to remain consistent with the *Piroozi* decision. We need to have it broken down that way. And as -- I understand that it is -- does create a lengthier verdict form. But in order to follow the law accurately and avoid any issues of error, I think we need to -- Defendants would propose ours.

THE COURT: All right. Well, I mean, I don't necessarily think Plaintiff's doesn't follow the *Piroozi*. I mean, we do have the breakdown; it's just in one question versus broken up.

MR. MCBRIDE: Well, it doesn't discuss the standard --

THE COURT: The standard of care. Right.

MR. MCBRIDE: Standard of care. And that's -- again, I think that the issues that --

THE COURT: It just has faults?

MR. MCBRIDE: Right.

THE COURT: Mr. Breeden?

MR. BREEDEN: Well, my biggest -- I don't know if there's one point in particular you wanted me to speak to, but my biggest issue with the Defense proposed is that they essentially lack something similar to question number 4 on Plaintiff's proposed. Which is to say that look, if the jury is going to apportion among different providers, they need to tell us what dollar amount or what damages they are apportioning because the testimony in this case is not that all the doctors created the same damage.

The testimony is that there is only a little window of delay time there, and that the delay did not actually cause the bowel resection surgery. That that was going to be needed regardless of whether this was found out in the first hour or 24 hours later, like it actually was. So that was my biggest problem with the Defense proposal is that they seem to want to get a number like 10 percent on there, and then come and argue, well, you got to reduce this entire verdict by 10 percent. And that would be incorrect under the law, in my opinion.

THE COURT: But don't they cover it in the allocation portion?

MR. BREEDEN: So what -- again, so let's say in the allocation

portion -- are you looking at Defense proposed?

THE COURT: Yes.

MR. BREEDEN: I have it on my phone here. So if you see in part 3?

THE COURT: Right.

MR. BREEDEN: They have allocation of negligence.

THE COURT: Uh-huh.

MR. BREEDEN: But they do not discuss what portion of the total damages is being allocated, and that's the problem. And, again, we talked about this a little bit in the motion in limine. My frustration that Piroozi is only very easy to apply if you have a case with the facts of Piroozi, where that was a failure to diagnose, where three or four different doctors had a chance to diagnose a very serious condition. And as a result, I think there was serious brain injury in that case.

So you have one set of damage there that it was alleged all the doctors were responsible for causing in different proportions. You don't have that here. Now, you have to proportion, well, what damages are you saying were severely caused? What proportion of that? And then of that that you find more than one healthcare provider contributed to, how would you apportion that liability? And that's what the problem is and why it's so difficult to do a jury form in this case.

And I've tried to propose something that I thought was reasonable and understanding to the jury, but. Again, my biggest concern is you're going to get a juror and they mark down, let's say, 10 percent for Bruce Hutchins. That would not result in an off the -- across

the board 10-percent reduction in damages in the case.

You would have to have the jury somehow tell us, okay, you said 10 percent for Bruce Hutchins. Ten percent of what? You couldn't say 10 percent of the bowel resection surgery because the irrefuted evidence is Nurse Hutchins didn't cause that. And I'm sorry I'm struggling. I'm trying to explain my position in different ways because it's a complex legal issue, and it's hard for me to express it clearly. But those are my concerns.

THE COURT: Ms. Hall?

MS. HALL: So briefly. The question number 3 on Plaintiff's proposed. That doesn't -- that asks the jury to decide a number for past medical expenses for future and past pain and suffering. It doesn't say what of that do you attribute to the bowel injury itself and what do you attribute to the pain and suffering the Plaintiff experienced as a result of the delay in diagnosing bowel -- and on and on and on.

That's something that certainly Mr. Breeden can argue in closing argument. But in terms of being on the actual verdict form, I don't think that that would be appropriate to say what do you apportion to the bowel resection? What do you apportion to the period in the PACU where she was in pain and that no doctor was called? What do you apportion for her pain and suffering when she goes to the ER for the first time and Dr. Christensen doesn't diagnose? That's something that Counsel can bring up in closing argument.

But in terms of putting it on the verdict form and to have question 3 and question 4, you're now asking -- I think that is going to

potentially result in confusion if there is a verdict in favor of Plaintiff because you've got a section where they have to complete what is the past medical expenses? What is this, what is that? And now, you're saying if you find that the other providers are partly responsible, explain the total amount of damages for which you think Dr. Brill and another provider are jointly caused -- or another provider jointly caused.

Well, that's already up top in question 3. They've already decided the amount of the damages. It's then their role to decide allocation of fault, and then the Court will decide what that does to the verdict, post-verdict.

THE COURT: All right. I mean, I agree. I don't want to have them trying to do math either on the percentages because I think that will be a mess. But let me -- I want to think about the standard -- the brief and the standard of care as to breaking it up to all three.

MR. MCBRIDE: And can I -- if I could just offer, Your Honor? This is a very -- we experienced this case, a situation in almost every other case where there has been multiple defendants. And that has been the same way since Piroozi five, seven years ago. And in fact, in the last case -- again, I hate to bring up prior cases, but it's just something that this is taken almost identically from the prior case.

It's not something we're just making up out of thin air. It's based on standard and hashed out, agreed upon verdict forms with other defendants and plaintiff's attorneys who do medical malpractice cases and have dealt with the issues of *Piroozi*. This is a Piroozi case. I understand Plaintiff's counsel is arguing that the fact -- he claims that the

facts are different, but this is *Piroozi*.

And this is exactly the type of verdict form that it is designed to avoid any possible error. And so that's why the Defense would submit that ours is appropriate, it's consistent with Piroozi, and it makes it easier for the jury to consider without having to make it too complicated.

THE COURT: Okay.

All right. So I'll let you guys know in the morning. Can you quickly decide where you want these three to go so that we can get the majority of them done aside from the ones I'm reserving ruling on?

MR. MCBRIDE: Sure.

MS. HALL: Yes.

MR. BREEDEN: I believe I took some notes, and I think it can be accomplished pretty quickly. Did you want to do it while you were here, Your Honor? Or you want me to --

THE COURT: Yeah.

MR. BREEDEN: So the risks are complication. I believe that would be appropriate after agreed instruction number 24.

THE COURT: And on behalf of Defense?

MR. BREEDEN: Which is the instruction on standard of skill and care in national.

MS. HALL: Sure, I don't have a problem with that.

THE COURT: All right. So we'll put that up through 24. And then the proximate cause?

MR. BREEDEN: I think that should be given right after the

risks and complications.

MS. HALL: I think that would be more appropriate to put it after the definition of --

THE COURT: Negligence?

MR. MCBRIDE: Yes.

MS. HALL: Yes.

THE COURT: Where is that at?

MS. HALL: Let me find it.

THE COURT: Number 19 or 20? Or even 21 because it goes on --

MS. HALL: I think it should go maybe after Plaintiff's burden of proof.

THE COURT: Okay.

MS. HALL: The Plaintiff has the burden to prove by a preponderance of the evidence.

THE COURT: After 21.

Mr. Breeden?

MR. BREEDEN: That would be acceptable.

THE COURT: All right. And then the non -- the *Piroozi* one.

MR. BREEDEN: I think that should go after agreed instruction 26 on pain and suffering, no definite standard. Right before the closing instruction.

MS. HALL: I think it might fit better if we put it somewhere -- I mean, we're talking about the definition of negligence. I think it would be more appropriate to put it maybe after the definition of

standard of care, which is before measure of damages.

MR. BREEDEN: So the Defense wants to stick that in there by the risks and complications instruction? I wouldn't have an objection to that.

MS. HALL: No, there's the standard of skill and care, and that it's a national standard. I think it would go well after that one.

MR. MCBRIDE: Before measure of damages.

THE COURT: Before risk. We inserted risk there.

MS. HALL: Yes, I'm sorry. Then before risk.

MR. BREEDEN: That's fine, Your Honor.

THE COURT: Mr. Breeden? Okay.

All right. So I'm going to -- you know what? Since I'm reserving ruling on two, we'll get here at 10 tomorrow. I told them 10:30. And I'll add the other two and then I'll read them on the record just so I don't want to read them now and then have an issue with ordering tomorrow.

MR. MCBRIDE: Yeah, that's smart. Yeah.

THE COURT: So we'll do that. And then I'll go over the verdict form as well. And I'm going to ask that you -- the ones that haven't been submitted, I know you technically submitted them. But what I request, and I don't know if you guys do this. We do it in criminal. Where you -- so you have a pleading sheet that says Defendant's proposed but not given, Plaintiff's proposed but not given to submit as a court exhibit for the appellate record.

MS. HALL: Okay.

THE COURT: So I'm going to ask the ones that I did not give that you do that for tomorrow.

MR. BREEDEN: You want me to just file and serve my own or you want a different exhibit given to you?

THE COURT: Just file it with the Court.

MR. BREEDEN: Yeah, okay. That's how I would handle it.

THE COURT: Yeah, okay. And then anything else outside the presence?

MS. HALL: No.

MR. BREEDEN: Nothing further from Plaintiff.

THE COURT: Oh, one more. The agreed upon you sent. "Although you are to consider only evidence in this case reaching a verdict", where do you want to put that?

MS. HALL: You want to put that one after the sympathy or before the sympathy one?

MR. BREEDEN: I'm sorry. Which one are you discussing?

THE COURT: The one that you guys just submitted today. "Although you are to consider only the evidence in this case in reaching a verdict, you must bring to the consideration of evidence".

MR. BREEDEN: That will be fine.

THE COURT: Put it where?

MR. BREEDEN: After the --

MS. HALL: What was the title, Adam? Do you recall?

MR. BREEDEN: I'm sorry, I don't.

MS. HALL: Hang on one second, Your Honor. Sorry, I don't

remember.

MR. BREEDEN: Maybe after agreed instruction 7, which talks about evidence, statements, lawyers, and rulings?

MS. HALL: Sure. I'm fine with that.

THE COURT: After 7. Okay. And then one more thing. The discussion of trial and media coverage. You seem to -- I'm supposed to give the *Bowman* instruction, which is essentially my admonishment that I give them every time we take a recess. So I have to put that in an instruction. This is kind of includes some of it, but not all of it.

So I just wanted to know what do you want to do with your number 2? I mean, mine's literally the don't communicate anyone anywhere regarding any merits of the case; reach, watch or listen to any news or media accounts. So it kind of has some of number 2, but not exactly how I'm supposed to give it.

MS. HALL: I think this was the one that I had -- in our discussion yesterday, I had said I don't really think it's needed, but I don't have a problem giving it.

MR. BREEDEN: I don't -- Your Honor, I'll leave that up to your preference. You can remove that one, if you like, if you think it's already covered by what you would already ready. Just as long as the jury is reminded of that.

THE COURT: And then secondly, actually 14 covers part of it, too. The independent investigation. So are you okay with me removing 2 and 14 and replacing it with the *Bowman* instruction as advised by the Nevada Supreme Court?

MR. BREEDEN: I would be comfortable with that.

MS. HALL: Same.

THE COURT: All right. Anything else?

MR. BREEDEN: Well, yeah.

MR. MCBRIDE: I don't believe so, Your Honor.

MR. BREEDEN: Your Honor, I think you said you were going to check and see if the actual Symphion device can go back into the jury room?

THE COURT: Oh, yeah. So with respect to that -- and correct if I'm wrong. That is -- there was testimony that that's not the same measurements. It's a different device, right? Like, that was simply demonstrative; is that correct?

MR. BREEDEN: It is the same -- not the one that was actually used on Ms. Taylor.

THE COURT: Well, of course not, obviously.

MR. BREEDEN: But it's another model of the same device.

THE COURT: But I thought there was testimony that that was a different size, and --

MR. MCBRIDE: It's different than the hysteroscope, which is what Dr. Brill brought. That mechanism where the Symphion slips inside. That's where it might be confusing to the jury because that's something that had to go back to the hospital. So that's not going to be --

THE COURT: Right. So it's not -- my question is it's not the actual --

MS. HALL: It's the actual Symphion used on Ms. Taylor during surgery.

MR. MCBRIDE: Right.

MS. HALL: So --

THE COURT: I know that. But it's not even an exact replica of the actual tool that was used?

MS. HALL: Correct.

THE COURT: It's just demonstrative purposes for that portion.

MR. BREEDEN: Oh. I believe it to be the actual tool that's used.

THE COURT: Missing a part.

MR. MCBRIDE: The hysteroscope that it goes into.

MR. BREEDEN: Well, yeah. The hysteroscope is the camera portion of it that that part goes through, but.

THE COURT: Right. Okay, so. I mean, this is -- I'm not inclined to send that back. It's demonstrative evidence. You can absolutely use it in closing. But because I don't -- if it's not the exact that everyone's been testifying to, which they break it down between the different parts, then I don't see a purpose for it going back. I do think there's a lack of foundation there.

MR. BREEDEN: And so I'm sorry. You're saying if I brought in a hysteroscope and the whole Symphion system, which is like on a cart and everything, that you would consider that?

THE COURT: I mean, quite frankly, I don't think

demonstrative evidence should go back, period.

MS. HALL: Nor do I.

MR. MCBRIDE: And I would agree with that as well, Your Honor. I don't --

THE COURT: I think admitted evidence is really the only thing that would go back. And that's what goes back in criminal cases. Like if there was a gun, it would be the gun that was used.

MR. MCBRIDE: Yeah, yeah. And I could --

THE COURT: Or you know, anything else. The money, the drugs. It's not demonstrative evidence. You can absolutely use it during closing. But when I was thinking about it and going back to the testimony I recall, I thought someone even said it was a different size, so.

MR. MCBRIDE: I think the other issue is we can't with any certainty because it -- you know, to determine whether or not this was the same Symphion device in use in 2017 at the time of her surgery. And that's another -- I think that's another issue altogether, but. I agree without having those two devices together.

First of all, I don't think it should be allowed anyway because it's not -- it's just demonstrative. But I think without -- it would be like offering up a gun with half the parts to, without the actual chamber or whatever that you would use -- you would have the bullets come through. So it would be different than -- there's just no reason to offer it without the actual hysteroscope.

MR. BREEDEN: Your Honor, I think what you're thinking of when you say something is a different is you're thinking of the curette

that Ms. Hall showed. And she showed a number 4 curette, and a number 2 was actually used during the procedure. I'm not talking about introducing the curette or allowing the jury to see and handle that up close. I'm talking about the resectoscope device.

THE COURT: I understand. And I still think it's demonstrative. You can use it in closing, but I'm not inclined for it to go back to the jury.

MR. MCBRIDE: Thank you, Your Honor.

THE COURT: Anything else?

MR. BREEDEN: 10 a.m. tomorrow?

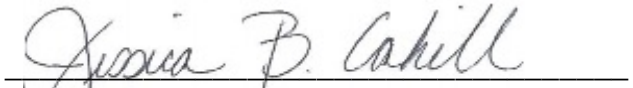
THE COURT: 10 a.m., and then they'll be here at 10:30. And hopefully, we'll have a few minutes to have a break before we start.

MS. HALL: Thank you.

THE COURT: Thank you. Have a good evening.

[Proceedings adjourned at 5:03 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.



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